



The Primary Care Services Improvement Project

Following your expression of interest in the Primary Care Services Improvement Project (PCSIP), this sheet provides more information about the research project.

What is the project aim?

Management of chronic diseases is now one of the major challenges facing health care systems. It has been noted that providing multi-disciplinary systematic care can improve the management and control of chronic diseases such as diabetes and depression. In recent years, several initiatives in the primary care setting have been implemented. Examples of these initiatives include the Practice Nurse Incentive and the Diabetes Incentive, which form part of Medicare's Practice Incentive Program (PIP). By analysing long-term costs and effects of primary care-based initiatives, the purpose of the PCSIP is to investigate whether such programs improve benefits to patients, considering costs to Practices, patients, and the health service associated with the implementation of these initiatives.

Who is organising the project?

The PCSIP is a collaboration between the Adelaide Northern Division of General Practice (ANDGP), and the Disciplines of General Practice and Public Health at the University of Adelaide.

Who is funding the project?

The project is funded by the Australian Research Council (ARC), SA Health, and the Central Northern Adelaide Health Service.

How is the project organised?

The PCSIP is a 2-year study allowing for data collection over a one-year period. We recruited 16 Practices in the Northern Division. Within each Practice, we intend to recruit a minimum of 10 patients with an established diagnosis of diabetes mellitus (type 2), depression (with or without anxiety), or obesity (i.e. a minimum of 30 patients per Practice). Eligible patients will be between 18 and 75 years of age and consider the participating Practice as their usual source of primary care. Patients who are pregnant, have bipolar disorder, schizophrenia, dementia, or live in a managed care facility will be excluded.

How will the project be conducted?

For the purpose of data collection, the PCSIP consists of two phases, Practice recruitment and patient recruitment.

(1) Practice recruitment

The project will classify the type of participating Practice based on the uptake of the primary care-based initiatives relevant to the conditions, such as diabetes incentives and Practice Nurse (PN).

- (1.1) What information will be collected about Practices in the Northern Division?
 - GP characteristics: data such as age, gender, and years in practice
 - Practice characteristics:



- General characteristics such as number of GPs, links to services provided by Allied Health professionals (AHPs), and desktop software and use of the PEN Computer Systems Clinical Audit Tool (CAT).
- Characteristics related to primary care-based initiatives such as patient register and recall system, involvement of a practice nurse and/or mental health nurse, and costs of initiatives.

(2) Patient recruitment

If you choose, experienced project staff can be made available to clean electronic patient records. This process involves making sure the information a GP enters into the patient's record has been entered in the correct location in the clinical desktop software. Data cleaning can improve searching of patient records (e.g. generating lists of patients based on their condition) and will assist with the identification of eligible patients. We emphasize this is an optional service.

After discussing your requirements and preferences, project staff can suggest alternatives for your consideration. For example, in Practices using Medical Director, cleaning can include running the HCN Maintenance Diagnosis Coder, conducting searches in Medical Director and manually reviewing patient records. This process may involve an estimated 4 hours of valuable input from trained project personnel. Further information on cleaning procedures can be found in the accompanying Data Cleaning document.

If required, in collaboration with the ANDGP, project staff can then install the CAT (at no cost) to enable identification of patients with eligible conditions. The CAT is a clinical information management tool and enhances the business capability of Practices. The CAT has many purposes, including highlighting areas in which Practices can improve recording of patient information, identifying population risk groups for targeted interventions, and monitoring progress towards data quality improvement. The CAT is compatible with the most GP Clinical Desktop Systems including Medical Director (versions 2 and 3), Best Practice (version 1.6.0.395 and later), and Genie (version 7.5.3 and later). Practices using Houston VIP do not need to have the CAT installed.

Once patients are identified, we would ask the relevant GP to review the list of potentially eligible patients to identify unsuitable patients (e.g. deceased, mentally incompetent, terminally ill). Project staff will then prepare an introductory letter to be sent to patients on behalf of the Practice. The letter describes the purpose of the project, the data to be collected from patients (as detailed below), and contact information for project staff. Patients will be asked for their informed written consent to the access of the required information.

(2.1) What information will be collected about patients?

The project will collect prospective data over a one-year period from the point at which patients are recruited to the study. We will also collect retrospective data describing disease and clinical pathways for patients over a two-year period before the point at which patients are recruited. We will request access to the following data sources from patients:

- medical records held at the Practice and ANDGP (if the patient has received services there);
- MBS and PBS records;
- hospitalisation records (from SA Health/ISAAC data); and
- a maximum of 2 survey documents over the 1 year follow-up period.

The information collected about patients includes some sociodemographic characteristics (such as age, gender, occupation and employment status), health services utilisation, clinical measures (such as HbA1C in patients with diabetes, baseline and follow up assessments of the severity of disease based on outcome measurement tools such as the Kessler Psychological Distress Scale (K10) in patients with depression and Body Mass Index for patients with obesity), and self report measures such as quality of life for all patients.



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Adelaide Northern Division of General Practice
1st Floor, 13 Elizabeth Way | PO Box 421 Elizabeth SA 5112
| www.andgp.org.au | ABN 12 061 979 048

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How will GPs and Practices be involved in the Project?

In order to collect information about Practices and GPs, Practices will be requested to complete two short surveys providing details of the uptake of primary care-based initiatives and resources used in implementing and operating these initiatives. A single researcher (Jodi Gray) will conduct all project interactions with your Practice. Jodi will also undertake the data cleaning (if requested), identify eligible patients, and extract data from the records of consenting patients. The use of electronic records will reduce the burden of all of the above tasks. However, we will work with Practices to identify the best practicable approach to each task in order to minimise disruption to the Practice.

As noted earlier, at the patient identification stage, we would ask the relevant GP for help in briefly reviewing generated patient lists to identify patients who may be unsuitable for participation in the project.

Over the one-year study period, Jodi will visit your Practice twice to extract data from consenting patients' records – once at the beginning of the study period, and then approximately 12 months later. To extract data from patient records, Jodi will require access to Practice electronic records. She will consult with you and your Practice to identify the most convenient approach to extracting these data, with the aim of minimising disruption to your normal practice.

In appreciation for your involvement, we offer a number of benefits to you and your practice. These include a payment of \$1,000 to each participating Practice, individualised newsletters providing tailored feedback on the project with peer comparisons of management pathways, the free service to clean Practice data, and the CAT's value to highlight opportunities to increase revenue from PIPs.

How will patients be involved in the Project?

As noted earlier, all eligible patients will receive an information sheet and consent forms. Consenting patients (i.e. those who give permission to access their data from the Practice's records), will be contacted by the project team to arrange patient surveys (two short surveys over a one-year period). These surveys aim to collect data on quality of life measures and other information if required. Patients won't need to do any extra health related activities and the project will not change the care they are currently receiving for their condition.

How will confidentiality be protected?

The extracted data from Practice electronic records will be de-identified before it leaves the Practice. This means that the names of patients will never be held in the same research database as their medical information. Only authorised project staff will have access to the information provided and no one will ever be able to view patients' names and medical information at the same time. All electronic data will be kept in a password protected computer. Presented results will be anonymised with respect to Practices and patients.

How will the data be analysed?

By synthesising the patient data with data from scientific literature, we will be able to map common pathways through the health care system for patients with each condition (i.e. how their condition progresses, and the types of complications they experience). The data collected will be analysed to identify differences in patient pathways and intermediate outcomes (such as control of HbA1c levels).

What are the expected benefits to patients and community?

By identifying efficient ways to treat patients under study, the outcomes of this project will provide an improved understanding of the impact of primary care-based initiatives which can, in turn, improve the quality of decision making around scarce resources and help avoid the implementation of comparatively inefficient interventions.



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Contact details

Further details concerning the project can be obtained by contacting:

Associate Professor Jon Karnon

Tel: 8303 3562

Email: jonathan.karnon@adelaide.edu.au

Dr. Hossein Afzali

Tel: 8313 0615 or 0404 626 686

Email: hossein.hajjalafzali@adelaide.edu.au

Jodi Gray

Tel: 8313 0640

Email: jodi.gray@adelaide.edu.au



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