



health quality
and complaints
commission

Credentialing

An HQCC perspective

Bundaberg - a short history
Mackay - a more recent history
Role of HQCC standards
Beyond credentialing

M.Ward August 2008

Bundaberg - a short history

Date	Event
April 2003	Dr Patel appointed
May 2003	First complaints
Oct 2004	Multiple adverse outcomes documented
Feb 2005	Chief Health Officer Audit
Mar 2005	Whistleblower (Toni Hoffman) goes public
May 2005	Dr Patel leaves Australia
Sept 2005	Publication of (Forster) Qld Health Systems Review
Nov 2005	Publication of (Davies) Qld Public Hospitals Inquiry
July 2008	Dr Patel extradited from USA to Australia



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Key findings Davies Commission

- Dr Patel
 - Deficiencies in surgical assessment, technique, post-operative management & follow-up
- Medical Board
 - Failure to find readily available evidence of USA malpractice and restrictions on practice
- Qld Health
 - Inappropriate use of 'Area of Need' mechanism
 - Suppressive response to complaints
- Hospital
 - No effective credentialing / privileging
 - Inadequate supervision and monitoring of performance
 - Permitted complex surgery beyond capacity of hospital
 - Poor management of persistent complaints

Key findings Davies Commission

- Qld Government
 - A 'culture of concealment'
 - Hospital performance data declared "cabinet in confidence"
 - Funding,
 - 14% less per capita < national average (all health)
 - 20% " " " " " " (hospitals)
 - Historical / activity based model driven by a preoccupation with elective surgery waiting lists

Key findings Davies Commission - Credentialing

(there was a failure) “to realise the essential purpose of credentialing and privileging; to assess the clinical skill and competence of a doctor to perform the task for which he or she is to be employed, before commencing work.”

Mackay - key conclusions

- Inadequate exchange of key past and current performance information amongst:
 - Royal Australasian College of Surgeons
 - Mackay Hospital
 - Medical Board of Queensland
- Inadequacies:
 - Surgeon
 - Poor judgement / surgical & interpersonal skills
 - Mackay Hospital:
 - Credentialing -delayed / poor processes
 - Poor performance management / reporting
 - RACS:
 - Suboptimal response to performance reports



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Mackay - Key recommendations

- Australia-wide reporting system for tracking the performance of registered health professionals
- Legislation to require information about unsatisfactory periods of supervision / reduction of clinical privileges related to special purpose registrants be transferred between relevant employers, specialist colleges registration boards
- Legal protection for health providers participating in the credentialing process
- RACS should review their policies and procedures regarding the management of concerns and complaints about surgeons for whose training or development they are responsible

Bundaberg and Mackay

Common Features

- Known history of problems not discovered or revealed
- Inadequate credentialing
- Inappropriate use of "Area of Need"
- Problems apparent within a few weeks
- Inadequate performance monitoring
- Whistleblowers required to get action
- Workforce-stressed provincial hospital with probably unrealistic community expectations



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Post Bundaberg improvements

- Changes to Medical Registration Act
- Formation and activities of HQCC
- Improvements in IMG registration and assessment
- Funding
 - Substantial increases
 - Shift to casemix determined model
 - Clinical Practice Improvement Payment Trial
- More open reporting eg
 - VLAD performance mortality and morbidity reporting and response systems
- Patient Safety, Clinical Practice Improvement and Skills Development Centres

Key questions

- How do we “join the dots “?
 - ie what would a “high value, low profile “ performance tracking system look like ?
- Would this increase medical leader/ managerial “confidence to act” ?
- What is a reasonable level of service expectation of provincial hospitals in a time of severe medical workforce shortage ?



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The status quo - a high profile, low value system

National Sentinel Events Report 2004-5

EVENT	N
Procedures involving the wrong patient or body part	53
Suicide of a patient in an inpatient unit	25
Retained instruments or other material after surgery	27
Intravascular gas embolism resulting in death or neurological damage	1
Haemolytic blood transfusion reaction resulting from ABO incompatibility	1
Medication error leading to the death of a patient	7
Maternal death or serious morbidity associated with labour or delivery	16
Infant discharged to the wrong family	0
Total	130

The status quo - a high profile, low value system

National Sentinel Events Report 2004-5

EVENT	N
Procedures involving the wrong patient or body part	53
Suicide of a patient in an inpatient unit	25
Retained foreign body	27
Intravascular damage	1
Haemolytic transfusion reaction	1
Medication error	7
Maternal death or serious morbidity associated with labour or delivery	16
Infant discharged to the wrong family	0
Total	130

High profile = selected for high 'embarrassment index'

Low value because :

High cost of data collection

Rare therefore low burden of disease impact

Clear under-reporting

Not useful for change because :

Not locally interpretable

Lag not lead indicators - not truly sentinel

Low profile, high value sentinel events (for 'joining the dots' of clinician performance)

- Data sources - widely dispersed but not shared:
 - Hospitals
 - Specialist colleges
 - Medical registration boards
- Data items - already collected but not linked:
 - Employment history
 - Training assessments
 - Performance reports
 - Inter-staff complaints
 - Clinical outcomes
 - Simple operational activity markers

Low profile, high value sentinel events (for 'joining the dots' of clinician performance)

- Data sources - widely dispersed but not shared:
 - Hospitals

High value because :

Low cost of data collection

Useful for change because :

Locally interpretable

Lead not lag indicators - truly sentinel

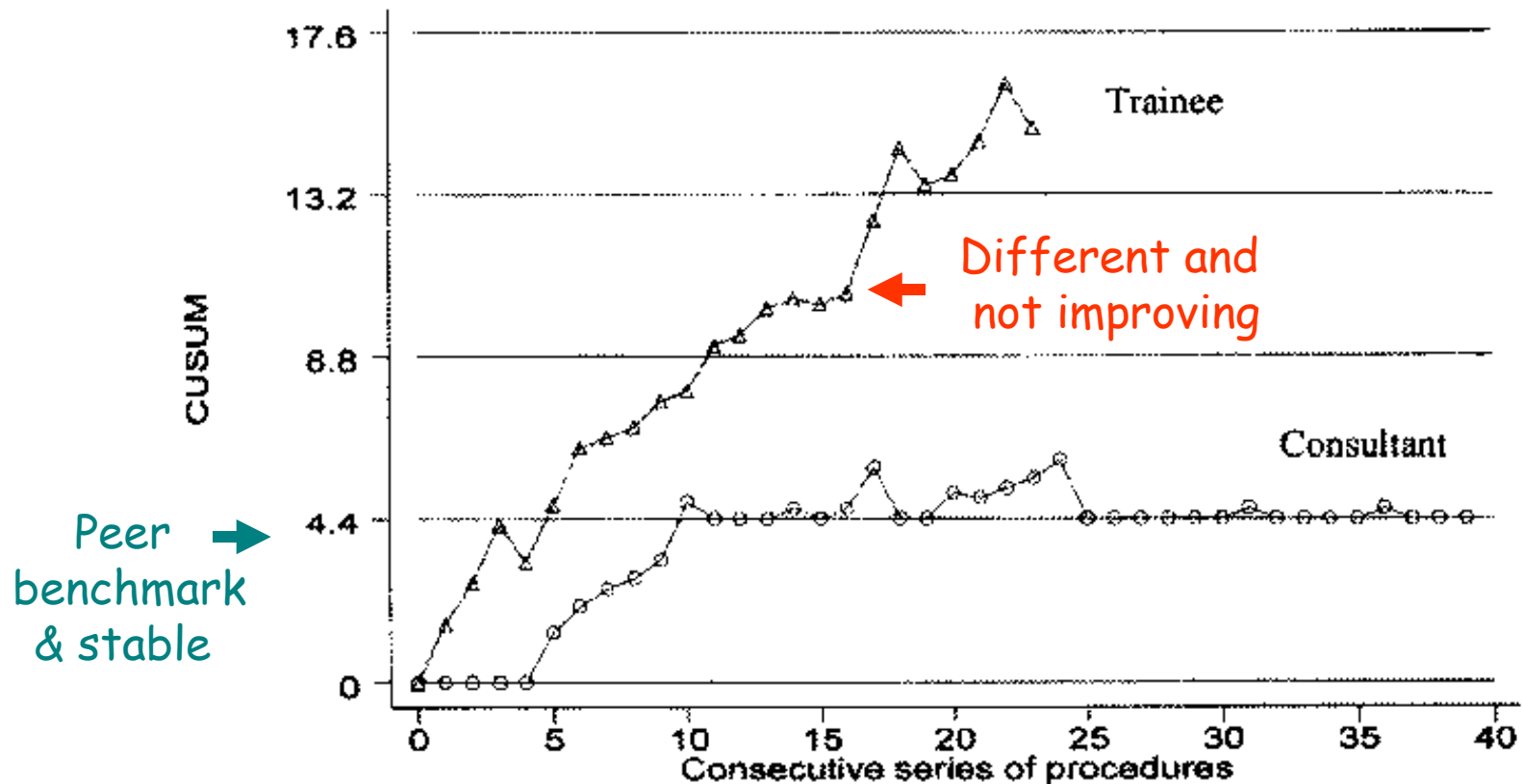
Amenable to cumulative times series analysis

.....therefore increases 'confidence to act'

- **Enter staff complaints**
 - Clinical outcomes
 - Simple operational activity markers

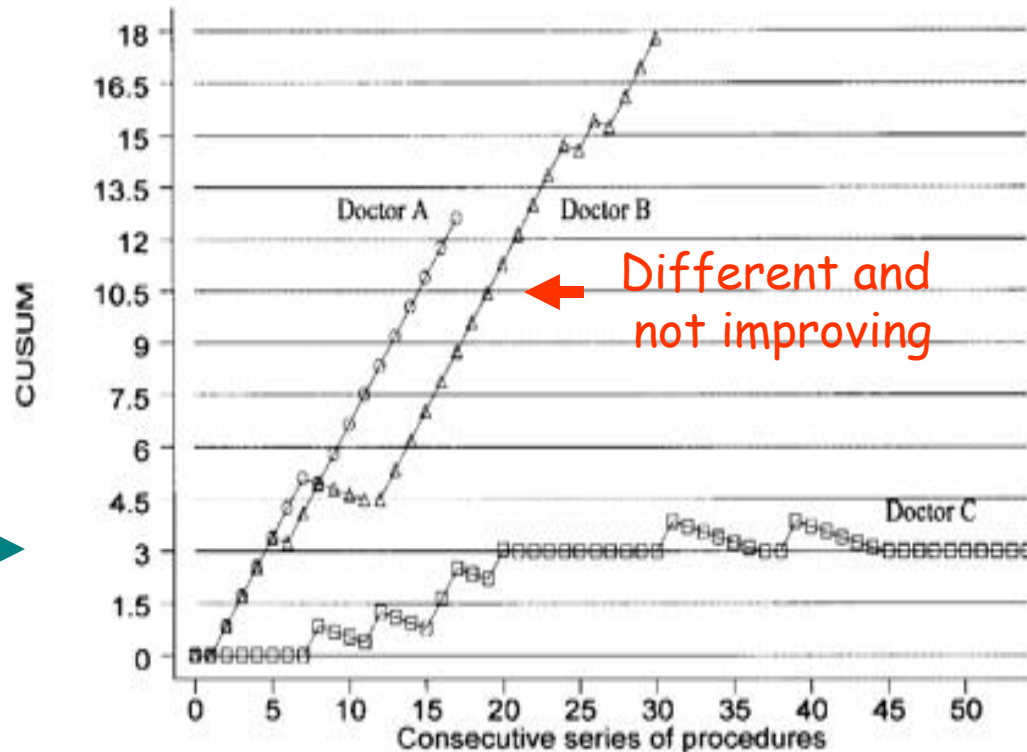
Cumulative time series analysis of clinician performance

How long should it take to perform a thyroidectomy ?



Cumulative time series analysis of clinician performance

Procedural success trends (ERCP)



Peer benchmark
& stable →

Different and
not improving ←

Another simple marker

Death certification by time of day

Harold Shipman

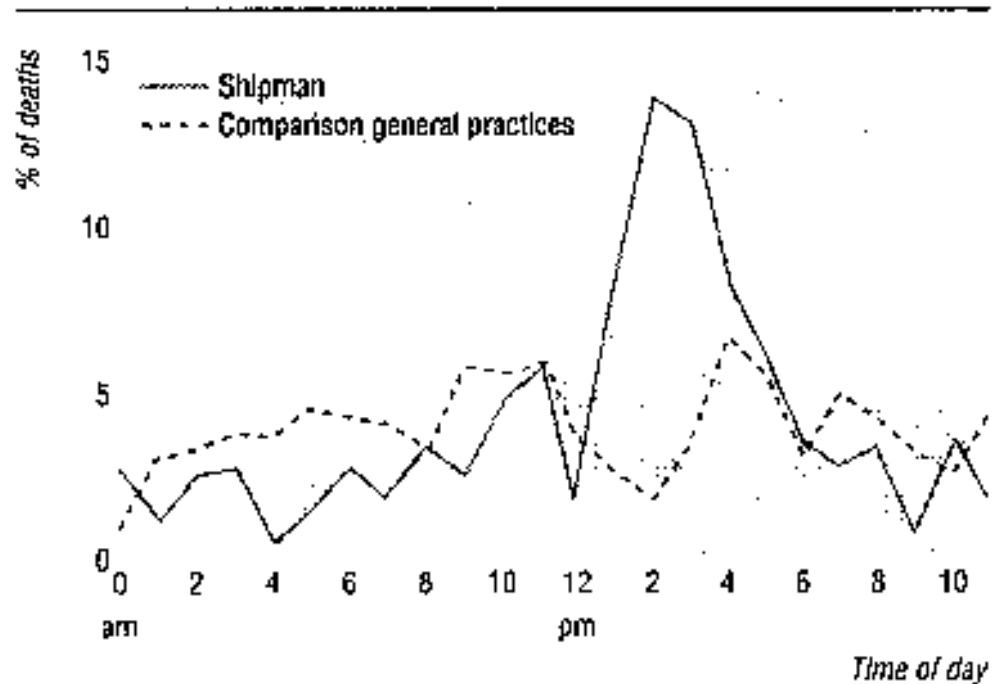


Fig 1 Percentage of deaths occurring at different times of day

Current HQCC Standards

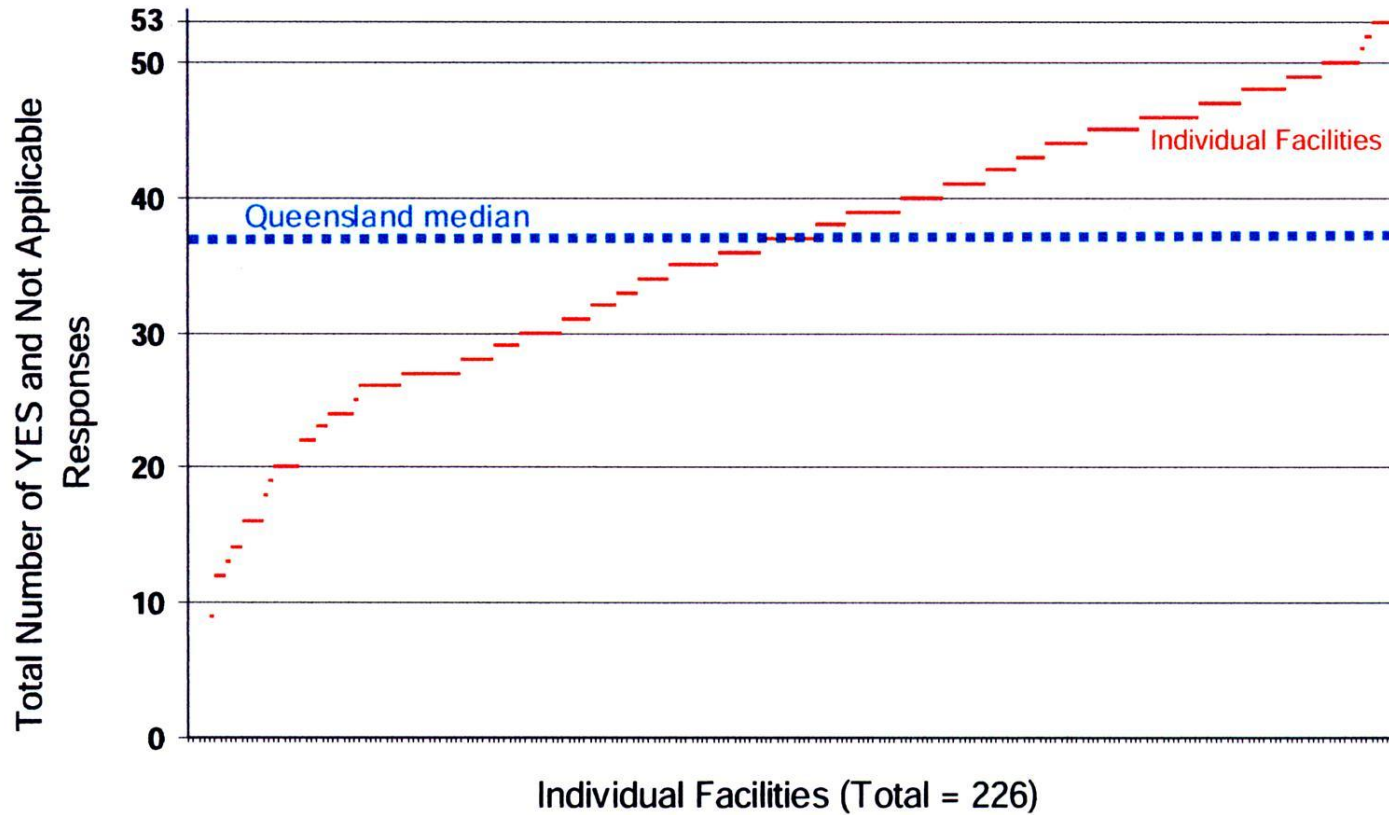
1. Review of Hospital Related Deaths
2. Credentialing
3. Surgical safety
 - Correct surgery
 - DVT prophylaxis
 - Antibiotic Prophylaxis
4. Hand hygiene
5. Complaints Management
6. Management of AMI Following Discharge
7. Providers' Duty to Improve the Quality of Health Services

HQCC standards

- Selection principles
 - High burden of disease
 - Evidence based best practice available
 - Wide variation in current practice
- General requirements
 - Is there a documented process ?
 - Does it align with HQCC standard ?
 - Is implementation of standard reviewed ?
 - Are there improvement initiatives ?
 - Is anything being done about deficiencies ?
- Credentialing
 - Standard = Australian Commission for Safety and Quality in Healthcare Credentialing Standard 2004

Compliance with all HQCC standards

Jul-Sept 07



Compliance with individual standards & improvement initiatives

Jul-Sept 07 n=226

Standard	Documented process ? (%)	% Facilities with Quality Initiative
Rev. Hosp Deaths	62	50
Management AMI	42	26
Prevention DVT	39	27
Correct site surg.	82	40
Antibiotic prophyl.	46	27
Hand Hygiene	97	56
Credentialing	94	62
Complaints Manag.	92	44

Key points

- Credentialing failures need to be addressed but are probably symptoms of more serious organisational failures
- HQCC standards provide an opportunity to test the hypothesis that external regulation works
- Credentialing needs to be given teeth by:
 - Free information exchange about problematic clinicians to allow us to “join the dots”
 - Legal protection for this exchange and credentialing
 - Use of statistical process control to track performance and thereby increase “confidence to act”
- Medical profession needs to overcome “Mokita”