



GOVERNANCE & SERVICE QUALITY
FOR HEALTH & COMMUNITY SERVICES

Discussion Paper

Development of Clinical Governance Indicators for Benchmarking in Victorian Community Health Services

June 2010



Victorian Healthcare Association

Introduction

This discussion paper outlines the recent work of the Victorian Healthcare Association (VHA) Clinical Governance project ('the project') in developing indicators to support effective clinical governance in the Victorian community health sector¹. This work follows on from some earlier work completed by VHA in the development of clinical indicators in the areas of care planning, diabetes care and GP communication. Consultation with the sector over the life of the project has highlighted the need, not only for clinical indicators, but for broader governance indicators that can be benchmarked across the sector to inform assessment of service quality by managers, the executive and board. This paper outlines the rationale and methodology used to develop the clinical governance indicator set as well as presenting recommendations for future work.

Background

Clinical Governance is a key aspect of the governance arrangements within health care settings to ensure safe, high quality health services are delivered to consumers. The increasing acuity of clients being seen in the community and the recognition of the need to drive quality in primary health to enable a strong platform for the provision of primary health care services as the foundation of the health care system (NHHRC 2009:6) have underpinned the further development of clinical governance systems and processes in the community health sector in Victoria. One of the main organisational elements supporting effective clinical governance is access to information to assist in monitoring and evaluation of safety and quality at all levels of the organisation (VQC, 2005).

In 2007 the project developed a checklist of potential information sources that could be used by organisations as indicators to report to boards to address clinical governance responsibilities (VHA, Board of Management Clinical Governance Reporting Guidelines, VHA, 2008). The sector provided feedback to the project that further work was required to formalise the indicators into an agreed uniform format to allow benchmarking across the sector.

Project Aims

The project aimed to develop and trial indicator formats for a range of clinical governance indicators in the primary care sector.

The specific aims of the project were to:

1. Review the main indicators currently in use in health services in Victoria
2. Identify the main categories of indicators, structure for, evidence base and reporting frameworks
3. Develop, pilot and evaluate a range of relevant clinical governance indicators
4. Develop guidelines for use of indicators
5. Identify potential benchmarking mechanisms for indicators
6. Identify broader governance indicators that may require future work

Methodology

The project methodology involved the establishment of a working group of sector representatives, clinicians and managers and department of health representatives as well as targeted consultation with relevant experts. The working group met over a 8 month period and were supported by a project worker.

¹ The project has been a partnership between VHA, the community health sector and the Department of Human Services (DHS). Funding was provided by the Primary Health Branch of DHS.

The working group investigated the types of indicators that were potentially available to the sector for use. The following main sources of information were examined by the working group:

- DH Service Coordination Survey indicators (DH, 2010)
- States Services Authority – Report on the 2008 Workforce data collection: Organisational benchmark and comparison report template (SSA, 2008)
- Proposed NHS indicators for community services in Department of Health Transforming Community Services Quality Framework: Guidance for Community Services (NHS, 2009)
- Work undertaken by Western District Health Service on consumer indicators
- Australian Institute of Primary Care Discussion Paper Clinical governance in Community health services (AIPC, 2007)
- Federally funded service indicators - e.g. family relationship services guidelines

Indicators where possible needed to fulfil as many requirements of a good indicator as listed:

- Utility – the value of the measure in supporting and enhancing practice
- Validity – the degree to which an indicator appears legitimate to stakeholders
- Measurability – the scope and quality of information available to support the measure
- Cost – the amount of funds, time, effort, materials, or expertise needed to collect, analyse, and use data on a specific measure
- Accepted Practice – the degree to which a measure is consistent with performance measurement used by other areas of health

A paper produced by the Australian Institute of Primary Care (2007) to discuss the development of indicators for clinical highlighted the greater sensitivity of process indicators over outcome indicator in determining service quality. Yet outcomes are what clients, service providers and funding bodies are primarily interested in. To overcome this the paper suggests that the use of process indicators in conjunction with outcome measures may provide a good overall picture.

Similarly the model used by the Canadian Centre for Health Services and Policy Research (2004) has provided a theoretical framework for understanding the types of clinical indicators that are useful to examine in community health. The diagram below shows the degree of influence over processes and outcomes.

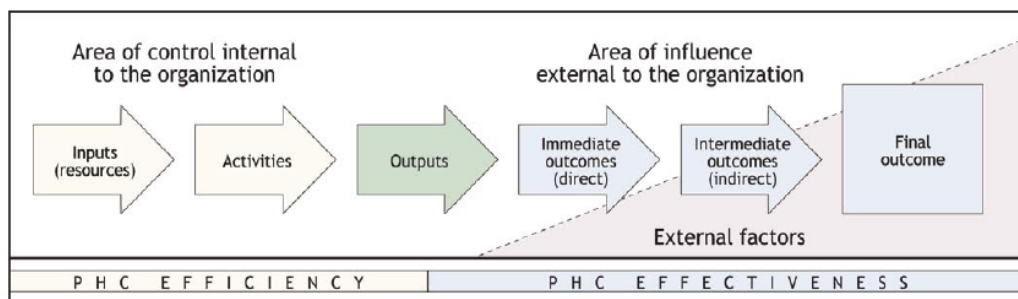


Diagram One: Treasury Board of Canada Results-based Logic Model

The model identifies the linkages between the activities of a program and the outcome. The model highlights that the area of most control for primary health

organisations is that of the processes that occur within the organisation to produce a service. Primary health has less control over the outcomes and this is an area of influence only because external factors such as the population, economic, environmental, cultural and social context heavily influence the impacts of interventions. As one moves along the outcome continuum from immediate to final outcomes the degree of influence of the primary health sector diminishes. From the model it can be seen that improving the processes, an area that organisations are able to control, will effect outcomes. Process measures are therefore important indicators to inform us about service delivery quality and to enable improvements to occur in both processes and outcomes. It is also logical to conclude that direct outcomes or impacts indicators may be valuable in examining effectiveness whereas final outcomes are less useful or attributable to primary health interventions.

An initial set of indicators were then developed by the working group or modified from existing indicators from other sectors. The working group chose to investigate potential indicators for use across the continuum of care:

- Entry to a service
- Intervention
- Exit/ discharge/referral

Indicators were then cross referenced to ensure coverage of the dimensions of quality and the domains in the Department of Health Clinical governance policy framework (see Appendix 1). The working group was conscious of taking both an organisational perspective and a consumer perspective on information that was relevant to service quality.

The identified indicators were divided into three groups

1. New indicators for development and piloting
 - % of clients with Initial Needs Identification (INI) conducted
 - Average length of wait for high priority category clients to mandated services
 - % of clients requiring interpreter receiving Interpreter
 - Priority group access
 - % of staff with current professional development plan
 - % of staff with formal clinical supervision arrangements
 - % of staff who are credentialled in last 5 years
 - % of staff who have individual scope of practice defined
 - % of clients that do not attend
 - Complaints resolved within 30 days
 - Complaints responded to within 5 days of receipt
2. Indicators currently in use or under development – DHSV oral health indicators, VHA indicators, DH VHIMS indicators, Service coordination survey indicators
3. Indicators for future development – indicators that were identified as important but perceived to be beyond the scope of the working group to develop

Results

The results of the pilot of the new indicators that were developed by the working group are presented in this section. 11 indicators were developed by the working group and underwent piloting with 3- 5 agencies each. The results of the pilot provided useful feedback about the face validity of the indicators and the ease of data collection.

Minor amendments were made to many of the indicators but two of the indicators required major amendments. Major amendments were required to the indicator related to percentage of staff credentialled to distinguish clearly between initial credentialling of staff that occurs at recruitment and re credentialling of staff that occurs on a regular ongoing basis. It was found that the priority group access indicator which compared the rate of access of priority clients with the demographic profile was difficult to collect and interpret meaningfully. The limitations of ABS data and the variable program catchment boundaries made it difficult to determine the demographic profile. The indicator was not useful or meaningful in the current form.

Discussion

A list of potential indicators for clinical governance benchmarking was developed after the pilot. The list incorporates both revised pilot indicators and existing indicators and indicates their development status and is presented below in Table 1

Continuum of Care Framework	No.	Potential Indicator	Status of Indicator (e.g. existing, piloted)
Entry	1.	% of clients with Initial Needs Identification (INI) conducted	Piloted by VHA in 2010
	2.	% of clients with Initial Needs Identification commenced within no more than 7 working days of Initial Contact	Existing Service Coordination Survey Item requiring modification
	3.	Average length of wait for high priority category clients to mandated services	Piloted by VHA in 2010
	4.	% of clients requiring interpreter receiving Interpreter	Piloted by VHA in 2010
Intervention	5.	VHA Care Plan Indicator Set	Piloted by VHA in 2008 and in use by some services
	6.	VHA Diabetes Care Indicator Set	Piloted by VHA in 2008 and in use by some services
	7.	DHSV Oral Health Indicator Set	Currently in use and benchmarked
	8.	DH VHIMS Incident Set	Under development by DH
	9.	% of clients with consent for disclosure of personal information completed	Existing Service Coordination Survey Item requiring modification
	10.	% of clients that do not attend	Piloted by VHA in 2010
	11.	% of staff with current professional development plan	Piloted by VHA in 2010
	12.	% of staff who received initial credentialling upon recruitment.	Amended from Piloted by VHA in 2010
	13.	% of staff who have been re credentialled in last 5 years	Amended from Piloted by VHA in 2010
	14.	% of staff who have individual scope of practice defined	Piloted by VHA in 2010
	15.	% of staff with formal clinical supervision contract	Piloted by VHA in 2010
	16.	% of complaints responded to within 5 days	Piloted by VHA in 2010
	17.	% of complaints resolved by organisation within 30 days	Piloted by VHA in 2010
Service exit/ Follow up	18.	VHA GP communication indicator	Piloted by VHA in 2008 and in use by some services

Table 1: Proposed Clinical Governance Indicators for Benchmarking

Table 1 outlines a range of service quality indicators that may be useful for the sector to benchmark to inform clinical governance. Detailed information about each indicator format and notes from the pilot are to be found in Appendix 1. The indicators are presented for the purposes of discussion and feedback and require further testing and modification prior to any benchmarking as outlined below.

i. VHA Indicators piloted in 2010

The indicators developed and piloted by the VHA working group participant organisations in 2010 require a larger scale trial with organisations not involved in their development.

ii. Indicators currently in use or under development

A number of indicators included in Table 1 are currently in use or under development and are discussed below:

Service coordination survey items (Table 1, Indicators 2 & 9)

The DH service coordination survey is intended to obtain a broad indication of whether services met, partly met or did not meet a particular Continuous Improvement Framework Standard. Responses are constructed to allow a range of compliance to be indicated (e.g. partly met – between 10-50% of files). The working group, including representation from the DH service coordination area, identified two key service coordination survey items that could be translated into quantitative indicators for benchmarking purposes. Indicator 2 (% of clients with initial needs identification commenced within no more than 7 working days of initial contact) and indicator 9 (% of clients with consent for disclosure of personal information completed) correspond to DH Service Coordination Continuous Improvement Framework criteria 4.2 and 4.10 and related Survey Items. DH Service Coordination Survey Item related to consent has been reworded to avoid some of the previously identified confusion interpreting this item in the past when administered as part of the service coordination survey. These service coordination items as they are now constructed in a formal indicator format did not require initial piloting as they had been used in the past but will require larger scale testing in the future.

Victorian Health Incident Management System (VHIMS)

As part of the DH VHIMS project a number of potential indicators and reports have been identified that will be available for services to use and to benchmark therefore the working group did not replicate this work.

VHA indicators piloted in 2008

In 2008 a VHA clinical indicator working group released and piloted a set of indicators in care planning, diabetes care and GP communication. The indicators have since been used by a number of organisations for internal quality improvement purposes. The care planning and GP communication indicators have also been used by services undertaking the DH ICDM Workforce Development PDSA training delivered by GPV and VHA. These indicators have been modified based on recent use and do not require further testing at this stage.

DHSV Oral Health indicators

The only mandated and benchmarked set of indicators available for use in community health currently is those provided by DHSV. These indicators require no further developmental work at this stage.

iii. Indicators for future development

A number of indicators were considered by the working group for inclusion as potential indicators but either could not be accessed externally or were beyond the scope of the working group to develop. These indicators requiring development in the future to augment the indicator set are discussed below.

Client Experience

A set of client experience indicators was identified by the working group as critical in providing governing bodies with a consumer perspective on all aspect of care across the continuum. A set of client experience indicators would balance the organisational perspective indicators presented in Table 1 and provide a range of client rated process and outcome indicators. The working group examined a number of examples of client experience surveys and literature and concluded that the development of a client experience survey and related indicators was a large project and beyond the scope of the working group.

The working group concluded that the development of a client experience survey needed to cover all aspect of the continuum of care as well as dimensions of quality. Liaison with the DH indicated the possible allocation of funding to develop a client experience survey in the future, however this is likely be an acute focussed survey. There is an obvious need for a similar survey relevant to community health clients. The NHS Transforming Community Services *Quality Framework: Guidance for Community Services 2009* provides good example of questions that may be included in a client experience survey relevant to community health clients.

Priority Group Access

The Priority Group Access indicator, developed and piloted by the working group in 2010, which compared the rate of access of priority clients with the demographic profile was found to be methodologically difficult to administer. Additional problems found with the indicator were:

- definitional issues and electronic recording of Homelessness and Refugee Status
- TRAK currently counts episodes of care rather than clients so requires further analysis to calculate number of clients
- Lack of currency of ABS data for use in denominator
- Variation in catchment boundaries for different program areas as compared with ABS denominator catchment

The future development of a similar indicator would be helpful to services in identifying access to services of particular priority groups. The working group believes that the information around ATSI status is more robust than for other priority groups and given the health need would be an important indicator for future development.

Indicator Objective:

To determine the percentage of clients requiring a priority service (DHS Community health priority tools, DH 2009) in the following categories:

1. ATSI
2. Homeless or at risk of homelessness
3. Refugee
4. Intellectual disability

(Categorisation of clients into these priority categories is reliant upon client reporting of status)

Numerator: % of nominated priority group clients (eg. ATSI or homeless) from total clients in 12 month period

Denominator: % of priority group in catchment

Community Participation

The working group investigated potential indicators for benchmarking in the area of community participation. The complexity of community participation means that reduction of the concept to a quantitative value is a challenge. The working group examined the DH document 'Doing it with us not for us: Strategic direction 2010-13 Participation Indicators' and found a range of qualitative and quantitative measures not easily translatable to a format suitable for benchmarking. The working group felt this indicator area was well addressed by the indicators described in the DH document and provided boards with suitable information despite the potential difficulty with benchmarking this information.

Governance Indicators

The Working group identified a number of indicators for development for the sector that are closely aligned with clinical governance but fall more broadly into the area of general governance indicators. The first three indicators have been developed by the state services authority and their format are established and they are currently used in small and large public health services

- Separation - count of all ongoing separations in organisation over previous 12 months
- Unplanned leave - average unplanned (sick and carers) leave per FTE (days)
- Staff satisfaction – via People Matter Survey

Outcome Indicators

The VHA project in a previous discussion paper "Indicator in Community Health, 2009" identified several potential generic direct outcome indicators that could be used in community/primary healthcare in the areas of self management, self efficacy, health literacy and health distress. Research needs to be undertaken to develop and trial appropriate indicators in this area. That discussion paper also addressed the difficulty of developing and using final outcomes indicators and the need for clarity of purpose in their use as different measures with different sensitivity are required for different objectives.

Informed consent for treatment

Informed consent for treatment is the procedure whereby patients (clients) consent to, or refuse, an intervention based on information provided by a health care professional regarding the nature and potential risks (consequence and likelihood) of the proposed intervention (Coy, 1989). The importance of this process should be reflected in a relevant indicator. The difficulty in developing an indicator at this stage

is the lack of clear informed consent processes in the community health sector. When informed consent for intervention processes are formalised (including recording information such as options discussed, capacity assessment and decisions made), perhaps with care planning processes then this indicator may be developed.

Quantity vs Quality indicators

The working group recognises that many of the indicators developed in the initial set provide information on the frequency of occurrence of various processes (credentialling, performance appraisal) rather than the quality of those processes. Many of the indicators could be adapted to address quality of systems to reflect the maturity of system development in the sector in the future. For example, rather than just examining the percentage of staff undergoing credentialling or performance appraisal, indicators could be established to examine whether processes such as performance appraisal included key elements such as review of performance plan.

General Indicator Development Considerations

The working group identified a number of general developmental issues that applied to all indicators. The issues identified were similar to those encountered by the former Rural and Regional Health and Aged Care (RRHAC) branch of the Department of Health in their development and trial of 35 financial and governance indicators. The RRHAC pilot revealed 15 potentially useful indicators of which only 2 have been released. The pilot of the indicators also highlighted that fact that indicator data had limitations as benchmarkable data as organisation varied considerably in composition and size. The challenges in collecting and analysing data are equally applicable to community health sector programs.

Data Availability

Organisations providing community health services do not have common client data systems and common functionality to allow uniform electronic retrieval of indicator data. Therefore the main challenge in implementing the set of indicators relates to ease of data access and reporting. During the trials the data was mainly extracted manually from individual client records or HR records (electronic or paper) by staff. Ideally this data would be extracted electronically from a report generated from client records system and human resources data. Further development of client and human resources management systems to address specific indicator requirements would assist the data retrieval process. Until then the method for indicator collection will have to remain initially mainly audit based.

Scope of Indicators

The application of the indicators by program area/ funding area or across organisations needs to be clarified. For some indicators the program area is specified but for others sampling criteria would need to include the scope of the sample. For example indicators such as indicator 10 % of staff with current professional development plan would be applied across the organisation. Other indicators would benefit from being broken down by program area e.g. indicator 15 - % of staff with formal clinical supervision as this would enable to separate out discipline or program area trends.

Sampling Methodology

The question of whether indicator data is obtained from entire populations or a sample and how the sample is collected needs further investigation. Ideally for

performance assessment a continuous data collection from all records would be gathered. Given the limitation of data availability, due to varying types and maturity of client and human resources management systems, continuous data collection for most of the indicators is not possible. Options could include continuous sampling over a given timeframe or a sample of the total population but both methods would introduce significant variation in sample size between services. Expert advice is needed in regard to suitable sample size and sample selection methods to allow benchmarking

Conclusions

The work of the VHA project has enabled the identification of a number of potential indicators and their possible format that could enable benchmarking in the sector and inform clinical governance. The indicators identified require further testing in the health sector to confirm validity.

To ensure the usefulness of any indicators to provide comparative data the sector requires the ability to benchmark clinical indicator and broader indicator data to inform clinical governance. Options for benchmarking currently in use include accreditation bodies such as the ACHS clinical indicator service, or member subscribed private benchmarking services or funded benchmarking options such as those provided by DHSV.

One of the main challenges in implementing the set of indicators relates to ease of data access and reporting. Further work would need to be done to enable indicators to be easily collected via health service data systems.

Recommendations

The VHA recognises the need to progress this work further but it is now beyond the scope of the VHA Clinical Governance project. To further enhance effective clinical governance and support the use of indicators that can be benchmarked across the sector the following recommendations for further work are made:

1. *Investigation of methodological and statistical issues related to sampling of benchmarking indicators*
2. *Formal trial of benchmark of indicators piloted in 2010 by VHA (including modified existing service coordination items)*
3. *Support the development of client experience survey and related indicators to provide the governing body with a client perspective on service quality*
4. *Further development of common functionality and data sets requirements, regardless of data system used by organisation, to allow electronic reporting of indicator data*
5. *Development of benchmarking facilities for clinical indicators/governance indicators in primary health to collect, collate and analyse comparative data on a like agency basis.*

And including the following recommendations previously made in the VHA discussion paper "Clinical Indicators in Community Health, 2009"

6. *Further research into appropriate direct outcome indicators.*
The VHA project identified several potential generic direct outcome indicators that could be used in community/primary healthcare in the areas of self management,

self efficacy, health literacy and health distress. Research needs to be undertaken to develop and trial appropriate indicators in this area.

7. *Development of further generic process (e.g. assessment) and disease specific indicators.*
8. *Further investigation of the appropriateness of final outcomes indicators in the primary healthcare sector.*

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VHA Clinical Governance Benchmarking Working Group

Continuum of Care framework		Potential Indicator	Data Availability	Status of Indicator (e.g. existing, piloted)	Dimension of quality <ul style="list-style-type: none"> Safety Effectiveness Appropriateness Efficient Acceptability Accessible 	DoH CG framework <ol style="list-style-type: none"> Consumer Participation Clinical Effectiveness Risk Management Effective Workforce 	Accreditation standard (QICSA - current, ACHS)
Entry	1.	% of clients with Initial Needs Identification (INI) conducted	Audit /electronic data reporting development required	Piloted by VHA in 2010	Appropriate	Clinical effectiveness Consumer Participation	ACHS 1.1.1 QICSA 2.2
	2.	% of clients with Initial Needs Identification commenced within no more than 7 working days of Initial Contact	Audit / electronic data reporting development required	Existing Service Coordination Survey Item requiring modification. Corresponds to Service Coordination Continuous Improvement Framework criteria 4.2. Needs to be formalised into quantifiable indicator.	Accessible Efficient	Clinical effectiveness	ACHS 1.1.1 QICSA 2.2
	3.	Average length of wait for high priority category clients to mandated services	Audit / electronic data reporting development required	Piloted by VHA in 2010	Accessible Appropriateness	Clinical effectiveness Risk Management	ACHS 1.3
	4.	% of clients requiring interpreter receiving Interpreter	Audit / electronic data reporting development required	Piloted by VHA in 2010 This indicator can be in theory easily obtained through Speed Minor for services using TRAK. Other systems may have to do client file audits	Accessible Appropriate	Consumer participation	
Intervention	5.	VHA Care Plan indicators	Audit/ electronic data reporting development required	Piloted by VHA in 2008 and in use by some services. Generic care planning process and outcome indicators.	Appropriate Effective	Clinical effectiveness	
	6.	VHA Diabetes care indicator set	Audit/ electronic data reporting development	Piloted by VHA in 2008 and in use by some services. VHA diabetes process indicators	Appropriate	Clinical effectiveness	

Continuum of Care framework		Potential Indicator	Data Availability	Status of Indicator (e.g. existing, piloted)	Dimension of quality <ul style="list-style-type: none"> Safety Effectiveness Appropriateness Efficient Acceptability Accessible 	DoH CG framework <ol style="list-style-type: none"> Consumer Participation Clinical Effectiveness Risk Management Effective Workforce 	Accreditation standard (QICSA - current, ACHS)
			required				
	7.	DHSV Oral Health indicators	electronic data reporting	Currently in use and benchmarked	Appropriate/effective	Clinical effectiveness	
	8.	DH VHIMS Incident Set	electronic data reporting	Under development by DH	Safety	Risk Management	
	9.	% of clients with consent for disclosure of personal information completed	Audit/ electronic data reporting development required	Existing Service Coordination Survey Item requiring modification. Corresponds to Service Coordination Continuous Improvement Framework criteria 4.10. Needs to be formalised into quantifiable indicator.	Appropriate	Clinical effectiveness Consumer Participation	
	10.	% of clients that do not attend	Audit/ electronic data reporting development required	Piloted by VHA in 2010	Efficient	-	
	11.	% of staff with current professional development plan	Audit/ electronic data reporting development required	Piloted by VHA in 2010	Appropriate	Effective Workforce	
	12.	% of staff who received initial credentialling upon recruitment.	Audit/ electronic data reporting development required	Amended from Piloted by VHA in 2010	Appropriate	Effective Workforce	
	13.	% of staff who have been re credentialled in last 5 years	Audit/ electronic data reporting development required	Amended from Piloted by VHA in 2010	Appropriate Effective	Effective Workforce	
	14.	% of staff who have individual scope of practice defined	Audit/ electronic data reporting development required	Piloted by VHA in 2010	Appropriate	Effective Workforce	
	15.	% of staff with formal clinical supervision	Audit/ electronic data reporting development	Piloted by VHA in 2010	Appropriate Effective	Effective Workforce	

Continuum of Care framework		Potential Indicator	Data Availability	Status of Indicator (e.g. existing, piloted)	Dimension of quality <ul style="list-style-type: none"> ▪ Safety ▪ Effectiveness ▪ Appropriateness ▪ Efficient ▪ Acceptability ▪ Accessible 	DoH CG framework <ol style="list-style-type: none"> 1. Consumer Participation 2. Clinical Effectiveness 3. Risk Management 4. Effective Workforce 	Accreditation standard (QICSA - current, ACHS)
		contract	required				
	16.	% of complaints responded to within 5 days	Audit/ electronic data reporting development required	Piloted by VHA in 2010	Safety Acceptability	Consumer Participation Risk Management	
	17.	% of complaints resolved by organisation within 30 days	Audit/ electronic data reporting development required	Piloted by VHA in 2008 and in use by some services	Safety Acceptability	Consumer Participation Risk Management	
service exit/case closure Follow up	18	VHA GP communication indicator - % of clients with evidence of communication from the community health service to GP	Audit	Piloted by VHA in 2008 and in use by some services	Appropriate	Clinical effectiveness	

Clinical Governance Benchmarking Indicators for Victorian Health Services

Background

This document contains details of the proposed indicators that could be used by organisations to support effective clinical governance

Data Sampling

Given the limitation of data availability, due to varying types and maturity of client and human resources management systems, continuous data collection for most of the indicators is not possible. Options could include continuous sampling over a given timeframe or a sample of the total population but both methods would introduce variation in sample size between services. Expert advice is needed in regard to suitable sample size and sample selection methods to allow benchmarking.

For internal uses organisation could use an formula that is used by QIC to determine the sample size for file audits to obtain a snapshot

'the square root of the total number of client records, plus 1'

(QIC Client Record Audit Tool)

Alternatively an organisation may decide to audit more files if the numbers in the program are small. However a small sample is usually all that is required to pick up a trend. The specified timeframe (the time period under study) for data collection can be nominated by the agency according to the number of anticipated clients in the denominator in that timeframe. Organisations need to keep careful note of their sampling methodology (sample size and selection) to enable valid trend comparison to be made over time.

Indicator Formats

In the following pages indicators are presented for organisations to apply to service/program areas. The indicators are structured as follows:

Numerator – the number of cases fulfilling the criteria

Denominator – the total number of cases

Measurement mode – the method by which the clinical indicator data is obtained

Appendix 2

Table 1: Summary of Indicators

Continuum of Care Framework	No.	Potential Indicator	Status of Indicator (e.g. existing, piloted)
Entry	1.	% of clients with Initial Needs Identification (INI) conducted	Piloted by VHA in 2010
	2.	% of clients with Initial Needs Identification commenced within no more than 7 working days of Initial Contact	Existing Service Coordination Survey Item requiring modification
	3.	Average length of wait for high priority category clients to mandated services	Piloted by VHA in 2010
	4.	% of clients requiring interpreter receiving Interpreter	Piloted by VHA in 2010
Intervention	5.	VHA Care Plan Indicator Set	Piloted by VHA in 2008 and in use by some services
	6.	VHA Diabetes Care Indicator Set	Piloted by VHA in 2008 and in use by some services
	7.	DHSV Oral Health Indicator Set	Currently in use and benchmarked
	8.	DH VHIMS Incident Set	Under development by DH
	9.	% of clients with consent for disclosure of personal information completed	Existing Service Coordination Survey Item requiring modification
	10.	% of clients that do not attend	Piloted by VHA in 2010
	11.	% of staff with current professional development plan	Piloted by VHA in 2010
	12.	% of staff who received initial credentialling upon recruitment.	Amended from Piloted by VHA in 2010
	13.	% of staff who have been re-credentialled in last 5 years	Amended from Piloted by VHA in 2010
	14.	% of staff who have individual scope of practice defined	Piloted by VHA in 2010
	15.	% of staff with formal clinical supervision contract	Piloted by VHA in 2010
	16.	% of complaints responded to within 5 days	Piloted by VHA in 2010
	17.	% of complaints resolved by organisation within 30 days	Piloted by VHA in 2010
Service exit/ Follow up	18.	VHA GP communication indicator	Piloted by VHA in 2008 and in use by some services

Appendix 2

Indicator 1 - Initial needs identification conducted

Indicator Objective: To determine the percentage of clients with initial needs identification conducted.

Rationale: Initial needs identification promotes client centred problem identification and service coordination.

Numerator: the number of clients for the organisation for whom an initial needs identification has been conducted

Denominator: the total number of clients registered for the organisation who received a service.

Measurement Mode – audit of client records

Indicator Application: Ideally this indicator would be applied to all program areas in a health service. The indicator could initially be reported on a program specific level for those programs with sector wide formalised initial needs identification tools such as the INI in the community health funded program.

Pilot Discussion Issues – This indicator provides information about the quantity of initial needs identification rather than the quality or completeness of the initial needs identification

Indicator 2 – Timely initial needs identification

Indicator Objective: To determine the percentage of clients with Initial Needs Identification commenced within no more than 7 working days of Initial Contact

Rationale: Consumer needs should be identified in a timely manner

Numerator: the number of clients with initial needs identification commenced within 7 days of initial contact

Denominator: total number of clients with an initial needs identification

Measurement Mode – audit of client data systems

Indicator Application: Ideally this indicator would be applied to all clients in a health service. The indicator could initially be reported on a program specific level for those programs with sector wide formalised initial needs identification tools such as the INI in the community health funded program.

Appendix 2

Indicator 3 – Length of wait for high priority category clients to mandated services

Indicator Objective: To determine the average number of days from Initial needs identification (INI) to service specific assessment for the highest category of priority clients of mandated services (including generic priority clients)

Rationale: Waiting times for various priority groups needs to be monitored to ensure effective appropriate services

Note

Mandated service	Level Descriptors
1. Dietetics	high, medium, and low
2. Counselling	Immediate, high, medium/low
3. OT - adult	high, medium, and low
4. OT - paediatric	high, medium, and low
5. Physiotherapy	high, medium / low
6. Podiatry	high, medium, and low
7. Speech Pathology	high, medium / low
8. Dental	High, low
9. Dental emergency	Category 1-5

Numerator: the total number of days from INI to service specific assessment for the highest priority clients in the specified service/program area during the stated time period

Denominator: the total number of consumers allocated in the priority category

Measurement Mode - audit of client data systems

Indicator 4 – Interpreter Use

Indicator Objective: To determine the percentage of clients who have indicated the need for an interpreter (consumer information template SCTT) who actually receive interpreters on their first contact with a service/program area

Rationale: The Language Services Policy identifies critical points, including initial assessment, at which professional accredited interpreters must be used (DHS, 2005).

Numerator: Number of first contacts after Initial Needs Identification involving interpreter

Denominator: Total number of clients who indicated need for interpreter on initial needs identification (e.g. SCTT consumer information template)

Measurement Mode: audit of client record systems

Appendix 2

Pilot Discussion Issues – This indicator can be in theory easily obtained through Speed Minor for services using TRAK. Other systems may have to do client file audits

Indicator 5 – VHA care plan Indicators (see appendix 3)

Indicator 6 - VHA diabetes care Indicators (see appendix 3)

Indicator 7 – DHSV Oral Health indicators

Indicator 8 – DH VHIMS incident indicators (under development)

Indicator 9 – Consent for disclosure of personal information

Indicator Objective: To determine percentage of clients with referrals who have completed consent for disclosure of personal information

Rationale: Consent for disclosure of personal information is required under privacy legislation

Numerator: Number of clients referred to a service (internal or external referral) where consent for disclosure of personal information has been completed

Denominator: Number of clients with referrals

Measurement Mode; audit of client record systems

Indicator 10 – Did Not Attend

Indicator Objective: to determine the percentage of clients that did not attend appointments in the month specified

Rationale: The percentage of Did Not Attend (DNA) provide information on the efficiency of a service

Numerator: Total number of DNA contacts in the service/program area nominated

Denominator: Total number of contacts (total = DNA's + contacts)

Measurement Mode ; audit of client record systems

Appendix 2

Pilot Discussion Issues - Indicator preferably applied to all contacts in 1 month period rather than sample as easily accessed from electronic systems. Also need to ensure definitional clarity around use of DNA. Need to distinguish clearly between cancellation vs DNA in terms of the time period involved.

Indicator 11 – Current Professional Development Plan

Indicator Objective: To determine the percentage of staff interacting with clients who have professional development plans

Rationale: Professional development planning is an important mechanism to maintain competence of staff

Definition

Permanent Staff: are staff either ongoing or on fixed term contracts. This excludes casuals Employment Agency staff, contractors, Consultants,

Staff interacting with clients: All service providers and support staff (e.g. receptionists, intake workers) who have direct interaction with clients

Numerator: Number of permanent staff interacting with clients with a current annual professional development plan (may be in annual performance appraisal)

Denominator: Number of permanent staff providing a service to client

Measurement Mode Audit

Indicator 12 –Initial Credentialling

Indicator Objective: To determine the percentage of permanent staff who were initially credentialled as part of the recruitment process.

Rationale: Credentialling is an important mechanism to monitor competence of staff

Definitions

Staff providing a service to clients: All service providers (not including support staff such as receptionists) who have direct interaction with clients

Credentialling- the formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of practitioners for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high quality health care services within specific organisational environments.

Appendix 2

(Australian Council for Quality in Health Care. National Standard on credentialling and defining the scope of practice. Australian Council for Safety and Quality in Health Care, Canberra, July 2004)

Initial Credentialling is the credentialling information generally checked once before the offer for employment of staff. Information to be verified through Initial credentialling includes:

- Verification of identity (e.g. photo identification)
- Evidence of current professional registration.
- Qualifications - review of tertiary qualifications (viewing originals or certified copies)
- Training undertaken
- Specialist Accreditation
- Referee Checks
- Drivers License as required
- Police Check
- Working with Children Check as necessary

(Reference How to guide for credentialling and scope of practice VHA)

Numerator: Number of staff providing a service to clients who were initially credentialled as part of the recruitment process.

Denominator: Number of staff providing a service to client

Measurement Mode: Audit

Indicator 13 –Re Credentialling

Indicator Objective: To determine the percentage of permanent staff who have been re-credentialled in the last 5 years

Rationale: Credentialling is an important mechanism to monitor competence of staff

Definitions

Credentialling- the formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of practitioners for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high quality health care services within specific organisational environments.

(Australian Council for Quality in Health Care. National Standard on credentialling and defining the scope of practice. Australian Council for Safety and Quality in Health Care, Canberra, July 2004)

Re-Credentialling is the process of collecting ongoing information collected periodically to confirm the credentials of an existing staff member. Information to be verified through re-credentialling includes:

- Annual Monitoring of Registration
- Police Checks ongoing
- Working with Children Check
- Ongoing Professional Development.

Appendix 2

- Supervision (management and clinical) feedback

Note: re-credentialling involves more than an annual check of certification for registration purposes (certification) and is a process of forming a view about ongoing competence, performance and professional suitability to provide safe, high quality health care services within specific organisational environments.

(Reference How to guide for credentialling and scope of practice VHA)

Numerator: Number of staff providing a service to clients who have been re-credentialled in the last 5 years

Denominator: Number of staff providing a service to client who have been at the service longer than 5 years

Measurement Mode: Audit

Indicator 14– Individual Scope of Practice Defined

Indicator Objective: To determine the percentage of staff with their individual scope of practice defined

Rationale: Defining the individual scope of practice is an important mechanism to ensure appropriate services are provided by appropriately skilled service providers.

Definitions

Staff providing a service to clients: All service providers (not including support staff such as receptionists) who have direct interaction with clients

Scope of Practice - Defining the scope of clinical practice follows on from credentialling and involves delineating the extent of an individual practitioner's clinical practice within a particular organisation based on the individual's credentials, competence, performance and professional suitability and the needs and the capacity of the organisation to support the practitioner's scope of clinical practice.

A statement of an individual's scope of practice and the types of activities/procedures they may perform needs to be documented. An organisation may attach this information via amendment to the position description or an addendum to the position description. This needs to take the form of a document that is specific to the individual (rather than a generic document) and includes the data and signature of the manager and staff member.

Numerator: Number of staff providing a service to clients with their individual scope of practice defined on appointment or reviewed in the last 5 years

Denominator: Number of permanent staff providing a service to clients

Measurement Mode: Audit

Appendix 2

Indicator 15 –Clinical Supervision

Indicator Objective: To determine the percentage of staff who have formal clinical supervision arrangements

Rationale: Clinical supervision is an important mechanism for supporting and maintaining the competence of staff

Definitions

Staff providing a direct funded service – Staff providing a direct service to clients as part of a service agreement (i.e. not support staff and administrative/reception staff)

Clinical Supervision - Clinical supervision is a formal process, between two or more professional staff, creating a supportive environment which encourages reflective practice and the improvement of therapeutic skills. Evidence of formal clinical supervision arrangements include:

- the presence of a clinical supervision contract
- clinical supervision provided by a supervisor who has received formal supervision training
- written record of supervision session are made
- regular dedicated time for supervision

(VHA Clinical Supervision in Community Health: Introduction and Practice Guidelines Sept 2008).

Clinical supervision is distinct from administrative or management supervision which is provided by a manager who is responsible for the overall performance of a team or program.

Administrative matters relating to service planning, development and delivery are addressed by ensuring that program activities are carried out in a manner that is consistent with funding and legislative requirements, external policy directions and the organisations internal policies and procedures.

Numerator: Number of staff providing a direct funded service to clients with current Clinical Supervision contracts

Denominator: Number of permanent staff providing a funded service to client

Measurement Mode; Audit

Indicator 16 – Complaints response

Indicator Objective: to determine the percentage of complaints responded to by the organisation within 5 days of receipt of complaint

Rationale: timely response to complaints is the ideal management of complaints

Definition

Appendix 2

Complaints response – response may consist of letter, phone call or e mail documented in client record

Numerator: Number of complaints responded to within 5 days

Denominator: total number of complaints by complainants who wish to be contacted

Measurement Mode: Audit

Indicator 17 – Complaints resolution

Indicator Objective: to determine the number of complaints resolved by the organisation within 30 days of receipt of complaint

Rationale: Timely resolution of complaints within the organisation is the ideal management of complaints

Definitions

Complaints Resolution: this term refers to the act of resolving or determining upon an action or course of action in relation to the complaint which then completes the complaints process. Complaints resolution does not indicate the satisfaction of the complainant with the process.

Numerator: no of complaints resolved within the organisation within 30 days

Denominator: total no of complaints by complainants who wish to be contacted

Measurement Mode: Audit

Indicator 18 - VHA GP communication indicator (see appendix 3)

VHA Clinical Indicator Summary

A) Care Plans

Indicator 1: Complete Care plans

Indicator 2: Incomplete Care Plans

Indicator 3: No Care Plan

Indicator 4: Reason for Incomplete Care Plans

Indicator 5: Care Plan Review

Indicator 6: Goal Attainment

Indicator 7: Objectives/Goal of Care Partially Attained

B) Diabetes Care

Indicator 8: Diabetes Best Practice Care Review

Indicator 9: Diabetes Care Review Data

C) Continuity of Care

Indicator 10: Communication to General Practitioner

A) Care Plan Indicators

DEFINITIONS

The following terms are defined for the purpose of the care plan indicators

Care Plan: A care plan is any documented plan of care that has **all of** the following elements completed:

- Client stated/agreed issues/problems
- Client stated/agreed objectives/goals,
- Client stated/agreed strategies/action
- Planned review date of care plan
- Timeframe for attainment of objectives/goals
- Responsibilities for implementing strategies/action
- Participants in development of care plan
- Consumer Acknowledgement (signed or verbal acknowledgement recorded)
- Date care plan developed
- Goal/Objective attainment

Sample Selection

Organisations can decide the sample upon which they apply the care planning indicators. However for benchmarking purposes the indicators would ideally be applied to client with chronic or complex needs.

Appendix One

Indicator 1: Complete Care plans

Indicator Objective: To determine the percentage of clients with a complete care plan

Rationale: A care plan promotes client centred objectives and strategies for care to be developed (see definition complete care plan page 9).

Indicator 1: Complete Care Plans

Numerator: the number of consumers for whom there is a complete care plan

Denominator: the total number of consumers registered for the service/program who received intervention during the time period under study.

Measurement Mode - consumer record audit, date of care plan on data system

Indicator 2: Incomplete Care Plans

Indicator Objective: To determine the percentage of clients with incomplete care plans due to omission of one or more of the individual elements that constitute a complete care plan (see definition of care plan page 9).

Rationale: A care plan promotes client centred objectives and strategies for care to be developed.

Indicator 2: Incomplete Care Plans

Numerator: the number of consumers for whom there is an incomplete care plan*

Denominator: the total number of consumers registered for the service/program who received intervention during the time period under study.

Measurement Mode - consumer record audit, date of care plan on data system

Indicator 3: No Care Plan

Indicator Objective: To determine the percentage of clients with no care plan (complete or incomplete)

Rationale: A care plan promotes client centred objectives and strategies for care to be developed

Indicator 3: No Care Plans

Numerator: the number of consumers for whom there is no care plan (complete or incomplete)

Denominator: the total number of consumers registered for the service/program who received intervention during the time period under study.

Measurement Mode - consumer record audit, date of care plan on data system

Appendix One

Indicator 4: Elements of Care Plan Present

Indicator Objective: To identify the reason for incomplete care plans due to omission of one or more of the individual elements that constitute a complete care plan.

Rationale: A care plan must contain all the specified elements to achieve the objective e.g. the signature or verbal agreement establishes consumer agreement to the care plan contents (see definition of care plan).

Indicator 4: Elements of Care Plan Present

NB: This indicator must be calculated separately for each individual element of a care plan therefore 10 calculations will be made.

Numerator: the number of consumers with a specified element of the care plan recorded in their care plan.

Denominator: the total number of consumers registered for the service/program who received intervention during the time period under study with a care plan (incomplete care or complete plan)

Measurement Mode - audit

Indicator 5: Care Plan Review

Indicator Objective: To determine the percentage of clients with care plans that are reviewed systematically.

Rationale: The review of a care plan for consumers is necessary for effective management

Indicator 5: Care Plan Review

Numerator: the number of consumers with a care plan that have been reviewed within 4 weeks of the planned review date

Denominator: the total number of consumers registered for the service/program that have a care plan with a planned review date that falls within the time period under study.

Measurement Mode - consumer record audit, review date noted on data system

Indicator 6: Goal Attainment

Indicator Objective: To determine the percentage of objectives/goals of care that have been met in the timeframe stated in the care plan for attainment of the goal/objective

Rationale: The achievement of agreed objectives/goals of care is a measure of the success of the interventions.

Appendix One

Indicator 6: Goal Attainment

Numerator: the number of objectives/goals met in the timeframe stated for attainment of each objective/goal for consumers with a care plan

Denominator: the total number of objectives/goals with the timeframe stated for attainment of each objective/goal for consumers with a care plan registered for the service/program who received intervention during the time period under study.

Measurement Mode - consumer record audit, achievement of goal/objectives noted on data system

NB Do not include objectives/goals with a goal attainment timeframe after the time period under study in the numerator or denominator. The timeframe selected will need to allow adequate time for goal attainment prior to the audit date

Indicator 7: Objectives/Goal of Care Partially Attained

Indicator Objective: To determine the percentage of objectives/goals of care that have been partially met in the timeframe stated in the care plan for attainment of the goal/objective

Rationale: The achievement of agreed objectives/goals of care is a measure of the success of the interventions. If this indicator reveals a high number of partially met objectives/goals further information may be sought to determine why goals are only partially met to assist service improvement.

Indicator 7: Goals of Care Partially Attained

Numerator: the number of objectives/goals partially met in the timeframe stated for attainment of each objective/goal for consumers with a care plan

Denominator: the total number of objectives/goals with the timeframe stated for attainment of each objective/goal for consumers with a care plan registered for the service/program who received intervention during the time period under study

Measurement Mode - consumer record audit, review date and achievement of objectives noted on data system

NB Do not include objectives/goals with a goal attainment timeframe after the time period under study in the numerator or denominator

Appendix One

B) Diabetes Care Indicators

Minimum Requirements of Diabetes Care

The frequency of the reviews presented in table 1 are minimum recommended frequencies. If additional risk factors are identified in a client review, such as periodontal disease in an oral health review or sensation changes in a podiatry review, the review period will need to be more frequent.

Review	Description	Minimum Frequency
HbA1c	Blood test of glycosylated haemoglobin	Six monthly
Cholesterol, triglycerides and HDL and LDL cholesterol (blood test)	Blood test of lipids	Six Monthly
BMI	Body weight in kilograms/height in meters squared.	Six monthly
Blood Pressure	Systolic pressure over diastolic pressure	Six monthly
Urinary Albumin Excretion	One of a number of tests that can be performed to determine albumin (protein) in the urine	Annually
Self care education	Includes diabetes knowledge, blood glucose monitoring, foot care, insulin administration	Annually
Examine feet	Review foot sensation, pedal pulses and foot deformities	Annually
Review diet	Review of general diet to determine whether detailed instructions need to be given by a Dietitian.	Annually
Review levels of physical activity	Assess current level of physical activity and develop a plan to increase as required	Annually
Review Smoking	Record the smoking status of the client	Annually
Review Medications	Review medication adherence and any possible drug interactions (pharmacist)	Annually
Comprehensive Eye examination	Review with ophthalmologist or optometrist for early check of retinopathy	Every two years
Review Oral Health	Oral examination by dentist	Every two years
Depression/Anxiety Screen	Review for depression/anxiety issues (e.g.K-10 as used in Service Coordination Psychosocial Profile)	Annually

Table 1: Minimum Requirements of Diabetes Care

Indicator 8: Diabetes Best Practice Care Review

Indicator Objective: To determine the percentage of clients with type 1 or type 2 Diabetes who have received the recommended reviews (see Table 1, pg 14) as part of best practice diabetes care (delivered either in the community health centre or externally)

Rationale: Diabetes Australia defines a minimum standard of assessment and care for individuals with diabetes. These recommendations have been modified for community health to reflect current best practice and include oral and mental health reviews. Individuals presenting to Community Health for management of diabetes (independent of the discipline of the worker involved or service provided) should be:

1. Screened to ensure they have received the recommended reviews in the recommended timeframes (see table 1, page 14)

Appendix One

2. Referred (or advised to follow up) for any review that has not occurred in the recommended timeframe

If the indicator results are poor then further investigation of both the process of screening of diabetes client needs and action taken to address unmet needs is needed

Indicator 8: Diabetes Best Practice Care Review

NB: This indicator must be calculated separately for each individual element of the minimum requirements of best practice diabetes care. See Appendix Three audit proforma for data collection and Appendix 4 for model client screening tool.

Numerator: The number of clients referred for diabetes management (type 1 or 2) with evidence of receiving the minimum requirements of best practice diabetes care within the recommended timeframes (see Table 1, page 14).

Denominator: the total number of clients presenting with a diabetes management need in the time period under study.

Measurement Mode - file audit of clients who were referred at least 6 months prior to audit date.

Indicator 9: Diabetes Care Review Data

Indicator Objective: To determine the percentage of clients with type 1 or type 2 Diabetes referred for any type of diabetes related management who have diabetes related results recorded in their client file

Rationale: Access to accurate up to date information regarding the parameters of diabetes care will guide the appropriate course of management for a client. This indicator becomes a proxy indicator for the effectiveness of communication between the GP and the community health centre.

Indicator 9: Diabetes Care Review Data

NB: This indicator must be calculated separately for each element of the review. See Appendix Three audit proforma for data collection

Numerator: The number of clients referred for diabetes management (type 1 or 2) in the time period under study with evidence of results recorded for HbA1c, Albumin, total cholesterol, HDL, LDL cholesterol and triglycerides blood pressure, BMI in the last 6 months

Denominator: The total number of clients presenting with a diabetes management need in the time period under study.

Measurement Mode - file audit of clients who were referred at least 6 months prior to audit date.

Appendix One

C) Continuity of Care Indicators

Indicator 10: Communication to General Practitioner

Indicator Objective: To determine the percentage of clients with evidence of communication (excluding referral acknowledgement) from the community health service to the Client's GP

Rationale: Community health staff must provide updates to GP's on assessments and the outcome of an episode of care to enable the GP to effectively manage the client's care

Indicator 10: Communication to General Practitioner

Numerator: The number of clients referred with a chronic or complex need who have evidence of communication from the community health service to the GP in the health record in the last 6 months

Denominator: The total number of clients referred with a chronic or complex need in the time period under study

Measurement Mode - file audit of clients who were referred at least 6 months prior to audit date.