Train IT Medical
Leading Your Practice Into The Digital Future

WA Primary Health Alliance
Better health, together

phn
PERTH NORTH, PERTH SOUTH, COUNTRY WA
An Australian Government Initiative

Practice Improvements & Team Based Care

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Learning Objectives:

1. Use electronic health records and software tools for patient and practice improvements.

2. Utilise third party data analytic tools for quality improvement activities.
3. Develop an understanding of the concept of care gaps.

4. Produce detailed data analytic reports from a patient, clinician and business perspective.

5. Design a planned approach to patient health improvements and meet QI PIP requirements.

6. Implement a team-based, systematic approach to improvements based on quality data and patient engagement.

My Health Record national statistics (as at 28 February 2019)

Consumer Statistics

90.1% National Participation Rate

State	Participation Rate*
ACT	86.7%
NSW	90.2%
NT	93.6%
QLD	91.2%
SA	89.3%
TAS	90.3%
VIC	89.3%
WA	90.4%

*Participation rate for MHR calculated using the number of people eligible for Medicare as at 31 January 2019

Provider Organisation Statistics

15,460 Healthcare provider organisations registered

Organisation Type*	Count
General Practice Organisations	6,902
Public Hospitals and Health Services	829
Private Hospitals and Clinics	184
Pharmacies	4,609
Aged Care Residential Services	198
Pathology and Diagnostic Imaging Services	84
Other categories of healthcare providers including Allied Health	2,228
Organisations with a cancelled registration	426

*Organisation type based on Healthcare Provider Organisation (HPI-O) data, except for Hospital provider data which is based on jurisdictional reported facilities that are connected to the My Health Record system.

My Health Record Usage

Clinical Document Uploads	**11,526,154**
Shared Health Summary	2,415,994
Discharge Summary	2,649,813
Event Summary	802,178
Specialist Letter	110,996
eReferral Note	108
Pathology Reports	4,813,761
Diagnostic Imaging Report	733,304
Prescription and Dispense Uploads	**32,037,150**
Prescription Documents	21,364,405
Dispense Documents	10,672,745
Consumer Documents	**224,224**
Consumer Entered Health Summary	146,552
Consumer Entered Notes	51,925
Advance Care Directive Custodian Report	21,788
Advance Care Planning Document	3,959
Medicare Documents	**853,604,930**
Australian Immunisation Register	2,912,647
Australian Organ Donor Register	736,230
Medicare/DVA Benefits Report	500,697,278
Pharmaceutical Benefits Report	349,258,775

Tiger's data:

Diabetes
Arthritis
Triple bypass
Kidney failure
Gout
Reflux
Emphysema

https://www.youtube.com/watch?v=4ynC-GQjwR4

Tiger's goals are our KPIs!

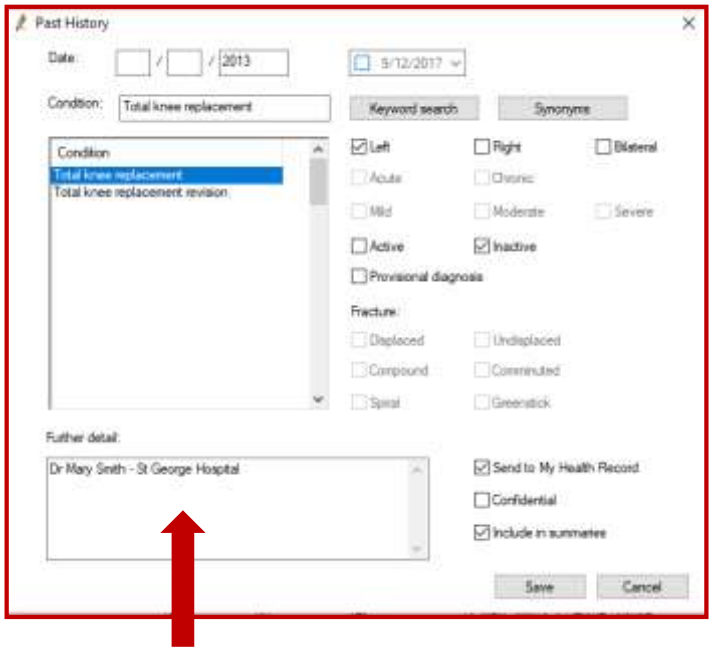
"Not telling his story over and over"

"Supporting his family caring for him"

Co-ordinated Planning | Care Goals | Care Gaps

https://www.youtube.com/watch?v=4ynC-GQjwR4

‘The data’ [coding]

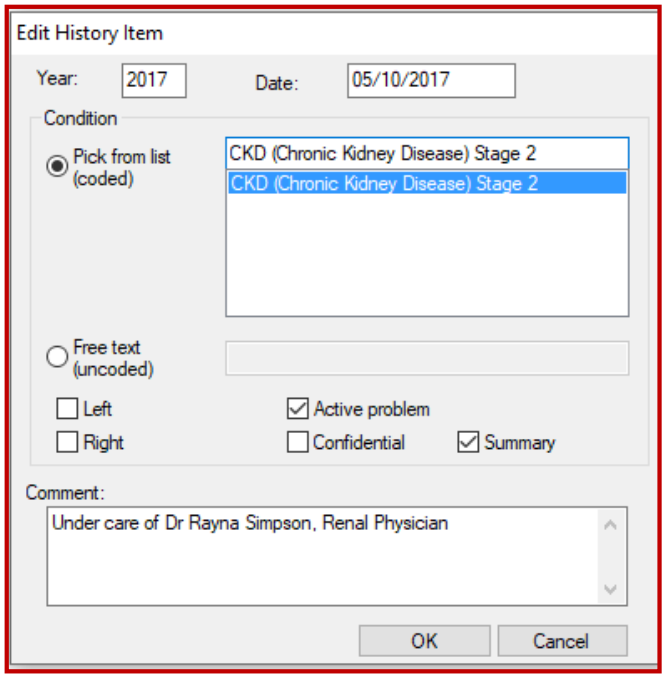


ONLY for Chronic conditions & significant active or inactive ‘events’ eg cabg

BEST TIP!

Add detail/comment

eg Care team involved



PIP QI – 10 measures

Smoking status
Alcohol status
Weight

Diabetes:
- with blood pressure recorded
- with current HbA1c result
- Immunised against influenza

Patients over 65 immunised against influenza

CVD: Necessary risk factors recorded to enable CVD assessment

COPD:
- Immunised against influenza

Cervical screening

New PIP to track patient' drinking & smoking

Data Improvements

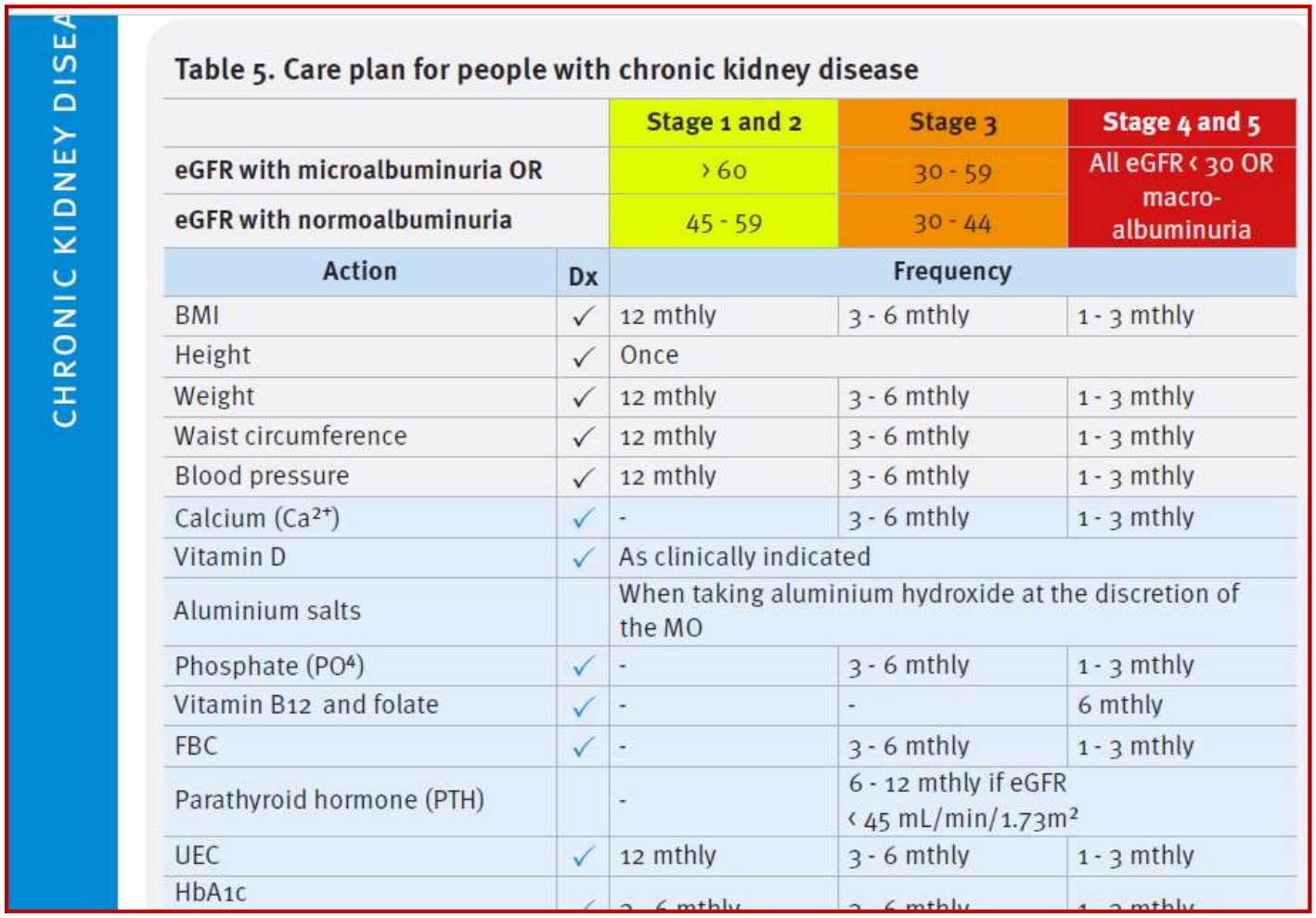
11. Aboriginal and Torres Strait Islander health
12. BMI
13. Blood Pressure
14. Diabetes - ACR
15. Kidney function test recorded
16. Chronic Kidney Disease - eGFR
17. GPMP and TCAs
18. Health Assessments
19. Breast Cancer Screening
20. Bowel Cancer Screening

Diabetes Cycle of Care:

Check	When	Target
HbA1c	At least every 6-12 months	53mmol/mol (7%) or less
Blood pressure	At least every six months	130/80 or less
Foot assessment	Low risk feet: At least every year High risk feet: At least every 3-6 months	Foot health maintained
Eye examination	At least every two years	Eye health maintained
Kidney health	At least every year	Microalbumin levels in target range Kidney function test in target range
Blood fats	At least every year	Total cholesterol less than 4mmol/L LDL less than 2mmol/L HDL 1mmol/L or above Triglycerides less than 2mmol/L
Weight	At least every six months	BMI 18.5-24.9
Waist circumference	At least every six months	Less than 94cm (men) Less than 80cm (women)
Healthy eating review	At least every year	Following a healthy eating plan
Physical activity review	At least every year	At least 30 minutes of moderate physical activity, five or more days a week and minimise time spent sitting
Medication review	At least every year	Safe use of medications
Smoking	At least every year	No smoking
Diabetes management	At least every year	Self-management of diabetes maintained
Emotional health	As needed	Emotional health and well-being maintained

NDSS Checklist: https://static.diabetesaustralia.com.au/s/fileassets/diabetes-australia/4732816f-9855-4c7e-bbec-ddd2f1144fea.pdf

Kidney Disease



CHRONIC KIDNEY DISEA

Table 5. Care plan for people with chronic kidney disease

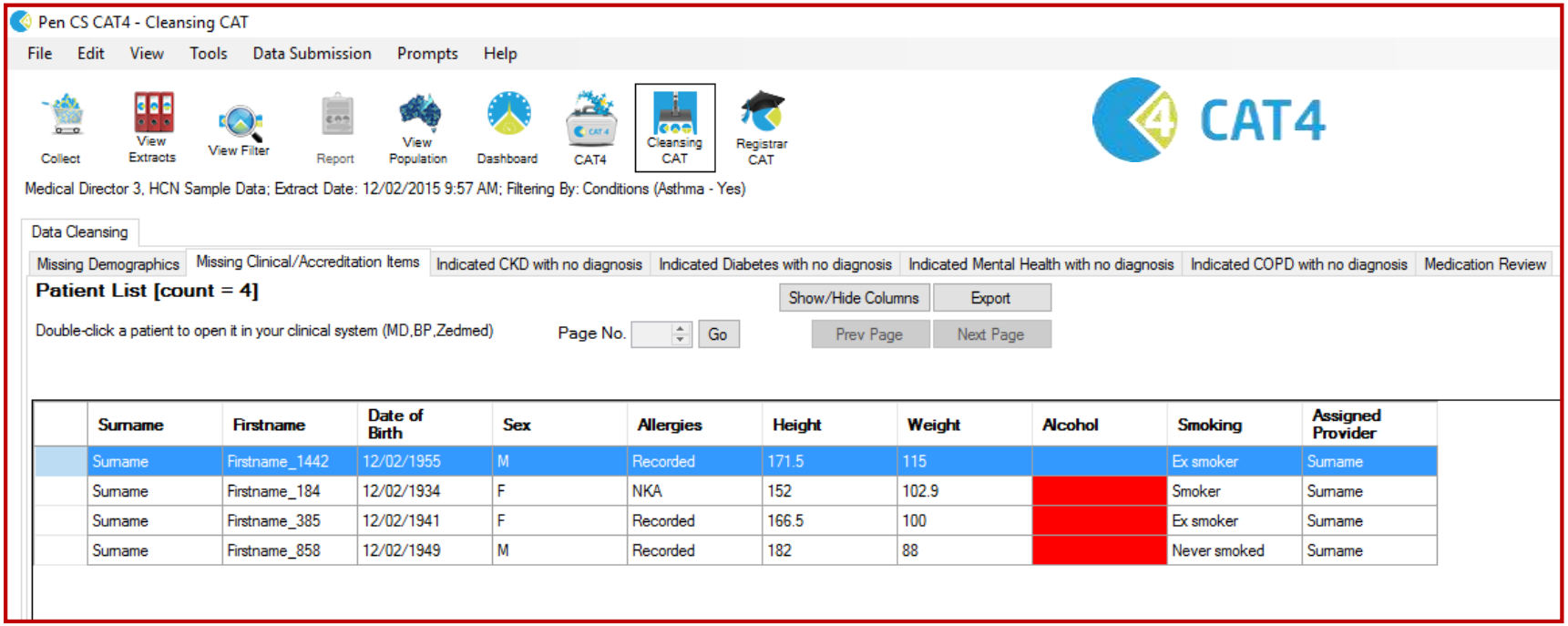
		Stage 1 and 2	Stage 3	Stage 4 and 5
eGFR with microalbuminuria OR		› 60	30 - 59	All eGFR ‹ 30 OR macro-albuminuria
eGFR with normoalbuminuria		45 - 59	30 - 44	
Action	**Dx**	**Frequency**		
BMI	✓	12 mthly	3 - 6 mthly	1 - 3 mthly
Height	✓	Once		
Weight	✓	12 mthly	3 - 6 mthly	1 - 3 mthly
Waist circumference	✓	12 mthly	3 - 6 mthly	1 - 3 mthly
Blood pressure	✓	12 mthly	3 - 6 mthly	1 - 3 mthly
Calcium (Ca^{2+})	✓	-	3 - 6 mthly	1 - 3 mthly
Vitamin D	✓	As clinically indicated		
Aluminium salts		When taking aluminium hydroxide at the discretion of the MO		
Phosphate (PO^4)	✓	-	3 - 6 mthly	1 - 3 mthly
Vitamin B12 and folate	✓	-	-	6 mthly
FBC	✓	-	3 - 6 mthly	1 - 3 mthly
Parathyroid hormone (PTH)		-	6 - 12 mthly if eGFR ‹ 45 mL/min/1.73m²	
UEC	✓	12 mthly	3 - 6 mthly	1 - 3 mthly
HbA1c	✓	3 - 6 mthly	3 - 6 mthly	1 - 3 mthly

Actions & Reminders – apply a systematic approach to care!

Action	Frequency
BMI	3 - 6 mthly
Height	
Weight	3 - 6 mthly
Waist circumference	3 - 6 mthly
Blood pressure	3 - 6 mthly
Calcium (Ca^{2+})	3 - 6 mthly
Vitamin D	ted
Aluminium salts	nium hydroxide at t
Phosphate (PO^4)	3 - 6 mthly
Vitamin B12 and folate	-
FBC	3 - 6 mthly
Parathyroid hormone (PTH)	6 - 12 mthly if eGFR ‹ 45 mL/min/1.73m
UEC	3 - 6 mthly
HbA1c (for people with diabetes)	3 - 6 mthly

Smoking, Alcohol, BMI – Identify Care Gaps!

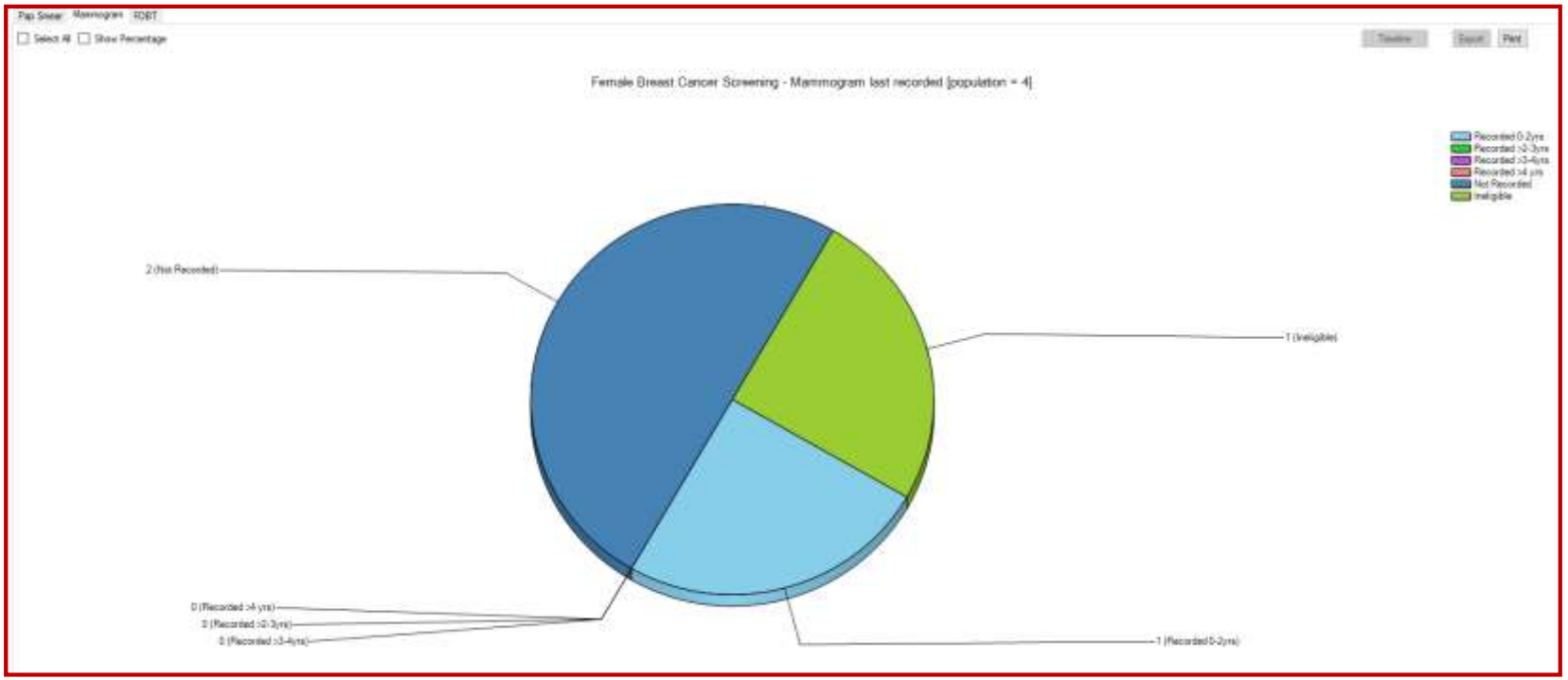
Per patient | per provider | per practice population



Surname	Firstname	Date of Birth	Sex	Allergies	Height	Weight	Alcohol	Smoking	Assigned Provider
Surname	Firstname_1442	12/02/1955	M	Recorded	171.5	115		Ex smoker	Surname
Surname	Firstname_184	12/02/1934	F	NKA	152	102.9		Smoker	Surname
Surname	Firstname_385	12/02/1941	F	Recorded	166.5	100		Ex smoker	Surname
Surname	Firstname_858	12/02/1949	M	Recorded	182	88		Never smoked	Surname

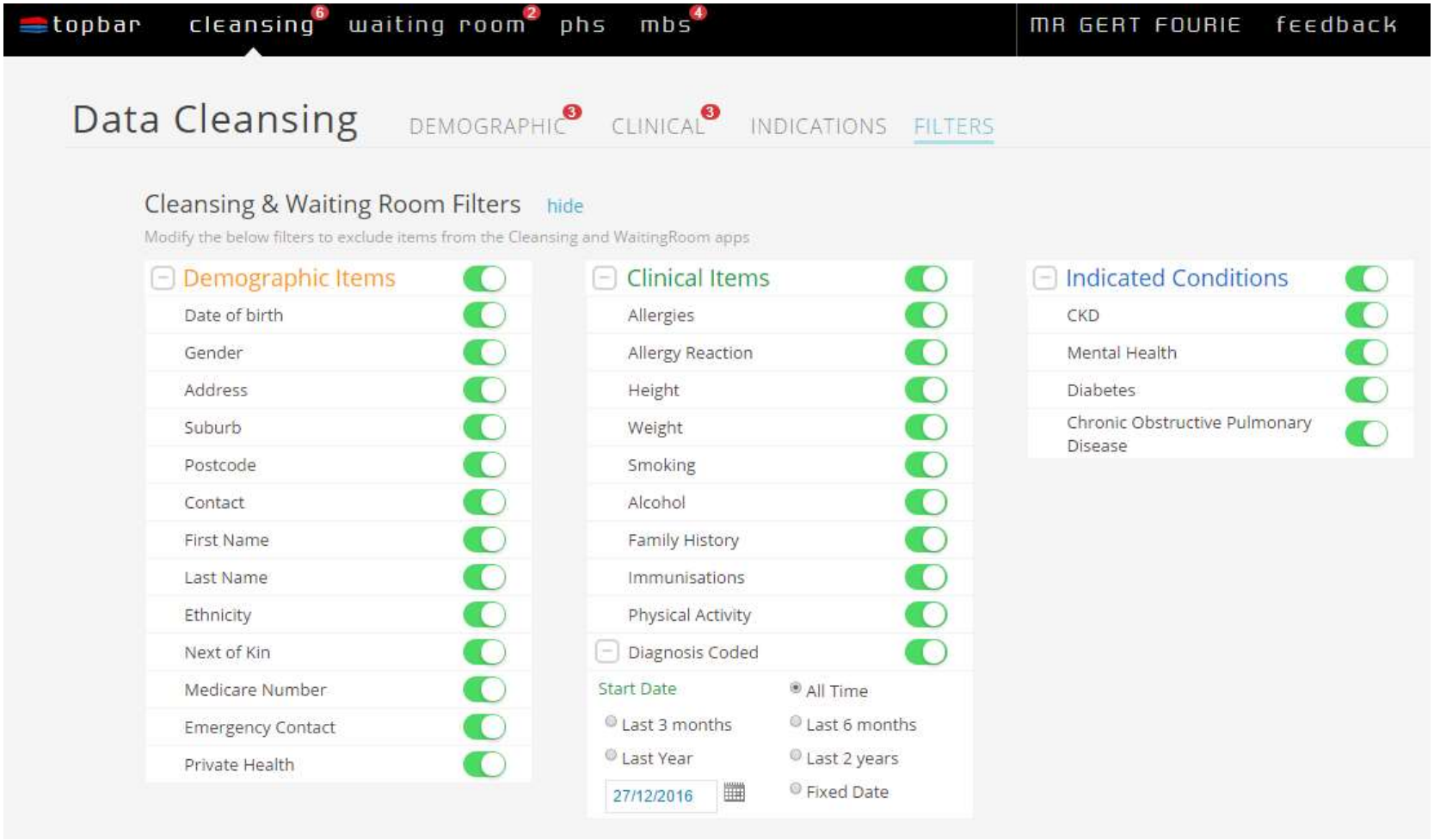
Cancer Screening: care gaps!

Identify all eligible patients NOT screened for FOBT, Cervical Screening (CST) or Mammograms



TopBar

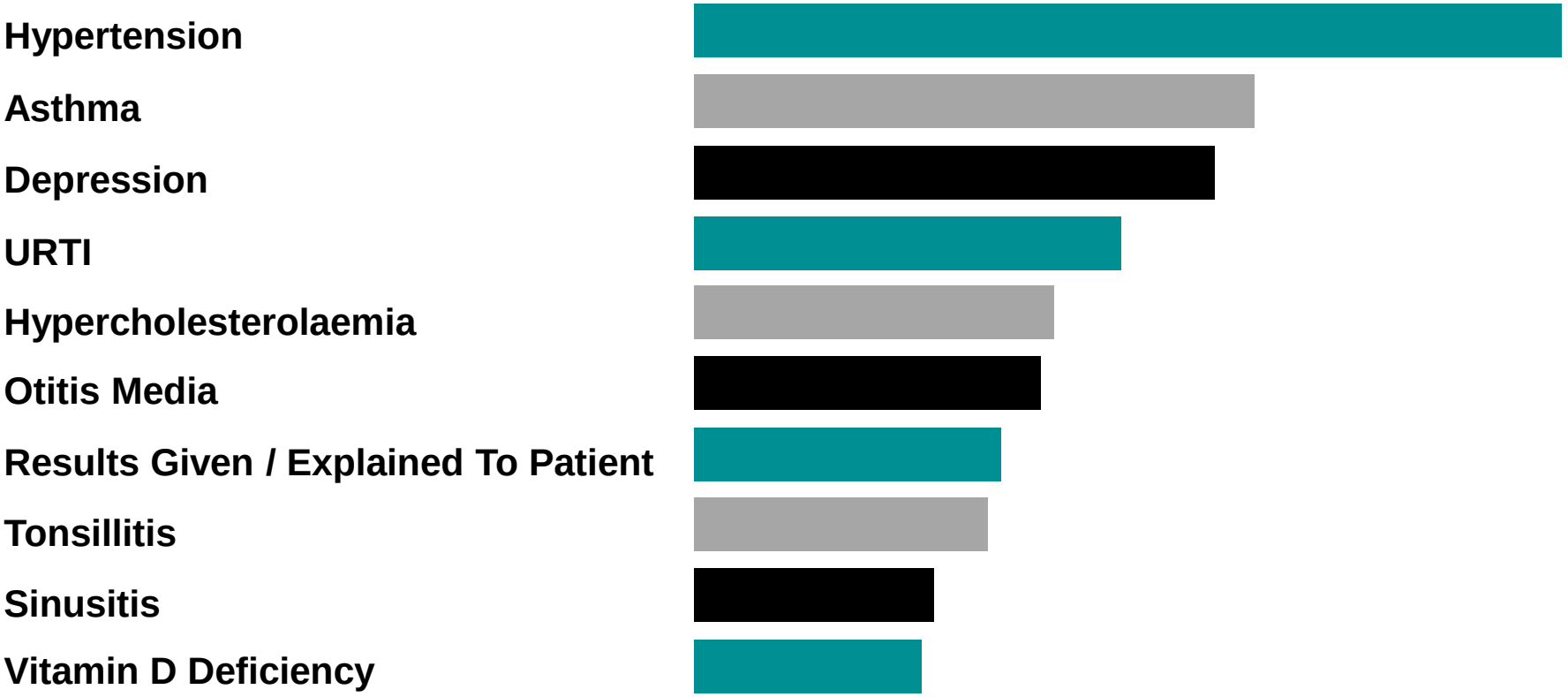
Proactive reminders (filters)



Know your population

Diabetes *n* =
Arthritis *n* =
Cardiovascular disease *n* =
Kidney disease *n* =
Gout *n* =
Reflux *n* =
Emphysema *n* =

Do you agree with this picture of your population?



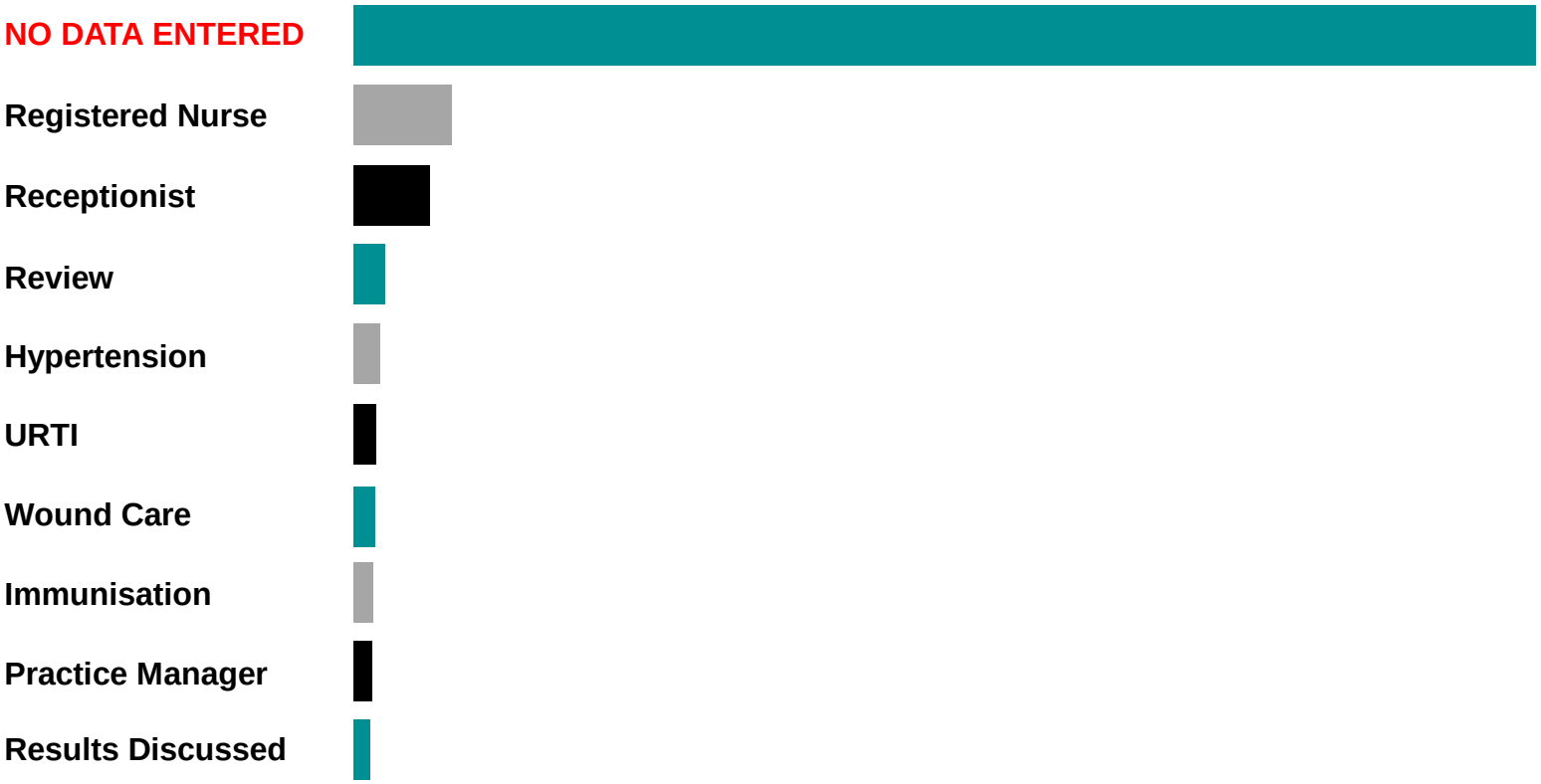
The ‘evidence’ says:

70.6% **NO DATA**

25.4% **FREE TEXT**

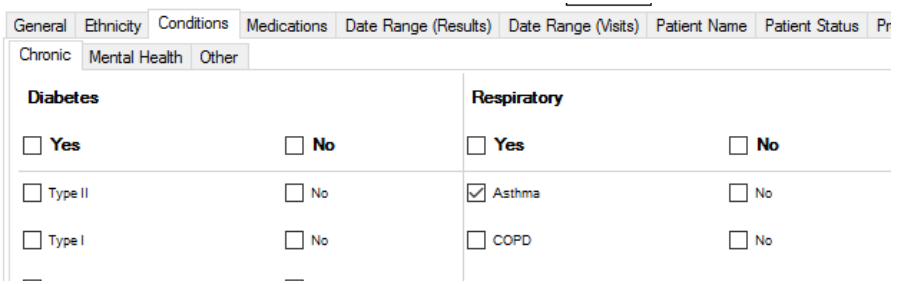
4.0% **CODED**

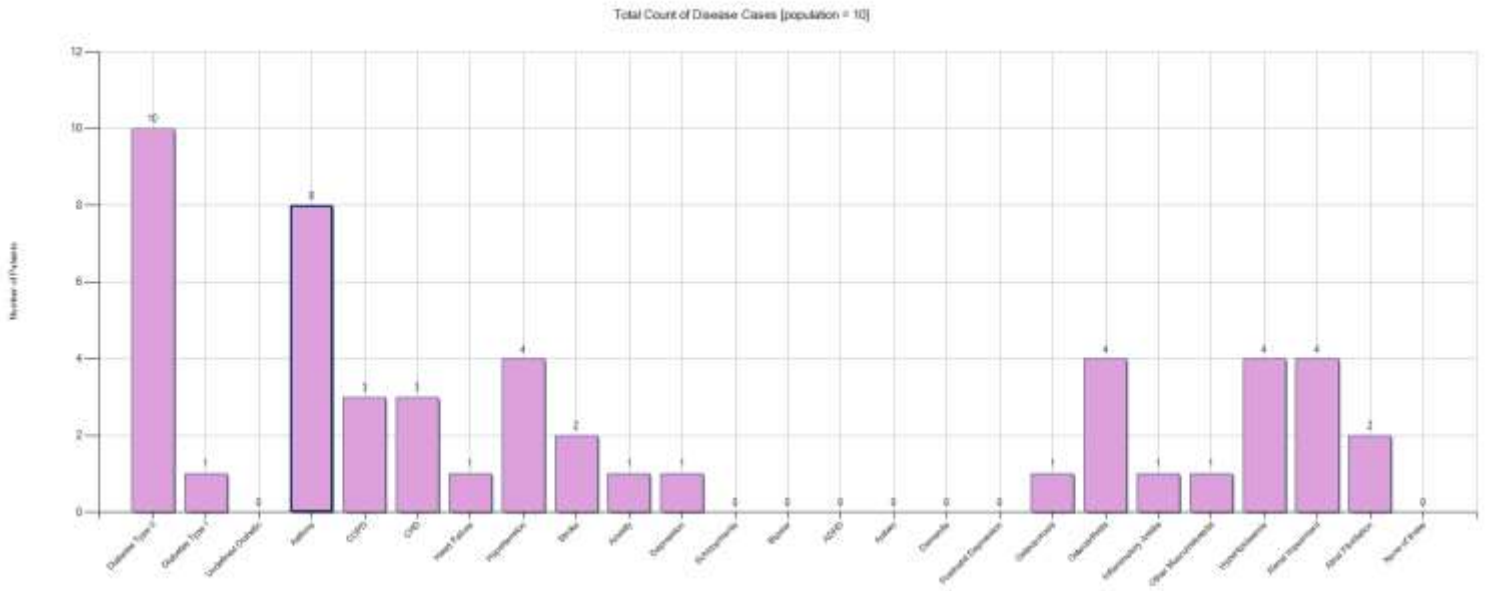
Top 10 ‘Reason for visit/contact’ as recorded in GP Software



Where's **your** evidence?

Build a Register of patients with a particular condition e.g. Diabetes etc

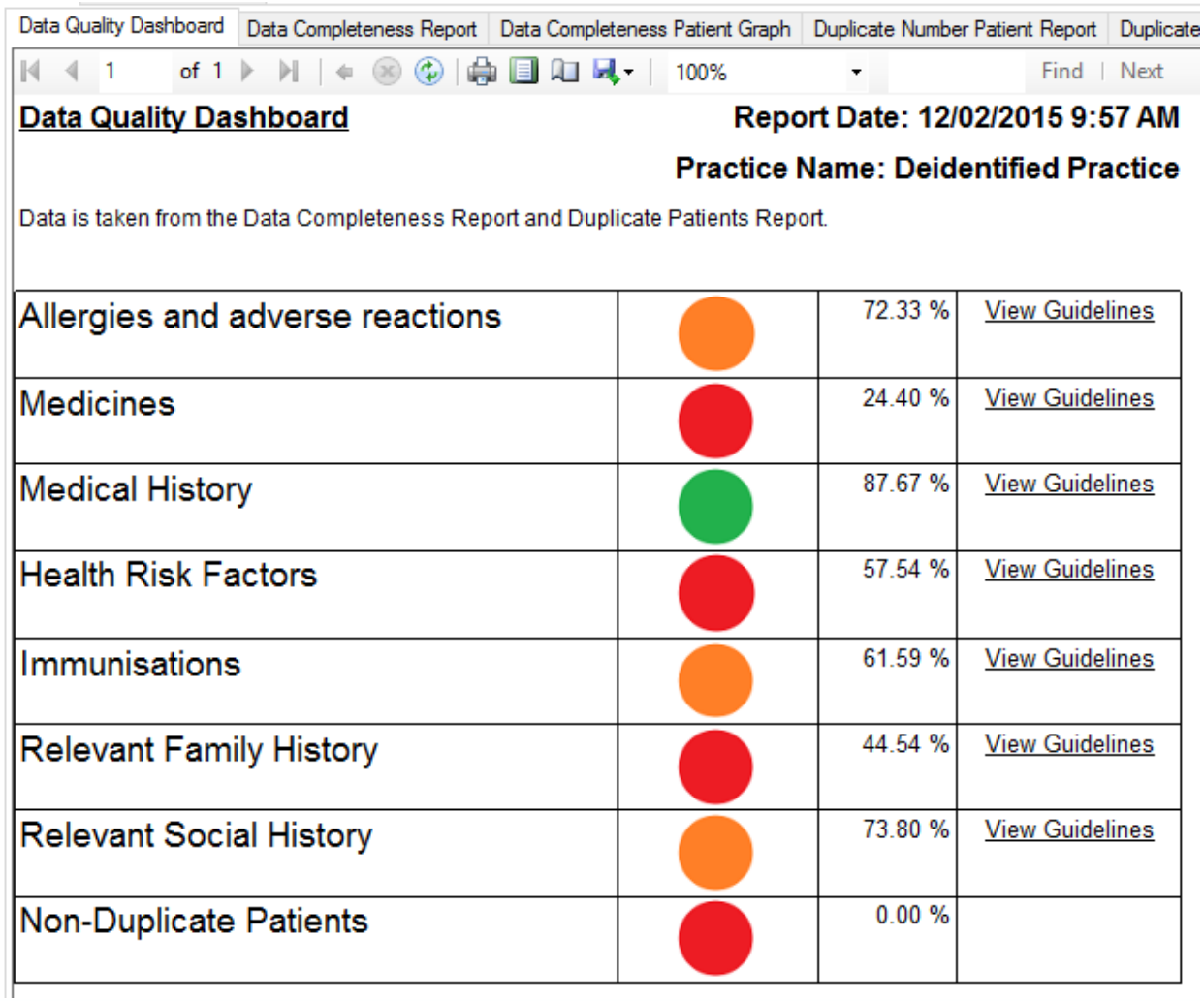




How do I improve?

	Whole Practice	GP 1	GP 2	GP 3	GP 4	GP 5	GP 6	GP 7	GP 8	GP 9
1. Allergy Recorded										
Total population	13697	2488	1996	921	1718	1839	936	604	686	43
Nothing recorded	28.8%	16.4	36.5	28.1	51.2	9.4	21.5	24.3	4.1	30.2
Active population	9576	1866	1628	684	1192	1445	795	397	514	30
Nothing recorded	17.7	29.5	28.5	19.7	39.9	4.2	13.8	14.9	01.0	10.0
2. Gender not recorded										
Total population	141	28	11	13	21	6	12	5	6	0
Active population	35	5	2	3	11	2	7	0	3	0
3. Smoking – nothing recorded										
Active population over 16 (Active (3x > 2 years)	27%	15.7	63.9	60.4	76.4	11.5	44.6	41.0	21.2	39.7
4. Recording of ATSI patients										
Total population	0	0	0	1	0	0	0	0	0	0
Active population (Active (3x > 2 years)	1	0	0	1	0	0	0	0	0	0
5. Diabetes Prevalence										
Total population	3.5%	2.9	2.8	1.4	8.8	5.1	2.5	1.2	4.2	4.7
Active population (Active (3x > 2 years)	4.6%	3.8	3.2	1.9	11.7	6.2	2.9	1.8	5.5	6.7
Diabetics 65+, 8+ medications	60.9 %	61.4	74.2%	50%	77.8%	63.6%	81.3%	60%	62.5%	100%
Diabetics 65+, 5+ medications	90.9%	88.7	93.6%	83.4%	92.9%	90.8%	100%	80%	75%	100%
6. Diabetes "at risk" *										
40-49 year olds	94	5	2	3	0	12	2	1	2	0
50+ year olds	288	29	55	6	8	131	10	6	17	1

Data Quality Dashboard



Data Quality Dashboard

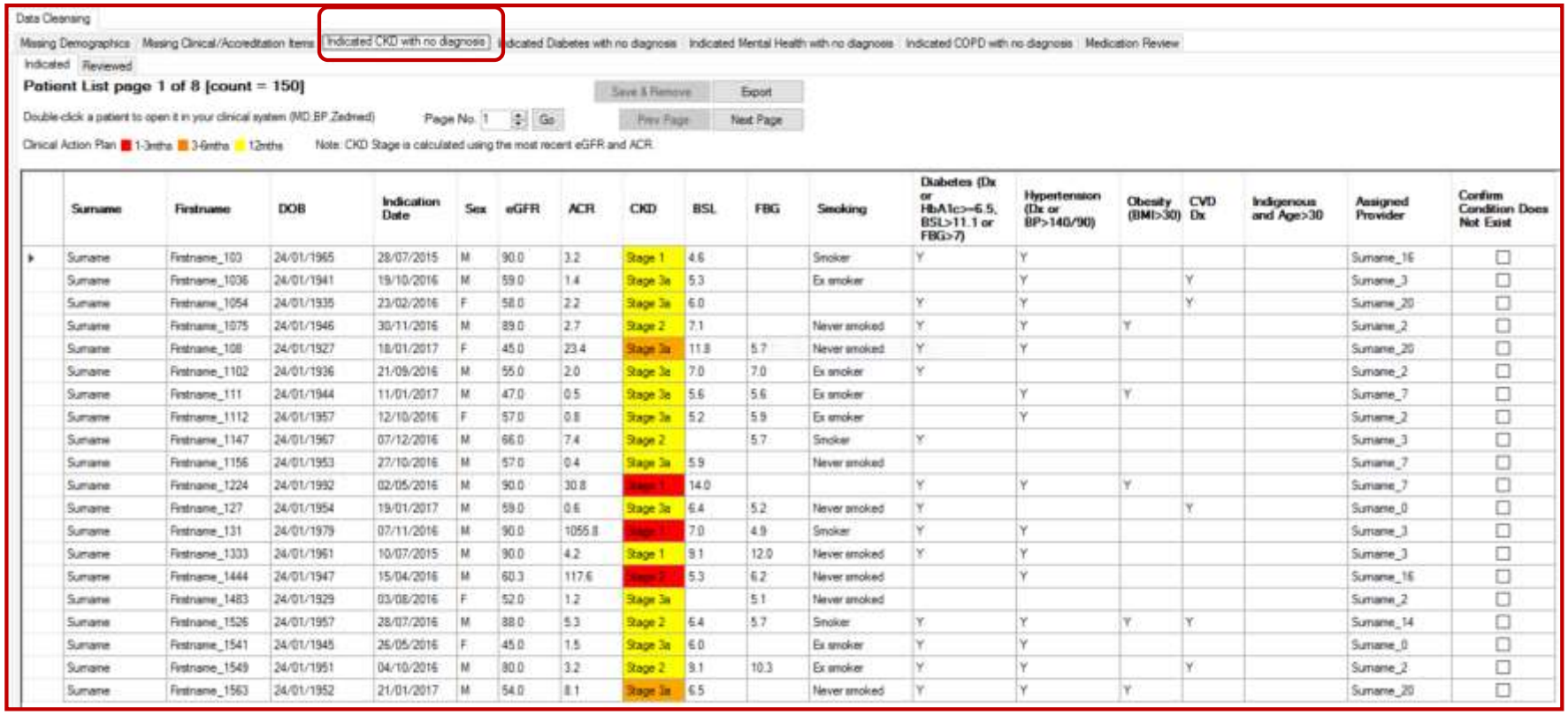
Report Date: 12/02/2015 9:57 AM

Practice Name: Deidentified Practice

Data is taken from the Data Completeness Report and Duplicate Patients Report.

Allergies and adverse reactions	72.33 %	View Guidelines
Medicines	24.40 %	View Guidelines
Medical History	87.67 %	View Guidelines
Health Risk Factors	57.54 %	View Guidelines
Immunisations	61.59 %	View Guidelines
Relevant Family History	44.54 %	View Guidelines
Relevant Social History	73.80 %	View Guidelines
Non-Duplicate Patients	0.00 %	

Identify at-risk patients – kidney disease



Data Cleansing

Missing Demographics | Missing Clinical/Accreditation Items | Indicated CKD with no diagnosis | Indicated Diabetes with no diagnosis | Indicated Mental Health with no diagnosis | Indicated COPD with no diagnosis | Medication Review

Indicated | Reviewed

Patient List page 1 of 8 [count = 150]

Save & Remove | Export

Double-click a patient to open it in your clinical system (MD.BP.Zedmed) Page No. 1 Go Prev Page Next Page

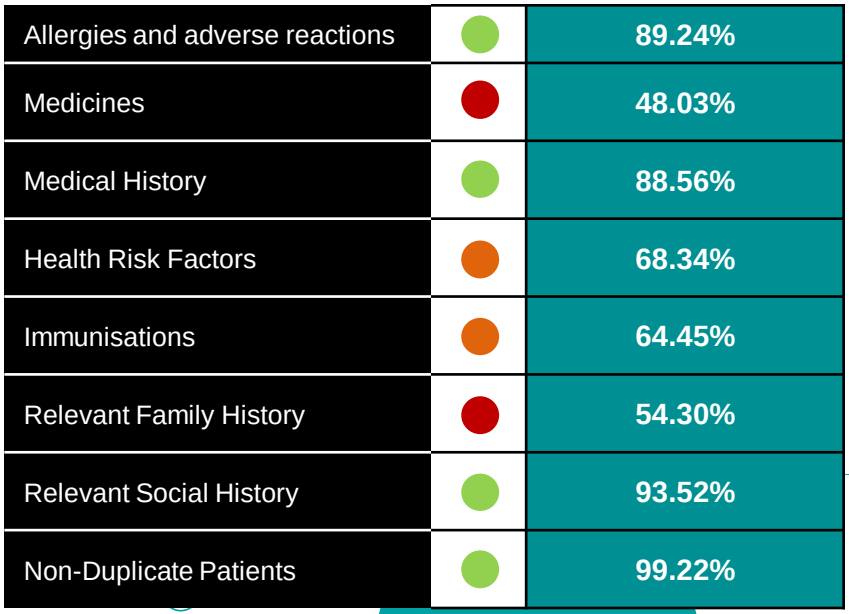
Clinical Action Plan 1-3mths 3-6mths 12mths Note: CKD Stage is calculated using the most recent eGFR and ACR

Surname	Firstname	DOB	Indication Date	Sex	eGFR	ACR	CKD	BSL	FBG	Smoking	Diabetes (Dx or HbA1c>=6.5, BSL>11.1 or FBG>7)	Hypertension (Dx or BP>140/90)	Obesity (BMI>30)	CVD Dx	Indigenous and Age>30	Assigned Provider	Confirm Condition Does Not Exist
Surname	Firstname_103	24/01/1965	28/07/2015	M	90.0	3.2	Stage 1	4.6		Smoker	Y	Y				Surname_16	☐
Surname	Firstname_1036	24/01/1941	19/10/2016	M	59.0	1.4	Stage 3a	5.3		Ex smoker		Y		Y		Surname_3	☐
Surname	Firstname_1054	24/01/1935	23/02/2016	F	58.0	2.2	Stage 3a	6.0			Y	Y		Y		Surname_20	☐
Surname	Firstname_1075	24/01/1946	30/11/2016	M	89.0	2.7	Stage 2	7.1		Never smoked	Y	Y	Y			Surname_2	☐
Surname	Firstname_108	24/01/1927	18/01/2017	F	45.0	23.4	Stage 3a	11.8	5.7	Never smoked	Y	Y				Surname_20	☐
Surname	Firstname_1102	24/01/1936	21/09/2016	M	55.0	2.0	Stage 3a	7.0	7.0	Ex smoker	Y					Surname_2	☐
Surname	Firstname_111	24/01/1944	11/01/2017	M	47.0	0.5	Stage 3a	5.6	5.6	Ex smoker		Y	Y			Surname_7	☐
Surname	Firstname_1112	24/01/1957	12/10/2016	F	57.0	0.8	Stage 3a	5.2	5.9	Ex smoker		Y				Surname_2	☐
Surname	Firstname_1147	24/01/1967	07/12/2016	M	66.0	7.4	Stage 2		5.7	Smoker	Y					Surname_3	☐
Surname	Firstname_1156	24/01/1953	27/10/2016	M	57.0	0.4	Stage 3a	5.9		Never smoked						Surname_7	☐
Surname	Firstname_1224	24/01/1992	02/05/2016	M	90.0	30.8	Stage 1	14.0			Y	Y	Y			Surname_7	☐
Surname	Firstname_127	24/01/1954	19/01/2017	M	59.0	0.6	Stage 3a	6.4	5.2	Never smoked	Y			Y		Surname_0	☐
Surname	Firstname_131	24/01/1979	07/11/2016	M	90.0	1055.8	Stage 1	7.0	4.9	Smoker	Y	Y				Surname_3	☐
Surname	Firstname_1333	24/01/1961	10/07/2015	M	90.0	4.2	Stage 1	9.1	12.0	Never smoked	Y	Y				Surname_3	☐
Surname	Firstname_1444	24/01/1947	15/04/2016	M	60.3	117.6	Stage 2	5.3	6.2	Never smoked		Y				Surname_16	☐
Surname	Firstname_1483	24/01/1929	03/08/2016	F	52.0	1.2	Stage 3a		5.1	Never smoked						Surname_2	☐
Surname	Firstname_1526	24/01/1957	28/07/2016	M	88.0	5.3	Stage 2	6.4	5.7	Smoker	Y	Y	Y	Y		Surname_14	☐
Surname	Firstname_1541	24/01/1945	26/05/2016	F	45.0	1.5	Stage 3a	6.0		Ex smoker	Y	Y				Surname_0	☐
Surname	Firstname_1549	24/01/1951	04/10/2016	M	80.0	3.2	Stage 2	9.1	10.3	Ex smoker	Y	Y		Y		Surname_2	☐
Surname	Firstname_1563	24/01/1952	21/01/2017	M	54.0	8.1	Stage 3a	6.5		Never smoked	Y	Y	Y			Surname_20	☐

Create an Improvement Culture

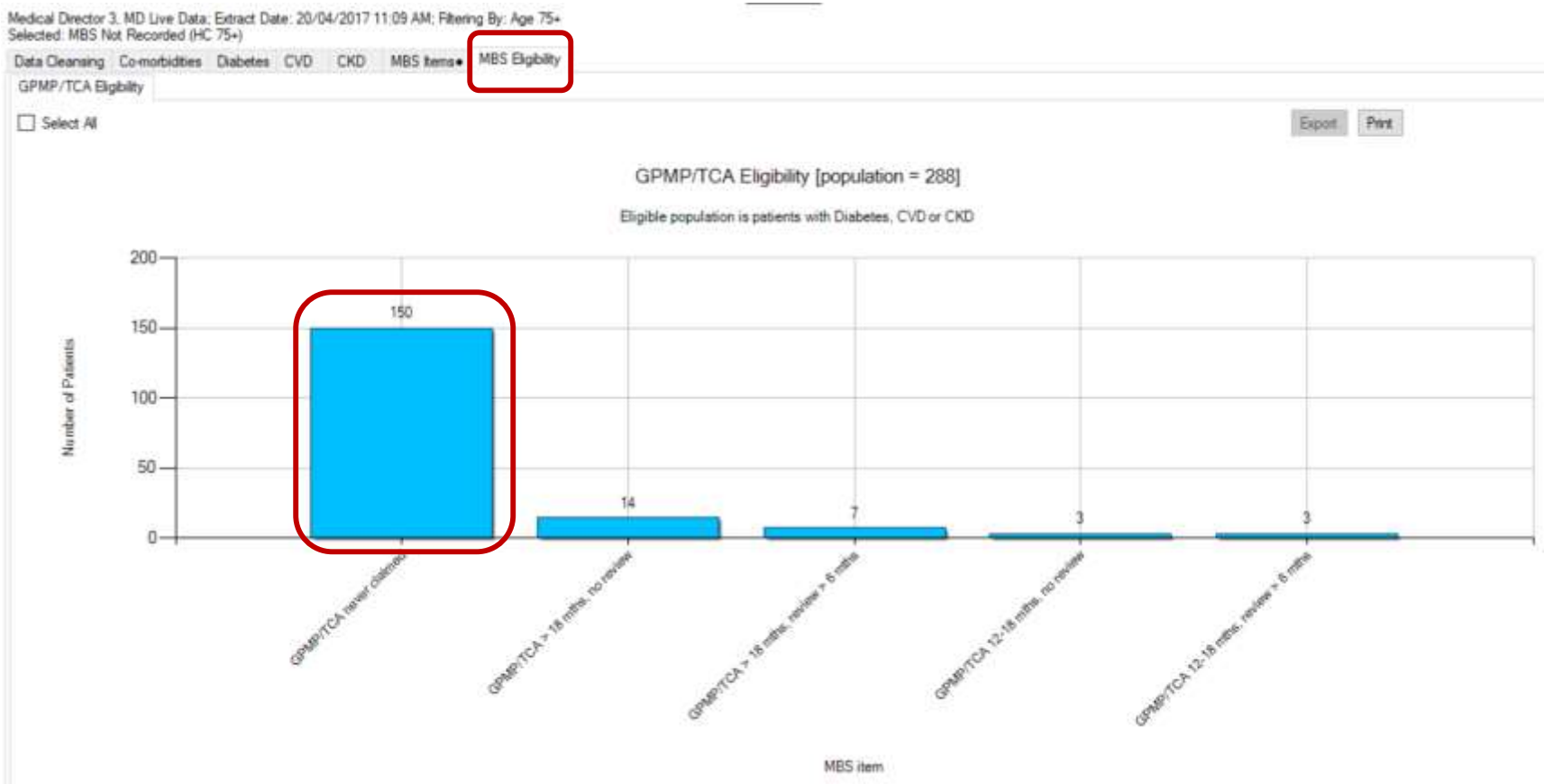
Example of coding improvement activity

- Generate Data Quality Dashboard in data extraction tool e.g. Pen CAT4 for individual providers (evidence based approach showing real data rather than assumption).
- Create PDSA to support Quality Improvement Activity



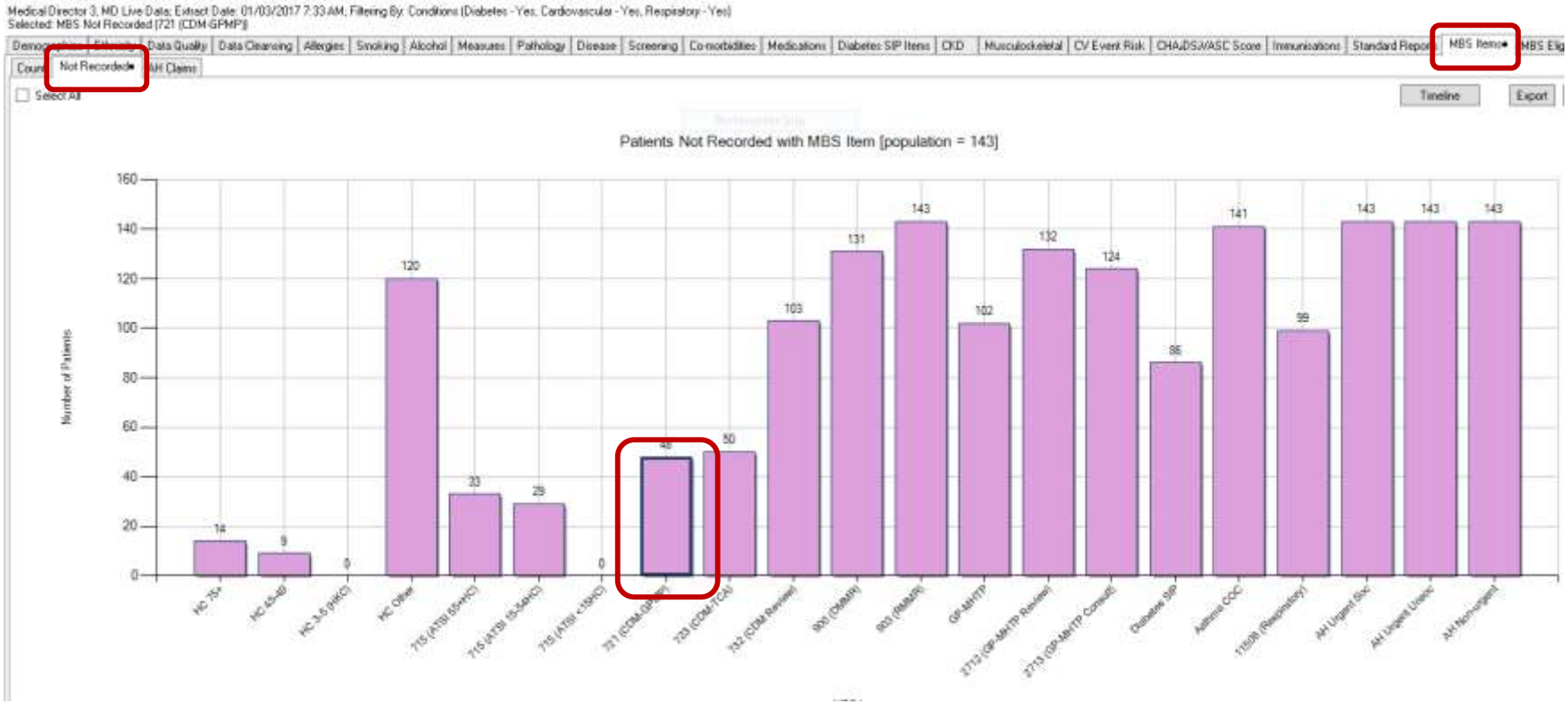
Improve Revenue

Identify patients with chronic conditions for whom a GPMP/TCA has never been claimed

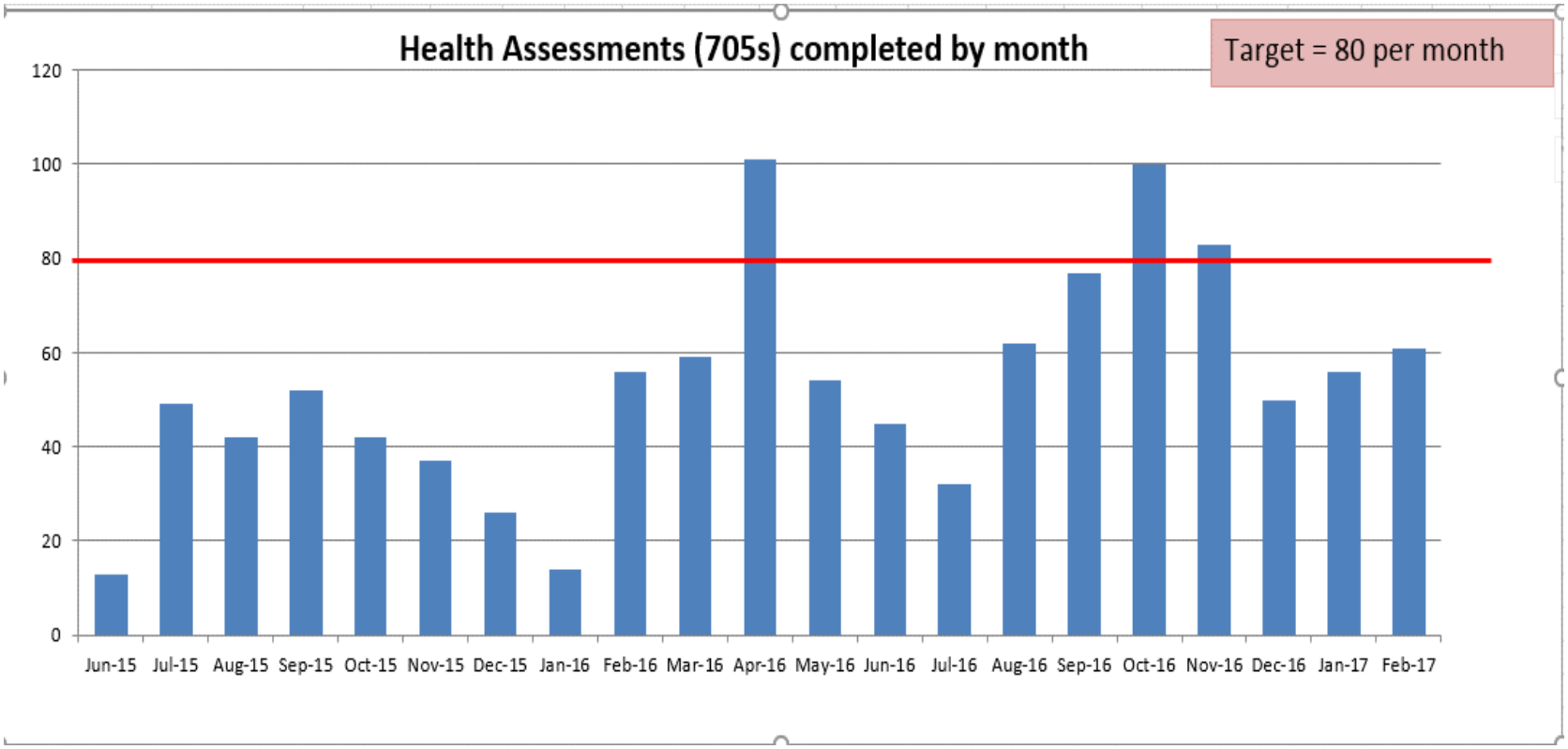


Business Process Improvements

Identify all patients with a chronic condition without a GP Management Plan



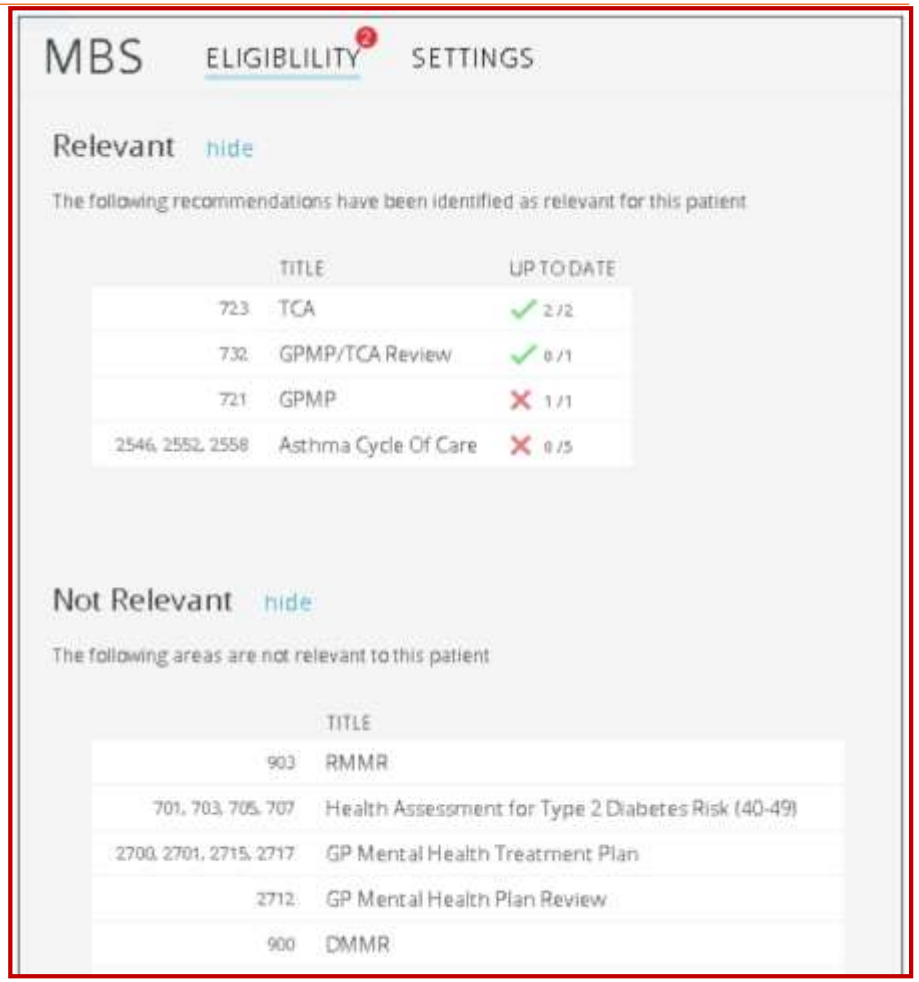
Your KPIs – track performance



Tips: Encourage a team effort to achieve the goals by setting a target on the graph & place graph in the staff room/noticeboard to encourage a proactive approach.

MBS app

- Assists in determining relevant MBS item numbers
- Looks at coded conditions & billing history



Tips for a Team Culture

1. Organise regular staff meetings – allocate actions & ownership
2. Help staff see their role in relation to meeting the standards
3. Promote a team based approach and quality improvement culture
4. Encourage staff participation by seeking feedback and input to improvement ideas
5. Include and record ethical dilemma discussions in your regular team meetings

Teamwork | Engagement

MANAGING COMPLEX CHANGE

= False Starts


VISION

+


SKILLS

+


INCENTIVES

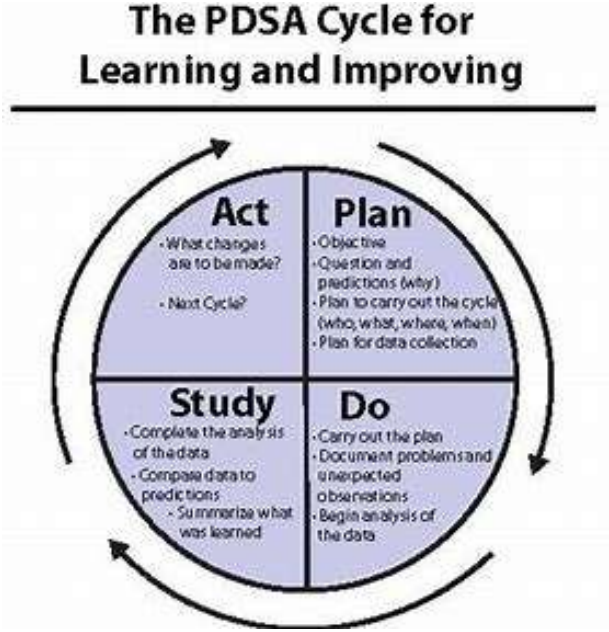
+


RESOURCES

+


ACTION PLAN

= CHANGE!



- Use QI tools such as **PDSA's** to facilitate improvement
- Consider new and **innovative** ways of working
- Focus on patient and staff experiences
- Identify improvements using **feedback from patients and staff**
- Use **data to measure** improvements

QI1.1 ►C Our practice seeks feedback from the team about our quality improvement systems and the performance of these systems
QI1.3 ►B Our practice uses relevant patient and practice data to improve clinical practice (eg chronic disease management, preventive health).

Practice Assist

PDSA Template

Version 1.2 2/4/2019

General Practice PDSA Plan

Practice: _____

Start Date: _____ End Date: _____

PURPOSE OF PLAN

What are you trying to accomplish? _____

_____

BUILDING BLOCK _____ CYCLE NUMBER _____

PLAN – Here you will write a concise statement of what you plan to do and the steps involved.		
What do you plan to do?		
What do you hope to achieve? (include measurement/outcome)		
How are you going to do this? (list the steps to be implemented)	BY WHO	BY WHEN

Evidence has shown that ***quality improvement activities lead to positive change in practices****,*

particularly when a ***whole practice team*** *approach is adopted****.***

Improving Recorded Ethnicity PDSA Plan

Practice: _____

Start Date: _____ End Date: _____

PURPOSE OF PLAN

What are you trying to accomplish? To manage and improve the quality of practice data by ensuring non-clinical patient data is accurate and up to date. To ensure patients have ethnicity recorded.

BUILDING BLOCK _____ CYCLE NUMBER _____

PLAN – Here you will write a concise statement of what you plan to do and the steps involved.		
What do you plan to do? To improve patient demographics by ensuring patients have ethnicity data recorded in the practice software in line with RACGP recommendations. **RACGP Standards reference**: https://bit.ly/2JYG40V		
What do you hope to achieve? (include measurement/outcome) Increased ethnicity status recordings by 5%.		
How are you going to do this? (list the steps to be implemented)	BY WHO	BY WHEN
Use the practice software to identify the number of patients missing their ethnicity status.		
Ensure all staff have individual access to Top Bar and know how to use it (organize refresher training if required)		
Identify (using Top Bar) and update ethnicity status data at each patient presentation		
Review the current new patient registration process, new patient form and ensure all new patient data is captured		
Run regular reports using required tool to ensure data is improving by at least 5%.		

Lead improvements, lead your team

Example from the outstanding Greenmeadows Medical, Port Macquarie, NSW

Accreditation Tip: Use your high quality data as evidence

Mandatory Criterion QI 1.3 – Improving clinical care

QI1.3 ► B Our practice uses relevant patient and practice data to improve clinical practice (eg chronic disease management, preventive health).

You must:
Show evidence that you have conducted a **quality improvement activity, such as a PDSA cycle or clinical audit**, at least once every three years.

You could:
- Use coded patient health information to audit patient health records and compare clinical practice.
- Maintain a continuous improvement register
- Maintain a clinical audit based on a quality improvement plan completed by the practice team.

PDSA/QI sample related to clinical coding

What is our GOAL (what are we trying to accomplish)	**Raise Awareness of Clinical Coding** ▪ Code diagnoses ▪ Enter reason for visit ▪ Enter for reason for medication ▪ Maintain updated allergy detail
What measures will we use? (i.e. data)	**Data Extradition Tools e.g. Pen CAT**
What ideas can we use? (how are we going to achieve our goal)	*List ideas here to work on in table below* Start a Quality improvement folder Team meeting Attend education e.g. webinars / face to face sessions Post-education follow-up team discussion GP & RN team review of clinical documentation (opportunistic or planned) Pen CAT / Polar Data Quality Audit

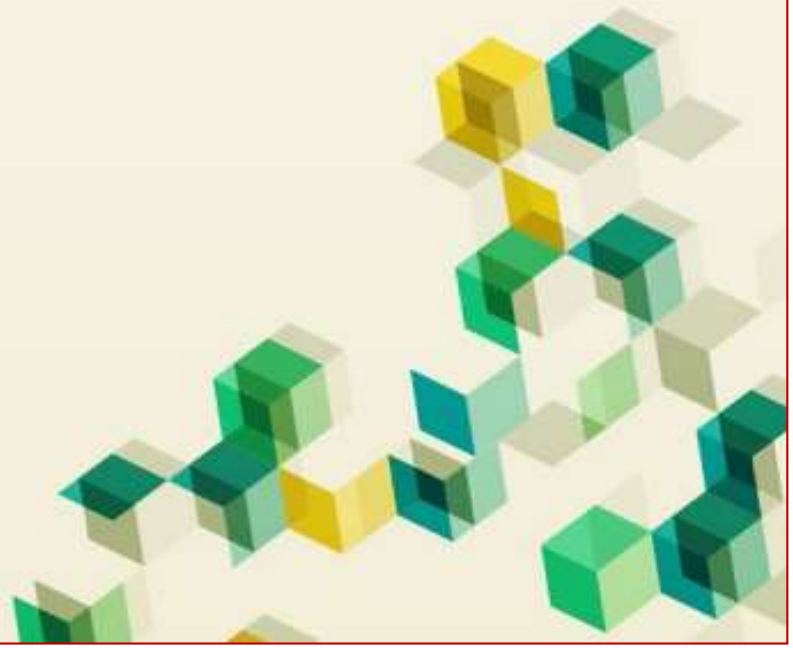
IDEAS	PLAN How will we do it – who, what, where and when?	DO Did we do it	STUDY What happened?	ACT What is our next step?
1.				
2.				
3.				
4.				
5.				

RACGP

Royal Australian College of General Practitioners

Improving health record quality in general practice

How to create and maintain health records that are fit for purpose



[Access RACGP resource]

Extra learning resources

Pen Clinical Systems

CAT4 Recipes

Topbar Youtube video

RACGP

Improving health record quality in general practice

Using Data for Better Health Outcomes

RACGP Standards for General Practices 5th edition

Australian Digital Health Agency:

Data Quality Checklist

My Health Record:

Improve data quality and safety

Train IT Medical

Practice Management Free Resources

Digital Health Free Resources (including Pen CAT4)

Advance Care Planning & Technology

Further assistance with My Health Record

- The My Health Record team at the WA Primary Health Alliance is available to support General Practice, Community Pharmacies, Aged Care facilities, Allied Health practices and Private Specialist practices with My Health Record
- For further support and training please contact the My Health Record team at myhealthrecord@wapha.org.au or contact your local Primary Health Liaison Officer or the Practice Assist Help Desk on 1800 22 77 478.
- Detailed information on My Health Record is available from www.myhealthrecord.gov.au
- Subscribe to the Practice Connect Newsletter at www.practiceassist.com.au for regular My Health Record updates

Thank you for inviting me

WA Primary Health Alliance
Better health, together

phn
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An Australian Government Initiative

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Keep in touch! With best wishes, Katrina Otto