Measured Quality Sponsor meeting
30 September 2002

Agenda

- **Background**
  1) Go through the slide presentation
  2) Go through 6 monthly report

- **Current Status – Phase 1, Cabinet Submission for Hospital & Public report**
  1) Provide copy of draft cab sub and public and hospital reports
  2) Issues: As a result of our request and subsequent agreement for Professor Bruce Barraclough to champion the work undertaken by QH, he has requested a copy of each of the hospital reports. Due to the sensitivity of the results and the restriction in distribution of the hospital report it would be unlikely that we will be able to do this. MQ propose that as an alternative to providing him with the hospital reports we offer to brief Prof Barraclough on the methodology used and to review the reports.
  3) Confirm distribution list for public report

- **Strategies to ensure further dissemination**
  1) Provide draft outline of presentation to ZM's
  2) Contact to be made this week to agree on date for brief

- **Finalisation Report & Budget request for completion of phase 2**
  1) As a result of discussion re: the finalisation report at the last sponsor meeting a draft budget increase request has been detailed
  2) Provide original of Finalisation report and draft budget increase request to complete Phase 2

- **Current Status – Phase 2**
  1) Provide summary of phase 2 changes
  2) Provide summary of DEA & seek approval to proceed with investigating its use

- **Next board meeting agenda & membership – 8 October, 11.30am – 1.30pm:**

Measured Quality Sponsor meeting
12 September 2002

Agenda

Issues / Actions

- **Finalisation Report:**

Note:
- Enough funding for Project Officers until December 2002 (partial completion of phase 2).
- Finalisation report will be submitted to the next Quality Council for consideration

Provide Steve with Finalisation report

- **Current Status – Cabinet Submission for Hospital & Public report:**

Note:
- The purpose of the contact with the 19 hospitals was to:
  1) Communicate the objectives of the MQPA &
  2) Flag the outlier clinical indicator results, seek some potential reasons for variation so as to form the basis of a media plan.

Provide Steve with a summary of the comments received and MQ issues.
- We have only documented feedback thus far. We have not commenced further discussions in order to highlight mis-conceptions or inaccuracies in the responses as this is technically 'out of scope'
- As a result of the presentation to the Minister and DG we have a draft cabinet submission which will have the Public report and 60 Hospital reports attached.
- Consideration by Cabinet date: 28 October 2002
- DG has requested that a 1 pager be drafted for each of the 19 hospitals that have been flagged as having 'outlier' clinical indicator results and potential reasons for variation. We are now refining the hospital responses to be suitable for the Cabinet submission

Provide Steve with a draft '1' pager to go to Cabinet

- **Strategies to ensure further dissemination**

Note:
- Discussions within the team suggest that due to the age of the data and the fact that as a result of our request for some potential reasons for variation a large number of hospitals have performed chart audits
- We are proposing to contact each ZM and seek the nomination of a representative to attend a brief from Measured Quality on the indicators used, methodology, process involved etc. We also thought it to be appropriate to include OIU, CDP, CHI, Clinical Audit in the process

- When the reports have been through Cabinet, the hard copy hospital reports can then be forwarded to each DM and ZM. It would be up to each DM or ZM as to who views the results eg. Different units etc. but what we would encourage is for the results to be discussed at forums such as: Zonal Forum, Development and Directions Forum, & Roundtable sessions
- Suggestion from some DM's have been to help form the basis of the service agreements. (due to the report having to go through Cabinet we have missed this financial years service agreement)
- The inclusion in the service agreements may also be an opportunity to seek each DM's commitment to participate in the improvement of the quality of the clinical coding practices, completion and timeliness of the Perinatal Data Collection, consistency in the use of reporting hierarchies in FAMMIS and DSS.

- **Delay in Phase 1 & Commencement of Phase 2**

Notes:
- Refer 6 monthly QIEP report & list of members of expert groups:
  1) Have commenced the process for revision of existing indicators through engaging expert groups,

Provide Steve with list of members for each reference group

  2) pulling next years data
- Issues: We need to be able to clearly articulate existing problems with data accuracy to ensure the quality of the reports progress, In order to get more timely data for the reports we have not been given the opportunity to formally receive feedback from all hospitals on refinement (only comment from the 19 hospitals visited and the DM's working group.

- **Next sponsor meeting agenda – 30 Sept, 3.00pm – 4.00pm**

- **Next board meeting agenda & membership – 8 October, 11.30am – 1.30pm**

Notes:
- Provide list of existing members, and ask if OK for Sabrina Walsh to join. Ask if there are any extras or deletions?
- Provide list of members for expert groups

Measured Quality Sponsor meeting
11 June 2002

Agenda

Issues / Actions

- Finalisation Report:
  1. Current functions to continue after 30 June 2003
  2. Activities that may have to be handed over and strategies to effect hand-over.

- Strategies for hand-over of Measured Quality 'sponsorship' on 26 July?

- Current Status – Submission to Director General re. Preparation for release of Hospital & Public report:
  1. Release date for reports?
  2. DM's response to 'bad performers'?

- Public Report:
  1. Current Status
  2. Proposed list of recipients
  3. Proposed 'Technical supplement'
  4. Proposed 'Summary report'

- Hospital Report:
  1. Current Status

- NEED FOR SPONSORS TO VIEW MASTER REPORT FOR EACH QUADRANT?

- ROUND THE QUADS.

Measured Quality Sponsor meeting
28 May 2002

Agenda

Issues / Actions

- Provide comments from District Managers on hospital report and confirm changes requested from Board.
- Clinical data: Hospital scores risk-adjusted but peer group and state means are not.
- Efficiency data: Should we place an extra caveat on this quadrant?
- Post verification process contact with hospitals – propose to send memo prior to release of reports.
- Brief to DG on release of Hospital and Public report

ONCE WE HAVE A DATE FOR RELEASE.

Next Sponsor Meeting: 11 June 2002

WHERE DID IT COME FROM?

SOME HOSPITALS HAVE PROBLEMS WITH IT

SET DATE FOR 4 WEEKS

OBSERVED RATES

ODDS RATIO.

From: Mark Waters
To: Cuffe, Glenn
Date: 20/05/02 8:13:29
Subject: re measured quality program

I have read the document given me on Friday re balanced scorecard for PA.
I cannot remember what you wanted me to do with it .
My comments are as follows -
I think in general terms the document is excellent however its major weakness is that it is using data from 99/2000.
If such a document were to be continued its usefulness would be much greater if it could look at data more recently collected e.g. 2000/2001 for collation in May 2002.
Certainly any efficiency conclusions will be lost in a wave of defensiveness if we use two year old data.

CC: Buckland, Steve

Acknowledge
99/00 - clinical
Hospital
+
Public
Reports

Queensland Government
Queensland Health

MEMORANDUM

Northern Downs Health Service District
PO Box 365, Chinchilla 4413

To: Dr G. Cuffe, Manager, Procurement Strategy Unit

Copies to:

From: Moina Lettice
District Manager
N. Downs Health Services District

Contact No: 46628843

Fax No: 46628230

Subject: **Feedback on Hospital Reports (Balanced Scorecard)**

I have read through both the Report and the Technical Supplement and found them both to be very readable. The general flow of the documents made them very easy to read and to follow the explanations and information provided. I could not put them down until I had finished them.

I found the data and associated reported outcomes extremely interesting from a DM perspective. I would value receiving a copy of the report and the technical supplement with the benchmarking data/tables related to each of the District's hospitals as this would be an excellent management tool to improve efficiency.

Thank you for the opportunity to read these documents.

Moina Lettice
District Manager
Northern Downs Health Services District
21 May, 2002

Queensland Government
Queensland Health

MEMORANDUM

Fraser Coast Health Service District

To: **Dr G Cuffe, Manager, Procurement Strategy Unit, Queensland Health**

Copies to:

From: **Mike Allsopp, District Manager, Fraser Coast Health Service District.**

Contact No: 07 4123 8274
Fax No: 07 4123 8447

Subject: **Comments re:Measured Quality Hospital Report**

Thank you for the opportunity to comment on the Measured Quality Hospital report.

The concept and quality of the documentation I consider provides a major step forward in the management of Hospital services for Queensland Health. In essence the concept utilises available information to constructively focus a health service on key areas to understand their performance. Understanding performance and comparing that performance with peers are the first steps in creating an environment and expectation of health services to take action to improve performance. It also establishes a consistent framework to focus staff internally on outcome management.

In terms of readability and logic flow the presented documentation is simple to understand and logical. The information aligns with what is required to successfully run a health service.

The positive aspects of the report from my perspcective are:

- It is simple. Particularly the "star" system and four primary quadrants. Complexity engenders avoidance. Simplicity encourages focus.
- The data gets to be qualified/approved by the District before publication. This is a major step forward in the "trust" issue. Comparative benchmarked performance information should be used to identify areas of variance. Variance needs to be examined to determine whether it is a data issue or a reality. Signing off of data before publication encourages ownership and participation in the next step of strategising performance improvement. Information is then seen to be used for its correct purpose and not just to beat you around the head .
- A consistent range of whole of Queensland Health performance indicators will focus the total organisation.
- Hospital peer groupings are appropriate.
- As the report is an annual event it can be utilised also as a basis for Performance Agreements with Districts and within Districts with their various service areas. Districts will need to have regular updates within the year to provide feedback on improvement achievement.
- The report importantly recognises that it is not perfect and will improve. Again a reinforcement of the continuous improvement principle.
- The document is a result of broad consultation not an insular few. This efficacy of this approach is reflected in the practicality of the final document.

- The data sources are sustainable through support by existing systems. This is essential. No indicator, with the exception of the Yes/No type, should be included unless there is a valid automatic data feed with consistent catchment dictionary and fields.
- Education will be required for staff to understand the management of the "drivers" that affect the result in order that they can improve performance in the management of those drivers.
- Concentrating on inpatient acute performance is step one. Improving analysis and data sources to include performance across the pre admission and discharge support continuums can be developed in the future. Not trying to do too much at once is important as focus will be lost.

Areas where I consider improvement is needed.

- The area of FTE analysis and indicators I consider is inadequate. FTE's mean nothing on their own unless associated with an output, particularly when it is being considered under the heading of "efficiency". Grouping of numeric FTE by Hospital size creates a performance range that is too broad. Accordingly, I consider that the FTE analysis should be either on a per 10000 bed day basis or 1000 weighted separation basis or some agreed output measure to determine the efficiency of the labour engaged. This also allows potential for cross analysis for improvement in staff and cost performance by reductions in ALOS. Labour is our major cost item and as such performance indicators should be concentrated on that item married to the result of utilising that labour.
- In looking at the result for Catering for Hervey Bay specifically in the report the issue of data check is highlighted. The crude formula utilised does not recognise that meals are also prepared for the Bayhaven Nursing Home from the Hervey Bay Kitchen. The figure that needs to be fed in is that refined by the Operational Services Reform Group. In reality the Hervey Bay figure is $27.36 for the 99/00 financial year compared to a benchmark of $29.00. The feeder should be determined on the formula's and adjustments prepared by the Operational Services Reform Group. A Cleaning and Portering Benchmarks should also be included on a similar base. However, I realise that such a suggestion is outside the scope of my requested comment but may be considered for the future.
- The calculation formula for Occupancy Rate does not agree with that traditionally used. The traditionally accepted figure is: Number of Occupied Bed Days/ Number of Available Bed days.
- The calculation for Length of Stay should refer to Overnight Bed Days and Separations excluding Day Only in order to be a useful figure. The title should be Average Length of Stay and not just Length of Stay. Similarly a % of Day Only of total admissions is a good indicator for performance improvement . The indicator as it currently stands is rather useless as major variance can occur for day services such as renal and chemotherapy where Hospitals have those specialties. While simplicity is important you can get too crude for useful. (Attached is a simple spreadsheet used by this District)
- In the FTE formula for Indicator 8 I do not understand why Overtime would be excluded. In DSS which is the logical feed the Standard FTE indicator includes Overtime. I don't see it as a "double dip" of the Overtime indicator mentioned later.
- As ACHS Accreditation is an indicator use should also be made where appropriate of ACHS Clinical Indicators to ensure consistency and ensure focus.

In conclusion I consider that the approach taken is a major step forward in utilising our vast data collection activities to focus on improving performance. Should you have any further questions please do not hesitate to contact me.

Mike Allsopp
DISTRICT MANAGER
FRASER COAST HEALTH SERVICE DISTRICT

23 May 2002

Board Meeting of Measured Quality Program Area

May 21 2002, 11.00 am – 1.00pm
17th Floor Conference Room
Queensland Health Building

AGENDA

Chair: Dr Filby

1. Welcome and apologies - Dr Filby

2. Program Update and progress

- Internal Business / Hospital Clinical Indicators Project
- Patient Satisfaction / Hospital Responsiveness Indicators Project
- Efficiency / Hospital Efficiency Indicators Project
- System Integration & Change / Hospital Continuity of Care, Sustainability and Capability Indicators Project

Seeking broad endorsement of progress for each project and Board's position on issues requiring resolution

3. Issues / Actions

- Program Area finalisation & main-streaming
    1. Discussion re: future patient satisfaction survey

4. Report Format

- 'Draft' hospital report – (Seek board final endorsement before release to hospitals)
- Outline and 'Draft' sections of public report – (Seek board comments)

STAMP.

5. OUTLINE PICK 1 OR 2 OF THE CONTENT BITS

AGE MARK WARDS TO.

5. Marketing and Communication

- Release strategy for Hospital and Public report

- 4 levels of audience:
    1. DG, DDG, GMHS & Zonal Managers
    2. District Managers & Hospital Executive
    3. Directors of divisions & senior specialists & consultants
    4. Registrars, Nurses, Business Managers & Quality co-ordinators

6. Next meeting

- 20 August 2002 – 10am – 12md

Measured Quality Sponsor meeting
17 May 2002

Agenda

Progress

- Provide current version of 'draft' hospital report and technical supplement (as attached) - due for release on 31 May 2002.

Issues / Actions

- Seek comments on public report draft sections provided on Wednesday (specifically seek direction on which data to use in clinical quadrant).
- Brief to DG on release of Hospital and Public report
- Endorse Agenda for Board meeting

HAND COPY TO ABELE
CLINICAL - GO WITH MQ DATA

Next Sponsor Meeting: 28 May 2002
Next Board Meeting: 21 May 2002

2 SIGNATURE - DOG
+
6 MITS

COPY OF REPORT.

TABLE
CIRCL. 02 03 OR MEDICAL SURGICAL ETC

HOSPITAL
B
C

Preparation for release of Hospital and Public reports for Measured Quality

SEE JJ - CARD + NOT VERIF.

CONT. NUP WITH BAYLEF

Hospital

- Hospital report distributed to hospitals: Friday, 31 May 2002 (hard copy)
- Hospital report distributed to each Zonal Manager, 25 May 2002 (hard copy)
- Technical report as supporting documentation to be distributed
- Original going to the District Manager with a covering memo detailing how widely the report should be distributed outside the hospital, possible questions and answers that the hospital may be asked: attached, mention the release of the public report on 28 June or day of estimates: 12 July
- Question and answer sheet provided
- Controlled copies
- PDF files available by 28 June
-

[redacted]

Questions:

1. Will the hospital report be distributed to the DM's via GMHS (as an internal document) or will it be distributed the DG?
2. Can the DM provide details from the hospital report to media or should they be FOI'd
3. Is the DM responding to questions or should questions be directed to corporate office?
4. Should the technical document be sent electronically or hard copy or made available on QHEPS or combination of the above.
5. Should we notify the communication officers in the HSD's.

Public

- Public report distributed: Friday, 28 June 2002 or day of estimates 12 July (hard copy)
- Public report going to 37 or 39 health councils (approx 10 per council) and to a range of state and local politicians. public report on 28 June or day of estimates: 12 July
- PDF file available soon after
-

Questions:

1. Do we need a Technical report as supporting documentation to be distributed
2. Will the public report be launched or just the standard media release? — ASK MINISTER
3. Should the technical document be sent electronically or hard copy or made available on QHEPS or combination of the above.
4. Should we notify the communication officers in the HSD's.
5. Should the report be made available on the inter & intra net?

Risks for release of hospital report:

List those hospitals that have a statistically significant variation or that the data shows a possible problem in a particular area.

Refer attachment

List possible reasons for the variation demonstrated in the report:
(note: these are only possibilities and until the variation is investigated at a more in depth / local level it is impossible to be 100% sure.)

Clinical

1. 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.

2. Variation highlighted in outcomes between hospitals within 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

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

4. 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 in when using outcome indicators for hospitals. These findings add weight to the view that chance and imprecision are large factors in this type of analysis.

   Q. Is it useful to 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

5. Quality of care issue

CONFIDENCE

6.

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Efficiency

1. Data collections vary from hospital to hospital (eg. Issue with corporate reporting hierarchy). The existing corporate / state reporting hierarchy is generally not meaningful to a hospital or HSD. 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 of an alternate hierarchy for there own purposes. As this alternate hierarchy is simply a mis-match collection across the state it does not accurately roll up to a statewide or corporate view.

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

3. 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

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

5.

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10.

Patient Satisfaction

1. As per Patient Satisfaction documentation for release of state report.

System Integration & Change

1. Lack of systematic approach to collecting and monitoring these sorts of indicators in the past provides us with limited accuracy of data and lack of interest by hospitals in this sort of information.

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

3. 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.

4.

5.

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7.

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9.

Summary of Key Decisions
(Identified in Font Size 14 & **Bold**)

Measured Quality Sponsor meeting (Dr Filby & Dr Buckland – as A/GMHS)
3 May 2002

Progress

- Provide current version of 'draft' hospital report (as attached) - due for release on 31 May 2002.

A summary of the recent changes to the hospital report was given and changes made were endorsed. It was noted that Dr Buckland believed that the Mater Adults should not be in the 'Principle Referral & Specialised' peer group, and perhaps the sub total 'cost of service' in the Efficiency quadrant could be re-named so that it was clear that the 3 stars inferred better performance, not higher.

Action:
Add the hospital score to the 'quartiles per indicator' – attach 2 section of the report and
Report the efficiency data as verified through DSS (eg. Redcliffe) – This highlights the inaccuracies of the data and will promote an improvement in the quality of the hospital level data(on the corporate reporting hierarchy.)
Discuss a name change to the 'cost of service' sub total in Efficiency quadrant.

- Time difference between the Facility (31 May 2002) & Public (30 June 2002) reports.

Issues / Actions

- Direction required for content of public report (options attached and to be discussed at meeting)

The 4 options for the public report were proposed and discussed. Direction was given to:

Action
- *A general description of hospitals at the start*

- *Write the body of the report in the format of presenting in each quadrant*
- *Identification of current QI activities that link with each quadrant.*
- *2 – 3 pages at the end discussing the diseases etc as per Vermont*

First draft due in 3 weeks (27 May).

A Possible release date for the public report could be 'Day of estimates' in early July 7th or 11th.

- Presentation / Comparability of AIHW national data with the Measured Quality data (examples to be presented and discussed)

An example of the differences between the AIHW data and Measured Quality data was provided and discussed. It was decided that while the data continues to be largely different, it would be less confusing if Measured Quality reported on our own data.

Action: The option of using the AIHW data was left open on the basis of further corrections to improve the similarity to MQ results.

- Evaluation of phase 1 (options to be presented and discussed)

Options for the evaluation of phase 1 were presented and discussed. Due to the leadership QLD has taken in this project it would be difficult to find an interstate peer that could provide a useful evaluation.

Action: It was therefore suggested that it should be performed internal to Q Health with a clinician and/or manager. Suggestions included Terry Mehan and Michael Cleary.

- Statistical Partnering for phase 1 (options to be presented and discussed)

Action: Direction was given to engage a statistical partner for the detailed statistical analysis of the report eg. Clinical - Bob Gibberd, but not to include the overall performance / summary statistical analysis in the partnering as this was merely a high level highlight of variation rather than specific performance indicators

- Analysis performed around the quadrants ie. Balance (options to be presented and discussed)

??????????????

- Direction required for Marketing & Communication ie. Options other than roundtables.

The possibility of using a large portion of the zonal forum in July & August was suggested as a venue to discuss the interpretation of the results from Measured Quality.

Next Sponsor Meeting: 17 May 2002
Next Board Meeting: 21 May 2002

Measured Quality Sponsor meeting
3 May 2002

Agenda

Progress

- **Provide current version of 'draft' hospital report (as attached) - due for release on 31 May 2002.**

Summary of changes:

1) Word, Font & General layout changes
2) Peer groups list brought forward into front section
3) Statistical significance table moved front section, to the bottom of the score section for Clinical and Patient Satisfaction.
4) Moved the 'indicator' number from left side of page to the far right and change to 'reference' Difficulties with re-numbering were mainly around the ability to easily reference a particular indicator in the technical document or master document from the hospital report. If we re-numbered according to their order in the hospital report, we would have to re-number all of the reference material. The reference material would then have to be custom made for the hospitals as the medium and small have varying numbers of indicators.
5) We reviewed the efficiency indicator names and added an extra column 'data type' in order to be more definitive eg. 'hours of sick leave per FTE'
6) Have re-ordered 'Overall performance at a glance' section and 'Quartiles per indicator - for each peer group', in accordance with the body of the report.
7) Have added a state report (attachment 3). This was added as a result of discussion about providing those medium and small hospitals that do not have enough activity / numbers to provide an accurate hospital indicator, therefore the next best thing is to provide them with their peer group report. (REFER LIST OF HOSPITALS WITH NO INDICTATORS REPORTED)
8) (REFER LIST OF INDICATOR OWNERS AND SUMMARY OF DISCUSSION WITH DSS) Issues with efficiency data have been highlighted to the 'data owners' and in some cases the 'data owners' have highlighted them to us. We need to determine what we intend to do with the reporting of the indicators:

a) identify which indicators we are not going to use in the report (as the current number is still to many) and place caveats on the data that we do, to identify the issues.
b) Not report any of the indicators we are not confident with and possibly liaise with HIC to report what they do: ***Quote 'Christina, FTE is a curly one. Yes we collect FTE to the definitions of the NHDD through the AIHW annual establishments collection. (FRAS) In the NHDD definition the requirement is for ON-JOB HOURS PAID FOR only and includes contract employees. The FTE that is captured in this (FRAS) collection is derived from all labour dollars spent and is more of a financial FTE as it is based on dollars. The other FTE is a***

payroll/HRM FTE as is based on hours. HRM/Payroll also exclude/include certain types of hours as well. eg: Special Leave, overtime. I guess it comes down to what you require and what you are using it for. FTE data is also accesable via DSS as another source. By using DSS you can use more flexibility as to which FTE hours you wish to include and exclude.

Either way each of the SPO's are summarising the issues with the data and data collection in the quadrant write-ups and can be referred to internally by the data owners or projects that will be looking to resolve these issues. Have already liased with Neil Gardener - Client Services and Ken Suddick – ODB re: the FTE data collection.

Clinical - Perinatal data collection

SI&C – Suggest a once a year Corporate Office survey to collect this sort of information as hospitals have indicated that they continually fill in the same sort of info on various surveys. We could potentially save time and money and recive a beter response rate and quality of responses by having it done this way.

Patient Satisfaction – needs to be sorted.

- **Time difference between the Facility (31 May 2002) & Public (30 June 2002) reports.**

Re-confirm with the sponsors

Do we need to put the hospital report through the strategic directions group?

Issues / Actions

- **Direction required for content of public report (options attached and to be discussed at meeting)**

Over to Adele to go through some options for the public report.

6 weeks for ministers office

6 weeks for printing

- **Presentation / Comparability of AIHW national data with the Measured Quality data (examples to be presented and discussed)**

(REFER PRESENTATION AND IAN SCOTT EMAIL TO EXPLAIN DIFFERENCES) The presentation of the AIHW data needs to be considered as we believe to present the AIHW results against the Measured Quality results would be extremely misleading. We think the only way to present the AIHW data is to do so completely separate to our data. Maybe the public report, maybe another attachment to the hospital report (attachment 4)

- **Evaluation of phase 1 (options to be presented and discussed)**

Previous direction was that we should organise an external evaluation of phase 1. We have briefly would like to progress according to the following options.

- **Statistical Partnering for phase 1 (options to be presented and discussed)**

Over to Roger

- **Analysis performed around the quadrants ie. Balance (options to be presented and discussed)**

Over to Roger

- **Direction required for Marketing & Communication ie. Options other than roundtables.**

Will be meeting with Robyn Muller and Glenda Viner on Tuesday to begin the preparation of the hospitals, HSD's and Zones for the hospital reports.

A suggestion has been to distribute to each Zone their hospitals reports prior to the release to the hospitals eg. Maybe shortly after the board on the 21st.

Should we approach Gloria Wallace and 4 DM's (one from each peer group) to proof read the hospital report and technical report prior to release?

Had planned to get a prof reader for the master document for each quadrant as well:

SI &C – OIU person
Patient Satisfaction – Anita Hansen
Efficiency – Director Corp Services
Clinical – Ian Scott

Have engaged MQP and will engage CDP to investigate further possibilities of engaging change agents forums for change etc.

- **Measured Quality presentation at Balanced Scorecard Learning Group**

Refer email to Dr Filby for approval to participate in presentation

Next Sponsor Meeting: 17 May 2002
Next Board Meeting: 21 May 2002

Measured Quality Sponsor meeting
3 May 2002

Agenda

Progress

- Provide current version of 'draft' hospital report (as attached) - due for release on 31 May 2002.
- Time difference between the Facility (31 May 2002) & Public (30 June 2002) reports.

Issues / Actions

- Direction required for content of public report (options attached and to be discussed at meeting)
- Presentation / Comparability of AIHW national data with the Measured Quality data (examples to be presented and discussed)
- Evaluation of phase 1 (options to be presented and discussed)
- Statistical Partnering for phase 1 (options to be presented and discussed)
- Analysis performed around the quadrants ie. Balance (options to be presented and discussed)
- Direction required for Marketing & Communication ie. Options other than roundtables
- Measured Quality presentation at Balanced Scorecard Learning Group

Next Sponsor Meeting: 17 May 2002
Next Board Meeting: 21 May 2002

Summary of Key Decisions
(Identified in Font Size 14 & **Bold**)

Measured Quality Sponsor meeting (Dr Filby)
8 April 2002

- Provide an update on the status of the verification process.

An update on the current status of the verification process for each quadrant was provided to the sponsors.

Clinical: **It was acknowledged that the clinical data as a whole was consistent with crystal reports (transition) at the hospitals. Some changes needed to occur but it was considered that further refinement of the crystal reports would result in consistency between MQ data and transition reports. Timeliness associated with the perinatal data was highlighted as a problem and re-analysis of this data will need to occur (once data is finalised in HIC)**

Efficiency: **The major problem with the efficiency data revolved around the FTE data from DSS. It was considered that this was due to differences in the reporting hierarchy used at the corporate level (corporate hierarchy) and those used at the hospital / district level (alternate hierarchy).**

Action: Highlight problems with data in report

Patient Satisfaction: **n/a**

System Integration & Change: **Some changes to hospital's response to the SI&C survey have been directly incorporated into the results of phase 1**

- AIHW data

It was acknowledged that the request for national comparitive data from AIHW has taken several weeks longer than the original timeframe identified. The data has now been provided (Friday, 5 April 2002) and the data analyst will review the data and progress its inclusion in the reports.

- Report Format

The format of the hospital report was discussed with several options being presented (including those previously identified at the MQ Board meeting). The result of these discussions finished with:

- **Summary page (3 stars, rolling from an overall rating per quad, down to indicator groups in each quadrant)**
- **Clinical & Patient Satisfaction quad's to identify hospital score, peer group mean, and identification of significance between 90% & 99.9% confidence intervals, and the 99.9% confidence interval.**
- **Efficiency & SI & C quad's to identify hospital score and peer group median only.**
- **At the end of the report every indicator is presented in quartiles (with state median) for each of the 4 peer groups.**

Action: Prepare an example hospital report from each of the 4 peer groups by Thursday, 11 April 2002.

- Phase 1 'In scope'

A direction to have the public report prepared by end of June 2002, round table sessions by end of May 2002, and hospital reports as soon as possible (with an example from each of the peer groups by Thursday 11 April 2002) was given.

- Peer Groups

The final version of the peer groups was presented, with Rockhampton being included in the 'large' peer group. This was done so on the basis that even though it had a large catchment area its activity was still to low for it to be comparible in the 'Principal Referral and Specialised' peer group.

Action: MQ to proceed with the endorsed version of the peer groups.

Measured Quality Sponsor meeting
12 February 2002

Agenda

Progress

1. 6 monthly progress report to QIEP – monthly progress report to sponsors (how much detail?) -- GANTT CHART ETC.
2. Inclusion of Mater hospital in reports – WAITING ON DATA TO BE SENT
3. Minutes / Notes from previous data meetings
4. System Integration & Change quadrant: Have now got responses from every facility (Weipa and Charters Towers surveys came in last week) – **100%** completion and return rate.
5. Submit next 3 clinical conditions & seek feedback from previous 2

Issues

1. Management of requests for indicator list.

   Issue: Markets the view that MQ will report on the current 'full list' of indicators (warts and all) ie. MQ have meaningless indicators
   Possible solution / s:

- Do not distribute lists of indicators until we have been through the process of verification with hospitals
- Distribute – but ensure that the receiver is aware that MQ is in the process of verification

Also

Mail-out of data to facilities occurred on Friday, 8 Feb 2002 **(see: attached memo & PAH data)**. As a courtasy we sent each of the QIEP Zonal Co-ordinators a copy of the memo. NZ have already asked if we could produce a Zonal report for them, so they could tie in with existing groups that review performance across the zone. AGREED

2. Clarify 'nursing home re-admissions' query.

   - Re-admissions for F/NOF(indicator: 6.3), or
   - Separations to Nursing homes (F/NOF: 6.5 & Stroke: 3.4)

3. Patient Satisfaction
   - Will there be another survey for phase 2?
   - Use of data (as per original approval) – Email from Roger?

LIST OF

Measured Quality Sponsor meeting
12 February 2002

Agenda

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PROGRESS

Enquiries to: Justin Collins, Program Area Manager – Measured Quality Program Area (QIEP)
Telephone: 07 324 74927
Facsimile: 07 323 41211
Our Ref: 1236-0355-031

Dr John O'Donnell
Chief Executive Officer
Mater Misericordiae Health Services
Raymond Tce
South Brisbane, QLD, 4101

Dear Dr O'Donnell

I am writing to formally seek your endorsement for the Mater Public Hospitals (Adult, Mothers' and Children's) being included within all elements of the Measured Quality initiative currently being undertaken by Queensland Health.

The general aim of the initiative is to improve the Queensland public health system's ability to provide quality services and deliver optimal outcomes by developing systems to routinely measure performance and utilise performance data.

The first phase of the initiative (until June 2002) covers acute adult inpatient services for overnight stay patients. Its scope is all public hospitals in Queensland which have more than 30 beds (approximately 57 hospitals).

The measures collected will initially be used in two major ways
- to provide information to individual hospitals on their performance on a range of indicators in comparison to their peer hospitals in Queensland; and
- to provide a collated report on the performance of the state public hospital system as a whole

It is also intended to use the data for comparison with the performance with other states and to facilitate benchmarking activities nationally.

The Measured Quality initiative is collating and analysing the performance of Queensland Health hospitals on a range of indicators relating to the nine elements identified in the National Performance Framework.

For convenience and to link to a balanced scorecard approach, the nine areas have been mapped to four quadrants
- clinical service measures;
- efficiency;
- patient satisfaction:, and
- system integration and change.

To date the Mater Misericordiae Health Services has participated actively in work relating to two of these quadrants:
- the recently completed patient satisfaction survey of patients from all 57 public hospitals; and
- by providing answers to a detailed questionnaire on System Integration and Change

The other two quadrants involve no additional special data collection.

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Brisbane, 4000

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(07) 323 40270

The clinical service measures comprises the analysis of the data currently available within the Queensland inpatient data collection for 14 sentinel clinical conditions (e.g AMI, heart failure, stroke asthma, fractured neck of femur, hip replacement).

The efficiency quadrant involves mainly the analysis of cost and workforce data which is available in Queensland Health's data systems

I believe that the Mater Adult, Mater Mothers and Mater Children's Hospitals participation in the Measured Quality initiative would be of considerable value to Queensland Health, particularly in its benchmarking activities. It would also allow Queensland Health to provide a complete picture of public acute services.

Furthermore, I believe that participation would also be of benefit to your services and thus would welcome your formal endorsement.

Yours sincerely

Dr John Youngman
General Manager (Health Services)
8 / 2 /2002

ISSUES / ACTIONS

Justin Collins - Notes from Technical document on Separations to Nursing Homes

From: Sara Hatten-Masterson
To: Justin Collins
Date: 07/02/2002 8:17
Subject: Notes from Technical document on Separations to Nursing Homes

Nursing Homes Separations: Defined as records where separation mode = "03". These are patients who are discharged to a nursing home for the first time i.e. the nursing home is not where they lived prior to being admitted to hospital. Although the initial episode of care is limited to acute care, if there is a change of episode type then these episodes are linked together i.e. the overall episode includes periods of rehabilitation and other non-acute care. Cases of 30-day in-hospital mortality are excluded from the analysis, as are persons aged less than 50 years. The table below shows the rate of first-time separations to nursing homes for each of the relevant conditions of interest for 1999/2000.

Condition/Procedure	Rate of Separations to Nursing Homes (%)
Stroke	12.9
Fractured Neck of Femur	20.5

Sara Hatten-Masterson
Senior Project Officer
Measured Quality Program Area
ph: (07) 3247 4913
email: sara_hatten-masterson@health.qld.gov.au

F/NOF + STROKE

IF

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DANNY. - RE-ADMISSIONS

NURSING HOME → HOSPITAL → NURSING HOME (NOT SEPARATE)

HOME → HOSPITAL → NURSING HOME

HOME → HOSPITAL → HOME (NOT SEPARATE)

DANNY - RE-ADMISSION ?.

RISK ADJUSTED FOR AGE + (1) - MORBIDITY'S

RE-ADMISSIONS

IF DISCHARGED & DIES HOME
+ RE-ADMITTED WITHIN 30 DAYS
IS PICKED UP IN RE-ADMISSIONS

PAGE 141

- TO ANOTHER SITE

ONLY HOSPITAL - DISADVANTAGED

RURAL

& 16 HOSPITALS

DOES NOT PICK UP IF RE-ADMISSIONS ARE
TO ANOTHER HOSPITAL, IE.

MT ISA - LOOKS BAD AS THEY HAVE NO ONE TO REFER TO.

RBH - LOOKS BAD AS THEY HAVE LOW REFERRALS.

RAGE HOSP - LOOKS GOOD BECAUSE THEY REFER PATIENTS TO

Summary of Key Decisions
(Identified in Font Size 14 & **Bold)**

Measured Quality Sponsor meeting
6 February 2002

CLINICAL – 10 mins

1. Seek comments on recommendations detailed on A4 summary sheet.

2. Of the 4 conditions, 3 have not been verified / commented on / fed back to expert clinicians.

   Issue: Unable to get Peter Steadman.
   Possible solution / s:
   - Attend Orthopedic Group – Chair: P Steadman and discuss?
   - In light of Dr Steadman's extensive commitments, should MQ consider another Orthopedic Surgeon for Phase 2?

GENERAL – 20 mins

1. Management of requests for indicator list.

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2. Inclusion of Mater hospital in reports

3. System Integration & Change quadrant: Have now got responses from every facility (Weipa and Charters Towers surveys came in last week) – **100%** completion and return rate.

4. Discuss operational view on data collection as mentioned last week.

<u>Progress</u>

- Program Area progress report

- As a result of the data meetings over the past 4 weeks we are now:

  1. Preparing data and drafting memo to forward to facilities for comments on accuracy, and if the data is understandable and explainable. (memo and 1 facilities report to GMHS by COB today.

2. Comments on Facility report are currently being investigated, eg. 4 ticks – 5 stars, overall rating (5 star hospital), re-arrangement of peer groupings, insignificance of state mean. Discuss further under scope.

3. Propose sending remaining clinical indicators over the next 2 – 3 weeks and sponsors make comments on summary sheet and return.

Issues / Actions

- Scope
- Marketing & Communication (see attached)
- Confirmation of Draft Agenda for Board meeting – 19 February 2002 (agenda to be presented at meeting and feedback provided in time for Board meeting – 14 February 2002).
- MQ Board involvement

1. Prior to board, identify members or clinicians that could present on specific topics.
2. Meet with individually or set-up sub-groups with board members to discuss and offer possible solutions on specific issues.

- Power Point presentation for Board meeting – 18 Dec 2001 to be provided to sponsors by Friday, 14 Dec 2001.
- Agenda from yesterday's sponsor data meeting (if enough time)

Measured Quality – Clinical Data
Sponsor meeting
5 February 2002

Agenda

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* CLARIFY NURSING HOME RE-ADMISSIONS
* MONTHLY PROJECT STATUS REPORT
* NOTES FROM DATA MEETINGS.
* NEED TO DM'S

Queensland Health Public Report

OPTION 1: Tables as presented by Sean Conway
OPTION 2: A write-up of the results of the Ontario Quadrant report. Include information comparing the groups of hospitals. The scope is restricted to the data in the measured quality report
OPTION3: A combination of 1 and 2 together with some data showing how Queensland Health Hospitals compare with other State Hospital Systems
OPTION 4: A report based on the Vermont option to include the measured quality data, data comparing Queensland with the other states and a descriptive section of what improvement strategies are being undertaken.

Purpose of the report
To start to meet the **community's** need for information on the quality and safety of the Queensland Health Public Hospital System.

- *Measurement is a means to quality—not an end unto itself – ie need to make the results public*
- *Figuring out how to give consumers useful information about how to make the best choices along with information about how to effectively use the health care system will fill an enormous need*

Issues
The publishing of a public report on the Queensland Health Public Hospital System presents an opportunity to:

1. Present the public with targeted and meaningful information about the state of health care in Queensland
   - *important in the present environment of close scrutiny by the press*

2. Begin a process of educating the public and politicians about the scope of health care to increase their understanding of the continuum of care
   - *Improve the understanding of where health care is delivered ie various settings of care as well as the concepts of prevention, treatment and maintenance. The public may begin to value their primary health care services more which is where the future savings in health care will depend.*

3. Develop a process of increasing sophistication and accuracy in indicator development to be able to report each year so that in perhaps 5 years, measures of the entire continuum of care will have been developed and will be reported under the National Health Priorities
   - *Target the development of performance indicators which will be able to measure what Queensland Health is trying to achieve in its strategic plan*
   - *In 5 years time we should be measuring and reporting health care processes and outcomes within Districts from prevention, through to maintenance in accordance with the strategic plan -they will also be performance indicators in the areas which have the greatest impact on health care.*
   - *When we begin to produce information that is more useful for patient care, it will be integral to clinicians' daily work, and no longer burden them, but rather it will assist their work.*

4. Produce a report which documents the large number of QIEP activities as evidence of improvement undertaken by Queensland Health
   - *it is an opportune time for first report as there is so much of a positive nature to report from QIEP and other activities*
5. Public reporting on health care performance is becoming more frequent over the world
   - *Queensland Health needs to keep up or better still, lead the way.*

Recommendations Option 4 is recommended

- **Need to produce a report people can read and will read.** Measures included should reflect the needs and values of the community not the business needs of Queensland Health.

- Public Report should be based on the quadrant indicators by reported within a framework of diseases and population groups. Reporting through the quadrant model best meets QH's organisational needs but would be meaningless to the public.

- The report should include a selected set of improvement activities of the QIEP targeting safety and quality across Queensland Health.

- Initially the report should only contain robust accurate measures we can stand by but with a plan to develop indicators along the continuum within the priority areas.

- It is important not to leave out older people and indigenous people (? Lack of indicators for this group) at this time.

Measured Quality – Clinical Data
Sponsor meeting
5 February 2002

Agenda

CLINICAL – 30 mins

1. Seek comments on recommendations detailed on A4 summary sheet.
2. Of the 4 conditions, 3 have not been verified / commented on / fed back to expert clinicians. Unable to get Peter Steadman. – ORTHOPEDIC GROUP – SZ

WHILE THE CIRCULATION OF ACTUAL DATA WILL BE LIMITED (FOR CLINICIANS: WILL NOT OCCUR AT ALL)

- REQUESTS FOR INDICATOR LIST

ISSUE: – MAY GIVE THE VIEW THAT WE INTEND TO INCLUDE ALL OF THE INDICATORS IN THE REPORTS – IE. MQ HAVE MEANINGLESS INDICATORS

POSSIBLE SOLUTIONS: (1) DO NOT DISTRIBUTE ANY LISTS OF INDICATORS (2) ~~DISTRIBUTE~~ DISTRIBUTE – BUT MAKE SURE THEY ARE AWARE THAT WE ARE IN THE PROCESS OF VERIFICATION AND IDENTIFICATION OF MEANINGFUL INDICATORS

- MATER HOSPITAL INCLUSION

– DR YOUNGHAN – DID YOU DISCUSS WITH MATER?

- HAVE NOW RECIEVED ALL RESPONSES FROM FACILITIES FOR SYSTEM INTEGRATION & CHANGE SURVEY. OUTSTANDING WERE WEIPA & CHARTER TOWERS. WE NOW HAVE THEM AND ENTERED INTO THE DATABASE.
- OPERATIONAL VIEW ON DATA COLLECTION
  - 6 MONTHLY REPORT?
  - HOW & WHO COLLECTS DATA?
  - DOES DSS FIT INTO THE PICTURE? OR SHOULD OTHER IT SOLUTIONS BE CONSIDERED?

TOMORROWS MEETING IS THE NORMAL SPONSOR MEETING WE HAVE PRIOR TO THE BOARD – 19/2/02. ONE OF THE AGENDA ITEMS IS DISCUSSION OF MARKETING & COMMUNICATION

- WHEN WE WENT THROUGH THE THOUGHT PROCESS ~~...~~ FOR OUR MARKETING + COMMUNICATION WE HAD VIGOROUS DISCUSSION ON THE SORT OF OBJECTIVES WE SHOULD HAVE FOR THE ROUND TABLES.

IE. • ACCURACY OF DATA
- UNDERSTANDABLE / EXPLAINABLE
- LOCAL VIEWPOINT — POST ZONAL FORUMS.

- - - - - - - - - - - - - - - - - -

• ID OF QH STRATEGIES FOR IMPROVEMENT.

DURING THIS PROCESS WE ALSO DISCUSSED THE ROLE OF MEASURED QUALITY (THE PROJECT) + MEASURED QUALITY (THE OPERATIONAL). — MED SUPER ×3 =

MQ (THE PROJECT) (PROPOSE) WILL NEED: $1500 20 20 20

'IN SCOPE' — • WORKSHOP FACILITATOR (AIRFARES + ACCOM) (FLAG ACCOM)
• ADMIN SUPPORT (ANOTHER ~~0.5~~ 1.0 FTE) AO4 AT LEAST UNTIL END OF PHASE ~~1~~ 2

• EXTEND DATABASE — ANOTHER 2-3 MONTHS AO8 — 0.5 → PHASE 3 ANOTHER

• M + C (JOURNALIST + REPORT WRITING) ~~0.5~~ ~~2-3 MONTHS~~ 1.0 AO6 AUG (SEPT OR)

P.P — • EXTERNAL EVALUATION OF PHASE 1

STAGE 2 — WILL BE STAGE 1 REVISITED + PATIENT SATISFACTION SURVEY ($850K)
— BALANCE (SOME)

MQ ~~(THE OPERATIONAL)~~ EXTENDED (PROPOSE) WILL NEED:

- CLINICAL CONSULTANT FOR ROUNDTABLES
- FURTHER POTENTIAL OF PHASE 1 DATA.
- BALANCE (EXTENSIVE)
- EXTENDED USE OF PATIENT SATISFACTION DATA — IE. TEST OF HOSPITAL FUNDING MODEL.

STAGE 2
- DAY ADMISSIONS
- GEOGRAPHICAL REPORT

VERIFICATION — EVALUATION
PUBLICATION

COI.0031.0006.00051

DATA MEETING —

SYSTEM INTEGRATION

- NAPA HOSPICE WANTING TO INCLUDES IN MR REPORTS.

- HAVE ALL PATIENTS FROM FACILITIES (

ZONAL FORUM — PRESENTATION.

→ NO DATA WE.

REQUEST FOR LIST OF INDICATORS — HOW DO WE MANAGE,

MAY GIVE A NEGATIVE VIEW THINKING WE ARE DOING ~~MEANINGLESS~~ INDICATORS

+

THAT THE REPORT WILL BE HUGE (GOOD OR BAD).

From: Cheryl Gee
To: Justin Collins
Date: 2/01/02 15:15:20
Subject: Re: Meeting Arrangements for January and February 2002

The 19th of Feb is booked in both DDGPO and GMHS diaries for the Board meeting.

I have also booked in the other meeting times on the following dates:

8:00am - 14/1/02 (1 hour)
8:30am - 22/1/02 (30 min)
8:00am - 30/1/02 (30 min)
2:00pm - 5/2/02 (30 min)
3:00pm - 12/2/02 (30 min - with Dr Filby only as GMHS in NZ all that week)

Let me know if any of these times are not suitable.

Cheryl G
for DDGPO

>>> Justin Collins 20/12/01 9:28:30 >>>
Thankyou Cheryl,

The 19th of February from 11am to 1pm would be great for the Board meeting if you could book that in.

We need to meet with Dr Filby and Dr Youngman once a week for about 30-60minutes from January the 14th up until the Board Meeting in February. If both aren't available at some time in each week, we will have to meet with just one of them I think.

Is there anytime in the week beginning the 14th of January where we might schedule Dr Youngman and Dr Filby for 30-60minutes? If not can you please book us in with Dr Filby for the 17th of January.

Thnkyou, Sara Hatten-masterson (on behalf of Justin)

>>> Cheryl Gee 12/19/01 04:48pm >>>
Justin

1. Dr Filby is fine in the morning of the 17th of Jan - but Dr Youngman is travelling to Dalby. Both Dr Filby and Dr Youngman are travelling on the 18th.

2. There are only two possible slots that I can see that are available for both John and David in mid February. These are 19 Feb at 11am-1pm or 25 Feb at 11am-1pm.

Cheryl G
>>> Justin Collins 19/12/01 2:43:01 >>>
Hi Cheryl,

I need to arrange time for two meetings with Dr Filby and Dr Youngman for the Measured Quality Program -

(1) A one-hour meeting on the 17 or 18 January. The purpose of this meeting is to review the data analysis of selected indicators.

(2) A t wo-hour meeting in mid-February, for the Measured Quality Board Meeting.

Thanks,
Christina Manolas (for Justin Collins)

Summary of Key Decisions

Measured Quality Sponsor meeting
30 January 2002

Facility Report:

- The usefulness / significance of the state mean & category columns & data in the facility report was discussed. It was proposed that this data be removed from the facility report and report Hospital score and Peer only.

- Discussion on the existing peer groups occurred. It was indicated that the same peer groupings should be used across each quadrant. It is not critical as to who is in a peer group as long as they roll up to AIHW groupings. It was suggested that the Children's hospitals should be grouped in with the large hospital group.

- The use of 4 ticks and 5 stars for the varying quadrants was discussed and a proposal to look at a way of keeping the rating consistent across all quadrants was agreed.

- The ability to 'roll up' indicators to give an overall rating / score of a facility was discussed. It was suggested that this would be useful to have this functionality included in the database functionality.

- Feedback of facility report should go to 1 District Manager from each of the Peer Groups, and Gloria Wallace to look at the entire dcoument.

The issue of the interpretation of the data presented at this meeting was raised and discussed. It was agreed that while the data presented and discussed were a very useful first step in the development of the Measured Quality program, the considerable and actual limitations in the validity, reliability, robustness and utility of these data, means that it is highly inappropriate and potentially misleading to use this data as measures of the actual performance of either individual hospitals or the hospital system as a whole. The aim of the Measured Quality Program Area is to also have extensive literature and information supporting the data results and this will assist in putting the results in context when discussing the performance of Queensland Health hospitals.

Scope issues to be resolved/timetabled in next 6 weeks

Key activities	**Issues requiring resolution/timetabling**
Data verification	Requires database manager, administrative support
QH response to data	Requires circulation of facility specific data to DMs for local explanations Roundtables
Data publication	Requires media person, database manager, administrative support
Data use	Roundtables to identify key actions to address variability
	Collaboratives to progress actions on strategically chosen indicators
Evaluation	May require additional resources
Mainstreaming data collection and analysis (6 monthly reports)	Will require current staff to discuss possibiilties with various staff from other systems (eg DSS)

Marketing and Communication Strategies

Objective	Strategies	Target Audience	Timeframe	Additional resources required	Risk in not conducting	Within existing scope
Readable reports	Data credibility: • Verification of data accuracy	Clinicians, Management, Public	Feb (completed 22 Mar)		Managers and clinicians not find credible as inaccurate	✖
	• National data for contextual information		End Feb		No context for judging performance	✓
	• Identification of possible explanations for findings				QH response to findings irrelevant	✖
	• Small group of District Manager's feedback on draft reports		April		Managers and clinicians not find credible as inaccurate or too complex presentation	✖ The Board was supposed to fillfil this role.
	Technical editor/ marketing expertise in writing public report and supporting documentation for facility reports		Late March/ April	Marketing expertise	Public report too complex Clinicians not find credible as too complex presentation	
Effective dissemination	Media releases and ministerial launch; clinical leaders supporting data and provided with media kit	Public Clinicians District staff	Late April/May	Marketing expertise	Reduced awareness of reports; reactive media rather than pro-active	✓
	Roundtables (linked with local activities or other QIEP activities where possible to reduce calls on District staff	District management Clinicians	Late April	Facilitator, travelling expenses, airfares	No local information on possible explanations for findings to feed into a QH response to findings If clinicians do not get to consider the data before it is publicly released, the culture of "judgement" may reign over "improvement"	✓but not to same extent. Considered fundamental.

Objective	Strategies	Target Audience	Timeframe	Additional resources required	Risk in not conducting	Within existing scope
	Identify existing effective Marketing and Communication stragegies which can be used in this Program: • Other QIEP programs • Other countries (Ontario) • National reports	Public, Clinicians, management	By end Feb		May implement non-workable strategies or miss opportunities to link with other planned activities	✓
Use of the data in service planning and provision	Zonal forums	Corporate, Zonal and District Managers	6 – 21 March	??		✓
	Circulation of facility specific data and performance category for indicators to District Managers seeking local explanation of data	District Managers	Zonal Forums + 2 weeks		No systematic information on possible local explanations to inform QH response	
	Ensuring data is credible (stated in above strategies but also relevant to this objective)					
	Establishing a newsletter	All QH staff	Post May 2002	Marketing expertise	Awareness and use of data limited to those involved in the roundtables and collaboratives	✖
	Collaboratives	Specific clinicians	Post May 2002	Project staff to support	Minimal changes implemented (of the improvements identified through the roundtable exercises)	✖ considered fundamental to getting the data used but not a part of MQ – possible budget bid?

NOT FORUMS – BEYOND

CLINICAL DATA

Meeting with Drs Filby & Youngman – 14 January 2002

Presentation of Write-up and Data for the first four conditions

Public Report: We should include indicators and results of outcomes where the performance is okay. We must not just focus on the issues or outcomes with significant outliers/variation.

- Look at outliers from National Performance for example for an outcome at the whole of state level compared to the National data for the same outcome from AIHW.
- Following on from this discuss any internal variance.
- Remember that the target audience is the community, as well as politicians etc.

- We need to allow the relevant hospitals time to look into any variance specific to them. In a process similar to what Cairns did following on from the AMI data.
- In the Technical Report we should annotate where there is a sense of uncertainty for example Caboolture has a high rate of transfers out for Heart Failure but is likely due to their relationship with the neighbouring Private Hospital.

It was identified that in the future we need to try and use standard definitions for the key data elements, example is for readmissions where the data dictionary uses a 28 day cut-off. We need to document why we used the trim points and definitions etc. that we did.

- Clinician involvement is mandatory and will assist in identifying possible reasons for variance and identification of caveats on some of the data.
- Write in such a way that clinicians can pick up and use

Dr. Filby suggested a "round table" process. Putting key clinicians in a room with all of the data and leaving them to discuss it and offer possible explanations for anomalies, variance etc. One weakness with the current round tables is the feedback process.

Dr Filby was a little uncomfortable with the outcome of separations to nursing homes:

- We are making an assumption about what going to a nursing home means
- In the age group for the majority of nursing homes, the numbers are decreasing
- It is not a good measure at the facility level due to the impact of locations of nursing homes etc. and some hospitals actually being the nursing home for an area.

- The current write-up format for the clinical data is fine.
- National Comparison is essential and we need to investigate this further with the AIHW.
- Ask the Institute for selected outcomes with the same exclusion/inclusion criteria, trim points etc. and from within the same timeframe, 1999-2000.

- Cost is not the problem, it will be the time for the data to be compiled and the approval process.
- We now need to scope the Clinician Workshop (round table) – facilitator etc.

The issue of the interpretation of the data presented at this meeting was raised and discussed. It was agreed that while the data presented and discussed were a very useful first step in the development of the Measured Quality program, the considerable and actual limitations in the validity, reliability, robustness and utility of these data, means that it is highly inappropriate and potentially misleading to use this data as measures of the actual performance of either individual hospitals or the hospital system as a whole. The aim of the Measured Quality Program Area is to also have extensive literature and information supporting the data results and this will assist in putting the results in context when discussing the performance of Queensland Health hospitals.

SYSTEM INTEGRATION & CHANGE DATA

Summary of Key Decisions

Measured Quality Sponsor meeting
22 January 2002

Progress

- Presentation of data for the System Integration and Change quadrant.

1) Re: validation of data, a request was made to the Sponsors for permission to send to each hospital:-

- The results of their questionnaire
- Analysis of the peer results
- Analysis of the State results.

The sponsors suggested that the above be sent to district Managers along with a memo that requests

- confirmation of questionnaire data
- re-submission of questionnaire data if required
- if re-submission is required then reasons must be given, eg,
  - aim of survey was unclear
  - questions was ambiguous
  - inappropriate people completed the question
  - turn-around time was inappropriate or
  - other reasons
- better, more precise or more appropriate wording of questions for more accurate interpretation, if necessary
- confirmation of data collected from sources other than questionnaire, eg median age of registered nursing staff.

The memo should clearly states the data will be used for comparative purposes with other peer hospitals and may be used for public reporting. It should also explain which indicators are likely to be chosen for reporting and include reasons why.

2) Dr Youngman will discuss with the Mater group of hospitals re: how they want to be included. Measured Quality will accommodate their views.
3) Dr Youngman requested cross-links between indicators within the quadrant be looked at as well as links across other quadrant.
4) Dr Filby requested that indicators related to Relationships with GPs be re-examined. Did he also mean indicators that are composite measures.

The issue of the interpretation of the data presented at this meeting was raised and discussed. It was agreed that while the data presented and discussed were a very useful first step in the development of the Measured Quality program, the considerable and actual limitations in the validity, reliability, robustness and utility of these data, means that it is highly inappropriate and potentially misleading to use this data as measures of the actual performance of either individual hospitals or the hospital

system as a whole. The aim of the Measured Quality Program Area is to also have extensive literature and information supporting the data results and this will assist in putting the results in context when discussing the performance of Queensland Health hospitals.

EXAMPLE FACILITY REPORT

Summary of Key Decisions

Measured Quality Sponsor meeting
30 January 2002

Facility Report:

- The usefulness / significance of the state mean & category columns & data in the facility report was discussed. It was proposed that this data be removed from the facility report and report Hospital score and Peer only.

- Discussion on the existing peer groups occurred. It was indicated that the same peer groupings should be used across each quadrant. It is not critical as to who is in a peer group as long as they roll up to AIHW groupings. It was suggested that the Children's hospitals should be grouped in with the large hospital group.

- The use of 4 ticks and 5 stars for the varying quadrants was discussed and a proposal to look at a way of keeping the rating consistent across all quadrants was agreed.

- The ability to 'roll up' indicators to give an overall rating / score of a facility was discussed. It was suggested that this would be useful to have this functionality included in the database functionality.

- Feedback of facility report should go to 1 District Manager from each of the Peer Groups, and Gloria Wallace to look at the entire document.

The issue of the interpretation of the data presented at this meeting was raised and discussed. It was agreed that while the data presented and discussed were a very useful first step in the development of the Measured Quality program, the considerable and actual limitations in the validity, reliability, robustness and utility of these data, means that it is highly inappropriate and potentially misleading to use this data as measures of the actual performance of either individual hospitals or the hospital system as a whole. The aim of the Measured Quality Program Area is to also have extensive literature and information supporting the data results and this will assist in putting the results in context when discussing the performance of Queensland Health hospitals.

EFFICIENCY DATA

Overall

Data verification process:

- not all indicators to be sent back to hospitals
- step 1 – cut back indicators
- step 2 – send back to facilities AND liaison with corporate groups

(Public) Reporting:

- Look at the general / macro topics first, with the aim to provide an overview of what the system looks like.
- After this overview, look at the micro-based issues.

National comparisons:

- Do not need to do on an individual indicator basis
- Current national data published on 1999/2000 data
- Back section of report putting Queensland results in context of the national results, by state and peer group comparisons.
- Need to clearly specify data differences, for example, year of collection, calculation used.
- Look at from published national reports such as NHPC

Indicators to be included in public report:

1. FTE Staff (EFF-1)
2. Hours of sick leave (EFF-5) – per week ?
3. Cost of sick leave (EFF-7) – per week ?
4. Hours of overtime (EFF-13) - per week ?
5. Cost of overtime (EFF-15) – per week ?
6. Length of Stay (EFF-19) - excluding same day ?
7. Occupancy Rate (EFF-17; EFF-18) ???
8. Cancellation Rate (EFF-24) ???
9. Catering labour and non-labour costs (EFF-36 and 37)
10. Energy per square metre (EFF-45.4)

The issue of the interpretation of the data presented at this meeting was raised and discussed. It was agreed that while the data presented and discussed were a very useful first step in the development of the Measured Quality program, the considerable and actual limitations in the validity, reliability, robustness and utility of these data, means that it is highly inappropriate and potentially misleading to use this data as measures of the actual performance of either individual hospitals or the hospital system as a whole. The aim of the Measured Quality Program Area is to also have extensive literature and information supporting the data results and this will assist in putting the results in context when discussing the performance of Queensland Health hospitals.

Summary of Key Decisions
(Identified in Font Size 14 & **Bold**)

Measured Quality Sponsor meeting
7 December 2001

Progress

- Provide an update on each of the Quadrant's indicators (latest information to be presented at meeting, so as a detailed review can be performed by the sponsors and feedback provided in time for Board meeting – 18 December 2001)

An update on each of the quadrants was provided to the sponsors.

Clinical: **A summary of indicators analysed so far was discussed with attention to which of the 2 indicators (Asthma or Colo-rectal Carcinoma) should be prioritised in its analysis for January. It was agreed that analysis of Asthma should commence first.**
Efficiency: **List of indicators including Key Question, Calculation and Rationale was provided and feedback to be provided to the team.**
Patient Satisfaction: **Prior to the provision of the patient satisfaction data, discussions with the Minister will occur and outcome advised.**
System Integration & Change: **If further assistance through communication with HSD's is required the General Manager – Health Services could assist.**

- Seek feedback on examples of:

  1. Public report
  2. Facility report
  3. Statistical Techniques & Terminology Brief

Dr Youngman believes the 2 major issues we need to be aware of are (1) Credability and (2) Media. In the star rating he was unsure about the words used. Is happy for these 2 issues to be debated at the board.
Dr Filby suggested that Measured Quality identify appropriate people to 'read through' the reports to provide feedback on the documents from a client/user perspective. The reports should be 'almost final draft' so the reviewer is not clouded by workings in the production of the report.

- Data Analyst – Peter Baade & Adam Pike (2 day per week - Approximately 3 months) – Epidemiology Services

- Database Designer – Sean Conway (full-time - Approximately 3 months) – Surgical Access Team

- An email has been sent to the NHPC members.

Issues / Actions

- Time difference between the Facility (28 Feb 2002) & Public (31 May) reports.

- Is it OK to present the Patient Satisfaction survey results at the Measured Quality Board Meeting on 18 December?

- Need for Quality Assurance Committee

It was suggested that we protect the information produced by Measured Quality from FOI prior to completion by stating that the information is misleading while it has not been fully analysed. It is the intention of Measured Quality that all data will be disclosed in the public report once the full analysis has been performed. Prior to the provision of the patient satisfaction data, discussions with the Minister will occur and outcome advised.

- Presentation of some data at the Senior Officers Forum.

It was noted that the recent communication with Cairns Base Hospital was very positive and demonstrated a successful process of flagging an area of concern and having the hospital look into possibilities for the variations

- Introduction & Methodology for overall report feedback from Board (lack of).

- Marketing & Communication:

- Confirmation of Draft Agenda for Board meeting – 18 Dec 2001 (agenda to be presented at meeting and feedback provided in time for Board meeting – 18 Dec 2001).

- Power Point presentation for Board meeting – 18 Dec 2001 to be provided to sponsors by Friday, 14 Dec 2001.

Measured Quality Sponsor meeting
7 December 2001

Agenda

Progress

- Provide an update on each of the Quadrant's indicators (latest information to be presented at meeting, so as a detailed review can be performed by the sponsors and feedback provided in time for Board meeting – 18 December 2001)

- Seek feedback on examples of:

  1. Public report
  2. Facility report
  3. Statistical Techniques & Terminology Brief

- Data Analyst – Peter Baade & Adam Pike (2 day per week - Approximately 3 months) – Epidemiology Services

- Database Designer – Sean Conway (full-time - Approximately 3 months) – Surgical Access Team

- An email has been sent to the NHPC members.

Issues / Actions

- Time difference between the Facility (28 Feb 2002) & Public (31 May) reports.

- Is it OK to present the Patient Satisfaction survey results at the Measured Quality Board Meeting on 18 December?

- Presentation of some data at the Senior Officers Forum.

- Introduction & Methodology for overall report feedback from Board (lack of).

- Marketing & Communication:

- Need for Quality Assurance Committee

- Confirmation of Draft Agenda for Board meeting – 18 Dec 2001 (agenda to be presented at meeting and feedback provided in time for Board meeting – 18 Dec 2001).

- Power Point presentation for Board meeting – 18 Dec 2001 to be provided to sponsors by Friday, 14 Dec 2001.

Summary of Key Decisions

(Identified in Font Size:14, **Bold**, and Brackets)

Measured Quality Sponsor meeting

24 October 2001

Agenda

Progress

- Provide an update on each of the Quadrants indicators (latest information to be presented at meeting, so as a detailed review can be performed by the sponsors and feedback provided in time for Board meeting – 30 Oct 2001)

Issues / Actions

- Consideration of Data Analyst or Database Designer position.

- Marketing & Communication discussions have resulted in several issues:
    1. Confirm that the audience for the facility data should be the Hospital executive.
    2. Discuss the targeted audience for the public report should include / exclude the general public / Treasury dept / State Government / HSD's
    3. As soon as the Facility reports are provided to Hospitals in February 2002, the risk that arises relates to our inability to respond until we have completed the public report in May 2002. Do we proceed with the Feb 2002 date for the release of the facility reports?

- Budget status update (latest information to be presented at meeting)

- Confirmation of Draft Agenda for Board meeting – 30 Oct 2001 (agenda to be presented at meeting and feedback provided in time for Board meeting – 30 Oct 2001).

- Power Point presentation for Board meeting – 30 Oct 2001 to be provided to sponsors by Friday, 26 Oct 2001.

Measured Quality Sponsor meeting
24 October 2001

Agenda

Progress

- Provide an update on each of the Quadrants indicators (latest information to be presented at meeting, so as a detailed review can be performed by the sponsors and feedback provided in time for Board meeting – 30 Oct 2001)

Issues / Actions

- Consideration of Data Analyst or Database Designer position.

- Marketing & Communication discussions have resulted in several issues:
    1. Confirm that the audience for the facility data should be the Hospital executive.
    2. Discuss the targeted audience for the public report should include / exclude the general public / Treasury dept / State Government / HSD's
    3. As soon as the Facility reports are provided to Hospitals in February 2002, the risk that arises relates to our inability to respond until we have completed the public report in May 2002. Do we proceed with the Feb 2002 date for the release of the facility reports?

- Budget status update (latest information to be presented at meeting)

- Confirmation of Draft Agenda for Board meeting – 30 Oct 2001 (agenda to be presented at meeting and feedback provided in time for Board meeting – 30 Oct 2001).

- Power Point presentation for Board meeting – 30 Oct 2001 to be provided to sponsors by Friday, 26 Oct 2001.

Summary of Key Decisions
(Identified in Font Size 14 & **Bold**)

Measured Quality Sponsor meeting
24 October 2001

Progress

- Provide an update on each of the Quadrants indicators (latest information to be presented at meeting, so as a detailed review can be performed by the sponsors and feedback provided in time for Board meeting – 30 Oct 2001)

A summary update on the indicators for each quadrant was provided to the sponsors. Feedback / comment on the documentation was requested by Friday 26 October.

Issues / Actions

- Consideration of Data Analyst or Database Designer position.

Approval was given to employ a Statistical Analyst (eg. 2 days per week for 12 weeks) and Database Designer as necessary. It was noted that the skills necessary to perform these tasks can be found with Queensland Health and negotiation with other units can be initiated.

- Marketing & Communication discussions have resulted in several issues:
  1. Confirm that the audience for the facility data should be the Hospital executive.

     It was agreed that the audience for the facility report should be the 'Broader Hospital Executive' in each facility.

  2. Discuss the targeted audience for the public report should include / exclude the general public / Treasury dept / State Government / HSD's

     It was agreed that the audience for the public report should be the 'general public'.

  3. As soon as the Facility reports are provided to Hospitals in February 2002, the risk that arises relates to our inability to respond until we have completed the public report in May 2002. Do we proceed with the Feb 2002 date for the release of the facility reports?

     It was agreed that the facility report should continue with the Feb 2002 completion date. It was also noted, if at all possible

we should try and bring the release of the Facility and Public reports closer together.

- Budget status update (latest information to be presented at meeting)

Budget / Financial status was approved

- Confirmation of Draft Agenda for Board meeting – 30 Oct 2001 (agenda to be presented at meeting and feedback provided in time for Board meeting – 30 Oct 2001).

Draft Agenda for Board meeting – 30 Oct 2001 was confirmed / approved.

- Power Point presentation for Board meeting – 30 Oct 2001 to be provided to sponsors by Friday, 26 Oct 2001.

Measured Quality Sponsor meeting
1 October 2001

Progress

- Staff are currently employed including the part time AO3. The Program Area Manager position is being advertised, with Justin Collins acting until the appointment.

- The accommodation on 3rd Floor Forestry House has been secured.

- As per the agreed milestones in July, the revised project timetable will be delivered by 15 October.

Broad milestones are at **Attachment A.**

Marketing and Communication

- These plans are currently being developed for each of the quadrants: internal business, patient satisfaction, efficiency and system integration & change.

- Small reference groups of hospital staff are being included in the process of finalising the questionnaire and indicators.

Issues / Actions

1. In the milestones it is assumed that formal 'sign off' by sponsors on draft material eg. final survey is a (1) one-week turn around time. Is this a reasonable assumption?

2. Propose next board meeting for 30 Oct 2001 and 18 December 2001

3. Report format

   Peer Groupings

   Seek confirmation that the peer groupings endorsed by Dr Filby are the same groupings to be used for each of the other quadrants (ie. Based on AIHW categories as per **Attachment B**).

   Types of Reports

   - **Public** report – a summary of the information which includes numbers in each peer group at or above average

   - **Facility** report – tables of data comparing facility results to peer group average

- **Technical** report – the "how did" document

- **Base analyses** – This includes all aspects of the program and is the feeder to various reports (eg. This could produce a formal report targeted to the Departmental Executive).

Questions for Facility report:

- Do we provide hospitals with the actual performance of their peer group hospitals?
  Why need to – so that benchmarking can occur and know where to go to talk to higher performers or the leaders may choose to go and spread the work
  Why not need to – league table issue. But is this a league table

Questions for Base analyses:

- Do we identify "high performing hospitals" in quadrants and across quadrants
  Eg could be departmental award for performance
  Could develop criteria for judging high performers in Internal Business – Surgery such as "A hospital is a high performer if it scores above average performance in half of the surgical indicators for each indicator in surgery"

  Could be a way of saying "well, you are doing very well in the clinical quadrant but not so well in the Efficiency quadrant" etc

  Could develop criteria for judging high performers across the quadrants

4. Seek 'in principle' endorsement of the 'Potential Indicators' for each of the following quadrants:

   - Internal Business (Effectiveness, Appropriateness, Safety, Accessibility)
   - Patient Satisfaction
   - Efficiency
   - System Integration and Change (Continuity of care)

Potential indicators are at **Attachment C.**

5. Seek approval to forward a memorandum from General Manager (Health Services) to District Managers. Memorandum will request each hospital (62) to nominate a senior position and incumbents name, to sign off the response to the Measured Quality Survey, and a contact in each hospital to answer queries that may arise, regarding the survey response.

Memorandum to be forwarded to Dr Youngman.

Attachment A - Broad Milestones for Phase I

Milestone	Target Date
Potential indicators in each project to Sponsors for endorsement	01/10/01
"Potential indicators, analysis plan and an example of one written up indicator in each project to Board and Sponsors "	09/10/01
Revised project timetable	15/10/01
Actual indicators submitted to Sponsor	22/10/01
Survey sent to Hospitals	29/10/01
Board meeting	30/10/01
"Preliminary analysis of indicators for which data is available and final list of indicators for Efficiency, Clinical and Pat Satisfaction"	09/11/01
Final data - System Integration and Change collected	14/12/01
Preliminary analysis of indicators for which data was available prior to survey	14/12/01
All data available and preliminary write-up of findings for 50% of data	14/12/01
Analysis plan for additional analysis (eg across quadrants)	09/11/01
Additional analysis completed	14/12/01
Draft write up of results for 80% of indicators to sponsors	25/01/02
Circulation for comments to Board (and Experts)	04/02/02
Sponsor endorsement of draft report progress to date	12/02/02
Final write up of results for 100% of indicators to sponsors	13/02/02
Sponsor endorsement of draft report progress to date	06/03/02

Attachment B - AIHW Categories

Category No.	Category Name		Hospitals for Patient Satisfaction Surveying
1	Principal referral	1	Cairns
		2	Gold Coast
		3	Ipswich
		4	Mater Adult
		5	Nambour
		6	Prince Charles
		7	Princess Alexandra
		8	Redcliffe
		9	Royal Brisbane
		10	Toowoomba
		11	Townsville
		12	Kirwan
		13	Royal Women's
2	Large Metropolitan	14	Caboolture
		15	Logan
		16	Q.E. II
		17	Mater Mother's
		18	Redland
3	Large Rural	19	Bundaberg
		20	Mackay
		21	Mount Isa
		22	Rockhampton
		23	Gladstone
		24	Hervey Bay
		25	Maryborough
4	Medium	26	Atherton
		27	Beaudesert
		28	Caloundra
		29	Dalby
		30	Gympie
		31	Ingham
		32	Innisfail
		33	Kingaroy
		34	Proserpine
		35	Warwick
5	Small	36	Ayr
		37	Cherbourg
		38	Chinchilla
		39	Cunnamulla
		40	Goondiwindi
		41	Miles
		42	Stanthorpe
		43	Yeppoon
		44	Biloela
		45	Charters Towers
		46	Palm Island
		47	Tully
		48	Mossman
		49	Wynnum

Attachment B (contd) - AIHW Categories

6	Remote acute	50	Bowen
		51	Charleville
		52	Emerald
		53	Longreach
		54	Mareeba
		55	Roma
		56	St. George
		57	Thursday Island
		58	Weipa
7	Children's	59	Mater Children's
		60	Royal Children's

Attachment C - Potential Indicators

Efficiency

In-patient data
Bed Occupancy Rates
Theatre Utilisation
Staffing
Patient Service Allocation
Asset and Stock
Maintenance and Energy Expenditure
Support and Corporate Services
Capital Productivity
Financial Viability
Allocative Efficiency

Patient Satisfaction

Access and Admission
General Patient Information
Treatment Information
Complaints Management
Physical Environment
Discharge and Follow-up

Internal Business

AMI
Heart failure
Stroke (other outcomes to be determined)
COPD
Pneumonia * Respiratory cause (lung abscess or lung empyema)
Asthma – child
Asthma – adult
Neck of Femur
Knee replacement
Hip replacement
Acute small bowel obstruction
Carcinoma of the rectum
(including analysis of ratio of acute\elective)
Diabetic Foot *New outcome of amputation
Laminectomy
Epilepsy

System Integration & Change
(Data gathered by survey marked with * - other data from existing centrally held data and patient satisfaction survey)

Continuity of Care

Admission Processes
- Patient satisfaction with admission process (patients admitted for AMI & #NOF)
- Use of pre-admission clinics.

Internal Processes
- Multidisciplinary Clinical Pathways in
  i. Unilateral hip replacement *
  ii. Unilateral knee replacement *
  iii. Fractured neck of femur *
  iv. Large bowel resection *
  v. Pneumonia *
  vi. C Section – elective *
  vii. C Section – emergency *
  viii. AMI *
  ix. Asthma *

Post Acute Processes
- Formalised shared care arrangements between hospitals that have maternity services and GPs for ante and post natal care. *
- Formalised arrangements for rehabilitation for post discharge AMI. *
- Formalised arrangements with GPs for follow-up in diabetes. *
- Patient satisfaction with their discharge process.
- Patient involvement with discharge process.

Capability

Use of Information
- Collection and use of data inter and intra hospital. *

Quality (overlap with Sustainability)
- Accreditation of all services per hospital. *

Sustainability

Credentialling
- Hospitals with an effective credentialling committee.

Quality (overlap with Capability)
- Accreditation of all services per hospital. *

Workforce Management

- Retention of allied health staff.
- Retention of nursing staff
- Median age of current workforce

Pharmacy

- Percentage of hospitals participating in a Drug Advisory Committee process

Information quality

- Fatal errors.
- Warnings.
- Submission of timely data

Tele health

- Hospitals that receive and provide tele-health in the previous six months. *

Sponsor meeting
June 18 2001

Program Management

Recruitment

- PAM – delays. Options may include secondment.

- Senior Project Officers
  3 applicants to be recommended for 2 positions (Responsiveness/Efficiency and Continuity of Care) however not a strong field.

  Clinical positions close today.

Recruitment has taken significant time (a lot of interest and time explaining the Program Area) – has meant delay in some activities.

Overdue

- Communication strategy
- Report writing (Introduction, Methodology)
- Statistical tender
- Scorecard background paper

Requires improvement

- Consultation with other Program Areas

Hospital Clinical Indicators Project
O&G indicators – panel has completed a preliminary cull – step is now to (1) define some variables better and (2) sort out prioritisation criteria and get them to apply.

Surgical and medical – wrote to 5 clinicians re: Workshop on 16th July – three responses in negative: 2 Yes, 1 No

Hospital Responsiveness Indicators Project

- Submission with sponsors for sign-off
- Union involvement – Budget sensitivities and DG agreement that Unions be involved in requirements of Districts
  - Helen Little has suggested that Unions be carefully managed – liaison with Sue Norrie, Michael Catchpoole and Nigal Cumberland.
  - Timing of information – Minister; Unions, DMs
- Additional questions

Union issue – Board membership: Michael Catchpoole?

Hospital Continuity of Care, Sustainability and Capability Indicators Project
Nil progress on measuring (no staff)
Links to Integration Implementation work in HOU
A question on integration from patient's perspective (discharge planning) in the Patient Satisfaction Survey

Hospital Efficiency Indicators Project
On track. Meeting to discuss data extraction and timeframes Tues.

Sponsor meeting
June 18 2001

Program Management

Recruitment

- PAM – no resolution

- Other positions recruited:
  - Senior Project Officer (Continuity of Care, Capability and Sustainaibility Indicators Project) – Ms Hebe de Souza
  - Senior Project Officer (Patient Satisfaction/Efficiency Indicators Project) – Ms Christina Manalos
  - Senior Project Officer (Clinical Indicators Project) – Ms Sara Hatten-Masterson
  - Senior Analyst (Mr Danny Youlden)

Overdue activities – as per last month's meeting and quarterly report

Hospital Clinical Indicators Project

- O&G indicators – no progress since last month due to no staff.

- Surgical and medical – workshop held 16th July - preliminary indicators identified

Hospital Responsiveness Indicators Project

- Tender advertised – closes 23rd July
- 15 requests for tender documentation
- Selection panels meeting on 25th and 30th – 1 week for questions -aiming for a recommendation to DG on 8th August. Timeframe based on 2 week turnaround with surveys being sent out end August.

Hospital Continuity of Care, Sustainability and Capability Indicators Project

Nil progress on measuring (no staff)

Hospital Efficiency Indicators Project

On track. Meeting to discuss data extraction and timeframes Tues.

MAJOR ISSUE: PAM RECRUITMENT

MEASURED QUALITY PROGRAM AREA

SPONSOR MEETING

22 APRIL 2001

PROGRESS

Program Management	**Issue seeking advice on**
• Recruitment Advertisements for Program Area Manager and Senior Project Officers for Responsiveness/Efficiency and Continuity of Care Projects to be run 3/4/01 – will result in recruitment by mid June My secondment – as agreed, I will act as the Program Area Manager and try to progress the Clinical Indicator Project until a PAM is recruited. The PAM will be recruited in mid June. My secondment is due to finish 31 July which will allow 6 week period of hand over and a focus on the Clinical Indicators Project. Require approval to recruit the Clinical Indicators Project Officer now to have in place by mid July –	Email sent to Dr Filby 18/4 on panel members – require approval to organise panels **Agreement that my secondment is to finish July 31,2001** Require approval to advertise the Clinical Indicators Project Officer position in order to finalise recruitment by mid July 2001

allowing a 2 week handover.	
Scorecard Literature review undertaken on balanced scorecard methodology and a draft "first cut" scorecard developed – refer Attachment 1. Indicators in this draft will be prioritised so that only 5 –10 exist in each	
Existing indicators	
Marketing and Communication Had planned for me to go but should we wait till PAM on board? Yes	
Hospital Clinical Indicators Project	
Surgical - *** meeting with SAT	
Medical	
Hospital Efficiency Indicators Project	
Hospital Responsiveness Indicators Project	
Hospital Continuity of Care, Sustainability and Capability Indicators Project	

O&G
Statistical advice

Patient Satisfaction
Submission (geri and john's comments)
Tender document

Continuity of Care, Sustainability and Capacity
Nil

BOARD MEETING

15 May 2001, 2 hours (2 can't attend)

Draft agenda attached

Summary of Key Decisions
(Identified in Font Size 14 & **Bold**)

Measured Quality Sponsor meeting (Dr Youngman)
15 April 2001

- Provide an update on the status of the verification process.

An update on the current status of the verification process for each quadrant was provided to the sponsors.

Clinical: **It was acknowledged that the clinical data as a whole was consistent with crystal reports (transition) at the hospitals. Some changes needed to occur but it was considered that further refinement of the crystal reports would result in consistency between MQ data and transition reports. Timeliness associated with the perinatal data was highlighted as a problem and re-analysis of this data will need to occur (once data is finalised in HIC).**

Efficiency: **Dr Youngman also indicated that ongoing problems with journals being processed has a major impact on the finance data, depending on when the report is ran.**
The other major problem with the efficiency data revolved around the FTE data from DSS. It was considered that this was due to differences in the reporting hierarchy used at the corporate level (corporate hierarchy) and those used at the hospital / district level (alternate hierarchy).
Dr Youngman indicated that MQ should not include inaccurate data in its reports but should highlight problems identified in the process of determining meaningful data and indicators.

Action: Investigate the best way to present the problems highlighted through the verification process but not include in the main body of the report.

Patient Satisfaction: **n/a**

System Integration & Change: **Some changes to hospital's response to the SI&C survey have been directly incorporated into the results of phase 1**

- AIHW data

It was acknowledged that the request for national comparitive data from AIHW has taken several weeks longer than the original timeframe identified. The data has now been provided (Friday, 5 April 2002) and the data analyst will review the data and progress its inclusion in the reports. Dr Youngman asked if the data that was being provided by AIHW is in the MQ peer groups. Dr Brown indicated that it was in the AIHW peer groups and could be converted to the MQ peer groups. Dr Youngman indicated that it was very important to view the clinical data in the national context so as to obtain a view of hospital performance within Queensland and its performance in comparison with other states.

Action: Determine the process of converting the AIHW data from existing peer groups to MQ peer groups

- Report Format

The format of the hospital report was discussed with the option being presented as a result of discussions with Dr Filby (last week):

- **Summary page (3 stars, rolling from an overall rating per quad, down to indicator groups in each quadrant)**
- **Clinical & Patient Satisfaction quad's to identify hospital score, peer group mean, and identification of significance between 90% & 99.9% confidence intervals, and the 99.9% confidence interval.**
- **Efficiency & SI & C quad's to identify hospital score and peer group median only.**
- **At the end of the report every indicator is presented in quartiles (with state median) for each of the 4 peer groups.**

Dr Youngman requested that the clinical data for the rural hospitals be included in the hospital reporting process. Dr Brown indicated that the clinical data gathered at the small hospitals did not have enough volume for it to be considered reliable.

Action: Determine a way to include the clinical data for the small and medium hospitals in the hospital reporting process (in the most meaningful manner)

- Phase 1 'In scope', Phase 2 as currently approved & extension of scope.

Timeframes to have the public report by end of June 2002 and round table sessions by end of May 2002 were discussed. Dr Youngman indicated that he would prefer to complete phase 1 as quickly as possible and obtain an evaluation to consider future activity.
Dr Youngman emphasised that the Measured Quality type process should become a routine part and the main stream process and national approach should be adopted as far as practical

A formal submission requesting extra funding to perform activities associated with Marketing & Communication and the Completion of the Report for Phase 1 & 2 was provided to Dr Youngman for consideration. The possibility of extending phase 2 including other hospital services was also raised.

Action: Dr Youngman to review submission and comment / feedback

Summary of Key Decisions
(Identified in Font Size 14 & **Bold**)

Measured Quality Sponsor meeting (Dr Filby)
8 April 2001

- Provide an update on the status of the verification process.

An update on the current status of the verification process for each quadrant was provided to the sponsors.

Clinical: **It was acknowledged that the clinical data as a whole was consistent with crystal reports (transition) at the hospitals. Some changes needed to occur but it was considered that further refinement of the crystal reports would result in consistency between MQ data and transition reports. Timeliness associated with the perinatal data was highlighted as a problem and re-analysis of this data will need to occur (once data is finalised in HIC)**

Efficiency: **The major problem with the efficiency data revolved around the FTE data from DSS. It was considered that this was due to differences in the reporting hierarchy used at the corporate level (corporate hierarchy) and those used at the hospital / district level (alternate hierarchy).**

Action: Highlight problems with data in report

Patient Satisfaction: **n/a**

System Integration & Change: **Some changes to hospital's response to the SI&C survey have been directly incorporated into the results of phase 1**

- AIHW data

It was acknowledged that the request for national comparitive data from AIHW has taken several weeks longer than the original timeframe identified. The data has now been provided (Friday, 5 April 2002) and the data analyst will review the data and progress its inclusion in the reports.

- Report Format

The format of the hospital report was discussed with several options being presented (including those previously identified at the MQ Board meeting). The result of these discussions finished with:

- **Summary page (3 stars, rolling from an overall rating per quad, down to indicator groups in each quadrant)**
- **Clinical & Patient Satisfaction quad's to identify hospital score, peer group mean, and identification of significance between 90% & 99.9% confidence intervals, and the 99.9% confidence interval.**
- **Efficiency & SI & C quad's to identify hospital score and peer group median only.**
- **At the end of the report every indicator is presented in quartiles (with state median) for each of the 4 peer groups.**

Action: Prepare an example hospital report from each of the 4 peer groups by Thursday, 11 April 2002.

- Phase 1 'In scope'

A direction to have the public report prepared by end of June 2002, round table sessions by end of May 2002, and hospital reports as soon as possible (with an example from each of the peer groups by Thursday 11 April 2002) was given.

- Peer Groups

The final version of the peer groups was presented, with Rockhampton being included in the 'large' peer group. This was done so on the basis that even though it had a large catchment area its activity was still to low for it to be comparible in the 'Principal Referral and Specialised' peer group.

Action: MQ to proceed with the endorsed version of the peer groups.

Queensland Government
Queensland Health

MINUTES

Board Meeting of the Measured Quality Program Area

Held 29th April 2004, 10am –

Conference Room, Floor 17, Queensland Health Building

CHAIR: Dr John Scott

Present:	**Apologies:**	**Program Area staff:**
Dr John Scott (Chair)	Dr Gerry Fitzgerald	Mr Justin Collins
Ms Norelle Deeth	Ms Sue Jenkins	Mr Sean Conway
Dr Glenn Cuffe	Mr Dan Bergin	Ms Noela Zuk
Ms Sabrina Walsh	Dr Arnold Waugh	Ms Louise Brown
Mr Paul Monaghan	Dr Jacinta Powell	Ms Cathy Renkin
Ms Anne Turner	Ms Jan Phillips	Ms Trisha Johnstone
Dr Ian Scott		Ms Jenny Burton
Dr Roger Brown		
Mr Mike Allsop		
Ms Sue Cornes		
Mr Peter Lewis-Hughes		
Ms Madonna Cuthbert		**Minutes:**
Ms Paula Bowman		Ms Jenny Burton

Reading Materials Issued prior to meeting:
Clinical Quadrant: Discussion paper - Measuring Evidence Based Gaps in QH
Patient Satisfaction: Issues/Discussion paper – Survey
System Integration & Change: Project Plan – Staff Survey

Papers handed out at meeting:
System Integration & Change - Hospital Survey 2004

1. Welcome and apologies (Dr John Scott)

Dr John Scott welcomed Board members. Apologies were noted and accepted.

2. Program Area Update and Progress Report (Mr Justin Collins)

Mr Justin Collins outlined current and planned activities.

Project Officers presented an overview of Phase 3 activities to date:

Clinical: Ms Louise Brown reported on the Clinical hospital report indicators. Louise also gave an overview of the discussion paper - Measuring Evidence-Practice Gaps in QH. Discussion followed.

Efficiency: Mr Sean Conway reported on the Efficiency hospital report indicators. Discussion followed.

Patient Satisfaction: Ms Cathy Renkin presented an overview of results of the pilot survey and outlined issues from the Discussion Paper. Discussion followed.

System Integration and Change: Ms Noela Zuk reported on the SIC hospital report indicators. Noela also outlined up-to-date details of the Staff survey process. Discussion followed.

3. Phase 3 (2004) Hospital & Zone report

Mr Justin Collins reported on the proposed distribution of the 2004 Hospital Report and dissemination to hospital sites. Discussion followed on distribution via the secure QHEPS site.

4. Phase 3 (2004) State & BOM report

Mr Justin Collins reported on the Phase 3 One-Off State Report outlining responsibility for distribution and advised of requests for data by Corporate Office units. Justin then presented an overview of the contents of the Board of Management Report.

5. Phase 3 (2004) Public Report

Mr Justin Collins outlined the progress of the Phase 3 Public Report.

6. Follow-up on Phase 2 outlier indicator actions taken by Hospitals

Mr Justin Collins outlined the purpose for Phase 2 Outlier responses from hospitals. Discussion followed on the timeframes involved.

7. Issues / Actions:

Approval has been given to continue as a project until December 2004

Discussions have occurred with each Zone re: how actions to improve identified Measured Quality indicators in current SLA's can translate to the Balanced Scorecard.

Dr John Scott thanked the Measured Quality Team for the excellent work done, noting that the relationships between all units needs to be aligned. Dr John Scott asked that suggestions be brought to next meeting.

The meeting concluded at 12.10pm

Queensland Government
Queensland Health

MINUTES

Board Meeting of the Measured Quality Program Area

Held 29th April 2004, 10am –

Conference Room, Floor 17, Queensland Health Building

CHAIR: Dr John Scott

Present:
Dr John Scott (Chair)
Ms Norelle Deeth
Dr Glenn Cuffe
Ms Sabrina Walsh
Mr Paul Monaghan
Ms Anne Turner
Dr Ian Scott
Dr Roger Brown
Mr Mike Allsop
Ms Sue Cornes
Mr Peter Lewis-Hughes
Ms Madonna Cuthbert
Ms Paula Bowman

Apologies:
Dr Gerry Fitzgerald
Ms Sue Jenkins
Mr Dan Bergin
Dr Arnold Waugh
Dr Jacinta Powell
Ms Jan Phillips

Program Area staff:
Mr Justin Collins
Mr Sean Conway
Ms Noela Zuk
Ms Louise Brown
Ms Cathy Renkin
Ms Trisha Johnstone
Ms Jenny Burton

Minutes:
Ms Jenny Burton

Reading Materials Issued prior to meeting:
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File Ref: 1236-0355-109

Discussion Paper for Measured Quality Program Board Meeting 29 April 2004

SUBJECT: **Measuring Evidence-Practice Gaps in Queensland Health (QH)**

PURPOSE: To propose formal measurement of evidence-practice gaps in QH.

BACKGROUND:

The release of the Evidence-Practice Gaps Report Volume 1 by the National Institute for Clinical Studies (NICS) in January 2004, highlighted eleven specific examples of health care practices where there is a gap between what is known from the best available research and what is actually done in day-to-day practice. The practices span a range of clinical settings and are set out in Attachment 1.

The report serves as a prompt for health care organisations to examine their performance in relation to evidence-based practice, and how this examination might be systematically carried out.

ISSUES:

Measurement of Evidence-Practice Gaps in Healthcare

While the report indicates that 'knowing-doing gaps' occur in every industry and that the problem is neither unique to healthcare nor Australia [NICS:2003;p.iv], ensuring clinical practice complies with the evidence helps save lives, averts or delays the onset and progress of disease, averts injuries and other harm, reduces healthcare costs and enhances health. There are inherent risks for the organisation in choosing not to pursue evidence practice gaps measurement; namely, continued preventable loss of life, injury, patient dissatisfaction with service, staff dissatisfaction with poor outcomes, financial loss and possibly litigation.

Responsibility for identifying best practice and endorsing practice across QH

Currently there is no specific area within QH that has designated responsibility for identifying preferred clinical practice, other than in specific areas such as elective surgery or condition or diseases, and what will be the endorsed practice in QH for a given condition or procedure.

The Clinician Development Program Area has largely addressed clinicians' training needs in the area of evidence-based practice but has not adopted an approval role. Likewise the Collaboratives for Healthcare Improvement (CHI) and the Clinical Pathways Program Area have focussed on the implementation of a preferred practice and the change required to reach that practice status, rather than the identification or endorsement of a preferred practice per se.

The issue of the responsibility in QH for making decisions about evidence-based practice has not been resolved, but is under consideration in the deliberations by the executive regarding a unit to address clinical innovation and improvement. For evidence-practice gap measurement to successfully cover the full range of clinical services there would need to be a recognised authority to sign-off on clinical standards.

Responsibility for measuring evidence-practice gaps

Currently there is also no specific area within QH that has designated responsibility for measuring evidence-practice gaps in health service delivery. The Measured Quality Service has addressed a

comprehensive range of indicators and made peer-group comparisons and national comparisons around performance against these indicators.
Eleven (11) examples of health care practices outlined in the NICS Report are shown in Attachment 1. A number of these practices fall outside the direct control of QH, but interface with community services provided by General Practitioners and other community groups.

Gaps between evidence and practice in those examples of health care practices outlined in the NICS Report that fall within the direct control of QH, could be measured to inform the need for promotion of strategies in these areas by QH.

Four (4) of the eleven gaps identified in the NICS Report could be measured by minor adjustments to current hospital collections, via the Measured Quality collection and analysis, or the work of the Collaborative for Healthcare Improvement (CHI) / Clinical Support Systems Project (CSSP).

Maternity

1. One in five women smoke during pregnancy. Although stopping smoking early in pregnancy will be of greatest benefit, quitting at any point during pregnancy is beneficial.

Medicine - Cardiac

2. Some heart failure morbidity and mortality could be prevented through the more widespread use of ACE inhibitor and beta-blocker therapies

General - Diabetes

3. It is estimated that almost three-quarters of people with diabetes are not having glycated haemoglobin tests performed as frequently as recommended

Surgery

4. A recent Australian study found that colonoscopic follow-up examinations are being done too frequently

The purview of the Measured Quality Service could be increased to include measurement of performance against practices that are measurable via indicators within the responsibility of QH. A restricted group of measures could be pursued per annum, with the intention to assess against the full list of practice gaps noted in the NICS Report by the end of the new Quality & Safety Program in 2008.

BENEFITS AND COSTS:

A major benefit of measuring evidence-practice gaps is to highlight areas of need for change in or acceleration of strategies to pursue evidence-based practice. Another benefit would be opening the lines of communication on the range of issues highlighted above.

Direct costs to the organisation would be those of measuring the performance/practice against evidence, and the promulgation of the evidence and the results of the measurement.

Indirect costs of not performing the measurement of evidence-practice gaps, and the promulgation of the results to inform change in practice would be potential sub-standard healthcare provision and provision of resources to support care which is recognised as not producing the most cost-effective outcome in health status for Queenslanders.

CONSULTATION:

The NICS report was distributed to and discussed with the following officers:

Justin Collins and Louise Brown, Measured Quality Service
Denise Curran, Clinical Pathways Program Manager
John Stibbard, Principal Policy Officer, Surgical Access Service
Kerry Grimes, Principal Policy Officer, Health Outcomes Unit
Dr Roger Brown, Team Leader, Clinical Strategy Team
Dr Glenn Cuffe, Manager, Procurement Strategy Unit

ATTACHMENTS:

1: Examples of evidence-practice gaps identified in NICS Evidence-Practice Gaps Report Volume 1.

RECOMMENDATION(S):

1. That the measurement of evidence-practice gaps in a set range of clinical areas be actively pursued in Queensland Health.

2. That Queensland Health measure its evidence-practice gaps in four (4) specific areas of maternity, cardiac care, general medicine, and surgery.

3. That responsibility be assigned in Queensland Health to identify evidence-based practice and dissemination of advice regarding the endorsed practice across the organisation.

4. That responsibility be assigned in Queensland Health to measure evidence-practice gaps.

Prepared by: Elizabeth Garrigan, Team Leader, Quality Strategy Team
(07) 323 40186

Attachment 1

NICS Identified Evidence-Practice Gaps

Smoking-related

1. Smoking is the largest preventable cause of death and disease in Australia. Giving a patient brief advice on smoking cessation can influence their decision to quit.

2. One in five women smoke during pregnancy. Although stopping smoking early in pregnancy will be of greatest benefit, quitting at any point during pregnancy is beneficial.

3. Evidence does not support annual chest x-ray screening of current or former smokers to detect lung cancer

Cardiac

4. For every 1000 patients with atrial fibrillation, by taking oral anticoagulants about 25 will avoid experiencing a stroke and 12 will avoid dying from a stroke

5. Some heart failure morbidity and mortality could be prevented through the more widespread use of ACE inhibitor and beta-blocker therapies

Diabetes

6. It is estimated that almost three-quarters of people with diabetes are not having glycated haemoglobin tests performed as frequently as recommended

Inappropriately prescribed antibiotics

7. Four out of five patients diagnosed with acute bronchitis are prescribed antibiotics, although there is no mandatory need for their early routine prescription

Hospital setting

8. The prevention of venous thromboembolism in hospital has been identified internationally as a stand-out opportunity to improve patient safety

9. Nine out of ten patients having elective colorectal surgery receive some form of bowel preparation, yet there is no evidence it improves patient outcomes

10. A recent Australian study found that colonoscopic follow-up examinations are being done too frequently

11. Many patients continue to suffer unnecessarily (the need for improved pain management)

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Queensland Health

MINUTES

Board Meeting of the Measured Quality Program Area

Held 20th November 2003, 2pm – 4pm

Training Room 3, 3rd Floor, Queensland Health Building

CHAIR: Dr Glen Cuffe

Present:	**Apologies:**	**Program Area staff:**
Dr Glenn Cuffe (Chair)	Dr John Scott	Mr Justin Collins
Ms Sabrina Walsh	Mr Mike Allsop	Ms Jenny Burton
Mr Paul Monaghan	Ms Sue Cornes	Ms Noela Zuk
Ms Dorothy Vicenzino (for Ms Anne Turner)	Dr Gerry Fitzgerald	Ms Louise Brown
Dr Ian Scott	Mr Peter Lewis-Hughes	Ms Kirstine Sketcher-Baker
Ms Norelle Deeth	Mr Arnold Waugh	
Ms Toni Pegram (for Dr Roger Brown)	Ms Gloria Wallace	**Minutes:**
	Ms Madonna Cuthbert	Ms Jenny Burton
	Mr Sean Conway	

1. Welcome and apologies (Dr Glen Cuffe)

Dr Glen Cuffe welcomed Board members. Apologies were noted and accepted.

2. Program Area Update and Progress Report (Mr Justin Collins)

Mr Justin Collins reported on revised membership of Board and the current status of staff recruitment. Justin gave an overview of the Milestones to date for Phase 1 & 2 and outlined current and planned activities.

3. Follow-up on Phase 2 reports and Actions taken by Hospitals

Mr Justin Collins reported on the number of web hits for the Public Report and outlined the development of a memo and template to be sent to District Managers and Zonal Managers requesting feedback on Phase 2 identified indicator 'outliers'. On-line access to the template will be available on the secure site.

4. Phase 3 Indicators and Reports

Project Officers presented an overview of Phase 3 activities:

Clinical: Ms Louise Brown reported on the Clinical Quadrant. The meeting endorsed the use of clinical indicators as presented.

Efficiency: In the absence of Mr Sean Conway, Mr Justin Collins reported on the Efficiency Quadrant.

- Discussion was held on the inclusion of 'Avoidable Admissions' indicator – Dr Ian Scott suggested a clarification of the definition of 'avoidable admissions'. Dr Glen Cuffe suggested that Mr Sean Conway write up a small clarification paper on the definition, to be included with these minutes.
- Discussion was held on changes to Cost Indicators and Staffing Indicators from Phase II.
  - A query arose on the rationale for inclusion of Prosthetic Usage, Pharmacy, Pathology & Radiography as indicators. Dr Glen Cuffe suggested that Mr Sean Conway create an argument to keep as an indicator.
  - A query arose on whether Litigation covered 'all claims' or 'all successful claims', and whether it should be included. Mr Sean Conway to provide information to elaborate.
  - Discussion was held on the rationale for inclusion of Asset Utilisation as an indicator.

The meeting endorsed the use of efficiency indicators as reported, with requested clarification.

System Integration and Change: Ms Noela Zuk presented an overview of this quadrant and changes to indicators.

- Hospital Survey:
  - An outline of the Phase III survey was presented to the meeting.
  - Discussion was held on the usefulness of the Clinical Pathway questions for benchmarking
  - Information was provided in regards to the Environmental Management question
- Employee Opinion Survey:
  - Information was provided and discussion followed

The meeting endorsed the use of System Integration and Change indicators as presented.

5. Issues / Actions:

Mr Justin Collins provided an outline of the continuing role of the program which is currently funded to 30 June 2004.

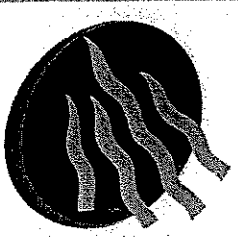
The meeting concluded at 3.55pm

Measured Quality Program
3rd Floor
Forestry House
GPO Box 48
Brisbane, QLD 4001

Measured Quality Program

Board of Management

Terms of Reference



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Queensland Health

November 2003

- Oversee and review changes to the scope, schedule, cost, quality, staffing, communications, risk, procurement and change management plans.
- Members attend and actively participate in all Board meetings.
- Provide advice and support to the Manager as appropriate.
- Review and accept reports on quality of the Program processes and deliverables.

Act as an interface to other areas impacted by the Program and assist in the resolution of Program boundary issues.

Appointment of Chairperson and Board

The Chairperson of the Board will be

Dr John Scott

The members of the Board are:

- **Dr John Scott (Sponsor), A/General Manager (Health Services)**
- **Ms Norelle Deeth (Sponsor), Deputy Director-General, Policy and Outcomes**
- Dr Glenn Cuffe, Manager, Procurement Strategy Unit (PSU)
- Mr Mike Allsop, District Manager, Fraser Coast Health Service District
- Mr Dan Bergin, Zonal Manager, Central Zone
- Dr Roger Brown, Team Leader, Clinical Strategy Team, PSU
- Ms Sue Cornes, Deputy Manager, Health Information Centre
- Dr Gerry FitzGerald, Chief Health Officer, Office of the Chief Health Officer
- Dr Peter Lewis-Hughes, State Manager, Pathology & Scientific Services
- Mr Paul Monaghan, Finance Manager, Finance Unit
- Dr Ian Scott, Director, General Medicine, Princess Alexandra HSD
- Ms Anne Turner, Director, Health Systems Strategy Branch
- Ms Gloria Wallace, State Manager, Organisational Development Unit
- Ms Sabrina Walsh, District Manager, Logan/Beaudesert Health Service District
- Dr Arnold Waugh, A/Director, Mental Health Unit

Queensland Government
Queensland Health

MINUTES

Board Meeting of the Measured Quality Program Area

Held 19th June 2003, 12.00md – 2.00pm

Conference Room, 17th Floor Queensland Health Building

CHAIR: Dr Buckland

Present:	**Apologies:**	**Program Area staff:**
Dr Steve Buckland (Chair)	Mr Paul Sheehy	Mr Justin Collins
Dr Glenn Cuffe	Ms Norelle Deeth	Mr Sean Conway
Dr Roger Brown	Dr Gerry FitzGerald	Mr Danny Youlden
Ms Sue Cornes	Dr Ian Scott	Ms Adele Thomas
Ms Elizabeth Garrigan	Ms Anne Turner	
Mr Mike Allsop		**Minutes:**
Ms Paula Bowman		Ms Adele Thomas
Ms Sabrina Walsh		
Mr David Jay		
Mr Paul Monaghan		
Ms Danielle Blumke (for Norelle Deeth)		

1. Welcome and apologies (Mr Justin Collins)

Mr Justin Collins welcomed Board members. Apologies were noted and accepted.

2. Program Area Update and Progress Report

Public Report - Mr Justin Collins reported that the public report was approved for release by the Department of Premier and Cabinet and was launched 18 June 2003. The communication strategy also includes:

- An article in Health Matters in July
- An article in Health Manager in July
- DG Forum at the end of the month

Ms Paula Bowman noted that there is a spot available in July in the 'What's Hot' program as well as the Senior Officers' Forum.

An evaluation of the impact of the public report will be conducted in 3 months time consisting of a short survey to the HSD Councils and a review of the number of hits on the QH Internet site. Other suggestions for evaluation are invited.

Internal Hospital Reports – An overview of the district presentations was provided together with an interim evaluation of their effectiveness.

3. Reports

The public report: Mr Justin Collins discussed the final version of the report which was released June 18 2003. Dr Buckland noted that it was a subject of discussion in his meeting with the AMA this week and intends to bring the MQP team to his next meeting with that group.
It was noted that both the public report and its technical supplement are available both on the QH Internet site and QHEPS.

Hospital reports: Both District Managers on the Board reported that the presentations went well and were received with interest within their Districts.

4. Issues / Actions

Data Envelopment Analysis (DEA): Mr Sean Conway gave the Board an overview of how the DEA model will work as a tool to relate a number of inputs to outputs as a measure of efficiency as well as being able to relate measures across the quadrants of the balanced scorecard.
There was some discussion about the usefulness of this type of tool and and it was suggested that the team continues to explore this model.

AIHW Data: The most recent AIHW data was received and it was noted that work still remains to be done on this data to produce comparable data sets.

QIEP review / mainstream MQP: Mr Justin Collins has prepared a submission for continuation of the project for 12 months in order to:

- consider broadening the scope of the project to 2 more service areas outside inpatient services
- build on existing work to further develop and refine quadrant indicators

A discussion ensued regarding what QH wants to measure.
The Board agreed that the submission should be lodged.

The meeting concluded at 2.05pm

Queensland Government
Queensland Health

MINUTES

Board Meeting of the Measured Quality Program Area

Held 11th March 2003, 8.30am – 10.00am

Conference Room, 18th Floor Queensland Health Building

CHAIR: Dr Buckland

Present:
Dr Steve Buckland (Chair)
Ms Norelle Deeth
Dr Gerry FitzGerald
Dr Glenn Cuffe
Dr Roger Brown
Dr Ian Scott
Ms Sue Cornes
Ms Elizabeth Garrigan
Mr Mike Allsop
Ms Paula Bowman
Ms Sabrina Walsh
Mr David Jay
Ms Anne Turner

Program Area staff:
Mr Justin Collins
Mr Sean Conway
Mr Danny Youlden
Ms Angela Evans
Mr Paul Donaldson

Apologies:
Mr Paul Monaghan
Mr Paul Sheehy

Minutes:
Ms Angela Evans

1. Welcome and apologies

Previous Board minutes from 8th October 2002 were accepted as true and accurate.

The revised Terms of Reference reflecting changes to the sitting Board members were endorsed.

2. Program Area Update and Progress Report

A summary of the activities surrounding the scheduled release of the Public Report was provided to the Board.

3. Strategy to disseminate the contents of the hospital reports

It was reported that Phase II analysis was already well under way and that a concentrated effort was being made to have a third and current year of data analysed prior dissemination to hospital. For this reason, hospital visits have been arranged to occur in April/early May 2003.

The Measured Quality Program will be briefing the change management groups (CDP, OIU, CHI, Risk Management, Clinical Audit) in March and these together with the Executive from each Zonal Management Unit have been kept informed of the program area's activities.

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It was noted that QHEPS will be used for the secure delivery of the hospital report results.

Summary of DEA: It was noted that Professor Tim Coelli, University of Queensland, has provided software for data analysis and that the MQP has engaged Dr Latiffa Ling to provide mentor-ship for this project. Data is currently being collected for inclusion in a DEA report.

4. Marketing and Communication

It was noted that the communication strategy for the public report is being finalised in conjunction with the Marketing and Communication Unit and the Minister's Office.

Ms Norelle Deeth congratulated the Measured Quality team for the exceptional job done in developing the report. Ms Deeth noted that this is the first time that such a report had been produced in Australia.

5. Issues / Actions

It was noted that a review of the Quality Improvement and Enhancement Program was currently being undertaken. Dr Steve Buckland stated that a definitive answer on Measured Quality's future would not be available until mid-April, however he was keen to see the process continue.

6. General Business

It was noted that the Phase 1 deliverables had been endorsed by the sponsors.

7. Next Meeting

Date: TBA
Time: TBA
Venue: TBA

JUSTIN'S NOTES

2. Program Area Update and Progress

Finalise changes to the Public report

Advice was provided from the Premier through the Ministers Office on the required changes to the report, just after the Cabinet consideration date.

Myself, Adele Thomas & Lisa Crawford had a series of meetings with the Ministers Office, Premiers and Cabinet & Marketing and Communication Unit in order to incorporate the changes into the report as requested by the Premier.

The final document was agreed upon and sent to the Premiers Office, in the hope that we could have it approved, printed and distributed just prior to XMAS.

Advice was then received back from the Premiers Office that there were still a number of issues that needed to be addressed in the document.

At this late stage we realised that we were not going to get the report out before XMAS, so we decided that due to the XMAS break, staff being on leave (both in Premiers and in our team), we would aim to have the second round of changes incorporated into the document by the end of February.

This time we dealt only with Premiers and Cabinet and had the requested changes back to Prem & Cab by the end of last month. While agreement has been sought once again with officers from Prem & Cab on the changes, some further queries have been made by the Executive Director (Elizabeth Fraser) which we are currently following up on.

A common brief will then be done to the Premier and Minister with the proposed media plan attached. The Premier will then communicate to the Minister on the strategy for release and the date for release.

Summary of issues:

Stronger link in the Exec Summ and Intro to Smart State Health 2020

Re-wording to reflect a less negative view on some of the indicator results

An addition to the Exec Sum and Intro which explains (in layman's terms) and promotes quality measurement and improvement process

Reassurance that QLD currently has a health system that ranks world's best
That the Govt is committed to continuous quality improvement
& Given this Govt's commitment we are releasing the first Public Report to the community on the quality of service being provided by QH (Market This)

Safety is a component of measuring quality of service and while all govt's aim to reduce the number of adverse and sentinal events, it is not possible to eliminate all of these. Reference: ? Bruce Barraclough

Provide a layman's explanation of terms such as in-hospital mortality

Re-configure and expand on information provided after poor results on the action being taken to address some of these issues.

Finalise communication strategy for Public report:

Lisa Crawford and I have been working on the strategy in conjunction with M&C Unit and the Ministers Office and while a number of people have been given the opportunity to comment or provide direction we have been unable to get answers on some fundamental questions such as:

Q. How will the report be distributed, will it be launched or released?

Q. Who will do the release? Who will be the media spokesperson?

Q. Should we have Bruce Barraclough on hand to champion the report or have him waiting in the wings for a just in case scenario?

Q. We plan to run through a lot these questions with Prem & Cab once the report is finalised as they seem pretty keen to help with this. May involve the Premiers marketing and communication unit to assist in finalising the strategy

Note: Report on Govt services was quite positive and this may be a good media environment to release the public report

Develop a strategy to disseminate the contents of the hospital reports and form a team from QH to undertake:

Refer documents emailed to board members

Restriction from Cabinet meant that any dissemination strategy would require visits to sites to highlight outlier results, answer question on the analysis and provide direction on where to go from here.

It was agreed that due to the age of the clinical data in the Phase 1 reports and the fact that some investigation had already been performed on the clinical outliers, any further request for dissemination would yield little benefits and potentially get HSD's offside.

Phase 2 analysis was already well under way and if a concentrated effort was made, a third and most current year of data would be analysed providing us with:

3 years clinical
2 years efficiency
2 years system integration & change
1 year patient satisfaction

On this basis hospital visits are being arranged to occur in April 03

Don't just leave the results but provide information on the next step for dissemination.

Key groups such as:

CDP, OIU, CHI, Risk Management, Clinical Audit and each zonal exec have been continually kept 'in the loop' so as they can be on hand to assist hospitals with any change management initiatives.

It was strongly felt that even though we could not distribute the hospital reports we needed to leave hospitals with something

Phased 2 Hospital reports are therefore being made available to relevant District Managers on a secure site through QHEPS, password protected, via PDF, which will clearly have cabinet in Confidence Caveats, Print Options switched off, text select options switched off. While all of these security items will be in place it may not be possible to completely eliminate ALL possibilities of printing the report, but it will be made as difficult as possible and therefore intention will be very clear if anything was to happen.

DM's (relevant hospitals)

ZM's, GMHS, DDG & DG (All reports)

Each Quadrant provide an update on the analysis and issues/problems encountered (Sean include status of DEA):
Clinical – Paul & Danny
Efficiency - Sean
System Integration & Change – Angela who is A/Project Officer while Adele is on sick leave.

3. Reports

Phase 1 deliverables have been endorsed by the sponsors and are in hard copy on the table. Please review them while you are here, for your information.

Phase 2 reports on QHEPS
Sean to talk through

4. Marketing & Communication

Brief on outlier results have been setup for 17th, 18th & 19th March for each Zone.
Note: A rep from the Zone will be accompanying us on each of our hospital visits.

Brief to change management groups 24th March

5. Issues / Actions – Mainstreaming.

QIEP review is underway

Discuss interim solution to keep the work underway, until a permanent solution can be made.

6. Next Meeting: May/June

Thank all staff (include Adele) – past and present
Glenn & Elizabeth
Roger & Ellen
Sue Cornes
Ian Scott
Mike & Sabrina & District staff that we have worked with
Sponsors – past and present
Lisa Crawford
Expert groups
Col Roberts & Ainsley Rowlands & Bill Stomfay

The **Preferred Option** has been the result of consultation with a range of groups and does not necessarily reflect one person or groups thoughts and ideas. It is a combination of all and is based on:

- feedback from 19 hospitals were the clinical indicator results were discussed
- feedback from District Manager & State Manager working party
- experience / lessons learned from Ontario and UK
- meeting (28/11/02) with change management groups (inc: OIU, CDP, Zones, CHI, Risk Management)
- discussions with members of the Measured Quality Board (including: Dr Ian Scott,...)

Measured Quality would like to aim to have several years data before further dissemination is attempted.

It is felt that the 2 main reasons for not proceeding with further dissemination of the phase 1 hospital reports is due to:

- age of data (clinical 99/00), &
- 19 hospitals have already performed some initial investigation for the negative clinical indicator results

Potential for getting the hospitals off side is large if we insist on them investigating 1999/2000 clinical data. Mark Waters raised the age of the data as a major issue in May 2002 (feedback from District Manager and State Manager working party).

When Measured Quality visited 19 hospitals to discuss the 'potential reason for variation', the hospital report was generally held in high regard, but was consistently requested when the hospitals were going to receive the full report. If we visit them again to discuss 'more of the same' and not leave them with the full report the 'trust' between Corporate Office and HSD's will be a significant issue and the potential for quality improvement may be lost.

Preferred Option:

Propose hospital visits to occur in April 2003 with:

- several years data (see spreadsheet for data availability)
- relevant hospital results made available to District Executive members through QHEPS (print options switched off & 'Cabinet in Confidence' caveat on front page)
- development of a collaborative team to assist hospitals with dissemination

Measured Quality Hospital report
Dissemination Strategy

The Measured Quality hospital reports were submitted to Cabinet on the 11th November 2002. Advice received from the Cabinet Legislation and Liaison Officer, Parliamentary and Ministerial Services Unit on the 14th November 2002 stated that a strategy should be finalised to manage the dissemination of the information from the 60 Hospital Reports and the formation of a Department of health team to undertake the work should be developed.

It is widely recognised that simply collecting, processing, analysing and disseminating comparative data is an enormous logistical and resource-intensive task, yet it is insufficient. Any strategy emphasising comparative data must consider how to engage the serious attention of those individuals to whom change is to be delivered.

Literature consistently states that in order to engage Clinicians and Line Managers to actively review their performance, a blame free environment must be fostered. This will help ensure genuine use of the information rather than a 'witch hunt' approach that will encourage Clinicians & Line Managers to 'play the system' / gaming.

If the Measured Quality hospital reports/results are not made available in some way, we may loose the opportunity to engage in real quality improvement.

Measured Quality data analysis availability

	Clinical	Patient Satisfaction	Efficiency	System Integration & Change
Phase 1	1999/2000	2000/2001	2000/2001	2000/2001
Phase 2	1999/2000 2000/2001 2001/2002* *analysis only	2000/2001	2000/2001 2001/2002	2000/2001 2001/2002
Phase 3 or operationalise/ mainstream	1999/2000 2000/2001 2001/2002 2002/2003	2000/2001 *2002/2003*** ** Only if work commences in January 2003	2000/2001 2001/2002 2002/2003	2000/2001 2001/2002 2002/2003
Phase 4 or operationalise/ mainstream	1999/2000 2000/2001 2001/2002 2002/2003 2003/2004	2000/2001 *2003/2004**** *** Only if work commences in January 2004 as proposed in 3 Dec 02 'briefing' to GMHS	2000/2001 2001/2002 2002/2003 2003/2004	2000/2001 2001/2002 2002/2003 2003/2004

2. Advice from Cabinet

"Senior Management can be briefed on the contents but cannot be given copies of the report"

3. MQ's objectives over the next 6 months

Develop a strategy that will provide hospitals with the tools and the support required to disseminate the results in the Hospital reports.

1) Have an endorsed strategy for dissemination by our sponsors (Steve Buckland & Norelle Deeth) and DG
2) Action the dissemination strategy for the phase 1 reports
3) Complete the next round of Hospital reports
4) Action the dissemination strategy for the phase 2 reports (include changes/lessons learned from the phase 1 report dissemination)

4. Where can Measured Quality 'link in' with existing groups (Zonal Management & existing projects / program areas / units) over the next 6 months to ensure that the reports are utilised to their full potential and to stimulate activities at the local level.

Open up discussion:

OIU
S Z
CHI
N Z
CDP
Risk

Other areas could include Pathology & Scientific Services (efficiency) Infection Control, Clinical Audit,

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MINUTES

Board Meeting of the Measured Quality Program Area

Held 8th October 2002, 11.00am–1.00pm

Conference Room, 17th Floor Queensland Health Building

CHAIR: Dr Buckland

Present:
Dr Steve Buckland (Chair)
Ms Norelle Deeth
Dr Glen Cuffe
Ms Sue Cornes
Ms Elizabeth Garrigan
Mr Paul Monaghan
Ms Toni Peggrem
Mr Mike Allsop
Ms Paula Bowman
Ms Sabrina Walsh

Program Area staff:
Mr Justin Collins
Ms Adele Thomas
Ms Jane Stanfield
Mr Sean Conway
Mr Danny Youlden

Apologies:
Prof Bryan Campbell
Ms Geri Taylor
Mr David Jay

Non-attendees:
Dr Ian Scott

1. Welcome and apologies

Dr Buckland welcomed Board members. Previous minutes for 21st May 2002 were accepted as true and accurate.

The Terms of Reference were endorsed by the Board with the addition that the Board has been involved in the development of the project plan for the Program Area.

2. Program Update and Progress

Phase I

Progress was summarised as:

•A cabinet submission was requested as a result of our Measured Quality brief to the Minister and DG on the 13th August.

•Sponsors requested that the clinical indicator 'outlier' results be raised with the relevant hospitals and that some short-term investigation be performed to determine some potential reasons for the variation. Feedback received from the hospitals will help form the basis of a media plan for each hospital if the results were viewed by the media and questions raised. Feedback received from the hospitals will be included in the Cabinet submission.

•The public reports and all hospital reports will be attached to the Cabinet (Information) Submission recommending that Cabinet "note the contents of the submission and that the Public report be released to the range of parties on the distribution list and for the hospital reports to be distributed to the relevant Zonal & District Managers only".

• The first draft is going to Parliamentary & Ministerial Services on 14th October with a range of discussions being planned with Premiers and Treasury prior to its first lodgement to Cabinet.
•The phase 1 public & hospital reports will be considered by Cabinet on 11th November.

A summary of the hospital responses regarding outlier clinical indicator results was provided. The board discussed a number of issues regarding this summary:
- Need for a clear remedial process regarding coding as the board agreed that coding and data quality should not be accepted as a reason for indicator outlier status.
- Possibility of masking and gaming behaviours developing over time if the program is not implemented with quality improvement in mind.

Phase 2

Efficiency Quadrant - MQ Efficiency Indicator Working Party was established and ch[redacted]
ave been made:

Staffing changes
- Majority of staff definitions changed from a financial perspective to a HR perspective
- Denominator 'Ordinary FTE'. *Discussion took place of the definition of this.*
- Medical Overtime to be split into junior/senior
- Nurse agency usage to be identified
- Sick leave includes paid and unpaid
- Unscheduled leave - all leave excluding recreation, Long Service, Maternity, Public Holiday
- WorkCover changed from premium based to leave taken. *After discussion, the Board agreed that there should be an additional indicator measuring workcover risk.*

Activity indicators
- Proportion same day = same day / total seps.
- Day Surgery and DOSA same as SAS
- Elective Surgery waiting list snapshot census at 1/7
- Access Block in Emergency Departments. *After discussion, the board agreed that this indicator should not be reported.*
- Occupancy rate, ALOS and OR cancellations remain.

Cost changes
- $ / W/Sep NHCDC data available for 29 facilities. After discussion, the Board agree that FRAC data should be reported for all sites as well.
- Top 10 DRGs by cost/volume identified specifically for each facility
- Casemix efficiency = Actual expenditure / Casemix budget
- Asset condition = net book value / gross book value
- Food, cleaning and linen not available until survey completed. (possibly December 02)

Patient Satisfaction Quadrant - Patient Complaints and Surveys Program Area
- Currently collating responses from District Managers in relation to progress of QI activities following initial survey reports from TQA.
- A submission for funding for future Patient Satisfaction surveys to be given to GMHS in November, including responses from District Managers.
- There may be potential to look at satisfaction by Clinical Specialty, eg. satisfaction of orthopaedic patients. There are issues relating to consent for this to occur as it will require

linking survey responses to UR numbers and possible requirement for ethics approval on recommendation from HIC.

System Integration and Change Quadrant - A reference group has been convened to refine the indicators. The Phase II survey has been distributed. Changes are proposed for HR indicators and there has been some refinement of indicators for clinical pathways, benchmarking and continuity of care. *Discussion took place regarding the usefulness of this quadrant in its present form and the need to develop information systems which can better measure effectiveness of models of care. It was noted that QH has no explicit framework from which to develop these indicators.*

Clinical Quadrant – Through feedback from districts and discussions with clinicians, indicators were adjusted as follows:

- Hip Replacement Complications of Surgery - exclude "revision" of hip replacement (as a complication) if it occurs more than two years from primary hip replacement surgery.
- Hysterectomy Complications of Surgery - Exclude pelvic malignancies
- Mortality - For stroke and #NOF, mortality will be "30 day in hospital mortality" (This brings it in line with the other mortality indicators)
- Long stay rates (LSR) - LSR for all indicators to include mortality which occurs after the long stay point
- Complications of surgery - Analysis will not change. Complications will be listed according to ICD codes which triggered the complication code (ICD T80-88 and Postprocedural disorders)
- Nursing home separation rates - No change in analysis, Include a comparison with hospitals with acute stroke unit, rehabilitation on site, no rehabilitation facilities
- Indicators which will have some adjustment:
    - All indicators with a Long stay rate outcome
    - Stroke Mortality
    - #NOF Mortality
    - Hip Replacement Complications of surgery
    - Hysterectomy Complications of surgery
- Indicators with added analysis component:
    - All Complication of surgery outcomes
    - Stroke Mortality / LSR / Nursing Home
    - stroke unit / rehab/ neither
    - #NOF Mortality/ LSR / Nursing Home
    - stroke unit / rehab/ neither
    - surgery <48hrs/ surgery >48hrs
    - Hysterectomy
    - malignancy included /malignancy exc.
    - Abdominal/ Vaginal/ LAVH

Summary of DEA – Data Envelopment Analysis (see attached slides 44-53)

- A linear programming technique
- Is capable of using multiple inputs and outputs of any form
- Identifies best practice within a sample
- Measures efficiency based on differences between observed and best practice units

3. Reports

Final versions of the hospital and public report were tabled at the meeting together with the distribution list for the public report.

4. Marketing and Communication

Dates to present to each of the Zonal Executives have been arranged
23rd October, 2002 – Northern Zone
30th October 2002 – Central Zone
November (date to be arranged) – Southern Zone.
Meetings will be arranged with 'Change management' groups prior to the Cabinet consideration date. These include:

- Clinician Development program area
- Organisational Improvement unit
- Risk Management program area
- Collaborative for Healthcare Improvement program area
- Clinical Audit program area

The zonal presentation was tabled at the meeting.

5. Issues/Actions

Some issues highlighted from phase 1 include:

- Data quality, in particular, the consistent feedback from the chart audits that clinical coding was a considerable factor in the variation in the clinical indicator results.
- FAMMIS reporting hierarchy issue impacts on the quality of the data for some hospitals.
- Support Services reform project collection through survey has an impact on the timeliness of the data.
- The availability of data through existing data collections for the System Integration & Change quadrants is an issue, and if the reporting of performance indicators is going to continue, consideration on how we start collecting the appropriate information needs to be progressed.
- The lack of patient satisfaction surveys over the next few years will mean that this quadrant of the balanced scorecard will not contain result beyond those that are currently available.

6. Next Meeting

Date: 11th February, 2003
Time: 11.30am-1.30pm
Venue: TBA

Measured Quality Program Area
3rd Floor
Forestry House
GPO Box 48
Brisbane, QLD 4001

Measured Quality

Program Area Board

Terms of Reference

Queensland Government
Queensland Health

17th September 2002

Measured Quality

Program Area Board

Terms of Reference

The Program Area Board for Measured Quality is established by the Program Area Sponsor and provides a high level of assurance to Queensland Health's Executive that the Program Area is adequately governed. The Program Area Board is accountable for ensuring:

- That the Detailed Project Plan, the selection report and the project plan for the next phase of the Program Area (e.g. implementation) are of acceptable quality.
- The appropriateness of strategic decisions/advice affecting the success of the Program Area – including changes to the scope, schedule, cost, quality, staffing, communications, risk, procurement and change management plans.

Responsibilities and duties include:

- Assist in the development of the Detailed Project Plan
- Oversee the execution of the Detailed Project Plan.
- Oversee and review changes to the scope, schedule, cost, quality, staffing, communications, risk, procurement and change management plans.
- Members attend and actively participate in all Program Area Board meetings.
- Provide advice and support to the Program Area Manager as appropriate.
- Review and accept reports on quality of the Program Area processes and deliverables.

Act as an interface to other areas impacted by the Program Area and assist in the resolution of Program Area boundary issues.

Appointment Chairperson and Program Area Board

The Chairperson of the Program Area Board will be

Dr Steve Buckland (Sponsor), General Manager, Health Services.

The members of the Program Area Board are:

- **Ms Norelle Deeth (Sponsor), Deputy Director-General, Policy and Outcomes**
- Mr Mike Allsop, District Manager, Fraser Coast Health Service District (HSD)
- Ms Paula Bowman, Manager, Organisational Improvement Unit
- Dr Roger Brown, Team Leader, Clinical Strategy Team, Procurement Strategy Unit
- Ms Sue Cornes, Deputy Manager, Health Information Centre
- Dr Glenn Cuffe, Manager, Procurement Strategy Unit (PSU)
- Dr Gerry FitzGerald, Chief Health Officer, Office of the Chief Health Officer
- Ms Elizabeth Garrigan, Team Leader, Quality Strategy Team, PSU
- Mr David Jay, Director, Capital Works Branch
- Mr Paul Monaghan, Finance Manager, Finance Unit
- Dr Ian Scott, Director, General Medicine, Princess Alexandra HSD
- Mr Paul Sheehy, Manager, Health Outcomes Unit
- Ms Anne Turner, Director, Health Systems Strategy Branch
- Ms Sabrina Walsh, District Manager, Logan Health Service District

Duration of Program Area Board

It is anticipated that the outcomes will be achieved by June 2003. The Program Area Board shall be dissolved after this period.

Secretariat

The secretariat for the meetings shall be the Measured Quality Program Area team. The Secretariat will coordinate any action items arising.

2002

Jan-2002	Feb-2002	Mar-2002	Apr-2002	May-2002	Jun-2002	Jul-2002	Aug-2002	Sep-2002	Oct-2002	Nov-2002	Dec-2002
				Completion of Phase 1 & Commence Phase 2							

2003

Jan-2003	Feb-2003	Mar-2003	Apr-2003	May-2003	Jun-2003	Jul-2003	Aug-2003	Sep-2003	Oct-2003	Nov-2003	Dec-2003
Complete phase 2 analysis					Dissemination				Formal feedback from Hospitals		

2004

Jan-2004	Feb-2004	Mar-2004	Apr-2004	May-2004	Jun-2004	Jul-2004	Aug-2004	Sep-2004	Oct-2004	Nov-2004	Dec-2004
Complete 2002/2003 analysis					Dissemination				Formal feedback from Hospitals		

2005

Jan-2005	Feb-2005	Mar-2005	Apr-2005	May-2005	Jun-2005	Jul-2005	Aug-2005	Sep-2005	Oct-2005	Nov-2005	Dec-2005
Complete 2003/2004 analysis					Dissemination				Formal feedback from Hospitals		

The development and distribution of performance indicators must be done with caution. Performance indicators should be viewed as a screening tool to flag potential issues or areas of quality improvement. Performance indicators are not precise measures of quality, and for this reason the Measured Quality public report should be used as a qualitive document to the public on hospital services that are being provided by Queensland Health. Each hospital report should only be provided to the relevant District Manager and Zonal Manager to allow further analysis of the results at a local level, and to determine the cause of any variation highlighted. If hospital reports were viewed by external parties to Queensland Health, without access to a more detailed analysis by hospitals, the misinterpretation of results would be the most likely outcome, thus leading to inaccurate labelling of a hospital's quality of care.

The quality of the data that is used for performance indicators will have a major impact on the level of meaningfulness of the indicators and the report. Data quality will vary across different data collections that have been used for the reports, in particular information systems that require the translation of activity from patient records. The greater the accuracy of the data collection, the more accurate the performance indicators will be. It is recognised though, that unless this data is utilised for performance reporting on a regular basis, there will be less incentive for hospitals to ensure accurate and reliable information is available. These reports are considered to be a 'first step' in improving the quality of existing data collections and hence any future 'Measured Quality' reports.

Scope of this visit

- Provide each Hospital with their data (explain distribution restrictions of the report)
  - Advice from Cabinet (11 Nov 02)
- Develop a strategy to disseminate the contents of the hospital reports
  - Clinical-3 years, Efficiency-2 years, SI&C-2 years, PS-1 year
  - Collaborative approach to dissemination
  - PDF / Electronic availability of results to DM only
- Promote further action with hospitals through interpretation of the results in light of local contexts

Data Envelopment Analysis

Purpose

To provide information relating to a linear programming technique, which identifies best practice within a sample and measures efficiency based on differences between observed and best practice units.

Background

The measurement of efficiency is increasingly difficult in a health care setting given the number of different inputs required to provide a service and the multiple outputs produced. A traditional example of efficiency measurement is input divided by output eg Food Services expenditure per occupied bed day. However if three outputs and four inputs are to be considered, the result is usually a number of indicators that make overall comparison between organisations difficult.

Data Envelopment Analysis (DEA) is an analytical tool that may assist in the identification of best practices in the use of resources among a group of organisations (DMU's). Such identification can highlight possible efficiency improvements that may help agencies to achieve their potential.

DEA is typically used to measure technical efficiency (the conversion of physical inputs such as the services of employees and machines into outputs relative to best practice).

Key Issues

Strengths:

- DEA is able to manage multiple input and multiple output models.
- It doesn't require an assumption of a functional form relating inputs to outputs.
- DMU's are directly compared against a peer or combination of peers.
- Inputs and outputs may have very different units.
- By identifying the 'peers' for organisations which are not observed to be efficient, it provides a set of potential role models that an organisation can look to for ways of improving its operations. This makes DEA a potentially useful tool for benchmarking and change implementation programs.

Weaknesses:

- Since DEA is an extreme point technique, measurement error may cause significant problems.
- DEA is good at estimating "relative" efficiency of a DMU but it converges very slowly to "absolute" efficiency. It can tell you how well you are doing compared to your peers but not compared to a "theoretical maximum."
- DEA scores are sensitive to input and output specification and the size of the sample.

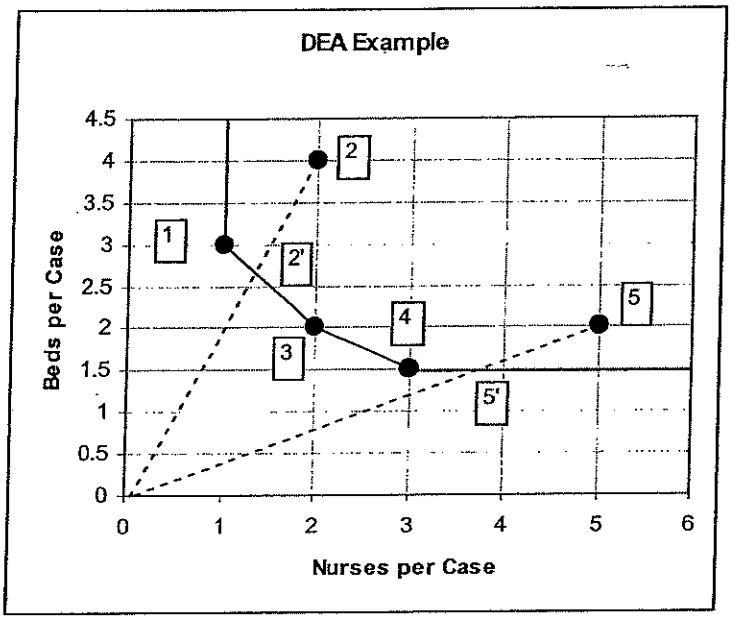
A simple example

Which are the most efficient or best practice hospitals in the sample?

Table 1 – Sample Hospital data

Hospital	Nurses	Beds	Cases	Nurses per case	Beds per case
1	200	600	200	1	3
2	600	1200	300	2	4
3	200	200	100	2	2
4	600	300	200	3	1.5
5	500	200	100	5	2

Graph 1 – Sample Hospital data



Hospitals 1, 3 and 4 are on the efficient frontier, so are assumed to be operating at best practice. However, hospitals 2 and 5 are north-east of the frontier, so are considered to be less efficient. This is because they appear to be able to reduce their input use and still maintain their output level compared with the performance of the best practice hospitals. For example, hospital 2 could reduce its use of both inputs by one third before it would reach the efficient frontier at point 2'.

Similarly, its technical efficiency score is given by the ratio 02'/02 which is equal to 67 per cent in this case. In terms of actual input levels, hospital 2 would have to reduce its number of nurses from 600 to 400 and its number of beds from 1200 to 800. At the same time, it would have to maintain its output of 300 treated cases before it would match the performance of the hypothetical best practice hospital 2'.

The frontier is reached between hospitals 1 and 3 in this case, so the hypothetical hospital 2' is a combination, or weighted average, of the operations of hospitals 1 and 3. If hospital 2 is looking for other hospitals to use as role models to improve performance, then it should examine the operations of hospitals 1 and 3 because these are the efficient hospitals most similar to itself.

The other less efficient hospital — hospital 5 — is in a different situation. It is north-east of the efficient frontier, but contracting its inputs in equal proportions leads to the hypothetical hospital 5', which still lies to the right of hospital 4 on the segment of the frontier which was extended parallel to the nurses per treated case axis. Thus, the peer group for hospital 5 solely consists of hospital 4

because it is the only one which 'supports' that section of the frontier on which the hypothetical 5' lies. But hospital 5' is not fully efficient because the number of nurses per treated case can be reduced, while the number of beds per treated case is held constant, thus moving from 5' back to 4. That is, to maximise its efficiency given the available data, hospital 5 has to reduce one input more than the other. In this special case, a radial contraction of inputs means that the frontier is reached, but a further reduction of one of the inputs can be achieved without a reduction in output. This extra input reduction available is known in DEA studies as input 'slack'.

(Extracted from: Steering Committee for the Review of Commonwealth/State Service Provision 1997, *Data Envelopment Analysis: A technique for measuring the efficiency of government service delivery,* AGPS, Canberra.)

Possible Input and Outputs for Measured Quality (60 hospitals)

Inputs	Outputs
Medical FTE	Weighted Separations level 1
Nursing FTE	Weighted Separations level 2
Other FTE	Weighted Separations level 3
Non Labour expenditure	Outpatient Occasions of Service (weighted by hospital funding model)
Number of Beds	Other care (weighted by hospital funding model)
Gross Asset value (Medical equipment)	Patient satisfaction (data currently n/a)
Inverse of training $	Inverse of long stay rate
	Inverse of in-hospital mortality

Benefits and Costs

The benefits of utilising a DEA approach for the measurement of efficiency are detailed below:

- Provides a common basis by which hospitals (DMU's) activity and resource consumption may be compared.
- Enables the identification of efficient hospitals within the cohort and those that require improvement, and the ability to identify specific areas of resource consumption or activity that needs to be improved in quantified terms.
- Enables the identification of hospitals performing in a similar manner and may lead to appropriate consultative forums or networks of like hospitals to progress performance improvement.

The following issues need to be considered with the implementation of DEA.

- Selection of appropriate input and output measures
- Data collation and validation
- Selection of appropriate constraints and the mathematical model
- Software requirements (SAS/OR $5k pa, Banxia Frontier Analyst $3k / $1k pa maint, Excel, EMS, others?)
- Interpretation of the results
- Selection of an appropriate tool to progress the dissemination of information and implement improvement activities.

Organisational reporting

- PST Benchmarking reports to Treasury every 6 months (Reports by Hospital, HSD, Zone or State?)
- State report to ODG on QH's performance include National comparitive data (AIHW) Aggregated by Zone up to State and to the NHPF dimensions
- Link in with ISAP? — ISAP can possibly inform of indicators for further refinement
- Commitment and demonstration of action for outlier indicators in accordance with this strategy to form part of the SLA's (while they are high level).
- If the SLA's are broken down to a lower level – put actual indicators in

Needs to go down to inpatient services

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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

Obj 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

Measured Quality Program

Summary Report on Meetings Held with the Districts in Preparation for Release of Facility Reports 16/07/02 – 30/07/02

The Measured Quality Program Area has compiled 60 facility reports which record the outcomes of the indicators analysed by the program area. At the beginning of July 2002, the Measured Quality Program was asked, as part of a media and communications plan, to discuss with the hospitals any significant variances noted for their facility. The aim of this discussion was to flag the existence of a variance, to explain the methodology used to measure the indicator and to identify potential reasons for the variance. This was to enable hospitals to be prepared should the reports become public. A time frame of one month was allocated.

Meetings were arranged with the hospitals if a variance was identified for their facility. The variances were reported if they were in the lowest five "performers" (ie highest five over the mean) for the state, with statistical significance above the 90% confidence level or the analysed data, when adjusted to a rate value, appeared significantly high despite low numbers or low statistical significance. Appointments were made with all the hospitals with clinical data, except Prince Charles, based on these criteria. Appointments were of one to two hours duration, one hour usually proved to be sufficient time.

The format of the meetings (see agenda attached) generally included an introduction and overview of the Measured Quality Program Area's aim and focus; an overview of the statistical methodology used and a discussion about the selected indicators' inclusion and exclusion criteria. The meeting was then open to discussion and potential reasons for the observed variance considered. This forum gave the opportunity to reinforce the positive outcomes as well and to further encourage the use of the report as a tool to flag potential quality activities and to learn from other facilities.

Hospital responses were, on the whole, positive. Certainly by the end of most meetings, the participants were keen to see the report and acknowledged the usefulness of such a report to the facility. The most frequent areas of concern raised were:

- queries related to the accuracy of the data when compared to hospital records. However, Danny Youlden explained the indicators inclusion and exclusion criteria and statistical methodology and generally this concern was allayed or unfounded. All hospitals were provided with a Technical Supplement to enable them to follow this data up. They were also informed of the existence of Crystal reports which would allow them to query Transition data at the hospital level.

- The clinical data related to 1999-2000. Often there had been changes in staff, procedures or quality processes since then. This was acknowledged by MQP participants. Once hospital representatives understood that this was the data available when the indicators were being developed, that the processes for analysis, verification and dissemination had had to be designed as well as carried out and that there was significant sensitivity surrounding the release of the data, including the present activity of visiting all the hospitals, this was less of an issue. MQP representatives reinforced that we intended to provide more timely data once the tool was developed, however, data available to corporate office would always be somewhat delayed. Danny Youlden encouraged hospital participants to access their own data "live" using the Crystal reports and Transition.

[redacted]

Concerns about media access / treatment of the data. MQP informed the hospitals that it was not our intention to release this data publicly, however, there remains the possibility that Freedom of Information Requests would be made and it would become available. The aim of these meetings was to give the facilities some time to prepare a response to media questions. This included giving them the raw data so they would be aware of the observed numbers of outcomes, which were often very small. Furthermore, we advised them of the media officer (Lisa Crawford) associated with the QIEP and encouraged them to liaise with her and their own media staff.

- Issues regarding the allocated peer groups. Each facility was provided with a list of the peer groups (see attached) and Justin Collins explained the rationale for the allocations. On the whole, the groups accepted this explanation and recognised the balance required to identify peer groups which pertained to all 32 indicators and compared "like with like" as far as possible. The issue of risk adjustment was explained by Danny Youlden. It is, however, clear that in an area such as Queensland the varying demographics and geographical locations are going to raise issues which are individual to each facility. The MQP team encouraged districts to examine these issues at a local

level, and reinforced the use of the report as way to "flag" variance for investigation and not necessarily as a precise measure of quality in an area. The use of measures of rurality arose out of this concern.

- Issues of coding and documentation and its potential impact on the outcomes observed. This is clearly a potential problem and has been consistently flagged as a potential reason for variance. We encouraged the staff to examine this at a local level.

- The availability of community services such as local rehabilitation units or nursing homes were considered to have significant impact on some outcomes. The availability of equipment, such as CT scans to accurately diagnose stroke, was also raised. This underscored the use of the tool from a corporate perspective, in terms of identifying /supporting community needs.

The information has now been presented and discussed with approximately 62 people. The following is a list of those who attended the meetings.

Bundaberg Health Service District:
Peter Leck, District Manager
Dr. Kees Nydam, Acting Director of Medical Services
Dr. Peter Miach, Director of Medicine
Dr. Julian Zarauskas, staff physician
Glennis Goodman, Director of Nursing Services
Tina Wallace, Director of Community Health Services
Leonie Raven, Quality Coordinator
Jenny Kirby, Manager Decision Support Unit

Cairns Health Service District:
Marlane Byrne, District Manager
Shaune Hunt, Executive Director of Nursing Services
Linda Williams, Executive Director of Community Health
Brett Grosser, Executive Director of Corporate Services
Bronwyn Luxon, District Hospitals Representative (proxy)
Jan Parr, Allied Health Representative (proxy)

Fraser Coast Health Service District:
Mike Allsopp, District Manager
Mitchell Price, Manager Clinical Costings (Transition II)
Julie Rampton, Director of Nursing (Maryborough)
Meryn Pease, Director of Nursing (Hervey Bay

Gold Coast Health Service District:
Brian Bell, Medical Superintendent
Peter Daveron, Deputy Director, Medical Division

West Moreton Health Service District:
Pam Lane, District Manager
Michael Daly, Exec Dir of Medical Services

Logan Beaudesert Health Service District:
Sabrina Walsh, District Manager
Gerry Costello, Exec Dir of Medical Services
Ros McCoy, Director of Nursing
Gary Bryant, Information Services

Mackay Health Service District:
Moina Lettice, District Manager
Craig Margetts, Exec Dir of Medical Services
Mary Scott, Director of Nursing

Mater Misericordiae Health Service:
Dr Julie Hudson, Executive Director, Clinical Support Services, Mater Public and Private
Dr Peter Leslie, ActingExec Director, Women's and Children's Services, Public and Private
Jennifer Skinner, Exec Director, Adult Health
Sue Williams, Manager, Clinical Risk and Quality Improvement Unit

Mt Isa Health Service District:
Graeme Jackson, District Manager
Simi Sachdev, Exec Dir of Medical Services
Mark Adcock, Executive Director of Nursing
Anne Neave, Quality Manager
Ken Bissett, Director of Corporate Services

Sunshine Coast Health Service District:
Martin Jarman, District Manager
Bill Rogers, Exec Dir of Medical Services
Ross McDonald, Director of Nursing
Martin Gregora, O&G
Don Martin, Surgery

QEII Health Service District:
Tracey Sylvester, Acting District Manager
Susan Brandis, Director, Allied Health
Catherine James, Director of Nursing
Marie Mackay, Manager, Organisational Development Unit
Jeff O'Brien, Manager, Corporate Services
Jackie Hawkins, Manager, HR

Redcliffe / Caboolture Health Service District:
Louise Harvey, District Manager
Mark Matussi, Exec Director Medical Services
Donna O'Sullivan, Med Super, Redcliffe Hospital
Garmin Premaratne, Director of Surgery

Toowoomba Health Service District:
Andy Cummings, Medical Superintendent
Mike Kerrin, Acting District Manager
Judy March, Director of Nursing
Michelle McKay, CNC Emergency Dept

Townsville Health Service District:
Val Coughlin-West, Acting District Manager
Penny Thompson, Manager – Quality Improvement
Kieran Keyes, Acting Executive Director of Business Services
Sue Keleher, Acting Executive Director of Nursing

The development and distribution of performance indicators must be done with caution. Performance indicators should be viewed as a screening tool to flag potential issues or areas of quality improvement. Performance indicators are not precise measures of quality, and for this reason the Measured Quality public report should be used as a qualitive document to the public on hospital services that are being provided by Queensland Health. Each hospital report should only be provided to the relevant District Manager and Zonal Manager to allow further analysis of the results at a local level, and to determine the cause of any variation highlighted. If hospital reports were viewed by external parties to Queensland Health, without access to a more detailed analysis by hospitals, the misinterpretation of results would be the most likely outcome, thus leading to inaccurate labelling of a hospital's quality of care.

The quality of the data that is used for performance indicators will have a major impact on the level of meaningfulness of the indicators and the report. Data quality will vary across different data collections that have been used for the reports, in particular information systems that require the translation of activity from patient records. The greater the accuracy of the data collection, the more accurate the performance indicators will be. It is recognised though, that unless this data is utilised for performance reporting on a regular basis, there will be less incentive for hospitals to ensure accurate and reliable information is available. These reports are considered to be a 'first step' in improving the quality of existing data collections and hence any future 'Measured Quality' reports.

Queensland Government
Queensland Health

MINUTES

Board Meeting of the Measured Quality Program Area

Held February 19, 2002 11.00am – 1.00pm

Conference Room, 17th Floor Queensland Health Building

CHAIR: Dr Filby

1. **Welcome and apologies**

Dr Filby welcomed Board members.

Present were:
Dr David Filby (chair)
Dr John Youngman
Dr Glenn Cuffe
Dr Roger Brown
Prof Bryan Campbell
Ms Christine McClintock (for Sue Cornes - on Leave)
Ms Elizabeth Garrigan
Ms Bronwyn Nardi (for Ms Susan Mahon)
Ms Jane Hansen (for Ms Jenny Pouwer)
Mr Paul Sheehy
Dr Ian Scott
Ms Geri Taylor
Mr Paul Monaghan

Program Area staff:
Justin Collins
Sean Conway

Apologies:
Mr David Jay
Dr Alan Isles
Ms Jenny Thomas

2. Progress review

Attached are the slides presented at the Board meeting

Program Management
Progress was overviewed in slide 2 (attached).

Culling of indicators
Process of the summary of the indicators was discussed with mention of the distribution of raw data to facilities occurring through a memo sent on 8 Feb 2002. Further reductions are anticipated as a result of this process.
The current list of indicators was circulated to the board members.

Hospital Clinical Indicators Project
Progress was overviewed in slides 3 – 6 (attached).
The extra step of verification of data accuracy was highlighted. Comments on the Colorectal Carcinoma indicators were made in relation to whether it took into account the medical and surgical aspects of the condition. It was indicated that the existing indicator was only considering the surgical aspects of this condition.

Hospital Continuity of Care, Sustainability and Capability Indicators Project
Progress was overviewed in slides 7 – 10 (attached).
The extra step of verification of data accuracy was highlighted. The issue of the particular element of the telehealth indicator was raised with the lack of a specific measure relating to Asthma. It was noted that the telehealth specialty lists were provided by the telehealth program area and are consistent with the work of that area.

Hospital Efficiency Indicators Project
Progress was overviewed in slide 11 – 15 (attached).
The extra step of verification of data accuracy was highlighted. Attention was drawn to the high number of indicators that had been culled from list for efficiency. It was also noted that there were small hospital numbers in some of the peer groups.

Hospital Responsiveness Indicators Project
Progress was overviewed in slides 16 – 22 (attached).
The extra step of verification of data accuracy was highlighted.
Comments from the board raised the similarity of the results across each indicator and if it is meaningful to be presented that way. Further discussion provided feedback from the Patient Complaints & Surveys Program Area & TQA workshops and the comments and issues raised by district staff.

Action: Review overlap between indicators but noting in particular the low response rate for mental health patients.

Discussion regarding the inclusion of the mental health results in the patient satisfaction quadrant of Measured Quality took place, with the decision to include the results for the purpose

of consistency with existing reports (ie. Patent Complaints & Surveys Program Area). It was also agreed that literature comments should be included in the supporting documentation regarding the difficulties surrounding surveys which included Mental Health and Indigenous members of the community and considerations that need to be taken into account when reviewing results.

3. Report format

Issues were overviewed in Slides 23 – 27 (attached). Three issues raised included: Appropriate Peer Groupings, usefulness of State Mean and Category columns, and use of 4 ticks versus 5 star categories.

Appropriate Peer Groupings: A proposed version of AIHW peer groupings was discussed. The new version allowed for at least 10 hospitals per group and finished with 4 peer groups in total. Comments included: Put all of the Mater hospitals into the same peer group.

State Mean and Category columns: It was agreed that the inclusion of the state mean for some indicators was useful and for others it was not. The work should continue on this basis and the issue should be considered for each indicator and presented in the most meaningful way.

4 ticks versus 5 star: It was suggested that a consistent 3 stars for each quadrant could be an option as the intention is to simply highlight areas of variance.

It was agreed that Option 2 was the best way to present the data and any impact regarding re-work and / or timeframe should be determined and endorsed accordingly.

Action: Further examples of set out to be developed.

4. Marketing and Communication

Objectives were overviewed in Slides 28 – 31 (attached).

It was suggested that the review of drafts by small groups of District Managers under Objective 1: readable and credible reports, should include some representatives from the hospital executive as well.

It was also suggested that Objective 3: Facilitating the use of the data in the service improvement planning, should flag those hospitals in the top 20% on performance so we can highlight what the hospital should be striving for.

Resource implications need to be considered in relation to the implementation of the marketing & communication strategy.

5. Next meeting

Date: 21 May 2002
Time: 11am to 1pm
Venue: 17th Floor Conference Room, QHB

DO WE PUT OF THIS TABLE — LOOK WITHIN PEER GROUPS.

COPY OF PUBLIC + HOSPITAL REPORT. ATTACH TO SUBMISSION

HAS NATIONAL SIGNIFICANCE.

IS IT USING STANDARD DEVIATION QUALITY IND - WHAT ARE YOU WILL HAVE THAT WE CAN IN

PROBLEM WITH EXISTING MEASUREMENT

Preparation for release of Hospital and Public reports for Measured Quality

SEND?

POSSIBLE CHAMPIONS

BRUCE BARACLOUGH

ALISON WILSON

AMA

COST OF CALLS TO BE CIRCULATED.

SUBMISSION

ACTION: TO BRUCE DATE 06

MEDICAL PLANS ETC.

Hospital

- Hospital report distributed to ~~hospitals~~: Friday, 31 May 2002 (hard copy) AVAILABLE FOR RELEASE
- Hospital reports ~~distributed to each Zonal Manager~~, 31 May 2002 (hard copy)
- Technical report as supporting documentation to be distributed
- Original going to the District Manager with a covering memo detailing how widely the report should be distributed outside the hospital, possible questions and answers that the hospital may be asked: attached, mention the release of the public report on 28 June or day of estimates: 12 July - DM
- Question and answer sheet provided
- Controlled copies
- PDF files available by 28 June

Questions:

1. Will the hospital report be distributed to the DM's via GMHS (as an internal document) or will it be distributed by the DG?
2. Can the DM provide details from the hospital report to media or should they be FOI'd ? – **The feeling from Dr Filby was that none of the hospital reports should be released / provided to the media until the public report is released (28 June or 12 July)**
3. Is the DM responding to questions or should questions be directed to ~~corporate office~~?
4. Should the technical document be made available on QHEPS ?
5. Should we notify the communication officers in the HSD's ? - **Yes**

Public

AVAILABLE

- Public report ~~distributed~~: ~~Friday, 28 June 2002 or~~ day of estimates 12 July (hard copy)
- Public report going to 37 or 39 health councils (approx 10 per council) and to a range of state and local politicians. public report on 28 June or day of estimates: 12 July
- PDF file available soon after

Questions:

1. Do we need a Technical report as supporting documentation to be distributed ? NX
2. Will the public report be launched or just the standard media release?
3. Should the technical document be made available on QHEPS ?
4. Should we notify the communication officers in the HSD's.? - **Yes**
5. Should the report be made available on the inter & intra net?

Risks for release of hospital report:

List those hospitals that have a statistically significant variation or that the data shows a possible problem in a particular area.

Refer attachment

List possible reasons for the variation demonstrated in the report.

(note: these reasons 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 a more in depth / local level (eg. At the hospital) it is impossible to be 100% sure why any particular variation has occurred.)

Clinical

1. 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.

2. Variation highlighted in outcomes between hospitals within 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

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

4. 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 ~~large~~ factors in this type of analysis.

   Q. ~~Is it useful to~~ 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 .

5. Quality of care issue

6. VARIATION IN PERFORMANCE FROM CLINICIAN TO CLINICIAN, HUMAN BEING FACTOR OF MAKING
7. DIFFICULT DECISIONS

8.

9.

10.

Efficiency

1. Data collections vary from hospital to hospital (eg. Issue with corporate reporting hierarchy). The existing corporate / state reporting hierarchy is generally not meaningful to a hospital or HSD. 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 of an alternate hierarchy for there own purposes. As this alternate hierarchy is simply a mis-match collection across the state it does not accurately roll up to a statewide or corporate view.

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

3. 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

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

5. HOSPITALS HAVE VARYING DEGREES OF RESOURCES
6. AND STAFF AVAILABLE TO TRAIN, SOME HOSPITALS
ARE UNABLE TO MONITOR OTHER PERFORMANCE
7. BY REVIEWING & COMPARING RESULT DATA.
8.
9.
10.

Patient Satisfaction

1. As per Patient Satisfaction documentation for release of state report.

System Integration & Change

1. Lack of systematic approach to collecting and monitoring these sorts of indicators in the past provides us with limited accuracy of data and lack of interest by hospitals in this sort of information.

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

3. 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.

4.

5.

6.

7.

8.

9.

A joint initiative of the
Ontario Hospital Association and the Ministry of Health and Long-Term Care

Hospital Reports 2001

September 2001

Hospital Report 2001 – Acute Care Report Released

Hospital Report 2001 – Acute Care was released on July 16 at a media conference in Toronto. Many more logged on to the live web and satellite broadcasts of the conference. Speaking on the panel were **Frank Norman**, OHA Board Chair; **Tony Clement**, Ontario Minister of Health and Long-Term Care; **David MacKinnon**, OHA President and CEO; **Adalsteinn Brown**, Lead Investigator Hospital Report 2001 Series, University of Toronto; **Michael Decter**, CIHI Board Chair and **Jennifer Zelmer**, CIHI Director of Health Reports and Analysis. A four-page supplement summarizing a representative sample of the findings was inserted in newspapers across Ontario on July 17 and the full report is available at the following websites: www.oha.com- *Hospital Report 2001*, www.gov.on.ca/health, www.cihi.ca and www.hospitalreport.ca. As an indication of the extent of public interest in the report, CIHI experienced the highest-ever hits on their website following the release

Hospital Report 2001 Series – More to Come!

The *Hospital Report 2001 – Acute Care Report* was the first in a series of reports to be released under the umbrella of the *Hospital Report 2001 Series*, a joint initiative of the Ontario Hospital Association and the Ministry of Health and Long-Term Care.

Other reports in the series include: system-level balanced scorecards for emergency care and complex continuing care; feasibility studies on rehabilitation, mental health and population health; and, special reports on nursing care and women's health. These different types of reports reflect the evolutionary process involved in moving to hospital-specific report cards, as seen in the recent acute care report. Typically, reports are developed in three phases. Phase I is a feasibility study. It examines whether the balanced scorecard approach is appropriate for use in a given health sector, whether indicators can be identified and whether the necessary data exists.

University of Toronto Research Collaborative:

- Department of Health Administration, U of T
- Faculty of Nursing, U of T
- Department of Rehabilitation Medicine, U of T
- Centre for Addiction and Mental Health
- Providence Centre
- University Health Network Research Institute

Institute for Clinical Evaluative Sciences

Canadian Institute for Health Information

Phase II is a system-level balanced scorecard, that is, a scorecard for the province as a whole. It includes calculating indicators for each quadrant of the scorecard both by geographical region and by hospital peer group (i.e. small, community and teaching hospitals). Investigators use system-level reports to refine the methodology before publishing data at a hospital-specific level.

In Phase III, researchers refine the risk-adjustment methods and indicator definitions, and publish hospital-specific results. In this phase, the focus on risk adjustment helps to ensure that comparisons between hospitals are as fair as possible – adjustments are made to each hospital's data to address differences in the patient population served.

The system-level balanced scorecard for complex continuing care will be released on December 6, 2001, with the scorecard for emergency care following shortly after on December 13. The remaining studies will be released late January 2002.

Hospital Report 2001 Series: Data Sources and Time Periods

	Acute Care (July 2001)	Emergency (November 2001)	CCC (November 2001)
Clinical Utilization and Outcomes	DAD* April 1999 – March 2000	NACRS♦ October 2000 - March 2001	MDS■ April 1999 - March 2000
Financial Performance	OHRS# April 1999 – March 2000	OHRS# April 1999 – March 2000	OHRS#, MDS■ April 1999 – March 2000
Patient Satisfaction	Patient/Family Survey May 2000 – July 2000	Patient/Family Survey August 2000 – October 2000	Patient/Family Survey February 2001 – June 2001
System Change and Integration	Hospital Survey December 2000 – January 2001	Hospital Survey May 2001 – June 2001	Hospital Survey May 2001 – June 2001

* Discharge Abstract Database ♦ National Ambulatory Care Reporting System
■ Minimum Data Set # Ontario Hospital Reporting System

Researchers Working to Develop Future Reports

In addition to producing the *Hospital Report Series 2001*, researchers have already started to work on activities to support future reports. This research looks at enhanced models for risk adjustment, indices to combine individual indicators, work to examine the relationship between different quadrants (e.g. patient satisfaction and clinical quadrants), and the development of a resource inventory for hospitals. Efforts are also being undertaken to examine variations in the coding of data in hospital charts and to examine care provided to patients across different sectors.

Along with its increased research activity, the project has also expanded from an organizational perspective. Complementing faculty from the Department of Health Policy, Management and Evaluation, the project includes investigators from the Department of Public Health Sciences, Rehabilitation Sciences, the Faculty of Nursing at the University of Toronto, The Institute for Clinical Evaluative Sciences (ICES), Providence Centre, the Centre for Addiction and Mental Health, and The University Health Research Network. Hospital executives and other stakeholders provided input to the project through advisory committees and numerous expert panels.

As research progresses on all fronts, the new research collaborative has begun planning for the future. Proposed areas for expansion include: ambulatory care, home care, the development of benchmarks and strong attention to improving the quality of data underlying the reports and, the province-wide implementation of a staff satisfaction survey.

Hospitals Signing up for SHoPSS 2001 – Inpatient and Emergency Department Surveys

The OHA is seeking the support of acute care hospitals to participate in the standardized hospital patient satisfaction surveys (SHoPSS) for both inpatient and emergency departments. The registration information package was faxed to Chief Executive Officers of all acute care hospitals and a copy was also faxed to the hospital SHoPSS contact in August 2001. The deadline for signing up was **Friday, September 28, 2001.** If your hospital has not signed up or you have misplaced the registration form, please contact **Susan Jacobs**, Project Assistant, Report Card at 416-205-1331.

If your hospital has already registered, Press Ganey will be scheduling a "set-up call" with your hospital SHoPSS contact. The consultant will be providing you with a Protocol Guide outlining how to implement the Emergency Department and/or Inpatient Survey for your hospital. You will have an opportunity to talk about issues such as selecting an appropriate sample size, pricing and report options. If you have not received a set-up call or do not know whom your Press Ganey contact is, please call **Monica Johnson** at Press Ganey at (847)-698-4811.

Patient Satisfaction Surveying - Why so Soon?

Some OHA members have asked why the SHoPSS process is taking place so soon after the release of *Hospital Report 2001*. Here's the answer to the question.

Since it's inception in 1998, the intent of the report card initiative has been to move to annual reporting. With the introduction of hospital-specific reporting in 1999 and the refinement of that methodology in 2000/01, we are now approaching the point where reports can be produced on an annual basis. In order to support this process, it is necessary to collect yearly patient satisfaction data.

Members will recall that they received their inpatient reports for the 2000 survey process from Press Ganey in January 2001 and their ER reports in March 2001. With this information, hospitals had several months to begin addressing patient satisfaction issues before the current SHoPSS process began. An annual survey process is important for trending, but maintaining the time period of surveying patients from August, September and October is particularly important for ER SHoPSS because the types of cases seen in the ER and the volume of cases varies considerably depending on the season in which surveying is conducted (e.g. flu season).

Hospital Accountability in 2001: New Realities and Challenges

This one-day conference on October 10, 2001 will discuss how governments are attempting to control health care spending through stricter accountability of those receiving public funds and how those changes are impacting an organization's ability to provide quality health care. Just added to the agenda is **Sharon Sholzberg-Gray,** President and CEO of the Canadian Healthcare Association (CHA). The focus of her presentation will be a policy brief released by the CHA in 2001 entitled *"Towards Improved Accountability in the Health System: Getting from Here to There."* **For further information, contact Patricia Syms Sutherland at 416-205-1312 or email psymssutherland@oha.com**

Hospital Report 2001 Conference

A one-day conference was held on September 28 to update delegates on the evolution of *Hospital Report 2001 Series*. The topics included Hospital Report...beyond 2001; benchmarking; aligning accountability; linking balanced scorecards to corporate and strategic planning; linkages and relationships with AIM and accreditation surveys; quality improvement initiatives for patient satisfaction; clinical utilization and outcomes; *Hospital Report 2001-Complex Continuing Care* and the use of indicators in complex continuing care; *Hospital Report 2001-Emergency Care*, indicators and rationale; and future directions. Chaired by **Bonnie Adamson**, President and CEO, Huron Perth Hospitals Partnership, speakers included **Colin Andersen**, Assistant Deputy Minister, Integrated Policy and Planning, Ministry of Health and Long-Term Care; **Adalsteinn Brown**, Principal Investigator, *Hospital Report 2001 Series*, University of Toronto; **Tena McLellan**, Director of Quality, The Ottawa Hospital; and **Russell Armstrong**, Director, Executive Services, The Ottawa Hospital.

Hospital Report Contacts

Paula Blackstein Hirsch, Project Director, University of Toronto - 416- 946-7388, email paula.blackstienhirsch@utoronto.ca

Lynn Raskin, OHA Health Issues & Member Relations – 415-205-1329, email lraskin@oha.com

Sandra Conley, OHA Public Affairs - 416-205-1348, email sconley@oha.com

Interpretation of hospital-specific outcome measures based on routine data

Michael Coory
Danny Youlden
Philip Baker

What outcome measures are available in routine data?

In Queensland, as in the rest of Australia and elsewhere in the developed world, routine hospital data contains only a limited number of variables that can be used as outcome indicators. The core set of outcomes are in-hospital mortality, length-of-stay and readmission. These outcomes have been extensively used in reports in the United States and Canada and have formed the basis of many journal articles. Occasionally, depending on the condition of interest, other outcome indicators can be created such as complication rates, however, this is the exception rather than the norm.

What technical problems should be considered when interpreting hospital-specific outcome measures?

Hospital report cards based on administrative data are routinely published in Canada and the United States and similar initiatives are being considered in the United Kingdom and other parts of Europe. In the United States, the comparison and ranking of hospitals is now a multimillion-dollar industry [1].

However, experts agree that comparisons of outcomes (e.g., mortality, length-of-stay, re-admission) across hospitals are difficult to interpret [2]. There are three main problems.

1. *Differences in case mix (bias)*
   Differences in outcome indicators among hospitals may be due to differences in the types of patients seen (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. In any case, even with perfect data, statistical models can only reduce, not eliminate, the effects of casemix differences [2].

2. *Chance (imprecision)*
   Even if the case mix adjustment could be perfect (and it can't), outcome indicators for hospitals would still be difficult to interpret because they are vulnerable to the play of chance [3]. For example, Poloniecki and his coworkers found that year to year differences in mortality following heart surgery were large (odds ratio 1.5) even when the underlying mortality and case mix did not change [4]. Similarly, using data from fertility clinics, Marshall and Spiegelhalter showed that there was great uncertainty about the rankings based on livebirth rates [5]. Many centres had substantial changes in ranks between years, even though their live birth rate did not change significantly.

We have analysed data (case mix adjusted) on mortality following acute myocardial infarction for hospitals in Queensland for a recent five-year period.

We found considerable year-to-year variation. For example one hospital went from the 2nd worst in 1995/96 to the 9th worst in 1996/97 to the 23rd worst (5th best) in 1997/98 to the 4th worst and then the 22nd worst (6th best) in 1999/00.

3. *Differences in measurement*
Differences among hospitals in the measurement of the adverse outcome of interest (e.g., readmission) or the variables used in the case-mix adjustment will falsely lead to apparent differences in the outcome indicator. For example, an important factor in explaining an observed decrease in case-mix adjusted mortality from cardiac surgery in New York State was an apparent increase in the prevalence of risk factors in the patients who had surgery. Between 1989 and 1991, there was an increase in the reported prevalence of renal failure, congestive heart failure, chronic obstructive pulmonary disease and unstable angina in the patients who had surgery. These increases were due to increased reporting, rather than genuine changes in case mix and accounted for 40% of the observed decrease in case-mix adjusted mortality [6].

In summary, besides differences in the quality-of-care, three possibilities need to be considered when differences are observed among hospitals for a particular outcome measure (Box 1). Because of these three alternative explanations and because no statistical method can completely account for them, interpretation of hospital-specific outcome measures based on routine data can be difficult.

Box 1
Reasons for differences in hospital-specific outcome measures

1. Differences in case mix
2. Chance
3. Differences in measurement
4. Differences in quality of care

Are such analyses useful?
Because of the above caveats, 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 [2].

That is, outcome indicators based on routine data should be used for screening. As a report from Ontario points out: *'Screening tests such as Pap smears or mammograms are often used in medicine and these screening tests produce both false positives (women with a positive test who do not have cancer and false negatives (women with cancer who have a negative test). Screening tests can help to identify cases that need follow up. The same is true for measures of comparative hospital performance. An effort is made to minimise false positives, but they cannot be eliminated. Thus, the measures of clinical performance [from routine hospital data] ... should be taken not as a definitive assessment of the quality of care, but rather the first step in a process of quality improvement that should involve more detailed analysis at every institution'* [7].

Rarely, serious failures of health care may occur and in these situations analyses of routine data can serve as an early warning system. One example from the United Kingdom is the Bristol case in which three doctors were found guilty by the General Medical Council of *serious professional misconduct* in relation to the deaths of 29 babies and young children [8]. A recent analysis suggests that monitoring outcomes through routine data could have identified the significant deviations from expected mortality rates [9].

Box 2
Role of hospital-specific outcome measures based on routine data

1. Screen routine data to stimulate interest in quality at individual hospitals and suggest avenues for more in-depth analyses.
2. Identify serious, '*once-in-a-lifetime*' failures of health care (e.g., Bristol case)

How should statistical outliers be investigated?
For those individual hospitals that are statistical outliers, a review of their past and present data and their more recent results should be undertaken. If this further analysis indicates that there is a consistent problem, more detailed study of the processes of care related to the outcome is probably warranted.

What are process measures?
Process measurement is an assessment of the degree to which health care adheres to processes that are proven by scientific evidence to affect health. Examples include the proportion of eligible patients with acute myocardial infarction who receive thrombolysis, or the proportion of such patients who receive coronary rehabilitation on discharge.

Process measures are attractive because once the eligible population is defined, case mix adjustment is generally not necessary. Further, process measures provide information that is actionable; it tells clinicians what is being done well and what needs improvement [10].

In general, routine hospital data does not contain data for process measurement. It is hoped that hospitals would respond to outcome measurement based on routine data by developing and implementing evidence-based process measures. In the future, improvements in information technology might make it possible to collect process measures routinely and on a state-wide basis via high-quality clinical databases [11].

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Queensland Government
Queensland Health

MINUTES

Board Meeting of the Measured Quality Program Area

Held December 18, 2001 12.30pm – 2.30pm

Training Room 1, 3rd Floor Queensland Health Building

CHAIR: Dr Filby

1. **Welcome and apologies**

Dr Filby welcomed Board members.

Present were:
Dr David Filby (chair)
Dr John Youngman
Dr Glenn Cuffe
Dr Roger Brown
Prof Bryan Campbell
Ms Sue Cornes
Ms Elizabeth Garrigan
Ms Bronwyn Nardi (for Ms Susan Mahon)
Ms Di Cameron (for Ms Jenny Pouwer)
Mr David Jay
Dr Ian Scott
Ms Geri Taylor

Program Area staff:
Justin Collins
Sara Hatten-Masteron
Ellen Hawes
Christina Manalos
Danny Youlden

Apologies:
Dr Alan Isles
Dr Chris Kennedy
Mr Paul Sheehy
Ms Jenny Thomas
Mr Paul Monaghan

2. Progress review

Program Management
Progress was overviewed in slide 2 (attached).

Recruitment
Temporary recruitment for database design and statistical analysis underway. Mr Collins appointed as the Program Area Manager.

Hospital Clinical Indicators Project
Progress was overviewed in slides 3 – 7 (attached).
Comments on the usefulness of all the potential indicators was noted. There needs to be some mechanism to ensure that the potential indicators make sense clinically otherwise not report.

Hospital Responsiveness Indicators Project
Progress was overviewed in slides 8 – 9 (attached). The survey and analysis has been completed and dissemination strategies are currently being finalised.

Hospital Efficiency Indicators Project
Progress was overviewed in slide 10 – 12 (attached). The issue was raised concerning the number of indicators and what may be appropriate to include in the public report: there needs to be enough to provide a comprehensive analysis of the quadrant but not so much that the key findings get lost in the detail.

Hospital Continuity of Care, Sustainability and Capability Indicators Project
Progress was overviewed in slides 13 –15 (attached). The high response rate was noted. It was noted that if possible psychometric testing of the questionnaire should proceed to increase the robustness of the data.

Action across all projects: Board members to provide comment on the definition of indicators by 21 December 2001 to Justin Collins.

3. Report format

Issues were overviewed in Slides 16 – 30 (attached). Two ways of presenting the data were proposed – a star system and a smiley face system, both using the performance categories detailed in the brief circulated prior to the meeting.

There was a clear preference away from smiley faces and colour (as makes photocopying difficult). It was also noted that the star system is very positive. The option then is some kind of star system which aligns the quartile 4 star with the confidence interval 5 star rating.

An additional analysis focussing on the 80% performance was noted as being important to focus everyone on the need to move the mean of performance rather than focussing on outliers.

The need for a "descriptor label" (eg better practice) in addition to the star system was discussed. If descriptive labels are used, wording to be changed from "requires review", which

may suggest a formal process, to something along the lines of "may warrant further investigation at a local level".

Another issue raised was how to identify changes over time – how will a hospital who gets a 3 star rating this year and a 4 star rating next year, identify this improvement?

All data to have footnotes which clearly detail the caveats pertaining to the data.

A key issue raised for discussion was the need for national comparisons to provide context for the findings. It was agreed that this should be pursued. However, the indicators for which national comparisons are to be provided, and the number of indicators, will be decided when data is available in January.

Action: The Team to propose a solution to the issues of performance categories and presentation in January. National comparison data to be further pursued and proposals made in January.

4. Marketing and Communication

Issues were overviewed in Slides 31 – 37 (attached).

It was decided that decisions on the number of indicators to be reported needed to be made after consideration of the findings.

It was agreed that some preparatory work needs to be conducted with clinical staff and other District staff. This work could be a series of workshops. The purpose of the workshops would be to discuss rationale for producing reports, discuss draft facility reports, identify possible problems with the data or reasons for variation which need to be provided in reports and to engender a sense of ownership of the data.

The Clinician Development Program was suggested as a possible mechanism for funding and organising the workshop, collaboratively with the Measured Quality Team.

The Sponsors noted their preference that contextual information is available to address variability and the suggested phased approach will facilitate this (ie. draft – consultation – public report).

The Sponsors also noted their preference for senior clinicians to be public advocates for the Program. The involvement of the Colleges was noted as very important.

Actions:
Prof Campbell to be involved with consultation strategies with Colleges
A strategy and timeframe for workshopping and dissemination to be provided to Board in late January. Links to other QIEP Programs to be identified in this process.

5. Next meeting

Date: mid February (to be advised)
Time: to be advised

Venue: to be advised

Queensland Government
Queensland Health

MINUTES

Board Meeting of the Measured Quality Program Area

Held October 30, 2001 1pm – 3pm

Training Room 3, 3rd Floor Queensland Health Building

CHAIR: Dr Filby

1. **Welcome and apologies**

Dr Filby welcomed Board members.

Present were:
Dr David Filby (chair)
Dr John Youngman
Dr Glenn Cuffe
Dr Roger Brown
Prof Bryan Campbell
Ms Sue Cornes
Ms Elizabeth Garrigan
Mr Paul Monaghan
Ms Bronwyn Nardi (for Ms Susan Mahon)
Ms Jenny Pouwer
Ms Jenny Stone (for David Jay)

Program Area staff:
Justin Collins
Hebe de Souza
Sara Hatten-Masteron
Ellen Hawes
Christina Manalos
Danny Youlden

Apologies:
Dr Alan Isles
Dr Chris Kennedy
Dr Ian Scott
Mr Paul Sheehy
Ms Geri Taylor
Ms Jenny Thomas

2. Progress review

Program Management
Progress was overviewed in slides 2 – 5 (attached).
Scoping issues regarding target groups and the number of hospitals were restated.
The target groups are: Public Report – General Public of Queensland, & Facility Report – 'Broader Hospital Executive' and
The 62 hospitals in the report cover 37 of the 39 Queensland Health, HSD's - the missing 2 Districts are Moranbah and North Burnett.

Recruitment
All positions are currently filled with two temporary secondments (PAM, Administrative Assistant). Advertisement for the PAM position is underway.

The sponsors have agreed on the temporary recruitment of staff for database design and statistical analysis.

Hospital Clinical Indicators Project
Progress was overviewed in slides 6 – 7 (attached). A summary list of indicators was circulated. There was no detailed discussion on progress.

Hospital Responsiveness Indicators Project
Progress was overviewed in slides 8 – 10 (attached). A summary list of indexes was circulated. The 44% response rate for the survey was regarded as acceptable in light of the Victorian result.

Hospital Efficiency Indicators Project
Progress was overviewed in slide 11 – 13 (attached). A summary list of indicators was circulated. DSS Team are assisting in the extraction of the financial data. There was no detailed discussion on progress.

Hospital Continuity of Care, Sustainability and Capability Indicators Project
Progress was overviewed in slides 14 –16 (attached). A summary list of indicators and the final Survey was circulated. There was no detailed discussion on progress.

Action across all projects: Board members to identify any areas of concern re: the summary list of indicators and provide feedback by 20 November 2001 to Justin Collins.

ISSUES REQUIRING RESOLUTION

Two broad issues were raised for discussion and resolution: the comparisons to be made a across facilities and statewide and data integrity issues.

Comparisons to be made

1. Norm vs criterion comparisons

   Other comprehensive statewide quality monitoring reports (internationally, national) focus on norm comparisons. For criterion comparisons, decisions are necessary as to the criteria to be used, its availability and the resources and timeframe necessary. It was recommended from the team to focus on norm comparisons for the first report and investigate criterion comparisons for other reports.

   Discussion ensued as to the need to provide some context for the results. For instance, if there is significant variability, is this variability above or below recognised good practice (eg in other state/country).

   It was agreed that national comparisons should be made if the timeframe allows.

2. Peer groupings across quadrants
   It was agreed at the previous board meeting that the AIHW peer grouping would be used for analysis and reporting purposes. Board members were provided with a list of the relationship between the AIHW peer groupings and casemix groupings. Due to timing issues (ie clinical analysis was started before decision to use AIHW), some of the data has been risk adjusted by the casemix methodology. This data can be re-grouped to the AIHW without peer group risk adjustment (only general risk adjustment). The casemix groupings were also amended for the T groups into 2 groups. There is no direct mapping across to the AIHW groupings. The team will continue to work on grouping the data consistently but noted that some inconsistencies may remain.

   The Board agreed that inconsistencies should be reduced were possible and that any remaining be identified and reviewed for the next report.

2. Peer group vs statewide comparisons

   It is agreed that data on peer group averages and the statewide average be provided for each indicator.

3. Zonal comparisons
   It was agreed that the database should contain the ability to provide zonal comparisons but that no zonal comparisons should be published.

4. The focus of the project was on increasing the performance of all services (ie moving the average) rather than on the outliers.
   If the focus is on increasing the performance of all services (ie moving the average) then only three categories are required for reporting (above, equal to, below average). If the focus is on outliers, then five categories are useful (above, somewhat above, equal to, somewhat below, below). Ontario used this methodology and reported some as 5 scale and some as 3 scale.

   It was agreed that this is best decided after the data is reviewed.

The use of the term "average" in this context was questioned.

It was agreed that the terminology for reporting would be reviewed and provided in a report to the Board.

Action: A report on terminology for reporting to be provided to Board by 23 November 2001.

Data Integrity Issues

A table was circulated which identified some of the data integrity issues, which need to be worked through. The Board underscored the importance of clearly identifying the strengths and weaknesses of the data and a clear explanation of the statistical techniques being used in each quadrant.

Action: A brief paper to be provided to the Board by 23 November 2001 on the methodology and statistical techniques being used for each quadrant.

3. Report format

Issues were overviewed in Slides 22 – 24 (attached). The following papers were provided to Board members for comment:

- Skeleton reports for the facility reports and the public report
- Paper on the methodology underpinning the report
- Draft introduction section for the "working document" – the introduction to the public report and the facility reports may be summarised from this broader introduction.

The Board raised the issue of the importance of ensuring that data made available through the Program Area was accompanied by commentary as to its interpretation and any caveats.

Action: Board members to provide feedback on tabled items by 20 November 2001.
The PAM to contact Joan Kennedy from the CHO's Office re: quality assurance committee.
An example public and facility report with some data to provided to Board by 20 November 2001.

4. Marketing and Communication

Issues were overviewed in Slides 25 (attached). The need for a newsletter and its target audience was discussed. It was agreed that a newsletter was not needed at this point in time, and should be considered some time after the facility reports are produced. Discussion ensued as to how to publish the data from the Program in a manner which will achieve action on improving services where required or on promulgating "best practice". It was agreed that the Strategic Forum provides an opportunity to flag the data with District Managers and that the Zonal Forums will provide an opportunity to work through data. Discussion ensured as to whether or not all the data should be provided at once or if some kind of prioritised program of release which takes into account facilities ability to act on the data, should be implemented.

Actions: Example data to be provided at the Strategic Forum. Marketing and Communication strategies to be reviewed following the Forum discussion.

5. Potential use of information

A handout was distributed, titled 'The Potential Use of Information'. There was a brief discussion on the potential use of the information that will be gathered by Measured Quality, and its possible use beyond the parameters of the Program Area.

6. Next meeting

Date: Tuesday 18 December, 2001
Time: 12.30pm – 2.30pm
Venue: Video Conference Room, 3rd Floor QHB

Queensland Government
Queensland Health

MINUTES

Board Meeting of the Measured Quality Program Area

Held Sept 11, 2001 11am – 1pm

3rd Floor Conference Room, Queensland Health Building

CHAIR: Dr Filby

11.00 – 11.45. Briefing on Patient Satisfaction Survey (Consultants)

FROM 11.45

1. **Welcome and apologies**

Dr Filby welcomed Board members.

Present were:
Prof Bryan Campbell
Dr Christine McClintock (for Ms Sue Cornes)
Dr Glenn Cuffe
Dr David Filby (chair)
Ms Elizabeth Garrigan
Ms Susan Mahon
Ms Julie Ellis (for Jenny Pouwer)
Mr Paul Sheehy
Dr Roger Brown

Program Area staff:
Justin Collins
Hebe de Souza
Sara Hatten-Masteron
Ellen Hawes
Christina Manalos
Danny Youlden

Apologies:
Mr David Jay
Dr Chris Kennedy
Dr Ian Scott
Ms Jenny Thomas
Dr John Youngman
Mr Paul Monaghan

2. Progress review - Roger Brown (A/Program Area Manager)

Dr Brown provided slides which overviewed progress in each project area:

- Program Management
- Hospital Clinical Indicators Project
- Hospital Efficiency Indicators Project
- Hospital Responsiveness Indicators Project
- Hospital Continuity of Care, Sustainability and Capability Indicators Project

Program Management
Dr Brown noted that recruitment has been completed except for the Program Area Manager position which will be re-advertised. Mr Collins has been seconded to the position until it is re-advertised. Dr Brown introduced the members of the team.

Dr Brown noted that the administrative responsibility for the Program had moved to the Procurement Strategy Unit. The key milestones for the program were noted (refer Slide 2).

Dr Filby noted that the reduced scope in the project plan (re: one data analyst rather than two) is something that can be reviewed and would consider a revised position after the Quality Council considers all project plans and assesses available funding and competing priorities.

Hospital Clinical Indicators Project
Progress was overviewed in slides 6 – 8 (attached). Prof Campbell noted that Sue Jenkins was developing O&G indicators as a part of the Clinical Audit program and that collaboration across the two Programs on this matter would be beneficial.

Action: Collaboration with Sue Jenkins to be initiated.

Hospital Responsiveness Indicators Project
Progress was overviewed in slides 9 – 11 (attached).
The reports and methodology was presented by the Consultants in the first part of the meeting.

Hospital Efficiency Indicators Project
Progress was overviewed in slide 17 (attached). Possible data sources have been identified.

Hospital Continuity of Care, Sustainability and Capability Indicators Project
Progress was overviewed in slides 12 –16 (attached). Interviews have been held with a range of potential stakeholders to ascertain existing measures/data relevant to this project. There appears to be little data that is systematically collected which is accurate and relatively current. The need to conduct a short survey of facilities to obtain a minimum data set for this project was raised and endorsed. Dr Filby indicated that the questions for this survey need to be defined in the next 3 weeks.

Action: Questions for potential survey to be available to sponsors in 3 weeks.

3. Report format and related developments -Ellen Hawes

Ms Hawes provided an overview of the issues to consider in developing the format for the reports and detailed possible formats (refer Slides 18 – 28)

4. Marketing and Communication – Roger Brown

While a detailed plan has not been developed as yet, core strategies from Nov 2001 – May 2002 were detailed and endorsed. Dr Filby indicated that the Zonal Forums should be utilised as much as possible and suggested that the patient satisfaction workshops, the Measured Quality workshops and the Zonal Forums be co-ordinated.

Action: Dates of Zonal Forums to be obtained. PAM to negotiate co-ordination.

5. Issues requiring resolution

Issues for resolution were raised for discussion. It was agreed that the Queensland Health response to the findings of the Measured Quality reports is not within the scope of Measured Quality but that such a response needs to be prepared, within the timeframes outlined.

It was noted that while the Measured Quality Program Area will not produce league tables, it may be possible for these to be produced by other parties by collating the data.

Benchmarking with Victoria was supported but whether or not this is within the scope of this Program Area needs further consideration.

6. Next meeting

Date: Tuesday 30 October, 2001
Time: 1pm – 3pm
Venue: Training Room 3, 3rd Floor QHB

Queensland Government
Queensland Health

MINUTES

Board Meeting of the Measured Quality Program Area

Held Sept 11, 2001 11am – 1pm

3rd Floor Conference Room, Queensland Health Building

CHAIR: Dr Filby

11.00 – 11.45. Briefing on Patient Satisfaction Survey (Consultants)

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Danny Youlden

Apologies:
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Dr Chris Kennedy
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Benchmarking with Victoria was supported but whether or not this is within the scope of this Program Area needs further consideration.

6. Next meeting

Date: Tuesday 30 October, 2001
Time: 1pm – 3pm
Venue: Training Room 3, 3rd Floor QHB

Queensland Government
Queensland Health

MINUTES

Board Meeting of the Measured Quality Program Area

Held May 15, 2001 11am – 1pm

8th Floor Conference Room, Queensland Health Building

CHAIR: Dr Filby

1. **Welcome and apologies**

Dr Filby welcomed Board members.

Present were:
Prof Bryan Campbell
Ms Sue Cornes
Dr Glenn Cuffe
Dr David Filby (chair)
Ms Elizabeth Garrigan
Mr Tony Hayes
Ms Margaret Marshall (for Susan Mahon)
Mr Paul Monaghan
Ms Jenny Pouwer
Dr Ian Scott
Ms Jenny Thomas
Dr John Youngman

Observers:
Dr Roger Brown
Ms Maree Geraghty (for Mike Edwards)

Program Area staff:
Ellen Hawes
Romana Madl

Apologies:
Mr David Jay
Dr Alan Isles
Dr Chris Kennedy

2. **Actions from January 2001 minutes**

Dr Filby noted that the actions from the January meeting had been completed (refer Attachment 1).

3. Quarterly progress review - Ellen Hawes (Program Area Manager)

Ms Hawes provided a powerpoint presentation which overviewed progress in each project area:

- Program Management
- Hospital Clinical Indicators Project
- Hospital Efficiency Indicators Project
- Hospital Responsiveness Indicators Project
- Hospital Continuity of Care, Sustainability and Capability Indicators Project

Program Management
Progress was overviewed in slides 3 – 15 (attached). Ms Hawes noted that recruitment was central to the progress of the project and sought member's commitment to circulate adverts as widely as possible.

Dr Filby noted that the reduced scope in the project plan (re: one data analyst rather than two) may be reviewed after the Quality Council considers all project plans and assesses available funding and competing priorities.

Dr Filby also noted that visits to Districts to market the Program Area should be linked to organised District activity where possible. Ms Garrison noted that the Quality Strategy Team have a process in place to co-ordinate marketing activities.

In relation to the development of the methodology for identifying catchment populations for facilities, Dr Filby noted that this work needs to be linked to work on regional health analyses (eg looking at the outcomes that are desired for communities rather than looking at the effectiveness of the services that are provided for a defined community). When the catchment methodology is further progressed, a meeting to be arranged to discuss linkages.

Action: Ms Hawes to send a copy of the adverts to Board Members for circulation to widen potential applicant pool.

Hospital Clinical Indicators Project
Progress was overviewed in slides 17 – 19 (attached). Prof Campbell noted that the professional colleges have been involved in developing clinical indicators for some time re: ACHS indicators and sought clarification on potential duplication. He noted that the Colleges may view this as duplication.

Ms Hawes noted that the indicators assembled to date were based on issues which other countries or States had identified as important to measure in health system performance

assessments. Where an ACHS indicator was available for an issue being measured by other countries, that indicator was selected. This was to reduce the potential for duplication.

Ms Hawes further noted that the ACHS indicators had some limitations in that a number are not currently collectable from existing information systems.

A further issue raised was that the ACHS indicators list many indicators for each speciality; Measured Quality is aiming to have a small number of indicators (eg 5-10) across all specialties for medical, surgical and obstetrics and gynaecology. The ACHS indicators also do not provide a comprehensive set of indicators relevant to the dimensions of the National Health Performance Framework.

Ms Thomas noted that a Commonwealth report (unpublished to date) was very critical of the ACHS indicators.

Dr Brown further noted that the Chair of the ACHS indicator development working party has noted that the indicators were designed to assure a minimum level of safety; they were not designed for comparative purposes.

Prof Campbell noted that he is attending the ACHS national meeting in the coming weeks. Ms Hawes suggested that a briefing paper be prepared on the of potential duplication for Prof Campbell to consider before the national meeting.

Action: Briefing paper to be written on development of clinical indicators and ACHS indicators.

Hospital Efficiency Indicators Project

Progress was overviewed in slide 20 (attached). Mr Monaghan, who has been leading this project, elaborated on the summary of progress. Mr Monaghan explained that lag and lead indicators had been identified in draft form and that effort was being expended on teasing out the linkages between the indicators and the organisation's strategic directions. Draft strategies and indicators will be circulated to Members for comment in the coming weeks.

Hospital Responsiveness Indicators Project

Progress was overviewed in slides 22 – 30 (attached). Dr Filby noted that a number of changes to the Patient Election Form had been identified across the Department and that the changes to the Form should be co-ordinated. Ms Garrigan noted that the temporary home of the Patient Election Form was the Quality Strategy Team. It was agreed that Measured Quality staff would work with the Quality Strategy Team to identify the longer-term changes needed to facilitate surveying inpatients about their satisfaction with hospital services. These changes will be provided to Dr Filby for consideration in progressing changes to the Form in a co-ordinated manner.

Members commented on the proposed methodology for the Patient Satisfaction Survey. Dr Scott queried why patients admitted through Emergency Departments were excluded. Ms Hawes noted that this would be reviewed. Dr Scott also suggested that stratification be conducted at the ward level. Ms Hawes noted that this had been discussed at Expert Group meetings for Patient Satisfaction Surveys and had been decided against because of the

involvement of a number of staff and the corresponding increase in the potential for error to occur.

Prof Campbell queried the timeframe for data collection. Ms Hawes noted that the timeframe would be the same: where hospitals saw under the required number of patients, a census of patients would be conducted.

Discussion focussed on the methodology for stratifying patients. The suggested methodology was to use the preliminary DRG and for Medical Records Officers in Health Information in facilities or Districts to run pre-written programs to obtain the sample. The critical success factors in this proposed methodology are (1) the availability of the preliminary DRG on HBCIS within the timeframe (proposed as 2 weeks after discharge) and (2) the ability to write a program for HBCIS that can be used across facilities.

(1) <u>The availability of the preliminary DRG on HBCIS within the timeframe (proposed as 2 weeks after discharge)</u>

Prof Campbell queried if the timeframe could be expanded – eg. if the majority of hospitals had the preliminary DRG in 6 weeks, the timeframe could be 6 – 7 weeks post discharge. Ms Hawes indicated that the rationale for the 2 week timeframe would be reviewed.

Ms Thomas noted that the literature indicated a negative correlation between satisfaction and time from discharge. Methodology to adjust for this correlation was briefly discussed.

Actions:

- *Rationale for exclusion criteria to be reviewed*
- *Rationale for 2 week timeframe to be reviewed and investigation to be conducted into potential methodology to adjust for the association between increasing time since discharge and reducing satisfaction levels.*

(2) <u>The ability to write a program for HBCIS that can be used across facilities</u>
Measured Quality staff had met with Health Information Centre staff on a number of occasions to discuss the feasibility and development of this program. Progress has been slow with concern that patient confidentiality would be breached. Now that legal advice has indicated that the survey can occur without breaching patient confidentiality, meetings have been arranged to progress this matter.

<u>Hospital Continuity of Care, Sustainability and Capability Indicators Project</u>
Progress was overviewed in slide 32 (attached).

<u>General Comments</u>
Dr Scott requested that the list of preliminary indicators be circulated to Board Members for information.

It was agreed that progress on the clinical indicators project be reported to Prof Campbell for reporting to the regular meetings of the professional colleges which is chaired by Prof Campbell.

Action: list of preliminary indicators be circulated to Board Members for information.

4. Next meetings

It was agreed that the quarterly meetings would be:

Tues 11 – 1pm July 10 2001 8th Floor Conf Room QHB

Tues 11 – 1pm Sept 11 2001 venue to be confirmed

Tues 11 – 1pm Dec 11 2001 venue to be confirmed

Attachment 1. Actions from January 2001 minutes

• Ontario's "system integration and change" survey to be circulated to members	Completed – sent with January minutes.
• A copy of the minutes of the meeting to be provided to Patient Surveys/Complaints Program Board for consideration	Completed in January.
•	
• Report coverage: to be determined after the Project approval phase is complete.	Coverage in Project Plan is the 61 "casemix" funded hospitals – based on Board comments on draft project plan and Sponsor's advice.
• Quality Reviewer: Nominations for a Quality Reviewer for the Program to be provided by board members with their comments on the Project Plan.	Board member nomination for quality reviewer - Ms Hazel Harden, Program Area Manager, Quality Medical Processes Program Area.

Queensland Government
Queensland Health

MINUTES

Board Meeting of the Measured Quality Program Area

Held October 25, 2000 9am – 11am

3th Floor Conference Room, Queensland Health Building

The meeting was chaired by Dr Youngman for Dr Filby who was unavailable.

1. **Welcome and apologies**

Present:
Prof Bryan Campbell
Ms Sue Cornes
Dr Glenn Cuffe
Ms Elizabeth Garrigan
Mr David Jay
Dr Chris Kennedy (via video conference)
Ms Susan Mahon
Mr Paul Monaghan
Ms Jenny Pouwer
Ms Geri Taylor
Ms Jenny Thomas
Dr Youngman (chair)

Observers:
Dr Roger Brown
Mr Mike Edwards

Program Area staff:
Ellen Hawes (Program Area Manager)
Vanessa Cornell

Apologies:
Dr Filby
Dr Alan Isles
Dr Ian Scott

Dr Youngman welcomed Board members. Members had been nominated because of their expertise in areas being assessed in the Measured Quality Program Area or because of their association with related programs and projects (eg Patient Surveys Program Area). Dr Youngman noted that Mr Steve Buckland had declined membership and requested that a District Manager be asked in his stead. It was noted that the Board already has District Management representation through Dr Kennedy.

2. Background of Program and purpose of meeting – Dr Youngman

Dr Youngman indicated that a risk to Queensland Health was the large number of groups currently existing to which Queensland Health provides data and the lack of co-ordination among these groups. He noted that the National Health Performance Committee, chaired by Dr Filby, had identified this risk (relevant to all jurisdictions) and was working towards a coordinated approach to performance monitoring. The agenda for the National Health Performance Committee is to gain consensus of the performance measures for quality health services. Dr Youngman noted that the Measured Quality Program Area was directly relevant to this agenda.

Dr Youngman noted the importance of scoping the agenda of the Measured Quality Program Area so that it did not increase the number of performance measures but rather focuses on a core set of indicators which can be collected from current information systems.

Dr Youngman opened the floor for discussion on the agenda/aim of the Measured Quality Program Area.

Ms Taylor noted that the Program Area was only approved at this point for 6 months and that the work to be completed was significant. She indicated that the manner in which the cells of the National Health Performance Framework were populated was the most important issue rather than ensuring an exhaustive process.

Prof Campbell endorsed the Measured Quality Program Area as being important for the overall co-ordination of the QIEP Program and that it was a key Program Area in the QIEP Program.

Mr Monaghan sought clarification on the involvement of external agencies (including Treasury). Dr Youngman responded that this would depend on the audience for the performance report. He noted that a key issue in reporting on performance will be the presentation of the data ie. the use of rates, percentages or numbers. He also noted that a major use of the data would be on analysing variability in performance rather than producing league tables (ie listing the "best" to "worst" hospital on various criteria).

Dr Cuffe noted that for the Measured Quality Program Area to have significant impact, it was important that it was linked to change processes (eg other QIEP Program Areas including the Change Management Program Area).

Ms Thomas indicated that the Measured Quality Program Area should focus on identifying the criteria for selecting core indicators and that the data for these indicators should be analysed in an environment in which potentially confounding variables are taken into account.

Summary: There was strong support among members for the Measured Quality Program Area to proceed in identifying a set of performance indicators through which the performance of Queensland health services can be assessed. There was also strong support that this occur in a manner that focuses on existing data collections, the synthesis and co-ordination of performance measures, analysis of the data in terms of variability and understanding what the factors which underpin favourable performance vs less favourable performance. Links to change processes must also be established.

Purpose of the meeting

Dr Youngman described the purpose of the meeting as being to seek:

- agreement on Terms of Reference for the Board (as per QIEP Governance document)
- endorsement of decisions made to date
- advice on planned progress over the approved 6 months and on planning for next 2 ½ years

Prof Campbell requested clarification on the Terms of Reference. The Terms of Reference were stated in the letter of invitation and are taken directly from the QIEP Governance document ie. :

1. A Program Area Board will be established for each Program Area.
2. Program Area Boards have the responsibility to:
   a. Influence the progress and direction of the Program Area through assisting in the development of the consolidated business case, where possible;
   b. Review progress against performance indicators at major milestones.
   c. Communicate with the Quality Council should the Program Area Sponsor be considered to be managing the Program Area contrary to the Board's advice.

3. Report on progress to date – Ellen Hawes (Program Area Manager)

Ms Hawes provided an overview of the Program Area aims, progress to date and planned progress over the 6 month project approved timeframe (powerpoint presentation attached). A list of decisions for which endorsement was being sought was provided to members and discussion was held for each project area in the Measured Quality Program.

3.1 Framework for performance assessment and Program Area Structure

Presented information on the aim of the Program Area, status of the Program Area (ie approved for 6 months) and current staffing. Performance reporting in Queensland Health was overviewed and a comparison between current reporting requirements and the domains in the National Health Performance Framework was discussed to highlight discrepancies and the need to review international and national indicators in addition to current Queensland indicators (ie. To identify measures that more comprehensively reflected the definition of the domains of the National Health Performance Framework) (refer Slide 9).

Members endorsed the National Health Performance Framework as the performance framework for the Measured Quality Program Area. Prof Campbell noted that the definition of the "Efficiency" domain in the Framework needs to be reviewed to ensure that financial efficiency is not the major focus.

Action: Ms Hawes to follow up with Prof Campbell on broader definition of Efficiency domain

Discussion ensued on the Program Structure and the work breakdown by Phases. The Program Area comprises three broad programs – hospital performance, community health performance and population reporting (refer Slide 12). Progress in each program has been categorised into two phase with Phase 1 being the approved of the Program Area and until June2001[1], and Phase 2 being after July 2001 (to be further defined in Project Plan). The focus of Phase 1 work is on Hospital Performance. The rationale for this focus is that (a) hospitals are the most

[1] These timeframes assume that the Program Area will be approved to continue at the Quality Council's deliberation of the Project Plan in February 2001.

significant users of resources and (b) data is more likely to be available for assessing performance.

Members endorsed the Program Structure. The categorisation of Programs into the Phases was broadly endorsed. Prof Campbell noted his concern that population reporting was not being progressed in Phase 1. Ms Hawes clarified that work on population reporting was being progressed by conducting meetings with key stakeholders to investigate the feasibility of population reporting in Phase 1 but that current resources were not sufficient to progress actual reporting by population for all indicators in Phase 1.

Summary: Framework for performance assessment and Program Area Structure broadly endorsed.

3.2 Progress to date and planned – Hospital Clinical Assessment Project

Progress was detailed in Slides 14 -18. Discussion ensued on the document compiling clinical indicators to be pursued. This document was briefly presented at the meeting (Slide 15). A sample extract of the document for one indicator is attached as Attachment A. This document is the first draft of the technical specifications for the clinical indicators to be used in the performance assessment.

Prof Campbell noted that the document needs to include existing benchmarks internationally and nationally as the existence of a benchmark may be an important criterion in prioritising the indicators for inclusion in the performance assessment.

Prof Campbell further noted that the development of the document and planned progress is of assistance to the Clinical Audit Program Area and that he will revise the Clinical Audit Program Area to be structured around following up on the results of the indicator analysis.

Action: Ms Hawes to ensure consideration of the availability of benchmarks in the development of prioritsation criteria.

Summary: Progress to date and planned progress broadly endorsed.

3.3 Progress to date and planned – Hospital Patient Satisfaction/Responsiveness Project

Progress was detailed in Slides 19 -21. Discussion ensued on the potential for duplication across the Patient Surveys Program Area and the Measured Quality Program Area. Prof Campbell indicated that the Patient Surveys Program Area had responsibility for developing and implementing a system for measuring patient satisfaction. Ms Hawes noted that discussions with the Program Area Manager of the Patient Surveys Program Area indicated that the initial focus of that Program Area would be on the development of a complaints system. This poses a problem for the Measured Quality Program Area as one of the aims of the Program Area is to conduct a baseline assessment of hospital performance as part of the evaluation of the QIEP Program and a key element to be assessed is patient satisfaction. An assessment of patient satisfaction is therefore required prior to the implementation of major activities of the QIEP program (ie before May – June 2001).

Suggestions on progressing this project included establishing a working group comprising members of both the Patient Surveys Program Area and the Measured Quality Program Area.

It was agreed that clarification is required on the relationship between the two Program Areas. A briefing paper will be developed and circulated out of session.

Action: Ms Hawes to develop briefing paper and circulate out of session

Summary: The relationship between the Patient Surveys Program Area and the Measured Quality Program Area to be clarified.

3.4 Progress to date and planned – Hospital Financial Indicator Project

Progress was detailed in Slides 22 -23. Prof Campbell noted that the indicators for efficiency should not focus only on financial efficiency. This issue is to be considered by the project working team.

Action: Project working team to consider efficiency measures wider than financial measures.

Summary: Progress to date and planned progress broadly endorsed.

3.4 Progress to date and planned – Hospital System Integration and Change Project

Progress was detailed in Slides 24 -25. Discussion ensued on the two suggested strategies to progress this project ie. To adapt and pilot the Ontario survey or to collaboratively review the Clinical Audit Tool with the Change Management Program Area. Ms Mahon indicated that a key barrier to using the Clinical Audit Tool in a survey to establish a baseline measure of "system integration and change" is the potential for low response rates. Prof Campbell suggested that a stratified sample may be a solution and Dr Youngman endorsed this suggestion.

It was agreed that the Change Management Program Area and the Measured Quality Program Area collaborate on developing a tool that is useful to both Program Areas.

Summary: Progress to date and planned progress broadly endorsed.

3.5 Progress to date and planned – QIEP Baseline Measures Project

Progress was detailed in Slides 26 -27.

Summary: Progress to date and planned progress broadly endorsed.

4. Terms of Reference and Board membership

Dr Youngman requested that any concerns relating to the Terms of Reference for the Board or the membership of the Board by relayed to Dr Filby or Ms Hawes out of session.

5. **Next meeting**

The next meeting of the Board will be to discuss the Project Plan for Measured Quality in 2001-2003. This meeting is planned for late January or February.

Attachment A. Sample extract from the Clinical Indicators Document (October 16 version).

- **Effectiveness Indicators**
  Avoidable Adverse Outcomes – Mortality

Indicator Topic	In-hospital mortality following common elective procedures in any procedure field: Hysterectomy; laminectomy/spinal fusion; cholecystectomy; transurethral prostatectomy; hip replacement; and knee replacement.
Quality Domain	Effectiveness
Indicator Intention	To identify hospitals where in-hospital mortality following common elective procedures is significantly higher or lower than that for other hospitals in the same peer group.
Rationale	High volume procedures.
Definition of terms	
Update Frequency	
Numerator	Deaths in hospital for specified procedures (Hysterectomy; laminectomy/spinal fusion; cholecystectomy; transurethral prostatectomy; hip replacement; and knee replacement)
Numerator source and details:	Hospital Morbidity Data Collection
Denominator:	Procedures with certain principal diagnoses relating to Hysterectomy; laminectomy/spinal fusion; cholecystectomy; transurethral prostatectomy; hip replacement; and knee replacement
Denominator source and details:	Hospital Morbidity Data Collection
Measurable:	Yes
Hospital level appropriate for:	
Available in other States:	Yes
Analysis issues:	Age-standardise Number of deaths per 100 patients receiving common elective procedures. (Outcome of interest, population at risk) * 100
Benchmark:	
Comment:	Investigate high death rates through Transition II intensive care use
Source:	USA MDS Definitions of Quality Indicators, Version 1.3, p2
Currently required for reporting:	TBD
Additional numerator details:	Nil

Additional denominator details:

All non-maternal/non-neonatal discharges age 18 years or older.

Screen diagnoses and procedures (all fields) to limit risk population to uncomplicated cases:
A. for hysterectomy (see page 34), exclude female genital cancer (see page 34) or pelvic trauma (see page 34),
B. for laminectomy/spinal fusion (see page 34), include only simple intervertebral disc displacement (see page 35),
C. for cholecystectomy (see page 35), include only non-acute, uncomplicated cholecystitis and/or cholelithiasis (see page 35),
D. for transurethral prostatectomy (see page 35), include only prostatic hyperplasia (see page 35),
E. for hip replacement (see page 35), include only osteoarthrosis of hip (see page 35),
F. for knee replacement (see page 35), include only osteoarthrosis of knee (see page 35).

Exclude cases transferred to another institution.
Exclude MDC 14 (pregnancy, childbirth, and puerperium) and MDC 15 (newborns and other neonates).

Page 34 and 35: In-hospital mortality following common elective procedures

Hysterectomy (Population at Risk):

ICD-9-CM Procedure Codes:

683	SUBTOT ABD HYSTERECTOMY
684	TOTAL ABD HYSTERECTOMY
685	VAGINAL HYSTERECTOMY
6851	LAP AST VAG HYSTERECTOMY#
6859	OTHER VAG HYSTERECTOMY#
686	RADICAL ABD HYSTERECTOMY
687	RADICAL VAG HYSTERECTOMY

Exclude female genital cancer (Population at Risk):

ICD-9-CM Diagnosis Codes:

179	MALIG NEOPL UTERUS NOS
1800	MALIG NEO ENDOCERVIX
1801	MALIG NEO EXOCERVIX
1808	MALIG NEO CERVIX NEC
1809	MAL NEO CERVIX UTERI NOS
181	MALIGNANT NEOPL PLACENTA
1820	MALIG NEO CORPUS UTERI
1821	MAL NEO UTERINE ISTHMUS
1828	MAL NEO BODY UTERUS NEC
1830	MALIGN NEOPL OVARY
1832	MAL NEO FALLOPIAN TUBE
1833	MAL NEO BROAD LIGAMENT
1834	MALIG NEO PARAMETRIUM
1835	MAL NEO ROUND LIGAMENT
1838	MAL NEO ADNEXA NEC

Board Meeting of the Measured Quality Program Area

October 25 2000 9am – 11am
3th Floor Conference Room
Queensland Health Building

WORKING AGENDA FOR CHAIR

Chair: Dr Filby

1. **Welcome and apologies - Dr Filby**
   (Dr Kennedy participating via video-conference)

2. **Background of Program and purpose of meeting – Dr Filby**

   - Background
     - Aim of the Program Area
     - Links to national activity on health system performance assessment
     - Business case submission to Quality Council and subsequent approval for 6 months and development of project plan for next 2 ½ years

   - Purpose of meeting
     - Agreement on Terms of Reference for the Board (as per QIEP Governance document)
     - Agreement on Board membership
     - Endorsement of decisions made to date
     - Advice on planned progress over the approved 6 months and on planning for next 2 ½ years

(I will provide you with detail on these dot points 23 October 2000)

3. **Report on progress to date – Ellen Hawes (Program Area Manager)**

   (Powerpoint presentation which will:
   - detail the framework for the performance assessment and discuss definitions of framework domains
   - overview the Program structure and phases and linkages to other QIEP Programs and Queensland Health strategic projects
   - detail the 6 month deliverable
   - discuss the Project Plan for next 2 ½ years
   - detail progress to date for:
     - human resources on Program Area
     - Hospital Clinical Indicator project
     - Hospital Patient Satisfaction/Experience/Responsiveness project
     - Hospital Efficiency project
     - Hospital Integration and system change project
     - QIEP Baseline project

.../2

4. **Discussion and agreement/endorsement of the business of the meeting:**
   - Seek agreement on Terms of Reference for the Board
   - Seek agreement on Board membership
   - Seek endorsement of decisions made to date
   - Seek advice on planned progress over the approved 6 months and on planning for next 2 ½ years

5. **Next meeting**

Board Meeting of the Measured Quality Program Area

October 25 2000 9am – 11am
3th Floor Conference Room
Queensland Health Building

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1. **Welcome and apologies - Dr Filby**
   (Dr Kennedy participating via video-conference)

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     - Hospital Efficiency project
     - Hospital Integration and system change project
     - QIEP Baseline project

.../2

4. **Discussion and agreement/endorsement of the business of the meeting:**
   - Seek agreement on Terms of Reference for the Board
   - Seek agreement on Board membership
   - Seek endorsement of decisions made to date
   - Seek advice on planned progress over the approved 6 months and on planning for next 2 ½ years

5. **Next meeting**

Queensland Government
Queensland Health

QUALITY IMPROVEMENT AND ENHANCEMENT PROGRAM: 1999-2004

Board Meeting of the Measured Quality Program Area

AGENDA NOTES FOR CHAIR

October 25 2000 9am – 11am
3th Floor Conference Room
Queensland Health Building

1. **Welcome and apologies - Dr Youngman**
   (Dr Kennedy participating via video-conference)

Board members were nominated by Program Area Sponsors (Drs Youngman and Filby)

Attendees include:
- Ms Geri Taylor
- Ms Sue Cornes
- Prof Bryan Campbell
- Ms Susan Mahon
- Ms Jenny Pouwer
- Ms Jenny Thomas
- Mr Paul Monaghan
- Mr David Jay
- Dr Chris Kennedy (participating via video conference)

Board members nominated because of their expertise in areas being assessed in the Measured Quality Program Area or because of their association with related programs and projects (eg Patient Surveys Program Area).

Apologies received from:
- Dr Filby
- Dr Ian Scott
- Dr Alan Isles

Invitation to participate as a board member declined from:
- Mr Steve Buckland who requested that a District Manager be asked in his stead. (Advice received 24 October).
- Ms Elizabeth Garrigan who is not participating in QIEP Program Boards.

Other participants in the Measured Quality Program Area:
Dr Roger Brown
Mr Mike Edwards
Ellen Hawes (Program Area Manager)
Vanessa Cornell

Note. DDG (P&O) expressed a wish that the Board be revised in size and composition with a focus on clinicians. Because the invitations had been sent and participants indicated a desire to be involved, this present approach is being taken. Suggest a rule that there is no substitution.

Board Meeting of the Measured Quality Program Area

AGENDA NOTES FOR CHAIR

2. Background of Program and purpose of meeting – Dr Youngman

Background

- Aim of the Program Area

  The aims of the Measured Quality Program Area, as detailed in the Business Case considered by the Quality Council in June 2000, are to:
  - improve the quality of care provided by the Queensland public health system by developing and applying a balanced scorecard to identify variations in performance
  - produce a public report on performance; and
  - contribute to the evaluation of the QIEP Program by providing baseline data on hospital performance; and providing an information base for the development of Program Area strategies.

- Links to national activity on health system performance assessment

  Dr Filby is the Chair of the National Health Performance Committee. This committee was formed at the request of the Australian Health Ministers' Conference to develop and maintain a national performance measurement framework for the health system. The committee replaces the the National Health Ministers' Benchmarking Working Group which produced three national reports on health sector performance indicators.

  The National Health Performance Committee has developed a framework for performance reporting which is broader than that used in previous reports which have focussed mainly on the acute care sector. The National Health Performance Framework was considered by the Australian Health Ministers Advisory Committee on Oct 9 2000. Draft minutes of that meeting are being written. However, it is anticipated that the draft Framework put to the Committee has been endorsed and will be forwarded to Australian Health Ministers for endorsement.

  It is important that any work on performance reporting be linked to this national framework. The Framework is used in the Measured Quality Program Area.

- Business case submission to Quality Council and subsequent approval for 6 months and development of project plan for next 2 ½ years.

  A business case for the Measured Quality Program Area was submitted to the Quality Council in June. This business case asked for approximately $5 million over three years to develop and publish a series of performance reports on Queensland hospital and community services and to conduct the first performance assessment prior to major implementation of the QIEP Program activities to provide a baseline of performance for the QIEP Program evaluation. A key issue will be timing – ie. That some QIEP activities may be underway when baseline measure is taken.

The Quality Council supported the concept of developing performance reports and endorsed the need to collect baseline measures of performance for the QIEP Program. The Council approved that the Measured Quality Program Area be provided with a notional budget of $ 1 million over the life of the Program Area (ie 2 ½ yers) and that it be funded for six months. The major deliverable for this 6 months was agreed to in subsequent meetings with the Program Sponsors. This deliverable includes the development of a project plan for the conduct of the Measured Quality Program Area over the next 2 ½ years.

Purpose of meeting

As per the QIEP Governance document, the Program Are Board has the responsibility to:

1. Influence the progress and direction of the Program Area through assisting in the development of the consolidated business case, where possible;
2. Review progress against performance indicators at major milestones;
3. Communicate with the Quality Council should the Program Area Sponsor be considered to be managing the Program Area contrary to the Board's advice.

The purpose of this meeting is to inform Board members of the background to the project and the progress made to date, and to seek advice on planned progress.

After the presentation by Ellen Hawes (Program Area Manager), discussion will be held seeking:

- Agreement on Terms of Reference for the Board (as per QIEP Governance document)
- Endorsement of decisions made to date and advice on planned progress over the approved 6 months and on planning for next 2 ½ years.

Board Meeting of the Measured Quality Program Area

AGENDA NOTES FOR CHAIR

3. Report on progress to date – Ellen Hawes (Program Area Manager)

Powerpoint presentation (20 minutes)

Handout to be provided at meeting.

Board Meeting of the Measured Quality Program Area

AGENDA NOTES FOR CHAIR

4. Discussion and agreement/endorsement of the business of the meeting:

Seek agreement on Terms of Reference for the Board

Proposed terms of reference as per QIEP Governance document: That the Program Are Board has the responsibility to:

1. Influence the progress and direction of the Program Area through assisting in the development of the consolidated business case, where possible;
2. Review progress against performance indicators at major milestones;
3. Communicate with the Quality Council should the Program Area Sponsor be considered to be managing the Program Area contrary to the Board's advice.

Seek endorsement of decisions made to date and planned progress. (The following to be provided as a handout to Board members to focus discussion.)

- Framework for the performance assessment (National Health Performance Framework)
- Program Structure
- Hospital Clinical Assessment Project decisions:
  - Consideration of international and national indicators (as proxy for validity of indicators)
  - Categorisation by measurability
  - Data extraction for interpretability and examination of reliability
  - Distribution to existing expert groups seeking comment and prioritisation
- Hospital Patient Satisfaction Assessment Project decisions:
  - To focus on patient satisfaction and patient experience as first phase in measuring Responsiveness
  - To use an existing Patient Satisfaction tool – either VIC or WA
  - To determine methodology (mail/phone, sample sizes, level of comparison required) and cost
- Hospital Financial Assessment Project decisions:
  - Focus on existing indicators
- Hospital System Integration and Change Assessment Project
  - Review Clinical Audit Tool as a possible survey instrument
  - Consider adapting Ontario survey and piloting in a District

Board Meeting of the Measured Quality Program Area

AGENDA NOTES FOR CHAIR

5. Next meeting

It is envisaged that a further meeting of the Board will required in mid January to consider the results of the work completed towards the 6 month deliverable and to comment and advise on the Project Plan for the next 6 months.

If the Project Plan is accepted by the Quality Council at its meeting in Feb – March 2001, quarterly meetings of the Board are envisaged.

Queensland Government
Queensland Health

MINUTES

Board Meeting of the Measured Quality Program Area

Held January 18, 2000 2am – 4.30pm

3th Floor Conference Room, Queensland Health Building

CHAIR: Dr Filby

1. Welcome and apologies

Dr Filby welcomed Board members.

Present were:
Prof Bryan Campbell
Ms Sue Cornes
Dr Glenn Cuffe
Dr David Filby (chair)
Ms Elizabeth Garrigan
Dr Alan Isles
Dr Chris Kennedy (via video conference)
Ms Susan Mahon
Mr Paul Monaghan
Dr Ian Scott
Ms Geri Taylor
Ms Jenny Thomas
Ms Sandra Thompson
Dr John Youngman

Observers:
Dr Roger Brown
Mr Mike Edwards
Mr Bryan Kennedy (Health Information Centre)

Program Area staff:
Ellen Hawes (Program Area Manager)
Romana Madl

Apologies:
Mr David Jay

2. Review 6 month progress

Ms Hawes provided an overview of the Program Area aim, framework, structure and status (refer slides 2-9).

Reviewing program aim

The issue of clarifying the aim of the Program Area was raised. The aim states that the focus is on identifying variation in services through a balanced scorecard methodology. There are two possible approaches to conducting the work of the Program Area and identifying variation:

- The performance assessment approach focuses on identifying existing indicators and assessing performance. This approach has been used by other states and internationally.

- The balanced scorecard approach has a management focus and identifies the vision, then the strategies and then the indicators aligned to each strategy. This approach has not been widely trialed in the health field. Ontario Hospital Association and the New Zealand Department of Health have produced performance reports which state that the balanced scorecard was the methodology used, but in both instances a performance assessment approach was used to identify indicators and the balanced scorecard was used as the reporting framework.

To date, a mixed approach has been used in the Program whereby the initial work was framed around the work of other health system evaluations and therefore has a performance assessment focus. This has resulted in the dimensions of Effectiveness, Accessibility, Appropriateness and Safety being defined by clinical indicators.

After greater analysis of the balanced scorecard methodology, it is being implemented to identify indicators in the other dimensions (ie patient satisfaction, Efficiency, Continuity of Care, Capacity and Sustainability).

The two approaches result in different indicators being identified. The application of the balanced scorecard methodology to all dimensions of the National Health Performance Framework will result in a more comprehensive set of indicators. However, it will require significant resources.

Board members agreed that the Program should result in tools to assist management (eg a balanced scorecard). However, the board also agreed that the Program Area should not attempt to fully populate indicators in each of the cells of the National Health Performance Framework. Members agreed that the mixed approach was appropriate from the perspective (a) that this work was new and needed to be conducted in a phased/evolving approach (ie the process, indicators and report will evolve over time) and (2) that expanding indicators in Effectiveness etc dimensions would require significant additional resources.

Summary

Board members endorsed the continuation of a mixed performance assessment – balanced scorecard approach.

Reviewing 6 month progress

Progress in each project was detailed in slides presented and discussion ensued on each project (refer slides 13-19 Clinical Indicators Project; slides 21-23 Patient Satisfaction Project; 24 Efficiency Project; 26-27 Continuity of Care, Capable and Sustainable Project).

Issues raised by board members included the following:

- Clinical Indicators Project
  The results may reveal issues which are more relevant to the integrity of the data collected than services provided. Members agreed that this would be an important outcome of the Program re: identifying areas where intervention strategies to improve data integrity were needed.

- Efficiency Indicators Project
  Mr Monaghan suggested that work needs to be conducted on clinical measures of efficiency through utilising Transition II data more effectively. This will be progressed in the coming months.

- Continuity of Care, Sustainability and Capability
  Members are interested in the Ontario survey and requested a copy be circulated.

Action: Ms Hawes to circulate Ontario "system integration and change" survey to members.

- Patient Satisfaction Project
  Detailed discussion occurred on the issues raised for patient satisfaction.

  Survey target: The recommendation was to survey inpatients only and to target medical, surgical, obstetric and psychiatric wards. This targeting was questioned as the wards would be general wards and the results would therefore not be applicable to all surgical etc wards. The rationale for targeting these wards was based on feedback from District staff using patient satisfaction surveys (and interstate contacts) that if the results of surveys were to be acted upon and service improvements put in place where necessary, it was important to link the findings to some entity in the hospital. District staff considered that having a ward identified gave them "somewhere to start" in identifying why there is a problem and what they can do about it.

  It was suggested that a better approach may be to link the survey to disciplines or to individual clinicians. The latter would be used as the "hook" into the broader team process rather than focusing on any individual clinician's behaviour.

  The administration of the survey would also affect how wards were surveyed eg. if the sample is chosen from admission data then using DRGs to sample is not possible.

  A number of members asked for clarification as to the purpose of conducting a patient satisfaction survey: was it to assess if the clinical services provided were acceptable, if the outcome was acceptable, or if the service as a whole was acceptable?

  Dr Filby indicated that the purpose was twofold: to ensure the clinical services were acceptable and to identify if any service improvements are required for the overall service patients receive while they are an inpatient.

It was decided that the primary purpose of the survey was to be more clearly defined and that this would facilitate decisions on the survey target and sampling frame. The other issues raised for consideration of the board will be affected by this decision.

The survey coverage was raised. Dr Filby noted that in the longer term, all hospitals should be surveyed. Dr Youngman noted that a focus on the hospitals which have Transition II may be more appropriate. Dr Scott provided an example of analysis of data for acute myocardial infarctions which suggested that the opportunity to improve outcomes was in the smaller hospitals. He suggested that smaller hospitals should be included. Ms Taylor suggested that the first survey be conducted with a view to learning as much about the process as about the data and that a smaller coverage may be more appropriate as the initial survey.

It was decided that the survey coverage issue should be considered out of session.

Dr Isles noted that neither the Patient Survey/Complaints Program Area or the Measured Quality Program Area had required funds to conduct a survey and asked from where the funding for the survey would be allocated. Dr Youngman indicated that a number of sources were possible and that the key issue should be on identifying the survey methodology and associated required funding.

Summary
Progress was broadly endorsed in each project.

The purpose of the patient satisfaction survey to be more clearly defined to facilitate decisions on issues raised for discussion. Progress on other issues relating to patient satisfaction surveys (as detailed in Slide 23) to be conducted out of session.

Action: A copy of the minutes of the meeting to be provided to Patient Surveys/Complaints Program Board for consideration.

3. Overview of Project Plan

Ms Hawes provided an overview of the aim, benefits, deliverables, scope and budget of the proposed plan for the next 2 ½ years (slides 33 – 39). The proposed projects were reviewed in terms of major activities and required resources (slides 40 –55). The project plan will be sent to members on 22 January 2001 with a two week period for comment.

Members agreed on the need for the program to be seen as credible by clinicians, particularly clinical leaders. Members felt that for this to occur, the methodology for selecting and analysing the indicators needs to be rigorous and open to external review (eg. through the statistical partnering project).

Ms Taylor noted that an important issue was for the Program milestones to be evaluated throughout the Program to ensure that it is providing useful information and that the evaluation be more than surveys. Ms Taylor also queried the level of staff proposed, suggesting that the activities outlined may require staff at higher levels.

Dr Scott also expressed concern about a sole focus on surveys for evaluation and suggested that focus groups with clinical leaders be included in the evaluation methodology. Dr Scott also indicated that the level of staff may need to be higher to conduct the outlined activities and achieve clinical buy-in to the Program.

Specific Issues requiring resolution: Report Coverage

The coverage of the Report to be determined after the Project approval phase is complete.

Specific Issues requiring resolution: Quality Reviewer

Nominations for a Quality Reviewer for the Program to be provided by board members with their comments on the Project Plan.

5. Next meeting

18 April 2001, 3rd Floor Conference Room, Queensland Health Building

Queensland Government
Queensland Health

MINUTES

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