Measuring your outcomes for diabetes with Dr Gary Deed

Chair, RACGP Specific Interests Diabetes

RACGP Specific Interests

Why measure outcomes/quality improvement in diabetes?

300 people develop diabetes each day = 1.9 M Australians

7Th commonest cause of death

First Nations people are 3 times more likely to develop diabetes and 4 times more likely to die from diabetes causes

85% are type 2 diabetes and mostly managed in general practice

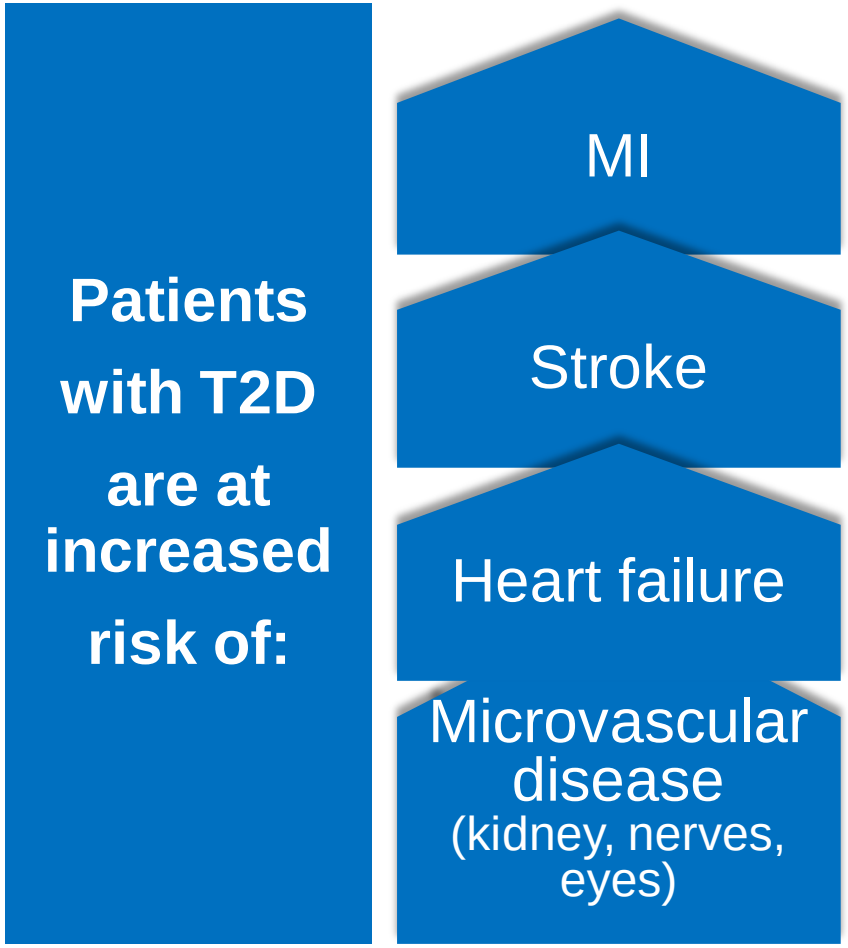
Average GP FTE has 70-80 diabetes patients

By setting goals and supporting patients achieve these helps in preventing complications

Goals cannot be achieved unless we record, measure and support outcomes

1. https://www.diabetesaustralia.com.au/about-diabetes/diabetes-in-australia/

Managing patients with T2D means not just controlling HbA_{1c} but preventing these interlinked micro- & macro-vascular events



54%
increased risk of MI (median 5.5 years) compared to those without T2D[2]

72%
increased risk of stroke (median 5.5 years) compared to those without T2D[2]

33%
increased risk of hospitalization for heart failure (at 4 years) compared to those without T2D[3]

>50%
develop microvascular disease within 10 years[1]

CV, cardiovascular; HbA_{1c}, glycated haemoglobin; MI, myocardial infarction; T2D, type 2 diabetes.

1. Litwak L, et al. *Diabetol Metab Syndr.* 2013;5:57. 2. Shah AD, et al. *Lancet Diabetes Endocrinol.* 2015;3:105-113. 3. Cavender MA, et al. *Circulation*. 2015;132:923-931.

Management of patients with type 2 diabetes and cardiovascular disease in primary care

Marson, A., Raffoul, N., Osman, R., & Deed, G. (2021). Management of patients with type 2 diabetes and cardiovascular disease in primary care. *Australian Journal for General Practitioners, 50*, 238-245.

https://www1.racgp.org.au/ajgp/2021/april/patients-with-type-2-diabetes-and-cardiovascular-d

Andrew Marson, Natalie Raffoul, Rawa Osman, Gary Deed

Background and objective
Approximately 65% of cardiovascular disease (CVD)–related deaths in Australia occur in people with diabetes or pre-diabetes. The aim of this study was to investigate general practice management of risk factors among patients with both conditions.

Methods
This was a cross-sectional study of 33,559 adult patients with both type 2 diabetes and CVD at 1 November 2018, using the general practice data program MedicineInsight.

Results
One-third of patients did not have a record in their current medications list for all three recommended medicines to reduce cardiovascular risk. Potentially suboptimal monitoring and achievement of targets for diabetes and cardiovascular risk factors was also identified. Most patients using metformin-based combination therapy were prescribed blood glucose-lowering medicines that do not have evidence of cardiovascular benefit.

RACGP Specific Interests

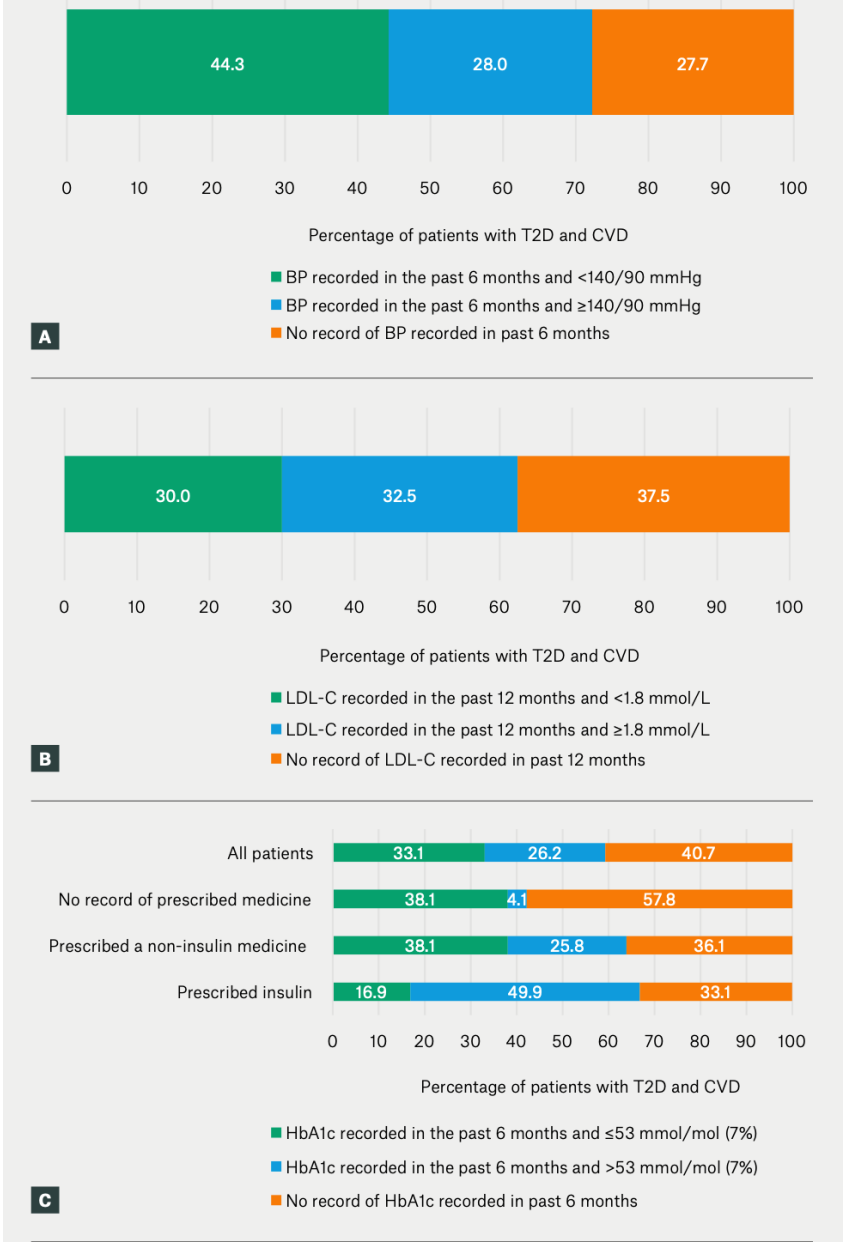
Healthy Profession. Healthy Australia.

We all can do better in measuring outcomes for patients

BP

LDL

HBA1c



https://www1.racgp.org.au/ajgp/2021/april/patients-with-type-2-diabetes-and-cardiovascular-d

RACGP Specific Interests

Healthy Profession. Healthy Australia.

How to get started – Step 1

Describe your improvement or change

What are the ways you could you improve outcomes for your diabetes patients?

DOCUMENT THIS PROCESS FOR AUDITING !

ASSESS THE PRACTICE DIABETES Register:

1. Address “coding” of patients
2. Database ‘cleansing’

FOCUS

1. Individual patients - yourself
2. Whole of practice – yourself and colleagues

Consider small steps like..

Have you identified your patient population?

I. *Code diabetes correctly*: i.e. Diabetes type 2 NOT NIDDM

Have you *identified patients with indicated diabetes with no diagnosis*?

I. Review your DIABETES REGISTER

Small steps

1. Have you identified patients who may not meet optimum type 2 diabetes management guidelines?

2. Does the practice have a routine reminder for appropriate diabetes care?

3. Have you reviewed clinical management goals for type 2 diabetes patients?

Then next steps….

Do you know how to initiate a patient reminder within clinical software?

Is there a system to ensure patients recently diagnosed with diabetes are incorporated into the reminder system?

1. Have you used the new Cardiovascular Risk Assessment Tool?
2. Have your patients been vaccinated?
3. Have you recorded the patients BMI?
4. Have you measured the patient's blood pressure?

For example:

Utilise your practice database for assessment of individual or practice clinical outcome measures/goals like:

1. Have you correctly identified your patient population?

2. Have you identified patients with indicated diabetes with no diagnosis?

USE SOFTWARE OR

PRIMARY SENSE

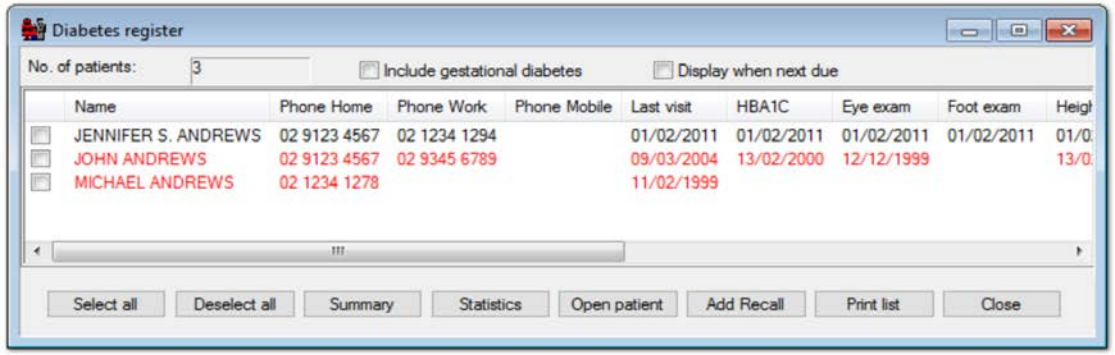
OR
PENCAT. ETC

Extract diabetes register patients

Medical Director

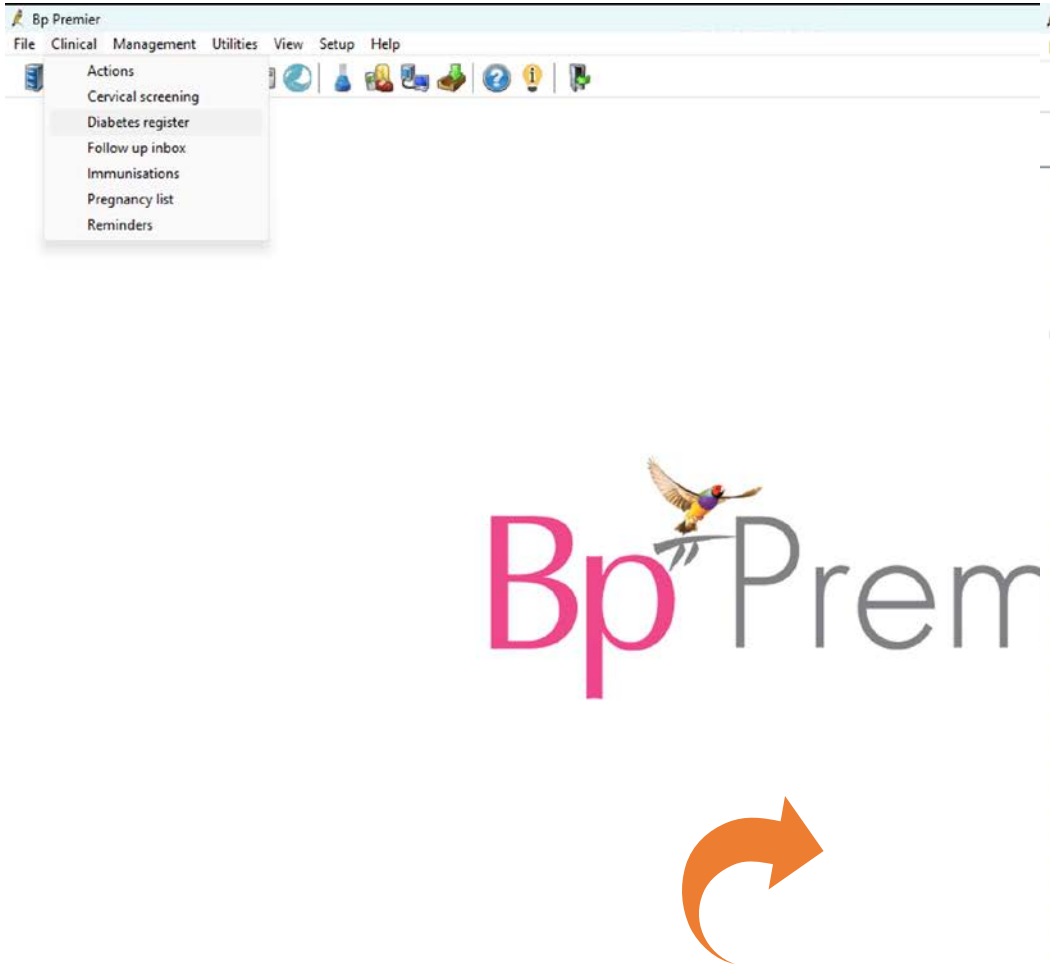
To search the Diabetes Register:

From the Clinical Front Screen, select **Search > Diabetes Register.** The **Diabetes Register** window appears, complete with search results.



Summary	Generates a printable summary of the results.
Statistics	Generates a printable summary of diabetes managements statistics.
Open patient	Opens the Clinical Window of a selected patient.
Add Recall	Records a Recall notification for each patient in the search results. See Adding, Editing, and Deleting Recalls for instructions on how to generate recalls.

https://www.medicaldirector.com/help/#rhsearch=diabetes&rhhlterm=diabetes&rhsyns=%20&t=topics-clinical%2FDiabetes_Register_Searches.htm



Bp Prem

Diabetes Register

File View Help

Show overdue only Usual doctor: Dr Gary Deed 72 patients

Na...	D	Age	Last Care cycle completed	Last Care cycle billed	Last BP	Last Weight	Last Foot exam	Last Eye exam	Last HbA1C	Last Lipids	Usual Dr.
Mr ...	2.	38 yrs	/ /	/ /	03/08/2023	/ /	/ /	/ /	16/12/2023	16/12/2023	Dr Gary Deed
Mrs...	2.	67 yrs	/ /	/ /	09/10/2023	27/09/2022	/ /	/ /	15/08/2023	15/08/2023	Dr Gary Deed
Ms ...	1.	67 yrs	20/09/2020	/ /	27/09/2022	21/10/2021	11/10/2021	18/10/2021	19/07/2023	08/08/2023	Dr Gary Deed
Mr ...	0.	78 yrs	/ /	/ /	30/08/2023	09/10/2023	/ /	/ /	03/08/2022	11/12/2023	Dr Gary Deed
Mrs...	1.	76 yrs	/ /	/ /	15/08/2023	05/05/2023	/ /	/ /	27/07/2023	31/08/2023	Dr Gary Deed
Cris...	0.	74 yrs	/ /	/ /	26/09/2022	25/07/2023	/ /	/ /	21/06/2023	21/06/2023	Dr Gary Deed
Mr ...	2.	67 yrs	/ /	/ /	15/12/2023	17/02/2022	/ /	/ /	11/12/2023	11/12/2023	Dr Gary Deed
Mr ...	1.	53 yrs	/ /	/ /	24/08/2022	08/12/2021	/ /	/ /	/ /	15/01/2022	Dr Gary Deed
Ms ...	2.	69 yrs	/ /	/ /	01/12/2023	07/04/2022	/ /	/ /	01/12/2023	01/12/2023	Dr Gary Deed
Mr ...	1.	86 yrs	27/09/2020	/ /	08/01/2024	08/01/2024	/ /	/ /	18/09/2023	06/11/2023	Dr Gary Deed
Mr ...	2.	53 yrs	/ /	/ /	07/11/2023	18/07/2023	/ /	/ /	10/01/2024	10/01/2024	Dr Gary Deed
Mr ...	1.	63 yrs	/ /	/ /	09/03/2022	03/06/2022	/ /	/ /	01/03/2022	01/03/2022	Dr Gary Deed
Mr ...	2.	27 yrs	/ /	/ /	/ /	/ /	/ /	/ /	08/09/2023	08/09/2023	Dr Gary Deed
Mr ...	3.	76 yrs	/ /	/ /	15/12/2023	20/07/2022	/ /	/ /	20/10/2023	20/10/2023	Dr Gary Deed
Mr ...	0.	25 yrs	/ /	/ /	10/10/2023	10/10/2023	/ /	/ /	05/10/2023	05/10/2023	Dr Gary Deed
Mr ...	2.	53 yrs	/ /	/ /	06/10/2023	08/06/2022	/ /	/ /	20/09/2023	20/09/2023	Dr Gary Deed
Mr ...	1.	71 yrs	/ /	/ /	20/12/2023	15/03/2022	/ /	/ /	11/04/2023	04/08/2023	Dr Gary Deed
Mr ...	0.	38 yrs	/ /	/ /	03/05/2023	03/05/2023	/ /	/ /	20/11/2023	20/11/2023	Dr Gary Deed
Mrs...	0.	64 yrs	/ /	/ /	/ /	09/11/2021	/ /	/ /	/ /	27/05/2023	Dr Gary Deed
Mr ...	2.	69 yrs	/ /	/ /	13/12/2023	13/07/2022	/ /	/ /	22/12/2023	22/12/2023	Dr Gary Deed
Mr ...	2.	30 yrs	/ /	/ /	31/01/2022	31/01/2022	/ /	/ /	06/02/2023	06/02/2023	Dr Gary Deed
Mr ...	2.	76 yrs	/ /	/ /	13/09/2023	18/03/2022	/ /	/ /	11/01/2024	11/01/2024	Dr Gary Deed
Ms ...	0.	68 yrs	/ /	/ /	31/08/2023	16/06/2022	/ /	/ /	03/10/2023	03/10/2023	Dr Gary Deed
Mrs...	0.	61 yrs	/ /	/ /	25/09/2023	13/01/2023	/ /	/ /	05/01/2024	05/01/2024	Dr Gary Deed
Mrs...	1.	68 yrs	/ /	/ /	05/10/2021	08/11/2023	/ /	/ /	18/03/2022	11/03/2023	Dr Gary Deed
Mis...	0.	41 yrs	/ /	/ /	16/06/2023	16/11/2023	/ /	/ /	01/12/2023	01/12/2023	Dr Gary Deed
Mrs...	1.	60 yrs	/ /	/ /	05/01/2023	22/04/2022	/ /	/ /	04/01/2023	04/01/2023	Dr Gary Deed
Ms ...	1.	76 yrs	/ /	/ /	20/10/2023	/ /	/ /	/ /	/ /	/ /	Dr Gary Deed
Mr ...	2.	45 yrs	/ /	/ /	08/11/2022	08/11/2022	/ /	/ /	23/02/2022	23/02/2022	Dr Gary Deed
Mr ...	2.	73 yrs	/ /	/ /	/ /	/ /	/ /	/ /	11/01/2022	01/02/2022	Dr Gary Deed
Mrs...	1.	81 yrs	/ /	/ /	/ /	25/11/2022	/ /	/ /	/ /	25/11/2022	Dr Gary Deed
Mr ...	2.	79 yrs	/ /	/ /	12/12/2023	07/03/2023	/ /	/ /	29/08/2023	29/08/2023	Dr Gary Deed
Mrs...	1.	80 yrs	/ /	/ /	12/12/2023	01/11/2022	/ /	/ /	23/08/2023	28/12/2023	Dr Gary Deed
Mrs...	1.	77 yrs	/ /	/ /	09/01/2024	29/08/2022	/ /	/ /	02/01/2024	02/01/2024	Dr Gary Deed
Mrs...	0.	71 yrs	/ /	/ /	06/10/2023	16/02/2022	/ /	/ /	29/09/2023	08/01/2024	Dr Gary Deed
Mr ...	1.	46 yrs	/ /	/ /	28/09/2023	28/09/2023	/ /	/ /	04/01/2024	04/01/2024	Dr Gary Deed
Ms ...	0.	69 yrs	/ /	/ /	06/11/2023	31/05/2023	/ /	/ /	02/11/2023	10/11/2023	Dr Gary Deed
Mr ...	2.	95 yrs	/ /	/ /	03/10/2023	28/11/2022	/ /	/ /	02/08/2023	04/10/2023	Dr Gary Deed
Mr ...	3.	61 yrs	/ /	/ /	25/09/2023	25/09/2023	/ /	/ /	27/07/2023	12/12/2023	Dr Gary Deed
Mis...	0.	32 yrs	/ /	/ /	27/05/2020	/ /	/ /	/ /	24/11/2022	24/11/2022	Dr Gary Deed

RACGP Specific Interests

Healthy Profession.
Healthy Australia.

Primary Sense™ Reports

GPs - Important clinical information about your patients are in most of these reports.

Select a report

Clinical Audit Queries

Keyword filter: Clear

Patient Lists

- Pregnant and Vaccinations
  Due influenza and/or pertussis
- Patients with Moderate Complexity (level 3)
  Eligible or due care planning items
- Chronic Lung Disease and Asthma
  Associated modifiable risk factors
- Patients with High Complexity (5 and 4)
  Eligible or due care planning items
- Diabetes Mellitus
  Diagnosed and undiagnosed
- Winter Wellness
  High risk patients at risk of seasonal respiratory infect...
- Hypertension Management
  Hypertension, no active ACR reading in last 12 months
- Voluntary Patient Registration
  Report of patients who are likely to meet the criteria f...
- Health Assessments
  Eligible or due
- Benzodiazepine in substance misuse
  High risk patients
- Haemochromatosis
  Associated risk indicators
- Cardiovascular Disease Risk Factors
  Modifiable risk factors
- Frailty Care Management
  Patients with Frailty risk factors
- Bowel and Breast Cancer Screening
  Patients eligible
- Cardiovascular Disease Management
  CVD, missing interventions and risk factors

Practice/PHN Reports

- Characteristics of the Practice Patient Population
  For comparison to the PHN version
- Accreditation
  % compliance
- Characteristics of the PHN patient population
  As an average for comparrison
- Summary Report of Practice Improvements
  Monitors changes
- Your Practice Data Quality
  Compared to PHN average

PIP QI

- PIP QI report - 10 measures
- Patients missing PIP QI or accreditation Measures

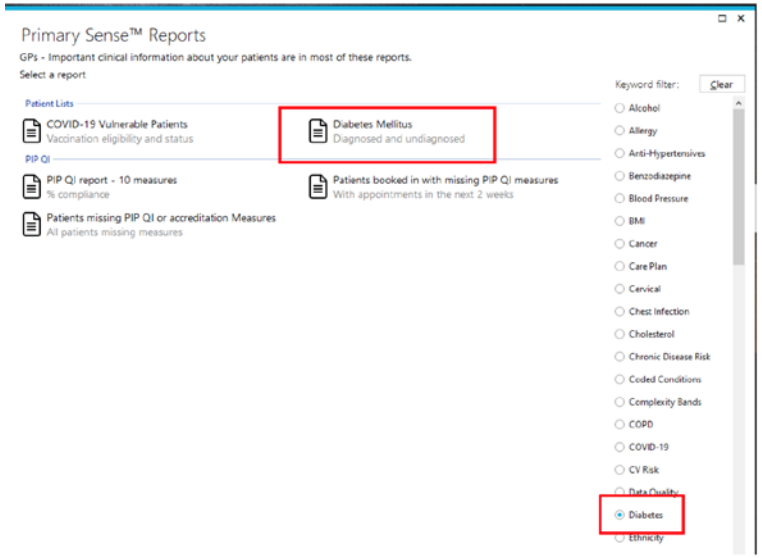
Keyword filter:

- Alcohol
- Allergy
- Anti-Hypertensives
- Benzodiazepine
- Blood Pressure
- BMI
- Cancer
- Care Plan
- Cervical
- Chest Infection
- Cholesterol
- Chronic Disease Risk
- Coded Conditions
- Complexity Bands
- COPD
- COVID-19
- CV Risk
- CVD
- Data Quality
- Diabetes
- Ethnicity
- Fasting Glucose

Extract diabetes register patients

Best Practice:
Primary sense

1. Select **Reports** on the Primary Sense menu.
2. Select **Diabetes** as the **Keyword filter**.
3. Select the **Diabetes Mellitus** report. This report will provide information on patients who may require a clinical review or diagnosis based on their recent HbA1c results.



https://www.nbmphn.com.au/getattachment/c21f2786-17db-43ba-b6ad-cea943a8d0c6/628_0323-Diabetes-Toolkit_Primary-Sense_v1-1_F_.pdf

RACGP Specific Interests

Healthy Profession.
Healthy Australia.

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Diabetes Mellitus

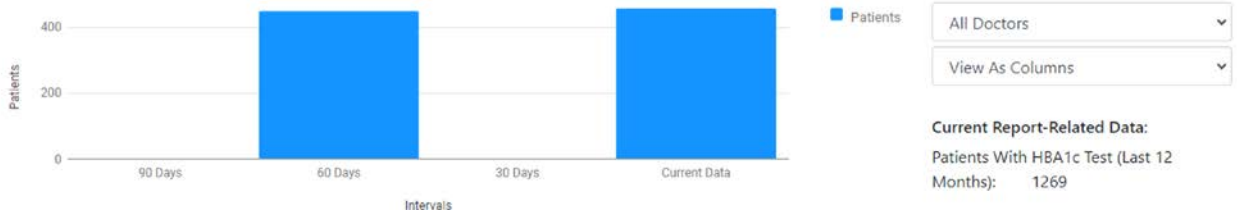
Healthcare Plus Medical Centre

11 January 2024 19:20

Which patients are included in this report? | What data is in this report? | How do we use this report? | What are ACG patient complexity levels?

Report Synopsis

Patients with diabetes across 30 day intervals



All Doctors

View As Columns

Current Report-Related Data:

Patients With HBA1c Test (Last 12 Months): 1269

1

Patients who may require a HbA1C test

Information about this table

Show 25 patients per page | Export To Excel | Export To CSV | Export To CSV (SMS) | Search:

Remove	ACG Score	Patient Name	Patient Phone	Last Visit	Existing Appt	GP Name	Clinic	Age	ATSI	Glucose Test Date	Glucose Result
No data available in table											

Showing 0 to 0 of 0 entries | Previous | Next

Patients who may need a clinical review for a diagnosis of diabetes

Information about this table

You can stratify patients who appear on this list by different measures

Patients with diabetes who may be eligible for chronic care occasions of service

Information about this table

Show 25 patients per page | Export To Excel | Export To CSV | Export To CSV (SMS)

2

RACGP Specific Interests

Healthy Profession. Healthy Australia.

What does the data show?

Individually: are there gaps in data? Missing HB A1c; BP etc

Whole of practice: are there gaps in management? Do we need to focus on care care planning/vaccinations etc

Primary Sense™ Reports

GPs - Important clinical information about your patients are in most of these reports.

Select a report

Clinical Audit Queries

Keyword filter: Clear

Patient Lists

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PRIMARY SENSE

Cardiovascular Disease Risk Factors

Healthcare Plus Medical Centre

11 January 2024 19:43

Which patients are included in this report? | What data is in this report? | How do we use this report? | What are ACG patient complexity levels?

Report Synopsis

Patients with CV risk > 10% across 30 day intervals

Patients

All Doctors

View As Columns

Report-Related Data:

Patients Meeting Criteria With Risk <10%:

Patients with a CVD risk of >15%

Information about this table

Show 25 patients per page

Export To Excel | Export To CSV | Export To CSV (SMS)

Remove	ACG Score	CV Risk Score	Patient Name	Patient Phone	Last Visit	Existing Appt	GP Name	Clinic	Age	ATSI	Smoker	Diabetic	HDL Ratio	SBP	On Statin

Patients with a CVD risk of 10-15%

Information about this table

Show 25 patients per page

Export To Excel | Export To CSV | Export To CSV (SMS)

Search:

Remove	ACG Score	CV Risk Score	Patient Name	Patient Phone	Last Visit	Existing Appt	GP Name	Clinic	Age	ATSI	Smoker	Diabetic	HDL Ratio	SBP	On Statin	A

Align Diabetes register patients who appear also on this list

Then consider doing CVD risk scores to decide on management changes

Healthy Profession. Healthy Australia.

CVD Risk Assessment: cvdcheck.org.au

RACGP Specific Interests

Healthy Profession. Healthy Australia.

Individual goals

Individual goals	
Encourage all people with type 2 diabetes to approach/reach these goals.	
Diet	Advise eating according to the *Australian dietary guidelines*, with attention to quantity and type of food Advise individual dietary review for people with difficulty managing weight, difficulty maintaining glucose levels in target range, CVD risk, or if otherwise concerned
BMI	Advise a goal of 5–10% weight loss for people who are overweight or obese with type 2 diabetes For people with BMI >35 kg/m^2 and comorbidities, or BMI >40 kg/m^2, consider facilitating greater weight-loss measures
Physical activity	Children and adolescents: at least 60 min/day of moderate-to-vigorous physical activity, plus muscle- and bone-strengthening activities at least three days/week Adults: 150 minutes of aerobic activity, **plus** 2–3 sessions of resistance exercise (to a total ≥60 minutes) per week
Cigarette consumption	Zero per day
Alcohol consumption	Advise ≤2 standard drinks (20 g of alcohol) per day for men and women
Blood glucose monitoring	Advise 4–7 mmol/L fasting and 5–10 mmol/L postprandial SMBG is recommended for patients with type 2 diabetes who are using insulin. Education should be provided regarding frequency and timing of insulin dose For people not on insulin, the need for and frequency of SMBG should be individualised, depending on type of glucose-lowering medications, level of glycaemic control and risk of hypoglycaemia, as an aid to self-management SMBG is recommended in pregnancy complicated by diabetes or gestational diabetes SMBG is also recommended for people with hyperglycaemia arising from intercurrent illness. It may be helpful in haemoglobinopathies or other conditions where HbA1c measurements may be unreliable

https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/diabetes/type-2-diabetes-goals-for-optimum-management

Clinical goals

Clinical management goals	
Treatment targets for people with type 2 diabetes include the following. For a comprehensive list of assessments and screening intervals, refer to the section 'Assessment of the patient with type 2 diabetes'.	
HbA1c	Target needs individualisation according to patient circumstances Generally ≤7% (53 mmol/mol)
Lipids	Initiation of pharmacotherapy is dependent on the assessment of absolute CVD risk (refer to the Australian absolute cardiovascular disease risk calculator). This uses multiple risk factors, which is considered more accurate than the use of individual parameters Once therapy is initiated, the specified targets apply; however, these targets should be used as a guide to treatment and not as a mandatory target
Total cholesterol	<4.0 mmol/L
HDL-C	≥1.0 mmol/L
LDL-C	<2.0 mmol/L; <1.8 mmol/L if established CVD is present
Non–HDL-C	<2.5 mmol/L
Triglycerides	<2.0 mmol/L
Blood pressure	≤140/90 mmHg Lower blood pressure targets may be considered for younger people and for secondary prevention in those at high risk of stroke The target for people with diabetes and albuminuria/proteinuria remains <130/80 mmHg. As always, treatment targets should be individualised and monitored for side effects from medications used to lower blood pressure
Urine albumin excretion	UACR: • women: <3.5 mg/mmol • men: <2.5 mg/mmol Timed overnight collection: <20 µg/min; spot collection: <20 mg/L
Vaccination	Recommended immunisations: influenza, pneumococcus, diphtheria-tetanus-acellular pertussis (dTpa). Consider: hepatitis B (if travelling), herpes zoster

BMI, body mass index; CVD, cardiovascular disease; GPs, general practitioners; HbA1c, glycated haemoglobin; HDL-C, high-density lipoprotein cholesterol; LDL-C, low-density lipoprotein cholesterol; SMBG, self-monitoring of blood glucose; UACR, urine albumin-to-creatinine ratio.

https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/diabetes/type-2-diabetes-goals-for-optimum-management

Whole of practice

Practice Incentive Goals based on RACGP goals

Quality Improvement Measures

The collection of the de-identified Improvement Measures that form the PIP Eligible Data Set are part of a system of quality improvement that includes reflective practice, a common data baseline, and data analysis. The Improvement Measures are not designed to assess individual general practice or general practitioner performance. They do support a regional and national understanding of chronic disease management in areas of high need, and future iterations will respond to emerging evidence on areas of high need.

The Improvement Measures are:

1. Proportion of patients with diabetes with a current HbA1c result
2. Proportion of patients with a smoking status
3. Proportion of patients with a weight classification
4. Proportion of patients aged 65 and over who were immunised against influenza
5. Proportion of patients with diabetes who were immunised against influenza
6. Proportion of patients with COPD who were immunised against influenza
7. Proportion of patients with an alcohol consumption status
8. Proportion of patients with the necessary risk factors assessed to enable CVD assessment
9. Proportion of female patients with an up-to-date cervical screening
10. Proportion of patients with diabetes with a blood pressure result.

PRIMARY SENSE

PIP QI report - 10 measures

Healthcare Plus Medical Centre

11 January 2024 20:47

Which patients are included in this report? | What data is in this report? | How do we use this report? | What are ACG patient complexity levels?

PIP QI results

Information about this table

Show 25 patients per page | Export To Excel | Export To CSV | Search:

Measure	Description	Numerator	Denominator	Percentage
	Regular Patient Count	6255		
QIM 01	Patients with Diabetes Type 1 with a current HbA1c result	22	35	62.86%
QIM 01	Patients with Diabetes Type 2 with a current HbA1c result	144	216	66.67%
QIM 01	Patients with Diabetes Type Undefined with a current HbA1c result	33	57	57.89%
QIM 02	Patients with a current smoker status result	226	5386	4.20%
QIM 02	Patients with an EX smoker status result	663	5386	12.31%
QIM 02	Patients with a non-smoker status result	3619	5386	67.19%
QIM 03	Patients with an overweight BMI result	393	1233	31.87%
QIM 03	Patients with an obese BMI result	414	1233	33.58%
QIM 03	Patients with an underweight BMI result	35	1233	2.84%
QIM 03	Patients with a healthy BMI result	391	1233	31.71%
QIM 04	Patients 65 years and older who have been immunised against influenza	725	1514	47.89%
QIM 05	Patients with diabetes who have been immunised against influenza	122	305	40.00%
QIM 06	Patients with COPD who have been immunised against influenza	60	108	55.56%
QIM 07	Patients with an alcohol consumption result	4702	5386	87.30%
QIM 08	Patients aged 45 to 74 years old with CVD Assessment risk factors recorded	751	2375	31.62%
QIM 08	Patients aged 35 to 44 years old with CVD Assessment risk factors recorded	3	10	30.00%

Step 2 – What are the impacts or outcomes?

What results are you expecting?
Have you already observed an impact/outcome?

For example:
All practitioners are coding patients with diabetes identically
Recalls for all diabetes patients working for:
- vaccinations
- HBA1C
- BP
- kidney health assessments
- weight management

Step 3 – Monitor and evaluate

How do you plan to monitor or evaluate the effectiveness of these changes?

For example:

- regular timely recalls for individual patients are entered and updated

- are you having practice meetings that address PIP gaps?

- have you set a regular individual reviews of goals into clinical records – eg HBA1c, kidney health BMI, and CVD risks. Eye health (REMEMBER ANNUAL DIABETES CYCLE OF CARE)

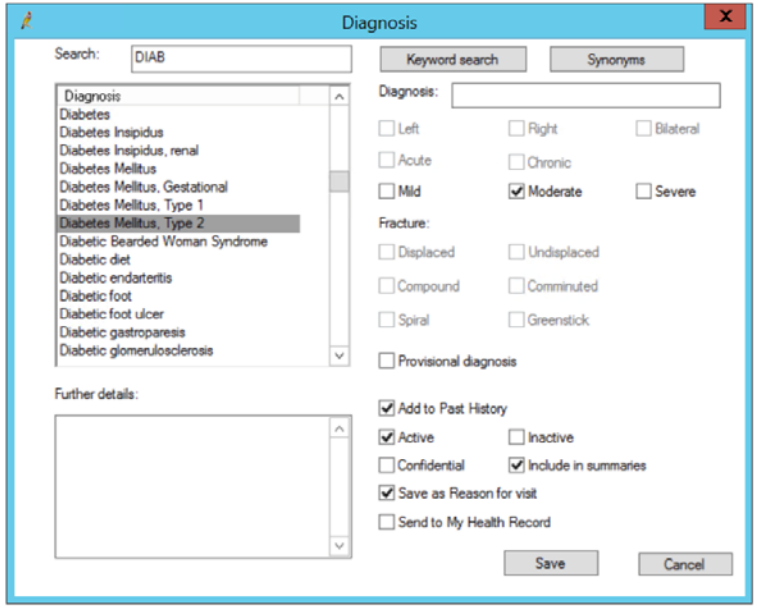
CASE EXAMPLES

Recording Coded Diagnosis

Best Practice

The diagnosis screen records a coded diagnosis[13] for the patient, which can be added to past history and uploaded to the patient's My Health Record.

1. Click **Diagnosis**.
2. Enter a partial **Search** item. The diagnosis list will filter to match the search term. Double-click on the condition you want to diagnose.
3. Tick any of the descriptive checkboxes on the right-hand side to provide more information. Fields enabled will depend on the selected condition.
4. Select the checkboxes at the bottom to determine where the condition is included in the patient record.
5. Click **Save** to save the diagnosis.



LET'S DO AN EXAMPLE:

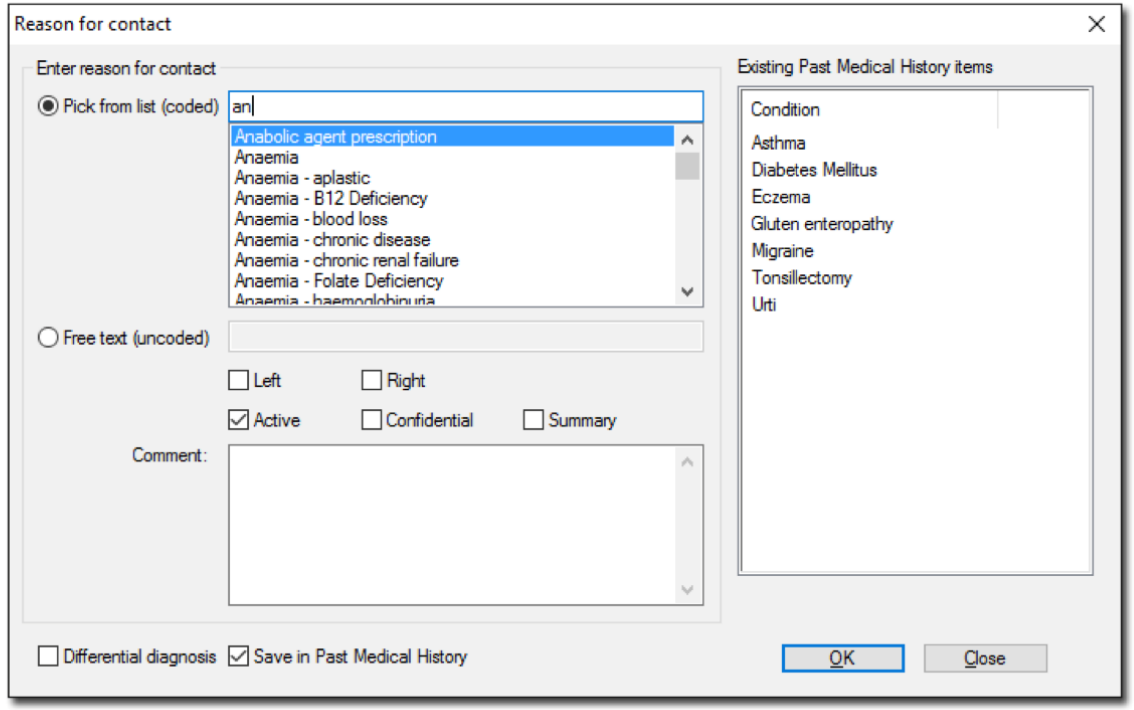
BEST PRACTICE

CODING DIABETES

Medical Director

The reason for contact[14] module allows you to enter a diagnosis into the progress notes.

1. Select the **Progress** tab in the patient's clinical record.
2. Click **Reason**.
3. Enter the first few letters of the diagnosis in the **Pick from list (coded)** text box. A list of diagnoses that start with the letters entered is displayed.
4. Double-click the required item from the list of choices. Select **OK**.



LET'S DO AN EXAMPLE:

MEDICAL DIRECTOR

CODING DIABETES

Diabetes Cycle of Care

The Diabetes Cycle of Care is established as best practice for patient outcomes and management of diabetes. The aim of the Diabetes Cycle of Care is to enhance prevention, diagnosis, and management of people with diabetes. The GP is the coordinator of the patient's care, who ensures that all aspects of the Cycle of Care are completed.

Essential Requirements

Six Monthly

- Measure height, weight and calculate BMI and waist circumference.
- Measure blood pressure.
- Foot assessment (high risk: every 1-3 months, low risk: annually).

Yearly

- Measure HbA1c, total cholesterol, triglycerides, and HDL cholesterol and eGFR.
- Test for micro albuminuria.
- Provide patient education regarding diabetes management, including self-care education.
- Review diet and levels of physical activity – reinforce information about appropriate dietary choices and levels of physical activity.
- Check smoking status – encourage smoking cessation.
- Review medication – consider Home Medicine Review.

Two yearly

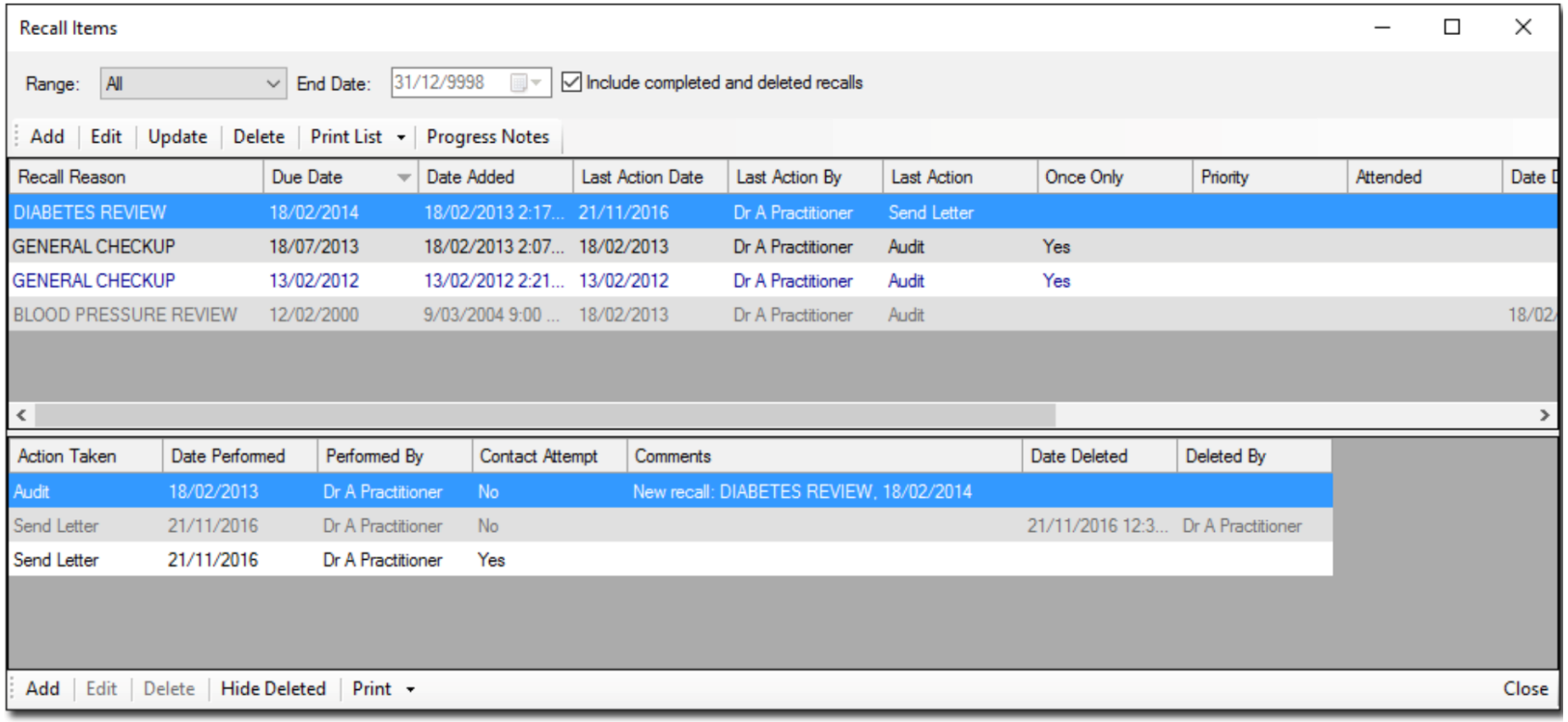
- Comprehensive eye examination by an ophthalmologist or optometrist to detect and prevent complications – requires dilation of pupils.

All elements of the Cycle of Care should be completed every 12 months.

Updating Recalls from within the Patient's Record

In the following example, a patient has returned to our practice for his annual diabetes review after receiving our recall notification. We now wish to mark this recall instance as completed, and generate a new recall, for next year's diabetes review.

1. Select **Clinical > Recall**. The **Recall Items** window displayed.



LET'S DO AN EXAMPLE:

MEDICAL DIRECTOR

SETTING UP DIABETES

RECALLS

LET'S DO AN EXAMPLE:

MEDICAL DIRECTOR

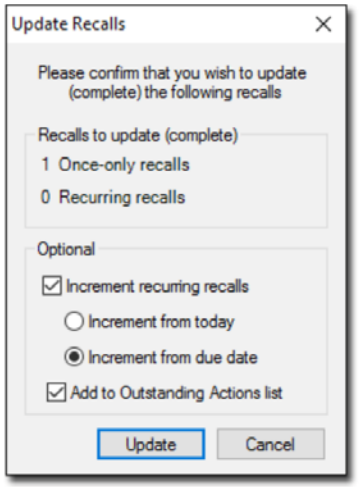
SETTING UP DIABETES

RECALLS

2. Select the recall you wish to update.

   In the example above, we have selected the patient's Diabetes Review. In this instance is it a recurring recall - the patient has returned for their review, and as such we need to mark this recall as completed, after which a new Diabetes Review recall will be generated automatically for us.

3. Click **Update**. The **Update Recalls** window appears. Notice in this example that the window indicates we have selected 1 Recurring recall to update.



- Tick the **Increment Recurring Recalls** check box. This will automatically generate a new recall for each selected recurring recall. Then, indicate whether you want to;
  - **Increment from today:** Regardless of when a recall's next due date was going to fall, it is calculated from today, instead.
  - **Increment from due date:** The recall's next due date occurs as per its pre-defined schedule.
- Tick the **Add to Outstanding Actions List** check box. An Outstanding Action is simply a reminder notice about the patient that appears on-screen upon opening the patient's record. See Outstanding Actions for more information.

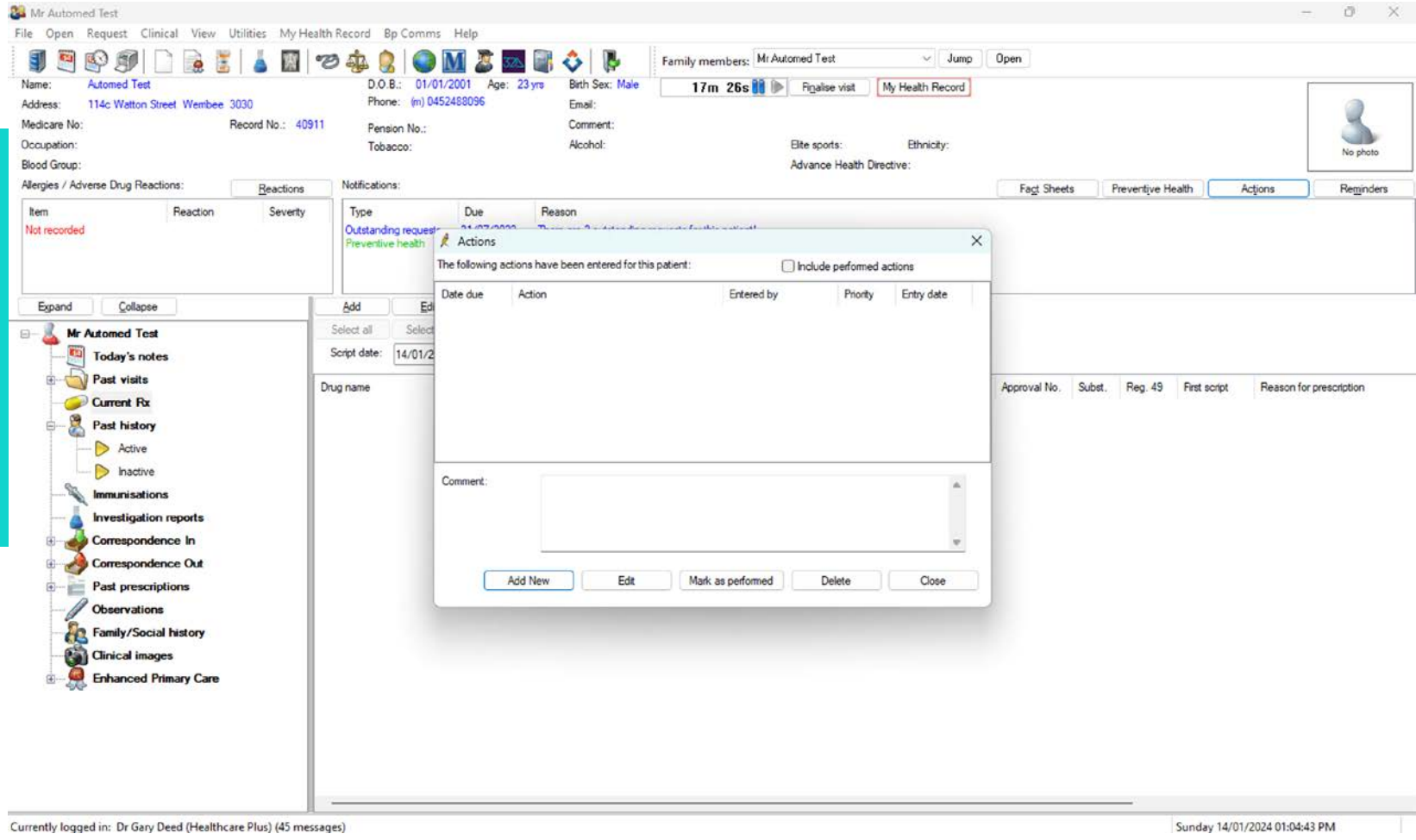
5. Click Update to confirm your selections. You will be prompted that the update was successful. If you elected to increment the recurring recall, a new recall will now appear within the patient's Recall Items window.

LET'S DO AN EXAMPLE:

BEST PRACTICE

SETTING UP DIABETES

RECALLS



RACGP Specific Interests

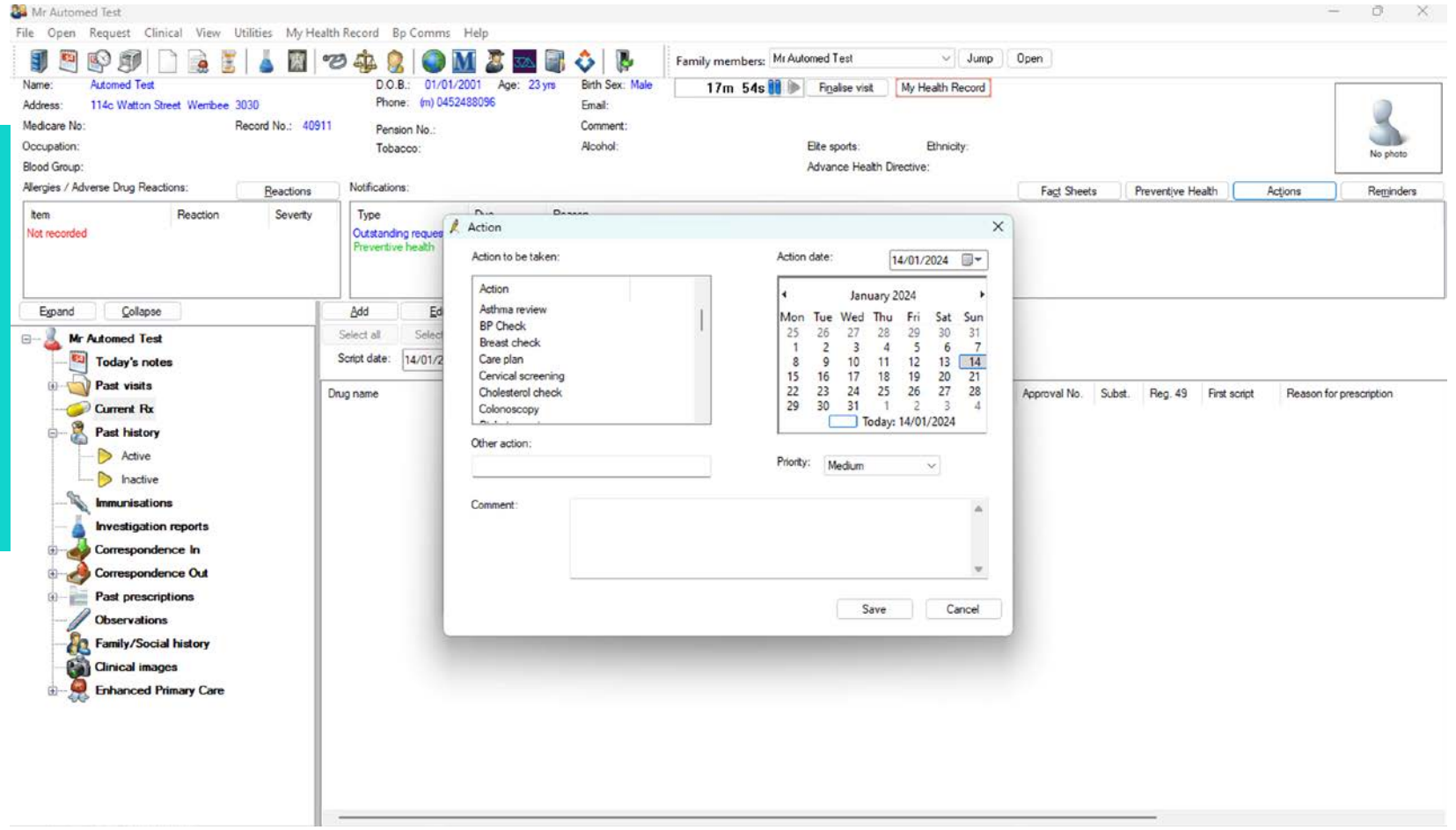
Healthy Profession.
Healthy Australia.

LET'S DO AN EXAMPLE:

BEST PRACTICE

SETTING UP DIABETES

RECALLS



RACGP Specific Interests

Healthy Profession.
Healthy Australia.

Monitor and evaluate – Document and Compete forms

For example: REMEMBER ANNUAL DIABETES CYCLE OF CARE

- 3rd Monthly HBA1c recalls for individual patients are entered and updated

- Set a regular individual reviews of goals into clinical records – eg

  - Kidney health (BP; urine ACR; eGFR annually – or more regularly if abn)
  - BMI
  - CVD risks
  - Eye health
  - Foot checks