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AMA submission to the Department of Health Australian Clinical Quality Registries – A National Strategy

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Overarching comments

The AMA tends to agree there is merit in the idea of establishing a system to broaden the range of clinical quality registries (CQR) and participation in them. Certainly, clinical quality registries (CQR) are widely recognised as a powerful tool to improve the quality and effectiveness of patient care within a clinical domain. Benefits are greatest when clinicians lead the development and implementation of CQR, and trust the validity of the clinical indicators, the benchmark methodology and the benchmarked data of their patients. It is also the case that fewer patient complications will undoubtedly lower the cost of providing healthcare – especially complex hospital care.

The use of a national framework, to create a consistent standard of CQR in Australia could be a sensible mechanism to achieve this outcome. Having said this, the degree to which healthcare provider organisations and individual clinicians are inspired to participate will depend on the details of the accreditation standards and governance arrangements – most of which appear to be a work in progress. There is a long way to go before the AMA will have a clear idea of how this proposed Strategy will positively or negatively impact clinicians and their healthcare organisations or achieves the intended purpose of improving the effectiveness and efficiency of healthcare.

Despite the substantial benefits that could be achieved if all CQR in Australia were of a consistent high standard, with similar architecture, operating systems, data structure and governance to permit comprehensive national reporting, the AMA remains concerned about some aspects of the proposed framework. These concerns are discussed below.

Impact on clinician registration under the National Registration and Accreditation Scheme (NRAS)

During the webinar, departmental officials seemed to confirm three important National Framework design parameters. First, future Commonwealth funding for CQRs will be conditional on meeting accreditation standards established under the proposed CQR National Strategy. Second, eligibility for CQR accreditation requires national clinician participation within the relevant clinical domain. Third, public and private hospitals cannot be compelled to participate. Instead, public and private hospitals retain the right to adopt their preferred approach to measuring safety and quality performance against clinical indicators[1]. This could include participation in the Australian Council on Healthcare Standards (ACHS) benchmarking service that sits outside of the proposed National CQR Strategy.

The AMA would welcome confirmation on these three points. It is not clear how a CQR can be expected to achieve national representation if the clinicians in public or private hospitals participate in alternative benchmarking methods?

Similarly, the AMA would welcome urgent clarification on a comment made during the webinar that seemed to suggest the Commission is considering individual clinician participation in an accredited CQR a requirement for registration under NRAS. If this were to transpire, it would be extremely heavy handed and impractical. For example, what if the clinician is employed by, or has admitting rights to, a healthcare provider/hospital that does not participate? More importantly, clinician participation in an accredited CQR or alternative benchmarking arrangement should depend on the clinician's confidence in the governance of the CQR, including the validity of clinical indicators used to measure patient outcomes, the patient risk adjustment methodology, the data validation and benchmarked data reporting arrangements. The AMA looks forward to further discussion of this issue.

Roles and responsibilities – CQR design and governance

During the webinar on 14th June 2019, AMA Secretariat was pleased to hear clinical colleges, associations and societies will have pivotal roles within the CQR governance structure where decisions such as the relevant clinical quality indicators within a clinical domain, and the management of outliers are made. However, AMA's reading of the consultation document suggests the real influence of clinical colleges, societies and associations has been minimised. This is because the development of the over-arching framework, and accreditation standards (not yet publicly released) will be prescribed by representatives of the Commission and governments[2]. This suggests clinical college influence will be minimised by pre-defined CQR strategy parameters such as the design of the clinical indicator instruments that determine which patient outcomes are measured, the consistent management of outliers and the granularity of benchmarked data reporting.

The AMA has a very strong view that representatives from clinical colleges, societies and associations should have a more prominent upstream role in the design phase of the framework, accreditation standards and governance parameters. They have the speciality and sub-specialty expertise, best practice standards and deep expertise regarding appropriate clinical indicators. Furthermore, practicing clinicians are best placed to shape the national framework for successful implementation in clinical workflows/health care provider environments. Most clinical colleges, societies and associations also already have their own

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[1] Maximising the potential of Australian Clinical Quality Registries, A National Strategy 2019-2029, p3

[2] ibid

trusted consumer advocates. This is a valuable asset that should not be wasted/duplicated with new consumer advocates with no prior experience or knowledge of the complexity and pitfalls of benchmark data interpretation.

Outlier management

Another pre-requisite for CQR accreditation is ‘consistent outlier management’. The AMA requests more detail on the intended meaning of this phrase. The interpretation of an outlier data point is not straight-forward. The measurement is a point in time and the cause will be relevant to the particular clinical indicator, the clinical domain and patient characteristics. Possible reasons for clinical variation might be inaccurate data, insufficient case-mix adjustment or some underlying problem with administrative practices, resource constraints (ie delayed access to diagnostic equipment/treatment), clinical knowledge or technique[3].

Causal attribution for patient complications if they do arise, is also fraught – especially in team care environments such as public hospitals, or when the course of treatment crosses the admitted/non-admitted boundary. For example, the observed outlier patient outcome, could be due to a break-down in clinical handover, or problems with post-operative care and/or outpatient rehabilitation support -all of which cannot be directly attributed to a single surgeon/physician.

Research also shows all hospitals have outlier trends that fluctuate from one clinical indicator data collection period to the next. It is not uncommon for a single hospital (public or private) to have many of its clinical indicators moving in desirable directions and some that move in undesirable directions, and these trends can fluctuate from one reporting period to the next[4].

The greatest value of measuring hospital performance against clinical indicators is generated when outliers are used by senior hospital managers and hospital boards to monitor performance over more than one reporting period to establish clinical areas with persistent negative trends. Causality cannot be established without follow-up investigations involving root cause analysis to fully understand the factor(s) – clinician, team, and/or hospital systems that contribute to the poor outcome. Importantly, this follow up should be in the spirit of cooperation where healthcare organisations and/or individuals involved are assisted to make the changes necessary.

As noted in the opening paragraph of this submission, the effectiveness of benchmarking is greatest when treating clinicians trust the validity of the clinical indicators, the benchmark methodology and the outcome data for their patients. Equally important, a clinician, like any other person, is most likely to accept and act on benchmarked data, if it is delivered in an open, no-blame workplace culture, from a clear position of beneficence[5].

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[3] Australian Council on Healthcare Standards (ACHS). Australasian Clinical Indicator Report: 2010–2017: 19th Edition. Sydney, Australia; ACHS; 2018.

[4] ibid

[5] K. Eva et al, ‘*Factors influencing responsiveness to feedback: on the interplay between fear, confidence, and reasoning processes’*, Advances in Health Science Education, 2012, Vol 17, p15-26

Reporting

The strategic objectives in the Strategy recognize the importance of clinician engagement to the success of any CQR, including those accredited under the National Framework. However, this will mean little, if the design, implementation, and granularity of benchmarked data reporting erodes, rather than inspires, clinician trust and willingness to participate.

Unwarranted variation against clinical indicators or patient reported outcomes may indeed flag problems with the quality of care provided but not all observed variation reliably flags poor quality healthcare or 'unwarranted variation'. Not all patient complications can be avoided. Individual patients can have multiple co-morbidities or prior treatments that directly affect the appropriateness of care and quality of patient outcomes arising from a single healthcare event or treatment. Accurate interpretations of outliers and healthcare variation are only possible with full information about the patient's clinical circumstance and clinical reason for treatment[6].

The AMA has a long track record of support for the My Health Record. However, even as the Record matures, the completeness of the data will always be limited by the patient-controlled nature of the Record and provider participation rates.

It will also be a long time before patient data in the My Health Record can be seamlessly co-opted to measure patient outcomes. Many hospitals and healthcare providers are still not fully connected to the My Health Record and able to access all functions within it. Patient data uploaded from providers who are connected, remains mostly unstructured and un-coded. Resolving interoperability is a very challenging ICT problem given the diversity of proprietary information systems used across the Australian healthcare sectors.

This means, an 'imperfect' understanding of the patient's clinical history and clinical reasons for treatment will likely endure for some time to come, and accurate interpretation of apparent 'unwarranted' variation informed by big data, will be indicative at best. This reality leads the AMA to question the extent to which full patient risk adjustment so frequently referred to in the consultation paper, is realistically possible for the purpose of CQR and reporting results.

Certainly, public hospitals do not currently have the screening systems in place to collect and code patient data to capture a full summary of the patient's health complexities and co-morbidities each time the patient presents to a public hospital. The AMA understands the most complete, and therefore reliable, hospital data sets are populated with clinical data related to an episode – the granularity of which is largely determined by the coding requirements related to hospital funding. A full patient summary would require the development and adoption of new patient screening tools and full information on clinical reason for treatment. The advantage of collecting this additional data in provider data systems, is undoubtedly increased accuracy in case mix adjustment and a more meaningful interpretation of apparent 'unwarranted' variation. The disadvantage is the increased cost impost on public and private healthcare providers at a time when public hospitals are already chronically underfunded and stressed.

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[6] Badgery-Parker T, et al. BMJ Safety & Quality 2018, Vol 28, Issue 3.

This points to two important deliberations. The first, is the cost benefit of collecting and coding the large amount of new data needed to calculate a full and accurate patient case mix adjustment for the purpose of benchmarking. The second, approach is to use existing data collections to measure patient outcomes against clinical indicators to flag apparent outliers as the first step in a process of further investigation. Senior hospital managers/clinical department heads should be responsible for conducting the subsequent in depth, root cause analysis of persistent outliers. Not only are senior hospital managers well placed to change system-wide processes that caused or contributed to the error, the close insights are a pre-requisite to sustaining high performing healthcare provider organisations.

Public hospitals must not be expected to absorb the costs of additional data collection and coding within their existing tight operating budgets. Public hospitals are already stressed, chronically underfunded and struggling to finance solutions to deal with growing long wait times for elective surgery and emergency care. See the 2019 AMA Public Hospital Report Card for an over-view of the funding stress faced by public hospitals.

The reporting requirements embedded in the National CQR accreditation standards/governance requirements must *not* include granular reports of identified clinician benchmarked data – either short term or long term. Not only is it very unlikely big data can adequately risk adjust for patient complexity, a punitive reporting approach is contra to the substantial international evidence[7] [8], and it will seriously threaten clinician engagement.

Clinicians will always be alert to and receptive to evidence based best practice if the source is trusted, but they strongly oppose recipe book medicine derived from an uninformed interpretation of unwarranted variation from big data that measures treatment provided, but not the patient’s full individual clinical circumstance or reason for treatment.

Rushing to ‘expose’ individual clinicians with adverse outlier data will not improve patient care in a complex, team-based hospital system. Instead, it will engender a culture of blame, fear, and reluctance to openly report or treat high risk/high complexity patients for fear of reputational damage.

With a population characterized by rising patient complexity, chronic disease and ageing, punishing the treating clinicians and/or hospital by exposure – will perversely lead to greater delays in patient care and poorer patient outcomes as individual clinicians and hospitals (public and private) rationally take steps to minimize their reputation exposure to these complex patient cohorts. This will diminish rather than improve the quality of healthcare in this country. This is very well demonstrated in Samer Nashef's excellent book, *The Naked Surgeon*. The NHS experience was that hospitals avoided difficult cases to make sure that their caseload was low-risk so that they looked good in published league tables. Hospitals and clinicians that take on difficult cases tend to appear as poor performers in league tables.

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[7] Patient safety without the blame game, BMJ 2013;347:f4615

[8] *Reporting and learning systems for patient safety incidents across Europe*, European Commission Patient Safety and Quality of Care working group 2014

There is a very real likelihood publishing identified clinician/hospital benchmarked data could harm patients rather than help them. As noted above, benchmarked data might deter clinicians and hospitals from treating complex patients in order to look good in league tables. The best predictor of quality treatment is treatment frequency. It would be a poor outcome indeed, if the approach to reporting identified outcome data perpetuates a reduced supply of clinicians with the skill and complex patient treatment experience needed to achieve the best outcome for complex patient cohorts. This outcome does not make any sense with a population that continues to get older and sicker.

Publishing identified league tables or funnel plots to help patients select high performing clinicians, could also encourage complex patients to select clinicians with high frequency use of less complex item numbers, against the advice of their referring general practitioner.

Furthermore, it is not clear how the general public will be helped to accurately interpret clinician performance expressed as standard deviations from the mean. Nor does the Strategy acknowledge the known risks that patients may avoid their local hospital based on a superficial and likely incomplete understanding of that hospital's performance relative to the patient complexity profile in the hospital catchment area.

The AMA also has genuine concerns there will be some attempt to link benchmarked performance data with the government's flawed out of pocket fees website.

Funding

The most productive mechanism for funding CQR is ultimately a question for governments. CQR are unlikely to succeed unless funding is adequate and certain. If private funders are considered, they must never be permitted to dictate 'best practice' or impinge on the independence of clinical decision making, benchmarked data analysis or the response to observed outliers.

It goes without saying, there is absolutely no compelling evidence that financial penalties or shaming poor performance helps healthcare providers lift their capacity to provide better, safer care. To the contrary these hospitals need new investment to improve.

The perfect incentive for genuine engagement in CQR would be far more likely if the Commonwealth fully funded all provider costs associated with active participation (data collection, coding and data validation and outlier follow up). There will also be additional staffing costs to allow participating clinicians time away from direct patient care to analyse the CQR data and their own results compared to peers.

A powerful motivator for genuine engagement would be obtained if healthcare providers retained any savings from increased healthcare effectiveness and efficiency. These funds could then be re-deployed to improve performance on elective and emergency waiting times.

Conclusion

It would seem this consultation still has a long way to go and there is a lot of the granular detail that is not yet finalised. The AMA does not oppose the idea of lifting the overall standards and coverage of CQR but it needs to be very carefully constructed and implemented to inspire clinicians and healthcare organisations to *willingly* participate. *Practicing* clinicians, represented by clinical colleges, societies and associations, must be involved in the Strategy co-design and implementation.

Clinicians do not knowingly provide their patients with low value care. Patient’s health conditions can be very, very, complex. Diagnoses is not an exact science, and wherever possible, the patient’s preference correctly come to bear on the treatments they receive. Knowledge and agreement on best practice evolves and changes over time as the evidence base grows.

Having said this, all doctors want our health system to be sustainable and this means a health system that is efficient and care provided is effective and responsive to the needs of the patient.

We look forward to an ongoing engagement with the Department of Health and the Commission of Safety and Quality in Health Care (ACSQHC) to discuss the issues raised in this submission.

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