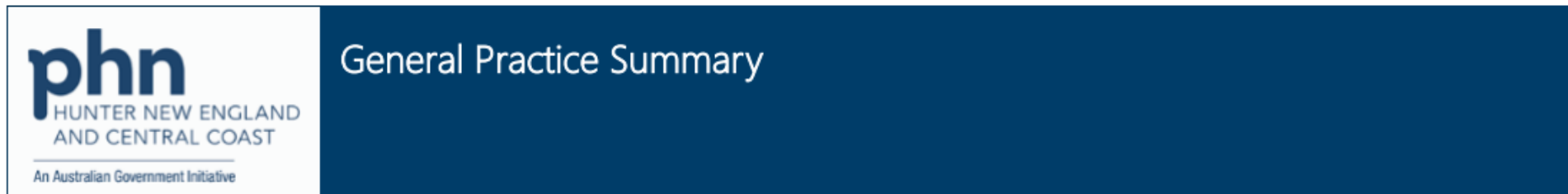




Interpretation of the HNECCPHN General Practice Summary in the context of Diabetes Mellitus



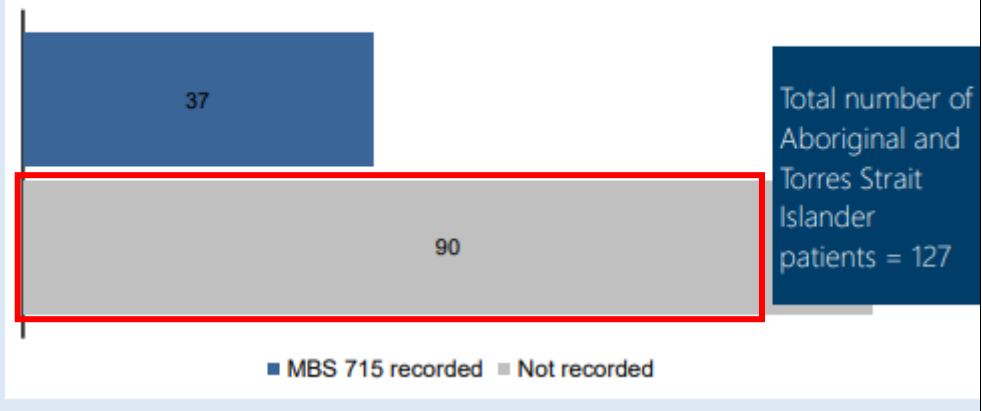


ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS																					
1.	<p>ETHNICITY</p> <table border="1"> <thead> <tr> <th></th> <th>Total patients</th> <th>% of group</th> </tr> </thead> <tbody> <tr> <td>Indigenous</td> <td>127</td> <td>6.1 % **</td> </tr> <tr> <td>Aboriginal</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 style="border: 2px solid red;"> <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>
	Total patients	% of group																						
Indigenous	127	6.1 % **																						
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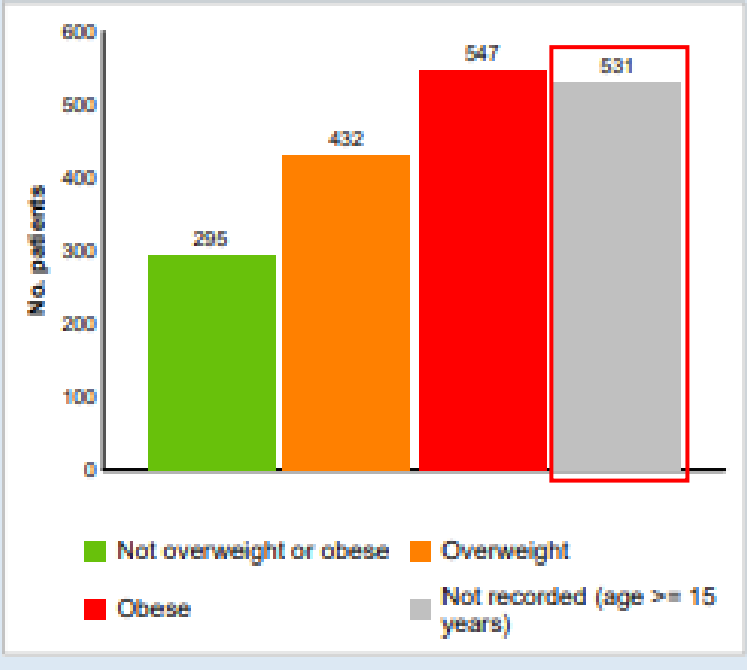


ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS
		<p>Also, when screening for Risk of Diabetes, the AUSDRISK Assessment asks if a patient is of Indigenous descent. A “yes” response adds 2 points to the AUSDRISK score in acknowledgement of the higher risk of diabetes in Indigenous populations</p> <p>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]</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>

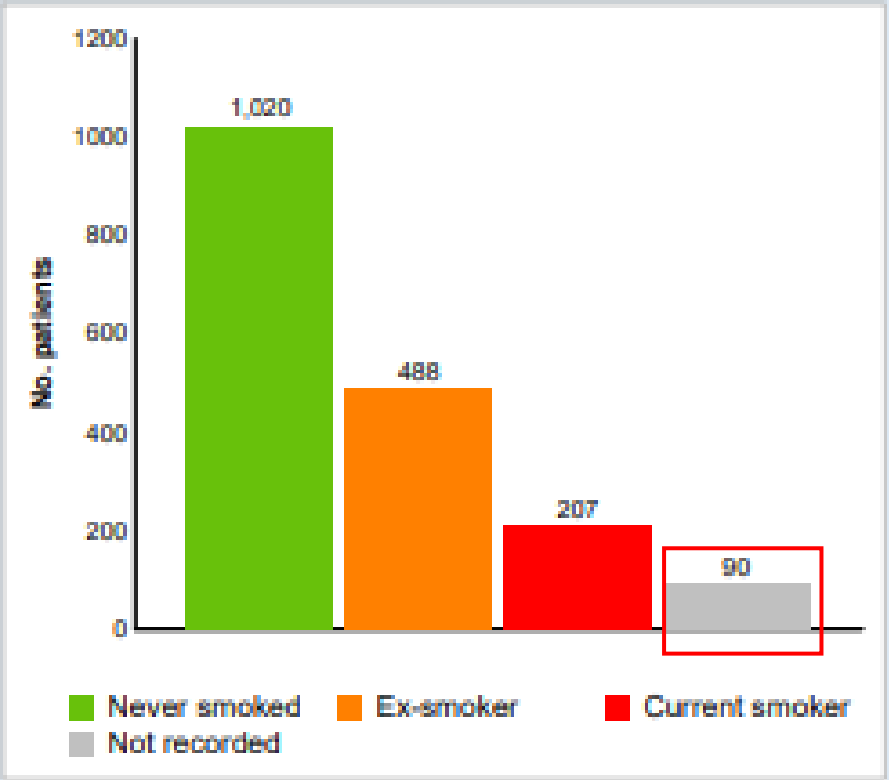


ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS								
2.	<p data-bbox="383 312 1256 403">ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES HEALTH ASSESSMENT (MBS item 715)</p>  <table border="1" data-bbox="383 419 1361 831"><thead><tr><th>Category</th><th>Count</th></tr></thead><tbody><tr><td>MBS 715 recorded</td><td>37</td></tr><tr><td>Not recorded</td><td>90</td></tr><tr><td>Total number of Aboriginal and Torres Strait Islander patients</td><td>127</td></tr></tbody></table> <p data-bbox="645 778 1032 802">■ MBS 715 recorded ■ Not recorded</p>	Category	Count	MBS 715 recorded	37	Not recorded	90	Total number of Aboriginal and Torres Strait Islander patients	127	<p data-bbox="1373 312 1776 879">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 data-bbox="1373 922 1776 1168">RACGP National Guide to a Preventative Health Assessment for Aboriginal and Torres Strait Islander People RACGP - The Royal Australian College of General Practitioners</p>	<p data-bbox="1809 312 2134 483">Provide patients with an Indigenous Health Assessment reminder card provided by the HNECCPHN.</p> <p data-bbox="1809 528 1933 552">Brochure</p> <p data-bbox="1809 600 1955 624">Reminders</p> <p data-bbox="1809 671 2101 807">Incorporate the AUSDRISK within the Indigenous Health Assessment.</p>
Category	Count										
MBS 715 recorded	37										
Not recorded	90										
Total number of Aboriginal and Torres Strait Islander patients	127										



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2.	<p data-bbox="389 320 698 363">LIFESTYLE RISKS</p> <p data-bbox="389 437 622 475">WEIGHT (BMI)</p>  <table border="1" data-bbox="389 504 1133 1177"><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 data-bbox="1368 309 1776 592">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 data-bbox="1368 635 1765 767">In this example, 531 patients have not had their height and weight recorded to calculate a BMI.</p> <p data-bbox="1368 815 1765 1059">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 data-bbox="1368 1102 1697 1171">NSW Health Get Healthy Coaching Service.</p>	<p data-bbox="1809 309 2136 553">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 data-bbox="1809 596 2063 624">RACGP Guidelines</p>
BMI Status	No. patients												
Not overweight or obese	295												
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ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS										
3.	<p data-bbox="387 327 584 371">SMOKING</p>  <table border="1" data-bbox="387 406 1272 1189"> <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="1368 311 1749 411">The data shows the smoking status of patients aged 15 years and over.</p> <p data-bbox="1368 454 1749 555">In this example, 90 patients do not have their smoking status recorded.</p> <p data-bbox="1368 598 1749 735">Patients whose smoking status is not recorded may miss out on healthcare appropriate for their circumstances.</p> <p data-bbox="1368 778 1749 879">These patients may miss out on smoking cessation interventions.</p> <p data-bbox="1368 922 1749 1098">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 1141 1749 1241">RACGP Diabetes Type 2 Guidelines recommend that patients who smoke...</p> <p data-bbox="1368 1284 1749 1385">RACGP Smoking, nutrition alcohol physical activity (SNAP) A population health</p>	<p data-bbox="1807 311 2130 555">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="1807 598 2130 842">Learn how to navigate in Medical Director Software Support via Online Help for Clinical Software Solutions for Medical Practitioners MedicalDirector</p> <p data-bbox="1807 885 2130 1129">Learn how to navigate in Best Practice Knowledge Base for Saffron version Select your Best Practice Software Knowledge Base (bpsoftware.net)</p>
Smoking Status	No. patients												
Never smoked	1,020												
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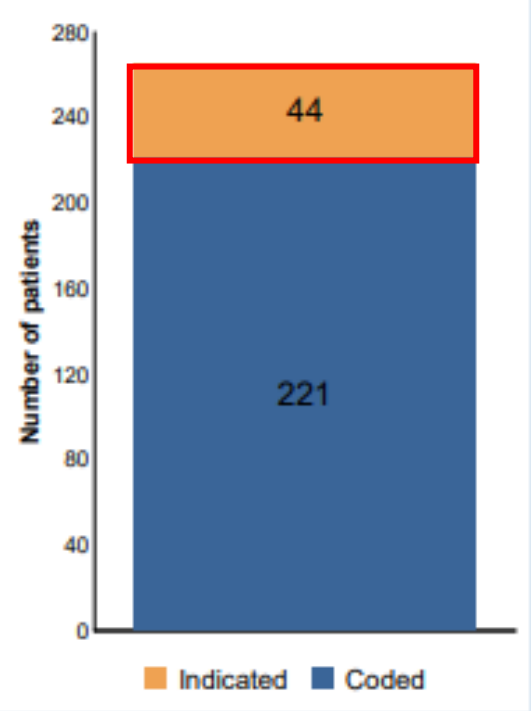


ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS																																														
		<p>guide to behavioural risk factors in general practice</p>																																															
<p>4.</p>	<p>DISEASE PREVALENCE</p> <p>Chart indicates numbers of patients at your practice coded with each diagnoses</p> <table border="1"> <caption>Disease Prevalence Data</caption> <thead> <tr> <th>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 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 women 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 Australian Government Department of Health</p>
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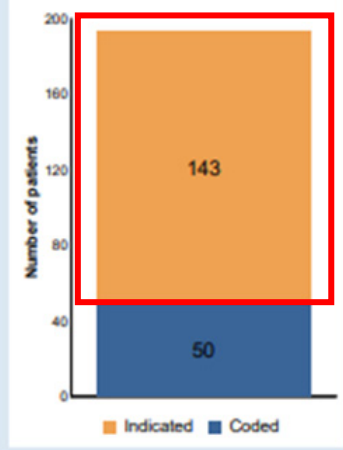


ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS
		<p>NB. Patients may be counted in more than one disease category according to their coded diagnosis.</p>	<p>Women with Gestational Diabetes Mellitus should be registered with the National Diabetes Services Scheme (NDSS). NDSS – 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="398 320 584 363">DIABETES</p>  <table border="1" data-bbox="398 421 927 1134"><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 312 1787 663">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 708 1787 844">In this example, 44 patients have pathology and/or medications that may indicate a diabetes diagnosis.</p> <p data-bbox="1368 888 1787 1059">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 1104 1787 1206">For example, the CVD Risk Assessment may be incorrect without a diagnosis of diabetes.</p>	<p data-bbox="1809 312 2136 555">Utilize PenCS Cleansing Cat module to identify patients for consideration of recording diabetes as a diagnosis. Home - Pen CS</p> <p data-bbox="1809 600 2085 699">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="389 320 712 347">CHRONIC KIDNEY DISEASE</p>  <p data-bbox="801 384 1272 421">Indicated CKD with no diagnosis</p> <p data-bbox="801 453 1272 628">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="801 660 1272 740">For more information see: https://help.pencs.com.au/display/CG/Indicated+Conditions+Report+Details</p>	<p data-bbox="1368 312 1783 592">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="1368 632 1783 807">In this example, 143 patients have pathology and/or medications that may indicate a Chronic Kidney Disease diagnosis.</p> <p data-bbox="1368 847 1783 991">If Chronic Kidney disease diagnosis is not coded, care may be suboptimal and complications can arise.</p>	<p data-bbox="1809 312 2134 560">Utilize PenCS Cleansing Cat module to identify patients for consideration of recording diabetes as a diagnosis. Home - Pen CS</p>

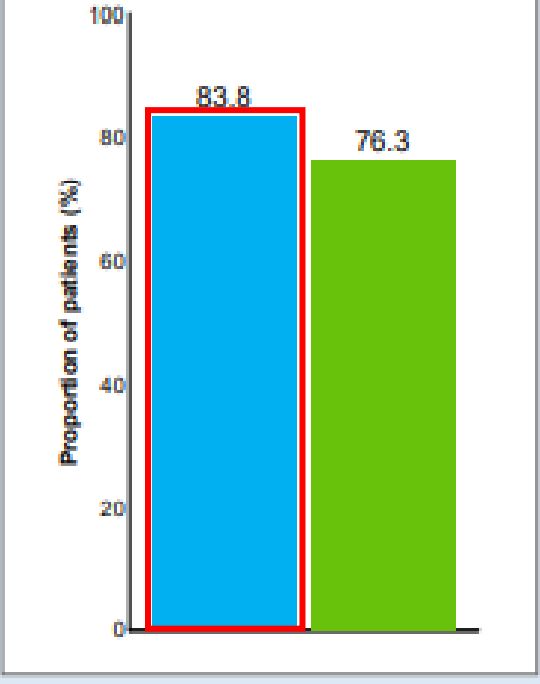


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7.	<p>MBS BILLING</p> <p>About MBS data</p> <p>For information on how PEN maps billing systems, and MBS items to category see: http://help.pencs.com.au/display/Mapping+All+Systems</p> <p>In some instances MBS mapping or missing, depending on local 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>In regard to 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>

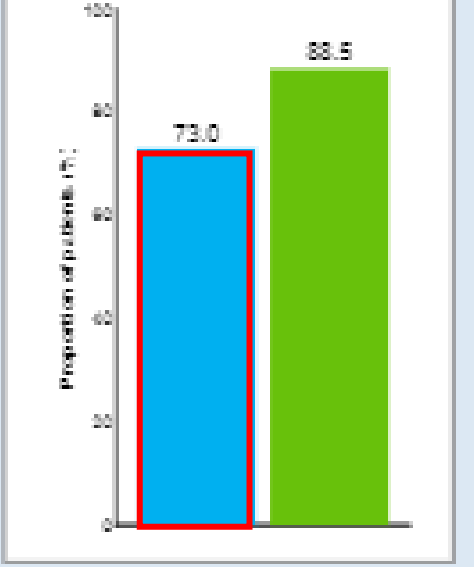


ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS
		<p>For example, 418 Practice Nurse attendances (MBS Item 10997) have been claimed.</p> <p>Department of Health Chronic Disease Management (formerly Enhanced Primary Care or EPC) — GP services</p>	

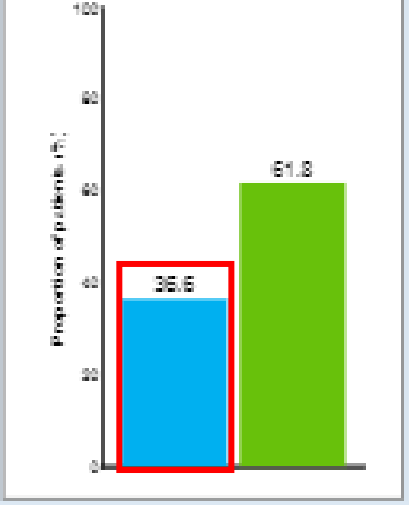


ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS						
8.	<p>QIM 01 - Proportion (%) of patients with Type 1 or Type 2 who have had an HbA1c measurement result recorded within the previous 12 months</p>  <table border="1"> <caption>HbA1c Measurement Results</caption> <thead> <tr> <th>Entity</th> <th>Proportion of patients (%)</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>	Entity	Proportion of patients (%)	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> <p>See HNECCPHN Quality Improvement</p>
Entity	Proportion of patients (%)								
Practice	83.8								
HNECCPHN area	76.3								



ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS						
9.	<p data-bbox="409 440 824 596">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</td><td>73.0</td></tr><tr><td>All other patients at HNECCPHN practices</td><td>88.5</td></tr></tbody></table>	Category	Proportion (%)	Practice	73.0	All other patients at HNECCPHN practices	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 448">RACGP SNAP Guide</p> <p data-bbox="1809 491 2092 520">Social-Family History</p> <p data-bbox="1809 563 2119 627">Smoking Cessation Readiness Assessment</p> <p data-bbox="1809 670 2119 766">Annual Diabetes Cycle of Care in CIS Diabetes Register</p> <p data-bbox="1809 809 2119 904">PenCS Missing Accreditation items, Diabetes Cycle of Care</p>
Category	Proportion (%)								
Practice	73.0								
All other patients at HNECCPHN practices	88.5								



ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS						
10.	<p>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"> <caption>BMI Classification Data</caption> <thead> <tr> <th>Group</th> <th>Proportion of patients (%)</th> </tr> </thead> <tbody> <tr> <td>Group 1 (Blue)</td> <td>36.6</td> </tr> <tr> <td>Group 2 (Green)</td> <td>61.8</td> </tr> </tbody> </table>	Group	Proportion of patients (%)	Group 1 (Blue)	36.6	Group 2 (Green)	61.8	<p>PIP QI Incentive Improvement Measure #3</p> <p>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>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>BMI is an indicator of risk of diabetes and cardio-vascular disease, and a progress measure in established diabetes.</p>	<p>Diabetes Cycle of Care</p> <p>Diabetes Register</p> <p>RACGP SNAP Assessment</p> <p>RACGP Type 2 Diabetes Guidelines</p>
Group	Proportion of patients (%)								
Group 1 (Blue)	36.6								
Group 2 (Green)	61.8								

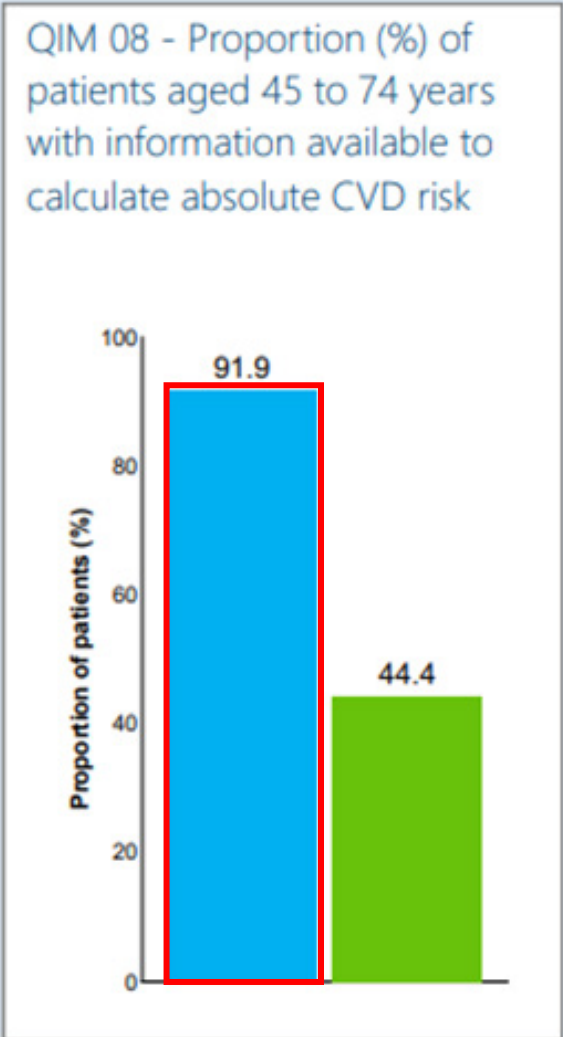


11.	<p>QIM 05 - Proportion (%) of patients with diabetes who were immunised against influenza in the previous 15 months</p> <table border="1"><thead><tr><th>Category</th><th>Proportion (%)</th></tr></thead><tbody><tr><td>Practice</td><td>73.8</td></tr><tr><td>All other HNECCPHN practices</td><td>63.8</td></tr></tbody></table>	Category	Proportion (%)	Practice	73.8	All other HNECCPHN practices	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 a influenza immunisation recorded, compared to 63.8% of patients with diabetes in all other HNECCPHN practices.</p>	<p>RACGP Diabetes Guideline</p> <p>Australian Immunisation Handbook</p>
Category	Proportion (%)								
Practice	73.8								
All other HNECCPHN practices	63.8								

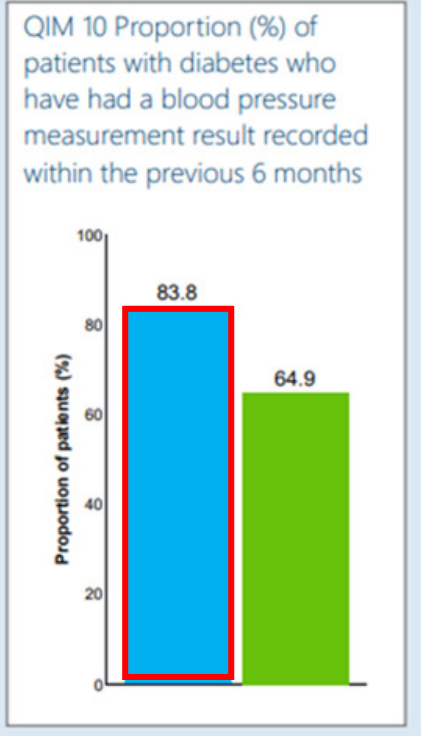


ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS
	<p>Notes</p> <p>PIP QI measures on this page have been calculated with data currently available (at time of this report) in HNECC PATCAT.</p> <p>A number of measures are best estimates based on data available. These include:</p> <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>		



ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS						
12.	<p data-bbox="412 336 949 536">QIM 08 - Proportion (%) of patients aged 45 to 74 years with information available to calculate absolute CVD risk</p>  <table border="1" data-bbox="389 320 949 1361"><caption>QIM 08 - Proportion (%) of patients aged 45 to 74 years with information available to calculate absolute CVD risk</caption><thead><tr><th>Category</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>	Category	Proportion (%)	Current Practice	91.9	Other Participating HNECCPHN Practices	44.4	<p data-bbox="1368 312 1771 376">PIP QI Incentive Improvement Measure #8</p> <p data-bbox="1368 416 1771 592">Proportion of regular clients aged 45 to 74 with information available to calculate their absolute Cardio-vascular Disease Risk.</p> <p data-bbox="1368 632 1771 879">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 data-bbox="1368 919 1771 1377">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</p>	<p data-bbox="1805 312 2040 376">RACGP Diabetes Guideline</p> <p data-bbox="1805 416 2141 632">Absolute Cardio Vascular Disease Risk Assessment Absolute CVD Risk Full Guidelines.pdf (cvdcheck.org.au)</p> <p data-bbox="1805 671 2141 879">Ensure a coded diabetes diagnosis is recorded in the patient record to enable an accurate Cardio-vascular Risk assessment.</p>
Category	Proportion (%)								
Current Practice	91.9								
Other Participating HNECCPHN Practices	44.4								



ACTIVITY	SUMMARY SCREEN SHOT	DEFINITION and RATIONALE	IMPROVEMENT IDEAS						
		<p>determined high risk for cardiovascular disease.</p> <p>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>Proportion of patients with diabetes who have had a blood pressure measurement result recorded within the previous 6 months</caption><thead><tr><th>Category</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>	Category	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>RACGP Diabetes Guideline</p>
Category	Proportion (%)								
Practice	83.8								
All other HNECCPHN practices	64.9								



PRIMARY CARE IMPROVEMENT



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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