Practice Report Data Quality Guide

Version 2.1 November 2018

How to use this guide

This guide aims to assist you with interpretation of the data provided by the EMPHN practice report. It will also provide instructions on how to replicate the data within POLAR.

Please note that the practice report is a snapshot in time and the data is as of the date stated on the front of the report. As POLAR data in your practice is updated every 24 hours, the data you generate via a walkthrough may differ from that in your practice report as the reports are created monthly.

Reports are received upon request. If you would like to receive a report or need further assistance with a report, please contact your EMPHN facilitator or email polar@emphn.org.au

POLAR Filters applied to data

Please refer to the filters applied to the data represented in the practice report and note that it may differ between tables/graphs.

Data definitions and descriptions

A definition/description is provided for each graph/table and any relevant measures to assist you with interpretation of the data.

How to replicate data in POLAR

Each table/graph in the report is accompanied by a POLAR walkthrough that will guide you through the required steps to view the same data in POLAR.

By following the steps in a walkthrough, it will direct you to the correct page in POLAR and what filters to apply to view the data (refer to diagram 1).

Tip

Please review each graph/table in the report individually and the relevant walkthrough. It is important that when moving onto another walkthrough for a new graph/table, that you clear the previously used filters within POLAR otherwise you will get incorrect data.

To delete filters used as part of a walkthrough, select the below icon on the filter bar:

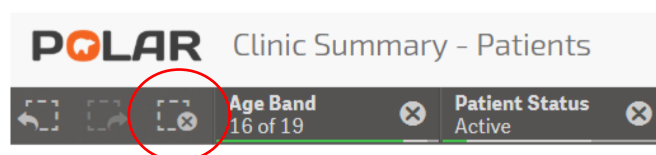

Diagram 1: Example on how to use a walkthrough in POLAR

Follow the steps below to access the correct page and filters to apply to replicate the search required.

Walkthrough					
Search	Step 1: Report	Step 2: Ribbon	Step 3: Ribbon drop down selection	Step 4: Filter Bar – left hand side	Step 5: Relevant graph/chart
BMI not recorded	Clinic Summary	Patients	Quality	Filters → Patients → Patient Status→ Active	Missing patient clinical data →BMI

Patient Demographics

Active Patient Numbers

POLAR Filters applied to data	
Measure	Filter
Total Active Patient Population	Active Patient
RACGP Active Population	RACGP Active Patient

POLAR Definitions/Descriptions	
Measure	Definition
Total Active Patient Population	A count of active patients as recorded by the clinical information system, i.e. total active patients within the software, not deceased or inactive.
RACGP Active Population	A patient is considered RACGP Active if they have had 3 or more clinical activities/encounters in the last 2 years. In the Best Practice clinical software, activities include ‘Surgery’, ‘Home’, ‘Hospital’, ‘Hostel’ and ‘Nursing home’ activity types. In the Medical Director clinical software an activity is derived when ‘The Non-Activity flag’ = ‘No’.

POLAR Walkthrough					
Search	Step 1	Step 2	Step 3	Step 4	Step 5
	Report	Ribbon	Ribbon drop down selection	Filter Bar – left hand side	Relevant graph/chart
Total Active Patient Population	Clinic Summary	Patients	Patients	Filters → Patients → Patient Status→ Active	Patient Count – Active (red number)
RACGP Active Population	Clinic Summary	Patients	Patients	Filters → Patients → RACGP Active→ Active	Patient Count (blue number)

Data Interpretation
Tips
On average, 1 FTE (full time equivalent) GP will have 1,000 to 1,200 patients. Total Active Patient Population numbers that exceed this may suggest database inaccuracies.
Look for similarities/differences between the 'Active population' and 'RACGP active population' • If the practice's patients are mainly older, they are more likely to have chronic conditions or have reasons to attend more frequently than younger, healthier patients, so you might see closer alignment between these two figures. If populations are significantly different, then this may indicate an inaccurate patient database. • If there is a large proportion of patients that are aged 45 years or less, then it is feasible that there is a marked difference between these two figures. Patients in this age group may have less than 3 visits in 2 years, therefore, will not fit within the RACGP active population.
• RACGP Standards for general practice (5th Edition) Quality Improvement Standard 1: Quality Improvement Criterion QI1.3►B Our practice uses relevant patient and practice data to improve clinical practice (e.g. chronic disease management, preventive health).
Activities to consider
Does the clinic have a policy on inactivating patients? If no, consider developing a policy. You may consider the following activities as part of this policy: • Agreeing on a definition of active patients for the practice. Archive inactive patients that do not fit within the practice's active patient definition. This may include: - Archive deceased patients - Merge duplicate patients - Archive patients with a postcode not relevant to your areas/state - Archive patients that have moved away or no longer attend the clinic - Archive patients that have never attended the clinic e.g. those patients that have registered for an appointment but have never turned up (online bookings) • Develop a procedure to archive inactive patients on a regular basis. You may consider different timeframes for different age groups: - All patients not seen for 3 years - Patients with specific chronic disease not seen for 2 years - Patients with interstate or rural postcodes not seen for 6 months

Top 15 Postcodes by Patient Count

POLAR Filters applied to data	
Measure	Filter
Postcodes by patient count	Active Patient

POLAR Definitions/Descriptions	
Measure	Definition
Postcodes by patient count	Postcode The postcode in which the patient resides/lives Patient count A count of unique patients

POLAR Walkthrough					
Search	Step 1	Step 2	Step 3	Step 4	Step 5
	Report	Ribbon	Ribbon drop down selection	Filter Bar – left hand side	Relevant graph/chart
Postcodes by patient count	Clinic Summary	Practice	Geography	Filters → Patients → Patient Status→ Active	Patients by Suburb

Data Interpretation
Tips/Activities to consider
This information can potentially assist with: - Practice marketing or promotion activities - Understanding patient population - Target groups for health assessments

Age Profile

POLAR Filters applied to data	
Measure	Filter
Age Profile	Active Patient

POLAR Definitions/Descriptions	
Measure	Definition
Patient Age	Age is calculated based upon the year difference between the Date of Birth (DOB) and when the data extract was run at the clinic. Age for deceased patients is calculated based upon the year difference between DOB and the Date of Death.

POLAR Walkthrough					
Search	Step 1	Step 2	Step 3	Step 4	Step 5
	Report	Ribbon	Ribbon drop down selection	Filter Bar – Left hand side	Relevant graph/chart
Age Profile	Clinic Summary	Patients	Patients	Filters → Patients → Patient Status→ Active	Age group

Data Interpretation
Tips
• Review what group has the highest age population. • The age distribution profile has an effect on the number of chronic disease patients that you would expect to see. That is, the older the popultaion, the more chronic disease cases one would expect to find and vise versa with younger population. • The exceptions to this are mental health conditions and asthma which has a younger age of onset.
Review data based on targeted aged groups: • 0-15 years • 45+ years • 65+ years
• Consider proportion of female Vs male patients and potential target age groups.
Activities to consider
• Review patient population link to chronic disease statistics such as top 10 SNOMED diagnosis and prevalence of chronic conditions.
• Link age of population to active and RACGP active statistics (ref to active patient number tips).

Demographic and Clinical data

POLAR Filters applied to data	
Measure	Filter
Allergy recording	RACGP Active
Age recorded	RACGP Active
Ethnicity recorded	RACGP Active
Indigenous status recorded	RACGP Active
Smoking status	RACGP Active → Only patients ≥15 years have been included
Alcohol intake	RACGP Active → Only patients ≥15 years have been included
Gender recorded	RACGP Active
BMI	RACGP Active → Only patients ≥18 years have been included
Postcode or suburb	RACGP Active

POLAR Definitions/Descriptions	
Measure	Definition
Allergy recording	Allergy status of patient.
Age recorded	A calculated age range based upon a patients age.
Ethnicity recorded	A patient’s cultural background or identity (not country of birth).
Indigenous status recorded	A flag value used to identify a patient as being Aboriginal and/or Torres Strait Islander.
Smoking status	Value to indicate the patient has last recorded smoking status.
Alcohol intake	How many standard drinks a patient consumes per day.
Gender recorded	A code specified by the clinical information system that represents a gender description. Male, Female, other.
BMI	A value recorded for a patient’s Body Mass Index (BMI), which is a patients’ weight in kilograms (kg) divided by his or her height in meters squared. Normal adult range: 18.50 - 24.99.
Postcode or suburb	Postcode The postcode in which the patient resides/lives.

POLAR Walkthrough					
Search	Step 1	Step 2	Step 3	Step 4	Step 5
	Report	Ribbon	Ribbon drop down selection	Filter bar – Left hand side	Relevant graph/chart
Identify patient with allergy recorded	Clinic Summary	Patients	Quality	Filters → Patients → RACGP Active → Active	Recorded patient clinical data
Identify patient with age recorded	Clinic Summary	Patients	Quality	Filters → Patients → RACGP Active → Active	Recorded patient demographic data
Identify patient with ethnicity recorded	Clinic Summary	Patients	Patients	Filters → Patients → RACGP Active → Active	Ethnicity
Identify patient with indigenous status recorded	Clinic Summary	Patients	Quality	Filters → Patients → RACGP Active → Active	Recorded patient demographic data
Identify patient with smoking status recorded	Clinic Summary	Patients	Quality	• Filters → Patients → RACGP Active → Active • Filters → Patients → →Patient Age → ≥15	Recorded patient clinical data

Identify patient with alcohol status recorded	Clinic Summary	Patients	Quality	• Filters → Patients → RACGP Active • Filters → Patients → →Patient Age → ≥15	Recorded patient clinical data
Identify patient with gender recorded	Clinic Summary	Patients	Quality	Filters → Patients → RACGP Active → Active	Recorded patient demographic data
Identify patient with BMI recorded	Clinic Summary	Patients	Quality	• Filters → Patients → RACGP Active → Active • Filters → Patients → →Patient Age → ≥18	Recorded patient clinical data
Identify patient with postcode or suburb recorded	Clinic Summary	Patients	Quality	Filters → Patients → RACGP Active → Active	Recorded patient demographic data

Data Interpretation

Tips

- RACGP Standards for general practice (5th Edition)
  Quality Improvement Standard 2: Clinical indicators
  Criterion QI2.1►A
  Our active patient health records contain a record of each patient's known allergies (at least 90% of active population).
- RACGP Standards for general practice (5th Edition)
  Quality Improvement Standard 2: Clinical indicators
  Criterion QI2.1►B
  Each active patient health record has the patient's current health summary that includes, where relevant (up to 75% of active patients):
    - adverse drug reactions
    - current medicines list
    - current health problems
    - past health history
    - immunisations
    - family history
    - health risk factors (e.g. smoking, nutrition, alcohol, physical activity)
    - social history, including cultural background.

- SNAP Guidelines: This guide has been designed to assist GPs and practice staff (the GP practice team) to work with patients on the lifestyle risk factors of smoking, nutrition, alcohol and physical activity (SNAP).
  SNAP Guidelines for recording risk factors such as:
    - Smoking – record for patients ≥10 years – note current smoking filters in POLAR are set to ≥ 15 years
    - Alcohol – record for patients >15 years
    - BMI - BMI noted every 2 years for ≥ 18yrs, note current BMI filters in POLAR not filtered by date of last recorded
      BMI CHARTS different for children aged 2-18

https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/snap
Note: • Ethnicity currently not available in Zedmed. • If your practice does not have matching Clinical and Practice Management Software, you will not currently see this table. • If your practice has recently changed clinical software, missing demographic and clinical data may be evident.
• The benchmark values are calculated based upon the average of the 10 highest performing practices for each recorded measure.
Activities to consider
• For any practice measures that do not meet accreditation standards, consider quality improvement activities to improve that data.
• High 'Missing data' allergies and smoking status generally indicates actual non recording of the relevant data. Remind the clinical team that these are Accreditation indicators, and strategies need to be considered to improve data.
• High 'Missing data' BMI could indicate that the measure(s) are not being taken or they are not being recorded in the correct place in the clinical file (e.g. are being 'free-texted' in the progress notes).
• High 'Missing data' for indigenous status recorded suggests that there may not be strategies in place to 'Ask the Question'. As this is an accreditation indicator, develop and implement strategies to improve collection of indigenous status such as review of 'New Patient registration' forms to ensure data is collected accurately. Refer to National best practice guidelines for collecting indigenous status in health data sets https://www.aihw.gov.au/reports/indigenous-australians/national-guidelines-collecting-health-data-sets/contents/table-of-contents

Chronic disease

Prevalence of Chronic Conditions in your practice (*Practice Active*)

POLAR Filters applied to data	
Measure	Filter
Prevalence of chronic conditions in your practice	Active Patients Active Diagnosis

Prevalence Statistics

Category	EMPHN Catchment Prevalence 2018*	Victorian Prevalence**	National Prevalence**
Respiratory	33.3%	31.8%	30.8%
Musculoskeletal	20.2%	29.4%	29.9%
Cardiovascular (CVD)^	20.5%	18.4%	18.3%
Mental Health	14.8%	17.5%	17.5%
Diabetes^^	6.7%	5.1%	5.2%
Cancer	1.2%	1.4%	1.4%
AOD	0.9%	1.0%	1.0%
Chronic Kidney Disease (CKD)	0.4%	0.9%	0.9%
Dementia***	0.5%	1.5%	1.5%

*EMPHN data is calculated annually, **National Health Survey, 2014-15 ,*** AIHW, 2012 Dementia in Australia ^The definitions of CVD differ between organisations. It's difficult to get consensus when different categories are used. Excludes Hypertension. ^^ Diabetes cases type 2 + 95%

POLAR Definitions/Descriptions	
Measure	Definition
Prevalence	The proportion of a particular population in your clinic diagnosed with a medical condition. It is arrived by comparing the active number of people found to have the condition with the total active number of people at your clinic. It is based on SNOMED level diagnosis for Active Patients

POLAR Walkthrough					
Search	Step 1	Step 2	Step 3	Step 4	Step 5
	Report	Ribbon	Ribbon drop down selection	Filter Bar – Left hand side	Relevant graph/chart
Prevalence of Chronic Conditions in your practice	Not currently available in POLAR				

Data Interpretation
Tips
• Compare the practice's chronic disease prevalence with national prevalence (ref to prevalence statistics) taking into account age distribution of the practice's patients. Under representation may indicate: - Diagnosis coding issues - An inaccurate database overall – data cleansing of active patients will impact this statistic
• RACGP Standards for general practice (5th Edition) Quality Improvement Standard 1: Improving clinical care Criterion QI1.3A Our practice team uses a nationally recognised medical vocabulary for coding (not flagged).
Activities to consider
• Develop clean registers of patients with chronic disease: - If chronic disease prevalence at your practice is lower than EMPHN catchment, Victorian or National Prevalence, determine how the clinicians are currently coding patients with chronic disease. Clinicians are probably doing it differently, with some using free text field in the clinical software and not drop down selections - Archiving inactive patients - Searching for patients that are indicative of chronic disease but not coded – pathology, medication
• As chronic disease register data cleansing activities are implemented, review the number of patients on the registers via the top 10 chronic conditions graph to see what changes (if any) have occurred regarding patient numbers e.g. - File inactivation → decreased numbers; - Improved coding → increased numbers e.g. Gradual increase in numbers over time usually reflects increased diabetes diagnosis/incidence through imrpoved coding.

Top 10 Chronic Conditions in you practice (*Practice Active*)

POLAR Filters applied to data	
Measure	Filter
Top 10 Chronic Conditions	Active Patients Active Diagnosis

POLAR Definitions/Descriptions	
Measure	Definition
Chronic Conditions	This is based on SNOMED level diagnosis for Active Patients. The number of individual chronic diseases are divided by the Active Population

POLAR Walkthrough					
Search	Step 1	Step 2	Step 3	Step 4	Step 5
	Report	Ribbon	Ribbon drop down selection	Filter bar – Left hand side	Relevant graph/chart
Top 10 Chronic Conditions in your practice	Clinic Summary	Clinical	Diagnosis	• Filters → Patients → Patient Status→ Active • Filters → Diagnosis → Diagnosis Active→ Active	Chronic Disease Category

Data Interpretation
Tips
• Refer to prevalence statistics to compare to EMPHN prevalence and national prevalence.
• Use this data to investigate and identify population chronic disease health issues that are specific to the practice – Review coding and any areas for improvement e.g. diabetes unknown.
• RACGP Standards for general practice (5th Edition) Quality Improvement Standard 1: Quality Improvement Criterion QI1.3►B Our practice uses relevant patient and practice data to improve clinical practice (e.g. chronic disease management, preventive health).
Activities to consider
• Idenify a chronic disease cohort and consider any activities that may be undertaken to improve the accuracy of recording diagnosis.
• Consider preventative activites that focus on a particular cohort e.g. Type 2 diabetes – Diabetes risk assessment, or CVD – Australian absolute CVD risk assessment.

Top 10 SNOMED Diagnoses (Practice Active patients and Active diagnoses)

POLAR Filters applied to data	
Measure	Filter
Top 10 SNOMED Diagnosis	Active Patients Active Diagnosis

POLAR Definitions/Descriptions	
Measure	Definition
Top 10 SNOMED Diagnosis (Practice Active patients and active diagnoses)	<u>SNOMED Code</u> An international standard for medical codes, terms, synonyms and definitions used in clinical documentation and reporting. <u>Diagnosis ID</u> The diagnosis recorded in the clinic. Diagnosis have been mapped to SNOMED codes where applicable. Not all diagnosis are mapped, as there may be no SNOMED code, there may be ambiguous coding or multiple diagnosis entered in one line e.g. Asthma, ?COPD – Ed, which could be coded to Asthma, COPD or Education. One of the aims of POLAR is to encourage clear / quality coding of diagnosis.

POLAR Walkthrough					
Search	Step 1	Step 2	Step 3	Step 4	Step 5
	Report	Ribbon	Ribbon drop down selection	Filter bar – Left hand side	Relevant graph/chart
Top 10 SNOMED Diagnosis	Clinic Summary	Clinical	Diagnosis	• Filters → Patients → Patient Status→ Active • Filters → Diagnosis → Diagnosis Active→ Active	SNOMED Diagnosis

Data Interpretation
Tips
• Use this data to investigate and identify population health issues that are specific to the practice.
• Are there any link to age of population and top SNOMED diagnosis categories?
• **Activities to consider**
• Identified areas of population health issues can lead to activities specific to that condition and/or chronic disease – practice awareness campaigns, training for staff on specific topics, identified group of patients to target for shared health summary uploads etc.

My Health Record

POLAR Filters applied to data	
Measure	Filter
Total number and proportion of patients with a Shared Health Summary uploaded	Active Patients
Uploaded SHS by provider and practice	Active Patients Provider
Uploaded SHS by Chronic Disease Category	Active Patients Active Diagnosis

POLAR Definitions/Descriptions	
Measure	Definition
Uploaded Shared Health Summary	This measure is the number of Active Patients who have a SHS and as a proportion (%) of the Active Patient population
Uploaded shared Health Summary by provider and practice (Practice Active	The number of SHS uploaded by a practitioner in the clinic. Provider The clinician/person providing an activity to a patient. Can be a doctor / nurse or administration staff.
Uploaded SHS by Chronic Disease Category	The percentage of Active Patients with a Higher Order categorised chronic disease who have a SHS

POLAR Walkthrough					
Search	Step 1	Step 2	Step 3	Step 4	Step 5
	Report	Ribbon	Ribbon drop down selection	Filter bar – Left hand side	Relevant graph/chart
Total number of Active people with a Shared Health Summary	Clinic Summary	Patients	MHR	Filters → Patients → Patient Status→ Active	Uploaded SHS
Total number of uploaded Shared Health Summary by provider	Available in future POLAR release				
Uploaded SHS by Chronic Disease Category	Available in future POLAR release				

Data Interpretation
Tips
• ePIP eHealth incentive: upload shared health summaries to My Health Record for a minimum of • 0.5% of the Standardised Whole Patient Equivalent (SWPE) or the default SWPE, whichever is greater
• For further information on Standardised Whole Patient Equivalent (SWPE), refer to https://www.humanservices.gov.au/organisations/health-professionals/enablers/standardised-whole-patient-equivalent
• Review uploaded SHS by chronic disease category and identify opportunities to increase uploads by reviewing top 10 chronic conditions graph
• **Activities to consider**
• Identify any clinical team members that require MyHealth record training – contact EMPHN for extra training digitalhealth@emphn.org.au
• Identify target groups that would benefit from a Shared Health Summary