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Queensland Government
Queensland Health

QUALITY IMPROVEMENT AND ENHANCEMENT PROGRAM

MINUTES

Board Meeting of the Measured Quality Program Area

Held 21st May 2002, 11.00am–1.00pm

Conference Room, 17th Floor Queensland Health Building

CHAIR: Dr Filby

1. **Welcome and apologies**

Dr Filby welcomed Board members. Previous minutes for 19th February 2002 were accepted as true and accurate

Present were:
Dr David Filby (Chair)
Dr John Youngman
Dr Glenn Cuffe
Dr Roger Brown
Dr Ian Ring (for Ms Sue Cornes)
Ms Elizabeth Garrigan
Ms Jane Hansen & Ms Julie Ellis (for Ms Jenny Pouwer)
Dr Ian Scott
Ms Geri Taylor
Mr Paul Monaghan
Ms Anita Hansen (for Dr Alan Isles)

Program Area staff:
Mr Justin Collins
Ms Adele Thomas

Apologies:
Prof Bryan Campbell
Mr Paul Sheehy

Non-attendees's:
Ms Sue Mahon
Mr David Jay
Ms Jenny Thomas

2. Program Update and Progress

Progress was overviewed in slides 3 - 4 (attached).

Hospital report & technical supplement, public report, master document
Report availability dates were given, with the hospital report release date to follow some time thereafter. The Board was informed about the current hospital report & technical supplement feedback process to the four District Managers and Gloria Wallace. Comments received back from Mark Waters and Moina Lettice had been very positive.

Milestones for each project / quadrant
The status of each milestone was delivered, with a brief overview on the current status of the (4) verification process.

Hospital Clinical Utilisation & Outcomes Indicators Project
Progress was overviewed in slide 5 (attached).
Details were given on the development and refinement of crystal reports from Transition, which allow hospitals to verify their results in the Measured Quality reports simply and easily. As a result of the verification process, the re-analysis of 1 condition was required and has since been completed.

Hospital Efficiency Indicators Project
Progress was overviewed in slide 6 (attached).
Problems highlighted during the verification process were overviewed and actions taken as a result were discussed (eg. meeting with DSS, FAMMIS & Finance to summarise existing problems with FTE data). A summary of issues will be detailed in the master document as well as sent to the 'data owner' for action.

Hospital System Integration & Change Indicators Project
Progress was overviewed in slide 7 (attached).
Changes to 3 indicators were highlighted, along with the reasons for the change. Some suggestions and changes for improving the results of the survey were highlighted. In particular, the feedback from most hospitals to date was that the volume of surveys, required to be completed by Corporate Office, was large and often duplicated. A suggestion to combine survey questions from different areas, refine and develop a good survey tool, and perform the survey once a year would perhaps increase the quality of results, reduce cost of performing multiple surveys, and be less burdensome on hospitals. A summary of issues will be detailed in the master document.

What happens next?
Progress was overviewed in slide 8 (attached).
Phase 2 requirements currently identified as being within scope were overviewed

3. Report format

The latest version of the hospital report (de-identified) was distributed to Board members.

Changes from the previous report were summarised.

Comments from the Board include:

- The report requires a clearer explanation on the statistical method used for each quadrant and the reasons for the differences (the why, and what, we have done).
- Several suggestions were made in relation to how, and where, this could be communicated. For example, either in Attachment 3, which gives a glossary of the terms used in the report or, alternatively, the report could provide an explanation at the bottom of each quadrant's page on the statistical methods used.
- Add some commentary on the risk adjustment used in the analysis in the 'Overview of the Indicators Used' section.
- Delete the caveat at the bottom of each page stating that 'The figures contained in this report are not official.....'

Action: Incorporate Board comments into the hospital report.

The draft Efficiency section of the public report was distributed to the Board members to be reviewed in conjunction with the outline provided in the email.

Comments from the Board include:

- Inclusion of a table at the back of the public report that lists hospitals in their peer groups, with their relative performance (1, 2, or 3 stars) for each sub-section, in each quadrant.

Action: Incorporate Board comments to Public report.

4. Marketing and Communication

Objectives were overviewed in slides 10 – 14 (attached).

The release strategy that was forwarded to board members was discussed in detail, with direction provided on some of the questions raised.

Hospital Report:

- Distributed to DM's via GMHS
- DM's to decide whether they wish to provide details of their hospital report to the media etc.
- DMs responsible for responding to questions raised as a result of report distribution.
- Notify communications officer in HSD's
- 1 hard copy of the Technical report is to be provided to each HSD. The report will also be available electronically

Possible reasons for variation between hospitals was referred to and discussed. Board members were asked to provide comments in relation to any additional reasons for variation that could be identified.

The use of prominent people to promote the Measured Quality reports was suggested as a strategy to add validity to the reports. Suggestions included: Bruce Barraclough & Andrew Wilson.

The three objectives of the Measured Quality reports were re-highlighted.

Objective 1: Has various activities to ensure that it is met

Objective 2: Currently underway. A release strategy for the Measured Quality reports is currently being developed.

Objective 3: Was to be met through the roundtable sessions. However, due to the nature of this exercise being outside the existing scope of Measured Quality, other suggestions / possibilities to meet this objective were requested from the Board.
Suggestions include: Linking Measured Quality with other Program Areas within QIEP including, CHI, CDPA & Clinical Audit.

5. Issues / Actions

Issues for mainstreaming Measured Quality was overviewed in slide 15 (attached)

Five issues to be considered for mainstreaming Measured Quality were raised. Documents for the evaluation of the Patient Satisfaction survey, previously distributed to board members via email, were referred to.

It was raised that the lessons learned need to be clearly highlighted if these activities are to be considered for mainstreaming. Although work performed to date has been well received, actual benefit to the organisation must be demonstrated.

Discussion took place regarding future Patient Satisfaction surveys. It was agreed that the preferred option for the Patient Satisfaction survey was to have a central / corporate approach, but with the flexibility for individual hospitals to use certain sections of the survey tool to perform regular or ongoing surveys within their hospital, so that they can monitor the effects of improvement strategies put in place. It was noted that the existing tool could be altered to suit QH needs as required, without legal or financial cost under the contractual arrangements with the vendor.

6. Next meeting

Date: 20th August 2002
Time: 11.00am to 1.00pm (correction from agenda – 10.00am to 12.00pm)
Venue: 17th Floor Conference Room, QHB

Marketing and Communication: 3 key objectives

- Readable and credible reports
- Effective dissemination of reports
- Facilitating the use of the data in service improvement planning

Obj 1. Readable and credible reports

- Data verification process
- National data for Clinical and Efficiency
- Review of drafts by small group of District Managers
- Technical editor/marketing person to edit material for various audiences

bj 2. Effective dissemination of reports

Pro-active media plan

- Media releases; launch; media kits for clinical leaders; articles in newsletters and peer reviewed journals
- Liaison with District communication staff
- Establish a newsletter

- Timely response to queries
- Identify existing effective dissemination strategies
  - QST Marketing Committee
  - Zonal forums
  - QHEPS page
  - promote at conferences and national forums
- Involving the Colleges in process

Obj 3. Facilitating the use of the data in service improvement planning

- Round Table 1
  - Clinical (Medical, Surgical, O&G)
  - Efficiency
  - System Integration and Change

  12 participants in each, participants make up to reflect zones and peer groups

- Round Table 2
  - 2 participants from each Round Table 1 invited to address the overall findings and consider balance issues

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SUBMISSION TO THE DIRECTOR GENERAL

DATE: 31 / 05 / 02

PREPARED BY: Justin Collins, Program Area Manager – Measured Quality (324 74927)

CLEARED BY: Roger Brown, Team Leader – Clinical Strategy Team (323 40693)

SUBMITTED THROUGH: Glenn Cuffe, Manager – Procurement Strategy Unit (322 52361) gcuffe 31/5/02

RECOMMENDED / NOT RECOMMENDED BY:

☐ General Manager (Health Services)

DOC 456 EJ 31/5/02

DEADLINE: **FILE REF:** 1236-0355-028

SUBJECT: Preparation for release of Hospital and Public reports for Measured Quality

APPROVED / NOT APPROVED

DIRECTOR-GENERAL'S COMMENTS:

(1) → DDG MS 10.6.02

(2) I agree to seek Ministers agreement. GMHS to action please

NB: Need to continually reinforce - 'a learning organisation' and own vision

Also, 'what measured is managed!'

MS 11.6.02

note DG's → Comms

(Dr) Robert Stable
Director-General
/ /

PURPOSE:

The purpose of this submission is to provide information to enable the Director General to be briefed by the General Manager (Health Services) on the format and detail of the Hospital reports and seek agreement for their release and for the briefing of the Minister.

BACKGROUND:

The Measured Quality Program Area forms part of the Quality Improvement and Enhancement Program (QIEP) and goal is to improve the capacity of the Queensland public health system to provide quality services and deliver optimal outcomes by developing systems to routinely measure and utilise performance data. These systems will be developed through the balanced scorecard methodology.

There will be two types of reports produced by Measured Quality:

1. A report for each of the sixty hospitals covered by the program area
2. A more general public report

The tentative target date for the release of both types of report is on or around the 12th July 2002.

ISSUES:

1. Format of the individual hospital report.

Attachment 1 provides a draft version of the hospital report which was developed after considerable consultation within Corporate Office and with selected District Managers.

The report format was designed to allow District Managers and hospital staff to identify areas were they may wish to concentrate improvement activity. The data presented is the best available but it is assumed any reasonable professional would understand the caution with which individual data should be treated.

2. Potential misinterpretation of hospital level data by the public.

The reports are not designed for the public. However, it is realistic to expect that the information in the hospital reports will become publicly available through informal channels or through freedom of information requests.

There are many potential explanations for the variations in the level of performance between different hospitals. See **attachment 2** for list of possible reasons for variation.

3. Individual hospitals showing poorer performance could be targeted by the media.

Hospitals have been rated on overall performance. It is considered that the most useful approach would be to release summarised performance data as shown in **attachment 3**. The release of this data will allow hospital performance to be discussed in its broader context.

BENEFITS AND COSTS:

The benefits associated with the preparation of a marketing and communication strategy include an approach that is pro-active in responding to questions raised as a result of the release of the Measured Quality reports.

CONSULTATION:

- Raw data for the Clinical, Efficiency, & System Integration and Change quadrants have been verified with hospitals and changes incorporated where possible.
- Clinical reference groups have been setup and utilised for the development of clinical performance indicators.

ATTACHMENTS:

1. Example Hospital Report
2. Possible reasons for variation
3. Overall performance for each hospital

RECOMMENDATION(S):

1. The Director General to endorse the format of the hospital report.
2. The Minister be briefed on the report.
3. Once the hospital report format is approved by the Director General, the hospital report is released to the Marketing and Communication Unit for the development of a detailed media plan.

(note: the reasons identified below are only possibilities and have not been collated as the collective or individual view of any hospital or Health Service District. Until the interpretation of the variation is investigated at the hospital level it is not feasible to be 100% sure why a particular variation has occurred.)

Clinical

- Variation in outcomes highlighted between hospitals may be a result of clinical coding practices varying from hospital to hospital ie. Hospital A may code a clinical condition a certain way and Hospital B may code it another way, thus resulting in different outcomes. Variation in accuracy and extent / detail of coding can also have significant impact.

- Variation highlighted in outcomes between hospitals within and across peer groups may be the result of different size hospitals treating sicker or healthier patients (i.e., differences in disease severity, coexisting conditions, age, smoking, nutrition, psychosocial factors, economic disadvantage, and the like). Statistical models can be used to adjust for these differences, but data might not be available for some potential confounders (e.g., severity, smoking, nutrition, psychosocial factors, economic disadvantage) and for those where data are available, the quality of the information might be questionable

- Long length of stay for older patients may be a result of limited rehab facilities and the non-availability of nursing home beds in the area.

- Some preliminary work has been done within and external to Queensland Health, to look at possible trends of clinical outcomes for specific hospitals and it has shown the ranking of hospitals varies considerably from year to year. In short, casemix adjustment is not be perfect, and a certain degree of chance must be factored when using outcome indicators for hospitals. These findings add weight to the view that chance and imprecision are factors in this type of analysis.

- Q. Why do this analyses? A. The analyses of outcome indicators cannot be definitive. They are best viewed as a screening tool to stimulate interest in quality at individual hospitals, and to suggest useful avenues for further investigation. This approach is attractive because in-depth evaluations are costly and there is a need to identify where to target scarce resources for improving quality of care

- Variation in hospital performance may be related to the differences in the quality of care provided between hospitals.

Patient Satisfaction

- A possible reason for variation between hospitals is the different characteristics of the physical environment, staff and of patients within the hospital. These differences between hospitals can be identified as one of the major reasons for variation.

- Weighting of patient characteristics to the hospital population is used on the data in the patient satisfaction quadrant and is an acceptable method used to adjust for possible confounding factors. Adjusting for differences in the types of patients seen at particular hospitals is important because certain groups of patients might systematically report lower levels of satisfaction than other groups. It is important to realise that risk-adjustment can only reduce, but not eliminate, the effects of casemix differences.

- **Efficiency**

- Data collections vary from hospital to hospital (eg. Issue with corporate reporting hierarchy). The existing corporate / state reporting hierarchy may not be meaningful at a hospital or HSD level. This is because of the variation from hospital to hospital on what costs / cost centres should be included in a hospital when providing an overall picture. As a result of this inconsistency / lack of agreement hospitals report on an alternate hierarchy for there own purposes. Alternate hierarchies make it difficult to roll up to a statewide or corporate view.

- Overall length of stay may be a result of limited rehab facilities and availability of nursing home beds in the area.

- Bed occupancy variation between hospitals and across peer groups may be a result of different size hospitals treating sicker or healthier patients (i.e., differences in disease severity, coexisting conditions, age, smoking, nutrition, psychosocial factors, economic disadvantage, and the like). Statistical models can be used to adjust for these differences, but data might not be available for some potential confounders (e.g., severity, smoking, nutrition, psychosocial factors, economic disadvantage) and for those where data are available, the quality of the information might be questionable

- Differences in infrastructure, management and variation in competence between hospitals may impact on variation in cost of service delivery.

- Varying degrees of staff skills and ability

- Different size hospitals have varying degrees of availability of staff to dedicate to the collection and monitoring of efficiency type indicators.

System Integration & Change

- Lack of a systematic approach to collecting and monitoring these sorts of indicators in the past results in limited accuracy of data and lack of interest by hospitals in this sort of information.

- Difficulties for rural and remote hospitals to attract and keep staff puts them at a distinct disadvantage when using workforce management indicators.

- A previous lack of a statewide approach to the implementation of telehealth equipment and services across Queensland has resulted in a mis-match and inconsistent use of telehealth facilities.