9 February 2012

Australian Commission on Safety and Quality in Health Care
C/o Leslie Trainor
Senior Project Officer
Australian Commission on Safety and Quality in Health Care
GPO Box 5480
Sydney NSW 2001

Consultation feedback: draft Australian Safety and Quality Goals for Health Care.

Dear Leslie,

Please find attached our feedback on the draft Australian Safety and Quality Goals for Health Care consultation paper. This is being prepared by Associate Professor Dominique Cadilhac and other members of the AuSCR Management Committee.

We understand that this is the first phase of a five year (initial) program. Overall, we are supportive of a focus that is based on priority areas associated with a large proportion of avoidable disease burden. Importantly, we are pleased that ‘stroke’ has been specifically highlighted in Goal 2 Appropriateness of Care - Priority Area 2. Our feedback mainly pertains to this area and issues related to stroke.

Regards,

Professor Sandy Middleton
Chair
AuSCR Steering Committee
Feedback questions | Response
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1. How do you think national safety and quality Goals could add value to your existing efforts to improve the safety and quality of care? | **Goal 2: Appropriateness of Care** value adds to our efforts over the last 20 years to improve the care of patients who experience stroke. Our researchers and policy partners have shown that not all patients with stroke receive appropriate care and that large potential opportunity cost savings could be made if there was greater application and access to evidence-based prevention and treatment interventions for stroke. Our efforts to date have included involvement in local, state-based and national audits of clinical care, clinical trials to provide evidence for effective treatments, and more recently the establishment of the first national clinical quality registry for stroke. Disease registries are an effective means of improving clinical practice. The Australian Stroke Clinical Registry (AuSCR) was established in 2009 to provide national, prospective, systematic data on clinical processes and outcomes for stroke. Participation in this is a voluntary. Given limited resources and lack of clear funding streams for clinical quality registries in Australia, currently only 18 hospitals (public, private and Children’s hospitals) are using AuSCR. However, many more hospitals desired the ability to use this register. The AuSCR Consortium represents academic and clinical stakeholders with a focus on improving the prevention, care and outcomes for people with stroke. The AuSCR initiative is led by a consortium of two leading academic research institutes: the National Stroke Research Institute (NSRI), a subsidiary organisation of the Florey Neuroscience Institutes, and The George Institute for Global Health (TGI) of The University of Sydney; and two leading non-government organizations: the National Stroke Foundation (NSF) and the Stroke Society of Australasia (SSA). These organisations formed a consortium to represent the broader Australian clinical and scientific stroke community in 2008 to address evidence-based gaps in stroke practice and establish the national register. The lack of routinely collected information on the quality of stroke care in hospitals was a major gap that needed to be addressed and the work program has commenced for this from the non-government sphere. We applaud a focus on stroke by the Australian Commission on Safety and Quality in Health Care, since it is the leading cause of adult disability and second leading cause of death in Australia. Much of the stroke burden could be prevented by improving access to evidence-based clinical practice. Specifically, the focus on stroke in the national safety and quality Goals should add value by encouraging recruitment of sites since individual hospitals will be able to use AuSCR to assist them at a local levels improve quality and report on their performance routinely.
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<td>2. Do you agree with the topics that have been included as Goals and priority areas? Are there other areas that should be considered? <strong>If additional safety and quality Goals or priority areas are proposed, referenced information should be provided to the Commission about how the proposed issue meets the criteria used to select the proposed Australian Safety and Quality Goals for Health Care (page 6).</strong></td>
<td>We agree that each of the goals and priority areas nominated are important topics requiring focussed national efforts. Another Goal that could be focussed on is related to <strong>health care infrastructure</strong>. This is because without appropriate health care infrastructure it is not possible to ensure the safety and quality of health care delivery. This may include priority areas related to workforce, the organisation of care and the availability of particular specialist services to ensure equitable access regardless of location. It is essential that there is an appropriately trained workforce available and the necessary systems are in place to ensure high quality care. For example, telemedicine is underutilised in Australia as a solution to providing access to specialists for rural-based health services. The infrastructure to support telemedicine programs is underdeveloped in a changing era of wireless communication and virtual networks of clinicians not bound by a particular hospital. More concerted efforts to utilise technology solutions and work with industry to ensure the highest quality of care is needed. Another example is establishment of dedicated staff and hospital units for stroke in the form of Stroke Care Units. Currently, routinely measuring how many patients get access to SCUs in Australia is not possible. However, this is the most generalisable and effective treatment for reduce disability and death after stroke. National audits by the National Stroke Foundation demonstrate disparities in health resources and infrastructure for stroke throughout the country, including access to SCUs. In addition, another important goal is ensuring appropriate transitions that occur for patients within the health system and supporting seamless high quality care across acute, sub-acute and primary settings. In stroke there is a need to ensure better integration of acute and rehabilitation services at a time that is going to be of most benefit to the patient. The same problems are probably evident for other conditions and separate goal specificities on health care infrastructure and patient transitions could cover off large potential gaps in the organisation and delivery of high quality and safe care.</td>
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<td>3. What do you think about the specificity of the Goals and priority areas? Are they too broad or too specific?</td>
<td><strong>Goal 2: Appropriateness of Care</strong> is very broad given acute coronary syndrome and stroke are lumped together. Each condition has unique attributes and there are different challenges in addressing issues around improvements in the quality of care for these conditions. For example, there is no debate about someone with an AMI receiving care in a CCU, however, many patients with stroke are not prioritised for management on a SCU. In addition, post AMI rehabilitation programs are very accessible and structured, but for stroke many rehabilitation services are not specialised and there are difficulties in accessing rehabilitation in suitable settings for an appropriate length of time given the broad spectrum of impairments and recovery associated with this condition, as well as the impact on families. Cardiac rehab is mostly provided in an outpatient setting whereas 30 - 40% of strokes go directly to inpatient rehab - this also highlights how vastly different these populations are and each should have its own separate focus. The consultation paper might be improved by separating out each of these conditions under this Goal, as was done for diabetes, to ensure each is considered on its own merits because the clinicians and researchers working in these areas are different and policy processes for acute treatment and rehabilitation vary.</td>
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<td>4. Do you think that there should be specific targets attached to the Goal or priority area? If so, what form should such a target take?</td>
<td>Priority areas under the broad Goals require targets to ensure there is pressure and incentives to achieve these targets over achievable timeframes and to promote routine monitoring and reporting with active quality improvement activities linked to the monitoring and reporting processes. Setting a target without the appropriate drivers in place to ensure a collective effort to reach the target means the target is not going to be useful and will be setup for failure. Targets should only be set if there is evidence to support why a particular target should be the ‘goal or ideal’ or a ‘feasible target’; and a reliable and agreed process for routinely measuring targets established.</td>
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<td>5. How do you see the Goals applying in different healthcare settings or for different population groups?</td>
<td>Each of the 3 Goals is broad enough to be applicable to different healthcare settings and population groups. Specifically, Priority 2 Management of acute coronary syndrome and stroke (though elsewhere in the document it is ‘or’ stroke) contributes to the greatest burden of disease after cancer; affects both males and females of different age groups; are influenced by socioeconomic or ethnic status; and prevention and treatment efforts span the whole continuum of care across the health system. As highlighted above, stroke and acute coronary syndrome have very different trajectories following an event, although primary prevention for both conditions may be similar. There is also evidence that access to evidence-based prevention and treatment is variable in Australia, making these conditions amenable to efforts to improve the quality of care. Efforts to address both these conditions as part of the Goal: Appropriateness of Care will provide opportunities to improve health in Australia in primary care and hospital settings.</td>
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| 6. What systems, policies, strategies, programs, processes and initiatives already exist that could contribute to achievement of the Goals? | Specifically, in the area of stroke a number of activities are being undertaken that could contribute to achieving the Goal: Appropriateness of Care. Briefly, these include (but are not limited to):  
  ● Clinical guidelines for stroke, last version disseminated in 2010.  
  ● Retrospective national audits of stroke care in acute and rehabilitation hospitals currently funded by the National Stroke Foundation since 2007.  
  ● Prospective, national registry of acute stroke care with 90+ day health outcome measures- AuSCR (currently no core funding available but supported by consortium partners and industry)  
  ● Work on tackling the prevention of cardiovascular disease through the establishment of primary prevention guidelines via the National Vascular Disease Prevention Alliance – supported by National Stroke Foundation, National heart Foundation, Kidney Australia and Diabetes Australia.  
  ● Australian Stroke Coalition (ASC) which includes reference groups to address particular facets of stroke care where identified gaps in evidence-based practice have been identified and prioritised for national action. This group is under the auspices of the National Stroke foundation and Stroke Society of Australasia.  
  ● Individual quality of care improvement programs by local health care providers, State-based Stroke Clinical Networks or the National Stroke Foundation (StrokeLink program).  
  ● Individual research projects funded by NHMRC and philanthropic organisations aimed at enhancing evidence to support implementation research interventions and health systems research |
to improve the quality and outcomes of stroke care. For example, a NHMRC partnership project, Stroke123 (AppID 1034415), has been funded in 2012. The main aim of this 4-year project is to demonstrate that integrated and comprehensive data coupled with an active and evidenced-based clinical practice improvement program is more effective than when compared to the status quo. This includes a non-randomised, multicentre, historical controlled prospective cohort study being conducted in Queensland and undertaking data linkage feasibility projects between AuSCR and the NSF audit, as well as AuSCR data with and various state-government datasets. This project is being lead by A/Prof Dominique Cadilhac.

However, a national collaborative effort to bring these activities into some sort of alignment is needed. The ASC and AuSCR Consortium partner organisations have begun establishment of a national alliance on Stroke Data and Quality of Care Monitoring. Last year, a Stroke Data and Quality Improvement workshop was held to address what the major issues are in stroke in various jurisdictions, for researchers and clinicians, as well as decision-makers. It was agreed that a fundamental objective is to get national data for stroke that is useful and consistent across the country as a first step towards improving the quality of care. This is discussed further under the next response.

7. What do you think should be the initial priorities for action under the Goals?

Goal: Appropriateness of Care - Priority area 2. Essential to improving clinical practice and providing feedback on temporal trends in patterns of care is the ready availability of reliable data on processes of care and outcomes. However, there is concern, that stroke care does not have an integrated system in place to enable the timely reporting of reliable, national data for many important aspects of routine clinical care. Since most people who suffer stroke are admitted to hospital, integrated systems of monitoring the organisation of care in hospitals can provide a good understanding of the burden of stroke in the population and provide evidence for quality improvement programs. Currently, there are various options for collecting stroke data and monitoring the quality of hospital care. These include government administrative data, as well as local state data collection initiatives. National data collection programs from the non-government sector are also undertaken. These various programs can lead to duplication of effort when the same data variables are collected twice. Harmonising data collection systems and processes, and establishing reliable linkage of data, can ensure the greatest return for the effort expended in obtaining those data. Although the technology and logistical implications remain unclear, the recognised benefits of being able to have agreed, nationally comparable patient-level data linked and harmonised will provide greater capacity to answer a range of research, policy and clinical practice problems efficiently for Australia and within each of the jurisdictions. For example, there are existing national data bases in disability (i.e. AROC) that are eager to integrate data from a stroke registry ensuring a fuller picture of the continuum of care is captured without adding extra burden to clinicians in providing the data.
The collection of data to monitor the quality of stroke care should also lead to an active process of review and the development of strategies to change clinician behaviour in addressing areas of underperformance within their control. It is important that any program of data monitoring include timely feedback with evidence-based quality improvement initiatives undertaken.

To achieve these aims:
- National organisations need to be working more formally with stroke clinical networks at the state level to advocate for the need to collect high quality data on stroke processes of clinical care.
- Fundamental measures shown to reflect and be high priority areas for stroke care quality need to be collected. For example, currently, there is no way of identifying which patients are receiving stroke unit care, as they do not have separate cost centers in the majority of hospitals. This is due to the fact that stroke unit care is often provided within another larger ward area and can come under a range of business cost centers within a hospital per se. In addition, tPA does not have its own ICD10 procedure code because it is classified as an infusion, not a procedure, therefore use of this intervention in stroke is not easily measured. Therefore, manual data collection processed which are time consuming for clinicians are used, but in the future work could be done to eliminate manual data collection if systems were developed to collect these ‘process of care’ data more readily.

8. How could the different stakeholders within the healthcare system be engaged in working towards achievement of the Goals?

While the stroke fraternity are making headway in establishing a broad group of stakeholders to address Stroke Data and Monitoring of Care Quality and Improvement this is mostly focussed on acute treatment and is driven outside the government sector. Further efforts to bring different levels of government into this arena - including technology and data; primary care (viz prevention) and rehabilitation is needed. Shared learning through various broad networks, such as the Population Health Research Network, focussed on health data and improving the collection and use of data (through data linkage potentials between various datasets) is also needed to avoid duplication of effort. There is growing interest in the field of stroke to maximise the use of data and explore data-linkage opportunities, however, funding (including that for R&D) and capacity to do this are needed.

9. What barriers exist in achieving the Goals? How could these be overcome?

Barriers include:
- Lack of core funding. Recurrent funding ensures sustainability of efforts and allows clear coordination of national efforts. Most programs have time limited funding. Core funding for mission critical infrastructure is needed. For example, currently there is no direct or clear method for funding national clinical quality registries and also sharing technology and other advancements in this field.
- Lack of formal communication and reporting of national efforts. Facilitation of communication between appropriate organisations, government departments and sectors, individuals and groups who are focussed on improving the data monitoring and quality of care efforts for stroke is needed, and infrastructure to support this communication is needed.

Presently, there are insufficient resources to integrate with a variety of existing IT systems in different hospitals to make transfer of data more convenient for staff – this detracts from
How could these be overcome?

Some suggestions to overcome barriers include:

- Establishment of recurrent funding streams for national clinical quality disease registries and associated quality improvement initiatives.
- Use of incentives to ensure agreed targets are a focus for all.
- Compulsory participation – mandating certain activities and routine reporting
- Simplifying how data are collected in the health sector and avoid manual data collection
- Investing in R&D to ensure optimal systems of data capture and potential for data linkage
- Improving processed of ethical clearances for national data collection programs to ensure follow-up data on patients can be obtained in a streamlined manner
- Simplifying how jurisdictional data may be accessed and linked to different data repositories
- National agreements for data sharing

References