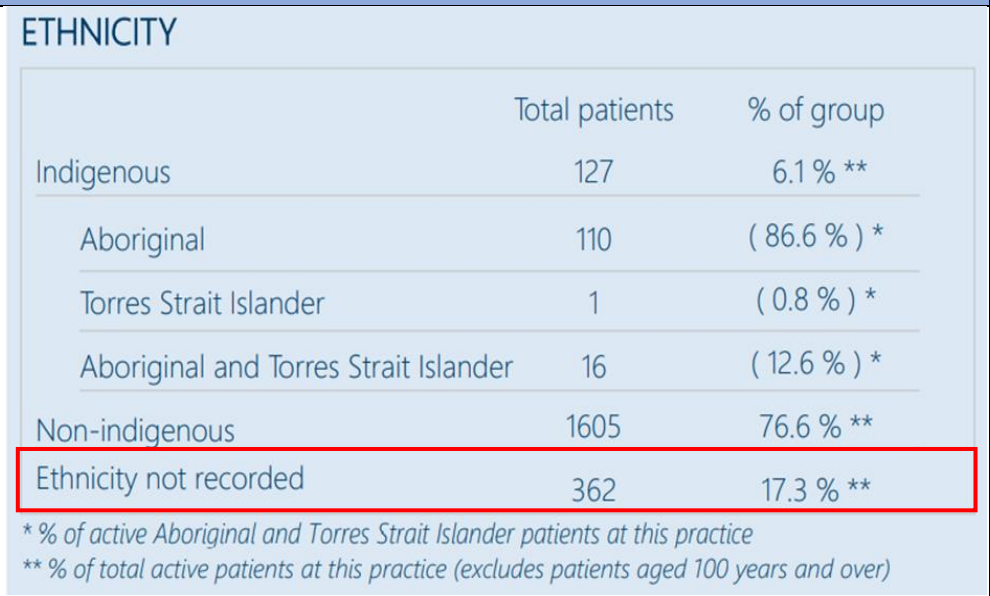
Interpretation of the HNECCPHN General Practice Summary in the context of Diabetes Mellitus

ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS
1.		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 whose ethnicity is not recorded risk missing out on health care appropriate for their circumstances. Specifically, recording Indigenous ethnicity is important as it identifies Indigenous patients for whom an Indigenous Health Assessment (MBS Item 715) should be attended. This helps to identify chronic disease such as Diabetes early and assists to close the gap in health disparities between indigenous and non-indigenous persons.	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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		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] Meets Closing the Gap Primary Health Care Strategy	New patient forms. Complete Social-Family History in the patient's record.

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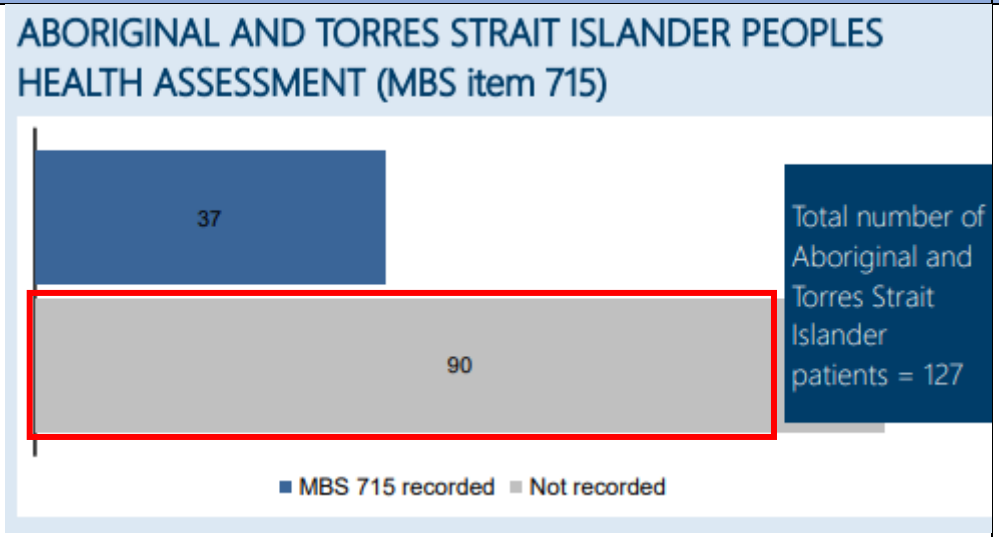
2.		This data shows proportions of Aboriginal and Torres Strait Islander patients who have or have not had a Health Assessment recorded (MBS Item 715). This includes assessment of a patient's health and physical psychological and social function and consideration of whether preventative health care and education should be offered to the patient to improve that patients' health and physical, psychological and social function.	Provide patients with an Indigenous Health Assessment reminder card provided by the HNECCPHN. Brochure Reminders Incorporate the AUSDRISK within the Indigenous Health Assessment RACGP National Guide to a Preventative Health Assessment for Aboriginal and Torres Strait Islander People RACGP - The Royal Australian College of General Practitioners

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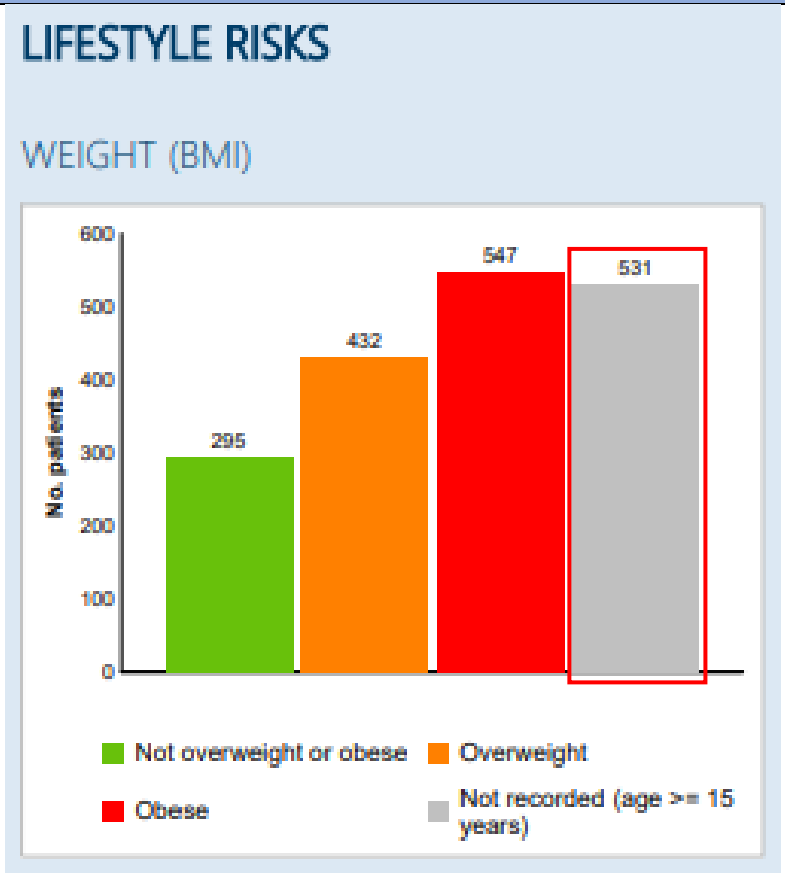
2.		The data shows the BMI status of patients aged 15 years and over who have had their BMI recorded in the last 2 years. BMI is classified as Obese (>=30), Overweight (25 to 30), or not overweight or obese (<25). In this example, 531 patients have not had their height and weight recorded to calculate a BMI. Patients whose weight and height (BMI) are not recorded may miss out on healthcare appropriate for their circumstances. RACGP Guidelines for Type 2 recommend that… NSW Health Get Healthy Coaching Service.	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 Application of RACGP Management of Type 2 Diabetes for General Practice Handbook Application of RACGP SNAP Guidelines

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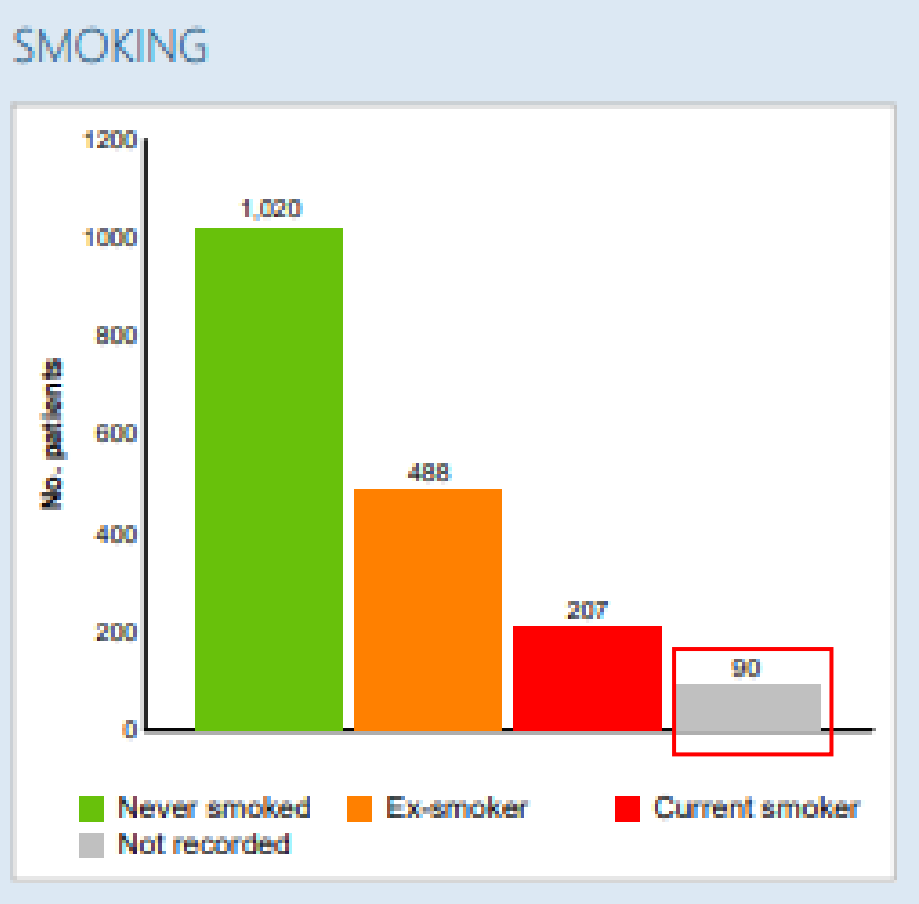
3.		The data shows the smoking status of patients aged 15 years and over. In this example, 90 patients do not have their smoking status recorded. Patients whose smoking status is not recorded may miss out on healthcare appropriate for their circumstances. These patients may miss out on smoking cessation interventions. Smoking is a risk factor to develop diabetes and adds 2 points to the AUSDRISK score. Australian Government Department of Health RACGP Diabetes Type 2 Guidelines recommend that patients who smoke… RACGP Smoking, nutrition alcohol physical activity	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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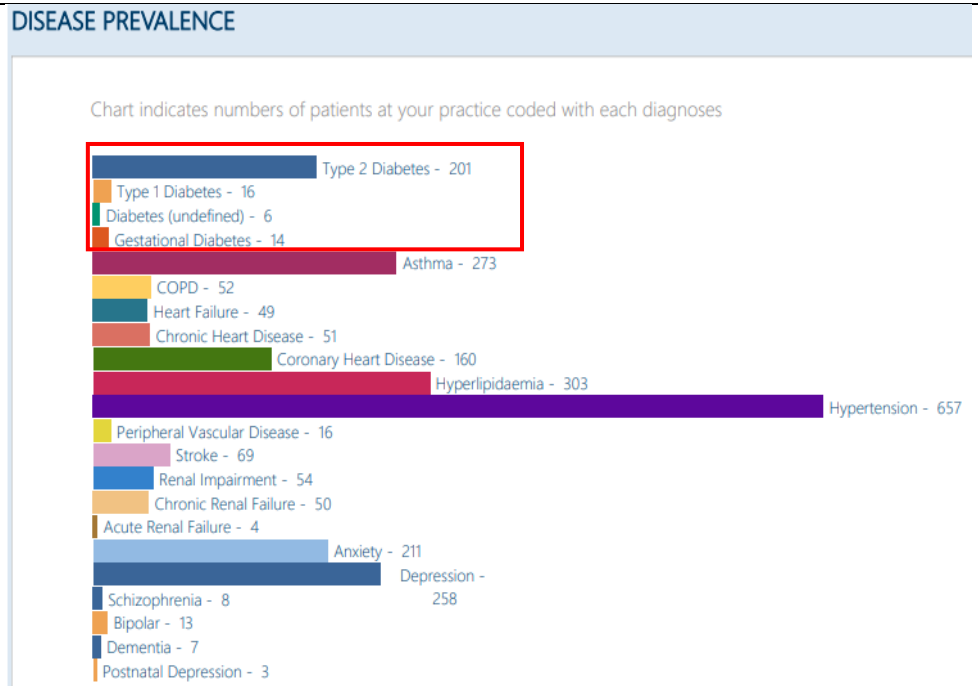
		(SNAP) A population health guide to behavioural risk factors in general practice	
4.		This chart indicates the number of patients with a coded Diabetes Mellitus diagnosis at your practice. For example, 201 patients have a coded diagnosis of Type 2 Diabetes Mellitus and 16 have a coded diagnosis of Type 1 Diabetes Mellitus. However, 6 patients are coded as having an “undefined” type of Diabetes Mellitus rather than Type 1, Type 2 or Gestational Diabetes Mellitus. Patients whose type of Diabetes is coded as “undefined” may miss out on healthcare appropriate for their circumstances. For Gestational Diabetes Mellitus, please note that it is coded for both active and inactive conditions in CAT4.	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 Please note that a history of Gestational Diabetes Mellitus adds 6 points of the 12 needed for a high-risk screening in the AUSDRISK tool. From age 40-49, a woman who has a score of 12 or more on the AUSDRISK tool should be offered a Diabetes Type 2 Health Assessment (MBS Item 701, 703, 705, 707) every three years

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		NB. Patients may be counted in more than one disease category according to their coded diagnosis.	Australian Government Department of Health Women with Gestational Diabetes Mellitus should be registered with the National Diabetes Services Scheme (NDSS). NDSS – NDSS After pregnancy, a 75gram OGTT should be ordered to assess status for Diabetes Mellitus Type 2. ADIPS

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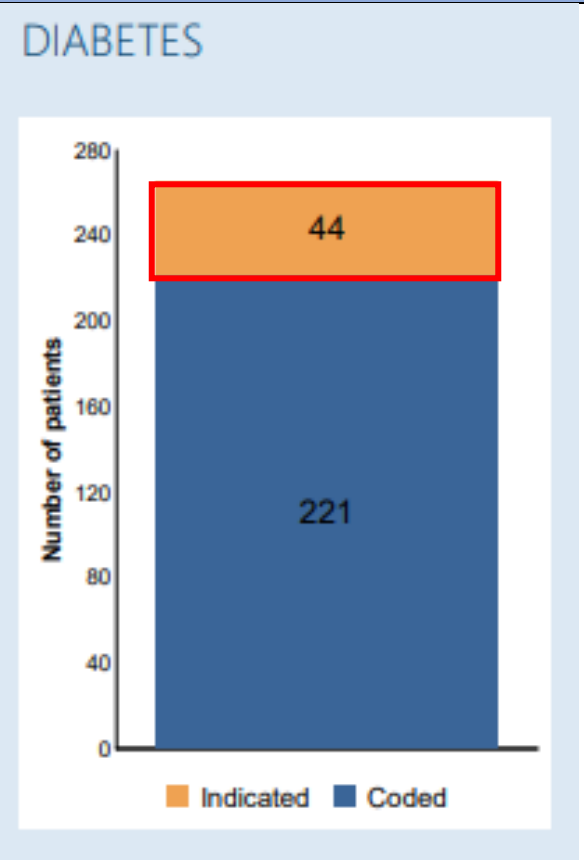
5.		The yellow group indicates patients without a coded diagnosis of Diabetes Mellitus, but who have a likelihood of having Diabetes Mellitus based on their pathology, including Hba1c and/or Fasting Blood Glucose, and/or medication and includes likely, possible and those for review groups. In this example, 44 patients have pathology and/or medications that may indicate a diabetes diagnosis. The risk is that if diabetes is not coded by diagnosis, care may be suboptimal to manage their diabetes and complications can arise. For example, the CVD Risk Assessment may be incorrect without a diagnosis of diabetes.	Utilize PenCS Cleansing Cat module to identify patients for consideration of recording diabetes as a diagnosis. Home - Pen CS See HNECCPHN Quality Improvement activity.

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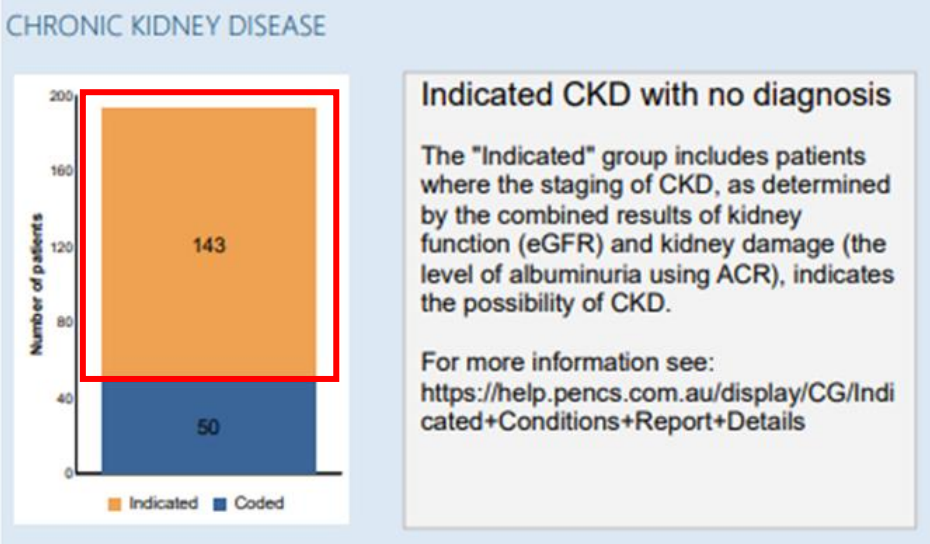
6.		The indicated group includes patients with a likelihood of having Chronic Kidney Disease based on pathology, including eGFR, Urine ACR, and/or medication and includes patients likely, possible and those for review. In this example, 143 patients have pathology and/or medications that may indicate a Chronic Kidney Disease diagnosis. If Chronic Kidney disease diagnosis is not coded, care may be suboptimal, and complications can arise.	Utilize PenCS Cleansing Cat module to identify patients for consideration of recording diabetes as a diagnosis. Home - Pen CS

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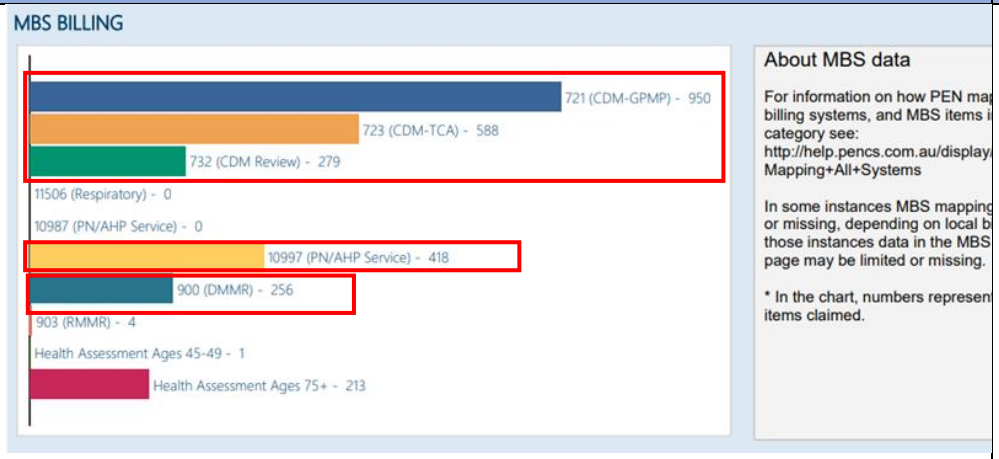
7.		The number of each MBS item claimed is represented in the graph. Regarding Chronic Disease, for example Diabetes, 950 GP Management Plans, 588 Team Care Arrangements, and 279 Reviews (of either item) have been successfully claimed by this practice. Chronic Disease Management MBS items are enablers to assist health professionals to manage the health care of a patient's chronic disease, for example diabetes. Patients with either a GPMP or a TCA can also receive monitoring and support services from a Practice Nurse or Aboriginal and Torres Strait Islander Health Practitioner on behalf of the GP (MBS Item 10997).	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 Diabetes and Chronic Disease Management

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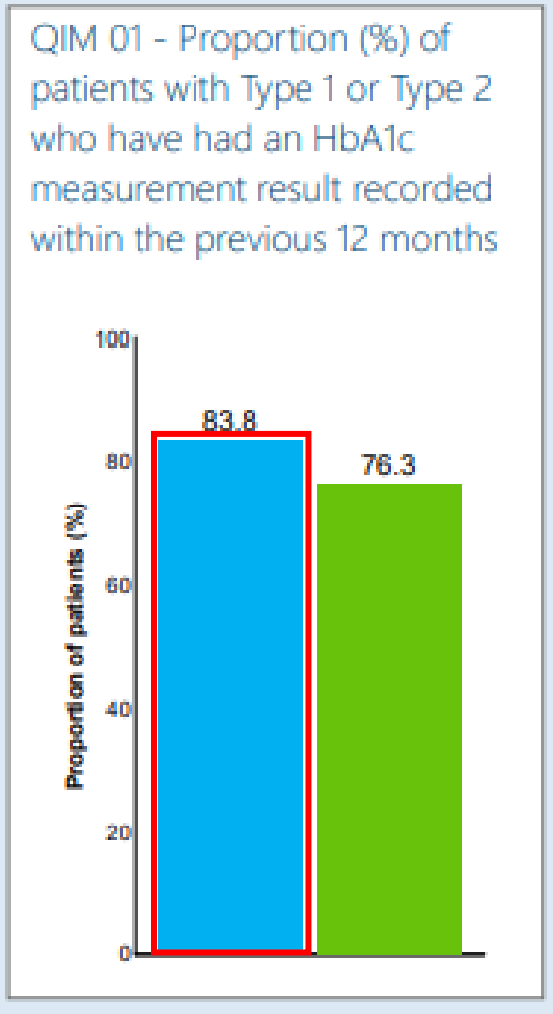
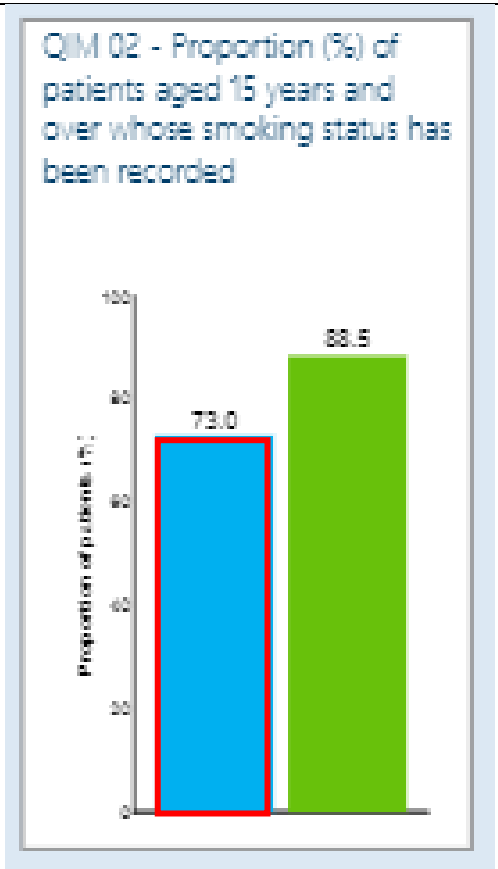
		For example, 418 Practice Nurse attendances (MBS Item 10997) have been claimed. Department of Health | Chronic Disease Management (formerly Enhanced Primary Care or EPC) — GP services	

ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS
8.		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”

ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS
			See HNECCPHN Quality Improvement Activity "Completing Diabetes Cycles of Care"
9.		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 practice's 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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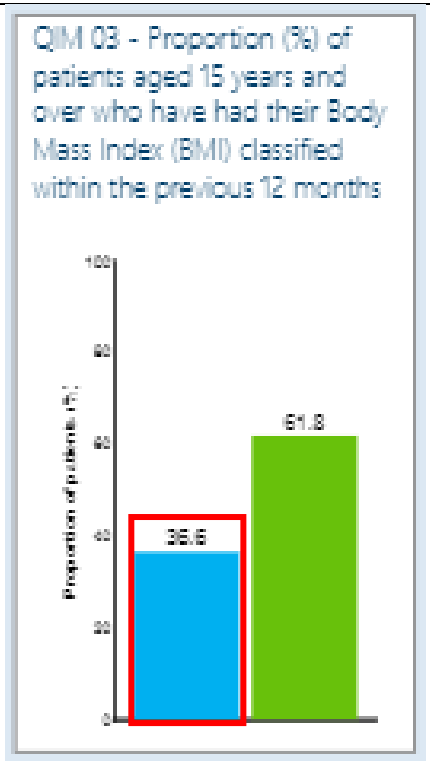
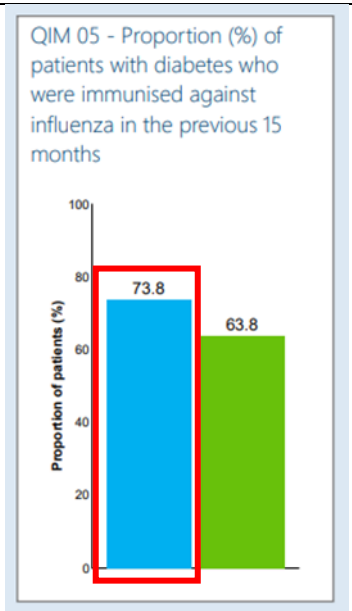
10.		PIP QI Incentive Improvement Measure #3 Proportion of regular clients aged 15 years and over who had their Body Mass Index (BMI) classified as obese, overweight, healthy, or underweight within the previous 12 months. For example, in this graph, 36.6 % of patients have had a BMI recorded, compared 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 Application of RACGP SNAP Assessment Application of RACGP Management of Type 2 Diabetes for General Practice Handbook

11.			PIP QI Incentive Improvement Measure #5 Proportion of regular clients with diabetes who were immunized against influenza in the previous 15 months. For example, in this graph, 73.8 % of patients with diabetes have had an influenza immunisation recorded, compared to 63.8% of patients with diabetes in all other HNECCPHN practices.	Application of RACGP Management of Type 2 Diabetes for General Practice Handbook Australian Immunisation Handbook

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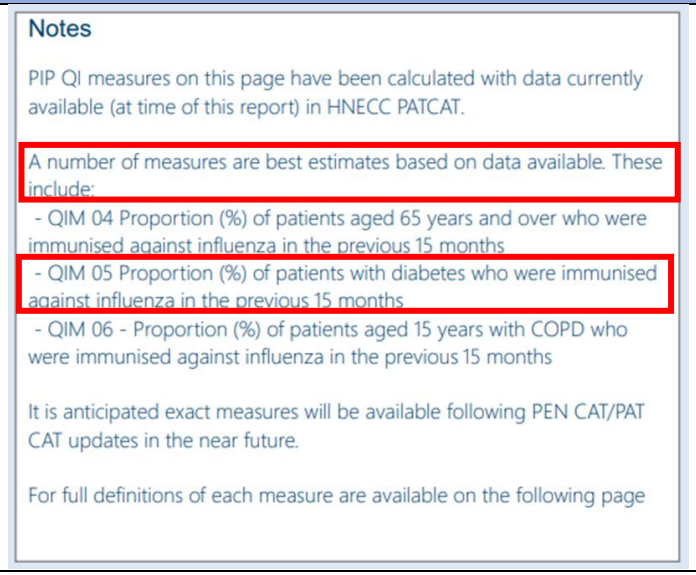
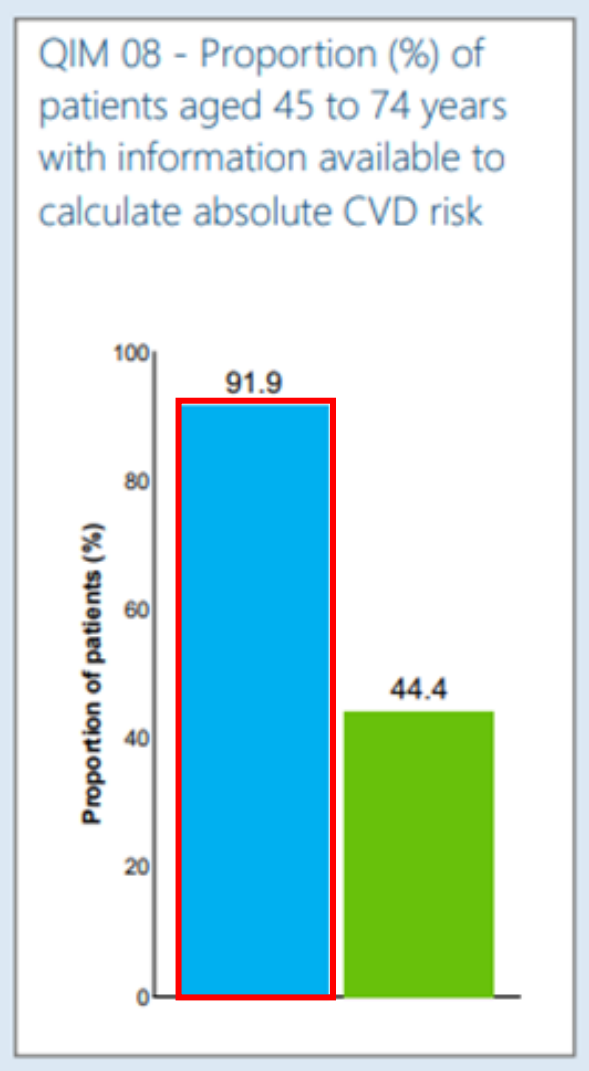
			

12.			PIP QI Incentive Improvement Measure #8 Proportion of regular clients aged 45 to 74 with information available to calculate their absolute Cardio-vascular Disease Risk. For example, in this graph, 91.9% of patients with information recorded to calculate Cardio-vascular Risk, compared to 44.4% of patients in all other participating HNECCPHN practices. Cardio-vascular disease is complication of diabetes. Diabetes 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 females are at clinically	Application of RACGP Management of Type 2 Diabetes for General Practice Handbook Absolute Cardiovascular Disease Risk Assessment Absolute_CVD_Risk_Full_Guidelines.pdf (cvdcheck.org.au) Ensure a coded diabetes diagnosis is recorded in the patient record to enable an accurate Cardio-vascular Risk assessment.

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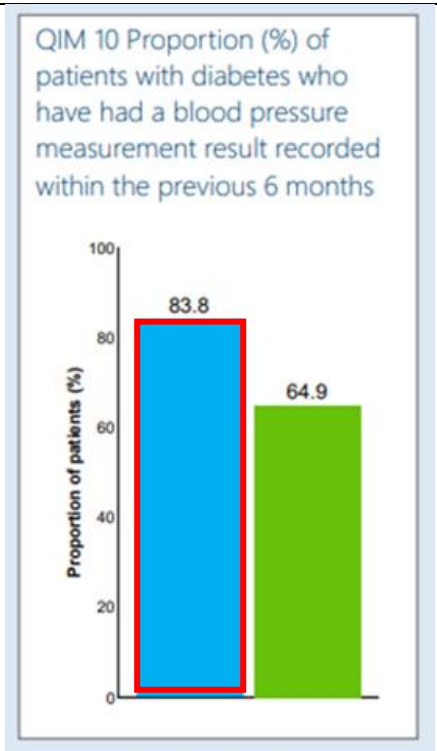
		determined high risk for cardio-vascular disease. Absolute_CVD_Risk_Full_Guidelines.pdf (cvdcheck.org.au)	
13.		PIP QI Incentive Improvement Measure #10 Proportion of regular clients who have Diabetes and who have had a blood pressure measurement result recorded at the primary health care service. For 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.	Application of RACGP Management of Type 2 Diabetes for General Practice Handbook

Data in this report is based on information in PATCAT received from the practice