

## Continuous Quality Improvement (CQI)

## Winter Wellness Strategy – Care of patients with Diabetes – using Cat 4

|  |  |  |  |
| --- | --- | --- | --- |
| **CQI steps** | | **Ask-Do-Describe** | |
| **Data report 1 - baseline** | **First CQI meeting** | **Why do we want to change?** | |
| * Gap | The current COVID-19 pandemic has impacted health system service delivery on the Gold Coast. Patients with diabetes will require their care to be reviewed and optimised particularly during the Winter. A seasonal, person centred care delivery process may assist and provide a systematic and evidence-based approach to comprehensive care. |
| * Benefits | Every winter there is a surge in both community and hospital healthcare demand. Proactive care planning and delivery by general practices for patients with diabetes may help to prevent hospital admissions, increase patient wellness and quality of life.  Chronic care management is incentivised through MBS item numbers and can meet PIP QI practice requirements.  Practice staff will become aware of their patients with diabetes, proactively inviting and allocating time for patient assessments, which may increase staff satisfaction with their work.  Focusing on patients with diabetes ensures efficient use of resources, may reduce avoidable hospital admissions and ultimately improves the health service experience for all consumers. |
| * Evidence | Australia has one of the highest life expectancies in the world and most Australians consider themselves to be in good health, however not all Australians are as healthy as they could be. Chronic diseases are the leading cause of ill health and death in Australia [(AIHW – Australia’s Health 2016)](https://www.aihw.gov.au/reports/australias-health/australias-health-2016/contents/chapter-3-leading-causes-of-ill-health). Chronic diseases are long lasting conditions with persistent effects, including social and economic consequences which may have a significant impact on peoples quality of life [(AIHW – Chronic disease)](https://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/chronic-disease/overview).  The number of people with type 2 diabetes is growing, most likely the result of rising overweight and obesity rates, lifestyle and dietary changes and an ageing population. Within 20 years, the number of people in Australia with type 2 diabetes may increase from an estimated 870,000 in 2014, to more than 2.5 million.  The most socially disadvantaged Australians are twice as likely to develop diabetes. If left undiagnosed or poorly managed, type 2 diabetes can lead to coronary artery disease (CAD), stroke, kidney failure, limb amputations and blindness. The early identification and optimal management of people with type 2 diabetes is therefore critical. [(RACGP)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/management-of-type-2-diabetes) The growing burden of chronic disease means that effective treatment for patients with chronic conditions and complex health care needs is vitally important. Development and implementation of new and innovative methods for early disease detection and treatment, including coordinated care planning, patient self-management and chronic disease management is a key role delivered by general practices [(AIHW – Australia’s Health 2016)](https://www.aihw.gov.au/reports/australias-health/australias-health-2016/contents/chapter-3-leading-causes-of-ill-health).  This risk of illness and disease may be experienced across the lifecycle, with older people at an increased risk of multiple chronic conditions that may impair their function and quality of life [(RACGP – Guidelines for preventive activities in general practice, pg. 66 & 85)](https://www.racgp.org.au/FSDEDEV/media/documents/Clinical%20Resources/Guidelines/Red%20Book/Guidelines-for-preventive-activities-in-general-practice.pdf). An annual cycle of care model with a [seasonal focus](https://gcphn.org.au/practice-support/support-for-general-practice/practice-based-population-health-management-program/) can assist with targeted, cost-effective and high quality care delivery and monitoring by general practice. Implementing a seasonal focus model in primary health care can ensure all critical elements of health care management for at risk patients can be achieved. |
| **What** do we want to change? | |
| * Topic | Identifying and managing vulnerable patients with diabetes |
| * Scope | Vulnerable and at-risk groups – to be determined by practice demographics |
| **How much** do we want to change? | |
| * Baseline | To be determined from:  [CAT4 Recipe – Diabetes Cross Tabulation Report](https://gcphn.org.au/wp-content/uploads/2020/07/CAT4-Recipe-Diabetes-Cross-Tabulation-Report.pdf)  Your patient list should ideally have between 50-100 patients. To further narrow down your patient list, please include one or more of the following:   * No blood pressure recorded * No Micro-albumin recorded   NB: A total of 5 items only can be used in a cross-tabulation report |
| * Sample | All patients identified in cross tabulation report |
| * Target | 100% of sample patients invited for care plan/review or missing items of care |
| * Preparedness | All staff believe this is a priority activity for their practice and patient population. |
| **Who** are involved in the change? | |
| * Leads   Contributors | Practice Manager/COVID-19 Team Leader  GPs/Practice Nurses/Receptionists |
| * External | PHN/DoH/QLD Health/Patients |
| **When** are we making the change? | |
| * Deadlines | Baseline data report generated (date)  Implementation between (date range)  Review meeting (date) |
| **How** are we going to change? | |
| * Potential solutions | **Identification:**   * As per baseline sample above   **Service delivery option:**   * Review eligibility for care plan or review (add your usual process here) * Consider most appropriate service delivery option (in practice or telehealth) * If in practice, consider social distancing requirements, types of patients booked in at the same time (consider only “well patients”   **Management:**   * Consider a person centred, seasonal approach to support comprehensive, evidence-based care delivery for patients with diabetes * [**Autumn – Prevention**](https://gcphn.org.au/practice-support/support-for-general-practice/practice-based-population-health-management-program/seasonal-focus-autumn/)   Prevention activities such reviewing and updating vaccinations, referral to cancer and other disease screening and AHP referrals. Review psychosocial factors and mental health support requirements as appropriate.  Review clinical measures and guidelines and order tests as appropriate   * [**Winter – Burden of Care**](https://gcphn.org.au/practice-support/support-for-general-practice/practice-based-population-health-management-program/seasonal-focus-winter/)   Review current referrals and specialist and allied health appointments with patient and/or carer to assess which ones are necessary or relevant. Reduce referrals, visits and unnecessary tests if appropriate. Coordinate any relevant tests and/or appointments to meet patient’s medical and personal requirements.  Review clinical measures and guidelines and order tests as appropriate  [Diabetes management during the coronavirus pandemic: Be proactive and prepared](https://www.racgp.org.au/getmedia/97a5abb4-1290-42cb-91c0-eabcaa8ca590/Diabetes-management-during-coronavirus-pandemic_1.pdf.aspx)   * [**Spring – Clinical Coding and Data Management**](https://gcphn.org.au/practice-support/support-for-general-practice/practice-based-population-health-management-program/seasonal-focus-spring/)   Develop an agreed process for the practice for clinical coding and data entry that will support data extraction. Revise current patient consent processes and implement processes and systems to capture patient consent to share data. Update patient contact details including next of kin and emergency contact. Consider uploading SHS to My Health Record. Review medications and consider HMR.  Review clinical measures and guidelines and order tests as appropriate   * [**Summer – Advance Care Planning**](https://gcphn.org.au/practice-support/support-for-general-practice/practice-based-population-health-management-program/seasonal-focus-summer/)   Discuss and promote Advance Care Planning and encourage patient or family member to upload to My Health Record.  Review clinical measures and guidelines and order tests as appropriate  NB: patients may enter the seasonal cycle at any point |
| * Select | *Choose potential solutions that will work well in your practice and meet the needs of your patients and team.* |
|  | | | |
| * **Implementation** | | * Implement | *Develop plan to suit practice processes (example below). Ensure task allocated to appropriate role.*   1. *Team meeting to discuss plan and confirm roles* 2. *Generate baseline measure from selected report* 3. *Recall patients and schedule appointments* 4. *Progress the most appropriate service delivery option* 5. *Book Practice Nurse appointment time prior to GP appointment* |
| * Record, share | *Documentation of plan to meet PIP QI requirements. Use team meeting minutes as a record of your activities or document meetings in* [*PIP QI Meeting template*](https://gcphn.org.au/wp-content/uploads/2020/02/CQI-Practice-Meeting-Template.docx)*. Plan date for review meeting to assess progress.* |
|  | | | |
| **Data Report 2**  **Comparison** | **Final CQI meeting** | **How much** did we change? | |
| * Performance | *Did you achieve your target?*  *If not, consider new activity to test as above* |
| * Worthwhile | *Did the activity provide the outcome expected?*  *Did this process provide patients with the required information and services?* |
| * Learn | *What lessons learnt can you use for other activities, what worked well, what could be changed or improved?* |
|  | **What next?** | |
| * Sustain | ***Maintenance*** *– Update processes and inform staff to ensure integration into usual business (example below).*   * *Reception to confirm/update personal details at each visit* * *Confirm/update social/family history/allergies/smoking and alcohol status regularly* * *Ensure new reminder in place for review of care plan/medication reviews* * *Consider any other new changes identified during the activity* |
| * Monitor | *Consider monthly data review of eligible at-risk groups and invite to attend services etc.* |