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Data driven healthy weight services and the global context

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The English National Childhood Measurement Program aims to establish the Body Mass Index (BMI) of approximately 1m school children every year. Data from this rolling initiative is used to inform the healthy weight services provided in the primary care setting across England. Data are also used to allow analysis of trends in growth patterns, and for as a vehicle for engaging children and families on matters of healthy weight. This national program that feeds into regional service planning is an excellent model for countries aiming to extend health coverage through better surveillance and strategic use of data. The model also provides cautionary lessons, as disadvantaged groups with the highest prevalence of obesity can be systematically excluded from data-collection: Schools for children with special needs are often exempted and BMI is an inappropriate measure of healthy weight in children with certain disabilities. Means for identifying and overcoming these barriers are discussed, along with the broader use of epidemiological surveillance in service of universal health coverage. The political economy of the British health system is discussed in reference to other models of provision around the world.

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The implementation of the balanced scorecard in the clinical departments

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Aim: The Balanced Scorecard (BSC) has been implemented in many hospitals worldwide providing positive results in the area of effectiveness, patient's satisfaction and reaching financial goals. Only few hospitals in Poland implemented the balance scorecard, none of them was a clinical hospital. Authors attempted to implement this method into the obstetrics and gynecology departments in one of clinical hospitals in Warsaw. The aim was to find out if this management tool will enhance effectiveness and quality of medical services in polish single payer healthcare system.

Methods: The researches were divided into two stages. The purpose of the first stage was to design the strategy map and the balanced scorecard. First series of workshops were held with hospital managers, the director of obstetrics and gynecology departments, physicians and nurses. Within 40 hours of discussion, nine strategic goals with more than 60 potential measures and initiatives have been defined. The purpose of the second stage was to implement designed balanced scorecard, monitor the defined measures and the results of the implementation into the departments.

Results: Implementation team did not manage to monitor all the measures in previously planned time period. Physicians and nurses resisted to implement improvements because it required additional working hours and there was no financial motivation for them. However, there were some promising initiatives among the departments. Therefore, the quality of services increased, the series of new procedures were introduced and housing conditions were improved. As a consequence, some measures such as number of treated patients, number of given births slightly improved. Unfortunately, no financial goals were met.

Conclusion: Polish single payer healthcare system does not promote effectiveness and also does not promote the quality of care provided. Potential outcomes does not motivate the hospital managers to make the implementation or use the balanced scorecard. This causes many difficulties in the researches, because successful implementation demands strong support from a hospital managers. This is an example of how single payer healthcare system needs to improve the way of contracting in order to promote quality of care and effectiveness of internal processes.

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