

Implementation of the Review of Divisions

Frequently Asked Questions #2

This second FAQ document has been developed in order to share questions asked by the Divisions network with responses provided by the Commonwealth Department of Health and Ageing.

It is a living document, and will contain a version control on the last updated version, for the benefit of all those in the Divisions Network.

ADGP and SBOs will ensure that Divisions are aware of updated versions of the document.

Version: 26 April 2005

POINTS

- Q1 In appendix D1, Page D1:56, D1:58, the “Source of numerator data” (D1:56) notes that “Standard national question to be developed” and “data coding” “to be developed”. When will these be developed and what do Divisions do in the meantime?**
- A1 A standard national question and data coding will be developed for this indicator prior before the beginning of the reporting period i.e. 1st July 2005.
- Q2 Is there an advantage for a Division to include in the plan more than the minimum requested and achieve more than the minimum points total?**
- A2 A. It is recognised the Point System is new and the first year will be one of adjustment. As the Points System may need development, it will not be used in isolation as a basis for decision making in the first year. Strong performance against the indicators will however be a component of consideration for incentives such as Earned Autonomy and the Performance and Development Funding Pool. However, there will be no adverse consequences as a result of not achieving the minimum score in the first year. The Point System will become an important element in considering the performance of an organisation from 2006-07. The experiences of the first year will inform decisions around any adaptations required.
- Q3 Can a Division choose to work at a level of indicator lower than the compulsory reporting indicator? Can a Division report a ‘null’ result against a compulsory indicator if it is beyond the capacity to report against it?**
- A3 Divisions must report on all compulsory indicators (marked ‘compulsory’) except for two of the three chronic disease domains. It is worth noting there is capacity within the new planning and reporting pro forma for Divisions to report any exceptional or extenuating circumstances.

KPIs

Q1 Under N_INT 2.2 “Source of numerator data” it lists, Type 1 Emergency Department Patients, Type 2 Medical Patients, Type 3 Surgical Patients...Will divisions need to report on one, a combination or all of these patient categories? Can a Division add its own local priorities?

A1 Divisions are able to report on one, a combination or all of these categories – the Division will determine which arrangements they focus their activities and report on, in keeping with identified local needs and priorities. Similarly, a Division can add its own local priorities as indicated by Type 5 – other patients (as specified).

DATA

Q1 GP patient data go straight to the Commonwealth? And in what form?

A1 No, Divisions will not be reporting individual patient or GP data to the Department.

Divisions will be asked to provide summary information about groups of general practices/GPs patients within the Division against some non-compulsory level 4 indicators. The summary information provided will be derived from various sources. With respect to data that comes from patient records, this will be unidentified summary data about patient outcomes at the population level so it cannot be used to identify individual clients or practices/GPs. It is designed to provide system level information that can inform primary health care policy and demonstrate the difference Divisions can make. With patient and GP consent, Divisions may have access to individual GP and patient data to support quality patient care, for example in diabetes management, but this will be part of Divisions’ local practice support and information systems.

Q2 What are the Department's timeframes to develop and put in place incentives for GPs to send their data to Divisions?

A2 It is not compulsory for GPs to transfer data. Divisions who wish to do this should work with their member GPs to develop the best method for their Division and GPs.

The Department and the Review Implementation Committee is currently developing an information strategy to address the needs of Divisions which are not already undertaking programs with general practices involving data collection. This will build on the range of initiatives already in place and make it easier for Divisions not currently undertaking programs with general practices to meet future data collection requirements.

Timeframes will be able to be better estimated once significant work has been done as part of the information strategy.

TEMPLATES

Q1 Page D2:16 lists the National Performance Indicators (including points) in relation to the aged care Domain under the National Priority area 'Access'. In the planning phase, is there any additional documentation required on this page for Divisions?

A1 In the planning phase, Divisions need to record strategies and key activities undertaken in relation to achieving the national objective outlined on D2:16 on the following page, D2:17.

Please note the National indicators on page D2:16 relate to core National Performance Indicators and the National Performance Indicators on page D2:18 are associated with the additional funding from the Strengthening Medicare Aged Care GP Panels Initiative.

Q2 On page D2:16, is it compulsory to report against the Level 1 and Level 2 indicators considering the Level 3 indicator is compulsory?

A2 Divisions must report on all compulsory indicators (marked 'compulsory'). This means N_RES 1.1, N_RES 1.2 and N_RES 3.1 are compulsory. N_RES 1.3, N_RES 2.1, N_RES 2.2 and N_RES 4.1 are not compulsory and reporting on them is at the discretion of the Division.

Q3 Pages D2:18, D2:19, D2:20 list National Performance Indicators (the 14 indicators are currently included in Divisions contracts under the Strengthening Medicare Aged Care GP Panels Initiative). These pages also have columns for indicator level and points. Are Divisions expected to complete these tables? Are they compulsory?

A3 Indicators on Pages D2:18, 19, 20 are performance indicators under the Strengthening Medicare Aged Care GP Panels Initiative. They are not part of the initial set of core National Performance Indicators for Divisions of General Practice. (National indicators are denoted by the **N_** prior to the indicator number).

All Divisions receive Strengthening Medicare Aged Care GP Panels Initiative funding and as such, all Divisions are required to report against the Strengthening Medicare Aged Care GP Panels Initiative performance indicators. These indicators do not currently have levels and points and the columns relating to points and levels can be left blank.

Q4 If compulsory, why is RACF Access the only domain that has additional indicators for reporting against?

A4 The RACF Access is the only domain that has additional indicators (in addition to the initial set of core National Performance Indicators) for reporting because the Strengthening Medicare Aged Care GP Panels Initiative is currently the only additional national program within the planning and reporting pro forma that has a national set of indicators. MAHS and WSRGP are the other additional national programs included with the planning and reporting pro forma but these national programs but do not

currently have national performance indicators.

The indicators for the Strengthening Medicare Aged Care GP Panels Initiative were included in the new planning and reporting pro forma so that Divisions can report this information at one point in time, in one pro forma. This will save Divisions reporting separately to the Strengthening Medicare Aged Care GP Panels Initiative program area.

The department has committed to a review of all indicators and in keeping with this commitment; the indicators associated with the Strengthening Medicare Aged Care GP Panels Initiative will soon be reviewed to ensure they are still needed and are consistent with the framework. Any indicators not fitting the principles will be removed.

Q5 If a Division feels that all their aged care strategies and activities relate to both the national objectives for the core Aged Care funding program and the Strengthening Medicare Aged Care GP Panels Initiative, can they just put all of the strategies and activities in the first box and write "see above" in the others?

A5 Yes. In response to feedback the Department acknowledges a number of activities/strategies can be designed to achieve more than one objective and this approach is in keeping with streamlined reporting.

This type of feedback will be important to include in the formal feedback process occurring in May that will provide input into the development of the automated, embedded template due in July 2005.

Q6 Given that the Strengthening Medicare Aged Care GP Panels Initiative indicators are reportable under the existing reporting template, do Divisions have to complete the data in both the planning and reporting pro forma and the Aged Care reporting template? If so, why and for how long will this continue?

A6 Divisions will report 2004-05 Strengthening Medicare Aged Care GP Panels Initiative information (6 and 12 month reports and standard data items) only in the existing format for that program area.

2005-06 information (6 and 12 month reports and standard data items) will be integrated and reported in the new Planning and Reporting Pro forma in which Annual Plans are currently being developed.

Q7 Why is the structure of the aged care tables different from the MAHS tables (which are a compulsory section for those Divisions receiving MAHS funding)?

A7 The structure of the Access RACF tables is different from the MAHS tables because although MAHS is an additionally funded national program with national objectives, it does not currently have national performance indicators that can be included in the tables. Divisions will use local performance indicators. The Residential Aged Care Domain uses the national indicators already collected under the Strengthening Medicare Aged Care GP Panels Initiative.

Q8 Can Divisions change the National Priority Area (NPA) under which a national domain (such as Workforce Support for Rural General Practice) is placed?

Q8 Yes. All activity must be reported against a NPA, however Divisions have flexibility as to which NPA their national and local domains are reported against.

Q9 Our Division holds a National Prescribing Service contract. How and where does our Division enter this information in the template? (This will also apply for NPS, HMR and possibly other potential contracts.)

A9 The program planning and reporting pro forma must be used for all planning and reporting purposes for core funding as well as the More Allied Health Services (MAHS), Workforce Support for Rural General Practitioners (WSRGP) and the Strengthening Medicare Aged Care GP Panels Initiative. Where possible, it would make sense to also include other DoHA funded program areas though in doing so, Divisions will need to ensure they still meet any contractual requirements associated with this other program areas.

Divisions could put their NPS work in under a local objective and it may best fit in the *General Practice Support* area (with cross references to possibly chronic disease, quality support and possibly others depending on work done by a particular Division in each area)

During the 2005-08 contract period the department is committed to working with all program areas to streamline the planning and reporting requirements for the Divisions network and where possible, will incorporate other program areas within this pro forma.

The financial planning and reporting pro forma includes line items for other DoHA funding and other Commonwealth funding.

Q10 Indicators N-PIC 1.3 and N_EEE 1.1 are about consumer engagement. Some more guidance around what is expected here would be good. For example: Do Divisions get extra points if they have consumer rep on the board as opposed to a rep at program levels?

A10 Every effort has been made to not embed specific structures and/or processes within the indicators, to allow maximum flexibility for Divisions. Rather than dictate the mechanism for community input (which will depend on organisational structure, local community and other factors), the indicators are targeting more the existence of a mechanism and its effectiveness. Appropriate and acceptable mechanisms will vary and do not lend themselves to bonus points.

Q11 Who determines domain name for local objectives?

A11 The Division decides local domain names.

Q12 Should the Division call local indicators by levels?

A12 The Department encourages the use of levels, as long as they are consistent with the definitions in the framework i.e. Level 1: Division process/structure,

Level 2: general practice/GPs structures/processes, Level 3: processes of care for patients families communities and Level 4: intermediate health outcomes. However, it is not compulsory to do this - Divisions have flexibility around local indicators.

Q13 Where a local indicator could go into a number of domains does DoHA have any guidance on how to decide what domain to put it under eg after hours could go in workforce, integration, or access?

A13 The organisation of the plan is not a pass or fail test but more of a system of best fit and that will depend on the primary purpose or intent of the activity. For specific guidance, your SBO and STO may provide assistance.

FUNDING ISSUES

Q1 Are Divisions able to retain their surpluses to operate as a company in the longer term?

A1 If uncommitted funds are held by the Division of General Practice, contractual arrangements between the Department and Divisions set out how a carry over of uncommitted funds may be considered. As close as possible to the end of each financial year a request for carry over can be made by the Division and should include information supporting the request. In the funding agreement, approval of this should be considered after the end of the financial year, when the Division's financial expenditure is certain.

A letter has recently been sent to Divisions about this matter, so Divisions can make a case about how they would use a carry over in 2005-06.

Q2 In the Financial Planning and Reporting - user guide proforma on page 4.70, under expense items there is no separate item for GP salaries. A lot of divisions employ GPs on a salaried basis and this will not show up if they are placed in "other salaries".

A2 All GP's who are non Board members but are salaried employees of the Division would have their salaries fall under the "other salaries" section.

Q3 On page 4.72 of the Future Directions Toolkit, section 3.3 "Surplus Deficit" Current year surplus (deficit) - division. If my Division received 80% of a program's funding from DoHA then would DoHA assume that 80% of any carryover from one financial year to the next would be DoHAs? There are obviously times when a Division receives funding from another source and that funding is not spent by the end of the year. Surely DoHA is not going to claim a percentage of these funds. Can you please clarify?

A3 The Department is interested in the treatment of surpluses only where DoHA funds have been part of the income stream. Should DoHA have contributed to the income stream, any surplus will be determined as a proportion of total DoHA revenue divided by total income excluding interest income unless the Division can justify an alternative basis.

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Q4 How do Divisions get auditors to audit a template? Is the template to be audited as a document or is it sufficient to put in audited figures?

A4 When the Division is undertaking its year end process the Annual Template should be completed at the same time as the Annual Published Accounts so the Division should put in its audited figures at the same time. The Annual Template does not need to be audited as a separate exercise and it is sufficient for the Division to ensure they can reconcile between these two reports & put in the audited figures. This reconciliation can be shown to their auditor.

Q5 The programs listed on the 6 month variance and Annual variance sheets on the financial template differ to the programs on the statement sheets. In other words, the order of the MAHS, WSRGP, GPII and AGED CARE columns are not consistent throughout the spreadsheet. This will create problems in the future as the cells are linked.

A5 The Department acknowledges this fault in the template and it will be corrected in the re issue of the planning and reporting documents following the automation process in July 2005, prior to the variance sheets being required for reporting purposes.

Q6 There is a problem with the FTE cell on the template. The cell does not recognise decimal points therefore if there is 0.4 FTE staff it automatically rounds down to zero.

A6 The Department acknowledges this fault in the template and it will be corrected in the next release of the planning and reporting documents following the automation process in July 2005. In the short term, Divisions are advised to add the correct information in the Notes section of the template where there is concern the department would otherwise have an inadequate understanding.

Q7 I'm after some clarification around the treatment of committed staff entitlements. Are they are still considered committed funds or uncommitted funds for the purposes of the new template? Further, if they are considered committed or uncommitted, will Division's need to complete the new pro forma requesting Departmental approval of the carry forward of staff entitlements?

A7 Both annual leave and long service leave are to be accrued in accordance with generally accepted accounting principles. These staff entitlements are considered committed funds in the new template and as such, a Division does not need to request approval for carry forward of such committed funds. If there is a carry forward surplus of DoHA funds at year end and there is a

definite commitment relating to the surplus then the 'notes' area at the bottom of the template should be utilised to provide an explanation to DoHA.

The department will soon release advice concerning the provision for staff redundancy.

Disclaimer

Please note that questions posted in these FAQs generally arise from questions or enquiries from members of the Divisions network. The responses published in this document and added to or revised from time to time are provided at the discretion of the Australian Government Department of Health and Ageing.

Feedback on the published FAQs or further questions can be directed in the first instance to Andrew Waters at ADGP (awaters@adgp.com.au).