Train IT Medical
Competence with Confidence

phn
EASTERN MELBOURNE
An Australian Government Initiative

Implementing Quality Improvements

- PIP QI -

Presented by:
Katrina Otto
Train IT Medical Pty Ltd
www.trainitmedical.com.au
katrina@trainitmedical.com.au

Learning Objectives:

1. Explain the new Practice Incentive Payment Quality Improvement (PIPQI)
2. Recognise and understand the importance of data quality
3. Learn to interpret practice data
4. Use data to identify and track areas for improvement
5. Develop a data quality plan and next steps

Learning Objective 1:

Explain the new Practice Incentive Payment Quality Improvement (PIP QI)

Practice Incentive Payments

1. PIPQI – *starts 1 August 2019*
2. eHealth Incentive
3. After Hours Incentive
4. Rural Loading Incentive
5. Teaching Payment
6. Indigenous Health Incentive
7. Procedural General Practitioner Payment
8. General Practitioner Aged Care Access Incentive

PIP QI supports general practices that encourage:

- Continuing Improvements
- Quality care
- Enhancing capacity
- Improving access and health outcomes for patients

"The PIP QI Incentive will give practices **increased flexibility** to **improve their detection and management** of a range of chronic conditions & **to focus on issues specific to their practice population**"

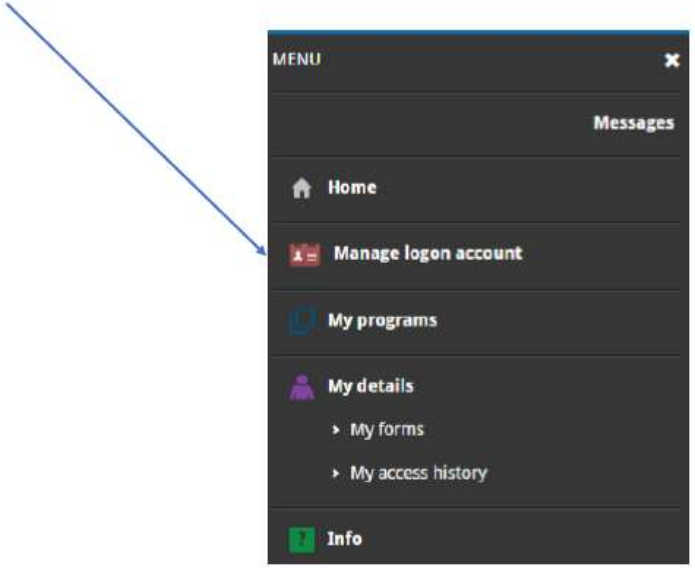
PIP QI from 1 August 2019

- First quarter payments (covering 1 August to 30 October) made 1 November.
- General practices complete an annual confirmation statement each year declaring compliance.
- Must maintain evidence of compliance for 6 years (not PHN responsibility)
- Dept Health conducts audits & compliance checks of payments made under the Practice Incentives Program

Katrina's tip: Document every improvement activity you do & celebrate each achievement

Access to PIP via PRODA

You may have previously provided your Individual HPOS PKI RA number to the PIP team to permit you to update the Practice PIP details. As you have a separate PRODA RA number, you will need to ensure this number is linked to PIP. To find your PRODA RA number, you will need to CLICK on **Manage logon account**



You will be taken to the following screen: **Hover over the MENU button** until you see the following icons:
Click on **My Login Details**:

PIPQI Preparation Checklist

DO NOW

- [x] Practice accreditation
- [x] Review data sharing agreement with EMPHN
- [x] Set up PRODA to apply online for PIPQI (from 1 August 2019)

DO NEXT

- [x] Install & learn Pen CS or Polar (your data extraction tool)
- [x] Review 10 measures in ‘Eligible Data Set’
- [x] Start Implementing Quality Improvement Activities

PIP QI – Eligible data set - Improvement measures

1. Proportion of patients with smoking status recorded
2. Proportion of patients with alcohol status recorded
3. Proportion of patients with weight recorded
4. Proportion of patients with up-to-date cervical screening.
5. Proportion of patients with diabetes with blood pressure recorded
6. Proportion of patients with diabetes with current HbA1c result
7. Proportion of patients with diabetes immunised against influenza
8. Proportion of patients COPD & immunised against influenza
9. Proportion of patients over 65 immunised against influenza
10. Proportion of patients with necessary risk factors to enable CVD assessment

QUESTION:

What are the prescribed targets?

ANSWER:

There are no prescribed targets associated with any of the Improvement Measures.

QUESTION:

Do you have to focus your quality improvement activities on the 10 Improvement Measures?

ANSWER:

No.

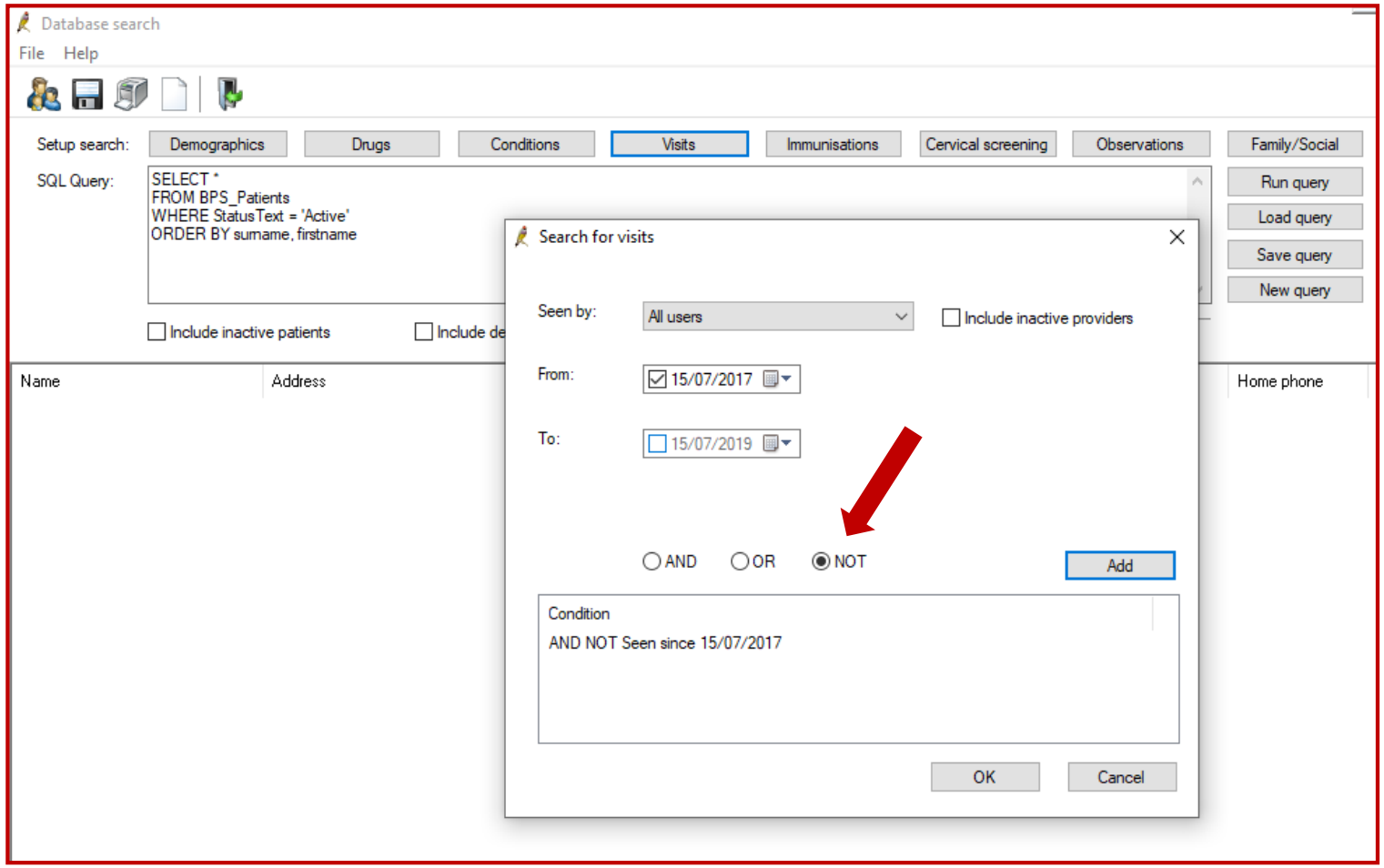
Focus on areas which are informed by your clinical information system data and meet the needs of your practice population.

Practices may focus their quality improvement activities on areas which are informed by their clinical information system data and meets the needs of their practice population.

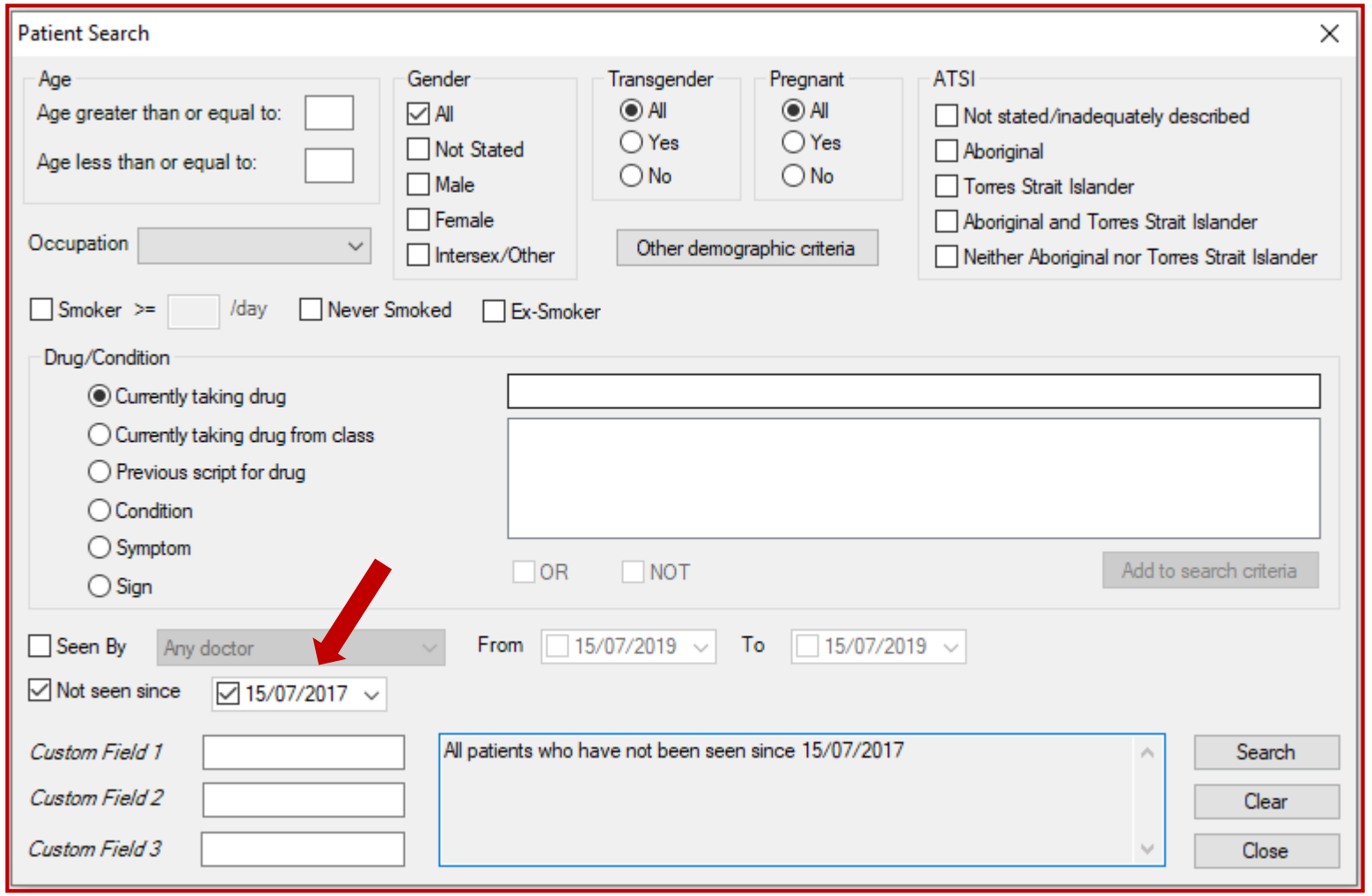
Learning Objective 2:

Recognise and understand the importance of data quality

Active versus Inactive patients



Active versus Inactive patients



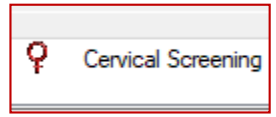
Know your clinical software

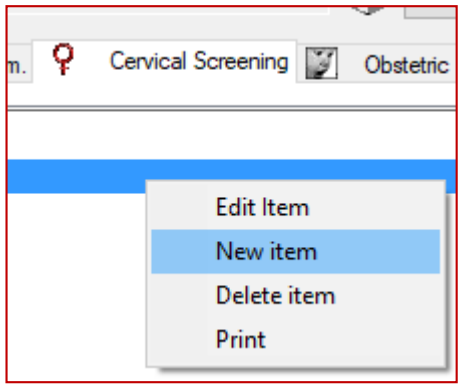
MedicalDirector®

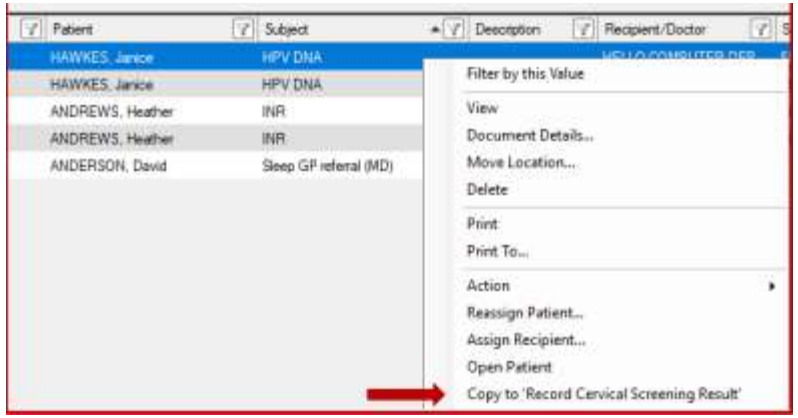
PIP QI – Eligible data set – needs to be coded in MD

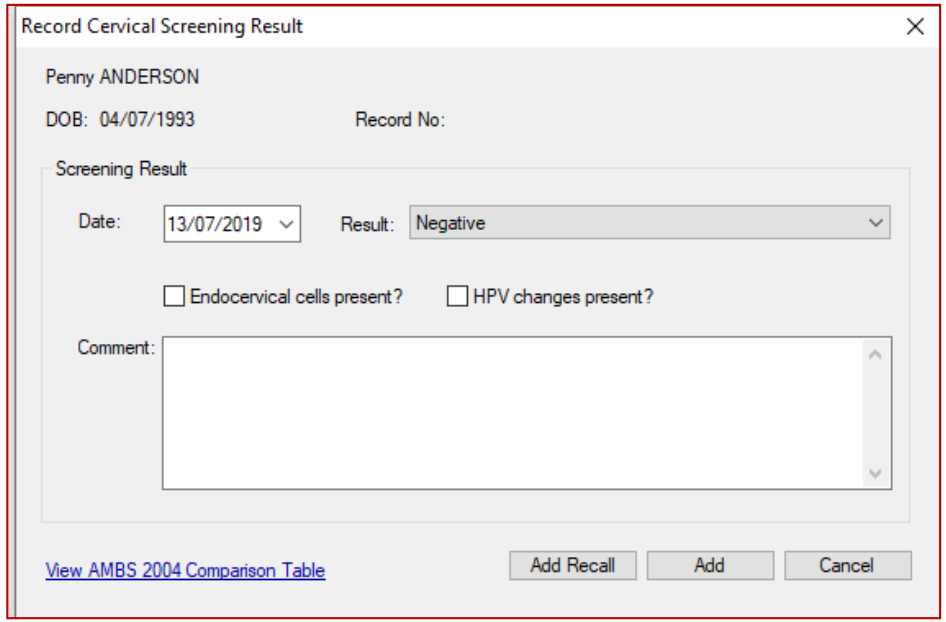
- Cervical screening result
- Coded diagnoses eg. diabetes, COPD etc.
- HbA1C result
- Alcohol
- Smoking
- Weight
- Patients with necessary risk factors to enable CVD assessment
- Blood pressure (for patients with diabetes)
- Influenza immunisation (specifically for patients with diabetes and COPD & aged 65+

Record cervical screening result from the Holding File or patient record



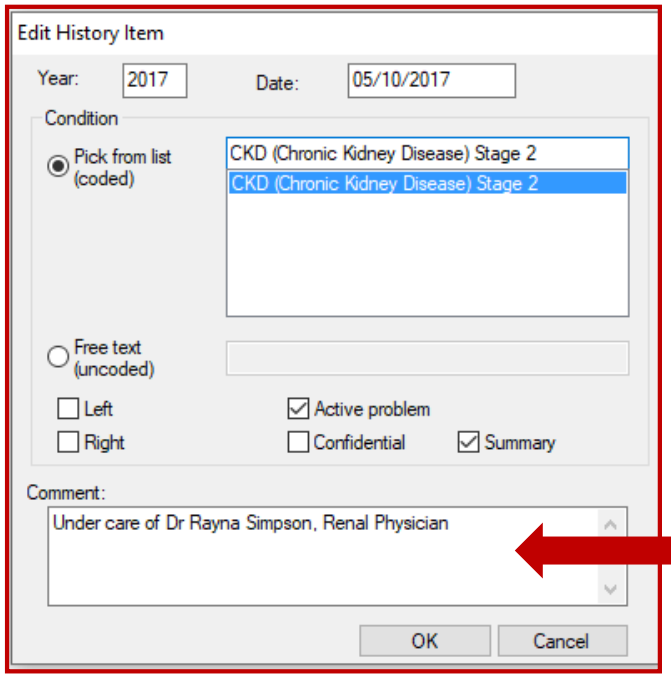






‘Coding’ a diagnosis is vital

The ‘Past History’ list



ONLY add significant active or inactive ‘events’ and chronic conditions

BEST TIP!!

Add comment

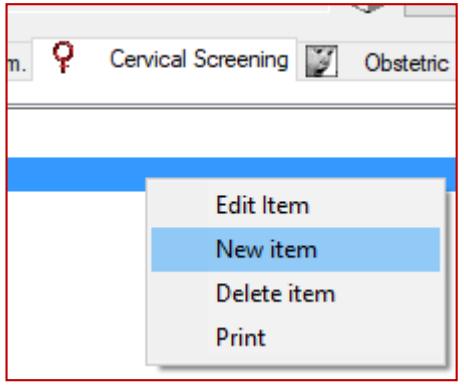
eg Care team involved, further detail of operation or condition.

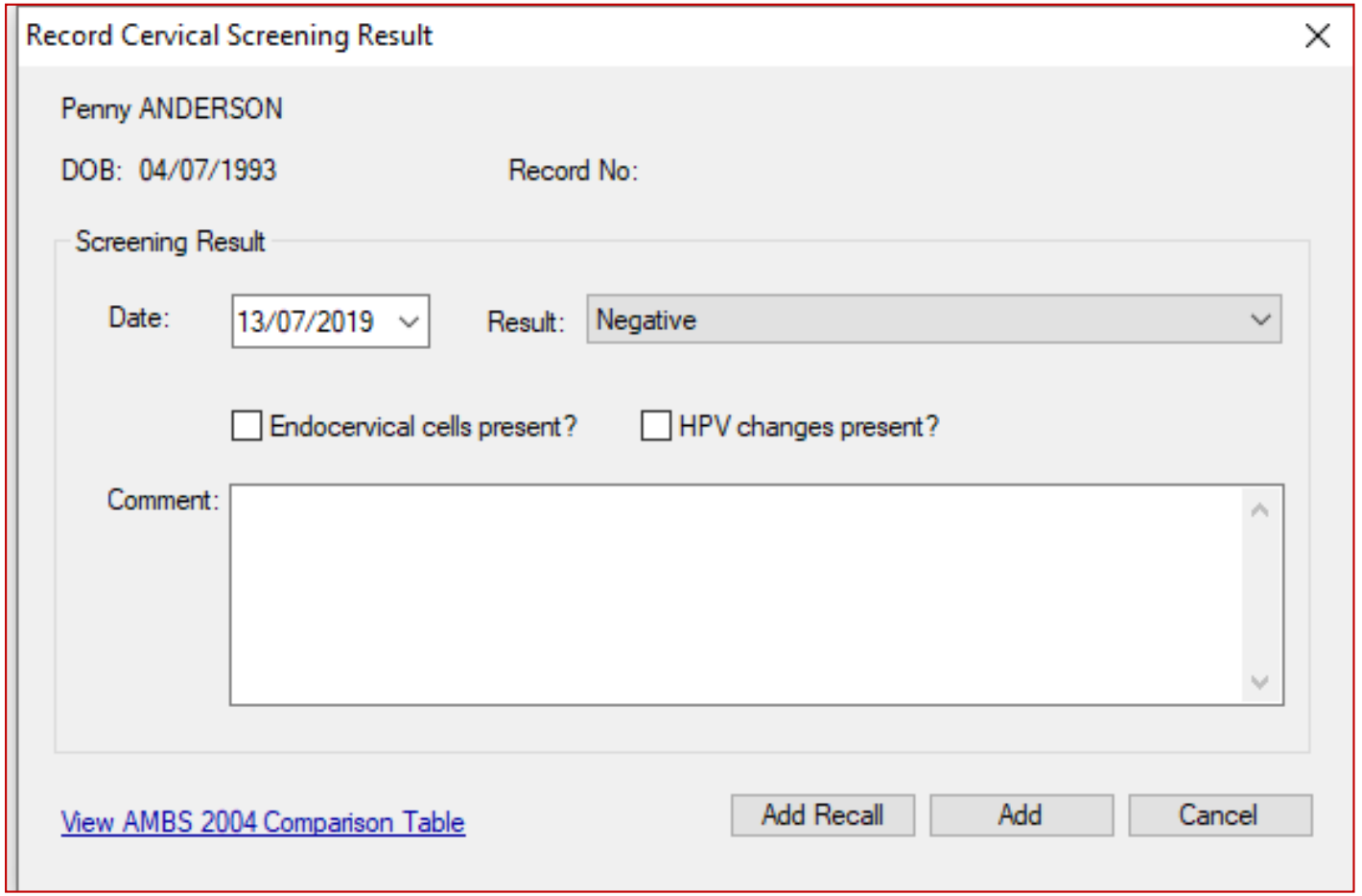
Know your clinical software

PIP QI – Eligible data set – needs to be coded in BP

- Cervical screening result
- Coded diagnoses eg. diabetes, COPD etc.
- HbA1C result
- Alcohol
- Smoking
- Weight
- Patients with necessary risk factors to enable CVD assessment
- Blood pressure (for patients with diabetes)
- Influenza immunisation (specifically for patients with diabetes and COPD & aged 65+

Record cervical screening result from the Inbox or patient record

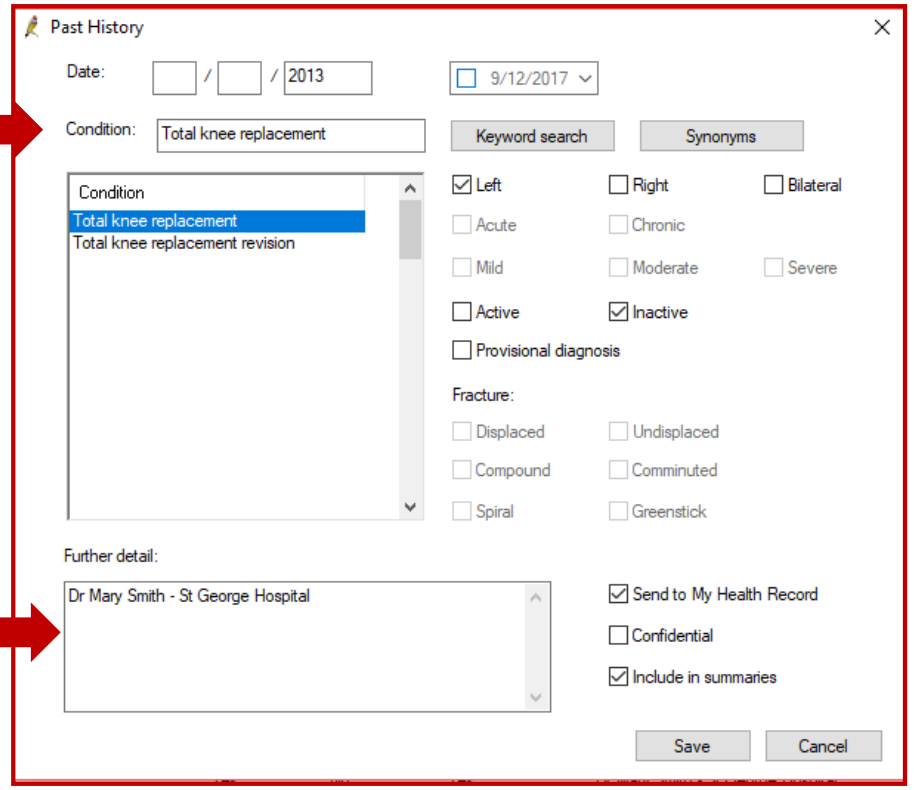




‘Coding’ a diagnosis is vital

‘Past History’ list

ONLY add significant active or inactive ‘events’ and chronic conditions.
Always select from coded picklist.



BEST TIP!!

Add further detail

eg Care team involved, details of operation or condition.

Know your population,
know your data extraction tool

POLAR

POpulation Level Analysis & Reporting

Know your population, know your data extraction tool

POLAR

41,806 PATIENTS	16,894 ACTIVE PATIENTS	679,238 SCRIPTS	120,077 IMMUNISATIONS
8,386 RACGP ACTIVE PATIENTS	576,737 ACTIVITIES	667,062 TESTS	793,204 MBS ITEMS

Set a baseline for QI Activities

POLAR

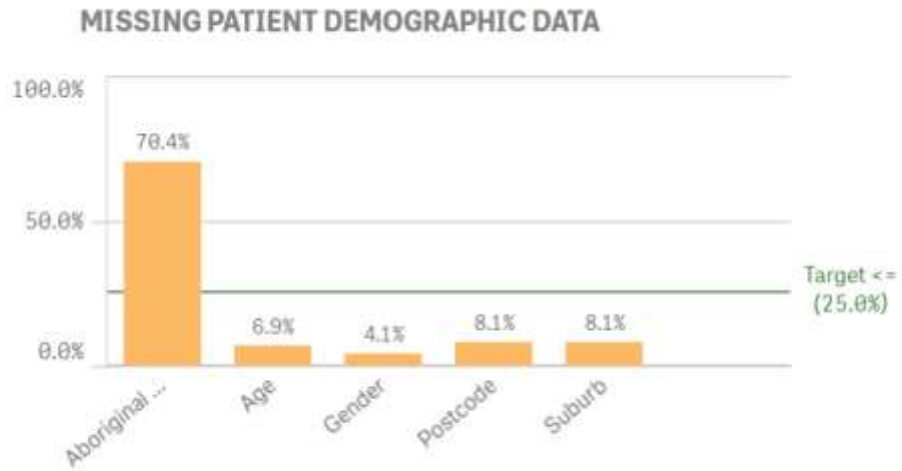
Baseline

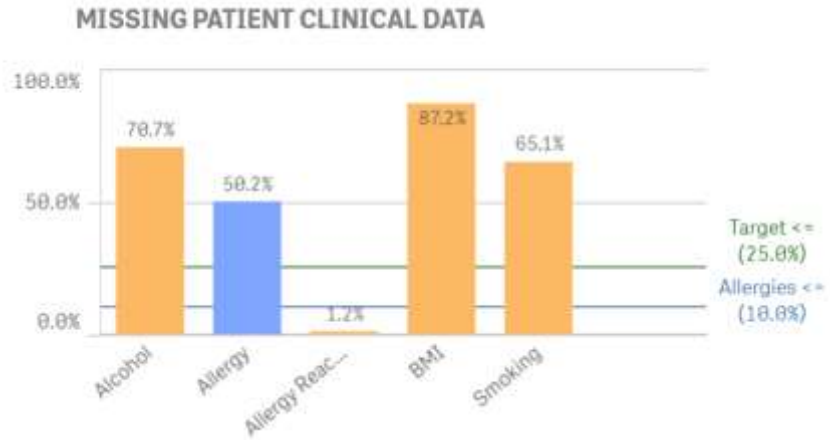
RECORDED PATIENT CLINICAL DATA

Quality Param Medical	% Recorded	Target
Alcohol	54.3%	75%
Allergy	95.0%	90%
Allergy Reaction	97.7%	75%
BMI	42.7%	75%
Smoking	77.3%	75%

Use POLAR to measure your success over time!

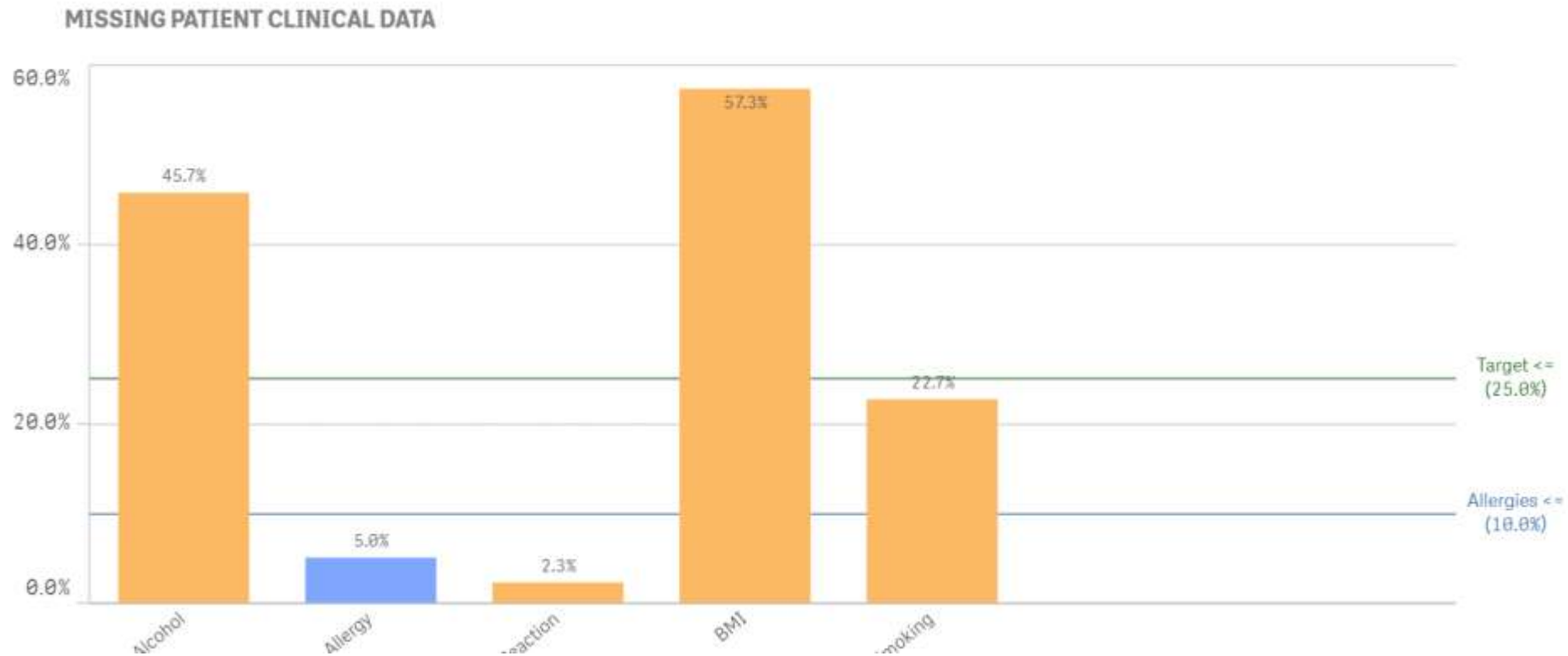
Data Quality Reports



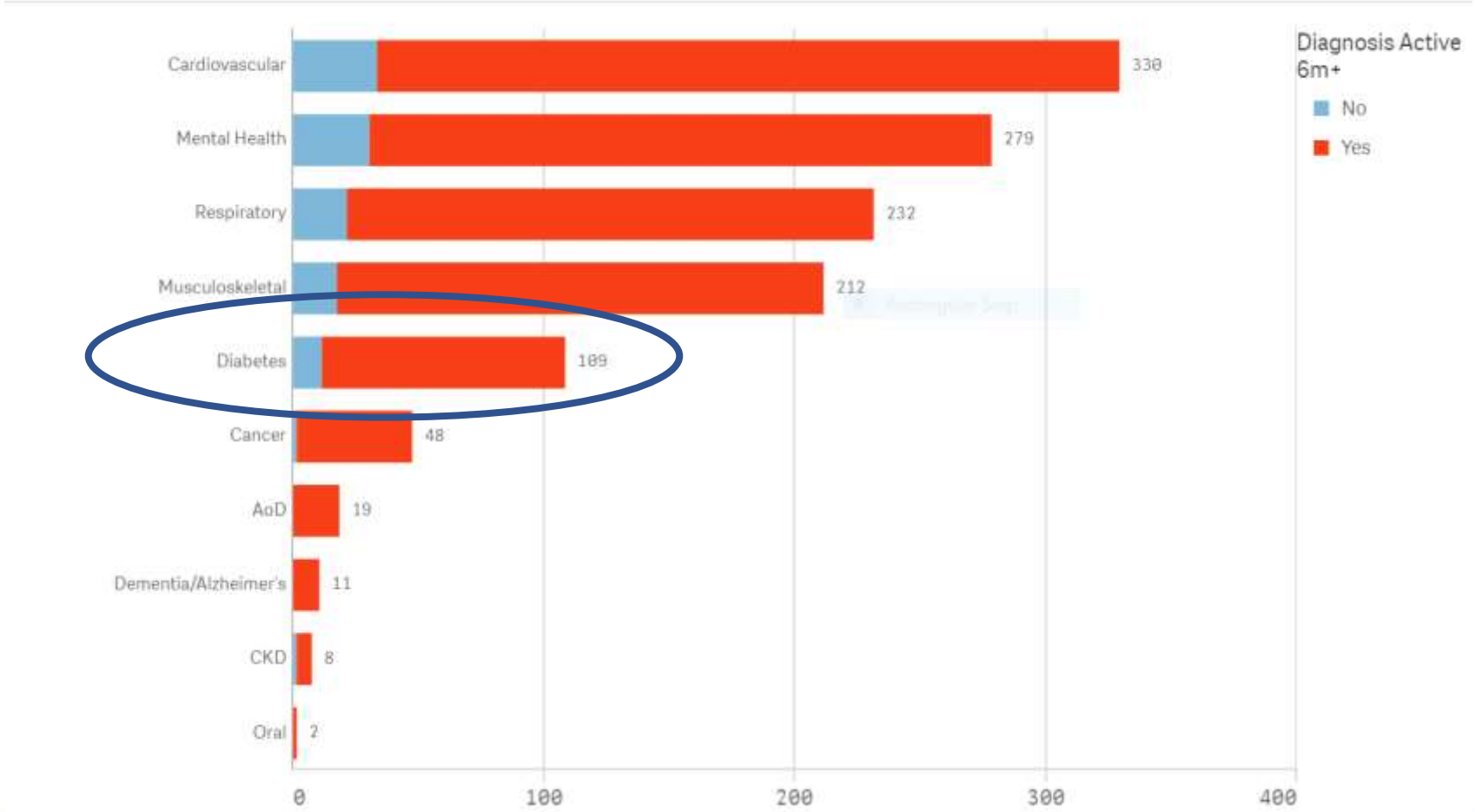


Missing Demographic and Clinical data

Accreditation compliance

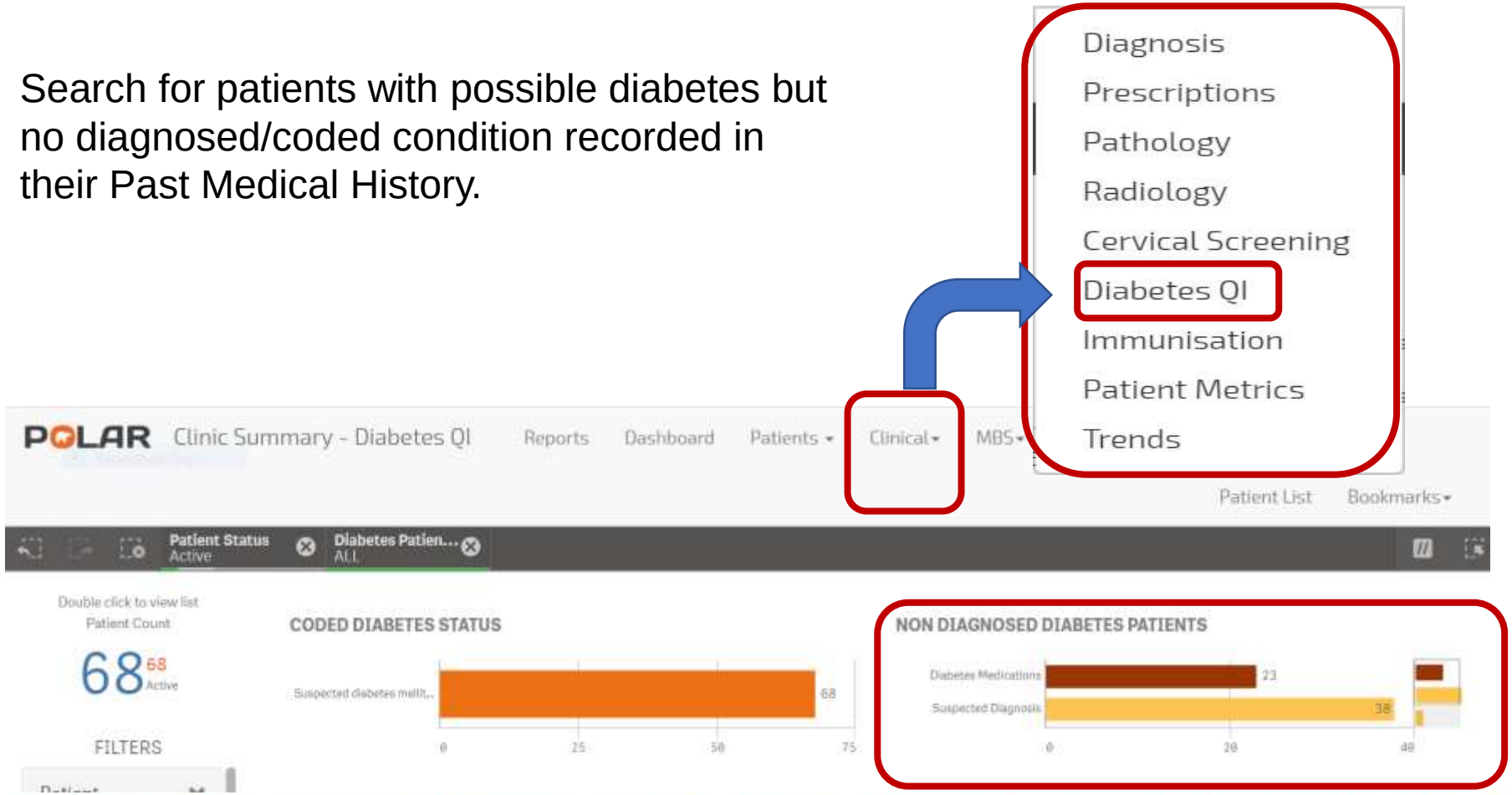


Chronic disease management

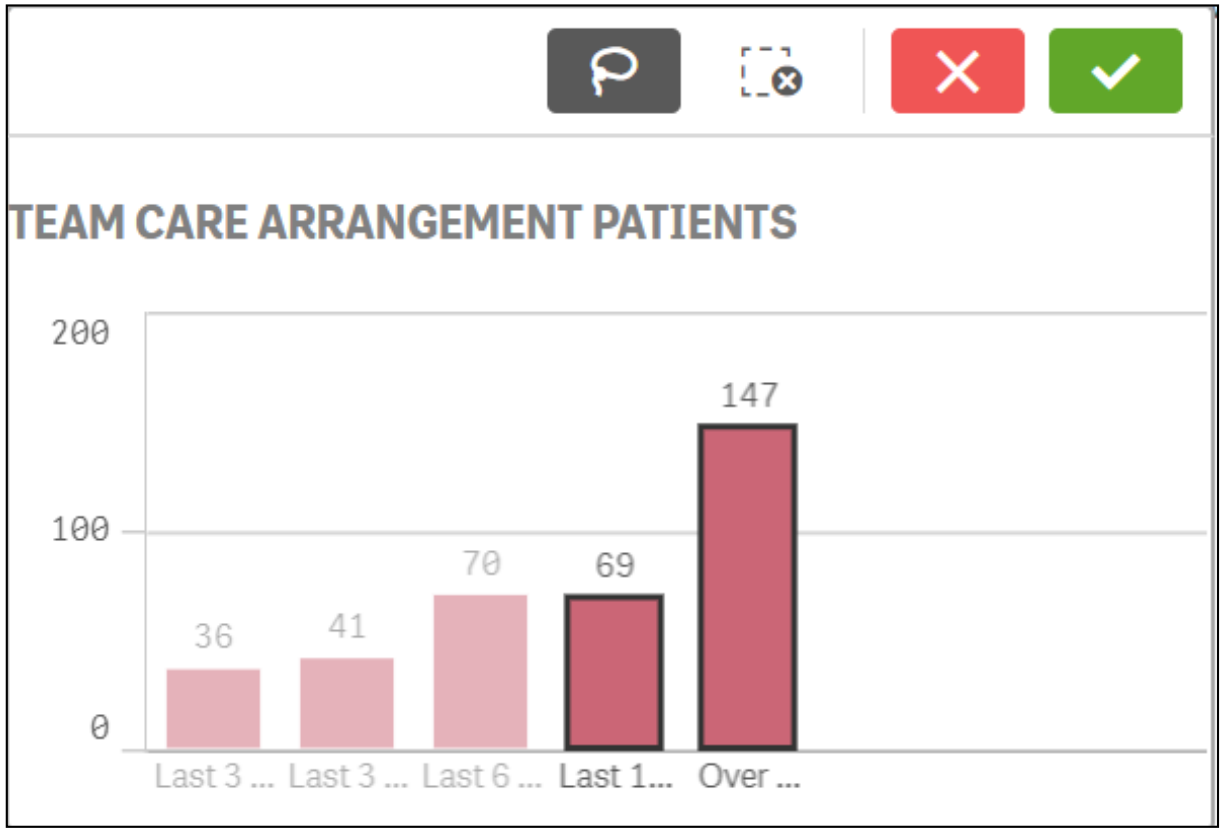


Improve diabetes management

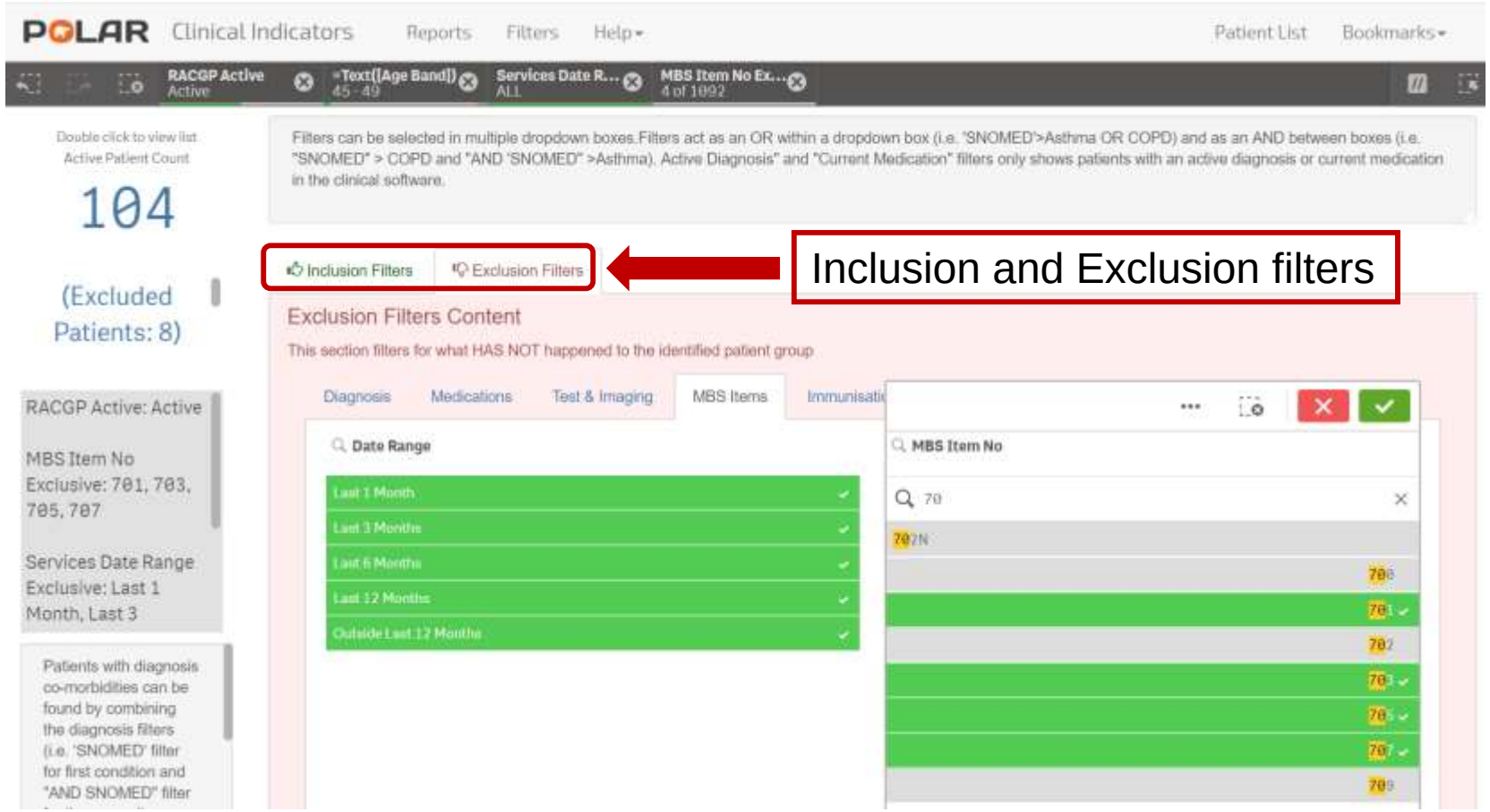
Search for patients with possible diabetes but no diagnosed/coded condition recorded in their Past Medical History.



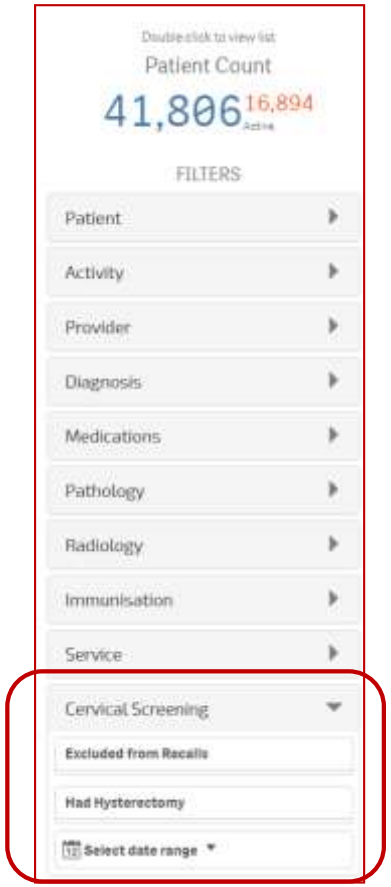
Care Planning Improvements

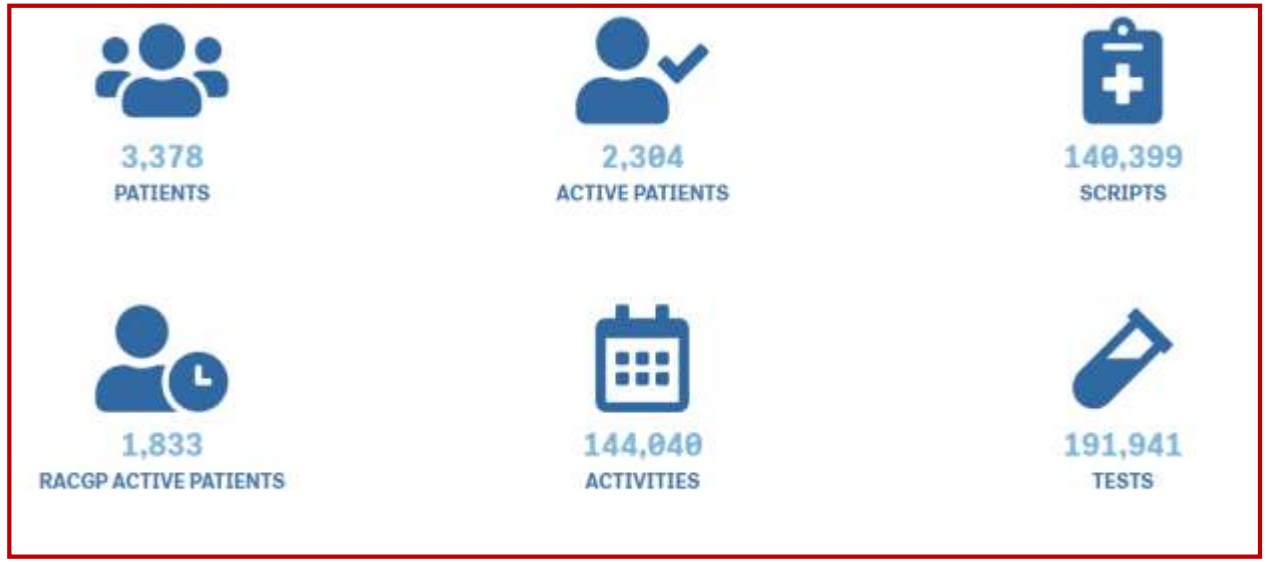


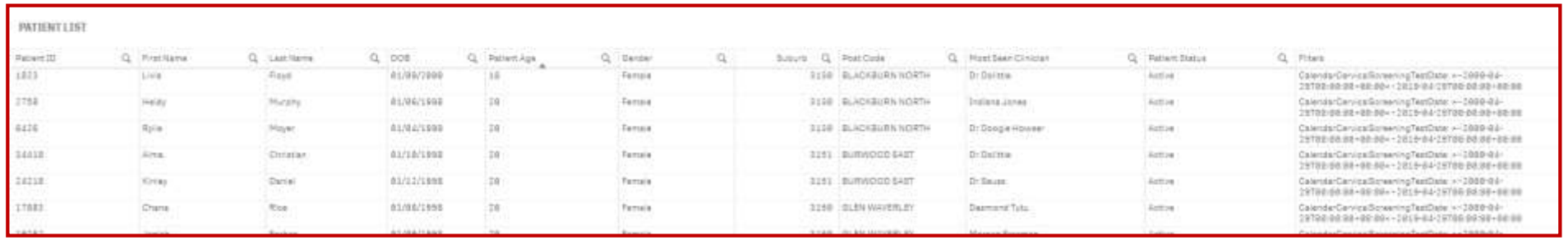
Customise ‘Queries’



Cervical screening







PIPQI Preparation Checklist

DO NOW

- [x] Practice accreditation
- [x] Review data sharing agreement with your PHN
- [x] Set up PRODA to apply online for PIPQI (from 1 August 2019)

DO NEXT

- [x] Install & learn Pen CS or Polar (your data extraction tool)
- [x] Review 10 measures in ‘Eligible Data Set’
- [x] Start Implementing Quality Improvement Activities

Learning Objective 3:

Learn to interpret practice data

Criterion QI1.1 – Quality improvement activities

Indicators

QI1.1►A Our practice has at least one team member who has the primary responsibility for leading our quality improvement systems and processes.

QI1.1►B Our practice team internally shares information about quality improvement and patient safety.

QI1.1►C Our practice seeks feedback from the team about our quality improvement systems and the performance of these systems.

QI1.1►D Our practice team can describe areas of our practice that we have improved in the past three years.

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 Extraction Tools eg. Pen CAT or POLAR**
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 eg. 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.				

Learning Objective 5:

Develop a data quality plan and next steps

Clinic - Patient View

Quality Improvement Measure	Chart	Sub-Measure	Patient Counts	Add to Patient list
QIM 1 - Patients with diabetes with a current HbA1c recorded (<12 months)		Type 1	12 / 20	Not Included
		Type 2	96 / 144	Not Included
QIM 10 - % of patients with diabetes and BP recorded			94 / 164	Not Included
QIM 2 - Patients with smoking status recorded		Current Smokers	185 / 5404	Not Included
		Ex-Smokers	1045 / 5404	Not Included
		Non-Smokers	3739 / 5404	Not Included
QIM 3 - Patients with BMI recorded		BMI >30	166 / 5399	Not Included
		BMI 25 - <30	188 / 5399	Not Included
		BMI 18.5 - <25	179 / 5399	Not Included
		BMI <18.5	17 / 5399	Not Included
QIM 4,5,6 - Influenza vaccinations given in past 15 months, by patient groups		Patients > 65	975 / 1254	Not Included
		Patients with diabetes	105 / 153	Not Included
		Patients with COPD	28 / 33	Not Included
QIM 7 - % of patients with alcohol status recorded		Currently Unavailable	0 / 0	Not Included
QIM 8 - CVD calculation elements - risk factors		Smoking Status, Systolic BP, Total & HDL Cholesterol etc.	951 / 2792	Not Included
QIM 9 - Cervical screening		2 year screening	1431 / 4270	Not Included
		5 year screening	1437 / 4270	Not Included

PIP QI - Draft

POLAR

NOTE:
THIS REPORT IS STILL IN DRAFT

Patient List

Please add at least one cohort to the output list

Diabetes is the current PIP QI Focus area for this Clinic

Numerator | Denominator | Difference

Clear all included cohorts from Patient List

+ Add Patient list to report Selections

Previous KPI | Next KPI

Proportion Of Regular Clients Who Have Type 1 Diabetes And Who Have Had A HbA1c Measurement Result ...

Evidence has shown that
quality improvement activities lead to positive change in practices*,*
particularly when a
whole practice team
approach is adopted.

Lead your team in continuous quality improvements

Example from the outstanding Greenmeadows Medical, Port Macquarie, NSW

	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

Table credit: Noel Stewart,

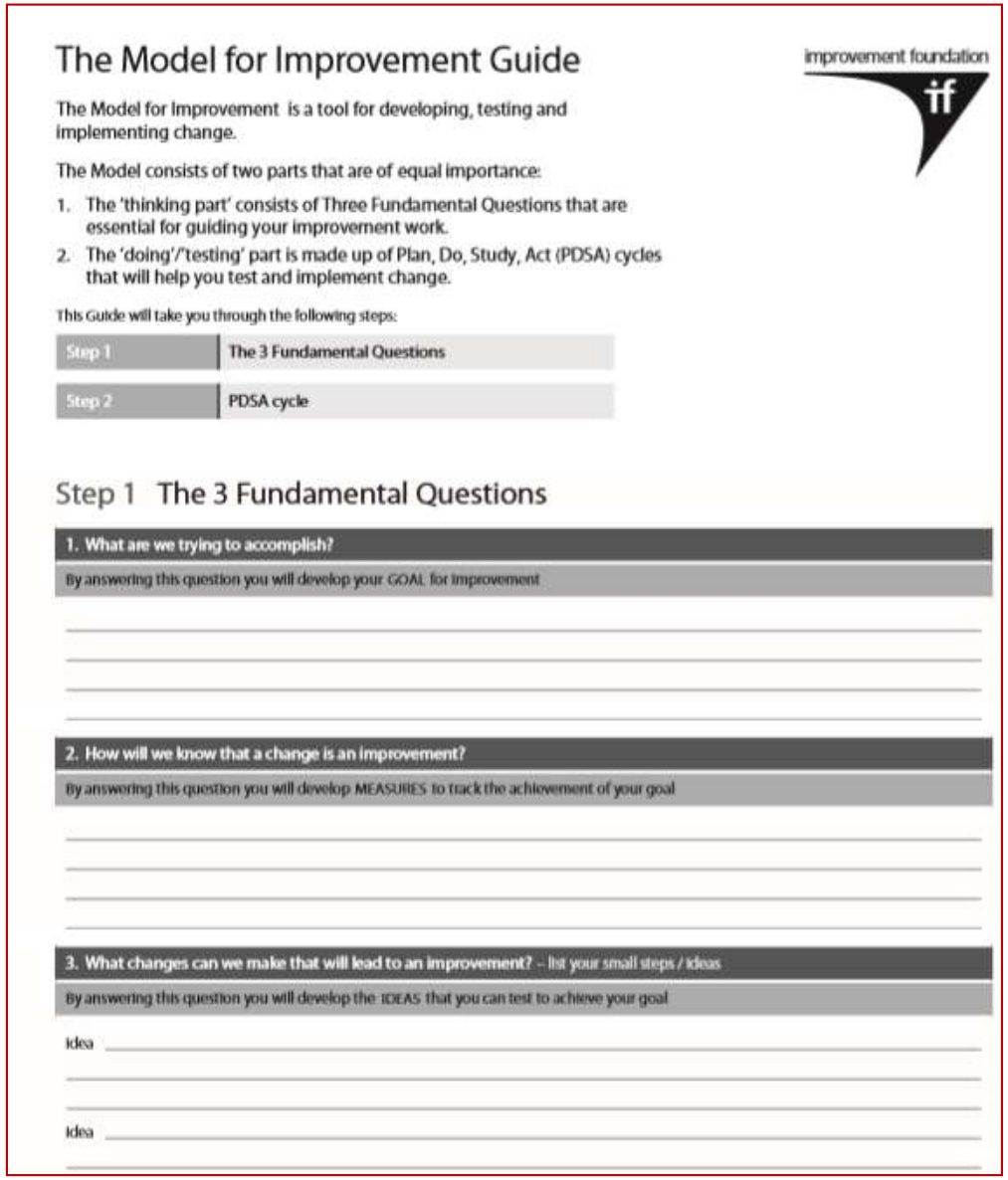
Measure	Whole Practice	GP 1	GP 2	GP 3	GP 4	GP 5	GP 6	GP 7	GP 8	GP 9
1. Proportion of patients with smoking status recorded	13697 28.8%	2488 16.4	1996 36.5	921 28.1	1718 51.2	1839 9.4	936 21.5	604 24.3	686 4.1	43 30.2
2. Proportion of patients with alcohol status recorded	9576 17.7	1866 29.5	1628 28.5	684 19.7	1192 39.9	1445 4.2	795 13.8	397 14.9	514 01.0	30 10.0
3. Proportion of patients with weight recorded	141 35	28 5	11 2	13 3	21 11	6 2	12 7	5 0	6 3	0 0
4. Proportion of patients with up-to-date cervical screening.	27%	15.7	63.9	60.4	76.4	11.5	44.6	41.0	21.2	39.7
5. Proportion of patients with diabetes with blood pressure recorded	0 1	0 0	0 0	1 1	0 0	0 0	0 0	0 0	0 0	0 0
6. Proportion of patients with diabetes with current HbA1c result	3.5% 4.6%	2.9 3.8	2.8 3.2	1.4 1.9	8.8 11.7	5.1 6.2	2.5 2.9	1.2 1.8	4.2 5.5	4.7 6.7
7. Patients with diabetes immunised against influenza	60.9 % 90.9%	61.4 88.7	74.2% 93.6%	50% 83.4%	77.8% 92.9%	63.6% 90.8%	81.3% 100%	60% 80%	62.5% 75%	100% 100%
8. Proportion of patients with COPD & immunised against influenza	94 288	5 29	2 55	3 6	0 8	12 131	2 10	1 6	2 17	0 1
9. Proportion of patients over 65 immunised against influenza										
10. Proportion of patients with necessary risk factors to enable CVD assessment										

Brainstorm ideas as a team

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.				

SAMPLE

Quality Improvement Activity form:



The Model for Improvement Guide

improvement foundation

The Model for Improvement is a tool for developing, testing and implementing change.

The Model consists of two parts that are of equal importance:

1. The 'thinking part' consists of Three Fundamental Questions that are essential for guiding your improvement work.
2. The 'doing'/'testing' part is made up of Plan, Do, Study, Act (PDSA) cycles that will help you test and implement change.

This Guide will take you through the following steps:

Step 1	The 3 Fundamental Questions
Step 2	PDSA cycle

Step 1 The 3 Fundamental Questions

1. What are we trying to accomplish?

By answering this question you will develop your GOAL for improvement

2. How will we know that a change is an improvement?

By answering this question you will develop MEASURES to track the achievement of your goal

3. What changes can we make that will lead to an improvement? – list your small steps / ideas

By answering this question you will develop the IDEAS that you can test to achieve your goal

idea

idea

SAMPLE

Quality Improvement Activity form:

Step 1: Three Fundamental Questions

1. **What are we trying to accomplish?**
   By answering this question you will develop your **GOAL** for improvement.
   Each new GOAL (1st Fundamental Question) will require a new Model for Improvement

2. **How will we know that a change is an improvement?**
   By answering this question you will develop **MEASURES** to track the achievement of your goal

3. **What changes can we make that will lead to an improvement?**
   By answering this question you will develop the **IDEAS** that you can test to achieve your goal

Idea:

Idea _____

Idea _____

Other idea _____

SAMPLE

Quality Improvement Activity form:

Which area of your practice might benefit from a QI Activity – Administrative or Clinical?	
QI Activity Description	
What will a successful outcome look like (10-word elevator pitch)?	
How will you measure success?	
What is your initial benchmark?	
Who will be leading this activity?	
Who will be on the team?	
How long will the activity need?	
What additional resources will be required?	

SAMPLE

Quality Improvement Activity:

Which area of your practice might benefit from a QI Activity – Administrative or Clinical?	Administrative /Clinical
QI Activity Description	Capture those patients that do not have an alcohol recording Ensure every patient that is between the ages of 48-49 has had their 45-49 Health Assessment
What will a successful outcome look like (10-word elevator pitch)?	Lifestyle risk factors such as smoking, nutrition, alcohol and physical activity are associated with many diseases. Our practice routinely measures and records each patient (C7.1G flagged) helps provide the most appropriate care This group is an at-risk group
How will you measure success?	See increase in the number of patients with recorded alcohol and increase in the 45-49 H/A before these patients are no longer eligible for this check Improvement in our practice data
What is your initial benchmark?	Practice bench mark report POLAR June 18 identified 210 patients aged between 48-49 and of these patients only 18.6% have alcohol recorded. This probably means that most of these patients have not had a 45-49 HA
Who will be leading this activity?	Practice Manager and Practice Nurse
Who will be on the team?	All admin team, nurses and doctors
How long will the activity need?	When all identified patients have had a 45-49 Health Assessment (6months)

SAMPLE

Quality Improvement Activity:

Goal
What are you trying to accomplish?
Improve the accuracy and completeness of the diabetes register by June 30th 2019

Measure
How do you know that change is an improvement?
Compare • The number of people on the diabetes register at the **start** of the improvement activity (baseline) • The number of people on the diabetes register at the **end** of the improvement activity

Ideas
What changes can you make that will lead to an improvement?
1. Archive all patients that do not fit within the practice's definition of active patients 2. Review definition of diabetes and code Type 1 and Type 2 3. Search for all patients on relevant medications that are not coded as having diabetes and code correctly 4. Search for all patients that have had a relevant test performed (e.g. HBA1c) but are not coded with diabetes and code correctly

Lead your team with positivity


VISION

+


SKILLS

+


INCENTIVES

+


RESOURCES

+


ACTION PLAN

= CHANGE!

Katrina's tips for a successful, happy practice of the future:

- Set small (achievable) clean-up goals (eg coded diagnosis, smoking status)
- Focus on key data items
- Celebrate progress – no matter how small
- Document and review improvement activities
- Train all staff on software & new processes
- Create a team spirit
- Monitor and communicate performance
- Celebrate progress (yes – again!)

Extra Learning Resources

RACGP

Improving health & record quality in general practice

RACGP – Standards for General Practice (5th Edition)

Using Data for Better Health Outcomes

Australian Digital Health Agency:

Importance of Data Quality

Data Cleansing & Clinical Coding

Data Quality Checklist

Train IT Medical

Practice Management Free Resources

Digital Health Free Resources (including Pen CAT4)

5 Steps to Data Quality Success (blog)

Cheatsheets to enter cervical screening in MedicalDirector and Bp Premier

Pen CAT4 summary sheet

More Learning Resources

Practice Incentive Payments

Practice Incentives Program Guidelines

Eligibility for the PIP

Data Analytic Systems

CAT4 Recipes

Topbar video

Polar Learning & Support

PRODA

PRODA E-Learning

PRODA Registration

DHS – Link your PRODA Account to HPOS

Quality Improvements

APCC – Model for Improvement

APCC - PDSA template

EMPHN resources

Practice Assist

Model for Improvement video

Where to Next

- EMPHN Letter
- Registration steps for PIP QI
- Support offered by EMPHN

- **EMPHN Quality Improvement Learning Module**
  - www.emphn.org.au/quality-improvement
    - Training videos
    - Practical guides
    - Checklists
    - Resources

Keep up to date by connecting with us:

katrina@trainitmedical.com.au

Twitter: trainitmedical

Facebook: trainitmedical

www.trainitmedical.com.au
Access more free practice resources
& blog posts
Subscribe to my blog

Thank you! With best wishes, Katrina Otto