

Quality Improvement in Diabetes

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Primary Care Improvement Officer

WE ACKNOWLEDGE THE TRADITIONAL OWNERS & CUSTODIANS OF THE
LAND THAT WE LIVE & WORK ON AS THE FIRST PEOPLE OF THIS COUNTRY.




QUALITY IMPROVEMENT LEARNING OUTCOMES

1. De-identified Data Sources

- HNE Diabetes Alliance Program - Managing Type 2 Diabetes Summary Report
- The PHN - General Practice Summary

2. Quality Improvement Activities

- Primary Care Support 
- Plan Do Study Act Model for Improvement Cycles
- PenCS CAT4 – Re-identify patients

3. Practice Clinical Information System (CIS)

- Diabetes Register
- Diabetes Record / Cycle of Care



Primary Care Support

Last updated February 14, 2022

PRINT SHARE

The PHN's Primary Care Improvement Team partner with practices to build a better Australian primary health system.

The PHN understand that General Practices are the cornerstone of primary health care and an invaluable part of the communities in which we live. Many factors, such as workforce shortages, digital innovations, and industry changes can be challenging for General Practice to navigate whilst trying to provide optimal patient care.



About Us



Quality Improvement Framework



Accreditation



Cancer Screening



Chronic Kidney Disease

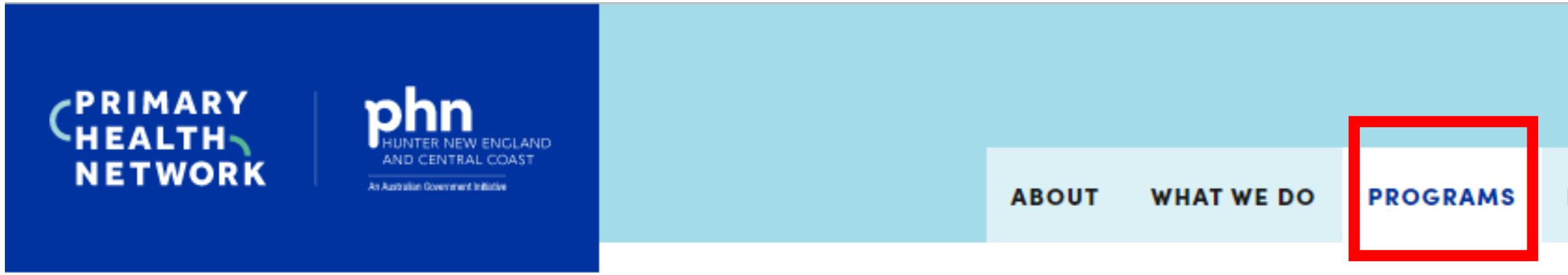


Diabetes

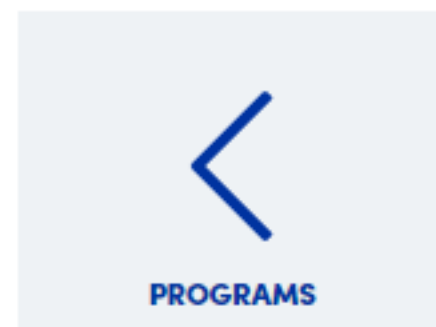
HNELHD & HNECCPHN Diabetes Alliance Program (DAP+) “The Alliance”

- HNELHD
- The PHN
- General Practice / AMS
 - > Data for Quality Improvement
 - > MBS Case Conferencing Model
 - > Chronic Disease Management
 - > Continuity of Carer/Practice for patient
 - > Multi-disciplinary team
 - > Integration between primary secondary tertiary sectors
 - > Health Professional transfer of knowledge (CPD)





Diabetes Alliance Expression of Interest Form



Home > PROGRAMS

Diabetes Alliance

Your Primary Care Improvement Officer can assist.



HNE Diabetes Alliance - YouTube

Practice name	
Address	
Email	
Phone number	
Fax number	
Contact name	
Contact's position	
Contact phone number	
Primary Care Improvement Officer (PCIO)	
Month preferred	
Days of week preferred	
Number of GP's participating	
Number of Practice Nurse's participating	
Electronic Referrals available?	



Diabetes Alliance Plus (DAP+) CONFERENCE

“Ensuring Equitable Access to Diabetes Care”

Friday 17 November – Sunday 19 November
Hunter Valley



DIABETES ALLIANCE PROGRAM PLUS (DAP+)

Inaugural Multidisciplinary Conference

Ensuring equitable access to diabetes care

SAVE THE DATE

The Diabetes Alliance Program Plus (DAP+) welcomes all clinicians caring for people with diabetes to attend the DAP+ Inaugural Multidisciplinary Conference, focussing on the provision of equitable access to diabetes care.

The conference topics over the 3 days will target information relevant to General Practitioners, Practice Nurses, Podiatrists, Dietitians, Exercise Physiologists, Aboriginal Health Practitioners and Workers and Diabetes Educators. Some of the key presenters will include Endocrinologists, Orthopaedic and Vascular Surgeons, Podiatrists, Dietitians, Diabetes Educators and many more experts in diabetes care.

DETAILS

WHEN Friday 17 November 2023 - Sunday 19 November 2023

LOCATION Hunter Valley NSW - Venue details to come.

COST TBA

OUR SPONSORS



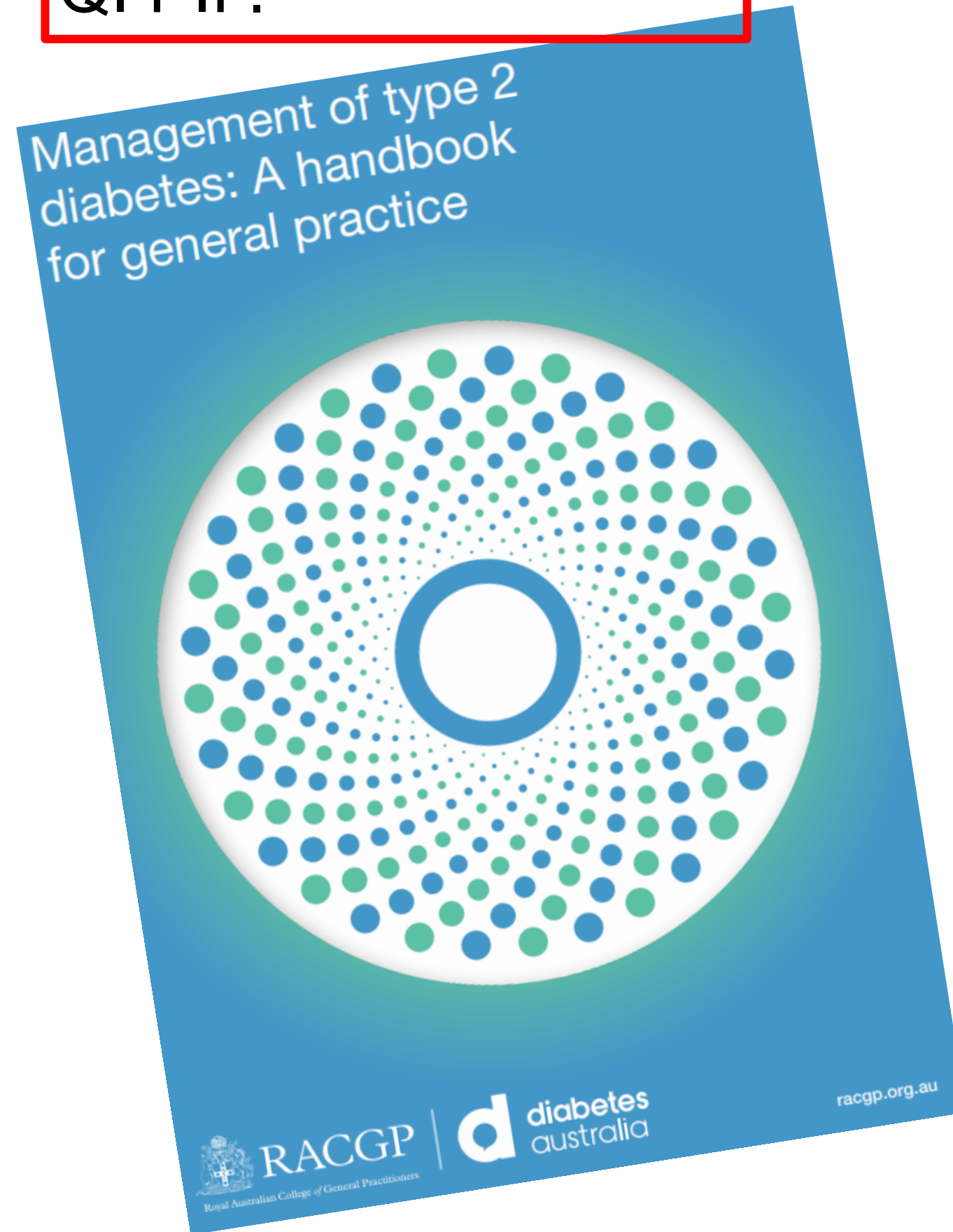
Generously sponsored by:



THEPHN.COM.AU

Diabetes Cycle of Care

Hot Tip: Diabetes Cycle of Care remains best practice.
MBS Item numbers and SIP replaced by QI PIP.



Box 1. Medicare Benefits Schedule (MBS) diabetes 'cycle of care' minimum requirements²

At least six-monthly:

- Measure weight, height and body mass index (BMI)
- Measure blood pressure
- Assess feet for complications

At least annually:

- Review and discuss diet, physical activity, smoking status, medications (need for more frequent review should be individualised, as outlined in Table 1)
- Assess diabetes management by measuring HbA1c
- Review and discuss complication prevention – eyes, feet, kidneys cardiovascular disease (CVD)
- Measure total cholesterol, triglycerides and high-density lipoprotein (HDL) cholesterol
- Assess for microalbuminuria

At least every two years:

- Comprehensive eye examination (more frequently for those at high risk)

Royal Australian College of General Practitioners. Management of type 2 diabetes: A handbook for general practice. [Online].; 2020 [cited 2023 July 11. Available from: <https://www.racgp.org.au/getattachment/41fee8dc-7f97-4f87-9d90-b7af337af778/Management-of-type-2-diabetes-A-handbook-for-general-practice.aspx>.

DIABETES REGISTER

Medical Director

Open File Patient User Tools Clinical Correspondence **Search** Resources Sidebar Messenger Help

Patient...
My Health Record Audit...
Asthma...
Diabetes Register...
Immunisation...
Cervical Screen Results...
Pregnancy List...
Prescription
Recall...
Influenza 'At Risk'...
Pneumococcal Disease 'At Risk'...

Permissions

User: Ms. Nadine Nurse

Section	Permission
Daily message	Deny access
Contacts	Add/Edit/Delete
Messages	Allowed
Export demographic data	Deny access
Export clinical data	Deny access
Import clinical data	Deny access
Subpoena Tool	Deny access
My Health Record Access	Not allowed
My Health Record Registration	Not allowed
Search clinical data	Allow access
Change patient confidential status	Allowed
Allocate investigation reports	Allowed
Reminder lists	Allow access
Word processor templates	Add/Edit/Delete
Word Processor	Allow clinical access
Setup/configuration	No access
Passwords	Deny access
Perform a backup	Deny access
Restore from a backup	Deny access
Printers	Deny access
Own preferences	No access

HOT TIP: Check that your User Permissions are set to allow access, e.g., Practice Nurse.

Best Practice

File **Clinical** Ma

Actions

- Cervical screening
- Diabetes register**
- Follow up inbox
- Immunisations
- Pregnancy list
- Reminders

Medical Director. Diabetes Register Searches. [Online].; n.d. [cited 2023 July 11. Available from: https://www.medicaldirector.com/help/index.htm#t=topics-clinical%2FDiabetes_Register_Searches.htm.

Best Practice. Diabetes Register. [Online].; 2020 [cited 2023 July 11. Available from: <https://kb.bpssoftware.net/bppremier/saffron/Clinical/Diabetes/DiabetesRegister.htm?Highlight=diabetes>.

DIABETES REGISTER

Medical Director Clinical Front Screen < Search < Diabetes Register

File Window Help

No. of patients: Include gestational diabetes Display when next due

	Name	Phone Home	Phone Work	Phone Mobile	Last visit	HbA1C	Eye exam	Foot exam	Height	Weight	BP	Lipids	Microalbumin	Diabetes recall	Diabetes assessment
<input type="checkbox"/>	ANDERSON, DAVID				12/04/2021		22/05/2011	18/02/2013	08/04/2021	08/04/2021	08/04/2021	15/06/2012		18/02/2014	08/04/2021
<input type="checkbox"/>	ANDREWS, JOHN				03/12/2012	26/05/2012	12/12/1999	12/05/2012	26/05/2012	26/05/2012	26/05/2012	15/06/2012	12/05/2012		12/05/2012
<input type="checkbox"/>	WATLAND, HENRY				18/02/2013				12/07/2012	12/07/2012	12/07/2012	15/06/2012			

Select all Deselect all Summary Statistics Open patient Add Recall Print list Close

Best Practice Main Screen < Clinical < Diabetes Register

File View Help

Show overdue only Usual doctor: All 8 patients

Name	D.O.B.	Age	Last Care cycle completed	Last Care cycle billed
Mr. Alan Abbott	30/06/1945	75 yrs	13/04/2021	27/10/2011
Mrs. Madeline Abbott	14/02/1978	43 yrs	27/10/2011	//
Mr. Felix Adams	30/12/1928	92 yrs	//	//
David Charles Alfreds	19/03/1930	91 yrs	//	//
Mrs. Janelle Allen	24/01/1965	56 yrs	//	//
Mrs. Frances Barrett	16/09/1972	48 yrs	//	//
Rose Bishop	24/01/1926	95 yrs	13/04/2021	//
Miss Daisy Duck	06/05/1940	81 yrs	19/05/2021	//

File View Help

Open patient Ctrl+O

Edit details

Mail merge

Print F9

Export

Close Ctrl+F4

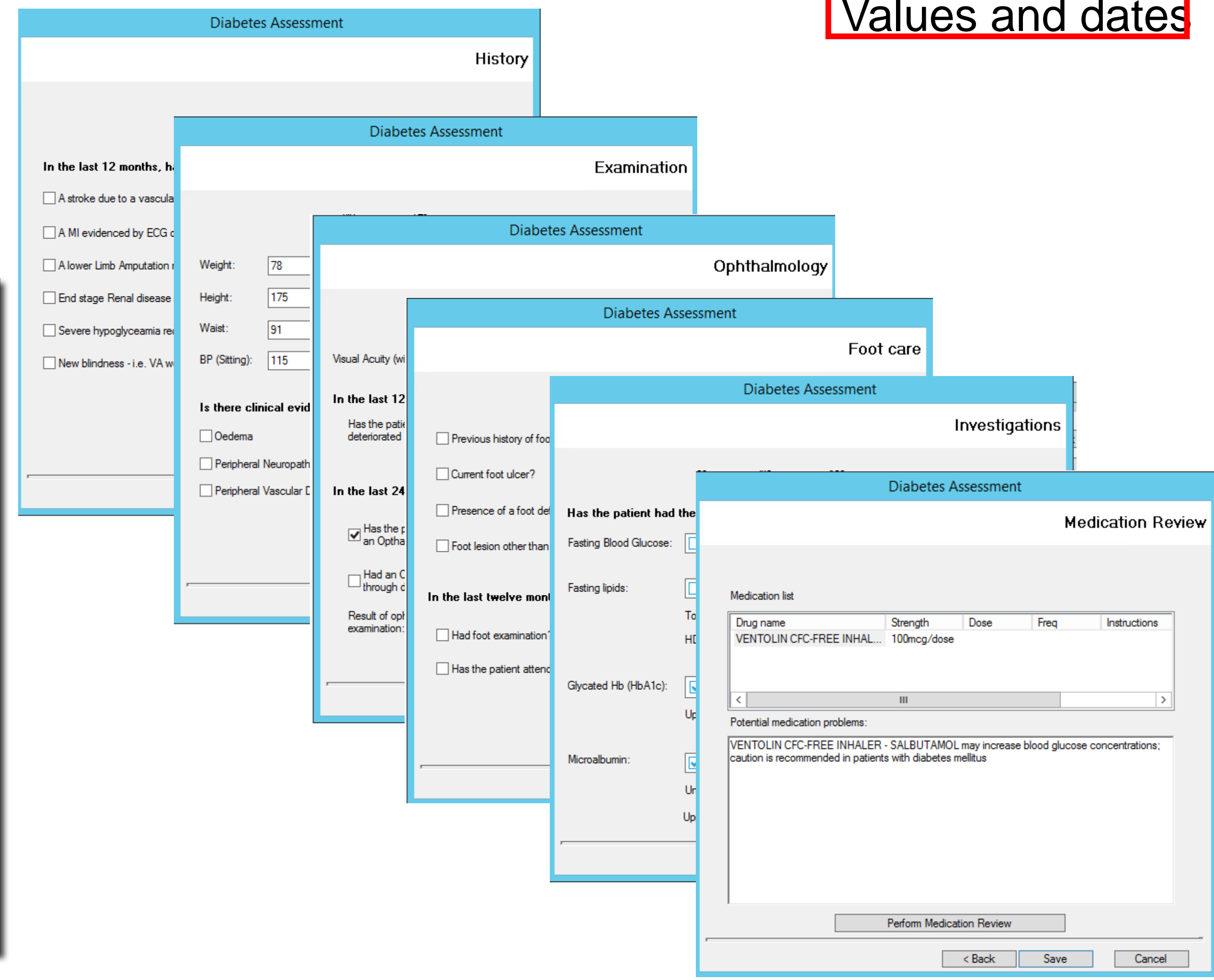
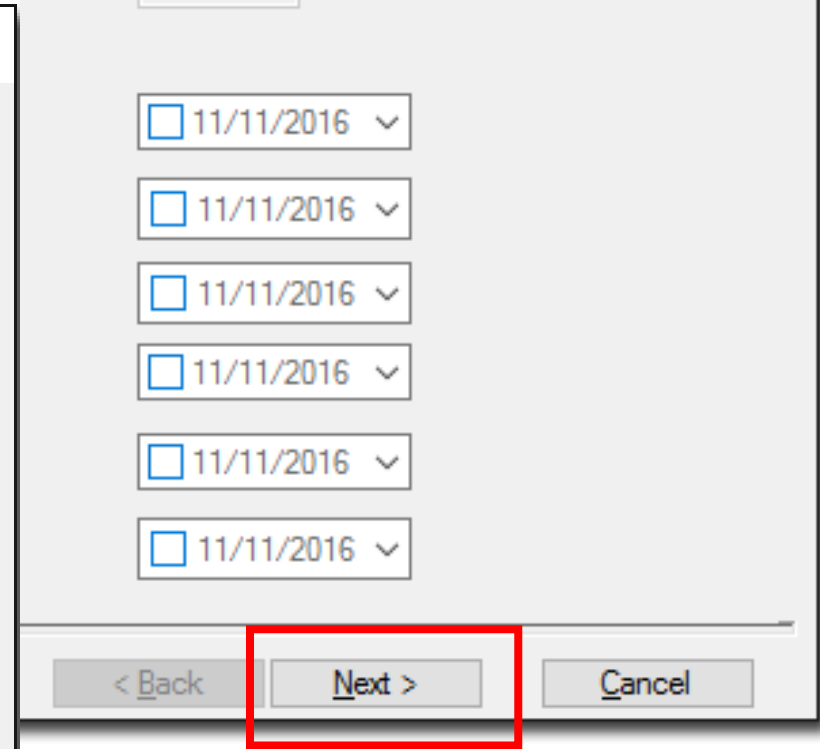
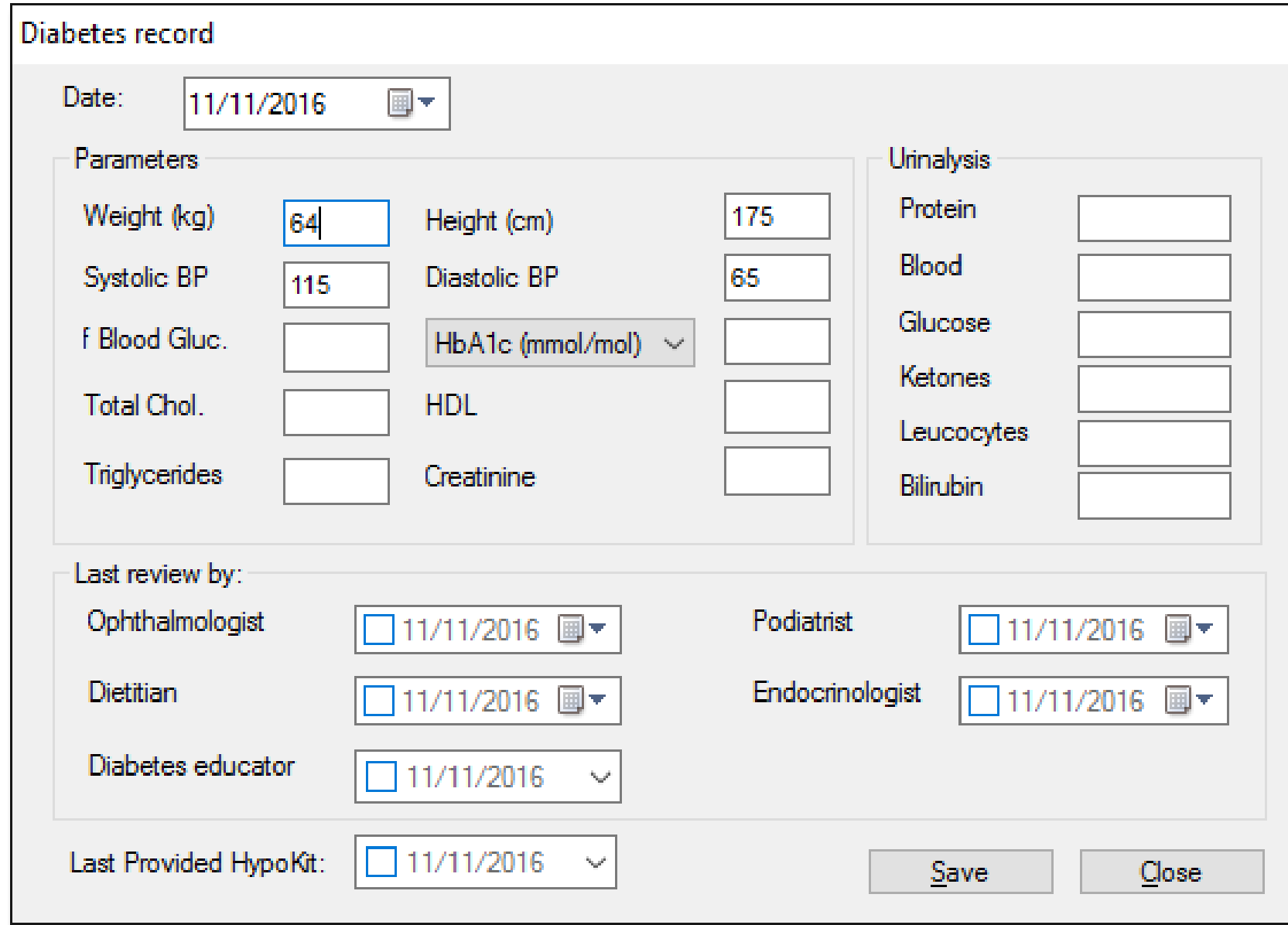
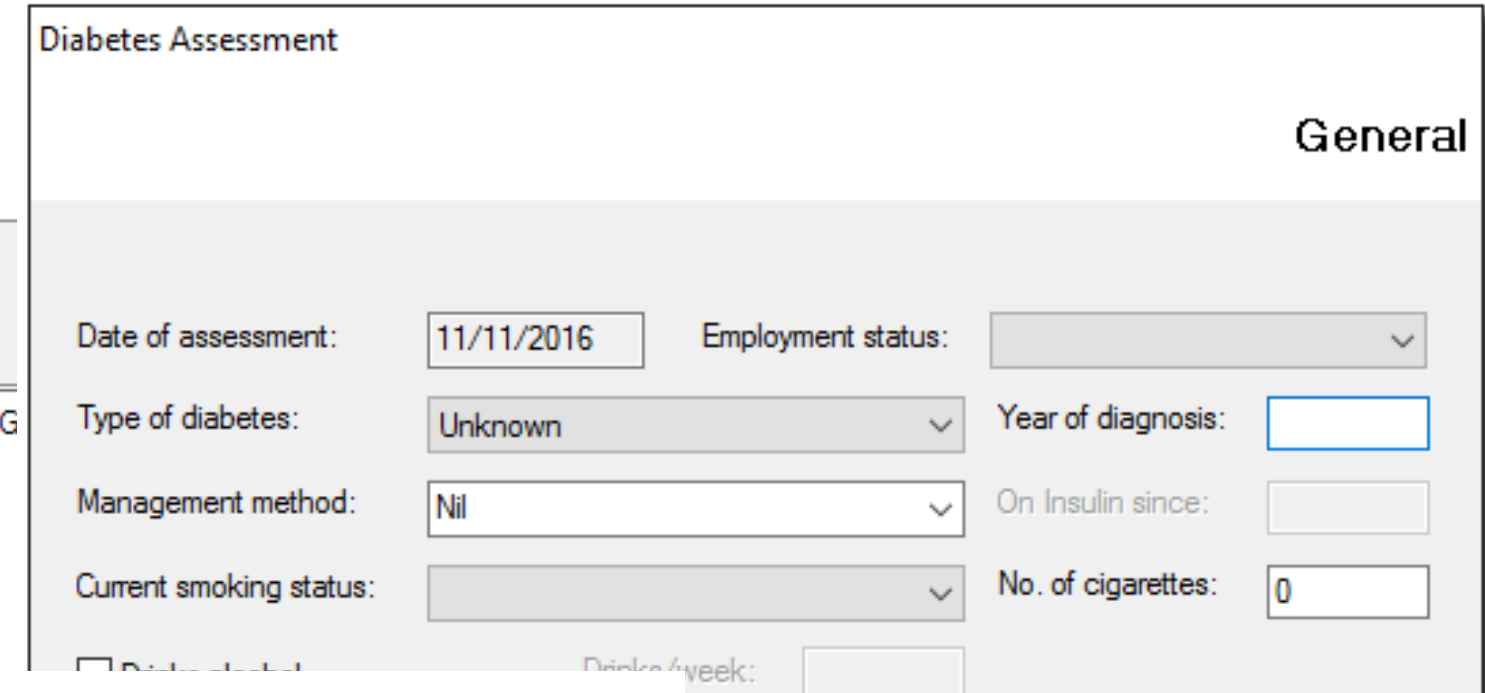
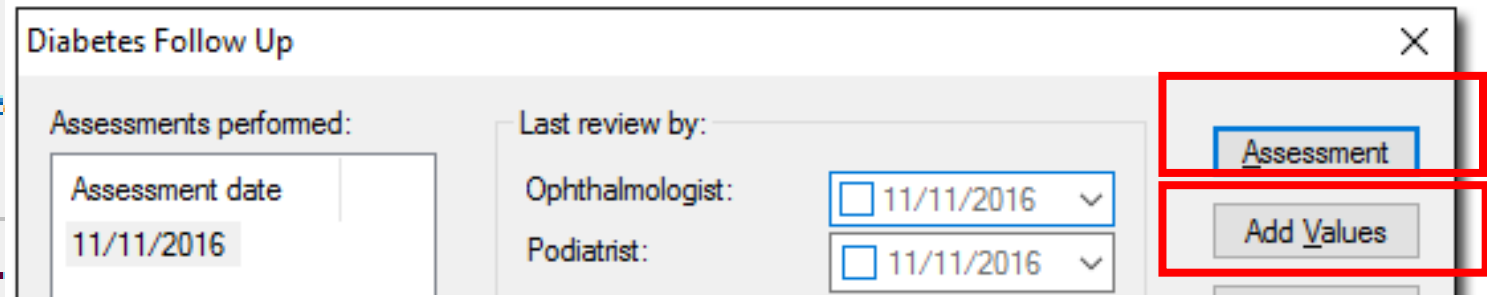
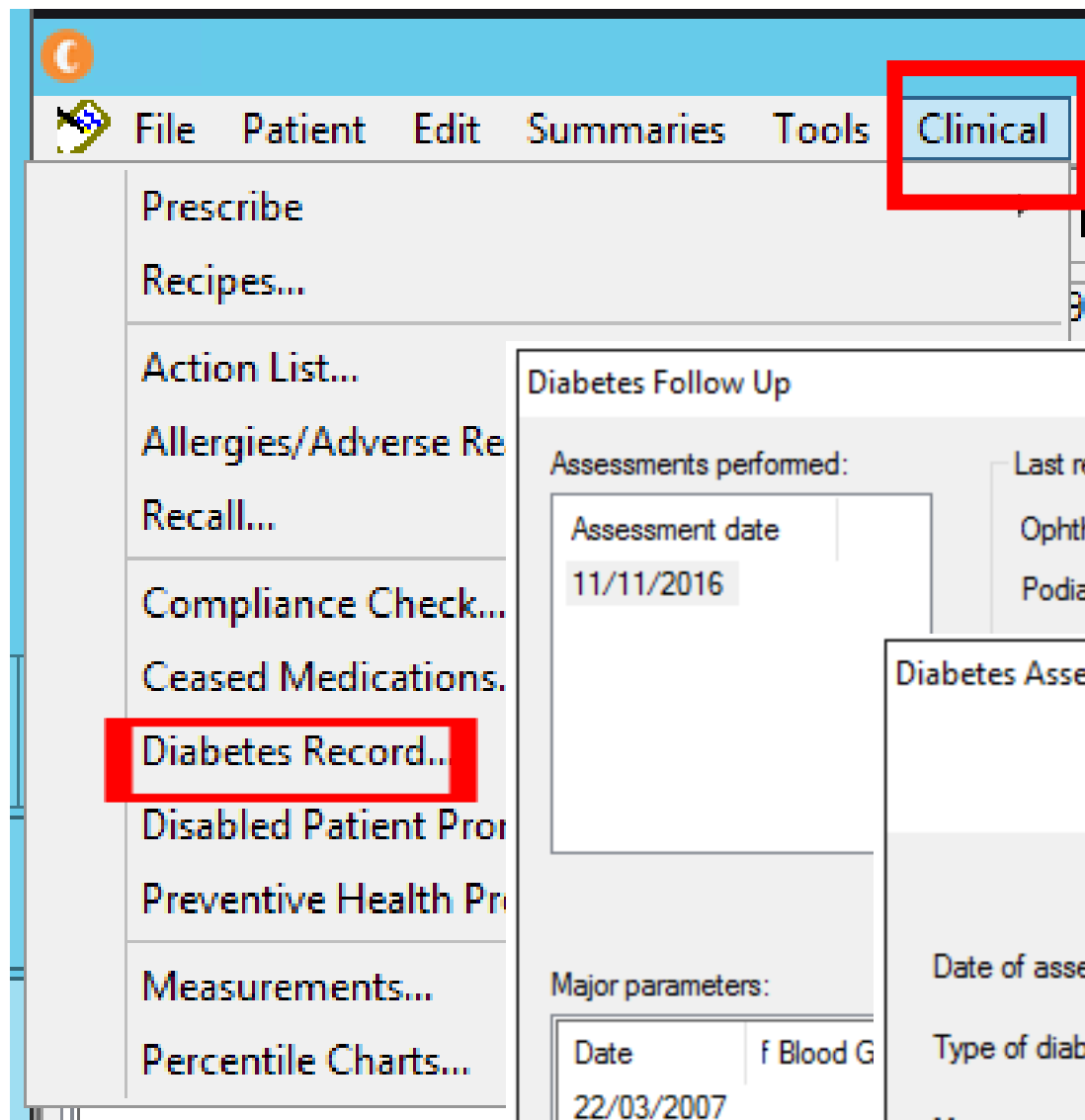
Medical Director. Diabetes Register Searches. [Online].; n.d. [cited 2023 July 11. Available from: https://www.medicaldirector.com/help/index.htm#t=topics-clinical%2FDiabetes_Register_Searches.htm.

Best Practice. Diabetes Register. [Online].; 2020 [cited 2023 July 11. Available from: <https://kb.bpssoftware.net/bppremier/saffron/Clinical/Diabetes/DiabetesRegister.htm?Highlight=diabetes>.

Medical Director Diabetes Record and Assessment

Diabetes Record
x 6 Assessment pages

Add Missing Values and dates



Medical Director. Diabetes Register Searches. [Online].; n.d. [cited 2023 July 11. Available from: https://www.medicaldirector.com/help/index.htm#t=topics-clinical%2FDiabetes_Register_Searches.htm.

Best Practice - Diabetes Cycle of Care

- Enhanced Primary Care
- ADF Post Discharge GP
- Health assessments
- Medication reviews**
- Care plans
- Diabetes Cycle of Care**
- Dementia Assessment

Diabetes Cycle of Care X

Every 6 months:

Date	BP	Weight	Height	BMI

Foot examination:

Date	Deformity (R)	Ulcers (R)	Neuropathy (R)	Pulses (R)

Every 12 - 24 months:

Fundus examination:

Date	Right

Investigations every 12 - 24 months:

Date	HbA1C	Cholesterol	HDL	LDL

Last visit to:

Endocrinologist:	<input type="text"/>	<input type="text"/>
Ophthalmologist:	<input type="text"/>	<input type="text"/>
Diabetes Educator:	<input type="text"/>	<input type="text"/>

Date that the last cycle of care was completed: Next review date: 5/10/2022 Send reminder

Add New Values

Diabetes Cycle of Care X

Observations: 5/07/2022 BP: / Weight: Height: Waist: BSL: Fasting

Foot examination: 5/07/2022

Right: Deformity <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcer <input type="checkbox"/> Yes <input type="checkbox"/> No Neuropathy <input type="checkbox"/> Yes <input type="checkbox"/> No Pulses <input type="checkbox"/> Present <input type="checkbox"/> Absent	Left: Deformity <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcer <input type="checkbox"/> Yes <input type="checkbox"/> No Neuropathy <input type="checkbox"/> Yes <input type="checkbox"/> No Pulses <input type="checkbox"/> Present <input type="checkbox"/> Absent
--	---

Fundus examination: 5/07/2022

Right: Left:

Investigations:

HbA1C: <input type="text"/> <input type="checkbox"/> 5/07/2022 <input type="text"/> mmol/mol	<input type="button" value="All same date"/>	<input type="button" value="Lookup tx"/>
Total Cholesterol: <input type="text"/> <input type="checkbox"/> 5/07/2022	Triglycerides: <input type="text"/> <input type="checkbox"/> 5/07/2022	
HDL Cholesterol: <input type="text"/> <input type="checkbox"/> 5/07/2022	LDL Cholesterol: <input type="text"/> <input type="checkbox"/> 5/07/2022	
Creatinine: <input type="text"/> <input type="checkbox"/> 5/07/2022	eGFR: <input type="text"/> <input type="checkbox"/> 5/07/2022	
Albumin/Creatinine ratio: <input type="text"/> <input type="checkbox"/> 5/07/2022		
Micro-albuminuria: <input type="text"/> <input type="checkbox"/> 5/07/2022 <input type="text"/> mcg/min		

Last visit to:

Endocrinologist: <input type="checkbox"/> 5/07/2022 <input type="text"/>	Dietitian: <input type="checkbox"/> 5/07/2022 <input type="text"/>
Ophthalmologist: <input type="checkbox"/> 5/07/2022 <input type="text"/>	Podiatrist: <input type="checkbox"/> 5/07/2022 <input type="text"/>
Diabetes Educator: <input type="checkbox"/> 5/07/2022 <input type="text"/>	

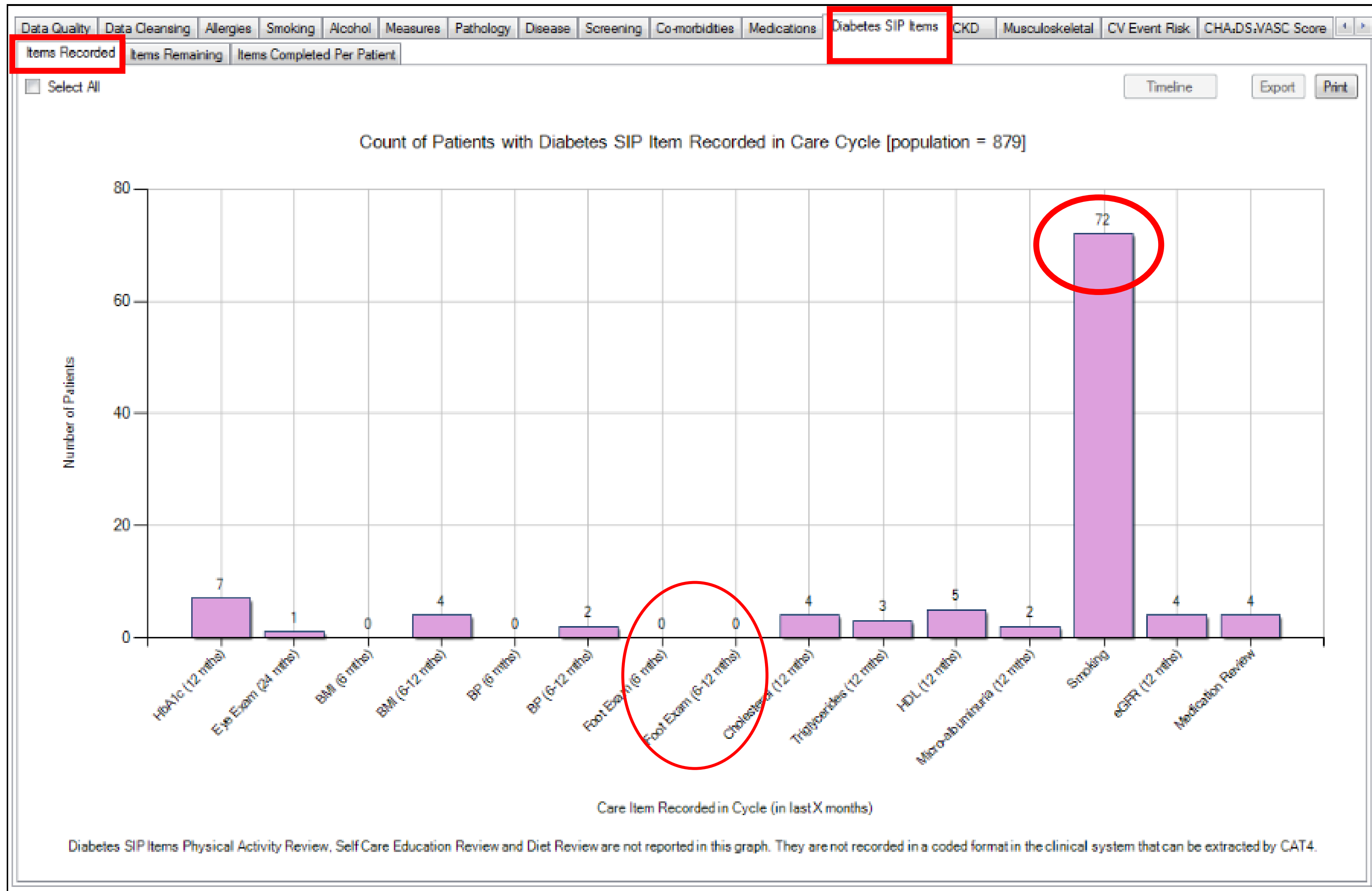
Best Practice. Diabetes Register. [Online].; 2020 [cited 2023 July 11. Available from: <https://kb.bppsoftware.net/bppremier/saffron/Clinical/Diabetes/DiabetesRegister.htm?Highlight=diabetes>.

CAT4

Practice-level

Diabetes Cycle of Care (SIP) Items Recorded Across Practice

Strengths & Opportunities



PenCS. Diabetes SIP (Service Incentive Payments) Items. [Online].; 2017 [cited 2023 July 11. Available from: <https://help.penCS.com.au/display/CG/Diabetes+SIP+%28Service+Incentive+Payment%29+Items>.

CAT4

Reidentify patients

Diabetes CoC
Items Completed
Per Patient

**Patients with
almost complete
Diabetes Cycle of
Care**

**Hot Tip: Start at
the right of chart!**



PenCS. Diabetes SIP (Service Incentive Payments) Items. [Online].; 2017 [cited 2023 July 11].

Available from:

<https://help.pencs.com.au/display/CG/Diabetes+SIP+%28Service+Incentive+Payment%29+Items>.

Item	Best Practice Mapping
HbA1c	Patient Record > Main Patient screen > Enhanced Primary Care > Diabetes Cycle of Care screen. OR Pathology HL7 results OR manually entered result OR Additional test name 'Blood haemoglobin A 1 c'
Eye Exam	Enhanced Primary Care > Diabetes Cycle of Care
BMI	Observations
Waist	Observations Or Enhanced Primary Care > Diabetes Cycle of Care
BSLF	Observations screen OR Enhanced Primary Care > Diabetes Cycle of Care screen. OR Pathology HL7 results with LOINC codes 14771-0, 14996-3
BP	Observations Or Enhanced Primary Care > Diabetes Cycle of Care
Foot Exam	Enhanced Primary Care > Diabetes Cycle of Care
Cholesterol	Enhanced Primary Care > Diabetes Cycle of Care OR Pathology HL7 results
Triglycerides	Enhanced Primary Care > Diabetes Cycle of Care OR Pathology HL7 results
HDL	Enhanced Primary Care > Diabetes Cycle of Care OR Pathology HL7 results
Microalbuminuria	Enhanced Primary Care > Diabetes Cycle of Care OR Pathology HL7 results This indicator uses both the Microalbumin and/or the ACR test results
Smoking	Open > Alcohol and Smoking History > Tobacco
eGFR	Enhanced Primary Care > Diabetes Cycle of Care OR Pathology HL7 results
Medication Review	Enhanced Primary Care > Medication Reviews

pencs

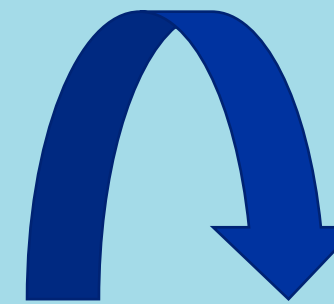
CAT4

Diabetes Cycle of Care items

Mapping to data location within Practice Clinical Information System (BP,MD, etc.)

PenCS. Diabetes SIP Mappings with clinical systems. [Online].; 2017 [cited 2023 July 11. Available from: <https://help.pencs.com.au/display/CG/Diabetes+SIP+Mappings+with+clinical+systems>.

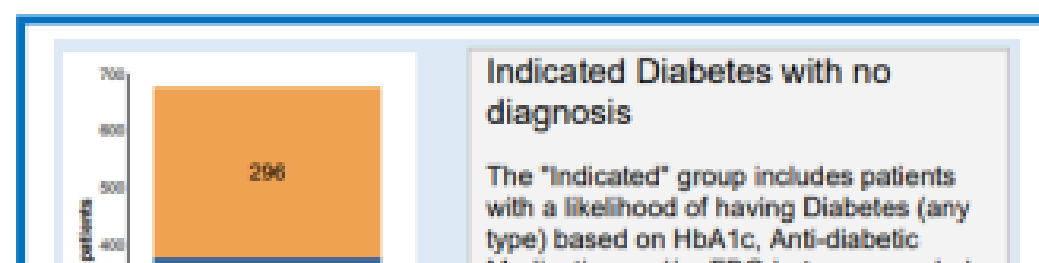
QUALITY IMPROVEMENT ACTIVITIES X 4 QUARTERS 1 YEAR



Quality Improvement Scenario 1: Patients Indicated Diabetes with No Diagnosis

A Practice's Data Dashboard example provided by HNECCPHN (based on PenCS CAT4 data) indicates that 296 patients are indicated as likely or possible to have diabetes, but do not have a coded diagnosis. Patients who have diabetes may not appear in lists, be searchable, nor be communicated in health summaries. Opportunities for patient care and practice sustainability may be missed.

Requirement:
eHealth PIP Requirement 3 is:
"Practices must ensure that where clinically relevant, they are working"



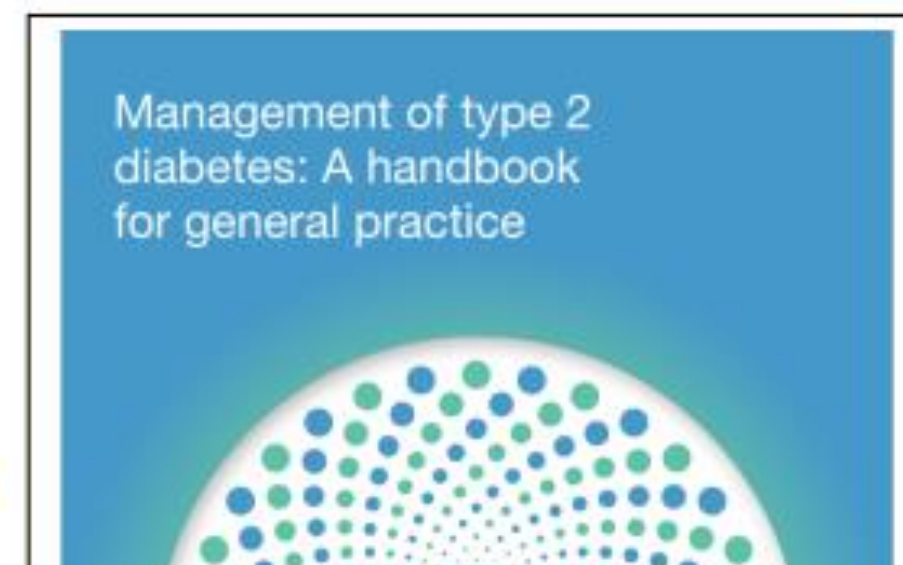
Quality Improvement Scenario 2: Chronic Disease Management

Using **Chronic Disease Management** enablers assists practice health professionals to provide appropriate care to patients. **Medical Benefit Schedule (MBS) Attendances** such as GP Management Plan (GPMP), Team Care Arrangement (TCA), Reviews of both, and Allied Health Consultations are beneficial to a patient's management of Diabetes. A GPMP provides the

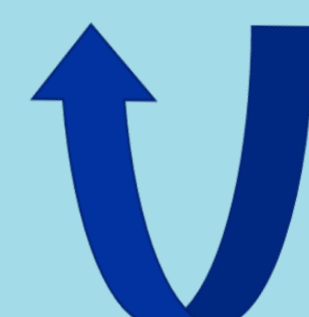


Quality Improvement Scenario 4: Diabetes Cycle of Care completion

Evidence-based care guidelines state that a **Diabetes Cycle of Care** should be completed every year. [Management-of-type-2-diabetes-A-handbook-for-general-practice.aspx](http://www.racgp.org.au/management-of-type-2-diabetes-A-handbook-for-general-practice.aspx) (racgp.org.au)



Your practice's **PenCS CAT4** tool can determine the number of patients remaining eligible for an annual diabetes cycle of care. [Identify patients eligible for an Annual Diabetes Cycle of Care - CAT Recipes - PenCS Help](#)



Quality Improvement Scenario 3: Diabetes Register in CIS




While looking at the **Diabetes Register list of all patients diagnosed with diabetes** in the Practice's clinical system, the Practice Nurse notices that there are patients whose Diabetes Cycle of Care is overdue (**red font-MD**), or without a completion date or a completion date more than 12 months ago (**BP**).

Medical Director Clinical Front Screen < Search < Diabetes Register

Name	Phone Home	Phone Work	Phone Mobile	Last visit	HbA1c	Eye exam	Foot exam	Height	Weight	BP	Lipids	Microalbumin	Diabetes recall	Diabetes assessment
ANDERSON, DAVID				12/04/2021		22/05/2011	18/02/2013	08/04/2021	08/04/2021	08/04/2021	16/06/2012		18/02/2014	08/04/2021
ANDREWS, JOHN				03/12/2012	26/05/2012	12/12/1999	12/05/2012	26/05/2012	26/05/2012	26/05/2012	16/06/2012	12/05/2012		12/05/2012
WATLAND, HENRY				18/02/2013				12/07/2012	12/07/2012	12/07/2012	16/06/2012			

Select all Deselect all Summary Statistics Open patient Add Recall Print list Close


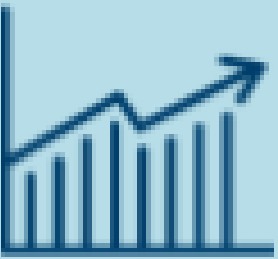

QUALITY IMPROVEMENT ACTIVITIES

Item	Action	Notes	Agreed
1	To improve screening and diagnosis of type 2 diabetes	1.1 Use AUSDIAB risk engine and selectively screen 1.2 Consider annual HbA1c testing with fasting BGL 1.3 OGTT though useful, for practical reasons uptake may be limited 1.4 Consider regular screening for Aboriginal and Torres Strait Islander people	
2	Consider identifying women of child bearing age and advise them of the importance of pre-conception planning and contraception	2.1 Do not use teratogenic medications prior to conceptions (most antihypertensive therapy except methyldopa, statins, oral hypoglycaemic agents except metformin should be stopped) 2.2 HbA1c should be <6-6.5% before conception and use folic acid 5mg daily from preconception till 12 weeks of gestation 2.3 Insulin therapy is strongly recommended to keep BGL in target (fasting BGL 4-5.5, 2HR post prandial <6.7mmol/l)	
3	Improve BMI recording and waist circumference measurement	3.1 Most practices enter weight but not height which means BMI is not calculated 3.2 Waist measurement helps to monitor overall metabolic profile	





QUARTERLY IMPROVEMENT MODEL – PLAN DO STUDY ACT

Hot Tip: Documentation useful for Accreditation and QI PIP.

The Thinking Part

	Goal <i>What are we trying to accomplish? SMARTA</i>
	Increase recording of Foot Check by 50% by Sept 2023
	Measure <i>How will we know that a change is an improvement?</i>
	Baseline: 1 August 2023 Re-measure: 30 Oct 2023 Numerator: Patients w/ T2DM without foot check Denominator: All Patients with Type 2 Diabetes Mellitus
	Idea <i>What can we do to achieve the goal?</i>
	1- Commence Nurse-led Diabetes clinic, Training in foot check 2- Keep CIS Diabetes Register up to date 3- Check with Allied Podiatrist and Correspondence-in

The Doing Part

Idea	
	Plan What? 2-Check/update Diabetes Register Who? Nurse Jane Where? Nurses Room PC When? Protected time Wed 12-1 What? Update Diabetes Register Predictions? Diabetes Register is updated by by 5
	Did <i>Was the plan executed? Any unexpected events or problems?</i> Yes, was executed as planned
	Study <i>Analysis of actions and data. Reflection on the results</i> Foot check recording increased by 25%
	Act <i>What will we take forward what is the next step or cycle?</i> Continue. Increase nurse time to second day.



HNE Diabetes Alliance Case Conferencing Program

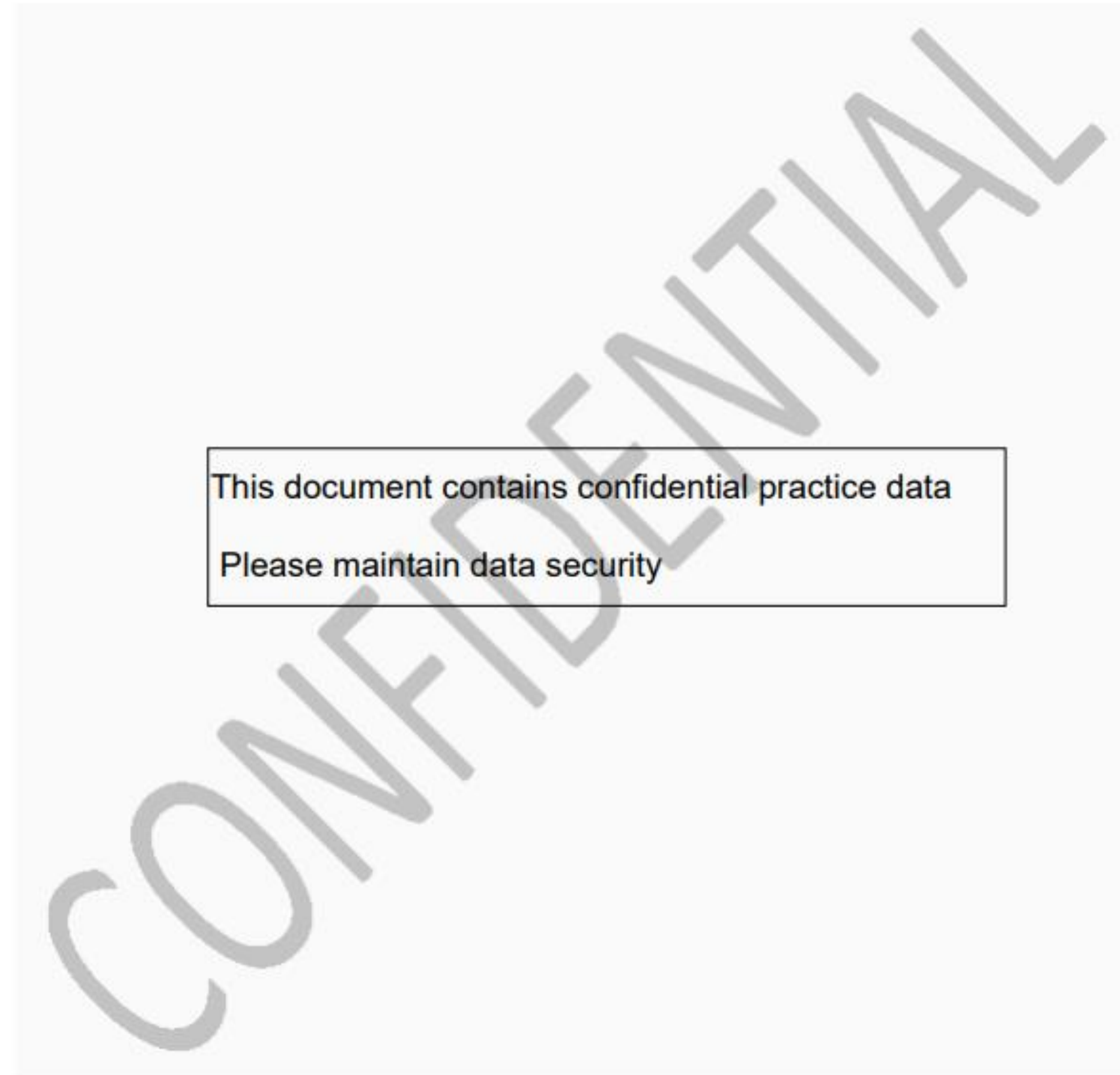
- Diabetes-specific Data Report
- Practice entries in Clinical Information System (CIS)
- Extracted by PenCS CAT4
- Interpretation by Endocrinologist at Diabetes Alliance Case Conferences
- Apply to Quality Improvement activities

This document contains confidential practice data

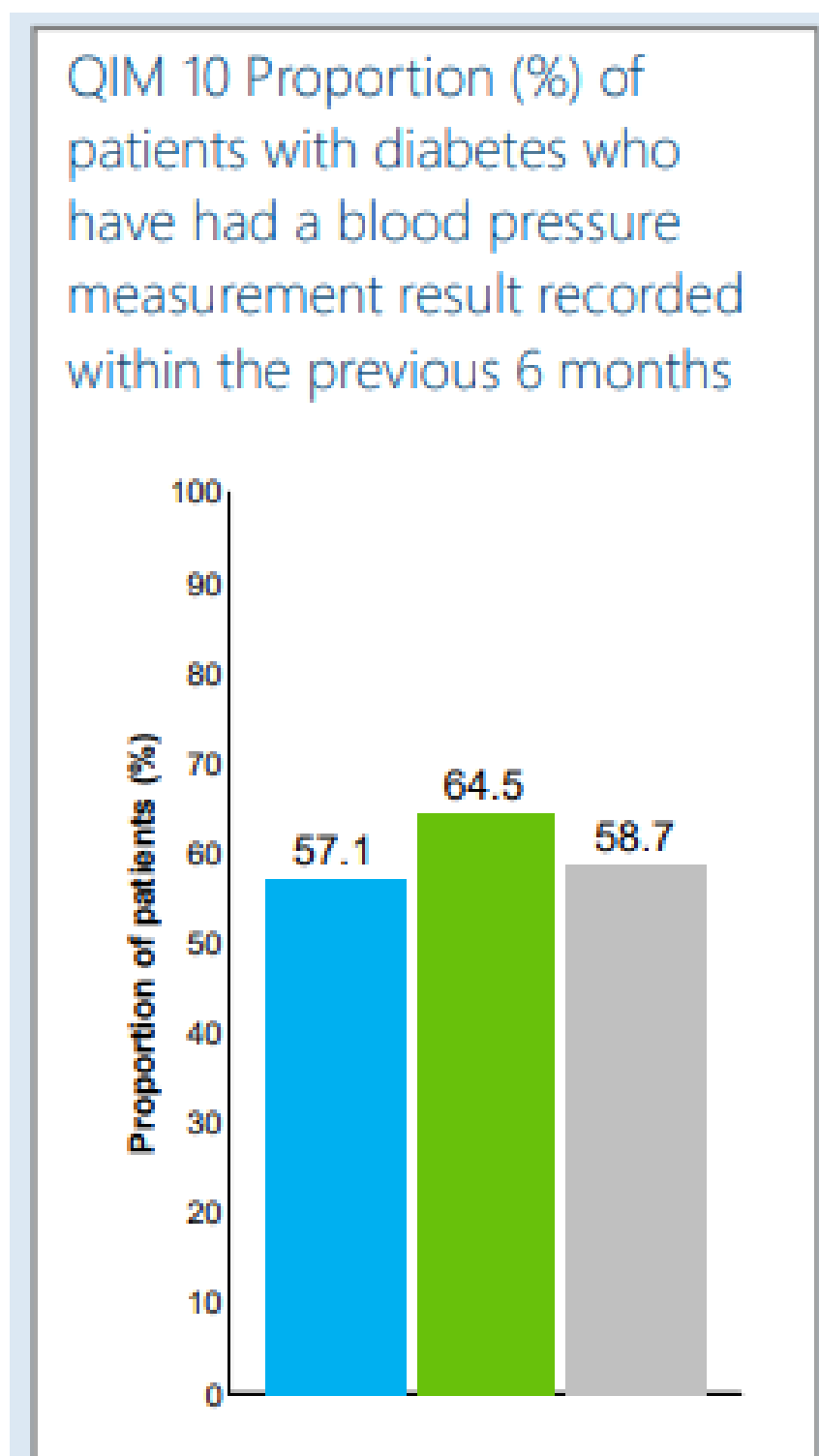
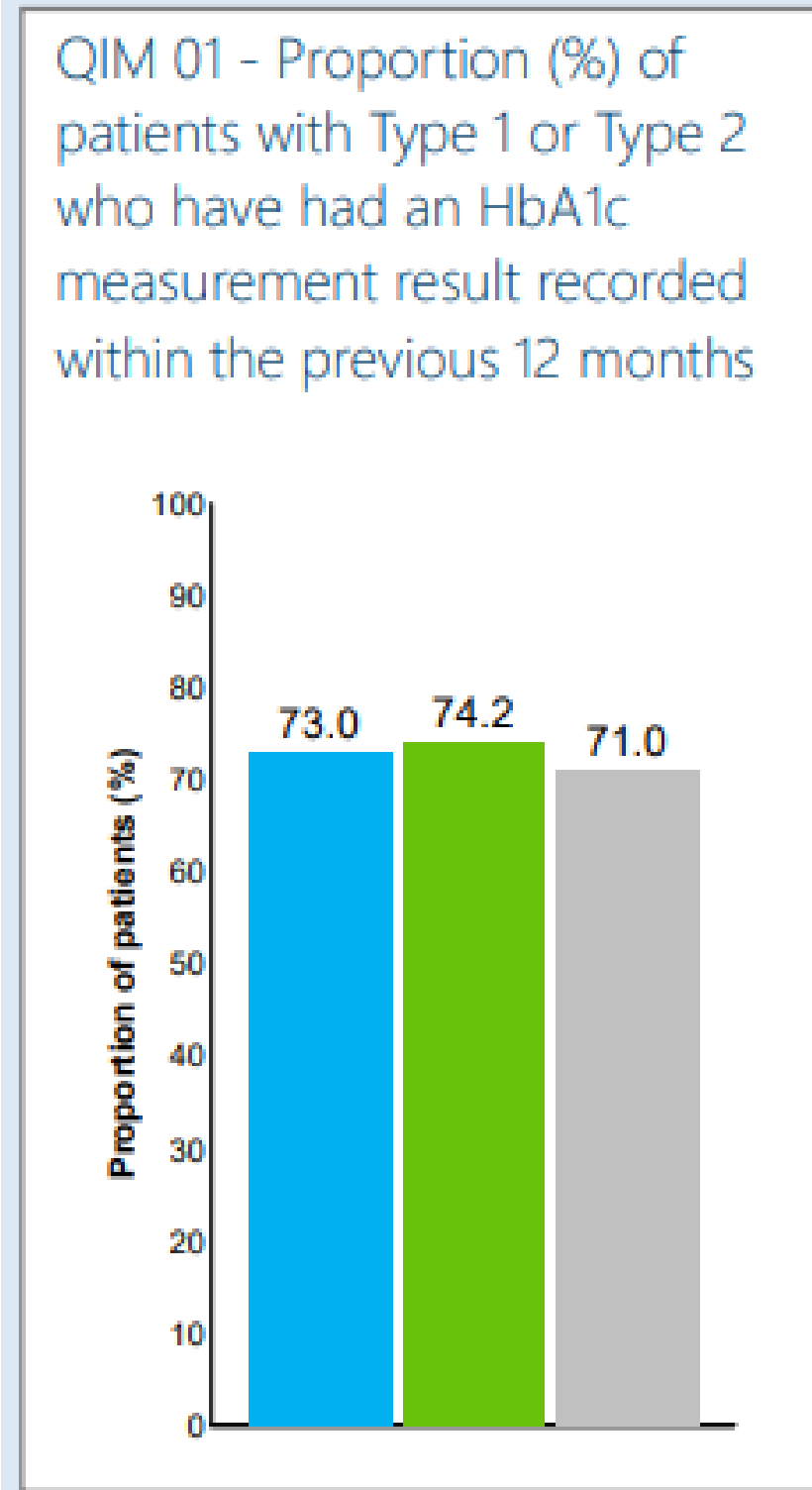
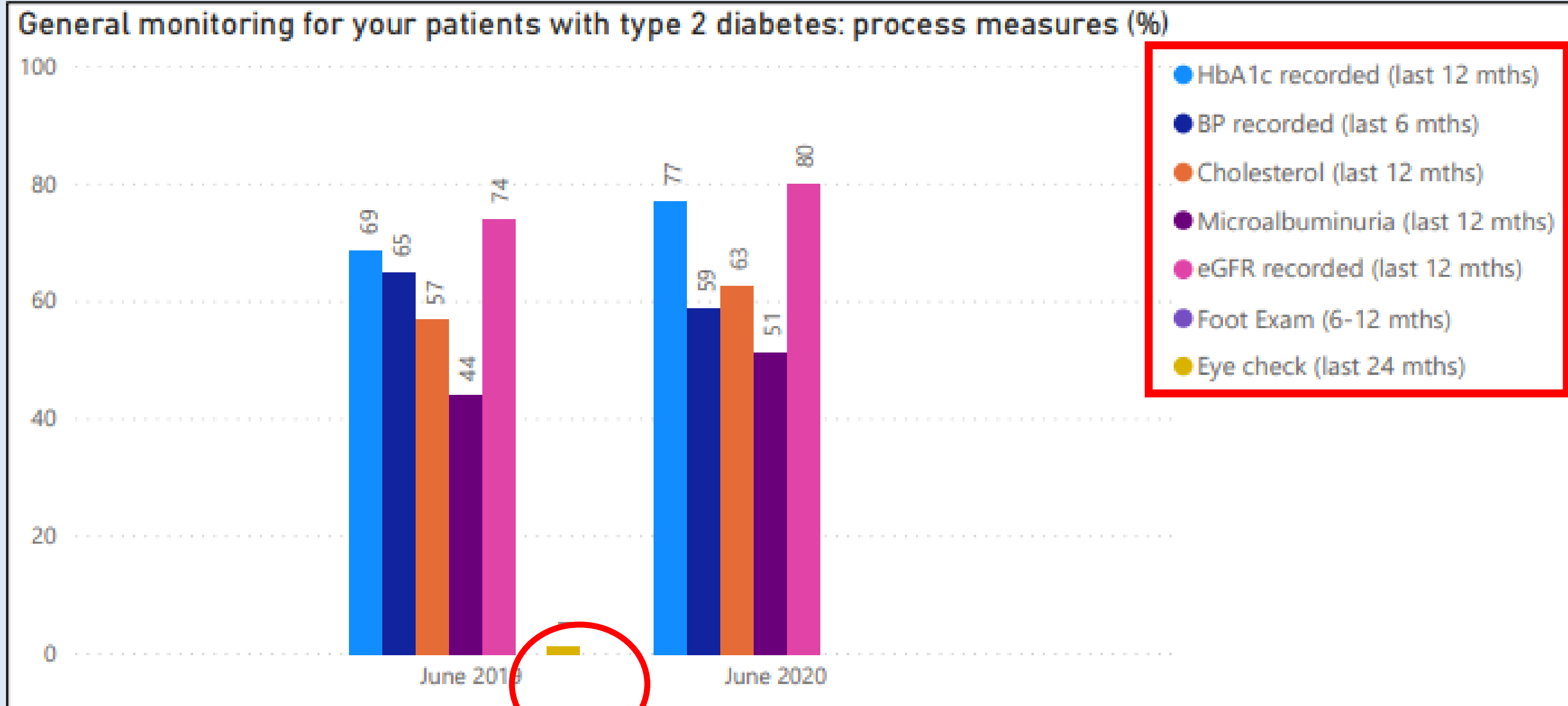
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The PHN General Practice Summary



Diabetes Cycle of Care (7 of 14 activities)



Process measures: all practices (%)

Period	HbA1c (<12 mths)	BP (<6 mths)	Cholesterol (<12 mths)	Microalbuminuria (<12 mths)	eGFR (<12 mths)	Foot exam (6-12 mths)	Eye check (<24 mths)
June 2019	73.8	68.2	68.4	51.0	76.5	15.0	23.8
June 2020	74.7	64.9	68.3	49.5	76.8	13.0	20.5

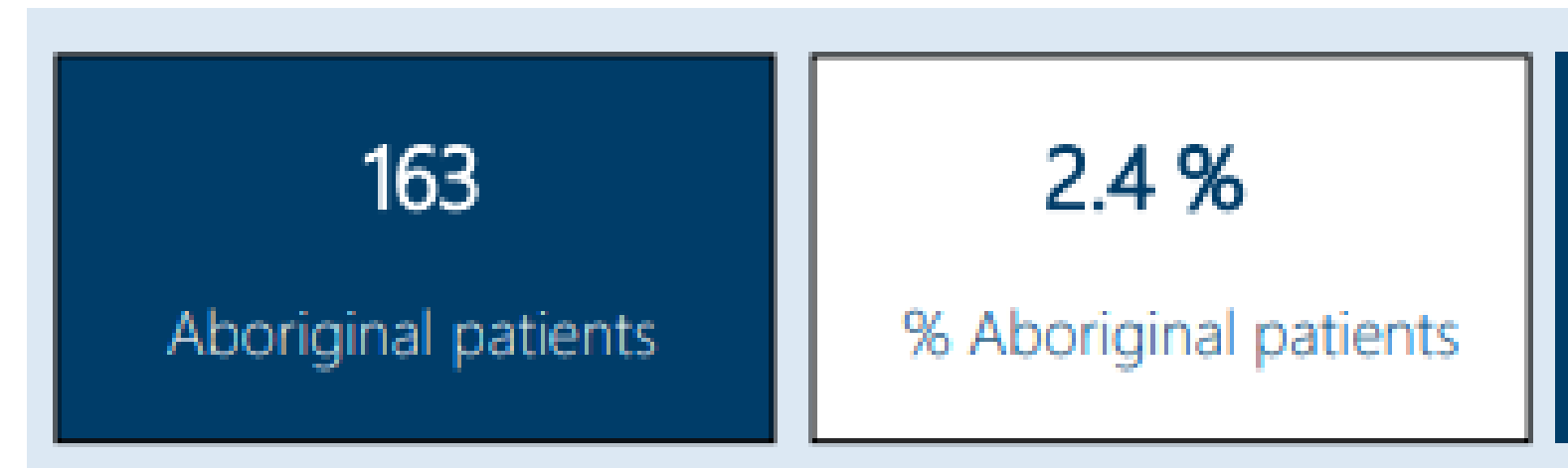
The PHN General Practice Summary

Hot Tip: Code Foot and Eye Checks as the Correspondence mail arrives.

HNE Diabetes Alliance Managing Type 2 Diabetes Summary Report



ETHNICITY



Active Aboriginal and Torres Strait Islander patients at your practice

Period	All Aboriginal patients**	Type 2 (including type 2 and 'undefined')	% of Aboriginal patients***	* all practices
June 2020	882	104	11.79	6.41
June 2019	993	98	9.87	6.37

ETHNICITY

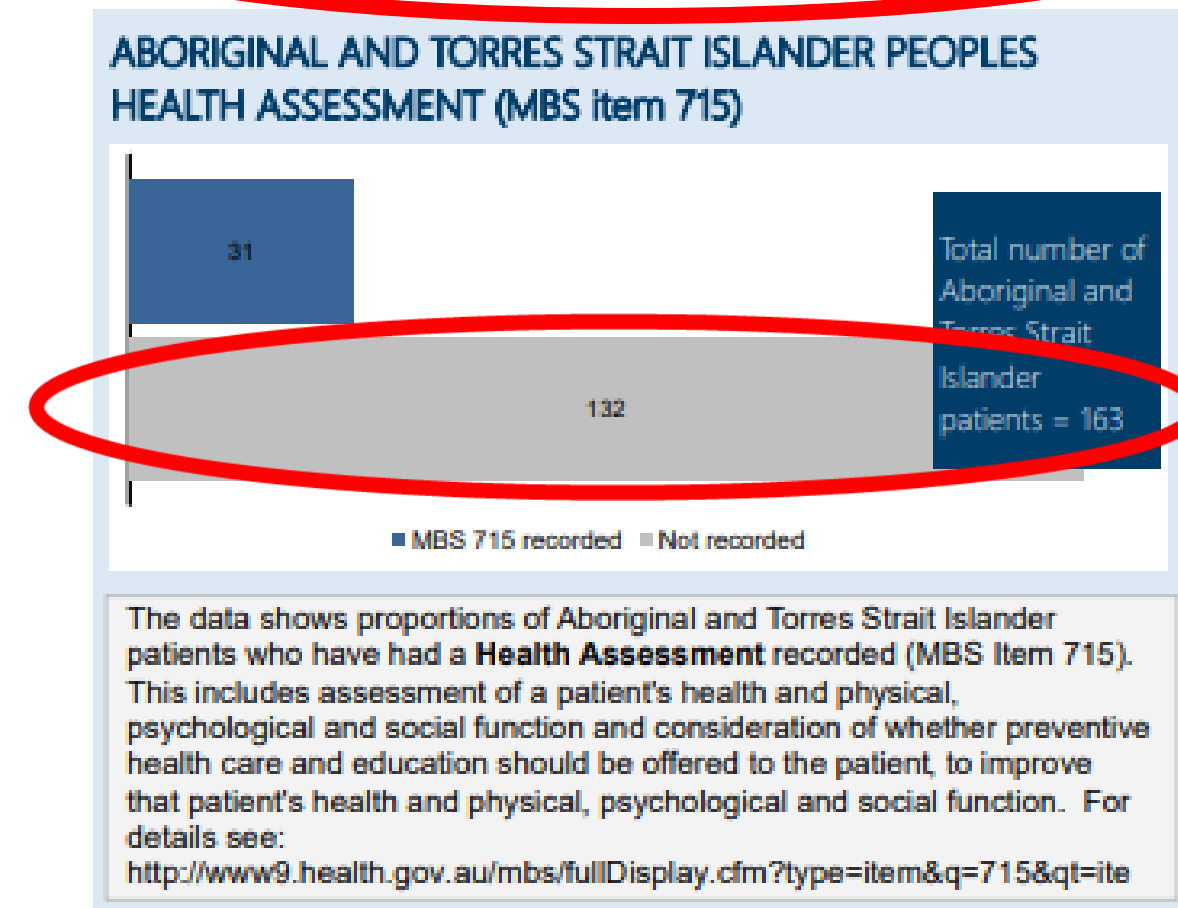
	Total patients	% of group
Indigenous	163	3.6 % **
Aboriginal	149	(91.4 %) *
Torres Strait Islander	4	(2.5 %) *
Aboriginal and Torres Strait Islander	10	(6.1 %) *
Non-Indigenous	6455	94.1 % **
Ethnicity not recorded	157	2.3 % **

HNE Diabetes Alliance Managing Type 2 Diabetes Summary Report

Hot Tip:

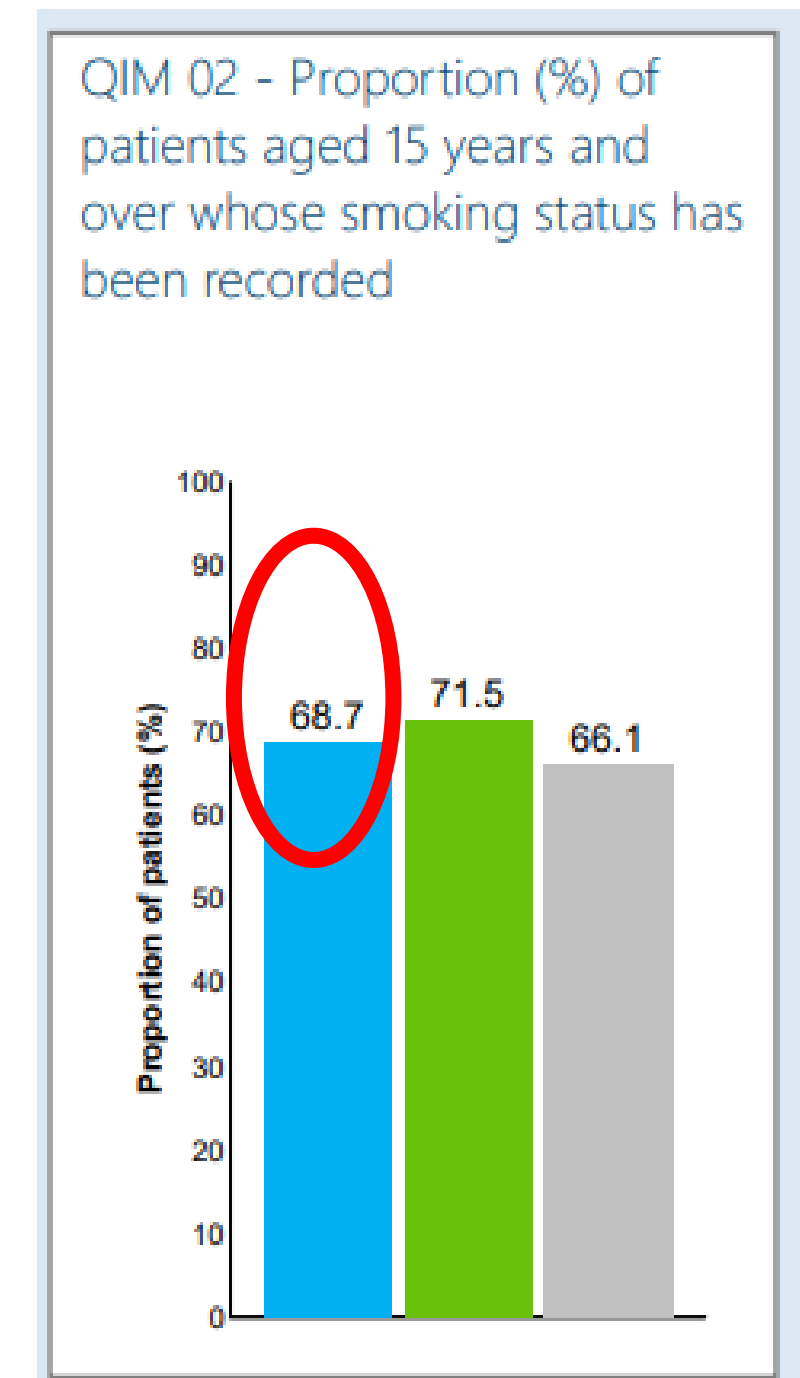
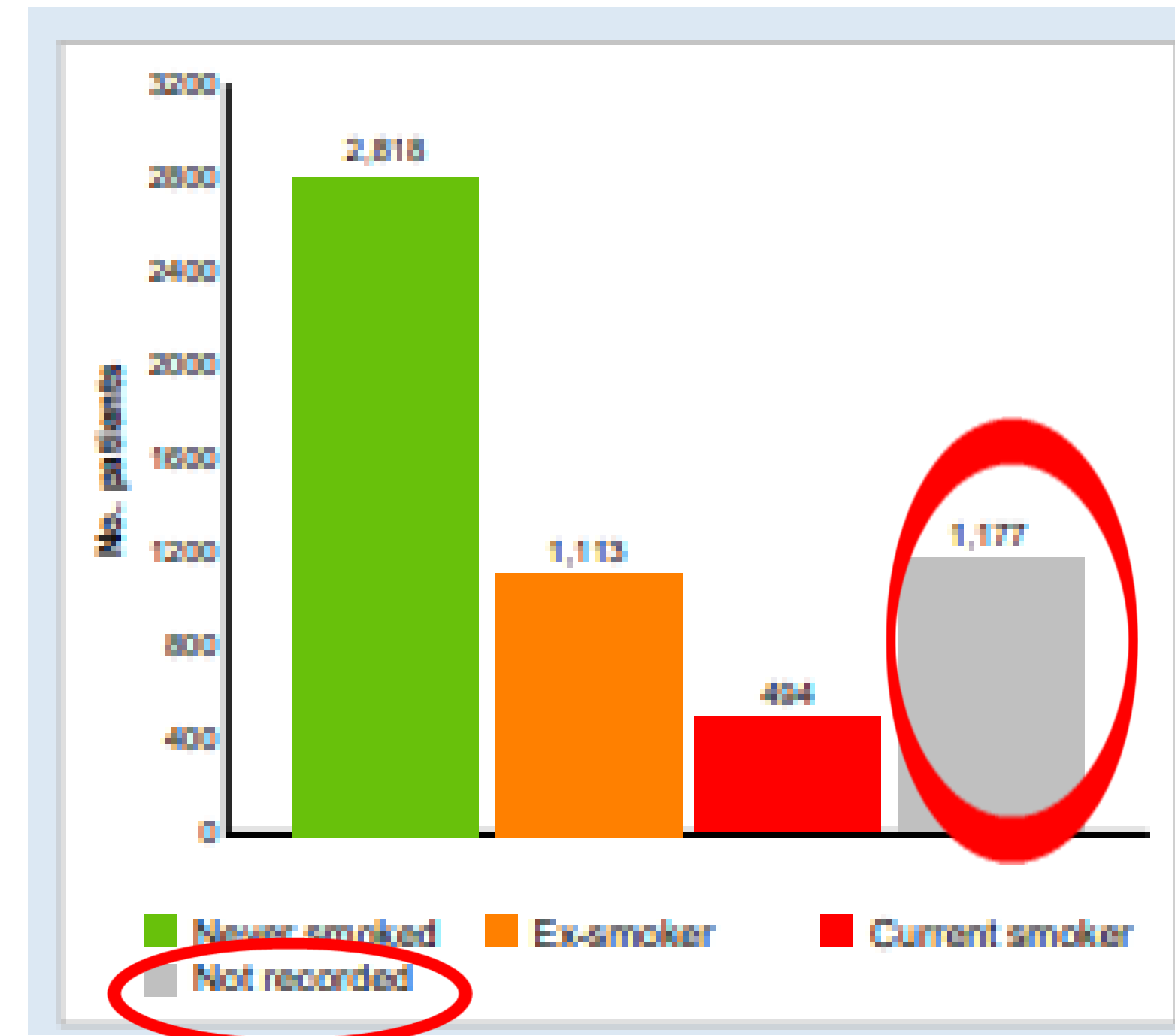
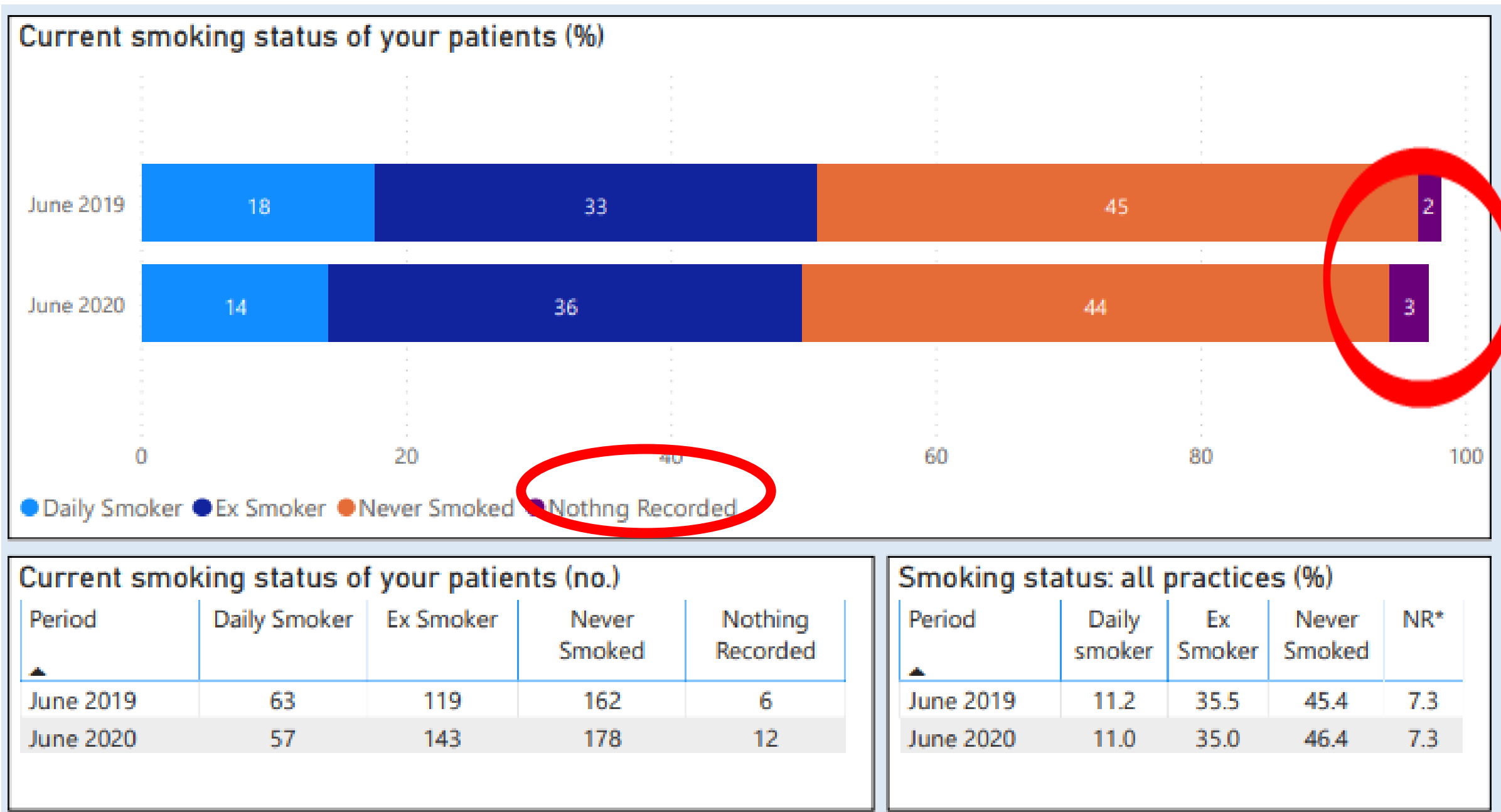
Increased risk of Diabetes in First Nations population.

Screening is important via AUSDRISK, 715 Health Assessment



The PHN General Practice Summary

SMOKING

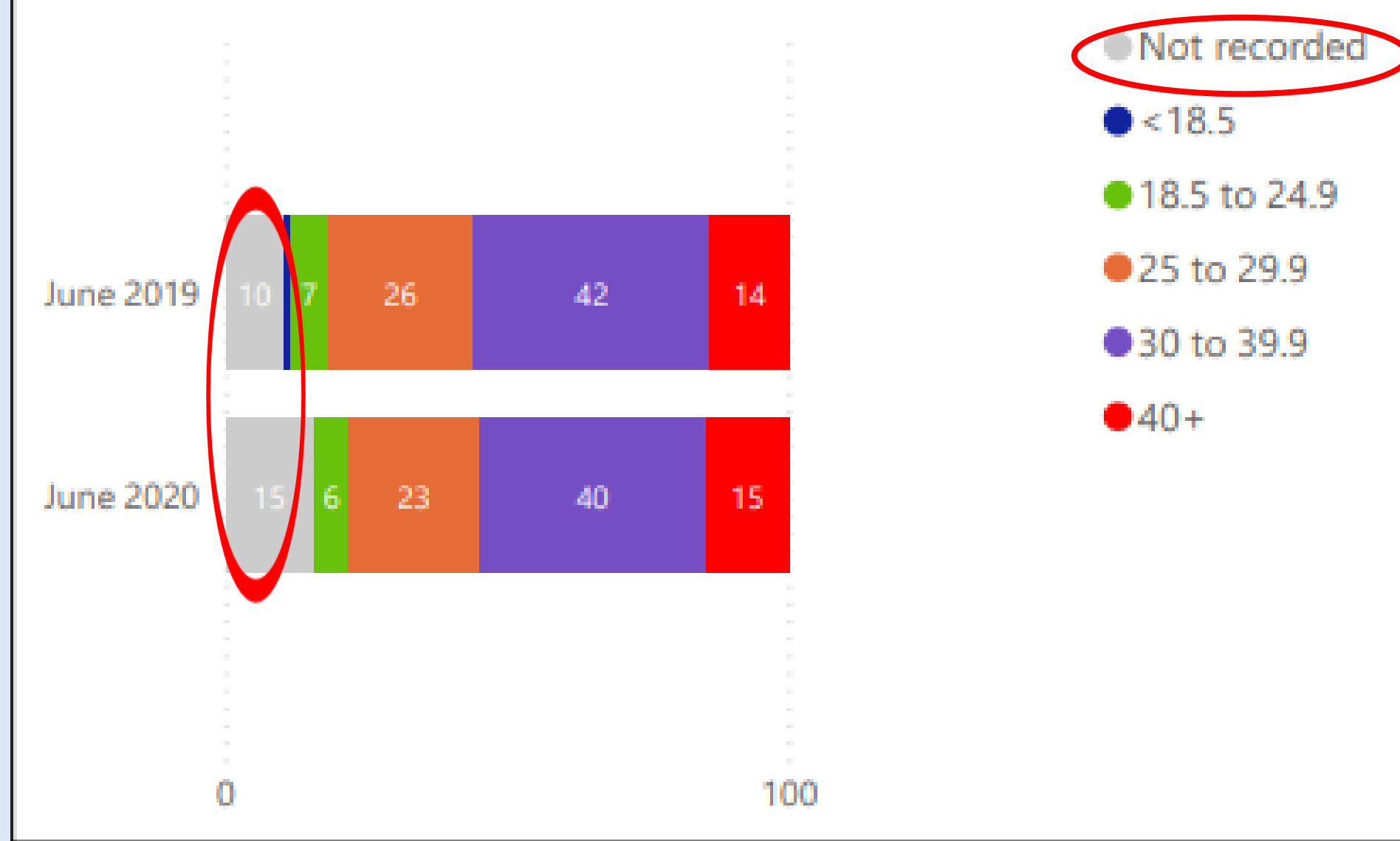


HNE Diabetes Alliance Managing Type 2 Diabetes Summary Report

The PHN General Practice Summary

BMI

BMI (in kg/m²) of your patients with type 2 diabetes (%)

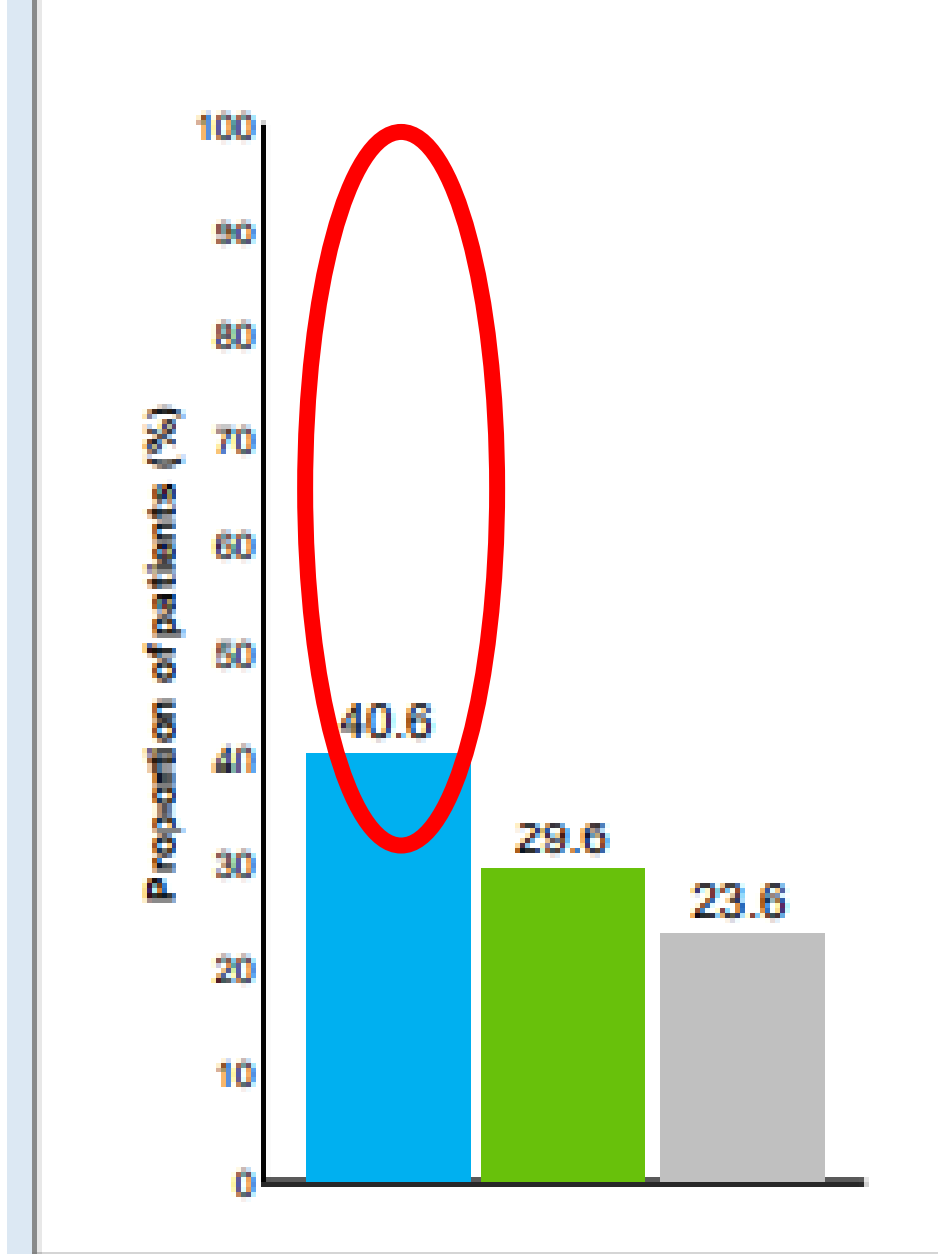


BMI (in kg/m²) of your patients (no.)

Period	<18.5	18.5-24.9	25-29.9	30-39.9	40+	Not recorded
June 2019	4	25	92	150	50	36
June 2020	2	23	94	160	60	62



QIM 03 - Proportion (%) of patients aged 15 years and over who have had their Body Mass Index (BMI) classified within the previous 12 months

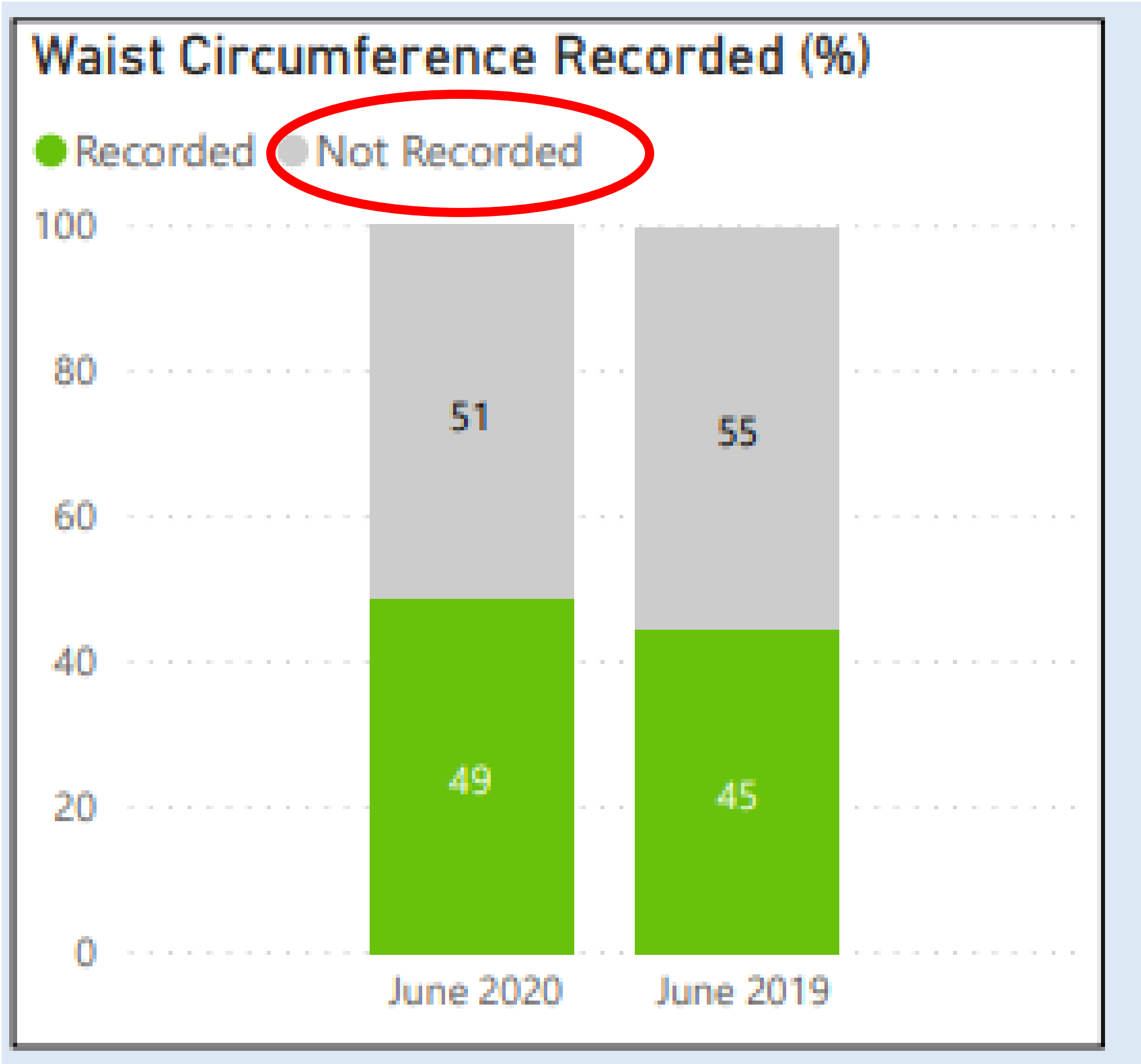


HNE Diabetes Alliance Managing Type 2 Diabetes Summary Report

The PHN General Practice Summary

WAIST CIRCUMFERENCE

Central adiposity indicates risk of CVD

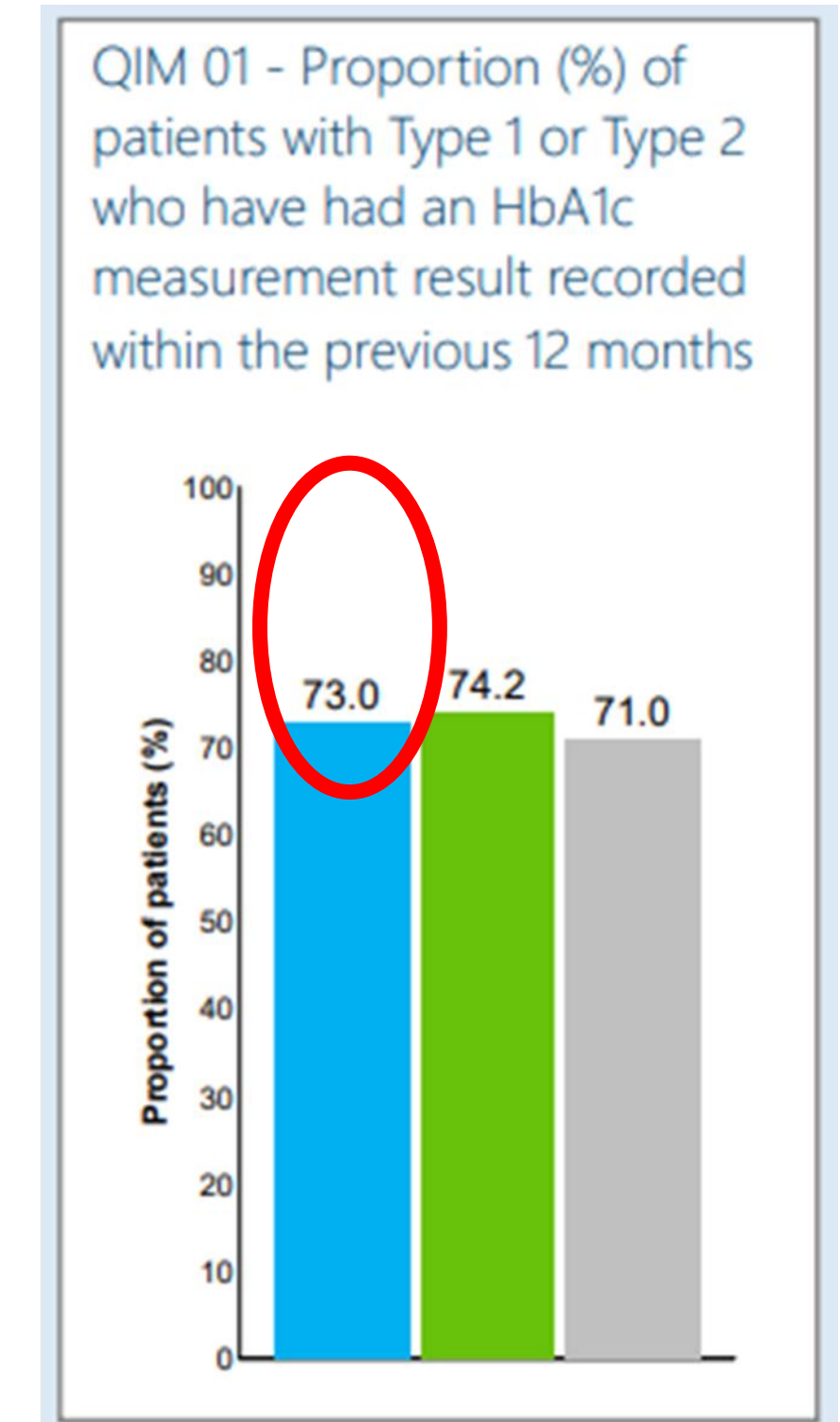
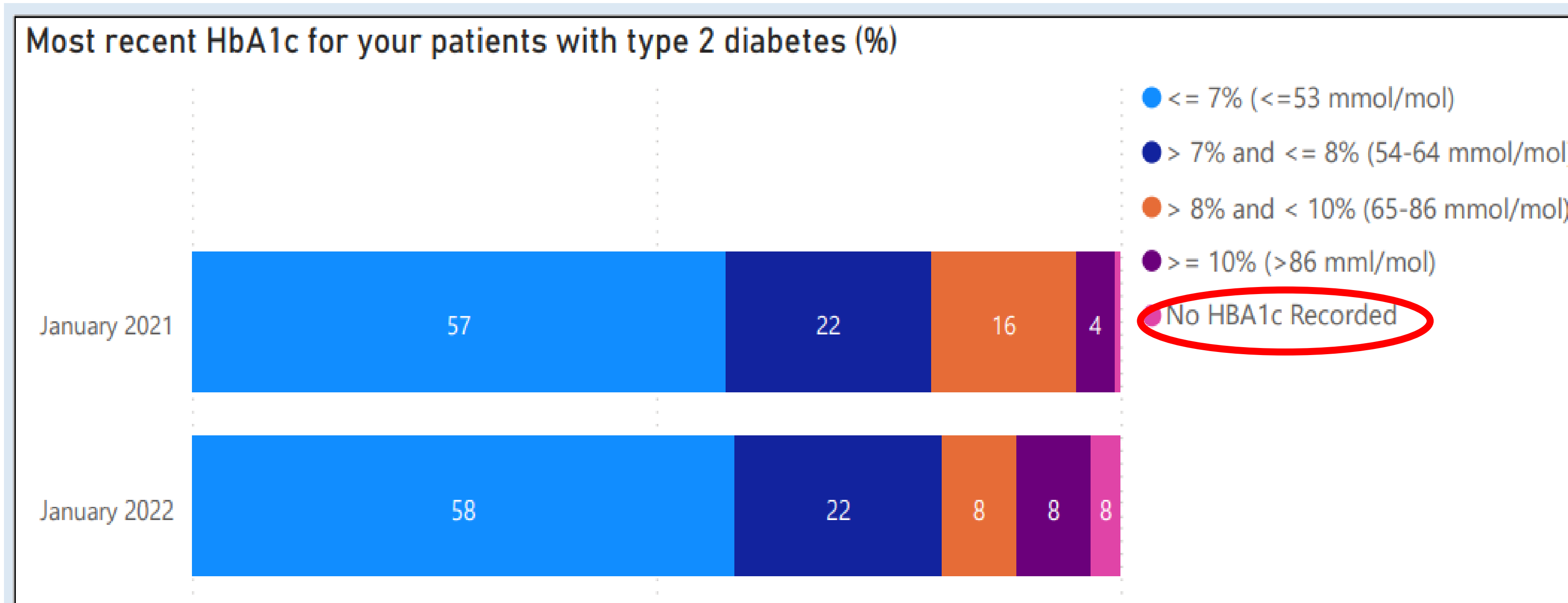


Hot Tip: Consider a practice blitz – every patient every time.

HNE Diabetes Alliance Managing Type 2 Diabetes Summary Report



PATHOLOGY - HbA1c



HNE Diabetes Alliance Managing Type 2 Diabetes Summary Report

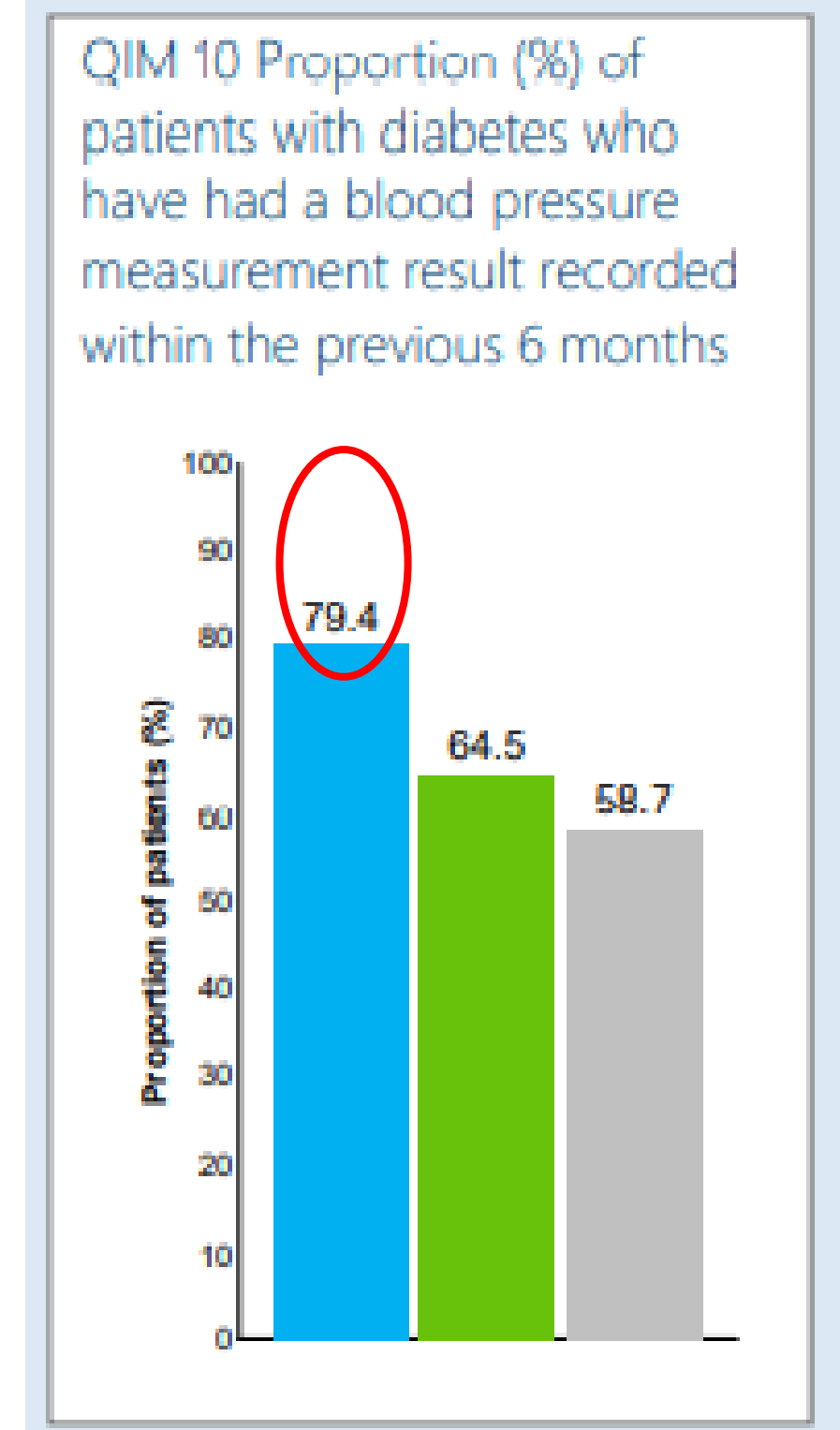
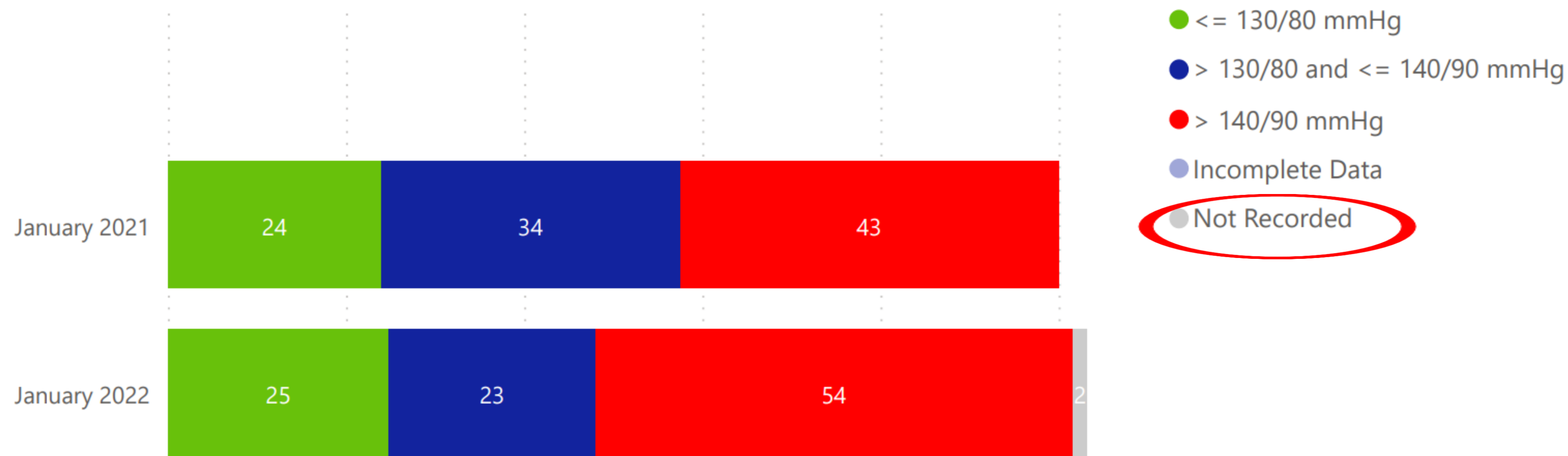
The PHN General Practice Summary

Hot Tip:
Consider prescribing after HbA1c attended.



Blood Pressure Recording

Most recent BP ranges for your patients with type 2 diabetes (%)



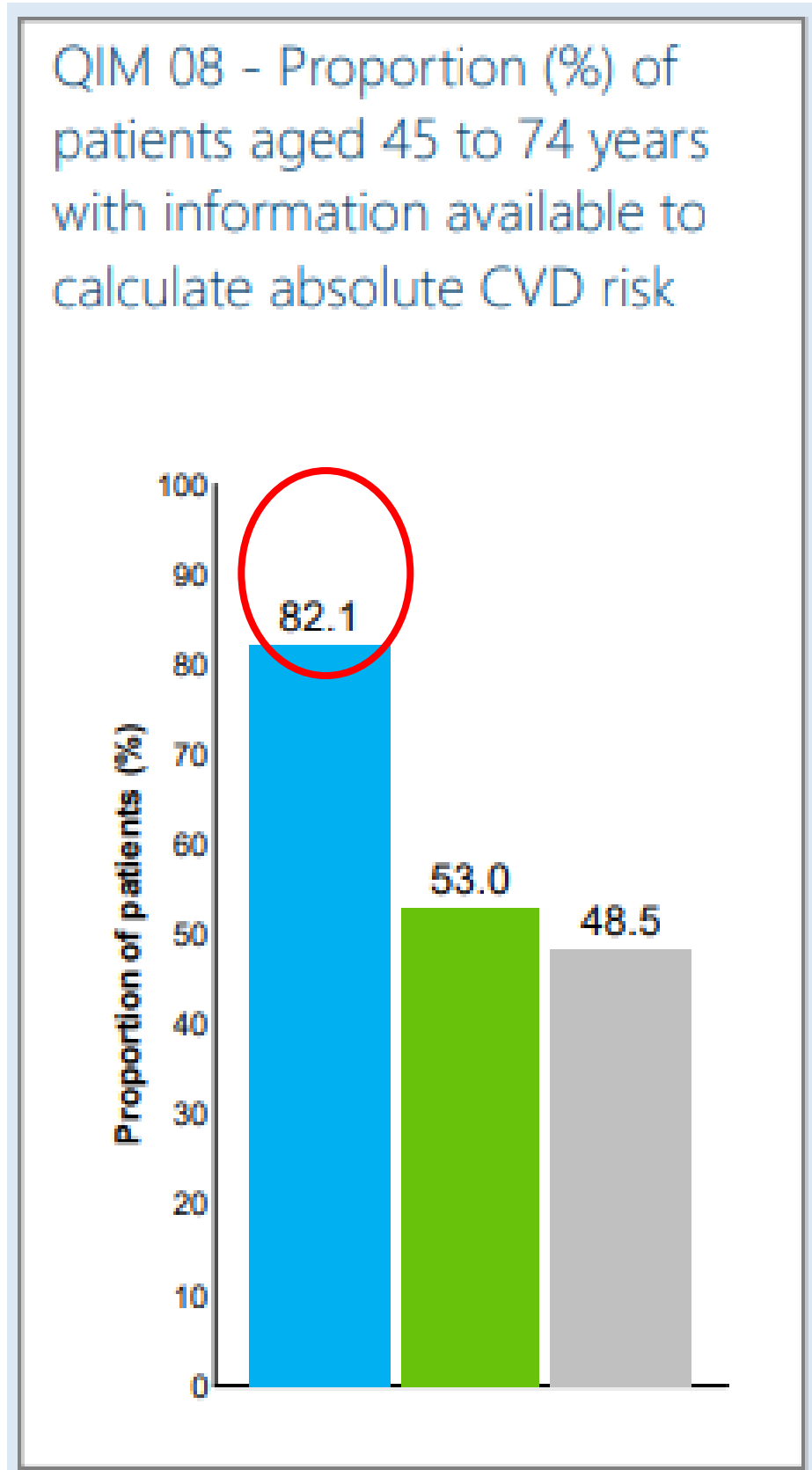
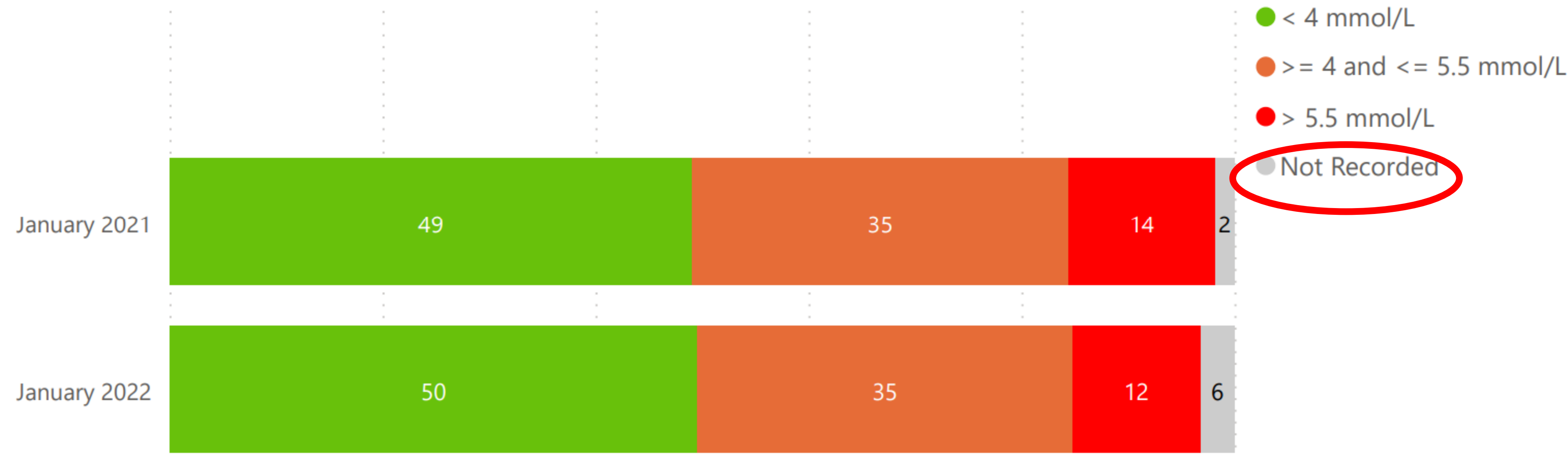
HNE Diabetes Alliance Managing Type 2 Diabetes Summary Report

Hot Tip: Code in Observations field, not just progress notes.



Cholesterol Results

Most recent cholesterol ranges for your patients with type 2 diabetes (%)



HNE Diabetes Alliance Managing Type 2 Diabetes Summary Report

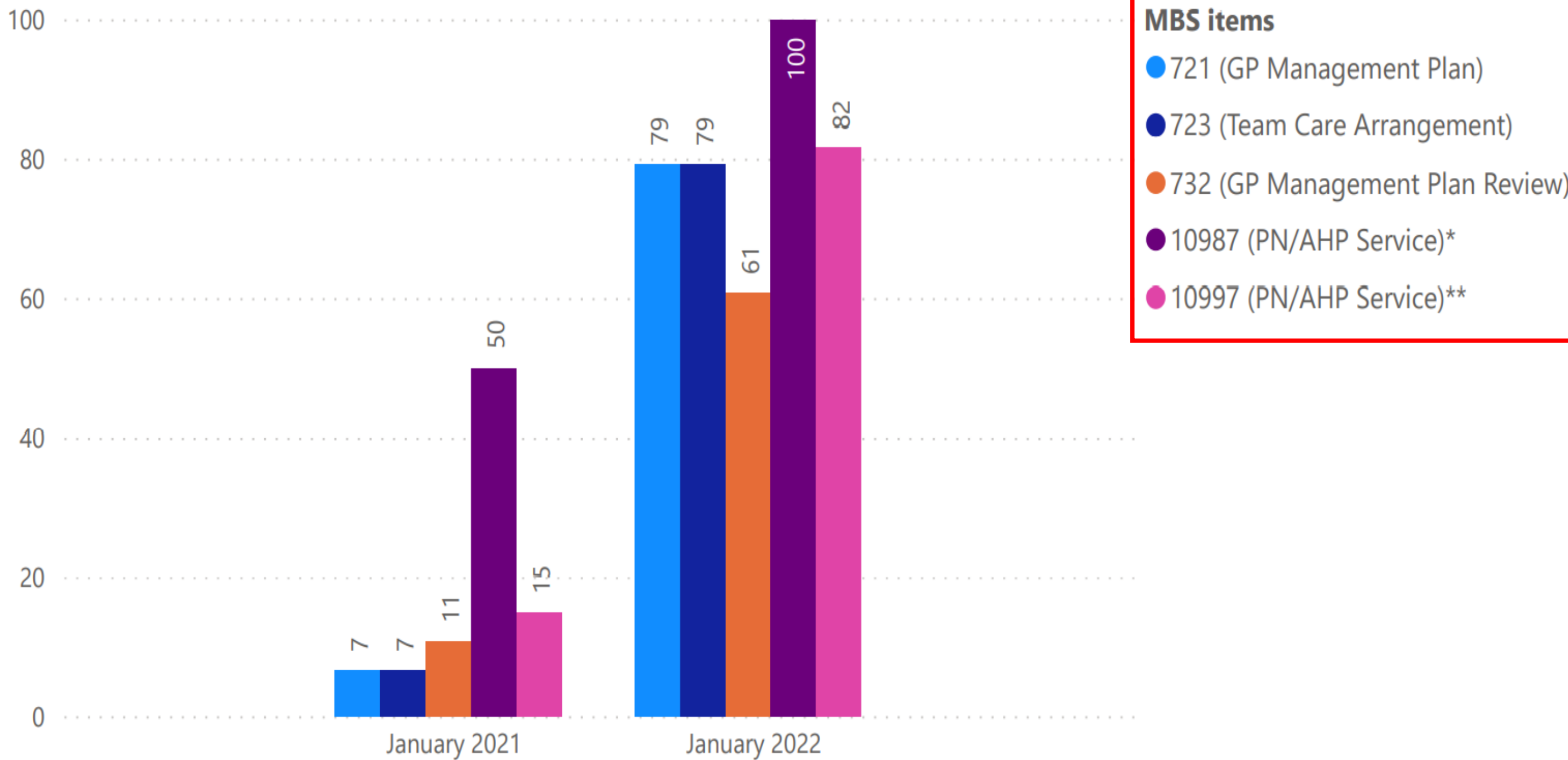
Hot Tip: Put Cholesterol request in your Diabetes pathology favourites.

The PHN General Practice Summary

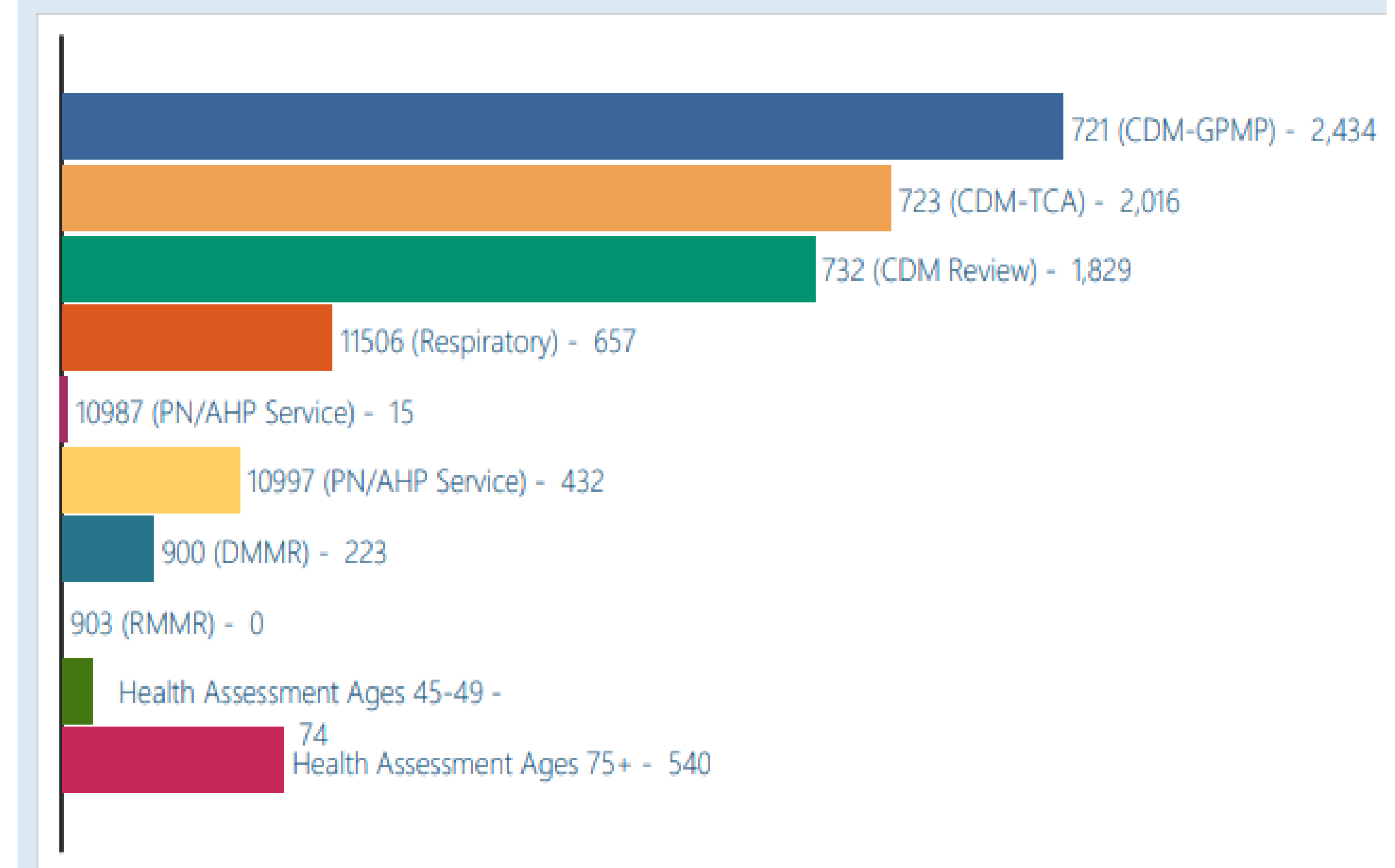


MBS Items Chronic Disease Management Health Care & Billing

MBS items for patients with type 2 diabetes (%)



MBS BILLING



HNE Diabetes Alliance Managing Type 2 Diabetes Summary Report

The PHN General Practice Summary

Hot Tip: Maximise care and billings.....you are doing the work.
Consider Practice Nurse, MPA, AHW/AHP maintaining Diabetes Cycle of Care.

INDICATED BUT NOT CODED DIAGNOSIS

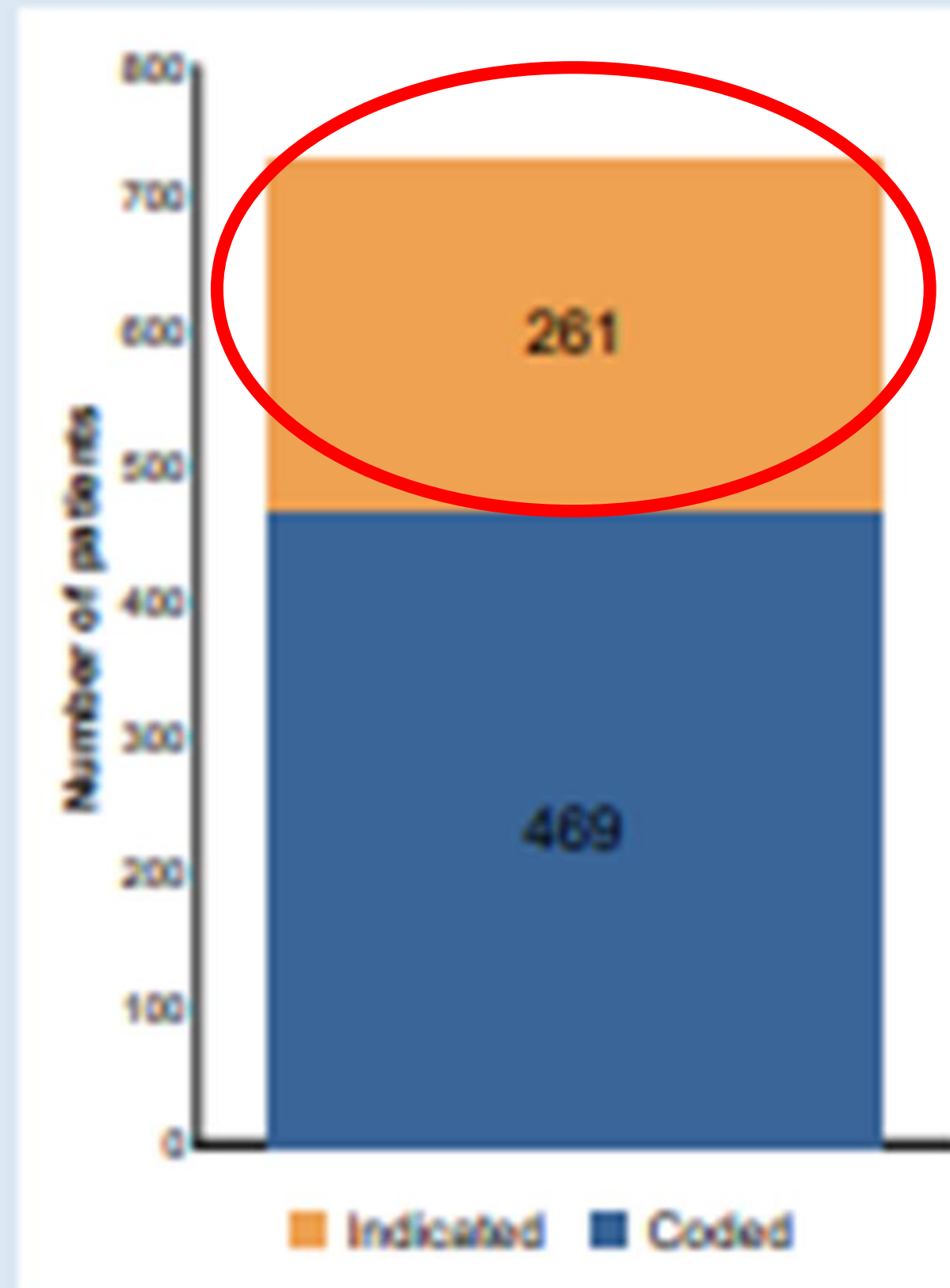
Hot Tip:

Coding is **required** by eHealth and Accreditation Standards.

Cease free-typing. Choose from diagnosis list.

Practice Clinical Info System (MD, BP, etc.) is populated with acceptable **National Medical Vocabulary** e.g., Sno-Med, Docle, Pye-finch.

DIABETES



Indicated Diabetes with no diagnosis

The "Indicated" group includes patients with a likelihood of having Diabetes (any type) based on HbA1c, Anti-diabetic Medication and/or FBG but are recorded in the patient record without a diagnosis

The PHN General Practice Summary

penCS INDICATED BUT NOT CODED DIAGNOSIS

Data Cleansing

Missing Demographics Missing Clinical/Accreditation Items Indicated CKD with No Diagnosis **Indicated Diabetes with No Diagnosis** Indicated Mental Health with No Diagnosis Indicated COPD with No Diagnosis Indicated Osteoporosis with No

Indicated Reviewed

Patient List page 1 of 9 [Count = 167] Save & Remove Save As Export Page No. 1

Double-click a patient to open it in your clinical system (MD, BP, Zedmed). Click on Column Heading to sort

Likely Possible Review

Surname	First Name	DOB	Indication Date	Sex	Anti-diabetic Medication	HbA1c	FBG	Eye Exam	BMI	BP	Foot Exam	Chol	Trig	HDL	Malb	Smoking	eGFR	Assigned Provider	Confirm Condition Does Not Exist
Surname	Firstname_1015	01/11/1948	30/11/2020	M			7.2		29.4	125/70		4.0	1.3	1.29		Never smoked	67	Surname_6	<input type="checkbox"/>
Surname	Firstname_1023	01/11/1975	18/01/2018	F	Y	5.8	5.2		44.5	135/93		6.6	1.7	1.12	0	Ex smoker	105.547		<input type="checkbox"/>
Surname	Firstname_10315	01/11/1935	20/07/2017	M		6.7			22.3	138/70		4.2	1.2	1.41		Ex smoker	67	Surname_8	<input type="checkbox"/>
Surname	Firstname_10435	01/11/1943	04/06/2021	F			9.3		23.7	127/76		5.7	2.1	1.19		Never smoked	65	Surname_6	<input type="checkbox"/>
Surname	Firstname_10520	01/11/1960	15/03/2019	F		6.2	6.1		27.8	144/68		5.1	5.3	0.94		Never smoked	97.799		<input type="checkbox"/>
Surname	Firstname_10599	01/11/1929	05/10/2021	F		5.8	7.4		24.9			3.4	0.6				76	Surname_3	<input type="checkbox"/>
Surname	Firstname_1061	01/11/1949	24/09/2021	F	Y		5.5		42.4	132/95		4.8	2.1	1.73		Ex smoker	84	Surname_5	<input type="checkbox"/>

Likely:
HbA1c >6.5
OR HbA1c recorded AND prescribed an anti-diabetic medication
OR FBG >7.

Possible:
HbA1c >6 and <6.5
OR prescribed an anti-diabetic medication excluding metformin.

Review: Prescribed metformin.

Condition Does Not Exist Option

CAT4 has an option to remove a patient from the Cleansing View reports by confirming that a particular condition does not exist. This will stop the patient from appearing on the Cleansing View and Cleansing App in Topbar. Only users of Topbar and CAT4 can use this option as it uses the Topbar server to store the information. CAT4 needs to be linked to Topbar in the Edit/Preferences/Topbar settings to activate this function, the details are provided here: [Linking CAT4 to Topbar](#)

Accessing a Patient Record (All Reports)

To access a patient record, double-click anywhere on the row containing the patient's details within the displayed report. This will open the patient record within the appropriate clinical system. Note: The clinical system must be open and logged in for the above step to complete. If the clinical system is not open, an alert message will pop up requesting the clinical system be started.

Clinical systems where this functionality is currently provided are

- Medical Director
- Best Practice
- Zedmed

Other clinical systems are planned to be added.


PenCS. Indicated Conditions Report Details. [Online].; 2017 [cited 2023 July 11. Available from: <https://help.pencs.com.au/display/CG/Indicated+Conditions+Report+Details>.

QUALITY IMPROVEMENT LEARNING OUTCOMES

1. De-identified Data Sources

- HNE Diabetes Alliance Program+ Managing Type 2 Diabetes Summary Report
- The PHN - General Practice Summary

2. Quality Improvement Activities

- Primary Care Support 
- Plan-Do-Study-Act Cycle Model for Improvement
- PenCS CAT4

3. Practice Clinical Information System (CIS)

- Diabetes Register
- Diabetes Cycle of Care Assessment



Primary Care Support

Last updated February 14, 2022

PRINT SHARE

The PHN's Primary Care Improvement Team partner with practices to build a better Australian primary health system.

The PHN understand that General Practices are the cornerstone of primary health care and an invaluable part of the communities in which we live. Many factors, such as workforce shortages, digital innovations, and industry changes can be challenging for General Practice to navigate whilst trying to provide optimal patient care.



About Us



Quality Improvement Framework



Accreditation



Cancer Screening



Chronic Kidney Disease



Diabetes



Questions Contact Details

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