



**Australian Government**  

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**Department of Health and Ageing**

## **DIVISIONS OF GENERAL PRACTICE PROGRAM**

**National Performance Indicators  
2008-09**

**Revised as at 22 December 2008**

## DOCUMENT HISTORY

This table is to record the document's history as major changes are made. As each version is drafted and submitted, the version number and changes made will be appropriately recorded.

<b>Version No.</b>	<b>Date</b>	<b>Description of Revision</b>
0.1	21 May 2008	User Guide Created
0.2	August 2008	Changes to DGPP Uptake of National Initiatives 2
0.3	22 December 2008	Changes to: <ul style="list-style-type: none"><li>- DGPP Prevention 1</li><li>- DGPP Chronic Disease Management 3</li><li>- DGPP Uptake of National Initiatives 1</li><li>- DGPP Prevention (SBO) 1</li><li>- DGPP Uptake of National Initiatives (SBO) 1</li><li>- DGPP Uptake of National Initiatives (SBO) 2</li></ul>

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## 1. INTRODUCTION

The National Performance Indicators (NPIs) are a major component of the National Quality and Performance System. They reflect expectations of the Divisions network and are central to capturing both national information and local information on the performance of Division network members in key health areas.

The NPIs reflect Government expectations of the Divisions network and assist Divisions network members to measure their progress and improve planning processes. Data derived from the NPIs are aggregated to provide better information with respect to a national picture of achievements and impact, and evidence of the contribution of Divisions to communities. The NPIs also form a transparent basis to identify and measure the performance of the Divisions network members.

The NPIs, which also include local performance indicators, align with the Divisions network Core Requirements as defined under the Divisions of General Practice Program. They are measurable and outcomes focussed rather than assessing the activities or process undertaken by the Divisions network. Where possible, the indicators have external data sources, and Division network members will be required to provide an explanation of the particular results in their Six and Twelve Month Reports.

The compulsory NPIs capture data from four Focus Areas. These are:

- Access;
- Prevention;
- Chronic Disease Management; and
- Uptake of National Initiatives.

Indicators in the Focus Area ‘Uptake of National Initiatives’ may change over time to reflect new Government initiatives and programs as they are introduced.

All NPIs are compulsory and Division network members’ performance will be partly assessed by the completeness of indicator information in Six and Twelve Month Reports, as well as achievements and progress made against previous results. Division network members are also required to develop a compulsory local performance indicator to be set for the full funding period. The local performance indicators are designed to recognise the local issues and impact Divisions have on the health of their communities.

Technical details have been developed to assist Division network members to report against the NPIs. They explain the indicator itself, outline the rationale behind the indicator and describe the mechanism by which Divisions report against the indicator. In addition the technical details provide an assessment guide against which Divisions’ performance will be measured.

Divisions and SBOs must refer to the technical details when reporting against the National Performance Indicators. Technical details for the AGPN are being updated and will be available in a separate document.

## 2. DIVISIONS OF GENERAL PRACTICE

### Access

<b>FOCUS AREA</b>	<b>ACCESS</b>		
<b>INDICATOR</b>	<b>DGPP Access 1</b> The number and proportion of PIP practices within the Division claiming <b>practice nurse</b> services.		
<b>RATIONALE</b>	Practice nurses assist GPs by contributing to a range of services, including chronic disease management and population health activities. It is anticipated that increased capacity in general practice provided by using the services of nurses will improve the quality and accessibility of primary care for patients, particularly those with chronic disease and/or complex conditions. <sup>1</sup>		
<b>REPORTING GUIDE</b>	Divisions will need to enter the results into the results table and provide an explanation in response to the data results.  <b>Numerator:</b> The number of PIP practices claiming practice nurse services within a Division.  <b>Denominator:</b> The number of PIP practices within a Division.		
<b>DATA SOURCE</b>	<b>Numerator:</b> Medicare Australia – MBS items 10993-10999. Medicare Australia – PIP data.  <b>Denominator:</b> Medicare Australia – PIP data.		
<b>GUIDE FOR DATA COLLECTION</b>	The Department will source the data and provide to the Divisions network.		
<b>COMMENTS</b>	MBS Item 10997 also applies to services provided by an Aboriginal Health Worker, but will be counted for the purposes of this indicator.  The number of non-PIP practices claiming practice nurse services is not available, however the number of practice nurse services claimed by non-PIP practices will be collected and incorporated into the results table.		
<b>ASSESSMENT GUIDE</b>	In assessing the results for this indicator, the possible areas of improvement are: 1. an increase in the number of PIP practices claiming practice nurse services; and 2. an increase in the number of practice nurse services being claimed.		
<b>HISTORY</b>	<b>Version No</b>	<b>Date</b>	<b>Brief Description of Revision</b>

<sup>1</sup> Australian Government Department of Health and Ageing, 2006, Guidelines for the Divisions Network Nursing in General Practice Program. Available at:  
<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pcd-prog-guidelines-nursing-genprac-health-pcd-prog-guidelines-nursing-genprac-pta+>

**DGPP Access 1**

The number and proportion of PIP practices within the Division claiming practice nurse services [*Jul-Dec 200X*  
*OR Jul 200X-Jun 200X*].

	<b>PIP practices claiming practice nurse services within the Division (MBS items 10993 – 10999)</b>	<b>Total number of PIP practices within Division</b>	<b>Practice nurse services claimed by PIP practices within the Division (MBS items 10993 – 10999)</b>
<b>Number</b>			
<b>Percent</b>		100	
In addition, a further _____ practice nurse claims were made by non-PIP practices.			
<b>Explanation of results:</b>			

<b>FOCUS AREA</b>	<b>ACCESS</b>		
<b>INDICATOR</b>	<b>DGPP Access 2</b>  The number of <b>health checks</b> and <b>health assessments</b> provided to patients of Aboriginal and/or Torres Strait Islander origin by general practitioners within the Division (compared to the estimated population in the area who could benefit from the health check).		
<b>RATIONALE</b>	Health checks are provided to ensure that Aboriginal and Torres Strait Islander people receive the optimum level of health care by encouraging prevention, early detection, diagnosis and intervention for common and treatable conditions that cause considerable morbidity and early mortality. <sup>2</sup>		
<b>REPORTING GUIDE</b>	Divisions will need to enter the results into the results table and provide an explanation in response to the data results.  <b>Numerator:</b> The number of health check and health assessment services provided to patients of Aboriginal and Torres Strait Islander origin.  <b>Denominator:</b> The estimated Aboriginal and/or Torres Strait Islander population in Division.		
<b>DATA SOURCE</b>	<b>Numerator:</b> Medicare Australia - MBS Items 704, 706, 708 and 710.  <b>Denominator:</b> Australian Bureau of Statistics (ABS).		
<b>GUIDE FOR DATA COLLECTION</b>	The Department will source the data and provide to the Divisions network.		
<b>COMMENTS</b>	<ul style="list-style-type: none"> <li>• A child health check (MBS Item 708) may be undertaken for an Aboriginal and/or Torres Strait Islander person who is 0 to 14 years of age (inclusive).</li> <li>• An adult health check (MBS Item 710) may be undertaken for an Aboriginal and/or Torres Strait Islander person between 15 years and 54 years of age (inclusive).</li> <li>• A health assessment (MBS Items 704 and 706) may be undertaken for an Aboriginal and/or Torres Strait Islander person who is at least 55 years old.</li> </ul> <p>Frequency of health checks:</p> <ul style="list-style-type: none"> <li>• A child health check may be provided every 9 months.</li> <li>• An adult health check may be provided every 18 months.</li> <li>• A health assessment (55 years and over) may be provided every 12 months.</li> </ul>		
<b>ASSESSMENT GUIDE</b>	In assessing the results for this indicator, the possible area of improvement is an increase in the number or proportion of Indigenous people who have had a health check.		
<b>HISTORY</b>	<b>Version No</b>	<b>Date</b>	<b>Brief Description of Revision</b>

<sup>2</sup> Australian Government Department of Health and Ageing. Medicare Benefits Schedule Book, 2007.

**DGPP Access 2**

The number of health checks/health assessments provided to patients of Aboriginal and/or Torres Strait Islander origin by general practitioners within the Division (compared to the estimated population in the area who could benefit from the health check) [Jul-Dec 200X OR Jul 200X-Jun 200X].

	Patients of Aboriginal and Torres Strait Islander Origin			Estimated Aboriginal and Torres Strait Islander Population in the Division		
	Child health checks (708)	Adult health checks (710)	Health assessments (55 years and over) (704 or 706)	Children	Adults	Adults 55 years and over
<b>Number</b>						
<b>Percent</b>				100	100	100
<b>Explanation of results:</b>						

## Prevention

<b>FOCUS AREA</b>	<b>PREVENTION</b>		
<b>INDICATOR</b>	<b>DGPP Prevention 1</b> The number of <b>45-49 year old health checks</b> provided to at-risk patients within the Division (compared to the total population aged 45-49 years in the Division)		
<b>RATIONALE</b>	One of the priority areas for the Australian Better Health Initiative (ABHI) is to encourage GPs to undertake a health check for a patient between 45 and 49 years of age (inclusive) who is at risk of developing a chronic disease. The aim of the health check is to assist with detection and prevention of chronic disease and enable early intervention strategies to be put in place where appropriate. <sup>3</sup>		
<b>REPORTING GUIDE</b>	Divisions will need to enter the results into the results table and provide an explanation in response to the data results.  <b>Numerator:</b> The number of 45-49 year old health checks provided to at-risk patients by GPs within the Division.  <b>Denominator:</b> The number of 45-49 year olds in the Division.		
<b>DATA SOURCE</b>	<b>Numerator:</b> Medicare Australia –MBS item 717.  <b>Denominator:</b> Australian Bureau of Statistics (ABS).		
<b>GUIDE FOR DATA COLLECTION</b>	The Department will source the data and provide to the Divisions network.		
<b>COMMENTS</b>	For the purposes of MBS item 717, ‘at-risk’ means: a patient must be at risk of developing a chronic disease. Specific risk factors include: <ul style="list-style-type: none"> <li>• lifestyle risk factors such as smoking, physical inactivity, poor nutrition or alcohol misuse;</li> <li>• biomedical risk factors, such as high cholesterol, high blood pressure, impaired glucose metabolism or excess weight; or</li> <li>• family history of a chronic disease.<sup>4</sup></li> </ul>		
<b>ASSESSMENT GUIDE</b>	In assessing the results for this indicator, the possible area of improvement is an increase in the number of 45-49 year old health checks.		
<b>HISTORY</b>	<b>Version No</b>	<b>Date</b>	<b>Brief Description of Revision</b>
	2	22/12/2008	Changed denominator to the number of 45-49 year olds in the Division given that most of the population in this age group would have one of these risk factors.

<sup>3</sup> Australian Government Department of Health and Ageing. Medicare Benefits Schedule Book, 2007.

<sup>4</sup> Ibid.

**DGPP Prevention 1**

The number of 45-49 year old health checks provided to at-risk patients by GPs within the Division [*Jul-Dec 200X OR Jul 200X-Jun 200X*].

	<b>45-49 year old health checks (MBS item 717)</b>	<b>Population of 45-49 year olds in the Division</b>
<b>Number</b>		
<b>Percent</b>		100
<b>Explanation of results:</b>		

<b>FOCUS AREA</b>	<b>PREVENTION</b>		
<b>INDICATOR</b>	<b>DGPP Prevention 2</b>		
	The average childhood <b>immunisation</b> coverage rate for the 60 to <63 months age group within the Division.		
<b>RATIONALE</b>	<p>The Immunise Australia Program has increased national immunisation coverage rates and has helped reduce the incidence of vaccine preventable diseases in the community. In order to achieve a level of immunity necessary to interrupt the spread of vaccine-preventable diseases, vaccine coverage rates need to exceed 90%<sup>5</sup>.</p> <p>Immunisation coverage rates for the 72 months old age group are considerably lower than those of the 12 to 24 months age group<sup>6</sup>. It is opportunistic to target those children at the 60 to &lt; 63 months age group to maximise immunisation coverage rates.</p>		
<b>REPORTING GUIDE</b>	Divisions will need to enter the results into the results table and provide an explanation in response to the data results.		
<b>DATA SOURCE</b>	Medicare Australia – Australian Childhood Immunisation Register (ACIR).		
<b>GUIDE FOR DATA COLLECTION</b>	The Department will source the data and provide to the Divisions network.		
<b>COMMENTS</b>			
<b>ASSESSMENT GUIDE</b>	In assessing the results for this indicator, the possible area of improvement is an increase in the coverage rate for this age group.		
<b>HISTORY</b>	<b>Version No</b>	<b>Date</b>	<b>Brief Description of Revision</b>

#### **DGPP Prevention 2**

The average childhood immunisation coverage rates for the 60 to <63 months age group within the Division [Jul-Dec 200X OR Jul 200X-Jun 200X].

	<b>Average coverage rate for the 60 to &lt;63 months age group within the Division</b>
	<b>%</b>
<b>Percentage</b>	
<b>Explanation of results:</b>	

<sup>5</sup> Australian Institute of Health and Welfare. A Picture of Australia's Children. AIHW: Canberra, 2005.

<sup>6</sup> Ibid.

<b>FOCUS AREA</b>	<b>PREVENTION</b>		
<b>INDICATOR</b>	<b>DGPP Prevention 3</b>		
	The number and proportion of electronic transfers of childhood <b>immunisation</b> data received by the Australian Childhood Immunisation Register (ACIR).		
<b>RATIONALE</b>	<p>The ACIR records details of vaccinations given to children under the age of seven who live in Australia, helping Australian parents to ensure that their children grow up healthy and are fully immunised. Health professionals also use the ACIR to monitor immunisation coverage levels, service delivery and disease outbreaks.</p> <p>The ACIR allows for both electronic and manual transmission of immunisation data. An increase in the level of electronic transfers will demonstrate an efficient and timely data exchange of immunisation records.</p>		
<b>REPORTING GUIDE</b>	<p>Divisions will need to enter the results into the results table and provide an explanation in response to the data results.</p> <p><b>Numerator:</b> The number of electronic childhood immunisation encounters received by the ACIR for this age group.</p> <p><b>Denominator:</b> The total number of encounters (electronic and manual) for the Division.</p>		
<b>DATA SOURCE</b>	Medicare Australia – Australian Childhood Immunisation Register (ACIR).		
<b>GUIDE FOR DATA COLLECTION</b>	The Department will source the data and provide to the Divisions network.		
<b>COMMENTS</b>	<p>For the purposes of this indicator, electronic transfers means anything not processed manually. The data will apply at the encounter level on the date of processing by Medicare Australia.</p> <p>Therefore, for the purposes of this indicator and for consistency reasons, data about each vaccination visit (or encounter) received by the ACIR electronically will be counted as one electronic transfer of childhood immunisation data.</p> <p>NB. Most QLD childhood immunisation data are transferred electronically to ACIR by VIVAS and most NT data are transferred electronically to ACIR by NT Health.</p>		
<b>ASSESSMENT GUIDE</b>	In assessing the results for this indicator, the possible area of improvement is an increase in the number of electronic transfers of immunisation data to ACIR.		
<b>HISTORY</b>	<b>Version No</b>	<b>Date</b>	<b>Brief Description of Revision</b>
	2	22/12/2008	Changed date of claim to date of processing by Medicare Australia due to timing issues with obtaining date of claim data..

**DGPP Prevention 3**

The number and proportion of electronic transfers of childhood immunisation data received by the Australian Childhood Immunisation Register (ACIR) [*Jul-Dec 200X OR Jul 200X-Jun 200X*].

	<b>CHILDHOOD IMMUNISATION DATA RECEIVED BY ACIR</b>	
	<b>Electronic transfers</b>	<b>Total number of transfers (electronic and manual)</b>
<b>Number</b>		
<b>Percent</b>		100
<b>Explanation of results:</b>		

<b>FOCUS AREA</b>	<b>PREVENTION</b>		
<b>INDICATOR</b>	<b>DGPP Prevention 4</b>		
	The number and proportion of female patients aged 20-69 whose patient record shows that they have had a <b>Pap smear</b> during the previous two year period.		
<b>RATIONALE</b>	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. <sup>7</sup>		
<b>REPORTING GUIDE</b>	Divisions will need to enter the results into the results table and provide an explanation in response to the data results.		
	<b>Numerator:</b> The number of female patients aged 20-69 years who have had a Pap smear in the last two years.		
	<b>Denominator:</b> Total number of female patients aged 20-69 years.		
<b>DATA SOURCE</b>	Division records, practice visits, etc.		
<b>GUIDE FOR DATA COLLECTION</b>	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.		
	<i>Or</i>		
	Divisions must obtain data from another source that has been negotiated on a State-wide basis with the Department.		
<b>COMMENTS</b>	Some women in this age group may not be required to have regular pap smears, such as those that have had a total hysterectomy.		
<b>ASSESSMENT GUIDE</b>	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.		
<b>HISTORY</b>	<b>Version No</b>	<b>Date</b>	<b>Brief Description of Revision</b>

#### **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 [*Jul-Dec 200X OR Jul 200X-Jun 200X*].

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

<sup>7</sup> <http://www.health.gov.au/internet/screening/publishing.nsf/Content/cervical-faqs#1>

## Chronic Disease Management

<b>FOCUS AREA</b>	<b>CHRONIC DISEASE MANAGEMENT</b>		
<b>INDICATOR</b>	<b>DGPP Chronic Disease Management 1</b>		
	The number and proportion of general practices within the Division using electronic <b>register/recall/reminder systems</b> to identify patients with a chronic disease for review and appropriate action.		
<b>RATIONALE</b>	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.		
<b>REPORTING GUIDE</b>	Divisions will need to enter the results into the results table and provide an explanation in response to the data results.		
	<p><b>Numerator:</b> 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.</p> <p><b>Denominator:</b> The number of general practices within a Division.</p>		
<b>DATA SOURCE</b>	Division records, practice visits, etc.		
<b>GUIDE FOR DATA COLLECTION</b>	<p>Divisions must obtain data from <u>at least 80% of practices</u> in the Division.</p> <p>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.</p> <p><b>Standard National Questions</b></p> <p>Q1 Does the practice have at least one register/recall/reminder system to identify patients with a chronic disease? [Y] [N]</p> <p>Q2 If yes, are any of the register/ recall/ reminder systems electronic? [Y] [N]</p> <p>Q3 <b>If yes to Q1 and 2</b>, please indicate <b>how many chronic diseases</b> are represented on the electronic practice system(s).</p>		
<b>COMMENTS</b>	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.		
<b>ASSESSMENT GUIDE</b>	<p>In assessing the results for this indicator, the possible areas of improvement are:</p> <ol style="list-style-type: none"> <li>an increase in the number of practices using electronic <b>register/recall/reminder</b> systems for chronic disease management;</li> <li>an increase in the number of diseases represented on an electronic register/recall/reminder system; and</li> <li>an increase in the number of practices providing data for this indicator.</li> </ol>		
<b>HISTORY</b>	<b>Version No</b>	<b>Date</b>	<b>Brief Description of Revision</b>

**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 [Jul-Dec 200X OR Jul 200X-Jun 200X].

	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
<b>Number</b>					
<b>Percent</b>				100	N/A

**DGPP Chronic Disease Management 1: Table 2:**

The number of chronic diseases represented using **electronic** practice register/recall/reminder systems [Jul-Dec 200X OR Jul 200X-Jun 200X].

	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
<b>Number of practices</b>					
<b>Percent</b>					<b>100</b>
<b>How were these data obtained?</b>					
<b>Explanation of results:</b>					

FOCUS AREA	CHRONIC DISEASE MANAGEMENT		
INDICATOR	<p><b>DGPP Chronic Disease Management 2</b></p> <p>The number of patients within the Division with <b>diabetes</b> whose last recorded HbA1c within the previous 12 months was:</p> <ul style="list-style-type: none"> <li>• less than or equal to 7.0%;</li> <li>• greater than 7.0% but less than or equal to 8.0%;</li> <li>• greater than 8.0% but less than 10.0%;</li> <li>• greater than or equal to 10.0%; or</li> <li>• not recorded.</li> </ul>		
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.<sup>8</sup></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><b>Numerator:</b> The number of patients with diabetes whose HbA1c in the past 12 months was:</p> <ul style="list-style-type: none"> <li>• less than or equal to 7.0%;</li> <li>• greater than 7.0% but less than or equal to 8.0%;</li> <li>• greater than 8.0% but less than 10.0%;</li> <li>• greater than or equal to 10.0%; or</li> <li>• not recorded.</li> </ul> <p><b>Denominator:</b> 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, <b>diabetes</b> 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.</p> <p>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"> <li>1. an increase in the number of patients identified with diabetes;</li> <li>2. an increase in patients with HbA1c recorded</li> <li>3. an increase in the number of patients with good clinical results; and</li> <li>4. an increase in the number of patients with the Aboriginal and Torres Strait Islander origin identified; and</li> <li>5. an increase in the number of GPs providing data for this indicator.</li> </ol>		
HISTORY	<b>Version No</b>	<b>Date</b>	<b>Brief Description of Revision</b>

<sup>8</sup> Diabetes Australia and RACGP, *Diabetes management in general practice 2004/5*, 10th edition. Diabetes Australia; 2004.

**DGPP Chronic Disease Management 2**

The number of patients within the Division with diabetes - last recorded HbA1c within the previous 12 months [Jul-Dec 200X OR Jul 200X-Jun 200X].

	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
<b>All</b>						
<b>Number</b>						
<b>Percent</b>						100
<b>Aboriginal and Torres Strait Islander origin (numbers)</b>						
<b>Aboriginal and Torres Strait Islander origin</b>						
<b>Non-Aboriginal and Torres Strait Islander origin</b>						
<b>Origin not recorded</b>						
<b>How were these data obtained?</b>						
<b>What number and proportion of GPs in your Division contributed data for this indicator?</b>						
<b>Number:</b> <b>Proportion:</b>						
<b>Explanation of results:</b>						

<b>FOCUS AREA</b>	<b>CHRONIC DISEASE MANAGEMENT</b>		
<b>INDICATOR</b>	<b>DGPP Chronic Disease Management 3</b>		
	The number of patients within the Division with <b>coronary heart disease</b> whose last recorded blood pressure within the previous 12 months was less than or equal to 130/80 mmHg.		
<b>RATIONALE</b>	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.		
<b>REPORTING GUIDE</b>	Divisions will need to enter the results into the results table and provide an explanation in response to the data results.  <b>Numerator:</b> 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.  <b>Denominator:</b> The total number of patients with coronary heart disease.		
<b>DATA SOURCE</b>	Division records, practice visits, Australian Primary Care Collaboratives, etc.		
<b>GUIDE FOR DATA COLLECTION</b>	Divisions must obtain data from <u>at least 10% of GPs</u> in the Division.		
<b>COMMENTS</b>	For the purpose of this indicator, <b>coronary heart disease</b> 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.  In the 6 Month Report, Divisions will have the option of reporting against either: - 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 130/180 mmHg; or - the number of patients within the Division with coronary heart disease whose last recorded blood pressure within the previous 12 months was less than 140/90mmHg.		
<b>ASSESSMENT GUIDE</b>	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.		
<b>HISTORY</b>	<b>Version No</b>	<b>Date</b>	<b>Brief Description of Revision</b>
	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.

DGPP Chronic Disease Management 3

Reporting Option 1 – 6 Month Report

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 [*Jul-Dec 200X OR Jul 200X-Jun 200X*].

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

DGPP Chronic Disease Management 3

Reporting Option 2 – 6 Month Report

The number of patients within the Division with coronary heart disease whose last recorded blood pressure within the previous 12 months was less than 140/90 mmHg [*Jul-Dec 200X*].

	<b>CHD patients whose last recorded blood pressure within the previous 12 months was less than 140/90 mmHg</b>	<b>CHD patients whose last recorded blood pressure within the previous 12 months was greater than or equal to 140/90 mmHg</b>	<b>Not recorded</b>	<b>Total</b>
<b>All</b>				
<b>Number</b>				
<b>Percent</b>				100
<b>How were these data obtained?</b>				
<b>What number and proportion of GPs in your Division contributed data for this indicator?</b>				
<b>Number:                      Proportion:</b>				
<b>Explanation of results:</b>				

## Uptake of National Initiatives

FOCUS AREA	UPTAKE OF NATIONAL INITIATIVES		
<b>INDICATOR</b>	<b>DGPP Uptake of National Initiatives 1</b> The number and proportion of general practitioners within the Division who prepare and review <b>GP Mental Health Care Plans</b> , and the number and proportion of general practitioners within the Division who provide <b>focussed psychological strategies</b> .		
<b>RATIONALE</b>	The GP Mental Health Care Plan is part of the <i>Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule (MBS)</i> initiative. It provides a structured framework for GPs to undertake early intervention, assessment and management of patients with mental disorders, as well as providing new referral pathways to clinical psychologist and allied mental health service providers. <sup>9</sup>  Focussed psychological strategies are specific mental health care management strategies derived from evidence based psychological therapies that have been shown to integrate the best external evidence of clinical effectiveness with general practice clinical expertise. These services may only be provided by a medical practitioner who is registered with Medicare Australia as having satisfied the requirements for higher level mental health skills for the provision of the service. The medical practitioner must provide the service in a general practice participating in the PIP or which is accredited. <sup>10</sup>		
<b>REPORTING GUIDE</b>	Divisions will need to enter the results into the results table and provide an explanation in response to the data results.  <b>Numerator:</b> The number of GPs claiming against MBS items 2710 or 2712; and MBS items 2721, 2723, 2725 or 2727.  <b>Denominator:</b> The number of GPs in the Division		
<b>DATA SOURCE</b>	<b>Numerator:</b> Medicare Australia –MBS items 2710 or 2712; and MBS item 2721, 2723, 2725 or 2727.  <b>Denominator:</b> Medicare Australia – MBS data.		
<b>GUIDE FOR DATA COLLECTION</b>	The Department will source the data and provide to the Divisions network.		
<b>COMMENTS</b>	For the purpose of this indicator, the number of GPs will be counted by head count and will be based on the most recent national workforce data available. This will generally be the number of GPs from the previous financial year.		
<b>ASSESSMENT GUIDE</b>	In assessing the results for this indicator, the possible areas of improvement are: 1. an increase in the number of GPs who prepare and review GP Mental Health Care Plans; and 2. an increase in the number of GPs who have undertaken training and are providing focussed psychological strategies.		
<b>HISTORY</b>	<b>Version No</b>	<b>Date</b>	<b>Brief Description of Revision</b>
	2	22/12/2008	Amended numerator to include all MBS items involving focussed psychological strategies (Items 2721, 2723, 2725, 2727). Included information on GP head count.

<sup>9</sup> <http://www.health.gov.au/internet/wcms/publishing.nsf/content/health-pcd-gp-mental-health-care-medicare>

<sup>10</sup> Australian Government Department of Health and Ageing. Medicare Benefits Schedule Book, 2007.

**DGPP Uptake of national initiatives 1**

The number and proportion of general practitioners within the Division who prepare and review GP Mental Health Care Plans, and the number and proportion of general practitioners who provide focussed psychological strategies [*Jul-Dec 200X OR Jul 200X-Jun 200X*].

	GP Mental Health Care Plan			Total number of GPs in the Division
	MBS item 2710 (Preparation)	MBS item 2712 (Review)	Practitioners claiming either Item 2710 or 2712	
Number of GPs claiming				
Percent				100
Explanation of results:				

Focussed Psychological Strategies						
	MBS Item 2721	MBS Item 2723	MBS Item 2725	MBS Item 2727	MBS Items 2721, 2723, 2725 or 2727	Total number of GPs in the Division
Number of GPs claiming						
Percent						100
Explanation of results:						

<b>FOCUS AREA</b>	<b>UPTAKE OF NATIONAL INITIATIVES</b>		
<b>INDICATOR</b>	<b>DGPP Uptake of national initiatives 2</b>		
	The number and proportion of <b>PIP practices</b> within the Division.		
<b>RATIONALE</b>	<p>An independent and voluntary system of practice accreditation was developed to enhance the delivery of services and facilities by general practices through a process of continuous quality improvement.</p> <p>In 1998, the General Practice Strategy Review Group published <i>General practice: changing the future through partnerships</i> providing a focussed push toward the widespread accreditation of general practices in Australia, recommending that ‘... national GP organisations actively promote participation in the accreditation process and that practices apply for accreditation’.<sup>11</sup></p> <p>Due to the unavailability of practice accreditation data the indicator will be the number and proportion of PIP practices within the Division.</p>		
<b>DATA SOURCE</b>	<p><b>Numerator:</b> Department of Health and Ageing Practice Incentives Program data.</p> <p><b>Denominator:</b> Division records.</p>		
<b>REPORTING GUIDE</b>	<p>Divisions will need to enter the results into the results table and provide an explanation in response to the data results.</p> <p><b>Numerator:</b> The number of PIP practices in the Division.</p> <p><b>Denominator:</b> The number of general practices in the Division.</p>		
<b>GUIDE FOR DATA COLLECTION</b>	<p><b>Numerator:</b> The Department will source the data and provide to the Divisions network.</p> <p><b>Denominator:</b> Division records</p>		
<b>COMMENTS</b>			
<b>ASSESSMENT GUIDE</b>	In assessing the results for this indicator, the possible area of improvement within the Division is an increase in the number of PIP general practices.		
<b>HISTORY</b>	<b>Version No</b>	<b>Date</b>	<b>Brief Description of Revision</b>
	2	August 2008	Revised to the number and proportion of PIP practices within the Division because practice accreditation data is not available.

**DGPP Uptake of national initiatives 2**

The number and proportion of PIP practices within the Division [Jul-Dec 200X OR Jul 200X-Jun 200X].

	<b>Total Number of PIP Practices</b>	<b>Total Number of Practices in Division.</b>
<b>Number</b>		
<b>Percent</b>		100
<b>Explanation of results:</b>		

<sup>11</sup> Royal Australian College of General Practitioners. RACGP Standards for General Practice. South Melbourne; RACGP, 2007.

### 3. STATE BASED ORGANISATIONS

#### Access

<b>FOCUS AREA</b>	<b>ACCESS</b>		
<b>INDICATOR</b>	<b>DGPP Access (SBO) 1</b>  The number and proportion of PIP practices within the State/Territory claiming <b>practice nurse</b> services.		
<b>RATIONALE</b>	Practice nurses assist GPs by contributing to a range of services, including chronic disease management and population health activities.  It is anticipated that increased capacity in general practice provided by using services of nurses will improve the quality of care for patients, particularly those with chronic disease and/or complex conditions. <sup>12</sup>		
<b>REPORTING GUIDE</b>	SBOs will need to enter the results into the results table and provide an explanation in response to the data results.  <b>Numerator:</b> The number of PIP practices claiming practice nurse services within the State.  <b>Denominator:</b> The number of PIP Practices within the State.		
<b>DATA SOURCE</b>	<b>Numerator:</b> Medicare Australia – MBS items 10993-10999. Medicare Australia – PIP data.  <b>Denominator:</b> Medicare Australia – PIP data.		
<b>GUIDE FOR DATA COLLECTION</b>	The Department will source the data and provide to the Divisions network.		
<b>COMMENTS</b>	MBS item 10997 also applies to services provided by an Aboriginal Health Worker, but will be counted for the purposes of this indicator.  The number of non-PIP practice claiming practice nurse services is not available, however the number of practice nurse services claimed by non-PIP practices will be collected and incorporated into the results table.		
<b>ASSESSMENT GUIDE</b>	In assessing the results for this indicator, the possible areas of improvement are: 1. an increase in the number of PIP practices claiming practice nurse services; and 2. an increase in the number of practice nurse services being claimed.		
<b>HISTORY</b>	<b>Version No</b>	<b>Date</b>	<b>Brief Description of Revision</b>

<sup>12</sup> Australian Government Department of Health and Ageing, 2006, Guidelines for the Divisions Network Nursing in General Practice Program. Available at:  
<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pcd-programs-nursing-gpinfo.htm>

**DGPP Access (SBO) 1**

*The number and proportion of PIP practices within the State claiming practice nurse services [Jul-Dec 200X OR Jul 200X to Jun 200X].*

	<b>PIP Practices claiming practice nurse services within the State (MBS items 10993-10999)</b>	<b>Total number of PIP Practices within the State</b>	<b>Practice nurse services claimed by PIP practices within the State (MBS items 10993 – 10999)</b>
<b>Number</b>			
<b>Percent</b>		100	
In addition, a further _____ practice nurse claims were made by non-PIP practices.			
<b>Explanation of results:</b>			

<b>FOCUS AREA</b>	<b>ACCESS</b>		
<b>INDICATOR</b>	<b>DGPP Access (SBO) 2</b>  The number of <b>health checks</b> and <b>health assessments</b> provided to patients of Aboriginal and/or Torres Strait Islander origin by general practitioners within the State (compared to the estimated population in the area who could benefit from the health check).		
<b>RATIONALE</b>	Health checks are provided to ensure that Aboriginal and Torres Strait Islander people receive the optimum level of health care by encouraging prevention, early detection, diagnosis and intervention for common and treatable conditions that cause considerable morbidity and early mortality. <sup>13</sup>		
<b>REPORTING GUIDE</b>	SBOs will need to enter the results into the results table and provide an explanation in response to the data results.  <b>Numerator:</b> The number of health check and health assessment services provided to patients of Aboriginal and Torres Strait Islander origin.  <b>Denominator:</b> The estimated Aboriginal and/or Torres Strait Islander population in the State.		
<b>DATA SOURCE</b>	<b>Numerator:</b> Medicare Australia - MBS Items 704, 706, 708 and 710.  <b>Denominator:</b> Australian Bureau of Statistics (ABS).		
<b>GUIDE FOR DATA COLLECTION</b>	The Department will source the data and provide to the Divisions network.		
<b>COMMENTS</b>	<ul style="list-style-type: none"> <li>• A child health check (MBS Item 708) may be undertaken for an Aboriginal and/or Torres Strait Islander person who is 0 to 14 years of age (inclusive).</li> <li>• An adult health check (MBS Item 710) may be undertaken for an Aboriginal and/or Torres Strait Islander person between 15 years and 54 years of age (inclusive).</li> <li>• A health assessment (MBS Items 704 and 706) may be undertaken for an Aboriginal and/or Torres Strait Islander person who is at least 55 years old.</li> </ul> Frequency of health checks: <ul style="list-style-type: none"> <li>• A child health check may be provided every 9 months.</li> <li>• An adult health check may be provided every 18 months.</li> <li>• A health assessment (55 years and over) may be provided every 12 months.</li> </ul>		
<b>HISTORY</b>	<b>Version No</b>	<b>Date</b>	<b>Brief Description of Revision</b>

<sup>13</sup> Australian Government Department of Health and Ageing. Medicare Benefits Schedule Book, 2007.

**DGPP Access (SBO) 2**

The number of health checks/health assessments provided to patients of Aboriginal and/or Torres Strait Islander origin by general practitioners within the State (compared to the estimated population in the area who could benefit from the health check) [Jul-Dec 200X OR Jul 200X-Jun 200X].

	Patients of Aboriginal and Torres Strait Islander Origin			Estimated Aboriginal and Torres Strait Islander Population in the State		
	Child health checks (708)	Adult health checks (710)	Health assessments (55 years and over) (704 or 706)	Children	Adults	Adults 55 years and over
<b>Number</b>						
<b>Percent</b>				100	100	100
<b>Explanation of results:</b>						

## Prevention

<b>FOCUS AREA</b>	<b>PREVENTION</b>		
<b>INDICATOR</b>	<b>DGPP Prevention (SBO) 1</b>		
	The number of <b>45-49 year old health checks</b> provided to at-risk patients within the State (compared to the total population aged 45-49 years in the State).		
<b>RATIONALE</b>	One of the priority areas for the Australian Better Health Initiative (ABHI) is to encourage GPs to undertake a health check for a patient between 45 and 49 years of age (inclusive) who is at risk of developing a chronic disease. The aim of the health check is to assist with detection and prevention of chronic disease and enable early intervention strategies to be put in place where appropriate. <sup>14</sup>		
<b>REPORTING GUIDE</b>	SBOs will need to enter the results into the results table and provide an explanation in response to the data results.		
	<p><b>Numerator:</b> The number of 45-49 year old health checks provided to at-risk patients by GPs within the State.</p> <p><b>Denominator:</b> The number of 45-49 year olds in the State.</p>		
<b>DATA SOURCE</b>	<p><b>Numerator:</b> Medicare Australia –MBS item 717.</p> <p><b>Denominator:</b> Australian Bureau of Statistics (ABS).</p>		
<b>GUIDE FOR DATA COLLECTION</b>	The Department will source the data and provide to the Divisions network.		
<b>COMMENTS</b>	<p>For the purposes of Medicare Item 717, 'at-risk' means: a patient must be at risk of developing a chronic disease. Specific risk factors include:</p> <ul style="list-style-type: none"> <li>• lifestyle risk factors such as smoking, physical inactivity, poor nutrition or alcohol misuse;</li> <li>• biomedical risk factors, such as high cholesterol, high blood pressure, impaired glucose metabolism or excess weight; or</li> <li>• family history of a chronic disease.<sup>15</sup></li> </ul>		
<b>HISTORY</b>	<b>Version No</b>	<b>Date</b>	<b>Brief Description of Revision</b>
	2	22/12/2008	Changed denominator to the number of 45-49 year olds in the State given that most of the population in this age group would have one of these risk factors.

### DGPP Prevention (SBO) 1

The number of 45-49 year old health checks provided to at-risk patients by GPs within the State [Jul-Dec200X OR Jul 200X – Jun 200X].

	45-49 year old health checks (MBS item 717)	Estimated population of 45-49 year olds in the State
<b>Number</b>		
<b>Percent</b>		100
<b>Explanation of results:</b>		

<sup>14</sup> Australian Government Department of Health and Ageing. Medicare Benefits Schedule Book, 2007.

<sup>15</sup> Ibid.

<b>FOCUS AREA</b>	<b>PREVENTION</b>		
<b>INDICATOR</b>	<b>DGPP Prevention (SBO) 2</b>		
	The average childhood <b>immunisation</b> coverage rate for the 60 to <63 months age group within the State.		
<b>RATIONALE</b>	<p>The Immunise Australia Program has increased national immunisation coverage rates and has helped reduce the incidence of vaccine preventable diseases in the community. In order to achieve a level of immunity necessary to interrupt the spread of vaccine-preventable diseases, vaccine coverage rates need to exceed 90%<sup>16</sup>.</p> <p>Immunisation coverage rates for the 72 months old age group are considerably lower than those of the 12 to 24 months age group<sup>17</sup>. It is opportunistic to target those children at the 60 to &lt; 63 months age group to maximise immunisation coverage rates.</p>		
<b>REPORTING GUIDE</b>	SBOs will need to enter the results into the results table and provide an explanation in response to the data results.		
<b>DATA SOURCE</b>	Medicare Australia – Australian Childhood Immunisation Register (ACIR).		
<b>GUIDE FOR DATA COLLECTION</b>	The Department will source the data and provide to the Divisions network.		
<b>COMMENTS</b>			
<b>HISTORY</b>	<b>Version No</b>	<b>Date</b>	<b>Brief Description of Revision</b>

**DGPP Prevention (SBO) 2**

*The average childhood immunisation coverage rates for the 60 to <63 months age group within the State [Jul-Dec 200X OR Jul 200X-Jun 200X].*

	<b>Average coverage rate for the 60 to &lt;63 months age group within the State</b>
	<b>%</b>
<b>Percentage</b>	
<b>Explanation of results:</b>	

<sup>16</sup> Australian Institute of Health and Welfare. A Picture of Australia's Children. AIHW: Canberra, 2005.

<sup>17</sup> Ibid.

<b>FOCUS AREA</b>	<b>PREVENTION</b>		
<b>INDICATOR</b>	<b>DGPP Prevention (SBO) 3</b>		
	The number and proportion of electronic transfers of childhood <b>immunisation</b> data received by the Australian Childhood Immunisation Register (ACIR).		
<b>RATIONALE</b>	<p>The ACIR records details of vaccinations given to children under the age of seven who live in Australia, helping Australian parents to ensure that their children grow up healthy and are fully immunised. Health professionals also use the ACIR to monitor immunisation coverage levels, service delivery and disease outbreaks.</p> <p>The ACIR allows for both electronic and manual transmission of immunisation data. An increase in the level of electronic transfers will demonstrate an efficient and timely data exchange of immunisation records.</p>		
<b>REPORTING GUIDE</b>	<p>SBOs will need to enter the results into the results table and provide an explanation in response to the data results.</p> <p><b>Numerator:</b> The number of electronic childhood immunisation encounters received by the ACIR for this age group.</p> <p><b>Denominator:</b> The total number of encounters (electronic and manual) for the State.</p>		
<b>DATA SOURCE</b>	Medicare Australia – Australian Childhood Immunisation Register (ACIR).		
<b>GUIDE FOR DATA COLLECTION</b>	The Department will source the data and provide to the Divisions network.		
<b>COMMENTS</b>	<p>For the purposes of this indicator, electronic transfers means anything not processed manually. The data will apply at the encounter level on the date of processing by Medicare Australia.</p> <p>Therefore, for the purposes of this indicator and for consistency reasons, data about each vaccination visit (or encounter) received by the ACIR electronically will be counted as one electronic transfer of childhood immunisation data.</p> <p>NB. Most QLD childhood immunisation data are transferred electronically to ACIR by VIVAS and most NT data are transferred electronically to ACIR by NT Health.</p>		
<b>HISTORY</b>	<b>Version No</b>	<b>Date</b>	<b>Brief Description of Revision</b>
	2	22/12/2008	Changed date of claim to date of processing by Medicare Australia due to timing issues with obtaining date of claim data.

**DGPP Prevention (SBO) 3**

The number and proportion of electronic transfers of childhood immunisation data received by the Australian Childhood Immunisation Register (ACIR) [Jul-Dec 200X OR Jul 200X-Jun 200X].

	<b>CHILDHOOD IMMUNISATION DATA RECEIVED BY ACIR</b>	
	<b>Electronic transfers</b>	<b>Total number of transfers (electronic and manual)</b>
<b>Number</b>		
<b>Percent</b>		100
<b>Explanation of results:</b>		

## Chronic Disease Management

<b>FOCUS AREA</b>	<b>CHRONIC DISEASE MANAGEMENT</b>		
<b>INDICATOR</b>	<b>DGPP Chronic Disease Management (SBO) 1</b>		
	The number and proportion of general practices within the State using electronic <b>register/recall/reminder systems</b> to identify patients with a chronic disease for review and appropriate action.		
<b>RATIONALE</b>	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.		
<b>REPORTING GUIDE</b>	SBOs will need to enter the results into the results table and provide an explanation in response to the data results.  <b>Numerator:</b> 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.  <b>Denominator:</b> The number of general practices within a State.		
<b>DATA SOURCE</b>	Divisions of General Practice Six and Twelve Month Reports.		
<b>GUIDE FOR DATA COLLECTION</b>	SBOs must collect data from <u>100% of Divisions</u> (with the exception of Tier 1 reporting Divisions) within their State.  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. <b>Standard National Questions</b> Q1 Does the practice have at least one register/recall/reminder system to identify patients with a chronic disease? [Y] [N] Q2 If yes, are any of the register/ recall/ reminder systems electronic? [Y] [N] Q3 <b>If yes to Q1 and 2</b> , please indicate <b>how many chronic diseases</b> are represented on the electronic practice system(s).		
<b>COMMENTS</b>	For this indicator, SBOs should support Divisions in the aim for general practices to have three (3) or more chronic diseases represented on an electronic practice register/recall/reminder system.		
<b>HISTORY</b>	<b>Version No</b>	<b>Date</b>	<b>Brief Description of Revision</b>

**DGPP Chronic Disease Management (SBO) 1: Table 1**

The number and proportion of general practices within the State using practice register/recall/reminder systems to identify patients with a chronic disease for review and appropriate action [Jul-Dec 200X OR Jul 200X-Jun 200X].

	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 State
<b>Number</b>					
<b>Percent</b>				100	N/A

**DGPP Chronic Disease Management (SBO) 1: Table 2:**

The number of chronic diseases represented using **electronic** practice register/recall/reminder systems [Jul-Dec 200X OR Jul 200X-Jun 200X].

	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
<b>Number of practices</b>					
<b>Percent</b>					<b>100</b>
<b>How were these data obtained?</b>					
<b>Explanation of results:</b>					

<b>FOCUS AREA</b>	<b>CHRONIC DISEASE MANAGEMENT</b>		
<b>INDICATOR</b>	<b>DGPP Chronic Disease Management (SBO) 2</b>		
	The number and proportion of Divisions that have successfully met the requirements for obtaining patient level data for diabetes, coronary heart disease and pap smears within the State.		
<b>RATIONALE</b>	Part of the role of SBOs is to support the improved utilisation of data by Divisions to inform planning and evaluation of health services and measure the effectiveness of health program delivery.		
<b>REPORTING GUIDE</b>	SBOs will need to enter the results into the results table and provide an explanation in response to the data results.  <b>Numerator:</b> The number of Divisions that have successfully met the requirements for obtaining patient level data.  <b>Denominator:</b> The number of Divisions within the State.		
<b>DATA SOURCE</b>	Divisions of General Practice Six and Twelve Month Reports.		
<b>GUIDE FOR DATA COLLECTION</b>	SBOs must collect data from <u>100% of Divisions (with the exception of Tier 1 reporting Divisions)</u> within their State.  SBOs will analyse the Reports of the Divisions and summarise the number and provide an explanation of the results.		
<b>COMMENTS</b>			
<b>HISTORY</b>	<b>Version No</b>	<b>Date</b>	<b>Brief Description of Revision</b>

**DGPP Chronic Disease Management (SBO) 2**

*The number and proportion of Divisions that have successfully met the requirements for obtaining patient level data for diabetes, coronary heart disease and Pap smears within the State [Jul-Dec 200X OR Jul 200X-Jun 200X].*

	Number of Divisions who met requirements for obtaining patient level data for			Total number of Divisions in State
	Diabetes	Coronary heart disease	Pap smears	
<b>Number</b>				
<b>Percent</b>				100
<b>Explanation of results:</b>				

## Uptake of National Initiatives

FOCUS AREA	UPTAKE OF NATIONAL INITIATIVES		
<b>INDICATOR</b>	<b>DGPP Uptake of National Initiatives (SBO) 1</b>		
	The number and proportion of general practitioners within the State who prepare and review <b>GP Mental Health Care Plans</b> , and the number and proportion of general practitioners within the State who provide <b>focussed psychological strategies</b> .		
<b>RATIONALE</b>	<p>The GP Mental Health Care Plan is part of the <i>Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule (MBS)</i> initiative. It provides a structured framework for GPs to undertake early intervention, assessment and management of patients with mental disorders, as well as providing new referral pathways to clinical psychologist and allied mental health service providers.<sup>18</sup></p> <p>Focussed psychological strategies are specific mental health care management strategies derived from evidence based psychological therapies that have been shown to integrate the best external evidence of clinical effectiveness with general practice clinical expertise. These services may only be provided by a medical practitioner who is registered with Medicare Australia as having satisfied the requirements for higher level mental health skills for the provision of the service. The medical practitioner must provide the service in a general practice participating in the PIP or which is accredited.<sup>19</sup></p>		
<b>REPORTING GUIDE</b>	<p>SBOs will need to enter the results into the results table and provide an explanation in response to the data results.</p> <p><b>Numerator:</b> The number of GPs claiming against MBS items 2710 or 2712; and MBS item 2721, 2723, 2725 or 2727.</p> <p><b>Denominator:</b> The number of GPs in the State.</p>		
<b>DATA SOURCE</b>	<p><b>Numerator:</b> Medicare Australia –MBS items 2710 and 2712; and MBS item 2721, 2723, 2725 or 2727.</p> <p><b>Denominator:</b> Medicare Australia – MBS data.</p>		
<b>GUIDE FOR DATA COLLECTION</b>			
<b>COMMENTS</b>	For the purpose of this indicator, the number of GPs will be determined by head count and will be based on the most recent national workforce data available, This will generally be the number of GPs from the previous financial year.		
<b>HISTORY</b>	<b>Version No</b>	<b>Date</b>	<b>Brief Description of Revision</b>
	2	22/12/2008	Amended numerator to include all MBS items involving focussed psychological strategies (Items 2721, 2723, 2725, 2727). Included information on GP head count.

<sup>18</sup> <http://www.health.gov.au/internet/wcms/publishing.nsf/content/health-pcd-gp-mental-health-care-medicare>

<sup>19</sup> Australian Government Department of Health and Ageing. Medicare Benefits Schedule Book, 2007.

**DGPP Uptake of national initiatives (SBO) 1**

The number and proportion of general practitioners within the State who prepare and review GP Mental Health Care Plans, and the number and proportion of general practitioners who provide focussed psychological strategies [Jul-Dec 200X OR Jul 200X-Jun 200X].

	GP Mental Health Care Plan			Total number of GPs in the State
	MBS item 2710 (Preparation)	MBS item 2712 (Review)	Practitioners claiming either Item 2710 or 2712	
Number of GPs claiming				
Percent				100100
Explanation of results:				

Focussed Psychological Strategies						
	MBS Item 2721	MBS Item 2723	MBS Item 2725	MBS Item 2727	MBS Items 2721, 2723, 2725 or 2727	Total number of GPs in the State
Number of GPs claiming						
Percent						100
Explanation of results:						

<b>FOCUS AREA</b>	<b>UPTAKE OF NATIONAL INITIATIVES</b>		
<b>INDICATOR</b>	<b>DGPP Uptake of national initiatives (SBO) 2</b>		
	The number and proportion of PIP practices within the State.		
<b>RATIONALE</b>	<p>An independent and voluntary system of practice accreditation was developed to enhance the delivery of services and facilities by general practices through a process of continuous quality improvement.</p> <p>In 1998, the General Practice Strategy Review Group published <i>General practice: changing the future through partnerships</i> providing a focussed push toward the widespread accreditation of general practices in Australia, recommending that ‘... national GP organisations actively promote participation in the accreditation process and that practices apply for accreditation’.<sup>20</sup></p> <p>Due to the unavailability of practice accreditation data the indicator will be the number and proportion of PIP practices within the State.</p>		
<b>DATA SOURCE</b>	<p><b>Numerator:</b> Department of Health and Ageing Practice Incentives Program data.</p> <p><b>Denominator:</b> Division/SBO records.</p>		
<b>REPORTING GUIDE</b>	<p>SBOs will need to enter the results into the results table and provide an explanation in response to the data results.</p> <p><b>Numerator:</b> The number of PIP practices in the State</p> <p><b>Denominator:</b> The number of general practices in the State.</p>		
<b>GUIDE FOR DATA COLLECTION</b>	<p><b>Numerator:</b> The Department will source the data and provide to the Divisions network.</p> <p><b>Denominator:</b> Division/SBO records.</p>		
<b>COMMENTS</b>			
<b>HISTORY</b>	<b>Version No</b>	<b>Date</b>	<b>Brief Description of Revision</b>
	2	22/12/2008	Revised to the number and proportion of PIP practices within the State because practice accreditation data is not available, consistent with the DGPP Uptake of National Initiatives 2.

**DGPP Uptake of national initiatives (SBO) 2**

The number and proportion of PIP practices within the State [Jul-Dec 200X OR Jul 200X-Jun 200X]

	<b>Total Number of PIP Practices</b>	<b>Total Number of Practices in the State.</b>
<b>Number</b>		
<b>Percent</b>		100
<b>Explanation of results:</b>		

<sup>20</sup> Royal Australian College of General Practitioners. RACGP Standards for General Practice. South Melbourne; RACGP, 2007.