Our HARC eBulletin covers topics that have direct relevance to current and emerging healthcare policy issues in Australia.

In this edition, we cover a range of topics including: end of life care; midwifery-led care; monitoring the safety and quality of the health system; out of hours call centres for triage; and the implementation of initiatives to improve quality of care in the health system. Our selection is chosen on the basis of the topic rather than on the results – as you will see we report positive, negative and inconclusive results – so readers get a well rounded view of the evidence.

We look forward to seeing you all at our forthcoming HARC forum on public confidence in the hospital system, which will be held in early 2009.

Many happy returns for the holiday season.

Mary Haines,
Health Services Research Director

News

HARC Welcomes New Partner: Greater Metropolitan Clinical Taskforce

HARC was established in 2006 as a partnership between the NSW Clinical Excellence Commission and the Sax Institute to connect clinicians, researchers, policy makers and managers who are interested in improving hospital performance through research. We are delighted to announce that the Greater Metropolitan Clinical Taskforce (GMCT) has recently joined as a HARC partner because it enables HARC to be even more closely aligned to practitioners and consumers. GMCT’s Executive Director, Kate Needham, said “through HARC our clinical networks will be connected to the latest health service research that will help us to consider ways to improve the way healthcare is organised and delivered in NSW”.

To read more about the GMCT, please click here

CEC Research Partnerships 2008-09: Second Round Now Open

Each year, the CEC provides significant funds to support the work of the Centre for Health Record Linkage (CHeReL). As a member of the CHeReL, the CEC has accumulated significant linkage credits and wishes to allocate them to worthwhile research projects that have a safety and quality focus. CEC anticipates allocating up to $30,000 worth of linkage credits per project, although larger projects will be considered. Applications from researchers close on 19th February 2009. For more information, click here.

HARC Forum: Public Confidence in the Hospital System

In early 2009 we will convene a HARC forum on public confidence in the hospital system. The forum will focus on questions such as how can we ensure that the public are confident the hospital system will deliver high quality care when they need it, and how can we create better information systems to govern, manage and run a health care system to ensure public confidence. Our international guest speaker will be Diane Watson from the Centre for Health Services and Policy Research, University of British Columbia who has recently completed a research project examining public confidence with the Canadian health system. Further details about this forum will be circulated early in 2009.
Review Round-Up

Hospital At Home Patients Have Similar Outcomes To Acute Hospitals Inpatients

When the outcomes of hospital at home patients were compared with hospital inpatients in a new Cochrane review, there were no significant differences on measures of functional ability, quality of life, and cognitive ability. There was even some evidence that hospital at home patients fared better than inpatients; they had significantly lower mortality after 6 months, and reported higher satisfaction with care. Economic analyses (two were included) found that when the costs of informal care were excluded, hospital at home was less expensive than acute hospital care.

This review was conducted by two independent reviewers who identified 10 relevant randomised controlled trials with a total of 1333 patients. The meta-analysis included fewer trials (5) because it required individual patient data.

For a link to the review, please click here [cited 2008 December 12]

Midwifery-Led Care Benefits Mothers and Babies

This Cochrane systematic review found that midwifery-led care was associated with benefits for mothers and babies, and had no identifiable adverse effects. The independent reviewers identified 11 trials, with a total of 12,276 women, which compared midwifery-led care with medical-led and shared care. Midwifery-led care was found to lead to: lower rates of foetal death before 24 weeks gestation; fewer antenatal hospitalisations; lower analgesia and anaesthetic use; fewer episiotomies and instrumental deliveries; and shorter length of hospital stays. It was also associated with higher rates of spontaneous vaginal delivery and breast feeding, and women reported feeling more in control during labour and childbirth. Importantly, the review found no significant differences between groups in foetal and neonatal death rates. In light of these results, the authors conclude that all women should be offered midwifery-led models of care, and women should be encouraged to choose this option.

For a link to the review, please click here [cited 2008 December 12]

Implementation of Clinical Guidelines – No Silver Bullet

Clinical guidelines are more likely to be effectively used when a combination of implementation strategies, such as education and reminders, are employed.

This ‘meta-review’ (systematic review of published reviews) of the factors affecting the implementation of clinical practice guidelines included 12 systematic reviews. As well as the importance of using multiple implementation strategies, the review found guidelines were more likely to be implemented if: they were easy to understand; could be tried out first; did not require specific resources; health professionals were familiar with them; and they were supported by peers and superiors.

While this review provides the best evidence to date on the factors that affect the implementation of clinical guidelines, it points out that the evidence base is thin and further research is still needed.

For a link to the review please click here, [cited 2008 December 12]
End of life discussions with terminal patients are shown to be beneficial for patients and carers in this study published in the *Journal of the American Medical Association*.

This prospective cohort study of patients with terminal cancer was conducted in 7 sites across the United States (US). It included 332 patients and their carers. Results demonstrate that end of life discussions with physicians benefited patients because they led to: less aggressive medical interventions, such as ventilation and resuscitation; fewer admissions to intensive care wards; and earlier admission to hospices. Patients who did receive aggressive care also reported significantly worse quality of life, and their carers’ were at a higher risk of major depressive disorders during bereavement.

This study is the first to provide physicians with evidence that end of life discussions help rather than harm patients and their carers.

For a link to the research paper, please click here. [cited 2008 December 12]

**Patients Perception Of Hospital Care In 2400 US Hospitals**

Hospitals do not need to compromise quality clinical care in order to achieve high patient satisfaction ratings, according to this recent study published in the *New England Journal of Medicine*. After analysing data for more than 2400 US hospitals, this study is the first to find that hospitals reporting high levels of patient satisfaction also tended to provide high quality clinical care. Another main finding was that hospitals where patients were more satisfied with their care also had higher nurse-staffing levels.

Data in this study was obtained by correlating results from the national Hospital Consumer Assessment of Healthcare Providers and Systems, the American Hospital Association’s annual survey of hospital characteristics, and indicators of clinical care. While approximately two thirds of patients rated their care highly (that is 9 or 10 out of 10), there was still room for improvement. The main areas identified were nursing care, communication about medications, pain control, and provision of clear discharge instructions. An important methodological feature of this study is that it harnessed existing data for the analysis. The authors conclude that: “we are hopeful that regular reporting of performance on patient-reported measures of quality will catalyze similar improvements in patient-centred care”.

For a link to the research paper, please click here. [cited 2008 December 12]

**Clinician-Led Stroke Care Redesign Program Improves Quality Of Care**

This Australian study demonstrates that stroke units in hospitals improve the quality of care and lead to better patient outcomes.

Twelve new stroke units were established in NSW hospitals between 2001 and 2003, bringing the state total to 19. The Greater Metropolitan Clinical Taskforce’s stroke network assisted with their implementation by engaging clinicians and consumers on the design and implementation of this major reform in stroke care. The clinical network ran training and education activities, developed clinical protocols, and a data collection system for monitoring. The study compares patient and process outcomes before and after stroke units were established. Results for 15 hospitals and 1587 patients indicated that stroke units improved adherence to evidence-based practice. They promoted more timely access to brain imaging, neurological examinations, allied health assessments, and family meetings within 7 days of admission. As a result, patients admitted to stroke units had fewer severe complications, fewer disabling outcomes, and were more likely to be independent when discharged from hospital.
Stroke units are internationally recognised as the most effective treatment for stroke, but this study provides evidence of the benefits in the Australian context. The authors conclude that “the success of the GMCT stroke unit programme has resulted from, among other things, effective implementation of a government policy by the development of a strong partnership between stroke clinicians and health service management.”


**Out Of Hours Call Centre For Healthcare Advice Provides Poor Advice**

The quality of advice given to patients who phone out of hours call centres is poor, according to this study published in the *British Medical Journal*.

In this Dutch study, researchers presented 7 different clinical case scenarios to 17 out of hours call centres over a period of 12 months. The case scenarios presented concerned a child with a fever, an adult with a fever, a child with vomiting, and an adult with nosebleed. Specially trained nurses or physicians, or triagists, answered the calls. The way they responded to each scenario was assessed against predetermined standards.

Overall, triagists’ responses fell well below the set standard for each case scenario. Urgency was underestimated in 41% of calls, obligatory questions were only asked 21% of the time, and appropriate home management advice was only given 40% of the time. The authors conclude that the study results demonstrate that training for triagists is inadequate. They suggest that computer based decision support systems may improve the safety of telephone triage.


**A Network Of Trauma Hospitals Saves Lives**

This study published recently in the *Medical Journal of Australia* is the first outside North America to demonstrate that trauma care networks reduce in-hospital mortality rates. It evaluated the impact of a trauma network – the Victorian State Trauma System (VSTS), which involved: designating certain hospitals as major trauma services; specifying the role of other hospitals in the system of trauma care; developing triage guidelines for referral to major trauma services; and establishing the Victorian State Trauma Registry.

Using 5 years of linked data from the Registry, researchers found that the VSTS significantly reduced the likelihood of dying in a Victorian hospital following major road trauma or serious head injury. It also led to an increase in the number of referrals to major trauma services from other hospitals and directly from the site of the accident. From these results, the authors conclude that similar trauma networks should be implemented in all jurisdictions.


**What Are People Talking About?**

**Is Health Care Getting Safer?**

We don’t know if health care is getting any safer, according to this analysis piece published in the *British Medical Journal*. Charles Vincent, Professor of Clinical Safety Research at the Imperial Centre for Patient Safety and Service Quality in the United Kingdom (UK), points out that many countries have established local and national reporting systems in an attempt to reduce adverse events in hospitals. These systems, however, only detect about 6% of the adverse events identified by systematic reviews of patient records.

Using the UK National Health Service as a case study, Professor Vincent and colleagues
examine trend data for 9 indicators of safety and quality. The lack of reliable data made it impossible to determine the effectiveness of various safety initiatives in the UK. The authors recommended, among other things, that policymakers shift the emphasis away from “unsystematic voluntary reporting towards systematic measurement”, and develop systematic measures in order to improve the safety and quality of clinical care.

For a link to the article, please click here [cited 2008 December 12]


**Special Commission Of Inquiry: Acute Care Services In NSW Public Hospitals**

After 10 months of investigation, Peter Garling SC released his final report of the *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (the Garling Report) in late November 2008. It pointed out that although the NSW public health system was amongst the best in the world it had recently entered a “period of crisis”, prompted by the growing prevalence of chronic disease, chronic workforce shortages, and the rising cost of health care.

Amongst the 139 recommendations made, the report highlighted the urgent need for a new culture where patient’s needs were paramount. It also criticised the rigid demarcations between the roles of doctors and nurses, and promoted the increasing use of nurse practitioners. The work of networks of clinicians was also praised, and recommendations made that they have an expanded role in designing and implementing new models of care in the future. Other recommendations focused on independent ongoing monitoring and reporting on the quality of care delivered in NSW hospitals. The NSW government will formally respond to the recommendations of the inquiry in March 2009.

For a link to the report, please click here [cited 2008 December 12]

**What Do We Mean by Rigorous Health-Systems Research?**

Anne Mills and colleagues from the London School of Hygiene and Tropical Medicine stimulate the debate on how rigour is defined in health-systems research in *The Lancet*. They argue that the standards for rigour in medical research are largely inappropriate for health-systems research. Because this research mostly involves evaluating complex interventions with numerous inter-related causes, it is necessary to draw on a range of research methods from various disciplines to determine their effectiveness. The authors urge caution regarding the use of randomisation because it is often not feasible or valid in health-systems research. The authors offer alternative quasi-experimental research designs and methodological techniques for ex-post adjustments, such as propensity score matching and the opportunistic selection of control groups. They also emphasise the importance of systematically applying a theoretical model of how the healthcare intervention is meant to work when testing its effectiveness. They argue that researchers need to give greater consideration to processes and contextual factors so that well-designed pilot studies are not rolled out in inappropriate settings.

The authors hope that outlining ways to increase methodological rigour in health-systems research will lead to better understanding of this field and ultimately, better research that is vital to improving health-system performance.

For a link to the article, please click here [cited 2008 December 12]