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Practice Incentives Program Quality Improvement Incentive Quality Improvement Measures

User Guide for Primary Health Networks

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1. INTRODUCTION

1.1 Purpose of the guide

This guide is intended to be a resource to assist Primary Health Networks (**PHNs**) to understand the reporting requirements and data involved in the Practice Incentives Program Quality Improvement Incentive (**PIP QI Incentive**). It provides an overview of the PIP QI Incentive, and describes the quality improvement measures in detail. This guide will cover what data the PHNs will receive, how to interpret it, what quality checks can be performed on the data, and how that data should be aggregated before its transferal to the national data custodian (the Australian Institute of Health and Welfare).

1.2 Objectives of the PIP QI Incentive

The PIP QI Incentive aims to recognise and support general practices that commit to improving the care they provide to their patients, with a focus on care relating to particular health priority areas.

The PIP QI Incentive is a payment to general practices for activities that support data driven continuous quality improvement in patient outcomes and the delivery of best practice care. In receiving the data, the PHN will be able to assess the quality improvement needs of practices within their network by looking at the patient cohorts that relate to these priority areas and understanding what data practices are routinely collecting.

1.3 Summary of the PIP Quality Improvement Measures

To support the program, data on 10 Quality Improvement Measures are collected:

1. Proportion of patients with diabetes with a current HbA1c result
2. Proportion of patients with a smoking status
3. Proportion of patients with a weight classification
4. Proportion of patients aged 65 and over who were immunised against influenza
5. Proportion of patients with diabetes who were immunised against influenza
6. Proportion of patients with COPD who were immunised against influenza
7. Proportion of patients with an alcohol consumption status
8. Proportion of patients with the necessary risk factors assessed to enable CVD assessment
9. Proportion of female patients with an up-to-date cervical screening
10. Proportion of patients with diabetes with a blood pressure result

2. THE PIP ELIGIBLE DATA SET

2.1 What is the PIP Eligible Data Set?

The PIP Eligible Data Set is the data that general practices provide to their local PHN for the purposes of the PIP QI Incentive.

The PIP Eligible Data Set is de-identified patient data, aggregated at the practice level that can be analysed by the demographic and clinical factors specified in the PIP Eligible Data Set Data Governance Framework.

It is comprised of only those fields required to:

- Calculate the 10 PIP QI Improvement Measures; and
- Conduct approved analysis (such as sex and age) in accordance with the PIP Eligible Data Set Data Governance Framework (see Principle 4).

The PIP Eligible Data Set is predominantly made up of derived fields, or flags, that are used to determine the proportions of clients shown in each report. The below table demonstrates which data elements are used to calculate the Improvement Measures.

Patient Demographics	**Clinical Measures**	**Pathology**
▪ Regular client indicator ▪ Age group ▪ Sex ▪ Indigenous status ▪ Practice ▪ Smoking status recorded indicator ▪ Smoking status ▪ Alcohol consumption status	▪ Diabetes diagnosis ▪ Diabetes status ▪ Blood pressure measurement recorded indicator ▪ Systolic blood pressure measurement result recorded indicator ▪ Cardiovascular disease recorded indicator ▪ COPD recorded indicator ▪ HbA1c measurement recorded indicator ▪ Influenza immunisation indicator ▪ Hysterectomy indicator ▪ Body mass index classification ▪ Body mass index recorded indicator	▪ HbA1C measurement result recorded indicator ▪ HDL cholesterol measurement result recorded indicator ▪ Total cholesterol measurement result recorded indicator ▪ Cervical screening indicator

2.2 What is received by the PHN?

Through the PIP QI data collection process, PHNs will receive the calculated Improvement Measures from practices – that is, they will receive a count of patients given as a denominator and numerator according to the specifications of each Improvement Measure. The numerators and denominators will be provided with a breakdown of the counts by age group, sex and whether the patient is Aboriginal or Torres Strait Islander. What comprises the denominators and numerators for each of the Improvement Measures is provided in Section 3, PIP Quality Improvement Measures.

The PIP QI Incentive data collection process does not supersede or replace existing or future data sharing agreements PHNs may have with practices and only relates to the collection of data as part of participation in the PIP QI Incentive.

2.3 How is the PIP Eligible Data Set received?

General practices can choose to submit their data in one of two ways depending on the capabilities of their current clinical information system.

Option 1	**General practices that already exchange data with their local PHN** • A general practice can continue to utilise the data extraction method agreed with their local PHN to submit the PIP Eligible Data Set.
Option 2	**General practices that do not currently exchange data with their local PHN** • A general practice can utilise the data extraction method offered by their local PHN to submit the PIP Eligible Data Set. • A general practice can purchase or licence their own data extraction tool which is compatible with their local PHN; or • A general practice can work with their clinical information system provider and local PHN to submit the PIP Eligible Data Set in accordance with the PIP Eligible Data Set Data Governance Framework. General practices in this situation may have previously applied for a PIP QI Incentive Exemption, which concluded 31 July 2020. The data is provided to the PHN as a report showing the counts of patients against each measure. Depending on the method of data submission used by the practice, the report is either generated by the clinical information system or by a data extraction tool (e.g. PEN or POLAR) and will be sent to PHNs in a JSON format.

2.4 How should the PIP Eligible Data Set be interpreted and how can it inform quality improvement?

The PIP QI Incentive is a mechanism for undertaking continuous quality improvement (CQI) through the collection and review of uniform, nationally consistent, general practice data, against ten key Improvement Measures that contribute to local, regional and national health outcomes.

In participating in the program, general practices are committing to undertaking CQI activities that support them in their role of managing their patients' health and improvements in digital maturity, data cleansing and clinical coding. In order to assist with this improvement, PHNs can use the PIP Eligible Data Set to inform the needs of practices within their network. The seven attributes of quality health records underpin the PIP QI Incentive and provide a useful framework for performing analysis of the data and working with practices to understand where quality improvement efforts are best placed:

- Completeness
    - Reviewing the data to ascertain whether sufficient information is being recorded in consultations. Gaps or lower than expected counts in the dataset may indicate that key data is not being captured, or is being captured in fields other than those being used for the data extract.

- Consistency
    - Reviewing for the use of standardised terminology or code sets. Gaps or lower than expected numbers may be the result of practices not recording data in a consistent manner, or recording data in free text fields that are not easily accessed or searchable, and which are not drawn upon to calculate the Improvement Measures.
- Legibility
    - Legibility includes making health information clear and able to be read and understood by others. Gaps in the data could be due to illegibility for data items that rely on record entry processing involving interpretation of notes or transposal of data.
- Accuracy
    - Comparisons between practices may inform interpretations of how accurately data is kept, however due to the de-identified nature of the data being reported, reviews for data accuracy should be informed by working closely with practice to understand the profile of each practice and the practice's assessment about the accuracy of their data.
- Relevance
    - Reviewing completeness of the data to understand whether current data recording processes are capturing data across the health priority areas as represented by the scope of the Improvement Measures. A component of this is sharing understanding that there are connections between certain Improvement Measures, for instance, patients with diabetes would benefit from improved quality of data around BMI and smoking status as these would be key inputs into their care pathway.
- Accessibility
    - Where there are gaps or low numbers in the data, it could indicate that the data is not being stored in an accessible manner. As the data is derived from the practice system, gaps could indicate where there may be alternative, additional, or peripheral sources of clinical information that are not making their way into the practice system. This could indicate a problem with the accessibility of clinical information.
- Timeliness
    - One of the parameters of the data involved in the calculation of the Improvement Measures is timeframe, with some Improvement Measures only being derived from data that has been recorded in the past six or twelve months. Therefore, gaps or lower than expected counts may be the result of data that is older and which may be potentially inaccurate. There could also be an issue with the recording of dates.

The review of incoming data will support PHNs to:

- Work with general practices to support quality improvement, for example:
    - by providing practices with reports based on their practice's data against the 10 Improvement Measures which will help identify potential areas for improvement and in which they can focus their CQI activities
    - by providing feedback on the quality of the data submitted
    - where the general practice agrees, by providing benchmarking against an aggregate of other general practices in the region
    - by providing advice on managing the patient population indicated in the data.

- Contribute to service planning and population health mapping at different levels including PHN boundaries, local health districts, jurisdictional boundaries and at the national level.

In addition to the benefits to practices and practitioners, the purpose of quality improvement is to benefit patients directly. For example, Improvement Measures allow the PHNs to guide preventative health programs in their network, and advise practices in understanding what patients may benefit from preventative treatments, or may need effective holistic management of a specified chronic disease, such as diabetes. This can help delay progression of the condition, improve quality of life, increase life expectancy, and decrease the need for high cost interventions.

3. DATA SET REQUIREMENTS

3.1 How should the data set be stored?

As regional data custodians in receiving the de-identified PIP Eligible Data Set from local data custodians PHNs should ensure that the data is protected during receipt, storage, aggregation and use processes. Although the risk of a privacy breach is minimal, given the data is provided in aggregated form, proven methods reduce the risk of breaching an individual's privacy to very low levels in the event of any small cell sizes. These protections are formalised in data sharing and licensing agreements with general practices and with data extraction companies. The PHN should have data governance committees in place to oversee their data governance framework, data policies, data procedures, data guidelines, and risk management plans that include specifications for audit trails, the notification and management of data breaches, and disaster recovery plans.

Access is a key aspect of storage security and should be associated with the purpose of the intended use of the data, as much as it is associated with specific resources and positions. In order to manage access to the stored data set, ensure that the access is only associated with the following activities:

- analysis of the data;
- creation of quality improvement plans;
- assignment of quality improvement plans to the correct general practitioner and/or general practice;
- confirmation of eligibility of the general practice to receive the PIP QI Incentive payment; and
- preparation of the data for transferal to the AIHW.

Many of the security arrangements will be managed through service level agreements and contractual arrangements with data extraction and data storage vendors. This is an appropriate mechanism to manage security, however PHNs should be aware they hold ultimate responsibility for the security of the PIP Eligible Data Set data once it has been transferred to them.

Part of the responsibility when holding de-identified data is putting in place mitigation against re-identification. The risk of re-identification will be higher where:

- There is a count of less than five in a cell (though the risk is mitigated if the denominator is >1,000)
- The data relates to a small community
- A count is used rather than a calculated value

The risks are minimised by a process called small cell suppression. This involves extracting the data, undertaking small number checks and transforming the data by calculating into the Quality Improvement Measures. PHNs may have small cell suppression requirements in existing Data Sharing Agreements with practices which cover the sharing of data, including the PIP Eligible Data Set. Small cell suppression will also be performed by the AIHW prior to releasing the national data.

The PIP Eligible Data Set falls under any privacy notices and privacy policies consistent with a PHNs' requirements under the Privacy Act 1988.

3.2 What are the reporting requirements of the PHN and what is the aggregation process?

PHNs will receive the counts for each Improvement Measure. This will consist of numerators and denominators. The aggregation of the data for reporting to the AIHW is an aggregation of each of the counts from all the practice in order to develop the Improvement Measure counts for the PHN as a whole.

The process is simply a sum of the practice counts for all reporting practices in the network, for each of the denominators and numerators, with the same breakdown by age group, sex and Indigenous status as has been reported in the counts from the practices.

3.3 How accurate is the data and what data quality checks can be performed?

The accuracy of reporting will be driven by the completeness and accuracy of the underlying data used to generate the measures. In a number of clinical systems, there are varying ways that clinical data can be entered depending on personal preference and workflows. Not all of these will result in a record being included in the quality improvement measure. There is a user guide available for general practices which includes which data fields are used to calculate the quality improvement measures.

Mapping guides have been developed for users of Medical Director and Best Practice software to show users which fields are used to calculate the measures. This will allow steps to be taken to improve data quality by providing training for staff who are entering data in the system, and confirming that the system supports capture of all information needed, such as the time and date a record is updated.

While these processes are robust, it is nonetheless advised that PHNs be equipped to review the dataset for data quality purposes. Data quality checks need not be complex. Consider checking for the following:

- A number of regular clients that exceeds the total number of clients.
- There should not be more regular clients than the total number of clients in any category (e.g. females aged 15-19).
- 0 in a numerator or denominator where you would expect to see a result.
- Results that vary significantly since the last reporting period, without any obvious environmental, community or clinical change or event that would explain the differences.

If you encounter an unexpected result, consider working with the practice to uncover what the underlying cause may be. The following are some common causes:

- Service delivery and patient demographic profile – do they just not have clients of certain demographic groups?
- Community profile – is the data reflective of the area the practice services?
- Environmental profile – is the data reflecting factors such as weather, seasonal changes, disease or the current situation of local economy?
- Clinical profile – are there changes to practice's services, programs, policies, procedures, funding or staffing that would be affect the capture of the underlying data?
- System profile – has the practice recently changed or update the practices systems which capture and store the data? Is there a new approach to records capture? Has the practice system recently adopted data cleansing procedures?
- Statistical profile – is the unexpected result a product of statistical chance? Is it statistically unexpected?

4. PIP QUALITY IMPROVEMENT MEASURES

4.1 Proportion of patients with diabetes with a current HbA1c result

QIM01 – Proportion of patients with diabetes with a current HbA1c result	
Description	Measuring the proportion of patients who have either type 1 or type 2 diabetes and who have had an HbA1c measurement result recorded in the 12 months before the census date
Purpose for collection	This informs the management of diabetes and the impact of effective management on progression of the disease, and reduce the need for high cost interventions.
Who does it apply to?	This measure applies to patients: • Who are regular clients of the service; • Have diabetes type 1 **or** 2 **or** an unspecified, generic or general diabetes diagnosis which does not specify either Type 1 or Type 2; and • Includes all age groups.
Who does it exclude?	Patients without type 1 or type 2 diabetes, including those who may have: • Secondary diabetes; • Gestational diabetes mellitus (GDM); • Previous GDM; • Impaired fasting glucose; and • Impaired glucose tolerance.
What data contributes to this measure?	The specific fields that are used to derive the fields required for the QIM calculation may vary depending on the clinical system practices use, but generally will involve: • Latest Visit Date • Second Latest Visit Date • Third Latest Visit Date (to determine in patient is a regular client) • Diagnosis (Diabetes Type 1) • Diagnosis (Diabetes Type 2) • HbA1c Measurement • HbA1c Measurement Date
How is it calculated?	The measure is calculated by dividing: *the number of regular clients, with type 1 or 2 diabetes, who have had an HbA1c measurement result recorded in the last 12 months* (**Numerator**) by _____

QIM01 – Proportion of patients with diabetes with a current HbA1c result	
	the total number of regular clients with type 1 or 2 diabetes (**Denominator**) (Numerator ÷ Denominator) x 100

What does this mean?

This measure is identifying how many regular clients who have diabetes have had an HbA1c result recorded in the last 12 months. For males and females in each age group it will show:

How many patients have had an HbA1c measurement result in the last 12 months? (Numerator)

How many patients have type 1 or type 2 diabetes? (Denominator)

4.2 Proportion of patients with a smoking status

QIM02a – Proportion of patients whose smoking status has been recorded	
Description	Proportion of regular clients aged 15 years and over whose smoking status has been recorded.
Purpose for collection	In Australia, smoking continues to be the behavioural risk factor responsible for the highest levels of preventable disease and premature death. Recording systems that document tobacco use almost double the rate at which clinicians intervene with smokers leading to higher rates of smoking cessation.
Who does it apply to?	This measure applies to: • Patients who are regular clients of the service, and • Are aged over 15 years of age.
Who does it exclude?	• Patients aged under 15 years of age
What data contributes to this measure?	The specific fields that are used to derive the fields required for the QIM calculation may vary depending on the clinical system practices use, but generally will involve: • Latest Visit Date • Second Latest Visit Date • Third Latest Visit Date • Date of Birth • Smoking Status • Smoking Status Recorded Date
How is it calculated?	The measure is calculated by dividing: The total number of regular clients aged over 15 whose smoking status was recorded in the previous 12 months (Numerator) by: The total number of regular clients aged over 15. (Denominator) (Numerator ÷ Denominator) x 100
What does this mean? This measure is identifying how many regular clients aged over 15 have had a smoking status recorded. For males and females in each age group it will show: How many patients have had their smoking status recorded in the last 12 months? (Numerator) How many regular clients were there in each age, sex and indigenous status group? (Denominator)	

QIM02b – Proportion of patients with a smoking status	
Description	Proportion of regular clients aged 15 years and over whose smoking status has been recorded as one of the following: current smoker; ex-smoker; or never smoked.
Purpose for collection	In Australia, smoking continues to be the behavioural risk factor responsible for the highest levels of preventable disease and premature death. Recording systems that document tobacco use almost double the rate at which clinicians intervene with smokers leading to higher rates of smoking cessation.
Who does it apply to?	This measure applies to: • Patients who are regular clients of the service, and • Are aged over 15 years of age.
Who does it exclude?	• People under 15 years
What data contributes to this measure?	The specific fields that are used to derive the fields required for the QIM calculation may vary depending on the clinical system practices use, but generally will involve: • Latest Visit Date • Second Latest Visit Date • Third Latest Visit Date • Date of Birth • Smoking Status • Smoking Status Recorded Date
How is it calculated?	The measure is calculated by dividing: The total number of regular clients aged over 15 whose smoking status was recorded in the previous 12 months as: Current smoker Ex-smoker Never smoked (Numerator) by: The total number of regular clients aged over 15 who had their smoking status recorded in the previous 12 months. (Denominator) (Numerator ÷ Denominator) x 100
What does this mean? This is for regular clients who are aged over 15 and who have had a smoking status result recorded and will show: How many patients are current smokers? (Numerator)	

QIM02b – Proportion of patients with a smoking status
How many patients had smoking status recorded? (Denominator) How many patients are ex-smokers? (Numerator) How many patients had smoking status recorded? (Denominator) How many patients have never smoked? (Numerator) How many patients had smoking status recorded? (Denominator)

4.3 Proportion of patients with a weight classification

QIM03a – Proportion of patients whose BMI is recorded	
Description	Proportion of regular clients aged 15 years and over and who have had their Body Mass Index (BMI) recorded within the previous 12 months.
Purpose for collection	To provide information to assist in public health planning to respond to the high rates of overweight and obesity, and the associated risks for Type 2 diabetes, cardiovascular disease, hypertension, osteoarthritis, some cancers and gallbladder disease. Australia's obesity rate now ranks fifth among Organisation for Economic Co-Operation and Development (OECD) countries (OECD 2017). BMI continues to be a common measure to identify adults who may be at an increased risk or morbidity and mortality due to their weight.
Who does it apply to?	This measure applies to: • Patients who are regular clients of the service, • Patients who have had a height measurement taken since turning 15 and a weight measurement taken in the previous 12 months, and • Who are aged 15 and over
Who does it exclude?	• People aged less than 15 • People aged over 18 and either shorter than 0.914m or taller than 2.108m
What data contributes to this measure?	The specific fields that are used to derive the data elements required for the QIM calculation may vary depending on the clinical system practices use, but generally will involve: • Latest Visit Date • Second Latest Visit Date • Third Latest Visit Date • Date of Birth • Height Measured • Weight Measured • Height Measured Date • Weight Measured Date
How is it calculated?	The measure is calculated by dividing: Number of regular clients aged 15 and over who had their BMI recorded Divided by: Total number of regular clients aged 15 and over. (Numerator ÷ Denominator) x 100
What does this mean? This is for regular clients aged 15 and over, and will show:	

QIM03a – Proportion of patients whose BMI is recorded
How many patients had their BMI recorded? (Numerator) ——————————————— How many patients were in each age, sex and indigenous status group? (Denominator)

QIM03b – Proportion of patients with a weight classification	
Description	Proportion of regular clients aged 15 years and over and who have had their Body Mass Index (BMI) classified as obese, overweight, healthy, or underweight within the previous 12 months.
Purpose for collection	To provide information to assist in public health planning to respond to the high rates of overweight and obesity, and the associated risks for Type 2 diabetes, cardiovascular disease, hypertension, osteoarthritis, some cancers and gallbladder disease. Australia's obesity rate now ranks fifth among Organisation for Economic Co-Operation and Development (OECD) countries (OECD 2017). BMI continues to be a common measure to identify adults who may be at an increased risk or morbidity and mortality due to their weight.
Who does it apply to?	This measure applies to: • Patients who are regular clients of the service, • Patients who have had a height measurement taken since turning 15 and a weight measurement taken in the previous 12 months, and • Who are aged 15 and over
Who does it exclude?	• People aged less than 15 • People aged over 18 and either shorter than 0.914m or taller than 2.108m
What data contributes to this measure?	The specific fields that are used to derive the data elements required for the QIM calculation may vary depending on the clinical system practices use, but generally will involve: • Latest Visit Date • Second Latest Visit Date • Third Latest Visit Date • Date of Birth • Height Measured • Weight Measured • Height Measured Date • Weight Measured Date
How is it calculated?	The measure is calculated by dividing:

QIM03b – Proportion of patients with a weight classification	
	Number of regular clients aged 15 and over who had a BMI classified as underweight, healthy, overweight or obese Divided by: Total number of regular clients aged over 15 who had a BMI recorded. (Numerator ÷ Denominator) x 100

What does this mean?

This is for regular clients aged 15 and over and will show:

How many have a BMI classified as underweight in the last 12 months? (Numerator)

How many patients had a BMI measurement recorded? (Denominator)

How many have a BMI classified as normal in the last 12 months? (Numerator)

How many patients had a BMI measurement recorded? (Denominator)

How many have a BMI classified as overweight in the last 12 months? (Numerator)

How many patients had a BMI measurement recorded? (Denominator)

How many have a BMI classified as obese in the last 12 months? (Numerator)

How many patients had a BMI measurement recorded? (Denominator)

4.4 Proportion of patients aged 65 and over who were immunised against influenza

QIM04 – Proportion of patients aged 65 and over who were immunised against influenza	
Description	Proportion of regular clients aged 65 years and over who were immunised against influenza in the previous 15 months.
Purpose for collection	To measure the extent to which best practice guidelines for influenza immunisation are being applied across Australia to inform public health and health promotion activity
Who does it apply to?	This measure applies to: • Patients who are regular clients of the service, and • Are aged 65 and over
Who does it exclude?	Patients under 65
What data contributes to this measure?	The specific fields that are used to derive the fields required for the QIM calculation may vary depending on the clinical system practices use, but generally will involve: • Latest Visit Date • Second Latest Visit Date • Third Latest Visit Date • Date of Birth • Immunisation Record (Influenza) • Immunisation Record Date
How is it calculated?	The measure is calculated by dividing: The number of regular clients aged 65 years and over who are immunised against influenza By The total number of regular clients who are aged 65 years and over (Numerator ÷ Denominator) x 100
What does this mean? For regular clients aged 65 years and over: How many have had an influenza vaccination in the last 15 months? (Numerator) How many were in each age, sex and indigenous status group? (Denominator)	

4.5 Proportion of patients with diabetes who were immunised against influenza

QIM05 – Proportion of patients with diabetes who were immunised against influenza	
Description	Proportion of regular clients with type 1 or type 2 diabetes who were immunised against influenza in the previous 15 months.
Purpose for collection	Diabetes was the underlying cause of around 10% of all deaths in Australia in 2016. People with diabetes are considered to be at high risk of complications from influenza. During recent influenza epidemics, diabetes was considered a significant risk factor for hospitalization. The administration of influenza vaccine to persons at risk of complications is the single most important measure in preventing or attenuating influenza infection and preventing mortality.
Who does it apply to?	This measure applies to: • Patients who are regular clients of the service, and • Have type 1 or type 2 diabetes
Who does it exclude?	Patients without type 1 or type 2 diabetes, including those who may have: • Secondary diabetes, • gestational diabetes mellitus (GDM) • previous GDM, impaired fasting glucose, • impaired glucose tolerance
What data contributes to this measure?	The specific data elements that are used to derive the fields required for the QIM calculation may vary depending on the clinical system practices use, but generally will involve: • Latest Visit Date • Second Latest Visit Date • Third Latest Visit Date • Date of Birth • Immunisation Record (Influenza) • Immunisation Record Date • Diagnosis (Diabetes Type 1) • Diagnosis (Diabetes Type 2)
How is it calculated?	The measure is calculated by dividing: The number of regular clients who are recorded as having type 1 or type 2 diabetes AND who are immunised against influenza By: The total number of regular clients who are recorded as having type 1 or type 2 diabetes. (Numerator ÷ Denominator) x 100

QIM05 – Proportion of patients with diabetes who were immunised against influenza
What does this mean? For regular clients who have type 1 or type 2 diabetes: How many have had an influenza vaccination in the last 15 months? (Numerator) ——————————————— How many have diabetes (Type 1 or 2)? (Denominator)

4.6 Proportion of patients with COPD who were immunised against influenza

QIM06 – Proportion of patients with COPD who were immunised against influenza	
Description	The proportion of regular clients who are aged 15 years and over, who are recorded as having chronic obstructive pulmonary disease (COPD), and who were immunised against influenza in the previous 15 months.
Purpose for collection	People with COPD are considered to be at high risk of complications from influenza. Data from several studies also provide evidence that influenza vaccination has a clinically important protective effect on influenza-related COPD exacerbations, and probably an effect on the total number of exacerbations in COPD patients. The administration of influenza vaccine to persons at risk of complications is the single most important measure in preventing or attenuating influenza infection and preventing mortality. While best practice guidelines recommend annual immunisation, a 15-month interval allows for cases when a client decides to receive a vaccine earlier than recommended (e.g. from a pharmacy), or delay and wait for the release of an 'enhanced' vaccine
Who does it apply to?	This measure applies to: • Patients who are regular clients of the service, and • Are aged 15 years or more, • Who have any diagnosis of COPD, and • Have been immunised against influenza.
Who does it exclude?	• Children under the age of 15 • Patients with documented medical reasons for not having the vaccination
What data contributes to this measure?	The specific data elements that are used to derive the fields required for the QIM calculation may vary depending on the clinical system practices use, but generally will involve: • Latest Visit Date • Second Latest Visit Date • Third Latest Visit Date • Date of Birth • Immunisation Record (Influenza) • Immunisation Record Date • Diagnosis (COPD)
How is it calculated?	The measure is calculated by dividing: The number of regular clients who are aged 15 years and over AND who have a diagnosis of COPD AND who are immunised against influenza By: _____

QIM06 – Proportion of patients with COPD who were immunised against influenza	
	The total number of regular clients who are aged 15 years and over AND who have COPD (Numerator ÷ Denominator) x 100

What does this mean?

For regular clients aged 15 years and over and who have COPD:

How many have had an influenza vaccination in the last 12 months? (Numerator)

How many have COPD? (Denominator)

4.7 Proportion of patients with an alcohol consumption status

QIM07 – Proportion of patients with an alcohol consumption status	
Description	Measures the proportion of regular clients who are aged 15 years and over who have had their alcohol consumption status recorded in the previous 24 months, generally through an Audit C assessment.
Purpose for collection	Excessive consumption is associated with health and social problems in all populations. Many chronic conditions share common risk factors that are largely preventable, including excessive alcohol consumption. While fewer Australians are drinking at levels that contribute to alcohol-related harm, about 26% of people drink more than is recommended on a single occasion, and they do this at least once each month.
Who does it apply to?	This measure applies to: • Patients who are regular clients of the service, and • Who are aged 15 years or over.
Who does it exclude?	• People aged under 15.
What data contributes to this measure?	The specific data elements that are used to derive the fields required for the QIM calculation may vary depending on the clinical system practices use, but generally will involve: • Latest Visit Date • Second Latest Visit Date • Third Latest Visit Date • Date of Birth • AUDIT/AUDIT-C • Other Alcohol Consumption Marker
How is it calculated?	The measure is calculated by dividing: The number of regular clients aged 15 and over who have had their alcohol consumption recorded By: The total number of regular clients who are aged 15 and over. (Numerator ÷ Denominator) x 100
What does this mean? For regular clients aged 15 years and over: How many have had their alcohol consumption status recorded in the last 24 months months? (Numerator) How many were in each age, sex and indigenous status group? (Denominator)	

4.8 Proportion of patients with the necessary risk factors assessed to enable CVD assessment

QIM08 – Proportion of patients the necessary risk factors assessed to enable CVD assessment	
Description	This measure identifies the proportion of all regular clients who age aged between 45 and 74 years, as well as Aboriginal and Torres Strait Islander regular clients who are aged 35 to 44 years, who have had all the information required to calculate their absolute CVD risk in the last 2 years. This includes having the following risk factors recorded: • Tobacco smoking status • Diabetes - Diabetes status: Type 1 or Type 2 Diabetes **OR** - Diabetes risk: Fasting Glucose Test result, **OR** a screening for glycosylated haemoglobin (HbA1c test result) • Systolic blood pressure • Total cholesterol and HDL cholesterol levels • Age • Sex
Purpose for collection	Assessment of absolute CVD risk based on multiple risk factors is more accurate than that based on individual risk factors due to the cumulative nature of risk effects. Basing patient management decisions on this approach should improve CVD outcomes.
Who does it apply to?	This measure applies to: • Patients who are regular clients of the service, • Are aged between 45 and 74 and, • Aboriginal and Torres Strait Islander regular clients aged 35 to 44.
Who does it exclude?	• Patients who have a known diagnosis of CVD as this measure is identifying those at risk of developing CVD, not those already with a CVD diagnosis. • Patients who do not have every risk factor recorded
What data contributes to this measure?	The specific fields that are used to derive the fields required for the QIM calculation may vary depending on the clinical system practices use, but this measurement will consider: • Latest Visit Date • Second Latest Visit Date • Third Latest Visit Date • Date of Birth • Sex • Smoking Status

<table>
<tr><th colspan="2">QIM08 – Proportion of patients the necessary risk factors assessed to enable CVD assessment</th></tr>
<tr><td></td><td>• Diagnosis (Diabetes Type 1)
• Diagnosis (Diabetes Type 2)
• Fasting Glucose Test Measurement
• HbA1c Measurement
• Total Cholesterol Measurement
• HDL Cholesterol Measurement
• Systolic Blood Pressure Measurement</td></tr>
<tr><td>How is it calculated?</td><td>The measure is calculated by dividing:
Number of regular clients aged 45 to 74 years who have had all CVD risk factors recorded;
By
Total number of regular clients aged between 45 and 74 years.
(Numerator ÷ Denominator) x 100</td></tr>
<tr><td colspan="2">What does this mean?
For regular clients aged between 45 years and 74 years with no diagnosis of CVD:
How many have had all the following information recorded in the last 24 months – smoking status, diabetes, systolic blood pressure, total cholesterol, HDL cholesterol, age and sex? (Numerator)
How many patients without known CVD were in the Practice in the same period? (Denominator)</td></tr>
</table>

4.9 Proportion of female patients with an up-to-date cervical screening

QIM09 – Proportion of female patients with an up-to-date cervical screening	
Description	Proportion of female regular clients aged 25 to 74, who have not had a hysterectomy and who have had a cervical screening [human papillomavirus (HPV) test] after 1 December 2017 and within the previous 5 years.
Purpose for collection	Australia has the lowest mortality rate and the second lowest incidence of cervical cancer in the world. The success of the cervical screening program is dependent upon the recruitment of women. Higher participation in cervical screening means that more women with precancerous abnormalities can have these detected and treated, which is necessary for achieving the overall aim of reducing incidence and mortality from cervical cancer.
Who does it apply to?	This measure applies to: • Patients who are regular clients of the service, and • Are aged between 25 and 74, and • Have had an HPV test
Who does it exclude?	• Men • Women who have had a complete hysterectomy • Women who are under 25 or over 74.
What data contributes to this measure?	The specific data elements that are used to derive the fields required for the QIM calculation may vary depending on the clinical system practices use, but generally will involve: • Latest Visit Date • Second Latest Visit Date • Third Latest Visit Date • Date of Birth • Sex • Patient History (Hysterectomy) • HPV Test Service Event • HPV Test Service Event Date
How is it calculated?	The measure is calculated by dividing: The number of female regular clients who are aged 25 to 74, who have not had a hysterectomy and who have had an HPV test after 1/12/17 and in the last 5 years. By: The total number of female regular clients who are aged 25-74 years who have not had a hysterectomy. (Numerator ÷ Denominator) x 100
What does this mean?	

QIM09 – Proportion of female patients with an up-to-date cervical screening
For female regular clients aged between 25 and 74 years: How many have had an HPV test in the last 5 years? (Numerator) _____ How many female clients who had not had a hysterectomy were there in the same period? (Denominator)

4.10 Proportion of patients with diabetes with a blood pressure result

QIM10 – Proportion of patients with diabetes with a blood pressure result	
Description	Proportion of regular clients who have diabetes and who have had a blood pressure measurement result recorded at the primary health care service within the previous 6 months.
Purpose for collection	Diabetes was the underlying cause of around 10% of all deaths in Australia in 2016 and recent reports show death rates for people with type 2 diabetes are rising. For people with type 1 or type 2 diabetes, monitoring blood pressure can help assure appropriate medical care to lower the risk of macro vascular (stroke, heart attack and heart failure) and microvascular (kidney disease, eye disease and peripheral neuropathy) complications.
Who does it apply to?	This measure applies to: • Patients who are regular clients of the service, and • Who have either type 1 or type 2 diabetes.
Who does it exclude?	Patients without type 1 or type 2 diabetes, including those who may have: • patients with secondary diabetes • gestational diabetes mellitus (GDM) • previous GDM • impaired fasting glucose • impaired glucose tolerance
What data contributes to this measure?	The specific data elements that are used to derive the fields required for the QIM calculation may vary depending on the clinical system practices use, but generally will involve: • Latest Visit Date • Second Latest Visit Date • Third Latest Visit Date • Diagnosis (Diabetes Type 1) • Diagnosis (Diabetes Type 2) • Systolic Blood Pressure Measurement • Diastolic Blood Pressure Measurement • Blood Pressure Measurement Date Recorded
How is it calculated?	The measure is calculated by dividing: The number of regular clients who have Type 1 or Type 2 diabetes and who have had a blood pressure measurement result recorded at the primary health care service within the previous 6 months By: The total number of regular clients who have Type 1 or Type 2 diabetes (Numerator ÷ Denominator) x 100

QIM10 – Proportion of patients with diabetes with a blood pressure result
What does this mean? For regular clients who have type 1 or type 2 diabetes: How many have had a blood pressure result recorded in the last 6 months? (Numerator) ——————————————————— How many regular clients are there with type 1 or type 2 diabetes? (Denominator)

Further Information

- PIP QI Incentive Guidelines
- PIP Eligible Data Set Data Governance Framework
- PIP QI Who do I ask
- PIP QI FAQs
- PIP QI Factsheet – What practices need to know
- PIP QI Factsheet - Consumer