
# Development of the first National Performance Indicators for Divisions of General Practice – Research Policy Interface in Action

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# The landscape – System 'Quality'

- General practice
  - RACGP Practice Accreditation
  - Divisions of General Practice – National Quality and Performance System (NQPS)
- States/Territories
  - Community health indicators
- Aboriginal Community Control Health Services
  - SAR
- National Health Performance Framework
- AIHW's Rural, Regional and Remote Health

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# Divisions of General Practice

- Voluntary geographic alliances of GPs
- 119
- 8 – 730 GPs
- $100 million pa Commonwealth funding
  - Support GPs/practices
  - Improve access to GP services
  - Encourage integration and multi-disciplinary care
  - Focus on prevention and early intervention
  - Better manage chronic conditions
  - Support quality and evidence-based care
  - Ensure growing consumer focus

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# Policy drivers

- Increase in demand for accountability in public policy
- Rise in evidence base for good practice
- Evidence of variability
- Review of Divisions Program (2003)
- Government Response to the Review (2004)
- → NQPS - demonstration to the parliament and stakeholders of value for money

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# Elements of NQPS

- Accreditation
- Performance indicators
- Learning reviews

- Development support
- Earned autonomy
- Performance and Development Funding Pool

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# Conceptual approach - CQI

*"CQI implies a continual process of self-examination, a never-ending search for improvement without a final destination"*

CQI:

- works at improving organisational structures and procedures
- uses/expands on QA activities such as accreditation
- outcome measurement increasingly important ~ measuring performance against clinical indicators
- considered best to have a mix of structure, process and outcome

http://qic.binaryblue.com.au/publications.html

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# Conceptual Approach - CQI

- Continuous quality improvement @ 2 levels
  - Divisions
  - General practices
- Implications for feedback loops
  - Government with Divisions
  - Divisions with general practices
- Implications for improvement mechanisms
  - Government with Divisions
  - Divisions with general practices

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# Initial Stages

- Earlier work → advice on a way forward
  - Advice accepted
  - Proposed framework endorsed
  - Method agreed
  - Costing accepted
  - Arrangements expedited

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# Indicator Development Process

- Hand-picked expert team
- Initial teleconference
- Draft indicators
- National consultation, stakeholders workshop, review by the RIC
- Revision of indicators
- National consultation, review by the RIC and DoHA, expert reviewers
- Revision, review by DoHA
- Finalisation

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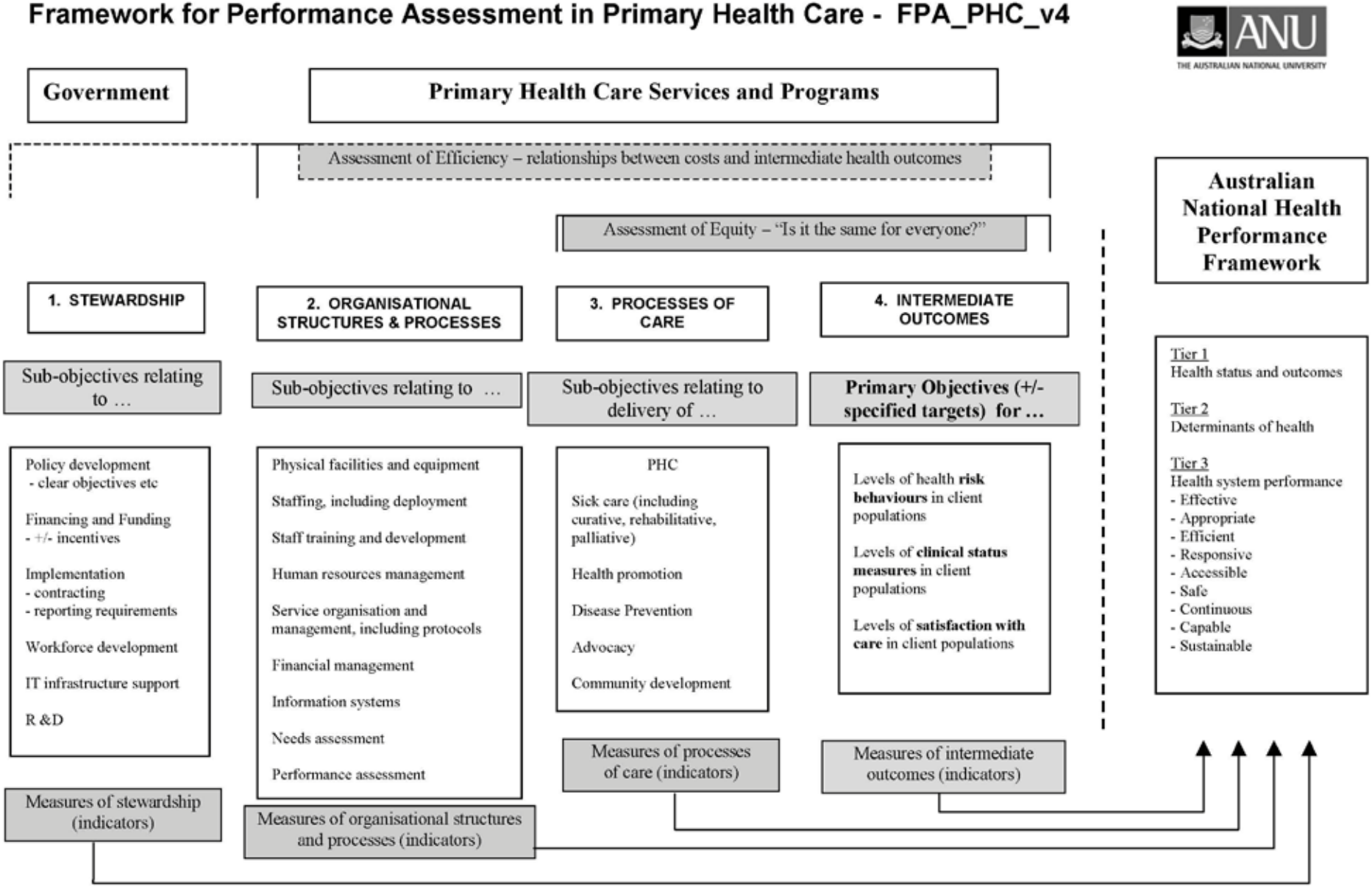
# Conceptual approach - FPA_PHC

Framework *(Sibthorpe 2005 – see APHCRI website)*

- Objectives-based
- Patient-focused
- Indicators at 4 levels
  - § Stewardship
  - § Organisational structures and processes – general practices
  - § Processes of care for patients
  - § [Intermediate] Outcomes for patients

# Framework for Performance Assessment in Primary Health Care - FPA_PHC_v4




**Beverly Sibthorpe, Australian Primary Health Care Research Institute, 2004.** http://www.anu.edu.au/aphcri/Publications/conceptual_framework.pdf

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# Framework adapted for NQPS

| Level 1<br>Organisational structures and processes - Divisions | Level 2<br>Organisational structures and processes – general practices/GPs | Level 3<br>Processes of care for patients, families and communities | Level 4<br>(Intermediate) Outcomes for patients, families and communities |
|---|---|---|---|
| | | §Sick care<br>§Health promotion<br>§Disease prevention<br>§Advocacy<br>§Community development | §Risk behaviours<br>§Clinical status<br>§Patient satisfaction |

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# Indicator Development
## ~ Program ~

| | |
|---|---|
| Dr John Aloizos | Immunisation |
| Dr Denise Ruth | Residential aged care |
| Mr Gawaine Powell-Davies<br>for Centre for GP Integration Studies | GP-hospital integration<br>Diabetes |
| Professor Jeffrey Richards | Mental health |
| Professor Nicholas Glasgow | Asthma |
| Associate Professor Libby Kalucy<br>for Primary Health Care Research and Information Service | Divisions reporting |
| Mr John Glover<br>for Population Health Information Development Unit | Population health mapping |
| Mr Bob Wells | Policy and strategy |
| Dr Beverly Sibthorpe | Team leader, framework |
| Mr Duncan Longstaff | Project officer |

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# Internal partnership

- Enthusiasm for the task
- Understanding of policy context
- Understanding of Divisions
- Acceptance of the framework
- Commitment to the whole, not domain
- Willingness to compromise
- Willingness to work to ‘get it right’

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# Indicators – Governance & Program

| | | Level 1 | Level 2 | Level 3 | Level 4 |
|---|---|---|---|---|---|
| Governance | 8 | 8 | | | |
| Immunisation | 6 | 2 | 3 | 1 | |
| Residential Aged Care | 7 | 3 | 2 | 1 | 1 |
| GPs and Hospitals | 4 | 2 | 2 | | |
| CD – Diabetes | 9 | 5 | 1 | 1 | 2 |
| Mental health | 9 | 5 | 2 | 1 | 1 |
| Asthma | 9 | 5 | 2 | 1 | 1 |
| Totals | 44 | 22 | 12 | 5 | 5 |

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# Indicator Development
## ~ Governance ~

- Working group
- 2-day workshop facilitated by Elizabeth Jameson, Board Matters Pty Ltd (Divisions network, Department, other stakeholders)
- All compulsory ~ progress 2005-2008
- Goal is accreditation
- Accreditation = greatly reduced reporting: 9 ➡ 2

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# Objectives

- Divisions will support general practices/GPs to provide optimal care and contribute to the achievement of the best possible health outcomes for patients with diabetes.

- Divisions will support general practices/GPs to provide early intervention and optimal care and contribute to the achievement of the best possible health outcomes for patients with mental health disorders, and assist in the reduction of the impact of mental disorder on individuals, families and communities, in collaboration with other mental health services as appropriate.

- Divisions will support general practices/GPs to provide optimal care and contribute to the achievement of the best possible health outcomes for patients with asthma.

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# Indicator Development
## ~ Program ~

- Guideline & evidence-based
- Support Government policies/programs
- Two rounds of consultation
- National/international expert review
- 100+ pages of feedback
- Collated, reviewed, incorporated into final version

# Organisational structures and processes

*Level 1 – All*

- Collaborate regionally to provide access to optimal care
- Support GPs to provide optimal care
- Facilitate access to CPD
- Receive electronic patient data (registers) from GPs to provide feedback
- Support GPs to capture Aboriginal and Torres Strait Islander origin

*Level 2 – All*

- Practice use of register/recall/reminder systems

*Level 2 – mental health*

- GP training

*Level 2 – Asthma*

- Access to spirometry

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# Level 3 - Processes of care

- Diabetes
  - Number of SIPs / estimated population with diabetes
- Mental health
  - Number of 3-step mental health plans / estimated population to benefit
- Asthma
  - Number of patients with asthma on register with smoking status recorded

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# Level 4 – outcomes for patients

- Diabetes *(clinical status)*
  - HbA1c levels
  - Cholesterol levels
- Mental health *(patient satisfaction)*
  - Registered 3-step mental health plan patients – understand condition, feel able to participate in management
- Asthma *(risk behaviour)*
  - Smoking among registered patients with asthma

**Priority Area: MANAGE CHRONIC DISEASE**
**Domain: DIABETES**

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**Objective**: Divisions will support general practices/GPs to provide optimal care and contribute to the achievement of the best possible health outcomes for patients with diabetes.
**Rationale**: Sustained improvements in health outcomes for people with chronic diseases such as diabetes have been associated with a more systematic approach in general practice including intensive follow up, use of clinical management guidelines integrated with self-management support programs and more effective use of nurse case managers and non-physician care providers. Systematic care includes having a disease register, regular recall and review, protected time, a practice nurse, clear written guidelines and a system for auditing standards of care. Supporting chronic disease care is a core role of Divisions.

| Level 1<br>Divisions<br>(Organisational Structures/Processes - Programs) | Level 2<br>General Practices/GPs<br>(Organisational Structures/Processes - Programs) | Level 3<br>Processes of Care for Patients, Families, Communities | Level 4<br>Intermediate Outcomes for Patients, Families, Communities |
|---|---|---|---|
| **N_DIA 1.1** Division collaborates with other organisations, service providers and consumer/carer groups to facilitate patient access to optimal diabetes care.<br>**2 points (compulsory)**<br><br>**N_DIA 1.2** Division takes a systematic approach to support general practices/GPs to provide optimal diabetes care.<br>**2 points (compulsory)**<br><br>**N_DIA 1.3** Division facilitates access to effective Continuing Professional Development (CPD) for diabetes care.<br>**2 points**<br><br>**N_DIA 1.4** Number and proportion of GPs from whom the Division is receiving electronic patient records to provide feedback for quality improvement in diabetes care.<br>**20 points**<br>**plus bonus points from 2006-07**<br><br>**N_DIA 1.5** Division takes a systematic approach to support general practices/GPs to consistently capture and record Aboriginal and Torres Strait Islander origin for patients with diabetes on the practice register/recall/ reminder systems.<br>**2 points (compulsory)** | **N_DIA 2.1** Number and proportion of general practices using a practice register/recall/reminder system to identify patients with diabetes for review and appropriate action.<br>**4 points (compulsory)**<br>**plus bonus points from 2006-07**<br>**>xx% of practices = 2 points**<br>**>xx% of practices = 4 points** | **N_DIA 3.1** Number of service incentive payments (SIPs) made to GPs practicing in the Division's area compared to the estimated population in the Division's area with diabetes.<br>**8 points (compulsory)**<br>**plus bonus points from 2006-07**<br>**>xx% = 4 points**<br>**>xx% = 8 points** | **N_DIA 4.1** Number and proportion of patients with diabetes on practice register/recall/reminder systems whose most recent HbA1c in the past 12 months was:<br>• 7.0% or less;<br>• more than 7% but less than 10.0%;<br>• 10.0% or more;<br>• not measured.<br>**20 points**<br>**plus bonus points from 2006-07**<br>**xx = 10 points**<br>**xx = 20 points**<br><br>**N_DIA 4.2** Number and proportion of patients with diabetes on practice register/recall/reminder systems whose most recent total cholesterol in the past 12 months was:<br>• less than 4.0 mmol/L;<br>• 4.0 mmol/L or more;<br>• not measured.<br>**20 points**<br>**plus bonus points from 2006-07**<br>**xx = 10 points**<br>**xx = 20 points** |

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# Technical Details

- Rationale
- Type of indicator
- Data required
- How data will be obtained
- Data coding
- How to calculate the measure
- How to report the result
- Data quality assurance processes
- Characteristics of Divisions for comparisons

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# Example 1 – Qualitative data

| **N_IMM 1.1** | |
|---|---|
| Method of calculation of the indicator | Half page description of a significant achievement[#] resulting from collaborations with other organisations, service providers and consumer/carer groups, for example, public health services, local councils, Aboriginal Community Controlled Health Services, other vaccine service providers, consumer/carer groups.<br>Description need not exceed half a page and must follow the format of aim, actions taken and outcomes.<br>**N_IMM 1.1 Significant Achievement**<br>**Aim:**<br>**Actions Taken:**<br>**Outcomes:** |
| Comments | [#] Significant achievement must not be previously reported in earlier financial years or against other indicators in this financial year. However, it might be related to substantial progress made with a significant achievement reported in a previous financial year. |

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# Example 2 – Quantitative data

- N_DIA 4.1 Number and proportion of patients with diabetes whose most recent HbA1c in the past 12 months was:
  - 7.0% or less;
  - more than 7% but less than 10.0%;
  - 10.0% or more;
  - not measured.

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# Example 2 – Quantitative data

| | |
|---|---|
| Numerator | Number of patients whose HbA1c in the past 12 months was:<br>· 7.0 or less<br>· more than 7 but less than 10.0<br>· 10.0 or more;<br>· not measured / not recorded |
| Source of numerator data | Practice register/recall/reminder systems |
| Data coding (if applicable) | HbA1c level (continuous data)<br>0 “not measured/not known” |
| Denominator | Number of patients with diabetes on the practice register/recall/reminder systems |
| Source of denominator data | Practice register/recall/reminder systems |
| Data coding (if applicable) | N/A |
| Mechanism for indicator data transfer to collation agency | Paper or electronic data transfer from practices to Divisions<br>Report to DoHA |
| Method of calculation of the indicator | Numerator<br>Numerator in each category divided by the denominator and multiplied by 100<br>Explanatory text for the result may be provided |
| Timing of reporting | Six-Month Progress Report<br>Annual Report |
| Disaggregation (equity) | Patient data disaggregated by Aboriginal and/or Torres Strait Islander origin and age |
| Comments | * For the Division to report against this indicator, 5% or more of GPs must participate. |

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# Example 2 – Quantitative data

Table N_DIA 4.1 Last measured HbA1c levels among patients with diabetes, all, Aboriginal and Torres Strait Islander origin and age, [insert Division name], [insert date - month and year]

| | | 7.0% or less | > 7 but < 10.0% | 10.0% or more | Not measured / not recorded | Total number of patients |
|---|---|---|---|---|---|---|
| | | | | | | |
| All | Number | | | | | |
| | Percent | | | | | *100* |
| ATSI origin | Number | | | | | |
| | Percent | | | | | *100* |
| Age <35 | Number | | | | | |
| | Percent | | | | | *100* |
| 35-44 | Number | | | | | |
| | Percent | | | | | *100* |
| 45-54 | Number | | | | | |
| | Percent | | | | | *100* |
| 55-64 | Number | | | | | |
| | Percent | | | | | *100* |
| 65-74 | Number | | | | | |
| | Percent | | | | | *100* |
| 75+ | Number | | | | | |
| | Percent | | | | | *100* |

Explanatory Text:

What number and proportion of GPs in your Division contributed data for this indicator?
Number: Proportion:

What number and proportion of those GPs provided the data to you using electronic patient records?
Number: Proportion:

How complete is general practice/GP capture of Aboriginal and Torres Strait Islander origin in these data?
Very good ÿ
Good ÿ
Fair ÿ
Poor ÿ
Don't know ÿ
Comment:

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# Points and Targets

- N_DIA 2.1 Number and proportion of general practices using a practice register/recall/reminder system to identify patients with diabetes for review and appropriate action. 4 points (compulsory)

Plus bonus points from 2006-07

- >xx% of practices = 2 points
- >xx% of practices = 4 points

- 2005-2006 - points for reporting
  - Ease network into system
  - No empirical basis for targets

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# Equity

- Indicator-level (Aus) rather than policy-level (NZ)
- Divisions PI analyses will take account of:
  - Differences between Divisions
    - state, geographic size, number of GPs, income, Index of Relative Social Disadvantage, proportion of population ATSI origin
  - Differences among patients:
    - age, sex, ATSI origin, language spoken at home

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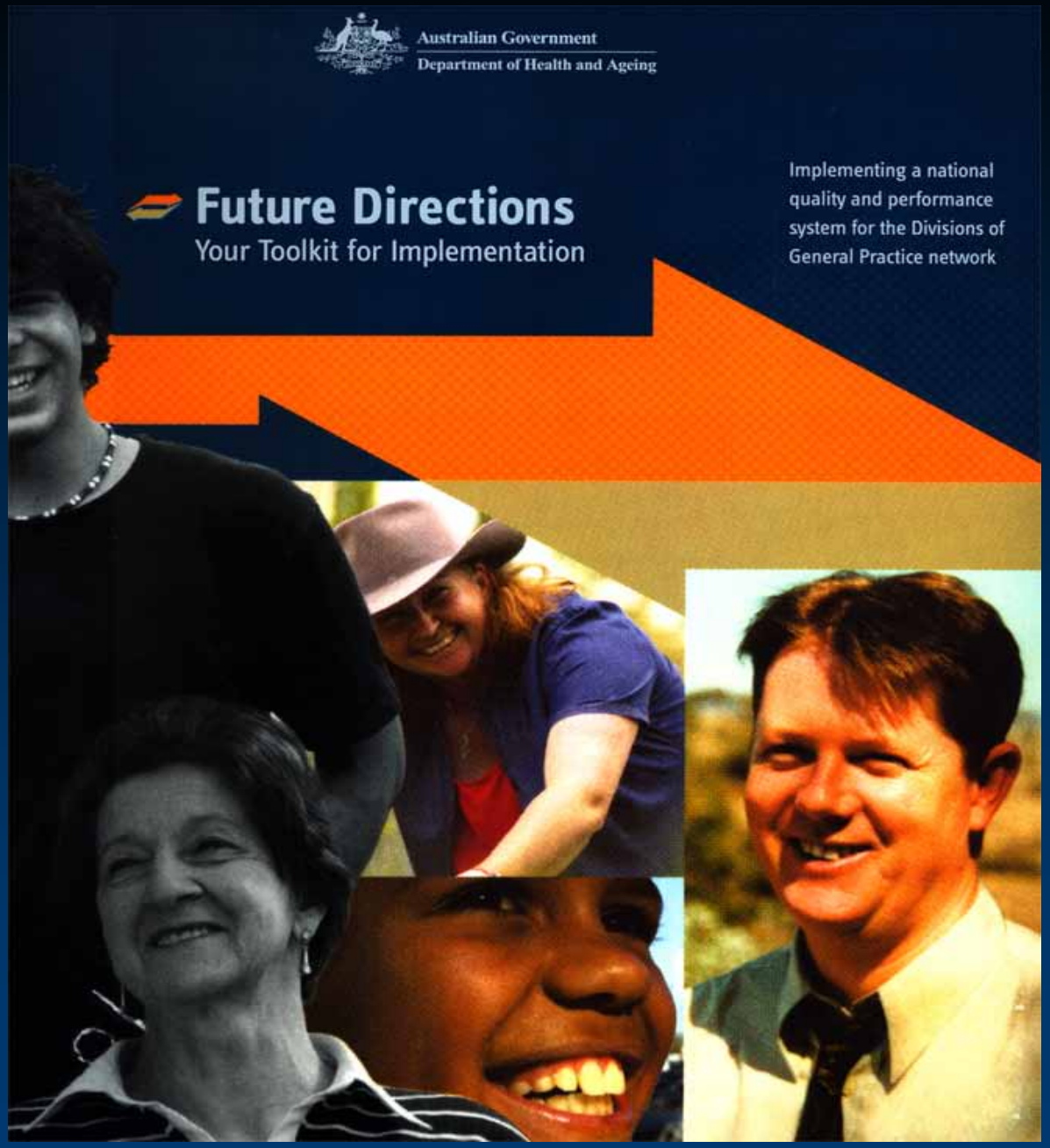

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# Information System to Support Electronic Level 3/4 Reporting

- Choose to participate 2005-2008
- Off-the-shelf information system to support GPs/ practices
- Build on existing systems & capacity
- Value-adding through national analysis, interpretation and feedback to Divisions
- IM/IT development and support for participating practices and Divisions

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# System Under Development

- Validity of performance of indicators assessed
- Targets developed
- Characteristics of Divisions for comparisons (e.g. rurality) refined
- Other data requirements reviewed
- Approaches to analysis and interpretation refined
- Mechanisms for feedback to Divisions (e.g. web based) developed, tested and refined

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# Initial Conditions for Partnership

- DoHA
  - Clear policy direction
  - Specific policy imperative
  - Confidence in what was being proposed
  - Tight timeframe
- APHCRI
  - Understanding of policy context
  - Understanding of policy imperative
  - “Ownership’ of framework
  - Enthusiasm to proceed

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# Development of the Partnership (1)

- Growing confidence in the work
- Responsiveness
- Wider adoption of the framework
- Inclusion in related work
- Input to related decisions
- Joint presentation in key forums
- Opportunity to present to RIC

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# Development of the Partnership (2)

- Joint implementation ‘road show’
- Shared media
- Joint posting on web-site
- ‘System under development’