

Clinical indicators and the RACGP

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Prepared by the RACGP National Standing Committee – Quality Care, National Standing Committee – General Practice Advocacy and Support and National Expert Committee on Standards for General Practices

The Royal Australian College of General Practitioners position statement on clinical indicators. It is intended to enhance and inform the standards for general practice.



Introduction

'Not everything that can be counted counts, and not everything that counts can be counted'
Attributed to Albert Einstein

Aim and purpose

The purpose of this paper is to clarify the role and purpose of clinical indicators and to outline The Royal Australian College of General Practitioners (RACGP) position on the use of clinical indicators in general practice.

The position outlined in this statement will be used to inform a range of RACGP quality improvement programs including:

- the Quality Assurance and Continuing Professional Development Program
- the *Standards for general practices*
- advocacy submissions on general practice improvement
- safety and quality policy and project developments.

The Royal Australian College of General Practitioners

The RACGP is the professional organisation that focuses on the safety and quality of general practice.

The college's mission is to improve health and wellbeing for all Australians by supporting general practitioners (GPs), registrars and medical students by assessing doctors skills and knowledge, supplying ongoing professional development activities, developing resources and guidelines, assisting GPs with issues that affect their practice, and developing standards that general practices use as part of the accreditation processes.

The RACGP has a proud history of supporting quality improvement in general practice through:

- Fellowship of the RACGP (FRACGP)
- training programs
- vocational registration with requirement for continuing professional development
- *Guidelines for preventive activities in general practice* (red book)
- practice standards and accreditation
- FRACGP as a requirement for unsupervised general practice
- quality assurance and ongoing professional development
- MBS focus on preventive health, patient safety and access
- quality framework for Australian general practice
- implementation of using information wisely approach to data management.

The RACGP national standing committees on quality care, general practice advocacy and support (GPAS), and standards of general practice oversee the college's commitment to quality improvement.

Purpose of clinical indicators

Clinical indicators support the attainment of safe, high quality health care in Australia. Clinical indicators have relevance for GPs, patients, governments and funders. When used appropriately, clinical indicators assist in better understanding what is being done to provide care and treatment. Indicators alone do not improve health care, however they are a key component of a broad quality improvement system.

A clinical indicator is 'a measure, process, or outcome used to judge a particular clinical situation and indicate whether the care delivered was appropriate'.¹ Indicators guide the assessment of health care processes and outcomes, monitor measures for the management of patient care and act as tools to flag patient care.²

Clinical indicators have a number of purposes, and typically they are developed to respond to three tasks:

- quality improvement
- accreditation
- evaluation.

Agreeing on the purpose of clinical indicators is essential for clarifying the scope of indicators and for identifying relevant stakeholders. For example, indicators have been used to establish mandatory requirements, and in other instances as benchmarks for ensuring high quality care and treatment. A clinical indicator can be framed at either a minimal, normative or aspirational level.

The audience for clinician indicators is linked to the purpose of the indicator. Within general practice the key audience for indicators is the profession, patients, governments, professional organisations and medical indemnity organisations.

Given the multiple purposes and audiences for clinical indicators, clinical indicators can have application at multiple levels. *Table 1* describes three levels where clinical indicators are relevant for general practice.

Table 1. Levels of application for clinical indicators		
General practice level	RACGP level	Health system level
Disease specific indicators	Disease specific indicators	Disease specific indicators
Preventive care indicators	Preventive care indicators	Preventive care indicators
General practice improvement indicators	General practice improvement indicators	Health system improvement indicators
General practice accreditation indicators	General practice accreditation indications	Quality and safety indicators
	Health system improvement indicators	

Managing the purpose, audience and broader context of indicators can be complex, so the following critical decision points need consideration when developing clinical indicators:

- clarifying the audience
- defining the purpose
- deciding the scope of indicators
- identifying the unit of analysis
- incorporating difference, diversity and complexity
- determining the type of evidence
- deciding the underlying evidence base.

To ensure clinical indicators are specific enough to reflect current practice and relevant enough to be achieved and monitored, clinical indicators need to include all the following elements:

- evidenced based
- practical (doable, easy to collect)
- useful in guiding and improving patient care
- reflect the quality of care provided in general practice (not other aspects of the health system)
- provide adequate important data to warrant measurement from both a practitioner and consumer perspective
- relate to a process of care and health outcome
- measure what it is purporting to measure
- sensitive to change
- acceptable to general practice, and the community.

Statistically, clinical indicators need to be valid, reliable and be able to offer data to explain variations in an outcome.

There are a number of different ways that a clinical indicator can be expressed. *Appendix 1* includes three different indicators for smoking cessation.

Drawing on the literature and current discussions within the RACGP national expert advisory committees, there is clear recognition of the benefits of using indicators for quality improvement, tempered by some concerns.

Benefits of clinical indicators

- Provide evidence of improvement and can assist with meeting accountability requirements
- Focus attention on areas of greatest importance and benefit
- Provide decision makers with information on key areas of care
- Provide a 'slice of reality' of a complex system
- Promote healthy questioning of a specific aspect of a practice system or the health system
- Focus on common events where it is possible to undertake statistical analysis
- Offer comparability for performance and quality comparison
- Ensure that the system and practitioners are focusing on what needs to be done.

Concerns with clinical indicators

- Health care systems are complex, and indicators may not reflect accurately what they purport to measure
- Not all aspects of quality care are able to be measured
- Articulating an indicator leads to that indicator becoming the focus and end point in itself, sometimes to the detriment of other equally important, but unmeasured, areas of care. This is particularly the case where indicators are coupled with incentives
- Measuring what is measurable is not always an accurate reflection of the system
- Indicators reflect a reductionist view
- Measurement alone does not lead to improvement
- Indicators have often been associated with performance and accountability, and seen by clinicians as a way to apportion blame and fault finding. This is particularly apparent when clinicians may not be able to manage the system being measured
- Primary health care is context and population specific and rarely amenable to accurate and consistent comparison.

These concerns suggest that clinical indicators by themselves will not enhance the quality of health care. Instead indicators need to be considered as part of a suite of quality improvement initiatives.

One researcher has offered the following advice to individuals developing indicators:

*'If you don't fully understand the indicators you have to work with; think they paint an inaccurate picture of how things really are on the ground; or suspect they are fundamentally flawed in some way – you can find yourself locked into an unhappy relationship with a performance measurement tool that you can neither challenge or improve.'*¹³

Application of clinical indicators

The RACGP is committed to ensuring a safe, high quality health care system. The RACGP supports clinical indicators as a practical identification and measurement tool for quality improvement. Well developed and effective indicators can shed light on the process of providing care and treatment.

The RACGP recommends that clinical indicators should be part of an ongoing quality improvement system that contributes to improvements in the delivery of care and treatment for patients.

The RACGP recognises that clinical indicators are useful for practice and practitioner based quality improvement but can be unhelpful for public reporting (eg. league tables).

The RACGP has developed and implemented indicators and standards for quality improvement for many years. However, the RACGP recognises that the medical landscape is changing and a renewed commitment to measuring and monitoring performance is essential, particularly given:

- GPs are increasingly interested (and able) to more easily review aggregated data for practice population care and offer services based on that analysis
- patients are expecting higher quality care and evidence that health providers are providing safe and effective care
- a number of national initiatives (Australian Institute of Health and Welfare, the National Health and Hospital Reform Commission, the National Preventative Health Taskforce) suggest national accountability benchmarks for primary care
- useful tools for measurement, such as the Clinical Audit Tool that supports practice population analysis and tools such as cholesterol measurement, that support individual patient health analysis are being used more effectively.

The RACGP supports the linking of payment incentives to achievement against clinical indicators. However, the RACGP recognises that the concept of pay-for-performance has been characterised by mixed results and a number of criticisms. In this context, the RACGP believes that the use of clinical indicators in a pay-for-performance context needs detailed professional wide consideration prior to implementation.*

The RACGP is committed to the provision of patient centred care. The patient-doctor relationship should be an integral consideration in the development and monitoring of clinical indicators. Indicators should have relevance to patients and their carers, enabling them to make effective decisions about care and treatment.

The RACGP recommends that clinical indicators be developed in the following areas:

- primary and secondary prevention
- patient centred care
- chronic disease management
- e-health
- quality care
- adverse events
- multidisciplinary care.

* The RACGP NSC – General Practice Advocacy and Support and unit are currently preparing a discussion paper on pay for performance

Principles to guide the development of clinical indicators

To guide the development of clinical indicators, the RACGP proposes six key principles:

1. Clinical indicators should be relevant for general practice and the community and should support the enhancement of safety and quality within general practice
2. Clinical indicators should relate to processes of care and health outcomes and should be useful in guiding and improving patient care
3. Clinical indicators should take account of social variance and social equity
4. Clinical indicators should be developed by GPs in order to ensure relevance and application
5. Clinical indicators should be evidence based, measurable, reliable, practical to implement, and sensitive to change
6. Clinical indicators should provide adequate data to warrant measurement and measure what they purported to measure.

The initial indicator push within the RACGP may be addressed in the next edition of the *Standards for general practices* and through the e-health program *Using information wisely*. However, not all indicators would be suitable for this context. Instead a number of indicators may be identified that are more suitable for inclusion in the next triennium of the Quality Assurance and Continuing Professional Development Program and to inform the college's work in the quality care, safety and health reform arena.

This paper

The RACGP convened an expert group of GPs to support the development of this paper. Members of the NSC–GPAS (Dr Beres Wenck), National Expert Committee on Standards for General Practice (Drs Lynton Hudson and Mike Civil[†]) and NSC–QC (Prof Mark Harris and Graeme Miller, A/Prof Ron Tomlins and Drs John Bennett, Barbara Booth and Caroline Johnston) attended a meeting on 17 December 2008 in Sydney to formulate this paper.

GP members were supported by the GPAS and Quality Care Units (Ian Watts, Lauren Cordwell, Jane London and Teri Snowdon).

[†] Dr Civil is also the Clinical Chair of the WA/NT Australian Primary Care Collaboratives

Appendix 1. Clinical indicators for smoking cessation

Examples of clinical indicators

Example 1

National Centre for Health Outcomes Development (United Kingdom)

Smoking cessation advice for smokers with selected conditions

Purpose	To help reduce the level of risk to health associated with smoking for patients with selected conditions and ensure high standards of primary health care and treatment delivered to them.
Indicator	Proportion of patients with any (or any combination of) the following conditions (comorbidity): coronary heart disease, stroke or transient ischaemic attack, hypertension, diabetes, COPD or asthma who smoke and whose certain notes contain a record that smoking cessation advice or referral to a specialist services, where available, has been offered within the previous 15 months.

Available at www.nchod.nhs.uk/NCHOD/Compendium.nsf/97d370db8516dc72802573a30020fcd4/6bfa3630683dc09f6525746a0021bee3!OpenDocument.

Example 2

Smoking cessation indicators for Australian Primary Care Collaboratives

Indicator A	Percentage of patients with smoking status recorded as: a) Never smoked b) Ex smoker c) Current smoker d) Not recorded.
Indicator B	Percentage of patients who are recorded as a current smoker or ex-smoker and who have had their smoking status assessed in the past 12 months.
Indicator C	Percentage of patients who are recorded as a current smoker who have had their readiness to change assessed.
Indicator D	Percentage of patients who are recorded as a current smoker who have had their readiness to change assessed in the past 12 months.

Appendix 1. Clinical indicators for smoking cessation

Example 3

Smoking cessation indicator from the AIHW national health data dictionary for cardiovascular disease (CV data)

Behaviour related risk factor intervention – purpose	
Data element type	Data element
Definition	The behaviour related risk factor(s) associated with an intervention(s)
Data domain	<ol style="list-style-type: none"> 1. Smoking 2. Nutrition 3. Alcohol misuse 4. Physical inactivity 5. Other 6. Not stated/inadequately described

Behaviour related risk factor intervention	
Data element type	Data Element
Definition	The intervention taken to modify or manage the patient's behaviour related risk factor(s)
Data domain	<ol style="list-style-type: none"> 01 No intervention 02 Information and education (not including written regimen) 03 Counselling 04 Pharmacotherapy 05 Referral provided to a health professional 06 Referral to community program, support group or service 07 Written regimen provided 08 Surgery 98 Other 99 Not stated/inadequately defined
Guide for use	<p>More than one code can be recorded.</p> <p>Code 01 Refers to no intervention taken with regard to the behaviour related risk factor intervention</p> <p>Code 02 Refers to where there is no treatment provided to the patient for a behaviour related risk factor intervention other than information and education</p> <p>Code 03 Refers to any method of individual or group counselling directed toward the behaviour related risk factor intervention. This code excludes counselling activities that are part of referral options as defined in code 5 and 6</p> <p>Code 04 Refers to pharmacotherapies that are prescribed or recommended for the management of the behaviour related risk factor intervention</p> <p>Code 05 Refers to a referral to a health professional who has the expertise to assist the patient manage the behaviour related risk factor intervention</p> <p>Code 06 Refers to a referral to community program, support group or service that has the expertise and resources to assist the patient manage the behaviour related risk factor intervention</p> <p>Code 07 Refers to the provision of a written regimen (nutrition plan, exercise prescription, smoking contract) given to the patient to assist them with the management of the behaviour related risk factor intervention</p> <p>Code 08 Refers to a surgical procedure undertaken to assist the patient with the management of the behaviour related risk factor intervention</p> <p>Code 99 Not stated/inadequately defined</p>

References

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