Hong Kong College of Health Service Executives

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Council Members

Message from the President

Getting Numbers to Work for You !

President Obama stepped into office with one clear thing in mind - to make health care reform a reality. After a short period in office, his "dream" came true and the victorious moment of signing the health care reform bill was witnessed by many, including many of us here in Hong Kong, on 23rd March 2010.

How did he do it when the other Presidents before him who promised health care reform for America never ever came close to anything like that? How did he convince both the House and the Senate to pass his proposal. I guess we are all convinced that besides being a charismatic leader, Obama comes across as a very seasoned debater who argued his points very clearly. It is interesting to note that the White House Administration has produced a short video on Numbers to convince the public why there is a need to change. Here are the Numbers:

1115 : Americans have to pay an average of US$1115 in insurance premium annually.

3 : Cost of health care premiums is rising 3 times as compared to wages

1 : 1 in every dollar in the US economy is spent on health care today

8 : This is the number of people every minute who are denied coverage, charged a higher rate or otherwise discriminated against because of a pre-existing condition

41 : The is the number of Nobel prize winners who wrote to the President calling for health care reform to be implemented. It is also the percentage of people under age of 65 who accumulated medical debit, had difficulties paying medical bills or struggled with both during the recent one year period.

50/50 : If you are a American under the age of 65, there is a 50/50 chance that you will find yourselves without coverage at some point in the next decade.

32 million : This is the number of Americans that will have health insurance coverage under the new health care reform proposal!

What frightening and interesting numbers. These are numbers that can jolt the nation to realize that health care reform must happen. Of course, most of these numbers do not make sense to us here in Hong Kong. The point is, every nation will have their own unique numbers that can paint or point to the challenges ahead of us and in Hong Kong, I just wonder what these numbers are or do we know what these numbers are? Can we make health care reform here in Hong Kong a reality with a better knowledge of numbers! Let's get numbers to work for us, not against us!

Dr MY CHENG

Spring Fashion- Health Care Reforms in America and Australia

The month of March in Hong Kong is an unusual month - the weather being hot on some days and then plunges to a low of 10 degree the next day. As we welcome spring this year, it is interesting to note that both the White House and the Australian Government announced plans to reform their health care system in March 2010. Does this herald the birth of a new trend – health care reforms in spring!

Let's take a look at the proposals of the health care reforms in both Australia and America, two vastly different systems but like all health systems in the world, face the same challenges of the present day – financially unsustainable system, too much inefficiency, waste and abuse, workforce issues, not enough local or clinical engagement, inequity in access, aging population etc. etc. This list can go on and on and for many seasoned health service executives, this list is much like a growing dim sum checklist which we can go tick off in our own health care systems.

The Dim Sum checklist of challenges facing health systems today:

- An ageing population
- Increasing burden of chronic diseases
- Rising health care costs
- Workforce shortages
- System fragmentation
- Inequality in access to care
- Too much pressure on public health system
- Unsustainable funding model
- Too much inefficiency and waste
- Not enough patient or community engagement
- Not enough on preventative health
- Lack of access to emerging medical technologies
- Lack of transparency and program integrity
- Declining quality and consumer confidence

Fortunately, both the Obama and the Rudd Administrations are taking matters seriously and have come up with proposals to tackle some of these challenges in their countries.

Obama's Proposal promises to put Americans in control of their health. Some of the highlights are:

- It makes insurance more affordable by providing tax cut to the middle class, reducing premiums costs for families and small business. This will help to provide health insurance to over 32 million Americans who cannot afford health care today. Under the plan over 95% of Americans will be insured- close to universal coverage
- New competitive health insurance market will be set up giving Americans more choices of insurance plans. A new website to help consumers compare the different insurance options along with health care consumer guidance and ombudsman for any of their health care questions
- Greater accountability by laying down rules to keep premiums low and prevent insurance industry abuse, keeping insurance industry more honest. New insurance plans will have to offer preventative care and immunizations at no cost
- End discrimination against Americans with pre-existing medical conditions such as mental health problems or women with history of domestic violence etc by making sure that uninsured Americans with pre-existing conditions will finally have the choice of quality, affordable insurance through a new insurance pool.
- Reduces budget deficit by more than $100 billion over the next ten years by cutting government overspending and reining in waste, fraud and abuse.
- It will provide additional federal financing to all states for the expansion of Medicaid- health plans for the needy

- It will ensure that gaps in the present prescription drug payments are closed
- It will strengthen provisions to make insurance affordable for individuals, families and increase protections for out of pocket costs, limiting such out of pocket costs so that families can continue to enjoy insurance coverage
- Invest in community health centres to provide quality care in underserved areas.

There are many other technical details of the Bill which to a non-American is fairly incomprehensible. Notwithstanding that, the gist of the health care reform proposal serves to address the fundamental issue of access to health care which no doubt, is a rather embarrassing issue for a superpower like America.

Let's now take a look at the Rudd's proposal. Here, the fundamental problem is not so much in access to health care but rather some of the structural issues that underpins the Australian health care system.The National Health and Hospitals Network (much like the NHS or HA?) will mean that the Commonwealth Government :

- Becomes the majority funder of public hospitals. For the first time, the Commonwealth will take the financial burden and leadership and this will end the perennial debates of Federal vs State cost-shifting or blame shifting. The increased stake of Commonwealth funding will be the key driver to put changes in place and will ultimately improve performance and health outcomes. The one who pays will have the bigger say – so ends the Federal and State ping pong ball game for years!
- Takes over all funding and policy responsibility for GP and primary care services. Again, this will end inefficiencies whereby there are duplications in services and service gaps in others. As a result of taking full funding responsibility for all GP and primary care services, the system will be better integrated and coordinated and more responsive to the needs of the patients.
- Allocates one third of GST to state and territory governments to fund the change. This again means that the Commonwealth will be footing the bill for health care and will increase this funding to ensure that the Australian health system is kept up to date.
- Sets National Standards for a unified health care system. By positioning itself as the payer of services, the Commonwealth Government is in a position to require national standards, transparent reporting and auditing in its hospital and community health care systems
- Runs Hospitals locally through Local Hospital Networks (LHN) As an integral part of the system wide reform, the Government will require that states introduce Local Hospital Networks – much like the Hospital Authority's Clusters, to collaborate and deliver health care and be held accountable for performance of the Network.
- Funds Hospitals directly for the hospital service they provide and not through a block grant from the Commonwealth to the States. The Local Hospital Network will receive 60 per cent of the efficient price of each service a Network provides to patients, using the system of activity based funding. This arrangement will ensure that each Local Hospital Network is funded for services it provides. With this mechanism, the Government will fund a share of every service that LHNs provide. Through greater transparency and direct funding of services actually provided, local communities will know how their hospitals are performing and how they are spending the resources.

Unlike the Obama's proposals, the Rudd Administration's proposal is a major economic reform that builds on the current strengths of the Australian health care system to ensure that this is sustainable in future. The Obama Administration, on the other hand, has a more fundamental issue to tackle- the problem of access to health care and the need to prevent the insurance industry from growing out of control!

Both proposals are not implemented yet and are in the process of public consultation. Like any health care reform proposals, the devil is in the details. I certainly hope that these proposals will some how not be thrown away or lost in the midst of political lobbying. Come next Spring – maybe we can see the revival of the Hong Kong's health care reform debate and mind you, Spring is a lovely season – a season of hope and new beginning!

Ms Margaret TAY

The Change 'WE' Need
– introduction of 'P4P' and Casemix system in Hospital Authority

Introduction

Last year, I was invited by the College to give a presentation on the development of the new Pay-for-performance (P4P) internal resources allocation mechanism and the Casemix system in Hospital Authority (HA) in 2008-09. At that meeting, I described the objectives for the new P4P system and the Casemix model for HA. The new system was applied to the HA budget planning starting from financial year 2009-10.

Early this year, I had the greatest honour to be asked to write on this topic again to contribute to the College's Newsletter. I would like to take this opportunity to share with members of the College about some of the management strategies adopted during the course of the development and implementation of the P4P and the Casemix system.

Background

The Chief Executive (CE) of HA announced in his key note speech at the 2007 Hospital Authority Convention that the development of a new internal resources allocation system would help to modernize HA. Adoption of a Casemix system to reward clusters fairly and transparently for productivity, "…*more work, more funding*…" was the way to move forward.

From first describing the need to look for a new internal resources allocation system in CE's keynote address at the HA Convention in May 2007, to the formal announcement of Pay for Performance (P4P) and Casemix funding system in November 2008, 18 months lapsed. It seemed to take longer than expected to review and develop a new resources allocation system. But considering that this involved the development and introduction of a Casemix system, I am sure that many would agree with me that this is in fact a world record!

Right from the start, a number of critical success factors were identified for the development of a local Casemix system. These were: high level commitment and support, stakeholders and clinicians buy-in and acceptance, technical readiness of HA which might include availability of appropriate expertise and credible casemix data, and opportunity for implementation.

Casemix systems are highly technical and complex. Explanation and communication of the Casemix concept to staff was not an easy task. Requesting those affected by the new system to accept it was even more difficult. Therefore, amongst the critical success factors, clinician acceptance was considered the most difficult to achieve and the outcome of engaging clinicians was most unpredictable, especially when the agenda was about a new funding system. At the project planning and development stage in 2007, a few change management strategies were incorporated as critical milestones of the Casemix project development plan which started in 2008.

Change Management

Changes in internal resources allocation systems have always been controversial and difficult. HA is the major health care provider in HK. Even minor change in our systems can result in significant impact. Organizations, especially health care

organizations are highly labour intensive. An organization's response to change is the summation of its people's response to change. Therefore, the people side of change, such as resistance to change, lack of acceptance by clinicians of the classification developed could have resulted in project failure. To effect change, managers and leaders must be able to manage the people side of change.

There are many theories for change management, from Lewin's (1947) early model of a three-staged "unfreeze-change-freeze", to the last decade Judson's (1991) 5-staged model of change, and Kotter's (1995) 8 steps to successful changes. I do not intend to review the change management theories here. However, although not fully designed in accordance with the phases of these change models, a number of strategies adopted by the Casemix project team closely reflected some of the key concepts that I would like to elaborate and share my view.

Communication

Effective communication is probably one of the most important processes required for successful change management. A comprehensive communication strategy was developed. It comprised of strategic communication programmes, targeting at different groups of HA staff and internal stakeholders, with different phases of communication for different themes, dovetailing with the phases of casemix development. These communication activities included a range of communication tools from interactive discussion workshops and forums, didactic knowledge transfer and promulgation sessions, to pamphlets, papers and website

Figure 1. Illustration of strategic approach to communication with different target groups.

	Objective	Phase 1	Phase 2
Frontline clinicians	• Enhance knowledge • Promulgation and Compliance with coding guidelines • Influence proper clinical documentation	• 3 – 6 months • Cluster 'Roadshows' • Coding guidelines • educational sessions	• 7–12 month onwards • Training sessions • Illustrations with examples
Clinical / middle managers	• Address issues & concerns • Buy-in & participation • General ownership of Casemix (DRG) system	• 1 – 3 months • Discussion paper • Seminar / workshops • Invitation to form Clinical Casemix Advisory & Technical Development Committees	• 4 – 12 months • CCC members as advocates • Clinical input for cost weight & clinical appropriateness • Incentives , behavioural change
Senior management	• Acceptance, participation & ownership of resources allocation principles	• 1 – 3 months • Nomination for Casemix Technical Development Committee	• Review casemix results • Identify issues and performance gap

information. The target audience included clinicians, middle managers, senior management, HA Board members, Government officers, media and politicians. Examples of the stratified communication approach with different objectives for different target groups are illustrated in figure 1.

Stakeholders Engagement

An elaborative project structure was set up as engagement and change management mechanism. A clinical advisory structure Clinical Casemix Committee (CCC) was formed to provide clinical input and advise on the technical development of the casemix system and review the casemix classification and the cost weight systems. The CCC was formed by representatives of each Central Coordinating Committees (COC) and Central Committees of various clinical and service disciplines in HA, usually the chairmen, chairladies or their delegates. The CCC was designed to have two clinicians as co-chairmen, one from surgical and another from medical stream in order achieve a balance of power and perceived fairness amongst clinicians.

A Casemix Development Committee (CDC) was formed by nominations from seven Cluster Chief Executives. Wearing the hats of CCEs, the CDC ensured technical development work was preceded in a fair and transparent manner to ensure a level playing field for all clusters.

By participation in the casemix development, and adopting their inputs and comments, members of CCC and CDC had a strong ownership for the products of the casemix project, as if this was their 'baby'. They would then become the Casemix leaders in the clusters and the cluster's change agent.

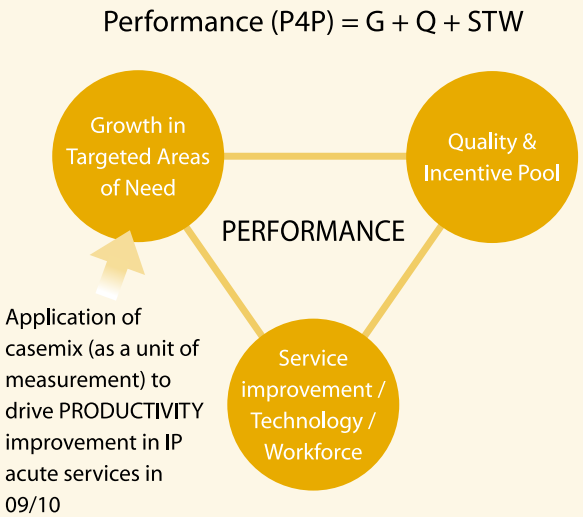
When the P4P and Casemix system development was near completion, discussion sessions were held with senior Government officers and HA Board members for their buy-in and blessing.

Creating a Vision and Establish the Need to Change

With all the technical development work progressing in 2008, but without a clear direction of changes in hospitals funding system, a lot of guessing, uncertainties, rumours and speculations had accumulated amongst the clusters near the end of 2008. In November 2008, in light of the new Government funding arrangement, in which HA will be given 2.9% recurrent funding growth for three years up to 2011/12, it was considered the best opportunity to announce the new P4P internal resources allocation system for the 'new money', and use casemix as the strategic purchasing units for 'buying hospital services most needed by HA' from the clusters.

A series of nearly 12 briefing sessions to all the clusters were arranged within 2 weeks time, and CE had to re-arrange his original schedule in order to attend all the sessions personally to demonstrate his commitment and importance of the new system, and to communicate his vision with the symbolic P4P logo, the 3-bubbles. (Figure 2)

Figure 2: HA's Pay for Performance Model



Forum for Direct Communication and Address Issues

A casemix workshop was strategically arranged at the end of November 2008. The workshop was attended by all the HA staff participated or contributed to the casemix project development, and also included seniors management teams, CCEs and other relevant HA staff. The workshop was structured to facilitate participants to deliberate the issues associated with casemix implementation constructively, and to achieve consensus on the casemix development direction particularly to identify areas of priority. The workshop had acknowledged that casemix system was not perfect and had issues, but the participant and contribution of various parties could help to build a better and fairer system for HA.

Quick Wins and Make Changes Permanent

Based on the outcome of the deliberation of the Casemix work in 2008, a plan to improve the creditability and acceptability of the casemix system was undertaken in 2009. A modified DRG system and a set of clinically more acceptable relative weights for measuring the hospital outputs were reviewed and endorsed by the casemix committees. Summary result of the casemix development project was described in the "Casemix Development Report". The result was reviewed at the second Casemix workshop in October 2009 and the progress was satisfactory. Of course, like any complicated project, one would expect that some issues were still outstanding and new issues emerged.

Figure 3: List of Pilot Quality QPIs

Strategic Priority Areas	Quality Performance Indicators	Performance Target
Access	**Waiting time SOPD - routine category** 1. Medicine 2. Surgery 3. Psychiatry 4. Orthopaedics	new case booking for routine cases 75th percentile at 52 weeks
	Cancer treatment waiting time 5. Breast cancer 6. Colorectal cancer	90% of patients < 55 days from diagnosis to first definitive treatment
Safety	7. MRSA bacteraemia for acute episodes	< 0.1258 MRSA bacteremia in acute beds per 1,000 acute patient days
	8. Casemix-adjusted unplanned readmission rate	HA's best performance
Specific disease Management/ integrated care	9. Fracture hip surgery (pre-op LOS)	70% of fracture hip surgery with pre-op LOS=2 days
	10. DM-HbA1c control in each cluster (combine SOPC and GOPC)	35% of DM patients treated in GOPD and SOPD with HbA1c of <7%
	11. Hypertension - BP control for GOPC patients	65% with BP < 140/90 mmHg
Appropriateness of care	12. Reduce avoidable hospitalization	To be determinate

It is important to make changes sustainable and 'institutionalize' the new approach. P4P is now an integral part of the HA's annual planning and budgeting tool. Casemix data has become part of routine management reporting. It is expected that Casemix data will soon be readily available to all, including clinicians for their own research and clinical audit.

Moving Forward

The P4P development did not stop at DRGs. In 2009, a new 'pay for quality' incentive programme was designed and developed with the collaboration of a number of teams in the HA Head Office. In the 2010-11 HA budget, $50 million was earmarked as a pilot programme to incentivize clusters to improve service quality. A number of quality performance indicators related to access, appropriateness of care, safety and specific diseases management were chosen as a pilot to measure performance against agreed targets. The list of selected quality performance indicators are listed in figure 3 below. Rewards would be given to clusters with significant achievement or improvement in quality performance.

It is expected that the list of quality performance indicators would gradually expand and serve to provide a better reflection of clusters performance in quality, and eventually fulfilling the original objectives of P4P, a system that "……*provide incentives to promote productivity and quality…..*" *Shane Solomon*.

The journey of the case mix team has been both a pleasant and difficult one but at the end of the day, I think we have been able to adopt international practices and adapt to the local scene to make the P4P and case mix project in HA something very unique to Hong Kong. As with all projects, the P4P project has a life of its own and we will continue to grow and nurture this in the future.

References

1. *Casemix Office. 2009. Casemix– 1 Year On. Report on Casemix Development.*
2. *Judson, Arnold S. 1991. Changing Behavior in Organization: Minimizing Resistance to Change. Cambridge, MA: Basil Blackwell.*
3. *Kotter J. Leading Change: Why Transformation Efforts Fail. Harvard Business Review, 1995; March-April*
4. *Kotter J. Leading Change. 1996. Harvard Business School Press.*
5. *Lewin K. Field Theory in Social Science, 1951. Harper & Row. New York.*
6. *Lewin K. Frontiers in Group Dynamics: Concept, Method and Reality in Social Science; Social Human Relations. 1947; 1: 5-41. Available at: http://hum.sagepub.com/cgi/reprint/1/1/5*
7. *Solomon S. Keynote Address by Chief Executive of Hospital Authority at the Hospital Authority Convention 2007 on 7 May 2007*

Dr. LEE Koon Hung

From Hospital Accreditation to Continuous Quality Improvement

Hospital accreditation is an organization-wide approach focusing on both clinical and supporting services which are instrumental in the patient process and experience. The beauty of the methodology is rigorous evidence in standards development and peer review processes to assess the levels of performance. The organization's commitment by adopting a sound governance structure is the key to the success for continuous quality improvement (CQI).

The core of the accreditation scheme is cyclical evaluation of services driven by external quality assurance in line with the performance management system. Healthcare managers are recognized as part of the system in developing quality standards and contributing information to support the process.

In Hong Kong (HK), it is the first time that both public and private hospitals join the same accreditation scheme to conduct peer review against the Evaluation and Quality Improvement Program (EQuIP 4) standards. The standards are developed by the Australian Council on Healthcare Standards (ACHS), an accrediting agent which has been recognized by the International Society for Quality in Health Care (ISQua) for its organization, standards and surveyor training.

How to Be an ACHS (Hong Kong) Surveyor

It is a new page for HK to have 21 healthcare workers appointed by ACHS as its international surveyors. They were all nominated by their institutions and then selected by the ACHS Program Support Committee to attend a 4-day surveyor induction course. After formal evaluation, suitable candidates were arranged to attend training surveys in hospitals. Formal appointment as ACHS surveyor was recommended upon satisfactory feedback from surveyor co-ordinator and hospitals.

On 5 March 2010, Ms Sandra Lee, JP, Permanent Secretary for Food and Health(Health) of HKSAR Government officiated the first appointment ceremony and witnessed the first major milestone of our quality journey. The appointed surveyors would participate in the surveys of pilot hospitals in HK in coming months.

Response of Pilot Hospitals

Congratulation to Hong Kong Sanatorium and Hospital for its accreditation award by ACHS after its Organization-wide survey in December 2009. With this encouraging result, all other pilot hospitals are actively preparing for their accreditation surveys with reference to the findings in consultancy surveys.

In the Symposium on Quality Improvement in Healthcare co-organized by Division of Quality and Safety and Hong Kong West Cluster of Hospital Authority (HA) in March 2010, quality managers of pilot hospitals have shared their arduous effort in the preparation process. One of them described their effort and passion like Don Quixote in the story of 'Titling at Windmill' and won the applause from the floor. The audiences appreciated and resonated their passion and participation of all healthcare workers despite the uncertainties they faced.

With the support of hospital management, staff in HA learn to demonstrate their achievements and improvements in daily practices during the evaluation process by external consultants. Although there are different priority actions to be followed up, the motivation and momentum driven by the value of CQI convince them to come together to strive for better quality.

Challenges Faced by HA Hospitals

In view of the fact that HA hospitals are relatively larger with an average bed size more than 1000, the service provision is more complex and patient volume is very high, the process and staff involved in the evaluation process of different aspects and systems in 45 criteria of hospital accreditation would be multiplied as compared with private hospitals. Besides, private hospitals have gone through Trent Accreditation Scheme for the past decade of which infrastructure and staff acceptance towards accreditation surveys are much well established among both management and frontline staff.

There are a few terminologies which are unfamiliar to most public hospitals such as credentialing and clinical care documentation. Credentialing and specifically clinical privileging involve the staff's interpretation in understanding the qualifications, maintenance of training records, evaluation and acknowledgement of experiences. Documentation of the daily clinical care is fundamental to dissemination of information, sharing of clinical care and illustration of achievements in our daily patient activities. With the new concept of CQI by evaluation, time is required for HA staff to grasp the notion and trial the implementation for preparation of the accreditation program.

Public hospitals in HK have outstanding coordinated care compared with our neighbor countries, the results of disease treatment and many health indicators are overall comparable or even superior to our international counterparts. However, it may have lead to less attention to the 'backyard', the supporting services whose management and standards will also impose significant risk at different levels of patients care.

Culture of Evaluation

In our daily work, it is not uncommon to have duplication of administrative and management activities which staff want to avoid. Despite the emphasis on cost-effectiveness, the information explosion could have generated multiple paper work and inefficiency. Sometimes, staff keep on collecting data without reviewing and implementing any improvement measures and thus result in wasting certain effort.

Evaluation is an effective tool to review the data/ information on hand, identify areas to focus our effort, and to dump outdated documents by regular review. It is a common finding that hospitals are overloaded with assessment forms. The accreditation process could help in evaluating the necessities of the forms and hence reducing avoidable administrative work.

Understanding About CQI

CQI has been used over a decade, it is now re-vitalized because the new culture could help us to focus on the Standards required for managing the quality of services in hospitals. The previous experience teaches us that the quality should be defined first before we pursue the investigation and re-investigation. For service improvement, it is quite often that audit of simple indicators could serve the purposes of evaluation and improvement.

As a CQI process, accreditation does not require many reinventions or introduction of new practice or indicators at one time. It is already very practical and effective for hospitals to focus on regular evaluation of the corporate key performance indicators and improving on them. Departments would only need to design a few indicators that are important to their core services for benchmarking as internal reference.

Sharing and Reporting

With the successful experience of private hospitals, their sharing could drive for quality improvement in public hospitals. Public reporting of the accreditation results could also facilitate the process of cross-fertilization for developing quality initiatives. Back to the fundamental, a hospital still needs to ensure an effective quality system to nurture the CQI culture.

FC PANG, Fion LEE

Abstracts

of the conjoint examination (2009) of the Australian College and Hong Kong College Health Service Executives fellowship thesis

Leading and Managing Change in the Community Network in Hong Kong

The SARS outbreak in 2003 was the primary catalyst in exposing the gaps and weaknesses of the public health care system in Hong Kong. The system was regarded as fragmented, and there was a lack of communication and collaboration among health care professionals. Much effort has been put on strengthening the primary care system, raising public health awareness, and developing a health care environment to encourage sustainable partnerships between the public and private health services.

To address the challenges, the government of Hong Kong has stepped up in the initiatives to reform the health care system. These initiatives included establishing a stronger primary care network, aiding in public-private partnerships (PPP), enhancing private medical services, improving medical servicing system, expanding healthcare promotion and the public healthcare safety net. These initiatives call for a stronger preventive health approach, which requires the collaborative efforts among the health care professionals in the community.

Prior to SARS, doctors in the community were accustomed to practicing medicine individually. There was no incentive among the doctors to form networks and in sharing resources and information. What the SARS epidemic had taught the community was the importance of a community-wide engagement of doctors. Several doctors have taken the initiatives to form local networks, engage the community to share ideas and information. Other leaders emerged to take charge in uplifting the spirits of health care professionals and renewed their commitment to fighting the disease.

The Hong Kong Medical Association (HKMA) Community Networks was established during the time of widespread fear in SARS by a group of doctors in Tai Po. As the HKMA President, Dr. Lo Wing Lok took the lead in the community to ensure that patients are provided with education on self-protection, disease prevention, and personal healthcare. Together, Dr. Chow Chun Kwan lead private doctors to participate in the community network to encourage public-private collaborations and facililtate efficient communication among the doctors. Through the network, doctors stepped out of their clinics and reached out for the citizens in the community.

The goal of the Tai Po Community Network is to provide quality health services and reassurance to patients. The Community Network focuses on conducting continual medical education (CME), achieving PPP, and providing public education to the community, schools and the elderly. It cooperates with the district office, corporations, the government, and academic institutions. Several initiatives have sprouted since 2003 that have called for such collaborative efforts towards public health. 'One School One Doctor Campaign' was a success that engaged the community in teaching students to maintain personal and environmental hygiene.

In acknowledging the importance of primary care and preventive medicine, the networks focus on conducting doctors meeting, public talk, providing programs on patient referral, school, child care and elderly, as well as IT and communication. In addition, the networks educate the public about environmental hygiene, drug abuse, mental health, diabetes, and glaucoma. Some of the programs and public education were conducted in collaboration with other private organizations and pharmaceutical companies such as Pfizer.

Leadership and good management practices are essential to ensuring a sustainable change in the primary health system and for the future of health care development. The success of the leadership in the HKMA Tai Po Community Network has already influenced other districts to promote health and enhance collaborations between the public and private sectors. Through networking and sharing of resources, experiences, and knowledge, doctors can better serve the public while preventing future crisis. The Tai Po Community Networks will continue to set an example and engage every stakeholder to actively promote health throughout Hong Kong.

As a community leader and a visionary, the HKMA President, Dr. Tse Hung Hing argues that private-public-partnerships are the cornerstone to sustaining and flourishing future community services. He firmly emphasizes that the goals of the PPP must take into consideration the views from patients, public doctors and private doctors. Dr. Tse continues to play an important role as a community leader in shaping government's policy on medical services, and in striving to create an environment for the public and private sectors to collaborate.

Dr CHOW Chun Kwan, John

Preventing Wrong Patient Wrong Site Surgery - A Case for Change Through Clinical Governance

Surgical complications represent a global public health problem. The World Health Organization estimates that each year half a million deaths related to surgery could be prevented. Thus, surgical care and its attendant complications represent a substantial burden of disease worthy of attention worldwide. Wrong patient wrong site surgery is a particular preventable category. And it should be prevented at all cost.

This paper reviews an initiative to identify potential sources of errors along the journey of a patient who undergoes surgery in New Territories Hospital East Cluster, Hospital Authority, Hong Kong (NTEC). The ultimate goal is to introduce a checklist first pioneered by the World Health Organization and to some extent standardize practices in the three acute hospitals in NTEC to prevent wrong patient wrong site surgery.

The surgical journey experienced by a patient is often convoluted and involves multiple steps. An analytical tool called Failure Mode and Effects Analysis (FMEA) was adopted to evaluate the inherent risks along the care process. Such technique has been used by aerospace, automotive and other high-risk industries for decades for its ability to systemically evaluate the entire complex process in a proactive, anticipating and positive approach. FMEA places the emphasis on the system design and not individuals when evaluating risks and errors. A number of features of wrong site surgery make it an ideal candidate for FMEA, namely,

- Potential serious consequences are involved;
- Surgery is often complex and involves multiples steps and personnel, as well as sophisticated equipment or supplies. In short, a lot of communication and coordination is needed;
- It also follows that standardization is difficult due to inherent heterogeneity of clinical conditions and heavy reliance on human judgment;
- An emphasis on hierarchy which is not necessarily conducive to team work and early identification and rectification of problems;
- Stressful environment with tight constraints in time and other resources which may induce more mistakes than usual.

The major steps of FMEA include:

1. Map out the major processes and sub-processes
2. Identify ways in which the processes/sub-processes may fail (known as "failure modes" in engineering circles).
3. For each failure mode, identify possible effects and the potential seriousness.
4. Prioritize the failure modes according to severity and frequency.
5. Redesign the system to neutralize/mitigate the risks.

In our case, the failure modes were identified around the three key processes of preventing wrong patient wrong site surgery: pre-operative verification, site marking and time out and improvement measures were so targeted.

Engagement of health care professionals was the key to prevent wrong patient and wrong site surgery. There was in addition a specific need to marry corporate and individual accountabilities. This was done through the introduction of clinical governance. Under the ambit of which, both the organization and individuals were brought to account in an appropriate and effective manner.

Historically, the quality of clinical services rests heavily on professional self regulation. This is however not adequate. For example, it does not address sufficiently corporate responsibility. Besides a multi-disciplinary team is often involved and team members are bound by varying professional codes. Both overseas and local experience indicates clearly in the case of medical mishap, the public and the government invariably express a legitimate request for corporate and individual accountability. Clinical governance can provide answer as to 'why' and 'how' corporate/individual accountability is to be met.

In steer the process, a number of skills are called for, mainly analytical skill, people skill, political skill. A good understanding the barriers to change is also essential to effectively implement changes. To this end Kotter's change model was referred to. Emphasis had been laid on building a vision, communicating it well enough, systematically planning for short-term wins.

In summary, to prevent wrong patient wrong site surgery, it is essential to engage the health care professionals to systematically evaluate the risks inherent in the whole surgical journey underwent by a patient. A specific tool called FMEA had been used for such a purpose. Clinical governance is throughout emphasized. In order to successfully introduce the change, various leadership skills are useful and an understanding of the impediment to change and how to overcome them is indispensable.

Dr YH CHONG

Past Events

The College organized a series of activities over the past few months, ranging from seminars, hospital visits and social events. Here we show you some of the happy moments!

1) 7 Nov 2009

Visit Union Hospital

Participants: 20

2) 21 Nov 2009

Visit HK Sanatorium & Hospital

Participants: 18

3) 11 Dec 2009

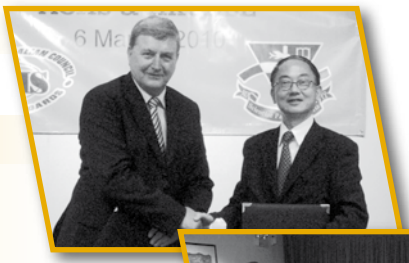
Role of Nursing in Hospital Accreditation

Morning Session: Hospital Accreditation - Nursing Perspective
At Function Room, Hong Kong Productivity Council

Participants: 65

Afternoon Session: Hospital Accreditation - Healthcare Managers/Executives Perspective
At Lecture Theatre, Hong Kong Productivity Council

Participants: 72



4) 6 March 2010

Fellows' Night & Spring Dinner

The College organized a Fellows Night on 6 March, 2010, the first time in the College history that Fellows are invited to an evening of free food and drinks! The College invited our guests from the Australian Council of Hospital Standards (ACHS) and Mr. Brian Johnson, the Chief Executive of ACHS delivered a short but interesting talk on " What's next after accreditation?"

Around 53 fellows and friends of the College gathered in the function room of the Hong Kong Academy of Medicine to relax and network with friends and fellows. To spice up the evening, lucky draw was arranged and one lucky guy went away that evening with the top prize of two nights stay at the Six Senses Spa and Resort in Phuket! So don't miss this event next year as you could be the lucky one to get the top prize!

Coming Up Soon!

Is it possible to have an error free system in the health care world of today? Our College will examine this important topic at its 4th Annual Conference on 10th July 2010. This will be followed immediately by our AGM and annual dinner. So come and hear Dr P Y Leung, Director of Quality and Safety of the Hospital Authority, Mr W K Chen, Controller of the Government Flying Service and Mr F Chan of the Electrical and Mechanical Services Department talk about how they manage risks in their area of work.

Look out for more details of this important event and come and support us !

Join us at the National Annual Congress of the Australasian College of Health Service Management from 14 – 16 July 2010 at the Esplanade Hotel Fremantle, Western Australia. This Congress is held in conjunction with the Centre for Health Assets Australasia (CHAA). The theme of the Congress is Sailing the Tides of Turbulence and will feature many prominent speakers from all parts of the world. All fellows are also invited to the Fellows Night on 13th July and the College will at the same time, organize visits to hospitals and of course, sight seeing to take in the various sights and smells of this beautiful part of Aussie land, of course, not forgetting the great wines from this part of the world too!

As a member of our College, you will be entitled to a huge discount on the registration fee, so hurry and indicate your interest to our Honorary Secretary, Ms Tammy So.

Application Form

Hong Kong College of Health Service Executives
香港醫務行政學院
Membership Application / Renewal Form 2010/11

A. Name:

(Family Name / other name)

Please (✓) ☐ **New** ☐ **Renewal**

(for membership renewal and no change in personal data, please skip to Part D)

Title : Prof / Dr / Mr / Ms / Mrs HKID No.: ☐☐☐☐☐☐☐ – ☐ Sex : M / F

Professional Qualification : _____

_____

Qualification in Health Care Management : _____

_____

Work Position Held : _____

Place of Work : _____ _____

(Department / Division) (Organization / Institution)

Nature of Organization : ☐ HA ☐ Government Department ☐ Private Hospital
☐ Academic Institute ☐ Other Public Organization
☐ Commercial Organization

B. Correspondence Address :

C. Contact Information:

Daytime Contact Phone No. : (off) _____ (mobile) _____

Fax No. : _____ Email : _____

D. Membership type: (please ✓ in the appropriate box)

Membership Type		HK Membership ** (HKCHSE)		Dual Membership (HKCHSE/ACHSE)	
Fellow *		HK$500	☐	HK$2,500	☐
Associate Fellow		HK$300	☐	HK$2,300	☐
Associate		HK$200	☐	N/A	☐

* Fellow membership only applied to those who have been conferred Fellow by the College

** If you are life member of the HKSHSE, you still need to pay full membership fee annually w.e.f. 2008/09.

Qualification for Associate Fellowship: holding a degree in management or a full time managerial position

Please send this application with cheque payable to **"Hong Kong College of Health Service Executives Ltd."** to **P.O. Box No. 70875, Kowloon Central Post Office, Hong Kong.**