Power Points

spreading the news to all points of the globe

A Word from the Editor

This is a bumper issue of PowerPoints as it combines the last 2 issues of the year into 1 mega issue.

We are very proud and thrilled that our Managing Director Patrick Power has won the Ernst & Young Technology Entrepreneur Of The Year award for the Australian Central Region. Patrick is competing in the National Awards in Sydney at the end of November.

Our next User Conference is being planned and we are trying to estimate numbers. So tell us if you are coming.

We are on FaceBook! Do join us by liking our page.

We've been busy attending conferences. Patrick and the costing consultants have written a paper about quality assurance in costing, which Patrick presented at PCSI Avignon. Garth has also been busy delivering his paper about the importance of coding in patient costing to the HIMAA delegates.

We welcome 3 new internal Directors to the organisation, as PHS restructures to align its focus on projects. With the new structure, PowerHealth Solutions is well placed to continue with its vigorous growth.

Merry Christmas and Happy New Year to everyone and remember that the PHS office shuts down for the holidays from 24th December 2012 to 4th January 2013, but will be manned by a skeleton crew during this period.

See you next year!

Theen Moy

Contents

PowerBilling & Revenue Collection

PowerPerformance Management2

Protect the environment: Think before you print

Entrepreneur of the Year

Patrick accepting his award from MC Peter Berner

Central Region

Our very own Managing Director Patrick Power has won the Australian 2012 Central Region Ernst & Young **Entrepreneur Of The Year** award in the Technology category, for his work in building the healthcare software development brand into one which is considered a market leader in Australia, New Zealand, Ireland and Hong Kong.

Recoginising the Opportunity

Back in 2000, Patrick recognised a gap in the Australian healthcare industry as the existing decision support systems were all imported from overseas and nearing the end of their life-cycle. He started a software development firm to exploit this niche.

Decision Support

He secured an R&D Federal grant in excess of $1 million to develop PowerPerformance Management (PPM), and funded the remaining 50% budget through retained earnings and reoccurring revenue. PPM has since become the leading decision support system in Australia, with state health departments such as NSW, WA and ACT adopting it state-wide across all public hospitals.

Hospital Billing

Similarly in 2007, PowerHealth Solutions recognised that Australian public hospital billing was fragmented with no specialised vendor. The result was a fit-for-purpose enterprise-wide billing application, PowerBilling & Revenue Collection (PBRC) that was developed through another R&D federal grant, to integrate and simplify the billing process across all clinical systems.

Benefitting the Public Health System

Through the billing application, PowerHealth Solutions has been able to deliver millions of additional dollars back into the public health system, as well as help hospitals increase their revenue through private patient billing.

Patrick with the other Central Region winners

Recognition for staff

Accepting the award on behalf of the company, Patrick has passed on the honours to all PHS staff by displaying everyone's name in a large Thank You plaque.

National Awards

Patrick will be competing against all the other regional winners (Eastern, Western, Southern) in the Technology Category at the National Awards ceremony to be held in Sydney on 29th November.

PHS User Conference Expression of Interest

Conference organisers Debbie and Theen have started planning this event and it would really help us to get an idea of attendance numbers.

When:	Mid April 2013
Where:	WA — a resort near Perth,
How long:	2 days (Mon & Tues) with an optional site visit on Wed
Dinner:	Conference Dinner on the Monday night
Cost:	a small registration fee, under $300
Other Costs:	as usual you pay for your airfare & accommodation.

Click here to submit your expression of interest:
http://www.powerhealthsolutions.com/news/2012-11-EOI/

Follow us on FaceBook
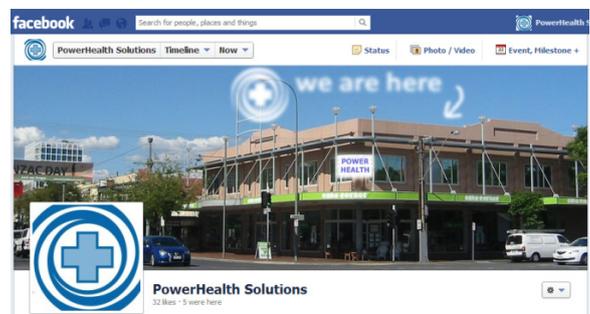
We have launched our FaceBook page and welcome everyone to check it out. Follow us as we gear up for the 2013 PHS User Conference. To join us, go to https://www.facebook.com/PowerHealthSolutions and click 👍 Like.

PHS at HIMAA 2012

PowerHealth Solutions participated in the 2012 **Health Information Management Association Australia** (HIMAA) 3-day national conference held in the Gold Coast, Queensland, from 29-31 October 2012.

Senior Costing Consultant Garth Barnett presented a paper entitled "Patient Costing & Clinical Engagement — It Starts With Coding" explaining to over 300 delegates (comprising Health Information Managers and Coders) where coding fits into the patient costing and funding process.

Health spending is projected to increase alarmingly and this is putting a lot of pressure on Government and personal budgets. Patient Costing is important to this issue as it is an essential Accountability Tool to monitor and manage health service costs.

Garth described the patient costing process and highlighted where and how clinical coding was important to this process. Using a case study based on data from a South Australian teaching hospital, Garth then demonstrated the costing process and analysis of the findings.

Afterwards, Garth sat on the Activity Based Funding panel with distinguished speakers Dr Tony Sherbon and Prof Ric Marshall to field questions from the floor.

Dr Tony Sherbon   Prof Ric Marshall

Click here to view and download Garth's paper "*Patient Costing & Clinical Engagement — It Starts With Coding*".

PHS at the PCSI Avignon 2012

PowerHealth Solutions has once again played a big part at the Patient Classification Systems International (PCSI) 3-day conference held in Avignon, France.

In addition to sponsoring the conference, Patrick Power presented a paper on "*Inspiring Health Costing Excellence With A Quality Assurance Framework*" (included in its entirety in this newsletter in the following section), and Nigel Michell demonstrated a live performance of Patient Level Costing.
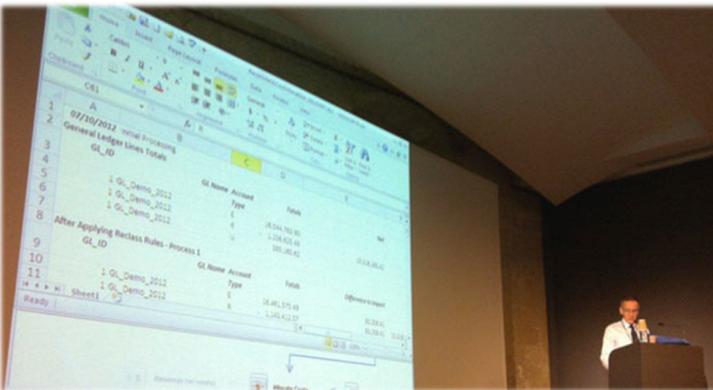
The conference theme focused on the "Future directions of Case Mix", and dealt with trends on casemix technical grounds and the application of casemix.

Inspiring Health Costing Excellence With A Quality Assurance Framework

Authored by Patrick Power, Garth Barnett, Andrew McBride

Executive Summary

The Inspiration

The main author was at an international conference in Montreal Canada last year where the *Australian Commonwealth Department of Health and Aging* (DOHA) announced to the audience that Australian hospitals that used *Diagnosis Related Groups* (DRGs) weights in their cost allocation methodology would be scored with a weighting of zero for those particular allocations.

As the Executive Director of PowerHealth Solutions (PHS), an organisation at the forefront of patient level costing in Australia and overseas, such a sweeping generalisation did not sit well with the author without the quantitative evidence to back it up. As a result, the authors undertook a study to compare the effectiveness of each allocation methodology.

Activity Based Funding

Activity Based Funding (ABF) is being implemented in Australia with the aim of providing greater clarity of health funding and to promote cost efficiencies.

ABF relies on the Commonwealth Government's *Independent Hospital Pricing Authority* (IHPA) to set a national efficient price, which in turn relies on the results from DOHA's *National Hospital Costing Data Collection* (NHCDC).

Gold Standard
Actual Costs = 10 points

Silver Standard
Planned Costs = 8 points

Bronze Standard
Actual Bed Hours = 5 points

DRG Weighted Actual Bed Hours = 0 points

For the purposes of the NHCDC, a Technical Working Group is developing the next version of the *Australian Hospital Patient Costing Standards* (AHPCS), which includes a proposed quality assurance framework where different alternative cost allocation methods are scored with different weightings. For example, for nursing salaries, the proposed scoring for the different allocation methodologies is actual costs (gold standard — 10 points); planned costs (silver standard — 8 points); actual bed hours (bronze standard — 5 points); DRG-weighted actual bed hours (0 points).

Allocation Methodology

For this study, PHS prepared three different versions of the NHCDC for a major metropolitan teaching hospital by adjusting the allocation methodology for nursing salary costs, whilst all other allocation set-ups remained constant.

The three different nursing cost allocation methods used were the:
- Exelcare nursing feeder system (ie gold standard),
- nursing DRG weighted actual bed hours (WABH), and
- actual bed hours (ABH).

The aim was to assess the relative quality of the latter two approaches for patient level nursing cost estimation, when compared to the agreed gold standard.

Results

The results from the study indicated that the use of ABH provides a marginally better understanding of patient level costs than does WABH.

The two approaches each explained approximately 60% of the variation in Exelcare assessed nursing requirements per episode. ABH was more efficient however, reducing residual variation by a further 5%.

Rewarding Australian hospitals who submit higher quality NHCDC data with a greater weighting in the development of the national efficient price for ABF is a significant positive step forward. However for this to be effective, the point scoring process developed by the *NHCDC Technical Working Group* needs to be based on statistical evidence.

In the Nursing Cost Allocation study, there was only a relatively small difference between the ABH and the WABH methods, yet under the proposed point scoring system, ABH would score 5 points, yet WABH would score no points.

To close, it is only with the development of a comprehensive quality assurance framework for the NHCDC studies based on statistical evidence, that the Commonwealth is more likely to develop a fair national efficient price that is crucial to underpinning ABF and its aims.

Introduction

Standardised Approach

With Activity Based Funding reform now well under way in Australia, it is an exciting time as the Commonwealth and State Governments finally get "fair dinkum" about a standardised national and collaborative approach to health costing and funding.

Quality Assurance Costing Framework

A key to encouraging health costing excellence is the establishment of a quality assurance costing framework, based on sound statistical evidence.

Protect the environment: Think before you print

Being at the forefront of patient level costing in Australia and overseas, PHS has a strong interest in the development of a rigorous costing framework and has undertaken a study that analyses the impact of alternative nursing cost allocation methodologies.

Background

ABF Implementation

ABF is being implemented in Australia with the aim of providing greater clarity of health funding and to promote efficiency for the benefit of consumers, clinicians, health units and Commonwealth/State Governments.

ABF relies on the Commonwealth Government's IHPA to set a national efficient price and classify and quantify different health activities to establish the funding for Local Hospital Networks (LHNs).

The information resulting from the NHCDC will be integral to IHPA in determining the national efficient price applicable for different health activities. It is therefore essential that the integrity of a national efficient price is contingent on LHNs across Australia applying a robust and consistent methodology when undertaking costing.

Periodic training and education of LHN staff, more frequent data submissions and automated data validation tools will also play a crucial role to the ongoing improvement of patient costing, consistent with national standards.

Quality in Patient Costing

Patient costing is a scientific but complex allocation process, which relies on a significant number of inputs that contribute to the calculation of the cost of activities. The quality in identifying these inputs, activities and allocation methodologies will dictate the value of the costing undertaken.

To assist LHNs and State Governments with the NHCDC studies, DOHA have developed AHPCS, which outline the process, principles and allocation methodologies available.

DOHA's *NHCDC Technical Working Group* is in the process of developing the next version of AHPCS, which includes a proposed quality assurance framework where different alternative cost allocation methods are scored with different weightings from 0 to 10.

The greater the score a LHN achieves the greater weighting they are likely to have on future NHCDC studies and the development of the national efficient price.

Nursing Cost Allocation Study

Methodology

PHS prepared three different versions of the NHCDC for a major metropolitan teaching hospital by adjusting the allocation methodology for nursing salary costs, whilst all other allocation set-ups remained constant.

The major teaching hospital selected for the 2009/2010 NHCDC study was chosen as it services a relatively large treatment population (ie creating a sample size of approximately 60,000 inpatient records) and delivers a diverse patient profile of DRGs, age, income and gender that should be highly generalisable nationally. The nursing weights used were drawn from the Commonwealth DOHA data collection service weights.

Statistical Approach

PHS engaged well-known Australian healthcare statistician Chris Aisbett, of Laeta Pty Ltd, to undertake the statistical analysis of the three studies using different nursing allocation methodologies.

Laeta's findings suggested that whilst there was insufficient data to address the aim of the study at a DRG level, the data was well suited for comparing the approaches at an aggregate level. This was done initially using the *Reduction In Variation* (RIV) across the whole treatment population.

In this scenario, the residual was between the Exelcare based cost per episode and the cost based on the alternative approaches. The exercise was then repeated using the sum across DRGs of the DRG residual variances.

Findings

The reduction in variation (per episode) achieved using WABH was 56% while ABH achieved 59%. The outcomes from the DRG aggregated measure were 55% and 59% for WABH and ABH respectively. The overall analysis was then conducted on the data with costs partitioned between direct and indirect costs.

The variance reduction for direct costs was the same as for total costs while for indirect costs WABH achieved 60% and ABH 62%.

The results are summarised below:

Reduction in Variation (RIV)	Nursing Weighted Actual Bed Hours (WABH)	Unweighted Actual Bed Hours (ABH)
RIV (per episode)	56%	59%
RIV (aggregated - direct/total)	55%	60%
RIV (aggregated - indirect)	60%	62%

In the absence of a set of nursing weights based on hours of stay, the use of ABH provides a marginally better understanding of patient level costs than does weighting by the values in current service weight schedules.
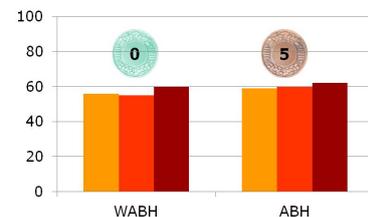
The two approaches each explained around 60% of the variation in Exelcare assessed nursing requirements per episode.

ABH was more efficient however, reducing residual variation by a further 5%.

Conclusion

Point scoring process

Rewarding Australian hospitals who submit higher quality NHCDC data with a greater weighting in the development of the national efficient price for ABF is a significant positive step forward.

However for this to be effective, the point scoring process developed by the NHCDC Technical Working Group needs to be based on statistical evidence, by testing and analysing the results of alternative allocation methods.

Weighting the points

In addition, further, consideration should be given to weighting the points on the materiality of each cost component. For example, it is more important to encourage a better allocation method for nursing salaries cost component, which accounts for 23.4% of the total cost (under the R14 NHCDC Study) as opposed to allied health salaries which account for 2.3% of the total cost.

Appropriate DRG hourly weights

Finally, the author believes that for most Wards, where patients treated vary significantly in terms of DRG and age, the cost allocation process would greatly benefit from the research and development of appropriate DRG hourly weights for some components of cost, such as nursing salaries.

The main author recently spent a week at a major metropolitan acute care Hospital in a Ward with the following composition:

- The first patient was a middle-aged man under observation while they looked for the cause of a recent stroke — *so almost no nursing care*.
- The second patient was a man in his 80s recovering from tracheostomy surgery — *so lots of nursing care due both to his age and DRG*.
- The third patient was a middle-aged man that had undergone a knee replacement (so lots of nursing care due to his DRG only) and finally the author was recovering from throat surgery, which entailed a feeding tube but did not hinder in any way his mobility — *so a medium level of nursing care was required due to his DRG only*.

From what the author observed, the need for nursing care across these four patients in the one ward was clearly very different and a simple allocation on hours, which is how these four patients will have been costed for the NHCDC, is very poor indeed.

Closing

To close, with the development of a comprehensive quality assurance framework for NHCDC studies based on statistical evidence, the Commonwealth is more likely to develop a fair national efficient price that is crucial to underpinning ABF and its aims.

Abbreviations

ABF	Activity Based Funding
ABH	Actual Bed Hours
AHPCS	Australian Hospital Patient Costing Standards
DOHA	Department of Health and Aging
DRG	Diagnosis Related Groups
IHPA	Independent Hospital Pricing Authority
LHN	Local Hospital Networks
NHCDC	National Hospital Costing Data Collection
PHS	PowerHealth Solutions
RIV	Reduction In Variation
WABH	Weighted Actual Bed Hours

Refererences

1. Sherbon A, IHPA and Activity Based Funding, Presented at the 2nd Annual Hospital Patient Costing Conference, March 2012, Brisbane, Queensland.
2. Australian Government Department of Health and Aging, Australian Hospital Patient Costing Standards, http://www.health.gov.au/internet/main/publishing.nsf/Content/Round_14-cost-reports.
3. McBride A, Barnett G, Moore P, 2009/10 NHCDC Costing Study
4. Aisbett C, The Impact of Weighting on Patient Level Nursing Cost Estimates, March 2012.
5. Australian Government Department of Health and Aging, Round 14 (2009/10) National Public Cost Weights Tables, http://www.health.gov.au/internet/main/publishing.nsf/Content/Round_14-cost-reports

PHS Restructures for Responsiveness

PowerHealth Solutions has restructured into 3 Divisions — Projects, Development, and Operations — each being headed up by an internal director. This new structure aligns the company towards project responsiveness, ensuring internal cohesiveness and focus. With the rapid growth experienced in the last few years, this is another step towards improved efficiency and productivity with a customer-centric focus. Meet our new internal directors — Evie, Brett and Amanda.

Evie Karagiannis — Projects Director

Evie heads up the new Projects Division with Consulting, Project Management, Integration and International Projects reporting to her. Evie is responsible for delivering PHS products and services for each project.

Evie has over 20 years experience in healthcare IT, spanning casemix project officer, decision support coordinator, TrendStar consultant, PAS billing consultant, costing consultant and as a PRINCE2-accredited project manager.

At PHS, Evie has worked in many roles including Costing Consultant, then Project Manager for many costing and billing projects including both the NSW Health state-wide costing and billing implementations, as well as Hong Kong Health Authority billing implementation.

Brett Michael — Development Director

Brett heads up the PHS Development Division with all Development Teams (PPM, PBRC-IE, PBRC-AE, Reporting) and the Testing Unit reporting to him. Brett is responsible for the design, development, testing, maintenance and support for all PHS products.

Brett has over 13 years experience in healthcare IT, with skills in software development, business analysis, systems architecture and project management. Prior to PHS, Brett ran his own consulting business in the collection, analysis and reporting of healthcare data.

At PHS, Brett has been responsible for standardising the tools and development methodology used by all of his teams, as well as being involved at the outset of many major software projects. Notable projects include building a team around the newly acquired PBRC-AE, architecting and managing the development of PBRC-IE, and designing and architecting PPM2.

Amanda Anderson — Operations Director

Amanda is a CPA with over 22 years experience in Finance, starting her career at KPMG. Amanda has since been the Chief Financial Officer in various small to medium enterprises.

Amanda heads up the Operations Division with Quality, Account Management, Sales & Marketing, Technical Writing, Administration & Finance, Human Resources and Infrastructure teams reporting to her. Amanda is responsible for the general operations of the company including finance, legal, expansion, processes, and management of growth. Amanda is also Company Secretary, providing a direct link to the Board of Directors.

At PHS, Amanda has been building on the existing structure of the company, such as the review and formalisation of policies & procedures especially in the areas of OH&S and HR. Amanda has also set up overseas companies in Hong Kong and Ireland, in addition to the existing UK and NZ entities. Amanda has setup monthly reporting to the Board and has reviewed & reissued all employee contracts. Her HR team has successfully implemented a new performance appraisal system.

PBRC-IE Update — Work List Items

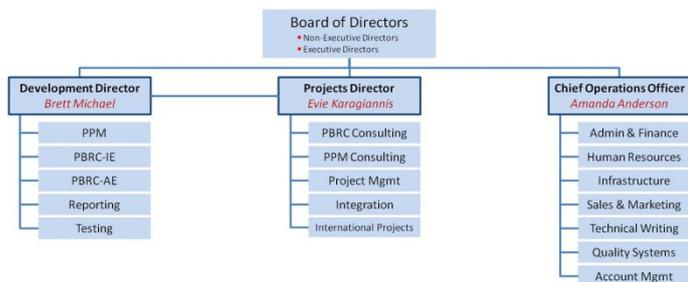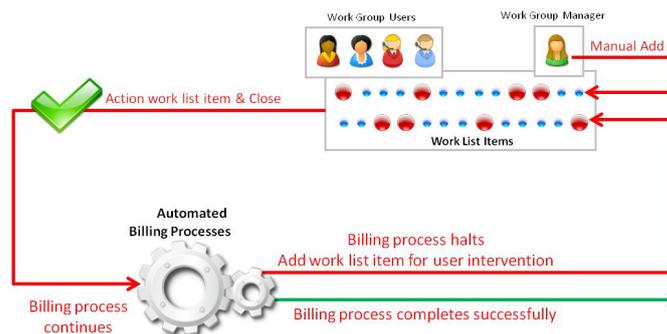**Personal Work List**   **Global Work List**   **Entity Work List**

Purpose

PBRC aims to fully automate the Billing Process by calculating charges based on service data received from clinical systems, generating invoices, and electronically claiming health fund reimbursements. However, human intervention is required to:
- make decisions — eg approve waivers, approve charge adjustments
- research information — eg find missing information
- resolve unexpected issues.

Each user intervention is highlighted by a **work list item** involving an **entity record** and is assigned to a user in a **work group**.

For example, when system discovers that **Recipient XYZ**'s gender is missing, it raises the work list item "**Recipient XYZ is missing gender information**" to alert the **Medical Records work group**. The work list item is then assigned (either automatically or manually) to the user Mary who belongs to that group.

Work list items can also be raised manually by the work group manager.

Personal Work List

Each user can see all the work list items assigned to them on their Personal Work List, which is in the left Control Panel.
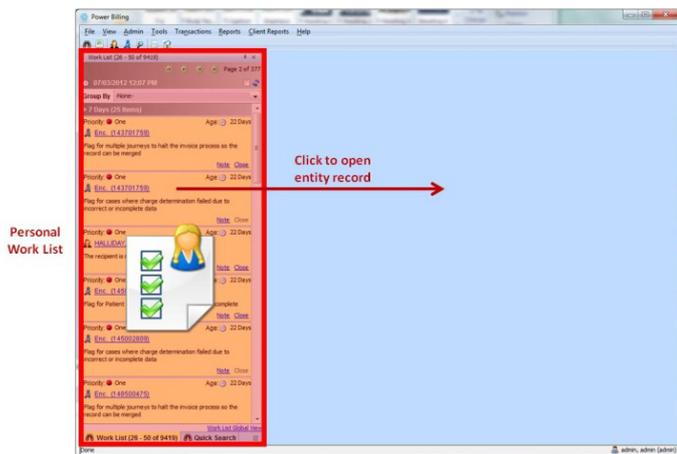
From the Personal Work List, you can:
▪ Group list by — age, type, priority, title, etc.
▪ Enter a note for the item to communicate with other users
▪ Reassign the item (if you have the authority) to another user
▪ Close the item once it has been actioned
▪ Open the entity record by clicking on the entity link.

Entity Work List

Work list items can also be tracked at the billing record level, so that you can see all the outstanding work list items for that entity record (eg Encounter, Recipient, Payor, Invoice).
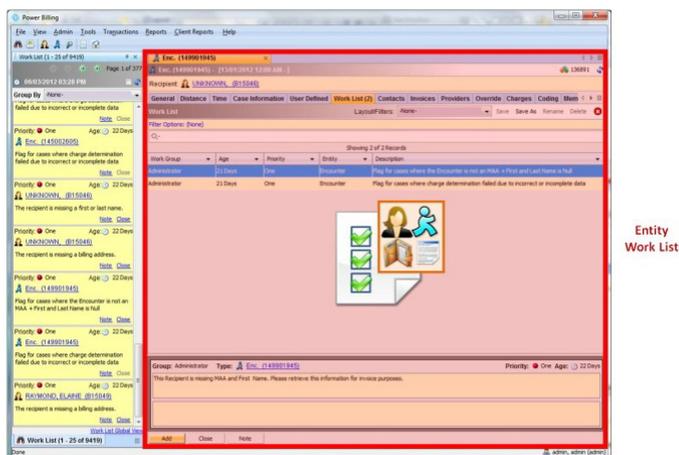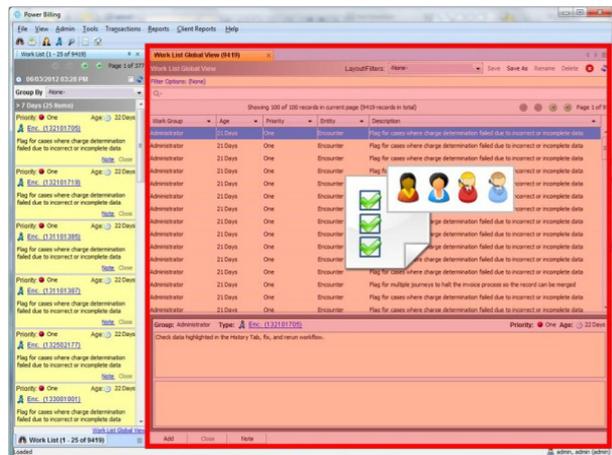

From the Entity Work List, you can:
▪ Click on any other entity tabs to view the entity record
▪ Sort the work list by clicking on any of the column headings
▪ Enter a note for the item to communicate with other users
▪ Reassign the item (if you have the authority) to another user
▪ Close the item once it has already been actioned.

Global Work List

You can view all the work list items assigned to your work group in the Global Work List. The Work Group Manager can use this list to manually re-assign items to users as required. A group member can use this list to acquire work list items.

From the Global Work List, you can:
▪ Sort the work list by clicking on any of the column headings
▪ Enter a note for the selected item to communicate with other users
▪ Reassign or Acquire the item (if you have the authority) to another user
▪ Close the item once it has already been actioned.

Management Tool

Work list items are a great management tool to:
▪ Optimise revenue by alerting staff of any disruptions in the automated process
▪ Track manual tasks in an open and transparent manner as opposed to paper trails that stay hidden
▪ Balance the workload among workgroup staff through work reassignment by managers
▪ Speed up the billing process by analysing for bottle necks in the automated processing flow.

Well done PPM Team

We just love getting positive feedback, so keep them coming! This is a really lovely one from GiGi Chan (a PPM2 user) to Debbie Thomas (the PHS Account Manager).

Dear Debbie,

This is not an issue or a problem.... but I just wanted you to relate to the team to encourage them with their excellent work and to let them know that as I am auditing the data and looking at the reports on the screens, running SQL queries etc... it just dawned on me as to how functional PPM2 (v1.3.3.1.1) is , the speed with which patients are costed and how easy it is to understand and pin point the cause of any issues from the user's side etc...

All of you should be very proud to be part of the development, consulting, training and be working on this EXCELLENT product.

Also, the support that I have experienced had been so great and makes a real difference during this period of the year when we are all so stressed to get the costs out to the Department.

THANK YOU VERY Much!!!

GiGi
Casemix

eastern**health**
GREAT HEALTH AND WELLBEING

Thanks Gigi. That really lifts our spirits. Well done to the PPM team!

Power Points

*spreading the news to all points of the globe*

PPM2 Update — Online Resource Browser

Single place to view PPM2 resources

PPM2 has a new *Online Resource Browser* that allows you to access system information directly from a single screen, such as:
▪ **Documents** — eg Release Notes, Import Specs, User Manual
▪ **Queries** — SQL queries to use in the Query Runner.

Online Resource Browser
Running inside PPM on a client PC

PHS Server
with up-to-date content
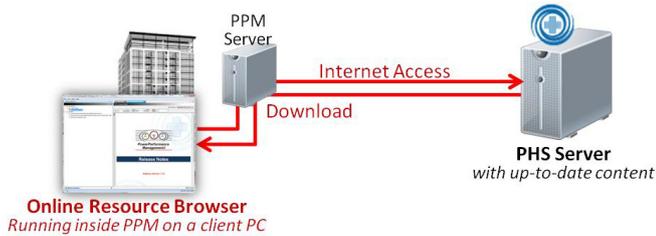
Automatic version matching

Over time, as each PPM2 software version is released, documents are updated as required. This means that there are multiple software versions and multiple resource versions, and they need matching up.

For example, by its very nature there will be a Release Notes document to match each software version released. However, as the Import Specifications document may not change as often as the software versions, one document version may apply to multiple software versions.
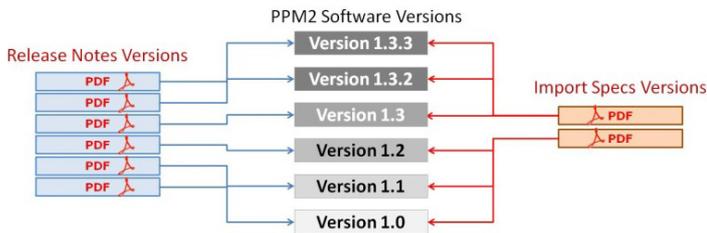

To shortcut the manual version matching, the system automatically finds the document that most closely matches your installed PPM2 version and displays its contents in the viewing pane.

If the exact match is not found, the system warns you of this using a yellow message on the top right and displays the next closest matching document or SQL query.

Viewing & Downloading documents
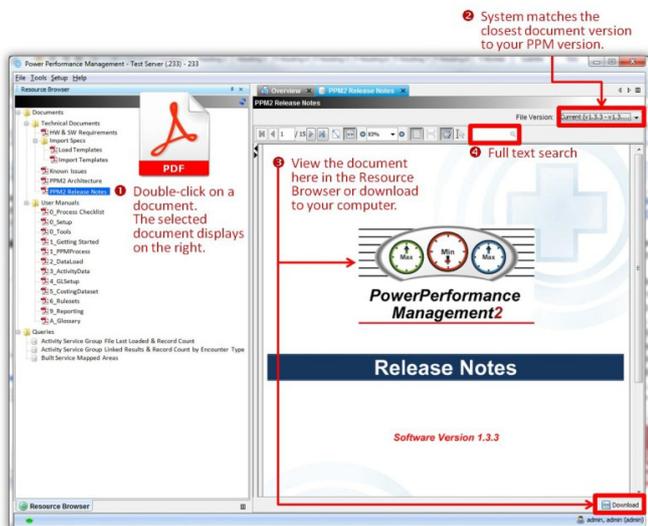
Viewing & Installing Queries
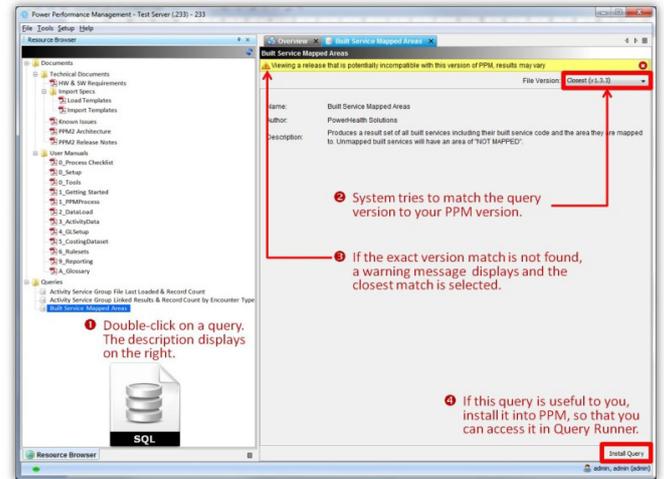
Once stop shop

The Online Resource Browser really simplifies the process of accessing all the technical documents and queries that are relevant to your PPM version. You are always informed if there is no exact match, the next best version is served up for you.


PBRC-AE Update — Edit Checks

Purpose

PBRC aims to fully automate the Billing Process by calculating charges based on service data received from clinical systems, generating invoices, and electronically claiming health fund reimbursements.

However, human intervention is required to:
- make decisions — eg approve waivers, approve charge adjustments
- research information — eg find missing information
- resolve issue — eg solve unexpected problems.
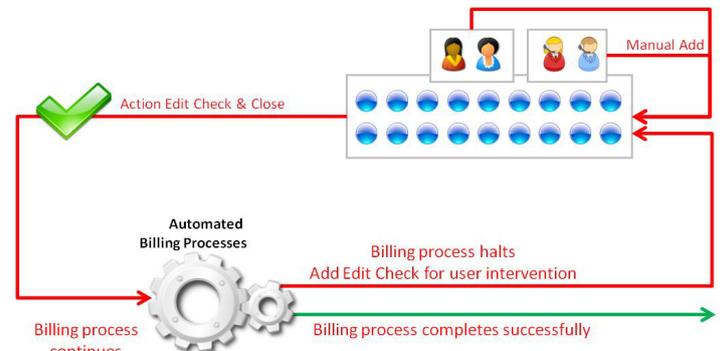
Each user intervention is highlighted by an **edit check** involving an **patient record** and categorized for a target **edit group**. For example, when system discovers a discrepancy in **Patient XYZ**'s accommodation, it raises the **Pt classified single room but is in shared ward** edit check to alert **PLO/Admissions Clerks**. Users can also add edit checks.

Open Edit Checks screen

Open the Edit Check screen from the Main Menu by selecting Accommodation Processing >> Edit Checks Screen.

Protect the environment: Think before you print

Edit Check search criteria

The Edit Check screen is useful for listing outstanding Edit Checks across the system. Users can search for specific types of Edit Checks using any of the search fields in the top section to find a manageable list of edit checks.

For example, you could look for edit checks by:
- Edit Group — the target user group
- Open — you would usually only be interested in Open edit checks
- Fin Class Type — patient financial class type
- Errors — either include or exclude the error that triggers edit checks
- Chargeable — chargeable or non-chargeable patients.

You can also search for edit checks by Sector, Hospital, Discharge Date range, Admission Date range, MRN, Source, Length of Stay, Exclude Dialysis, and Nursing Home.

Managing Edit Checks

You can perform the following actions on the Edit Checks listed:
- Sort the list of edit checks — surname, MRN, admission date, discharge date, error, error date, closed date
- Action the edit check — perform the required task either somewhere else in PBRC or outside of the system altogether
- Enter a comment — eg communicate followup actions with other users
- Mark the edit check as needing to be rechecked
- Close the edit check once it has been actioned and record the date.

Management Tool

Edit Checks are a great management tool to:
- Optimise billing revenue by alerting staff of any disruptions in the automated process
- Track task progress in visibly online vs hidden paper trails
- Improve communications between users and reduce paper.

Results for the July Babies

Congratulations to **Nguyet Vo**, who got 3 out of 4 guesses right (Patrick, Blake, Annabel). Nguyetwins double movie tickets to Event Cinemas!

Baby 1 = Patrick Power

Baby 2 = Carlo Mattiazzo

Baby 3 = Blake Kloeden

Baby 4 = Annabel Kueh

Employee Profiles

Brett Mander

Brett is a new Project Manager, and has been actively involved in costing and billing implementations such as Austin Health, SA Medical Imaging, and Calvary ACT. Brett is also project managing the St John of God implementation which is just starting.

He loves travelling, and has been to Europe, the United States, and sailed the Caribbean on the biggest cruise liner in the world. He has also travelled extensively around Australia.

Fav Food:	Chinese, Italian and Indian
Fav Movie:	Ocean's 11 series
Fav Band/Singer:	Dance music, eg Top 40
Fav Holiday Destn:	United States
Fav Book:	Australian Aviation magazine
Fav Sport/Team:	Crows in the AFL
Interests:	Aviation (has a collection > 100 model aircraft) Engineering, Cars, Technology, Gardening.

Frank la Fratta

Frank has been at PHS since the very early days, and is experienced in Costing, Revenue, and Billing Consulting. Frank is currently in the PBRC team, and involved in projects such as HKHA, Medica, NSW Ambulance, Mater and St John of God.

Frank enjoys being kept very busy by his 2 year old son Luke, who has an extremely active social life that fills up every weekend. When Frank does have any free time, he enjoys reading, watching football and cooking up a summer BBQ.

Fav Food:	Lasagna, curry and a boutique beer
Fav Movie:	"The Good the Bad and the Ugly" and any Spaghetti Western
Fav Band/Singer:	The Stone Roses, Nick Cave, The Shins
Fav Holiday Destn:	Rome, Italy
Fav Book:	Any good historical fiction like Imperium (Robert Harris), or some Norman Mailer
Fav Sport/Team:	Crows (AFL)
Interests:	Slow travel through Europe, saving the world.

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