EMPHN
Practice Report

phn EASTERN MELBOURNE
An Australian Government Initiative

EMPHN provides this report as a snapshot of your general practice data to enable you to focus on patient care and opportunities for improvement.

The report includes Clinical, Business, Data Quality, Quality Improvement, Hospitalisation risk, MyMedicare, Accreditation, Benchmarking and more.

These reports are distributed quarterly, but are available monthly on request via the following email: digitalhealth@emphn.org.au

To access the latest live data log in to polarexplorer.org.au

POLAR Demo Clinic

Practice Report 01/11/2024

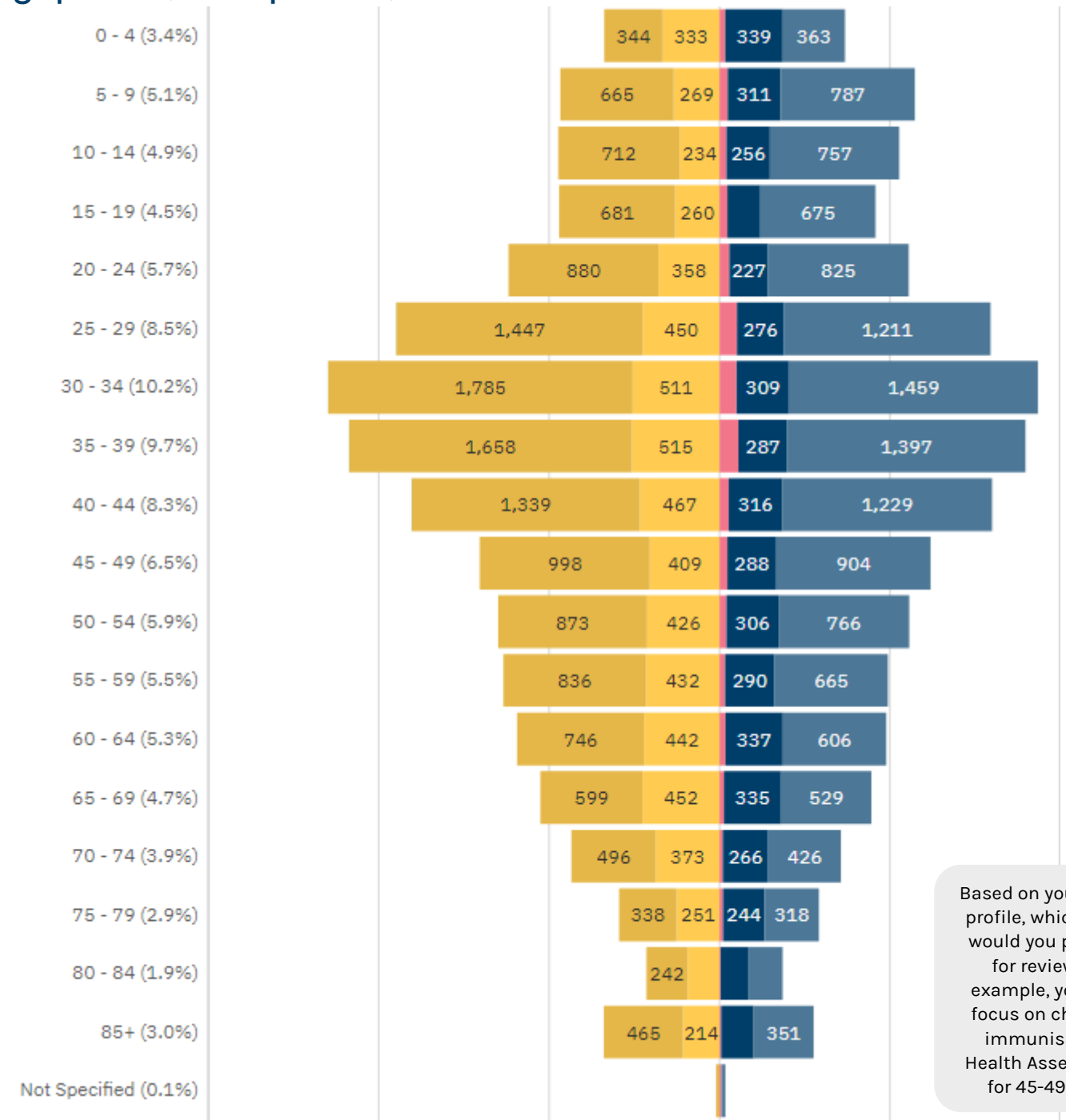
Most recent logins
Dr Who - 06/10/24
Dr Seuss - 11/09/24
Dr Doogie Howser - 26/08/24

Patient demographics

Patient count

Measure	Patient counts
Total active patient population	40,982
Total RACGP active population (3 or more visits in 2 years)	11,534
Indigenous population - active	197
Indigenous population – RACGP active	63

Age profile (active patients)



Based on your patient profile, which cohort would you prioritise for review? For example, you could focus on childhood immunisations, Health Assessments for 45-49 or 75+

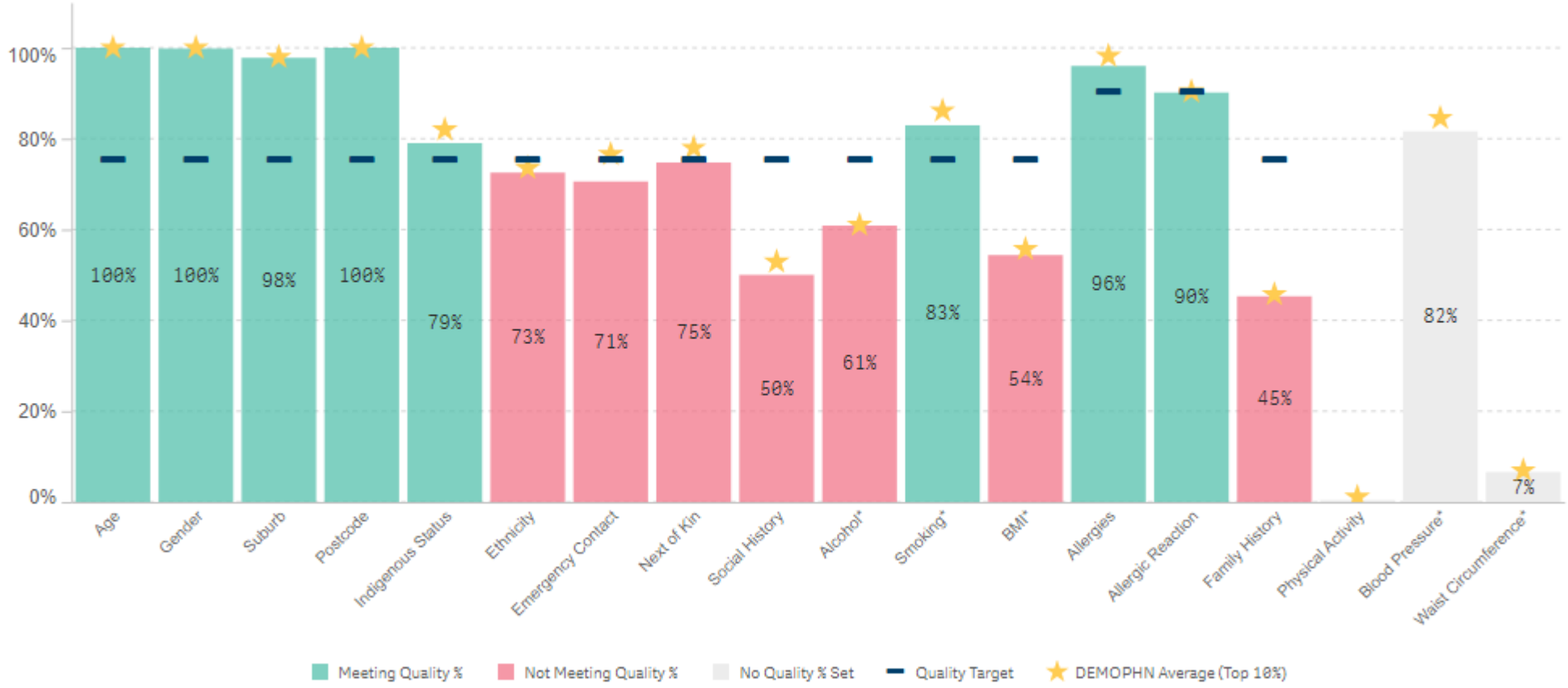
CIS active patients, RACGP active and inactive splits for male and female categories, other/intersex & not recorded CIS active, RACGP active or inactive

Note: Patient counts will only be displayed on the chart if there is enough space.

- Female CIS Active & RACGP Active (6,584)
- Male CIS Active & RACGP Active (4,933)
- Other/Intersex CIS Active (4)
- Other Female CIS Active (15,123)
- Other Male CIS Active (13,492)
- Not Recorded CIS Active (846)

Demographic and clinical data quality

Which quality measures would you focus on improving for the next 6 months?



Recording guidelines	★ Benchmark values ★	Notes
• SNAP: Smoking status: ≥ 10 years • SNAP: BMI: > 18 years, every 2 years • SNAP: Alcohol consumption: ≥ 15 years • RACGP: 90% of allergies recorded • RACGP: a current health summary for at least 75% of active health records	• Calculated based on the average of the top performing 10% of practices for each recorded measure	• Based on RACGP active patient population • BMI figures are based on records with no specified date range • Smoking Status Recorded for ≥ 10 years • Asterisks indicate age specific cohorts are used • Physical activity, blood pressure and waist circumference are included in the RACGP recommendations, however there are no set targets.

Practice incentive program (PIP) quality improvement measures (QIM)

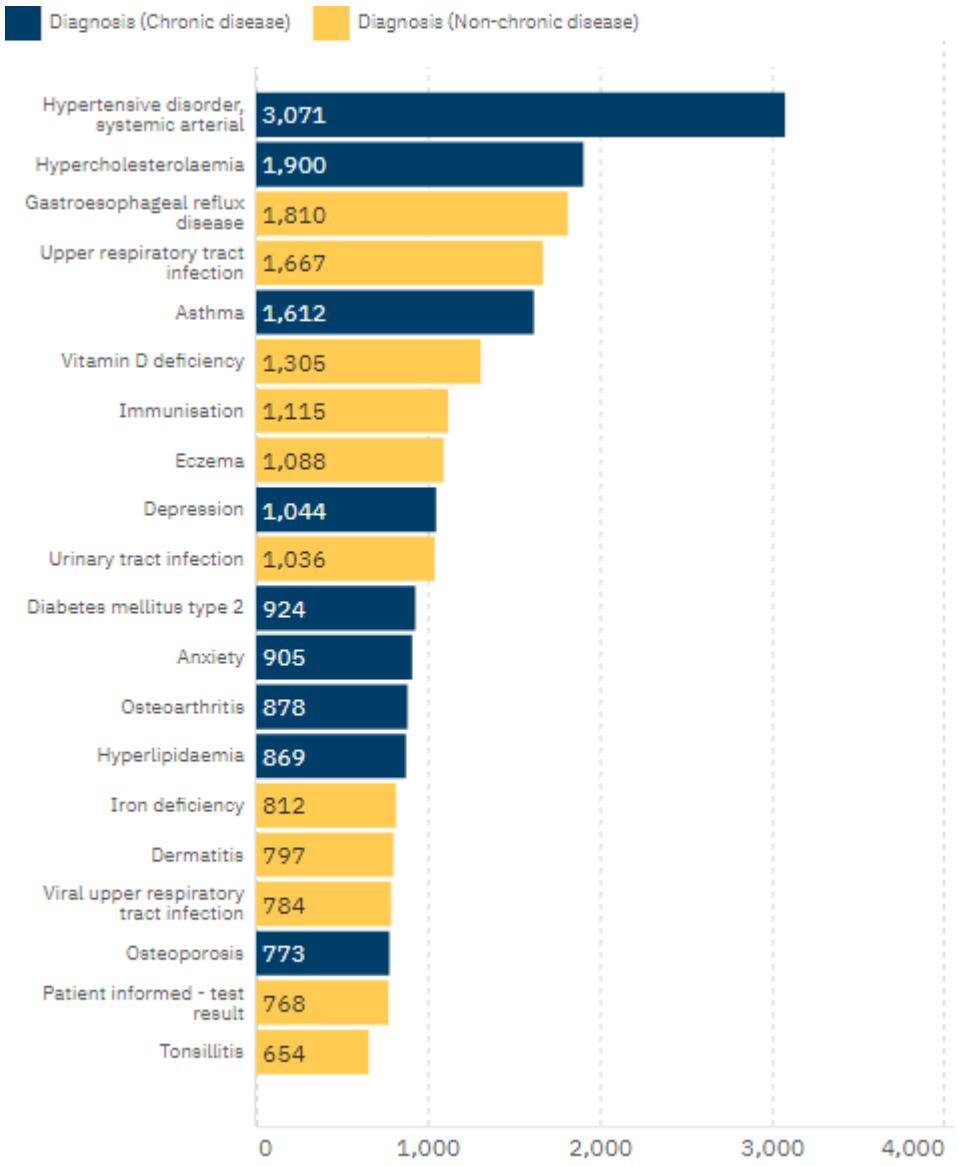
Group	PIP Quality Improvement Measure	Measure Recorded (Numerator)	Eligible Patients (Denominator)	Practice %	3 Month Change	12 Month Change	Last 13 Month Trend
Diabetes	QIM_1.1: Proportion of patients with Type 1 diabetes with a current HbA1c result	29	43	67%	-4.65%	2.33%	
	QIM_1.2: Proportion of patients with Type 2 diabetes with a current HbA1c result	429	589	73%	-1.11%	-0.95%	
	QIM_1.3: Proportion of patients with Undefined diabetes with a current HbA1c result	146	237	62%	-2.41%	-8.26%	
	QIM_10: Proportion of patients with diabetes with an up-to-date blood pressure recorded	427	815	52%	-4.59%	-3.51%	
Smoking	QIM_2.1: Proportion of patients recorded as a current smoker	653	6,731	10%	-0.18%	-0.36%	
	QIM_2.2: Proportion of patients recorded as an ex smoker	1,130	6,731	17%	0.12%	0.44%	
	QIM_2.3: Proportion of patients recorded as never smoked	4,948	6,731	74%	0.06%	-0.08%	
	QIM_2.4: Proportion of patients with a smoking status recorded	6,731	9,629	70%	-0.42%	1.63%	
BMI	QIM_3.1: Proportion of patients with BMI recorded as "obese"	654	2,218	29%	0.41%	2.50%	
	QIM_3.2: Proportion of patients with BMI recorded as "overweight"	731	2,218	33%	0.32%	0.30%	
	QIM_3.3: Proportion of patients with BMI recorded as "healthy"	784	2,218	35%	-0.46%	-2.34%	
	QIM_3.4: Proportion of patients with BMI recorded as "underweight"	49	2,218	2%	-0.28%	-0.45%	
	QIM_3.5: Proportion of patients with a BMI recorded	2,220	9,629	23%	-0.95%	0.94%	
Flu	QIM_4: Proportion of patients aged 65 years and over with an influenza immunisation recorded	1,159	2,581	45%	-5.82%	-4.00%	
	QIM_5: Proportion of patients with Diabetes with an influenza immunisation recorded	302	791	38%	-4.84%	-4.32%	
	QIM_6: Proportion of patients with COPD with an influenza immunisation recorded	67	137	49%	-5.17%	-8.62%	
Alcohol	QIM_7: Proportion of patients with an Alcohol Consumption recorded	5,978	9,629	62%	0.55%	2.36%	
CVD	QIM_8: Proportion of patients with the necessary risk factors recorded for a CVD risk assessment	1,351	3,070	44%	0.85%	4.94%	
Cervical	QIM_9: Proportion of female patients clients with an up-to-date cervical screening record	1,746	4,198	42%	0.64%	7.28%	

Improving measure Deteriorating measure Measure influence outside of practice control or highly seasonal e.g. flu

Which QIM would you focus on improving for the next PIP quarter?
Tip: Open the PIP QI report to identify these patients in POLAR

Diagnosis and Prevalence including chronic conditions

Top 20 coded diagnoses



Prevalence of Chronic Conditions in your practice

Active Patients, Active Diagnosis

Chronic conditions	Practice Prevalence %	LGA Prevalence %
Alcohol and other drugs (AoD)	0.3%	0.3%
Cancer	1.6%	1.6%
Cardiovascular	12.1%	12.0%
Chronic Kidney Disease (CKD)	0.2%	0.2%
Dementia/Alzheimer's	0.2%	0.2%
Diabetes	3.3%	3.2%
Disability	1.0%	1.0%
Mental Health	6.7%	6.7%
Musculoskeletal	6.6%	6.6%
Respiratory	5.2%	5.3%

Comparison LGA: Whitehorse (C)

How does the information about medical condition prevalence inform your practice activities?

How does your practice compare with your Local Area?

Patients at Risk of Hospitalisation

The Hospitalisation Avoidance Tool (HAT) report calculates the risk of hospitalisation or emergency presentation within 12 months.
In the table below, for patients identified as either "Urgent" or "High Risk", eligible MBS item counts are shown.
The percentages indicate the proportion of the at risk patients that are eligible for the relevant MBS services.
Note: these percentages will appear to add up to more than 100% as patients can be eligible for multiple services)

MBS Item	Urgent Risk Patients	Urgent Risk Patient %	High Risk Patients	High Risk Patient %	No. of Claims (Oct-2024)	Items Eligible
GP Management Plan (GPMP)	204	50%	692	63%	146	3,336
Team Care Arrangement (TCA)	224	55%	725	66%	128	3,498
GPMP or TCA review	137	34%	276	25%	91	1,300
GP Mental Health Plan	156	38%	334	30%	41	887
GP Mental Health Plan review	61	15%	99	9%	24	494
Chronic Disease Nurse Assessment	227	56%	509	46%	44	2,087
45-49 Health Assessment	10	2%	51	5%	0	439
75+ Health Assessment	167	41%	366	33%	29	956
Home Medication Review	369	90%	810	74%	4	2,483
Heart Health Check	53	13%	220	20%	11	4,844
	408	**100%**	**1,101**	**100%**	**518**	**20,324**

The table above provides an opportunity to prioritise and recall patients at risk of hospitalisation.

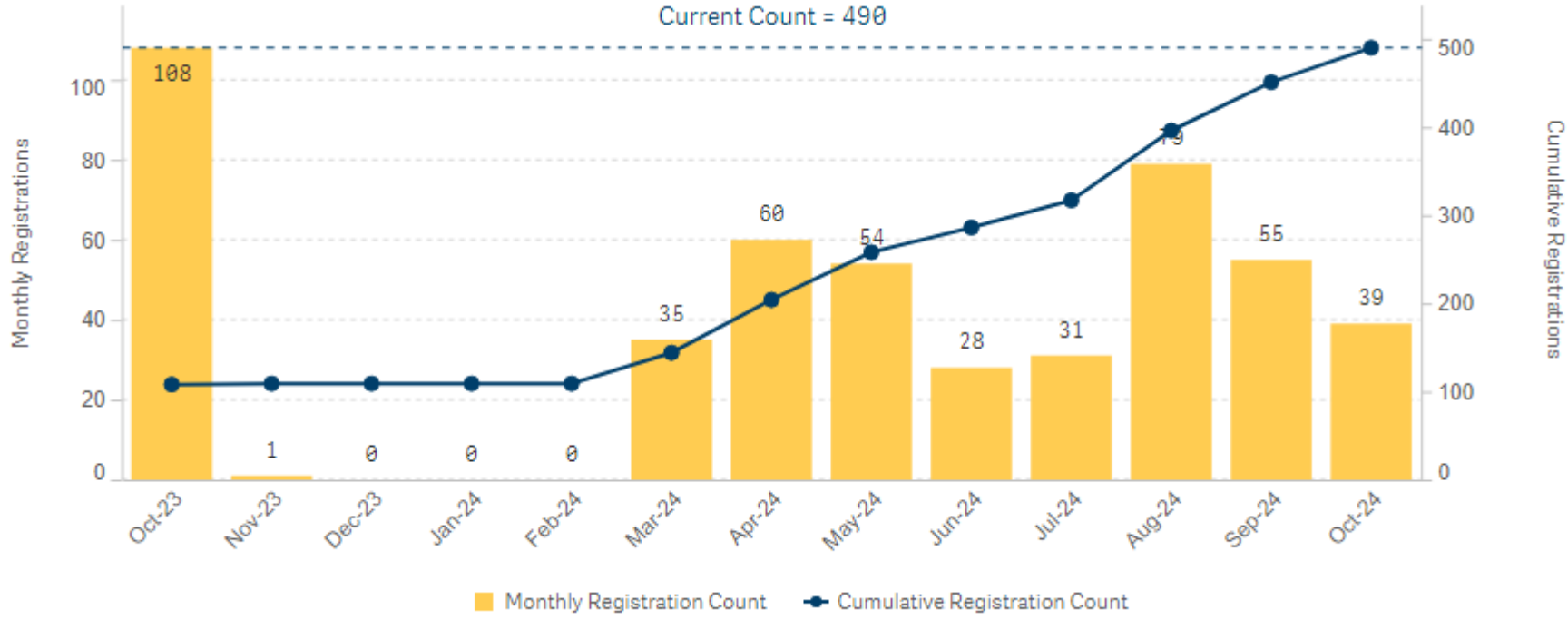
How does this information influence your activities to prioritise patients at risk of hospitalisation?

For example, you could review urgent risk patients who haven't had a service provided.

MyMedicare Registrations

Registration Rate: 4% (490 of 11,534 patients)

Percentage of Clinic Active & RACGP Active patients who are registered for MyMedicare. (PHN Top 10% Avg Registration Rate: 4%)



How can you use this information to increase MyMedicare Registrations at your practice?

For example you may focus on percentage registration rate when discussing this with your team.

My Health Record - Shared Health Summary (SHS) Patient Uploads

Provider	This Quarter (0)	Last Quarter (139)
Dr Dolittle	0	17
Indiana Jones	0	16
Desmond Tutu	0	15
Dr Doogie Howser	0	15
Dr Richard Kimble	0	15
Dr Strange	0	15
Dr Who	0	14
Valentino Rossi	0	14

Dr Seuss	0	10
Morgan Freeman	0	8

Model for Improvement and Plan Do Study Act (PDSA)

Eastern Melbourne PHN have developed an editable PDSA template to support you with quality improvement activities at your practice. This template will assist you with focusing on your practice priorities each quarter

Support

For support with POLAR contact digitalhealth@emphn.org.au
For quality improvement support contact practicesupport@emphn.org.au

PIP-QI Current and upcoming quarters

PIP Quarter	Start Date	End Date
Q1 2025	01/11/2024	31/01/2025
Q2 2025	01/02/2025	30/04/2025
Q3 2025	01/05/2025	31/07/2025
Q4 2025	01/08/2025	31/10/2025

PIP QI guidelines

Data glossary

Item	Definition
Total active patient population	Patients marked Active / Enabled within the Clinical Information System (CIS)
Total RACGP active population	Patients who have visited the clinic on 3 or more occasions (separate days) over a two-year period
Indigenous population - active	Indigenous patients marked Active / Enabled within the Clinical Information System (CIS).
Indigenous population - RACGP active	Indigenous patients who have visited the clinic on 3 or more occasions (separate days) over a two-year period.
Coded diagnosis (SNOMED)	This is what a clinical diagnosis entered into the CIS is mapped to by the POLAR system. • SNOMED is an international standard for defining medical terms and is the preferred coding system for Primary Care environments.