National Health Co-op

Better Health Together

Data To Lobby For Change Locally And Nationally

Using Data in Primary Care Services

Liz Obersteller

National Health Cooperative, ACT

24th October 2015

Overview

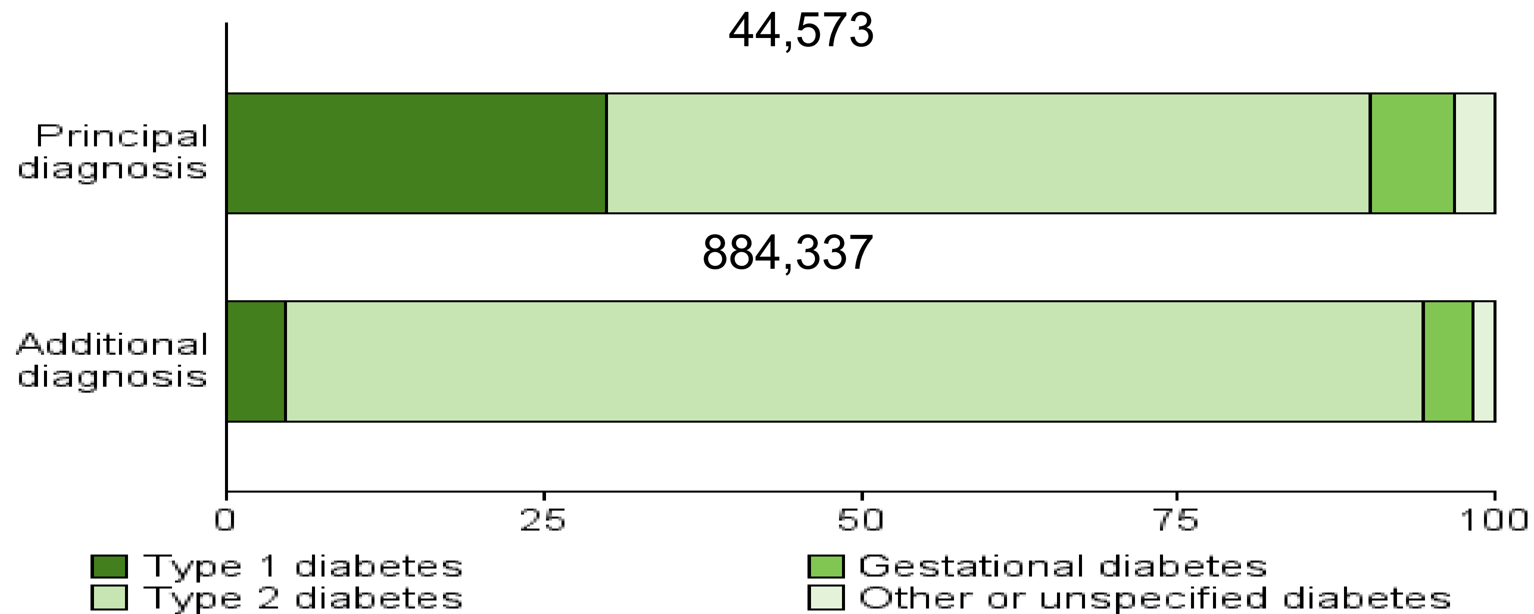
- National Health Cooperative
- National Issues
- Data in Primary Care Services
  - Data collection systems
  - PIP payments
  - Diabetes Cycle of Care
  - Audits
- Future options

National Health Co-op
Better Health Together

National Health Cooperative

National Health Co-op
Better Health Together

Hospitalisations by Diabetes Type, 2013-14



Source: AIHW National Hospital Morbidity Database

http://www.aihw.gov.au/diabetes/hospital-care/

National Health Co-op
Better Health Together

Headlines

BREAKING NEWS

Huge cost of poor pre-hospital care

“About one in 10 admissions for renal failure occurred in patients with a history of diabetes who had not received a renal function test in the year before admission and were not dispensed an ACEI or ARB."

BY MARGARET SCHEIKOWSKI AAP SEPTEMBER 07, 2015 12:03PM

National Health Co-op
Better Health Together

Why Do we Need to Collect, Evaluate and Use Data in Primary Health Care

Research using routinely collected data can drive health system effectiveness and health improvement

Jorm, Louisa(2015)Routinely collected data as a strategic resource for research: priorities for methods and workforce. Public Health Res Pract. 015;25(4):e2541540

National Health Co-op
Better Health Together

Primary Heath Care – Improving Outcomes

- There is wide spread evidence that interventions delivered at primary health care level ***can be highly effective and cost effective***

- Evidence based interventions in primary care ***can offer value for money health care***

- However ***gaps remain between recommended care and actual care***

OECD (2015), *Cardiovascular Disease and Diabetes: Policies for Better Health and Quality of Care*, OECD Health Policy Studies, OECD Publishing, Paris.
DOI: http://dx.doi.org/10.1787/9789264233010-en

Information Systems to Drive Performance and Outcomes

- Designing quality indicators in PHC is challenging

- Current Australian system provides good data on the number of services provided but less information on types of care provided and the outcomes of that care

National Health Co-op
Better Health Together

Data Collection in General Practice

- A wide range of data is able to be generated, which provides information about costs, throughput, management patterns and the frequency of presentation of various conditions to GPs.

- Several collections contain detailed information about problems managed, and the related management actions undertaken by GPs, which can be used in assessing the quality of care.

National Health Co-op
Better Health Together

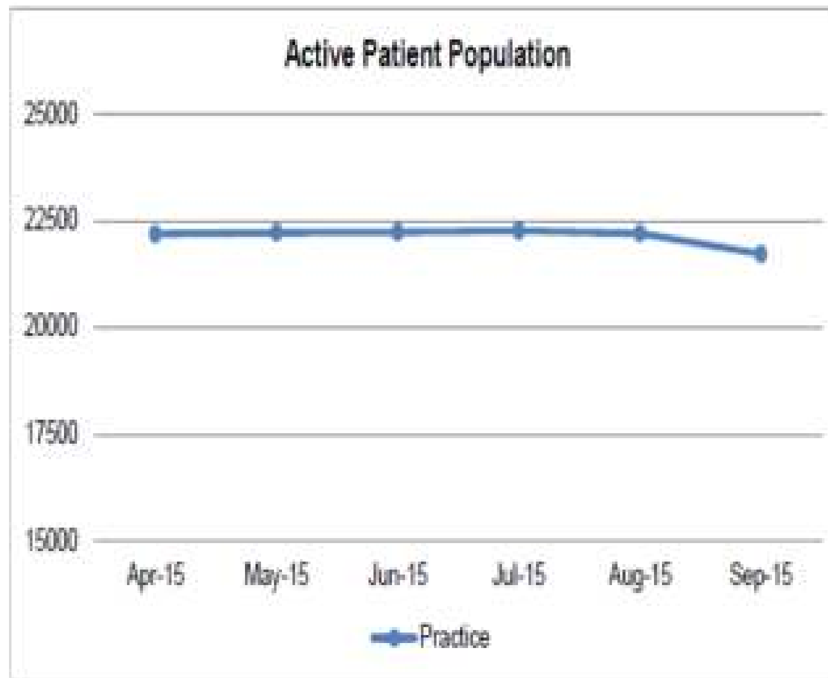
NHC and Capital Health Network – PENCAT 4

- Clinical Audit Tool (CAT) provides
  - essential population health graphs,
  - charts and reports
- Allows the practice to investigate and identify health priorities for the local population
- Compare care with other practices within CHN

National Health Co-op
Better Health Together

NHC Patient Snap Shot

Section 1 Patient population characteristics Reporting period Apr-15 to Sep-15



Key Points

- There are 21736 patients in the database.
- This represents a change of -465 patients in the reporting period

[1] NHC actice patient population is 72.6% of the total patient population

[3] AVE actice patient population is 65.4% [2] of the total patient population

Goals to consider

- Increase the % active patients to streamline patient management processes

Activities to consider

- Have a policy in place to routinely deactivate inactive patients

[3] The benchmark or aggregated data for CHN

National Health Co-op

Better Health Together

978 patient recorded with diabetes = 4.5% active patient population

18% without recorded HbA1c

DIABETES	Sep-15	Aug-15	Jul-15	Jun-15	May-15	Apr-15	Mar-15	Feb-15	Jan-15
# Patients	978	982	979	971	956	951	948	944	934
% of total patients	4.5%	4.4%	4.4%	4.4%	4.3%	4.3%	4.3%	0.0%	4.2%
HbA1c Recorded	82%	81%	81%	81%	79%	79%	80%	79%	79%
Not Recorded	18%	19%	19%	19%	21%	21%	20%	21%	21%
<= 7%	42%	42%	42%	43%	42%	42%	41%	42%	42%
>7% and <= 8%	18%	18%	18%	17%	17%	17%	18%	18%	17%
>8% and < 10%	16%	16%	15%	15%	14%	14%	14%	14%	14%
>= 10%	6%	6%	6%	6%	6%	6%	6%	6%	6%

30% with HbA1c >7%

National Health Co-op
Better Health Together

PEN CAT 4

- Can show data outcomes compared to other practices
- Data extracted from Best Practice
- Requires in some cases data to be manually entered

GP Management Plan - Diabetes

- Enable GPs to plan and coordinate the health care of patients with chronic or terminal medical conditions
- Sets out the services to be provided by the GP;
- Lists the actions persons can take to help manage their condition

DIABETES GPMP	Sep-15	Aug-15	Jul-15	Jun-15	May-15	Apr-15	Mar-15	Feb-15	Jan-15
# Patients with Diabetes	978	982	979	971	956	951	948	944	934
GPMP Recorded (721)	687	687	685	674	660	652	648	639	633
TCA Recorded (723)	681	682	678	667	654	646	641	631	624
Review Recorded (732)	527	519	510	502	497	487	475	466	460

National Health Co-op
Better Health Together

- Financial incentive may support low intensity of collaboration as focuses on activities rather than on better health outcomes

Practice Incentive Payments – Diabetes Cycle of Care

- Provides a number of incentives that aim to encourage general practices to improve the quality of care provided to patients. It recognises general practices that provide comprehensive quality care

- Limitation
  - No record of the consultation.
  - Assume all GPs have participated to the same level of service to receive the PIP
  - Low levels of completion rates
    - ?related to integration of data within practices

Practice Incentive Payments (PIP) – Diabetes Cycle of Care

The person with type 2 diabetes visited a GP an average of eight times per year in 2013*

National Figures completion of Diabetes Cycle of Care

	FEB 2012	MAY 2012	AUG 2012	NOV 2012	FEB 2013	MAY 2013	AUG 2013	NOV 2013	FEB 2014	MAY 2014	AUG 2014	NOV 2014	FEB 2015	MAY 2015
Number of PIP practices receiving a Diabetes Incentive outcomes payment for the quarter(%)	44.7	45.3	46.8	46.3	47.1	48.1	48.4	20.1	19.7	20.5	20.9	21.8	21.5	21.5

Medicare Locals Statistics Reports

* Bettering the Evaluation and Care of Health (BEACH) study

Summary of limitations of current data collections

- Tendency for a diagnosis/problem not to be linked to a service
- The inability to ***follow the treatment*** of an individual ***over time*** in order to ***determine outcomes***
- The ***inability to link data*** with other ***relevant health information***
- Low level of participation

Australian Institute of Health and Welfare 2008. Review and evaluation of Australian information about primary health care: a focus on general practice. Cat. no. HWI 103. Canberra: AIHW.

National Health Co-op
Better Health Together

Continued

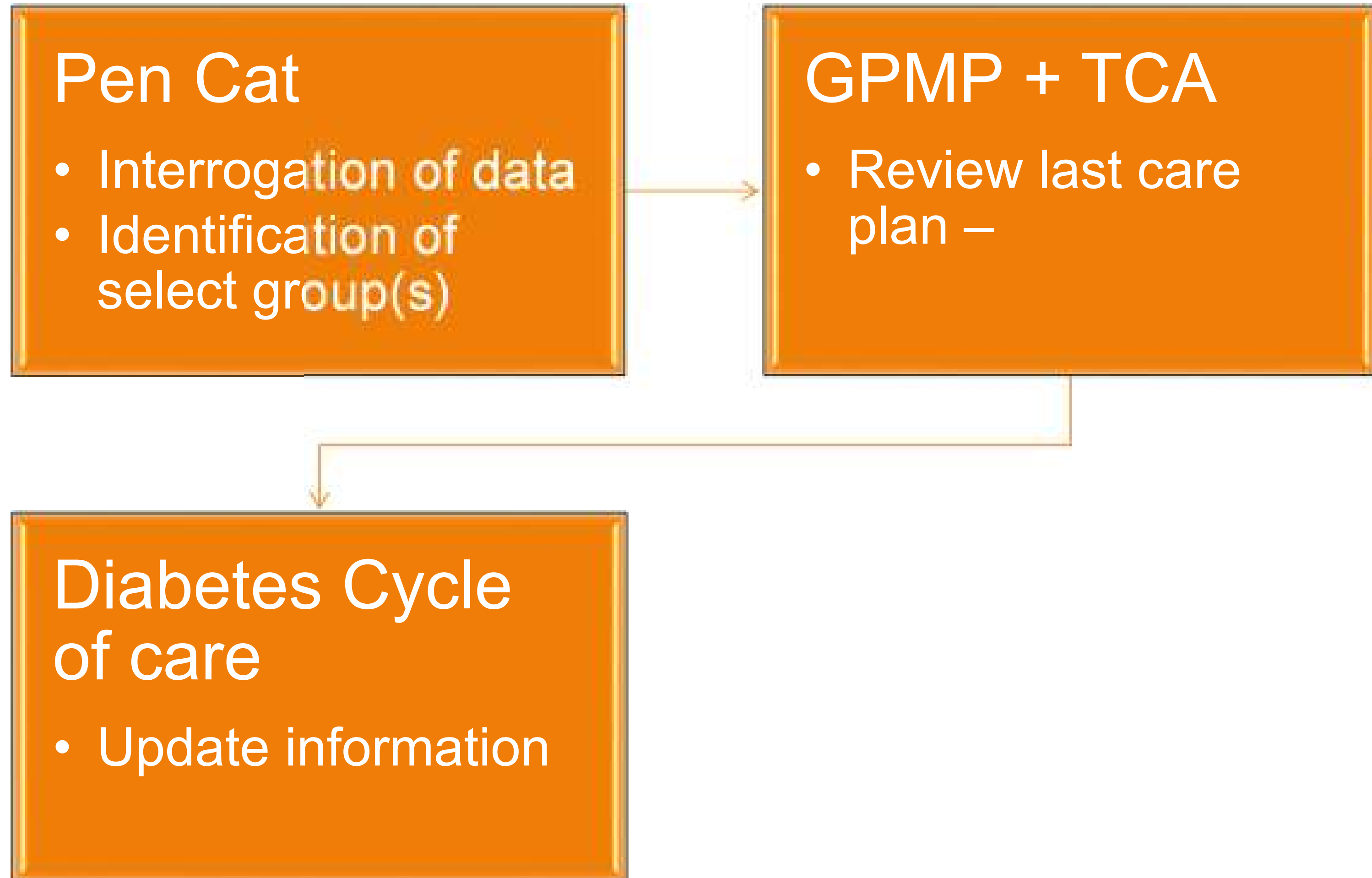
- Most quality metrics ***do not gauge quality***, rather they are ***process measures*** that ***capture compliance*** with guidelines
- Often do not cover the ***full cycle of care*** for the condition and ***track the health status after care*** is completed
- System need ***do not follow patients across services*** and sites and the time for the full cycle of care.
- Limited evidence to show that the ***data sources*** are used to ***evaluate safety and quality goals*** to ***fit with reality***

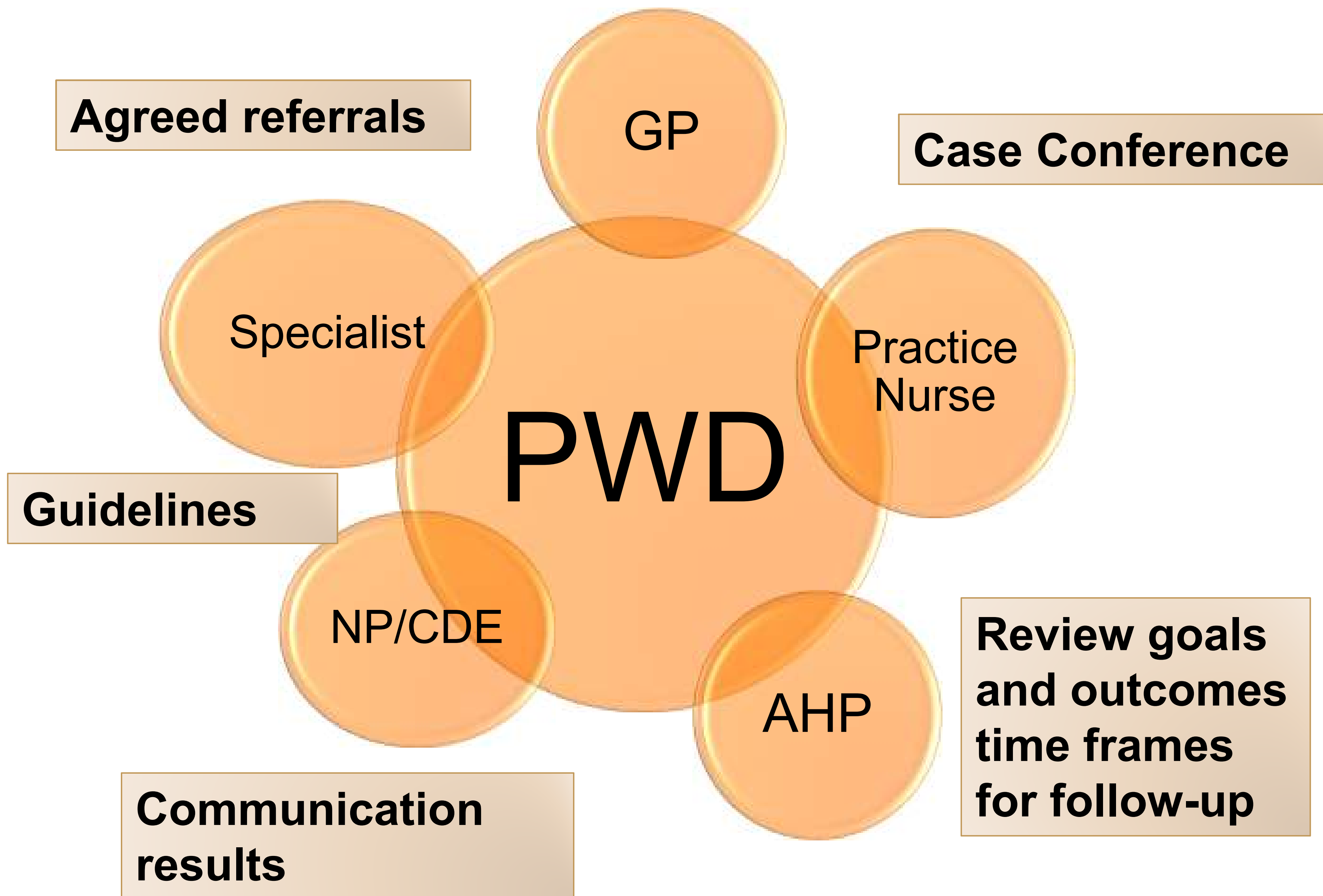
Care Coordination Model at NHC

Despite the limitation discussed above there is scope to integrate the data and use it to achieve positive outcomes.

NHC is using the data to develop a model that supports;

- **Integrated patient centred care**
- **Collaboration, coordination and safe effective communication**
- **Provides immediate feedback of measurable and clinically meaningful improvements**


Pen Cat
• Interrogation of data
• Identification of select group(s)
GPMP + TCA
• Review last care plan –
Diabetes Cycle of care
• Update information


Individualization
Agreed referrals
GP
Case Conference
Specialist
Practice Nurse
PWD
Guidelines
NP/CDE
AHP
Review goals and outcomes time frames for follow-up
Communication results

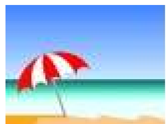
- Coordination of care
- Sharing ideas and collective actions between different health care stake holders (including PWD)
- Maximising the rate at which pt. receive appropriate and timely care
- Provision of high quality care at reasonable prices and costs

Bettering the Evaluation and Care of Health (BEACH)

- Characteristics of the GPs
- Patients seen
- All consultations recorded - including indirect consultations (e.g. telephone) - which result in a management action e.g. prescription, referral, et

Limitations

- No facility for longitudinal analysis of individual patient records.
- GPs who do not register 375 Medicare items in 3 months are excluded from the survey.



BEACH

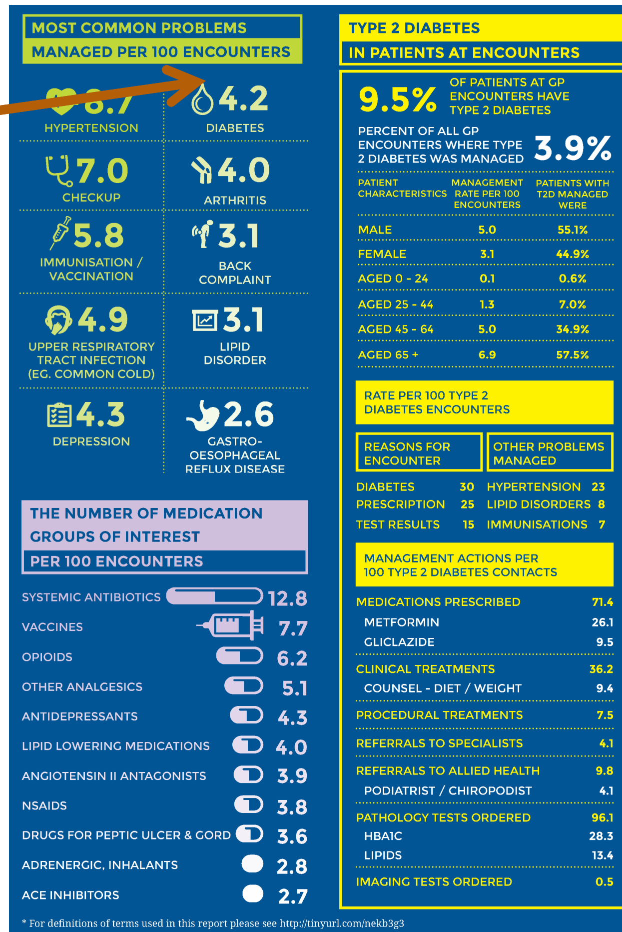
THE UNIVERSITY OF SYDNEY

National Health Co-op
Better Health Together

SUMMARY OF BEACH 2013-14

Diabetes Specific

Diabetes managed at 4.2 per 100 encounters



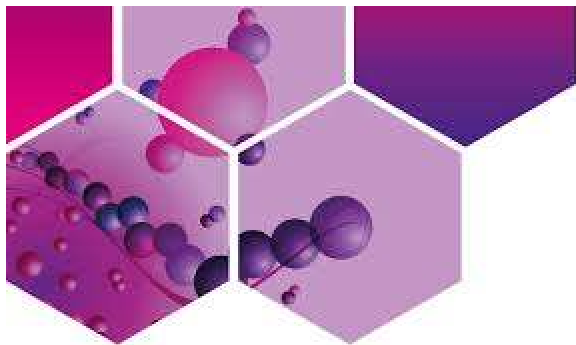
9.5% of GP encounters had type 2 diabetes

74 actions related to prescribing

National Health Co-op
Better Health Together

Mapping Glycaemic Control Across Australia (MGCAA) project

- An observational study to raise awareness, promote reflection with the aim of leading to change how we manage diabetes and in turn changing diabetes outcomes
- A unique opportunity to look at regional level data using postcode identification.



National Health Co-op
Better Health Together