PRIMARY HEALTH NETWORK

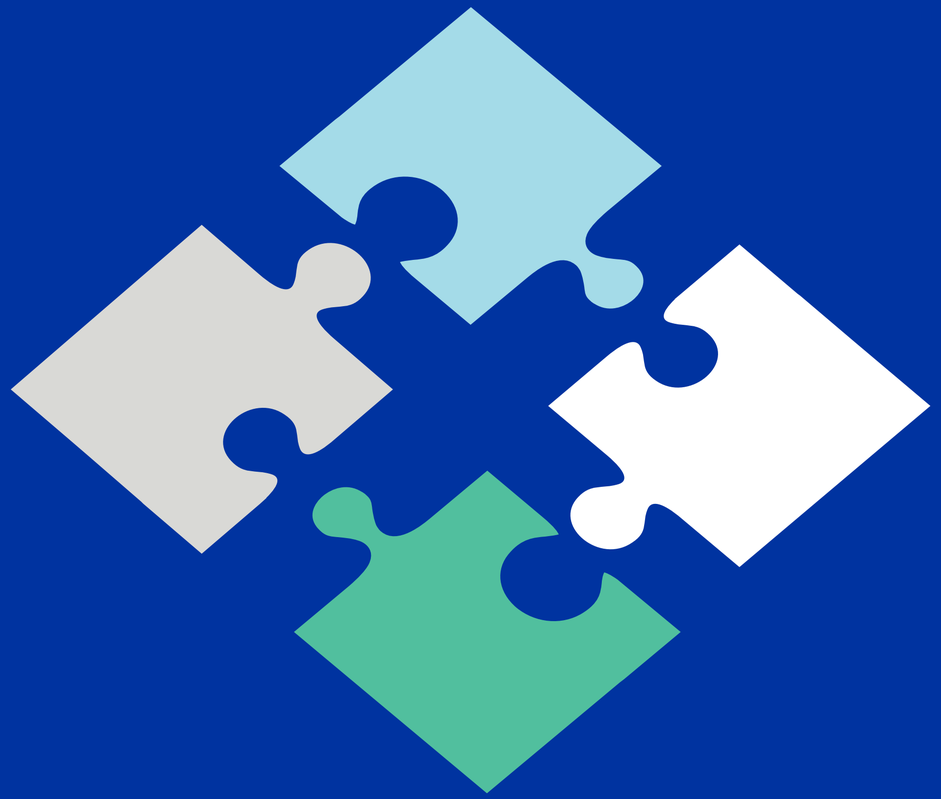
LUMOS

- INSIGHTS AND OPPORTUNITIES

22nd March 2023

WE ACKNOWLEDGE THE TRADITIONAL OWNERS & CUSTODIANS OF THE LAND THAT WE LIVE & WORK ON AS THE FIRST PEOPLE OF THIS COUNTRY.

Learning Objectives



- Quick recap – what is LUMOS?
- Why data is essential?
- Three key areas of the Practice report.
- What Lumos data is showing for NSW.

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What is LUMOS

Lumos is a partnership initiative between Primary Health Networks and the NSW Ministry of Health.

SO, WHAT IS IT!!

- It is an ethically approved program with strict governance structures that securely links data sets across Primary Care, Emergency Department, Hospital Admissions, Outpatient, Ambulatory and Mortality.
- LUMOS is *FREE*
- You are provided a unique biannual report
- It provides an exclusive opportunity to better understand your Patient's journey through the Health system
- Opportunity to better coordinate health care across sectors
- Support evidence based strategic decision making, identify areas of need and prioritise allocation of resources.
- Your PHN PCIO is here to help

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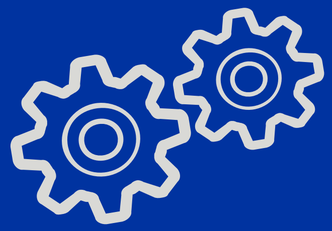
Why Data is essential!

Market your products



Financial leavers for business success

Learn from the past

Find opportunities to work collaboratively

plan ahead

It saves you time!!

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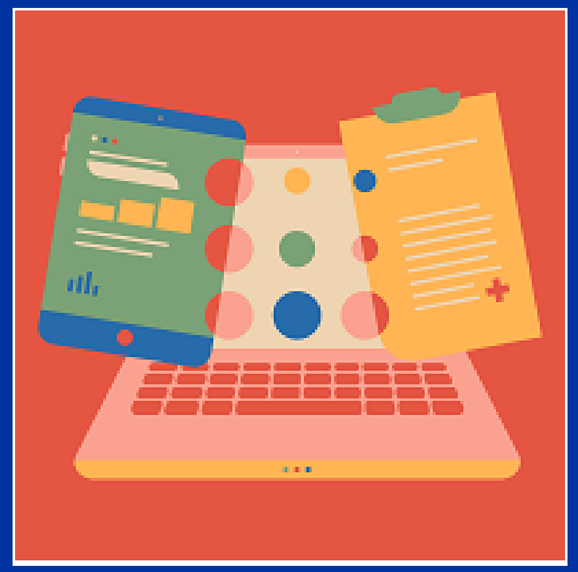
Why Data is essential!



Proof is on the SAPHE – Secure Analytics Primary Health Environment

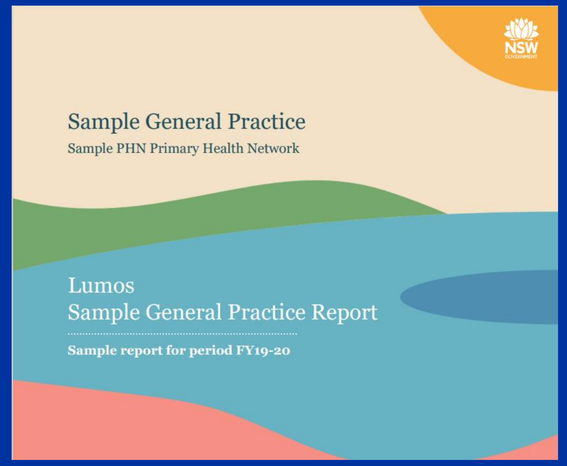
- Remote Desktop with variety of analytics programs
- Restricted access – can be applied for to use with planning, funding management, or evaluation of health services.
- Very strict conditions which must protect data integrity
- Evolve to support evidence-based reporting of programs and initiatives.

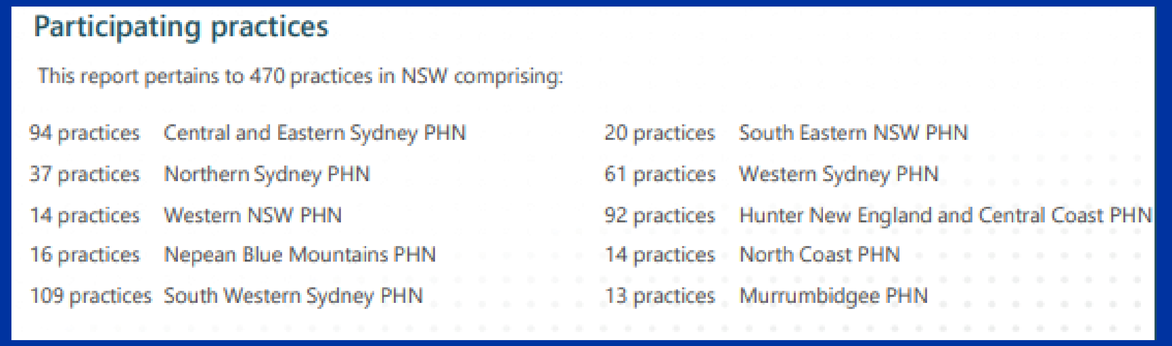
Three Key areas in your Practice Report

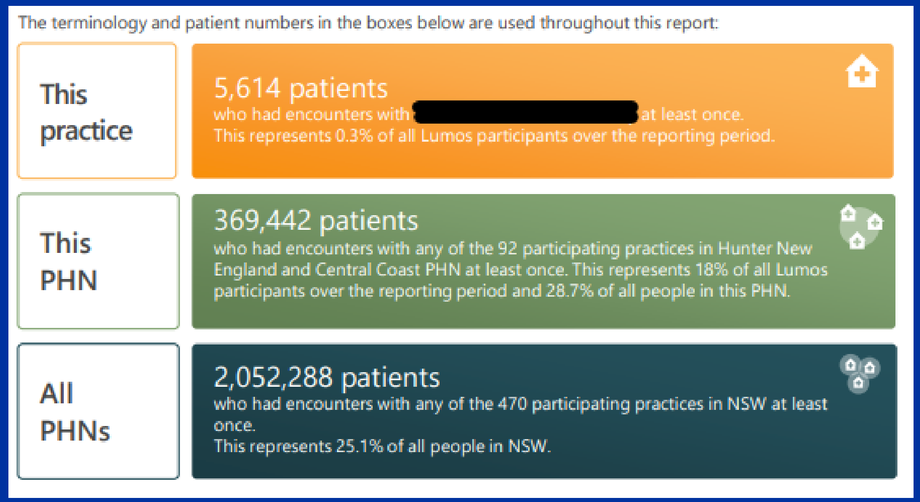
The report is unique to YOUR Practice!!

Maps any patient interaction with your practice and the linked data sets across the state.

Results are shown as percentages – they are high level data analysis – they are a snapshot in time – and are comparable across consecutive reports = quantitative evidence







Knowing how often patients had encounters with your practice can help you understand demand on your services. Your patients each had an average of 6.7 encounters with your practice in FY19-20. Of your patients, 93 (3%) also had encounters with another Lumos participating practice in NSW. Across this PHN, these values were 5.9 and 20,414 (8%), respectively.

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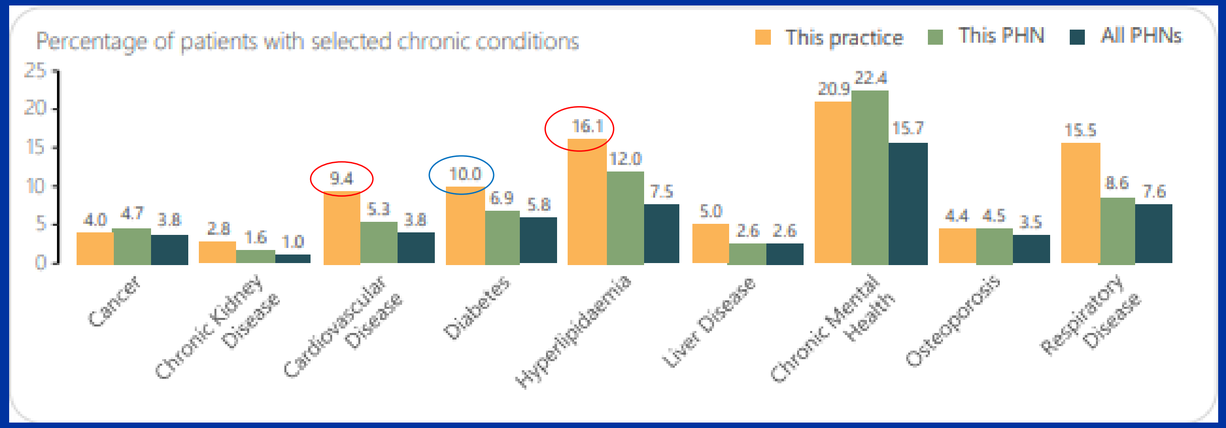
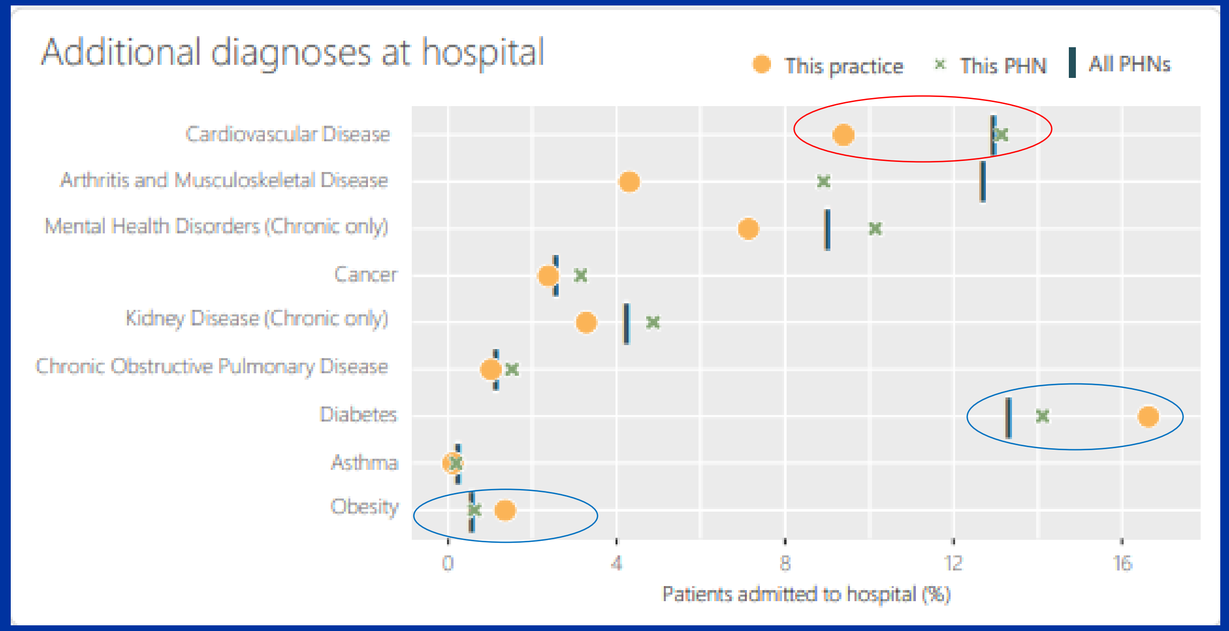
Area 1 – Disease prevalence





- Oct 2020 -> Sept 2021 : Peek COVID period
- Rural Remote
- High average Male < 50yrs & Women 20 -> 35yrs
- 60% top two disadvantaged percentiles
- High percentage of Aboriginal patients
- High incidence of ED encounters in all triage categories – consistent with pre- COVID data

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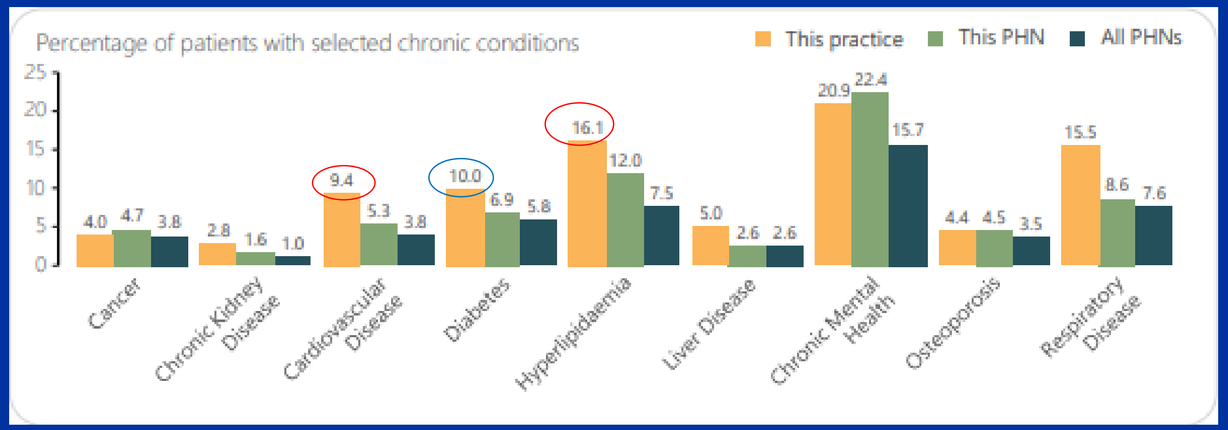
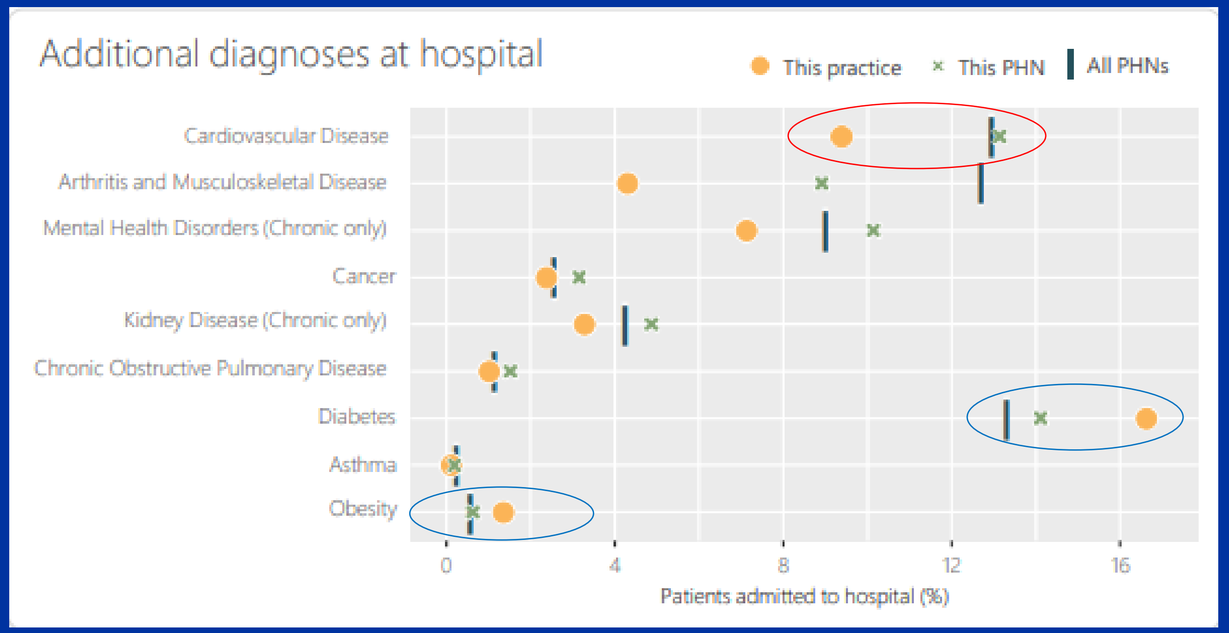
Area 1 – Disease prevalence opportunities





- Reinforce quality screening and preventative treatments for cardiovascular disease within practice
- Opportunity for preventative screening and early intervention for pre-diabetic patients – QI: Weight recording, targeted preventative programs for women 20 -> 35yrs, risk factor review CAT4, collaborative community programs – evidence to show need.

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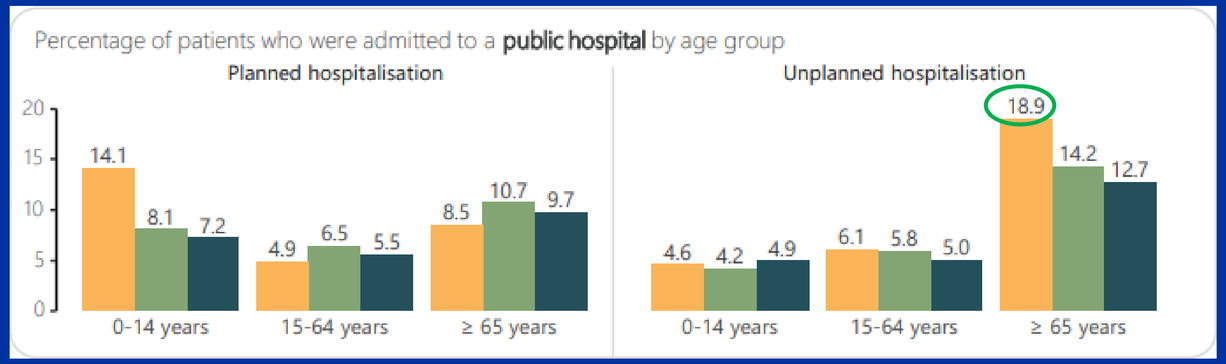
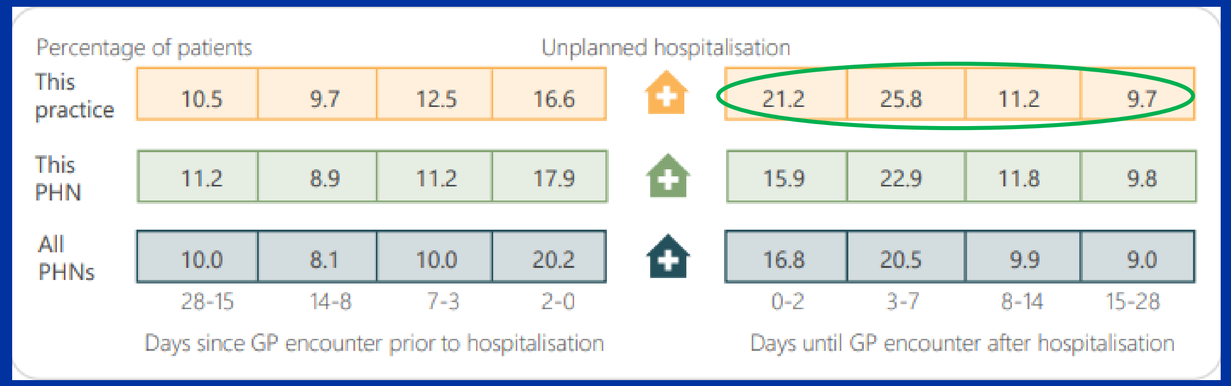
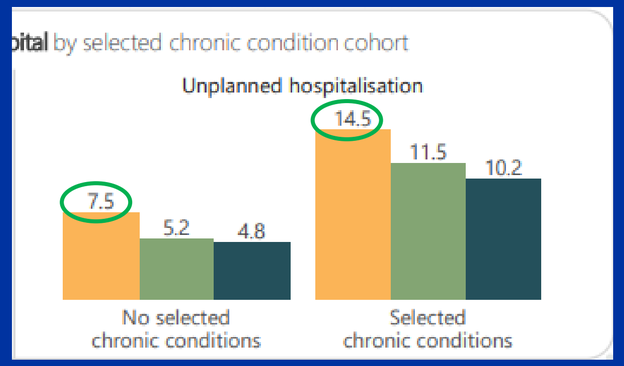
Area 2 – Unplanned Hospitalisations







- Oct 2020 -> Sept 2021 : Peek COVID Period
- Major City
- High average elderly population < 60yrs
- 60% pf patient in 2 & 3 disadvantaged percentiles
- Low percentage of Aboriginal patients
- High incidence of Unplanned Hospital encounters
- Patients who attend ED -> Admission -> Outpatient service = 2.2% Higher than PHN average

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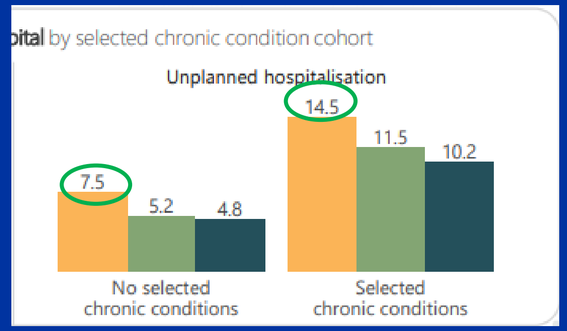
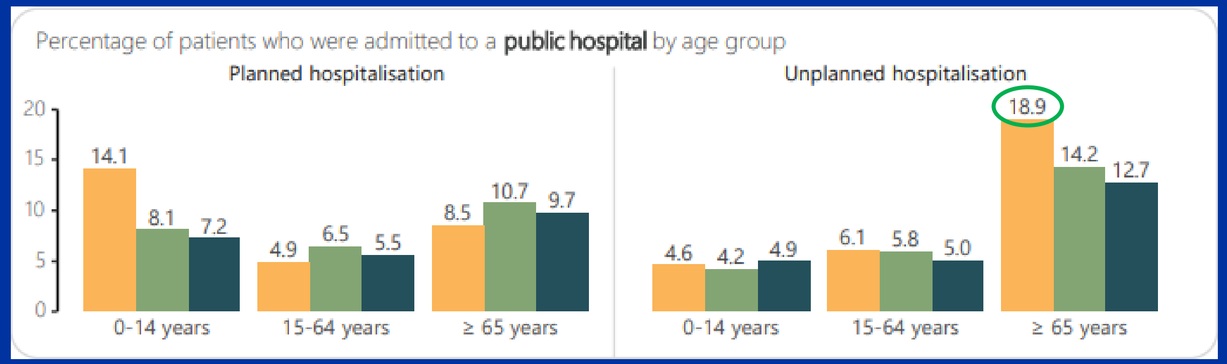
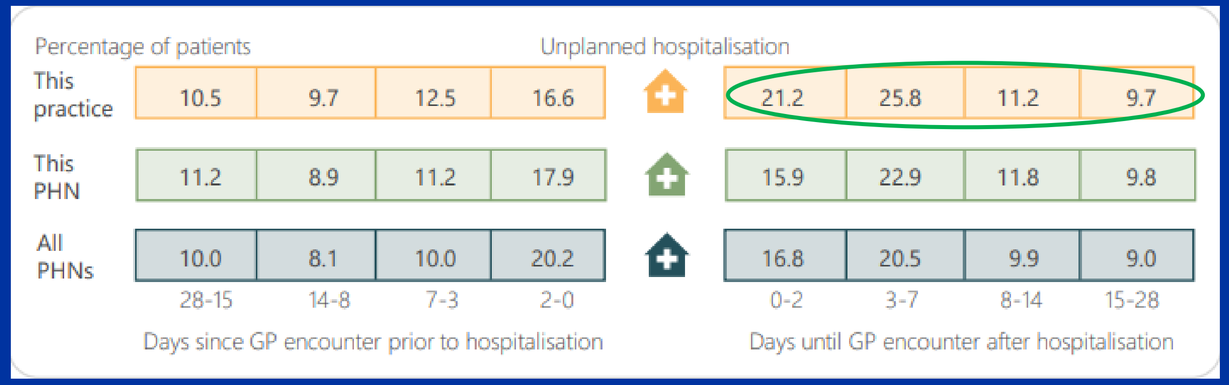
Area 2 – Unplanned Hospitalisation opportunities







- Opportunity to effect re-admission of patients < 60yrs. < 65yrs account for 24.7% of patients seen
- Other age groups are on average experiencing a reduction in re-admission thanks to accessibility of practice services.
- Clearly have strong links with hospital and ensuring follow up in General Practice.
- If there is a large Elderly cohort in aged care facilities this could offer an opportunity to identify planning and management initiatives. Prevention of community patient readmission reduces associated costs of increased care needs.

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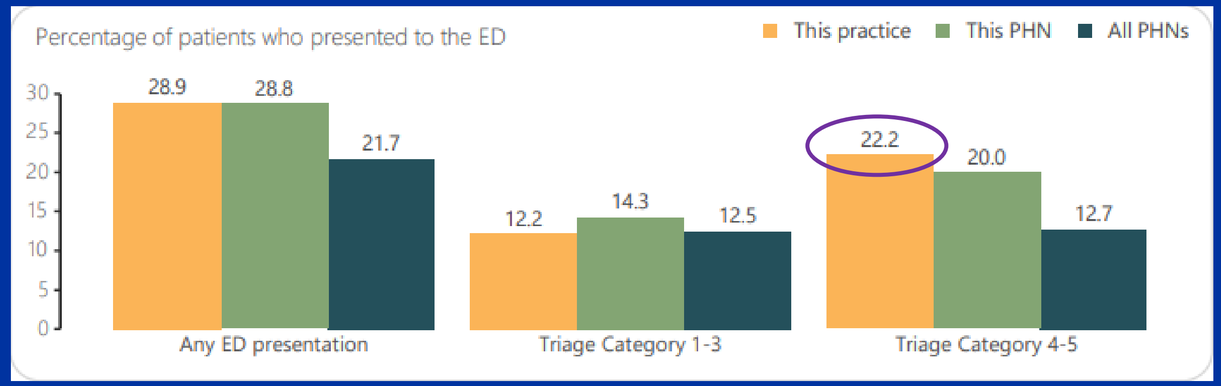
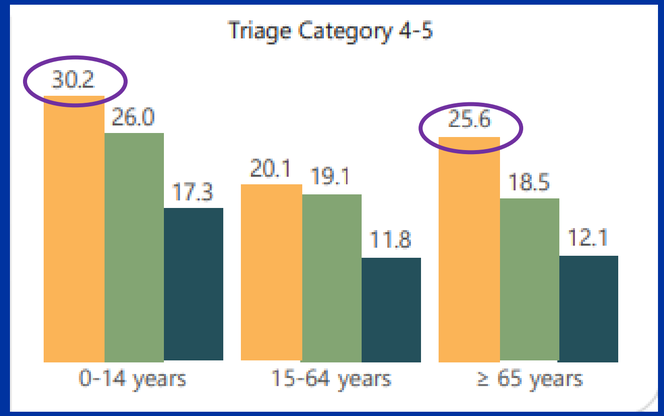
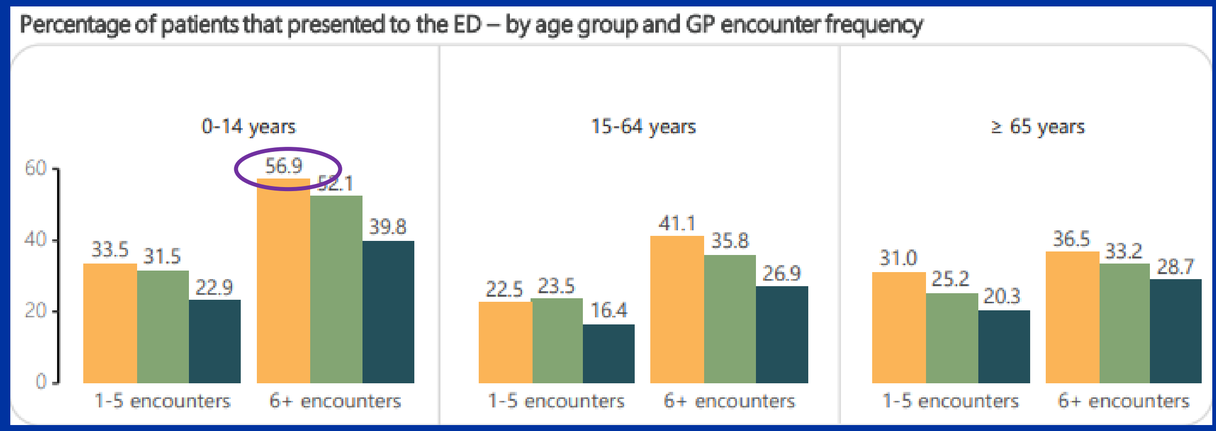
Area 3 – Triage Category 4 - 5







- Oct 2020 -> Sept 2021 : Peek COVID period
- Rural Remote
- Higher than PHN average patient population between 15yrs -> 60yrs
- 50% of patients are in the most disadvantaged percentile
- Co-located General Practice and Hospital facility

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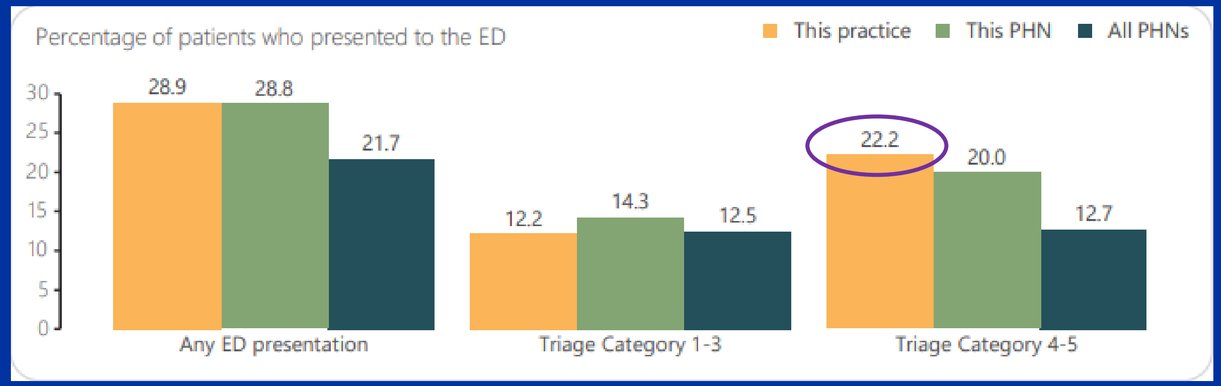
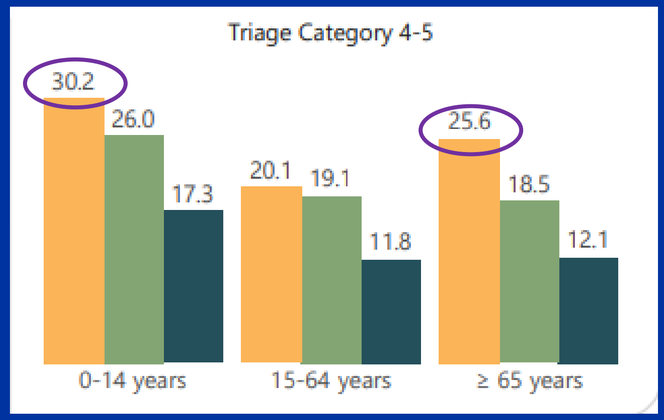
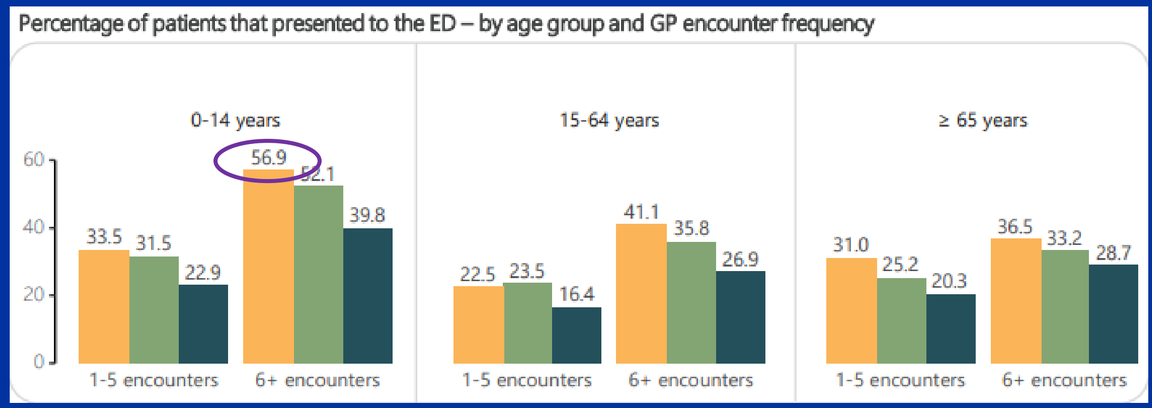
Area 3 – Triage Category 4 – 5 reduction opportunity







- 2.2% higher than PHN average attendance at local ED
- Children and Elderly make up the biggest patient cohort.
- Review of fee structure due to patient socioeconomic status, possibility of further recruitment to increase access capacity, aged care agreements/ management planning.
- Opportunity here might include a review of service availability to new parents and elderly patients. Nurse led clinics that target education of health literacy.

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Lumos data in NSW

Impacts of Diabetes

- Early intervention
- Where you live

Impacts of where people with diabetes live

Access to healthcare in regional and remote areas has been identified as a priority for NSW Health. This analysis of data from the Lumos program uses the Accessibility and Remoteness Index of Australia (ARIA+)[1] to explore the impacts of where people live on diabetes care and patient journeys.

Impact of Diabetes Managed Early in General Practice

Emerging evidence suggests that detecting and managing diabetes in the general practice setting is associated with a lower risk of unplanned admissions to hospital. This highlights the importance of coordination between and continuity of care across the primary and acute care settings. Here we compare people over two years with diabetes that was first recorded in a general practice setting with those with diabetes that was first recorded in a hospital record.

Impacts of Primary Care

Patients who have prompt follow-up after discharge from hospital have fewer unplanned readmissions

Impacts of GP capacity

Practices who see their patients more often are associated with fewer ED presentations and hospital admissions than practices who see their patients less often.

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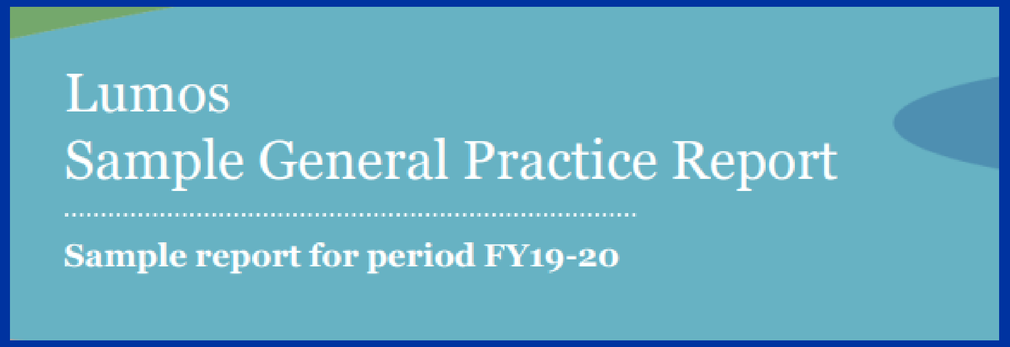
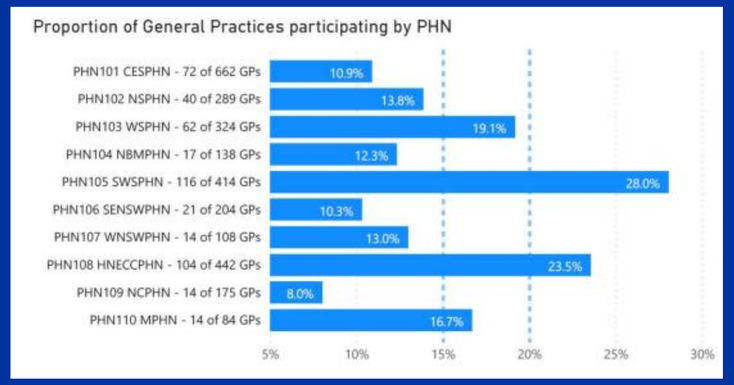
How can I get more information and become a part of LUMOS



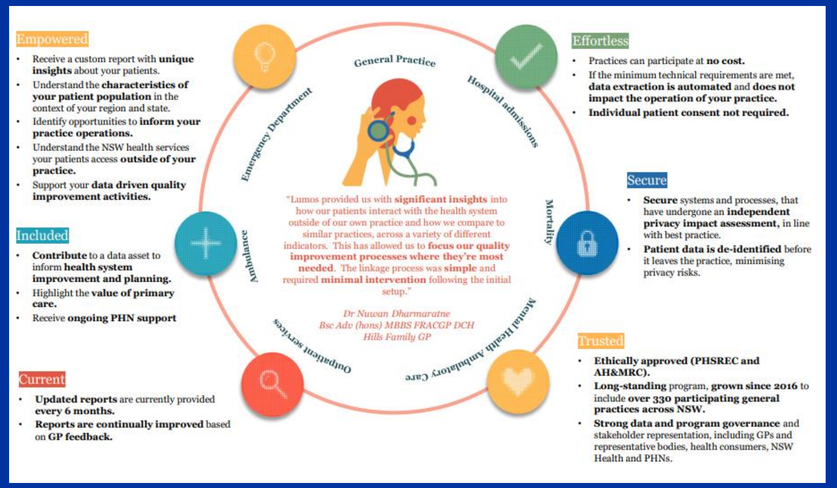
If you would like to access more information you can visit the Lumos web page on the HNECC PHN & NSW Health site

Additionally, if you would like to access your free **Lumos Practice report** - you only need to contact your local PCIO or James McNeill via email on jmcneill@thephn.com.au



You are able to complete the consent to participate in LUMOS at any time, the next linkage occurs in early April 2023.

Help us get back to leading the state recruitment in this 'first of its kind' initiative.



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Questions?

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