![phn MURRUMBIDGEE - An Australian Government Initiative]

Sample Medical Centre
Quality Improvement Report

Feb 2019

Table of Contents

Executive Summary

Digital information can transform the quality and sustainability of health and care. Used effectively, it can help save lives, improve health and wellbeing and support a sustainable health system that delivers safe, high quality and effective health services for all Australians.

Improvement in general practice data can involve examining practice structures, systems and clinical care. This data can be gathered from patient or staff feedback, an audit of clinical databases, or the analysis of near misses and mistakes.

MPHN plays a role in supporting Quality Improvement (QI) in general practice with strategies to embed QI systems, improve data quality, analyse the practice's data and identify areas for improvement, assist with goal setting and improvement activities, provide progress reports and feedback. Ultimately, quality improvement activities will lead to improved clinical care and outcomes in general practice.

MPHN acknowledges the support provided by South Western Sydney PHN in the creation of this report.

Disclaimer

This report is presented for the purpose of supporting the addressed Murrumbidgee PHN practice with their quality improvement activities.

The report includes data provided to Murrumbidgee PHN by the addressed practice via PenCS, as well as data freely available on public websites such as the Australian Institute of Health and Welfare and the Australian Bureau of Statistics.

Data in this report remain confidential for use by the addressed practice and internally for MPHN purposes.

Data from Commonwealth secure confidential websites have not been included in this report.

The MPHN has taken all steps to ensure the information in this report is as accurate as possible and correct at time of report.

Data may vary to other publically available sources due to differing sources accessed.

THE MPHN does not guarantee, and accepts no legal liability whatsoever arising from, or connected to, the use of any material contained in this report.

The MPHN recommends that users exercise their own skill and care with respect to use of this report.

Practice Data Quality Benchmark Report
Sample Medical Centre

Active Patients

Nov 2018	1,720
Feb 2019	1,680
MPHN	159,530

* Active population baced on RACGP definition of 3 visits in last 2 years.

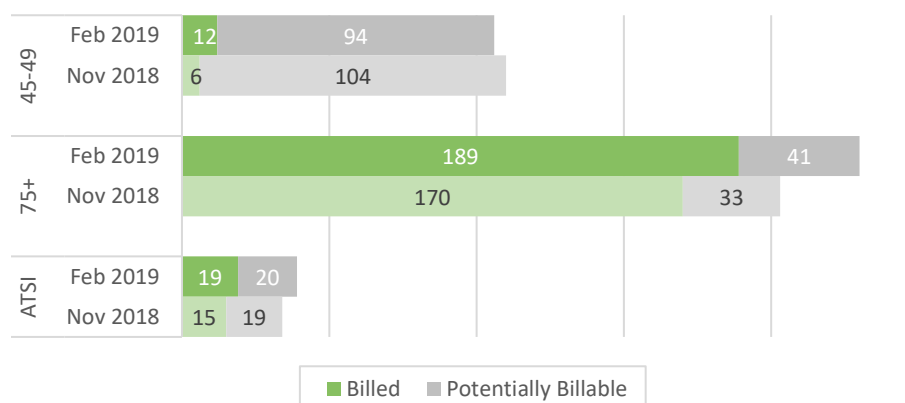** MPHN based on 52 practices submitting data

Data Quality Dashboard

Measures Recorded	Nov 2018	Feb 2019	MPHN Feb 2019
Allergies	98%	100%	94%
Age	98%	100%	100%
Ethnicity	94%	94%	77%
Smoking Status	99%	99%	83%
Alcohol Intake	94%	95%	54%
Blood Pressure	81%	85%	87%
BMI	60%	68%	56%
Waist	26%	27%	16%
Physical Activity	1%	1%	2%

The data quality dashboard above follows a 'traffic light' colour system to indicate performance against RACGP Accreditation Standards; 90% patients with allergies recorded and 75% patients with completed health summary.

Health Assessments

Figures in the table below are based on patient demographics and MBS items billed

Consider recalling all eligible patients for their appopriate health assessment

Legend: ■ Billed   ■ Potentially Billable

45-49:
- Feb 2019: 12 (Billed), 94 (Potentially Billable)
- Nov 2018: 6 (Billed), 104 (Potentially Billable)

75+:
- Feb 2019: 189 (Billed), 41 (Potentially Billable)
- Nov 2018: 170 (Billed), 33 (Potentially Billable)

ATSI:
- Feb 2019: 19 (Billed), 20 (Potentially Billable)
- Nov 2018: 15 (Billed), 19 (Potentially Billable)

Clinical Conditions Snapshot

In the Murrumbidgee region, there are higher rates of prevalence or hospital related admissions for cardiovascular disease (CVD), diabetes, chronic kidney disease (CKD), chronic obstructive pulmonary disease (COPD) and mental health conditions. The following graph represents your practice's latest figures of diagnosis compared to possible indicated diagnoses. See below for explanations
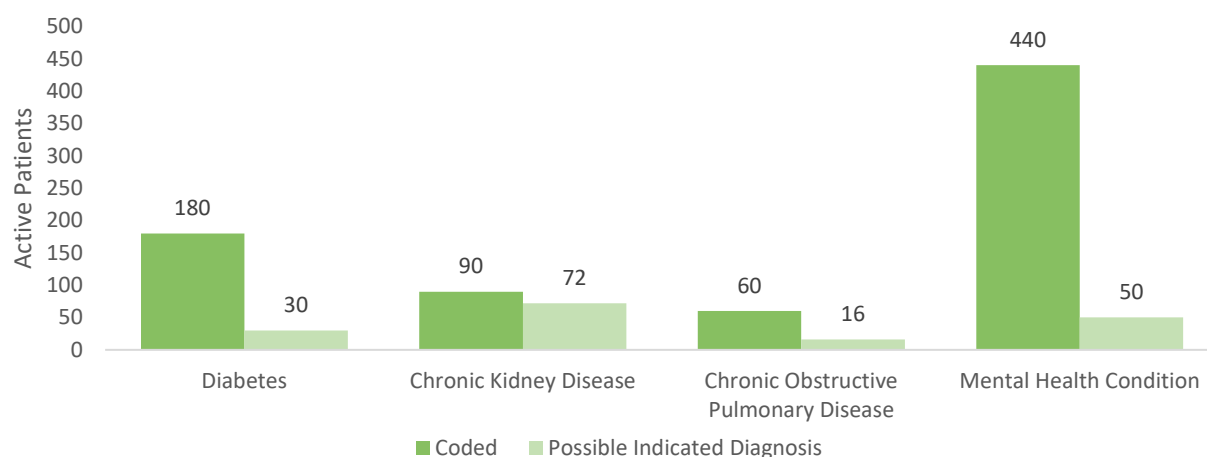
Diabetes, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease and Mental Health Conditions
Figures compare the number of patients with a coded diagnosis versus number of patients without a coded diagnosis who have a possible indication of the clinical condition based on clinical markers, treatment provided and/or billed MBS items.

Improvement Plan

Select two things you would like to focus on over the next six months, and write a brief synopsis of what changes you would like to make to hopefully achieve improvements in these areas

Focus Area (6 month):

Plan:

Focus Area (6 month):

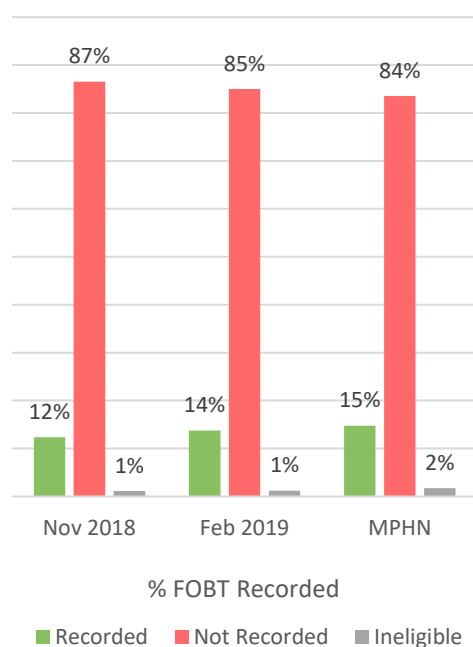**Plan:**

Cancer Screening Report

Cervical Cancer Screening

Graph below shows the currentness of screening for patients eligible for cervicle screening.
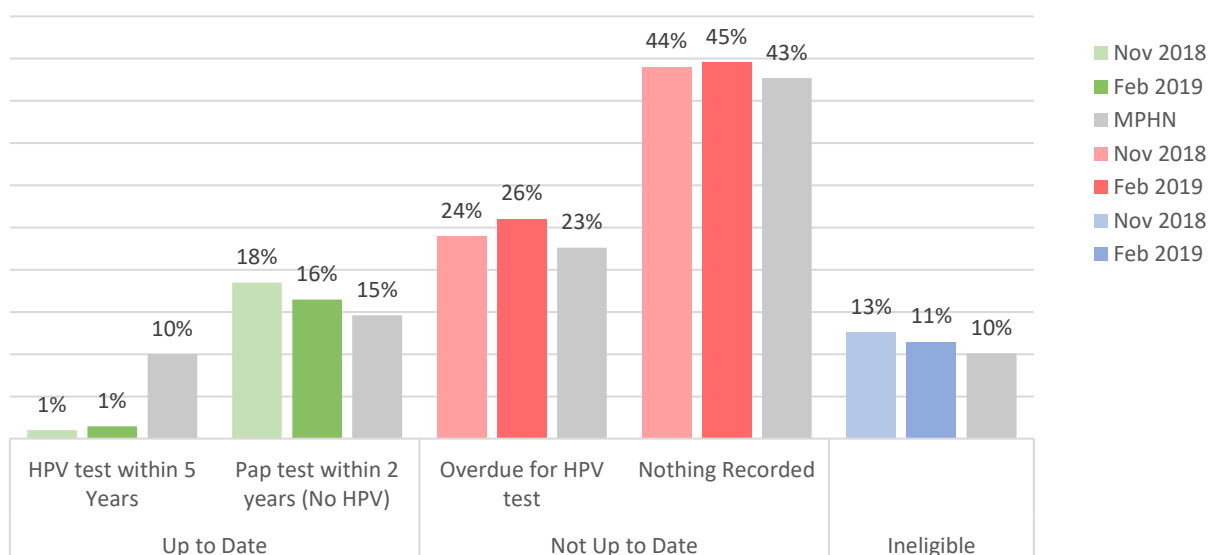
Bowel Cancer Screening

Graph below shows the status of patients eligible for bowel cancer screening, and of those patients with a recorded FOBT, the currency of this test.
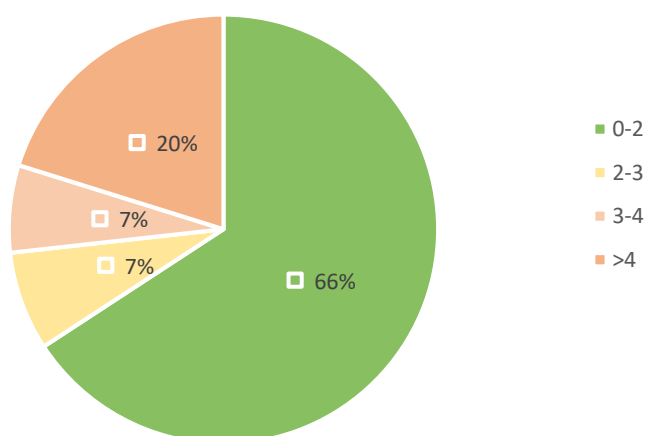
Breast Cancer Screening

Graph below shows the status of patients eligible for breast cancer screening, and of those patients with a recorded mammogram, the currency of this test.
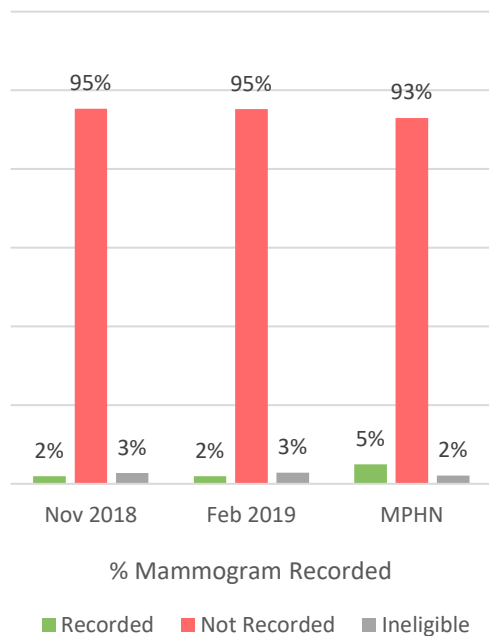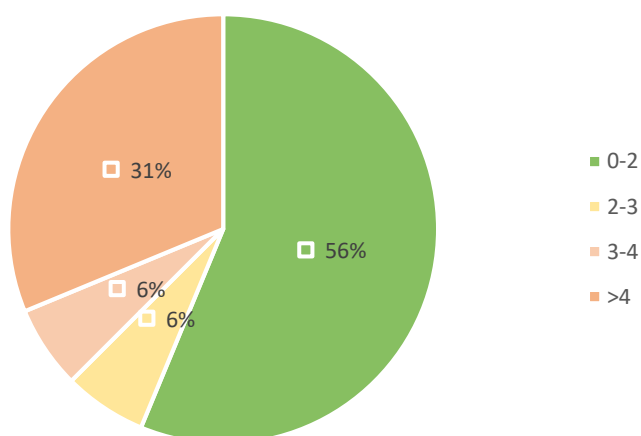

% Mammogram Recorded

Recorded   Not Recorded   Ineligible

Mammogram Last Recorded (Years)

- 0-2
- 2-3
- 3-4
- >4

Respiratory Clinical Report

Coded COPD Population

Nov 2018	59	3%
Feb 2019	60	3%
MPHN	5,571	3.49%

* MPHN based on 52 practices submitting data

Coded Asthma Population

Nov 2018	315	18%
Feb 2019	300	18%
MPHN	17,220	10.79%

Coded Smoking Statistics

Smoking Statistic	Nov 2018	Feb 2019	MPHN
Smoking Status Recorded	99%	99%	83%
Daily Smoker	13%	13%	14%
Irregular Smoker	1%	1%	1%
Ex Smoker	23%	23%	18%
Never Smoked	62%	62%	49%

Patients with a coded Asthma Diagnosis	300
Patients with a billed Asthma Cycle of Care	75

COPD Coded Diagnosis vs Indicated w/No Coded Diagnosis
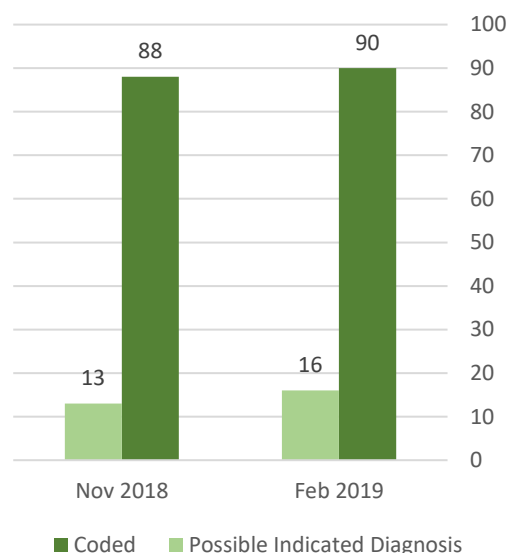
Figures show number of patients with a coded diagnosis of COPD, versus indicated diagnosis with no COPD coding based on clinical markers, medications and billed MBS items

Consider reviewing patients indicated with no diagnosis

COPD Patient Vaccinations

Graphs show active patients coded with COPD and their current vaccination status.

Influenza

- Current year
- Previous year
- Prior to previous year
- Nothing Recorded

Pneumococcal

- Up to date
- Overdue
- At Risk, nothing recorded
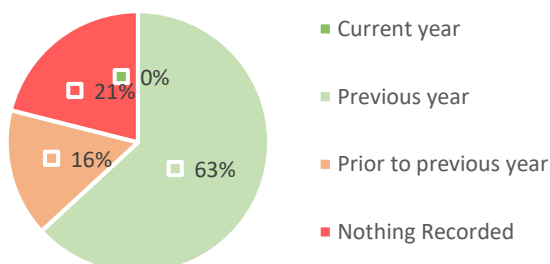
Billables

Table shows active patients coded with COPD and/or Asthma and their MBS billings in the last 12 months
Consider creating a Asthma Cycle of Care, GPMP and TCA for patients coded with a Respiratory condition

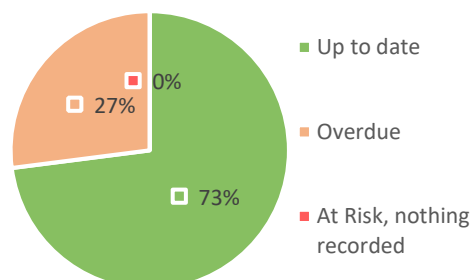|		Billed	Potentially Billable
CDM-GPMP (MBS 721) recorded	Feb 2019	98	258
	Nov 2018	89	272
CDM-TCA (MBS 723) recorded	Feb 2019	84	272
	Nov 2018	79	282
CDM - Review (MBS 732) recorded	Feb 2019	53	303
	Nov 2018	52	309
DMMR (MBS 900) & RMMR (MBS 903) recorded	Feb 2019	3	150
	Nov 2018	7	146
Spirometry	Feb 2019	11	46
	Nov 2018	10	46

■ Billed   ■ Potentially Billable

Murrumbidgee HealthPathways is a web-based portal with condition-specific 'pathways'. Each pathway supports clinicians with assessment, management and local referral information. The HealthPathways site is designed to be used at point of care.

The secure portal is not for use by patients, however there will be appropriate local resources for GPs to provide to patients.

To gain access or request a demo of Murrumbidgee Health Pathways, please contact the HealthPathways team healthpathways@mphn.org.au

Cardiovascular Disease Clinical Report

Coded CVD Population

Nov 2018	128	7%
Feb 2019	130	8%
MPHN	9,316	5.84%

* MPHN based on 52 practices submitting data

5 Year Cardiovascular Event Risk

- 0.3%
- 0.5%
- 2.0%
- 15.3%
- 12.3%
- 39.4%
- 30.2%

Legend:
- >= 30 %
- 25-29 %
- 20-24 %
- 16-19 %
- 10-15 %
- 5-9 %
- <5 %
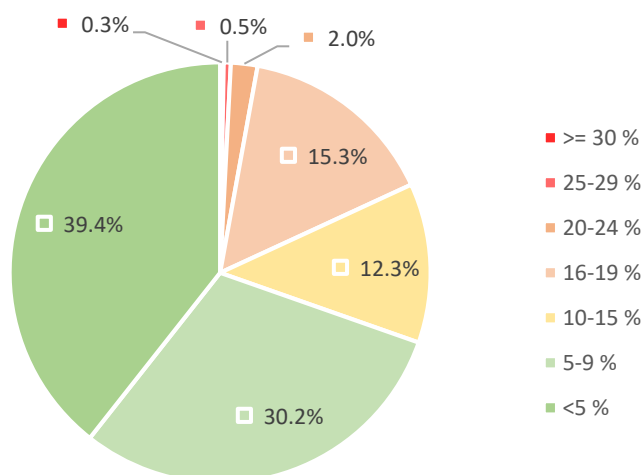
Calculation uses the Absolute Cardiovascular Risk Assessment (Framingham Risk Equation).
Absolute risk describes an individual's chance of getting cardiovascular disease (which includes all heart, stroke and blood vessel diseases) based on risk factors including gender, age, systolic blood pressure, smoking status, total cholesterol, HDL cholesterol, diabetes and left ventricular hypertrophy

Active Patients with CVD Risk Factors

Risk Factor	Recorded w/Risk Factor	Recorded No Risk Factor	Not Recorded
High Waist Circumference	25%	2%	73%
Diabetes	8%	92%	0
Hypertension	22%	63%	15%
Physically Inactive	0%		99%
Overweight	43%	20%	37%
Daily Smoker	14%	85%	1%
Alcohol Drinker	65%	29%	6%

Alcohol Drinker: ≥15 years, ≥2 drinks/day), Overweight: (BMI ≥ 25kg/m2), Hypertension: SYS > 140 or DIA >90, Waist circumference: (men ≥94cm, women ≥80cm)

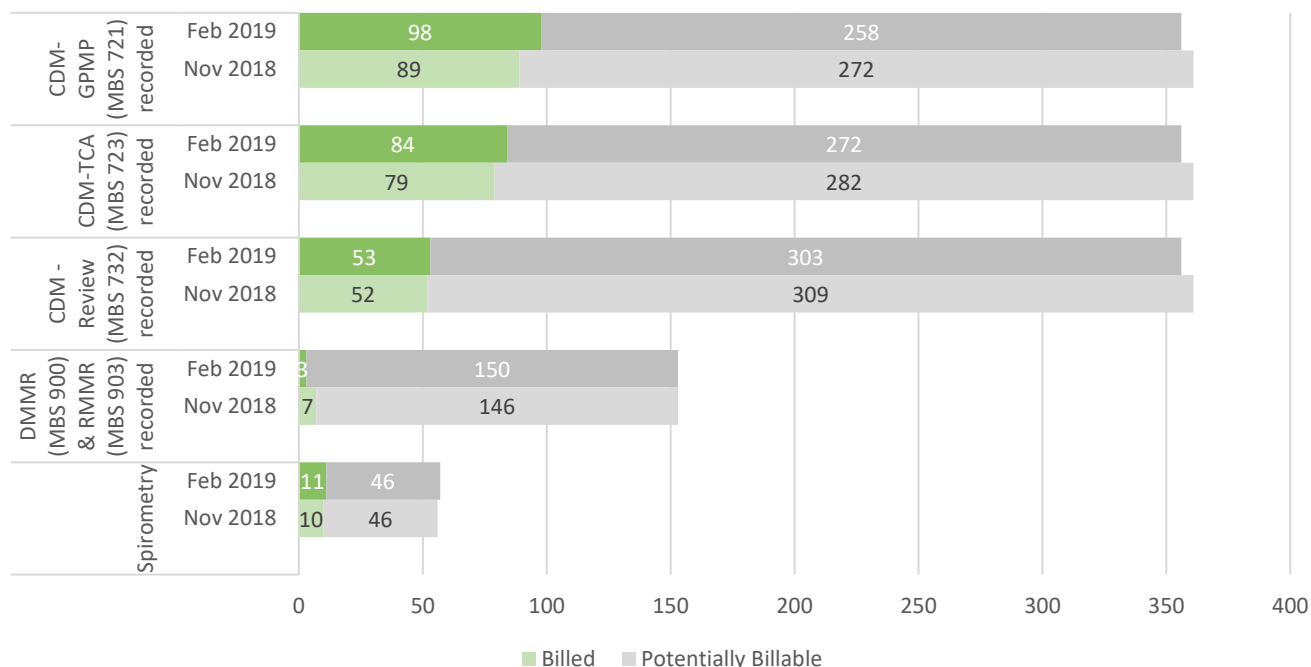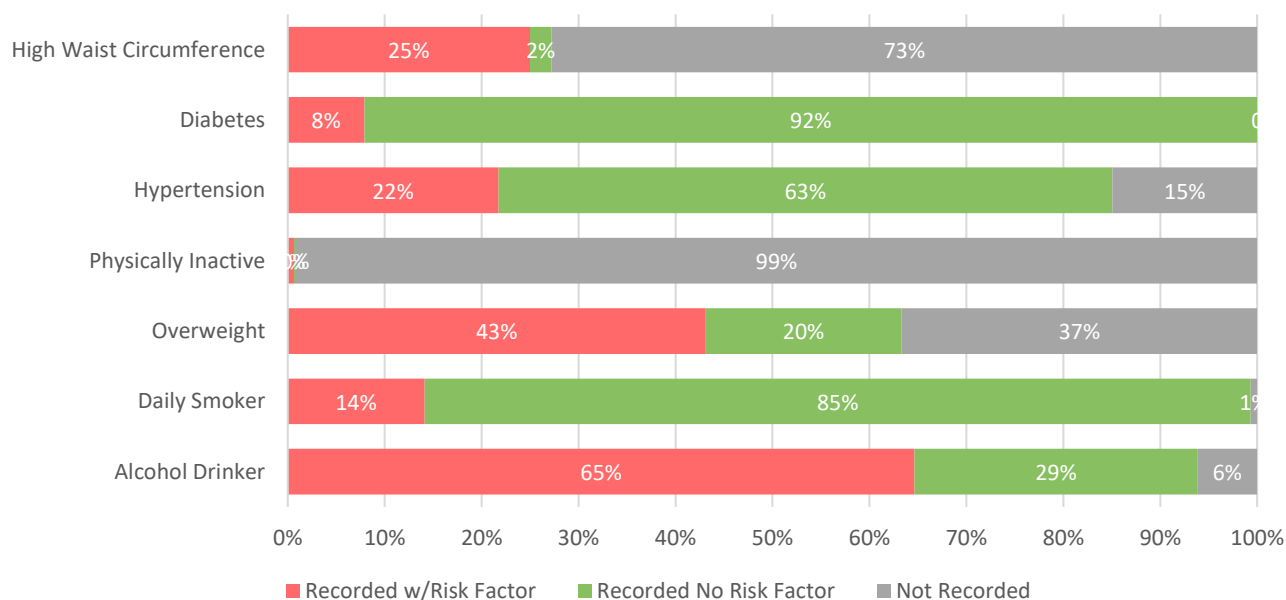## Billables

Table shows active patients coded with CVD and their MBS billings in the last 12 months

Consider creating a GPMP and TCA for all patients coded with CVD

		Billed	Potentially Billable
CDM-GPMP (MBS 721) recorded	Feb 2019	75	54
	Nov 2018	63	62
CDM-TCA (MBS 723) recorded	Feb 2019	69	60
	Nov 2018	57	68
CDM-Review (MBS 732) recorded	Feb 2019	33	96
	Nov 2018	36	89
DMMR (MBS 900) & RMMR (MBS 903) recorded	Feb 2019	5	124
	Nov 2018	10	115

■ Billed ■ Potentially Billable
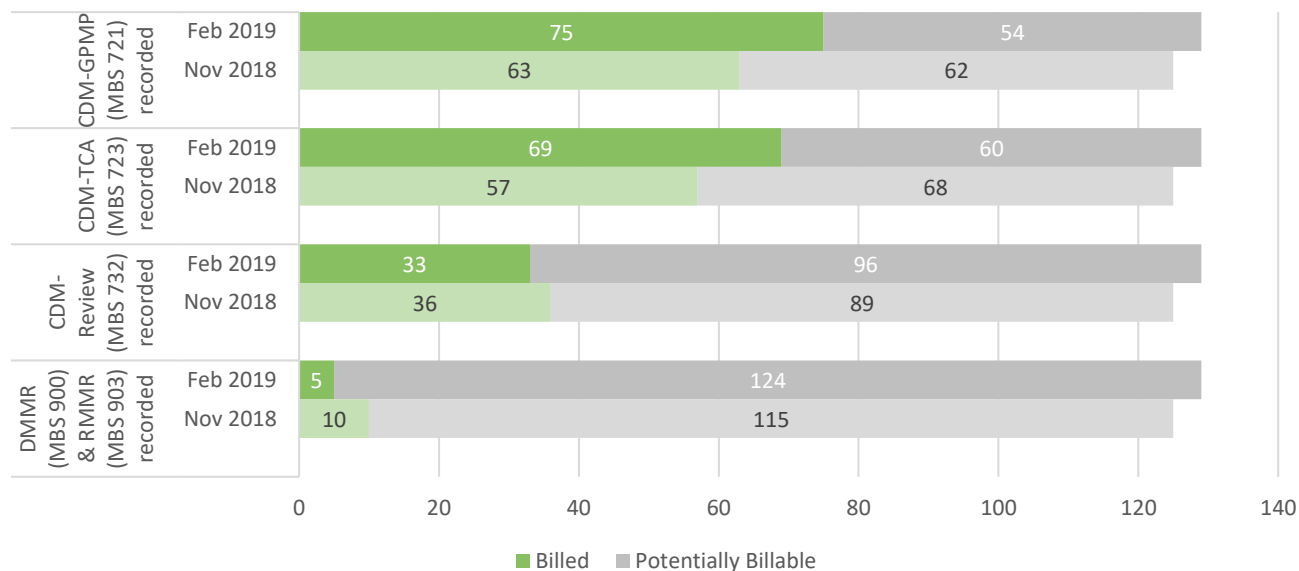
Diabetes Clinical Report

Coded Diabetes Population

Nov 2018	140	8%
Feb 2019	135	8%
MPHN	11,657	7.31%

* MPHN based on 52 practices submitting data

Data Cleansing

Type	Nov 2018	Feb 2019
Type 1	6	12
Type 2	80	83
Undefined	51	44

Diabetes Cycle of Care Completion

Item	Nov 2018	Feb 2019	MPHN
HBA1c (12 months)	84%	87%	75%
Eye Exam (24 months)	0%	0%	17%
BMI (6 months)	46%	40%	41%
BMI (12 months)	51%	50%	41%
Blood Pressure (6 months)	68%	66%	65%
Blood Pressure (12 months)	65%	68%	67%
Foot Exam (6 months)	0%	0%	10%
Foot Exam (12 months)	0%	0%	11%
Cholesterol (12 months)	80%	76%	66%
Triglycerides (12 months)	80%	76%	66%
HDL (12 months)	76%	70%	58%
Microalbumin (12 months)	55%	46%	53%
Smoking status (12 months)	99%	99%	93%
eGFR (12 months)	87%	89%	78%
Overall Record Completion	57%	55%	53%

Billables

Table shows active patients coded with Diabetes and their MBS billings in the last 12 months
Consider creating a Diabetes Cycle of Care, GPMP and TCA for all patients coded with Diabetes

|		Billed	Potentially Billable
Diabetes cycle of care (MBS 2517)	Feb 2019	40	91
	Nov 2018	48	88
CDM-GPMP (MBS 721) recorded	Feb 2019	94	37
	Nov 2018	84	52
CDM-TCA (MBS 723) recorded	Feb 2019	89	42
	Nov 2018	83	53
CDM-Review (MBS 732) recorded	Feb 2019	46	85
	Nov 2018	52	84
DMMR (MBS 900) & RMMR (MBS 903) recorded	Feb 2019	5	95
	Nov 2018	7	104
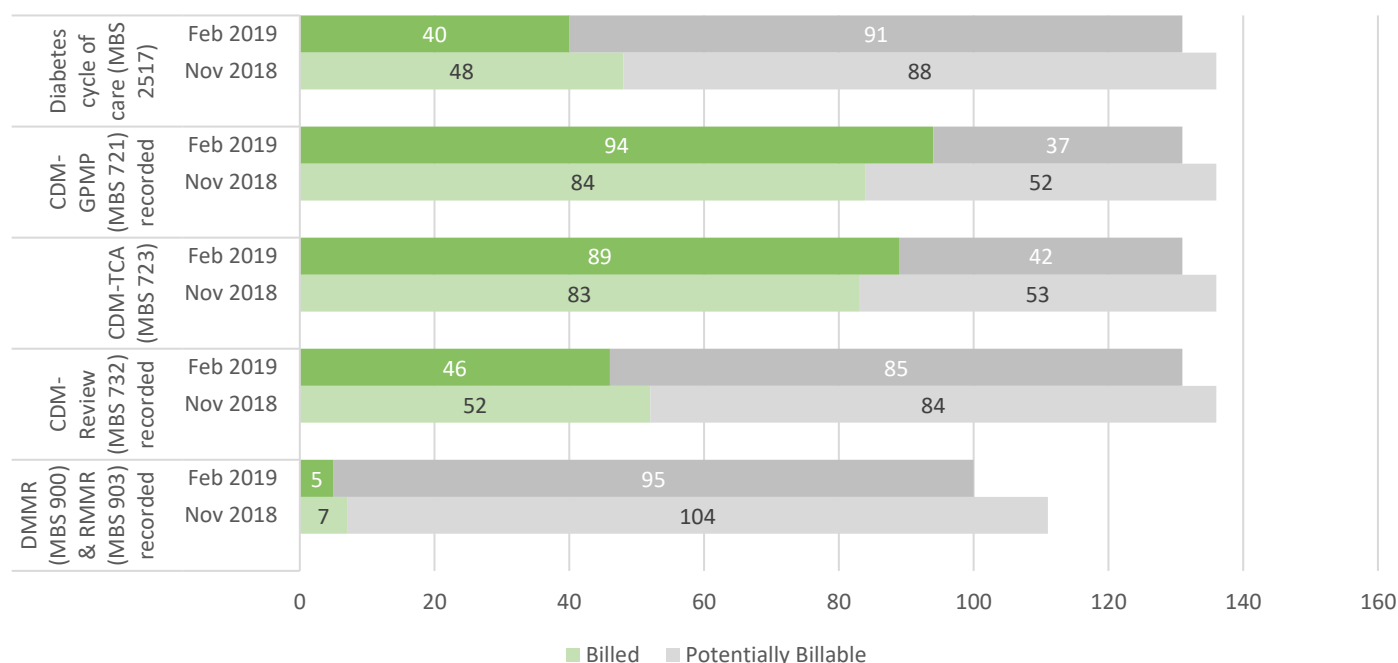
Prevention - AUSDRISK Eligibility

Number of patients eligible for an AUSDrisk type 2 diabetes risk evaluation

Patients with a 'high' risk score result may be eligible for a health assessment MBS item

Patients aged 40 to 49 years	230
Indigenous patients aged 15 to 54 years	13

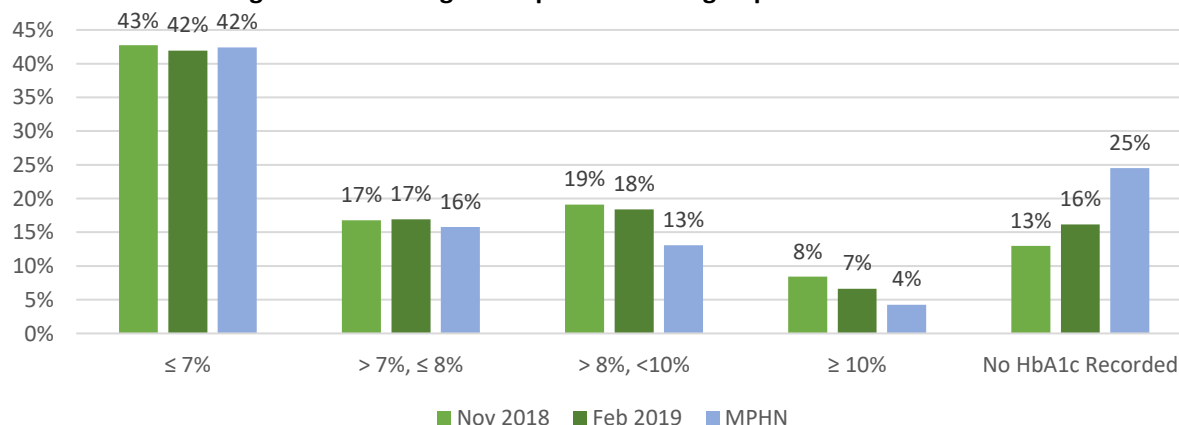## Diabetes Coded Diagnosis vs Indicated, No Coded Diagnosis
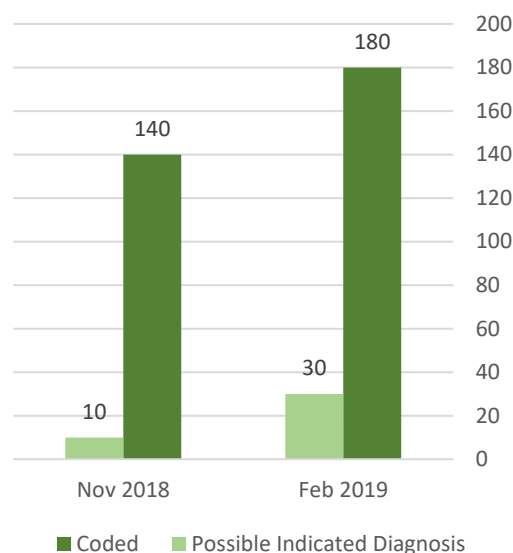
Figures show number of patients with a coded diagnosis of diabetes, versus indicated diagnosis with no diabetes coding based on clinical markers, medicaitons and billed MBS items

Consider reviewing patients indicated with no diagnosis

HbA1c Management

Graph shows latest HbA1C recorded for active patients with coded Diabetes

Consider reviewing diabetes management plans according to patient circumstances with HbA1c >7% *

*General practice management of type 2 diabetes 2016–18, RACGP, Diabetes Australia
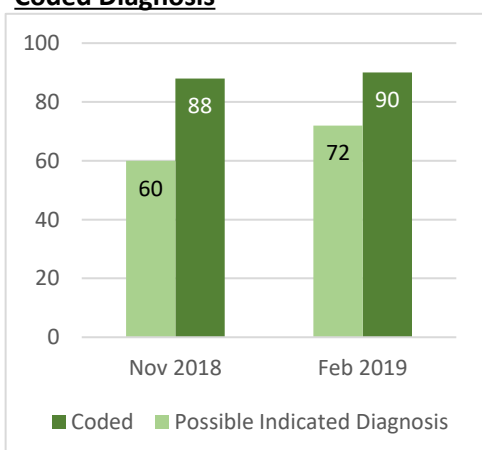
Chronic Kidney Disease Clinical Report

Coded CKD Population

Nov 2018	85	5%
Feb 2019	86	5%
MPHN	2,827	1.77%

* MPHN based on 52 practices submitting data

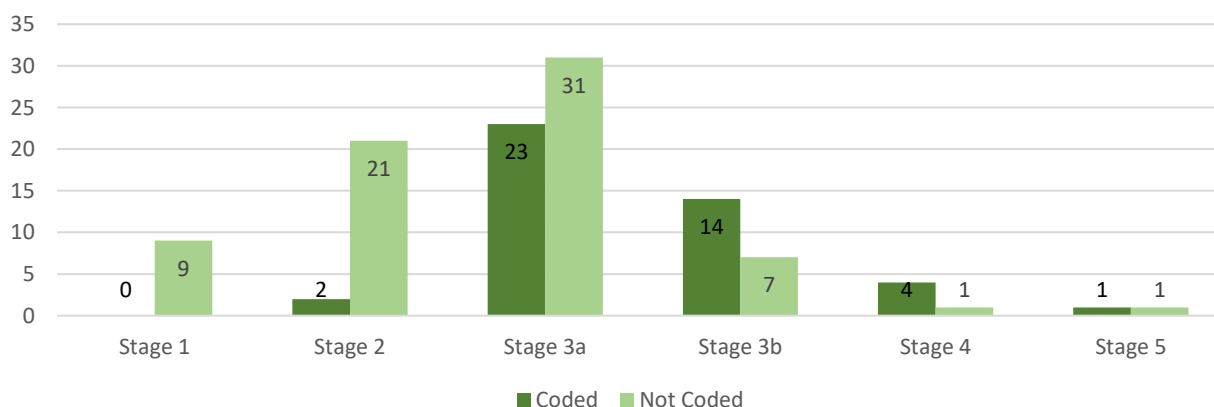## CKD Coded Diagnosis vs Indicated, No Coded Diagnosis

Figures show number of patients with a coded diagnosis of CKD, versus indicated diagnosis with no CKD coding based on clinical markers, medicaitons and billed MBS items
Consider reviewing patients indicated with no diagnosis

Active Patients with CKD Risk Factors

Risk Factor	Nov 2018	Feb 2019	MPHN
Diabetes diagnosis or indicated diabetes*	17%	17%	16%
Current Smoker	27%	27%	28%
BMI (≥30kg/m2)	43%	44%	41%
Cardiovascular Disease diagnosis	13%	13%	11%
Hypertension diagnosis or indicated hypertension**	64%	64%	59%
Aboriginal or Torres Strait Islander and Age >30	2%	2%	3%

  * indicated diabetes = HbA1c≥6.5%,BSL>11 or FBG>7)

  ** indicated hypertension = Systolic>140 or Diastolic>90

CKD Stages and Coding

Graph shows latest number of patients in each stage of CKD by coded diagnosis or indicated diagnosis based on latest eGFR and albumin creatinine ratio
Consider coding patients correspondingly and reviewing care plans where indicated

Billables

Table shows active patients coded with CKD and their MBS billings in the last 12 months

Consider creating a GPMP and TCA for all patients coded with CKD

			Billed	Potentially Billable
CDM-GPMP (MBS 721) recorded	Feb 2019		53	35
	Nov 2018		49	39
CDM-TCA (MBS 723) recorded	Feb 2019		52	36
	Nov 2018		46	42
CDM-Review (MBS 732) recorded	Feb 2019		27	61
	Nov 2018		29	59
DMMR (MBS 900) & RMMR (MBS 903) recorded	Feb 2019		7	60
	Nov 2018		9	55
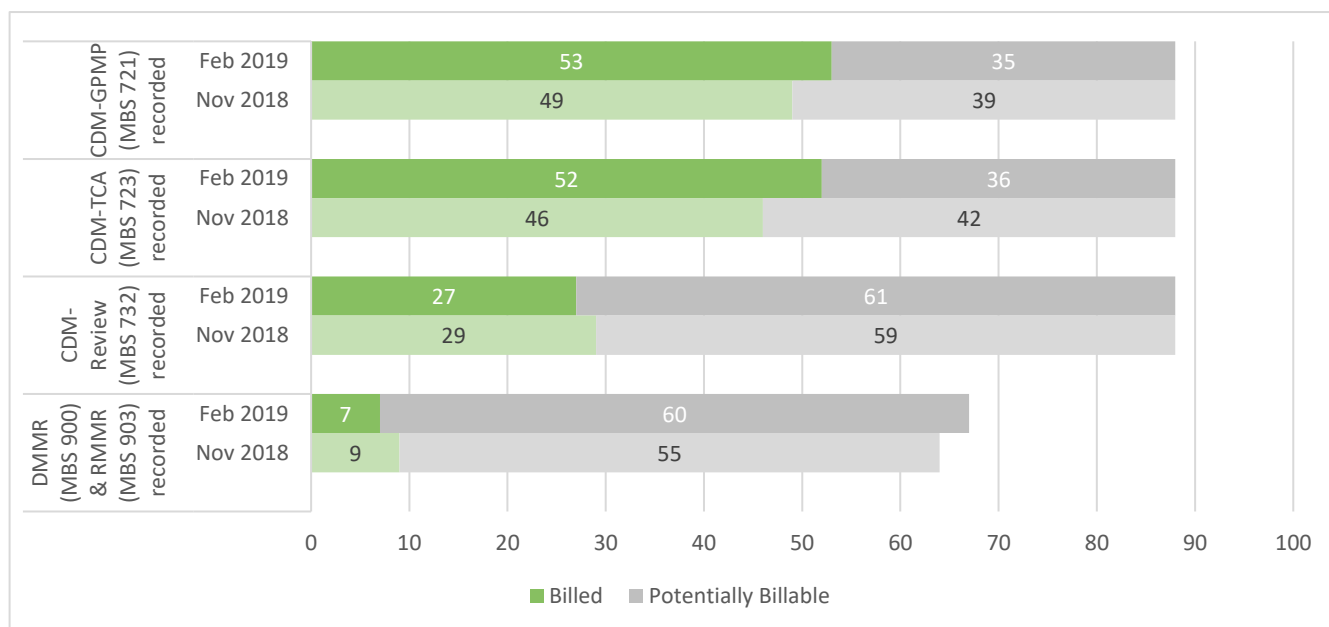
Depression Clinical Report

Coded Depression Population

Nov 2018	260	17%
Feb 2019	278	17%
MPHN	17,125	10.73%

* MPHN based on 52 practices submitting data

Chronic Disease Risk Factors

Waist Circumference: 12% / 0% / 88%
Physical Activity: % / 100%
BP: 13% / 42% / 44%
BMI: 32% / 6% / 62%
Alcohol: 7% / 4% / 90%
Smoking: 25% / 74% / 1%

■ Recorded with Risk Factor   ■ Recorded no Risk Factor   ■ Not Recorded
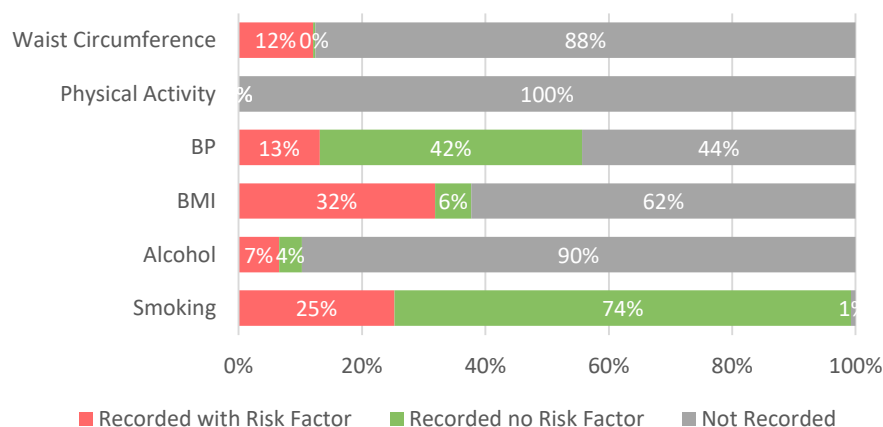
Comorbidities

Diabetes Type I	0%
Diabetes Type II	5%
Undefined Diabetes	2%
Asthma	19%
COPD	6%
CHD	6%
Hypertension	29%
Hyperlipidaemia	35%
Renal Impairment	6%
Anxiety	58%
Schizophrenia	1%
Bipolar	5%

Smoking = regular/irregular smoker; alcohol = drinker; BMI = ≥30kg/m^2; BP - last reading > 140/90; physical activity = insufficient or sedentary

Billables

Table shows active patients coded with Depression and their MBS billings in the last 12 months
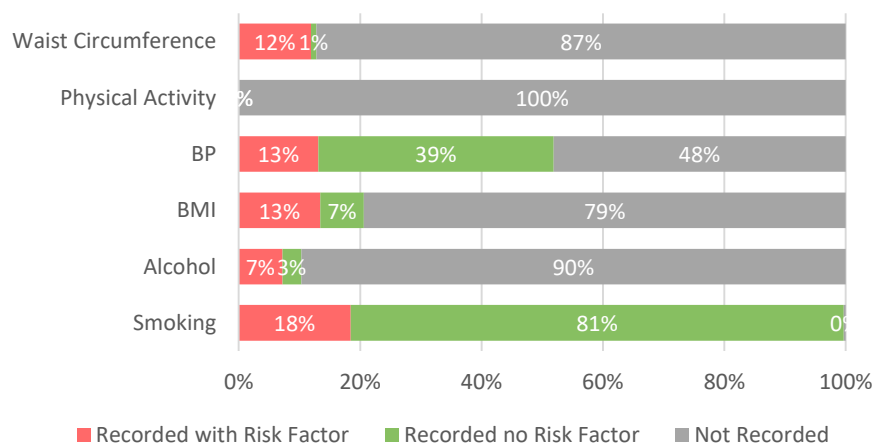

MH Consult (2713)
Feb 2019: 27 / 246
Nov 2018: 28 / 252

MHTP (2700-01, 2715, 2717)
Feb 2019: 36 / 237
Nov 2018: 32 / 248

MHTP Review (2712)
Feb 2019: 4 / 269
Nov 2018: 2 / 278

■ Billed   ■ Potentially Billable
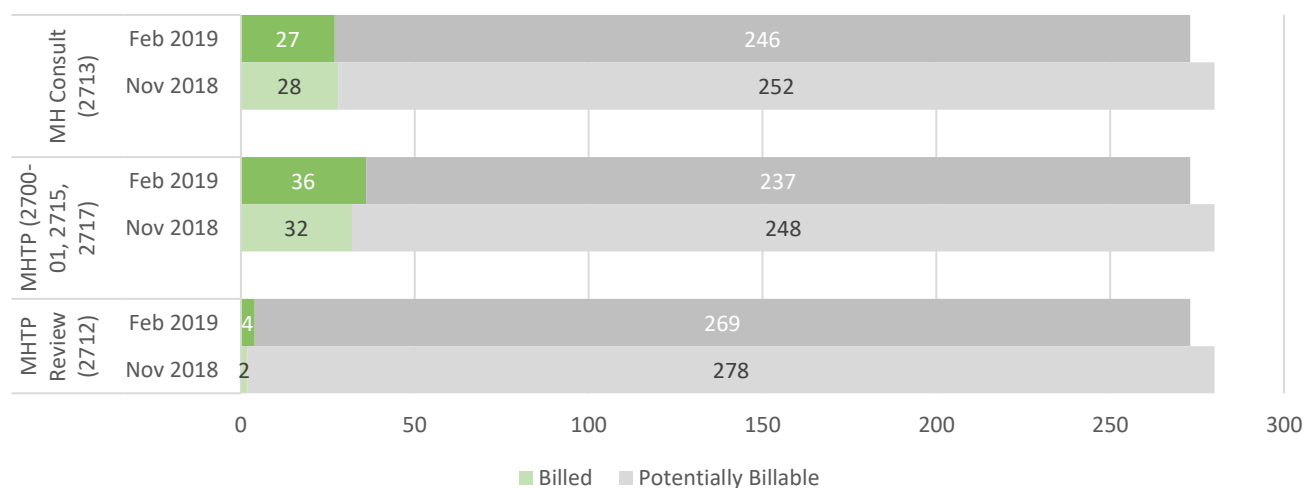
Anxiety Clinical Report

Coded Anxiety Population

Nov 2018	330	19%
Feb 2019	324	19%
MPHN	12,909	8.09%

* MPHN based on 52 practices submitting data

Chronic Disease Risk Factors

Waist Circumference: 12% 1% 87%
Physical Activity: % 100%
BP: 13% 39% 48%
BMI: 13% 7% 79%
Alcohol: 7% 3% 90%
Smoking: 18% 81% 0%
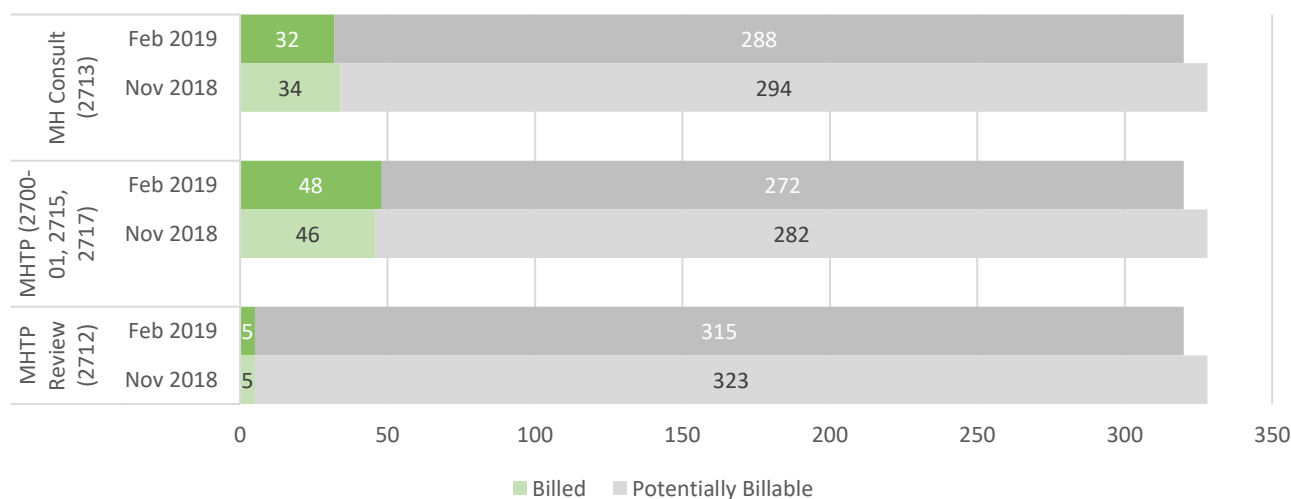
■ Recorded with Risk Factor ■ Recorded no Risk Factor ■ Not Recorded

Smoking = regular/irregular smoker; alcohol = drinker; BMI = ≥30kg/m²; BP - last reading > 140/90; physical activity = insufficient or sedentary

Comorbidities

Diabetes Type I	0%
Diabetes Type II	6%
Undefined Diabetes	3%
Asthma	21%
COPD	6%
CHD	3%
Hypertension	26%
Hyperlipidaemia	33%
Renal Impairment	6%
Depression	49%
Schizophrenia	2%
Bipolar	5%

Billables

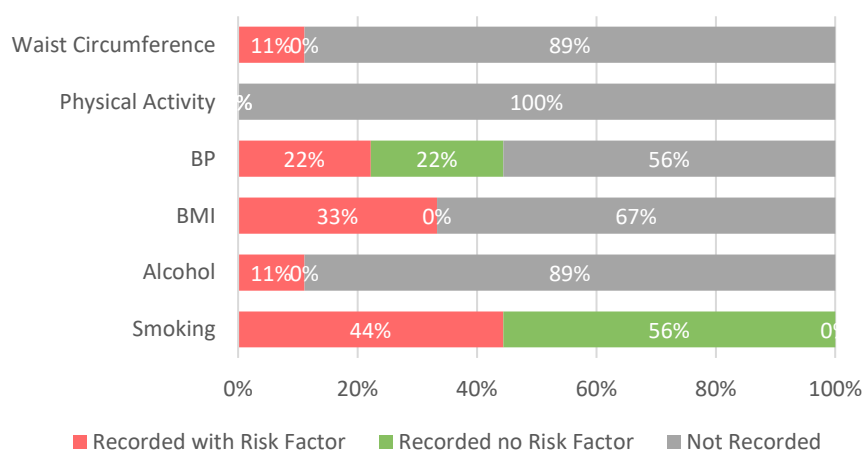Table shows active patients coded with Anxiety and their MBS billings in the last 12 months

		Billed	Potentially Billable
MH Consult (2713)	Feb 2019	32	288
	Nov 2018	34	294
MHTP (2700-01, 2715, 2717)	Feb 2019	48	272
	Nov 2018	46	282
MHTP Review (2712)	Feb 2019	5	315
	Nov 2018	5	323

■ Billed ■ Potentially Billable

Schizophrenia Clinical Report

Coded Schizophrenia Population

Nov 2018	10	1%
Feb 2019	20	1%
MPHN	909	0.57%

* MPHN based on 52 practices submitting data

Chronic Disease Risk Factors

**Recorded with Risk Factor** ▪ **Recorded no Risk Factor** ▪ **Not Recorded**

Smoking = regular/irregular smoker; alcohol = drinker; BMI = ≥30kg/m^2; BP - last reading > 140/90; physical activity = insufficient or sedentary

Comorbidities

Diabetes Type I	0%
Diabetes Type II	11%
Undefined Diabetes	0%
Asthma	33%
COPD	0%
CHD	11%
Hypertension	22%
Hyperlipidaemia	22%
Renal Impairment	11%
Depression	44%
Anxiety	56%
Bipolar	33%

Billables

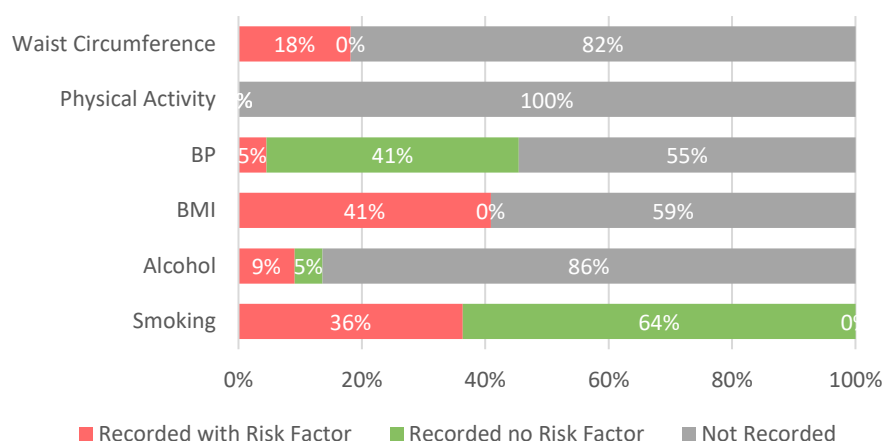Table shows active patients coded with Schizophrenia and their MBS billings in the last 12 months

▪ Billed ▪ Potentially Billable
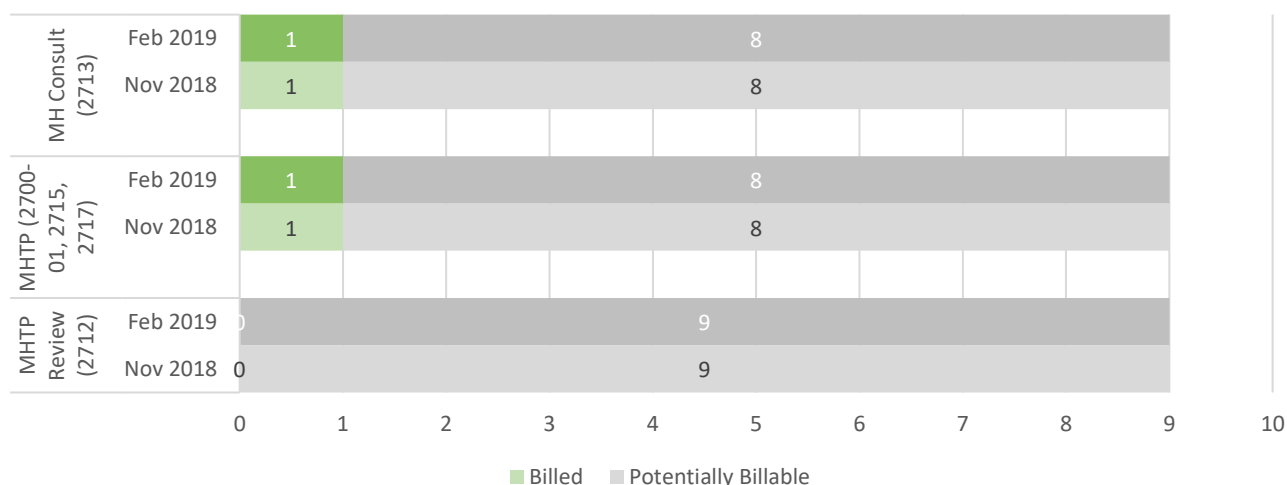
Bipolar Clinical Report

Coded Bipolar Population

Nov 2018	21	1%
Feb 2019	23	1%
MPHN	1,499	0.94%

* MPHN based on 52 practices submitting data

Chronic Disease Risk Factors

Recorded with Risk Factor ■ Recorded no Risk Factor ■ Not Recorded

Smoking = regular/irregular smoker; alcohol = drinker; BMI = ≥30kg/m²; BP - last reading > 140/90; physical activity = insufficient or sedentary

Comorbidities

Diabetes Type I	0%
Diabetes Type II	5%
Undefined Diabetes	0%
Asthma	36%
COPD	0%
CHD	5%
Hypertension	14%
Hyperlipidaemia	18%
Renal Impairment	0%
Depression	68%
Anxiety	73%
Schizophrenia	14%

Billables

Table shows active patients coded with Bipolar and their MBS billings in the last 12 months


■ Billed ■ Potentially Billable
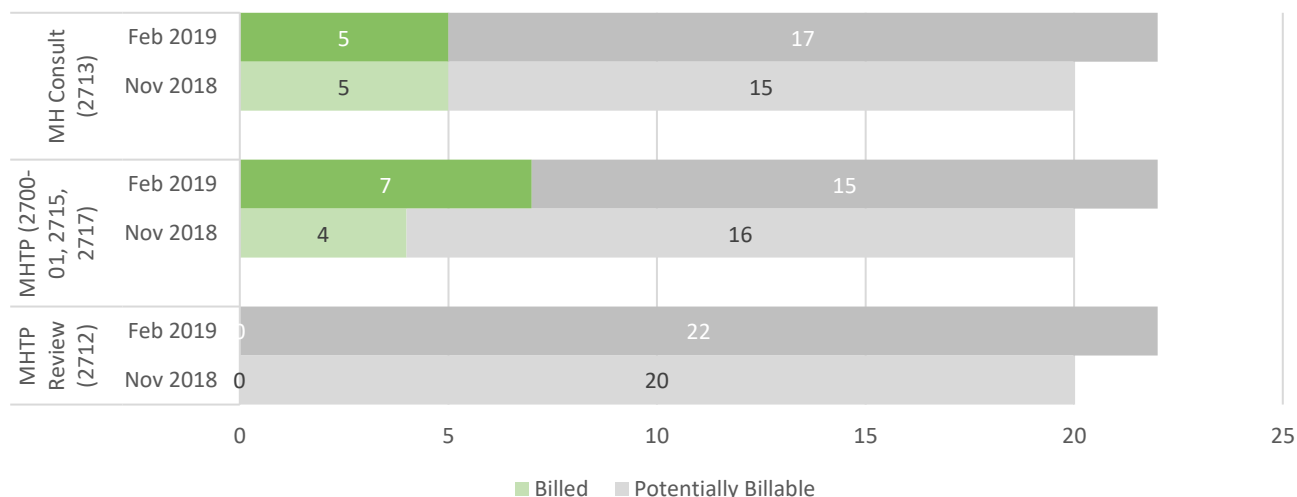
My Health Record Report

Shared Health Summaries Uploaded

Graph shows the percentage of Shared Health Summaries uploaded, for patients with an Active My Health Record.

A shared health summary represents a patient's status at a point in time, including; medical conditions, medicines, allergies and adverse reactions, and immunisations. A shared health summary can be created at any consultation; however uploading a shared health summary may be particularly beneficial for patients with chronic conditions and co-morbidities.

- Patient has MyHR and SHS: 37%
- Patient has MyHR and no SHS: 63%
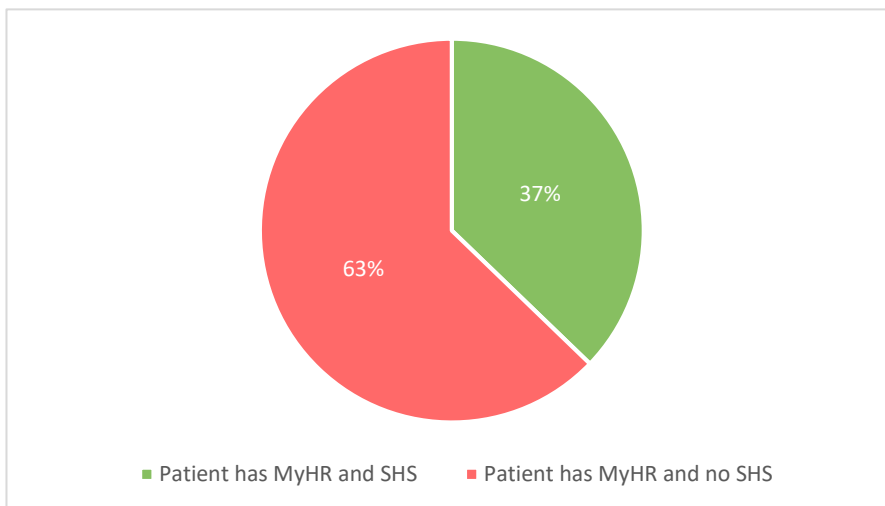
Shared Health Summary Age

Graph shows the age of Shared Health Summaries uploaded by the practice, from the date the extract was taken This graph should not be used to measure uploads in respect to ePIP compliance, as it is not aligned with ePIP quarterly dates.

< 1 month	1 - 2 months	2 - 3 months	3 - 6 months	> 6 months	No SHS
12	0	0	10	106	216
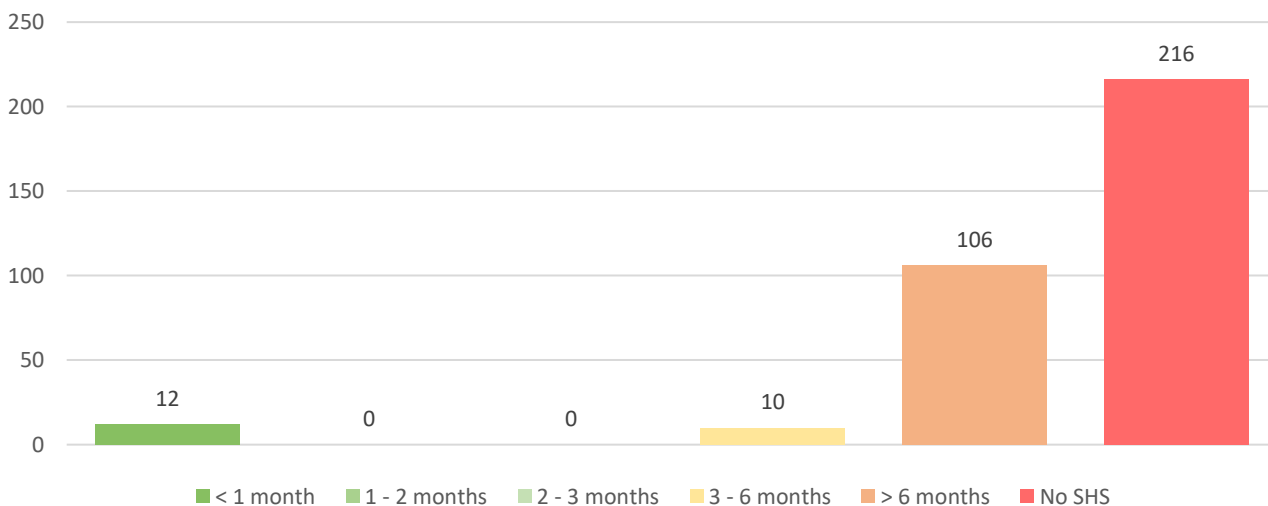
Sample LGA

POPULATION
ERP 8,572

POPULATION CHANGE
2016-2036 -7.2%

ABORIGINAL & TORRES STRAIT ISLANDER 2.6%

AREA SIZE
KM2 2,066

POPULATION DENSITY
Persons/KM2 4.1

AGE Older than 65 years
26.9%

GENDER
Females 49.5%

MEDIAN AGE
45.5 years

INTERNET
No internet at home 31.1%

EDUCATION
School leaver participation higher education 10.2%

Born predominantly non-English speaking country resident
Australia 5 years plus 2.4%

SOCIOECONOMIC INDEX
Australia av score 1,000 954

Private Insurance
39.2 per 100

INCOME Weekly income less $1,000 per week 78.1%

PENSION CONCESSION CARD 33.9%

Health Conditions & Screening

PREMATURE DEATHS MALES
ASR per 100,000 341.6

PREMATURE DEATHS FEMALES
ASR per 100,000 244.8

SUICIDE MORTALITY RATE
rate per 100,000 123.0

PREMATURE DEATHS FROM CIRCULATORY DISEASES
0 - 74 years; ASR per 100,000
69.8

PREMATURE DEATHS FROM ISCHAEMIC HEART DISEASE
0 - 74 years; ASR per 100,000
34.0

PREMATURE DEATHS FROM EXTERNAL CAUSES
0 - 74 years; ASR per 100,000
45.6

PREMATURE DEATHS FROM ROAD TRAFFIC INJURIES
0 - 74 years; ASR per 100,000
16.8

PREMATURE DEATHS FROM CANCER
0 - 74 years; ASR per 100,000
118.1

INCIDENCE LUNG CANCER
DSER per 100,000 68.2

BREAST SCREENING
39.6%

Use/Possess
Cocaine 23.3 per 100,000
Ampethamines 128.3 per 100,000
Ecstacy 116.7 per 100,000
Cannabis 653.3 per 100,000

Risk Factors

OBESE MALES
ASR per 100 39.8

OBESE FEMALES
ASR per 100 38.1

MALES WAIST CIRCUMFERENCE
ASR per 100 71.3

Well People, Resilient Communities across the Murrumbidgee

HNA
2018