phn BRISBANE SOUTH
An Australian Government Initiative

Quality Improvement Toolkit for General Practice

General QI

PIP QI Ten Measures

Version 4 - 2025

Contents

Introduction

Purpose

This Practice Incentives Program Quality Improvement (PIP QI) toolkit is designed to support your practice to complete activities that will assist with making measurable and sustainable improvements to better care for your patients. Our Introduction toolkit provides more detailed information on the quality improvement process.

The Model for Improvement

This toolkit will help your practice complete PIP QI activities using the Model for Improvement (MFI) framework. The MFI uses the Plan-Do-Study-Act (PDSA) cycle and it is an evidence-based approach to achieving successful change.

It offers the following benefits:

- A simple approach that anyone can apply.
- Allows for highly effective planning, developing, and implementing change.
- Reduces risk, cost, and time by testing small changes.
- Makes it easier to measure change results.

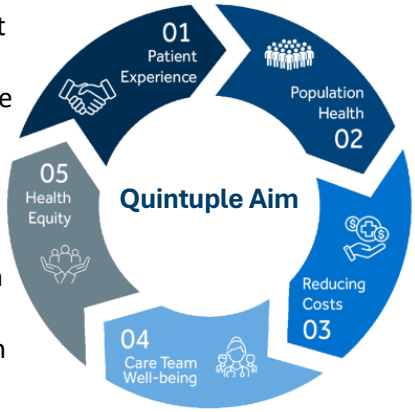
QI team approach

QI is a team process as diverse perspectives, knowledge, and skills from different staff members can provide effective ideas for change.

A team effort will allow for gaps and inefficiencies in the practice to be easily identified. It also helps to maintain motivation and promote lasting changes and encourages continuous quality improvement (CQI) efforts.

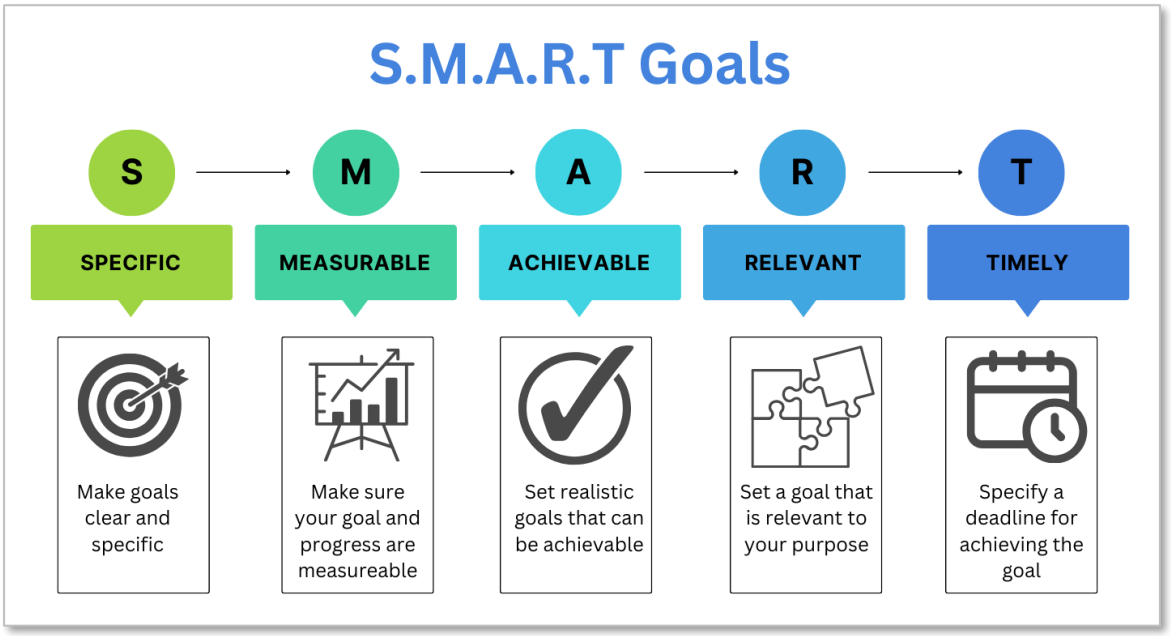
Quintuple aim

The goal of the quintuple aim is to enhance patient experience, improve population health, reduce costs, improve work life balance of health care providers including clinicians and staff, and to achieve greater health equity for all. Awareness of the quintuple aim with CQI will create a more equitable and sustainable healthcare system.



Goal

The toolkit activities will guide you to explore your data to understand your patient population and the care pathways that are being provided in your practice. This will assist with the development of S.M.A.R.T goals to improve your practice's data management processes to ensure your policies and procedures at up to date.



Practice Incentive Program Quality Improvement (PIP QI)

The PIP QI aims to recognise and support accredited practices to improve patient care by providing an incentive that encourages participation in CQI activities. To take part in the program, please ensure your practice is registered.

Apply for the Practice Incentives Program (PIP)

General practices wanting to participate in the program can apply via Services Australia. For more information please refer to the PIP QI Incentive Guidelines from the Department of Health, Disability and Ageing. If you have any questions, please contact the enquiry line:

Contact details for any PIP QI related questions:

 PIP QI Enquiry Line - 1800 222 032

 pip@humanservices.gov.au

Once your application has been approved, please inform Brisbane South PHN of your PIP QI Identifier Number and any other additional information for your practice to be identified as participating in the PIP.

PIP QI 10 measures

The PIP QI 10 measures can assist practices to identify priority areas to work on to review their current patient data, set specific targets, and measure performance. Practices can choose to undertake any of the Quality Improvement Measures (QIMs), which are:

1 Proportion of patients with diabetes with a current HbA1c result in the last 12 months

2 Proportion of patients with a smoking status recorded in the last 12 months

3 Proportion of patients with a BMI recorded in the last 12 months

4 Proportion of patients aged 65 and over who were immunised against influenza in the past 15 months

5 Proportion of patients with diabetes who were immunised against influenza in past 15 months

6 Proportion of patients with COPD who were immunised against influenza in the past 15 months

7 Proportion of patients with an alcohol consumption status recorded in the last 24 months

8 Proportion of patients with the necessary risk factors assessed to enable CVD assessment in the last 2 years

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

10 Proportion of patients with diabetes with a blood pressure result recorded in the last 6 months

PIP payment

The Practice Incentives Program (PIP) Quality Improvement (QI) Incentive is a payment to general practices who participate in continuous quality improvement activities to improve patient outcomes and deliver best practice care.[1]

Qualifying for the PIP QI incentive payment

General practices enrolled in the PIP QI Incentive commit to implementing CQI 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 Quality Improvement Measures that contribute to local, regional, and national health outcomes.

1. Data set

The PIP Eligible Data Set is de-identified patient data that general practices provide their local PHN to qualify for the PIP QI Incentive, which is part of a system of quality improvement activities that includes reflective practice, a common data baseline, and data analysis. The data set must be managed in accordance with the PIP Eligible Data Set Data Governance Framework.[2] After PIP QI Incentive registration, the anonymised data set is submitted to Brisbane South PHN automatically. Brisbane South PHN will provide feedback to help general practices identify priority areas and continuous QI activities.

2. Continuous Quality Improvement

The Royal Australian College of General Practitioners (RACGP) defines continuous quality improvement (CQI) as an ongoing activity undertaken within a general practice with the primary purpose to monitor, evaluate, and improve patient safety. To meet the PIP QI requirements, your practice must be able to demonstrate that CQI has been undertaken as a team. The RACGP recommends practices to engage in CQI to review systems and processes to effectively deliver high quality health care services.[3]

Please refer to the PIP QI Incentive fact sheet from the Department of Health for more information, or contact the Services Australia enquiry line for further information.

Contact details for any PIP QI related questions:

PIP QI Enquiry Line - 1800 222 032

pip@humanservices.gov.au

[1] Department of Health | PIP QI Factsheet
[2] Department of Health, Disability and Ageing | PIP QI Measures
[3] RACGP Standards for General Practice (5th edition)

Aim of this toolkit

The aim of this toolkit is to support you to perform CQI for your practice to reduce the incidence of the most prevalent chronic conditions in Australia. The activities in this toolkit will require the use of three systems: Primary Sense, Brisbane South HealthPathways, and Practice Reports. These systems will help you identify gaps in patient data for each of the ten PIP QI measures and will assist to improve data management workflow for high-quality care to be delivered. Please familiarise yourself with these systems before beginning the activities.

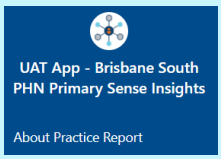
Primary Sense

Primary Sense is a clinical decision support tool that enables general practices to extract and analyse their patient data. Please visit Primary Sense webpage and the Brisbane South PHN website to find video training and learning resources on how to use Primary Sense.

There are 3 PIP QI reports in Primary Sense that can help with finding patient data.

- Patients missing PIP QI or accreditation measures.
- Patients booked in with missing PIP QI measures.
- PIP QI 10 measures - proportion of patients report.

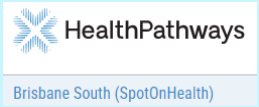
Brisbane South PHN Practice Reports



The Practice Reports allows practices to track their PIP QI progress. Please refer to the How to Guide: Using Practice Reports. If you have any questions on how to access the reports, please get in contact with the Digital Health team at Brisbane South PHN.

support@bsphn.org.au

Brisbane South HealthPathways



Brisbane South HealthPathways is an online portal that provides clinicians up to date and localised evidence-based information on the assessment and management of clinical conditions. It also provides guidance on the most appropriate referral pathways.[4]

The Plan, Do, Study, Act (PDSA) cycle will help your practice collect data and set goals to improve processes. The PDSA cycle is a problem-solving model used to test improvement change and it will guide you to undertake CQI activities with the PIP QI ten measures.[4] Performing CQI encourages a culture of learning, innovation, and proactive identification of issues. This leads to better patient health outcomes, system processes, and overall practice development.[5] There are four stages involved in the PDSA cycle and here is an example of how it can be used to benefit your practice and improve your PIP QI activities.

1. **Plan** to understand the requirements of the PIP QI guidelines.
    - Develop a plan to test the change.
    - Identify what data you need to collect either by choosing a specific measure to focus on. Alternatively, the selection of a measure can be informed by clinical system data to help identify the gaps in patient care.

2. **Do** identify patients at your practice who meet the criteria for the **Q**uality **I**mprovement **M**easures (QIM).
    - Run a test on a small scale.
    - Document problems and unexpected observations.
    - Begin to collect data.

3. **Study** by analysing the patient data and identify opportunities for your practice to improve PIP QI measures.
    - Evaluate the results.
    - Review and reflect on the results.

4. **Act** by setting goals to review systems and refine continuous quality improvement activities to implement change.
    - Adapt (make modifications and run another test); adopt (test the change on a larger scale); or abandon (discard this change idea altogether)
    - Plan for the next PDSA.

This toolkit can be used by practices and individual professionals as evidence for:

- Practice Incentive Payment Quality Improvement (PIP QI).
- RACGP accreditation standards.
- Continuous professional development hours.

[4] RACGP - Improving clinical care
[5] A scoping review of continuous quality improvement in healthcare system

ACTIVITY 1 – Understanding your PIP QI ten measures

This activity will help you gather your PIP QI quarterly results using Brisbane South PHN Practice Reports. It will also assist your practice to set clear objectives for future improvements by guiding you to address the following questions:

Goal

What change are we trying to achieve?

Measure

How will we know that an improvement has been made?

Idea

What changes can we make that will lead to an improvement?

Select one PIP Quality Improvement Measure (QIM) topic to focus on, complete more if you wish, then move on to Activity 2 – Improving your results.

1 Proportion of patients with diabetes with a current HbA1c result in the last 12 months

Brisbane South PHN region: percentage of patients with up-to-date HbA1c recorded (as of Apr 2025)

- Type 1 Diabetes: 48.8%
- Type 2 Diabetes: 65.5%
- Undefined Diabetes: 60.7%

Let's increase the HbA1c recording of diabetes patients to improve health outcomes!

Diabetes

Diabetes was in the top 10 leading causes of mortality recording 6,050 deaths in Australia in 2021-2022 (11.2% of all deaths).[6]

Type 1 Diabetes
From 2020 to 2021, around 58,600 people were newly diagnosed with type 1 diabetes. It is estimated that 2 in 3 individuals diagnosed are under 30 years age.[7] As part of their care, people with Type 1 diabetes should have their glycosylated haemoglobin (HbA1c) measured at least every 12 months.[8]

Type 2 Diabetes
The number of people living with Type 2 diabetes increased almost 3-fold in the past twenty years between 2000 to 2021 from 400,000 people to almost 1.2 million (4.6%) people. In just 2021 alone, around 45,700 people were newly diagnosed with type 2 diabetes. This is equivalent to 125 people per day.[9]

People with Type 2 diabetes should have their HbA1c measured at least every 12 months. HbA1c is now acceptable as a diagnostic test for diabetes. The threshold for diagnosis is a HbA1c level of 6.5% or above (=>48 mmol/mol).[10] Effective management of diabetes can reduce associated complications, such as stroke, blindness, or kidney disease, and improve quality of life, increase life expectancy, and decrease the need for high-cost interventions.[11,12]

Undefined HbA1c diabetes result
Patients with a recorded HbA1c result, but do not have a diabetes type 1 or type 2 recorded in their clinical profile require further assessment. Patients with a HbA1c between 6.0 - 6.4% (42-46mmol/L) have a high likelihood of diabetes and require annual follow up and risk factor advice.[13]

Certain population groups have a higher prevalence of Type 2 diabetes and have a greater need for diabetes care. For example, patients who identify as Aboriginal and Torres Strait Islanders, people who live in remote and very remote areas, and people experiencing socioeconomic disadvantage, should be prioritised.[14] It is critical for practices to improve data recording and management to significantly enhance patient health outcomes.

Finding out your performance
To find out the proportion of diabetes patients with a current HbA1c result in the last 12 months, measure your baseline change percentage by comparing the current quarter and previous quarter results using Practice Reports. Please refer to the How to Guide: Using Practice Reports for instructions. Document your results in the following table and check how your practice is tracking every quarter.

If your practice requires access to the reporting software, please contact Digital Health team at:

support@bsphn.org.au

[6] Diabetes: Australian facts, Diabetes deaths - Australian Institute of Health and Welfare (aihw.gov.au)
[7] Diabetes: Australian facts, Type 1 diabetes - Australian Institute of Health and Welfare (aihw.gov.au)
[8] Practice Incentives Program Quality Improvement Measures - Technical Specifications (health.gov.au)
[9] Diabetes: Australian facts, Type 2 diabetes - Australian Institute of Health and Welfare (aihw.gov.au)
[10] HbA1c for Diagnosis of Diabetes Mellitus (May 2023) - Australian Diabetes Society
[11] Practice Incentives Program Quality Improvement Measures - Technical Specifications (health.gov.au)
[12] AIHW - Diabetes: Australian facts, Diabetes-related complications
[13] HbA1c for Diagnosis of Diabetes Mellitus (May 2023) - Australian Diabetes Society
[14] AIHW - Determinants of health for First Nations people

HbA1c result recorded			
	Current Quarter	Previous Quarter	% Change
Type 1			
Type 2			
Undefined			

Criteria

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.

Goal

To improve the recording of HbA1c results for patients with either Type 1 or Type 2 diabetes and categorise patients with an undefined diabetes diagnosis.

Measure

To identify the number of patients with diabetes and HbA1c recorded in the past 12 months.

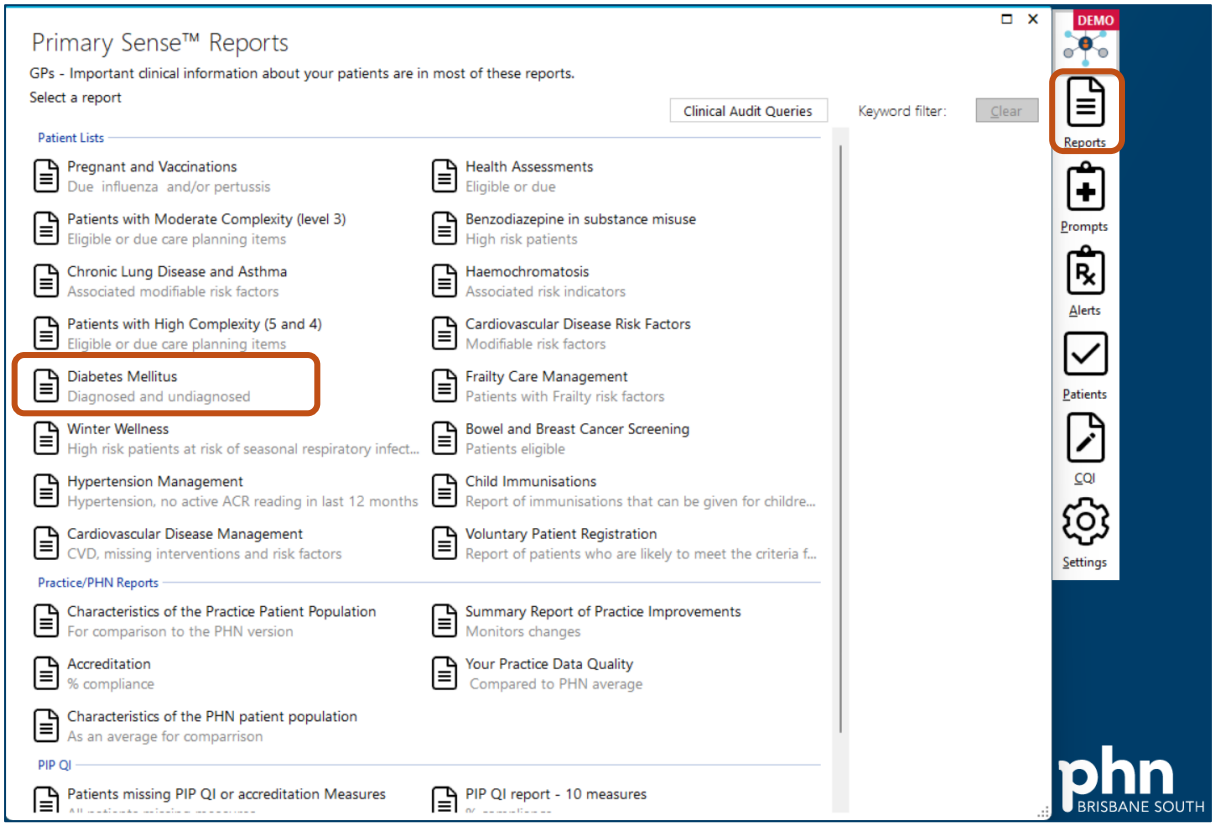
Recommendations

1. Review the following Brisbane South HealthPathways clinical pages:
   - Diabetes
   - Diabetes Advice
   - Screening and Diagnosis of Diabetes in Adults
   - Management of Type 1 Diabetes
   - Management of Type 2 Diabetes
   - Diabetes Complications
   - Diagnosing Diabetes in Children and Adolescents
2. Read RACGP's Guidelines for preventive activities in general practice 10th edition to assist with patient care management: Diabetes - page 242.
3. Also, the RACGP has created a handbook in line with the Australian National Diabetes Strategy 2021-2030 to address diabetes in Australia. The Management of Type 2 diabetes: A handbook for general practice has information on prevention methods, assessment guidelines, and managing emergencies.
4. Review RACGP's Improving health record quality in general practice to produce and maintain high-quality patient records.
5. Check out Brisbane South PHN's approved CPD activity for patients who may need a clinical review for a diagnosis of diabetes.

Finding your patient population

Primary Sense

A Primary Sense Diabetes Mellitus report will show a list of your patients that have either Type 1 or Type 2 diabetes and those that need to be reviewed for a diabetes diagnosis.



Type 1 or Type 2 Diabetes

Two reports can be used to find patients without a HbA1c result recorded:

- *Reports > Diabetes Mellitus > Patients with diabetes who may be eligible for chronic care occasions of service > Filter: HbA1c Test Date (click on the arrows next to the heading).*

  Check your list of patients that have had a HbA1c test in the past 12 months and review their clinical profile to ensure that type 1 or type 2 diabetes is showing on their record.

- *Reports > Patients missing PIP QI or accreditation measures > Filter: Diabetics with missing factors (click on the arrows next to the heading).* Patient data showing *HbA1c* indicates that a HbA1c result has not been recorded.

Undefined HbA1c Diabetes

- *Reports > Diabetes Mellitus > Patients who may need a clinical review for a diagnosis of diabetes > Filter: HbA1c Test Date (click on the arrows next to the heading).*

This report will help with finding which patients had a significant result recorded in the past 12 months. Flag these patients for recall and a consultation to determine if their condition is either type 1 or type 2 diabetes.

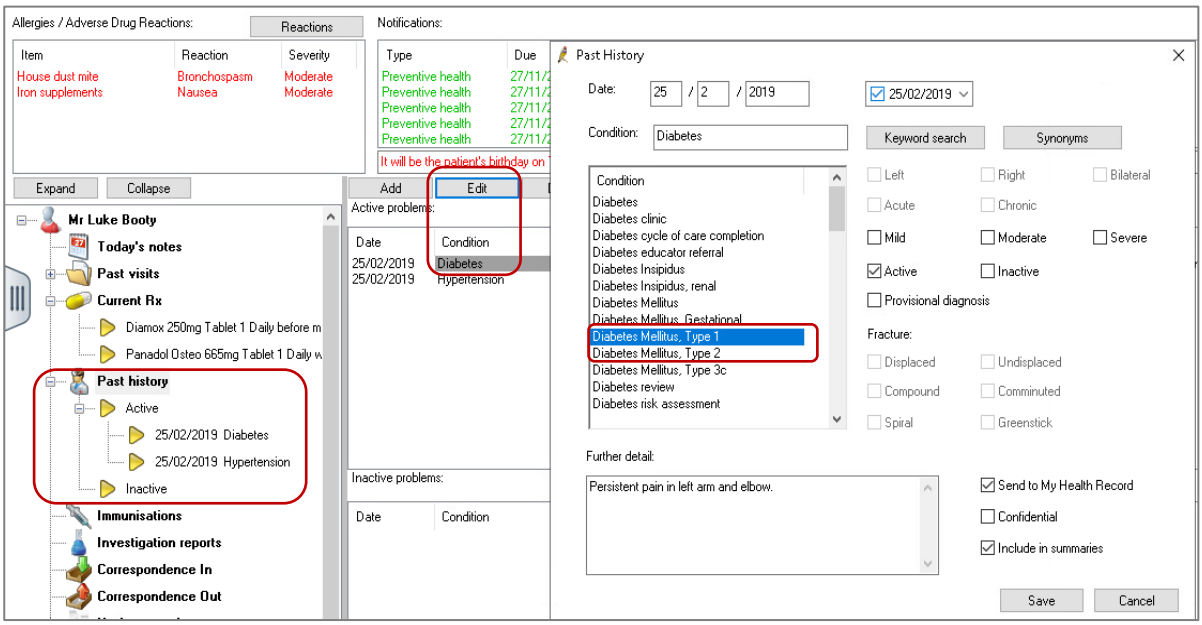
Clinical software instructions

Best Practice

- To check if HbA1c results are included in a patient's clinical profile, view the instructions on how to access the Diabetes register.
- Diabetes cycle of care tool can assist providers with developing a scheduled plan to manage their patients with diabetes.
- Diabetes searches - search for patients with diabetes or at risk of developing diabetes.
- The Diabetes risk assessment tool can be used to determine if a patient is at risk of developing type 2 diabetes.

Please note: Diabetes diagnosis must be recorded in *Past history* of patient profile under *Active*. Otherwise, choose *Edit* select from the list of diabetes conditions (see screenshot). In the *Condition* section choose *Diabetes Mellitus, Type 1* or *Diabetes Mellitus, Type 2*, for the patient profile to show the specific type of condition listed.

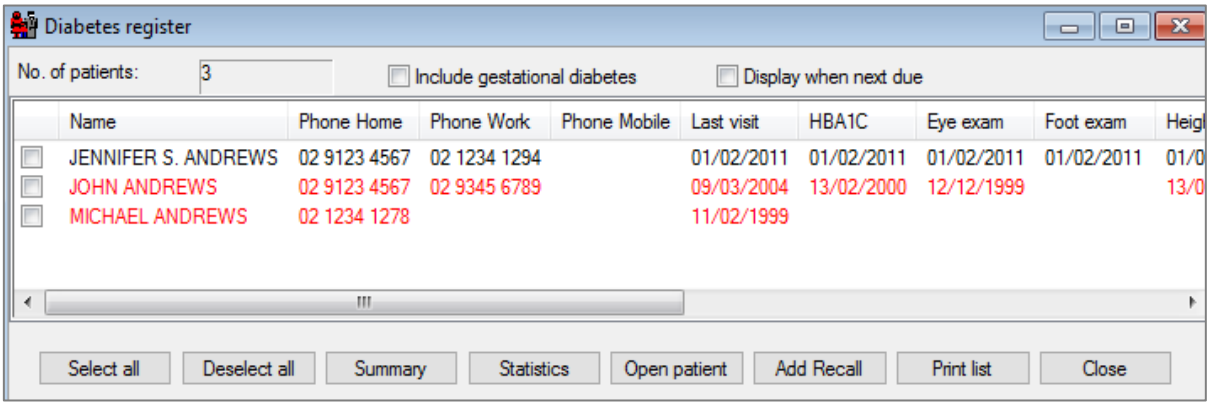
Steps: *Patient Profile > Past History > click on Diabetes > Edit > Select from the list of conditions either Diabetes Mellitus, Type 1* or *Diabetes Mellitus, Type 2*



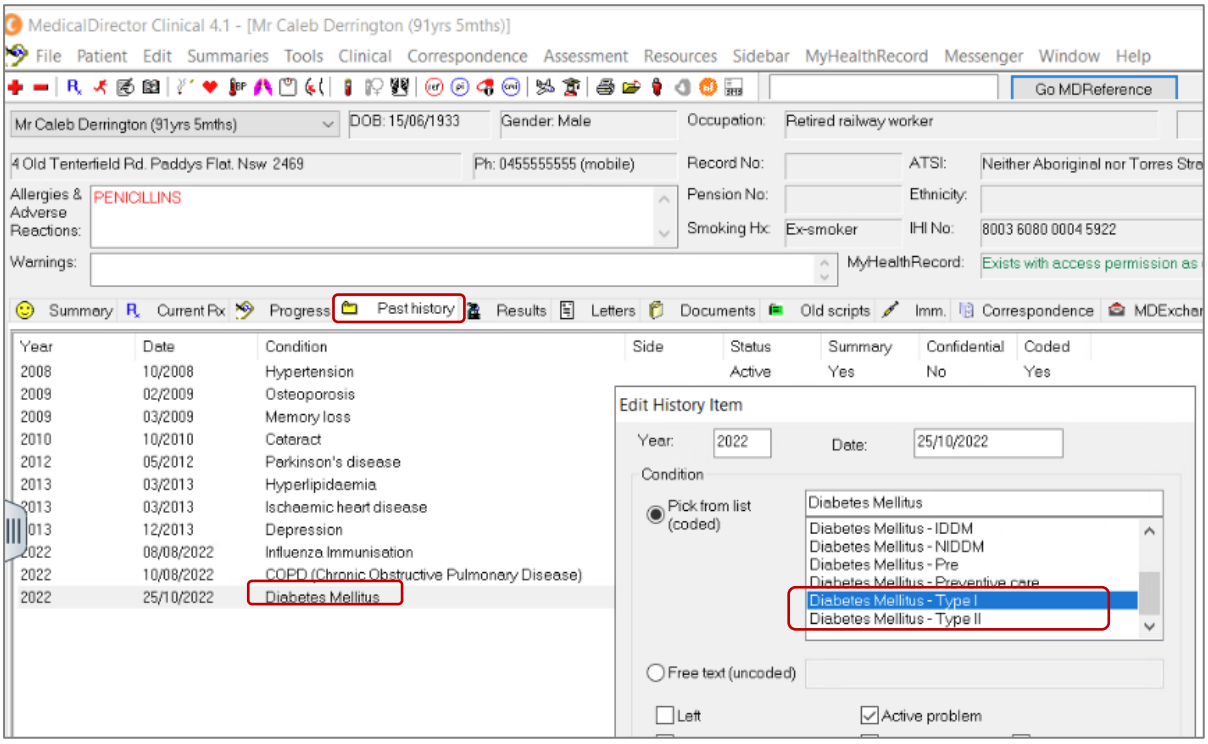
MedicalDirector

- Refer to the Diabetes Module to check if patients have a diabetes diagnosis recorded in past history.
- Use the Diabetes Register Searches to ensure that HbA1c results are properly recorded.

NOTE: *An up-to-date diabetes register is a requirement of the PIP diabetes incentive. An accurate register from practices enables Brisbane South PHN to report the PIP QI data from practices to the Department of Health.*



Steps: *Patient Profile > Past History tab > right click on Diabetes Mellitus > Edit > Select from the list of conditions either Diabetes Mellitus – Type I or Diabetes Mellitus – Type II*



If you need support completing this activity, please contact the GPQI team:

07 3864 7540 support@bsphn.org.au

REVIEW

Complete the questions below to review how the practice can effectively reduce HbA1c levels and improve the recording of results for patients with diabetes.

After reviewing the difference in percentages between your previous quarter and your current quarter results, are they what you expected?

What lifestyle interventions do you think the practice can introduce to patients with type 2 diabetes to improve their overall health and well-being? For example, referring patients to a Credentialled Diabetes Educator (CDE), or the Self-Management of Chronic Conditions service, or programs such as MyDesmond Program. Refer to the Model for Improvement (MFI) & Plan, Do, Study, Act (PDSA) template to help with outlining any changes to your patient care plans.

How can you ensure the practice improves the recording HbA1c results? For example, identify patients using the Primary Sense – Diabetes Mellitus report or adding prompts/reminders in the clinical software to obtain HbA1c results. Refer to the MFI and PDSA template to help with outlining any changes to your practice's procedures.

Now that you have reviewed the HbA1c recording status of your patients with diabetes, why not complete the next topic and check the smoking status of your patients, or move on to Activity 2 to improve your results.

2 Proportion of patients with a smoking status recorded in the last 12 months

Brisbane South PHN region: percentage of patients with a smoking status recorded (as of Apr 2025)

- Smoking status recorded: 71.5%
- Current smoking status recorded: 12.9%
- Ex-smoker status recorded: 19.6%
- Never smoked status recorded: 67.5%

Smoking

In Australia, smoking continues to be the behavioural risk factor most responsible for the highest levels of preventable disease and premature death. The Department of Health, Disability and Ageing have found that if general practices record tobacco use, clinicians are more likely to intervene with current smokers and this leads to higher rates of smoking cessation.[15] The criteria used to obtain the percentage for smoking status recorded is calculated by dividing:

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)

Recording the smoking status of your patients is critical for improving patient health and preventing chronic diseases that result from smoking, such as lung cancer, heart disease and stroke.[16]

To find out the proportion of patients with a recorded smoker or non-smoker status, measure your baseline change percentage by comparing your current quarter and previous quarter results using Practice Reports. Please refer to the How to Guide: Using Practice Reports for instructions. Document your results in the following table and check how your practice is tracking every quarter.

If your practice requires access to the reporting software, please contact Digital Health team at:

support@bsphn.org.au

[15] Practice Incentives Program Quality Improvement Measures - Technical Specifications (health.gov.au)
[16] Department of Health - Effects of smoking and tobacco

Smoking status recorded			
	Current Quarter	Previous Quarter	% Change
Smoking status recorded			
Current smoker recorded			
Ex-smoker recorded			
Never-smoker recorded			

Criteria

Regular patients aged 15 years and over whose smoking status has been recorded.

Goal

To improve the smoking status recording for patients aged 15 years and over who are current smokers, ex-smokers, or those that have never smoked.

Measure

Increase the number of patients to have their smoking status included into their records, as either current smoker, ex-smoker or never smoked within the last 12 months.

Recommendations

1. The following pages in HealthPathways can assist:
   - Smoking cessation
   - Medications for smoking cessation
   - Lung cancer—suspected
2. The National Lung Cancer Screening program is a new initiative for eligible smokers to participate. For more information, please visit National Lung Cancer Screening Program.
3. Read RACGP's Guidelines for preventive activities in general practice 10th edition to assist with patient care management: Smoking and nicotine vaping - page 230.
4. Review RACGP's Improving health record quality in general practice to produce and maintain high-quality patient records.
5. Also, read through the RACGP's Smoking, Nutrition, Alcohol and Physical activity (SNAP) guide for tips on assessing smoking status and introducing lifestyle interventions to current smokers.
6. Brisbane South PHN has a self-paced activity available to assist with identifying and updating the smoking status recording of 30 active patients who are 15 years old and over.
7. A target poster is also available to help your practice track improvement measures for recording smoking status. If you would like a copy, please contact the GPQI team on 07 3864 7540 or at support@bsphn.org.au.

Finding your patient population

Primary Sense

Primary Sense can help you identify your patients that do not have a smoking status recorded.

- *Reports > Patients missing PIP QI or accreditation measures > Filter: Smoking status (click on the arrows next to the heading).* Patient data showing N indicates the smoking status has not been recorded.

Clinical software instructions

Best Practice

Please see information on how to record smoking status in the Social and family history section of a patient's profile.

MedicalDirector

The Smoking tab should be used to record smoking status**.**

If you need support completing this activity, please contact the GPQI team:

07 3864 7540 support@bsphn.org.au

REVIEW

Complete the questions below to review how the practice can improve the recording of patients' smoking status and facilitate smoking cessation efforts among current smokers.

After reviewing the difference in percentages between your previous quarter and your current quarter results, are they what you expected?

What interventions do you think the practice can introduce to current smokers to improve their health and well-being? For example, nicotine replacement therapy or behavioural intervention – referral to Quitline. Refer to the MFI and PDSA template to help with outlining any changes to your patient care plans.

How can you ensure the practice improves the recording of smoking status of patients? For example, identify patients using Primary Sense report – Patients Missing PIP QI or Accreditation Measures report, or focus on obtaining the smoking status of patients coming in for an appointment in the next 2 weeks. Refer to the MFI and PDSA template to help with outlining any changes to your data management procedures.

Now that you have reviewed your smoking status recording, why not attempt the next topic and assess the BMI status recording of your patients, or move on to Activity 2 to improve your results.

3 Proportion of patients with a BMI recorded in the last 12 months

Brisbane South PHN region: percentage of patients with up-to-date BMI recorded (as of Apr 2025)

- BMI recorded: 28.3%
- BMI underweight: 2.4%
- BMI healthy: 27.8%
- BMI overweight: 31.6%
- BMI obese: 38.0%

Body Mass Index

Body mass index (BMI) is the measure of body weight relative to height used to assess the extent of weight deficit or excess. BMI is the weight in kilograms divided by the square of the height in metres.[17]

Being underweight, overweight, and obese, can lead to higher rates of morbidity. Excess weight is a major risk factor for many chronic diseases, such as type 2 diabetes, cardiovascular disease, and osteoarthritis. In 2022, 66% (2 in 3) of Australian adults and 26% (1 in 4) of children aged 2 to 17 years old were classified as overweight or obese. Australia's obesity rate ranks sixth highest among Organisation for Economic Co-Operation and Development (OECD) countries, which shows that a high BMI is a significant public health concern.[18] Alternatively, being underweight means malnourishment and can lead to a compromised immune function, respiratory diseases, and digestive diseases.[19]

To find out the proportion of patients with a BMI recorded in the last 12 months, measure your baseline change percentage by comparing the current quarter and previous quarter results using Practice Reports. Please refer to the How to Guide: Using Practice Reports for instructions. Document your results in the table below and check how your practice is tracking every quarter.

If your practice requires access to the reporting software, please contact Digital Health team at:

support@bsphn.org.au

[17] Body mass index (BMI) and waist measurement | Department of Health, Disability and Ageing
[18] Overweight and obesity, About - Australian Institute of Health and Welfare
[19] WHO - Malnutrition

BMI classification: Recorded			
	Current Quarter	Previous Quarter	% Change
Recorded			
Underweight			
Healthy			
Overweight			
Obese			

Criteria

Regular patients aged 15 years and over and who have had their body mass index (BMI) recorded within the previous 12 months.

Goal

Ensure the height, weight, & BMI of patients are recorded in their patient record.

Measure

Identify the number of patients aged 15 years and over who have had their Body Mass Index (BMI) measured and recorded within the previous 12 months and improve on this proportion. For patients who have been classified as underweight, overweight, or obese in the last 12 months, introduce health promotion strategies.

Note: For 15-24 year olds, BMI should be used to assess weight classification if both height and weight were recorded in the past 12 months. For patients aged 25 years and over, height does not need to be measured again if already included and use the height recorded since turning 25. Weight needs to be measured and recorded every 12 months. This QI measure excludes patients aged 18+ who are shorter than 0.914 metres or taller than 2.108 metres or patients that have refused measurement.

Recommendations

1. Key pages in HealthPathways include:
   - Overweight and obesity in children and adolescents
   - Weight management in overweight and obese adults
   - Older adults' weight and nutrition
2. Read RACGP's Guidelines for preventive activities in general practice 10th edition to assist with interventions: Overweight and obesity – page 254.
3. Review RACGP's Improving health record quality in general practice to produce and maintain high-quality patient records.
4. The RACGP's Smoking, Nutrition, Alcohol and Physical activity (SNAP) guide can assist with recommending healthy lifestyle changes to patients.

Finding your patient population

Primary Sense

A Primary Sense report will show if a patient does not have their BMI recorded in the system.

Reports > Patients Missing PIP QI or Accreditation Measures > Filter: BMI (click on the arrows next to the heading). An N indicates there are no details recorded for that patient.

Clinical software instructions

Best Practice

Please see Available clinical functions page to find out how to enter BMI details into the patient's profile.

MedicalDirector

Please see instructions on where to enter BMI details.

If you need support completing this activity, please contact the GPQI team:

07 3864 7540 support@bsphn.org.au

REVIEW

Complete the questions below to assess how the practice can improve BMI recording and how to effectively support patients in achieving healthy lifestyle changes.

After reviewing the difference in percentages between your previous quarter and your current quarter results, are they what you expected?

What lifestyle interventions do you think the practice can promote to patients who are underweight, overweight, or obese, for their overall health and well-being to improve? For example, referring patients to Health and Wellbeing Queensland's 10,000 Steps Program. Refer to the MFI and PDSA template to help with outlining any changes to your patient care plans.

How can you ensure the practice improves the recording of BMI status of patients? For example, identify patients using Primary Sense – Patients Missing PIP QI or Accreditation Measures report, or have the nurse measure height and weight in the waiting room before the doctor sees the patient. Refer to the MFI and PDSA template to help with outlining any changes to your data management procedures.

Now that you have reviewed the BMI recording status of your patients, why not attempt the next section and find patients aged 65+ who are eligible for an influenza vaccination, or move on to Activity 2 to improve your results.

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

Brisbane South PHN region: percentage of patients aged 65+ immunised against influenza (as of Apr 2025)

- Proportion immunised: 51.1%

Let's vaccinate more people aged 65+ and protect them from the risk of influenza complications.

Influenza vaccination for 65 year olds and over

For people aged 65 and over, influenza vaccination is the single most effective way to prevent influenza-related complications. There is evidence that influenza vaccination reduces hospitalisations that result from severe influenza infection and pneumonia and reduces all-cause mortality among adults over 65 years of age.[20] In Australia, mortality rates for people over 65 years old are high. In 2024, 392 out of 500 people in this age group were reported to have died from influenza-related health issues, such as pneumonia or bronchitis.[21] This highlights the importance of encouraging elderly individuals to get vaccinated.

To find out the proportion of your patients aged 65 and over who were immunised against influenza in the last 15 months, measure your baseline change percentage by comparing your current quarter and previous quarter results using Practice Reports. Please refer to the How to Guide: Using Practice Reports for instructions. Document your results in the following table and check how your practice is tracking every quarter.

If your practice requires access to the reporting software, please contact Digital Health team at:

support@bsphn.org.au

Influenza vaccination 65 years old and over			
Results	Current Quarter	Previous Quarter	% Change
Criteria 	Regular patients aged 65 years and over who were immunised against influenza in the previous 15 months.		
Goal 	To improve the recording of influenza vaccinations received in the last 15-months among patients who are 65 years and over.		

[20] Practice Incentives Program Quality Improvement Incentive Quality Improvement Measures

[21] Australian Surveillance Report 2024

Measure	To identify and increase the proportion of patients aged 65 years and over who have been immunised against influenza within the last 15 months.
Recommendations	1. HealthPathways has three relevant pages: • Influenza • Immunisation - Influenza • Acute Respiratory Infections in Residential Aged Care Facilities 2. Read RACGP's Guidelines for preventive activities in general practice 10th edition to assist with patient care management: Immunisation – page 154. 3. Review RACGP's Improving health record quality in general practice to produce and maintain high-quality patient records. 4. Brisbane South PHN has a target poster available to help your practice track improvement measures for influenza vaccinations for 65 year olds and over. If you would like a copy, please get in contact with the GPQI team on 07 3864 7540 or email at support@bsphn.org.au.

Finding your patient population

Primary Sense

Two Primary Sense reports can be used to know if a patient requires an influenza vaccination.

- *Reports > Winter Wellness > filter by Age to find patients 65 years and over (click on the arrows next to the heading to filter)> Last Fluvax Vaccination date.*
- *Reports > Patients Missing PIP QI or Accreditation Measures > filter by Fluvax to find patients 65+ (click on the arrows next to the heading to filter)> Patients with 'Over 65' indicated on the report require a vaccination.*

Please check the Australian Immunisation Register (AIR) through your clinical software to make sure a patient has not already received an influenza vaccination elsewhere.

Clinical software instructions

Best Practice

Use the Searching the database instructions to identify patients that are due/overdue for their influenza vaccination. Also, please ensure that patients have not received an influenza vaccination elsewhere by checking the AIR information in Best Practice.

Refer to the Record and send immunisations to the AIR page on how to properly record influenza vaccinations.

MedicalDirector

Check if your patient has already been vaccinated against influenza elsewhere by viewing a patient's Immunisation history on the AIR using Medical Director.

Please see Recording an immunisation or Editing immunisations to ensure the influenza vaccination is included properly. Once the immunisation has been inputted into the system, refer to Updating encounters with AIR to ensure AIR records are accurate.

If you need support completing this activity, please contact the GPQI team:

07 3864 7540 support@bsphn.org.au

REVIEW

Complete the questions below to review how the practice can effectively improve influenza vaccinations for patients aged 65 years and over.

After reviewing the difference in percentages between your previous quarter and your current quarter results, are they what you expected?

How can you ensure more patients aged 65+ receive an influenza vaccination? For example, identify patients using Primary Sense reports, such as Winter Wellness, or focus on patients coming in for an appointment in the next 2 weeks and check their eligibility with the AIR. Refer to the MFI and PDSA template to help with outlining any changes to your practice's procedures.

Now that you have reviewed the influenza vaccination status of your patients aged 65+, why not attempt the next section to check if your patients with diabetes require an influenza vaccination, or move on to Activity 2 to improve your results.

5 Proportion of patients with diabetes who were immunised against influenza

Brisbane South PHN region: percentage of patients with diabetes immunised against influenza (as of Apr 2025)

- Proportion immunised: 40.3%

Influenza vaccination for people with diabetes

People with diabetes are at higher risk of severe illness, hospitalization or death from influenza. Vaccinating diabetes patients also reduces the likelihood of spreading the virus in the community.[22]

To find out the proportion of patients with diabetes who were immunised against influenza in the last 15 months, measure your baseline change percentage by comparing your current quarter and previous quarter results using Practice Reports. Please refer to the How to Guide: Using Practice Reports for instructions. Document your results in the following table and check how your practice is tracking.

If your practice requires access to the reporting software, please contact Digital Health team at:

 support@bsphn.org.au

Influenza vaccination: Patients with diabetes			
Results	Current Quarter	Previous Quarter	% Change
Criteria 	Regular patients with type 1 or type 2 diabetes who were immunised against influenza in the previous 15 months.		
Goal 	To improve the number of patients who have a type 1 or type 2 diabetes diagnosis to be immunised against influenza.		
Measure 	Identify and increase the proportion of patients that have type 1 or type 2 diabetes who had an influenza vaccination in the past 15 months to have their immunisation recorded in their clinical profile.		

[22] Diabetes Australia - Getting ready for the flu season: Vaccinate please!

Recommendations

1. The following HealthPathways pages are highly recommended:
   - Influenza
   - Influenza Immunisation
2. Read RACGP's Guidelines for preventive activities in general practice 10th edition to assist with patient care strategies: Immunisation – page 154.
3. Review RACGP's Improving health record quality in general practice to help produce and maintain high-quality patient records.
4. Brisbane South PHN has a target poster available to help your practice track improvement measures for recording influenza vaccinations for your patients with diabetes. If you would like a copy, please get in contact with the GPQI team on 07 3864 7540 or at support@bsphn.org.au.

Finding your patient population

Primary Sense

Primary Sense provides a report that will show all your patients with recorded diagnosis of diabetes who are due/overdue for an influenza vaccination.

- *Reports > Diabetes Mellitus > under the heading 'Patients with diabetes who may be eligible for chronic care occasions of service' > Filter: Fluvax date (click on the arrows next to the heading) > search for patients who have not been immunised with influenza in the past 15 months.*

Please check the Australian Immunisation Register (AIR) using your clinical software to make sure a patient has not already received an influenza vaccination elsewhere.

Clinical software instructions

Best Practice

Use the Searching the database instructions to identify patients that are due/overdue for their influenza vaccination. Also, please ensure that patients have not received an influenza vaccination elsewhere by checking the AIR information in Best Practice.

Refer to the Record and send immunisations to the AIR page on how to properly record influenza vaccinations.

MedicalDirector

Check if your patient has already been vaccinated against influenza elsewhere by viewing a patient's Immunisation history on the AIR using MedicalDirector.

Please see Recording an immunisation or Editing immunisations to ensure the influenza vaccination is included properly. Once the immunisation has been inputted into the system, refer to Updating encounters with AIR to ensure AIR records are accurate.

If you need support completing this activity, please contact the GPQI team:

07 3864 7540 support@bsphn.org.au

REVIEW

Complete the questions below to review how the practice can effectively improve influenza vaccination rates for patients with diabetes.

After reviewing the difference in percentages between your previous quarter and your current quarter results, are they what you expected?

How will you identify all patients with diabetes who have not had their influenza vaccination? For example, identify patients using Primary Sense reports or focus on patients coming in for an appointment in the next 2 weeks and check their eligibility with the AIR. Refer to the MFI and PDSA template to help with outlining any changes to your patient care plans.

Now that you have reviewed your patients with diabetes who require an influenza vaccination, why not attempt the next section to check the influenza vaccination status of your patients with COPD, or move on to Activity 2 to improve your results.

6 Proportion of patients with COPD who were immunised against influenza

Brisbane South PHN region: percentage of COPD patients immunised against influenza (as of Apr 2025)

Let's increase these vaccination rates and immunise more COPD patients!

- Proportion immunised: 52.9%

Influenza vaccination for people with COPD

People with COPD are 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.[23]

To find out the proportion of patients with COPD who were immunised against influenza in the last 15 months, measure your baseline change percentage by comparing your current quarter and previous quarter percentages using Practice Reports. Please refer to the How to Guide: Using Practice Reports for instructions. Document your results in the following table and check how your practice is tracking.

If your practice requires access to the reporting software, please contact Digital Health team at:

support@bsphn.org.au

Influenza vaccination: Patients with COPD			
Results	Current Quarter	Previous Quarter	% Change
Criteria	Regular patients 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.		
Goal	Improve the recording of patients aged 15 years and over, who have a COPD diagnosis and have been administered an influenza vaccination in their clinical profile.		

[23] Practice Incentives Program Quality Improvement Incentive Quality Improvement Measures

Measure	Identify and increase the proportion of COPD patients who had an influenza vaccination in the past 15 months to have their immunisation recorded in their clinical profile.
Recommendations	1. The HealthPathways pages can be of assistance: • COPD • Acute Exacerbation of COPD 2. Brisbane South PHN has a self-paced activity that will assist your practice to identify and recall 10 patients with COPD that are due for an influenza vaccination. 3. Brisbane South PHN has a target poster available to help your practice track improvement measures for influenza vaccinations for COPD patients. If you would like a copy, please get in contact with the GPQI team on 07 3864 7540 or email at support@bsphn.org.au.

Finding your patient population

Primary Sense

Primary Sense provides a report that will show all your patients with recorded diagnosis of COPD who are due/overdue for an influenza vaccination.

- *Reports > Chronic Lung Disease > Filter: Diagnosis – COPD (click on the arrows next to the heading) > Press Shift to filter: History of Fluvax as well > search for patients who have not been immunised with influenza in the past 15 months.*
- *Reports > Patients Missing PIP QI or Accreditation Measures > filter by Fluvax to find patients with COPD (click on the arrows next to the heading to filter)> Patients with 'COPD' indicated on the report require a vaccination.*

Please check the Australian Immunisation Register (AIR) using your clinical software to make sure a patient has not already received an influenza vaccination elsewhere.

Clinical software instructions

Best Practice

Use the Searching the database instructions to identify patients that are due/overdue for their influenza vaccination. Also, please ensure that patients have not received an influenza vaccination elsewhere by checking the AIR information in Best Practice.

Refer to the Record and send immunisations to the AIR page on how to properly record influenza vaccinations.

MedicalDirector

Check if your patient has already been vaccinated against influenza elsewhere by viewing a patient's Immunisation history on the AIR using Medical Director.

Please see Recording an immunisation or Editing immunisations to ensure the influenza vaccination is included properly. Once the immunisation has been inputted into the system, refer to Updating encounters with AIR to ensure AIR records are accurate.

If you need support completing this activity, please contact the GPQI team:

07 3864 7540 support@bsphn.org.au

REVIEW

Complete the questions below to review how the practice can effectively improve influenza vaccination rates for patients with COPD.

After reviewing the difference in percentages between your previous quarter and your current quarter results, are they what you expected?

How can you ensure the practice increases the number of influenza vaccinations for patients with COPD? For example, identify patients using Primary Sense reports, focus on patients coming in for an appointment in the next 4 weeks, check eligibility with the AIR? Refer to the MFI and PDSA template to help with outlining any changes to your practice's procedures.

Now that you have reviewed the influenza vaccination status for your patients with COPD, why not complete the next section and assess the recording of alcohol consumption of your patients, or move on to Activity 2 to improve your results.

7 Proportion of patients with an alcohol consumption status recorded in the last 24 months

Brisbane South PHN region: percentage of patients with an alcohol consumption status recorded (as of Apr 2025)

- Alcohol consumption recorded: 79.2%

Let's increase the recording of alcohol consumption to reduce chronic disease rates in our region!

Alcohol Consumption

Excessive alcohol consumption is a behavioural risk that is largely preventable, and it is associated with many chronic conditions, such as liver disease, kidney disease, cardiovascular disease, and mental health problems. While fewer Australians are drinking at levels that do not contribute to alcohol-related harm, there are about 26% of people that drink more than the recommended amount on a single occasion and excessive alcohol consumption occurs at least once every month.[24]

To find out the proportion of patients with an alcohol status recorded in the past 24 months, measure your baseline change percentage by comparing your current quarter and previous quarter results using Practice Reports. Please refer to the How to Guide: Using Practice Reports for instructions. Document your results in the following table and check how your practice is tracking every quarter.

If your practice requires access to the reporting software, please contact Digital Health team at:

support@bsphn.org.au

Alcohol consumption			
Results	Current Quarter	Previous Quarter	% Change
Criteria	Regular patients 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.		

[24] Practice Incentives Program Quality Improvement Incentive Quality Improvement Measures

Goal	Improve the recording of alcohol consumption status for patients aged 15 years old and over and flag those who are at high risk and introduce health promotion strategies.
Measure	Identify the number of patients aged 15 years old and over who had their alcohol consumption status recorded in the last 24 months and assist patients who report excessive consumption levels to reduce the proportion that have a high consumption status.
Recommendations	1. Review the following pages on HealthPathways pages: • Alcohol Withdrawal • Alcohol Screening and Intervention • Alcohol and Drug Treatment 2. Read through RACGP's Guidelines for preventive activities in general practice 10th edition to assist with patient care strategies: Alcohol – page 196. 3. Review RACGP's Improving health record quality in general practice to produce and maintain high-quality patient records. 4. Also, read through the RACGP's Smoking, Nutrition, Alcohol and Physical activity (SNAP) guide for tips on assessing alcohol consumption status.

Finding your patient population

Primary Sense

Primary Sense can assist in identifying patients who do not have alcohol consumption data recorded.

- *Reports > Patients Missing PIP QI or Accreditation Measures > Filter: Alcohol status (click on the arrows next to the heading).* Patient data showing N indicates the alcohol status has not been recorded.

Clinical software instructions

Best Practice

Please see information on how to record alcohol status in the Social and family history section of a patient's profile.

MedicalDirector

The Alcohol tab should be used to record alcohol consumption status.

If you need support completing this activity, please contact the GPQI team:

07 3864 7540 support@bsphn.org.au

REVIEW

Complete the questions below to review how your practice can effectively assist your high-risk patients with their alcohol consumption.

After reviewing the difference in percentages between your previous quarter and your current quarter results, are they what you expected?

What lifestyle interventions do you think the practice can introduce to patients who have high alcohol consumption to improve their health and well-being? For example, assisting patients with stress management or referring patients to join Lives Lived Well program. Refer to the MFI and PDSA template to help with outlining any changes to your patient care plans.

How can you ensure your practice improves the recording of the alcohol consumption of patients? For example, identify patients using Primary Sense – Patients Missing PIP QI or Accreditation Measures report, or reception staff to check all patients booked in for the week and leave a note on patient profile if alcohol consumption measures are missing? Refer to the MFI and PDSA template to help with outlining any changes to your data management procedures.

Now that you have reviewed the alcohol consumption status of your patients, why not attempt the next section and complete a CVD risk assessment for eligible patients, or move on to Activity 2 to improve your results.

8 Proportion of patients with the necessary risk factors assessed to enable cardiovascular disease (CVD) assessment

Brisbane South PHN region: percentage of patients with CVD risk factors assessed (as of Apr 2025)

- CVD assessment: 58.5%

Let's increase our CVD assessment rates and improve health outcomes for our region!

Cardiovascular Disease Assessment

Evaluating a patient's cardiovascular disease (CVD) risk by considering multiple factors like blood pressure and cholesterol, provides a more accurate assessment than looking at individual risk factors alone.

To find out the proportion of patients with the necessary risk factors to enable CVD assessment, measure your baseline change percentage by comparing your current quarter and previous quarter results using Practice Reports. Please refer to the How to Guide: Using Practice Reports for instructions. Document your results in following table and check how your practice is tracking.

If your practice requires access to the reporting software, please contact Digital Health team at:

support@bsphn.org.au

Cardiovascular disease risk			
Results	Current Quarter	Previous Quarter	% Change

Criteria

Regular patients who are 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

Goal	Improve the recording of CVD risk factors for people aged 45 to 74 years old, as well as for Aboriginal and Torres Strait Islander patients aged 35 to 44 years old.
Measure	Increase the proportion of patients who are aged 45 to 74 years old, as well as Aboriginal and Torres Strait Islander patients aged 35 to 44 years old, to have their health information recorded for all the CVD risk factors for an absolute CVD risk to be calculated in the last 2 years.
Recommendations	1. This HealthPathways page should be reviewed: Cardiovascular Risk Assessment. 2. Review the CVD assessment guideline and risk calculator for guidance on risk assessment procedures. 3. Read through RACGP's Guidelines for preventive activities in general practice 10th edition to assist with patient care strategies: Cardiovascular – page 94. 4. Review RACGP's Improving health record quality in general practice to help produce and maintain high-quality patient records.

Finding your patient population

Primary Sense

Primary Sense can help with CVD risk assessment by identifying which patients have risk factors recorded, and those who have a CVD risk of 10-15% and which patients have a risk of greater than 15%.

- *Reports > Cardiovascular disease risk factors > Choose topic to assess: Patients with a CVD greater than 15% and/or patients with a CVD risk 10-15%.*

Clinical software instructions

Best Practice

Please use the Cardiovascular Disease Risk Assessment Calculator.

MedicalDirector

Please see Cardiovascular Risk Calculator (Absolute CVD Risk).

If you need support completing this activity, please contact the GPQI team:

07 3864 7540 support@bsphn.org.au

REVIEW

Complete the questions below to review how the practice can improve the recording of CVD risk factors and what lifestyle changes can be introduced for patients with a high CVD risk.

After reviewing the difference in percentages between your previous quarter and your current quarter results, are they what you expected?

What lifestyle interventions do you think the practice can introduce to patients who have high CVD risk to improve their overall health and well-being? For example, referring patients to The Heart Foundation's MyHeart, MyLife program. Refer to the MFI and PDSA template to help with outlining any changes to your patient care plans.

How can you ensure your practice improves the recording CVD risk factors? For example, identify patients using Primary Sense – Cardiovascular Disease Risk Factors report, or focus on patients coming in for an appointment in the next 2 weeks and inquire about smoking status, alcohol consumption etc. Refer to the MFI and PDSA template to help with outlining any changes to your data management procedures.

Now that you have completed CVD risk factors assessment for your patients, why not attempt the next section and check if eligible patients have an up-to-date cervical screening, or move on to Activity 2 to improve your results.

9 Proportion of eligible patients with an up-to-date cervical screening

Brisbane South PHN region: percentage of patients with an up-to-date cervical screening (as of Apr 2025)

- Cervical screening test: 43.3%

Let's improve our cervical screening rate and protect more people from this preventable disease!

Cervical Screening

Australia has the lowest mortality rate and the second lowest incidence of cervical cancer in the world. However, to keep incidence rates low and prevent deaths from cervical cancer, it is essential to increase participation in screening. Routine screening enables for early detection of precancerous abnormalities – allowing for immediate treatment.[25]

To find out the proportion of eligible patients, measure your baseline change percentage by comparing your current quarter and previous quarter percentages using Practice Reports. Please refer to the How to Guide: Using Practice Reports for instructions. Document your results in the following table and check how your practice is tracking.

If your practice requires access to the reporting software, please contact Digital Health team at:

support@bsphn.org.au

Cervical screening			
Results	Current Quarter	Previous Quarter	% Change

Criteria	Regular patients 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.
Goal	Improve the cervical screening numbers for eligible people with a cervix who have been under-screened or never-screened within the past 5 years.

[25] Practice Incentives Program Quality Improvement Incentive Quality Improvement Measures

Measure	Increase the percentage of eligible people with a cervix who are aged 25 to 74, to be up-to-date with cervical screening.
Recommendations	1. Visit this HealthPathways page: Cervical cancer screening. 2. Discuss self-collect method option with patients: Cervical screening self-collection. 3. Read RACGP's Guidelines for preventive activities in general practice 10th edition to assist with screening rates: Cervical cancer – page 48. 4. Review RACGP's Improving health record quality in general practice to help produce and maintain high-quality patient records. 5. Brisbane South PHN has a self-paced activity that assists practices to improve the recording of their cervical screening tests. 6. Brisbane South PHN has a target poster available to help your practice track improvement measures for cervical screening. If you would like a copy, please get in contact with the GPQI team on 07 3864 7540 or at support@bsphn.org.au.

Finding your patient population

Primary Sense

Primary Sense can help with identifying which of your patients do not have a cervical screening recorded.

- *Reports > Patients with missing PIP QI or accreditation measures > Filter: Cervical screening (click on the arrows next to the heading) > The patients names with N do not have a cervical screening result recorded.*

**Please note if you have a patient who only attends the practice for their 5 year cervical screening test, they will not appear in the Primary Sense report. You will need to search for eligible patients using your clinical software. Primary Sense only collects information on RACGP active patients and will only pick up patients who have visited the practice 3 or more times in the past 2 years.*

Clinical software instructions

Best Practice

To find your patients that require a cervical screening, please see Searching the database.
Refer to the Cervical Screening page, which has a video on how to record cervical screening results or self-collection results.

MedicalDirector

To find your eligible patients, please see Searching for patients page.

Please see Cervical Screening page to find where to include the information in MedicalDirector.

If you need support completing this activity, please contact the GPQI team:

07 3864 7540 support@bsphn.org.au

REVIEW

Complete the questions below to review how your practice can effectively improve cervical screening rates.

After reviewing the difference in percentages between your previous quarter and your current quarter results, are they what you expected?

How can you ensure the cervical screening rates for your practice improves? For example, identify patients using Primary Sense – Cervical Screening report, or focus on patients coming in for an appointment in the next 4 weeks and check a patient's eligibility through the National Cancer Screening Register (NCSR) Portal. Refer to the MFI and PDSA template to help with outlining any changes to your data management procedures.

Now that you have reviewed your cervical screening results, why not attempt the next section and check if the blood pressure information for your patients with diabetes have been recorded, or move on to Activity 2 to improve your results.

10 Proportion of patients with diabetes that had a blood pressure result recorded in the last 6 months.

Brisbane South PHN region: percentage of patients with their blood pressure recorded (as of Apr 2025)

- Blood pressure recorded for diabetes patients: 55.9%

Let's increase the recording of diabetes patients with blood pressure results to improve health outcomes!

Diabetes with blood pressure result

Diabetes was the underlying cause of around 22,000 deaths representing 11% all deaths in Australia in 2022 and among the top 10 leading cause of death in Australia.[26] People with type 1 or type 2 diabetes have a 2 to 4 times greater chance of developing cardiovascular disease. It is essential that blood pressure for patients with diabetes is monitored regularly to reduce the risk of diabetes related chronic diseases.[27]

To find out the proportion of patients with diabetes that had a blood pressure result recorded, measure your baseline change percentage by comparing your current quarter and previous quarter percentages using Practice Reports. Please refer to the How to Guide: Using Practice Reports for instructions. Document your results in the following table and check how your practice is tracking.

If your practice requires access to the reporting software, please contact Digital Health team at:

support@bsphn.org.au

Diabetes with blood pressure result recorded			
Results	Current Quarter	Previous Quarter	% Change

Criteria

Regular patients who have diabetes and who have had a blood pressure measurement result recorded at a primary health care service within the previous 6 months.

[26] AIHW | Diabetes: Australian facts

[27] Practice Incentives Program Quality Improvement Incentive Quality Improvement Measures

Goal	Improve the recording of blood pressure for patients with diabetes.
Measure	Increase in the recording of blood pressure results for diabetes patients within the past 6 months.
Recommendations	1. The following HealthPathways pages are recommended: • Diabetes • Diabetes Advice • Management of Type 1 Diabetes • Management of Type 2 Diabetes • Diabetes Complications • Diabetes Medications 2. Read through Guidelines for preventive activities in general practice 10th edition to assist with patient care strategies: Diabetes – page 242. 3. Review RACGP's Improving health record quality in general practice to produce and maintain high-quality patient records. 4. Brisbane South PHN has a self-paced activity available to assist you to identify and recall 15 patients with diabetes who have not had a blood pressure recorded in the last 6 months. 5. Also, a target poster available is also available to help your practice track improvement measures for diabetes patients with blood pressure results. If you would like a copy, please get in contact with the GPQI team on 07 3864 7540 or at support@bsphn.org.au.

Finding your patient population

Primary Sense

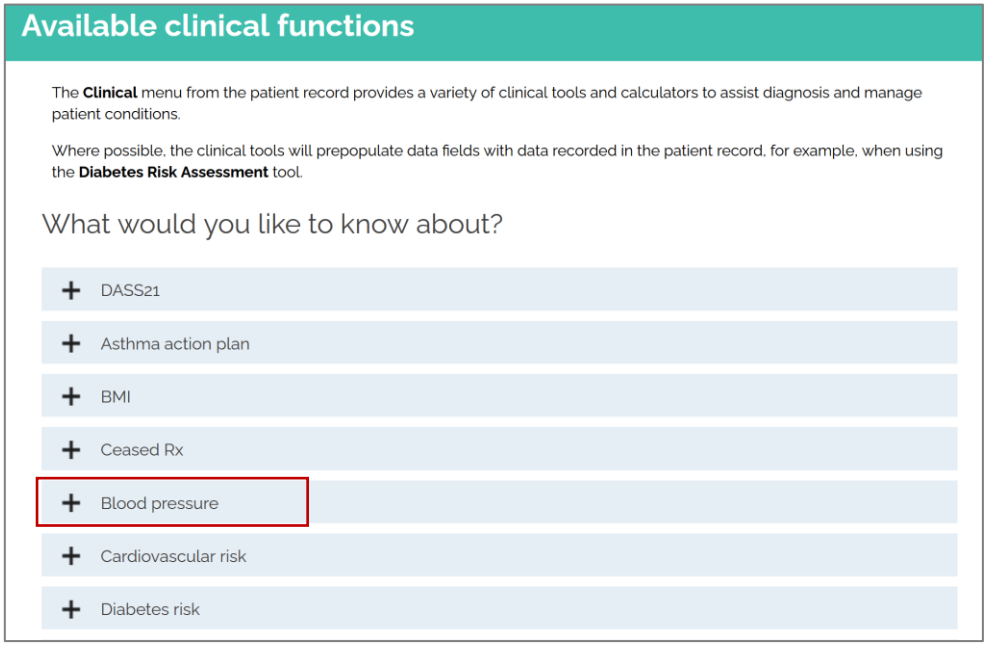
Primary Sense reports can help with identifying which of your patients do not have a blood pressure result recorded.

- *Reports > Diabetes Mellitus > Scroll down to the title: Patients with diabetes who may be eligible for chronic care occasion of service > Filter: BP Date (click on the arrows next to the heading) > The patients names indicating Nil do not have BP results recorded.*
- *Reports > Patients with missing PIP QI or accreditation measures > Filter: Diabetes with missing factors (click on the arrows next to the heading) > The patients names with 'BP' indicated in the report do not have a blood pressure result recorded.*

Clinical software instructions

Best Practice

Please see Available clinical functions page and select Blood Pressure to find the instructions on how to properly record a patient's blood pressure into the system.



MedicalDirector

Please see instructions on where to input Blood pressure results.

If you need support completing this activity, please contact the GPQI team:

07 3864 7540 support@bsphn.org.au

REVIEW

Complete the questions below to review how the practice can effectively improve the recording of blood pressure results for diabetes patients.

After reviewing the difference in percentages between your previous quarter and your current quarter results, are they what you expected?

What lifestyle interventions do you think the practice can introduce to diabetes patients to improve their overall health and well-being? For example, referring patients to Credentialled Diabetes Educator (CDE), or the Self-Management of Chronic Conditions service, or programs such as MyDesmond Program. Refer to the MFI & PDSA template to help with outlining any changes to your patient care plans.

What quality improvement changes would you like to implement in the practice to improve your blood pressure recording result for your diabetes patients? For example, using prompts/reminders in clinical software or opportunistically checking diabetes patients to increase blood pressure recording. Refer to the MFI and PDSA template to help with outlining any changes to your data management procedures.

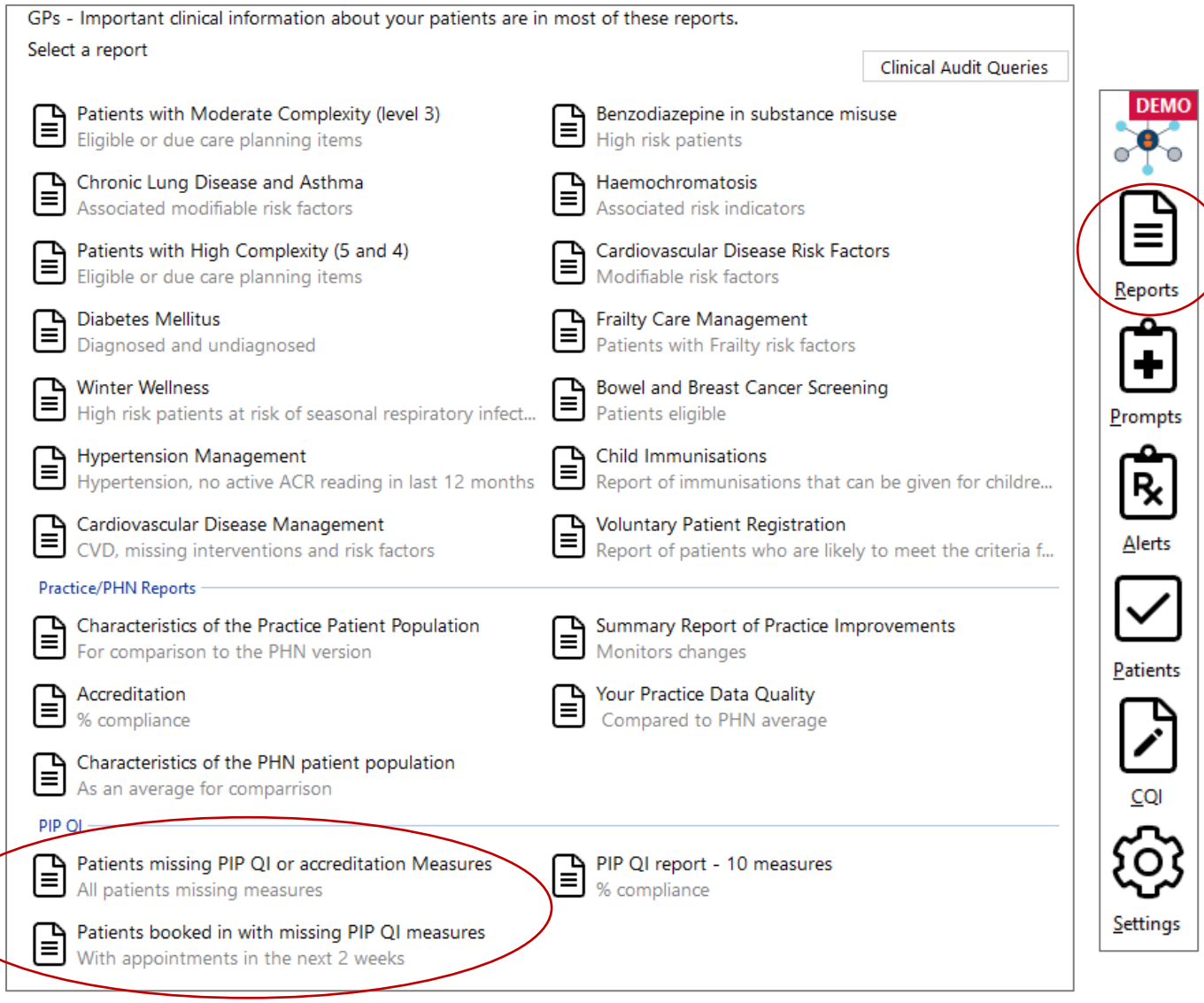
Now that you have reviewed the blood pressure recording for your diabetes patients, why not move on to Activity 2 to improve your results.

ACTIVITY 2 – Improving your results

To increase your quality improvement percentage results that you have just recorded and reviewed, this activity will help you develop plans and procedures to implement in your practice to enhance patient-centred care. Doing this activity will enable your practice to perform continuous quality improvement, which encourages a culture of learning, innovation, and proactive identification of issues. This will lead to better patient health care outcomes, system processes and overall practice development.[28]

Recommendations

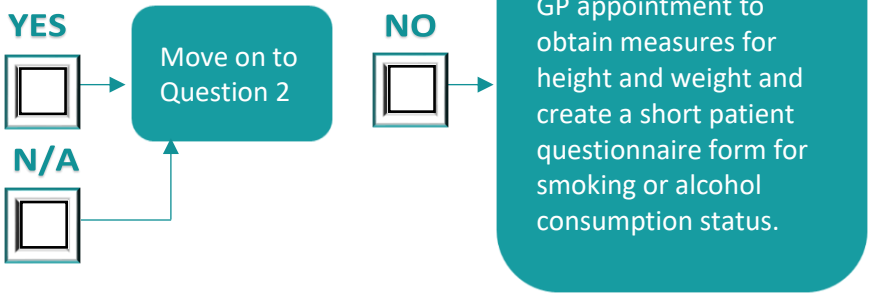
- As a team, review and analyse current practice processes in recording and maintaining data quality.
- Please use **Primary Sense** and select the ***Patients Missing PIP QI or Accreditation Measures*** or ***Patients booked in with missing PIP QI measures*** report (see screenshot) to complete this activity.
- Review the Model for Improvement (MFI) & Plan, Do, Study, Act (PDSA) example and use the MFI & PDSA template to record your improvement at the end of this activity.



2.1

QUESTION 1

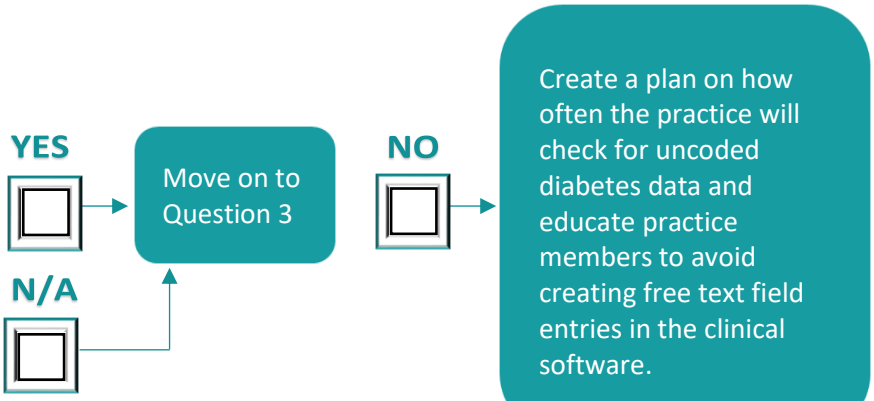
For PIP QI measures 2,3 and 7: Does the practice have a process in place to easily obtain height, weight, waist measurements, smoking and alcohol consumption status?



2.2

QUESTION 2

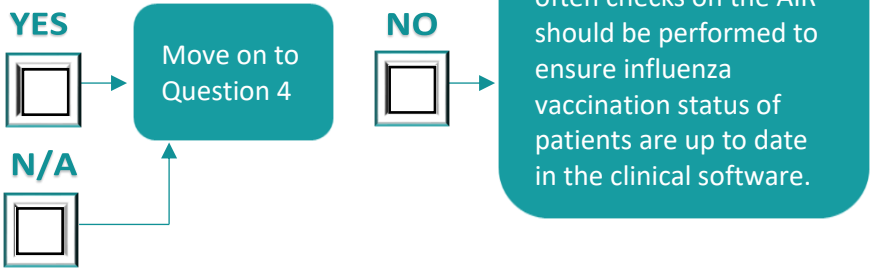
For PIP QI diabetes measures 1, 5 and 10: Does the practice have a plan in place to check if all active patients with diabetes are coded correctly as either Type 1 or Type 2?



2.3

QUESTION 3

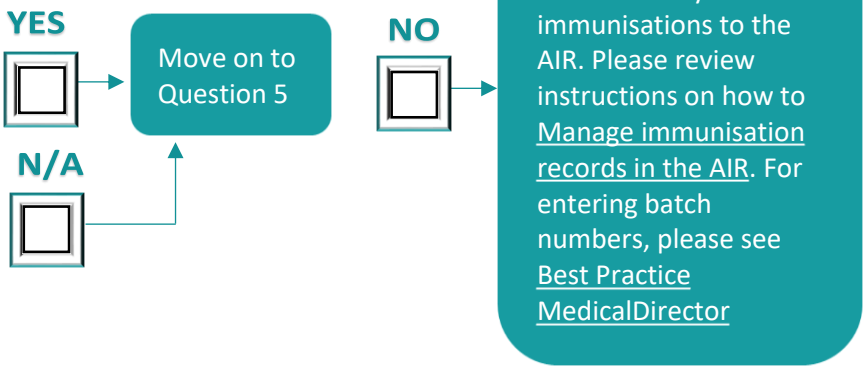
For PIP QI influenza measures 4, 5 and 6: Does the practice check the AIR to ensure patient influenza vaccination information are up to date?



2.4

QUESTION 4

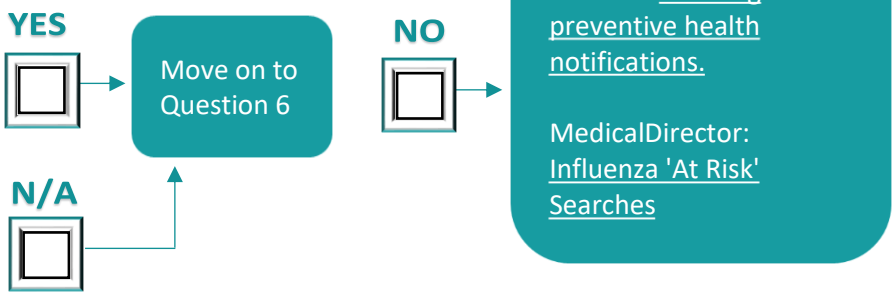
For PIP QI influenza measures 4, 5 and 6: Do relevant team members know how to record specific immunisation codes and batch numbers correctly into the clinical software to prevent uncoded immunisation data?



2.5

QUESTION 5

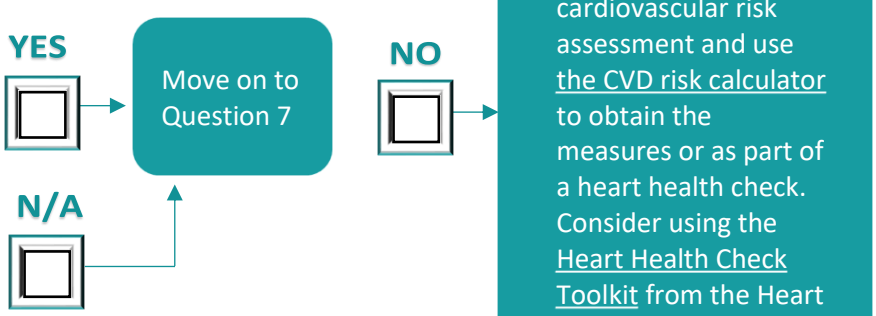
For PIP QI influenza measures 4, 5 and 6: Are relevant staff members aware that preventive health notifications for patients can be used for influenza vaccinations?



2.6

QUESTION 6

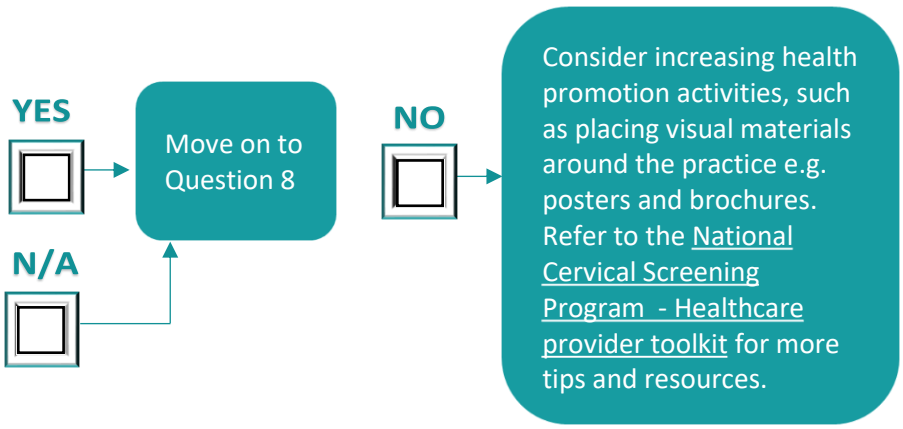
For PIP QI measure 8: Does the practice have a strategy on how to obtain missing CVD risk factors?



2.7

QUESTION 7

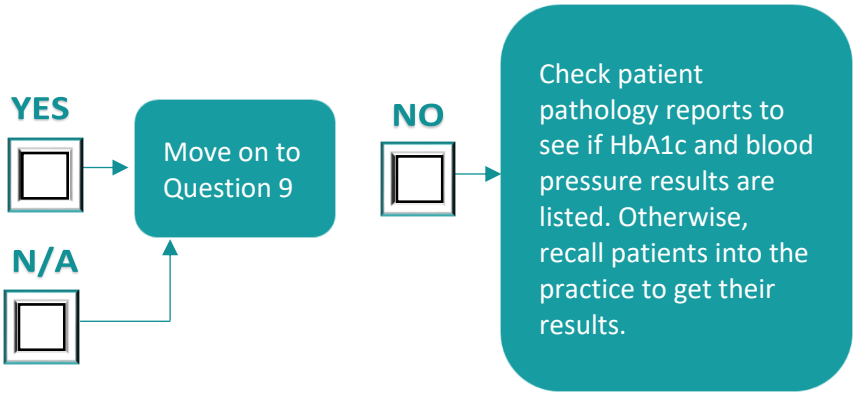
For PIP QI measure 9: Does the practice have a plan on how to increase cervical screening participation rates?



2.8

QUESTION 8

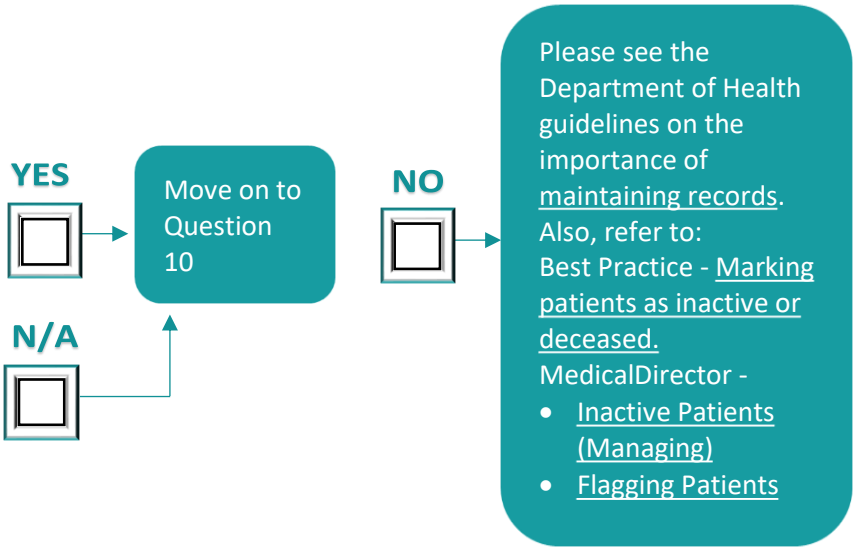
For PIP QI measures 1 and 10: Does the practice already have a plan on how missing diabetes factors (HbA1c or BP results) from patients will be easily obtained?



2.9

QUESTION 9

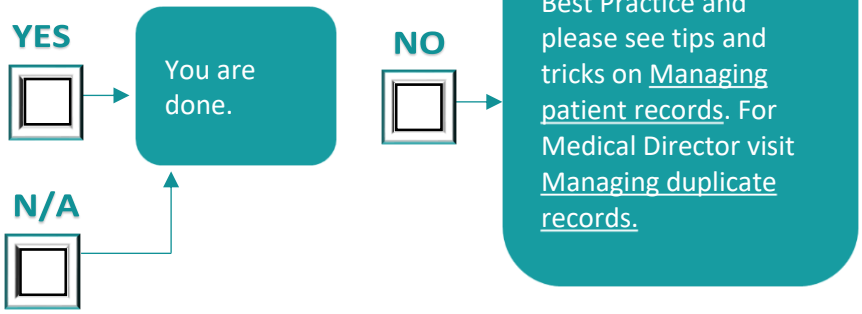
For all PIP QI measures: To ensure high quality patient data, does the practice have an administrative record keeping policy for marking patients deceased, deleted, or inactive in the clinical system?



2.10

QUESTION 10

For all PIP QI measures: Do the relevant staff members know how to merge duplicate patient records for patient information to reflect greater accuracy of their health status?



REVIEW

Complete the questions below to review how the practice can effectively improve its PIP QI results.

After reviewing your patient data reports with missing risk factors recorded, were there any unexpected results?

What plan will your practice put into place to improve the recording of risk factors, immunisation status and including other patient information? For example, training will be provided to relevant staff members, or the practice performs data cleansing activity every month to check for inconsistencies.

Use the MFI and PDSA template to assist you with implementing any changes in the practice.

MFI Example **MFI Template**

Congratulations! You have now finished this activity.
Next, let's recall patients into the practice.

ACTIVITY 3 – Patient recalls and reminders

After finding your eligible patients in Activity 1 and reviewing ways on how the practice can improve its PIP QI results in Activity 2, patients now need to be recalled into the practice to prevent the risk of health complications. Brisbane South PHN has a Recall and Reminder toolkit to assist practices by ensuring patients are followed up with an appropriate recall/reminder/prompt. Having an effective recall and reminder process will help improve your results for your PIP QI measures and improve patient health outcomes for your practice.

3.1

QUESTION 1

Has the practice decided on which group of patients are going to be prioritised and contacted? E.g. diabetes patients.

YES ☐ → Move on to Question 2

NO ☐ → Select one PIP QI measure that needs to be prioritised and recall patients into the practice e.g. change % for influenza vaccinations among 65+ patients were low.

3.2

QUESTION 2

Is there a plan in place to collect health information for specific PIP QI measures once the patients are in the practice?

YES ☐ → Move on to Question 3

NO ☐ → Consider other strategies to collect a range of PIP QI data. For example, patients fill out a questionnaire in the waiting room that asks questions on physical assessment/health check status such as alcohol consumption and smoking status.

3.3

QUESTION 3

Will the practice create a schedule of when to recall patients for specific PIP QI measures (e.g. every 3 months) or when to recall patients for similar measures?
E.g. recall patients for PIP QI influenza vaccination measures (aged 65+, patients with diabetes or with COPD) before peak flu season.

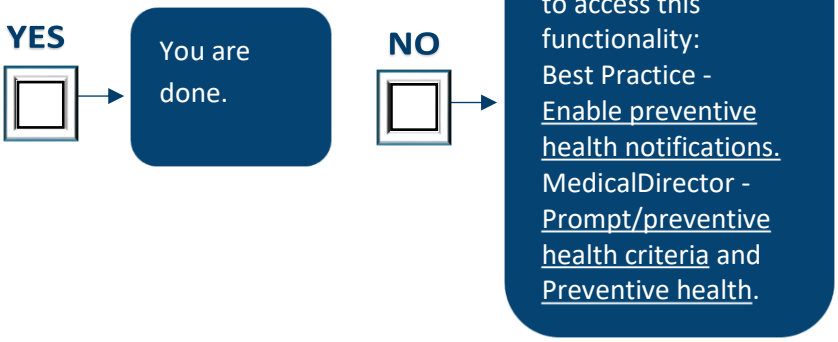
YES ☐ → Move on to Question 4

NO ☐ → Create a schedule of when to recall patients back into the practice to improve your PIP QI results.

3.4

QUESTION 4

Do relevant staff members know how to use the preventive health patient profile prompts for alerts such as an influenza vaccination, diabetes review, and smoking risk?



REVIEW

Complete the questions below to review your process on how to effectively improve your patient recalls and reminders processes.

After reviewing your patient recall schedule, were there any unexpected results? E.g. too many diabetes patients with missing recorded factors.

What plan will your practice put into place to ensure patient recalls for PIP QI measures are a smooth process?

Use the MFI template to assist you with implementing any changes in the practice.

MFI Example **MFI Template**

Congratulations! You have now finished this activity.
Next, let's look at the online resources page.

Online resources

Online resources that will assist with improving your PIP QI measures results.

Websites	Links
Diabetes	
Diabetes Australia	Prevention
Department of Health, Disability and Ageing	The Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK)
RACGP	Management of type 2 diabetes: A handbook for general practice
Smoking	
Department of Health, Disability and Ageing	Tobacco facts My QuitBuddy app Smoking, vaping and tobacco resources
Queensland Government	Quit HQ Vaping Exposed
Tackling Indigenous Smoking	Resources to support activities
BMI Measurements	
Queensland Government	Chronic Conditions Manual: Body measurements adults
Department of Health, Disability and Ageing	BMI and waist measurement Get Up and Grow - Healthy eating program for children Eat for health: Australian dietary guidelines
National Health and Medical Research Council (NHMRC)	Clinical practice guidelines for the management of overweight and obesity
Influenza	
Australian Immunisation Handbook	Catch-up Calculator
Queensland Health	Influenza vaccination guidelines and resources Notification Guidelines and Resources for Public Health Units
Department of Health, Disability and Ageing	Information, resources, advice and campaign materials for health professionals Resources for health care settings

AIR: Australian Immunisation Register	Accessing the AIR, Submitting to the AIR and AIR Reports
COPD	
Lung Foundation Australia	COPD Overview Management Clinical tools and resources Health professionals training - COPD diagnosis and early planning
Australian Commission on Safety and Quality in Health	Related resources – COPD clinical care standard
Queensland Health	Chronic Conditions Manual: Prevention and Management of Chronic Conditions in Australia – 3rd edition 2024
Alcohol Consumption	
NHMRC	Alcohol: Australian guidelines to reduce health risks from drinking alcohol
Alcohol and Drug Foundation	Prevention and early intervention
Department of Health, Disability and Ageing initiatives	Little Habit campaign Every Moment Matters campaign Every Moment Matters: Alcohol and pregnancy
DrinkWise	Facts and Advice
Cardiovascular Disease Risk	
The Heart Foundation	Heart Health Check resources Heart Health Check toolkit
The Heart Research Institute	Heart Health
Cervical Screening	
Cancer Council	Discussing cervical screening with women who have never screened. Self-collection HPV test: information for under-screened or never-screened women. Cervical Screening: About the test Cancer screening module Self-collection and the Cervical Screening Test
Department of Health, Disability and Ageing	Self-collection for the Cervical Screening Test National Cervical Screening Program – Healthcare provider toolkit The Cervical Screening Test – Easy read guide

Australian Centre for Prevention of Cervical Cancer	National Strategy for the Elimination of Cervical Cancer in Australia
Daffodil Centre	Research and resources hub
General	
RACGP	Guidelines for preventive activities in general practice 10th edition Improving health record quality in general practice
Department of Health, Disability and Ageing	Administrative record keeping guidelines for health professionals
Services Australia	Apply for the Practice Incentives Program

Brisbane South PHN Toolkits

After completing this toolkit, other Brisbane South PHN toolkits can help with identifying the additional healthcare needs your patients may require, such as other vaccinations or screening tests. The following toolkits can assist your practice with delivering better patient-centred care:

Cancer Screening: Review patients eligible for cancer screening (breast, bowel, lung and cervical) and ensure you have systems in place to manage these patients.

Pneumococcal and **Influenza** toolkits are available to help you review patients at your practice eligible for vaccinations.

All of Brisbane South PHN's toolkits are available on our website, why not complete more to improve processes and patient health outcomes for your practice.

Model for Improvement and Plan-Do-Study-Act (PDSA) example

Please visit Brisbane South PHN QI Tools and Resources page to view the MFI diagram and the MFI & PDSA template.

Quality Improvement Record

Model for Improvement and Plan-Do-Study-Act (PDSA) template.
For more information on the Model for Improvement and PDSA method, visit the Brisbane South PHN Quality Improvement website.

Our General Practice Quality Improvement (GPQI) Team can work with you to provide practical advice and resources to help implement your QI activities.
For support call 3864 7540 or email support@bsphn.org.au.

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Practice name:

Date:

Team members:

Goal: What are you trying to accomplish?

Create a S.M.A.R.T. goal (Specific, Measurable, Achievable, Relevant, Time-bound)

Example: We aim to increase the BMI recording rates from 35% to 40% between 1st July and 31st December.

Our S.M.A.R.T. goal is to increase the proportion of our active patients with COPD who have an influenza vaccine by 20% by 31st July.

Measure: How will you measure and track your improvement?

Outline how you will collect the data, including how often and where from.

We will measure the percentage of active patients with COPD who have had a flu vaccine. To do this we will:
A) Identify the number of active patients with COPD.
B) Identify the number of active patients with COPD who have had a flu vaccination.
B divided by A x 100 produces the percentage of patients with COPD who have had a flu vaccination.

BASELINE MEASUREMENT: 47% of active patients with COPD have a flu vaccination DATE:

Ideas: What changes could you make that will lead to an improvement?

Brainstorm with your team ideas to help reach your goal. Test the ideas using the Plan-Do-Study-Act (PDSA) method.

Four blank PDSA templates are provided on the following pages to record the testing of different ideas.

Ideas		Date completed
Idea 1:	Identify patients with COPD who have not had a flu vaccination in the past 15 months.	
Idea 2:	Source and provide endorsed patient education resources (in waiting rooms, toilets etc.).	
Idea 3:	Run an awareness campaign for COPD and flu vaccination.	
Idea 4:		

Plan-Do-Study-Act (PDSA) Cycle

Idea: Identify patients with COPD who have not had a flu vaccination in the past 15 months.

PLAN *Plan the test including how to collect data.*

Include what, who, when, where, predicted outcome and data to be collected.

Mary will conduct a search on Primary Sense and identify active patients with COPD who have not had a flu vaccination recorded in the past 15 months. The practice nurse will ensure there is adequate stock of the vaccine to ensure patient demand is met. Mary will search the appointment book to see if any of the patients have an upcoming appointment. Mary will contact patients by phone to see if she can book an appointment with the nurse and the GP for the vaccination.

Who: Receptionist. When: Begin 20th May. Where: Dr Bill's office.
Data to be collected: Number of active patients with COPD and the number of active patients with COPD who have not had a flu vaccination recorded in the past 15 months.

DO *Run the test on a small scale.*

Was the plan carried out? What was done? Document any unexpected events or problems. Record any observations and data collected.

Done – completed 20th May –the receptionist completed a search on Primary Sense to identify patients with COPD who had not received their flu vaccination in the past 15 months. The receptionists then phoned patients who appeared on the list to arrange an appointment. The practice nurse monitored vaccine stock levels.

STUDY *Analyse and study the outcome.*

Review and reflect on the results. Compare what happened to your predictions.

The practice managed to increase the number of COPD patients with their flu vaccination by 15%. The goal was to increase by 20%. Therefore, the goal was not met. However, the practice was still happy with the progress.

ACT *Record the next steps.*

Does your idea work? Does it need any changes? Will you test a new idea?

The practice will continue to contact patients with COPD who have not had the flu vaccine recorded.

Now that you have finished all the activities...

- **Log** your CPD hours.
- **Celebrate** your achievements.
- **Keep** this as evidence of improvements for accreditation.
- **Complete** more toolkits to continue seeing improvements in your practice!

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Brisbane South Primary Health Network (BSPHN)
ABN 53 151 707 765

 www.bsphn.org.au

 support@bsphn.org.au

 07 3864 7540

 First floor, Building 20 Garden City Office Park, 2404 Logan Road,
Eight Mile Plains, QLD 4113

 PO Box 6435, Upper Mt Gravatt, QLD 4122

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