HEALTH INDICATORS – MODEL B HEALTH CARE UNITS

Correia, Clara GP Nurse – USF Sta Joana
Matos, Virginia Technical Assistant – USF Sta Joana
Rocha, Carla GP Nurse – USF Sta Joana

Corresponding author: Clara Marisa Correia – marisaclara09@gmail.com

Introduction

Health care indicators are measurement units that allow the periodical monitoring and evaluation of the variables in an organization. Variation is achieved through comparison with the corresponding benchmark standards [1].

In broad terms, health care indicators are summary measures that indirectly reflect relevant information on different attributes and health care dimensions and on its determining factors, including the health care system performance [2].

They are, therefore, «representatives», «translations» of phenomena we aim to know and monitor, presented in consensual technical language, and have the capacity to keep us informed on their status and relevant changes, at any given moment.

Indicators may be used for evaluation, establishing priorities, ongoing quality improvement, quality system and care documentation, comparing results between health care units or even for the comparison of results within the same health care unit over a period of time (benchmarking).

Their goal is to support health care professionals in quantifying, qualifying and comparing their activity; they serve as a basis for the contractualization process, and support of the ongoing quality improvement processes, to allow a rational and sustainable management [3].

The objective of this article is to present some of the health care indicators used by ACeS Baixo Vouga for the Model B Health Care Units, and the contractualization methodology for those indicators.

Methodology

Contractualization [4], is an instrument of goal oriented management, operated through:

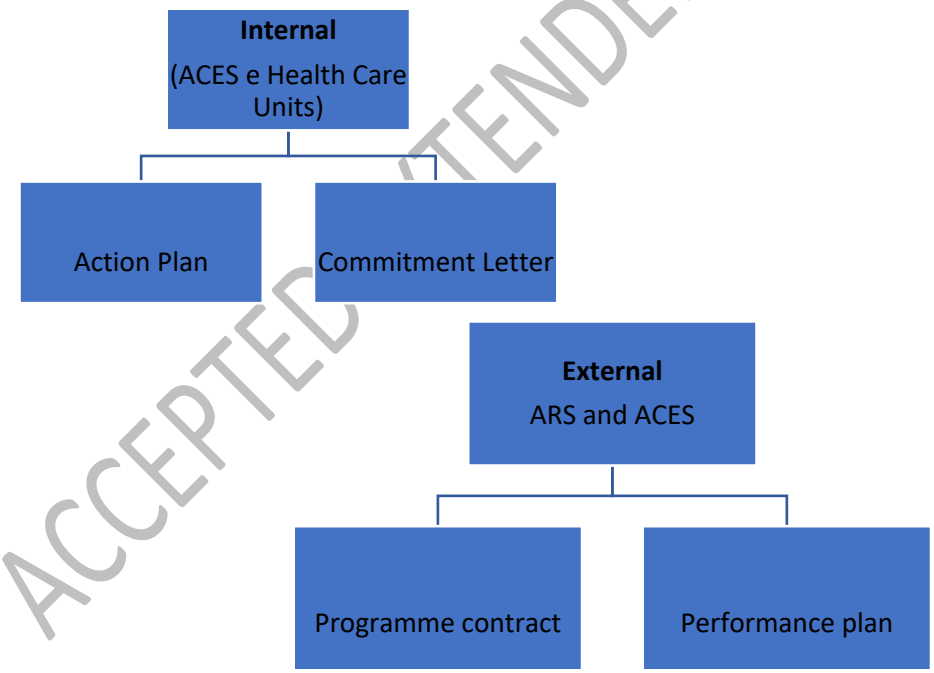
- A commitment to achieve contracted results;

- Based on health care needs (National Health Plan, Regional Health Plan, Local Health Plan);
- Oriented towards health gains;
- Clearly identifying and allocating resources (human and material);
- Monitoring, accompaniment and evaluation.

It is used to improve results, optimizing health care provision:
- Guaranteeing functional autonomy of different level organizations;
- Adapting and rationalizing funds and resource usage;
- Holding responsible and accountable all parties involved in planning, managing, operationalizing, monitoring, and evaluating the health care services provided.

Contractualization is a negotiating process between two different level organizations, whose main values are: Transparency, Rigor, Engagement, Rationality, Proximity, and Leadership.

Figure 1 – Contractualization Process [5]



Operationalized by the negotiation of a multi-annual Action Plan (3 years), establishing annual objectives, centered on the patient (person/citizen/family/community), focusing on results and oriented by the care process (defocusing from the health care professional):
- Management of integrated care pathways;

- What should happen: expected results and acceptable variation [4]

Table 1 - Indicators from ACeS Baixo Vouga – Model B Health Care Units (2018)

		Indicador		Min aceit	Min esper	Máx espe	Máx aceit
Access	Coverage or usage	**3**	Rate of medical home visitations for 1.000 enrolled	12	18	35	40
		6	Rate of medical appointments usage – 3 years	80	85	95	100
		99	Rate of nursing appointments usage – 3 years	70	75	85	90
		330	Index of annual medical appointments usage	0,9	0,94	2	2
		331	Index of annual nursing appointments usage.	0,8	0,88	2	2
	Distribution of daily appointments with the patient present	**346**	Proportion of appointments in the time interval [8; 11[h	15	20	30	35
		347	Proportion of appointments in the time interval [11; 14[h	20	23	32,5	35
		348	Proportion of appointments in the time interval [14; 17[h	20	23	32,5	35
		349	Proportion of appointments in the time interval [17; 20] h	10	15	25	35
	Personalization	**1**	Proportion of appointments by the Family Doctor	75	78	88	90
		5	Proportion of appointments by the Family Nurse	60	65	75	80
	Appointments on the day	**344**	Proportion of appointments on the day they were scheduled	15	20	35	45
	Guaranteed maximal response time	**335**	Proportion of appointments for prescription renewal 72H	80	85	100	100
		342	Proportion of appointments scheduled by patient <= 15 work days	60	65	100	100
Health Management	Management of the diabetic patient	**39**	Proportion of diabetics with HgbA1c <= 8,0 %	50	60	100	100
		261	Proportion of diabetics with registered risk of diabetic foot ulcer	75	80	100	100
		274	Proportion of type 2 diabetics with indicated for insulin therapy	75	85	100	100
		275	Proportion of type 2 diabetics indicated for metformin as a monotherapy	60	70	100	100
		350	Costs with diabetics therapeutics	120	120	300	320
		351	Costs with controlled diabetics therapeutics	120	120	300	320
	Management of respiratory disease	**49**	Proportion of COPD patients, with FeV1 every 3 years	40	60	100	100
	Management of patients with Arterial Hypertension	**20**	Proportion of hypertensive patients < 65 years, com BP < 150/90	50	67	100	100
		352	Costs with hypertensive patients therapeutics	50	50	90	95
		353	Costs with controlled hypertensive patients therapeutics	50	50	100	105
	Multimorbility	**365**	Rate of avoidable hospitalizations in adult	0	0	800	900

			population				
Health Management	Women's health care	**11**	Proportion of pregnant women with at least one medical appointment in the 1st trimester	70	75	100	100
		45	Proportion of women [25;60[years with cervical cancer screening	47	52	100	100
		295	Proportion of puerpera with 5+ nursing prenatal appointments and postpartum checkup	70	75	100	100
		307	Proportion of pregnant women with 1st trimester ecography	70	75	100	100
	Adult health care	**46**	Proportion of patients [50; 75[years with colorectal cancer screening	47	52	100	100
		98	Proportion of patients >= 25 years with tetanus vaccine	85	92	100	100
		262	Proportion of patients with type 2 diabetes risk assessment (every 3 years)	10	22	100	100
	Elderly health care	**30**	Proportion of elderly patients with chronic conditions with flu vaccine	50	55	100	100
		294	Rate of nursing home visitations per 1000 elderly patients enrolled	500	650	1650	1650
		297	Proportion of elderly patients with no prolonged prescribed therapeutics of anxiolytics/sedatives/hypnotics	77	80	100	100
	Child and youth health care	**14**	Proportion of newborns with at least one medical appointment up to the first 28 days of life	85	95	100	100
		93	Proportion of 2 year olds with the National Vaccination Plan completed or in completion	95	98	100	100
		94	Proportion of 7 year olds with the National Vaccination Plan completed or in completion	95	98	100	100
		95	Proportion of 14 year olds with the National Vaccination Plan completed or in completion	95	98	100	100
Prescription Qualification	Pharmacotherapeutic prescription	**255**	Ratio of billed quinolone and antibiotics (per package)	0	0	8	10
		257	Ratio of billed cephalosporin and antibiotics (per package)	0	0	5	7
		259	Ratio between billed DDD of coxibs and billed NSAIDs	0	0	12	15
		276	Ratio between prescribed DDD of DPP-4 and oral antidiabetics	0	0	36	40
		341	Costs with prescribed subsidized drugs per average patient	90	90	130	135
	Complementary Diagnosis and Therapeutic Means prescription	**354**	Costs with subsidized Complementary Diagnosis and Therapeutic Means for average patient	25	25	45	50

Outcomes [4]

Accompaniment, monitoring, and performance evaluation of all intervening parties and respective interactions and determinants, allowing the qualification and explicit acknowledgement of:

- Levels of performance. Allocation of incentives for higher performances and implementation of accompaniment and improvement processes for lower performances.
- Impact of financial constraints. Resource limitations and its appropriate weighting on performance levels.

References:

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[5] Operacionalização da Contratualização nos Cuidados de Saúde Primários para 2019. Administração Central do Sistema de Saúde, IP. 2019.