PCS CLINICAL AUDIT TOOL

USER GUIDE – APCC REPORT AND SUBMISSION

PEN COMPUTER SYSTEMS PTY LTD

VERSION 2.7

Additional Module

COMPANY CONTACT DETAILS

Head Office:

Pen Computer Systems Pty Ltd
Level 6, 10-14 Smith St
PARRAMATTA NSW 2150

Phone: 61 2 9635 8955
Fax: 61 2 9635 8966
Email: enquiries@pencs.com.au
Web: www.pencs.com.au

Melbourne Office:

Pen Computer Systems Pty Ltd
Level 5, 434 St Kilda Road
MELBOURNE VIC 3004

Phone: 61 3 9866 8477
Fax: 61 3 9866 5699

DOCUMENT IDENTIFIER:

CLINICAL AUDIT TOOL USER GUIDE – APCC REPORT AND SUBMISSION

Document Version	Release Approval Date	Created/Modified By	Revision
2.4	14/02/2009	Christine Chidgey	Initial Document to accompany CAT User Guide 2.4
2.4.1	26/03/2009	Christine Chidgey	Updates following APCC Pilot
2.5	28/05/2009	Christine Chidgey	Update to Appendix 1 for Best Practice and Genie upgrades
2.5.1	25/06/2009	Christine Chidgey	Add APCC web site details
2.7	5/11/2009	Christine Chidgey	Updates for changes to the APCC Report • COPD-008 has been removed • General section has been renamed Prevention • GEN-001 to GEN-006 have been updated to apply to patients >= 18 years age • New Prevention indicators GEN-009 to GEN-019 have been added • A Prevention indicators entry form has been added for indicators where the numerator cannot be collected

DOCUMENT IDENTIFIER: 3
CLINICAL AUDIT TOOL USER GUIDE – APCC REPORT AND SUBMISSION 3

1. INTRODUCTION 5

1.1. Clinical Audit Tool (CAT) 5
1.2. CAT APCC Report and Submission 5
1.3. CAT APCC Report and Submission User Guide 6
1.4. Definitions, acronyms and abbreviations 6
1.5. Related Documents 6

2. SYSTEM REQUIREMENTS 7

2.1. Clinical Desktop System Compatibility 7

3. INSTALLATION 7

4. APCC REPORT 8

4.1. APCC Practice Token 9
4.2. APCC Report 10

5. MANUAL INDICATORS DATA ENTRY 11

6. REPORT SUBMISSION 14

7. REPORT SUBMISSION HISTORY 17

8. THE APCC REPOSITORY 18

9. APPENDIX 1 - VENDOR COMPATIBILITY WITH APCC INDICATORS 19

10. APPENDIX 2 - APCC REPORT QUICK REFERENCE 20

1. INTRODUCTION

1.1. Clinical Audit Tool (CAT)

The 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, 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 is scheduled for submission 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. Definitions, acronyms and abbreviations

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
GPMP	GP Management Plan
PCS	Pen Computer Systems

1.5. Related 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 - 'PCS Clinical Audit Tool – User Guide'.

2.1. Clinical Desktop System Compatibility

The CAT APCC Report and Submission is compatible with the following clinical desktop systems:

- Medical Director Versions 2 and 3
- Best Practice
- Genie

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 main CAT User Guide - 'PCS Clinical Audit Tool – User Guide'.

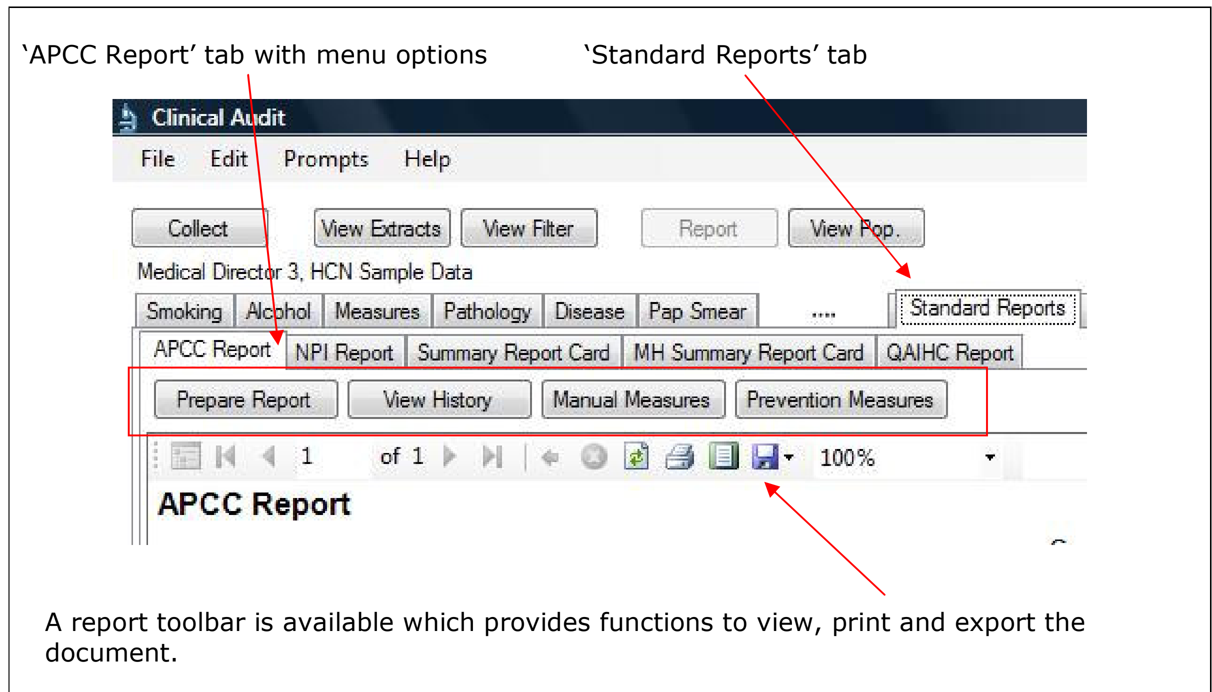
4. APCC Report

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

For practices participating in the APCC program, the APCC 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 an 'APCC Practice 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.



A report toolbar is available which provides functions to view, print and export the document.

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. APCC Practice Token

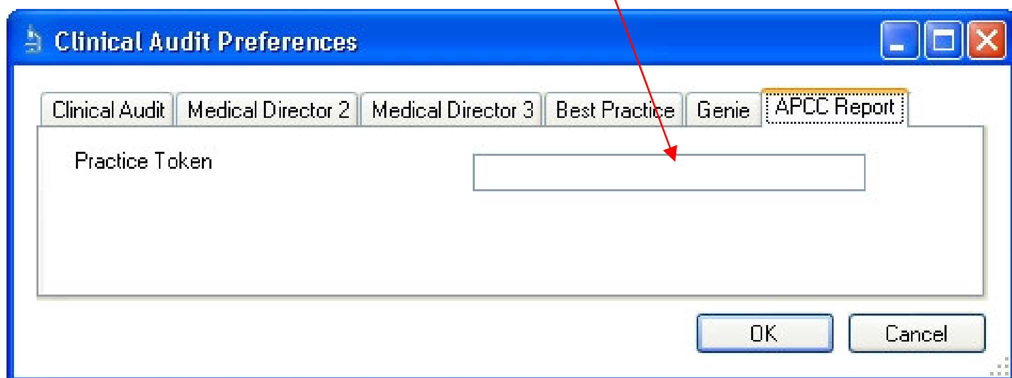
APCC participating practices will be provided with an 'APCC Practice Token'. This token must be set in CAT before you will be able to submit any data to the APCC repository.

To set this token

- Choose Edit > Preferences from the top menu

- The Preferences Dialog box will open, click on the 'APCC' tab

- Copy and paste your practice token into the field provided and click 'OK'



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

4.2. APCC Report

The APCC report provides a set of statistical indicators that promote practice improvement.

It provides statistics on
1) Key chronic disease areas:
- CHD
- Diabetes
- COPD

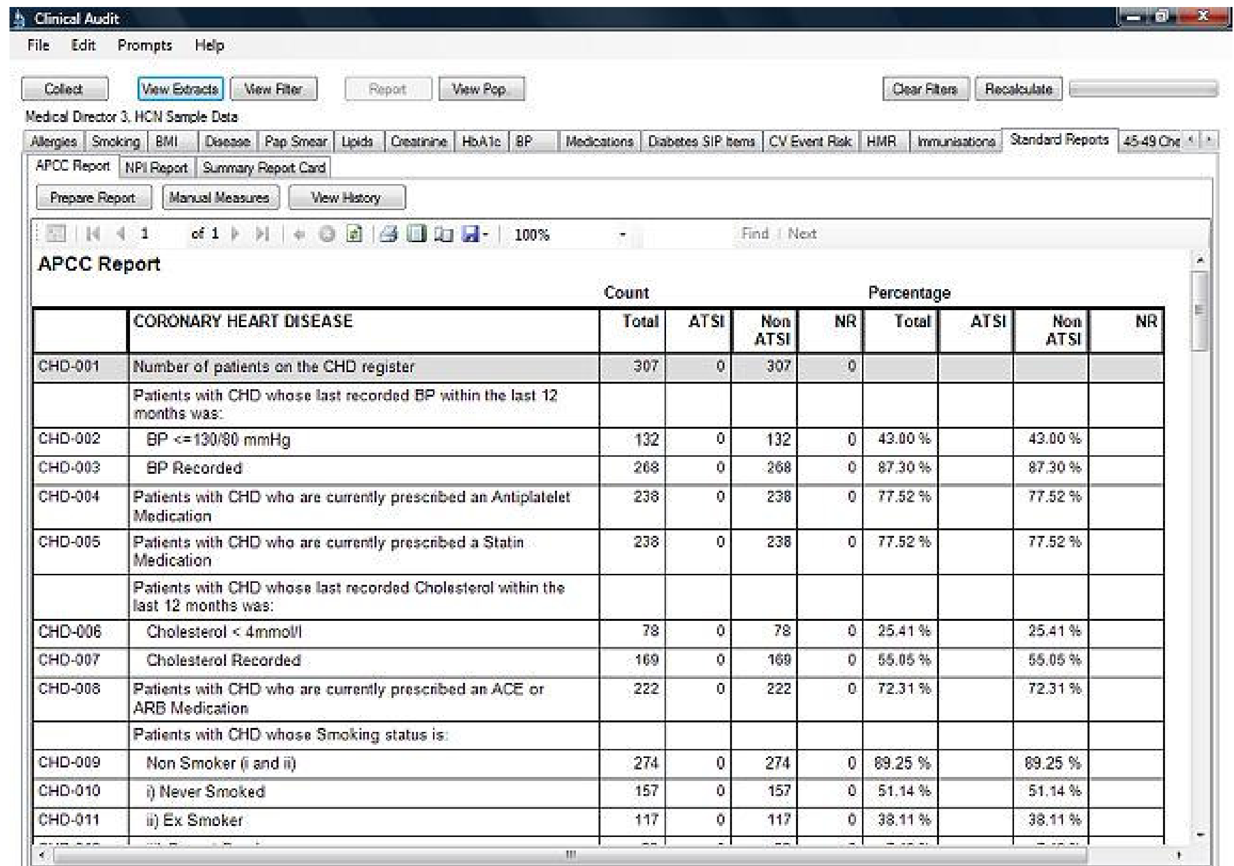
2) General population areas
- Smoking
- Pap Smear
- Breast Screen

The statistics in 1) and 2) are automatically calculated from the GPs clinical desktop system and are broken down by ethnicity - ATSI, Non ATSI and Not Recorded.

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.

3) Manual Measures
There are a set of Manual Measures that focus on practice level outcomes. These are not calculated. The practice is required to update them manually.

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



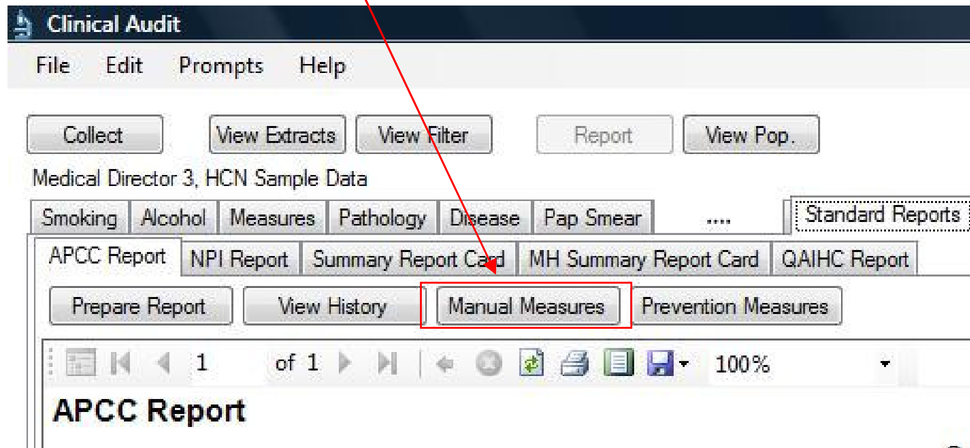
APCC Report

		Count				Percentage			
	CORONARY HEART DISEASE	Total	ATSI	Non ATSI	NR	Total	ATSI	Non ATSI	NR
CHD-001	Number of patients on the CHD register	307	0	307	0				
	Patients with CHD whose last recorded BP within the last 12 months was:								
CHD-002	BP <=130/80 mmHg	132	0	132	0	43.00 %		43.00 %	
CHD-003	BP Recorded	268	0	268	0	87.30 %		87.30 %	
CHD-004	Patients with CHD who are currently prescribed an Antiplatelet Medication	238	0	238	0	77.52 %		77.52 %	
CHD-005	Patients with CHD who are currently prescribed a Statin Medication	238	0	238	0	77.52 %		77.52 %	
	Patients with CHD whose last recorded Cholesterol within the last 12 months was:								
CHD-006	Cholesterol < 4mmol/l	78	0	78	0	25.41 %		25.41 %	
CHD-007	Cholesterol Recorded	169	0	169	0	55.05 %		55.05 %	
CHD-008	Patients with CHD who are currently prescribed an ACE or ARB Medication	222	0	222	0	72.31 %		72.31 %	
	Patients with CHD whose Smoking status is:								
CHD-009	Non Smoker (i and ii)	274	0	274	0	89.25 %		89.25 %	
CHD-010	i) Never Smoked	157	0	157	0	51.14 %		51.14 %	
CHD-011	ii) Ex Smoker	117	0	117	0	38.11 %		38.11 %	

5. Manual Indicators Data Entry

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

Click the 'Manual Measures' menu option to open the form.



There are 10 manual measures.

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

Note that the majority of the measures will not change between reporting periods.

Click the 'Manual Measures' menu option.
The 'Manual Measures' screen will open.

Enter all the measures and click the 'Save' button to save the values.

These 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 (No selected)
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 (No selected)
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
MAN-008	The number of full time equivalent practice nurses employed at the practice.	0
MAN-012	Does the practice have a practice wide, systemised register for the following?	0

CHD	None	Hypertension	None	COPD	None
Asthma	None	Diabetes	None	Diabetes Risk	None
Any Mental Heatlh	None	Osteoporosis	None	Any Cancer	None
Other (comma seperated values)		Paper		Electronic	

MAN-013 Does the practice have a practice wide, systemised recall/ reminder system for the following?

CHD	None	Hypertension	None	COPD	None
Asthma	None	Diabetes	None	Diabetes Risk	None
Any Mental Heatlh	None	Osteoporosis	None	Any Cancer	None
Other (comma seperated values)		Paper		Electronic	

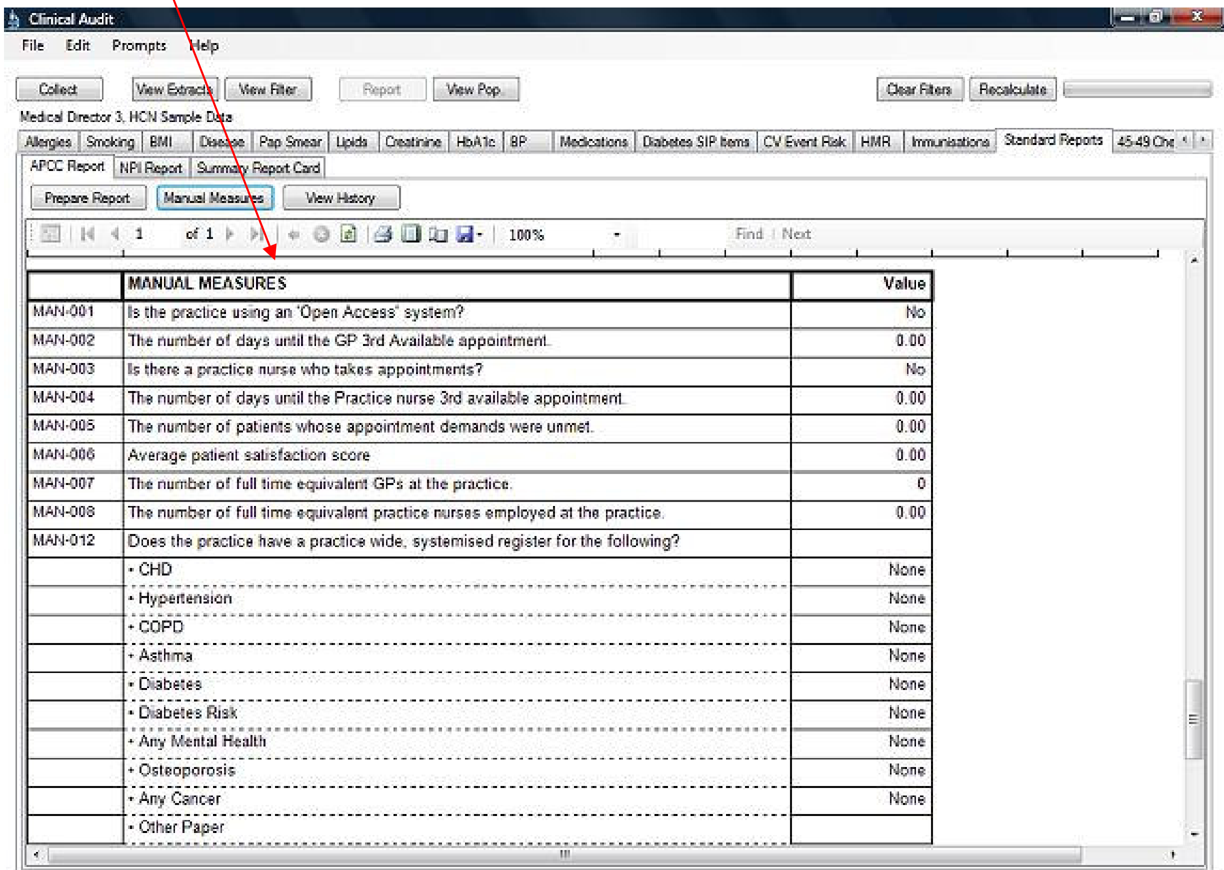
Save Cancel

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

On saving the manual 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)



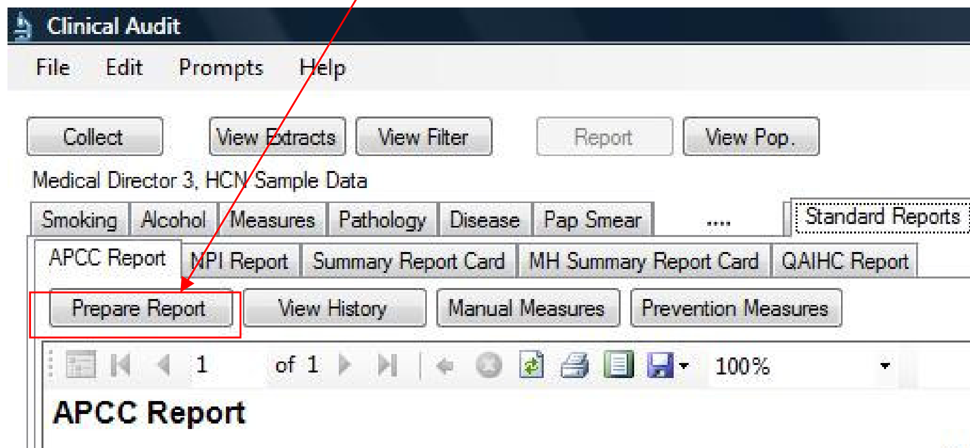
	MANUAL MEASURES	Value
MAN-001	Is the practice using an 'Open Access' system?	No
MAN-002	The number of days until the GP 3rd Available appointment.	0.00
MAN-003	Is there a practice nurse who takes appointments?	No
MAN-004	The number of days until the Practice nurse 3rd available appointment.	0.00
MAN-005	The number of patients whose appointment demands were unmet.	0.00
MAN-006	Average patient satisfaction score	0.00
MAN-007	The number of full time equivalent GPs at the practice.	0
MAN-008	The number of full time equivalent practice nurses employed at the practice.	0.00
MAN-012	Does the practice have a practice wide, systemised register for the following?	
	- CHD	None
	- Hypertension	None
	- COPD	None
	- Asthma	None
	- Diabetes	None
	- Diabetes Risk	None
	- Any Mental Health	None
	- Osteoporosis	None
	- Any Cancer	None
	- Other Paper	

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

6. Report Submission

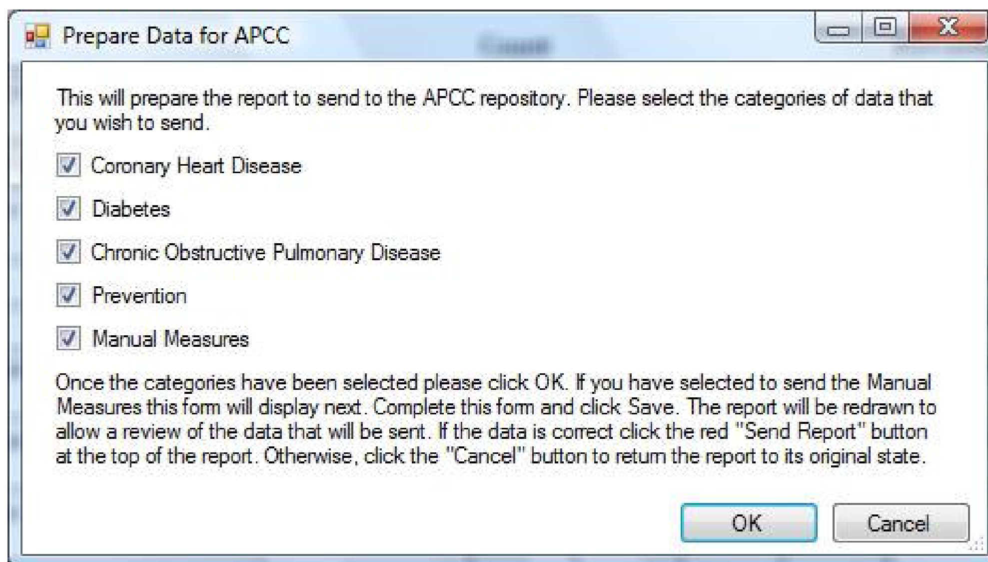
All or selected categories of measures can be submitted to the APCC data repository.

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



Click the 'Prepare Report' menu option.
The 'Prepare Data for APCC' screen will open.

This screen allows the user to select which categories of data they wish to send to the APCC.



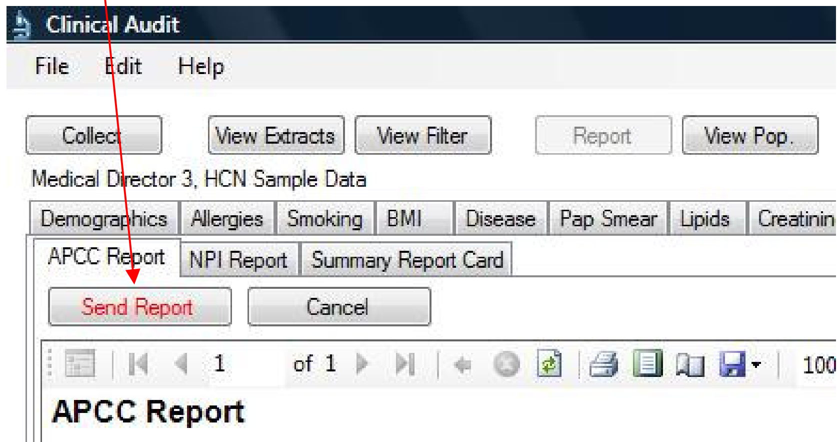
Once the categories are selected, click the 'OK' button.

- If the Prevention category is selected the Prevention indicators form 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. Complete or update this form and click 'Save'.

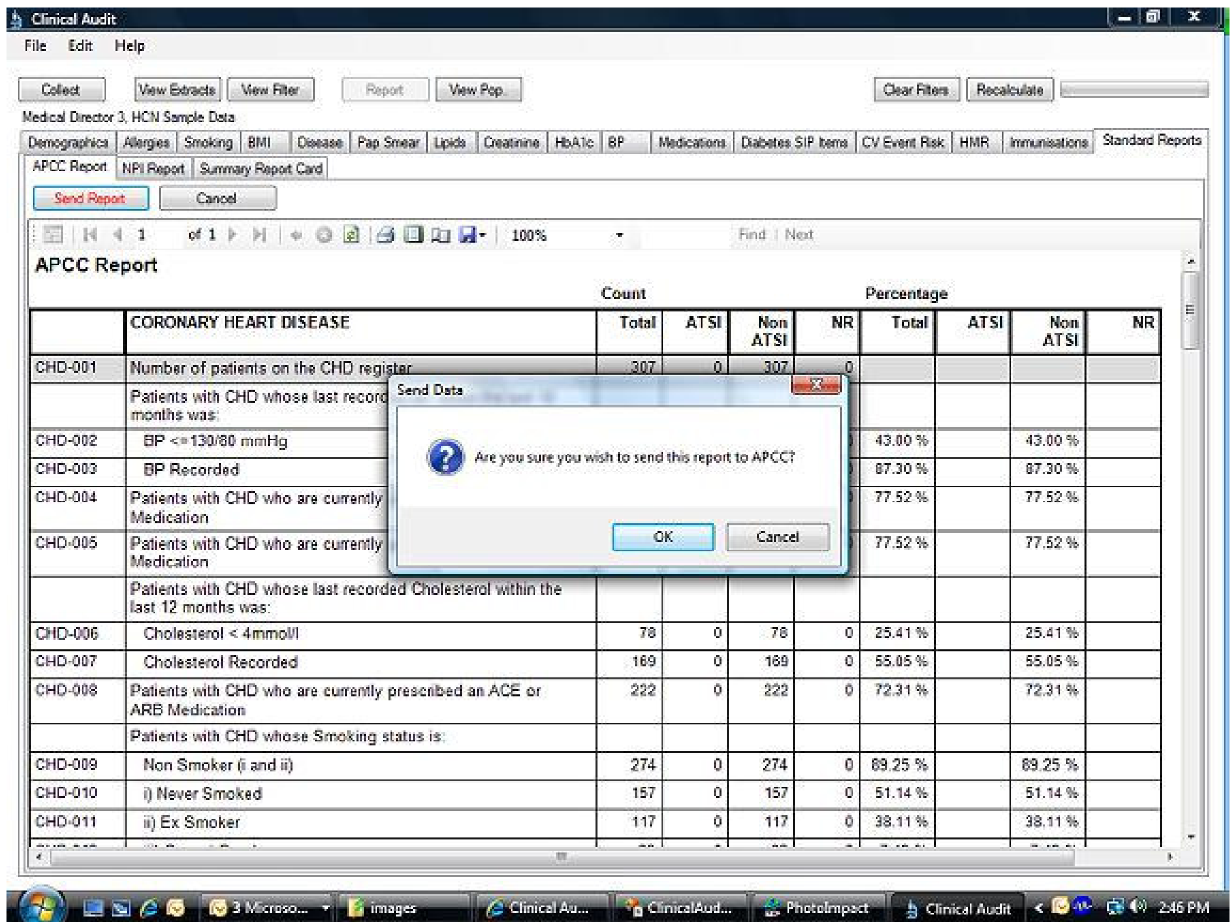
- The report will be refreshed with the selected report sections only.
- The 'Send Report' button will become active.

The user now has the chance to check the report before sending it.

'Send Report' button is active



Clicking the 'Send Report' button will give the user the chance to confirm.



After the 'Send Report' is confirmed, an XML file is created, saved and transmitted to the APCC repository.

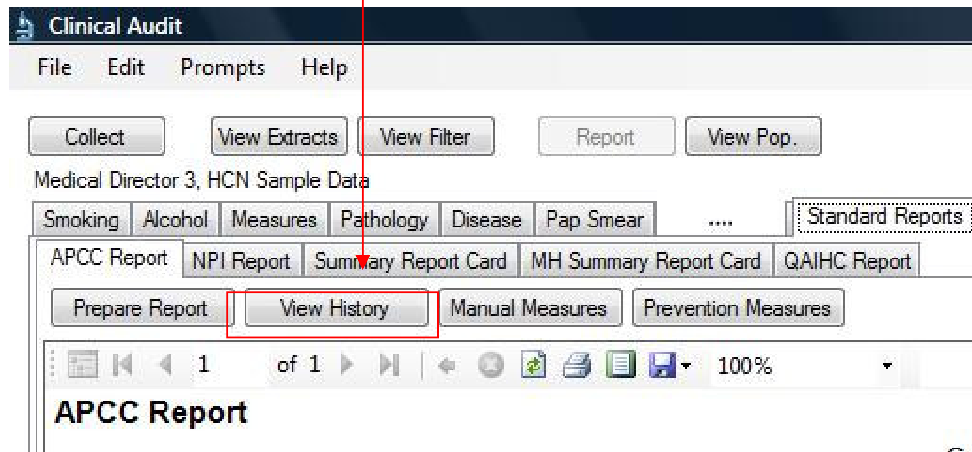
The user will be notified of whether the send has been successful.

It is important to note that the XML file contains the APCC Practice Token to ensure it is received correctly into the APCC 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

7. Report Submission History

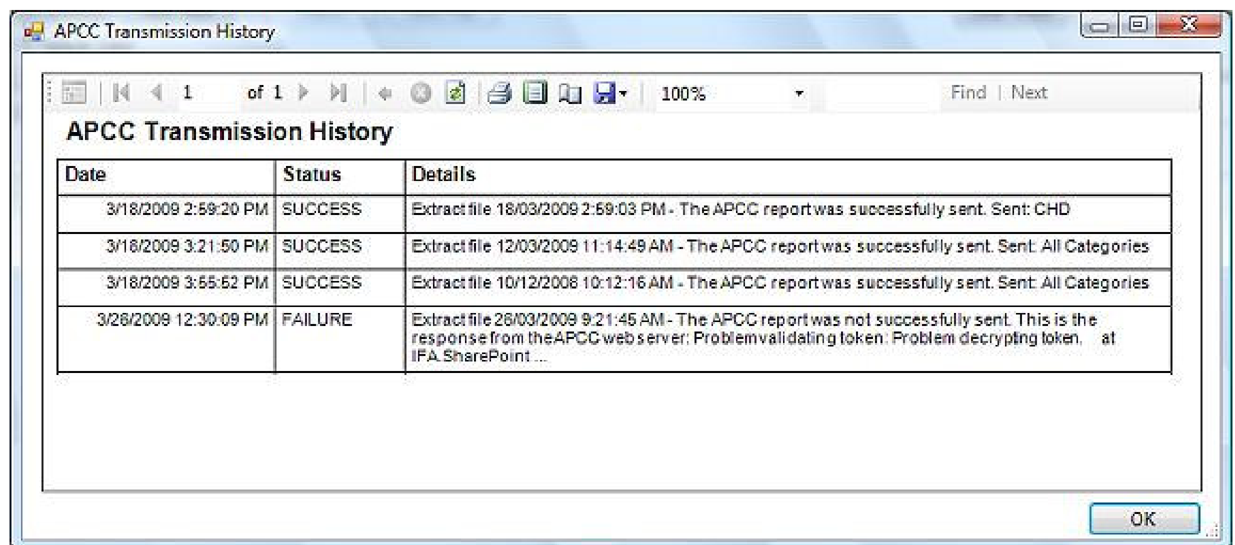
A list of reports that have been submitted to the APCC data repository can be viewed from the 'APCC Report' > 'View History' menu option.



The 'APCC Transmission History' screen 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.



APCC Transmission History

Date	Status	Details
3/18/2009 2:59:20 PM	SUCCESS	Extract file 18/03/2009 2:59:03 PM - The APCC report was successfully sent. Sent: CHD
3/18/2009 3:21:50 PM	SUCCESS	Extract file 12/03/2009 11:14:49 AM - The APCC report was successfully sent. Sent: All Categories
3/18/2009 3:55:52 PM	SUCCESS	Extract file 10/12/2008 10:12:16 AM - The APCC report was successfully sent. Sent: All Categories
3/26/2009 12:30:09 PM	FAILURE	Extract file 26/03/2009 9:21:45 AM - The APCC report was not successfully sent. This is the response from the APCC web server: Problem validating token: Problem decrypting token. at IFA.SharePoint ...

8. The APCC Repository

The CAT APCC Report supports the APCC program in automating the data extraction and subsequent submitting of the data to the APCC 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.

9. Appendix 1 - Vendor Compatibility with APCC Indicators

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

	Extract File version		
Indicator	**1_4**		**1_6**
	Best Practice	**Genie**	**MD**
CHD-014		No Assessed field	
COPD-007		No Assessed field	
COPD-009		NO – no spirometry results being collected yet	
GEN-006		No Assessed field	
GEN-008	No Breast Screen field	No Breast Screen field	No Breast Screen field
GEN-009	CRF and CVD Other not collected, hence not included Absolute Risk Assessment manually entered	CRF not collected Absolute Risk Assessment manually entered	Absolute Risk Assessment manually entered
GEN-010	Diabetes Risk Assessment manually entered	Diabetes Risk Assessment manually entered	Diabetes Risk Assessment manually entered
GEN-011 to GEN-014	Physical Activity not collected	Physical Activity not collected Alcohol not collected	
GEN-019	MBS items manually entered	MBS items manually entered	MBS items manually entered if non Pracsoft practice

10. Appendix 2 - APCC Report Quick Reference

	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 • Aspirin class • Clopidogrel
CHD-005	Statin	Patients with CHD who are currently prescribed a Statin Medication	% of CHD patients prescribed a drug from • Statin class
	Cholesterol	Patients with CHD whose last recorded Cholesterol within the last 12 months was:	
CHD-006	(i)	Cholesterol < 4mmol/l	% of CHD patients with 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 • 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 the denominator is not the total number of patients with CHD – only a % is provided for this indicator] [Note 2 the clinical systems do not currently record the date of smoking assessment and hence this indicator will be 0]
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 - 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
	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 Cholesterol within the last 12 months was:	
DIA-007	(i)	Cholesterol < 4 mmol/l	% of Diabetes patients with 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, Cholesterol, BP, 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 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% - 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: The total number of care items completed -- % 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	Aspirin	Patients with Diabetes who are aged >=55 and prescribed Aspirin	% of Diabetes patients who are aged 55 or over and are prescribed a drug from • Aspirin class
DIA-015	ACR	Patient with Diabetes who have had a urinary ACR or other urinary Microalbumin test result in the last 12 months	% of Diabetes patients who have had a 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	% of Diabetes patients who have had an Pneumovax immunisation in the last 5 years

	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	% of COPD patients recorded as Current or Ex Smoker, who have had their smoking status recorded as assessed in the last 12 month [Note the denominator is not the total number of patients with COPD – only a % is provided for this indicator] [Note 2 the clinical systems do not currently record the date of smoking assessment and hence this indicator will be 0]
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	% of COPD patients who have had an Pneumovax immunisation in the last 5 years

	PREVENTION		**Data**
	SMOKING		
		Number of patients >= age 18 in total population	Number of patients who are active in the GP clinical system (ie. who are not flagged as deceased or inactive) [This is the denominator for GEN-001 to GEN-005]
	Smoking Status	Patients >= age 18 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 the denominator is not the total number of patients – only a % is provided for this indicator] [Note 2 the clinical systems do not currently record the date of smoking assessment and hence this indicator will be 0]
	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 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 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 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 >= age 35 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 >= age 35 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 >= age 18 in total population	[This is the denominator for GEN-015 to GEN-018]
GEN-015	Waist meets targets	Patients >= age 18 with Waist last recorded <= 102cm male, 88 cm female	% of patients where waist meets target measurement
GEN-016	Waist recorded	Patients >= age 18 with Waist recorded	% of patients where waist recorded

GEN-017	BMI meets targets	Patients >= age 18 with BMI last recorded <= 30	% of patients where BMI meets target measurement
GEN-018	BMI recorded	Patients >= age 18 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

	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 Full Time Equivalent	The number of full time equivalent GPs at the practice.	Textbox – allow decimals
MAN-008	Practice Nurse Full Time Equivalent	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	Registers	Does the practice have a practice wide, systemised register for the following? • CHD • Hypertension • COPD • Asthma • Diabetes • Diabetes Risk • Any Mental Health • Osteoporosis • Any Cancer • Other Other registers not included above can be entered in manually	Radio buttons for each register: Electronic, Paper Textbox
MAN-013	Recall/Reminder Systems	Does the practice have a practice wide, systemised recall/ reminder system for the following? • CHD • Hypertension • COPD • Asthma • Diabetes • Diabetes Risk • Any Mental Health • Osteoporosis • Any Cancer • Other Other registers not included above can be entered in manually)	Radio buttons for each register: Electronic, Paper Textbox