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Department of Health

Practice Incentives Program
Quality Improvement Incentive
Quality Improvement Measures

User Guide for General Practices

ACKNOWLEDGMENT

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1. INTRODUCTION

1.1 Purpose of the guide

This guide is intended to be a resource to assist general practices to understand the reporting process and data involved in the Practice Incentives Program Quality Improvement Incentive (**PIP QI Incentive**). It provides an overview of the PIP QI Incentive, answers some key questions and describes the Quality Improvement Measures in detail. This guide will cover the data required to generate the measures and the scope and format of data that is reported from the local data custodian (General Practice) to the regional data custodian (Primary Health Networks), and then to the national data custodian (the Australian Institute of Health and Welfare).

The extraction of data, and the identification of patients who meet the criteria for each measure, will be automated by clinical software vendors. The information on inclusion and exclusion criteria for each of the measures is included in this guide purely to support practices to understand what data fields in their practice system the extraction is drawing from – you do not need to do anything to select the data fields that will be reported.

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 (CQI) in patient outcomes and the delivery of best practice care.

The Royal Australian College of General Practitioners defines CQI as an ongoing activity undertaken within a general practice with the primary purpose to monitor, evaluate or improve the quality of healthcare delivered to patients.

The PIP QI Incentive represents a move away from process focussed funding towards outcome focussed funding.

The PIP QI Incentive is a mechanism for undertaking CQI through the collection and review of uniform, nationally consistent, general practice data, against 10 key Quality Improvement Measures that contribute to local, regional and national health outcomes.

The data collected for the purposes of the PIP QI Incentive is known as the PIP Eligible Data Set. The PIP Eligible Data Set is de-identified patient data 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 PIP QI ten 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 Improvement Measures, which are counts of the number of patients for each of the ten measures, as well as the associated analysis data, is provided by general practices as part of their participation in the PIP QI Incentive. Any other data shared by a general practice with a third party is outside the scope of the PIP QI Incentive governance and dataset arrangements.

General practices commit to undertaking CQI activities that support them in their role of managing their patients' health. Improvements in digital maturity, data cleansing, clinical coding, and the seven attributes of quality health records[1] underpin the PIP QI Incentive:

- Completeness
- Consistency
- Legibility
- Accuracy
- Relevance
- Accessibility
- Timeliness.

Data collected through the PIP QI Incentive has the potential to benefit patients directly. For example, Improvement Measures allow the practice to understand what proportion of their patients may benefit from preventative treatments, or may need recall to ensure effective 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.

1.3 Summary of the PIP Quality Improvement Measures

To support the program, data on 10 Quality Improvement Measures are collected. For each of these measures a count is made of a numerator and denominator. These are what are reported to the PHN. The details of how these counts are calculated is given in Section 3 PIP Quality Improvement Measures. The Improvement Measures are:

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

[1] RACGP, Quality health records in Australian primary healthcare: A guide; https://www.racgp.org.au/download/Documents/PracticeSupport/2013qualityhealthrecords.pdf

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 (age group, sex and Indigenous status) in accordance with the PIP Eligible Data Set Data Governance Framework (see Principle 4).

The PIP Eligible Data Set is predominantly made up of counts calculated from derived fields, or flags, that are used to determine the numerator and denominator of patients for each Improvement Measure. The below table demonstrates which data elements the PIP Eligible Data Set is based on.

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

Reports submitted from each practice for each Improvement Measure show the number of patients who fall into each measure, broken down by age, sex and Indigenous status. For example, Table 1 below provides an example of what would be reported for QIM02 - Proportion of patients with a smoking status recorded.

Table 1 – Example of QIM2 report – Proportion of patients with a smoking status recorded

Proportion of regular patients with a smoking status recorded within the previous 12 months															
			Current smoker			Ex-smoker			Never smoked			Total			
			Males	Females	Not stated	Males	Females	Not stated	Males	Females	Not stated	Males	Females	Not stated	Total
Indigenous	Age Group	15-24	6	6	0	20	10	0	15	15	0	41	31	0	72
		25-34	7	5	0	21	11	0	14	16	0	42	32	0	74
		35-44	9	7	0	19	11	0	20	21	0	48	39	0	87
		45-54	10	8	0	10	10	0	25	15	0	45	33	0	78
		55-64	11	9	0	8	10	0	21	18	0	40	27	0	67
		65 and over	5	9	0	7	7	0	22	23	0	32	39	0	71
Not Indigenous	Age groups	15-24	7	8	0	10	15	0	15	14	0	32	37	0	69
		25-34	6	9	0	11	14	0	17	12	0	34	35	0	69
		35-44	10	9	0	12	13	0	13	14	0	35	36	0	71
		45-54	9	10	0	20	12	0	14	16	0	43	38	0	81
		55-64	11	10	0	21	11	0	12	14	0	44	35	0	79
		65 and over	5	5	0	22	10	0	10	8	0	37	23	0	60
Not stated	Age groups	15-24	5	8	0	10	16	0	18	20	0	33	44	0	77
		25-35	10	9	0	9	10	0	12	15	0	31	34	0	65
		35-44	12	7	0	8	8	0	14	16	0	34	31	0	65
		45-54	6	8	0	7	9	0	10	8	0	23	25	0	48
		55-64	6	10	0	6	8	0	12	14	0	24	32	0	56
		65 and over	10	10	0	5	8	0	8	10	0	23	28	0	51

2.2 What is the PIP Eligible Data Set used for?

The PIP Eligible Data Set can **only** be used for the purposes of:

1. Improving the quality of care and patient outcomes;
2. Improving the capacity for general practices to benchmark their activities against peers on an agreed set of improvement measures;
3. Providing nationally consistent, comparable data against specified quality improvement measures to create regional and national health data sets;
4. Contributing to service planning and population health mapping at different levels including, PHN boundaries, jurisdictional (state/territory) boundaries, and nationally; and
5. Confirming participant eligibility for the receipt of Commonwealth funding under the PIP QI Incentive.

The Improvement Measures are not designed to assess individual general practices or general practitioner performance. They are intended to support a regional and national understanding of chronic disease management in areas of high need.

2.3 How is the PIP Eligible Data Set submitted to the PHN?

General practices can choose to submit their data 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 in your practice, the report is either generated by your clinical information system or by a data extraction tool (e.g. PEN or POLAR). The data flow and transformations that occur, between the practice, the PHN and the AIHW are shown in Figure 1 below.

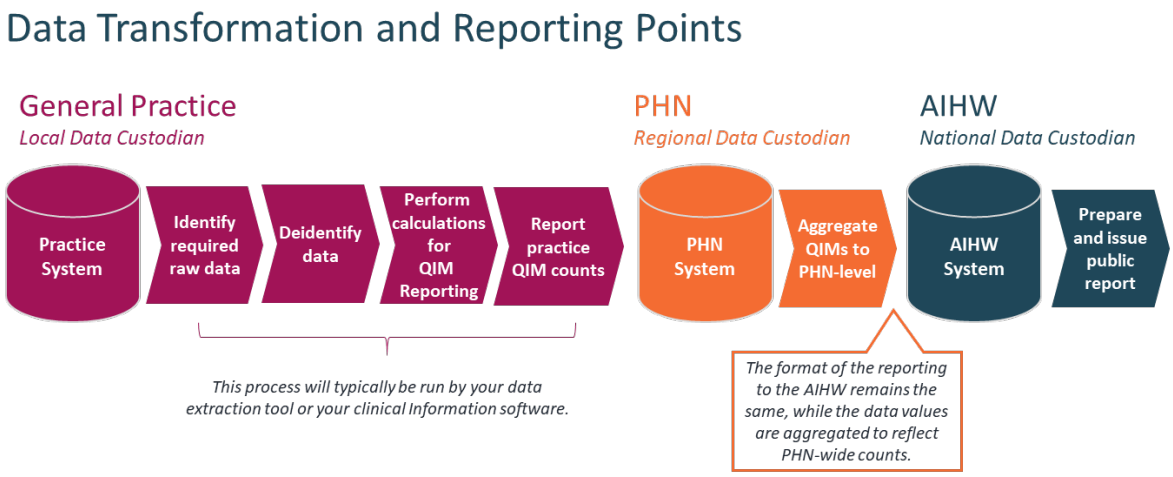

Figure 1

2.4 What does the PHN do with the data?

Quality Improvement

The PIP Eligible Data Set will assist 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 Quality 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.

The data provided to the PHN will only be accessed by the PHN and be used for the purposes described above. PHNs have their own policies and procedures around who in the PHN has access to the data.

Aggregation of the data

After they receive your data, the PHN will aggregate the data from all practices submitting data within the network. This means they will add the data together to produce total counts for each Improvement Measure for the PHN as a whole. This data will then be transferred to the national data custodian, the Australian Institute of Health and Welfare (AIHW).

2.5 What does the AIHW do with the data?

This aggregated data will be used by the AIHW for national level analysis and research. Researchers may apply to access the data securely and in accordance with data access and release protocols, which will be developed in accordance with the PIP Eligible Data Set Data Governance Framework.

As the PIP Eligible Data Set is de-identified and aggregated, the information accessed for approved research purposes will not be identifiable. In addition to this, the AIHW has organisational checks and approval processes that ensure that information remains de-identified and secure when accessed for research purposes.

2.6 What security protections are placed around the data?

The data being collected through the PIP QI Incentive is important to help the health system make decisions about programs and services to best meet the health needs of the community. It will be used to evaluate the impact and effectiveness of these programs to support continuous improvement, both to support improved health outcomes for the community, and to ensure the sustainability of the health system into the future. The PIP Eligible Data Set Data Governance Framework has established processes to ensure that this minimises the impact on patient's privacy, by

- Collecting only de-identified data
- Minimising the risk of re-identification, by excluding data elements that would facilitate this, such as date of birth and ethnicity
- Applying business rules – for example, age is presented as a five-year age group, not as a specific age.

- Applying thresholds to report values, either by using small cell suppression, where any cells that have less than five individuals will not be reported, or by restructuring the table by combining rows to increase the numbers in each cell. This applies to both the numerator and denominator
- Only publishing results as a proportion, not as a count
- Providing patients with the option of opting out from their data being included.

Personal information is protected by law. All local, regional and national data custodians have current privacy notices and privacy policies consistent with the Privacy Act 1988, and relevant state or territory legislation.

Privacy of individual patients

The protection of patient privacy is paramount. No personally identifying information of any patient is provided as part of the PIP Eligible Data Set to regional data custodians or the national data custodian. The PIP Eligible Data Set is not linked to other data sets if such linkage could reasonably result in the data being re-identified.

Privacy of participating general practices and General Practitioners

Regional data custodians require registration information from general practices participating in the PIP QI Incentive. This identifying information is *not* part of the PIP Eligible Data Set. It is collected to administer the PIP QI Incentive.

The provision of identifying information to the Department of Health and Services Australia occurs to administer the program, including program compliance, statistics and research, policy development, payment of the incentive, and accountability for the expenditure of Commonwealth funds.

Local Data Custodians (general practice) protection of privacy

Local data custodians use robust data extraction tools that de-identify patient information so they can confidently share that information with third parties. Practice culture combined with digital systems enable them to meet their existing obligations to keep their patients' health information secure and private, and they know that any de-identified health data shared is to improve patient outcomes.

Regional Data Custodians (Primary Health Networks) protection of privacy

Regional data custodians ensure that an individual's privacy is protected in the process of preparing, supplying and receiving de-identified data from local data custodians to the PIP Eligible Data Set. Proven methods reduce the risk of breaching an individual's privacy to very low levels. This is formalised in data sharing and licensing agreements with general practices and with data extraction companies. Regional data custodians have data governance committees to oversee their data governance frameworks, 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.

National Data Custodian (the Australian Institute of Health and Welfare) protection of privacy

The national data custodian ensures privacy policies and privacy notices comply with all relevant legislation. No identifying information is provided to the national data custodian.

2.7 Is the data de-identified?

As mentioned above, the data reported is de-identified. There are two elements to de-identification. In the first case, the specification and requirements for the data set do not request any identifiable information. The dataset comprises of patients counts, and does not include any 'unit record level' data, or data about specific patients. It does not include any data containing names or addresses. During extraction, the data extraction tool or clinical information system will de-identify the underlying data and will not produce or report any identified datasets supplementary to the Improvement Measures as part of the PIP QI Incentive reporting requirements.

The second element to de-identification is making sure that patients cannot be re-identified from the patient counts. This can happen when a count is a low enough number, that someone viewing the data could reasonably work out which individuals were included in that count. As the counts are usually presented in cells of a tables, these are called 'small cells'.

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 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.

The AIHW will not release any results without the consideration and application of appropriate small cell suppression.

3. PIP QUALITY IMPROVEMENT MEASURES

3.1 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 your 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 is used to calculate this measure?	The specific fields that are used to derive the fields required for the QIM calculation may vary depending on the clinical system you 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)

The results will be separated into males and females, in each age range, by Aboriginal and Torres Strait Islander status as shown below:

Calculation 1: Proportion of patients with diabetes type 1 with HbA1c measurement within the previous 12 months													
			With HbA1c			Without HbA1c			Total				
			Males	Females	Not stated	Males	Females	Not stated	Males	Females	Not stated	Total
Indigenous	Age groups	0-4										
		5-14										
		15-24										
		25-34										
		35-44										
		45-54										
		55-64										
		over										
Not Indigenous	Age	0-4										
		5-14 etc										
		15-24										
		25-34										
		35-44										
		45-54										
		55-64										
		over										
Not stated	Agen groups	0-4										
		5-14 etc										
		15-24										
		25-34										
		35-44										
		45-54										
		55-64										
		over										
Calculation 2: Proportion of patients with diabetes type 2 with HbA1c measurement within the previous 12 months													
			With HbA1c			Without HbA1c			Total				
			Males	Females	Not stated	Males	Females	Not stated	Males	Females	Not stated	Total
Indigenous	Age groups	0-4										
		5-14 etc										
Not Indigenous	Age groups	0-4										
		5-14 etc										
Not stated	Age groups	0-4										
		5-14 etc										

QIM01 – Proportion of patients with diabetes with a current HbA1c result

3.2 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 your service, and • Are aged over 15 years of age.
Who does it exclude?	• Patients aged under 15 years of age
What is reported to the PHN?	To generate this measure, the following data is reported to the PHN: • Sex • Age group • Regular client indicator • Indigenous status • Smoking status recorded indicator
What data is used to calculate this measure?	The specific fields that are used to derive the fields required for the QIM calculation may vary depending on the clinical system you 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

QIM02a – Proportion of patients whose smoking status has been recorded

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)

The results will be separated into males and females, in each age range, by Aboriginal and Torres Strait Islander status as shown below:

Proportion of regular patients whose smoking status has been recorded													
			Smoking status recorded			Smoking status not recorded			Total			
			Males	Females	Not stated	Males	Females	Not stated	Males	Females	Not stated	Total
Indigenous	Age groups	15-24										
		25-34										
		35-44										
		45-54										
		55-64										
		over										
Not Indigenous	Age groups	15-24										
		25-34										
		35-44										
		45-54										
		55-64										
		over										
Not stated	Age groups	15-24										
		25-35										
		35-44										
		45-54										
		55-64										
		over										

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 your service, and • Are aged over 15 years of age.

QIM02b – Proportion of patients with a smoking status	
Who does it exclude?	• People under 15 years
What is reported to the PHN?	To generate this measure, the following data is reported to the PHN: • Sex • Age group • Regular client indicator • Indigenous status • Smoking status recorded indicator
What data is used to calculate this measure?	The specific fields that are used to derive the fields required for the QIM calculation may vary depending on the clinical system you 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) How many patients had smoking status recorded? (Denominator) How many patients are ex-smokers? (Numerator)	

QIM02b – Proportion of patients with a smoking status

How many patients had smoking status recorded? (Denominator)

How many patients have never smoked? (Numerator)

How many patients had smoking status recorded? (Denominator)

The results will be separated into males and females, in each age range, by Aboriginal and Torres Strait Islander status as shown below:

Proportion of regular patients with a smoking status recorded within the previous 12 months																
			Current smoker			Ex-smoker			Never smoked			Total				
			Males	Females	Not stated	Males	Females	Not stated	Males	Females	Not stated	Males	Females	Not stated	Total
Indigenous	Age groups	15-24													
		25-34													
		35-44													
		45-54													
		55-64													
		65 and over													
Not Indigenous	Age groups	15-24													
		25-34													
		35-44													
		45-54													
		55-64													
		65 and over													
Not stated	Age groups	15-24													
		25-35													
		35-44													
		45-54													
		55-64													
		65 and over													

3.3 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 your 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 is reported to the PHN?	To generate this measure, the following data is reported to the PHN: • Sex • Age group • *Regular client indicator* • Indigenous status • *BMI recorded indicator* Where a field is italicised, it indicates that it has been derived from other data in your CIS before or during the extraction process.
What data is used to calculate 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 you 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

QIM03a – Proportion of patients whose BMI is recorded	
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:

How many patients had their BMI recorded? (Numerator)

How many patients were in each age, sex and indigenous status group? (Denominator)

Results will be separated by age, sex and indigenous status as shown below:

Proportion of regular patients whose BMI has been recorded												
			BMI recorded			BMI not recorded			Total			
			Males	Females	Not stated	Males	Females	Not stated	Males	Females	Not stated	Total
Indigenous	Age groups	15-19										
		20-24										
		25-34										
		35-44										
		45-54										
		55-64										
		over										
Not Indigenous	Age groups	15-19										
		20-24										
		25-34										
		35-44										
		45-54										
		55-64										
		over										
Not stated	Age groups	15-19										
		20-24										
		25-34										
		35-44										
		45-54										
		55-64										
		over										

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.

QIM03b – Proportion of patients with a weight classification	
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 your 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 is reported to the PHN?	To generate this measure, the following data is reported to the PHN: • Sex • Age group • *Regular client indicator* • Indigenous status • *BMI classification* • *BMI recorded indicator* Where a field is italicised, it indicates that it has been derived from other data in your CIS before or during the extraction process.
What data is used to calculate 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 you 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

QIM03b – Proportion of patients with a weight classification

How is it calculated?

The measure is calculated by dividing:

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)

Results will be separated into age, sex and indigenous status groups as shown below.

Proportion of regular patients with a weight classification																				
			Underweight			Healthy			Overweight			Obese			Total					
			Males	Females	Not stated	Males	Females	Not stated	Males	Females	Not stated	Males	Females	Not stated	Males	Females	Not stated	Total
Indigenous	Age groups	15-19																	
		20-24																	
		25-34																	
		35-44																	
		45-54																	
		55-64																	
		65 and over																	
Not Indigenous	Age groups	15-19																	
		20-24																	
		25-34																	
		35-44																	
		45-54																	
		55-64																	
		65 and over																	
Not stated	Age groups	15-19																	
		20-24																	
		25-34																	
		35-44																	
		45-54																	
		55-64																	
		65 and over																	

3.4 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 your service, and • Are aged 65 and over
Who does it exclude?	Patients under 65
What is reported to the PHN?	To generate this measure, the following data is reported to the PHN: • Sex • Age group • *Regular client indicator* • Indigenous status • *Influenza immunisation indicator* Where a field is italicised, it indicates that it has been derived from other data in your CIS during the extraction process.
What data is used to calculate this measure?	The specific fields that are used to derive the fields required for the QIM calculation may vary depending on the clinical system you 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

QIM04 – Proportion of patients aged 65 and over who were immunised against influenza

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)

Results will be broken into age, sex and indigenous status groups as shown below:

Proportion of regular patients aged 65 and over immunised against influenza													
			Immunised against Flu			Not immunised			Total				
			Males	Females	Not stated	Males	Females	Not stated	Males	Females	Not stated	Total
Indigenous	65 and over	Proportion										
Not Indigenous	65 and over	Proportion										
Not stated	65 and over	Proportion										

3.5 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 your 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 is reported to the PHN?	To generate this measure, the following data is reported to the PHN: • Sex • Age group • *Regular client indicator* • Indigenous status • *Influenza immunisation indicator* • *Diabetes status* Where a field is italicised, it indicates that it has been derived from other data in your CIS during the extraction process.
What data is used to calculate 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 you use, but generally will involve: • Latest Visit Date • Second Latest Visit Date • Third Latest Visit Date • Date of Birth • Immunisation Record (Influenza)

<table>
<tr><th colspan="2">QIM05 – Proportion of patients with diabetes who were immunised against influenza</th></tr>
<tr><td></td><td>• Immunisation Record Date
• Diagnosis (Diabetes Type 1)
• Diagnosis (Diabetes Type 2)</td></tr>
<tr><td>How is it calculated?</td><td>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</td></tr>
<tr><td colspan="2">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)
Results will be broken into age, sex and indigenous status groups for both diabetes type 1 and diabetes type 2 as shown below:</td></tr>
</table>

QIM05 – Proportion of patients with diabetes who were immunised against influenza

Calculation 1: Proportion of regular patients with diabetes type 1 immunised against influenza

			Immunised against flu			Not immunised			Total			
			Males	Females	Not stated	Males	Females	Not stated	Males	Females	Not stated	Total
Indigenous	Age groups	0-4										
		5-14										
		15-24										
		25-34										
		35-44										
		45-54										
		55-64										
		over										
Not Indigenous	Age groups	0-4										
		5-14 etc										
		15-24										
		25-34										
		35-44										
		45-54										
		55-64										
		over										
Not stated	Age groups	0-4										
		5-14 etc										
		15-24										
		25-34										
		35-44										
		45-54										
		55-64										
		over										

Calculation 2: Proportion of regular patients with diabetes type 2 immunised against diabetes

			Immunised against flu			Not immunised			Total			
			Males	Females	Not stated	Males	Females	Not stated	Males	Females	Not stated	Total
Indigenous	Age groups	0-4										
		5-14 etc										
Not Indigenous	Age groups	0-4										
		5-14 etc										
Not stated	Age groups	0-4										
		5-14 etc										

3.6 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 your 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 is reported to the PHN?	To generate this measure, the following data is reported to the PHN: • Sex • *Age group* • *Regular client indicator* • Indigenous status • *Influenza immunisation indicator* Where a field is italicised, it indicates that it has been derived from other data in your CIS during the extraction process.
What data is used to calculate 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 you use, but generally will involve: • Latest Visit Date • Second Latest Visit Date

QIM06 – Proportion of patients with COPD who were immunised against influenza	
	• 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: 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)

Results will be broken into age, sex and indigenous status groups as shown below:

Proportion of regular patients with COPD immunised against influenza												
			Immunised against flu			Not immunised			Total			
			Males	Females	Not stated	Males	Females	Not stated	Males	Females	Not stated	Total
Indigenous	Age groups	15-24										
		25-34										
		35-44										
		45-54										
		55-64										
		over										
Not Indigenous	Age groups	15-24										
		25-34										
		35-44										
		45-54										
		55-64										
		over										
Not stated	Age groups	15-24										
		25-34										
		35-44										
		45-54										
		55-64										
		over										

3.7 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 your service, and • Who are aged 15 years or over.
Who does it exclude?	• People aged under 15.
What is reported to the PHN?	To generate this measure, the following data is reported to the PHN: • Sex • Age group • *Regular client indicator* • Indigenous status • *Alcohol consumption status indicator* Where a field is italicised, it indicates that it has been derived from other data in your CIS during the extraction process.
What data is used to calculate 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 you 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: _____

QIM07 – Proportion of patients with an alcohol consumption status	
	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)

Results will be broken into age, sex and indigenous status groups as shown below:

Proportion of regular patients with an alcohol consumption status												
			Alcohol status recorded			No alcohol status			Total			
			Males	Females	Not stated	Males	Females	Not stated	Males	Females	Not stated	Total
Indigenous	Age groups	15-24										
		25-34										
		35-44										
		45-54										
		55-64										
		65 and over										
Not Indigenous	Age groups	15-24										
		25-34										
		35-44										
		45-54										
		55-64										
		65 and over										
Not stated	Age groups	15-24										
		25-34										
		35-44										
		45-54										
		55-64										
		65 and over										

3.8 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 your 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 is reported to the PHN?	To generate this measure, the following data is reported to the PHN: • Sex • Age group • *Regular client indicator* • Indigenous status • *CVD risk factors assessed*

QIM08 – Proportion of patients the necessary risk factors assessed to enable CVD assessment	
	Where a field is italicised, it indicates that it has been derived from other data in your CIS during the extraction process.
What data is used to calculate this measure?	The specific fields that are used to derive the fields required for the QIM calculation may vary depending on the clinical system you use, but this measurement will consider: • Latest Visit Date • Second Latest Visit Date • Third Latest Visit Date • Date of Birth • Sex • Smoking Status • Diagnosis (Diabetes Type 1) • Diagnosis (Diabetes Type 2) • Fasting Glucose Test Measurement • HbA1c Measurement • Total Cholesterol Measurement • HDL Cholesterol Measurement • Systolic Blood Pressure Measurement
How is it calculated?	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
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) Results will be broken into age, sex and indigenous status groups as shown below:	

QIM08 – Proportion of patients the necessary risk factors assessed to enable CVD assessment

Proportion of regular patients with risk factors assessed to enable CVD assessment

			CVD Risk factors assessed			CVD risk factors not assessed			Total			
			Males	Females	Not stated	Males	Females	Not stated	Males	Females	Not stated	Total
Indigenous	Age groups	45-54										
		55-64										
		65-74										
Not Indigenous	Age groups	45-54										
		55-64										
		65-74										
Not stated	Age groups	45-54										
		55-64										
		65-74										

3.9 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 your 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 is reported to the PHN?	To generate this measure, the following data is reported to the PHN: • Sex • Age group • *Regular client indicator* • Indigenous status • *Cervical screening indicator* Where a field is italicised, it indicates that it has been derived from other data in your CIS during the extraction process.
What data is used to calculate 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 you 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

QIM09 – Proportion of female patients with an up-to-date cervical screening	
	• 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?

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)

Results will be broken into age, sex and indigenous status groups as shown below:

Proportion of regular female patients with an up to date cervical screening									
			HPV test in last 5 years		No HPV test in last 5 years		Total		
			Females	Not stated	Females	Not stated	Females	Not stated	Total
Indigenous	Age groups	25-34							
		35-44							
		45-54							
		55-64							
		65 to 74							
Not Indigenous	Age groups	25-34							
		35-44							
		45-54							
		55-64							
		65 to 74							
Not stated	Age groups	25-34							
		35-44							
		45-54							
		55-64							
		65 to 74							

3.10 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 your service, and • Who have either type 1 or type 2 diabetes.
Who does it exclude?	• Patients with secondary diabetes • gestational diabetes mellitus (GDM) • previous GDM • impaired fasting glucose • impaired glucose tolerance
What is reported to the PHN?	To generate this measure, the following data is reported to the PHN: • Sex • Age group • *Regular client indicator* • Indigenous status • Blood pressure measurement result recorded Where a field is italicised, it indicates that it has been derived from other data in your CIS during the extraction process.
What data is used to calculate 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 you 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

QIM10 – Proportion of patients with diabetes with a blood pressure result	
	• 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

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)

Results will be broken into age, sex, indigenous status and diabetes type groups as shown below:

Proportion of regular patients with Type 1 or Type 2 diabetes with a blood pressure result												
			Blood pressure measurement result recorded in last 6 months			No blood pressure measurement recorded in last 6 months			Total			
			Males	Females	Not stated	Males	Females	Not stated	Males	Females	Not stated	Total
Indigenous	Age groups	0-4										
		5-14										
		15-24										
		25-34										
		35-44										
		45-54										
		55-64										
		65 and over										
Not Indigenous	Age groups	0-4										
		5-14										
		15-24										
		25-34										
		35-44										
		45-54										
		55-64										
		65 and over										
Not stated	Age groups	0-4										
		5-14										
		15-24										
		25-34										
		35-44										
		45-54										
		55-64										
		65 and over										

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