

Patient Management Task Force

Paper No. 6

**Improving the System:
Capacity and Capability Building**

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Introduction

Responding to changing technologies, heightened community expectations and needs requires high levels of organisational and system adaptability. However, service provision often seems to function not as a system, but as a collection of vaguely related, autonomous providers.

The Task Force has been asked to advise on incentives and other strategies that could be used to encourage health services to achieve benchmark performance in patient management. There is a range of factors that influence performance at the individual hospital level and metropolitan-wide.

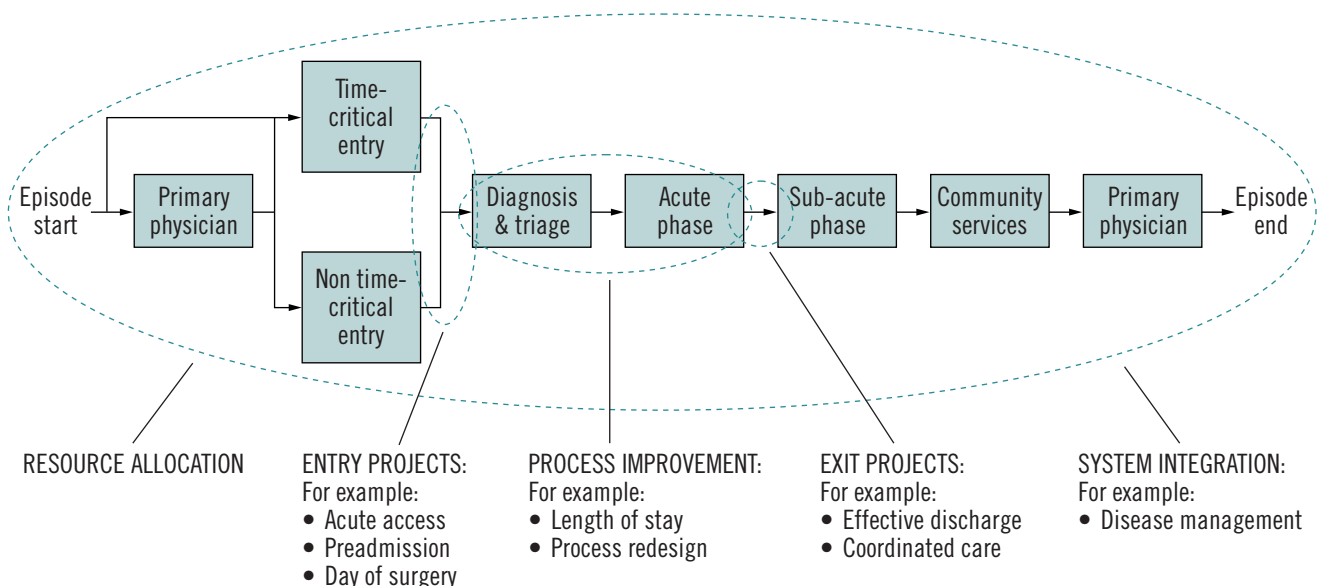
This paper includes specific proposals in a number of these areas, including:

- Developing a culture of collaboration and the sharing of information, experience and learning.
- Encouraging clinician and executive leadership and involvement.
- Accelerating the adoption of new IT-based technologies to optimise patient care.
- Fostering performance measurement and inter-hospital benchmarking.
- Refining and streamlining incentives and other driving forces in current funding systems (alongside adjustments to the health service agreement process).
- Planning and decision making about the role and location of metropolitan health services.
- Addressing Commonwealth–State issues that limit the ability to link Commonwealth funded services (such as general practitioners) with State funded services (such as hospitals).
- Informing the community and involving consumers in their health care (including disease management approaches).

Service provision often functions less like a system, more like a collection of vaguely related, autonomous providers.

Our common goal must be a well-integrated system providing improved community and population health as well as positive patient experiences and outcomes—a system in which the Victorian public gets the best possible value for money.

Figure 1: System Improvement Projects: Addressing the ‘Episode of Care’ (Simplified)



Source: Southern Health Planning and Development Unit

The Patient Management Task Force

The Patient Management Task Force has been set up to identify specific areas for improvement in in-hospital patient management processes and to advise on the system factors that will encourage best practice in patient management. One objective is to engage actively with hospital management and clinicians in dealing with problems of access to emergency services and elective surgery, both at the individual health service level and in professional forums. The Task Force is also seeking to obtain views from a wide range of stakeholder groups on effective solutions.

The Task Force's terms of reference and membership are at Appendix 1.

An objective of the Task Force is to engage actively with hospital management and clinicians in dealing with problems of access to emergency services and elective surgery, both at the individual health service level and in professional forums.

The Task Force has a principal focus on major metropolitan hospitals¹ and is carrying out its work in three stages. The information gathering stage is now complete. An overview paper, *Serving the Needs of the Patient: Better Patient Management in Melbourne's Public Hospitals*, was released in early March 2001.

The second stage involves publishing papers on 'action areas' for consideration and comment by the field. Papers have already appeared on the following topics:

- emergency services
- ambulatory care
- multi-day medical and elective surgery patients
- improving hospital care for older Victorians.

The Task Force's terms of reference require it, 'to advise on incentives and other strategies that could be used to encourage health services to achieve benchmarks'. This paper has a particular focus on the system factors that will encourage the adoption of best practice in patient management. Written responses to all Task Force papers are invited (by submission or email at patient.management@dhs.vic.gov.au).

The final stage of the Task Force's work will be the preparation of a short paper incorporating a summary of its principal themes, key areas for action and any changes to the Task Force's published views resulting from feedback received.

¹ The Alfred Hospital (Bayside Health); Austin and Repatriation Medical Centre; Box Hill, Maroondah and Angliss hospitals (Eastern Health); Frankston Hospital (Peninsula Health); Monash Medical Centre (Clayton and Moorabbin) and Dandenong Hospital (Southern Health); Northern Hospital (Northern Health); Royal Melbourne Hospital (Melbourne Health); St Vincent's Hospital; Western Hospital and Sunshine Hospital. (Western Health)

Recommendations

1. Metropolitan health services and the Department of Human Services should establish a limited number of collaborative projects to foster implementation of the patient management and clinical practice improvements proposed by the Task Force. These projects should be commenced during 2001–02 and should include the evaluation and comparison of health service/hospital performance as well as publication of individual health service results.
2. Metropolitan health services should place a high priority on the further development of collaborative arrangements with other providers. This should be reflected in strategic plans as well as the chief executive officer's performance agreement with the board.
3. In partnership with clinician groups and health services, the Department of Human Services should establish annual health care improvement awards.
4. In close collaboration with relevant medical, nursing and allied health organisations and health care providers, the Department of Human Services should establish a clinical leadership program for Victoria. Funds should be allocated for the establishment of this program during 2001–02.
5. The Department of Human Services should establish a Council of Clinical Leadership to advise on the development and implementation of the leadership program.
6. In collaboration with industry, the Department of Human Services should develop and report a consolidated, simple set of well-defined performance indicators covering outputs, resource use, quality and safety, access, and patient care process improvement.
7. The strategic plan for each metropolitan health service should set out how it intends to implement key patient management practice improvements.
8. Each annual health service agreement should include an account of the steps to be taken by the metropolitan health service and the support to be provided by the Department of Human Services to implement patient management practice improvements.
9. The performance of the metropolitan health service in meeting statewide policy objectives should be the focus of an annual board appraisal by the Ministers.
10. Twice-yearly performance reviews with the Department of Human Services should include a comparative assessment of the metropolitan health service's performance in critical areas of patient management practice as well as the Department's performance in providing necessary support.
11. The annual performance appraisal of chief executive officers by the Board Chair and the Secretary of the Department of Human Services should include an assessment of progress towards implementing key patient management practice improvements and results achieved.

12. The Department of Human Services should provide more flexibility to health services in meeting the priority needs of patients by permitting WIES conversion to substitutable services.
13. A joint Departmental/provider task force should review price-setting and review arrangements including rewards for good performance. The objective should be enhancements to the system so that it:
 - Is transparent and clearly understood by both purchaser and providers
 - Reflects actual costs
 - Incorporates transparent incentives/rewards for best practice.
14. The Department of Human Services should establish a new consolidated quality funding program that focuses explicitly on the key priorities of the system. This should be implemented in 2001–02 and should include an at-risk component tied to the metropolitan health service's performance in meeting agreed targets.
15. Commencing with the 2001–02 health service agreement, each metropolitan health service and the Department of Human Services should select a small set of specific improvement targets against which performance is assessed, and to which at-risk payments are allocated.
16. Over the next year, as part of the continuing evolution of casemix funding, the Department of Human Services in conjunction with health services should evaluate the development of capitation and episode payment schemes for chronic conditions that are suitable for disease management approaches.
17. The Department of Human Services should further encourage the use of comparative hospital data by developing web-based access, providing query tools and publishing regular analyses of comparative performance in specific areas. In the short term, the Department should publish an annual compendium of basic performance data, to be released by 31 October 2001.
18. The Department of Human Services should obtain Health Insurance Commission data on primary health care service utilisation and link them with admitted and other hospital utilisation data to enable a more complete picture of service utilisation patterns and trends to be made available to service evaluators and planners.
19. In collaboration with professional colleges and organisations and the industry, the Council of Clinical Leadership or other agreed body, should establish specific targeted collaborative projects that enable clinicians and managers to focus on the appropriateness of care, and to identify where improvements can be made.

20. As soon as possible, the Department of Human Services in collaboration with health services should develop, communicate and implement a strategic plan outlining the ways in which Victorian hospitals will use proven clinical support applications to improve patient safety and support patient management practice improvement.
21. The Department of Human Services should take a stronger role in mandating priorities for information technology systems, and fostering collaboration among metropolitan health services in information systems management and development.
22. The Department of Human Services should continue to work towards the creation of an electronic health record subject to appropriate privacy and confidentiality requirements. An electronic health record incorporating a unique patient identifier is an important early step in this process.
23. The metropolitan health services plan to be prepared by the Department of Human Services in collaboration with metropolitan health services and expert clinicians should:
 - Tackle the uneven distribution of access to some services across the metropolitan area to ensure better access to forms of treatment that patients use frequently and regularly (such as dialysis).
 - Determine the location of key specialist clinical services.
 - Address the role and function of outer metropolitan general hospitals in the broader network of health services.
 - provide sufficient detail to inform the development of metropolitan health services strategic plans during 2001–02.
24. The Department of Human Services should work with the Commonwealth to improve links between GPs and other parts of the health system, such as hospitals, and to provide adequate incentives for GP after-hours services.
25. The Department of Human Services should negotiate with the Department of Health and Aged Care to pilot a Commonwealth-funded program of hospital-based GP locum services.
26. Metropolitan health services and the Department of Human Services should continue to develop ways of informing their communities and involving patients in their care.
27. Metropolitan health services should establish a CEOs forum to guide the implementation of strategies that will foster best practice in patient management.
28. Each metropolitan health service should review the Task Force’s findings and recommendations to identify the key areas for priority attention. Planned action on these priority areas and necessary support from the Department should be documented as part of the 2001–02 health service agreement.

Observations and Findings

1. A culture of collaboration among the metropolitan health services (and with community-based health services) is essential, so that hospitals can learn from each other and so that ideas that work well are communicated and taken up more widely.

'Bringing down waiting lists and keeping them in line with clinical priorities, whilst meeting the demands for emergency care requires a whole systems approach involving primary care, community care, mental health and social services.'²

Overall system policies are important too. The policy emphasis on competition and contestability advocated during the 1990s was widely seen as discouraging the development of collaborative approaches within and between agencies and the Department of Human Services. Dissemination of new ideas and clinical practices is impeded when organisations and professionals become reluctant to share information for fear of losing a competitive edge.

A policy and cultural shift to a more collaborative, partnership-oriented approach now underpins a range of Government policy developments,³ but it will not flourish without practical support. Workload demands, professional demarcation barriers ('turf pressures'), information gaps and management neglect can all work against more collaborative relationships.

One collaborative approach that has been successful in generating significant improvement to hospital operations is the *National Demonstration Hospitals Program* (NDHP).

In Victoria, the *Emergency Breakthrough Collaboration* employs the Breakthrough process improvement methodology across participating Victorian emergency departments in metropolitan and rural areas. The Breakthrough methodology was designed by the Institute of Healthcare Improvement in the United States to bring together health agencies sharing a commitment to making major, rapid changes to produce breakthrough results. The Breakthrough series provides the clinical, technical and social support for health care organisations to make positive changes and generate momentum for sustaining the improvement process beyond the initial Breakthrough series.

Some Victorian hospitals are members of the Health Roundtable. Those that participate generally value highly the supportive but rigorous approach to the examination of practice and performance.

There is a need for a small number of collaborative projects, involving all metropolitan health services, to focus specifically on implementation of the patient management and clinical practice changes proposed by the

Understanding, trust and respect for differing views are fundamental to improving collaboration within and between organisations, just as they are for individuals.

The National Demonstration Hospitals Program brings groups of hospitals together to pursue process improvements of relevance and interest to the system.

² Harrison, A. and New, B. *Access to elective care*, King's Fund Review, 2000 p. 18

³ Victorian Government (2001) Second Stage Submission to Public Accounts and Estimates Committee Inquiry into State Government Service Agreements

The system needs to value and encourage innovation in patient management practice.

Task Force. Involving clinicians (doctors, nurses and other health care workers), hospital executive management and the Department, they would concentrate initially on:

- Substituting ambulatory for inpatient care.
- Improving management of planned and emergency inpatient admissions.
- Responding better to the special needs of older people in the hospital setting.
- Developing effective operational links with pre- and post-hospital care providers.

A structured process is required to ensure that these projects are followed through and that outcomes are disseminated and acted upon. The metropolitan health service CEOs and the Department should take responsibility for this.

The Task Force believes that metropolitan health service boards need to take a close interest in the development of collaborative arrangements between themselves and other providers. The primary care and population health advisory committee is one vehicle for improved collaboration in the local area, but other broader initiatives are needed too.

The Task Force believes that metropolitan health service boards need to take a close interest in the development of collaborative arrangements between themselves and other providers.

The system also needs to value and encourage innovation in patient management practice. A prestigious annual award could be presented for excellence in various categories (such as quality, case management, care innovation and process improvement) to teams within or across hospitals. An independent group of eminent people would judge entries. Seed funding would need to be provided by the Department, with carefully selected sponsorship.

Recommendations

1. Metropolitan health services and the Department of Human Services should establish a limited number of collaborative projects to foster implementation of the patient management and clinical practice improvements proposed by the Task Force. These projects should be commenced during 2001–02 and should include the evaluation and comparison of health service/hospital performance as well as publication of individual health service results.
2. Metropolitan health services should place a high priority on the further development of collaborative arrangements with other providers. This should be reflected in strategic plans as well as the chief executive officer's performance agreement with the board.
3. In partnership with clinician groups and health services, the Department of Human Services should establish annual health care improvement awards.

2. Strong engagement and involvement from clinicians is essential in setting and monitoring standards of clinical practice and patient care management.

To drive the advances in patient care management required to keep Melbourne's public hospital services at the forefront of contemporary practice, more structured processes are needed to involve clinicians in leadership roles.

The United Kingdom National Health Service has recognised the need to support clinicians in the critical leadership role they must play in achieving better care outcomes and/or improving the cost-effectiveness of health care by developing a clinical governance structure. The clinical governance initiative is a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which excellence in clinical care will flourish.

As a result of the Ministerial Review of Health Care Networks 2000, hospitals have developed clinical governance structures. It is evident that clinicians also need to be more actively involved in setting and monitoring clinical policy, for setting and monitoring standards of clinical practice for specific health conditions, and in supporting clinical leadership. There must also be greater transparency about the performance of providers.

A collaborative approach characterised by strong executive support, team-building and cooperation between clinicians from nursing, medical and allied health disciplines, together with innovative clinical solutions, brought about remarkable improvements in patient access to Royal North Shore Hospital.

The Task Force believes that a clinical leadership program in Victoria is needed to:

- Promote and enable leadership and management training and support to clinicians who perform executive management roles.
- Identify and analyse data sets to monitor variations in practice.
- Support clinical audit through the learned colleges and similar organisations.
- Provide a forum for exchange of information and research into the most cost-effective ways of providing clinical care.
- Build on infrastructure already established (such as the Clinicians Health Channel).
- Encourage the development and dissemination of standards of clinical practice and patient management.

Clinicians need to be more actively involved in setting and monitoring clinical policy, standards of clinical practice, and in supporting clinical leadership.

Recommendations

4. In close collaboration with relevant medical, nursing and allied health organisations and health care providers, the Department of Human Services should establish a clinical leadership program for Victoria. Funds should be allocated for the establishment of this program during 2001–02.
5. The Department of Human Services should establish a Council of Clinical Leadership to advise on the development and implementation of the leadership program.

3. A stronger link is needed between policy objectives, performance measurement and accountability arrangements.

The Task Force believes that the current Health Service Agreement inhibits constructive dialogue between the Department and metropolitan health services. A better approach would be to enhance the health service agreement process through discussion between health services and the Department on how individual services will go about achieving benchmark targets set for the industry as a whole. The Task Force supports:

- An explicit focus on key system-wide objectives.
- Development of a ‘balanced scorecard’ suite of indicators for monitoring progress and reporting to metropolitan health services boards and executive management, and to the Minister and Department.
- Using this suite of indicators in the annual health service agreement negotiation.
- Mid-year and end-of-year performance reviews, based on the suite of indicators.
- Responses to new issues as they arise.

The balanced scorecard should consist of a consolidated, simple set of performance indicators that:

- Includes a mix of quality and safety, resource use, patient care process, and access/activity indicators.
- Can be used at all levels of the system: for metropolitan or Victoria-wide aggregate performance monitoring, for comparisons between peer hospitals and metropolitan health services, and to foster improvement and innovation (as well as addressing poor performance) at a unit or individual provider level.

Each metropolitan health service is expected to prepare a strategic plan informed by the metropolitan health services plan now being developed. The strategic plan could set out how the metropolitan health service intends to attain benchmark performance in patient management practice.

Boards and chief executive officers are accountable for the performance of the metropolitan health services in meeting statewide policy objectives. An annual statement of objectives, together with some specific performance

Improvements to planning and accountability arrangements are necessary so that the overall strategy for the hospital sector informs and drives metropolitan health service plans and health service agreements.

targets agreed between the Department and individual agencies, would form the basis for a clear understanding between the Minister and Board. This would allow an annual board appraisal by the Ministers that could focus on the critical accountabilities for service delivery and resource management and an assessment of the 'degree of difficulty' experienced by the hospital in achieving progress on its priority areas. Chief executive officers' performance plans (and their assessments) must relate the overall priorities and targets to the specific circumstances of the individual health service

Health service agreements should be linked closely to the Government's priority objectives for the system, as reflected in the proposed suite of performance indicators. From 2001–02, each annual health service agreement should include a focus on the steps to be taken by the metropolitan health service, and the support to be provided by the Department, to improve benchmark performance for the three to five key priority areas for each service. These priority areas should be developed collaboratively and should be monitored by objective performance assessment. The three to five priority areas do not need to be (nor are they likely to be) the same for all services. They should reflect the policy priorities of the system as a whole and take account of the areas of relative strength and weakness of each service. This could include:

- Analysing variations in practice and steps taken to reduce inappropriate variation.
- Changes to practice such as admission on day of treatment/surgery, and same-day admissions.

To support and drive this process, the Department could publish a health services priorities report that outlines the priority areas for each service, as well as an annual report on progress.

Recommendations

6. In collaboration with the industry, the Department of Human Services should develop and report a consolidated, simple set of well-defined performance indicators covering outputs, resource use, quality and safety, access, and patient care process improvement.
7. The strategic plan for each metropolitan health service should set out how it intends to implement key patient management practice improvements.
8. Each annual health service agreement should include an account of the steps to be taken by the metropolitan health service and the support to be provided by the Department of Human Services to implement patient management practice improvements.
9. The performance of the metropolitan health service in meeting statewide policy objectives should be the focus of an annual board appraisal by the Ministers.

Boards and chief executive officers are accountable for the performance of the metropolitan health services in meeting statewide policy objectives.

10. Twice-yearly performance reviews with the Department of Human Services should include a comparative assessment of the metropolitan health service's performance in critical areas of patient management practice, as well as the Department's performance in providing necessary support.
11. The annual performance appraisal of chief executive officers by the Board Chair and Secretary of the Department of Human Services should include an assessment of progress towards implementing key patient management practice improvements and results achieved.

4. A stronger link is needed between policy objectives, funding distribution and the way certain services are funded.

The good performance of metropolitan health services in meeting targets for category 1 patients on the waiting list can be partly attributed to a close alignment between the benchmarks set for incentive payments under the Department's Hospital Access Program and high levels of clinician acceptance. However, the Task Force believes that current incentive schemes directed at other patient access targets (such as emergency services) have reached the end of their 'product lifecycle'. It also suggests that process and quality improvement funding has become overly complex, with too many small funding pools that may have conflicting objectives. The accompanying administrative and reporting requirements are also overly complex.

Many aspects of the performance of the public hospital system at present are a direct consequence of current funding arrangements.

More broadly, however, the Task Force recognises a number of tensions inherent in current funding systems. From the point of view of the funding body, the objectives are to:

- Encourage providers to deliver system objectives (policy compliance)
- Encourage providers to give good customer service
- Reward good performance.

However, the funding body is also obliged to underwrite poor performance; it is simply not possible to allow major health service providers to 'fall over'.

From the perspective of the provider, the way in which the funding body acts on these objectives can sometimes create unintended consequences:

- Uncertainty with respect to the return on effort required to achieve bonus payments—a budget challenge for the commitment of resources.
- The workforce interprets bonuses for good performance as penalties for poor performance.
- There appear to be perverse incentives; under-performers are sometimes seen to benefit from targeted assistance, while consistently good performers manage within their budgeted allocations.

The Task Force believes there should be a clear, global, system view of what constitutes good performance in terms of patient care management. This

may vary from year to year in the light of changing demands on the system, as well as changes in care delivery capacity.

At the same time, the Task Force believes that consistently poor performance should be dealt with firmly. Managers and boards of directors must be held accountable for the performance of their organisations (refer Recommendations 9–11). There needs to be Departmental support for health services experiencing continuing difficulties. Actions will depend on individual circumstances. They may include a comprehensive or targeted review of financial and management systems, with a targeted action plan to improve financial performance. These reviews should not be considered as evidence of failure, but as recognition of the need for continued improvement.

The primary method for making payments to metropolitan health services is in the form of WIES (weighted inlier equivalent separations), or WIES equivalents. There is a direct relationship between the ‘equivalent’ price and the WIES price. While the Department has readily supported and encouraged the conversion of WIES funded throughput to fund other services, such as sub-acute bed days. The Task Force believes that hospitals should be given even more flexibility in determining the priority needs of patients by permitting WIES conversion to substitutable services.

There should be a clear, global, system view of what constitutes good performance in terms of patient care management.

Recommendation

12. The Department of Human Services should provide more flexibility to health services in meeting the priority needs of patients by permitting WIES conversion to substitutable services.

Several reports have pointed to the need for simplification of the various funding streams through which the Department currently funds health services. This has been recognised by the Department in its submission to the Parliamentary Accounts and Estimates Committee inquiry into service agreements.⁴

In order to focus attention on the key priorities of the system and to provide a pool of funds sufficient to support an adequate ‘baseline’ allocation, as well as meaningful incentive payments, the various initiatives and funding streams that currently support practice and process improvement (including incentive and bonus schemes under the Hospital Access Program, quality initiatives, system effectiveness and a range of others) could be consolidated into a new program. The new program—which would be introduced in 2001–02—should include an at-risk component tied to the metropolitan health service’s performance in meeting agreed targets, derived from the suite of performance indicators proposed above. Meeting challenging but achievable targets (not necessarily uniform across all hospitals) would earn an amount sufficient to represent a real reward for good performance.

⁴ Victorian Government (2001) Second Stage Submission to Public Accounts and Estimates Committee Inquiry into State Government Service Agreements

The performance and reporting framework should cover the key objectives for the health system. A balanced scorecard approach with a suite of indicators is seen as most appropriate to deal with services who must meet a number of objectives, encompassing service delivery, meeting emergency demands, efficiency and budget. Within that framework, services need a set of specific targeted improvements that reflect the service demands and the past organisational ability of the particular health service.

More generally, however, there is a need for system-wide investment in strategies to enable patient flow process improvements and increased productivity. The Department of Human Services has recently introduced a Productivity Investment Fund that is available to its funded agencies and internal programs that require financial assistance to implement productivity improvement projects. Savings from projects sponsored by the fund are intended to assist agencies and programs to meet the Government's 1.5 per cent productivity dividend. In New South Wales, the Department of Health establishes efficiency expectations with each area health service as part of the allocation of three-year budgets. Area health services (and local level hospitals) are allowed to retain efficiencies, but must demonstrate that their re-allocation to agreed priorities (as part of area health service plans) represents value for money.

There is a need for system-wide investment in strategies to enable patient flow process improvements and increased productivity.

In Victoria, some \$30 million could be made available for priority areas such as improved practice, quality and safety, if the 1.5 per cent productivity saving were removed from hospital/health service budgets and allocated through the Department for transparent reinvestment on specific work processes and projects which enhance productivity. Such an arrangement would need to be managed so that access to the productivity investment fund is seen to be fair by all the participants—both purchaser and providers.

In its papers on hospital care for older people, ambulatory services and elective admissions, the Task Force has advocated variations to current funding models. Specific incentives to encourage hospitals to substitute same-day for multi-day treatment are recommended. The Task Force has also suggested that funds be made available to keep occupancy levels in short stay units optimally placed to accommodate unplanned peaks in demand.

One example of how the funding arrangements could be adjusted to promote good practice is the payment under the Victorian Ambulatory Classification System (VACS) for telephone pre-admission. Pre-admission assessment typically begins with a nurse's review of the pre-admission form using agreed criteria, possibly followed up with a telephone call so that the patient does not attend a formal pre-admission clinic. The payment under VACS should be included in the WIES payment, to ensure that it reflects the actual cost of the admission.

The annual process for determining 'cost weights' to enable a price—a 'weighted inlier-equivalent separation' (WIES)—to be attached to each

Diagnosis-Related Group (DRG), entails averaging the costs for that DRG across the reporting hospitals. Where one hospital establishes a 'profitable' approach to treating patients in a particular DRG, that reduced cost will flow through to a lower relative price for that DRG in succeeding years. The reverse is of course true, that if a cost rises, it will also flow through to price relativities in succeeding years.

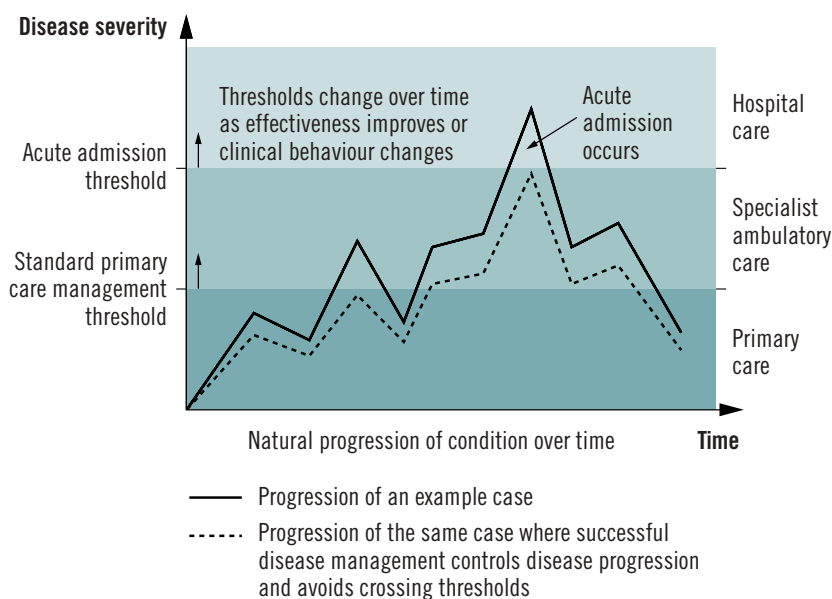
This is only a real issue for the major hospitals, whose throughput volume is sufficient to influence the cost weights, but it does mean that if a significant clinical process or patient management improvement is established, it is not necessarily in that hospital's best interest to widely disseminate their approach, since that will quickly erode their comparative advantage. In a context of extremely tight hospital budgets, the loss of even a small marginal cost (or revenue) advantage is important.

The Task Force believes that a more sophisticated and transparent price-setting process and a more systematic approach to promoting and conducting detailed analyses of comparative performance are required.

Disease management approaches such as those being developed under the Primary Care Partnerships initiative offer opportunities to improve early detection, early intervention and the provision of care continuity between general practice, hospitals and community health providers. Such approaches should also assist in reducing urgent admissions through emergency departments by people experiencing chronic and complex conditions. An episode payment system that includes the acute in-patient episode, the sub-acute episode, and post-discharge care and follow up could be developed to promote disease management. One option is to undertake pilot projects for a limited number of conditions, such as stroke, chronic obstructive pulmonary disease and congestive cardiac failure.

A more sophisticated and transparent price-setting process and a more systematic approach to promoting and conducting detailed analyses of comparative performance are required.

Figure 2: Successful Disease Management Controls Disease Progression



Recommendations

13. A joint Departmental/provider task force should review price-setting and review arrangements including rewards for good performance. The objective should be enhancements to the system so that it:
 - Is transparent and clearly understood by both purchaser and providers
 - Reflects actual costs
 - Incorporates transparent incentives/rewards for best practice.
14. The Department of Human Services should establish a new consolidated quality funding program that focuses explicitly on the key priorities of the system. This should be implemented in 2001–02 and should include an at-risk component tied to the metropolitan health service's performance in meeting agreed targets.
15. Commencing with the 2001–02 health service agreement, each metropolitan health service and the Department of Human Services should select a small set of specific improvement targets against which performance is assessed, and to which at-risk payments are allocated.
16. Over the next year, as part of the continuing evolution of casemix funding, the Department of Human Services in conjunction with health services should evaluate the development of capitation and episode payment schemes for chronic conditions that are suitable for disease management approaches.

5. New information systems are creating enhanced opportunities for the provision of comparative health performance information to agencies, clinicians and patients.

The latest *Report on Government Services*⁵ argues that measuring and reporting performance has three benefits:

- Identifying scope for improvement and from whom to learn.
- Fostering yardstick competition, by promoting greater debate about comparative performance.
- Enhancing measurement approaches and techniques for aspects of performance, such as unit costs and service quality.

The challenge is to disseminate information in useful ways to clinicians, managers and policy makers.

The Task Force recognises that there is no shortage of statistics. Hospitals and the Department regularly receive data from the Victorian Admitted Episodes Dataset and other sources. The challenge is to disseminate the information in useful ways to clinicians, managers and policy makers. This means the information has to be managed: to relate to an expressed need, to be relevant and meaningful for the user, to be timely, and to foster discussion and debate.

⁵ Steering Committee for Government Service Provision, 2001, *Report on Government Services*

The Internet is making health care utilisation data readily available

Internet-based technologies make access to health care utilisation data much easier than in the past. For example, the trend in general practitioner services to the elderly that the Task Force noted in paper 5 of this series was largely revealed by the aggregate Medicare statistics placed on the Internet by the Health Insurance Commission.

In the United States, a Federal–State–industry partnership is working to build a standardised, multi-State health data system (The Healthcare Cost and Utilization Project⁶). The system comprises a family of administrative longitudinal databases—including State-specific hospital-discharge databases and a national sample of discharges from community hospitals—and powerful, user-friendly software that can be used with both these and other administrative databases.

In the past, comparative data on a variety of Victorian public hospital performance measures (but not detailed DRG-related information) was published annually as the Hospital Comparative Data series. It was published electronically for 1996–97⁷ and 1997–98.⁸ The 1998–99 data are currently being prepared. The Task Force believes that new approaches must be tried to make current (or at least recent) data available.

In the past, there were difficulties with the information published in the Hospital Comparative Data series. There was a lack of standard definitions for a number of items, and even where good definitions existed, a lack of consistency in the data supplied. The Department of Human Services has also provided metropolitan hospitals with restricted use data sets of the Victorian Admitted Episodes Database since 1996–97. A number of hospitals use these data for service planning, benchmarking and monitoring functions. However, use is limited because the database is not easily interrogated and requires substantial data processing to configure reports that are useful for comparative analysis and performance improvement.

One way to increase the availability and usefulness of this information is to develop a query tool along the lines of those used in the US. NSW Health is developing a toolkit for hospitals on responding to the data and assessing its implications.

6 HCUPnet, Healthcare Cost and Utilization Project. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/data/hcup/hcupnet.htm>

7 <http://www.dhs.vic.gov.au/ahs/vhcd9697/over.htm>

8 aimsinfo.health.vic.gov.au/vhcd199798mainpage.htm

The Task Force suggests that query tools be developed to enable both specialist and non-specialist users to draw valid and reliable conclusions from the data. All data collected against a suite of performance indicators along the lines proposed by the Task Force should be presented in a manner that will enable boards, executive management and the Department to review performance and compare performance with peer hospitals.

Clinicians must be able to compare the costs and appropriateness of a range of interventions and identify where improvements can be made. Such data could be provided through the Clinicians Health Channel. Public access to comparative information should be available via the Better Health Channel or a similar site.

Recommendations

17. The Department of Human Services should further encourage the use of comparative hospital data by developing web-based access, providing query tools and publishing regular analyses of comparative performance in specific areas. In the short term the Department should publish an annual compendium of basic performance data, to be released by 31 October.
18. The Department of Human Services should obtain Health Insurance Commission data on primary health care service utilisation and link them with admitted and other hospital utilisation data to enable a more complete picture of service utilisation patterns and trends to be made available to service evaluators and planners.

6. By comparing variations in practice patterns, clinicians and managers can focus on the appropriateness of care and identify where improvements can be made.

Professional colleges have a role in setting and maintaining clinical standards. This should be reinforced by regular clinical audit processes to explore and understand variations in service delivery.

Previously, audit was considered a way of 'correcting' bad practice. Audit is now recognised as a way of obtaining information with which to compare clinicians, hospital and units, to establish the *status quo*, reflect on opportunities for service improvement and change systems to achieve better health and financial outcomes for the community.

There should be a system focus on clinical audit, actively seeking out differences in practice and facilitating work with the colleges to explore and understand differences in service delivery. This could be done with the involvement of the Council of Clinical Leadership proposed by the Task Force (Recommendation 5).

Professional colleges have a role in setting and maintaining standards and their participation in establishing the tools and providing guidance with the implementation of clinical audit is therefore important. Also, colleges provide forums for the presentation and validation of new techniques.

Structures and processes that enable clinicians and managers to focus on the appropriateness of care, and to identify where improvements can be made, include:

- Collection and dissemination of hospital-specific and provider-specific information on variations in admission rates and length of stay for certain procedures and conditions (for example, the rate of emergency department admissions for chest pain). Medical interventions and treatment pathways could be compared within specialty areas and across hospitals.
- Internal assessment and reporting by metropolitan health services of the extent to which well-established clinical guidelines are being followed by clinical staff in their hospitals.
- Enhancements to the Clinicians Health Channel to support the dissemination of timely, accurate and relevant data on variations in practice and improvement methodologies, as well as access to guidelines and protocols, and training and support links.

Inappropriate Admissions and Avoidable Hospitalisations

Evidence from the literature suggests that some admissions to emergency departments are inappropriate and could be managed differently.

It has long been observed that some emergency admissions, particularly of elderly people, occur because 'hospital beds may provide the only refuge for many people, despite their inappropriateness and expense'.⁹ Studies of inappropriate emergency admission in particular have produced widely varying estimates of incidence, depending largely on the instruments and methods used to assess inappropriateness. However, there is some convergence in estimates of the rate of clinically inappropriate emergency admission for older patients at about 20 per cent.¹⁰

The clearest definition of inappropriateness is provided by Coast (1996b),¹¹ who described avoidable admissions as 'those patients for whom there may potentially be a lower technology alternative to admission to the acute hospital'. Coast also distinguished between an inappropriate admission and an avoidable hospitalisation. An avoidable hospitalisation does not mean that the patient has no requirement for care in the acute hospital at the present time. An

continues

9 Barlow J, Brodhurst S, Perman-Howe P. Fast movers. *Community Care*, 1996 March 21–27:24–25

10 Goddard M, McDonagh M and Smith D, *Acute Hospital Care: Final Report*, York Centre for Health Economics, 1999

11 Coast J. Appropriateness versus efficiency: the economics of utilisation review. *Health Policy* 1996;36:69–81

inappropriate admission is therefore the hospitalisation of a patient when a better alternative exists. While avoidable hospitalisations are not currently inappropriate, they may become so if the health care system were to be reorganised in some way.

In a Scottish government study reviewing emergency pressures (May 1998), doctors interviewed agreed that 10 per cent of patients would have not have been admitted if they could have been adequately supported in their own homes.

‘The patients’ perspective was also investigated and 40 per cent of patients interviewed would prefer home/community based outpatient treatment in the event of another episode of the same or similar illness.’

A review in the North Health region of New Zealand between 1992 and 1996¹² showed that about 15 per cent of public hospital admissions for people under 65 years of age could be prevented, or at least controlled, by providing quality primary care. Cardiac and respiratory conditions predominated among the ‘avoidable’ conditions defined in the review. It also found that rates of avoidable admissions were highest among people in the lowest socio-economic groups.

Recommendation

- 19 In collaboration with professional colleges and organisations and the industry, the Council of Clinical Leadership or other agreed body, should establish specific targeted collaborative projects that enable clinicians and managers to focus on the appropriateness of care, and to identify where improvements can be made.

7. New technologies are rapidly opening up new options for health care delivery.

Health services in Victoria and Australia have been slow in adopting new communications and information technologies that could significantly improve the responsiveness of service delivery. The Task Force’s papers on emergency services, hospital care for older people and multi-day elective admissions have identified opportunities to improve patient management through:

- Better clinical decision support applications (order-entry systems, results reporting, scheduling and so on).

¹² Jackson G, Kelsall L, Parr A and Papa D, *Socio-economic inequalities in health care: a preliminary analysis of the link between health status and socioeconomic status in the North Health region*, North Health, Auckland, 1998.

- Enhancing the Clinicians Health Channel (for web access to clinical pathways and guidelines, comparative rates and so on) and Better Health Channel (for local service information and consumer health information).
- Telemedicine/telemanagement to expand hospital in the home.
- Links between providers and clinicians, such as real-time emergency department waiting time information available on screen for general practitioners.

Clinical care is the core business of health services and a key information principle is that all information should be a by-product of clinical care. Yet, clinical data in health services exist today largely as an electronic by-product of administrative functions.

Online Health

The Alfred Hospital will become the only hospital in Australia to be involved in a technology trial that allows doctors to communicate and share medical records online. The national Health eSignature Authority will allow doctors to share radiology and pathology results, medical profiles and referrals in a secure environment online. The Alfred will be linked to 20 general practice surgeries in Melbourne's South-East as part of the trial. (*The Age*, 10 March 2001)

A key benefit of new information technologies is improved patient safety and reductions in the risk of error. There are real opportunities for metropolitan health services to take full advantage of innovation in information and communications technology to deliver better patient care through process improvement. To improve patient management and clinical care, hospitals need systems that support clinicians to diagnose, treat and care for the patient at the bedside. These systems should enable hospitals to prospectively develop and then activate a care plan for each new patient, communicate this care plan to community providers who will take responsibility for the patient after discharge (enabling prospective management of resources), support comparative evaluation and inform clinical practice.

The Task Force sees the key priorities in Victoria as:

- Developing the use of information technology systems (including supporting the related organisational change that may be necessary) that would enable hospitals to monitor and plan better use of inpatient beds and other key resources, and manage better inpatient admission to hospital.
- Improving the links between patient management systems within and between hospitals and other care providers. This would initially focus on measures to support the process improvement initiatives proposed by the Task Force, such as increasing diagnostic response times, the provision of computerised discharge information to GPs,

There are real opportunities for metropolitan health services to take full advantage of innovation in information and communications technology to deliver better patient care through process improvement.

and transferring information from the emergency department to other parts of the hospital.

- Developing telemedicine and telemanagement options, so that clinicians can exchange diagnostic information and provide immediate care in remote locations (for example, in the home, to support expansion of hospital in the home options).
- Linking clinical systems such as the ordering of pathology tests, radiology examinations and consultations, and dispensing of drugs. By enabling rapid and reliable transfer of this information, time lost waiting for, or searching for diagnostic results can be minimised.
- Creating the capacity to deliver information for clinical decision making to health care providers at the point of care.

Victoria is a small IT market, made much smaller by fragmented purchasing, with a vendor market that has limited offerings to the health industry. It is likely that a centrally coordinated approach would optimise benefits for health services.

The benefits of an electronic health record and unique patient identifier are well established and much work has already been done to plan for and introduce these initiatives. From a patient management perspective, they can help by providing clinicians with relevant information about a patient, and by enabling electronic transfer of essential treatment information when a patient presents to another clinician or health service. The Task Force supports the implementation of these innovations across the metropolitan health services as soon as possible to build on the developmental work done through the Victorian Hospital Patient Register Working Group.

Recommendations

20. As soon as possible, the Department of Human Services in collaboration with health services should develop, communicate and implement a strategic plan outlining the ways in which Victorian hospitals will use proven clinical support applications to improve patient safety and support patient management practice improvement.
21. The Department of Human Services should take a stronger role in mandating priorities for information technology systems, and fostering collaboration among metropolitan health services in information systems management and development.
22. The Department of Human Services should continue to work towards the creation of an electronic health record subject to appropriate privacy and confidentiality requirements. An electronic health record incorporating a unique patient identifier is an important early step in this process.

8. Coordinated, metropolitan-wide planning is needed to ensure a balance between overall system-wide performance and individual health service performance.

In its deliberations on best practice in managing multi-day admissions and delivering emergency services, the Task Force has noted that service and hospital planning are key drivers of system-wide development. It has pointed to the need for clustering of services across geographical areas (such as emergency services clusters), the opportunities presented by streaming of patients (such as by focusing particular campuses on elective surgery) and on the need to balance access and safety/quality objectives. For some services which are generally once or twice in a lifetime event for any given individual, proximity to home is much less significant than for treatments which require frequent and regular hospital attendances. Planning should involve 'rezoning Melbourne' to take this into account.

Service and hospital planning are key drivers of system-wide development.

These are the key themes in hospital role delineation:

- Encouraging greater networking and inter-hospital coordination, with metropolitan Melbourne as one city of networked hospital services, each performing complementary roles but not providing all services in every location.
- Fostering greater specialisation in certain areas (such as ophthalmology, paediatrics and acquired brain injury), to deliver safety and quality benefits to patients as well as cost advantages to the community.
- Supporting the development of elective surgery campuses to enable well-planned schedules with very high occupancy and concentrated resources. This will provide benefits to patients on waiting lists, particularly in terms of timely and predictable access.
- Developing the outer metropolitan services as general hospitals providing a broad range of basic services and having close relationships with the higher intensity specialist services at hospitals nearer to the city centre.

The development of a metropolitan health services plan by the Department provides an opportunity to address these issues. The Task Force believes that the development of the plan should be an iterative process, with the metropolitan health services closely involved. It should take account of the views of the professional colleges and other professional bodies, as well as stakeholders such as universities.

Recommendation

23. The metropolitan health services plan, to be prepared by the Department of Human Services in collaboration with metropolitan health services and expert clinicians, should:

- Tackle the uneven distribution of access to some services across the metropolitan area to ensure better access to forms of treatment that patients use frequently and regularly (such as dialysis).
- Determine the location of key specialist clinical services.
- Address the role and function of outer metropolitan general hospitals in the broader network of health services.
- Provide sufficient detail to inform the development of metropolitan health services strategic plans during 2001–02.

9. Commonwealth Government policies in relation to Commonwealth-funded primary care and aged care services have a strong impact on public hospital performance.

In its papers on emergency services and hospital care for older people, the Task Force referred to the development of an emergency to home care outreach service in South Australia. It noted that special funding for the service has continued and the hospital has extended referral rights to a selected group of local general practitioners, with strict criteria designed to ensure that the service is not used as a substitute for community-based care.

The ability of hospitals to manage the in-hospital phase of a person's health care is inextricably linked to the pre- and post-hospital phases.

General practitioners and residential care providers (both areas of Commonwealth responsibility) are key partners in minimising unnecessary demands on hospital emergency departments and optimising the flow of patients through the hospital when they do need to be admitted. The effect of private health insurance changes on the private hospital sector is another area where Commonwealth action can have profound impacts on public hospital care.

There are real opportunities to make improvements and the Commonwealth can play a constructive role in achieving this change:

General Practice

- Using information and communications technology to link general practice to other parts of the health system.
- Building links between general practitioners and other parts of the system, and providing greater financial incentives for GPs to provide after hours and home (including nursing home) visits.
- Co-location of GPs in emergency departments.

Private Hospital and Residential Care Sector

- Shifting of complex, often chronic care patients from the private hospital system to the public sector.
- Building links between public hospital outreach units and aged residential care (including nursing home) visits.
- Improving access to aged residential and community-based care.

The Task Force has observed that adequate provision of aged residential and community-based care is a key element in the capacity of hospitals to manage their patient flows and that Victoria has called for urgent Commonwealth action on this matter.

The Task Force has noted the recent decision of the Commonwealth to increase the Medicare rebate for after-hours GP consultations. However, more can be done at the local level to improve access. The Task Force proposes a joint project with the Commonwealth to establish hospital-based GP out-of-hours services. The project would:

- Identify best practice in existing services.
- Review evidence relating to out-of-hours care to ensure initiatives have an evidence base.
- Develop links with the Better Health Channel and the Clinicians Health Channel.
- Develop standards.
- Develop recommendations on funding arrangements.

Recommendations

24. The Department of Human Services should work with the Commonwealth to improve links between GPs and other parts of the health system, such as hospitals, and to provide adequate incentives for GP after hours services.
25. The Department of Human Services should negotiate with the Department of Health and Aged Care to pilot a Commonwealth-funded program of hospital-based GP locum services.

10. Informing the community and involving patients in their care will deliver better patient outcomes and improve system efficiency.

The Task Force has identified several areas in which consumer and community participation are essential to improved practice and better access to care when it is needed. Victoria has taken a lead in supporting and promoting the uptake of research evidence into clinical practice and health care service delivery to get the best health outcomes for consumers. This is a complex process, involving not just knowledge, but behavioural, social, organisational, and economic aspects. It involves:

- Supporting the production and dissemination of evidence-based approaches.

- Maximising use of evidence in acute health service delivery.
- Supporting and evaluating organisational strategies which promote safe, effective care.
- Promoting consumer participation in decision-making.
- Promoting innovative service models that enhance service responsiveness and effectiveness for groups with special needs.

Information needs to be provided to consumers to enable them to exercise informed choice about where to go for treatment. As well as authoritative information and advice about particular conditions and treatments such as that provided on the Better Health Channel, consumers need information about access to services. For example, by providing hospital-specific waiting times for elective surgery, patients could choose to seek treatment in a hospital with shorter waiting times than at their local hospital.

The Task Force has recommended that the Department should commission an appropriate peak body—one with experience in community education about health issues and the provision of information to consumers—to develop community information and education strategies to support the shift to ambulatory care.

Opportunities for consumers and communities to participate in decisions about the type and location of health services are being provided through the metropolitan health services' community advisory committees. Mechanisms are still needed through which consumers can have a real say in making the difficult choices about priorities that need to be made. In the United Kingdom and some other countries, citizens' juries have been employed to help make such choices.

Citizens' Juries

Citizens' juries¹³ are an attempt to involve the public in decisions which affect their own communities. Out of concern at the low level of public involvement in democratic processes, citizens' juries were piloted in the United Kingdom in 1996 and 1997. Adapted from similar approaches in America and Germany, they have since raised a great deal of interest across Britain.

Methodology

A small group of ordinary people (12–16) are recruited to be broadly representative of their area. Asked to address a question or questions on an important planning or policy matter, they sit for up to four days, assisted by independent moderators. They are informed about the issue, cross-examine witnesses and discuss the matter fully. Their conclusions are compiled in a report, which is submitted, subject to

continues

¹³ Source: Institute for Public Policy Research ([http://www.pip.org.uk/models.htm#Citizens' Juries](http://www.pip.org.uk/models.htm#Citizens%20Juries))

jurors' approval, to the commissioning body. The commissioning body is expected to publicise the jury's findings and either follow the recommendations, or explain why they have not been adopted.

Involving citizens

A citizens' jury involves ordinary members of the public in their capacity as citizens, not as service users, experts or members of any interest group.

A collective civic voice

Jurors are asked to take part in a serious civic task: developing a shared view of the question/s they have been asked to address. The style of moderation and the way the agenda is structured reflects this objective.

A public, democratic mechanism

The citizens' jury is a complement to existing bodies and other forms of public consultation, not a replacement. They are part of 'open government' and take place in the public domain.

A unique combination

Time scrutiny, deliberation, independence and authority.

Examples

- Walsall Health Authority (August 1996) *Priorities in palliative care—choosing between four models*
- Fife Council (March 1997) *Creating Job Opportunities in a deprived area*
- Independent Television Commission (November 1997) Taste and decency on television—principles for judging what is and what is not acceptable on television. (2 juries)

The Internet has revolutionised information flows, with 43 per cent of Australian adults having used the Internet and 28 per cent of households now connected to the Internet.¹⁴ People commonly use the Internet to obtain health-related information. The development by the Victorian Government of the Better Health Channel (and more recently the Clinicians Channel, which is partially accessible to the public) is one response to this. The result is that many patients and their carers are now more knowledgeable about the possibilities, efficacy and risks of particular interventions. However, as the population ages, more people will experience two or more conditions at the same time and information about the complexities of multiple therapies, and their interaction, is not available on the Web.

¹⁴ Australian Bureau of Statistics. 2000. *Use of the Internet by householders*. Cat No 8147

Initiatives to assist clinician–patient communication and improve clinical and care management information flows are likely to have significant benefits for chronically ill patients.

Health professionals may be placed in the difficult situation where patients can be more informed than they are regarding health management. It has been identified that for clinicians to keep up to date with advances in drugs, treatment technologies and alternatives, they would need to read 19 articles per day, every day of the year. In the USA, so-called patient helpers—interested and knowledgeable patients with time to explore the Internet and sift information—have been found to be of value to both clinicians and fellow sufferers alike.¹⁵ A variety of other specific projects are underway to improve information flows to consumers via the Internet. For example, the Women’s and Children’s Health Service is developing a way of making each patient’s record available to that patient over the Internet. The Centre for Clinical Effectiveness at Monash University is currently managing an initiative that aims to give patients at Monash Medical Centre improved access to the main clinical information database used by the hospital itself.

Initiatives to assist clinician–patient communication and improve clinical and care management information flows are likely to have significant benefits for chronically ill patients. For example, the Sharing Health Care initiative is part of the Commonwealth’s Enhanced Primary Care Package and is based on evidence that self-management education and training, incorporating self-efficacy principles, results in many positive outcomes for people with chronic conditions. Benefits include increased self-confidence, more effective management of stress and pain, and improved opportunities to learn from and support others with the same or similar conditions. Skills learnt in self-management programs have been shown to complement medical treatment, rehabilitation and disease-specific self-care effectively.¹⁶ Some hospitals give their patients the clinical pathway for their particular condition as part of the pre-admission process. Patients know what to expect, are likely to be less anxious and are better placed to point out to the clinician where they think their case may be different.

In 1999–2000, 712 complaints made to Victorian public hospitals related to communication problems.¹⁷ This represented 31 per cent of the total number of complaints. The cost of this may be significant. There are approximately 150 complaints liaison officers or patient representatives in Victoria in the public and private sectors.¹⁸ While the full-time equivalent staffing will be smaller than this, resolving complaints can take up substantial amounts of clinical staff and hospital management time. Improving communication with patients and their families, to the extent that this can reduce complaints, can result in cost savings.

15 New York Times. Patient Power, June 25, 2000

16 Department of Health and Aged Care. *Sharing Health Care* at www.health.gov.au/pubhlth/strateg/chronic/

17 Health Service Commissioner. *Annual Report 1999–2000*.

18 Health Service Commissioner. *Annual Report 1998–99*.

Recommendation

26 Metropolitan health services and the Department of Human Services should continue to develop ways of informing their communities and involving patients in their care.

11. Bringing about clinical practice and patient management process improvements will depend on commitment from metropolitan health services working with each other and supported by the Department.

One of the Task Force's key themes is the need for greater collaboration and systematic analysis, comparison of performance and sharing of knowledge. To achieve this, there will need to be a closer alignment of the work of a range of groups. The main candidates to play a leading role are:

- Department of Human Services (for example through the funding guidelines)
- Informal and ad hoc collaborative groups
 - Department of Human Services and industry (such as the Emergency Breakthrough Collaboration)
 - Industry only (such as the metropolitan chief executive officers group)
- Established groups
 - Ministerial Advisory Committees (such as the Ministerial Emergency and Critical Care Committee) and Consultative Councils (such as the Consultative Council on Anaesthetic Mortality and Morbidity)
 - Professional colleges (such as the College of Surgeons) and associations (such as the Victorian Healthcare Association)

With respect to implementing practice and process change within hospitals, the Department can help (for example, through the Designing Care initiative) but ultimately, it is the metropolitan health services that must take collective and individual responsibility for putting the changes into practice. While there are several formal and informal bodies to support interchange of ideas and joint action across hospitals and health services, none is currently set up to fulfil the role of initiating and sustaining the necessary change processes.

The Task Force believes that metropolitan health services must set up such a coordinating body. The coordinating group should be at a very senior level and capable of putting into action the key themes that underlie many of the Task Force's recommendations: fostering collaborative arrangements and learning across hospitals, encouraging more assertive use of performance indicators and benchmarking and supporting patient management practice change (such as day of surgery admissions and the shift to ambulatory care), as well as particular initiatives (such as the establishment of emergency services clusters). For these reasons, the Task Force believes that the chief executive officers forum should take on

Implementing the Task Force's recommendations will require concerted action by metropolitan health services, the Department of Human Services and other professional groups.

responsibility for driving and monitoring the implementation of its key recommendations to health services. The forum should:

- Have a formal work program and executive support.
- Develop an implementation plan which spells out priorities, time frames and responsibilities—and monitor progress.
- Critically assess the results of the various initiatives.
- Work with the Department on issues that require its support.

Recommendations

27. Metropolitan health services should establish a forum for chief executive officers to guide the implementation of strategies that will foster best practice in patient management.
28. Each metropolitan health service should review the Task Force's findings and recommendations to identify the key areas for priority attention. Planned action on these priority areas and necessary support from the Department should be documented as part of the 2001–02 health service agreement.

Appendix 1: Patient Management Task Force

Terms of Reference

1. To identify essential organisational and patient management practices that should be in place in all hospitals.
2. To determine the extent to which these practices are occurring in metropolitan health services, identify specific areas where improvements should occur and advise on how these improvements could be quickly achieved.
3. To determine key indicators of good patient management practice and the benchmarks that should be achieved by health services.
4. To advise on incentives and other strategies that could be used to encourage health services to achieve benchmarks.
5. To communicate and engage with representative bodies of health professionals, practitioners, managers and other stakeholders in identifying and implementing good patient management practices.

Membership

Dr Michael Walsh (Chair), Chief Executive, Bayside Health

Dr Jim Breheny (Deputy Chair), Chair, Austin and Repatriation Medical Centre Board

Professor Gordon Clunie, Chair, Ministerial Advisory Emergency and Critical Care Committee

Ms Ella Lowe, Executive Director Operations, Peninsula Health

Mr Robert Burnham, General Manager, Northern Hospital

Dr Heather Buchan, Assistant Director, Quality and Care Continuity Branch, Acute Health Division, Department of Human Services

Mr Geoff Lavender, Regional Director, Barwon-South Western Region, Department of Human Services (Project Director)

Project Team

Ms Robynne Cooke, Austin & Repatriation Medical Centre

Ms Julie La Gamba, Acute Health Division, Department of Human Services

Mr Nick Legge, Aged, Community and Mental Health Division, Department of Human Services

Mr Peter Lewis, Acute Health Division, Department of Human Services

Mr Amos Yee, Acute Health Division, Department of Human Services

Appendix 2: Case Study, Royal North Shore Hospital

The Division of Medicine at Royal North Shore Hospital (RNSH) took responsibility for dealing with problems of restricted access to the emergency department and difficulties with patient access to ward beds. Complete elimination of restricted access at RNSH over eight months has meant that the hospital, formerly one of the worst performers in New South Wales, is now demonstrating best practice in appropriate bed utilisation.

A collaborative approach characterised by strong executive support, team-building and cooperation between clinicians from nursing, medical and allied health disciplines, together with innovative clinical solutions, brought about remarkable improvements in patient access to Royal North Shore Hospital.

Structural Changes

- Emergency department incorporated into Division of Medicine.

Policy Changes

- Restricted access; weekend leave; over-census beds.

Team-building Initiatives

- Daily meetings with divisional nursing unit managers, clinical supervisor and bed manager.
- Friday afternoon meetings with all medical registrars, divisional medical and nursing heads, clinical supervisor and bed manager.
- Data provided to medical staff on clinical practice variation, such as length of stay.

Clinical Initiatives

- Ambulatory care ward open 7 days per week, with extended after-hours service. Currently treating 700 patients per month who previously required inpatient beds.
- Early morning blood collection for patients awaiting results prior to discharge.
- Day-only angiography, including patients transferred from other hospitals.
- Fax referral to rehabilitation beds to expedite transfer.
- Weekend discharge rounds by divisional medical head and clinical supervisor.

Accommodation Initiatives

- Reconfiguration of beds to short-stay.
- Use of off-site residential accommodation for patients not requiring inpatient beds.
- Free patient transport (taxi vouchers, hospital transport) provided to facilitate discharge.
- Nursing home liaison committee established.

A range of measures was applied across the hospital. While each initiative by itself may seem relatively straightforward, the consistent application of the whole package has effectively eliminated the problem of restricted access at RNSH since October 1999.

The sustained, consistent application of these initiatives by a determined team, with strong leadership support has also increased surgical activity in the winter months, when there was previously a reduction caused by higher demand for emergency admissions.