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Supplementary Material

Developing indicators and measures of high-quality for Australian general practice

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Supplementary File 1: Details on Advisory Group and Research Group members

Note: These details remain blinded until the review is complete.

Advisory Group

Name of Advisory Group member	Affiliation and role e.g., general practitioner

Research Team

Name of researcher	Affiliation and role

Core group of researchers

Name of researcher	Affiliation and role

Supplementary file 2. Details of indicators and measures

This document provides details of indicators and measures of high-quality general practice and the results of our review process. As described in the body of this report, each attribute was reviewed by two small groups, each comprising between 3 and 6 participants at two workshops convened by NBM and SWS PHNs.

Participants reported in small group work on whether each indicator and measure were relevant (Yes/No) and feasible (Yes/No). Where a yes/no response was not recorded in the workshop reporting documents, a question mark "?" is noted in the appropriate column. All No responses for relevance are highlighted yellow and all No responses for flexibility are highlighted green. Workshop participants also provided comments on the reporting documents which have been summarised in the 4th column. The research team decision on each indicator/ measure is documented in the column on the far right.

To help with the readability and flow of the tables, shading is used and the types of indicators and measures are identified with letters A, B and C.

Key:

A. Structural indicators and measures
B. Process indicators and measures
C. Outcome indicators and measures

Attribute 1

Attribute One addresses the accountability of general practice to patients and is aligned with the Quadruple Aim: "improving the individual experience of care" (Bodenheimer and Sinsky 2014). This attribute is defined as:

- At its core high quality general practice provides evidence based, person centred, comprehensive care (including preventive, chronic and acute care), with patient- general practice team partnerships as a key aim.

Table 1. Indicators and measures addressing Attribute 1

Accountability to our patients				
Indicator and related measures	**Relevant Yes/ No**	**Feasible Yes/ No**	**Workshop comments/ recommendations**	**Research team decision**
PERSON CENTRED CARE AND PATIENT-TEAM RELATIONSHIP				
A. Structural indicators and measures				
Indicator A1: Availability of information for patients **Measure:** **Written and Electronic information in appropriate languages**	Y Y	Y Y	Multiple languages at PHN level for practice distribution Multicultural mental health	To keep
B. Process indicators and measures				
Indicator B1: Patient input/feedback on health care delivery **Measure:** **Evidence of formal process to consider patient input and incorporate into practice care delivery**	Y Y	Y Y	Inconsistent - but usually brief collection for accreditation Costs of consistent collection versus benefits Can be collected by practices (waiting room survey) - who collates and analyses - time costs AGPAL not frequent enough New patient information /enrolment forms - added onto form – ethnicity, use of interpreter Approach volunteer groups of patients SMS surveys/ other surveys Patient engagement – more difficult	To keep
C. Outcome indicators and measures				
Indicator C1: Patient perceptions of care **Measure:** **Results of Patient Reported Experience Measure (PREM)**	Y Y	Y Y	Time and cost issues - need staff time to arrange surveys Funding for follow-up implementation	To keep
Indicator C2: Patient Activation **Measure:** **Serial Patient Activation Measure (PAM) scores**	Y Y	? ?	Time and cost constraints	To keep as a “blue sky” measure indicating there is more work to be done regarding feasibility due to

				costs/time taken to administer the PAM. Improvements in PAM scores are associated with decreases in hospitalisation (Insignia Health 2019) and could be used to measure savings to the system
Indicator C3: Strength of team- patient relationship **Measure:** **Results using validated survey tool**	Y Y	? ?	As above: C2 Could discuss in team meetings	To keep as a "blue sky" measure using survey tool available (Ridd et al 2011). Electronic administration could reduce time and costs. Include team meetings as part of the measure.
EVIDENCE-BASED COMPREHENSIVE CARE: PREVENTIVE HEALTH CARE				
B. Process indicators and measures				
Indicator B1: Risk factors recorded				
Measures:				
B1.1 % active patients ≥15 years with a BMI recorded who have weight classification (obese, overweight, healthy, underweight) within the previous 12 months	Y Y	Y Y	Capturing 7-25 years, presentation is spasmodic	To keep
B1.2 % active patients ≤ 15 years with height/ length and weight recorded in the previous 12 months	Y Y	Y Y		To keep
B1.3 % active patients ≥15 years with a smoking status recorded/ updated (current, ex-smoker, never smoked) in previous 24 months	Y Y	Y Y	Not always collected or reviewed. Software programs may not allow to record lower ages. Check when software allows to record smoking.	To keep Patients aged 14 years or above deemed to have competency can be seen without their parents. Medical Director software allows recording from age 15. Best Practice software allows recording from any age.
B1.4 % active patients ≥15 years with alcohol	Y	Y	As above (B1.3)	To keep

consumption status recorded in previous 24 months	Y	Y		Patients aged 14 years or above deemed to have competency can be seen without their parents. Medical Director software allows recording from age 15. Best Practice software allows recording from any age.
B1.5 % active patients aged 14-19 with other substance use recorded	Y Y	Y Y	Important – not easily captured e.g. disclosure Doctors behavioural change needed (e.g. need to ask) ?Not seen enough Harder to divulge <16 years Feasibility difficult with lower range as present with parents, may not want to divulge	To keep as a "blue sky" measure Suggest standardised survey or tick box in the EMR.
B1.6 % active patients aged 18 years and over with BP recorded in previous 24 months	Y Y	Y Y	Red Book guidelines	To keep
Indicator B2: Childhood adverse events recorded **Measure:** **% active patients aged 0-19 years screened for adverse childhood events in previous 12 months**	? Y	? ?	Potential measure Poverty, social determinants Time constraints to cover this in standard consult Hard for child to speak about this/ parents to admit this Would need resources and support, allied health to support those that are suffering adverse events For social worker to assist	To keep as a "blue sky" measure due to difficulties in measuring at present One option to standardise this measure would be to include a screening tool to be offered to parents to fill at vaccination visits or 4 year old healthy kids check. Gives the parent the option of disclosing if they feel comfortable.
Indicator B3: Early detection of cancer				
Measures:				
B3.1% active patients aged 50-74 years with FOBT recorded in the previous 24 months	Y Y	Y Y	On government scheme GP gets results but not if patient has not used	To keep
B3.2 % active female patients age 20-74 without hysterectomy with up-to-date cervical screening	Y Y	Y Y		To keep

B3.3 % active female patients aged 50-74 years with no history of breast cancer years screened with mammogram in previous 30 months	? Y	? Y	Coding issues – breast screen lagging at the moment	To keep as a "blue sky" measure until coding issue resolved. Even though Breast Screen is not yet sending coded data PenCS has manual work arounds for MD and BP software -requires manually entering the breast screen result in the results tab - an extra step but would allow for the data to be extracted.
Indicator B4: Adult vaccination				
Measures:				
B4.1 % active patients aged 65 and over immunised against influenza in previous 15 months	Y Y	Y Y	B4.1-B4.5: Has software with prompts All done in doctor's clinic as long as patients do not move practices (e.g. multiple GPs or multiple practices) Pencat tools; incomplete AIR data; Pencat issues; overseas immunisation	To keep
B4.2 % active patients with DM immunised against influenza in previous 15 months	Y Y	Y Y	As above	To keep
B4.3 % active patients with COPD ≥15 years immunised against influenza in previous 15 months	Y Y	Y Y	As above	To keep
B4.4 % active patients ≥65 years with one dose of pneumococcal immunisation recorded and for Aboriginal and Torres Strait Islander patients aged ≥50 years two doses at 5 year interval	Y Y	Y Y	As above	To keep
B4.5 % active patients >70-79 years with Shingles vaccination	Y Y	Y Y	As above	To keep
Indicator B5: Childhood vaccination **Measure:** **% active patients ≥ 4 years who are fully immunised according to guidelines**	Y Y	Y ?	GP does not know which patient is not immunised National Register does not go to GP e.g. school vaccination	To keep as a "blue sky" measure as it requires software modifications to extract this data.

			Incomplete data on AIR Pencat incompetencies – difficult to differentiate names of immunisations	
Indicator B6: Aboriginal and Torres Strait Islander preventive health care **Measure:** **% active patients identified as Aboriginal or Torres Strait Islander with Aboriginal Health Check in previous 15 months**	Y Y	Y Y	Problems finding those who identify – some will not disclose (biggest problem) Patients have been receptive Medical students are good resources for Aboriginal and Torres Strait Islander health assessments	To keep
C. Outcome indicators and measures				
Indicator C1: Patient perceptions of preventive health **Measure:** **PREMs to include patient report of discussion regarding health behaviours/risk factors:** **• Healthy eating** **• Exercise /physical activity** **• Risks of smoking/ Quit support** **• Alcohol use** **• Unintentional injuries (home risk factors)** **• Unsafe sexual practices** **• Unmanaged psychosocial stress**	Y Y	Y Y	Patients need to understand what is preventable – who provided and how Plus CALD aspect Location specific Screening and preventive health are good measures of quality care/ practice	To keep
EVIDENCE-BASED COMPREHENSIVE CARE: CHRONIC CARE				
A. Structural indicators and measures				
Indicator A1: Systems for management of chronic diseases **Measure:** **Patient chronic disease registers Y/N**	Y Y	Y Y	Need quality data coded Will be different in solo /small group practices/ large practice Measures need to be disease specific Will benefit in allocating practice resources/ population health	To keep

Indicator A2: Known prevalence of diabetes **Measure:** **% of active patients with Diabetes coded**	Y Y	Y Y	As above	To keep
Indicator A3: Known prevalence of respiratory disease			As above	
Measures:				
A3.1 % active patients with COPD coded	Y Y	Y Y		To keep
A3.2 % active patients with Asthma coded	Y Y	Y Y		To keep
Indicator A4: Known prevalence of CVD **Measure:** **Prevalence of active CVD patients by category coded**	Y Y	Y Y		To keep
Indicator A5: Known prevalence of renal disease **Measure:** **% active patients with renal disease coded**	Y Y	Y Y		To keep
Indicator A6: Prevalence of mental health conditions **Measure:** **% active mental health patients within each mental health category**	Y Y	Y N		To keep
Indicator A7: Mental Health: Prevalence of co-morbidity **Measure:** **% active patients with diagnosed mental illness, also diagnosed with each of: diabetes, CVD, respiratory and renal disease**	Y Y	Y N	Challenges: to identify mental health patients and to code by diagnosis. MH plan could be inaccurate.	To keep Measure is not asking for presence or absence of MH plan.
Indicator A8: Advance Care Planning **Measure:** **% active patients 75 years and over with discussions about Advance Care Planning recorded on file**	Y Y	Y N	Health assessment completed shows good measure including ACP will indicate very high measure using (CriSTAL) Tool for VACD Pinning down people who have an ACP on file	To keep as a “blue sky” measure Consider annual 75 years and over Health assessment completed as indicator.

			challenging Discussions but not necessarily results in an ACP	ACP discussed/not discussed can be captured in Medical Director, but not in Best Practice.
B. Process indicators and measures				
Indicator B1: Use of systems for management of chronic diseases **Measure:** **Use of registers for patient follow up and recall Y/N**	Y Y	Y Y	Potential to expand and on practice register software as to case	To keep
Indicators for Diabetes care **Indicator B2: Monitoring CV risk**	Y Y	Y Y	Annual cycle of Care for all diabetes measures	To keep
Measures:				
B2.1 % active DM patients with BP recorded in previous 6 months	Y Y	Y Y		To keep
B2.2 % active DM patients with BMI recorded	Y Y	Y Y		To keep
B2.3 % active DM II patients with total Cholesterol, HDL, triglyceride and LDL levels recorded	Y Y	Y Y		To keep
B2.4 % active DM patients >16 years not smoking	Y Y	Y Y		To keep
Indicator B3: Diabetes care: Monitoring renal function				
Measures:				
B3.1 % active DM patients with eGFR recorded in previous 12 months	Y Y	Y ?		To keep
B3.2 % active DM patients with urine ACR recorded in previous 12 months	Y Y	Y Y		To keep
Indicator B4: Diabetes care: Managing risk factors **Measure:** **% active DM II patients aged >60 prescribed a statin**	Y Y	Y Y	If follow guidelines answer yes and yes, however if use statins - controversial	To keep Follows RACGP guidelines for >60 years
Indicator B5: Diabetes care: Managing complications				
Measures:				

B5.1 % active DM patients who have retinal screening performed in the previous 24 months	Y Y	Y Y		To keep
B5.2 % active DM patients who have diabetic foot assessment in previous 12 months	Y Y	Y Y		To keep
Indicator B6: Diabetes care: Monitoring blood sugar control: **Measure:** **% active DM patients with HbA1c recorded in previous 12 months**	Y Y	Y Y		To keep
Indicators for Respiratory Disease **Indicator B1: Use of spirometry record**	Y Y	Y Y	Asthma management plan with spirometry Quarterly or six monthly or annually	To keep
Measures:				
B1.1 % active COPD patients with spirometry	Y Y	Y Y		To keep
B1.2 % active asthma patients with spirometry recorded in previous 24 months	Y Y	Y Y		To keep
Indicator B2: Respiratory Disease: Monitoring risk factors				
Measures:				
B2.1 % active COPD patients with smoking status recorded	Y y	Y Y		To keep
B2.2 % active asthma patients >15 years with smoking status recorded	Y Y	Y Y		To keep
Indicator B3: Respiratory Disease: Planning care **Measure:** **% active asthma patients with asthma management plan**	Y Y	Y Y	Easy for children, harder in adults	To keep as a “blue sky” measure
Indicator B4: Respiratory Disease: Monitoring control **Measure:** **% active COPD patients with COPD Assessment Tool**	Y Y	? Y	Haven’t used COPD assessment tool	To keep as a “blue sky” measure

recorded				
Indicator B5: Respiratory Disease: **Appropriate use of medication**				
Measures:				
B5.1 % active COPD patients on LAMA	? Y	? Y		To keep
B5.2 % active asthma patients >=12 years on ICS containing controller	Y Y	Y Y	Use of LABA in children is controversial – a good idea to identify them, but controversial	To keep as a "blue sky" measure as update in management needs to reach Australian guidelines
Indicators for Cardiovascular Disease **Indicator B1: Monitoring CVD risk**				
Measures:				
B1.1 % active patients 45 -74 years with the necessary risk factors assessed (smoking, diabetes, BP, Total Chol, HDL Chol, age, gender) to enable CVD assessment in previous 24 months	Y Y	Y Y	Cardiovascular Risk Assessment MBS item (B1.1-B1.3)	To keep
B1.2 % active patients with no known CVD 45-75 years with absolute CVD risk calculated in previous 24 months	? Y	? Y	As above	To keep
B1.3 % active Aboriginal / Torres Strait Islander patients with no known CVD 35-75 years with absolute CVD risk calculated in previous 24 months	? Y	? Y	As above	To keep
Indicator B2: Monitoring CVD **Measure:** **% active hypertension patients ≥18 years with BP recorded in the previous 6 months**	? Y	? Y	Very general	To keep. Relevant, feasible and follows guidelines.
Indicator B3: Management of CV disease				
Measures:				
B3.1 % active CVD patients ≥18 years with statin prescribed	N Y	N Y		To keep. Relevant, feasible and follows guidelines.
B3.2 % active patient with heart failure coded who have ECG and Echocardiography on file	N Y	N Y	Too much detailed data	**To remove** as not enough evidence for this as quality measure

Indicators for renal disease **Indicator B1: Screening for renal disease**				
Measures:				
B1.1 % active DM patients screened for nephropathy (eGFR and ACR) in previous 12 months	Y Y	Y Y	2.1 under diabetes	To keep
B1.2 % active patients coded as having hypertension screened for nephropathy (eGFR and ACR) in previous 12 months	Y Y	Y Y		To keep
B1.3 % active Aboriginal and/ or Torres Strait Islander patients aged >30 years screened for nephropathy (eGFR and ACR) in previous 24 months	Y Y	Y Y		To keep
Indicator B2: Monitoring renal disease patients				
Measures:				
B2.1 % active renal disease patients with BP recorded in previous 12 months	? Y	? Y	Too much detail B2.1-B2.4	To keep. Relevant, feasible and follows guidelines.
B2.2 % active renal disease patients with eGFR recorded in the previous 12 months	? Y	? Y	As above	To keep. Relevant, feasible and follows guidelines.
B2.3 % active renal disease patients with urine ACR recorded in the previous 12 months	? Y	? Y	As above	To keep. Relevant, feasible and follows guidelines.
B2.4 % active renal disease patients with Chronic Kidney Disease Stage recorded	? Y	? N	As above Dependent on results and specialist letter etc.	To keep. Relevant, feasible and follows guidelines.
Indicators for mental health **Indicator B1: Treatment planning undertaken**				
Measures:				
B1.1 % active mental health patients with 2715 GP Mental Health Treatment Plan in previous 12 months	Y Y	Y N	Achievable? How would we identify if not necessarily related to a mental health diagnosis? Can do plan without diagnosis	To keep Evidence shows improved access to psychologists through this item number (Harrison et al 2012)
B1.2 % active mental health patients with 2712 review of Mental Health Treatment Plan in previous 12 months	Y Y	Y N	Achievable if looking at patients in a 2715 who also had a 2712	**To remove** This is a process measure with not a lot of evidence to show it improves care.

				We can't look for improvement as an inductor of practice quality – it is not like HBA1c and would be difficult to extract the scores in any care. The outcome tool is part of the mental health treatment plan.
Indicator B2: Management of people with mental health conditions				
Measures:				
B2.1 % active patients ≥15 years with a BMI recorded who have weight classification (obese, overweight, healthy, underweight) within the previous 12 months	N Y	N Y	Too much detail (B2.1-B2.4)	To keep Important co-morbidity
B2.2 % active patients ≥15 years with a smoking status recorded/ updated (current, ex-smoker, never smoked) in previous 24 months	N Y	N Y	As above	To keep Important risk factor
B2.3 % active patients ≥15 years with alcohol consumption status recorded in previous 24 months	N Y	N Y	As above	To keep Important co-morbidity
B2.4 % active mental health patients with follow-up GP visit within seven and 30 days of hospital discharge related to psychiatric condition	? Y	? Y	As above If receive the discharge summary ? If patient is contactable	To keep as a "blue sky" measure
Indicator B1: Advance Care Planning **Measure:** **% active patients 75 years and over with Advance Care Plan uploaded to myHR**	Y Y	Y N	Same measures in acute care setting	To keep as a "blue sky" measure Would be difficult to audit as likely a PDF not a searchable result
C. Outcome indicators and measures				
Indicator C1: Optimal diabetes outcomes				
Measures:				
C1.1 % active DM II patients with Hba1C≤8%	Y Y	Y Y		To keep
C1.2 % active DM II patients with BP<140/90 mmHg	Y Y	Y Y		To keep

Indicator C2: Managing risk in DM patients				
Measures:				
C2.1 % active DM II patients with Lipids to target in the previous 12 months	Y Y	Y Y		To keep
C2.2 % active DM II patients with microalbuminuria on ACE inhibitor or ARB	Y Y	Y Y		To keep
Indicator C3: COPD control **Measure** **% active COPD patients hospitalised in previous 6 months**	Y Y	Y Y		To keep
Indicator C4: CV optimal outcome **Measure:** **% active hypertension patients whose most recent BP is <140/90 mmHg**	Y Y	Y Y		To keep
Indicator C5: Dialysis **Measure:** **% active patients with renal disease on dialysis**	? Y	? Y		To keep
ACUTE CARE: PRESCRIBING SAFETY				
A. Structural indicators and measures				
Indicator A1: Safe prescribing of opioids and benzodiazepines **Measure:** **Practice has a policy on the safe prescription of opioids and benzodiazepines (BZDs) -Y/N**	Y Y	Y Y		To keep
B. Process indicators and measures				
Indicator B1: Safe prescribing of opioids and benzodiazepines **Measure:** **BZD and opioid policy discussed with all new prescribers - Y/N**	Y Y	Y Y	Registrars always ask Annual review of opioid contracts may need to look at lyrica in the near future	To keep
C. Outcome indicators and measures				
Indicator C1: Safe prescribing of opioids and	Y	Y	Practice based intervention - then data is	To keep

benzodiazepines **Measure:** **% active patients prescribed opioids who report discussion of risks of opioid use**	Y	Y	collected but no guarantee of discussion taking place	

Attribute 2

Attribute two refers to the way that care is delivered in high quality primary health care and reflects professional accountability. It aligns with the Quadruple Aim: "improving the work life of clinicians and staff" (Bodenheimer and Sinsky 2014). Attribute two is defined below:

- High-functioning multidisciplinary teams engage in continuing care, that is coordinated and integrated care with other services and the medical neighbourhood.
- High quality general practice care is supported by clinical governance, staff training and data-enabled practice quality improvement.
- Engagement with general practice education and/ or research provides a means of sustaining the quality of the health system.

Table 2. Indicators and measures addressing Attribute 2: Professionally accountable

Professionally accountable				
Indicator and related measures	**Relevant Yes/ No**	**Feasible Yes/ No**	**Comments/ recommendations**	**Team Decision**
MULTIDISCIPLINARY TEAM BASED, CONTINUING CARE, THAT IS COORDINATED AND INTEGRATED CARE WITH OTHER SERVICES AND THE MEDICAL NEIGHBOURHOOD				
A. Structural indicators and measures				
Indicator A1: Practice goal/mission			Defines the practice's direction	
Measures:				
A1.1 Defined practice mission or goal Y/N	Y Y	Y Y	Displayed on website, on board in waiting room, with registrars	To keep
A1.2 Mission/goal accessible to staff Y/N	Y Y	Y Y		To keep
A1.3 Mission/goal accessible to patients Y/N	Y Y	Y Y	On request	To keep
Indicator A2: Practice Profile **Measure:**	Y Y	Y Y	Documented on website Staff ratios, efficiency for running practice	To keep

Total number of staff in each professional category including FTE			Number of patients, type of patient, type of staff	
Indicator A3: Data Sharing with local hospitals			Note: Up to 25% practices in region not using computers (solo practitioners)	
Measures:				
A3.1 Able to receive electronic discharge summary Y/N	Y Y	Y Y	It's good and works	To keep
A3.2 Able to receive data in real time e.g. shared EHR or real time electronic shared care plan Y/N	Y Y	N Y	PHN working towards Trying to do electronic share care plan using Linked HER Not well received by Allied health	To keep as a "blue sky" measure
Indicator A4: Data sharing with other health care providers **Measure:** **GP system for notification of specialist and allied health care correspondence**	? Y	? Y	? My Health Record Not sure if specialists are receiving this Some specialists are sending back electronically	To keep as a "blue sky" measure
Indicator A5: Use of My Health Record				
Measures:				
A5.1 Upload: % of active patients with Shared Health summaries uploaded to MyHR	Y Y	? Y	Need patient permission??	To keep Requires structural inputs such as practice being registered for MyHR and practice to have EMR. Once this is achieved upload can be done. You do not need patient consent to each upload but you do have to respect their directive to not upload information if they request.
A5.2 Access: % of cross views of MyHR	Y ?	? ?	Not feasible for all – confusion ?? Not sure is this important to patient	**To remove** as there is no evidence for this as an indicator of quality

B. Process indicators and measures				
Indicator B1: Team-based care				
Measures:				
B1.1 Regular clinical review meetings involving all team members	Y Y	Y ?	How regular? Challenging to make this happen	To keep
B1.2 Assigned care teams to coordinate care for individual patients	Y Y	? ?	Depends on size of practice	To change to a "blue sky" measure May be more practical in the future if/when that enrolment model comes into effect. Can be done in any size practice small or large, i.e. >6 Drs in practice. May need to break into pod structures. Good demonstration of coordinated care teams in PCMH model leading to improved patient care. Need to have clear responsibilities of each member of the care team with ability to overlap roles when other members aren't available.
B1.3 Reports from each team member in patient file	Y Y	Y Y	Need to consider who has access All contact with patient and notes to be written in file and is something that must continue	To keep
Indicator B2: Care planning				
Measures:				
B2.1 % active patients with chronic disease who have had GP management plan in previous 12 months	Y Y	Y Y	Unclear attribute And to recall patients Doing the plan to meet criteria	To keep

B2.2 % active patients with chronic disease who have had a medication management review (HMR) in previous 12 months	Y Y	Y N	Dependent on availability of pharmacist Note – need for timely reporting RMMR for nursing homes Need to know more about it and time to follow up these patients	To keep as a "blue sky" measure as systems change required to streamline this process.
C. Outcome indicators and measures				
Indicator C3: GP and staff Satisfaction				
Measures:				
C3.1 Annual staff turnover	? Y	? Y	Affects patients Is easy to measure Patients to have exit survey	**To remove** measure Willard-Grace et al (2019) demonstrate burnout is associated with clinician turnover but staff turnover is more multifactorial.
C3.2 Survey measuring GP and staff satisfaction with: ○ **enjoyment of work;** ○ **impact on local community health;** ○ **safety in work;** ○ **income from work;** ○ **time with patients;** ○ **work / life balance**	Y Y	? Y		To keep PHNs can provide the tool
Indicator C4: Patient experience of continuity of care **Measure:** **PREMS questions re: patients reporting delays in being notified about abnormal test results**	Y Y	Y Not yet	Also to survey patient about their experience Patient feedback box	To keep
Indicator C5: Care plan engages patient **Measures:** **Added questions to PREMs;** **PAM Scores**	Y Y	? ?	Health literacy comes into this Time constraint is an issue Depends and follow-up with patient Extra questions on care plan	To keep PAM scores valuable as an outcome
Indicator C6: Hospital follow-up				
Measures:				
C6.1 % of active patients reviewed following ED	Y	Y	Generally do follow-up – does not always	To keep as a "blue sky"

presentation (within 7 days)	Y	N	work as it relies on patient	measure due to information gap not under control of practice.
C6.2 % of active patients reviewed following admission (within 3 days)	? Y	N N	After discharge – three days if serious Maybe discharge summary to go to nurses to follow up (system)	To keep as a "blue sky" measure as it requires a partnership between LHD/PHN and system wide changes. Structures need to be in place to ensure a practice is informed of hospital admissions. Could be trialled with the Integrated Care patients first.
CLINICAL GOVERNANCE				
A. Structural indicators and measures				
Indicator A1: Clinical governance systems in place **Measure:** **Practice currently accredited according to RACGP or ACRRM standards**	Y Y	Y Y	Very important to meet standards	To keep
STAFF TRAINING				
B. Process indicators and measures				
Indicator B1: Regular staff education undertaken **Measure:** **Number of meetings/ attendence record**	Y Y	Y Y	Required as part of accreditation	To keep
Indicator B2: Assessment of learning needs **Measure:** **Evidence of process for assessment of learning needs**	Y Y	Y Y	Practice manager will review this and tick off	To keep
DATA-ENABLED PRACTICE QUALITY IMPROVEMENT				
A. Structural indicators and measures				
Indicator A1: Data quality and completeness of demographic and key health data				
Measures:				

A1.1 % active patients with date of birth recorded	Y Y	Y Y	Quality and safety of health records (A1.1-A1.3)	To keep
A1.2 % active patients with gender recorded	Y Y	Y Y	As above	To keep
A1.3 % active patients with allergy or nil known coded	Y Y	Y Y	As above Enabled in accreditation (also ethnicity, social determinants, medications)	To keep
B. Process indicators and measures				
Indicator B1: Improving the quality of our practice				
Measures:				
B1.1 Evidence of work on data cleansing	Y Y	Y Y		To keep
B1.2 Data Reports and date of most recent report	Y Y	Y Y		To keep
B1.3 Evidence of formal review of the collected data	Y Y	Y Y		To keep
C. Outcome indicators and measures				
Indicator C1: Consumer satisfaction with Quality **Measure:** **Analysis of validated survey responses**	Y Y	Y Y	Patient satisfaction - Practice, accreditation and improvement survey (PAIS) within accreditation process	To keep Need more regularly than accreditation cycle
EDUCATION, TRAINING AND RESEARCH TO SUPPORT QUALITY AND SUSTAINABILITY				
A. Structural indicators and measures				
Indicator A1: Registered for postgraduate GP training **Measure:** **Accredited as training practice with Regional Training Organisation**	Y Y	Y Y	Not continuous	To keep
B. Process indicators and measures				
Indicator B1: Engagement with student training **Measure:** **Number of medical/ nursing and allied health students undertaking placements over previous 12 months**	Y Y	Y N	Ideally but not always able to take on students Need for space and staff time	To keep

Indicator B2: Research activity **Measure** **Evidence of engagement with research or PDSA activities**	? Y	? N	Another step up No funding available	To keep as a "blue sky" measure

Attribute 3

Attribute three refers to the way that general practice care is accessible, responsive to population health needs and focussed on providing equitable care. It aligns with the Quadruple Aim: "improving the health of populations" (Bodenheimer and Sinsky 2014).

Table 3. Indicators and measures addressing Attribute 3: Accountable to the community

Accountable to the community				
Indicator and related measures	**Relevant Yes/ No**	**Feasible Yes/ No**	**Comments/ recommendations**	**Team decision**
A. Structural indicators and measures				
Indicator A1: Urgent access to care **Measure:** **Provides same day appointments**	Y Y	Y Y	For appropriate urgent cases triaged Need for appropriate triage mechanism Multistream approach, allocated times Same day appointments triage by health professional Every doctor on that day/practice team	To keep
Indicator A2: Access to non-face-to-face care e.g. telephone, email etc. **Measure:** **Process documented and advertised to patients for phone/ email access**	Y Y	Y Y	Receiving calls, responding appropriately After hours contingency Privacy concerns with electronic communication – not encouraged Fax preferred – confidentiality Feasible for the team – not individual Patients aware of the policy	To keep

Indicator A3: Access to home based care **Measure:** **Practice provides home / RACF visits**	Y Y	? N	GP practice and area dependant (skill dependent) Alternate arrangements should be in place Community demographics e.g. are there local RACFs, do we offer it? Do we do it well? Importance of GP engagement with areas in which they are interested Security issues for staff Patients have other alternatives – home doctor Casualising of workforce Time/clinical reimbursement system Patient willing to pay	**To remove** Whilst the measure promotes equitable care and continuous care through all phases of life, under the current setting there are issues that affect a GP or practice's ability to offer this service.
Indicator A4: Patient demographics recorded - understanding of local population	Y Y	Y Y	Including Aboriginality	To keep
Measures:				
A4.1 % active patients with cultural and linguistic status recorded	Y Y	Y Y	Measure quality should attempt to assess level of cultural awareness and sensitivity (patient measured?) Service provided Specialise health needs Rewarded for health services	To keep
A4.2 % active patients who identify as Aboriginal and/or Torres Strait Islander	Y Y	Y Y	Measure quality should attempt to assess level of cultural awareness and sensitivity (patient measured?) ?Creates services for PHN - identify	To keep
A4.3 % active patients with Aboriginal and Torres Strait Islander status coded	Y Y	Y Y	Measure quality should attempt to assess level of cultural awareness and sensitivity (patient measured?) Bottom line Skills for health professions/ identify	To keep

A4.4 % active patients 16 years and over with Australian Government Health Care Card	Y Y	Y Y	Improves understanding of patient population and access to care, removes barriers to care Identify care Socio economic sociological planning What service meets the needs of the population	To keep
Indicator A5: Meets the needs of Aboriginal and Torres Strait Islander patients **Measure:** **Registered for PIP Indigenous Health Incentive Y/N**	Y Y	Y Y	See A4.4 Not the only one (self identification norm) PIP has requirements CTG measures separately, practice not signed up – cross reference	To keep
Indicator A6: Health related social needs assessed **Measure:** **% active patients with screening for health related social needs recorded**	Y Y	Y Y	Will need significant GP education/training especially if adapting tools Housing, employment, income, food security Define social needs Education/employment needs Tool to measure? Low income, card holders	To change to a "blue sky" measure given GP training needed and appropriate tools developed
Indicator A7: Community engagement **Measure:** **Patient /family advisory Council: Y/N**	Y Y	? ?	For individual practices – very difficult ?More appropriate for groups of practices e.g. geographic clusters Focus groups Surveys Balanced surveys Exit surveys Happy or Not feedback	To keep as "blue sky" measure This measure can help direct practice improvements in a patient centred way. If practices are not able to engage their own Patient and Family Advisory Council, it may be possible to seek PHN consumer council feedback on broader issues. To be further considered
B. Process indicators and measures				
Indicator B1: Provides health care to vulnerable communities				
Measures:				

B1.1 Bulk billing for concession card holders Y/N	Y ?	Y ?	Allows access. May not allow all practices to remain financially viable What determines practice eligibility and sustainability Does not capture low income patients	To keep Practices that prioritise access to vulnerable populations by bulkbilling concession card holders and show improvement in other measures could be given a QI payment bundle (maybe under new models of payment in the future)
B1.2 Evidence of stratification of data to vulnerable populations	? ?	Y ?	Knowledge and use of interpreter services Advertise availability of bilingual GP ?Clarification of what indicator means Stratifying to particular patients Improvement rather than absolute levels Stratifying co-morbidities	**To remove** as too vague
Indicator B2: Meets the needs of CALD communities **Measure:** **Provides bilingual services as required**	Y ?	Y ?	Phone service Patients reporting experience Accreditation	To keep
C. Outcome indicators and measures				
Indicator C1: Access to regular primary care provider				
Measures (add to PREMS):				
C1.1 % active patients reporting they have a specific GP/ Practice nurse/ Care team	Y ?	Y ?	Community level measure Practice able to identify/offer usual DR Three times in two years Pen Cat captured Team based	To change to a “blue sky” measure of continuity of care
C1.2 % active patients reporting difficulties obtaining care over previous 12 months	Y ?	Y ?	Important for hospital avoidance and obtaining timely care Patient surveys Difficulty interpreting the difficulties –	To keep

			quantitative and qualitative	
C1.3 % active patients reporting same day response to phone call to GP/ nurse	Y ?	Y ?	See C1.2 If urgent – face to face ideal - need to see patient, not a phone call Non face to face clinical advice and communication should be remunerated Contact type – email/fax Face to face contact Communication	To keep
Indicator C2: Access for low SES **Measure: Compare % active patients who are health care card holders with % holding health care cards in practice LGA**	Y ?	? ?	Blunt instrument Needs to distinguish aged pensioner from disability from lower SE status Seeing a large range of patients How to identify LGA?	To change to a "blue sky" measure Needs work on the tools for the social determinants of health and ways of screening for these in practices.

Attribute 4

Attribute four refers to the way high quality general practice promotes efficient stewardship of health resources. It aligns with the Quadruple Aim: "reducing the per capita costs of care for populations" (Bodenheimer and Sinsky 2014).

Table 4. Indicators and measures addressing Attribute 4: Accountable to society

Accountable to society				
Indicator and related measures	**Relevant Yes/ No**	**Feasible Yes/ No**	**Comments/ recommendations**	**Team decision**
C. Outcome indicators and measures				
Indicator C1: Avoidable hospital care			Key would be to identify presentations that are avoidable versus non avoidable	
C1.1 Use of linked data to measure ED presentations by triage level	N ?	? ?	Triage level of limited utility for hospital avoidance e.g. vaccine preventable, diabetic complications Measure by diagnoses e.g. DRGs (Diagnosis	**To remove** measure

			Related Group)	
C1.2 Use of linked data to measure potentially preventable hospital admissions	Y ?	Y ?	More relevant than above	To keep
Indicator C2: Duplication of care			Note: lot of specialist duplication	
C2.1 Use of linked data to measure visits to other general practices	Y ?	? ?	Measures like dissatisfaction, second opinion, specialised services, drug seeking – needs qualitative data for reasons	**To remove** measure
C2.2 Use of linked data to measure duplication of pathology and radiology services	Y ?	Y ?	Resource use/cost efficiency/patient safety and comfort	To keep as a "blue sky" measure. Useful in the future to demonstrate waste in the system and push for better integration of patients health information/results

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