Quality Improvement Guide

Quality Improvement Measure 10:

Blood Pressure Recording for Patients with Diabetes

JANUARY 2022

Supporting general practice, commissioning health services into gaps and driving service integration.

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QUALITY IMROVEMENT MEASURES

Proportion of patients with diabetes with a blood pressure result

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Quality Improvement

Quality Improvement is a system of regularly reviewing and refining processes in order to improve them, and therefore improve the quality of care your patients receive and their health outcomes. A growing body of evidence demonstrates that Quality Improvement activities lead to positive change in practices, particularly when implemented using a whole of team approach.

Practice Incentives Program Quality Improvement Incentive

The Practice Incentives Program (PIP) Quality Improvement (QI) Incentive is a payment to general practices for activities that support continuous quality improvement in patient outcomes and the delivery of best practice care. General practices enrolled in the PIP QI Incentive commit to implementing continuous quality improvement activities that support them in their role of managing their patients' health.

They also commit to submitting nationally consistent, de-identified general practice data, against 10 key Improvement Measures that contribute to local, regional and national health outcomes.

The Improvement Measures allow general practices to understand which patients may benefit from preventative treatments or may need recall to ensure effective management of a specified chronic disease (e.g. diabetes).

This can help delay progression of the condition, improve quality of life, increase life expectancy, and decrease the need for high-cost interventions.

Quality Improvement Measures (QIMs)

The collection of the de-identified Improvement Measures that form the PIP Eligible Data Set are part of a system of quality improvement that includes reflective practice, a common data baseline, and data analysis.

The Improvement Measures are not designed to assess individual general practice or general practitioner performance. They do support a regional and national understanding of chronic disease management in areas of high need, and future iterations will respond to emerging evidence on areas of high need.

QIM 10 - Proportion of proportion of patients with diabetes with a blood pressure result

Diabetes was the underlying cause of around 10% of all deaths in Australia in 2016 and recent reports show death rates for people with Type 2 diabetes are rising. For people with Type 1 or Type 2 diabetes, monitoring blood pressure can help assure appropriate medical care to lower the risk of macro vascular (stroke, heart attack and heart failure) and microvascular (kidney disease, eye disease and peripheral neuropathy) complications. [1]

Who does this QIM apply to?

This QIM applies to any patients who:

- are regular clients of the service and
- have type 1 or type 2 diabetes.

It does not include patients without type 1 or 2 diabetes who may have:

- patients with secondary diabetes
- gestational diabetes mellitus (GDM)
- previous GDM

- impaired fasting glucose
- impaired glucose tolerance

The specific data elements that are used to derive the fields required for the QIM calculation may vary depending on the clinical system practices use, but generally will involve:

- latest Visit Date
- second Latest Visit Date
- third Latest Visit Date
- diagnosis (Diabetes Type 1)
- diagnosis (Diabetes Type 2)
- systolic Blood Pressure Measurement
- diastolic Blood Pressure Measurement
- blood Pressure Measurement Date Recorded

The Importance of Data Cleansing

Data, in the form of a clinical record, provides a view of your patient's health status. By having accurate and up-to-date patient information that is recorded correctly in the clinical software, you will have accurate, accessible and comprehensive data. This can be used to provide the most effective care to your patients, which may assist in the prevention and management of chronic disease.

Data can be used to:

- diagnose a condition and determine appropriate treatment
- identify health related risks
- help manage a condition and minimise risk; and
- ensure that care is based on best practice guidelines.

From a general practice perspective, data can be used to:

- identify improvements in health service systems
- efficiently manage groups of people with similar health conditions; and
- inform resource planning and reduce waste.

To get the most out of your clinical software, data needs to be collected accurately, recorded in the right place and maintained over time. If not, patient care may be compromised, and efficiency suffers.

From a general practice perspective, data can be used to:

- identify improvements in health service systems
- efficiently manage groups of people with similar health conditions; and
- inform resource planning and reduce waste.

To get the most out of your clinical software, data needs to be collected accurately, recorded in the right place, and maintained over time. If not, patient care may be compromised, and efficiency suffers. Good data quality is a powerful resource for general practices but requires a consistent and coordinated approach from all the general practice team.

Quality Improvement Data Cleansing Guide

This cleansing guide uses CAT4 to identify inactive and duplicate patients, patients with no DOB or gender recorded, before looking for missing accreditation items from your practice software.

Start here: Login to Pen SC CAT4 ➡ CAT4 ➡ View extracts ➡ select the latest extract ➡ View filter

1

Archive inactive patients within your clinical software

Clear Filters ➡ Report section below ➡ Visits ➡ Last Visit ➡ >36mnths ➡ Export
Most clinical systems have a feature to bulk activate patients who have not visited the practice in a significant period – refer to clinical software guide.

2

Identify and merge duplicate patients

Clear Filters ➡ Select 'active 3x 2 yrs' ➡ Recalculate ➡ Report section below ➡ Data Quality tab ➡ Duplicate Number Patient Report tab ➡ Export ➡ Duplicate Name Patient Report tab ➡ Export

3

Identify and update patients with no DOB recorded

Clear Filters ➡ Cleansing CAT view ➡ Select 'No Age' ➡ Recalculate ➡ Report section below ➡ Missing Demographics ➡ Export

4

Identify and update patients with no gender recorded

Clear Filters ➡ Cleansing CAT view ➡ Select Gender 'Other' ➡ Recalculate ➡ Report section below ➡ Missing Demographics ➡ Export

How do we get Started?

All the information contained in this guide is to assist you in increasing the recording of Blood Pressure in patients with Diabetes.

Using the various tools, information and resources in this guide is one part of gaining success in this QI activity, our team of Practice Facilitators are here to support your clinic preparation, implementation, and evaluation of the activity.

Request Practice Facilitation support

Using Data to Drive Success

The PHN Exchange is an innovative population health knowledge management system that's designed to support, influence and improve health outcomes.

Gathering data from multiple sources, PHN Exchange presents a customisable view for PHN staff, health planners and health providers to use in a multitude of ways to better inform decision making.

As a living needs assessment tool, PHN Exchange has been specifically designed to localise data and information and deepen understandings about communities in a given region.

The PHN Exchange can be found HERE.

Publicly available Health Risk data can be used to inform your practice on Chronic Disease, obesity, health and wellbeing and other factors across the western Victorian region, however more specific data can be found via logging in to access your practice data.

General Practices have access to several features within the PHN Exchange that have been organised into a dashboard named the GP Hub. **Please contact the Practice Facilitation Help Desk for support to access your practice's data 1300 176 271.**

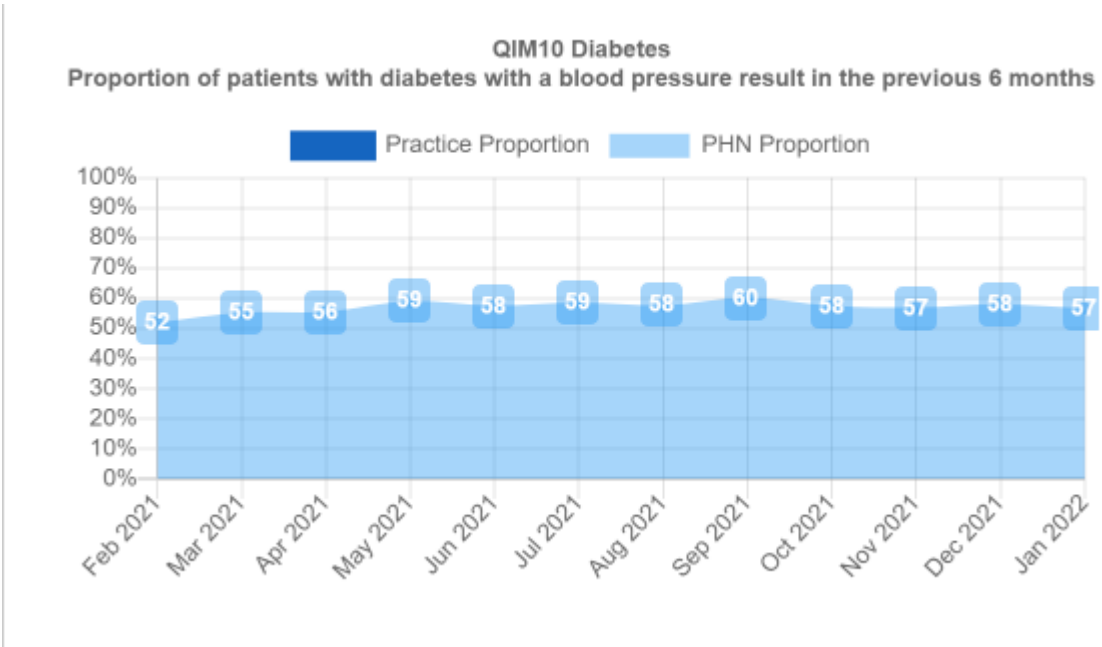
The GP Hub also contains helpful information to assist a practice in data quality such as your last data extract date and:

- Provides trend over time and benchmarking against your peers within the PHN Catchment, the benchmark is calculated from the average of all participating practices.
- Provides a tool to assist the practice to undertake data analysis and evidence-based quality improvement activities.
- Supports partnership between your practice and Western Victoria PHN, by providing a common suite of reports.

Data displayed in the GP Hub is generated from extracted general practice data. All data is an aggregated estimate of practice data.

The value of the GP Data Report is reliant on the quality and completeness of practice records and clinical coding within your clinical information system.

Note: Charts below only show WVPHN region baselines, actual charts will have a second line with the practice result.



QUALITY IMROVEMENT MEASURES

QIM 10 -
Proportion of patients with diabetes with a blood pressure result

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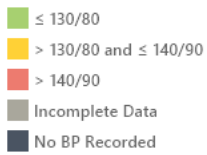
Change Improvement Ideas

Focus Area	Why improve this focus area?	QI Ideas "What" of the Action Plan	Resources
Proportion of patients with diabetes with a blood pressure result	To potentially lower the risk of macro vascular (stroke, heart attack and heart failure) and microvascular (kidney disease, eye disease and peripheral neuropathy) **complications.** Up to date clinical record Opportunity to provide education and information to patients Quadruple Aim: • Patient experience • Provider satisfaction • Cost and sustainability • Population health	Identify the patients that are eligible to have a GP management plan, a Health Assessment, TCA as well as having a review of any of the above due and set prompts to record blood Pressure. Search for all patients with a weight over 90kg with no BMI recorded and check to see if they have a height recorded, then calculate their BMI. Search for patients over 50 with no height/weight recorded. Provide a list of patients to relevant practitioner of patients identified without a BMI who have other risk factors (smoking, ethnicity, blood pressure etc) Focus on patient groups (e.g., patients with high cholesterol or high blood glucose levels)	**Clinical Audit Tools** Cat4 – install Topbar – install and set up prompts Pen Recipe GP Hub/PHN Exchange **Health Pathways** Newly Diagnosed Type 2 Diabetes Managing Type 2 Diabetes Kidneys and Diabetes Absolute Cardiovascular Disease Risk Assessment Hypertension Chronic Kidney Disease **Patient/Clinic Resources** GoShare Heart Foundation Diabetes Australia Care Monitor

Plan Do Study Act (PDSA): Increase Blood Pressure recordings in patients with Diabetes

Practice Name		**Cycle number**	
Staff initiator:		**Position title:**	
Start date:		**End date:**	
Purpose	What are we trying to accomplish? What do you plan to do?		
	Increase blood pressure recordings in software for patients with Diabetes. Have a sustainable health coaching model utilising the Practice Nurse. Engage a Practice Nurse to provide health coaching and care plans 1 day a week for patients with diabetes and engage local allied health providers to refer patients to.		
	How will we know that change is an improvement? What do you hope to achieve? (include measurement/outcome)		
	Patients with diabetes will have managed blood pressure, and this can be noted in clinical software with improved BP recordings accessed via clinical software or via CAT4 traffic light system 		
	What change can we make that will result in improvement?		
	Health coaching and care plans for patients with Diabetes to improve coordination of care, patient engagement and encourage patients to make lifestyle changes to improve their health and wellbeing - monitoring blood pressure can help assure appropriate medical care to lower the risk of macro vascular (stroke, heart attack and heart failure) and microvascular (kidney disease, eye disease and peripheral neuropathy) complications Engage with local allied health professionals to ensure patients receive holistic coordinated care that is aimed at improving their health		
PLAN	**By answering this, you will develop the GOAL for improvement. The goal must be SMART - Specific, Measurable, Achievable, Relevant, Time-limited**		
	From the questions/answers above, write your statement or aim of what you are attempting to achieve.		

Write a concise statement of what you plan to do, and the steps involved	Over the next two months, increase the proportion of active patients who have diabetes and who have had a blood pressure recording within the previous 6 months by xx%.		
	How are you going to do this? (list the steps to be implemented)		
	Steps	**By whom**	**By when**
	Consult with the PHN practice facilitator, develop a plan of action and present it at staff meetings.		
	Form a QI team, discuss workflow and allocate roles & responsibilities. [ideally – practice manager (can include PHN practice facilitator) and at least one GP, nurse and admin staff.]		
	Recruit Practice Nurse 1 day per week to provide one on one health coaching and care plans to Type 1 and 2 Diabetes patients (from existing staff)	PM	
	Analyse baseline data to identify eligible Diabetes patients	PM PN	
	Recall and reminders for Type 1 and 2 Diabetes patients who are due for GPMP/TCA and Review of GPMP/TCA - book them in with Practice Nurse	PM	
	Ensuring clinical staff are using Topbar to identify missing BP recording for patients attending the clinic.	All staff	
	Ensure relevant Allied Health are included in GPMP/TCA to refer patients to.		
	Refer patients to Allied Health that are conducing group programs to utilise the Medicare Group items for Diabetes.	PN	
	Use GPMP and TCA sessions to educate and support patients with the management of their blood pressure and continue to record at each visit to the practice		
	At completion of specified QI period, measure change by repeating data reports using Pen/clinical software.	PM PN	
DO	**This may include how the patients react, how the doctors react, how the nurses react, how it fits in with your system or flow of the patient visit. You will ask, "Did everything go as planned?"**		
Implement your plan and write down observations you have during your implementation.	What did you observe?		
	Where there any unexpected events?		
STUDY	You will ask, "Do I have to modify the plan"		
After implementation you will study the	What did you learn?		

results and record how well it worked, if you met your goal and document areas of improvement.	Has there been an improvement?
	Did you meet your measurement goal?
	What could be done differently?
ACT	**If it did not work, what you can do differently in your next cycle to address that.** **If it did work, are you ready to spread it across your entire practice?**
Here you will write what you came away with for this implementation, whether it worked or not.	What did you conclude from this cycle?

To access additional PDSAs and other quality improvement ideas, please contact the Practice Connect website or your practices facilitation team on QI@westvicphn.com.au

Optimising Medicare Benefits Schedule (MBS) Items

In some practices, practice nurses also manage or contribute to nurse-led clinics to which GPs can refer patients. The benefits of employing a nurse can include improved outcomes in chronic disease; an increased range of services available at the practice, including patient education, improved integration and referral to services; and enhanced consumer satisfaction.

The blood pressure recordings can be achieved through the ongoing management of regular patient consultations and/or by management of chronic diseases by nurses and general practitioners.

Care Plans

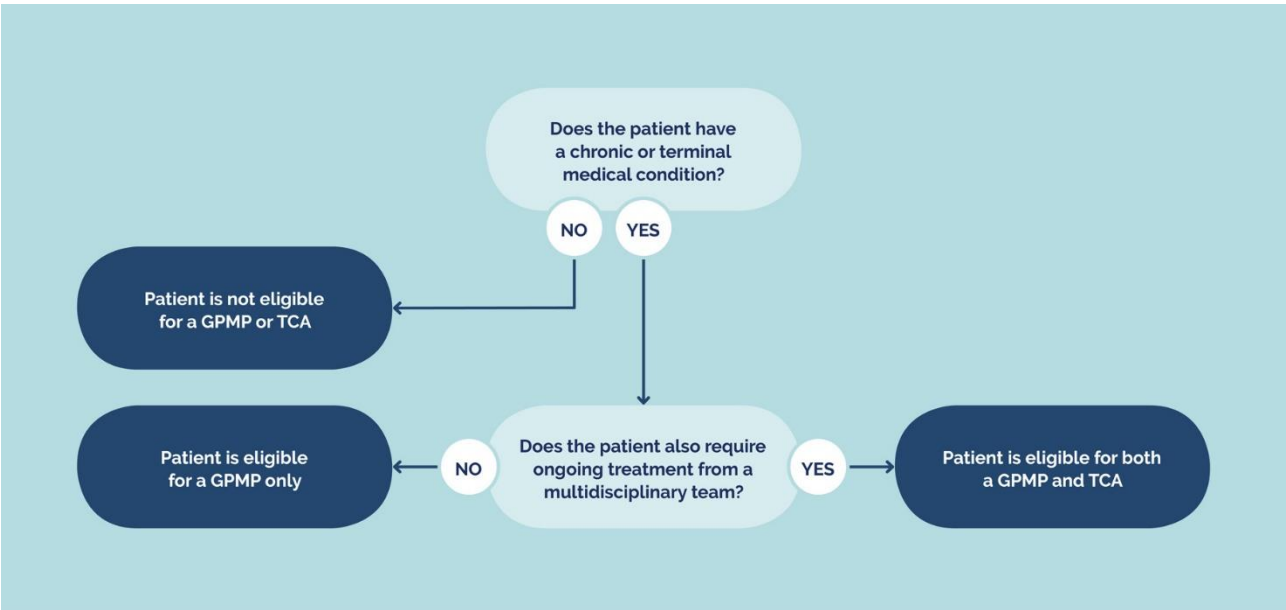
The MBS provides a series of Medicare item numbers which provide rebates for medical practitioners to manage chronic or terminal medical conditions by preparing, coordinating, reviewing or contributing to chronic disease management plans (CDMP). General practices can increase the recording of the blood pressure and other key health information as part of any of these management plans, or through their reviews.

There are five MBS item numbers in the chronic disease management items list.

Item Number	Description	Fee[2]	Claiming Frequency
721	Preparation of a GP Management Plan (GPMP)	Fee: $150.10	Once every 12 months
723	Coordination of the development of Team Care Arrangements (TCA)	Fee: $118.95	Once every 12 months
729	Contribution to a Multidisciplinary Care Plan or to a review for a patient who isn't in a residential aged care facility	Fee: $73.25	Once every 3 months
731	Contribution to a Multidisciplinary Care Plan or to a review for a resident in an aged care facility	Fee: $73.25	Once every 3 months
732	Review of either a GPMP or TCA	Fee: $74.95	Once every 3 months

Utilise item 10997 for follow-up by PN or Aboriginal and Torres Strait Islander Health Practitioner if patient has a GP Management Plan or TCA in place. Fee: $12.50.

Figure 1: Care plan criteria



Health Assessments

Health Assessments are another way of increasing the recording of the blood pressure for patient cohorts. A health assessment provides opportunity for examining a patient's lifestyle to identify possible improvements as well as early warning signs of disease or illness. Heart disease, diabetes and some cancers can often be picked up in their early stages, when treatment may be more successful.

Health assessments are generally included in a patient's routine medical care.

There are four time-based MBS health assessment items:

Item Number	Description	Type	Fee[1]
701	Attendance by a medical practitioner to undertake a short health assessment, lasting not more than 30 minutes	Brief	Fee: $61.75
703	Attendance by a medical practitioner to undertake a medium health assessment, lasting more than 30 minutes but less than 45 minutes	Standard	Fee: $143.50
705	Attendance by a medical practitioner to undertake a long health assessment, lasting at least 45 minutes but less than 60 minutes	Long	Fee: $198.00
707	Attendance by a medical practitioner to undertake an extended health assessment, lasting at least 60 minutes	Prolonged	Fee: $279.70
715	Aboriginal and Torres Strait Islander peoples health assessments for children, adults and older people	<15 years old ≥ 15 years ≤ 55 years old ≥ 55 years old	$220.85

Using care plans and health assessments as the optimum time to increase the blood pressure recordings of the practice's patients with coded diabetes, means the practice is achieving all four outcomes of the quadruple aim. For patients who have a GPMP or TCA already in place, general practices may elect to recall and review the patients for a review of their care plan every three months using the item number 732.

Practitioners can claim item 732 twice on the same day. One claim will be for the GPMP review and the other to the TCAs review. The Medicare claimant will then need to correctly fill in the MBS item descriptions and explanatory notes.

Figure 2: Quadruple Aim

[1] Please note that the information provided is a general guide only. It is ultimately the responsibility of treating practitioners to use their professional judgment to determine the most clinically appropriate services to provide, and then to ensure that any services billed to Medicare fully meet the eligibility requirements outlined in the legislation.
This sheet is current as of the Last updated date shown and does not account for MBS changes since that date.

My Health Record and Maximising ePIP opportunities

In addition to using GPMPs and TCAs to maximise opportunities to increase blood pressure recordings for patients with diabetes, your practice may also consider uploading shared health summaries to My Health Record. This will not only contribute to your practice achieving the outcomes of the quadruple aim, it will also maximise your ePIP opportunities.

A Shared Health Summary may be authored and uploaded by the GP, practice nurse or Aboriginal Health Practitioner. It is a valuable way to share key pieces of relevant health information for other health professionals who are involved in that patient's care, to view.

View an example of a Shared Health Summary

GP Consultation Checklist

Workflow and Minimum Clinician Data Entry[2]	
Review previous consultation notes	☐
Review or collect history	☐
Current Medications	☐
Recent side effects/allergies	☐
Examination and Management (enter all observations – BP, pulse in correct fields)	☐
Findings/Diagnosis	☐
Patient Education	☐
Add/Remove recall or make next appointment	☐
Reason for contact	☐
MBS item/Voucher	☐
Create a Shared Health Summary	☐
Upload to My Health Record	☐

Budgeting for the Nurse Led Clinic

In the Australian Practice Nurse Association (APNA) website you will find some publicly available tools to assist general practice.

The Nurse clinic tools and resources page offers some very good resources on building a business case and how to define the goals of the work you are undertaking.

The nurse led clinic budget module can assist in providing ways of maintaining your clinic and includes access to a nurse led budget template. In this template you can input the relevant information on running the clinics and determine allocation of staff and other resources.

APNA Nurse Clinic Budget Template

[2] https://trainitmedical.com.au/wp-content/uploads/2019/03/CESPHN-MyHR-presentations-2019-Train-IT-Medical-V05-to-share-1.pdf

Resources

Diabetes and Blood Pressure Management

General Practice Management of Type 2 diabetes – RACGP

Improving GP diabetes management - PDSA cycle - RACGP

Living with diabetes and blood pressure – Diabetes Australia

Heart Health Check Toolkit - Heart Foundation

HealthPathways

Newly Diagnosed Type 2 Diabetes

Managing Type 2 Diabetes

Kidneys and Diabetes

Type 1 and type 2 Diabetes in Pregnancy

Diabetic Retinopathy

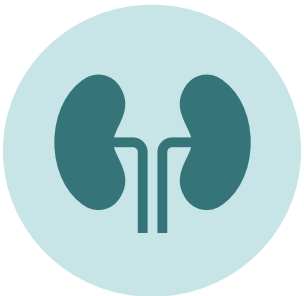
Absolute Cardiovascular Disease Risk Assessment

Hypertension

Chronic Kidney Disease

Post-acute Stroke Care

Pen CS Recipes



QIM10 – Blood Pressure for patients with Diabetes

My Health for Life

Other resources

PDSAs

PDSA Clinical Coding

PDSA Data Cleansing

PDSA Improving Type 2 Diabetic Patient Indicators

PDSA Increase blood pressure recordings for patients with Diabetes

PDSA Increase patient numbers with uploaded shared health summaries

Quality Improvement Posters

QI Poster Template PPTX

QI Poster – Blood Pressure recording in patients with Diabetes PPTX

QI Poster – Blood Pressure recording in patients with Diabetes PDF

Webinars

Innovative approaches to CDM

Exercise and Diabetes

Quality Improvement Poster Example