This document contains confidential practice data
Please maintain data security
DEMOGRAPHIC PROFILE

<table>
<thead>
<tr>
<th>Total patients</th>
<th>Aboriginal patients</th>
<th>% Aboriginal patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>6858</td>
<td>163</td>
<td>2.4 %</td>
</tr>
</tbody>
</table>

All values in this report are calculated with active patients (seen 3 or more times in the past 2 years).

AGE PROFILE BY GENDER

ETHNICITY

<table>
<thead>
<tr>
<th>Total patients</th>
<th>% of group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous</td>
<td>163</td>
</tr>
<tr>
<td>Aboriginal</td>
<td>149</td>
</tr>
<tr>
<td>Torres Strait Islander</td>
<td>4</td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander</td>
<td>10</td>
</tr>
<tr>
<td>Non-indigenous</td>
<td>6455</td>
</tr>
<tr>
<td>Ethnicity not recorded</td>
<td>157</td>
</tr>
</tbody>
</table>

LIFESTYLE RISKS

WEIGHT (BMI)

SMOKING

GENDER

** Represents % of total active patients at this practice

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ABOUT THIS REPORT

Report Date: this report provides a snapshot of patients at your practice at a point in time, which is determined by the last successful data upload completed automatically by the PEN CAT scheduler (approximately first week of each month or manually uploaded by the practice within the same timeframe). HNECC PHN compiles this report retrospectively, approximately third week of each month.

Data Source: the aggregated totals and percentages contained within this Practice Support Dashboard, reflect de-identified data extracts submitted to PEN CAT. Where no totals appear, a data extract has not been received. Information contained within this report is supplied from coded fields within your clinical information system. If data is not coded correctly, it may not display in this report.

Dashboard Purpose: this report should be used as a guide only and has been developed by the HNECC Primary Health Network, for the purpose of data quality improvement to support accreditation activities. For more information on PATCAT report data and data mapping with clinical information systems visit https://help.pencs.com.au

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About Weight data

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).

About Smoking data

The data shows the smoking status of patients aged 15 years and over.
**DISEASE PREVALENCE**

Chart indicates numbers of patients at your practice coded with each diagnoses

- **Type 2 Diabetes** - 388
- **Type 1 Diabetes** - 40
- **Diabetes (undefined)** - 42
- **Gestational Diabetes** - 75
- **Asthma** - 773
- **COPD** - 161
- **Heart Failure** - 51
- **Chronic Heart Disease** - 51
- **Coronary Heart Disease** - 291
- **Hyperlipidaemia** - 873
- **Hypertension** - 1,355
- **Peripheral Vascular Disease** - 15
- **Renal Impairment** - 152
- **Chronic Renal Failure** - 135
- **Acute Renal Failure** - 20
- **Anxiety** - 1,071
- **Depression** - 866
- **Schizophrenia** - 33
- **Bipolar** - 59
- **Dementia** - 30
- **Postnatal Depression** - 23

*Patients may be counted in more than one disease category according to their coded diagnoses*

**About disease prevalence data**

The data shows the number of patients at this practice with each diagnosis.

Diagnoses or conditions are mapped in PEN CAT to each clinical system.

Sometimes conditions are flagged for a patient if there is a record of that condition in the patient history, although the condition may not be currently active. For example, if a patient was diagnosed with anxiety and this remains on their patient history, anxiety will be included in the prevalence count even if the patient no longer has or is being treated for anxiety.

**CODED AND INDICATED DIAGNOSES**

**CHRONIC KIDNEY DISEASE**

**Indicated CKD with no diagnosis**

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.

**COPD**

**Indicated COPD with no diagnosis**

The "Indicated" group includes patients with a likelihood of having COPD based on relevant respiratory medication or an adverse spirometry reading being recorded in the patient record without a diagnosis.

**DIABETES**

**Indicated Diabetes with no diagnosis**

The "Indicated" group includes patients with a likelihood of having Diabetes (any type) based on HbA1c, Anti-diabetic Medication and/or FBG but are recorded in the patient record without a diagnosis

**MENTAL HEALTH**

**Indicated Mental Health with no diagnosis**

The "Indicated" group includes patients with a likelihood of having a Mental Health condition based on a mental health medication or a mental health care plan being recorded in the patient record without a diagnosis.
**General Practice Summary**
Sample practice report

**MBS BILLING**

<table>
<thead>
<tr>
<th>MBS Code</th>
<th>Description</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>721</td>
<td>(CDM-GPMP) - 2,434</td>
<td></td>
</tr>
<tr>
<td>723</td>
<td>(CDM-TCA) - 2,016</td>
<td></td>
</tr>
<tr>
<td>712</td>
<td>(CDM Review) - 1,829</td>
<td></td>
</tr>
<tr>
<td>11506</td>
<td>(Respiratory) - 657</td>
<td></td>
</tr>
<tr>
<td>10987</td>
<td>(PN/AHP Service) - 15</td>
<td></td>
</tr>
<tr>
<td>10997</td>
<td>(PN/AHP Service) - 432</td>
<td></td>
</tr>
<tr>
<td>900</td>
<td>(RMMR) - 223</td>
<td></td>
</tr>
<tr>
<td>903</td>
<td>(RMMR) - 0</td>
<td></td>
</tr>
<tr>
<td>721</td>
<td>(CDM-GPMP) - 2,434</td>
<td></td>
</tr>
</tbody>
</table>

**MENTAL HEALTH CARE**

**TREATMENT PLANS, REVIEWS, AND CONSULTS**

<table>
<thead>
<tr>
<th>MBS Code</th>
<th>Description</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>2700</td>
<td>Preparation of a GP Mental Health Treatment Plan (effective from 1 November 2011);</td>
<td></td>
</tr>
<tr>
<td>2701</td>
<td>GP Mental Health Treatment Consult</td>
<td></td>
</tr>
<tr>
<td>2712</td>
<td>Review of a GP Mental Health Treatment Plan;</td>
<td></td>
</tr>
<tr>
<td>2713</td>
<td>GP Mental Health Treatment Consult</td>
<td></td>
</tr>
</tbody>
</table>

**ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES HEALTH ASSESSMENT (MBS item 715)**

![Chart showing the number of Aboriginal and Torres Strait Islander patients who have had a Health Assessment recorded (MBS Item 715).](chart)

**PREVENTION**

**Childhood immunisation**

![Chart showing the percentage of fully and not fully immunised children.](chart)

**Influenza immunisation (people 65 years and over)**

![Chart showing the percentage of patients aged 65 and over who have been immunised against influenza in the last 12 months.](chart)

**NOTE**

Data shown in the charts above indicate what has been recorded in your clinical software and extracted into PATCAT. Actual rates of childhood immunisation for patients in your practice may differ from those shown.

**About MBS data**

In some instances, MBS mapping may be incomplete or missing, depending on local billing software. In those instances, data in the MBS billing chart on this page may be limited or missing.

*In the chart, numbers represent numbers of MBS items claimed.*
About Bowel Cancer Screening (FOBT) data

The data shows the FOBT status of patients in the age range between 50 and 75 years. Patients are excluded (ineligible) if they have been diagnosed with one or more specific cancers and/or a small number of other diagnoses (for list of diagnostic exclusions see: http://help.pencs.com.au/display/CG/FOBT).

Groups of FOBT results may assist your practice in identifying patients who are overdue for screening, or underscreened (eg where an FOBT was last recorded > 3-4 years ago).

Numbers of FOBT results without matching pathology requests are an indicator of participation by your patients in the National Bowel Cancer Screening Program.

Other high risk patients may require screening outside of the National Bowel Cancer Screening Program. A family history may assist to identify these patients.

For more information see: http://www.bowelcancer.org.au

About Breast Screening data

The Breast Screening target population includes women aged between 50 and 74 years. Patients are excluded (ineligible) if they have been diagnosed with one or more specific cancers and/or mastectomy.

Although not reported here, Aboriginal women aged between 40 and 74 years should also be considered.

BreastScreen results may be delivered electronically to your practice in HL7 format. A regular check of correspondence may assist data cleansing of breast screening data. Cancer Institute NSW can also provide a list of patients to assist updating of clinical records.

About Cervical Screening data


Although women who have had hysterectomies are excluded in these numbers, pathology may indicate screening may continue to be required for that group.

NOTE

Data shown in the charts above indicate what has been recorded in your clinical software and extracted into PATCAT. Actual cancer screening rates for patients in your practice may differ from those shown.
PIP QI INCENTIVE IMPROVEMENT MEASURES

QIM 01 - Proportion (%) of patients with Type 1 or Type 2 who have had an HbA1c measurement result recorded within the previous 12 months

QIM 02 - Proportion (%) of patients aged 15 years and over whose smoking status has been recorded

QIM 03 - Proportion (%) of patients aged 15 years and over who have had their Body Mass Index (BMI) classified within the previous 12 months

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 and over with COPD who were immunised against influenza in the previous 15 months

QIM 07 - Proportion (%) of patients aged 15 years and over whose alcohol consumption status has been recorded

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

QIM 09 - Proportion (%) of female patients aged 25 to 74 years with up to date cervical screening

QIM 10 - Proportion (%) of patients with diabetes who have had a blood pressure measurement result recorded within the previous 6 months

Notes

PIP QI measures on this page have been calculated with data currently available (at time of this report) in HNECC PATCAT.

A number of measures are best estimates based on data available. These include:
- 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 and over with COPD who were immunised against influenza in the previous 15 months

It is anticipated exact measures will be available following PEN CAT/PATCAT updates in the near future.

For full definitions of each measure are available on the following page.
## PIP QI INCENTIVE IMPROVEMENT MEASURES - DEFINITIONS

<table>
<thead>
<tr>
<th>Measure</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>QIM 01</td>
<td>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.</td>
</tr>
<tr>
<td>QIM 02</td>
<td>Proportion of regular clients aged 15 years and over whose smoking status has been recorded as one of the following: current; ex-smoker; or never smoked.</td>
</tr>
<tr>
<td>QIM 03</td>
<td>Proportion of regular clients aged 15 years and over who have had their Body Mass Index (BMI) classified as obese, overweight, healthy or underweight within the previous 12 months.</td>
</tr>
<tr>
<td>QIM 04</td>
<td>Proportion of regular clients aged 65 years and over who were immunised against influenza in the previous 15 months.</td>
</tr>
<tr>
<td>QIM 05</td>
<td>Proportion of clients with diabetes who were immunised against influenza in the previous 15 months.</td>
</tr>
<tr>
<td>QIM 06</td>
<td>Proportion of regular clients who are aged 15 years and over, are recorded as having chronic obstructive pulmonary disease (COPD), and were immunised against influenza in the previous 15 months.</td>
</tr>
<tr>
<td>QIM 07</td>
<td>Proportion of regular clients who are aged 15 years and over who have had their alcohol consumption status recorded.</td>
</tr>
<tr>
<td>QIM 08</td>
<td>Proportion of regular clients aged 45 to 74 years with information available to calculate their absolute CVD risk.</td>
</tr>
<tr>
<td>QIM 09</td>
<td>Proportion of female regular clients aged 25 to 74, who have not had a hysterectomy and who have had a cervical screening [either Papanicolaou smear (Pap test) within the previous 2 years, or human papillomavirus (HPV) test] within the previous 5 years.</td>
</tr>
<tr>
<td>QIM 10</td>
<td>Proportion of regular clients who have diabetes and who have had a blood pressure measurement result recorded at the primary health care service.</td>
</tr>
</tbody>
</table>