

PCS Clinical Audit Tool

Version 2.12

Additional Module

User Guide – APCC Report and Submission

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2.4.1	26/03/2009	Christine Chidgey	Updates following APCC Pilot
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2.9	21/06/2010	Christine Chidgey	Updates for changes to the APCC Report <ul style="list-style-type: none"> • Cholesterol indicators to check LDL as well • ACR indicators to check eGFR as well • GEN indicators to include ATSI >= 15 years age • GEN-022 to GEN-036 are new • MAN-032 to MAN-038 are new <p>QAIHC Report included in submission to APCC</p>
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2.11	09/01/2011	Christine Chidgey	Updated to include practiX in Vendor Compatibility Appendix Add MAN-038 to Appendix 1

<p>2.12</p>	<p>26/07/2011</p>	<p>Christine Chidgey</p>	<p>Add configuration instructions for collecting Assessments data from the PrimaryCare Sidebar®</p> <p>Updates for revised screens</p> <ul style="list-style-type: none"> • The preference tab formally titled "APCC Report" has been changed to "Improvement Foundation". Within this section, the "APCC Practice Token" label has been changed to "Health Service Token". Both of these changes recognise the fact that health services submitting data to the Improvement Foundation may be participating in programs other than the APCC. • The preference tab has a new "Report Data Categories Submitted" button. This is where the health service can choose which of its reports it will upload to the Improvement Foundation. This is to allow a more streamlined upload of data each month. • The submission process has been updated to allow for a number of different reports to be submitted to the IF repository at the same time.
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1 Introduction

1.1 Clinical Audit Tool (CAT)

The PCS Clinical Audit Tool™ (CAT) analyses clinical information from GP Clinical Desktop Systems. It translates data into real statistical and graphical information that is easy to understand and action. This allows practitioners to assess and improve the quality and completeness of patient information. The benefit to the practice is to assist with its ongoing accreditation and provide opportunities to grow practice income. The emphasis of the tool is to help practice staff to take specific action to improve patient coverage in chronic disease management and prevention.

Other benefits of CAT are many and include:

- targeting patients with particular needs
- targeting patients with specific health risk profiles
- improved compliance with statistical data collections
- extracting data to meet the needs of others
- meeting reporting requirements

Statistics that are required for the Australia Primary Care Collaboratives (APCC) program and the DoHA Future Directions Key Performance Indicators for Divisions are a by-product of the use of the system.

1.2 CAT APCC Report and Submission

PCS has been working with the Royal Australian College of General Practitioners (RACGP) and the Improvement Foundation (IF), who are contracted by DoHA, to deliver the Australian Primary Care Collaboratives (APCC) data definitions for the new APCC Program Measures. These measures are required to be reported by APCC practices. The first report for submission was uploaded in early April 2009.

Most of the measures can be calculated automatically by CAT using data that exists in the clinical system. The remaining few will require manual entry by the practice.

The reporting process has a number of steps:

1. The APCC practice does a data extraction using the existing 'Collect' function in CAT. The CAT data extract file includes data to meet the new APCC data requirements.
2. The APCC Program Measures that can be automatically calculated can be viewed in CAT under the 'Standard Reports' tab > 'APCC Report'. These are clinical measures (CHD, Diabetes, COPD and Prevention for Smoking, Pap Smear, Breast Screen, Risk Factors, Waist/BMI and Management Plans) and this report gives the practice the opportunity to target clinical areas for improvement.

3. The remaining measures can be manually entered by the practice using a data entry form provided in CAT.
4. The full set of measures can be reviewed and submitted by the practice from CAT to the APCC data repository.

1.3 CAT APCC Report and Submission User Guide

The purpose of this document is to provide instructions on how to use the APCC Report and submit the report to the APCC Repository. It should be used as an add-on guide to the main user guide: 'PCS Clinical Audit Tool – User Guide'. Some user instructions in this guide assume a general understanding of how to use CAT. References will be made to the main user guide where necessary.

1.4 Glossary of Terms

Term	Definition
APCC	Australia Primary Care Collaboratives
AR	Absolute Risk Assessment
CAT	Clinical Audit Tool
COPD	Chronic Obstructive Pulmonary Disease
CHD	Coronary Heart Disease
CRF	Chronic Renal Failure
Clinical Desktop System	A general term used for the computer program used by a clinician to record patient clinical information
DRAT	Diabetes Risk Assessment
FTE	Full Time Equivalent
GPMP	GP Management Plan
IF	Improvement Foundation
PCS	Pen Computer Systems
QAIHC	Queensland Aboriginal and Islander Health Council
QRG	Quick Reference Guide

Table 1: Glossary of Terms used

1.5 Relevant Documents

'PCS Clinical Audit Tool – User Guide'

This User Guide provides instructions on how to install and use the functionality provided by the CAT. It should be available as a prerequisite to this guide and will be referred to throughout this guide where necessary.

This guide is available from <http://help.pencs.com.au/cat.htm>.

2 System Requirements

Please refer to the System Requirements in the main CAT User Guide:

- **'Clinical Audit Tool – User Guide'**

2.1 Clinical Desktop Compatibility

CAT is compatible with the following clinical desktop systems:

- Medical Director Versions 2 and 3
- Best Practice
- Genie
- Zedmed
- practiX
- Communicare
- Medinet

Note that some data items may not currently be collected by some systems. Please refer to Appendix 1 for further information.

3 Installation

Please refer to the System Requirements in the main CAT User Guide:

- **'Clinical Audit Tool – User Guide'**

4 APCC Report

The APCC Report is found under the 'Standard Reports > Indicator Sets' tab.

For practices participating in the APCC program, the IF has developed a process where the report, along with a set of manually entered measures, can be submitted to its data repository. CAT provides functionality along with the APCC report to support this process.

APCC participating practices will be provided with a 'Health Service Token' which is entered via the CAT Preferences screen.

The APCC Report functionality is available from a set of menu options contained at the top of the APCC Report tab.

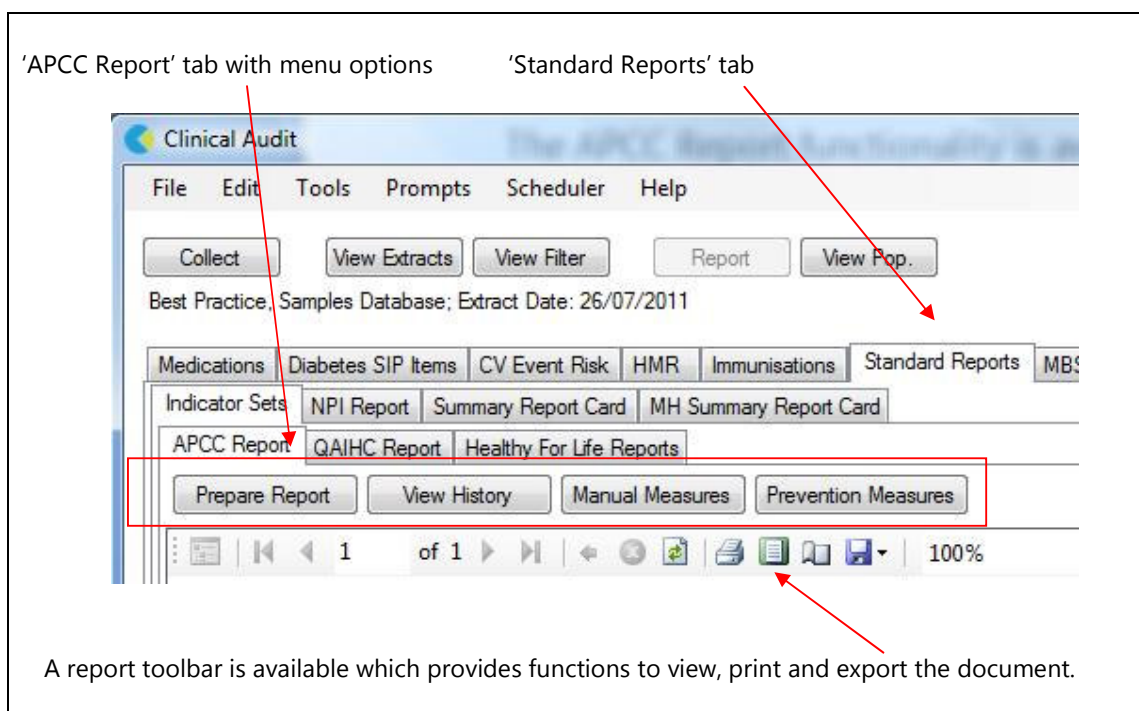


Figure 4A: APCC Report overview

The 'APCC' Report menu options are:

- Prepare Report – this will guide the user through the data transmission process
- View History – allows the user to view a list of previous reports that have been submitted
- Manual Measures – a data entry screen for the manual measures
- Prevention Measure – a data entry screen for the prevention measures that are not collected

4.1 Health Service Token

APCC participating practices will be provided with a 'Health Service Token'. This token must be set in the CAT preferences before you will be able to submit any data to the IF repository.

To set this token

- Choose Edit > Preferences from the top menu

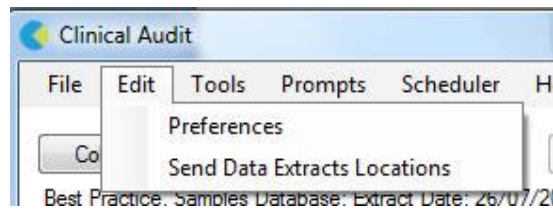


Figure 4.1A: Edit > Preferences

- The Preferences Dialog box will open, click on the 'Improvement Foundation' tab
- Copy and paste your health service practice token into the field provided
- Click the Edit button to set the report data categories you will be submitting
- Click 'OK'

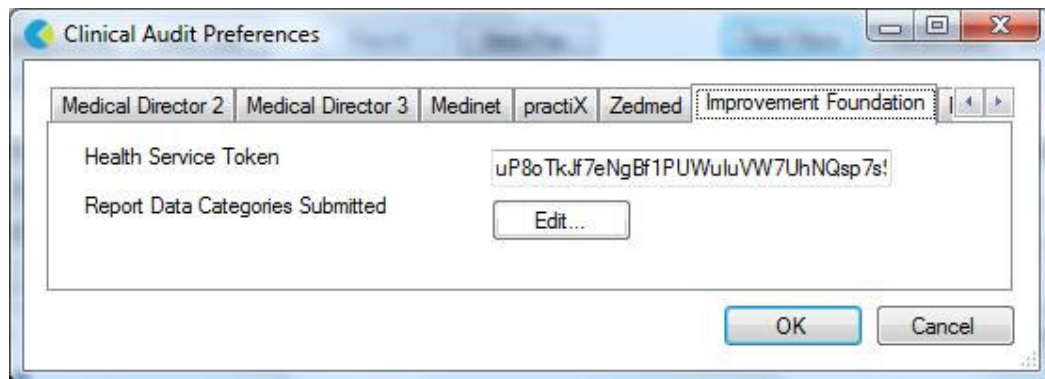


Figure 4.1B: Preferences Improvement Foundation tab

Note: You will not be able to send your data to the IF repository unless you have entered a valid health service token.

4.2 APCC Report

The APCC report provides a set of statistical indicators that promote practice improvement. It provides statistics in the following categories:

Key chronic disease categories:

1. **Coronary Heart Disease**
2. **Diabetes**
3. **Chronic Obstructive Pulmonary Disease**

4. **Prevention:**

- Smoking
- Pap Smear
- Breast Screen
- Risk Assessments (AR and DRAT) *
- Waist and BMI
- GP Management Plans
- Immunisations
- Estimated Glomerular Filtration Rate (eGFR)

* NOTE: For this report to collect Assessment Data from the PrimaryCare Sidebar® you must have your Prompts Preferences > Patient Data Storage Shared Directory set. Refer to the next section in this Guide for instructions.

5. **Manual Measures - Access and Care Redesign**

The statistics in categories 1-3 and most of the statistics in category 4 are automatically calculated from the GPs clinical desktop system and are broken down by ethnicity - ATSI, Non ATSI and Not Recorded (Figure 4.2A). There are some measures in category 4 that cannot be calculated and these are required to be entered manually.

The statistics in category 5 are a set of Manual Measures that focus on practice level outcomes. With the exception of MAN-037 and MAN-038 if billing is active, these cannot be calculated and are required to be entered manually.

Note that some clinical systems do not provide all the data that is required to calculate some indicators. Please check **Appendix 1 – Vendor Compatibility with APCC Indicators** for details.

The full set of indicators is described in **Appendix 2 – APCC Report Quick Reference**.

Demographics Allergies Smoking Alcohol Measures Pathology Disease Pap Smear Medications Diabetes SIP Items CV Event Risk HMR Immunisations Standard Reports

Indicator Sets NPI Report Summary Report Card MH Summary Report Card

APCC Report QAIHC Report Healthy For Life Reports

Prepare Report View History Manual Measures Prevention Measures

1 of 1 100% Find | Next

APCC Report

	CORONARY HEART DISEASE	Count				Percentage			
		Total	ATSI	Non ATSI	NR	Total	ATSI	Non ATSI	NR
CHD-001	Number of patients on the CHD register	134	0	69	65				
	Patients with CHD whose last recorded BP within the last 12 months was:								
CHD-002	BP <=130/80 mmHg	75	0	44	31	55.97 %		63.77 %	47.69 %
CHD-003	BP Recorded	111	0	65	46	82.84 %		94.20 %	70.77 %
CHD-004	Patients with CHD who are currently prescribed an Antiplatelet Medication	91	0	48	43	67.91 %		69.57 %	66.15 %
CHD-005	Patients with CHD who are currently prescribed a Statin Medication	101	0	54	47	75.37 %		78.26 %	72.31 %
	Patients with CHD whose last recorded LDL/Cholesterol within the last 12 months was:								
CHD-006	LDL <= 2mmol/l or if no LDL, Cholesterol < 4mmol/l	3	0	2	1	2.24 %		2.90 %	1.54 %
CHD-007	Cholesterol Recorded	4	0	2	2	2.99 %		2.90 %	3.08 %
CHD-008	Patients with CHD who are currently prescribed an ACE or ARB Medication	85	0	44	41	63.43 %		63.77 %	63.08 %
	Patients with CHD whose Smoking status is:								
CHD-009	Non Smoker (i and ii)	80	0	47	33	59.70 %		68.12 %	50.77 %
CHD-010	i) Never Smoked	29	0	13	16	21.64 %		18.84 %	24.62 %
CHD-011	ii) Ex Smoker	51	0	34	17	38.06 %		49.28 %	26.15 %
CHD-012	iii) Current Smoker	14	0	3	11	10.45 %		4.35 %	16.92 %
CHD-013	iv) Not Recorded	40	0	19	21	29.85 %		27.54 %	32.31 %

Figure 4.2A APCC Report

4.3 Collecting Assessments from the PrimaryCare Sidebar®

To collect Assessment Data from the PrimaryCare Sidebar® you must have your Prompts Preferences > Patient Data Storage Shared Directory set.

- Choose Edit > Preferences from the top menu
- The Preferences Dialog box will open, click on the 'Prompts' tab (Figure 4.3A)
- Click the Browse button to locate the Patient Data Shared Directory. This is the folder that you have already configured in the PrimaryCare Sidebar®. This is where the PrimaryCare Sidebar® is saving your Assessments data. CAT needs to know where to collect this data from.
- Click 'OK'

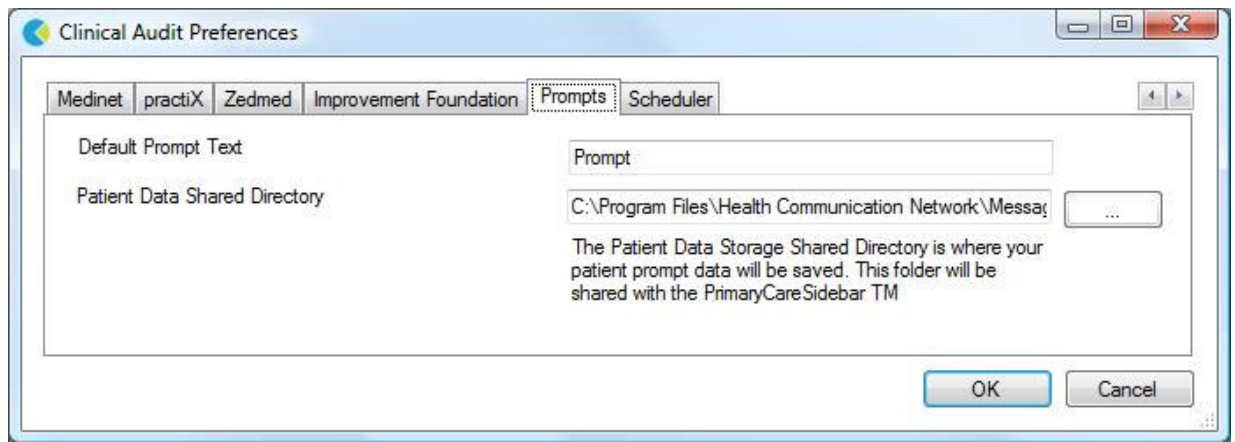


Figure 4.3A Prompts Preferences Dialogue

5 Manual Measures Data Entry

The manually entered measures are entered using the 'APCC Report' > 'Manual Measures' data entry form.



The APCC will provide you with information about what each of these measures is and how to calculate the measures that require calculation.

The majority of the measures will not change between reporting periods. Once you have entered the values they will be saved and redisplayed when you reopen the form. It will only be necessary to update values that have changed.

- Click the 'Manual Measures' menu option to open the form (Figure 5A)

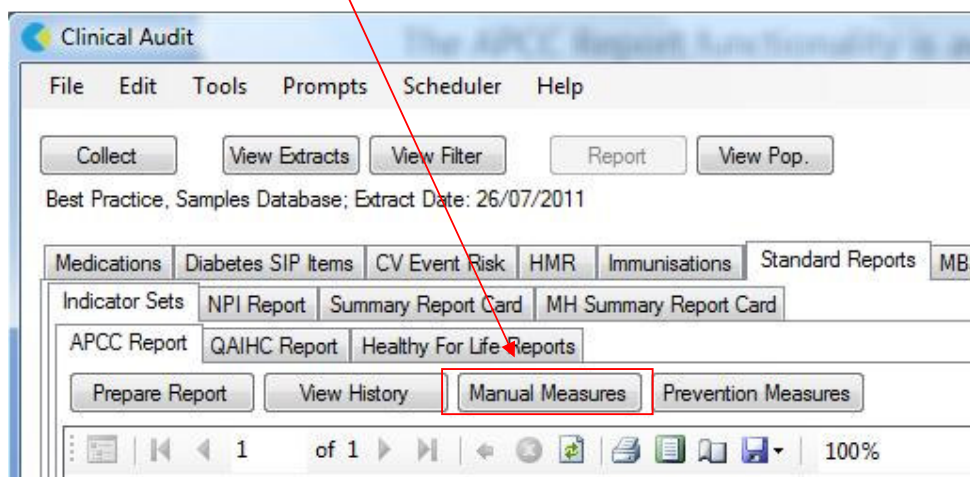


Figure 5A: APCC Manual Measures menu option

- The 'Manual Measures' screen will open (Figure 5B)
- Enter all the measures and click the 'Save' button to save the values

Values are saved to the system registry where other CAT settings (eg. Preferences) are saved so they will be remembered next time you open the form.

Manual Measures

Please enter the Manual Measures for the APCC report:

MAN-001 Is the practice using an 'Open Access' system? Yes No

MAN-002 The number of days until the GP 3rd Available appointment. 0.00

MAN-003 Is there a practice nurse who takes appointments? Yes No

MAN-004 The number of days until the Practice nurse 3rd available 0.00

MAN-005 The number of patients whose appointment demands were unmet. 0

MAN-006 Average patient satisfaction score. 0.00

MAN-007 The number of full time equivalent GPs at the practice. 0.00

MAN-008 The number of full time equivalent practice nurses employed at the practice. 0.00

Does the practice have a practice wide, systemised register for the following?

MAN-012 CHD None MAN-013 Hypertension None MAN-014 COPD None

MAN-015 Asthma None MAN-016 Diabetes None MAN-017 Diabetes Risk None

MAN-018 Any Mental Health None MAN-019 Osteoporosis None MAN-020 Any Cancer None

Other (comma seperated values) MAN-021 Paper MAN-021 Electronic

Does the practice have a practice wide, systemised recall/ reminder system for the following?

MAN-022 CHD None MAN-023 Hypertension None MAN-024 COPD None

MAN-025 Asthma None MAN-026 Diabetes None MAN-027 Diabetes Risk None

MAN-028 Any Mental Health Electronic MAN-029 Osteoporosis None MAN-030 Any Cancer None

Other (comma seperated values) MAN-031 Paper MAN-031 Electronic

MAN-032 The number of full time equivalent Aboriginal Health Workers employed at the practice. 0

MAN-033 The number of full time equivalent Allied Health Workers employed at the practice. 0

MAN-034 The number of full time equivalent Administration/Management Staff employed at the practice. 0

MAN-035 The number of full time equivalent Psychologists/Counsellors employed at the practice 0

MAN-036 The percentage of total practice staff who have had Aboriginal and Torres Strait Islander Cultural Awareness Training 0.00

MAN-038 The percentage of Aboriginal and Torres Strait Islander peoples who have received a health assessment in the past year. 0.00

Save Cancel

Figure 5B: Manual Measures entry form

NOTE 1: MAN-009, MAN-010 and MAN-011 are intentionally spare

NOTE 2: MAN-037 can be calculated from the GPs clinical desktop system and hence is not required to be entered manually

NOTE 3: MAN-038 can be calculated where MBS items are being collected. It will not be available for manual entry in this case.

- On saving the manual measures form the APCC Report will be refreshed.
Scroll down the report to the 'Manual Measures' section to view the data you have entered and saved.

Manual Measures report section (towards the bottom of the report) (Figure 5C)

MANUAL MEASURES - ACCESS AND CARE REDESIGN		Total	ATSI	Non ATSI	NR	Total	ATSI
MAN-037	Total number of patients marked as active in the practice's clinical system	8376	4	3266	5106		

MANUAL MEASURES - ACCESS AND CARE REDESIGN		Value
MAN-001	Is the practice using an 'Open Access' system?	Yes
MAN-002	The number of days until the GP 3rd Available appointment.	11
MAN-003	Is there a practice nurse who takes appointments?	Yes
MAN-004	The number of days until the Practice nurse 3rd available appointment.	12
MAN-005	The number of patients whose appointment demands were unmet.	13
MAN-006	Average patient satisfaction score	14
MAN-007	The number of full time equivalent GPs at the practice.	15
MAN-008	The number of full time equivalent practice nurses employed at the practice.	16
Does the practice have a practice wide, systemised register for the following?		
MAN-012	• CHD	Electronic
MAN-013	• Hypertension	Paper
MAN-014	• COPD	None
MAN-015	• Asthma	Electronic
MAN-016	• Diabetes	Paper
MAN-017	• Diabetes Risk	None
MAN-018	• Any Mental Health	Electronic
MAN-019	• Osteoporosis	Paper
MAN-020	• Any Cancer	None

Figure 5C: APCC Report - Manual Measures section

NOTE 1: MAN-009, MAN-010 and MAN-011 are intentionally spare

NOTE 2: MAN-037 requires breakdown by ATSI status and hence is displayed as the first MAN indicator following the previous indicators with the same breakdown

6 Prevention Measures Data Entry

Some prevention measures cannot be calculated from the clinical system. These are:

GEN-009: Absolute Risk Assessment *

GEN-010: Diabetes Risk Assessment *

GEN-019: GPMP (note: this is calculated where MBS items are being collected)

* Note: For users who have the PrimaryCare Sidebar® installed CAT will collect assessments data and these measures will be automatically calculated. The manual data entry form fields will not be available in this case.

GEN-009 will report 'CVD Risk – NVDPA' assessments completed in the required timeframe.

GEN-010 will report 'AUSDRISK – Diabetes' assessments completed in the required timeframe.

Where measures are not calculated they are entered using the 'APCC Report' > 'Prevention Measures' data entry form:

- Click the 'Prevention Measures' menu option to open the form
- The 'Prevention Measures' screen will open (Figure 6A)
- Enter all the measures and click the 'Save' button to save the values

NOTE: These values must be entered for each new collection that is done.

NOTE 2: Where fields are calculated they will not be available for data entry.

NOTE 3: If all 3 fields are calculated the 'Prevention Measures' menu option will be greyed out.

Prevention Measures

Please enter the Prevention Measures for the APCC report:

GEN-009 Number of nonATSI patients aged 45-74 or ATSI patients aged 35-74 WITHOUT a diagnosis of CVD, Diabetes, COPD or CRF who have had an Absolute Risk Assessment (AR)

Total ATSI Non-ATSI Non Recorded

GEN-010 Number of nonATSI patients aged 45-74 or ATSI patients aged 35-74 WITHOUT a diagnosis of CVD, Diabetes, COPD or CRF who have had a Diabetes Risk Assessment (DRAT)

Total ATSI Non-ATSI Non Recorded

GEN-019 Number of patients WITH a diagnosis of CVD, Diabetes, COPD or CRF with a GPMP (MBS 721, 729 or 731) within the last 2 years.

Total ATSI Non-ATSI Non Recorded

Figure 6A: Prevention Measures entry form

- On saving the prevention measures form the APCC Report will be refreshed. Scroll down the report to the 'Prevention Measures' section to view the data you have entered and saved.

7 Report Submission

All categories or only selected categories of measures can be submitted to the IF data repository.

Categories for selection are:

- APCC Report
 - Coronary Heart Disease
 - Diabetes
 - Chronic Obstructive Pulmonary Disease
 - Prevention
 - Manual Measures – Access and Care Redesign
- QAIHC Report*
- Healthy For Life Report*

* NOTE: The QAIHC and Healthy For Life Reports can be submitted at the same time as the APCC Report. They will only be available for submission if the data extract is version 1_6 or greater.

The selected categories are submitted using the 'APCC Report' > 'Prepare Report' menu option.

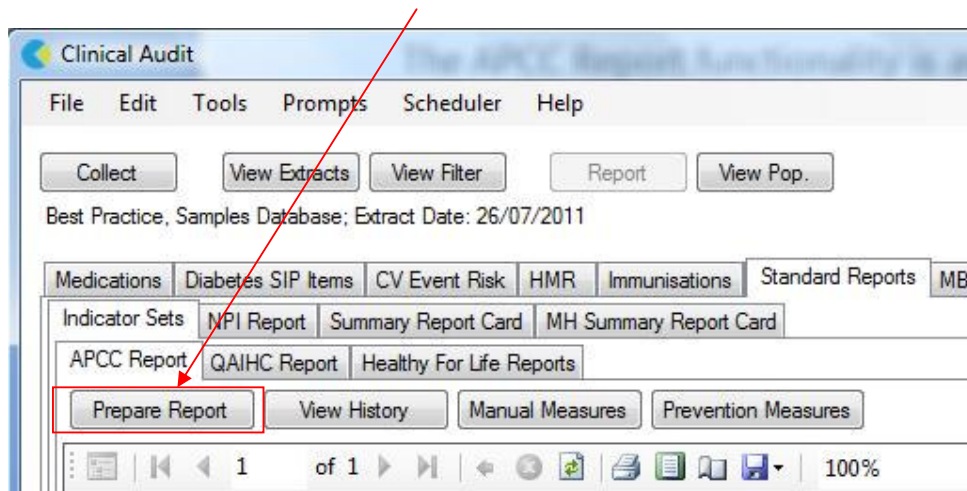


Figure 6A: APCC Prepare Report menu option

- Click the 'Prepare Report' menu option (Figure 6A)
- The 'Prepare Data for Improvement Foundation' screen will open (Figure 6B)
This screen confirms to the user the categories of data they have selected to send to the IF.

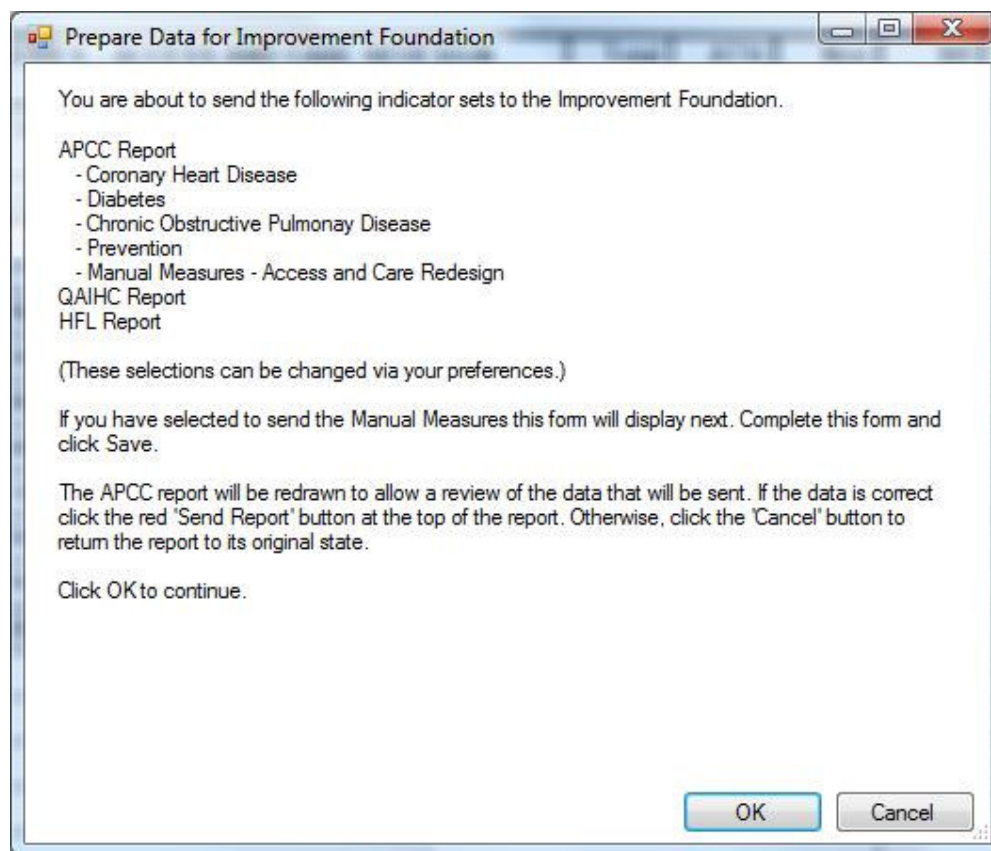


Figure 6B: IF Prepare Report selections

Depending on your selections you may have further screens to complete:

- If the Prevention category is selected the Prevention indicators form (Figure 6A) will be displayed to allow input of indicators that cannot be calculated. Complete or update this form and click 'Save'.
- If the Manual Measures category is selected the Manual Measures form will be displayed (Figure 5B). Complete or update this form and click 'Save'.
- The APCC Report will be refreshed with the selected APCC report categories only. The QAIHC and Healthy For Life Reports can be viewed from their respective tabs under Standard Reports > Indicator Sets. If they have not been selected they will be empty.
- The 'Send Report' button will become active (Figure 6C).
The user now has the chance to check the report(s) before sending.

'Send Report' button is active

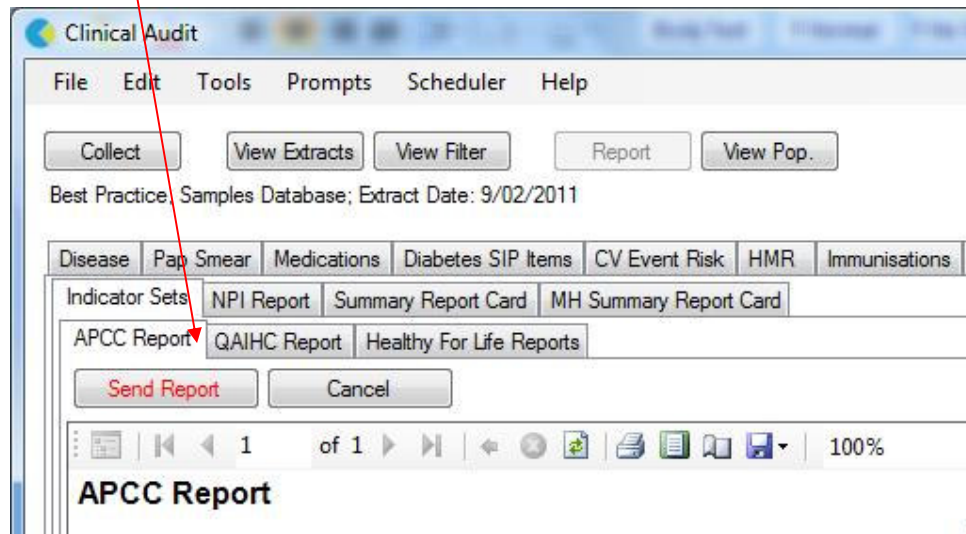


Figure 6C: APCC Report ready to send

- Once the report(s) is checked click the 'Send Report' button
- The 'Send Data' dialogue box is displayed (Figure 6D) allowing the user to confirm the send
- Click 'OK' to continue or 'Cancel' to cancel the send
- On clicking 'OK' to confirm the send, an XML file* is created, saved and transmitted to the IF repository.
- The user will be notified of whether the send has been successful.

* It is important to note that the XML file contains the Health Service Token to ensure it is received correctly into the IF repository for each practice. The file is also compressed and encrypted before being sent for security purposes.

THERE IS NO PATIENT SPECIFIC INFORMATION IN THE DATA SUBMITTED

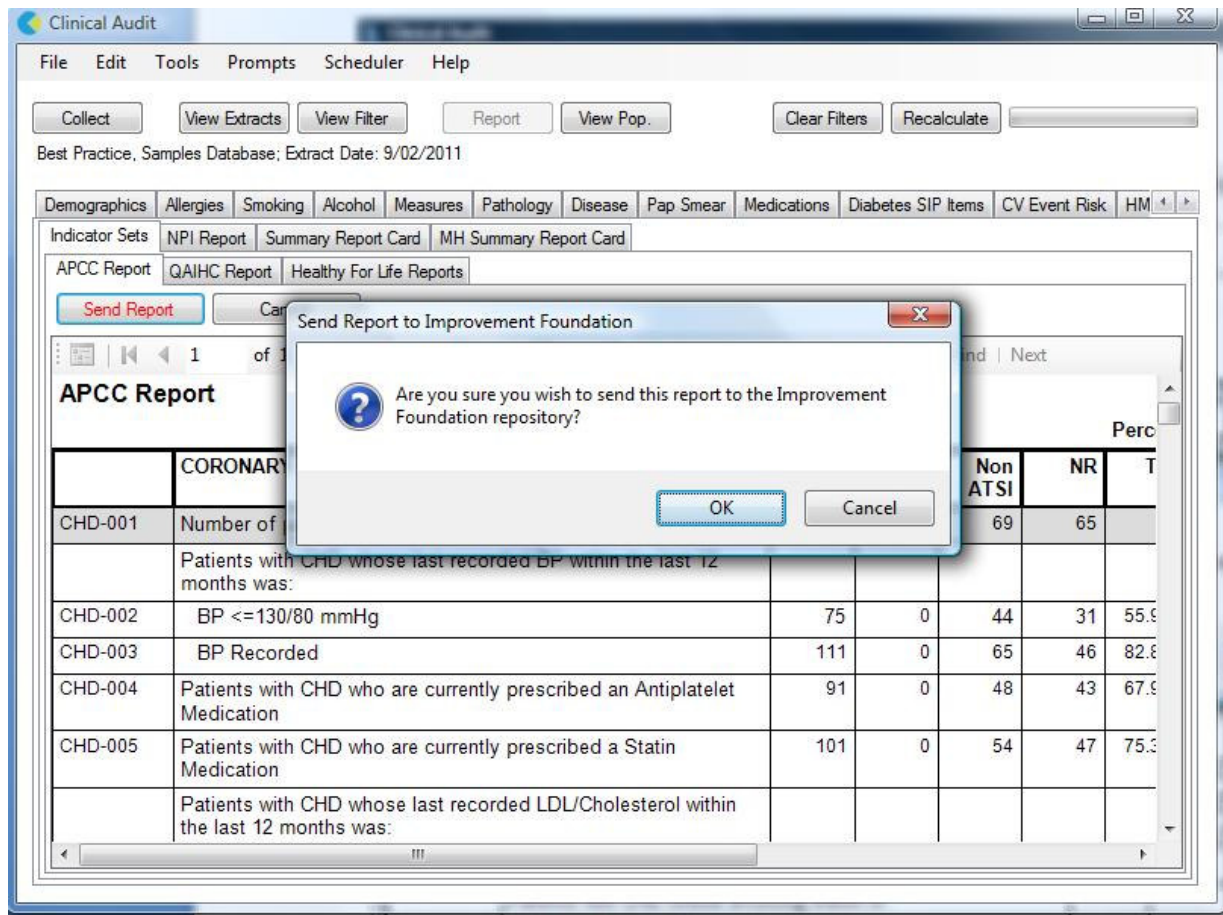


Figure 6D: APCC Report – Confirm send dialogue

8 Report Submission History

A list of reports that have been submitted to the IF data repository can be viewed from the 'APCC Report' > 'View History' menu option (Figure 8A).

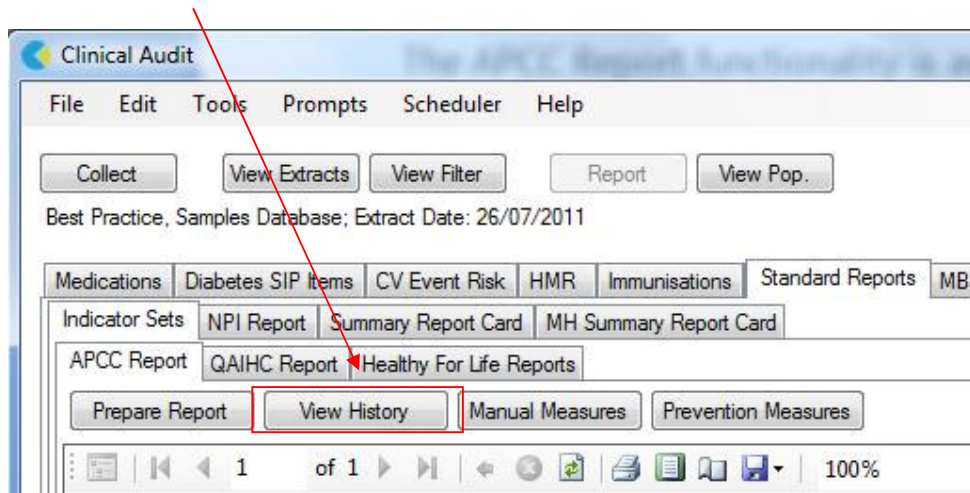


Figure 8A: APCC View History menu option

The 'APCC Transmission History' screen (Figure 8B) will display the details of each report that has been submitted to the APCC:

- Date of Submission
- Status of Submission (Success or Failure)
- Details of the data that was submitted
 - If success, the extract file that was sent and the categories that were selected
 - If failure, the extract file and the error message returned

An extract file can be reloaded from the 'View Extracts' pane if the report needs to be reviewed or printed.

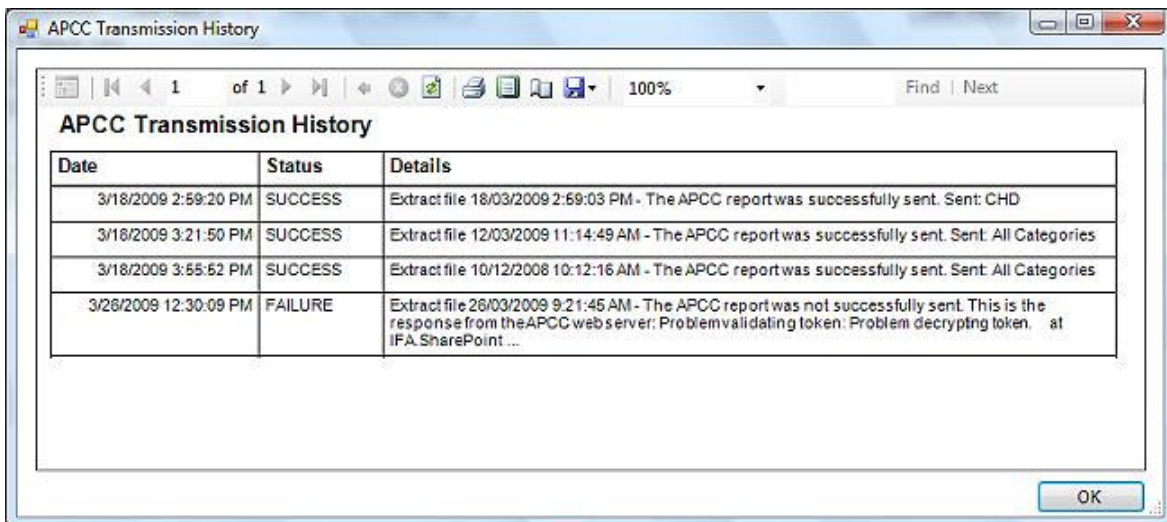


Figure 8B: APCC Transmission History details

9 The IF Repository

The CAT APCC Report supports the APCC program in automating the data extraction and subsequent submitting of the data to the IF on line reporting web portal. This assists in reducing the practice workload and disruption.

Practices will be provided with login details so that they can access this web portal. They will need to contact their Division for details or visit the APCC web site at <http://www.apcc.org.au>. This web site provides a number of user guides about how to logon to the web portal and the functionality that is available once logged on.

10 Appendix 1 – Vendor compatibility with APCC Indicators

The table below details which indicators do not currently have data collected from each vendor clinical system.

Indicator	Extract File Version				
	1_8	1_8	1_4	1_4	1_6
	MD	Best Practice	Genie	Zedmed	practiX
CHD-014	Smoking – Assessment only recorded if data has changed	Smoking – Assessment only recorded if data has changed	Smoking - No Assessed field	Smoking – Assessment only recorded if data has changed	Smoking - No Assessed field
CHD-018			No ACR	No ACR	
COPD-007	Smoking – Assessment only recorded if data has changed	Smoking – Assessment only recorded if data has changed	Smoking - No Assessed field	Smoking – Assessment only recorded if data has changed	Smoking - No Assessed field
DIA-027	Smoking – Assessment only recorded if data has changed	Smoking – Assessment only recorded if data has changed	Smoking - No Assessed field	Smoking – Assessment only recorded if data has changed	Smoking - No Assessed field
DIA -015			No ACR	No ACR	
GEN-006	Smoking – Assessment only recorded if data has changed	Smoking – Assessment only recorded if data has changed	Smoking - No Assessed field	Smoking – Assessment only recorded if data has changed	Smoking - No Assessed field

	MD	Best Practice	Genie	Zedmed	practiX
GEN-008	No Breast Screen field	No Breast Screen field	No Breast Screen field	No Breast Screen field	No Breast Screen field
GEN-009	Absolute Risk Assessment manually entered if PrimaryCare Sidebar® is not installed	Absolute Risk Assessment manually entered if PrimaryCare Sidebar® is not installed	CRF and CVD Other not collected, hence not included Absolute Risk Assessment manually entered	CRF and CVD Other not collected, hence not included Absolute Risk Assessment manually entered	Absolute Risk Assessment manually entered
GEN-010	Diabetes Risk Assessment manually entered if PrimaryCare Sidebar® is not installed	Diabetes Risk Assessment manually entered if PrimaryCare Sidebar® is not installed	Diabetes Risk Assessment manually entered	Diabetes Risk Assessment manually entered	Diabetes Risk Assessment manually entered
GEN-011 to GEN-014			Physical Activity not collected Alcohol not collected	Physical Activity not collected Alcohol not collected	Physical Activity not collected
GEN-019	MBS items manually entered if non Pracsoft practice	MBS items manually entered if non BP billing practice	MBS items manually entered	MBS items manually entered	
MAN-038	MBS items manually entered if non Pracsoft practice	MBS items manually entered if non BP billing practice	MBS items manually entered	MBS items manually entered	

11 Appendix 2 – APCC Report Quick Reference Guide

	CORONARY HEART DISEASE		Data
CHD-001	CHD Register	Number of patients on the CHD register	Number of patients with a CHD coded diagnosis [This is the denominator for most of the CHD % indicators following]
	Blood Pressure	Patients with CHD whose last recorded BP within the last 12 months was:	
CHD-002	(i)	BP <= 130/80 mmHg	% of CHD patients with systolic BP <= 130 and diastolic BP <= 80 recorded in the last 12 months
CHD-003	(ii)	BP Recorded	% of CHD patients with a systolic BP and diastolic BP recorded in the last 12 months
CHD-004	Anti-platelet	Patients with CHD who are currently prescribed an Antiplatelet Medication	% of CHD patients prescribed a drug from either <ul style="list-style-type: none"> • Aspirin class • Clopidogrel
CHD-005	Statin	Patients with CHD who are currently prescribed a Statin Medication	% of CHD patients prescribed a drug from <ul style="list-style-type: none"> • Statin class
	Cholesterol	Patients with CHD whose last recorded LDL/Cholesterol within the last 12 months was:	
CHD-006	(i)	LDL <= 2mmol/l or if no LDL, Cholesterol < 4mmol/l	% of CHD patients with LDL <= 2mmol/l or if no LDL, Total Cholesterol < 4mmol/l recorded in the last 12 months

CHD-007	(ii)	Cholesterol Recorded	% of CHD patients with Total Cholesterol recorded in the last 12 months
CHD-008	ACE/ARB	Patients with CHD who are currently prescribed an ACE or ARB Medication	% of CHD patients prescribed a drug from either <ul style="list-style-type: none"> • ACE Inhibitor class • Angiotension Receptor Blocker Class
	Smoking Status	Patients with CHD whose Smoking status is:	
CHD-009	A.	Non Smoker	% of CHD patients with a smoking status recorded as Non Smoker (i) and (ii)
CHD-010	(i)	Never Smoked	% of CHD patients with a smoking status recorded as Never Smoked
CHD-011	(ii)	Ex Smoker	% of CHD patients with a smoking status recorded as Ex Smoker
CHD-012	(iii)	Current Smoker	% of CHD patients with a smoking status recorded as Current Smoker (Daily or Irregular)
CHD-013	(iv)	Not Recorded	% of CHD patients with a smoking status not recorded
CHD-014	B.	Proportion of Patients with CHD who are recorded as Current Smoker or Ex Smoker and who have had their smoking status assessed in the last 12 mths	% of CHD patients recorded as Current or Ex Smoker, who have had their smoking status recorded as assessed in the last 12 month [Note: as the denominator for this indicator is not the total number of patients with CHD only a % is provided] [Note 2: some clinical systems do not record the assessment date and hence this indicator will be 0; others only record the date of last update]

CHD-015	MI/ACS	Patients with CHD who have had a Myocardial Infarction (MI) or Acute Coronary Syndrome (ACS) within the last 12 months	% of CHD patients with a coded diagnosis of MI or ACS
CHD-016	CHD Death	Patients with CHD recorded as Deceased in the last calendar month	Number of patients that were recorded as deceased in the last calendar month. This indicator does not look at the actual date of death but rather at the date this was recorded. [Note the patients included in this indicator are no longer on the CHD register] [Only a number is provided for this indicator]
CHD-017	CHD All	CHD Patients who satisfy all the following measures: - Blood Pressure <= 130/80 mmHg last 12 months - Anti-platelet Medication - LDL <= 2mmol/l or if no LDL, Cholesterol < 4mmol/l last 12 months - ACE or ARB Medication	% of CHD patients who meet the criteria for indicators CHD-002, CHD-004, CHD-006 and CHD-008
CHD-018		CHD Patients who have had an eGFR AND urinary ACR or other urinary Microalbumin test result in the last 12 months	% of CHD Patients who have had an eGFR AND urinary ACR or other urinary Microalbumin test result in the last 12 months

	DIABETES		Data
DIA-001	Diabetes Register	Number of patients on the Diabetes Register	Number of patients with a Diabetes coded diagnosis [This is the denominator for most of the Diabetes % indicators following]
	HbA1c	Patients with Diabetes whose last recorded HbA1c within the last 12 months was:	
DIA-002	(i)	HbA1c <= 7.0%	% of Diabetes patients with HbA1c <= 7.0% recorded in the last 12 months
DIA-003	(ii)	HbA1c > 7.0% and <= 8.0%	% of Diabetes patients with HbA1c > 7.0% and <= 8.0% recorded in the last 12 months
DIA-004	(iii)	HbA1c > 8.0% and <= 10.0%	% of Diabetes patients with HbA1c > 8.0% and <= 10.0% recorded in the last 12 months
DIA-005	(iv)	HbA1c > 10.0%	% of Diabetes patients with HbA1c > 10.0% recorded in the last 12 months
DIA-006	(v)	HbA1c Not Recorded	% of Diabetes patients with HbA1c not recorded in the last 12 months

	Cholesterol	Patients with Diabetes whose last recorded LDL/Cholesterol within the last 12 months was:	
DIA-007	(i)	LDL <= 2mmol/l or if no LDL, Cholesterol < 4 mmol/l	% of Diabetes patients with LDL <= 2mmol/l or if no LDL, Total Cholesterol < 4mmol/l recorded in the last 12 months
DIA-008	(ii)	Cholesterol Recorded	% of Diabetes patients with Total Cholesterol recorded in the last 12 months
	Blood Pressure	Patients with Diabetes whose last recorded BP within the last 12 months was:	
DIA-009	(i)	BP <= to 130/80 mmHg	% of Diabetes patients with systolic BP <= 130 and diastolic BP <= 80 recorded in the last 12 months
DIA-010	(ii)	BP Recorded	% of Diabetes patients with a systolic BP and diastolic BP recorded in the last 12 months
	Key Measures	Diabetes Service Incentive Payment (SIP) key measures: (HbA1c, LDL/Cholesterol, BP x2, eGFR, ACR or other urinary Microalbumin test, Smoking status recorded) Required timeframes for these measures are: HbA1c in last 12 months Cholesterol in last 12 months BP in last 6 months and the previous 6 months eGFR in last 12 months ACR or other urinary Microalbumin test in last 12 months	
DIA-011	(i)	Patients with Diabetes who have received all key measures of the annual cycle of care within the required timeframe and satisfy all the following measures: - HbA1c <= 7.0% - LDL <= 2mmol/l or if no LDL, Cholesterol < 4mmol/l - BP <=130/80 mmHg - Smoking status of Non Smoker or Ex Smoker	% of Diabetes patients who have the key measures recorded in the required timeframe and who meet the criteria for key measures DIA-002, DIA-007, DIA-009, DIA-015 and who have a Smoking status recorded as Non Smoker or Ex Smoker

DIA-012	(ii)	Patients with Diabetes who have received all key measures of the annual cycle of care within the required timeframe	% of Diabetes patients who have the key measures recorded in the required timeframe
DIA-013	Annual Cycle of Care	Diabetes Annual Cycle of Care	The Diabetes Annual Cycle of Care has 17 items. There are 13 collected by CAT: 2 X BMI (BMI is required each 6mths), 2 X BP, 2 X Foot check, HbA1c, Cholesterol, Triglycerides, HDL, ACR or other urinary Microalbumin test, Eye Exam (in last 24 mths) , Smoking Review There are 4 not collected: Diet Review, Physical Activity Review, Medicine Review, Self Care Education
		Percentage of Annual Cycle of Care Items Completed for Patients with Diabetes (based on 17 items possible)	This indicator is calculated as: $\frac{\text{The total number of care items completed}}{\text{No. of patients on the Diabetes Register X 17 (ie. the total number possible)}} \%$ [As not all items are collected this indicator can never be 100%]
DIA-014 has been removed			
DIA-015	ACR	Patient with Diabetes who have had an eGFR AND urinary ACR or other urinary Microalbumin test result in the last 12 months	% of Diabetes patients who have had an eGFR and urinary ACR or other urinary Microalbumin test result in the last 12 months
DIA-016	Fluvax	Patients with Diabetes who have had an Influenza vaccine within the last 12 months	% of Diabetes patients who have had an Influenza vaccine in the last 2 years

DIA-017	Pneumovax	Patients with Diabetes who have had a Pneumovax immunisation within the last 5 years, or 2 vaccines at any time	% of Diabetes patients who have had an Pneumovax immunisation in the last 5 years or have at least 2 doses recorded
DIA-018	Waist	Patients with Diabetes with last waist recorded Male <=102cm, Female <=88cm	% of Diabetes patients who have had a waist recorded and Male <=102cm, Female <=88cm
DIA-019	Waist Recorded	Patients with Diabetes with waist recorded	% of Diabetes patients who have had a waist recorded
DIA-020	BMI	Patients with Diabetes with last BMI recorded < 25	% of Diabetes patients who have had a BMI recorded and BMI < 25
DIA-021	BMI Recorded	Patients with Diabetes with BMI recorded	% of Diabetes patients who have had a BMI recorded
	Smoking Status	Patients with Diabetes whose Smoking status is:	
DIA-022	A.	Non Smoker	% of Diabetes patients with a smoking status recorded as Non Smoker
DIA-023	(i)	Never Smoked	% of Diabetes patients with a smoking status recorded as Never Smoker (i) and (ii)
DIA-024	(ii)	Ex Smoker	% of Diabetes patients with a smoking status recorded as Ex Smoker
DIA-025	(iii)	Current Smoker	% of Diabetes patients with a smoking status recorded as Current Smoker (Daily or Irregular)
DIA-026	(iv)	Not Recorded	% of Diabetes patients with a smoking status not recorded

DIA-027	B.	Proportion of Patients with Diabetes and who are recorded as Current Smoker or Ex Smoker and who have had their smoking status assessed in the last 12 mths	<p>% of Diabetes patients recorded as Current or Ex Smoker, who have had their smoking status recorded as assessed in the last 12 month</p> <p>[Note: as the denominator for this indicator is not the total number of patients with Diabetes only a % is provided]</p> <p>[Note 2: some clinical systems do not record the assessment date and hence this indicator will be 0; others only record the date of last update]</p>
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CHRONIC OBSTRUCTIVE PULMONARY DISEASE			Data
COPD-001	COPD Register	Number of patients on the COPD Register	Number of patients with a COPD coded diagnosis [This is the denominator for most of the COPD % indicators following]
	Smoking Status	Patients with COPD whose Smoking status is:	
COPD-002	A.	Non Smoker	% of COPD patients with a smoking status recorded as Non Smoker
COPD-003	(i)	Never Smoked	% of COPD patients with a smoking status recorded as Never Smoker (i) and (ii)
COPD-004	(ii)	Ex Smoker	% of COPD patients with a smoking status recorded as Ex Smoker
COPD-005	(iii)	Current Smoker	% of COPD patients with a smoking status recorded as Current Smoker (Daily or Irregular)
COPD-006	(iv)	Not Recorded	% of COPD patients with a smoking status not recorded

COPD-007	B.	Proportion of Patients with COPD and who are recorded as Current Smoker or Ex Smoker and who have had their smoking status assessed in the last 12 mths	<p>% of COPD patients recorded as Current or Ex Smoker, who have had their smoking status recorded as assessed in the last 12 month</p> <p>[Note: as the denominator for this indicator is not the total number of patients with COPD only a % is provided]</p> <p>[Note 2: some clinical systems do not record the assessment date and hence this indicator will be 0; others only record the date of last update]</p>
COPD-008 has been removed			
COPD-009	Spirometry	Patients with COPD who have a Spirometry result Recorded	% of COPD patients who have had a Spirometry at any time
COPD-010	Fluvax	Patients with COPD who have had an Influenza vaccine within the last 12 months	% of COPD patients who have had an Influenza vaccine in the last 2 years
COPD-011	Pneumovax	Patients with COPD who have had a Pneumovax immunisation within the last 5 years, or 2 vaccines at any time	% of COPD patients who have had an Pneumovax immunisation in the last 5 years or have at least 2 doses recorded

	PREVENTION		Data
	SMOKING		
		Number of patients >= age 18, ATSI >=15 in total population	[This is the denominator for GEN-001 to GEN-005]
	Smoking Status	Patients >= age 18, ATSI >=15 whose Smoking status is:	
GEN-001	A.	Non Smoker	% of patients with a smoking status recorded as Non Smoker (i) and (ii)
GEN-002	(i)	Never Smoked	% of patients with a smoking status recorded as Never Smoker
GEN-003	(ii)	Ex Smoker	% of patients with a smoking status recorded as Ex Smoker
GEN-004	(iii)	Current Smoker	% of patients with a smoking status recorded as Current Smoker (Daily or Irregular)
GEN-005	(iv)	Not Recorded	% of patients with a smoking status not recorded
GEN-006	B.	Proportion of Patients who are recorded as Current Smoker or Ex Smoker and who have had their smoking status assessed in the last 12 mths	% of patients recorded as Current or Ex Smoker, who have had their smoking status recorded as assessed in the last 12 month [Note: as the denominator for this indicator is not the total number of patients (>= age 18, ATSI >=15) only a % is provided] [Note 2: some clinical systems do not record the assessment date and hence this indicator will be 0; others only record the date of last update]

PAP SMEAR			
		Number of Female patients aged 20-69 who are eligible for a Pap Smear	[This is the denominator for GEN-007]
GEN-007	Pap Smear	Pap Smear last 2 years	% of Female patients aged 20-69 who are eligible for a Pap Smear and are recorded as having had a Pap Smear in the last 2 years
BREAST SCREEN			
		Number of female patients aged 50-69	[This is the denominator for GEN-008]
GEN-008	Breast Screen	Breast Screen last 2 years	% of female patients aged 50-69 who are recorded as having had a Breast Screen in the last 2 years [Currently the clinical systems do not have a coded data item for this and hence the indicator will be 0]
RISK FACTORS			
ABSOLUTE RISK ASSESSMENT			
		Number of patients non ATSI aged 45-74 or ATSI aged 35-74 without CVD, Diabetes COPD or CRF	[This is the denominator for GEN-009]
GEN-009	Absolute Risk Assessment	Have had an Absolute Risk Assessment	% of patients WITH chronic disease (as defined above) who have had a risk assessment [Note: Numerator will be entered manually]

DIABETES RISK ASSESSMENT			
		Number of patients aged >= 40, ATSI >=15 with Diabetes	[This is the denominator for GEN-010]
GEN-010	Diabetes Risk Assessment	Have had a Diabetes Risk Assessment	% of patients with Diabetes who have had a diabetes assessment [Note: Numerator will be entered manually]
MODIFIABLE RISK FACTORS			
		Number of items for patients >= age 35, ATSI >=15 without CVD, Diabetes COPD or CRF	[This is the denominator for GEN-011 / GEN-013]
GEN-011	Risk factors that meet targets - Prevention	Number of items where the last recorded measurement meets the following: - BP systolic <=130 - Cholesterol < 4 - Smoker – never or ex - Waist <= 102cm male, 88 cm female - Alcohol <= 2 drinks per day - Physical activity = assessed	The total number of items recorded that meet recommended targets ----- Number of patients WITHOUT chronic disease (as defined above) X 6 (total items)
		Number items for patients >= age 35, ATSI >=15 with CVD, Diabetes COPD or CRF	[This is the denominator for GEN-012 / GEN-014]
GEN-012	Risk factors that meet targets - Management	Number of items where last recorded measurements meet the following: - BP systolic <=130 - Cholesterol < 4 - Smoker – never or ex - Waist <= 102cm male, 88 cm female - Alcohol <= 2 drinks per day - Physical activity = assessed	The total number of items recorded that meet recommended targets ----- Number of patients WITH chronic disease (as defined above) X 6 (total items)

		Number items for patients \geq age 35, ATSI \geq 15 without CVD, Diabetes COPD or CRF	[This is the denominator for GEN-011 / GEN-013]
GEN-013	Risk factors recorded - Prevention	Number of items with a measurement recorded: - BP systolic, Cholesterol, Smoker, Waist, Alcohol, Physical activity	The total number of items recorded ----- Number of patients WITHOUT chronic disease (as defined above) X 6 (total items)
		Number items for patients \geq age 3, ATSI \geq 15 with CVD, Diabetes COPD or CRF	[This is the denominator for GEN-012 / GEN-014]
GEN-014	Risk factors recorded - Management	Number of items with a measurement recorded: - BP systolic, Cholesterol, Smoker, Waist, Alcohol, Physical activity	The total number of items recorded ----- Number of patients WITHOUT chronic disease (as defined above) X 6 (total items)
WAIST and BMI			
		Number of patients \geq age 18, ATSI \geq 15 in total population	[This is the denominator for GEN-015 to GEN-018]
GEN-015	Waist meets targets	Patients \geq age 18, ATSI \geq 15 with Waist last recorded \leq 102cm male, 88 cm female	% of patients where waist meets target measurement
GEN-016	Waist recorded	Patients \geq age 18, ATSI \geq 15 with Waist recorded	% of patients where waist recorded
GEN-017	BMI meets targets	Patients \geq age 18, ATSI \geq 15 with BMI last recorded $<$ 25	% of patients where BMI meets target measurement
GEN-018	BMI recorded	Patients \geq age 18, ATSI \geq 15 with BMI recorded	% of patients where BMI recorded
GP MANAGEMENT PLANS			
		Number of patients with CVD, Diabetes COPD or CRF	[This is the denominator for GEN-019]
GEN-019	GPMP established	A GPMP (MBS 721, 729 or 731) established within the last 2 years	% of patients WITH chronic disease (as defined above) who have a GPMP

IMMUNISATIONS			
		Number of patients >= age 18, ATSI >=15 in total population	[This is the denominator for GEN-022 to GEN-023]
GEN-022	Fluvax	Patients >= age 18, ATSI >=15 who have had an Influenza vaccine within the last 12 months	% of patients who have had an Influenza vaccine in the last 2 years
GEN-023	Pneumovax	Patients >= age 18, ATSI >=15 who have had a Pneumovax immunisation within the last 5 years, or 2 vaccines at any time	% of patients who have had an Pneumovax immunisation in the last 5 years or have at least 2 doses recorded
ATSI HEALTH ASSESSMENTS			
GEN-024	ATSI Key Health Check Inputs	Percentage of Key Health Check Inputs Completed for ATSI Patients (based on 8 or 9 items possible where age >=15 and 4 where age <15) ATSI >=15: Smoking, Height, Weight, eGFR, ACR, Cholesterol, BSL, BP, Pap smear (where eligible) ATSI <15: Smoking, Height, Weight, BP	This indicator is calculated as: $\frac{\text{The total number of key items completed}}{\text{No. of ATSI patients } \geq 15 \times 8 \text{ (or 9) + No. ATSI patients } < 15 \times 4 \text{ (ie. the total number possible)}} \%$
ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)			
	eGFR	Number of patients >= age 18, ATSI >=15 in total population	[This is the denominator for GEN-025 to GEN-036]
GEN-025	(i)	eGFR >= 45 and <60 (CKD 3a) recorded within the last 12 months	% of patients with eGFR >= 45 and <60 recorded in the last 12 months
GEN-026	(ii)	eGFR >=30 and < 45 (CKD 3b) recorded within the last 12 months	% of patients with eGFR >=30 and < 45 recorded in the last 12 months
GEN-027	(iii)	eGFR >=15 and < 30 (CKD 4) recorded within the last 12 months	% of patients with eGFR >=15 and < 30 recorded in the last 12 months
GEN-028	(iv)	eGFR < 15 (CKD 5) recorded within the last 12 months	% of patients with eGFR < 15 recorded in the last 12 months

	eGFR – Recording Quality	Number of patients \geq age 18, ATSI \geq 15 in total population	Quality measures: ACR or other urinary microalbumin test, diastolic and systolic BP recorded in the last 12 months
GEN-029	(i)	eGFR \geq 45 and $<$ 60 (CKD 3a) and have all quality measures recorded in the last 12 months	% of patients with eGFR \geq 45 and $<$ 60 recorded in the last 12 months and have quality measures recorded
GEN-030	(ii)	eGFR \geq 30 and $<$ 45 (CKD 3b) and have all quality measures recorded in the last 12 months	% of patients with eGFR \geq 30 and $<$ 45 recorded in the last 12 months and have quality measures recorded
GEN-031	(iii)	eGFR \geq 15 and $<$ 30 (CKD 4) and have all quality measures recorded in the last 12 months	% of patients with eGFR \geq 15 and $<$ 30 recorded in the last 12 months and have quality measures recorded
GEN-032	(iv)	eGFR $<$ 15 (CKD 5) and have all quality measures recorded in the last 12 months	% of patients with eGFR $<$ 15 recorded in the last 12 months and have quality measures recorded
	eGFR – Risk Profile	Number of patients \geq age 18, ATSI \geq 15 in total population	Risk profile: ACR \geq 2.6(male), \geq 3.6 (female) or 24hr urinary albumin $>$ 30 mg/day and BP \leq 130/80 recorded in the last 12 months
GEN-033	(i)	eGFR \geq 45 and $<$ 60 (CKD 3a) and match risk profile with measures recorded in the last 12 months	% of patients with eGFR \geq 45 and $<$ 60 recorded in the last 12 months and match risk profile
GEN-034	(ii)	eGFR \geq 30 and $<$ 45 (CKD 3b) and match risk profile with measures recorded in the last 12 months	% of patients with eGFR \geq 30 and $<$ 45 recorded in the last 12 months and match risk profile
GEN-035	(iii)	eGFR \geq 15 and $<$ 30 (CKD 4) and match risk profile with measures recorded in the last 12 months	% of patients with eGFR \geq 15 and $<$ 30 recorded in the last 12 months and match risk profile
GEN-036	(iv)	eGFR $<$ 15 (CKD 5) and match risk profile with measures recorded in the last 12 months	% of patients with eGFR $<$ 15 recorded in the last 12 months and match risk profile

	MANUAL MEASURES		Data Entry Selections
MAN-001	Open Access	Is the practice using an 'Open Access' system?	Yes or No radio button
MAN-002	GP Third Available	The number of days until the GP 3rd Available appointment.	Textbox – 2 decimals
MAN-003	Practice Nurse	Is there a practice nurse who takes appointments?	Yes or No radio button
MAN-004	Nurse Third Available	The number of days until the Practice nurse 3rd available appointment.	Textbox – 2 decimals
MAN-005	Unmet Demand	The number of patients whose appointment demands were unmet.	Textbox – 2 decimals
MAN-006	Patient Satisfaction	Average patient satisfaction score	Textbox – 2 decimals
MAN-007	GP FTE	The number of full time equivalent GPs at the practice.	Textbox – allow decimals
MAN-008	Practice Nurse FTE	The number of full time equivalent practice nurses employed at the practice.	Textbox – allow decimals
MAN-009		Intentionally spare.	
MAN-010		Intentionally spare.	
MAN-011		Intentionally spare.	

MAN-012 to MAN-021	Registers	<p>Does the practice have a practice wide, systemised register for the following?</p> <ul style="list-style-type: none"> • CHD • Hypertension • COPD • Asthma • Diabetes • Diabetes Risk • Any Mental Health • Osteoporosis • Any Cancer • Other <p>Other registers not included above can be entered in manually</p>	<p>Radio buttons for each register: Electronic, Paper</p> <p>Textbox</p>
MAN-022 to MAN-031	Recall/Reminder Systems	<p>Does the practice have a practice wide, systemised recall/ reminder system for the following?</p> <ul style="list-style-type: none"> • CHD • Hypertension • COPD • Asthma • Diabetes • Diabetes Risk • Any Mental Health • Osteoporosis • Any Cancer • Other <p>Other registers not included above can be entered in manually)</p>	<p>Radio buttons for each register: Electronic, Paper</p> <p>Textbox</p>
MAN-032	Aboriginal Health Worker FTE	The number of full time equivalent aboriginal health workers employed at the practice.	Textbox – allow decimals
MAN-033	Allied Health Worker FTE	The number of full time equivalent allied health workers employed at the practice.	Textbox – allow decimals

MAN-034	Administration /Management FTE	The number of full time equivalent management and administration staff employed at the practice.	Textbox – allow decimals
MAN-035	Psychologists /Counsellors FTE	The number of full time equivalent psychologists and counsellors employed at the practice.	Textbox – allow decimals
MAN-036	Staff with cultural awareness	The percentage of practice staff who have had Aboriginal and Torres Strait Islander cultural awareness training	Textbox – allow decimals
MAN-037	Active Patients	The total number of patients that are active in the practice clinical database	Calculated values broken down by ATSI status
MAN-038	ATSI Health Assessments	The percentage of ATSI patients who have received a health assessment in the past 12 months (MBS 704, 706, 710 or 715)	Calculated if the practice clinical and billing systems are provided by the same vendor and MBS items are being collected (check Appendix 1 for Vendor compatibility with MBS items). Textbox – allow decimals