Analysing patient data to improve population health and business efficiency in general practice settings

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Welcome

A stronger primary health system.
Learning Outcomes

At the end of this workshop, the participant should be able to:

1. Identify how patient data can be used to improve health outcomes

2. Reflect on how you can use patient data to align with local and national population health priorities

3. Describe how data extraction and analysis can improve business efficiency and provide business development opportunities for general practice
Case Study 1: Broughton Clinic

- Port Broughton, SA - seaside rural community ~ 170km Nth Adelaide
- Private health service operating for over 30 years
- Originally solo GP, 2nd GP employed to cope with population growth
- Staff: 2 GPs, 1 practice manager and 4 part time reception staff.

At commencement of project, patient database had 5890 ‘active’ patients, - senior citizens, retirees, fishing and farming families and holiday makers

Staff felt patient information & activities could be better organised – joined Australian Primary Care Collaboratives (APCC) to learn how to use data inputted into their system more efficiently.

**Goal:** To accurately define the patient population and measure outcomes by conducting regular data cleansing and review.
Case Study 1: Broughton Clinic

What did they do?

• *Reviewed patient data base* - archived patients who had left practice or not visited in two years. This reduced active patient numbers by ~ 40% to approximately 3500 patients (from 5890).

• *Cleansed data* - enabled accurate definition of practice population, key cohorts to be highlighted and health outcomes identified/measured
  – E.g clinic’s first data review showed less than 20% of patients with diabetes had a recorded Hba1c.
  – Ongoing efforts with this patient group, including a focus on ensuring GPs correctly code patients, improved quality measure of Hba1c <7 to near 70%.

• *Improved practice revenue* - systematic efforts to track GPMPs, TCAs, SIPs, resulted in financial benefits. This allowed a nurse to be employed to manage population health / chronic disease at the clinic.

Adapted from: Australian Primary Care Collaborative Case Study: Broughton Clinic
How do you collect data and patient information at your practice?

What sort of information have you searched for?

What were you trying to achieve and why?
Collecting quality data – what do you need?

- Patient management software
- Additional extraction tools
- Clean practice data – up to date high quality data
Data Cleansing tools

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<thead>
<tr>
<th>Surname</th>
<th>Firstname</th>
<th>Date of Birth</th>
<th>Sex</th>
<th>Address</th>
<th>Suburb</th>
<th>Postcode</th>
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<th>Work Phone</th>
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</table>
Common general practice data quality problems

- No gender selected
- Patients have not visited for 2 years
- Deceased patients
- Duplicate patients
- Uncoded diagnoses
- Free text recalls (huge outstanding actions lists)

*What strategies does your practice use to address these issues?*
Common extraction tools

• PenCat (CAT tools)
• Practice Health Atlas
• Canning Tool
Clinical Audit Tool (CAT)

RECIPE steps:
In "Conditions" Tab, under "Mental Health" category, select "Yes"
Click on the 'Results' tab in the filtre button next to '<= 12 mths' to select only results entered in the last 12 months.
'recalculate' to apply the filter
Clinical Audit Tool (CAT)

Patients Not Recorded with MBS Item [population = 622]

with last recorded item 18/12/2012 - 17/12/2013

MBS item

Number of Patients

45, 68, 483, 1, 0, 0, 0, 679, 679, 575, 615, 620, 599, 519, 555, 584, 622, 622, 622, 622, 622, 622
**Clinical Audit Tool (CAT)**

![Clinical Audit Tool (CAT) screenshot](image)

- **Cross Tabulation Reidentify Report**
  - **[patient count = 61]**
  - **Filtering By:** Active Patient, Conditions (Mental Health - Yes)
  - **Selected:** MBS Items (GP-MHCP), MBS Not Recorded (2712 (GP-MHCP Review))

<table>
<thead>
<tr>
<th>ID</th>
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<th>First Name</th>
<th>Known As</th>
<th>Sex</th>
<th>D.O.B</th>
<th>Address</th>
<th>City</th>
<th>Postcode</th>
<th>Phone (H)</th>
<th>Phone (W)</th>
<th>Phone (M)</th>
<th>MBS Items</th>
<th>MBS Not Recorded</th>
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<td>5555 9999</td>
<td>055123456</td>
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<td>5555 1234</td>
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<td></td>
<td>GP-MHCP 2715 20/11/2012</td>
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</table>
What is population health exactly and what does it look like in general practice?
Population Health

• focuses on understanding health and disease in the community
• Involves health promotion and disease prevention activities

(Australian Institute of Health and Welfare (AIHW)

• In general practice it has been defined as:

'\textit{The prevention of illness, injury and disability...\textit{reduction in burden of illness}...\textit{rehabilitation of those with chronic disease}...\textit{recognises social, cultural and political determinants of health \textit{[which require]} \textit{organised and systematic responses to improve and restore the health of populations and individuals}}...'}

(Department of Health and Ageing)
Population health and health priorities

• A population health approach ensures populations who do not enjoy the same level of health as the general population are given access to health services and interventions.

• Australian Government has identified:
  – priority population groups (E.g ATSI, socioeconomically disadvantaged)
  – age groups (E.g babies, elderly)
  – disease priorities (9 National health priority areas)
Changing burden of illness: from acute to chronic

National Health Priority Areas

- Cancer control (first set of conditions, 1996)
- Cardiovascular health (1996)
- Injury prevention and control (1996)
- Mental health (1996)
- Diabetes mellitus (added 1997)
- Asthma (1999)
- Arthritis and musculoskeletal conditions (2002)
- Obesity (2008)
- Dementia (2012)
Population health & Primary Health Networks

• Population health data helps inform service planning

• Population health informs the work of Primary Health Networks

• PHNs work to:
  
  – **Understand** the health of their catchment population
  
  – **Identify** health needs and gaps in services at the local level
  
  – **Examine** opportunities for better targeting of services
  
  – **Establish** formal and informal linkages with the acute and aged care sectors, and other services in the primary healthcare sector
Gippsland has high numbers of families with young mothers and single parents, Aboriginal families, families exposed to violence and economically disadvantaged families.
Can you describe the patient profile of your practice (by priority population, chronic disease and/or age)?

Is it reflected in GML’s health priorities?

Do you think your practice meets the healthcare needs of these identified groups?
How does population health fit into everything PM’s do?
Practice managers....

- Busy +++
- Managing everything!
- Recruiting and retaining staff
- Rostering
- Accreditation....
Practice Manager...

- Performs all or some of the practice management tasks in a healthcare setting

- A healthcare practice manager's tasks may include:
  - strategic planning,
  - review and implementation of processes in a practice that increase efficiency and contribute to the overall notion of 'excellence in healthcare
  - Financial management
  - Human resource management
  - Planning & marketing
  - Information management
  - Risk management
  - Governance & organisational dynamics
  - Business & clinical operations
  - Professional responsibility
Accreditation: RACGP Standards

Standard 1.3 Health promotion and prevention of disease
• 1.3.1. Health promotion and preventative care; Our practice provides health promotion, illness prevention and preventative care and a reminder system based on patient need and best available evidence

Standard 1.5 Continuity of care
• 1.5.3 System for follow up of tests and results: Our practice has a system for the follow up and review of tests and results.

Standard 2.1 Collaborating with patients
• 2.1.1. Respectful and culturally appropriate care: Our practice provides respectful and culturally appropriate care for patients

Standard 3.1 Quality and Safety
• 3.1.1 Quality improvement activities: Our practice participates in quality improvement activities
To improve quality of care through a population health approach

*How many (or what percentage) of our practice patients have the following chronic conditions?*

- Asthma
- Diabetes
- Cardio Vascular Disease (CVD)
- Hypertension
- Obesity
- Diagnosed Mental Health condition?
To improve quality of care and business efficiency and sustainability

• How many (or what percentage) of our practice patients are eligible for the following MBS funded services?
  – GPMP (& Reviews)
  – TCA (& Reviews)
  – 45 – 49 year old Health Check
  – Annual Health Assessment

• Have we got the ‘right’ staffing profile to provide recommended care?

• Could we build a business case for additional staffing through analysis of practice population data?
Let’s have a break...........
A stronger primary health system.

2018
Business development in general practice

- Practices are struggling with rising operational costs
- Medicare rebates are not rising to meet this reality (problem for bulk-billed clinics particularly)
- Inclination to increase patient fees
- Increasing patient complexity
How is your practice meeting these challenges?

What business development opportunities are there?
Get on board now... don’t get left behind

*There are active discussions in Canberra now about more payments for outcomes*


Analysing data will help provide outcomes evidence of:

- patients who need evidence based care
- planned care based on patient or population health needs
- reduced exacerbations of chronic disease by monitoring patient progress & need for follow-up care via prompts in the electronic health record
- Reduced ED presentations and hospitalizations
Get on board now... don’t get left behind

Using practice population health data effectively can:

- Increase practice revenue through use of relevant chronic disease MBS items numbers and other financial incentives, **without necessarily increasing patient fees or throughput**

- **Monitor practice performance** by tracking patient data and comparing it with national guidelines or internal benchmarks
## Business Modeling

<table>
<thead>
<tr>
<th>Item description</th>
<th>Actual Earned (A)</th>
<th>Estimated total value (B)</th>
<th>Estimated potential new income (B-A)</th>
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<tbody>
<tr>
<td>EPC Health Assessment Items</td>
<td>$66,782</td>
<td>$125,807</td>
<td>$59,026</td>
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<tr>
<td><strong>EPC Chronic Disease Management Items</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>GPMP &amp; TCA and Reviews</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*(formerly EPC Multidisciplinary Care Plan Items)*¹</td>
<td></td>
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<tr>
<td>Diabetes GPMP/TCA/Review</td>
<td>$22,185</td>
<td>$95,317</td>
<td>$73,132</td>
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<tr>
<td>Asthma GPMP/TCA/Review</td>
<td>$47,247</td>
<td>$141,750</td>
<td>$94,503</td>
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<td>Mental Health GPMP/TCA/Review</td>
<td>$57,141</td>
<td>$96,010</td>
<td>$38,870</td>
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<td>CHD GPMP/TCA/Review</td>
<td>$14,961</td>
<td>$44,943</td>
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<td>Stroke GPMP/TCA/Review</td>
<td>$4,667</td>
<td>$14,121</td>
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<td>COPD GPMP/TCA/Review</td>
<td>$3,716</td>
<td>$9,465</td>
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<td>Bone Disease GPMP/TCA/Review</td>
<td>$24,423</td>
<td>$73,323</td>
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<td>CDM services by a Practice Nurse (10997/10986/10987)</td>
<td>$0</td>
<td>$13,682</td>
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<td><strong>Sub-Total</strong></td>
<td><strong>$174,340</strong></td>
<td><strong>$488,611</strong></td>
<td><strong>$314,272</strong></td>
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<td>PNIP Subsidy (see calculator³)</td>
<td>$0</td>
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<td>$0</td>
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<td>Service Incentive Program (SIP) Items</td>
<td>$1,044</td>
<td>$82,473</td>
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<td>Medication Management Item 900²</td>
<td>$0</td>
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<td>Aged Care items Item Numbers</td>
<td>$275</td>
<td>$5,514</td>
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<td><strong>Totals</strong></td>
<td><strong>$242,441</strong></td>
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## Chronic Disease Management

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<tr>
<th>Item</th>
<th>Name</th>
<th>$</th>
<th>Description / Recommended Frequency</th>
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<tbody>
<tr>
<td>721</td>
<td>GP Management Plan (GPMP)</td>
<td>$144.25</td>
<td>Management plan for patients with a chronic or terminal condition. Not more than once yearly</td>
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<td>723</td>
<td>Team Care Arrangement (TCA)</td>
<td>$114.30</td>
<td>Management plan for patients with a chronic or terminal condition and complex needs requiring ongoing care from a team including the GP and at least 2 other health or care providers. Enables referral for 5 rebated allied health services. Not more than once yearly</td>
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<tr>
<td>732</td>
<td>Review of GP Management Plan and/or Team Care Arrangement</td>
<td>$72.05</td>
<td>The recommended frequency is every 6 months. If a GPMP and TCA are both reviewed on the same date item 732 can be claimed twice on the same day</td>
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<tr>
<td>729</td>
<td>GP Contribution to, or Review of, Multidisciplinary Care Plan</td>
<td>$70.40</td>
<td>Contribution to, or review of, a multidisciplinary care plan prepared by another provider (e.g. community, home or allied health providers, specialists), for patients with a chronic or terminal condition and complex needs requiring ongoing care from a team including the GP and at least 2 other health or care providers. Not more than once every 3 months</td>
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<tr>
<td>731</td>
<td>GP Contribution to, or Review of, Multidisciplinary Care Plan prepared by RACF</td>
<td>$70.40</td>
<td>GP contribution to, or review of, a multidisciplinary care plan prepared by RACF, at the request of the facility, for patients with a chronic or terminal condition and complex needs requiring ongoing care from a team including the GP and at least 2 other health or care providers. Not more than once every 3 months</td>
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</table>
A stronger primary health system.

FREQUENTLY ...

... of focussed psychological strategies by an appropriately trained and registered GP working in an accredited practice.
### Health Assessments

<table>
<thead>
<tr>
<th>Item</th>
<th>Name</th>
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<th>Description / Recommended Frequency</th>
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<tbody>
<tr>
<td>701</td>
<td>Brief Health Assessment</td>
<td>$59.35</td>
<td>lasting not more than 30 minutes</td>
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<tr>
<td>703</td>
<td>Standard Health Assessment</td>
<td>$137.90</td>
<td>&gt;30 - 44 minutes - see MBS for complexity of care requirements</td>
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<td>705</td>
<td>Long Health Assessment</td>
<td>$190.30</td>
<td>&gt;45 - &lt;60 minutes - see MBS for complexity of care requirements</td>
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<td>707</td>
<td>Prolonged Health Assessment</td>
<td>$268.80</td>
<td>&gt; 60 minutes - see MBS for complexity of care requirements</td>
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<td>715</td>
<td>Aboriginal and Torres Strait Islander Health Assessment</td>
<td>$212.25</td>
<td>Not timed</td>
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# Practice Incentive Program

<table>
<thead>
<tr>
<th>Item</th>
<th>Activity</th>
<th>Item Number &amp; type of consult</th>
<th>PIP ($ per SWPE)</th>
<th>SIP ($ per patient)</th>
<th>Notes</th>
<th>PIP Enquiry Line: 1800 222 032</th>
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<tbody>
<tr>
<td><strong>Diabetes</strong></td>
<td>Patient register and recall/reminder system</td>
<td>N/A</td>
<td>$1.00 per SWPE (Approx. $1000 per FTE GP)</td>
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<td>One-off payment only. Practice must be registered for PIP. Incentive payable with quarterly PIP payments.</td>
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<tr>
<td></td>
<td>Annual Cycle of Care for patients with Diabetes</td>
<td>Level B - 2517 or 2518 Level C - 2521 or 2522 Level D - 2525 or 2526</td>
<td>$40 per Diabetic patient</td>
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<td>These item numbers should be used in place of the usual attendance items, when a consultation completes the minimum annual requirements of care.</td>
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<td></td>
<td>Outcomes payment</td>
<td>N/A</td>
<td>$20 per Diabetic patient, per annum</td>
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<td>Payment only made to practices that have a min. of 2% of their patient population as diagnosed diabetics. Payment made to practices where 50% of diabetes patients have a completed Annual Cycle of Care.</td>
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<td><strong>Asthma</strong></td>
<td>Sign-on payment</td>
<td>N/A</td>
<td>$0.25 per SWPE (Approx. $250 per FTE GP)</td>
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<td>One-off payment only. Practice must be registered for PIP. Incentive payable with quarterly PIP payments.</td>
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<td>Asthma Cycle of Care</td>
<td>Level B - 2546 or 2547 Level C - 2552 or 2553 Level D - 2558 or 2559</td>
<td>$100 per patient, per annum plus consultation fees</td>
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<td>These item numbers should be used in place of the usual attendance items, when a consultation completes the minimum requirements for the Asthma Cycle of Care. The Asthma Cycle of Care targets patients with moderate to severe asthma.</td>
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<td><strong>Cervical Screening</strong></td>
<td>Sign-on payment</td>
<td>N/A</td>
<td>$0.25 per SWPE (Approx. $250 per FTE GP)</td>
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<td>One-off payment only. Practice must be registered for PIP. Incentive payable with quarterly PIP payments.</td>
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<td></td>
<td>Screening women aged 20-69 years inclusive, who have not been screened in the past 4 years</td>
<td>Level A - 2497 Level B - 2501 or 2503 Level C - 2504 or 2506 Level D - 2507 or 2509</td>
<td>$35 per patient</td>
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<td>These MBS items must be used instead of the standard consultation items, in order to be eligible for this payment</td>
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<td>Outcomes payment</td>
<td>N/A</td>
<td>$3.00 per female WPE aged between 20 and 69, per annum</td>
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<td>Payment is made to practices where a minimum of 70% of women aged between 20 and 69 yrs inclusive have been screened in the past 30 months (paid on a quarterly basis).</td>
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## Practice Incentive Payments

<table>
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<th>Item</th>
<th>Activity</th>
<th>PIP ($ per SWPE)</th>
<th>Notes</th>
<th>PIP Enquiry Line: 1800 222 032</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>eHealth</strong></td>
<td><strong>Requirement 1:</strong> Integrating Healthcare Identifiers into Electronic Practice Records</td>
<td>$6.50 per SWPE, per annum</td>
<td>To qualify practices must meet each of the requirements:</td>
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<td></td>
<td><strong>Requirement 2:</strong> Secure messaging capability</td>
<td>Capped at $12,500 per quarter</td>
<td><strong>Requirement 1:</strong> 1. Apply for a Healthcare Provider Identifier-Organisation (HPI-O) 2. Ensure each GP within the practice has a Healthcare Provider Identifier-Individual (HPI-I) 3. Use a compliant clinical software system to access, retrieve and store verified Individual Healthcare Identifiers (IHI) for patients</td>
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<td></td>
<td><strong>Requirement 3:</strong> Data records and clinical coding</td>
<td></td>
<td><strong>Requirement 2:</strong> 1. Apply for a NASH PKI Certificate 2. Have a standards-compliant secure messaging capability and use it where feasible 3. Work with your secure messaging vendor to ensure it is installed and configured correctly 4. Have a written policy to encourage its use</td>
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<td></td>
<td><strong>Requirement 4:</strong> Electronic transfer of prescriptions</td>
<td></td>
<td><strong>Requirement 3:</strong> 1. Be working towards recording the majority of diagnoses electronically using a medical vocabulary that can be mapped against a nationally recognised disease classification or terminology system 2. Provide a written policy to this effect to all GPs</td>
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<td></td>
<td><strong>Requirement 5:</strong> Personally controlled electronic health (eHealth) record system</td>
<td></td>
<td><strong>Requirement 4:</strong> Use a software system that is able to send an electronic prescription to a Prescription Exchange Service (PES)</td>
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<tr>
<td>Practice Nurse</td>
<td>Practice employs or retains the services of a Registered Nurse, Enrolled Nurse or Aboriginal Health Worker</td>
<td>Capped at $125,000 per annum</td>
<td><strong>Requirement 5.</strong> 1. Use compliant software to access the personally controlled electronic health (eHealth) record system and create and post Shared Health Summaries and Event Summaries when available 2. Apply to participate in the eHealth record system upon obtaining a HPI-O</td>
<td></td>
</tr>
<tr>
<td>Quality Prescribing</td>
<td>Practice participation in quality use of medicines programs, endorsed by the National Prescribing Service</td>
<td>$1.00 per SWPE</td>
<td>This incentive aims to broaden the range of services a nurse can provide. Payments are based on practice SWPE and nurse hours. Refer to ACTML website for complete PNIP guidelines.</td>
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<tr>
<td>Teaching</td>
<td>Aims to encourage general practices to provide teaching sessions to undergraduate and graduate medical students preparing for entry into the Australian Medical profession.</td>
<td>$100.00 per session</td>
<td>This incentive is to assist practices in keeping up to date with information on the quality use of medicines. Payment will only be made if the practice meets a minimum participation level, set at an average of three activities per FTE GP per year.</td>
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</tr>
</tbody>
</table>
Clinic GPs asked “Are quality and sustainability mutually exclusive?”. Can we provide great patient care and be rewarded financially?

By analysing patient data the practice was able to improve patient care and generate income.

Brooke Street Medical Centre reported key ingredients to success:
- A team approach - the right people doing the right work, including Allied Health providers via relevant MBS items
- Clear team communication
- An organised approach to MBS Chronic Care Items
- A viable business model
- Regular review
A stronger primary health system.
Work with your practice team

• Educate and promote use of data to extract important population health information to improve health outcomes and business efficiency
  – create data analysis culture within the practice

• Use data to discuss performance and practice capability needs (staffing, infrastructure business case for changed practice) with practice principals, business owners, etc.

• Use data to discuss performance with clinical staff (GPs, Nurses, AHPs)
Utilise your clinical staff

• Utilise staff to collect and analyse practice population data
  – E.g nurse run CDM clinic for diabetes– assess data for completed Annual Cycle of Care. Is there a business case for having a podiatrist on site?

• Ensure patient coding is entered correctly and completed to improve data analysis

• In Broughton Clinic Case Study - a nurse has now been employed to manage population health / chronic disease efforts at the clinic
Practice Manager’s role & Business Systems

- Working with practice team to focus data analysis activities: (Why?)
  - Health
  - Quality
  - Business

- Determining the type of data needed (What?)
- Determining roles and responsibilities (Who?)
- Determining frequency (When?)
Best practice guidelines and references

RACGP Curriculum for Australian General Practice
http://curriculum.racgp.org.au


Using data for better health outcomes
http://www.racgp.org.au/digitalbusinesskit/

Medicare Locals Accreditation Standards
Any comments or questions?

Thank you