**QI Action Plan- \*add practice name\***

**Diagnosis of Diabetes QI Activity**

|  |
| --- |
| **Ask-Do-Describe**  |
| **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 record.
 |
| **Benefits** | * Patients: Diagnosing diabetes early ensures patients have optimal self-management and treatment to reduce the risk of diabetes related complications.
* Practice: Having a coded diagnosis for all patients with diabetes is critical for quality and 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** | * Diabetes is a national health priority and the early identification and optimal management of people with type 2 diabetes is critical [(RACGP Management of type 2 diabetes, 2020).](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/diabetes/introduction)
* Three of the ten indicators of the National PIP QI Incentive program are Diabetes related [(DoHAC, Practice Incentives Program – Quality improvement measures, 2023).](https://www.health.gov.au/resources/publications/practice-incentives-program-quality-improvement-measures?language=en)
 |
| **What** do we want to change?  |
| **Topic** | To improve the accuracy and completeness of coded diagnosis of Diabetes Mellitus at \*practice name\* |
| **How much** do we want to change?  |
| **Baseline***Baseline data is the % of your current performance.**Add your practice performance percentage or baseline number.**Baseline data for QI activities can be obtained from multiple sources e.g.:** *Data analytic tools- e.g., Primary Sense, Diabetes Mellitus report.*
* *Clinical information systems using the “search” function/patient registers, e.g. Cleaning up uncoded and free text data.*
 | **Example:** *Current baseline performance is \*XX\* patients who were identified as likely to have diabetes. Patients who may require further assessments, investigations or a coded diagnosis.*  |
|  |
| **Sample***Sample is the number of patients to be reviewed as potentially having Diabetes to meet your target.****Add your practice sample.****This number could be determined from a Primary Sense Diabetes Mellitus Report.*  | **Example:** *Our sample was ALL the patients identified by Primary Sense as potentially having Diabetes.* |
|  |
| **Target***Your target is the planned % result of the improvement. Target is the number of patients who are identified as likely to have Diabetes and who may require a coded diagnosis and were actioned to complete your goal.* | **Example:** *\*XX\* identified patients will be assessed to determine whether they require further assessment, investigation, or a coded diagnosis of Diabetes.*  |
|  |
| **Who** is involved in the change?  |
| **Contributors***Add names of the practice team involved* | **Practice Manager:** **GPs:** **Practice Nurses:** **Receptionists:** **GCPHN QI Project Officer:**  |
| **When** are we making the change?  |
| **Deadlines***Add key dates here for this activity.*  | **Baseline data report generated:****Implementation between (from/to):****Review meeting/s:** **Final evaluation meeting:**  |
| **How** are we going to change?  |
| **Implement***List some improvement strategies in order of implementation.* ***(see Appendix 1 for suggestions)*** | **1.****2.****3.** |
| **STOP: The next section is to be completed after implementation has already commenced.** |
| **Monitor***A minimum of one QI* *activity review /touchpoint is required.**You can include multiple reviews/touchpoints – list by date.*  | **Review 1 - Date:***What is working/not working?**Has there been a change in your performance? If not, why not?* |
| **STOP: The next section is to be completed at the end/closure of activity.**  |
| **How much** did we change?  |
| **Performance***Did you achieve your target?* *If not, reflect on why not* | **Example:** * *Number of patients with an uncoded diagnosis has decreased from baseline XX to XX.*
* *This was an \*increase/decrease\* from our baseline data.*
 |
|  |
| **Worthwhile***Was the effort to complete the improvement activity worth the outcome?**Did the team value the improvement activity?**Did another unexpected positive result occur? (e.g. increased care plans completed)* | **Example:*** *We believe the effort to complete the activity* ***was worthwhile*** *as we decreased the number of patients with an uncoded diagnosis of Diabetes.*

***OR*** * *We believe this activity* ***was not worth*** *the effort required, as we did not significantly reduce the number of patients with an uncoded diagnosis of Diabetes.*
 |
|  |
| **Learn***What lessons learnt* *could you use for other improvement activities?**What worked well, what could have been changed or improved?* | **Example:** *To promote awareness of the significance of coding and prevent it from being overlooked, we identified the necessity to create a coding policy. This policy will also serve to educate new staff members.* |
|  |
| **What next?**  |
| **Sustain***Implement new processes and systems into business as usual - which parts of this activity, if any, will you incorporate into business as usual at your practice?* | **Example:** *GPs will continue to correctly code the Diabetes diagnosis instead of using free text.*  |
|  |
| **Monitor** | **Example:** *Review Diabetes Mellitus Primary Sense report quarterly and initiate corrective measures as required.* |
|  |

|  |
| --- |
| **Appendix 1 – Potential solutions** |
| ***Review suggested implementation strategies listed below. You do not have to implement all options that are brainstormed/listed.**** Archive inactive patients as per practice data cleansing policy.
* Determine how your clinicians are currently coding patients with diabetes (does this include free text field).
* Increase relevant staff’s awareness of the importance of using [consistent coding](https://www.digitalhealth.gov.au/healthcare-providers/initiatives-and-programs/my-health-record) and how to accurately record a coded diagnosis.
* Search for all patients who do not have a diagnosis of diabetes but are on insulin and/or oral hypoglycaemic medications. Review and code appropriately. Alternatively, identify a list of patients for review, as they most likely have diabetes. Patients may require further assessments, investigations or a coded diagnosis. For example, using *Primary Sense - Diabetes Mellitus report.*
* A list could be exported to Excel, filtered by GP and the separate lists could be provided to each GP with a list of their regular patients.

The GPs could complete the review of each of their patients and made notes on the list (printed copy of excel spreadsheet). They could take actions such as;* + Phoning patients.
	+ Coding a diagnosis of diabetes.
	+ Generating investigation requests.
* Alternatively, GPs could record the actions they would like the PM or PN to undertake, such as inviting patients for a consultation or further investigations.
* The lists of patients can then be returned to the PM to collate the information and ensure that outstanding actions are taken or delegated.
* The PM could follow up with those GPs who did not return their lists within a fortnight.
* Consider developing a clinical coding policy and procedure. Including education to new staff within orientation.
* Consider utilising the [NDSS registration](https://www.ndss.com.au/about-the-ndss/registration/) to support with identifying patients who may have diabetes. Patients also may benefit from registering with the NDSS, as this provides information and support services, as well as diabetes-related products at subsidised prices, to people with diabetes.
* Once patients have been appropriately coded, the practice could consider implementing the “Care of Diabetes QI activity’’.
 |