

Quality Improvement in Diabetes

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HNELHD

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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

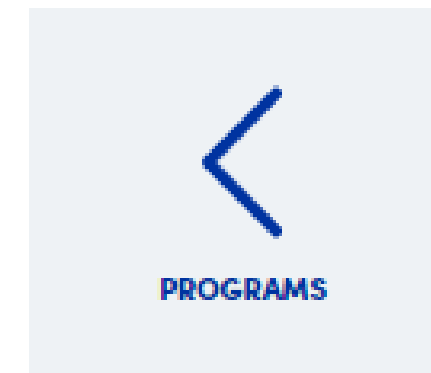
- HNE Diabetes Alliance Program - Managing Type 2 Diabetes Summary Report
- The PHN - General Practice Summary

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



Home > PROGRAMS

Primary Care Support

Last updated February 14, 2022

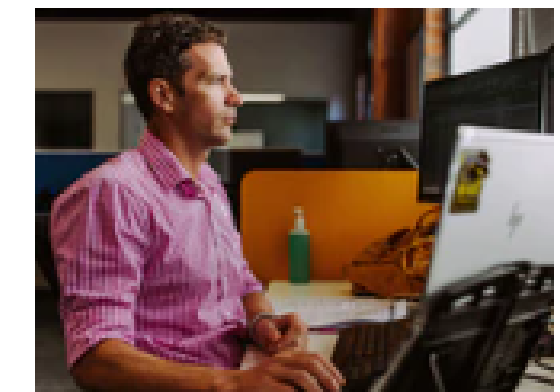
PRINT SHARE

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.



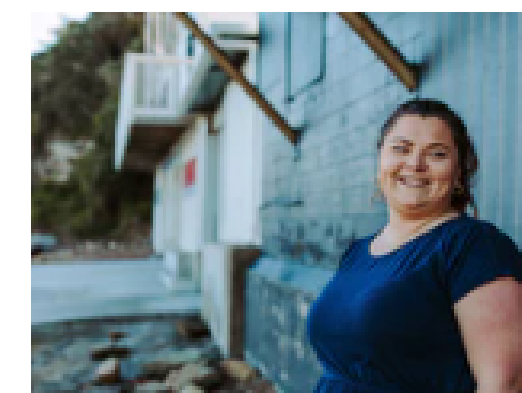
About Us



Quality Improvement Framework



Accreditation



Cancer Screening



Chronic Kidney Disease



Diabetes

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

- HNELHD
- The PHN
- General Practice / AMS
 - > Case Conferencing Model...”team”
 - > Data for Quality Improvement
 - > Health Professional transfer of knowl
 - > Continuity of Care...patient outcomes
 - > Chronic Disease Management
 - > Integration between primary and tertiary sectors





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

Please maintain data security



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	



Sample report

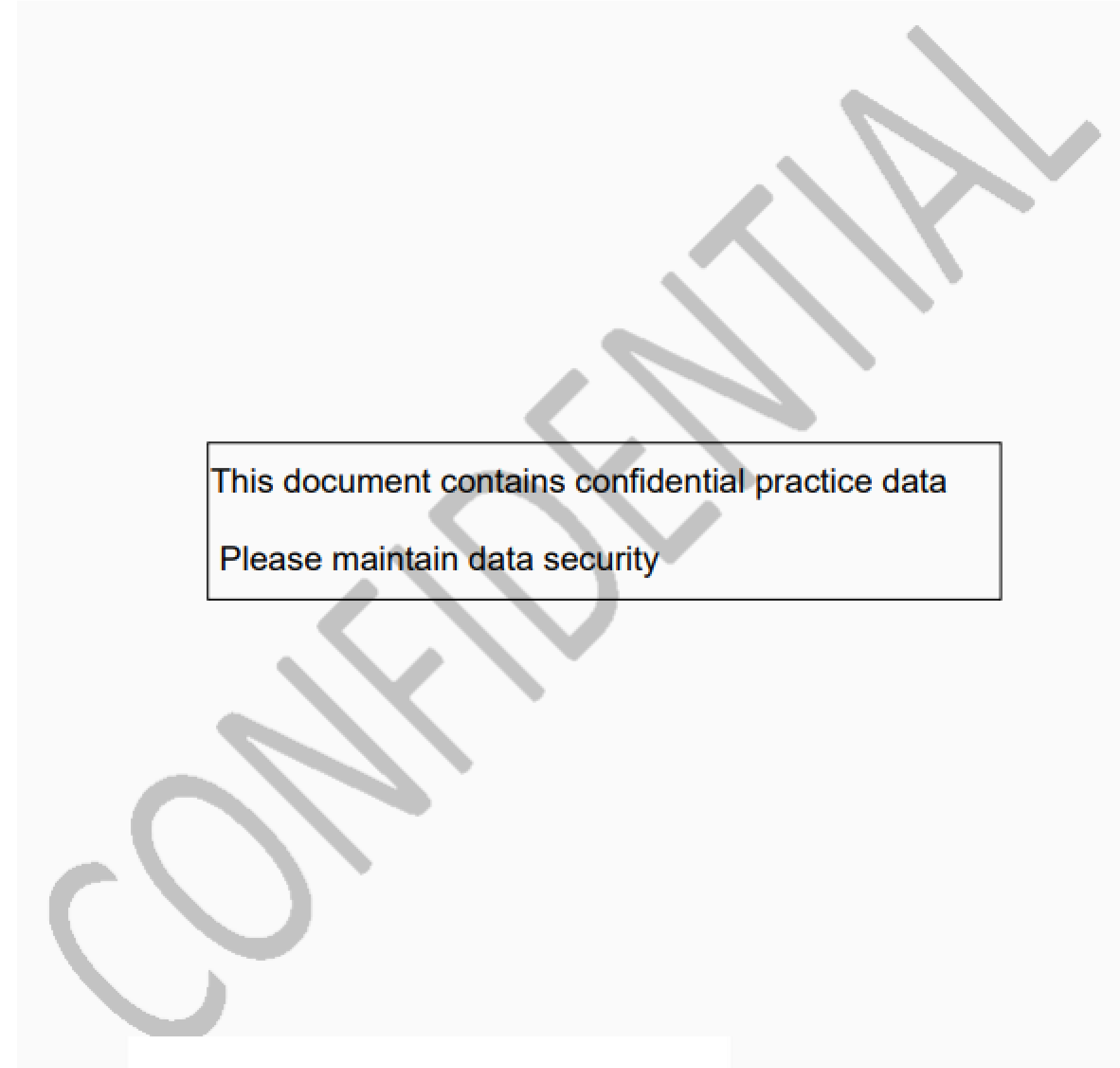
Agreed Clinical Practice Improvement



Health
Hunter New England
Local Health District

The PHN General Practice Summary

— **Generic** disease profile



Diabetes Cycle of Care

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

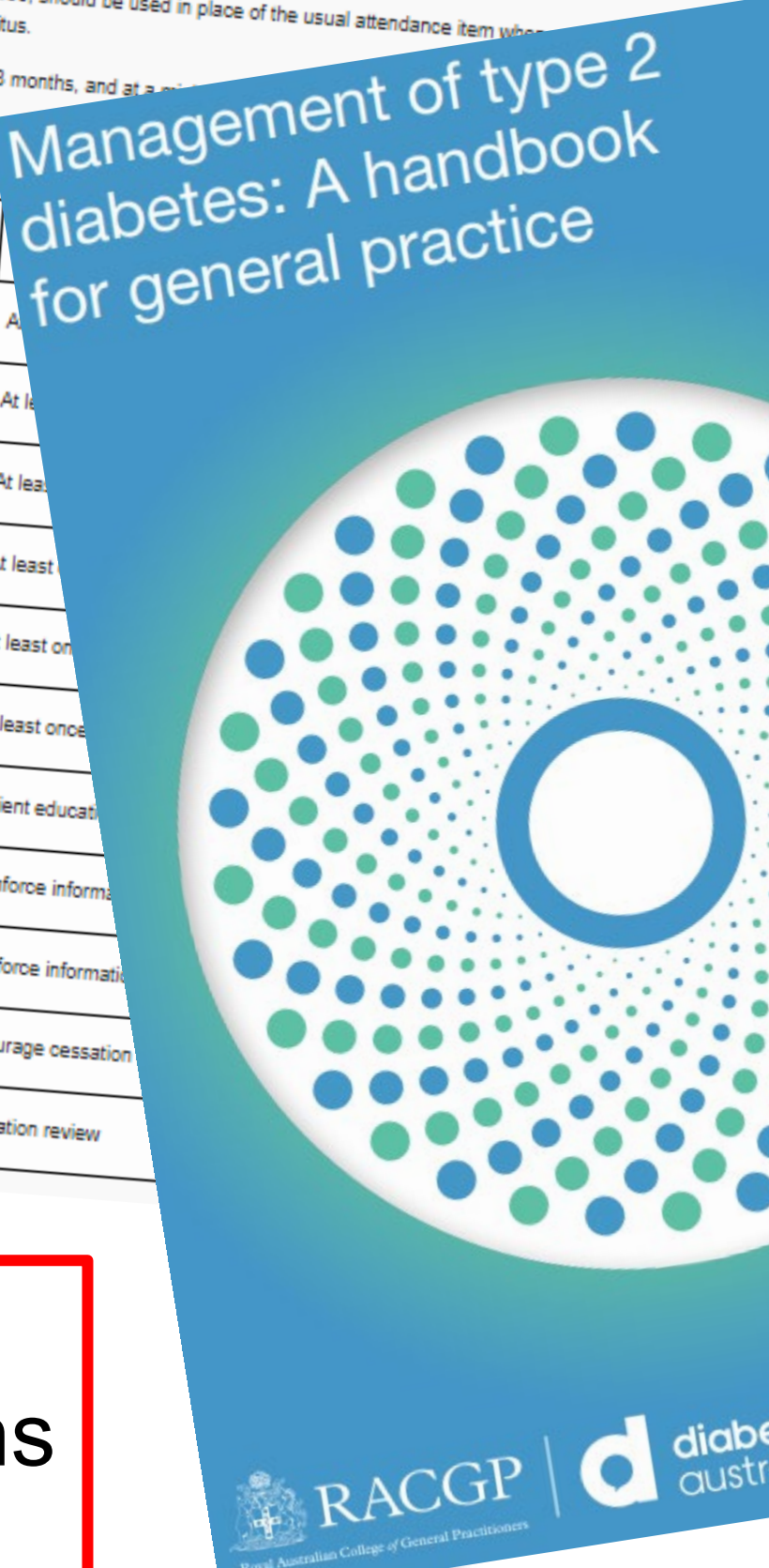
At least annually:

- 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)

Hot Tip: Diabetes Cycle of Care remains best practice. CoC SIP replaced by QI PIP.



Diabetes Sip Data Category Mappings BP

The table below lists the data items that make up the Diabetes SIP. It combines data items already provided in the preceding together.

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 A1c'
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

Mapping to data

within Practice Clinical
Information System
(BP,MD, etc.)

for Diabetes Cycle of
Care items.

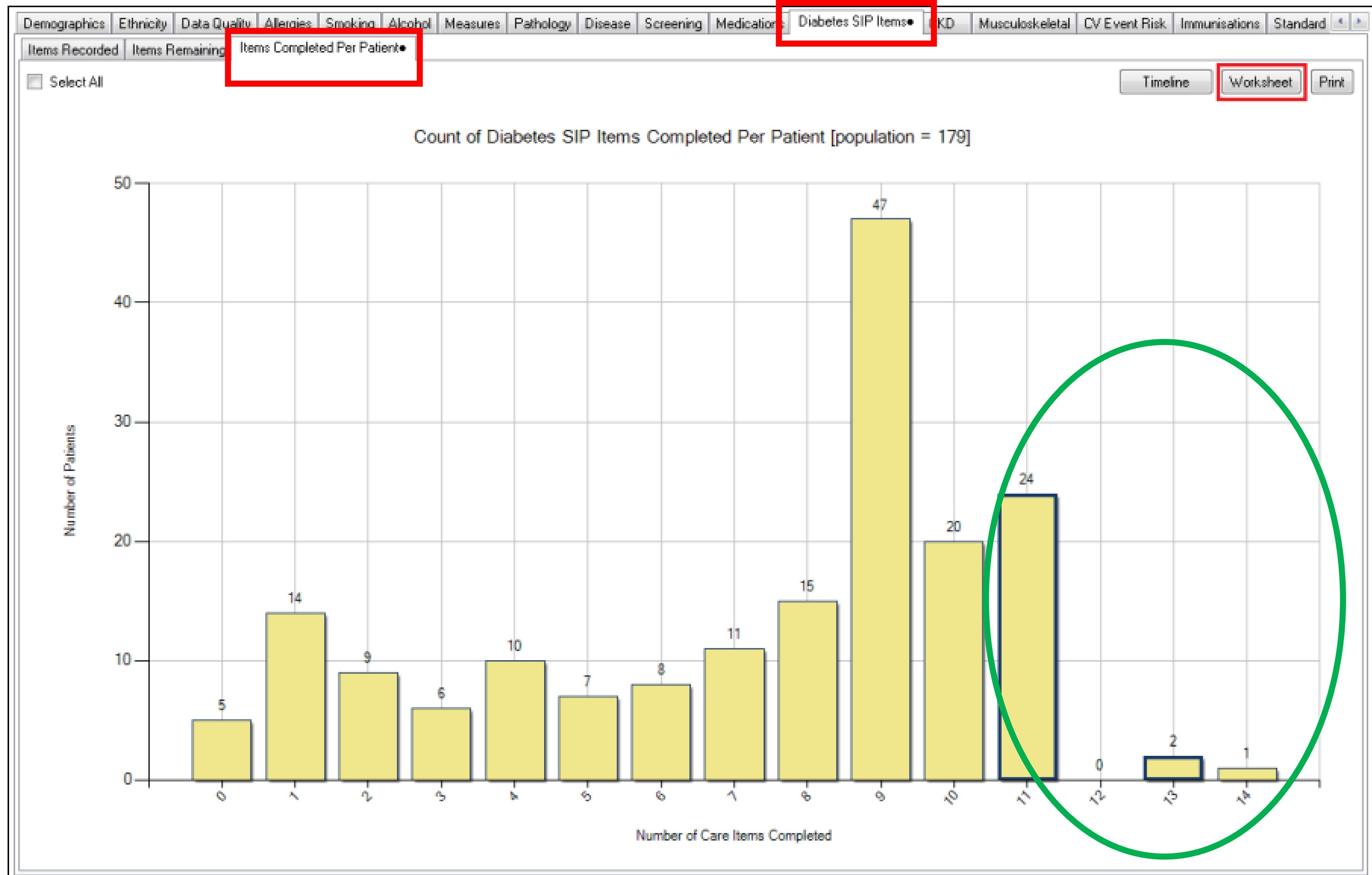


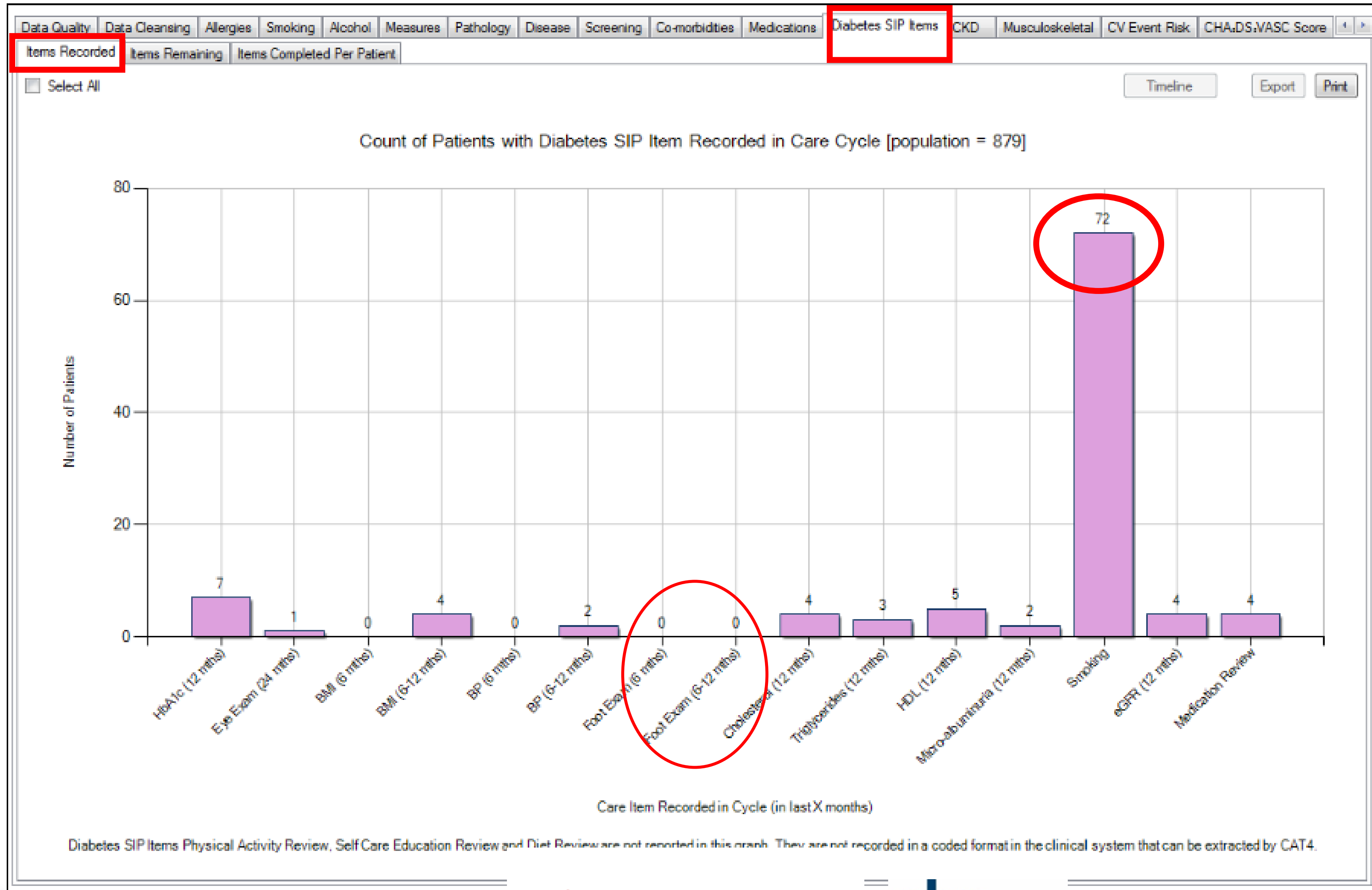
Reidentify patients

Diabetes CoC
Items Completed
Per Patient

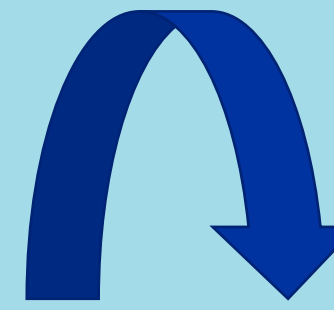
**Patients with
almost complete
Diabetes Cycle of
Care**

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





QUALITY IMPROVEMENT ACTIVITIES X 4 QUARTERS 1 YEAR

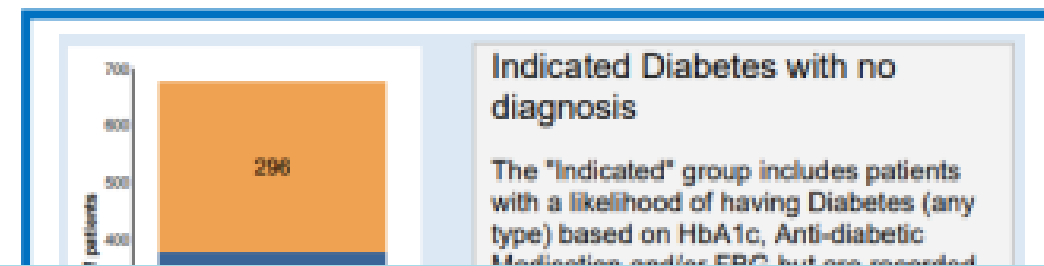


Quality Improvement Scenario 1: Patients Indicated Diabetes with No Diagnosis

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



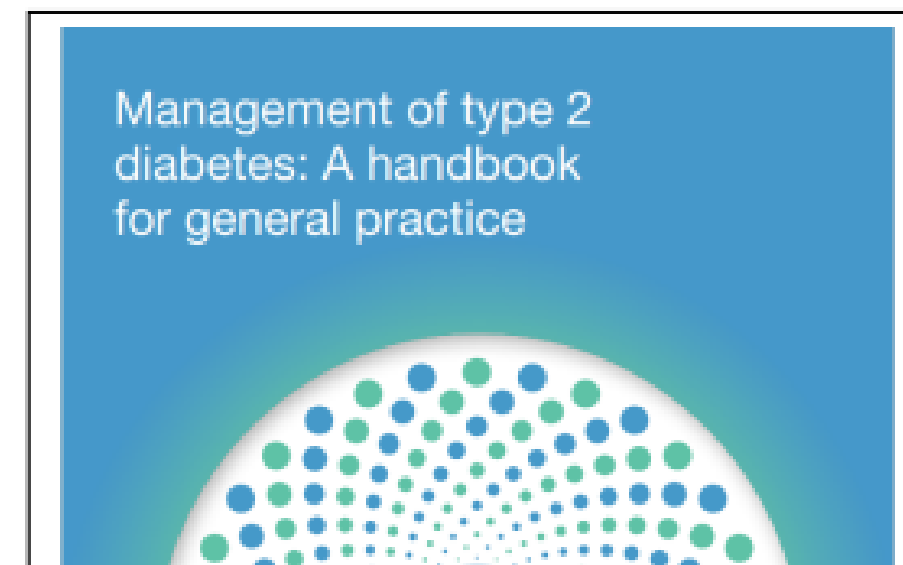
Quality Improvement Scenario 2: Chronic Disease Management

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](http://www.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
<input type="checkbox"/> 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
<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	16/06/2012	12/05/2012		12/05/2012
<input type="checkbox"/> WATLAND, HENRY				18/02/2013				12/07/2012	12/07/2012	12/07/2012	16/06/2012			

Select all

Deselect all

Summary

Statistics

Open patient

Add Recall

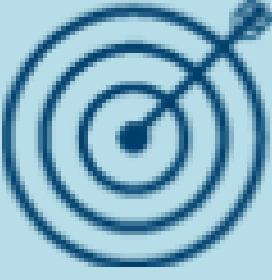
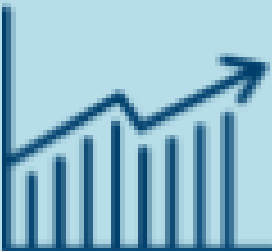

Print list

Close





QUARTERLY IMPROVEMENT MODEL – PLAN DO STUDY ACT

Hot Tip: Useful for Accreditation and QI PIP.

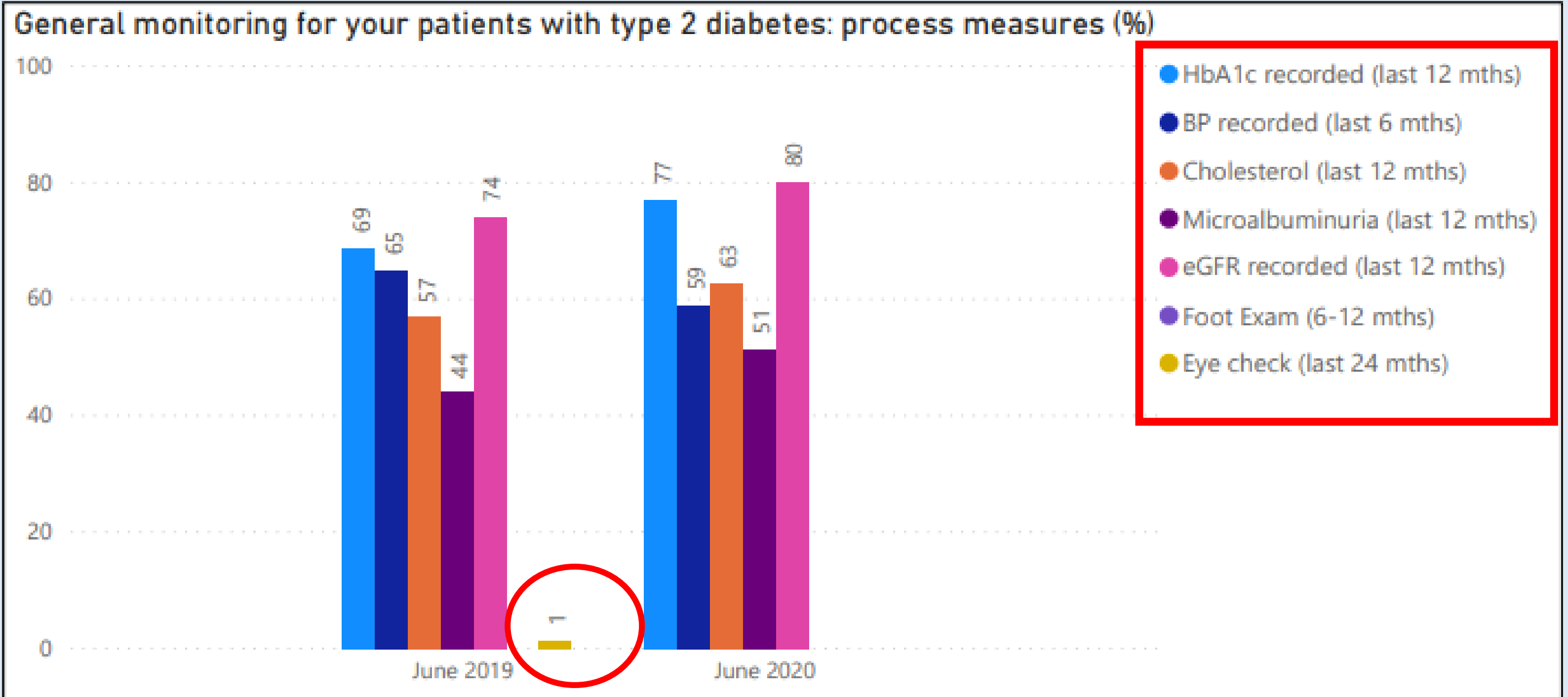
The Thinking Part

	Goal <i>What are we trying to accomplish? SMARTA</i>
	Measure <i>How will we know that a change is an improvement?</i> Baseline: Re-measure: Numerator: Denominator:
	Idea <i>What can we do to achieve the goal?</i> 1 – 2 – 3 –

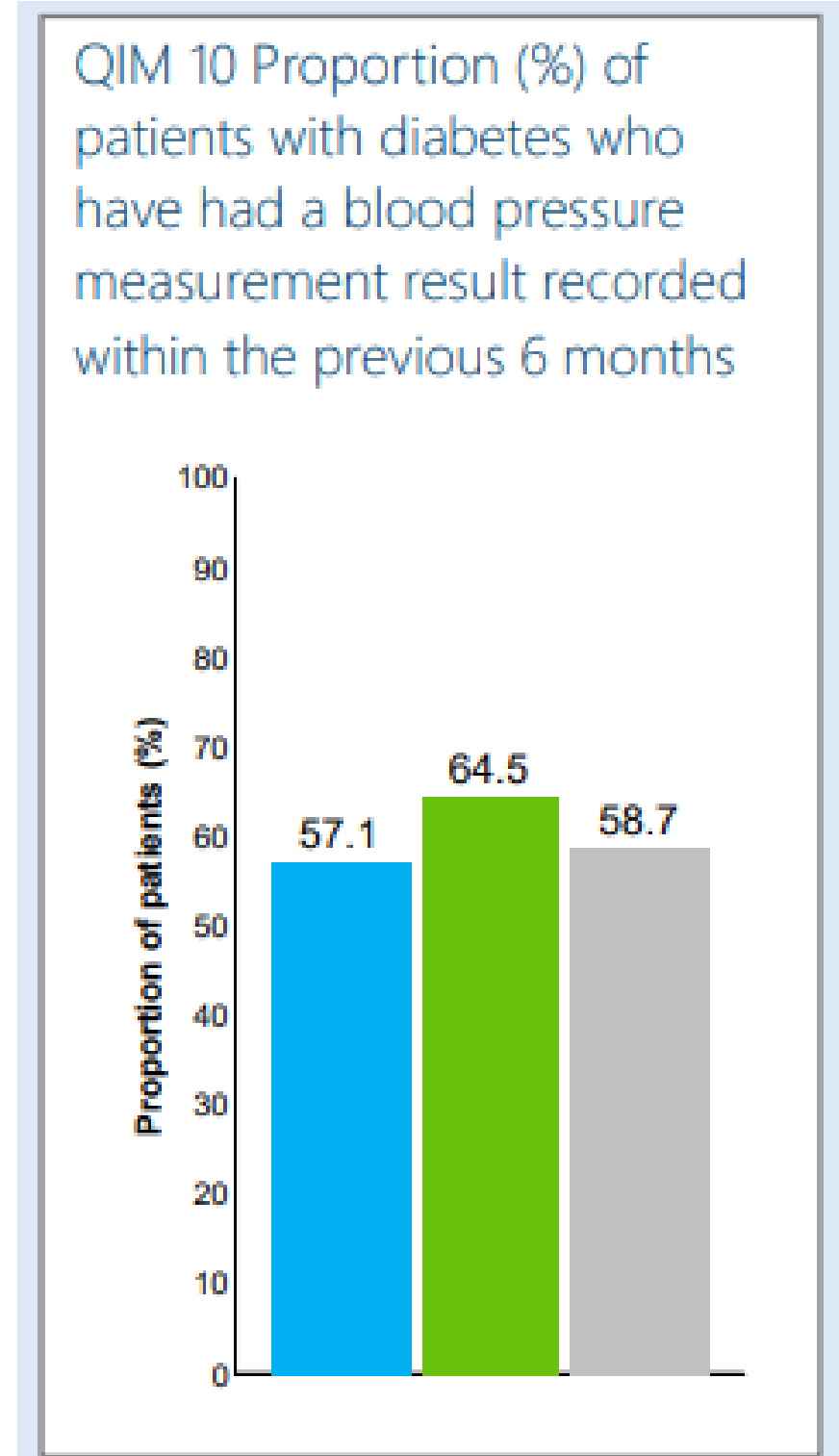
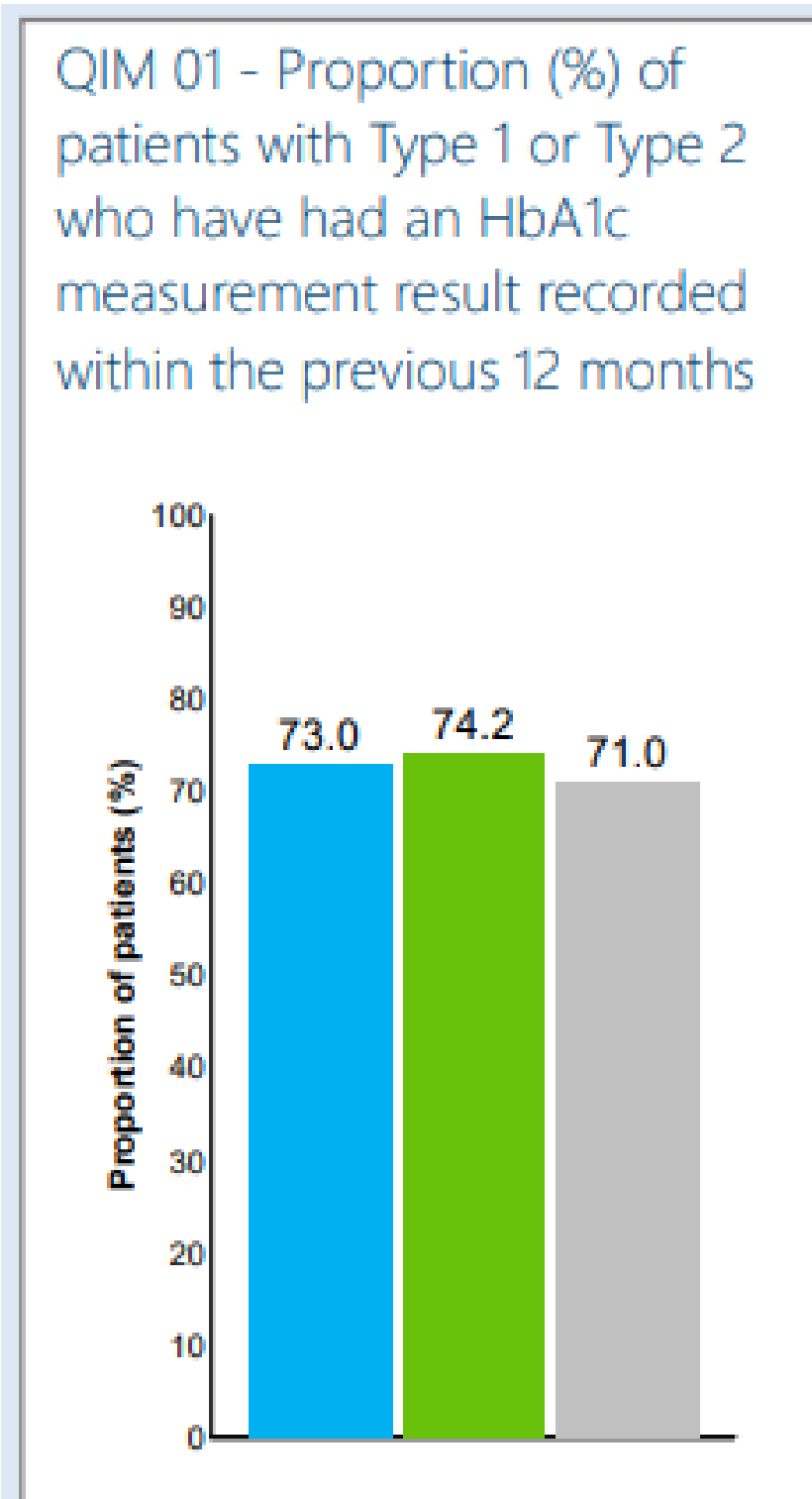
The Doing Part

<i>Idea</i>	
	Plan What? Who? Where? When? What? Predictions?
	Did <i>Was the plan executed? Any unexpected events or problems?</i>
	Study <i>Analysis of actions and data. Reflection on the results</i>
	Act <i>What will we take forward what is the next step or cycle?</i>

DIABETES CYCLE OF CARE ACTIVITIES (7 OF THE 13)



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



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

QIM PIP Measures (Last page of PHN 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

Hot Tip:

Increased risk of Diabetes in First Nations population.

Screening is important via AUSTRISK, 715 Health Assessment

163

Aboriginal patients

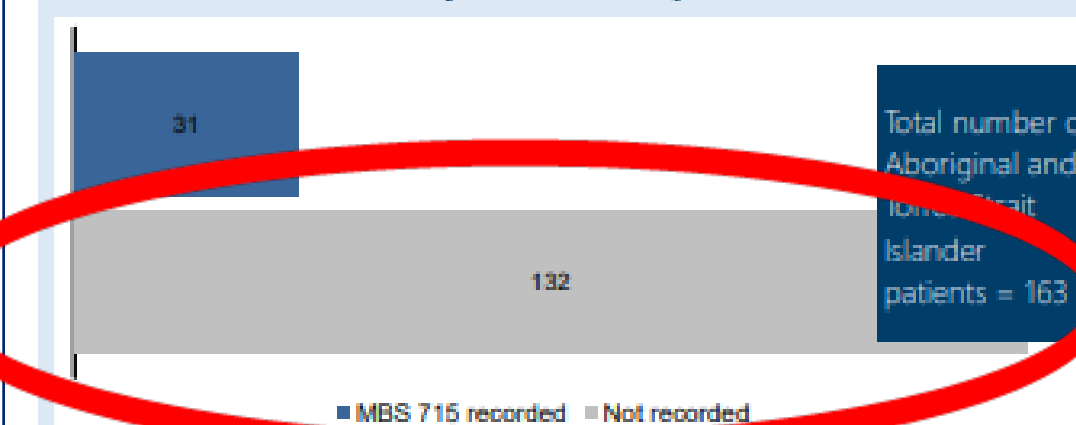
2.4 %

% Aboriginal patients

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 % **

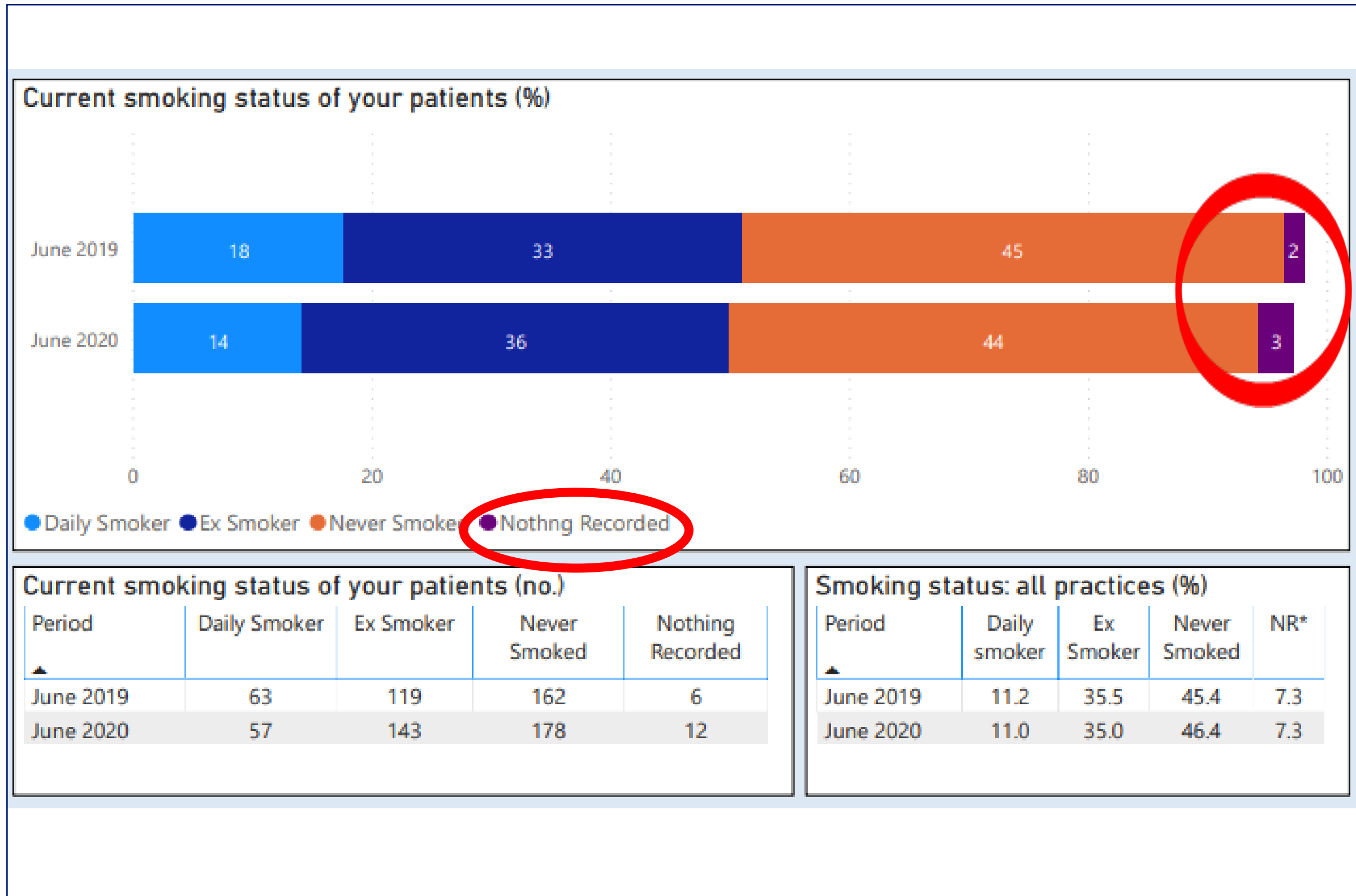
ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES HEALTH ASSESSMENT (MBS item 715)



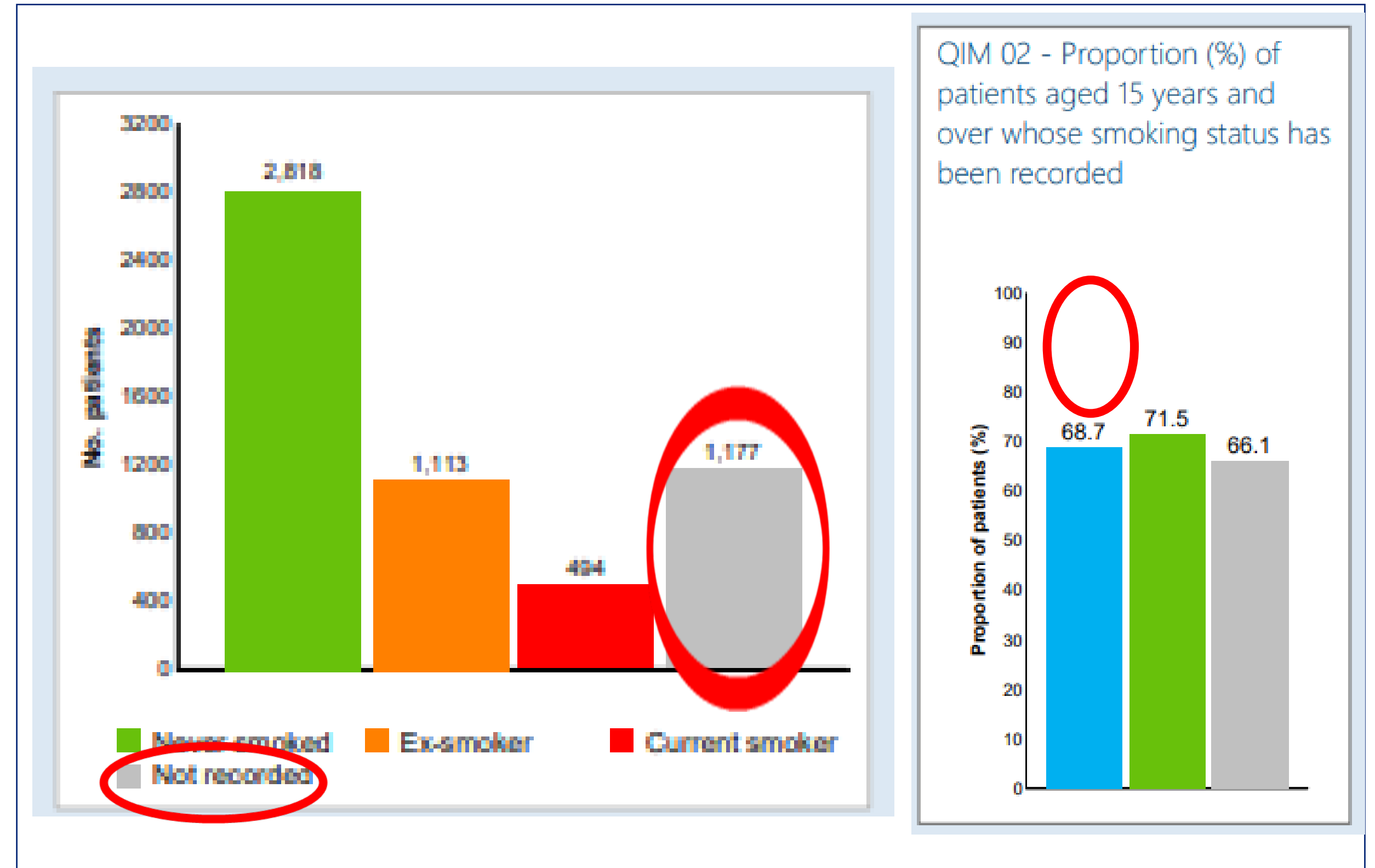
The data shows proportions of Aboriginal and Torres Strait Islander patients who have had a **Health Assessment** recorded (MBS Item 715). This includes assessment of a patient's health and physical, psychological and social function and consideration of whether preventive health care and education should be offered to the patient, to improve that patient's health and physical, psychological and social function. For details see: <http://www9.health.gov.au>

The PHN Practice Summary

SMOKING



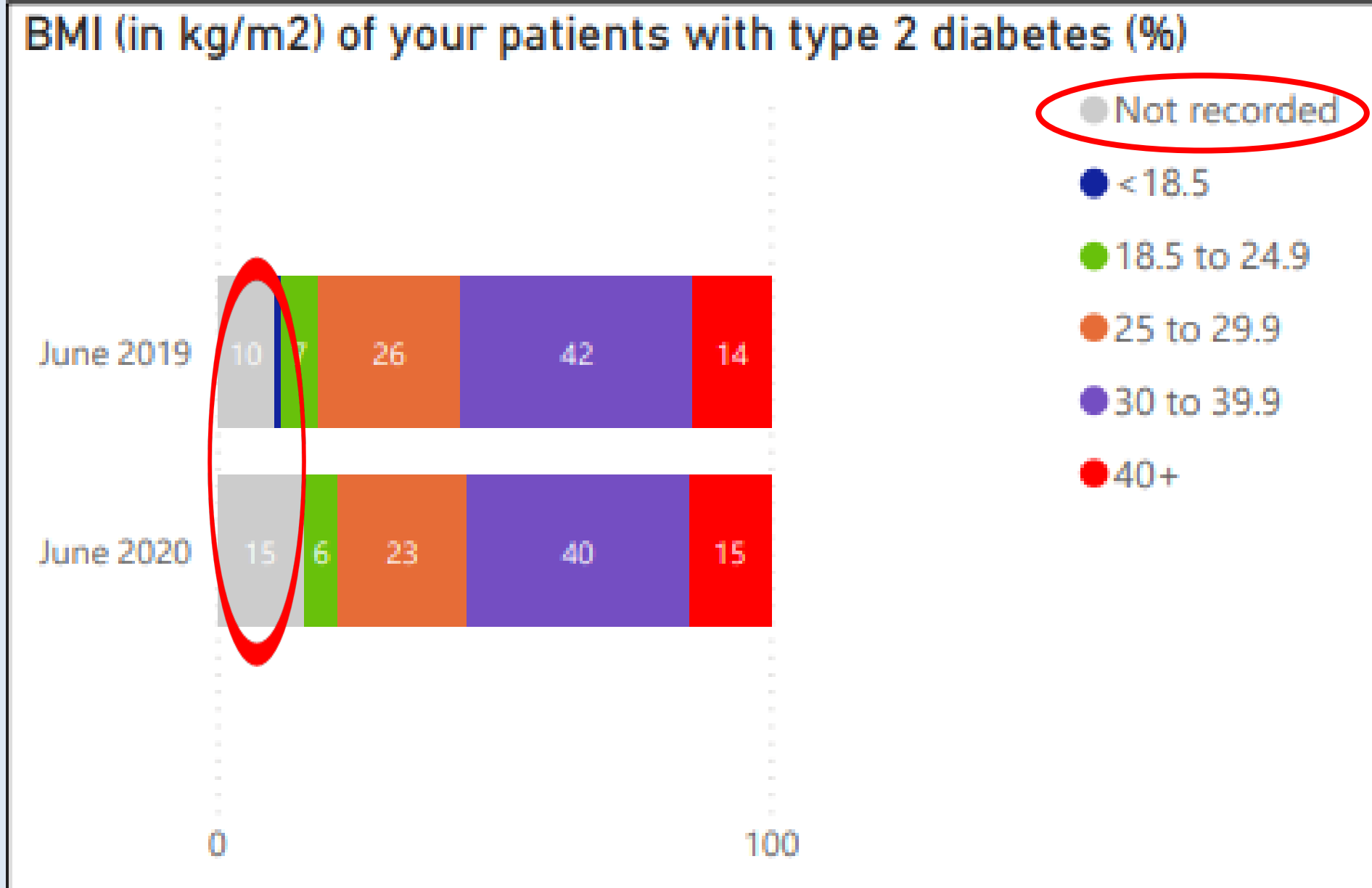
HNE Diabetes Summary



The PHN Practice Summary

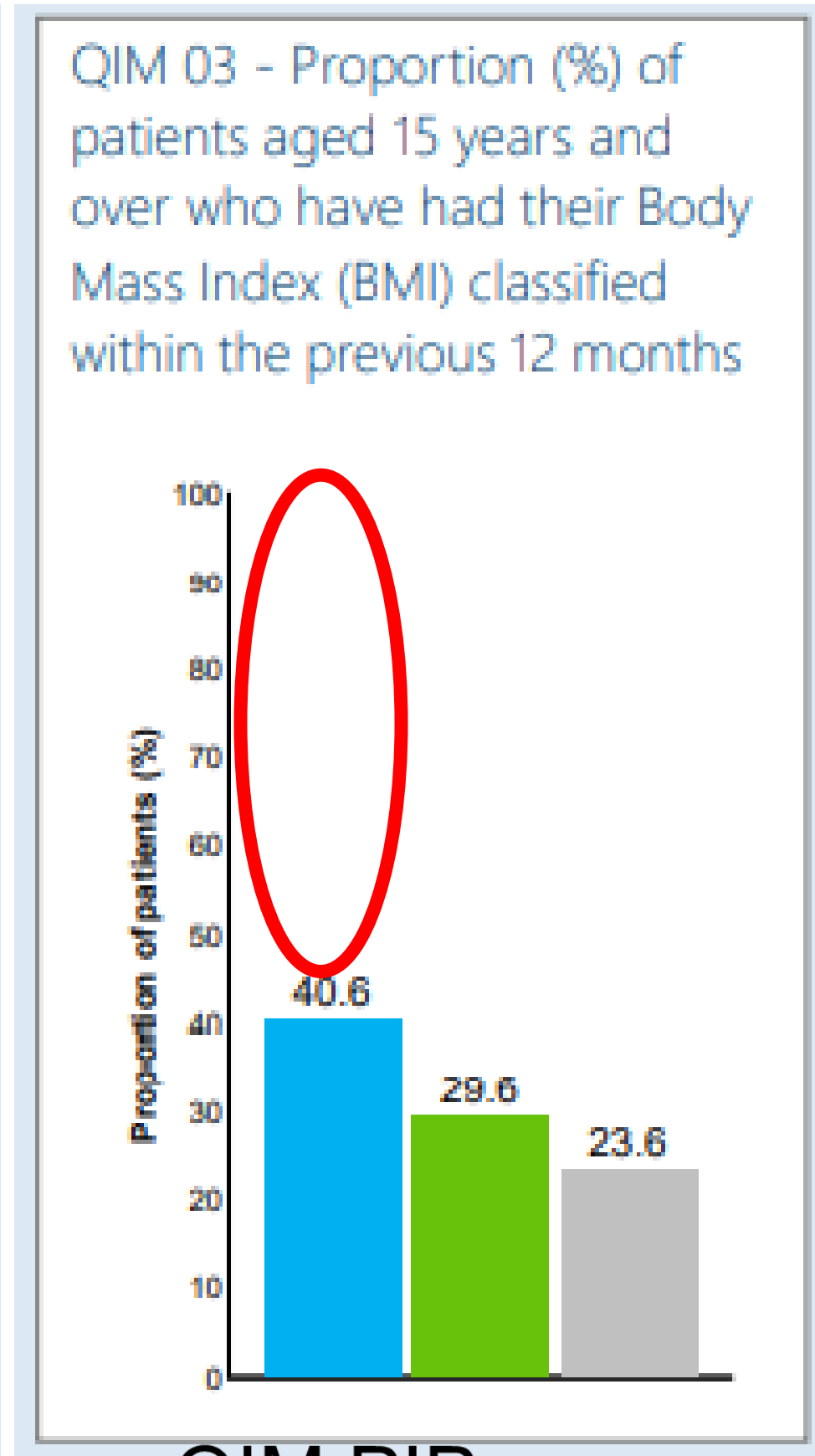
QIM PIP Measures (Last page of PHN report)

BMI



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



HNE Diabetes Summary

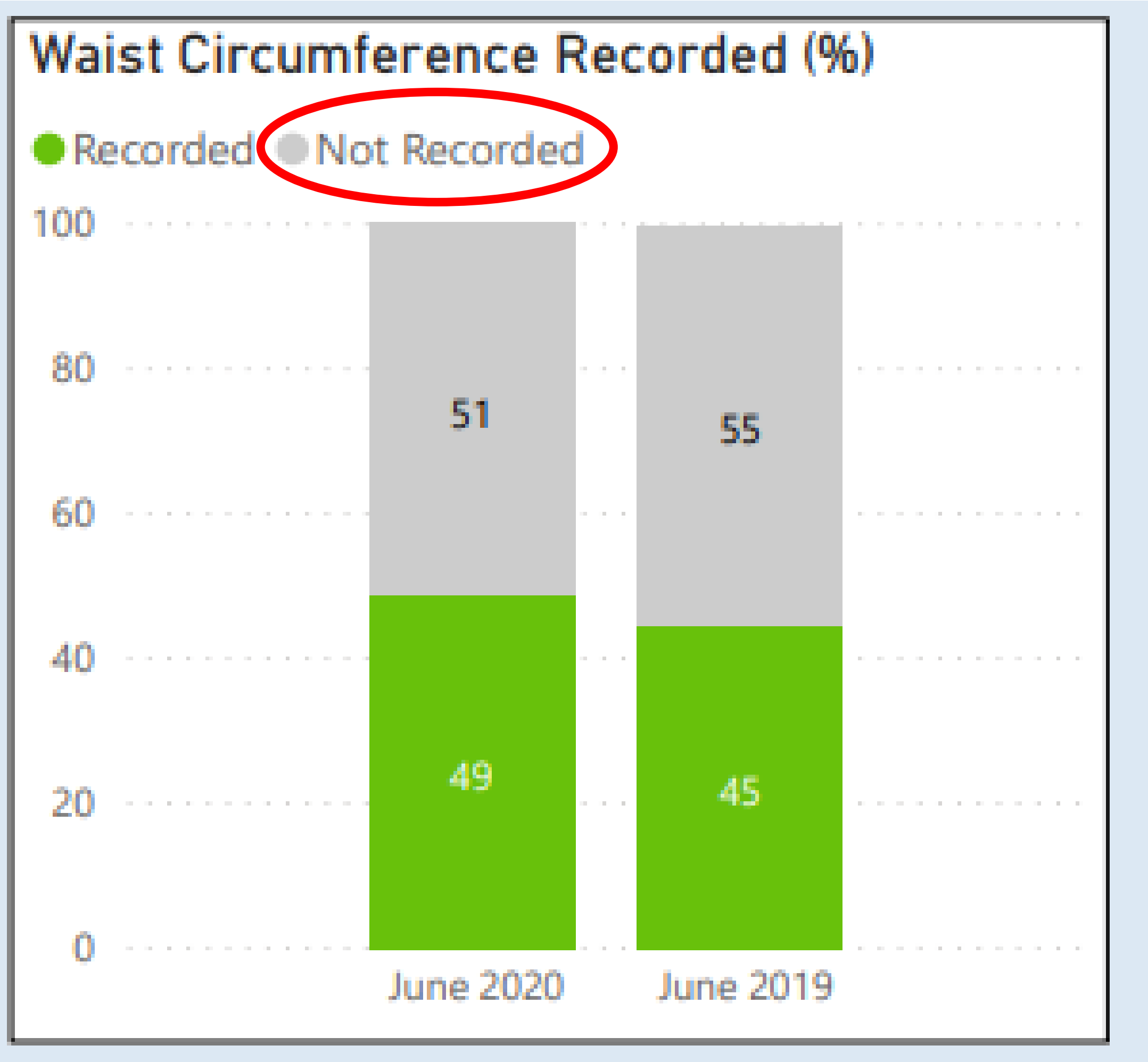
The PHN Practice Summary

QIM PIP Measures (Last page of PHN report)



WAIST CIRCUMFERENCE

Indicates Risk of CVD

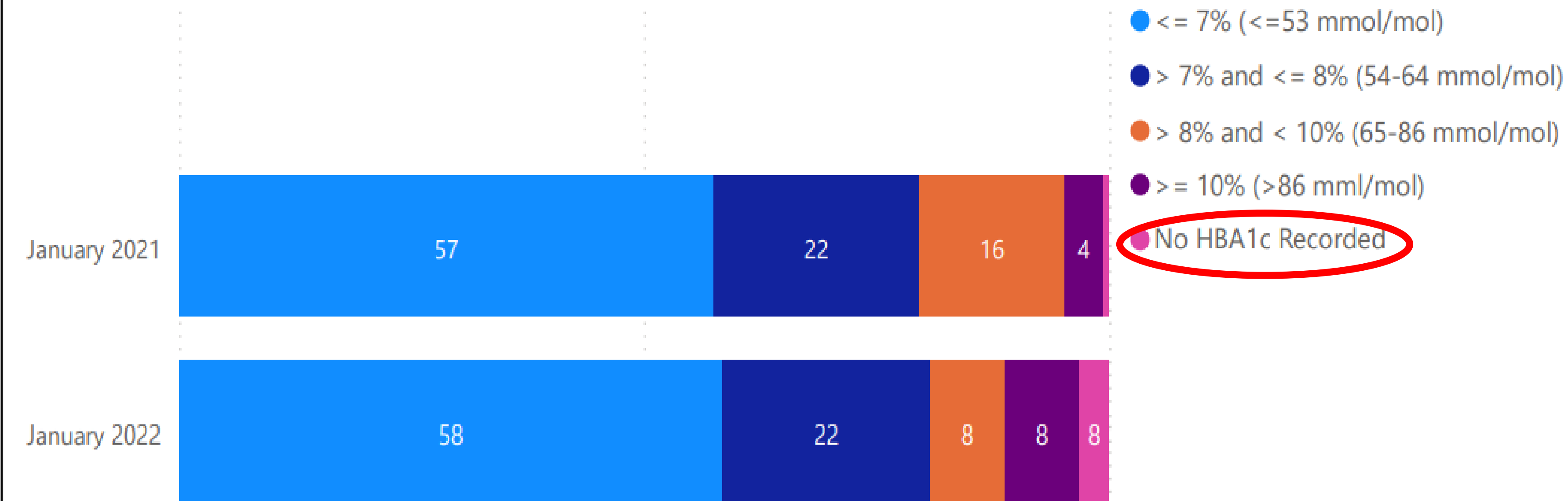


HNE Diabetes Summary



PATHOLOGY - HbA1c

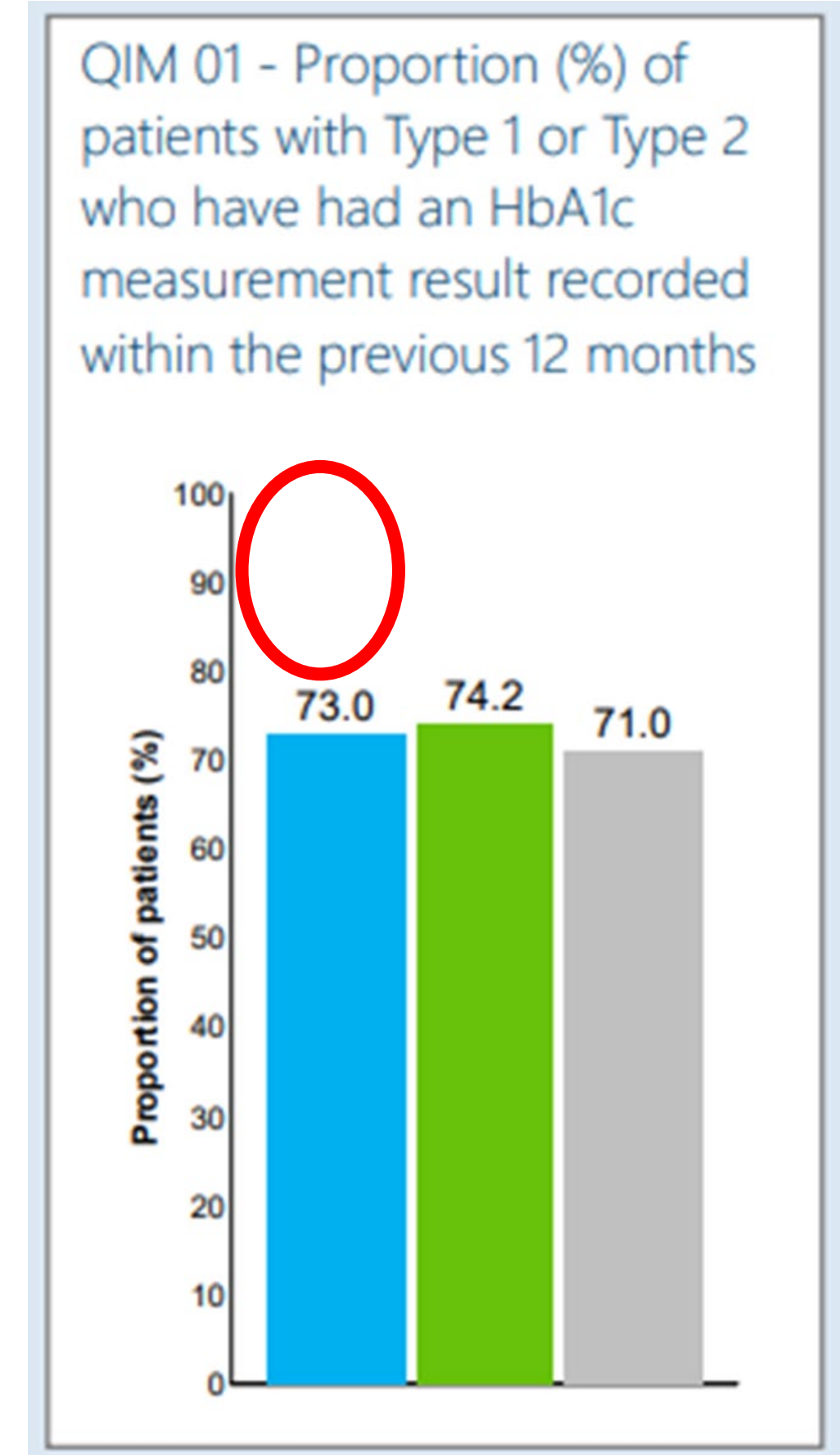
Most recent HbA1c for your patients with type 2 diabetes (%)



HNE Diabetes Summary

Hot Tip:

Consider 3 monthly prescriptions after HbA1c attended.

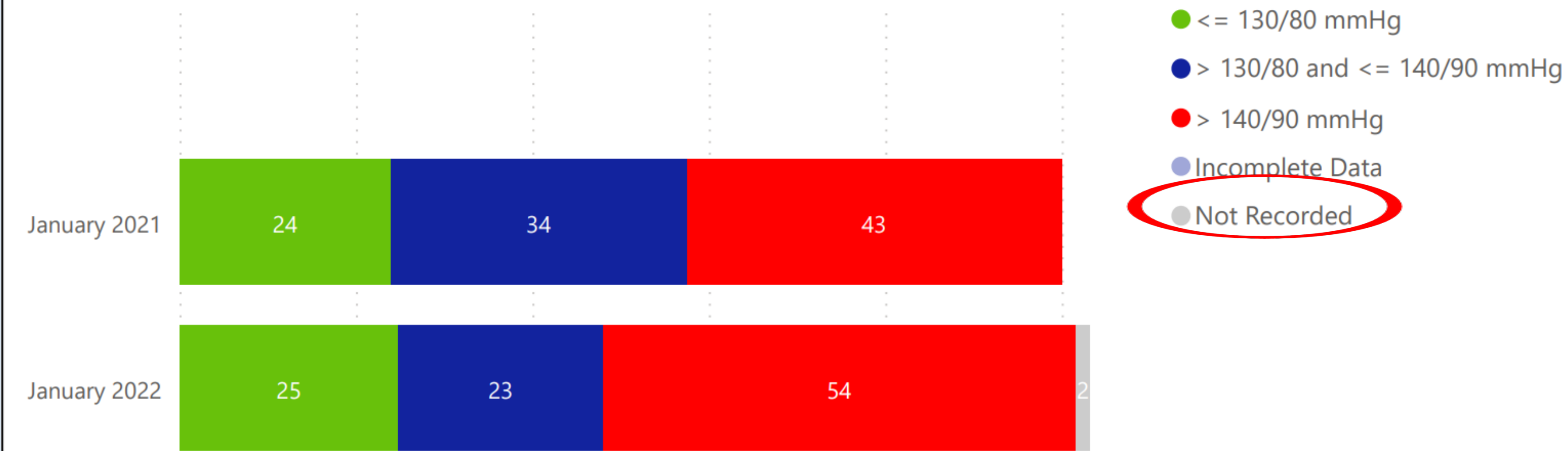


QIM PIP Measures (Last page of PHN report)



Blood Pressure Recording

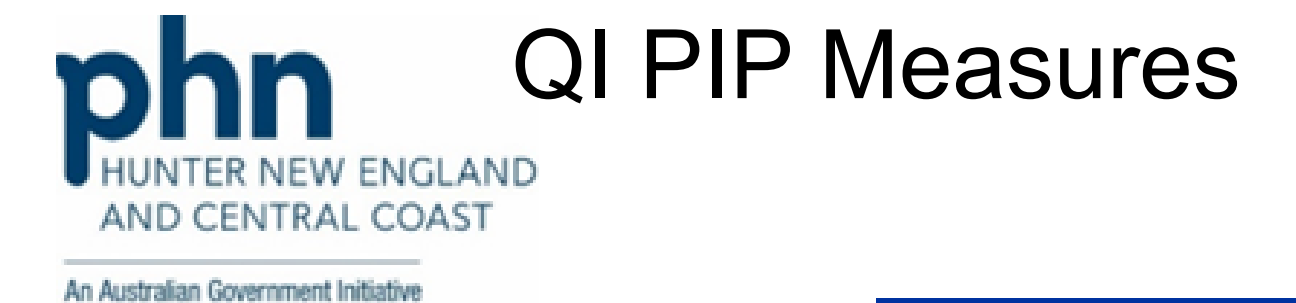
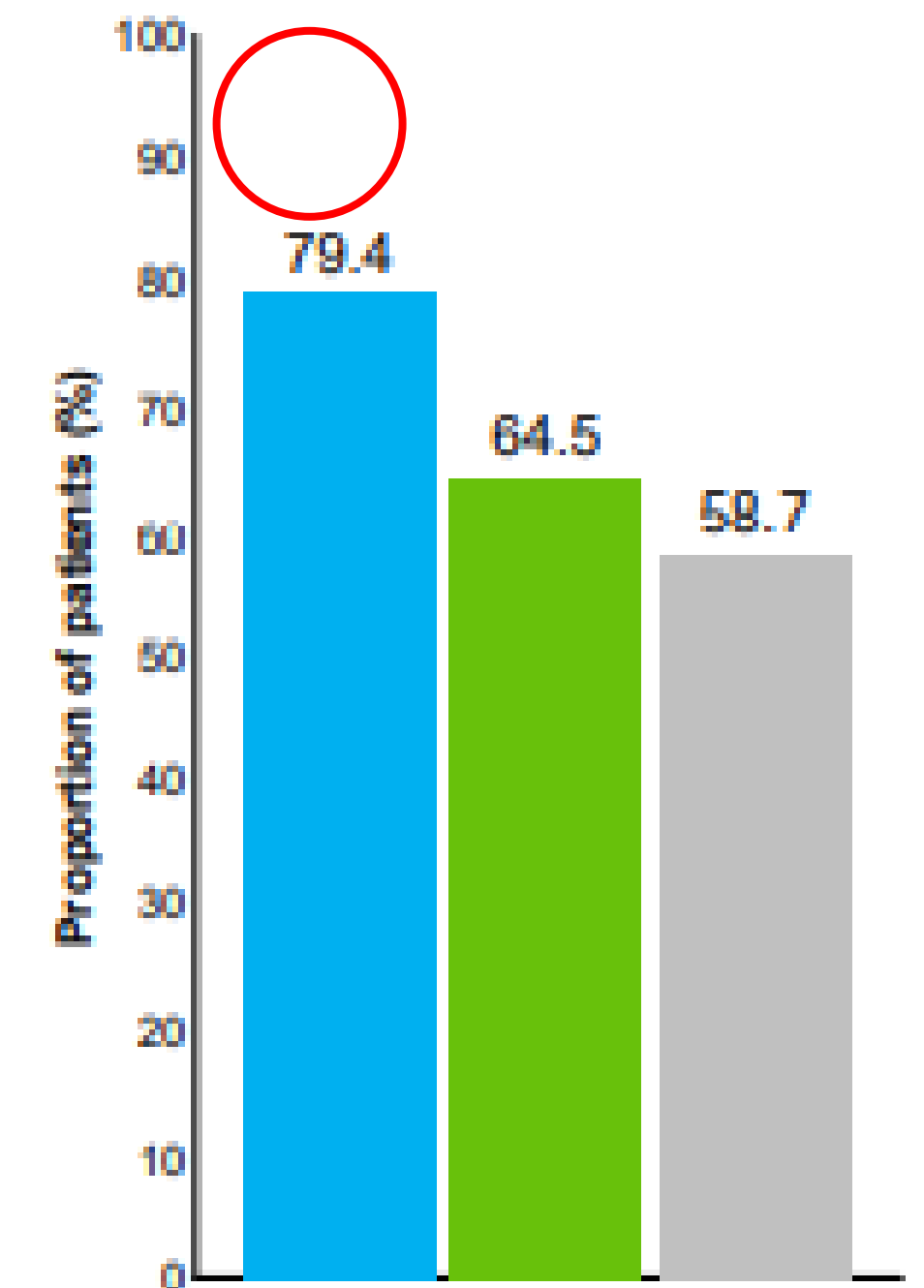
Most recent BP ranges for your patients with type 2 diabetes (%)



HNE Diabetes Summary

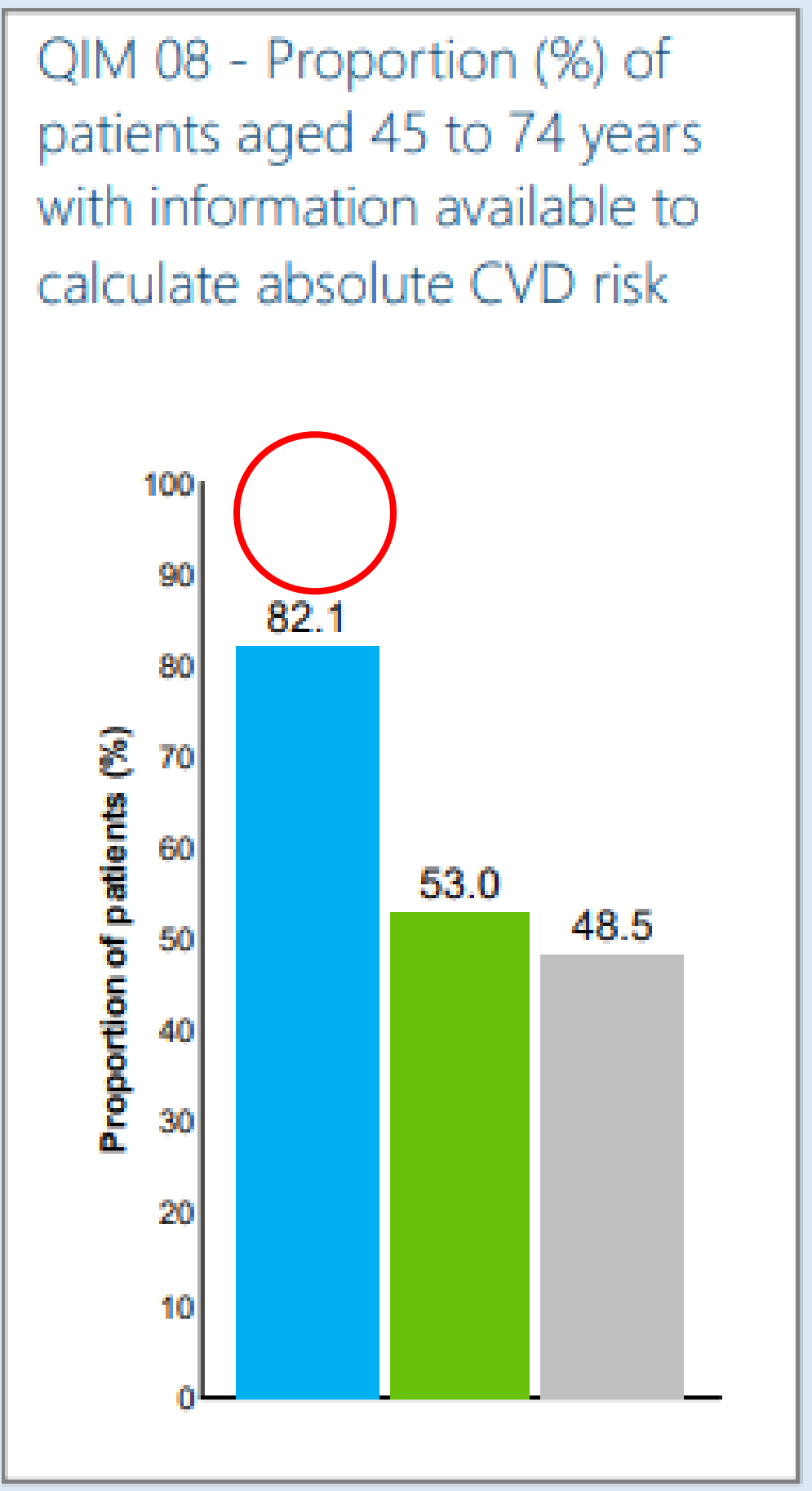
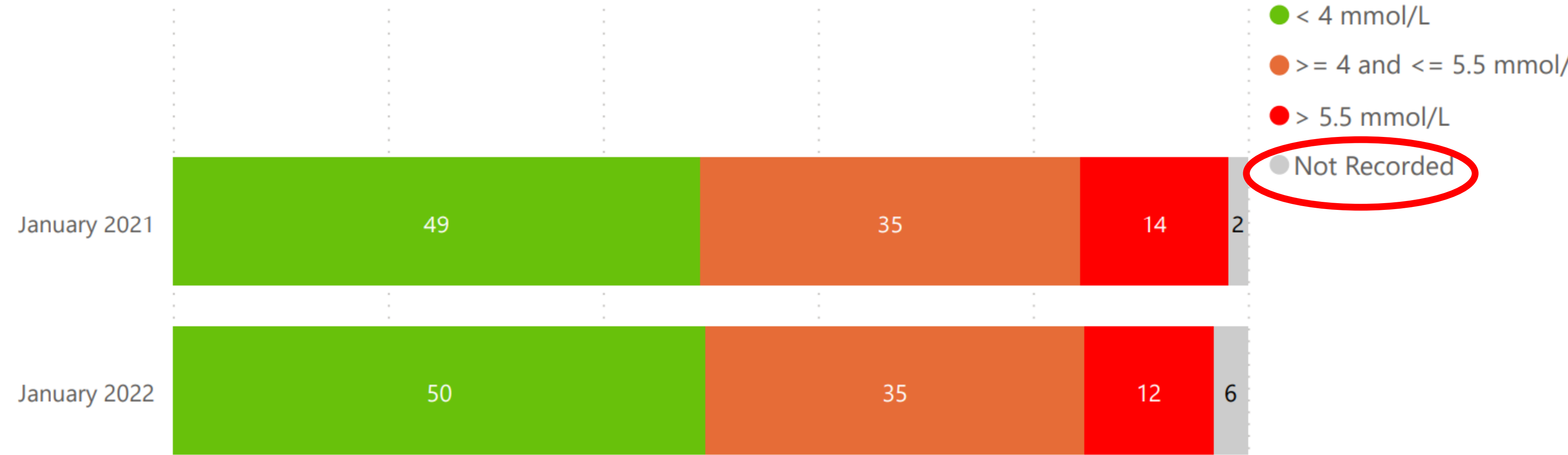
Hot Tip: Code in Observations field, not just progress notes.

QIM 10 Proportion (%) of patients with diabetes who have had a blood pressure measurement result recorded within the previous 6 months



Cholesterol Results

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



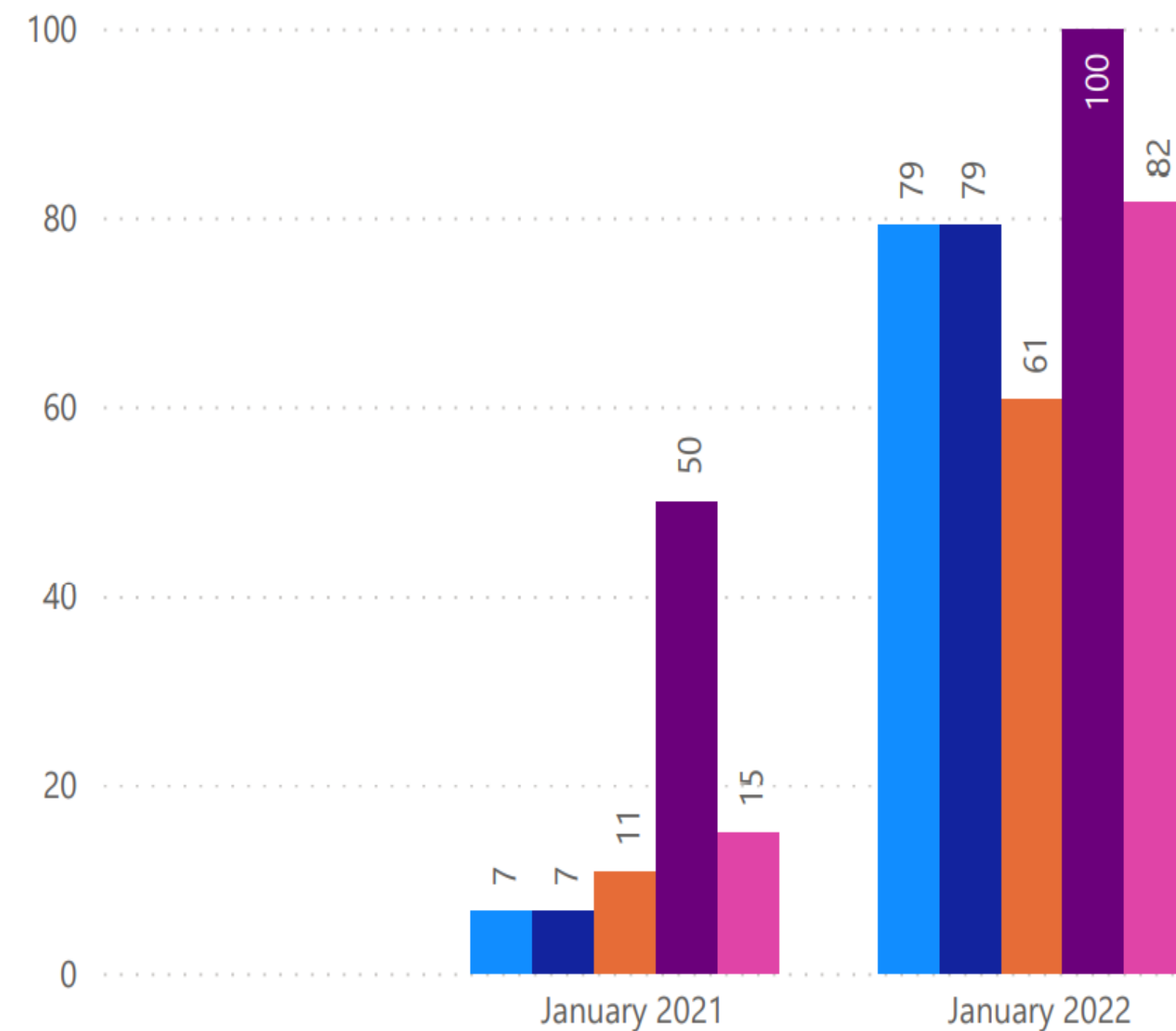
HNE Diabetes Summary

QI PIP Measures



MBS Items Chronic Disease Management Health Care & Billing

MBS items for patients with type 2 diabetes (%)



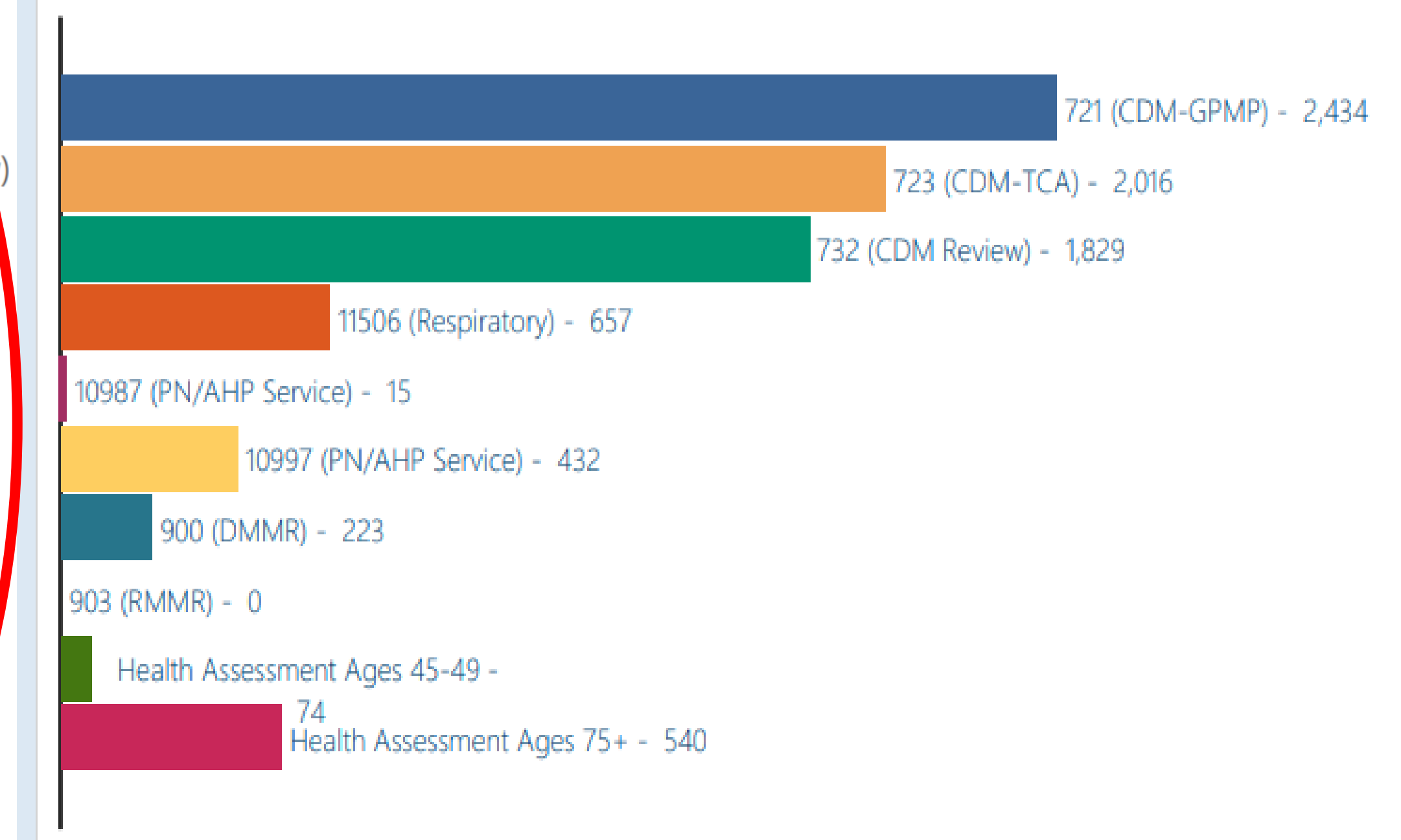
HNE Diabetes Summary

MBS items

- 721 (GP Management Plan)
- 723 (Team Care Arrangement)
- 732 (GP Management Plan Review)
- 10987 (PN/AHP Service)*
- 10997 (PN/AHP Service)**

Also consider timed Diabetes Cycle of Care 2517, 2521, 2525.

MBS BILLING



The PHN Practice Summary

Hot Tip: Maximise care and billings.....you are doing the work.

Consider Practice Nurse, MPA, AHW/AHP maintaining Diabetes Cycle of Care.

Provide protected time for this work.



INDICATED BUT NOT CODED DIAGNOSIS

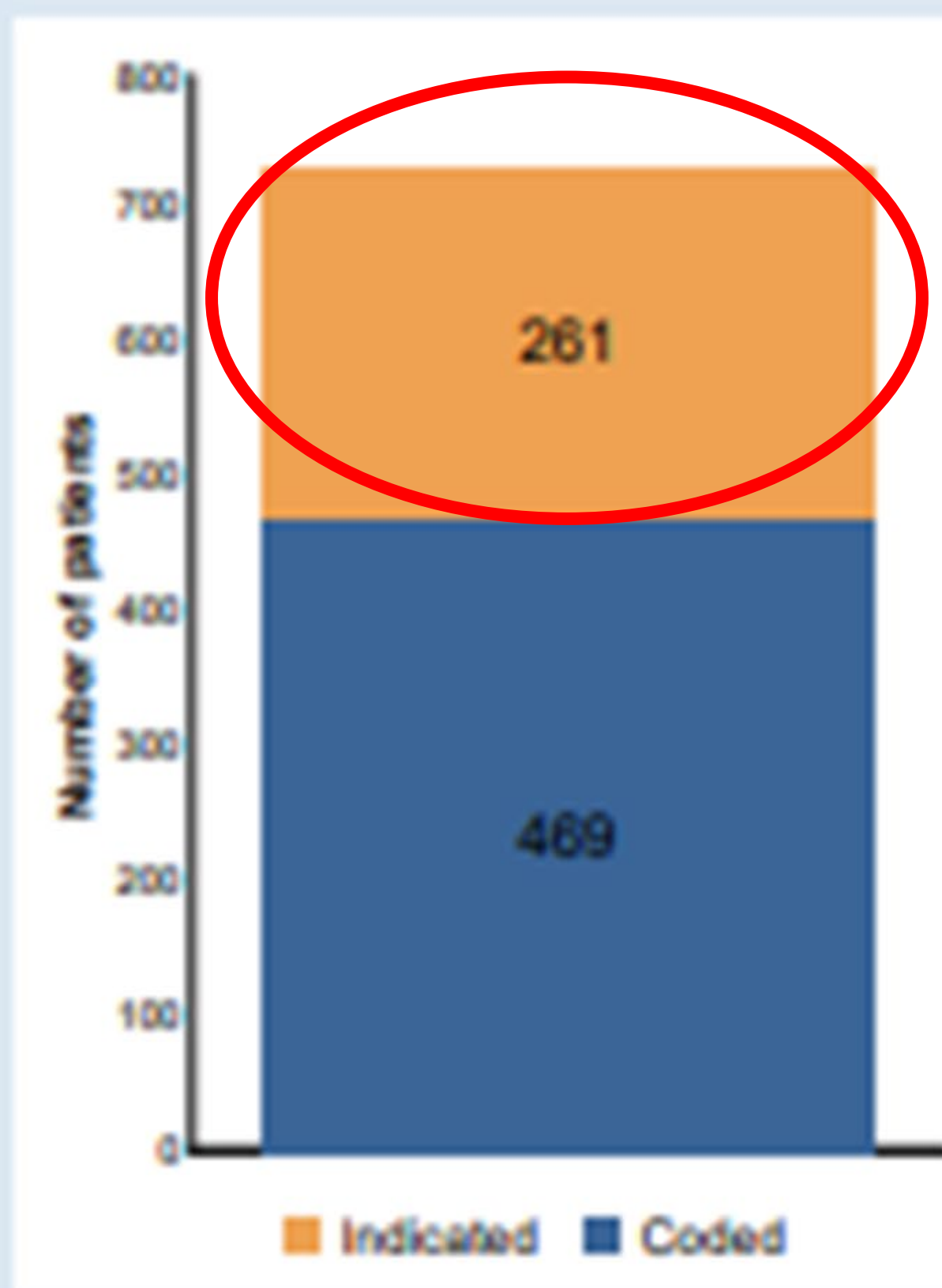
Hot Tip:

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

INDICATED BUT NOT CODED DIAGNOSIS penCS

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	Sumname_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	Sumname_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	Sumname_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	Sumname_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	Sumname_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.



Medical Director

Best Practice

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'...

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	Not allowed
My Health Record Access	Not allowed
My Health Record Registration	Allow access
Search clinical data	Allowed
Change patient confidential status	Allow access
Allocate investigation reports	Add/Edit/Delete
Reminder lists	Allow clinical access
Word processor templates	No access
Word Processor	Deny access
Setup/configuration	Deny access
Passwords	Deny access
Perform a backup	Deny access
Restore from a backup	Deny access
Printers	Deny access
Own preferences	No access

File **Clinical** Ma

Actions

Cervical screening

Diabetes register

Follow up inbox

Immunisations

Pregnancy list

Reminders

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



DIABETES REGISTER

Medical Director Clinical Front Screen < Search < Diabetes Register

File Window Help

No. of patients: 3 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	16/06/2012		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	16/06/2012	12/05/2012		12/05/2012
<input type="checkbox"/>	WATLAND, HENRY				18/02/2013				12/07/2012	12/07/2012	12/07/2012	16/06/2012			

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 Cycle of Care

File Patient Edit Summaries Tools **Clinical**

- Prescribe
- Recipes...
- Action List...
- Allergies/Adverse R...
- Recall...
- Compliance Check
- Ceased Medication
- Diabetes Record..**
- Disabled Patient Pr...
- Preventive Health F...
- Measurements...
- Percentile Charts...

Diabetes Record

Diabetes Follow Up

Assessments performed:

Assessment date
18/02/2013
08/04/2021

Last review by:

Ophthalmologist: 5/07/2022

Podiatrist: 5/07/2022

Dietitian:

Endocrinologist:

Diabetes educ...

Last provided i...

Major parameters:

Date	f Blood Gluc.	Height (cm)	We
22/10/2011		175	77.
13/02/2012		175	77
18/02/2012			
16/06/2012			
12/07/2012		175	78
18/02/2013		175	78
08/04/2021		175	78

Assessment

Add Values

x 7 Assessment pages

Diabetes Assessment

General

Date of assessment: 05/07/2022 Employment status: Unknown

Type of diabetes: Unknown Year of diagnosis:

Management method: Don't know On Insulin since:

Current smoking status: Daily smoker No. of cigarettes: 5

Drinks alcohol Drinks/week: 2

Adequate exercise

Patient has seen a Dietitian 18/07/2012

Patient has seen a Diabetes Educator 05/07/2022

Patient has seen an Endocrinologist 05/07/2022

Date of last EPC Health Assessment: 05/07/2022

Date of last EPC Health Care Plan: 05/07/2022

Date of last EPC Case Conference: 05/07/2022

< Back Next > Cancel

Diabetes Assessment

Medication Review

Medication list

Drug name	Strength	Dose	Freq	Instructions
VENTOLIN CFC-FREE INHAL...	100mcg/dose			

Potential medication problems:

VENTOLIN CFC-FREE INHALER - SALBUTAMOL may increase blood glucose concentrations; caution is recommended in patients with diabetes mellitus

Add Values

Diabetes record

Date: 5/07/2022

Parameters

Weight (kg)		Height (cm)	175
Systolic BP		Diastolic BP	
f Blood Gluc.		HbA1c (mmol/mol)	
Total Chol.		HDL	
Triglycerides		Creatinine	

Urinalysis

Protein	
Blood	
Glucose	
Ketones	
Leucocytes	
Bilirubin	

Last review by:

Ophthalmologist 5/07/2022 Podiatrist 5/07/2022

Dietitian 18/07/2012 Endocrinologist 5/07/2022








Diabetes educator 5/07/2022

Last Provided HypoKit: 5/07/2022

Save Close



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"/>

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	
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Fundus examination: 5/07/2022

Right:	Left:	
<input type="text"/>	<input type="text"/>	

Investigations:

HbA1C:	<input type="text"/>	<input type="checkbox"/> 5/07/2022	<input type="text"/>	<input type="text"/>	<input type="text"/>
Total Cholesterol:	<input type="text"/>	<input type="checkbox"/> 5/07/2022	<input type="text"/>	Triglycerides:	<input type="text"/>
HDL Cholesterol:	<input type="text"/>	<input type="checkbox"/> 5/07/2022	<input type="text"/>	LDL Cholesterol:	<input type="text"/>
Creatinine:	<input type="text"/>	<input type="checkbox"/> 5/07/2022	<input type="text"/>	eGFR:	<input type="text"/>
Albumin/Creatinine ratio:	<input type="text"/>	<input type="checkbox"/> 5/07/2022	<input type="text"/>		
Micro-albuminuria:	<input type="text"/>	<input type="checkbox"/> 5/07/2022	<input type="text"/>	<input type="text"/>	<input type="text"/>

Last visit to:

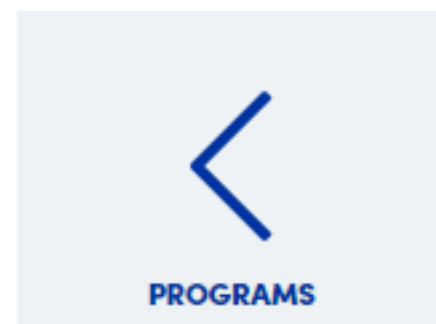
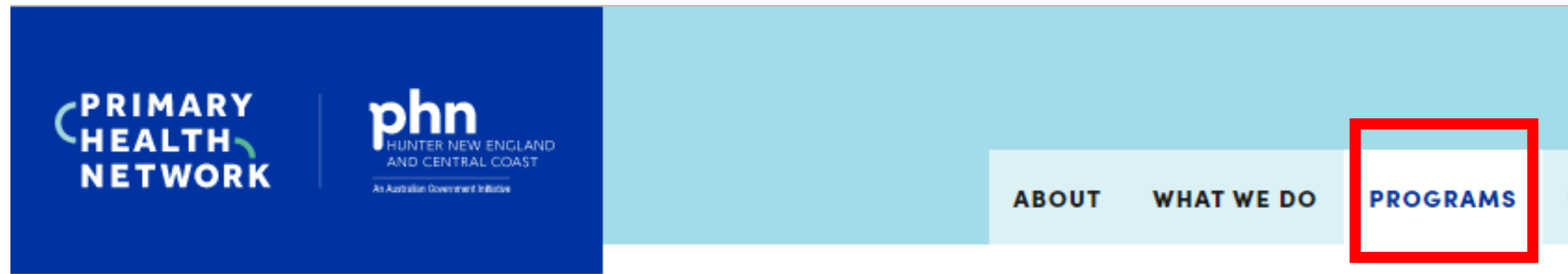
Endocrinologist:	<input type="checkbox"/> 5/07/2022	<input type="text"/>	...	Dietitian:	<input type="checkbox"/> 5/07/2022	<input type="text"/>	...
Ophthalmologist:	<input type="checkbox"/> 5/07/2022	<input type="text"/>	...	Podiatrist:	<input type="checkbox"/> 5/07/2022	<input type="text"/>	...
Diabetes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

Save Cancel

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

Add New Values





Home > PROGRAMS

Diabetes Alliance

Your Primary Care Improvement Officer can assist.



[HNE Diabetes Alliance - YouTube](#)



Diabetes Alliance Expression of Interest Form


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?	

QUALITY IMPROVEMENT LEARNING OUTCOMES

1. De-identified Data Sources

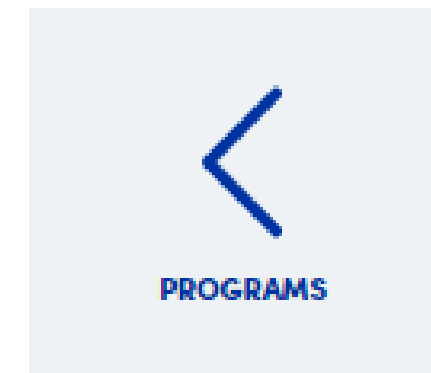
- HNE Diabetes Alliance Program - Managing Type 2 Diabetes Summary Report
- The PHN - General Practice Summary

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

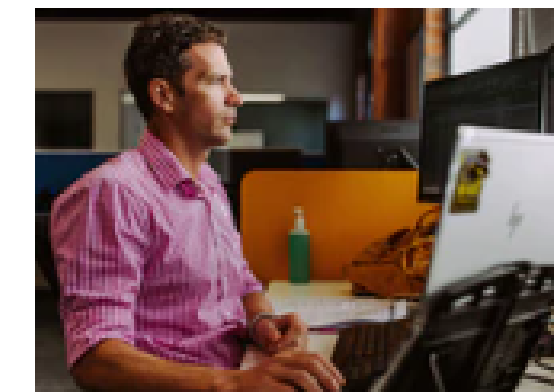
PRINT SHARE

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.



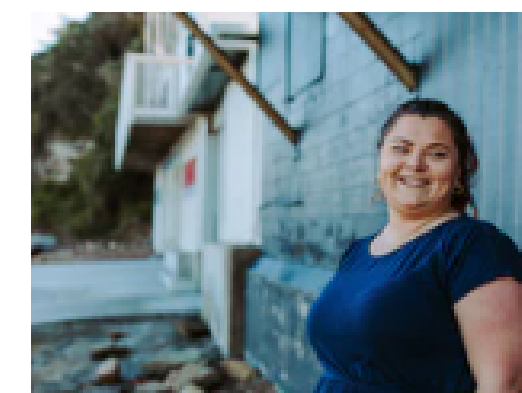
About Us



Quality Improvement Framework



Accreditation



Cancer Screening



Chronic Kidney Disease



Diabetes



Questions Contact Details

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Your PCIO

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