



AUSTRALIAN COMMISSION ON
SAFETY AND QUALITY IN HEALTHCARE



National Indicators of safety and quality – next steps

Neville Board RN, BA, MPH

11 June 2009



1 – INFORMATION STRATEGY

2 – REPORTING SAFETY AND QUALITY

3 – FUTURE OPTIONS



1 – INFORMATION STRATEGY and the show so far

2 – REPORTING SAFETY AND QUALITY

3 – FUTURE OPTIONS



▶ Australian Commission on

- lead and coordinate improvements in safety and quality in health care in Australia by identifying issues and policy directions, and recommending priorities for action
- disseminate knowledge and advocate for safety and quality
- report publicly on the state of safety and quality including performance against national standards
- recommend national data sets for safety and quality, working within current multilateral governmental arrangements for data development, standards, collection and reporting
- provide strategic advice to Health Ministers on best practice thinking to drive quality improvement, including implementation of strategies, and
- recommend nationally agreed standards for safety and quality improvement.

AUSTRALIAN CHARTER OF HEALTHCARE RIGHTS

The Australian Charter of Healthcare Rights describes the rights of patients and other people using the Australian health system. These rights are essential to make sure that, wherever and whenever care is provided, it is of high quality and is safe.

The Charter recognises that people receiving care and people providing care all have important parts to play in achieving healthcare rights. The Charter allows patients, consumers, families, carers and services providing healthcare to share an understanding of the rights of people receiving healthcare. This helps everyone to work together towards a safe and high quality health system. A genuine partnership between patients, consumers and providers is important so that everyone achieves the best possible outcomes.

Guiding Principles

These three principles describe how this Charter applies in the Australian health system.

1 Everyone has the right to be able to access health care and this right is essential for the Charter to be meaningful.

2 The Australian Government commits to international agreements about human rights which recognise everyone's right to have the highest possible standard of physical and mental health.

3 Australia is a society made up of people with different cultures and ways of life, and the Charter acknowledges and respects these differences.



For further information please visit www.safetyandquality.gov.au

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTHCARE

What can I expect from the Australian health system?

MY RIGHTS	WHAT THIS MEANS
Access I have a right to health care.	I can access services to address my health care needs.
Safety I have a right to receive safe and high quality care.	I receive safe and high quality health services, provided with professional care, skill and competence.
Respect I have a right to be shown respect, dignity and consideration.	The care provided shows respect to me and my culture, beliefs, values and personal characteristics.
Communication I have a right to be informed about services, treatment, options and costs in a clear and open way.	I receive open, timely and appropriate communication about my health care in a way I can understand.
Participation I have a right to be included in decisions and choices about my care.	I may join in making decisions and choices about my care and about health service planning.
Privacy I have a right to privacy and confidentiality of my personal information.	My personal privacy is maintained and proper handling of my personal health and other information is assured.
Comment I have a right to comment on my care and to have my concerns addressed.	I can comment on or complain about my care and have my concerns dealt with properly and promptly.

Patient Charter of Rights

Open Disclosure

HCAI

Patient I-D issues

Medication Safety

Clinical Handover

Accreditation

Info management

Patients at risk

WHERE ARE WE NOW?

Currently there are few national reports providing data on the safety and quality of health care in Australia.

We generate large amounts of retrospective information on activity description, service volumes, measures of population health and access to services.

NHCAs starting to address performance, including safety and quality

Some strong state initiatives



WHAT ARE THE GAPS? Part I

National and state reporting have very few elements of clinical quality – they focus on access, throughput, cost, service volumes and descriptives, population health, payments

Reporting for safety is generally poorly understood, with little measurable yield or benefit from the rollout of incident reporting systems across most states and private hospital ownership chains

Patient experience is not routinely and separately addressed as part of reporting

National data collections are reported retrospectively, with a time lag and granularity that cannot support targeted feedback, analysis and action for improvement

WHAT ARE THE GAPS? Part II

The focus on jurisdictional reporting under AHMAC, NHCA and COAG hides significant variation at provider level and promotes inconsistent reporting

Safety and quality data in primary care and ambulatory hospital care is exceptionally scant

Clinical expert groups struggle to develop national standards for quality indicators and supporting data elements through current national data development process

The absence of integration of the E-Health/clinical information (primary purpose) and reporting information (secondary use) “worlds”

1 – INFORMATION STRATEGY and the show so far

2 – REPORTING SAFETY AND QUALITY

3 – FUTURE OPTIONS



National Safety and Quality Framework



My care is based on the best knowledge and evidence

Use guidelines to reduce unjustified variation in standards of care

Collect and use data to improve safety and quality of care

My care is based on the best knowledge and evidence

**Learn from
patient
experiences**

**Encourage
research that will
improve safety and
quality**

National Indicators of Safety and Quality

Purpose: to enable the Commission to report publicly and systematically on safety and quality, including ‘performance against standards’.

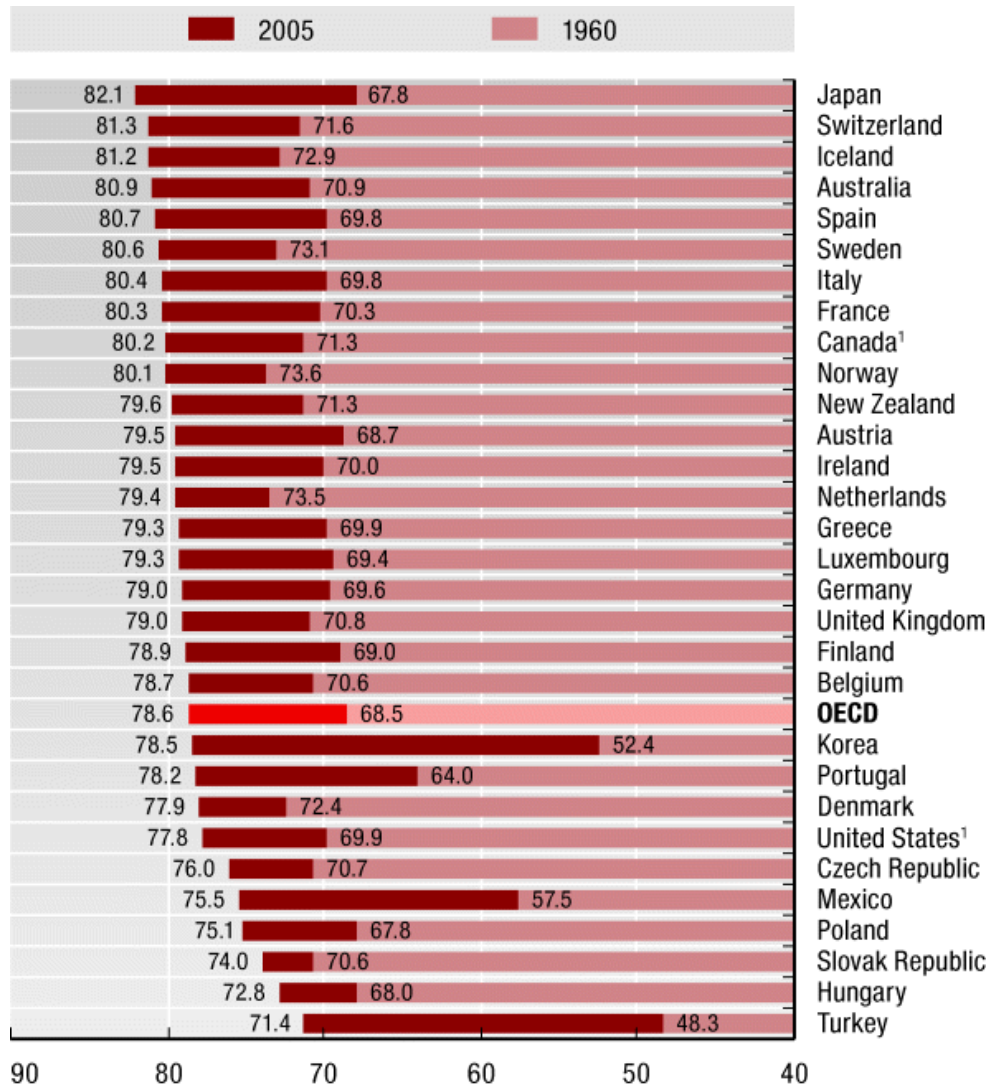
A primary aim is to recommend key indicators for national reporting on safety and quality.

- **International comparison**
- **National time trends and regional variation**
- **Facility level**
- **Disease specific**
- **Surveys and audits, including patient experience**

PRINCIPLES OF INDICATOR USE

- 1. Designed for reporting within a structured and timely cycle of feedback**
- 2. Appropriate levels of disaggregation will be used**
- 3. Development prioritised by clinical relevance and feasibility**
- 4. Borrow best models of reporting and feedback already developed**
- 5. Reporting should lead to review and action**

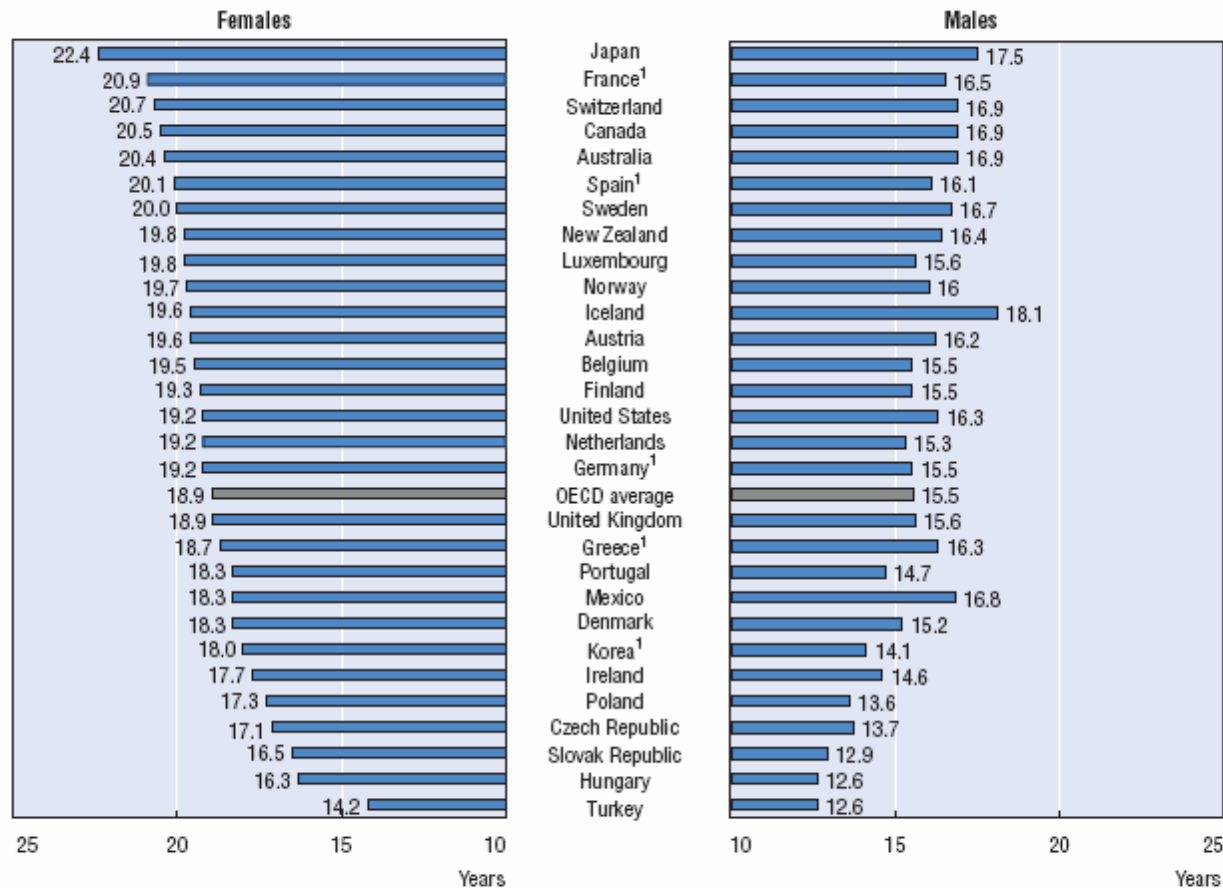
BALANCED SCORECARD



Years

BALANCED SCORECARD

Figure 5. Life expectancy at age 65, 2000



Note: Each country calculates its life expectancy according to methodologies that can vary somewhat. These differences in methodology can affect the comparability of reported life expectancy estimates, as different methods can change a country's life expectancy estimates by a fraction of a year.

1. 1999.

Source: OECD Health Data 2003.

EXHIBIT 5

Comparison Of Rankings Based On Age-Standardized Death Rates (SDRs) Per 100,000 From Amenable Mortality (Both Sexes Combined) In Nineteen Organization For Economic Cooperation And Development (OECD) Countries, 1997-98 And 2002-03

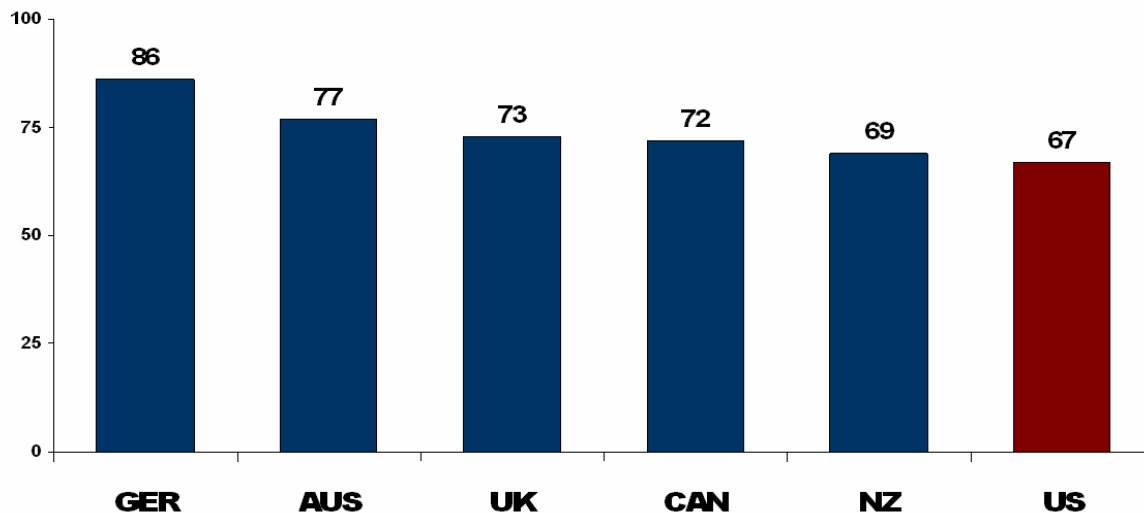
Rank, 1997-98	Country	Amenable mortality (SDR, ages 0-74)		Rank, 2002-03	Change in rank
		1997-98	2002-03		
1	France	75.62	64.79	1	-
2	Japan	81.42	71.17	2	-
3	Spain	84.26	73.83	4	-1
4	Australia	87.95	71.32	3	+1
5	Sweden	88.44	82.09	9	-4
6	Italy	88.77	74.00	5	+1
7	Canada	88.88	76.83	6	+1
8	Netherlands	96.89	81.86	8	-
9	Greece	97.27	84.31	10	-1
10	Norway	98.64	79.79	7	+3
11	Germany	106.18	90.13	12	-1
12	Austria	108.92	84.48	11	+1
13	Denmark	113.01	100.84	15	-2
14	New Zealand	114.54	95.57	14	-
15	United States	114.74	109.65	19	-4
16	Finland	116.22	93.34	13	+3
17	Portugal	128.39	104.31	18	-1
18	United Kingdom	129.96	102.81	16	+2
19	Ireland	134.36	103.42	17	+2

SOURCE: Authors' calculations based on data from the World Health Organization mortality database.

NOTES: Denmark: 2000-01; Sweden 2001-02; Italy, U.S.: 2002. SDR is standardized death rate.

Medications Reviewed When Discharged from the Hospital, Among Sicker Adults, 2005

Percent of hospitalized patients with new prescription who reported prior medications were reviewed at discharge



Note: Indicator was not updated due to lack of data. Baseline figures from Scorecard 2006 are presented.
AUS=Australia; CAN=Canada; GER=Germany; NZ=New Zealand; UK=United Kingdom; US=United States.
Data: 2005 Commonwealth Fund International Health Policy Survey.

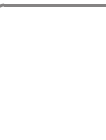
Patient experiences

The following table has been derived by Baker from Commonwealth Fund data^{145p12}. The report has revealed wide variations in performance across countries. The results demonstrate that Australia's overall ranking is equal third, with the UK being ranked first and the United States being ranked last. While Australia's worst areas of performance were in Quality Care, it was ranked first for Long, Healthy & Productive Lives.

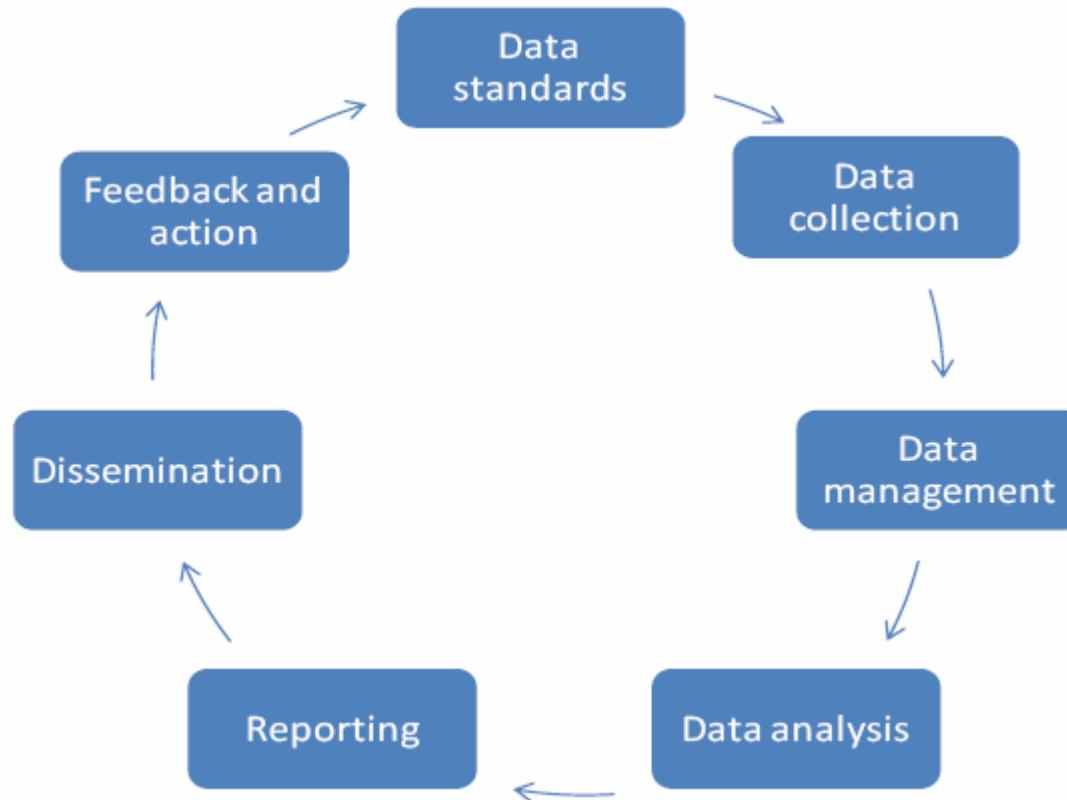
	Australia	Canada	Germany	New Zealand	United Kingdom	United States
Overall ranking (2007)	3.5	5	2	3.5	1	6
Quality Care	4	6	2.5	2.5	1	5
Right Care	5	6	3	4	2	1
Safe Care	4	5	1	3	2	6
Coordinated Care	3	6	4	2	1	5
Patient-Centred Care	3	6	2	1	4	5
Access	3	5	1	2	4	6
Efficiency	4	5	3	2	1	6
Equity	2	5	4	3	1	6
Long, Healthy & Productive Lives	1	3	2	4.5	4.5	6
Health Expenditure per capita 2004 (or 2003 where *)	\$2,876*	\$3,165	\$3,005*	\$2,083	\$2,546	\$6,102

WHY REPORT?

- **Transparency**
- **Consumer choice**
- **Accountability**
- **To drive improvement in performance**



Safety and quality data development



The Public Release of Performance Data

What Do We Expect to Gain? A Review of the Evidence

Martin N. Marshall, MSc, MD, FRCGP

Paul G. Shekelle, MD, PhD

Sheila Leatherman, MSW

Robert H. Brook, MD, ScD

INFORMATION ABOUT THE PERFORMANCE of hospitals, health professionals, and health care organizations is increasingly being released into the public domain.¹ The data, often produced in the form of "report cards," "provider profiles," or "consumer reports," necessitates the development and dissemination of standardized reports on quality of care and facilitates comparisons of performance over time, among providers, and against defined standards of good practice. Health care performance data have been made public in the United States for more than a decade,² and the production and dissemination of report cards is now a multimillion-dollar industry. However, evaluation of the impact of report cards has not kept pace with the development of reporting systems.³⁻⁷ In addition, there has been minimal agreement among the various stakeholders about expected gains from the release of comparative performance data. It has therefore proved difficult to judge whether the benefits of public disclosure of performance data outweigh the disadvantages.

The failure to articulate a clear rationale for the public release of performance data is illustrated by the wide variety of ways in which commentators believe the data might be used. The most common expectation is that such data will promote an efficient market

Context Information about the performance of hospitals, health professionals, and health care organizations has been made public in the United States for more than a decade. The expected gains of public disclosure have not been made clear, and both the benefits and potential risks have received minimal empirical investigation.

Objective To summarize the empirical evidence concerning public disclosure of performance data, relate the results to the potential gains, and identify areas requiring further research.

Data Sources A literature search was conducted on MEDLINE and EMBASE databases for articles published between January 1986 and October 1999 in peer-reviewed journals. Review of citations, public documents, and expert advice was conducted to identify studies not found in the electronic databases.

Study Selection Descriptive, observational, or experimental evaluations of US reporting systems were selected for inclusion.

Data Extraction Included studies were organized based on use of public data by consumers, purchasers, physicians, and hospitals; impact on quality of care outcomes; and costs.

Data Synthesis Seven US reporting systems have been the subject of published empirical evaluations. Descriptive and observational methods predominate. Consumers and purchasers rarely search out the information and do not understand or trust it; it has a small, although increasing, impact on their decision making. Physicians are skeptical about such data and only a small proportion makes use of it. Hospitals appear to be most responsive to the data. In a limited number of studies, the publication of performance data has been associated with an improvement in health outcomes.

Conclusions There are several potential gains from the public disclosure of performance data, but use of the information by provider organizations for quality improvement may be the most productive area for further research.

JAMA. 2000;283:1866-1874

www.jama.com

economy in health care,^{8,9} usually in the belief that information about performance will encourage consumers to choose to access high-quality providers.¹⁰⁻¹³ Some authorities suggest that the information could be used by providers as a marketing tool.¹⁴ Others suggest that it will help to control costs^{15,16} or at least counter the influence of cost as the principal determinant of purchaser decision making.¹⁷⁻¹⁹ In addition, public information about performance has been proposed as a tool to regulate the health system,^{10,20} a method of ensuring accountability of provider

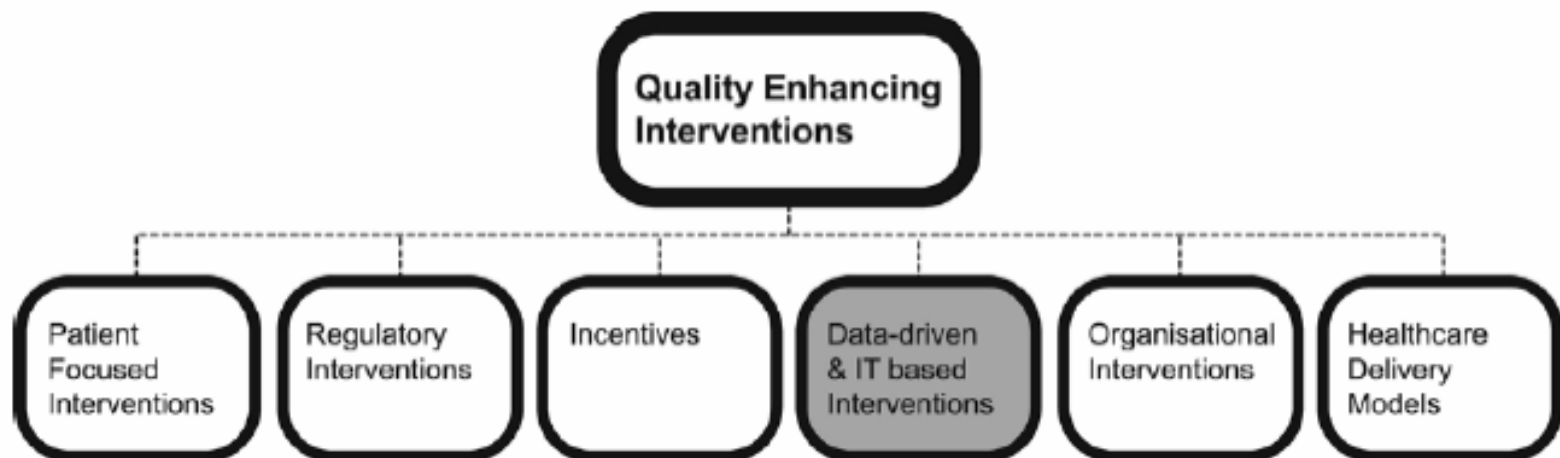
Author Affiliations: School of Postgraduate Medicine and Health Sciences, University of Exeter, Exeter, England (Dr Marshall); RAND Health Program, Santa Monica (Drs Shekelle and Brook), Greater Los Angeles Veterans Affairs Healthcare System, Los Angeles (Dr Shekelle), Calif; Center for Health Care Policy and Evaluation, United Health Group, Minnetonka, Minn (Ms Leatherman); Judge Institute of Management, University of Cambridge, Cambridge, England (Ms Leatherman); and University of California, Los Angeles, Center for Health Services, Los Angeles (Dr Brook). Dr Marshall is now with the National Primary Care Research and Development Centre, University of Manchester, Manchester, England.

Corresponding Author and Reprints: Martin N. Marshall, MSc, MD, FRCGP, Senior Research Fellow, National Primary Care Research and Development Centre, University of Manchester, Fifth Floor, Williamson Bldg, Oxford Road, Manchester M13 9PL, UK (e-mail: mmarshall@fs1.pcr.man.ac.uk).

Public reporting and quality of care

Does public release of performance results improve quality of care?

Since the last major review of healthcare public reporting (Marshall *et al*, 2000), new studies provide additional support for the conclusion that the public release of performance data stimulates change at the level of the hospital.



“reliable flow of useful information”

Baker, GR, *High Performing Healthcare Systems*, 2008, Longwoods Toronto, p.17

Reviewing own facility against peers!

Nation's 26 worst hospitals shamed

Clara Pirani
Medical Reporter

TWENTY-SIX hospitals and health facilities across Australia have been told to improve patient care within 60 days or risk losing funding.

However, patients have no way of knowing the seriousness of the problems at the sites that failed to meet minimum accreditation standards.

A report by the Australian Council on Healthcare Stan-

woman of Professional Indemnity Review in the early 1990s commissioned a report that found 14,000 people died every year from adverse events in Australian hospitals.

"In the end these are public institutions so it's appropriate that we have access to their performance information."

Ross Wilson, director of the NSW Centre for Healthcare Improvement, said governments needed to address the lack of information about the level of preventable patient harm in hospitals. "They

AUSTRALIAN : 25 JUNE 2005

Statistical process control of process with change introduced

Statistical process control of a fictitious process to which a change has been introduced. The process is stable prior to the change and re-stabilizes after the implementation phase, but at a new level.

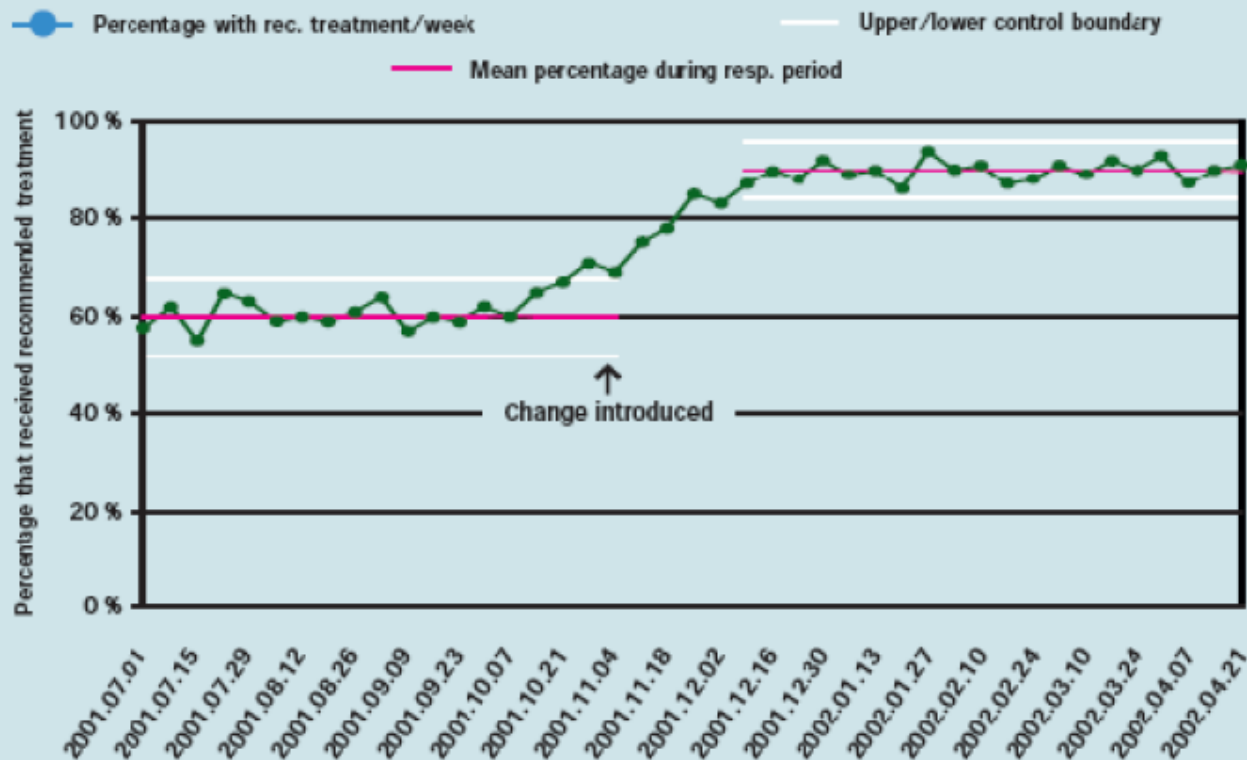


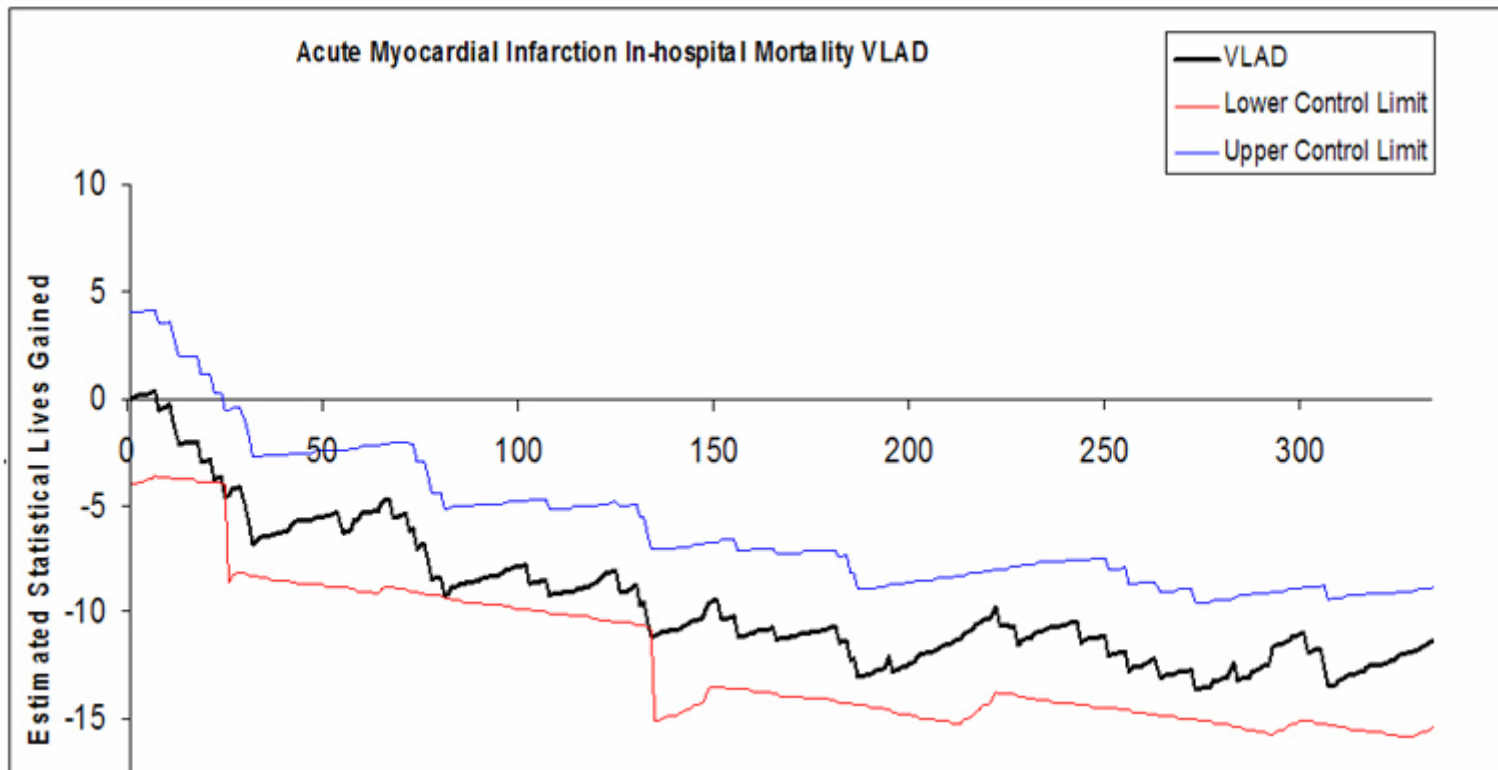
Figure 5. Example of a statistical process control chart

Reproduced with permission from *Handbook for Establishing Quality Registries*.²³

The 11 indicators chosen to address large portions of the sector are:

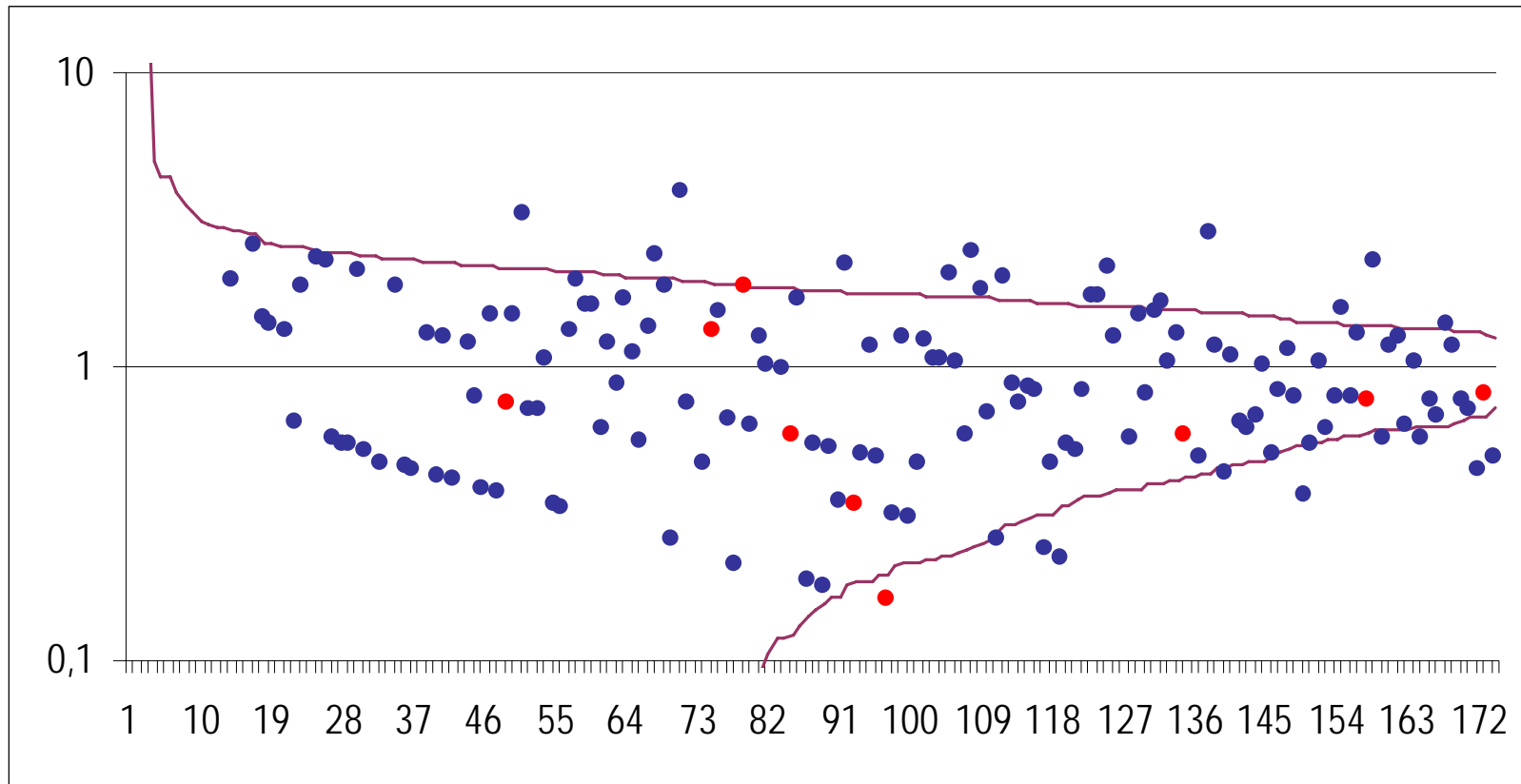
- Death in low mortality DRGs (AusPSI)
- Complications of anaesthesia (AusPSI)
- In-hospital fracture (AusPSI)
- Postoperative haemorrhage or haematoma (AusPSI)
- Postoperative deep vein thrombosis/pulmonary embolus (AusPSI)
- Obstetric trauma - vaginal or caesarean delivery (AusPSI). Combined measure.
- Stroke in-hospital mortality (QCI)
- Heart failure in-hospital mortality (QCI)
- AMI (heart attack) in-hospital mortality (QCI)
- Pneumonia in-hospital mortality (QCI)
- Fractured neck of femur in-hospital mortality (QCI)

Sample report: Expected minus Observed



A Funnel Plot

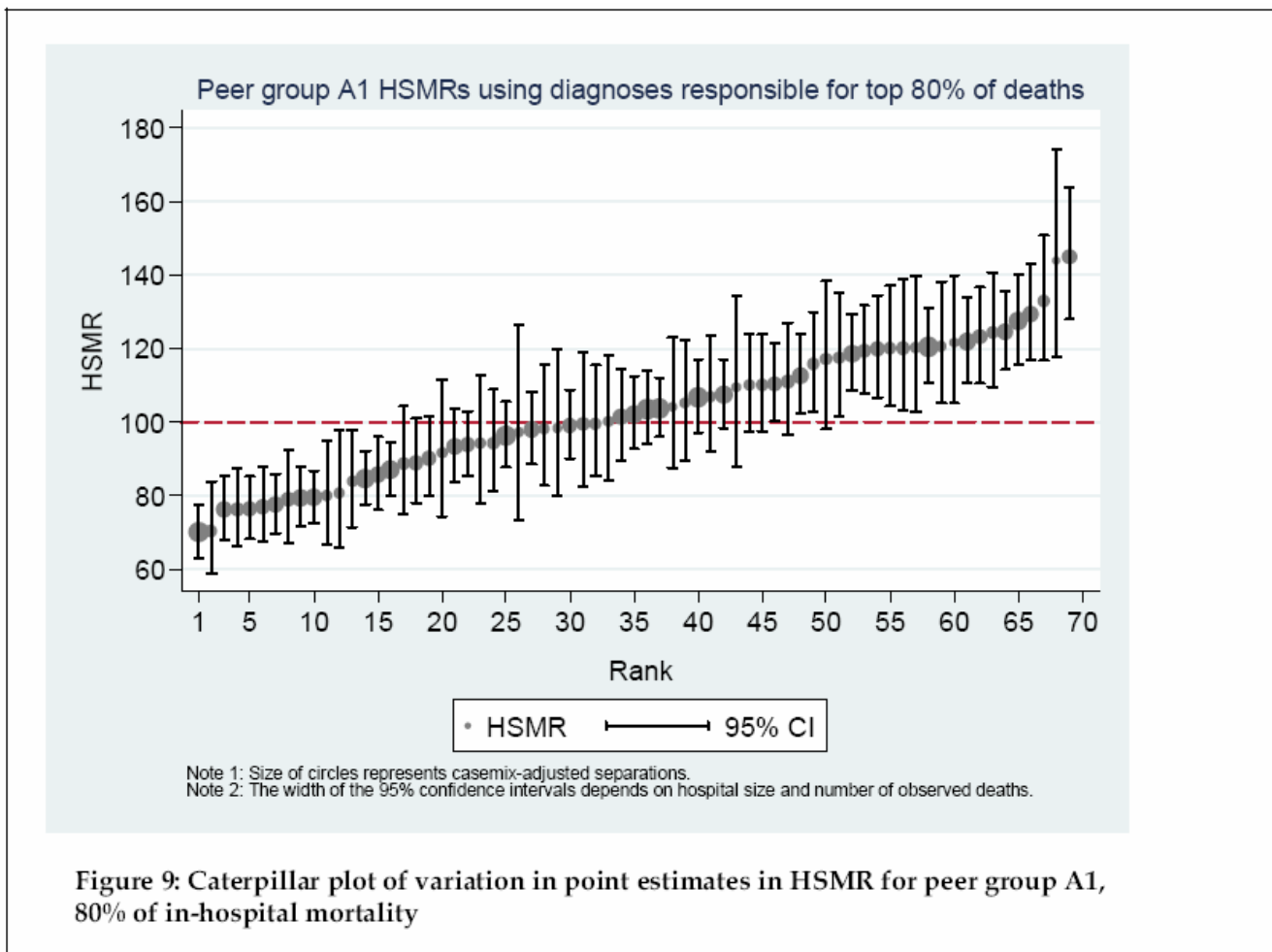
Example of a Funnel Plot representing risk of PT-DVT in 175 hospitals



Bernal-Delgado, E, Validation of Patient Safety Indicators (PSIs) for Spanish SNS, Government of Aragon, October 2008

A Caterpillar Plot

Sample caterpillar plot – HSMRs



National indicators of safety and quality – concurrent activities

In April 2008, the National Health and Hospitals Reform Commission released *Beyond the blame game: Accountability and performance benchmarks for the next Australian Health Care Agreements* which described specific benchmarks for a range of measures of performance, including safety and quality.

In June 2008, the COAG Reform Group announced the development of a suite of healthcare performance indicators. It is anticipated that around 40 *performance* indicators will be identified, including a subset of safety and quality indicators, and a more specific set of access measures (access is considered an element of quality).

In November 2008, the NSW Clinical Excellence Commission convened a NSW workshop on *Measuring Hospital Performance: Transparency, Openness, Integrity*. A suite of indicators were identified for further development.

National indicators of safety and quality – next steps

Commission staff will prepare its recommended approach on national indicators on safety and quality in health care

The Commission's Private Hospital Sector, Primary Care and Inter-Jurisdictional Committees will review the proposal

Commissioners will review and endorse the recommendations in the form of an AHMAC paper

The Commission will provide the paper to AHMAC in the second half of 2009.

1 – INFORMATION STRATEGY and the show so far

2 – REPORTING SAFETY AND QUALITY

3 – FUTURE OPTIONS



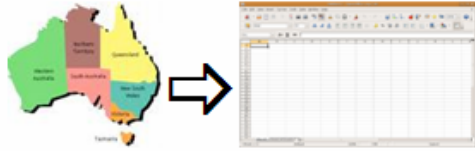
OUTCOMES OF A REPORTING STRATEGY

- **Balanced scorecard - routine publications of measures of Australian health care with international comparisons, national trends and regional and disease group disaggregation**
- **Mature reporting systems supporting a culture of investigation and action**
- **Targeted feedback - healthcare systems and providers reviewing own performance routinely and against peer facilities**
- **New data sets and standards addressing specific clinical areas and settings**

Examples of reporting systems

Phase 1

Responding to AHMC and COAG


Who	 <p>Jurisdictions to ACSQHC (via Hand Hygiene Australia for SAB and Hand Hygiene compliance)</p>
What	Collate and forward summary HAI data from hospitals to national HAI collection (SAB and Hand Hygiene compliance to be held by Hand Hygiene Australia on behalf of ACSQHC)
When	Monthly data reported quarterly within 7 days of end of quarter
How	Email and/or web submission, from jurisdictions to Hand Hygiene Australia
Rationale	To meet AHMC direction that hospitals monitor and report <i>through</i> their relevant jurisdiction <i>into</i> a national data collection
Commencing	2Q2009 (for Hand Hygiene compliance and SAB) 2Q2010 (for <i>Clostridium Difficile</i>)

"spreadsheets"

Examples of reporting systems

Phase 1


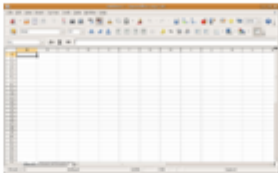
Responding to AHMC and COAG

Who	 Jurisdiction and Hand
What	Collate an national H be held by
When	Monthly d
How	Email and Hygiene A
Rationale	To meet A through th
Commencing	2Q2009 (f 2Q2010 (f

Phase 2

Supporting local hospitals so change can happen where it matters
Voluntary public reporting for transparency and compliance



Who	 → 
What	Individual hospitals to ACSQHC or Hand Hygiene Australia
What	Summary counts, denominators and rates by hospital, plus any other HAI data a given facility chooses to provide
When	Monthly submission as a minimum with ad hoc submission possible at anytime
How	<u>Webform</u> reporting submission or batch upload
Rationale	Individual hospitals submit data and obtain reports and feedback to allow for timely responses
Commencing	3Q2010


"spreadsh

"Leapfrog"

Examples of reporting systems


Phase 1

Responding to AHMC and COAG

Who	 Jurisdiction and Hand
What	Collate an national HAI be held by
When	Monthly d
How	Email and Hygiene A
Rationale	To meet A through th
Commencing	2Q2009 (f 2Q2010 (f



Phase 2

Supporting local hospitals
Voluntary public reporting

Who	 Individual:
What	Summary plus any
When	Monthly possible
How	Webform
Rationale	Individual feedback
Commencing	3Q2010

Phase 3

Detailed surveillance to allow research, analysis and targeted responses

Who	 ↔  Individual hospitals to and from national HAI surveillance database
What	Detailed granular (case level) data
When	High level of availability of system (99.97% of 24/7) to allow ad hoc anytime access for input and output
How	A range of options ranging from web submission and batch upload through to automated secure messaging between systems, including pathology labs, administrative data systems, etc.
Rationale	Detailed reporting and alerting Individual facilities submit this data and generate ad hoc reports allowing comparison between facilities, peers and benchmark
Commencing	As soon as practicable

"spreadsh

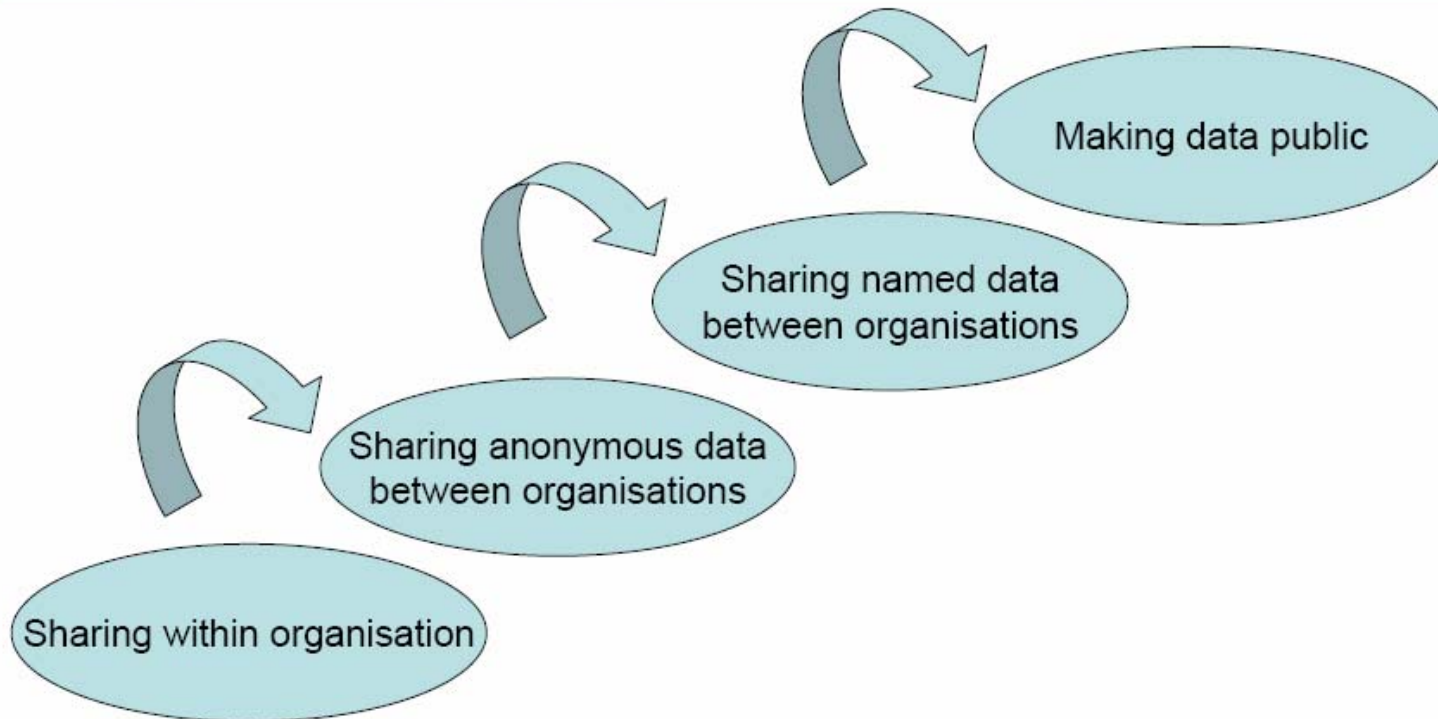
"Lea

"CDC"

From voluntary to public reporting



Use of data – an evolution



THANK YOU!

Neville Board

Email: neville.board@safetyandquality.gov.au

Phone: 02 9263 3587

Fax: 02 9263 3613