

## Continuous Quality Improvement (CQI)

## Project Example: Diagnosis of Diabetes (CAT4)

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| **CQI steps** | **Ask-Do-Describe** |
| **Data report one - baseline** | **First CQI meeting**  | **Why do we want to change?** |
| * Gap
 | We identified two related gaps in relation to diabetes mellitus:Some of our patients may have diabetes mellitus but require further investigations or assessments to confirm or exclude the diagnosis.Some patients have enough evidence to support a diagnosis of diabetes mellitus, but the diagnosis has not been coded in their medical records.  |
| * Benefits
 | Patients: Diagnosing diabetes early ensures patients have the best possible opportunities to reduce the risk of adverse health outcomes.Practice: Having a coded diagnosis for all patients with diabetes is a necessary first step for us as a practice to measure the quality of our care. An accurate list of patients will help us identify those who require additional monitoring and treatment.Practitioner: An up-to-date list of patients with diabetes will provide an accurate reflection of work completed. It will also provide opportunities to conduct reviews for eligible patients. |
| * Evidence
 | The RACGP ‘General Practice management of type 2 diabetes’ states: ‘Diabetes is a national health priority’ and concludes: ‘the early identification and optimal management of people with type 2 diabetes is therefore critical’. (1) This CQI project aligns with the Guideline.Diabetes is one of the ten indicators of the national PIP QI Incentive program. (2) This CQI project therefore aligns with the priorities of the PIP QI Incentive program. |
| **What** do we want to change? |
| * Topic
 | Our topic is Diagnoses of Diabetes mellitus.Our aim is to increase the number of patients with a coded diagnosis of diabetes mellitus. |
| * Scope
 | All patients who have been identified as possibly or likely having a diagnosis of diabetes. |
| **How much** do we want to change? |
| * Baseline
 | We used PEN CS software to generate and export a list of patients with ‘indicated diabetes with no diagnosis’. The filter was ‘active patients’.See guide to Cleansing Cat here: [https://help.pencs.com.au/display/CG/Data+Cleansing](https://help.pencs.com.au/display/CG/Data%2BCleansing) See how to identify Indicated not coded Diabetes Patients here [https://help.pencs.com.au/display/CG/Indicated+Conditions+Report+Details](https://help.pencs.com.au/display/CG/Indicated%2BConditions%2BReport%2BDetails)*(Insert number)* patients were identified as likely to have diabetes and who may require further assessments, investigations or a coded diagnosis. |
| * Sample
 | Our sample was all the patients identified by PEN CS as potentially having diabetes. |
| * Target
 | All (number) identified patients will be assessed to determine whether they require further assessment, investigation or a coded diagnosis of diabetes. |
| * Preparedness
 | All members of the practice team indicated that they are willing to participate in the project and that they agreed with the plan described in this project summary and the minutes of the meetings. |
| **Who** are involved in the change? |
| * Leads

Contributors | The leads were GP and PMAll GPs in the practice contributed.  |
| * External
 | PHN Practice Support staff  |
| **When** are we making the change? |
| * Deadlines
 | The project started on (date)The first checkpoint was on (date) with GCPHN. At that time, implementation was proceeding according to time and planThe project duration was estimated to require a maximum of three months. It was successfully concluded ahead of time on (date) |
| **How** are we going to change? |
| * Potential solutions
 | The team agreed that there were two main approaches – a single GP could review all the cases, or the cases could be assigned to all the GPs in the practice to review |
| * Select
 | The team agreed that the second option was appropriate, i.e. the sample would be split between the GPs |
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| **Implementation** | * Implement
 | * The PM exported the list of patients to Excel. The PM checked the records of each patient on the list and assigned a GP for that patient.
* The ‘usual’ GP was assigned in the following order: the one who the patient consults with most; or who ordered the HbA1c or FBG that suggests a diagnosis of diabetes; or the last one to see the patient
* A separate sheet was prepared for each GP with the names of the patient from the sample for them to review
* The GPs completed the reviews and made notes on the sheets. They took actions such as phoning patients, coding a diagnosis of diabetes or generating investigation requests. Alternatively, they recorded the actions they would like the PM or PN to undertake, such as inviting patients for a consultation or further investigations.
* The sheets were returned to the PM who collated the information and ensured that outstanding actions were taken or delegated.
* The PM followed up with those GPs who did not return their sheets within a fortnight.
* Some GPs had scheduled leave and conducted the reviews on their return
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| * Record, share
 | * *Number of* team meetings were held specifically to discuss the PIP QI Incentive program and this CQI project.
* The initial meeting was *on (date*) and the final meeting *on(date).* The minutes of the meetings are available as separate documents.
* The CQI project summary was shared with every member of the team by e-mail and they were given opportunities to provide feedback.

*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.* |
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| **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* |

**References**

* 1. RACGP. Tailored information for general practices to manage type 2 diabetes [Available from: <https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/management-of-type-2-diabetes>. Accessed 12/06/2019.
* 2. Department of Health. PIP QI Incentive guidance [Available from: <https://www1.health.gov.au/internet/main/publishing.nsf/Content/PIP-QI_Incentive_guidance>. Accessed 15/08/2019.