RACP Comments on the Candidate Indicators

SPECIFIC COMMENTS		
Dimension	**Candidate Indicator**	**Comment**
Accessibility	First contact to service wait time	"First contact" is vague and needs to be more specific. It could mean first phone call or first interface. Most practices don't usually contact informal first contact.
	Eligible patients who received a service	The meaning of the description: "The proportion of eligible patients requesting a service who received a service" is unclear because the sentence is poorly expressed. The sentence needs rewording so the meaning is clear.
	Non-attendance at booked service	This is an outcome that is difficult to measure because of the reasons for non-attendance. For example, some patients may not attend because they did not have the money to pay for any gap fees they would have incurred.
Appropriateness	Health summary	The description refers to 'regular patients'. A definition of 'regular patients' is required. The description also refers to "comprehensive health summary". It should also state correct health summary as this is more important than a comprehensive health summary.
Acceptability	Patient complaints response	Some complaints may be verbal and informal and are normal. Accordingly, the definition of the type of complaints that need to be responded to needs to be more specific.
	Informed consent for treatment	Informed consent is difficult to assess: delivery of requisite information does not necessarily mean the patient has understood the information.
Effectiveness	Patient improvement	Patient improvement is highly dependent on socio-cultural status. The description is too broad and ambitious and needs to be more specific. In respect of diabetic care, the management of this disease is more effectively measured by having complications screened—for example, cholesterol levels, blood pressure measurement—rather than how well the diabetes is controlled (to overcome the fact that the higher the dose of insulin, the higher the BMI in general).
Continuity of care	Timely review and follow-up of diagnostic results	There are not many clinical guidelines related to timeframes for reviewing patients.
	Medication reconciliation	Medication reconciliation is dependent on hospitals/facilities/patient to provide this information rather than a General Practice.
Safety	Adverse drug reactions and medication allergies	Documentation of adverse drug events/allergies in the service's patient health record is dependent on whether hospitals communicate the information to the general practitioner. In terms of the ACSQHC definition of primary health care, allied health professionals might not document reactions/allergies. Not many primary care practices have incident reporting systems.

GENERAL COMMENTS
1. The non-specific nature of some proposed clinical indicators may make them invalid to be used as comparators between practices. For example: • "The proportion of patients assessed, using a validated assessment tool appropriate to the scope of the practice and patient's needs"; • "The proportion of Aboriginal and Torres Strait Islander patients who have received communications that are culturally appropriate"; • "The proportion of patients who have received communications that is culturally and linguistically appropriate".
2. Many of the proposed clinical indicators are left to the local primary health care provider or practice to define. This may make assessments of comparison of performance between different practices invalid. These clinical indicators include: • "The proportion of patients whose wait from first contact to first service is within the locally agreed timeframe "; • "The proportion of patients whose initial needs identification was conducted, within the locally agreed timeframe"; • "The proportion of goals partially met in the timeframe stated for attainment of each goal, or appropriately renegotiated, for patients with a care plan", • "The proportion of practice referrals that are issued in accordance with the practice's policy for referral processes (for appropriateness and timeliness)"; • "The proportion of patients where timely reporting of care assessments or outcomes was communicated to the patient's GP or specialist doctor"; • "The proportion of patients whose diagnostic results were reviewed by a clinician and acted on in a timely manner in accordance with agreed clinical guidelines".
3. The indicators are designed for all primary health care providers and are, therefore, unlikely to be sensitive and specific to the needs of individual providers.
4. Most of the indicators do not meet the criteria set by the developers. They are not precise and cannot be implemented. Many are multi stepped have no validity beyond face validity. Therefore, it is unlikely they will achieve the desired outcomes. A targeted clinical audit may be a far more useful way of supporting practice improvement if appropriately robust indicators cannot be identified.
5. Most of the candidate indicators have been demonstrated to only have face validity and have not been linked to improved health outcomes. With these indicators, there will be great difficulty in obtaining data for evaluation as part of day to day practice. The results sought could probably be obtained by a simple patient feedback mechanism asking about objectives met, satisfaction and any improvement in status.
6. There are some indicators with demonstrated validity that have not been included; for example, patients with asthma having an asthma plan.
7. A selection of fewer indicators but with demonstrated validity is recommended.