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

General Practice Summary

The PHN July 2021 V1

ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS
1.	ETHNICITY | | 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 % ** | ** % of active Aboriginal and Torres Strait Islander patients at this practice* *** % of total active patients at this practice (excludes patients aged 100 years and over)*	Number and percentage of active patients at practice whose ethnicity is not recorded. In this Dashboard example, 362 patients do not have their ethnicity demographic recorded. Patients of Aboriginal &/or Torres Strait Islander origin are at increased risk of developing Chronic Kidney Disease. Patients whose ethnicity is not recorded risk missing out on health care appropriate for their circumstances. 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	Learn how to code ethnicity in patient records in your practice's software by searching for Data Mapping in PenCS [Home - Pen CS] Train practice staff to align your practice's techniques to the "National best practice Guidelines for collecting Indigenous status in health data sets" [Home - Australian Institute of Health and Welfare (aihw.gov.au)] Provide print material to patients, such as posters and brochures. [indigenous-identification-DLbrochure.pdf.aspx (aihw.gov.au)]

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		Kidney Disease. This assists to close the gap in health disparities between Indigenous and non-Indigenous persons. 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 3(a). Are you of Aboriginal, Torres Strait Islander, Pacific Islander or Maori descent? (required) No [0 points Yes [2 points Helps to meet the National Closing the Gap Primary Health Care Strategy	New patient forms. Complete Social-Family History in the patient’s record.
2.	Aboriginal and Torres Strait Islander patients	These measures indicate the number and percentage of Aboriginal and Torres Strait Islander patients in your practice. For example, this practice has 163 patients of Aboriginal	Consider that Chronic Kidney Disease is over-represented in this ethnicity group. An annual Kidney Health Check could form part of

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	163 Aboriginal patients 2.4 % % Aboriginal patients	and/or Torres Strait Islander origin, representing 2.4% of the practice's patients. Consider if this percentage is representative of the overall population in your geographical area. QuickStats (abs.gov.au)	the annual Indigenous Health Assessment.
2.	ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES HEALTH ASSESSMENT (MBS item 715) 37 90 Total number of Aboriginal and Torres Strait Islander patients = 127 MBS 715 recorded Not recorded	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. RACGP National Guide to a Preventative Health Assessment for Aboriginal and	Provide patients with an Indigenous Health Assessment reminder card provided by the HNECCPHN. Brochure Reminders Incorporate the AUSDRISK within the Indigenous Health Assessment.

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		Torres Strait Islander People RACGP - The Royal Australian College of General Practitioners	
2.	LIFESTYLE RISKS WEIGHT (BMI) No. patients: 0, 100, 200, 300, 400, 500, 600 295, 432, 547, 531 Not overweight or obese; Overweight; Obese; Not recorded (age >= 15 years)	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 (>=30), Overweight (25 to 30), or not overweight or obese (<25). In this example, 531 patients have not had their height and weight recorded to calculate a BMI. Patients with obesity over 30 kg/m2 are at increased risk of developing Chronic Kidney Disease. 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…	Learn how to code weight, height and BMI in patient records in your practice's software by searching for Data Mapping in PenCS Home - Pen CS RACGP Guidelines

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		NSW Health Get Healthy Coaching Service.	

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3.	SMOKING No. patients: 1200, 1000, 800, 600, 400, 200, 0 1,020 · 488 · 207 · 90 Never smoked · Ex-smoker · Current smoker · Not recorded	The data shows the smoking status of patients aged 15 years and over. In this example, 90 patients do not have their smoking status recorded. Patients whose smoking status is not recorded may miss out on healthcare appropriate for their circumstances. Patients who are smoke are at increased risk of developing Chronic Kidney Disease. These patients may miss out on smoking cessation interventions. Smoking is a risk factor for Chronic Kidney Disease. Smoking is a risk factor to develop diabetes and adds 2 points to the AUSDRISK score. Australian Government Department of Health	Learn how to code smoking in patient records in your practice's software by searching for Data Mapping in **CAT4 at PenCS** Home - Pen CS Learn how to navigate in **Medical Director** Software Support via Online Help for Clinical Software Solutions for Medical Practitioners | MedicalDirector Learn how to navigate in **Best Practice** Knowledge Base for Saffron version Select your Best Practice Software Knowledge Base (bpsoftware.net)

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		RACGP Diabetes Type 2 Guidelines recommend that patients who smoke… RACGP Smoking, nutrition alcohol physical activity (SNAP) A population health guide to behavioural risk factors in general practice	
4.	DISEASE PREVALENCE Chart indicates numbers of patients at your practice coded with each diagnoses 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	This chart indicates the number of patients with 3 types of Chronic Kidney Disease whose diagnosis is coded at your practice. 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. Patients whose type of Chronic Kidney Disease is coded as a non-specific type may miss out on healthcare	Learn how to code disease in patient records in your practice's software by searching for Data Mapping in CAT4 at PenCS Home - Pen CS

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		appropriate for their circumstances. For Chronic Kidney Disease, please note that it is coded for both active and inactive conditions in CAT4. NB. Patients may be counted in more than one disease category according to their coded diagnosis.	

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5.	CHRONIC KIDNEY DISEASE 200 160 120 80 40 0 Number of patients 143 50 Indicated Coded	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. 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. In this example, 143 patients have pathology results that may indicate a Chronic Kidney Disease diagnosis. The risk is that if Chronic Kidney Disease is not coded by diagnosis, management of their care may be suboptimal and complications can arise. In addition, the CVD Risk Assessment is not possible to determine without considering a Urine Microalbuminuria, and	Utilize **PenCS Cleansing Cat** module to identify patients for consideration of recording Chronic Kidney Disease as a diagnosis. Home - Pen CS See HNECCPHN Quality Improvement activity.

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		associated diabetes disease and coded Blood Pressure observation.	
7.	MBS BILLING 721 (CDM-GPMP) - 950 723 (CDM-TCA) - 588 732 (CDM Review) - 279 11506 (Respiratory) - 0 10987 (PN/AHP Service) - 0 10997 (PN/AHP Service) - 418 900 (DMMR) - 256 903 (RMMR) - 4 Health Assessment Ages 45-49 - 1 Health Assessment Ages 75+ - 213 About MBS data For information on how PEN ma[...] billing systems, and MBS items i[...] category see: http://help.pencs.com.au/display[...] Mapping+All+Systems In some instances MBS mappin[...] or missing, depending on local b[...] those instances data in the MBS[...] page may be limited or missing. * In the chart, numbers represen[...] items claimed.	The number of each MBS item claimed is represented in the graph. 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. 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. Patients with either a GPMP or a TCA can also receive monitoring and support services from a Practice Nurse or Aboriginal and Torres Strait	Set reminders in patient record in Clinical Information System for the anticipated date of the Chronic Disease Item attendance. Software Solutions for Medical Practitioners | MedicalDirector Select your Best Practice Software Knowledge Base (bpsoftware.net) Send Reminder of planned attendance to patients via phone, mail, or SMS. Consider a third party reminder vendor. See HNECCPHN Quality Improvement Activity Chronic Disease

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		Islander Health Practitioner on behalf of the GP (MBS Item 10997). For example, 418 Practice Nurse attendances (MBS Item 10997) have been claimed. Department of Health | Chronic Disease Management (formerly Enhanced Primary Care or EPC) — GP services	Management and Chronic Kidney Disease

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8.	QIM 01 - Proportion (%) of patients with Type 1 or Type 2 who have had an HbA1c measurement result recorded within the previous 12 months Proportion of patients (%) 100 80 60 40 20 0 83.8 76.3	PIP QI Incentive Improvement Measure #1 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. 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. 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.	Consider providing single prescriptions without repeats to motivate patient to attend pathology. Set Reminder in patient record. Utilize the Diabetes Register in practice software to drive planned Cycle of Care activities, such as HbA1c pathology. Select your Best Practice Software Knowledge Base (bpsoftware.net) Software Solutions for Medical Practitioners | MedicalDirector See HNECCPHN Quality Improvement Activity “Utilizing Diabetes Register” See HNECCPHN Quality Improvement

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			Activity “Completing Diabetes Cycles of Care”
9.	QIM 02 - Proportion (%) of patients aged 15 years and over whose smoking status has been recorded Proportion of patients (%) 73.0 88.5	PIP QI Incentive Improvement Measure #2 Proportion of regular clients aged 15 years or over whose smoking status has been recorded as current smoker, ex-smoker, or never smoked. 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.	RACGP SNAP Guide Social-Family History Smoking Cessation Readiness Assessment Annual Diabetes Cycle of Care in CIS Diabetes Register PenCS Missing Accreditation items, Diabetes Cycle of Care

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10.	QIM 03 - Proportion (%) of patients aged 15 years and over who have had their Body Mass Index (BMI) classified within the previous 12 months 36.6 61.8	PIP QI Incentive Improvement Measure #3 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. 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. BMI is an indicator of risk of diabetes and cardio-vascular disease, and a progress measure in established diabetes.	Diabetes Cycle of Care Diabetes Register RACGP SNAP Assessment RACGP Type 2 Diabetes Guidelines

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12.	QIM 08 - Proportion (%) of patients aged 45 to 74 years with information available to calculate absolute CVD risk Proportion of patients (%) 100, 80, 60, 40, 20, 0 91.9 44.4	PIP QI Incentive Improvement Measure #8 Proportion of regular clients aged 45 to 74 with information available to calculate their absolute Cardio-vascular Disease Risk. 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. 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>60, or diabetes with microalbuminuria (>20 mcg/min or Urine Albumin Creatinine Ratio >2.5 mg/mmol for males, >3.5 mg/mmol for	RACGP Diabetes Guideline Absolute Cardio Vascular Disease Risk Assessment Absolute_CVD_Risk_Full_Guidelines.pdf (cvdcheck.org.au) Ensure a Urine Microalbuminuria pathology result is coded in the patient record to enable an accurate Cardio-vascular Risk assessment.

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		females are at clinically determined high risk for cardio-vascular disease. [Absolute_CVD_Risk_Full_Guidelines.pdf (cvdcheck.org.au)]	
13.	QIM 10 Proportion (%) of patients with diabetes who have had a blood pressure measurement result recorded within the previous 6 months Proportion of patients (%) 100 80 60 40 20 0 83.8 64.9	PIP QI Incentive Improvement Measure #10 Proportion of regular clients who have Diabetes and who have had a blood pressure measurement result recorded at the primary health care service. 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. 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	RACGP Diabetes Guideline

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		practice. Diabetes and Cardio-vascular disease is strongly associated with Chronic Kidney Disease.	
	QIM 07 - Proportion (%) of patients aged 15 years and over whose alcohol consumption status has been recorded Proportion of patients (%) 100, 80, 60, 40, 20, 0 54.7 39.8	This measure indicates the proportion of patients in the practice aged 15 years and over whose alcohol consumption status has been recorded. For example, in this practice 54.7% of patients do not have a coded assessment recorded.	AUDIT-C assessment tool in practice software CAT4 mapping guide for coding assessments

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Hunter New England Central Coast Primary Health Network (HNECC PHN)