



On the Radar

Issue 378
16 July 2018

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On the Radar

Editor: Dr Niall Johnson niall.johnson@safetyandquality.gov.au
Contributors: Niall Johnson

Reports

Digital-first primary care and its implications for general practice payments
NHS England
London: NHS England; 2018. p.36.

URL	https://www.england.nhs.uk/2018/07/help-shape-modern-primary-care-says-nhs-england-as-part-of-nhs-long-term-plan/
Notes	Digital technologies have come to alter many aspects of our lives, but how they will re-shape healthcare is very much a work in progress. NHS England has released this paper seeking views on how healthcare systems commission, contract and pay for care that grasps the opportunities digital innovation offers while ensuring that new technology is safely integrated into health and care pathways and does not unfairly destabilise existing services. The paper sets out a number of ways in which the payments for general practice in the UK context may be updated to account for the emergence of digital-first access to primary care. These approaches may not withstand contact with the reality of the UK health system, but could serve as a useful concept to respond to – and to inform similar reflections in other settings/countries.

Investing in medication adherence improves health outcomes and health system efficiency: Adherence to medicines for diabetes, hypertension, and hyperlipidaemia

OECD Health Working Papers, No. 105

Khan R, Socha-Dietrich K

Paris: OECD Publishing; 2018. p. 39.

DOI	https://doi.org/10.1787/8178962c-en
Notes	<p>The authors of this OECD Health Working Paper observe that poor adherence to medications affects approximately half of the patient population, leading to severe health complications, premature deaths, and an increased use of healthcare services. They assert that three most prevalent chronic conditions – diabetes, hypertension, and hyperlipidaemia – stand out for their magnitude of avoidable health complications, mortality, and healthcare costs. Three broad reasons are identified for the low rates of adherence to chronic disease medications:</p> <ol style="list-style-type: none"> 1. The problem of poor adherence has rarely been explicitly included in national health policy agendas 2. Interventions tend to attribute the problem exclusively to patients, while the authors argue that the evidence suggests that health system characteristics – in particular the quality of patient-provider interaction, procedures for refilling prescriptions, or out-of-pocket costs – are key 3. Patients with chronic conditions frequently feel left out of the decision about their therapy and are inclined to not engage. <p>The paper suggests some enablers that for improving adherence to medication at the system level. These include:</p> <ul style="list-style-type: none"> • Acknowledge that the problem exists and to adequately recognise its main drivers. • Routine adherence measures as well as adherence-related quality and performance indicators should be encouraged in order to improve health system effectiveness and efficiency. • Shifting to payment systems that reward providers for the quality of patient outcomes would provide strong motivation to improve adherence. • Steer and support better adherence by enabling clinicians and patients and their communication.

For further information on the Commission’s work on medication safety, see

<https://www.safetyandquality.gov.au/our-work/medication-safety/>

For further information on the Commission’s work on health literacy, see

<https://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/health-literacy/>

For further information on the Commission’s work on shared decision making, see

<https://www.safetyandquality.gov.au/our-work/shared-decision-making/>

Journal articles

Implementation of a whole of hospital sepsis clinical pathway in a cancer hospital: impact on sepsis management, outcomes and costs

Thursky K, Lingaratnam S, Jayarajan J, Haeusler GM, Teh B, Tew M, et al.

BMJ Open Quality. 2018;7(3).

DOI	https://doi.org/10.1136/bmjopen-2018-000355
Notes	<p>Paper describing how one (Australian) cancer hospital devised, tested and implemented a sepsis clinical pathway that applied to the entire hospital. The process included establishing a multidisciplinary sepsis working party, process mapping of practices for recognition and management of sepsis, development and implementation of a clinical pathway document that supported nurse-initiated sepsis care, prompt antibiotic and fluid resuscitation. The project was evaluated using process and outcome measures for patients with sepsis were collected pre- and post-implementation. The results from 323 patients showed that time to antibiotics was halved (55 vs 110 min, $p < 0.05$) and that patients with sepsis had lower rates of intensive care unit admission (17.1% vs 35.5%), post-sepsis length of stay (7.5 vs 9.9 days), and sepsis-related mortality (5.0% vs 16.2%) (all $p < 0.05$).</p>

For information on the Commission’s work on healthcare associated infection, see

<https://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/>

Impact of Inpatient Harms on Hospital Finances and Patient Clinical Outcomes

Adler L, Yi D, Li M, McBroom B, Hauck L, Sammer C, et al

Journal of Patient Safety. 2018;14(2):67-73.

DOI	https://dx.doi.org/10.1097/PTS.0000000000000171
Notes	<p>Over the years there has been some discussion of the economics of patient safety. This US study reinforces the evidence that safe care is good for patients and good for business. The paper reports on a retrospective analysis of inpatient harm from 24 hospitals in a large US health system conducted during 2009 to 2012 using the Institute of Healthcare Improvement Global Trigger Tool for Measuring Adverse Events in order to determine the impact of all-cause inpatient harms on hospital finances and patient clinical outcomes. Of the 21,007 inpatients in the study, 15,610 (74.3%) experienced no harm, 2818 (13.4%) experienced temporary harm, and 2579 (12.3%) experienced harm. The study found that</p> <ul style="list-style-type: none"> • A patient with harm was estimated to have higher total cost, higher variable cost, lower contribution margin, longer length of stay, higher mortality probability, and higher 30-day readmission probability. • A patient with temporary harm was estimated to have higher total cost, higher variable cost, lower contribution margin, longer length of stay and higher 30-day readmission probability. • Total health system reduction of harm was associated with a decrease of \$108 million in total cost, \$48 million in variable cost, an increase of contribution margin by \$18 million, and savings of 60,000 inpatient care days. <p>This led the authors to the conclusion that their “all-cause harm safety study indicates that inpatient harm has negative financial outcomes for hospitals and negative clinical outcomes for patients.”</p>

NHS proposes to stop funding 17 “unnecessary” procedures
 Iacobucci G.
 BMJ. 2018;362:k2903.

DOI	https://doi.org/10.1136/bmj.k2903
Notes	<p>This news item in the <i>BMJ</i>, the NHS in England has proposed to stop funding 17 procedures it considers unnecessary, to save money and eliminate unwarranted clinical variation across the country. This is not to say that all the procedures are effectively banned but that should only be performed when specific clinical criteria are met. The 17 routine procedures are carried out about 350 000 times a year in total and cost over £400m a year. The NHS is aiming for what it termed a “moderate” reduction of around 170 000 procedures a year, which would save £200m.</p> <p>There are four procedures that should no longer be routinely commissioned unless a successful individual funding request (IFR) is made:</p> <ul style="list-style-type: none"> • Snoring surgery (in the absence of obstructive sleep apnoea) • Dilatation and curettage for heavy menstrual bleeding • Knee arthroscopy for patients with osteoarthritis • Injections for non-specific low back pain without sciatica <p>Then there are 13 procedures that should be commissioned or performed only when specific clinical criteria are met:</p> <ul style="list-style-type: none"> • Breast reduction • Removal of benign skin lesions • Grommets for glue ear in children • Tonsillectomy for recurrent tonsillitis • Haemorrhoid surgery • Hysterectomy for heavy menstrual bleeding • Chalazia removal • Arthroscopic shoulder decompression for subacromial shoulder pain • Carpal tunnel syndrome release • Dupuytren’s contracture release • Ganglion excision • Trigger finger release • Varicose vein surgery

For information about healthcare variation and access to the *Australian Atlas of Healthcare Variation* series, see <https://www.safetyandquality.gov.au/atlas/>

Electronic Health Records Associated With Lower Hospital Mortality After Systems Have Time To Mature
 Lin SC, Jha AK, Adler-Milstein J
 Health Affairs. 2018;37(7):1128-35.

DOI	https://doi.org/10.1377/hlthaff.2017.1602
Notes	<p>The introduction and implementation of innovation does not always proceed smoothly. The potential of systems such as electronic health records (EHR) to improve the safety and quality of care is understood but have not been fully realised. This article found that as systems (and their use) mature, the benefits are being realised. As has been observed, proving benefit realisation and return on investment is often not straightforward. The authors also note variation in impact and this reflects, in part, the importance of understanding context when introducing, implementing and embedding change in complex systems such as healthcare.</p>

For further information on the Commission’s work on safety in e-Health, see <https://www.safetyandquality.gov.au/our-work/safety-in-e-health/>

From pilot project to system solution: innovation, spread and scale for health system leaders

Shaw J, Tepper J

BMJ Leader. 2018 [epub].

DOI	https://dx.doi.org/10.1136/leader-2017-000055
Notes	From the specific of EHR to the more general in this piece on innovation and the role and purpose of ‘health system leaders’ in guiding such changes, especially when scaling up an innovation. Again, the importance of understanding context needs to be recognised. The authors of this piece recognise that successful spread and scaling of effective innovations does not just happen inevitably, but ‘conceptual clarity and well-defined strategies are essential’ along with the need to ‘generate interest, excitement and commitment for specific innovations from a broad community of stakeholders’.

Using a pediatric trigger tool to estimate total harm burden hospital-acquired conditions represent

Stockwell DC, Landrigan CP, Schuster MA, Klugman D, Bisarya H, Classen DC, et al.

Pediatric Quality & Safety. 2018;3(3):e081.

DOI	https://doi.org/10.1097/pq9.0000000000000081
Notes	This US study asserted that of 240 harms identified using an all-cause trigger tool at six children's hospitals, only approximately 25 per cent (58 of the 240) were covered by the definitions on the US Centers for Medicare and Medicaid Services (CMS) list of hospital-acquired conditions (HACs) that may then be used in reporting and payment strategies. This may be the case but it may also be something of a misunderstanding (or misrepresentation) of the role and purpose of a HACS list – which is rarely, if ever, meant to be a comprehensive list of possible complications. Rather they tend to focus on complications that are largely preventable, should not happen and potentially have serious complications. In some instances they may also have been influence by emotive or even political issues. Recognising that HACS are thus constrained, the conclusion that “to better understand and ultimately mitigate [all] harm, more comprehensive harm identification and quantification may be needed to address events unidentified using this approach.”

For information on the Commission’s work on hospital acquired complications, see

<https://www.safetyandquality.gov.au/our-work/indicators/hospital-acquired-complications/>

Physician Burnout, Well-being, and Work Unit Safety Grades in Relationship to Reported Medical Errors

Tawfik DS, Profit J, Morgenthaler TI, Satele DV, Sinsky CA, Dyrbye LN, et al

Mayo Clinic Proceedings. 2018 [epub].

DOI	https://doi.org/10.1016/j.mayocp.2018.05.014
Notes	Burnout and its potential impacts for safety and quality and the well-being of patients and staff, has been the subject of some attention in recent times. This piece adds to that literature by reporting on a survey of US clinicians on their perceptions and views on burnout. Based on the response from 6,995 physicians to a 2014 survey, the authors report that 3574 (54.3%) reported symptoms of burnout , 2163 (32.8%) reported excessive fatigue , and 427 (6.5%) reported recent suicidal ideation , with 255 of 6563 (3.9%) reporting a poor or failing patient safety grade in their primary work area and 691 of 6586 (10.5%) reporting a major medical error in the prior 3 months. Physicians reporting errors were more likely to have symptoms of burnout, fatigue, and recent suicidal ideation. The authors suggest that “Interventions to reduce rates of medical errors must address both physician well-being and work unit safety.”

URL	https://www.healthaffairs.org/toc/hlthaff/37/7
Notes	<p>A new issue of <i>Health Affairs</i> has been published with the themes ‘Chronic Care, Prescription Drugs, And More’. Articles in this issue of <i>Health Affairs</i> include:</p> <ul style="list-style-type: none"> • Interruptions In Private Health Insurance And Outcomes In Adults With Type 1 Diabetes: A Longitudinal Study (Mary A M Rogers, Joyce M Lee, Renuka Tipirneni, Tanima Banerjee, and Catherine Kim) • Population Health And Economic Impacts Of Reaching Chronic Hepatitis B Diagnosis And Treatment Targets In The US (Mehlika Toy, David W. Hutton, and Samuel So) • Specialty Drug Coverage Varies Across Commercial Health Plans In The US (James D Chambers, David D Kim, Elle F Pope, Jennifer S Graff, Colby L Wilkinson, and Peter J Neumann) • Growing Number Of Unsubsidized Part D Beneficiaries With Catastrophic Spending Suggests Need For An Out-Of-Pocket Cap (Erin Trish, Jianhui Xu, and Geoffrey Joyce) • Value-Based Insurance Design Improves Medication Adherence Without An Increase In Total Health Care Spending (Rajender Agarwal, Ashutosh Gupta, and A Mark Fendrick) • Financing Medicare Into The Future: Premium Support Fails The Risk-Bearing Test (Sherry A Glied) • Physician Perspectives In Year 1 Of MACRA And Its Merit-Based Payment System: A National Survey (Joshua M Liao, Judy A Shea, Arlene Weissman, and Amol S Navathe) • New Approaches In Medicaid: Work Requirements, Health Savings Accounts, And Health Care Access (Benjamin D Sommers, Carrie E Fry, Robert J Blendon, and Arnold M Epstein) • Is Inpatient Volume Or Emergency Department Crowding A Greater Driver Of Ambulance Diversion? (Renee Y Hsia, Nandita Sarkar, and Yu-Chu Shen) • Hospital-Physician Consolidation Accelerated In The Past Decade In Cardiology, Oncology (Sayeh S Nikpay, Michael R Richards, and D Penson) • Electronic Health Records Associated With Lower Hospital Mortality After Systems Have Time To Mature (Sunny C Lin, Ashish K Jha, and Julia Adler-Milstein) • Factors Contributing To Geographic Variation In End-Of-Life Expenditures For Cancer Patients (Nancy L Keating, Haiden A Huskamp, Elena Kouri, D Schrag, M C Hornbrook, D A Haggstrom, M B Landrum) • Transgender And Cisgender US Veterans Have Few Health Differences (Janelle Downing, Kerith Conron, Jody L Herman , and John R Blosnich) • Complicated: Medical Missteps Are Not Inevitable (Ilana R Yurkiewicz)

BMJ Quality and Safety online first articles

URL	https://qualitysafety.bmj.com/content/early/recent
Notes	<p>BMJ <i>Quality and Safety</i> has published a number of ‘online first’ articles, including:</p> <ul style="list-style-type: none"> • Speaking up about care concerns in the ICU: patient and family experiences, attitudes and perceived barriers (Sigall K Bell, Stephanie D Roche, Ariel Mueller, Erica Dente, Kristin O’Reilly, Barbara Sarnoff Lee, Kenneth Sands, Daniel Talmor, Samuel M Brown)

URL	https://academic.oup.com/intqhc/advance-access
Notes	<p><i>International Journal for Quality in Health Care</i> has published a number of 'online first' articles, including:</p> <ul style="list-style-type: none">• A centralized automated-dispensing system in a French teaching hospital: return on investment and quality improvement (Sarah Berdot; Virginie Korb-Savoldelli; Emmanuel Jaccoulet; Vincent Zaugg; Patrice Prognon; Laetitia Minh Mai Lê; Brigitte Sabatier)

Online resources

Advertising hub and online complaints

<https://www.tga.gov.au/advertising-hub>

The Therapeutic Goods Administration (TGA) has developed this 'web hub' that brings together news and information about the regulation of therapeutic goods advertising. The online hub contains tools for both consumers and advertisers, including fact sheets, e-learning modules and forms for reporting unfair or misleading advertising and submitting enquiries.

The new complaint form makes it easy for anyone to lodge complaints about advertisements for medicines and medical devices.

Consumers can use the hub to educate themselves on the rules that protect them against unfair or misleading ads for therapeutic goods. Fact sheets such as "The top 10 things to look out for in medicine advertisements" explain the controls in place to protect the health and safety of consumers. Advertisers can learn how to meet the requirements of a compliant advertisement through e-learning modules on the hub.

[UK] NICE Guidelines and Quality Standards

<https://www.nice.org.uk>

The UK's National Institute for Health and Care Excellence (NICE) has published new (or updated) guidelines and quality standards. The latest reviews or updates are:

- NICE Guideline NG99 **Brain tumours (primary) and brain metastases in adults**
<https://www.nice.org.uk/guidance/ng99>
- NICE Guideline NG100 **Rheumatoid arthritis in adults: management**
<https://www.nice.org.uk/guidance/ng100>
- Quality Standard QS33 **Rheumatoid arthritis in over 16s**
<https://www.nice.org.uk/guidance/qs33>

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