



National Prescribing Service Limited



Information sheet describing data management, evaluation and privacy

for
AGPN/NPS Prescribing Data in General
Practice Demonstration (PDGPD) project

27 March 2009

National Prescribing Service Limited

National Prescribing Service Limited is an independent, non-profit organisation for Quality Use of Medicines, funded by the Australian Government Department of Health and Ageing.

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in collaboration with

Australian General Practice Network Limited

The Australian General Practice Network (AGPN) represents 111 local divisions of general practice and eight state and territory-based entities. More than 90 per cent of GPs are division members. AGPN's involvement in health activities is broad, from health promotion through to medical education. It delivers local health solutions through general practice, to ensure Australians can access a high quality health care.

AGPN acknowledges the financial support of the Australian Government Department of Health and Ageing.

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What is this information sheet for?

This information sheet provides answers to a series of frequently asked questions for the Prescribing Data and General Practice Demonstration (PDGPD). The project has been developed by the National Prescribing Service (NPS) in conjunction with the Australian General Practice Network (AGPN). Up to 180 practices and 20 Divisions across Australia will be selected for the project.

This information sheet is divided into two sections:

Section 1: What will the evaluation for the PDGPD project involve?

Section 2: How have privacy and confidentiality issues been addressed?

Overview of data management for the PDGPD project

The Prescribing Data and General Practice Demonstration (PDGPD) project is a quality improvement activity for GPs. The PDGPD project is focused on two clinical areas: management of hypertension and chronic heart failure (CHF). The project aims to assist GPs in the management of patients with these conditions through the support of optimal prescribing. Achieving an improvement in the care of these conditions in the primary care setting would have considerable impact both clinically and economically.

Some work using prescribing data to address these issues in primary care has been undertaken in recent years. However use of electronic prescribing data extraction is very limited for the purposes of quality improvement and manual extraction of prescribing data for indicator calculations can be time-consuming and complicated. To make this feasible, the Canning data extraction software tool has been modified to automatically extract relevant prescribing data and automatically calculate eight clinical prescribing indicators used in this project. The Canning data extraction software tool allows GPs to extract prescribing information from Medical Director software, allowing for review of patient management. Information is provided on best practice and GPs are supported to discuss this in practice groups. The project will also investigate the acceptability and sustainability of the quality improvement activity in general practice.

SECTION 1: What will the evaluation for the PDGPD project involve?

In order to investigate the impact of the PDGPD project QI activity and assess the value, feasibility and sustainability of this and similar interventions, the project will include a formal evaluation. The evaluation will use:

- non-identifiable clinical and demographic data from patients with CHF and/hypertension drawn from GPs' clinical databases via the Canning tool
- practice characteristics such as size and anonymised GP demographics entered into and extracted via the Canning tool.

The patient/GP/practice evaluation data will be rendered non-identifiable, encrypted and transferred securely to the NPS at a number of time points throughout the project (on installation of the Canning tool, 0, +3, +6,+12, and +18 months). Automated extraction and data transfer will be initiated by the project facilitator in cooperation with a nominated participating practice staff member. The evaluation will gauge the impact of the QI activity on short term patient outcomes (e.g. blood pressure) and prescribing (e.g. use of ACE inhibitors in heart failure), whilst taking into account co-morbidities (e.g. diabetes), risk factors (e.g. smoking), demographics (e.g. age and sex) and characteristics of the treating GP (e.g. age and years in practice) and the practice (e.g. number of GPs and rural/urban location). Collected data will be treated as strictly confidential, be rendered non-identifiable and only accessible to the project research team via a central database at the NPS. The data will only be used for the purposes of evaluating the PDGPD intervention. The evaluation will compare patient and prescribing outcomes for the intervention and control groups over the course of the project. Additionally, the analysis will investigate factors related to differences in those outcomes at the patient, GP and practice level.

At the conclusion of the intervention a brief anonymous, self-completion survey will also be posted to all GPs participating in the project to determine the feasibility and sustainability of the QI activity. A small number of focus groups (six) with a sample of practice staff (volunteers) from the intervention arms of the project will also be conducted to obtain further detail regarding the feasibility of the QI activity. Focus group participants will be paid for their time.

The evaluation protocol and data collection instruments will be subject to approval by the RACGP Ethics Committee.

Who will have access to the evaluation data?

All data collected for evaluation will be treated as strictly confidential, be rendered non-identifiable and only accessible to the project research team via a central database at the NPS. The data will be stored on a password protected server located in a secure area of the NPS. Only the project research team on the PDGPD project will have access to the data for the sole purpose of evaluating the project and they will not know which particular practice/GP/patient the information belongs to.

A report describing the outcomes from the PDGPD will be prepared by the NPS. Only aggregate results will be presented and no practice will be able to be identified in the report. No individual GP, practice or patient will be identified in the report. The report will contain the analysis of the impact of the QI activity over the term of the project and the feedback on the feasibility and sustainability of the activity in general practice. The report will be sent to all participating practices and divisions, the Department of Health and Ageing and will be publicly available on the NPS website.

What if a practice gets randomised to the control arm?

Assignment to the intervention and control arms of the project will be completely random and will be carried out by the NPS as each practice is enrolled. Practices will be informed as to their allocation. All practices randomised to the control arm will receive the QI activity including the installation of the Canning tool six months after those practices in the intervention arms receive it. Control practices will be eligible for the same incentives and benefits and incentives as those randomised to the intervention arms. Having a control arm is important as it allows us to best (although not perfectly) isolate the effect of participating in the PDGPD QI activity by having data from comparable practices subjected to the same conditions/environment as those receiving the intervention.

What are “aggregate clinical indicators”?

The Canning data extraction software tool has been modified to automatically extract and calculate the eight clinical prescribing indicators used in this project. GPs within a single practice will therefore be able to review their prescribing behaviour for hypertension and chronic heart failure patients using the Canning tool. In addition, at three-monthly intervals, each practice will be asked to send the clinical indicator results summed (“aggregated” by the Canning tool) for their practice to the NPS. The results for all participating practices will then be aggregated by NPS the divisional and national level so that practices can compare their outcomes with the divisional and national averages. Access to the aggregated data will be via a password-protected website hosted by the NPS. The project facilitator will be able to view divisional and national aggregate data, but will only be able to view practice level data for practices in their division. Practices will be able to view data for other practices in their own division, but the data will be anonymised so that the individual practices cannot be identified.

Will the Canning tool affect other programs on a general practice’s computer or network?

The Canning tool is widely used in general practice across Australia and has been extensively tested. The Canning tool to be used in the project will be the publicly available version. Software liability for the project is addressed through the current liability conditions that apply to the Canning tool. Running a data extraction

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with the Canning tool may temporarily slow the network including any Medical Director software (including backup functions) that is in use. However, extractions need only be performed infrequently, and can be run overnight to avoid affecting system backups.

Can general practices do the QI activity and not participate in the evaluation component of the PDGPD project?

No. Participating practices and GPs must consent to carry out the activities associated with the evaluation while they are part of the study. This information is vital to understanding the impact of the QI activity.

Can a general practice withdraw from the project?

A general practice can withdraw from the project at any time without prior notice. Withdrawal from the project will be undertaken in writing through the project facilitator. However, this may affect QPI/PIP eligibility. There is no financial penalty to the practice if the practice withdraws. Individual practices will not be required to uninstall the Canning tool.

Can an individual GP withdraw from the project?

Yes. Individual GPs may withdraw from the project at any time without prior notice. Withdrawal will be undertaken through the project facilitator. However, this may affect QPI/PIP eligibility. If individual GPs withdraw from the project, this may also affect their eligibility for QA&CPD/PPD points. There is no financial penalty to the practice if the GP withdraws. In addition, if the practice is to continue to participate, the practice principal must agree to ensure the data for all relevant patients (i.e., those with hypertension and/or CHF) is available for the purposes of the clinical indicator feedback for GPs and evaluation of the project, even if an individual GP chooses to withdraw from the PDGPD project.

Section 2– How have data privacy and confidentiality issues been addressed?

Why does the PDGPD project need patient data?

Non-identifiable patient data will be used to evaluate the impact of the QI activity. Patient data allows us to demonstrate the benefit of such QI activities for patient health and establish the value of such QI activities to other GPs and funders of health initiatives. It also allows us to identify factors that may be associated with facilitating or hindering improvement in patients in a practice (e.g. smoking, older patient population) so we can target future QI activities where it will result in most benefit.

Do patients need to consent for their data to be used?

All patient level data will be rendered non-identifiable by the Canning data extraction software tool before it leaves GPs' computers. Therefore its collection without written patient consent does not breach national privacy laws. Participating practices will also be asked to display a notice in practice waiting rooms to alert patients to the practice's participation in the PDGPD project and the option to have themselves excluded from the project if they wish. These measures were approved by the RACGP Ethics Committee.

Why do you need information about the practice and the GPs?

A small amount of non-identifiable information will be collected on GPs (e.g. age, patient load) and their practice (e.g. size) as part of the evaluation of the QI activity because it is important to know which features of a GP or practice may influence patient and prescribing outcomes. For example, large practices or GPs with large patient loads may find it more or less difficult to implement the QI activity. Similarly, if it is practice policy at one practice to bulk bill all recalled patients, patients may be more likely to return for review than at a practice which does not bulk bill. These factors in turn may influence the degree to which practices/GPs may demonstrate change as a result of participating in the project.

How can I be sure the patient and GP/practice information will remain confidential?

Any information collected, used and stored for the PDGPD project will remain anonymous (identified only by an ID number) and comply with the National Privacy Principles contained in the Privacy Act 1988 (Commonwealth), as well as the Joint NHMRC/AVCC Statement and Guidelines on NHMRC Research Practice and Australian Code for Responsible Conduct of Research. The data will be stored on a password protected server located in a secure area of the NPS. Only the project research team on the PDGPD project will have access to the data for the sole purpose of evaluating the project and they will not know which particular practice/GP/patient the information belongs to.

Will the PDGPD project produce any reports or publications?

A report describing the outcomes from the PDGPD will be prepared by the NPS. Only aggregate results will be presented and no practice will be able to be identified in the report. No individual GP, practice or patient will be identified in the report. The report will contain the analysis of the impact of the QI activity over the term of the project and the feedback on the feasibility and sustainability of the activity in general practice. The report will be sent to all participating practices and divisions, the Department of Health and Ageing and will be publicly available on the NPS website.

Will the indicator results be used to assess GP performance or to set benchmarking standards?

No. Individual GP-level indicator results calculated by the Canning tool are not transmitted to NPS by the tool. These results are supplied purely for the use of GPs within the practice. Practice-level indicator results are only required to be sent to NPS so that aggregate divisional and national level data can be calculated and displayed for the purposes of peer comparison. It is important to note that differences in practice demographics can lead to large variations between results for different practices.

Where do I get further information?

This information sheet is one of three:

- Information sheet for general practices and GPs.
- Information sheet for Divisions of General Practice.
- Information sheet - data management, evaluation and privacy.

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or visit AGPN website via: [Prescribing Data Project](#) or www.agpn.com.au (under *What's News*)