

PRIORITY AREA 5: CHRONIC DISEASE

Objective Description

Domain	National Objective	Rationale
DIABETES	Divisions will support general practices/GPs to provide optimal care and contribute to the achievement of the best possible health outcomes for patients with diabetes	Sustained improvements in health outcomes for people with chronic diseases such as diabetes have been associated with a more systematic approach in general practice including intensive follow up, use of clinical management guidelines integrated with self-management support programs and more effective use of nurse case managers and non-physician care providers. Systematic care includes having a disease register, regular recall and review, protected time, a practice nurse, clear written guidelines and a system for auditing standards of care. Supporting chronic disease care is a core role of Divisions.

National Performance Indicators

Level	Indicator	Results for the reporting period	Explanatory Text
1	N_DIA 1.1 Division collaborates with other organisations, service providers and consumer/carer groups to facilitate patient access to optimal diabetes care.	<p>Significant Achievement</p> <p>Aim: To establish a Diabetes Alliance Group (comprised of Diabetes NGO, hospital, community health, consumers and GPs) to meet quarterly</p> <p>Actions Taken:</p> <ul style="list-style-type: none"> Consultation with stakeholders to encourage appropriate representation on the Diabetes Alliance Group Research into training and education opportunities and availability was completed Training and education program developed Developed a draft 'pathway' document to encourage effective use of evidence-based clinical information to treat people with diabetes Delivered the first 'accredited practice nurse' course Development of tools to assist with the assessment and referrals of people with diabetes to make the best use of resources within the region has commenced <p>Outcomes:</p> <ul style="list-style-type: none"> Received positive feedback via the 'accredited practice nurse' course evaluation An increase in the number of accredited practice nurses has occurred as a result of the course. Major progress achieved in establishing the Diabetes Alliance Group 	
	N_DIA 1.2 Division takes a systematic approach to support general practices/GPs to provide optimal diabetes care.	<p>Significant Achievement</p> <p>Aim: To encourage practices/GPs to be part of the National Primary Care Collaboratives (NPCC) and the associated quality improvement programs</p> <p>Actions Taken:</p> <ul style="list-style-type: none"> Division now represented on the NPCC Steering Committee Provided support to GPs by advertising Diabetes Australia events, utilising input from consumer reference group and GP diabetes program manager for local activity design <p>Outcomes:</p> <ul style="list-style-type: none"> Increased practice/GP engagement in the NPCC 'Plan, Do, Study, Act' cycles 	To date, 15 practices have or are involved with the NPCC with interest in the 3rd wave from another 8 practices.
	N_DIA 1.3 Division facilitates access to effective Continuing	We undertook 2 point activity on 'Adjusting Insulin/ Secondary Failure in the GP setting'.	

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	Professional Development (CPD) for diabetes care.	<p>Comments:</p> <p>Event was attended by 88 GPs. Evaluation responses indicated a high level of satisfaction by attending GPs; a moderate to high level of immediate increased knowledge; and 3 month follow-up evaluation showed a moderate level of retained knowledge with a significant positive change in clinical practice with relation to best practice guidelines.</p>	
	N_DIA 1.4 Number and proportion of GPs from whom the Division is receiving electronic patient records to provide feedback for quality improvement in diabetes care.	Table N_DIA 1.4	Table N_DIA 1.4
	N_DIA 1.5 Division takes a systematic approach to support general practices/GPs to consistently capture and record Aboriginal and/or Torres Strait Islander origin for patients with diabetes on the practice register/recall/ reminder systems.	<p>Significant Achievement</p> <p>Aim: To implement an effective method to consistently capture and record Indigenous Australian origin for patients with diabetes on the practice RRR systems</p> <p>Actions Taken:</p> <ul style="list-style-type: none"> Researched sources of Indigenous Australian patient information to identify differences in data. Consulted with practices/GPs re data currently captured on their RRR systems Consultation undertaken with AIHW, ABS and Community Health Services to ensure a consistent approach to data collection is developed A draft 'information pack' for delivery to practices on cultural awareness and what and how best to ask appropriate Indigenous Australian questions has been completed. <p>Outcomes:</p> <ul style="list-style-type: none"> Excellent advice and direction provided by Community Health Services, AIHW and ABS to work towards consistent data collection and recording, utilising national data standards Increased awareness of areas of data discrepancies and various collection methods Major progress achieved in drafting an effective method to consistently capture and record this information Improved collaboration with GPs/practices and other stakeholder groups Positive feedback obtained from stakeholders on the draft 'information pack'. 	<p>The establishment of quality data coding in the local community health services will set a good precedent for GP practices and the learnings and processes from this may be transferable.</p> <p>Consistent quality data coding is an important step in the adoption of a systematic approach.</p>
2	N_DIA 2.1 Number and proportion of general practices using a practice register /recall/reminder system to identify patients with diabetes for review and appropriate action.	Table N_DIA 2.1	Table N_DIA 2.1
3	N_DIA 3.1 Number of service incentive payments (SIPs) made to GPs practicing in the Division's area compared to the estimated population in the Division's area with diabetes	Table N_DIA 3.1	Table N_DIA 3.1

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Level	Indicator	Results for the reporting period	Explanatory Text
4	N_DIA 4.1 Number and proportion of patients with diabetes on practice register/recall/reminder systems whose most recent HbA1c in the past 12 months was: <ul style="list-style-type: none"> ▪ 7.0% or less; ▪ more than 7% but less than 10.0%; ▪ 10.0% or more; ▪ not measured/not recorded. 	Table N_DIA 4.1	Table N_DIA 4.1
	N_DIA 4.2 Number and proportion of patients with diabetes on practice register/recall /reminder systems whose most recent total cholesterol in the past 12 months was: <ul style="list-style-type: none"> ▪ less than 4.0 mmol/L; ▪ 4.0 mmol/L or more; ▪ not measured/not recorded. 	Table N_DIA 4.2	Table N_DIA 4.2

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Table N_DIA 1.4 Number and proportion of GPs from whom the Division is receiving electronic patient records to provide feedback for quality improvement in diabetes care. Black Division, June 2007

	Receiving records & providing feedback	Not receiving records	Total number of GPs in Division
Number	165	385	550
Percent	30%	70%	100
Explanatory text:			
GPs are providing electronic patient records to provide feedback for quality improvement of diabetes care, linked to involvement in the National Primary Care Collaboratives.			

Table N_DIA 2.1 Number and proportion of general practices using a practice register/recall/reminder system to identify patients with diabetes, for review and appropriate action, Black Division, June 2007

	No Practice register/recall/reminder system (No to Q(1))	Practice register/recall/reminder but not used for identifying patients with diabetes for review and appropriate action (Yes to Q(1) and No to Q(2))	Practice register/recall/reminder used for identifying patients with diabetes for review and appropriate action (Yes to both Q(1) and Q(2))	Not known/missing	Number of practices for whom data available	Total number of practices in the Division
Number	50	60	50	40	160	200
Percent	31%	38%	31%	N/A	100	N/A
Explanatory text:						
Good improvement on last year's numbers re use of computerised systems.						
Education on the benefits of using computerised systems is incorporated into regular site visits. A conscious effort is being made to increase the number of practices using electronic practice systems.						
QA: How were these data obtained?						
Data was obtained from survey conducted in October 2006.						

Table N_DIA 3.1 Number of service incentive payments (SIPs) made to GPs practicing in the Division's area compared to the estimated population in the Division's area with diabetes. Black Division, June 2007

	Number of SIPs	Estimated number of people with diabetes	SIPs:population ratio
Number	2,415	20,000	0.12:1
Explanatory text:			
Data extracted from data package provided by DoHA.			
The Division ensures GPs are aware of the benefits and eligibility rules of SIPs through regular site visits. New GPs are provided with information packs on the various incentive payments available.			

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Domain

DIABETES

Reflection on work towards all objectives within this domain

Notable achievements and key contributing factors	Delivered the first 'accredited practice nurse' course to a number of general practice staff in February. Requests from other GP practices and AMSs for training and updates for practice nurses/staff. This training program will be an ongoing process with the Train the Trainer component included.
Notable challenges and key contributing factors	Standard quality data coding will encourage accurate and consistent data collection and reporting. At present the Division does not receive electronic data from practices / clinics. The Clinics themselves are not able to provide this data, bearing in mind that current data input is only as good as the personnel inputting. Another challenge is that the project officer progressing this work also oversees multiple other projects and has limited time (.8 of a FTE position) to achieve specific outcomes in the area of diabetes.
What did the Division learn from the strategic approaches used?	That there was an ongoing need for training on data collection and patient RRR systems. Training provided in February, however regular updates will be required.
How were community needs met?	Provision of this training improved the monitoring and follow up of patients to support best practice of diabetes management as outlined in the NPCC program.
Recommendations	<ul style="list-style-type: none"> • Continue to encourage feedback from practices on training and implementation of patient information and RRR systems. • Practices/AMSs to inform the Division if further training is required. • There is a need to have a dedicated project officer in the area of chronic disease management so that many of the above reporting requirements can possibly be met.