AMA Submission on Redesigning the Practice Incentives Program

November 2016

Introduction

Since the introduction of the Practice Incentive Program (PIP) the nature and number of incentives have been regularly modified in an effort to support quality care and to encourage targeted activities in line with Government policy objectives for improving access and health outcomes. While the AMA has expressed concern at some of these changes where they have been implemented as part of Budget cuts, we understand that the PIP is broadly intended to support the evolution of general practice. The PIP over the last two decades has helped to drive initiatives such as:

- the computerisation of practices and active use of practice data and systems to improve the quality of patient care;
- improved vaccination and cervical screening rates;
- ensuring access to after hours services and attendances at aged care facilities;
- encouraging rural proceduralists to maintain their skills;
- ensuring medical student exposure to general practice;
- encouraging practices to employ and utilise the skills of practice nurses; and
- enhanced care for those with specified chronic conditions.

Over 5,400 practices participate in the program[1] and around 83 per cent of general practice care in Australia is provided by PIP practices[2]. The reach of PIP is extensive and is a critical component of practice funding.

Although the AMA is committed to engaging in reform of the PIP, the process is hamstrung by the absence of any additional funding to support change. Indeed the PIP has been subject to successive funding cuts including in the most recent Budget and it is disappointing that stakeholders are being asked to engage in a process that potentially asks us to favour the introduction of a Quality Incentive Payment at the expense of other worthy funding incentive payments.

Strengths of the PIP

The key strength of the PIP is that it encourages practice accreditation. The Royal Australian College of General Practitioners' *Standards for general practice* against which general practices are assessed are designed to reflect contemporary practice, and facilitate safe, high quality primary health care and continuing quality improvement[3]. According to the College these standards are used by over 80% of Australian general practices for accreditation.

We agree that the regular review of incentives is appropriate provided this process is not simply an excuse for Government cost-cutting to general practice. The role of the PIP Advisory Group (PIPAG), which consists of representatives from key stakeholder groups, is vital when reviewing and implementing incentives. Given the close relationship between accreditation

[1] Department of Human Services, Practice Incentives Program (PIP) Data, data for May 2016 http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-PIP_Data

[2] Commonwealth of Australia. Report on Government Services 2016, Volume E: Health Services, Chapter 10, p 10.42

[3] The Royal Australian College of General Practitioners. Standards for general practices 4th edition

and the PIP there is a risk that if incentives are viewed as unattainable or of poor financial value to the practice that practices will disengage from both the PIP and accreditation.

What should be kept or changed?

The AMA supports the concept of data driven quality improvement, whereby general practices can assess their own data to identify areas for quality improvement specific to their practice or patient cohort and undertake action for improvement. The capacity to undertake internal clinical audits and to appropriately interpret the data will be essential.

The PIPAG, of which the AMA is a member, in earlier discussions on the re-design of the PIP, advised that the *Indigenous Health Incentive*, *Teaching Incentive*, *Aged Care Access Incentive*, *eHealth Incentive*, *Rural Loading*, and *Procedural GP Payment* should remain in the PIP as standalone incentives. It is therefore disappointing to see that it is proposed to cut the *Aged Care Access Incentive,* the *Indigenous Health Incentive*, and the *Procedural GP Payment* in order to fund the new Quality Improvement Incentive. The AMA believes that if the Government is serious about strengthening general practice than it must truly invest in it and provide the additional funding to support this new initiative. Instead, it has stripped $21.2 million from the PIP funding pool for the Trial of Health Care Homes, reducing the funding available to support the new incentive, and contributing to a financial imperative to cut these incentives.

Removal of the *Aged Care Access Incentive (ACAI)* is of particular concern in that it would remove an important supplement to support and encourage general practitioners to attend patients in residential aged care facilities (RACFs). Since the introduction of this incentive there has been steady growth in the number of Level B-D attendances to aged care facilities. Given that the remuneration of RACF attendance items fails to adequately account for the opportunity cost of leaving the practice and are further diluted in value should a GP see more than one patient at the same facility, some credit for the continuation of services must go to the incentive. Tinkering with this incentive may simply result in a further decline of GPs willing to provide services to RACFs.

The maintenance of procedural skills for GPs in this country should be a priority for the Government if they truly want to support the provision of the right care, in the right place, at the right time and equity of access for Australian's living outside of metropolitan areas. The *Procedural GP Payment* plays an important role in supporting GPs to maintain their procedural skills so that local communities have access to surgical, anaesthesia and obstetric services.

Rural medicine requires strong procedural skills and local GPs are the backbone of rural health care. GPs with procedural skills who practice in rural areas help ensure that comprehensive health care is available and that treatment and patient management is patient–centred and timely. Shortages of skilled professionals in rural and regional areas result in poorer patient health outcomes. For example the Regional Health Status Profile Report (Gippsland 2012) reveals a decline in patient health outcomes, after and in the 10 years, since the introduction of Optimal Treatment Pathways – which transfers patients away from their homes and families to receive care in metropolitan based "centres of excellence". In addition, where pregnant women in rural areas have to travel outside their local area to access obstetric services there is a higher likelihood they will fail to seek antenatal and postnatal services and

will encounter stress, financial burden, social disruption and a lack of continuity in care[4]. This incentive helps offsets the associated costs for the GP and the practice in enabling the GP to maintain those skills.

The *Indigenous Health Incentive* was introduced as a key part of the Closing the Gap campaign to support mainstream general practices and Indigenous health services to provide better health care for Aboriginal and Torres Strait Islander patients, including best practice management of chronic disease. Since the introduction of this incentive there has been a reduction in the proportion of Aboriginal and Torres Strait Islander babies born with a low birth weight. There have also been significant increases in the number of health checks performed and increased access to medicines[5]. Early evidence provides no clear-cut view that the incentive has led to better health outcomes for Aboriginal and Torres Strait Islander people. The AMA acknowledges that Aboriginal and Torres Strait Islander people continue to experience stubbornly high levels of treatable and preventable conditions, such as type 2 diabetes, rheumatic heart disease, kidney disease, and other life-shortening conditions, high levels of chronic conditions at younger ages, high levels of undetected and untreated chronic conditions, and higher rates of co-morbidity in chronic disease. However, it must be noted that when managing complex and chronic conditions sustained support is required as improvements in outcomes will emerge over the longer term. The AMA therefore has deep reservations about the impact to Aboriginal health if the incentive is removed.

Some aspects of the incentive could be covered under the RACGP's Standards, such as practices routinely recording the identification of Aboriginal and Torres Strait Islander patients and considering the patient's cultural beliefs. The latter, a practice may demonstrate by having a cultural safety policy and providing practice staff with cultural safety training. However, there is a significant risk that if this incentive is removed the attention of mainstream practices participating in the proposed Quality Improvement Incentive could be diverted to other areas, particularly if they have only a small number of Aboriginal and Torres Strait Islander patients. Medicare and Census data would suggest that around 50 per cent of Aboriginal and Torres Strait Islander people attend an Aboriginal Community Controlled Health Service[6][7]. This means there is significant potential for the remaining 50 per cent to be attending either a mainstream general practice or State or Territory run Aboriginal Health Service.

Should the Government proceed with the removal of this incentive some mitigation of the impact could be achieved by:

- collecting data on key clinical indicators specific to Aboriginal health as part of a Quality Improvement Incentive;
- expanding the parameters for the Closing the Gap scripts to all practitioners, regardless of whether the patient has been referred by their GP;

[4] Hoang QL, Kilpatrick S, 2012. Small rural maternity units without caesarean delivery capabilities: is it safe and sustainable in the eyes of health professionals in Tasmania? *Rural and Remote Health* 12: 1941. (Online) 2012.

[5] The Close the Gap Campaign Steering Committee. *Close the gap progress and priorities report 2016*.

[6] Kathryn S Panaretto, Mark Wenitong, Selwyn Button and Ian T Ring**,** Aboriginal community controlled health services: leading the way in primary care. Med J Aust 2014; 200 (11): 649-652.

[7] The Close the Gap Campaign Steering Committee. *Close the gap progress and priorities report 2016 p 20.*

- including an indicator that the patient is registered for the PBS Co-payment Measure in the My Health Record; and
- providing training to all practitioners to check patient CTG eligibility and to include the CTG notation on any PBS scripts for registered patients.

However the AMA is not confident that these mitigations would be sufficient and that the momentum generated on Closing the Gap would be lost.

The viability of rural practices is highly dependent on the additional funding received via the PIP. Removal of *Aged Care Access Incentive,* the *Indigenous Health Incentive*, and the *Procedural GP Payment* will negatively impact on the funding received by rural practices as the rural loading is a percentage of the total of other PIP payments received. Modelling will need to be done on the impact to rural practices of the removal of these three and the other four incentives versus the likely payment under the Quality Improvement Incentive. Consideration should be given to increasing the loading percentages to compensate where appropriate.

Recommendations:

1. That $21.2 million be returned to the PIP to enable the retention of the Aged Care Access Incentive, the Indigenous Health Incentive and the Procedural GP Payment.

2. That comprehensive modelling is done of the impact to practice funding of the streamlining of incentives, particularly for practices in RRMA's 3-7.

3. That consideration be given to increasing the rural loading percentages if modelling demonstrates practices in in RRMA's 3-7 will be financial disadvantage by the new incentive.

Ensuring the efficiency and effectiveness of the PIP

To ensure transparency and accountability around the use of PIP funding it is essential that practices have clear lines around eligibility criteria and the requirements of the incentive.

Requirements must be easily measured and reportable. This will reduce the administrative burden involved in participating and administering the incentive which should ensure that a greater proportion of the funding is directed to the targeted activities.

As outlined in the public webcast on 16 November 2016, payment for the Quality Improvement Incentive would only be made upon the submission of practice data. Not only is this a clear requirement of the incentive it is one that is easily quantifiable.

The streamlining of a number of incentives into the Quality Improvement Incentive will make for a more efficient process for the Department of Human Services (DHS) in processing PIP payments. It should also reduce the administrative burden on practices. It will reduce DHS

administration in preparing and sending multiple reports for each practice and the need for each practice to review whether or not they have met the requirements for the period.

Recommendations:

4. Incentive requirements should be easily measured and reportable.

Quality Improvement Incentive

The payment discussion provides two design options for the Quality Improvement Incentive – Option 1 Redesign for Quality and Option 2 Third Party Provider. While the AMA acknowledges that a number of practices may already be working with a third party quality improvement provider, the AMA does not the support the concept of PIP funding being paid directly to any organisation other than the practice.

If third party providers were to directly receive funding an unintended consequence of this could be that over time practices would have reduced control over the nature of their quality improvement activities. Certainly, the AMA acknowledges that practices may need assistance in identifying and developing their quality improvement activities, and that practices may wish to obtain such services from a preferred provider, but the control of which services and which provider to access those services from should remain with the practice. The AMA would not want to see PIP funding driving an explosion of quality improvement providers of dubious value.

The discussion paper also suggests that Primary Health Networks (PHN) could fulfil the roll of a third party quality improvement provider. The AMA would strongly oppose this. PHNs are already funded to support general practices in attaining the highest standards in safety and quality through the showcasing and disseminating research and evidence of best practice, including collecting and reporting data to support continuous improvement. Practice incentives should not be directly paid to a PHN. Currently, the AMA is unconvinced that PHNs across the board are meeting their objectives following a number of members consistently raising concerns about some PHN's governance mechanisms and lack of engagement with general practices.

The AMA's preference would be to see parts 1 and 2 of Option 1 as outlined in the discussion paper introduced. This option would support both those practices who are already familiar with quality improvement activities and those who are not. This option has the most potential for engaging general practice participation at the outset because it will support practices to evolve in their quality improvement activities.

The AMA believes that discussions around how the incentive might evolve are pre-emptive at this stage and would caution the Department against running before it can walk with the Quality Improvement Incentive. The pay for performance aspect outlined in part 3 under Option 1 raises concerns within our membership, and for good reason. Evidence of the effectiveness of pay for performance in improving health care quality is mixed and there is little evidence that it improves patient outcomes as it can lead to perverse behaviour and

unintended consequences[8]. This opportunity to redesign the PIP needs to be carefully managed to ensure maximum engagement and participation. The AMA suggests that the KISS principle be applied to enhance practices willingness to participate. Evolution of the Quality Improvement Incentive should be based on the experiences of practices and their actual needs. For this reason the AMA would be supportive of the approach outlined where practices share their data and participate in an internal quality improvement process.

Recommendations:

5. That parts 1 and 2 of Option 1 be introduced as it will best encourage and support practice involvement and progression towards quality improvement.

6. That PIP funding should be paid directly to practices and never to third parties who may provide services to the practice.

Key aspects of quality improvement that should be captured

While strongly supportive of the concept of practices having the flexibility to focus on the quality improvement issues that are important to their practice, the AMA, in considering the introduction of the Quality Improvement Incentive, had always expected that some aspects of the existing quality measures would be retained. The AMA is concerned that the quality of care could be retrograded unless some measures of current focus areas are included – even if it is only knowing how many of the practice's patients have asthma or diabetes, or how many of the appropriate aged female patients have been screened for cervical cancer.

The AMA believes a Quality Improvement Incentive should encourage and support practices to better prepare and utilise their data for quality improvement purposes. For example, this may involve data cleansing, improved coding, use of atomised fields and minimising free text.

The AMA supports practices sharing data for the purpose of quality improvement within practices. This is an important process for practices in understanding how they are tracking on quality indicators, how they compare with other practices in their local area and for identifying where improvements can be made. This incentive will support practices not currently doing this to put in place the processes that will inform their quality improvement activities into the future. Practices that already share data with organisations such as PHNs and receive data analysis reports with benchmarking should be able to easily meet the requirements of the new incentive.

Whatever indicators for quality may be agreed, key principles to be applied for their inclusion should include:

- it facilitates improvement in data quality;
- should be easy to record and extract;

[8] Ryan AM and Werner RM. Doubts about Pay-for-Performance in Health Care. *Harvard Business Review*. 9 October 2013

- recording the data should not disrupt practice work flows or the nature of consultations;
- should correspond with key health issues in the Australian context;
- should not increase the demands on GP time; and
- should not increase the administrative burden for GPs or practice staff.

Overall the AMA is supportive of general practices being empowered to make better use of their data to drive quality improvement.

Recommendations:

7. That key quality indicators be developed on which data can be easily collected, extracted and shared without disrupting the clinical workflow.

8. That the Quality Improvement Incentive empower data driven quality improvement within practices.

Data tools

The availability of Clinical Audit Tools such as PEN CAT will enable the task of data extraction to be routinely undertaken. While there are some concerns that multiple extraction tools will complicate data analysis at the end point the AMA believes that restricting the extraction tool to say only one provider has significant potential to stifle ongoing improvement of the tool. The AMA would prefer to see extraction tools developed that are compatible across software platforms and which utilise standardised data definitions to deliver standardised data outputs that can easily be compiled and interpreted.

Recommendations:

9. Clinical audit tools be required to utilise standardised data definitions to deliver standardised data that can be easily compiled and interpreted.

Payment mechanism

The AMA broadly supports the payment structure outlined under Option 1 in the discussion paper. However, the models discussed during the webcast, while covering participation payments and ultimately an improvement payment, failed to make mention of any sign on payment as was mentioned in the discussion paper. Practices will want greater clarity around this.

The AMA would be supportive of a sign-on payment that encourages and supports practices to have in place the facility to extract and share their data while participating in a Quality Improvement cycle. A sign-on payment would not only help those practices yet to start on a quality improvement pathway but would also provide some reward to those who have

already made such a commitment. Sign-on payments are usually a fixed amount designed to encourage and support practices to engage. Consideration will need to be given as to whether a fixed payment will best support this process, particularly if access to an extraction tool is influenced by practice size.

Currently PIP payments are generally made quarterly, given the payments for participation under the proposed incentive will be linked to the submission of data, the AMA would suggest that the frequency of payments may need to be adjusted accordingly. For example, if data is to be subtracted monthly, then payments should be monthly. The frequency of data submissions will need to take account of the administrative burden in extracting and sending the data. If it can be done automatically the AMA would have no objection to monthly submissions and payments as regular and consist cash flow would certainly be of benefit to practices.

The AMA would encourage the Department of Health to give careful consideration to linking the participation payment to practices SWPE values. Currently, the SWPE provides a reasonably reliable measure as to a practices' size, patient and servicing profile. The size of a practice and the patient profile will certainly influence the quantum of data being collected and shared and the participation payment should reflect this. However, should Health Care Homes be rolled out nationally in the future, it can be expected that practices SWPE value will decrease.

This will be because MBS billings, a key element in calculating the SWPE, will decrease as more patients are enrolled into packages of care. Therefore, the SWPE may not be the best measure of a practice moving forward. This of course, will have implications for the remaining PIP incentives as well. An alternative, at least for practices participating in the Quality Improvement Incentive, may be that their data extractions should provide a reliable indication of the practice size, patient profile and perhaps service profile.

The AMA would suggest that some work is done using data from those practices already submitting data to either their PHN or quality improvement organisation to compare the reliability of that data as a comparable measure to the SWPE. The AMA would also suggest if the SWPE is going to be retained that the way it is calculated will need to be modified to account for the services provided as part of a package of care.

The AMA would also suggest that PIPAG should give some consideration to how the participation payment is structured within the incentive. As there is more than one element to the incentive, ie data submission and participating in a quality improvement cycle or activity, consideration should be given as to whether a participation payment will be structured for example on a tiered basis to support each element of the incentive. There is growing concern within the profession of incentive payments that are contingent on meeting multiple requirements before a payment is triggered. Incentives structured this way give practices less choice over what aspects they will participate in and effectively punishes those practices who have met 75 per cent of the requirement and are yet to attain the final 25 per cent. The all or nothing approach can actually discourage any form of participation.

Recommendations:

10. That the payment structure in line with Recommendation 5 consists of the following:

- a sign-on payment of set amount that recognises and supports practices for implementing or having the mechanisms to participate in the incentive; and

- a participating payment that acknowledges the quantum of data collected and shared

- that PIPAG give consideration to how the participation payment is structured to best encourage participation ; and

11. That careful consideration be given to impact of packaged care on the SWPE, and modifications, or a comparable alternative measure be identified.

Conclusion

The AMA believes that a well-designed and appropriately funded Quality Improvement Incentive has the potential to encourage and reward practices for quality improvement efforts. It should facilitate improvements in recording of clinical data and encourage practices to utilise their data to drive changes that will improve patient care and deliver better health outcomes for patients.

The information gathered should not only highlight the value of general practice within the Australian health system but should also inform and support quality innovations within the general practice community while providing a strong evidence base to drive well-informed Government health policy initiatives.

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