**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 (racgp.org.au)](https://www.racgp.org.au/getattachment/41fee8dc-7f97-4f87-9d90-b7af337af778/Management-of-type-2-diabetes-A-handbook-for-general-practice.aspx)



Your practice’s **PenCS CAT4** tool can determine the number of patients who require an annual diabetes cycle of care. [Identify patients eligible for an Annual Diabetes Cycle of Care - CAT Recipes - PenCS Help](https://help.pencs.com.au/display/CR/Identify%2Bpatients%2Beligible%2Bfor%2Ban%2BAnnual%2BDiabetes%2BCycle%2Bof%2BCare)

The Practice Nurse and Quality Improvement Team wish to improve the completion of Diabetes Cycle of Care for each patient. The team pick this topic for improvement and create a **Model for Improvement** for the PIP QI Quarter beginning 1 May.

The **SMART goal** is 100% of patients with diabetes in the practice will have commenced an annual cycle of care by 31 July.

**Data Baseline:**

**Numerator:** Number of patients without a completed Diabetes Cycle of Care

**Denominator:** Number of Patients diagnosed with Diabetes Type 2

**Example:** 300/600 = 50%

**Review Date:** 31 July

**PLAN:**

**Idea 1:** Use **Clinical Information System** tools to commence and complete a patient’s Diabetes Cycle of Care.

**TIP:**

BP: Diabetes Cycle of Care Tool in Enhanced Primary Care < Current < Diabetes Cycle of Care [Diabetes Cycle of Care (bpsoftware.net)](https://kb.bpsoftware.net/bppremier/saffron/Clinical/EPC/EPC-DiabetesCycleofCare.htm).

MD: Patient Clinical window < Clinical < Diabetes Record < Assessment. [MD Online Help (medicaldirector.com)](https://www.medicaldirector.com/help/#t=topics-clinical%2FDiabetes_Assessment.htm)

**Idea 2**: Use **TopBar** to opportunistically identify outstanding activities of Diabetes Cycle of Care when patient is present. [Diabetes Cycle of Care Eligibility - USER GUIDES TOPBAR - PenCS Help](https://help.pencs.com.au/display/TUG/Diabetes%2BCycle%2Bof%2BCare%2BEligibility). (*Please note MBS Item Numbers for Diabetes Cycle of Care and Incentive Payments have ceased.)*



**Idea 3**: Set up **Nurse-led clinics**. Consider Role, Individual and Context Scope of practice; setting; logistics, appointment book, equipment, documentation. [Explaining the essential elements of a nurse clinic (apna.asn.au)](https://www.apna.asn.au/nursing-tools/nurse-clinics/Buildingblocks)

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**Idea 4**: Attend HNECCPHN or other **Nurse Education** Events to upskill in Chronic Disease Management. [Education Events - Primary Health Network - Page 2 (thephn.com.au)](https://thephn.com.au/education-events/p2)

**Idea 5**: Run a report in **CAT4 Diabetes Cycle of Care Items completed per patient** and concentrate on patients with the most items completed, e.g., patients with 10-15 already completed. [Cycle of Care by Items Completed Per Patient - CAT GUIDES - PenCS Help](https://help.pencs.com.au/display/CG/Cycle%2Bof%2BCare%2Bby%2BItems%2BCompleted%2BPer%2BPatient)



**Idea 6**: Run a **CAT4 report of items recorded** to determine the practice’s strengths and weaknesses. [Diabetes Items - CAT GUIDES - PenCS Help](https://help.pencs.com.au/display/CG/Diabetes%2BSIP%2B%28Service%2BIncentive%2BPayment%29%2BItems)



**Idea 7:** Use your **Practice’s PHN CAT4 Dashboard** to benchmark performance against other practices for Quality Improvement Measure QIM 01(HbA1c/12months), QIM 10 (BP/6 months), and Influenza immunization QIM 5.

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**Idea 8:** Make sure your activities are coded correctly.[Diabetes Data Category Mappings BP - Data Mapping - PenCS Help](https://help.pencs.com.au/display/ADM/Diabetes%2BSip%2BData%2BCategory%2BMappings%2BBP) [Pathology Data Mappings All Systems - Data Mapping - PenCS Help](https://help.pencs.com.au/display/ADM/Pathology%2BData%2BMappings%2BAll%2BSystems) [Diabetes Data Category Mappings MD3 - Data Mapping - PenCS Help](https://help.pencs.com.au/display/ADM/Diabetes%2BSip%2BData%2BCategory%2BMappings%2BMD3)

**TIP**: Contact your supplier to ensure **Pathology Results** are sent to practice in HL7 format.

**Idea 9:** Use the **Clinical Information System** efficiently. [Diabetes Cycle of Care (bpsoftware.net)](https://kb.bpsoftware.net/bppremier/saffron/Clinical/EPC/EPC-DiabetesCycleofCare.htm) [MD Online Help (medicaldirector.com)](https://www.medicaldirector.com/help/#t=shared-content%2FStart_Clinical_Diabetes.htm)

**TIP**: BP: **Physical Activity** Prescriptions must be **printed** for this assessment to save, but does not populate Cycle of Care.

**TIP**: BP: Use **Observations** fields to record height, weight so that Cycle of Care will automatically calculate BMI.

**TIP**: BP: Assess **smoking status** in Alcohol and Smoking History < Tobacco.

MD: Assess **smoking status** in Patient Details < Smoking Tab.

**TIP**: BP: Record a **Medication Review** in Enhanced Primary Care folder to code it for Cycle of Care.

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**By end of July quarter, the Quality Improvement Team complete the Improvement Cycle:**

**DO: What did you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**STUDY: What were the reviewed results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ACT: What can be added, continued, and/or removed from process? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**