

National Type 2 Diabetes Prevention Program

Using the PEN Clinical Audit Tool to identify eligible patients

The commonwealth government announced a commitment of \$103.4M to tackle the rising incidence of Type 2 Diabetes across Australia. A new item number MBS 713 was introduced on 1 July 2008, designed to support GPs to assess the risk of patients who are at high risk of developing Type 2 Diabetes.

Clinical trials have provided strong evidence that progression to Type 2 Diabetes can be prevented or delayed by lifestyle modification. Randomised Control Trials in the US and Finland have demonstrated reductions in the incidence of Type 2 Diabetes of 58% over 3 years.

Given this strong evidence the government has provided funds for subsidised accredited Lifestyle Modification Programs. The programs run for a minimum of 10 face to face hours over a number of months, and support participants to make healthy lifestyle choices which will reduce their risk of developing Type 2 Diabetes.

To be eligible for the program patients must be:

- Aged 40 – 49 years old or 15 -54 years old for aboriginal patients
- Not developed Type 2 Diabetes
- Score 15 or above on the AUSDRISK Test – indicating they have a high risk of developing Type 2 Diabetes

For information about the program including downloadable tools visit www.health.gov.au/epc for downloadable referral forms and the AUSDRISK tool. More information can be found at www.agpn.com.au

Why use practice data to identify patients?

- Evidence from states where the program has been trialled suggest that where there is little activity to identify patients there are fewer referrals to lifestyle modification programs
- Eligible patients are less likely to visit their GP as they are not yet experiencing symptoms
- Eligible patients are working age and may not be aware that they are at risk or what they can do about it.
- Divisions have a key role in supporting practices to take a population health and prevention approach and supporting Patients become active and responsible health consumers able to manage their own health risks and choices.
- Once identified the practice staff can send a letter to each patient and encourage them to take the Diabetes Risk Test.
- By identifying eligible patients and using item 713, GPs can be compensated at a higher rate for preventative activities already being undertaken in General Practices

Identifying patients using the PEN Clinical Audit Tool

The following is a step by step guide on how to use the PEN Clinical Audit tool to identify eligible patients

1. Click 'Collect' to extract data or to use data extracted from previous search
2. Click 'Hide Extracts'
3. Click 'View Filter'
4. On the 'General' tab under 'age' column enter 40 – 49
5. Under the 'last visit' column select 'active (3x <2 years)'
6. Select the 'Conditions' tab
7. Check the 'Hypertension' box under the cardiovascular column - this is a risk factor under the AUSDRISK test, and may increase the likelihood of identifying patients in the high risk group
8. Check the 'No' box under Diabetes – this will automatically exclude all patients who already have Diabetes but meet the other criteria
9. Click 'Recalculate'
10. Click 'Hide filter'
11. Select the 'BMI' tab and select the groups 'Obese' (red) and 'Overweight' (orange) to narrow your search
12. Click 'export'
13. From here, you can print the list and contact each patient via telephone, or save the list as an excel spreadsheet for mail merging with an appropriate letter (a Medical Director template letter for patients is available on the GP NSW website).
14. If mail merging, send each patient their letter and a copy of the AUSDRISK test available from www.health.gov.au/epc along with other patient information that is available on the DoHA website such as the lifestyle modification programs information leaflet

Note: Click on the 'Incomplete' tab, next to the 'BMI' tab. Here you will find a list of patients who do not have the necessary data to create a BMI, and thus will not appear in the BMI list. To ensure your list includes all eligible patients, where possible, add height and/or weight data to these patient files.

For more information about the Diabetes Prevention program or LMP programs please contact the Chronic Disease Team on 9239 2900 for questions about using the PEN Clinical Audit Tool please contact jacquelineowens@gpnsw.com.au