Implementing Quality Improvements
- PIP QI -

Presented by:
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Learning Objectives:

1. Explain the new Practice Incentive Payment Quality Improvement (PIPQI)
2. Develop an understanding of relevant data systems
3. Design Quality Improvement activities.
4. Create a practice plan to meet eligibility for PIPQI.

Learning Objective 1:

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

PIP QI supports general practices that encourage:

Continuing Improvements

Quality care

Enhancing capacity

Improving access and health outcomes for patients

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 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
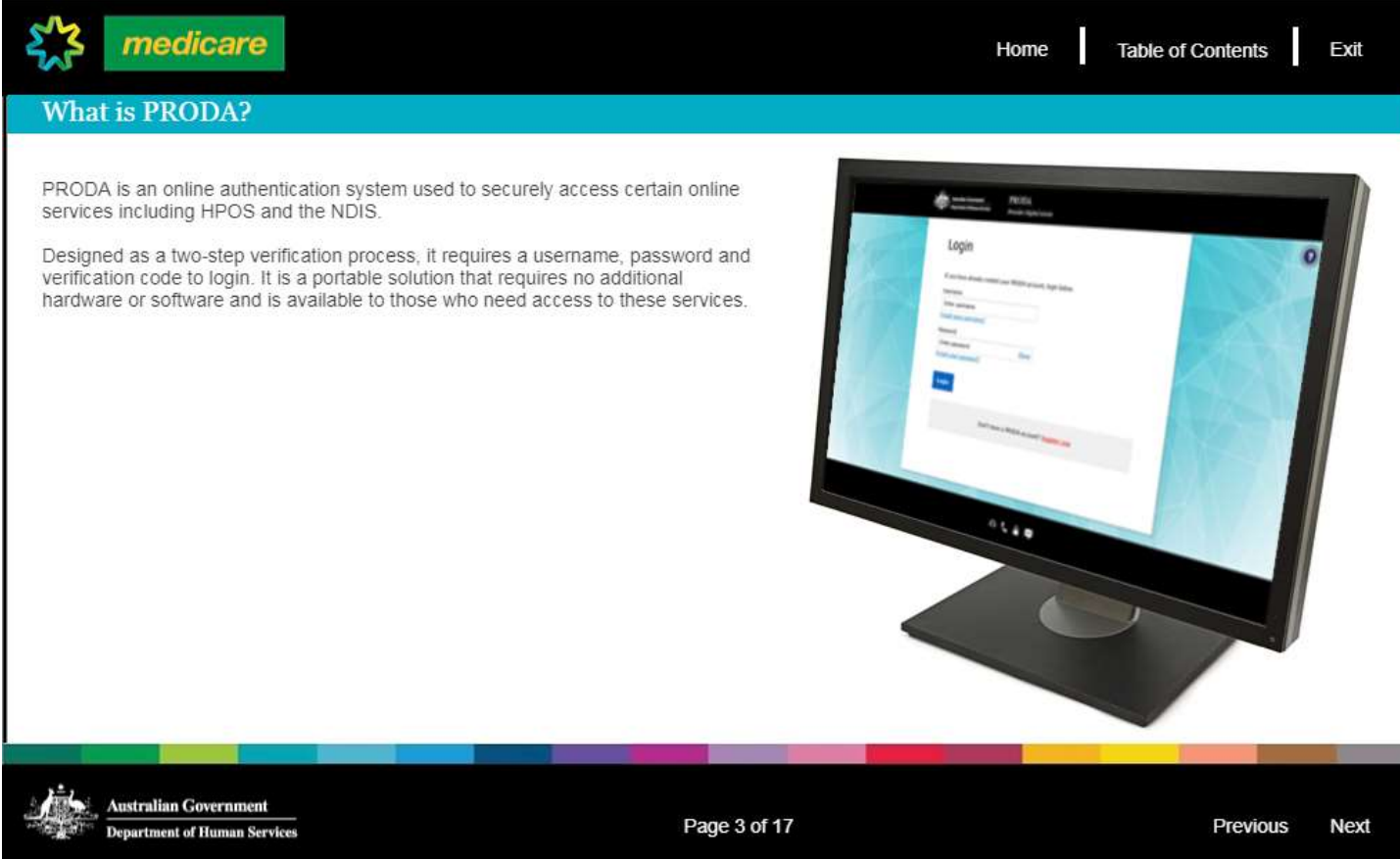
PIPQI Preparation Checklist

DO NOW

☑ Practice accreditation

☑ Review data sharing agreement with CESPHN

☑ Set up PRODA so you can apply online for PIPQI on 1 August

DO NEXT

☑ Install & learn Pen CS or Polar (data extraction tools)

☑ Review the Improvement Measures

☑ Start Implementing Quality Improvement Activities

PRODA? Provider Digital Access

Used to securely access government online services

Access to PIP via PRODA
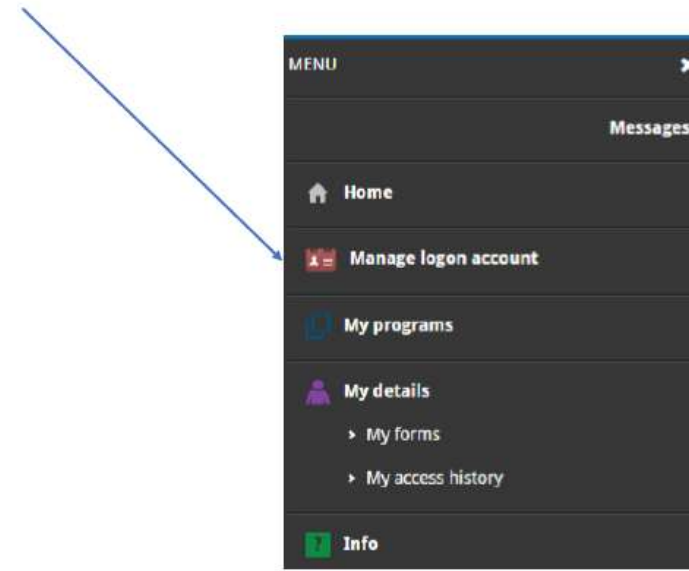
PIP QI – Eligible data set - Improvement measures

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.

"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**"

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:

Develop an understanding of relevant data systems

POpulation Level Analysis & Reporting

Set a baseline for QI Activities

Baseline
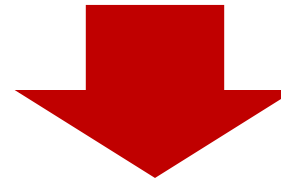
RECORDED PATIENT CLINICAL DATA

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%
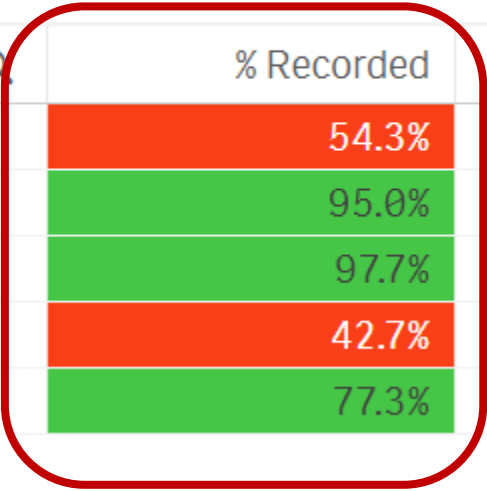
Smokers? *n* =
Alcohol *n* =
Overweight *n* =
Immunised against influenza? *n* =
At risk of CVD *n* =

Use data analytic tools to identify improvements eg alcohol recorded

Lead your team in continuous quality improvements

Example from the outstanding Greenmeadows Medical, Port Macquarie, NSW

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

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.

Example from rural WA

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										
6. Proportion of patients with diabetes with current HbA1c result	0 1	0 0	0 0	1 1	0 0	0 0	0 0	0 0	0 0	0 0
7. Patients with diabetes immunised against influenza										
8. Proportion of patients with COPD & immunised against influenza	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
9. Proportion of patients over 65 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%
10. Proportion of patients with necessary risk factors to enable CVD assessment	94 288	5 29	2 55	3 6	0 8	12 131	2 10	1 6	2 17	0 1

Measure	Practice Target	Practice Baseline	GP1 Result	GP2 Result	GP3 Result	GP4 Result
1. Proportion of patients with smoking status recorded	90%	44%	23%	20%	55%	12%
2. Proportion of patients with alcohol status recorded	75%	23%	5%	8%	6%	2%
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. Patients with diabetes immunised against influenza						
8. Proportion of patients with 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						
11. Proportion of patients aged 75+ with a Health Assessment in < 12 months	50%	2%	3%	6%	6%	8%
12. Proportion of patients > 50 years with bowel screening test done in last 2 years	65%	1%	3%	7%	10%	16%

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 ...

75.0%

68.4% 68.4% 66.7%
63.2% 63.2% 60.0% 60.0% 60.0%

52.6% 52.6% 50.0% 50.0% 52.6%

50.0%

May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19
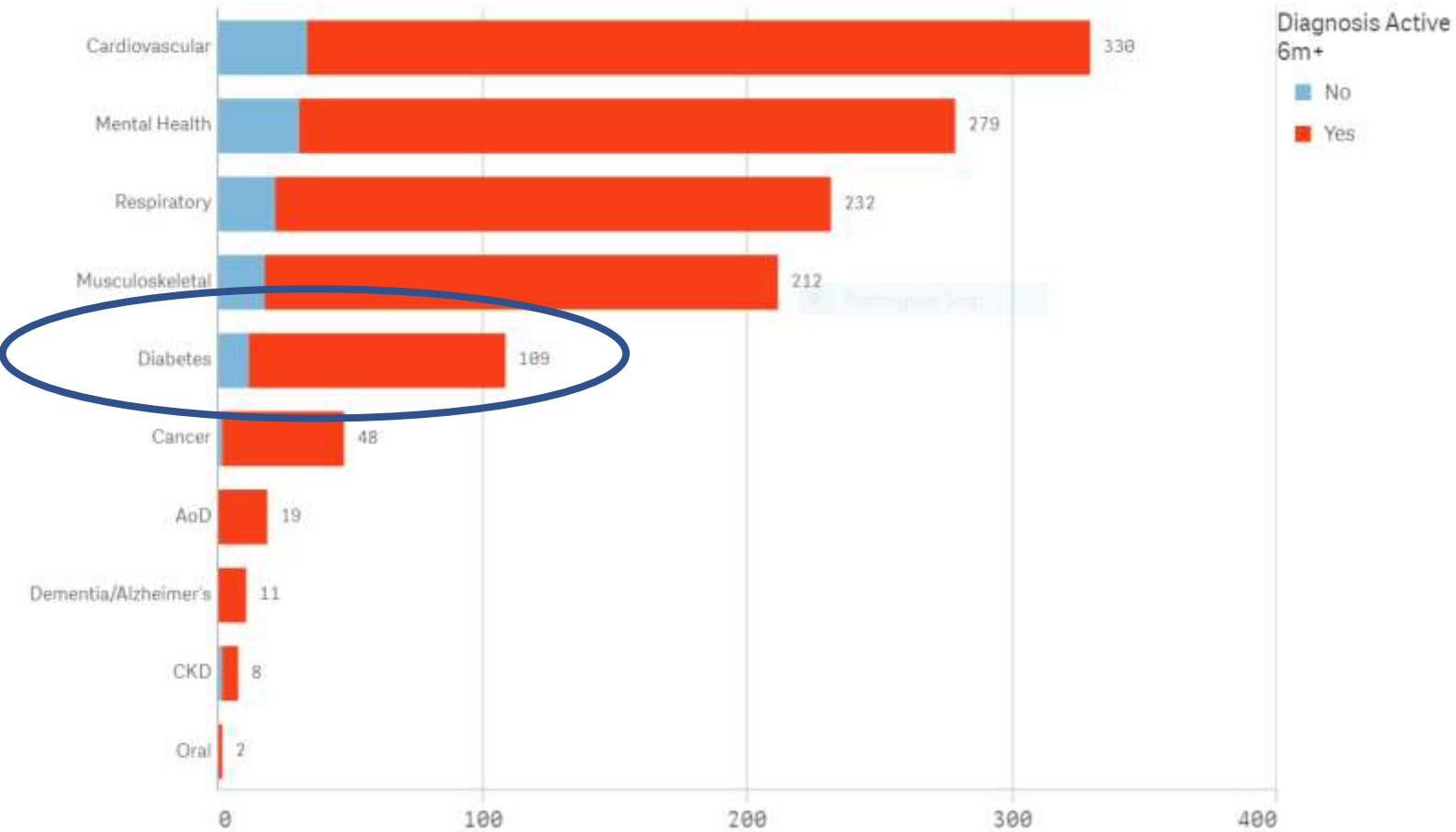
Improve diabetes management

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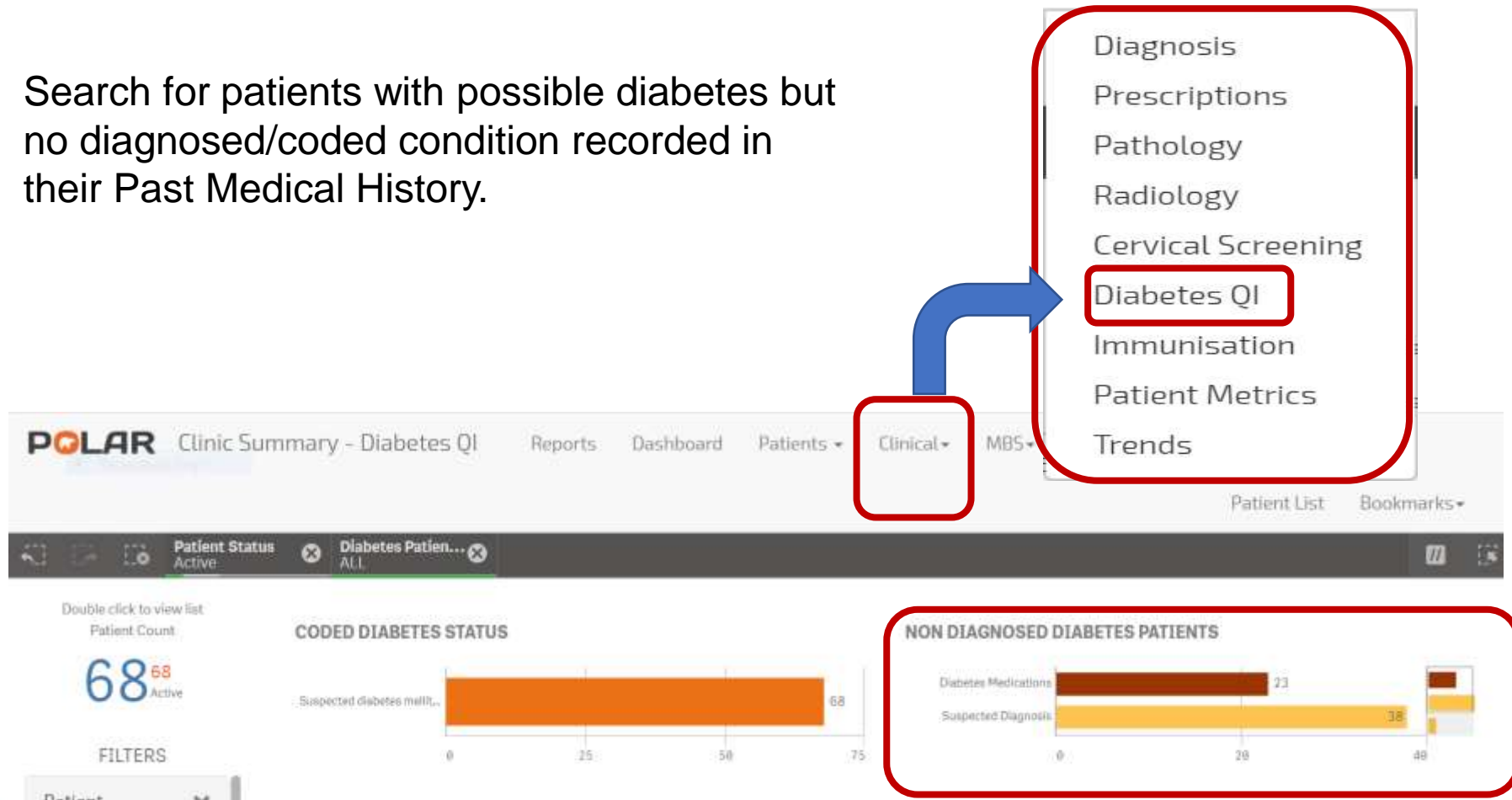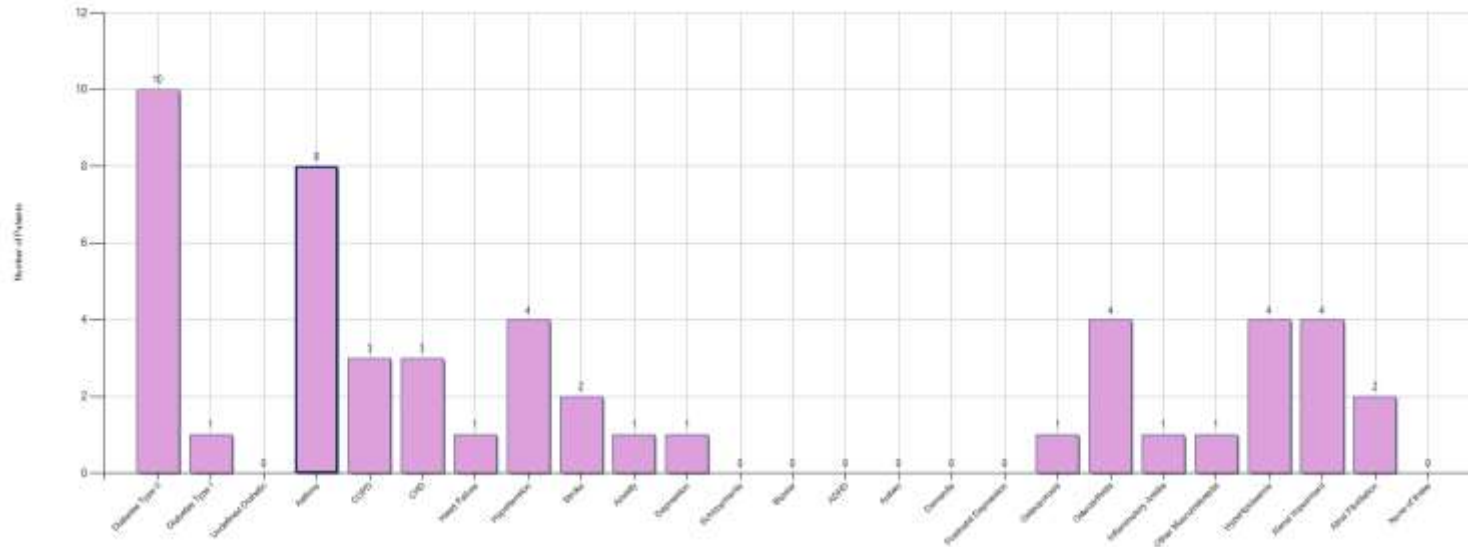
Chronic disease management

Proactive Population Based Approach

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

Lead your team in continuous quality improvements

Example from the outstanding Greenmeadows Medical, Port Macquarie, NSW

The data [coding]

'Past History'

ONLY for Chronic conditions & significant active or inactive 'events' eg CKD

BEST TIP!!

Add detail/comment

eg Care team involved

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

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.				

Create an Improvement Culture - with evidence-based improvements

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

Allergies and adverse reactions	🟢	89.24%
Medicines	🔴	48.03%
Medical History	🟢	88.56%
Health Risk Factors	🟠	68.34%
Immunisations	🟠	64.45%
Relevant Family History	🔴	54.30%
Relevant Social History	🟢	93.52%
Non-Duplicate Patients	🟢	99.22%

Use TopBar for continual improvements

Proactive reminders (filters)

Learning Objective 3:

Design Quality Improvement activities & a plan to meet eligibility for PIP QI.

PCMN Quality Improvement Activity Planning Sheet

Name of Practice: Date:

Name of your QIA:

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?	

PCMN Quality Improvement Activity Planning Sheet

Name of Practice: SAMPLE PRACTICE   Date: June 2018

Name of your QIA

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)

We suggest that:

- ☐ Your practice is Accredited under the RACGP 5th Standards
- ☐ You have a PRODA account to apply for PIP QI through HPOS online from August 1
- ☐ You know your PIP Identifier Number
- ☐ You have a data extraction tool installed (PenCat or POLAR)
- ☐ You have completed a current Data Management Agreement (DMA) and display a Patient Privacy Poster for either POLAR or PEN
- ☐ That your data extraction tool is uploading to us correctly, at least once per quarter, but preferably monthly
- ☐ You are receiving your Benchmark reports (BMR) from CESPHN
- ☐ You have informed us, who in your practice should be receiving the benchmark reports (we strongly suggest that two people receive the reports)
- ☐ You have a Quality Improvement (QI) team which consists of a leader (preferably a GP) and at least one other member of the practice team
- ☐ You have shared the BMR and spoken to your whole practice about Continuous Quality Improvement (CQI) and how it will affect the practice going forward
- ☐ If your practice team has identified an area which **they** believe would benefit the practice population

phn
CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

More CESPHN resources

POLAR Privacy Notice

Pen CS Privacy Notice

VISION + SKILLS + INCENTIVES + RESOURCES + ACTION PLAN = CHANGE!

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

- Set small, easily achievable 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!)

Improving health record quality in general practice

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

Data Quality Checklist for all 'active' patients

1. **Demographics – are the contact details up-to-date?**
   - Double-click on the patient's telephone number to check and update details

2. **Medication List – is the Current Meds list accurate?**
   - Right click to delete/cease medications no longer relevant (they can then be found in the Old/Past Scripts thereafter)
   - If none, tick No medications

3. **Past History List – does it contain only significant conditions that a hospital or specialist would need to know?**
   - Right click to edit, delete or add new
   - If none, tick No significant past history (PMH) box

4. **Allergies – have you also recorded adverse reactions?**
   - Double-click in allergies box and Add, Edit, Delete
   - If none, tick No Known Allergies/Adverse Reactions/Nil Known

5. **Immunisations – have immunisations been recorded?**

Access RACGP resource

Download the 'Data Quality' Checklist

Train IT Medical

trainitmedical.com.au

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

CESPHN
APCC – Model for Improvement
APCC - PDSA template
Model for Improvement video

Your PHN is here to help!

Dedicated email support: pipqi@cesphn.com.au

Fabulous resources, PEN & POLAR learning and PDSA samples:

https://www.cesphn.org.au/general-practice/practice-support-and-development/quality-improvement

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Thank you!   With best wishes, Katrina Otto