'JEC 30'

CABINET SUBMISSION

ADDENDUM:

MET:

MIN

DG

HELEN LITTLE

BRUCE PICARD

TONY HAYES

GLENN CUFFE

JUSTIN COLLINS

SUSAN ROBERTS

HANDOUT 1

A SHOUT ON: ~~EACH~~ HOSPITAL BOARD - 3 PM

AGENDA

CABINET SUBMISSIONS

6-8 WEEKS

END OF SEPT

REGISTRATION

BRAD SMITH

4/14/7

PURPOSE

NOTE + APPROVE ITEMS

SUMMARY

ISSUES - RELATIONSHIP WITH NORTH ~~RELATIONSHIP~~ ROAD

MEASURED QUALITY

Presentation of Public & Hospital reports

Purpose: **To seek approval for release of Measured Quality reports**

Measured Quality

1. Aim

- Queensland Health 'leading the way'
- International reference articles & advice

2. Deliverables

- 1 * Public Report (incl: tech supplement)
- 60 * Hospital Reports (incl: technical supplement)
- 1 * Master document (includes 1 chapter for each quadrant)

3. Credibility and usefulness of reports

- Indicator Selection
- Accuracy and Ownership
- Robustness of indicator results
- Indicator and report presentation

4. Preparation for release of hospital reports

- Response to media
- Hospitals 'outliers' for clinical indicators have been contacted

5. Effective dissemination and facilitation of change / improvement

- Understanding the reports

INFORMATION SUBMISSION

CABINET SECRETARIAT

ROSS WALKER - PREMIER'S
47693 IN CABINET

ADVICE TO PREMIER.

PUBLIC - TO BE RELEASED

HOSKINSON - SEE TO DMS

56066
AMANDA HALLAM

EXTERNAL PARTIES
~~TREASURY~~
~~ROSS~~ - PREMIERS.

INFO SUB
LIMITED 200.

CABINET ON:
30 SEPT

FROM
LODGE: 24 TH

~~DRAFT~~ FIRST LODGE 16 TH

2ND SEPT

HANDOUT 2

PRESENTATION

Measured Quality Program Area

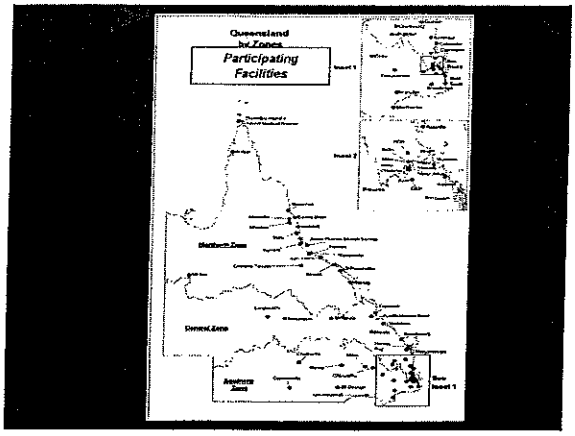
Queensland Government
Queensland Health

AIM

AIM OF THE PROGRAM AREA

"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."

- It is in essence a quality monitoring program
- It will develop a core set of indicators for measuring quality of services
- It is about identifying variation



BSC & NHPF

Clinical Outcomes	Patient Satisfaction
• Effectiveness • Appropriateness • Safety • Accessibility	• Responsiveness
Efficiency	**System Integration & Change**
• Efficiency	• Continuity of Care • Capability • Sustainability

'Queensland Health 'Leading the way'

- First in Australia to undertake the development of a 'Balanced Scorecard' for Public Hospitals
- Has the support of the Australian Council for Safety and Quality in health care

INTERNATIONAL LINKS

- Similar to work undertaken in Ontario, Canada
- Informal discussions with the University of Calgary about 'Lessons Learned' from the Ontario work
- Articles from the University of Birmingham have provided 'Lessons Learned' from the UK use of performance indicators

DELIVERABLES

PUBLIC REPORT

Purpose

- *Provide a snapshot for the community on the performance of its public hospitals and the activities Queensland Health is undertaking to address any problems identified*

HOSPITAL REPORTS

Purpose

- *Provide data to hospitals on a set of core indicators, measuring the quality of services.*

- Information contained in database can be manipulated to provide District reports, peer group reports, zonal and Statewide reports.

MASTER DOCUMENT

Purpose

- *Provide details on the method, indicator descriptions, etc. for Queensland Health and other health service agencies on the process of developing the reports.*

CREDIBILITY

INDICATOR SELECTION

Expert groups consulted

- Medical
  - Dr Ian Scott. PAH
  - Prof Charles Mitchell. PAH
- Surgical
  - Dr Christina Steffen, Cairns Base
  - Dr Russell Stitz
  - Dr Don Pitchford. Gold Coast
  - Dr David MacIntosh, Cairns

INDICATOR SELECTION

Expert groups consulted (cont'd)

- Obstetrics & Gynaecology
  - Prof Michael Humphrey. Cairns Base
  - Dr Dereyck Charters. Gold Coast
  - Dr Mano Haran . Logan

ACCURACY AND OWNERSHIP

Data verification process

Raw data extracted for 3 quadrants, then sent to each hospital to be verified.
(Patient Satisfaction data verified previously)

ROBUSTNESS OF RESULTS

Statistical Methods

- **Clinical** - Risk Adjustment with measure of statistical significance against peer group mean
- **Efficiency**- Single hospital score, compared to peer group median
- **System integration and change** - Single hospital score, compared to peer group median
- **Patient satisfaction**- Weighted, with measure of statistical significance against peer group mean

INDICATOR AND REPORT PRESENTATION

Clinical Outcomes	Patient Satisfaction
· 1999/2000	· 2001/2002
Efficiency	**System Integration & Change**
· 2001/2002	· 2001/2002

INDICATOR AND REPORT PRESENTATION

Comments from District Manager review working party

District Managers:

Dr Mark Waters
Ms Moina Lettice
Mr Mike Allsop
Mr Jeff Hollywood

State Manager:

Ms Gloria Wallace

INDICATOR AND REPORT PRESENTATION

Summary of positive comments:

- Reported indicators are extremely interesting
- Major step forward in the management of hospital services
- Helps staff focus on outcomes management
- Easy to read and practical document
- A major step forward in trust between Corporate Office and Districts as the Hospitals have had the opportunity to verify the data
- Hospital peer groupings are appropriate
- Could be used as a basis for Performance Agreements with Districts and within Districts

INDICATOR AND REPORT PRESENTATION

Summary of positive comments (cont'd):

- Data sources are sustainable through support by existing systems
- Focus on in-patient acute performance is a good first step and has allowed focus in the first report
- Very useful initiative
- Easy to read and practical document
- Excellent document

INDICATOR AND REPORT PRESENTATION

Summary of comments on suggested changes:

- Various suggestions on efficiency indicator refinement
- 1999 / 2000 clinical data is getting old
- Different years data across the quadrants makes it difficult to draw any conclusions between the quadrants

PREPARATION FOR RELEASE OF REPORTS

RESPONSE TO MEDIA

In anticipation of questions from the media. strategies have been developed in conjunction with the Marketing and Communication Unit

- Seek comments from hospitals with outlier clinical results
- Identify project communication objective
- Identify Key target groups
- Identify Key Messages
- Draft a Communication Plan Timeframe

CONTACT MADE WITH HOSPITALS

The process of contacting each hospital

- Results for 32 clinical indicators were ranked (Hospital with highest rates to lowest)
- 29 Hospitals were identified and contact made with District Manager
- Met with District Manager and members of the executive and explained the methodology used to derive the results
- Assisted with identifying some possibilities for the results
- Requested formal response on possibilities for the results highlighted and details incorporated into Queensland Health and local Hospital media plans

EFFECTIVE DISSEMINATION

UNDERSTANDING THE REPORTS

Preliminary contact has been made with each Zone

Once approval for the release of the reports has been given Measured Quality can:

- Brief representatives from Northern, Central & Southern Zones on the results and methodology used
- Assist with engaging hospital staff and other projects (QIEP) to disseminate and use results effectively

UNDERSTANDING THE REPORTS

'Lack of clarity over the aims of an indicator system will inevitably lead to problems over ownership of the data and disputes over their meaning and proper use'

– During initial contact with hospitals, detailed explanation on the use of the indicator results was given

UNDERSTANDING THE REPORTS

Key Messages

"Reported indicators are exactly that: indicators to focus attention on issues of interest. They are neither proof of a problem or its solution"

" use of indicators as clues to performance, discussed and interpreted by clinicians and managers in the light of local contexts and with the aim of continuously improving the quality of clinical care. Such approaches foster trust and communication between clinicians and managers, with the result that they are better able to work through problems with care delivery and improve quality"

HANDOUT 3

PUBLIC REPORT

HANDOUT 4

HOSPITAL REPORT

HANDOUT 5

LIST OF INDICATORS

HANDOUT 6

LIST OF IN-SCOPE HOSPITALS

Table 1: Hospital Name and Peer Group

Hospital Name	Peer Group			
	Principal Referral and Specialised	Large	Medium	Small
Atherton Hospital			✓	
Ayr Hospital				✓
Barcaldine Hospital				✓
Beaudesert Hospital			✓	
Biloela Hospital				✓
Bowen Hospital				✓
Bundaberg Hospital		✓		
Caboolture Hospital		✓		
Cairns Base Hospital	✓			
Caloundra Hospital			✓	
Charleville Hospital				✓
Charters Towers Hospital				✓
Cherbourg Hospital				✓
Chinchilla Hospital				✓
Cunnamulla Hospital				✓
Dalby Hospital			✓	
Emerald Hospital				✓
Gladstone Hospital		✓		
Gold Coast Hospital	✓			
Goondiwindi Hospital				✓
Gympie Hospital			✓	
Hervey Bay Hospital		✓		
Ingham Hospital			✓	
Innisfail Hospital			✓	
Ipswich Hospital		✓		
Island Medical Service				✓
Joyce Palmer Health Service				✓
Kingaroy Hospital			✓	
Logan Hospital		✓		
Longreach Hospital				✓
Mackay Base Hospital		✓		
Mareeba District Hospital				✓
Maryborough Hospital		✓		
Mater Misericordiae Public Adult Hospital	✓			
Mater Misericordiae Public Childrens Hospital	✓			
Mater Misericordiae Public Mothers Hospital	✓			
Miles Hospital				✓
Mossman Hospital				✓
Mount Isa Hospital		✓		
Nambour Hospital	✓			
Princess Alexandra Hospital	✓			
Proserpine Hospital			✓	
Queen Elizabeth II Jubilee Hospital		✓		
Redcliffe Hospital		✓		
Redland Hospital		✓		
Rockhampton Base Hospital		✓		
Roma Hospital				✓
Royal Brisbane Hospital (inc. Royal Women's)	✓			
Royal Childrens Hospital	✓			
St George Hospital				✓
Stanthorpe Hospital				✓
The Prince Charles Hospital	✓			
Thursday Island Hospital				✓
Toowoomba Hospital	✓			
Townsville General Hospital (inc. Kirwan)	✓			
Tully Hospital				✓
Warwick Hospital			✓	
Weipa Hospital				✓
Wynnum Hospital				✓
Yeppoon Hospital				✓

HANDOUT 7

DRAFT MEDIA PLAN FOR PUBLIC REPORT

HANDOUT 8

DRAFT MEDIA PLAN FOR HOSPITAL REPORT

Queensland Government
Queensland Health

COMMUNICATION STRATEGY
Measured Quality Facility Report
Queensland Hospitals in the Twenty-First Century A First Report: 2002

To inform the community and hospital staff Queensland Health aims to improve service by implementing a State-wide method for managing and using patient complaints and survey data.

BACKGROUND:
The Measured Quality Program Area of the Quality and Improvement Enhancement Program has produced a State-wide public report based on 60 individual hospital reports, providing a snapshot of the performance of Queensland's public hospitals.

The first stage of the measurement process focuses on inpatient services, the largest component of Queensland Health's services.

The report, *Queensland Hospitals in the Twenty-First Century A First Report: 2002*, measures four different aspects or quadrants of health care delivery.

The four quadrants are:
- **Clinical Utilisation and Outcomes:** measures the clinical performance of hospitals for a number of disease and surgical conditions.
- **Patient Satisfaction:** measures patients' perceptions of and satisfaction with their hospital experience.
- **Efficiency:** measures how hospitals manage their resources.
- **System Integration and Change:** measures a hospital's ability to adapt to its changing health care environment.

Where possible, data has been adjusted to account for potentially confounding factors such as sex, age, and a patient's health status.

The report outlines how Queensland Health developed the method of measurement and the results of this measurement. It compares the results across similar peer groups of hospitals and with national performance data. Peer groups are based on the hospital's size and geographic location to reduce the impact of these factors on patient outcomes.

The 60 hospitals included in the report have been classified as follows:
Principal Referral and Specialised hospitals x 12
Large hospitals x 13
Medium hospitals x 10
Small hospitals x 25

The individual facility reports provide details of the ratings achieved by individual hospitals within their peer groupings.

ISSUES

- Journalists will request individual facility reports on local hospitals once they are aware of their existence. A decision needs to be made on whether access will be granted administratively, or only through a Freedom of Information request.
- Queensland Health needs to identify a departmental spokesperson to talk to the overall performance of Queensland Health.
- Queensland Health/Districts need to identify a district spokesperson to talk to the individual facility reports (should they be released) and answer media questions locally.
- District Managers should be briefed on the need to prepare media plans, particularly where their facility showed substantial variation from their peers. An example is available for reference.
- The earlier results of the Patient Satisfaction Survey were announced based on the percentage of overall results, rather than the results of the Overall Care Index, for example Toowoomba Health Service District - 98% of patients were satisfied with their overall care. However, the results from the Measured Quality data may translate into 'one or two star' performance out of a possible three. This contradiction will need to be addressed.

PROJECT COMMUNICATION OBJECTIVES

The project aims to improve the accountability of health services by:

- *measuring* the quality of services and reporting this to the public;
- *informing* the community on aspects of health care, assisting and encouraging public debate and community participation in decisions regarding improvements in health care;
- *improving* Queensland Health's responsiveness to community needs and expectations by encouraging participation and feedback; and
- *establishing* an ongoing process that reports on performance and supports continuous improvement.

COMMUNICATION OBJECTIVES

- Queensland Health is acting on its commitment to continuous improvement.
- Queensland Health is delivering on its commitment to be open and transparent.
- In conducting the report, Queensland Health is developing a model to improve quality of care across its facilities. The report is not designed to provide definitive answers to the quality of care but indicates areas for further investigation at individual hospitals.
- One year's data should not viewed as a precise measurement. Queensland Health will look at trends over time.
- Patients will ultimately benefit from resulting enhanced quality of care and improvements to accountability.
- Queensland Health is one of the first Australian State or Territory health service providers to conduct a report of this kind and it is a pilot.
- Queensland Health is improving responsiveness to community needs and expectations by encouraging participation and feedback.

KEY TARGET GROUPS

- District Management and staff
- Corporate Office executive and staff
- QIEP Areas
- Queensland public
- Local communities

DETAILED COMMUNICATION PLAN:

Target Audience	Message	Tool	Responsibility	Date
EXTERNAL Local-area community	Can be used in a pro-active/reactive manner Positive local results Areas for improvement Broad Queensland Health context (key messages, background)	Local media Press release Radio interview (if necessary)	Marketing and Communication to prepare shell media release. District communication officers/hospitals to localise release and issue to relevant media.	To be issued after the *Queensland Hospitals in the Twenty-First Century A First Report: 2002* is released publicly.
Local-area community and Queensland public	Reactive Detailed responses to variations indicated in the facility report to be issued where required. *See Attachment 1 (not complete).* Detailed explanation of method if required. *See Attachment 2 (not complete).*	Where required – expected local and state media, including The Courier-Mail and radio.	Marketing and Communication, Measured Quality Team and relevant hospital to develop. Hospital to nominate spokesperson for local/state media with approval from DG.	After the release of the public report, where necessary.
INTERNAL District staff	Background to reports Results What does it mean for me?	District newsletter	Hospital to prepare and issue with assistance from Marketing and Communication.	After the release of the public report.

Generally, all hospitals in this peer group compare favourably with international standards. It is inevitable when ranking hospitals that one will have the lowest score. This does not mean the hospital is performing "poorly", but suggests potential areas where the hospital may need to review practice. The aim of these reports is not to give definitive answers, but to provide a mechanism for making comparisons over time. It is designed to flag the areas where there may be quality issues, so they can be investigated in greater detail.

Detailed responses to facility report variations.

Why does Hospital X have almost twice its peer group average for stroke in-hospital mortality?

A review of the Stroke mortality group revealed that without exception, these patients had "Not for Resuscitation" arrangements put in place when it was recognised that their prognosis was poor. This means the patients have chosen not to have emergency lifesaving treatment in the event of cardiac arrest.

This group consists of 19 patients, who would have discussed the option with their doctors and families upon admittance. Stroke patients are generally very unwell with 90 per cent having existing conditions, such as high blood pressure or cardio vascular disease. Stroke is often a result of these factors, however, the pre-existing conditions leading to a stroke may not have been included in the coding. Potentially, these co-morbidities may not have been picked up in the risk-adjustment if they were not coded. So although stroke was coded as the major diagnosis, this may not necessarily have been their cause of death.

Senior medical officers will conduct a more detailed analysis of these charts and review protocols used, including coding, when patients choose not to have emergency lifesaving treatment. Hospital X currently has regular meetings involving coders and medical personnel to clarify queries.

Why does Hospital X appear to have such a high number of NFRs?
We have to allow for a certain degree of chance that the 19 patient records used for the report's data were NFRs. It may be that our doctors are more comfortable initiating discussions about this option. It is an option discussed with patients who tend to be very unwell and their families.

Why are patients admitted to Hospital X after having a stroke almost 30 per cent more likely to stay longer than if admitted to other hospitals in this peer group? (State?)

A review of the charts for the 'Stroke Long Stay' patients has revealed that in most instances the extended stay was due to social reasons. Results pertain to six patients. In three cases, patients were living at home alone before their stroke and were unable to return to independent living. They therefore had to wait for appropriate nursing home or hostel placement. In one case, the completions of home modifications, essential before the patient could safely be sent home, were delayed. In the remaining two cases, the spouse was preparing to care for the patient. In these cases, it did appear the spouse might have had some difficulty adjusting. This may indicate the need for further documentation.

These charts will be analysed more extensively by the relevant clinicians to identify any opportunities for improvement in these processes.

Longer rates of stay can also relate to the distance a patient can safely travel after treatment, and on the necessity for follow-up treatment. If a patient lives considerable distance from the hospital, it may be safer to keep them in hospital longer. Although this doesn't appear to be the case with these six patients, it is important to note. (Including this comment will help educate the journalist/public on the issue.)

Although the long-stay rate for Hospital X is relatively high, the number of patients included in the report is quite small. Six patients stayed for 66 days or longer, compared to an expected number of 2.3. It is quite likely this is due to chance, and the data for the following year will be monitored.

Why are people 30 per cent more likely to die in hospital X when admitted with pneumonia than any other in its peer group?

The charts for the Pneumonia mortality group have also been reviewed. Investigation has revealed that while the primary diagnosis was pneumonia, the cause of death was related to co-morbidities or other events, such as myocardial infarction or gastro-intestinal bleed, in several of these patients. Other patients were gravely ill on presentation with community-acquired pneumonia and died very soon after admission.

Importantly, the data used for the report was from 1999-2000. This was the latest available data at the time of the report. Since then pneumonia in-hospital mortality rates have dropped significantly. After examining data for 2000-2001 and 2001-2002, it is evident the year surveyed was unusual. There may have been a particularly virulent strain in the area that year, especially considering many patients were gravely ill on admittance after acquiring pneumonia in the community.

ATTATCHMENT 2

To formulate general questions and answer

Aim of Report
The analysis of clinical treatment outcomes is not designed to provide definitive answers to the quality of care hospitals are providing. The results provide a screening tool to suggest useful avenues for further investigation into quality at individual hospitals. This method was used because in-depth evaluations are costly. There was an initial need to identify where to allocate scarce resources for improving the quality of care.

Potential reasons for variations
Variances may indicate differences in the quality of care a hospital is providing. The report aims to highlight these areas where there may be room for improvement.

Other reasons may include:

- *Data*

This part of the report was based on data from 1999-2000 as it was the most up-to-date at the time. Some preliminary work within and external to Queensland Health has shown hospital ranks vary considerably from year to year. Adjusting for different casemixes is not perfect and a certain degree of chance must be considered when using indicators based on outcomes. Queensland Health is developing a tool to measure quality over time and does not expect this report covering such a small timeframe to give definitive answers to quality of care.

It is inevitable when ranking hospitals that one will have the lowest score. This does not mean the hospital is performing "poorly", but suggests potential areas where the hospital may need to review practice or is, in fact, doing very well. The aim of these reports is not to give definitive answers, but to provide a mechanism for comparing them over time.

- *Coding*

Some variations may be the result of different hospitals or individual staff members interpreting the clinical codes differently. For example, the same condition may be coded a variety of ways by different hospitals, which results in a different outcome. Variations in accuracy and the detail of coding can also impact significantly. Increased variation may occur in the coding or reporting of secondary diagnoses, or co-existing illnesses.

- *Sicker or Healthier Patients*

Other variations may result from different sized hospitals treating patients who are sicker or healthier. Patients will naturally have differences in disease severity, potentially varying coexisting conditions, different ages, general health including nutrition, exercise and smoking status, psychosocial factors and economic conditions. Statistical models can be used to adjust for these differences, but data may not be available for all factors and, even when it is, can never fully account for the patient mix. Coding may also be affected the amount of detail the clinician documents in the patient's chart.

- *Other Differences*

Differences in infrastructure, management, and skills between hospitals may impact on variations in service delivery costs.

Staff skills and availability to monitor issues such as overtime varies across hospitals.

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

Where to from here