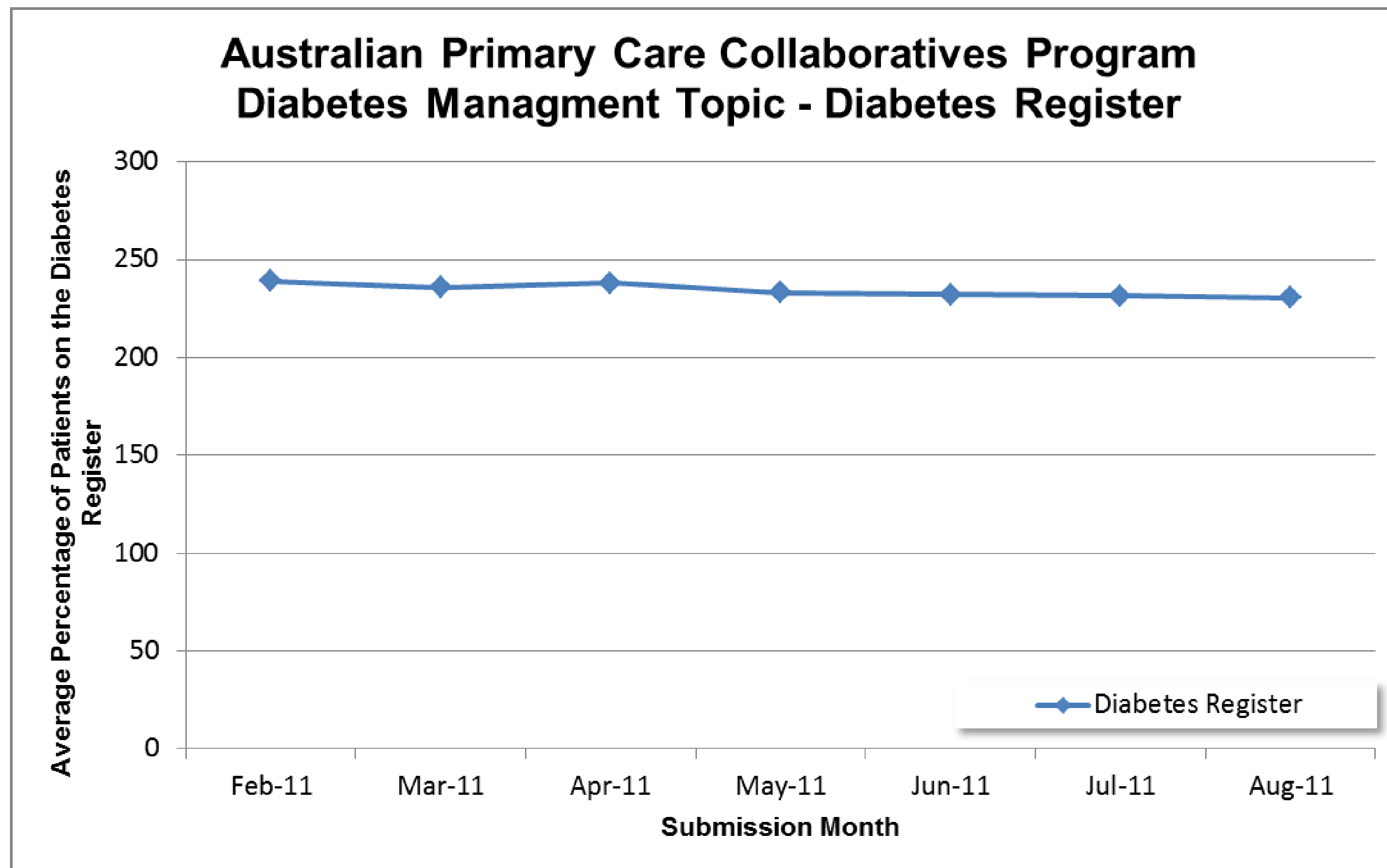
Diabetes Prevention and Management Wave Results (baseline to month six)

67 Health Services



Diabetes Register: The number of people within the clinical database that are coded with a diagnosis matching the Diabetes definition.

After the first learning workshop, which occurred after the baseline data submission (Feb 2011), health services were encouraged to focus on 'cleansing' their data. This work involves archiving patients that no longer attend the health service and updating clinical databases to appropriately code patients that have a diagnosis matching the Diabetes definition. This graph shows a slight reduction in the number of patients, which is primarily attributed to archiving of patients who longer attend the health services.

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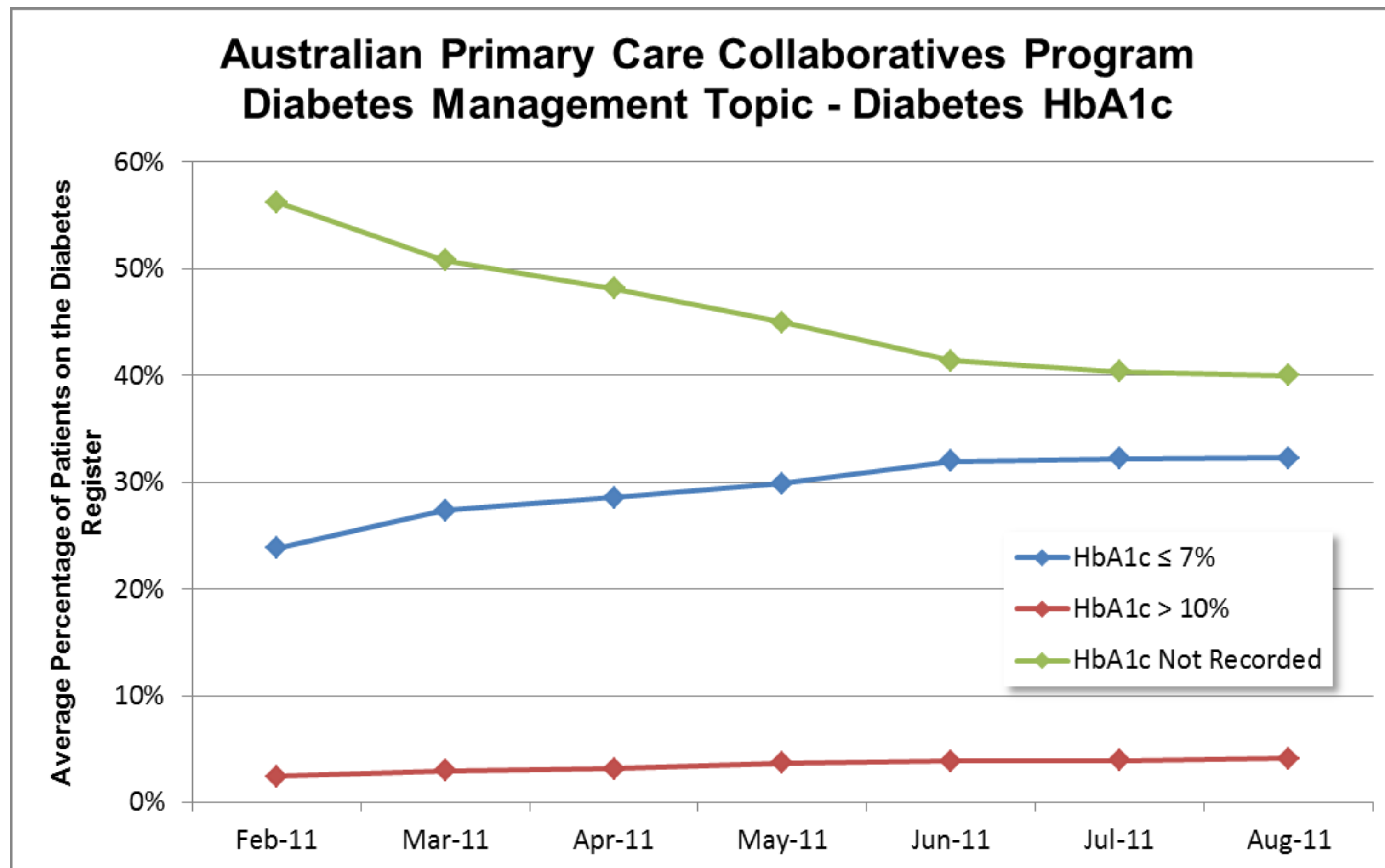

HbA1c Not Recorded: The percentage of people on the Diabetes Register whose HbA1c has not been recorded within the previous 12 months.

HbA1c ≤ 7%: The percentage of people on the Diabetes Register whose HbA1c has been recorded within the previous 12 months AND whose last recorded HbA1c result was ≤ 7.0%.

HbA1c > 10%: The percentage of people on the Diabetes Register whose HbA1c has been recorded within the previous 12 months AND whose last recorded HbA1c result was > 10%.

The HbA1c less than or equal to 7% measure has improved by 8.4% since baseline submission. Some of this improvement is as a result of archiving patients and clinical databases. Early Plan, Do, Study, Act (PDSA) cycles submitted by participating health services show that some participants have been actively targeting the improvement of their patients' HbA1c levels, with over 30 PDSAs submitted across the wave, which directly relate to the HbA1c measures. The HbA1c Not Recorded measure has decreased by 16.2% since baseline, which is attributed to archiving of non-active patients and improved recording of HbA1c values.

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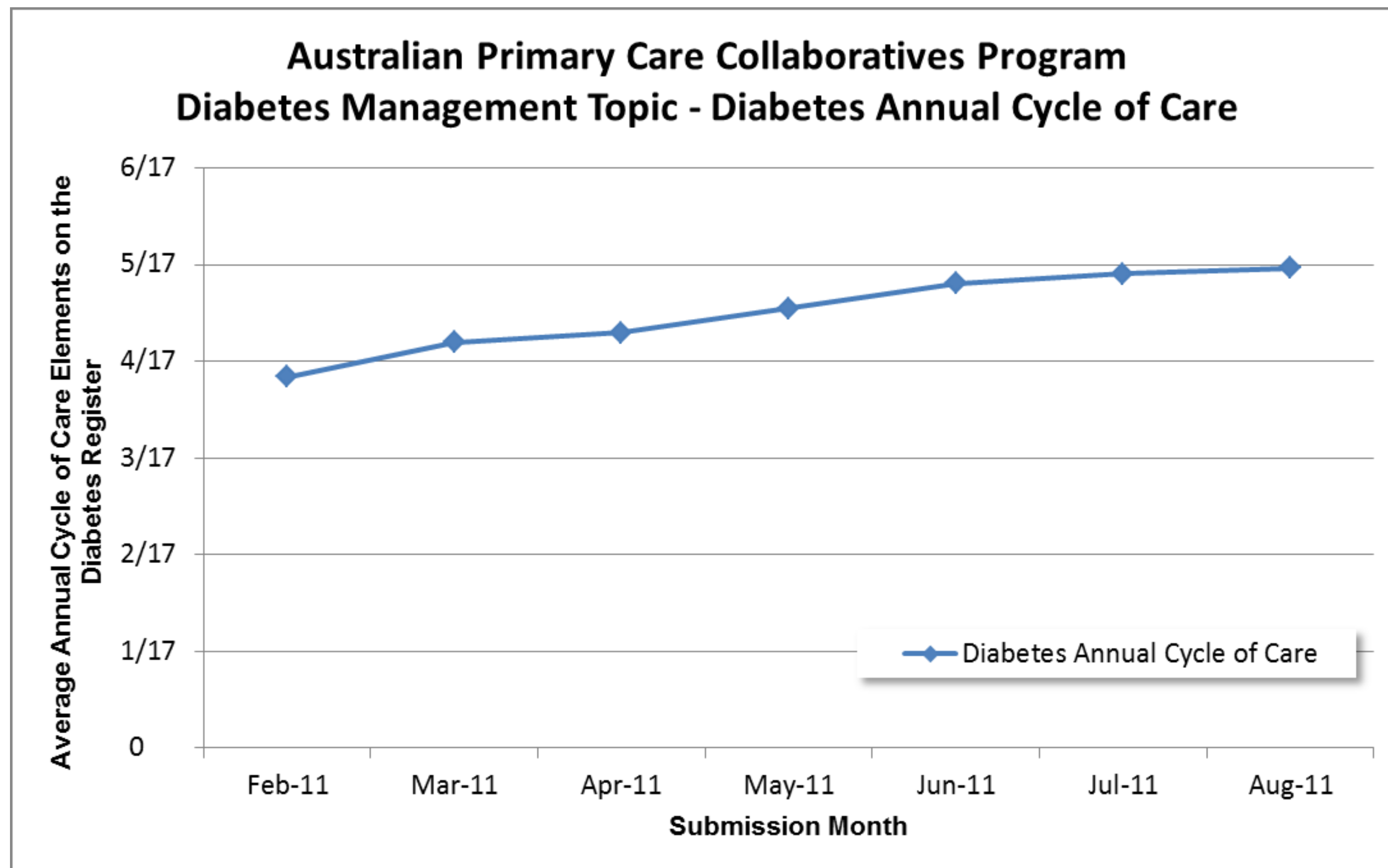

Annual Cycle of Care:
The percentage of annual cycle of care elements recorded for people on the Diabetes Register. Annual cycle of care elements include:

- BMI
- Blood Pressure
- Foot assessment
- HbA1c control
- Lipids (total chol, trig, HDL)
- Microalbuminuria
- Self Care Education
- Diet Review
- Physical Activity
- Smoking
- Medication Review
- Eye examination (24 mths)

**Note only 12 elements are listed; however, some are repeated due to the indicated frequency, In total, these make up the 17 elements of the Annual Cycle of Care measure.*

As health services update their Diabetes registers it becomes easier to identify gaps in patient information, particularly for the annual cycle of care. Through investigating the early PDSAs, it is evident that some participants have focused their early changes on recalling patients to update their management plans, and correctly record elements of the cycle of care within their clinical databases. This has resulted in an average improvement of approximately one additional element in the Annual Cycle of Care being recorded, per patient, per participating health service.

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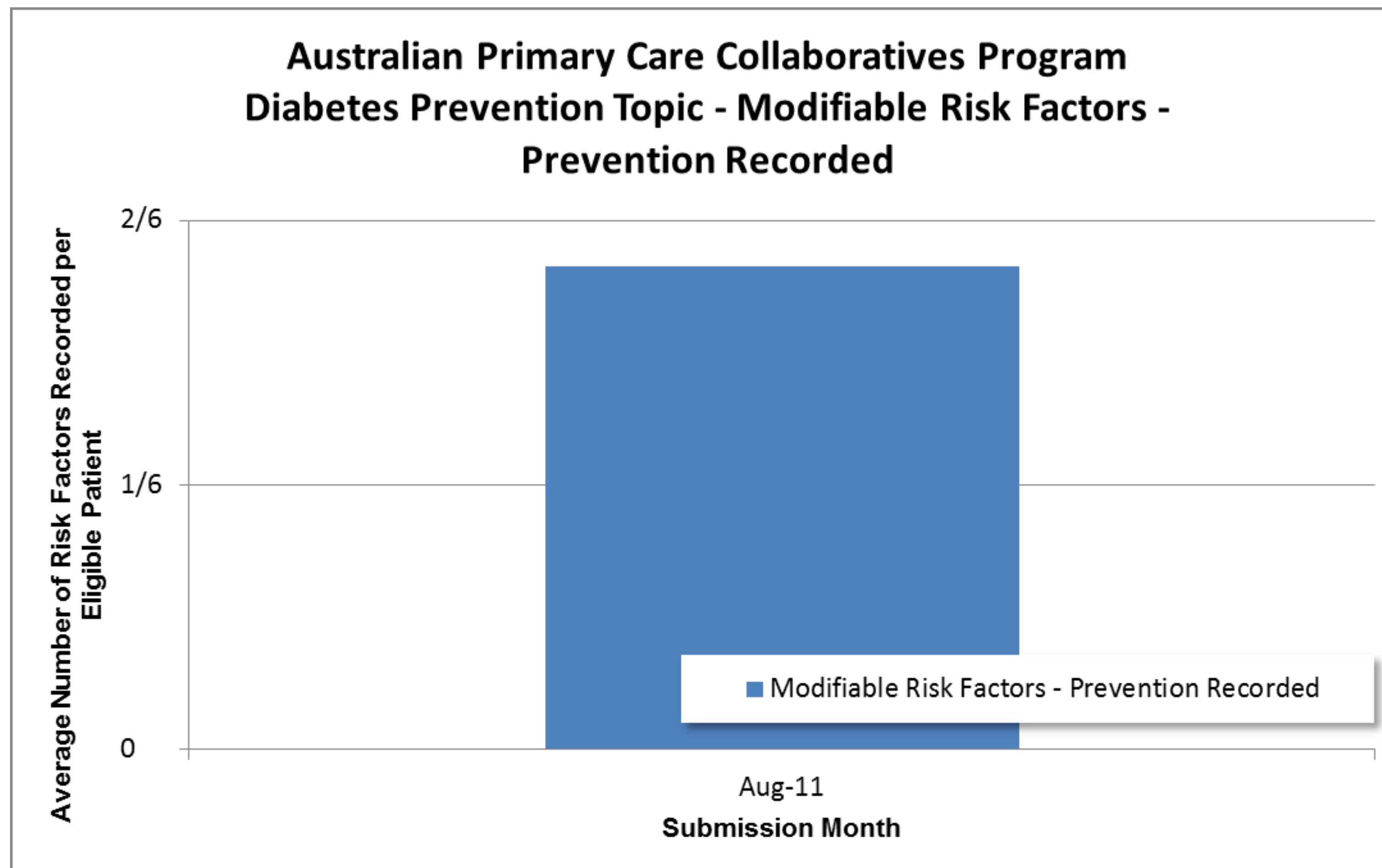

Modifiable Risk Factors – Prevention Recorded: The percentage of modifiable risk factors that have been recorded for people within the clinical database that are aged:

a) Non-ATSI people aged >=35, OR
b) ATSI peoples aged >=15 without a specified chronic disease.

Risk factors include:

- BP systolic
- Cholesterol
- Smoking
- Waist Circumference
- Alcohol
- Physical Activity

The above graph shows the baseline submission for the Modifiable Risk Factor (recorded) measure for the prevention of diabetes. Currently the average number of diabetes risk factors recorded per patient, per participating health service is just under two risk factors. As this measure relates to a larger population of patients within participating health services (aged ≥ 35 or ≥ 15 for Aboriginal and Torres Strait Islander patients) improvements are likely to be less noticeable, compared with measures that relate to a specific disease group, which have smaller denominators.

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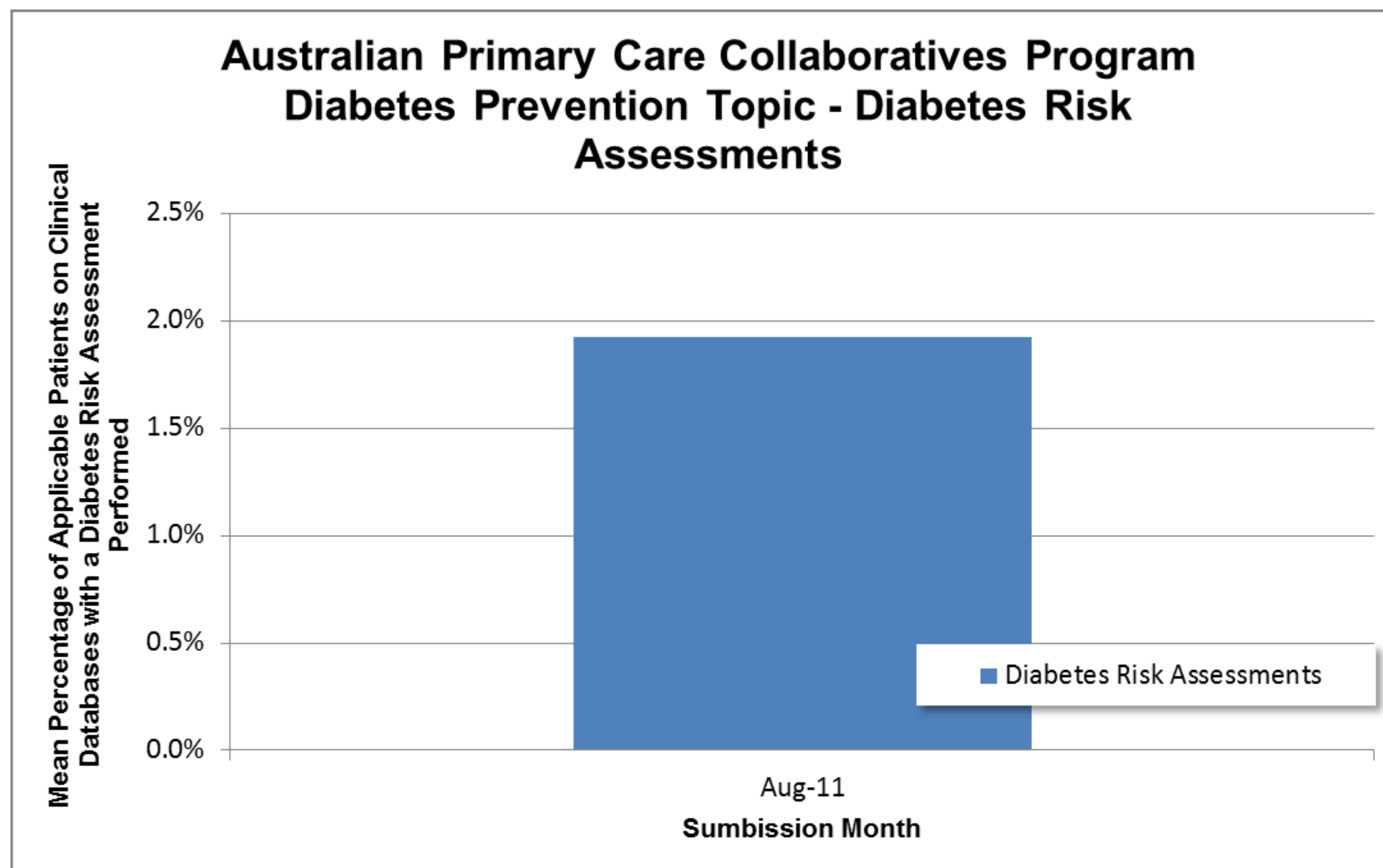

Diabetes Risk Assessment: The percentage of people within the clinical database aged:

a) Non-ATSI people aged >=40, OR
b) ATSI peoples aged >=15,

on the clinical database currently without a diagnosis of diabetes (not on the Diabetes Register), who have had a Diabetes Risk

A key element to the prevention of diabetes is to identify patients' level of risk for developing diabetes. The Type 2 Diabetes Risk Assessment Tool (AUSDRISK) is used to identify individuals at risk of developing Type 2 diabetes within 5 years. Through a series of lifestyle and personal questions, the tool generates a score that indicates whether an individual has a low, intermediate or high risk of developing diabetes within 5 years. Currently, participating health services have completed Diabetes Risk Assessments for an average of 2% of their patient population that is not currently diagnosed with diabetes. This measure has a large denominator, with all patients over 40 (or 15 for Aboriginal and Torres Strait Islander peoples) being eligible for this measure.