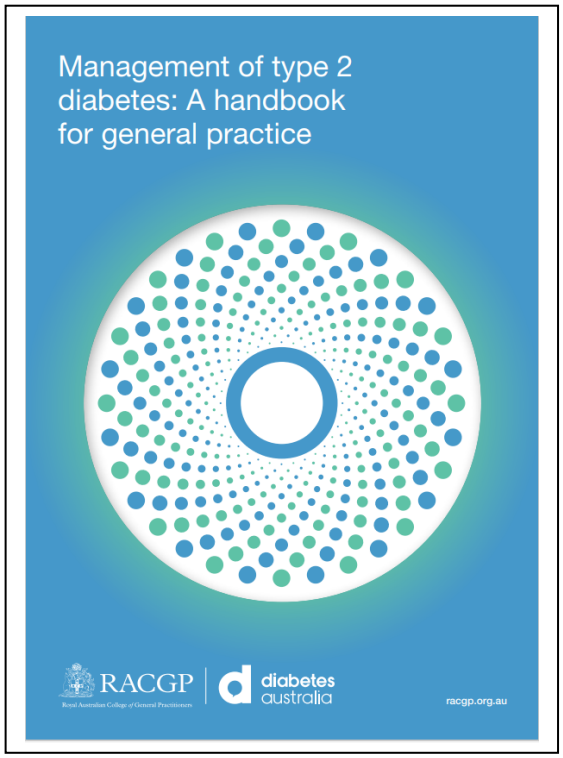
Quality Improvement Scenario 4: Diabetes Cycle of Care completion

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)



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

These are patients with a coded diabetes diagnosis who have not had a Diabetes MBS item number billed in the last 12 months. (**MBS Item Numbers** GPs in rooms 2517,2521,2525; GPs not in rooms 2518,2522,2526; OMP in rooms 2620, 2622,2624; OMP not in rooms 2631,2633,2635) Note AN.0.54 | Medicare Benefits Schedule (health.gov.au)

Note: Some providers do not bill the Diabetes Cycle of Care MBS Item numbers, rather the standard consult item is billed. However, a patient's completed Diabetes Cycle of Care is not searchable in CAT4 without a Diabetes Cycle of Care MBS Item billed.

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 with an outstanding Diabetes Cycle of Care
Denominator: Number of Patients diagnosed with Diabetes Type 2
Example: 300/600 = 50%

Review Date: 31 July

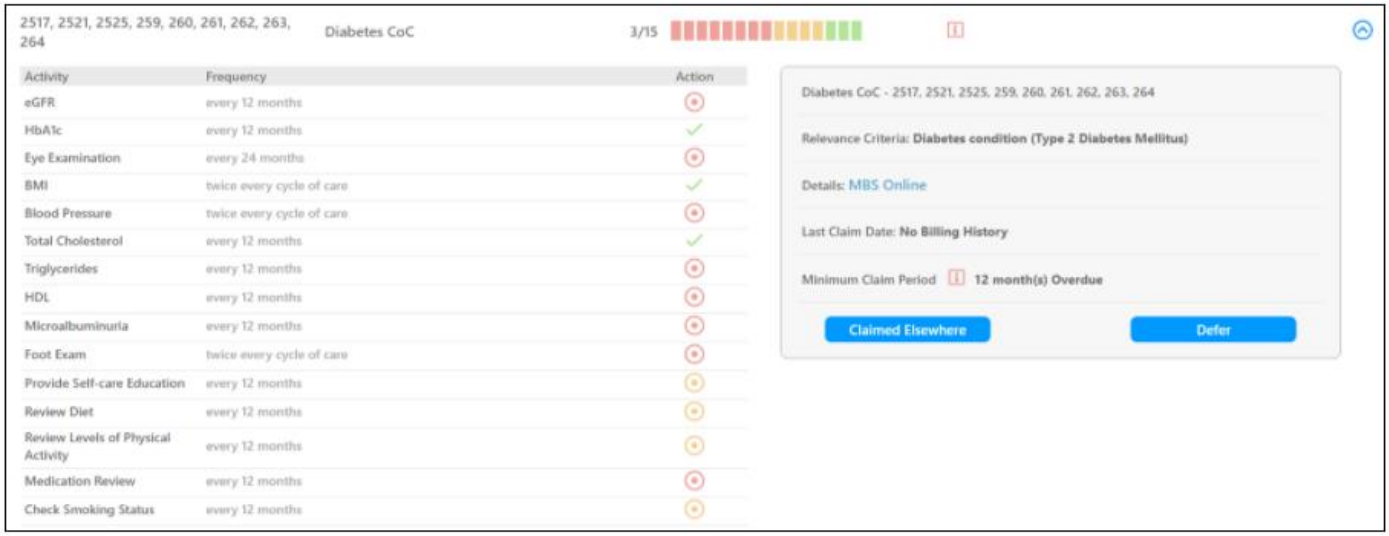
PLAN:

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).

MD: Patient Clinical window < Clinical < Diabetes Record < Assessment. MD Online Help (medicaldirector.com)

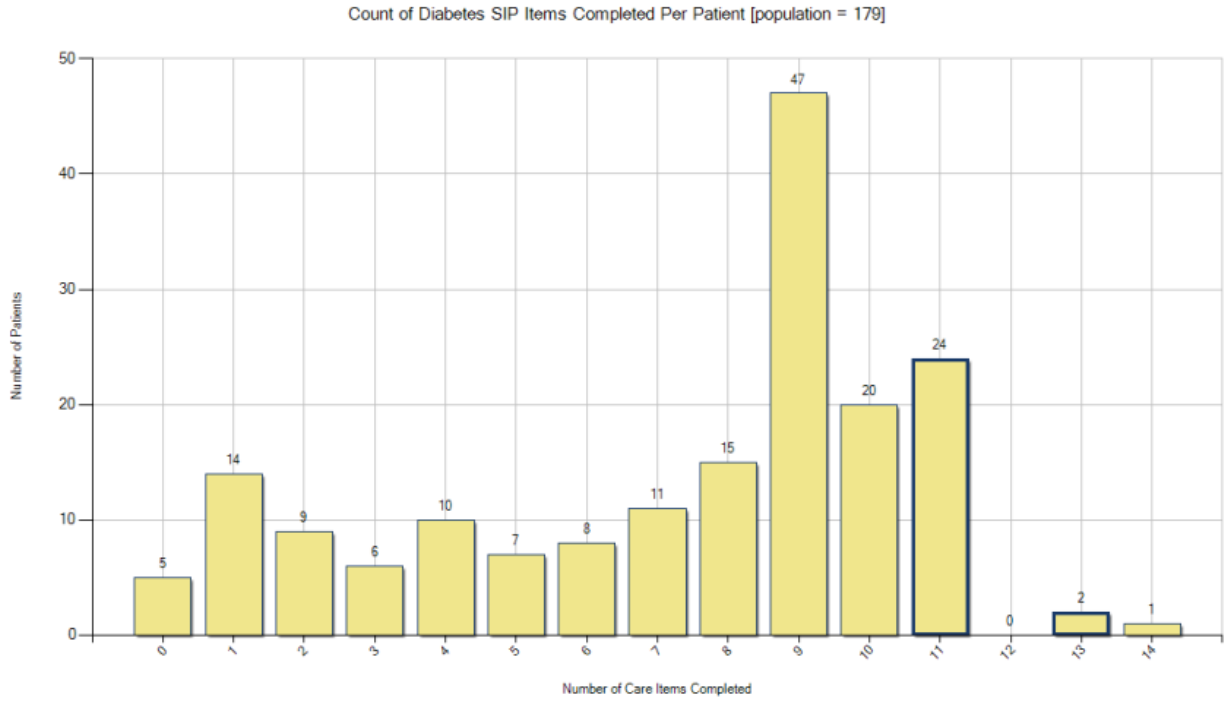
Idea 2: Use **TopBar** to opportunistically identify outstanding activities of Diabetes Cycle of Care when patient is present. Diabetes Cycle of Care Eligibility - USER GUIDES TOPBAR - PenCS Help



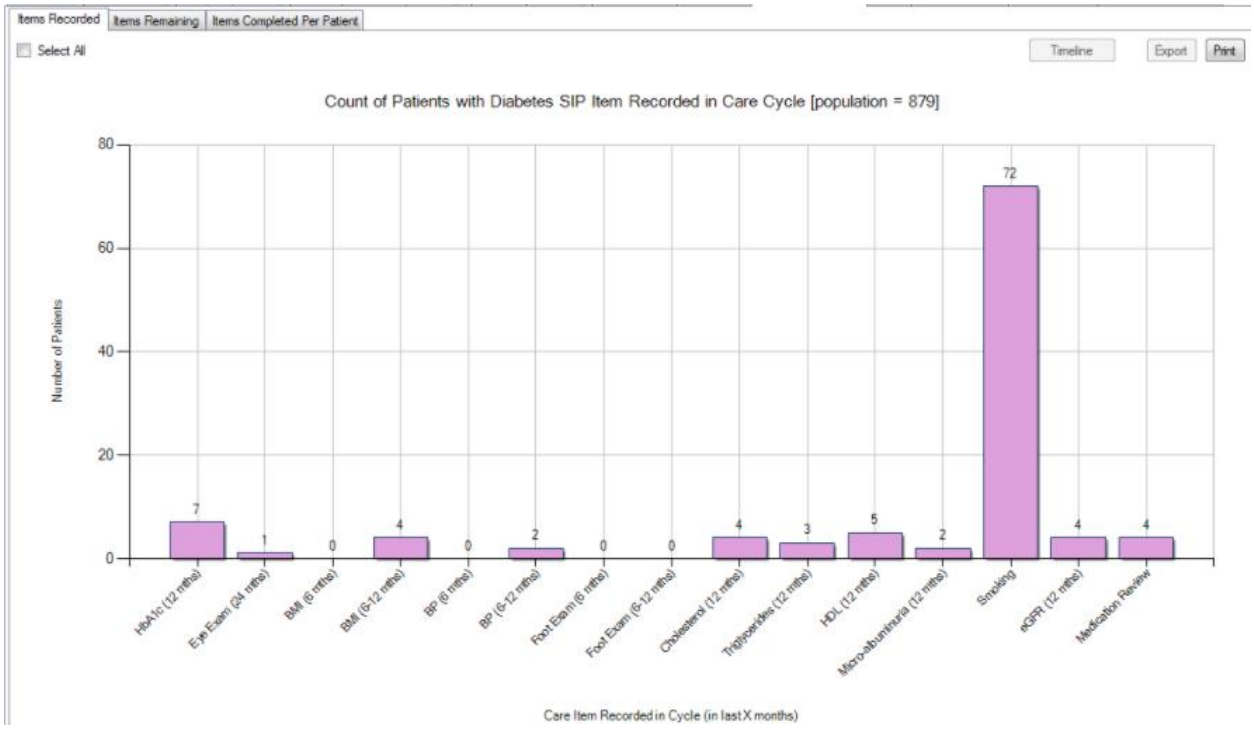
Idea 3: Set up **Nurse-led clinics**. Consider Role, Individual and Context Scope of practice; setting; logistics, appointment book, equipment, documentation. Explaining the essential elements of a nurse clinic (apna.asn.au)

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)]

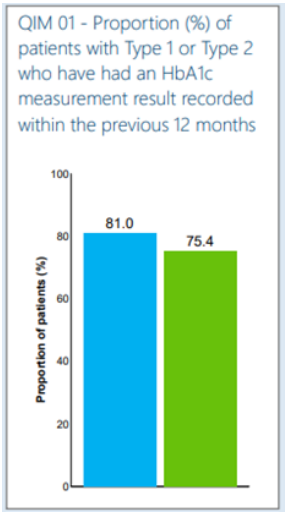
Idea 5: Run a report in **CAT4 Diabetes SIP Items completed per patient** and concentrate on patients with the most items completed, e.g., patients with 10-15 already completed. [Cycle of Care by Items Completed Per Patient - CAT GUIDES - PenCS Help]

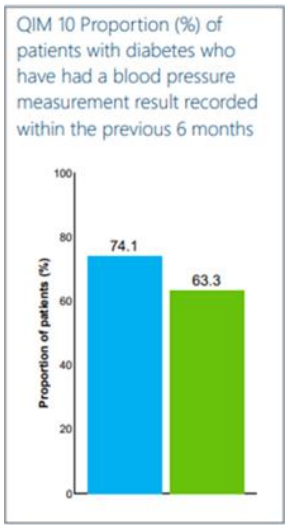


Idea 6: Run a **CAT4 report of items recorded** to determine the practice's strengths and weaknesses. [Diabetes SIP (Service Incentive Payment) Items - CAT GUIDES - PenCS Help]



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.





Idea 8: Make sure your activities are coded correctly. Diabetes Sip Data Category Mappings BP - Data Mapping - PenCS Help Pathology Data Mappings All Systems - Data Mapping - PenCS Help Diabetes Sip Data Category Mappings MD3 - Data Mapping - PenCS Help

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) MD Online Help (medicaldirector.com)

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

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

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

TIP: BP: Assess **smoking status** in Alcohol and Smoking History < Tobacco.
MD: Assess **smoking status** in Patient Details < Smoking Tab.

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?