Needs assessments, resource allocation, commissioning and outcome monitoring - bringing data together, but does it fit?

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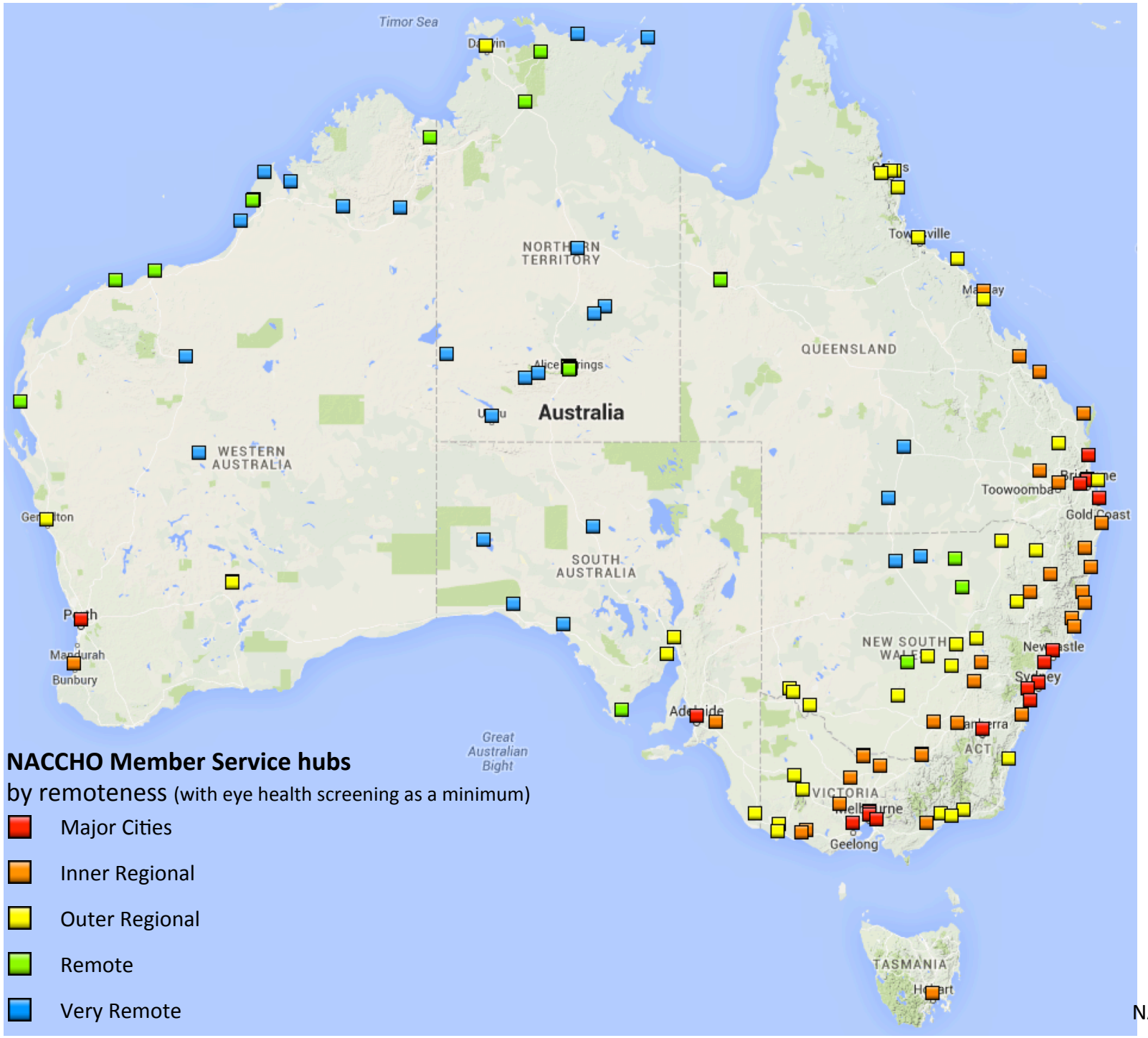
Bringing data together

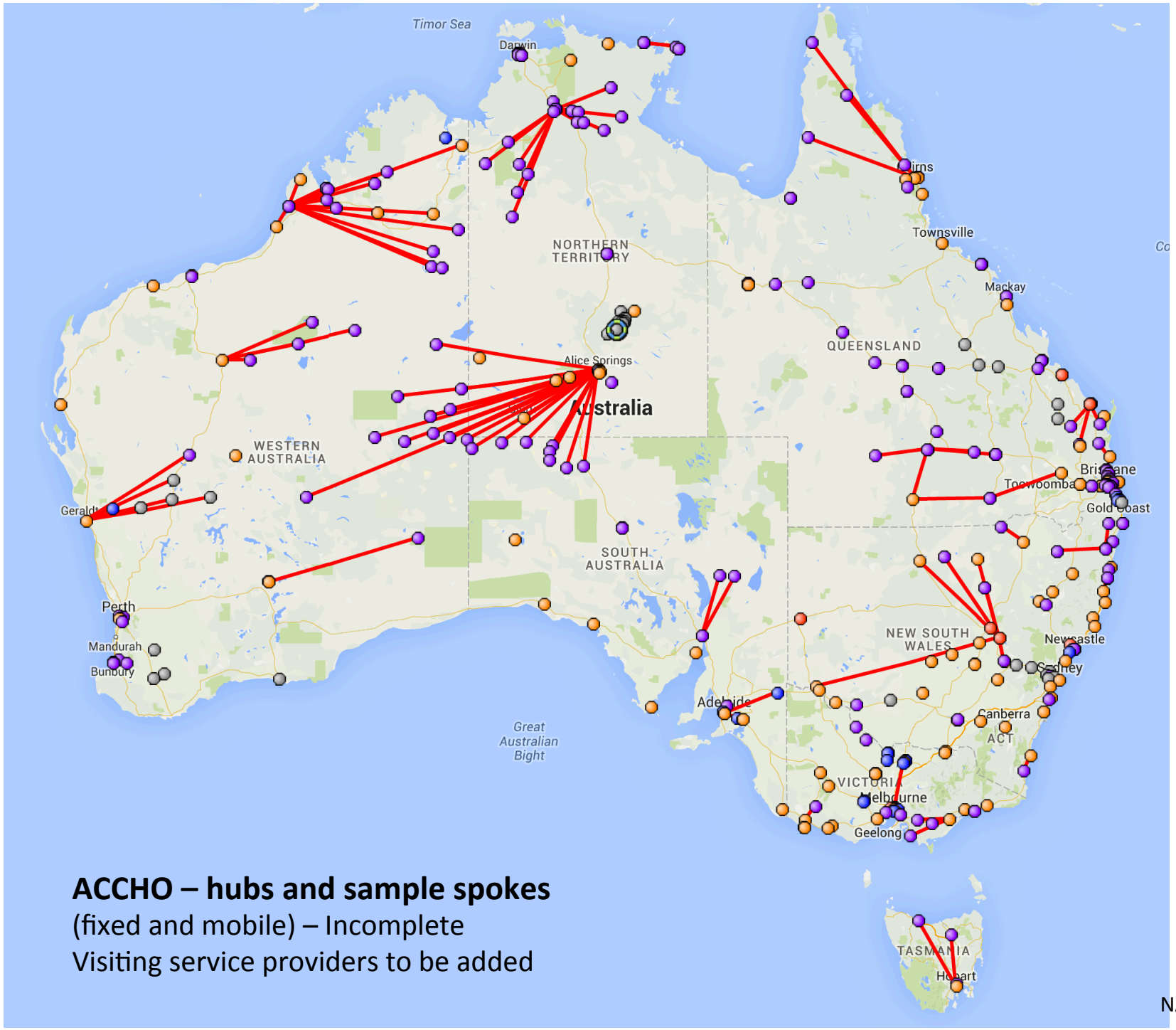
- Data collation and analysis is required to develop the evidence bases necessary to budget, allocate resources, justify our existence and compete for funding whether we are working as
  - Board Members
  - CEOs
  - Policy advisors
  - Planners
  - Business developers
  - Funds holders
  - Funding recipients
  - Managers and/or
  - Researchers

Dimensioning data Management in the ACCHO Sector − the specialised health sector for Aboriginal and Torres Strait Islander Peoples.

- There are 142 organisations delivering CPHC services through over 300 outlets across the country
- There are over 350,000 patients receiving over 3 million episodes of care with interventions by multiple providers for each episode of care
- Where there is access to an within a 30 minute drive time of an ACCHO utilisation rates vary from about 30% in metropolitan areas to over 300% in remote and very remote areas i.e. people travel further, attend multiple service locations and/or there is an under-estimate of the population
- A few regional ACCHOs have over 50% non-Aboriginal patients because of accessibility, bulk billing and quality and comprehensiveness of services available
- Some regions e.g. the Kimberley and south east Queensland have web-based single clinical and allied health records for each patient that, with patient consent, are shared across all providers. These unique records provide high quality demographic, population health, epidemiological and outcome data
- Distribution of Services and some of the outlets are as follows:


Timor Sea
NORTHERN TERRITORY
QUEENSLAND
Australia
WESTERN AUSTRALIA
SOUTH AUSTRALIA
NEW SOUTH WALES
ACT
VICTORIA
TASMANIA
Great Australian Bight
Townsville
Toowoomba
Gold Coast
Geelong
Bunbury
NACCHO Member Service hubs
by remoteness (with eye health screening as a minimum)
Major Cities
Inner Regional
Outer Regional
Remote
Very Remote

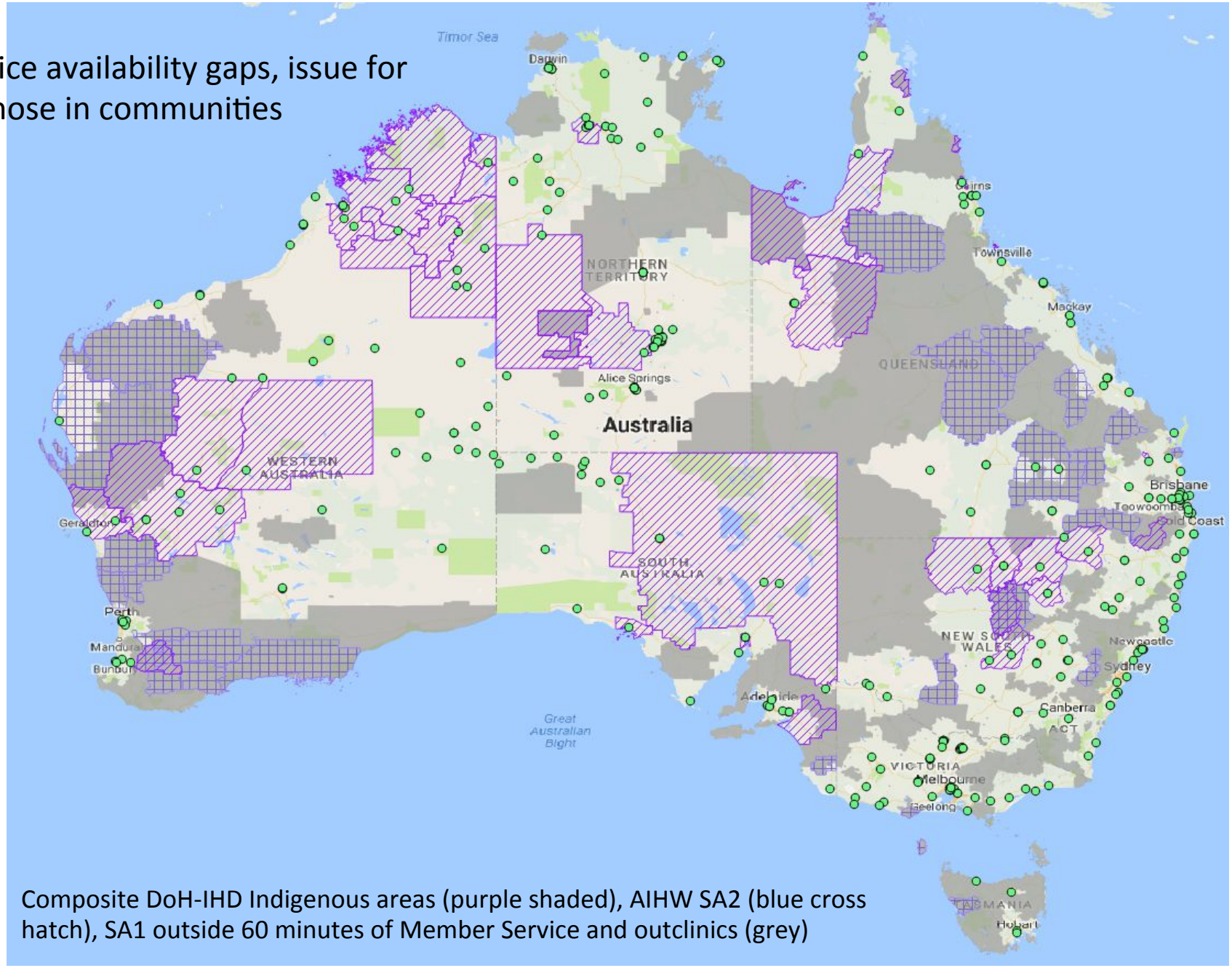
NACCHO 2016



ACCHO – hubs and sample spokes
(fixed and mobile) – Incomplete
Visiting service providers to be added

NACCHO 2016

Service availability gaps, issue for all those in communities



Composite DoH-IHD Indigenous areas (purple shaded), AIHW SA2 (blue cross hatch), SA1 outside 60 minutes of Member Service and outclinics (grey)

Composite with Member Services and outclinics

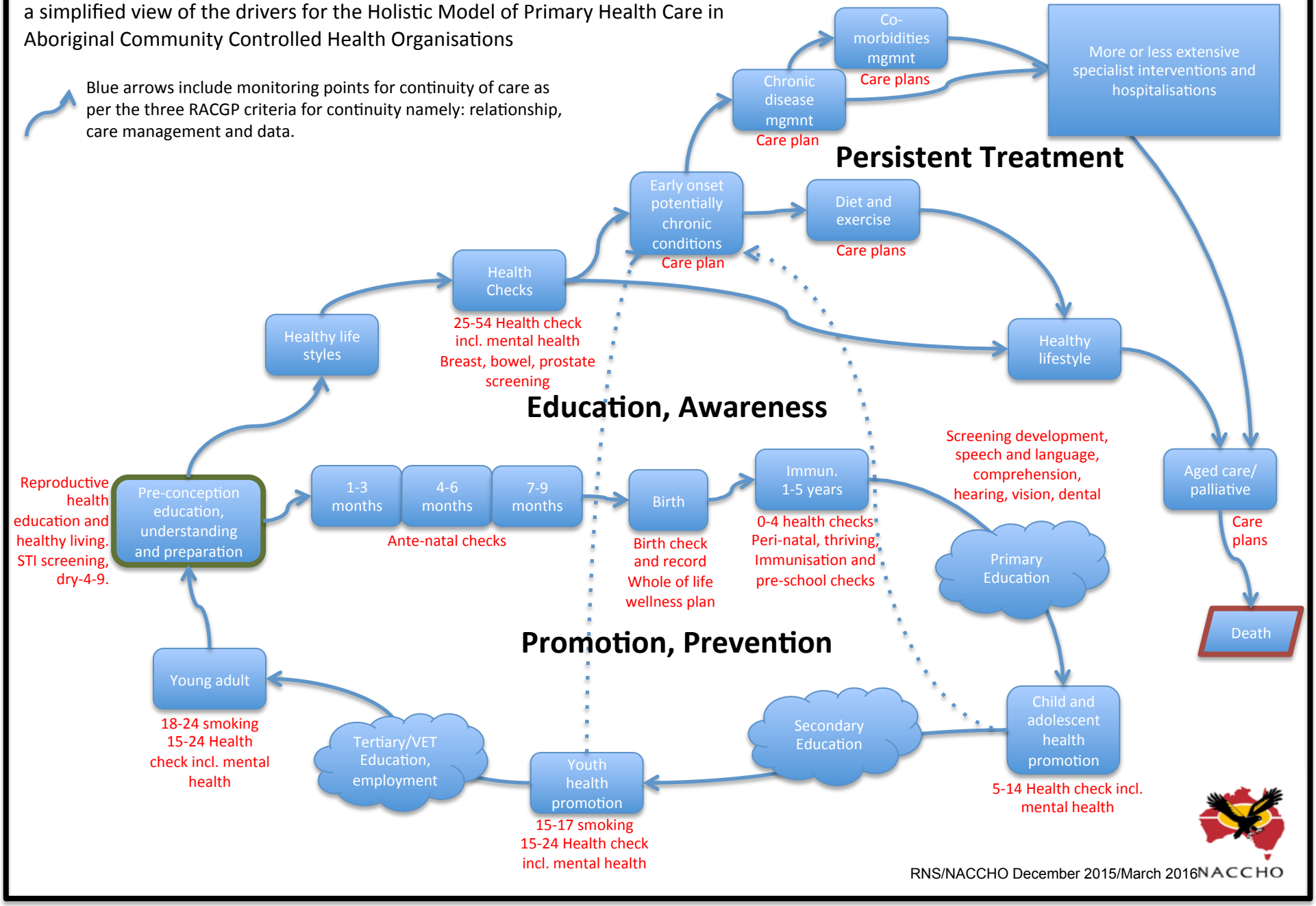
ACCHO Model of Care

- ***The Aboriginal understanding of health is holistic and includes land, the physical body, mind, clan, relationships, and lore, it is social, emotional and cultural wellbeing of the whole community not just the individual.***
- The model of care has been developed with over 40 years of service provision not just in urban and regional centres but very remote as well, e.g. Urapuntja (40th Anniversary this year)
- ACCHOs were one of the first networks of primary care providers to collaboratively develop electronic health records 20 years ago driven by Care Plans
- ACCHOs have been providing summary patient statistics and activity measures to the Commonwealth since the mid-1980s (Service Activity Reports, now Online Service Reports)
- The model of care is based on the patient journey with Well-being Plans and care plans for specific events or conditions.

Mapping the patient journey through Life Cycle Interventions

a simplified view of the drivers for the Holistic Model of Primary Health Care in Aboriginal Community Controlled Health Organisations

Blue arrows include monitoring points for continuity of care as per the three RACGP criteria for continuity namely: relationship, care management and data.



RNS/NACCHO December 2015/March 2016 NACCHO

Integrated Team Care trial might be “new” to the Commonwealth but it has been the *modus operandi* of the ACCHOs for decades

The majority of the ACCHOs long standing electronic patient record systems reflect this ethic

Our sector needs to bring data together

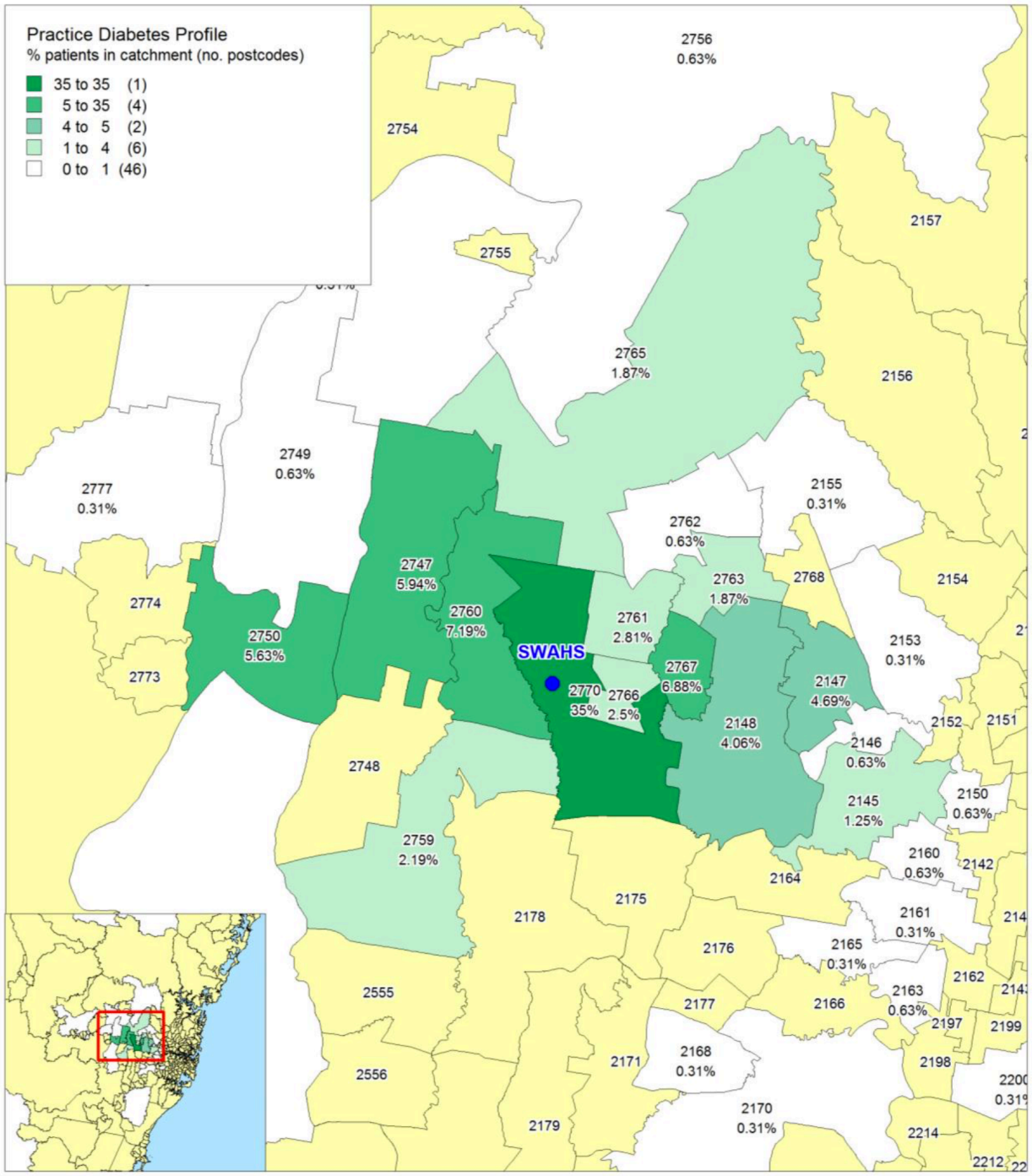
- Data aggregation and sharing − protocols, agreements, upskilling are re-current issues,
- Complexity of data arrangements is being rationalised as willingness to collaborate increases,
- Data management technologies such as business intelligence, data mining and geoprocessing tools are enabling improved responsiveness to requests for information;
- Better communications are enabling better definition of questions to which answers can be provided;
- Adopting supply chain modeling and the idea of information products enables greater re-usability of data and analyses;
- Wider appreciation of the use of data and building information products (components) into reporting is facilitating broader workforce and community awareness and engagement at the local level
- New government policies for “contestability” highlight the need for the rapid delivery of quality, timely, accurate and complete data;
- Where ACCHOs and their representative bodies can accumulate expertise and integrate data management processes data is now flowing much better, however, the same is not the case when data is required from outside the Sector or when outside organisations want data from the ACCHOs and/or their representative bodies.

Problems/realities .. 1

- Data Quality, the Sector has good data, could be better but CQI focused data quality activities are being diligently followed driven as much by the demands of
  - a workforce with a high turn over, especially of GPs,
  - External specialists and service providers providing interventions for patients and not being consistent in their data recording
  - Other sectors providing services and not giving timely feedback to the principal provider
  - Telehealth providers
  - New entrant providers not understanding the holistic model of care
- The ACCHO sector may have good quality electronic data and the experience of using and sharing it … but what about other Sectors?
- New fund holding models for Primary Health have been in a state of constant flux since the introduction of Medicare Locals and their replacement by Primary Health Networks
- Previous single public sources of budgeting, funding, contracting, reporting and monitoring have been replaced by 31 separate independent private businesses

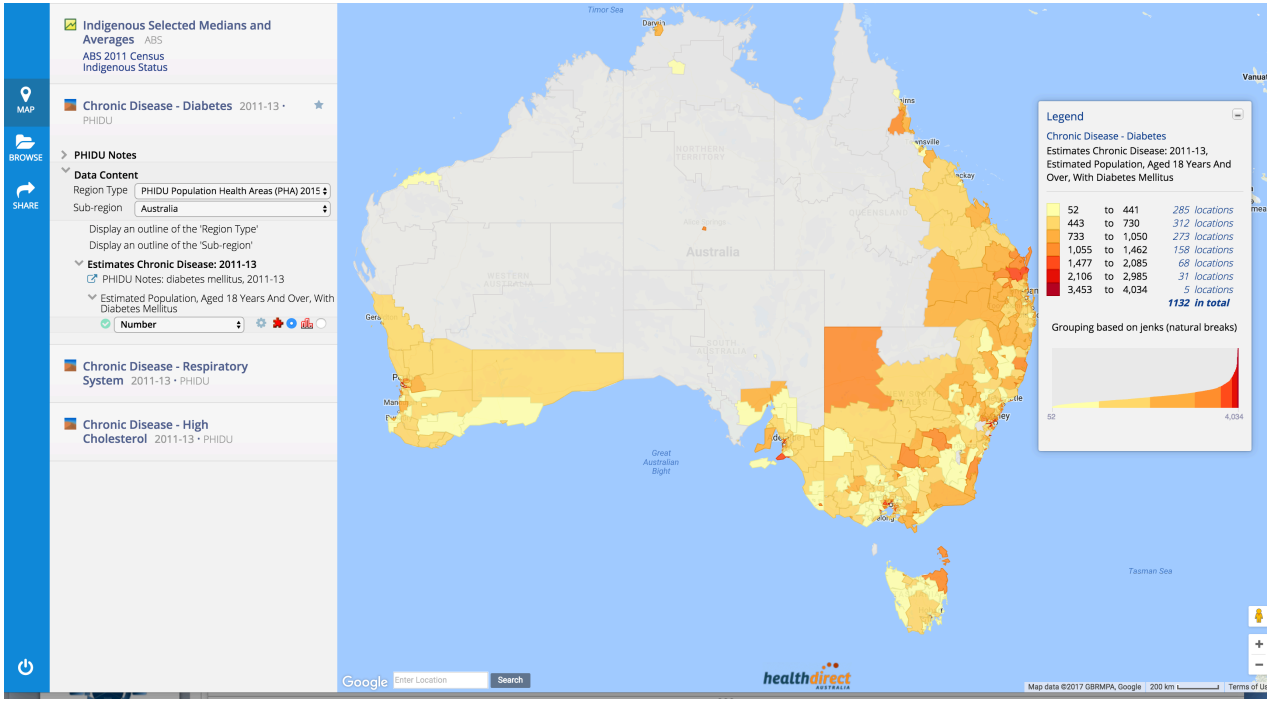
Problems/realities .. 2

- Former reporting (data) pathways from the actual service providers to the funds holders to the national data collections are currently chaotic
- Access to relevant data is being switched on and off (e.g. MBS item uptake) also by private/NFP outsourced data holding contractors
- Publication and research bodies come and go (National Health Performance Authority, BEACH)
- Workforce training bodies re-organise e.g. National Training Quality Frameworks with new for profit providers entering and leaving the "market" affecting workforce skills classifications and staffing planning and staff performance reporting
- MBS and PBS items come and go
- Major funded programs come and go, programs are shuffled between departments killed off then re-birthed, but what happens to the data?
- Scales of data aggregation and data publication are being changed capriciously e.g. post-codes to Medicare Local to now PHN boundaries, Hospital health district boundaries change, local government boundaries (e.g. happening now in NSW, maybe?) … as in the following slides ..



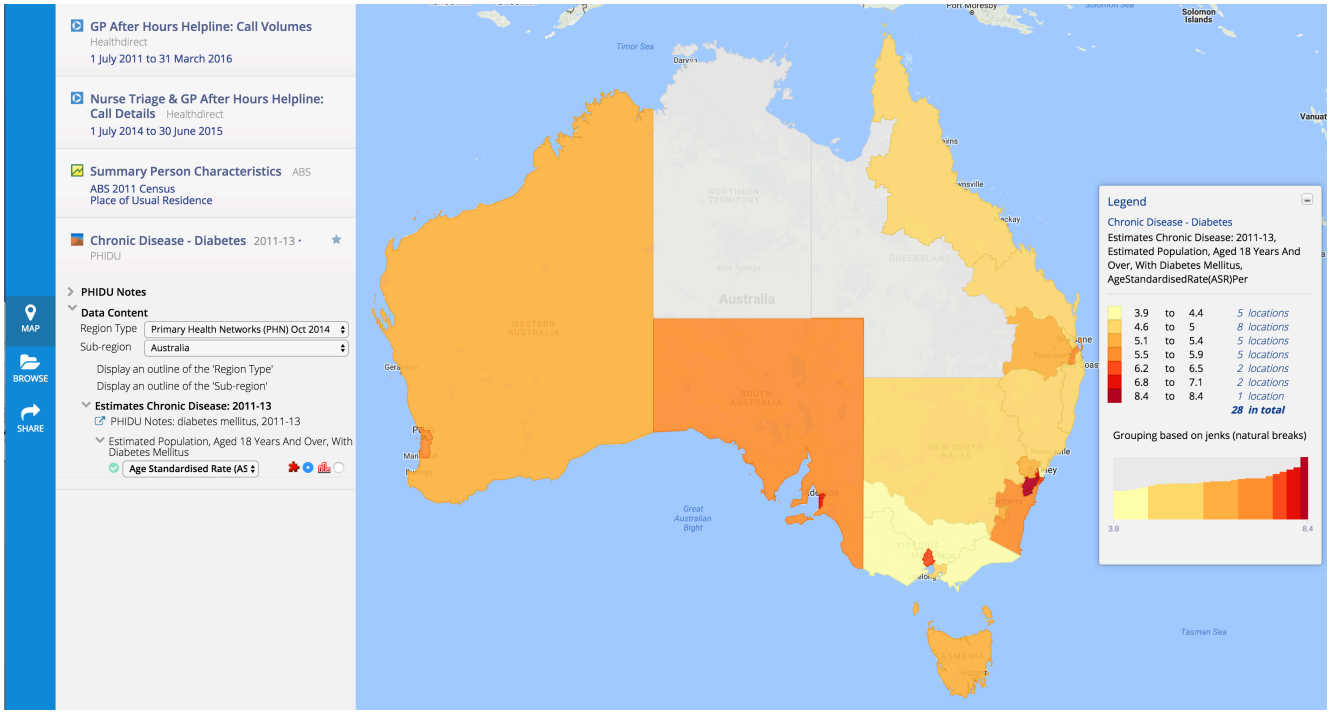
Post Code − useful in metropolitan and inner regional areas

Note: Yellow indicates no data for that postcode



PHIDU Population Health Areas

PHN Areas - useless



Meanwhile .. at the national scale

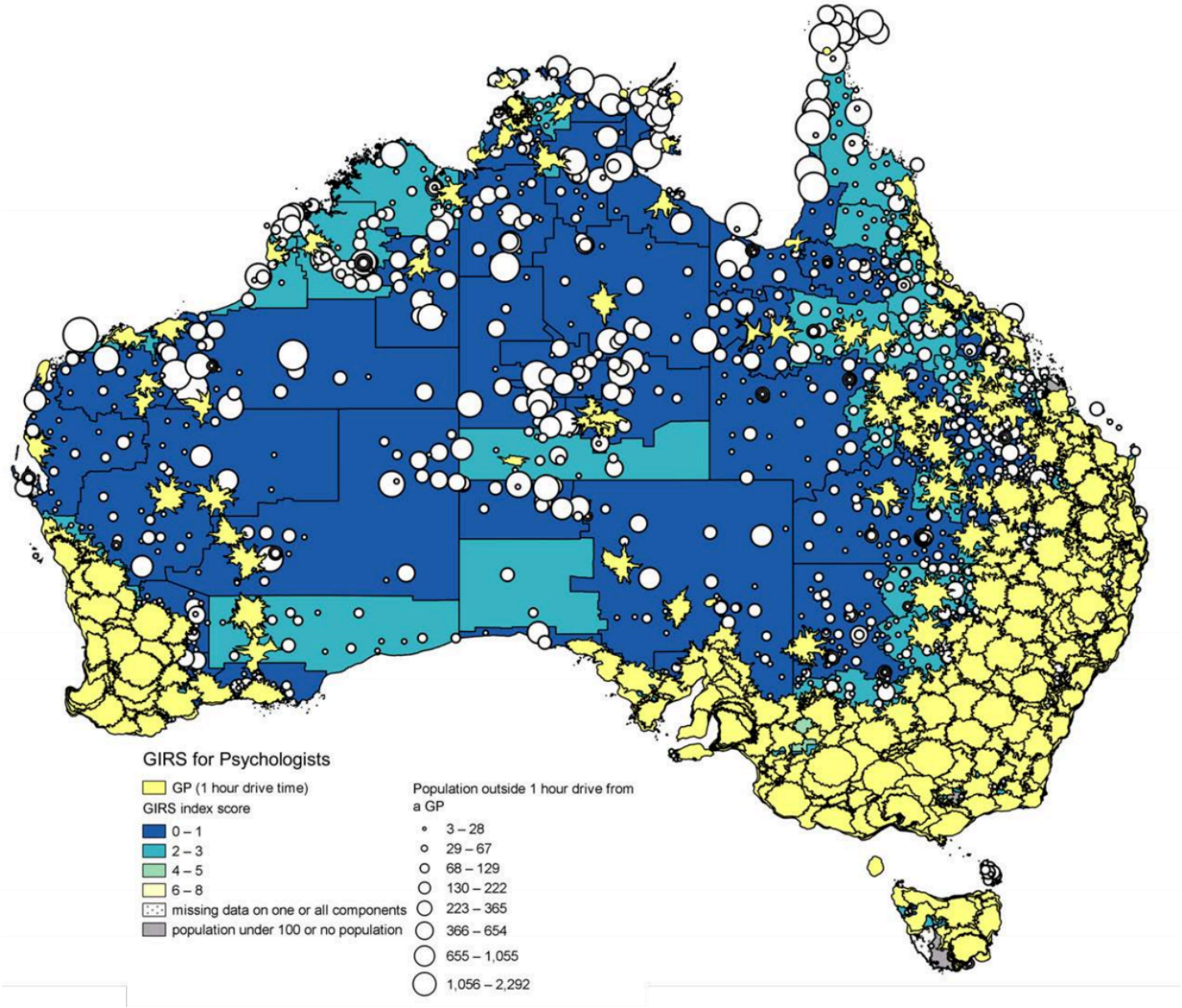


Figure 8.3: Map of psychologist GIRS scores, by SA2, with drive time boundaries of GPs and mesh block populations added

And … by the way

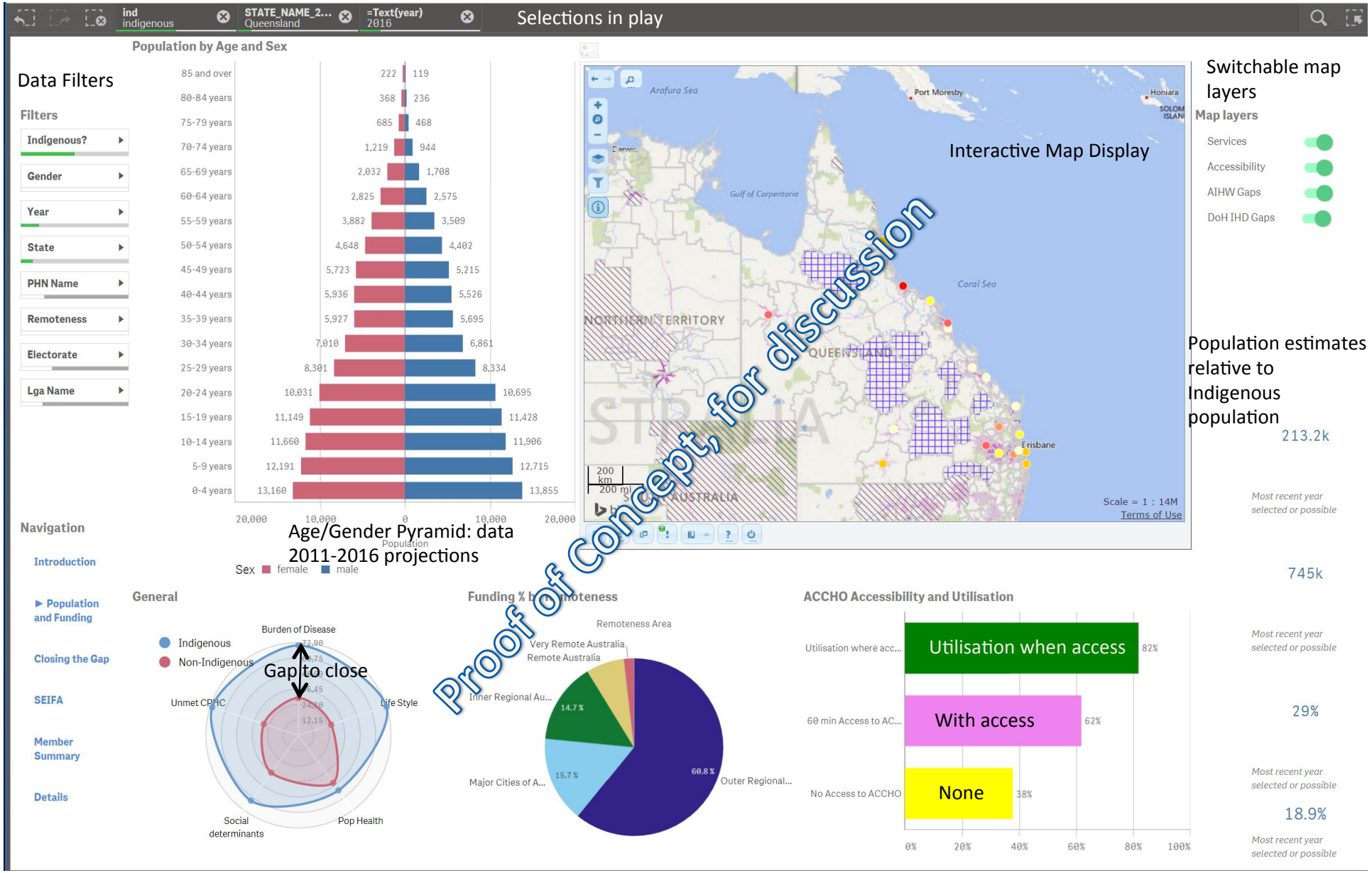
- Now we are all required to contribute to:
  - Needs Assessments,
  - Resource Allocation,
  - Commissioning and
  - Outcome monitoring.
- Each of these steps is being undertaken across 31 PHNs engaging with 142 ACCHOs, ?? Hospital Health Districts, 7000+ private and corporate GP practices, ??specialists and ??Allied, mental, AoD health providers and now aged care providers .. will NDIS providers be added to the mix?
- And BTW we all have a directive to Close the Gap in health inequality for Aboriginal and Torres Strait Islander people − across ALL PROVIDER SECTORS
- Close the Gap requires not just Aboriginal and Torres Strait Islander data but also, in equal detail, that of the general population; obviously there cannot be a focus on one without the other.

Some of the ACCHO sector recent efforts and thoughts

- Prior to the DoH decreeing national Key Performance Indicators − NT and Qld had developed their own − these jurisdictional efforts have been consistent and extended over the last 7 or more years. The DoH nKPIs have a more chequered history and less certain future;
- NACCHO with input from some Members and some State Affiliates has prepared a concept model to better understand and be able to monitor certain Close the Gap in health issues;
- The Model aims to
  - bring together Needs Assessment, resource allocation, commissioning and outcome monitoring into a rational framework and
  - highlight data absence and discontinuities to allow demonstration of the impact on health outcomes of improvements in data access and quality

Shared Integrated Evidence Base: Concept for scoping and development … QAIHC-NACCHO

Contact: John Gregg 0410 931 460, Roderick Wright 0438 350 649, Dr Rob Starling CIO 0411 500 887



Short cuts to more detailed sheets

Health and related needs categories (high level)

ASGS-RA (remoteness) by Data Filters (loading)

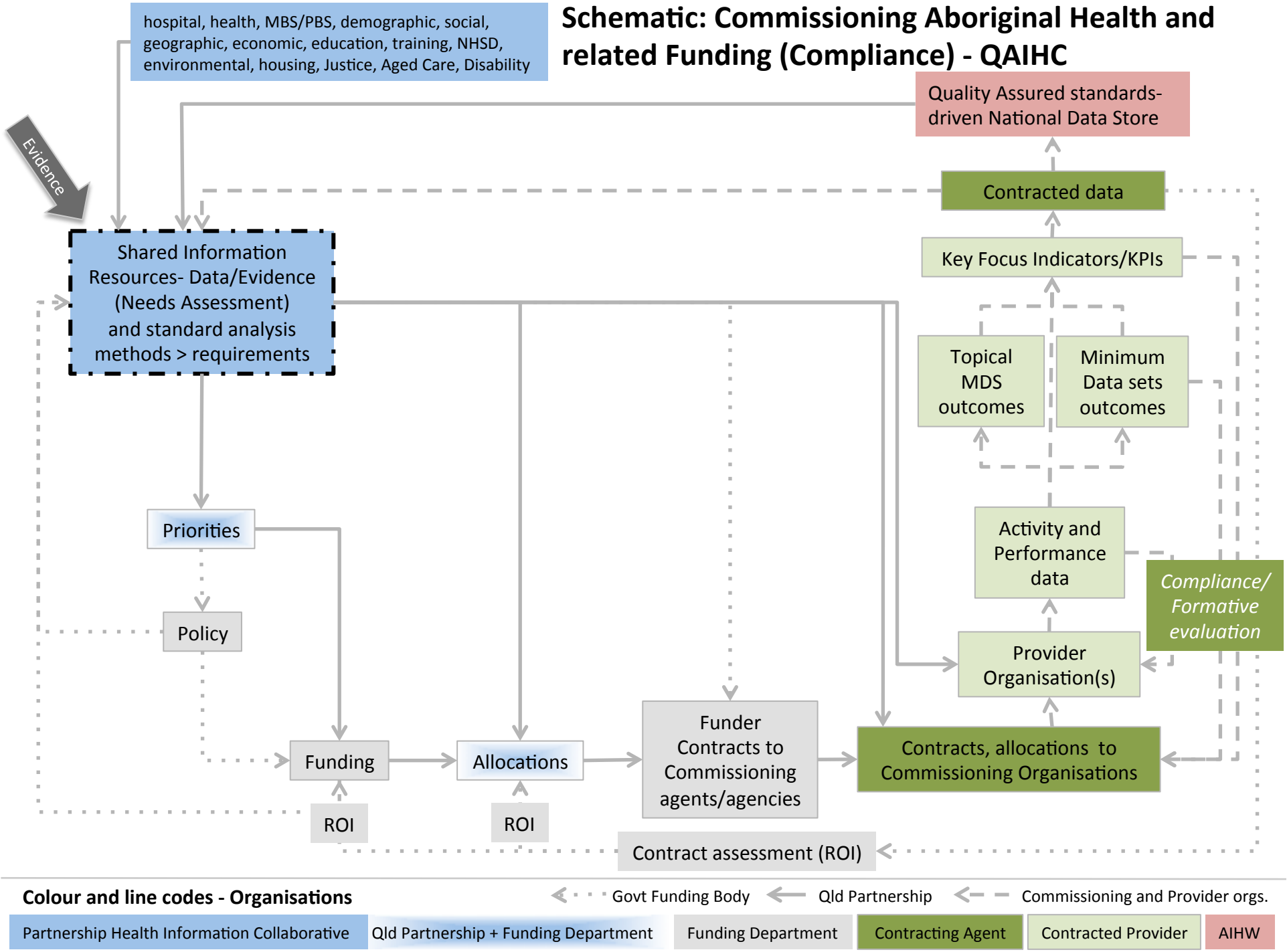
Accessibility to AICCHS and utilisation

Proportional funding

Schematic of data flows to support commissioning model

- A schematic has also been developed to clarify potential data flows in an attempt to provide a context for data related decisions with their upstream and downstream impacts and impacts on feedback loops.
- We invite comments, suggestions and pointers to other work that will help us get our heads around quality and consistent data collection to enable us to start looking forward in a rational, economical, sustainable and patient focused manner and supporting and developing agencies and businesses that can plan with some certainty.

Schematic: Commissioning Aboriginal Health and related Funding (Compliance) - QAIHC



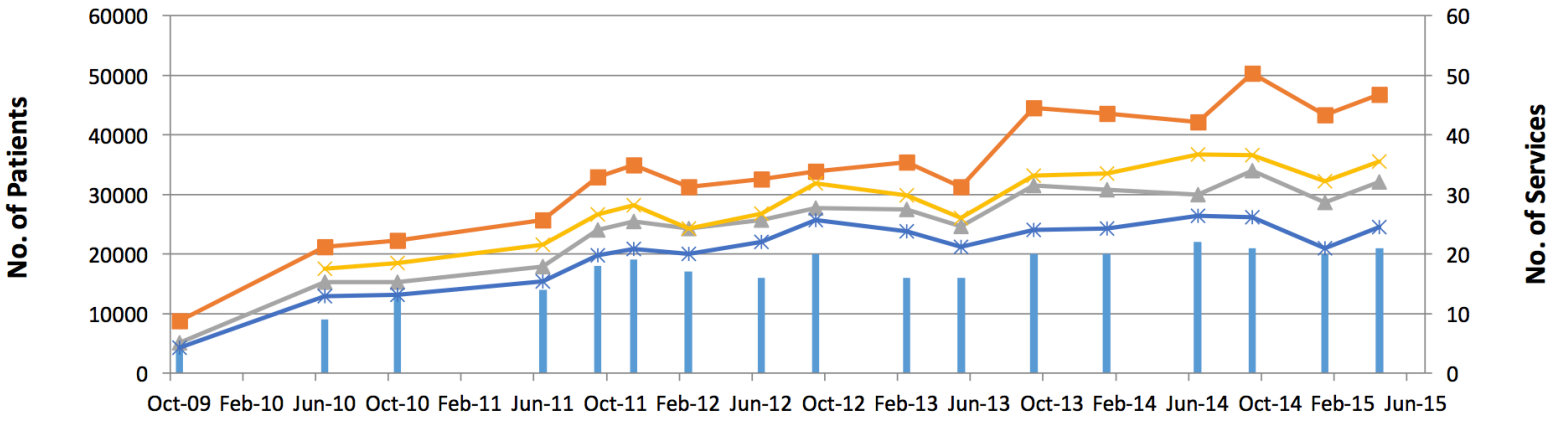
Is the AHHA Data and Innovation Collaboration Network an appropriate forum to?

- Identify and work together to address common issues to reduce the duplication of effort and associated costs;
- Provide cross Sector input/review at the Policy and Budget level along with regulations and actual Contracts with special reference to data/ reporting requirements and standards
- Work with the Digital Transformation Office to actually implement the Open Data principles and Gov 2.0 directives, and recommendations of recent ANAO and Productivity Commission reports
- Support the Departments of Health, AIHW and other bodies with jurisdictional and national data responsibilities to reduce the complexity and improve access to and the consistency, accuracy, timeliness and completeness of Comprehensive Primary Health data and information.
- Inform resource allocations to be more effective for patients and the Budget
- Convene to Workshop the Model and Schematic and other ideas to see if there is a practical and sustainable way of reducing the complexity of the data environment that is both a legacy and an emerging vulnerability/risk for current and future investments.

Appended slides for discussion .. if required.

Growing reach of Service Delivery is shown in the following time series

1.3 Recent and Regular Patient Numbers for QAIHC Member Services



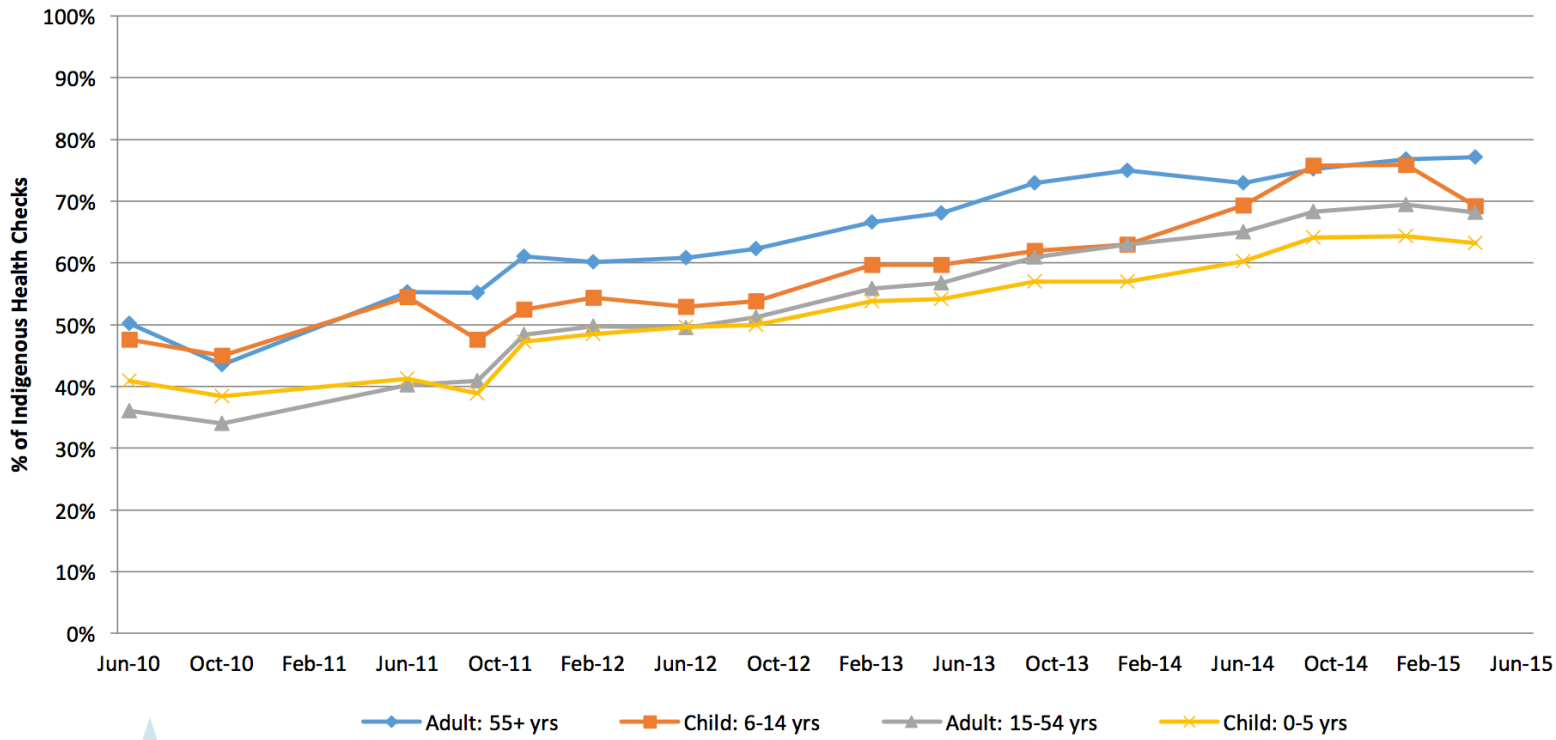
	Oct-09	Jun-10	Oct-10	Jun-11	Sep-11	Nov-11	Feb-12	Jun-12	Sep-12	Feb-13	May-13	Sep-13	Jan-14	Jun-14	Sep-14	Jan-15	Apr-15
No. of services	5	9	13	14	18	19	17	16	20	16	16	20	20	22	21	20	21
Recent Patients	8800	21217	22253	25687	32942	34935	31310	32546	33813	35396	31234	44566	43518	42196	50353	43374	46747
Recent Indigenous Patients	5100	15257	15241	17851	23980	25446	24317	25745	27652	27446	24676	31431	30733	29954	33926	28670	32139
Regular Patients #		17541	18440	21566	26629	28120	24279	26753	31902	29775	26066	33165	33461	36683	36587	32166	35541
Regular Indigenous Patients #	4300	12938	13136	15433	19727	20845	19948	22039	25717	23787	21218	23975	24300	26389	26167	21007	24463

Proportion of recent and regular patients over time and the number of services submitting data

RESULTS:

- In April 2015, 51,896 Indigenous patients or 33%* (1 in 3) of Indigenous Queenslanders had been seen at QAIHC services at least once over the previous two year period.
- AICCHS sending monthly data for the QAIHC Core Indicators has increased

2.1 Indigenous Adult Patients with Current Health Assessments



Proportion of regular Indigenous adult patients with current health assessments over time

RESULTS OF REGULAR INDIGENOUS CLIENTS:

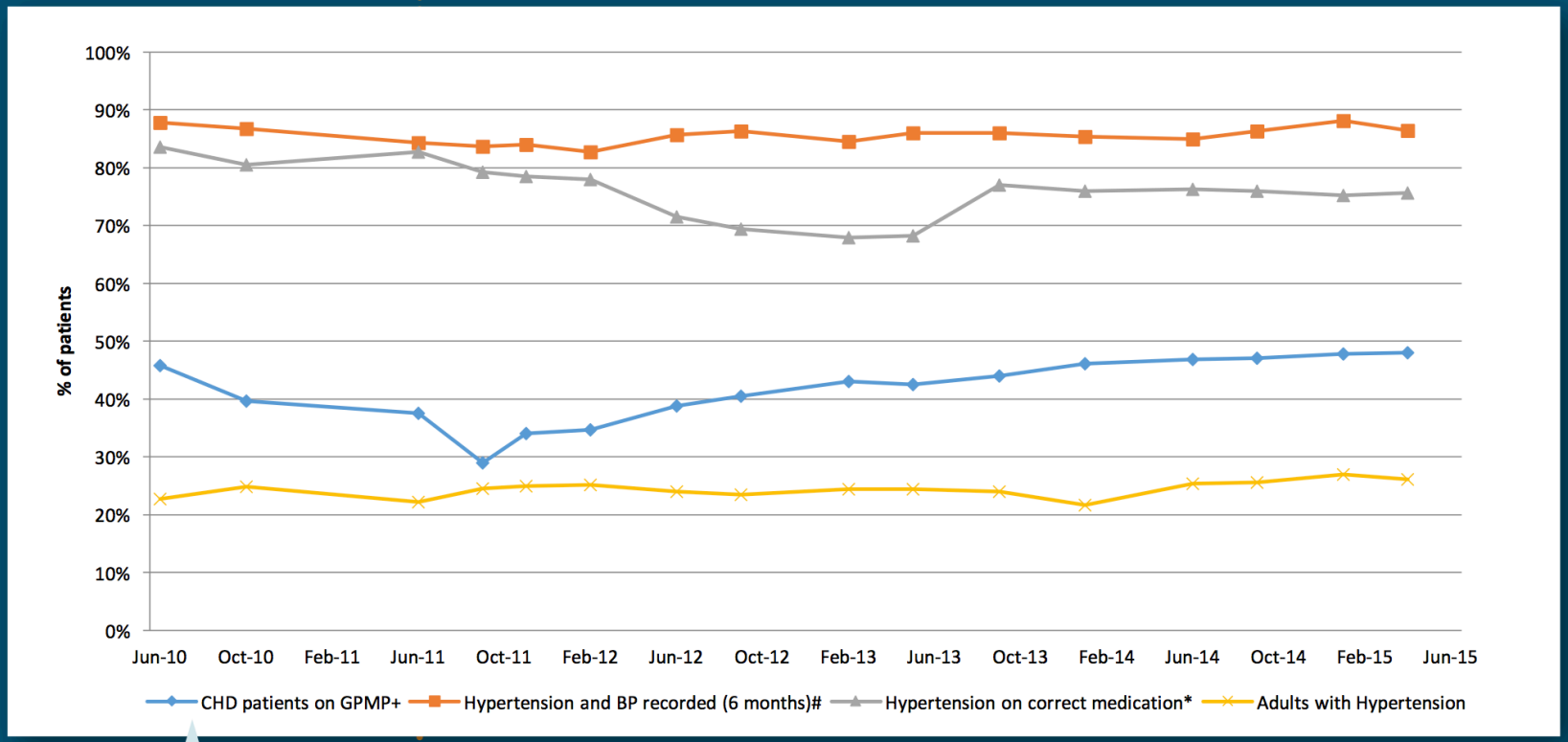
Over time, there has been a clear increase in the proportion of Aboriginal and Torres Strait Islander clients, both adults and children, who have current health checks.

This reflects hard work in the services. Possible contributory factors include:

QAIHC Indicators – example time series for:

- Hypertension
- Type 2 Diabetes

2.4 Clinical Management of Indigenous Adult Hypertensive Patients

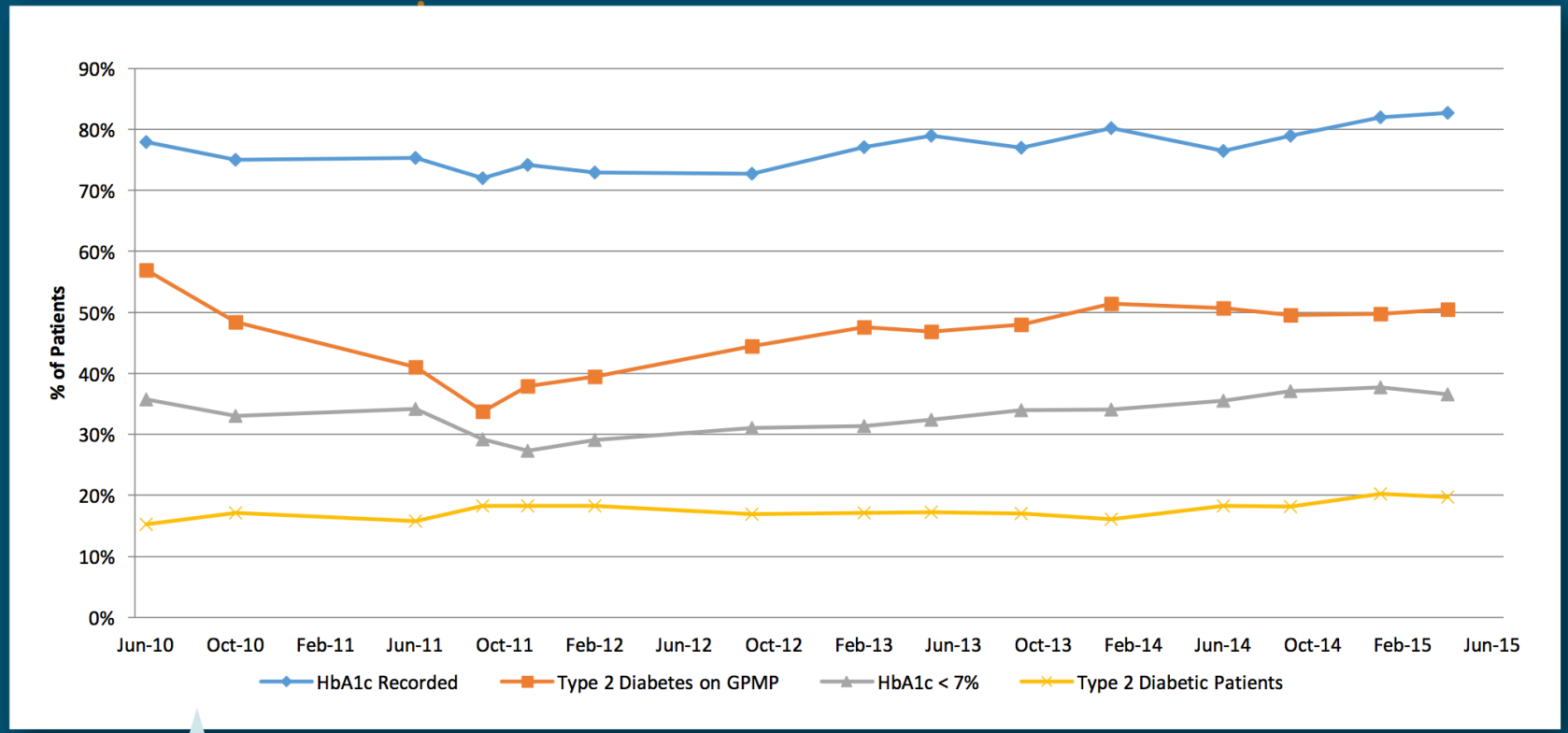


Proportion of regular Indigenous adult hypertension patients and their management outcomes over time

RESULTS OF REGULAR INDIGENOUS CLIENTS:

The upward trend in the proportion of patients with hypertension may reflect increased health checks activity, the increased number of participating services and, thus, total patients represented in the data collection, improved systems of care delivery:

2.5 Clinical Management of Indigenous Adult Patients with Type 2 Diabetes



Proportion of regular Indigenous adult Type 2 diabetic patients and their management outcomes over time

RESULTS OF REGULAR INDIGENOUS CLIENTS:

The upward trend in the proportion of patients with Type 2 Diabetes may reflect increased health checks activity; the increased number of participating services; and, thus, total patients represented in the data collection and improved systems of care delivery.