Safety and Quality Reform in Health Care

VHA Governance Forum
Melbourne May 18 2017

A/Prof Amanda Walker
Senior Clinical Advisor
ACSQHC
The Commission

- Australian Government agency
- Leads & coordinates national improvements in safety & quality of health care based on best available evidence
- Aims to ensure that the health system is better informed, supported & organised to deliver safe & high quality care
- Works in partnership with patients, consumers, clinicians, managers, policy makers & health care organisation
- Aims to achieve a sustainable, safe & high-quality health system
Report exposes the hospitals of horror

Patients' lives could have been saved

EXCLUSIVE
By JOHN KIDMAN

PRELIMINARY findings of a 10-month investigation have backed up allegations of clinical malpractice linked to deaths at two Sydney hospitals.

The examination of 47 complaints that more than 60 per cent of patients whose treatment was scrutinised were subjected to "unsafe standards" of care.

However, insiders say the revelations are just the tip of the iceberg, with many further disturbing incidents yet to be explored.

A few Macarthur Area Health Service (MHS) staff, who initially reported the more than 100 claims of mismanagement, negligence and patient neglect last November, say they have received nothing but victimisation and grief over their stance.

Hospital sources say some of the casualties were "nothing short of horrific" but, despite the damning findings of their investigation, no one has been held to account.

In one case, a 73-year-old remain under observation due to a history of hypertension and chest pain, she was sent home after receiving three doses of morphine.

Within an hour of being released, she collapsed and died of a massive heart attack on her front doorstep.

Elsewhere, a 72-year-old woman, who died of heart failure arising from a massive infection after having a plate inserted to repair a leg frac-
Safety and Quality Reform in Health Care

• including
  • Pricing for Quality
  • Targeting Zero Report
  • Other National Safety and Quality reforms
Reform:

• **reform**  [rɪˈfɔːm]  
  • VERB  
  • reforms (third person present) · reformed (past tense) · reformed (past participle) · reforming (present participle) · re-form (verb) · re-forms (third person present) · re-formed (past tense) · re-formed (past participle) · re-forming (present participle)  

• make changes in (something, especially an institution or practice) in order to improve it:  
  • e.g. "the Bill will reform the tax system"  

• synonyms: improve · make better · better · ameliorate · refine
“Reforms”

- Background
- **Using data to drive improvement**
- HACS
- Readmissions
- Atlas of Clinical Variation
- Clinical Quality Registries
- National Standards 2nd Edition
- Targeting Zero
- Challenges
Disclaimer
Intro

• Australia’s health system generally performs well compared to other OECD countries.
• A significant proportion of admissions in Australian hospitals are associated with an adverse event.
• Australian data systems are not sufficient to support improvements in this area.
• Reduction in the rate of adverse events (patient safety) and unwarranted variation (quality – appropriateness of care)– potentially produces productivity savings, over and above benefits to patients
Data driving improvement
‘We know more about staff health and safety than patient safety’
Do the sick no harm…

It may seem a strange principle to enunciate as the very first requirement in a hospital that it should do the sick no harm.

— Florence Nightingale

First sentence of Preface to Notes on Hospitals (1859, 3rd Ed., 1863),
“We provide safe care here”

Is it safe in your facilities
On weekends…
Out of business hours…
When X is not rostered on…
When Y is rostered on…
From the Rolls Royce experience
To the burning car wreck...
Homicide victims rarely talk to police

They usually are not able to tell story before dying, prosecutors say.

BY MICHAEL BUCK
The Express-Times

When police detectives investigate homicides, they usually have to stitch together what happened from a variety of sources and witnesses.

Rarely do they have a written statement from the victim about the chain of events that led to their demise.

But that’s exactly the scenario that prosecutors and investigators have in Tamaqua.

Ward’s case: Ward was shot in the face in October and succumbed Dec. 51 to her wounds. Her death came after she gave police a detailed written account of what happened.

“It’s very rare,” said Northampton County First Deputy District Attorney Terry Houck. “Usually you have a scenario when a victim dies shortly after a homicide.

“This young lady gave us a whole statement about what happened.”

Last week, Northampton County Coroner Zachary Lysak ruled Ward’s death a homicide that was directly related to the injuries she suffered in the shooting.

Police investigators and prosecutors in Pennsylvania and New Jersey called the case unique, and prosecutors on both sides of the Delaware River could not recall similar situations.

Warren County Assistant Prosecutor Craig Barto said he has not had to deal with a situation like Ward’s in court.

But, Barto came close on a few occasions. One was a case involving Donna Kozyczynski, the estranged Lopatcong Township woman who died in June 2006 because of the neglect of her caregivers. The second was a case in which Christopher Sipos ran back into his home, which had been intentionally set on fire, to retrieve some belongings. He was severely injured.

Kozyczynski’s case never made it to court, and while Sipos made it out of the fire alive, he was never able to speak with investigators before he died.

Houck said in his 30-plus years in law enforcement, he has not encountered this situation.

“Sometimes in auto accident cases, you might have it,” he said. “It’s very rare you would have a shooting victim that gives you so much information before their death.”

Easton police Inspector Matthew Gernold, the investigator assigned to the case, said Ward’s statement greatly aided in the police investigation because they were able to match it against Freeman’s account and the evidence collected at the scene.

Gernold said he used Ward’s statement when he sat down with the members of the district attorney’s office to determine whether to file the involuntary manslaughter charge.

Authorities decided to amend the charges against Freeman following the latter’s ruling on the death.

“In a homicide usually we don’t have anything from the victim,” Gernold said.

Phillipsburg Police Ed Mirenda said he has situations similar to Ward’s, but has never had to deal one personally.

“That scenario usually happen very rarely,” Mirenda said.
One in 10 patients are harmed while in hospital

Estimates show that in Australia as many as 1 in 10 patients is harmed while receiving hospital care. The harm can be caused by a range of errors or adverse events.

0.04% Serious harm – death (1,782)
0.149% Temporary (6,812)
From the patient’s perspective
Don Berwick

- Don’t kill me
- Don’t harm me
- Don’t do things that cannot help me
- Reliably do things that can help me
- Relieve my pain – physical and emotional
- Don’t make me feel helpless
- Share information
- Don’t make me wait
- Don’t waste money
The “Lake Wobegon” effect

Board members’ self-assessment of performance compared with a typical health service in Victoria

Percentage of Board members

- Overall quality of health care
- Safe and skilled workforce
- Experience or satisfaction of patients and families with health care
- Identifying, managing and reporting health care incidents

Worse | About the same | Better or much better
NRMA / RACV Survey, 2008

94% of male drivers believe they are better than average drivers
Data without context

• “Data without context or intelligence tells as much of a story as the words of a dictionary”

• DR Database
DATA CHALLENGES

Feedback loops
GOVERNANCE
National performance against Standard 1 - Governance for safety
## Standard 1 - Clinical governance - core actions NOT MET (Jan 2016 - Sept 2016)

<table>
<thead>
<tr>
<th>Action NOT MET</th>
<th>Number of hospitals</th>
<th>% of total hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actions are taken to minimise risks to patient safety</td>
<td>14</td>
<td>51%</td>
</tr>
<tr>
<td>Actions are taken to reduce risks to patients identified through the incident management system</td>
<td>14</td>
<td>51%</td>
</tr>
<tr>
<td>A system is in place to define and regularly review the scope of practice for the clinical workforce</td>
<td>14</td>
<td>51%</td>
</tr>
</tbody>
</table>
Clinical Governance: Two Key Ideas

- Accountability for the care we deliver
- Creating an environment for clinical excellence
DID YOU KNOW

THERE IS A SPECIES OF ANTELOPE CAPABLE OF JUMPING HIGHER THAN THE AVERAGE HOUSE? THIS IS DUE TO ITS POWERFUL HIND LEGS AND THE FACT THAT THE AVERAGE HOUSE CANNOT JUMP.
“Creating an environment for clinical excellence”:

If you were to design a health system intended to disengage clinicians, how closely would it resemble the one you are currently working in?
An organisation’s responsibilities for clinical governance

Working together to address patient harms and improve patient care

a clinician’s professional responsibilities
NATIONAL MODEL
CLINICAL GOVERNANCE FRAMEWORK

February 2017
“Money, Money, Money”
ABBA, circa 1976
CLINICAL GOVERNANCE IS EQUALLY AS IMPORTANT AS CORPORATE GOVERNANCE
Need to apply the same rigour – not always easy!
Using data to measure safety and quality

• Recent use administrative and other data to examine quality of care and the modalities of delivery of care.
  • (Admin data to avoid burden)
• This will allow examination of patient outcomes
(Pricing for Quality)
Hospital Acquired Complications (HAC) using routinely collected hospital data

- AR-DRG system originally designed for gathering information on (for example) readmission rates, length of stay, complications of care
- Rich data source
  - information for clinicians
  - peer review
  - benchmarking to improve safety and quality
- Condition Onset Flag identifies conditions that patients acquire while receiving treatment or before admission
- Very strong evidence in the literature to support changes in clinical behaviour when given data
- Proof of concept study completed
1. Comparison of HAC patients with and without HACs reported

After identification of episodes with at least one HAC has been achieved in a suitable sample, the first logical analysis is to compare episodes with at least one HAC and episodes with no HACs. Table 5 illustrates key differences including:

Episodes with at least one HAC have longer average length of stay relative to episodes with no HACs, with a length of stay approximately 11 days longer.

Eleven per cent of episodes with at least one HAC are long stay outliers based on NEP16 inlier bounds, compared with only two per cent of episodes with no HACs.

More than half of episodes with at least one HAC have length of stay greater than the average in their DRG, compared with only 22 per cent of episodes with no HACs.

<table>
<thead>
<tr>
<th>Table 5: Comparison of key statistics between HAC and non-HAC cohort</th>
</tr>
</thead>
<tbody>
<tr>
<td># Episodes</td>
</tr>
<tr>
<td>Non HAC Episodes</td>
</tr>
<tr>
<td>Average Length of Stay (excl Sameday/ Incl ICU)</td>
</tr>
<tr>
<td>Non HAC Episodes</td>
</tr>
<tr>
<td>Average Length of Stay (excl Sameday/ excl ICU)</td>
</tr>
<tr>
<td>Non HAC Episodes</td>
</tr>
<tr>
<td>Separation Category</td>
</tr>
<tr>
<td>Non HAC Episodes</td>
</tr>
<tr>
<td>Same Day</td>
</tr>
<tr>
<td>Short Stay Outlier</td>
</tr>
<tr>
<td>Inlier</td>
</tr>
<tr>
<td>Long Stay Outlier</td>
</tr>
<tr>
<td>ALOS</td>
</tr>
<tr>
<td>Non HAC Episodes</td>
</tr>
<tr>
<td>Below ALOS</td>
</tr>
<tr>
<td>Above ALOS</td>
</tr>
</tbody>
</table>
Health Care Agreements influence safety and quality

Heads of Agreement between the Commonwealth and the States and Territories on Public Hospital Funding

This Agreement is made between the COMMONWEALTH OF AUSTRALIA (Commonwealth) and NEW SOUTH WALES, VICTORIA, QUEENSLAND, WESTERN AUSTRALIA, SOUTH AUSTRALIA, TASMANIA, the AUSTRALIAN CAPITAL TERRITORY and the NORTHERN TERRITORY (the States)

Preliminaries

1. This Agreement sets out the shared objective of the Commonwealth and the States (the Parties) to improve health outcomes for all Australians and ensure the sustainability of the Australian health system.
2. We intend this agreement to build on and complement the policy and reform directions outlined in the National Healthcare Agreement (NHA) and the National Health Reform Agreement (NHRA). It is also subject to the Intergovernmental Agreement on Federal Financial Relations and should be read in conjunction with that agreement and any subsidiary schedules.
3. The Parties agree this Agreement will form the basis of negotiations leading towards a time-limited addendum of the National Health Reform Agreement (in the form of an additional schedule) to commence on 1 July 2017. The addendum will amend specified elements of the operation of the National Health Reform Agreement for a period of three years, ceasing 30 June 2020.

Pricing for quality and safety

9. While most health care in Australia is associated with good clinical outcomes, preventable adverse events and complications continue to occur across the health system. By reducing hospital acquired complications, there is potential to not only improve patient safety, but also achieve efficiencies.
10. The Parties, in conjunction with the Australian Commission on Safety and Quality in Health Care (ACSQHC) and the IHPA, will develop a comprehensive and risk-adjusted model to integrate quality and safety into hospital pricing and funding.
   a. The model will determine how funding and pricing can be used to improve patient outcomes and reduce the amount that should be paid for specified adverse events, ineffective interventions, or procedures known to be harmful.
   b. This could include an adjustment to the amount the Commonwealth contributes to public hospitals for a set of agreed hospital acquired conditions. Any downward adjustment to an individual state would not be deducted from the available pool of funding under the overall cap of 6.5 per cent.
11. The Parties agree to develop the model for implementation by 1 July 2017.
Readmissions (within 28 days)

- Modelling data under review
- Model due end June

- HACs
- Complications of surgery
- *Chronic disease eg COPD / CCF / DM*  
  *(Primary care vs acute models of care)*

- Not mental health
- Not dialysis / chemotherapy / radiation / palliative care
Pricing Signals vs Direct Penalties
Sentinel Events
List under review
Atlas of Clinical Variation

“unwarranted variation”
Australian Atlas of Healthcare Variation

- Australian equivalent of Dartmouth or NICE Atlas
- Documents health care variations with a focus on regional variation
- Provides suggestions on possible causes of variation
- Suggests ways to explore & reduce unwarranted variation
- Initial atlas uses administrative data mapped to patient postcode
Fibre optic colonoscopy

COLONSCOPY
Number of procedures performed

2013-2014
589,748

30x
HIGHER IN SOME AREAS COMPARED TO OTHERS

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

www.safetyandquality.gov.au/atlas
CT imaging of the lumbar spine

CT SCAN - LOWER BACK
Number of procedures performed

2013-2014
314,033

11.8x HIGHER IN SOME AREAS COMPARED TO OTHERS

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

www.safetyandquality.gov.au/atlas
Antipsychotics - 65 years and over

ANTIPSYCHOTICS
Number of prescriptions dispensed - 65 years and over

2013-2014
919,026

7.1x HIGHER IN SOME AREAS COMPARED TO OTHERS

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

www.safetyandquality.gov.au/atlas
Antipsychotic medicines 17 years and under
Other issues identified

- Second only to Iceland in use of antidepressants among OECD countries
- More than 30 million PBS prescriptions for antimicrobials were dispensed in 2013-14
- 7x variation in knee arthroscopy
- 10x variation in opioid prescribing
- 6.5 x variation in cataract surgery
- Women in regional areas up to 5x more likely to undergo a hysterectomy or endometrial ablation than those living in metropolitan areas
- ADHD meds – 75x variation
International Comparison

ANTIMICROBIALS
Number of prescriptions dispensed

2013-2014
30,355,539

PER 1,000 PEOPLE

Australia: 1199
United States: 842
Canada: 642

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

www.safetyandquality.gov.au/atlas
Actions to address this variation

- Clinical Care Standards:
  - Antimicrobial Stewardship
  - Hip Fracture Care
  - Acute Stroke
  - Delirium
  - Osteoarthritis of the Knee
  - Heavy Menstrual Bleeding
  - DVT Prophylaxis
  - Cataracts
Where does your service sit?
Atlas 2\textsuperscript{nd} Edition

Coming soon

Interactive online version
Clinician responses to data
Human beings, who are almost unique in having the ability to learn from the experience of others, are also remarkable for their apparent disinclination to do so.
Douglas Adams
Homer Simpson, on learning that he had 24 hours to live

- **Denial**  “No way, I’m not gonna die”
- **Anger**  “Why, You @#$*!!!!”
- **Fear**  “What’s after fear? What’s after fear?”
- **Bargaining**  “Doc, you gotta get me outta this - I’ll make it worth your while!!”
- **Acceptance**  “Oh, well. We all gotta go sometime.”

“My, Homer, you’re making astounding progress!”

Dr Hibbard
Kubler-Ross’ stages of grief = Della-Fiorentina’s stages of processing your performance data

- DENIAL
- ANGER
- BARGAINING
- DEPRESSION / FEAR
- ACCEPTANCE
Does this resonate at the Board level?
“Harm is inevitable”... so why try and do anything about it...
Central Venous Access Devices – Healthcare Associated Infections NSW

- Previously considered a consequence of breaching the skin barrier – i.e. unavoidable
- 3.6 per 1000 line days
- Implementing an HAI improvement bundle
- 1.2 per 1000 line days
Clinical Quality Registry Data

Disease or system specific information
# Registries have different purposes and applications

<table>
<thead>
<tr>
<th>Registry type</th>
<th>Purpose</th>
<th>Info collected</th>
<th>Example(s)</th>
</tr>
</thead>
</table>
| **Epidemiological**          | Measure incidence of condition/disease, e.g. for policy planning, forecasting, surveillance etc | • Basic patient identifiers  
|                              |                                                                         | • Disease state/severity                   | • Australian National CJD registry  
|                              |                                                                         |                                             | • National Cancer Statistics clearing house  
|                              |                                                                         |                                             | • Australian Breast Implant Registry  
| **Post-marketing surveillance** | Track users of medical products, e.g.  
|                              | • Adverse event reporting for medicines  
|                              | • Patients with implants in event of recall  | • Patient identifiers for follow-up  
|                              |                                                                         | • Adverse events                           |                                                                         |
| **Clinical Quality Registry** | Track progress of patients  
|                              | Analyse and feed back into clinical practice and decision-making  | • Case-mix data for risk-adjustment  
|                              |                                                                         | • Longitudinal outcomes data  
|                              |                                                                         | • Treatments given                         | • Victorian Prostate Cancer Registry  |
National economic evaluation of CQRs

- Conservatively evaluated the economic impact of five clinical quality registries in Australia Incl. Vic. Prostate Ca Registry
- Preliminary findings:
  - Significant net positive returns on investments and a positive benefit to cost ratio
  - Substantial benefits measured reflecting improvements to clinical practice and outcomes over time
  - Showing that registries, when correctly implemented and sufficiently mature, deliver significant value for money
National Safety and Quality Health Service Standards
Minimising Harm
Increasing Reliability
Safe, High Quality Patient Care
<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>S1. Governance for Safety and Quality</strong></td>
<td></td>
<td>• Resulted in better integration of governance &amp; quality systems (83%)&lt;br&gt;• Clarified the roles &amp; responsibilities of Boards (82%)</td>
</tr>
<tr>
<td><strong>S3. Preventing &amp; Controlling Healthcare Associated Infection</strong></td>
<td></td>
<td>• 13.5% reduction in SAB&lt;br&gt;• 40% reduction in MR SAB rates&lt;br&gt;• 50% reduction in CLABSI</td>
</tr>
<tr>
<td><strong>S4. Medication Safety</strong></td>
<td>National Medication Chart&lt;br&gt;Residential Aged Care Medication chart</td>
<td>• 30% reduction in prescription errors&lt;br&gt;• Reduction in medication errors from 5.2/1,000 to 1.7/1,000&lt;br&gt;• Reduction in total number of prescriptions from 13.3 per resident to 5.6</td>
</tr>
<tr>
<td><strong>S7. Blood and Blood Products</strong></td>
<td></td>
<td>• 70M reduction in blood products</td>
</tr>
<tr>
<td><strong>S9. Recognising &amp; Responding to Clinical Deterioration</strong></td>
<td></td>
<td>• 30%(NSW) - 20% (Vic) reduction - in hospital cardiac arrest rates</td>
</tr>
</tbody>
</table>
NSQHSS vs Accreditation Scheme
External Accreditation processes

Issues have been raised – under review
It’s not about.....
It should be about.....

OUTCOMES
Review of the NSQHS Standards
Version 1 of the National Safety and Quality Health Service (NSQHS) Standards

1. **Standard 1** Governance for Safety and Quality in Health Service Organisations
2. **Standard 2** Partnering with Consumers
3. **Standard 3** Healthcare Associated Infections
4. **Standard 4** Medication Safety
5. **Standard 5** Patient Identification and Procedure Matching
6. **Standard 6** Clinical Handover
7. **Standard 7** Blood and Blood Products
8. **Standard 8** Preventing and Managing Pressure Injuries
9. **Standard 9** Recognising and Responding to Clinical Deterioration in Acute Health Care
10. **Standard 10** Preventing Falls and Harm from Falls
8 Standards
Reviewing the whole NSQHS Standards

Version 2 (currently in draft)

• One new standard
  • Comprehensive care

• One renamed
  • Clinical Handover → Communicating for safety

• Three standards removed:
  • Patient identification and procedure matching → Communicating for safety
  • Pressure injuries → Comprehensive care
  • Falls → Comprehensive care
8 Standards

- Clinical Governance for Health Service Organisations
- Partnering with Consumers
- Preventing and Controlling Healthcare-associated Infection
- Medication Safety
- Comprehensive Care
- Communicating for Safety
- Blood Management
- Recognising and Responding to Acute Deterioration
Timeframes

• Resources developed next 7 months
• Materials released late 2017
• Anticipated implementation from beginning of 2019
Targeting Zero
Targeting zero
Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care
Report of the Review of Hospital Safety and Quality Assurance in Victoria
Challenges
<table>
<thead>
<tr>
<th>Challenges</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Culture</td>
<td>Low level of clinical engagement in patient safety initiatives <em>that is the hospital’s responsibility</em></td>
</tr>
<tr>
<td></td>
<td>Patient safety at the side remaining the province of enthusiasts &amp; specialists – not integrated into business as usual</td>
</tr>
<tr>
<td></td>
<td>This is curious given that safety is perhaps the dominant concern of clinicians in their day to day work</td>
</tr>
<tr>
<td></td>
<td>The narrative – <em>harm is inevitable</em></td>
</tr>
<tr>
<td></td>
<td><strong>Stewardship accountabilities</strong></td>
</tr>
<tr>
<td>Challenges</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Clinical risk management</strong></td>
<td></td>
</tr>
<tr>
<td>High tolerance levels for risky providers, units and systems of care</td>
<td></td>
</tr>
<tr>
<td>Routine non-compliance with guidelines</td>
<td></td>
</tr>
<tr>
<td>Bedside to the board perceptions</td>
<td></td>
</tr>
<tr>
<td><strong>Foundational clinical governance processes not embedded</strong></td>
<td></td>
</tr>
<tr>
<td>Open disclosure</td>
<td></td>
</tr>
<tr>
<td>Incident management surveillance</td>
<td></td>
</tr>
<tr>
<td>Patient consent</td>
<td></td>
</tr>
<tr>
<td>Person centred care</td>
<td></td>
</tr>
<tr>
<td>• Health literacy</td>
<td></td>
</tr>
<tr>
<td>• Shared decision making</td>
<td></td>
</tr>
</tbody>
</table>
Recommendations for achieving patient safety

• Integrate into business as usual
• Ensure that leaders (clinical, management and board) establish and sustain a safety culture system through strong clinical governance
• Create centralised and coordinated oversight from health care organisations, state and territory administrations and nationally
• Partner with patients and families for the safest care
  • Health literacy and shared decision making
• Support the health care workforce
• Address safety across the care continuum
Recommendations for achieving patient safety

• Create a **common set of safety metrics** that report meaningful outcomes in real time – measurement is foundational to advancing improvement
• Public reporting and public accountability
• Health system learning and response
• Clinical registry data
Bon Courage!
Thank you!

Contact details:

Amanda.Walker@safetyandquality.gov.au

www.safetyandquality.gov.au