phn MURRAY

An Australian Government Initiative

VICTORIA State Government

EMBEDDING EYE HEALTH PREVENTATIVE CARE INTO PRIMARY CARE

Orientation and activities package for general practice

Quality and systems improvement project

Leadership | Collaboration | Respect | Accountability | Innovation

Murray PHN acknowledges its catchment crosses over many unceded First Nations Countries following the Dhelkunya Yaluk (Healing River).

We pay our respects and give thanks to the Ancestors, Elders and Young People for their nurturing, protection and caregiving of these sacred lands and waterways, acknowledging their continuation of cultural, spiritual and educational practices.

We are grateful for the sharing of Country and the renewal that Country gives us.

We acknowledge and express our sorrow that this sharing has come at a personal, spiritual and cultural cost to the wellbeing of First Nations Peoples.

We commit to addressing the injustices of colonisation across our catchment, and to listening to the wisdom of First Nations communities who hold the knowledge to enable healing.

We extend that respect to all Aboriginal and Torres Strait Islander Peoples

We aspire to be an anti-racist organisation, embedding cultural humility as a daily practice, to improve health outcomes and health equity in our communities. We recognise cultural humility as a life-long commitment to self-reflection, personal growth and redressing power imbalances in our society.

This package is intended for use by PHN staff and general practices participating in the ***embedding eye health preventative care into primary care*** project. Murray PHN acknowledges that some content in this package has been extracted and adapted from materials created by Vision 2020 Australia, PenCS, and Murray PHN's Eye Health Tool Kit for General Practice 2022.

The ***embedding eye heath preventative care in primary care project*** is supported by the Victorian Government.

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Background Information

Many eye conditions are preventable if detected or treated early. Regular eye examinations are an effective measure for identifying common eye problems and can prevent avoidable blindness and vision loss.

While eye disease can occur at any age, the risk factors include:

- being over 40 years of age
- smoking
- hypertension
- diabetes
- having a family history of eye disease

Some groups experience greater barriers to accessing eye health care, for example Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds.

In addition, emerging evidence suggests that increased digital screen time is associated with vision problems in children[1]. It is recommended that children have a full eye examination with an optometrist prior to commencing school and then regular visits as they progress through primary and secondary school.[2]

This project will therefore focus on underserviced groups and patients with known risk factors.

The impacts of vision loss are multifaceted. Vision loss is associated with serious injuries caused by falls and motor vehicle accidents, depression related to lost independence and reduced social engagement. There are also strong associations between vision loss and dementia[3].

Many eye conditions have no symptoms in their early stages and therefore identifying those at higher risk of eye disease is important in primary health care. General practice plays a crucial role in reducing avoidable blindness and vision loss and its associated burden of disease.

The Victorian Department of Health (DOH) has funded Murray PHN to partner with Eastern Melbourne PHN to lead the development and implementation of a quality and systems improvement pilot project to improve eye screening and detection of eye conditions/disease for at risk groups across Victoria to reduce the prevalence of avoidable blindness and vision loss. The project is being undertaken in partnership with Vision 2020 Australia, Gippsland PHN, North Western Melbourne PHN, and Western Victoria PHN.

This project will engage 5-10 general practices in each of the Victorian PHN regions named above, to focus on identifying, developing, and implementing quality and sustainable system improvements to support the ongoing identification and appropriate referral to eye health professionals of people at risk of developing eye disease or vision loss. Using a whole of practice approach, practices will also focus on increasing engagement with local optometrists and ophthalmologists.

This pilot project will commence in February 2023 with an induction phase, continue with an 8-month quality improvement activity phase from March to October 2023 and then finalise with an evaluation phase in November 2023.

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[1] Timorkhan, M.A., 2022. Children's vision health during the COVID-pandemic. *Middle East Journal of Family Medicine*, *20*(4).
[2] Good vision for life. 2020, Back to school: make the first test of the year an eye exam. Good vision for life. https://goodvisionforlife.com.au/2020/01/30/back-to-school-make-the-first-test-of-the-year-an-eye-exam/.
[3] Burton MJ, et al. 2021. The Lancet Global Health Commission on Global Eye Health: vision beyond 2020. *Lancet Glob Health. Apr;9(4)*

Project objectives

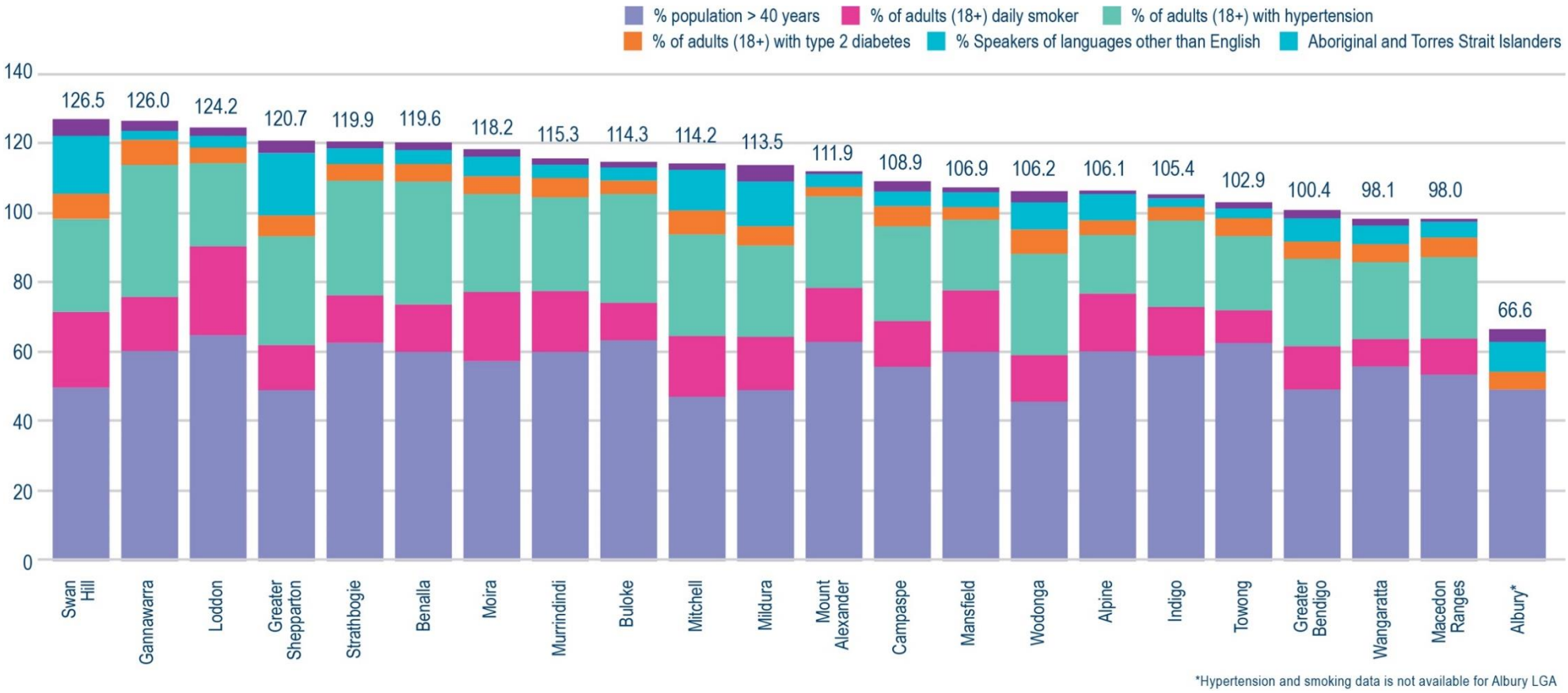
The project objectives are to develop a systematic, cost effective and sustainable approach to the delivery of eye health preventative care in primary care, leading to an increase in the rates of eye screening, referral and detection of eye conditions/disease for at risk groups in Victoria.

Key messages

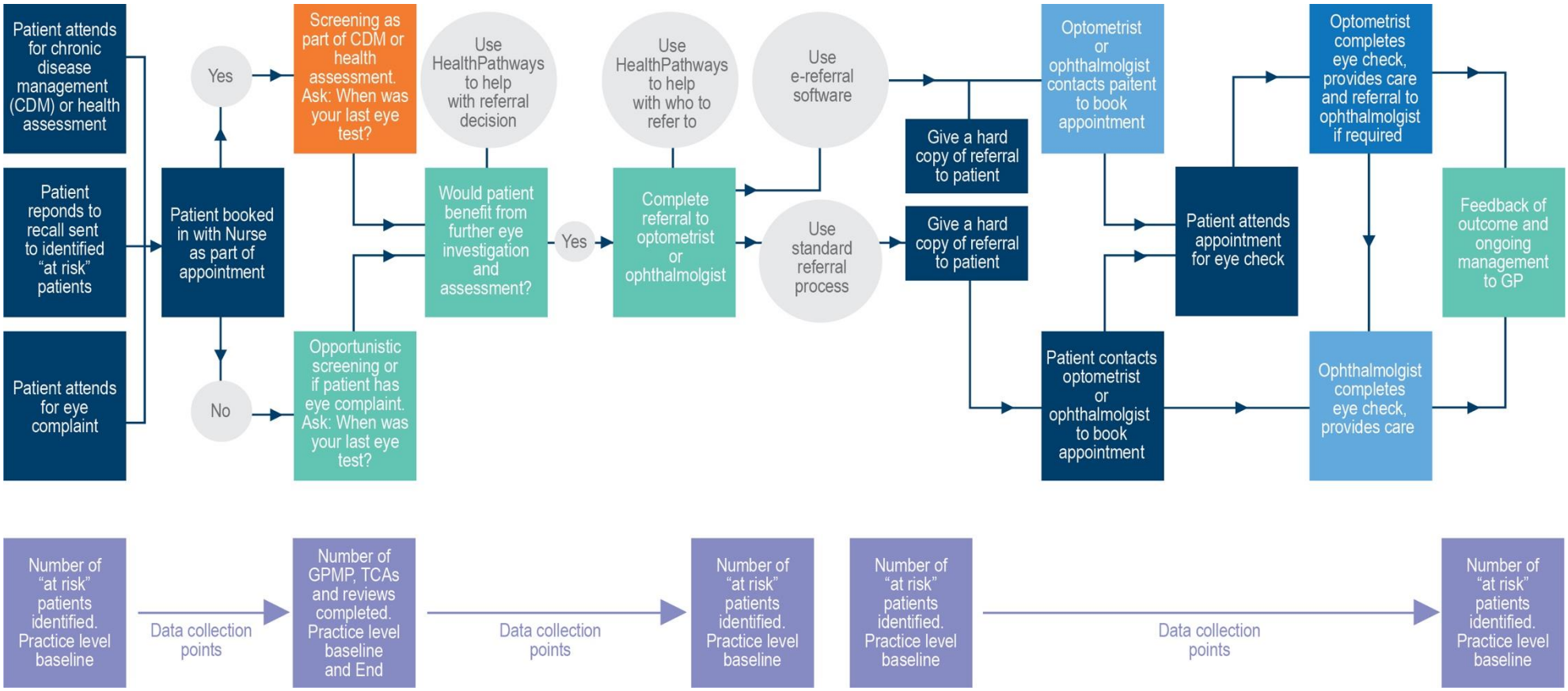
1. Help identify people who may be at risk of eye conditions.
2. Ask those at-risk of eye conditions “when was your last eye test?”.
3. Educate people on eye health and vision care, including how to prevent vision loss.
4. Promote the importance of eye tests to people 40 years and older who may not present with symptoms.
5. Refer people to an appropriate eye health provider.
6. Seek immediate advice on potential ocular emergencies from a local optometrist or ophthalmologist.
7. Encourage people who are blind or have vision loss to link with support services to assist with everyday activities.

Regional data on risk factors for vision loss and eye disease

Proportion of population with risk factors for eye disease by LGA in the Murray PHN region



Screening and referral flowchart



Data collection

Indicators		Survey of current eye health knowledge, systems, processes, training, and use of HealthPathways	Number of patients in each risk group[1] for poor eye health identified within the practice.	Number of patients in each risk group[1] with GPMP and TCA completed in last 12 months	Number of patients in each risk group[1] with GPMP review completed in last 12 months	Number of patient referrals for an eye check to optometrist or ophthalmologist	Number of patients that attended eye appointments	Outcome of referral
Baseline	**Measured**	Yes	Yes	Yes	Yes	Not applicable		
	Timeframe	Induction	Induction	Induction	Induction			
	Method	Pre-pilot survey	Baseline data collection form	Baseline data collection form	Baseline data collection form			
Monthly Data Collection	**Measured**	Not applicable				Yes	Yes	Yes
	Timeframe					7th of the month for prior month	7th of the month for prior month	7th of the month for prior month
	Method					Referral data collection form	Outcome data collection form	Outcome data collection form
End	**Measured**	Yes	Yes	Yes	Yes	Not applicable		
	Timeframe	Evaluation period	Evaluation period	Evaluation period	Evaluation period			
	Method	Post-pilot survey	Post-pilot data collection form	Post-pilot data collection form	Post-pilot data collection form			
How to collect data for reporting		Survey responses required via Microsoft FORMS	CAT4 Recipes POLAR	CAT4 Recipes POLAR	CAT4 Recipes POLAR	Manually track patients who are referred using Patient Tracking sheet. Record referral counts on Referral data collection form.	Manually track outcomes received from Opt/Ophth using Patient Tracking sheet. Record count of outcomes on Outcome data collection form.	Categorise outcome of referral from reports received from Opt/Ophth
Data filters and specifications		Not applicable	Active Patients: Active (not inactive or deceased) and RACGP Active (i.e., 3 visits in 2 years). [1]Risk groups for poor eye health: 40 years and older, smokers, diabetes, hypertension, Aboriginal and Torres Strait Islanders Number of Active Patients. Number of Active Patients in each risk group[1].	Number of Active Patients in each risk group[1]. Filter MBS item 721 (or 92024) claimed in last 12 months Filter MBS item 723 (or 92025) claimed in last 12 months	Number of Active Patients in each risk group[1]. Filter MBS item 732 (or 92028) claimed in last 12 months	Number of patients referred: Optometrist OR Ophthalmologist Method of referral Patient gender Risk factor(s)	Number of clinical reports received back indicating that the patient attended the eye check	Number of referral outcomes in each category: 1. Diagnosis (7 categories) 2. Treatment (5 categories) 3. Further action (5 categories)

Calendar of activities and deliverables

Phase	Month	Activity	Commitment requirement (indicative)
Induction	February 2023	• Collect baseline data • Complete pre pilot survey • Participate in induction meeting with PHN staff to review project requirements and develop project QI activities plan	• 1hr for data collection and completion of survey • 2hr induction meeting - attendance by all practice project team members and PHN project staff
QI Activities	March 2023	• Enrol in and commence eye health professional development modules • Participate in professional development webinar (World Glaucoma Week) **Tuesday 14 March** • Commence QI activities • Track referrals and report data at end-of-month • Participate in monthly check in meeting with PHN project staff	• 1-2hrs PD modules (per person) • 1hr professional development webinar (optional) • Dedicated time on QI activities (2hrs) • 30min data collection • 30min meeting with PHN - attendance by at least the practice project lead
	April 2023	• Complete eye health professional development modules • Continue QI activities • Track referrals and report data at end-of-month • Participate in collaborative QI network meeting (optional lunch time informal sharing of ideas) • Participate in monthly check in meeting with PHN project staff	• Dedicated time on QI activities (2hrs) • 30min data collection • 30min QI network meeting (optional) • 30min meeting with PHN - attendance by at least the practice project lead
	May 2023	• Participate in professional development webinar (Macula Month) **Tuesday 9 May** • Continue QI activities • Track referrals and report data at end-of-month • Participate in monthly check in meeting with PHN project staff	• 1hr professional development webinar (optional) • Dedicated time on QI activities (2hrs) • 30min data collection • 30min meeting with PHN - attendance by all the practice project team
	June 2023	• Continue QI activities • Track referrals and report data at end-of-month • Participate in monthly check in meeting with PHN project staff	• Dedicated time on QI activities (2hrs) • 30min data collection • 30min meeting with PHN - attendance by at least the practice project lead

	July 2023	• Participate in professional development webinar (Diabetes Awareness Week) **Wednesday 12 July** • Continue QI activities • Track referrals and report data at end-of-month • Participate in collaborative QI network meeting (optional lunch time informal sharing of ideas) • Participate in monthly check in meeting with PHN project staff	• 1hr professional development webinar (optional) • Dedicated time on QI activities (2hrs) • 30min data collection • 30min QI network meeting (optional) • 30min meeting with PHN - attendance by at least the practice project lead
	August 2023	• Participate in professional development webinar (Children's vision) **Wednesday 30 August** • Continue QI activities • Track referrals and report data at end-of-month • Participate in monthly check in meeting with PHN project staff • Identify and record case study (patient referred to eye care provider, patient attended visit and feedback received). Use template supplied by your PHN.	• 1hr professional development webinar (optional) • Dedicated time on QI activities (2hrs) • 30min data collection • 15min case study preparation • 30min meeting with PHN - attendance by all the practice project team
	September 2023	• Continue QI activities • Track referrals and report data at end-of-month • Participate in monthly check in meeting with PHN project staff	• Dedicated time on QI activities (2hrs) • 30min data collection • 30min meeting with PHN - attendance by at least the practice project lead
	October 2023	• Participate in professional development webinar World Sight Day (Cataracts) **Thursday 12 October** • Continue QI activities • Track referrals and report data at end-of-month • Participate in monthly check in meeting with PHN project staff	• 1hr professional development webinar (optional) • Dedicated time on QI activities (2hrs) • 30min data collection • 30min meeting with PHN - attendance by at least the practice project lead
Wrap up	November 2023	• Complete post pilot survey and evaluation • Follow up any outstanding data • Participate in wrap-up meeting with PHN project staff	• 30min completion of survey • 1hr meeting with PHN - attendance by all the practice project team

Professional Development: Eye Health - Vision 2020 Australia

Vision 2020 Australia, the peak body for eye health and vision care organisations in Australia, have developed a range of professional development and training opportunities for health professionals working across the primary care sector.

In addition to the training and webinars hosted by Vision 2020 Australia, the activities undertaken as part of this project may be suitable for GPs to include as part of their CPD requirements.

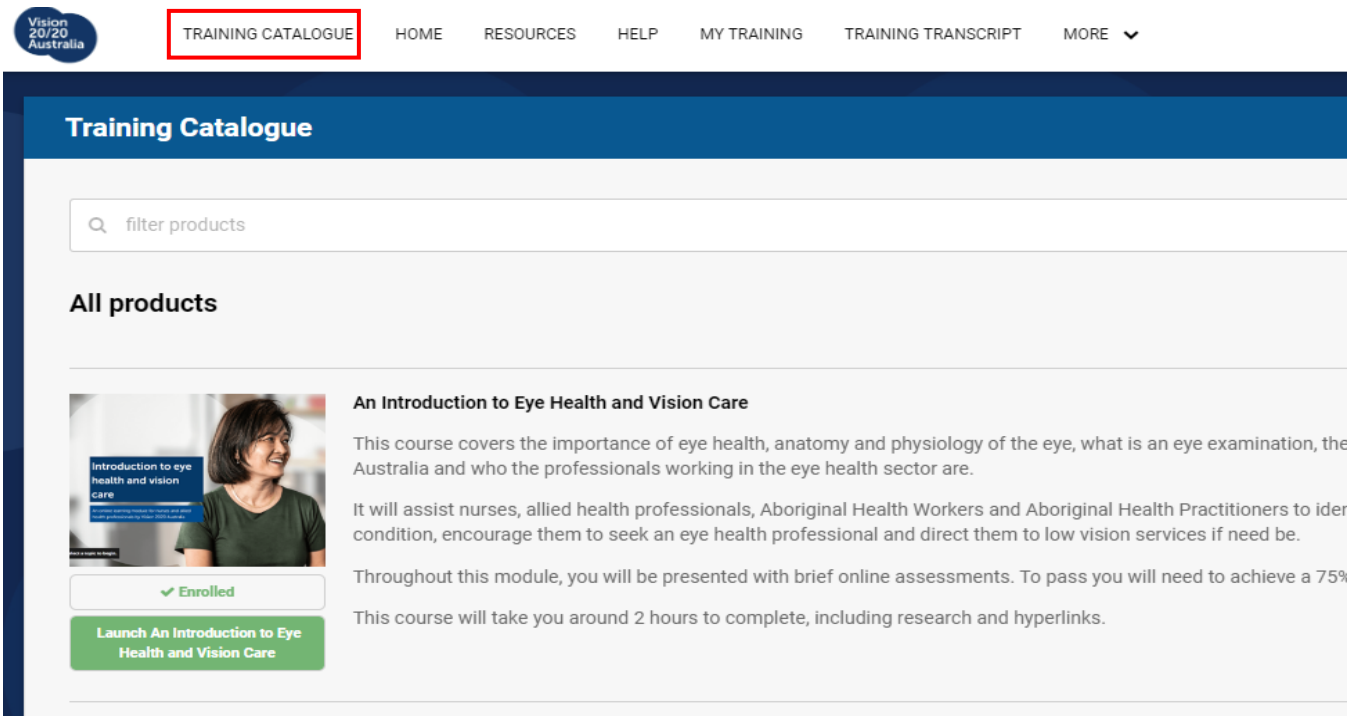
Free online training modules

Training can be accessed via Vision 2020 Australia's online training platform:

https://vision2020australia.kineoportal.com.au/portal/self-registration.jsp?group=484812

Users can only register with the platform using the above link. The link gives direct access to the registration form. Once registration is complete a success message will appear on the screen and an automated welcome email is sent to the user.

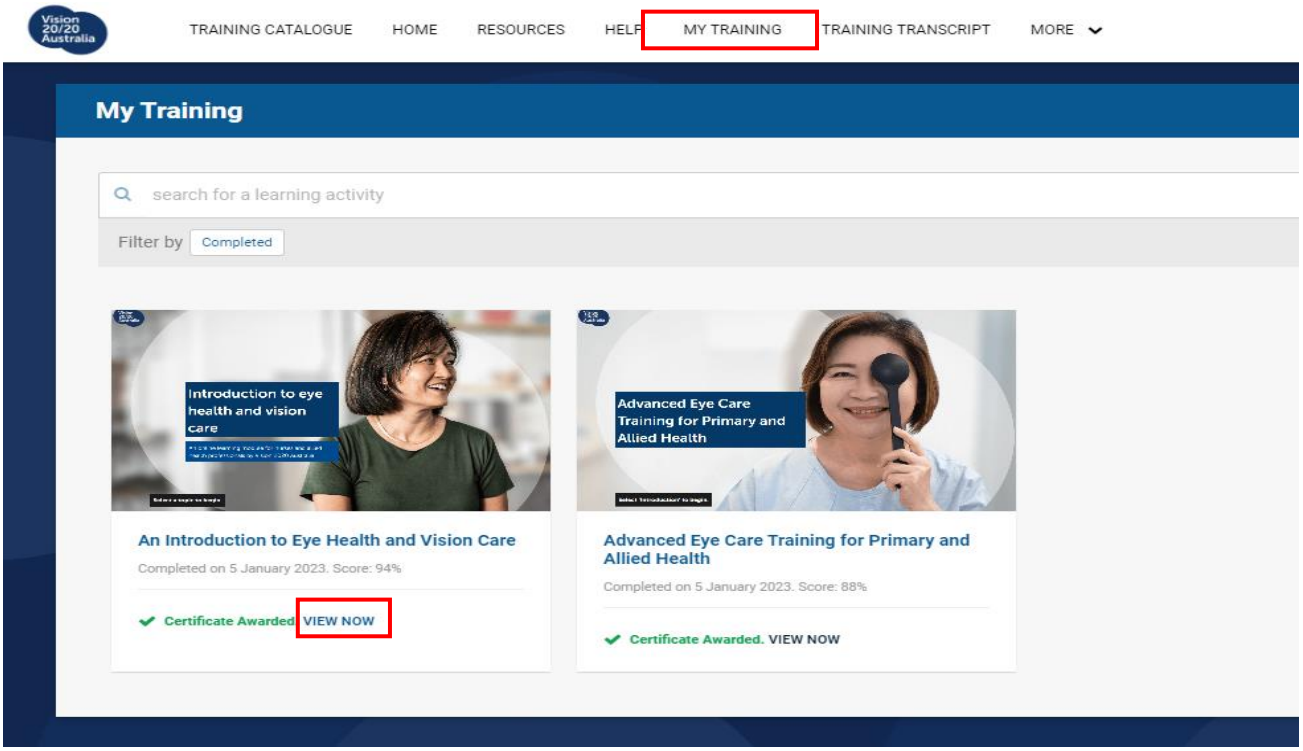
Users can then select the course they wish to enrol in via the training catalogue tab on the top menu bar.



Users must complete all pre and post survey questions, assessment questions and interactions to complete a course.

Clinicians from the practice's eye health project team are required to complete the Vision 2020 Australia training modules relevant for their profession. A certificate of training is required as evidence of completion of training and can be accessed from the My Training tab on the top menu bar

Other clinical staff at the practice are encouraged to complete training relevant to their profession.



Course Title	Audience & Description
An Introduction to Eye Health and Vision Care	This two hour course is for **nurses, allied health professionals, Aboriginal Health Workers and Practitioners** and covers the importance of eye health, anatomy and physiology of the eye, what is an eye examination, the main eye conditions causing vision loss in Australia and who are the professionals working in the eye health sector. It will assist participants to identify people at risk of developing an eye condition, encourage them to seek an eye health professional and direct them to low vision services if needed.
Advanced Eye Care	One hour course for **nurses, allied health professionals and Aboriginal Health Workers and Practitioners** (prerequisite is Intro course). The course includes an overview of how to conduct a basic vision assessment, the vision and eye health requirements for driving in Australia, the risks to eye health associated with chronic disease and the impact of medium- and long-term use of systemic medications on eye health.
Common Eye Conditions	Two hour course for **general practitioners.** This course will cover the main causes of vision loss and blindness in Australia, how to conduct a basic vision assessment, common eye infections and an introduction to ocular emergencies. It will also include details on who is part of the eye care team, your role in eye health preventative care and the referral process to optometry and ophthalmology services.

Diabetes Eye Care	One hour course for **diabetes educators** and others working with people with diabetes, including **Aboriginal health workers and practitioners.** This course will dive into the detail of how diabetes can affect eye health and vision and your role in vision loss prevention through education and support provided to people living with diabetes. This course was developed in partnership with the Australian Diabetes Educators Association. Pre-requisite: Completion of the course *An Introduction to Eye Health and Vision Care* (2 hours).
Emergency Eye Care	One hour course for **general practitioners, practice nurses and Aboriginal health workers and practitioners.** This course will provide information on the types of ocular emergencies that may present to you, how to assess them and refer them appropriately to eye care services to ensure timely management.

Free live webinars in 2023

All practice staff are encouraged to participate in the webinars hosted by Vision 2020 Australia throughout the course of the project as these will provide a deeper focus on the most common eye diseases.

Participants will first need to register with EventBrite to access the webinars. Participants can click on each of the registration links provided below and request a reminder be sent to them once registrations are open for that webinar (usually 2-4 weeks prior). The webinars coincide with national/international awareness raising events and focus on the five main causes of vision loss to provide a deeper understanding of the most common eye conditions in Australia.

Webinars will run for 1 hour and will be hosted on Zoom. All webinars will be recorded. The style of each webinar will vary according to the topic but will be a mixture of individual presentations and discussions panels. There will be time for Q&A as part of each webinar.

Date	Title	EventBrite link
Tuesday, 6.30 pm **14 March 2023**	Vision 2020 Australia - Eye Health Webinar 1: Glaucoma deep-dive	Registration link
Tuesday, 6.30 pm **9 May 2023**	Vision 2020 Australia - Eye Health Webinar 2: Macular degeneration	Registration link
Wednesday, 6.30 pm **12 July 2023**	Vision 2020 Australia – Eye Health Webinar 3: Diabetes and eye health	Registration link
Wednesday, 6.30 pm **30 August 2023**	Vision 2020 Australia - Eye Health Webinar 4: Children's vision	Registration link
Thursday, 6.30 pm **12 October 2023**	Vision 2020 Australia - Eye Health Webinar 5: Cataracts deep-dive	Registration link

Optometry engagement letter

Optometrist Name

Optometrist Address

Date

Dear

Murray PHN (Primary Health Network) is partnering with Vision 2020 Australia, and Victorian PHNs to implement a project called **Embedding Eye Health Preventative Care into Primary Care**. This partnership builds on the important eye health promotion work done in the past by the Vision Initiative to improve eye health and vision care in Victorian communities.

With the aim to increase the rates of eye screening and early detection of eye conditions/disease for at-risk groups in Victoria, this project is funded by the Victorian Department of Health and will involve working with general practices and other primary care providers to embed systems to identify those at highest risk of eye disease and if appropriate, refer to optometry services for a comprehensive eye examination.

As a result, you may receive an increase in the number of patients referred to you for an eye check.

To ensure the best outcomes for patients referred to you, it would be appreciated if you could provide written post consultation findings and feedback to the referring GP to allow for ongoing management and care. If you require any resources or assistance in developing systems to streamline the provision of feedback to the referring GP, Murray PHN would be happy to discuss possible opportunities for collaboration.

Murray PHN will be working with the following general practices in the XXX LGA:

I will call you in the next few weeks to discuss the project and any questions you may have. In the meantime if you have any queries, please feel free to contact us.

Yours sincerely

Name

Position

Phone

Email

Referral template to Optometry

Referrer Organisation
Address
Suburb State Postcode
Contact details

Date:
Optometrist Name
Optometry practice name
Address
Suburb State Postcode

Dear Optometrist Name

Re: Referral of Patient Name for an eye health check

Thank you for seeing the following patient for assessment of their eye health.

Patient Details:

Patient Name:

Date of Birth:

Address:

Contact number:

Referral Details:
Concerned about (Please tick)

☐ Visual Fields ☐ Glaucoma ☐ Macular degeneration

☐ Visual Acuity ☐ Diabetic retinopathy ☐ Cataract

Other: _____

Clinical reason for referral (symptoms, duration, severity):

Additional relevant medical history that may assist in your review of the patient includes:

Current medications:

I look forward to receiving your written report regarding this patient upon completion of the examination.
Yours sincerely,

Referrers name
Job title
Organisation name

Ophthalmology HealthPathways

The following conditions are listed in Murray PHN HealthPathways. Some conditions have not been adapted or localised for the Murray PHN region. Victorian public hospital specialist clinics have state-wide referral criteria for the conditions marked with an asterisk (*).

Cataracts *	Keratitis*
Children's Eye Problems	Low Vision Assistance

Corneal Problems
• Corneal Ulcers and Abrasions *
• Herpes
  • Herpes Simplex Keratitis / Dendritic Ulcer *
  • Herpes Zoster Ophthalmicus
• Pterygium*
	Red Eye
	• Acute Bilateral Red Eye
	• Allergic Conjunctivitis
	• Chronic Bilateral Red Eye
	• Infective Conjunctivitis
	• Iritis
	• Scleritis
	• Unilateral Red Eye

Diabetic Retinopathy*	Trauma in Eyes* • Foreign Body in Eye *

Eye Assessment in Adults	Vision Loss
	• Floaters, Flashes, Retinal Detachment
	• Glaucoma
	  • Acute Angle-closure Glaucoma (AACG) *
	  • Open-Angle Glaucoma (OAG)*
	• Macular Degeneration*
	• Refractive Error
	• Sudden or Recent Vision Loss*
	• Transient Monocular Vision Loss

Eyelid Problems • Ectropion and Entropion • Eyelid Lesions	
Irritated and Dry Eyes* • Keratoconjunctivitis Sicca • Blepharitis	Ophthalmology Referrals • Immediate Ophthalmology Referral* • Urgent or Routine Ophthalmology Referral*

Pre-pilot survey

Before commencing any work on quality or systems improvements within your practice, it is important to know what your practice is currently doing with respect to eye health. This will help with the design of an action plan that is best suited to your practice and will help with evaluating whether the project has achieved its objectives.

The pre-pilot survey link will be sent to you via email prior to the scheduled orientation visit.

Please complete the pre-pilot survey using the link provided by your PHN.

A PDF copy of the survey can be seen here.

Baseline data collection form

The following data will be collected during the induction period, prior to commencing any quality improvement activities. The data may be obtained either by your PHN (from the data extracted from your clinical software each month and sent to your PHN via a data extraction tool i.e. POLAR or CAT) or can be collected at the practice using the data extraction tool. Instructions for collecting this data at the practice are provided in Appendix 1 (CAT) and Appendix 2 (POLAR).

Practice name:	Data extraction date: (i.e. date the extraction tool collected data from the clinical software)

Risk category	**Number of ACTIVE RACGP patients**			
	Measure 1	**Measure 2**	**Measure 3**	**Measure 4**
	Number in cohort	GPMP (MBS item 721 or 92024) claimed in last 12 months	TCA (MBS item 723 or 92025) claimed in last 12 months	GPMP review (MBS item 732 or 92028) claimed in last 12 months
Total number of ACTIVE RACGP patients in practice		Not applicable	Not applicable	Not applicable
40 years and older				
Smoker				
Diabetes (Unknown, Type 1, Type 2)				
Hypertension				
Aboriginal and Torres Strait Islander				

Note: ACTIVE RACGP patients includes those patients who have had 3 or more clinical activities/ encounters in the last 2 years and are not deceased or marked as inactive.

Patient referral tracking template

(This tracking sheet is for general practice internal use only and will not be collected)

Patient details	**Risk factors (List all that apply)**	**REFERRAL**				**OUTCOME OF REFERRAL (i.e., correspondence received)**				
Name D.O.B. Gender (male/ female/ other)	• over 40 yrs • diabetes • smoker • hypertension • CALD • Aboriginal and/or Torres Strait Islander • Family history of eye disease • Increased digital screen time- child	**When**	**How**	**To Whom**		**When**	**What: Review correspondence, select the response from the options provided for each question**			
		Date sent	Electronic OR Manual OR Informal	Name of Optometrist	Name of Ophthalmologist	Date received	Have you received correspondence indicating that the patient attended the visit with the eye care provider? **1 Yes** **2 No, patient didn't attend**	Was a diagnosis made by the eye care provider? What was it? **1 No** **2 Refractive error** **3 Glaucoma** **4 Cataract** **5 Macular degeneration** **6 Diabetic retinopathy** **7 Other**	Has any treatment been provided or recommended? **1 No** **2 Corrective lenses** **3 Surgery** **4 Medication** **5 Other**	Is any further action required? **1 None** **2 Referral to another health professional** **3 Ongoing management by eye care provider** **4 Ongoing management by GP** **5 Other**
Example *John Smith* *1/1/1960, male*	*Diabetes, over 40*	*14/3/23*	*Manual*	*Len Glasses*		*30/3/23*	*1*	*4*	*3*	*3*

Referral data collection form

The referral data collection form is to be completed based on information recorded in the patient tracking sheet. Practices should count the total number of referrals made each month (based on the date the referral was sent) and then provide a breakdown of the number of referrals in each response category for the 3 referral questions.

Referral metrics		How many referrals to eye health providers have been completed this month via each method? **1 Manually sent to provider (mail or fax)** **2 Electronically sent to provider (secure messaging)** **3 Informal either verbally and/or written referral communicated to patient but not sent to provider**						Of the patients referred to an eye health provider this month, what was the breakdown of gender? **1 Male** **2 Female** **3 Other**			Of the patients referred to an eye health provider this month, what were the risk factors identified? **1 Over 40** **2 Diabetes** **3 Smoker** **4 Hypertension** **5 CALD** **6 Aboriginal and/or Torres Strait Islander** **7 Family Hx of eye disease** **8 Increased digital screen time**							
Month	***Total for the month***	**Count for each option**						**Count for each option**			**Count for each option**							
		Optometrist			**Ophthalmologist**													
		1	**2**	**3**	**1**	**2**	**3**	**1**	**2**	**3**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Example	***8***	***2***		***4***	***2***			***4***	***4***		***3***	***2***	***1***	***2***	***0***	***0***	***2***	***0***
March 2023																		
April 2023																		
May 2023																		
June 2023																		
July 2023																		
August 2023																		
September 2023																		
October 2023																		

Outcome data collection form

The outcome data collection form is to be completed based on information recorded in the patient tracking sheet. Practices should count the total number of referral outcomes received each month (based on the date the outcome correspondence was received) and then provide a breakdown of the number of referral outcomes in each response category for the 4 referral outcome questions.

Referral Outcome metrics		Have you received correspondence indicating that the patient attended the visit with the eye care provider? **1 Yes** **2 No, patient didn't attend**		Was a diagnosis made by the eye care provider? If so, what was it? **1 No** **2 Refractive error** **3 Glaucoma** **4 Cataract** **5 Macular degeneration** **6 Diabetic retinopathy** **7 Other**							Has any treatment been provided or recommended? **1 No** **2 Corrective lenses** **3 Surgery** **4 Medication** **5 Other**					Is any further action required? **1 None** **2 Referral to another health professional** **3 Ongoing management by eye care provider** **4 Ongoing management by GP** **5 Other**				
Month	***Total for the month***	**Total count**		**Total count**							**Total count**					**Total count**				
		1	**2**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**1**	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**
Example	***3***	***2***	***1***		***1***				***1***			***1***			***1***	***1***		***1***		
March 2023																				
April 2023																				
May 2023																				
June 2023																				
July 2023																				
August 2023																				
September 2023																				
October 2023																				

Quality Improvement: Activities to get started

There are some activities that your practice can complete to start embedding eye health preventative care into your everyday workflows, systems, and clinical practice. Further, there are some ideas that could be tested, using a quality improvement framework called the Model for Improvement, to see if the idea or change you make would lead to an improvement.

Activity 1: Updating patient information to include "When was your last eye test?"

The aim of this activity is to review your practice process for collecting and recording new patient information

Description	Status	Action to be taken
Does your practice have an up-to-date new patient registration form? Does this form include the question "When was your last eye test?"	☐ Yes: see ideas for testing ☐ No: see action to be taken	Develop a new patient registration form or include a question regarding the patient's last eye test. See ideas for testing.

Ideas for testing

- How will you record this information in your clinical software?
- Is it possible to run a report on this information at a practice level, via an extraction tool or your clinical software?

Activity 2: Understand your patient population

The aim of this activity is to collect data to determine the number of patients at your practice who are at risk of poor eye health

This activity forms the baseline data collection for this project. Your PHN may already have been able to collect this data on your behalf for reporting purposes, but it is important for practices to understand how to identify their at-risk population cohort using a data extraction and reporting tool such as the Clinical Audit Tool (CAT4) or Population Level Analysis & Reporting (POLAR). Instructions for using either CAT4 or POLAR to identify your at-risk population can be found in Appendix 1 and 2 respectively. Once you have identified your at-risk population cohort, you can test ideas to engage with this population around eye health.

Ideas for testing

- Opportunistic screening: Can you add a reminder to an "at risk" patient's file so that the treating health professional is prompted to ask the patient about eye health at their next visit?

Activity 3: Health assessments for patients at risk of poor eye health

The aim of this activity is to embed the question "When was your last eye test?" into your health assessments

Medicare Benefits Schedule (MBS) item numbers 701-707 and 715 enable general practices to provide health assessments for much of Australia's population who are at increased risk of eye disease. Health assessments are a good opportunity to ask patients about their eye health.

Whether conducting a brief (701), standard (703), long (705), or prolonged (707) consult, or a health assessment with an Aboriginal or Torres Strait Islander patient (715), primary health care providers can ask *"When was your last eye test"?*

Description	Status	Action to be taken
Do your Health Assessment templates contain the question "When was your last eye test?"	☐ Yes: see ideas for testing ☐ No: see action to be taken	Add the question "When was your last eye test?" into your health assessment templates.

Ideas for testing

- Send an invitation to your eligible identified at-risk patient cohort to book in for a health assessment at which you can ask "when was your last eye test?"
- What considerations need to be given when engaging with specific patient groups?
- Consider how to standardise referral of patients who have one or more risk factors for eye disease and have not had a recent eye test

Health assessment categories

- Age 45-49 at risk of developing chronic disease
- Age 75 and older
- Age 40-49 at risk of developing Type 2 diabetes
- Comprehensive medical assessment for aged care residents
- Aboriginal & Torres Strait Islanders
- People with intellectual disability
- Refugees and humanitarian entrants

Activity 4: GP management plans for patients with chronic disease

The aim of this activity is to embed the question "When was your last eye test?" into your GP Management Plans

For patients with eye disease, chronic conditions and/or risk factors for poor eye health, GP management plans and team care arrangements can be used for eligible patients to embed eye health management and preventative care. Developing (MBS Item 721) or reviewing (MBS Item 723) a GP management plan with a patient provides a good opportunity to ask about a patient's eye health.

Description	Status	Action to be taken
Do your GP Management Plan and Diabetes Cycle of Care templates contain the question “When was your last eye test?”	☐ Yes: see ideas for testing ☐ No: see action to be taken	Add the question “When was your last eye test?” into your GPMP and Diabetes Cycle of Care templates.

Ideas for testing

- Recall your at-risk patients who are overdue for a review of their GPMP and include the question “When was your last eye test?” as part of their review.

Activity 5: Referrals to optometrists

The aim of this activity is to include Optometry/ Ophthalmology as part of the multidisciplinary care team for patients with, or at risk of poor eye health

Optometry and/or ophthalmology can be included as part of the patient’s multidisciplinary care team and documented in the GP Management Plan and Team Care Arrangement. Services provided by an optometrist will not count towards the 5 Medicare rebated allied health visits under a Team Care Arrangement.

Tip: As part of the referral process, it is suggested that practice nurses and GPs send the patient’s care plan to the optometrist and/or ophthalmologist.

All people aged over 40 should be encouraged to have regular eye examinations as a minimum, once every 2-3 years.

People who notice a change in vision should be encouraged to have an eye examination as soon as possible, irrespective of age or when they last had an eye examination.

Where a person has multiple risk factors, for example, is over 40 years of age and has diabetes, more frequent eye examinations may be required.

Ideas for testing

- Do you have a standard referral template for optometry? There is a template referral letter in this induction package that you could use.
- Consider adding an optometrist to the TCA as part of GPMP/TCA review (for those who already have a GPMP and have risk factors for eye disease).
- Ensure an optometrist and/or ophthalmologist are part of the GPMP/TCA for patients with diabetes.
- Consider adding an optometrist to the TCA as part of GPMP/TCA development (for those who do not already have a GPMP but would benefit and be eligible for one and have risk factors for eye disease).

Activity 6: Get to know your local optometrists

The aim of this activity is to build connections with local optometry services

Description	Status	Action to be taken
Do you know the optometry services in your area? Are they listed in your practice software?"	☐ Yes: see further ideas for building connections ☐ No: see action to be taken	Add the contact details of the optometry services in your area to the directory in your practice software. A list of optometrists can be obtained via the KeepSight website or via the National Health Services Directory Enter your postcode to obtain a list of services in your area.

Further ideas

- Do you know what services your local optometrist can provide? Make contact and ask if you can have a tour of their practice to show you what assessments and tests they can perform. Request an eye test for yourself.
- Invite local optometrists to speak to your team at QI and/or staff meetings.
- How could you encourage optometrists to provide feedback on your referral.

Activity 7: Using HealthPathways

The aim of this activity is for clinicians to be aware of and have access to referral pathway information provided in HealthPathways

HealthPathways is an online resource for primary health care clinicians, offering clinical and referral pathway information and resources that reflect current best practice and evidence, and are designed for use at the point of care. There are a range of pathways related to eye health which are grouped within the ophthalmology sections. A full list of ophthalmology HealthPathways is provided within this induction package.

Description	Status	Action to be taken
Do your GPs and nurses have access to Murray HealthPathways?	☐ Yes: see further ideas ☐ No: see action to be taken	Learn more and request access via Murray HealthPathways

Further ideas

- Organise a HealthPathways demonstration visit for your clinicians. This can be organised via your Quality Improvement Consultant or your Eye Health Project Coordinator.

Activity 8: Resources

The aim of this activity is to understand the suite of resources available in the eye health space and what might be suitable for your practice

Description	Status	Action to be taken
Does your practice have appropriate eye health literacy resources available for patients?	☐ Yes: see further ideas ☐ No: see action to be taken	Review the Vision 2020 resources pack provided to your practice at the orientation visit. Determine which resources to order for your practice. An order form is included in the pack. Return this form to your PHN facilitator. The following resources are available for display in waiting rooms and for patients: • Posters: "Over 40? Get tested" • Posters in languages other than English • Information sheets in English and community languages on main eye conditions that cause vision loss and blindness • Pamphlets for Aboriginal and Torres Strait Islander audience

Further ideas

- Once you have received your first supply of eye health patient resources, you can place further orders directly with Vision 2020 Australia via their website visioninitiative.org.au/order-resources
- Display posters and brochures promoting eye health in clinic waiting rooms.
- Do you have appropriate resources to engage your patients at risk of poor eye health? E.g. your Aboriginal and Torres Strait Islander and CALD patients.

Quality Improvement: Model for Improvement and Plan Do Study Act cycles

After completing the activities above, you may identify areas for improvement and generate ideas that you could test to see if the change leads to an improvement. Follow these steps to conduct a quality improvement activity using the Model for Improvement (MFI) and Plan, Do, Study, Act (PDSA). The model consists of two parts that are of equal importance.

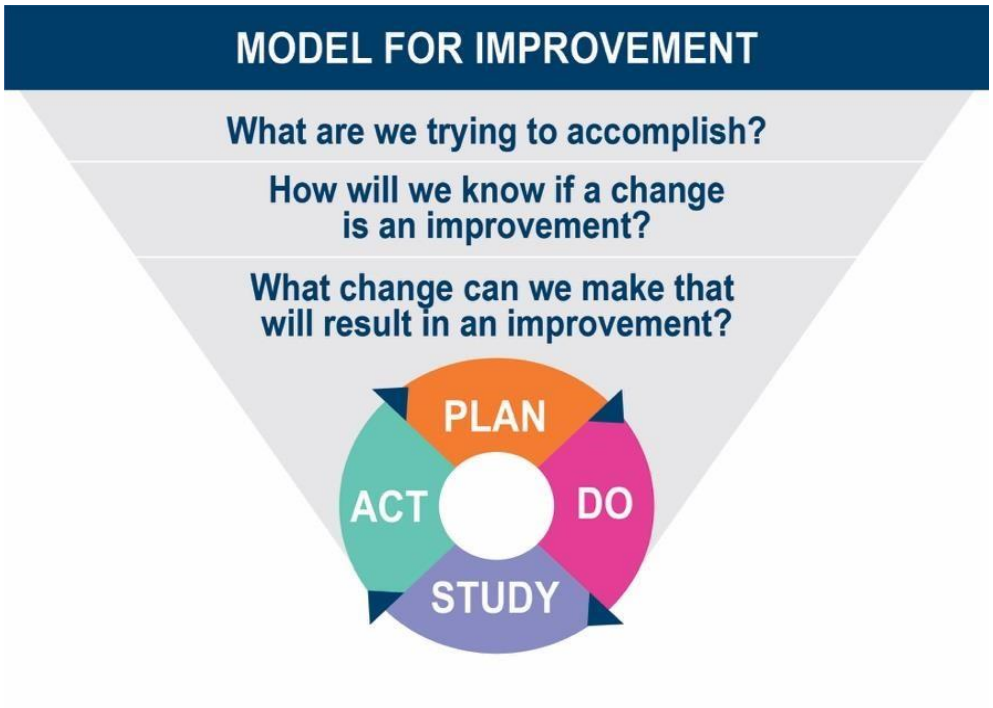
Step 1: The 'thinking' part consists of three fundamental questions that are essential for guiding improvement work

- **What are we trying to accomplish?** - This will help you develop your **GOAL** for improvement
- **How will we know that a change is an improvement?** Develop **MEASURES** to track the achievement of your goal. The goal you choose must be SMART - Specific, Measurable, Achievable, Relevant, Time-limited.
- **What changes can we make that will lead to an improvement?** List your steps. This will help you develop **IDEAS** that you can test to help you achieve your goal. Note that each new GOAL (the first fundamental question) will require a completed Model for Improvement template.

Step 2: The 'doing' part is made up of Plan, Do, Study, Act (PDSA) cycles that will help to bring about rapid change

This includes:

- Your ***IDEAS*** for testing that you noted when answering the third fundamental question in Step 1
- **PLAN** – what will you do?
- **DO** – was the plan executed?
- **STUDY** – record, analyse and reflect on the results
- **ACT** – what will you take away from this cycle?



Step 1: The three fundamental questions

1. What are we trying to accomplish?
This will help you develop your GOAL for improvement.

2. How will we know that a change is an improvement?
Develop MEASURES to track the achievement of your goal.

3. What changes can we make that will lead to an improvement?
List your steps. This will help you develop IDEAS that you can test to help you achieve your goal. Note that each new GOAL (the first fundamental question) will require a completed Model for Improvement template.

Step 2: PDSA cycle

You will have noted your IDEAS for testing when you answered the third fundamental question in Step 1. You can use this template to test and idea.

IDEA | Describe the idea you're testing
Refer to the third fundamental question.
PDSA cycle number:

PLAN | What will you do?
Explain your idea.
Who will carry it out?

When will it take place? Where?
What do you predict will happen?
What data/information will you collect that will help you measure improvement?
Notes:

DO | Was the plan executed?

Consider the data you collected and document any unexpected events or problems.

STUDY | Record, analyse and reflect on the results

What have you learned? Do your outcomes compare with your predictions? If not, what happened?

ACT | What will you take away from this cycle?

What's your next step or idea, and how might you apply the cycle again?

Other QI ideas for testing

1. There is emerging evidence that children who have increased their screen time and reduced their physical activity may be at increased risk for developing vision problems. Practices could ask the question “Have you had your eyes checked” when children are presenting for their vaccinations.
2. Nurses could host webinars on the importance of eye checks with a targeted patient cohort.
3. Practice managers could develop a card/resource to provide to the patient to encourage attendance at an eye check appointment.
4. Patients who are prescribed long-term corticosteroids are at-risk of developing ocular side effects and should be referred for regular eye examinations. You could recall these patients and/or add a reminder to their file to check when their last eye test was done and provide a referral if required.
5. If available, use non-mydriatic photography for people with diabetes under the following MBS item numbers:
   a. 12325 (Indigenous Australians)
   b. 12326 (Non-Indigenous Australians)

If you think of more ideas which could improve the identification, screening, and referral of patients at-risk of poor eye health, list them below then test them within your practice. Ideas can be shared with other practices as part of the collaborative QI Network meetings to be held in **April and July 2023**.

Your ideas:

Resources

1. Guide to eye health for primary health care providers: Vision 2020 Australia

   www.visioninitiative.org.au/professional-guide

2. Collateral for display in waiting rooms and for patients: Vision 2020 Australia

To order, go to: **https://www.visioninitiative.org.au/order-resources**

Posters: “Over 40? Get tested”

- Posters in languages other than English
- Information sheets in English and community languages on main eye conditions that cause vision loss and blindness
- Pamphlets for Aboriginal and Torres Strait Islander audience

3. Collateral for eye health awareness days: Vision 2020 Australia

To order, go to: **https://www.visioninitiative.org.au/order-resources**

- Social media tiles
- Social media messaging
- Social media tiles in languages other than English
- Hard copy information sheets on topics (eg glaucoma, macular disease; diabetic eye disease)
- Hard copy materials in languages other than English on topics
- Hard copy materials for Aboriginal and Torres Strait Islander audience

4. KeepSight is a national eye check recall and reminder system for people with diabetes, led by Diabetes Australia. Healthcare providers can access the free digital platform to register patient details.
5. Good Vision for Life is a hub of information including a search function to find a local optometrist, plus information about healthy eyes.
6. Patients who are blind or have vision loss can be referred to Vision Australia for support to live the life they choose. Services include:
   - Aids and equipment
   - Technology training on phones, computers, and tablets
   - Specialised support to remain independent and get around safely
   - Specialised children’s services
   - Access to social and recreational groups
   - Education and employment support
   - Audio materials for learning and leisure
   - NDIS and My Aged Care support

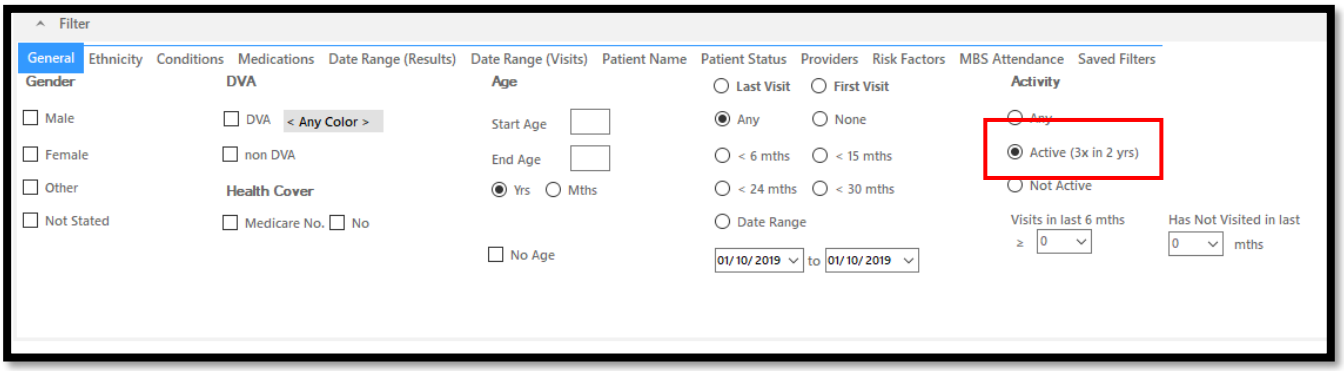
Appendix 1: CAT4 recipes for baseline data collection

Total practice population

The number of RACGP active patients.

1. General Tab (Top Filter)

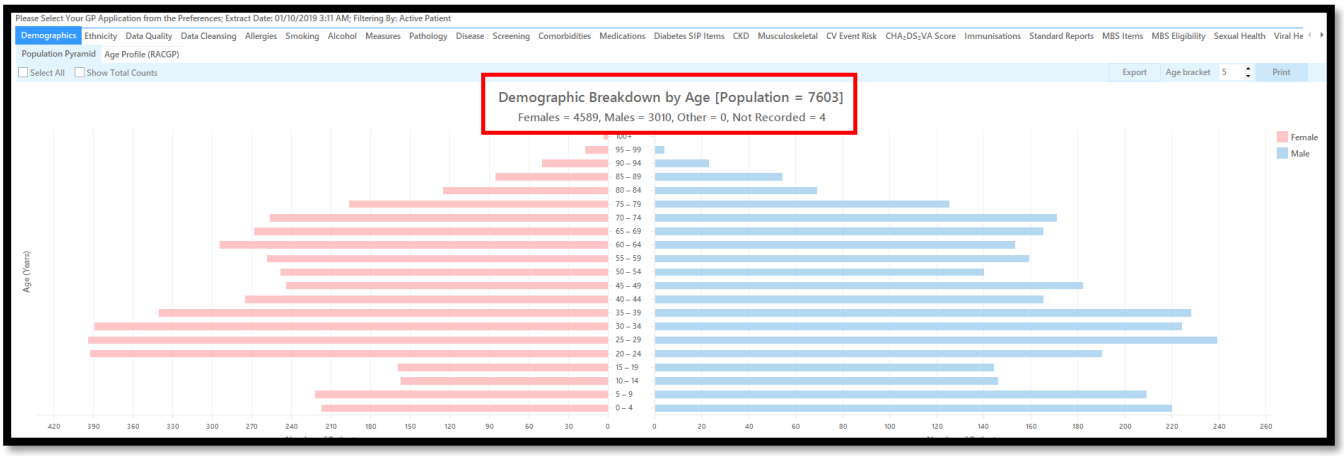
- Activity: Active (3x in 2 yrs)



2. Recalculate (Top Right-Hand Corner)

3. Demographics Tab (Bottom Filter)

- Population Pyramid Tab



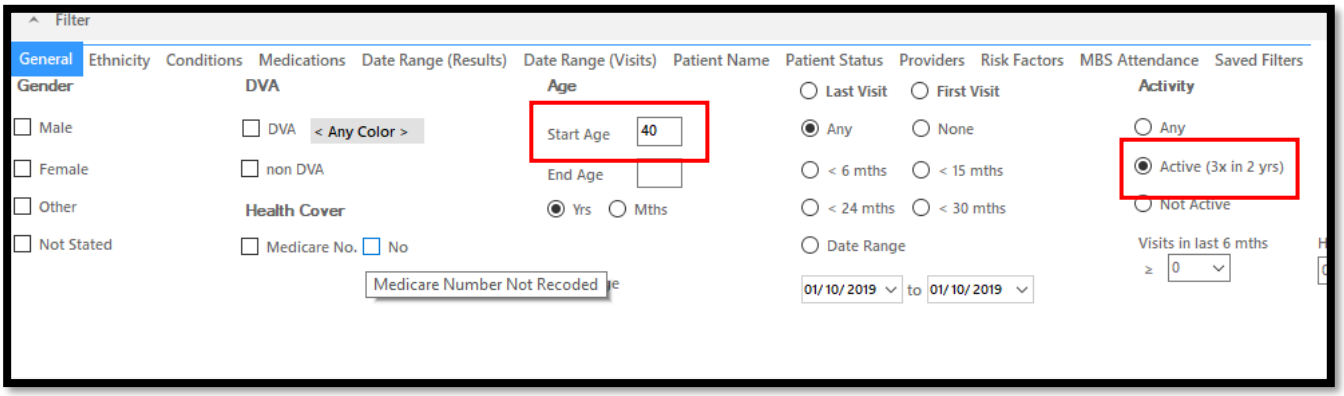
*The demographic breakdown will provide the total number of RACGP active patients.

40 years and older

The number of RACGP active patients, 40 years and older, who have had a GPMP, TCA or GPMP review in the last 12 months.

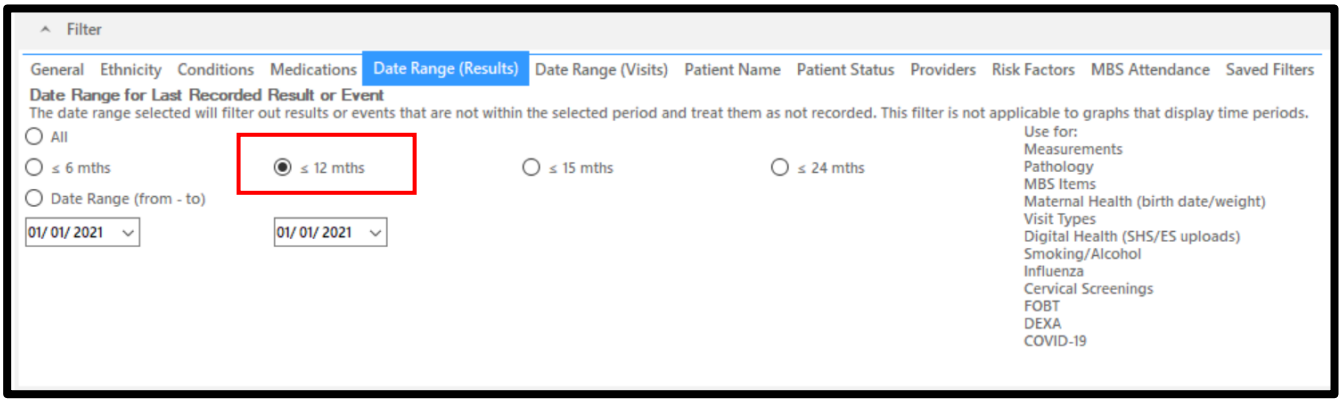
1. General Tab (Top Filter)

- Start Age: 40
- Activity: Active (3x in 2 yrs)



2. Date Range (Results) Tab (Top Filter)

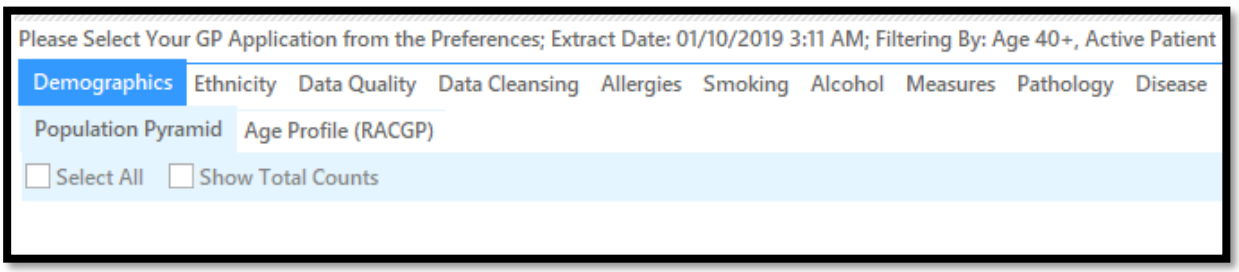
- <12 mths

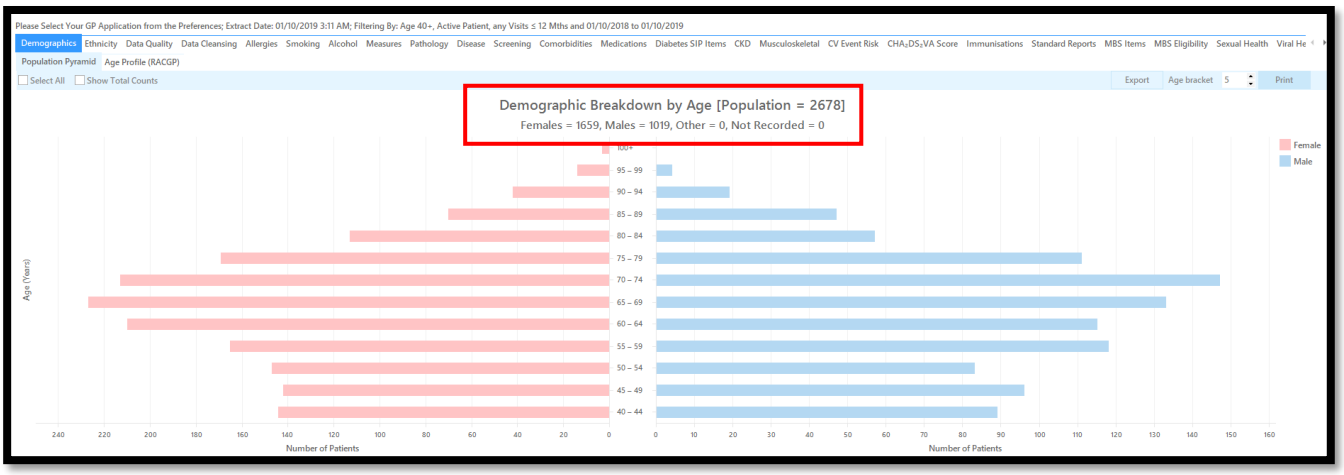


3. Recalculate (Top Right-Hand Corner)

4. Demographics Tab (Bottom Filter)

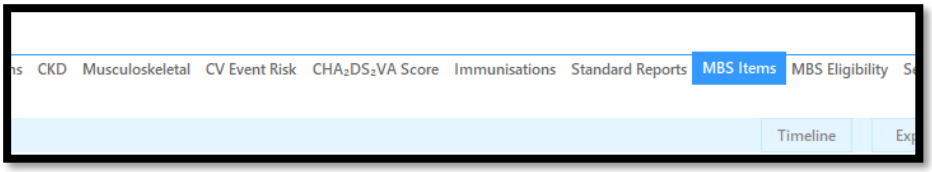
- Population Pyramid Tab

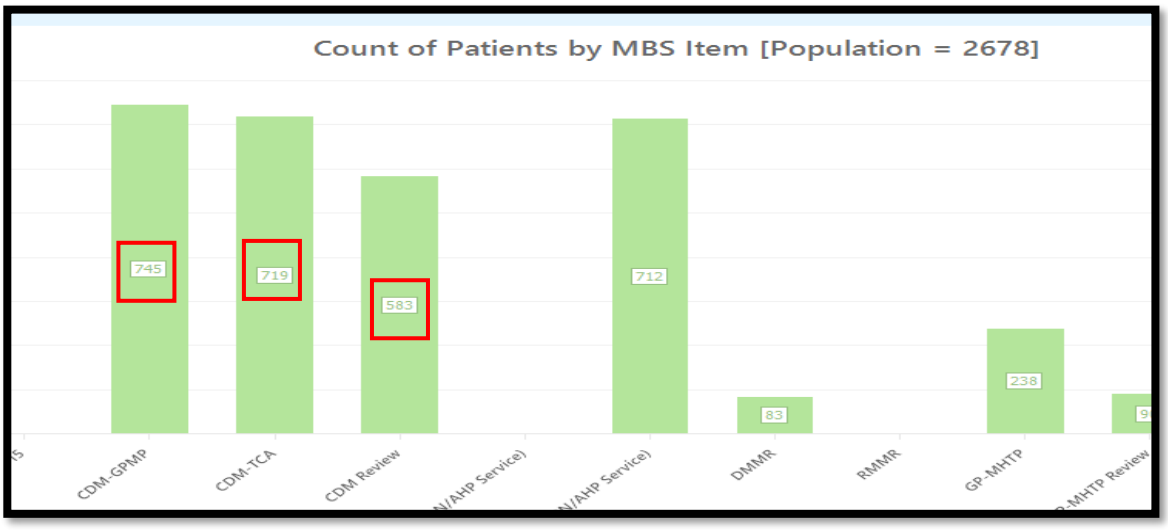




*The demographic breakdown will provide the total number of RACGP active patients over the age of 40 years old.

5. MBS Items Tab (Bottom Filter)

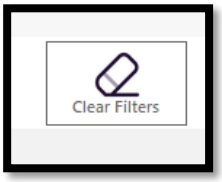


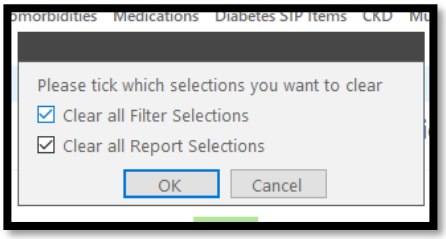


* The graph will provide you with the number of RACGP active patients, 40 years and older, who have had a GPMP, TCA or GPMP Review in the last 12 months.

IMPORTANT REMINDER

Please remember to clear your filter selection after each report. This button is in the top right-hand corner.



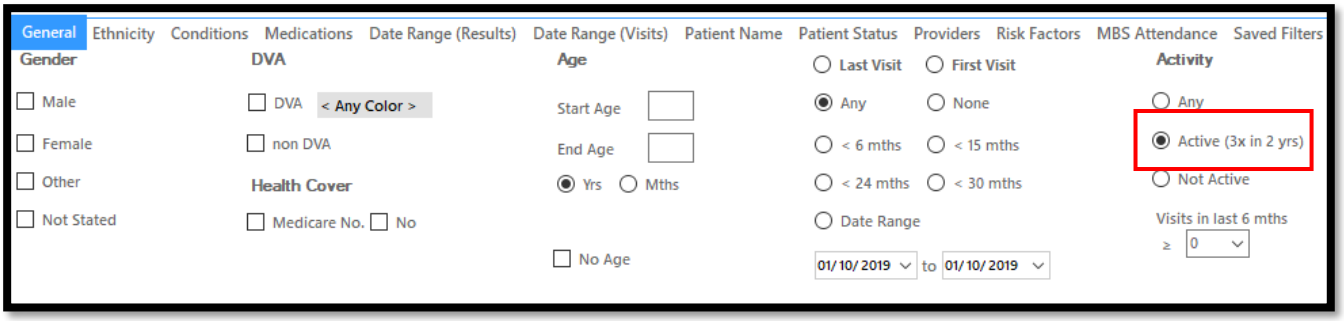


Diabetes (unknown, Type 1, Type 2)

The number of RACGP active patients with diabetes (unknown, type 1, type 2) who have had a GPMP, TCA or GPMP review in the last 12 months.

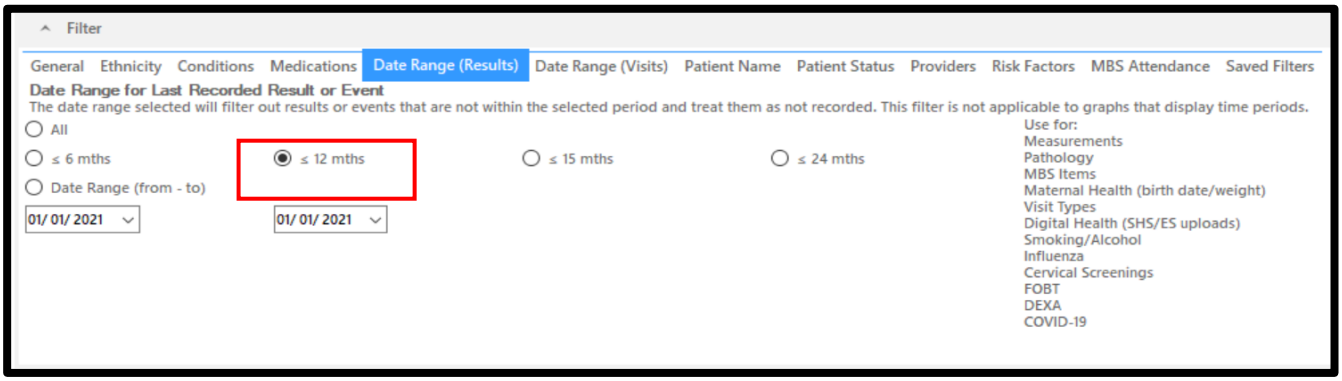
1. General Tab (Top Filter)

- Activity: Active (3x in 2 yrs)



2. Date Range (Results) Tab (Top Filter)

- <12 mths



3. Conditions Tab (Top Filter)

- Diabetes: Yes

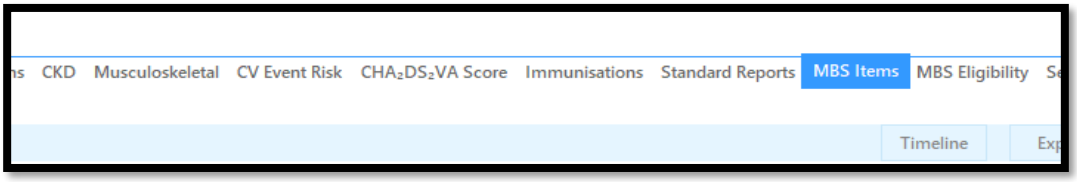
4. Recalculate (Top Right-Hand Corner)

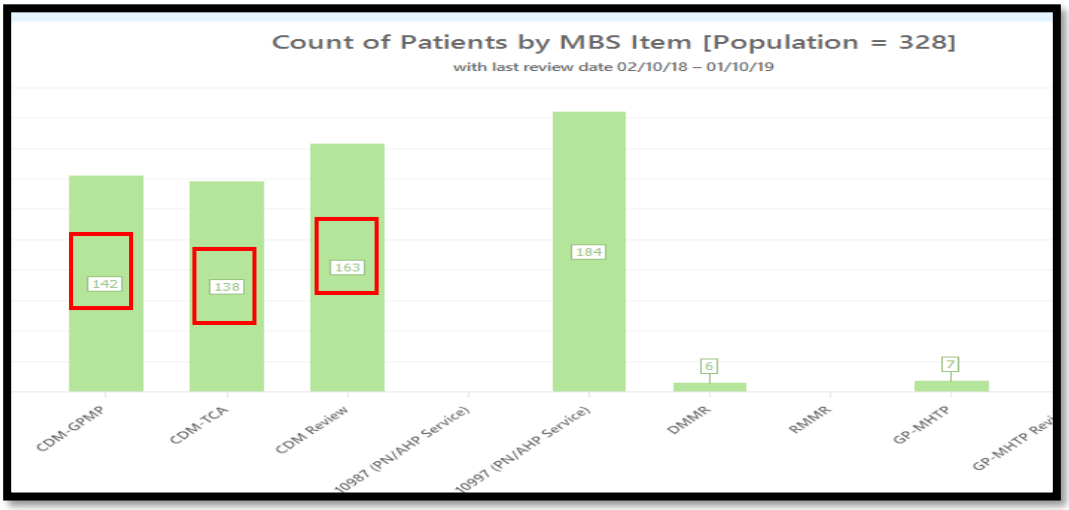
5. Demographics Tab (Bottom Filter)

- Population Pyramid Tab

*The graph will provide you with the number of RACGP active patients with diabetes.

6. MBS Items Tab (Bottom Filter)

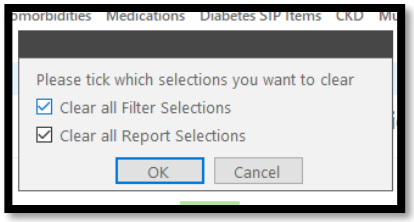




* The graph will provide you with the number of RACGP active patients, with diabetes, who have had a GPMP, TCA or GPMP Review in the last 12 months.

IMPORTANT REMINDER

Please remember to clear your filter selection after each report. This button is in the top right-hand corner.

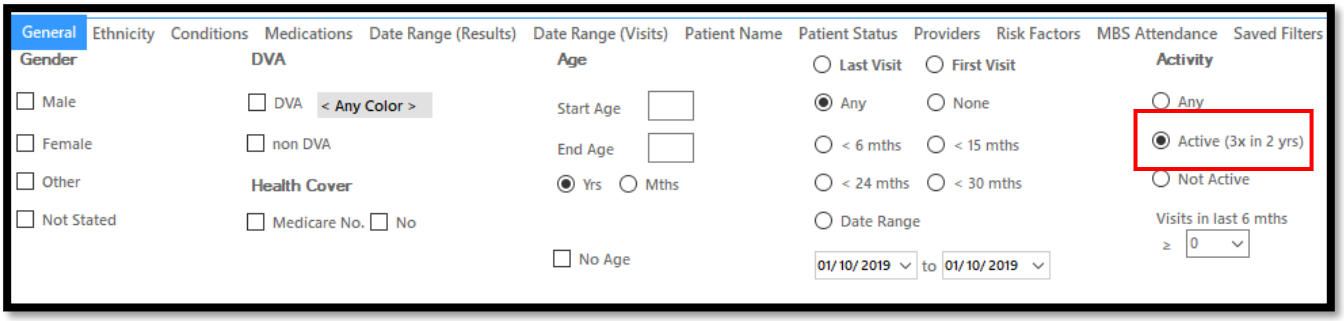


Hypertension

The number of RACGP active patients with hypertension who have had a GPMP, TCA or GPMP review in the last 12 months.

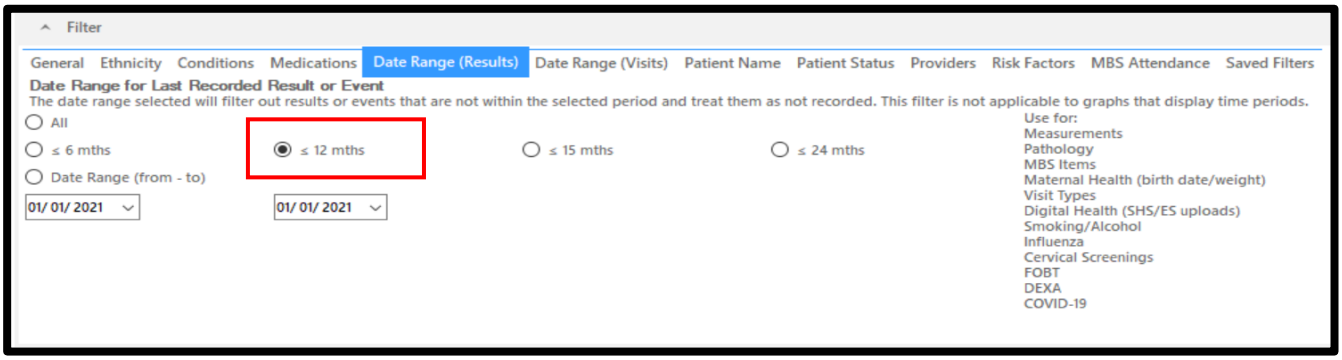
1. General Tab (Top Filter)

- Activity: Active (3x in 2 yrs)



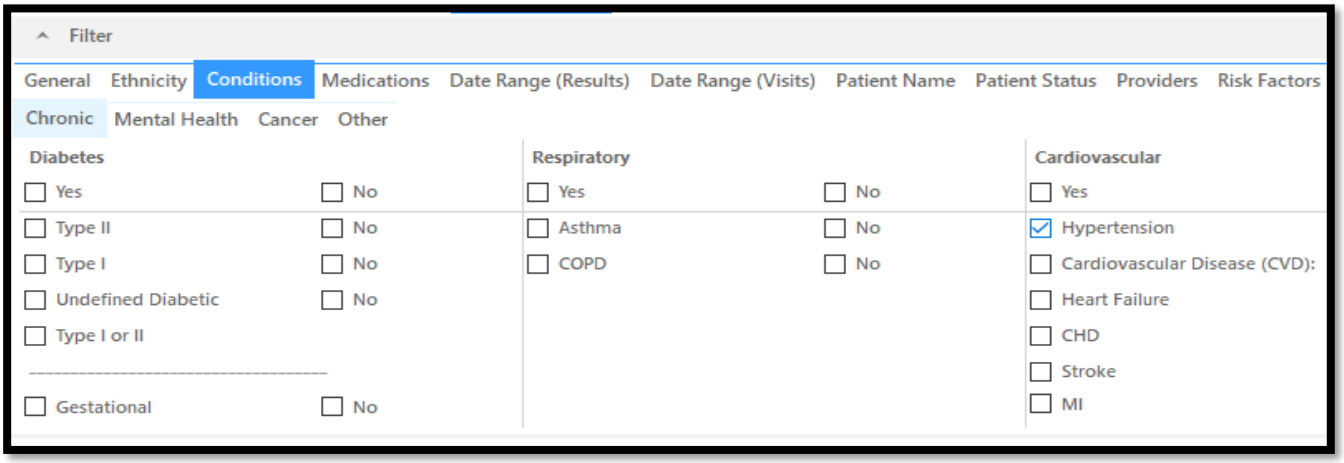
2. Date Range (Results) Tab (Top Filter)

- <12 mths



3. Conditions Tab (Top Filter)

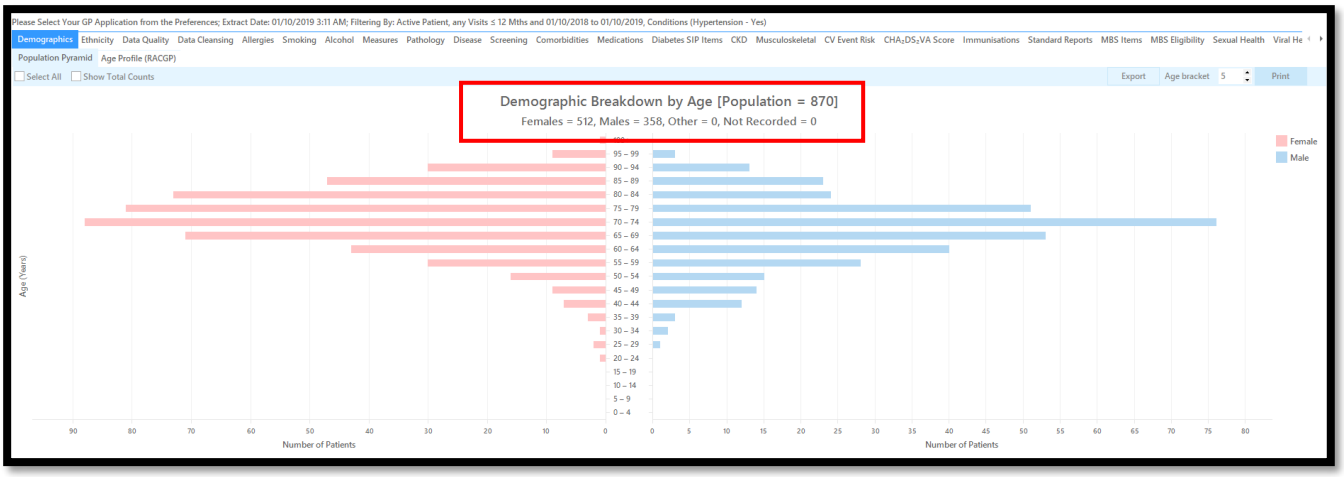
- Cardiovascular: Hypertension



4. Recalculate (Top Right-Hand Corner)

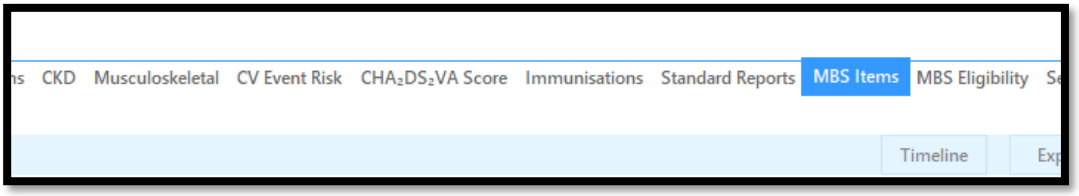
5. Demographics Tab (Bottom Filter)

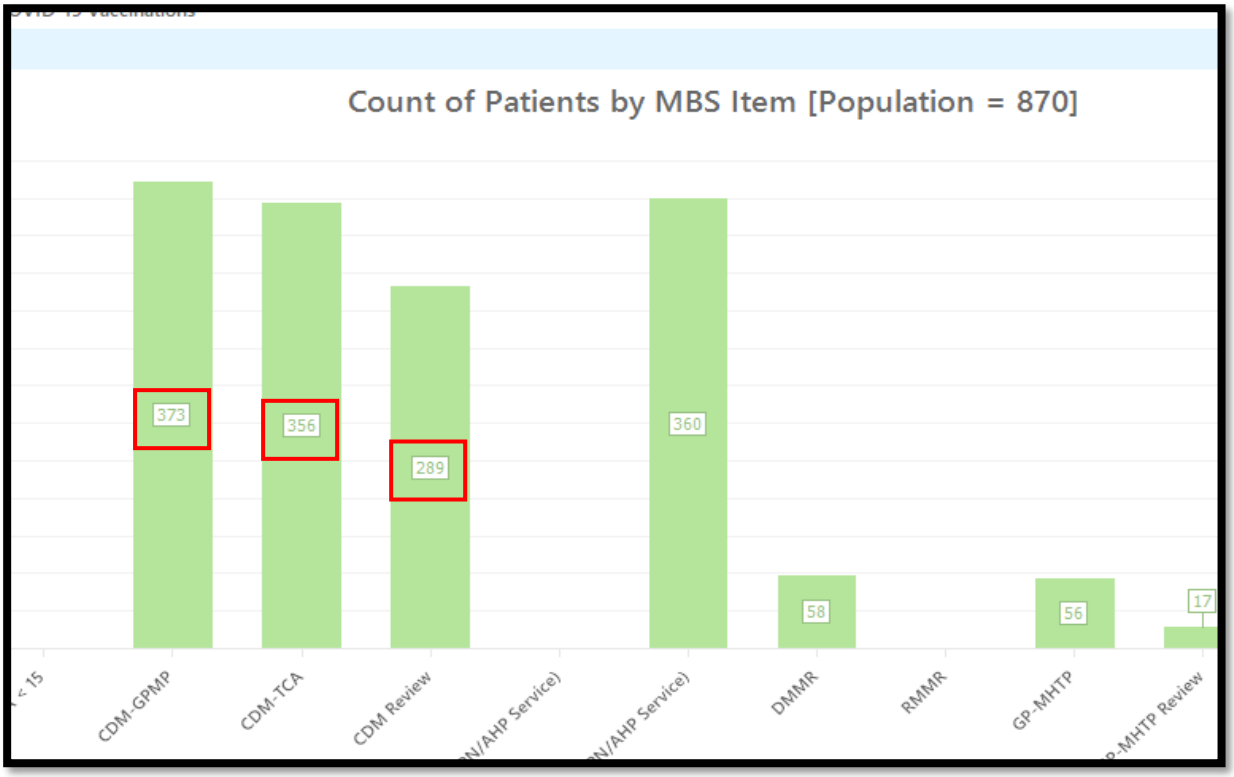
- Population Pyramid Tab



*The graph will provide you with the number of RACGP active patients with hypertension.

6. MBS Items Tab (Bottom Filter)





* The graph will provide you with the number of RACGP active patients, with hypertension, who have had a GPMP, TCA or GPMP Review in the last 12 months.

IMPORTANT REMINDER

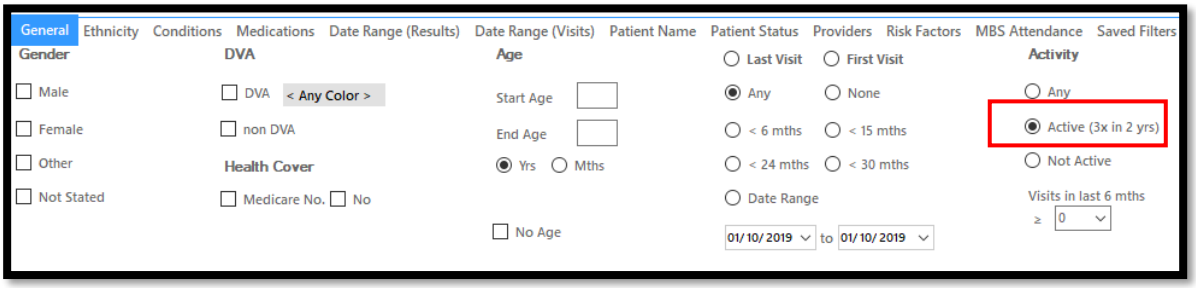
Please remember to clear your filter selection after each report. This button is in the top right-hand corner.

Aboriginal or Torres Strait Islander

The number of RACGP active patients who identify as Aboriginal or Torres Strait Islander.

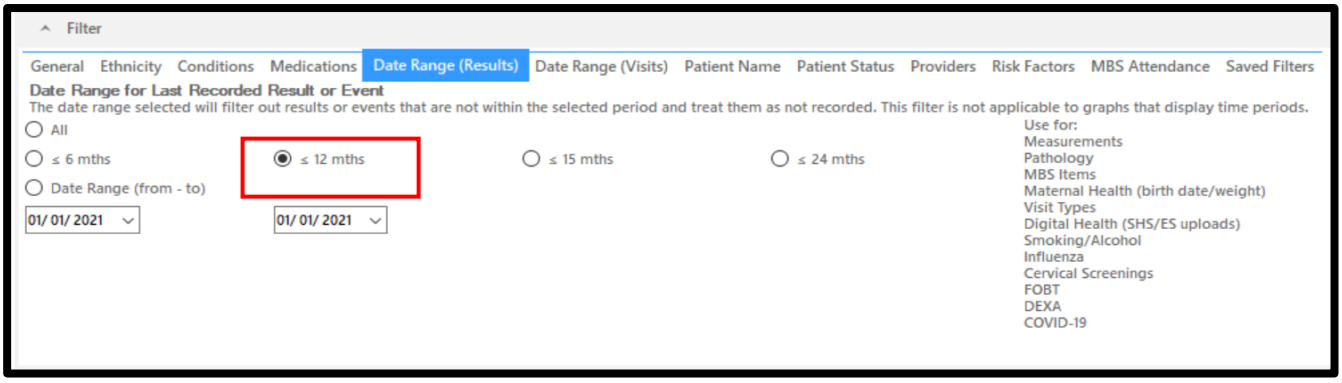
1. General Tab (Top Filter)

- Activity: Active (3x in 2 yrs)



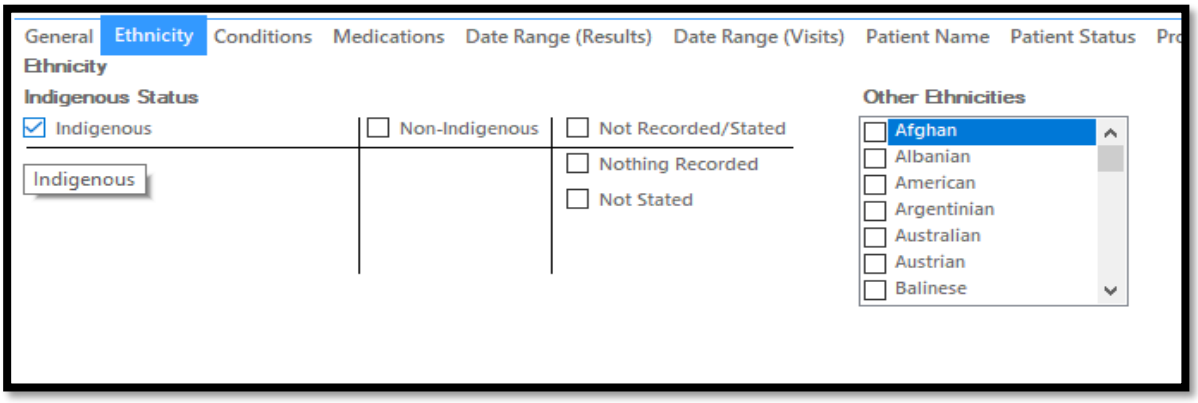
2. Date Range (Results) Tab (Top Filter)

- <12 mths



3. Ethnicity Tab (Top Filter)

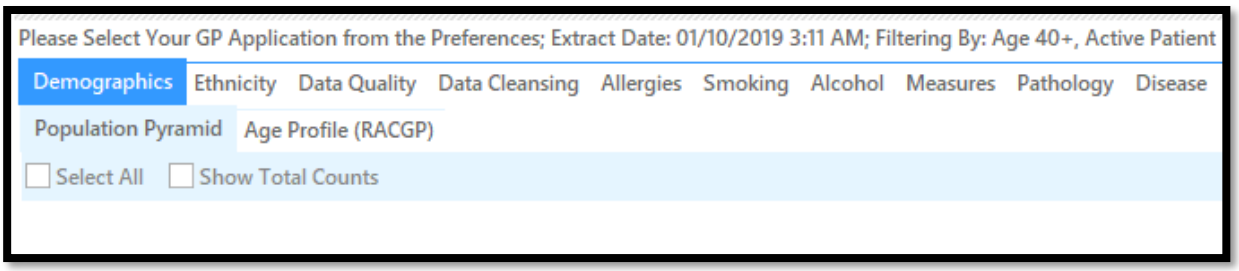
- Indigenous Status: Indigenous

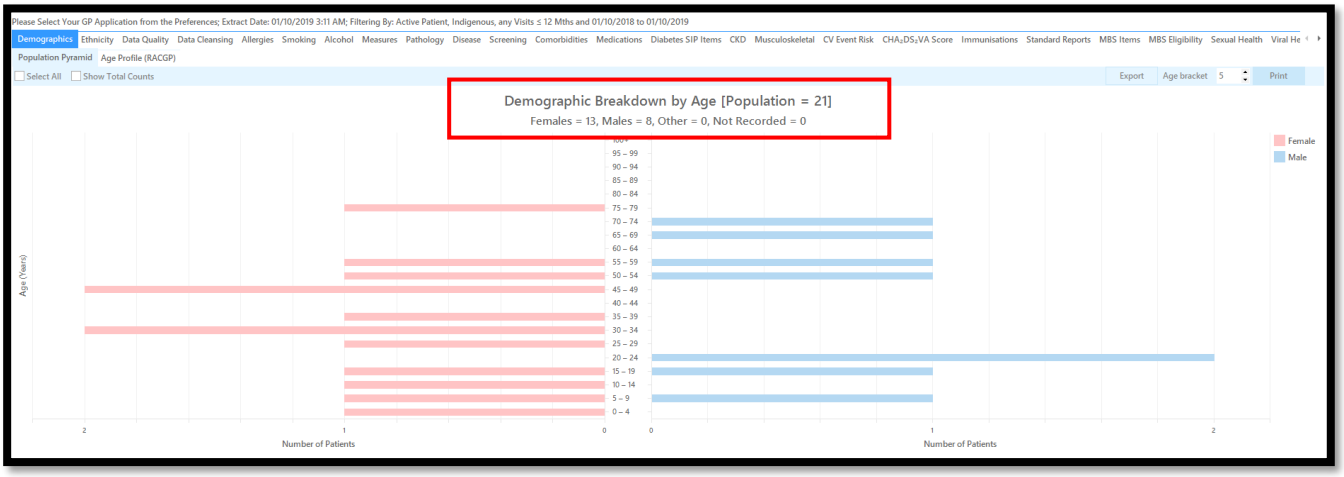


4. Recalculate (Top Right-Hand Corner)

5. Demographics Tab (Bottom Filter)

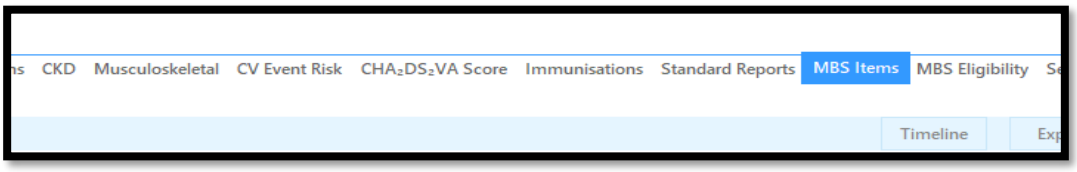
- Population Pyramid Tab

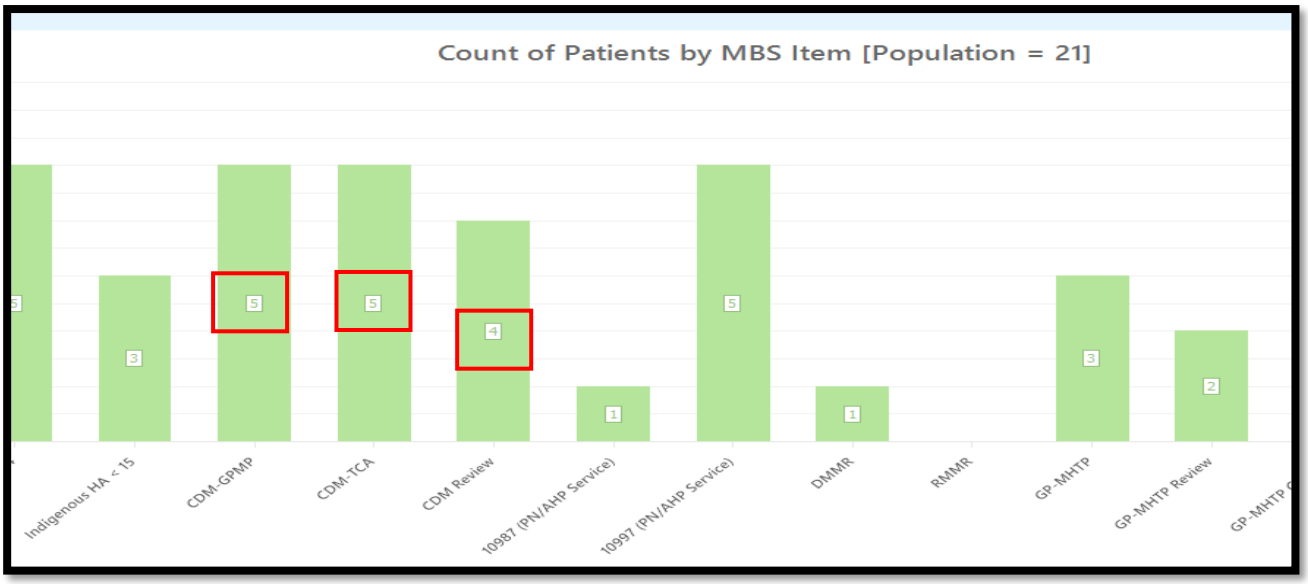




*The demographic breakdown will provide the total number of RACGP active patients who identify as Aboriginal or Torres Strait Islander.

6. MBS Items Tab (Bottom Filter)





*The demographic breakdown will provide the total number of RACGP active patients who identify as Aboriginal or Torres Strait Islander and have had a GPMP, TCA or GPMP Review in the last 12 months.

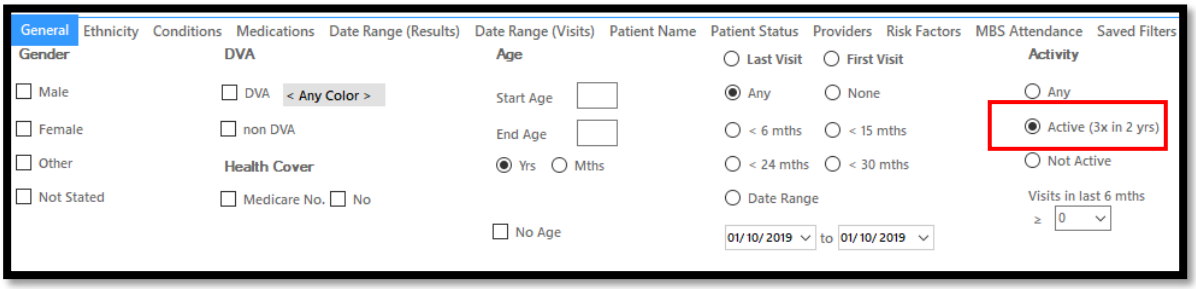
Smoking

The number of RACGP active patients who smoke and have had a GPMP, TCA or GPMP review in the last 12 months.

As the smoking status is sensitive to the date range restriction of 12 months, the data presented via this method may exclude patients whose smoking status has not been recorded in the last 12 months. To overcome this, use the MBS attendance field and remove the data range (results) restriction.

1. General Tab (Top Filter)

- Activity: Active (3x in 2 yrs)



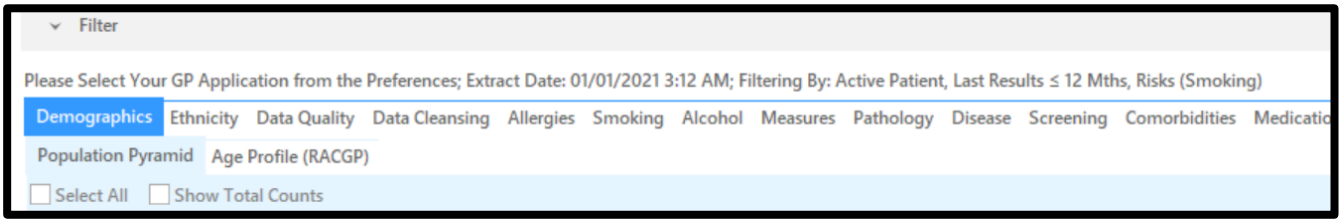
2. Risk Factors Tab

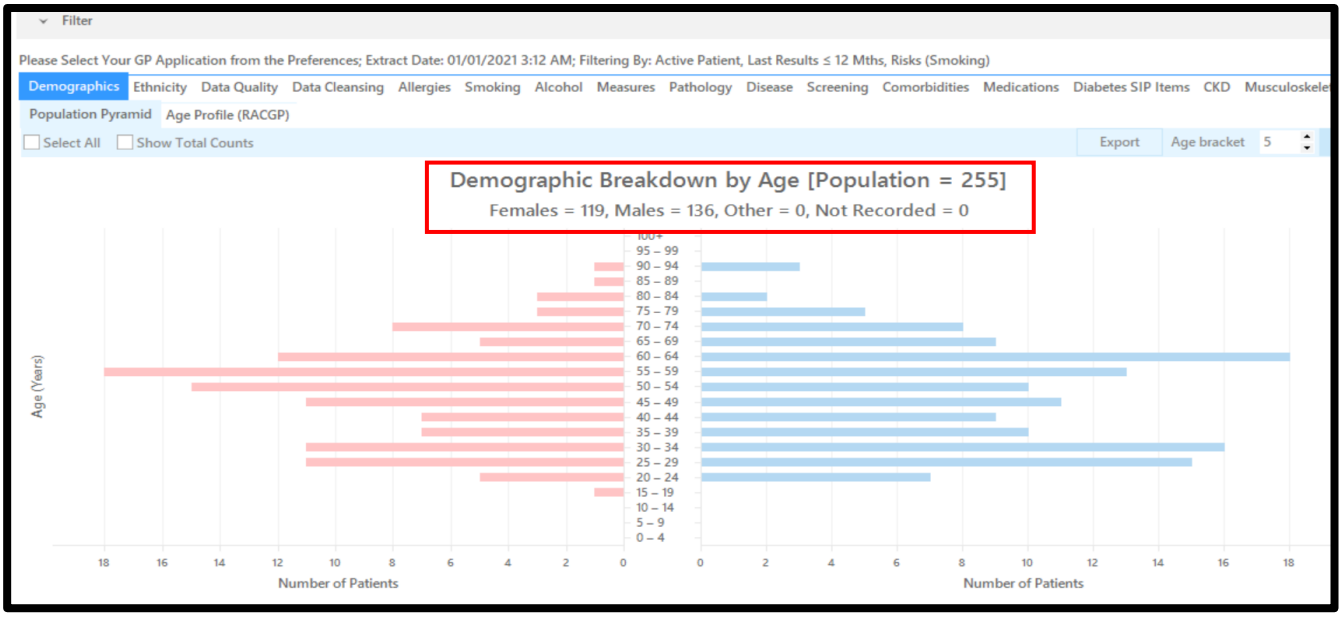
- Substance Abuse: Smoking

3. Recalculate (Top Right-Hand Corner)

4. Demographics Tab (Bottom Filter)

- Population Pyramid Tab





*The demographic breakdown will provide the total number of RACGP active patients who are smokers.

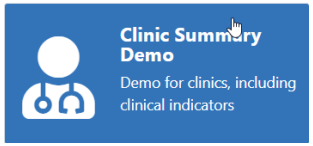
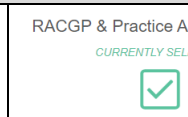
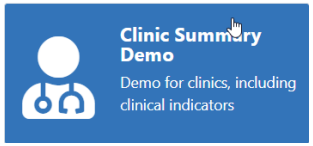
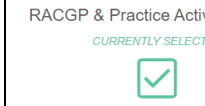
5. MBS Attendance

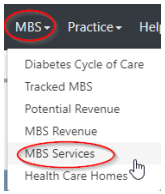
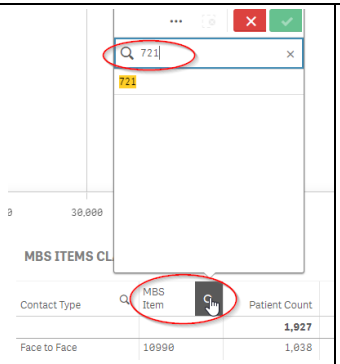
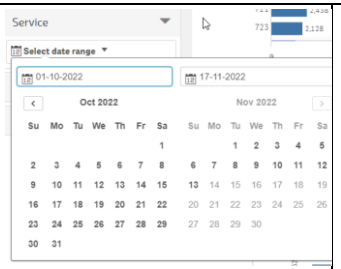
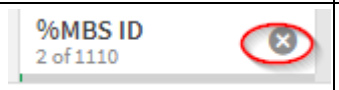
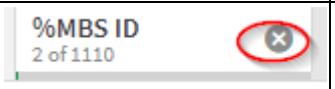
- < 12 months
- MBS Item Numbers (721, 723,732)
- Any of selected

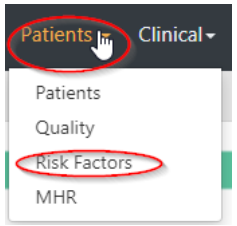
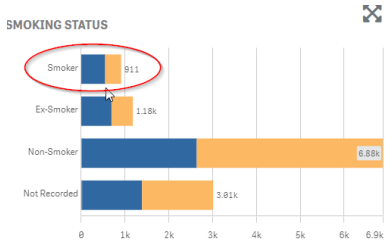
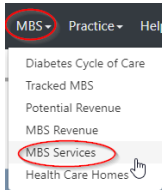
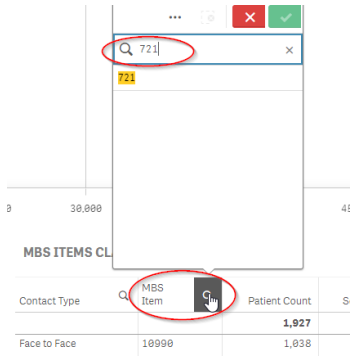
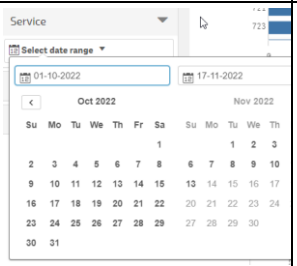
6. Recalculate (Top Right-Hand Corner)

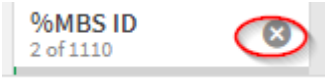
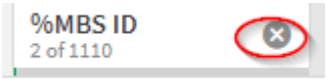
This can only be done using live practice data and therefore the results cannot be demonstrated here.

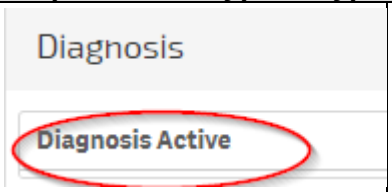
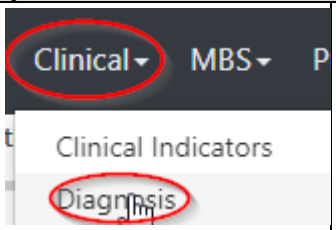
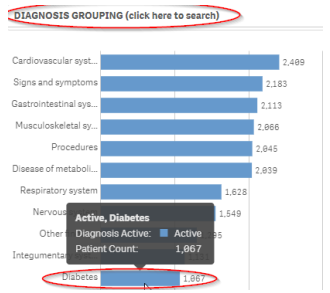
Appendix 2: POLAR walkthroughs for baseline data collection

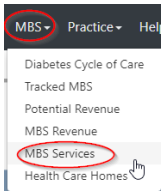
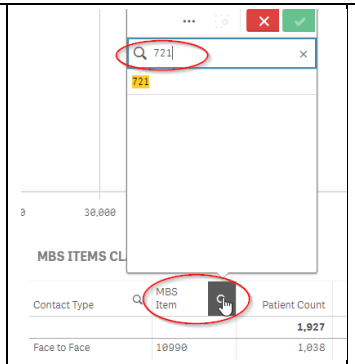
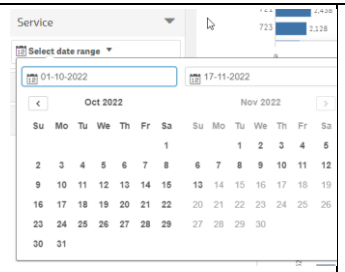
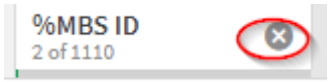
<table>
<tr><th colspan="6">Embedding eye health into primary care POLAR data collection</th></tr>
<tr><td colspan="5">Practice:</td><td>TOTAL</td></tr>
<tr><td colspan="5">Risk Factor Category Data: 40 years and older</td><td></td></tr>
<tr><td>Baseline Total number of Active/ RACGP Active patients in total.</td><td>Select Clinic Summary Report
Tick the shortcut RACGP & Practice Active top right hand side.
The number under patient count is your baseline data</td><td> 
</td><td> 
</td><td> 
</td><td></td><td>Cell D9</td></tr>
<tr><td>Total Number of Active/ RACGP Active patients aged 40 years and over</td><td>Select Clinic Summary Report
Tick the shortcut RACGP & Practice Active top right hand side.
Go to Patients/Patients and select all patients over the age of 40 years.</td><td> 
</td><td> 
</td><td> 
</td><td> 
</td><td>Cell D10</td></tr>
</table>

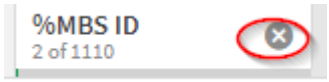
Total number of Active/ RACGP patients 40 years and over who have had an item 721 or 92024 claimed in the last 12 months	Leave all the search filters on then go to **MBS/MBS Services**. In the table **MBS Items Claimed** in the Search under **MBS Item** type in 721 and confirm the selection Repeat to add item 92024. Then go to the calendar filter on the left hand side under **service** and select the last 12 months.					Cell E10
Repeat for item 723 & 92025	Remove the filter %MBS ID only Leave the other filters on.		Then repeat the MBS/MBS Items adding 723 and 92025 and confirm the selection			Cell F10
Repeat for item 732,92028	Remove the filter %MBS ID Leave the other filters on.		Then repeat the MBS/MBS Items adding 732, 92028 and confirm the selection			Cell G10

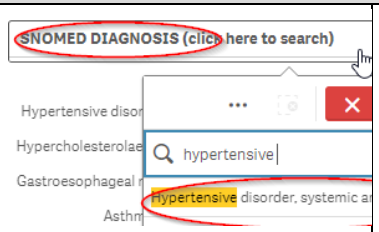
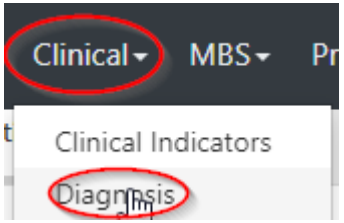
Risk Factor Category Data: Smoker						
Total number of Active/ RACGP Active patients who are current smokers	Remove all the filters except the **Active/RACGP Active** patient filters then go to **Patients/Risk Factors**. Select the **Smokers** from the **Smoking status** graph and confirm the selection. The number of patients under Patient Count is the number of patients who are Active/RACGP Active and are current smokers.					Cell D11
Total number of Patients who are smokers who have had an item 721 or 92024 in the last 12 months	Leave all the search filters on then go to **MBS/MBS Services** In the table **MBS Items Claimed** in the Search under MBS Item type in 721 and confirm the selection Repeat to add item 92024. Then go to the calendar filter on the left hand side under **service** and select the last 12 months.	Repeat previous steps for measure 2 				**Cell** E11

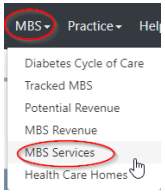
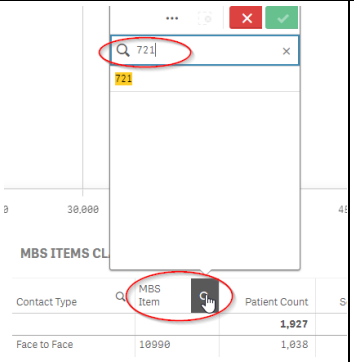
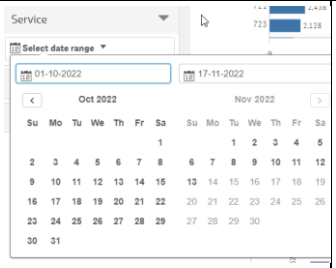
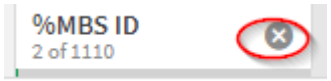
Total number of patients who are smokers and have had an item 723 or 92025	Remove the filter %MBS ID Leave the other filters on. Repeat under **MBS/MBS services** adding item 723 and 92025		Then repeat the MBS/MBS Items adding 723 and 92025 and confirm the selection			Cell F11
Total number of patients who are smokers and have had an item 732 and 92028	Remove the %MBS ID and leave the other filters on. Repeat to add item 732 and 92028		Then repeat the MBS/MBS Items adding 732 and 92028 and confirm the selection			Cell G11

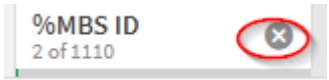
Risk Factor Category Data: Diabetes (Unknown, Type 1, Type 2)						
Total number of patients who are Active/RACGP Active who have a diagnosis of Diabetes Mellitus Type 1,2,unknown.	Remove all the filters except both the **RACGP/Active Patients** Filters Select the **Diagnosis** filter on the left and then select **Diagnosis Active** and confirm the selection From **Clinical** drop down list select **Diagnosis/Diagnosis** Grouping then select **Diabetes** and confirm the selection. The number under Patient Count is now all your RACGP Active/Active with an active diagnosis of Diabetes.					*Cell D12*

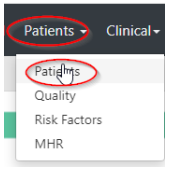
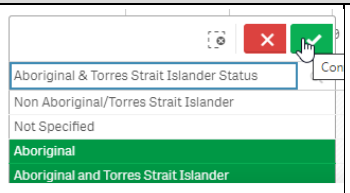
Total number of patients who are Active/RACGP Active have an active diagnosis of *Diabetes Mellitus Type 1,2,unknown and have had an item 721, or 92024 in the last 12 months*	Leave all the filters on then go **to MBS/MBS Services** In the table **MBS Items Claimed** in the Search under MBS Item type in 721 and confirm the selection Repeat to add item 92024. Then go to the calendar filter on the left hand side under **service** and select the last 12 months.					*Cell E12*
Total number of patients who are Active/RACGP Active have an active diagnosis of *Diabetes Mellitus Type 1,2,unknown and have had an item 723 or 92025 in the last 12 months*	Remove the %MBS ID filter and leave the other filters on. Repeat to add item 723 and 92025					*Cell F12*

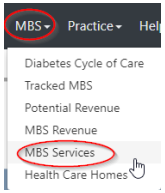
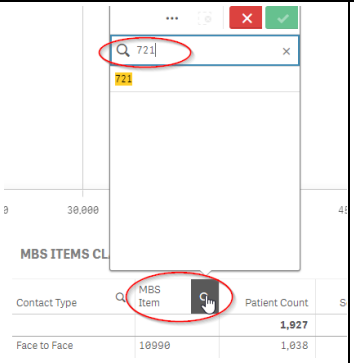
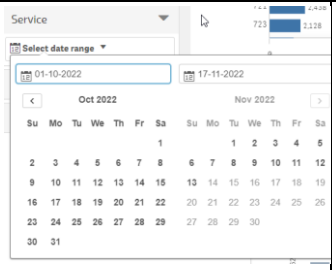
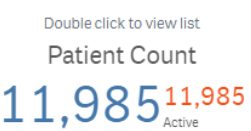
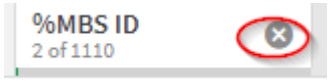
Total number of patients who are Active/RACGP Active have an active diagnosis of *Diabetes Mellitus Type 1,2,unknown and have had an item 732 or 92028 in the last 12 months*	Remove the %MBS ID filter and leave the other filters on. Repeat to add item 732 and 92028					*Cell G12*

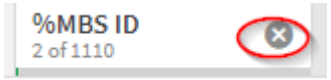
Risk Factor Category Data: Hypertension						
Total number of patients who are Active/RACGP Active who have an active diagnosis of Hypertension	Remove all the filters except keep the **RACGP Active/Patient Active** and **Diagnosis Active** Filters on. Under **Clinical** select **Diagnosis** under **SNOMED Diagnosis** and in the search put in Hypertensive Disorder and confirm the selection.					*Cell D13*

	You now have the number of patients who are RACGP Active/Active and have an active diagnosis of Hypertension					
Total number of patients who are Active/RACGP Active who have an active diagnosis of Hypertension and have had an item 721, or 92024 in the last 12 months	Leave all the filters on then go to **MBS/MBS Services** In the table **MBS Items Claimed** in the Search under MBS Item type in 721 and confirm the selection Repeat to add item 92024. Then go to the calendar filter on the left hand side under **service** and select the last 12 months.					E13
Total number of patients who are Active/RACGP Active who have an active diagnosis of Hypertension and have had an item 723	Remove the %MBS ID filter and leave the other filters on. Repeat to add item 723 and 92025					Cell F13

or 92025 in the last 12 months						
Total number of patients who are Active/RACGP Active who have an active diagnosis of Hypertension and have had an item 732 or 92028 in the last 12 months	Remove the %MBS ID filter and leave the other filters on. Repeat to add item 732 and 92028					Cell G13

Risk Factor Category Data: Aboriginal and Torres Strait Islander						
Total Number of Active/ RACGP Active patients who are Aboriginal or Torres Strait Islander or both	Leaving both the **Active/RACGP Active** filters remove all the other filters. Select the **Patients** drop down list and select patients. Go to the **Aboriginal & Torres Strait Islander** Status table on the right hand side select					Cell D14

	Aboriginal/Aboriginal and Torres Strait Islander and Torres Strait Islander and confirm the status. Patient Count is now all your Active/RACGP Active Aboriginal and Torres Strait Islander patients.					
Total Number of Active/ RACGP Active patients who are Aboriginal or Torres Strait Islander or both who have had an item 721 or 92024 in the last 12 months	Leave all the filters on then go to **MBS/MBS Services** In the table **MBS Items Claimed** in the Search under MBS Item type in 721 and confirm the selection Repeat to add item 92024. Then go to the calendar filter on the left hand side under **service** and select the last 12 months.					Cell E14
Total Number of Active/ RACGP Active patients who are	Remove the %MBS ID filter and leave the other filters on.					Cell F14

Aboriginal or Torres Strait Islander or both who have had an item 723 or 92025	Repeat to add item 723 and 92025					
in the last 12 months Total Number of Active/ RACGP Active patients who are Aboriginal or Torres Strait Islander or both who have had an item 732 or 92028 in the last 12 months	Remove the %MBS ID filter and leave the other filters on. Repeat to add item 732 and 92028					Cell G14