APNA Response

AIHW consultation regarding *A potentially preventable hospitalisation indicator for general practice*

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2 November 2018

The Australian Primary Health Care Nurses Association (APNA) welcomes the opportunity to contribute to the Australian Institute of Health and Welfare's (AIHW) consultation regarding "A potentially preventable hospitalisation indicator for general practice". We are providing this submission on behalf of our membership, Australian primary health care nurses.

Primary health care nursing refers to nursing that takes place within a range of primary health care settings, each sharing the characteristic that they are part of the first level of contact with the health system. Primary health care nurses are skilled, regulated and trusted health professionals who work in partnership with their local communities to prevent illness and promote health across the lifespan. In Australia, nurse practitioners, registered nurses (RN) and enrolled nurses (EN) practice in primary health care in a range of clinical and non-clinical roles, in urban, rural and remote settings.

APNA Submission

Introductory statement:

One of the clinical settings in which that primary health care nurses actively practice is general practice, where they have a significant role in screening, assessing and care planning for patients, as well as undertaking population health activities.

APNA is contributing to this AIHW consultation, because nurses in general practice make a significant contribution to the management of potentially preventable hospitalisations. This contribution is magnified when carried out in a team-based approach to care with general practitioners and other members of the multidisciplinary team all working together to their full scope of practice.

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

APNA agrees with the potentially preventable hospitalisation (PPH) definition as stated in the AIHW consultation paper. This definition refers to "general practice teams" which is important. We believe it is important that the nomenclature in this paper and any related documents, should reflect the multidisciplinary nature of general practice service delivery and the benefits of multiple professionals working to their full scope of practice, because such an approach is essential to comprehensively managing PPHs (Douglas *et al* 2009).

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

APNA generally agrees with this definition however would like to comment on some of the terms used within this – specifically "general practice teams" and "GP leaders" (it is assumed this refers to "general practitioner leaders").

With respect to the term "general practice teams", APNA strongly supports the use of this term as it accurately reflects an intention of multidisciplinary care. This is as compared to the term "general practitioner teams", which we note the consultation paper appears to use interchangeably throughout the document, as well as "GP teams". APNA expressly states that we believe the term that should be used consistently is "general practice teams". APNA opposes any drift in language toward nomenclature that denies the core multidisciplinary nature of patient-centred care, this approach to care being known to produce better patient outcomes (Wagner *et al* 2012). The rationale for multidisciplinary care is contained within the Alma Ata Declaration of 1978: Principles of Primary Health Care (World Health Organization and International Conference on Primary Health Care 1978), which recognises the inseparability of health from the social, environmental and economic factors that affect human life. It is characterised by a focus on the promotion of health and the prevention of illness, according to principles of equity, access, and community empowerment, and is achieved by care delivered by multidisciplinary teams.

Of note, a multidisciplinary approach to care is being encouraged via the current Commonwealth Government's Health Care Homes (HCH) model as the means by which to deliver high quality primary care for patients with complex and chronic disease, with one of the expected outcomes of care to be delivered via the HCH model in fact including reduced demand on hospitals and better patient management with a shift of focus from treatment to prevention (Department of Health 2016).

The consultation paper also appears to generally use the term "GP" instead of the more encompassing "general practice". For example on the bottom of page 7, the document refers to "GP interventions", which would be better expressed as "general practice interventions" in this document and any ensuing related document, again to reflect the multidisciplinary nature of the work in general practice. We need to be clear that "GP" stands for the individual "general practitioner" and not "general practice", and that the abbreviation should be used accordingly.

APNA acknowledges the challenge in reaching a common definition as to the makeup of a "general practice team" and that this is difficult to definitively describe in practice. The consultation paper states on page 7 that "the focus [of this proposed PPH indicator] is on services delivered by general practice teams rather than primary care and community care broadly" and then goes on to state that this includes "care provided by general practitioners, medical specialists, dentists, nurses and allied health professionals". It is unclear if this list refers to the general practice team or the primary health care/community care team more broadly. APNA believes that usually medical specialists and dentists sit outside of general practice and thus would be categorised under broader primary care and community care service category, and that the "general practice team" would most often be any of GPs, nurse practitioners, RNs, ENs, support staff and allied health professionals.

The term "GP leaders" is used in the definition and APNA agrees that the GP would lead a patient's "medical" care, but when it comes to the overall coordination of their care so that it is timely, seamless, culturally appropriate, and delivered according to their individual health literacy and psychosocial status, this important work is often best led by a nurse due to their training and preparation for holistic care. APNA believes that instead of "GP leaders", the term "lead clinician" provides scope for the most appropriate member of the general practice team to perform the lead role for a patient's overall care coordination, depending on a patient's particular health care needs or wishes (a patient may wish to nominate their "lead clinician"). This is particularly the case for rural and remote areas, where in many cases the community does not have access to a regular GP, so instead a nurse is supported by a fly in/fly out GP or phone-based medical support services – that is, the nurse is the consistent deliverer of care.

Considering all of this, APNA believes the definition should instead read:

> "The general practice team consists of all people who work or provide care within the general practice, and similar primary health care organisations such as Aboriginal Community Controlled Health Services and community health organisations. The team is often multidisciplinary, and could be made up of GPs, nurse practitioners, RNs, ENs, support staff and allied health professionals, with a nominated lead clinician. The team is ideally constructed to service the unique requirements of the community it services, including rurally/remotely."

APNA also provides further remark with respect to the commentary on primary, secondary and tertiary preventative health services that sits with this definition on page 7 of the consultation paper. We highlight that lifestyle interventions are primary preventative activities, and that screening is in fact a secondary preventative health service (Royal Australian College of General Practitioners 2018).

Overall, the document appears to take a biomedical approach to health, with little attention to the social determinants of health and the role of the general practice team in health promotion and education, advocacy, community engagement, health literacy, navigation of health systems and access to general practice services. The cost of a general practitioner consultation and related care including investigations and medication, transport to appointments, long waiting times to see a GP, lack of GPs in rural and remote areas, cultural and language barriers, and ability to participate in self-management/lifestyle interventions, do not seem to have been considered as contributing to an individual's adherence with health care advice, with the flow on effect of this to preventable hospitalisation.

Recognition of the role of nurses in primary health care is increasing nationally and internationally and is being seen as essential to achieving improved population health outcomes and better access to primary health care services for communities. A broader role for nurses enables services to focus on the prevention of illness and health promotion, and offers an opportunity to improve patient engagement and the management of chronic disease as well as reduce demand on the acute hospital sector.

APNA would also like to note that, while this does not relate to the question being asked, we would like to highlight a section of the consultation paper (p. 8) which states that "the general practice focused PPH indicator is intended to inform understanding about the appropriateness of care provided by GPs, and by general practice teams under direction of a GP more generally." APNA highlights that as regulated health professionals, nurses are ultimately responsible and accountable to the Nursing and Midwifery Board of Australia (NMBA) for their clinical practice (NMBA 2016), though nursing practice of course also operates within the constraints of the Medicare Benefit Schedule and employment structures within general practice.

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)?

APNA supports a well-considered, evidence-based review of conditions that should be in and out of scope for this proposed indicator.

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

Yes, APNA agrees with this approach.

Q5. Do you agree that this approach reduced inclusions of duplicate hospitalisations?

Yes, APNA agrees with this approach.

Q6. Do you agree with the proposal to:

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

APNA agrees with the approach of separately reporting those aged 75-84 years old.

However, we believe that reporting for those aged 85 years and over should also be included as part of this proposed indicator, as a separate report. This is as a key age group in the context of Australia's ageing population. It is important to be able to monitor health behaviour/health service usage of this age group with regards to PPHs, as high users of hospitals compared with other age groups (AIHW 2018), to allow for targeted general practice responses to be developed for this age group. It is not uncommon for this age group to present and be admitted to hospital for reasons such as

investigations that are too onerous to be conducted in the community perhaps due to transport issues or for carer stress, and there are the regular reports of older people from residential aged care presenting and/or being admitted to hospital unnecessarily. Hospitalisation is risky for older people, commonly leading to functional decline and consequent pain and suffering for the individual older person and their family, as well as high cost to the health care system overall (The Kings Fund 2012). Furthermore, general practice has a role to play in actively managing older people as they develop the condition of frailty, in terms of linking them to available support services through the My Aged Care system as an outcome of the annual health assessment for a person aged 75 years old and over (Medicare Benefits Schedule item numbers 701, 703, 705 and 707), work which may lead to minimisation of PPHs. Reporting on PPHs for this age group is important for planning for the future, with the proportion of older people in the Australian community set to increase, to enable general practice to respond sooner than later.

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

Overall, APNA agrees that same-day hospitalisations should be excluded from the proposed PPH indicator, to enable consistency and comparability as much as possible, despite (as the paper acknowledges) the impact that resultant data may not necessarily reflect the true prevalence as some same day hospitalisations will be for conditions included in the indicator. APNA agrees it would then be necessary to develop a PPH indicator for general practice for Emergency Department (ED) presentations, to better understand this aspect of hospital presentations and where general practice can contribute to minimising these.

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

APNA supports a well-considered, evidence-based, multidisciplinary review of procedures that should be in and out of scope for this proposed indicator.

In some instances where first line general practice treatment is not curative, some conditions may become chronic and require higher level tertiary interventions. The examples given in the paper for surgical procedures such as grommets for chronic glue ear are good examples. If such conditions are left without procedural interventions such as grommets, a child may be left with both speech and hearing impediments. Also, treatment of cellulitis in general practice is a common issue and if the PPH indicator was to measure higher than expected admissions for particular age groups or demographic groups or particular types of infection, the results could guide better education for clinicians around management of such conditions, adherence &/or review of treatment guidelines and better AMR scrutiny.

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?

APNA agrees with the population groups as listed that should be in focus for specialised indicators or disaggregation – that is by remoteness, sex, Indigeneity, Primary Health Network (PHN).

APNA would also suggest exploring data disaggregation by the following population groups: local government areas (LGAs), housing status/homelessness, migrant and refugee populations, people of a non-English speaking background (NESB) and who are culturally and linguistically diverse (CALD), war veterans and people who are/have been incarcerated. It could also be useful to perform disaggregation of data for younger age groups, with children being high hospital users (Freed *et al* 2016).

We further add that developing specialised indicators according to the priority areas of PHNs: mental health, Aboriginal and Torres Strait Islander health, aged care, and alcohol and other drugs could be beneficial (Department of Health 2018). Additionally, they could also be developed with reference to the conditions of focus by the *National Strategic Framework for Chronic Conditions* (Australian Health Ministers' Advisory Council 2017) cancer, cardiovascular disease, chronic kidney disease, chronic respiratory disease (including asthma), diabetes, endometriosis, eye health and musculoskeletal conditions (arthritis and osteoporosis)

For reasons we have already stated at Q6, while the proposed PPH currently excludes people aged 85 years and over group apparently due to reasons of complexity and whether this can in fact be managed by general practice, APNA believes understanding the PPH issue amongst this age group is important and hence this age group should be included as a specialised indicator, as part of the currently proposed PPH indicator. Such measurements may guide general practice education in better implementation of early intervention and complex condition management of older people, especially referral for community supports services that will assist keeping the older person well in their own home.

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

In the available timeframe, APNA has not been able to fully consider opportunities here. However we propose that it would be of interest to consider the possibility of linking data of the following policies and programs with the proposed PPH indicator data, to explore whether they provide any protectiveness for hospital presentation, alongside the proposed PPH indicator:

- Practice Incentive Payments;
- Aboriginal and Torres Strait Islander policies and programs;
- Aged care policies and programs such as the Commonwealth Home Support Program (CHSP), the Home Care Package (HCP) program and residential aged care;
- Disability policies and programs such as the National Disability Insurance Scheme (NDIS).

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

APNA proposes that in due course, it would be of real potential benefit to be able to compare PPH data disaggregated by geographical region, with the corresponding workforce numbers for GPs, nurses, nurse practitioners and allied health, using available data sources (e.g. the National Health Workforce Data Set), to explore any correlations with PPHs from this perspective.

Concluding comment:

APNA is positive that data collected via the proposed PPH indicator, has the power to drive better health outcomes in patients. We also believe that it may further drive innovation in general practice service delivery, toward improved integrated and coordinated, team-based care, to assist with managing the issue of potentially preventable hospitalisations.

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About APNA

The Australian Primary Health Care Nurses Association (APNA) is the peak professional body for nurses working in primary health care. APNA champions the role of primary health care nurses; to advance professional recognition, ensure workforce sustainability, nurture leadership in health, and optimise the role of nurses in patient-centred care.

APNA is bold, vibrant and future-focused. We reflect the views of our membership and the broader profession by bringing together nurses from across Australia to represent, advocate, promote and celebrate the achievements of nurses in primary health care.

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