On the Radar

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This week's content

Reports

Making Shared Decision-making a Reality: No decision about me, without me
Coulter A, Collins A

| Notes | The latest report from The King’s Fund looks at how the NHS may face the challenge of implementing shared decision-making. This report discusses what is meant by the term ‘shared decision-making’ and speculates as to what skills and resources will be required to implement it in the NHS. Apparently, the principle of shared decision-making in the context of a clinical consultation is ‘that it should:
| • support patients to articulate their understanding of their condition and of what they hope treatment (or self-management support) will achieve
| • inform patients about their condition, about the treatment or support options available, and about the benefits and risks of each
| • ensure that patients and clinicians arrive at a decision based on mutual understanding of this information
| • record and implement the decision reached.

The paper outlines the importance of communication skills and sets out how clinicians might approach consultations to arrive at shared decisions. It also suggests that tools that help patients in making decisions are just as important as guidelines for clinicians. Clinicians will find evidence for the benefits of shared decision-making and practical support in implementing it. |

URL http://www.kingsfund.org.uk/publications/nhs_decisionmaking.html |
For information on the Commission’s work on patient-centred care, see http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PCCC

Four Pillars: Recommendations for Achieving a High Performing Health System
Ontario Hospital Association

Notes
A new brief report (22-page) developed collaboratively by the Ontario Association of Community Care Access Centres (OACCAC) and the Ontario Hospital Association (OHA) suggests that ‘doing four things better would dramatically improve patient access to Ontario’s health care system and the quality of the care they receive’.

The paper identifies the strategic challenges facing Ontario’s health care system, and outlines the actions that must be taken to ensure it can meet the access and quality of care needs of patients in today’s challenging economic environment. The pillars they identify are:

- Setting Ambitious Goals
- Planning Properly
- Letting Evidence Drive Care Decisions, and
- Connecting Care.

URLs

The U.S. Health System in Perspective: A Comparison of Twelve Industrialised Countries
Squires D
The Commonwealth Fund, 2011.

Notes
The costs of health care – and the apparently ever-increasing rate of growth – are a widespread feature of healthcare reform debates, both here and overseas. This Commonwealth Fund paper presents a short analysis of OECD data on the health systems in 12 countries, including Australia and the USA. Given the Commonwealth Fund’s location, the paper focuses on the US data but the data given and the comparisons made also cast light on the other countries. The paper follows on the 2007 and 2010 Commonwealth Fund paper that examined the comparative performance of the US health care system compares with others internationally.

The basic findings are that the US system is very expensive and that Australia tends to be at that OECD average or better on costs. Figures are in US dollars. Whereas the US cost of health care in 2008 was $7,538 per capita or 16.0% of GDP, the OECD median was $2,995 and 8.7%, with Australia $3,353 and 8.5% (2007). The OECD median growth rate in costs was 3.9%, Australia 3.6%.

Australia was also about the OECD median on doctor-population ratios, doctor consultation rates, hospital beds/population rates, length of stay, and drug utilization; but was higher on hospital discharges per 1,000 population and CT usage (showing a higher rate of usage). Costs per discharge were highest in the US ($16,7098) compared with an OECD median of $7,729 and Australia recorded $5,949.

The report notes that a range of factors have been suggested as contributing to the high cost of health care in the USA. These have included: administrative
‘complexity, the aging of the population, the practice of ‘defensive medicine’ under threat of malpractice litigation, chronic disease burden, health care supply and utilization rates, access to care, resource allocation, and the use of technologically advanced equipment and procedures’. It also notes that ‘major reasons for higher spending include substantially higher prices and more fragmented care delivery that leads to duplication of resources and extensive use of poorly coordinated specialists.’ They also note that national policies and approaches, such as the NZ approach to drug purchasing that includes nationally negotiated rates, reference pricing, and comparative cost-effectiveness review for new medications, can be used to restrain costs.

A couple of other recent items have shown how interpreting cost forecasts is not straightforward given reform activities. A report covered in Health Affairs suggests that US health spending is estimated to rise at an average rate of 5.8% per annum for the next 10 years and reaching $US4.64 trillion (19.4% of GDP) by 2020. This is juxtaposed by a blog post by Karen Davis of the Commonwealth Fund who notes that the same US Centers for Medicare and Medicaid Services report shows that national health spending grew at a historically low rate of 3.9 percent in 2010.

URLs


Mirror mirror paper 2010:

Health Affairs item:

Commonwealth Fund blog story:

Notes

The US Agency for Healthcare Research and Quality (ARHQ) funded a 2009 workshop on human factors can be applied to home-based care. Health care devices, technologies, and practices are moving into the home. The factors driving include costs of health care, growing numbers of older adults, increasing prevalence of chronic conditions and diseases, improved survival rates for people with those conditions and diseases, and a range of innovations. The health care that results varies considerably in its safety, effectiveness, and efficiency, as well as in its quality and cost.

This report reviews the state of current knowledge and practice about many aspects of health care in residential settings and explores the short- and long-term effects of emerging trends and technologies. The report also identifies design problems and imbalances between technological system demands and the capabilities of users. The authors recommend critical steps to improve health care in the home with the recommendations covering the regulation of health care technologies, proper training and preparation for people who provide in-home care, and how existing housing can be modified and new accessible housing can be better designed for residential health care.

URL
http://www.nap.edu/catalog.php?record_id=13149
Evidence Links Increases In Public Health Spending To Declines In Preventable Deaths
Mays GP, Smith SA
Health Affairs 2011;30(8):1585-1593.

Following on the costs discussion above, is this latest piece in *Health Affairs* which argues that public health spending can produce measureable health improvements. The study tried to evaluate the efficacy of US public health spending by examining whether changes in spending by local public health agencies over a thirteen-year period contributed to changes in rates of community mortality from preventable causes of death, including infant mortality and deaths due to cardiovascular disease, diabetes, and cancer.

The authors report that mortality rates fell between 1.1 percent and 6.9 percent for each 10 percent increase in local public health spending and that these results suggest that increased public health investments can produce measurable improvements in health. They do caution that ‘more money by itself is unlikely to generate significant and sustainable health gains; improvements in public health practices are needed as well’.


It Takes A Village
Beresford L
The Hospitalist 2011;July 2011.

This article covers practices to improve care transitions and prevent hospital readmissions for indigent or poor patients with examples from a number of US cities. It is also includes a list of suggested steps for improvements.


Defining Health Information Technology-Related Errors: New Developments Since To Err Is Human
Sittig DF, Singh H
Archives of Internal Medicine 2011;171(14):1281-1284.

The use of health IT is widespread; it is also seen as holding potential for safety and quality issues. However, there can be unintended consequences and new errors emerge. In this piece errors are seen as malfunctions during use, incorrect use by individuals, and insufficient interaction between HIT and another system component. The paper uses a framework with socio-technical model dimensions (e.g., hardware/software, clinical content, workflow, human–computer interface) to examine errors and potential ways to reduce their incidence.


Explaining Michigan: developing an ex post theory of a quality improvement program.
Dixon-Woods M, Bosk CL, Aveling EL, Goeschel CA, Pronovost PJ
Milbank Quarterly. 2011;89:167-205.

In this paper the authors explore a ex post theory in order to understand the success of the Michigan Keystone project in reducing infections. They focus on the networked community, multimodal interventions, data-driven processes, and

*On the Radar* Issue 51
placing of catheter-related blood stream infections as a social problem as being critical factors.

URL http://www.milbank.org/quarterly/8902feat.html
http://www.milbank.org/quarterly/8902feat.pdf

For information on the Commission’s work on healthcare associated infections, see http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-03

BMJ Quality and Safety online first articles

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<td>• Visualising differences in professionals' perspectives on quality and safety (31 July)</td>
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<td>• Role of organisational structure in implementation of sedation protocols: a comparison of Canadian and French ICUs (5 August)</td>
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International Journal for Quality in Health Care online first articles

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Online resources

International Forum for Quality and Safety in Healthcare: Solutions for Tough Times
http://internationalforum.bmj.com/2012-forum
17–20 April 2012
Le Palais des Congrès de Paris
The organisational streams for the 17th International Forum for Quality and Safety in Healthcare are:
1. Safe and reliable care
2. Better value, lower cost
3. Clinical improvement
4. Transformational change
5. Workforce and culture
6. Patient engagement
7. Leadership
8. Primary care
9. Technology for improvement.

On the Radar Issue 51
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