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Introduction

The indicators outlined in this document represent the work of the Community Health Working Group in finalising a set of process and structure indicators as part of the broader work of the Department of Health, Victorian Community Health Indicators Project.

The indicators in this document have undergone review and initial piloting in the community health sector. The indicators are presented in two sections in this document. The first section contains indicators that may be benchmarked and the second section indicators that may be useful internally within organisation but are not suitable for sector wide benchmarking.

Background

The aim of the Victorian Community Health Indicators project is to improve the quality and safety of care provided by State-funded primary health agencies, including building the evidence for the effectiveness, acceptability and appropriateness of that care.

The Victorian Health Priorities Framework 2012–2022: Metropolitan Health Plan identifies priority areas for the development and operation of the Victorian health system into the future. In particular, the framework recognises the importance of a health outcomes framework that encompasses the measurement of client experiences, health outcomes, efficiency and effectiveness of health services.

The Victorian Community Health Indicators project has developed a set of clinical indicators that is consistent with the State Framework. It builds on previous collaborative work of the Department of Health with the sector, including the Clinical Governance in Community Health and the Oral Health Indicators projects led by the Victorian Healthcare Association and Dental Health Services Victoria respectively. The indicators have also referenced and contextualised the relevant practice level indicator of safety and quality for primary health care developed by the Australian Commission on Safety and Quality in Healthcare.

Overview of Indicators

The indicators presented in this manual have been divided into two distinct groups:

1. Indicators for benchmarking: these indicators have been developed for the purpose of comparing an organisation’s performance with like organisations.

   Sector targets for the indicators have not generally been set. Appropriate targets will be determined and set after the indicators have been piloted in the sector.

2. Indicators for internal use: these indicators are for use within an organisation. The indicators can be used to compare changes over time within a program/service (trend) or differences between program/service areas at one point in time.
Section 1: Indicators for Benchmarking

Indicator 1 Response to urgent referrals

Identifying and Definitional Attributes

Short name: Response to urgent referrals
Description: The percentage of clients who have been urgently referred whose referral acknowledgement was sent within two working days of receipt of referral
Rationale: Acknowledgement of referrals confirms that the service has received the referral, preventing consumers slipping through the gaps.

Quality Dimension
Accessible

Collection and Usage Attributes

Numerator: The number of clients with urgent referrals whose referral acknowledgement was sent within 2 working days of receipt of referral
Denominator: The total number of clients referred with urgent referrals
Population A minimum of 30 clients with urgent referrals who have been referred to intake from an external service in a one month period
Computation: \((\text{Numerator} \div \text{Denominator}) \times 100\)
Computation description: The timeframe is specified as follows in the Service Coordination Practice Manual:
1. urgent referrals should be acknowledged within no more than 2 working days of receipt
2. non urgent or routine referrals should be acknowledged within no more than 7 working days of receipt.
NOTE: If the urgency of referral is not acknowledged in the referral by the organisation, then it is assumed to be routine. This excludes self-referrals and internal agency referrals

Indicator 2 Response to routine referrals

Identifying and Definitional attributes

Short name: Response to routine referrals
Description: The percentage of clients who have been routinely referred whose referral acknowledgement was sent within 7 working days of receipt of referral
Rationale: Acknowledgement of referrals confirms that the service has received the referral, preventing consumers slipping through the gaps.

Quality Dimension

Collection and Usage Attributes

Numerator: The number of clients with routine referrals whose referral acknowledgement was sent within 7 working days of receipt of referral
Denominator: The total number of clients referred with routine referrals
Population: A minimum of 30 clients who have been referred to intake with non urgent referrals in a one month period
Computation: \((\text{Numerator} \div \text{Denominator}) \times 100\)
Computation description: The timeframe is specified as follows in the Service Coordination Practice Manual:

1. urgent referrals should be acknowledged within no more than 2 working days of receipt
2. non urgent or routine referrals should be acknowledged within no more than 7 working days of receipt.

NOTE: If the urgency of referral is not acknowledged in the referral by the organisation, then it is assumed to be routine. This excludes self-referrals and internal agency referrals

Indicator 3 Timely initial needs identification

**Identifying and Definitional attributes**

**Short name:** Timely initial needs identification  
**Description:** The percentage of clients with Initial Needs Identification commenced within no more than 7 working days of Initial Contact  
**Rationale:** Consumer needs are identified in a timely manner  
**Quality Dimension:** Appropriate

**Collection and Usage Attributes**

**Numerator:** Number of clients with initial needs identification commenced within 7 working days of initial contact  
**Denominator:** Total number of clients with an initial needs identification  
**Population:** All clients from program areas with an Initial Needs Identification undertaken in a 1 week period  
**Computation:** \( \frac{\text{Numerator}}{\text{Denominator}} \times 100 \)  
**Computation description:**

**Initial Contact:** First contact with the consumer. The Victorian Service Coordination Practice Manual (VSCPM, 2009) identifies that consumer contact (via outreach, presentation or correspondence or service provider referral) is part of the Initial Contact.

**Initial Need Identification:** Initial Needs Identification (INI) “is a broad, shallow screening process to uncover underlying and presenting issues. It is sometimes referred to as triage or service screening. The service provider engages in a broad conversation to identify consumer needs, including illness prevention, early intervention, self-management capabilities and restorative options. It is not a diagnostic process, but a determination of the consumer’s risk, eligibility and priority for service, with the aim of reaching a balance between service capacity and consumer needs.” (VSCPM, 2009:16).

References:
Indicator 4 Consent for disclosure of personal information

Identifying and Definitional Attributes

Short name: Consent for disclosure of personal information
Description:
Rationale: Consent for disclosure of personal information is required under privacy legislation
Quality Dimension: Appropriate

Collection and Usage Attributes

Numerator: Number of clients referred to an external service where consent for disclosure of personal information has been documented
Denominator: Number of clients who are externally referred
Population: A minimum of 30 clients who have been referred to any external service/program in the previous 3 months
Computation: \[ \left( \frac{\text{Numerator}}{\text{Denominator}} \right) \times 100 \]
Computation description: Consent to collect information and consent to share information are separate processes. Consent to share may have a different process if internal compared to external agency.

References:
## Indicator 5 Interpreter Use

### Identifying and Definitional attributes

<table>
<thead>
<tr>
<th>Short name:</th>
<th>Interpreter Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description:</td>
<td>The percentage of clients who have indicated the need for an interpreter who actually receive interpreters on their first contact with a service/program area</td>
</tr>
<tr>
<td>Rationale:</td>
<td>The DH Language Services Policy identifies several critical points, including initial assessment, treatment, discharge and referral at which professional accredited interpreters must be used (DHS, 2005 under review). (Policy currently being reviewed)</td>
</tr>
<tr>
<td>Quality Dimension</td>
<td>Accessible</td>
</tr>
</tbody>
</table>

### Collection and Usage Attributes

| Numerator: | Total number of first contacts after Initial Needs Identification involving interpreter |
| Denominator: | Total number of clients who indicated need for interpreter on initial needs identification (e.g. SCTT consumer information template) |
| Population | All clients from all program areas indicating the need for an interpreter on INI in a 1 month period |
| Computation: | \((\text{Numerator} - \text{Denominator}) \times 100\) |

**Computation description:**

**Critical Points for Interpreting:** from 2005 Language Service Policy DHS (being reviewed and need to update when available)

- Clients who are not able to communicate through written or spoken English have access to information in their preferred language at critical points. These include:
  - when they need to be informed of their rights
  - give informed consent
  - be advised of critical information relating to their health and wellbeing and/or
  - participate in decision making related to their health.
- Language services are provided by appropriately qualified professionals.
- Persons, including family members under 18 years of age, are not used as interpreters

### References:
## Waiting Time Indicators

The following indicators calculate the average waiting time for the various levels of priority in the mandated services as outlined in the DH document “Community health priority tools, 2009” and shown in the table below. The descriptors used by different services vary however the indicators use a standard highest, medium and lowest to refer to the various categories.

**Note 1**: Calender days has been used in the calculation of the indicators instead of working days to simplify calculations as the waiting time may extend beyond one week.

<table>
<thead>
<tr>
<th>Mandated service</th>
<th>Level Descriptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Dietetics</td>
<td>high, medium, and low</td>
</tr>
<tr>
<td>2. Counselling</td>
<td>Immediate, high, medium/low</td>
</tr>
<tr>
<td>3. OT – adult</td>
<td>high, medium, and low</td>
</tr>
<tr>
<td>4. Physiotherapy</td>
<td>high, medium / low</td>
</tr>
<tr>
<td>5. Podiatry</td>
<td>high, medium, and low</td>
</tr>
<tr>
<td>6. Speech Pathology - adult</td>
<td>high, medium / low</td>
</tr>
<tr>
<td>7. Dental</td>
<td>High, low</td>
</tr>
<tr>
<td>8. Dental emergency</td>
<td>Category 1-5</td>
</tr>
</tbody>
</table>
## Indicator 6 Waiting time for highest priority clients

### Identifying and Definitional attributes

<table>
<thead>
<tr>
<th>Short name:</th>
<th>Waiting time for highest priority clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description:</td>
<td>The average number of calendar days from initial needs identification (INI) to service specific assessment for the highest category of priority clients of mandated services (including generic priority clients)</td>
</tr>
<tr>
<td>Rationale:</td>
<td>Waiting times for various priority groups needs to be monitored to ensure effective appropriate services</td>
</tr>
</tbody>
</table>

### Quality Dimension

- Accessible

### Collection and Usage Attributes

| Numerator: | The total number of calendar days from INI to service specific assessment for the highest priority clients in the specified service/program area |
| Denominator: | The total number of consumers allocated in the priority category |
| Population | All clients within nominated category over a 3 month period |
| Computation: | (The total number of days for all sample ÷ Denominator) |

### References:
## Indicator 7 Waiting time for mid priority clients

### Identifying and Definitional attributes

<table>
<thead>
<tr>
<th>Short name:</th>
<th>Waiting time for mid priority clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description:</td>
<td>The average number of calendar days from initial needs identification (INI) to service specific assessment for the middle category of priority clients of mandated services (including generic priority clients)</td>
</tr>
<tr>
<td>Rationale:</td>
<td>Waiting times for various priority groups needs to be monitored to ensure effective appropriate services</td>
</tr>
</tbody>
</table>

### Collection and Usage Attributes

| Numerator: | The total number of days from INI to service specific assessment for the mid priority clients in the specified service/program area during the stated time period |
| Denominator: | The total number of consumers allocated in the priority category |
| Population | All clients within nominated category over a 3 month period |

Computation: The total number of days for all sample ÷ Denominator

Computation description:

References:
Indicator 8 Waiting time for lowest priority clients

Identifying and Definitional attributes

Short name: Waiting time for lowest priority clients

Description: The average number of calendar days from initial needs identification (INI) to service specific assessment for the lowest category of priority clients of mandated services (including generic priority clients)

Rationale: Waiting times for various priority groups needs to be monitored to ensure effective appropriate services

Quality Dimension

Collection and Usage Attributes

Numerator: The total number of days from INI to service specific assessment for the lowest priority clients in the specified service/program area during the stated time period

Denominator: The total number of consumers allocated in the priority category

Population All clients within nominated category over a 3 month period

Computation: The total number of days for all sample-Denominator

Computation description:

References:
Indicator 9 Adverse drug reactions and medication allergies

Identifying and Definitional attributes

| Short name: | Adverse drug reactions and medication allergies |
| Description: | The percentage of clients who have been asked about adverse drug reactions and medication allergies |
| Rationale: | Medication safety related incidents contribute to adverse health events (Australian Commission on Safety and Quality in Health Care, Patient safety in primary health care: Discussion paper 2010) |

Quality Dimension

| Appropriate, Safe |

Collection and Usage Attributes

| Numerator: | The number of clients who have recorded in their record that they have been asked about drug reactions and medication allergies |
| Denominator: | The total number of client in the relevant service area (podiatry or dental) |
| Population | Relevant populations include those clients receiving services from podiatry and dental. For dental the sample would include all clients seen in one month period. For podiatry the sample would comprise a minimum of 30 clients over the previous 12 months |
| Computation: | \((\text{Numerator} ÷ \text{Denominator}) \times 100\) |
| Computation description: | All podiatrists administer medication (e.g. non credentialed podiatrist administer local anaesthetic) therefore there is an expectation questions regarding adverse drug reactions and medication allergies would be asked. |

References:
Indicator 10 Did not attend

**Identifying and Definitional attributes**

<table>
<thead>
<tr>
<th>Short name:</th>
<th>Did not attend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description:</td>
<td>The percentage of clients that did not attend a booked service</td>
</tr>
<tr>
<td>Rationale:</td>
<td>The percentage of clients that Did Not Attend (DNA) provides information on the efficiency of a service</td>
</tr>
<tr>
<td>Quality Dimension</td>
<td>Efficient</td>
</tr>
</tbody>
</table>

**Collection and Usage Attributes**

<table>
<thead>
<tr>
<th>Numerator:</th>
<th>Total number of DNA recorded in the service/program area nominated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator:</td>
<td>Total number of contacts (total = DNA’s + contacts)</td>
</tr>
<tr>
<td>Population:</td>
<td>All clients (from all program areas) in 1 month period</td>
</tr>
<tr>
<td>Computation:</td>
<td>((\text{Numerator}/\text{Denominator}) \times 100)</td>
</tr>
<tr>
<td>Computation description:</td>
<td>Cancellation - Clients that contact the service to cancel booked appointment (no timeframe).</td>
</tr>
<tr>
<td></td>
<td>Did not attend - Clients that do not contact service and do not attend booked service</td>
</tr>
</tbody>
</table>

References:
Indicator 11 Diabetes care data

Identifying and Definitional Attributes

Short name: Diabetes care data
Description: The percentage of clients with type 1 or type 2 Diabetes referred for any type of diabetes related management who have diabetes related results recorded in their client file
Rationale: Access to accurate up to date information regarding the parameters of diabetes care will guide the appropriate course of management for a client. This indicator becomes a proxy indicator for the effectiveness of communication between the GP and the community health centre.

Quality Dimension

Collection and Usage Attributes

Numerator: The number of clients referred for diabetes management (type 1 or 2) with evidence of results recorded for each of the following items:
- HbA1c (12 months)
- Albumin (12 months)
- total cholesterol, HDL, LDL cholesterol and triglycerides (12 months)
- blood pressure (12 months)
- BMI (12 months)

Denominator: The total number of clients presenting with a diabetes management need

Population

A minimum of 30 clients who have been referred for management of diabetes to any internal service/program in the previous 12 months

Computation: \((\text{Numerator} \div \text{Denominator}) \times 100\)

Computation description: This indicator must be calculated separately for each element of the review

References:

See appendix 1: Diabetes Care Guidelines
Indicator 12 Care plan present

**Identifying and Definitional attributes**

<table>
<thead>
<tr>
<th>Short name:</th>
<th>Care plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description:</td>
<td>The percentage of clients with multiple or complex needs with a care plan</td>
</tr>
<tr>
<td>Rationale:</td>
<td>A care plan promotes client centred objectives and strategies for care to be developed</td>
</tr>
<tr>
<td>Quality Dimension</td>
<td>Appropriate, Acceptable</td>
</tr>
</tbody>
</table>

**Collection and Usage Attributes**

| Numerator:          | The number of clients with multiple or complex needs for whom there is a care plan for the current episode of care |
| Denominator:        | The total number of consumers with multiple or complex needs registered for the service/program who received intervention |
| Population:         | A minimum of 45 clients over 3 month period taken from between 6-12 months prior to collection date. Clients to be taken from EICD or HACC clients or where there is clear expectation that all clients in program area have a care plan |

**Computation:**

(Numerator ÷ Denominator) × 100

**Computation description:**

Types of Care Plans

Care plans can be service specific, intra-agency or interagency:

- A service-specific plan is developed by a single service. Service specific care plans are usually documented using program specific tools or formats. Examples include: an Individual Treatment Plan, an Asthma Management Plan, an Advanced Care Plan, a GP Management Plan an Individual Support Plan. (Good Practice Guide DH 2009).
- An intra-agency care plan is used with consumers require multiple services from within a single organisation in order to coordinate service delivery.
- An inter-agency care plan is used with consumers who have complex or multiple needs and require services from more than one organisation.

Note agency need to describe group that indicator is applied to

Organisations will need to identify a sub population (or target group) of clients with multiple or complex needs where the expectation is that care plans are undertaken for 100% of clients, e.g. diabetes & HARP.

**References:**
**Indicator 13 Communication to general practitioner re care plan**

**Identifying and Definitional attributes**

**Short name:** Communication to General Practitioner re care plan

**Description:** The percentage of clients with chronic and complex disease with evidence of communication regarding a care plan from the community health service to the Client’s GP

**Rationale:** Community health staff must provide updates to GP’s on care planning to enable the GP to effectively manage the client’s care.

**Quality Dimension**

**Appropriate**

**Collection and Usage Attributes**

**Numerator:** The total number of clients with complex and chronic needs with evidence of communication regarding a care plan from the community health service to the Client's GP in the last twelve months

**Denominator:** The total number of clients with complex and chronic needs who have a care plan

**Population**

A minimum of 45 clients over 3 month period taken from between 6-12 months prior to collection date. Clients to be taken from EICD or HACC clients or where there is clear expectation that all clients in program area have a care plan

**Computation:** \[(\text{Numerator} \div \text{Denominator}) \times 100\]

**Computation description:** Client consent

Not all clients will necessarily consent to the care plan being released to the GP or may not have GP details recorded. If the indicator result is low these issues may need further investigation

**References:**
## Indicator 14 Complete care plans

### Identifying and Definitional attributes

<table>
<thead>
<tr>
<th>Short name:</th>
<th>Complete care plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description:</td>
<td>The percentage of clients with multiple or complex needs with a complete care plan</td>
</tr>
<tr>
<td>Rationale:</td>
<td>All elements of a care plan need to be completed in order to promote client centred objectives and strategies for care</td>
</tr>
<tr>
<td>Quality Dimension</td>
<td>Appropriate</td>
</tr>
</tbody>
</table>

### Collection and Usage Attributes

| Numerator: | The total number of clients with multiple or complex needs for whom there is a care plan with all elements completed (see definition of care plan) |
| Denominator: | The total number of consumers with multiple or complex needs registered for the service/program who received intervention during the time period under study. |
| Population | A minimum of 45 clients over 3 month period taken from between 6-12 months prior to collection date. Clients to be taken from EICD or HACC clients or where there is clear expectation that all clients in program area have a care plan |

| Computation: | (Numerator÷Denominator)×100 |
| Computation description: | Care Plan: A care plan is any documented plan of care that has all of the following elements completed:

1. Date care plan developed
2. Participants involved in development of care plan
3. Client agreed issues/problems
4. Client agreed objectives/goals,
5. Client agreed strategies/action
6. Responsibilities for implementing strategies/action
7. Timeframe for attainment of objectives/goals
8. Nominated review date of care plan
9. Client Acknowledgement (signed or verbal acknowledgement recorded) |

| References: | |

---
**Indicator 15 Care plan review**

### Identifying and Definitional attributes

<table>
<thead>
<tr>
<th>Short name</th>
<th>Care plan review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>The percentage of clients with care plans that are reviewed systematically within 4 weeks of the planned review date.</td>
</tr>
<tr>
<td>Rationale</td>
<td>The review of a care plan for consumers is necessary for effective management</td>
</tr>
</tbody>
</table>

**Quality Dimension**

Appropriate

### Collection and Usage Attributes

<table>
<thead>
<tr>
<th>Numerator</th>
<th>The total number of consumers with a care plan that has been reviewed within 4 weeks of the planned review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>The total number of consumers registered for the service/program that have a care plan with a planned review date</td>
</tr>
</tbody>
</table>

**Population**

A minimum of 45 clients over 3 month period taken from between 6-12 months prior to collection date. Clients to be taken from EICD or HACC clients or where there is clear expectation that all clients in program area have a care plan

**Computation**

\[(\text{Numerator} / \text{Denominator}) \times 100\]

**Computation description:**

\[(\text{Numerator} / \text{Denominator}) \times 100\]

**References:**
Indicator 16 Goal achievement

Identifying and Definitional attributes

Short name: Goal achievement
Description: The percentage of objectives/goals of care that have been fully met in the timeframe stated
Rationale: The achievement of agreed objectives/goals of care is a measure of the success of the interventions.

Quality Dimension: Effective

Collection and Usage Attributes

Numerator: The total number of objectives/goals fully met in the timeframe stated for achievement of each objective/goal for consumers with a care plan
Denominator: The total number of objectives/goals with the timeframe stated for achievement of each objective/goal for consumers with a care plan registered for the service/program.
Population: A minimum of 45 clients over 3 month period taken from between 6-12 months prior to collection date. Clients to be taken from EiCD or HACC clients or where there is clear expectation that all clients in program area have a care plan

Numerator or Denominator Criteria: NB: Do not include objectives/goals with a goal achievement timeframe after the time period under study in the numerator or denominator.

Computation: \((\text{Numerator} \div \text{Denominator}) \times 100\)
Computation description: The care plan should have some capacity to note whether its goals were met. For example if the goals of the care plan have been:

- Fully met
- Partially met
- Not met

Refer to internal indicator 24 for indicator for percentage of care plans partially met

References:
Indicator 17 Diabetes Best Practice Care Review

Identifying and Definitional Attributes

| Short name: | Diabetes Best Practice Care Review |
| Description: | The percentage of clients with type 1 or type 2 Diabetes who have received the recommended reviews as part of best practice diabetes care (delivered either in the community health centre or externally) for |
| | • HbA1c, |
| | • BMI |
| | • examine feet, |
| | • review diet, |
| | • review levels of physical activity, |
| | • review smoking |
| | • review oral health |
| | • Depression |
| | • Self-Care Education |

Rationale:

Diabetes Australia defines a minimum standard of assessment and care for individuals with diabetes. These recommendations have been modified for community health to reflect current best practice and include oral and mental health reviews. Individuals presenting to Community Health for management of diabetes (independent of the discipline of the worker involved or service provided) should be:

1. Screened to ensure they have received the recommended reviews in the recommended timeframes
2. Referred (or advised to follow up) for any review that has not occurred in the recommended timeframe

The reviews to be addressed by the indicator are those which are relevant to and feasible for Community Health. If the indicator results are poor then further investigation of both the process of screening of diabetes client needs and action taken to address unmet needs is needed

Quality Dimension

Appropriate

Collection and Usage Attributes

Numerator:
The number of clients referred for diabetes management (type 1 or 2) with evidence of receiving the minimum requirements of best practice diabetes care within the recommended timeframes (e.g. review diet annually)

Denominator:
The total number of clients presenting with a diabetes management need
<table>
<thead>
<tr>
<th>Population</th>
<th>A minimum of 30 clients who have been referred for management of diabetes to any internal service/program in the previous 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computation:</td>
<td>((\text{Numerator} ÷ \text{Denominator}) × 100)</td>
</tr>
<tr>
<td>Computation description:</td>
<td>This indicator must be calculated separately for each specified element of the minimum requirements of best practice diabetes care</td>
</tr>
<tr>
<td>References:</td>
<td>Refer Appendix 1 – minimum requirements of diabetes care</td>
</tr>
</tbody>
</table>
Indicator 18 Consumer self-management

Identifying and Definitional attributes

Short name: Consumer self-management

Description: The percentage of clients/carers satisfied that the intervention helped them manage their problem.

Rationale: Self-management is a key element of integrated chronic disease management which can improve self-efficacy, wellbeing and service usage.

Quality Dimension: Acceptable, Effective

Collection and Usage Attributes

Numerator: The total number of clients/carers satisfied or highly satisfied that the visit has helped them manage their problem.

Denominator: The total number of clients/carers who participated in consumer/carer surveys.

Population: All clients (from all program areas) who have responded to survey when last conducted in organisation.

Computation: \[(\text{Numerator}/\text{Denominator}) \times 100\]

Computation description: Measurement Mode: 12 monthly audit.

References: Indicator derived from item 15 from the PHCOSS survey. (Victorian Government Department of Health, Chronic Disease Self Management: A fact sheet for Primary Care Partnerships)
Indicator 19 Consumer involvement in decision making

Identifying and Definitional attributes

Short name: Consumer involvement in decision making
Description: The percentage of clients/carers satisfied or highly satisfied with their involvement in decisions about their care or treatment.
Rationale: Client involvement in decision making is linked to better health outcomes (Doing it with us not for us: Strategic direction 2010-2013)

Quality Dimension

Appropriate, Acceptable

Collection and Usage Attributes

Numerator: The total number of clients/carers satisfied or highly satisfied with their involvement in decisions about their care or treatment
Denominator: The total number of clients/carers who participated in consumer/carer surveys
Population: All clients (from all program areas) who have responded to survey when last conducted in organisation
Computation: \[(\text{Numerator} \div \text{Denominator}) \times 100\]
Computation description:

Target: Target for community health services is 90% as stated in DoH policy
References: Indicator 2.3 for Community Health Services from Victorian Government Department of Health, Doing it with us not for us Strategic direction 2010-2013
Indicator 20 Communication to General Practitioner re end of episode

**Identifying and Definitional Attributes**

<table>
<thead>
<tr>
<th>Short name:</th>
<th>Communication to General Practitioner re end of episode</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description:</td>
<td>The percentage of clients referred by a GP with evidence of discharge/end of episode communication from the community health service to the Client’s GP.</td>
</tr>
<tr>
<td>Rationale:</td>
<td>Community health staff must provide regular communication to GPs regarding the outcome of the client’s episode of care to enable the GP to effectively manage the client’s care. Refer notes below.</td>
</tr>
<tr>
<td>Quality Dimension</td>
<td>Appropriate</td>
</tr>
</tbody>
</table>

**Collection and Usage Attributes**

| Numerator: | The total number of clients referred by a GP who have evidence of end of episode/discharge communication from the community health service to the GP in the health record |
| Denominator: | The total number of clients referred by GP with closed episode |
| Population | A minimum of 30 clients who have been referred by GP in the previous 3 months |
| Computation: | \((\text{Numerator}÷\text{Denominator})×100\) |
| Computation description: | The intent of this indicator stems from the Department of Health’s *Guideline on feedback to general practitioners for community health services, 2011*, that outlines the need for consistent, timely and appropriate feedback to GP’s for maintaining high quality care. Feedback from community health professionals to GPs should occur with regard to: |

- acknowledgement of referral
- outcomes from assessment/re-assessment and planned interventions for the client
- change to a person’s condition or status, or change in treatment
- referral to an additional service provider
- periodic progress
- discharge or end of course of care (including outcomes of treatment)
- notice of failure to attend by a referred client

A sample feedback report is provided in the Department of Health’s *Guidelines on feedback to general practitioners for community health services 2011*. Where the GP did not refer the client, a further note is suggested as to the purpose of the report.
**Indicator 21 Complaints acknowledgement**

**Identifying and Definitional attributes**

- **Short name:** Complaints acknowledgement
- **Description:** The percentage of complaints acknowledged by the organisation within two working days of receipt of complaint.
- **Rationale:** Timely response to complaints is the ideal management of complaints.
- **Quality Dimension:** Acceptable

**Collection and Usage Attributes**

- **Numerator:** Number of complaints acknowledged within two working days of receipt of complaint
- **Denominator:** Total number of complaints by complainants who wish to be contacted
- **Population:** Include all complainants who wish to be contacted in 12 month period
- **Computation:** \((\text{Numerator} ÷ \text{Denominator}) \times 100\)
- **Computation description:** A ‘Complaints acknowledgement’ may consist of letter, phone call or e mail documented in the client record.

A complaints acknowledgement requires at a minimum the following three aspects of complaints management to be conveyed to the complainant:

- Contact details of person handling complaint
- How the complaint will be handled
- How long the complaint process would take

**References:**
Indicator 22 Complaints closed

Identifying and Definitional attributes

Short name: Complaints closed
Description: The percentage of complaints closed by the organisation within 30 working days of receipt of complaint
Rationale: Timely resolution of complaints is the ideal management of complaints
Quality Dimension: Acceptable

Collection and Usage Attributes

Numerator: Number of complaints closed within 30 working days of receipt of complaint
Denominator: Total number of complaints by complainants who wish to be contacted
Population: Include all complainants who wish to be contacted in 12 month period
Computation: \((\text{Numerator} ÷ \text{Denominator}) × 100\)
Computation description: A complaint is ‘closed’ if the complainant accepts the organisation’s response, if not accepted the complaint remains open and complainant is informed of alternative recourse. Use of term consistent with VHIMS data set specification 2011

The complaints management process involves several key points in the operation of the complaints handling process:

- Communication - information in relation to the complaints handling process
- Receipt of complaint - record the complaint and identify and record outcome sought by complainant and departments/programs involved
- Tracking of complaint - complaint process should be recorded throughout and complainant provided with up-to-date reports upon request
- Acknowledgement of complaint – receipt of acknowledgement of complaint should be provided immediately to the complainant
- Initial assessment of complaint – complaint is assessed with criteria including urgency, severity, complexity and impact
- Investigation of complaint – investigation of all aspects of complaint, according to the severity of complaint
- Response to complaints – organisation provides a response and resolves complaint or identifies process for resolving
- Communicating the decision – action regarding the complaint is communicated as soon as possible to complainant
- Closing the complaint – if the complainant accepts
response then complaint is closed, if not accepted the complaint remains open and complainant informed of alternative recourse

References:

AS4269 Customer Satisfaction - AS ISO 10002-2006a
Section 2: Indicators for Internal Use

Indicator 23 Client experience feedback participation

Identifying and Definitional attributes

Short name: Client experience feedback participation

Description: The percentage of all active clients who provided feedback about their experience.

Rationale: Client feedback is integral to quality care.

Quality Dimension Acceptable

Collection and Usage Attributes

Numerator: The total number of clients who provided feedback about their experience

Denominator: The total number of active clients of the service

Numerator or Denominator Criteria: Measurement Mode: Audit of feedback mechanisms/standard patient experience instrument

Computation description: Note this indicator is not a response rate but a measure of the percentage of all active clients who provided feedback. Agencies may also wish to calculate the following

The response rate: the percentage of clients given surveys who responded

The sample: the percentage of all active clients given surveys (note an absolute number should also be recorded)

Agencies may wish to specify in more detail the method of feedback to be examined via the indicator which may include:

- Client experience/satisfaction surveys
- Forums/Focus Groups
- Client Interviews
- Suggestions/Complaints/Compliments

References:
Indicator 24 Goal(s) partially attained

Identifying and Definitional attributes

Short name: Goal(s) partially attained

Description: The percentage of objectives/goals of care have been partially met in the timeframe stated

Rationale: The achievement of agreed objectives/goals of care is a measure of the success of the interventions.

Quality Dimension: Effective

Collection and Usage Attributes

Numerator: The number of objectives/goals partially met in the timeframe stated for attainment of each objective/goal for consumers with a care plan

Denominator: The total number of objectives/goals with the timeframe stated for attainment of each objective/goal for consumers with a care plan registered for the service/program who received intervention during the time period under study.

Numerator or Denominator Criteria:

Computation description: The measure of goal attainment is subjective and organisations may need to develop their own criteria. One example is provided below.

The care plan should have some capacity to note whether its goals were met. For example: The goals of the care plan have been:

- Fully Met
- Partially Met
- Not met

References:
Indicator 25 Recall Systems

Identifying and Definitional attributes

Short name: Recall Systems
Description: The percentage of clients attending a recall appointment
Rationale:
Quality Dimension: Appropriate

Collection and Usage Attributes

Numerator: Number of clients attending recall appointment within timeframe specified by organisation
Denominator: Number of clients contacted for recall within specified service area

Numerator or Denominator Criteria:
Computation description:
1. Indicator for not tied in with care plan process
2. Define recall in CH context— as compared with best practice in discipline (e.g. risk based recall in dental– children and high risk groups)
3. Dental has an in built recall function

References:
Indicator 26 Follow up of diagnostic results

Identifying and Definitional attributes

Short name: Follow up of diagnostic results
Description: The percentage of clients receiving the results of diagnostic tests
Rationale:
Quality Dimension: Appropriate

Collection and Usage Attributes

Numerator: The number of results communicated to clients
Denominator: The number of clients referred for a diagnostic test
Numerator or Denominator Criteria: Note the indicator provided is only relevant for situations where the results are not communicated directly to the client. In this situation there is an expectation that the service provider ordering the tests is responsible for informing the client of a normal and abnormal result.

If the client receives results of a test directly (e.g. pap smear) the indicator needs to be amended to reflect follow up of abnormal results only with the client and would be: the percentage of abnormal results with appropriate client follow up in a timely manner

Computation description:
References:
Indicator 27 Referral content

Identifying and Definitional attributes

Short name: Referral content

Description: The percentage of clients whose referral contained appropriate contact and clinical and contact information and a current medication list.

Rationale: Appropriate

Collection and Usage Attributes

Numerator: The proportion of clients whose referral contained appropriate identifying, clinical and contact information and a current medication list.

Denominator: The proportion of clients who had a referral.

Numerator or Denominator Criteria: The use of this indicator would require organisation to identify the relevant items expected in a referral which can include:

- Name of client, DOB and address of client
- Clinicians involved in client’s care, reason for involvement and contact details of providers
- Presenting issue/diagnosis
- Past history
- Summary of Assessment findings
- Summary of Intervention/treatment to date
- Medication list
- Signature, date and name and designation of service provider

Computation description: Unclear if referral is referral received or sent. Agencies to determine use for either scenario.

References:
Indicator 28 Initial Credentialling

Identifying and Definitional attributes

Short name: Initial Credentialling

Description: The percentage of permanent staff who were initially credentialled as part of the recruitment process.

Rationale: Credentialling is an important mechanism to monitor competence of staff

Quality Dimension: Appropriate, Safe

Collection and Usage Attributes

Numerator: Number of staff providing a service to clients who were initially credentialled as part of the recruitment process.

Denominator: Number of staff providing a service to clients

Numerator or Denominator Criteria: Definitions

Staff providing a service to clients: All service providers (not including support staff such as receptionists) who have direct interaction with clients

Credentialling: the formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of practitioners for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high quality health care services within specific organisational environments.


Initial Credentialling is the credentialling information generally checked once before the offer for employment of staff. Information to be verified through Initial credentialling includes:

- Verification of identity (e.g. photo identification)
- Evidence of current professional registration.
- Qualifications - review of tertiary qualifications (viewing originals or certified copies)
- Training undertaken
- Specialist Accreditation
- Referee Checks
- Drivers License as required
- Police Check
- Working with Children Check as necessary

(Reference How to guide for credentialling and scope of practice VHA)

Computation description:
## Indicator 29 Re Credentialling

### Identifying and Definitional attributes

<table>
<thead>
<tr>
<th>Short name:</th>
<th>Re credentialling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description:</td>
<td>The percentage of permanent staff who have been re-credentialled in the last 5 years.</td>
</tr>
<tr>
<td>Rationale:</td>
<td>Credentialling is an important mechanism to monitor competence of staff</td>
</tr>
<tr>
<td>Quality Dimension</td>
<td>Appropriate, Safe</td>
</tr>
</tbody>
</table>

### Collection and Usage Attributes

<table>
<thead>
<tr>
<th>Numerator:</th>
<th>Number of staff providing a service to clients who have been re-credentialled in the last 5 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator:</td>
<td>Number of staff providing a service to clients who have been at the service longer than 5 years</td>
</tr>
</tbody>
</table>

#### Numerator or Denominator Criteria:

**Definitions**

*Credentialling* - the formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of practitioners for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high quality health care services within specific organisational environments.


*Re-Credentialling* is the process of collecting ongoing information collected periodically to confirm the credentials of an existing staff member. Information to be verified through re-credentialling includes:

- Annual Monitoring of Registration
- Police Checks ongoing
- Working with Children Check
- Ongoing Professional Development.
- Supervision (management and clinical) feedback

**Computation description:**

re-credentialling involves more than an annual check of certification for registration purposes (certification) and is a process of forming a view about ongoing competence, performance and professional suitability to provide safe, high quality health care services within specific organisational environments.

**References:**

VHA How to guide for credentialling and scope of practice)
Indicator 30 Individual scope of practice defined

**Identifying and Definitional attributes**

**Short name:** Individual scope of practice defined

**Description:** The percentage of staff with their individual scope of practice defined

**Rationale:** Defining the individual scope of practice is an important mechanism to ensure appropriate services are provided by appropriately skilled service providers.

**Quality Dimension**

Appropriate, Safe

**Collection and Usage Attributes**

**Numerator:** Number of staff providing a service to clients with their individual scope of practice defined on appointment or reviewed in the last 5 years

**Denominator:** Number of permanent staff providing a service to clients

**Numerator or Denominator Criteria:**

**Definitions**

*Staff providing a service to clients:* All service providers (not including support staff such as receptionists) who have direct interaction with clients

*Scope of Practice* - Defining the scope of clinical practice follows on from credentialling and involves delineating the extent of an individual practitioner’s clinical practice within a particular organisation based on the individual's credentials, competence, performance and professional suitability and the needs and the capacity of the organisation to support the practitioner’s scope of clinical practice.

A statement of an individual’s scope of practice and the types of activities/procedures they may perform needs to be documented. An organisation may attach this information via amendment to the position description or an addendum to the position description. This needs to take the form of a document that is specific to the individual (rather than a generic document) and includes the data and signature of the manager and staff member.

**Computation description:**

**References:**
Indicator 31 Clinical Supervision

Identifying and Definitional attributes

Short name: Clinical Supervision

Description: The percentage of staff who have formal clinical supervision arrangements

Rationale: Clinical supervision is an important mechanism for supporting and maintaining the competence of staff

Quality Dimension: Appropriate

Collection and Usage Attributes

Numerator: Number of staff providing a direct funded service to clients with current Clinical Supervision contracts

Denominator: Number of permanent staff providing an intervention to client

Numerator or Denominator Criteria: Staff providing a direct funded service – Staff providing a direct service to clients as part of a service agreement (i.e. not support staff and administrative/reception staff)

Clinical Supervision - Clinical supervision is a formal process, between two or more professional staff, creating a supportive environment which encourages reflective practice and the improvement of therapeutic skills. Evidence of formal clinical supervision arrangements include:

- the presence of a clinical supervision contract
- clinical supervision provided by a supervisor who has received formal supervision training
- written record of supervision session are made
- regular dedicated time for supervision

(VHA Clinical Supervision in Community Health: Introduction and Practice Guidelines Sept 2008).

Clinical supervision is distinct from administrative or management supervision which is provided by a manager who is responsible for the overall performance of a team or program. Administrative matters relating to service planning, development and delivery are addressed by ensuring that program activities are carried out in a manner that is consistent with funding and legislative requirements, external policy directions and the organisations internal policies and procedures.

Computation description:

References:
Indicator 32 Professional development

Identifying and Definitional attributes

Short name: Professional development
Description: The percentage of staff with a current professional development plan

Rationale:
Quality Dimension: Appropriate

Collection and Usage Attributes

Numerator: Number of staff providing a direct service to clients that have a current professional development plan.
Denominator: Number of permanent staff providing a direct service to clients

Numerator or Denominator Criteria:
Computation description:
References:
Indicator 33 Infection control

Identifying and Definitional attributes

Short name: Infection control

Description: The percentage of the services eligible workforce who have received infection control training.

Rationale:

Quality Dimension Safe

Collection and Usage Attributes

Numerator: Number of eligible staff who have received infection control training.

Denominator: Number of eligible staff

Numerator or Denominator Criteria: Measurement Mode: Audit

References:
Appendix 1 Minimum Requirements of Diabetes Care

The frequencies of the diabetes related reviews presented in table 1 below are minimum recommended frequencies used to formulate the diabetes care indicators. If additional risk factors are identified in a client review, such as periodontal disease in an oral health review or sensation changes in a podiatry review, the review period will need to be more frequent.

**Table 1: Minimum Requirements of Diabetes Care**

<table>
<thead>
<tr>
<th>Review</th>
<th>Description</th>
<th>Medicare Service Incentive Program Frequency</th>
<th>Community Health Review Minimum Frequency Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI</td>
<td>Body weight in kilograms/height in meters squared</td>
<td>Six monthly</td>
<td>Annual</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Systolic pressure over diastolic pressure</td>
<td>Six monthly</td>
<td>Annual</td>
</tr>
<tr>
<td>Examine feet</td>
<td>Review foot sensation, pedal pulses and foot deformities</td>
<td>Six monthly</td>
<td>Annual</td>
</tr>
<tr>
<td>HbA1c</td>
<td>Blood test of glycosylated haemoglobin</td>
<td>Annual</td>
<td>Annual</td>
</tr>
<tr>
<td>Cholesterol, triglycerides, HDL and LDL, cholesterol</td>
<td>Blood test of lipids</td>
<td>Annual</td>
<td>Annual</td>
</tr>
<tr>
<td>Microalbuminurria</td>
<td>One of a number of tests that can be performed to determine albumin (protein) in the urine</td>
<td>Annual</td>
<td>Annual</td>
</tr>
<tr>
<td>Self-care education</td>
<td>Includes diabetes knowledge, blood glucose monitoring, foot care, insulin administration</td>
<td>Annual</td>
<td>Annual</td>
</tr>
<tr>
<td>Review diet</td>
<td>Review of general diet to determine whether detailed instructions need to be given by a Dietitian.</td>
<td>Annual</td>
<td>Annual</td>
</tr>
<tr>
<td>Review levels of physical activity</td>
<td>Assess current level of physical activity and develop a plan to increase as required</td>
<td>Annual</td>
<td>Annual</td>
</tr>
<tr>
<td>Review Smoking</td>
<td>Record the smoking status of the client</td>
<td>Annual</td>
<td>Annual</td>
</tr>
<tr>
<td>Review Medications</td>
<td>Review medication adherence and any possible drug interactions (pharmacist)</td>
<td>Annual</td>
<td>Annual</td>
</tr>
<tr>
<td>Comprehensive Eye examination</td>
<td>Review with ophthalmologist or optometrist for early check of retinopathy</td>
<td>Every two years</td>
<td>Every two years</td>
</tr>
<tr>
<td>Review Oral Health</td>
<td>Oral examination by dentist</td>
<td>Not stated</td>
<td>Every two years</td>
</tr>
<tr>
<td>Depression/Anxiety Screen</td>
<td>Review for depression/anxiety issues (e.g.K-10 as used in Service Coordination Psychosocial Profile)</td>
<td>Not stated</td>
<td>Annually</td>
</tr>
</tbody>
</table>

NB: table based on Diabetes Management in General Practice Guidelines for Type 2 Diabetes 2011/2012, Diabetes Australia and RACGP (note additional elements of depression and oral health added to table)