An Australian Government Initiative

Polar Demo
Practice Report
Data Quality

Practice Report prepared by Demonstration PHN from a data extraction from POLAR dated Nov 2019

PHN Facilitator -

These reports are available monthly, practices can request additional reports via the following email:

Support@outcomehealth.org.au

Patient Demographics

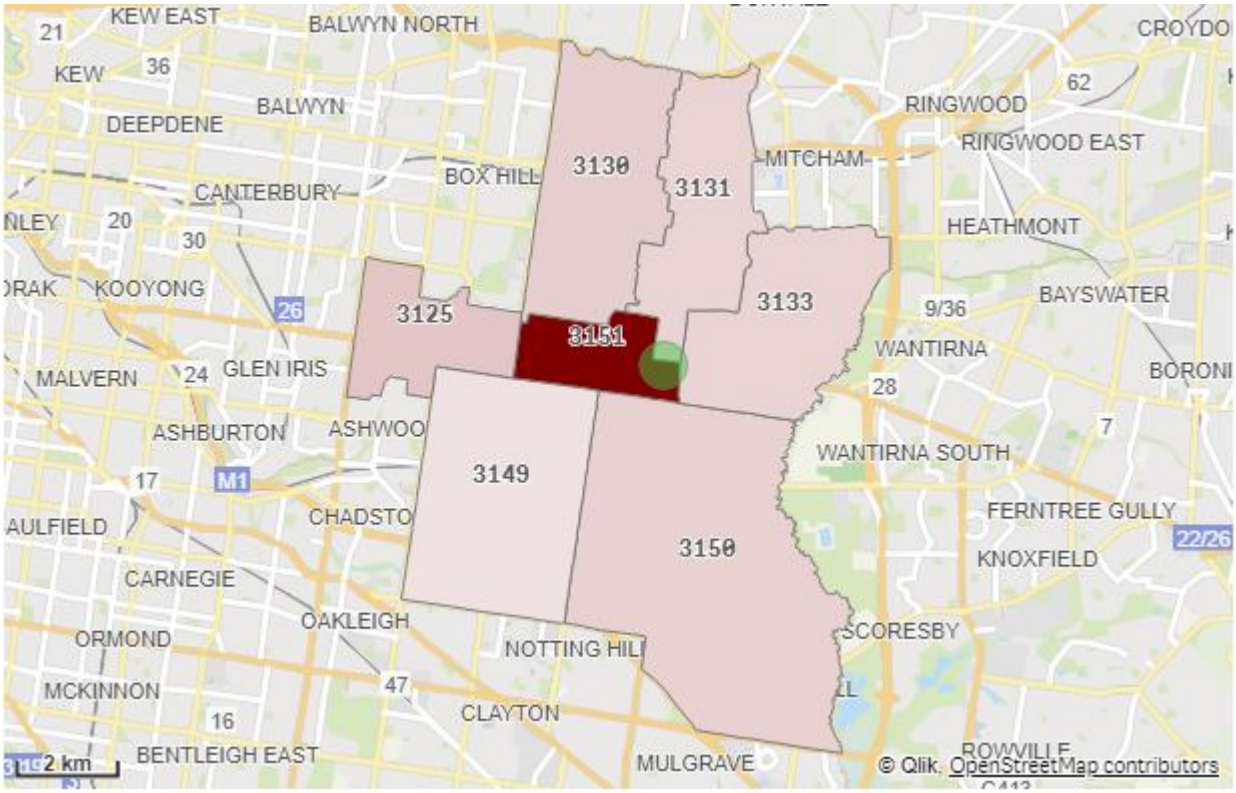
Active patient numbers

Tip: Removing inactive patients from the database is an important step in ensuring your disease registers are accurate and up to date.

Measure	Nov 2019
Total Active Patient Population	18,973
RACGP Active Population	8,010

Insights	*Actions*	*Timeframes*
On average 1 FTE GP will have 1000-1200 patients. Patient numbers that exceed this may suggest data cleaning activities.		
Is there a current policy on deactivating patients who have not been seen for a number of years?		

Top 15 postcodes by patient count (Active)



Legend

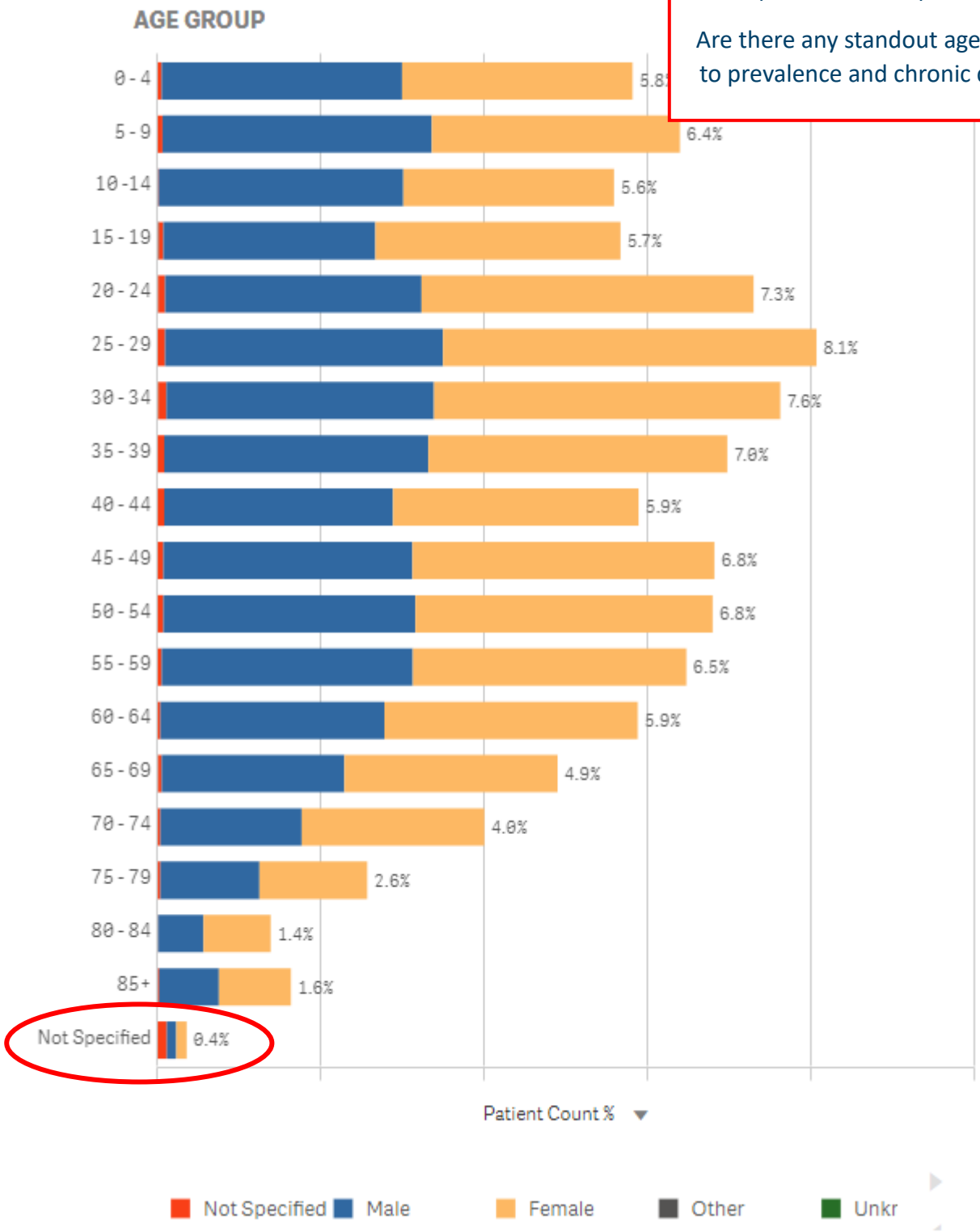
Patient Color Legend

- approx. 777 patients and below
- approx. 3,108 patients
- approx. 6,216 patients
- approx. 9,323 patients

Age Profile (Active)

Tip: Review not specified cohort

Are there any standout age groups – link to prevalence and chronic disease areas



Insights	*Actions*	*Timeframes*

Demographic and Clinical data (RACGP Active)

Measures Recorded	*Age Criteria*	*Nov 2019*	*Demonstration PHN Benchmark**	*Comments & RACGP Criterion*
Emergency Contact	All	59.88%	98.54%	*C7.1B Our active patient health records contain, for each active patient, their identification details, contact details, demographic, next of kin, and emergency contact Information.*
Next of Kin	All	73.51%	99.38%	*C7.1 B Our active patient health records contain, for each active patient, their identification details, contact details, demographic, next of kin, and emergency contact Information.*
Indigenous status recorded	All	81.54%	99.91%	*C7.1 E Our practice routinely records the Indigenous status of our patients in their patient health record. Does the practice have strategies in place to ask the question?*
Ethnicity recorded	All	56.83%	99.17%	*Currently not available in Zedmed C7.1F Our practice routinely records the cultural backgrounds of our patients in their patient health record, where relevant*
Gender Recorded	All	99.89%	100.00%	
Social History	All	57.87%	98.66%	*C7.1 G Our patient health records contain, for each active patient, lifestyle risk factors..*
Alcohol Intake	≥ 15 **	48.42%	92.99%	*C7.1 G Our patient health records contain, for each active patient, lifestyle risk factors..*
Allergy Recording	All	96.00%	99.98%	*C7.1 A Our practice has an individual patient health record for each patient, which contains all health information held by our practice about that patient.*
BMI	≥18**	49.97%	86.34%	*C7.1 G Our patient health records contain, for each active patient, lifestyle risk factors.*
Family History	All	40.99%	91.39%	*C7.1 G Our patient health records contain, for each active patient, lifestyle risk factors.*
Smoking Status	≥ 15 **	83.84%	99.20%	*C7.1 G Our patient health records contain, for each active patient, lifestyle risk factors.*

Note: ***Practices who do not have matching Clinical and Practice Management Software will not currently see this table.***

**The benchmark values are calculated based upon the average of the 10 highest performing practices for each recorded measure.*

***SNAP Guidelines recommends smoking status recorded for ≥10yrs, BMI recording > 18yrs and every 2 years, Alcohol recording ≥15yrs*

Note: For this report - BMI figures are based on BMI being recorded with no date range.

Smoking is recorded for ≥ 15

Note: The RACGP encourages practices to work towards all of your RACGP active records to contain a current health summary however to satisfy the 5th standards your practice must have 90% of allergies recorded and a current health summary for at least 75% of your RACGP active health records.

Insights	*Actions*	*Timeframes*

PIP QI Measures

PIP QI Improvement Measure	*Measure Recorded (Numerator)*	*Eligible Patients (Denominator)*	*Percentage*
QIM 1.1 - Proportion of regular clients who have Type 1 diabetes and who have had a HbA1c measurement result recorded within the previous 12 months.	14	24	58%
QIM 1.2 - Proportion of regular clients who have Type 2 diabetes and who have had a HbA1c measurement result recorded within the previous 12 months.	210	271	77%
QIM 1.3 - * Non official value add. Proportion of regular clients who have an unknown diabetes type diganosis and who have had a HbA1c measurement result recorded within the previous 12 months.	61	82	74%
QIM 2.1 - Proportion of regular clients who are aged 15 years and over and whose smoking status has been recorded as 'current smoker'	763	5,476	14%
QIM 2.2 - Proportion of regular clients who are aged 15 years and over and whose smoking status has been recorded as 'ex-smoker'	1,125	5,476	21%
QIM 2.3 - Proportion of regular clients who are aged 15 years and over and whose smoking status has been recorded as 'non-smoker' and have never smoked	2,574	5,476	47%
QIM 2.4 - * Non official value add. Proportion of regular clients who are aged 15 years and over and whose smoking status has not been recorded	1,014	5,476	19%
QIM 3.1 - Proportion of regular clients who are aged 15 years and over and who have had their BMI classified as obese within the previous 12 months - where obese is classified as a BMI score of 30 or over.	404	5,476	7%
QIM 3.2 - Proportion of regular clients who are aged 15 years and over and who have had their BMI classified as overweight within the previous 12 months -	328	5,476	6%
QIM 3.3 - Proportion of regular clients who are aged 15 years and over and who have had their BMI classified as healthy within the previous 12 months - where healthy is classified as a BMI score of 18.5 to less than 25.	200	5,476	4%
QIM 3.4 - Proportion of regular clients who are aged 15 years and over and who have had their BMI classified as underweight within the previous 12 months - where underweight is classified as a BMI score of less than 18.5.	16	5,476	0%
QIM 3.5 - * Non official value add. Proportion of regular clients who are aged 15 years and over and who have not had their BMI classified.	4,528	5,476	83%
QIM 4 - Proportion of patients aged 65 and over who were immunised against influenza in the past 15 months.	802	1,321	61%
QIM 5 - Proportion of patients with diabetes who were immunised against influenza in the past 15 months.	176	281	63%

QIM 6 - Proportion of patients with COPD who were immunised against influenza in the past 15 months.	70	108	65%
QIM 7 - Proportion of patients with an alcohol consumption status.	2,603	5,476	48%
QIM 8 - Proportion of regular clients aged 45 to 74 years with information available to calculate their absolute CVD risk.	648	2,618	25%
QIM 9 - Number of female regular clients who are aged 20 to 74 years - who have not had a hysterectomy and who have had a cervical screening test within the previous 5 years (HPV).	414	2,175	19%
QIM 10 - Proportion of patients with diabetes with a blood pressure result in the past 6 months.	187	293	64%

Measures may change as specifications are refined by the Department of Health.

Insights	*Actions*	*Timeframes*

Chronic Disease

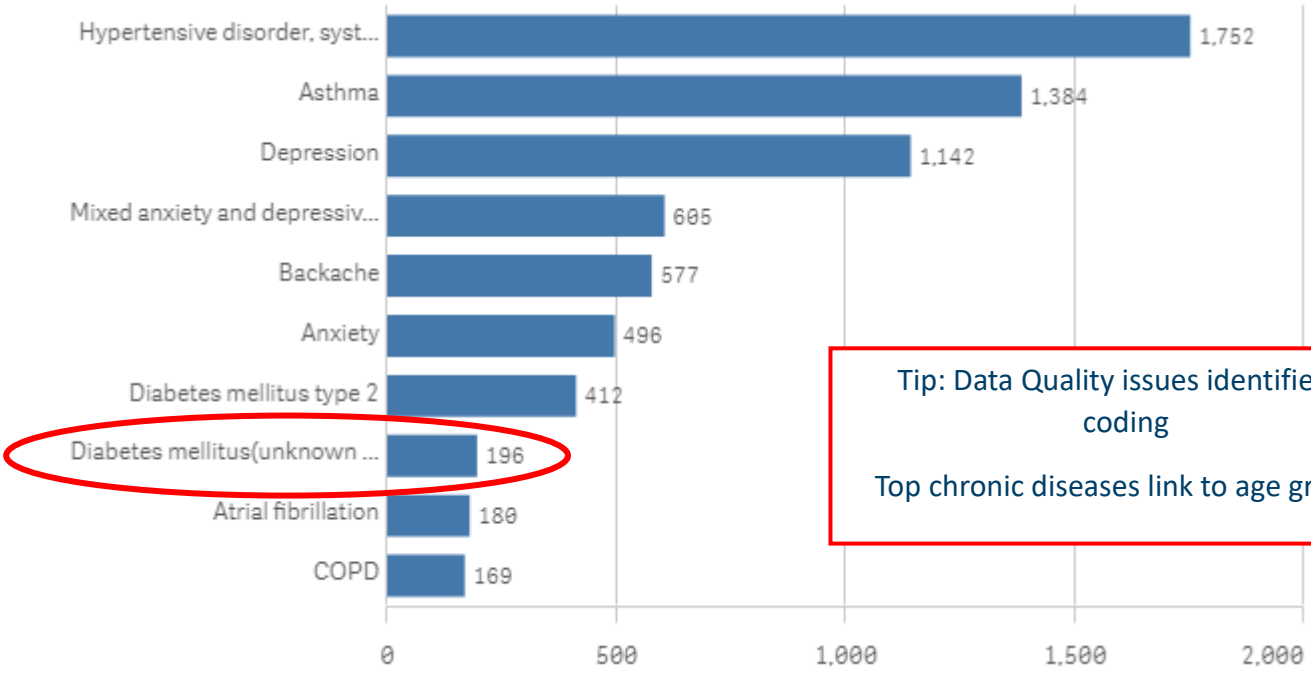
Tip: Does prevalence data indicate data quality issues (review next two graphs) or are there links to age groups?

Prevalence of Chronic Conditions in your practice (*Active Patients, Active Diagnosis*)

Category	*Practice Prevalence*	*EMPHN Catchment Prevalence 2018**	*Victorian Prevalence***	*National Prevalence***
Respiratory	9.1%	33.3%	31.8%	30.8%
Musculoskeletal	6.5%	20.2%	29.4%	29.9%
Cardiovascular (CVD)	10.8%	20.5%	18.4%	18.3%
Mental Health	12.9%	14.8%	17.5%	17.5%
Diabetes	3.2%	6.7%	5.1%	5.2%
Cancer	2.1%	1.2%	1.4%	1.4%
AOD	0.6%	0.9%	1.0%	1.0%
Chronic Kidney Disease (CKD)	0.2%	0.4%	0.9%	0.9%
Dementia	0.0%	0.5%	1.5%	1.5%

Insights	*Actions*	*Timeframes*

Top 10 Chronic Conditions in your practice (*Active Patients, Active Diagnosis*)

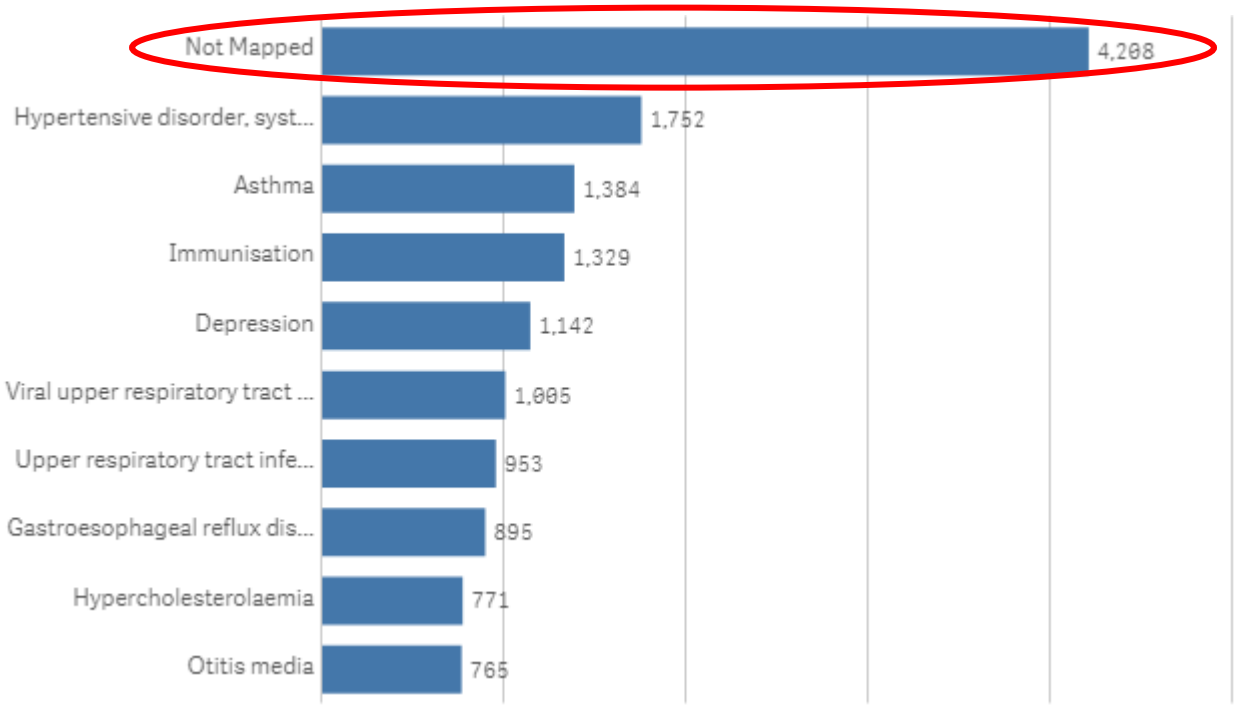


Tip: Data Quality issues identified – coding

Top chronic diseases link to age groups

Insights	*Actions*	*Timeframes*

Top 10 SNOMED Diagnoses (Active Patients and Active Diagnoses)



Insights	*Actions*	*Timeframes*

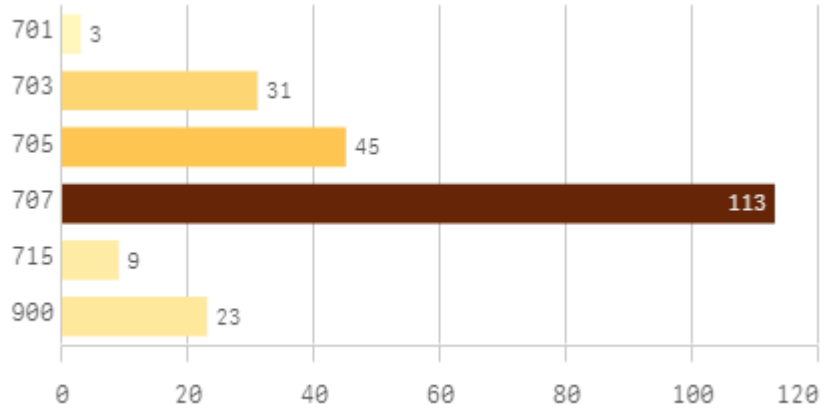
MBS CLAIMING

Health Assessments (Active Patients)

Potential MBS Items	*Patients Needing*
Home medications review	1,897
45-49 health assessment if at risk of chronic, once only	1,126
75 and over health assessment every year	658
Indigenous Health Assessment every nine months	173

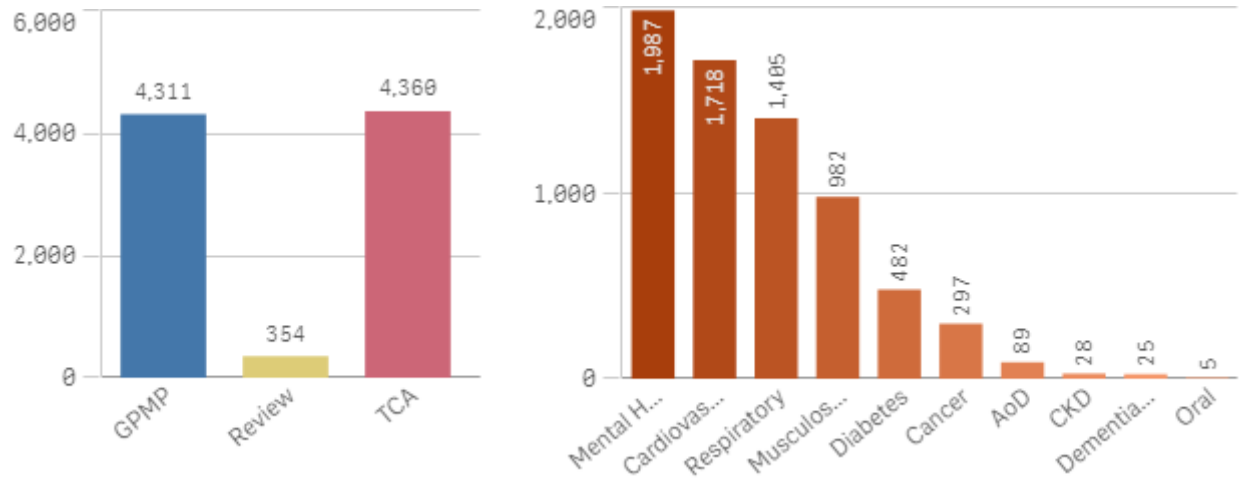
Home Medications Review - MBS item 900
Indigenous Health Assessment every 9 months - MBS items 701,703,705,707
45-49 Health Assessment if at risk of chronic disease (once only) - MBS items 701,703,705,707
75 and over Health Assessment annual - MBS items 701,703,705,707

Actual MBS Services Claimed (last 12 months)



Care Plans/Team Care Arrangements and Reviews

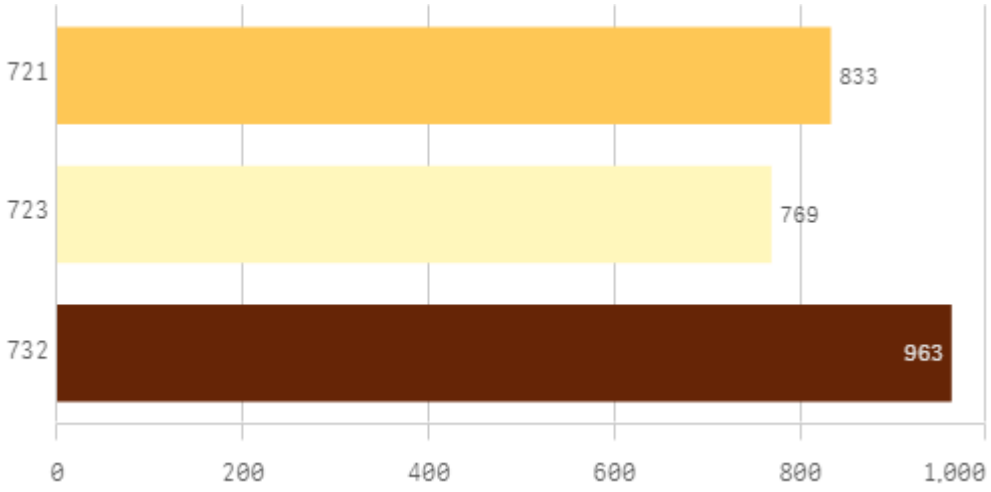
Patients eligible for GPMP/TCA and Reviews (Active Patients)



Note: *The same patient may appear in multiple chronic disease categories.*

Insights	*Actions*	*Timeframes*

GPMP/TCA and Reviews claimed (last 12 months)

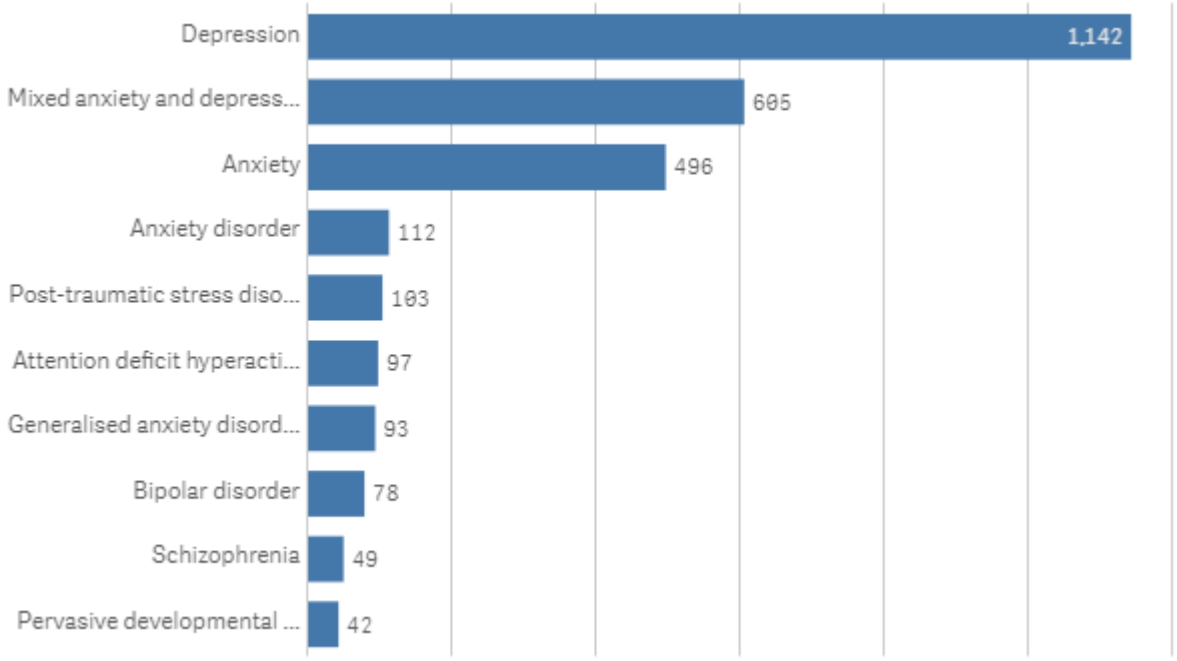


MBS Items
721 – Preparation of a GP Management Plan (GPMP)
723 – Coordination of Team Care Arrangements (TCAs)
732 – GP management plan (GPMP) / Team Care Arrangement (TCA) Review

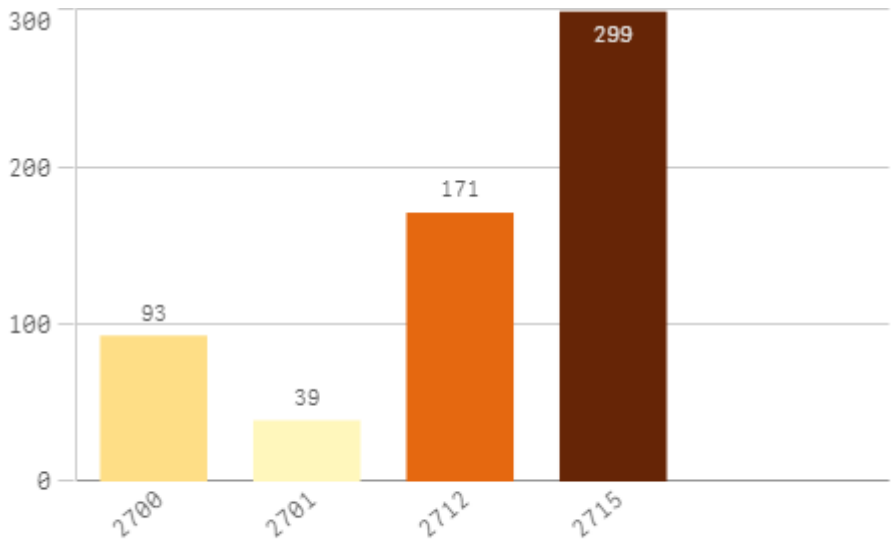
Insights	*Actions*	*Timeframes*

Mental Health

Top 10 SNOMED Diagnoses (Active Patients and Active Diagnoses)



GP Mental Health Treatment Plans and GP Mental Health Treatment Plan Reviews claimed (last 12 months)



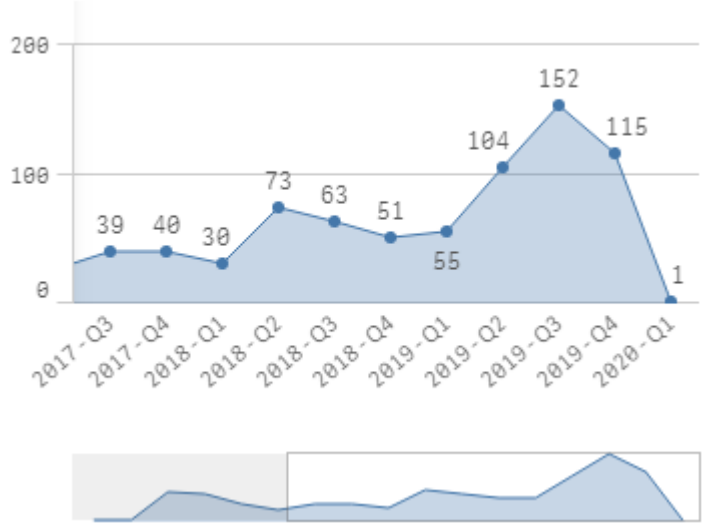
Insights	*Actions*	*Timeframes*
Note: The same patient may appear in multiple diagnosis categories.		

My Health Record

Total number and proportion of *Active patients* with a Shared Health Summary (SHS) uploaded (*Active Patients*)

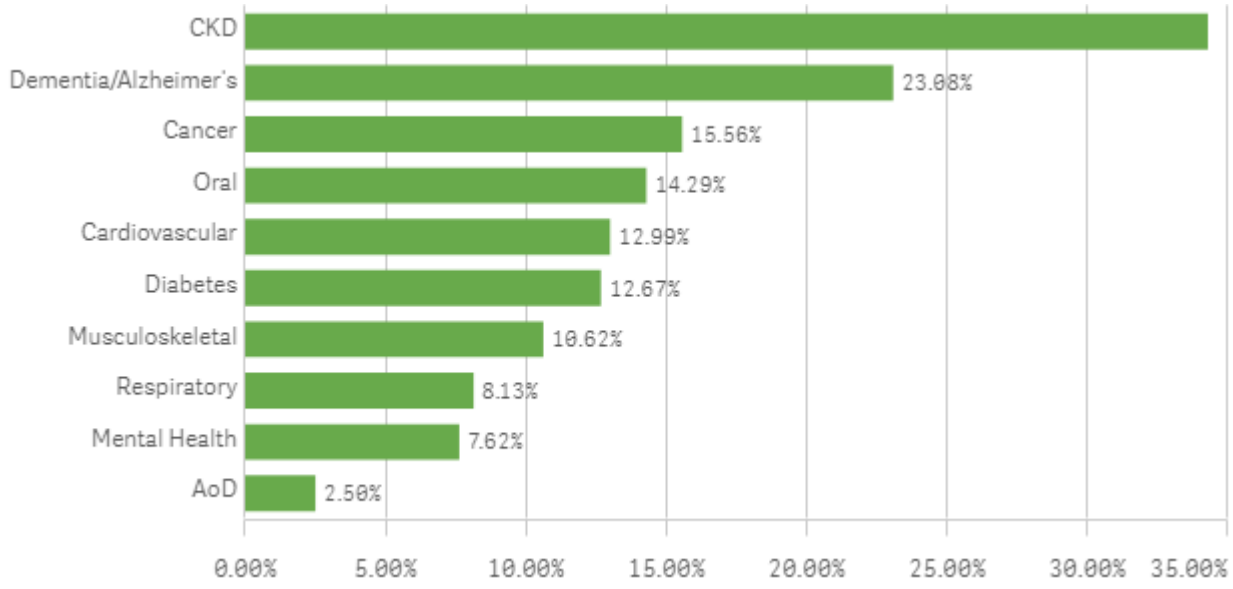
921 SHS Uploads **4.85%** of Clinic Patients

Uploaded SHS by provider and practice (*Active Patients*)



Provider	SHS Uploads
Morgan Freeman	103
Dr Doogie Howser	99
Valentino Rossi	98
Indiana Jones	95
Dr Richard Kimble	94
Dr Who	93
Dr Dolittle	91
Desmond Tutu	86
Dr Strange	86
Dr Seuss	76

Uploaded SHS by Chronic Disease Category



Insights	*Actions*	*Timeframes*
For training requirements contact polar@emphn.org.au		

Quality Improvement Plan

Develop a QI plan to provide structure and timelines to guide your team through quality improvement activities.

Tip: To support your practice team with implementing quality improvement activities, refer to the **EMPHN Quality Improvement Learning Module**: www.emphn.org.au/quality-improvement

Goal: What are you trying to accomplish?
Tip: Create a **SMART** goal (Simple, Measurable, Achievable, Realistic and Timely). How good do you want to be and by when?
Measure: What data will you use to track your improvement journey?
Tip: Consider how you will use the Demonstration PHN practice report and POLAR to capture the data needed to measure your activities undertaken. Refer to **Appendix A** to record your data throughout your improvement journey.
Activities/Ideas: What changes will you make that will lead to an improvement (small steps)?
Tip: Capture a list of practical steps to undertake and test using PDSA cycles. Refer to **Appendix B** for a PDSA template to record your activities.

Activity/Ideas	**Date Completed**	**Notes**

Appendix A

Data Report

Use this spreadsheet to capture your data to track your improvement journey. It is important to capture your baseline data before you start any improvement activity.

Measure	Practice Target	Baseline Data Date: _____	Month/PIP Quarter											

Appendix B
PDSA Template

Activity/Idea:

_____

_____

_____

_____

PDSA Cycle:

Plan: What exactly will you do? Include what, who, when, where, prediction and date to be collected.

_____

_____

_____

_____

Do: Was the plan executed? Document any unexpected events or problems.

_____

_____

_____

_____

Study: Record, analyse and reflect on the results.

_____

_____

_____

_____

Act: What will you take forward from this cycle? (What is your next step/PDSA cycle?)