

***National Objectives and Performance
Indicators
for
Divisions of General Practice***

Priority Area: GOVERNANCE

Domain: PERFORMANCE IMPROVEMENT CULTURE

Objective: To ensure sound governance reflecting a culture of continuous quality improvement

Rationale: Sound governance is a legal, contractual and ethical obligation of all organisations. This is particularly so for publicly funded organisations. Ongoing systematic evaluation and improvement of the effectiveness of the organisation ensures continuous quality improvement.

Level 1 Divisions (Organisational Structures/Processes - Governance)	Level 2 General Practices/GPs (Program Structures/Processes)	Level 3 Processes of Care for Patients, Families, Communities	Level 4 Intermediate Outcomes for Patients, Families, Communities
<p>N_PIC 1.1 The organisation is accredited by a recognised accreditation model.¹ 2 points (compulsory) 50 points for achieving accreditation</p> <p>N_PIC 1.2 The organisation's board composition is appropriate to support the effective discharge of governance and financial accountabilities. 2 points (compulsory)</p> <p>N_PIC 1.3 The organisational structure includes a mechanism to effectively capture relevant community input. 2 points (compulsory)</p> <p>N_PIC 1.4. The organisation has the following:</p> <ul style="list-style-type: none"> • Comprehensive governance and operational policies manual in place that are subject to ongoing review 2 points (compulsory) • Annual board performance appraisals, with externally facilitated review at least every three years 2 points (compulsory) • Annual CEO performance reviews against agreed indicators and position description 2 points (compulsory) • An independent committee established to provide assurance on financial, remuneration and other matters to the board 2 points (compulsory) • Appropriate skills training program for each member of the board and management 2 points (compulsory) • An effective system to ensure board members and staff are given adequate orientation to their respective roles 2 points (compulsory) • A framework to evaluate the organisation's core programs and these evaluations are an essential part of board/management performance review 2 points (compulsory) 	<p>N/A</p>	<p>N/A</p>	<p>N/A</p>

¹ Organisations have three years (until 2008) to obtain accreditation. **If accredited**, organisations are not required to respond to all of the governance performance indicators – only those not incorporated within their selected accreditation model. The technical details summarise the indicators included in each of the three recognised accreditation models. **If not accredited**, organisations must respond to all of the governance performance indicators; identify if the organisation is registered to become accredited; and include a plan to progress towards accreditation.

Priority Area: GOVERNANCE

Domain: EFFECTIVE EXTERNAL ENGAGEMENT

Objective: Collaborations with key stakeholders influence local primary health care policy, planning and service delivery

Rationale: Sound working relationships between key stakeholders contribute to the effectiveness of the interaction between general practice and other health care and support providers. Community input into the program of activities ensures the relevance of the activities to the wider community.

Level 1 Divisions (Organisational Structures/Processes - Governance)	Level 2 General Practices/GPs (Program Structures/Processes)	Level 3 Processes of Care for Patients, Families, Communities	Level 4 Intermediate Outcomes for Patients, Families, Communities
<p>N_EEE (DIV) 1.1 The Division's programs are well informed by relevant community input. 2 points (compulsory)</p> <p>N_EEE (DIV) 1.2. The Division's collaborations with key stakeholders (for example, local government, regional health services, non-government organisations, consumer groups, relevant Indigenous health organisations, the SBO, other health service providers etc) influence local primary health care policy, planning and service delivery. 2 points (compulsory)</p>	<p>N/A</p>	<p>N/A</p>	<p>N/A</p>

Priority Area: GOVERNANCE

Domain: FINANCIAL, COMPLIANCE AND RISK MANAGEMENT

Objective: To ensure sound financial management, compliance with all legal and contractual requirements and mitigation of identified risks.

Rationale: Sound financial management ensures a high standard of accountability and ensures the appropriate management of the program, including improving accountability and transparency of public funding and ensuring funding is used for the purposes for which it is provided. Sound compliance and risk management contributes to the effective management of the organisation's resources, assets and liabilities to protect its board, management and staff and enables the organisation to achieve its optimal outcomes

Level 1 Divisions (Organisational Structures/Processes - Governance)	Level 2 General Practices/GPs (Program Structures/Processes)	Level 3 Processes of Care for Patients, Families, Communities	Level 4 Intermediate Outcomes for Patients, Families, Communities
<p>N_FCR 1.1 The organisation has systems for written financial reporting to the board (minimum of a quarterly basis), that include variance between actual expenditure and budget, financial ratio reporting and assurance of compliance with legal and contractual requirements 2 points (compulsory)</p> <p>N_FCR 1.2 The organisation has written risk management plans based on an appropriate and recognised risk management framework. These plans cover the main areas of the organisation's operation (for example, governance, financial, knowledge management and, where appropriate, clinical risk) and include a legal and contractual compliance program. 2 points (compulsory)</p>	<p>N/A</p>	<p>N/A</p>	<p>N/A</p>

Priority Area: PREVENTION AND EARLY INTERVENTION

Domain: IMMUNISATION

Objective: Divisions will support general practices/GPs to implement the current National Immunisation Handbook, including the Australian Standard Vaccination Schedule (ASVS), the National Immunisation Program (NIP) and the General Practice Immunisation Incentives Scheme (GPII).

Rationale: General practice has an important role in immunisation through support of the implementation of government initiatives, including those aimed at limiting childhood vaccine preventable disease transmission in the community.

Level 1 Divisions (Organisational Structures/Processes - Programs)	Level 2 General Practices/GPs (Organisational Structures/Processes - Programs)	Level 3 Processes of Care for Patients, Families, Communities	Level 4 Intermediate Outcomes for Patients, Families, Communities
<p>N_IMM 1.1 Division collaborates with other organisations, service providers and consumer/carer groups to promote and support quality immunisation practices. 2 points (compulsory)</p> <p>N_IMM 1.2 Division takes a systematic approach to support general practices/GPs to comply with the ASVS and participate in local immunisation programs. 2 points (compulsory)</p>	<p>N_IMM 2.1 Number and proportion of general practices registered in the General Practice Immunisation Incentives (GPII) Scheme. 4 points (compulsory) plus bonus points from 2006-07 >xx% of practices = 2 points >xx% of practices = 4 points</p> <p>N_IMM 2.2 Number and proportion of general practices accessing ACIR/GPII reports in the two preceding quarters. 4 points (compulsory) plus bonus points from 2006-07 >xx% of practices = 2 points >xx% of practices = 4 points</p> <p>N_IMM 2.3 Number and proportion of general practices transferring childhood immunisation data to ACIR electronically. 4 points (compulsory) plus bonus points from 2006-07 >xx% of practices = 2 points >xx% of practices = 4 points</p>	<p>N_IMM 3.1 Childhood immunisation coverage rates by general practices and Division. 8 points (compulsory) plus bonus points from 2006-07 >xx% of practices ≥ 95% = 4 points >xx% of practices ≥ 95% = 8 points</p>	

Priority Area: ACCESS
Domain: RESIDENTIAL AGED CARE

Objective: Divisions will facilitate access and support general practices/GPs to provide optimal care and contribute to the achievement of the best possible health outcomes for older people living in residential aged care facilities (RACFs).

Rationale: Older people living in RACFs should have access to quality medical care at the same standard that applies to the community generally, and that meets their specific medical needs. There has been a decline in GP attendances to residential care patients in the context of an ageing population, increased numbers of residential aged care beds and an increased proportion of residents classified as high care. Divisions have a key role in improving access to appropriate general practice services for older people living in RACFs.

Level 1 Divisions (Organisational Structures/Processes - Programs)	Level 2 General Practices/GPs (Organisational Structures/Processes - Programs)	Level 3 Processes of Care for Patients, Families, Communities	Level 4 Intermediate Outcomes for Patients, Families, Communities
<p>N_RES 1.1 Division collaborates with RACFs, service providers and consumer/carer groups to facilitate access to general practice services for residents of RACFs within the Division's boundaries. 2 points (compulsory)</p> <p>N_RES 1.2 Division takes a systematic approach to support GPs visiting RACFs to provide optimal care to RACF patients. 2 points (compulsory)</p> <p>N_RES 1.3 Division facilitates access to effective Continuing Professional Development (CPD) for the care needs of RACF patients. 2 points</p>	<p>N_RES 2.1 Number and proportion of general practices whose GPs visit RACFs using register/recall/reminder systems to identify RACF patients for review and appropriate action. 4 points plus bonus points from 2006-07 >xx% of practices = 2 points >xx% of practices = 4 points</p> <p>N_RES 2.2 Number and proportion of general practices providing written patient information appropriate for their patient population about the nature and extent of their availability for RACF visits. 4 points plus bonus points from 2006-07 >xx% of practices = 2 points >xx% of practices = 4 points</p>	<p>N_RES 3.1 Number of: i) GP consultations in RACFs; ii) comprehensive medical assessments (CMAs); iii) residential medication management reviews (RMMRs), provided by GPs practicing in the Division's area, compared to the number of RACF beds in the Division's area. 8 points (compulsory) plus bonus points from 2006-07 ratio i) >xx = 4 points ratio i) >xx = 8 points ratio ii) >xx = 4 points ratio ii) >xx = 8 points ratio iii) >xx = 4 points ratio iii) >xx = 8 points</p>	<p>N_RES 4.1 Number and proportion of RACFs satisfied with general practice involvement in their RACF. 16 points plus bonus points from 2006-07 >xx% Never/sometimes Q1 = 2 points >xx% Never/sometimes Q1 = 4 points >xx% Never/sometimes Q2 = 2 points >xx% Never/sometimes Q2 = 4 points >xx% Very satisfied Q3 = 2 points >xx% Very satisfied Q3 = 4 points >xx% Very satisfied Q4 = 2 points >xx% Very satisfied Q4 = 4 points</p>

Priority Area: INTEGRATION
Domain: GPs AND HOSPITALS

Objective: Divisions will work with relevant hospitals¹ to improve local service planning, timely and appropriate exchange of patient health information, and integration of care for patients, families and communities.

Rationale: General practice and hospitals are major local sources of health care. Their role in the care of individuals is closely linked and some health/service problems require a coordinated response from the two sectors. This objective reflects two of the four main aims of collaboration between general practice and hospitals. These are:

- developing a better working relationship between the two parties to improve problem solving; and
- improving transitions of care.

The other two aims are:

- providing care in the most appropriate setting; and
- reducing the need for hospitalisation through better prevention.

These are more variable and less common areas of collaboration, and are not reflected in this indicator set.

¹ 'Relevant hospitals' refers to the hospitals with which GPs in the Division share most care for their patients. These may be local or referral/base hospitals. Some local but specialised hospitals may not be relevant in this sense.

Level 1 Divisions (Organisational Structures/Processes - Programs)	Level 2 General Practices/GPs (Organisational Structures/Processes - Programs)	Level 3 Processes of Care for Patients, Families, Communities	Level 4 Intermediate Outcomes for Patients, Families, Communities
<p>N_INT 1.1 Division collaborates with relevant hospitals to facilitate local service planning, timely and appropriate exchange of patient information, and sharing of clinical care for patients, families and communities, involving consumers and other service providers where relevant. 2 points (compulsory)</p> <p>N_INT 1.2 An agreed system operates between hospitals and local general practice for the timely and appropriate exchange of patient information for discharge notifications. 2 points</p>	<p>N_INT 2.1 Number and proportion of GPs satisfied with the agreed system for timely and appropriate exchange of patient information for discharge notifications. 4 points plus bonus points from 2006-07 >xx% satisfied = 2 points >xx% satisfied = 4 points</p> <p>N_INT 2.2 Number and proportion of GPs satisfied with arrangements for sharing clinical care between general practice and hospitals. 4 points plus bonus points from 2006-07 >xx% satisfied Q1 = 2 points >xx% satisfied Q1 = 4 points</p> <p>>xx% satisfied Q2 = 2 points >xx% satisfied Q2 = 4 points</p> <p>>xx% satisfied Q3 = 2 points >xx% satisfied Q3 = 4 points</p>		

	<p>>xx% satisfied Q 4 = 2 points >xx% satisfied Q 4 = 4 points</p> <p>>xx% satisfied Q 5 = 2 points >xx% satisfied Q 5 = 4 points</p>		
--	---	--	--

Priority Area: MANAGE CHRONIC DISEASE

Domain: DIABETES

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.

<p>Level 1 Divisions (Organisational Structures/Processes - Programs)</p>	<p>Level 2 General Practices/GPs (Organisational Structures/Processes - Programs)</p>	<p>Level 3 Processes of Care for Patients, Families, Communities</p>	<p>Level 4 Intermediate Outcomes for Patients, Families, Communities</p>
<p>N_DIA 1.1 Division collaborates with other organisations, service providers and consumer/carer groups to facilitate patient access to optimal diabetes care. 2 points (compulsory)</p> <p>N_DIA 1.2 Division takes a systematic approach to support general practices/GPs to provide optimal diabetes care. 2 points (compulsory)</p> <p>N_DIA 1.3 Division facilitates access to effective Continuing Professional Development (CPD) for diabetes care. 2 points</p> <p>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. 20 points plus bonus points from 2006-07 >20% of practices = 5 points >40% of practices = 10 points >60% of practices = 15 points >80% of practices = 20 points</p> <p>N_DIA 1.5 Division takes a systematic</p>	<p>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</p>	<p>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. 8 points (compulsory) plus bonus points from 2006-07 >xx% = 4 points >xx% = 8 points</p>	<p>N_DIA 4.1 Number and proportion of patients with diabetes whose most recent HbA1c in the past 12 months was:</p> <ul style="list-style-type: none"> • 7.0% or less; • more than 7% but less than 10.0%; • 10.0% or more; • not measured. <p>20 points plus bonus points from 2006-07 xx = 10 points xx = 20 points</p> <p>N_DIA 4.2 Number and proportion of patients with diabetes whose most recent total cholesterol in the past 12 months was:</p> <ul style="list-style-type: none"> • less than 4.0 mmol/L; • equal to or greater than 4.0 mmol/L; • not measured. <p>20 points plus bonus points from 2006-07 xx = 10 points xx = 20 points</p>

<p>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. 2 points (compulsory)</p>			
---	--	--	--

Priority Area: MANAGE CHRONIC DISEASE

Domain: MENTAL HEALTH

Objective: 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.

Rationale: This addresses the aims of the National Mental Health Strategy, reaffirmed in the National Mental Health Plan, 2003-08.

<p>Level 1 Divisions (Organisational Structures/Processes - Programs)</p>	<p>Level 2 General Practices/GPs (Organisational Structures/Processes - Programs)</p>	<p>Level 3 Processes of Care for Patients, Families, Communities</p>	<p>Level 4 Intermediate Outcomes for Patients, Families, Communities</p>
<p>N_MNH 1.1 Division collaborates with other organisations, service providers and consumer/carer groups to facilitate patient access to early intervention and optimal mental health care and assist in the reduction of the impact of mental disorder on individuals, families and communities. 2 points (compulsory)</p> <p>N_MNH 1.2 Division takes a systematic approach to support general practices/GPs to provide early intervention and optimal mental health care. 2 points (compulsory)</p> <p>N_MNH 1.3 Division facilitates access to effective Continuing Professional Development (CPD) for mental health care. 2 points</p> <p>N_MNH 1.4 Number and proportion of GPs from whom the Division is receiving electronic patient records to provide feedback for quality improvement in mental health care. 20 points plus bonus points from 2006-07 >20% of practices = 5 points >40% of practices = 10 points >60% of practices = 15 points >80% of practices = 20 points</p>	<p>N_MNH 2.1 Number and proportion of GPs in the Division registered to claim for the formulation of 3-step mental health plans. 4 points plus bonus points from 2006-07 >xx% of GPs = 2 points >xx% of GPs = 4 points</p> <p>N_MNH 2.2 Number and proportion of general practices using a practice register/recall/reminder system to identify those patients who have had a 3-step mental health plan formulated by their GP, for review and appropriate action. 4 points (compulsory) plus bonus points from 2006-07 >xx% of practices = 2 points >xx% of practices = 4 points</p>	<p>N_MNH 3.1 Number of 3-step mental health plans completed by GPs practicing in the Division's area, compared to the estimated population in the Division's area who could benefit from a 3-step mental health plan. 8 points (compulsory) plus bonus points from 2006-07 >xx% = 4 points >xx% = 8 points</p>	<p>N_MNH 4.1 Number and proportion of patients on practice register/recall /reminder systems who have had a 3-step mental health plan who report that they: a) understand their condition; b) feel able to participate in the management of their condition. 20 points plus bonus points from 2006-07 a) xx = 5 points a) xx = 10 points b) xx = 5 points b) xx = 10 points</p>

<p>N_MNH 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 3-step mental health plans on the practice register/recall/ reminder systems.</p> <p>2 points (compulsory)</p>			
---	--	--	--

Priority Area: MANAGE CHRONIC DISEASE

Domain: ASTHMA

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 asthma.

Rationale: Optimal asthma care can be defined from Cochrane reviews. It includes proactive care (regular review) in conjunction with written asthma action plans (WAPs), training in self-management, and appropriate use of inhaled corticosteroids.

<p>Level 1 Divisions (Organisational Structures/Processes - Programs)</p>	<p>Level 2 General Practices/GPs (Organisational Structures/Processes - Programs)</p>	<p>Level 3 Processes of Care for Patients, Families, Communities</p>	<p>Level 4 Intermediate Outcomes for Patients, Families, Communities</p>
<p>N_ASM 1.1 Division collaborates with other organisations, service providers and consumer/carer groups to facilitate patient access to optimal asthma care. 2 points (compulsory)</p> <p>N_ASM 1.2 Division takes a systematic approach to support general practices/GPs to provide optimal asthma care. 2 points (compulsory)</p> <p>N_ASM 1.3 Division facilitates access to effective Continuing Professional Development (CPD) for asthma care. 2 points</p> <p>N_ASM 1.4 Number and proportion of GPs from whom the Division is receiving electronic patient records to provide feedback for quality improvement in asthma care. 20 points plus bonus points from 2006-07 >20% of practices = 5 points >40% of practices = 10 points >60% of practices = 15 points >80% of practices = 20 points</p> <p>N_ASM 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 asthma. 2 points (compulsory)</p>	<p>N_ASM 2.1 Number and proportion of general practices using a practice register/recall/ reminder system to identify patients with asthma for review and appropriate action. 4 points (compulsory) plus bonus points from 2006-07 >xx% of practices = 2 points >xx% of practices = 4 points</p> <p>N_ASM 2.2 Number and proportion of general practices with access to spirometry. 4 points plus bonus points from 2006-07 >xx% of practices = 2 points >xx% of practices = 4 points</p>	<p>N_ASM 3.1 Number and proportion of patients on practice register/recall/ reminder system with asthma aged 10 years and over in the 12 month reporting period with a record of smoking status. 8 points (compulsory) plus bonus points from 2006-07 >xx% = 2 points >xx% = 4 points</p>	<p>N_ASM 4.1 Number and proportion of patients on the practice register/recall/ reminder system with asthma aged 10 years and over in the 12 month reporting period recorded as a current smoker. 10 points plus bonus points from 2006-07 <xx% = 15 points <xx% = 30 points</p>

