Personal response

I support the goal of delivering high quality safe care.

Acknowledgement of activity relating to case conferences where the patient is absent is welcomed both as a recognition of the time and resources involved and for the patient in some cases where meaningful engagement is limited due to cognitive issues.

I welcome recognition of the substantial time and resources expended in teaching, training and research – all of which are critical to maintaining an informed, competent and capable workforce in to the future

Pricing / funding for safety and quality: Whether linking pricing to the suggested processes and outcomes will achieve the stated goals unclear. The suggested punitive approach may well not achieve this. Broader engagement in bundles of care and the alignment of pricing with quality / safety would be better achieved through lower base tariffs and financial incentives to deliver against agreed standards.

It is a pity that using hip fracture care as a test case for pricing quality (through incentivisation) seems to have dropped off the radar. This was a really opportunity to work through the potential power that guidelines, standards and registries can have when developed and delivered well.

Hospital acquired complications – the use of the condition onset flag is highly variable yet has to potential to provide critical information about how our health system currently performs. The introduction of penalties for certain potentially preventable conditions is likely to have an impact on reporting and coding of these events. That is not in the best interests of quality improvement. Older people are particularly susceptible to a number of the listed. It is too soon to impose penalties. More time is required to get an accurate and consistent approach to the use of the condition onset flag. The suggestion of penalising hospitals for failing to report HACs using the COF is a possible mechanism to improve reporting and then everyone starts on a level playing field.

The selection of delirium as a HAC will prove to be enormously contentious and challenging. It is also likely to result in less reporting and awareness – things we don't want at present. The health system is only just waking up to the need to actually assess cognition – to impose penalties for something that is poorly understood, poorly assessed and managed will be a negative step. The focus has to be on increasing awareness, identification of risk and then prevention and management.

Unplanned readmissions – we are already starting to see the issues relating to this with patients with complications from a private procedure ending up readmitted to the public system. This needs very careful consideration and requires the use of linked data. Implying causality in relation to a readmission will be enormously challenging in an older population. Hip fracture patients are a perfect example where these people represent some of the most frail members of our society – does a readmission with a UTI following discharge with a hip fracture count as a preventable readmission. What about those patients really keen to try and manage at home who then fail and re-present to hospital, possibly from a fall. To avoid this happening. The system could potentially push more people in to RACF.

Would strongly suggest collaborating with the Australian and New Zealand Society for Geriatric Medicine for issues relating to older people. The Society is happy to engage constructively in what are clearly challenging times.

Jacqueline Close

Professor Jacqueline CT Close MD FRCP FRACP
Consultant Geriatrican
President – Australian and New Zealand Society for Geriatric Medicine

Principal Research Fellow
Neuroscience Research Australia
Barker St
Randwick
NSW 2031
Australia

+61 2 93991055
j.close@neura.edu.au