

DIABETES

QUALITY IMPROVEMENT TOOLKIT



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This toolkit is intended as a guide for how quality improvement can be used to improve outcomes for people living with, or at risk of developing diabetes. General Practices and health services are complex environments, therefore you should test any system changes that you are planning to make using the Model for Improvement and Plan, Do, Study, Act (PDSA) cycles.

This toolkit does not set out to provide a clinical resource for the management of diabetes. Such information can be found in diabetes clinical guidelines produced by relevant clinical advisory organisations, as noted in the following page.

DIABETES GUIDELINES'

The Royal Australian College of General Practitioners (RACGP) has developed an evidence based guide to the diagnosis and management of type 2 diabetes in the primary care setting, titled 'General practice management of type 2 diabetes! This guide includes recommendations and information on a range of topics, including the following:

- identifying risk of diabetes in asymptomatic patients
- preventing type 2 diabetes
- patient centred diabetes care
- patient education and self-care
- glycaemic monitoring and glycaemic emergencies
- managing cardiovascular risk
- neuropathy and nephropathy
- pregnancy with pre-existing diabetes
- diabetes and end-of-life care.

The Diabetes Australia Guideline Development Consortium comprising of Diabetes Australia, Australian Diabetes Society, the Australian Diabetes Educators' Association (ADEA), the RACGP, the Diabetes Unit at the Menzies Centre for Health Policy at the University of Sydney, have produced five national evidence based guidelines for the management of type 2 diabetes, which are:

- Guidelines for Diagnosis, Prevention and Management of Chronic Kidney Disease in Type 2 Diabetes
- Guidelines for Case Detection and Diagnosis of Type 2 Diabetes
- Guidelines for Blood Glucose Control in Type 2 Diabetes
- Guidelines for Patient Education in Type 2 Diabetes
- Guidelines to the Primary Prevention of Type 2 Diabetes.

These guidelines have been succinctly captured in HealthPathways point-of-care resources.

PLANNING FOR IMPROVEMENT

Ideally, before embarking on your quality improvement journey, you will have engaged your team and there is agreement to focus on a particular area (e.g. diabetes) for a period of time. This is best documented in a Quality Improvement Plan.

A Quality Improvement Plan is a valuable document for guiding your quality improvement work and keeping your effort focused. If you have not already developed a Quality Improvement Plan, refer to the 'Continuous Quality Improvement Fundamentals' module.

Example Aims for Diabetes

An example management aim for diabetes in a Quality Improvement Plan might be:

'Within one year, 50% of Active patients with diabetes will have a recorded HbA1c result less than or equal to 7% within the previous 12 months.'

An example management aim for diabetes in a Quality Improvement Plan might be:

'Within one year, 60% of the eligible general practice or health service population will have a Type 2 diabetes risk assessment (AUSDRISK) completed.'

These aims (or goals as they are sometimes referred to) are at a high level and ideally present a reasonable challenge for the team over a period of 12 months or 18 months. The target set in the aim needs to reflect your organisation's population and current performance. If you set the target too high or too low, the aim may not resonate with the team and you could lose engagement.

As primary care is a very busy and complex environment, it is recommended that your plan has one area of focus for the period. The above examples are provided as an example for diabetes management and diabetes prevention. While it is possible to attempt both together, it is not recommended.

Example measurement for these aims

Management Measurement

- HbA1c under control
 - Description: The proportion of Active patients with diabetes who have a recorded HbA1c result within the past year and whose last recorded HbA1c result was less than or equal to 7%.

Numerator = The number of Active patients with diabetes and a recorded Hba1c result within the past year and whose last recorded HbA1c result was less than or equal to 7%.
Isdunhi

Denominator = The number of Active patients with diabetes.

This measure exists in some software, in which case you may not need the calculation. Simply dividing the numerator result by the denominator result will produce a proportion (i.e. 117 (numerator) divided by 465 (denominator) equals 25%).

This measure is a direct measure of the example aim and will allow monitoring of progress over time. However, this measure is unlikely to respond quickly and to early process changes, therefore, additional measurement is recommended. This will depend on where you choose to start and the following are examples of additional measurement.

- HbA1c Recorded

Proportion of Active clients who have diabetes and who have had an HbA1c measurement result recorded within the previous 12 months.

You can use the new PIP QI measure QIM 1 – HbA1c status for patients with diabetes. While the guideline states that HbA1c should be tested every 6 months, this measurement will help you measure early work to improve HbA1c recording.

- GP Management Plans

The proportion of clients with diabetes with a GP Management Plan claimed within the previous 12 months.

This measure should also respond to early process work. There is an assumption that when a GP Management Plan follow up is in place, other elements of diabetes care are being delivered.

You could use other measurement such as BP recorded, immunisation status, smoking status recorded, eGFR recorded, etc. There are many other diabetes related measures available in most clinical software.

PREVENTION MEASUREMENT

- AUDRISK Assessment
 - Description: The percentage of people within the clinical database who are currently without a diagnosis of diabetes and who have had a AUDRISK Assessment aged: a) Non-Aboriginal and Torres Strait Islander people aged 40 and above, OR b) Aboriginal and Torres Strait Islander people aged 15 and older.

Numerator = The number of people within the clinical database aged: a) Non-Aboriginal and Torres Strait Islander people aged 40 and above, OR b) Aboriginal and Torres Strait Islander people aged 15 and older who are currently without a diagnosis of diabetes and who have had a AUDRISK Assessment.

Denominator = The number of people within the clinical database aged: a) Non-Aboriginal and Torres Strait Islander people aged 40 and above, OR b) Aboriginal and Torres Strait Islander people aged 15 and older who are currently without a diagnosis of diabetes.

This measure may be available in your clinical software, in which case the manual calculation may not be required.

Your Quality Improvement Plan should already have an established understanding of your population and your organisation's performance. Following this, a decision to focus on diabetes and establish an aim and measures will provide a framework for you to monitor over time and report progress to your team.

This document provides example activities. Although they are presented in a linear fashion, knowledge of your organisation's performance with regard to diabetes prevention and management should guide where you will start and the activities you choose to undertake.

The below activities are detailed in the following pages, with example Model for Improvement cycles (where relevant) to stimulate thinking:

1. Know your patient population
2. Recall and review patients diagnosed with diabetes with no recorded HbA1c within the past year
3. Recall patients diagnosed with diabetes with no recorded blood pressure within the past 6 months
4. Ensure influenza immunisations are provided
5. Complete GPMP and Team Care Arrangement (TCA) and eligible reviews
6. Support patient self-management.

MAKING CHANGES TO YOUR SYSTEMS

At this stage you should have established an aim for your diabetes work and decided on how you will measure your progress over time. In this toolkit, we'll principally be focusing on diabetes management as this is where most of the system change opportunity exists. Later in this tool we'll look at an idea to improve diabetes risk assessment. (Page 16)

KNOW YOUR PATIENT POPULATION

Before commencing improvement work on diabetes management, you will need to fully understand your diabetes patient population. While some of this work may have been done to guide your decision to focus on diabetes, a more detailed understanding of your organisation's population is now needed to help inform your early improvement activities.

Some of the questions that you may want to answer are:

- How many patients are coded with diabetes (the register) and does this seem about right, taking into account the prevalence of diabetes in your PHN's catchment area?
- What proportion of patients coded with diabetes have not had an HbA1c result recorded in the past 12 months?
- What proportion of patients coded with diabetes have not had their blood pressure recorded in the past 6 months?
- What proportion of patients coded with diabetes do not have a current influenza vaccination?
- What proportion of patients coded with diabetes have all elements of their annual cycle of care completed and recorded?
- What proportion of patients coded with diabetes have not had a GP Management Plan claimed within the past year?
- What proportion of eligible patients do not have a recorded AUSTRISK assessment?

Once you have a good understanding of how your organisation is performing with regard to the delivery of diabetes care, you will be able to consider where to start your work.

Data quality and clinically coded diagnosis

Coding is critical to quality and safety, and your computer systems cannot perform at their best without coding. While there is a place for contextual notes in free text, these notes should be in addition to appropriate coding.

By clinically coding diagnoses you can produce Diabetes register which allows you to more easily monitor spirometry, pathology testing, vaccinations, blood pressure recording, care planning, and referrals to relevant specialists and allied health providers.

Achieving and maintaining data quality

Data quality is more than just coding. It means that data, relevant to the patient's care needs, are accurate, complete and up-to-date.

A team approach is critical. Every person on your team has a responsibility to ensure that data quality is maintained and if each person is doing their part, your organisation will achieve and maintain quality data. If not, inevitably, data quality will reduce over time.

Once off data cleaning

There is a place for once off data cleaning, but this should be done after the team has developed an agreed approach to maintaining data quality. If not, your cleaning efforts will be eroded over time.

As you are focusing on diabetes, there are specific data cleaning exercises you can undertake in your clinical software, PenCS CAT4 and Cleansing CAT.

- CAT4 – to ensure all patients are correctly coded with diabetes, select the CAT Recipe
- PAT CAT – to view diabetes prevalence in your PHN catchment, use this mapping recipe
- CAT4 - select this CAT Recipe to identify patients without HbA1c results recorded in the last 12 months, or alternatively use the recipe relating to the PIP QI measure – “QIM 1 -HBA1C status for patients with diabetes”
- CAT4 – to identify blood pressure recording – “QIM 10 – Blood pressure for patients with diabetes”
- CAT4 – for influenza vaccinations – “QIM 5 – Influenza immunisation for patients with diabetes”
- CAT4 – use this CAT Recipe to identify outstanding diabetes cycle of care items

Alternatively do a bulk clean-up of free text diagnosis in your clinical software. For specific advice on data cleansing exercises in your clinical software, please refer to your provider.

For all CAT 4 recipes, please go to <https://help.pencs.com.au/>

MAKING CHANGES TO YOUR GENERAL PRACTICE SYSTEMS

Where to start your improvement activities

By this stage you should have in place:

- commitment from your team to focus on diabetes
- a Quality Improvement Plan related to diabetes with:
 - a clear aim
 - measures (about 3) to guide your work over the next year
 - high level strategies, ideas or tactics for change
 - identified members of the quality team or at least coordinator for the Quality Improvement Plan
- protected time to carry out essential coordination activities, and
- a sound understanding of your population and your organisation's current performance relating to the delivery of care for patients with diabetes.

You will need to decide what to do first and this will depend on where you are starting from. For example, if your organisation's performance in delivering elements of the diabetes cycle of care is poor, but you also have missing or out of date data, then you may need to commence with data quality. If your data quality is reasonable, then you could commence with process changes to improve your performance with the diabetes cycle of care, such as increasing the proportion of diabetes patients who have had an HbA1c recorded in the last year.

System changes vs tasks

System change

System change (or process change) is typically where you will seek to change the way people (staff, patients or suppliers) change the way they routinely behave. For example, the way your organisation/staff routinely ensures that all patients coded with diabetes have HbA1c testing undertaken every year.

Tasks

These are generally actions that can be undertaken (such as data cleansing activities) but are not really a system change. The system change will come after you have a current and accurate register of patients coded with diabetes.

Identifying which of the change ideas (as they come up) is a task and which is a system change, will help you determine whether you use the Model for Improvement. The Model for Improvement is best used to test a system change, whereas tasks can simply be undertaken at the appropriate time.

Change ideas

When making changes to your systems, it is advised that you make small changes over time in a planned and coordinated way. The following change ideas are provided as suggested activities to improve outcomes for patients with diabetes. The change ideas are not intended to be implemented all at once, or necessarily in the order below. It would be best to start on just one change idea that is most suited to your team and your organisation.

Model for Improvement examples are also provided, where appropriate, to help you understand how to break change down into small incremental steps and ensure the change is an improvement before scaling or implementing.

Model for Improvement Example - Improving HbA1c results

Goal: Over the next two months, increase the proportion of Active clients who have diabetes and who have had an HbA1c measurement result recorded within the previous 12 months to 70%.

Note: you can use the PIP QI measure QIM 1 – HbA1c status to directly measure this goal and the target above (70%) is based current performance being 60%. Therefore, a 10% improvement in two months.

Measures:

PIP QI measure QIM 1 – HbA1c status

Ideas:

- Make a list of patients with diabetes who have not had an HbA1c test in the last year.
- Send out letters or SMSs to select patients requesting them to come in to speak with their GP.
- Work with the receptionist(s) to proactively identify patients on the list (above) who have booked an appointment in the near future.

So far, we have established the first part of the Model for Improvement (the goal, measurement and ideas for change).

The next step is to test system changes using PDSA cycles. From the ideas above, or using a combination of these, you can decide on a PDSA cycle for testing. Ideally the PDSA cycle will help you understand what changes you can make to your systems and/or processes that will improve on the current result and be sustainable over time.

To undertake the test in a small way, you could initially search in the clinical software to identify all patients who have not had an HbA1c test in the past year. This is not a PDSA, but it will help you quantify the scope of the work that will be involved and will identify individual patients. Once you have this list, you could undertake a PDSA cycle by:

- Working with one GP to identify which patients on the list generated above are usually seen by that GP.
- Recall an agreed number of these patients on a particular day and ask them to contact the practice to make an appointment.
- Provide a list of the patients recalled to reception so that they can note who has contacted the practice and who has made an appointment.
- Following an agreed period of time, say two weeks, you could assess the outcome of the test, see how effective it was and consider any changes to your process.

Immunisations

All patients with diabetes should be strongly encouraged to have an influenza vaccination annually. Influenza is a respiratory disease and the vaccine prevents deterioration and reduces the risk of exacerbations, hospitalisation and death. An annual influenza vaccination is funded under the National Immunisation Program for people with a diagnosis of diabetes.

The pneumococcal vaccine is funded under the National Immunisation Program for adults with medical conditions, including diabetes, that increase their risk of acquiring invasive pneumococcal disease. A pneumococcal vaccine reduces risk of the bacterial infection *Streptococcus pneumoniae*. This bacterial infection can cause meningitis, pneumonia, bacteraemia and conditions like otitis media. Consult the National Immunisation Handbook for complete information on the vaccines, dosages, contraindications, etc.

Model for Improvement example – Influenza vaccination

Goal: Increase to 70% the proportion of Active patients coded with diabetes who have had an influenza vaccination within the past 15 months.

Note: As influenza vaccination is a seasonal vaccination, you will need to take into account timing. Therefore, it might be best to commence with work on increasing the proportion of patients diagnosed with diabetes who have influenza vaccinations in the winter months.

Measures:

You could use the PIP QI measure - QIM 5 – Influenza immunisation for patients with diabetes.

The proportion of Active clients with diabetes who are immunised against influenza. A person is considered immunised against influenza if they have received an influenza vaccine within the previous 15 months.

Ideas:

- Identify and recall patients diagnosed with diabetes who have not had an influenza vaccine this year.
- Contact local pharmacies to establish a relationship in which you can identify patients who have had influenza vaccinations at the pharmacy.
- Run an awareness campaign on the importance of influenza vaccination.
- Hold a dedicated influenza vaccination clinic.

PDSA cycles

As per the previous example, some of the above ideas may not be suitable for PDSA cycles, such as 'contact local pharmacies to see if you can establish...'. However, if the local pharmacy was interested in collaborating, PDSA cycles could be used to develop and refine the system that is used to notify the practice of patients that have received a vaccination.

Recalling patients may be a place to start, but also consider holding dedicated influenza vaccination clinics. You could start by planning one clinic at the start of the immunisation season and testing the results. If the results are positive, you can scale this idea to multiple clinics and implement over time.

Make sure you focus on small tests (involving small groups of patients) using PDSA cycles.

Systematic and Proactive Care for Patients with Diabetes

Managing care efficiently and consistently across a general practice or health service requires a planned, systematic and proactive approach. It is important your patients with, or at risk of developing, diabetes are offered appropriate evidence-based and patient-centred interventions.

Nurse clinics offer an alternative model of care delivery where the nurse is the primary provider of care for the patient. In the general practice or health service setting, nurse clinics support a team based approach to care delivery, which involves GPs and other members of the practice team. Accountability and responsibility for patient care and professional practice remain with the nurse.

Nurse clinics can provide holistic and patient centred care by:

- developing ongoing relationships with patients, their carers and families
- spending the time needed to create individualised care plans with patient-determined goals, as well as coordinating any requests for pathology and referrals to relevant specialists and/or allied health providers
- supporting patients with strategies to enhance self-management and undertaking risk assessments for co-morbid conditions and/or assessing patients' health literacy.

There is no one model for a nurse clinic. Several factors need to be considered, including:

- the size of the practice and available treatment rooms
- available resources including the number of practice nurses employed in the practice and their skill set(s)
- business planning, including sources of finance
- governance frameworks
- the ability of practice nurses to form collaborative working relationships with GPs and/or form micro teams with other staff in the practice, as well as health and social care providers in the community.

Model for Improvement example - Increasing the completion of all elements in diabetes cycles of care

Goal: Over the next three months, increase to 20% the proportion of Active patients coded with diabetes who have had all the elements of their annual cycles of care completed within the last 12 months.

Measures:

- The number of Active patients coded with diabetes in the clinical software
- The number of Active patients coded with diabetes who have all elements completed in the diabetes cycle of care (B)
- The proportion of patients with diabetes who have all elements completed in the diabetes cycle of care (B divided by A).

Ideas:

- Identify and recall patients diagnosed with diabetes who have not had all the items completed in their diabetes cycles of care.
- Ask staff for ideas on how to encourage patients to undertake pathology testing and foot and eye examinations.
- Ask a GP or PN to upskill the team on ways to support patients to undertake all elements of their cycles of care.
- Offer patients the opportunity to see the nurse for assessment of diet, physical activity, alcohol and smoking status, as well as BP and BMI measurements, prior to a GP consult.
- Access resources (e.g. from Diabetes Australia on managing diabetes, health management and lifestyle modification advice) and provide to patients during the next consultation and/or opportunistically.
- Access/develop care plan templates that incorporate co-morbidities.

PDSA Cycles

When applying the Model for Improvement to the ideas above, it is clear that some will need to be undertaken first. Initially, you can:

- identify patients diagnosed with diabetes who have not had all the items completed in their diabetes cycles of care
- involve the whole team in asking for ideas on how to encourage patients to undertake pathology testing and foot and eye examinations
- undertake internal upskilling/education, and
- source appropriate resources.

Then, you will be in a position to start testing the recall of patients.

Subsequent testing of this idea using PDSA cycles is likely to:

- improve the effectiveness of recalling patients
- make changes to roles and responsibilities as required.

Recalling patients to a clinic to improve the completion rates of activities required to meet the annual cycle of care should be tested on a small scale, ideally during a morning or an afternoon session. You may have a GP and a nurse who is interested in diabetes and this may be a good place to start. If you try recalling a small number of patients to a clinic in the first instance, you will be able to study the outcome and identify any other consequences that may arise. It is from these small tests that you will learn how to refine the process to a point where you have confidence that it could be scaled up (with more GPs and nurses or fully implemented across the organisation).

Given that you should be able to identify patients and outstanding elements of the annual cycle of care, you may be able to logically group patients and invite them to clinics that are targeted to deliver specific care (for instance foot checks).

GP Management Plans and Team Care Arrangements and Eligible Reviews

The RACGP provides evidenced based recommendations for the diagnosis and management of type 2 diabetes in the primary care setting, including goals for optimum management.

These guidelines, along with local public and private services, have been succinctly captured in HealthPathways point-of-care resources.

In addition to ongoing pathology testing (including blood glucose levels), blood pressure recording, immunisations and completion of annual cycles of care, a care plan should consider:

- feet and eye examinations
- diet and physical activity
- measurement of parameters, including weight
- assessment of smoking and alcohol status
- patient health literacy
- co-morbidities
- risk factor monitoring for co-morbidities, including cardiovascular disease
- lifestyle modifications, where required
- development of an Action Plan

- community supports, and
- end of life care.

Diabetes Australia provides tools, such as a type 2 diabetes risk calculator, and e-learning modules on topics including:

- diabetes essentials
- diabetes in practice for nurses.

In addition, the Australian Primary Health Care Nurses Association (APNA), in conjunction with ADEA, has developed the 'Diabetes Management in a Primary Care Setting' online learning course for primary health care nurses and the Mobile Learning Unit at the University of Melbourne has developed an interactive CPD accredited course focused on best practice principles in diabetes management.

Model for Improvement Example - GP Management Plans

Goal: Over the next two months, increase to 40% the proportion of our patients diagnosed with diabetes who have had a GP Management Plan claimed in the previous 12 months or a GP Management Plan review claimed within the past 6 months.

Measures:

- The number of Active patients coded with diabetes in the clinical software (A)
- The number of Active patients coded with diabetes who have had a GP Management Plan claimed in the previous 12 months or a GP Management Plan review claimed within the past 6 months (B)
- The proportion of Active patients with diabetes who have had a GP Management Plan claimed within the previous 12 months or a GP Management Plan review claimed within the past 6 months (B divided by A).

Ideas

- Recall patients coded with diabetes without a GP Management Plan to come in for an appointment.
- In the clinical software, flag patients coded with diabetes without a GP Management Plan and opportunistically implement a GP Management Plan at the next visit.
- Review and improve recall and reminder systems for GP Management Plan and their reviews.
- Review and improve workflows and educate staff.
- Conduct an annual audit of patients with diabetes that do not have a GP Management Plan.

PDSA Cycles

Ensure that you use PDSA cycles to test ideas and that these tests are small in scale. PDSA cycles ideally focus on a small group of patients or clinicians to test ideas, learn from these tests and make small but rapid improvements over time.

Patient Self Management

To provide comprehensive care, integrate self-management support into the care delivery system. Self-management support includes a range of initiatives for patients that are delivered via different modes, including consultations, action plans, brochures, online videos, TV, telephone, support groups or mobile phone apps.

Develop written Action Plans for diabetes in consultation with your patients. Consider the severity of the disease and the unique circumstances of each patient prior to commencing the plan. Supporting patients to undertake daily blood glucose level monitoring will help them to continually focus on their self-management and will likely reduce their risk of hypoglycaemia and/or hyperglycaemia.

Adherence with the Action Plan will require patients to be able to understand what they need to do when they become unwell. Check their health literacy, especially in older, frail and cognitively impaired patients.

Action Plans should not replace comprehensive self-management plans that incorporate patient goals, ongoing education and regular reviews of the patient's health and wellbeing.

Model for Improvement Example - Diabetes Action Plans

Goal: Over the next two months, increase to 40% the proportion of our Active patients diagnosed with diabetes who have an Action Plan.

Measures:

- The number of Active patients coded with diabetes in the clinical software (A)
- The number of Active patients coded with diabetes who have Action Plans completed (B)
- The proportion of Active patients with diabetes who have a completed Action Plan (B divided by A).

Ideas:

- Recall patients for specific appointments to develop Action Plans.
- Develop a tracking sheet to monitor the completion of Action Plans and inform all clinical staff of this sheet.
- Source and utilise appropriate resources and templates (e.g. from the ADEA).
- Involve the whole team in developing plans and allocate roles and responsibilities.

PDSA Cycles

Looking at the ideas above for this Model for Improvement, the last three ideas would need to be undertaken first:

- Developed a tracking sheet
- Sourced appropriate resources, and
- Involved the whole team in basic planning around action plans

Then, you will be in a position to start testing the recall of patients.

Subsequent testing of this idea using PDSA cycles is likely to:

- improve the effectiveness of recalling patients
- improve the tracking sheet and its use
- make changes to roles as responsibilities as required.

Diabetes Prevention

Risk assessment is about identifying individuals who have risk factors that might lead to a chronic condition in the future. Early identification of risk factors provides an opportunity to educate and encourage preventative behaviours, with the aim of decreasing the risk that the patient develops diabetes.

Consider establishing a system for managing the risk assessment process, as it is likely that the list of patients requiring risk assessment will be quite large. Your general practice or health service may choose to undertake risk assessments (for appropriate individuals) as part of a health assessment. Alternatively, you may choose to prioritise individuals based on specific considerations, such as:

- clinical history - including individuals who are known to have high blood pressure, high cholesterol, require BMI or waist circumference
- lifestyle – including individuals that have a recorded history of smoking, consume greater than the recommended safe level of alcohol or lead a sedentary lifestyle
- patients from hard to reach groups.

For patients with a high risk of developing diabetes, it is important that education and interventions are provided to reduce the risk of this occurring.

Patients who are at high risk of developing diabetes (an AUSDRISK score ≥ 12 who have had diabetes excluded) can be referred to lifestyle risk modification programs following a risk assessment. Generally, these programs involve group education and motivation sessions that support lifestyle changes. These sessions are likely to address:

- the risk of developing diabetes and the importance of regular risk assessments
- dietary advice
- physical activity advice
- behavioural strategies to support lifestyle changes
- smoking cessation and alcohol reduction
- community resources.

Model for Improvement Example - risk assessment for diabetes

Goal: Over the next two months, increase the proportion of patients within the risk groups who have received an AUSDRISK assessment by 20%.

Measures:

- The number of active patients within the clinical database aged 40 and older for non-Aboriginal and Torres Strait Islander peoples and 15 and older for Aboriginal and Torres Strait Islander peoples who are currently without a diagnosis of diabetes (A)
- The number of active patients within the clinical database aged 40 and older for non-Aboriginal and Torres Strait Islander peoples and 15 and older for Aboriginal and Torres Strait Islander peoples who are currently without a diagnosis of diabetes and who have had an AUSDRISK assessment (B)
- The proportion of active patients within the clinical database aged 40 and older for non-Aboriginal and Torres Strait Islander peoples and 15 and older for Aboriginal and Torres Strait Islander peoples who are currently without a diagnosis of diabetes and who have had an AUSDRISK assessment (B divided by A).

Ideas:

- Import a template of the AUSDRISK into our clinical software
- Train staff on how to accurately record completion of risk assessments in clinical software
- Set up prompts in the clinical software to alert clinicians that a risk assessment is required
- Source resources, such as posters, and display in the waiting room.
- Include AUSDRISK assessment in all health assessments
- Add the AUSDRISK questions to the new patient form
- Ask flagged patients to complete the AUSDRISK tool while in the waiting room
- Promote the assessments to high risk patients
- Hold specific sessions and book patients in for assessments
- Develop specific recall and reminder lists for patients at moderate to high risk
- Develop a flowchart with action plans for patients identified as low, medium or high risk
- Set up SMS reminders to support and motivate targeted patients to attend appointments.

PDSA Cycles

Some of the ideas above may not be suitable for PDSA cycles, such as importing templates and sourcing resources. These activities are important but can be undertaken as straightforward tasks.

Ideas such as setting up prompts to alert clinicians, adding the AUSDRISK questions to the new patient forms and asking flagged patients to complete the AUSDRISK tool while in the waiting room, are focussed at the system level as you are trying to change the way things are routinely done.

Therefore, these types of ideas are suited to testing via PDSA cycles.

Try to keep the tests small; you may initially focus on setting prompts for patients at risk of diabetes that are visiting the practice to see a specific GP over the next two weeks. Test the outcomes after the two weeks and then consider what improvements you can make. As there may be flow-on activities from this test, e.g. the concept of SMS reminders to support and motivate targeted patients, you may choose to follow patients along this journey and learn to concurrently improve the way you prompt and support clinicians to target and undertake risk assessments on patients at risk of developing diabetes.