AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
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Consultation on the Draft Clinical Care Standards

Consultation Now Open

In collaboration with consumers, clinicians, researchers and health organisations, the Commission has developed draft Clinical Care Standards for **Acute Coronary Syndrome** and **Antimicrobial Stewardship**.

A Clinical Care Standard provides a small number of quality statements that describe the clinical care that a patient should be offered for a specific condition.

The Commission is now inviting feedback on these draft Clinical Care Standards from healthcare professionals, peak healthcare and consumer organisations, consumers and any other interested parties. Feedback can be provided through completing a brief survey or by making a written submission. Further details on the consultation are available at www.safetyandquality.gov.au/our-work/clinical-care-standards/consultation/

Consultation on the Draft National Consensus Statement on End-of-Life Care in Acute Hospitals
Consultation Now Open

As part of its work on improving the safety and quality of end-of-life care in acute hospitals, the Commission has developed the *Draft National Consensus Statement: Essential Elements for Safe and High-Quality End-of-Life Care in Acute Hospitals* (the Consensus Statement).

The draft Consensus Statement aims to provide guidance for health services to develop their own systems for delivering safe, timely and high quality end-of-life care in a way that is tailored to their population, resources and available personnel, whilst being in line with relevant jurisdictional or other programs.

The Commission is holding an open consultation process from 31 January to 31 March 2014. The Commission is accepting written submissions on the draft Consensus Statement and is conducting a series of workshops in each of Australia's capital cities during the consultation period.

Interested parties are invited to provide feedback through completing a brief survey or by making a detailed written submission.

To download a copy of the draft Consensus Statement, and for more information on the consultation process, please visit www.safetyandquality.gov.au/our-work/recognition-and-response-to-clinical-deterioration/end-of-life-care-in-acute-hospitals/consultation-on-draft-national-consensus-statement-on-end-of-life-care-in-acute-hospitals/

Books

The Quality Cure: How focusing on health care quality can save your life and lower spending too
Cutler D
University of California Press, Berkeley, 2014

Notes	From the publisher's description: "In the United States, the soaring cost of health care has become an economic drag and a political flashpoint. Moreover, although the country's medical spending is higher than that of any other nation, health outcomes are no better than elsewhere, and in some cases are even worse. In *The Quality Cure*, renowned health care economist and former Obama advisor David Cutler offers an accessible and incisive account of the issues and their causes, as well as a road map for the future of health care reform—one that shows how information technology, realigned payment systems, and value-focused organizations together have the power to resolve this seemingly intractable problem and transform the US health care system into one that is affordable, efficient, and effective."
URL	http://www.ucpress.edu/book.php?isbn=9780520282001

Reports

Providing integrated care for older people with complex needs: Lessons from seven international case studies
The King's Fund

Notes	This UK report synthesises evidence from seven case studies covering Australia, Canada, the Netherlands, New Zealand, Sweden, the United Kingdom and the United States. It considers similarities and differences of programs that are successfully delivering integrated care, and identifies lessons for policy-makers and service providers to help them address the challenges ahead. Key findings: • There is no single organisational model that best supports integrated care. The starting point should be a clinical/service model designed to improve care for people, not an organisational model with a pre-determined design. • Although all seven programmes made considerable efforts to improve communication between professionals and organisations, few used shared electronic medical records or integrated IT systems. Evidence from the case studies suggests that personal contact with a named care co-ordinator and/or case manager is more effective than remote monitoring or telephone-based support. • Organisational integration does not necessarily lead to patients receiving integrated care. Four of the seven case study programmes focused on integrating care at the micro-service level. • The literature on care co-ordination suggests that effective approaches often have a GP or primary care physician at the centre of a team-based approach. However, within the case study programmes, primary care physicians are rarely part of the 'core' team. Professionals need to work together in multidisciplinary teams (with clearly defined roles) or provider networks – generalists and specialists, in health and social care. The authors suggest that policy makers should: • recognise the importance of addressing the agenda of integrated care for older people with complex needs • provide stimulus through funding or other means to support the development of local initiatives to improve care for this group of patients • avoid a top-down policy that requires structural or organisational mergers • remove barriers, such as differences in financing and eligibility, in the system.
URL	http://www.kingsfund.org.uk/publications/providing-integrated-care-older-people-complex-needs

Global Atlas of Palliative Care
World Health Organization, 2014

Notes	This Atlas attempts to quantify the need for and availability of palliative care worldwide, estimating that around 20 million people need end of life palliative care. It also draws the attention to the huge unmet need in palliative care and significant inequalities across countries, and provides useful information for those wishing to increase access. The Atlas addresses the following questions: • What is palliative care? • Why is palliative care a human rights issue? • What are the main diseases requiring palliative care?

	• What is the need for palliative care? • What are the barriers to palliative care? • Where is palliative care currently available? • What are the models of palliative care worldwide? • What resources are devoted to palliative care? • What is the way forward?
URL	www.who.int/nmh/Global_Atlas_of_Palliative_Care.pdf

Monitoring the Mental Health Act in 2012/13
Care Quality Commission (CQC), 2014

Notes	This annual report into the use of the (UK) Mental Health Act provides an insight into the experiences of patients who received care under the act throughout 2012/13. It highlights five key areas which the (UK) Care Quality Commission will examine following the results of this report: • community care • reporting on death • emergency and mental health crisis • involving people who use services • investigating complaints relating to the use of the Mental Health Act. An infographic is also available at the second link below.
URL	www.cqc.org.uk/sites/default/files/media/documents/cqc_mentalhealth_2012_13.pdf http://www.cqc.org.uk/public/publications/reports/mental-health-act-2012/13/infographic-mental-health-act-2012/13

Journal articles

Scope and outcomes of surrogate decision making among hospitalized older adults
Torke AM, Sachs GA, Helft PR, Montz K, Hui SL, Slaven JE, Callahan CM
JAMA Internal Medicine 2014 [epub 20 January 2014]

Notes	This US study explores the relationship between surrogate decision making and hospital outcomes amongst older patients. In this prospective, observational study 47.4% of older medical patients required involvement from a surrogate decision maker. The kinds of decisions that most frequently needed to be made included decisions about: • life-sustaining treatments such as resuscitation status • procedures and operations • discharge planning. These patients experienced a more complicated hospital course with increased use of mechanical ventilation, artificial nutrition and increased length of stay. They also had an increased risk of dying or being discharged to an extended-care facility. Surrogate decision makers were most frequently daughters (58.9%), sons (25.0%) or spouses (20.6%). The paper raises the issue of how best to support surrogate decision makers who are frequently being asked to make complex and weighty medical decisions on behalf of a relative.
DOI	http://dx.doi.org/10.1001/jamainternmed.2013.13315

Impact of DECISION + 2 on patient and physician assessment of shared decision making implementation in the context of antibiotics use for acute respiratory infections.
Légaré F, Guerrier M, Nadeau C, Rheaume C, Turcotte S, Labrecque M
Implementation Science 2013;8(1):144.

Notes	A more explicit approach to identifying expectations is the shared decision making skills program by Légaré et al in a RCT looking at the impact of the DECISION + 2 training program on shared decision making by doctors and patients. The study found that implementation of the training program had a statistically significant effect on patients' perceived participation in decision making—suggesting that doctors can be trained to encourage patients to assume a more active role in health decision making. Among physicians, there was an effect on teaching physicians but not for resident physicians. The authors suggest this may have been partly due to a ceiling effect, since there were high rates of reported shared decision making behaviour prior to the intervention in this teaching University clinic.
DOI	http://dx.doi.org/10.1186/1748-5908-8-144

Decision aids for people facing health treatment or screening decisions
Stacey D, Légaré F, Col NF, Bennett CL, Barry MJ, Eden KB, Holmes Rovner M, Llewellyn Thomas H, Lyddiatt A, Thomson R, Trevena L, Wu JHC
Cochrane Database of Systematic Reviews 2014, Issue 1 . Art. No.: CD001431

Notes	Decision aids can help patients to identify and make a decision about the best health treatment or screening option when there is more than one reasonable option, when no option has a clear advantage in terms of health outcomes, and when each option has benefits and harms that patients may value differently. From the abstract: "This updated review, with searches updated in June 2012, includes 115 studies involving 34,444 participants. Findings show that when patients use decision aids they: a) improve their knowledge of the options (high-quality evidence); b) feel more informed and more clear about what matters most to them (high-quality evidence); c) have more accurate expectations of possible benefits and harms of their options (moderate-quality evidence); and d) participate more in decision making (moderate-quality evidence). Patients who used decision aids that included an exercise to help them clarify what matters most to them, were more likely to reach decisions that were consistent with their values. However, the quality of the evidence was moderate for this outcome, meaning that further research may change these findings."
DOI	http://dx.doi.org/10.1002/14651858.CD001431.pub4

For information about the Commission's work on shared decision making, see:
http://www.safetyandquality.gov.au/our-work/shared-decision-making/

Taking action to preserve the miracle of antibiotics
Cruickshank M, Duguid M, Gotterson F, Carter D
Australian Veterinary Journal 2014; 92(1-2):3-7

Notes	Resistance to antibiotics has been described as one of the greatest threats to both human and animal health today. With the increasing pressure on human health from resistant organisms, initiatives are needed to highlight the problem and help generate solutions. Part of the solution to addressing the problem of antibiotic

	resistance is to promote a coordinated "One Health" approach, involving consistent messages about the responsible use of antibiotics and collaboration across all sectors where antibiotics are used. In this article, the authors describe the problem of antibiotic resistance, how human health is tackling the problem from a local, national and global level, and how these solutions could potentially apply to animal health. The development of antibiotic resistance is an issue for prescribers and users of antibiotics across all sectors, and like human health professionals, veterinarians are in an ideal position to help promote the responsible use of antibiotics and reduce the development and spread of antibiotic resistance.
DOI	http://dx.doi.org/10.1111/avj.12144

Managing expectations of antibiotics for upper respiratory tract infections: a qualitative study.
Mustafa M, Wood F, Butler CC, Elwyn G.
Annals of Family Medicine 2014;12(1):29-36.

Notes	In a small qualitative study of Welsh family physicians (n=20), Mustafa and colleagues explored GPs' methods for managing expectations of antibiotics for upper respiratory tract infections. Most physicians reported a preference for knowing the patient's expectations, but preferred to use indirect communication methods to elicit these. The authors found that "clinicians prefer to use open questions and build a foundation for nonantibiotic management by using strategies to indicate their reasoning and influence expectations…. all the while avoiding conflict and potential threats to ongoing physician-patient relationship."
DOI	http://dx.doi.org/10.1370/afm.1583

For information about the Commission's work on antimicrobial stewardship, see:
http://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/antimicrobial-stewardship/

Engaging Residents and Fellows to Improve Institution-Wide Quality: The First Six Years of a Novel Financial Incentive Program
Vidyarthi AR, Green AL, Rosenbluth G, Baron RB
Academic Medicine 2014 [epub]

Notes	The authors of this study developed a quality improvement (QI) program for the University of California, San Francisco Medical Center (UCSFMC), a 600-bed teaching hospital that provides tertiary care for children and adults. The aim of the program was to engage residents and fellows in hospital-wide QI efforts by providing financial incentives and the opportunity to gain systems-based practice (SBP) experience. The study describes how the QI program was developed, and evaluates its success in meeting goals set during its first six years. Approximately 5,275 residents and fellows participated in the QI program, and a total of 55 projects were completed. Among the 18 projects that encompassed all of the graduate medical education (GME) training programs, goals were achieved for 11 (61%) in three domains: patient satisfaction, quality/safety, and operation/utilisation. Among the 37 projects that were specific to GME training programs, goals were achieved for 28 (76%) in four categories: patient-level interventions, enhanced communication, workflow improvements, and effective documentation. Residents and fellows earned an average of $800 in bonuses per fiscal year for achieving these goals.

	The authors conclude that participation provided an experience that may promote SBP competence and resulted in improved quality of care across the UCSFMC.
DOI	http://dx.doi.org/10.1097/ACM.0000000000000159

For information about the work of the Joint Working Party of the Commission and the Independent Hospital Pricing Authority, see:
http://www.safetyandquality.gov.au/national-priorities/jwp-acsqhc-ihpa/

From the archives:
What is value in health care?
Porter ME
New England Journal of Medicine 2010; 363(26), pp2477-2481

Notes	In the context of healthcare variation, it is worth revisiting Michael Porter's NEJM Perspective piece. Porter argues that achieving high value for patients must become the principal health care goal because it aligns the interests of all actors in the system. Value is the relationship between outcomes and costs. It cannot be measured using inputs or volume of services, and a shift from volume to value is a key requirement. Porter advises that "[t]he only way to accurately measure value is to **track patient outcomes and costs longitudinally**", incorporating the entire patient journey. Porter argues that "in any complex system, attempting to control behavior without measuring results will limit progress to incremental improvement" but advises that the principal purpose of measurement "is not comparing providers but enabling innovations." Failing to prioritise value "has **slowed innovation, led to ill-advised cost containment, and encouraged micromanagement of physicians' practices, which imposes significant costs of its own."** The suggested framework is a 3-tier Outcome Measures Hierarchy. Tier 1: survival; health status achieved or retained Tier 2: recovery and return to function; disutility of care (e.g. adverse events; complications; side-effects) Tier 3: sustainability, recurrences; long-term consequences of care (e.g. iatrogenic illness) The framework is applied using breast cancer and knee osteoarthritis as examples.
URL	www.nejm.org/doi/full/10.1056/NEJMp1011024

Health Policy
January 2014; 114(1), pp. 1-96

Notes	This special issue of *Health Policy* focuses on geographic variation in health care. Articles include: • Forty years of **unwarranted variation** - And still counting, J.E. Wennberg • **Geographic variation in health care** - A special issue on the 40th anniversary of "Small area variation in health care delivery", L. Sundmacher, R. Busse • A **systematic review of medical practice variation** in OECD countries, A.N. Corallo, R. Croxford, D.C. Goodman, E.L. Bryan, D. Srivastava, T.A. Stukel • **Atlas of Variations in Medical Practice in Spain**: The Spanish National Health Service under scrutiny, E. Bernal-Delgado, S. García-Armesto, S. Peiró • **Disparities in access to health care** in three French regions, M.K. Gusmano, D. Weisz, V.G. Rodwin, J. Lang, M. Qian, A. Bocquier, V. Moysan, P. Verger • Analyzing **regional variation** in health care utilization using (rich) household microdata, P. Eibich, N.R. Ziebarth

	• Understanding the gap between **need and utilization in outpatient care**—The effect of supply-side determinants on regional inequities, S. Ozegowski, L. Sundmacher • Changes in **geographic variation** in the uptake of **cervical cancer screening** in Taiwan: Possible effects of " leadership style factor"? S.-T. Chiou, T.-H. Lu • Is **variation management** included in regional healthcare governance systems? Some proposals from Italy, S. Nuti, C. Seghieri • From data to decisions? Exploring how **healthcare payers respond to the NHS Atlas of Variation in Healthcare in England**, L. Schang, A. Morton, P. DaSilva, G. Bevan • "Whose data is it anyway?" The implications of putting **small area-level health and social data online**, D.J. Exeter, S. Rodgers, C.E. Sabel
URL	www.journals.elsevier.com/health-policy/

For information about the Commission's work on variation in health care, see http://www.safetyandquality.gov.au/our-work/medical-practice-variation/

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Building **clinical networks**: a developmental evaluation framework (Peter Carswell, Benjamin Manning, Janet Long, Jeffrey Braithwaite) • Using quality improvement to optimise **paediatric discharge efficiency** (Christine M White, Angela M Statile, Denise L White, et al) • From 'reckless' to 'mindful' in the use of outcome data to inform service-level **performance management**: perspectives from child mental health (Miranda Wolpert, Jessica Deighton, Davide De Francesco, et al) • Using **balanced metrics and mixed methods** to better understand QI interventions (Peter J Kaboli, Hilary J Mosher)
URL	http://qualitysafety.bmj.com/content/early/recent