Guest editorial:
Transformational quality systems require robust data – and robust data managers

Cathy Balding

Healthcare quality programs have been part of the healthcare landscape for many decades – or centuries, if we want to date back to early pioneers such as Florence Nightingale, and data have always been at the core of quality improvement. Nevertheless, a lack of valid and targeted data and measures renders it difficult to see the impact of all this improvement activity. Are healthcare consumers receiving better care? Are they safer now than they used to be? We would like to think so; at the very least the level of awareness of safety and quality issues is completely different from what it was even 20 years ago. But has that awareness translated into tangible change for every consumer? I am currently running a series of workshops on the topic ‘Getting Started as a New Quality Manager’ for The Australian Council on Quality Standards (ACHS). Many of the stories and problems raised in those workshops are exactly the same as I experienced when I started out over 20 years ago. What does this tell us?

Until the 1980s, the quality of care experienced by consumers depended significantly on the health professional caring for them. This person-depndant approach, while great for some patients, did not translate to a consistent and systematic approach to high-quality care for every consumer. In the 1980s and 1990s, health service managers began to develop more organisation-wide approaches to the quality of care provided, based largely on the introduction of total quality management (TQM) into healthcare. TQM emerged from manufacturing, and while it introduced a number of useful improvement concepts it was not always well adapted for the healthcare environment and culture, and alienated many clinicians.

The word quality itself began to take on a negative connotation for the many clinicians and staff who found themselves involved in administrative quality management activities that did not appear to have direct connections with improving care for patients. The quality manager, as bureaucratic keeper of the quality system, was increasingly labelled as ‘quality’ and therefore seen as responsible for all quality monitoring and improvement, rather than for the system to support monitoring and improvement. Towards the end of the 1990s, healthcare began to shape its own approach based on a combination of the various tools and strategies used up until that time, and adapted tools from other industries. Until the mid-1990s, however, there was still no common understanding or definition of quality care in healthcare or how the various pieces of the quality jigsaw should fit together. We still had person-dependent quality systems that relied heavily on the enthusiasm and drive of quality champions in each health service, with little idea of the return on investment in time and resources.

What changed all this was, of course, data. The 1990s saw the advent of public inquiries into poor care and large-scale studies into adverse events in various countries, and these were the circuit breakers. We found we were not quite as good as we thought we were, despite our years of accreditation and quality programs. We learned that errors and adverse events in healthcare across the world were at unacceptably high levels, and that it is indeed safer to go skydiving than it is to be admitted to hospital. Estimates varied depending on study variables, but the rate of adverse events was, and still is, in the order of 10% of all admissions, with some studies estimating it to be up to and beyond 30%. This equates to approximately 10,000 iatrogenic injuries per day worldwide. It is estimated that only about half of all patients receive evidence-based care and that important diagnoses are undetected in about 30% of cases. These problems and adverse events have a human and dollar cost: it is estimated that some adverse events increase the average case cost up to seven times. While a few of these problems can be attributed to rogue clinicians, we have had to come to terms with organisational and governance issues being at the root of most of the poor care issues (Braithwaite & Coiera 2010; Hindle et al. 2006; Classen et al. 2011; Ehsani, Jackson & Duckett 2006).

The combination of hard data and public exposure was powerful enough to restart our quality engines and send us down a more focused and, seemingly, effective track. In the face of this information we had to concede that our improvement efforts were not effective enough to prevent harm and poor care, ostensibly for two key reasons: there was nowhere near the same focus on formal governance of clinical care as there was for corporate matters, and our quality efforts were not targeted at the right priorities. Almost overnight, safety became the dominant dimension of quality programs, and clinical governance was developed as a system of accountability for the safety and quality of care. Over the last decade, clinical governance has grown and developed into a framework that encompasses features of our previous quality programs, but with a broadened scope of accountability and support systems, including staff roles, organisational culture and consumer participation (Balding 2008). Valid and reliable data in the dimensions...
of quality care, namely that they are safe, responsive, effective, appropriate, integrated and accessible, are key to effective governance, and yet we still do not have an agreed minimum quality dataset for governing bodies in the same way that we have for the reporting of financial data.

Progress is slower than we would like. The complexity of healthcare organisations and the system itself, multiple healthcare cultures and agendas, and perverse financial and political incentives make it difficult to achieve an agreed way forward. The new quality managers I meet are still struggling to collect and present good data that prompt action. As with corporate governance data, clinical data need to be of sufficient quality to fulfill a number of requirements: to tell the story of the quality of care consumers are receiving; set priorities for improvement; identify risk and problems with care; inform resource allocation; and drive the development and achievement of strategic quality goals. Meeting these needs is proving to be a challenge. An over reliance on incident data and a lack of understanding of other data sources on the part of many quality managers, together with the slow progress of automated clinical information systems, means that many quality systems, decisions and actions are not based on valid, reliable data.

But we are about to experience the game changer, and this will present many opportunities for Health Information Managers (HIMs). The first ever set of mandatory National Safety and Quality Health Service Standards (Australian Commission on Safety and Quality in Healthcare 2011), to be introduced from 1 January 2013, will raise the quality bar considerably. The Standards, developed by the Australian Commission on Safety and Quality in Healthcare (the Commission) as part of a broader review of accreditation in Australia, must be used as part of the accreditation process for all acute/high risk organisations from next year, and, as we see in the article by Way (2012), robust evidence will be required to demonstrate that the Standards are met. Much of this evidence will be derived from the patient record, via auditing or coding data.

This is just the beginning. Clinical standards, national quality indicators and national safety and quality goals are also in the pipeline (see Australian Commission on Safety and Quality in Healthcare website1). I have recently finished a review of small rural hospital issues with meeting the new Standards and found, not surprisingly, that data collection is one of their greatest concerns, with some of these concerns borne of limited knowledge of existing administrative and clinical data collection systems (Australian Commission on Safety and Quality in Healthcare 2012). Reinvention and duplication of quality data collection is an ongoing problem and may only be exacerbated as more hospitals move to collecting national indicators of safety and quality over the coming years.

Why wouldn’t I nominate the introduction of the personally-controlled electronic health record (PCEHR) as the game changer? There is no doubt that the PCEHR has the potential to significantly improve the safety and quality of healthcare, but if this implementation happens without a broader framework of focus, planning and monitoring, the quality gains made are unlikely to be either systemic or systematic. HIMs in regional health service and consulting roles are perfectly positioned to advise on data existence, collection, analysis and presentation within this changing environment, as noted by Westlake (2012) in her article in this issue of HIM-I on the HIM as quality manager, and can grab the opportunity to make themselves even more invaluable to their organisations. Without their input, it is likely that health services will find meeting the new Standards even more challenging, and in some instances, impossible. We do not want to see health service quality managers complaining about the same data problems in 10 years’ time! Let’s use the drivers presented by the Standards and the PCEHR to get quality governance information bedded down once and for all. HIMs should play a key role in this milestone, either in traditional roles or in quality management roles.

Finally, I would like HIMs to think about their role in the quality of care experienced by the consumers in their organisation. Just because they are not in a direct care position does not mean that their ‘back of house’ role cannot drive and support excellent care. Many quality systems address maintenance and improvement of care and services, with too few organisations using their quality governance structures and processes to pursue something more significant and sustainable for consumers. Of course, the HIMs in quality roles are already contributing to this, but all HIMs have a role to play. We do not ‘do’ quality; we use quality systems to monitor, improve and create quality care. Data can be used as a key component of progressing the organisation towards transformation in the way that consumers experience your care and services. A quality plan and system are only as good as the extent to which they impact on the care the consumer receives; supporting it to be good today, and driving it to be great over the long term. HIMs are the keepers of valuable knowledge about the current quality of care delivered by their organisations that can help them identify safety problems and improvement priorities, and to set goals for achieving quality care for every consumer, every time.

References
Australian Commission on Safety and Quality in Healthcare (2011). National Safety and Quality Health Service Standards. Sydney, ACSQHC.


1 www.safetyandquality.gov.au

Editorial


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