Response to Inquiry into Primary Health and Aged Care Services Measures
9 September 2011

The Secretary
Standing Committee on Economy and Infrastructure
Parliament House
EAST MELBOURNE VIC 3002

Dear Sir,

Response to Inquiry into Primary Health and Aged Care Services Measures

The following is Dental Health Services Victoria’s (DHSV) submission for your consideration responding to the Terms of Reference of the Inquiry into Primary Health and Aged Care Services Measures.

DHSV is the leading public oral health agency in Victoria. DHSV provides dental services through The Royal Dental Hospital of Melbourne (RDHM) and purchases dental services for public patients from 58 community health agencies throughout Victoria. DHSV also delivers oral health promotion programs across Victoria to improve oral health in the community and reduce demand on public dental services. It also has a significant role in oral health research and supporting education and training for Victoria’s current and future oral health professionals. DHSV is classified as a metropolitan health service under the Health Services Act.

DHSV is passionate about improving Victoria’s oral health and ensuring greater levels of access, high quality service and sustainable dental practice for oral health and the wider health care sector.

We appreciate that to address these challenges requires the ability to focus on the wider health care sector as a whole and in doing so the capture, analysis, review and subsequent utilisation of patient data is a key factor that warrants consideration.

Oral health is fundamental to overall health and wellbeing and DHSV looks forward to working with the Committee and other parties to assist in delivering quality health outcomes, improved access and more responsive health care.

We welcome the opportunity to discuss our submission further with you and the Committee and look forward to reviewing the recommendations of the Committee when they are concluded.

Deborah Cole
Chief Executive Officer
Dental Health Services Victoria
Inquiry into Primary Health and Aged Care Services Measures

Terms of Reference:

1. Australia, like most other western countries, should mandate the provision of information on the reasons people receive primary health care treatments, that is, epidemiological coding according to the International Classification of Primary Care or similar;
2. Australia should mandate the provision of waiting times and waiting lists for primary care services;
3. Australia should mandate the requirement for provision of information about outcome measures, such as appropriate treatment for all patients with diabetes in primary care settings, appropriate treatments for asthma in those settings and so on;
4. Conditions for which hospitalisations can be avoided should be considered a surrogate for the adequacy of our primary health care system;
5. Actual rates of provision of residential aged care for each community should be provided, as opposed to bed ratios;
6. Comparable rates of community care alternatives should be provided for these communities;
7. Quality data for residential aged care across a community and for each individual setting should be more clearly available and provided; and
8. Potentially unnecessary or avoidable hospitalisations of patients in residential care should be used as a surrogate indicator for poor care in these settings.

Collection of data in relation to primary health care treatments:

DHSV supports the in principle position of collecting patient level data in relation to primary health care treatments.

Accurate, reliable, complete and timely data is critical if we are to plan for, and deliver, improved population health for all Victorians. It is also critical in order to ensure that evidence based decision making is able to occur in the health setting.

There are numerous public health benefits from collecting and reporting clinical data including the capacity to inform program, policy and guideline development, and for the evaluation of the effectiveness of those measures to improve public health over time.

In noting our support for the data collection, we also acknowledge the challenges that face Government (Federal and State) in establishing a collection platform. Dental care is provided predominantly in the private sector, and one of the major challenges is capturing private dental data to measure improvements in oral health of the whole community (see Figure 1 - private is predominantly represented by the non-government component).
Some of the issues that will need to be addressed include:

- **Minimum data set:** The potentially rich data that will be available from a primary health platform will only be available for use if the agreed minimum content is collected for all episodes of care. A more comprehensive data set will come from the inclusion of private data where possible.
- **Data validation:** Control processes will need to be developed to review and assess data quality. In effect, over time, the validation processes in place at the commencement of data collection will impact the overall usefulness of the data in the medium term.
- **Platform (Warehouse):** The data in question will be sourced from multiple sources with varying levels of existing technology. The storage environment for the collected data will need to be able to capture and sort the minimum data set submissions from a wide range of primary environments.
- **Education:** An investment in education of human resources at the data source (primary care providers) will be required. Noting the geographical spread of provider locations the educational resources developed will need to be available in multiple forms.
Wait list management in the primary care setting:

DHSV, in its capacity as a lead agency in state-wide oral health care has significant experience in relation to the management of patient wait lists.

Noting our experience in this area we make the following comments in relation to the establishment and maintenance of a wait list tool within the primary care setting:

- **Workforce capacity:** Reviewing our experience in the provision of a state-wide service we note that consistent delivery of care in rural and regional areas is heavily dependent on workforce related issues. Wait list analysis and management will need to factor this variable into consideration.

- **Triage:** The principle of wait list management, in our view, assumes that presenting clients are managed in order of need. This principle is applied well in the emergency and surgical environments. In our view a substantial parcel of work will be required to apply it into a primary care environment due to the significant patient numbers involved and the likely large number of individual treatments involved.

- **Wait lists by definition do not focus on work delivered:** One of the challenges facing the health sector in relation to wait list management is how we communicate the "message" to the general public. By definition wait lists reflect work yet to be done, they do not traditionally report work completed. As wait list management [including the management of referral patterns] improved in the public heath surgical setting wait lists numbers have at times increased. To the uninformed these increases have been seen as a negative variable or an under performance. At times the increase has reflected improvements in the overall system in identifying patients in need of care, who previously, prior to the system improvements, had been overlooked and not captured.

- **Wait list management:** In acknowledging the benefits of a well managed wait list, DHSV also note that without clear definitions (protocols) for addition to and removal from a wait list, the "information" available from a macro view of the wait list is less than useful.

- **Duplication management:** It is our experience that there will be an immediate requirement to manage patient duplications on the developed wait list. These duplications will occur as patients currently have multiple providers, they are not, in our view, errors.

It is our experience that the geographic distribution of public dental services is extensive but not comprehensive. As such, it is our view that there are some areas of Victoria where geographical access to oral health services is challenging. Add to this a high demand for care and it is not difficult to understand that wait list volumes and waiting times differ across the State. Of significant interest to DHSV is the measurement of wait times rather than waiting list numbers in isolation.

Applying this to the challenge of wait list management in the wider primary care setting it is our view, and our experience, that a large number of variables need to be considered, particularly if targets and performance measures’ are to be mandated.

Another variable that in our experience will impact on wait list management relates to the fact that many elements of primary care do not have a profile of universal access, predominately because of varying funding rates within the Commonwealth model and practitioners fee scales being set at levels that preclude access by large segments of the population. DHSV provides significant oral health care to segments of the population that are vulnerable and most in need. The capacity of this group to contribute to care (fund a co-payment) is nominal.
Implementation of care measures:

DHSV agrees that consistent care delivery is a valid and appropriate goal and that there should be measures in place to assist in outcome measurement.

That being said, we understand the significant challenges that exist in establishing and mandating the capture and reporting of data elements that would assist in establishing and monitoring output measures in the primary health care setting.

- Measure matrix: The in principle position of setting and capturing performance measures is appropriate and supported. The logistical challenge of documenting the required minimum elements such that consistent data, per episode of care, can be captured remains a significant challenge. The quantum of potential conditions to be captured, expanded into measures and multiplied by patients is significant. The cost of compliance (establishment and maintenance of the system) would also have to be considered as a potential barrier.
- Measurement metric: Once the logistical issue of data capture and data volume has been considered, the health system would be required to reach agreement on the metrics that were to be captured and how they are to be reported. In effect, what do we want to know and how do we want it reported.
- Minimum data set: It is our experience that forming a consensus view on the initial minimum set of care measures content and application is critical to ensuring engagement. Relevant professional associations and bodies would be well placed to contribute to these discussions.
- Research translation: It is our experience that significant benefits will be achieved in relation to patient outcomes, in the medium to long term, if the sector works together to ensure that research outcomes are managed and translated into changes or enhancements to the delivery of clinical care. DHSV are committed to translating research findings into clinical practice, and have included developing a mechanism for translating and exchanging knowledge with and between agencies to inform program policy and clinical practice as a goal in our current strategic plan.

Avoidable hospitalisation within the primary health care setting:

We agree that avoidable hospitalisations are an important indicator and as such should be continually monitored. We however do not agree that in themselves they are a surrogate measure for the adequacy of our primary health care system. It is our view that a number of factors impact on the hospitalisation rate including:

- Access: Access to primary care, in particular dental care, is not consistent across the State. In some circumstances patients are forced to manage their health issues, and where required seek alternative care, outside of the primary care setting. Acute hospital emergency departments are an obvious alternative, to the patient, providing immediate low cost care. The duty of care that is intrinsic within the emergency department setting makes this an attractive point of call as quality care will be provided. This is a significant variable and one that has immediate impact on hospital presentation rates. As such a raw measure of avoidable hospitalisation rates may be very misleading as to the effectiveness of a component of the health care delivery system without consideration of other service delivery factors.
- Recall: Many components of primary care service delivery have a recall profile, that being a profile that requires patients to be seen again for review or follow up care. The efficiency or otherwise of the recall system will have a direct impact on hospital presentation rates.
• Health Literacy: One of the most significant opportunities within primary health care delivery is our ability to improve the health literacy of the population. The differential rates of the population in understanding the importance of general health and diet accompanied by personal health complications (co-morbidities) is not a set of variables that the primary health care providers are positioned or resourced to manage alone.

• Prevention verses Treatment: It is the view of DHSV that the greatest opportunity we have to improve general health is to ensure that as a community we focus on health prevention and not only treatment. The opportunity to educate the general public on health issues and to provide early intervention treatments is essential to improving the general health of the population in the medium term. DHSV has invested in this area and has developed and continues to develop a series of health promotion and health prevention messages for delivery to the entire Victorian population, and in particular to at risk populations.

• Timely care: It is our experience that a lack of preventative oral health care means that patients attend to a dental condition only when it becomes problematic. By this time it is often too late for simple treatments. For children with early childhood dental caries, hospitalisation could be avoided by increasing access to dental services, particularly preventative programs. In 2003/04, the most common reason for children under 15 to undergo general anaesthetic in Australian hospitals was for dental extractions and restorations.

In noting the above views, we acknowledge that only a percentage of emergency department presentations lead to a hospital admission. We also note that regardless of admission status, the cost of care delivered in the emergency department is high per presentation (relative to cost of care in the primary care setting) and the opportunity cost of providing the equivalent of primary care in an acute setting also needs to be considered.

In considering the impost of primary care presentations into an acute setting, it is also our view that we should be managing a system that proactively follows up after admission to avoid re-presentation for the same condition and further unrelated presentations.

**Actual rates of provision of residential aged care:**

With the knowledge that our population is ageing and this is being discussed in many health forums at an increasing frequency, DHSV agrees that an understanding of actual levels of residential aged care service provision rather than rates or ratios is appropriate.

• Service Planning: Our capacity to plan and deliver services to the residential aged care setting is premised on a clear understanding of the actual bed count and utilisation rate.

• DHSV currently provides a outreach domiciliary care service to a number of residential aged care facilities as do the community agencies that we fund.
**Provision of quality criteria for residential aged care:**

DHSV's stated mission is to lead improvement in oral health for all Victorians, particularly vulnerable groups and those most in need.

It is our strong view that residents in aged care facilities are a key client group and that minimum reporting criteria regarding quality outcomes within this setting should be readily available.

Some challenges in achieving this include:

- **Minimum data set:** To facilitate the collection of consistent high quality data a minimum data set of indicators would need to be established and monitored. Many of the key elements are in place and would be being reviewed as part of the accreditation process. The ability to report these in a agreed format and time horizon would need to be documented.

- **Data definition:** On agreeing the required minimum data set, the sector would be required to establish performance standards for each metric. It is our view that the sector has an agreed set of data elements that facilitate accreditation and that these may need to be widened as we consider reporting in relation to quality indicators.

- **Treatment plans:** Treatment plans need to be developed to prevent oral disease, and reduce its influence on chronic disease conditions.

**Avoidable hospitalisation within the residential aged care setting:**

DHSV, and associated funded community agencies, are long established providers of care in the residential aged care setting.

Based on our experience we believe that a number of factors, many outside of the control of care providers, impact on hospital presentation rates by aged care residents and that the measurement of avoidable hospitalisation rates as a stand alone quality indicator may be misleading. DHSV provides a series of services to residents in aged care facilities, including a domiciliary service, where patients are seen within the aged care setting. It is our experience that the availability (access) of funded outreach services to residential aged care facilities is a factor in itself and one not in the immediate control of facility managers.
Current Measurement and Data Collection:

As a general comment DHSV would agree that the Victorian Government would not have access to comprehensive information in relation to an individual’s medical history before they present at a hospital or how a patient moves through the health system.

Service providers (hospitals and other health care professionals) maintain local records of each patient treated. A patient record is maintained by each provider but rarely would a single comprehensive file of an individual’s complete medical history exist. As such we believe that it would be rare for a health provider to have a full appreciation of a patient’s medical history.

In stating this we acknowledge that all of the relevant data is captured, it is however on disparate systems, many of which are paper based.

The fact that individuals may seek treatment from a range of separate providers further complicates the challenge of gathering a broad understanding of the patient medical history and the patient journey.

Currently the Victorian Government has access to the oral health data that is available from those eligible people that access public care (20% of the eligible population of concession card holders and their dependants). In addition it has access to in-patient data and national and health survey data. What it does not access is the large component of private health insurance data, Medicare data and the data that is collected in private practices by self-funded individuals receiving care.

It is well known that the data currently collected in relation to groups with specific health care needs, including Aboriginal and Torres Strait Islanders status is not adequate. There are continuing problems with the underidentification of Aboriginal and Torres Strait Islander people and other groups in many health-related data collections. A more systematic approach is required to ensure that questions related to indigenous, multicultural and other status questions are asked correctly and consistently of all clients, and that this information is recorded accurately. Reliable data is essential for measuring the effectiveness of health services in meeting the needs of specific populations, and for further policy development, planning and improvement in service delivery.

It is also well known, that the Australian population is transient, and thus patient data collected in one state, will vary to the data collected in another. In 2005–06 the Victorian Department of Human Services conducted a review of data reporting requirements of Dental Health Services Victoria for public dental services. The review found that the reporting approach was ad hoc and provided a mix of high-level and aggregated data that did not always meet the needs of program accountability and service planning.

Following the review, the department committed to undertaking a common data set project that would streamline data reporting required of Dental Health Services Victoria. The outcomes of the project would be:

- To replace current data reports with unit-level data collection
- Enable the department to produce reports to meet identified needs and provide performance feedback to Dental Health Services Victoria

In February 2011, the Department released the Dental Health Program Data Set (DHPDS), and subsequently DHSV upgraded our data collection system to include the DHPDS.
What to capture, how to manage and what to report:

The Committee has correctly identified the potential dividends that would be available from increased data capture, analysis and review. DHSV agrees that health outcomes would improve and that access indicators and management of access would improve in an environment where data in relation to provision of primary care was captured.

The Committee is also correct in noting the State’s current inability to mandate the data capture standard (content and volume) being canvassed in the paper. Our current governance environment precludes us from capturing and accessing this data in the medium term.

The Federal Government (via Medicare and numerous departmental structures) is a material funder of primary care and aged care services. A significant amount of data is captured in relation to the care provided in these environments. The capacity to expand the capture of higher quality patient care data via the Medicare system is, in our view, an option. Provider data (identifiers) are already captured. Elementary patient level data is also captured (date of service provision, name). Other demographic details of services provided and patient demographics are also on file.

Whilst a significant level of dental services are provided within the private dental setting, data regarding this care may be available through private health insurance providers. This offers an opportunity to capture a large amount of data from a smaller number of providers, rather than attempting to collect a minimum data set from independent private dental practitioners.

The opportunity therefore exists to commence data capture in relation to patient condition and care by expending the data elements provided and captured. The opportunity is transparent; the privacy and governance issues are however significant and remain outstanding issues.

It is our view that the greatest opportunity exists in capturing and utilising data for use in a research capacity and the subsequent translation of findings into improved care. DHSV has successfully translated evidenced based research into improved clinical service delivery.

It is also our view that a “complete” patient service data set is not required to achieve significant service improvements. In our experience, high quality patient level data is the key, not high volume data.

DHSV are aware that the Commonwealth government allocated the Department of Health and Ageing in the 2010-2011 budget $466 million for the introduction of personally controlled electronic health records, and that the public will be able to register for a personally controlled e-health record from 2012-13. We support this policy position but also acknowledge that it will not be mandatory to register for a personally controlled e-health record to receive health care, and thus many people, including those that access the services provided by DHSV, will choose not to opt in.