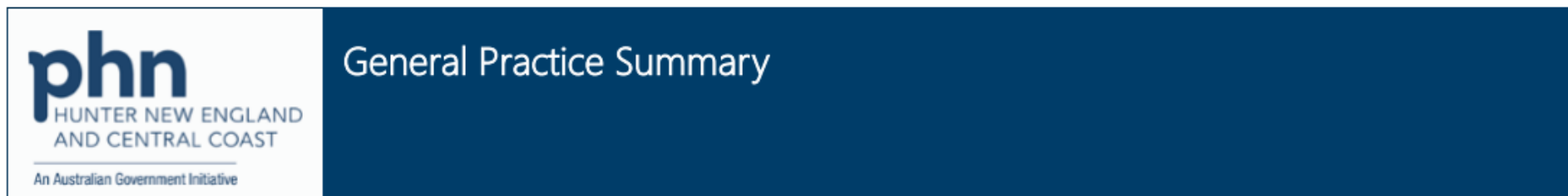




Interpretation of the HNECCPHN General Practice Summary in the context of Diabetes Mellitus



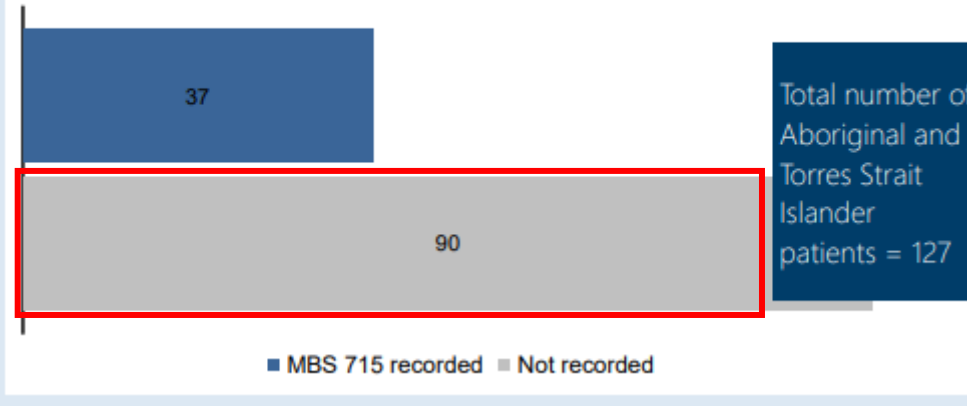


ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS																					
1.	<p>ETHNICITY</p> <table border="1"> <thead> <tr> <th></th> <th>Total patients</th> <th>% of group</th> </tr> </thead> <tbody> <tr> <td>Indigenous</td> <td>127</td> <td>6.1 % **</td> </tr> <tr> <td>Aboriginal</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> <td>Ethnicity not recorded</td> <td>362</td> <td>17.3 % **</td> </tr> </tbody> </table> <p><small>* % of active Aboriginal and Torres Strait Islander patients at this practice</small> <small>** % of total active patients at this practice (excludes patients aged 100 years and over)</small></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 whose ethnicity is not recorded risk missing out on health care appropriate for their circumstances.</p> <p>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.</p>	<p>Learn how to code ethnicity in patient records in your practice's software by searching for Data Mapping in PenCS Home - Pen CS</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" Home - Australian Institute of Health and Welfare (aihw.gov.au)</p> <p>Provide print material to patients, such as posters and brochures. indigenous-identification-DLbrochure.pdf.aspx (aihw.gov.au)</p>
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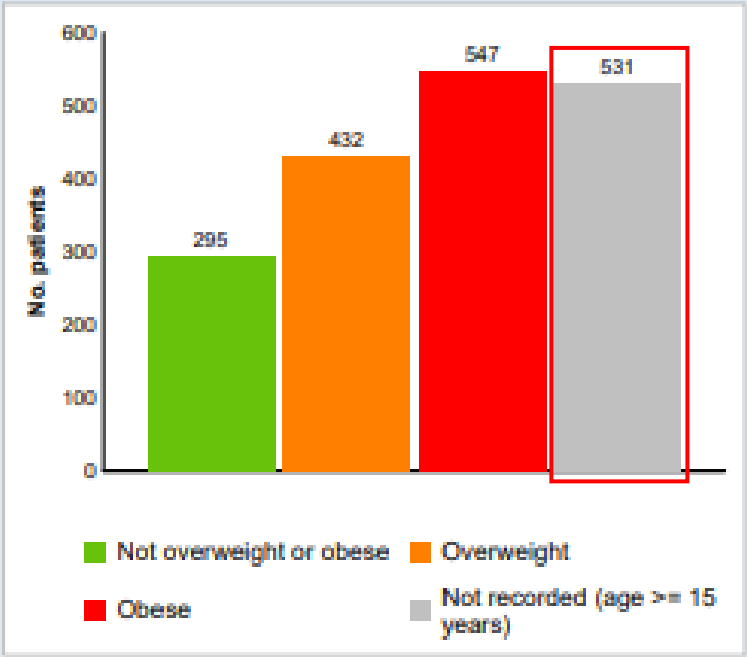


ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS
		<p>Also, when screening for Risk of Diabetes, the AUSDRISK Assessment asks if a patient is of Indigenous descent. A “yes” response adds 2 points to the AUSDRISK score in acknowledgement of the higher risk of diabetes in Indigenous populations</p> <p><small>3(a). Are you of Aboriginal, Torres Strait Islander, Pacific Islander or Maori descent? (required)</small> <input type="radio"/> No [0 points] <input type="radio"/> Yes [2 points]</p> <p>Meets Closing the Gap Primary Health Care Strategy</p>	<p>New patient forms.</p> <p>Complete Social-Family History in the patient’s record.</p>

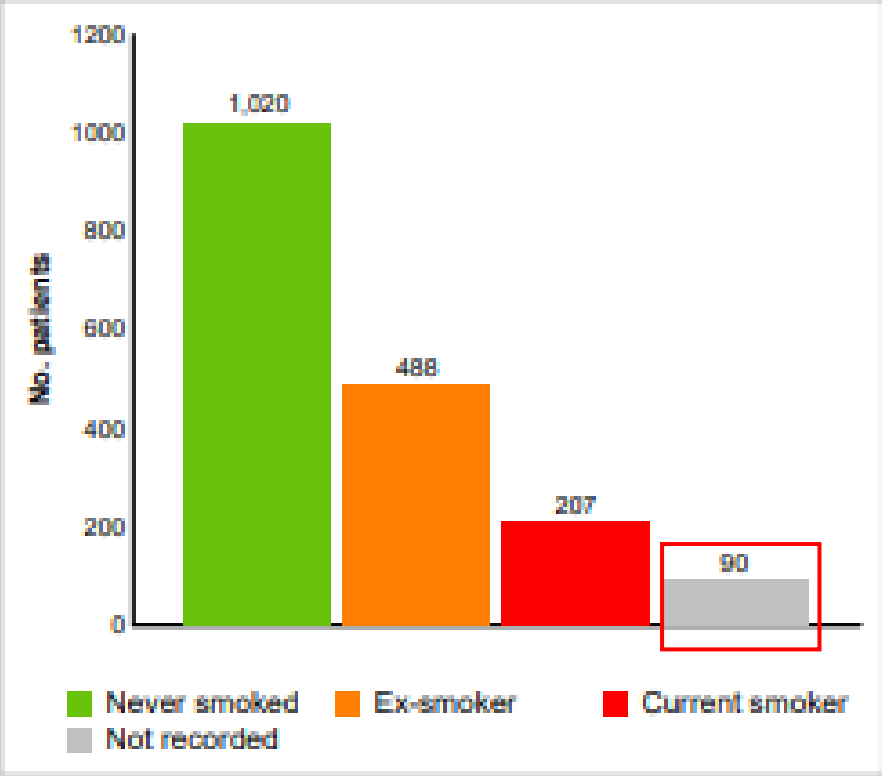


ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS								
2.	<p>ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES HEALTH ASSESSMENT (MBS item 715)</p>  <p>Total number of Aboriginal and Torres Strait Islander patients = 127</p> <p>■ MBS 715 recorded ■ Not recorded</p> <table border="1"><caption>Chart Data</caption><thead><tr><th>Category</th><th>Count</th></tr></thead><tbody><tr><td>MBS 715 recorded</td><td>37</td></tr><tr><td>Not recorded</td><td>90</td></tr><tr><td>Total</td><td>127</td></tr></tbody></table>	Category	Count	MBS 715 recorded	37	Not recorded	90	Total	127	<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>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> <p>RACGP National Guide to a Preventative Health Assessment for Aboriginal and Torres Strait Islander People RACGP - The Royal Australian College of General Practitioners</p>
Category	Count										
MBS 715 recorded	37										
Not recorded	90										
Total	127										

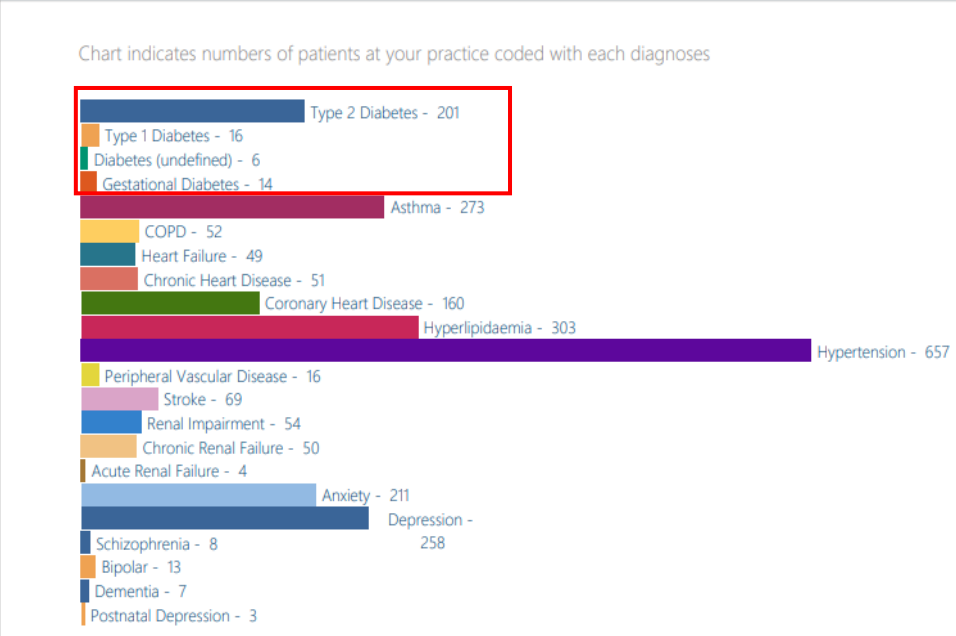


ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS										
2.	<p>LIFESTYLE RISKS</p> <p>WEIGHT (BMI)</p>  <table border="1"> <caption>Weight (BMI) Data</caption> <thead> <tr> <th>BMI Status</th> <th>No. patients</th> </tr> </thead> <tbody> <tr> <td>Not overweight or obese</td> <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 >= 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 (≥ 30), Overweight (25 to 30), or not overweight or obese (< 25).</p> <p>In this example, 531 patients have not had their height and weight recorded to calculate a BMI.</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>NSW Health Get Healthy Coaching Service.</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 Home - Pen CS</p> <p>Application of RACGP Management of Type 2 Diabetes for General Practice Handbook</p> <p>Application of RACGP SNAP Guidelines</p>
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3.	<p data-bbox="389 336 584 379">SMOKING</p>  <table border="1" data-bbox="389 419 1267 1198"><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="1368 320 1749 419">The data shows the smoking status of patients aged 15 years and over.</p> <p data-bbox="1368 464 1771 563">In this example, 90 patients do not have their smoking status recorded.</p> <p data-bbox="1368 608 1771 742">Patients whose smoking status is not recorded may miss out on healthcare appropriate for their circumstances.</p> <p data-bbox="1368 786 1749 885">These patients may miss out on smoking cessation interventions.</p> <p data-bbox="1368 930 1771 1106">Smoking is a risk factor to develop diabetes and adds 2 points to the AUSDRISK score. Australian Government Department of Health</p> <p data-bbox="1368 1150 1727 1249">RACGP Diabetes Type 2 Guidelines recommend that patients who smoke...</p> <p data-bbox="1368 1294 1715 1359">RACGP Smoking, nutrition alcohol physical activity</p>	<p data-bbox="1805 320 2121 563">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</p> <p data-bbox="1805 608 2136 850">Learn how to navigate in Medical Director Software Support via Online Help for Clinical Software Solutions for Medical Practitioners MedicalDirector</p> <p data-bbox="1805 895 2136 1137">Learn how to navigate in Best Practice Knowledge Base for Saffron version Select your Best Practice Software Knowledge Base (bpsoftware.net)</p>
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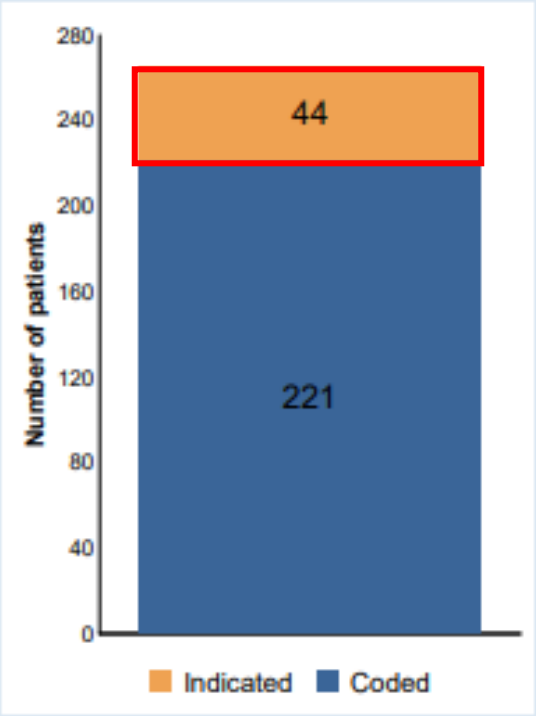


ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS																																														
		(SNAP) A population health guide to behavioural risk factors in general practice																																															
4.	<p>DISEASE PREVALENCE</p> <p>Chart indicates numbers of patients at your practice coded with each diagnoses</p>  <table border="1"> <caption>Disease Prevalence Data</caption> <thead> <tr> <th>Disease</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>	Disease	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 a coded Diabetes Mellitus diagnosis at your practice.</p> <p>For example, 201 patients have a coded diagnosis of Type 2 Diabetes Mellitus and 16 have a coded diagnosis of Type 1 Diabetes Mellitus.</p> <p>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.</p> <p>For Gestational Diabetes Mellitus, please note that it is coded for both active and inactive conditions in CAT4.</p>	<p>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</p> <p>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.</p> <p>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</p>
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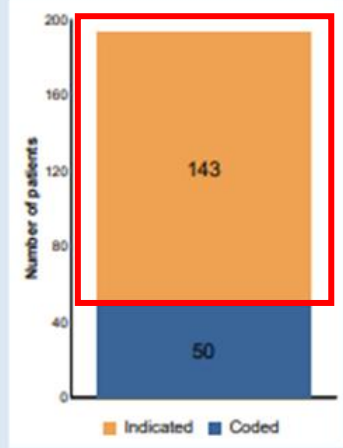


ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS
		<p>NB. Patients may be counted in more than one disease category according to their coded diagnosis.</p>	<p>Australian Government Department of Health</p> <p>Women with Gestational Diabetes Mellitus should be registered with the National Diabetes Services Scheme (NDSS). NDSS – NDSS</p> <p>After pregnancy, a 75gram OGTT should be ordered to assess status for Diabetes Mellitus Type 2. ADIPS</p>



ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS						
5.	<p data-bbox="394 328 952 375">DIABETES</p>  <table border="1" data-bbox="394 427 927 1145"><thead><tr><th>Category</th><th>Number of patients</th></tr></thead><tbody><tr><td>Coded</td><td>221</td></tr><tr><td>Indicated</td><td>44</td></tr></tbody></table>	Category	Number of patients	Coded	221	Indicated	44	<p data-bbox="1368 320 1787 675">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.</p> <p data-bbox="1368 719 1787 855">In this example, 44 patients have pathology and/or medications that may indicate a diabetes diagnosis.</p> <p data-bbox="1368 900 1787 1070">The risk is that if diabetes is not coded by diagnosis, care may be suboptimal to manage their diabetes and complications can arise.</p> <p data-bbox="1368 1115 1787 1219">For example, the CVD Risk Assessment may be incorrect without a diagnosis of diabetes.</p>	<p data-bbox="1809 320 2145 568">Utilize PenCS Cleansing Cat module to identify patients for consideration of recording diabetes as a diagnosis. Home - PenCS</p> <p data-bbox="1809 612 2145 716">See HNECCPHN Quality Improvement activity.</p>
Category	Number of patients								
Coded	221								
Indicated	44								



ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS						
6.	<p data-bbox="389 328 712 352">CHRONIC KIDNEY DISEASE</p>  <table border="1" data-bbox="389 392 730 842"><caption>Chronic Kidney Disease Patient Data</caption><thead><tr><th>Category</th><th>Number of Patients</th></tr></thead><tbody><tr><td>Indicated</td><td>143</td></tr><tr><td>Coded</td><td>50</td></tr></tbody></table> <p data-bbox="801 395 1272 427">Indicated CKD with no diagnosis</p> <p data-bbox="801 459 1272 635">The "Indicated" group includes patients where the staging of CKD, as determined by the combined results of kidney function (eGFR) and kidney damage (the level of albuminuria using ACR), indicates the possibility of CKD.</p> <p data-bbox="801 667 1272 754">For more information see: https://help.pencs.com.au/display/CG/Indicated+Conditions+Report+Details</p>	Category	Number of Patients	Indicated	143	Coded	50	<p data-bbox="1373 320 1783 600">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.</p> <p data-bbox="1373 643 1783 818">In this example, 143 patients have pathology and/or medications that may indicate a Chronic Kidney Disease diagnosis.</p> <p data-bbox="1373 861 1783 999">If Chronic Kidney disease diagnosis is not coded, care may be suboptimal, and complications can arise.</p>	<p data-bbox="1809 320 2141 568">Utilize PenCS Cleansing Cat module to identify patients for consideration of recording diabetes as a diagnosis. Home - PenCS</p>
Category	Number of Patients								
Indicated	143								
Coded	50								

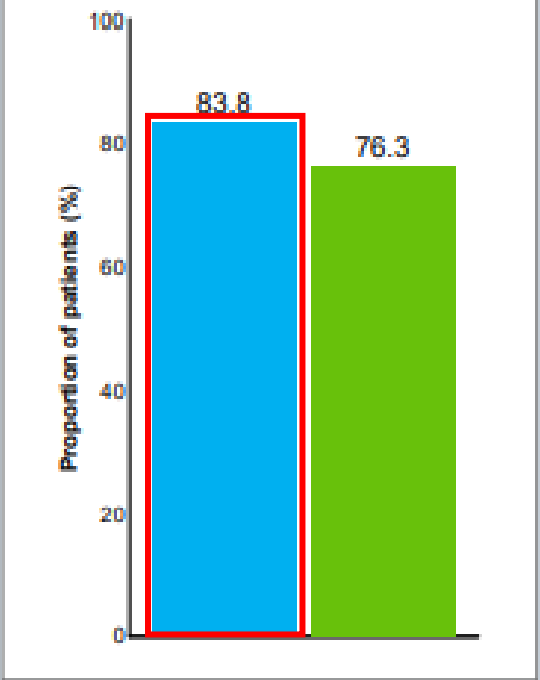


ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS
7.	<p>MBS BILLING</p> <p>About MBS data</p> <p>For information on how PEN mapping systems, and MBS items in category see: http://help.pencs.com.au/display/Mapping+All+Systems</p> <p>In some instances MBS mapping or missing, depending 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>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.</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 diabetes.</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 Islander Health Practitioner on behalf of the GP (MBS Item 10997).</p>	<p>Set reminders in patient record in Clinical Information System for the anticipated date of the Chronic Disease Item attendance.</p> <p>Software Solutions for Medical Practitioners MedicalDirector</p> <p>Select your Best Practice Software Knowledge Base (bpsoftware.net)</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 Diabetes and Chronic Disease Management</p>

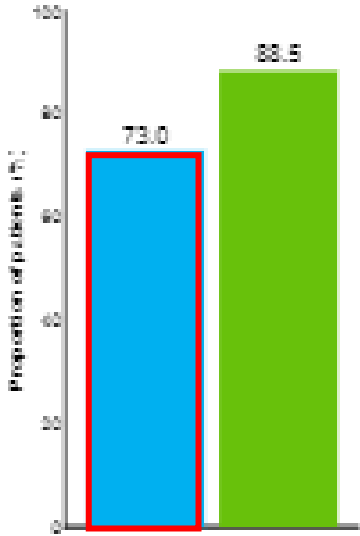


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		<p>For example, 418 Practice Nurse attendances (MBS Item 10997) have been claimed.</p> <p>Department of Health Chronic Disease Management (formerly Enhanced Primary Care or EPC) — GP services</p>	

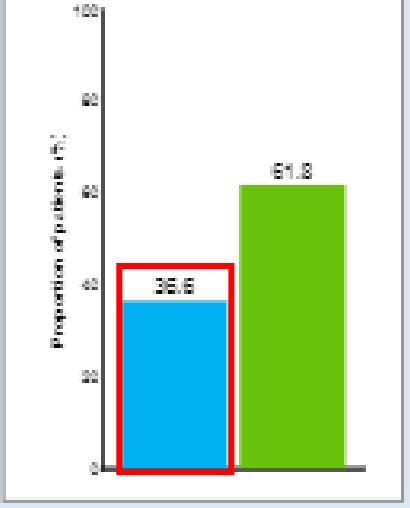


ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS						
8.	<p>QIM 01 - Proportion (%) of patients with Type 1 or Type 2 who have had an HbA1c measurement result recorded within the previous 12 months</p>  <table border="1"><caption>QIM 01 - Proportion (%) of patients with Type 1 or Type 2 who have had an HbA1c measurement result recorded within the previous 12 months</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>PIP QI Incentive Improvement Measure #1</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. Select your Best Practice Software Knowledge Base (bpsoftware.net)</p> <p>Software Solutions for Medical Practitioners MedicalDirector</p> <p>See HNECCPHN Quality Improvement Activity “Utilizing Diabetes Register”</p>
Category	Proportion (%)								
Practice	83.8								
HNECCPHN area	76.3								

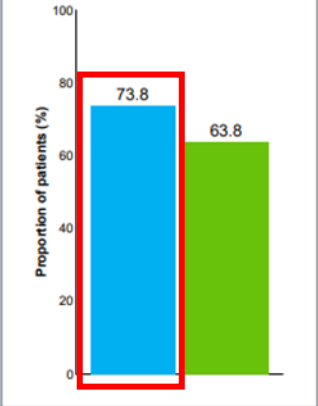


ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS						
9.	<p data-bbox="405 520 824 676">QIM 02 - Proportion (%) of patients aged 15 years and over whose smoking status has been recorded</p>  <table border="1" data-bbox="439 778 797 1315"><thead><tr><th>Category</th><th>Proportion of patients (%)</th></tr></thead><tbody><tr><td>Practice</td><td>73.0</td></tr><tr><td>All other patients at HNECCPHN practices</td><td>88.5</td></tr></tbody></table>	Category	Proportion of patients (%)	Practice	73.0	All other patients at HNECCPHN practices	88.5	<p data-bbox="1368 496 1765 563">PIP QI Incentive Improvement Measure #2</p> <p data-bbox="1368 608 1765 778">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 823 1765 1034">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.</p>	<p data-bbox="1805 316 2085 486">See HNECCPHN Quality Improvement Activity "Completing Diabetes Cycles of Care"</p> <p data-bbox="1805 496 2085 523">RACGP SNAP Guide</p> <p data-bbox="1805 568 2085 595">Social-Family History</p> <p data-bbox="1805 639 2085 707">Smoking Cessation Readiness Assessment</p> <p data-bbox="1805 751 2085 850">Annual Diabetes Cycle of Care in CIS Diabetes Register</p> <p data-bbox="1805 895 2085 994">PenCS Missing Accreditation items, Diabetes Cycle of Care</p>
Category	Proportion of patients (%)								
Practice	73.0								
All other patients at HNECCPHN practices	88.5								



ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS						
10.	<p data-bbox="398 403 763 587">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="383 635 790 1145"><caption>BMI Classification Data</caption><thead><tr><th>Category</th><th>Proportion of patients (%)</th></tr></thead><tbody><tr><td>Recorded BMI</td><td>36.6</td></tr><tr><td>All other HNECCPHN practices</td><td>61.8</td></tr></tbody></table>	Category	Proportion of patients (%)	Recorded BMI	36.6	All other HNECCPHN practices	61.8	<p data-bbox="1368 389 1767 453">PIP QI Incentive Improvement Measure #3</p> <p data-bbox="1368 499 1783 743">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="1368 790 1760 962">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="1368 1008 1749 1176">BMI is an indicator of risk of diabetes and cardio-vascular disease, and a progress measure in established diabetes.</p>	<p data-bbox="1809 389 2114 421">Diabetes Cycle of Care</p> <p data-bbox="1809 461 2047 493">Diabetes Register</p> <p data-bbox="1809 533 2101 596">Application of RACGP SNAP Assessment</p> <p data-bbox="1809 643 2114 778">Application of RACGP Management of Type 2 Diabetes for General Practice Handbook</p>
Category	Proportion of patients (%)								
Recorded BMI	36.6								
All other HNECCPHN practices	61.8								



11.	<p>QIM 05 - Proportion (%) of patients with diabetes who were immunised against influenza in the previous 15 months</p>  <table border="1"><thead><tr><th>Category</th><th>Proportion of patients (%)</th></tr></thead><tbody><tr><td>Immunised (Blue)</td><td>73.8</td></tr><tr><td>Not Immunised (Green)</td><td>63.8</td></tr></tbody></table>	Category	Proportion of patients (%)	Immunised (Blue)	73.8	Not Immunised (Green)	63.8	<p>PIP QI Incentive Improvement Measure #5</p> <p>Proportion of regular clients with diabetes who were immunized against influenza in the previous 15 months.</p> <p>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.</p>	<p>Application of RACGP Management of Type 2 Diabetes for General Practice Handbook</p> <p>Australian Immunisation Handbook</p>
Category	Proportion of patients (%)								
Immunised (Blue)	73.8								
Not Immunised (Green)	63.8								

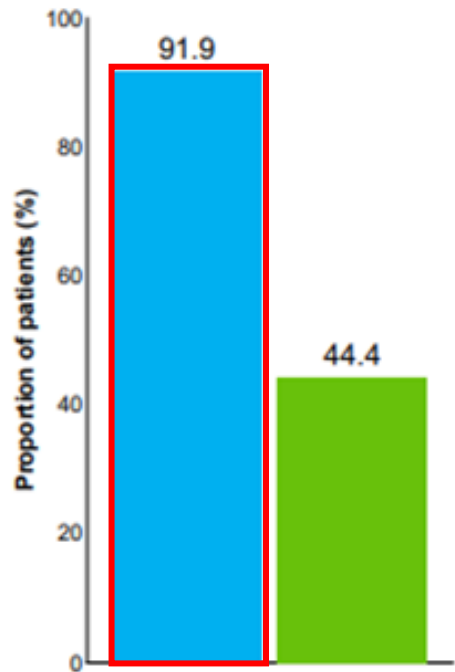


ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS
	<p>Notes</p> <p>PIP QI measures on this page have been calculated with data currently available (at time of this report) in HNECC PATCAT.</p> <p>A number of measures are best estimates based on data available. These include:</p> <ul style="list-style-type: none">- QIM 04 Proportion (%) of patients aged 65 years and over who were immunised against influenza in the previous 15 months- QIM 05 Proportion (%) of patients with diabetes who were immunised against influenza in the previous 15 months- QIM 06 - Proportion (%) of patients aged 15 years with COPD who were immunised against influenza in the previous 15 months <p>It is anticipated exact measures will be available following PEN CAT/PAT CAT updates in the near future.</p> <p>For full definitions of each measure are available on the following page</p>		



12.

QIM 08 - Proportion (%) of patients aged 45 to 74 years with information available to calculate absolute CVD risk



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.

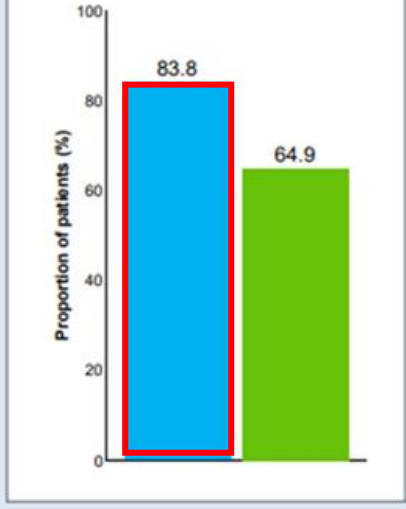
Cardio-vascular disease is complication of diabetes. Diabetes is known to increase risk of cardio-vascular disease. The Absolute Cardio-vascular Disease Risk Assessment determines that patients with diabetes and age >60, or diabetes with microalbuminuria (>20 mcg/min or Urine Albumin Creatinine Ratio >2.5 mg/mmol for males, >3.5 mg/mmol for females) are at clinically

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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.



ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS						
		<p>determined high risk for cardiovascular disease. Absolute CVD Risk Full Guidelines.pdf (cvdcheck.org.au)</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>Practice Type</th><th>Proportion of patients (%)</th></tr></thead><tbody><tr><td>Practice</td><td>83.8</td></tr><tr><td>Other HNECCPHN practices</td><td>64.9</td></tr></tbody></table>	Practice Type	Proportion of patients (%)	Practice	83.8	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>Application of RACGP Management of Type 2 Diabetes for General Practice Handbook</p>
Practice Type	Proportion of patients (%)								
Practice	83.8								
Other HNECCPHN practices	64.9								



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

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