phn MURRAY

An Australian Government Initiative

# QUALITY IMPROVEMENT FOR GENERAL PRACTICE

## 2022 HANDBOOK

Murray PHN acknowledges its catchment crosses over many unceded First Nations Countries following the Dhelkunya Yaluk (Murray 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 listen 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 handbook has been developed by Murray PHN using, in part, information from documents originally developed by North Western Melbourne PHN, Eastern Melbourne PHN and South Brisbane PHN.

### Disclaimer

While the Australian Government Department of Health has contributed to the funding of this material, the information contained in this toolkit does not necessarily reflect the views of the Australian Government and is not advice that is provided, or information that is endorsed, by the Australian Government. The Australian Government is not responsible in negligence or otherwise for any injury, loss or damage however arising from the use of or reliance on the information provided herein.

## Contents

# PURPOSE

This toolkit is designed to help general practice complete quality improvement (QI) activities and improve patient information in medical records. It focuses on priority populations and health conditions identified through Murray PHN's comprehensive needs assessment. Quality improvement activities will benefit not only your practice, but the health outcomes of your patients and the community.

# MURRAY PHN HEALTH NEEDS ASSESSMENT

Murray PHN generates a full Health Needs Assessment every three years and updates it annually to reflect local emerging or changing issues. The Health Needs Assessment is a population health-based analysis of the health needs of our communities. Combined with the national health priorities set by the Commonwealth Government, the Health Needs Assessment helps Murray PHN determine our region's local health priorities. Based on this understanding of regional needs, we engage and work with primary health care and local communities to improve health and wellbeing for everyone. Find our latest Health Needs Assessment here: murrayphn.org.au/about/keydocuments/

# PRIORITY AREAS

# QUALITY IMPROVEMENT IN GENERAL PRACTICE

Quality improvement is a system of monitoring and refining processes to improve coordination of care and deliver better health outcomes for patients.

The Royal Australasian College of General Practitioners (RACGP) defines continuous quality improvement as an ongoing activity undertaken within general practice. The primary aim is to monitor, evaluate and improve the quality of health care delivered to patients.

Undertaking quality improvement activities leads to positive change in practices, particularly when implemented using a whole practice approach. It aims to refine systems and workflows, resulting in sustainable improvement. Improving aspects of your practice helps you to deliver better care and health outcomes to your patients. Participating in quality improvement also makes the practice a better place to work and encourages a stronger and more viable business.

Most health services will have a significant amount of data about their patients. This data can provide a powerful insight into a patient's current and potential future state of health. Quality improvement activities encourage use of this information at a practice level.

Benefits and outcomes of quality improvement are often categorised into the following areas:

- Improving patients' access to quality and safe care and delivering better health outcomes
- Enhancing staff satisfaction, morale and teamwork, and building a sustainable workforce
- Reducing the burden of disease, avoidable hospitalisations and health inequalities locally
- Minimising costs by improving the return on innovative investments and managing the cost of providing care.

Examples:

| | |
|---|---|
| **Immunisation** | Promote influenza immunisation to persons aged 65+ to improve by 5% |
| **Chronic disease** | Increase uptake of asthma care plans by 20% by January 2020 |
| **Digital health** | Increase number of Shared Health Summaries by 15% of active patients |
| **Workforce** | Undertake a team health check before December 2019 and identify opportunities for professional development for each staff member |

## Using your practice data to drive quality improvement

Murray PHN can provide several tools to help practices to analyse and improve their data.
The PEN CS suite including CAT4 and Topbar are provided at no cost. The benefits of using these tools include:

- Enhance the quality of patient information in your practice to:
  - Support more coordinated, comprehensive care
  - Improve quality and safety
  - Meet accreditation standards
  - Increase practice revenue
- Monthly benchmarking reports that your practice can use to reflect on and gain insights into opportunities for quality improvement
- Enrich the understanding of population health needs in the Murray PHN region.

## CAT 4

- CAT4 is the software used by practices to submit data to Murray PHN for the purposes of the Practice Incentives Program Quality Improvement (PIP QI) payment.
- The PIP Eligible Data Set is de-identified patient data, aggregated at the practice level that can be analysed by demographics and clinical factors.
- There are 10 PIP QI measures and this data is provided to the Australian Institute of Health and Welfare on a quarterly basis.
- Data sharing enables eligibility for the PIP QI Incentive payments. Murray PHN is measured by the Commonwealth Department of Health on PIP QI compliance and the percentage of data sharing practices.

## Data quality improvement support

Identifying patients for QI activities and communicating with them relies on recording accurate patient information, including date of birth, address, ethnicity and mobile phone number. It also relies on test results and text recorded. For example, effective immunisation numbers rely on all the data elements to be accurate and recorded in the correct place within your clinical software.

Your local Quality Improvement Consultant can also assist you with data cleansing through the Murray PHN Data Quality Program.

### *Recommended approach to sustainable quality improvement*

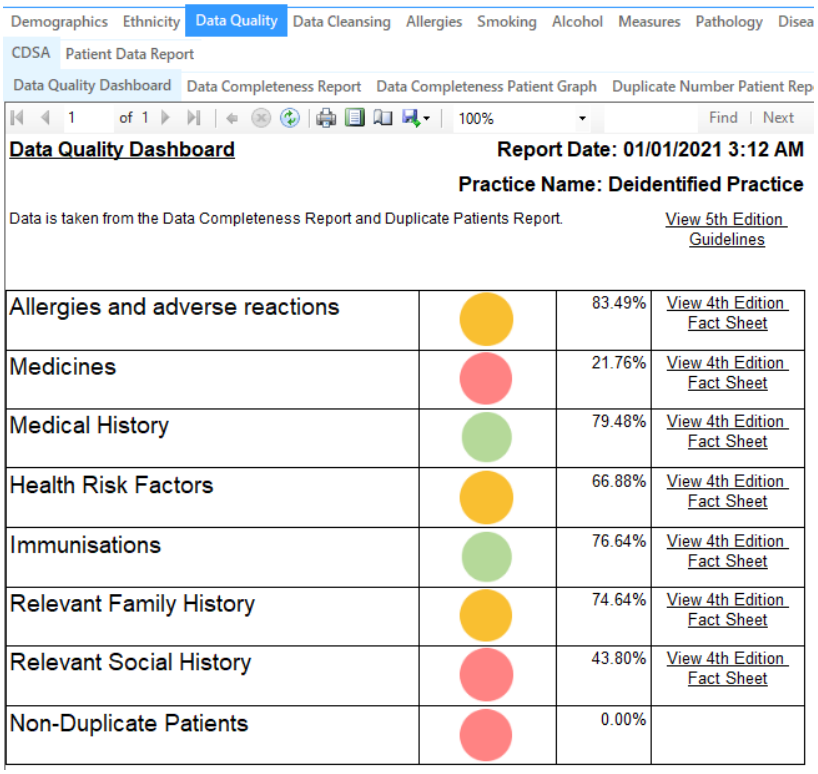
1. Implement a sustainable data collection, recording and maintenance process
2. Develop an understanding of how clean and complete your clinical database is and identify any gaps
3. Work with your team and discuss any missing or inaccurate data you've found and then identify gaps in the collection, recording and maintenance process. A detailed list of CAT recipes can be found here: http://help.pencs.com.au/display/CG

# EXAMPLE: USING CAT PLUS

To view your current data quality in your CAT 4, simply open your Data Quality report tab. Ensure you have applied the Active (3x visits in 2 years) filter to give you the most accurate results.

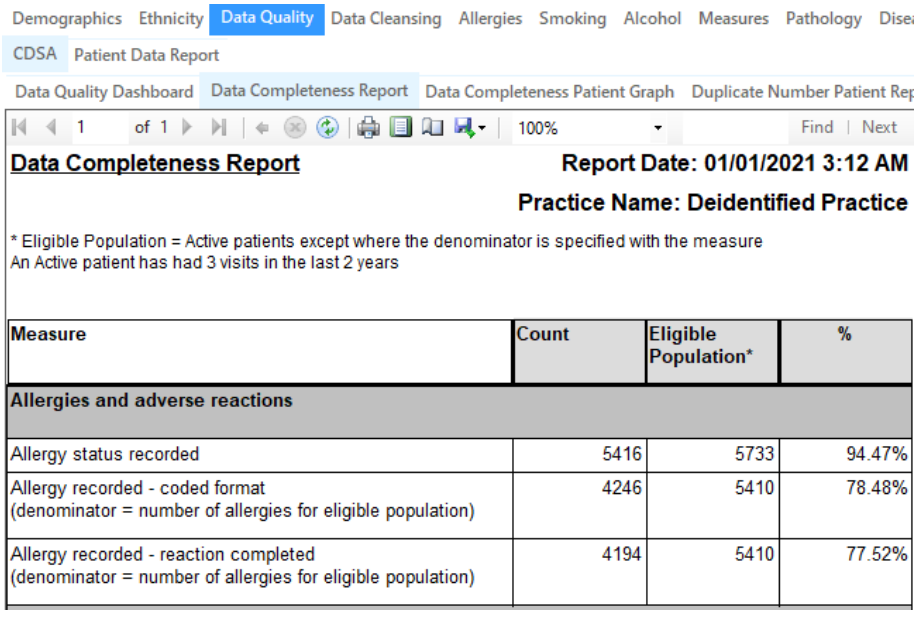
## EXAMPLE: Data Quality Dashboard

This dashboard provides a report indicating the overall status of data quality based on the data indicators. It displays each data content section with a traffic light status icon calculated from the percentage completeness of each data indicator within the section. This feature provides practices with on overview of their data quality.



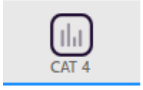

| | | | |
|---|---|---|---|
| Allergies and adverse reactions | | 83.49% | View 4th Edition Fact Sheet |
| Medicines | | 21.76% | View 4th Edition Fact Sheet |
| Medical History | | 79.48% | View 4th Edition Fact Sheet |
| Health Risk Factors | | 66.88% | View 4th Edition Fact Sheet |
| Immunisations | | 76.64% | View 4th Edition Fact Sheet |
| Relevant Family History | | 74.64% | View 4th Edition Fact Sheet |
| Relevant Social History | | 43.80% | View 4th Edition Fact Sheet |
| Non-Duplicate Patients | | 0.00% | |

For a more detailed analysis, practices can view the Data Completion Report. This report provides a percentage of completeness for each data indicator.




| Measure | Count | Eligible Population* | % |
|---|---|---|---|
| **Allergies and adverse reactions** | | | |
| Allergy status recorded | 5416 | 5733 | 94.47% |
| Allergy recorded - coded format (denominator = number of allergies for eligible population) | 4246 | 5410 | 78.48% |
| Allergy recorded - reaction completed (denominator = number of allergies for eligible population) | 4194 | 5410 | 77.52% |

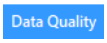
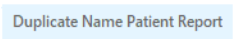
## EXAMPLE: Data cleansing - CAT 4 Recipes




### *Improve patient demographic information*

1. **Duplicate patient report, by name:** This report will enable you to view, print and/or save a list of patients with matching demographic information. You can also use the 'Duplicate Number Patient Report' to view patients with matching Medicare number, HCC numbers or DVA number.

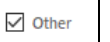
| | |
|---|---|
|   | Click on the 'Clear Filters' button from the menu bar before starting a new search |
|   | Click on the 'View Population' button in the menu bar to view the results. |

| | |
|---|---|
|   | In the report section of the screen, select the 'Data Quality' tab |
|   | Select the 'Duplicate Name Patient Report' sub tab. |

2. **Patient with no date of birth entered:** This report will enable you to add a note into the patient's file as a prompt to update the missing information during their next appointment.

| | |
|---|---|
|   | Click on the 'Clear Filters' button from the menu bar before starting a new search |
|   | From the filters panel under the 'General' tab select 'No Age' under the Age column |
|   | Click on the 'Recalculate' button from the menu bar |
|   | Click on the 'View Population' button in the menu bar to view the results. |

3. **Patient with no gender entered:** This report can be used to identify and correct patients' records with no gender recorded.

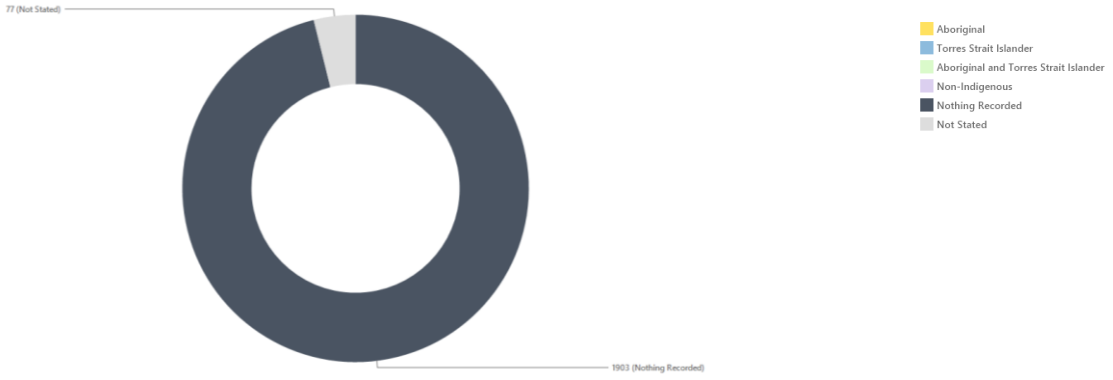
| | |
|---|---|
|   | Click on the 'Clear Filters' button from the menu bar before starting a new search |
|   | From the filters panel under the 'General' tab select 'Other' under the Gender column |
|   | Click on the 'Recalculate' button from the menu bar |
|   | Click on the 'View Population' button in the menu bar to view the results. |

## EXAMPLE: Data cleansing - CAT 4 Recipes

CAT 4

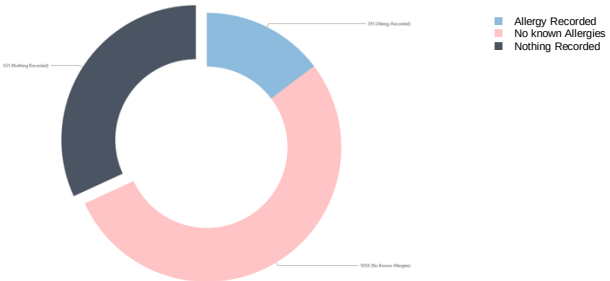
### *Improve recorded patient risk factor information*

1. **Identify patients with missing ethnicity status**

| | |
|---|---|
| Clear Filters | Click on the 'Clear Filters' button from the menu bar before starting a new search |
| Recalculate | Click on the 'Recalculate' button from the menu bar |
| Ethnicity | In the apply filter section of the screen, select the 'Ethnicity' tab |
| The ethnicity graph will display as below. Select the 'Not Recorded' slice of the graph   | |

Online resource: help.pencs.com.au/display/CG/Ethnicity

2. **Identify patients with missing allergies and/or adverse reactions**

| | |
|---|---|
| Clear Filters | Click on the 'Clear Filters' button from the menu bar before starting a new search |
| General<br>Active (3x in 2 yrs) | From the filters panel under the 'General' tab select the 'Active (3x in 2yrs)' box |
| Recalculate | Click on the 'Recalculate' button from the menu bar |
| Allergies | In the reports pane select the 'Allergies' tab |
| Click on the 'nothing recorded' slice of the graph   | |
| Export | Click 'Export' on the top right of the graph window. This will show a list of all patients with no allergy status recorded. |

Note:

- To identify patients with no smoking status recorded, the process is the same, only that you use the 'Smoking' tab on the reports pane.
- To identify patient with no alcohol status recorded, the process is the same only that you use the 'Alcohol' tab on the reports pane.

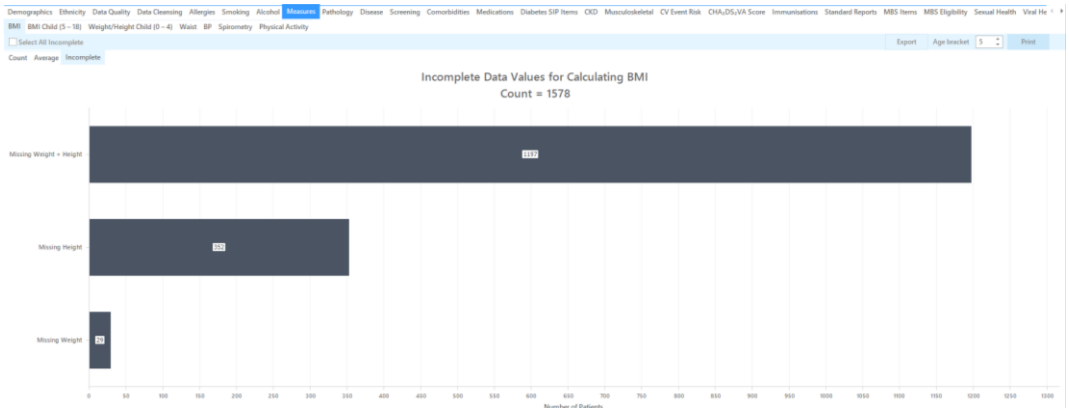
## EXAMPLE: Data cleansing - CAT 4 Recipes

CAT 4

### *Add weight, height and waist measurements to patient record*

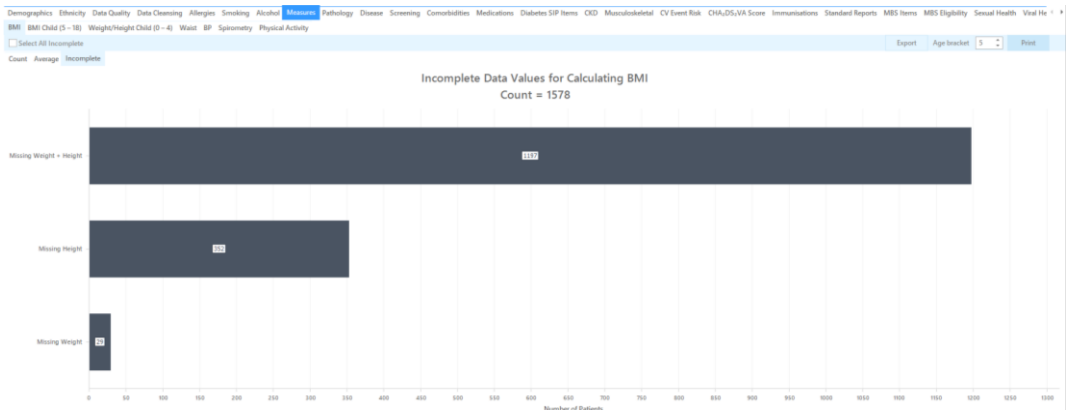
**1. Identify patients with missing weight/height**

- Click on the 'Clear Filters' button from the menu bar before starting a new search
- From the filters panel under the 'General' tab select the 'Active (3x in 2yrs)' box
- Click on the 'Recalculate' button from the menu bar

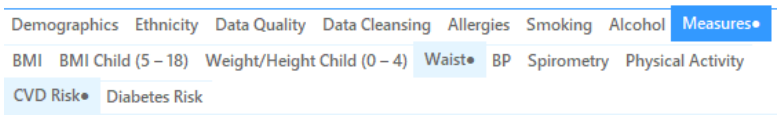
| | |
|---|---|
| Clear Filters | Click on the 'Clear Filters' button from the menu bar before starting a new search |
| General<br>Active (3x in 2 yrs) | From the filters panel under the 'General' tab select the 'Active (3x in 2yrs)' box |
| Recalculate | Click on the 'Recalculate' button from the menu bar |
| Measures | In the reports pane select the 'Measures/BMI/Incomplete' tab. This will show you the numbers of patients with missing weight, height or both values<br>  |
| Export | Click 'Export' on the top right of the graph window. This will show a list of all patients with no weight/height measures recorded. |

2. **Identify patients with missing waist:** Waist is generally measured for adults. The age group of interest is dependent on your population and risk factors.

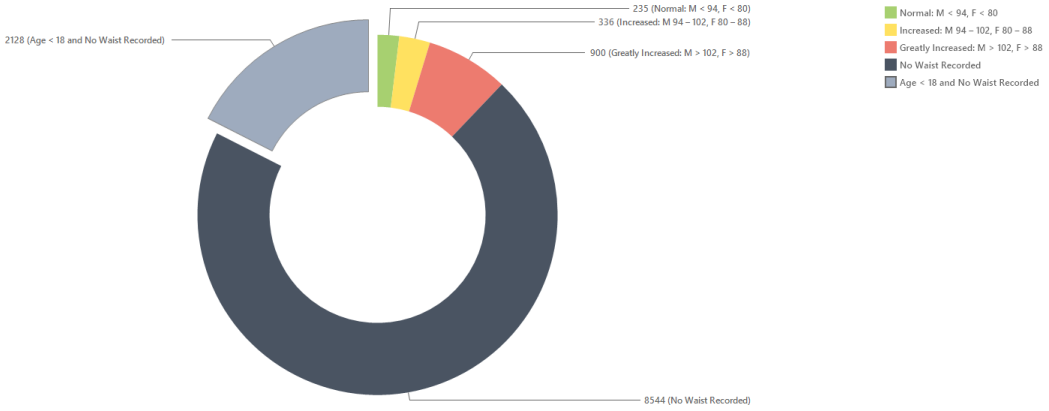
| | |
|---|---|
| Clear Filters | Click on the 'Clear Filters' button from the menu bar before starting a new search |
| General<br>Active (3x in 2 yrs) | From the filters panel under the 'General' tab select the 'Active (3x in 2yrs)' box |
| Start Age<br>End Age<br>Yrs Mths | In the 'General' filter tab, enter the 'Start Age' where prompted |
| Recalculate | Click on the 'Recalculate' button from the menu bar |

| | |
|---|---|
| Measures | In the reports pane select the 'Measures/BMI/Incomplete' tab. This will show you the numbers of patients with missing weight, height or both values<br>  |
| Export | Click 'Export' on the top right of the graph window. This will show a list of all patients with no weight/height measures recorded. |

To find patients with missing weights, use the 'Measurements/Waist' tab.
There are two different graphs available, one for cardiovascular disease (CVD) risk and one for diabetes risk.




Click once to select 'no waist recorded' slice of the graph




| | |
|---|---|
| Export | Click on 'Export'. This will create a list of patients with no waist recorded. |

Online resource: Additional Data Quality CAT 4 Recipes including bulk cleansing can be accessed on the PEN CS help website: help.pencs.com.au/display/CR/Improve+Data+Quality

# PRACTICE INCENTIVES PROGRAM (PIP) QUALITY IMPROVEMENT (QI) INCENTIVE

The PIP QI Incentive is designed for general practice to encourage changes that are relevant to your patient population. It allows you to focus on improving patient outcomes and access to care while also developing a more effective business.

## How the new payment works

The PIP QI payment has been available to general practices since 1 August 2019. It is for practices that choose to participate in quality improvement activities to improve patient outcomes and deliver best practice care.

General practices wanting to qualify for the incentive need to work with Murray PHN to undertake the collection, submission and review of a de-identified set of data.

As with all other PIP incentives, registration and payment for the PIP QI Incentive is through Services Australia which administers the PIP on behalf of the Australian Department of Health.

Participation in the incentive is voluntary, and practices may withdraw at any time by completing the following form: servicesaustralia.gov.au/ip007

## Eligibility criteria and how to apply

To be eligible to receive a PIP QI Incentive payment, general practices must:

- Be eligible for the PIP and hold a PIP identifier
- Register for the PIP QI Incentive payment: servicesaustralia.gov.au/quality-improvement-incentive-for-practice-incentives-program?context=23046#a1
- Electronically submit the PIP Eligible Data Set (comprising of 10 Improvement Measures) to Murray PHN quarterly
- Undertake quality improvement activities in partnership with Murray PHN.

## Qualifying for the PIP QI payment

To qualify for the PIP QI payment, general practices must:

- Participate in continuous quality improvement activities
- Submit the PIP Eligible Data Set to Murray PHN.

For answers to frequently asked questions, visit: servicesaustralia.gov.au/quality-improvement-incentive-for-practice-incentives-program?context=23046#a3

## After you apply

It is important to let Murray PHN know if you are or are interested in participating, so our Quality Improvement Consultants can support you. Partnering with Murray PHN will enable you to:

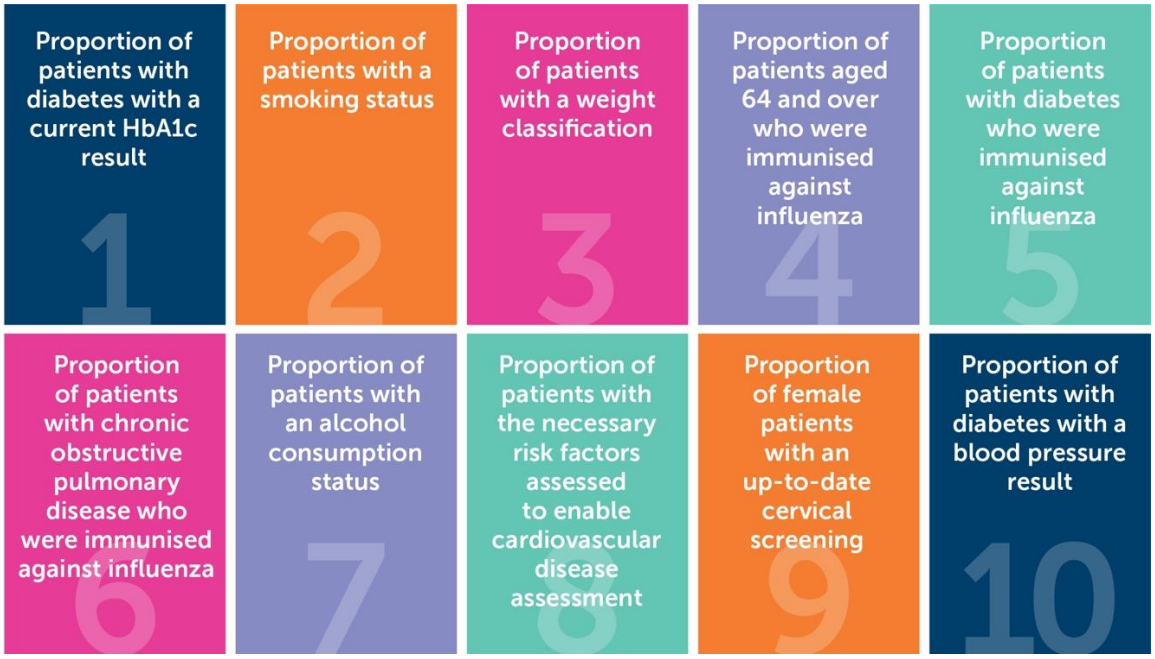
- Enter into data sharing and licencing agreements
- Plan and implement quality improvement activities
- Monitor and report to meet the requirements of PIP QI.

## The 10 improvement measures

To meet the PIP QI Incentive eligibility requirements, general practices must submit the below PIP Eligible Data Set (MDS). The MDS is comprised of 10 improvement measures that represent key health priority areas. The areas of chronic disease are those that are largely responsible for the burden of disease in Australia, and their associated risk factors.

Data-informed quality improvement in these areas may help to delay progression of chronic conditions, improve quality of life, increase life expectancy and decrease the need for high-cost interventions. The de-identified data will also aid public health policy, planning, service delivery and trend analysis.

### *Improvement measures*




Practices can focus their quality improvement activities on these 10 improvement measures, noting there are no prescribed targets associated with any of the measures. Practices will also be required to show evidence of quality improvement activities in other areas that meet the needs of their practice population.

## Murray PHN's role

Murray PHN supports general practice with continuous quality improvement activities through the collection and review of practice data on the above 10 improvement measures.

Participating practices are required to share a minimum set of de-identified aggregated data with Murray PHN, such as the number of patients who are diabetic, the percentage who smoke and their weight profile.

There is no requirement for individual patient data, and any measures from an individual practice will not be available to the Department of Health.

More information on general medical data collection can be found on the Department of Health's website: health.gov.au/internet/main/publishing.nsf/Content/Data-Access-Release-Policy

# DATA ANALYSIS TOOLS

To meet the PIP QI data reporting requirements, data must be collected and stored correctly. There are various clinical audit tools available to extract, report and visualise data, including PHN Exchange GP Data Report, CAT Plus and POLAR. Murray PHN will assist you in using the most appropriate tools for your practice.

## Data sharing

Practices that are currently sharing data with Murray PHN must comply with the PIP QI guidelines, in addition to existing PIP guidelines. Our Quality Improvement Consultants will need to record your PIP Practice Identifier to ensure the quarterly data submissions are scheduled.

You will need to update your current data sharing and licencing agreements with Murray PHN.

Murray PHN can provide you with information on QI activities and training, and access to a GP Data Report including the 10 improvement measures. This report is designed to give you a visual snapshot of your practice.

## PHN Exchange

PHN Exchange is a web-based, printable summary of individual practice data. It is easy-to-read reports that tracks trends over time and provides a benchmarking function.

### *Key features include:*

- Web-based data reporting system tailored to individual general practices
- Automated with up to 15-months trends updated monthly
- Provides data quality reporting for PIP QI.

### *Actionable data includes:*

- Demographic data
- Disease prevalence
- Screening rates
- Chronic disease management
- Identifies clinical care, quality and business opportunities.

The report is available to practices that data share with Murray PHN and it is displayed on the secure PHN Exchange platform. It is confidential and is not shared with any other practice.

The report is not intended to replace your own practice's data analysis but uses de-identified data to display data quality trends over time.

If you would like further information about this report, please contact your local Quality Improvement Consultant.

## Non-data sharing practices

Practices with a data extraction tool (for example, CAT Plus Scheduler) that are not currently sharing data with Murray PHN will need to follow these steps:

1. Contact Murray PHN to advise that you have applied for the PIP QI Incentive
2. Provide Murray PHN with your PIP Practice Identifier
3. Sign a new End User Licence Agreement (EULA)
4. Maintain evidence of undertaking continuous quality improvement activities
5. Submit the PIP Eligible Data Set on a quarterly basis
6. Sign the annual confirmation statement.

Practices without an extraction tool that are not currently sharing data with Murray PHN but wish to participate, must comply with the PIP QI guidelines in addition to the existing PIP guidelines. These general practices must obtain a data extraction and clinical audit tool such as CAT Plus (this can be obtained under license with Murray PHN). Please contact Murray PHN for more information.

Practices that wish to only share the minimum data set will still need to apply for the PIP QI Incentive through HPOS and provide Murray PHN with their PIP Practice Identifier. Alternative arrangements can be made at a practice level to capture the minimum data set. Practices with incompatible software will be provided with a secure web-based access portal to submit data.

## Privacy and data governance

Patients expect strong safeguards to ensure their health information is safe and secure, and that the privacy of their health information is respected. Health care providers have professional and legal obligations to protect their patients' health information. Protection of the data recorded as part of the PIP QI reporting process is ensured by using a specified, limited, de-identified data set, and access to information is strictly limited.

## Privacy for patients

The protection of patient privacy is paramount and no personal identifying information is provided as part of the PIP Eligible Data Set. Digital systems enable practices to meet their existing obligations to keep their patients' health information secure and private, and any de-identified data shared is solely for the purpose of improving patient outcomes. General practices must ensure the accuracy and completeness of the data contained in their clinical information systems and use it to improve the quality of patient care.

## Prohibited use

The PIP Eligible Data Set is prohibited from being commercialised by any Data Custodians. Patient information within the PIP Eligible Data Set remains de-identified at regional and national levels. The only Data Custodian who can access identified information is the Local Data Custodian (participating general practices).

For more information about the PIP QI data governance arrangements, download the PIP Eligible Data Set Data Governance Framework: health.gov.au/internet/main/publishing.nsf/Content/PIP-QI_Incentive_guidance

# CONDUCTING A QUALITY IMPROVEMENT ACTIVITY

Plan, Do, Study, Act (PDSA) is a model for improvement that provides a framework for testing, developing and implementing change.


Source: pointofcarefoundation.org.uk/resource/using-patient-experience-for-improvement/improving-care/model-for-improvement-pdsa-cycles/

## When to use the PDSA

When planning any change or improvement workflows, you need to identify what you want to achieve and how the improvement will be measured. A PDSA cycle enables practices to test out smaller scale changes in a structured way. Plan, Do, Study, Act cycles are a good tool to test if a proposed change will succeed and as a result, encourage learning from the ideas that were successful, and those that weren't.

## How to use the PDSA

Some key questions to answer before testing an improvement concept:

- What are you trying to achieve?
- How will you know if the change is an improvement?
- What measures of success will you use?
- What changes can you make that will result in improvement?

Quality improvement is an ongoing process. The completion of each PDSA cycle should lead directly into the start of the next cycle.

Your practice should learn from the test:

- What worked
- What didn't work
- What should be kept, changed or abandoned.

This new knowledge is then used to plan the next test. Your team continues in this way, refining the change until it is ready to implement.

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

- What are we trying to accomplish?
- How will we know that the proposed change will be an improvement?
- What changes can we make that will lead to an improvement?

**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:

- Helping you test the ideas
- Helping you assess whether you are achieving your desired objectives
- Enabling you to confirm which changes you want to adopt permanently.

The Plan-Do-Study-Act (PDSA) cycle is a useful tool for documenting a test of change. Running a PDSA cycle is another way of testing a change - you develop a plan to test the change (Plan), carry out the test (Do), observe, analyse and learn from the test (Study), and determine what modifications, if any, to make for the next cycle (Act).

Fill out one PDSA worksheet (at the end of this document) for each change you test. In most improvement projects, teams will test several different changes, and each change may go through several PDSA cycles as you continue to learn. Keep a file (either electronic or hard copy) of all PDSA cycles for all the changes your team tests.

| | |
|---|---|
| PLAN  | What are you going to do? Who will be involved? When will it take place? How will it be done? What will you measure? |
| | What are your expectations? |
| DO  | How did you implement the plan? Did you encounter any unexpected issues? Did you achieve any unexpected benefits? |
| STUDY  | What results did you achieve? Did they differ from your expectations? How? What have you learnt from this cycle? |
| ACT  | What action will you take to refine or retest the improvement activity? How will you implement and embed the change/s? |

## Does every idea need a PDSA cycle?

Not every idea needs to be tested through a PDSA framework as they may be simple or administrative-based tasks. An example of this could be putting up promotional materials in your waiting area to increase bowel cancer screening awareness.

## Implementing a change

Once you have tested a change and determined that it is effective, you will need to implement the change and make it a sustainable process within the organisation. For simple changes, implementation will be relatively straightforward. For other changes, effective implementation will require training and ongoing monitoring to ensure that the team does not return to the ‘old way’ of doing things.

When considering implementation, ask yourself, what other changes are needed to support implementation of this change long term? Your new way of working may require modifying supporting material such as job descriptions or policies. For example, you could add regular review of the accuracy of patient registers as a part of the practice nurse’s role to ensure routine coding by staff is maintained.

Initially, testing the change may only involve a small group of people, however, implementing the change may affect others. You will need to consider how to engage staff who may be resistant and how you will promote the benefits of the ‘new way’ of working. You may find that the data you collect through testing provides valuable information to help convince the wider team about the benefits associated with the change you are proposing. For example, you could print monthly graphs showing the improvement achieved after implementing the ideas tested in your PSDA cycles and present them at your clinical meetings. You may consider auditing the new system twice a year. For example, an audit of whether the patient registers are being appropriately maintained.

# IDEAS FOR ACTIVITIES - ACCREDITATION

| *Criterion QI1.3 – Improving clinical care* | |
|---|---|
| **Indicators** | |
| *QI1.3A Our practice team uses a nationally recognised medical vocabulary for coding.* | You could:<br>• Use patient management software to code patient health information<br>• Keep clinical data and reports, such as rates of childhood vaccinations, completed adult health checks and updated risk factors. |
| *QI1.3 B Our practice uses relevant patient and practice data to improve clinical practice (e.g. chronic disease management, preventive health).* | **You must:** Show evidence you have conducted a QI activity, such as a PDSA cycle or clinical audit, at least once every three years. |

| *Criterion QI2.1 – Health summaries* | |
|---|---|
| **Indicators** | |
| *QI2.1 A Our active patient health records contain a record of each patient's known allergies.* | **You must:** Include records of known allergies in active patient health records.<br>You could: Keep records of when GPs ask patients about allergies. |
| *QI2.1 B Each active patient health record has the patient's current health summary that includes, where relevant:*<br>- *Adverse drug reactions*<br>- *Current medicines list*<br>- *Current health problems*<br>- *Past health history*<br>- *Immunisation*<br>- *Family history*<br>- *Health risk factors (e.g. smoking, nutrition, alcohol, physical activity)*<br>- *Social history, including cultural background.* | **You must**: Keep a current health summary in each active patient's health record.<br>You could: Conduct a regular audit of patient health records. |

| *Criterion C7.1 – Content of patient health records* | |
|---|---|
| **Indicator** | |
| *C7.1 E Our practice routinely records the Aboriginal or Torres Strait Islander status of our patients in their patient health record.* | **You must:** Document the patient's Aboriginal and/or Torres Strait Islander status in patient health records.<br>You could: Maintain a policy addressing the management of patient health information. |

# IDEAS FOR ACTIVITIES - OTHER OPPORTUNITIES

1. **Immunisation: follow-up at-risk** (COPD/Diabetes/65+) patients who have no current (<15months) Influenza vaccination recorded
   - Patients aged 65 and over who are not immunised against influenza = X%
   - Patients with diabetes who are not immunised against influenza = X%
   - Patients with COPD who are not immunised against influenza = X%

2. **Aboriginal and Torres Strait Islander health**
   - Aboriginal and/or Torres Strait Islander patients who have not had Health Assessment in last 12 months = X (X%)
   - Aboriginal and/or Torres Strait Islander patients with 1+ Chronic disease without GPMP/TCA (last result <24mths, Active) = X (X%)
   - Aboriginal and/or Torres Strait Islander patients with 1+ Chronic disease without GPMP/TCA review (last result <6mths, Active) = X (X%)
   - Practice Incentive Program – Indigenous Health Incentive

Resource: Five steps towards excellent healthcare for Aboriginal and Torres Strait Islander people – RACGP

3. **Health assessments**
   - Patients aged 75+ who have not had Health Assessment in last 12 months = X (X%)
   - Patients aged 45-49 years who have not had Health Assessment in last 12 months = XX (%)

4. **Chronic disease management**
   - Patients with 1+ Chronic disease who have not had GPMP/TCA in last 24 months = X (X%)
   - Patients with 1+ Chronic disease who have not had GPMP/TCA review in last 6 months = X (X%)
   - Patients with 5 or more medications who have not had a Medication Management review in last 12 months = X (X%)

5. **Mental health**
   - Patients with Mental Health diagnosis without a Mental Health Treatment Plan in last 12 months = X (X%)
   - Identify patients who may be eligible for new 10 additional Medicare subsidised psychological therapy sessions for people subject to further restrictions in areas impacted by the COVID-19 pandemic – currently X patients with mental health diagnosis

## Step 1: The three fundamental questions

### 1. What are we trying to accomplish?

*This will help you develop your GOAL for improvement.*

- **Our goal is to:** Record physical activity in all active patients' records.
- **Our S.M.A.R.T. goal is to:** Increase the number of our patients aged 50 years and older who have physical activity recorded by 10% by 31 August.

  *(A S.M.A.R.T. goal is: Specific, Measurable, Achievable, Relevant, Time-limited)*

### 2. How will we know that a change is an improvement?

*Develop MEASURES to track the achievement of your goal.*

We will measure the percentage of active patients aged 50 years and older who have physical activity recorded. To do this we will:

A. Identify the number of active patients aged 50 years and older
B. Identify the number of active patients aged 50 years and older who have physical activity recorded

B divided by A x 100 produces the percentage of patients aged 50 years and older who have physical activity recorded.

We will do this search at the beginning of our QI and at the end of the QI activity. Times and dates outlined in the PDSA below.

### 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.*

Our ideas for change:

1. Using CAT4, identify active patients aged 50 years and older.
2. Prioritise higher risk groups (overweight, hypertensive, with mental health issues or with a chronic disease) to make the task less daunting. Use CAT4 to search these patients.
3. Collect information on activity status via a survey form from patients waiting to see the RN or GP. RN or GP to enter information.
4. Do a CAT4 search on patients aged 50 years and older and chronic disease who have a TCA. Physical activity information may have been recorded by a dietician or exercise physiologist and reported back to GP. Enter this into the practice software.
5. Teach practice staff where to record the physical activity status in the software.
6. Source and provide endorsed patient education resources on physical activity (in waiting rooms, etc.).
7. The team selects one idea to begin testing with a PDSA cycle.

**Note:** Each new GOAL (1st fundamental question) will require a new model for improvement guide.

## 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 are testing** |
|---|
| *Refer to the third fundamental question.*<br>Increase the number of our patients aged 50 years and older who have physical activity recorded by 10% by 31 August. |
| *PDSA cycle number:* |
| **PLAN \| What will you do?** |
| *Explain your idea.*<br>Collect information on activity status via a survey form from patients waiting to see the RN or GP. RN or GP to enter information. |
| *Who will carry it out?*<br>Receptionist |
| *When will it take place? Where?*<br>Begin 3 August and continue for four weeks in the practice in the waiting room. |
| *What do you predict will happen?*<br>20% increase in the number of our patients, who visit the practice over this time period, aged 50 years and older who have physical activity recorded. |
| *What data/information will you collect that will help you measure improvement?*<br>Number of active patients aged 50 years and older and number of active patients aged 50 years and older who have physical activity recorded. |
| **DO \| Was the plan executed?** |
| *Consider the data you collected and document any unexpected events or problems.*<br>Completed 30 August – the receptionist and RN developed a short survey form to collect relevant information. The data searches were conducted in CAT4 by the practice manager, with the receptionist being upskilled to conduct further relevant searches. The RN collected the forms and entered the information into the practice software. |
| **STUDY \| Record, analyse and reflect on the results** |
| *What have you learned? Do your outcomes compare with your predictions? If not, what happened?*<br>There were not many patients who had physical activity recorded so the nurse spent a lot of time recording the information each day. A total of 132 active patients (40%) who attended in the four weeks and were aged 50 years and older, have had their activity status recorded = 20% higher than predicted. Allocating the data entry just to the nurse took too much of her time. |
| **ACT \| What will you take away from this cycle?** |
| *What's your next step or idea, and how might you apply the cycle again?*<br>1. Need to share the workload and ask GPs and all nurses to regularly record patients' physical activity status.<br>2. Need to monitor monthly benchmark report data from the PHN to ensure recording rates continue to increase.<br>3. Ensure the clinical team know where to record the in the physical activity status in medical software.<br>4. Remind the whole team that this is an area of focus for the practice. |

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# The model for improvement

## Step 1: The three fundamental questions

### 4. What are we trying to accomplish?

*This will help you develop your GOAL for improvement.*

### 5. How will we know that a change is an improvement?

*Develop MEASURES to track the achievement of your goal.*

### 6. 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 are 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?*