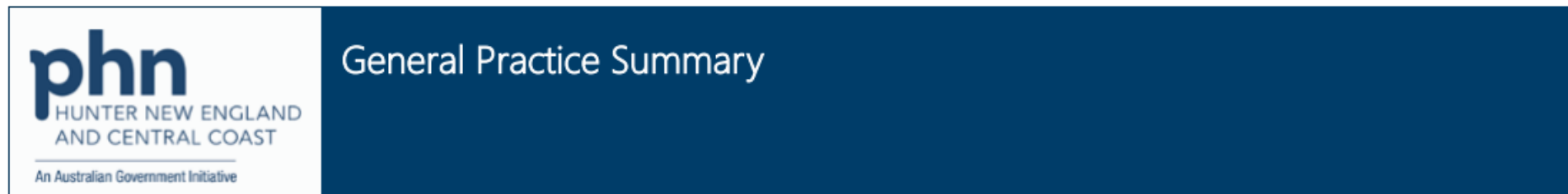




# Interpretation of the HNECCPHN General Practice Summary in the context of Chronic Kidney Disease




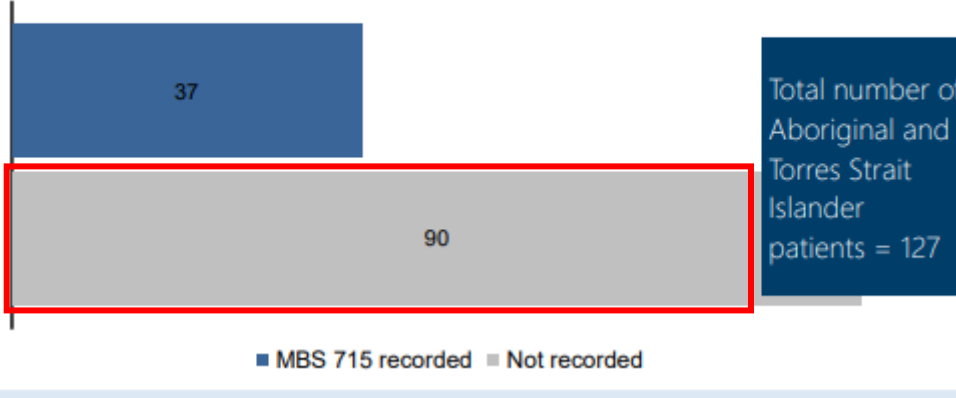


ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS																					
1.	<p><b>ETHNICITY</b></p> <table border="1" data-bbox="389 480 1346 927"> <thead> <tr> <th></th> <th>Total patients</th> <th>% of group</th> </tr> </thead> <tbody> <tr> <td>Indigenous</td> <td>127</td> <td>6.1 % **</td> </tr> <tr> <td>Aboriginal</td> <td>110</td> <td>( 86.6 % ) *</td> </tr> <tr> <td>Torres Strait Islander</td> <td>1</td> <td>( 0.8 % ) *</td> </tr> <tr> <td>Aboriginal and Torres Strait Islander</td> <td>16</td> <td>( 12.6 % ) *</td> </tr> <tr> <td>Non-indigenous</td> <td>1605</td> <td>76.6 % **</td> </tr> <tr style="border: 2px solid red;"> <td>Ethnicity not recorded</td> <td>362</td> <td>17.3 % **</td> </tr> </tbody> </table> <p><i>* % of active Aboriginal and Torres Strait Islander patients at this practice</i>  <i>** % of total active patients at this practice (excludes patients aged 100 years and over)</i></p>		Total patients	% of group	Indigenous	127	6.1 % **	Aboriginal	110	( 86.6 % ) *	Torres Strait Islander	1	( 0.8 % ) *	Aboriginal and Torres Strait Islander	16	( 12.6 % ) *	Non-indigenous	1605	76.6 % **	Ethnicity not recorded	362	17.3 % **	<p>Number and percentage of active patients at practice whose ethnicity is not recorded.</p> <p>In this Dashboard example, 362 patients do not have their ethnicity demographic recorded.</p> <p>Patients of Aboriginal &amp;/or Torres Strait Islander origin are at increased risk of developing Chronic Kidney Disease.</p> <p>Patients whose ethnicity is not recorded risk missing out on health care appropriate for their circumstances.</p> <p>Recording Indigenous ethnicity is important as it identifies patients for whom an annual Indigenous Health Assessment (MBS Item 715) should be attended to identify chronic disease, such as Chronic</p>	<p>Learn how to code ethnicity in patient records in your practice's software by searching for Data Mapping in PenCS <a href="#">Home - Pen CS</a></p> <p>Train practice staff to align your practice's techniques to the "National best practice Guidelines for collecting Indigenous status in health data sets" <a href="#">Home - Australian Institute of Health and Welfare (aihw.gov.au)</a></p> <p>Provide print material to patients, such as posters and brochures. <a href="#">indigenous-identification-DLbrochure.pdf.aspx (aihw.gov.au)</a></p>
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		<p>Kidney Disease. This assists to close the gap in health disparities between Indigenous and non-Indigenous persons.</p> <p>Also, when screening for Risk of Diabetes, the AUSDRISK Assessment asks if a patient is of Indigenous descent. A “yes” response adds 2 points to the AUSDRISK score in acknowledgement of the higher risk of diabetes in Indigenous populations</p> <p><small>3(a). Are you of Aboriginal, Torres Strait Islander, Pacific Islander or Maori descent? (required) <input type="radio"/> No [0 points] <input type="radio"/> Yes [2 points]</small></p> <p>Helps to meet the National Closing the Gap Primary Health Care Strategy</p>	<p>New patient forms.</p> <p>Complete Social-Family History in the patient’s record.</p>
2.	Aboriginal and Torres Strait Islander patients	<p>These measures indicate the number and percentage of Aboriginal and Torres Strait Islander patients in your practice.</p> <p>For example, this practice has 163 patients of Aboriginal</p>	<p>Consider that Chronic Kidney Disease is over-represented in this ethnicity group.</p> <p>An annual Kidney Health Check could form part of</p>



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	 <p>163 Aboriginal patients</p> <p>2.4 % % Aboriginal patients</p>	<p>and/or Torres Strait Islander origin, representing 2.4% of the practice's patients.</p> <p>Consider if this percentage is representative of the overall population in your geographical area. <a href="http://abs.gov.au">QuickStats (abs.gov.au)</a></p>	<p>the annual Indigenous Health Assessment.</p>
2.	<p><b>ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES HEALTH ASSESSMENT (MBS item 715)</b></p>  <p>37</p> <p>90</p> <p>Total number of Aboriginal and Torres Strait Islander patients = 127</p> <p>■ MBS 715 recorded ■ Not recorded</p>	<p>This data shows proportions of Aboriginal and Torres Strait Islander patients who have or have not had a Health Assessment recorded (MBS Item 715). This includes assessment of a patient's health and physical psychological and social function and consideration of whether preventative health care and education should be offered to the patient to improve that patients' health and physical, psychological and social function.</p> <p>RACGP National Guide to a Preventative Health Assessment for Aboriginal and</p>	<p>Provide patients with an Indigenous Health Assessment reminder card provided by the HNECCPHN.</p> <p>Brochure</p> <p>Reminders</p> <p>Incorporate the AUSDRISK within the Indigenous Health Assessment.</p>

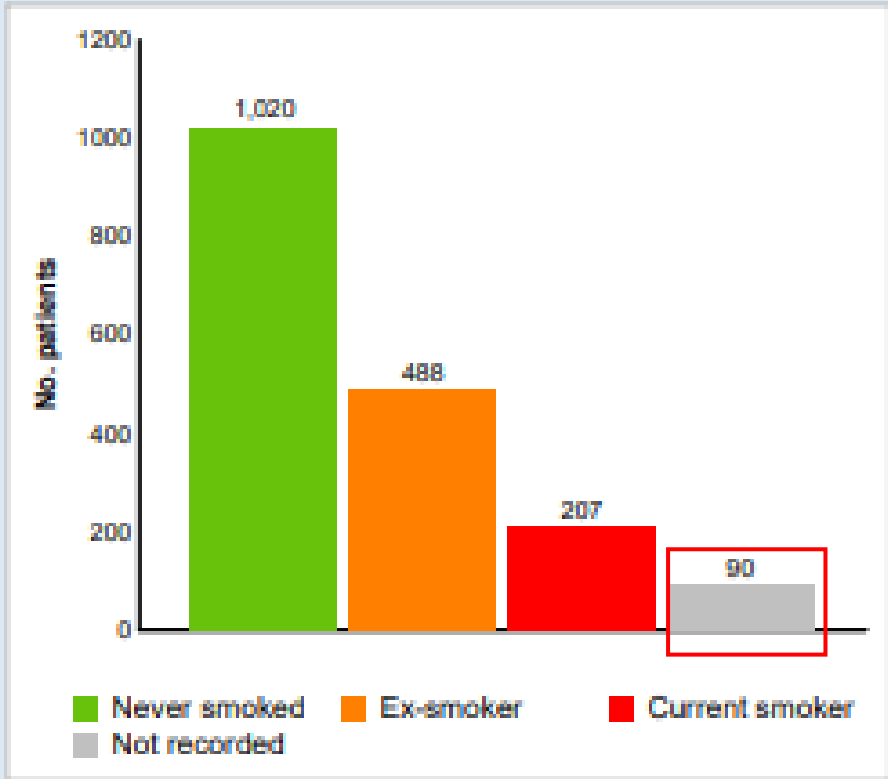


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		Torres Strait Islander People <a href="#">RACGP - The Royal Australian College of General Practitioners</a>											
2.	<p><b>LIFESTYLE RISKS</b></p> <p>WEIGHT (BMI)</p>  <table border="1"> <caption>Weight (BMI) Data</caption> <thead> <tr> <th>BMI Status</th> <th>No. patients</th> </tr> </thead> <tbody> <tr> <td>Not overweight or obese</td> <td>295</td> </tr> <tr> <td>Overweight</td> <td>432</td> </tr> <tr> <td>Obese</td> <td>547</td> </tr> <tr> <td>Not recorded (age &gt;= 15 years)</td> <td>531</td> </tr> </tbody> </table>	BMI Status	No. patients	Not overweight or obese	295	Overweight	432	Obese	547	Not recorded (age >= 15 years)	531	<p>The data shows the BMI status of patients aged 15 years and over who have had their BMI recorded in the last 2 years. BMI is classified as Obese (<math>\geq 30</math>), Overweight (25 to 30), or not overweight or obese (<math>&lt; 25</math>).</p> <p>In this example, 531 patients have not had their height and weight recorded to calculate a BMI.</p> <p>Patients with obesity over 30 kg/m<sup>2</sup> are at increased risk of developing Chronic Kidney Disease.</p> <p>Patients whose weight and height (BMI) are not recorded may miss out on healthcare appropriate for their circumstances. RACGP Guidelines for Type 2 recommend that...</p>	<p>Learn how to code weight, height and BMI in patient records in your practice's software by searching for Data Mapping in PenCS <a href="#">Home - Pen CS</a></p> <p>RACGP Guidelines</p>
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		NSW Health Get Healthy Coaching Service.	



ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS										
3.	<p data-bbox="383 323 584 368">SMOKING</p>  <table border="1" data-bbox="383 405 1267 1187"> <caption>Smoking Status Data</caption> <thead> <tr> <th>Smoking Status</th> <th>No. patients</th> </tr> </thead> <tbody> <tr> <td>Never smoked</td> <td>1,020</td> </tr> <tr> <td>Ex-smoker</td> <td>488</td> </tr> <tr> <td>Current smoker</td> <td>207</td> </tr> <tr> <td>Not recorded</td> <td>90</td> </tr> </tbody> </table>	Smoking Status	No. patients	Never smoked	1,020	Ex-smoker	488	Current smoker	207	Not recorded	90	<p data-bbox="1379 308 1783 408">The data shows the smoking status of patients aged 15 years and over.</p> <p data-bbox="1379 451 1783 552">In this example, 90 patients do not have their smoking status recorded.</p> <p data-bbox="1379 595 1783 732">Patients whose smoking status is not recorded may miss out on healthcare appropriate for their circumstances.</p> <p data-bbox="1379 775 1783 879">Patients who are smoke are at increased risk of developing Chronic Kidney Disease.</p> <p data-bbox="1379 922 1783 1026">These patients may miss out on smoking cessation interventions.</p> <p data-bbox="1379 1069 1783 1134">Smoking is a risk factor for Chronic Kidney Disease.</p> <p data-bbox="1379 1177 1783 1350">Smoking is a risk factor to develop diabetes and adds 2 points to the AUSDRISK score. <a href="#">Australian Government Department of Health</a></p>	<p data-bbox="1816 308 2119 552">Learn how to code smoking in patient records in your practice's software by searching for Data Mapping in <b>CAT4 at PenCS</b> <a href="#">Home - Pen CS</a></p> <p data-bbox="1816 595 2128 839">Learn how to navigate in <b>Medical Director</b> Software Support via Online Help for Clinical <a href="#">Software Solutions for Medical Practitioners   MedicalDirector</a></p> <p data-bbox="1816 882 2128 1126">Learn how to navigate in <b>Best Practice</b> Knowledge Base for Saffron version <a href="#">Select your Best Practice Software Knowledge Base (bpsoftware.net)</a></p>
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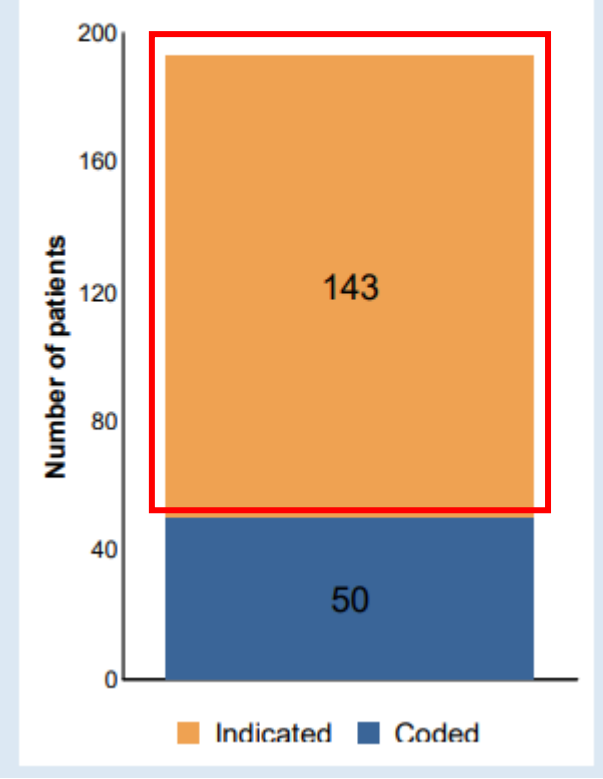
ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS																																														
		<p>RACGP Diabetes Type 2 Guidelines recommend that patients who smoke...</p> <p>RACGP Smoking, nutrition alcohol physical activity (SNAP) A population health guide to behavioural risk factors in general practice</p>																																															
4.	<p><b>DISEASE PREVALENCE</b></p> <p>Chart indicates numbers of patients at your practice coded with each diagnoses</p> <table border="1"> <caption>Disease Prevalence Data</caption> <thead> <tr> <th>Diagnosis</th> <th>Number of Patients</th> </tr> </thead> <tbody> <tr><td>Type 2 Diabetes</td><td>201</td></tr> <tr><td>Type 1 Diabetes</td><td>16</td></tr> <tr><td>Diabetes (undefined)</td><td>6</td></tr> <tr><td>Gestational Diabetes</td><td>14</td></tr> <tr><td>Asthma</td><td>273</td></tr> <tr><td>COPD</td><td>52</td></tr> <tr><td>Heart Failure</td><td>49</td></tr> <tr><td>Chronic Heart Disease</td><td>51</td></tr> <tr><td>Coronary Heart Disease</td><td>160</td></tr> <tr><td>Hyperlipidaemia</td><td>303</td></tr> <tr><td>Hypertension</td><td>657</td></tr> <tr><td>Peripheral Vascular Disease</td><td>16</td></tr> <tr><td>Stroke</td><td>69</td></tr> <tr><td>Renal Impairment</td><td>54</td></tr> <tr><td>Chronic Renal Failure</td><td>50</td></tr> <tr><td>Acute Renal Failure</td><td>4</td></tr> <tr><td>Anxiety</td><td>211</td></tr> <tr><td>Depression</td><td>258</td></tr> <tr><td>Schizophrenia</td><td>8</td></tr> <tr><td>Bipolar</td><td>13</td></tr> <tr><td>Dementia</td><td>7</td></tr> <tr><td>Postnatal Depression</td><td>3</td></tr> </tbody> </table>	Diagnosis	Number of Patients	Type 2 Diabetes	201	Type 1 Diabetes	16	Diabetes (undefined)	6	Gestational Diabetes	14	Asthma	273	COPD	52	Heart Failure	49	Chronic Heart Disease	51	Coronary Heart Disease	160	Hyperlipidaemia	303	Hypertension	657	Peripheral Vascular Disease	16	Stroke	69	Renal Impairment	54	Chronic Renal Failure	50	Acute Renal Failure	4	Anxiety	211	Depression	258	Schizophrenia	8	Bipolar	13	Dementia	7	Postnatal Depression	3	<p>This chart indicates the number of patients with 3 types of Chronic Kidney Disease whose diagnosis is coded at your practice.</p> <p>For example, 54 patients have a coded diagnosis of Renal Impairment, 50 have a coded diagnosis of Chronic Renal Failure and 4 patients are coded as having Acute Renal Failure.</p> <p>Patients whose type of Chronic Kidney Disease is coded as a non-specific type may miss out on healthcare</p>	<p>Learn how to code disease in patient records in your practice's software by searching for Data Mapping in CAT4 at PenCS <a href="#">Home - Pen CS</a></p>
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		<p>appropriate for their circumstances.</p> <p>For Chronic Kidney Disease, please note that it is coded for both active and inactive conditions in CAT4.</p> <p>NB. Patients may be counted in more than one disease category according to their coded diagnosis.</p>	



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5.	<p data-bbox="387 320 943 360">CHRONIC KIDNEY DISEASE</p>  <table border="1" data-bbox="387 424 987 1206"><caption>CHRONIC KIDNEY DISEASE - Patient Counts</caption><thead><tr><th>Category</th><th>Number of Patients</th></tr></thead><tbody><tr><td>Coded</td><td>50</td></tr><tr><td>Indicated</td><td>143</td></tr></tbody></table>	Category	Number of Patients	Coded	50	Indicated	143	<p data-bbox="1368 312 1794 592">The yellow group indicates patients without a coded diagnosis of Chronic Kidney Disease, but who have a likelihood of having Chronic Kidney Disease based on their pathology, including eGFR and/or Urine Microalbuminuria.</p> <p data-bbox="1368 632 1794 807">This includes patients whose Kidney Function Stage is 1 to 5, and whose timeliness for Clinical Review is 1-3 months, 6 months and 12 months.</p> <p data-bbox="1368 847 1794 991">In this example, 143 patients have pathology results that may indicate a Chronic Kidney Disease diagnosis.</p> <p data-bbox="1368 1031 1794 1206">The risk is that if Chronic Kidney Disease is not coded by diagnosis, management of their care may be suboptimal and complications can arise.</p> <p data-bbox="1368 1246 1794 1380">In addition, the CVD Risk Assessment is not possible to determine without considering a Urine Microalbuminuria, and</p>	<p data-bbox="1805 312 2145 592">Utilize <b>PenCS Cleansing Cat</b> module to identify patients for consideration of recording Chronic Kidney Disease as a diagnosis. <a href="#">Home - PenCS</a></p> <p data-bbox="1805 632 2145 735">See HNECCPHN Quality Improvement activity.</p>
Category	Number of Patients								
Coded	50								
Indicated	143								

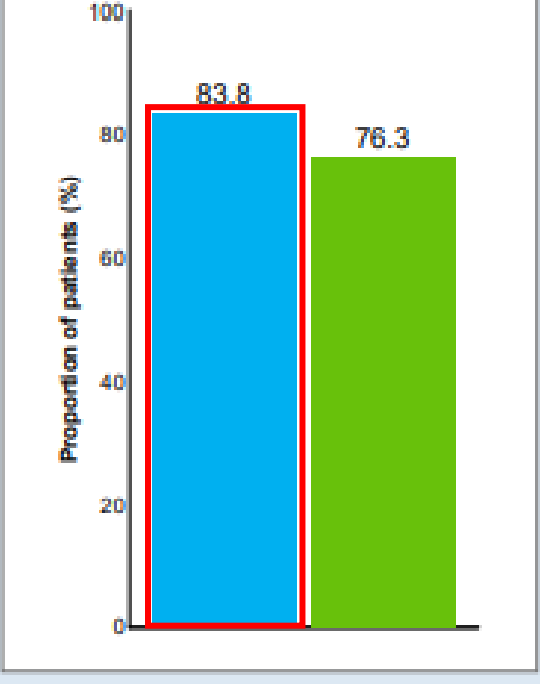


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		<p>associated diabetes disease and coded Blood Pressure observation.</p>	
<p>7.</p>	<p><b>MBS BILLING</b></p> <p><b>About MBS data</b></p> <p>For information on how PEN mapping systems, and MBS items in category see: <a href="http://help.pencs.com.au/display/Mapping+All+Systems">http://help.pencs.com.au/display/Mapping+All+Systems</a></p> <p>In some instances MBS mapping or missing, depending on local billing those instances data in the MBS page may be limited or missing.</p> <p>* In the chart, numbers represent items claimed.</p>	<p>The number of each MBS item claimed is represented in the graph.</p> <p>In regards to Chronic Disease, for example Chronic Kidney Disease, 950 GP Management Plans, 588 Team Care Arrangements, and 279 Reviews (of either item) have been successfully claimed by this practice.</p> <p>Chronic Disease Management MBS items are enablers to assist health professionals to manage the health care of a patient's chronic disease, for example Chronic Kidney Disease.</p> <p>Patients with either a GPMP or a TCA can also receive monitoring and support services from a Practice Nurse or Aboriginal and Torres Strait</p>	<p>Set reminders in patient record in Clinical Information System for the anticipated date of the Chronic Disease Item attendance.</p> <p><a href="#">Software Solutions for Medical Practitioners   MedicalDirector</a></p> <p><a href="#">Select your Best Practice Software Knowledge Base (bpsoftware.net)</a></p> <p>Send Reminder of planned attendance to patients via phone, mail, or SMS.</p> <p>Consider a third party reminder vendor.</p> <p>See HNECCPHN Quality Improvement Activity Chronic Disease</p>

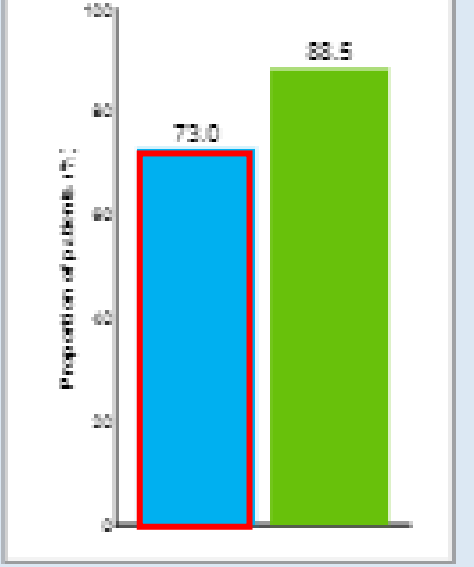


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		<p>Islander Health Practitioner on behalf of the GP (MBS Item 10997).</p> <p>For example, 418 Practice Nurse attendances (MBS Item 10997) have been claimed.</p> <p><a href="#">Department of Health   Chronic Disease Management (formerly Enhanced Primary Care or EPC) — GP services</a></p>	<p>Management and Chronic Kidney Disease</p>

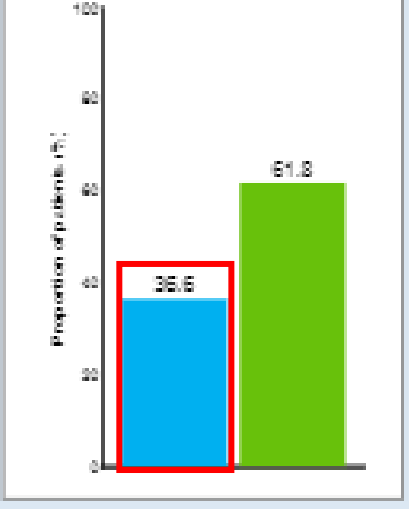


ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS						
8.	<p>QIM 01 - Proportion (%) of patients with Type 1 or Type 2 who have had an HbA1c measurement result recorded within the previous 12 months</p>  <table border="1" data-bbox="383 635 920 1321"> <caption>Proportion of patients with HbA1c recorded</caption> <thead> <tr> <th>Category</th> <th>Proportion (%)</th> </tr> </thead> <tbody> <tr> <td>Practice</td> <td>83.8</td> </tr> <tr> <td>HNECCPHN area</td> <td>76.3</td> </tr> </tbody> </table>	Category	Proportion (%)	Practice	83.8	HNECCPHN area	76.3	<p><b>PIP QI Incentive Improvement Measure #1</b></p> <p>Proportion of regular clients who have Type 1 or Type 2 diabetes and who have had an HbA1c measurement result recorded within the previous 12 months.</p> <p>For example, in this practice 83.8% of patient with Diabetes have had an HbA1c recorded. In all other practice in the HNECCPHN area, 76.3% of patients have had an HbA1c recorded.</p> <p>There are 217 patients within the practice diagnosed with Type 1 or Type 2 Diabetes (from Item 1 in this Guide). This graph indicates that about 181 have had a HbA1c collection and 36 are outstanding.</p>	<p>Consider providing single prescriptions without repeats to motivate patient to attend pathology.</p> <p>Set Reminder in patient record.</p> <p>Utilize the Diabetes Register in practice software to drive planned Cycle of Care activities, such as HbA1c pathology. <a href="#">Select your Best Practice Software Knowledge Base (bpsoftware.net)</a></p> <p><a href="#">Software Solutions for Medical Practitioners   MedicalDirector</a></p> <p>See HNECCPHN Quality Improvement Activity “Utilizing Diabetes Register”</p> <p>See HNECCPHN Quality Improvement</p>
Category	Proportion (%)								
Practice	83.8								
HNECCPHN area	76.3								

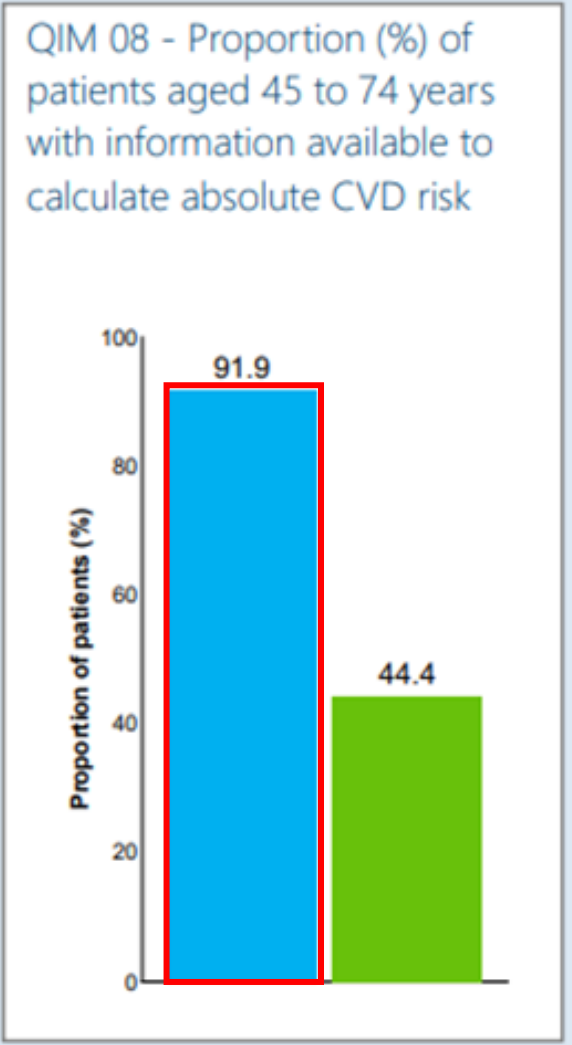


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9.	<p data-bbox="405 440 824 596">QIM 02 - Proportion (%) of patients aged 15 years and over whose smoking status has been recorded</p>  <table border="1" data-bbox="389 699 860 1267"><caption>Smoking Status Recording Data</caption><thead><tr><th>Category</th><th>Proportion (%)</th></tr></thead><tbody><tr><td>Practice (Blue bar)</td><td>73.0</td></tr><tr><td>All other patients at HNECCPHN (Green bar)</td><td>88.5</td></tr></tbody></table>	Category	Proportion (%)	Practice (Blue bar)	73.0	All other patients at HNECCPHN (Green bar)	88.5	<p data-bbox="1368 419 1765 483">PIP QI Incentive Improvement Measure #2</p> <p data-bbox="1368 528 1749 700">Proportion of regular clients aged 15 years or over whose smoking status has been recorded as current smoker, ex-smoker, or never smoked.</p> <p data-bbox="1368 745 1778 954">For example in this graph, 73.0 % of this practices patients had their smoking status recorded, compared to 88.5% of all other patients at HNECCPHN practices.</p>	<p data-bbox="1809 312 2074 408">Activity “Completing Diabetes Cycles of Care”</p> <p data-bbox="1809 419 2092 451">RACGP SNAP Guide</p> <p data-bbox="1809 491 2092 523">Social-Family History</p> <p data-bbox="1809 563 2119 627">Smoking Cessation Readiness Assessment</p> <p data-bbox="1809 667 2119 770">Annual Diabetes Cycle of Care in CIS Diabetes Register</p> <p data-bbox="1809 810 2119 914">PenCS Missing Accreditation items, Diabetes Cycle of Care</p>
Category	Proportion (%)								
Practice (Blue bar)	73.0								
All other patients at HNECCPHN (Green bar)	88.5								



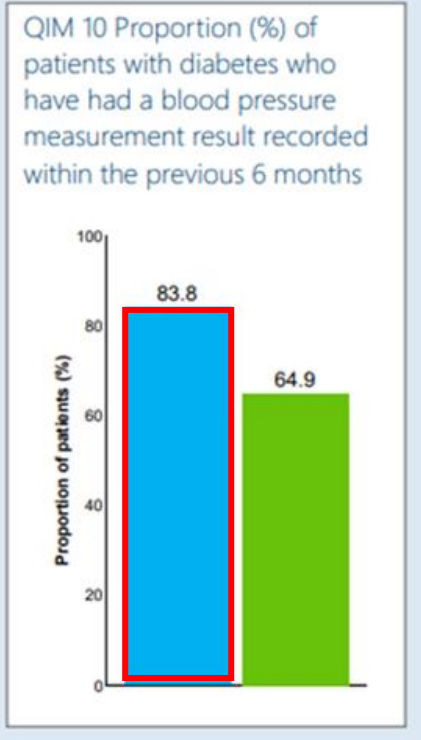
ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS						
10.	<p data-bbox="398 323 763 504">QIM 03 - Proportion (%) of patients aged 15 years and over who have had their Body Mass Index (BMI) classified within the previous 12 months</p>  <table border="1" data-bbox="383 555 790 1066"><caption>Proportion of patients with BMI recorded</caption><thead><tr><th>Category</th><th>Proportion (%)</th></tr></thead><tbody><tr><td>Recorded</td><td>36.6</td></tr><tr><td>All other HNECCPHN practices</td><td>61.8</td></tr></tbody></table>	Category	Proportion (%)	Recorded	36.6	All other HNECCPHN practices	61.8	<p data-bbox="1373 312 1765 371">PIP QI Incentive Improvement Measure #3</p> <p data-bbox="1373 419 1783 663">Proportion of regular clients aged 15 years and over who had their Body Mass Index (BMI) classified as obese, overweight, healthy, or underweight within the previous 12 months.</p> <p data-bbox="1373 711 1776 882">For example in this graph, 36.6 % of patients have had a BMI recorded, compared to 61.8% of patients in all other HNECCPHN practices.</p> <p data-bbox="1373 930 1749 1094">BMI is an indicator of risk of diabetes and cardio-vascular disease, and a progress measure in established diabetes.</p>	<p data-bbox="1809 312 2119 339">Diabetes Cycle of Care</p> <p data-bbox="1809 387 2047 414">Diabetes Register</p> <p data-bbox="1809 456 2007 515">RACGP SNAP Assessment</p> <p data-bbox="1809 563 2074 622">RACGP Type 2 Diabetes Guidelines</p>
Category	Proportion (%)								
Recorded	36.6								
All other HNECCPHN practices	61.8								



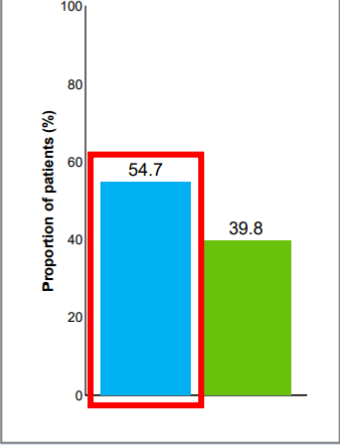
ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS						
12.	<p>QIM 08 - Proportion (%) of patients aged 45 to 74 years with information available to calculate absolute CVD risk</p>  <table border="1" data-bbox="389 320 958 1369"> <caption>QIM 08 - Proportion (%) of patients aged 45 to 74 years with information available to calculate absolute CVD risk</caption> <thead> <tr> <th>Group</th> <th>Proportion (%)</th> </tr> </thead> <tbody> <tr> <td>Current Practice</td> <td>91.9</td> </tr> <tr> <td>Other Participating HNECCPHN Practices</td> <td>44.4</td> </tr> </tbody> </table>	Group	Proportion (%)	Current Practice	91.9	Other Participating HNECCPHN Practices	44.4	<p>PIP QI Incentive Improvement Measure #8</p> <p>Proportion of regular clients aged 45 to 74 with information available to calculate their absolute Cardio-vascular Disease Risk.</p> <p>For example in this graph, 91.9% of patients with information recorded to calculate Cardio-vascular Risk, compared to 44.4% of patients in all other participating HNECCPHN practices.</p> <p>Cardio-vascular disease is complication of Chronic Kidney Disease. Chronic Kidney Disease is known to increase risk of cardio-vascular disease. The Absolute Cardio-vascular Disease Risk Assessment determines that patients with diabetes and age&gt;60, or diabetes with microalbuminuria (&gt;20 mcg/min or Urine Albumin Creatinine Ratio &gt;2.5 mg/mmol for males, &gt;3.5 mg/mmol for</p>	<p>RACGP Diabetes Guideline</p> <p>Absolute Cardio Vascular Disease Risk Assessment <a href="#">Absolute CVD Risk Full Guidelines.pdf (cvdcheck.org.au)</a></p> <p>Ensure a Urine Microalbuminuria pathology result is coded in the patient record to enable an accurate Cardio-vascular Risk assessment.</p>
Group	Proportion (%)								
Current Practice	91.9								
Other Participating HNECCPHN Practices	44.4								





ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS						
		<p>females are at clinically determined high risk for cardiovascular disease.</p> <p><a href="#">Absolute CVD Risk Full Guidelines.pdf (cvdcheck.org.au)</a></p>							
13.	<p>QIM 10 Proportion (%) of patients with diabetes who have had a blood pressure measurement result recorded within the previous 6 months</p>  <table border="1"><caption>QIM 10 Proportion (%) of patients with diabetes who have had a blood pressure measurement result recorded within the previous 6 months</caption><thead><tr><th>Group</th><th>Proportion (%)</th></tr></thead><tbody><tr><td>Practice</td><td>83.8</td></tr><tr><td>All other HNECCPHN practices</td><td>64.9</td></tr></tbody></table>	Group	Proportion (%)	Practice	83.8	All other HNECCPHN practices	64.9	<p>PIP QI Incentive Improvement Measure #10</p> <p>Proportion of regular clients who have Diabetes and who have had a blood pressure measurement result recorded at the primary health care service.</p> <p>For example in this graph, 83.8 % of patients with diabetes have had a blood pressure recorded at this practice, compared to 64.9 % of patients with diabetes in all other HNECCPHN practices.</p> <p>This can be a process measure of a subgroup of patients with diabetes. This could be a proxy for the quality of recording of BP for patients with chronic disease in the</p>	<p>RACGP Diabetes Guideline</p>
Group	Proportion (%)								
Practice	83.8								
All other HNECCPHN practices	64.9								



ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS						
		<p>practice. Diabetes and Cardiovascular disease is strongly associated with Chronic Kidney Disease.</p>							
	<p>QIM 07 - Proportion (%) of patients aged 15 years and over whose alcohol consumption status has been recorded</p>  <table border="1"> <caption>Alcohol Consumption Status Data</caption> <thead> <tr> <th>Category</th> <th>Proportion of patients (%)</th> </tr> </thead> <tbody> <tr> <td>Recorded (Blue)</td> <td>54.7</td> </tr> <tr> <td>Not Recorded (Green)</td> <td>39.8</td> </tr> </tbody> </table>	Category	Proportion of patients (%)	Recorded (Blue)	54.7	Not Recorded (Green)	39.8	<p>This measure indicates the proportion of patients in the practice aged 15 years and over whose alcohol consumption status has been recorded.</p> <p>For example, in this practice 54.7% of patients do not have a coded assessment recorded.</p>	<p>AUDIT-C assessment tool</p> <p>in practice software</p> <p>CAT4 mapping guide for coding assessments</p>
Category	Proportion of patients (%)								
Recorded (Blue)	54.7								
Not Recorded (Green)	39.8								



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