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ABF PCSI Conference 2017

Preparing for safety and quality changes – HACs

13 October 2017

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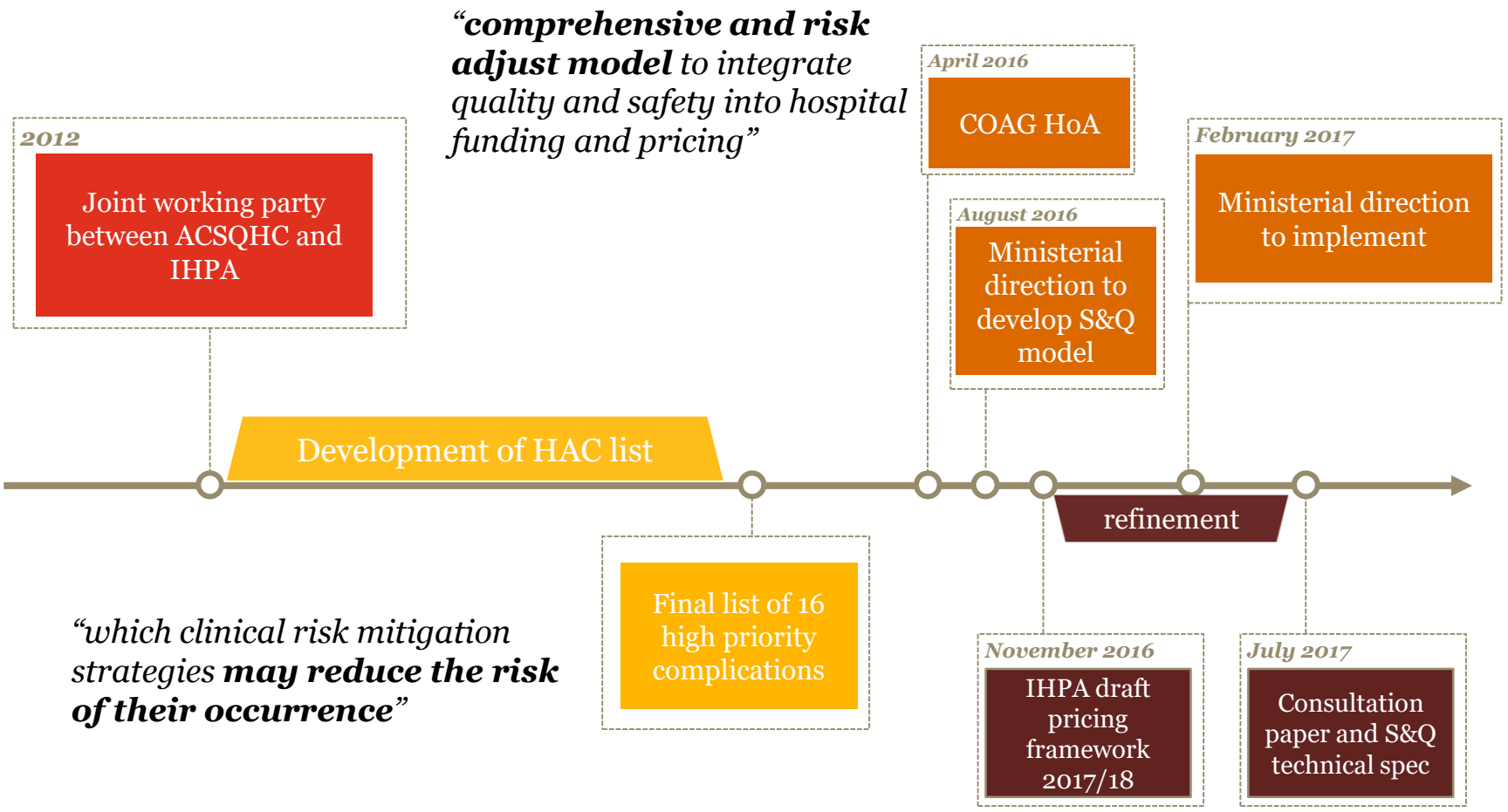
Agenda

- Data collection
- Reporting
- Education and clinical engagement
- System considerations

Where are we now?



Complication	Diagnosis
01 Pressure injury	• Stage III ulcer • Stage IV ulcer • Unspecified decubitus ulcer and pressure area
02 Falls resulting in fracture or intracranial injury	• Intracranial injury • Fractured neck of femur • Other fractures
03 Healthcare associated infection	• Urinary tract infection • Surgical site infection • Pneumonia • Blood stream infection • Central line and peripheral line associated bloodstream infection • Multi-resistant organism • Infection associated with prosthetics/implantable devices • Gastrointestinal infections
04 Surgical complications requiring unplanned return to theatre	• Post-operative haemorrhage/haematoma requiring transfusion and/or return to theatre • Surgical wound dehiscence • Anastomotic leak • Vascular graft failure • Other surgical complications requiring unplanned return to theatre
05 Unplanned intensive care unit admission	• Unplanned admission to intensive care unit
06 Respiratory complications	• Respiratory failure including acute respiratory distress syndrome requiring ventilation • Aspiration pneumonia

Complication	Diagnosis
07 Venous thromboembolism	• Pulmonary embolism • Deep vein thrombosis
08 Renal failure	• Renal failure requiring haemodialysis or continuous veno-venous haemodialysis
09 Gastrointestinal bleeding	• Gastrointestinal bleeding
10 Medication complications	• Drug related respiratory complications/depression • Haemorrhagic disorder due to circulating anticoagulants • Hypoglycaemia
11 Delirium	• Delirium
12 Persistent incontinence	• Urinary incontinence
13 Malnutrition	• Malnutrition
14 Cardiac complications	• Heart failure and pulmonary oedema • Arrhythmias • Cardiac arrest • Acute coronary syndrome including unstable angina, STEMI and NSTEMI
15 Third and fourth degree perineal laceration during delivery	• Third and fourth degree perineal laceration during delivery
16 Neonatal birth trauma	• Neonatal birth trauma

National Safety and Quality Health Service Standards

Source: Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards (September 2012)*. Sydney. ACSQHC, 2012.

Data collection…things to consider in getting ready for 1 July 2018

Now

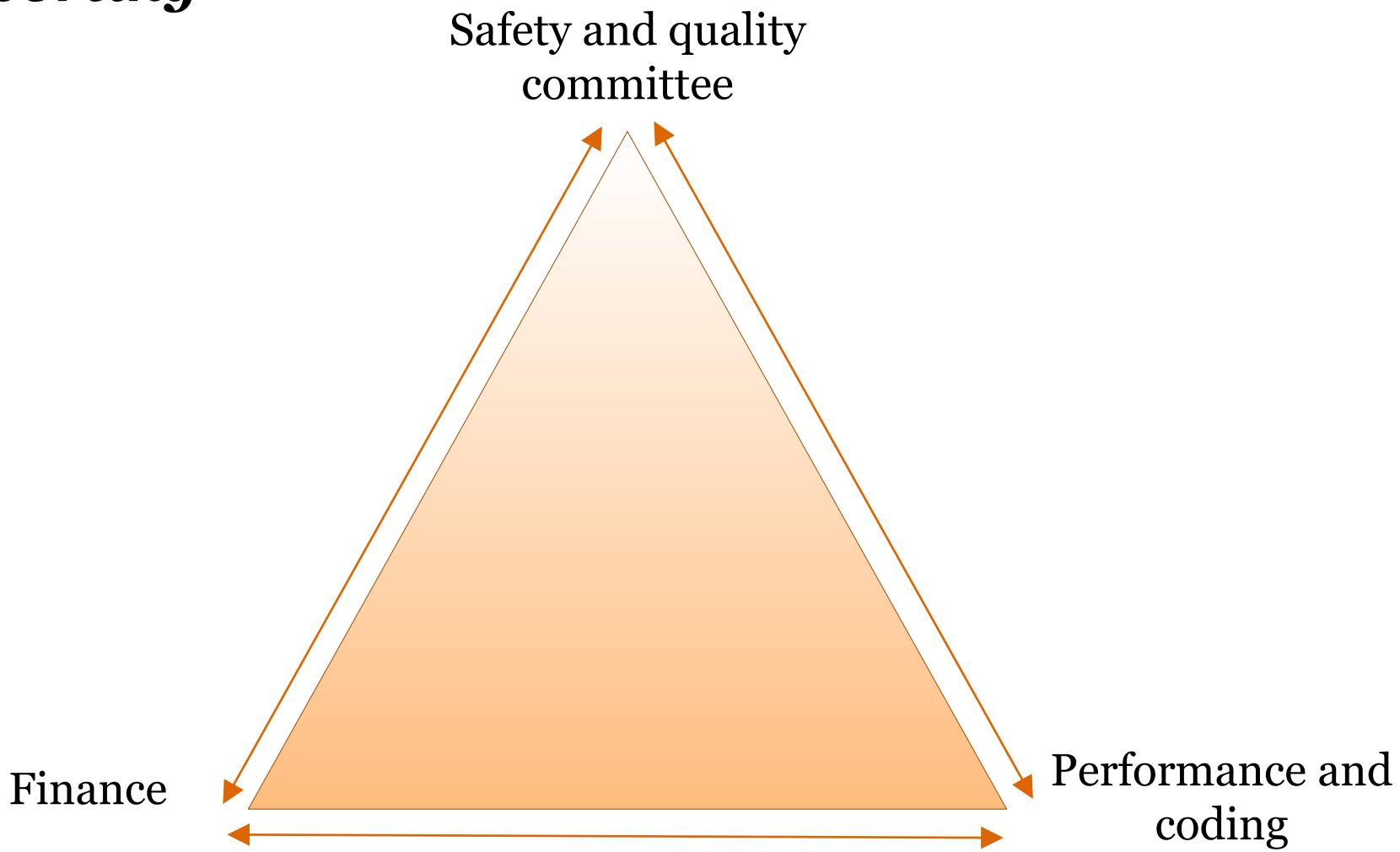
- What's currently being collected – national standards – not new data to collect.
- Existing processes for data collection and coding already in place but will become more important

Things to consider in getting ready

- Is there a difference in what currently collected (and reported) as safety and quality indicators in your organisation and the HAC list?
- Assess whether existing data collection and coding processes are adequate – e.g. frequency and quality assurance
- What other tools could help you in collecting data on HACs?

How should this be incorporated into clinical and financial decision making?

Reporting


Safety and quality committee
Finance
Performance and coding

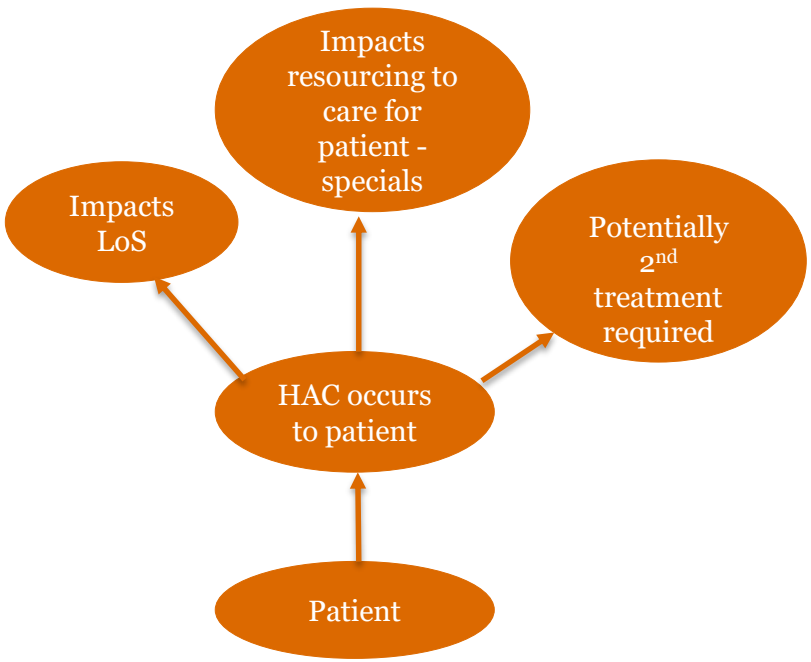
Some potential benefits…

- Bringing quality into the conversation - supported by finance – could help drive decision making, given the broader perspectives added to the conversation.
- Alignment of reporting PS&Q committees and finance can help with communication to assist front-line staff understand clinical decision making
- Greater link to patient pathways and monitoring of high risk patient areas through an understanding of the risk adjustment model
- Could drive greater coding, transparency and translation in data through the whole organisation

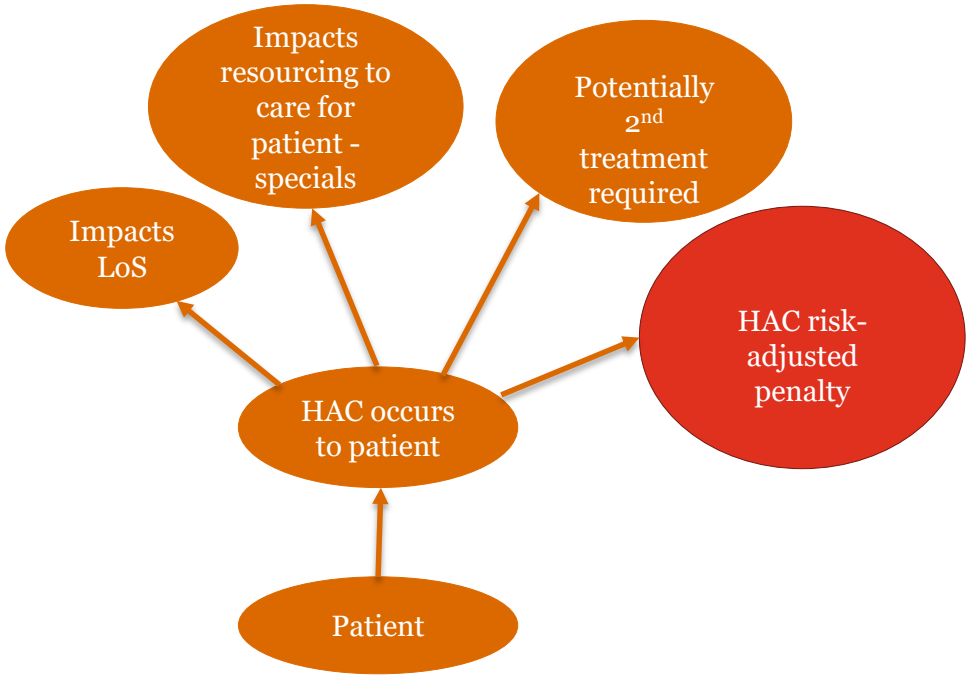
...and some more questions

- How will internal reporting need to change?
- What lessons might be learned through the shadow year to provide insights into risk areas and how this affects clinical pathway improvements?
- What strategy/methodology will be needed for the provision of the new HAC adjustment to ensure that the health system remains stable from a budget and cash perspective?
- How can you ensure quality and transparency of reported data?

Education and clinical engagement



Current

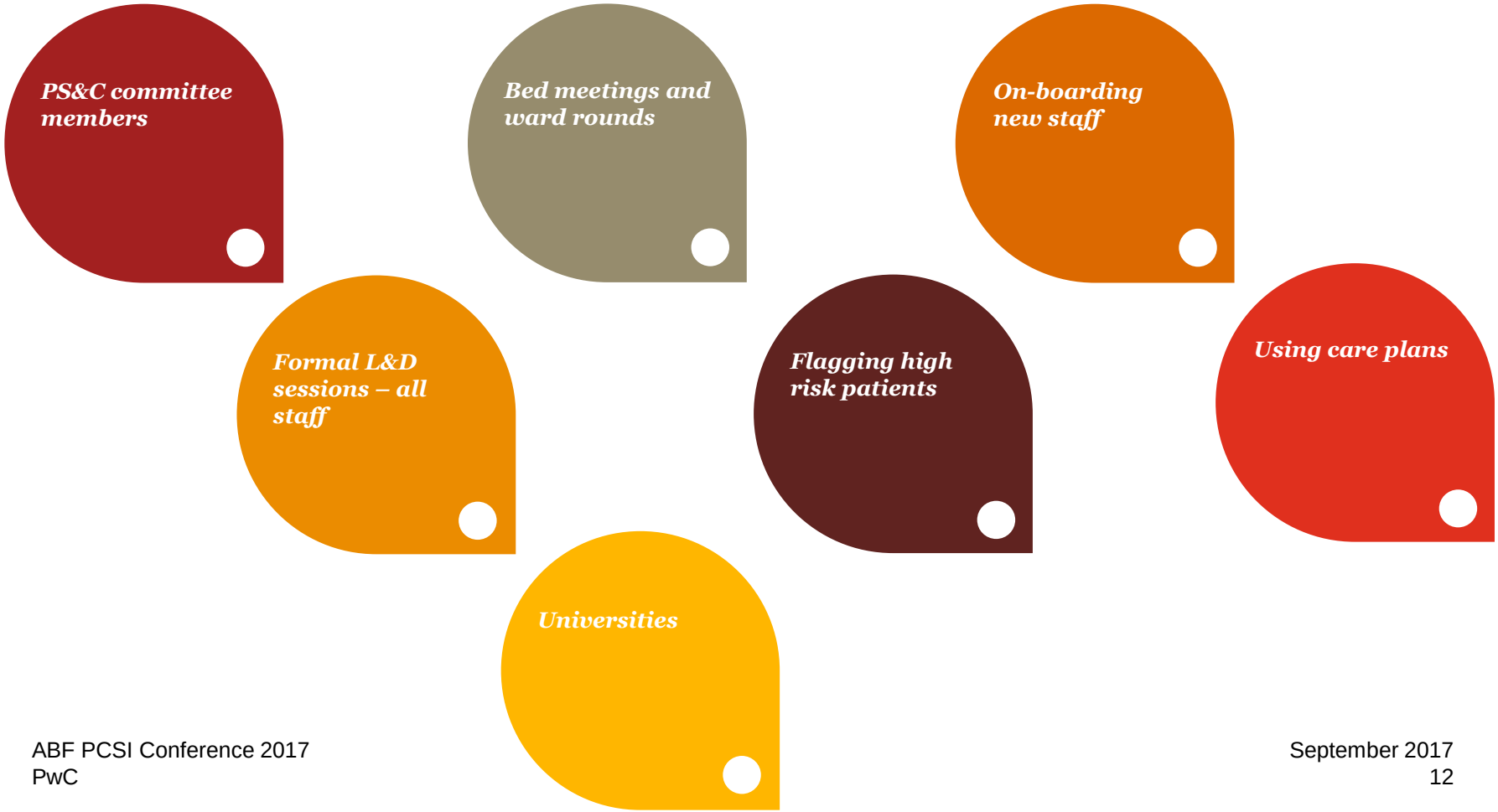


1 July 2018

Education needs to be targeted to all stakeholders. To understand ***why data is being collected for IHPA*** purposes and how this ***affects their day to day decision making*** in providing quality patient care

Ideas to drive engagement in your organisation

Identify ***roles who are accountable*** for ***driving the education*** – **Board to bedside**



System wide considerations

- Will there be national and state forums to discuss these new funding arrangements?
- Will learning be shared across States and Territories?
- Recognition that each State is different - some considerations might include rural vs metro for implementation of this change
- Is there anything that can be learnt from the Private Sector on this subject?

What next for your organisation?

Thank you