Preparing for winter

Quality Improvement Toolkit for General Practice

COORDINARE

phn
SOUTH EASTERN NSW
An Australian Government Initiative

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COORDINARE acknowledges that this resource has been adapted from the Disaster Prepare Toolkit developed by Brisbane South PHN.

Please note: due to constant developments in research and health guidelines, information in this document may be subject to change. Please contact info@coordinare.org.au if you have any feedback regarding the content of this document.

1. Aim of this toolkit

To review your practice systems in the context of the pandemic and flu season and implement improvements to ensure your practice is best placed to provide your patients with the right care at the right time.

Every winter there is a rise in demand for health services and given the current pandemic this is likely to be further compounded. The Department of Health has noted that reduced circulation of influenza virus and lower levels of influenza vaccine coverage compared with previous years may have resulted in low levels of community immunity. This, coupled with international borders reopening could lead to increased influenza cases and transmission this season. Proactively planning for winter and the flu season can help streamline processes and ensure those most at risk of becoming unwell get the care they need.

It is critical to ensure those most vulnerable to complications from influenza receive the appropriate care including vaccination.

The Communicable Diseases Network Australia (CDNA) and NSW Health has identified a number of groups who are more vulnerable during the flu season.

This includes:

- persons aged ≥65 years of age
- Aboriginal or Torres Strait Islander peoples aged 6 months and over
- people who have medical conditions predisposing them to severe influenza, such as cardiac disease, chronic respiratory conditions
- people with chronic illness including diabetes mellitus and / or multiple chronic conditions; and
- people on multiple medications.

This toolkit aims to help practices identify and implement processes to support those vulnerable groups most at risk of becoming unstable, very unwell, or admitted to hospital during the flu season.

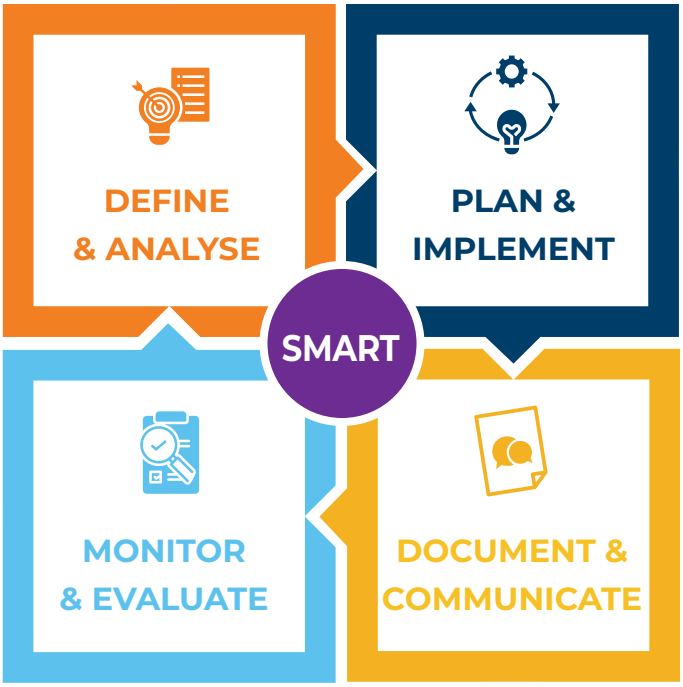
Key questions to consider, which will be explored throughout this toolkit

- Who are the key people who will contact patients about prevention activities?
- Who are the key people who will ensure your vulnerable patient population are cared for?
- Who are the key people to complete data cleansing activities?

2. The Quality Improvement Methodology (QIM)

As part of the Sentinel Practices Data Sourcing (SPDS) Project COORDINARE has developed a structured but simple population health approach to continuous quality improvement. The quality improvement methodology and SPDS program outcomes, as well as perceived impact, have been detailed in a peer-reviewed publication in one of the most respected Australian journals within the general practice and primary care context. You can review the publication here.[§]

The methodology uses SMART goal setting as the overarching framework to ensure goals are specific (S), measurable (M), achievable (A), realistic (R) and time based (T), and consists of four fundamental components that are essential for guiding improvement.



This QI toolkit is designed to support your practice to make easy, measurable and sustainable improvements to provide best practice care for your patients. The toolkit will help your practice complete QI activities using COORDINARE's continuous Quality Improvement Methodology (QIM).

Throughout the toolkit you will be guided to explore your data to understand more about your patient population and the pathways of care being provided in your practice. Reflections from the module activities and the related data will inform improvement ideas for you to action using the QIM.

Step 1: Define and analyse

- Undertake **baseline data cleansing** and initial **clinical auditing**. This will help ensure your practice has high quality data and help you to **identify** what needs improving.
- Take the time to **understand** what your **current processes** are, **what** the problem is and **why** there is a problem. By doing this you can **define** your improvement goal(s).
- Set realistic objectives which are specific, measurable, realistic and have a defined time-frame **(SMART).** Use **plain language** and avoid jargon so that the meaning is clear to everyone.

Step 2: Plan and implement

- Achieving improvements requires the collaborative effort of the entire practice team and all members of the team should feel empowered to contribute.
- It is important to obtain all of practice support and in doing so, to develop a shared vision for quality improvement and the patient outcomes the practice is looking to achieve.
- Make sure you identify a staff member who is dedicated to leading the work, they will be the Practice Champion.
- As a team you need to agree on what you will measure. This should be guided by the needs of your practice population or by your business priorities. These could be based on practice data e.g. Clinical Audit Tools and clinical database audits, near misses and patient and/or staff feedback.
- If you need help identifying the needs of your practice population, you can contact your Health Coordination Consultant to assist you in looking at your practice data.

Step 3: Document and communicate

- Map out and write down your idea for improvement.
- It is good practice to ensure internal processes are aligned with the steps and stages of the Improvement Plan. This will ensure everyone in your practice has a consistent approach to quality improvement and help your practice embed quality improvement as business as usual.
- Any issues, concerns or 'red flags' should be communicated across the entire practice team in team meetings or team huddles.
- Remember to celebrate your wins! Sharing results and progress help keep the team focussed. A great way to do this is to display Data Quality Snapshot Reports for all practice staff to see. If you need a hand with this you can contact your Health Coordination Consultant.

✔ Helpful tips

Using COORDINARE's Improvement Plan ensure to document:

- What issues you found in the planning stage when you reviewed the practice data?
- Which of the issues will your practice work on?
- What is your baseline measure?
- What is the SMART goal to achieve the improvement?
- When will it start and end?
- Who is the practice champion?
- How will you keep the practice team updated?

[§] *Abhijeet Ghosh, Elizabeth Halcomb, Sandra McCarthy and Christine Ashley (2020) Structured yet simple approaches to primary care data quality improvements can indeed strike gold.* Australian Journal of Primary Health 27(2) 143-151.

Step 4: Monitor and evaluate

- Monitor progress as you go, acknowledge staff contributions and celebrate success, even the small ones.
- Ensure you undertake Improvement Auditing by comparing your baselines measures with more recent data auditing. This can be done monthly and filled out in the Monitoring and Revision section of the Improvement Plan.
- Participating in Benchmarking activities with your Health Coordination Consultant on a quarterly basis is another great way to monitor and review your progress.
- It is useful to reflect on what happened at the completing of the goal period. You should consider:
  - Did the activity result in an improvement?
  - If not, why?
- Did any other changes happen that you hadn't planned?
- By looking at the results you can decide whether your practice should Adapt, Adopt or Abandon the idea.

COORDINARE provides 3 key tools to help you plan and monitor QI:

1.

The Improvement Plan
This template supports you to identify areas for improvement, set SMART goals and monitor improvements over time

2.

The Facilitation Tool
This template documents the practice's data quality initiative (SPDS) measures to assist with benchmarking and identification of measures requiring improvement.

3.

The Tracking Tool
This template helps you chart your data over time so you can monitor your chosen measure as part of QI activity.

PIP QI

Some of the activities in this toolkit relate to the Practice Incentive Program Quality Improvement (PIP QI) measures. Keep an eye out for this icon throughout the toolkit.

3. Where to go for more support

Your Health Coordination Consultant (HCC) can provide support to undertake the activities in this toolkit. You can contact your HCC directly or via these details.

info@coordinare.org.au

1300 069 002

4. HealthPathways

HealthPathways is a free web-based portal designed to support health professionals in planning patient care through primary and secondary health care systems within the local region. It will help you manage and refer your patient to the right care, in the right place, at the right time.

HealthPathways content is developed collaboratively by general practitioners, hospital clinicians, and a wide range of other health professionals. They are designed to be efficient, simple and quick for GPs to use. HealthPathways are tailored to best meet the needs of the local communities and aim to help GPs support their patients by outlining:

- the best management and treatment options for common medical conditions
- information on how to refer to the most appropriate local services and Specialists
- educational resources and information for patients to enable better self-management of health.

Within South Eastern NSW there are two different HealthPathways initiatives supporting each Local Health District. To access them use the links below.

ACT and Southern NSW Username: together Password: forhealth	**Illawarra Shoalhaven** Username: connected Password: 2pathways

5. How to use this toolkit

There are checklists included in this toolkit that will guide you and your practice.

- The toolkit is broken down in to 8 sections covering various components of patient management
- Each section has a series of activities designed to help you reflect on your practice processes so you can identify areas for improvement
- Each activity contains checklists and resources that will help guide you along the journey
- Once you have completed the simple reflection activities you will reach the end of the section. Now you have identified possible areas for improvement you could consider setting a goal using using COORDINAREs Quality Improvement Methodology (QIM) to develop your Improvement Plan.

   Look out for this symbol as a prompt to consider writing up an Improvement Plan

- Remember to get in touch with your HCC if you need help with these activities and supporting tools.
- If you find your process is not working and you are not seeing improvements, then review your process and start again.
- Please note: Some of the GP practice services e.g., prevention or chronic disease management (CDM) may be difficult to provide or need to be postponed during a pandemic/natural disaster as resources are finite or reduced (in the practice and more generally in the health system). It is important that the practice has a team approach to establishing priorities to ensure vulnerable populations receive the care they need.

6. Patient Management activities

6.1. Activity: Vulnerable populations

Support for vulnerable people, their families and their caregivers is an essential part of a comprehensive response to the winter season, particularly in the case of a pandemic. During times of isolation and quarantine, vulnerable people need safe access to nutritious food, basic supplies, money, medicine to support their physical health, and social care.

Dissemination of accurate information is critical to ensuring that vulnerable people have clear messages and resources on how to stay physically and mentally healthy during the pandemic and what to do if they should fall ill.

Note: Vulnerable populations may benefit from social prescribing, and this is now available in the SE NSW PHN catchment as part of a COORDINARE commissioned initiative. Social prescribing involves the referral of patients to local non-clinical services to improve their health and wellbeing and has the potential to address unmet patient needs, easing pressure on GPs and other healthcare professionals.

The aim of this activity is to review your practice's management of vulnerable patient populations.

It is suggested that you meet as a practice team to discuss how you will provide care for your vulnerable populations.

	Activity	Things to consider
1.	**Have you identified your vulnerable patient populations?** ☐ Yes, continue with next activity ☐ **No, refer to the 'Things to consider' in next column** PIP QI	1. Refer to COORDINARE's data quality (SPDS) program resource - Winter Strategy – clinical data auditing activities using CAT4 - for instructions on searching for vulnerable patient groups who are more at risk in the lead up to and during winter. It is important to ensure their immunisation and COVID vaccinations are up to date and that relevant treatments including annual cycle of care, exacerbations plans etc have been completed: • Patients with outstanding Diabetes Annual Cycle of Care items • Patients with Diabetes who have not been immunised for Influenza in the last 12 months • Patients with Asthma who have not had an Asthma Cycle of Care done and recorded in the last 12 months • Patients with Asthma or Chronic Obstructive Pulmonary Disease (COPD) who have not been immunised for Influenza in the last 12 months • Patients aged 50 years and over who have not been immunised for Influenza in the last 12 months • Patients with multiple chronic condition categories • Patients with multiple medications • Patient aged 65 years and above with Chronic Obstructive Pulmonary Disease (COPD) 2. Refer to COORDINARE's Activities for COVID 19 Vaccination Data Auditing Guide to ensure you have identified patients most vulnerable to COVID for vaccination
2.	**Do you have any patients who are experiencing homelessness?** ☐ **Yes, refer to the 'Things to consider' in next column** ☐ No, continue with next activity	Do you have a process in place to identify these patients? ☐ Yes ☐ No Do you have a process in place to provide follow up care for these patients? ☐ Yes ☐ No Does a person in the practice have responsibility for these patients? ☐ Yes ☐ No

	Activity	Things to consider
3.	**Have you identified your Aboriginal and / or Torres Strait Islander patients?** ☐ Yes, confirm all the items under 'Things to consider' are in place and then move to next activity ☐ **No, refer to the 'Things to consider' in next column**	Refer to COORDINARE's data quality (SPDS) program Cleansing Manual for instructions on using CAT4 to find Aboriginal and/or Torres Strait Islander patients. Refer to the following resources on the COORDINARE website to guide your QI work with Aboriginal and Torres Strait Islander patients: • Aboriginal Health Quality Improvement toolkit • Aboriginal and Torres Strait Islander QI Recipe • clinical supports and other information **HealthPathways** Illawarra-Shoalhaven HealthPathways Aboriginal and Torres Strait Islander Health ACT-Southern NSW HealthPathways Aboriginal and Torres Strait Islander Health Do you have a process in place to provide follow up care for these patients? ☐ Yes ☐ No Does a person in the practice have responsibility for these patients? ☐ Yes ☐ No
4.	**Do you have any patients who are from refugee and migrant populations?** ☐ **Yes, refer to the 'Things to consider' in next column** ☐ No, continue with next activity	Refer to COORDINARE's data quality (SPDS) program Data Cleansing Manual for instructions on using CAT4 to filter by ethnicity. Consider using or adapting this model of care for refugees in supporting the mental health of your refugee patients. See COORDINARE website for tools, information on support services and translated resources **HealthPathways** Illawarra-ShoalhavenHealthPathways Refugee Health ACT-Southern NSW HealthPathways Refugee Health Do you have a process in place to provide follow up care for these patients? ☐ Yes ☐ No Do all providers have access to the Translating and Interpreting Service (TIS)? ☐ Yes ☐ No Does a person in the practice have responsibility for these patients? ☐ Yes ☐ No
5.	**Do you have any patients who are veterans?** ☐ **Yes, refer to the 'Things to consider' in next column** ☐ No, continue with next activity	Use CAT4 to identify DVA patients. Do you have a process in place to provide follow up care for these patients? ☐ Yes ☐ No Does a person in the practice have responsibility for these patients? ☐ Yes ☐ No

	Activity	Things to consider
6.	**Do you have any patients who are victims of family and domestic violence?** ☐ **Yes, refer to the 'Things to consider' in next column** ☐ No, continue with next activity	The COORDINARE website has information on sources of help **HealthPathways** Illawarra-Shoalhaven HealthPathways Domestic Family Violence ACT-Southern NSW HealthPathways Assault or Abuse Do you have a process in place to identify these patients? ☐ Yes ☐ No Do you have a process in place to provide follow up care for these patients? ☐ Yes ☐ No Does a person in the practice have responsibility for these patients? ☐ Yes ☐ No
7.	**Do you have any 'at-risk' or socially disengaged adolescents? This may include children and young people in out of home care.** ☐ **Yes, refer to the 'Things to consider' in next column** ☐ No, continue with next activity	**HealthPathways** Illawarra-Shoalhaven HealthPathways Child or Young Person at Risk ACT-Southern NSW HealthPathways Child or Young Person at Risk Do you have a process in place to identify these patients? ☐ Yes ☐ No Do you have a process in place to provide follow up care for these patients? ☐ Yes ☐ No Does a person in the practice have responsibility for these patients? ☐ Yes ☐ No
8.	**Do you have any patients who are housebound?** ☐ **Yes, refer to the 'Things to consider' in next column** ☐ No, continue with next activity	Do you have a process in place to identify these patients? ☐ Yes ☐ No Do you have a process in place to provide follow up care for these patients? ☐ Yes ☐ No Does a person in the practice have responsibility for these patients? ☐ Yes ☐ No

	Activity	Things to consider
9.	**Do you have any patients with dementia?** ☐ **Yes, refer to the 'Things to consider' in next column** ☐ No, continue with next activity	Use CAT4 to identify patients with dementia. **HealthPathways** Illawarra-Shoalhaven HealthPathways Older Persons' Health ACT - Southern NSW HealthPathways Older Adults' Health Do you have a process in place to provide follow up care for these patients? ☐ Yes ☐ No Does a person in the practice have responsibility for these patients? ☐ Yes ☐ No
10.	**Do you have any patients who are in a residential aged care facility?** ☐ **Yes, refer to the 'Things to consider' in next column** ☐ No, continue with next activity	Refer to the COORDINARE website for information on how to embed access to Allied Health services in RACFs Do you have a process in place to identify these patients? ☐ Yes ☐ No Do you have a process in place to provide follow up care for these patients? ☐ Yes ☐ No Does a person in the practice have responsibility for these patients? ☐ Yes ☐ No
11.	**Do you have any patients who are pregnant?** ☐ **Yes, refer to the 'Things to consider' in next column** ☐ No, continue with next activity	Refer to instructions from Best Practice or MedicalDirector to identify these patients. Do you have a process in place to provide follow up care for these patients? ☐ Yes ☐ No Does a person in the practice have responsibility for these patients? ☐ Yes ☐ No
	 **After reviewing your practice's vulnerable patient population, are there any changes with the management of your patients you would like to implement?** ☐ **Yes, set goals and outline actions to be taken** ☐ No, you have completed this activity	Use COORDINARE's Quality Improvement Methodology (QIM) and resources below to develop your Improvement Plan: - Improvement plan - Facilitation Tool - Tracking Tool

6.2. Activity: Managing COVID positive patients

Around 80% of people who test positive for COVID-19 are likely to only experience mild symptoms and can be appropriately cared for in their home. Some people with moderate symptoms can be safely cared for in the home with appropriate monitoring. These people can receive holistic care from a GP in the comfort of their own home which minimises the impact on our entire healthcare system.

The aim of this activity is to review your practice's preparedness for managing patients with COVID-19.

	Activity	Things to consider
1.	**Do you have a person from the practice who is a key contact to receive notifications of positive results, any updates on patients or any other COVID updates?** ☐ Yes, confirm all the items under 'Things to consider' are in place and then move to next activity ☐ **No, refer to the 'Things to consider' in next column**	Do you have a process in place for this person to communicate key messages? ☐ Yes ☐ No Do you have a backup key contact in case this person is not available? ☐ Yes ☐ No
2.	**Do you have a process in place for managing COVID positive patients?** ☐ Yes, confirm all the items under 'Things to consider' are in place and then move to next activity ☐ **No, refer to the 'Things to consider' in next column**	Refer to assessment and management of patients with suspected COVID-19. Refer to HealthPathways home page for current alerts and updates. Home page has current alerts and updates. See COVID-19 on contents list or use as search function. • Illawarra-Shoalhaven HealthPathways • ACT-Southern NSW HealthPathways Refer to the COORDINARE website for workflow documents from local practices: • Bulli Medical Practice • Terralong Street Surgery • Woonona Medical Practice Do you have a process in place for identifying and monitoring your COVID positive patients? ☐ Yes ☐ No Do you have a process in place for managing COVID positive patients face to face? ☐ Yes ☐ No Do you have a plan in place for managing COVID positive patients remotely? ☐ Yes ☐ No Do you have a plan in place for managing COVID positive patients at home or in RACFs? ☐ Yes ☐ No

	Activity	Things to consider
3.	**Do you know where to access information on managing health care workers exposed to, or living with, COVID-19?** ☐ Yes, continue with next activity ☐ **No, refer to the 'Things to consider' in next column**	Refer to the NSW Health framework. Refer to HealthPathways: Illawarra-Shoalhaven HealthPathways or ACT-Southern NSW HealthPathways
4.	**Do you know where to access MBS telehealth item numbers?** ☐ Yes, continue with next activity ☐ **No, refer to the 'Things to consider' in next column**	Refer to MBS telehealth information.
 **After reviewing your practice's procedures for managing positive COVID-19 patients, are there any changes with the management of your patients you would like to implement?** ☐ **Yes, set goals and outline actions to be taken** ☐ No, you have completed this activity	Use COORDINARE's Quality Improvement Methodology (QIM) and resources below to develop your Improvement Plan: • Improvement plan • Facilitation Tool • Tracking Tool	

6.3. Activity: Preventive health

General practice is at the forefront of healthcare in Australia and in a pivotal position to deliver preventive healthcare. Preventive healthcare is an important activity in general practice. It includes the prevention of illness, the early detection of specific disease, and the promotion and maintenance of health. The partnership between GP and patient can help people reach their goals of maintaining or improving health. Preventive care is also critical in addressing the health disparities faced by disadvantaged and vulnerable population groups.

Prior to completing this activity consider, during a natural disaster or pandemic some referral services will be affected e.g. breast screening. Immunisations could also make preventive health care more challenging. As a practice, consider if some services will need to be placed on hold.

The aim of this activity is to review the preventive health measures provided in your practice.

	Activity	Things to consider
1.	**Have you considered how you would continue to provide preventive health interventions if patients are preferring telehealth appointments?** ◗ **Immunisations (adult & children)** ◗ **Cancer screening (breast, bowel & cervical)** ◗ **Health assessments** ◗ **Cardiovascular risk** ◗ **High blood pressure** ☐ Yes, confirm all the items under 'Things to consider' are in place and then move to next activity ☐ **No, refer to the 'Things to consider' in next column** PIP QI	Refer to COORDINARE's data quality (SPDS) program data cleansing manual for instructions on the CAT4 searches below. ◗ Patients aged 65 years who have not been immunized against influenza in the past 15 months. ◗ Patients with diabetes who have not been immunized against influenza in the past 15 months. ◗ Patients over 15 with COPD who have not been immunized against influenza in the past 15 months. ◗ Patients who do not have an up-to-date cervical screening recorded. ◗ Patients without an up-to-date mammogram recorded. ◗ Patients without an up-to-date FOBT recorded. ◗ Patients 45-74 with information missing to calculate absolute CVD risk ◗ Hypertensive patients without a BP recorded in 6 mths. ◗ Patients 15 and over without their height and weight recorded in 12 mths. ◗ Patients 15 and over without their alcohol consumption status recorded. ◗ Patients 15 and over without their smoking status recorded. Refer to COORDINARE's guide: Cancer Screening Data QI Activities **HealthPathways** Illawarra-Shoalhaven HealthPathways Preventive Care ACT-Southern HealthPathways Lifestyle and Preventive Care As a practice team, meet to discuss key priorities and how you will be able to manage these patients in your practice. Do you have a process in place to provide care for these patients? ☐ Yes ☐ No

	Activity	Things to consider
2.	**Have you considered how you would continue to maintain quality improvement activities?** ☐ Yes, confirm all the items under 'Things to consider' are in place and then move to next activity ☐ **No, refer to the 'Things to consider' in next column**	Consider the QI Recipes available on COORDINARE's website including: ◗ vaccination management QI Recipe ◗ alcohol intake QI recipe Refer to the NSW Cancer Institute's Cancer Screening and Primary Care: A Quality Improvement Toolkit for primary care. Is someone responsible for continuous quality improvement (CQI) in the practice? ☐ Yes ☐ No Is there a process to ensure QI is done on a regular basis? ☐ Yes ☐ No
3.	**Do you have a plan on how you will communicate with patients about preventive health activities?** ☐ Yes, continue with next activity ☐ **No, refer to the 'Things to consider' in next column**	Who will have the responsibility to identify eligible patients for preventive health appointments? Do you have a person who is responsible for identifying eligible patients for preventive health appointments? ☐ Yes ☐ No Do yo have a process for communicating with patients about preventive health? ☐ Yes ☐ No
	 **After reviewing your practice's preventive health approach, are there any changes with the management of your patients you would like to implement over the next 12 months?** ☐ **Yes, set goals and outline actions to be taken** ☐ No, you have completed this activity	Use COORDINARE's Quality Improvement Methodology (QIM) and resources below to develop your Improvement Plan: ◗ Improvement plan ◗ Facilitation Tool ◗ Tracking Tool

6.4. Activity: Chronic disease management

Chronic diseases are the leading cause of ill health, disability and death in Australia. The effects of chronic disease can be profound, both on an individual's health and wellbeing, and on the health care system. In 2020 and 2021, the lives of all Australians have been affected by the COVID-19 pandemic to varying degrees.

Prior to completing this activity, consider, during a natural disaster or pandemic some referral services will be affected e.g. allied health, specialists etc. Some services may not be delivered remotely. As a practice, consider if some services will need to be placed on hold.

The aim of this activity is to review your practice's chronic disease management procedures.

	Activity	Things to consider
1.	**Do you have a system to ensure your patients with a chronic medical condition are still receiving appropriate care?** ☐ Yes, continue with next activity ☐ **No, refer to the 'Things to consider' in next column** PIP QI	Refer to COORDINARE's data quality (SPDS) program data cleansing manual for instructions on the CAT4 searches below to identify the following patients: • CVD patients with no BP recorded • CHD patients with no smoking status recorded • Patients with incorrect diabetes diagnosis recorded • Diabetes patients without an HbA1c recorded in the last 12 mths • Diabetes patients without an up-to-date BP recorded in the last 6 mths. • COPD patients with no smoking status recorded. • Renal impairment patients with no eGFR recorded in the last 6 mths. When searching for patients in vulnerable groups who have not been immunised refer to COORDINARE's guide: Clinical Data Auditing Activities Focussing on High Risk Patients As a practice team, meet to discuss key priorities and how you will be able to manage these patients in your practice.
2.	**Have you discussed as a practice team what should be the minimum care provided to patients with a chronic disease?** ☐ Yes, confirm all the items under 'Things to consider' are in place and then move to next activity ☐ **No, refer to the 'Things to consider' in next column**	Do you have a process for communicating with patients about preventive health? ☐ Yes ☐ No Does someone have the responsibility to identify patients and monitor their interaction with the practice? ☐ Yes ☐ No Is there a documented procedure outlining the minimum care? ☐ Yes ☐ No
3.	**Will the practice proactively contact patients with a chronic disease who have not had a visit in the past 6 months?** ☐ Yes, continue with next activity ☐ **No, refer to the 'Things to consider' in next column**	Use CAT to search for specific conditions. Do you have a person responsible for identifying these patients? ☐ Yes ☐ No Do you have a process in place to identify these patients? ☐ Yes ☐ No Do you have a process in place to provide care for these patients? ☐ Yes ☐ No

	Activity	Things to consider
4.	**Are you aware that COORDINARE has several QI resources available to assist you to manage your patients with a chronic medical condition?** ☐ Yes, continue with next activity ☐ **No, refer to the 'Things to consider' in next column** PIP QI	Consider utilizing QI Recipes available on COORDINARE's website - COVID-19 chronic disease management QI Recipe - patients with cardiac conditions QI Recipe - patients with chronic kidney disease QI Recipe - patients with diabetes QI Recipe - patients with multiple chronic conditions QI Recipe - patients with asthma QI Recipe - patients with COPD QI Recipe - healthy ageing QI Recipe. Refer to the models of care developed by practices in SENSW, available on the COORDINARE website: - Nurse led diabetes clinic - Enhanced care for high-risk diabetes patients - Nurse led Respiratory clinic - Respiratory educators in general practice - Weight management clinic - Bone health clinic - Hospital transition to home
	After reviewing your practice's chronic disease management procedures, are there any changes with the management of your patients you would like to implement over the next 12 months? ☐ **Yes, set goals and outline actions to be taken** ☐ No, you have completed this activity	Use COORDINARE's Quality Improvement Methodology (QIM) and resources below to develop your Improvement Plan: - Improvement plan - Facilitation Tool - Tracking Tool

6.5. Activity: Patients with a mental health condition

The potential for COVID-19 to impact mental health and wellbeing was recognised early in the pandemic. Throughout 2020 and in the early months of 2021, many researchers gathered evidence revealing heightened psychological distress during the pandemic. Between 16 March 2020 and 19 September 2021, 21.0 million MBS mental health-related services were processed nationally ($2.3 billion in benefits paid).[2]

The aim of this activity is to review your patients who may have a mental health condition.

	Activity	Things to consider
1.	**Do you know how many patients in your practice have a mental health condition?** ☐ Yes, continue with next activity ☐ **No, refer to the 'Things to consider' in next column**	Use CAT4 to find patients with a mental health condition by undertaking the following searches: • patients with a mental health condition Also, searches for patients based on medications taken, including: • anti-depressants • antipsychotics • mood stabilisers • pain relief medications
2.	**Have you discussed as a team the minimum care you will provide to patients with a mental health condition?** ☐ Yes, confirm all the items under 'Things to consider' are in place and then move to next activity ☐ **No, refer to the 'Things to consider' in next column**	Do you have a person responsible for identifying these patients? ☐ Yes ☐ No Do you have a process in place to identify these patients? ☐ Yes ☐ No See COORDINARE's website for information and a short video on the Stepped Care approach. Does your practice follow the Stepped Care approach by prescribing interventions that match an individual's needs, ranging from the least to the most intensive? ☐ Yes ☐ No Have you discussed as a practice team what will be the minimum care provided? ☐ Yes ☐ No Have you identified who will take responsibility to identify patients and monitor their interaction with the practice? ☐ Yes ☐ No Do they have a documented procedure? ☐ Yes ☐ No
3.	**Do you have access to information on mental health services?** ☐ Yes, continue with next activity ☐ **No, refer to the 'Things to consider' in next column**	Ensure the team is familiar with local/ regional mental health services Illawarra-Shoalhaven HealthPathways Mental health ACT-Southern NSW HealthPathways Mental health

2 https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/mental-health-impact-of-covid-19

	Activity	Things to consider
4.	**Do you complete mental health treatment plans on patients?** ☐ Yes, continue with next activity ☐ **No, refer to the 'Things to consider' in next column**	Refer to MBS criteria for MHTP. Undertake CAT search to identify patients with a mental health condition who have not got a MHTP.
5.	**Are you aware that some mental health consultations are only available to claim via videoconference, not available via telephone?** ☐ Yes, continue with next activity ☐ **No, refer to the 'Things to consider' in next column**	Review MBS Telehealth mental health items.
	 **After reviewing your patients who have a mental health condition, are there any changes with the management of your patients you would like to implement over the next 12 months?** ☐ **Yes, set goals and outline actions to be taken** ☐ No, you have completed this activity	Use COORDINARE's Quality Improvement Methodology (QIM) and resources below to develop your Improvement Plan: - Improvement plan - Facilitation Tool - Tracking Tool

6.6. Activity: Medication reviews including deprescribing

Deprescribing is the process of discontinuing drugs that are either potentially harmful or no longer required. It can be achieved in older people and may be associated with improved health outcomes without long-term adverse effects. The risk of drug withdrawal effects can often be mitigated by carefully monitoring and gradually tapering the dose. Deprescribing should ideally be a shared decision-making process between the patient and the prescriber.

The aim of this activity is to identify opportunities to conduct medication reviews including deprescribing.

	Activity	Things to consider
1.	**Do you know patients who are on multiple medications?** ☐ Yes, continue with next activity ☐ **No, refer to the 'Things to consider' in next column**	Use CAT4 to identify patients who are on multiple medications. Refer to COORDINARE's QI Recipe for patients on multiple medications. Also, search for patients on multiple medications who have not been immunised for influenza, using COORDINARE's guide: Clinical Data Auditing Activities Focussing on High Risk Patients Do you have a process in place to identify these patients? ☐ Yes ☐ No Do you have a person responsible for identifying these patients? ☐ Yes ☐ No Do you have a process in place to provide follow up care these patients? ☐ Yes ☐ No
2.	**Do you review and update the medication list for each patient? (Consider whether patient still needs listed medications).** ☐ Yes, continue with next activity ☐ **No, refer to the 'Things to consider' in next column**	Review instructions from Best Practice or MedicalDirector on how to identify medications that have not been prescribed recently.
3.	**Are all GPs aware of the benefits of accessing MyHealth Record (MHR) for patient information including: medication data, discharge summaries, allergies, immunisations, MBS claiming history and pathology and diagnostic imaging reports.** ☐ Yes, continue with next activity ☐ **No, refer to the 'Things to consider' in next column**	Refer to MHR for information on accessing. Further information is available on the COORDINARE website Review instructions, summary sheets and online demonstrations at digitalhealth.gov.au

	Activity	Things to consider
4.	**Do you conduct deprescribing on patients?** ☐ Yes, continue with next activity ☐ **No, refer to the 'Things to consider' in next column**	Refer to the clinical support and training resources on COORDINARE's website to guide your practice in opioid management and deprescribing, including a suite of tools developed by Woonona Medical Practice: • Medication stewardship in General Practice implementation guide • Opioid agreement - Trial • Opioid agreement • Opioid patient handout • Opioid policy and protocol template Review Primary Health Tasmania Deprescribing Resources Review Deprescribing Guide, NSW TAG NPS Medicinewise **HealthPathways** Illawarra- Shoalhaven HealthPathways Medication Management and Polypharmacy in Older Persons ACT-Southern NSW HealthPathways Medication Management and Polypharmacy in Older Persons
5.	**Are all providers registered for SafeScript NSW once it is rolled out to SE NSW?** ☐ Yes, continue with next activity ☐ **No, refer to the 'Things to consider' in next column**	Refer to information to registers for SafeScript NSW
6.	**Do you complete home medication reviews (HMRs) on patients?** ☐ Yes, confirm all the items under 'Things to consider' are in place and then move to next activity ☐ **No, refer to the 'Things to consider' in next column**	Refer to MBS criteria for HMRs. Refer to documents on COORDINARE's website on opioid management, including a suite of tools developed by Woonona Medical Practice. • Medication stewardship in General Practice implementation guide • Opioid agreement - Trial • Opioid agreement • Opioid patient handout • Opioid policy and protocol template Consider using this COORDINARE model of care in implementing a process for undertaking medication reviews in collaboration with a local pharmacist. Do you have a process in place to identify patients eligible for a HMR? ☐ Yes ☐ No Do you have a person responsible for identifying these patients? ☐ Yes ☐ No Do you have a process in place to provide HMRs to these patients? ☐ Yes ☐ No

	Activity	Things to consider
7.	**Do you have a pharmacy or medical student who could assist with coordinating medication management activities?** ☐ Yes, continue with next activity ☐ **No, refer to the 'Things to consider' in next column**	Identify options for utilising a student.
	 **After reviewing your practice's medication management processes, are there any changes with the management of your patients you would like to implement over the next 12 months?** ☐ **Yes, set goals and outline actions to be taken** ☐ No, you have completed this activity	Use COORDINARE's Quality Improvement Methodology (QIM) and resources below to develop your Improvement Plan: ◗ Improvement plan ◗ Facilitation Tool ◗ Tracking Tool

6.7. Activity: Maintaining quality patient records

The quality of practice and clinical health records has a direct impact on the quality of care that your practice team provides to your patients. It is important that you design and implement effective arrangements for maintaining quality patient records.

The aim of this activity is to identify data cleansing activities for your practice.

	Activity	Things to consider
1.	**Are all chronic diseases coded in past history using the drop down menu supplied?** ☐ Yes, continue with next activity ☐ **No, refer to the 'Things to consider' in next column**	Refer to COORDINARE's data quality (SPDS) manual for guidance on coding using your eMR and fixing past coding issues.
2.	**Are patient details up to date including:** • **address and phone number** • **next of kin** • **emergency contact** • **allergy status** • **ethnicity** ☐ Yes, continue with next activity ☐ **No, refer to the 'Things to consider' in next column**	Refer to COORDINARE's data quality SPDS Data Cleansing Manual for tips on avoiding data entry errors and easy quality improvements. Does the practice have a process whereby the administration team continually check and update these details? ☐ Yes ☐ No
3.	**Does your practice regularly update lifestyle risk factors including:** • **height, weight & BMI** • **waist circumference** • **smoking status** • **alcohol status** • **physical activity assessment** ☐ Yes, continue with next activity ☐ **No, refer to the 'Things to consider' in next column** PIP QI	Refer to the most recent COORDINARE SPDS Quarterly Data Quality Snapshot available from your Health Coordination Consultant. Use it to benchmark your practice's data for that quarter. Does the practice have a process in place to ensure these details are recorded and kept up to date? ☐ Yes ☐ No

	Activity	Things to consider
4.	**Do you regularly update patient consent?** ☐ Yes, continue with next activity ☐ **No, refer to the 'Things to consider' in next column**	Refer to RACGP information SPDS practices must set up SPDS patient information posters in main reception area/waiting rooms. For help contact your Health Coordination Consultant.
5.	**Do you update and upload shared health summaries?** ☐ Yes, continue with next activity ☐ **No, refer to the 'Things to consider' in next column**	Instructions are available as summary sheets or online demonstrations at digitalhealth.gov.au Also see COORDINARE's website
6.	**Are you aware that the RACGP has a quality patient records improvement guidance to assist general practices?** ☐ Yes, continue with next activity ☐ **No, refer to the 'Things to consider' in next column**	Refer to RACGP Improving patient record management in general practice.
	 **After reviewing your practice's data cleansing procedures, are there any changes with the management of your patients you would like to implement over the next 12 months?** ☐ **Yes, set goals and outline actions to be taken** ☐ No, you have completed this activity	Use COORDINARE's Quality Improvement Methodology (QIM) and resources below to develop your Improvement Plan: ◗ Improvement plan ◗ Facilitation Tool ◗ Tracking Tool

6.8. Activity: Recalls, reminders and patient follow-up

Having a recall and reminder system for the follow up of tests, results, referrals and appointments in the practice is essential for safe continuing care and preventive care. To facilitate safe, good quality care, appropriate systems must be in place to ensure that pathology, radiology, and any other investigative tests and/or referrals are properly initiated, acted upon, and the results communicated in a timely manner.

Your practice may need to modify recalls, reminders and patient follow-ups during a pandemic or natural disaster.

The aim of this activity is to review your practice's recall, reminder and patient follow-up procedures.

	Activity	Things to consider
1.	**Do you have a documented recall and reminder management protocol?** ☐ Yes, continue with next activity ☐ **No, refer to the 'Things to consider' in next column**	Refer to Train IT Medical sample recall management protocol. Refer to the RACGP - Guiding principles for clinical follow up systems in general practice software Refer to page 8 of COORDINARE's Aboriginal Health Quality Improvement Toolkit.
2.	**Do you have a dedicated person responsible for contacting patients about a recall and reminder?** ☐ Yes, confirm all the items under 'Things to consider' are in place and then move to next activity ☐ **No, refer to the 'Things to consider' in next column**	Do they have a documented procedure? ☐ Yes ☐ No How often do they check if there is a patient to contact for a recall? ☐ Daily ☐ Weekly ☐ Monthly ☐ When they get time How often do they check if there is a patient to contact for a reminder? ☐ Daily ☐ Weekly ☐ Monthly ☐ When they get time Have you discussed this at a team meeting to ensure all relevant team members understand the process. ☐ Yes ☐ No
3.	**Do you need to make any changes to your procedures if practice team members are working remotely?** ☐ **Yes, refer to the 'Things to consider' in next column** ☐ No, continue with next activity	Do you know what changes you would need to make? ☐ Yes ☐ No Is there someone who has responsibility to update the procedure? ☐ Yes ☐ No
4.	**Do you need to change the way you contact patients about a recall or reminder?** ☐ **Yes, refer to the 'Things to consider' in next column** ☐ No, continue with next activity	Does someone have responsibility to update the procedure? ☐ Yes ☐ No Is there a process in place to inform staff about the changes? ☐ Yes ☐ No

	Activity	Things to consider
5.	**Have you as a practice team discussed how you will continue to ensure patients are attending for their reminder appointments? (e.g. breast screen, cervical screening, immunisations, health assessments, bone density etc).** ☐ Yes, continue with next activity ☐ **No, refer to the 'Things to consider' in next column**	Have you met as a team to discuss key priorities and how you will be able to manage these patients in your practice? ☐ Yes ☐ No Is there a procedure in place to manage these patients? ☐ Yes ☐ No
	 **After reviewing your practice's recall, reminder and patient follow-up, are there any changes with the management of your patients you would like to implement over the next 12 months?** ☐ **Yes, set goals and outline actions to be taken** ☐ No, you have completed this activity	Use COORDINARE's Quality Improvement Methodology (QIM) and resources below to develop your Improvement Plan: ◗ Improvement plan ◗ Facilitation Tool ◗ Tracking Tool

Improvement Plan Example

PRACTICE NAME:

Example Practice

1. WHAT ISSUES DID YOU FIND?

This is where you list any of the issues that you discovered through your initial audit. The issues could be based on practice data e.g. Clinical Audit Tools and clinical database audits, cultural audit tool, readiness tool, near misses and patient and/or staff feedback. It could also include issues or challenges identified with internal processes and workflows. Once you have a detailed list you can use it in future Improvement plans.

- More than half our diabetes patients did not have a flu vaccination recorded in the last 12 months
- COVID has resulted in our staff resources being redirected away from chronic disease for 2 years and also diabetes patients being reluctant to attend the practice.
- A lot of patients are tending to go to pharmacies for flu vaccination.

2. WHAT ARE YOU TRYING TO IMPROVE?

Pick one area - Quality Improvement Measure (QIM) you are going to work on. You could pick something from the list you identified above. Other useful resources to help you pick your QIM is your benchmarking report or your Sentinels Practice Data Sourcing (SPDS) quarterly data quality snapshot.

Influenza immunisation coverage for our diabetes population.

3. WHAT IS YOUR BASELINE?

In order to measure your improvement you need to know where you are starting from. Without measuring, it is impossible to know whether the change has resulted in an improvement.

The percentage of diabetes patients without an influenza vaccination recorded in the last 12 months is 62%

4. SET YOUR GOAL

Use SMART goal setting to ensure your goal is specific (S), measurable (M), achievable (A), realistic (R) and time based (T).

Reduce the percentage of diabetes patients who do not have an influenza vaccination recorded to 45% by the end of this year's winter season.

5. IMPROVEMENT PLAN – START DATE

1 April 2022

6. IMPROVEMENT PLAN – END DATE

1 September 2022

7. WHO IS YOUR PRACTICE CHAMPION

This is the staff member who is dedicated to leading the work.

Nurse Cindy.

8. WHAT WILL YOUR PRACTICE CHAMPION DO?

Provide an overview of the actions and responsibilities of the Practice Champion for the duration of the Improvement Plan

- Undertake data cleansing to ensure we are working with an up-to-date database, eg inactivate patients who have not been active for 2 years.
- Search for any patients who have an uncoded diagnosis of diabetes by checking the uncoded diagnosis list and by searching for patients taking diabetes medication but without a coded diagnosis
- Contact your Health Coordination Consultant for advice on running some of the queries.
- Run the CAT4 report of unvaccinated diabetes patients and check the list to remove those who are deceased, visitors to the area etc.
- Utilise the AIR to check patients' immunisation histories.
- Provide the list to Senior Receptionist for sending SMS.
- Re-run the CAT4 report each month and contact patients who have not responded and any newly diagnosed diabetes patients.
- Plot our results for each month using COORDINARE's Tracking Tool.

9. WHO WILL BE SUPPORTING THE PRACTICE CHAMPION?

The Practice Champion should consult with the practice team to establish who else in the practice will support the activity and what their role will be. Provide an overview of the actions and responsibilities of any other staff that will be supporting the Practice Champion for the duration of the Improvement Plan.

- The Practice Manager will meet with Nurse Cindy to discuss progress and any issues that arise.
- The Senior Receptionist will send the reminder SMS to call patients in for vaccination.
- The Senior Receptionist and Nurse Cindy will call those patients who don't respond to the reminder SMS.
- Doctors will be requested to code all newly diagnosed diabetes patients and not to free text.

10. HOW WILL YOU COMMUNICATE YOUR PROGRESS?

Provide an overview of how you will communicate any issues or concerns, as well as share your results and progress with both your practice team and external stakeholders like patients and COORDINARE.

- Progress results will be presented at monthly team meetings.
- A graphs of each month's results will be posted on the kitchen wall.
- Results to date will be provided to COORDINARE at catchups with our Health Coordination Consultant.

11. HOW OFTEN WILL YOUR PRACTICE TEAM MEET?

Provide an overview of how often your practice team will meet. Consider an ongoing / recurring calendar appointment for the duration of the Improvement Plan.

Monthly

Improvement Plan Template

If you are setting more that one goal, click here to download the template.

PRACTICE NAME:

1. WHAT ISSUES DID YOU FIND?

This is where you list any of the issues that you discovered through your initial audit. The issues could be based on practice data e.g. Clinical Audit Tools and clinical database audits, cultural audit tool, readiness tool, near misses and patient and/or staff feedback. It could also include issues or challenges identified with internal processes and workflows. Once you have a detailed list you can use it in future Improvement plans.

2. WHAT ARE YOU TRYING TO IMPROVE?

Pick one area - Quality Improvement Measure (QIM) you are going to work on. You could pick something from the list you identified above. Other useful resources to help you pick your QIM is your benchmarking report or your Sentinels Practice Data Sourcing (SPDS) quarterly data quality snapshot.

3. WHAT IS YOUR BASELINE?

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4. SET YOUR GOAL

Use SMART goal setting to ensure your goal is specific (S), measurable (M), achievable (A), realistic (R) and time based (T).

5. IMPROVEMENT PLAN – START DATE

6. IMPROVEMENT PLAN – END DATE

7. WHO IS YOUR PRACTICE CHAMPION

This is the staff member who is dedicated to leading the work.

8. WHAT WILL YOUR PRACTICE CHAMPION DO?

Provide an overview of the actions and responsibilities of the Practice Champion for the duration of the Improvement Plan

9. WHO WILL BE SUPPORTING THE PRACTICE CHAMPION?

The Practice Champion should consult with the practice team to establish who else in the practice will support the activity and what their role will be. Provide an overview of the actions and responsibilities of any other staff that will be supporting the Practice Champion for the duration of the Improvement Plan.

10. HOW WILL YOU COMMUNICATE YOUR PROGRESS?

Provide an overview of how you will communicate any issues or concerns, as well as share your results and progress with both your practice team and external stakeholders like patients and COORDINARE.

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Provide an overview of how often your practice team will meet. Consider an ongoing / recurring calendar appointment for the duration of the Improvement Plan.

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