



Divisions Performance Indicator Report 2008-09: Divisions' ability to meet reporting thresholds

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Executive summary

Divisions of General Practice report on a set of National Performance Indicators (NPIs) as part of their accountability to their funding source. This report examines patterns in the ability of Divisions to gather the data required to report on four NPIs for their 12 month reports for 2008-09. The four indicators were: Chronic Disease Management 1, 2, and 3, and Prevention 4. These are the only indicators that require Divisions to collect the data. Divisions were classified into two groups: 1) those that met all reporting thresholds; and 2) those that did not meet thresholds. We used data from the 2007-08 Annual Survey of Divisions to examine associations between Divisions' characteristics and activities; and differences in reporting performance across Divisions.

A total of 111 Divisions provided data for analysis, including the two hybrid Division/State-Based Organisations in the Northern Territory and ACT.

Table 1 shows a summary of the key findings.

Table 1 Summary of key findings

<p>Overall ability of Divisions to meet reporting thresholds on NPIs CDM 1, 2 3 and Prevention 4 for 2008-09 (12 month report)</p> <p>Of 111 Divisions included in analyses:</p> <ul style="list-style-type: none"> • 86% met reporting thresholds for all 4 indicators (CDM 1, 2, 3; Prevention 4) • Prevention 4 had the largest number of Divisions that did not meet reporting thresholds <ul style="list-style-type: none"> ➤ Divisions relied on state based Cervical Screening registers, which did not provide sufficient information about the number of GPs and practices on which data were based.
<p>Barriers to meeting thresholds</p> <ul style="list-style-type: none"> • Overall lack of resources in practices • Disinclination of GPs in some practices to release patient data • Reluctance in some practices to use computerized systems • Incomplete data collection in Divisions with small numbers of Australian Primary Care Collaboratives (APCC) participating practices in their catchment area. Divisions' reliance on APCC practices for data combined with few APCC participating practices led to incomplete data • Divisions with large numbers of GPs and less external funding were less likely to meet thresholds • Divisions in more populated areas had more difficulty gathering sufficient data. Practices in their catchment areas had: <ul style="list-style-type: none"> ➤ Lower IM/IT capacity ➤ Greater need for technical assistance in IM/IT and electronic data transfer.
<p>Enablers to meeting thresholds</p> <ul style="list-style-type: none"> • Participation in APCC enabled practices to provide clean data for Divisions' NPIs. Divisions that met their thresholds had more practices involved in the APCC and used alternative methods to source data from non-APCC practices • Divisions worked with practices to improve the quality of data entered into medical software • Training on the use and value of the Canning and PEN CAT tools.



Overview

The Primary Health Care Research and Information Service (PHC RIS) collects and manages data from Divisions of General Practice six and 12 month reports, and the Annual Survey of Divisions (ASD). Therefore, PHC RIS is in a unique position of having intimate knowledge of a large database of current and longitudinal information about Divisions' activities. Appropriate analyses of data contained in Divisions' six and 12 month reports integrated with ASD data may shed light on the relationships between contextual information and process and outcome indicators.

This brief report is the third in a series designed to:

- 1 Construct a comprehensive picture of the range, processes and outcomes of Divisions' actions, by integrating information from the ASD with six and 12-month reporting data.
- 2 Identify the characteristics associated with Divisions' ability to report on National Performance Indicators (NPIs).

Method: Rationale

Divisions report on a set of National Performance Indicators (NPIs) as part of their accountability to their major funder, the Australian Government Department of Health and Ageing (DoHA). As part of the performance monitoring process, the *Divisions Funding and Performance Section* in DoHA requested PHC RIS to develop reports that critically reflect on the performance of the Divisions of General Practice.

For the purposes of this report, PHC RIS examined Divisions' performance in reporting on all the NPIs that required Divisions to provide the data, as opposed to data that were sourced from Medicare or an external register. We used data from the 2007-08 Annual Survey of Divisions to examine potential associations between environmental or programmatic factors and Divisions' reporting abilities.

The Indicators

Chronic Disease Management indicators 1, 2, and 3, and Prevention 4 are the only indicators for which Divisions were required to collect data from practices or GPs. Technical details pertaining to these indicators are provided in

Appendix A ASD questions and NPI technical details

Questions from the ASD used for analysis.

DGPP CDM 1 measures:

The number and proportion of general practices within the Division using electronic register/recall/reminder systems to identify patients with a chronic disease for review and appropriate action.

Divisions are required to collect data from 80% of General Practices in their catchment area and there is an expectation that this number will increase with time.

DGPP CDM 2 measures:

The number of patients within the Division with diabetes whose last recorded HbA1c within the previous 12 months was:

- *less than or equal to 7.0%*
- *greater than 7.0% but less than or equal to 8.0%*
- *greater than 8.0% but less than 10.0%*
- *greater than or equal to 10.0% or*
- *not recorded.*

Divisions are required to collect data from 10% of General Practitioners in their catchment area and there is an expectation that this number will increase with time¹.

DGPP CDM 3 measures:

The number of patients within the Division with coronary heart disease whose last recorded blood pressure within the previous 12 months was <selected clinical parameter>.

¹ The first report in this series analyses the content of National Performance Indicators CDM1 and CDM2 in greater detail.

The Department of Health and Ageing had three reporting options for the 2007-08 period. Divisions were able to choose to report on one of the following three clinical parameters: less than 130/80 mmHg; less than or equal to 130/80 mmHg; less than 140/90 mmHg.

Divisions are required to collect data from 10% of General Practitioners in their catchment area and there is an expectation that this number will increase with time.

DGPP Prevention 4 measures:

The number and proportion of female patients aged 20-69 whose patient record shows that they have had a Pap smear during the previous two year period.

Divisions are required to collect data from 10% of General Practitioners in their catchment area and there is an expectation that this number will increase with time.

Procedure

Quantitative and qualitative information was extracted from the online data provided by Divisions in their 2008-09 12-month reports and the 2007-08 Annual Survey of Divisions (ASD). Each indicator consists of quantitative results tables, with free form full text description of how the data were obtained and explanatory text. Data from the 2007-08 ASD rather than the 2008-09 survey were used because data from 2008-09 survey were not yet available when these analyses commenced. Moreover, it is likely that ASD variables, such as Divisions activities, have a delayed effect on NPIs.

SPSS (Version 17) was used to analyse quantitative data and *N-Vivo 8* was used to manage qualitative data.

In this report, we examined the association between environmental and programmatic influences, (using ASD data) and Divisions' ability to collect sufficient data to meet the required threshold for their 2008-09 12-month NPI report. The Divisions included in this report were separated into two groups: 1) those that met the data collection threshold for all four of the NPIs examined; and 2) those that did not meet the threshold for all four NPIs examined. All analyses focusing on systemic and environmental and programmatic influences were based on the differences between these two groups.

Environmental influences included location, rurality, and the health workforce characteristics in their catchment area. These factors were largely outside of the direct control of Divisions. Programmatic factors that were within Divisions' control included Divisions' engagement in the Information Management Maturity Framework (IMMF); and information management/information technology (IM/IT) training or support delivered to general practices in their catchment area. For a list of questions analysed, refer to Appendix A.

Quantitative data were analysed and the current report presents results of comparisons between groups where the difference between groups was large enough to be meaningful. Twenty-five Divisions did not meet their reporting threshold and differences of greater than 10% between the two groups were considered meaningful.

For ease of comparison, data are reported in whole numbers only. Where averages are reported, standard deviations are provided in brackets.



Both Divisions and SBO/Division hybrids (in ACT and NT) were included in this data set as both of these groups reported on the indicators presented in this report. A total of 111 Divisions were included for analysis.

Results

Overall ability to report on four indicators

Overall, 86 (77%) Divisions of general practice met the reporting thresholds for all indicators that required them to collect their own data. The remaining 25 (23%) Divisions did not meet the minimum threshold for data collection from GPs. Table 2 shows the number and proportions of Divisions that totally and partially met their reporting requirements for all four indicators.

Table 2 The number of indicator reporting thresholds met by Divisions in their 2007-08 12-month report

Number of Indicator thresholds met	Number of Divisions	Percent	Cumulative Percent
Zero indicators	0	0	0
One indicator	2	2%	2%
Two indicators	10	9%	11%
Three indicators	13	12%	23%
Four indicators	86	77%	100%

Note: Due to rounding errors, numbers may not add up to 100%.

The Prevention 4 indicator had the largest number of Divisions that did not meet the reporting threshold (Figure 1).

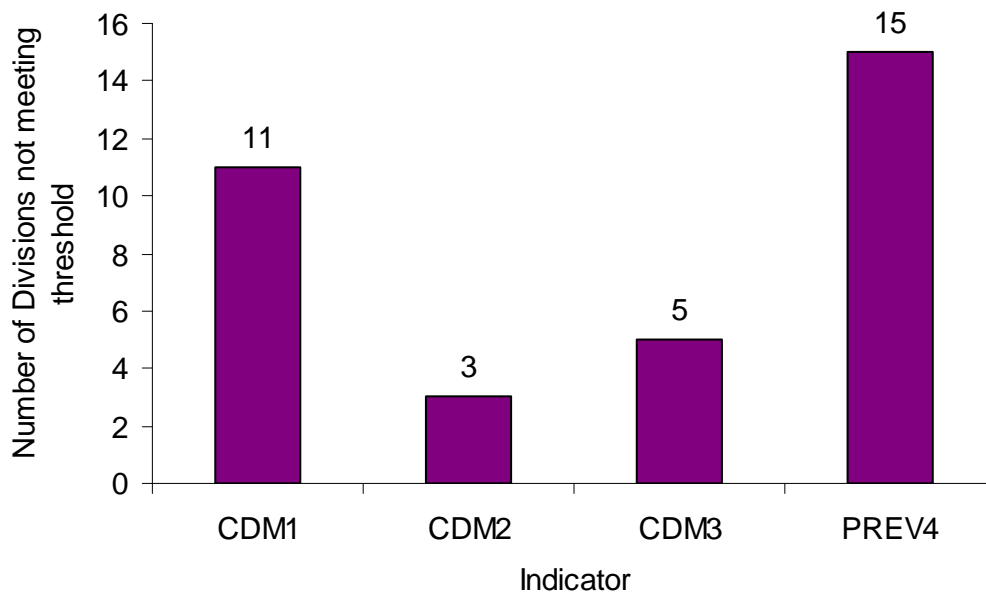


Figure 1 Number of Divisions not meeting the data collection threshold for each indicator

Factors associated with the ability to report

1 *Environmental influences*

This section focuses on systemic and environmental factors, beyond the control of the Divisions, which may affect their ability to report.

Divisions that did not meet the reporting threshold for at least one indicator were distributed across six states: New South Wales (n=13), Western Australia (n=5), South Australia (n=3), Queensland (n=2) Tasmania (n=1) and the Australian Capital Territory (n=1).

There was no meaningful difference in ability to report between Divisions in different RRMA categories.

General practice workforce composition differed between the two groups of Divisions. Divisions that did not meet all the thresholds had:

- ⇒ more General Practitioners (GPs) (mean=251, SD=163) than Divisions that did meet all the thresholds (mean=180, SD=142)
- ⇒ more female GPs (mean=103, SD=80) than Divisions that did meet all the thresholds (mean=65, SD=61)
- ⇒ less external funding (median=\$18 208, range=\$0-\$1 710 787) than those that did meet the threshold on all indicators (median=\$19 915, range=\$0-\$2 974 646).

Taken together, these results suggest that Divisions with a larger GP workforce in their catchment area and less external funding experienced more difficulty meeting their reporting thresholds. However, the standard deviations are large relative to the means and so this association should be interpreted with caution.

Divisions' ability to meet reporting thresholds was not affected by other workforce characteristics, such as the size of practices, or the number of practice nurses, international medical graduates, GPs working in corporate general practice, or Aboriginal community-controlled health services.

Divisions were asked whether the support provided by State-Based Organisations assisted them to increase Division IM/IT capacity. While most Divisions (n=89, 80%) stated that the State-Based Organisation provided useful support, such support was not associated with Divisions' ability to report or not.

2 *Engagement in Programs & Service Delivery*

This section focuses on the relationship between Divisions' engagement in programs and delivery of services to general practice, and their ability to meet the data collection thresholds on the NPIs.

Contrary to expectations, there was little evidence of an association between the current use of the IMMF and Divisions' ability to report to the appropriate threshold, as shown in Table 3.

Table 3 Divisions achievement of the indicator threshold, by current engagement in the IMMF

	Did not meet the threshold on all indicators		Met the threshold on all indicators	
	Number	Percent	Number	Percent
Used the IMMF	15	60%	43	50%
Did not use the IMMF	10	40%	43	50%
Total	25	100%	86	100%

Divisions that met the reporting threshold were more likely to *intend to use* the IMMF in a structured manner as part of their business plan in the future compared to Divisions that did not meet the reporting thresholds (see Table 4 in Appendix B). By contrast, more Divisions that did not meet the thresholds planned to use the IMMF *in an ad-hoc manner*. This difference in intended use may reflect an increased capacity and a tendency towards more structured and organised governance practices in some Divisions, leading to increased performance in meeting their reporting thresholds.

The level of IM/IT capacity within practices may have influenced Divisions' ability to report adequately on four indicators. Divisions that did not meet the reporting thresholds showed a higher rate of referral of general practices to local IT support services and organisations (Table 5 in Appendix B). This suggests that Divisions that did not meet the threshold had practices that required more IT assistance due to lower levels of IM/IT capacity.

The pattern of requests for technical assistance by practices further supports the contention that lower IM/IT capacity and infrastructure within general practices may have led to more difficulties in data collection from practices and, subsequently, in Divisions' reporting. Divisions that did not meet all of their thresholds were more likely to:

- ⇒ deliver technical assistance than Divisions that met the threshold (see Table 6 in Appendix B)
- ⇒ have higher rates of practice requests for IM/IT support (Table 7 in Appendix B)
- ⇒ have higher rates of practice requests for support with electronic data transfer (EDT; Table 8 in Appendix B).

There was no meaningful difference between Divisions that met and those that did not meet their reporting thresholds on all indicators, based on:

- ⇒ engagement in coordinated IM/IT activities with other Divisions
- ⇒ delivery of training (by Divisions) to general practice on:
 - basic computer literacy
 - support for general practice to access the IM/IT Practice Incentive Program payments.

Divisions' explanations of results

Typically, Divisions that met their thresholds had more practices that were involved in the APCC and/or used alternative methods to source data from non-APCC practices. By contrast, Divisions that did not meet their thresholds had low numbers of participating practices in their catchment area, yet also relied primarily on APCC practices as sole providers of data. Interaction of these two factors may have resulted in incomplete data collection. In addition, a change in the APCC measure from 140/90 to 130/80mm/Hg for CDM 3 in April meant that APCC data could not be used for CDM 3. Divisions that met the thresholds derived their data from other/multiple sources.



Organisations that were unable to report adequately on the Prevention 4 indicator sourced their data solely from the state cervical screening registers. Divisions that met their thresholds used these resources less commonly. Many Divisions that used these sources also reported that the registers did not provide data on the number of practices or GPs from which information was obtained. The limitations of such sources of data underscore the uncertainty of making inferences about the representativeness of cervical screening data.

Irrespective of whether Divisions did or did not meet their thresholds, similar data collection tools were used (Prevention 4 indicator excepted). Canning and PEN CAT were the most common clinical audit tools. Divisions encountered difficulties with practices entering information incorrectly into their medical software. Some Divisions screened the 'cleanness of data' before including it in their performance indicator set and discovered that many GPs entered test results into the free text sections of their software. This meant that data could not be extracted by the Division.

Many Divisions cited lack of GP interest, involvement or authorisation of data collection as barriers to data collection. Other barriers included ageing GPs and resistance to move toward computerisation in their practices. Interestingly, this was rarely cited as a barrier to data collection by Divisions that *did not* meet their data collection thresholds. It is possible that Divisions that met their thresholds were more proactive in seeking out the information from practices in their catchment area compared to those that did not meet the thresholds.

Divisions that did not meet the threshold cited restrictions on the number of APCC practices in their area as a barrier, but this was seldom identified by Divisions that did meet their thresholds.

Practices' lack of resources was also cited as a reason for not collecting data, and this occurred across all Divisions, whether or not they met reporting thresholds.

Most Divisions undertook activities aimed at improving their data collection processes. They worked with practices to improve the quality of data that was entered into medical software and increased training on the use and value of the Canning and PEN CAT tools.

Discussion

Eighty-six percent of Divisions met their reporting thresholds at 12 months for four indicators (CDM 1, 2 3 and Prevention 4). Divisions were required to supply data collected from at least 80% of general practices for CDM 1, and 10% of GPs for CDM 2, 3, and Prevention 4.

The Prevention 4 NPI had the largest number of Divisions that did not meet the reporting threshold. Explanatory text showed that these Divisions relied on state based Cervical Screening registers that did not provide information on the number of GPs and practices on which data was based.

Practices that participated in the Australian Primary Care Collaboratives (APCC) Program provided clean data for Divisions' National performance indicators. However, while Divisions that did not meet their thresholds relied primarily APCC practices for data, typically, they had fewer APCC participating practices in their catchment area.

Divisions that did not meet the reporting thresholds were more likely to have a larger number of GPs, and less external funding. This finding suggests that Divisions in areas with a large GP workforce had more difficulty gathering sufficient data.

Divisions that did not meet the reporting thresholds also had practices with

- ⇒ less IM/IT capacity
- ⇒ greater need for technical assistance and support in terms of IM/IT and electronic data transfer.

However, the characteristics of Divisions that met or did not meet the reporting thresholds were on a continuum, rather than polarised. All faced similar challenges of practice capacity, technical problems related to practice software and data extraction tools and disinclination in some practices to use computerised systems and/or release patient level data.

Having identified baseline reporting levels, the challenge in 2010 will be the extent to which Divisions make efforts to improve the amount and quality of data that they collect from their practices and GPs for these NPIs.

Appendices

Appendix A ASD questions and NPI technical details

Questions from the ASD used for analysis

How many Primary Care Providers do you estimate were practising in your Division's catchment area at 30 June 2008?

Please estimate:

- Total estimated number of GPs practising in catchment
- How many were females?
- How many were GPs working in a corporate general practice?
- How many were international medical graduates (formerly OTDs)?
- How many practice nurses were practising in catchment?

What amount of external funding did your Division secure or receive, in addition to that provided by the Australian Government Department of Health and Ageing as core or Multi-Program Agreement (MPA) funding in the financial year 2007-08?

My Division currently uses the Information Management Maturity Framework (IMMF)? Yes/No

My Division intends to use the IMMF resource in the future:

- Annually as part of your business planning cycle
- On an ad hoc basis
- Not at all

Usefulness of IM/IT support and services provided to your Division by your state Based Organisation (SBO): Have you found the support and services of your State Based Organisation (SBO) to be useful in increasing your organisation's capacity in IM/IT? Yes/no

How does your Division manage and use information infrastructure in program delivery? My Division refers requests from general practice for technical support to vendors, local IT support services and other organisations. Yes/no

What IM/IT training did your practices seek from your Division and what activities did your Division undertake with practices? Divisions provided: Electronic data transfer (eg. the use of messaging software, broadband and security) yes/no

What IM/IT training did your practices seek from your Division and what activities did your Division undertake with practices? The Divisions delivered:

- Basic computer literacy training. Yes/no
- Support in accessing IM/IT Practice Incentives Program payments. Yes/no.

My Division participates in coordinated activities focusing on IM/IT with other Divisions on a regional, state, territory or national basis. Yes/no

DGPP CDM 1, 2 and 3 and Prevention 4 National Performance Indicators and technical details

FOCUS AREA	CHRONIC DISEASE MANAGEMENT		
INDICATOR	DGPP Chronic Disease Management 1 The number and proportion of general practices within the Division using electronic register/recall/reminder systems to identify patients with a chronic disease for review and appropriate action.		
RATIONALE	Register/recall/reminder systems are an important component of high quality chronic disease management, allowing practices to identify patients with chronic disease, recall them as required and ensure they are providing comprehensive patient care.		
REPORTING GUIDE	Divisions will need to enter the results into the results table and provide an explanation in response to the data results. Numerator: The number of general practices using a register/recall/reminder system (electronic and/or manual) to identify patients with a chronic disease for review and appropriate action. Denominator: The number of general practices within a Division.		
DATA SOURCE	Division records, practice visits, etc.		
GUIDE FOR DATA COLLECTION	Divisions must obtain data from <u>at least 80% of practices</u> in the Division. The following questions relate to the use of a practice-based system and are to be answered at practice level (not Division or pathology-based systems), even if the system is not currently used by all GPs in the practice. Standard National Questions Does the practice have at least one register/recall/reminder system to identify patients with a chronic disease? [Y] [N] If yes, are any of the register/ recall/ reminder systems electronic? [Y] [N] yes to Q1 and 2 , please indicate how many chronic diseases are represented on the electronic practice system(s).		
COMMENTS	For this indicator, Divisions should be aiming for general practices to have three (3) or more chronic diseases represented on an electronic practice register/recall/reminder system.		
ASSESSMENT GUIDE	In assessing the results for this indicator, the possible areas of improvement are: 1. an increase in the number of practices using electronic register/recall/reminder systems for chronic disease management; 2. an increase in the number of diseases represented on an electronic register/recall/reminder system; and 3. an increase in the number of practices providing data for this indicator.		
HISTORY	Version No	Date	Brief Description of Revision



DGPP Chronic Disease Management 1: Table 1: The number and proportion of general practices within the Division using practice register/recall/reminder systems to identify patients with a chronic disease for review and appropriate action. Reporting periods are 1 July 200X to 31 December 200X for 6 month reporting and 1 July 200X to 30 June 200X for 12 month reporting.

	Practices using <i>electronic</i> system	Practices using <i>manual</i> system	No register/ recall/ reminder system	Number of practices for whom data available	Total practices in the Division
Number					
Percent				100	N/A

DGPP Chronic Disease Management 1: Table 2: The number of chronic diseases represented using **electronic** practice register/recall/reminder systems. Reporting periods are 1 July 200X to 31 December 200X for 6 month reporting and 1 July 200X to 30 June 200X for 12 month reporting.

	1 chronic disease represented	2 chronic diseases represented	3 chronic diseases represented	>3 chronic diseases represented	Total number of practices using <i>electronic</i> system
Number of practices					
Percent					100
How were these data obtained?					
Explanation of results:					



FOCUS AREA	CHRONIC DISEASE MANAGEMENT		
INDICATOR	<p>DGPP Chronic Disease Management 2 The number of patients within the Division with diabetes whose last recorded HbA1c within the previous 12 months was:</p> <ul style="list-style-type: none"> • less than or equal to 7.0%; • greater than 7.0% but less than or equal to 8.0%; • greater than 8.0% but less than 10.0%; • greater than or equal to 10.0%; or • not recorded. 		
RATIONALE	<p>Glycaemic control is related to the risk of complications and can be influenced by good diabetes care. The level of 7.0% or less corresponds with guidelines and signifies good glycaemic control; more than 7.0% but less than 10.0% indicates impaired glycaemic control; 10.0% or more indicates poor glycaemic control.</p>		
REPORTING GUIDE	<p>Divisions will need to enter the results into the results table and provide an explanation in response to the data results.</p> <p>Numerator: The number of patients with diabetes whose HbA1c in the past 12 months was:</p> <ul style="list-style-type: none"> • less than or equal to 7.0%; • greater than 7.0% but less than or equal to 8.0%; • greater than 8.0% but less than 10.0%; • greater than or equal to 10.0%; or • not recorded. <p>Denominator: The total number of patients with diabetes.</p>		
DATA SOURCE	Division records, practice visits, Australian Primary Care Collaboratives, etc.		
GUIDE FOR DATA COLLECTION	Divisions must obtain data from <u>at least 10% of GPs</u> in the Division.		
COMMENTS	<p>For the purpose of this indicator, diabetes refers to diabetes type 1 and diabetes type 2. It does not refer to gestational diabetes mellitus (GDM), previous GDM, impaired fasting glucose or impaired glucose tolerance. As this indicator is shared with the APCC Program, if the APCC indicator changes, this indicator will also change.</p>		
ASSESSMENT GUIDE	<p>In assessing the results for this indicator, the possible areas of improvement are:</p> <ol style="list-style-type: none"> 1. an increase in the number of patients identified with diabetes; 2. an increase in patients with HbA1c recorded 3. an increase in the number of patients with good clinical results; and 4. an increase in the number of patients with the Aboriginal and Torres Strait Islander origin identified; and 5. an increase in the number of GPs providing data for this indicator. 		
HISTORY	Version No	Date	Brief Description of Revision



DGPP Chronic Disease Management 2: The number of patients within the Division with diabetes - last recorded HbA1c within the previous 12 months. Reporting periods are 1 July 200X to 31 December 200X for 6 month reporting and 1 July 200X to 30 June 200X for 12 month reporting.

Last recorded HbA1c levels within previous 12 months					
≤7.0%	>7.0% but ≤ 8.0%	>8.0% but <10.0%	≥10.0%	Not recorded	Total
All					
Number					
Percent					100
Aboriginal and Torres Strait Islander origin (numbers)					
Aboriginal and Torres Strait Islander origin					
Non- Aboriginal and Torres Strait Islander origin					
Origin not recorded					
How were these data obtained?					
What number and proportion of GPs in your Division contributed data for this indicator?					
Number:			Proportion:		
Explanation of results:					

FOCUS AREA	CHRONIC DISEASE MANAGEMENT		
INDICATOR	DGPP Chronic Disease Management 3 The number of patients within the Division with coronary heart disease whose last recorded blood pressure within the previous 12 months was less than or equal to 130/80 mmHg.		
RATIONALE	High blood pressure is a major risk factor for a range of cardiovascular diseases, including coronary heart disease. The risk of disease increases as the level of blood pressure increases.		
REPORTING GUIDE	Divisions will need to enter the results into the results table and provide an explanation in response to the data results. Numerator: The number of patients with coronary heart disease whose last recorded blood pressure within the previous 12 months was less than or equal to 130/80 mmHg. Denominator: The total number of patients with coronary heart disease.		
DATA SOURCE	Division records, practice visits, Australian Primary Care Collaboratives, etc.		
GUIDE FOR DATA COLLECTION	Divisions must obtain data from <u>at least 10% of GPs</u> in the Division.		
COMMENTS	For the purpose of this indicator, coronary heart disease is defined as current or past history of at least one of the following: myocardial infarction, unstable angina pectoris, angina, revascularisation as evidenced by angioplasty +/- stent, or coronary artery bypass surgery.		
ASSESSMENT GUIDE	In assessing the results for this indicator, the possible areas of improvement are: 1. an increase in the number of patients identified with coronary heart disease; 2. an increase in patients with blood pressure recorded; 3. an increase in the number of patients with good clinical results; and 4. an increase in the number of GPs providing data for this indicator.		
HISTORY	Version No	Date	Brief Description of Revision
	2	22/12/2008	Advising Divisions of changes to reporting for the Australian Primary Care Collaboratives Program and reporting options for the first 6 month reporting period.
	3	23/06/2009	Indicator for use in 2008-09 12 month report and in 2009-10 planning and reporting.



DGPP Chronic Disease Management 3: The number of patients within the Division with coronary heart disease whose last recorded blood pressure within the previous 12 months was less than or equal to 130/80 mmHg. Reporting periods are 1 July 200X to 31 December 200X for 6 month reporting and 1 July 200X to 30 June 200X for 12 month reporting.

	CHD patients whose last recorded blood pressure within the previous 12 months was less than or equal to 130/80 mmHg	CHD patients whose last recorded blood pressure within the previous 12 months was greater than 130/80 mmHg	Not recorded	Total
All				
Number				
Percent				100
How were these data obtained?				
What number and proportion of GPs in your Division contributed data for this indicator?				
Number: Proportion:				
Explanation of results:				



FOCUS AREA	PREVENTION		
INDICATOR	DGPP Prevention 4 The number and proportion of female patients aged 20-69 whose patient record shows that they have had a Pap smear during the previous two year period.		
RATIONALE	A Pap smear every two years can prevent the most common form of cervical cancer in up to 90% of cases and is a female's best protection against cervical cancer. ⁷		
REPORTING GUIDE	Divisions will need to enter the results into the results table and provide an explanation in response to the data results. Numerator: The number of female patients aged 20-69 years who have had a Pap smear in the last two years. Denominator: Total number of female patients aged 20-69 years.		
DATA SOURCE	Division records, practice visits, etc.		
GUIDE FOR DATA COLLECTION	Divisions must obtain data from <u>at least 10% of GPs</u> in the Division in the first year. It is expected that this proportion will increase over time. Or Divisions must obtain data from another source that has been negotiated on a State-wide basis with the Department.		
COMMENTS	Some women in this age group may not be required to have regular pap smears, such as those that have had a total hysterectomy.		
ASSESSMENT GUIDE	In assessing the results for this indicator, the possible areas of improvement are: 1. an increase in the number of female patients aged 20-69 having had a pap smear in the previous two years; and 2. an increase in the number of GPs providing data for this indicator.		
HISTORY	Version No	Date	Brief Description of Revision

DGPP Prevention 4: The number and proportion of female patients aged 20-69 whose patient record shows that they have had a Pap smear during the previous two year period.
Reporting periods are 1 July 200X to 31 December 200X for 6 month reporting and 1 July 200X to 30 June 200X for 12 month reporting

WOMEN AGED 20-69			
	Had a pap smear in the previous two years	Number not recorded as screened/not known	Total
Number			
Percent			100
How were these data obtained?			
What number and proportion of GPs in your Division contributed data for this indicator?			
Number:	Proportion:		
Explanation of results:			

Appendix B Data

Results related to Divisions' engagement in programs and service delivery

Table 4 Divisions' intended method of future engagement with the IMMF, by achievement/non-achievement of reporting thresholds

	Did not meet the threshold on all indicators		Met the threshold on all indicators	
	Number	Percent	Number	Percent
Annually, as part of business planning cycle	13	52%	53	62%
Ad hoc basis	11	44%	23	27%
Not at all	1	4%	10	12%
Total	25	100%	86	100%

Note: Due to rounding errors, numbers may not add up to 100%.

Table 5 Achievement of the indicators' threshold, by referral of general practices to information technology providers for assistance

	Did not meet the threshold on all indicators		Met the threshold on all indicators	
	Number	Percent	Number	Percent
Did not refer requests from general practice	11	44%	20	23%
Referred requests from general practice	14	56%	66	77%
Total	25	100%	86	100%

Note: Due to rounding errors, numbers may not add up to 100%.

Table 6 Achievement of the indicators' threshold, by provision of technical assistance to general practices

	Did not meet the threshold on all indicators		Met the threshold on all indicators	
	Number	Percent	Number	Percent
Did not provide technical assistance	10	40%	49	57%
Provided technical assistance	15	60%	37	43%
Total	25	100%	86	100%

Note: Due to rounding errors, numbers may not add up to 100%.



Table 7 Achievement of the indicators' threshold, by requests for IM/IT support from general practices

	Did not meet the threshold on all indicators		Met the threshold on all indicators	
	Number	Percent	Number	Percent
Practices did not request IM/IT support	7	28%	36	42%
Practices requested IM/IT support	18	72%	50	58%
Total	25	100%	86	100%

Table 8 Achievement of the indicators' threshold, by provision of technical assistance to general practices

	Did not meet the threshold on all indicators		Met the threshold on all indicators	
	Number	Percent	Number	Percent
Practices did not request support with EDT	1	4%	16	19%
Practices requested support with EDT	24	96%	70	81%
Total	25	100%	86	100%