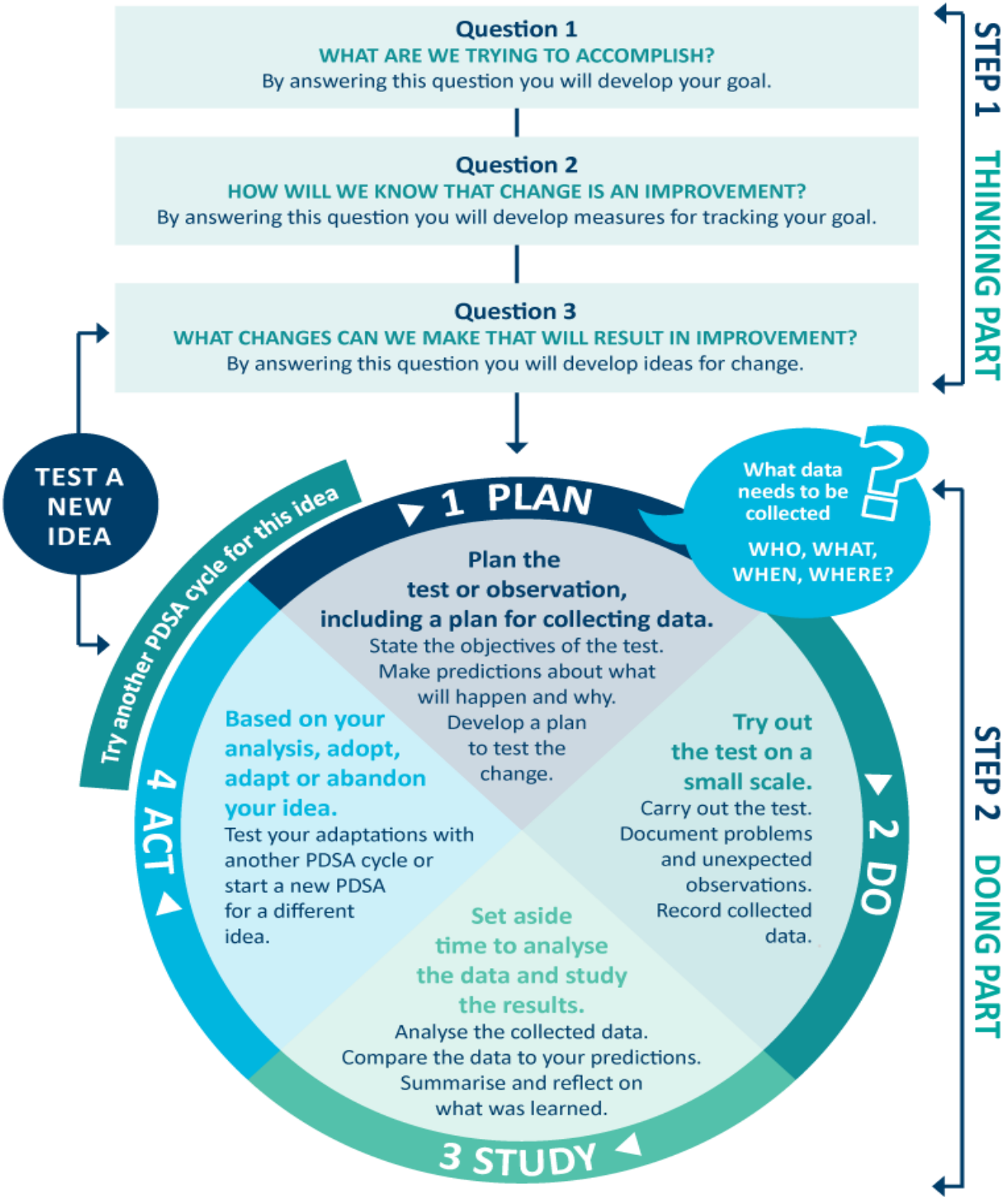
Model for Improvement diagram



Source: http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx

MFI and PDSA template

Step 1: The thinking part - The 3 fundamental questions

Practice name: Practice Flintstones	**Date: 01/08**
Team members: Wilma (practice nurse), Fred (GP) and Betty (receptionist)	

Q1. What are we trying to accomplish? (Goal)

By answering this question, you will develop your GOAL for improvement.
Record this as a S.M.A.R.T. goal (**S**pecific, **M**easurable, **A**chievable, **R**elevant, **T**ime bound).

By 31 December, we will increase the number of our active patients with diabetes type I or II who have had their blood pressure (BP) recorded in the last 6 months by 30.

Q2. How will I know that a change is an improvement? (Measure)

By answering this question, you will determine what you need to MEASURE in order to monitor the achievement of your goal. Include how you will collect your data (e.g. Primary Sense reports, patient surveys etc). Record and track your baseline measurement to allow for later comparison.

We will measure the number of patients with diabetes type I or II who have a current BP recorded each month until the end of December.

To do this, we will initially run the Primary Sense report (as referenced in the plan section) to establish our baseline (the number of patients with diabetes type I or II who have a current BP recorded)

We will then run the Primary Sense report at the end of each month and record our increases to track improvements.

BASELINE MEASUREMENT: 55 patients DATE: 01 August

Q3. What changes could we make that will lead to an improvement? (List your IDEAS)

By answering this question, you will generate a list of IDEAS for possible changes you could implement to assist with achieving your S.MA.R.T. goal. You will test these ideas using part 2 of this template, the 'Plan, Do, Study, Act (PDSA)' cycle. Your team could use brainstorming or a driver diagram to develop this list of change ideas.

IDEA: Search Primary Sense to identify patients with diabetes who have not had their BP recorded. Contact these patients to book in appointments.

IDEA: Send reminder to patients with diabetes type I or II who have an overdue GPMP/review.

IDEA: Review recall and reminder system to ensure routine patient care reminders are being initiated.

IDEA: Invite all active eligible patients diagnosed with diabetes type I or II but no CVD diagnosis to complete a 699-heart health check.

Note: Each new GOAL (1st Fundamental Question) will require a new Model for Improvement plan.

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

MFI and PDSA template

Step 2: The doing part - Plan, Do, Study, Act

You will have noted your IDEAS for testing when you answered the 3rd fundamental question in step 1. You will use this template to test an idea. Ensure you communicate the details of the plan to the entire practice team.

IDEA	Record the change idea you are testing
Which idea are you going to test? *(Refer to Q3, step 1 above)*	
Search Primary Sense to identify patients with diabetes who have not had their BP recorded. Contact these patients to book in appointments.	
PLAN	**Record the details of how you will test your change idea**
Plan the test, including a plan for collecting data	What exactly do you plan to do? Record who will do what; when they will do it (day, time etc) and for how long (1 week, 2 weeks etc); and where (if applicable); the data to be collected; and predictions about the outcome.

WHAT: Search Primary Sense to identify diabetic patients who have not had their BP recorded. Contact these patients to book in appointments.

WHO/WHEN/WHERE: Wilma, the practice manager will run a Diabetes Mellitus report in Primary Sense on 15 August. Wilma will also double check the existing appointment field to ensure the patients do not already have an appointment booked. If they do have any appointment booked, Wilma will flag this in the alerts section of Primary Sense. Wilma will then ask Betty, the receptionist to contact the list of patients with the view to book appointments.

DATA TO BE COLLECTED: Identify patients with diabetes who have no BP recorded.
This will be done using the Primary Sense report function using the following instructions:

1. Open Primary Sense
2. Click on reports
3. Click on diabetes in the keyword filter section
4. Double click on the Diabetes Mellitus report to run the report
5. Scroll down to the 'Patients with diabetes who may be eligible for chronic care occasions of service' category to find patients with BP date and BP recorded sections. You can use the up and down arrow function next to the BP date to filter.
6. Optional - Export the report to Excel or CVS to save or print.

PREDICTIONS: We predict that we will see an increase of 30 patients with diabetes type I or II having their BP recorded bringing the total to 85.

DO	Run the test, then record your actions, observations and data
Run the test on a small scale	What did you do? Were there any deviations from the original plan? Record exactly what you did, the data collected and any observations. Include any unexpected consequences (positive or negative).

16 August - Wilma, the practice manager ran the diabetes mellitus report in Primary Sense. Wilma checked the existing appointment field in the Primary Sense report to identify any patient who had an existing appointment. Wilma found a small amount of patients had appointments booked so she added alerts in Primary Sense so that Fred, the GP could action this at the patient's appointment.

18 August - Betty, the receptionist set up an SMS communication for the patients identified from Wilma.

25 August – Fred, the GP saw his first diabetic patient from the list and recorded his BP. Fred also saw that the patient identified as Aboriginal so due to his risk factors and the fact that Aboriginal and Torres Strait Islander people are eligible for the My Health for Life (MH4L) program, regardless of their existing chronic condition, he referred the patient to the (MH4L) program to assist with decreasing the risk of him developing any further chronic conditions.

20 September – Wilma ran the Primary Sense report again to see how they were tracking. Wilma asked Betty to send out another SMS which had a link to a QLD Health article which detailed the importance of patients with diabetes getting their BP checked and inviting patients to book an appointment. Wilma also sent an email to the clinical staff and asked them to be vigilant in recording BP results for patients with diabetes and explained the PDSA project.

30 October – Wilma ran the Primary Sense report again to see how they were tracking. Wilma was particularly interested to see if her SMS and email from last month had an impact. Wilma was excited to see that they had recorded BPs for 15 additional patients with diabetes. This brought them to a total of 16.

22 December – Wilma had been very busy and hadn't had a chance to run the Primary Sense report since October. Wilma ran the Primary Sense report to analyse the results of the project since they were closing over the Christmas break and found that they had recorded a further 15 BPs recorded for patients with diabetes which took them to a total of 31.

STUDY	Analyse the data and your observations
Analyse the results and compare them to your predictions	Was the plan executed successfully? Did you encounter any problems or difficulties? What worked/didn't work? What did you learn on the way? Compare the data to your predictions. Summarise and reflect on what was learned.

The plan was successful and went better than we expected. We originally expected an increase from 55 to 85 which would have resulted in an increase of 30 but we saw an increase of 31 which equates to a total of 86 patients overall.

We learnt that it is very easy to incorporate other preventative health programs such as My Health for Life to support patients.

We were very proud of what we achieved so we included this in our monthly staff email to congratulate the team on what we achieved together. The team is excited to see what other quality improvement activities we can do.

Communicate the results of your activity with your whole team. Celebrate any achievements, big or small.

ACT	Record what you will do next
Based on what you learned from the test, record what your next actions will be	Will you adopt, adapt or abandon this change idea? Record the details of your option under the relevant heading below. *ADOPT: record what you will do next to support making this change business as usual*; ADAPT: *record your changes and re-test with another PDSA cycle; or ABANDON: record which change idea you will test next and start a new PDSA.*

ADOPT: Our team value the importance of checking and recording BP results for patients with diabetes and will continue to do this as part of the practice process when engaging with our patients with diabetes and incorporate this into business as usual.

ADAPT: We are going to look out for eligible patients to refer to the MH4L program where possible. This is especially important for patients with diabetes and who identify as Aboriginal or Torres Strait Islander.

ABANDON:

Repeat step 2 to re-test your adapted plan or to test a new change idea