PIP QI report - 10 measures

Demo Practice

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Which patients are included in this report? | What data is in this report? | How do we use this report? | What are ACG patient complexity levels?

Which patients are included in this report?

• Active Patients (based on RACGP criteria of 3 visits in past 2 years)
• Patients who contribute towards the 10 PIP QI measures

What data is in this report?

• Age of patients - to protect patient confidentiality, the age of all patients older than 90 years are displayed as 90
• Gender
• Medication lists
• Coded diagnoses
• Pathology requests/results
• Observations
• The data are up-to-date with the time stamp on this report.

How do we use this report?

• Quality Improvement Quality improvement is foundational to contemporary high performing primary care. It includes team based approaches, peer review, reflective practice, best practice, and data analysis. It can improve uptake of evidence-based practices for better patient outcomes, better professional development, and better system performance.
• The Practice Incentives Program (PIP) Quality Improvement (QI) Incentive is a payment to general practices for activities that support continuous quality improvement in patient outcomes and the delivery of best practice care. General practices enrolled in the PIP QI Incentive commit to implementing continuous quality improvement activities that support them in their role of managing their patients' health. They also commit to submitting nationally consistent, de-identified general practice data, against ten key Improvement Measures that contribute to local, regional and national health outcomes. The Improvement Measures allow general practices to understand which patients may benefit from preventative treatments, or may need recall to ensure effective management of a specified chronic disease (e.g. diabetes). This can help delay progression of the condition, improve quality of life, increase life expectancy, and decrease the need for high cost interventions.
• Quality Improvement Measures are the collection of the de-identified Improvement Measures that form the PIP Eligible Data Set are part of a system of quality improvement that includes reflective practice, a common data baseline, and data analysis. The Improvement Measures are not designed to assess individual general practice or general practitioner performance. They do support a regional and national understanding of chronic disease management in areas of high need, and future iterations will respond to emerging evidence on areas of high need.
• The results can be filtered by clicking on each column. Clicking on columns will rearrange the results alphabetically, chronologically or from high to low or low to high
• The 'Search' function can help you find specific content
• The report can be exported as an Excel or CVS file by clicking the 'Export To Excel' or 'Export to CSV' tabs
• All reports that are generated are automatically saved to a folder on your practice computer.
• The report can be printed by clicking the right mouse button while hovering the cursor over the report and selecting the 'print' option.

What are ACG patient complexity levels?

- There are five complexity levels, ranging from 1 to 5. For data analysis purposes, there is a sixth level, level 0. Level 0 is for those patients with no recorded diagnoses or significantly incomplete or missing data
- Level 0 indicates a very low level of complexity with no known risks for poor health outcomes, while level 5 is the highest complexity. Patients with level 5 complexity typically have significant multi-morbidity and polypharmacy and are at greatest risk of poor health outcomes.
    - Level 5: High complexity, characterized by instability, multimorbidity, polypharmacy or patients requiring end-of-life care
    - Level 4: High to moderate complexity, characterized by multimorbidity
    - Level 3: Moderate complexity. Patients typically have at least 1 chronic condition and are at risk of progressive deterioration.
    - Level 2: Low to moderate complexity. Patients typically have one risk factor
    - Level 1: Low complexity. Patients are generally healthy and only present because of acute, time-limited conditions or minor issues.
- Patients with higher levels of complexity are more likely to be hospitalized than those with lower levels. However, complexity is not directly related to the risk of being hospitalized. Many Primary Sense reports therefore includes both estimates.
- If the complexity of a patient is calculated from results that are more than 12 months old, the level will be displayed in brackets, e.g. (3), rather than 3.
- If there is insufficient information to calculate a complexity level, the result will be displayed as 'N/A'
- The complexity levels of patients in this report were calculated with the Johns Hopkins ACG tool. The ACG is underpinned by a robust evidence base of >30 years of practical application. The tool is used in 20 countries and has been validated in different healthcare settings, including general practice.

PIP QI results

Information about this table

- Proportion of patients with diabetes with a HbA1c result in the past 12 months
- Proportion of patients over 15 yrs with a smoking status
- Proportion of patients over 15 yrs with a BMI in the previous 12 months
- Proportion of patients aged 65 and over with influenza vaccine in the previous 15 months
- Proportion of patients with diabetes with influenza vaccine in the previous 15 months
- Proportion of patients with COPD with influenza vaccine in the previous 15 months
- Proportion of patients over 15yrs with an alcohol consumption status
- Proportion of patients with the necessary risk factors assessed to enable CVD assessment (smoking, blood pressure, lipids - uncoded diabetes not included),
- Proportion of patients with cervical screening in the previous 5 years
- Proportion of patients with diabetes with a blood pressure result in the previous 6 months

Show 25 patients per page

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Measure	Description	Numerator	Denominator	Percentage
	Regular Patient Count	100		
QIM 01	All Patients with Diabetes recorded and a current HbA1c result	37	58	63.79%
QIM 01	Patients with Diabetes Type 1 with a current HbA1c result	8	15	53.33%
QIM 01	Patients with Diabetes Type 2 with a current HbA1c result	24	35	68.57%
QIM 01	Patients with Diabetes Type Undefined with a current HbA1c result	1	8	12.50%
QIM 02	All Patients over 15 with a current smoking status recorded	70	90	77.78%
QIM 02	Patients with a current smoker status result	15	90	16.67%
QIM 02	Patients with an EX smoker status result	16	90	17.78%
QIM 02	Patients with a non-smoker status result	39	90	43.33%
QIM 03	All Patients with a BMI recorded outside (high or low) of the recommended guidelines	70	89	78.65%
QIM 03	Patients with an overweight BMI result	31	89	34.83%
QIM 03	Patients with an obese BMI result	15	89	16.85%
QIM 03	Patients with an underweight BMI result	5	89	5.62%
QIM 03	Patients with a healthy BMI result	19	89	21.35%
QIM 04	Patients 65 years and older who have been immunised against influenza	14	20	70.00%
QIM 05	Patients with diabetes who have been immunised against influenza	8	15	53.33%
QIM 06	Patients with COPD who have been immunised against influenza	9	12	75.00%
QIM 07	Patients with an alcohol consumption result	40	90	44.44%
QIM 08	All Patients aged 35 to 74 years old with CVD Assessment risk factors recorded	28	62	45.16%
QIM 08	Patients aged 45 to 74 years old with CVD Assessment risk factors recorded	27	60	45.00%
QIM 08	Patients aged 35 to 44 years old with CVD Assessment risk factors recorded	8	11	72.73%
QIM 09	Female patients with an up-to-date cervical screening (last 5 years)	33	58	56.90%
QIM 10	Patients with diabetes with a blood pressure result	49	58	84.48%

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