PRIMARY SENSE PRACTICE USER GUIDE – Practice Software

January 2026

V1.13

Contents

Revision History / Change Log

Version	Date	Author	Description of Changes
1.4	27/06/2025	C.Steward	Release up new format user guide
1.5	02/07/2025	C.Steward	Updated with release 2.42 changes
1.6	25/08/2025	C.Steward	Updated with PIPQI Diabetes information
1.7	22/09/2025	C.Steward	Updated Alert information and data extraction
1.8	13/10/2025	C.Steward	Updated prompt information and alcohol rules, added mapping information
1.9	15/10/2025	C.Steward	Added atomised pathology testing
1.10	15/10/2025	C.Steward	Added Hep C report & release 2.44 updates
1.11	01/12/2025	C.Steward	Updated with release 2.45 changes
1.12	07/01/2026	C.Steward	Add ACG information
1.13	23/01/2026	C.Steward	Add CVD Risk Screening, Recall and Treatment report

1. Overview

How to use this User Guide

This Guide was developed to help staff at participating Primary Health Network (PHN) Practices to understand and adopt Primary Sense. It can be used by staff as a reference guide, or for the purposes of upskilling staff on how Primary Sense works in general practice.

1.1. Definitions

Primary Health Network (and "PHN")	Participating PHNs rolling out Primary Sense in their region.
Primary Sense Administrators or Primary Sense Team	The set of staff employed by the Lead PHN who deliver or provide direct or indirect support of the Primary Sense services, and ensure the overall system is working and fit for purpose.
Primary Health Insights (and "PHI" or "PHI platform")	The national data storage and analytics platform managed by the Lead PHN (for and on behalf of all PHNs) and on which the Primary Sense Application is hosted. Includes the secure, dedicated storage "lockbox" for each PHN and the analytics and data processing tools hosted on or provided through the platform (including Power BI Premium, Azure Synapse Analytics, etc).
Clinical Information System (CIS)	The Clinical Practice Software used in the practice. Currently Medical Director and Best Practice are supported by Primary Sense.
Best Practice (BP)	Clinical Practice Software used at multiple practices.
Medical Director (MD)	Clinical Practice Software used at multiple practices.

1.2. Roles and responsibilities

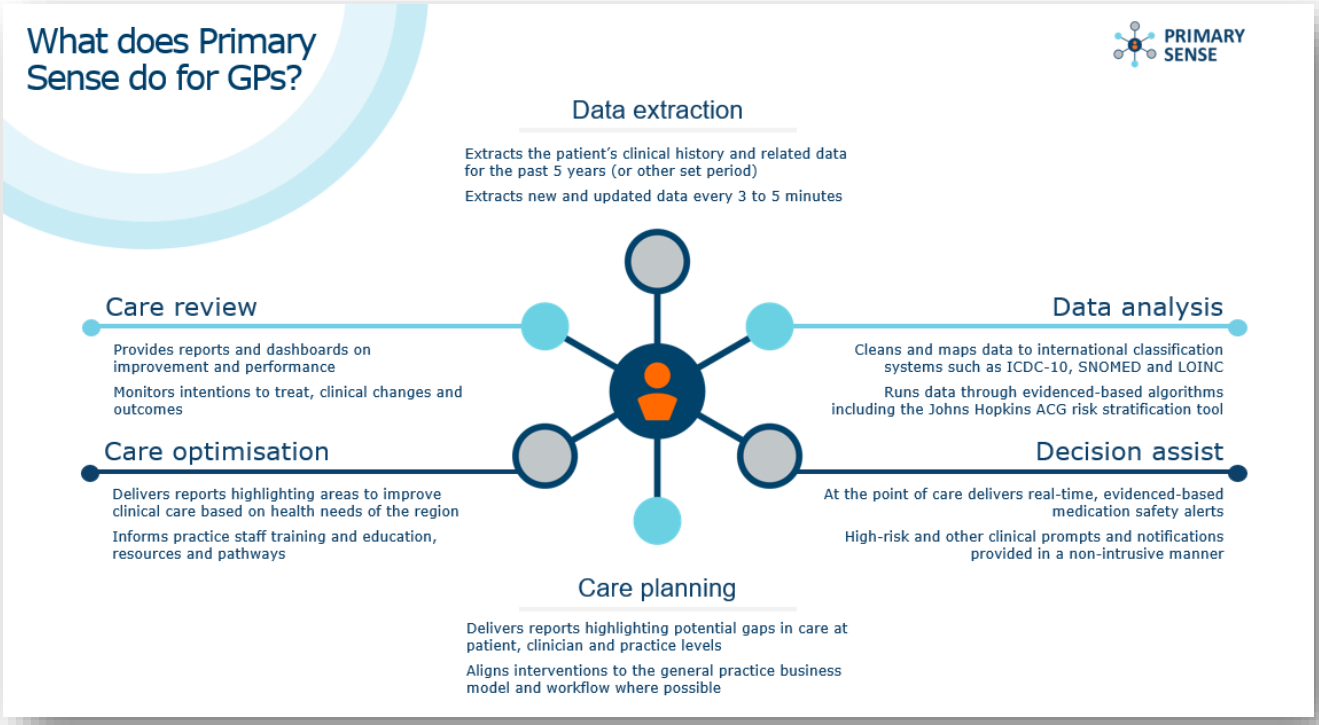
Primary Sense is jointly owned by participating PHNs, with WA Primary Health Alliance (WAPHA) as the Lead PHN.

Primary Sense is hosted on the Primary Health Insights (PHI) platform. The application in PHI is managed by the Primary Sense administrators, the application in general practice is managed by their respective PHN, with the support of the national Managed Service Provider (MSP).

1.3. Overview of Primary Sense

Primary Sense is a data extraction, analysis and decision support tool designed to assist with improving the delivery and quality of care to patients in the general practice setting. The tool uses the evidenced-based Johns Hopkins University ACG® System to enable population health management at a practice and PHN level. Key features of the product are outlined in the following diagram:

The patient is at the centre, supported by their GP



Primary Sense is designed to digitally enable a comparatively small PHN Practice Support team to provide:

- a greater level of support, in more detail, to more practices, in a timelier manner than has otherwise been possible
- PHN insights that can be incorporated directly into the normal business workflow of a general practice. This allows PHNs to enhance rather than replace traditional continuous quality improvement (CQI) methods.

The Application is intended to be easy for general practices:

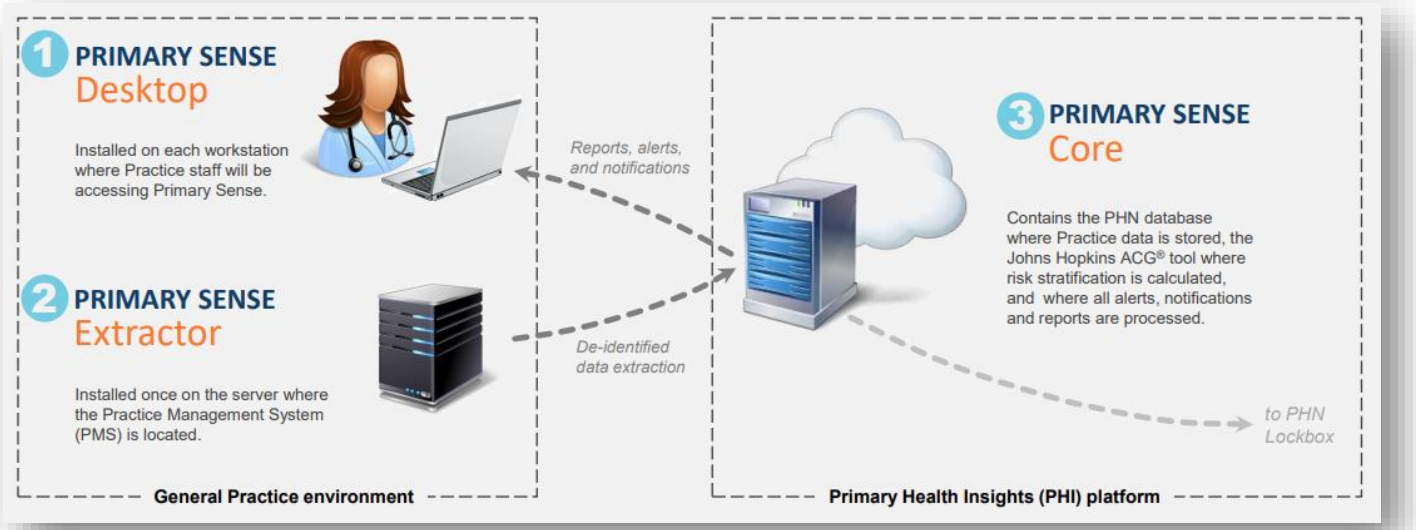
- to find out information
- to commence and complete the various processes required to gain access
- to download and install the software
- to use at both practice and individual practitioner levels.

It is designed and operated to be highly secure, reliable, responsive, and to integrate with the most common clinical information systems used by General Practices across Australia (currently Best Practice and Medical Director).

Primary Sense is also designed to integrate with and leverage the capabilities of the PHI platform to:

- reduce cost and complexity for PHNs
- simplify the storing, managing, analysis, and reporting on general practice data by PHNs, through enabling use of common tools and processes.

When used at a General Practice, Primary Sense consists of three key components – two installed within the General Practice environment, and one that stays in the Primary Sense cloud environment hosted on the PHNs' Primary Health Insights platform.



1.3.1. Key Benefits of Primary Sense

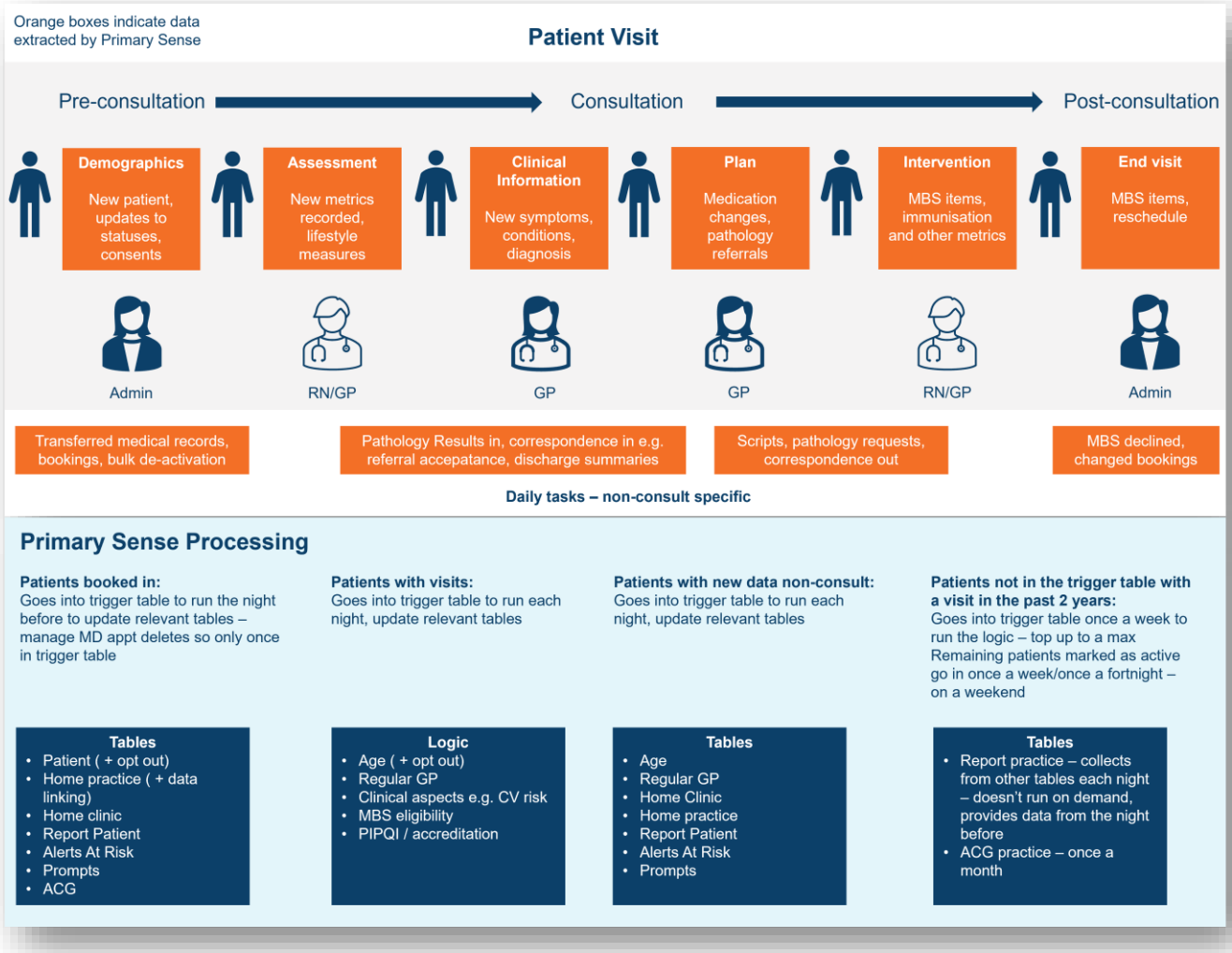
The tool:

- includes the Johns Hopkins University ACG® System – the world's leading population health analytics software – that identifies high risk groups and predicts future health needs to improve patient's care plan
- is easy to use with most GPs requiring little to no training to get started
- can be quickly installed by practice IT support staff
- is compatible with major practice management software products e.g. Medical Director and Best Practice
- provides real time medication safety alerts, patient care prompts and notifications incorporated into the existing workflow
- reports are automatically generated with the click of a button and self-selected by the practice and individual practitioners.

1.3.2. Key points for Practice users:

- Although a complex system, Primary Sense is simple and intuitive to use.
- The system has been designed to be fast, with minimal impact on a practice's servers. This is done through multiple, small data collections every few minutes. Data collections are transferred to the Primary Sense Core for analysis in PHI.

- As the system operates continuously, practice level system errors and failures need to be monitored by PHN staff, which can be done in an easy-to-use dashboard via the Management Portal.



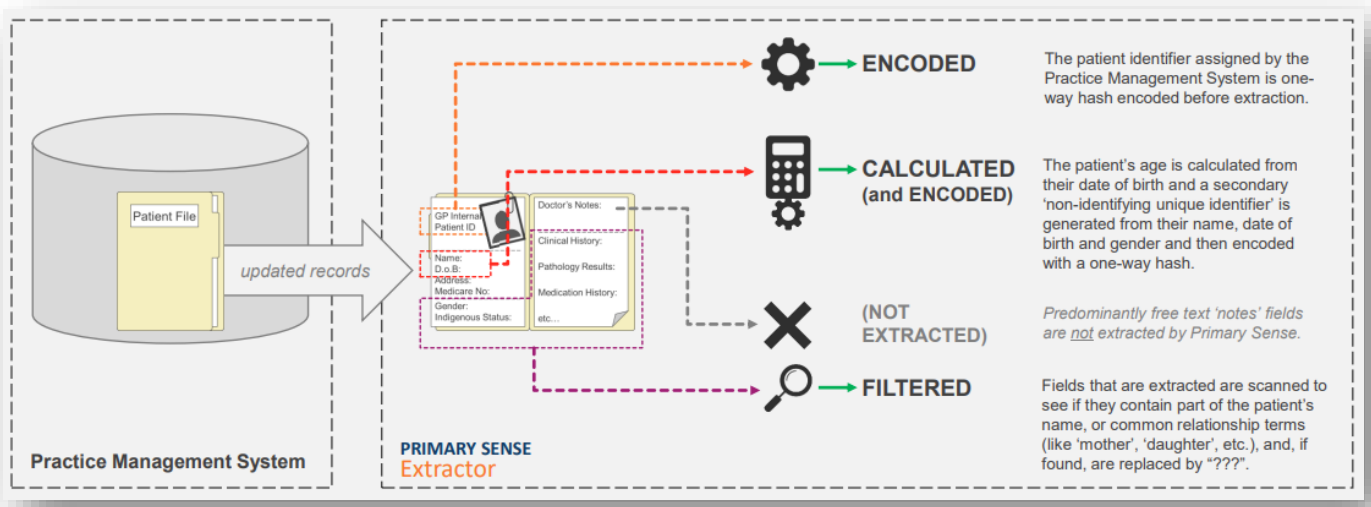
1.4. How Primary Sense works

Primary Sense consists of:

- An **extractor** that is installed on the same physical (or virtual) server where the practices clinical information system (CIS) is installed (currently not compatible with cloud-based applications and some other GP software).
- A **desktop application** which is installed on any workstation where a user is likely to need access to its capabilities, which could include general practitioners (GPs), nurses, the practice manager and administration staff.
- An application program interface **(API)** that transfers the data and messages to a GP or practice's computer.
- A **database** in the PHI where extracted data is processed into insights and presented as reports, medical alerts or prompts back to the practice.
- A **Management Portal** where PHN's can monitor system performance and manage onboarding practices.

1.5. Primary Sense Data Extraction

The Primary Sense Extractor reads updates to patient data stored in the Practice Management System and sends a de-identified sub-set of this data to the Primary Sense Core for processing, enhancement and storage.



1.5.1. Primary Sense Data Extraction – De-identification

Primary Sense does not extract names, addresses, Medicare numbers, phone numbers, or any data that uniquely identifies individuals.

The Primary Sense Extractor accesses identifiable data only to:

- create a hashed, non-identifying unique ID for linking and deduplication within a practice,
- calculate patient age (capped at 90; ages under 1 set as 1), or
- scan extracted fields—some of which may contain free text—to mask any patient names or relationship terms with "???".

The primary identifier used is the internal record number assigned by the Practice Management System, which is also hashed before extraction.

1.5.2. Primary Sense Data Extraction – Hash Encoding

Primary Sense avoids extracting identified data by using one-way hash encoding for any fields that are sourced from identifiable data. This applies to both the practices internal identifier and the secondary 'non-identifying unique identifier'. Unlike encryption, hash encoding is designed to be one-way, and both non-reversible and non-recoverable.

- Encryption is two-way: data is encrypted at the start using a known key and can be decrypted back into its original form using the same key. Primary Sense (like any secure software system) uses encryption on data that is being transmitted between the Desktop or Extractor and the Core – it is not readable while in transit but can be decrypted and stored once received.

- Hash Encoding is one-way: data is processed using a secure algorithm that turns it into a fixed-length string of characters (regardless of the actual length of the data itself) called a "hash". There is no key, and the data cannot be passed back through the algorithm or any other process

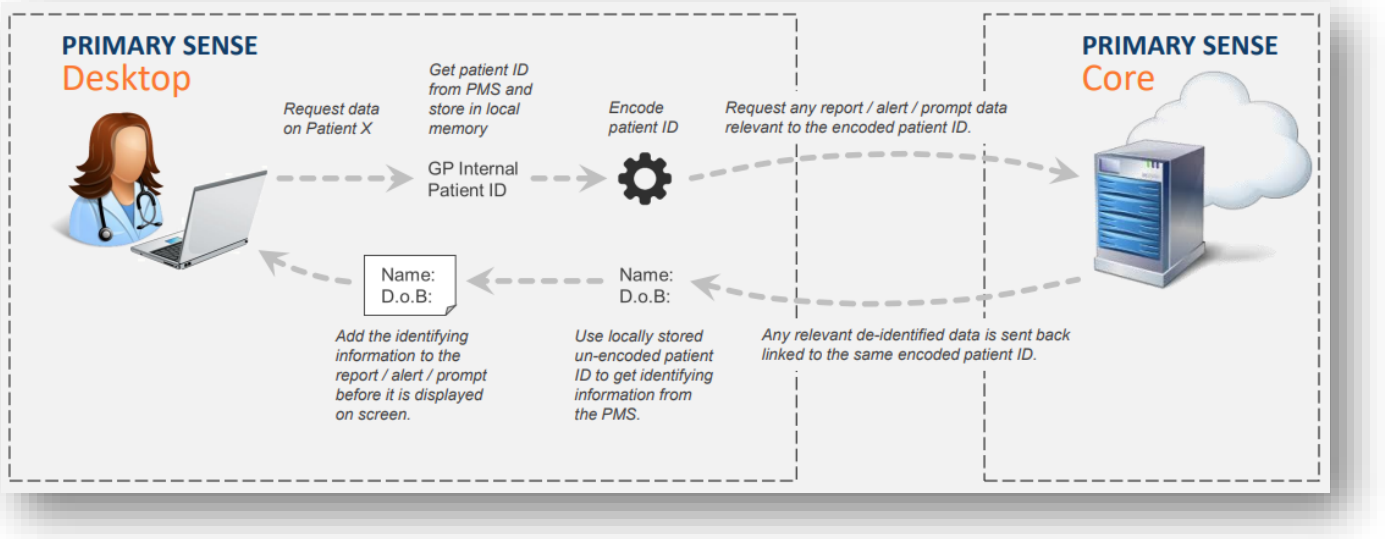
to return it to its original state. The same source data will always result in the same hash, so two hashes can still be compared to identify if the original data is the same without knowing what that data was.

Primary Sense uses one-way hash encoding to generate the secondary 'non-identifying unique identifier'. The hash function uses the patient's surname, first name, data of birth and gender as inputs to produce the hash, but the output hash does contain any of that data and cannot be processed or de-coded to recreate that data.

Example:
Input: John Smith 1 January 1980 M
is hashed into…
Output: 42e5ecda590e3a1bb11090fa6f7431724fbe0c1d

1.5.3. Extracted Data used in Reports, Prompts and Alerts

The Primary Sense Desktop application displays patient and doctor names within alerts, prompts, and certain reports. All identifying information is generated locally by the Desktop, exclusively within the General Practice setting.



The Primary Sense Desktop can request information about a specific patient from the Primary Sense Core if:

- the Desktop sends a proactive request for any relevant Prompts at the beginning of a new consult;
- the Desktop sends a proactive request for any relevant Alerts whenever a new script is being prepared;
- a person using the Desktop requests a Report that needs to contain identifying data (like names) to be of value; or
- a person using the Desktop adjusts consent information for the Practice's patient population in the Administration screen.

In all the above cases, the only information sent to the Primary Sense Core that 'identifies' a patient record is the same encoded internal identifier that was previously extracted. The Core compiles any relevant information and sends it back to the Desktop, which then uses the locally-stored un-encoded

internal identifier to request the relevant identifying information (such as the patient's name) from the Practice Management System and then add that information into the correct field in the report, alert or prompt before it is displayed on-screen to the person using the Desktop.

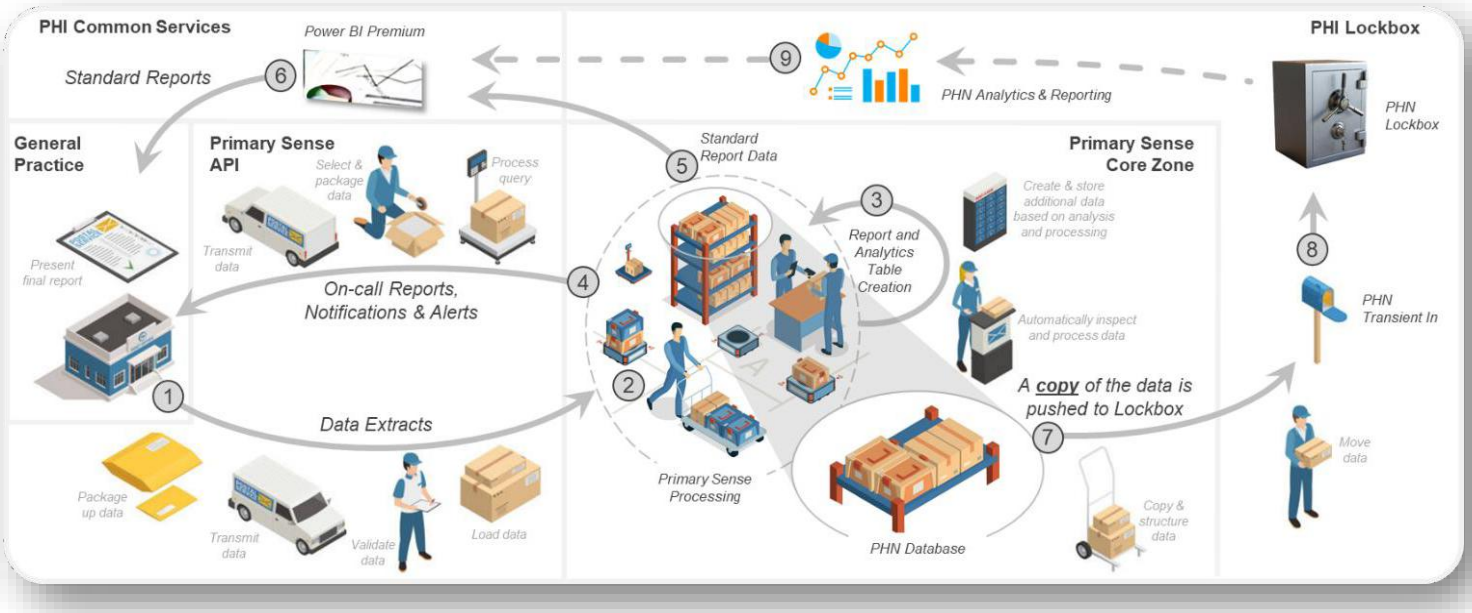
Primary Sense can display that identifying data on-screen when that is needed – because all identifying data is only accessed locally by the Desktop inside the Practice.

Internal practitioner identifiers from the Practice Management System are encoded, and can be re-identified, by the Desktop in the same way as internal patient identifiers.

1.6. Primary Sense within PHI – Data Flow

Consider the analogy, that Primary Sense within PHI is established as a common 'mail distribution centre' serving multiple 'floors' (PHNs) by centralizing the process of collecting, processing and passing on information from GPs. Data 'parcels' are extracted from GPs, deidentified and processed in the Core Zone 'mail room' and then re-packaged and sent back to the GP as reports, notifications or alerts, as well as duplicated and sent to each PHN's own 'mailbox' on their 'floor' for analysis and reporting.

1. Primary Sense includes server software installed on each GPs' local database server for their clinical information system (CIS), such as Best Practice or Medical Director. On a set but configurable schedule (usually every 3 – 5 minutes), this server software:



a) Sends a request to the Primary Sense Core via the Primary Sense API asking for the exact SQL query to be run for this specific practice to extract agreed data (in line with data sharing and/or project agreements, including for any research projects).

b) Runs the SQL query against the CIS database, including only records that have been updated or added since the last time the query was executed.

c) Sends the data to the Primary Sense API.

The Primary Sense API then packages the extracted data, transmits it over the internet to the

Primary Sense Core, unpacks the data, validates that the data is in the expected format, and then loads the data into waiting Data Extract tables inside the PHN's specific database in the Core.

2. Inside the Primary Sense Core, the extracted data is mapped against standard reference tables, creating additional fields for reporting, and assessing telemetry data contained in the extract about how Primary Sense is performing within the general practice.
3. Dedicated processes create additional tables within each PHN's specific database for reporting and analytics. This includes Stored Procedures to create tables specifically for use in creating reports provided back to GPs on demand, as well as running patient data from the GP through the Johns Hopkins University ACG® System.
4. Primary Sense also includes desktop software installed on each practitioner's or staff member's workstation. This software monitors the prescriptions to see if a patient specific medication alert should be returned, or a notification prompt should be triggered during a consult or returns a selected report (which contains a defined cohort of their patient population). If the specific report requested is intended to contain identifying data, the desktop software takes the de-identified data sent via the Primary Sense API and contacts the GP's CIS for the information and displays identifying data in alert/prompts/reports.
5. Data is sent to the PHN's lockbox. Reports or dashboards created in the PHI Power BI Premium tenancy which can be configured as either public (anybody with a link to the report can view the data), restricted (only users with a PHI 'guested' account – can view the data) or filtered (each user can only view records they have specifically been given permission to see, such as only their own GP or PHN).
6. On a set but configurable schedule (usually once a week), a data pipeline run by the Primary Sense Core will take a copy of all new or updated data in each PHN's database, package it up in both 'raw' (i.e. the data that came in from the GP, including any additional fields containing mapped or analysed data) and 'structured' formats (i.e. structured into a proper star schema optimised for data analytics and reporting). This data will be sent using the pipeline to the Transient In storage account of the PHN's PHI lockbox. This is a storage account each lockbox contains, that users outside that PHN can write into, but not read.
7. A data pipeline run within the PHN's PHI lockbox (set up as part of the Primary Sense onboarding process) will detect whenever new Primary Sense data is sent to the Transient In storage account, and will then read the data, copy it into the Lockbox Data Lake and/or the Lockbox Data Warehouse, and delete the data from the Transient In storage account.
8. As and when needed or decided, PHN data analysts can further process, analyse and report on the data. This can include creating new reports or dashboards which can be opened up to GPs or other external users through the PHI Power BI Premium tenancy.

2. Data Overview and Management

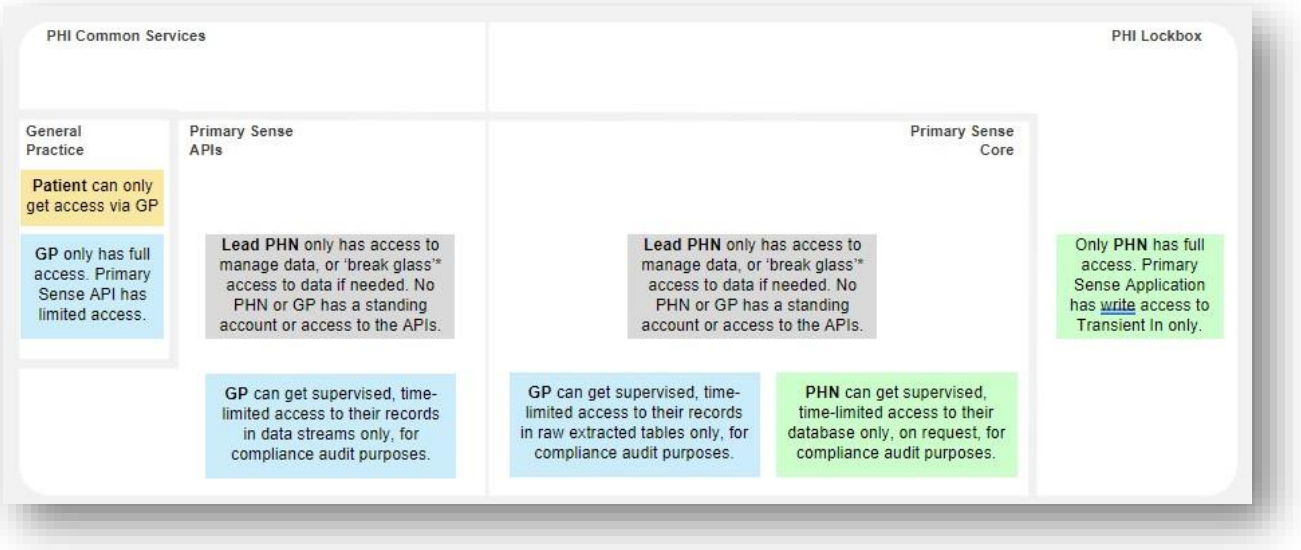
Key points for Practice users:

- Primary Sense's data processes and mappings are complex and extensive, and are the intellectual property of the PHN owners, therefore, PHN data policies and procedures will need to be in place to manage access to the Primary Sense data.
- Primary Sense uses the highest standards of data security to extract, analyse and manage general practice data.
- Data extracted from Primary Sense is governed responsibly, privacy protected and securely stored and managed in Australia by PHI.
- All transmission of data is compressed and sent over secure channels. It is stored or contained in reports that are locked down under multiple layers of access control.
- Once in the lockbox within PHI, Primary Sense administrators do not have access to the data but can collaborate with PHN staff to improve any mapping and interpretation in the Primary Sense application source data.

No identifying data (e.g. name, date of birth, Medicare number, residential address) about an individual is extracted from a general practice's clinical information system.

2.1. Data access roles – Patient, GP, Lead PHN, PHN

The level of access to data by each person or organisation with a defined data governance role



within each discrete part of the Primary Sense data flow is contained below:

*'Break glass' access refers to an administrator account that has sufficient privileges to view data or take an action but can only be used in an emergency or if specifically requested by a Custodian / Sponsor.

2.2. Data access by the Lead PHN

As both Administrator or the Primary Sense Service, and Data Steward of the Primary Sense Data, the Lead PHN needs to have a certain level of access to parts of the data 'packages' moving or stored within the Primary Sense API and Core Zone:

Primary Sense Data Components	Primary Sense System Scripts & Process	Primary Sense Team "Break Glass" Accounts	Primary Sense Team Administrator Accounts	Primary Sense Team Standard Accounts	Participating PHN (inc. WAPHA) Staff
Metadata *(table and field names, data formats, data volumes, etc.)*	Full Access	Read Access	Read Access	Read Access	No Access (Audit Access to own PHN data only on request)
Telemetry Data *(data records added or updated, tables and fields specific to API performance activity or system health)*	Full Access	Read Access	Read Access	Read Access	No Access (Audit Access to own PHN data only on request)
Mapping Data *(fields in GP data used for mapping against reference data sets)*	Full Access	Read Access	Read Access	No Access	No Access (Audit Access to own PHN data only on request)
Reference Data *(Not GP or PHN data – third-party sourced or created by or for project)*	Full Access	Read Access	Read Access (Scripted Write Access)*	Read Access	No Access (All PHNs only access via copies in Common Zone)
All Data *(all fields, all tables)*	Full Access	Read Access	No Access	No Access	No Access (Audit Access to own PHN data only on request)

* Any updates to Reference Data (or other programmatic components within Primary Sense) will only occur through a proper Change Management process that has been tested and then deployed into Production via script.

Data that is extracted from Primary Sense comes from different clinical software systems. To enable consistency, where possible, data is mapped to international classification systems like:

- International Classification of Primary Care (ICPC2+) *ICPC-2 PLUS*
- Logical Observation Identifiers Names and Codes (LOINC®) *Logical Observation Identifiers Names and Codes (LOINC)*

At times, additional classifications might be required.

The Primary Sense logic is a series of structured queries run on the data to link data to reference tables, apply calculations and criteria. This process identifies patients most at risk.

The logic runs when the data is received in the database, for example:

- when new data for the patient is entered by the GP e.g. new medications,
- when the practice requests data back e.g. running a report,
- when the practice's data generated throughout the day is analysed and ready for prompts the next day.

Practice staff can provide feedback if the reports, prompts or alerts are right or wrong to enable auditing and corrections as required. There is also the ability to opt in and out of various functions:

- The GP can choose which alerts and prompts they want/don't want to receive.
- Patients can choose whether to share their data for primary purposes (e.g. risk factors presented back to the treating GP). (See patient consent in Section 7 for further information).
- Patients can choose whether to share their data for secondary purposes (e.g. aggregated data for planning).
- Reports are returned only when clicked on in the desktop app.

Only data used for the Primary Sense logic is extracted, and only within timeframes relevant for this purpose. Primary Sense has two functions for use of data - the primary purpose and the secondary purpose. For more detail of how this is defined in the Data Sharing Agreement see Appendix 1.

3. Data Mapping Information

3.1. How the mapping works

3.1.1. ICPC Codes for Diagnosis and Reason for Visit

Primary Sense uses the ICPC-2 PLUS codes developed by the University of Sydney, which is a user-friendly coding system, which classifies symptoms, diagnoses (problem labels), past health problems and processes (such as procedures, counselling and referrals). ICPC-2 PLUS

It currently contains approximately 8,000 terms that are commonly used in Australian general practice.

An ICPC code ID is allocated to the extracted data on insertion into the database by matching the reason for visit or diagnosis to the 'description' to the 'reference table'. These mapping tables are maintained and updated on a regular basis.

Note that there are additional complexities that must be managed in the mappings. i.e. To populate the "Cardiovascular Disease Risk Factors" report in the desktop app, patients with cardiovascular disease need to be excluded (classification 11), but the report must also identify patients who are diabetic for inclusion (classification 1). Hence, additional classifications are used to group and differentiate the two in the report diagnosis refence table, which the report logic draws on.

Below is an example of how the ICPC ID works in the logic:
The ICPC code ID is applied to the extracted data by matching the two descriptions in extracted data and the reference table. This ID can then be used to determine how the diagnosis is managed in the report, alert and prompt logic. The criteria to map to descriptions allows mapping left and right stents without needing both in the reference table.

Extracted data inserted into DB		Reference table- each description has its own ID					A classification is applied as some reports use 11(CVD) and 1 (diabetes)			
ICPC Code ID	Reason	ID	Grouper	Grouper description	ICPC2+	Description	Classification		Report ID	ICPC Code ID
10966	Cva (Cerebrovascular Accident)	10966	K90	Stroke/CVA	K90010	CVA (Cerebrovascular Accident)	11	CVD	15	10966
10385	Ischaemic Heart Disease	10385	K76	Ischaemic heart disease	K76014	ischaemic heart disease	11	CVD	15	10385
10304	Myocardial Infarction	10304	K75	Acute MI	K75002	Myocardial infarction	11	CVD	15	10304
10434	Heart failure	10434	K77	Heart Failure	K77011	heart failure	11	CVD	15	10434
9873	Stent, coronary artery x 3	9873	K53	Treatment/ procedure	K53009	Stent, coronary artery	11	CVD	15	9873
10777	Cardiomyopathy ?viral	10777	K84	Heart disease other	K84041	Cardiomyopathy	11	CVD	15	10777
10970	Strokes	10970	K90	Stroke/CVA	K90010	Stroke	11	CVD	15	10970
9873	Stent, coronary artery-Right	9873	K53	Treatment/ procedure	K53009	Stent, coronary artery	11	CVD	15	9873
9873	Stent, coronary artery left	9873	K53	Treatment/ procedure	K53009	Stent, coronary artery	11	CVD	15	9873

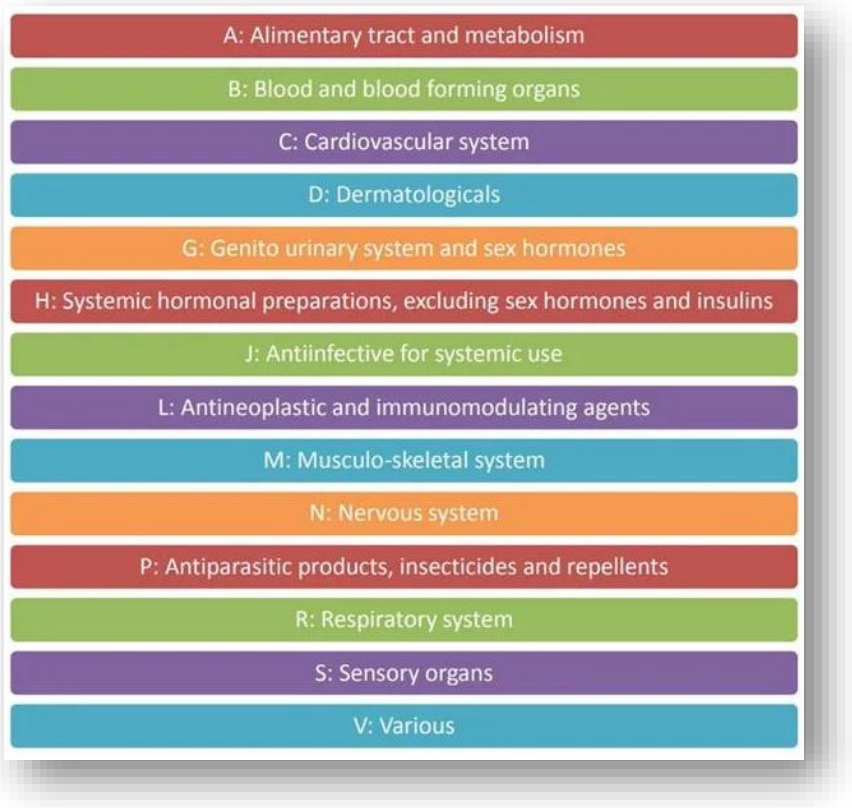
3.1.2. ATC Codes for Medications

Primary Sense uses the Anatomical Therapeutic Chemical (ATC) classification system Anatomical Therapeutic Chemical (ATC) Classification to map medications extracted from the core systems. It is a globally recognized method for categorizing medications. It organizes drugs into groups based on:

- **The organ or system** they act upon.
- Their **therapeutic**, **pharmacological**, and **chemical** properties.

The ATC system was developed and is maintained by the WHO Collaborating Centre for Drug Statistics Methodology, based at the Norwegian Institute of Public Health in Oslo, Norway and is updated annually.

Drugs are classified in groups at five different levels.
ATC 1st level - The system has fourteen main anatomical or pharmacological groups (1st level). The ATC 1st levels are shown below:



ATC 2nd level - Pharmacological or Therapeutic subgroup

ATC 3rd& 4th levels - Chemical, Pharmacological or Therapeutic subgroup

ATC 5th level - Chemical substance

Example:

Metformin, a common diabetes medication:

- **A** – Alimentary tract and metabolism
- **A10** – Drugs used in diabetes
- **A10B** – Blood glucose-lowering drugs, excluding insulins
- **A10BA** – Biguanides
- **A10BA02** – Metformin

This code allows systems to identify metformin precisely and apply relevant alerts, dosage checks, and reporting rules.

Primary Sense uses these classifications to map and identify medications prescribed in the core systems, and uses the codes as filters or triggers for reports, prompts and medication safety alerts, for example, a medication safety alert may reference all drugs used in diabetes which is identified by looking at all drugs with an ATCClassifcation ID pf A10.

Primary Sense medication mapping tables are maintained and updated on a regular basis as new medications are prescribed in the core systems.

3.1.3. LOINC Codes for Pathology

Primary Sense maintains reference tables for pathology results types which includes test names and results with descriptions and LOINC codes. LOINC stands for Logical Observation Identifiers Names and Codes. It's a global standard developed by the Regenstrief Institute in the U.S. to uniquely identify laboratory tests and clinical observations. LOINC Getting Started.

Each pathology test—like a full blood count or cholesterol level—is assigned a LOINC code that acts like a universal label. This helps different systems understand and exchange pathology data consistently and assists with the correct mapping of results from core systems into Primary Sense.

Extracted data from the core systems is mapped to Primary Sense LOINC reference tables where it is also assigned a classification. This allows identification of specific types or results, such as Cholesterol, Creatinine, HBA1C and EGFR, which are used as filters or triggers for reports, prompts and medication safety alerts.

Labs often also create their own internal codes or use slightly different LOINC codes depending on how the test is performed, the specimen type, or the reporting format. LOINC codes are also highly specific, for example, a test for white cell count in blood vs. synovial fluid will have different codes. Some results are also extracted without a LOINC code, and these are then checked for the description, result format and requested test name to correctly add them to the reference table.

Primary Sense LOINC mapping tables are maintained and updated on a regular basis as new results and codes are extracted from the core systems, and classifications are checked to ensure that the correct results are surfaced for reports and triggering prompts and medication safety alerts.

Example:

HbA1c results are recorded in numerous forms across the pathology and core systems with varying LOINC codes. These are all mapped in the Primary Sense Reference Table to a loinc classification indicating that the result is a verified HbA1c result.

LOINC	TestName	LOINCClassificationID
17856-6	HBA1C	5
17856-6	HbA1c (D-10)	5
17856-6	HbA1c (NGSP)	5
1964^E0185	HbA1c (NGSP)	5
4548-4	Blood HbA1c Fraction	5
4548-4	Glycated Haemoglobin (HbA1C)	5
4548-4	HbA1c	5
4548-4	HbA1c (DCA)	5
4548-4	HbA1c (NGSP)	5
4548-4	HbA1c NGSP	5
59261-8	Blood HbA1c Fraction IFCC	5
59261-8	HbA1c	5
59261-8	HbA1c (IFCC)	5
59261-8	IFCC HbA1c	5
AUSLAB^A1CIFC	HbA1c IFCC	5
AUSLAB^A1CPOC	HbA1C NGSP (POC)	5
HAPS^HBA1IF	HbA1c (IFCC)	5
NULL	HbA1C	5
NULL	HbA1c (SI)	5
	HbA1c (NGSP)	5
	HbA1c IFCC	5
	HbA1c	5
	HbA1c (IFCC)	5
	HbA1c (SI)	5
	HbA1C NGSP (POC)	5
AUSLAB^HBA1NS	HbA1c (NGSP)	5
2133^C0183	HBA1c (IFCC)	5
AUSLAB^HBA1IF	HbA1c (IFCC)	5
59261-8	HbA1c IFCC	5
59261-8	HbA1c mmol/mol	5

3.2. MBS Items

Primary Sense maintains a reference table with MBS items, related fee and start and end date. Changes to fees are maintained by storing the history with dates. A NULL EndDate value indicates that the item is current with the assigned fee. For example:

ItemNo	StartDate	EndDate	Fee
93690	1/11/2023	NULL	$41.40
93690	1/07/2023	31/10/2023	$41.20
93690	1/07/2022	30/06/2023	$39.75

This data is then available for use by the Johns Hopkins University ACG® System and is also available in the PHN Lockbox tables.

3.3. Data extracted

Below is the list of data tables and how far back (in terms of timeframe) the initial extraction goes to collect the records. Only patients marked as 'active' have their records extracted from the practice.

Description	Table Name	Timeline
List of patients at each practice	Patient	All
List of staff at each practice, ID and role only	Staff	All
List of consultations for each patient	Consultation	5 years
List of appointment dates for each patient	Appointment Date	Extracts in advance at least 2 weeks
List of visits for each patient	Patient Visit	5 years
List of service items for each visit	MBS Billed Record	5 years
List of pathologies ordered for each patient	Pathology Request With Suppression	5 years (except certain genetic tests)
List of pap smear tests for each patient	Pap Smear	5 years
List of pathologies results for each pathology ordered (pathology providers not known)	Pathology Result	5 years (except certain genetic tests)
List of document types Names such as 'Discharge Summaries' or 'Scan results'. No content, just name type.	Document With Suppression	5 years
List of allergic reactions for each patient	Allergic Reaction	All
List of historical visits for each patient, clinical history and diagnosis	Clinical History	All
List of visit reasons for each patient	Visit Reason	All
List of documents for each patient	Document	5 years

List of immunisations for each patient	Immunisation With Suppression	All
Has Medicare card, Health insurance flag (no details)	Patient	All
Has Concession card (Pensioner, Healthcare, Seniors, Concession)	Patient	All
List of observations for each patient inc: Pulse Systolic Diastolic Weight Temp O2Saturation Height BMI Resp TOBACCO ALCOHOL Waist BSL K10 Hip WHRatio CVRisk HeadCirc DASS21 DiabRisk MMSE PND Audit-C Activity Expiration Inspiration	Observation	5 years
List of patient lifestyle records for each patient: Alcohol status and assessments Smoking history and numbers Veteran Status RACF status Lives alone status	Patient Lifestyle	All
List of medications for each patient	Medication	5 years unless ceased date is null
List of prescriptions for each patient	Prescription	5 years
List of pregnancies for each patient EDC LNMP Pregnancy End date	Pregnancy	All
Births Birth records	Birth	All

Birth date Birth weight Pregnancy ID linked where possible		

3.4. Pathology Results

Pathology results must be received into Best Practice and Medical Director in atomised HL7 format for the results to be picked up by the Primary Sense data extractor. Atomised pathology results are HL7 results that contain the data in predefined coded segments broken down into individual components and stored in a structured format rather than as a single document like a PDF.

Instead of receiving a full pathology report as one file, atomisation means each piece of information (e.g. test name, result value, units, reference range, date) is stored separately in a database. This allows Primary Sense to:

- **Extract** structured pathology results.
- **Search** and filter results.
- **Identify** specific results.
- **Trigger** alerts and prompts based on specific values.

Example 1

A lipid panel test is performed for a patient. In a traditional format, the result might be stored as a PDF report that includes:

- Doctor's name
- Date of test
- Cholesterol levels
- Notes

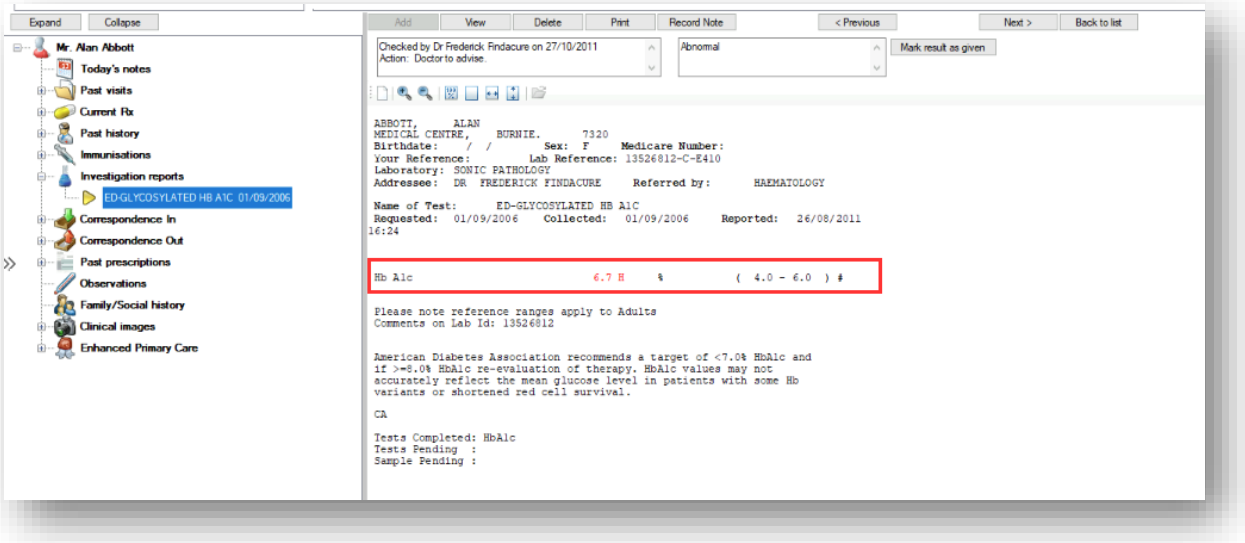
In an **atomised format**, each result is stored like this in individual fields in a database:

- **Test Name**: LDL Cholesterol
- **Result**: 3.2 mmol/L
- **Reference Range**: 0–3.0 mmol/L
- **Date**: 12 Oct 2025

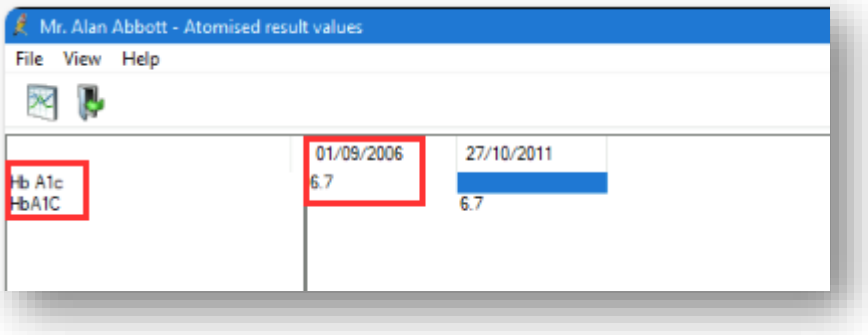
This allows Primary Sense to automatically flag that the LDL is high, add patients with these results to any at risk groups, and trigger a prompt or medication safety alert for the GP to act upon.

Example 2

A diabetes panel test is performed for a patient. In a traditional format the result will be stored and viewable as a PDF with the results inset in the document. Below is a screenshot of a document type (PDF) result in Best Practice. The result type and value are inset in the document (right side of the screen).

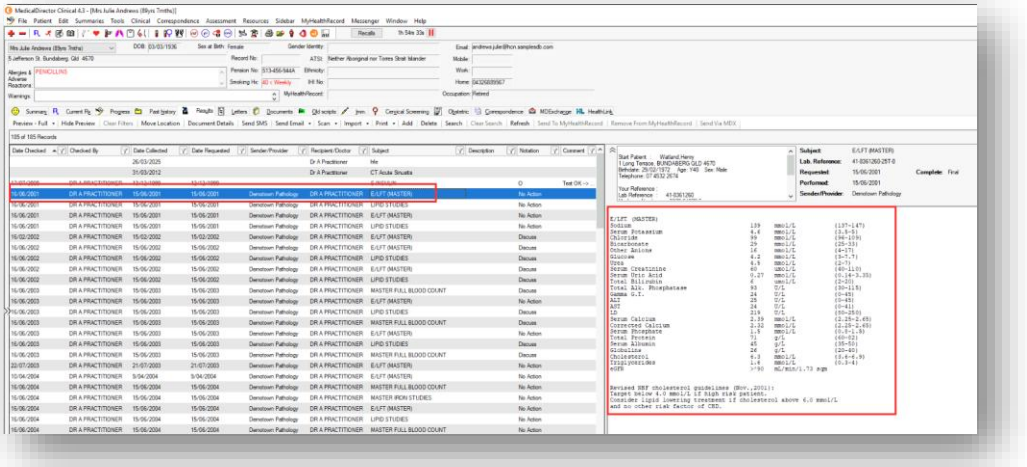


In an **atomised format**, the result will render in a results value table where it can be referenced as a unique result for the generation of Primary Sense reports, prompts or medication safety alerts. Below is an example of the atomised result table in Best Practice.

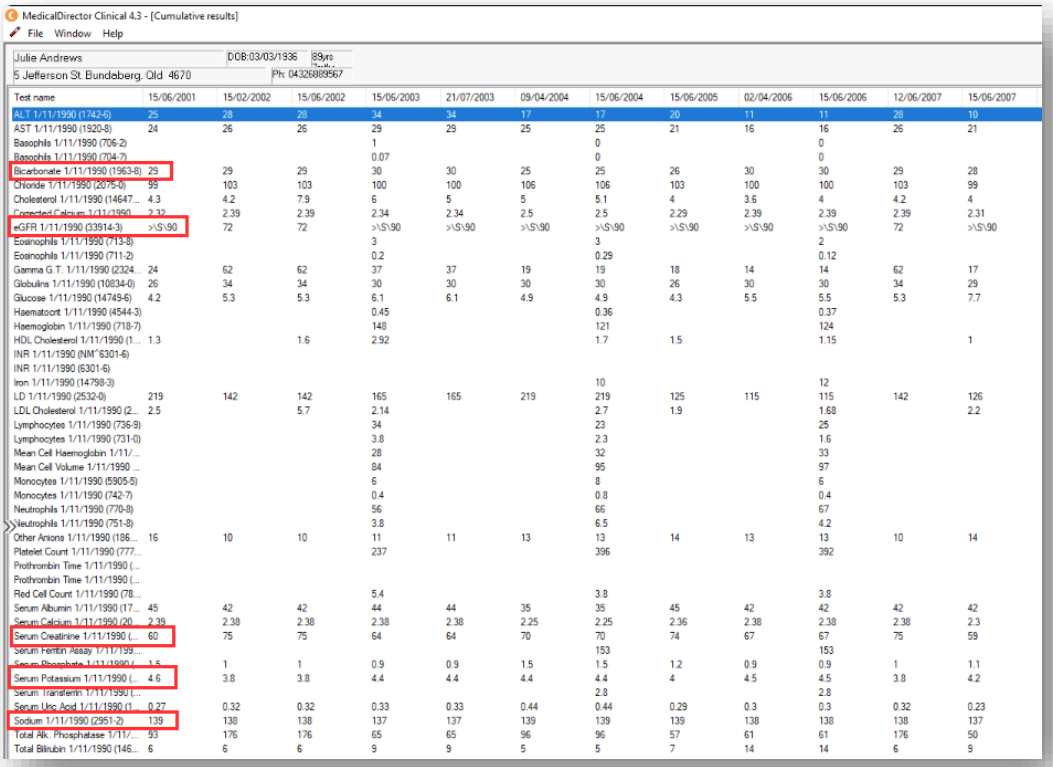


Example 3

An E/LFT panel study test is performed for a patient. In a traditional format the result will store and be viewable as a PDF with the results inset in the document. Below is a screenshot of a document type (PDF) result in Medical Director. The result types and values are inset in the document (right side of the screen).



In an **atomised format**, the result will render in a results value table where individual results such as Creatinine or eGFR can be referenced as a unique result for Primary Sense reports, prompts or medication safety alerts. Below is an example of the Cumulative Results (atomised results) Table in Medical Director.



MedicalDirector Clinical 4.3 - [Cumulative results]

File Window Help

Julie Andrews DOB:03/03/1936 89yrs

5 Jefferson St Bundaberg Qld 4670 Ph: 04326889567

Test name	15/06/2001	15/02/2002	15/06/2002	15/06/2003	21/07/2003	09/04/2004	15/06/2004	15/06/2005	02/04/2006	15/06/2006	12/06/2007	15/06/2007
ALT 1/11/1990 (1742-6)	25	28	28	34	34	17	17	20	11	11	28	10
AST 1/11/1990 (1920-8)	24	26	26	29	29	25	25	21	16	16	26	21
Basophils 1/11/1990 (706-2)				1			0			0		
Basophils 1/11/1990 (704-7)				0.07			0			0		
Bicarbonate 1/11/1990 (1963-8)	29	29	29	30	30	25	25	26	30	30	29	28
Chloride 1/11/1990 (2075-0)	99	103	103	100	100	106	106	103	100	100	103	99
Cholesterol 1/11/1990 (14647...	4.3	4.2	7.9	6	5	5	5.1	4	3.6	4	4.2	4
Corrected Calcium 1/11/1990 ...	2.32	2.39	2.39	2.34	2.34	2.5	2.5	2.29	2.39	2.39	2.39	2.31
eGFR 1/11/1990 (33914-3)	>\S\90	72	72	>\S\90	>\S\90	>\S\90	>\S\90	>\S\90	>\S\90	>\S\90	72	>\S\90
Eosinophils 1/11/1990 (713-8)				3			3			2		
Eosinophils 1/11/1990 (711-2)				0.2			0.29			0.12		
Gamma G.T. 1/11/1990 (2324...	24	62	62	37	37	19	19	18	14	14	62	17
Globulins 1/11/1990 (10834-0)	26	34	34	30	30	30	30	26	30	30	34	29
Glucose 1/11/1990 (14749-6)	4.2	5.3	5.3	6.1	6.1	4.9	4.9	4.3	5.5	5.5	5.3	7.7
Haematocrit 1/11/1990 (4544-3)				0.45			0.36			0.37		
Haemoglobin 1/11/1990 (718-7)				148			121			124		
HDL Cholesterol 1/11/1990 (1...	1.3		1.6	2.92			1.7	1.5		1.15		1
INR 1/11/1990 (NM^6301-6)												
INR 1/11/1990 (6301-6)												
Iron 1/11/1990 (14798-3)							10			12		
LD 1/11/1990 (2532-0)	219	142	142	165	165	219	219	125	115	115	142	126
LDL Cholesterol 1/11/1990 (2...	2.5		5.7	2.14			2.7	1.9		1.68		2.2
Lymphocytes 1/11/1990 (736-9)				34			23			25		
Lymphocytes 1/11/1990 (731-0)				3.8			2.3			1.6		
Mean Cell Haemoglobin 1/11/...				28			32			33		
Mean Cell Volume 1/11/1990 ...				84			95			97		
Monocytes 1/11/1990 (5905-5)				6			8			6		
Monocytes 1/11/1990 (742-7)				0.4			0.8			0.4		
Neutrophils 1/11/1990 (770-8)				56			66			67		
Neutrophils 1/11/1990 (751-8)				3.8			6.5			4.2		
Other Anions 1/11/1990 (186...	16	10	10	11	11	13	13	14	13	13	10	14
Platelet Count 1/11/1990 (777...				237			396			392		
Prothrombin Time 1/11/1990 (...												
Prothrombin Time 1/11/1990 (...												
Red Cell Count 1/11/1990 (78...				5.4			3.8			3.8		
Serum Albumin 1/11/1990 (17...	45	42	42	44	44	35	35	45	42	42	42	42
Serum Calcium 1/11/1990 (20...	2.39	2.38	2.38	2.38	2.38	2.25	2.25	2.36	2.38	2.38	2.38	2.3
Serum Creatinine 1/11/1990 (...	60	75	75	64	64	70	70	74	67	67	75	59
Serum Ferritin Assay 1/11/199...							153			153		
Serum Phosphate 1/11/1990 (...	1.5	1	1	0.9	0.9	1.5	1.5	1.2	0.9	0.9	1	1.1
Serum Potassium 1/11/1990 (...	4.6	3.8	3.8	4.4	4.4	4.4	4.4	4	4.5	4.5	3.8	4.2
Serum Transferrin 1/11/1990 (...							2.8			2.8		
Serum Uric Acid 1/11/1990 (1...	0.27	0.32	0.32	0.33	0.33	0.44	0.44	0.29	0.3	0.3	0.32	0.23
Sodium 1/11/1990 (2951-2)	139	138	138	137	137	139	139	139	138	138	138	137
Total Alk. Phosphatase 1/11/...	93	176	176	65	65	96	96	57	61	61	176	50
Total Bilirubin 1/11/1990 (146...	6	6	6	9	9	5	5	7	14	14	6	9

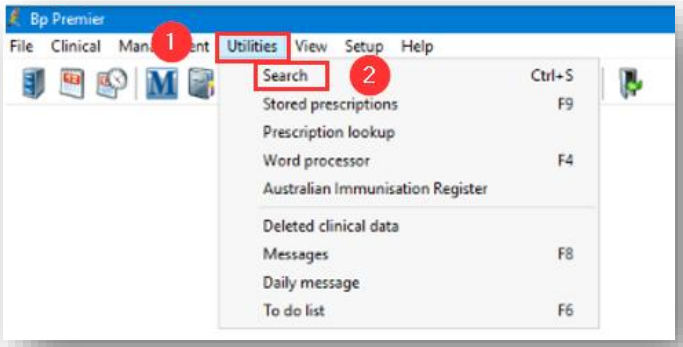
3.4.1. How to check that Best Practice is receiving atomised results

Follow the steps below to determine if atomised results are coming into your CIS correctly. If you complete the steps below and the dates and results in the table do not match the information on the pdf version of the test results, there may be an issue with your atomised results coming into your CIS.

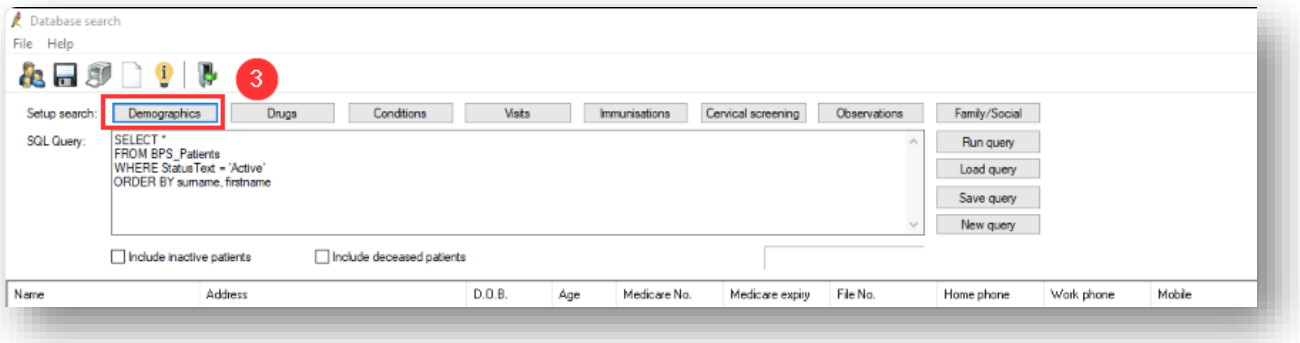
3.4.1.1. Finding a patient by Internal ID and not name

In Best Practice you can search on the patients ID (InternalID) via the search function. If specific patient testing is requested by Primary Sense an Internal ID will be provided. To find the patient using the Internal ID, do the following steps:

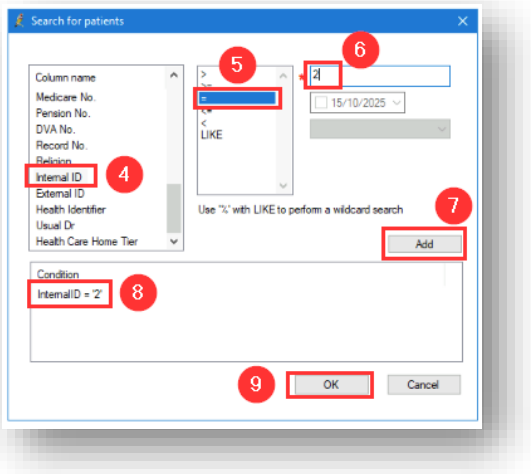
1. On the main menu bar select 'Utilities'.
2. Select 'Search'.



The SQL search screen will appear with a preset SQL Query statement.

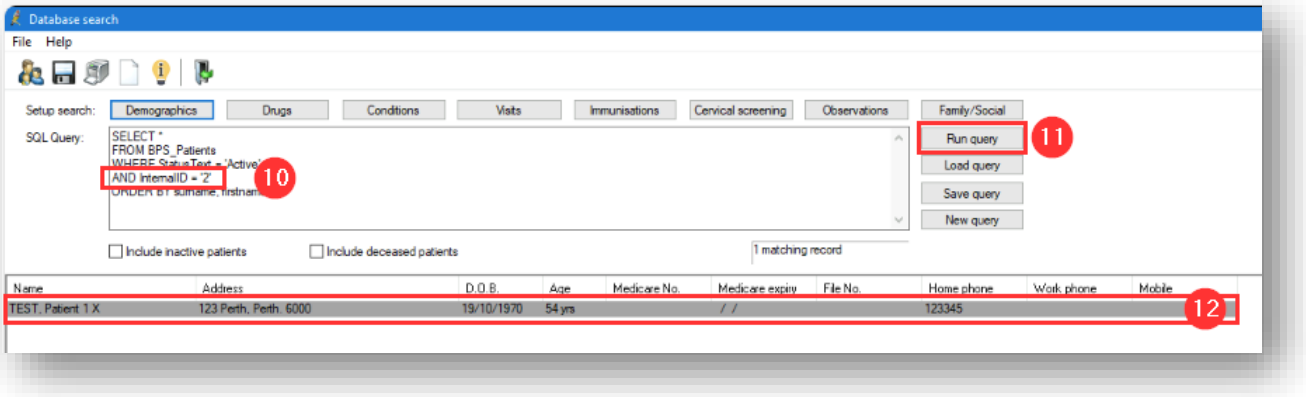


3. Click on the 'Demographics' button. A 'Search for patients' box will appear.



4. Scroll down the Column name and select Internal ID.
5. Select =
6. Enter the Internal ID provided by Primary Sense.
7. Click ‘Add’.
8. Verify that the statement is in the Condition box correctly.
9. Click ‘OK’.

The database search screen will update.

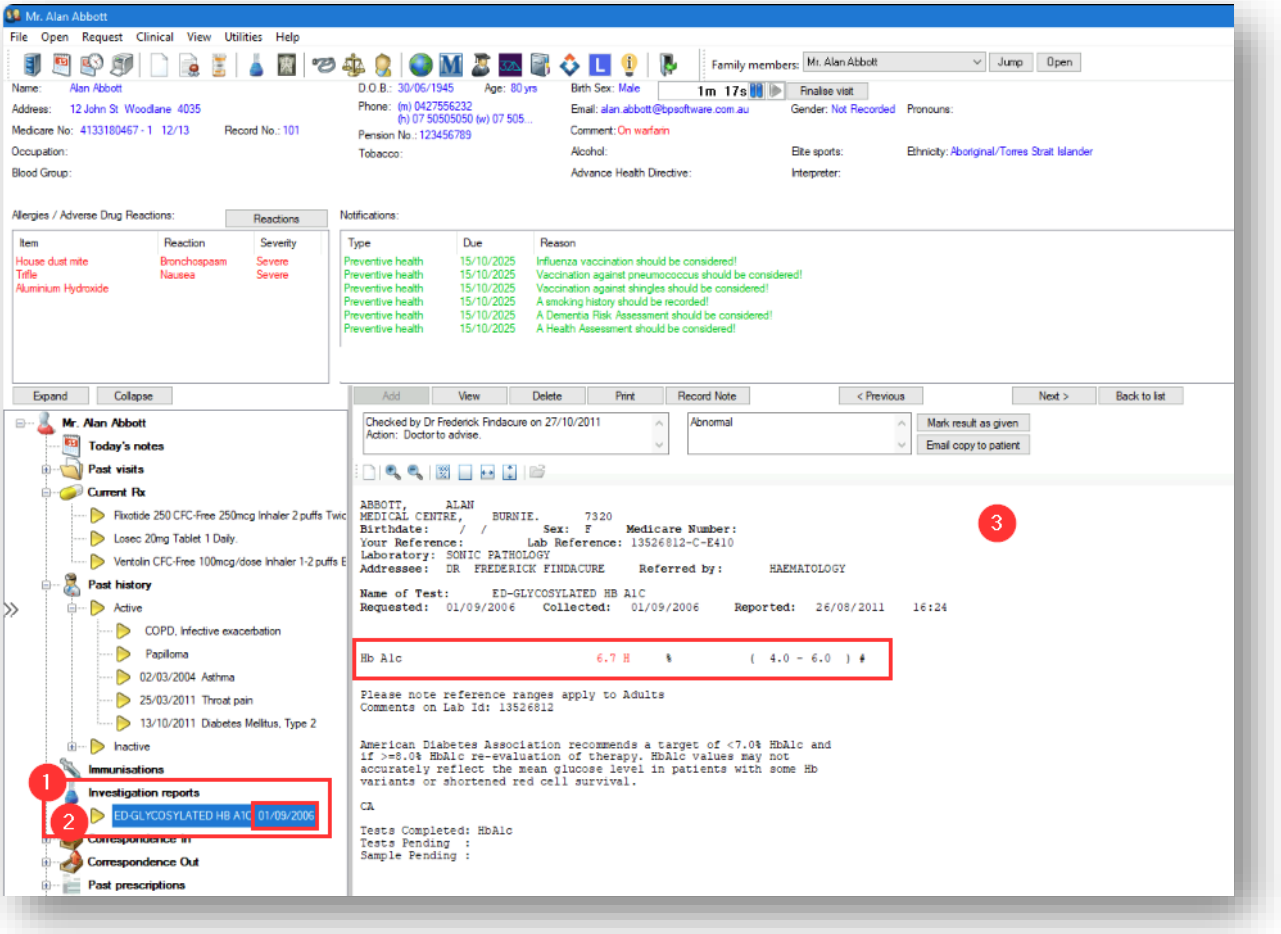


10. Confirm that the new line appears in the SQL query box.
11. Run query.
12. Double click on the patient returned in the results box to open the patient record.

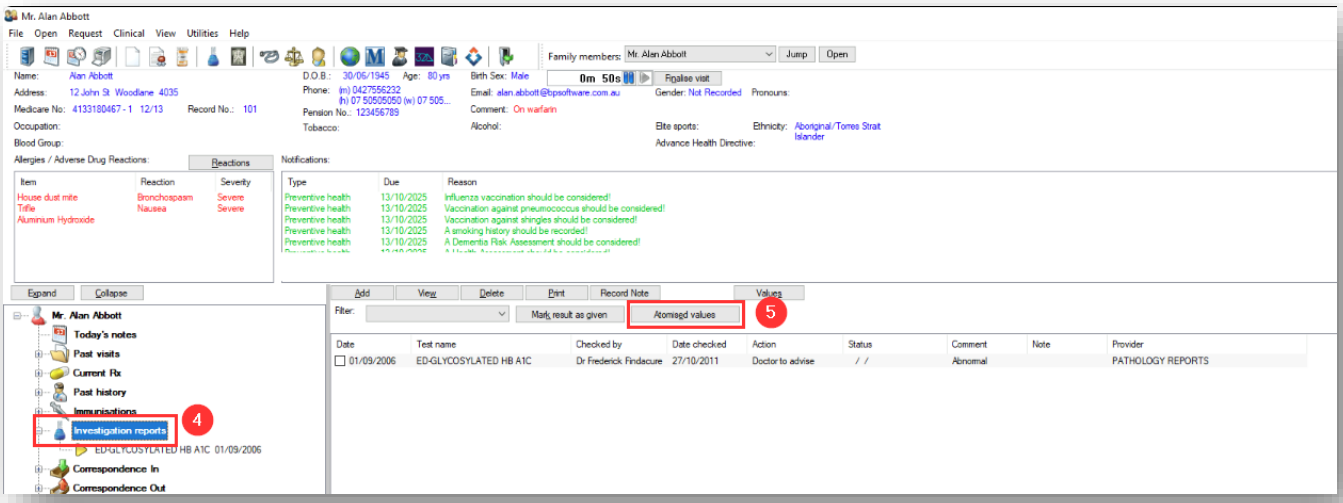
3.4.1.2. Checking Pathology Results

Open a patient record with pathology results

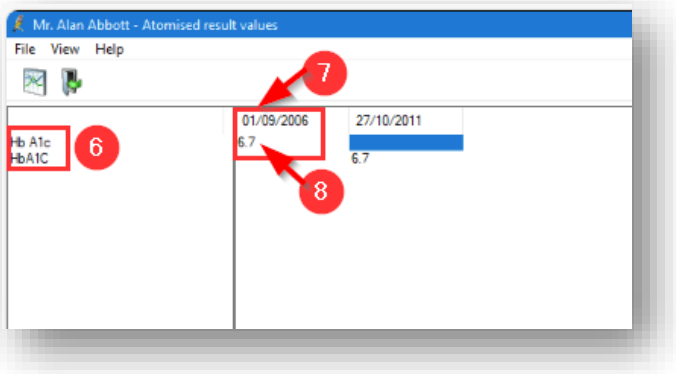
1. Open the '**Investigation Reports'** tab.
2. Select a recent test.
3. Open the result. You will see this screen below. Note down the date, test type and results shown in the pdf results page.



4. Return to the main 'Investigation reports' screen.
5. Click the 'Atomised values' button



The Atomised results table should appear.



6. Confirm the test result name.
7. Confirm that the date of the results exists in the atomised values.
8. Confirm that the results values display in the table correctly.

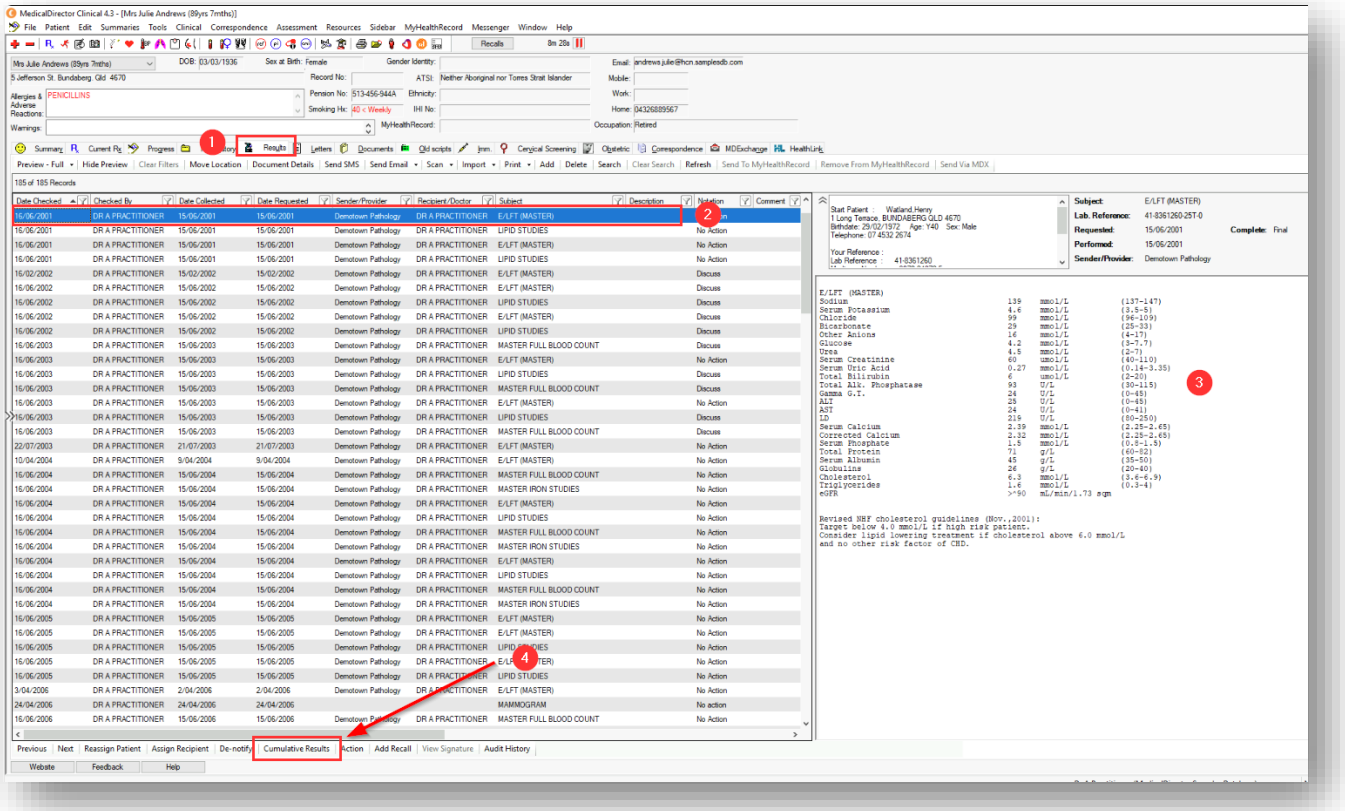
This screenshot above shows that the atomised results are being correctly stored and displayed in Best Practice.

3.4.2. How to check that Medical Director is receiving atomised results

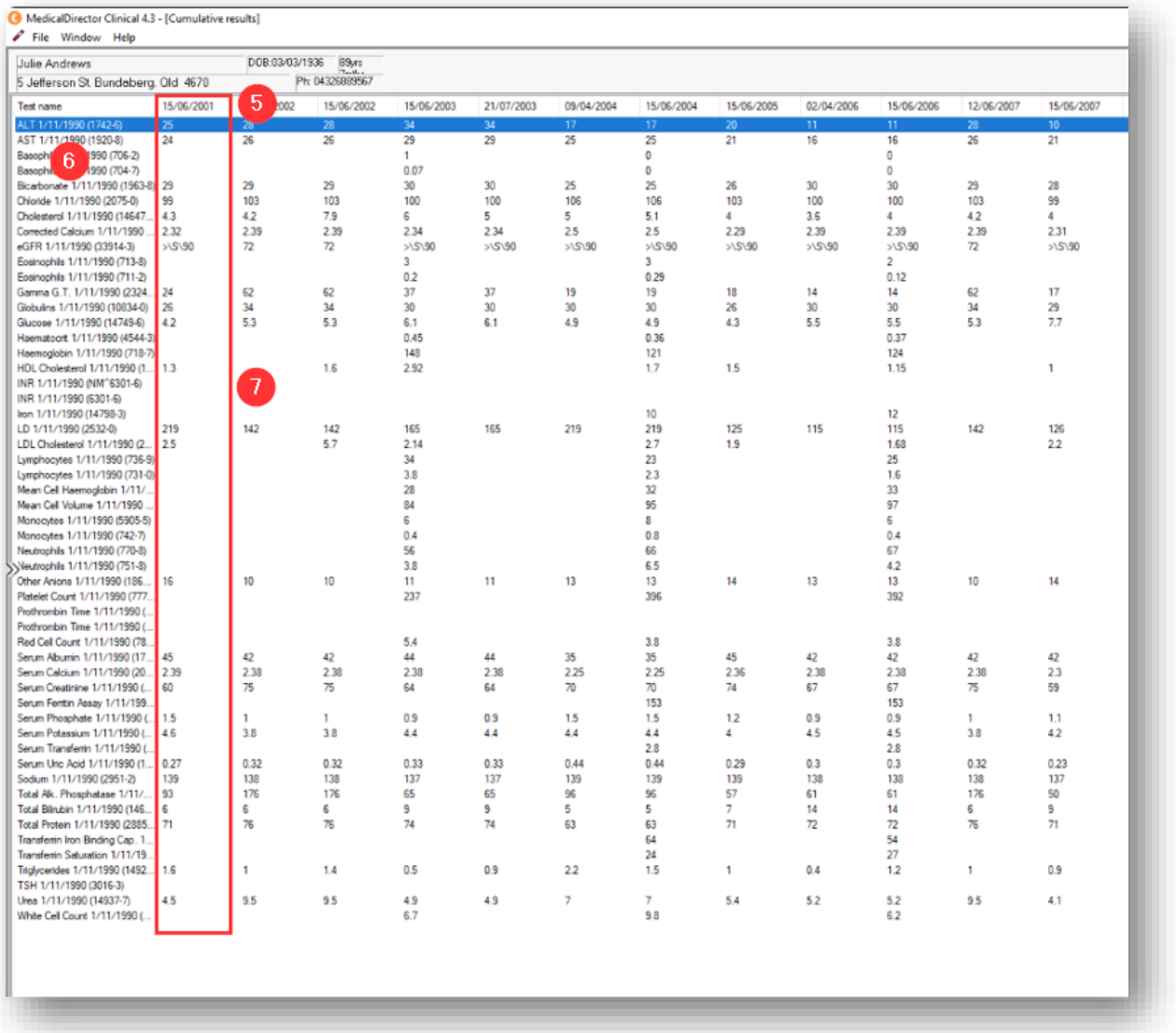
Follow the steps below to determine if atomised results are coming into your CIS correctly. If you complete the steps below and the dates and results in the table **do not** match the information on the pdf version of the test results, there may be an issue with your atomised results coming into your CIS.

Open a patient record with pathology results.

1. Open the results tab
2. Select a recent test
3. Note the date, results type and values in the pdf results page, shown on the right side of the screen
4. Select Cumulative Results at the bottom of the page



5. Confirm that the date of the results exists in the Cumulative Results.
6. Confirm the test result name.
7. Confirm that the results values display in the table correctly.



The above screenshot shows that the test results are stored and displayed correctly.

4. Patient Consent

4.1. Patient Consent Overview

1. If a patient opts out of data sharing, practices must disable data sharing options in their profile.
2. The 'Patients' tab enables practice staff to manage patient consent for data sharing within the Primary Sense Desktop. Should a patient opt out of data sharing, practice staff must disable the data sharing options within the Primary Sense Desktop accordingly. This task can be performed at any time by any practice staff member with access to the Primary Sense Desktop application.
3. Primary Sense patient data options include:
    - **Analyse Data** – enables PHNs to access data and report back only to the patient's practice on their risk factors. If this is turned off the patient would not appear in any reports and would not receive prompts or alerts.
    - **Link Data tool** – enables PHNs to link data from practices the patient attends and reports back to those practices only on their risk factors

Note: *This is automatically deactivated by your PHN unless the practice has specifically requested to connect to their own group of practices during the onboarding process.*

    - **Data for Planning** – PHN uses aggregated data from a patient's practice to inform education, research and better healthcare.
4. Practices may choose to link their data when they have multiple sites, and this is managed during the onboarding process when the practices are set up as a group.

4.2. Opting Out from the CIS

Best Practice:

The Opt Out flag from BP is honoured within Primary Sense. Practices on BP can still choose to opt out patients via the Primary Sense desktop app.

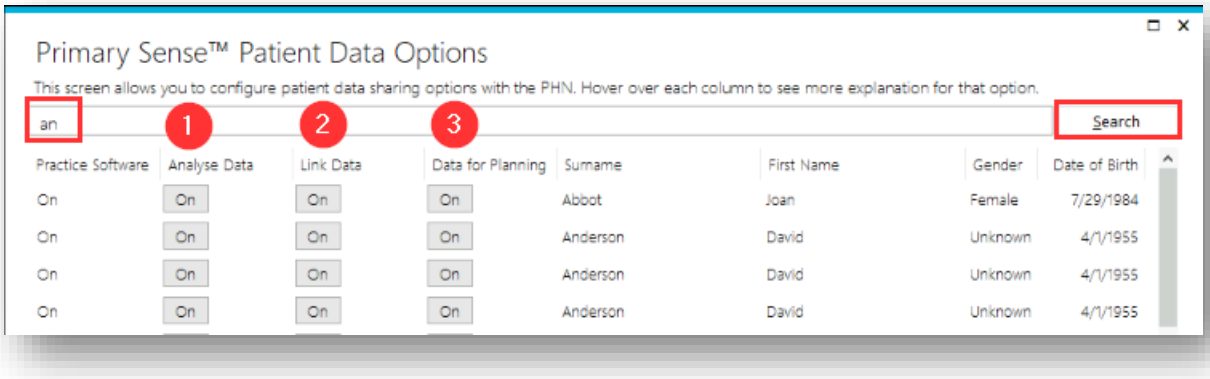
Medical Director:

Following vendor advice due to mixed use of the Opt Out flag in MD, all practices using MD must opt out patients via the Primary Sense desktop app.

4.3. How to turn off Patient Data

1. Access the Primary Sense Desktop by locating the Primary Sense icon on your desktop, or via the bottom toolbar:

2. This side bar appears when the icon is clicked. Select the 'Patients' tab:
3. Search for a patient's name by typing two letters (minimum) of their surname, and select 'search'



4. Select the patient and deactivate the data sharing option to which they do not wish to consent.

Data sharing options include:

1. **Analyse Data** – patient agrees to the local PHN accessing de-identified data to report back to the practice only on the patient's risk factors.
2. **Link Data tool** – patient agrees to link their data with additional practices they attend to inform healthcare

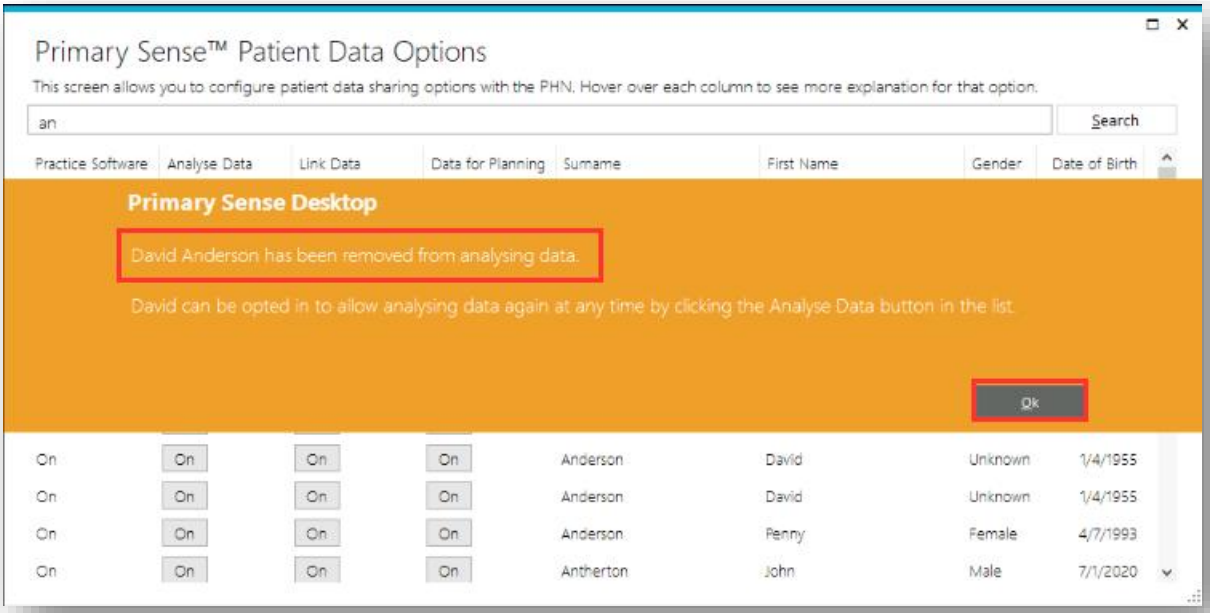
3. **Data for Planning** – patient agrees to share de-identified, aggregated data with the local PHN for population health planning, education and better healthcare

If the patient chooses to switch off "Analyse Data", then the other options disappear, and any data held is deleted that night and no further data is extracted. If opted out completely, the font of the patient's name turns red.

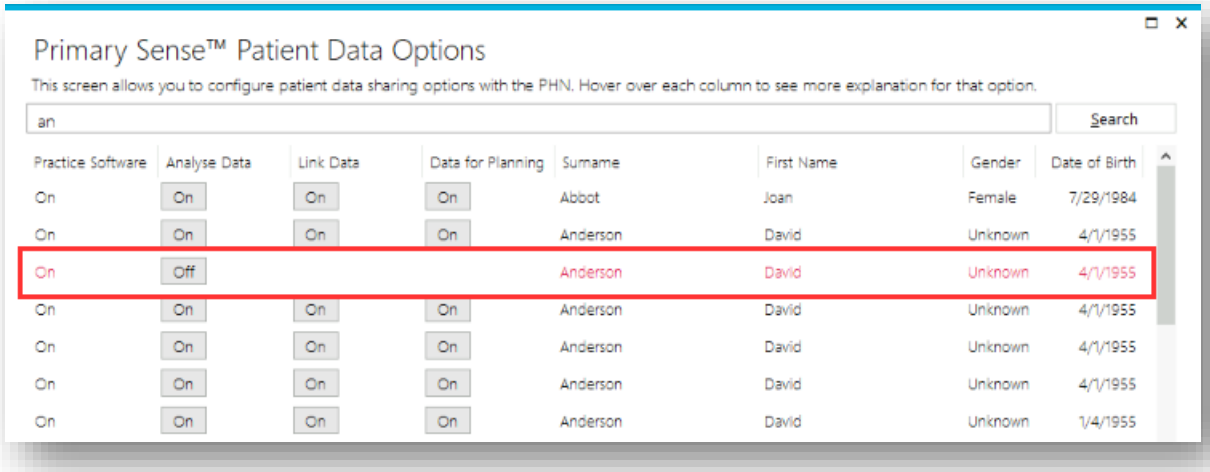
Example 1

Patient wishes to opt out of all data sharing.

***Action:** Turn OFF 'Analyse Data' and receive confirmation below:*



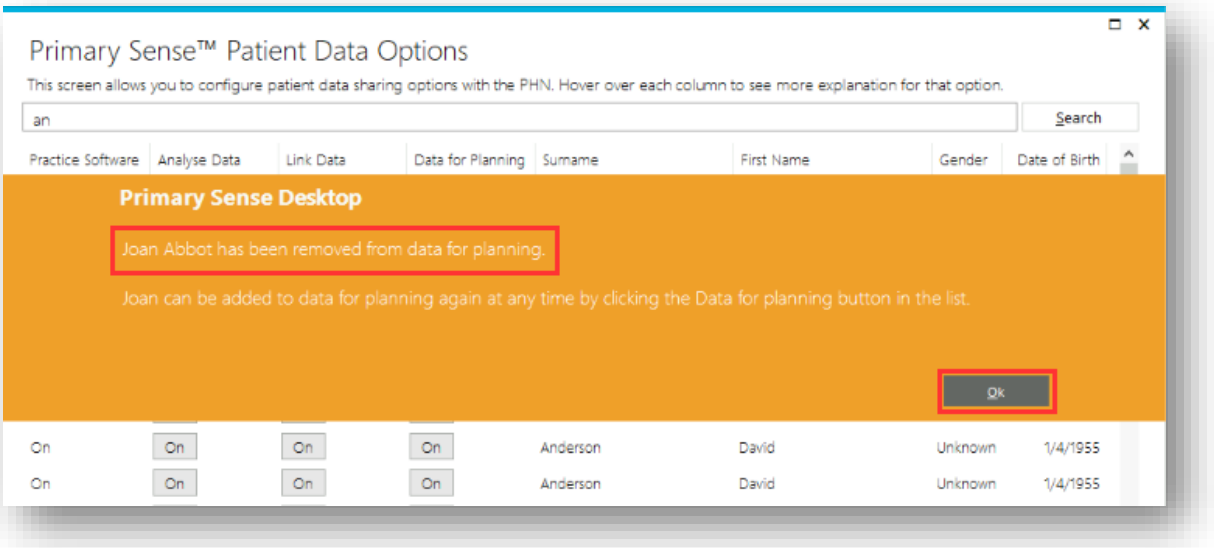
Result: *Analyse data is switched OFF, and options to Link data and Data for planning are unavailable by default (no data sharing).* Patient name turns red.



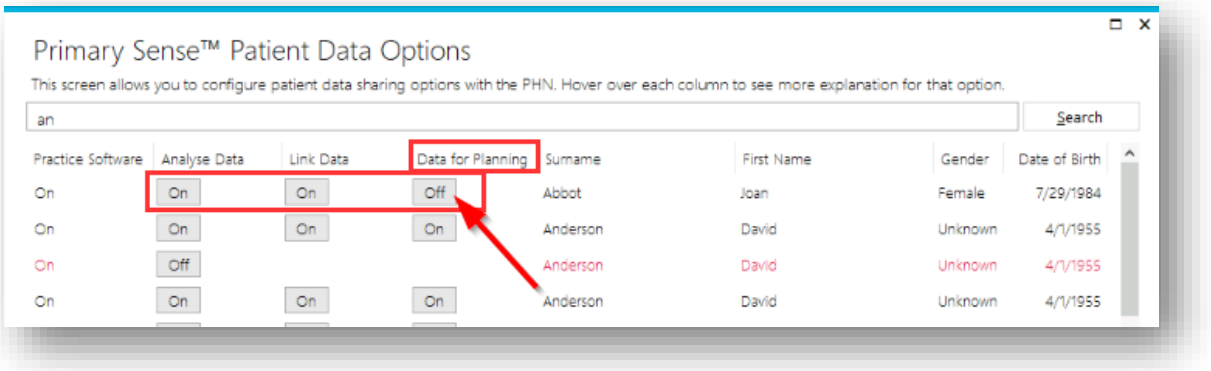
Example 2

Patient declines sharing data for use by the PHN for population health planning purposes but is happy for use data to inform their care by the practice via Reports, Prompts and Alerts in Primary Sense.

Action: *Turns OFF 'Data for planning' and receives confirmation below:*



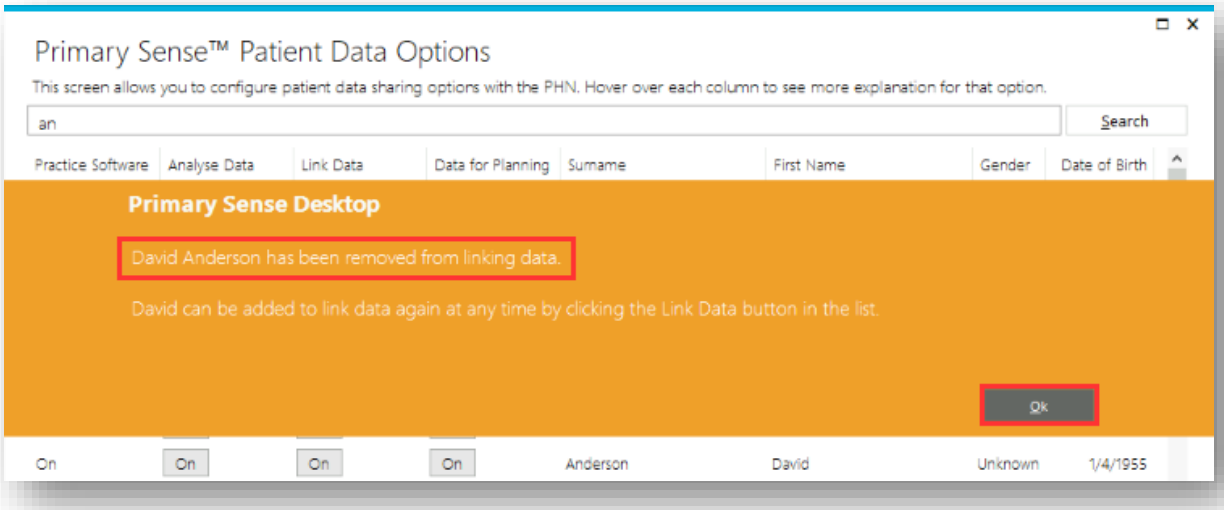
Result: *Data for planning is switched OFF, but Analyse data remains ON*



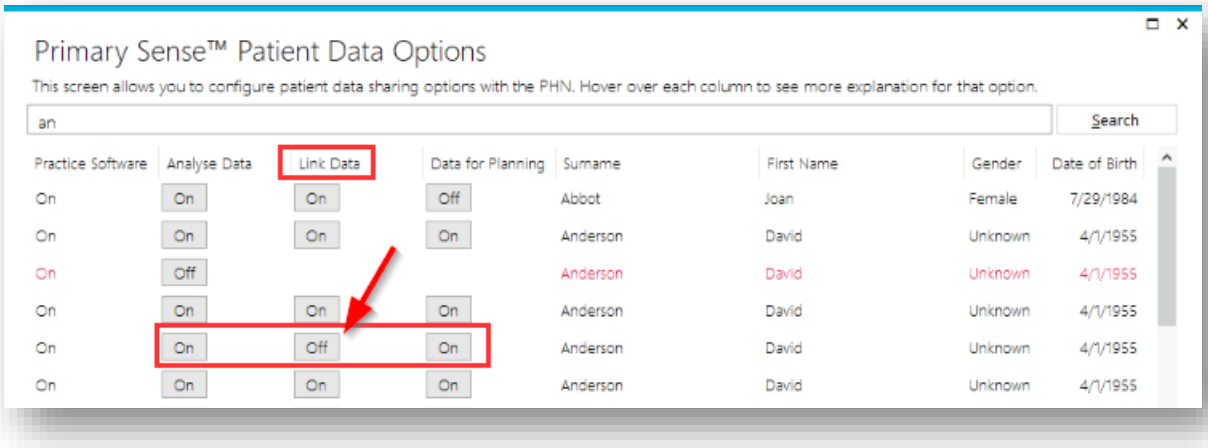
Example 3

*Patient declines to **'Link Data'** with additional practices*

Action: *Turn OFF 'Link data' and receives confirmation below:*



Result: *Link data is switched OFF, but Analyse data and Data for planning remains ON*



5. The Johns Hopkins University ACG® System.

- The Johns Hopkins University ACG® System. is a third-party application and while they guard their IP, they collaborate with us to refine and validate the tool for use in Australia.
- The Johns Hopkins University ACG® System runs when the patient's visit generates data for the ACG input file and once a month for the whole practice.

Primary Sense uses the data outputs from the ACG® System, which is backed by 30 years' experience ensuring a robust evidence base, utilising data to best inform risk identification from data such as morbidity, disease burden and medication profiles. It has been used in 20 different countries from general practices to hospital settings to better inform individual patient and population risk management. The robust data platform relies on relative morbidity burden and disease profiling to manage patient care in a more targeted way. In the UK it has been used in 1200 General Practices. The ACG® System categorises the practice population into six complexity bands[1] from no complexity to very high complexity due to multi-morbidities and disease types. Multi-morbidity is common and far more of a risk factor for poor outcomes than age or individual diseases and requires efficiently coordinated care. From the UK data it is estimated that the top 1 % of the highest risk patients utilise 18 % of health resources. The cost utilisation increases exponentially with number of co-morbidities.

[1] The Johns Hopkins University uses the term Resource Utilization Bands (RUBs). We have permission to refer to these as 'complexity bands' as this is language Australian GPs are more familiar with.

Data is imported into ACG® System when either a practice first onboards, or when there are subsequent visits by the patient. ACG® will also run once a month for the practice to enable some further use of its predictive scores. The ACG® takes some patient demographics; diagnosis recorded in the past 12 months as an ICPC2+ code, or long-term condition as an ICPC2+ code determined by University of Sydney; current medications; some pathology and PBS/MBS costs for the patient. The results are imported into the Primary Sense database.

5.1. Adjusted Clinical Groups (ACGs ®)

The first step of the ACG® grouping logic is to assign each diagnosis code to one or more of 32 diagnosis groups referred to as Aggregated Diagnosis Groups, or ADGs. Numbers in bold indicate high impact ADGs.

ADG	Duration	Severity
1. Time Limited: Minor	Acute	Low
2. Time Limited: Minor-Primary Infections	Acute	Low
3. Time Limited: Major	Acute	High
4. Time Limited: Major-Primary Infections	Acute	High
5. Allergies	Recurrent	Low
6. Asthma	Recurrent or Chronic	Low

7. Likely to Recur: Discrete	Recurrent	Low
8. Likely to Recur: Discrete- Infections	Recurrent	Low
9. Likely to Recur: Progressive	Recurrent	High
10. Chronic Medical: Stable	Chronic	Low
11. Chronic Medical: Unstable	Chronic	High
12. Chronic Specialty: Stable- Orthopedic	Chronic	Low
13. Chronic Specialty: Stable- Ear, Nose, Throat	Chronic	Low
14. Chronic Specialty: Stable-Ophthalmology	Chronic	Low
15. Chronic Specialty: Unstable-Orthopedics	Chronic	High
16. Chronic Specialty: Unstable-Ear, Nose, Throat	Chronic	High
17. Chronic Specialty: Unstable-Ophthalmology	Chronic	High
18. Dermatologic	Acute, Recurrent	Low to High
19. Injuries/Adverse Effects: Minor	Acute	Low
20. Injuries/Adverse Effects: Major	Acute	High
21. Psychosocial: Time Limited, Minor	Acute	Low
22. Psychosocial: Recurrent or Chronic, Stable	Recurrent or Chronic	Low
23. Psychosocial: Recurrent or Persistent, Unstable	Recurrent or Chronic	High
24. Signs/Symptoms: Minor	Uncertain	Low
25. Signs/Symptoms: Uncertain	Uncertain	Uncertain
26. Signs/Symptoms: Major	Uncertain	High
27. Discretionary	Acute	Low to High
28. See and Reassure	Acute	Low
29.Prevention/Administrative	N/A	N/A
30. Malignancy	Chronic	High

31. Pregnancy	Acute	Low
32. Dental	Acute, Recurrent, Chronic	Low to High

5.2. Complexity bands

ACGs are collapsed into resource utilization or complexity score bands:

The ACG® considers patient demographics and diagnoses recorded in the past 12 months as an ICPC2+ code, or long-term condition as an ICPC2+ code determined by the University of Sydney. Conditions and diagnoses are assessed for risk within the ACG tool.

ACG categories are designed to represent clinically logical categories for persons expected to require similar levels of healthcare resources (i.e. resource groups). For example, a pregnant woman with significant morbidity, an individual with a serious psychological condition, or someone with two chronic medical conditions may all be expected to use approximately the same level of resources.

ACG Bands are defined as:

- 0 - No or Only Invalid diagnosis
- 1 - Healthy Users
- 2 - Low
- 3 - Moderate
- 4 - High
- 5 - Very High

The results are imported into the Primary Sense database. **Anything added to the progress notes as text cannot be extracted or analysed;** therefore, it is important that practice staff use the drop-down selections in their clinical software.

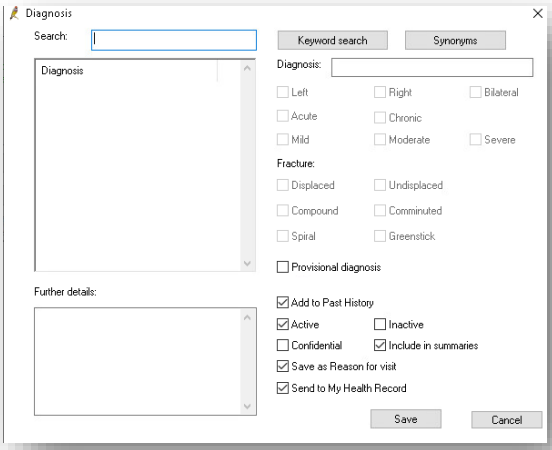
If the complexity of a patient is calculated from results that are more than 12 months old, the level will be displayed in brackets, e.g. (3), rather than 3 in reports and prompts.

5.2.1. Best Practice data referenced

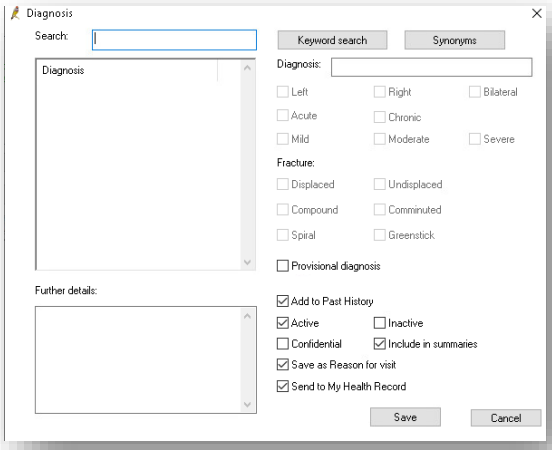
Demographics

- Age and sex

Diagnosis recorded



Long-term condition

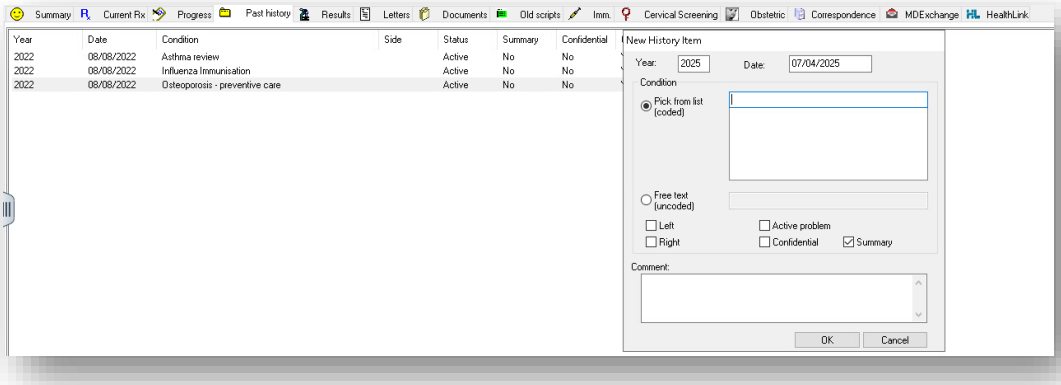


5.2.2. Medical Director data referenced

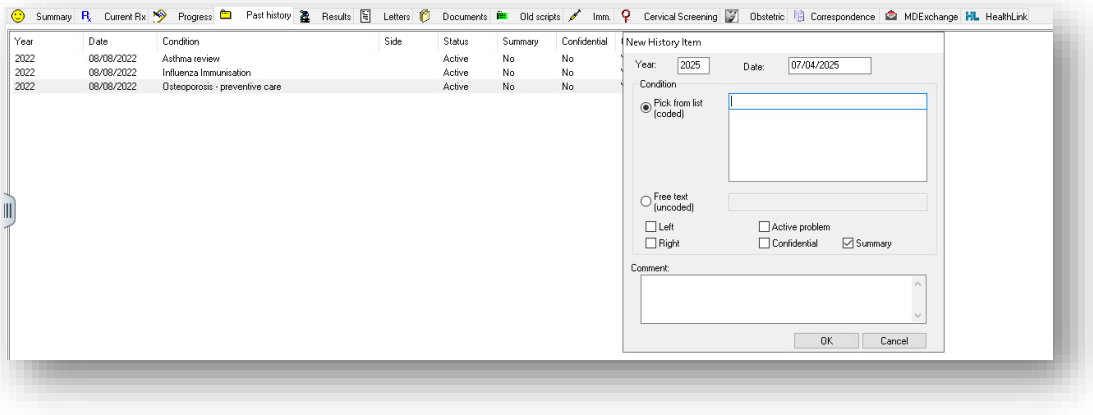
Demographics

- Age and sex

Diagnosis recorded



Long-term condition



The relationship between ACG categories, reference ACG concurrent risks and complexity scores are defined below:

ACG Description	0 to 64yrs	65yrs +	Complexity score
6-9 Other ADG Combinations, Age > 34, 3 Major ADGs	6.451	1.776	5
6-9 Other ADG Combinations, Age > 34, 4+ Major ADGs	12.218	3.015	5
10+ Other ADG Combinations, Age 1 to 17, 2 Major ADGs	12.171	N/A	5
10+ Other ADG Combinations, Age > 17, 3 Major ADGs	7.536	2.213	5
10+ Other ADG Combinations, Age > 17, 4+ Major ADGs	18.71	4.666	5
Infants: 0-5 ADGs, 1+ Major ADGs, low birth weight	10.955	N/A	5
Infants: 6+ ADGs, 1+ Major ADGs	10.538	N/A	5
Infants: 6+ ADGs, 1+ Major ADGs, low birth weight	31.997	N/A	5
Pregnancy: 0-1 ADGs, delivered	2.51	N/A	4
Pregnancy: 2-3 ADGs, no Major ADGs, delivered	2.888	N/A	4
Pregnancy: 2-3 ADGs, 1+ Major ADGs	2.572	N/A	4
Pregnancy: 2-3 ADGs, 1+ Major ADGs, delivered	3.195	N/A	4
Pregnancy: 4-5 ADGs, no Major ADGs	2.234	N/A	4
Pregnancy: 4-5 ADGs, no Major ADGs, delivered	3.197	N/A	4
Pregnancy: 4-5 ADGs, 1+ Major ADGs	2.938	N/A	4
Pregnancy: 4-5 ADGs, 1+ Major ADGs, delivered	3.722	N/A	4
Pregnancy: 6+ ADGs, no Major ADGs	2.553	N/A	4
Pregnancy: 6+ ADGs, no Major ADGs, delivered	3.636	N/A	4
Pregnancy: 6+ ADGs, 1+ Major ADGs	4.06	N/A	4

Pregnancy: 6+ ADGs, 1+ Major ADGs, delivered	5	N/A	4
Pregnancy: 6+ ADGs, 1+ Major ADGs, not delivered	2.897	N/A	4
4-5 Other ADG Combinations, Age 18 to 44, 2+ Major ADGs	2.307	N/A	4
4-5 Other ADG Combinations, Age > 44, 2+ Major ADGs	2.81	0.812	4
6-9 Other ADG Combinations, Age < 6, 1+ Major ADGs	1.831	N/A	4
6-9 Other ADG Combinations, Age 6 to 17, 1+ Major ADGs	2.234	N/A	4
6-9 Other ADG Combinations, Males, Age 18 to 34, 2+ Major ADGs	3.648	N/A	4
6-9 Other ADG Combinations, Females, Age 18 to 34, 2+ Major ADGs	3.332	N/A	4
6-9 Other ADG Combinations, Age > 34, 2 Major ADGs	3.616	1.088	4
10+ Other ADG Combinations, Age 1 to 17, 1 Major ADGs	3.188	N/A	4
10+ Other ADG Combinations, Age > 17, 0-1 Major ADGs	2.79	0.889	4
10+ Other ADG Combinations, Age > 17, 2 Major ADGs	4.572	1.422	4
Infants: 0-5 ADGs, no Major ADGs, low birth weight	2.745	N/A	4
Infants: 0-5 ADGs, 1+ Major ADGs	2.784	N/A	4
Infants: 0-5 ADGs, 1+ Major ADGs, normal birth weight	1.943	N/A	4
Infants: 6+ ADGs, no Major ADGs, low birth weight	3.999	N/A	4
Infants: 6+ ADGs, 1+ Major ADGs, normal birth weight	5.478	N/A	4

5.3. Expanded diagnosis clusters (EDCs)

EDCs are used to easily identify people with specific diseases or symptoms, or combinations. Each diagnosis code maps to one or more EDCs. Diagnosis codes within an EDC share similar clinical characteristics and are expected to evoke similar types of diagnostic and therapeutic responses. Where a single diagnosis code indicates more than one underlying condition, more than one EDC may be assigned. EDCs have many applications, particularly in areas of profiling and disease/case management. EDCs can be used to:

1. Describe the prevalence of specific diseases within a single population;
2. Compare disease distributions across two or more populations; and,
3. Aid disease management/case management processes by identifying individual patients by condition and displaying a patient condition profile.

Both EDCs and ADGs are aggregations of diagnosis codes. However, there is a significant difference in the methodology underlying the grouping of diagnosis codes: ADGs are groups of diagnoses with similar expected healthcare needs, while EDCs are clinically similar clusters.

EDC Type	EDC	EDC Description
Administrative	ADM02	Surgical aftercare
	ADM03	Transplant status

	ADM05	Administrative concerns and non-specific laboratory abnormalities
	ADM06	Preventive care
	ADM07	Medical Counselling/advice
	ADM08	Family Planning/Fertility
	ADM09	Social Services/Support
Allergy	ALL01	Allergic reactions
	ALL03	Allergic rhinitis
	ALL04	Asthma, w/o status asthmaticus
	ALL05	Asthma, with status asthmaticus
	ALL06	Disorders of the immune system
Cardiovascular	CAR01	Cardiovascular signs and symptoms
	CAR03	Ischemic heart disease (excluding acute myocardial infarction)
	CAR04	Congenital heart disease
	CAR05	Congestive heart failure
	CAR06	Cardiac valve disorders
	CAR07	Cardiomyopathy
	CAR08	Heart murmur
	CAR09	Cardiac arrhythmia
	CAR10	Generalized atherosclerosis
	CAR11	Disorders of lipid metabolism
	CAR12	Acute myocardial infarction
	CAR13	Cardiac arrest, shock
	CAR14	Hypertension, w/o major complications
	CAR15	Hypertension, with major complications
	CAR16	Cardiovascular disorders, other
Dental	DEN01	Disorders of mouth
	DEN02	Disorders of teeth
	DEN03	Gingivitis
	DEN04	Stomatitis
Ear, Nose, Throat	EAR01	Otitis media
	EAR02	Tinnitus
	EAR03	Temporomandibular joint disease
	EAR04	Foreign body in ears, nose, or throat
	EAR05	Deviated nasal septum
	EAR06	Otitis externa
	EAR07	Wax in ear
	EAR08	Deafness, hearing loss
	EAR09	Chronic pharyngitis and tonsillitis
	EAR10	Epistaxis
	EAR11	Acute upper respiratory tract infection
	EAR12	ENT disorders, other
Endocrine	END02	Osteoporosis
	END03	Short stature
	END04	Hypothyroidism

	END05	Other endocrine disorders
	END06	Type 2 diabetes, w/o complication
	END07	Type 2 diabetes, w/ complication
	END08	Type 1 diabetes, w/o complication
	END09	Type 1 diabetes, w/ complication
Eye	EYE01	Ophthalmic signs and symptoms
	EYE02	Blindness
	EYE03	Retinal disorders (excluding diabetic retinopathy)
	EYE04	Disorders of the eyelid and lacrimal duct
	EYE05	Refractive errors
	EYE06	Cataract, aphakia
	EYE07	Conjunctivitis, keratitis
	EYE08	Glaucoma
	EYE09	Infections of eyelid
	EYE10	Foreign body in eye
	EYE11	Strabismus, amblyopia
	EYE12	Traumatic injuries of eye
	EYE13	Diabetic retinopathy
	EYE14	Eye, other disorders
	EYE15	Age-related macular degeneration
Female Reproductive	FRE01	Pregnancy and delivery, uncomplicated
	FRE02	Female genital symptoms
	FRE03	Endometriosis
	FRE04	Pregnancy and delivery with complications
	FRE05	Female infertility
	FRE06	Abnormal pap smear
	FRE07	Ovarian cyst
	FRE08	Vaginitis, vulvitis, cervicitis
	FRE09	Menstrual disorders
	FRE10	Contraception
	FRE11	Menopausal symptoms
	FRE12	Utero-vaginal prolapse
	FRE13	Female gynecologic conditions, other
	FRE14	Pregnancy with termination
Gastrointestinal/Hepatic	GAS01	Gastrointestinal signs and symptoms
	GAS02	Inflammatory bowel disease
	GAS03	Constipation
	GAS04	Acute hepatitis
	GAS05	Chronic liver disease
	GAS06	Peptic ulcer disease
	GAS07	Gastroenteritis
	GAS08	Gastroesophageal reflux
	GAS09	Irritable bowel syndrome
	GAS10	Diverticular disease of colon
	GAS11	Acute pancreatitis
	GAS12	Chronic pancreatitis

	GAS13	Lactose intolerance
	GAS14	Gastrointestinal/hepatic disorders, other
	GAS15	Hepatitis C
General Signs & Symptoms	GSI01	Nonspecific signs and symptoms
	GSI02	Chest pain
	GSI03	Fever
	GSI04	Syncope
	GSI05	Nausea, vomiting
	GSI06	Debility and undue fatigue
	GSI07	Lymphadenopathy
	GSI08	Edema
General Surgery	GSU01	Anorectal conditions
	GSU02	Appendicitis
	GSU03	Benign and unspecified neoplasm
	GSU04	Cholelithiasis, cholecystitis
	GSU05	External abdominal hernias, hydroceles
	GSU06	Chronic cystic disease of the breast
	GSU07	Other breast disorders
	GSU08	Varicose veins of lower extremities
	GSU09	Nonfungal infections of skin and subcutaneous tissue
	GSU10	Abdominal pain
	GSU11	Peripheral vascular disease
	GSU12	Burns--1st degree
	GSU13	Aortic aneurysm
	GSU14	Gastrointestinal obstruction/perforation
	GSU15	Alimentary or excretory surgical openings
Genetic	GTC01	Chromosomal anomalies
	GTC02	Inherited metabolic disorders
Genito-urinary	GUR01	Vesicoureteral reflux
	GUR02	Undescended testes
	GUR03	Hypospadias, other penile anomalies
	GUR04	Prostatic hypertrophy
	GUR05	Stricture of urethra
	GUR06	Urinary symptoms
	GUR07	Other male genital disease
	GUR08	Urinary tract infections
	GUR09	Renal calculi
	GUR10	Prostatitis
	GUR11	Incontinence
	GUR12	Genito-urinary disorders, other
Hematologic	HEM01	Other hemolytic anemias
	HEM02	Iron deficiency, other deficiency anemias
	HEM03	Thrombophlebitis
	HEM04	Neonatal jaundice
	HEM05	Aplastic anemia
	HEM06	Deep vein thrombosis

	HEM07	Hemophilia, coagulation disorder
	HEM08	Hematologic disorders, other
	HEM09	Sickle cell disease
Infections	INF01	Tuberculosis infection
	INF02	Fungal infections
	INF03	Infectious mononucleosis
	INF04	HIV, AIDS
	INF05	Sexually transmitted diseases
	INF06	Viral syndromes
	INF07	Lyme disease
	INF08	Septicemia
	INF09	Infections, other
Malignancies	MAL01	Malignant neoplasms of the skin
	MAL02	Low impact malignant neoplasms
	MAL03	High impact malignant neoplasms
	MAL04	Malignant neoplasms, breast
	MAL05	Malignant neoplasms, cervix, uterus
	MAL06	Malignant neoplasms, ovary
	MAL07	Malignant neoplasms, esophagus
	MAL08	Malignant neoplasms, kidney
	MAL09	Malignant neoplasms, liver and biliary tract
	MAL10	Malignant neoplasms, lung
	MAL11	Malignant neoplasms, lymphomas
	MAL12	Malignant neoplasms, colorectal
	MAL13	Malignant neoplasms, pancreas
	MAL14	Malignant neoplasms, prostate
	MAL15	Malignant neoplasms, stomach
	MAL16	Acute leukemia
	MAL18	Malignant neoplasms, bladder
Musculoskeletal	MUS01	Musculoskeletal signs and symptoms
	MUS02	Acute sprains and strains
	MUS03	Degenerative joint disease
	MUS04	Fractures (excluding digits)
	MUS05	Torticollis
	MUS06	Kyphoscoliosis
	MUS07	Congenital hip dislocation
	MUS08	Fractures and dislocations/digits only
	MUS09	Joint disorders, trauma related
	MUS10	Fracture of neck of femur (hip)
	MUS11	Congenital anomalies of limbs, hands, and feet
	MUS12	Acquired foot deformities
	MUS13	Cervical pain syndromes
	MUS14	Low back pain
	MUS15	Bursitis, synovitis, tenosynovitis
	MUS16	Amputation status
	MUS17	Musculoskeletal disorders, other

Neonatal	NEW01	Newborn status, uncomplicated
	NEW02	Newborn status, complicated
	NEW03	Low birth weight
	NEW04	Prematurity
	NEW05	Disorders of newborn period
Neurologic	NUR01	Neurologic signs and symptoms
	NUR02	Headaches
	NUR03	Peripheral neuropathy, neuritis
	NUR04	Vertiginous syndromes
	NUR05	Cerebrovascular disease
	NUR06	Parkinsons disease
	NUR07	Seizure disorder
	NUR08	Multiple sclerosis
	NUR09	Muscular dystrophy
	NUR10	Sleep problems
	NUR12	Quadriplegia and paraplegia
	NUR15	Head injury
	NUR16	Spinal cord injury/disorders
	NUR17	Paralytic syndromes, other
	NUR18	Cerebral palsy
	NUR19	Developmental disorder
	NUR20	Central nervous system infections
	NUR21	Neurologic disorders, other
	NUR22	Migraines
	NUR23	Organic brain syndrome
	NUR24	Dementia
	NUR25	Delirium
	NUR26	Autism Spectrum Disorder
Nutrition	NUT01	Failure to thrive
	NUT02	Nutritional deficiencies
	NUT03	Obesity
	NUT04	Nutritional disorders, other
Psychosocial	PSY01	Anxiety, neuroses
	PSY02	Substance use
	PSY03	Tobacco use
	PSY05	Attention deficit disorder
	PSY06	Family and social problems
	PSY07	Schizophrenia and affective psychosis
	PSY08	Personality disorders
	PSY09	Depression
	PSY10	Psychologic signs and symptoms
	PSY12	Bipolar disorder
	PSY13	Adjustment disorder
	PSY14	Psychological disorders of childhood
	PSY15	Eating disorder
	PSY16	Impulse control

	PSY17	Psych-physiologic and somatoform disorders
	PSY18	Psychosexual
	PSY19	Sleep disorders of nonorganic origin
	PSY20	Major depression
	PSY21	Post traumatic stress disorder
Reconstructive	REC01	Cleft lip and palate
	REC02	Lacerations
	REC03	Chronic ulcer of the skin
	REC04	Burns--2nd and 3rd degree
Renal	REN01	Chronic renal failure
	REN02	Fluid/electrolyte disturbances
	REN03	Acute renal failure
	REN04	Nephritis, nephrosis
	REN05	Renal disorders, other
	REN06	ESRD
Respiratory	RES01	Respiratory signs and symptoms
	RES02	Acute lower respiratory tract infection
	RES03	Cystic fibrosis
	RES04	Emphysema, chronic bronchitis, COPD
	RES05	Cough
	RES06	Sleep apnea
	RES07	Sinusitis
	RES08	Pulmonary embolism
	RES09	Tracheostomy
	RES11	Respiratory disorders, other
	RES12	Acute respiratory failure
	RES13	Chronic respiratory failure
	RES14	Aspiration and bacterial pneumonias
Rheumatologic	RHU01	Autoimmune and connective tissue diseases
	RHU02	Gout
	RHU03	Arthropathy
	RHU04	Raynauds syndrome
	RHU05	Rheumatoid arthritis
Skin	SKN01	Contusions and abrasions
	SKN02	Dermatitis and eczema
	SKN03	Keloid
	SKN04	Acne
	SKN05	Disorders of sebaceous glands
	SKN06	Sebaceous cyst
	SKN07	Viral warts and molluscum contagiosum
	SKN08	Other inflammatory conditions of skin
	SKN09	Exanthems
	SKN10	Skin keratoses
	SKN11	Dermatophytoses
	SKN12	Psoriasis
	SKN13	Disease of hair and hair follicles

	SKN14	Pigmented nevus
	SKN15	Scabies and pediculosis
	SKN16	Diseases of nail
	SKN17	Other skin disorders
	SKN18	Benign neoplasm of skin and subcutaneous tissues
	SKN19	Impetigo
	SKN20	Dermatologic signs and symptoms
Toxic Effects and Adverse Events	TOX01	Toxic effects of nonmedicinal agents
	TOX02	Adverse effects of medicinal agents
	TOX03	Adverse events from medical/surgical procedures
	TOX04	Complications of mechanical devices

5.4. Hospital risk score

As not all hospital discharge summaries are received in the GP software, nor can the software distinguish between a planned and unplanned admission, Primary Sense uses the secondary criterion used by ACG for making predictions about hospitalisation relating to the age of a person. Persons older than 65 yrs are thought to have an increased likelihood of hospitalisation compared to younger individuals. The ACG System uses age 55 as the threshold for separating two hospitalisation risk groups. The hospitalisation prediction model differs from the Hospital Dominant Morbidity Types marker.

Hospital Dominant Morbidity Types represent a small subset of diagnoses associated with high rates of admission in the following 12 months. The hospital prediction model identifies a larger pool of patients at risk for hospitalisation. Given Closing the Gap, Johns Hopkins University ACG® System have been validating the hospital risk score for the Australian context.

There are five predictive model outputs related to the likelihood of hospitalisation. These models are intended to be used for the indicated outcome. A value of providing multiple model outputs is greater sensitivity of each model calibrated to a particular outcome, as compared to using a single model.

The model uses standard coefficient weights derived from the selected reference population. These weights are then applied to each patient based on the specific risk factors identified by the ACG System. The weights are additive at the patient level as in the following example.

Because this model is based on a logistic regression technique, the final probability is determined with a transformation of the sum of weights.

Predictive Modeling Factors for Patient with Prior Hospitalization		
Demographic	Age: 60	-11.798
	Gender: F	-0.006
Diagnosis-based Markers	2 Hospital Dominant Morbidity Types	0.266
	ACG 5060 – 10+ ADGs, 3 Major	0.340
	END09 - Type 1 Diabetes w/Complications	0.256
	CAR14 - Hypertension w/o Complications	0.092
Pharmacy-based Markers	CARx030- High Blood Pressure	-0.004
	INFx010 – Infections/Acute Major	0.046
Cost Percentile Markers	Total Cost 51-75th Percentile	9.300
Probability of Hospitalization = $\frac{1}{1+e^{-1*sum\ of\ coefficients}}$		0.181

Probability scores indicating the likelihood of a future hospitalisation event are generated as a percentage. The probability of an inpatient hospitalisation score is the probability score for an acute care inpatient hospital admission excluding admissions for childbirth or injury within the 12 months subsequent to the observation period. Primary Sense presents a hospitalisation risk score of >80% in reports and prompts.

5.5. Conditions coded and/or indicated by medication

The ACG System uses condition markers to highlight specific conditions that are high prevalence chronic conditions, commonly selected for disease management or warranting ongoing medication therapy.

- **Diagnosis -** the condition was identified only from diagnosis information, by one or more EDCs.
- **Medication -** the condition was identified only from pharmacy information
- **Both -** the condition was identified by both diagnosis and pharmacy criteria

The ACG System measures adherence for 17 conditions where the chronic administration of medication is, in most instances, appropriate.

Each targeted condition is associated with one or more target drug classes identified by the Johns Hopkins clinician advisors as a subset of drugs that once started, should be given continuously. The resultant condition-drug class pairings are presented in the Condition-Drug Class Pairings table.

Condition	Medications used to indicate the condition	
Bipolar Disorder	Anti-convulsants	Anti-psychotics
Congestive Heart Failure	ACEI/ARB	Diuretics
	Aldosterone receptor blockers	Inotropic agents
	Beta-blockers	Vasodilators
Depression	Anti-depressants	

Diabetes	Insulins	Other Anti-Hyperglycemic Agents
	Meglitinides	Sulfonylureas
	Miscellaneous antidiabetic agents	Thiazolidinediones
	Non-Sulfonylureas	
Disorders of Lipid Metabolism	Bile acid sequestrants	HMG-CoA reductase inhibitors
	Cholesterol absorption inhibitors	Miscellaneous antihyperlipidemic agents
	Fibric acid derivatives	
Glaucoma	Ophthalmic glaucoma agents	
Human Immunodeficiency Virus	HAART* (see below)	
Hypertension	ACEI/ARB	Calcium channel blockers
	Aldosterone receptor blockers	Diuretics
	Anti-adrenergic agents	Vasodilators
	Beta-blockers	
Hypothyroidism	Thyroid drugs	
Immunosuppression/Transplant	Immunologic agents	
Ischemic Heart Disease	Antianginal agents	Calcium channel blockers
	Beta-blockers	
Osteoporosis	Hormones	
Parkinson's Disease	Anticholinergic antiparkinson agents	Dopaminergic antiparkinsonism agents
Persistent Asthma	Adrenergic bronchodilators	Leukotriene modifiers
	Immunosuppressive monoclonal antibodies	Mast cell stabilizers
	Inhaled corticosteroids	Methylxanthines
Rheumatoid Arthritis	Disease-modifying anti-rheumatic drugs (DMARDs)	Immunologic agents
Schizophrenia	Anti-psychotics	

Seizure Disorder	Anti-convulsants

Please note low back pain, ischemic heart disease, bipolar and schizophrenia do not have medication markers that are sufficient to indicate the medication is specifically being used for that condition. Primary Sense adds in the following medication markers for COPD and chronic renal failure.

COPD	LAMA – Long-Acting Muscarinic Antagonist LABA – Long-Acting Beta-2 Agonist
Chronic Renal Failure	Sodium Bicarbonate, Anti-anaemics

5.6. Chronic condition count

The ACG System includes a chronic condition count as an aggregate marker of case complexity. Under the ACG scoring system, a chronic condition is an alteration in the structures or functions of the body that is likely to last longer than twelve months and is likely to have a negative impact on health or functional status.

The ACG System defines a limited set of Expanded Diagnosis Clusters (EDCs) that represent high impact and chronic conditions likely to last more than 12 months with or without medical treatment (see the following table). From this list of EDCs, individual diagnosis codes were tested against the criteria for chronic conditions stated above by Johns Hopkins.

EDCs considered in the Chronic Condition Count Marker	
Acute hepatitis	Hypertension, w/o major complications
Acute leukemia	Hypertension, with major complications
Acute lower respiratory tract infection	Hypothyroidism
Acute myocardial infarction	Impulse control
Acute renal failure	Inflammatory bowel disease
Acute sprains and strains	Inherited metabolic disorders
Adjustment disorder	Irritable bowel syndrome
Administrative concerns and non-specific laboratory abnormalities	Ischemic heart disease (excluding acute myocardial infarction)
Adverse events from medical/surgical procedures	Kyphoscoliosis
Age-related macular degeneration	Lactose intolerance
Anxiety, neuroses	Low back pain
Aplastic anemia	Low impact malignant neoplasms
Arthropathy	Malignant neoplasms of the skin
Asthma, w/o status asthmaticus	Malignant neoplasms, bladder

Asthma, with status asthmaticus	Malignant neoplasms, breast
Attention deficit disorder	Malignant neoplasms, cervix, uterus
Autism Spectrum Disorder	Malignant neoplasms, colorectal
Autoimmune and connective tissue diseases	Malignant neoplasms, esophagus
Benign and unspecified neoplasm	Malignant neoplasms, kidney
Bipolar disorder	Malignant neoplasms, liver and biliary tract
Blindness	Malignant neoplasms, lung
Cardiac arrhythmia	Malignant neoplasms, lymphomas
Cardiac valve disorders	Malignant neoplasms, ovary
Cardiomyopathy	Malignant neoplasms, pancreas
Cardiovascular disorders, other	Malignant neoplasms, prostate
Cardiovascular signs and symptoms	Malignant neoplasms, stomach
Cataract, aphakia	Migraines
Central nervous system infections	Multiple sclerosis
Cerebral palsy	Muscular dystrophy
Cerebrovascular disease	Musculoskeletal disorders, other
Chromosomal anomalies	Nephritis, nephrosis
Chronic cystic disease of the breast	Neurologic disorders, other
Chronic liver disease	Neurologic signs and symptoms
Chronic pancreatitis	Newborn Status, Complicated
Chronic renal failure	Obesity
Chronic respiratory failure	Organic brain syndrome
Chronic ulcer of the skin	Osteoporosis
Cleft lip and palate	Other endocrine disorders
Congenital anomalies of limbs, hands, and feet	Other hemolytic anemias
Congenital heart disease	Other skin disorders
Congestive heart failure	Paralytic syndromes, other
Cystic fibrosis	Parkinson's disease
Deafness, hearing loss	Peripheral neuropathy, neuritis
Deep vein thrombosis	Peripheral vascular disease
Degenerative joint disease	Personality disorders
Delirium	Prostatic hypertrophy
Dementia	Psychological disorders of childhood

Depression	Psychosexual
Developmental disorder	Psych-physiologic and somatoform disorders
Diabetic retinopathy	Pulmonary embolism
Disorders of lipid metabolism	Quadriplegia and paraplegia
Disorders of Newborn Period	Renal disorders, other
Disorders of the immune system	Respiratory disorders, other
Eating disorder	Retinal disorders (excluding diabetic retinopathy)
Emphysema, chronic bronchitis, COPD	Rheumatoid arthritis
Endometriosis	Schizophrenia and affective psychosis
ESRD	Seizure disorder
Eye, other disorders	Short stature
Failure to thrive	Sickle cell disease
Fluid/electrolyte disturbances	Skin keratoses
Gastrointestinal signs and symptoms	Sleep apnea
Gastrointestinal/Hepatic disorders, other	Spinal cord injury/disorders
Generalized atherosclerosis	Strabismus, amblyopia
Genito-urinary disorders, other	Substance use
Glaucoma	Thrombophlebitis
Gout	Tracheostomy
Hematologic disorders, other	Transplant status
Hemophilia, coagulation disorder	Type 1 diabetes
High impact malignant neoplasms	Type 2 diabetes
HIV, AIDS	Vesicoureteral reflux

5.7. Active ingredient count

An active ingredient count is calculated as the count of unique active ingredient/route of administration combinations encountered in the patient's prescriptions. This marker is a proxy for identifying poly-pharmacy patients, with an active ingredient count of 14 or greater get additional weight in the predictive models.

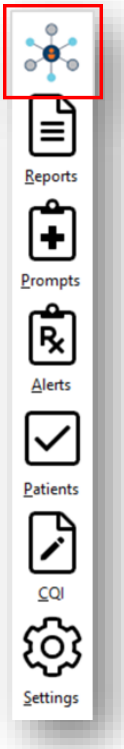
6. Desktop Functionality

6.1. Desktop Overview

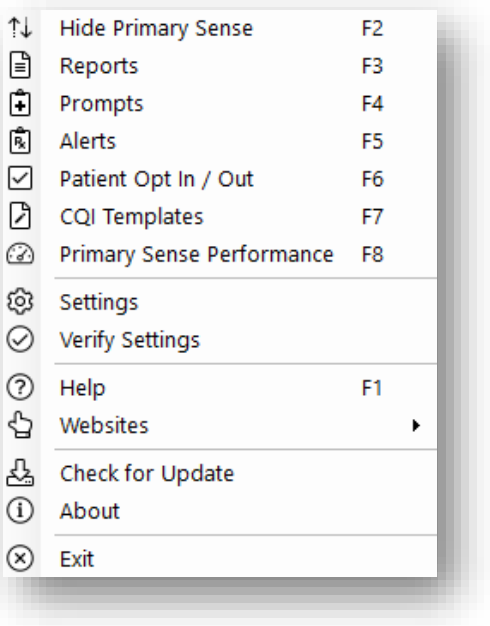
Primary Sense is an easy-to-use population health management, clinical decision support and data extraction tool that helps general practices deliver the right care to patients at the right time.

The Desktop Application is accessed via the Primary Sense icon on your desktop, or via the bottom toolbar.

This side bar appears when the icon is clicked:



By right clicking anywhere on the interface - all options are visible (below). Some options take you to the Primary Sense website.



6.2. MBS items in reports and prompts

For reference:

GPMP	721, 229,92024,92068,965,392,92029,92060
GPMP review	732, 233,92028,92072,967,393,92030,92060
MH CP	2700, 2701, 2715, 2717, 272, 276, 277, 281, 282, 92116, 92128, 92117, 92129, 92112, 92124, 92113, 92125
MH CP review	2712, 277, 92114, 92126
Health Assessments	699, 177, 701, 703, 705, 707, 715, 224, 225, 226, 227, 228, 92004, 92011,92016,92023 If these MBS codes are not recorded then Health Assessment Visit Reason ICPC Codes IDs 44811 (K43007), 44812 (K43007), 44741 (K43007), 45109 (K43007), 45110 (K43007), 631 (A30028), 34749 (A30028) are referenced instead for Assessment Date.
Nursing Home MBS	731, 90001, 90020, 90035, 90043, 90051, 90092, 90093, 90095, 90096, 90183, 90188, 90202, 90212, 92026, 92070, 92027, 92071
DMR (medication review)	900, 245, 903, 249
Nurse review	10997, 10987
Spirometry	11505,11506

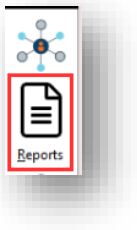
Note: Changes in MBS items commenced on 1st July 2025 have been incorporated.

7. Primary Sense Reports

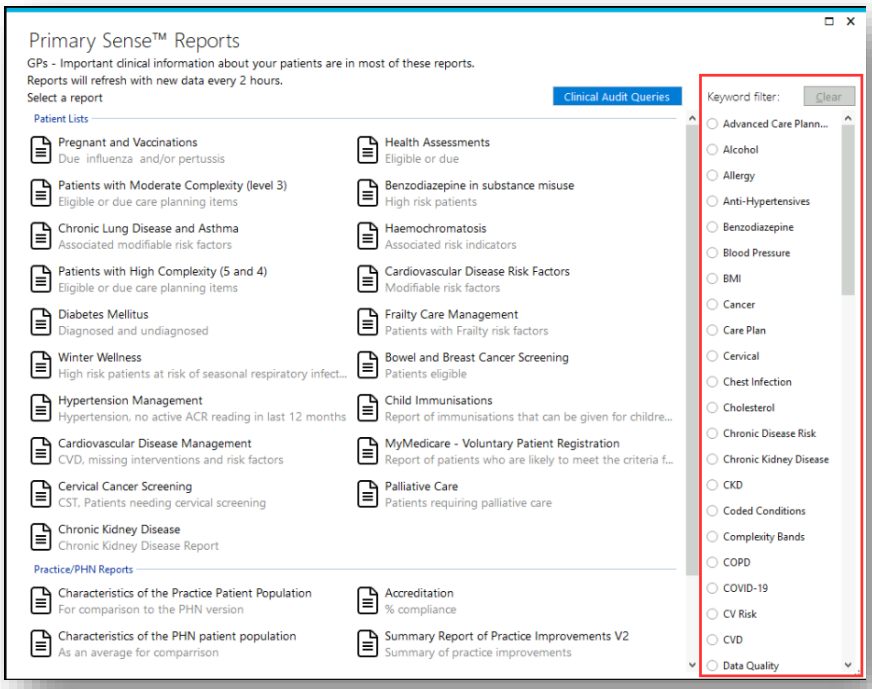
7.1. Reports Overview

Primary Sense Reports are accessible to all practice staff with access to a Primary Sense Desktop Application. For data security and privacy purposes, the reports can *only* be viewed in the practice using the Primary Sense Desktop.

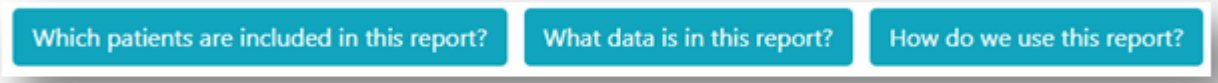
Reports are accessed by selecting the Reports tab from the Desktop Menu and double clicking on the report of choice.



- To search for a specific topic in a report use the 'Keyword Filter'



- The tabs at the top of the page can be clicked to bring up relevant information.

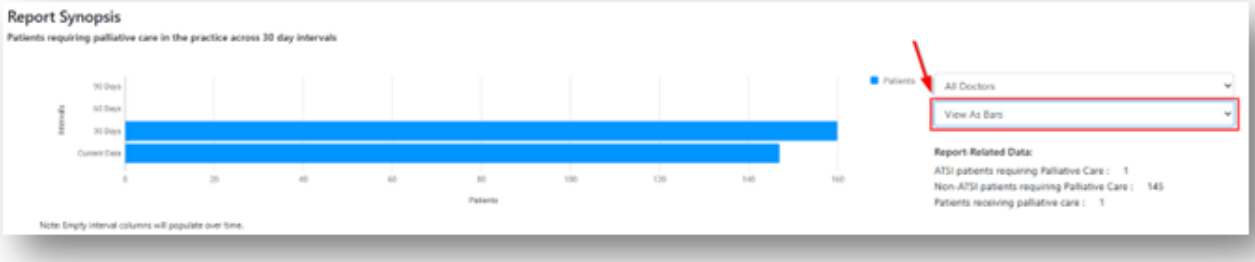


- The results can be filtered by clicking on each column. Clicking on columns will rearrange the results alphabetically, chronologically or from high to low or low to high.
- The 'Search' function can help you find specific content.

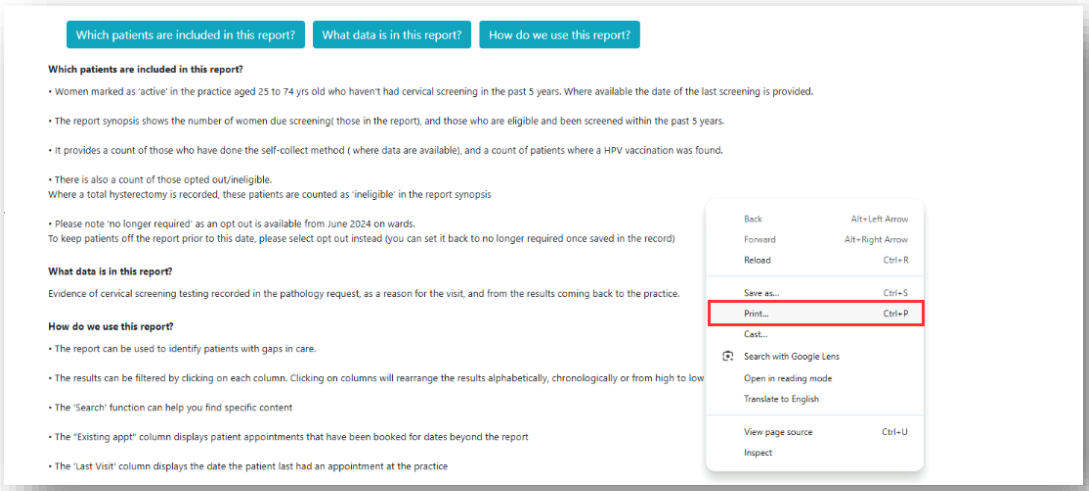
Try searching by today's date to create a list of patients visiting, a month or year e.g. '08' or '2023' to find a last visit dates in a particular range, or by 'GP Name' to bring up patients with a specific regular GP.

- Patients can be removed from the report for 12 months, by clicking 'Remove.' This action cannot be reversed and removes that patient from this report for all clinicians.
- Arrows at the top of each column can be used to reverse the ordering.

- Results can be filtered to a specific GP who has most accessed the patient record.
- Synopsis can be viewed as columns or bars.



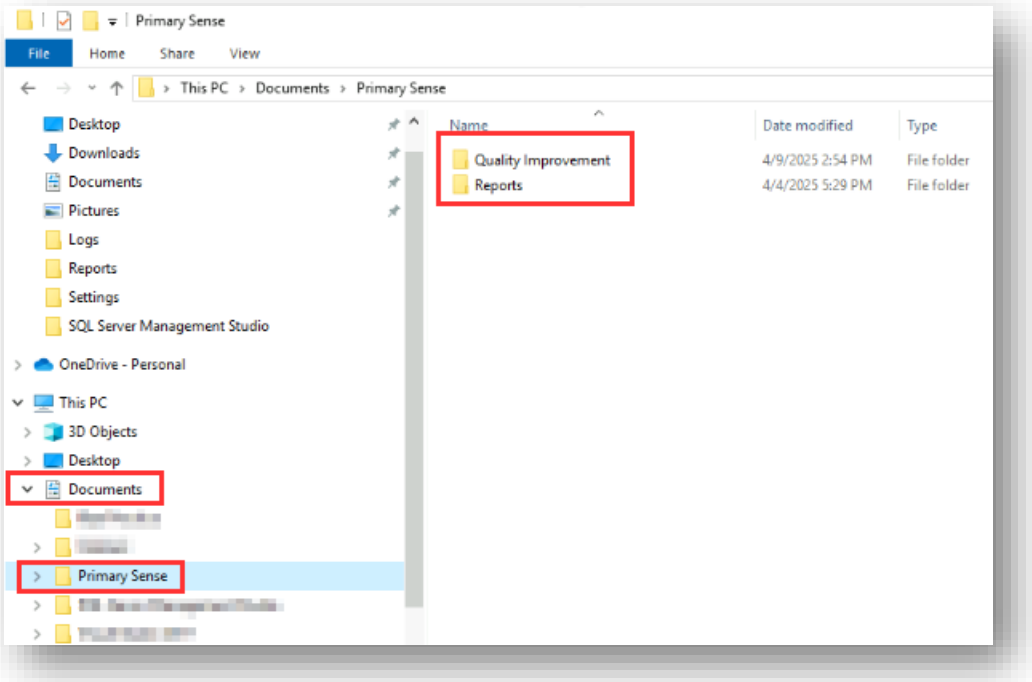
- Reports data refreshes every 2 hours. Reports can be printed by right clicking on the report and selecting Print from the menu.



7.2. Saving and Exporting Reports

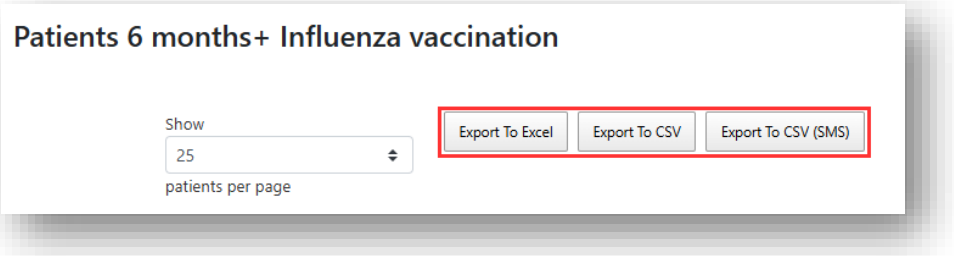
7.2.1. Saving

When a Report is opened in Primary Sense, a folder is automatically created on the computer in use under Documents > Primary Sense. All Reports will then be saved in this folder.

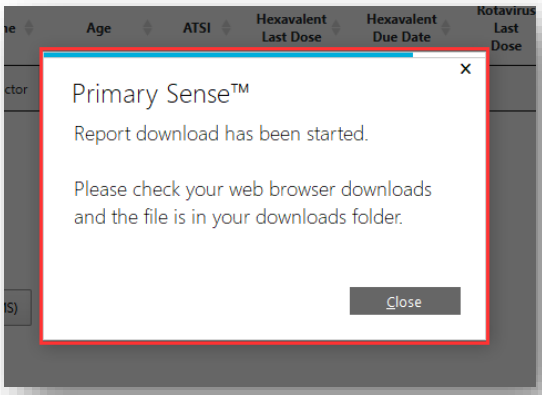


7.2.2. Exporting

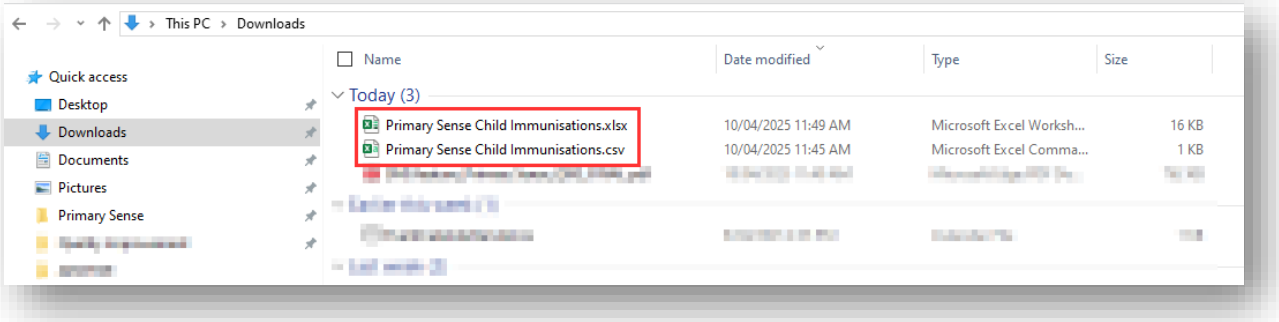
- The table can be exported to Excel or CSV for further analysis. ‘Export To CSV (SMS)’ will create a patient recall list for use with HotDoc© or other compatible applications.



- Applications such as Google Sheets or Libre Office can be used to view and filter the export if Excel is unavailable. Please follow your PHN / Practice guidelines for appropriate use of applications.
- Any filters applied to the data at the time, will be carried over when exported.
- To export, select the required format. This message will pop up when a list starts to download.

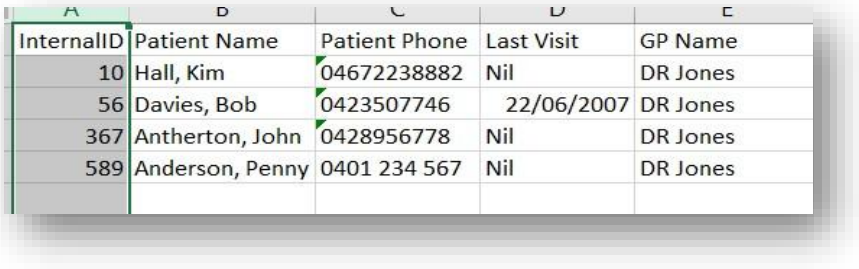


- The file will be available in the downloads folder as a .xlsx or .csv



7.2.3. Exporting for SMS

- To export SMS functionality, click the 'Export to CSV (SMS)' button, near the top of the report, to download the list with the applied filters.
- Open the CSV file from the downloads folder, format it according to what is required by the practice's SMS system and then upload it into the SMS system.
- The internal ID, as used by your practice management system software, identifies the patient to send SMS communication to. Tabs enable quick deletion of rows of patients.



InternalID	Patient Name	Patient Phone	Last Visit	GP Name
10	Hall, Kim	04672238882	Nil	DR Jones
56	Davies, Bob	0423507746	22/06/2007	DR Jones
367	Antherton, John	0428956778	Nil	DR Jones
589	Anderson, Penny	0401 234 567	Nil	DR Jones

NOTE: BP Comms module does not support the import of an external CSV file so Primary Sense lists cannot be imported into the module for sending out bulk SMS communications.

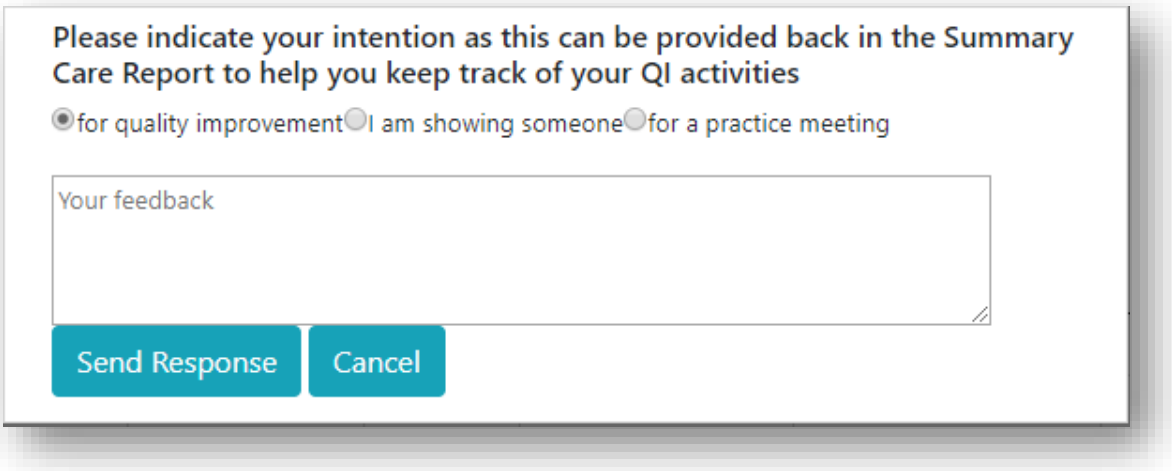
7.3. Removing Patients from Reports

For patient list reports, practice staff can remove a patient from the report by clicking on the 'remove' tab against the patient's name. This removes the patient from the report for ***12 months*** and allows practices to manage the list and remove patients that have been recalled or have declined an intervention. This action cannot be reversed and removes that patient from this report for all clinicians.

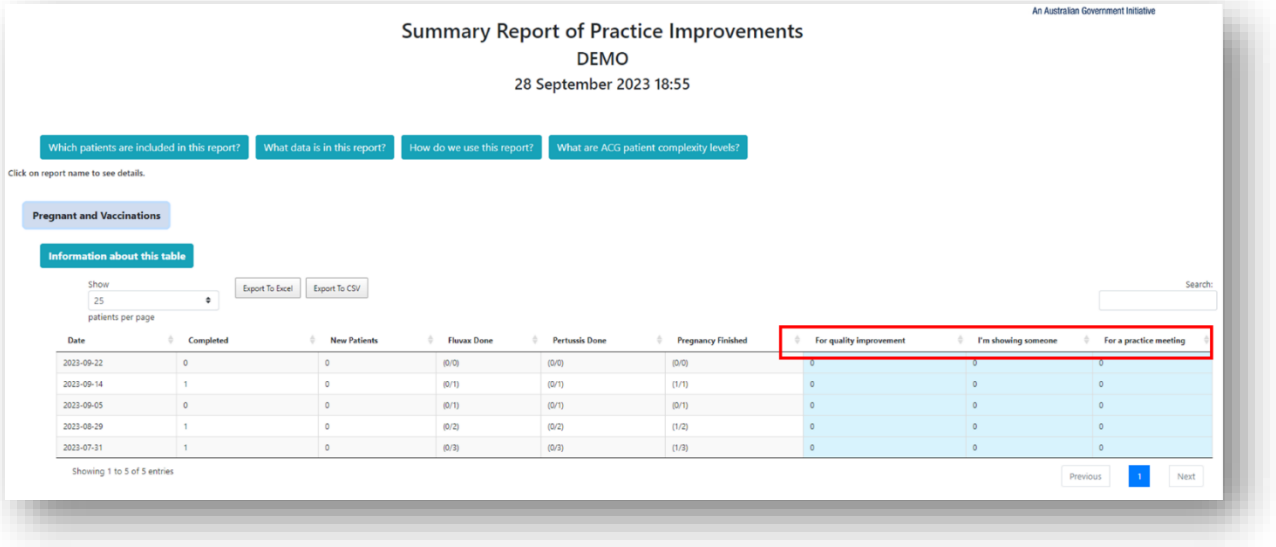
Note that if a suggested intervention, such as a Health Assessment, is subsequently done then Primary Sense *automatically* removes the patient from the future list – this does not need to be manually done.

7.4. Indication to use a Report for QI activity

When a report is exported to Excel, this option box below will appear:



The ‘intention’ radio button marked will be recorded against the individual patient list report onto the ‘Summary Report of Practice Improvements’:



7.5. Calculating Patient GP

The system begins by selecting consultations from the past 3 months to ensure high-frequency patients, who may have frequent visits, are represented by their most current history.

If fewer than 5 visits are returned, the search extends to include consultations within the past year. If this still doesn’t yield 5 or more visits, the date range is widened progressively, adding one year at a time, up to a maximum of 5 years. At that point, if fewer than 5 visits are returned, the process stops.

If the top two GPs have equal numbers of visits, the GP from the most recent consultation is chosen.

Included roles and status for Doctors are:

Roles	Status
Contract doctor	Full time
Employee doctor	Part Time
Principal doctor	Locum
Registrar	
Doctor	

7.6. Calculating Home Clinic

The system sets the Home Clinic by the most often visited clinic in the last 5 visits where data sharing between practices is enabled.

7.7. Calculating RACGP Active for Reporting

RACGP Active patients are calculated following the guidelines set out in the *Practice Incentives Program Quality Improvement Measures - Technical Specifications*:

- *"A regular client means a client (patient) who has visited a particular primary health care provider three or more times in the last two years. This includes clients who have had more than one visit with a provider in a day, or who have seen multiple providers in a practice in a day.*
- *Visits should only be considered as such if they are eligible for an MBS rebate.*
- *Non-clinical events, such as administration and patient notification activities, should not be counted as visits for the purposes of this rule.*
- *Deceased patients are to be excluded."*

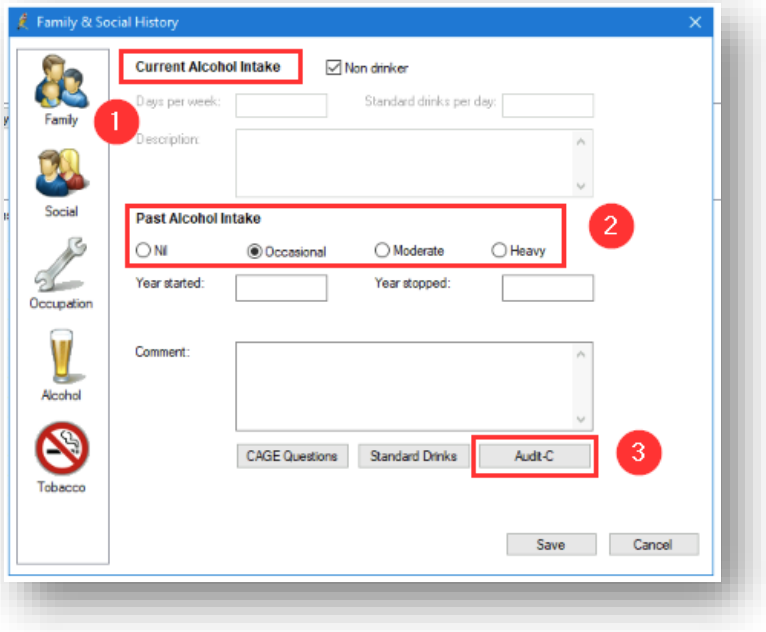
Where sites use a billing system incompatible with data extraction into Primary Sense, the Reason for Visit is used in place of the 'eligible for an MBS rebate'.

7.8. Calculating Alcohol Status

Alcohol status recorded is calculated for patients over 15 years of age with an alcohol consumption status ever recorded in their GP record, as per RACGP guidelines Practice Incentives Program Quality Improvement Measures. Data is valid when alcohol status in the CIS is not recorded as empty or Nothing Recorded, or the Audit C has a value recorded.

Best Practice

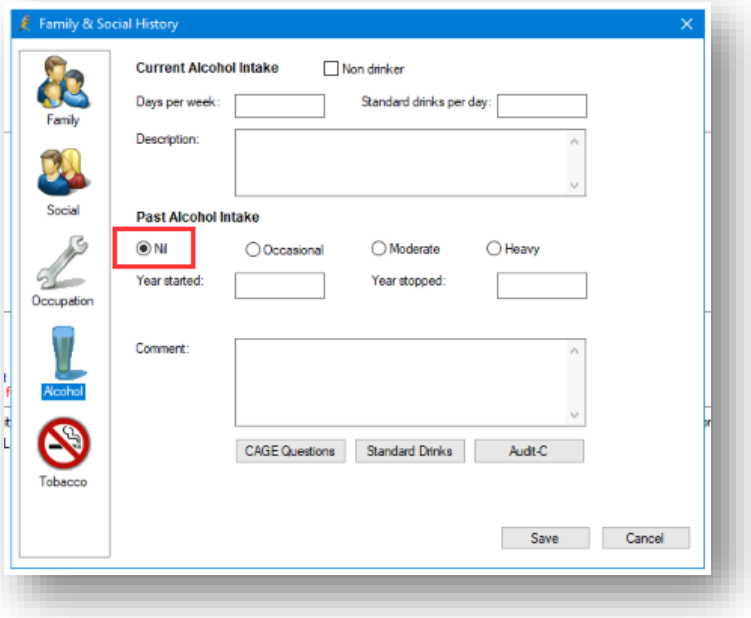
In Best Practice, the alcohol data is extracted from records in the Alcohol tab of the Family & Social History section.



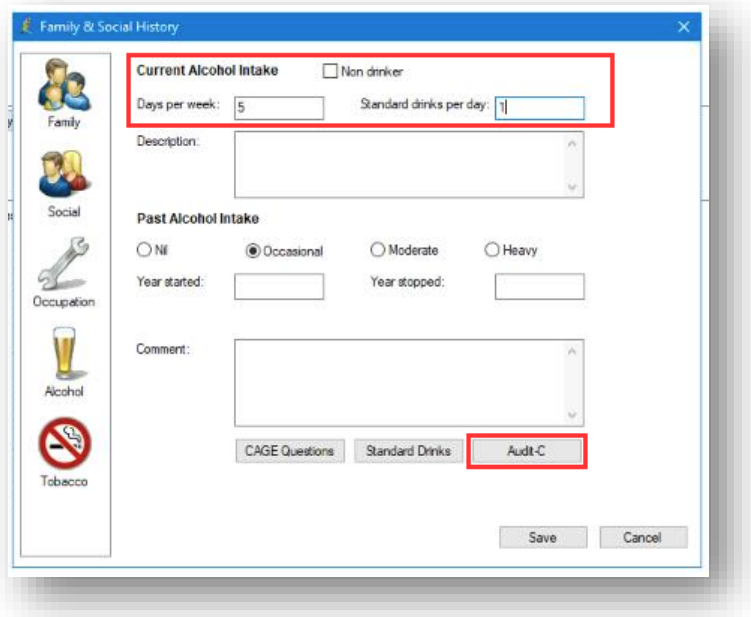
To be extracted by Primary Sense, data must be recorded in **1.** Current Alcohol Intake, or **3.** Audit C.

Data recorded in **2.** Past Alcohol Intake **IS NOT EXTRACTED** and will not be used in any Primary Sense calculations or as an indicator that the alcohol status has been recorded. E.g., if a patient only has a record in the Past Alcohol Intake such as below, this **will not** be extracted, and the patient will be recorded as

missing an alcohol reading.



Alcohol readings recorded as Non drinker, or an entry in the Days per week and standard drinks per day are used as alcohol recorded. A recording of a completed Audit C will also be used to indicate alcohol status recorded.

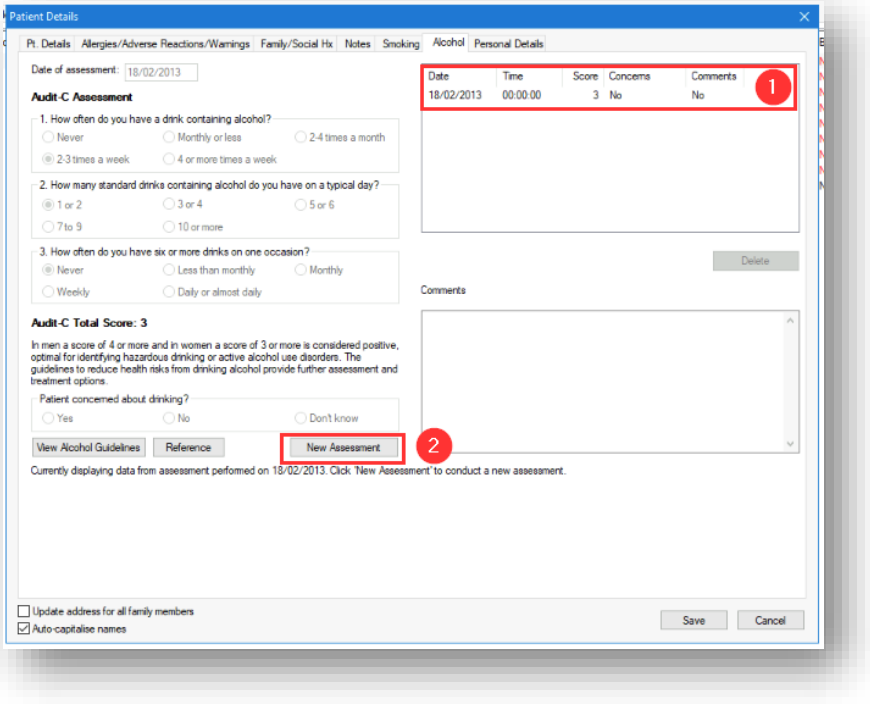


Medical Director

In Medical Director, the alcohol data is extracted from records in the Alcohol tab of the patient details.

A completed Audit C1 record is used to indicate alcohol status recorded. If no Audit C has been completed,

users can add a New Assessment2 and complete an Audit C record and this will be counted as status recorded.



7.9. Calculating Smoking

Smoking data is extracted from the CIS and mapped to the status Nothing Recorded, Nonsmoker Smoker or Ex-smoker.

ID	Description	MD Smoker	BP Smoking Status
1	Nothing Recorded		0
2	Nonsmoker	N	1
3	Smoker	Y	3
4	Ex-smoker	X	2

In addition, the following is extracted for use in reports:

- **Last smoking assessment date:** Sourced from the updated assessment dates a detailed below.
- **Smoking Start Year**: Extracted from both current and past smoker records.
- **Smoking Stop Year**: Captured for ex-smokers where available.
- **Cigarettes Per Day**: Included for both current and past smokers, where recorded.

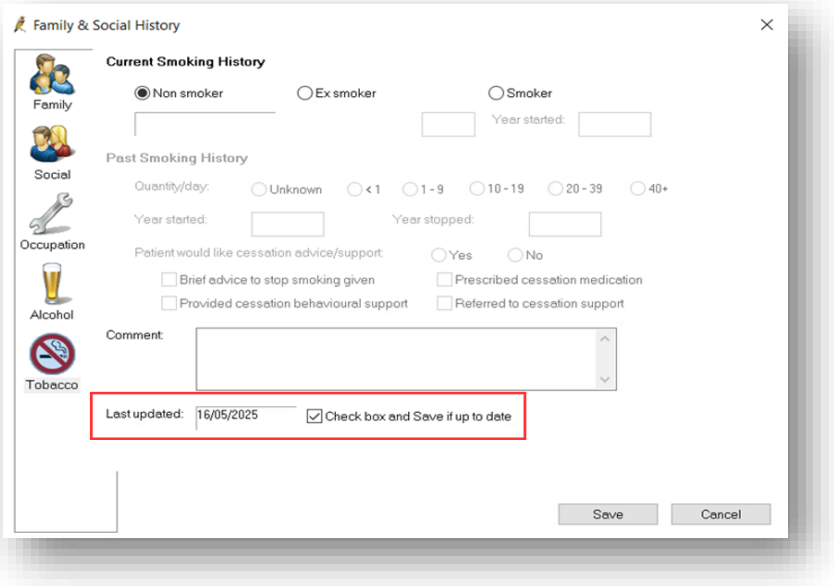
Smoking status recorded for PIPQI reports is calculated as per RACGP Guidelines Practice Incentives Program Quality Improvement Measures

- Clients aged between 15 and 29.999 years of age are included if their smoking status has been recorded within the past 12 months.
- Clients aged 30 years and over are included if their smoking status has been recorded at least once since turning 30.

Smoking status recorded for accreditation reports is calculated for all clients 10 years and above.

Best Practice

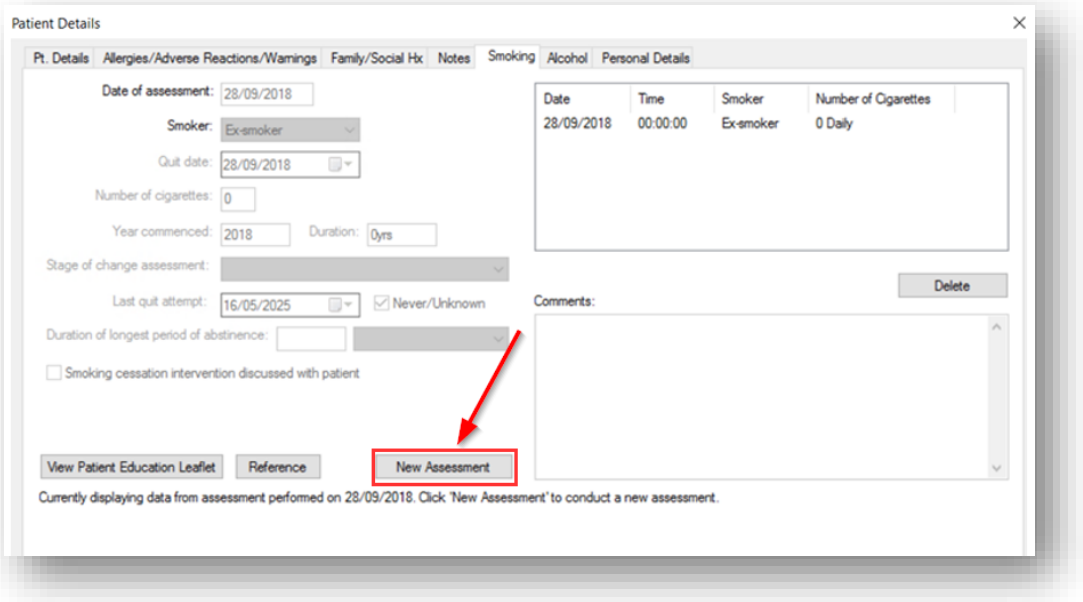
In Best Practice, if the patient's smoking status remains unchanged, the clinician should tick 'Check box and save if up to date'. This will update the date to today, which Primary Sense can extract as the latest recorded Smoking Status date.



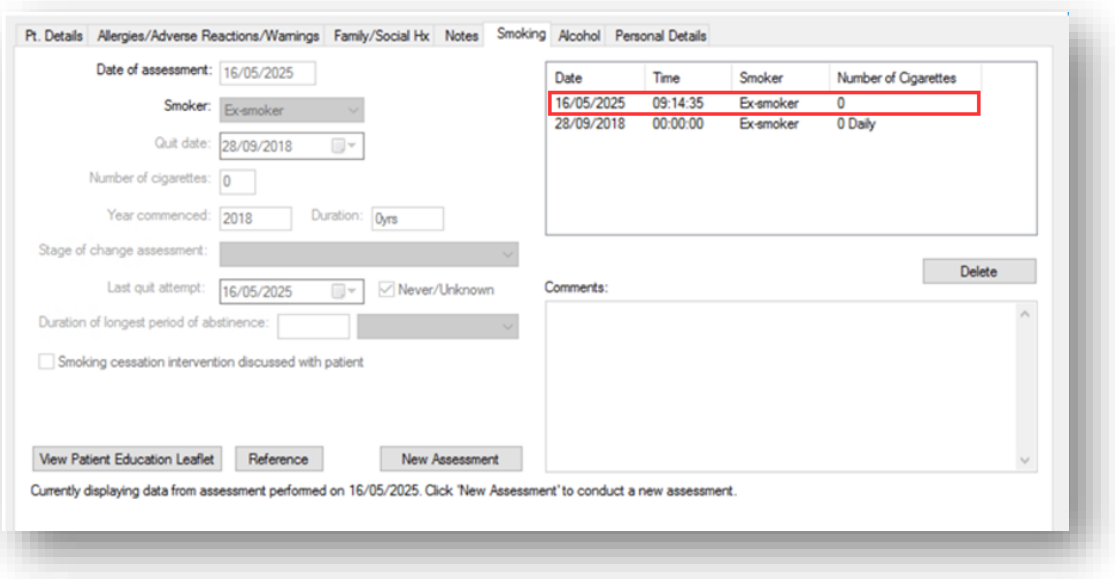
Medical Director

In Medical Director, clinicians should select 'New Assessment' in the Smoking Tab to update and record the latest smoking status (including if the status has not changed), which Primary Sense can extract as the latest recorded Smoking Status date.

Original current Smoking Assessment



Updated Smoking Assessment details from New Assessment



7.10. Calculating Age

The patient age is calculated as of the day the report is run. To protect patient confidentiality, the age of all patients older than 90 years are displayed as 90.

7.11. Declined Vaccinations

Practices using Medical Director can record that a vaccination has been offered and declined. Primary Sense displays this in select reports by displaying the date as DD-MM-YYYY (D) with the letter (D) after the date, e.g. 01-07-2022 (D).

This applies to Flu, Pneumococcal and Covid vaccinations. The report will display the declined date, and the number will not be included in any vaccine given calculations.

This applies to the following reports:

- Chronic Lung Disease and Asthma
- Diabetes Mellitus
- Frailty Care Management
- Winter Wellness

7.12. Report Types

The desktop application has two types of reports:

- **Summary reports**
  - provides an aggregate view of patient information at a practice or practitioner level.
- **Patient list reports**
  - re-identifies the patient at the practice level only with suggested interventions or possible Medicare Benefits Scheme (MBS) item numbers.

Available Reports:

Practice/PHN Reports	
Accreditation	**Summary**
Characteristics of the PHN patient population	**Summary**
Characteristics of the Practice Patient Population	**Summary**
Summary Report of Practice Improvements V2	**Summary**

PIP QI	
PIP QI report - 10 measures	**Summary**
Patients booked in with missing PIP QI measures	**Patient List**
Patients missing PIP QI or accreditation Measures	**Patient List**

General Reports	
Benzodiazepine in substance misuse	Patient List
Bowel and Breast Cancer Screening	Patient List
Cardiovascular Disease Management	Patient List
Cardiovascular Disease Risk Factors	Patient List
Cervical Cancer Screening	Patient List
Child Immunisations	Patient List
Chronic Lung Disease and Asthma	Patient List
CKD Report	Patient List
CVD Risk Screening, Recall and Treatment	Patient List
Diabetes Mellitus	Patient List
Frailty Care Management	Patient List
Haemochromatosis	Patient List
Health Assessments	Patient List
Hepatis C	Patient List

Hypertension Management	Patient List
Lung Cancer Screening	Patient List
MyMedicare - Voluntary Patient Registration	Patient List
Palliative Care	Patient List
Patients with High Complexity (5 and 4)	Patient List
Patients with Moderate Complexity (level 3)	Patient List
Pregnant and Vaccinations	Patient List
Winter Wellness	Patient List

7.13. Adjusted Clinical Groups (ACGs ®) – overview of use in reports

ACGs are the building blocks of the Johns Hopkins University ACG® System. ACGs are a series of mutually exclusive, health status categories defined by morbidity, age and gender. They are based on the premise that the level of resources necessary for delivering appropriate healthcare to a population is correlated with the illness burden of that population. ACGs are a person-focused method of categorising patients' illnesses. Over time, each person develops numerous conditions. Based on the pattern of these morbidities, the ACG approach assigns each individual to a single ACG category.

The complexity bands are formed by combining the ACGs to measure overall morbidity burden on a scale of 0-5, with 5 being the most complex/morbidity burden.

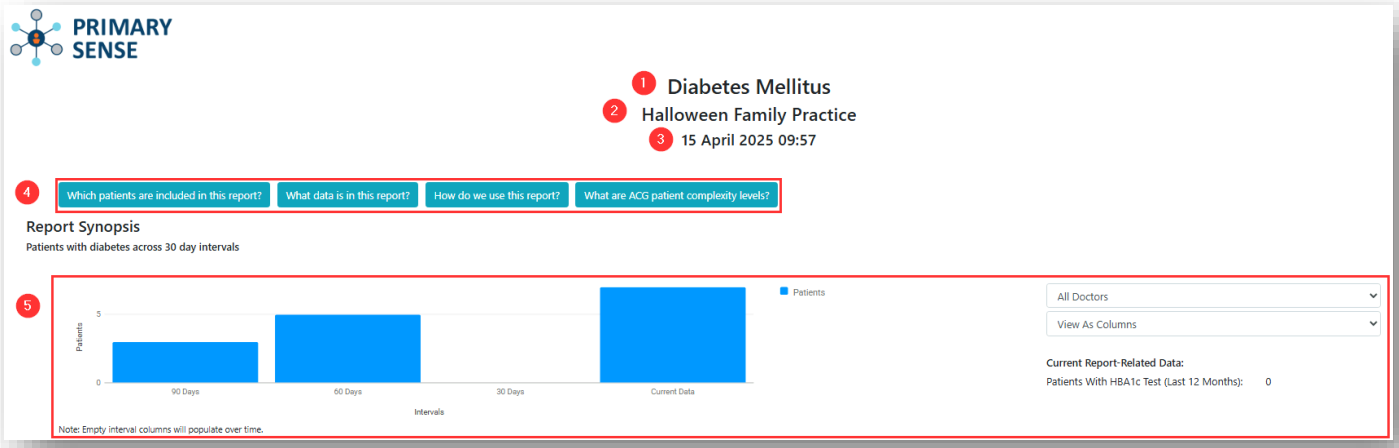
For further information regarding the Johns Hopkins University ACG® System, please see *The Johns Hopkins University ACG® System.* in this document.

If the complexity of a patient is calculated from results that are more than 12 months old, the level will be displayed in brackets, e.g. (3), rather than 3.

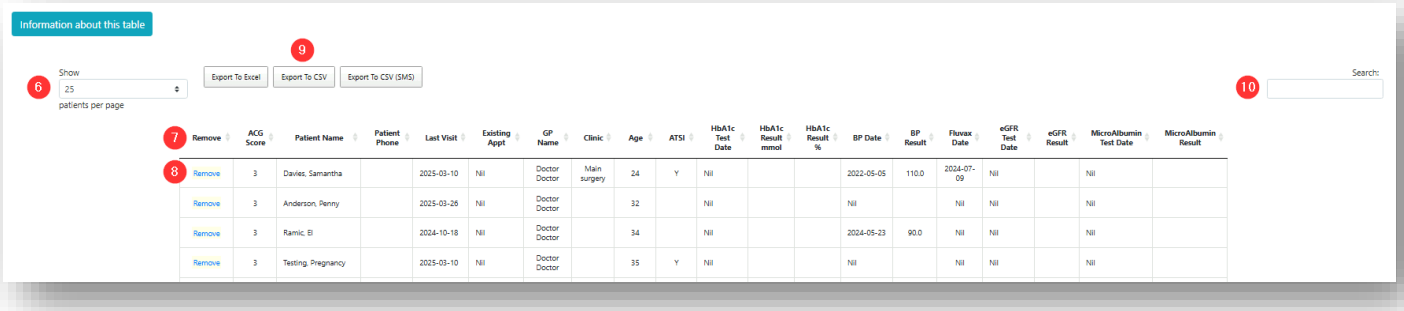
7.14. Report structure

7.14.1. Overview

Most reports within the Primary Sense desktop application follow a similar structure. For data security and privacy purposes, the reports can ***only*** be viewed in the practice using the Patient List Primary Sense desktop app. To access a report, click on the 'Reports' tile and double click on any of the reports.



1. **Report** name
2. **Practice name** (in this case, we are using the "Halloween Family Practice" practice)
3. **Date and time** in which the report was generated
4. **Tabs** at the top provide additional information on how to use the report – click to open
5. **Graph** - most reports include a graph at the top so practices can see their trends going back 90 days, in 30-day increments. Graphs can also be viewed in Bars by selecting 'View As Bars' from the dropdown.



6. **Show** – Allows user to select the number of records they want to see in the table view from 25, 50, 100, 200 or All
7. **Table** – some reports contain multiple tables, which can be viewed by scrolling down. Generally, these tables include the date of the last visit per patient, and if the patient has an upcoming appointment booked. All reports include the patient's age and usually the Johns Hopkins University ACG® System complexity rating band to assist practices in prioritising these lists. The column headings can be filtered / ordered by clicking the arrows.
8. **Remove** – practice staff can 'remove' a patient from the report by clicking on the remove tab against the patient's name. This replaces 'remove' with the current date, and the patient is removed for 12 months for this report for all clinicians. This allows the practice to manage the list and remove patients that have been recalled or have declined an intervention.

Note: *If a suggested intervention, such as a health assessment, is subsequently done then Primary Sense automatically removes the patient from the future list – this does not need to be manually done.*

9. **Export** – click the button to export the table to excel or CSV. Any filters applied to the data at the time, will be carried over.
10. **Search** – can be used to search for any attribute in the table i.e. GP name, patient name, age etc.

Additional note:

GP and Practice - a process works to determine who each patient's regular GP is likely to be, based on the most frequently seen GP (the GP who has opened the patient's consultation notes the most) within the last 5 visits. The logic uses a similar formula to determine which is the patient's regular practice when data sharing between practices is enabled, and which is the home clinic when practices share a server by establishing which location the patient visits most frequently. This enables a GP to view/and or download their specific patient list. See *Calculating Patient GP* for rules.

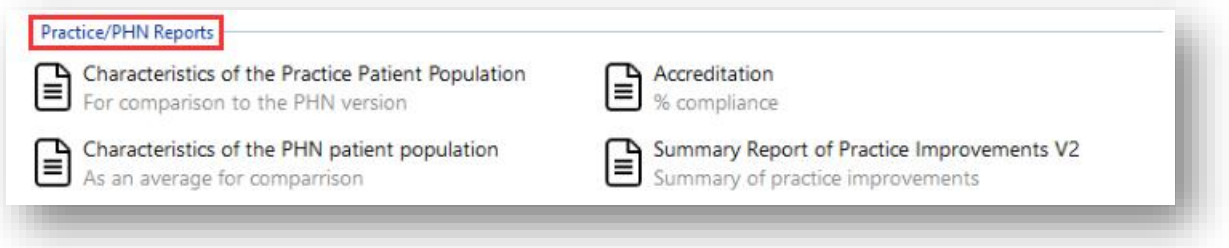
7.14.2. Summary Reports

Summary Reports provide an aggregated overview of the practice or an individual practitioner's aggregated patients in the chosen areas. These reports are useful for the whole practice team, enabling a snapshot view of the practice. Where possible, benchmarked data to the PHN average will be included. The reports cover age, gender, disease, medications prescribed, data quality profiles of the practice and the national Practice Incentive Program Quality Improvement (PIP QI) measures.

7.14.3. Patient List Reports

Patient List Reports connect with a practice's database to provide patient name and phone numbers to enable targeted interventions and identify patients eligible for certain MBS item numbers. Most of these reports follow a standard format of providing a patient name, phone number, last visit date and if booked in for an appointment in the future. They have been updated to use the relevant Covid-19 and Chronic Condition Management MBS items. Reports are listed alphabetically.

7.15. Practice / PHN Reports



7.15.1. Characteristics of the Practice Patient Population (Report ID 1)

These two reports (Characteristics of the Practice Patient Population and PHN Patient Population) provide a standardised summary of the practice population profile, with the PHN version an average of all the practices enabling comparison. Population profiles are available by practice and by individual GP. All data in these reports is based on active patients that have visited the general practice in the past three years, as this is the requirement for the analysis within the Johns Hopkins University ACG® System.
Report includes:

- Age and gender analysis.
- Risk band/complexity assessment of patients by age grouping.
- High impact conditions (conditions deemed to have significant impact as determined by Johns Hopkins University ACG® System).
- Conditions coded and/or indicated by medication.
- Diagnosis number per patient.
- Number of active ingredients (prescribed medications) per patient.

7.15.2. Characteristics of the PHN Patient Population (Report ID 13)

This report lists characteristics of the patient population of the PHN as an average for all practices. It provides an overview of demographics, ACG risk stratification scores and diagnostic clusters across total age groups, aggregated from all practices using Primary Sense and submitting data via Primary Sense for the PHN

Report includes:

- Age and gender analysis.
- Risk band/complexity assessment of patients by age grouping.
- High impact conditions (conditions deemed to have significant impact as determined by Johns Hopkins University ACG® System).
- Conditions coded and/or indicated by medication.
- Diagnosis number per patient.
- Number of active ingredients (prescribed medications) per patient.

7.15.3. Accreditation (report ID 3)

This report assists practices to prepare for accreditation. It focuses on data quality in line with The Royal Australian College of General Practitioners (RACGP) standards for general practice (5th edition).
It includes:

Total number of patients and the percentage recorded:

- Ethnicity.
- Smoking status. See *Calculating Smoking* for rules.
- BMI.
- Alcohol use. See *Calculating Alcohol Status* for rules.

- Allergy status

Data Item	Practice Data	RACGP Minimum Target
Active Patient Number	360	
Allergy Status recorded	99.72%	90% Active Patients
Smoking > 10yrs old recorded	94.72%	75% Active Patients
Alcohol > 15 yrs old recorded	88.30%	75% Active Patients
BMI recorded	85.00%	75% Active Patients
Ethnicity recorded	41.94%	75% Active Patients

7.15.4. Summary Report of Practice Improvements V2 (Report ID 29)

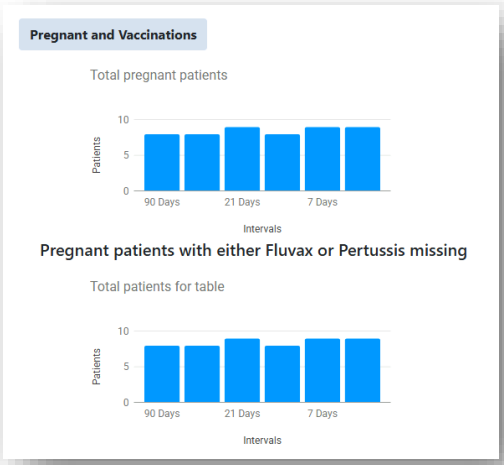
This report summarises the patient lists reports. The report tables will only appear and populate with data when patient list reports have been run in the past 3 months.

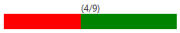
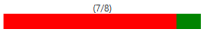
The information in the report such as how many people are missing a health assessment is stored in the PS database, accruing changes as the reports get re-run and interventions are done. This information goes back 90 days using red and green bars to show number done vs number not. It does not enable re-identification of any patients but allows the practice to track the volume of patients in other reports within a given timeframe.

As new patient list reports become available, they are added to this report (noting the practice must run them).

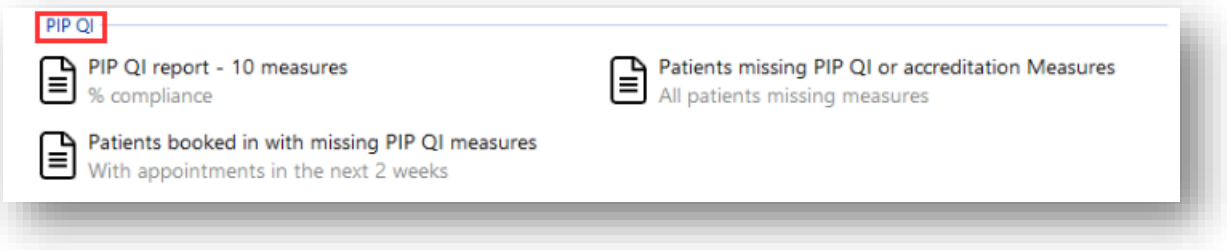
Refer to each report specification for details of what is included. Refer to each report specification for details of what is included. For comparison, previous versions of the report are stored in the Documents > Primary Sense folder.

Example Report Output:



Date	Number of Patients	Pregnant patients missing Fluvax	Pregnant patients missing Pertussis	Pregnant patients missing RVS	For quality improvement	I'm showing someone	For a practice meeting
2025-04-04	9	(6/9) 	(6/9) 	(4/9) 	0	0	0
2025-04-01	9	(6/9) 	(8/9) 	No Data	0	0	0
2025-03-25	8	(5/8) 	(7/8) 	No Data	0	0	0
2025-03-20	9	(6/9) 	(9/9) 	No Data	0	0	0
2025-03-10	8	(6/8) 	(8/8) 	No Data	0	0	0
2025-01-29	8	(6/8) 	(8/8) 	No Data	0	0	0

7.16. PIP QI Reports



7.16.1. Patients returned in the PIP QI Reports with Diabetes.

The logic used in the Primary Sense query determines how many patients appear in the reports.

The following logic is applied to the PIP QI reports related to diabetes statistics:

- *Patients must be RACGP active (AIHW - a client (patient) who has visited a particular primary health care provider three or more times in the last two years.)*
- *Visit is a billed visit only (AIHW - Visits should only be considered as such if they are eligible for an MBS rebate.)*
- *Merged patients are only counted once*
- *Diagnosis is from clinical history tables*
- *Diagnosis is active*
- *Diagnosis does not have a status of deleted*
- *Diabetes diagnosis is from the Primary Sense diabetes reference table classifying type 1, type 2 and undefined*
- *Patient status is active (not inactive or deceased)*
- *Record status is active or updated and not deleted*

There are also further technical specifications defined by *Practice Incentives Program Quality Improvement Measures - Technical Specifications* which are coded into the Primary Sense reports.

- *Excluded patients as per AIHW - secondary diabetes, gestational diabetes mellitus (GDM), previous GDM, impaired fasting glucose, impaired glucose tolerance.*
- *Any patients who have had gestational diabetes but also have Type 1 or 2 diabetes will be included.*
- ***Any patient with a fasting glucose >7 is excluded.***

HbA1c recorded looks for records ONLY in the past 12 months. An HbA1c result is referenced from:

- *Loinc codes identifying an HbA1c result in the pathology results table where the results have not been marked as deleted*
- *HbA1c results in the Observation table*

The reference tables for diabetes and the diabetes types are maintained in Primary Sense and are updated regularly when diagnosis are added to the Core Systems Best Practice and Medical Director. Free text diagnoses from the cores are also mapped to ICPC codes in the reference tables.

7.16.2. PIP QI Report - 10 measures (Report ID 14)

This report provides the results as a percentage against the 10 quality improvement measures as outlined below. The report refreshes each time it's run so a practice doesn't have to wait until the end of the quarter to access its data and identify trends. Note that additional reports exist which enable practices to target specific *patients* with missing PIP QI measures i.e. 'Patients booked in with missing PIP QI measures' and 'Patients with missing PIPQI or accreditation measures.'

PIP QI Report - 10 measures:

- Proportion of patients with diabetes with a current HbA1c result
- Proportion of patients with a smoking status - Patients who haven't had their smoking status re-asked in the CIS within the past 12 months will be marked as "smoking not recorded," even if they have a smoking status on file. See *Calculating Smoking* for rules.
- Proportion of patients with a weight classification
- Proportion of patients aged 65 and over who were immunised against influenza
- Proportion of patients with diabetes who were immunised against influenza
- Proportion of patients with COPD who were immunised against influenza
- Proportion of patients with an alcohol consumption status. See *Calculating Alcohol Status* for rules.
- Proportion of patients with the necessary risk factors assessed to enable CVD assessment
- Proportion of female patients with an up-to-date cervical screening.
    - The opt out flag sits against the patient record to allow patients that have never had a cervical screening record done but have opted out to have the status recorded
    - Patients with self-collected tests are included in the report (Recorded as Self Collected in the CIS Cervical Screening pathology request form). Please note pathology requests don't register in the CIS until the result comes back
- Proportion of patients with diabetes with a blood pressure result

7.16.3. Patients booked in with missing PIP QI measures (Report ID 18)

This report lists patients with upcoming appointments in the next two weeks who have missing PIP QI measures, and allergies not recorded. Active patients are based on RACGP criteria of three visits in the past two years.

Report includes

- Ethnicity recorded
- Smoking status recorded - Patients who haven't had their smoking status re-asked in the CIS within the past 12 months will be marked as "smoking not recorded," even if they have a smoking status on file. See *Calculating Smoking* for rules.
- BMI recorded
- Alcohol status recorded. See *Calculating Alcohol Status* for rules.
- Allergy status recorded
- Diabetes missing influenza vaccination, BP, HbA1c
- Influenza vaccination due, over 65, COPD
- CV risk factors recorded (Y or N)
- Cervical screening done.
    - The opt out flag sits against the patient record to allow patients that have never had a cervical screening record done but have opted out to have the status recorded.
    - Patients with self-collected tests are included in the report (Recorded as Self Collected in the CIS Cervical Screening pathology request form). Please note pathology requests don't register in the CIS until the result comes back.

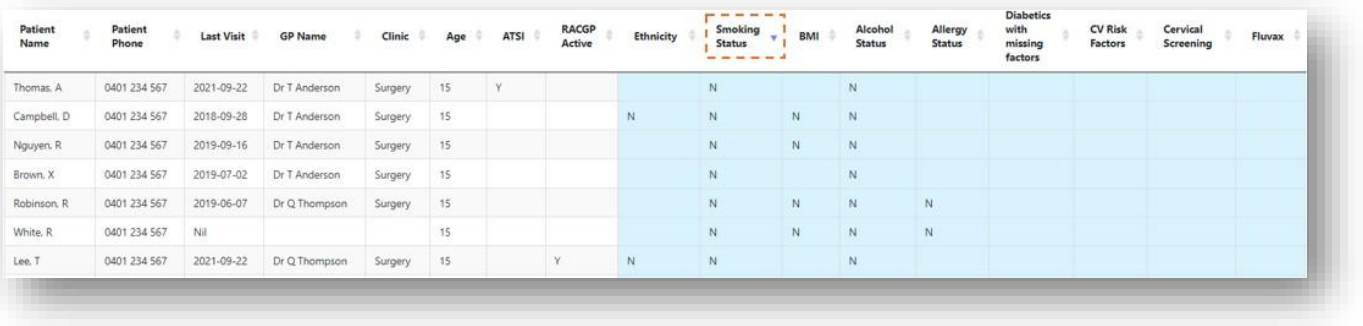
7.16.4. Patients with missing PIPQI or accreditation measures (Report ID 12)

This report lists patients marked as active who are missing one or more accreditation or PIPQI measures. (N indicates not recorded). Where the patient meets RACGP active definition of three visits in the past two years, that is shown. To prevent potential re-identification, patients aged over 90yrs are presented as 90yrs. Due to the recent Covid vaccination program inflating numbers of patients marked as active, the best way to find regular patients is to filter on those with smoking status recorded by clicking the up and down arrow in that column.

Searching the doctor's name can generate a GP list, and clicking on the arrows by each column header can create lists for a missing measure. Exporting to excel will keep the selections made (user instructions are provided in each report).

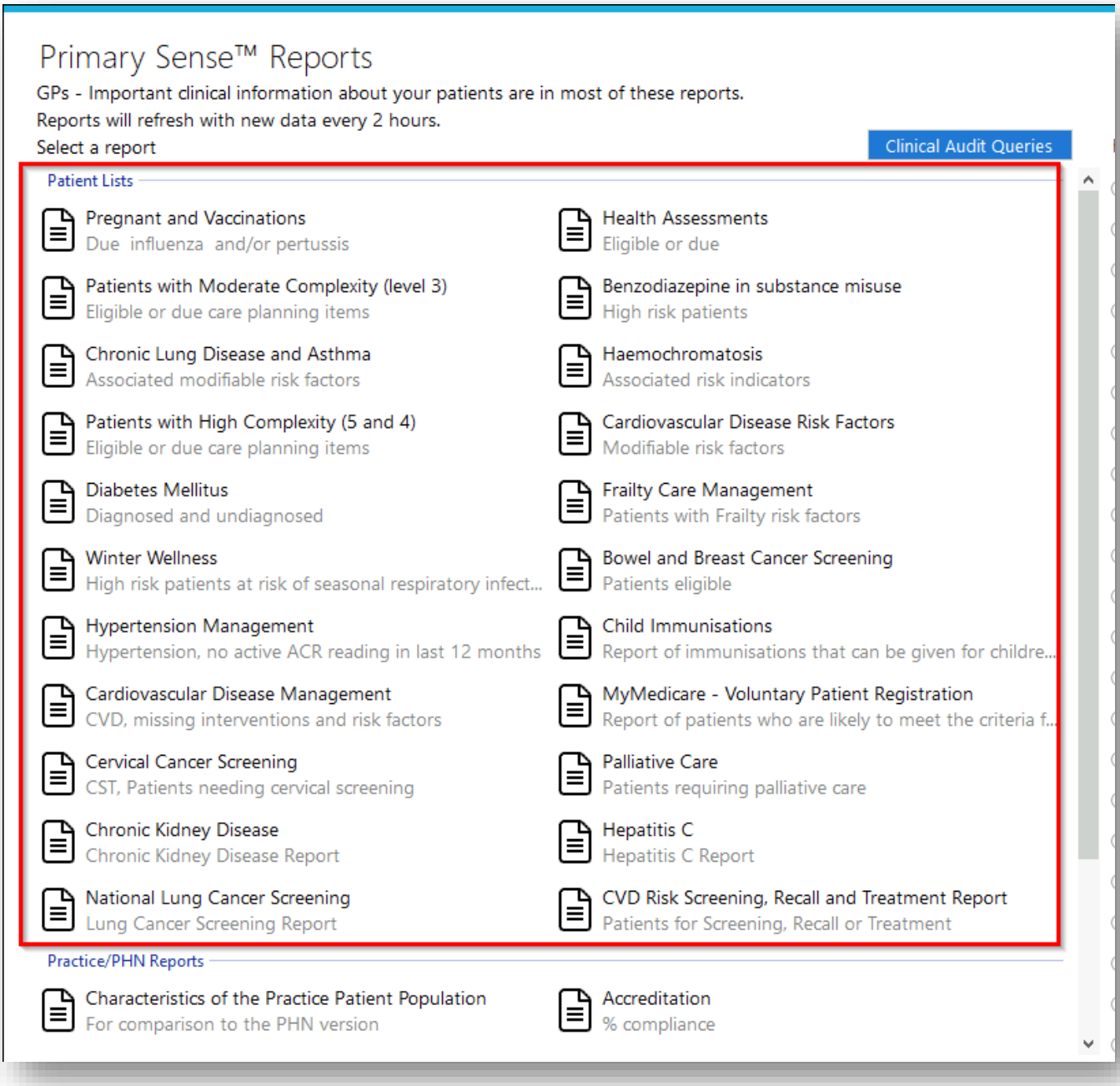
Report includes

- Ethnicity
- Smoking status - Patients who haven't had their smoking status re-asked in the CIS within the past 12 months will be marked as "smoking not recorded," even if they have a smoking status on file. See *Calculating Smoking* for rules.
- BMI
- Alcohol status. See *Calculating Alcohol Status* for rules.
- Allergy status
- Diabetics with missing influenza vaccination



Patient Name	Patient Phone	Last Visit	GP Name	Clinic	Age	ATSI	RACGP Active	Ethnicity	Smoking Status	BMI	Alcohol Status	Allergy Status	Diabetics with missing factors	CV Risk Factors	Cervical Screening	Fluvax
Thomas, A	0401 234 567	2021-09-22	Dr T Anderson	Surgery	15	Y			N		N					
Campbell, D	0401 234 567	2018-09-28	Dr T Anderson	Surgery	15			N	N	N	N					
Nguyen, R	0401 234 567	2019-09-16	Dr T Anderson	Surgery	15				N	N	N					
Brown, X	0401 234 567	2019-07-02	Dr T Anderson	Surgery	15				N		N					
Robinson, R	0401 234 567	2019-06-07	Dr Q Thompson	Surgery	15				N	N	N	N				
White, R	0401 234 567	Nil			15				N	N	N	N				
Lee, T	0401 234 567	2021-09-22	Dr Q Thompson	Surgery	15		Y	N	N		N					

7.17. General Reports



7.17.1. Pregnant and Vaccinations (Report ID 5)

This report will identify pregnant women without a record of vaccination for pertussis, influenza, or RSV during this pregnancy (less than 42 weeks gestation). Women under 15 years and over 45 years are excluded as they require more monitoring than this report is designed to provide.

Which patients are included in this report?

Pregnant women without a record of vaccination for pertussis, RSV and/or influenza during this pregnancy (less than 42 weeks gestation). Women under 15yrs and over 45yrs are excluded as they would require more monitoring than is the intention of this report.

What data is in this report?

- Pregnancy recorded (not marked as ended)
- 'Patient name'
- 'Last Visit' displays the last visit that was billed (excludes administration and normal after care entries in patient record)
- 'Existing appt' will display the next booked appointment
- 'GP Name' displays the GP who most accesses patient record
- 'Age'
- Immunisations (Pertussis, RSV and Fluvax). N indicates vaccine not received within the recommended date range. N/A is shown if vaccine not recommended within current date range. If a patient has declined, the date declined is presented against N.
- 'Weeks Pregnant' based on USS or LNMP date
- 'Estimated due date' based on USS or LNMP date
- 'Source' the data used to calculate EDD
- Data used is current at the point of time the report was requested

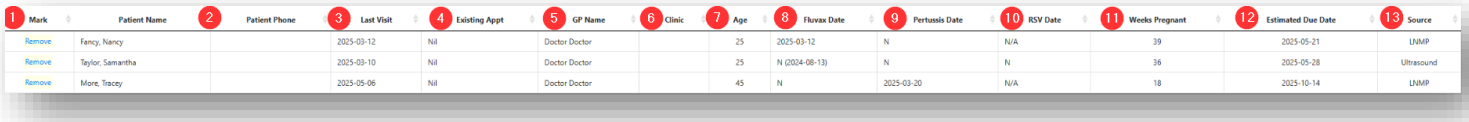
Information about this table

This report is pregnant women without a record of vaccination for pertussis, RSV and/or influenza during this pregnancy.

Vaccination is recommended every pregnancy. A single dose of pertussis vaccine is strongly recommended for pregnant women in the third trimester of every pregnancy (preferably between 20 and 32 weeks but can be any time in the final trimester), whilst influenza vaccination timing is usually at diagnosis of pregnancy and at least before the influenza season, but can also occur at any time. The RSV (Abrysvo) is due between 28 and 36 weeks of pregnancy. Please also check the Australian Immunization Register and refer to *Vaccine recommendations for pregnant women – a guide for health professionals*.

How to Interpret

These patients have not yet received fluvax - indicated by N. Patients who are not yet due pertussis and/or RSV are N/A, patients who are due pertussis but have not received it are indicated by N. If a patient has declined the date declined is presented.



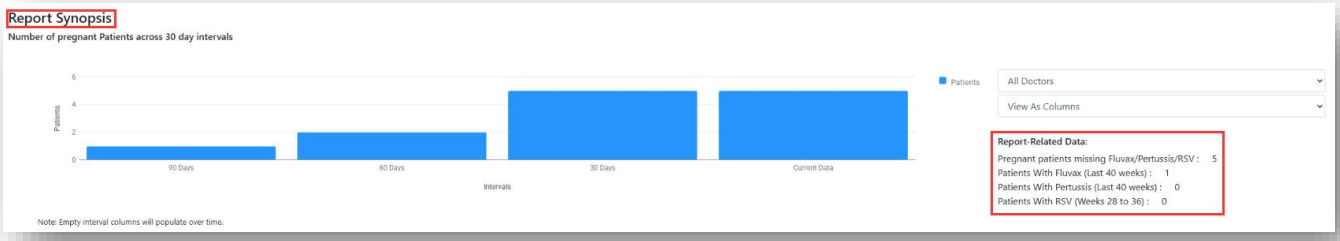
1 Mark	Patient Name	2 Patient Phone	3 Last Visit	4 Existing Appt	5 GP Name	6 Clinic	7 Age	8 Fluvax Date	9 Pertussis Date	10 RSV Date	11 Weeks Pregnant	12 Estimated Due Date	13 Source
Remove	Fancy, Nancy		2025-03-12	Nil	Doctor Doctor		25	2025-03-12	N	N/A	39	2025-05-21	LNMP
Remove	Taylor, Samantha		2025-03-10	Nil	Doctor Doctor		25	N (2024-08-13)	N	N	36	2025-05-28	Ultrasound
Remove	More, Tracey		2025-05-06	Nil	Doctor Doctor		45	N	2025-03-20	N/A	18	2025-10-14	LNMP

1. **'Remove'** - Patients can be removed from the report for 12 months, by clicking 'Remove.' This action cannot be reversed and removes the patient from this report for all clinicians.
2. Patient demographic data.
3. **'Last Visit'** column displays the date the patient last had an appointment at the practice.
4. **'Existing appt'** column displays patient appointments that have been booked for dates beyond the report.
5. **'GP Name'** shows the GP who has most accessed the patient record. See *Calculating Patient GP* for rules.
6. **'Clinic'** displays most attended clinic if data is shared.
7. **'Age'** - Patient age at time the report is run.
8. **'Fluvax Date'** - If influenza vaccination is given (can be throughout the pregnancy). If the vaccine was given in the three months prior to the pregnancy it will appear in brackets () indicating it should be repeated. Not given is indicated by N.
9. **'Pertussis date'** - If pertussis vaccine is given (preferably between 28 and 32 weeks but can be any time in the final trimester). Patients who are due but have not received the vaccine are indicated by N. If vaccine not due, N/A is shown.
10. **'RSV Date'** - If RSV is given (preferably between 28 and 32 weeks but can be any time in the final trimester). Patients who are due but have not received the vaccine are indicated by N. If vaccine not due, N/A is shown.
11. Weeks pregnant.
12. Estimated Due date.
13. **'Source'** for Estimated Due date - (ultrasound scan (Ultrasound) or record of the Last Normal Menstrual Period (LNMP)).

Report Synopsis

Number of pregnant patients across 30 day intervals

- Pregnant patients missing Fluvax/Pertussis/RSV
- Patients With Fluvax (Last 40 weeks)
- Patients With Pertussis (Last 40 weeks)
- Patients With RSV (Weeks 28 to 36)



7.17.2. Patients with moderate complexity (band 3) (Report ID 7)

This report highlights patients who would be eligible for coordinated care to better manage chronic diseases and mental health conditions. These patients have an ACG complexity score of 3. The report uses ACG to provide a count of chronic conditions and of mental health conditions as a mechanism to select potential eligibility for MBS care plan items. While many of the mental health conditions are included as a chronic condition, a separate count of mental health conditions is provided to help the practice assess which approach would be more beneficial for the patient.

What data is in this report?

- A count of the chronic conditions
- A count of the mental health conditions
- Eligibility for any of the following:
    - Chronic Condition Management Plan (GPCCP)
    - Mental health treatment plan
    - GPCCP review
    - GPMHP review
    - Practice Nurse item number 10997

7.17.3. Chronic Lung Disease and Asthma (Report ID 9)

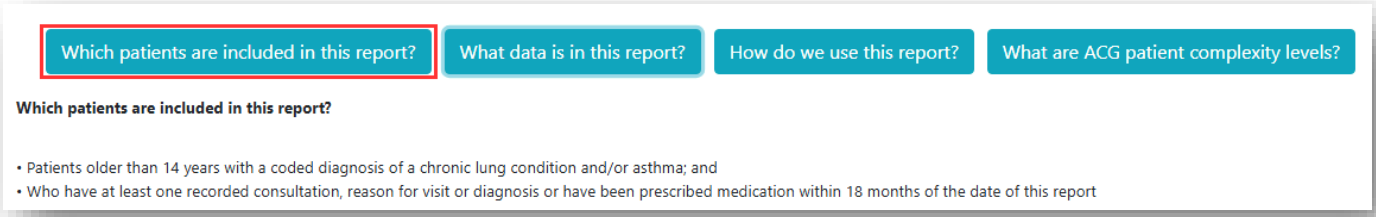
Overview

This report includes patients older than 14 years with a coded diagnosis of a chronic lung condition and/or asthma or who have at least one recorded consultation, reason for visit or diagnosis.

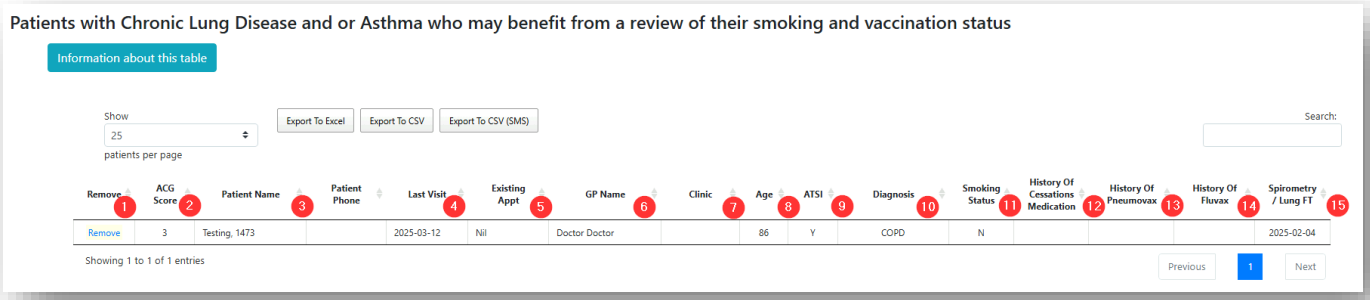
Report Content

Which patients are included in this report?

Patients included reference ICPC Classifications Respiratory Classification 4 and/or COPD Classification 22.



What data is in this report?



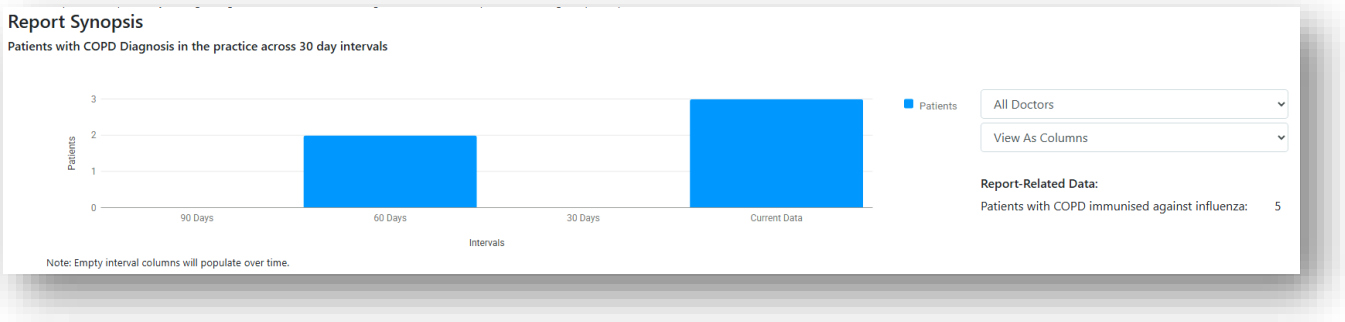
1. **'Remove'** - Patients can be removed from the report for 12 months, by clicking 'Remove.' This action cannot be reversed and removes the patient from this report for all clinicians.
2. **'ACG Score'** - the complexity bands formed by combining the ACGs to measure overall morbidity burden on a scale of 0-5, with 5 being the most complex/morbidity burden.
3. Patient demographic data.
4. The **'Last Visit'** column displays the date the patient last had an appointment at the practice.
5. The **'Existing Appt'** column displays patient appointments that have been booked for dates beyond the report.
6. **'GP Name'** shows the GP who has most accessed the patient record. See *Calculating Patient GP* for rules.
7. **'Clinic'** displays most attended clinic if data is shared.
8. **'Age'** - Patient age at time the report is run (to protect patient confidentiality, the age of all patients older than 90 years are displayed as 90).
9. **'ATSI'** where patient is identified as: Aboriginal, Aboriginal/Torres Strait Islander or Torres Strait

Islander.

10. **‘Diagnosis’** – Diagnosis if classified as Respiratory or COPD.
11. **‘Smoking status’** Y =current smoker; N =non-smoker (ex-smoker codes are excluded); Blank =not recorded.
12. **‘History of smoking cessation medications’** where smoking is current.
13. **‘History of Pneumovax’** - date of last recorded Pneumococcal vaccination. DD-MM-YYYY (D) = Date Vaccination Declined.
1. **‘History of Fluvax’** - date of flu vaccination recorded within 15 months of the date of the report. DD-MM-YYYY (D) = Date Vaccination Declined. See *Declined Vaccinations* for rules.
14. **‘Spirometry / Lung FT’** - Date of last spirometry MBS spirometry items 11505 and 11506, spirometry observation, or record of a pathology request for investigation LUNG FUNCTION TESTING, Lung Function, LUNG FUNCTION REF, or Spirometry.

Report Synopsis

Patients with COPD Diagnosis in the practice across 30-day intervals



7.17.4. Patients with high complexity (5 and 4) (Report ID 11)

This report shows patients with the highest risk of morbidity and mortality (ACG scoring 0-5, 5 being the highest complexity). These patients are in complexity band 5 and 4 and have attended the practice at least once in the previous 12 months.

The report aims to promote 'cycles of care' by linking to interventions such as care plans, TCAs and reviews. It also presents the number of medications these patients are currently on, as a count in the past 12 months, and before that, which may prompt a review of the medication list for accuracy, and/or poly-pharmacy issues. The report also includes the date of the last medication review by a pharmacist where there is one, the last date the patient visited the practice, and if they have an existing appointment. Table 1 and 2 are identical with complexity band 5 shown in table one and band 4 in table 2.

What data is in this report?

- Patients in the complexity band 5
- Patients in complexity band 4
- If there is a greater than 80% of risk of hospitalisation in the next 12 months (based on primary care data only using the Johns Hopkins ACG tool)
- A count of current medications in the past 12 months, and a count prior to that date
- Eligibility for any of the following:
  - Chronic Condition Management Plan (GPCCP)
  - GPCCP review
  - Medication review (900)
  - Practice Nurse item number (10997): 5 in a 12-month period

7.17.5. Diabetes Mellitus (Report ID 16)

The report has three sections to target patients at risk of diabetes, those with diabetes not coded, and those with diabetes with gaps in annual cycles of care. This report contains multiple tables, and an ACG is provided in each.

Table 1 - Patients who may require a HbA1C test

Remove	ACG Score	Patient Name	Patient Phone	Last Visit	Existing Appt	GP Name	Clinic	Age	ATSI	Glucose Test Date	Glucose Result
Remove	3	Smith, R	0401 234 567	2022-07-24	Nil	Dr W Taylor	Surgery	33		2023-04-01	7.4
Remove	1	Brown, Y	0401 234 567	2021-09-22	Nil	Dr W Taylor	Surgery	49		2023-04-01	7.3
Remove	1	Smith, R	0401 234 567	2021-08-27	Nil	Dr W Taylor	Surgery	80		2023-04-01	7.5

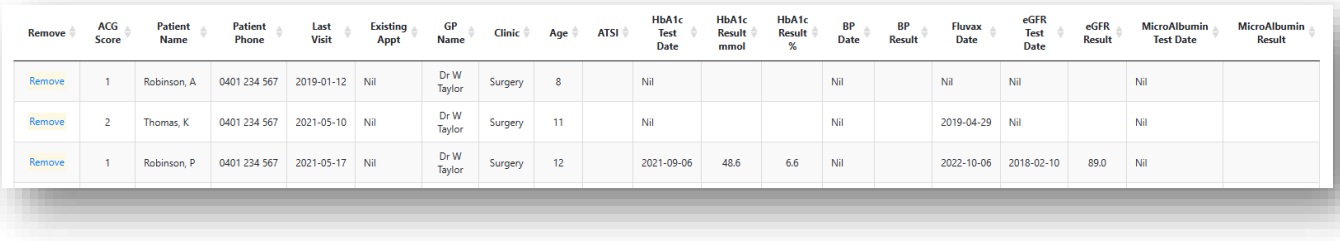
- This table lists patients with a fasting glucose >7.0mmol/l in the three months before this report who do not have a HbA1c result. As these patients are not the target group at risk of developing diabetes Type 1 or 2 as indicated by a raised fasting glucose that should be followed up with a HbA1c.
- Patients are excluded from the list if they:
    - have a coded diagnoses of diabetes mellitus
    - have polycystic ovarian syndrome
    - are prescribed anti-diabetic medication
    - are pregnant.

Table 2 - Patients who may need a clinical review for a diagnosis of diabetes

Remove	ACG Score	Patient Name	Patient Phone	Last Visit	Existing Appt	GP Name	Clinic	Age	ATSI	Diabetic Medication	Glucose Test Date	Glucose Result	HbA1c Test Date	HbA1c Result mmol	HbA1c Result %
Remove	0	Williams, D	0401 234 567	2021-05-13	Nil	Dr W Taylor	Surgery	28			2021-05-05	8.9	Nil		
Remove	3	Campbell, E	0401 234 567	2021-09-22	Nil	Dr W Taylor	Surgery	31			2019-03-01	7.8	Nil		
Remove	1	Ryan, P	0401 234 567	2020-11-18	Nil	Dr W Taylor	Surgery	32			2021-01-21	8.0	Nil		
Remove	1	Taylor, C	0401 234 567	2021-05-02	Nil	Dr W Taylor	Surgery	40			2017-07-18	7.3	Nil		
Remove	1	Smith, G	0401 234 567	2021-09-22	Nil	Dr W Taylor	Surgery	49			2021-02-03	8.3	2009-12-03	50.8	6.8

- This table lists patients who may have a diagnosis of diabetes that has not been coded.
- It includes patients with a fasting glucose >7.0mmol/l more than three months before this report, lists any anti-diabetic medication prescribed for the patient and HbA1c results prior to the fasting glucose result.
- Patients are excluded from the list if they have a coded diagnoses of diabetes mellitus or polycystic ovarian syndrome or are pregnant.
- Not all the patients in this list will have a diagnosis of diabetes mellitus – clinical review is recommended.
- HbA1c results can be provided in % or mmol/mol.

Table 3 - Patients with diabetes who may be eligible for chronic care occasions of service



Remove	ACG Score	Patient Name	Patient Phone	Last Visit	Existing Appt	GP Name	Clinic	Age	ATSI	HbA1c Test Date	HbA1c Result mmol	HbA1c Result %	BP Date	BP Result	Fluvax Date	eGFR Test Date	eGFR Result	MicroAlbumin Test Date	MicroAlbumin Result
Remove	1	Robinson, A	0401 234 567	2019-01-12	Nil	Dr W Taylor	Surgery	8		Nil			Nil		Nil	Nil		Nil	
Remove	2	Thomas, K	0401 234 567	2021-05-10	Nil	Dr W Taylor	Surgery	11		Nil			Nil		2019-04-29	Nil		Nil	
Remove	1	Robinson, P	0401 234 567	2021-05-17	Nil	Dr W Taylor	Surgery	12		2021-09-06	48.6	6.6	Nil		2022-10-06	2018-02-10	89.0	Nil	

- The table lists patients with a coded diagnosis of diabetes mellitus but excludes those patients with gestational diabetes. The most recent results are displayed (HBA1C; blood pressure; influenza vaccination; Albumin Creatinine Ratio (ACR) and Albumin Excretion Rates (AER).
- ACR results are displayed as ‘normal’, 'microalbuminuria' (ACR values of 2.5- 25mg/mmol for males and 3.5-35 mg/mmol for females; or AER values of 20- 200mg/min) and 'macroalbuminuria' (ACR of >25mg/mmol for males and
- >35mg/mmol for females; or AER >300mg/min).
- Proteinuria results are not included.
- HbA1c results can be provided in % or mmol/mol.
- Fluvax Given has date recorded as DD-MM-YYYY (D) if the Vaccination was declined. See *Declined Vaccinations* for rules.

7.17.6. Winter Wellness (Report ID 23)

Overview

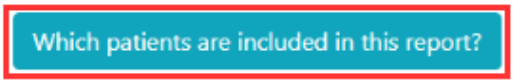
The Winter Wellness report assists clinics by identifying patients who may be vulnerable to seasonal respiratory infections. Vulnerable patients are those who are generally older, with multi-morbidity, frailty, certain diseases or immunosuppressed.

Report Content

Vulnerable patients over 5 years old who may be eligible for seasonal vaccinations.
The criteria used are:

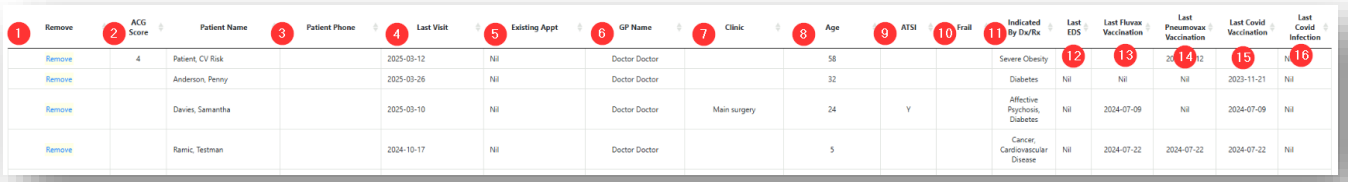
- diagnosed CKD,
- neurological disorders,
- obesity,
- affective psychosis,
- liver disease,
- severe disabilities,
- very high complexity,
- Aboriginal and Torres Strait Islander people,
- immunosuppressed patients (diagnosis or indicated by medication),
- people with either diagnosed or on medication indicating:
    - diabetes
    - cancer
    - heart disease or
    - respiratory disease
    - chronic inflammation
    - hypertension

Which patients are included in this report?



- Vulnerable patients are those who are generally older, with multi-morbidity, frailty, certain diseases or immunosuppressed. Conditions are identified by diagnosis and/or medications used to treat the conditions (Rx) - patients with high complexity scores are also included for your consideration.
- Please note the fluvax is only shown if it was given in the past 15 months, covid vaccination and pneumovax is the last date given.
- The date of the last COVID infection recorded is provided if documented.
- Please click on Information about this table for more explanation.
- EDS is a discharge summary where received from the hospital.
- Patients that are RACGP active

What data is in this report?



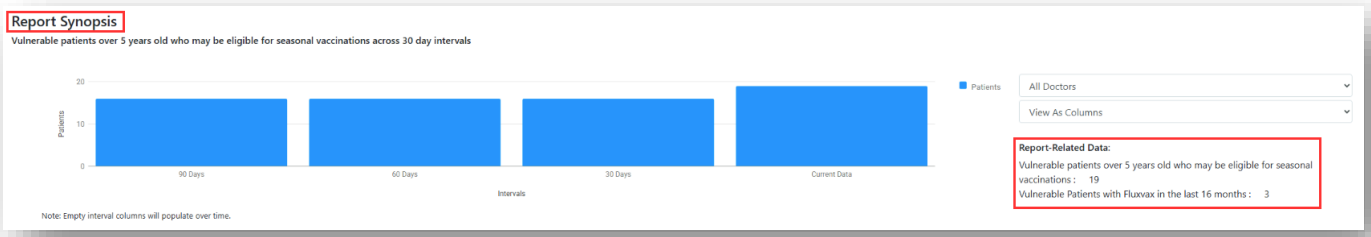
1 Remove	2 ACG Score	Patient Name	3 Patient Phone	4 Last Visit	5 Existing Appt	6 GP Name	7 Clinic	8 Age	9 ATSI	10 Frail	11 Indicated By Dx/Rx	Last EDS	Last Fluvax Vaccination	Last Pneumovax Vaccination	Last Covid Vaccination	Last Covid Infection
Remove	4	Patient, CV Risk		2025-03-12	Nil	Doctor Doctor		58			Severe Obesity	12	13	14	15	16
Remove		Anderson, Penny		2025-03-26	Nil	Doctor Doctor		32			Diabetes	Nil	Nil	Nil	2023-11-21	Nil
Remove		Davies, Samantha		2025-03-10	Nil	Doctor Doctor	Main surgery	24	Y		Affective Psychosis, Diabetes	Nil	2024-07-09	Nil	2024-07-09	Nil
Remove		Ramic, Testman		2024-10-17	Nil	Doctor Doctor		5			Cancer, Cardiovascular Disease	Nil	2024-07-22	2024-07-22	2024-07-22	Nil

1. **'Remove'** - Patients can be removed from the report for 12 months, by clicking 'Remove.' This action cannot be reversed and removes the patient from this report for all clinicians.
2. **'ACG Score'** - the complexity bands formed by combining the ACGs to measure overall morbidity burden on a scale of 0-5, with 5 being the most complex/morbidity burden.
3. Patient demographic data.
4. **'Last Visit'** column displays the date the patient last had an appointment at the practice.
5. **'Existing appt'** column displays patient appointments that have been booked for dates beyond the report.
6. **'GP Name'** shows the GP who has most accessed the patient record. See *Calculating Patient GP* for rules.
7. **'Clinic'** displays most attended clinic if data is shared.
8. **'Age'** - Patient age at time the report is run.
9. **'ATSI'** where patient is identified as: Aboriginal, Aboriginal/Torres Strait Islander or Torres Strait Islander
10. **'Frailty'** - calculated by referencing the ACG Frailty Flag.
11. **'Indicated by Dx/Rx'** - Conditions are identified by diagnosis or medications (Rx) used for treatment. Patients with high complexity scores are also considered. The criteria used are:

a. Diagnosed CKD, neurological disorders, obesity, affective psychosis, liver disease and severe disabilities
b. With very high complexity
c. Aboriginal and Torres Strait Islander people
d. Immunosuppressed patients (diagnosis or indicated by medication)
e. People with either diagnosed or on medication indicating diabetes, cancer, chronic inflammation, hypertension heart disease and/or respiratory disease.

12. **'Last EDS'** date where the last Electronic Discharge Summary (EDS) was recorded.
13. **'Last Fluvax Vaccination'** - date of flu vaccination recorded within 15 months of the date of the report. DD-MM-YYYY (D) = Date Vaccination Declined. See *Declined Vaccinations* for rules.
14. **'Last Pneumovax vaccination'** - date of last recorded Pneumococcal vaccination. DD-MM-YYYY (D) = Date Vaccination Declined. See *Declined Vaccinations* for rules.
15. **'Last Covid vaccination'** - date of last recorded Covid vaccination. DD-MM-YYYY (D) = Date Vaccination Declined. See *Declined Vaccinations* for rules.
16. **'Last Covid Infection'** - The date of the last recorded COVID infection is shown if documented.

Report Synopsis



Vulnerable patients over 5 years old who may be eligible for seasonal vaccinations across 30 day intervals.

Lists the number of Vulnerable Patients with Fluxvax administered in the last 16 months.

7.17.7. Hypertension Management (Report ID 25)

Overview

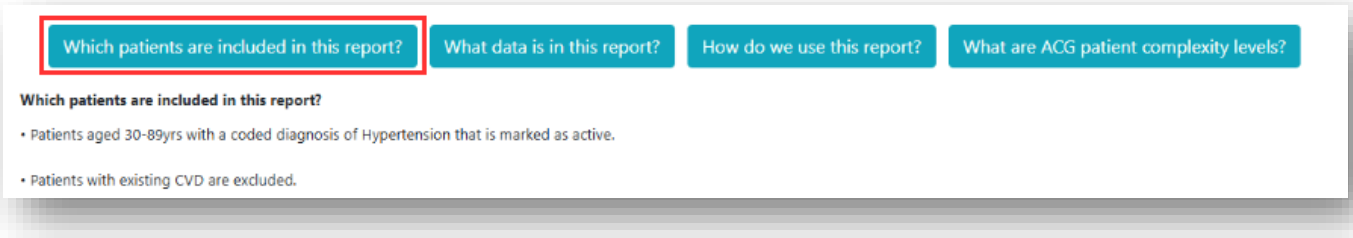
The Hypertension Management report was made available in the August Release 2.14 (Friday 18 August), and is designed to highlight patients aged 30-89 years, with coded Hypertension that are marked as 'active' in the Clinical Information System (i.e. Best Practice or Medical Director), and who are missing the recommended annual monitoring interventions and/or missing recommended medications.

The table within the report highlights where specific prescriptions for anti-hypertensive or lipid lowering medication is either missing or not recorded in the past 18 months – practices may wish to use the 'search' function to target patients with an existing appointment date for further review in a consult. Note that patients with existing CVD are excluded from the report.

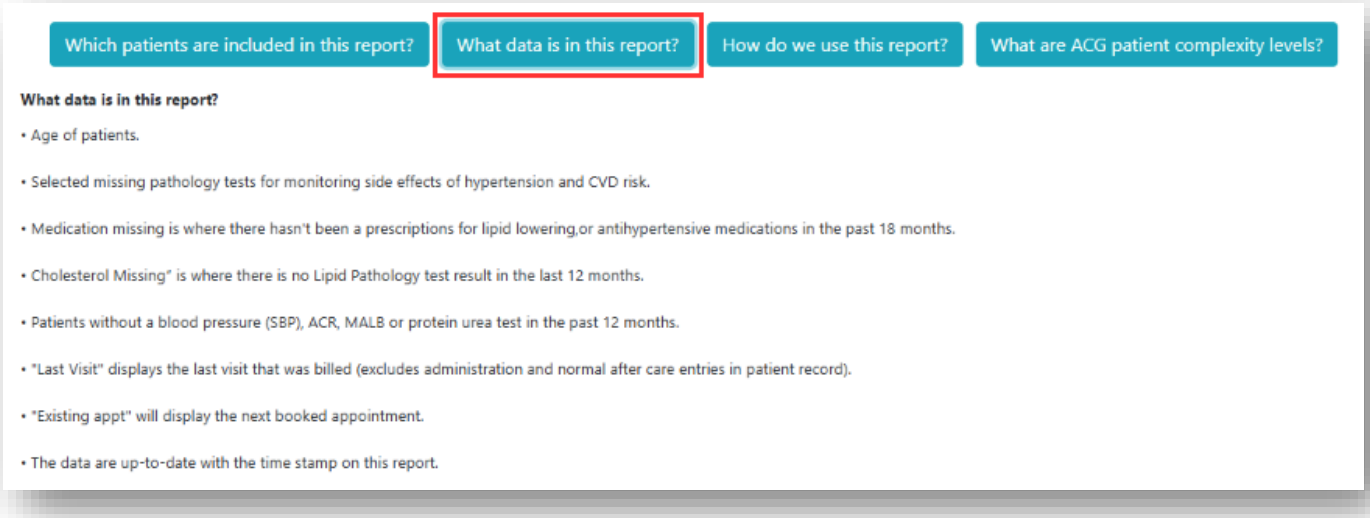
Report Content

- Patients aged 30-89yrs with a coded diagnosis of hypertension without prescriptions for lipid lowering, or antihypertensive medications in the past 18 months.
- blood pressure (SBP), cholesterol, Albumin Creatinine Ratio (ACR), microalbumin urea (MALB) or proteinuria test in the past 12 months.

Which patients are included in this report?

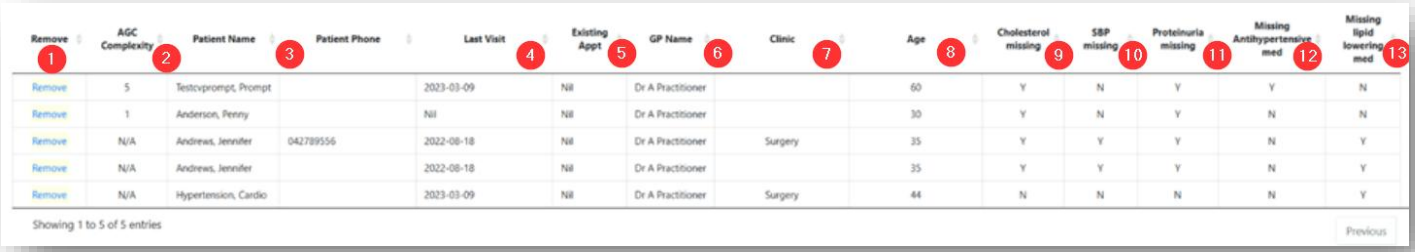


What data is in this report?



Patients included in the report are those active in the Clinical Information System (CIS). The RACGP 'Active'

definition does not apply to this report.



Remove 1	AGC Complexity 2	Patient Name 3	Patient Phone	Last Visit 4	Existing Appt 5	GP Name 6	Clinic 7	Age 8	Cholesterol missing 9	SBP missing 10	Proteinuria missing 11	Missing Antihypertensive med 12	Missing lipid lowering med 13
Remove	5	Testcvprompt, Prompt		2023-03-09	Nil	Dr A Practitioner		60	Y	N	Y	Y	N
Remove	1	Anderson, Penny		Nil	Nil	Dr A Practitioner		30	Y	N	Y	N	N
Remove	N/A	Andrews, Jennifer	042789556	2022-08-18	Nil	Dr A Practitioner	Surgery	35	Y	Y	Y	N	Y
Remove	N/A	Andrews, Jennifer		2022-08-18	Nil	Dr A Practitioner		35	Y	Y	Y	N	Y
Remove	N/A	Hypertension, Cardio		2023-03-09	Nil	Dr A Practitioner	Surgery	44	N	N	N	N	Y

Showing 1 to 5 of 5 entries

Previous

Patients without a blood pressure (SBP), ACR, MALB or protein urea test in the past 12 months.

1. **'Remove'** - Patients can be removed from the report for 12 months, by clicking 'Remove.' This action cannot be reversed and removes the patient from this report for all clinicians.
2. **'ACG Score'** - the complexity bands formed by combining the ACGs to measure overall morbidity burden on a scale of 0-5, with 5 being the most complex/morbidity burden.
3. Patient demographic data.
4. **'Last Visit'** column displays the date the patient last had an appointment at the practice.
5. **'Existing appt'** column displays patient appointments that have been booked for dates beyond the report.
6. **'GP Name'** shows the GP who has most accessed the patient record. See *Calculating Patient GP* for rules.
7. **'Clinic'** displays most attended clinic if data is shared.
8. Patient age at time the report is run.
9. **'Cholesterol missing'** - Patients without a Lipid Pathology test result in the last 12 months
10. **'SBP missing'** - Patients without a Systolic Blood Pressure recorded in the last 12 months
11. **'Proteinuria missing'** - Patients without a Micro Albumin or Albumin-to-Creatinine Ratio Pathology test result recorded in the last 12 months
12. **'Missing Antihypertensive med'** - there has been no prescription for antihypertensive medications in the past 18 months.
13. **'Missing lipid lowering med'** - there has been no prescription for lipid lowering medications in the past 18 months.

Report Synopsis

- Patients with Hypertension diagnosis in the practice across 30-day intervals missing the listed records.

7.17.8. Cardiovascular Disease Management (Report ID 27)

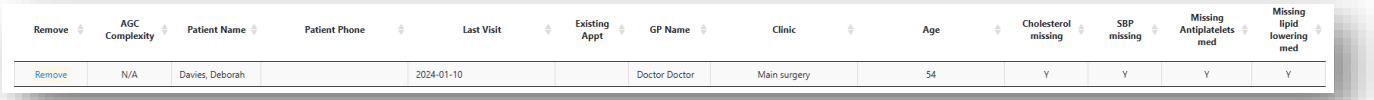
This report highlights gaps in care for patients with cardiovascular disease.

Please note patients may appear in more than one table.

- Patients aged 30-89 yrs old with Cardiovascular disease or risk of related events including Transient Ischemic attacks and Atrial fibrillation. with missing interventions.
- Patients missing interventions are included. Medications require a script in the past 18 months to be considered as active.
- Conditions are used where active or inactive due to risks.
- Nursing home patients are excluded based on related MBS billing.

Report Content

Table 1 - Patients with Stroke or Transient Ischemic Attacks



Remove	AGC Complexity	Patient Name	Patient Phone	Last Visit	Existing Appt	GP Name	Clinic	Age	Cholesterol missing	SBP missing	Missing Antiplatelets med	Missing lipid lowering med
Remove	N/A	Davies, Deborah		2024-01-10		Doctor Doctor	Main surgery	54	Y	Y	Y	Y

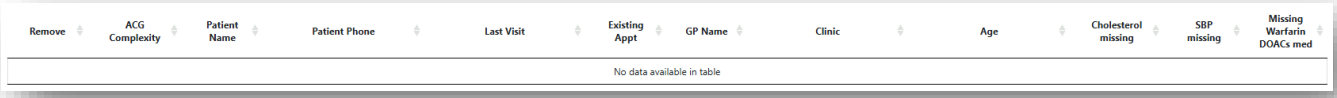
- Y means missing or not recorded.
- Report synopsis - Patients with Cardio disease in the practice across 30-day intervals
- Patients with Stroke/TIA, missing treatments
- Patients with Atherosclerotic/PVD, missing treatments
- Patients with Atrial Arythmia, missing treatments
- Patients with Cardio disease, due Fluvax

Table 2 - Patients with Atherosclerotic Disease or Peripheral Vascular Disease

Remove	AGC Complexity	Patient Name	Patient Phone	Last Visit	Existing Appt	GP Name	Clinic	Age	Cholesterol missing	SBP missing	Missing Antiplatelets med	Missing lipid lowering med
No data available in table												

- Y means missing or not recorded.
- Patients with coded stroke or Transient Ischemic Attacks marked active or inactive without:
  - blood pressure reading in the last 12 months or
  - lipid tests in the last 12 months or
  - prescription for anti-platelet therapy (e.g. Aspirin / Clopidogrel) in the past 18 months
  - prescription for a lipid lowering medication in the past 18 months.

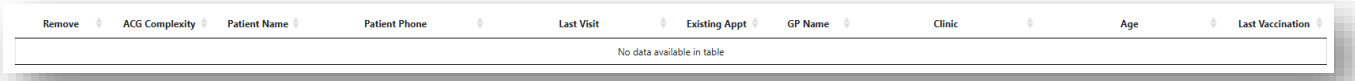
Table 3 - Patients with Atrial fibrillation, Atrial flutter



Remove	ACG Complexity	Patient Name	Patient Phone	Last Visit	Existing Appt	GP Name	Clinic	Age	Cholesterol missing	SBP missing	Missing Warfarin DOACs med
No data available in table											

- Y means missing or not recorded.
- Patients with coded atherosclerosis or Peripheral Vascular Disease active or inactive without:
  - blood pressure reading in the last 12 months or
  - lipid tests in the last 12 months or
  - prescription for anti-platelet therapy (e.g. Aspirin / Clopidogrel) in the past 18 months
  - prescription for a lipid lowering medication in the past 18 months.

Table 4 - Patients with CVD that are due Influenza Vaccination



Remove	ACG Complexity	Patient Name	Patient Phone	Last Visit	Existing Appt	GP Name	Clinic	Age	Last Vaccination
No data available in table									

- Y means missing or not recorded.
- Patients in this table have the conditions listed in the rest of the report and haven't had a seasonal influenza vaccination as of 1st Feb each year. They are in a separate table due to everyone potentially being listed at the beginning of year, which may detract from the cardiac disease management interventions as listed in the other tables. Please Check AIR.

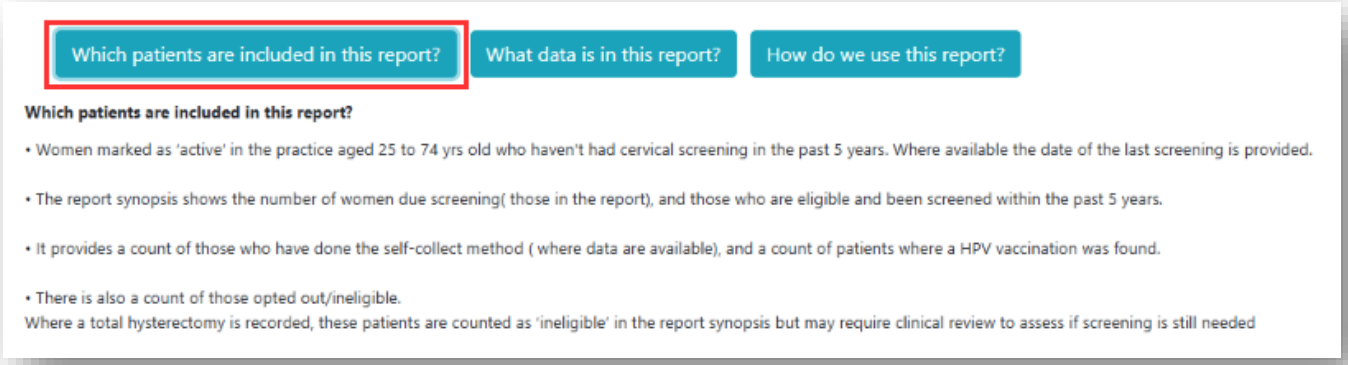
7.17.9. Cervical Screening Report (Report ID 30)

Overview

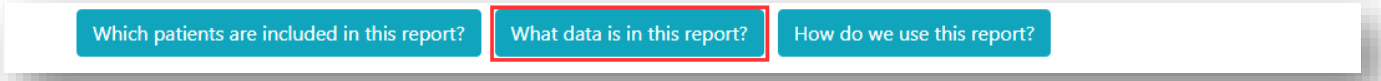
The Cervical Cancer Screening report was made available in the January Release V2.35 (31 January). The report was funded by C2CPHN. The report displays patient data to facilitate identifying patients who may be due for a cervical screen. The report looks for evidence of cervical screening testing recorded in the pathology request, as a reason for the visit, and from the results coming back to the practice. The report follows recommendations listed in:
Who should get a Cervical Screening Test | Australian Government Department of Health and Aged Care
Clinicians should also refer to *Home | National Cancer Screening Register* as patients may have completed screening at another clinic.

Report Content

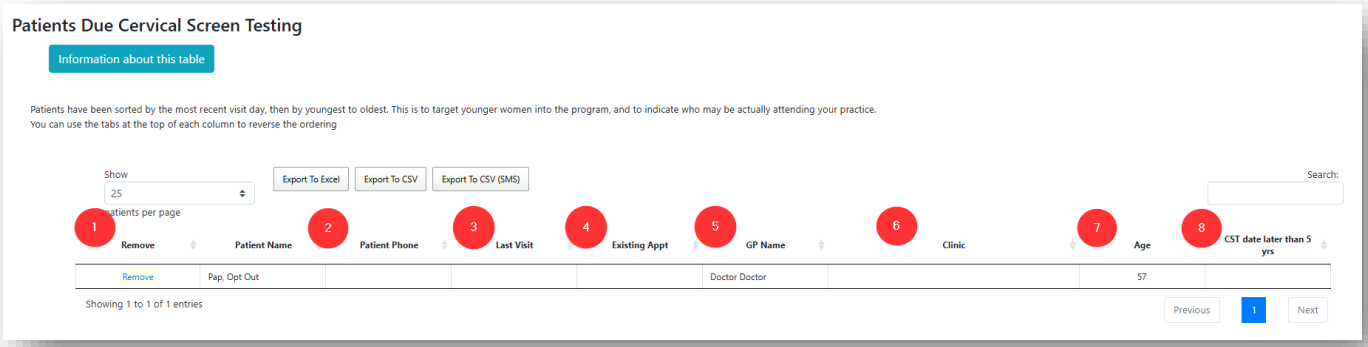
Which patients are included in this report?



What data is in this report?



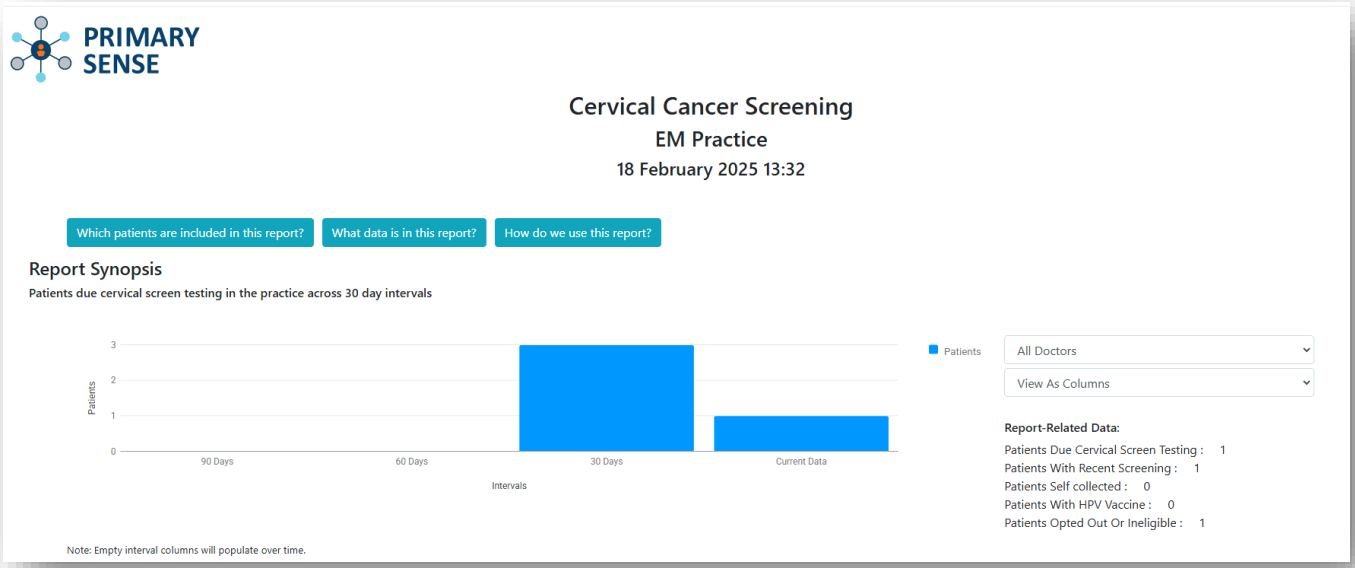
- Evidence of cervical screening testing recorded in the pathology request, as a reason for the visit, and from the results coming back to the practice.
- Patients included in the report are those active in the Clinical Information System (CIS). The RACGP 'Active' definition does not apply to this report.



Patients have been sorted by the most recent visit day, then by youngest to oldest. This is to target younger women into the program, and to indicate who may be attending your practice.
You can use the tabs at the top of each column to reverse the ordering.

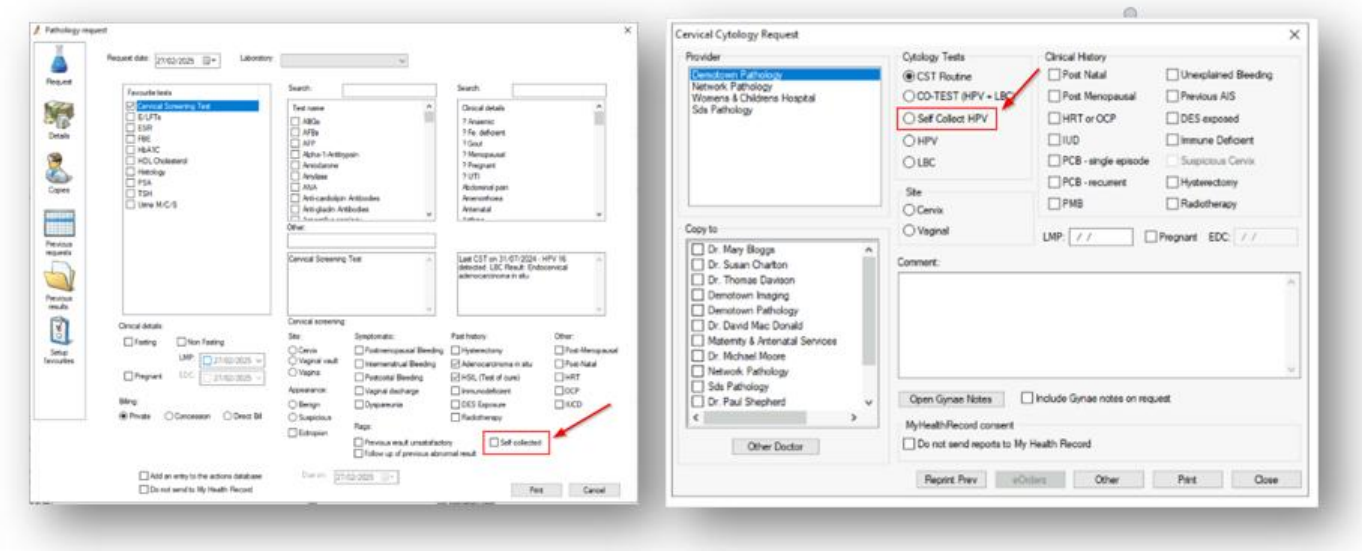
1. **'Remove'** - Patients can be removed from the report for 12 months, by clicking 'Remove.' This action cannot be reversed and removes the patient from this report for all clinicians.
2. Patient demographic data.
3. **'Last Visit'** column displays the date the patient last had an appointment at the practice.
4. **'Existing appt'** column displays patient appointments that have been booked for dates beyond the report.
5. **'GP Name'** shows the GP who has most accessed the patient record. See *Calculating Patient GP* for rules.
6. **'Clinic'** displays most attended clinic if data is shared.
7. **'Age'** - Patient age at time the report is run.
8. **'CST date later than 5 years'** indicates that over 5 years has passed since the last recorded screening date (noting data only goes back 5 years on initial extract so will likely be blank until clinics have been on Primary Sense for over 5 years)

Report Synopsis



- Patients meeting all criteria and requiring a screening.
- Patients with Recent Screening – within the last 5 years.
- Patients with self-collected tests are included in the report (Recorded as Self Collected in the CIS Cervical Screening pathology request form).

> ***Note:*** *Self-collected in Best Practice will not show in the report until the result has been received.*



- Number of women where at least one HPV vaccination is found.
- Patients who have opted out of screening in the CIS or where a total hysterectomy is recorded, these patients are counted as 'ineligible' in the report synopsis. Patients who have opted out will have a flag next to them on the patient table

7.17.10. Health Assessments (Report ID 6)

This report shows the risk metrics for patients who would be eligible for proactive care to prevent or delay the onset of a chronic disease. These patients are eligible for a health assessment (will need to be confirmed at the practice). The risk of chronic disease risk score are those factors that are provided as examples under the MBS requirement. A count of two or more is used to suggest eligibility. Patients with nursing home MBS items are excluded.

Report Content

Which patients are included in this report?

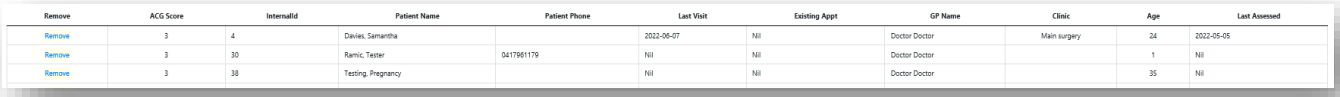
Table 1 - Health Assessments of patients aged 40-49 years (includes 45-49 years)

- MBS Health Assessments referenced are 701, 703, 705, 707, 715, 224, 225, 226, 227, 228, 92004, 92016. If these MBS codes are not recorded then Health Assessment Visit Reason ICPC Codes IDs 44811 (K43007), 44812 (K43007), 44741 (K43007), 45109 (K43007), 45110 (K43007), 631 (A30028), 34749 (A30028) are referenced instead for Assessment Date.
- Table 1 does not include Aboriginal and Torres Strait Islander people as they are listed in table 2
- Patients with a Chronic Disease Risk Score (CDRS) of ≥2 or a Diabetes Risk Score (DRS) (based on the modified AUSDRISK score).
- Chronic Disease Risk Score (CDRS) based on MBS criteria for the *assessment* including:
  - smoking,
  - alcohol use,
  - high cholesterol,
  - high blood pressure,
  - impaired glucose metabolism or excess weight
- The CDRS range is 0 to 6, with 6 indicating the highest risk. Patients scored one point for each of the following six factors:
  - Smoker;
  - higher than recommended alcohol use;
  - Systolic blood pressure >140 mmHg;
  - BMI >25;
  - Fasting BGL >7 mmol/L;
  - Total cholesterol >5.5 mmol/L.
- The DRS score is calculated by giving points for the following factors:
  - Male gender =3;
  - Age 40-44 =2 or 45-49 =4;
  - Fasting BGL >7 mmol/L =6;
  - smoker =2;
  - prescribed antihypertensive medication =2;
  - Aboriginal and Torres Strait Islander =2.
- Higher scores indicate greater risk of poor health outcomes.
- Consider offering patients at high-risk further investigations to exclude diabetes and opportunities to address modifiable risk factors.
- Some patients in this list may be eligible for more than one type of health assessment.
- Patients with a family history of diabetes are eligible for a 45-49 year old health assessment, but this information cannot be extracted from practice software.

What data is in this report?

1. **'Remove'** - Patients can be removed from the report for 12 months, by clicking 'Remove.' This action cannot be reversed and removes the patient from this report for all clinicians.
2. **'ACG Score'** - the complexity bands formed by combining the ACGs to measure overall morbidity burden on a scale of 0-5, with 5 being the most complex/morbidity burden.
3. Patient demographic data.
4. **'Last Visit'** column displays the date the patient last had an appointment at the practice.
5. **'Existing Appt'** column displays patient appointments that have been booked for dates beyond the report.
6. **'GP Name'** shows the GP who has most accessed the patient record. See *Calculating Patient GP* for rules.
7. **'Clinic'** displays most attended clinic if data is shared.
8. **'Age'** - Patient age at time the report is run (to protect patient confidentiality, the age of all patients older than 90 years are displayed as 90)
9. **'Chronic Disease Risk Score'** - See above information for the calculations of the CDRS
10. **'Diabetes Risk Score'** - See above information for the calculations of the DRS
11. **'Last Assessed'** – Date of last Health Assessment

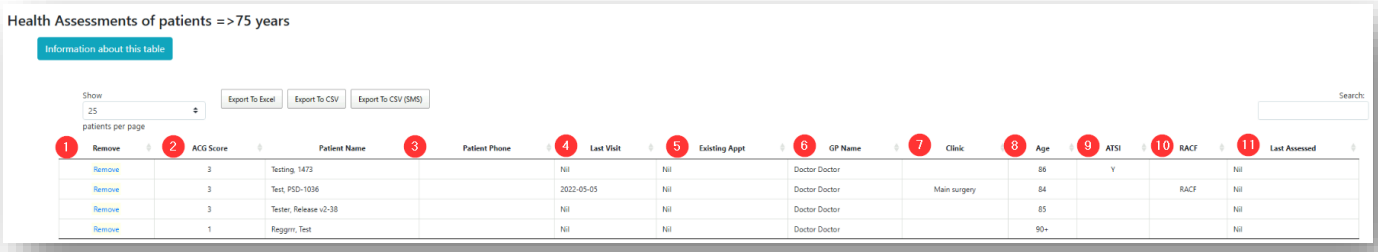
Table 2 - Health Assessments of Aboriginal and Torres Strait Islander patients



- This table lists patients who are recorded as Aboriginal and Torres Strait Islander and have not had a health assessment in the previous nine months (as indicated by the presence of MBS item 715 or 228 or ICPC Codes listed above). Includes new COVID-19 Telehealth item numbers.

Table 3 - Health Assessments of patients =>75 years

- This table lists patients who are =/> 75 years, and who have not had a health assessment in the previous 12 months (as indicated by the presence of MBS items 703, 705 or 707 or ICPC Codes listed above).



1. **'Remove'** - Patients can be removed from the report for 12 months, by clicking 'Remove.' This action cannot be reversed.
2. **'ACG Score'** - the complexity bands formed by combining the ACGs to measure overall morbidity burden on a scale of 0-5, with 5 being the most complex/morbidity burden.
3. Patient demographic data.
4. **'Last Visit'** column displays the date the patient last had an appointment at the practice.
5. **'Existing Appt'** column displays patient appointments that have been booked for dates beyond the report.
6. **'GP Name'** shows the GP who has most accessed the patient record. See *Calculating Patient GP* for rules.
7. **'Clinic'** displays most attended clinic if data is shared.
8. **'Age'** - Patient age at time the report is run (to protect patient confidentiality, the age of all patients older than 90 years are displayed as 90)
9. **'ATSI'** where patient is identified as: Aboriginal, Aboriginal/Torres Strait Islander or Torres Strait Islander
10. **'RACF'** identified by patients having an Aged care MBS billing code withing the last 12 months. Does not reference marked as RACF in the CIS. MBS codes referenced are 731, 90001, 90020, 90035, 90043, 90051, 90092, 90093, 90095, 90096, 90183, 90188, 90202, 90212, 92026, 92070, 92027, 92071.
11. **'Last Assessed'** – Date of last Health Assessment

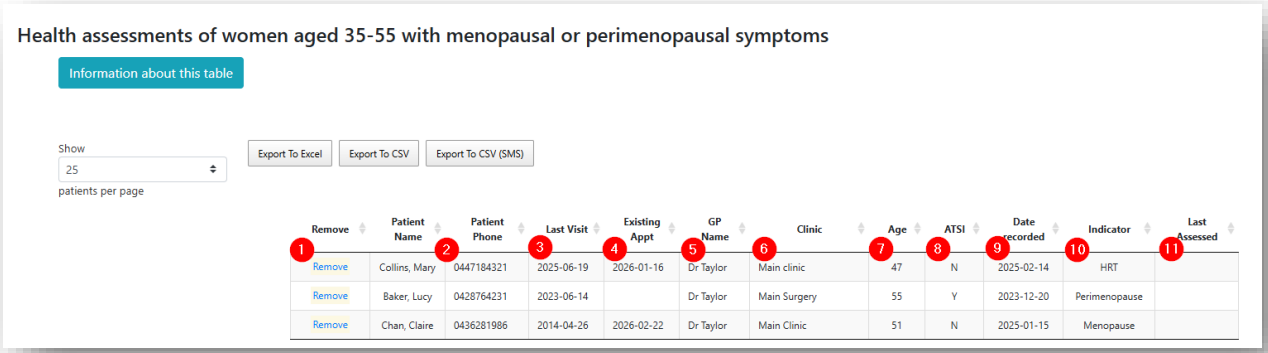
Table 4 - Health assessments of women aged 35-55 with menopausal or perimenopausal symptoms

A new government initiative was introduced on 1 July 2025, and included two new temporary MBS items (695 and 19000) for Health Assessments targeting women experiencing Menopause or Perimenopause.

Both of these new items apply only to patients who are experiencing one or more symptoms for the following, or undergoing treatment for those symptoms as shown in the indicator column, with the last date recorded:

- Premature ovarian insufficiency;
- Early menopause;
- Perimenopause;
- Menopause

and have not received these services within the preceding 12 months.



1. **'Remove'** - Patients can be removed from the report for 12 months, by clicking 'Remove.' This action cannot be reversed.
2. Patient demographic data.
3. **'Last Visit'** column displays the date the patient last had an appointment at the practice.
4. **'Existing Appt'** column displays patient appointments that have been booked for dates beyond the report.
5. **'GP Name'** shows the GP who has most accessed the patient record. See *Calculating Patient GP* for rules.
6. **'Clinic'** displays most attended clinic if data is shared.
7. **'Age'** - Patient age at time the report is run (to protect patient confidentiality, the age of all patients older than 90 years are displayed as 90)
8. **'ATSI'** where patient is identified as: Aboriginal, Aboriginal/Torres Strait Islander or Torres Strait Islander
9. **'Date Recorded'** – The date the diagnosis/Reason for visit indicator was recorded
10. **'Indicator** –The diagnosis/Reason for visit indicator which meets the report criteria
11. **'Last Assessed'** – Date of last Health Assessment MBS item 695 or 19000

7.17.11. Benzodiazepine in substance misuse (Report ID 8)

This report highlights patients with substance misuse or a severe mental health condition, which have been prescribed benzodiazepine. Patients on this report may be eligible for mental health care occasions of service.

Report includes:

- ACG score
- The generic drug names
- Date the drug was started
- The count of mental health conditions
- Mental health care plan
- Mental health care plan review

7.17.12. Hemochromatosis (Report ID 10)

The report lists patients with a raised transferrin saturation result (>50%) or two raised ferritin results (>300 ug/l for men and >200 ug/l for women) who do not have a coded diagnosis of haemochromatosis or a record of a hemochromatosis gene (HFE) test. It states that patients are eligible for an MBS rebate for the HFE gene test if the patient:

- has elevated transferrin saturation levels, or two or more abnormally raised serum ferritin results
- has a first-degree relative with haemochromatosis
- is homozygous for the C282Y gene variant or a compound heterozygote.

These patients may also be eligible for a venesection (MBS) item 13757.

Report includes:

- Transferrin saturation result and date
- Date of the first and second ferritin results

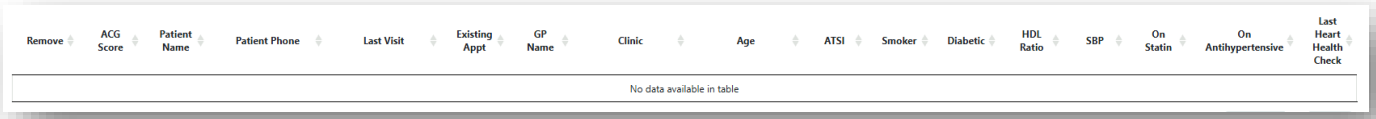
7.17.13. Cardiovascular Disease Risk Factors (Report ID 27)

Overview

This report highlights patients who are at risk of cardiovascular disease. Only patients who are not on dual therapy (statin and antihypertensive) are included in the report. An ACG score is provided in each table, and a link to the CVD calculator is provided. Note that CV risk is currently still calculated using the old Heart Foundation calculator, however a link to the new Australian CVD risk calculator is available in the report *Australian CVD risk calculator*

Which patients are included in this report?

- Patients between 30-79 years of age for ATSI, 35-79 years of age for diabetics, and 45-79 years old for other groups; and
- A CVD risk score of moderate to high in the next 5 years; and
- they are not prescribed anti-lipid or antihypertensive medication; and
- who have at least one recorded consultation (reason for visit or diagnosis) or have been prescribed medication within 18 months of the date of this report



What data is in this report?

Table 1 - Patients with high CVD risk

- The table lists patients with high CVD risk
- CVD risk scores were calculated using the Framingham risk calculator, which includes: SBP (treated and untreated),
    - total cholesterol,
    - HDL,
    - gender,
    - age
    - smoking status
- The table lists patients whose most recent recorded SBP was >180, and/or with a total cholesterol >7.5 mmol/l
- 'Clinically determined' is a level D recommendation of CVD risk guidelines and based on the clinical information or pathology results available in medical records. Risk and appropriate treatment (or not) should therefore be considered by the treating clinician for each individual patient
- Patients are not on dual therapy (statin and antihypertensive)
- Date of last healthy heart check MBS item
- CVD scores may underestimate the risk of patients with the following conditions or characteristics:
    - Left ventricular hypertrophy;
    - Aboriginal and Torres Strait Islander people;
    - CKD;
    - Depression;

- socioeconomic disadvantage;
- Family history of premature CVD

Table 2 - Patients with moderate CVD risk

- The table lists patients with a moderate CVD risk
- CVD risk scores were calculated using the Framingham risk calculator, which includes: SBP (treated and untreated), total cholesterol, HDL, gender, age and smoking status
- CVD scores may underestimate the risk of patients with the following conditions or characteristics: Left ventricular hypertrophy; Aboriginal and Torres Strait Islander people; chronic kidney disease; depression; socioeconomic disadvantage; family history of premature CVD
- Date of last Healthy Heart Check MBS item
- The table lists patients with high CVD risk
- CVD risk scores were calculated using the Framingham risk calculator, which includes:
  - SBP (treated and untreated),
  - total cholesterol,
  - HDL,
  - gender,
  - age
  - smoking status
- The table lists patients whose most recent recorded SBP was >180, and/or with a total cholesterol >7.5 mmol/l
- 'Clinically determined' is a level D recommendation of CVD risk guidelines and based on the clinical information or pathology results available in medical records. Risk and appropriate treatment (or not) should therefore be considered by the treating clinician for each individual patient
- Patients are not on dual therapy (statin and antihypertensive)
- Date of last healthy heart check MBS item

7.17.14. Bowel and Breast Cancer Screening (Report ID 24)

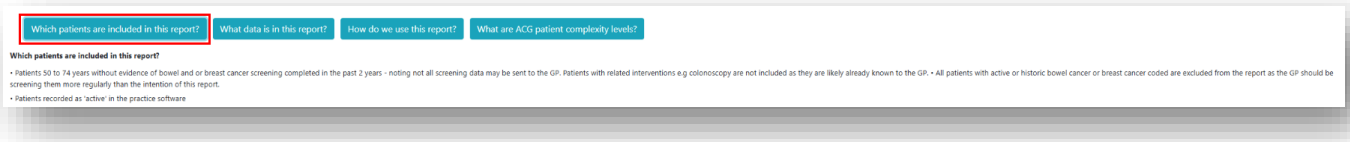
This report includes patients aged 45 - 74 years (and female Aboriginal and Torres Strait Islander patients aged 40-49, as they are eligible for breast cancer screening from age 40 in some states) without evidence of bowel and/or breast cancer screening completed in the past two years (noting that not all screening data may be sent to the GP.) Patients with related interventions e.g. colonoscopy are not included.

Patients with either **active or inactive** bowel screening codes are excluded from the report if the procedure date is within the last two years.

The report uses patients marked as active in the practice software. Due to the recent Covid-19 vaccination programs inflating numbers of patients marked as active, practices are advised where they have good percentage of smoking recorded that the best way to find their regular patients is to filter on that column by clicking the up and down arrow in the 'smoking status' column.

Report Content

Which patients are included in this report?



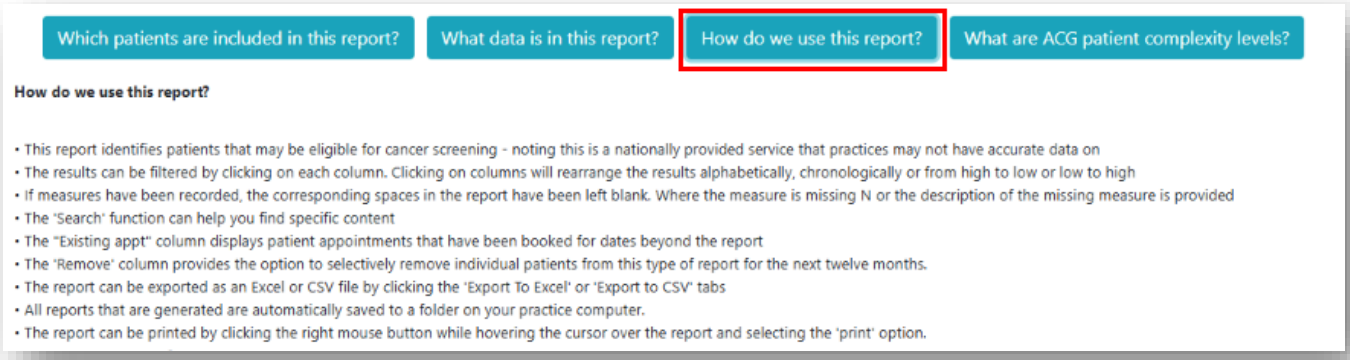
- Patients 50 to 74 years without evidence of bowel and or breast cancer screening completed in the past 2 years - noting not all screening data may be sent to the GP. Patients with related interventions e.g. colonoscopy are not included as they are likely already known to the GP.
- All patients with active or historic bowel cancer or breast cancer coded are excluded from the report as the GP should be screening them more regularly than the intention of this report.
- Patients recorded as 'active' in the practice software

What data is in this report?

- Age of patients - to protect patient confidentiality, the age of all patients older than 90 years are displayed as 90
- Gender
- Coded diagnoses
- Pathology requests/results

- Observations and lifestyle measures
- The data are up-to-date with the time stamp on this report.

How do we use this report?



- This report identifies patients that may be eligible for cancer screening - noting this is a nationally provided service that practices may not have accurate data on
- The results can be filtered by clicking on each column. Clicking on columns will rearrange the results alphabetically, chronologically or from high to low or low to high
- If measures have been recorded, the corresponding spaces in the report have been left blank. Where the measure is missing N or the description of the missing measure is provided
- The 'Search' function can help you find specific content
- The "Existing appt" column displays patient appointments that have been booked for dates beyond the report
- The 'Remove' column provides the option to selectively remove individual patients from this type of report for the next twelve months.
- The report can be exported as an Excel or CSV file by clicking the 'Export To Excel' or 'Export to CSV' tabs
- All reports that are generated are automatically saved to a folder on your practice computer.
- The report can be printed by clicking the right mouse button while hovering the cursor over the report and selecting the 'print' option.

Table 1 - Male patients eligible for bowel cancer screening

- Male patients: Excludes patients with a colonoscopy in the past two years, bowel cancer and colostomy
- Includes risk factors of smoking and obesity - ‘N/A’ means not recorded.
- Alcohol use is how the practice software describes it or the AUDITC - ‘N/A’ means not recorded

Table 2 - Female patients eligible for breast cancer screening and or bowel cancer screening

- Excludes women with a history of breast cancer
- Excludes patients with a colonoscopy in the past two years, bowel cancer and colostomy
- Includes risk factors of smoking and obesity. ‘N/A’ means not recorded.
- Alcohol use is how the practice software describes it or the AUDITC. ‘N/A’ means not recorded
- The 'screening' column indicates which screening could be done. N/A means not recorded

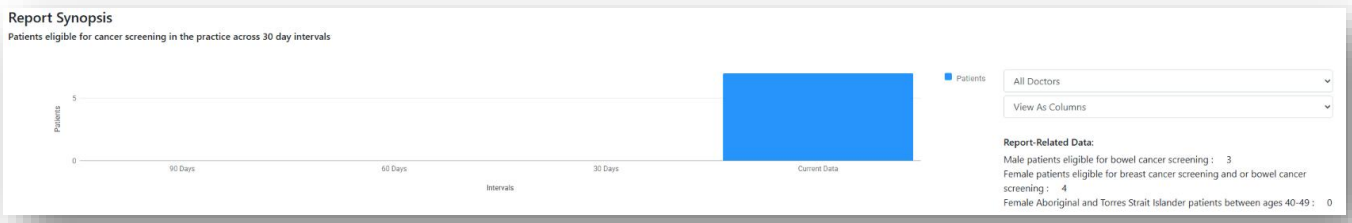
Table 3 - Female Aboriginal and Torres Strait Islander patients between ages 40-49

- Includes all patients that identify as female and Aboriginal/Torres Strait Islander within the ages of 40-49
- Includes risk factors of smoking and obesity. ‘N/A’ means not recorded.
- Alcohol use is how the practice software describes it or the AUDITC. ‘N/A’ means not recorded
- The 'screening' column indicates which screening could be done. N/A means not recorded

Columns Returned

1. **‘Remove’** - Patients can be removed from the report for 12 months, by clicking ‘Remove.’ This action cannot be reversed and removes the patient from this report for all clinicians.
2. Patient demographic data.
3. **'Last Visit'** - displays the date the patient last had an appointment at the practice.
4. **‘Existing Appt’** - displays patient appointments that have been booked for dates beyond the report.
5. **‘GP Name’** - the GP who has most accessed the patient record. See *Calculating Patient GP* for rules.
6. **‘Clinic’** - most attended clinic if data is shared.
7. **‘Age’** - Patient age at time the report is run.
8. **‘Smoking Status’**- Latest smoking status recorded, returns Smoker, Non-smoker or Ex-smoker.
9. **‘Alcohol Status’ -**
10. **‘Obese’ –** Patients where BMI >= 30
11. **‘Screening’** – Indicates which screening can be done

Report Synopsis



- Male patients eligible for bowel cancer screening
- Female patients eligible for breast cancer screening and or bowel cancer screening
- Female Aboriginal and Torres Strait Islander patients between ages 40-49

- Results can be filtered to a specific GP who has most accessed the patient record.
- Synopsis can be viewed as columns or bars.

7.17.15. Frailty Care Management (Report ID 17)

This report includes patients 65 yrs and over who have frailty risk factors recorded in the past 2 years (including falls, nutrition issues, lethargy or feeling depressed), and/or have a frailty flag generated by Johns Hopkins ACG tool (including incontinence, decubitus skin ulcers or dementia), and may be at risk of seasonal respiratory infections, increasing frailty, or isolated. As some of this information may not be well coded the report is intended as a resource to help identify patients with frailty indicators that may require review or confirmation of their frailty status.

Report includes

- ACG score
- If there is a greater than 80% of hospital risk in the next 12 months
- Count of chronic conditions (from ACG)
- If marked as living alone
- The frailty indicator(s) listed
- ACG frailty flag if present (as a Y)
- If the patient is on sedatives
- Chest infection(s) in the past 2 years
- Influenza infection in the past 2 years
- Date of last influenza vaccination in the past 15 months. Date recorded as DD-MM-YYYY (D) if the Vaccination was declined. See *Declined Vaccinations* for rules.

7.17.16. MyMedicare - Voluntary Patient Registration (Report ID 28)

Overview

The Voluntary Patient Registration report was made available in the September Release 2.17 (Tuesday 26 August), and is designed to highlight patients 'at risk,' who would benefit from enrollment. Voluntary patient enrollment is intended to promote continuity of care, strengthen the relationship between a patient, their General Practice and preferred care team, and help participating practices and providers better understand and meet their patients' needs.

Primary Sense can identify both at risk patients who would benefit from enrollment, and those that are currently experiencing fragmented care within a practice – the Voluntary Patient Registration report captures both, allowing practices to identify patients likely to meet the criteria for voluntary patient registration, and encourage that conversation at the point of care.

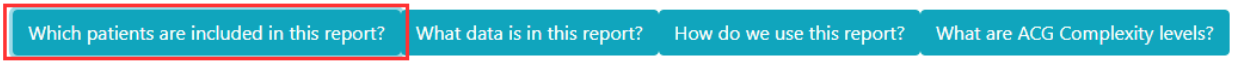
Practices may consider using the 'search' field to identify patients with scheduled appointments, facilitating ongoing discussions during consultations. For instance, entering today's date can generate a list of patients who are visiting on that specific day.

Details on what constitutes both 'high risk' and 'fragmented care' are included in the 'information about this table' tab for patients likely to meet criteria for voluntary patient registration.

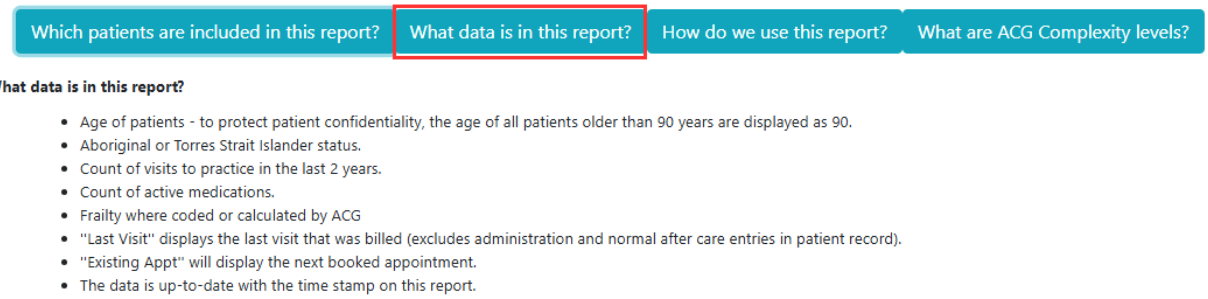
***Note:** Practices are encouraged to confirm with a patient if they are enrolled elsewhere or check PRODA as this is not captured within the report itself.*

Report Content

Which patients are included in this report?



- Patients with a high hospital risk score - >80% in the past 12 months
- Frailty – calculated from ACG or coded by the GP
- Severe/excessive/major polypharmacy >10 medications prescribed in the past 18 months and not ceased
- Two or more hospital or ED attendance in the past year (where able to be extracted)
- ACG band 5
- Aged care residents (patients that have been billed an MBS item in the past 12 months that indicates they are in a Residential Aged Care Facility (RACF)) are included in a separate table



Patient Visits

- Shows the number of visits to the practice. Data may be filtered by GP.
- GP allocation is based on who the patient has seen the most.

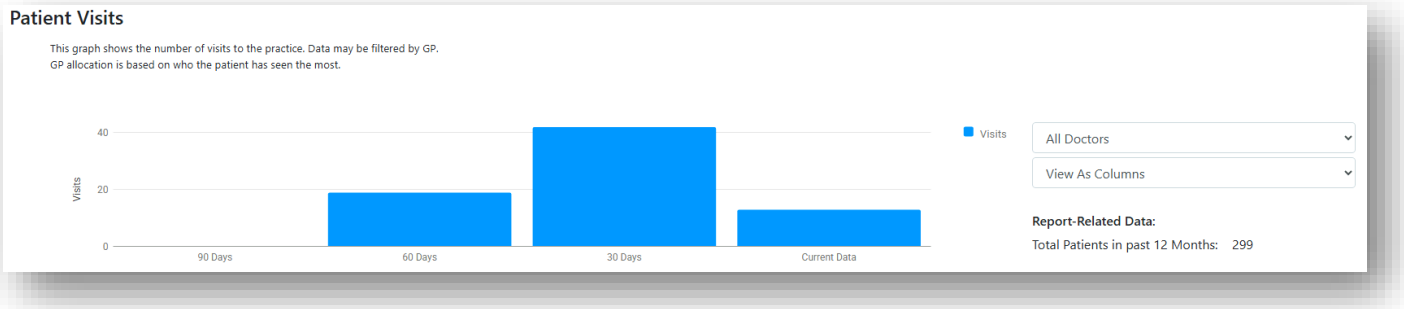
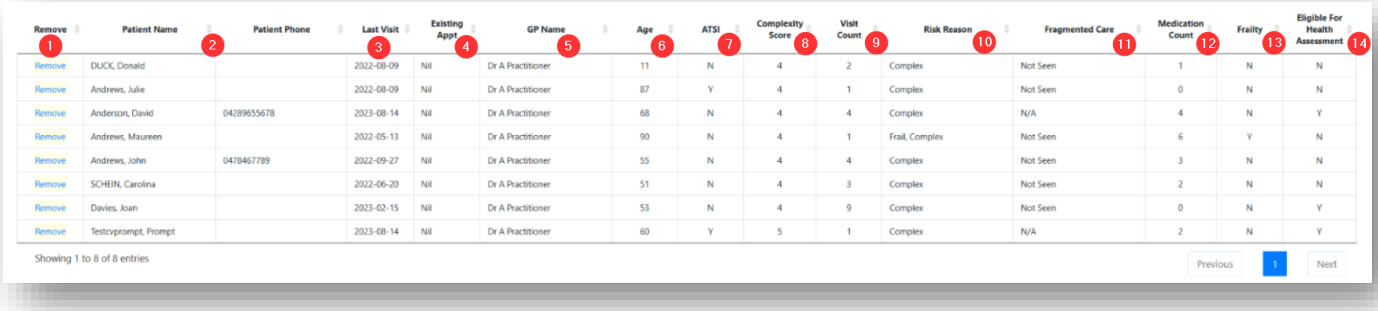


Table 1 - Patients likely to meet criteria for voluntary patient registration

- Most patients will need to have 2 face-to-face visits recorded with the same practice in the previous 24 months to be eligible to register with that practice.
- For patients registered with a practice in a remote location (in Modified Monash Model (MMM) 6 and 7 locations) this requirement is reduced to one face-to-face visit recorded at the same practice in the previous 24 months.



Remove 1	Patient Name 2	Patient Phone	Last Visit 3	Existing Appt 4	GP Name 5	Age 6	ATSI 7	Complexity Score 8	Visit Count 9	Risk Reason 10	Fragmented Care 11	Medication Count 12	Frailty 13	Eligible For Health Assessment 14
Remove	DUCK, Donald		2022-08-09	Nil	Dr A Practitioner	11	N	4	2	Complex	Not Seen	1	N	N
Remove	Andrews, Julie		2022-08-09	Nil	Dr A Practitioner	87	Y	4	1	Complex	Not Seen	0	N	N
Remove	Anderson, David	0428965678	2023-08-14	Nil	Dr A Practitioner	68	N	4	4	Complex	N/A	4	N	Y
Remove	Andrews, Maureen		2022-05-13	Nil	Dr A Practitioner	90	N	4	1	Frail, Complex	Not Seen	6	Y	N
Remove	Andrews, John	0478467789	2022-09-27	Nil	Dr A Practitioner	55	N	4	4	Complex	Not Seen	3	N	N
Remove	SCHEIN, Carolina		2022-06-20	Nil	Dr A Practitioner	51	N	4	3	Complex	Not Seen	2	N	N
Remove	Davies, Joan		2023-02-15	Nil	Dr A Practitioner	53	N	4	9	Complex	Not Seen	0	N	Y
Remove	Testcvprompt, Prompt		2023-08-14	Nil	Dr A Practitioner	60	Y	5	1	Complex	N/A	2	N	Y

Showing 1 to 8 of 8 entries

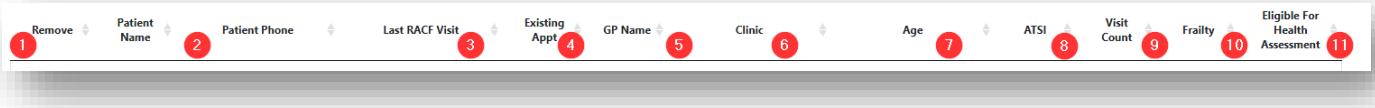
Previous 1 Next

1. **‘Remove’** - Patients can be removed from the report for 12 months, by clicking ‘Remove.’ This action cannot be reversed and removes the patient from this report for all clinicians.
2. Patient demographic data.
3. **'Last Visit'** column displays the date the patient last had an appointment at the practice.

4. **'Existing appt'** column displays patient appointments that have been booked for dates beyond the report.
5. **'GP Name'** shows the GP who has most accessed the patient record. See *Calculating Patient GP* for rules.
6. **'Age'** - Patient age at time the report is run.
7. **'ATSI'** where patient is identified as: Aboriginal, Aboriginal/Torres Strait Islander or Torres Strait Islander
8. **'ACG Score'** - the complexity bands formed by combining the ACGs to measure overall morbidity burden on a scale of 0-5, with 5 being the most complex/morbidity burden.
9. **'Visit Count'** - Count of visits to practice in the last 2 years
10. **'Risk reason'** will display one or more reasons the patient is determined to be high-risk. Possible reasons are:
    a. Hosp = Hospital Risk
    b. Frail = ACG Frailty or frailty coded by the GPy
    c. PolyRX = More than 10 medication each prescribed in the past 18 months
    d. ED's = 2 or more discharge summaries (ED or inpatient) in the past year
    e. Complex = ACG Band 4 or 5
11. **'Fragmented care'** will display one or more reasons the patient is determined to have fragmented care. Possible reasons are:
    a. Not Seen = no attendance in the past 6 months
    b. Multi-GP = attended 3 or more GPs within the practice in the past 6 months
12. **'Medication Count'** - Count of active medications
13. **'Frailty'** is calculated by referencing the ACG Frailty Flag or coded in the CIS
14. **'Eligible For Health Assessment'** - a Health Assessment hasn't been billed in the past 12 months

Table 2 - Aged Care Residents

- Patients in this table have been billed an MBS item in the past 12 months that indicates they are in a residential aged care facility (RACF). If they are in an RACF they are eligible to register for MyMedicare



1. **'Remove'** - Patients can be removed from the report for 12 months, by clicking 'Remove.' This action cannot be reversed.
2. Patient demographic data.
3. **'Last RACF Visit' -** the date the patient last had a relevant MBS item billed. *See MBS items in reports and prompts* for rules.
4. **'Existing appt'** column displays patient appointments that have been booked for dates beyond the report.
5. **'GP Name'** shows the GP who has most accessed the patient record. See *Calculating Patient GP* for rules.
6. **'Clinic'** displays most attended clinic if data is shared.
7. **'Age'** - Patient age at time the report is run (to protect patient confidentiality, the age of all patients older than 90 years are displayed as 90)
8. **'ATSI'** where patient is identified as: Aboriginal, Aboriginal/Torres Strait Islander or Torres Strait Islander
9. **'Visit Count'** - Count of visits to practice in the last 2 years
10. **'Frailty'** is calculated by referencing the ACG Frailty Flag or coded in the CIS

11. **‘Eligible For Health Assessment’** - a Health Assessment hasn’t been billed in the past 12 months

7.17.17. Child Immunisations (Report ID 26)

This report shows patients aged between 0 and 5 who are currently due or have missed a vaccination. Due dates are guidelines only based on recommendations from the Department of Health and Aged Care.

This report does not check patients for allergies to medication – please check for any allergies before administering any vaccinations.

The report shows due dates in colours representing the timeframe of the vaccination.

- N/A = Vaccination is not required or no longer elligible
- Green = Vaccination has been given
- Blue = Vaccination is currently due now
- Grey = Vaccination date is upcoming, but not currently due

- Some vaccinations include an allowance for a catch-up schedule, recommended guidelines for these can be found here *Catch-up vaccination*
- Consider RSV Immunisation for infants up to 24 months after reviewing the maternal immunisations and child risk factors. Refer to the following guidelines: *Respiratory syncytial virus (RSV) | The Australian Immunisation Handbook*.
- Where vaccination schedules differ by state, ATSI status, or medical conditions, these are listed with 'Consider' and should be reviewed.

This report is generated by the practice software records ONLY. It does not show other immunisations recorded in Australian Immunisation Register (AIR). Always check AIR before vaccine administration.

Report Content

Which patients are included in this report?

- Patients between 0 and 5 years of age; and
- Who are currently due or have missed a vaccination

What data is in this report?

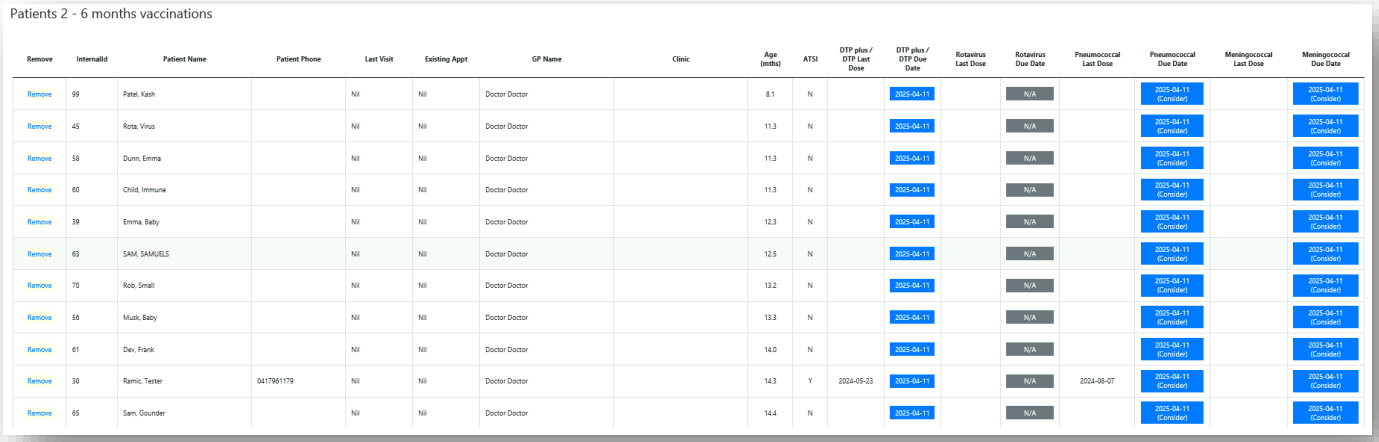
Report includes:

- Five tables split into age groups.
  - 2 - 6 months vaccinations
  - 6 months+ vaccinations (Influenza)
  - 12 month vaccinations
  - 18 month vaccinations
  - 4 year vaccinations
- Record of last vaccination (if any) for each of the following:
  - Hexavalent

  - Rotavirus
  - Pneumococcal
  - Meningococcal
  - Influenza
  - Meningococcal B
  - Meningococcal ACWY
  - MMR
  - Childhood HIB
  - Hepatitis A
- Date for when the next vaccination was due based on age of the patient, colour coded to reflect vaccination status:
  - N/A = Vaccination is not required or no longer eligible
  - Green = Vaccination has been given
  - Blue = Vaccination is currently due now
  - Red = Vaccination was due more than 2 months ago and has not been given yet
  - Grey = Vaccination date is upcoming, but not currently due

Due dates marked as '(Consider)' indicate where a patient may consider a vaccination based on their location and medical condition.

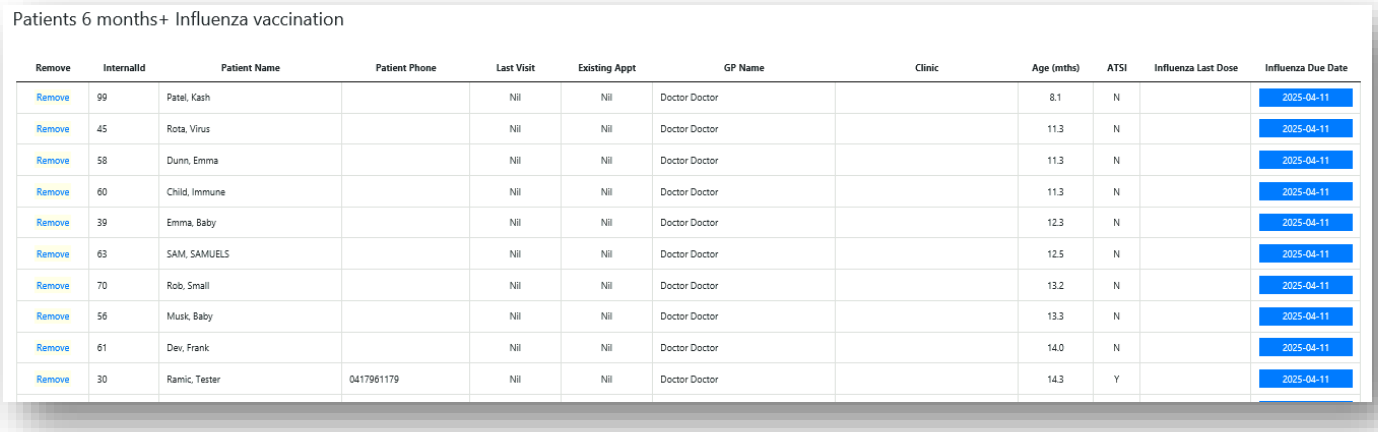
Table 1 - 2 - 6 months vaccinations



Patients 2 - 6 months vaccinations

Remove	InternalId	Patient Name	Patient Phone	Last Visit	Existing Appt	GP Name	Clinic	Age (mths)	ATSI	DTP plus / DTP Last Dose	DTP plus / DTP Due Date	Rotavirus Last Dose	Rotavirus Due Date	Pneumococcal Last Dose	Pneumococcal Due Date	Meningococcal Last Dose	Meningococcal Due Date
Remove	99	Patel, Kash		Nil	Nil	Doctor Doctor		8.1	N		2025-04-11		N/A		2025-04-11 (Consider)		2025-04-11 (Consider)
Remove	45	Rota, Virus		Nil	Nil	Doctor Doctor		11.3	N		2025-04-11		N/A		2025-04-11 (Consider)		2025-04-11 (Consider)
Remove	58	Dunn, Emma		Nil	Nil	Doctor Doctor		11.3	N		2025-04-11		N/A		2025-04-11 (Consider)		2025-04-11 (Consider)
Remove	60	Child, Immune		Nil	Nil	Doctor Doctor		11.3	N		2025-04-11		N/A		2025-04-11 (Consider)		2025-04-11 (Consider)
Remove	39	Emma, Baby		Nil	Nil	Doctor Doctor		12.3	N		2025-04-11		N/A		2025-04-11 (Consider)		2025-04-11 (Consider)
Remove	63	SAM, SAMUELS		Nil	Nil	Doctor Doctor		12.5	N		2025-04-11		N/A		2025-04-11 (Consider)		2025-04-11 (Consider)
Remove	70	Rob, Small		Nil	Nil	Doctor Doctor		13.2	N		2025-04-11		N/A		2025-04-11 (Consider)		2025-04-11 (Consider)
Remove	56	Musk, Baby		Nil	Nil	Doctor Doctor		13.3	N		2025-04-11		N/A		2025-04-11 (Consider)		2025-04-11 (Consider)
Remove	61	Dev, Frank		Nil	Nil	Doctor Doctor		14.0	N		2025-04-11		N/A		2025-04-11 (Consider)		2025-04-11 (Consider)
Remove	30	Ramic, Tester	0417961179	Nil	Nil	Doctor Doctor		14.3	Y	2024-05-23	2025-04-11		N/A	2024-08-07	2025-04-11 (Consider)		2025-04-11 (Consider)
Remove	65	Sam, Gounder		Nil	Nil	Doctor Doctor		14.4	N		2025-04-11		N/A		2025-04-11 (Consider)		2025-04-11 (Consider)

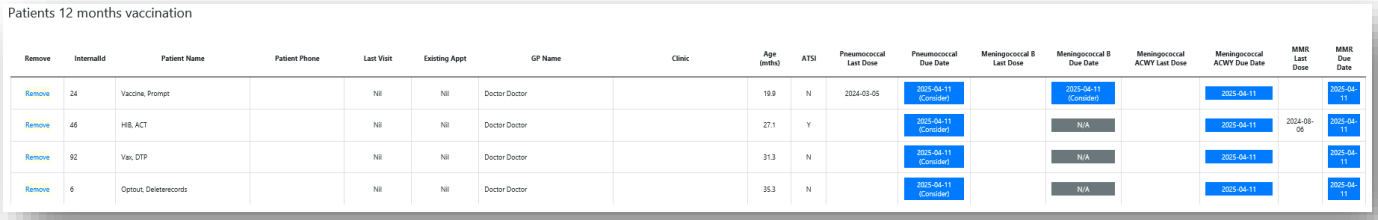
Table 2 - 6 months+ vaccinations (Influenza)



Patients 6 months+ Influenza vaccination

Remove	InternalId	Patient Name	Patient Phone	Last Visit	Existing Appt	GP Name	Clinic	Age (mths)	ATSI	Influenza Last Dose	Influenza Due Date
Remove	99	Patel, Kash		Nil	Nil	Doctor Doctor		8.1	N		2025-04-11
Remove	45	Rota, Virus		Nil	Nil	Doctor Doctor		11.3	N		2025-04-11
Remove	58	Dunn, Emma		Nil	Nil	Doctor Doctor		11.3	N		2025-04-11
Remove	60	Child, Immune		Nil	Nil	Doctor Doctor		11.3	N		2025-04-11
Remove	39	Emma, Baby		Nil	Nil	Doctor Doctor		12.3	N		2025-04-11
Remove	63	SAM, SAMUELS		Nil	Nil	Doctor Doctor		12.5	N		2025-04-11
Remove	70	Rob, Small		Nil	Nil	Doctor Doctor		13.2	N		2025-04-11
Remove	56	Musk, Baby		Nil	Nil	Doctor Doctor		13.3	N		2025-04-11
Remove	61	Dev, Frank		Nil	Nil	Doctor Doctor		14.0	N		2025-04-11
Remove	30	Ramic, Tester	0417961179	Nil	Nil	Doctor Doctor		14.3	Y		2025-04-11

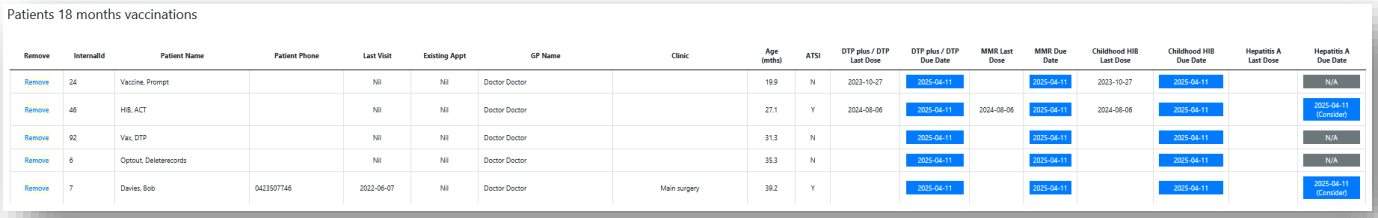
Table 3 - 12 month vaccinations



Patients 12 months vaccination

Remove	InternalId	Patient Name	Patient Phone	Last Visit	Existing Appt	GP Name	Clinic	Age (mths)	ATSI	Pneumococcal Last Dose	Pneumococcal Due Date	Meningococcal B Last Dose	Meningococcal B Due Date	Meningococcal ACWY Last Dose	Meningococcal ACWY Due Date	MMR Last Dose	MMR Due Date
Remove	24	Vaccine, Prompt		Nil	Nil	Doctor Doctor		19.9	N	2024-03-05	2025-04-11 (Consider)		2025-04-11 (Consider)		2025-04-11		2025-04-11
Remove	46	HIB, ACT		Nil	Nil	Doctor Doctor		27.1	Y		2025-04-11 (Consider)		N/A		2025-04-11	2024-08-06	2025-04-11
Remove	92	Vax, DTP		Nil	Nil	Doctor Doctor		31.3	N		2025-04-11 (Consider)		N/A		2025-04-11		2025-04-11
Remove	6	Optout, Deleterecords		Nil	Nil	Doctor Doctor		35.3	N		2025-04-11 (Consider)		N/A		2025-04-11		2025-04-11

Table 4 - 18 month vaccinations



Patients 18 months vaccinations

Remove	InternalId	Patient Name	Patient Phone	Last Visit	Existing Appt	GP Name	Clinic	Age (mths)	ATSI	DTP plus / DTP Last Dose	DTP plus / DTP Due Date	MMR Last Dose	MMR Due Date	Childhood HIB Last Dose	Childhood HIB Due Date	Hepatitis A Last Dose	Hepatitis A Due Date
Remove	24	Vaccine, Prompt		Nil	Nil	Doctor Doctor		19.9	N	2023-10-27	2025-04-11		2025-04-11	2023-10-27	2025-04-11		N/A
Remove	46	HIB, ACT		Nil	Nil	Doctor Doctor		27.1	Y	2024-08-06	2025-04-11	2024-08-06	2025-04-11	2024-08-06	2025-04-11		2025-04-11 (Consider)
Remove	92	Vax, DTP		Nil	Nil	Doctor Doctor		31.3	N		2025-04-11		2025-04-11		2025-04-11		N/A
Remove	6	Optout, Deleterecords		Nil	Nil	Doctor Doctor		35.3	N		2025-04-11		2025-04-11		2025-04-11		N/A
Remove	7	Davies, Bob	0423507746	2022-06-07	Nil	Doctor Doctor	Main surgery	39.2	Y		2025-04-11		2025-04-11		2025-04-11		2025-04-11 (Consider)

Table 5 - 4 year vaccinations

Patients 4 years vaccinations

Remove	InternalId	Patient Name	Patient Phone	Last Visit	Existing Appt	GP Name	Clinic	Age (mths)	ATSI	DTP plus / DTP Last Dose	DTP plus / DTP Due Date	Pneumococcal Last Dose	Pneumococcal Due Date	Hepatitis A Last Dose	Hepatitis A Due Date
Remove	7	Davies, Bob	0423507746	2022-06-07	Nil	Doctor Doctor	Main surgery	39.2	Y		2025-04-11		2025-04-11 (Consider)		2025-04-11 (Consider)
Remove	47	Four, Years		Nil	Nil	Doctor Doctor		58.3	Y	2021-12-05	Vaccinated		2025-04-11 (Consider)	2021-12-05	2025-04-11 (Consider)

7.17.18. Palliative care Report (Report ID 31)

Overview

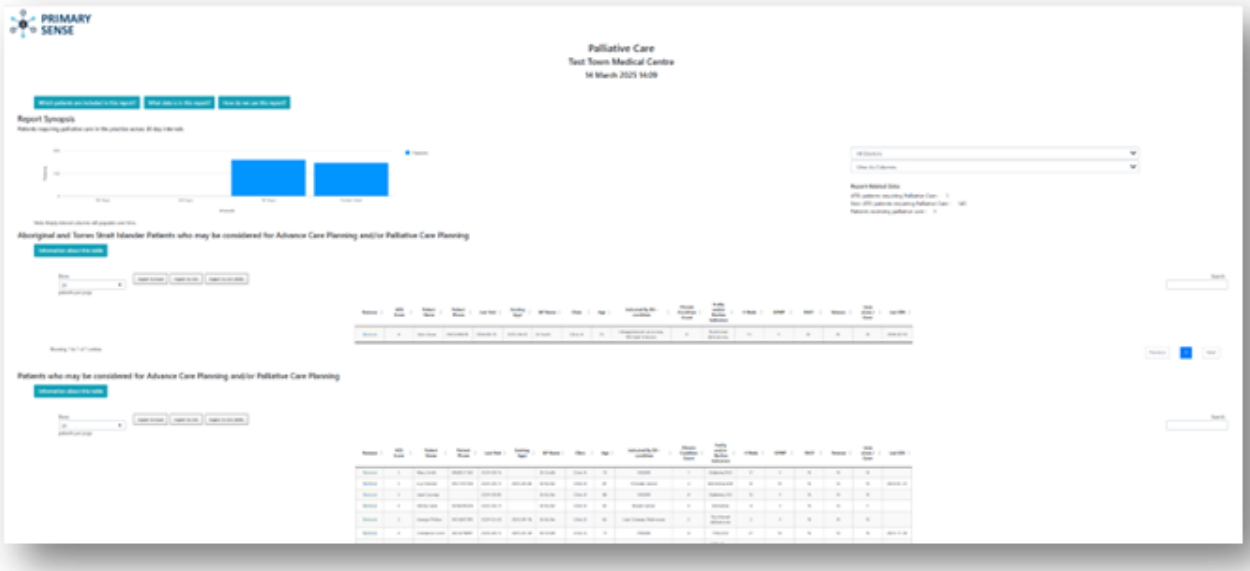
The Palliative Care report was made available in the January Release V2.35 (31 January). The report was funded by BSPHN. The report displays Patients 65 yrs and over who may be considered for palliative care. In the case of Aboriginal and Torres Strait Islander (ATSI) patients, the age range is 55 yrs and over.

Considered for palliative care means the patient has certain diseases or conditions which are in advanced stage, with comorbidities or compounding factors that indicate a decline in their health.

The aim is to highlight 1-2% of patients who may be considered for palliative care discussions at the practice and/or discussions around implementing an advanced care plan.

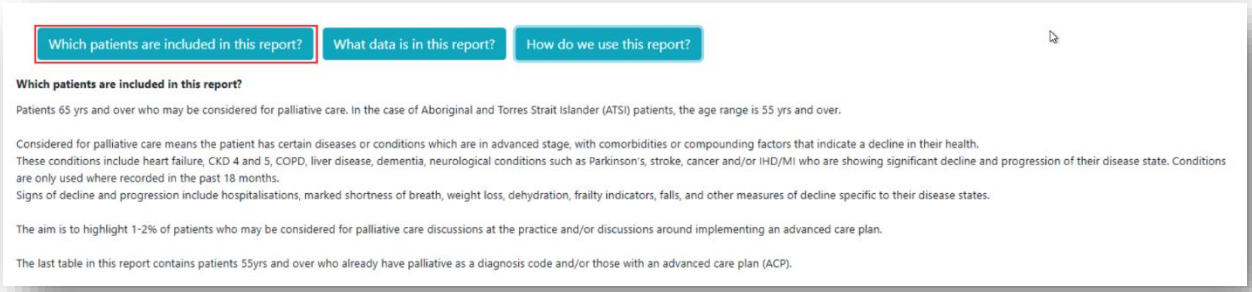
This report identifies patients who may be palliative that may require review or confirmation of their status.

Please see these resources for further information:
Supportive and Palliative Care Indicators Tool *https://www.spict.org.uk/e-spict/*
Computer screening for palliative care needs in primary care
https://bjgp.org/content/bjgp/68/670/e360.full.pdf
The Gold Standards Framework Proactive Identification Guidance (PIG)
https://www.goldstandardsframework.org.uk/cd-content/uploads/files/PIG/NEW%20PIG%20-%20%20%2020.1.17%20KT%20vs17.pdf
Development of a tool for defining and identifying the dying patient in hospital: Criteria for Screening and Triaging to Appropriate Alternative care (CriSTAL)
https://spcare.bmj.com/content/bmjspcare/5/1/78.full.pdf
RACGP Palliative and end-of-life care *https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/silver-book/part-a/palliative-care*
Prompts for End of Life Planning (PELP) Framework
https://www.caringathomeproject.com.au/Portals/13/Documents/caring@home-PELP-Framework.pdf
Advance Care Planning Australia *Advance Care Planning*



Report Content

Which patients are included in this report?



Diagnosis/Conditions

Due to the extensive case finding and risk of report timeouts, the Johns Hopkins ACG data are used for most of this report

To be returned in the table '*Aboriginal and Torres Strait Islander Patients who may be considered for Advance Care Planning and/or Palliative Care Planning'* or '*Patients who may be considered for Advance Care Planning and/or Palliative Care Planning (non- ATSI, 65 yrs and over)'*, a patient must have one of the following conditions with additional diagnosis/conditions as listed:

- **Chronic Obstructive Pulmonary Disease (COPD)** – *must also have a frailty indicator/nutritional deficiencies **and** Shortness Of Breath/Dyspnoea*
- **Heart Failure** – *must also have a frailty indicator/sign of deterioration **and** Shortness Of Breath/Dyspnoea*
- **Dementia / Alzheimer's Disease** – *must also have a frailty indicator (not dementia)/nutritional deficiencies*
- **Chronic Kidney Disease** – *must also have a frailty indicator/sign of deterioration **and** Shortness Of Breath/Dyspnoea*
- **Stroke** – *must also have hypertension with major complications **or** diabetes or CKD 4/5 **or** a frailty indicator /nutritional deficiency*
- **Parkinson's Disease** – *must also have a frailty indicator /nutritional deficiency*
- **Muscular dystrophy** – *must also have a frailty indicator /nutritional deficiency*
- **Multiple sclerosis** – *must also have a frailty indicator /nutritional deficiency*

- **Ischemic Heart Disease (IHD) / Myocardial Infarction (MI) / Coronary Artery Disease (CAD), Peripheral Vascular Disease (PVD)** – *must have CKD 4/5* ***or*** *diabetes and Hypertension, with major complications*
- **Malignancy recorded in the past 18 months** – *must also have a frailty indicator /nutritional deficiency*

Frailty Indicators / Deterioration

Frailty Concepts follow the guidelines adopted in the ACG John Hopkins Tool. See *Johns Hopkins ACG System Version 12.0 User Documentation_web.pdf* for more information on fields referencing ACG data.

Frailty Concept Diagnoses (Examples) Dementia (DEM)
- Senile dementia with delusional or depressive features Senile dementia with delirium
- Severe Vision Impairment (VIS) Profound impairment, both eyes Moderate or severe impairment, better eye/lesser eye: profound

Decubitus Ulcer (DEC)
- Decubitus Ulcer

Major Problems of Urine Retention or Control (URC)
- Incontinence without sensory awareness
- Continuous leakage

Loss of Weight (WEI)
- Abnormal loss of weight and underweight
- Feeding difficulties and mismanagement

Absence of Fecal Control (AFC)
- Incontinence of feces

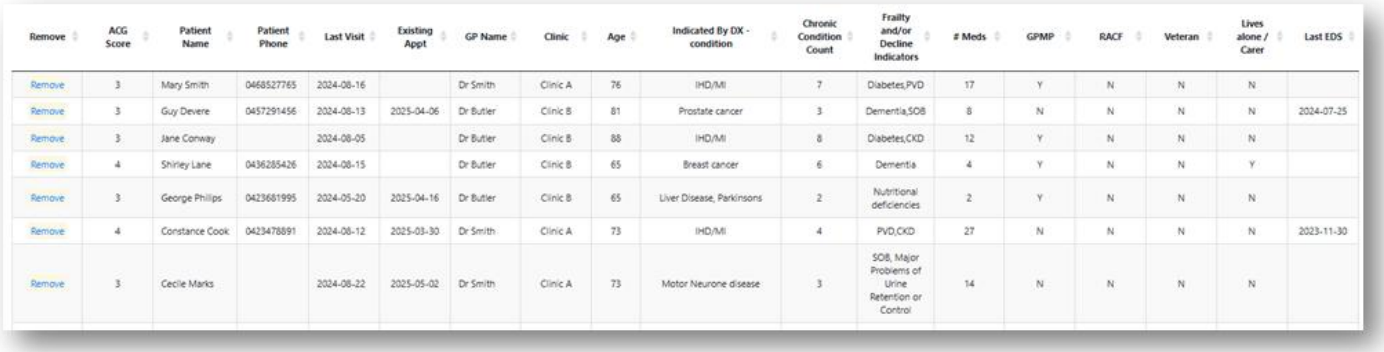
Social Support Needs (SSN)
- Lack Of Housing
- Inadequate Housing
- Inadequate material resources

Difficulty in Walking (WLK)
- Difficulty in walking
- Abnormality of gait

Fall (FAL)
- Fall On Stairs Or Steps
- Fall From Wheelchair

General Deterioration
- from ACG conditions or from a diagnosis of Dyspnoea.

Example of data returned in the table for patients who may be considered for Advance Care Planning and/or Palliative Care Planning. Refer to information on conditions and frailty columns to see the rules for display.



Remove	ACG Score	Patient Name	Patient Phone	Last Visit	Existing Appt	GP Name	Clinic	Age	Indicated By DX - condition	Chronic Condition Count	Frailty and/or Decline Indicators	# Meds	GPMP	RACF	Veteran	Lives alone / Carer	Last EDS
Remove	3	Mary Smith	0468527765	2024-08-16		Dr Smith	Clinic A	76	IHD/MI	7	Diabetes,PVD	17	Y	N	N	N	
Remove	3	Guy Devere	0457291456	2024-08-13	2025-04-06	Dr Butler	Clinic B	81	Prostate cancer	3	Dementia,SOB	8	N	N	N	N	2024-07-25
Remove	3	Jane Conway		2024-08-05		Dr Butler	Clinic B	88	IHD/MI	8	Diabetes,CKD	12	Y	N	N	N	
Remove	4	Shirley Lane	0436285426	2024-08-15		Dr Butler	Clinic B	65	Breast cancer	6	Dementia	4	Y	N	N	Y	
Remove	3	George Philips	0423681995	2024-05-20	2025-04-16	Dr Butler	Clinic B	65	Liver Disease, Parkinsons	2	Nutritional deficiencies	2	Y	N	N	N	
Remove	4	Constance Cook	0423478891	2024-08-12	2025-03-30	Dr Smith	Clinic A	73	IHD/MI	4	PVD,CKD	27	N	N	N	N	2023-11-30
Remove	3	Cecile Marks		2024-08-22	2025-05-02	Dr Smith	Clinic A	73	Motor Neurone disease	3	SOB, Major Problems of Urine Retention or Control	14	N	N	N	N	

What data is in this report?

- Patients included in the report are those active in the Clinical Information System (CIS) with an ACG record created or updated in last past 18 months.
- See *Johns Hopkins ACG System Version 12.0 User Documentation_web.pdf* for more information on fields referencing ACG data.

Information about this table

The report is divided into three tables.

Table 1 - Aboriginal and Torres Strait Islander Patients who may be considered for Advance Care Planning and/or Palliative Care Planning

- Patients aged 55yrs and above.
- ATSI where patient is identified as:
- Aboriginal, Aboriginal/Torres Strait Islander or Torres Strait Islander

Table 2 - Patients who may be considered for Advance Care Planning and/or Palliative Care Planning (non- ATSI, 65 yrs and over)

- Patients aged 65 yrs and above who are not Aboriginal and Torres Strait Islander.

Table 3 - Patients receiving Palliative Care

- Patients aged 55yrs and above that have a palliative diagnosis or a referral to palliative services in the past 12 months currently

There is no defined sort order for results.

Columns Returned

1. **'Remove'** - Patients can be removed from the report for 12 months, by clicking 'Remove.' This action cannot be reversed and removes the patient from this report for all clinicians.
2. **'ACG Score'** - the complexity bands formed by combining the ACGs to measure overall morbidity burden on a scale of 0-5, with 5 being the most complex/morbidity burden.
3. Patient demographic data.
4. **'Last Visit'** column displays the date the patient last had an appointment at the practice.
5. **'Existing Appt'** column displays patient appointments that have been booked for dates beyond the report.
6. **'GP Name'** shows the GP who has most accessed the patient record. See *Calculating Patient GP* for rules.
7. **'Clinic'** displays most attended clinic if data is shared.
8. **'Age'** - Patient age at time the report is run (to protect patient confidentiality, the age of all patients older than 90 years are displayed as 90)
9. **'Indicated By Dx condition'** listing the conditions defined above in the report
10. **'Chronic Condition Count'** displayed from patient ACG record.
11. **'Frailty and/or Decline Indicators'** is calculated by referencing the ACG Frailty Flag. In addition, it references the Johns Hopkins ACG System Frailty Concept Codes and Descriptions codes:
    a. Absence of Fecal Control (AFC)
    b. Decubitus Ulcer (DEC)
    c. Dementia (DEM)
    d. Difficulty in Walking (WLK)
    e. Fall (FAL)
    f. Loss of Weight (WEI)
    g. Major Problems of Urine Retention or Control (URC)
    h. Malnutrition and/or Catabolic Illness (MAL)
    i. Severe Vision Impairment (VIS)
    j. Social Support (SSN)
    k. General deterioration sourced from ACG conditions or from a diagnosis of Dyspnoea.
    l. Additional conditions listed under the criteria
12. **'Number of Medications'** displayed from the ACG Tables.
13. **'GPMP'** Y = GPMP or GPCCP MBS items billed for the patient in the past 12 months.
14. **'RACF'** identified by patients having an Aged care MBS billing code withing the last 12 months. Does not reference marked as RACF in the CIS.

15. **'Veteran'** where patient has been flagged in the CIS as a veteran.
16. **'Lives alone / Carer'** where patient has Lives Alone recorded in the CIS.
17. **'Advanced Care Planning'** where patients have ICPC code A62023 Advance Health Directive recorded against a visit within the last 12 months.
18. **'Last EDS'** date where the last Electronic Discharge Summary (EDS) was recorded.

Report Synopsis

- Patients meeting all criteria and suggested for or receiving Palliative Care.

Frailty

Diagnosis	EDC Description
Referencing the ACG Frailty	Absence of Fecal Control Decubitus Ulcer Dementia Difficulty in Walking Fall Loss of Weight Major Problems of Urine Retention or Control Malnutrition and/or Catabolic Illness Severe Vision Impairment Social Support
Shortness of breath (SOB)	
General Deterioration	Nutritional deficiencies (e.g. poor appetite, dehydration, excessive weight loss)

7.17.19. CKD Report (Report ID 32)

Overview

The Chronic Kidney Disease (CKD) report was made available in June Release V2.41 (10th June 2025) as it was identified as important by the Clinical Advisory Group after their discussions with Kidney Health Australia. The report displays patients who meet the criteria for the initial detection and diagnosis of CKD as per the guideline: *Chronic Kidney Disease (CKD) Management in Primary Care.* As per page 16 of the guideline, palliative care and nursing home patients are excluded.

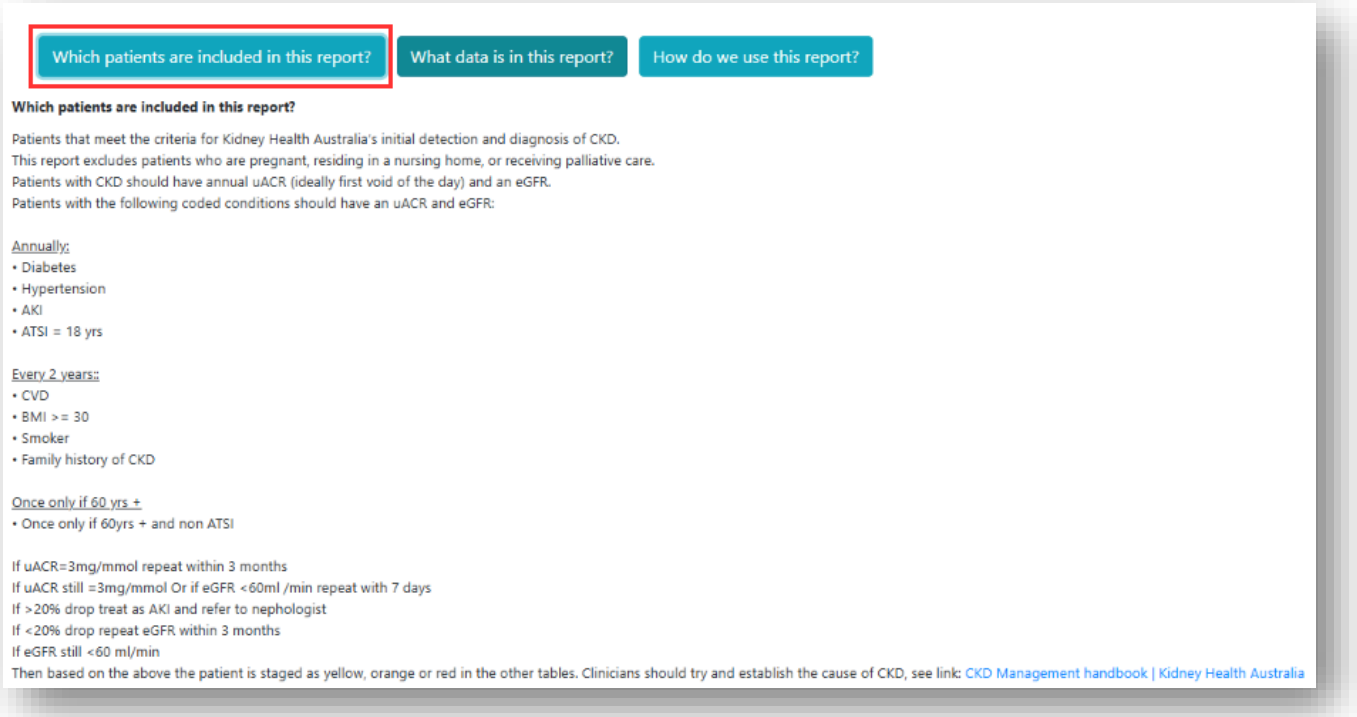
The report has four tables.

1. Patients with risk of CKD
2. Patients who should be considered for the Yellow Clinical Action Plan (see p.26 of the linked guide)
3. Patients who should be considered for the Orange Clinical Action Plan (see p.27 of the linked guide)
4. Patients who should be considered for the Red Clinical Action Plan (see p.28 of the linked guide)

Report Content

Which patients are included in this report?

- All patients active in the Clinical Information System (CIS) are included in the report output.
- Patients over the age of 18 are included.
- Palliative care and nursing home patients are excluded.



Diagnosis/Conditions

- CKD diagnosis coded whether just 'CKD' or a stage of CKD. Renal markers are provided to inform the stage of CKD or indicate CKD where it's not coded.

- Diabetes (presented as years since first occurred or where year is not available, year of diabetes first recorded)
- Hypertension coded, marked as active, if it is just recorded as the visit reason it cannot be overridden with an inactive clinical history record.
- Acute Kidney Injury, such as nephritis, acute failure and tubular necrosis.

Observations

- Latest BMI is provided.
- Latest systolic blood pressure and date.
- Latest smoking recorded date and the status.

Pathology

- Latest 2 ACRs (urine albumin creatine ratio) with date to allow comparison of change.
- Latest 2 eGFR2 (estimated glomerular filtration rate) with date to allow comparison of change.

Immunisations

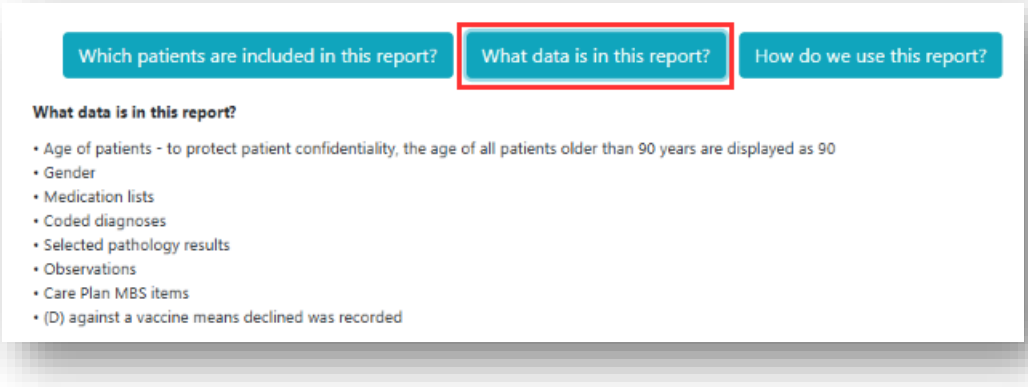
- **Influenza vaccine** – Date of last influenza vaccination in the past 15 months. Practices using Medical Director can record that a vaccination has been offered and declined. Primary Sense displays this in select reports by displaying the date as DD-MM-YYYY (D) with the letter (D) after the date, e.g. 01-07-2022 (D).

- **Pneumococcal vaccine** – date of last dose. Practices using Medical Director can record that a vaccination has been offered and declined. Primary Sense displays this in select reports by displaying the date as DD-MM-YYYY (D) with the letter (D) after the date, e.g. 01-07-2022 (D).

Medications

- SGLT2 inhibitors where not ceased and first or last prescribed date is within the last 18 months.

What data is in this report?



The report has four tables:

1. Patients with risk of CKD
2. Patients who should be considered for the Yellow Clinical Action Plan (see p.26 of the linked guide)
    - eGFR ≥60mL/min/1.73m2 with microalbuminuria (A2) or

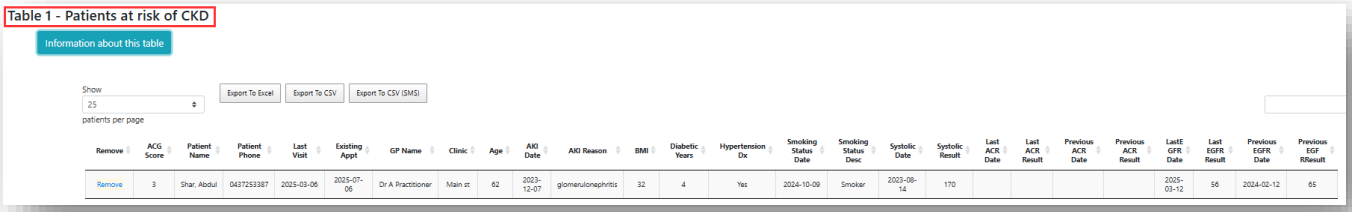
- eGFR 45-59 mL/min/1.73m2 with normoalbuminuria (A1)

3. Patients who should be considered for the Orange Clinical Action Plan (see p.27 of the linked guide)
   - eGFR 30-59mL/min/1.73m2 with microalbuminuria (A2) or
   - eGFR 30-44 mL/min/1.73m2 with normoalbuminuria (A1)
4. Patients who should be considered for the Red Clinical Action Plan (see p.28 of the linked guide)
   - Macroalbuminuria irrespective of eGFR or
   - eGFR <30 mL/min/1.73m2 irrespective of albuminuria

Information about the table/s

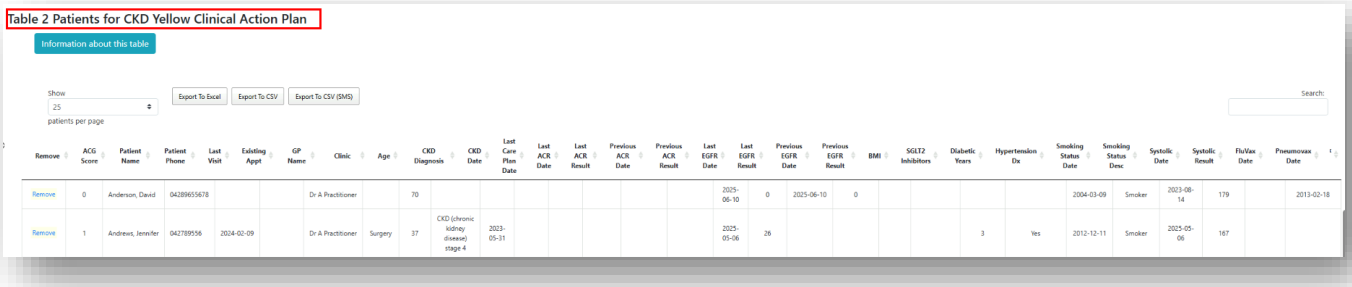
The report is divided into four tables.

Table 1 - Patients with risk of CKD



- Patients in this table have two low eGFR <60ml/min or ACR ≥3mg/mmol who need tests repeating.
- If the test is repeated within 3 months and is still out of range, patients will appear on the other tables.
- The second eGFR relates to referring to nephrologist if 20% decline within a week.

Table 2 - Patients who should be considered for the Yellow Clinical Action Plan

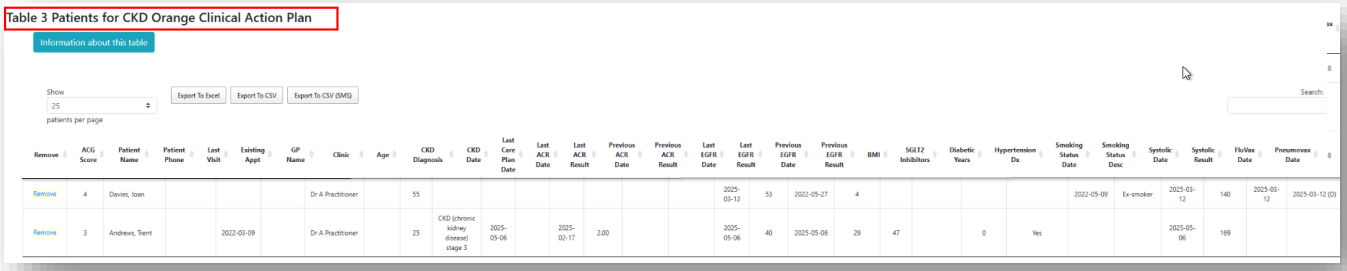


Patients in this table have eGFR ≥ 60ml/min with micoalb (uACR 3.0-30mg/mmol or eGFR ≥ 45-59 ml/min with normoalb (uACR<3.0mg/mmol).
Reader is asked to Consider:

- a 12 month review
- Diabetes risk assessment

- CV risk assessment
- ACE or ARB
- Statin (+/- ezetimibe) in mod CV risk
- consider SGLT2 inhibitor (with ACR ≥3mg/mmol)

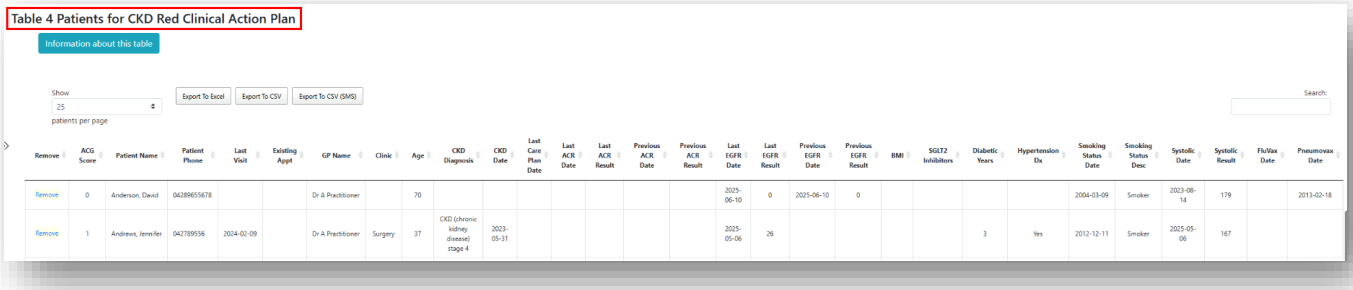
Table 3 - Patients who should be considered for the Orange Clinical Action Plan



Patients in this table have eGFR 30-59mL/min/1.73m2 with microalbuminuria (A2) or eGFR 30-44 mL/min/1.73m2 with normoalbuminuria (A1)
Reader is asked to consider:

- 3 – 6 months reviews,
- medication reviews,
- Diabetes risk assessment
- CV risk assessment,
- ACE or ARB,
- Statin (+/- ezetimibe) in mod CV risk,
- SGLT2 inhibitor (with ACR ≥3mg/mmol
- referral nephrologist

Table 4 - Patients who should be considered for the Red Clinical Action Plan



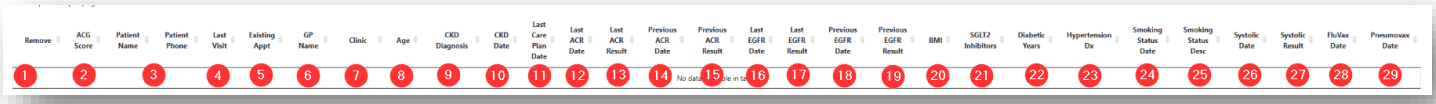
Patients in this table have Macroalbuminuria (uACR >30mg/mmol) irrespective of eGFR or eGFR <30 mL/min irrespective of albuminuria. These patients have automatic high CV risk
Reader is asked to consider:

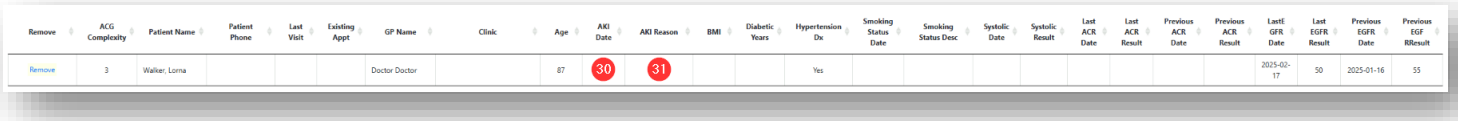
- reviews 1-3 months
- medication reviews,
- Diabetes risk

- ACE or ARB,
- Statin (+/- ezetimibe)
- consider SGLT2 inhibitor,
- refer nephrologist or consider palliation

Results are sorted by Patient ID.

Columns Returned



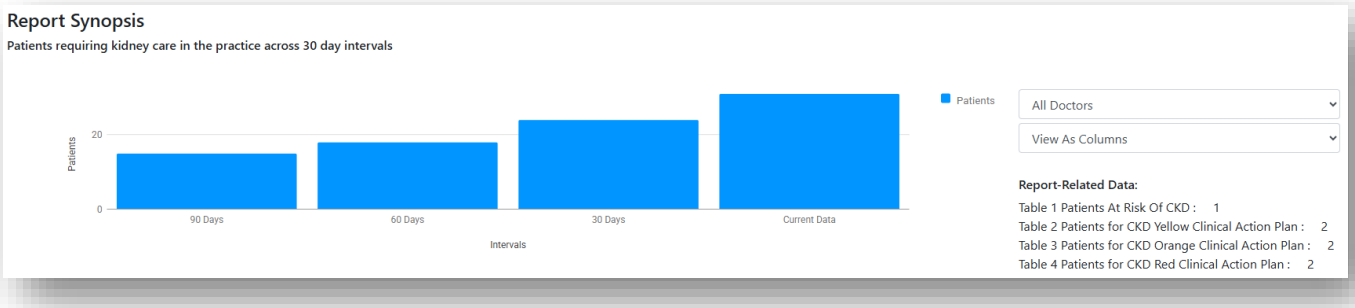


1. **'Remove'** - Patients can be removed from the report for 12 months, by clicking 'Remove.' This action cannot be reversed and removes the patient from this report for all clinicians.
2. **'ACG Score'** - the complexity bands formed by combining the ACGs to measure overall morbidity burden on a scale of 0-5, with 5 being the most complex/morbidity burden.
3. Patient demographic data.
4. **'Last Visit'** column displays the date the patient last had an appointment at the practice.
5. **'Existing Appt'** displays patient appointments that have been booked for dates beyond the report.
6. **'GP Name'** shows the GP who has most accessed the patient record.
7. **'Clinic'** displays most attended clinic if data is shared.
8. **'Age'** - Patient age at time the report is run. All patients older than 90 years are displayed as 90.
9. **'CKD Diagnosis' –** Recorded CKD diagnosis.
10. **'CKD Date' –** Date of CKD diagnosis.
11. **'Last Care Plan date'** - GPMP or GPCCP MBS items billed for the patient in the past 12 months. See
12. **'Last ACR date'** - Latest ACR (urine albumin creatine ratio) date
13. **'Last ACR Result'** - Latest ACR (urine albumin creatine ratio) result. See
14. **'Previous ACR Date'** – second last ACR (urine albumin creatine ratio) date to allow comparison of change.
15. **'Previous ACR Result'** - second last ACR (urine albumin creatine ratio) result to allow comparison of change.
16. **'Last EGFR Date'** - Latest EGFR (estimated glomerular filtration rate) date
17. **'Last EGFR Result'** - Latest EGFR (estimated glomerular filtration rate) result. See
18. **'Previous EGFR Date'** - second last EGFR (estimated glomerular filtration rate) date to allow comparison of change.
19. **'Previous EGFR Result'** - second last EGFR (estimated glomerular filtration rate) result to allow comparison of change.
20. **'BMI'** - Latest BMI recorded from CIS.
21. **'SGLT2 Inhibitors'** – Name of prescribed current medication for type 2 diabetes. See

22. **‘Diabetic Years’** - Diabetes presented as years since first occurred, or where year is not available, year of diabetes first recorded.
23. **‘Hypertension DX’** – patient with an inactive or active hypertension diagnosis recorded. Y if code found. See
24. **‘Smoking Status Date’** - Latest smoking status recorded date
25. **‘Smoking Status Desc’**- Latest smoking status recorded, returns Smoker, Non-smoker or Ex-smoker.
26. **‘Systolic date’** - Latest systolic blood pressure recorded date
27. **‘Systolic result’** - Latest systolic blood pressure recorded
28. **‘Last Fluvax Vaccination’** - date of flu vaccination recorded within 15 months of the date of the report. DD-MM-YYYY (D) = Date Vaccination Declined. See *Declined Vaccinations* for rules.
29. **‘Last Pneumovax vaccination’** - date of last recorded Pneumococcal vaccination. DD-MM-YYYY (D) = Date Vaccination Declined. See *Declined Vaccinations* for rules.
30. **‘AKI Date’** – latest recoded date for an Acute Kidney Injury diagnosis code recorded.
31. **‘AKI Reason’** - Acute Kidney Injury, such as nephritis, acute failure and tubular necrosis. See

Report Synopsis

- Patients requiring kidney care in the practice across 30 day intervals



7.17.20. Hepatitis C report (report ID 33)

Overview

The Hepatitis C report was funded by **ASHM Health** (previously Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine), the peak body representing healthcare professionals working across HIV, viral Hepatitis, and sexual and reproductive health. The report can be utilized to identify patients with Hepatitis C, those at risk of Hepatitis C or re-infection, and to monitor treatments and tests conducted.

The report includes patients with a Diagnosis of Hepatitis C and the date first recorded, and patients with recorded risk factors for Hepatitis C: drug misuse, HIV, liver cirrhosis, risky sexual behaviour, needle stick injury, Hepatitis C contact and Hepatitis B.
The report highlights where there has been an abdominal ultrasound (noting as it is difficult to pinpoint liver scans), the name of the scan and the date. The medications used to treat Hepatitis C and the date last prescribed, and relevant liver function blood tests and the date are provided.

The **AST to Platelet Ratio Index** (APRI) score is provided. This is a calculation using AST result divided by platelet result. ASHM Health have indicated the upper limit of AST as 35 U/L not 40 as mostly published. If the APRI score is less than 1.0, this indicates cirrhosis is unlikely. An APRI score of 1.0 or greater means the liver has scarring and is likely to have cirrhosis.

The selection of ICPC codes, medication and pathology codes was done by ASHM.

The report has 2 tables. Some patients may appear in both tables due to the risk of re-infection.

Table 1:

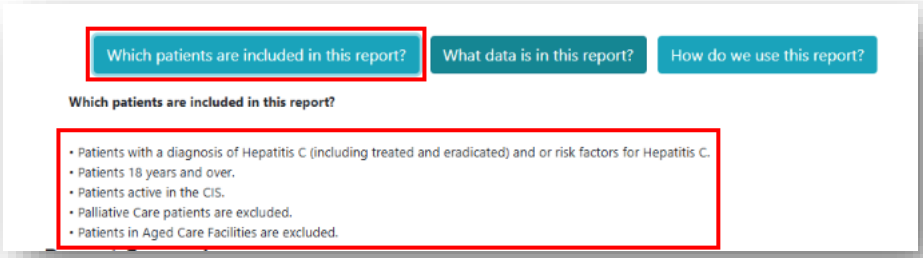
This table lists patients with a coded diagnosis of Hepatitis C and no additional risk factors. The APRI calculation is included to assess liver damage using the most recent AST and platelet results. The latest ALT value and its date are also shown. If an abdominal ultrasound is available, the date and a description preferably indicating a liver scan are provided. The date of the most recent Hepatitis C test is included. For patients receiving medication for Hepatitis C that has not been ceased, the date of the last prescription is listed.

Table 2

This table includes patients who are considered at risk for the condition. For those with a Hepatitis C diagnosis, the information is included due to the potential for re-infection due to risk factors. The APRI calculation, based on the most recent AST and platelet results, is used to assess liver damage. The latest ALT and its corresponding date are also provided.

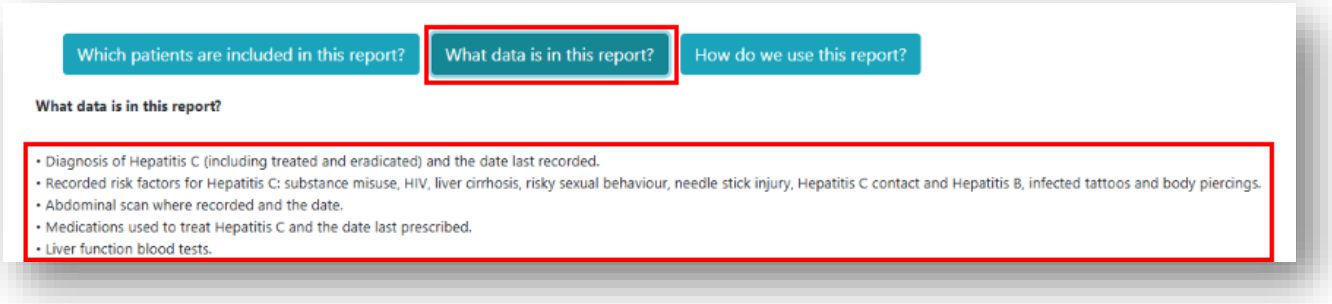
Report Content

Which patients are included in this report?



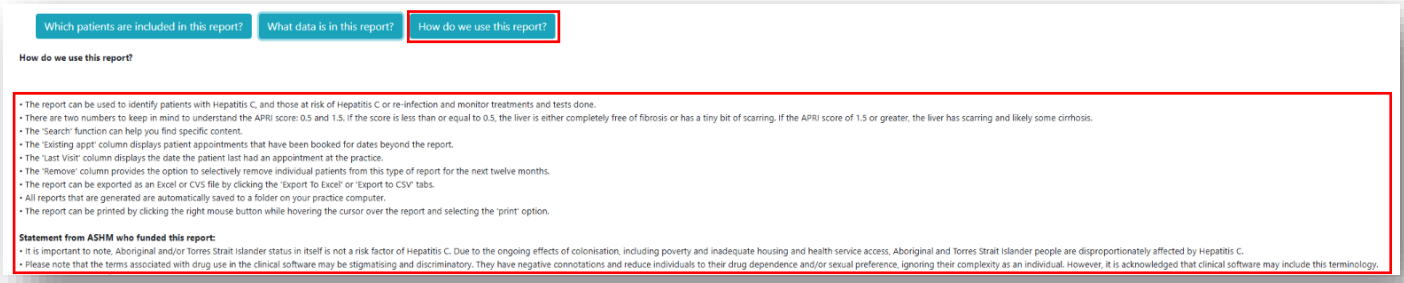
- Patients with a diagnosis of Hepatitis C (including treated and eradicated) and or risk factors for Hepatitis C.
- Patients 18 years and over.
- Patients active in the CIS.
- Palliative Care patients are excluded.
- Patients in Aged Care Facilities are excluded.

What data is in this report?



- Diagnosis of Hepatitis C (including treated and eradicated) and the date last recorded.
- Recorded risk factors for Hepatitis C: substance misuse, HIV, liver cirrhosis, risky sexual behaviour, needle stick injury, Hepatitis C contact and Hepatitis B, infected tattoos and body piercings.
- Abdominal scan where recorded and the date.
- Medications used to treat Hepatitis C and the date last prescribed.
- Liver function blood tests.

How do we use this report?



- The report can be used to identify patients with Hepatitis C (including treated and eradicated), and those at risk of Hepatitis C or re-infection and monitor treatments and tests done.
- There are two numbers to keep in mind to understand the APRI score: 0.5 and 1.5. If the score is less than or equal to 0.5, the liver is either completely free of fibrosis or has a tiny bit of scarring. If the APRI score of 1.5 or greater, the liver has scarring and likely some cirrhosis.
- The 'Search' function can help you find specific content.
- The ‘Existing appt’ column displays patient appointments that have been booked for dates beyond the report.
- The 'Last Visit' column displays the date the patient last had an appointment at the practice.
- The 'Remove' column provides the option to selectively remove individual patients from this type of report for the next twelve months.
- The report can be exported as an Excel or CVS file by clicking the 'Export To Excel' or 'Export to CSV' tabs.
- All reports that are generated are automatically saved to a folder on your practice computer.
- The report can be printed by clicking the right mouse button while hovering the cursor over the report and selecting the 'print' option.

Statement from ASHM, the organization that provided funding for this report:

- It is important to note, Aboriginal and/or Torres Strait Islander status in itself is not a risk factor of Hepatitis C. Due to the ongoing effects of colonisation, including poverty and inadequate housing and health service access, Aboriginal and Torres Strait Islander people are disproportionately affected by Hepatitis C.
- Please note that the terms associated with drug use in the clinical software may be stigmatising and discriminatory. They have negative connotations and reduce individuals to their drug dependence and/or sexual preference, ignoring their complexity as an individual. However, it is acknowledged that clinical software may include this terminology.

Information about this table

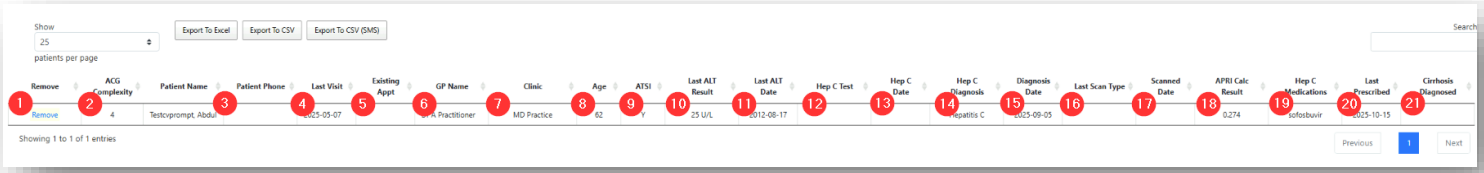
The report includes 2 tables.

Table 1 - Patients With Coded Diagnosis Of Hepatitis C

Patients in this table have a coded diagnosis of Hepatitis C (including treated and eradicated). If they have risk factors for Hepatitis C they will also appear in table 2 due to re-infection risks. The APRI calculation is

provided to assess liver damage based on the latest AST and platelet result. The latest ALT and date is also provided. Where an abdominal ultrasound can be found the date and description is provided - ideally indicating a liver scan. The latest Hepatitis C test date is also provided. Where medications for treating Hepatitis C are found, the last date of the prescription is provided.

Columns Returned

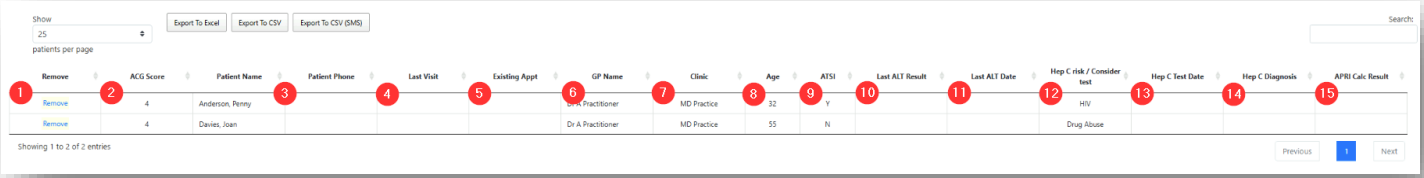


1. **'Remove'** - Patients can be removed from the report for 12 months, by clicking 'Remove.' This action cannot be reversed.
2. **'ACG Complexity'** - the complexity bands formed by combining the ACGs to measure overall morbidity burden on a scale of 0-5, with 5 being the most complex/morbidity burden.
3. Patient demographic data.
4. **'Last Visit'** - displays the date the patient last had an appointment at the practice.
5. **'Existing Appt'** - displays patient appointments that have been booked for dates beyond the report.
6. **'GP Name'** - the GP who has most accessed the patient record. See *Calculating Patient GP* for rules.
7. **'Clinic'** - most attended clinic if data is shared.
8. **'Age'** - Patient age at time the report is run (to protect patient confidentiality, the age of all patients older than 90 years are displayed as 90).
9. **ATSI' -** where patient is identified as: Aboriginal, Aboriginal/Torres Strait Islander or Torres Strait Islander will display 'Y'.
10. **'Last ALT Result'** - the latest result in U/L.
11. **'Last ALT date'** – the date of the last ALT result.
12. **'Hep C test'** - the type of testing done e.g. RNA or PCR.
13. **'Hep C Date'** – the date of the latest Hep C test.
14. **'Hep C Diagnosis'** – the description of the diagnosis.
15. **'Diagnosis Date'** – Date of the diagnosis when first recorded.
16. **'Last scan type'** – searches for scans related to the liver, abdominal ultrasound is included. The description is provided due to the variations available in the records and is capped to fit in the table cell
17. **'Scanned date' –** the date of the last scan
18. **'APRI calc result' –** the result of the calculation
19. **'Hep C medications' –** drugs used to treat Hep C where the first or last date is in the last 18 months, and the medication is not ceased.
20. **'Last prescribed'** – the date of the last prescription
21. **'Cirrhosis diagnosed' -** date of the first recorded diagnosis

Table 2 - Patients With Hepatitis C Risk Factors

Table 2 has similar fields but focuses on those with risk factors so does not include medications.
This table lists patients at risk for Hepatitis C due to factors such as substance misuse, HIV, liver cirrhosis, risky sexual behaviour, needle stick injury, infected tattoos, body piercing, exposure to Hepatitis C or B. Hepatitis C diagnosis (including treated and eradicated) is only noted when ongoing risk factors also exist.

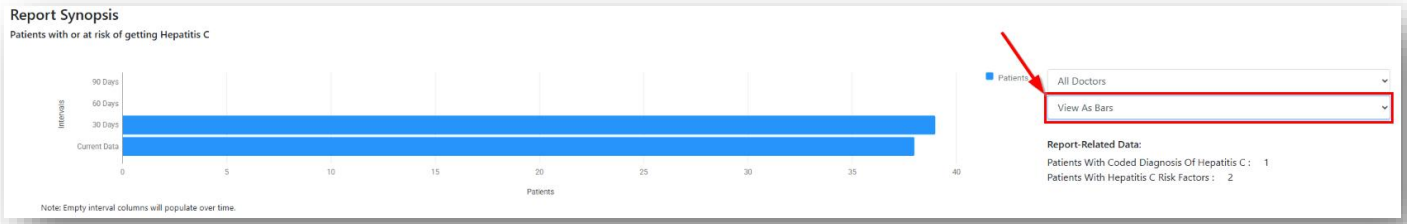
APRI scores, latest ALT (with date) are included to assess liver health.



1. **'Remove'** - Patients can be removed from the report for 12 months, by clicking 'Remove.' This action cannot be reversed.
2. **'ACG Score'** - the complexity bands formed by combining the ACGs to measure overall morbidity burden on a scale of 0-5, with 5 being the most complex/morbidity burden.
3. Patient demographic data.
4. **'Last Visit'** - displays the date the patient last had an appointment at the practice.
5. **'Existing Appt'** - displays patient appointments that have been booked for dates beyond the report.
6. **'GP Name'** - the GP who has most accessed the patient record. See *Calculating Patient GP* for rules.
7. **'Clinic'** - most attended clinic if data is shared.
8. **'Age'** - Patient age at time the report is run (to protect patient confidentiality, the age of all patients older than 90 years are displayed as 90).
9. **ATSI' -** where patient is identified as: Aboriginal, Aboriginal/Torres Strait Islander or Torres Strait Islander Y will be displayed.
10. **'Last ALT Result'** - the latest result in U/L
11. **'Last ALT date'** – the date of the last ALT result
12. **'Hep C risk / Consider test'** – risk behaviour including substance misuse, HIV, liver cirrhosis, risky sexual behavior, needle stick injury, Hepatitis C contact and Hepatitis B
13. **'Hep C Test Date'** – the date of the latest Hep C test
14. **'Hep C Diagnosis'** – the description of the diagnosis if there is one
15. **'APRI calculation' –** the result of the calculation

Report Synopsis

- Patients With Coded Diagnosis of Hepatitis C
- Patients With Hepatitis C Risk Factors
- Results can be filtered to a specific GP who has most accessed the patient record.
- Synopsis can be viewed as columns or bars.



7.17.21. National Lung Cancer Screening (report ID 34)

Overview

The National Lung Cancer Screening Report was developed to support the rollout of the National Lung Cancer Screening program (NLCSP) The National Lung Cancer Screening Program. The report includes active patients aged 50-70 who have a smoking or ex-smoking status.
Primary Sense records smoking status as Nothing Recorded, Nonsmoker, Smoker or Ex-smoker.
To be eligible for the NLCSP, the patient must have:

- a history of cigarette smoking of at least 30 pack-years and still smoke: OR
- at least 30 pack-years and have quit in the past 10 years.

When the year smoking stopped is available, it will be extracted. If not, and a change in smoking status from Smoker to Ex-smoker is detected, this date will be used.
The term "Pack-year" measures the number of cigarettes a person has smoked. The data is used but not as criteria for the report due to data quality issues. The report updates with results as the data is entered, highlighting patients where data is missing.

Pack-years are calculated by multiplying the number of cigarette packs smoked per day by the number of years the person has smoked. 20 cigarettes are considered 1 pack.

One pack-year equals smoking 20 cigarettes daily for a year or 40 cigarettes daily for six months:
- 1 pack/day for 1 year = 1 pack-year
- 2 packs/day for 6 months = 1 pack-year

Patients may have Low-Dose Computed Tomography (LDCT) scans more frequently than every 2 years, with the date of the last scan provided. Imaging request search terms will evolve as more are added to the reference table.

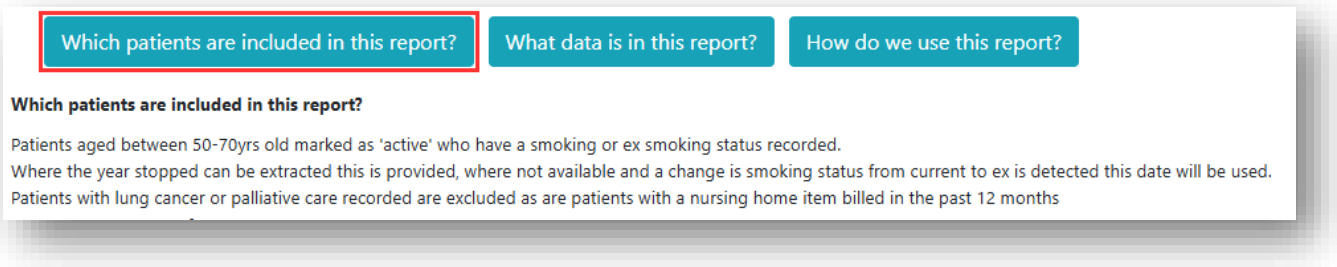
The report includes coded respiratory diseases to help staff identify at-risk individuals. It also provides information on the history of smoking cessation medication history.

Patients are excluded if they are:

- Receiving palliative care,
- Have a Lung cancer diagnosis,
- Are in Aged Care Facility recorded by a nursing home MBS item billed in the past 12 months.

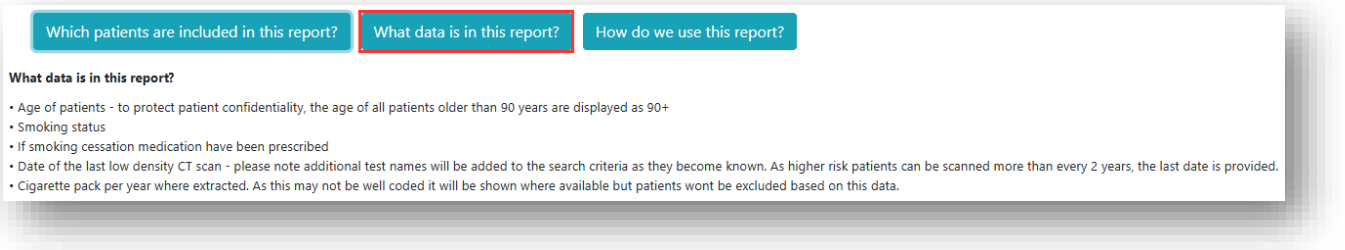
Report Content

Which patients are included in this report?



- Patients aged between 50-70yrs old marked as 'active' in the CIS who have a smoking or ex-smoking status recorded.
- Where the year stopped can be extracted this is provided, where not available and a change is smoking status from current to ex is detected this date will be used.
- Patients with lung cancer or palliative care recorded are excluded as are patients with a nursing home item billed in the past 12 months.

What data is in this report?



- Age of patients - to protect patient confidentiality, the age of all patients older than 90 years are displayed as 90+
- Smoking status
- If smoking cessation medication have been prescribed
- Date of the last low density CT scan - please note additional test names will be added to the search criteria as they become known. As higher risk patients can be scanned more than every 2 years, the last date is provided.
- Cigarette pack per year where extracted. As this may not be well coded it will be shown where available, but patients will not be excluded based on this data being unavailable.

Information about this table

The report includes a table with eligibility criteria for the screening program. It covers all patients, even if smoking data is incomplete. When available, packs per year information is provided.

Notes

Patients are eligible for the program if they:

- are aged between 50 and 70 years
- show no signs or symptoms of lung cancer (that is patients are asymptomatic) and
  - have a history of at least 30 pack-years of cigarette smoking and are still smoking **OR**
  - have a history of at least 30 pack-years of cigarette smoking and quit in the past 10 years.

Definition of 'pack-years'

The term ‘pack-year’ is a way of measuring the number of cigarettes a person has smoked.
Pack-years are calculated by multiplying the number of cigarette packs smoked per day by the number of years the person has smoked.

- For example, 1 pack-year is equal to smoking 20 cigarettes (1 pack) per day for 1 year, or 40 cigarettes

per day for half a year:
  - 1 pack a day for 1 year = 1 pack year
  - 2 packs a day for 6 months = 1 pack year
- A healthcare provider can help you calculate your pack-years.
- To be eligible for the NLCSP, patients must have a history of cigarette smoking of at least 30 pack-years and still smoke; OR at least 30 pack-years and have quit in the past 10 years.

According to the screening and assessment pathway:

- Participants with no findings will stay in the program and be screened again in 2 years.
- Those with low to moderate risk of cancer will stay in the program, have another screening at 12 months or 3 months and may be referred to a specialist.
- Those with high risk of cancer or suspected lung cancer will be referred to a specialist linked to a multidisciplinary team (MDT).

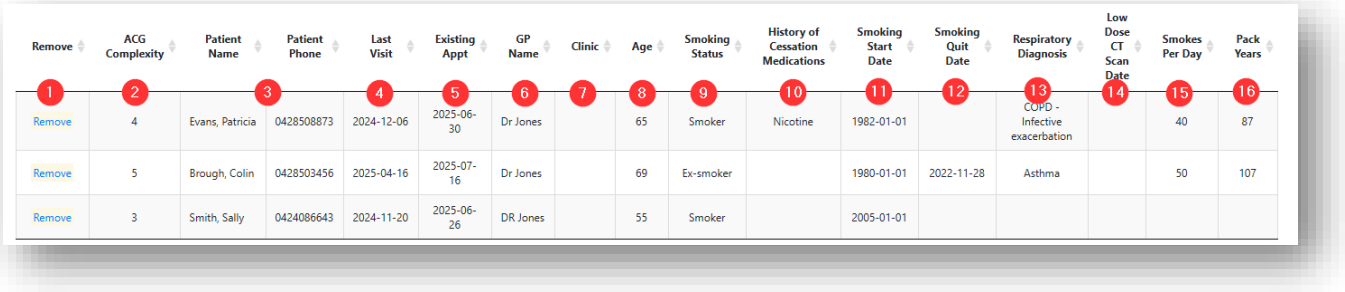
The LDCT scan

There will be 2 new mandatory bulk billing MBS items for LDCT scans under the NLCSP:

- 1 MBS item for the screening LDCT scan done by the participant every 2 years.
- 1 MBS item for any follow-up LDCT scans that may be required in the 2-year screening period depending on the results of the screening LDCT scan.

The MBS items mean that patients will not have any out-of-pocket costs for the LDCT scan through the NLCSP. This is because as a bulk-billed item, a radiology provider accepts the schedule fee as full payment for the service (and cannot charge a co-payment) when claiming from MBS.

Columns Returned

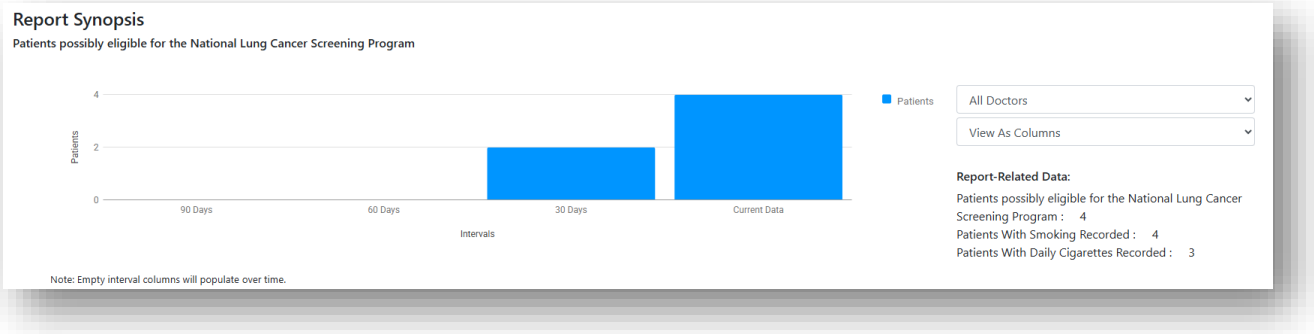


Remove (1)	ACG Complexity (2)	Patient Name (3)	Patient Phone (4)	Last Visit (5)	Existing Appt (6)	GP Name (7)	Clinic (8)	Age (9)	Smoking Status (10)	History of Cessation Medications (11)	Smoking Start Date (12)	Smoking Quit Date (13)	Respiratory Diagnosis (14)	Low Dose CT Scan Date (15)	Smokes Per Day (16)	Pack Years
Remove	4	Evans, Patricia	0428508873	2024-12-06	2025-06-30	Dr Jones		65	Smoker	Nicotine	1982-01-01		COPD - Infective exacerbation		40	87
Remove	5	Brough, Colin	0428503456	2025-04-16	2025-07-16	Dr Jones		69	Ex-smoker		1980-01-01	2022-11-28	Asthma		50	107
Remove	3	Smith, Sally	0424086643	2024-11-20	2025-06-26	DR Jones		55	Smoker		2005-01-01					

1. **'Remove'** - Patients can be removed from the report for 12 months, by clicking 'Remove.' This action cannot be reversed and removes the patient from this report for all clinicians.
2. **'ACG Complexity'** - the complexity bands formed by combining the ACGs to measure overall morbidity burden on a scale of 0-5, with 5 being the most complex/morbidity burden.
3. Patient demographic data.
4. **'Last Visit'** - displays the date the patient last had an appointment at the practice.
5. **'Existing Appt'** - displays patient appointments that have been booked for dates beyond the report.
6. **'GP Name'** - the GP who has most accessed the patient record. See *Calculating Patient GP* for rules.
7. **'Clinic'** - most attended clinic if data is shared.
8. **'Age'** - Patient age at time the report is run.
9. **'Smoking status'** for smoker or ex-smoker. Non-smoker and Not recorded smoking status will not be in this report. Ex-smoker is included if cessation is in the past 10 years.

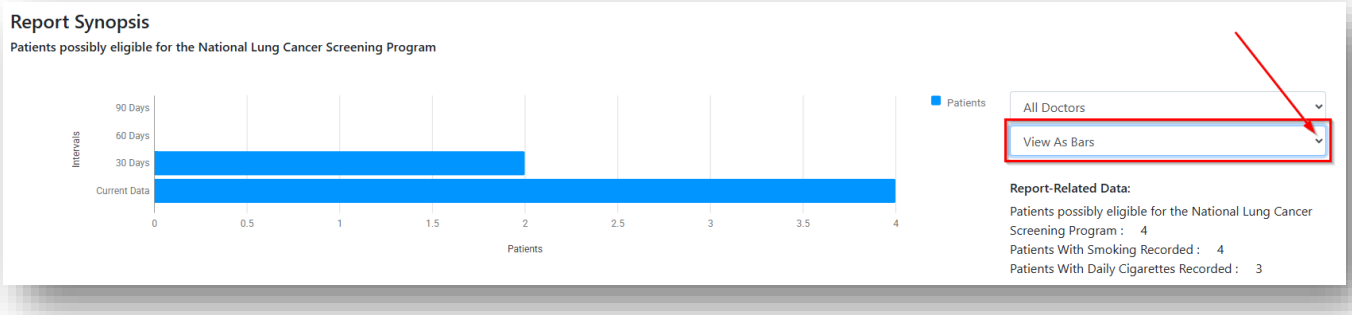
10. **'History of cessation medication'** – if nicotine replacement is prescribed and not marked as ceased.
11. **'Smoking Start Date'** - will default to 1 January if a full date isn't provided.
12. **'Smoking Quit Date'** - will use recorded change of status date, or default to 1 January if a full date isn't provided.
13. **'Respiratory Diagnosis'** – Respiratory conditions recorded including Ashma, COPD, Respiratory failure and disease
14. **'Low dose CT Scan Date'** – Date of the request where this can be determined (referencing various naming conventions)
15. **'Smokes Per Day'** – number of cigarettes smoked per day if recorded
16. **'Pack Years' –** calculated if sufficient data found. Pack-years are calculated by multiplying the number of cigarette packs smoked per day by the number of years the person has smoked. 20 cigarettes are considered 1 pack, = 7300 cigarettes per year.

Report Synopsis



- Patients possibly eligible for the National Lung Cancer
- Screening Program
- Patients With Smoking Recorded
- Patients With Daily Cigarettes Recorded

- Results can be filtered to a specific GP who has most accessed the patient record.
- Synopsis can be viewed as columns or bars.



7.17.22. CVD Risk Screening, Recall and Treatment (report ID 35)

Overview

This report was developed as part of the **PHASES project** in Queensland, a statewide initiative to reduce cardiovascular disease (CVD) by improving primary care. It stands for **Preventing Heart Attacks and Stroke Events through Surveillance** and uses digital tools like Primary Sense, practice support, and community campaigns to empower general practices to identify, prevent, and manage CVD risks earlier. The project's aim is to strengthen primary care's role in preventive healthcare and improve long-term health outcomes for Queenslanders. PHASES with Primary Sense: Project Overview

Primary Sense can assist with the project success by providing data-driven insights to general practitioners (GPs) at the point of care and facilitating early intervention by helping GPs and other primary care providers identify patients at high risk for CVD, enabling proactive guidance on lifestyle and behaviour modifications before conditions become severe.

This report has 4 tables. Due to the criteria for each table, patients should only appear in 1 table. Where patients are automatic high risk but also have CVD, CVD is used to determine which guideline therapy and targets are applied

Table 1: Intermediate and high CVD risk patients without prior CVD not on guideline therapy

This table lists patients who face a significant risk of developing cardiovascular disease within the next five years and are currently missing one or both of the recommended medications to help manage that risk.

Table 2: Patients with prior CVD not on guideline-recommended therapy

This table lists patients with CVD who are missing one or more of the three recommended medications to reduce the risk of another cardiovascular event.

Table 3: Patients at high CVD risk (including prior CVD) on guideline therapy but treatment targets not met

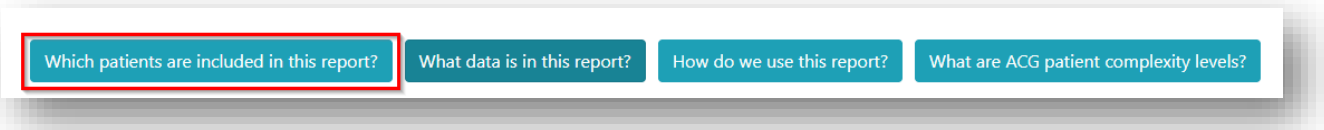
Patients listed are receiving appropriate medications, but their risk factors—such as smoking—remain unmanaged.

Table 4: Patients likely to be at high CVD risk - incomplete/outdated risk factors (priority screening)

Patients in this table do not have the metrics to calculate CV risk but are likely at high risk of a CV event due to other modifiable (e.g. blood pressure) and non-modifiable factors (e.g. age).

Report Content

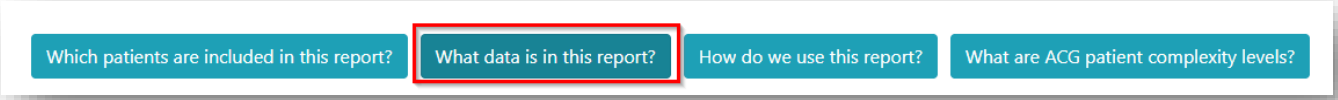
Which patients are included in this report?



- All people aged 45-79 years.
- People with diabetes aged 35-79 years.

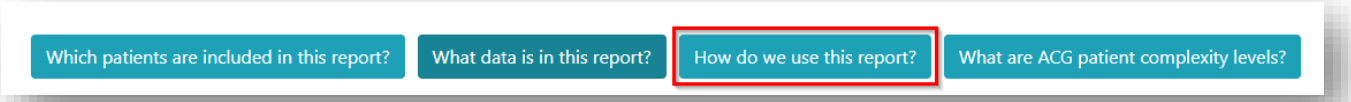
- First Nations people aged 30-79 years (assess individual risk factors 18-29 years).
- Patients at intermediate and high risk of a CVD event (according to 2023 Australian CVD risk tool and/or 2012 Framingham-based tool), not on guideline-recommended therapy.
- Patients with prior CVD not on guideline-recommended therapy.
- Patients at high CVD risk on guideline-recommended therapy but not meeting treatment targets.
- Patients with prior CVD on guideline-recommended therapy but not meeting treatment targets.
- Patients likely to be at high CVD risk who have insufficient risk factors to enable risk score measurement including those not recorded or out of date.
- Patients with a documented reason for a visit in the past 18 months.
- Patients with billed Residential Aged Care Home MBS items or recorded as palliative are excluded.

What data is in this report?



- Patient demographics including age, sex at birth, Aboriginal and Torres Strait Islander status, smoking and diabetes status (where available).
- Select CVD related pathology results (e.g. Lipids, Cholesterol, Renal).
- Names of CVD related Medications prescribed in the past 18 months.
- Observations including last blood pressure recording and time since recorded.
- Dates of MBS items for CVD and CCM services completed in the last 12months.
- Date of last visit.
- Existing appointment date.
- GP/clinic.
- 2023 Australian CVD risk tool score.
- Date of last Heart Health Check (MBS item 699).
- Date of last Care Plan (MBS items 721 or 965).
- Date of last Care Plan Review (MBS item 732 or 967).
- Where a field is blank, no record has been found.

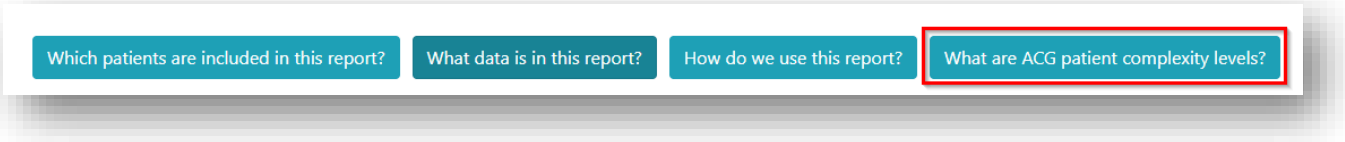
How do we use this report?



- This report can be used to identify the different patient groups that may require screening, recall, intervention or clinical management.
- The report also identifies those patients likely to be at high CVD risk who have insufficient risk factors to enable risk score measurement (including those not recorded or out of date) and are recommended for priority screening.
- All results can be sorted by clicking on each column, to rearrange the results alphabetically, chronologically or from high to low/low to high.

- A date range filter is provided so that only risk factors measured within specified time frames are displayed.
- The date of the last MBS billed item are provided.
- The 'Search' function can help you find specific content.
- The ‘Existing appt’ column displays patient appointments that have been booked for dates beyond the report.
- The 'Last Visit' column displays the date the patient last had an appointment at the practice.
- The 'Remove' column provides the option to selectively remove individual patients from this type of report for the next twelve months.
- The report can be exported as an Excel or CSV file by clicking the 'Export to Excel' or 'Export to CSV' tabs.
- All reports that are generated are automatically saved to a folder on your practice computer.
- The report can be printed by clicking the right mouse button while hovering the cursor over the report and selecting the 'print' option.

What are ACG Complexity Levels?



- There are five complexity levels, ranging from 1 to 5. For data analysis purposes, there is a sixth level, level 0. Level 0 is for those patients with no recorded diagnoses or significantly incomplete or missing data.
- Level 1 indicates a very low level of complexity with no known risks for poor health outcomes, level 5 is the highest complexity. Patients with level 5 complexity typically have significant multi-morbidity and polypharmacy and are at greatest risk of poor health outcomes.
- Levels overview:
  - Level 5: High complexity, characterized by instability, multimorbidity, polypharmacy or patients requiring end-of-life care.
  - Level 4: High to moderate complexity, characterized by multimorbidity.
  - Level 3: Moderate complexity. Patients typically have at least 1 chronic condition and are at risk of progressive deterioration.
  - Level 2: Low to moderate complexity. Patients typically have one risk factor.
  - Level 1: Low complexity. Patients are generally healthy and only present because of acute, time-limited conditions or minor issues.
  - Level 0: no or only invalid diagnosis.
- Patients with higher levels of complexity are more likely to be hospitalized than those with lower levels. However, complexity is not directly related to the risk of being hospitalized. Many Primary Sense reports therefore include both estimates.
- If the complexity of a patient is calculated from results that are more than 12 months old, the level will be displayed in brackets, e.g. (3), rather than 3.
- If there is insufficient information to calculate a complexity level, the result will be displayed as ‘N/A’.
- The complexity levels of patients in this report were calculated with the Johns Hopkins ACG tool. The ACG is underpinned by a robust evidence base of >30 years of practical application. The tool is used in 20 countries and has been validated in different healthcare settings, including general practice.

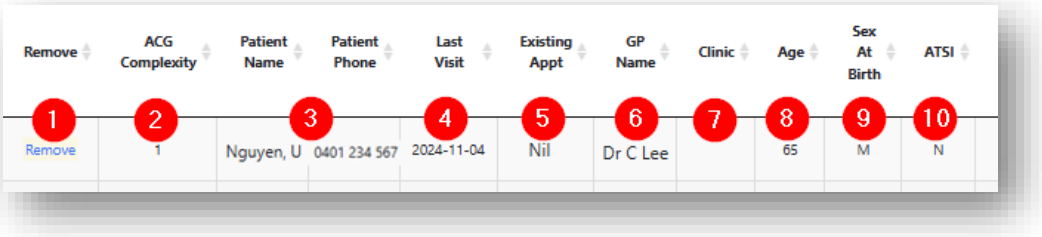
Information about these tables

The report includes 4 tables.
Diagnosis/Conditions referenced from patient Clinical Information System (CIS) are:

- CVD
- Diabetes
- Familiar hypercholesterolemia
- CKD (References eGFR/ACR results)

Columns Returned

Standard across all tables:



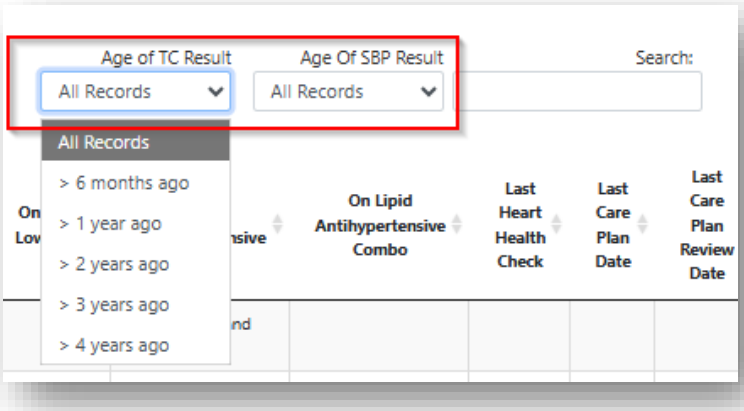
1. **'Remove'** - Patients can be removed from the report for 12 months, by clicking 'Remove.' This action cannot be reversed.
2. **'ACG Complexity'** - the complexity bands formed by combining the ACGs to measure overall morbidity burden on a scale of 0-5, with 5 being the most complex/morbidity burden. See *The Johns Hopkins ACG® Version 12.0 User Documentation* for more information on ACG data.
3. Patient demographic data.
4. **'Last Visit'** - displays the date the patient last had an appointment at the practice.
5. **'Existing Appt'** - displays patient appointments that have been booked for dates beyond the report.
6. **'GP Name'** - the GP who has most accessed the patient record. See User Guide for rules.
7. **'Clinic'** - most attended clinic if data is shared.
8. **'Age'** - Patient age at time the report is run (to protect patient confidentiality, the age of all patients older than 90 years are displayed as 90).
9. **'Sex at Birth'** – F = Female, M = Male, O = Other, U = Unknown, N = Not Recorded
10. **'ATSI' -** patients identified as: Aboriginal, Aboriginal/Torres Strait Islander or Torres Strait Islander will display 'Y'. If not, then 'N'

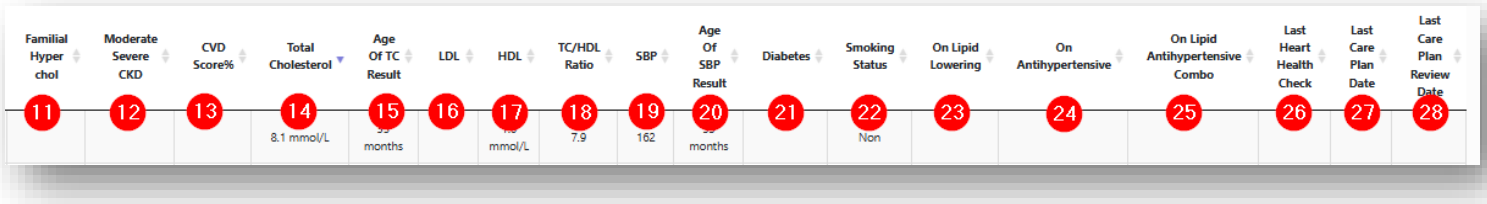
Table 1 - Intermediate and high CVD risk patients without prior CVD not on guideline therapy

- Intermediate and high CVD risk patients without prior CVD not on guideline therapy (includes automatic high CVD risk).
- No prior CVD.
- Age /group band: (Aboriginal and Torres Strait Islander and 30 ≥ age ≤ 79) OR (Diabetes and 35 ≥ age ≤ 79)
  OR (Neither Aboriginal and Torres Strait Islander nor Diabetes and 45 ≥ age ≤ 79).

- Risk Status: CVD risk category = intermediate to high OR meets automatic high-risk criteria (i.e. Moderate-severe CKD (eGFR <45ml /kg/min/1.73 m2 OR uACR> 25 men, >35 women; OR Recorded Familial hypercholesterolemia).
- Therapy status: Not on any antihypertensive AND not on any lipid-lowering therapy.
- Recency: ≥1 recorded consultation within the last 18 months (reason for visit/diagnosis) OR Any medication prescribed within the last 18 months from report date.

Results can be filtered by time passed since the last Total Cholesterol or Systolic Blood Pressure test to identify those needing review.





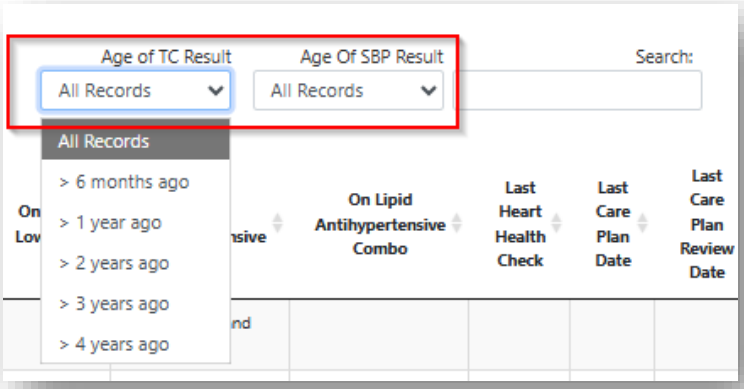
11. **'Familiar hypercholesterolemia'** – Y displayed if diagnosis in CIS
12. **'Moderate Severe CKD'** – Y displayed if diagnosis in CIS (Moderate-severe CKD (eGFR <45ml /kg/min/1.73 m2 OR uACR> 25 men, >35 women)
13. **'CVD Score %' =>5**
14. **'Total Cholesterol'** - Latest Total Cholesterol result
15. **'Age of TC Result'** – Time since last Total Cholesterol result, displays 'this month' or total in months e.g. '33 months'
16. **'LDL' –** latest Low-Density Lipoprotein result
17. **'HDL' –** Latest High-Density Lipoprotein result
18. **'TC/HDL Ratio'** – latest Total Cholesterol to HDL Ratio result
19. **'SBP'** – Latest recorded Systolic Blood Pressure
20. **'SBP'** – Time since last recorded Systolic Blood Pressure, displays 'this month' or total in months e.g. '33 months'
21. **'Diabetes'** – Y displayed if diagnosis in CIS (Type 1 and gestational diabetes diagnosis are excluded due to the heart foundation calculation acknowledging overestimates with Type 1 diabetics)
22. **'Smoking Status'** - Smoker, Non = Non-smoker, Ex = Ex-smoker, N/A if no record in CIS
23. **'On Lipid Lowering' –** Displays prescribed medication
24. **'On Antihypertensive' –** Displays prescribed medication
25. **'On Lipid Antihypertensive Combo' –** Displays prescribed medication

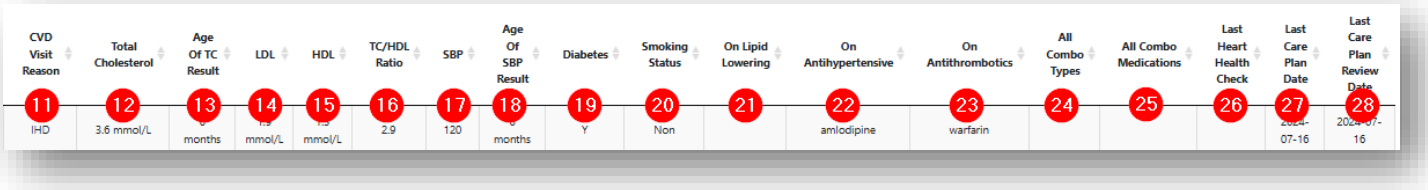
26. **'Last Heart Health Check'** - last billed MBS item 699 Heart Health Assessment
27. **'Last Care Plan date'** – last billed 721 GP Management Plan (GPMP) or 965 Prepare GP Chronic Condition Management Plan
28. **'Last Care Plan Review Date' –** last billed 732 Review of GPMP or Team Care Arrangements (TCA) or 967 Review GP Chronic Condition Management Plan

Table 2 - Patients with prior CVD not on guideline-recommended therapy

- Age: 30 ≥ age ≤ 79.
- Condition: prior CVD.
- Therapy status: Missing any one or more of the following therapies:
  - Antiplatelet
  - Antihypertensive
  - Lipid-lowering
- Medication definition: Active therapy requires a prescription within the past 18 months.
- Conditions are used where active or inactive due to risks.

Results can be filtered by time passed since the last Total Cholesterol or Systolic Blood Pressure test to identify those needing review.





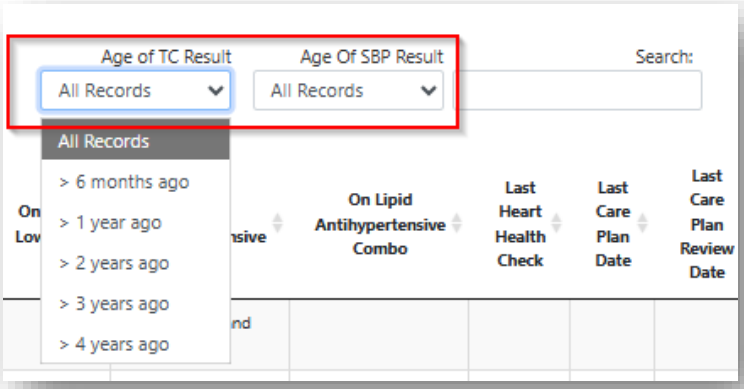
11. **'CVD Visit Reason'** – latest CVD reason for visit / diagnosis in CIS (reason for visit / diagnosis list defined by PHASES Project)
12. **'Total Cholesterol'** - Latest Total Cholesterol result
13. **'Age of TC Result'** – Time since last Total Cholesterol result, displays 'this month' or total in months e.g. '33 months'
14. **'LDL' –** latest Low-Density Lipoprotein result
15. **'HDL' –** Latest High-Density Lipoprotein result
16. **'TC/HDL Ratio'** – latest Total Cholesterol to HDL Ratio result
17. **'SBP'** – Latest recorded Systolic Blood Pressure

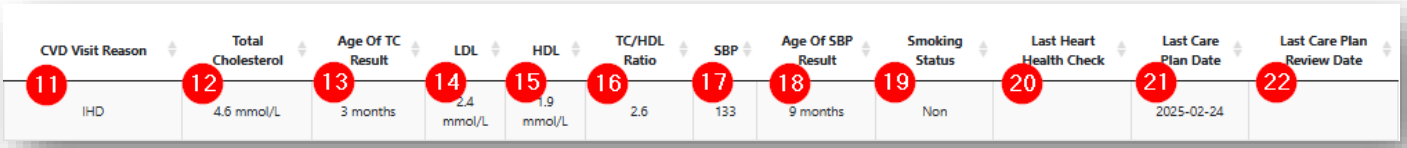
18. **'Age of SBP Result'** – Time since last recorded Systolic Blood Pressure, displays 'this month' or total in months e.g. '33 months'
19. **'Diabetes'** – Y displayed if diagnosis in CIS (Type 1 and gestational diabetes diagnosis are excluded due to the heart foundation calculation acknowledging overestimates with Type 1 diabetics)
20. **'Smoking Status'** - Smoker, Non = Non-smoker, Ex = Ex-smoker, N/A if no record in CIS
21. **'On Lipid Lowering' –** Displays prescribed medication
22. **'On Antihypertensive' –** Displays prescribed medication
23. **'On Antithrombotics' –** Displays prescribed medication
24. **'All Combo Types' –** Displays prescribed medication e.g. statin and lipid lowering and anti-platelet (this field may be empty until some medications come onto the PBS)
25. **'All Combo Medications' –** Displays prescribed medication where medication type is a combination medication
26. **'Last Heart Health Check'** - last billed MBS item 699 Heart Health Assessment
27. **'Last Care Plan date'** – last billed 721 GP Management Plan (GPMP) or 965 Prepare GP Chronic Condition Management Plan
28. **'Last Care Plan Review Date' –** last billed 732 Review of GPMP or Team Care Arrangements (TCA) or 967 Review GP Chronic Condition Management Plan

Table 3- Patients at high CVD risk (including prior CVD) on guideline therapy but treatment targets not met

- Selects patients who meet all of the following:
  - Age /group band : 30 ≥ age ≤ 79).
  - Risk Status: High CVD risk -
    - Includes high CVD risk score.
    - Includes automatic high risk categories.
- Data completeness: Complete set of risk factors recorded for those with a high CVD risk score; not for those who are automatic high risk or prior CVD as not needed.
- Therapy Status: On guideline-recommended therapy (active prescription = within past 18 months) AND who meet at least one of the following 'not at target' criteria:
  - On lipid-lowering therapy AND LDL ≥ 1.8 mmol/L if no prior CVD, or LDL ≥ 1.4 mmol/L if prior CVD.
  - On antihypertensive therapy AND systolic BP ≥ 140 mmHg.
- Current smoker.
- Where the CVD visit reason is blank this means the patient is auto high risk, intermediate or high CV Risk.

  Results can be filtered by time passed since the last Total Cholesterol or Systolic Blood Pressure test to identify those needing review.





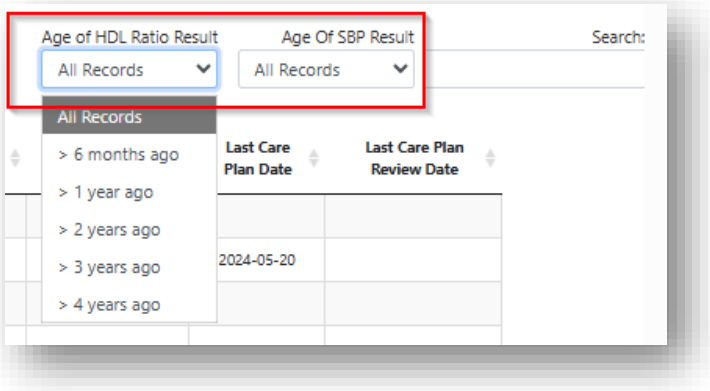
11. **'CVD Visit Reason'** – latest CVD reason for visit / diagnosis in CIS. If blank this means the patient is auto high risk, intermediate or high CV Risk (reason for visit / diagnosis list defined by PHASES Project)
12. **'Total Cholesterol'** - Latest Total Cholesterol result
13. **'Age of TC Result'** – Time since last Total Cholesterol result, displays 'this month' or total in months e.g. '33 months'
14. **'LDL' –** latest Low-Density Lipoprotein result
15. **'HDL' –** Latest High-Density Lipoprotein result
16. **'TC/HDL Ratio'** – latest Total Cholesterol to HDL Ratio result
17. **'SBP'** – Latest recorded Systolic Blood Pressure
18. **'Age of SBP Result'** – Time since last recorded Systolic Blood Pressure, displays 'this month' or total in months e.g. '33 months'
19. **'Smoking Status'** - Smoker, Non = Non-smoker, Ex = Ex-smoker, N/A if no record in CIS
20. **'Last Heart Health Check'** - last billed MBS item 699 Heart Health Assessment
21. **'Last Care Plan date'** – last billed 721 GP Management Plan (GPMP) or 965 Prepare GP Chronic Condition Management Plan
22. **'Last Care Plan Review Date' –** last billed 732 Review of GPMP or Team Care Arrangements (TCA) or 967 Review GP Chronic Condition Management Plan

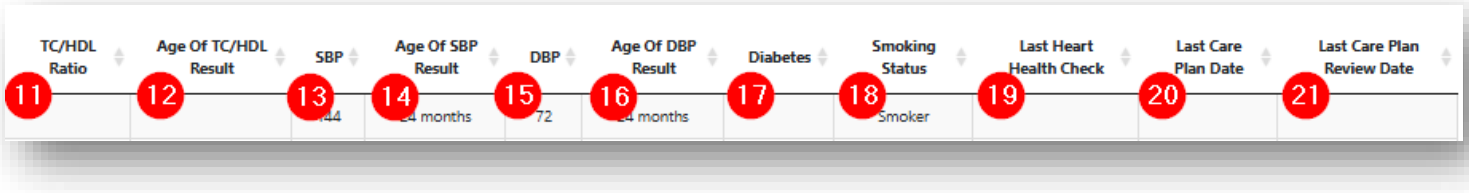
Table 4 - Patients likely to be at high CVD risk - incomplete/outdated risk factors (priority screening)

- Select patients who meet **all** of the following:
  - Age: Male aged ≥75 years.
  - Male or female aged ≥70 years who is a current smoker.
  - Any person aged ≥70 years with diabetes.
  - Aboriginal and Torres Strait Islander person aged ≥55 years who is a current smoker or has diabetes.
  - Male aged ≥65 years with both

        - Systolic BP ≥150 mmHg AND.
        - Total cholesterol:HDL ratio ≥5.
    - Any person aged ≥60 years with all three of the following:
        - Current smoker
        - Elevated BP (systolic ≥140 mmHg or diastolic ≥90 mmHg)
- Recency: AND have had at least one consultation within the past 2 years.

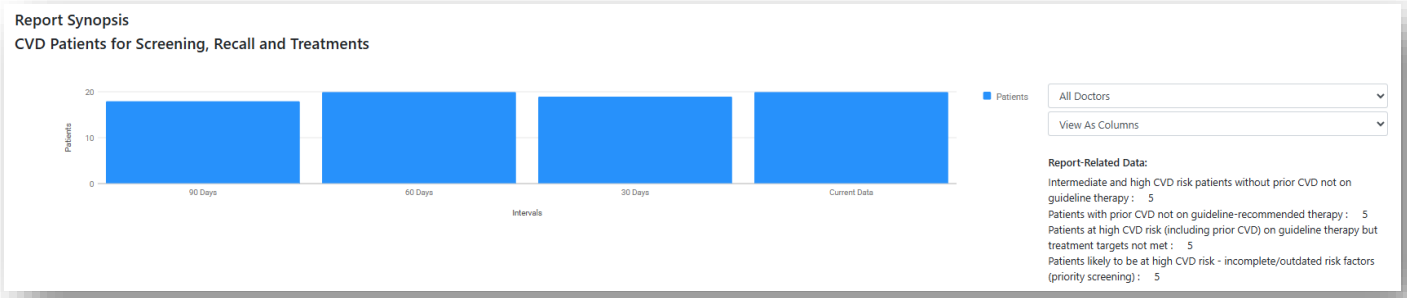
Results can be filtered by time passed since the last High-Density Lipoprotein (HDL) result or Systolic Blood Pressure test to identify those needing review.





11. **'TC/HDL Ratio'** – latest Total Cholesterol to HDL Ratio result
12. **'Age of TC/HDL Result'** – Time since last Total Cholesterol to HDL Ratio result, displays 'this month' or total in months e.g. '33 months'
13. **'SBP'** – Latest recorded Systolic Blood Pressure
14. **'Age of SBP Result'** – Time since last recorded Systolic Blood Pressure, displays 'this month' or total in months e.g. '33 months'
15. **'DBP'** – Latest recorded Diastolic Blood Pressure
16. **'Age of DBP Result'** – Time since last recorded Diastolic Blood Pressure, displays 'this month' or total in months e.g. '33 months'
17. **'Diabetes'** – Y displayed if diagnosis in CIS (Type 1 and gestational diabetes diagnosis are excluded due to the heart foundation calculation acknowledging overestimates with Type 1 diabetics)
18. **'Smoking Status'** - Smoker, Non = Non-smoker, Ex = Ex-smoker, N/A if no record in CIS
19. **'Last Heart Health Check'** - last billed MBS item 699 Heart Health Assessment
20. **'Last Care Plan date'** – last billed 721 GP Management Plan (GPMP) or 965 Prepare GP Chronic Condition Management Plan
21. **'Last Care Plan Review Date' –** last billed 732 Review of GPMP or Team Care Arrangements (TCA) or 967 Review GP Chronic Condition Management Plan

Report Synopsis



- Intermediate and high CVD risk patients without prior CVD not on guideline therapy
- Patients with prior CVD not on guideline-recommended therapy
- Patients at high CVD risk (including prior CVD) on guideline therapy but treatment targets not met
- Patients likely to be at high CVD risk - incomplete/outdated risk factors (priority screening)

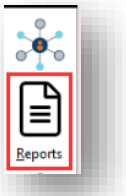
- Results can be filtered to a specific GP who has most accessed the patient record.
- Synopsis can be viewed as columns or bars.

8. Clinical Audit Queries

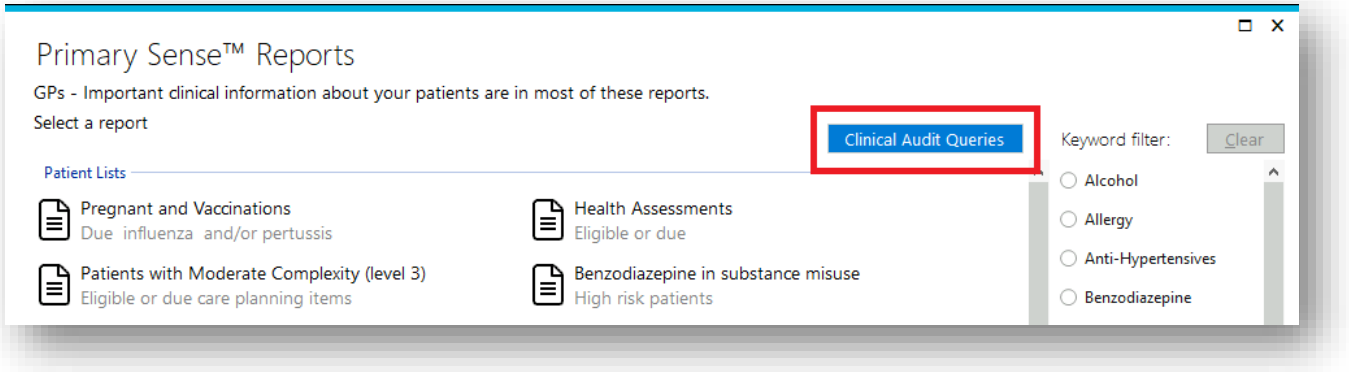
8.1. Using Clinical Audits Overview

Clinical audit queries are similar to reports, but are a more simplistic lists of patients, enabling the volume of queries to be more extensive as there are less requirements in the logic and database processing. The intention is for use in recall lists, enrolment in projects, etc. The tab is located in the reports tile in the desktop.

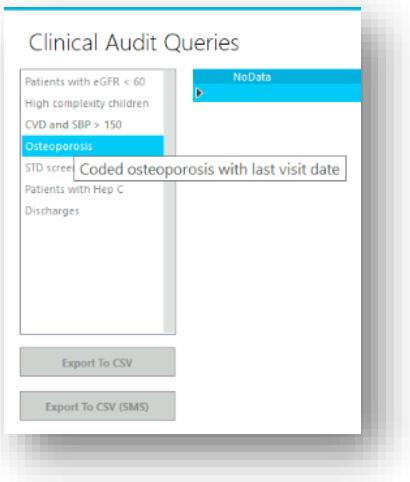
Clinical audit queries are accessed by selecting the Reports tab from the Desktop Menu,



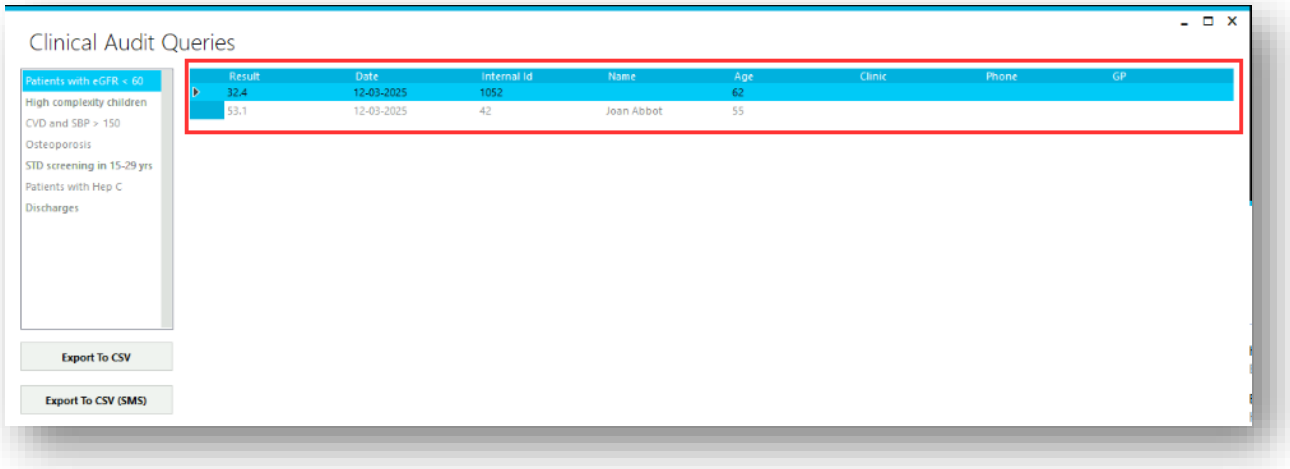
clicking on the 'Clinical Audit Queries' button and double clicking on the Audit of choice.



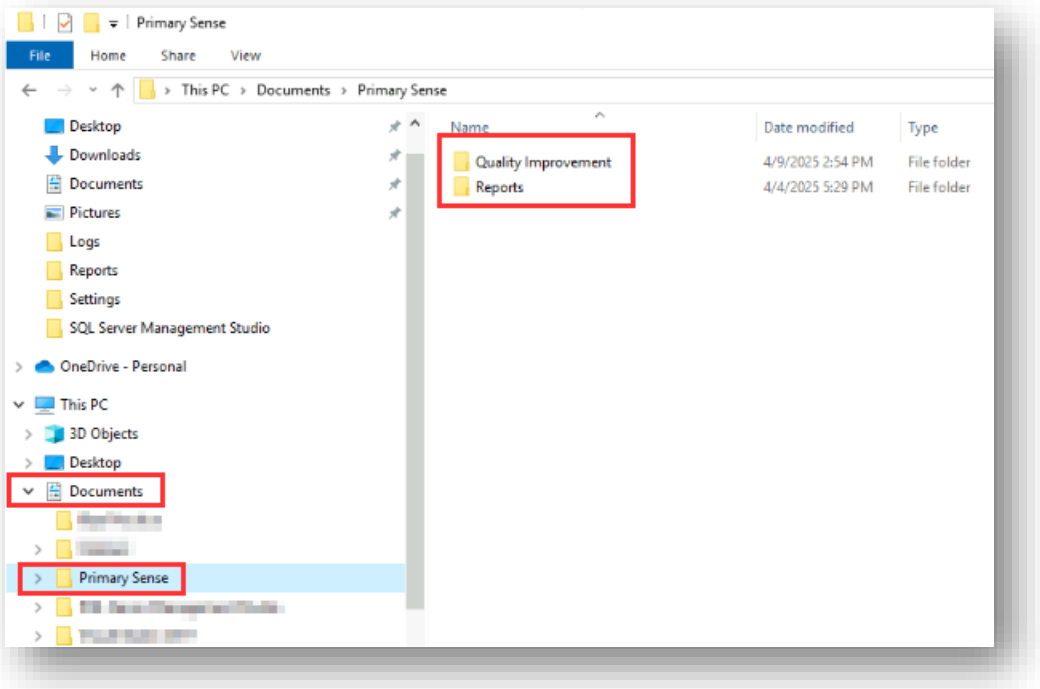
The list is to the left and each title has a hover over tool tip.



Double click the required audit to return any data on the right of the screen.



- The table can be exported to Excel or CSV for further analysis. 'Export To CSV (SMS)' will create a patient recall list for use with HotDoc© or other compatible applications.
- Applications such as Google Sheets or Libre Office can be used to view and filter the export if Excel is unavailable. Follow your PHN or Practice regulations for use of applications.
- When an Audit is exported the clinician will need to select where they want the audit saved. It does not export automatically as the reports do.



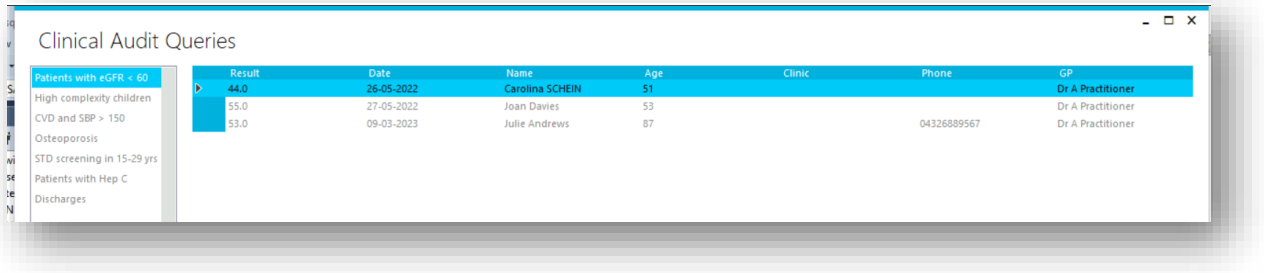
8.2. Current Clinical Audit Queries

The queries are shown below with the tool tip giving the explanation. Most will only show the last date, be that a test or date of visit

The queries are shown below with the tool tip giving the explanation. Most will only show the last date, be that a test or date of visit.

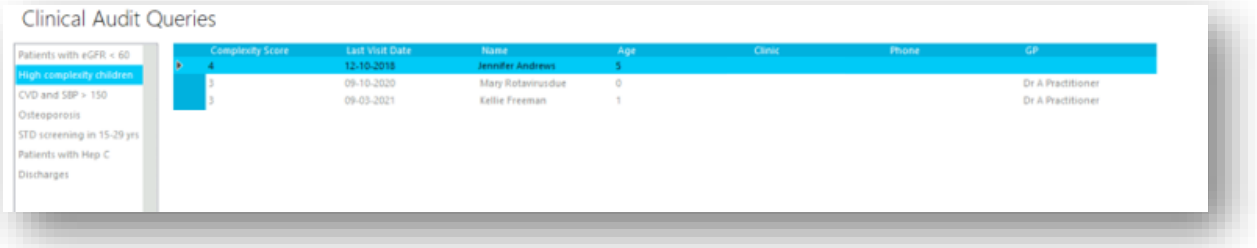
8.2.1. Patients with eGFR < 60 (Audit 1)

Shows the latest eGFR where it is less than 60 and the patient doesn't have dialysis recorded.
Contains data from the last 2 years.



8.2.2. High Complexity Children (Audit 2)

Shows children less than 17 yrs old with ACG band 3, 4 or 5 with last visit date.
Contains data from the last 2 years.



8.2.3. CVD and SBP > 150 (Audit 3)

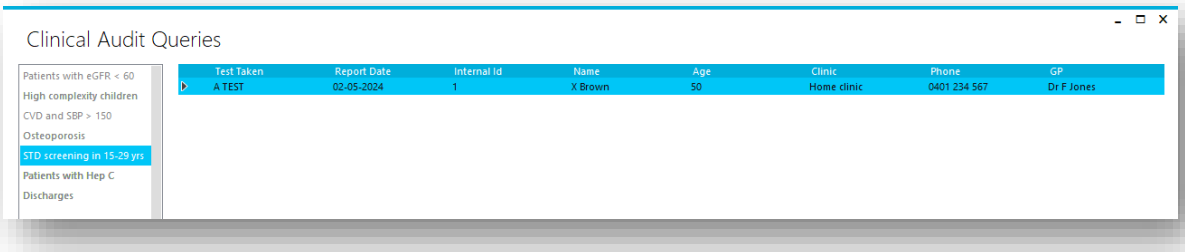
Shows coded CVD and last blood pressure where Systolic Blood Pressure > 150 mmHg.
Contains the most recent data for each patient from the last 18 months.

8.2.4. Osteoporosis (Audit 4)

Shows coded osteoporosis with last visit date.
Contains data with no time restriction.

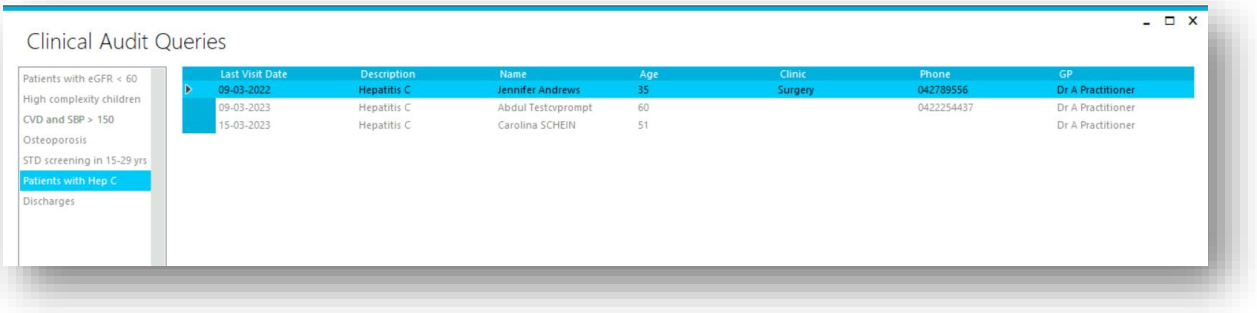
8.2.5. STD Screening in 15-29 yrs (Audit 5)

Shows date of last STD testing in patients aged 25-29 yrs (includes chlamydia, HIV, syphilis, gonorrhoea).
Contains data from the last 18 months.



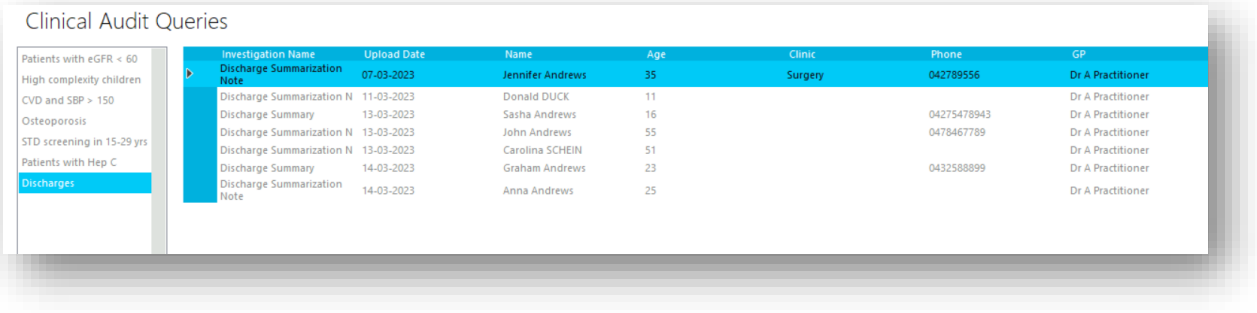
8.2.6. Patients with Hep C (Audit 6)

Shows diagnosed Hepatitis C still active with date of last visit.
Contains data with no time restriction.



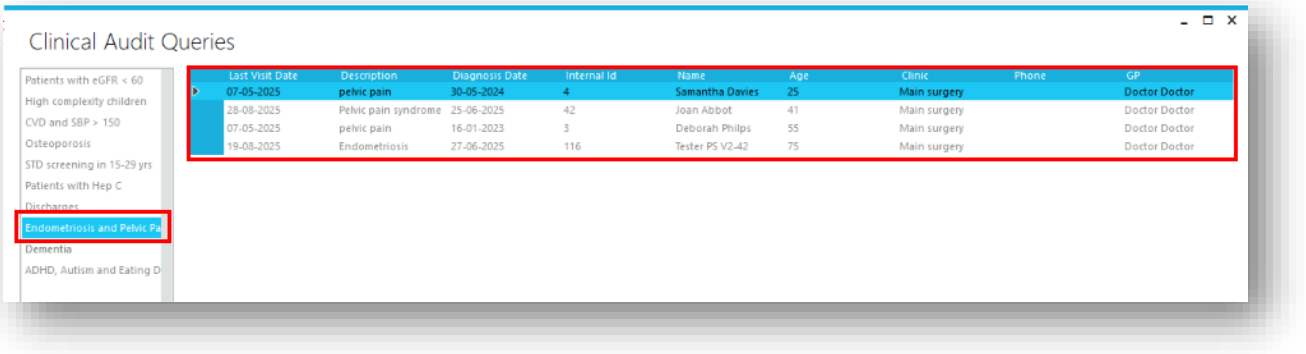
8.2.7. Discharges (Audit 7)

Shows patients where last discharge summary was received in the past 18 months (sourced from document type in the CIS).



8.2.8. Endometriosis and Pelvic Pain (Audit 8)

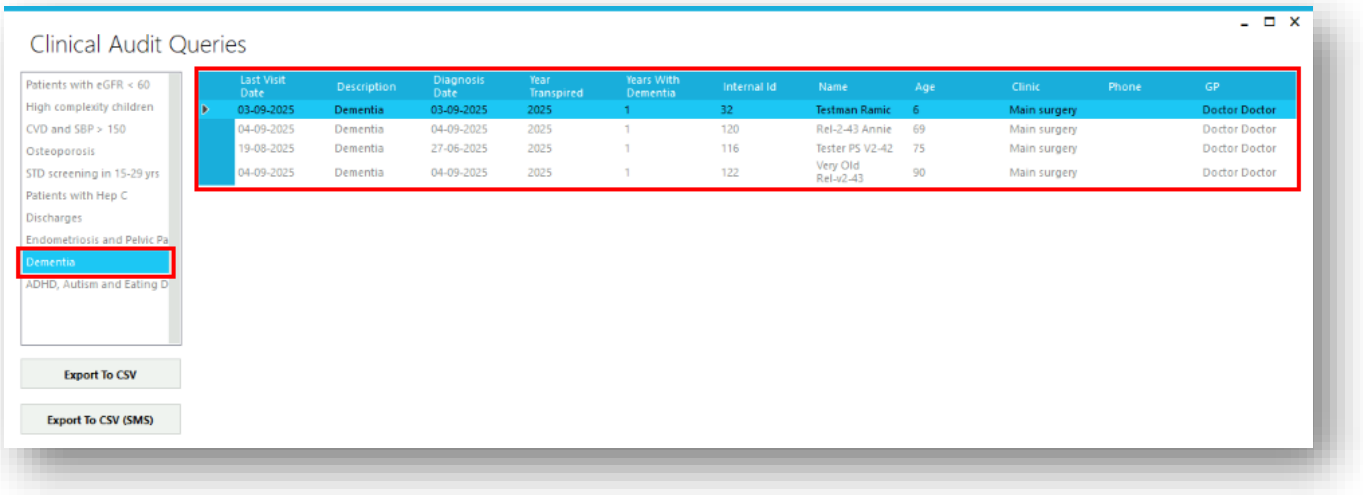
This audit returns patients who have a recorded diagnosis of Endometriosis, Dysmenorrhoea, Pelvic pain or Heavy Menstrual Bleeding.
Patients must be active in the Clinical Information System (CIS) at the practice.
Contains data from the last 2 years.



- **Last Visit Date**
- **Diagnosis Description** – Must be an active condition in the CIS. Examples include:
  - Pain, pelvic, F
  - Pain;pelvic;F
  - Dysmenorrhoea
  - Dysmenorrhoea - Primary
  - Dysmenorrhoea, primary
  - Idiopathic Period Pain
  - Primary dysmenorrhoea
  - Ectopia - Endometrium
  - Ectopic endometrium
  - Endometriosis
  - Adenomyosis
  - Uterine adenomyosis
  - Pain, pelvic
  - pelvic pain
  - Chocolate cyst
  - Endometrioma
  - Menstrual pain
  - Menstruation - Pain
  - Period Pain
  - Menstrual bleeding, heavy
  - Heavy menstrual bleeding
  - Chronic Pelvic pain
  - Left Pelvic pain
  - Pelvic pain syndrome
  - Right Pelvic pain
- **Diagnosis Date**
- **Internal Patient ID** – Patient CIS ID Number
- **Name**
- **Age**
- **Home Clinic** - displays most attended clinic if data is shared.
- **Phone number**
- **GP** - consultations from the past 3 months to ensure high-frequency patients, who may have frequent visits, are represented by their most current history. If fewer than 5 visits are returned, the search extends to include consultations within the past year. If this still doesn't yield 5 or more visits, the date range is widened progressively, adding one year at a time, up to a maximum of 5 years. At that point, if fewer than 5 visits are returned, the process stops. If the top two GPs have equal numbers of visits, the GP from the most recent consultation is chosen.

8.2.9. Dementia (Audit 9)

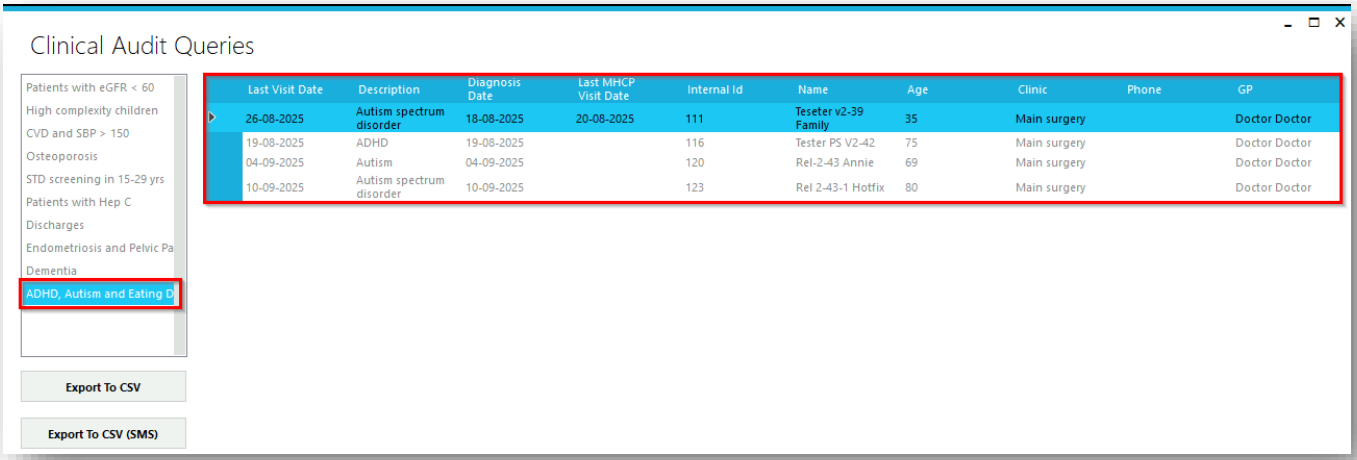
This audit returns patients where a Dementia code identified by the ICPC grouper P70 has been recorded as a diagnosis.
Patients must be active in the Clinical Information System (CIS) at the practice.



- **Last Visit Date**
- **Diagnosis Description** – Must be an active condition in the CIS, Dementia defined by ICPC2+ Grouper P70.
- **Diagnosis Date**
- **Year Transpired**
- **Years with Dementia**
- **Internal Patient ID** – Patient CIS ID Number
- **Name**
- **Age**
- **Home Clinic** - displays most attended clinic if data is shared.
- **Phone Number**
- **GP** - consultations from the past 3 months to ensure high-frequency patients, who may have frequent visits, are represented by their most current history. If fewer than 5 visits are returned, the search extends to include consultations within the past year. If this still doesn't yield 5 or more visits, the date range is widened progressively, adding one year at a time, up to a maximum of 5 years. At that point, if fewer than 5 visits are returned, the process stops. If the top two GPs have equal numbers of visits, the GP from the most recent consultation is chosen.

8.2.10. ADHD, Autism or Eating Disorders (Audit 10)

This audit returns patients of any age where ADHD, Autism or Eating Disorders have been documented in the past 2 years. It also shows the date of the last MH care plan or review.
Patients must be active in the Clinical Information System (CIS) at the practice.



- **Last Visit Date**
- **Diagnosis Description** – Must be an active condition in the CIS
- **Diagnosis Date**
- **Date of last mental health care plan, MBS items included are:**

Item	Description
2700	GP Mental Health Treatment Plan (face-to-face, without mental health skills training, 20–39 minutes)
2701	GP Mental Health Treatment Plan (face-to-face, without mental health skills training, ≥40 minutes)
2715	GP Mental Health Treatment Plan (face-to-face, with mental health skills training, 20–39 minutes)
2717	GP Mental Health Treatment Plan (face-to-face, with mental health skills training, ≥40 minutes)
272	Review of GP Mental Health Treatment Plan (face-to-face)
276	Consultation for a patient with a mental disorder (face-to-face, <20 minutes)
277	Consultation for a patient with a mental disorder (face-to-face, ≥20 minutes)
281	Prescribed medical practitioner (with mental health skills training), 20–39 minutes, for preparation of a GP Mental Health Treatment Plan
282	Prescribed medical practitioner (with mental health skills training), ≥40 minutes, for preparation of a GP Mental Health Treatment Plan
92116	Telehealth version of item 2715 (GP with mental health training, 20–39 min)
92128	Telehealth version of item 277 (Consultation ≥20 min)
92117	Telehealth version of item 2717 (GP with mental health training, ≥40 min)
92129	Telehealth version of item 281 (Prescribed medical practitioner, 20–39 min)
92112	Telehealth version of item 2700 (GP without mental health training, 20–39 min)
92124	Telehealth version of item 272 (Review of GP Mental Health Treatment Plan)
92113	Telehealth version of item 2701 (GP without mental health training, ≥40 min)

92125	Telehealth version of item 276 (Consultation <20 min)

- **Internal Patient ID** – Patient CIS ID Number
- **Name**
- **Age**
- **Home Clinic** - displays most attended clinic if data is shared.
- **Phone Number**
- **GP** - consultations from the past 3 months to ensure high-frequency patients, who may have frequent visits, are represented by their most current history. If fewer than 5 visits are returned, the search extends to include consultations within the past year. If this still doesn't yield 5 or more visits, the date range is widened progressively, adding one year at a time, up to a maximum of 5 years. At that point, if fewer than 5 visits are returned, the process stops. If the top two GPs have equal numbers of visits, the GP from the most recent consultation is chosen.

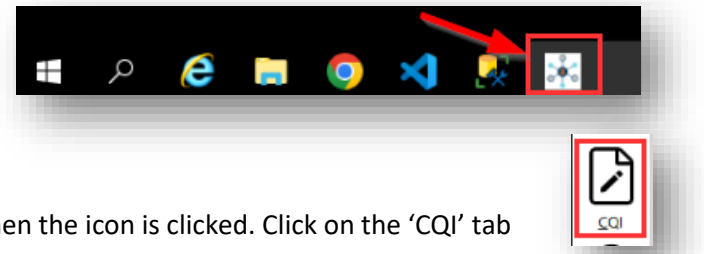
9. CQI (Continuous Quality Improvement)

9.1. CQI Overview

The CQI section of the Primary Sense Desktop provides activities and templates to support PIP QI requirements for CQI. Many of the templates provided reference Primary Sense reports (available under the 'Reports' tab).
Primary Sense reports support:

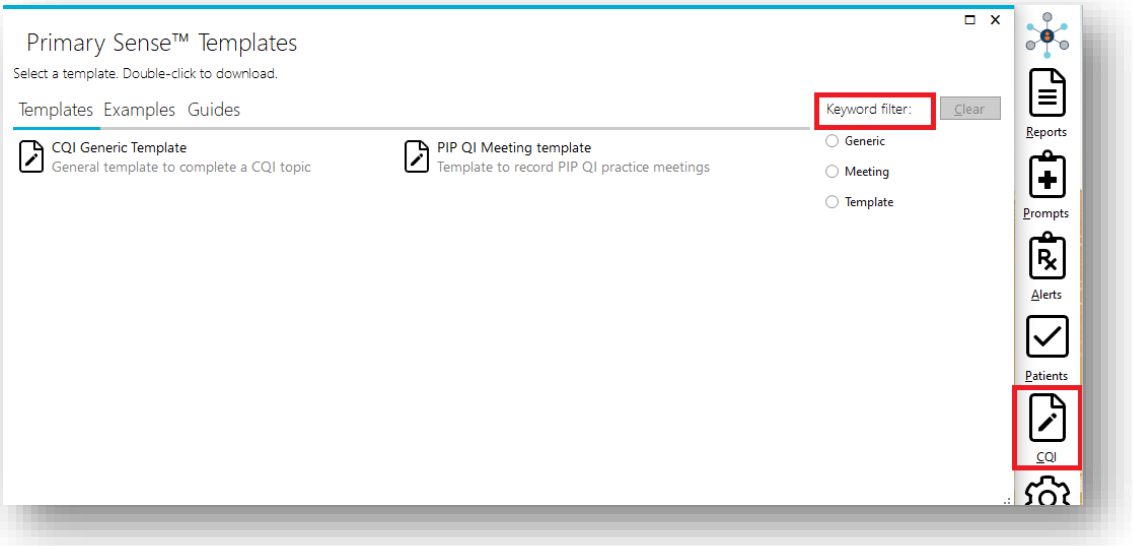
- the identification of potential areas for improvement
- the implementaion of CQI activites; and
- provide a monitoring report to track changes overtime (Summary Report of Practice Improvements report)

Access the Primary Sense Desktop by locating the Primary Sense icon on your desktop, or via the bottom toolbar:

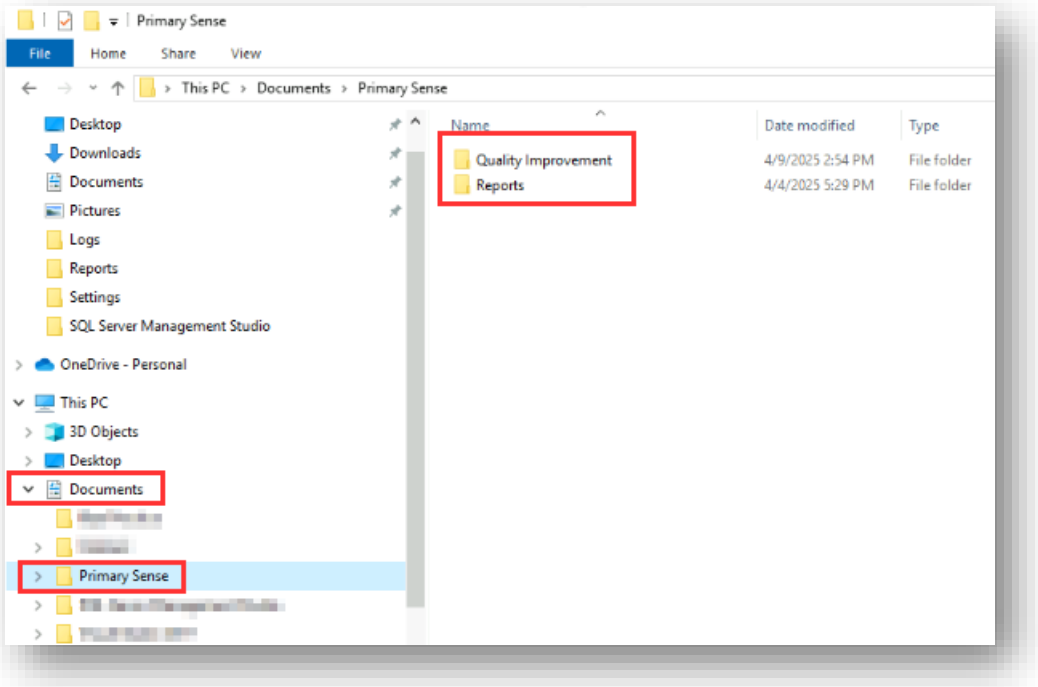


This side bar appears when the icon is clicked. Click on the 'CQI' tab

To search for a specific topic in the CQI tab, use the 'Keyword filter':



- When a CQI Document is opened in Primary Sense, a folder is automatically created on the computer in use under Documents > Primary Sense. All CQI Document will then be saved in this folder.

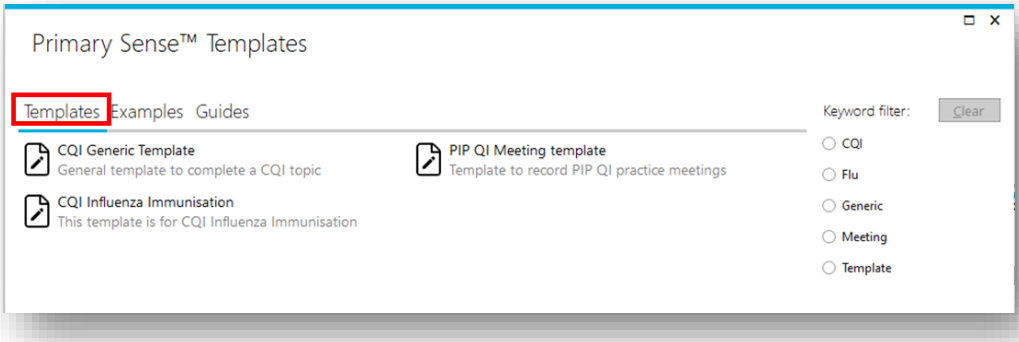


9.2. Available resources

9.2.1. Templates

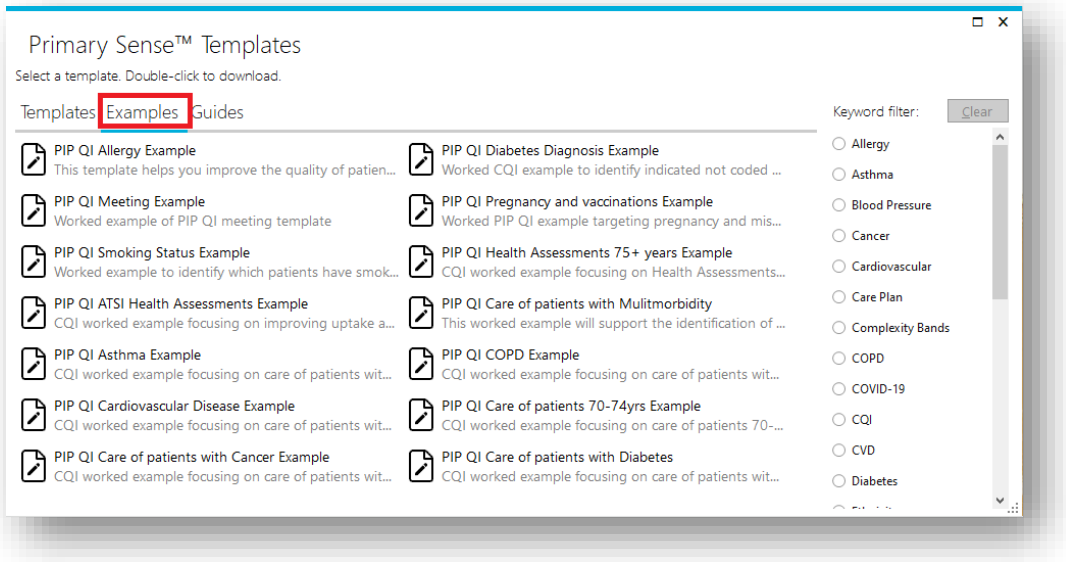
This tab includes:

- Generic CQI Action plan
- Generic PIP QI Meeting template
- Generic CQI Influenza Immunisation template



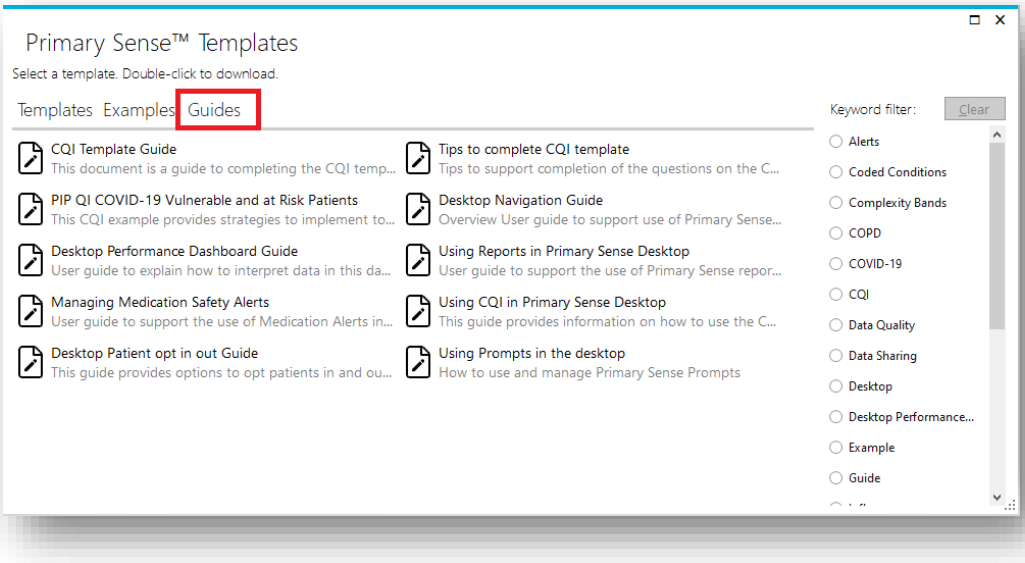
9.2.2. Examples

This tab includes a selection of pre-filled CQI Action Plans that can edit to support the practice's CQI activities.



9.2.3. Guides

This tab includes guides on Primary Sense Desktop navigation and functionality, how to use the templates and tips for undertaking CQI.



10. Medication safety alerts

10.1. Medication Safety Alerts Overview

Primary Sense Medication Safety Alerts are real-time notifications of a potential safety issue. Primary Sense checks the practice every two seconds for a new medication being prescribed, to assess whether the current patient would be at risk in the event a specific medication is prescribed (as per the available alerts).

Medication alerts are generated at the point of prescribing, i.e., when a clinician is entering the prescription into the clinical software. Alerts are only sent to doctors who selected this function. Primary Sense medication alerts are different to Medical Director and BP alerts. They are more specific, relate only to high-risk medications and take individual patient factors into account. For example, an alert for prescribing metformin will only be generated when a GP prescribes it for a patient with a recent eGFR <30ml/min.

Alerts are not intended to replace clinical judgement and can be overridden or marked as inappropriate for the patient if necessary.

Note: *Alerts rely on coded data, accurate current medication lists, and may fail to arrive due to system issues.*

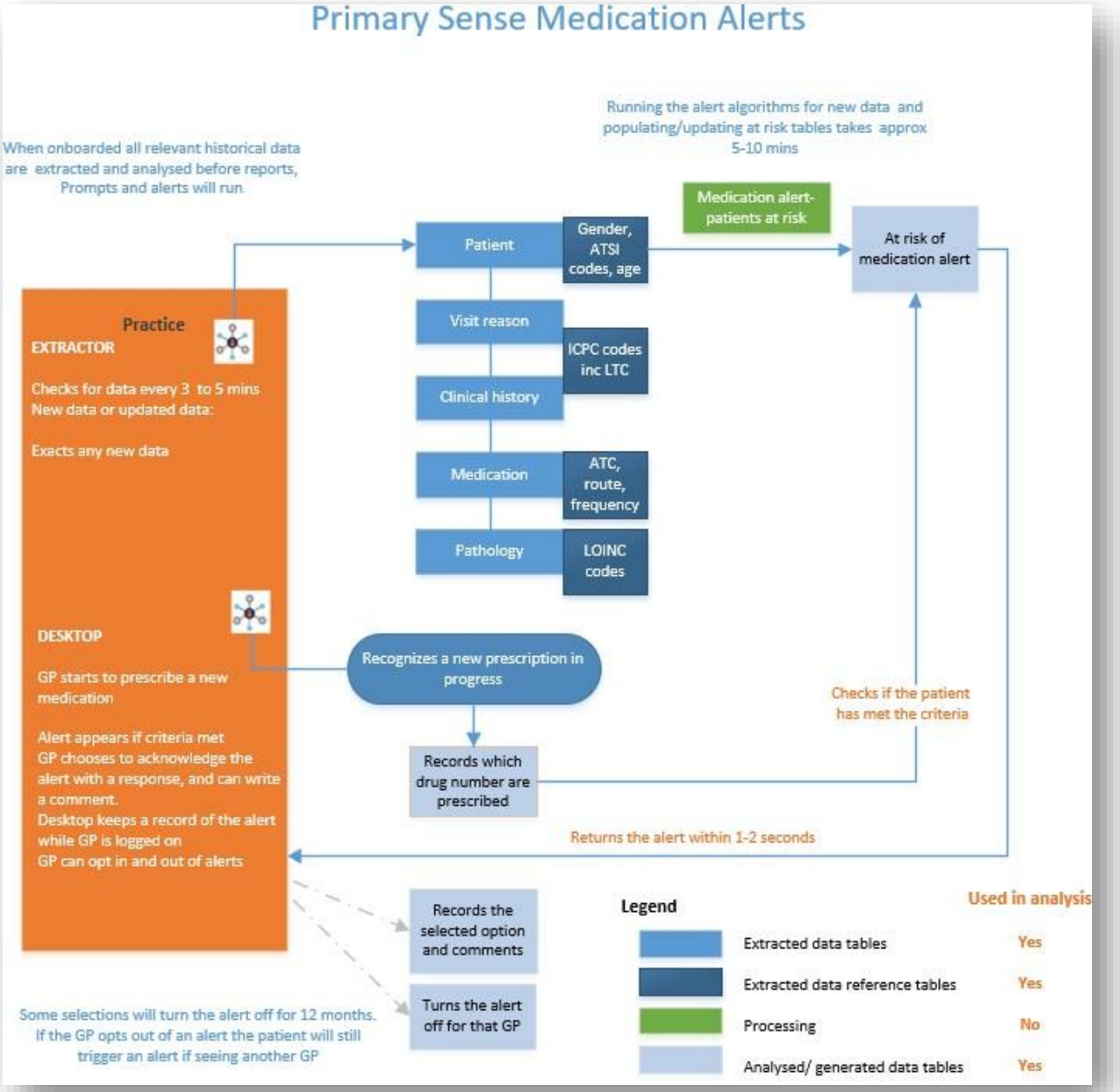
- GPs generally accept alerts as each is evidence based and was developed based on extensive literature review.
- Alerts have a high interaction rate with GP's clicking an option about 60-70% of the time.

An alert is a real-time notification of a potential safety issue when the GP starts to prescribe a pre-identified medication for the patient. The alerts were determined by a clinical reference group, who searched for existing indicators and contemporary drug warnings to establish a potential list of indicators to choose from. Indicator sources included:

- Literature review of studies with existing prescribing indicators in General Practice
- Review of Government therapeutic warnings
  - Australian Government – Therapeutic Goods Administration – Medicines Safety Update
  - UK Government – Drug Safety Update
  - US Food and Drug Administration – Drug safety communications
  - US Food and Drug Administration (pharmacogenomics)
- Review of contemporary GP prescribing guidelines, particularly where drug related safety issues were identified.

10.2. Medication Alert process in Primary Sense

The medication alert process is shown below:



Note: *Results in PDFs cannot be read so are not referenced in alerts.*

10.3. Managing Medication Safety Alerts

Individual GPs can manage their alert preferences (opt in / out) and review alerts generated that day via the Alerts tab:

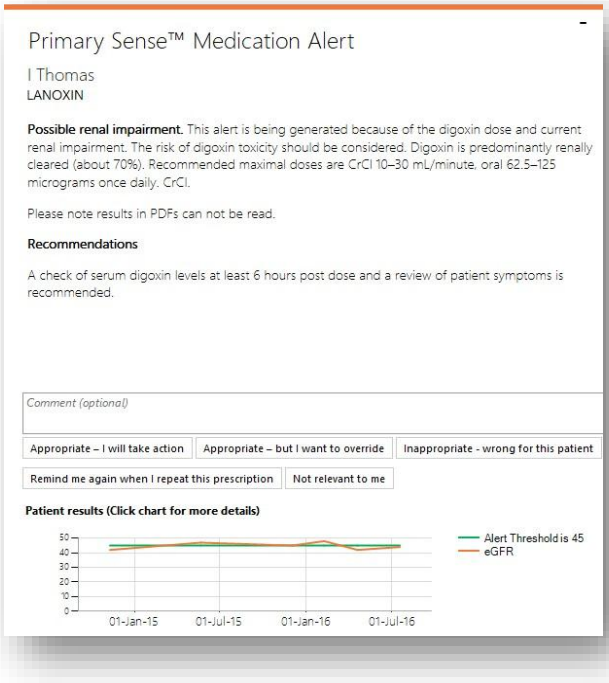
Access the Primary Sense Desktop by locating the Primary Sense icon on your desktop, or via the bottom toolbar:

This side bar appears when the icon is clicked. Click on the 'Alerts' tab

If an alert is triggered it appears within seconds on the GP's screen, displaying the reason for the alert and the recommendations, including links to further information. Alerts provide five options for the GP to select. Once selected, the responses are captured in the database.

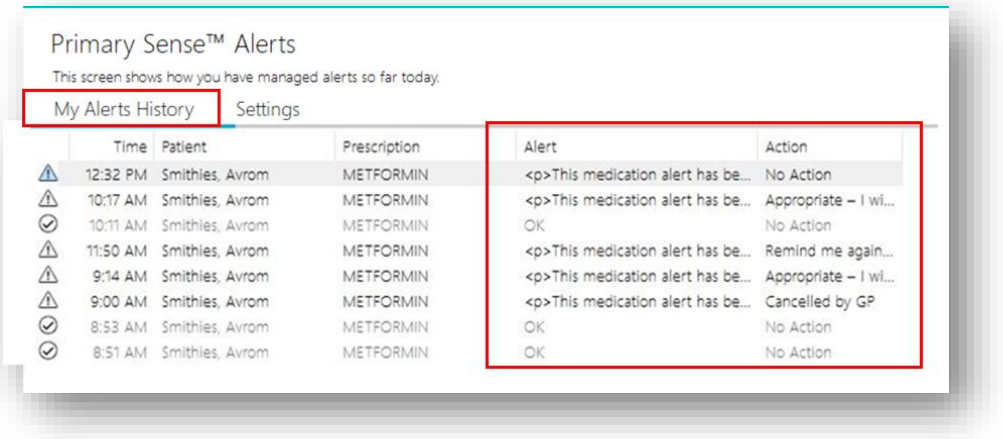
- Appropriate - I will take action.
- Appropriate - but I want to override.
- Inappropriate - wrong for this patient.
- Remind me again when I repeat this prescription.
- Not relevant to me (in case a GP is logged on at more than one PC as the alert will go to both PCs).

When the GP makes a selection, anything other than "remind me next time" will disable that alert for that GP and that patient for 12 months. The GP can also add comments when the alert appears to help shape future development and identify any potential issues.

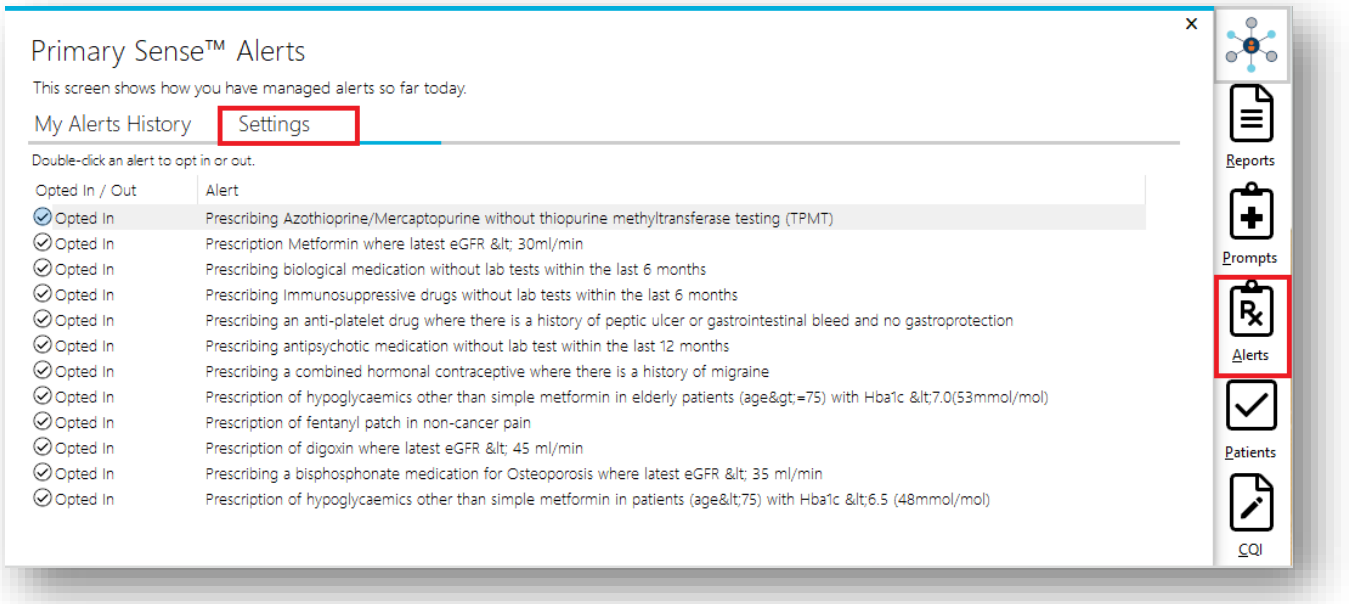


A GP can review the alerts triggered during their shift, by clicking 'My Alerts History.'
Under 'My Alerts History' the GP can see alerts generated during the day, and the action selected. Logging off will clear the history. The alert can be reopened to review More Information.

Double clicking on a **Medication Safety Alerts** will retrieve the record for the GP to review the More Info contents, but the action can't be changed.

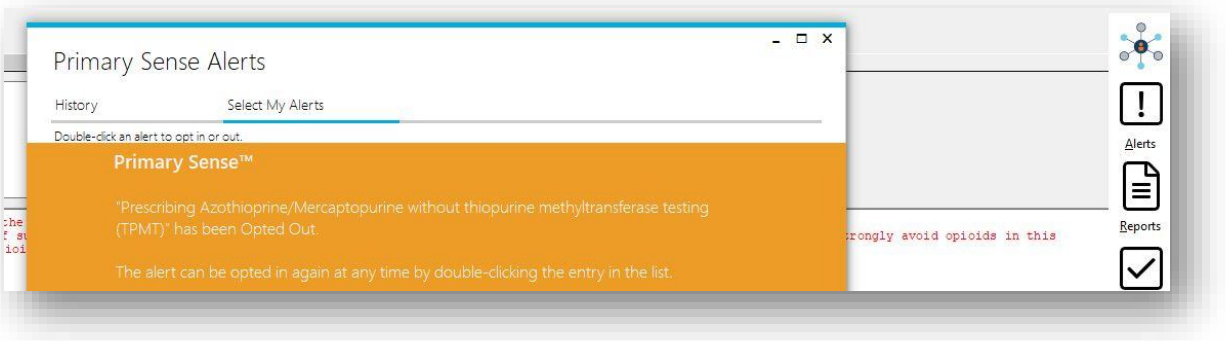


Clicking on '**Settings**' shows all alerts available to the current user, and if they are opted in/out for that user.



10.4. Opting in and out of Medication Safety Alerts

To switch an alert OFF, double click on the title to receive this confirmation:



The selected alert will now be displayed in **RED**. This is specific for the user logged in.

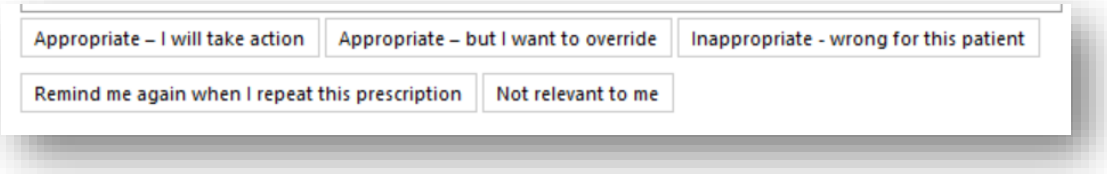
Note: *'Prescribing an opiod drug where there is a known substance use disorder or severe mental health conditon' has been turned off for all Primary Sense users (even though it may display as "On" at the practice).*

How to re-enable an alert:

To re-enable an alert, go to the **'Settings'** tab and double click on the alert title that was opted out. The selected alert will no longer display in red. Note: this is specific for the user logged in.

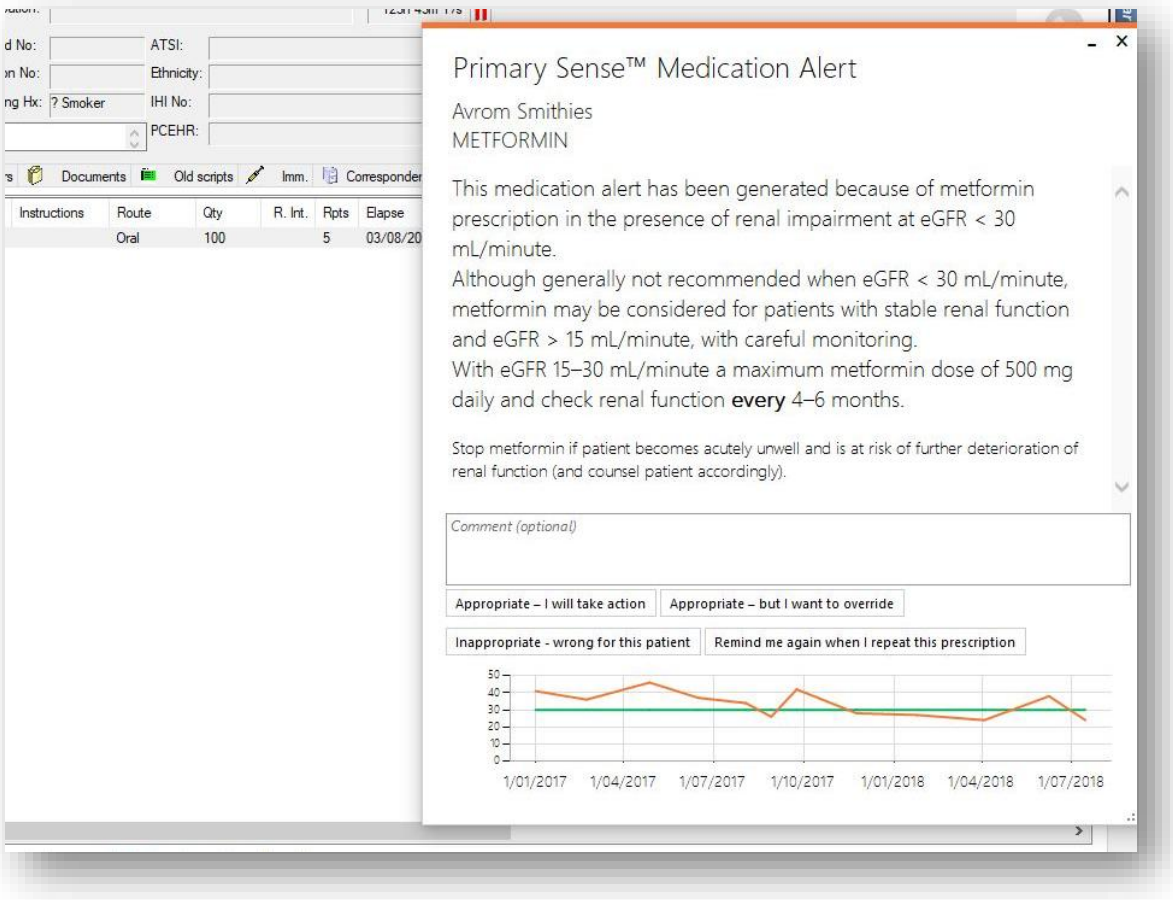
10.5. Using Alerts

In the alert message, clicking anything but 'Remind me again when I repeat this prescription' or 'Not relevant to me' will switch the alert off for 12 months for the patient, **and for any other GP prescribing for this patient.**



- Graphs contain the patients' clinical results if relevant to that alert.
- Links to relevant documentation may be available in the text.
- If the GP believes that the alerts has been triggered incorrectly, they are encouraged to enter as much data as possible into the Comment box for analysis by the Primary Sense Team.

Example of an alert



10.6. Current Medication Safety Alerts

Described below are the current medication alerts within the Primary Sense desktop app. The text and hyperlinks below are available to the GP within the displayed alert onscreen.

10.6.1. Prescribing Azathioprine/ Mercaptopurine without thiopurine methyltransferase (TPMT) testing (Alert ID 1)

Thiopurine methyltransferase breaks down the thiopurine-based immunosuppressive drugs.

Approximately 0.3% of the population has a profound genetic deficiency of thiopurine methyltransferase, with approximately 10% of the population intermediate metabolisers. Individuals with intermediate or deficient TMPT activity are at increased risk for myelotoxicity after receiving standard doses of azathioprine.

A deficiency of thiopurine methyltransferase is associated with grossly elevated concentrations of thioguanine nucleotides and severe haematological toxicity (agranulocytosis). Measuring thiopurine methyltransferase activity before starting azathioprine therapy is to be advisable to identify patients at risk of acute haematological toxicity. However, in practice this is variable.

Variants in the protein's gene, TPMT, can reduce the activity of the protein, resulting in toxic levels of the drug and bone marrow suppression.

Alert message

Possible missing genetic testing. This medication alert has been generated because of the absence of a screening/result for thiopurine methyltransferase (TPMT) deficiency while this patient is prescribed azathioprine or mercaptopurine therapy. A deficiency of thiopurine methyltransferase is associated with grossly elevated concentrations of thioguanine nucleotides and severe haematological toxicity (agranulocytosis) with potentially fatal consequences.

Measuring thiopurine methyltransferase activity before starting azathioprine therapy is strongly advised. Up to 10% of patients have low or absent TMPT activity. Dosage modifications according to TPMT activity may also help prevent myelotoxicity. https://www.nps.org.au/australian-prescriber/articles/fatal-azathioprine-toxicity *http://www.dorevitch.com.au/IamaDoctor/TestingGuide/NewTestingInnovations/TPMTGenotypeTesting.aspx*

Alert recommendation

If not done, can you please request this test. With all pathology companies order TPMT testing. The test is often performed by specialists before therapy, but exceptions occur. Guidelines now suggest routine testing before therapy *https://www.labtestsonline.org.au/learning/test-index/tpmt*

Alert Rules

- No time limit.
- Looks for any genetic screening or results for thiopurine methyltransferase (TPMT) deficiency, i.e. TPMT Enzyme Activity Test or TPMT Genetic Test (Genotype).
- 6-MMP Testing which is used for monitoring drug safety and efficacy of thiopurine drugs such as azathioprine and mercaptopurine is also used as a confirmation of testing.
- Triggered by prescription of medications mercaptopurine and azathioprine.

10.6.2. Prescribing metformin where latest eGFR <30ml/min (Alert ID 2)

Metformin may accumulate in people with renal impairment and increases the risk of lactic acidosis - a rare but potentially fatal adverse drug reaction. The risk increases with conditions: where tissue hypoperfusion and hypoxaemia are a problem (for example in cardiac or respiratory failure, or following a myocardial infarction), increasing age, higher doses of metformin (generally above 2 g/day).

Metformin prescribed to a patient with renal impairment where the eGFR is <30ml/min was rated in the highest risk band for the prescribing-safety indicators for GPs in the UK.

Metformin should be used with caution if GFR 30-60 mL/min/1.73m2, and is not recommended if GFR < 30 mL/min/1.73m2. It should be temporarily interrupted during periods of ill health and/or change in kidney function.

Alert message

Possible renal impairment. This medication alert has been generated because of metformin prescription in the presence of renal impairment at eGFR < 30 mL/minute. Metformin should be ceased. eGFR between 30-60mL/min/1.73m requires dose reduction and regular monitoring of eGFR

https://www.racgp.org.au/getattachment/41fee8dc-7f97-4f87-9d90-_b7af337af778/Management-of-type-2-diabetes-A-handbook-for-general-practice.aspx

Alert recommendation

Please consider stopping metformin if eGFR is < 30 mL/Minute/1.73m.

Alert Rules

- Sources eGFR from pathology results and also the Observation Table.
- References results less than 30.0ml/min.
- Uses last result available as reference for check.
- Displays a graph of latest results.
- References all medications being prescribed containing Metformin.

10.6.3. Prescribing a biological drug without laboratory tests within the last six months (Alert ID 3)

Biologic disease modifying anti rheumatic drugs (bDMARDs) have proven to be very effective in treating severe RA, are cost effective and work faster than traditional DMARDs. They selectively block pro-inflammatory cytokines that play a critical role in the pathogenesis of inflammatory disease or act through B or T lymphocytes to decrease cytokine production.

These medications are generally well tolerated but the existence of any contraindications to their use needs to be considered before prescribing them.

Live attenuated vaccines (e.g. rubella (MMR), BCG, yellow fever, herpes zoster and oral polio) are not recommended.

Transient dose-dependent neutropaenia and thrombocytopaenia have been reported. Very rarely late-onset neutropaenia, delayed pancytopaenia or aplastic anaemia has been recorded.

Elevations in transaminase (ALT) +/- indirect bilirubin elevations have been observed Generally, three monthly FBC, electrolytes, creatinine and LFTs are recommended.

Alert message

Possible missing pathology. This medication alert has been generated because of lack of recent (within six months) ELFT and FBC lab tests while the patient is on a biologic medication (i.e. targeted immunosuppression/anti-inflammatory agents). Treatment with biologic agents requires ongoing monitoring. Please note results in PDFs cannot be read, and some cumulative pathology results may not be imported into your system.

Alert recommendation

Generally, three to six monthly FBC, electrolytes, creatinine, and LFTs are recommended with more frequent monitoring on initiation. Regular monitoring can be organised using Rule 3 exemption request on pathology forms and stating how often ordered tests need to occur. e.g. Rule 3 exemption of 3 monthly FBC, ESR, ELFTs monitoring of biological medication.

https://www.nps.org.au/australian-prescriber/articles/managing-the-drug-treatment-of- rheumatoid-arthritis#article https://www.nps.org.au/australian-prescriber/articles/managing-the- drug-treatment-of-rheumatoid-arthritis#article

Alert Rules

- Checks for tests within the last 6 months.
- Must have a U&E, LFT **and** a FBC pathology result within the last 6 months. Primary Sense counts one of the listed loinc codes from the panel as an indication of a completed panel.
- White Blood Cell Count (WBC) is used as the indicator of FBC panel (in certain scenarios specific white cells are referenced).
- Alkaline Phosphatase (ALP) is used as the indicator of LFT panel.
- Sodium is used as the indicator of U&E panel from the Pathology results tables, Creatinine from the Observation table is also used as the indicator of U&E panel.

Test Name	Panel Type
White Blood Cell Count (WBC)	FBC
Alkaline Phosphatase (ALP)	LFT
Sodium (Na^+)	U&E
Serum Creatinine	U&E

10.6.4. Prescribing an immunosuppressive drug without laboratory tests within the last six months (Alert ID 4)

Medication guidelines advise regular laboratory monitoring when patients are prescribed immunosuppressive therapy. Examination of full blood count (FBC), electrolytes, urea, creatinine, fasting glucose, liver function tests and lipids is advised every three months.

Drug-related emergency room visits, and hospital admissions (DRVs) are a significant contributor to morbidity, mortality and health care costs worldwide. The proportion of total DRVs that are associated with laboratory or physiologic abnormalities, and therefore, potentially preventable is high.

The most common laboratory-related DRVs were:

- abnormalities in electrolytes (hyponatremia, hyper- and hypokalaemia)
- blood dyscrasias (anaemia, neutropenia)
- metabolic disturbances (hyper and hypoglycaemia)
- acute renal failure.

Alert message

Possible missing pathology. This medication alert has been generated because of lack of recent (within six months) electrolytes and liver function tests (ELFT), FBC, fasting glucose and lipids lab tests while the patient is on immunosuppressive medication. Immunosuppressive therapy is a common cause of drug related misadventure. *RACGP - Elderly patients taking immunosuppressive medications*

Please note, results in PDFs cannot be read, and some cumulative pathology results may not get imported into your system.

Alert recommendation

Regular monitoring with FBC, electrolytes, urea, creatinine, fasting glucose, liver function tests and lipids is advised every three months. More frequent monitoring on drug initiation may be required. Regular monitoring can be organised using the Rule 3 exemption request on pathology forms and stating how often ordered tests need to occur e.g. Rule 3 exemption of quarterly FBC, ELFTs monitoring of immunosuppressant therapy *https://www.nps.org.au/australian-prescriber/articles/long-term-management-of-patients-taking-immunosuppressive-drugs*

Alert Rules

- No age range.
- Checks for tests within the last 6 months.
- Must have both a LFT **and** a FBC pathology result within the last 6 months. Primary Sense counts one of the listed loinc codes from the group as an indication of a completed test.
- White Blood Cell Count (WBC) is used as the indicator of FBC panel (in certain scenarios specific white cells are referenced).
- Alkaline Phosphatase (ALP) is used as the indicator of LFT panel.

Test Name	Panel Type
White Blood Cell Count (WBC)	FBC
Alkaline Phosphatase (ALP)	LFT

10.6.5. Prescribing an anti-platelet drug where there is history of peptic ulcer or gastrointestinal bleed and no gastroprotection (Alert ID 5)

Antiplatelet (aspirin, clopidogrel, prasugrel, ticlopidine) therapy is indicated for the prevention of atherothrombotic events in patients who have had a myocardial infarction or ischaemic stroke, or who have established peripheral arterial disease. Combined with aspirin, the brand leader, clopidogrel bisulfate, may also be used to prevent atherothrombotic events in patients with acute coronary syndrome.

Antiplatelet drugs also feature heavily in avoidable hospital admissions from adverse drug events – particularly gastrointestinal bleeding.

Those patients with high risks for upper gastrointestinal bleeding should receive co-therapy with a gastroprotective drug, preferably a proton pump inhibitor at a standard dose. Unfortunately, although H2-receptor antagonist can significantly reduce upper gastrointestinal bleeding risk in patients taking low-dose aspirin, it is ineffective in the prevention of upper gastrointestinal bleeding in clopidogrel users.

Alert message

Possible missing medication. This medication alert has been generated because the prescription of antiplatelet (aspirin, clopidogrel, prasugrel, ticlopidine, dipyridamole) therapy in the context of a previous peptic ulcer or gastrointestinal bleed.

Alert recommendation

Gastroprotection with a PPI is indicated. As esomeprazole and omeprazole have interactions with clopidogrel, pantoprazole is recommended. *https://onlinelibrary.wiley.com/doi/pdf/10.1111/j.1440-1746.2012.07085.x* *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3752180/*

Alert Rules

- No age range.
- No time limit on diagnosis.
- History of peptic ulcer or gastrointestinal bleed diagnosis taken from reason for visit or clinical history.
- No current Proton pump inhibitors medications – there may be a ceased or end date or no prescription in history.

10.6.6. Prescribing an antipsychotic drug without laboratory test within the last 12 months (Alert ID 7)

Patients with serious mental illness have markedly elevated rates of metabolic disturbance, including obesity, diabetes, and dyslipidaemia. Antipsychotic treatment can be a contributing factor.

Antipsychotics can cause blood dyscrasias including agranulocytosis and leukopenia. There is an increased risk of developing diabetes with certain antipsychotics, particularly olanzapine, clozapine and the phenothiazines.

Antipsychotics considered a high-risk of causing hyperlipidaemia include clozapine, quetiapine, olanzapine and the phenothiazines.

Antipsychotics have been associated with hyponatraemia caused by drug-induced syndrome of inappropriate antidiuretic hormone.

Early detection and intervention for cardiometabolic risks, and a judicious tailoring of the use of antipsychotic medications can help to improve long-term outcomes in these patients. Annual blood monitoring is recommended.

Alert message

Possible missing pathology. This medication alert has been generated because of lack of recent (within 12 months) FBC, ELFT, fasting glucose and lipid lab tests.

https://www.ranzcp.org/files/resources/college_statements/clinician/cpg/schizophrenia- disorders-cpg.aspx https://www.ranzcp.org/files/resources/college_statements/clinician/cpg/schizophrenia-disorders-cpg.aspx

Patients prescribed antipsychotic medication should have physical and laboratory monitoring for cardiometabolic risks. Please note, results in PDFs cannot be read, and some cumulative pathology results may not be imported into your system.

Alert recommendation

Lifestyle interventions to prevent weight gain and address cardiovascular risk should begin shortly after starting antipsychotic medication. If there is evidence of weight gain, consideration should be given to switching to weight-neutral antipsychotic in liaison with the patient's psychiatrist. Absolute cardiovascular risk should guide the use of antihypertensives and statin therapy.

Alert Rules

- No age range.
- Checks for results within the last 12 months.
- Must have a U&E, LFT, Cholesterol and a FBC pathology result. Primary Sense counts one of the listed loinc codes from the panel as an indication of a completed panel.
- White Blood Cell Count (WBC) is used as the indicator of FBC panel (in certain scenarios specific white cells are referenced).
- Alkaline Phosphatase (ALP) is used as the indicator of LFT panel.
- Sodium is used as the indicator of U&E panel from the Pathology results tables, Creatinine from the Observation table is also used as the indicator of U&E panel but is not referenced in the Pathology tables as Sodium is the main reference for that panel.
- Cholesterol is referenced from the pathology tables and also from the Observation table.

Test Name	Panel Type
White Blood Cell Count (WBC)	FBC
Alkaline Phosphatase (ALP)	LFT
Sodium (Na^+)	U&E
Serum Creatinine	U&E

10.6.7. Prescribing a combined hormonal contraceptive where there is a history migraine (Alert ID 8)

Women who have a history of migraine should be advised about the risk of using the combined oral contraceptive pill. The UK Medical Eligibility Criteria for Contraceptive Use (MEC) now considers women with migraine – category 3 - a condition where the theoretical or proven risks usually outweigh the advantages of using the medication.

Women with Migraine and Aura – category 4 - a condition which represents an unacceptable health risk if the method is used.

Alert message

Possible clinical risk. This medication alert has been generated because of the combination of migraine (or migraine therapies) and oral contraceptive therapy. The UK Medical Eligibility Criteria for Contraceptive Use (MEC) now considers women with migraine - a category 3 - a condition where the theoretical or proven risks usually outweigh the advantages of using the method. The provision of a method requires expert clinical judgement and/or referral to a specialist contraceptive provider. Since use of the method is not usually recommended, unless more appropriate methods are not available, or not acceptable, women with migraine and aura - a category 4 - condition which represents an unacceptable health risk if the method is used. *https://www.fsrh.org/ukmec/*

Alert recommendation

A. The diagnosis of migraine should be reviewed and confirmed.

B. Progesterone only contraception, IUDs or other alternate methods should be considered as alternatives.

C. Documented shared decision making, with a decision by the patient to make an informed decision to continue therapy despite risks, may also be an option.

https://www.mayoclinic.org/diseases-conditions/migraine-with-aura/multimedia/migraine-aura/vid-20084707

Alert rules

- Age must be between 12 and 50 years of age.
- Must be Sex at Birth female.
- No time limit on the diagnosis or migraine medication.
- Patients with a history of migraine as a diagnosis in visit reason or in clinical history.
- Migraine also referenced by a previous medication prescription for migraine medication.

10.6.8. Prescribing a hypoglycaemic drug (other than single preparation metformin) in patients >75yrs where HbA1c < 7% (<53mmols) (Alert ID 9)

Studies reveal that intensive treatment of type 2 diabetes (HbA1c <7) in older or complex patients (>3 chronic conditions) is common. In these populations, hypoglycaemia requiring A&E presentation and hospitalisation is increased.

A substantial proportion of these patients were taking sulfonylurea or insulin. Intensive treatment in these populations confers little benefit. For the majority of adults older than 65 years, the harms associated with a haemoglobin A1c (HbA1c) target lower than 7.5% are likely to outweigh the benefits.

In an American trial of older patients (>75) with Hba1c <7.0%, a reminder to prompt deprescribing of insulin / sulfonylurea resulted lower hypoglycaemic rates.

This indicator recognises the importance of hypoglycaemia avoidance overachieving glycaemic targets among the elderly. For the majority of older adults, an HbA1c target between 7.5% and 9% will maximise benefits and minimise harms.

Sulphonylureas should be used with caution because the risk of hypoglycaemia increases exponentially with age.

Avoid using medications other than metformin to achieve haemoglobin A1c<7.5% in most older adults; moderate control is generally better.

There is no uniformly agreed-upon definition of “elderly”, although it is generally accepted that this is a concept that reflects an age starting sometime after age 65.

Canadian guidelines recommend a HbA1c target of <8.5 in frail elderly. Maintain HbA1c at or above 8% rather than below a specific level, in keeping with the conclusion that lower HbA1c levels are associated with increased hypoglycaemic events without accruing meaningful benefit for frail older adults with type 2 diabetes

Alert message

Possible overprescribing of hypoglycaemic medication. This medication alert has been generated to bring your attention to this patient’s HbA1c results. Elderly populations with a HbA1c < 54 mmol/mol (7.1%) prescribed more than just simple metformin, are at risk of hypoglycaemia requiring A&E presentation and hospitalisation. This indicator recognises the importance of hypoglycaemia avoidance overachieving glycaemic targets among the elderly. Individualised HbA1c targets are recommended. For healthy individuals at low risk of hypoglycaemia, target should be 7-7.5% (53-59 mmol/mol. For frail individuals with complex comorbidities, target HbA1c should be relaxed to <= 8.5% (69 mmol/mol).

https://www.racgp.org.au/getattachment/41fee8dc-7f97-4f87-9d90-b7af337af778/Management- of-type-2-diabetes-A-handbook-for-general-practice.aspx
In an American trial of older patients (> 75 yrs) with Hba1c < 53mmol/mol (7.0%) a reminder to prompt deprescribing of insulin / sulphonylureia resulted in lower hypoglycaemic rates.

https://www.ncbi.nlm.nih.gov/pubmed/28848316

Alert recommendation

Please consider the therapeutic regime and decrease if you feel warranted. You may want to consider repeating the HbA1C in three months if medication is altered. Please note, results in PDFs cannot be read, and some cumulative pathology results may not be imported into your system.

Alert rules

- Patients over the age of 75 included.
- HbA1c referenced as mmol/mol.
- HbA1c referenced from the pathology tables and the Observation table.
- HbA1c less than 7% (<53mmols)
- Ozempic, Tirzepatide and Saxenda diabetic drugs used for weight loss are excluded.

10.6.9. Prescribing a Fentanyl patch where there is non-cancer pain (Alert ID 10)

Fentanyl is a highly potent opioid. It is an excellent therapeutic option for cancer pain, but the RACGP position is that it is not suitable for chronic non cancer pain.

Transdermal fentanyl “patches”: reminder of potential for life-threatening harm from accidental exposure, particularly in children.

Children are at risk as they may touch, suck, chew, or swallow a patch that has not been disposed of properly. Also, children have a lower threshold for fentanyl overdose than adults. Please provide clear information to patients and caregivers regarding:

- risk of accidental patch transfer
- ingestion of patches
- need for appropriate disposal of patches.

Oral transmucosal fentanyl rapidly achieves high plasma concentrations and is indicated to treat breakthrough pain in cancer patients who are not opioid naive.

Fentanyl-related mortality is currently relatively low in Australia compared to the US and parts of Europe. However, fentanyl misuse is on the rise in Australia.

It has known diversional potential, extremely high street value and risk of misuse. Therefore, it should be used only as indicated.

Alert message

Possible clinical risk. This medication alert has been generated because of a prescription of a fentanyl patch and no coded cancer diagnosis. Fentanyl is a highly potent opioid. It is an excellent therapeutic option for cancer pain, but the RACGP position is that it is unsuitable for non-cancer pain.

https://www.racgp.org.au/FSDEDEV/media/documents/Clinical%20Resources/Guidelines/Drugs%20of%20dependence/Prescribing-drugs-of-dependence-in-general-practice-Part-C2.PDF
Fentanyl has a known high abuse potential. Diversion rates are high with extremely high street value and risk of misuse. Children are at risk as they may touch, suck, chew, or swallow a patch that has not been disposed of properly. Also, children have a lower threshold for fentanyl overdose than adults
https://www.tga.gov.au/sites/default/files/msu-2014-08.pdf
https://www.gov.uk/drug-safety-update/transdermal-fentanyl-patches-reminder-of-potential-for- life-threatening-harm-from-accidental-exposure-particularly-in-children

Alert recommendation

Please review the reason for prescribing and/or add a coded cancer diagnosis to the medical record.

Alert rules

- No age limits.
- Excludes patients who have the listed cancer diagnosis in reasons for visit or clinical history.
- Only active diagnosis codes in the CIS are referenced.
- Carcinomas in situ are excluded from the active cancer list.
- Excludes patients in palliative care.
- Triggered only by prescription for fentanyl transdermal patches.

10.6.10. Prescribing digoxin where latest eGFR < 45 ml/min (Alert ID 11)

Reduced renal function may cause digoxin to accumulate and result in toxicity, especially in older people where it has a prolonged elimination half-life. The risk of digoxin toxicity can be reduced by basing dosage regimens on body weight and creatinine clearance, monitoring potential electrolyte imbalances and being aware of possible drug interactions.

Prescription of digoxin at a dose >125 mg daily in a patient with renal impairment (for example, CKD 3 or worse) was rated in the second highest risk band for the prescribing-safety indicators for GPs in the UK.

Alert message

Possible renal impairment. This alert is being generated because of the digoxin dose and current renal impairment. The risk of digoxin toxicity should be considered. Digoxin is predominantly renally cleared (about 70%). Recommended maximal doses are CrCl 10 - 30 mL/minute, oral 62.5 - 125 micrograms once daily. CrCl <10 mL/minute, oral 62.5 micrograms once daily or on alternate days. Please note, results in PDFs cannot be read.

Alert recommendation

A check of serum digoxin levels at least six hours post dose and a review of patient symptoms is recommended.

Alert Rules

- Sources eGFR from pathology results and also the Observation Table.
- References results less than 45.0ml/min.
- Uses the latest result as the reference.
- Displays a graph of latest results.
- References all digoxin medications being prescribed.

10.6.11. Prescribing a bisphosphonate drug for osteoporosis where latest eGFR <35ml/min (Alert ID 12)

Bisphosphonates are not recommended for therapy when eGFR < 35ml/mi/1.73m2 (ref 1)

Unfortunately, both osteoporosis and chronic kidney disease are common in the aged population.

This indicator enables safer options for osteoporosis prescribing in general practice.

Alert message

Possible renal impairment. This medication alert has been generated because of a prescription of bisphosphonate therapy and the patient's current renal status. Bisphosphonates not recommended for therapy when eGFR < 35ml/mi/1.73m2.

https://www.nps.org.au/australian-prescriber/articles/treating-osteoporosis-1

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5079786/

Alert recommendation

Safer alternatives should be sought e.g. Denosumab *https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/osteoporosis*
https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all- racgp-guidelines/osteoporosis

Alert Rules

- No time limit.
- Sources eGFR from pathology results and also the Observation Table.
- References results less than 35.0ml/min.
- Uses the latest result as the reference.
- Displays a graph of latest results.
- References all Bisphosphonates medications being prescribed.

10.6.12. Prescribing a hypoglycaemic drug (other than single preparation metformin) in patients ≤ 75yrs where latest HbA1c < 6.5% (<48mmol) (Alert ID 13)

Current comprehensive systematic reviews investigating the benefits and harms of intensive glycaemic control compared at best show no benefit, and many show increased harms from death and hypoglycaemia. This is true for both type 1 and type 2 diabetes.

Less intensive therapy is advocated.

Alert message

Possible overprescribing of hypoglycaemic medication. This medication alert has been generated because of tight glycaemic control in a diabetic patient (HbA1c < 48 mmol/mol (6.5%). Tight control is associated with poorer outcomes which prompts a consideration to reduce hypoglycaemic medication in this patient. Comparison between tight glycaemic control (Hba1c 42 mmol/mol to 48 mmol/mol (6.0 to 6.5%) and conventional care (HbA1c target 53 mmol/mol to 63 mmol/mol (7.0 to 7.9%) have failed to produce significant health benefits.

https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD010137.pub2/full

There is no renal or cerebrovascular benefit. The only subgroup differences between tight and non-tight glycaemic control groups were that more people with tight glycaemic control died owing to cardiovascular causes (32 vs 18 per 1000 people), but fewer had a non-fatal myocardial infarction (36 vs 46 per 1000 people). *https://www.cochranelibrary.com/cca/doi/10.1002/cca.1791/full*

In addition, both minor and major hypoglycaemia are more commonly associated with tight glycaemic control. This is true for type 2 diabetes and type 1 diabetes.

Alert recommendation

Please consider reduction of insulins or sulphonylureas first. You may want to consider repeating the HbA1C in three months if medication is altered. Please note, results in PDFs cannot be read, and some cumulative pathology results may not be imported into your system.

Alert Rules

- Patients up to and including 75 years old included.
- HbA1c referenced as mmol/mol.
- HbA1c referenced from the pathology tables and the Observation table.
- HbA1c less than 6.5% (<48mmol)
- Ozempic, Tirzepatide and Saxenda diabetic drugs used for weight loss are excluded.

11. GP and Nurse Prompts

11.1. Prompts Overview

Primary Sense Prompts focus on the most at-risk patients and provide on screen prompts to highlight potential gaps in care including use of the Johns Hopkins complexity and hospital risk scores.

Primary Sense uses the Johns Hopkins ACG® System (Adjusted Clinical Groups) to quickly identify complex patients by analysing health data and predicting their risk of hospitalisation in real time during a consultation. Primary Sense provides patient health data to general practitioners and nurses during consultation, assisting in timely intervention. With real time care prompts, decisions can be taken based on patients' complexity and hospital risk scores.

Prompts will only be generated when the patient file in the clinical software has been opened by a General Practitioner, Nurse, Aboriginal and Torres Strait Islander Health Practitioner and Aboriginal Health Worker (logged in to the software), and only in specific circumstances (where specific criteria are met i.e. complexity scores and gaps in care).

The criteria for GP and Nurse prompts are distinct, customized to align with the specific responsibilities of their respective roles.

Nurse prompts will trigger for Registered Nurses, Practice Nurses, Nurse Practitioners, Child and Maternal Nurses, Aboriginal and Torres Strait Islander Health Practitioners and Aboriginal Health Workers logged into the CIS.

Prompts appear when the Clinician opens the patient's record in the clinical software and are specific to each patient. They only contain 3 items at a time, and these have been given clinical priority in order of appearance.

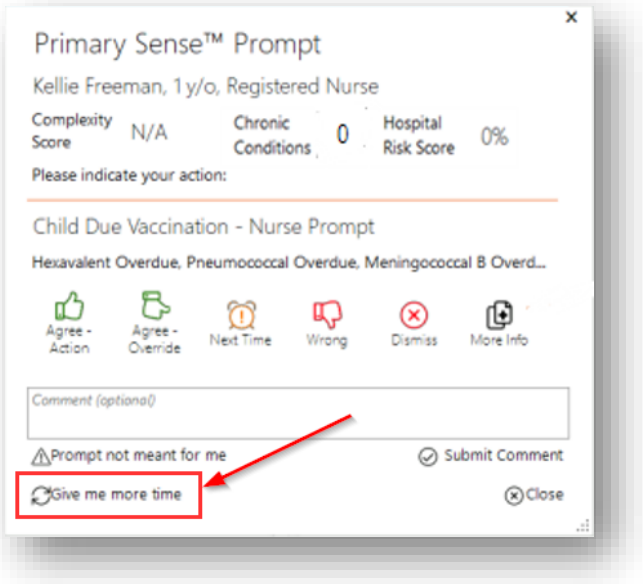
When one element is actioned that allows a subsequent element to appear on the next prompt.

- Prompts are more frequent events than alerts – about 10% of visits generate a prompt compared to 0.5 % of visits for an alert. Prompts get responded to about 4% of the time within practice.
- There have been increases in the suggested interventions done when compared to clinicians without access to the prompts.

Prompts stay visible for 3 minutes to prevent multiple prompts being open on the screen at one time. If more time is required, they can click '**Give me more time**' which re-sets the 3 minutes.

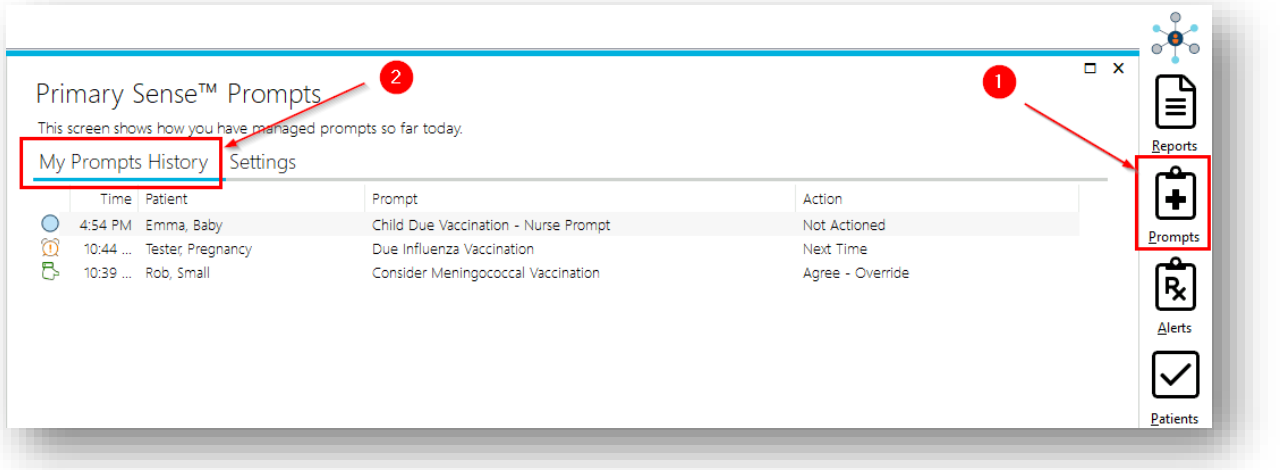
The prompts will disappear from the History tab when the clinician has logged off or after 24 hrs.

Double clicking on a **Prompt** will retrieve the record for the clinician to change their selection and/or see additional information about the prompt.



Clinicians can retrieve the prompt from the "**My Prompts History**" by selecting:

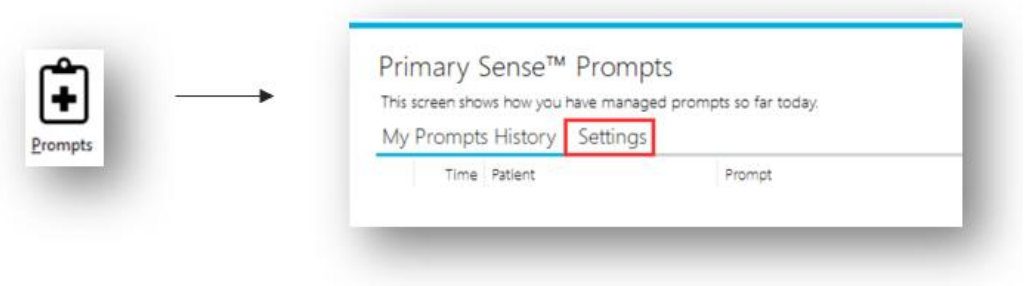
1. Prompts icon and then
2. My Prompts History.



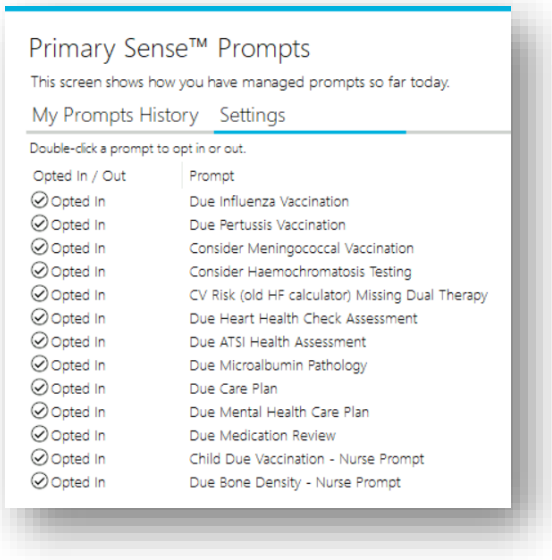
3. This allows the Clinician to review any prompts from that day and make changes to the selected options.

11.2. Opting in and out of Care Prompts

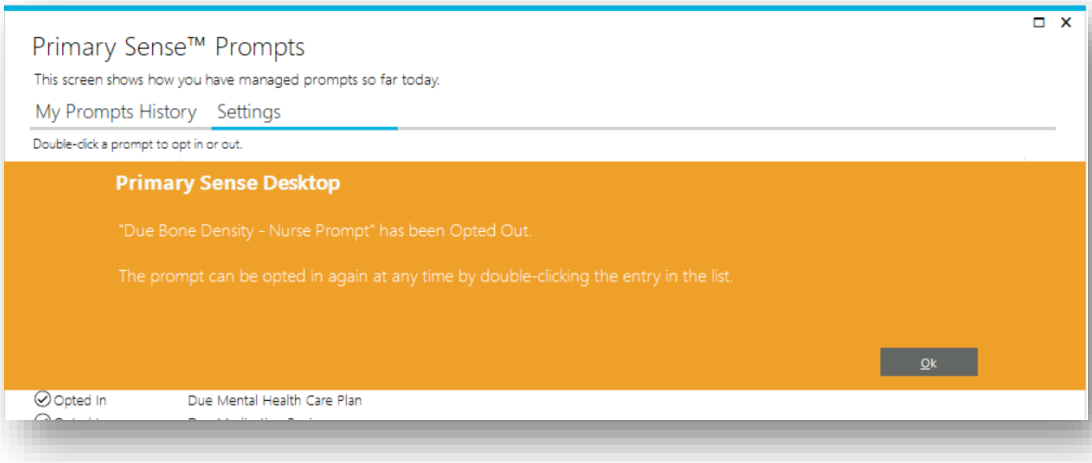
Clinicians can opt in and out of care prompts from the '**Prompts > Settings**' tab.
Prompts designated with '**Nurse Prompt**' are exclusively intended for Nurses, Aboriginal and Torres Strait Islander Health Practitioners and Aboriginal Health Workers.
To opt out of a prompt, select the Prompts icon from the Primary Sense Toolbar and select the Settings icon.



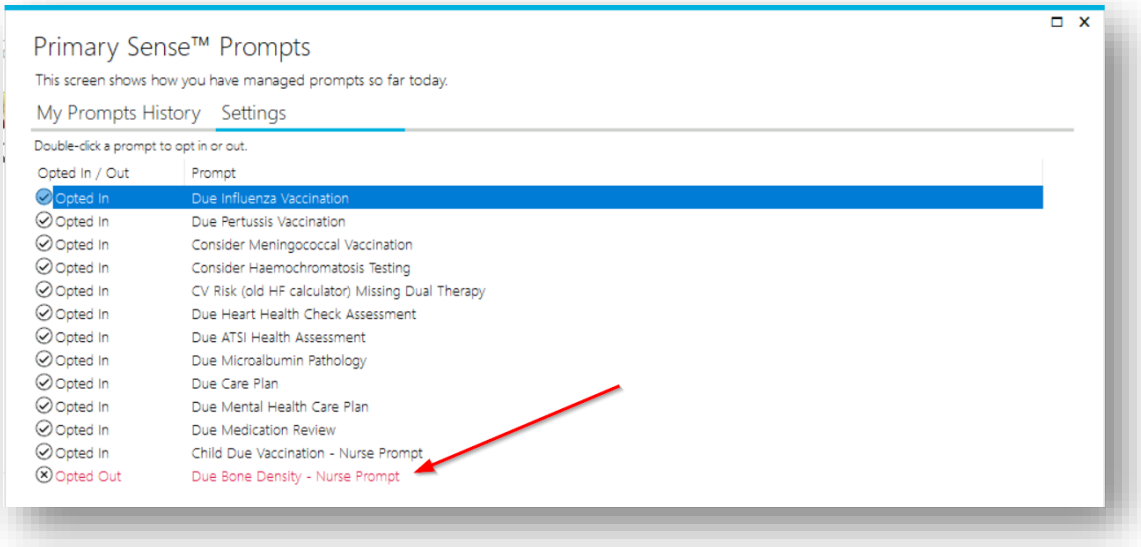
The list of prompts will display.



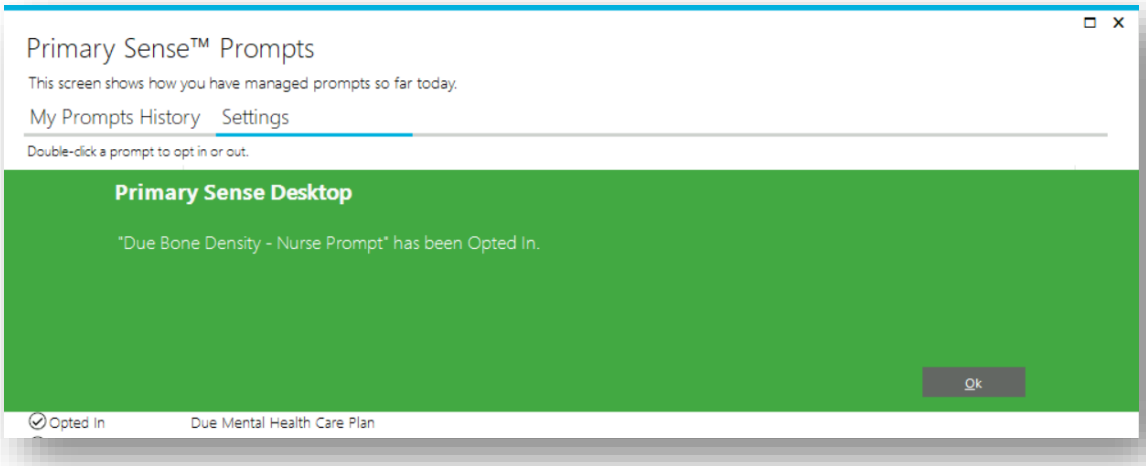
Double click on the prompt to opt out. This will trigger the below confirmation message:
Note: this is specific for the logged in user.



Select '**OK**' to disable the prompt for all patients for the currently logged-in clinician.
The disabled prompts are displayed in **RED** as 'Opted Out.'

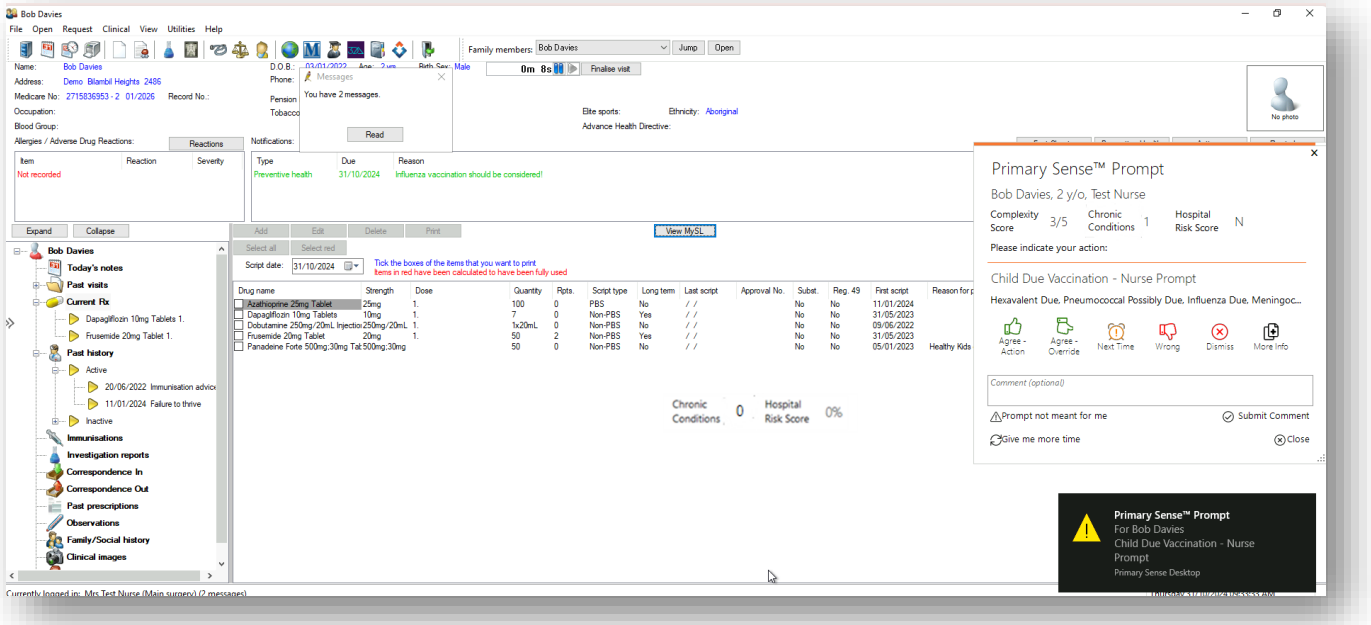


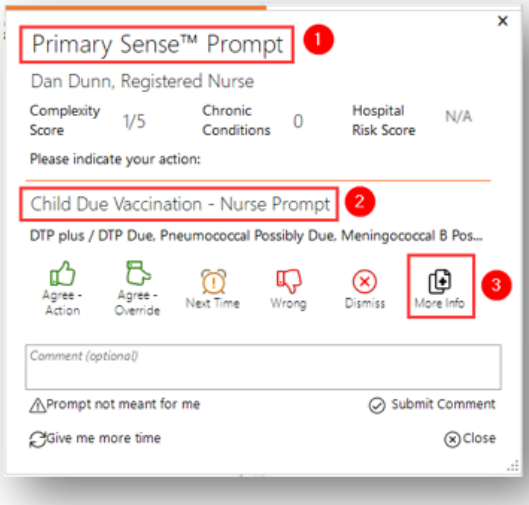
To re-enable or opt in to a prompt, double click on the title to receive the below confirmation. Select OK to opt back in to the prompt.



11.3. Using Prompts

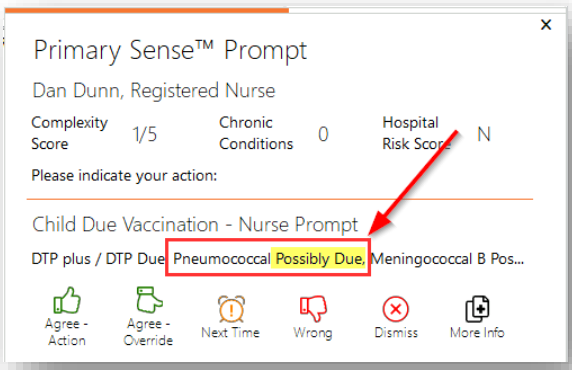
Prompts can be viewed from the Primary Sense Desktop Application when triggered.





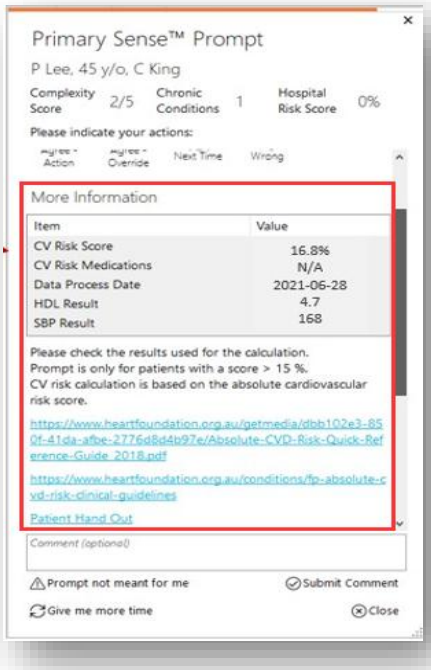
1. Notification that the prompt has been triggered
2. Name of the Prompt

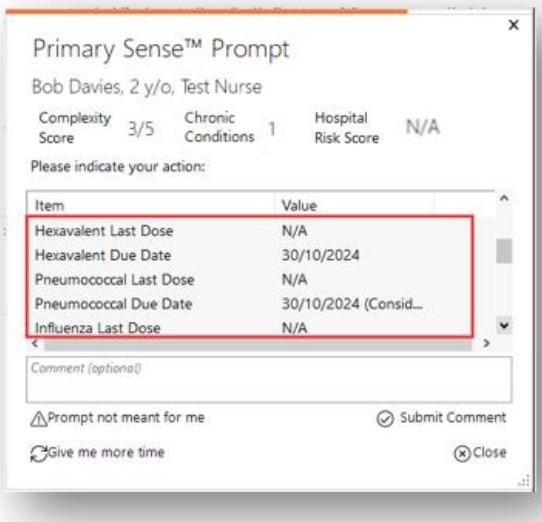
NOTE: *Vaccines due display in a list under the Prompt name. Vaccines such as Pneumococcal which have variable application rules display with the text 'Possibly Due'. Clinicians must review each patient individually for applicability.*



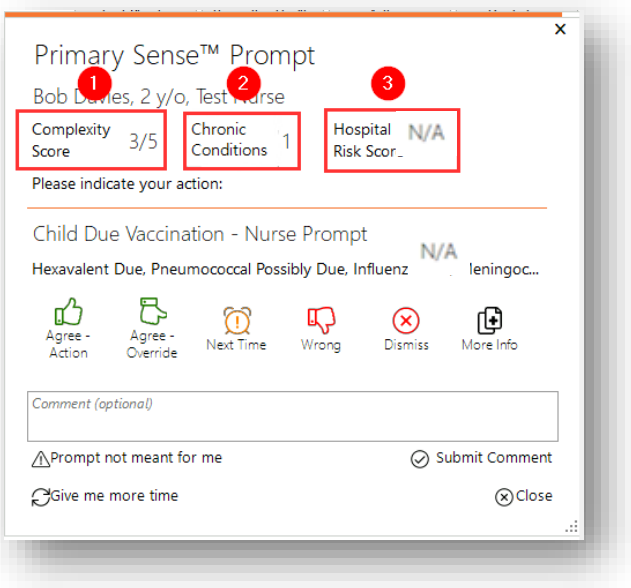
Prompts are generated by the practice software records ONLY. The do not show immunisations recorded in Australian Immunisation Register (AIR). Always check AIR before vaccine administration.

3. '**More Info**' button to display any additional patient information relevant to that prompt will display, such as vaccines suggested and last dates due or given as well as links to pertinent documentation.





The prompts also display the following information for the patient:



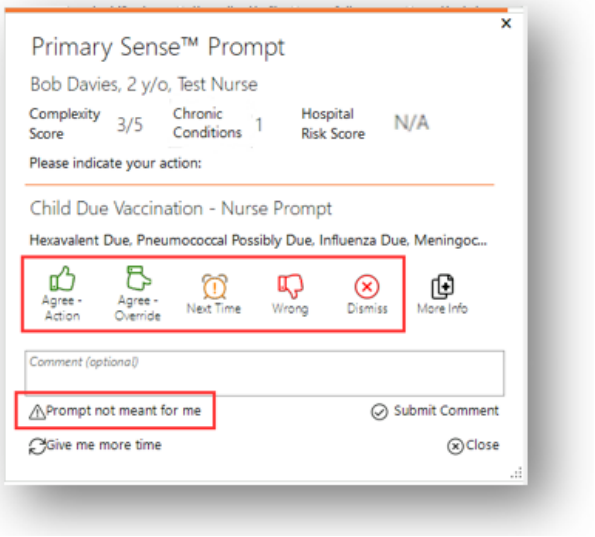
Complexity Score - The complexity bands formed by combining the ACGs to measure overall morbidity burden on a scale of 0-5, with 5 being the most complex/morbidity burden. A score of N/A will appear if there is no clinical data, such as a diagnosis or medications, available for the past 12 months, which is necessary for ACG calculation. See *ACG System Overview - Johns Hopkins ACG® System* for more information about the ACG System.

1. **Chronic Conditions -** The number of recorded chronic conditions in the CIS.

2. **Hospital Risk Score -** The risk of hospitalisation within the next 12 months. A score of N/A will appear if there is no clinical data, such as a diagnosis or medications, available for the past 12 months, which is necessary for ACG calculation.

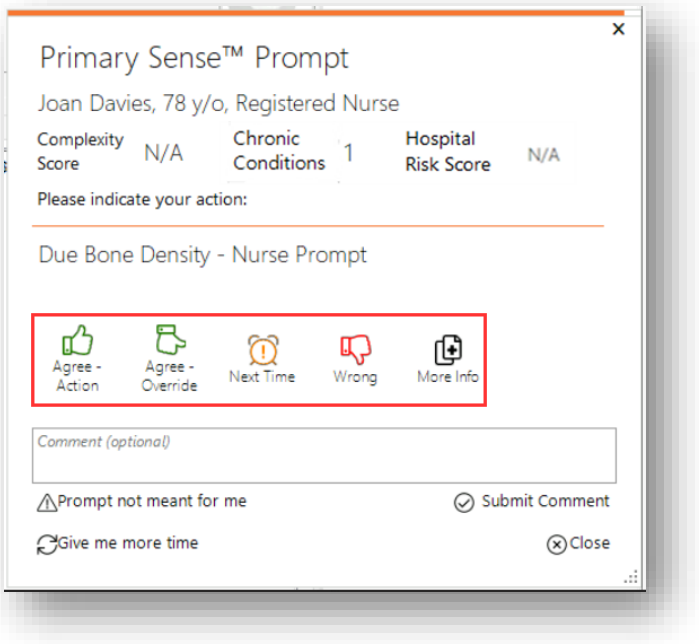
11.3.1. Prompt Actions

Clinicians can select from the following actions:

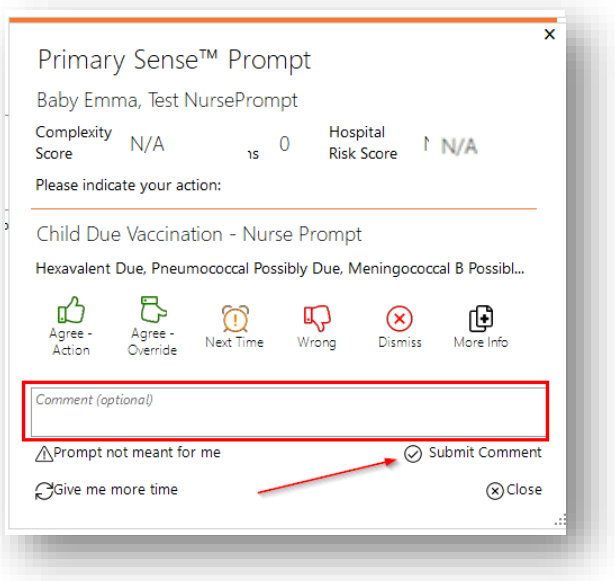


- **Agree – Action** (A related action will be taken based on the prompt during this appointment or as a follow up)
- **Agree – Override** (The prompt is correct for this patient but there is a clinical reason for not actioning it now)
- **Next Time** (Prompt will trigger when you open that patient's record next time)
- **Wrong** (The prompt does not appear to be correct for this patient, please record a comment with as much information as possible to allow for audit checking and future development)
- **Dismiss** (to be used when there are a series of prompts such as 3 childhood immunisations at age intervals, or a series of medications/vaccinations and the prompt is not applicable. Dismiss will stop all the prompts in the series for 12 months).
- **Prompt not meant for me**

Prompts that are part of a series, i.e. prompts for vaccinations that require multiple doses, where each dose can potentially trigger a separate iteration of the prompt, will also have a '**Dismiss**' option, which will disable the entire series of prompts for that patient for 12 months, rather than just the prompt for the current dose. Non-series prompts will not display '**Dismiss**' as an option.



Selecting an action other than **'Next Time'** or **'Prompt not meant for me'** will disable the prompt for that patient for 12 months.
Comments can be submitted related to the prompt and should be recorded for any prompt that is deemed '**Wrong**' or '**Prompt not meant for me**.'



The submission will be acknowledged after the prompt is submitted. The submitted comment cannot be deleted or updated.

11.4. GP prompts

11.4.1. Due Influenza vaccination (Prompt ID 1)

Will prompt for ACG band 4 and 5 patients and pregnant women. Provides the date of the last influenza vaccination if available and weeks pregnant if applicable.

Text

Influenza vaccinations will re-set as due on 1 February each year.

Tool tip

Please check AIR.

https://www.servicesaustralia.gov.au/organisations/health-professionals/services/medicare/australian-immunisation-register-health-professionals

Prompt Rules

- Patients with an ACG Score of 4 or 5.
- Pregnant patients.
- Fluvax records recorded in the CIS (Primary Sense does not read AIR records).
- Immunisations recorded in the Immunisation table, does not look for vaccines in the medication table.
- Prompts for vaccines that have been recorded as declined.

11.4.2. Due Pertussis Vaccination (check RSV at 28-36 weeks) (Prompt ID 2)

Will prompt after 20 weeks of pregnancy. Provides last pertussis vaccination date if available and weeks pregnant

Text

Prompt will not occur for patients that have declined where that has been entered in the practice.

Tool Tip

Please check AIR, please confirm weeks pregnant.

https://www.health.gov.au/health-topics/immunisation/immunisation-throughout-life/national- immunisation-program-schedule

https://www.servicesaustralia.gov.au/organisations/health-professionals/services/medicare/australian-immunisation-register-health-professionals

Prompt Rules

- Pregnant patients.
- Pertussis vaccine records recorded in the CIS (Primary Sense does not read AIR records).
- Immunisations recorded in the Immunisation table, does not look for vaccines in the medication table.
- Does not prompt for vaccines that have been recorded as declined.

11.4.3. Consider Meningococcal vaccination (Prompt ID 3)

Will prompt for 3 doses for children aged between 6 weeks and 12 months. Provides the date of the last vaccine. The gaps between dosages as being 2 doses within the first 16 weeks at 8 week intervals, the 3rd being at 12 months of age regardless of when it started with the exception of the dosages having started after 10 months of age. In the case of it starting after 10 months, dosages occur at 3 8-week intervals as a dose at 12 months would be too early. Anyone starting meningococcal vaccination at age ≥12 months requires only 2 doses of vaccine 8 weeks apart. Only available up to 23 months old.

Text

Meningococcal B vaccine catch-up is available for all children less than 2 years of age but not funded in all jurisdictions. Prompt will not occur for patients that have declined. Consider giving paracetamol 30 minutes before or as soon as possible after the Men B vaccination. For more details, refer to the https://ncirs.org.au/ncirs-fact-sheets-faqs-and-other-resources/meningococcal

Tool tip

Please check AIR.

https://www.health.gov.au/health-topics/immunisation/immunisation-throughout-life/national-immunisation-program-schedule

https://www.servicesaustralia.gov.au/organisations/health- professionals/services/medicare/australian-immunisation-register-health-professionals

Prompt Rules

- Children aged 6 weeks to 24 months
- Immunisations recorded in the Immunisation table, does not look for vaccines in the medication table.
- Does not prompt for vaccines that have been recorded as declined.

11.4.4. Due Hepatitis A vaccination (Prompt ID 4)

Will prompt for Hepatitis A for ATSI children 18 months and 4 years for WA, NT SA and QLD. Prompt will provide date of last Hep A vaccination. The minimum timeframe is 6 months apart between the 18 month and 4-year doses.

Text

Only for ATSI children in QLD, NT, WA and SA. Prompt will not occur for patients that have declined.

Tool Tip

Please check AIR.

https://www.health.gov.au/health-topics/immunisation/immunisation-throughout-life/national- immunisation-program-schedule

https://www.servicesaustralia.gov.au/organisations/health-professionals/services/medicare/australian-immunisation-register-health-professionals

Prompt Rules

- Children 18 months and 4 years
- ATSI status
- Immunisations recorded in the Immunisation table, does not look for vaccines in the medication table.
- Does not prompt for vaccines that have been recorded as declined.

11.4.5. CV Risk (old HF calculator) Missing Dual Therapy (Prompt ID 5)

Will prompt for high CV risk where there isn't a history of CVD and the patient isn't on dual therapy (statin and antihypertensive). Prompt will provide the systolic blood pressure and HDL ratio used in the calculation and the date of processing the CV risk score, and one of the medications if present. Note that CV risk is currently still calculated using the old Heart Foundation calculator, however a link to the new calculator is available in the prompt.

Text

Prompt is only for patients with a high CV risk score without dual therapy. CV risk calculation is based on the absolute cardiovascular risk score.

Tool tip

Based on the latest extractable results. *https://www.heartfoundation.org.au/getmedia/dbb102e3- 850f-41da-afbe-2776d8d4b97e/Absolute-CVD-Risk-Quick-Reference-Guide_2018.pdf*

https://www.heartfoundation.org.au/conditions/fp-absolute-cvd-risk-clinical-guidelines

Patient handout: *https://www.heartfoundation.org.au/Activities-finding-or-opinion/key-statistics- risk-factors-for-heart-disease*

11.4.6. Due ATSI Health Assessment (Prompt ID 6)

Prompts for an MBS health assessment if CV risk >10% and no CV risk medications are present, and it is > 9 months since the last health assessment. Returns the date of the last health assessment if there is one.

Text

Prompt is only for patients with a score > 10% with statin and/or antihypertensive not prescribed. CV risk calculation is based on the absolute cardiovascular risk score.

Tool tip

Please check with Medicare.
http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-MedicareHealthAssessments

11.4.7. Due Care Plan (Prompt ID 7)

Will prompt for ACG band 4 and 5, and for 3 where there is a >80% risk of hospitalisation in the next 12 months, and a GPCCP has not been billed in the past 12 months. Will provide the date of the last GPCCP if there is one.

Is the patient does not have a GPCCP (721, 229, 92024, 92068, 965, 392, 92029, 92060) billed in the last 12 months and the last GPCCP review (732, 233, 92028, 92072, 967, 393, 92030, 920610) is over 3 months ago or not done then a prompt will be triggered.

Type	GP Item	PMP Item	Telehealth GP	Telehealth PMP	Short Description
Prepare GPMP (Old)	721	229	92024	92068	Prepare a GP Management Plan (GPMP) face-to-face or telehealth (ceased July 2025)
Review GPMP (Old)	732	233	92028	92072	Review a GPMP face-to-face or telehealth (ceased July 2025)
Prepare GPCCMP (New)	965	392	92029	92060	Prepare a GP Chronic Condition Management Plan face-to-face or telehealth
Review GPCCMP (New)	967	393	92030	92061	Review a GP Chronic Condition Management Plan face-to-face or telehealth

Text

Eligibility for the prompt with a complexity score of 3 is based on 3 or more chronic conditions (complexity 3s need to have a >80% hospital risk score)

Tool tip

Please check with Medicare. *http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&q=721*

Prompt Rules

- Patients with an ACG Score of 4 or 5 OR score of 3 with a >80% (Probability IP Hospitalisation ACG score > 0.26) risk of hospitalisation in the next 12 months calculated by ACG Tool.
- Is the patient does not have a GPCCP (721, 229, 92024, 92068, 965, 392, 92029, 92060) billed in the last 12 months ago and the last GPCCP review (732, 233, 92028, 92072, 967, 393, 92030, 920610) is over 3 months ago or not done then a prompt will be triggered.

11.4.8. Due microalbumin pathology (Prompt ID 8)

Prompts for a microalbumin in patients with a diagnosis of CKD and or diabetes/diabetes indicated by medication who haven't had urine microalbumin tested in the past 12 months. Returns the last results and the date done, with if the result is micro, macro or normal.

Text

Please check the results used for the calculation.

ACR results are displayed as 'normal', 'microalbuminuria' (ACR values of 2.5-25mg/mmol for males and 3.5-35 mg/mmol for females; or AER values of 20-200mg/min) and 'macroalbuminuria' (ACR of >25mg/mmol for males and >35mg/mmol for females; or AER

>300mg/min). Proteinuria results are not included.

Tool tip

Based on the latest extractable results.
https://www.racgp.org.au/afpbackissues/2007/200709/200709phillips.pdf

Prompt Rules

- Patients with a diagnosis of CKD referenced from diagnosis or reason for visit ICPC codes
- Patients with a diagnosis of Diabetes referenced from diagnosis or reason for visit ICPC codes
- Microalbumin referenced from pathology result, pathology request and observation tables.
- eGFR latest result shown from pathology result, pathology request and observation tables

11.4.9. Due Mental Health Care Plan (Prompt ID 9)

Will prompt for a complexity score 3 and above where the patient has 2 or more mental health conditions and a GP mental health treatment plan has not billed in the past 12 months. Will provide the date of the last GP mental health treatment plan if there is one.

Text

Eligibility for the prompt is based on two or more Mental Health conditions as per MBS guideline.

Tool tip

Please check with Medicare.
http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&q=2715&qt=item

Prompt Rules

- Patients with an ACG Score of 3 or above.
- Patients with at least two Expanded Diagnostic Clusters Psych codes as calculated by the ACG Tool
- No time limit on the reasons for visit or diagnosis referenced by the ACG tool
- No billed MBS Item 2700, 2701, 2715, 2717, 272, 276 ,277, 281, 282, 92116, 92128, 92117, 92129, 92112, 92124, 92113 or 92125 in the last 12 months

11.4.10. Due Heart Health Check Assessment (Prompt ID 10)

Prompts for an MBS healthy heart check only when the CV risk missing medication prompt criteria are met and is more than 12 months since the last health assessment if there is one. Returns the date of a last health assessment if there is one.

Note: *Practices are encouraged to confirm on PRODA that the patient hasn't received a health assessment elsewhere in the last 12 months as last assessment date is only referenced from the practice CIS.*

If MBS codes are not recorded then Health Assessment Visit Reason ICPC Codes IDs 44811 (K43007), 44812 (K43007), 44741 (K43007), 45109 (K43007), 45110 (K43007), 631 (A30028), 34749 (A30028) are referenced instead for Assessment Date.

Text

Eligibility criteria is for a CV risk Health Assessment.

Tool tip

Please check with Medicare.
http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-MedicareHealthAssessments

11.4.11. Due medication review (Prompt ID 11)

Can only prompt if a GPCCP is due and ACG complexity score is 4 or 5, the medication count is >6 and a DMMR has not been billed in the past 12 months. Medications included are those that have not been ceased. Excludes most topical applications in the count.

Text

Eligibility for the prompt is based on patients with a complexity score of 4 or 5 with 7 or more current medications (those not ceased) while also being due a GPCCP

Tool tip

Based on the current medication list, check MBS.
http://www9.health.gov.au/mbs/search.cfm?q=900&sopt=S

11.4.12. Consider Haemochromatosis testing (Prompt ID 12)

Will prompt if there are 2 raised ferritins, or a raised transferrin saturation. A raised transferrin saturation on the same day as a ferritin will override a normal ferritin result. Prompt will provide Ferritin and transferrin saturation results and the date.

Text

Eligibility for the prompt is raised transferrin saturation result (>50%) or two raised ferritin results (>300 ug/l for men and >200 ug/l for women) who do not have a coded diagnosis of haemochromatosis or a record of a HFE test. Patient may require further investigations or a coded diagnosis.

Tool Tip

Please check the MBS rebate for the HFE gene test.

11.5. Nurse Prompts

11.5.1. Child Due Vaccination- Nurse Prompt (Prompt ID 13)

Will prompt for patients aged under 5 years who are currently due or overdue for a vaccination. Shows the due date and last dose date (where available). Due dates are guidelines only based on recommendations from the Department of Health and Aged Care.

IMPORTANT: Prompts displayed in Primary Sense are based on the recommendations from the National Immunisation Program Schedule. Some vaccines are prompted because they are relevant for certain groups due to medical conditions or for Aboriginal and Torres Strait Islander children in some states. See *National Immunisation Program Schedule*

All clinical staff are required to review each prompt and assess its clinical indication and necessity on an individual basis for each child. Prior to administering any vaccines, staff must verify the child's current vaccination status in AIR.
This prompt ONLY references immunisations recorded in the CIS.

Text

Eligibility for the prompt is based on patients under 5 years old that are currently due or overdue for a vaccination. Some vaccinations are marked to be considered based on their circumstances. Consider giving Panadol 30 minutes before or as soon as possible after the Meningococcal B vaccination. For more details, refer to the https://ncirs.org.au/ncirs-fact-sheets-faqs-and-other-resources/meningococcal

Tool tip

Based on guidelines from Department of Health and Aged Care

11.5.2. Bone Density Testing Due - Nurse Prompt (Prompt ID 14)

This will prompt for Bone Density testing due if evidence of a previous bone density test was not found, and the patient is age 70 or above. This is a prompt for the initial bone density test only, and if evidence of a test is found will not re-prompt based on results. The prompt will repeat as per prompt suppression timeframes listed below until a result is found.

Note: *if subsequent Bone Density tests are needed, Primary Sense cannot prompt these as they are dependent on result types which Primary Sense cannot currently process.*

Text

This patient meets the age criteria for bone density testing and evidence of a previous test was not found - please check the patient's record. This prompt is for the first test only at age 70 or above.

Tool tip

Based on extractable data.

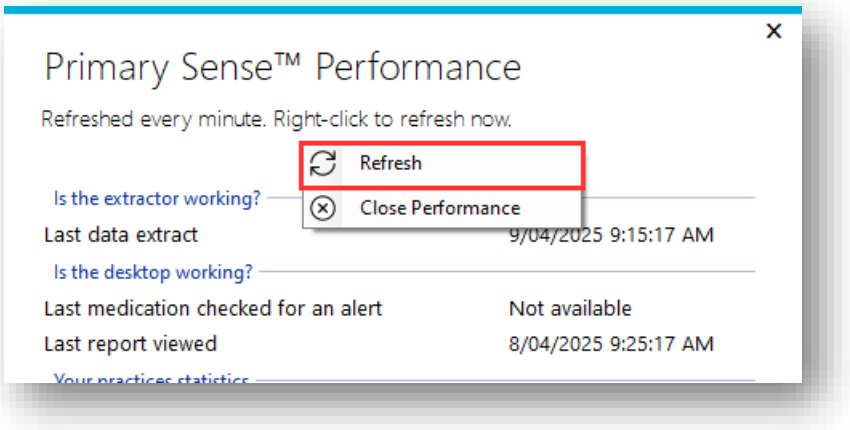
12. Settings

This tab is used specifically during the installation and set-up process. More details are available within the installation guides here: *Resources and documents — Primary Sense*

13. Performance Dashboard

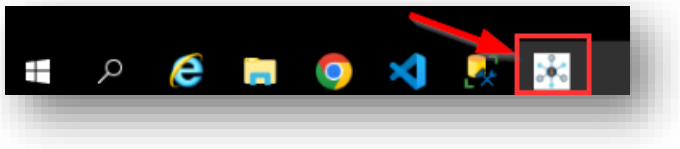
Overview

- The Primary Sense Performance dashboard can be used to assist with CQI activities and in reviewing use of Primary Sense within the practice.
- Data refreshes every minute. To refresh immediately, right click on the dashboard and select **Refresh**.

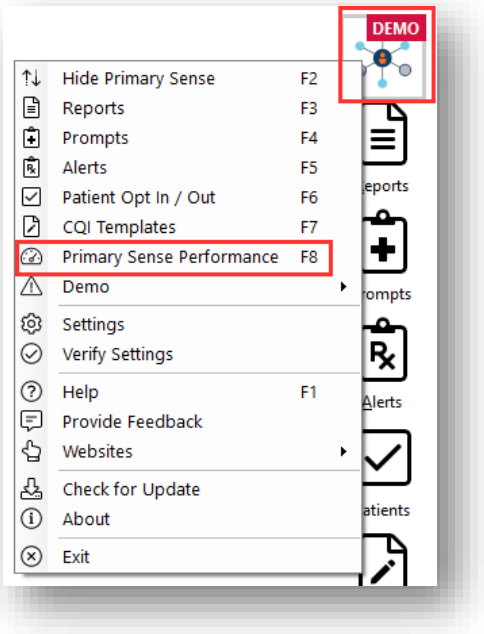


Accessing the Performance Dashboard:

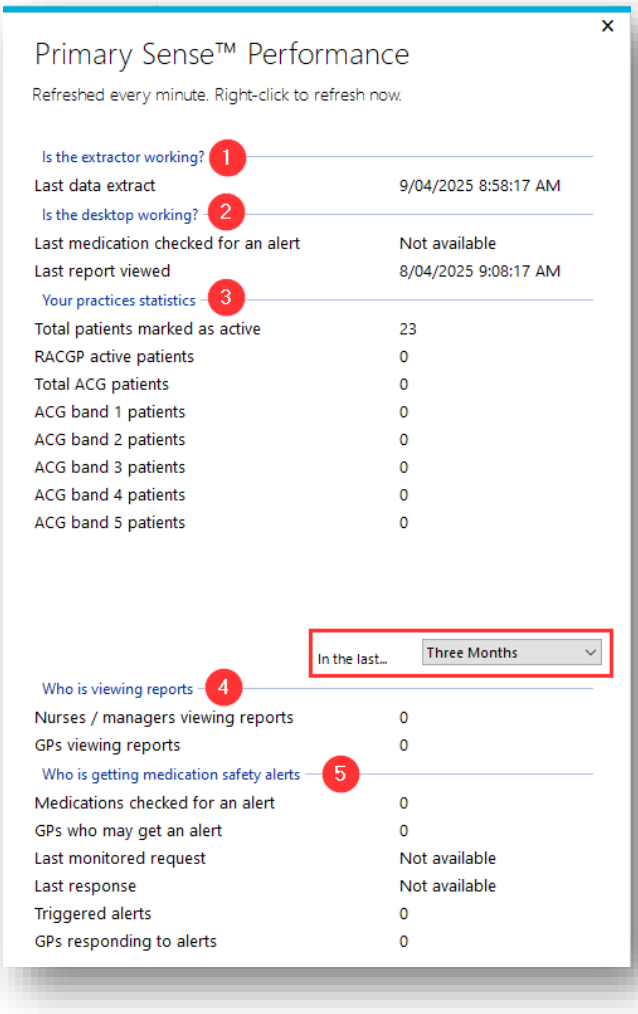
1. To access the Performance Dashboard, locate the Primary Sense icon on your desktop, or via the bottom toolbar:



2. **Right click** anywhere on the tool and select 'Primary Sense Performance.' The dashboard will open in a new window.



3. Toggle the '**In the last…**' drop down to see information during a specific time period.



Details of dashboard indicators:

1	**Is the extractor working?**	
	Last data extract	The date and time data was last extracted from your clinical software system via the Primary Sense Extractor.
2	**Is the desktop working?**	
	Last medication checked for an alert	The last date and time a medication was monitored from your clinical software system via the Primary Sense Desktop. **Note:** medication monitoring will only occur if the Primary Sense Desktop is installed on a workstation being used for prescribing (e.g. GP computer)
	Last report viewed	The last date and time a report was opened from Primary Sense Desktop.
3	**Your practices statistics**	
	Total patients marked as active	Total number of patients in your clinical software system not inactivated or deceased.
	RACGP active patients	Number of patients who have attended the practice three times or more in the past 2 years and have not been inactivated or deceased.
	Total ACG patients	Number of patients analysed through ACG (patients with one or more visits in the past 12 months)
	ACG band 1 patients	Number of patients classified as band 1 – low complexity. Patients are generally healthy and only present because of acute, time-limited conditions or minor issues.
	ACG band 2 patients	Number of patients classified as band 2 – low to moderate complexity. Patients typically have one risk factor.
	ACG band 3 patients	Number of patients classified as band 3 – moderate complexity. Patients typically have at least 1 chronic condition and are at risk of progressive deterioration.
	ACG band 4 patients	Number of patients classified as band 4 – moderate to high complexity. Patients are characterised by multimorbidity.
	ACG band 5 patients	Number of patients classified as band 5 – high complexity. Patients are characterised by instability, multimorbidity, polypharmacy or patients requiring end of life care.
4	**Who is viewing reports**	
	Nurses/managers viewing reports	Number of reports viewed by nurses/managers since time specified in the drop-down box.
	GPs viewing reports	Number of GPs viewing reports since time specified in the drop-down box.
5	**Who is getting medication safety alerts**	
	Medications checked for an alert	Number of medications monitored from clinical software system for an alert via the Primary Sense Desktop. **Note:** medication monitoring will only occur if the Primary Sense Desktop is installed on a workstation being used for prescribing (e.g. GP computer)

GPs who may get an alert	Number of GPs who are currently or have previously prescribed medications in the clinical software system on a workstation that also has Primary Sense Desktop installed
Last monitored request	The last date and time a medication was monitored from your clinical software system via the Primary Sense Desktop. **Note:** medication monitoring will only occur if the Primary Sense Desktop is installed on a workstation being used for prescribing (e.g. GP computer)
Last response	Last date and time a GP responded to a medication alert from Primary Sense Desktop.
Triggered alerts	Total number of triggered medication alerts since time specified in the drop-down box
GPs responding to alerts	Number of GPs who have responded to a medication alert since time specified in the drop-down box

14. Notifications

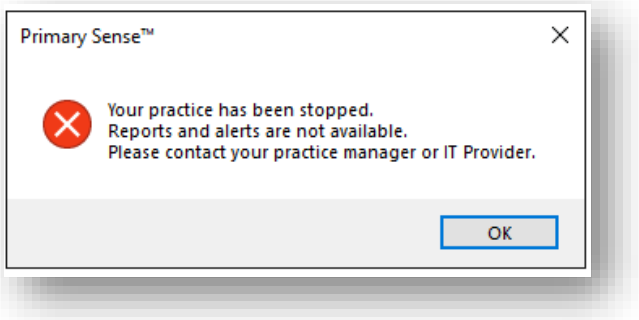
If your desktop app is displaying with orange or red tiles, please contact your IT provider to verify whether the Primary Sense Extractor is running. If you need further support, please contact your PHN for assistance. Note that data presented via Primary Sense may be out of date during this period.

14.1. Orange tiles

When a practice has not extracted data from the clinical software system via the Primary Sense Extractor for more than 24 hours, the top three tiles will display in orange:

14.2. Red tiles

When the Primary Sense Extractor has stopped running, the top three tiles will display in red. Clicking the Reports or Alerts button will display a message:



15. GP Dashboard

15.1. Overview

The GP Dashboard summarises interactions with Primary Sense medication safety alerts and care prompts for missing interventions, compared to the PHN average. It was developed by the Primary Sense Clinical Advisory Group.

With the new Primary Sense GP Dashboard, general practitioners (GPs) can view the number of:

- **Medication safety alerts** they received and responded to/interacted with in the past 30 days, compared to PHN average
- **Care prompts** they received and responded to/interacted with in the past 30 days and year to date, compared to PHN average
- **Accumulated time to review towards quality improvement** by interacting with evidence-based Primary Sense alerts and care prompts, each accruing 2 minutes which may be usable for CPD time
- **Reports downloaded** in the past 30 days
- **ACG band 4 and 5 patients seen** (with high complexity) in the past 12 months compared to PHN average.

The PHN average and individual GP interactions are refreshed daily to provide the most recent numbers.

The GP dashboard makes it easy for GPs to review possible CPD time by providing accumulated total time at 30 days and year to date (commencing 1 January each year).

Each interaction with Primary Sense where the GP selects an action on medication safety alerts or care prompts may contribute 2 minutes towards CPD time under Reviewing Performance (RP) and Measuring Outcomes (MO) categories.

Reviewing Performance are activities that require reflection on feedback about your work and Measuring Outcomes are activities that use your work data to ensure quality results.

The Primary Sense Clinical Advisory Group recommends claiming a **maximum of 2 hrs** for interactions with Primary Sense medication safety alerts and care prompts.

"Primary Sense is making it simple to accrue potential CPD time in your daily work while also targeting your most at-risk patients"

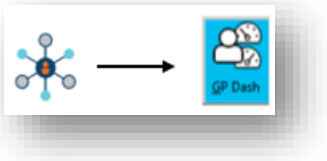
Prof. Mark Morgan, Professor of General Practice and Chair of RACGP Expert Committee for Quality Care.

NOTE: Primary Sense does not guarantee these points will be accepted by RACGP.

The following RACGP article may be of interest - *Improving health record quality in general practice*
https://www.racgp.org.au/FSDEDEV/media/documents/Running%20a%20practice/Practice%20resources/Improving-health-record-quality-in-general-practice.pdf

15.2. Accessing and Navigating the GP Dashboard

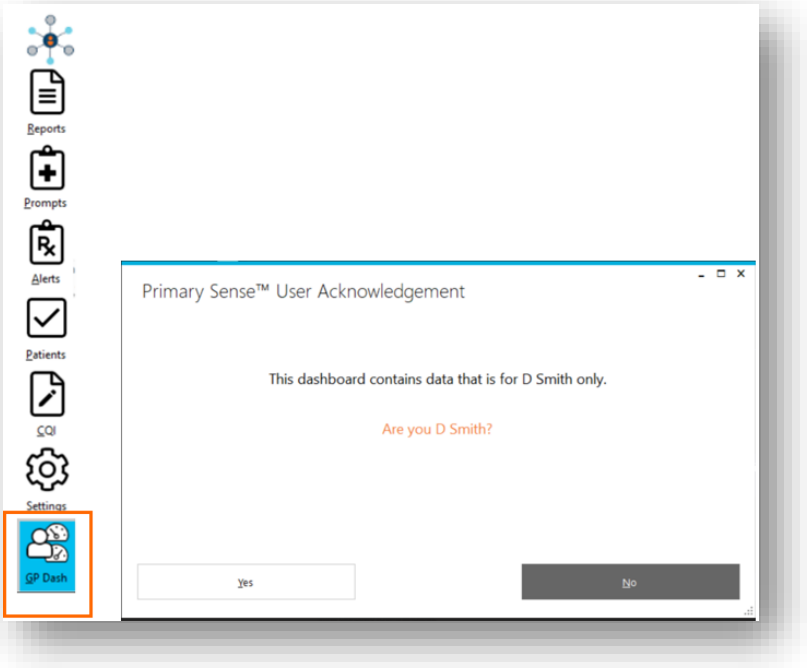
Expand the Primary Sense icon from the Desktop and select the GP Dashboard (GP Dash) at the bottom of the list.



When GPs are logged into the Clinical Information Software (CIS), it will identify the user and request verification of their identity. This is the only verification step.

Selecting 'No' will close the window. Selecting 'Yes' will open the dashboard and populate the data.

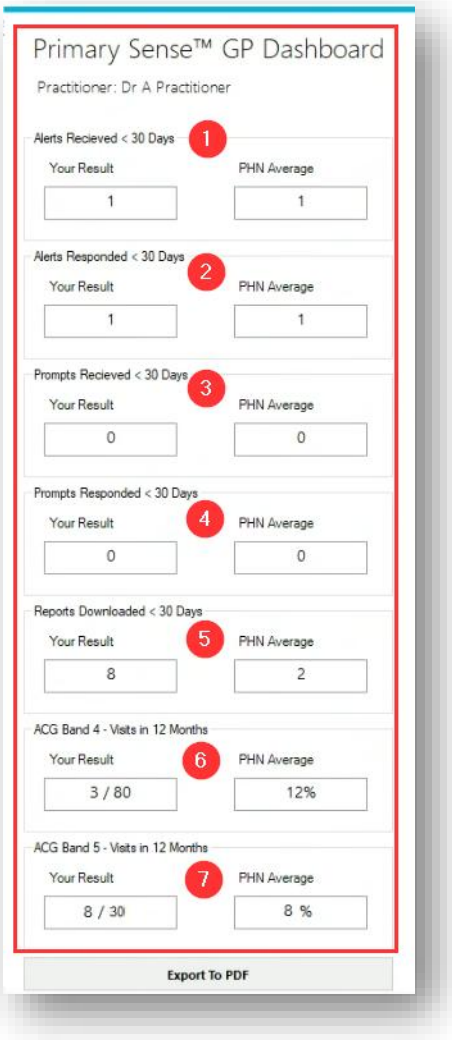
If the verification does not display the GPs name, please ensure the GP is logged into the CIS and close and reopen Primary Sense.



The dashboard presents the logged-in GPs results in comparison to the Primary Health Network average. The PHN average and individual GP interactions are refreshed daily overnight so data from the current day will not be included in the numbers.

NOTE: A high turnover of GPs can influence the average.

The left screen is fixed and displays the following statistics:



1. Medication Safety Alerts (Alerts) received in the last 30 days
2. Medication Safety Alerts (Alerts) responded to in the last 30 days
3. Prompts received in the last 30 days
4. Prompts responded to in the last 30 days
5. Reports downloaded in the last 30 days
6. The most complex patients with ACG band 4 that have visited (had a reason for visit documented by their regular GP) in the past 12 months / all patients of that band for that GP*
7. The most complex patients with ACG band 5 that have visited (had a reason for visit documented by their regular GP) in the past 12 months / all patients of that band for that GP*

NOTE: *Only patients identified in Primary Sense with their GP logged into the dashboard as their Regular GP will be included in sections 6 and 7. Primary Sense determines the regular GP by evaluating the last five patient records accessed. If two GPs have each had two visits, the GP with the most recent consultation date is selected as the regular GP.*

High Complexity patients can be found in the Patients with High Complexity (5 and 4) report and recalled for the missing interventions listed in the report, and/or a care prompt may be triggered when these patients visit next.

15.3. Auto logging off the dashboard

After 5 minutes the dashboard will close and clear data, and the user will need to reopen it from the toolbar. This prevents other users from viewing individual GP data if they are away from their PC.
The GP dashboard will also close if the user is changed in the Primary Sense settings, or if the user is changed in the CIS (BP) via the Change User functionality.

15.4. GP Accumulated Totals and Prompt Numbers

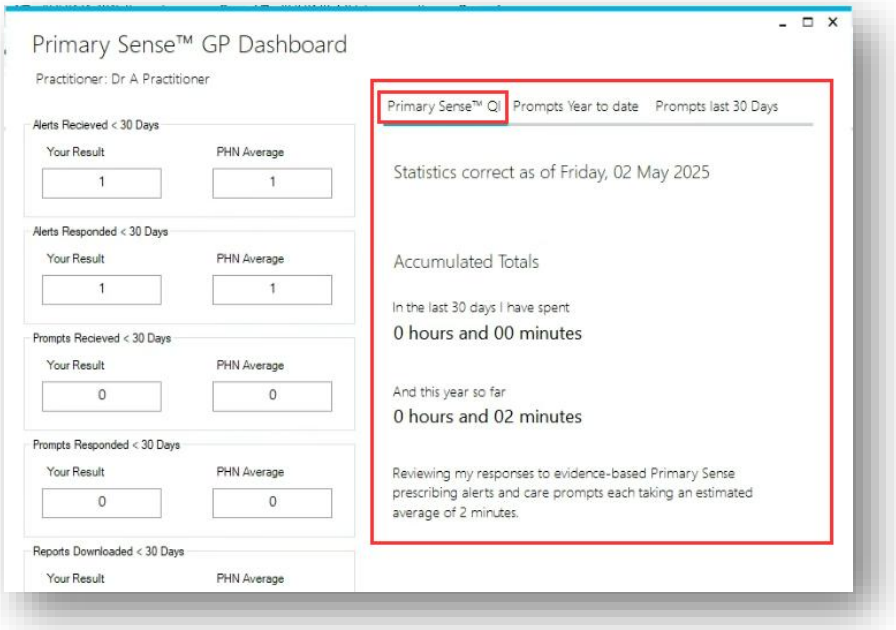
The right screen has tabs which can be switched to view data from Primary Sense QI , Prompts Year to date (response rate), and Prompts last 30 days (response rate).

The Primary Sense QI Tab will display the accumulated totals of time allocated for the last 30 days and for the year to date (commencing 1 January each year).

For Primary Sense **Prompts**, when GPs click on any action other than 'Prompt not meant for me' the total will accrue 2 minutes towards the time spent in quality improvement.

For **Medication Safety Alerts**, when GPs click on any action other than 'Not relevant to me' the total will accrue 2 minutes towards the time spent in quality improvement.

15.4.1. Primary Sense QI Tab

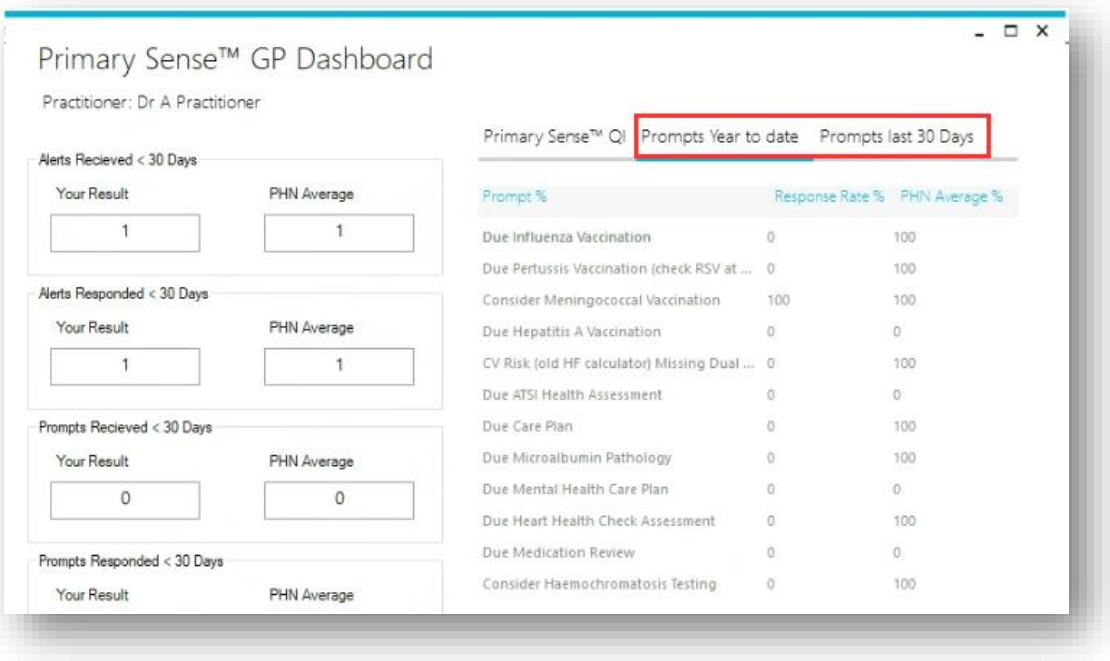


Time is displayed for the last 30 days, and the year to date from 1st January based on 2minutes per prompt

of medication safety alert.

The accumulated totals may contribute towards CPD time under the RACGP category RP and MO.

15.4.2. Prompts Year to date and Prompts last 30 days



Prompt data displays with the name of the prompt, the GP response rate, and the PHN average response rate. Calculations reset on January 1st each year for the year to date.

The *Prompts Year to Date* and *Prompts last 30 Days* displays the prompt, the GP response rate, and the PHN average response rate.

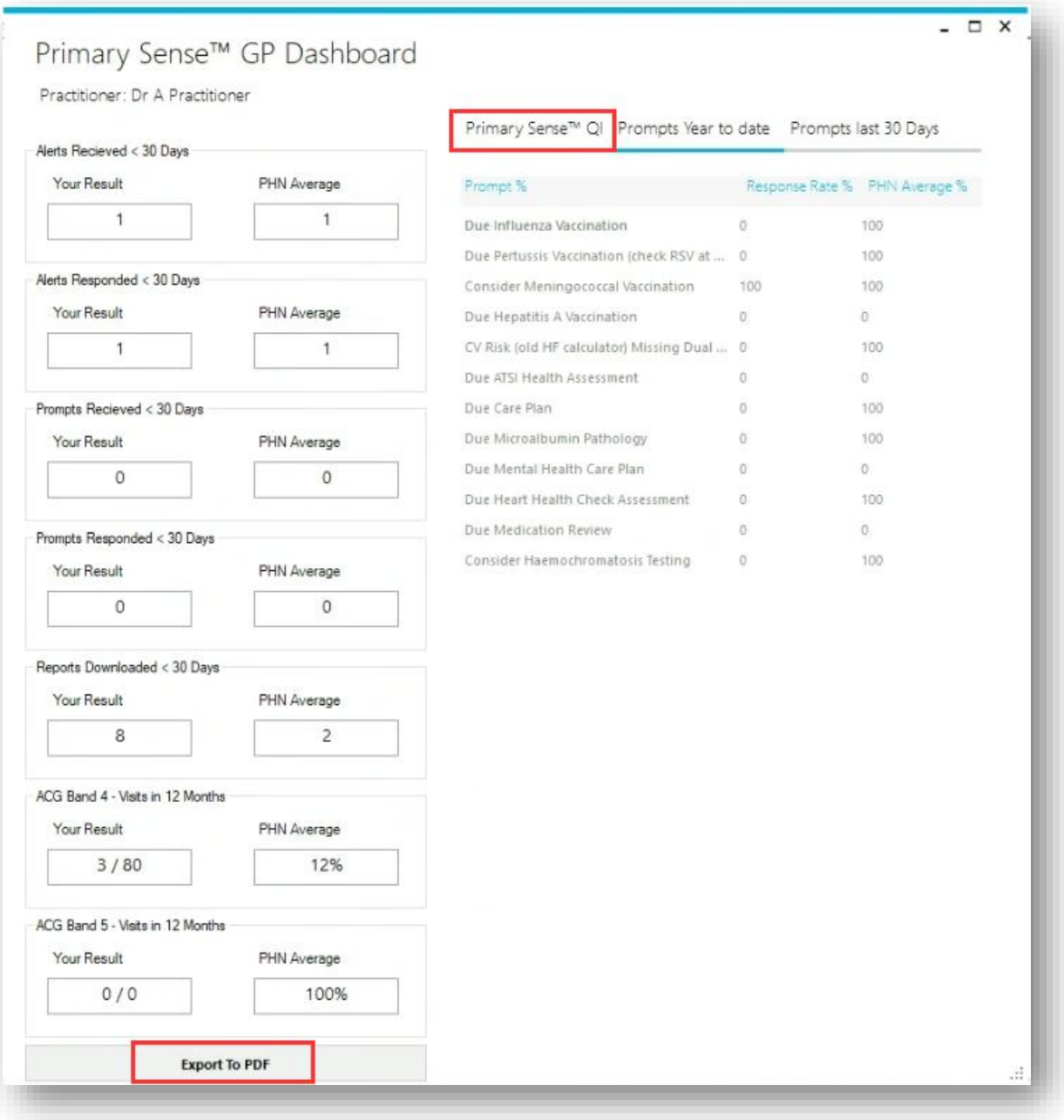
NOTE: *If the GP does not have any records returned, they may have opted out of receiving prompts and alerts.*

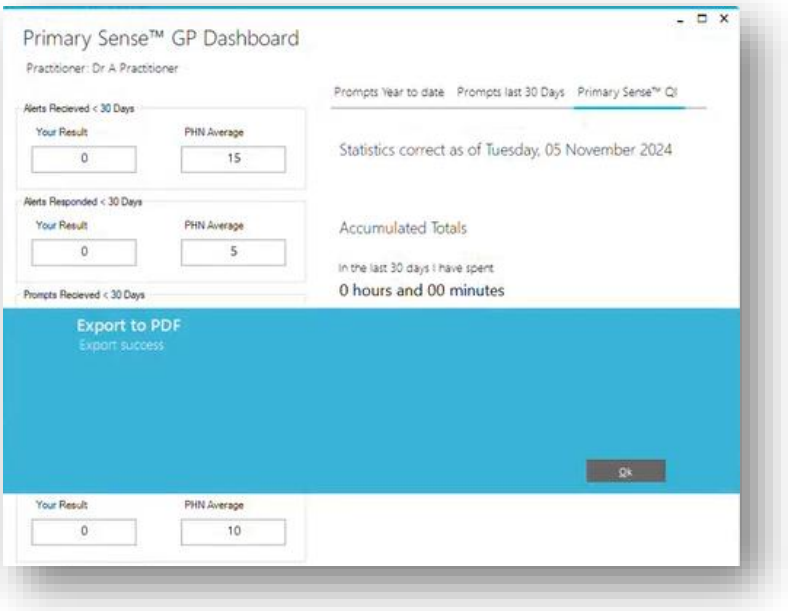
To check the GP opt out of prompts or alerts status go to the '**Prompts or Alerts > Settings**' tab. This is only relevant to the logged in user.

See *Opting in and out of Medication Safety Alerts* and *Opting in and out of Care Prompts* for more information on opting in and out of prompts and alerts.

15.5. Exporting PDF summary from Primary Sense GP Dashboard

The Primary Sense QI tab enables GPs to print out their results for possible submission to RACGP. From the *Primary Sense QI tab*, select 'Export to PDF' button.





Select *OK*.
Statistics will be exported showing the responded prompt and alerts data numbers.

PRIMARY SENSE

Dashboard Export for Practitioner: Dr A Practitioner

Statistics correct as of Monday, 24 March 2025

This year I have spent 0 hours and 56 minutes reviewing my responses to evidence-based Primary Sense prescribing alerts and care prompts each taking an estimated average of 2 minutes.

Alerts Received

Alerts Received < 30 days	Alerts Received PHN Average
2	2

Alerts Responded < 30 days

Alerts Responded	Alerts Responded PHN Average
1	1

Prompts Received < 30 days

Prompts Received	Prompts Received PHN Average
26	26

Prompts Received < 30 days

Prompts Responded	Prompts Responded PHN Average
14	14

Reports Downloaded < 30 days

Reports Downloaded	Reports Downloaded PHN Average
1	1

ACG Band 4 - Visit Percentage in 12 Months

ACG Band 4 - Visit Percentage in 12 Months	ACG Band 4 - Visit Percentage in 12 Months - PHN Average
100%	100%

ACG Band 5 - Visit Percentage in 12 Months

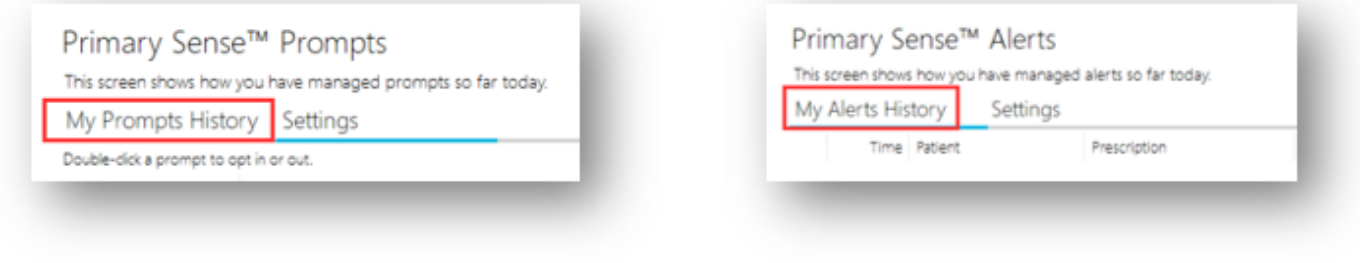
ACG Band 5 - Visit Percentage in 12 Months	ACG Band 5 - Visit Percentage in 12 Months - PHN Average
0%	0%

Prompt	Response Rate 30 Days (%)	PHN Avg 30 Days (%)	Response Rate YTD (%)	PHN Avg YTD (%)
Due Influenza Vaccination	50	50	50	50
Due Pertussis Vaccination	50	50	50	50
Consider Meningococcal Vaccination	50	50	50	50
Due Hepatitis A Vaccination	50	50	66	66
CV Risk (old HF calculator) Missing Dual Therapy	50	50	66	66
Due ATSI Health Assessment	50	50	50	50
Due Care Plan	66	66	66	66
Due Microalbumin Pathology	66	66	66	66
Due Mental Health Care Plan	50	50	50	50
Due Heart Health Check Assessment	50	50	50	50
Due Medication Review	50	50	50	50
Consider Haemochromatosis Testing	50	50	50	50

15.6. Reviewing Care Prompts and Medication Safety Alerts

GPs can view their prompts and alerts history and from the '*My Prompts History*' or '*My Alerts History*' tabs.

Prompts > My Prompts History **or** **Alerts > My Alerts History**



For more information see *Managing Medication Safety Alerts* and *Using Prompts* for more information on reviewing Prompts and Alerts.

15.7. ACG Complexity Bands

The Johns Hopkins University ACG® System Complexity bands are referenced in the GP dashboard. See *Complexity bands* for more information about these scores.

16. APPENDIX 1: DATA SHARING

16.1. Permitted Purpose

Shared Data may be used by the PHN, and disclosed to third parties by the PHN, only for the Primary Purposes and the Secondary Purposes, as specified below:

16.2. Primary Purposes

The PHN can use the Shared Data for the following primary purposes:

(a) Providing reports, alerts and notifications back to the Practice via the Software;

(b) Generate, process and submit data for PIP QI;

(c) Provide reports, advice and feedback on quality improvement and other practice improvement areas by the PHN to the Practice via reports, phone calls, emails, in- person meetings and other forms of communication;

(d) Undertake and publish population health analysis and research to improve community health outcomes by:

  (i) additional statistical reporting for the Practice;

  (ii) commissioned service planning;

  (iii) population health planning;

  (iv) public health service mapping;

  (v) development and further enhancement of community health promotion and prevention strategies;

  (vi) assist in the comparison of Aggregated Data with current health trends;

  (vii) identification of health service gaps;

  (viii) evaluation of commissioned services and other health service programs; and

  (ix) supporting the commissioning of services in accordance with the Department of Health's Commissioning Framework.

(e) Create Aggregated Data to provide to the Commonwealth Department of Health and other Local, State and Federal government bodies to support health policy and program planning, development and evaluation, including health workforce policy and programs; and

(f) Collaborate and work with other Primary Health Networks to support Primary Purposes (a), (b), (c) (d) and (e) at regional, state and national levels.

16.3. Secondary Purposes

A. The PHN can use the Shared Data for the following secondary purposes:

(a) Provide Shared Data (Aggregated or not) to third parties, including health industry peak bodies, for research or other purposes where:

  (i) the purpose aligns to and supports one or more Primary Purposes;

(ii) the scope of the Shared Data to be shared has been documented, including any data linkage;

(iii) any research that will use the Shared Data has received all required Ethics approvals;

(iv) the third party has agreed to abide by data security, privacy and consent requirements in line with this Agreement and all relevant Privacy Laws; and

(v) a proposal or other documentation containing sufficient detail to demonstrate that (i) through (iv) above, inclusive, have been satisfied has been:

(1) reviewed by the Primary Sense Clinical Advisory Group, or another body that is external to the PHN and the third parties and which contains individuals with appropriate and relevant experience and expertise in primary health care and general practice; and

(2) endorsed by the Primary Sense Clinical Advisory Group, or other body as specified in A, as a result of the review as having sufficiently demonstrated compliance with (i) through (iv), above.

B. The PHN can only use the Shared Data for a secondary purpose if the PHN has:

(a) maintained a record that the purpose has been approved in line with clause A, above, that includes sufficient detail to demonstrate how the purpose complies with the requirements of that clause;

(b) made that record easily accessible to the Practice (such as on a website, newsletter or by direct communication to the Practice);

(c) provided a means whereby the Practice can easily opt out by notifying the PHN that:

(i) their Shared Data in part or in its entirety is not permitted to be used for that particular purpose; or

(ii) their Shared Data in part or in its entirety is not to be used for any secondary purpose,

(d) maintained a record of all Practice opt out notifications received from any Practice under sub-clause (c); and

(e) complied with any opt out notification provided by the Practice under sub-clause (c).

16.4. Excluded Purpose

Shared Data may not be used by the PHN, or disclosed to third parties by the PHN, for any of the Excluded Purposes, as specified below:

Excluded Purposes

The PHN may not use the Shared Data, or knowingly permit the Shared Data to be used, for the following excluded purposes:

(a) Any commercial purpose or gain for the PHN or any other third party for the purposes of making a profit. For the avoidance of doubt, the PHN is permitted to charge a third party a fee for the use of the Shared Data or Aggregated Data for a Permitted Purpose on a

reasonable cost recovery basis; or

(b) Any performance benchmarking or financial audit undertaken by a Commonwealth or State Government agency or any other funding body, without the express permission of the Practice on each occasion.