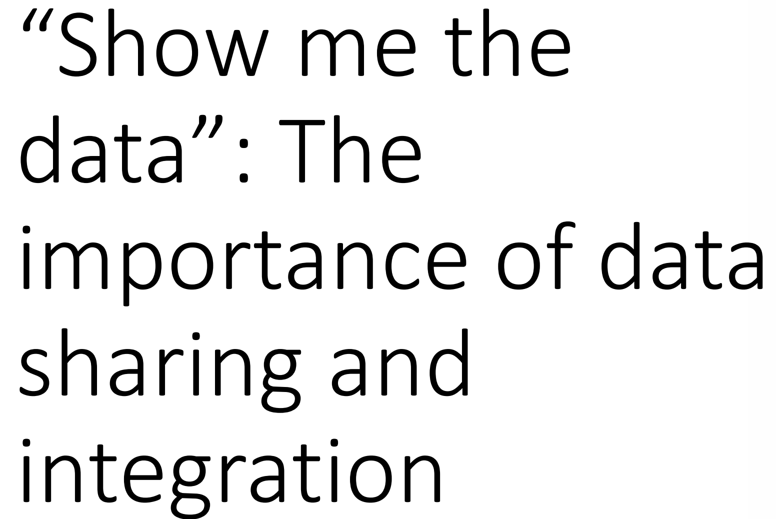
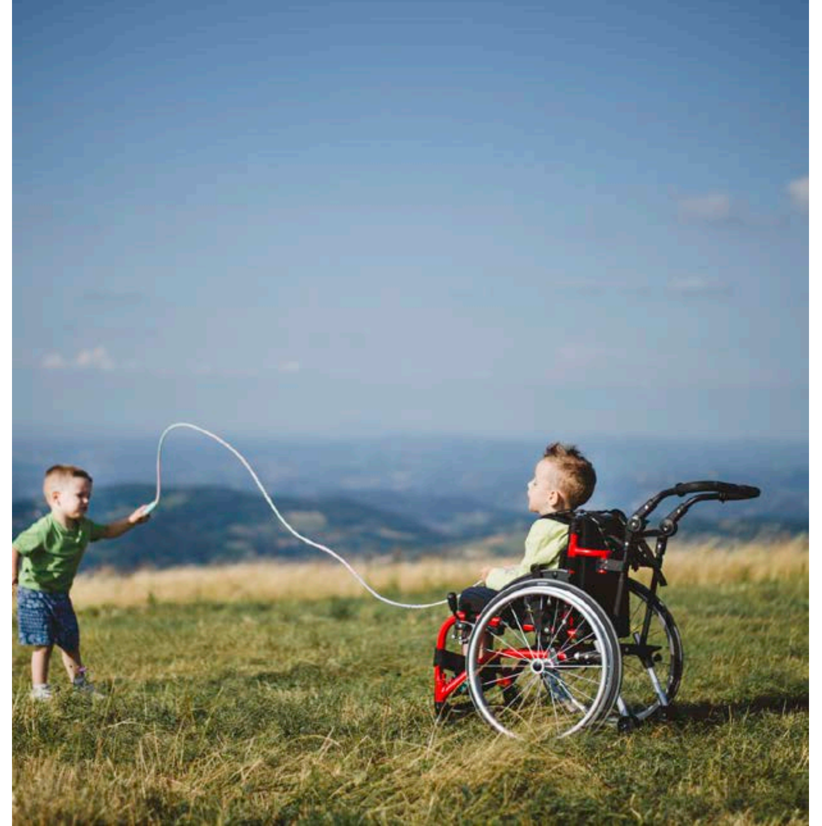


“Show me the data”: The importance of data sharing and integration

Walid Jammal

Lumos Symposium

July 2022



Meet May, Elvirio, and Jack

What do they expect?

Value:

Value has different definitions in different context:

- **Policy makers and health economists**
- **Front line clinicians and health workers**
- **Patients and their families**

Links to the quadruple aim

$$\text{Value} = \frac{\text{Quality (Tq \& Sq \&Sa)}}{\text{Cost}}$$

A shared dream

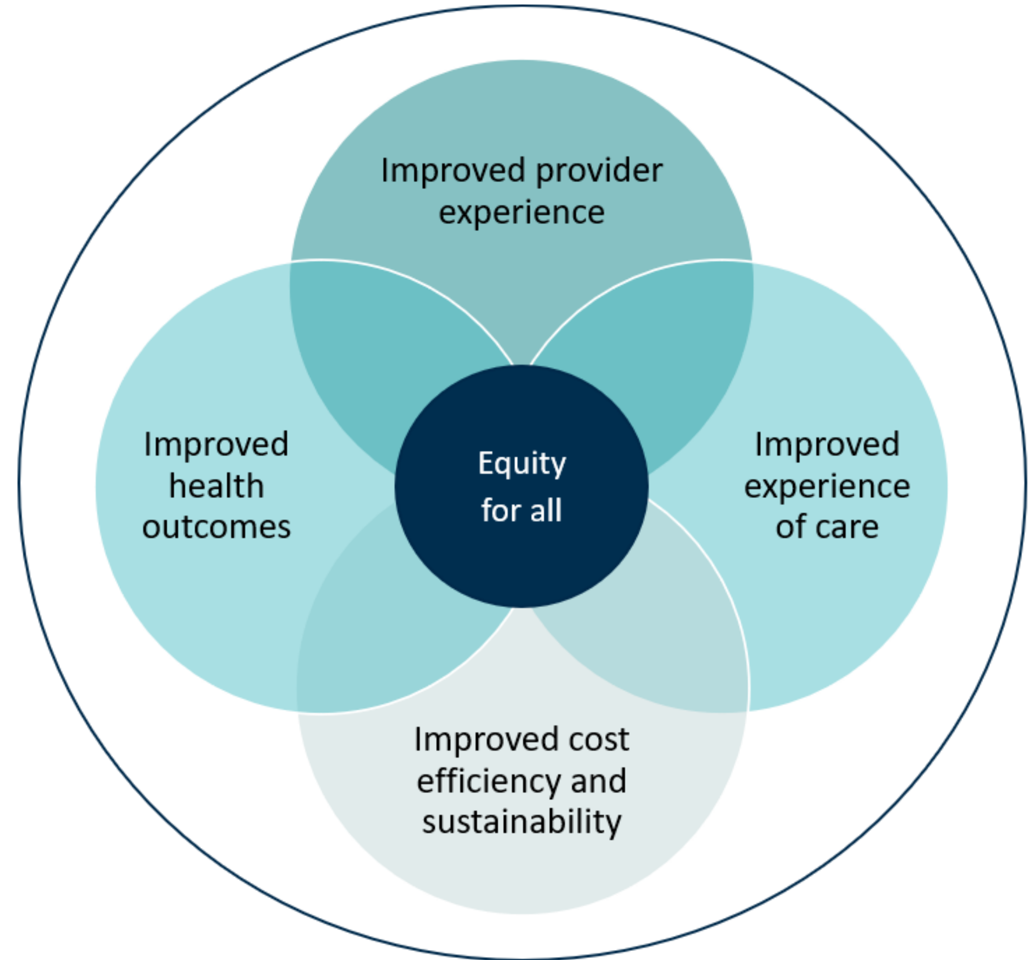
- **Improved access:** “Health care team, be there when I need you”
- **Accountability;** "Take responsibility for making sure we receive the best possible health care"
- **Comprehensive:** “Provide or help us get the health care, information and services we need”
- **Continuous:** “Be our partner in time in caring for us”
- **Co-ordinated and integrated:** “Help us navigate the health care system to get the care we need in a safe and timely way”
- **Patient Centred:** “Recognise that we are the most important part of the care team, and that we are ultimately responsible for our overall health and wellness”
- *Implementation of Oregon’s PCPCH Program: Exemplary Practice and Program Findings. Final Report, September 2016*

- My health care team listens to and understands what matters to me, develops a care plan in collaboration with me and my family and carers, and supports me to live the life I want to the best of my ability
- I access my chosen primary health care service and its multidisciplinary team acts in a coordinated manner to provide care, treatment and service coordination with others involved in my care
- My primary health care service recognises that factors other than health care plays a role in my health and wellbeing and takes that into account in my care plan
- I am shown how to use new kinds of services and I am supported to use them until I am confident
- My treatment journey records (e-records) are available for my care team to access with my consent so that I don’t have to repeat my whole story every time
- I am able to use video-teleconferencing when face to face care is not essential and I am supported by remote monitoring that is relevant to my health care
- I don’t have to avoid or put off care because of cost
- I plan my care with people who work together to understand me and my priorities, who respect my choices and bring together services to achieve outcomes important to me
- I am asked about my experience of the services I use and feel confident that this feedback is used to improve services for me and others
- I trust that I am in good hands and receiving the best care possible (quality, safety, best evidence)
- I am supported to understand my physical and mental health challenges and to set and achieve goals
- I am supported to manage my wellbeing and health care at home as much as possible
- When I use a new service or move between services and settings, there is a seamless handover and a plan in place for what happens next
- I am not disadvantaged, and I don’t miss out on services because of where I live, my diverse background or my lived experience

Primary Health Reform Steering Group Recommendations September 2021.pdf

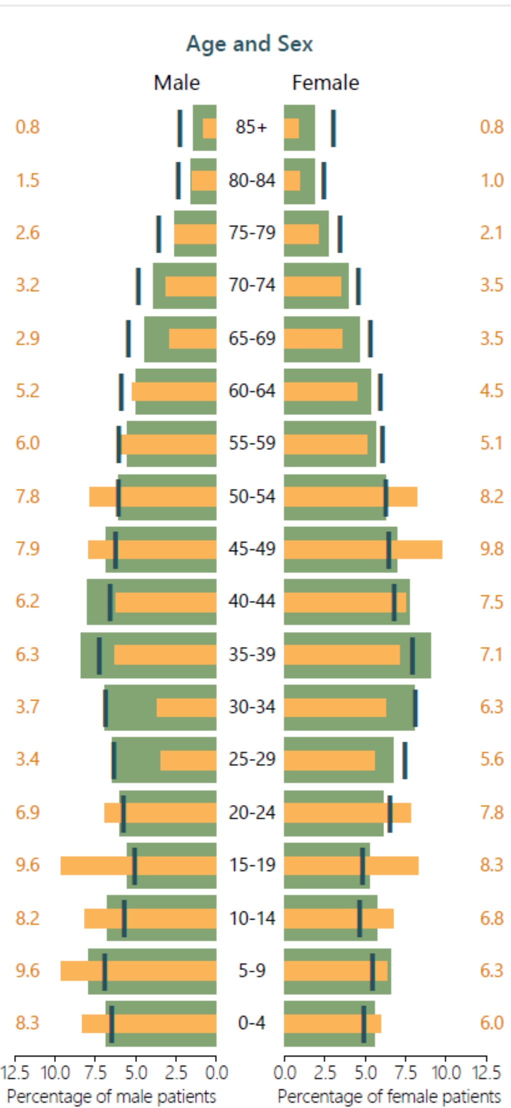
From the Quadruple aim to the Quintuple Aim

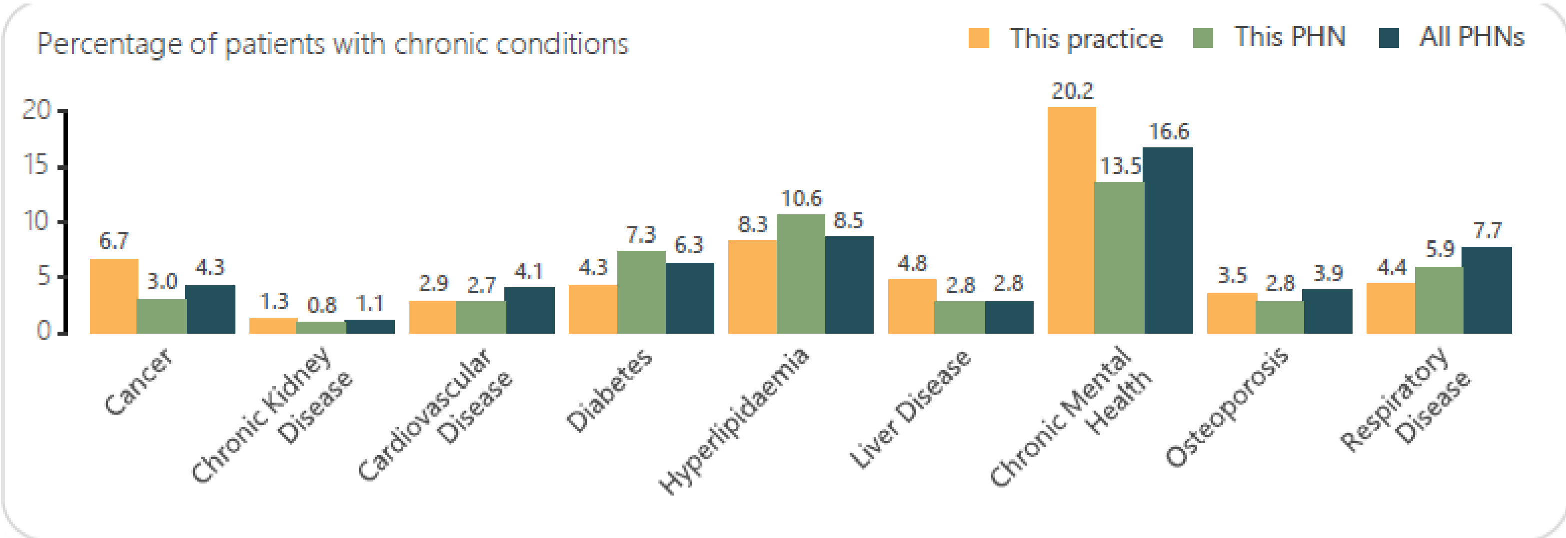
- Mate K. On the Quintuple Aim: Why Expand Beyond the Triple Aim. Institute for Healthcare Improvement. 4 Feb 2022. Available at: http://www.ihi.org/communities/blogs/on-the-quintuple-aim-why-expand-beyond-the-triple-aim?utm_source=IHI_Homepage&utm_medium=Rotating_Feature



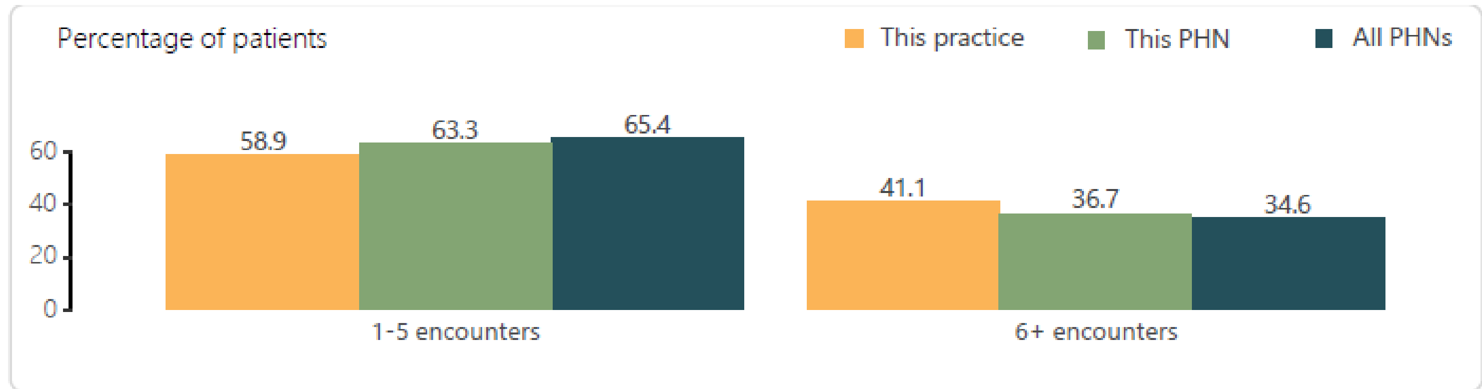
Lumos: Leveraging intrinsic motivations

Lumos –good for understanding your "market"

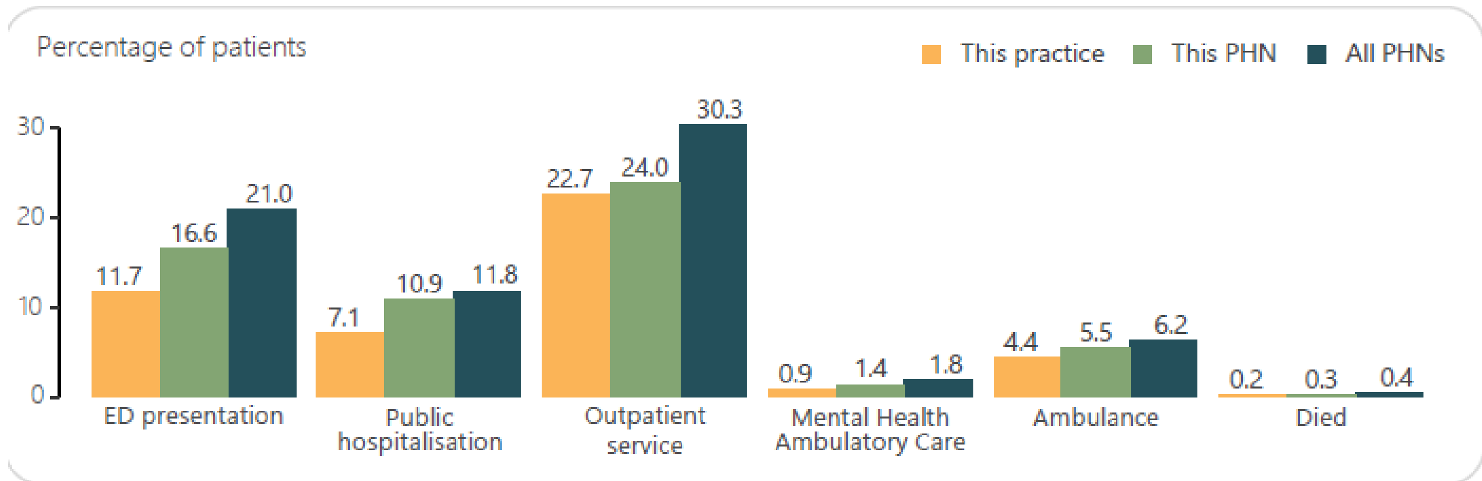




Lumos: good for showing "your value"



GP encounters are defined as doctor or nurse encounters.



Note that some patients have used multiple health services, and therefore the percentages may sum to over 100%.

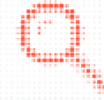
Lumos: shining the light on "shared savings"

General practice activity can affect hospital visits

Practices that saw their patients with higher frequency* were associated with patients having:

- **10% fewer ED presentations**
- **12% fewer unplanned hospitalisations**

than practices with lower overall patient visit rates.



- This was observed in both patients who attended the practice frequently and those who attended less often.

Practice characteristics

Practices that saw patients more often tended to be:

- located outside of major cities
- smaller (patient population)

Patient characteristics

Patients managed by higher frequency practices tended to be:

- older
- from a disadvantaged area
- more likely to have a chronic condition

***Higher frequency** = practices where >30% of patients visited at least 12 times in 2 years.

hills FamilyGP

Lumos: good for QI

The correct identification of patients with renal disease is important because:
- correct identification also affects the management of comorbid illnesses
-affects the use of medications
- impacts on preventative activities we take for patients

What is the problem we are trying to solve?
There are 146 ACTIVE patients who otentially have renal disease incorrectly coded

What is our Aim?
We want to correctly CODE the patients flagged as potentially having renal disease in PENCAT on June 2019 by October 2019.

How will we know a change is an improvement?
We will measure this number on a run chart every 2 weeks

Renal Disease at Hills Family General Practice

Change ideas Do Study Act

Plan	Do	Study	Act
13th June Tim and Kylie to examine the first 5 patient to gain a better understanding	Looked at the first 5 patients	2 out of the 5 patients did not have renal disease	Review next 10 patients
Tim and Kylie to review the next 10 people on the Pencat list	look at the last 3 GFR – and if positive for 2 out of three for CKD stage 3 – meet with 4 doctors to correctly code	Doctors agreed that it was helpful and they correctly identified the patients	Stage 3 kidney disease can be correctly coded by clinical pharmacist and nurse in practice And can be rolled out
Tim and Kylie to review the next 10 people on the pencat list –	look at the last 3 GFR – and if positive for 2 out of three for CKD stage 2 – meet with doctors and do a urine acr and contact patients	This led to some discussion around significance of coding these patients, but consensus was to code patients showing eGFR between 60 and 90ml/min AND elevate UACR for 3 months or more	Stage 2 kidney disease can be correctly coded by clinical pharmacist and nurse in practice, or actions could be added to BP to prompt doctors to follow up on equivocal or incomplete data.
Tim and Kylie to review the next 10 people on the pencat list –	look at the last 3 GFR – and if positive for 2 out of three for CKD stage 1 – meet with doctors and do a urine acr and contact patients	Tim and Kylie discussed with several GPs and it was decided that coding patients showing eGFR between > 90ml/min AND elevate UACR for 3 months or more was beneficial and could be done.	Stage 1 kidney disease can be correctly coded by clinical pharmacist and nurse in practice, or actions could be added to BP to prompt doctors to follow up on equivocal or incomplete data.

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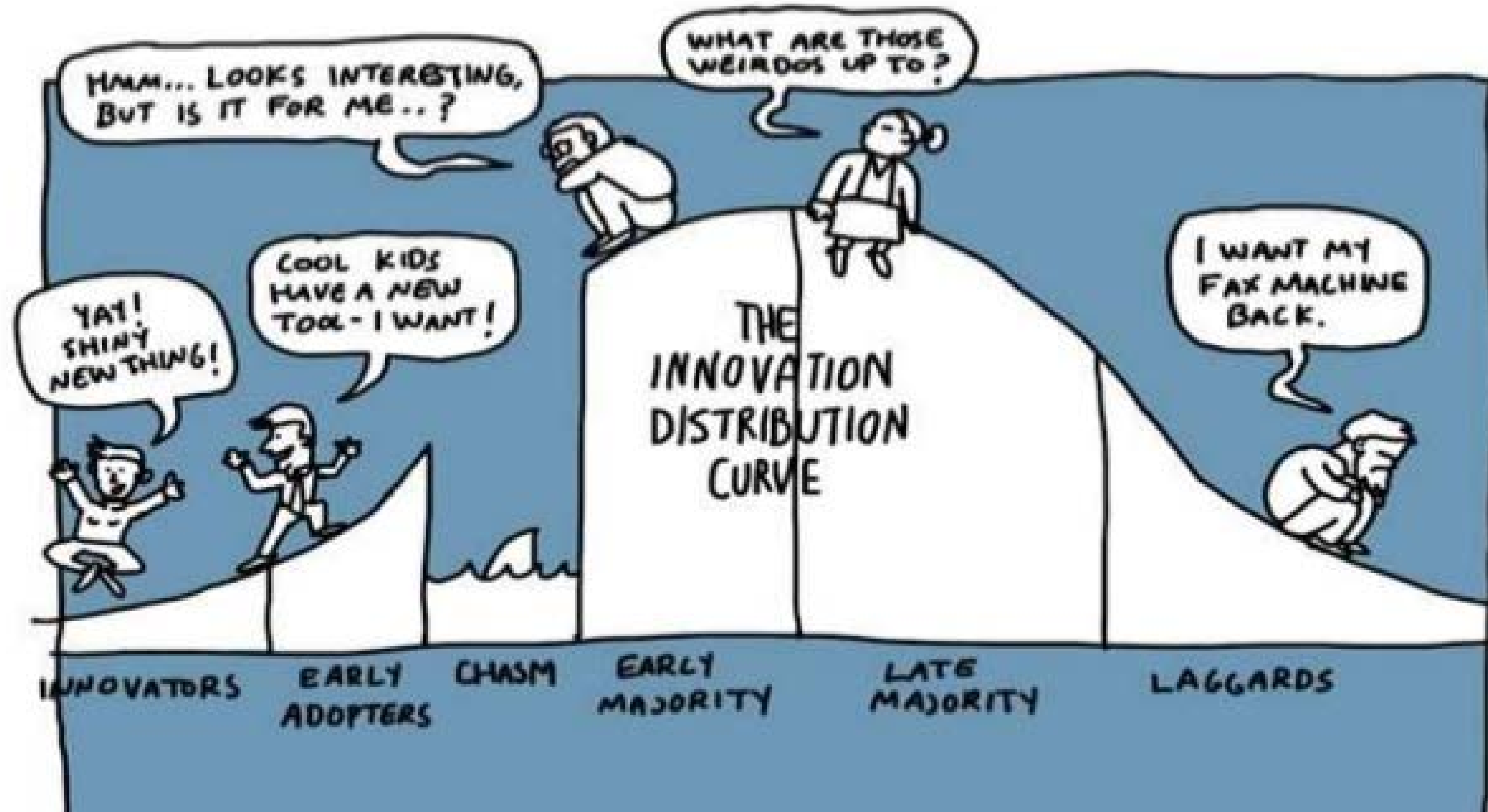
Beware the chasm!



Thank you