THE UNIVERSITY OF SYDNEY

BEACH
Family Medicine Research Centre
Sydney School of Public Health

Primary Health Network (PHN) reports available from BEACH data

Data period: We suggest that four years of combined data are used. Five years can be used if the PHN is looking for even more statistical power.

Measurement of change over time pre-post intervention in specific areas of interest to an individual can be planned either now or later.*

With few exceptions (e.g. ratios etc) all results are provided with 95% confidence intervals.

Comparison areas: all results will be provided with comparative National average (standard)

- age standardised PHN results compared with national average can also be requested*.
- additional comparators can also be requested (e.g. state/territory or rurality level)*.

*If the PHN has specific morbidities of interest, they can request quality measures.**

OUTPUT

1. **Inflow and outflow**

   Proportion of patient encounters that happen within the PHN that are with people who live outside the PHN and the proportion of encounters with people who live inside the PHN that happened in other PHNs.

2. **Prevalence of chronic conditions & multimorbidity**

   2.1 Prevalence estimates for common chronic conditions diagnosed among patients at encounters and in the PHNs/ active patients (those who attended at least once in 2015-16); total population including:

   - Hypertension
   - Osteoarthritis
   - Hyperlipidaemia
   - Depression
   - Anxiety
   - Gastro-oesophageal reflux disease
   - Chronic back pain
   - Type 2 diabetes
   - Asthma
   - Ischaemic heart disease
   - Osteoporosis
   - Malignant neoplasms
   - Hypothyroidism
   - Atrial fibrillation
   - Insomnia
   - Congestive heart failure
   - Chronic renal failure
   - Stroke/cerebrovascular attack
   - Dementia
   - Sleep apnoea
   - Peripheral vascular disease
   - Glaucoma
   - Rheumatoid arthritis
   - Type 1 diabetes

2.2 Multimorbidity including:

- the proportion of patients at encounters, and the proportion in the PHN's population, with mutimorbidity (2+ and/or 3+ chronic conditions) or complex multimorbidity (chronic conditions in 3 or more different body systems),
- the distribution of patient at encounters, and of the PHN population: who have a number of diagnosed chronic conditions (i.e. 1+, 2+, 3+, 5+, 7+ 9+)
- the most common combinations of 2 or more chronic conditions
- the most common combinations of 3 or more chronic conditions

3. Polypharmacy and Adverse drug events

Extent of polypharmacy (5+ long term medications) and prevalence of adverse drug events in the previous 6 months.

4. Patient risk factors in adults aged 18 years and over (sample about 35,000 nationally per year)

- obesity**:** distribution of BMI of patients at encounters (underweight; normal; overweight; and three levels of obesity, morbid obesity being the highest)
- daily tobacco smoking of patients at encounters
- alcohol drinking status of patients at encounters (non-drinker, previous drinker, responsible drinker, hazardous drinker).

5. PHN Content of GP-patient encounters report

- **GP characteristics** of participating GPs in this PHN c.f. national average
- **Patient characteristics at encounters in this PHN:** Age, sex, Indigenous status, Commonwealth health care card status (yes/no); ATSI status (yes/no); non-English speaking background (yes/no), socioeconomic disadvantage (SEIFA) and rurality of residence(ASGC).
- **Content of encounters in this PHN**
  - **Average number** of:
    - problems managed at encounters,
    - chronic conditions managed at encounters,
    - management actions used per 100 encounters and per 100 problems.

  —medications (total)

  -Prescribed medications (including supplied)

  -Advised medications for OTC purchase

  —clinical treatments

  —procedural treatments

  —referrals (total)

  -Referrals to specialists

  -Referrals to allied health professionals

  —imaging tests ordered

  —pathology tests ordered
  - **Problems managed**

  Frequency & rate of management of each of the top 30 problems managed, rate per 100 encounters.

6. **Average length of consultation** (measured by recorded finish time minus start time): Mean, median, interquartile range

Family Medicine Research Centre, Level 7, 16–18 Wentworth St. Parramatta 2150. PO Box 533, WENTWORTHVILLE NSW 2145
Ph: +61 2 9845 8150 Fax: +61 2 9845 8155 Email: helena.britt@sydney.edu.au
Web: http://sydney.edu.au/medicine/fmrc/

7. Quality indicators

Below are some suggested quality indicators.

- Psychological problem management rate and GP actions in their management
  (*Note that the national indicator using Medicare data is a measure of GP claiming behaviour, not of GP frequency of management of depression or anxiety, their use of psych counselling themselves, or their referral rate to psychologists, or prescribing of medications).*
  - Depression management issues (as above for all psych problems)
  - Anxiety management issues
- Opioids prescribed per 100 problems managed
- NSAIDS prescribed per 100 encounters with patients aged 65+
- Antibiotics per 100 upper respiratory tract infections contacts managed
- Imaging test for back problems (new cases)
- Prescribing of PPI's for GORD per 100 GORD problems managed
- Prescribing of benzodiazepines for any problem, rate per 100 problems managed.

Cost: $20,000 +GST = $22,000 (as at 16 Feb 2016).
Excludes any * items listed above, for which additional costs can be quoted.

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Dr Helena Britt
Professor of Primary Care Research
Director, Family Medicine Research Centre
Sydney School of Public Health,
University of Sydney
Email: Helena.britt@sydney.edu.au