

Western Sydney Diabetes Prevention Toolkit

Continuous Quality Improvement

The **Western Sydney Diabetes Prevention Toolkit** aims to provide primary care providers with practical resources and strategies to enhance early detection and support patients at risk of diabetes (pre-diabetes) in primary care.

NSW Government
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An Australian Government Initiative
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Acknowledgements

This QI toolkit has been developed by WentWest - Western Sydney PHN and the Western Sydney Diabetes Partners. We acknowledge that some resources used or referenced within this toolkit are from organisations including the Department of Health, Disability and Ageing (DHDA), Services Australia, Royal Australian College of General Practitioners (RACGP); Pen CS; TrainIT Medical; Best Practice; and Medical Director. These organisations retain copyright over their original work. Referencing of material is provided throughout.

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Where to get help?

Western Sydney Primary Health Network
E: support@wentwest.com.au
P: (02) 8811 7117
www.wentwest.com.au

Tools and Enablers

2kg Challenge | **GoShare** | **HealthPathways** | **PenCS Suite**

Introduction

Western Sydney Diabetes

Western Sydney Diabetes (WSD) is committed to tackling this growing health crisis by increasing awareness, improving early detection, and providing targeted support to at-risk individuals. Its goals are to slow disease progression, reduce the number of people at risk, and enhance long-term health outcomes for those already diagnosed. [1]

People in Western Sydney are nearly twice as likely to develop diabetes compared to other parts of Sydney. However, evidence shows that early intervention can make a measurable difference. Even modest changes such as losing 2kg can reduce the risk of developing diabetes by up to 30%.

Western Sydney has some of the highest rates of type 2 diabetes in NSW, with 13% of adults living with diabetes and another 25% have prediabetes. Many people are at high risk and don't know it. Early identification and small lifestyle changes can delay or prevent diabetes altogether.

What is the 2kg Challenge?

The 2kg Challenge is here to help you understand Type 2 Diabetes, catch it early, and stop it from happening. It is part of the **Western Sydney Changing Diabetes partnership**, which brings together experts, like a doctor who specialises in diabetes (an Endocrinologist) and a qualified Dietitian. They guide you through the program. We also have coordinators and helpers who run the program and support the community to make healthy changes that last.

2kg Challenge To Beat Diabetes

The **2kg Challenge** is here to help you learn more about type 2 diabetes, catch it early, and take small steps to stop it from happening. It is a **free, evidence-informed[1] 8-week program** that helps adults reduce their risk of type 2 diabetes through simple, sustainable lifestyle changes.



Refer Your Patients Who:

- ✓ Have pre-diabetes or are at risk of type 2 diabetes (e.g., if you live in Western Sydney, are over 40, or have a family history of diabetes), and
- ✓ Are above a healthy weight, and
- ✓ Want easy, practical tips to eat better and live healthier

How You Can Get Involved:

- Talk to eligible patients during consultations.
- Encourage them to sign up at 2kgchallenge.com.au
- Display 2kg Challenge resources.
- Share GoShare 2kg Challenge bundle.

Navigating this toolkit

This toolkit includes practical, flexible activities that are **not sequential**. We recommend starting with **Section One – Practice Readiness** to assess your current state. Use the **links below** to navigate directly to each activity section.

01 Module 1: Leadership – preparing your practice
06 Module 2: Data-Driven Improvement
12 Module 3: Patient Registration & Engagement
18 Appendices

Use the **Model for Improvement** and **Plan-Do-Study-Act (PDSA) cycles.** to test changes, drive progress and embed high-quality diabetes care

[1] [1] Meyerowitz-Katz G, Seelan S, Gaur P, Francisco R, Ferdousi S, Astell-Burt T, Feng X, Colagiuri S, Maberly G, Hng T-M. Detecting the hidden burden of pre-diabetes and diabetes in Western Sydney. Diabetes Res Clin Pract. 2019;151:247–251.

Module 1

Leadership – preparing your practice

On completion of this module, you will:

- Assess your practice's readiness to implement the 2kg Challenge, with a focus on identifying and supporting patients at risk of Prediabetes.
- Engage the leadership team to communicate consistent referral pathways and understand how the 2kg Challenge empowers patients to make small, sustainable changes that reduce their risk of type 2 diabetes.

Activity Navigation

1.1 Activity - Practice Readiness Checklist
1.2 Activity - Practice QI Plan - Prediabetes
1.3 Activity - MBS and PIP Optimisation
1.4 Activity - Prediabetes Team workflow

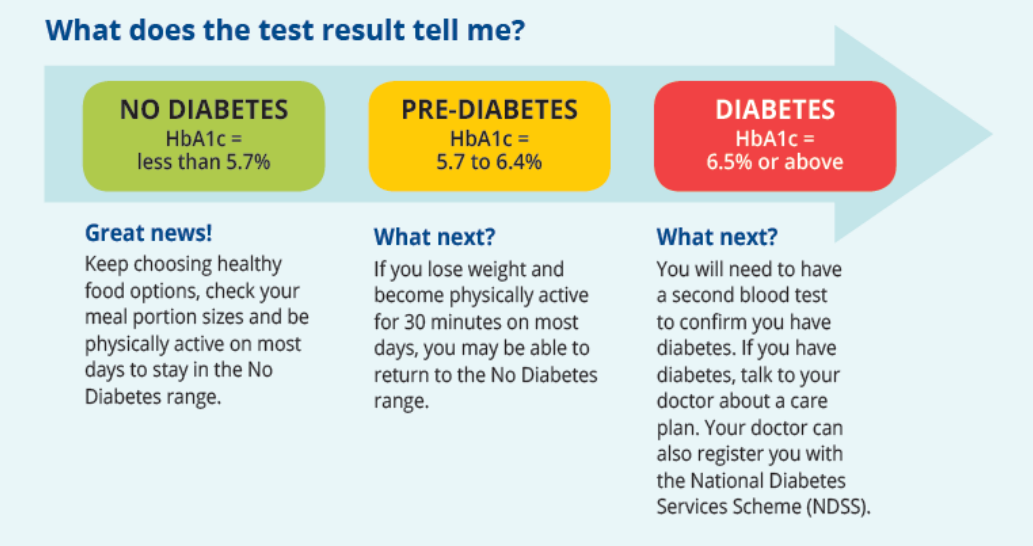
Why focus on Prediabetes?

Prediabetes often goes undetected and is influenced by a combination of factors, including genetics, lifestyle, and increasing rates of above a healthy weight and obesity. Certain population groups, including people from Aboriginal, Torres Strait Islander, Asian, Middle Eastern, and Pacific Islander backgrounds, face a higher risk. Understanding and addressing prediabetes is a key opportunity for targeted prevention efforts in the region.

The Royal Australian College of General Practitioners (RACGP) recognises that primary care providers are at the forefront of health care in Australia and are in a pivotal position to deliver preventive health care through the early detection of specific disease, and the promotion and maintenance of health.

Opportunistic testing for diabetes in all adults through blood tests is recommended. An annual HbA1c test to check for diabetes is covered by Medicare. There is some variation in how Prediabetes is defined, with most guidelines identifying it as an HbA1c of 5.7–6.4%, while some Australian bodies use a higher threshold of 6.0–6.4%. It's important to recognise that risk increases along a continuum, rather than beginning at a single cutoff.

You can delay or prevent the progression of type 2 diabetes by modifying lifestyle risks. Refer to **RACGP's Smoking, nutrition, alcohol, physical activity (SNAP)** guideline.



Source: **WSD Know your risk flyer to find out more.**

1.1 Activity - Practice Readiness Checklist

Essential preparations for delivering high-quality, team-based diabetes prevention and early detection, supported by engaged leadership, structured planning, and data-driven continuous improvement.

Change Principle (What)	Change Ideas (How - Actions)	Assigned to
1. Engaged leadership – preparing your practice	☐ Nominate a **QI lead**/Diabetes Prevention Champion. ☐ **Brief the practice team** (GPs, nurses, admin, allied health) on project goals. ☐ Define **clear team roles** (patient identification, recalls, bookings, follow-ups, referrals). ☐ Schedule regular team huddles/**meetings to track progress**. ☐ Review available **tools & enablers (**e.g., CAT4, GoShare, Health2Sync, 2kg Challenge, HealthPathways). ☐ Establish **recall/reminder systems** (BP/MD software, GoShare, SMS)	*Need help? contact your* **WentWest Primary Care Facilitator**
2. Data driven improvements,	☐ Conduct **data cleansing** and archive inactive records. ☐ Ensure diagnoses are **coded e.g. Prediabetes** ☐ Use **CAT4/Pen CS recipes to identify at-risk patients:** ○ HbA1c between 5.7 to 64 % with no coded diagnosis. ○ High-risk groups (Aboriginal & Torres Strait Islander, Pacific Islander, South Asian, Middle Eastern, above a healthy weight). ☐ Flag **eligible patients in clinical system** (Topbar, Cubiko, or recalls). ☐ Maintain accuracy of the **Prediabetes register** with consistent coding. ☐ Run monthly audits & reports to track referrals to 2kg Challenge.	
3. Patient Registration and Engagement	☐ Use the **2kg Challenge & Diabetes Prevention Communication Toolkit**: ○ Posters in waiting rooms. ○ Website banners/social media posts. ○ On-hold phone messages. ○ SMS/email templates. ☐ **Tailor materials** (translations, culturally appropriate). ☐ **Engage patients** during opportunistic visits (i.e. health assessments). ☐ Align with **key awareness events** (e.g. National Diabetes Week). ☐ **Encourage patient to sign to 2kg Challenge** and refer to local walking/exercise groups.	
4. Team Based Care	☐ Allocate dedicated appointments (~20 mins) for diabetes risk checks. ☐ Train nurses/staff in **Disk risk assessment & referral pathways**. ☐ Use **HealthPathways** for assessment, management, and referrals. ☐ Offer **nurse-led AUSDRISK/HbA1c screening** with GP follow-up. ☐ Provide **check-in calls/sessions** to monitor patient progress in lifestyle programs (e.g., 2kg Challenge).	
5. Monitor, Reflect, and Celebrate	☐ Track **weekly/fortnightly progress** (number of 2kg referrals, HbA1c tests). ☐ Run **PDSA cycles to test change ideas** and improve workflows. ☐ Gather and review **patient feedback** on engagement and program usefulness. ☐ **Share outcomes and celebrate progress** at team meetings. ☐ Document reflection for RACGP CPD via Quick Log.	

1.2 Activity – Practice QI Plan: Diabetes Prevention

Please complete the following table to outline your plan to complete the goal.

Engaged Leadership	**Goal**	**Increase early detection of Diabetes for people aged 40+ by conducting HBA1C testing in the past 12months from ##% *(## patients)* to ##% *(## patients)* by DD/MM/YYYY.**		
	Measure/s	No. of HbA1c recorded, monthly No. of Diabetes coded (Prediabetes, Type 2)	**Search criteria**	i.e. CAT4 filters
	QI Lead and Team	Who will need to be involved?	**Period**	Start date - end date

	Actions *Tip: Use PDSA cycles to test change ideas*	**Resources**	**Who**	**Period**	**Update**
Data-Driven Improvement	**Clean patient data** – review the "Indicated Diabetes but not diagnosed" patient list.	• **CAT4 Data Cleansing** • Archiving **BP** | **MD**		Start date - end date	Allocated a usual care provider to patients
	Update patient register – extract a list of active patients with no diabetes diagnosis who are at risk and agreed on a coded condition for Prediabetes	**CAT4- at-risk of diabetes**			
	Review HBA1C status – check results and recall patients for assessment.	•			
Patient Registration	**Strengthen recall systems** – ensure reminders are in place for patients with Prediabetes or at risk.	•			
	Promote the 2kg Challenge – encourage eligible patients to sign up and schedule follow-up check-ins.	•			
	Educate patients – share Prediabetes information proactively using GoShare resources.	•			
	Refer to lifestyle programs – support patients to join programs such as Step 1 of the 2kg Challenge.	•			
	Host awareness activities – organise a Diabetes Awareness Week in July with population screening.	•			
Team-Based Care	**Upskill the team** – train staff in using GoShare to support recalls and patient sign-ups.				
	Provide clinical access –ensure staff can access HealthPathways for diabetes guidelines.				
	Define team workflows – set clear processes for identifying, engaging, and monitoring at-risk patients.	•			
	Use communication toolkit – raise awareness of Prediabetes and the 2kg Challenge among patients.	•			

Reflection	**Outcomes Summary**	As a team, what did you learn? What changes would you make to your practice as a result? **RACGP CPD Tip:** utilise the self-reporting feature on Quick Log mycpd.racgp.org.au to document reflection.

1.3 Activity - MBS and PIP Optimisation

This quick guide outlines key Medicare Benefits Schedule (MBS) items for Diabetes risk assessment and management. Each item number is **linked** to its criteria, descriptor, and fact sheets. Click **here** for a full list of MBS items.

HEALTH ASSESSMENTS (HA)	ELIGIBLE GROUPS		
Heart Health Check 20-min CVD risk check for eligible patients 30+ (ANNUALLY)		699	
• Comprehensive Medical Assessment (CMA) for Residents of RACFs (ANNUALLY) • People with an Intellectual Disability (ANNUALLY) • One-off Veterans' Health Check (ONCE ONLY) • Refugees with Medicare access (ONCE ONLY)	• 75 Years or Older (ANNUALLY) • 45 to 49 Years at risk of developing chronic disease (ONCE ONLY) • 40 to 49 Years at High Risk of Diabetes following AUSDRISK Tool (3 YEARLY)	701 703 705 707	< 30 mins 30-45 mins 45 - 60 mins ≥ 60 mins

OTHER HEALTH ASSESSMENTS	Face to Face	Telehealth*
NEW **Menopause and Perimenopause Health Assessment**	695	
Aboriginal and Torres Strait Islander Peoples Health Assessment (EVERY 9 MONTHS)	715	92004
Patients <25 with eligible disability: assessment, diagnosis & plan (≥45mins) (ONCE)	139	92142

CHRONIC CONDITIONS MANAGEMENT (CCM)	Face to Face	Telehealth*
NEW **GP chronic condition management plan**** (EVERY 12 MONTHS if clinically relevant)	965†	92029†
NEW **GP chronic condition management plan Review**** (EVERY 3 MONTHS if clinically relevant)	967†	92030†
Practice Nurse /AHW follow-up services for a patient with a chronic condition (5 PER YEAR)	10997^	Phone 93203 Video 93201
Practice Nurse/AHW follow-up services for Indigenous Patients (10 PER YEAR)	10987^	Phone 93202 Video 93200
Domiciliary Medication Management Review (DMMR) (ANNUALLY) Note: From 1 July 2027, a GP chronic condition management plan will be required to access domiciliary medication management reviews	900	
GP contribution to multidisciplinary plan – Community (EVERY 3 MONTHS)	729	92026
GP contribution to multidisciplinary plan (MCP) – RACF (EVERY 3 MONTHS)	731	92027
Case Conference GP organises (MAX. 5 TIMES PER PATIENT PER CALENDAR YEAR)	735, 739, 743	
Case Conference GP participating (MAX. 5 TIMES PER PATIENT PER CALENDAR YEAR)	747, 750, 758	

**Patients with a General Practitioner Chronic Disease Management Plan (GPCCMP) can access the following MBS services:

- Allied Health Services: Up to 5 individual sessions per year (10 for Aboriginal or Torres Strait Islander patients).
- Nurse or Health Practitioner Services: Up to 5 services annually, provided on behalf of a doctor.
- Type 2 Diabetes Care: If eligible, up to 8 yearly group sessions for dietetics, education, or exercise.

The current allied health referral form will be replaced by **referral letters**, aligning with referrals to medical specialists.

CASE CONFERENCING			
Case Conference GP organises (MAX. 5 TIMES PER PATIENT PER CALENDAR YEAR)	735	739	743
Case Conference GP participating (MAX. 5 TIMES PER PATIENT PER CALENDAR YEAR)	747	750	758

DIAGNOSTIC PROCEDURES	
24-hr BP for suspected hypertension (patient not treated), including report and treatment plan (ONCE ANNUALLY if criteria met)	11607
HbA1C point-of-care (POC) test for established diabetes, done by or on behalf of GP at an accredited practice for POC testing (Not > 3 Times Per 12 Months Per Patient)	73812

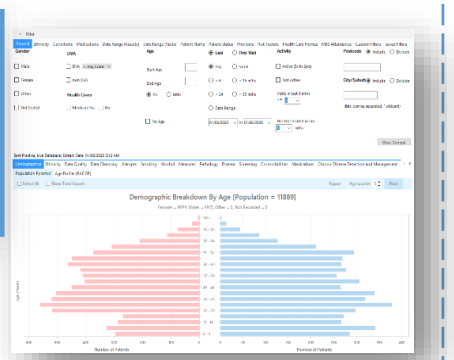
† Only available **MyMedicare** enrolled patients at the practice
* **Telehealth** (Video Consults) and ***Telephone** (Phone Consults) available to Medicare-eligible patients with an established practice relationship who have attended in-person within the past year can access services. (Exceptions apply)

Whilst all care has been taken in preparing this document, this information is a guide only and is subject to change without notice.
Last updated 1 July 2025

1.4 Activity –Prediabetes Team workflow - Sample

Check patient is MyMedicare registered and has had annual HbA1c

Recall templates and recipes
Refer to Module 2 Data-Driven Improvements – Diabetes Prevention Toolkit



01
Perform records search and actively recall eligible patients + opportunistic identification.

02
Collect risk factors & invite patients to sign up to 2kg Challenge.

03
GP completes risk assessment and recommends **HbA1c pathology request if required.**

04
Provides lifestyle advice + assists patient to sign up to 2kg Challenge.

05
Patient recalled test results and check-in with 2kg Challenge progress.

06
Follow up monitoring of diabetes risk +/- meds

Here's a suggested outline of roles and responsibilities -
please allocate tasks in the way that best suits your team

Roles and Responsibility

GP
- Order/interpret HbA1c
- Confirm diagnosis & initiate care plan
- Add reminders for reviews

Practice Nurse
- Run CAT4 searches for at-risk patients
- Review HbA1c status
- Refer to 2kg Challenge & lifestyle programs
- Track recalls & follow-ups

Admin
- Manage recalls/SMS/phone reminders
- Flag patients at booking/check-in
- Keep patient registers updated
- MyMedicare enrolled (status review)

Practice Manager
- Oversee workflow & staff training
- Monitor QI measures (HbA1c, 2kg Challenge signups)

Aboriginal Health Worker
- Support culturally safe screening & engagement
- Promote prevention from age 18 & over

Allied Health
- Provide diet, exercise, mental health support
- Report back on patient progress

Module 2

Data-Driven Improvement

On completion of this module, you will:

- Use CAT4 to drive proactive identification of patients with or at risk of Diabetes
- Apply data-driven strategies to plan, implement, and review quality improvement (QI) activities.

Identifying 'at risk' Patients

Refer to **Western Sydney HealthPathways** for information on diabetes assessments, targeting at-risk groups and recommendations for testing

Opportunistic or targeted identification of patients who are:

- Are over 18 years old.
- Don't eat healthily or exercise regularly.
- Have a family history of diabetes.
- Are from a high-risk background (e.g. Pacific Islander, Indian, Chinese, Southeast Asian, Middle Eastern, African, Aboriginal or Torres Strait Islander)
- Have a higher waist measurement.
- Had diabetes in pregnancy.
- Smoke
- Have other health issues like high blood pressure, cholesterol, or Polycystic Ovary Syndrome (PCOS) [2]

Prediabetes is not recognised coded condition in Australia, please query with your clinician how these have been coded i.e. intermediate hyperglycaemia or free text.
Try to standardise and assigned a code for Prediabetes.

Before You Begin

☐ Ensure **CAT4 is installed and staff are trained -** use **CAT4 guide** or **videos**
☐ **Clean your data** using **CAT4** (e.g. inactive records, remove duplicates).
☐ ensure diagnoses are **coded, not free text** – use **CAT4 condition mapping**
☐ **Filter by doctor**, condition, or age to create a smaller patient list.

Use CAT4 recipes to identify patients:

☐ **2.1 Activity – Identifying patients with an indicated Diabetes**
☐ **2.2 Activity – Identify Patients at Modifiable Risk Factors**
☐ **2.3 Activity – Identify Patients at Clinical Risk of Diabetes**
☐ **2.4 Activity – At-risk of Diabetes & due HBA1C**

Measuring Outcome CPD Tip: Collaborate as a team to generate a **CAT4 list of patients per GP.**

Track & Reflect

☐ Download the **audit worksheet or run chart** template
☐ **Run a PDSA** on a change idea and record your baseline
☐ As a team, reflect on What worked? What didn't?
☐ **Completed QI documentation for CPD**

Need support?
PEN CS Support 1800 762 993 **support@pencs.com.au**
WentWest (02) 8811 7117 **support@wentwest.com.au**

[2] https://www.diabetesaustralia.com.au/diabetes-risk/

2.1 Activity – Identifying patients with an indicated Diabetes

Indicated Diabetes with no Diagnosis CAT4 report showing diabetes and Prediabetes likelihood based on HbA1c, anti-diabetic medication, or fasting blood glucose (FBG) without a diagnosis. or full details on the criteria used for this report please see here: **Indicated Conditions Report Details**

RED:	ORANGE:	YELLOW:
HbA1c >= 6.5 OR HbA1c recorded AND on anti-diabetic medication OR FBG > 7	HbA1c >6 and <6.5 OR on anti-diabetic medication excluding Metformin	ANY of the following On Metformin* *Metformin is also used for other conditions such as PCOS

➢ **Starting point:** **Log into Pen CS CAT4** → Show Extracts → load latest data extract → Hide Extract

➢ **In Filter Panel**

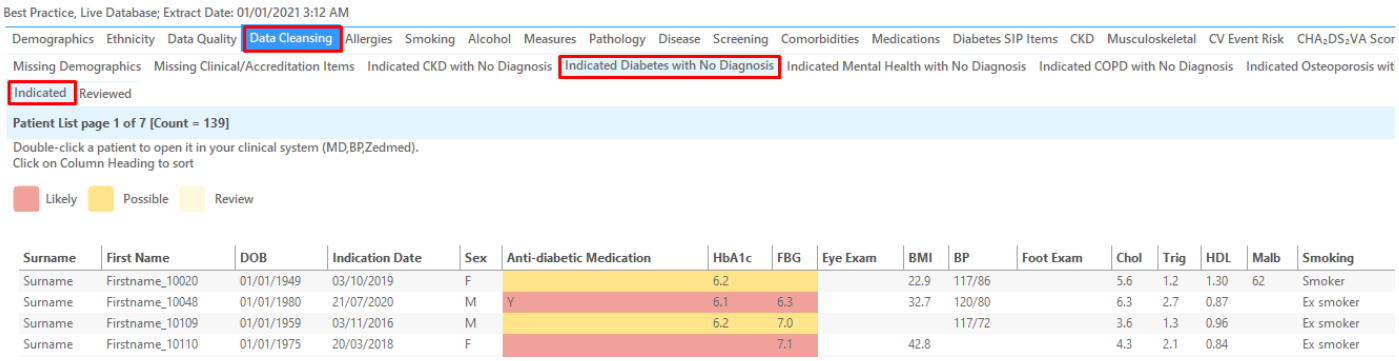
1. General tab →**Age** → **Start Age = 18**

2. Choose either **Active or MyMedicare status:**
   - Optional 1: Under 'General' tab → Activity → Select 'Active (3 x in 2 yrs)'
   - Optional 2: Under 'Patient Status' tab → tick 'Registered with MyMedicare'

3. **Recalculate** 

➢ **In Report Panel**

4. **"Data Cleansing" tab → select 'Indicated Diabetes with no diagnosis'**



The colours indicated the likelihood of the patient having diabetes, but it is recommended to review all patients listed. Assigned providers are listed and there is an option to confirm that the condition does not exist for false positive listings.

5. Optional: Select Export → XLS File → Save (e.g. Create a folder C:/ClinicalAudit/CAT Patient Follow-up)

6. Optional: **filter patient list by provider** (select → Visits → Assigned Provider → Report button)

7. Optional: **create a Topbar prompt** (Daily CAT button → CV Event Risk →Export → Topbar Prompt button)

If you identify large numbers of patients who have been coded in free text **Medical Director** and **Best Practice** offer a method to clean up 'in

Use the **Measuring Outcomes table** to track progress and support **self-reflection** over time.

Register all Medicare card holders with the National Diabetes Services Scheme (NDSS).

2.2 Activity – Identify Patients at Modifiable Risk Factors

Looking after physical health is essential for everyone, but people at risk of or living with Diabetes and other chronic conditions often face additional challenges. These may include medication side effects, lifestyle-related risks such as smoking, poor nutrition, low physical activity, and comorbidities like obesity and Cardiovascular.

As part of a whole-person approach, it's important for care teams to assess and address modifiable lifestyle risks using the **SNAP framework: Smoking, Nutrition, Alcohol, and Physical Activity**.

Practice Measures and Monitoring

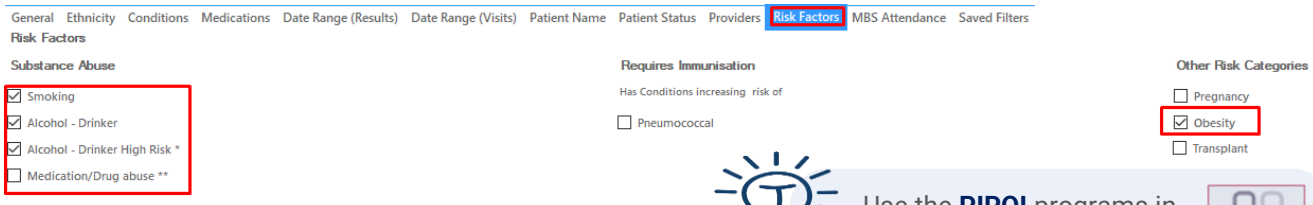
To assess and monitor lifestyle risk factor recording in your practice, complete the following steps in **Pen CS CAT4**:

CAT4 recipes: Finding patients at risk of diabetes with modifiable lifestyle risks

➢ **Starting point:** **Log into Pen CS CAT4** → Show Extracts → load latest data extract → Hide Extract

➢ **In Filter Panel**

1. General tab →**Age** → **Start Age = 18**
2. Choose either **Active or MyMedicare status:**
   - Optional 1: Under 'General' tab → Activity → Select 'Active (3 x in 2 yrs)'
   - Optional 2: Under 'Patient Status' tab → tick 'Registered with MyMedicare'
3. **Conditions** tab → **Chronic** → **Diabetes** tick "**No**"
4. **Risk Factors** tab → **Other Risk** → select **Smoking, Alcohol and Obesity** - *you might have to reduce the amount of risk factors if you don't get any patients matching all criteria*



5. **Recalculate**



Tip: Use the **PIPQI** programs in CAT filter patients list by as **Smoking; BMI**, **Alcohol**, **Cervical Screening** and **CVD Risk** recorded

➢ **In Report Panel**

6. Optional: **Measures** tab → BP tab → select ">140/90" or no BP
7. Optional: refine your patients with **MBS Eligibility**

Optional 1: Health Assessment Eligibility

- ☐ 75+ year old (not billed in the past 12 months)
- ☐ 45 – 49 year old (never claimed)
- ☐ Indigenous (item 715)

Optional 2: Chronic Condition Management Eligibility

- ☐ CCM Plan Never Claimed
- ☐ CCM Plan >18 Months, No Review
- ☐ CCM Plan >18 Months, Review >6 Months
- ☐ CCM Plan 12-18 Months, No Review
- ☐ CCM Plan 12-18 Months, Review >6 Months

1. Optional: Select Export →  XLS File → Save (e.g. Create a folder C:/ClinicalAudit/CAT Patient Follow-up)
2. Optional: **filter patient list by provider** (select → Visits → Assigned Provider → Report button)
3. Optional: **create a Topbar prompt** (Daily CAT button → CV Event Risk →Export → Topbar Prompt button)

Use the **Measuring Outcomes table** to track progress and support **self-reflection** over time.

2.3 Activity – Identify Patients at Clinical Risk of Diabetes

RACGP recommends diabetes risk assessment every three years from age 40.

People with high- risk factors should have **annual HbA1c testing**
(or **AUSDRISK** every 3 years)[3]

CAT4 recipes: Identify Patients at Risk of Diabetes Mellitus type 2

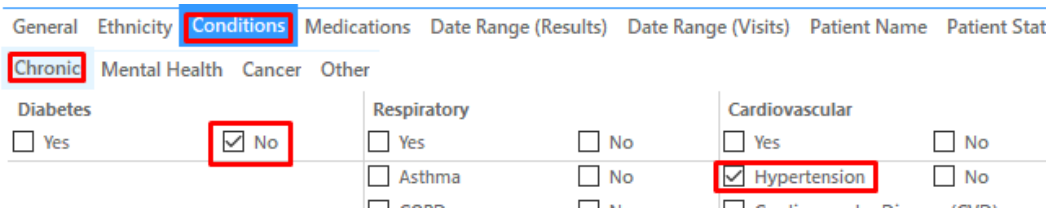
➢ **Starting point: Log into Pen CS CAT4** → Show Extracts → load latest data extract → Hide Extract

➢ **In Filter Panel**

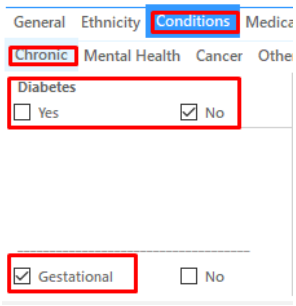
1. General tab →**Age** → **Start Age = 18**

2. Choose either **Active or MyMedicare status:**
   - Optional 1: Under 'General' tab → Activity → Select 'Active (3 x in 2 yrs)'
   - Optional 2: Under 'Patient Status' tab → tick 'Registered with MyMedicare'

3. **Optional 2: Patients with hypertension and age >=40 years**
   - **General tab** →**Age** → **Start Age = 40**
   - **Conditions** tab → **Chronic** tab → select **No to Diabetes** and tick **Hypertension**

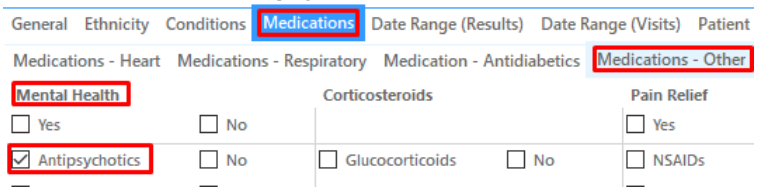


4. **Optional 2: Women with history of Gestational Diabetes Mellitus**
   Conditions tab → **Chronic** tab → select **No to Diabetes** and tick **Gestational**



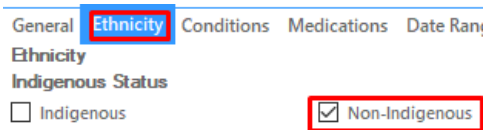
Encourage the patient with a history of Gestational Diabetes ***to join the National Gestational Diabetes Register***. This will allow them to receive reminders about annual diabetes testing.

5. **Optional 3: Patients taking anti-psychotic medication**
   Conditions tab → **Chronic** tab → select **No to Diabetes** → **Medications** tab → **Medications-Other tab**→ **Mental Health** tick **Antipsychotics**



Utilise the health assessment for people **aged 40 to 49, high risk of developing type 2 diabetes** or other targeted health assessments.

6. **Optional: Ethnicity tab**



7. **Recalculate**



2.4 Activity – At-risk of Diabetes & due HBA1C

Annual **HbA1c testing** is recommended for all adults to support **early identification and management** of diabetes risk.

*This activity is for identifying patients aged 40+ with a who **have not had an HbA1c test in the past 12 months** so they can be recalled and supported with Health Assessments or Care Plans if eligible.*

➢ **Starting point: Log into Pen CS CAT4** → Show Extracts → load latest data extract → Hide Extract

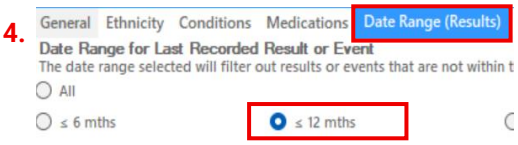
➢ **In Filter Panel**

1. General tab →**Age** → **Start Age = 40**

2. Choose either **Active or MyMedicare status:**
   - Optional 1: Under 'General' tab → Activity → Select 'Active (3 x in 2 yrs)'
   - Optional 2: Under 'Patient Status' tab → tick 'Registered with MyMedicare'

3. **Conditions** tab → **Chronic** → **Diabetes** tick "**No**"

4. **Date Range (Results)** tab → **≤12month**

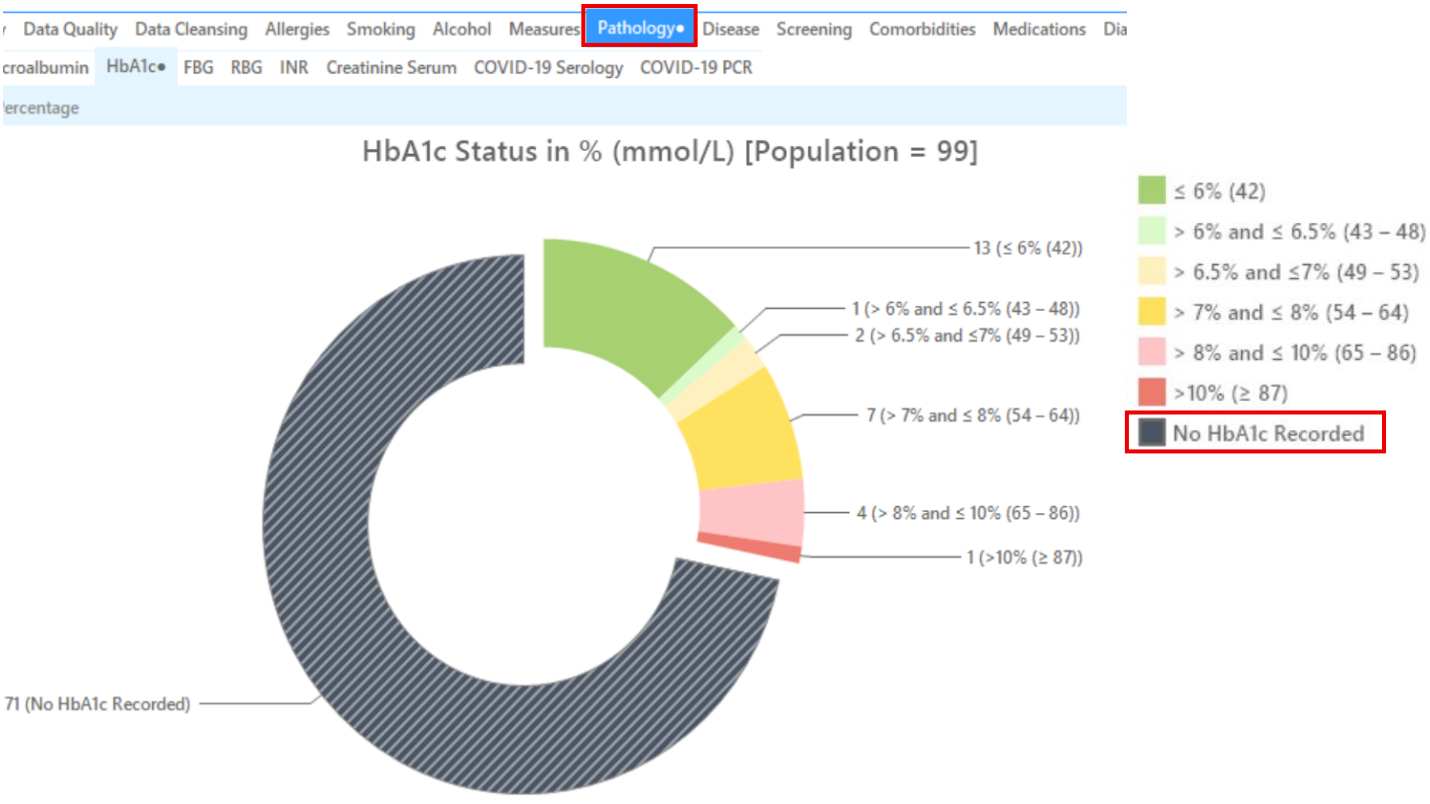


5. **Recalculate**



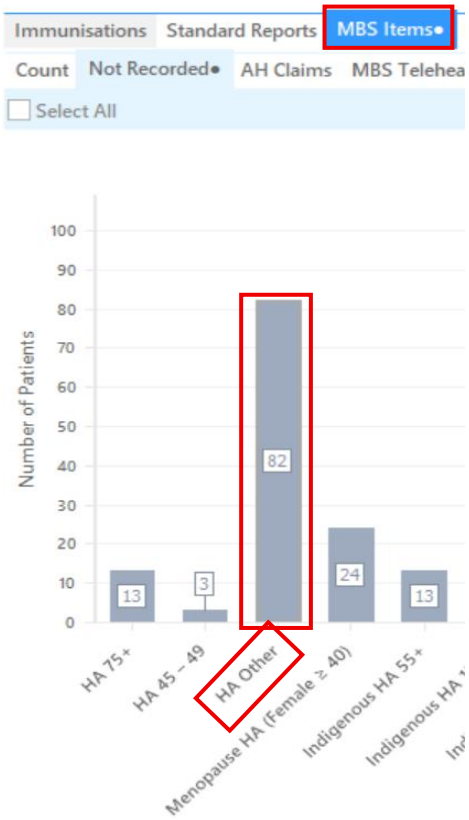
➢ **In Report Panel**

6. **Pathology** tab → **HbA1C** tab → select **no HbA1C Recorded**



7. Once you have selected no HBA1C recorded you can refine your patients with **MBS Eligibility** or **MBS items**

8. **MBS items** tab → **Not recorded** → select **HA other**
HA Other = a type 2 diabetes risk evaluation for people aged 40-49 years with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool



Utilise the health assessment for people **aged 40 to 49, high risk of developing type 2 diabetes** or other targeted health assessments.

9. Select **Report** to see the cross-tabulation report of patients with no HBA1C results in past 12 months for are due health assessment for people aged 40 to 49, high risk of developing type 2 diabetes.



8. Optional: Export → XLS File → Save (e.g. Create a folder C:/ClinicalAudit/CAT Patient Follow-up)

9. Optional: **filter patient list by provider** (select → Visits → Assigned Provider → Report button)

10. Optional: **create a Topbar prompt** (Daily CAT button → CV Event Risk →Export → Topbar Prompt button)

Use the **Measuring Outcomes table** to track progress and support **self-reflection** over time.

Module 3

Patient Registration & Engagement

On completion of this module, you will:

- Identify and use MyMedicare, GoShare, and awareness days to engage patients in pre-diabetes prevention and early detection.
- Apply patient invitation scripts and promote the 2kg Challenge to support preventive care.

Activity Navigation

3.1 Activity – Communication Toolkit
3.2 Activity – GoShare
3.3 Activity – Health Awareness Days
3.4 Activity – 5 Simple Steps

MyMedicare: Person-Centred Care and Pre-Diabetes

MyMedicare supports a person-centred approach to pre-diabetes prevention by strengthening partnerships between patients, GPs, and care teams.

Built on dignity, compassion, coordination, personalised care, and self-management, MyMedicare focuses on what matters to the patient.

In pre-diabetes, continuity, trust, and shared decision-making help patients act early and lower diabetes risk. Programs like **MyMedicare** and the **Patient Centred Medical Home** (PCMH) embed these values, improving engagement, access, and outcomes.

MyMedicare Patient Resources:

- MyMedicare - Poster 1
- MyMedicare - Poster 2
- MyMedicare - First Nations
- Our MyMedicare Patient Guide
- MyMedicare - DL Brochure
- Introducing MyMedicare Video
- Registering in MyMedicare Video

Bringing It Together

Using **MyMedicare**, **GoShare**, and the **2kg Challenge**, practices can engage patients early, strengthen relationships, and promote preventive action.

Early engagement reduces diabetes risk, improves wellbeing, and builds healthier communities.

For more information, refer to **Guidelines for Preventative Activities in General Practice**.

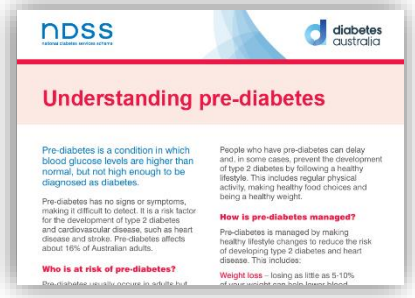
2kg Challenge: a free 8-week lifestyle program that supports small, meaningful changes.

It helps patients:

- Reduce risk of **diabetes** and **CVD**
- Improve **physical & mental health**
- Boost **social wellbeing**
- Increase **energy**

Western Sydney Diabetes Resources

Understanding Pre-Diabetes



ARE YOU AT RISK OF DIABETES? Flyer



3.1 Activity – Practice Communication Toolkit

We have developed a suite of promotional materials to share with your networks and increase registrations. No referral is needed, patients can sign up **here**

SMS (160 characters max):

Your blood test shows you may have Prediabetes. Book a doctor visit & join the 2kg challenge—losing just a little weight can help. Start today! **https://bit.ly/4cPjv8g**

Phone Script:

Hi [Patient's Name], this is [Your Name] from [Clinic Name]. I'm calling about your recent blood test.

Your HbA1c test shows you may have Prediabetes. This means your blood sugar is a bit high, and you could get diabetes if nothing changes.

But the good news? You *can* lower your risk! Even losing a small amount of weight—just 2 kilos—can really help.

We have a new program called the **2kg Challenge** that can help you get started. Would you like me to send you the details?

Also, we recommend making an appointment with your doctor to talk about your results. Would you like me to book that for you?

Social Media Post (Facebook/Instagram):

🚨 ***Prediabetes? Here's what you need to know.***

Before Type 2 diabetes starts, you might be told you have pre-diabetes. This means your blood sugar is higher than normal but not high enough to be diabetes. It's a warning to help you make changes to stay healthy and stop it from getting worse

Good news! you can **stop diabetes before it starts**.

- ✅ Losing just 2kg can lower your risk of getting type 2 diabetes by up to 30%
- ✅ Eat smart, move more
- ✅ A dietitian can help – ask your doctor today

Small changes = big results. 💪
#Prediabetes #StopDiabetes #2kgChallenge #YouCanDoThis



Download tile 1 **Download tile 2** **Download tile 3** **Download tile 4**

Website Copy:

You may be at risk for diabetes — here's what that means and what you can do.

Your recent HbA1c test shows you might have **Prediabetes**. This means your blood sugar is a bit high, but not yet high enough to be called diabetes.

That might sound scary—but here's the good news:

✓ Losing just 2kgs can lower your risk by 30%
✓ Eating well and staying active helps
✓ A dietitian can show you easy food and lifestyle changes

What's next?

- Talk to your GP soon
- Join the **2kg Challenge program**
- Ask about seeing a dietitian
- Start small — even small steps help a lot

You're not alone. We're here to help you stay healthy.

Waiting Room Screen

Download here



Poster and Flyer

Physical copies can be ordered directly from WentWest using the **CQI EOI Form** (limited allocation per practice).

Download here



Download here



GoShare

patient education platform

GoShare is a free* patient education platform enabling health professionals to send tailored, trusted resources—such as videos and fact sheets—via email or SMS to help patients manage their health, improve health literacy, and boost engagement.

GoShare **topics** including patient stories, information sheets, animations & more including

- Western Sydney Diabetes Together
  - **2kg challenge**
  - Basic dietary advice
  - How much should I eat?
  - What is Haemoglobin A1C?
  - Understanding Carbohydrates
  - How to get active
  - How is diabetes detected?

To get started or request access, please contact our team support@wentwest.com.au

**Free access provided through WentWest for general practices in* Western Sydney.

Quick Instructions

For Best Practice (BP) Users
Using GoShare BP PSI Integration

1. **Install & Access:**
   - Ensure GoShare PSI is installed and activated in Best Practice. GoShare PSI download instructions
   - Log into GoShare PSI.
2. **Create Campaign**
   - Choose eligible patients by selecting a pre-built query from the GoShare PSI library.
3. **Send Bundle**
   - Choose SMS or email delivery.
   - Review and send to patients (you can stagger the sending in batches).

All Users – Web-Based
Using GoShare Portal

1. **Log In:** https://goshare.realtimehealth.com
2. **Build a Bundle**
   - Find Heart Health Check resources (videos, fact sheets).
   - Click "Add to bundle", then ★ (star icon) to save.
3. **Send to Patients**
   - Click "Send bundle to list".
   - Download CSV template.
   - Populate with patient details (Name, Phone, Email).
   - Upload, review, and send.
   - Direct Sends (Optional).
   - Click "Send bundle" → "New Recipient" → enter details → "Done".

For Medical Director /Zedmed Users
Using CAT4 & GoShare Plus

1. **Extract Patient List**
   - Open CAT4, apply filters:
     i. ≥2 visits in 24 months
     ii. Risk factors
     iii. With or at risk of Diabetes
   - Export selected patient list as CSV file.
2. **Upload to GoShare Plus**
   - Log into GoShare Plus.
   - Select MyMedicare or CCM bundle.
   - Upload CSV via "Send bundle to list".
   - Match fields and send via SMS or email.
   - Follow Up.

3.3 Activity - Health Awareness Days

Use these 2025 dates to run targeted promotions, social media posts, clinics, or patient education campaigns:

Date / Month	Health Event	GP Promotion Idea	Link to 2kg Challenge / Screening
March 3-16	Seniors' Week (NSW) Festival	Offer free diabetes risk checks for over 60s	HbA1c testing + 2kg Challenge for healthy ageing
March 4	World Obesity Day	Waiting room "Know Your Risk" station	Highlight small weight loss (2kg) reduces risk
April 9-17	NSW Youth week	Target at-risk youth (family history, above a healthy weight)	Early HbA1c testing + prevention focus
May 31	World No Tobacco Day	Link smoking cessation with diabetes prevention	Combine quit support with risk screening
June	Men's Health Month	Men's health clinic: HbA1c, BP, waist checks	"Just 2kg can lower your risk" messaging
July	Dry July	Encourage alcohol-free month check-ups	Include HbA1c testing & 2kg Challenge
July 13-19	National Diabetes Week	Posters, SMS reminders, screening blitz	Promote 2kg Challenge + HbA1c priority testing
July 7-14	NAIDOC Week	Partner with Aboriginal health workers	Culturally safe risk checks + 2kg Challenge
September 1-5	Women's Health Week	Invite women with GDM/PCOS/menopause history	Risk checks + small steps prevention messaging
September 2-8	Body Image & Eating Disorders Awareness Week	Promote balanced self-care, not drastic changes	"Even 2kg makes a difference"
October	Mental Health Month	Screen patients on antipsychotics or with depression	Integrate metabolic & diabetes risk checks
November	National Diabetes Month	Whole-practice campaign & HbA1c blitz	"1 in 3 don't know they're at risk" + 2kg Challenge
November 14	World Diabetes Day	Blue Day: staff in blue, free risk assessments	Point-of-care HbA1c + 2kg Challenge promotion

Interested in viewing a full calendar year of Health Awareness events click **here**.

3.4 Activity – 5 Simple Steps

Help your patients become familiar with the 5 simple steps of the 2kg challenge! The 8-week program will take them through each of these steps:

Step 1: Choose a coaching service

Here are two great programs to help patients take their first step toward a healthier lifestyle:

Get Healthy Service

- Free online or phone health coaching
- A personal coach to set goals, stay motivated, and build healthier habits at times that fit their schedule
- Support available for Aboriginal communities, people who speak different languages, and those using the National Relay Service

No Money No Time

- Easy-to-use website with practical food and nutrition tips
- Free quiz to understand eating habits
- Personalised advice and quick, healthy recipes from experts
- Options to save results, set goals, and track progress

Step 2: Exercise options in Western Sydney

Face-to-Face Programs

- Active and Healthy
- Blacktown City Council
- Blacktown Older Women's Network
- CanToo
- City of Parramatta
- Beat It – Diabetes Exercise Program
- Football NSW Walking Football
- Heart Foundation Walking Groups
- Live Life Get Active

Face-to-Face Programs

- North West Community Services Inc
- Parkrun
- Ramblers
- Reclink Australia
- Robinhood Free Outdoor Fitness
- The Big Issue, Street Soccer
- The Hills Shire Council
- Western Sydney Parklands
- Workers Blacktown, Line Dancing

Online Programs

- Active and Healthy
- City of Parramatta
- Exercise Right
- Get Active Victoria
- Live Life Get Active
- NHS Fitness Studio Exercise Videos
- Virtual Y

Step 3: Handy tools and resources

Western Sydney Healthy Living Resources

- Healthy Recipe Book
- Healthy Living Options
- Affordable Food Edition
- Out & About Directory
- Online Edition - Healthy Living Options

Additional Resources

- Educational Videos – Western Sydney Diabetes
- Brochures – Western Sydney Diabetes
- Food, Cooking & eBook – No Money No Time
- Healthy Eating Quiz – No Money & No Time
- Recipes, Hacks & More – No Money & No Time

Step 4: 'Keep it Up'

- **Setting Realistic Person-centred goals** – use Get Healthy Action Plan
- **at Smart** - Try the Healthy Eating Quiz from No Money No Time
- **Stay Active** – refer to Step 2
- **Self-Monitor** – Visit your GP quarterly basis – use Get Healthy daily checklist or activity planner
- **Stay Informed** - refer to Step 3 or explore our event calendar.

Step 5: Become a 2kg Champion

Celebrate how far you've come by becoming a 2kg Champion! Tell your family, friends, and doctor about the 2kg Challenge. Follow us on Facebook and Instagram

Module 4

Appendices

4.1 Model for Improvement and PDSA cycles

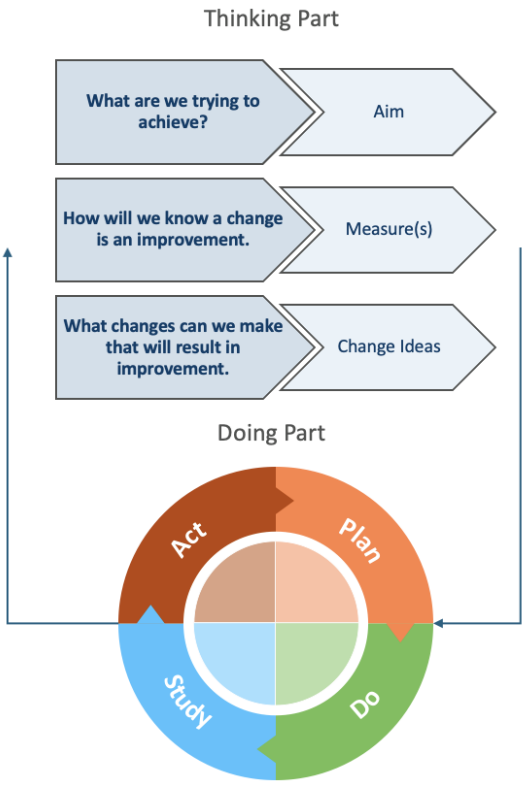
Start by documenting **your practice QI team** and define your problem and specified a robust ***Problem Statement***.

Practice name:	*Add your primary healthcare service name here*	**Date:**	Start date
QI team:	*List the team members involved*		
Problem:	*Describe why this work is strategically important. What problem is the team addressing? What does our data indicate about it, and what are the causes?*		
Problem Statement:	*Document your succinct problem statement here*		

Next, move onto the **Model for Improvement (MFI)**, the **'Thinking Part'** focuses on the overall improvement strategy, while the **'Doing Part'** implements changes through the **Plan-Do-Study-Act (PDSA) cycle**. This model uses PDSA cycles to test changes, ensuring measurable and sustainable improvements. Watch short video on MFI and PDSA's.

Step 1: Model for Improvement (Thinking Part)

1. **Goal / Aim:** What are we trying to accomplish? Develop a S.M.A.R.T. (Specific, Measurable, Attainable, Realistic, Time-bound) and people-crafted Aim Statement.
2. **MEASURE:** How will we know that a change is an improvement? Identify what good looks like and develop a measure(s) of success.
   Tip: *Use a **Run Chart** to plot trends.*
3. **CHANGE IDEAS:** What changes can we make that will result in an improvement? Engage the whole team in formulating change ideas *using* ***Institute for Healthcare Improvement QI tools*** such as brainstorming, ***driver diagrams*** or ***process mapping*** **Each change idea may involve multiple small rapid PDSA cycles.**



Step 2: Plan-Do-Study-Act (PDSA) (Doing Part)

1. PLAN: Describe the change idea (what, who, when, where). Predict outcomes and define the data to collect.

2. DO: Carry out the plan. Collect data. Consider what worked well and why? Document any unexpected observations, events or problems.

3. STUDY: Analyse results, compare them to predictions, and reflect on what you learned.

4. ACT: Based on what you learned from the test, consider what you will do next (e.g., adopt, adapt or abandon)? How does this inform the plan for your next PDSA?

For guidance, download template or for support on conducting quality improvement in your primary healthcare services, please contact the WentWest Primary Care Delivery team on support@wentwest.com.au

Source: Langley, G., Nolan, K., Nolan, T., Norman, C. & Provost, L. 1996, The Improvement Guide, Jossey-Bass, San Francisco, USA

MFI and PDSA – Diabetes Prevention

Practice name: [Insert Practice Name]
Date: [Insert Date]
QI Team: [List GPs, nurses, admin, practice manager, pharmacist if applicable]

Problem Statement

Our practice needs to improve early detection of Prediabetes and patient referral to lifestyle programs (e.g., the 2kg Challenge, Get Healthy Service). Current data shows many at-risk patients have had an up-to-date HbA1c and are not consistently referred to prevention programs.

Model For Improvement (MFI)

AIM	1. What are we trying to accomplish?
Increase the proportion of active patients aged 40–74 with diabetes risk recorded (HbA1c) from __ patients (X%) to ___ patients (Y%) by [insert date, e.g. 6 months], and increase referrals to lifestyle prevention programs by 20% in the same period.	
MEASURE(S)	**2. How will we know that a change is an improvement?**
• **Process:** % of eligible patients with documented HbA1c. • **Outcome:** % of eligible patients referred to a diabetes prevention program (2kg Challenge, Get Healthy Service). • **Balancing:** Staff time required for recalls and data entry.	
CHANGE IDEAS	**3. What changes can we make that will result in improvement?**
Idea 1	**Use CAT4 recipes to identify at-risk patients with no recent HbA1c recorded (if clinically relevant)**
Idea 2	**Use nurse-led workflows to check HbA1c status during chronic disease checks and opportunistic visits.**
Idea 3	**Send GoShare education bundles and SMS recalls promoting the 2kg Challenge.**
Idea 4	**Engage admin to book eligible patients for Diabetes Risk Assessments + referral in bundled appointments.**
Idea 5	**Host a practice-wide Diabetes Awareness Week with opportunistic risk assessments.**
Next steps:	*Each idea may involve multiple short and small PDSA cycles.*

Plan-Do-Study-Act (PDSA)

Idea	Plan	Do	Study	Act
1.1	Use CAT4 to identify patients at risk and recall them for HbA1c + referral. • Who: Practice Manager runs CAT4, Admin sends SMS recalls. • When: Week 1–2. • Where: At practice. • Prediction: At least 20% will book within 2 weeks.	Extracted patient list. Sent SMS to 50 patients. Bookings monitored in recall system.	15/50 (30%) booked appointments. Of those, 10 completed HbA1c, 6 referred to 2kg Challenge. Admin reported SMS system worked smoothly; some outdated phone numbers.	Clean patient contact details before next recall. Scale to 100 patients next month. Add a script for receptionists to mention prevention programs when patients call.
2.1	Introduce **Diabetes Risk Assessments** at opportunistic visits. • Who: Practice nurse. • When: During BP checks, care plans, flu clinics (Week 3–4). • Prediction: Nurses will identify 10 new at-risk patients weekly.	Nurses trialled **Diabetes Risk Assessments** during 20 opportunistic visits. Results documented in clinical software.	12 patients screened, 8 high-risk, 5 referred to 2kg Challenge. Nurses confident with process but requested a quick electronic template.	Create a Best Practice/Medical Director template for **Diabetes Risk Assessments**. Provide refresher training for nurses on referral pathways. Expand to all nurse-led clinics.

4.2 Measuring Outcomes – Audit Worksheet

1. Choose the QI activity measure that aligns with your practice goal
2. Enter a practice target and baseline for each QI activity measure in the table below
3. Track your progress over time by entering a result for reporting period.
4. Consider run charts to plot results over time.

Measure:	Practice Target	Baseline date	Result 1 date	Result 2 date	Result 3 date	Result 4 date
Example PIPQI	*# (%)*	*%*	*# (%)*	*# (%)*	*# (%)*	*# (%)*
MyMedicare registered patients						
MyMedicare registered and CCM patients						
Patients due for CCM or review						
Patients with 'Diabetes'						
Patients with a billed Care Plan in the past 12 months						
Insert QI activity measure						
Insert QI activity measure						
Insert QI activity measure						

** Per RACGP, an active patient has **3+ visits in 2 years**. This filter may exclude new or at-risk patients who don't see their GP regularly*

4.3 Group reflection – after completing activities

Measuring Outcome CPD Tip: Collaborate as a team to generate a **CAT4 list of patients per GP.**

As a team, analysis and review **baseline** data results and discuss change ideas and actions.
Use **PDSA cycles** to test and measure change ideas

The degree to which the learning needs were met:	To what degree this activity was relevant to your practice:
☐ Not met ☐ Partially met ☐ Entirely met	☐ Not met ☐ Partially met ☐ Entirely met

What did you learn? What changes would you make to your practise as a result?

What did you learn?

- *Data cleansing is essential before running recalls (outdated contacts reduced effectiveness).*
- *Nurses can confidently complete Diabetes Risk Assessments when provided with clear templates and referral pathways.*
- *Patients were more engaged when they received GoShare resources or education about the 2kg Challenge.*
- *Opportunistic screening (flu clinic, BP checks) is a powerful way to catch under-screened patients.*

What changes will you make?

- *Incorporate the 2kg Challenge and Prediabetes assessment into nurse-led workflows and chronic disease reviews.*
- *Incorporate GoShare education bundles into all recalls and opportunistic screening.*
- *Clean and update patient contact information regularly.*
- *Continue quarterly PDSA cycles to monitor uptake of diabetes risk assessments and referrals.*
- *Celebrate small wins to keep the team motivated and engaged.*

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WentWest the Western Sydney Primary Health Network