AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T | 61 2 6270 5400
F | 61 2 6270 5499
E | info@ama.com.au
W | www.ama.com.au
42 Macquarie St Barton ACT 2600
PO Box 6090 Kingston ACT 2604

16 November 2018

The Australian Institute of Health and Welfare
1 Thynne St
Bruce ACT 2617

By Email: PPH_feedback@aihw.gov.au

AMA response to consultation paper: A potentially preventable hospitalisation indicator specific to general practice

The AMA welcomes the opportunity to comment on the above paper. It is the position of the AMA that clinical indicators must be developed independent of government and ratified by the relevant medical specialty. As such, input from the AMA Council of General Practice Executive Committee has informed the comments and suggestions provided in this submission.

The AMA supports the monitoring and continual improvement of health care quality through the use of clinical indicators. They create the basis for quality improvement and prioritisation and provide a method for assessing the quality and safety of care at a system level.[1]

The purpose of a potentially preventable hospitalisation indicator specific to general practice must be about analysing processes, identifying what changes could be made to improve the process, and establishing a plan to make improvements. It cannot be utilised to assign fault for an ineffective process, rather it should determine what can be done differently to improve the outcome.

Developing potentially preventable hospitalisation indicator specific to general practice

Quality of care can be defined as 'the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge'.[2] The purpose for introducing a PPH for general practice must be to support the provision of quality care.

Nutrition, environment, lifestyle, poverty and the social structure of society have been demonstrated to have powerful effects on health as measured by mortality rates.[3] As such, all reports which make use of data from an indicator specific to general practice must make note of the complex causes of ill-health and potential under-resourcing of primary and community care. The findings of the most recent AIHW report *Potentially preventable hospitalisations in Australia by small geographic areas*, which uses the pre-existing National Healthcare Agreement indicator, revealed that there was significant variation of rates of PPH between

[1] Clinical Indicators Position Statement, 2012 https://ama.com.au/position-statement/clinical-indicators-2012
[2] Lohr, K.N. (ed.) (1990) Medicare: A strategy for Quality Assurance. Vols I and II, Washington DC: national Academy Press, 1990
[3] Mant J.2001. Process versus outcome indicators in the assessment of quality of health care. *International Journal for Quality in Health Care 2001*: Volume 13, Number 6: pp 475-480

regions. At the level of Primary Health Networks, some areas were almost three times as high as others, while at the scale of smaller local areas some were more than five times as high.[4] There are many factors which may contribute to the disparities, such as availability of primary care services, social determinants of health, or hospital reporting practices. These must be acknowledged or there is a risk that the data will be used to claim that GPs are underperforming when the reality is that a region is experiencing workforce shortage.

It is also imperative that indicators are assessed on the basis of the strength of scientific evidence for their ability to predict outcomes. An ideal indicator should be:[5]

- Based on agreed definitions, and described exhaustively and exclusively;
- Highly or optimally specific and sensitive, i.e. it detects few false positives and false negatives;
- Valid and reliable;
- Able to discriminate well;
- Able to relate clearly identifiable events for the user (for example, it is relevant to clinical practice);
- Permit useful comparisons; and
- Evidence based.

As well as meeting these criteria, clinical indicators should:

- Give an indication of the quality of the patient care delivered;
- Comply with high quality standards;
- Be constructed in a careful and transparent manner;
- Be relevant to the important aspects of quality of care;
- Measure the quality in a valid reliable manner with minimal inter and intra-observer variability so that they are suitable for comparisons between professionals, practices, and institutions;
- Be selected from research data with consideration for optimal patient care (preferably an evidence-based guideline), supplemented with expert opinion;
- Be relevant to important aspects (effectiveness, safety and efficiency) and dimensions (professional, organisational and patient oriented) of quality of care;
- Be feasible (that is, be appropriate, measurable and improvable) as well as valid and reliable; and
- Be defined exactly and expressed as a quotient.

Response to Key Questions

The AMA notes that the aim of the proposed general practice focused PPH is to address some of the limitations identified in the existing National Healthcare Agreement (NHA) PPH indicator, in particular, to adopt a longer-term view of potential preventability, remove older age groups that have increased complexity and less certain preventability of conditions, take a narrower focus on conditions commonly managed by general practice teams, and to re-asses the types of hospitalisations considered to be potentially preventable due to these conditions.

The following are AMA responses to the key questions highlighted in the discussion paper.

---

[4] AIHW (2018) Web report: Potentially preventable hospitalisations in Australia by small geographic areas. HPF 36 [last updated: 31 Oct 2018].
[5] Mant J. *op cit.*, pp 475-480

Q1. Do you agree with this definition of potentially preventable hospitalisation, in light of the purpose of the indicator? Why or why not?

admission to hospital for a condition where the hospitalisation could have potentially been prevented through the provision of appropriate individualised preventative care and other health interventions delivered by general practice teams.

The AMA supports the definition of potentially preventable hospitalisation as described above, however the use of "general practice teams" is not specific enough. Instead, the AMA would prefer "GP-led primary care teams".

PPH's are the responsibility not just of GP Teams, but of the system. A PPH, even one specific to general practice, is a measure of the success or failure of the "healthcare neighbourhood".[6] A medical neighbourhood is made up of many services, such as, community health, transfer arrangements, follow up, and clinical handover. By utilising the indicator in a manor which reflects a potential failure in the neighbourhood, more effective solutions can be sought.

It is also important to note that locations and populations have significantly different resourcing and community composition. For example, rural and remote areas have far fewer GPs and other medical or community health services. A GP-led primary care team acknowledges the breadth of the team – it may be a sole GP in a community spread over hundreds of kilometres, or a GP in a metropolitan area where allied and tertiary services are abundant.

Q2. Do you agree with this definition of general practitioner teams? How could it be improved?

The general practice team consists of all people who work or provide care within the practice. Practice teams are often multidisciplinary, made up of GP leaders, nurses and allied health professionals designed to service the unique requirements of each community.

The AMA agrees with this definition for a *GP-led primary care team*, but we would like to see the team noted as one component of a "healthcare neighbourhood":

"Neighbourhoods … operate with the general practice or Aboriginal medical service as the hub and include health and social care services. Neighbourhoods support the practice through engagement with care coordination, shared care planning, effective communication, data sharing, and a team-based approach to care… It refocusses the health system from operating in silos to integrated implementation with primary care as the hub."[7]

It is also important that it acknowledges the increasing role that virtual teams can play. As multidisciplinary care adapts to advances in telecommunications, interactions between teams may be more frequent through virtual meetings, in both rural/remote and urban settings. As this is an area where change occurs at a rapid pace, it is important that this definition is reassessed for purpose regularly.

Q3. Do you have any comments for condition exclusion, or comments in regards to the listed conditions (for example, vaccine-preventable conditions, acute conditions, or chronic conditions)?

[7] *Ibid.*

The AMA considers the list of included and excluded conditions is a good starting point, however would encourage the establishment of a working/advisory group comprised of key stakeholders with clinical experience in general practice to regularly review what conditions should be included and excluded for the purposes of the PPH for general practice. The AMA would expect that any indicator must be continually tested and adapted to ensure it is achieving its goals and providing usable, relevant data.

Q4. Do you agree that this approach optimises consistency across the proposed indicator? Please provide comments.

The AMA has no objection to this approach at this point in time and has no further comments to add.

Q5. Do you agree that this approach reduces inclusion of duplicate hospitalisations?

The AMA appreciates the effort involved in limiting the indicator to presentations that could reasonably have been prevented in general practice. It is important to note that some PPH hospitalisations may lead to duplicate hospitalisations. Poor diabetic management may give rise to a hospitalisation for an acute condition such as cellulitis or gangrene, resulting in a longer duration of hospitalisation and increased rate of, or identification of, further complications. Measuring the rate of duplicate hospitalisation may have a role the AIHW should consider in assessing the value to the health system of quality preventative care, acute care and chronic disease management provided in general practice.

The AMA is also concerned about the lack of discussion surrounding re-admissions to hospital where the GP has not received the patient's discharge letter or had a chance to see the patient. GPs are often blamed for readmission of a patient when they have never received any notification that their patient was admitted to hospital, let alone discharged. Noting the concept of the "healthcare neighbourhood", this is within the handover of care which is a crucial component in preventing re-hospitalisations.

Q6. Do you agree with the proposal to:

- exclude patients 85 years and over, and
- Separately report those aged 75 to 84 due to increased complexity and potential reduction of preventability of these hospitalisations?

The AMA does not agree with the proposal to exclude patients 85 years and over. Patients 85 and over should be reported separately, but normalised to Socio-Economic Indexes for Areas and age ranges. While it is true that people aged over 75 are over-represented in hospitalisation statistics and multiple comorbidities can make this more challenging, removing the population from the indicator implies that there is no capacity for quality improvement in this field. The AMA only supports the use of a general practice specific PPH indicator for use in quality improvement. We acknowledge that these data may be challenging to interpret given the imprecision of coding, as noted in the consultation paper, however this too may lead to improvement in the coding practice.

The AMA supports separately reporting those aged 75 to 84, with the additional category of 85 and older also reported. The AMA also supports further work in this area, as noted in the consultation paper, as clear data on PPHs for this population may be useful for supporting more GP visits to aged care facilities, or other relevant services and infrastructure as required.

Q7. Do you agree with the proposal to remove same-day hospitalisations to reduce the impact of variations in admission practice?

The AMA does not agree with this proposal. While it is true that admission practices vary between hospitals, simply excluding same-day hospitalisations due to this could undermine the accuracy of data and could lead to individuals or health care organisations altering the provision of care to achieve specific benchmarks, thereby undermining patient care.

It is also important to note that a visit to the emergency department has no out-of-pocket costs to the patient which can be a significant pull factor, particularly where the hospital has a good reputation and there may be no bulk-billing general practices available at the time.

The concept of a potentially avoidable general practice-type emergency department presentations, noted on page 13 of the consultation paper, would also be useful in providing a more robust picture potentially preventable hospitalisation events.

Q8. Do you agree with these procedure exclusions? Would you recommend any further exclusions for these conditions, or for other conditions?

The AMA at this time has no objections to the exclusions and has no further inclusions to add.

Q9. Are there other population groups you would wish to see in greater detail with respect to potentially preventable hospitalisations, either through specialised indicators or through disaggregation?

Patients from Residential Aged Care Facilities (RACFs) could be a specialised indicator which would be useful in demonstrating the quality of care accessible to and provided in and for these patients.

In addition, disaggregation of cultural and linguistically diverse groups and SEIFA groups would be useful for understanding the primary care needs in underserved communities.

Q10. Are there any polices or programs that might be of particular interest to the long-term trends for a particular condition or conditions?

The cessation of the Practice Incentive Program Diabetes, Quality Use of Medicines, and Asthma Incentives may have some impact on the trends for hospitalisations due to diabetes, adverse drug events or asthma. Alternatively, the Workforce Incentive which enables practices to integrate non-dispensing pharmacists and allied health providers into general practice may see an improvement in trends for adverse drug events and contribute to improvements in chronic disease management.

The lack of appropriate nursing ratios in RACFs and MBS rebates for GP telehealth items in RACFs, the proposed cessation of the PIP Aged Care Access Initiative and changes to rebates for after-hours care provided by Medical Deputising Services are examples of policies or programs that may influence trends.

Q11. Would there be other usages for the proposed specification not detailed here?

The AMA believes that the specification will be important for service model design and financing of such models. Ideally, reform of general practice must move toward a system which encourages patient-centred longitudinal care coordinated by a GP. This specification may allow insight into where and how this can be achieved.

Additional Comments

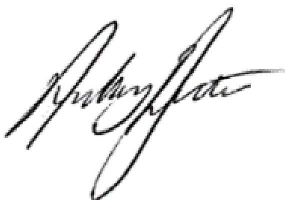
It is the position of the AMA that a general practice specific PPH indicator must be supported by evidence and prior to implementation must be tested to ensure appropriateness, reliability and validity. The indicator must be reviewed, evaluated and updated on an ongoing basis to ensure continued appropriateness, reliability and validity over time.

Noting the concept of the "healthcare neighbourhood" discussed in the responses to questions one and two, a PPH indicator specific to general practice could provide useful data for identifying areas of concern. Once the area is identified, closer examination is required to determine how to improve the local system. The AMA supports the use of high-quality data to encourage continual improvement of the system.

Implemented correctly, a PPH indicator for general practice could be leveraged to compliment reform of funding structures of care delivery. Implemented incorrectly, it could undermine patient confidence in general practice, specific GPs, or the hospital system. It also has the potential to lead to individuals or health care organisations altering the provision of care to achieve specific benchmarks, thereby undermining patient care.

It is therefore crucial that due consideration is given to any potentially preventable hospitalisation indicator specific to general practice.

Yours sincerely



Dr Tony Bartone
President