Thank you for joining the NQPHN Diabetes and Obesity Continuous Quality Improvement (CQI) Program

Why participate in a Continuous Quality Improvement (CQI) about diabetes and obesity?

Over 80% of Mackay adults are overweight or obese[1].

Regional obesity statistics reveals 83.4 per cent of the Mackay adult population is overweight or obese, this is one of the main risks for developing type 2 diabetes, which represents 85–90 per cent of all cases of diabetes.[1]

Northern Queensland Primary Health Network (NQPHN) and Mackay Base Hospital and Health Services have partnered with other key stakeholders to tackle the problem head on. The aim of the Diabetes and Obesity CQI is to increase the identification of patients with risk factors for chronic disease.

NQPHN's aggregated de-identified regional data highlights that 5.5 per cent of the Mackay region's population who have visited a GP in the last 24 months have a coded diagnosis of diabetes. The national average is 5.1 per cent.[3]

Data further highlights that coding and recording of suggested risk factors and indicators do not meet practice accreditation levels across the region. Clinical measures such as waist circumference, BMI, and physical activity status could be utilised by GPs and the practice team to enact early interventions that are proven to positively impact weight management and diabetes prevention.[2]

GPs and the general practice teams are perfectly placed to affect significant improvements of both obesity and diabetes management and interventions in the Mackay region. Interventions in general practice are proven to show benefit in changing lifestyle behaviour related to risk factors.

Further to this, the collected de-identified data can be used to inform the needs assessment to help fund activities and outcomes.

What support will you receive during this CQI?

Your NQPHN Practice and Provider and Engagement Support (PPES) Program Officer will work with you to identify the areas of focus and support you to achieve the CQI activity goals. The de-identified data you submit to NQPHN each month will be used to report back to you on your practice progress.

Outcomes

Upon completion of the CQI program you will have improved accuracy and cleanliness of the clinical data for your patients who are diabetic, overweight or obese—enabling you to provide best practice care, leading to better health outcomes.

1 Yearbook 2017, Progress in Australian Regions

2 The Royal Australian College of General Practitioners, Clinical guidelines, General Practice Management of type 2 diabetes

3 Australian Bureau of Statistics

› See next page for CQI goals.

Northern Queensland Primary Health Network acknowledges the Traditional Custodians of the lands and seas on which we live and work, and pay our respects to Elders past and present.

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Goals for the Continuous Quality Improvement (CQI) Program

phn NORTHERN QUEENSLAND
An Australian Government Initiative

GOAL – 1 – Ensure all diabetic patients are coded with the correct diagnosis in the clinical software.

The first activity in this CQI Program is to identify patients who meet that criteria, yet do not have a coded diagnosis of diabetes, or have an incorrect type recorded in the clinical software. These patients should be coded correctly in the appropriate drop down field in your clinical software, rather than have a diagnosis typed in to the free text field.

GOAL – 2 – Increase HbA1c recording for diabetic patients to 95% or higher, and increase ACR recording by 10%.

Seventy seven per cent of patients diagnosed with type 2 diabetes in our region have had their HbA1c recorded in the last 12 months. In addition, less than 50% of patients living with diabetes in our region have had a urine albumin creatinine ratio (ACR) screening in the past 12 months Glycated haemoglobin (HbA1c) needs individualisation according to patient circumstances. It is recommended patients diagnosed with diabetes have an HbA1c recorded at least every 12 months.

GOAL – 3 – Increase adult waist measurement recorded in clinical software to 75% or higher.

Clinical guidelines state that adult waist circumference should be measured and recorded in a patient's medical record every two years, or every six months for patients who are at risk of a chronic disease.

Measuring the waistline is a simple tool that can be widely implemented in clinical practice to improve risk stratification. On its own, BMI may be misleading, especially in older people and muscular individuals, and classifications may need to be adjusted for some ethnic groups.[2]

GOAL – 4 – Increase adult smoking, alcohol, and physical activity status recorded in clinical software to 75%.

Each of the risk factors smoking, alcohol, and physical activity can be associated with many diseases and are often interrelated. In our region, 99 per cent of patients currently do not have a physical activity status recorded. Structured exercise training and a healthy diet is associated with HbA1c reduction in patients with type 2 diabetes.[2]

GOAL – 5 – Increase the number of intervention (health literacy) materials provided to identified patients including:

- Referral to *My health for life* Program
- Physical activity assessment completed and physical activity prescription provided
- Diabetes Management Program (DESMOND, SMART programs).