



Better Practice Management



October 2008

Workshop using Pen Clinical Audit Tool and analysing MBS item number usage



Acknowledgments:

This workbook has been produced by Noel Stewart and Janina De Silva for the North East Valley Division of General Practice as part of a workshop designed for practice managers and, practice nurses of the North East Valley Division of General Practice.

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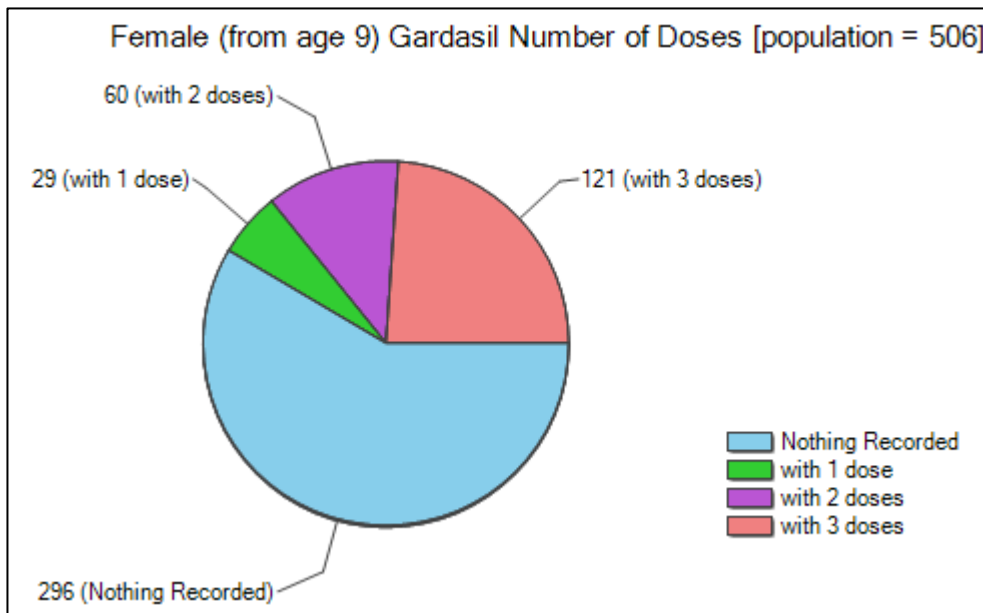


Clinical Audit New Features September 2008

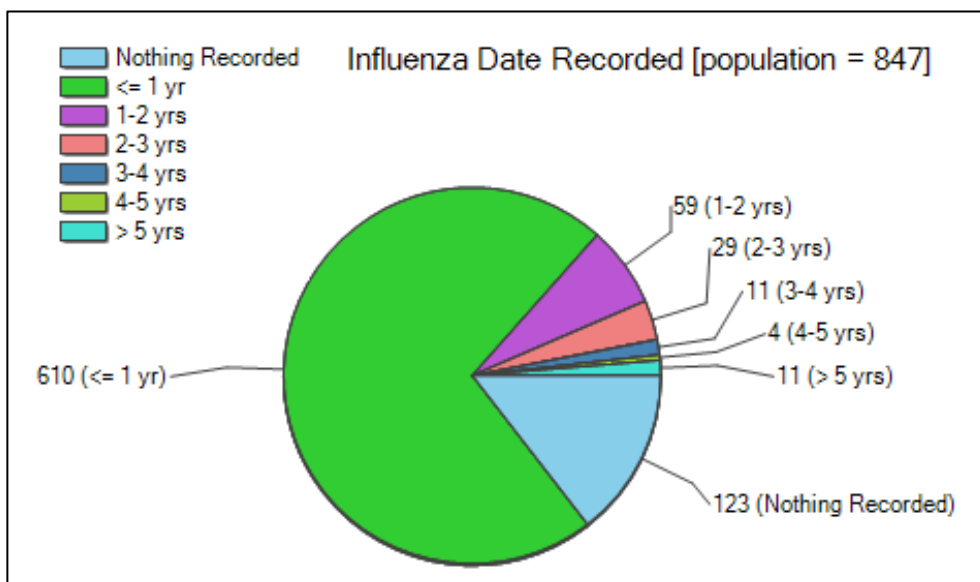
The September 2008 version of CAT includes 3 new features, adding to the June feature which allowed clinical analysis by individual doctor.

1. New Immunisation Tab - reports for Influenza, Pneumococcal, HPV (Gardasil) and Pertussis.

Gardasil – this provides graphs on which patients have had 0, 1, 2 or 3 injections – this makes it easy to recall those patients who have not completed the course of 3 injections.



Influenza, Pneumococcal - display the most recent date the patient had the immunisation and the report can identify which patients have not yet been immunised.



Pertussis – works the same way as Influenza and Pneumococcal above.

2. Summary Report - this report provides an instant snapshot of practice data quality across most of the graphs provided. This means the user doesn't have to go to each tab and write the figures down. The report can be exported to Excel so the user can create a month by month set of figures if they choose. The user can also use the filters to target specific populations.

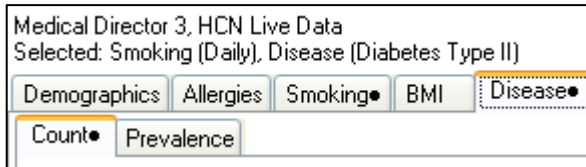
CAT Summary Report Card		Report Date: 3/9/2008 11:33		
Filtering By: Age >= 75				
* Active = 3 visits in last 2 years				
Measure	Total Population		Active Population *	
	Count	%	Count	%
Demographics				
Total Population	847		783	
Date of Birth Not Recorded	0	0.00 %	0	0.00 %
Gender Not Recorded	0	0.00 %	0	0.00 %
ATSI Recorded	0	0.00 %	0	0.00 %
DVA Recorded	164	19.36 %	152	19.41 %
Allergies				
Nothing Recorded	43	5.08 %	16	2.04 %
Smoking				
10+ and Nothing Recorded	83	9.80 %	42	5.36 %
Height and Weight Measures				
Height Only Not Recorded	104	12.28 %	103	13.15 %
Weight Only Not Recorded	1	0.12 %	1	0.13 %
Neither Height or Weight Recorded	385	45.45 %	324	41.38 %
BMI's Completed (Both Recorded)	357	42.15 %	355	45.34 %
Conditions				
Undefined Diabetes	2	0.24 %	2	0.26 %
Pregnancies Currently Open	0	0.00 %	0	0.00 %
HMR				
Patients with >= 5 medications	685	80.87 %	653	83.40 %
Pap Smear Population				
Eligible Females aged 18-70	0		0	
Pap Smear Not Recorded	0	0.00 %	0	0.00 %
Pap Smear Date > 4 years ago	0	0.00 %	0	0.00 %
Pap Smear Date 3-4 years ago	0	0.00 %	0	0.00 %
Pap Smear Date 2-3 years ago	0	0.00 %	0	0.00 %

At Risk Population = Diabetes / CVD / 45-59 **				
Total At Risk Population	355		343	
Lipids for At Risk				
(Diabetes/CVD/45-49)				
Cholesterol Not Recorded	104	29.30 %	93	27.11 %
HDL Not Recorded	179	50.42 %	168	48.98 %
LDL Not Recorded	255	71.83 %	243	70.85 %
Triglycerides Not Recorded	104	29.30 %	46	27.11 %
Creatinine for At Risk				
(Diabetes/CVD/45-49)				
Creatinine Not Recorded	35	9.86 %	25	7.29 %
Microalbumin Not Recorded	306	86.20 %	294	85.71 %
18 and Over Population				
Total 18+ Population	847		783	
BP (18 and over)				
18+ and BP Not Recorded	114	13.46 %	67	8.56 %
Diabetes Population				
Total Diabetes Population	145		141	
HbA1c (Diabetes only)				
Diabetes and HbA1c Not Recorded	11	7.59 %	8	5.67 %
Diabetes SIP (Diabetes only)				
HbA1c > 12 mths or Not Recorded	39	26.90 %	36	25.53 %
Eye Exam > 24 mths or Not Recorded	110	75.86 %	106	75.18 %
BMI > 6 mths or Not Recorded	112	77.24 %	108	76.60 %
BP > 6 mths or Not Recorded	35	24.14 %	32	47.52 %
Foot Exam > 6 mths or Not Recorded	137	94.48 %	133	94.33 %
Cholesterol > 12 mths or Not Recorded	48	33.10 %	45	65.96 %
Triglycerides > 12 mths or Not Recorded	49	33.79 %	46	32.62 %
HDL > 12 mths or Not Recorded	72	49.66 %	69	48.94 %
Microalbuminuria > 12 mths or Not Recorded	118	81.38 %	114	80.85 %
Smoking Not Recorded	9	6.21 %	5	3.55 %

3. Cross-Tabulation – this is very exciting!!! A cross tabulation report will provide the ability to find patients who appear on more than one graph - this will assist with the identification of target population risk groups.

For example: Create a list of diabetes Type II patients that are daily smokers and overweight or obese.

- a. Click on the **Smoking** tab and select: **Daily smoker** from the pie chart
- b. Click on the **Disease** tab and select **Diabetes Type II** from the bar chart – you will notice how the tabs are marked with a dot.



- c. Click on the **BMI** tab and select the overweight, obese and morbidly obese chart legends
- d. Click on the **Report** button (this is new – found near top left of screen) – this will list the patients that fit the criteria.
- e. Add additional criteria if you wish, such as high blood pressure.
- f. Print or save the report.

To clear the report:

Simply click on the **Clear Filters** button (top right of screen).



Ensure there is a tick in the **Clear all Report Selections** and then press **OK**.

PEN Clinical Audit Tool

CASE STUDY 1 – Analysing by individual doctor

Total population = 51,675
 Active population = 7,104 (seen 3 times in last 2 years)

	GP1	GP2	GP3
1. Allergy Recorded			
<u>Active population</u>			
Allergy recorded	18.2%	13%	5%
No Known Allergy recorded	74.4%	52%	0%
Nothing recorded	7.4%	35%	95%
2. Smoking – nothing recorded			
<u>Active population over 16</u> (Active (3x > 2 years))	17.8%	44.2%	95%
3. Diabetes Prevalence			
<u>Active population</u> (Active (3x > 2 years))			
Diabetes Type II	6.1%	3.4%	0.2%
Diabetes Type I	0.3%	0.2%	0%
Undefined diabetic	0.1%	0.1%	3.6%

Questions for small group discussion:

Allergies and smoking

- How would you categorise each of the 3 doctors, as far as their electronic record keeping?
 GP1 -
 GP2 -
 GP3 -
- Can you see any similarities with GP1, GP2 or GP3 with doctors at your practice? (No names please).
- What strategies would you put in place to improve the recording of allergy and smoking status? Team meeting? Discussion with individual GPs? Do you feel confident in bringing this up at a team meeting?

Diabetes

- Discuss the varying % figures. What's wrong with having "undefined diabetic"? Why is it recorded as "undefined diabetic"? How would you re-categorise the undefined diabetic?

PEN Clinical Audit Tool

CASE STUDY 2 – Four extracts from a practice

1. Allergy Recorded	October 2007	March 3 2008	April 21 2008	August 26 2008
<u>Total population</u>	7127	6993	8019	7138
Nothing recorded	22.6%	21.8%	23.3%	11.1%
<u>Active population</u>	5439	5530	5558	5086
Nothing recorded	15.5%	8.7%	7.6%	4%
2. Gender not recorded				
<u>Total population</u>	84	0	0	0
<u>Active population</u>	26	0	0	0
3. Smoking – nothing recorded				
<u>Active population over 16 (Active (3x > 2 years))</u>	33.8%	17.4%	14.2%	8.4%
4. Recording of ATSI patients				
<u>Total population</u>	3	3	3	3
<u>Active population</u>	2	3	3	3
5. Diabetes Prevalence				
<u>Total population</u>	4.5%	4.8%	4.0%	4.0%
<u>Active population</u>	5.8%	6.0%	5.6%	5.7%
<u>Undefined diabetic (active)</u>	1.3%	0.9%	0.3%	0.1%

Questions:

1. In what areas do you see the quality improvements in the data?
 Allergies:
 Gender not recorded:
 Smoking:
 ATSI:
 Diabetes prevalence:
2. Look at the October 2007 column – what measures would you have put in place to improve the figures?
3. Now look at all 4 columns. How do you think this quality improvement was achieved?
4. How would you share the success with staff and clinicians?

CASE STUDY 3 – Composite Report using Clinical Audit

Total population = all patients

Active population = seen 3 times in last 2 years

1. Allergy Recorded	Practice 1	Practice 2	Practice 3	Practice 4	Practice 5	Practice 6	Practice 7	Practice 8	Your Practice
<u>Total population</u>	8347	2534	11159	7127	7902	6829	9446	13761	22739
Allergy recorded	8.0%	22.2%	8.9%	20.6%	5.8%	18.6%	14%	18.2%	12.3%
No Known Allergy recorded	32.1%	71.3%	26.0%	56.9%	24.6%	63%	58.1%	42%	49.0%
Nothing recorded	59.9%	6.5%	65.1%	22.6%	69.5%	8.4%	27.2%	39.7%	38.8%
<u>Active population</u>	2815	1881	4106	5439	1952	4090	3893	8083	9213
Allergy recorded	17.6%	27.2%	17.6%	24.2%	17.9%	24.7%	25.9%	25.4%	20.9%
No Known Allergy recorded	64.2%	72.2%	51.9%	60.3%	69.9%	70.8%	74.3%	57.3%	75.8%
Nothing recorded	18.3%	0.6%	30.4%	15.5%	12.2%	4.4%	3.8%	17.4%	3.2%
2. Gender not recorded									
<u>Total population</u>	37	1	78	84	1011	164	583	306	3175
<u>Active population</u>	0	1	0	26	6	4	66	5	37
3. Smoking – nothing recorded									
<u>Total population</u>	71%	12.5%	92.4%	42.8%	78.7%	70%	38.7%	82%	58.9%
<u>Active population</u> (Active (3x > 2 years))	37.6%	4.0%	84.4%	37%	30.4%	22.9%	17.1%	81%	26.5%
<u>Active population over 16</u> (Active (3x > 2 years))	26.0%	1.1%	82.4%	33.8%	19.0%	9.1%	4.6%	18.2%	10.4%
4. Recording of ATSI patients									
<u>Total population</u>	?	0	0	3	3	3	2	7	2
<u>Active population</u> (Active (3x > 2 years))	5	0	0	2	0	3	2	6	2
5. Diabetes Prevalence									
<u>Total population</u>	3.2%	17.5%	1.1%	4.5%	2.24%	2.86%	1.8%	17.58%	2.4%
<u>Active population</u> (Active (3x > 2 years))	6.8%	22.8%	3.0%	5.8%	7.22%	2.2%	3.8%	29.32	5.3%
<u>% Diabetes in postcode area</u>	5.6%	5.6%	5.7%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%

PEN Clinical Audit Tool

Case Study 3 - Composite report of 9 practices

Questions:

Allergies

1. Which practice has a good set of figures? Based on what criteria?
2. How would you get Practices 1, 3, 5 and 9 to improve the recording of “allergy status”?

Gender

What do we do to ensure all patients have their gender recorded?

Smoking

Practice 3 has no recording of smoking status of 82.4% of active patients over 16. Why do you think this is so? How would you redress this situation?

ATSI patients and Diabetes Prevalence

All practices have under recorded the number of ATSI patients and diabetes prevalence. How would you redress this situation?

“Hands-on” session - suggested activities using CAT

Understand your practice population. What is the disease prevalence in the practice population?

Understand the “skill” or “interest” mix of your GPs and nurses. For example, target a specific area such as diabetes and do it well. Build up your skill areas and later, move to another area.

Diabetes

1. Finding patients “at risk” of developing diabetes – Conditions: diabetes No, Medications: antidiabetic agents No, Conditions: Cardiovascular – Hypertension, BMI: overweight to morbidly obese. (Add age ranges 40-40 for item 713 – referral to a Lifestyle Modification Program)
2. Managing diabetic patients. Conditions: Diabetes Yes
 - a. How well are my diabetic patients being controlled (HbA1c Tab)
 - b. HbA1c – identify those with no HbA1c recorded
3. Find which of my diabetic patients are hypertensive?
4. Which diabetic patients have depression – can be referred to a mental health nurse.
5. Which patients with CVD and/or Diabetes have BMI’s greater than 30?
6. Identify diabetic patients on 5+ medicines and over 65 – can be referred for a HMR. Do the search by provider to direct the patients to their usual doctor.

Immunisations

1. Gardasil – find those patients who have not completed the 3 injection course. Identify those eligible women who have not commence the course of injections
2. Fluvax – identify those patients who have haven’t had their Fluvax this year

Women’s health

1. Identify female patients over 18 who are eligible for a pap smear. If too many to manage, break up into age groups. Designate a staff member (nurse) to contact patients.

Other

What else?



Analysing item number usage

Information from the North East Valley Division of General Practice website

Business modelling by analysing item number usage

The following Excel spreadsheets allow you to use practice management software (listed above) to analyse item number use. You type in the \$ totals of an item number for a given period (e.g. last 6 months) and the spreadsheet works out the number of claims for that item number. Many thanks to Julian Flint (Western Adelaide GPN), Janina DE Silva (North East Valley DGP) and Graeme Berry (Pivot Western GPN) for the development of these spreadsheets.

- ❖ [Current Item Number Utilisation](#) - **PHA version**. An Excel spreadsheet which allows for the input of MBS item number income and used to prepare the Practice Health Atlas - **New May 2008** (xls)
- ❖ [Current Item Number Utilisation](#) - **not to be used with the PHA**. This version has additional items from the July 2008 new MBS items and can be used for used for business modelling. - **New August 2008** (xls)
- ❖ [Current Item Number Utilisation including nurse item numbers](#) - **not to be used with the PHA**. This version has additional items from the July 2008 new MBS items and can be used for used for business modelling. - **New August 2008** (xls)
- ❖ [Number crunch](#) - a reprint of an article by Noel Stewart from *Australian Doctor* July 18, 2008. This outlines how you can "crunch" and analyse the chronic disease item number usage, helping make better use of patient care planning - **New August 2008** (pdf)

Instructions for extracting MBS Item Number Data for the business modelling component of PHA

Please **Note**: Practice Management software vendors are encouraged to supply a "cheatsheet" on how to extract the item number usage for a given period. Contact Noel Stewart on (03) 9496 4333 for more information.

- | | |
|---|---|
| ➤ Practice 2000 - New August 2008 (pdf) | ➤ Pracsoft - New May 2008 (pdf) |
| ➤ ZedMed - New May 2008 (Word) | ➤ No front desk software - provided by the Practice Health Atlas team at Adelaide West GP Network. New May 2008 (Word) |
| ➤ Genie - thanks to Dr Lindsey Hyde - New August 2008 (Word) | ➤ MediFlex coming soon - New |



Analysing item number usage

Case Study 1 – Item number usage

The table below shows us an example of a completed “*Current Number Utilisation*” Excel spreadsheet. From a business modelling perspective the figures provide a few interesting discussion points.

Item	Description	No. of claims	\$ Amount received
700	Annual Health Assessment 75 years and over - in consulting room	48	8,238.80
702	Annual Health Assessment 75 years and over - not at consulting room, hospital or Residential Aged Care Facility	0	
710	Aboriginal & Torres Strait Islander Health Check (15 - 55 years)	0	
712	Residential Aged Care Comprehensive Medical Assessment (CMA)	11	2,136.15
717	45 Year Old Health check	2	200.00
721	Preparation of a GP Management Plan by a GP (including on discharge for private patients)	468	59,797.00
723	Coordination of Team Care Arrangements by a GP (including on discharge for private patients)	319	32,248.95
725	Review of a GP Management Plan by a GP	4	255.40
727	Coordination of a review of Team Care Arrangements by a GP	2	127.70
731	Contribution to Multi-disciplinary care plan in Residential Aged Care Facility	4	254.80
734	Organise and Coordinate a Case Conference in a Residential Facility	0	
900	Domiciliary Medication Management Review (DMMR)	1	134.10
903	Residential Medication Management Review (RMMR)	0	
2517-2526, 2620-2635	Subgroup 2: Diabetes Mellitus Annual cycle of care	98	3,207.05
2546-2559, 2664-2677	Subgroup 3: Asthma Cycle of Care	0	
11506	Spirometry	3	63.00
2710	Preparation of a GP Mental Health Care Plan	213	32,577.60
2712	GP Mental Health Care Plan Review	49	5,036.60
2713	GP Mental Health Consultation	1	91.00
Total			144,368.15

Questions for small group discussion:

Points to consider

Where are the gaps? What is not being claimed? What would you do, as a practice manager or nurse, to increase the uptake of certain item numbers? Would you feel confident in discussing these issues with a team meeting of clinicians?

Case Study 2 - Current Item Number utilisation (including Practice Nurse Numbers)

Item	Description	No. of claims	\$ Amount received
700	Annual Health Assessment 75 years and over - in consulting room		
702	Annual Health Assessment 75 years and over - not at consulting room, hospital or Residential Aged Care Facility		
709	Healthy Kids Check - 4 year old health check by a GP		
710	Aboriginal & Torres Strait Islander Health Check (15 - 55 years)		
711	Healthy Kids Check - 4 year old health check by a practice nurse		
712	Residential Aged Care Comprehensive Medical Assessment (CMA)		
717	45 Year Old Health check		
721	<i>Preparation of a GP Management Plan by a GP (including on discharge for private patients)</i>		
723	<i>Coordination of Team Care Arrangements by a GP (including on discharge for private patients)</i>		
725	<i>Review of a GP Management Plan by a GP</i>		
727	<i>Coordination of a review of Team Care Arrangements by a GP</i>		
731	Contribution to Multi-disciplinary care plan in Residential Aged Care Facility		
734	Organise and Coordinate a Case Conference in a Residential Facility		
900	Domiciliary Medication Management Review (DMMR)		
903	Residential Medication Management Review (RMMR)		
2517-2526, 2620-2635	Subgroup 2: Diabetes Mellitus Annual cycle of care		
2546-2559, 2664-2677	Subgroup 3: Asthma Cycle of Care		
11506	Spirometry		
2710	Preparation of a GP Mental Health Care Plan		
2712	GP Mental Health Care Plan Review		
2713	GP Mental Health Consultation		
714	Health Assessment for Refugee (Clinic)		
716	Health Assessment for Refugee (Home)		
10993	Immunisation provided by a PN		
10996	Wound care provided by a PN		
10994	Cervical Screen and preventative health check by a PN		
10995	Cervical Screen and preventative health check by a PN (4 years plus)		
10998	Cervical Screen only preformed by a PN		
10999	Cervical Screen only preformed by a PN (4 years plus)		
Total			\$

Questions for small group discussion:

Points to consider

Understand your practice population. What is the disease prevalence in the practice population?

Understand the “skill” or “interest” mix of your GPs, nurses and allied health. For example, target a specific area such as diabetes and do it well. Build up your skill areas and later, move to another area.

1. The above table provides an opportunity to measure previous activities in all areas that relate to GP/PNs or PN specific (retrospective and current), on a monthly basis.
2. Disease specific and agreed patient contact targets are easily measured and communicated to the practice team. For example, you may wish to restructure clinical and administrative roles and responsibilities within the practice. This could involve upskilling (from improved entry or pap smear accreditation).
3. Workforce expansion and required skill mix of clinical staff are easily identified through measurable activities. Provides evidence for business cases to expand the PN team.
4. Provides the PNs with a greater understanding of the practices business modelling and financial targets.
5. Provides an opportunity for the PN to measure and celebrate their contributions to clinical care, focussing on preventative and health promotion activities.
6. The business modelling should also include a review process – what has worked well, what hasn't how could we do things differently. For example increasing the number of 45 health checks hasn't worked. How would you do it differently?
7. Business modelling can help form partnerships. For example, the practice does not have the capacity to handle mental health issues (space limitations, skill set). Utilise the local area mental health team, a mental health nurse (Janine at the division).

Think → Plan → Do → Review

Remember

No two practices are the same, networking and listening provides an opportunity for reflection and to question. If the idea or implementation does not fit your situation, simply modify it to what is achievable. You may still be able to utilise the methodology in other areas. Don't be daunted or overwhelmed.

Change happens slowly.

Success is easier if you tackle change through smaller and achievable tasks.

My Work Plan

At the completion of this workshop your job is to document what you intend to do back at your work location and how you are going to follow it up. The tasks that you document here could range from the very simple to the complexities of thorough data cleansing or setting up management systems.

What I plan to do tomorrow/next week

Priority Order	Task	How am I going to do it
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		

What I plan to in the next few weeks/months

Priority Order	Task	How am I going to do it
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		

Some suggested activities

Clinical Audit Tool

- Arrange installation of CAT and start using it
- Spend more time on using the CAT
- Educate doctors on using the CAT
- Encourage the GPs to attend the CAT “hands-on” training session on November 20
- Install CAT on several PCs and create a folder on the server for the storage of extracts.
- Target patients that would benefit from a HMR.
- Target patients that would benefit from an item 717
- Utilise the recall system so that GPMP and TCA reviews take place
- Organise a practice visit from Noel and/or Janina to demonstrate the power of the CAT and business modelling
- Buy Noel a bottle of wine, preferably a New Zealand Sauvignon Blanc (Oyster Bay comes to mind)

Item Number Usage

- Download the Excel spreadsheet from NEV division website
- Download the Practice Management software instructions for item number report
- Fill out the spreadsheet for last 6 months and present to a team meeting.

Data cleansing

- Identify patients not seen in last 3 years and make them inactive
- Opportunistically correct inaccurate diagnoses and histories in clinical software
- Check all patients have their gender correctly recorded
- Download “data cleansing” checklist from NEV website
- Obtain 28 page book “Clean up your act” available from NEVDGP

Education

- Make sure that all clinicians understand 100% how to record accurate histories/summaries and “reason for contact” in progress notes
- Start a process so that all patients have their smoking and/or allergy status recorded
- Start a process so that all clinical staff know how to correctly fill in history items and reason for contact

Follow-up support/practice visits/training are available from the division.
Simply call Janina and/or Noel on (03) 9496 433

Appendix - PEN CAT Testimonials

Hi Noel,

Just wanted to thank you so much for the PEN analysis you recently provided. I can't tell you just how helpful this information is, not to mention how useful it is to the practice re accreditation. The de-identified comparisons with other clinics in the area is phenomenal! It really helps us identify where our weakness are; sometimes I feel like our efforts are aimless – well, not anymore! Can't wait to play around with it more.

If it's OK with you, I would like to be trained in using such data and related tools in MD to continue to improve our data and services to patients.

Denise
Practice Manager

Hi Noel,

Well we had our Accreditation visit today and thankfully all went exceptionally well, no extra work. YIPPY.

Just wanted to say thanks for the PEN audit tool. Did you know we have gone from 17.4% unrecorded allergies now to 6.0% and our smoking from 18.2% to 8.4%. It's good to be able to see the results from effort.

I will send you the new doctor update soon but I am a little over paperwork and I am going home early today for a good stiff drink.

Cheers
Dianne
Practice Manager

Hi Noel

Thank-you so much for introducing the PEN Clinical Audit Tool to us – it has been fantastic. Initially we used it to help “data cleanse” our clinical records, particularly with allergy and smoking status. We found that the presentation you gave on the use of the Pen Clinical Audit Tool for the care of our diabetic patients was also of great value as it fitted in with our emphasis on preventative medicine.

We now intend to analyse the clinical data by individual doctor and we will use the information as the basis for our next team meeting.

Colleen
Practice Manager