Victorian Healthcare Association

Clinical Indicators In Community Health

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A) Clinical Indicators and Clinical Governance

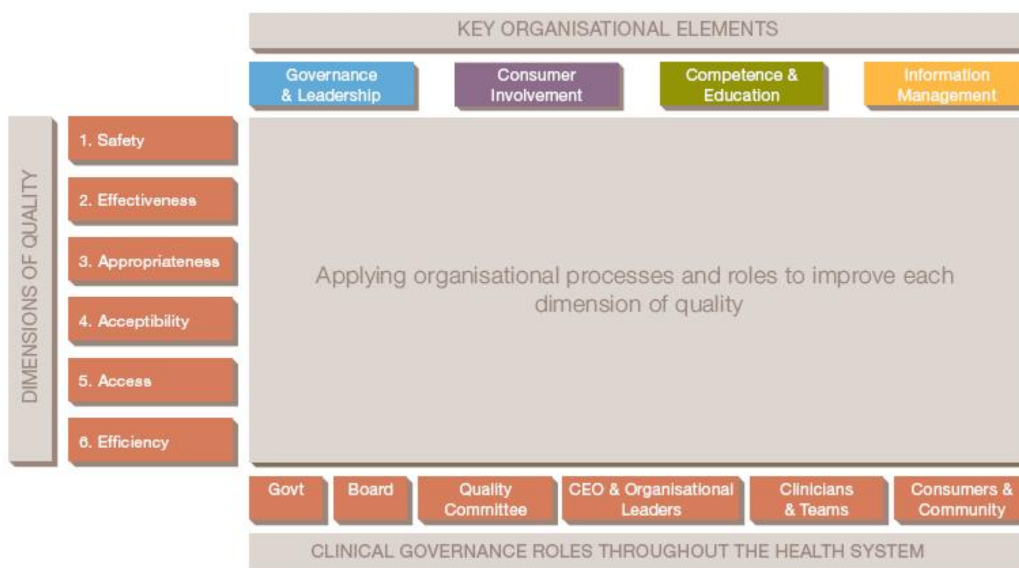
Clinical Governance and the Victorian Quality Council's Safety and Quality Framework

Clinical Governance has been defined as

> *The systems by which the governing body, managers and clinicians share responsibility and are held accountable for patient or client care, minimising risks to consumers, and for continuously monitoring and improving the quality of clinical care.*
> (Australian Council on Healthcare Standards)

The effective governance of clinical services involves the participation of BoM, managers and staff in a range of activities to ensure the safety and quality of clinical services. In the community health context, clinical services can be seen as all those services that involve interaction with clients whether it be through intake, 1:1 consultations or group work in a variety of settings
The Victorian Quality Council (VQC) describes clinical governance activities in detail in the document 'Better Quality, Better Health Care' (VQC, 2005). The principles and theoretical framework for safety and quality presented in the VQC document form the basis for the approach used by the Clinical Governance in Community Health Project. The VQC framework describes the intersection between four critical organisational processes essential for quality improvement and each of the six dimensions of quality, as well as exploring related roles and responsibilities throughout the health system as seen below in figure 1.

Figure 1: Diagrammatic representation of Victorian Quality Council Safety and Quality Framework (2003)



Indicators can provide information on the dimensions of quality to enable monitoring and continuous improvement of the quality of clinical care. For the purposes of this framework, the dimensions of quality are described as follows:

- ***Safety*** of health care: A major objective of any health care system should be the safe progress of consumers through all parts of the system. Harm arising from care must be avoided and risk minimised in care delivery processes.
- ***Effectiveness*** of health care: Consumers of health services should be able to expect that the treatment they receive will produce measurable benefit. The effectiveness of health care relates to the extent to which a treatment, intervention or service achieves the desired outcome.

- ***Appropriateness*** of care: It is essential that the interventions that are performed for the treatment of a particular condition are selected based on the likelihood that the intervention will produce the desired outcome for each patient. Essentially, the appropriateness of health care is about using evidence to do the right thing to the right patient, at the right time, avoiding over and under utilisation.

- ***Acceptability*** of care is the degree to which a service meets or exceeds the expectations of informed consumers. Opportunities must be provided for health consumers to participate collaboratively with health services and service providers in health service planning, delivery, monitoring and evaluation at all levels.

- ***Access*** to services: Health Services should offer equitable access to health services for the population they serve on the basis of need, irrespective of geography, socio-economic group, ethnicity, age or sex.

- ***Efficiency*** of service provision: Health services must ensure that resources are utilised to achieve value for money.

What are clinical indicators?

Clinical Indicators can be seen as indicators of the clinical management and/or outcome of care. They draw attention to areas where further investigation may be required rather than being a precise measure of quality of care.

Why do we need clinical indicators in community health?

Clinical Indicator provide a means for clinicians, management and Boards of Management to assess and benchmark the **effectiveness** and **appropriateness** of clinical care and identify areas for improvement.

What are the main types of clinical indicators?

Clinical indicators can be divided into:

System/Provider Perspective Indicators - Processes involved in delivering services e.g.
- Staff education
- Use of care planning
- Use of guidelines

Client perspective indicators - the services received by clients e.g.
- Care received by an individual
- Screening rate
- Antenatal visit before x weeks
- Health outcomes client satisfaction[1]

A mixture of process and outcome indicators can potentially be used. Process indicators are considered to have greater sensitivity than outcome indicators in determining the quality of health services but need to be linked to outcomes. However failures of process do not necessarily result in poor outcomes. In addition outcome indicators can be confounded by factors outside clinical care such as socio economic factors. A mixture of process indicators with outcome measures can be used, where process indicators could be based on practice guidelines. Eg diabetes – compliance with diabetes guidelines (process) and HbA1c measure (outcome).

Criteria for clinical indicators
- Process or outcome indicators related to a health outcome
- Data is available
- Minimal reporting burden

Appropriateness
Process indicators
- Presence of Care plans
- Audit of care pathways e.g diabetic clients receiving referrals to pod, diabetes nurse, dietician etc

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- All physio clients receiving full assessment

Effectiveness
- Generic – Quality of Life
- Disease specific outcomes – e.g HBA1c
- Discipline specific measures – dental indicator set, Austoms, Care plan outcomes

Clinical Indicator Format

1. Structure of the Clinical Indicator

Numerator – the number of cases fulfilling the criteria
Denominator – the total number of cases
Measurement mode – the method by which the clinical indicator is obtained

2. Indicator Format
Indicator topic
Rationale:
Definitions
Indicator Type (e.g. appropriate, efficient, outcome, process etc)
Numerator;
Denominator:
Measurement Mode
Red Flag (when further action needs to be taken)

Resources

Clinical Governance in Community Health Services: Development of a Clinical Indicator Framework Discussion Paper. Australian Institute for Primary Care, Mar 2007

Health Outcomes Overview – An Australian Perspective. Centre for Health Services Development. University of Wollongong Feb 2007

Identifying and reviewing primary care and community health performance indicators: A mapping project for the National Health Performance Committee. Research Centre for Primary Health Care and Equity, April 2006

Victorian Quality Council. (2003), *Better Quality, Better Health Care, A Safety and Quality Improvement Framework for Victorian* Health Services, Metropolitan Health and Aged Care Services Division, Department of Human Services: Melbourne.

B) Clinical Indicators in Community Health

This section presents care planning and diabetes care clinical indicators that have been developed by the Clinical Indictor Working Group, as part of the VHA Clinical Governance in Community Health Project. An initial set of draft indicators underwent a small-scale pilot in September 2007 and was presented to the sector in November 2007. Since that time the indicators have been redeveloped based on feedback from the sector and a further pilot. The clinical indicators presented in this document represent process measures. The Clinical Indictor Working Group is currently investigating outcome measures in the areas of self management and quality of life.

A) Collecting Clinical Indicator Data

In the following pages clinical indicators are presented for organisations to apply to service/program areas. The indicators are structured as follows:

Numerator – the number of cases fulfilling the criteria
Denominator – the total number of cases
Measurement mode – the method by which the clinical indicator data is obtained

Measurement mode
Data related to the numerator and denominator can be collected via a number of means. If data is able to be extracted electronically then this is a quick easy way to obtain indicator data. If electronic data is not available for the indicators then a client file audit will need to be conducted

Sample Size and Timeframe of Measurement
The number of client records that need to be reviewed for a clinical audit will depend on the size of the organisation or program. An equation that is used for QIC file audits to determine the sample size for a snapshot is '*the square root of the total number of client records, plus 1'* (QIC Client Record Audit Tool)

Alternatively an organisation may decide to audit more files if the numbers in the program are small. However a small sample is usually all that is required to pick up a trend. Data from all clients in a program or continuous data collection is generally more easily collected when obtained from electronically retrieved data systems.

The specified timeframe (the time period under study) for data collection can be nominated by the agency according to the number of anticipated clients in the denominator in that timeframe.

Conducting an audit
For each of the indicators provided:

- Choose an appropriate service/program area/s for auditing
- Choose a timeframe for selecting files that will enable you to obtain the required number of files. The timeframe you use for selecting the files will be dependent on the size and number of cases you see in your service. See the information contained in measurement mode for each indicator in the guide.
- Record indicator data using a standardised form. The appendices provide a suggested format for recording the indicator information

When conducting the audit consider using an independent person to assist objectivity of the audit.

C) Introduction to Care Plan Clinical Indicators

1. BACKGROUND AND RATIONALE

"*Care Planning is a process of deliberation that incorporates a range of existing activities such as care coordination, case management, referral, feedback, review, re-assessment, monitoring and exiting. Care planning involves the judgment / determination of relative need as well as competing needs, and assists consumers to come to decisions that are appropriate to their needs, wishes, values and circumstances. Care planning also provides a means of synthesizing assessment information and agreed strategies".* Victorian Service Coordination Practice Manual 2007

Traditionally care planning stems from the acute sector where there was a need to coordinate a number of differing services. More recently care planning has been translated into the community sector where the focus has been on an individual plan of action that guides the collaborative service provision between the provider and the consumer. A consumer accessing one service within an agency may have a service specific care plan. These are usually developed and documented using agency or program tools. These service specific care plans may be known as individual treatment plans, consumer care plans, individual service plans, individual program plans, personal action plans, plans of management, services contract. A client using multiple services within the community centre may need an intra agency care plan or with external agencies an interagency care plan.

Funding guidelines (e.g. Primary Health Branch Policy and Funding Guidelines—2006–07 to 2008–09: diabetes management) from the Department of Human Services identify the development of care plans and care managed activities as the expected standard of service delivery.

The Victorian Service Coordination Practice Manual identifies benefits to the consumers include:

- Takes into account social, emotional and health needs (not just the presenting issues)
- is consumer centred
- encourages and empowers self management
- Is underpinned by communication between stakeholders.

The Better Health Channel fact sheet on mental health-care plans indicates that the benefits of care plans include;

- Assist in setting and achieving goals
- Encourages the client to be involved in their care
- Manages long term care in a clear, concise way
- Provides an essential checklist to ensure continuity of care
- Prompts the client to take more responsibility for their care needs
- Encourages a team approach to the client centred plan
- Focuses on improving and maintaining health rather than waiting for illness onset
- Increases client and carer awareness of which services are needed and why.

The Victorian Disability Act 2006 outlines an approach to planning that reflects the individualised planning and support approach, which supports people with a disability to explore their goals and needs within the community. It is expected that consumers will be collaboratively involved in a person-centred planning process that identifies and measures consumer outcomes across a range or 16 life areas.

Hackney and Cormier (2001) discuss that within the counselling environment the development of treatment / counselling plans is an interactive process and that the plan becomes "part of the relationship in that it reflects what you and your client are focusing on, how you relate to one another and what potential outcomes will be realized". The authors state "these goals are related and may be classified as immediate, intermediate or long term".

Across a diverse range of types of service provision it is accepted as good practice to develop a plan collaboratively with the consumer to guide the service delivery. This plan should be:

- developed collaboratively and signed off by the consumer and the service provider
- have goals and strategies to address these goals identified
- be reviewed systematically and changed as required

Examples of Care plans can be found in the following places:

SCOT Service Coordination Plan - http://www.health.vic.gov.au/pcps/coordination/sctt2006.htm
General Practice Victoria - http://www.gpdv.com.au/

2. REFERENCES

Better Health Channel Fact Sheet – '*Mental health – care plans*' http:/www.betterhealth.vic.gov.au

Hackney,H.I., Cormier, L.S. '*The professional counselor. A process guide to helping'.* Allyn and Bacon, 2001

Primary Care Partnerships Victoria. " *Victorian Service Coordination Practice Manual – A Statewide Primary Care Partnership Initiative"* 2007

Scheil, M, 'Individual program planning as and exemplar of best practice in the delivery of consumer-oriented mental health care' *Australian Health Review* vol24. No 3, 2001 pp 100-104.

3. DEFINITIONS

The following terms are defined for the purpose of the care plan indicators

Care Plan: A care plan is any documented plan of care that has **all of** the following elements completed:

- Client stated/agreed issues/problems
- Client stated/agreed objectives/goals,
- Client stated/agreed strategies/action
- Review date of care plan
- Timeframe for attainment of objectives/goals
- Responsibilities for implementing strategies/action
- Participants in development of care plan
- Consumer Acknowledgement (signed or verbal acknowledgement recorded)
- Date care plan developed
- Goal/Objective attainment

A care plan may take any of the following forms:

Service Specific Care Plan **–**a care plan which is developed and documented using specific program or agency tools, and may be referred to as a Consumer Care Plan, an Individual Treatment Plan, a Self Management Plan, a Personal Action Plan, a Service Plan, or a GP Management Plan.

Intra Agency Care Plan - a care plan that involves a number of services or practitioners within the same agency.

Interagency Care Plan - occurs where a consumer has complex or multiple needs and requires the services of more than one agency. It ensures that the needs of a consumer are discussed with them, their carer and relevant practitioners such as their GP, in the context of possible options and subsequently worked through to an agreed strategy. Also referred to as multi-agency care planning.

Care Plan Review: The goals and strategies listed in a care plan are regularly reviewed at a date set on initial preparation or last review (nominated review date). The review is to determine whether goals have been met or need renegotiating/ updating. Care plans meed to indicate the nominated review date and the actual review date when conducted.

Incomplete Care Plan: a documented care of plan that is missing one or more of the following elements:

- Client stated/agreed Issues/problems
- Client stated/agreed Objectives/goals,
- Client stated/agreed Strategies/action
- Review date of care plan
- Timeframe for attainment of objectives/goals
- Responsibilities for implementing strategies/action
- Participants in development of care plan

- Consumer Acknowledgement (signed or verbal acknowledgement recorded)
- Date care plan developed
- Goal/Objective attainment

NB: Some services may produce treatment notes with goals and strategies identified but this does not constitute a care plan unless all the elements listed are included.

Consumer: Patient, client, carer, family.

Client Stated/Agreed: in line with self-management principles the client is central in managing their health. To reflect this all issues/ problems, objectives/goals and strategies /action should be developed in partnership with the client and tailored to the identified needs and priorities of the person. Where the client is unable to contribute directly to the development of goals a carer, advocate or family member may assist.

4. CARE PLAN INDICATORS APPLICATION TO SERVICE/PROGRAM AREAS

The following set of care plan indicators can be used with all clients who attend the agency. However individual organisations may decide to apply the indicators to service/program areas where there is an expectation/requirement for care plans to be prepared for each client. Organisation may decide not to include specific types of service provision e.g. single session counselling, emergency/crisis appointments where planning for intervention does not follow the care plan format or definition.

5. INDICATOR TYPE

The care plan indicators are comparative rate based indicators addressing the appropriateness, efficiency and processes of client care

D) Care Plan Indicators

Indicator 1: Complete Care plans

Indicator Objective: To determine the percentage of clients with a complete care plan

Rationale: A care plan promotes client centred objectives and strategies for care to be developed (see definition complete care plan page 9).

Indicator 1: Complete Care Plans
See Appendix One audit proforma for data collection

Numerator: the number of consumers for whom there is a complete care plan

Denominator: the total number of consumers registered for the service/program who received intervention during the time period under study.

Measurement Mode - consumer record audit, date of care plan on data system

Indicator 2: Incomplete Care Plans

Indicator Objective: To determine the percentage of clients with incomplete care plans due to omission of one or more of the individual elements that constitute a complete care plan (see definition of care plan page 9).

Rationale: A care plan promotes client centred objectives and strategies for care to be developed.

Indicator 2: Incomplete Care Plans
See Appendix One audit proforma for data collection

Numerator: the number of consumers for whom there is an incomplete care plan*

Denominator: the total number of consumers registered for the service/program who received intervention during the time period under study.

Measurement Mode - consumer record audit, date of care plan on data system

* Incomplete care plan = (total number of clients - number of clients with complete or absent care plans)

Indicator 3: Reason for Incomplete Care Plans

Indicator Objective: To identify the reason for incomplete care plans due to omission of one or more of the individual elements that constitute a complete care plan.

Rationale: A care plan must contain all the specified elements to achieve the objective e.g. the signature or verbal agreement establishes consumer agreement to the care plan contents (see definition of care plan page 9).

Indicator 3: Reason for Incomplete Care Plans

NB: This indicator must be calculated separately for each individual element of a care plan therefore 10 calculations will be made. See Appendix One audit proforma for data collection

Numerator: the number of consumers with a specified element of the complete care plan recorded in their care plan.

Denominator: the total number of consumers registered for the service/program who received intervention during the time period under study with an incomplete care plan

Measurement Mode - consumer record audit

Indicator 4: Care Plan Review

Indicator Objective: To determine the percentage of clients with care plans that are reviewed systematically.

Rationale: The review of a care plan for consumers is necessary for effective management (see definition of care plan review page 9).

Indicator 4: Care Plan Review

Numerator: the number of consumers with a care plan that have been reviewed in the month nominated for review

Denominator: the total number of consumers registered for the service/program that have a care plan with a review date that falls within the time period under study.

Measurement Mode - consumer record audit, review date noted on data system

Indicator 5: Goal Attainment

Indicator Objective: To determine the percentage of objectives/goals of care that have been met in the timeframe stated in the care plan for attainment of the goal/objective

Rationale: The achievement of agreed objectives/goals of care is a measure of the success of the interventions.

Indicator 5: Goal Attainment
See Appendix Two audit proforma for data collection

Numerator: the number of objectives/goals met in the timeframe stated for attainment of each objective/goal for consumers with a care plan

Denominator: the total number of objectives/goals with the timeframe stated for attainment of each objective/goal for consumers with a care plan registered for the service/program who received intervention during the time period under study.
.
Measurement Mode - consumer record audit, achievement of goal/objectives noted on data system
See Appendix Two audit proforma for data collection

NB Do not include objectives/goals with a goal attainment timeframe after the time period under study in the numerator or denominator. The timeframe selected will need to allow adequate time for goal attainment prior to the audit date

Indicator 6: Objectives/Goal of Care Partially Attained

Indicator Objective: To determine the percentage of objectives/goals of care that have been partially met in the timeframe stated in the care plan for attainment of the goal/objective

Rationale: The achievement of agreed objectives/goals of care is a measure of the success of the interventions. If this indicator reveals a high number of partially met objectives/goals further information may be sought to determine why goals are only partially met to assist service improvement.

Indicator 6: Goals of Care Partially Attained
See Appendix Two audit proforma for data collection

Numerator: the number of objectives/goals partially met in the timeframe stated for attainment of each objective/goal for consumers with a care plan

Denominator: the total number of objectives/goals with the timeframe stated for attainment of each objective/goal for consumers with a care plan registered for the service/program who received intervention during the time period under study

Measurement Mode - consumer record audit, review date and achievement of objectives noted on data system

NB Do not include objectives/goals with a goal attainment timeframe after the time period under study in the numerator or denominator

E) Introduction to Diabetes Care Clinical Indicators

1. BACKGROUND AND RATIONALE

The burden of chronic disease is increasing where in Victoria, approximately 70 per cent of the total burden of disease is attributed to six groups: cardiovascular disease, cancers, injuries, mental health conditions, asthma and diabetes. In 2001, approximately one million Australians were diagnosed with type 2 diabetes[1]. Community health is increasingly involved in chronic disease management through programs such as the Hospital Admission Reduction Program (HARP) – Chronic Disease Management and Early Intervention in Chronic Disease (EICD). The community health sector needs to provide effective, appropriate care to clients with chronic health needs and in particular diabetes clients. The ongoing management of a client with diabetes should include education and being linked to other health services that can provide routine ongoing care[2].

The care required by diabetes clients is described in an annual cycle of care **(**RACGP 2007-08 Diabetes Management in General Practice: see Minimum requirements of diabetes care definition below**)**. The role of community health workers is to review their needs in relation to overall diabetes care and management and link clients to the appropriate service either internally or externally. Clinical Indicator 7 - Diabetes Best Practice Care Review has been developed to provide information about this aspect of care.

Communication between health providers in community health and GP's concerning clients with diabetes is essential in ensuring a coordinated team based approach to diabetes management. It is important that clients have a regular GP and that communication occurs between the GP and the community health service. Indicator 8 and 9 provide information about communication between GP and community health.

2. DEFINITIONS

The following terms are defined for the purpose of the Diabetes Care Indicators

Type 1 Diabetes - usually affects children and young adults. It is the less common form of diabetes, with just 10-15% of all people with diabetes having type 1 Diabetes. People with type 1 diabetes must have insulin injections.

Type 2 Diabetes[3] - formerly known as non-insulin dependent diabetes or mature-age onset diabetes. It is by far the most common form, affecting 85-90% of all people with diabetes.

Diabetes Management Need: treatment, monitoring or education of diabetes or a direct complication of diabetes as indicated on the Initial Needs Identification/reason for referral

GP Communication: telephone discussion, referral outcome, Care plan summary, discharge summary involving the GP. (Note this excludes the SCOT referral acknowledgement form)

Minimum requirements of diabetes care

The following is a recommended list of reviews that a client with diabetes should receive to ensure the minimum requirements of diabetes care are met. The individual reviews may be conducted either in the community health service or externally. The table is based on reviews recommended by Diabetes Australia and Royal Australian College of General Practitioners[4]. These recommendations have been modified for community health to reflect current best practice and include oral and mental health reviews. There is an increasing awareness of the need to address dental problems associated with diabetes, as dental problems are more common in people with diabetes[5,6]. Similarly people living with diabetes have a two fold increased risk of co morbid depression when compared to individuals without diabetes[1,7].

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[1] DHS Diabetes self-management Guidelines for providing services to people newly diagnosed with Type 2 diabetes. March 2007

[2] ibid

[3] Diabetes Australia Website. Available from http://www.diabetesaustralia.com.au/_lib/doc_pdf/resources/

[4] Diabetes Australia, Royal Australian College of General Practitioners 2007-08 Diabetes Management in General Practice. Gorokan NSW: Diabetes Australia. Available from http://www.racgp.org.au/guidelines/diabetes

[5] Zoellner H. Oral problems in patients with diabetes. Diabetes Management Journal 2006;14:8–19.

[6] Bjelland S, Bray P, Gupta N, Hirscht R. Dentists, diabetes and peridontitis. Aust Dent J 2002;47:202–7.

The frequency of the reviews presented in table 1 are minimum recommended frequencies. If additional risk factors are identified in a client review, such as periodontal disease in an oral health review or sensation changes in a podiatry review, the review period will need to be more frequent.

Review	Description	Minimum Frequency
HbA1c	Blood test of glycosylated haemoglobin	Six monthly
Cholesterol, triglycerides and HDL and LDL cholesterol (blood test)	Blood test of lipids	Six Monthly
BMI	Body weight in kilograms/height in meters squared.	Six monthly
Blood Pressure	Systolic pressure over diastolic pressure	Six monthly
Urinary Albumin Excretion	One of a number of tests that can be performed to determine albumin (protein) in the urine	Annually
Self care education	Includes diabetes knowledge, blood glucose monitoring, foot care, insulin administration	Annually
Examine feet	Review foot sensation, pedal pulses and foot deformities	Annually
Review diet	Review of general diet to determine whether detailed instructions need to be given by a Dietitian.	Annually
Review levels of physical activity	Assess current level of physical activity and develop a plan to increase as required	Annually
Review Smoking	Record the smoking status of the client	Annually
Review Medications	Review medication adherence and any possible drug interactions (pharmacist)	Annually
Comprehensive Eye examination	Review with ophthalmologist or optometrist for early check of retinopathy	Every two years
Review Oral Health	Oral examination by dentist	Every two years
Depression/Anxiety Screen	Review for depression/anxiety issues (e.g.K-10 as used in Service Coordination Psychosocial Profile)	Annually

Table 1: Minimum Requirements of Diabetes Care

The table provided in Appendix 4 is a suggested screening tool for use by services in recording whether individual clients have received the recommended reviews.

3. INDICATOR TYPE

The diabetes indicators are comparative rate based indicators addressing the appropriateness, efficiency and processes of diabetes care

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[7] Anderson RJ, Freedland KE, Clouse RE, Lustman PJ: The prevalence of co morbid depression in adults with diabetes: a metaanalysis. *Diabetes Care,*2001; 24:10691078.

F) Diabetes Care Indicators

Indicator 7: Diabetes Best Practice Care Review

Indicator Objective: To determine the percentage of clients with type 1 or type 2 Diabetes who have received the recommended reviews (see Table 1, pg 14) as part of best practice diabetes care (delivered either in the community health centre or externally)

Rationale: Diabetes Australia defines a minimum standard of assessment and care for individuals with diabetes. These recommendations have been modified for community health to reflect current best practice and include oral and mental health reviews. Individuals presenting to Community Health for management of diabetes (independent of the discipline of the worker involved or service provided) should be:

1. Screened to ensure they have received the recommended reviews in the recommended timeframes (see table 1, page 14)
2. Referred (or advised to follow up) for any review that has not occurred in the recommended timeframe

If the indicator results are poor then further investigation of both the process of screening of diabetes client needs and action taken to address unmet needs is needed

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Indicator 7: Diabetes Best Practice Care Review

NB: This indicator must be calculated separately for each individual element of the minimum requirements of best practice diabetes care. See Appendix Three audit proforma for data collection and Appendix 4 for model client screening tool.

Numerator: The number of clients referred for diabetes management (type 1 or 2) with evidence of receiving the minimum requirements of best practice diabetes care within the recommended timeframes (see Table 1, page 14).

Denominator: the total number of clients presenting with a diabetes management need in the time period under study.

Measurement Mode - file audit of clients who were referred at least 6 months prior to audit date.

Indicator 8: Diabetes Care Review Data

Indicator Objective: To determine the percentage of clients with type 1 or type 2 Diabetes referred for any type of diabetes related management who have diabetes related results recorded in their client file

Rationale: Access to accurate up to date information regarding the parameters of diabetes care will guide the appropriate course of management for a client. This indicator becomes a proxy indicator for the effectiveness of communication between the GP and the community health centre.

Indicator 8: Diabetes Care Review Data

NB: This indicator must be calculated separately for each element of the review. See Appendix Three audit proforma for data collection

Numerator: The number of clients referred for diabetes management (type 1 or 2) in the time period under study with evidence of results recorded for HbA1c, Albumin, total cholesterol, HDL, LDL cholesterol and triglycerides blood pressure, BMI in the last 6 months

Denominator: The total number of clients presenting with a diabetes management need in the time period under study.

Measurement Mode - file audit of clients who were referred at least 6 months prior to audit date.

Indicator 9: Communication to General Practitioner

Indicator Objective: To determine the percentage of clients with evidence of communication (excluding referral acknowledgement) from the community health service to the Client's GP

Rationale: Community health staff must provide updates to GP's on assessments and the outcome of an episode of care to enable the GP to effectively manage the client's diabetes care

Indicator 9: Communication to General Practitioner
See Appendix Three audit proforma for data collection

Numerator: The number of clients referred with a diabetes management need (type 1 or 2) who have evidence of communication from the community health service to the GP in the health record in the last 6 months

Denominator: The total number of clients referred with a diabetes management need in the time period under study

Measurement Mode - file audit of clients who were referred at least 6 months prior to audit date.

Appendix One: Care Planning Indicator 1-3 Data Collection Table

Care Plan Elements (✓/X)	Record 1	Record 2	Record 3	Record 4	Record 5	Record 6	Record 7	Record 8	Record 9	Record 10	Total
1. **No Care Plan (a)***** (✓ if no care plan)											
2. **Client stated/agreed Issues / Problems**											
3. **Client stated/agreed Objectives / Goals**											
4. **Client stated/agreed Strategies / Actions**											
5. **Review Date Stated**											
6. **Timeframe for goal attainment**											
7. **Responsibilities for action identified**											
8. **Participants Identified**											
9. **Consumer Acknowledgement**											
10. **Dated**											
11. **Goal Attainment**											
Complete Care Plan * (b)***											
Incomplete Care Plan ** (c)***											

*** Completed Care Plan – Presence of completed care plan is dependent on all items 2-10 being present**
**** Incomplete Care Plan - Presence of incomplete care plan is dependent on one or more or items 2-10 being omitted**
***** No care plan (a) + Complete care plan (b) + Incomplete care plan (c) = total number of files/clients**

Appendix Two: Care Plan Review (Indicator 4) and Attainment Data (Indicator 5-6) Collection Table

	Nominated Care plan Review Date	Actual Care Plan Review Date	Care Plan reviewed in nominated month (✓/X)	Goal/ objective 1	Goal/ objective 2	Goal/ objective 3	Goal/ objective 4	Goal/ objective 5	Goal/ objective 6	Goal/ objective 7	Total Goals Met	Total Goals Partially Met	Total numbe of goals/ jective
				Goal/Objective Met (M), Partially met (PM) or Not met (NM) in timeframe									
Record 1													
Record 2													
Record 3													
Record 4													
Record 5													
Record 6													
Record 7													
Record 8													
Record 9													
Record 10													
Total													

Appendix Three: Diabetes Care Review Data (Indicators 7-9) Collection Table

Assessment Type		Record 1 (✓/X)	Record 2 (✓/X)	Record 3 (✓/X)	Record 4 (✓/X)	Record 5 (✓/X)	Record 6 (✓/X)	Record 7 (✓/X)	Record 8 (✓/X)	Record 9 (✓/X)	Record 10 (✓/X)	Total
HbA1c	Review in timefame											
	Result recorded											
Total Cholesterol,	Review in timefame											
	Results recorded											
Triglycerides	Review in timefame											
	Results recorded											
HDL cholesterol	Review in timefame											
	Results recorded											
LDL cholesterol	Review in timefame											
	Results recorded											
BMI	Review in timefame											
	Results recorded											
Blood Pressure	Review in timefame											
	Results recorded											
Albumin in urine	Review in timefame											
	Results Recorded											

Appendix Three: Diabetes Care Review Data (Indicators 7-9) Collection Table

Assessment Type		Record 1 (✓/X)	Record 2	Record 3	Record 4	Record 5	Record 6	Record 7	Record 8	Record 9	Record 10	Total
Received self care education	Review in timefame											
Examine feet	Review in timefame											
Diet	Review in timefame											
Physical activity	Review in timefame											
Smoking Status	Review in timefame											
Medication Review	Review in timefame											
Eye examination	Review in timefame											
Oral Health	Review in timefame											
Depression/Anxiety Screen	Review in timefame											
Communication to GP												

Appendix Four: Suggested Format for screening tool for diabetes best practice review

Minimum Requirements of Diabetes Care	Within last 6 months	7-12 months ago	1-2 years ago	More than 2 years ago	Never	Don't know	If shaded area marked, consider the following action*	Action taken
HbA1c Review							Request to GP	
Cholesterol Review							Request to GP	
BMI Review							Referral to	
Blood Pressure Review							Request to GP	
Urinary Albumin Review							Request to	
Diabetes Self care education							Referral to	
Neurovascular Assessment							Referral to	
Dietary Review							Referral to	
Physical Activity Review							Referral to	
Smoking Review							Referral to	
Medication Review							Referral to	
Eye Review							Request to GP	
Oral Health Review							Referral to dentist	
Depression/anxiety screen							Referral to	

*To be tailored to appropriate actions for agency