This document contains confidential practice data

Please maintain data security
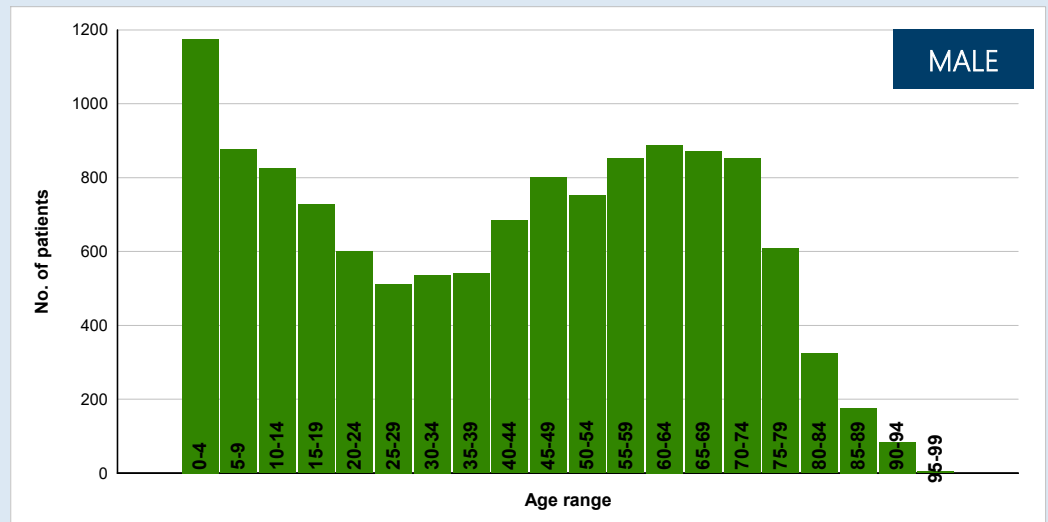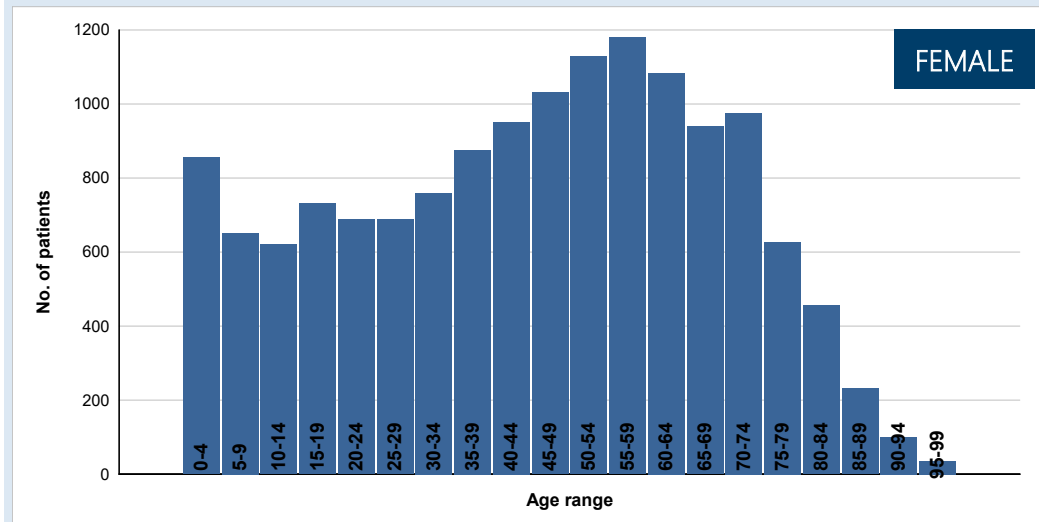
General Practice Summary

Sample practice report

DEMOGRAPHIC PROFILE

6858	163	2.4 %	All values in this report are calculated with active'patients (seen 3 or more times in the past 2 years).
Total patients	Aboriginal patients	% Aboriginal patients	

AGE PROFILE BY GENDER

FEMALE

MALE

ETHNICITY

	Total patients	% of group
Indigenous	163	3.6 % **
Aboriginal	149	(91.4 %) *
Torres Strait Islander	4	(2.5 %) *
Aboriginal and Torres Strait Islander	10	(6.1 %) *
Non-indigenous	6455	94.1 % **
Ethnicity not recorded	157	2.3 % **

* % of active Aboriginal and Torres Strait Islander patients at this practice
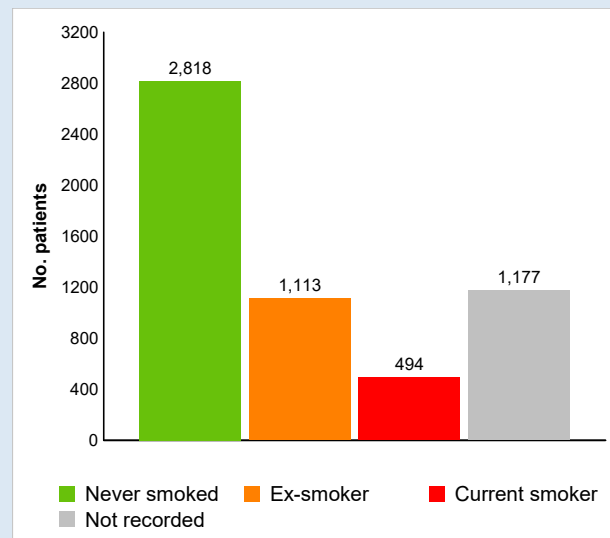*** % of total active patients at this practice (excludes patients aged 100 years and over)*

GENDER ***

Male 46.46%

Female 53.54%
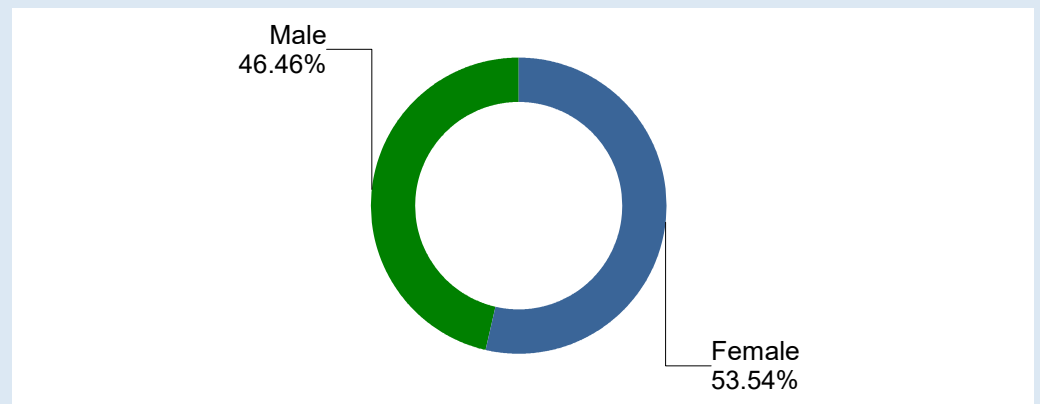
*** Represents % of total active patients at this practice

LIFESTYLE RISKS

WEIGHT (BMI)

- Not overweight or obese
- Overweight
- Obese
- Not recorded (age >= 15 years)

SMOKING

- Never smoked
- Ex-smoker
- Current smoker
- Not recorded

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.
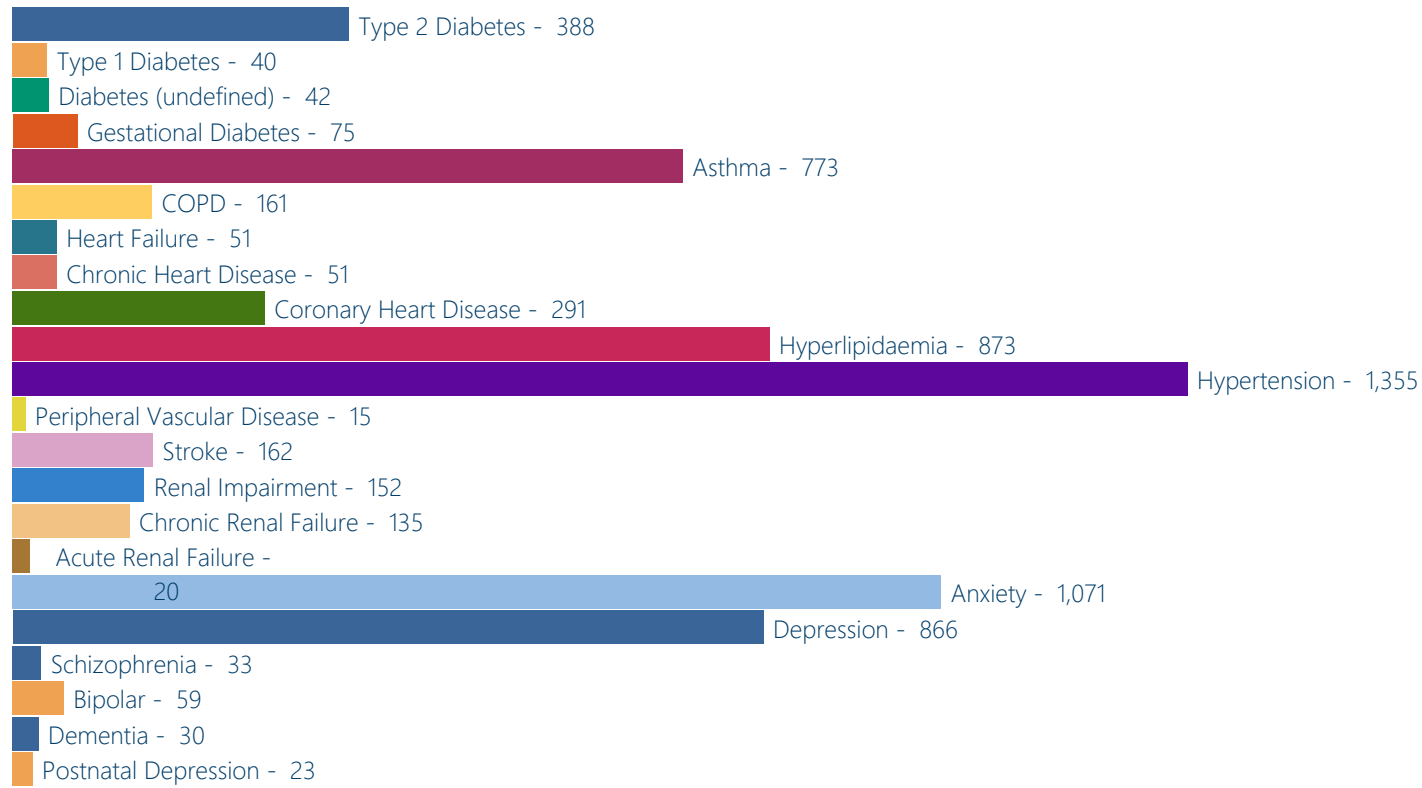
ABOUT THIS REPORT

Report Date: this report provides a snapshot of patients Prat 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 restrospectively, approximately third week of each month.

Data Source: the aggregated totals and percentages contained within this Practice Support Dashboard, reflect de-identfied 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

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
- Stroke - 162
- 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

Number of patients

- Indicated: 369
- Coded: 135

Legend: Indicated, Coded
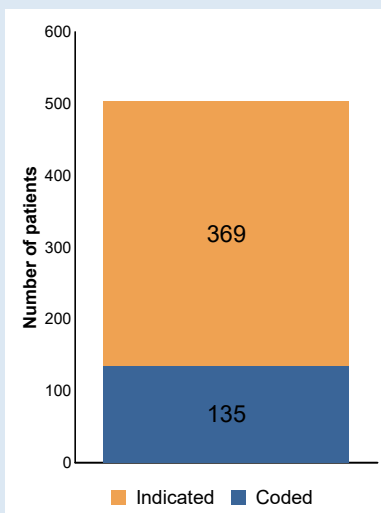
Indicated CKD with no diagnosis

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

Number of patients

- Indicated: 77
- Coded: 161

Legend: Indicated, Coded
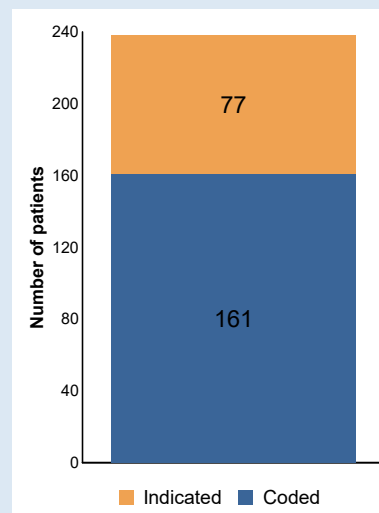
Indicated COPD with no diagnosis

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

Number of patients

- Indicated: 261
- Coded: 469

Legend: Indicated, Coded
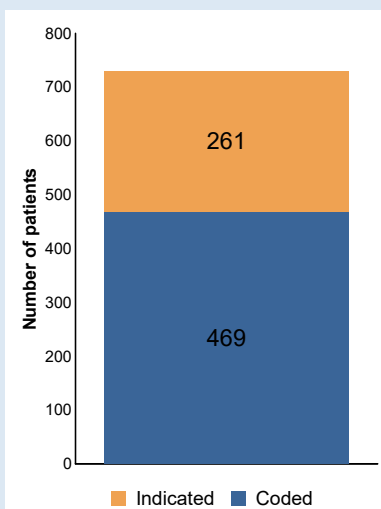
Indicated Diabetes with no diagnosis

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
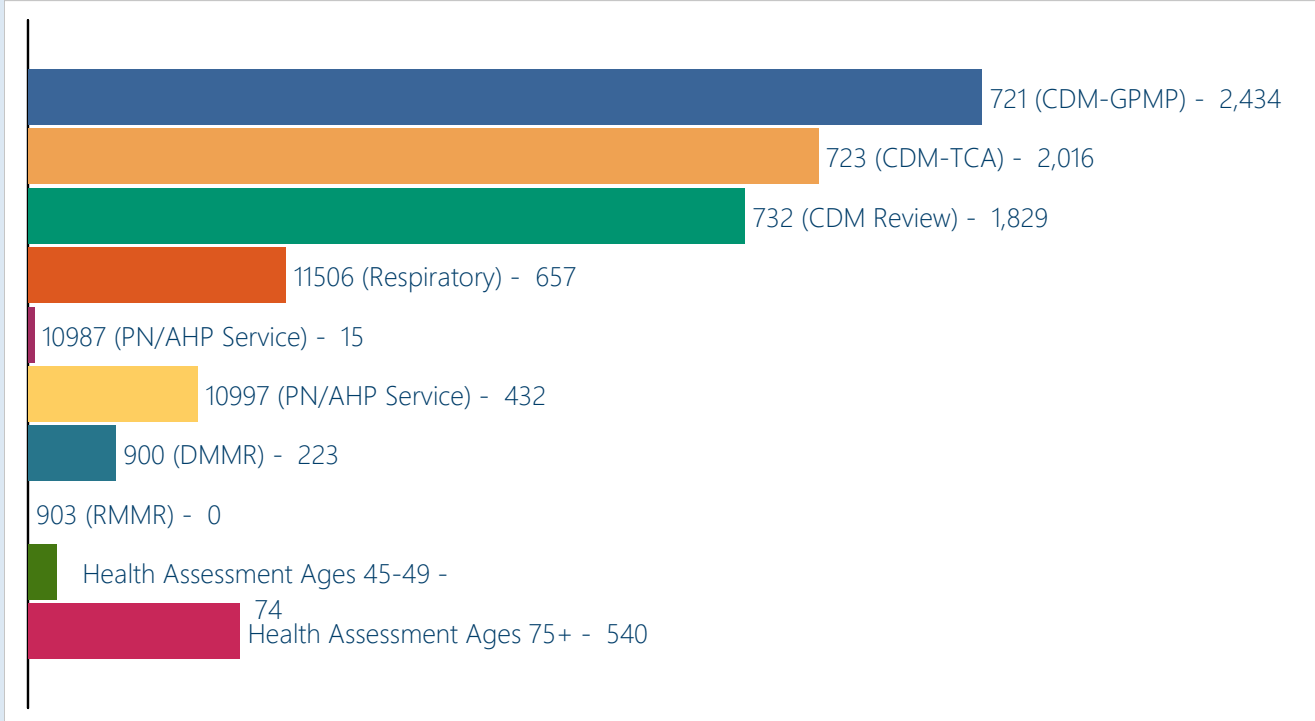
MENTAL HEALTH

Number of patients

- Indicated: 1,467
- Coded: 1,459

Legend: Indicated, Coded
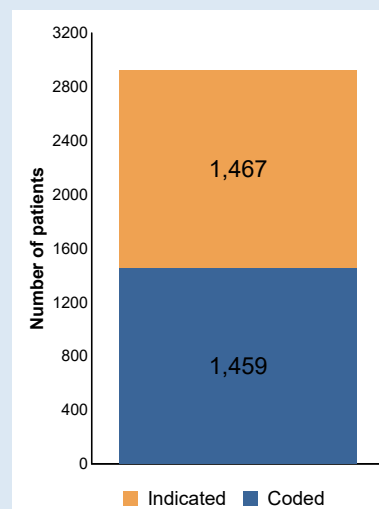
Indicated Mental Health with no diagnosis

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.

MBS BILLING

721 (CDM-GPMP) - 2,434
723 (CDM-TCA) - 2,016
732 (CDM Review) - 1,829
11506 (Respiratory) - 657
10987 (PN/AHP Service) - 15
10997 (PN/AHP Service) - 432
900 (DMMR) - 223
903 (RMMR) - 0
Health Assessment Ages 45-49 - 74
Health Assessment Ages 75+ - 540

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.

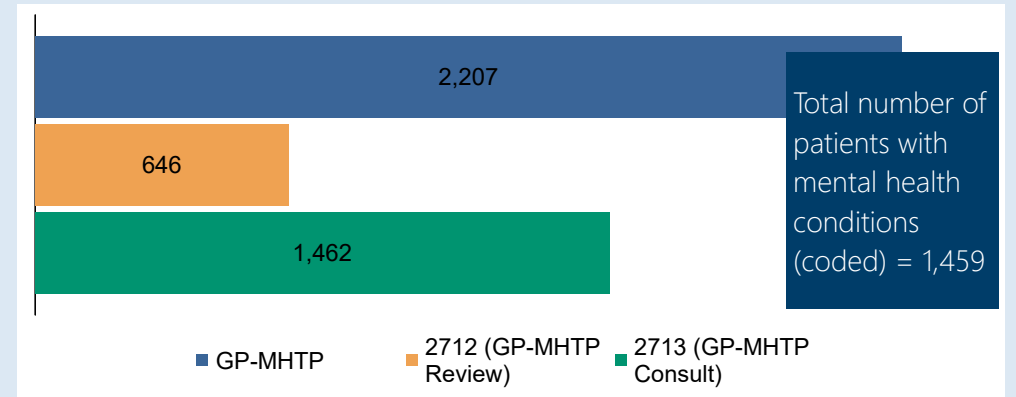* In the chart, numbers represent numbers of MBS items claimed.

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

31
132

Total number of Aboriginal and Torres Strait Islander patients = 163

- MBS 715 recorded ■ Not recorded
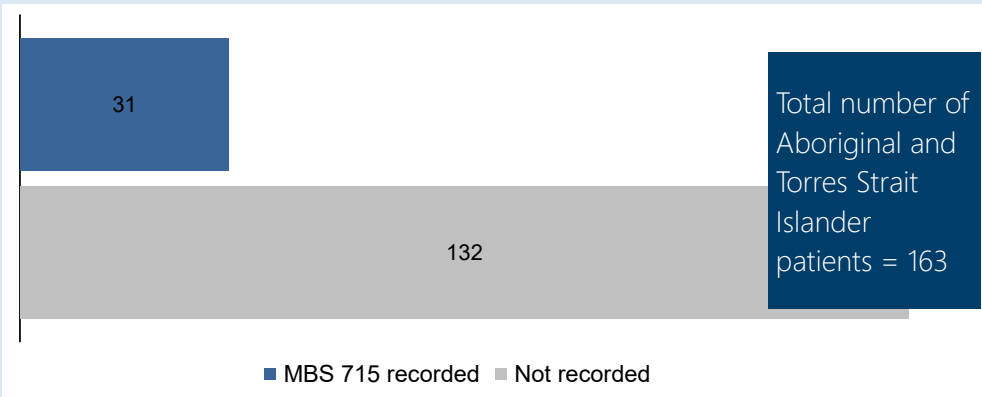
The data shows proportions of Aboriginal and Torres Strait Islander patients who have had a **Health Assessment** recorded (MBS Item 715). This includes assessment of a patient's health and physical, psychological and social function and consideration of whether preventive health care and education should be offered to the patient, to improve that patient's health and physical, psychological and social function. For details see: http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&q=715&qt=ite
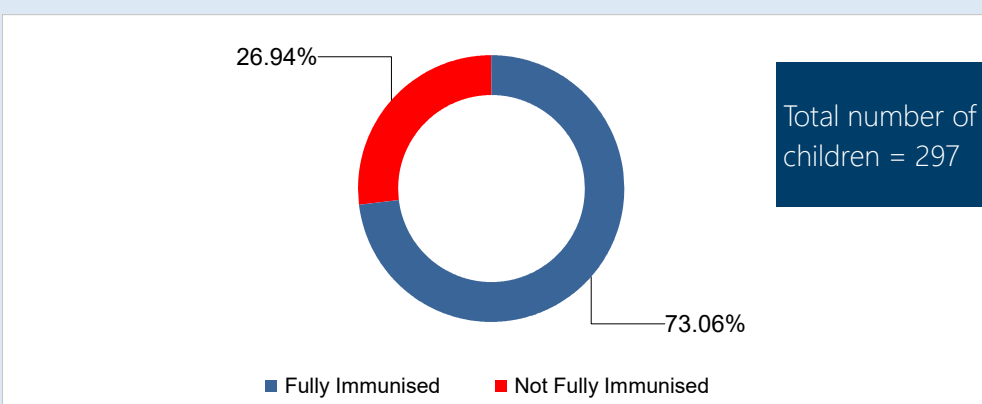
MENTAL HEALTH CARE
TREATMENT PLANS, REVIEWS, AND CONSULTS

2,207
646
1,462

Total number of patients with mental health conditions (coded) = 1,459

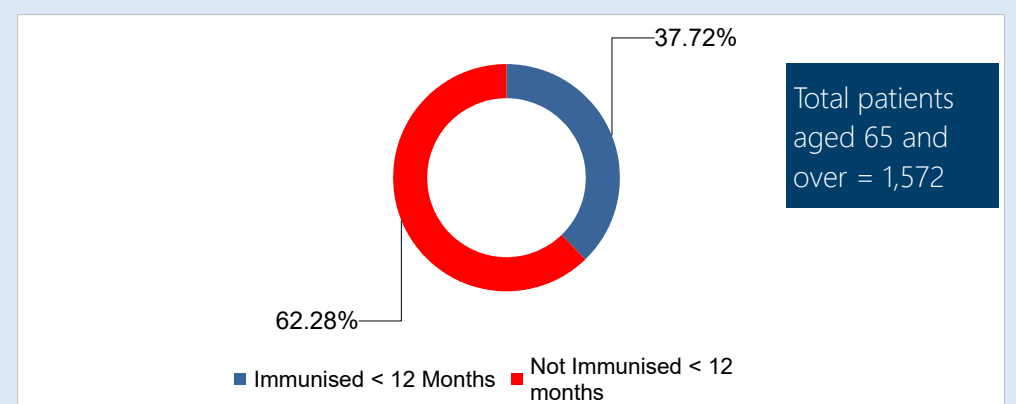- GP-MHTP ■ 2712 (GP-MHTP Review) ■ 2713 (GP-MHTP Consult)

GP Mental Health Treatment Medicare items include:
MBS items 2700, 2701, 2715 or 2717 - Preparation of a GP Mental Health Treatment Plan (effective from 1 November 2011);
MBS item 2712 - Review of a GP Mental Health Treatment Plan; and
MBS item 2713 - GP Mental Health Treatment Consultation.
For details see:
https://www1.health.gov.au/internet/main/publishing.nsf/Content/pacd-gp-mental-health-care-pdf-qa

PREVENTION

Childhood immunisation

26.94%
73.06%

Total number of children = 297

- Fully Immunised ■ Not Fully Immunised

Influenza immunisation (people 65 years and over)

37.72%
62.28%

Total patients aged 65 and over = 1,572

- Immunised < 12 Months ■ Not Immunised < 12 months

Childhood immunisation data shows the number of children who have recieved all the immunisations required for their age (recorded at this general practice).

Influenza immunisation data shows the number of patients aged 65 years and over who have been immunised against influenza in the last 12 months.

The NSW Immunisation Schedule is available at https://www.health.nsw.gov.au/immunisation/Publications/nsw-immunisation-schedule.pdf

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.

CANCER SCREENING

Bowel Cancer Screening (FOBT)
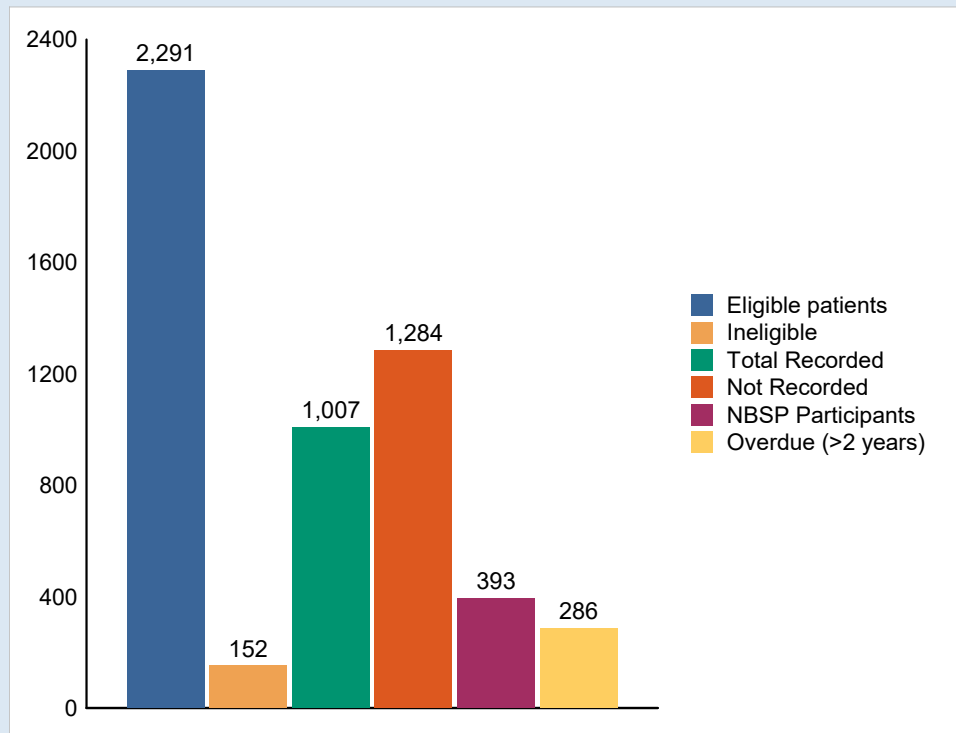
About Bowel Cancer Screening (FOBT) data

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 exlusions 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

* Cohort includes active patients aged from 50 to 75 years of age who are eligible for FOBT. See notes(above right) for exclusion criteria

Breast Screening
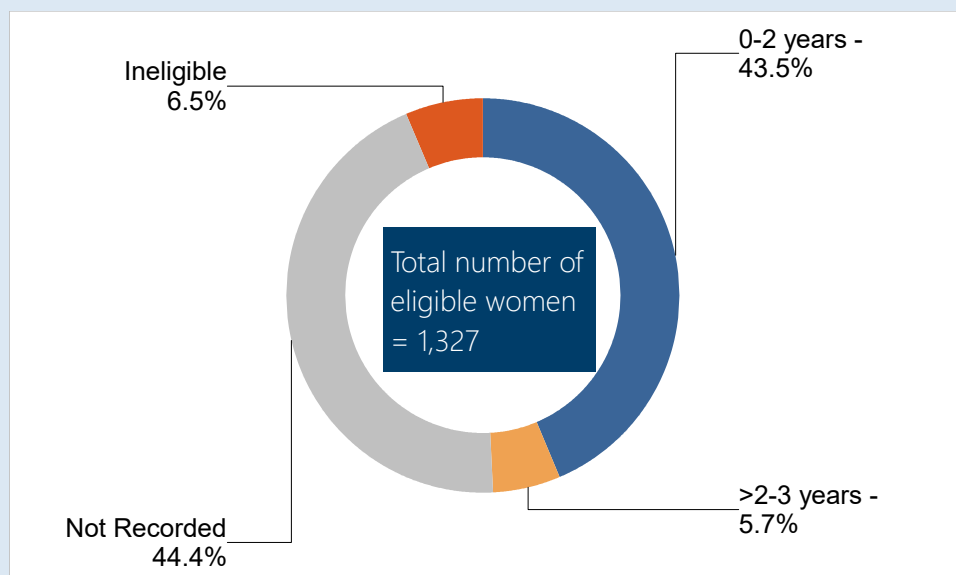
About Breast Screening data

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 sxcreening data. Cancer Institute NSW can also provide a list of patients to assist updating of clinical records.

* Cohort includes active female patients aged from 50 to 74 years of age who are eligible for screening. See notes (above right) for exclusion criteria

Cervical Screening
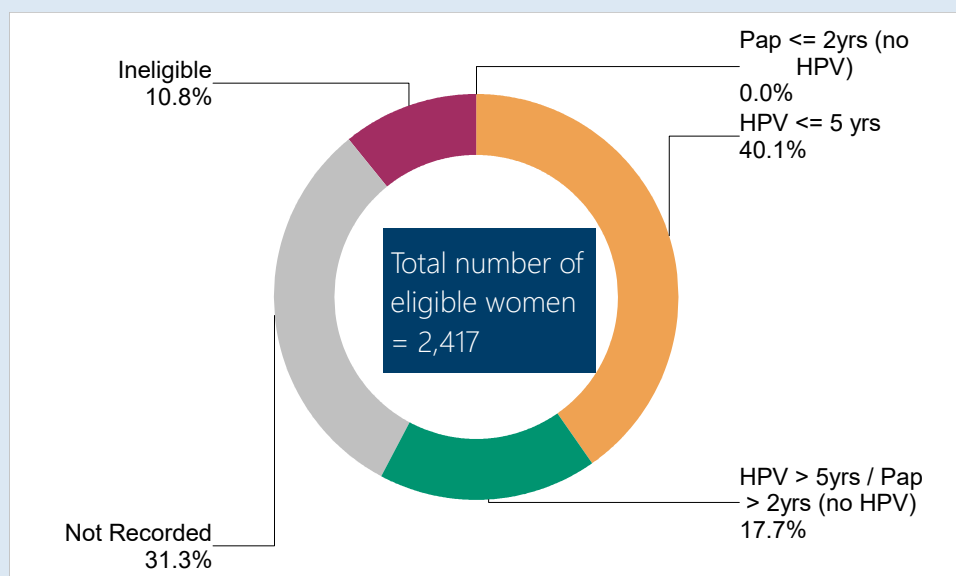
About Cervical Screening data

The cervical screening target population includes women aged between 25 and 74 years. The data shows numbers of women screened in relation to the new and old National Cervical Screening program (see: http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/cervical-screening-1).

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

* Cohort includes active female patients aged from 25 to 74 years of age who are eligible for screening. See notes (above right) for exclusion criteria
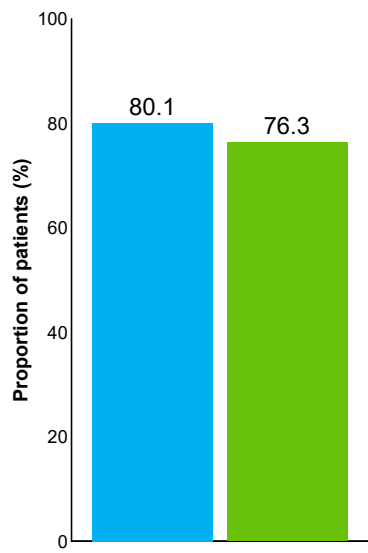
NOTE
Data shown in the charts above indicate what has been recorded in your clinical software and extracted into PATCAT. Actual cancer screening rates for patients in your practice may differ from those shown.

PIP QI INCENTIVE IMPROVEMENT MEASURES

Legend: ■ Your practice ■ HNECC PHN practices

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

- Your practice: 80.1
- HNECC PHN practices: 76.3

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

- Your practice: 79.3
- HNECC PHN practices: 148.1
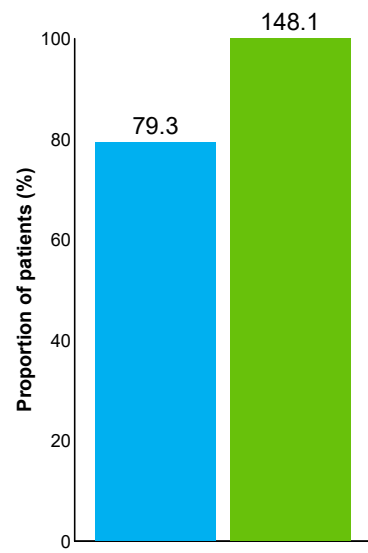
QIM 03 - Proportion (%) of patients aged 15 years and over who have had their Body Mass Index (BMI) classified within the previous 12 months
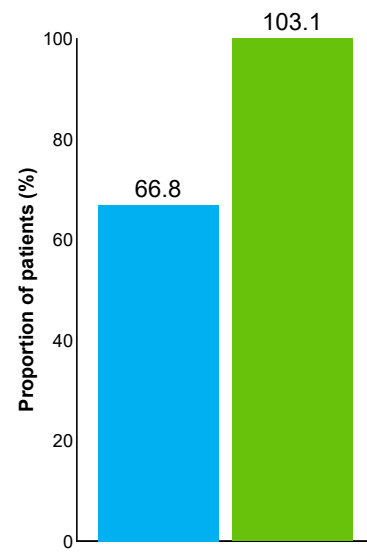
- Your practice: 66.8
- HNECC PHN practices: 103.1

QIM 04 - Proportion (%) of patients aged 65 years and over who were immunised against influenza in the previous 15 months

- Your practice: 75.1
- HNECC PHN practices: 68.3

QIM 05 - Proportion (%) of patients with diabetes who were immunised against influenza in the previous 15 months

- Your practice: 67.4
- HNECC PHN practices: 63.8
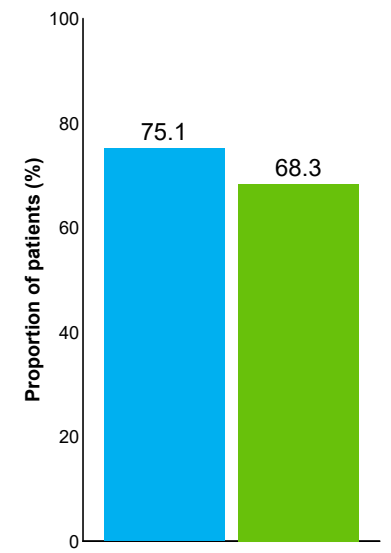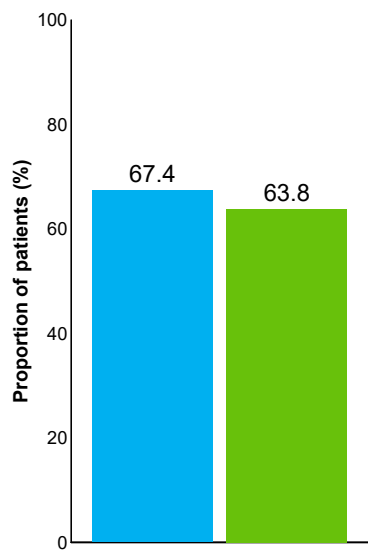
QIM 06 - Proportion (%) of patients aged 15 years and over with COPD who were immunised against influenza in the previous 15 months

- Your practice: 77.6
- HNECC PHN practices: 68.6

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

- Your practice: 66.6
- HNECC PHN practices: 39.8

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

- Your practice: 77.9
- HNECC PHN practices: 44.4

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

- Your practice: 47.8
- HNECC PHN practices: 47.8

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

- Your practice: 65.4
- HNECC PHN practices: 64.9

Notes

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

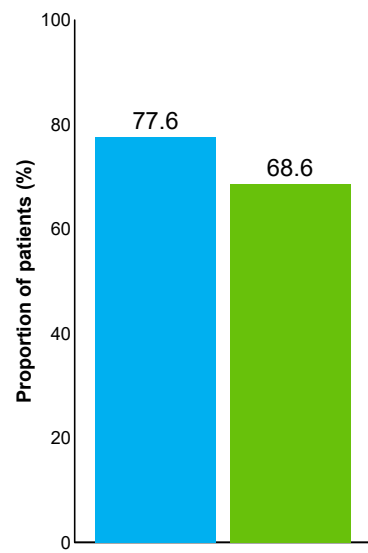A number of measures are best estimates based on data available. These include:
 - QIM 04 Proportion (%) of patients aged 65 years and over who were immunised against influenza in the previous 15 months
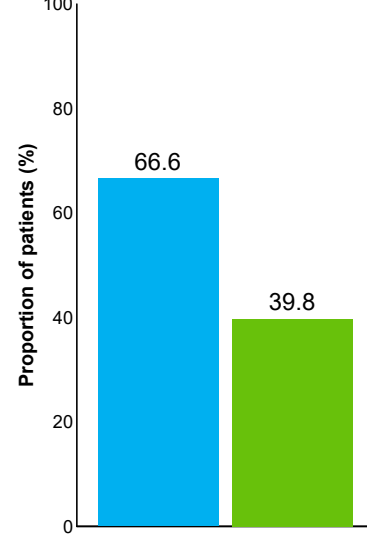 - QIM 05 Proportion (%) of patients with diabetes who were immunised against influenza in the previous 15 months
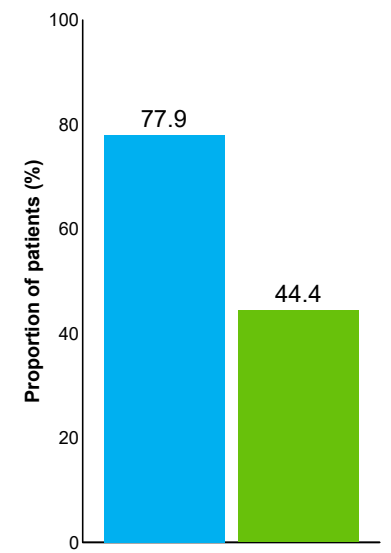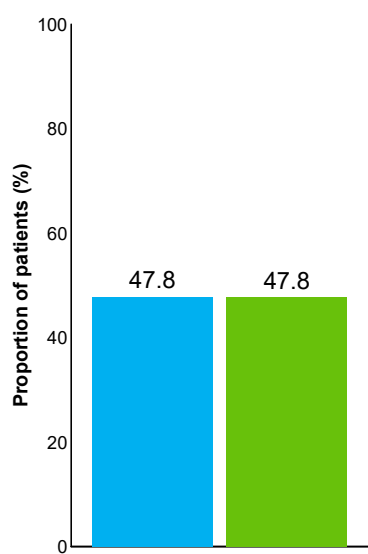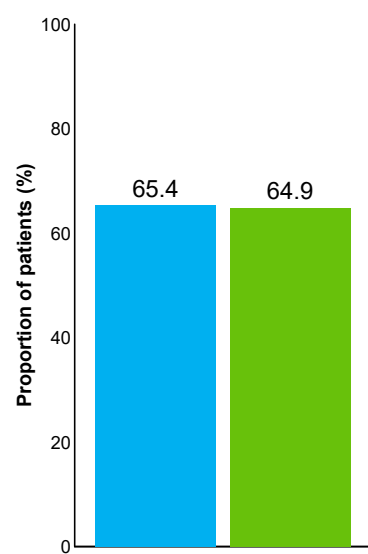 - QIM 06 - Proportion (%) of patients aged 15 years with COPD who were immunised against influenza in the previous 15 months

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

For full definitions of each measure are available on the following page

PIP QI INCENTIVE IMPROVEMENT MEASURES - DEFINITIONS

Measure	Definition
QIM 01	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.
QIM 02	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.
QIM 03	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.
QIM 04	Proportion of regular clients aged 65 years and over who were immunised against influenza in the previous 15 months.
QIM 05	Proportion of clients with diabetes who were immunised against influenza in the previous 15 months
QIM 06	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.
QIM 07	Proportion of regular clients who are aged 15 years and over who have had their alcohol consumption status recorded.
QIM 08	Proportion of regular clients aged 45 to 74 years with information available to calculate their absolute CVD risk.
QIM 09	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.
QIM 10	Proportion of regular clients who have diabetes and who have had a blood pressure measurement result recorded at the primary health care service.