phn BRISBANE SOUTH
An Australian Government Initiative

QUALITY IMPROVEMENT TOOLKIT FOR GENERAL PRACTICE

DISASTER PREPARE

Patient management MODULE

Version 1

December 2021

DISASTER PREPARE – PATIENT MANAGEMENT

The Quality Improvement (QI) toolkit

This QI toolkit is made up of modules that are **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 the Model For Improvement (MFI).

Throughout the modules 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 MFI.

The MFI uses the Plan-Do-Study-Act (PDSA) cycle, a tried and tested approach to achieving successful change. It offers the following benefits:

- A simple approach that anyone can apply.
- Reduces risk by starting small.
- It can be used to help plan, develop and implement change that is highly effective.

The MFI helps you break down your change implementation into manageable pieces, which are then tested to ensure that the change results in measurable improvements, and that minimal effort is wasted. There is a bowel cancer screening example using the MFI at the end of this module.

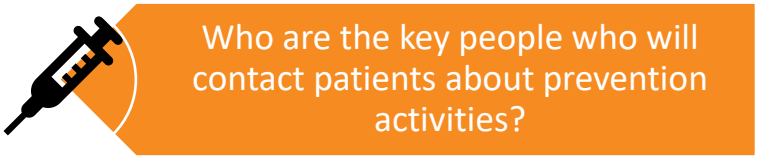
If you would like additional support in relation to quality improvement in your practice please contact Brisbane South PHN on support@bsphn.org.au.

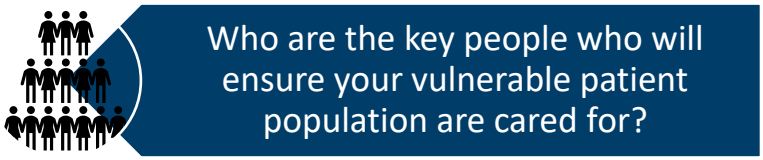
Due to constant developments in research and health guidelines, the information in this document will need to be updated regularly. Please contact Brisbane South PHN if you have any feedback regarding the content of this document.

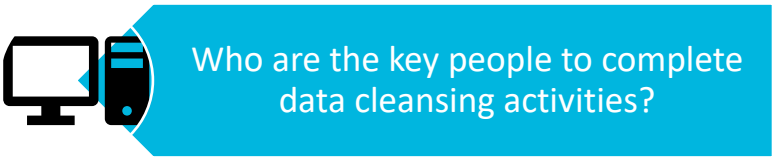
This icon indicates that the information relates to the ten Practice Incentive Program Quality Improvement (PIP QI) measures.

Toolkit aim - to review your practice systems to ensure patients are provided with the right care at the right time during the pandemic to support a person -centred approach to their care.

Key questions to consider







Contents

How to use this toolkit

There are checklists included below that will guide you and your practice.

- Use this toolkit to guide you along the journey.
- Set yourselves timelines to achieve your goals.
- Consider potential internal or external factors that could impact the activity and factor these into your planning e.g. accreditation preparation, staff leave (planned or unplanned), global pandemic, influenza vaccination season.
- Review your progress regularly.
- If you find your process is not working and you are not seeing improvements, then review your process and start again.

For more support

 support@bsphn.org.au

 1300 467 265

PATIENT MANAGEMENT

General practitioners work in close and respectful relationships to deliver accessible, integrated patient care: leading, supporting and coordinating their flexibly configured clinical teams; contributing appropriately to external clinical teams, and engaging with diverse specialists and other sector services according to individual patient or family needs.

The GP plays a central role in the delivery of health care to the Australian community. The GP:

- is most likely the first point of contact in matters of personal health
- coordinates the care of patients and refers patients to other specialists
- cares for patients in a whole of person approach and in the context of their work, family and community
- cares for patients of all ages, both sexes, children and adults across all disease categories
- cares for patients over a period of their lifetime
- provides advice and education on health care
- performs legal processes such as certification of documents or provision of reports in relation to motor transport or work accidents.[1]

Please note: Some of the GP practice services (e.g. prevention or CDM) will be difficult to provide or need to be postponed during a pandemic/natural disaster as resources are finite or reduced (in the practice and also more generally in the health system). As a practice you will need to be directed towards meeting any new challenge.

Activity 1.1 – Preventative 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.[2]

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 preventative health measures provided in your practice.

Description	Status	Action to be taken
Have you considered how you would continue to provide preventative health if patients are preferring telehealth appointments? • Immunisations (adult & children) • Cancer screening (breast, bowel & cervical) • Health assessments • High CV risk • Hypercholesterolaemia • High blood pressure	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to CAT4 recipes: (ideas only). • Identify pregnant patients without Pertussis immunisation • Identify Patients Eligible for Shingles Vaccination • Find patients eligible for cervical screening • Find patients who do not have an FOBT recorded • Find patients who have not had a mammogram recorded

[1] https://www.racgp.org.au/education/students/a-career-in-general-practice/what-is-general-practice
[2] https://www.racgp.org.au/download/Documents/Guidelines/Redbook9/17048-Red-Book-9th-Edition.pdf

Description	Status	Action to be taken
• Childhood obesity • Advance care planning		• Identify patients eligible for a Self-Collected Cervical Screening Test • PIP QI improvement measures • Find high risk patients eligible for My Health For Life • Find indigenous patients eligible for My Health For Life • Find patients eligible for My Health For Life with high CV Event risk • Find patients with familial hypercholesterolaemia eligible for My Health For Life • Find patients with high blood pressure eligible for My Health For Life • Find patients with high cholesterol eligible for My Health For Life • Identify Patients at Risk of Diabetes Mellitus Type II • Identify patients not on Lipid lowering medication with HDL<1 and Cholesterol >6.5mmol/L • SpotOnHealth HealthPathways – advance care planning. As a practice team, meet to discuss key priorities and how you will be able to manage these patients in your practice.
Have you considered how you would continue to maintain quality improvement activities?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Access BSPHN QI toolkits.
Do you have a plan on how you will communicate with patients about preventative health activities?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Consider and develop your plan. Will you use SMS, phone call etc. Who will have the responsibility to identify eligible patients for preventative health appointments?

Description	Status	Action to be taken
 After reviewing your practice's preventative 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 in actions to be taken**. ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 1.2 – 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.

Description	Status	Action to be taken
Do you have a system to ensure your patients with a chronic medical condition are still receiving appropriate care?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to CAT4 recipes (ideas only). • CVD Patients with no BP recorded • Identify elevated CV risk - Part A • Identify elevated CV risk - Part B • Identifying CHD patients not on antithrombotics • Identifying Coronary Heart Disease (CHD) patients not on ACE or ARB medication • Identifying Coronary Heart Disease (CHD) patients not on lipid modifiying medication • Identifying Coronary Heart Disease patients with high BP recorded in the last 12 months • Identifying the smoking status of Coronary Heart Disease (CHD) patients • Identify patients with a stroke or TIA not on antiplatelet therapy

Description	Status	Action to be taken
		• Identify patients with a stroke or TIA not on BP lowering medication • Identify patients with a stroke or TIA not on cholesterol lowering medication • Identify patients with diabetes without HbA1c results recorded in the last 12 months • Identify Patients with Type II Diabetes and CVD not on Statins • Patients taking Glucocorticoids who are smokers • Identify outstanding Diabetes Cycle of Care Items - cross tabulated. As a practice team, meet to discuss key priorities and how you will be able to manage these patients in your practice.
Have you discussed as a practice team what should be the minimum care provided to patients with a chronic disease?	☐ Yes, **see action to be taken**.	Outline what is the minimum care for chronic disease patients:
	☐ No, **see action to be taken.**	Discuss as a practice team what will be the minimum care provided. Will this be in line with the CDM criteria (GPMP &/or TCA plan every 6 months). Who will have the responsibility to identify patients and monitor their interaction with the practice?

Description	Status	Action to be taken
Will the practice proactively contact patients with a chronic disease who have not had a visit in the past 6 months?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to CAT4 recipe on last visit. (*You may wish to search by a specific chronic condition, or age).*
Will you review your patients with a chronic medical condition to ensure they continue to have regular blood and urine tests?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to example CAT4 recipes: • Diabetes patients with no HbA1c recorded in the past 12 months • Identify outstanding diabetes cycle of care items • Identify patients who are missing data for CVD risk assessment.
Do you regularly review the COVID-19 status report from Australian Immunisation Register (AIR)?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to the AIR42 report.
Are you aware that Brisbane South PHN have a number of QI toolkits available to assist you to manage your patients with a chronic medical condition?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to toolkits available from website.
 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 in actions to be taken**. ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 1.3 – Supporting 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).[3]

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

Description	Status	Action to be taken
Do you know how many patients who have a mental health condition?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to instructions from CAT4: • Number of patients with a mental health condition • Indicated mental health with no diagnosis • Identify patients seen by an individual provider. You can also search for patients based on medications, including: antidepressants, antipsychotics, mood stabilisers, pain relief medications.
Have you discussed as a team the minimum care you will provide to patients with a mental health condition?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Outline what is the minimum care for patients with a mental health condition: Discuss as a practice team what will be the minimum care provided. Who will have the responsibility to identify patients and monitor their interaction with the practice?
Do you have access to tools and assessments to assist with identification of mental health condition?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to list of tools and assessments available in the mental health introduction QI toolkit.

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

Description	Status	Action to be taken
Do you complete mental health treatment plans on patients?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to MBS criteria for MHTP. Refer to MBS QI toolkit from Brisbane South PHN for instructions on how to complete templates.
Are you aware that some mental health consultations are only available to claim via videoconference, not available via telephone?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to the fact sheet from MBS.
 After reviewing your patient's 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 in actions to be taken**. ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 1.4 – Vulnerable populations

Support for vulnerable people, their families and their caregivers is an essential part of the countries' comprehensive response to the 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.

Please note: when considering your vulnerable patient population, some of these patients may not be vaccinated which would mean they may not be eligible for face to face consultations.

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

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

Description	Status	Action to be taken
Do you have any patients who are experiencing homelessness?	☐ Yes, **see action to be taken**. ☐ No, continue with activity.	How do you identify these patients? How do you provide any follow-up care for these patients? Does a person in the practice have responsibility for these patients? ☐ Yes ☐ No If yes, who is this person?
Do you have any patients who identify as Aboriginal and Torres Strait Islander?	☐ Yes, **see action to be taken**. ☐ No, continue with activity.	Refer to CAT4 instructions on ethnicity filtering to identify these patients. How do you provide any follow-up care for these patients? Does a person in the practice have responsibility for these patients? ☐ Yes ☐ No If yes, who is this person?
Do you have any patients who are from refugee and migrant populations?	☐ Yes, **see action to be taken**. ☐ No, continue with activity.	Refer to CAT4 instructions on ethnicity filtering to identify these patients. How do you provide any follow-up care for these patients? Does a person in the practice have responsibility for these patients? ☐ Yes ☐ No If yes, who is this person? Do all providers have access to the Translating and Interpreting Service (TIS)? ☐ Yes ☐ No

Description	Status	Action to be taken
Do you have any Veterans patients?	☐ Yes, **see action to be taken**. ☐ No, continue with activity.	Refer to CAT4 instructions to identify DVA patients. How do you provide any follow-up care for these patients? Does a person in the practice have responsibility for these patients? ☐ Yes ☐ No If yes, who is this person?
Do you have any patients who are victims of family and domestic violence?	☐ Yes, **see action to be taken**. ☐ No, continue with activity.	How do you identify these patients? How do you provide any follow-up care for these patients? Does a person in the practice have responsibility for these patients? ☐ Yes ☐ No If yes, who is this person?
Do you have any 'at-risk' or socially disengaged adolescents? This may include children and young people in out of home care.	☐ Yes, **see action to be taken**. ☐ No, continue with activity.	How do you identify these patients? How do you provide any follow-up care for these patients? Does a person in the practice have responsibility for these patients? ☐ Yes ☐ No If yes, who is this person?
Do you have any patients who are housebound?	☐ Yes, **see action to be taken**. ☐ No, continue with activity.	How do you identify these patients? How do you provide any follow-up care for these patients?

Description	Status	Action to be taken
		Does a person in the practice have responsibility for these patients? ☐ Yes ☐ No If yes, who is this person?
Do you have any patients with dementia?	☐ Yes, **see action to be taken**. ☐ No, continue with activity**.**	Refer to CAT4 instruction on dementia patients to identify these patients. How do you provide any follow-up care for these patients? Does a person in the practice have responsibility for these patients? ☐ Yes ☐ No If yes, who is this person?
Do you have any patients who are in a residential aged care facility?	☐ Yes, **see action to be taken**. ☐ No, continue with activity**.**	How do you identify these patients? How do you provide any follow-up care for these patients? Does a person in the practice have responsibility for these patients? ☐ Yes ☐ No If yes, who is this person?
Do you have any patients who are pregnant?	☐ Yes, **see action to be taken**. ☐ No, continue with activity**.**	Refer to instructions from Best Practice or MedicalDirector to identify these patients. How do you provide any follow-up care for these patients? Does a person in the practice have responsibility for these patients? ☐ Yes ☐ No If yes, who is this person?

Description	Status	Action to be taken
Do you regularly review the COVID-19 status report from Australian Immunisation Register (AIR)?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to the AIR42 report.
 After reviewing your practice's vulnerable patient population, 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 in actions to be taken**. ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 1.5 – Medication reviews including deprescribing

Many of the risks associated with each part of the medication management pathway can be avoided by using systems and processes that are designed to improve safety and are based on evidence from initiatives that have demonstrated significant benefit.

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.

Description	Status	Action to be taken
Do you review and update medication list for each patient? (Consider whether patient still needs listed medications).	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Review instructions from Best Practice or MedicalDirector on how to identify medications that have not been prescribed recently.
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 & diagnostic imaging reports.	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to information on accessing MHR.
Do you conduct deprescribing on patients?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to deprescribing resources.

Description	Status	Action to be taken
Are all providers registered for QScript to be able to prescribe scheduled medications?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to information to register for QScript.
Do you know patients who are on multiple medications?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to instructions from CAT4 on medication count per patient. You may wish to filter the report by individual provider.
Do you complete home medication reviews (HMRs) on patients?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to MBS criteria for HMRs. Refer to MBS QI toolkit from Brisbane South PHN for instructions on how to complete templates.
Do you have a system to ensure patients on ongoing medications will still be able to get repeat scripts and webster packs completed?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Meet as a team to discuss how you can ensure patients receive their regular medications. Ensure systems are in place for electronic prescriptions.
Do you have a pharmacy or medical student who could assist with coordinating medication management activities?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	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 in actions to be taken**. ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 1.6 – 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 for your practice.

Description	Status	Action to be taken
Are all chronic diseases coded in past history using drop down menu supplied?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to instructions from CAT4 on data cleansing.
Are patient details up to date including: • address and phone number • next of kin • emergency contact • allergy status • ethnicity.	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	
Update lifestyle risk factors including: • height, weight & BMI • waist circumference • smoking status • alcohol status • physical activity assessment.	☐ Yes, continue with activity. ☐ No, **see action to be taken**.	Refer to your practices benchmark and trend reports supplied by Brisbane South PHN to monitor your practices data recording. Instructions are available on how to access your reports. Refer to CAT4 recipes: • add height, weight and waist measurements to patient record • Smoking status • Alcohol status • Physical activity.
Do you regularly update patient consent?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to instruction from CAT4 on including patient consent.
Do you update and upload shared health summary?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to instruction from CAT4 on shared health summaries.
Are you aware Brisbane South PHN has a quality patient records QI toolkit to assist general practices?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to QI toolkit.

Description	Status	Action to be taken
 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 in actions to be taken**. ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 1.7 – 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 preventative 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.[4]

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.

Description	Status	Action to be taken
Do you have a documented recall and reminder management protocol?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to Train IT Medical sample recall management protocol.
Do you have a dedicated person responsible for contacting patients about a recall and reminder?	☐ Yes: **see action to be taken.**	Who is the person responsible? 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.
	☐ No: **see action to be taken.**	Develop a procedure for following up on recall and reminder appointments. Appoint a person/people to ensure this is done. Ensure this is added to their position description and task list.

[4] https://ama.com.au/position-statement/patient-follow-recall-and-reminder-systems-2013

Description	Status	Action to be taken
		Discuss this at a team meeting to ensure all relevant team members understand the process.
Do you need to make any changes to your procedures if practice team members are working remotely?	☐ Yes, **see action to be taken**. ☐ No, continue with activity.	Outline what changes you would need to make: Who has responsibility to update the procedure? When will this be completed?
Do you need to change the way you contact patients about a recall or reminder?	☐ Yes, **see action to be taken**. ☐ No, continue with activity.	Outline what changes you would need to make: Who has responsibility to update the procedure? When will this be completed?
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 activity. ☐ No, **see action to be taken.**	Meet to discuss key priorities and how you will be able to manage these patients in your practice.
 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 in actions to be taken**. ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 1.8 – Managing positive COVID-19 results

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 safety 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.

Description	Status	Action to be taken
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, **see action to be taken.**	Who is this contact person? How will they communicate key messages to the practice?
	☐ No, **see action to be taken.**	Appoint a key contact person for the practice. Have a back-up in case this person is unavailable.
Do you have GPs available to care for positive COVID-19 patients remotely?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to assessment and management of patients with suspected COVID-19.
Do you know where to access information on managing health care workers exposed to, or living with, COVID-19?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to the framework.
Do you know where to access MBS telehealth item numbers?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to MBS telehealth information.
After reviewing your practice's procedures for managing positive COVID-19 test, 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 in actions to be taken**. ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Links to other prepare QI toolkits

This toolkit, is part of a suite of disaster prepare QI toolkits. Identify if your practice would like to complete another one of the following topics:

- *Toolkit aim - to review your systems to ensure your practice has adequate planning to continue working during a natural disaster or pandemic.*

Business planning	• *Toolkit aim - to review your systems to ensure your practice has adequate planning to continue working during a natural disaster or pandemic.*
Business continuity	• *Toolkit aim - to review your practice business systems to ensure continuity of the practice is maintained during the pandemic.*
Infection control	• *Toolkit aim - to review your practice systems to ensure infection control and safe work environments are maintained during the pandemic.*

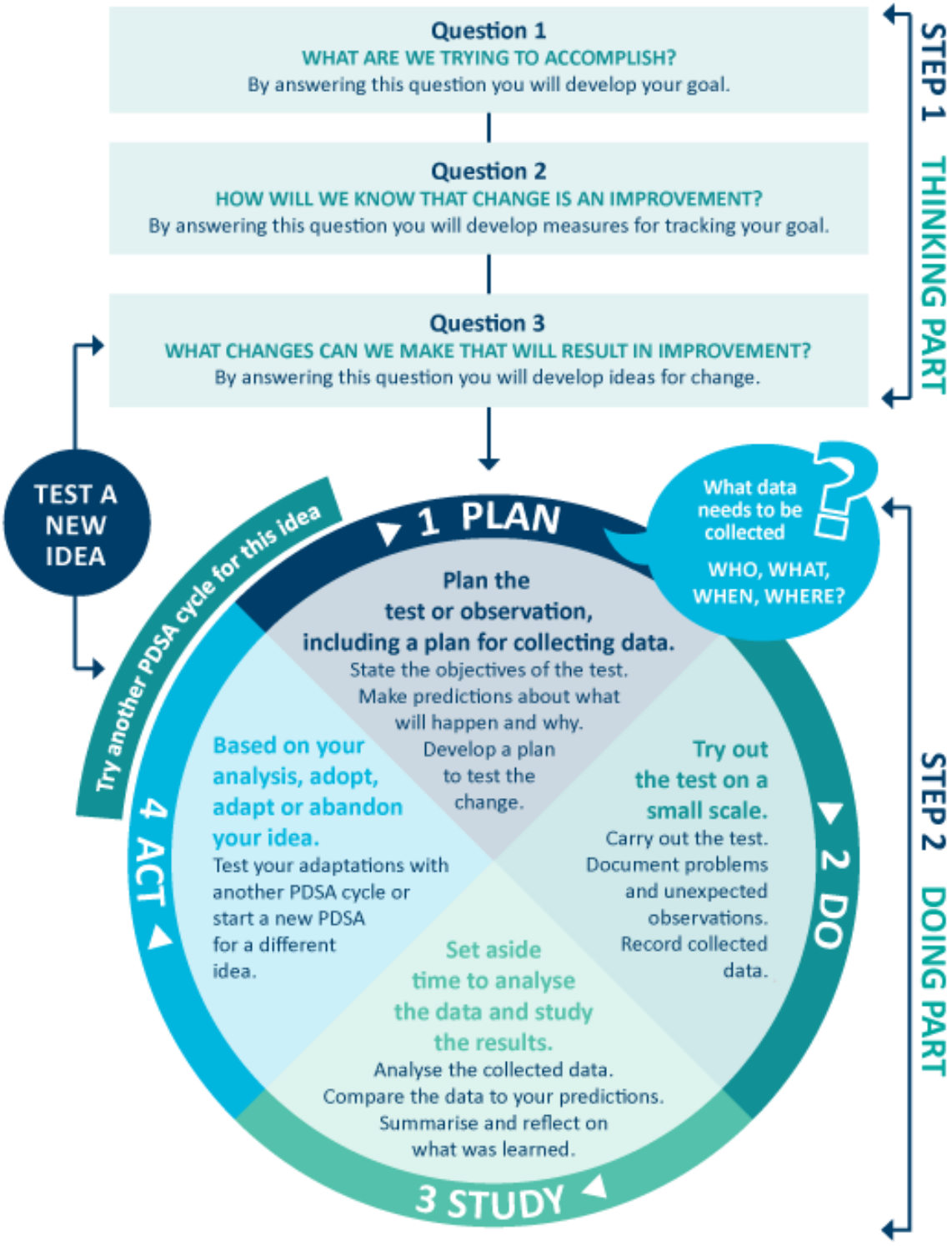
Brisbane South PHN have a full suite of toolkits are available in a variety of topics including: chronic conditions, mental health, prevention, patient populations and quality records and business.

Example PDSA for patient management

See below for suggested goals related to patient management you may wish to achieve within your practice:

Goal	How you may achieve your goal
Ensure 90% of active patients aged 15 years and older have smoking status – current smoker, ex-smoker or never smoked.	Refer to CAT4 recipe: identifying patients with no allergy or smoking status recorded.
Ensure 75% of active patients aged 15 years and older have BMI classified as obese, overweight, healthy or underweight within the previous 12 months.	Refer to CAT4 recipe: adding, height, weight and waist measurements to patients records.
Ensure 90% of active patients aged 15 years and older have their alcohol status recorded.	Refer to CAT4 data to identify the list of patients who do not have their alcohol status recorded.
Increase the cervical screening of the number of eligible female patients aged 25 to 74 years by 10%	Refer to CAT4 recipe: eligible for cervical screening.
Ensure that 90% of active diabetes patients have their blood pressure recorded	Refer to CAT4 recipe: CVD with no BP recorded – *please note: you will be required to select diabetes instead of CVD.*

Model for Improvement diagram



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

MFI and PDSA template EXAMPLE

Step 1: The thinking part - The 3 fundamental questions

Practice name:	**Date:**
Team members:	

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).

Our goal is to:
Increase the number of people who undertake bowel cancer screening.
This is a good start, but how will you measure whether you have achieved this goal? The team will be more likely to embrace change if the goal is more specific and has a time limit.
So, for this example, a better goal statement would be:

Our S.M.A.R.T. goal is to increase the proportion of our patients aged 50 (first timers) that participate in bowel cancer screening by 15% by 31 December.

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. CAT4 reports, patient surveys etc.). Record and track your baseline measurement to allow for later comparison.

We will measure the percentage of active patients aged 50 years that participate in bowel cancer screening. To do this we will:

A) Identify the number of active patients aged 50 years.
B) Identify the number of active patients aged 50 years with a FOBT result.

B divided by A x 100 produces the percentage of patients aged 50 years who have a FOBT result recorded.
This is a good measure, however, please note that as you measure this over time, some people who were included in earlier results will have turned 51 and will not be included. In later measurements, people who have just turned 50 will be included.

BASELINE MEASUREMENT: 27% of active patients aged 50 years have a FOBT result DATE:

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.M.A.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: Identify patients aged 49 by completing a search on CAT4. Contact these patients via letter, phone, SMS etc. to encourage participation in the bowel screening program.

IDEA: Contact eligible patients aged 50 years and 6 months who have not had an FOBT recorded to discuss options for testing.

IDEA: Add bowel cancer screening to templates for chronic disease management and 45-49 year old health assessments.

IDEA: Clinical team develop a system for flagging eligible patients and addressing screening opportunistically.

IDEA: Source and provide endorsed patient education resources (in waiting rooms, toilets etc.).

IDEA: Run an awareness campaign for bowel cancer awareness month in June.

Note: Each new GOAL (1st Fundamental Question) will require a new MFI 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)*	
Contact eligible patients aged 50 years and 6 months who have not had an FOBT recorded to discuss options for testing. .	
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: John to use Sue's office to conduct search on CAT4 and identify active patients aged 50 years who have not had a FOBT result recorded. Searches will be conducted on CAT4 to identify the number of active patients aged 50 years who have not had a FOBT result recorded. Lists of patients will be provided to each GP for review. A Topbar prompt will be created for eligible patients for the vaccine. WHO/WHEN/WHERE: Who: Receptionist. When: 17 November. Where: Dr Brown's office. DATA TO BE COLLECTED: Number of active patients aged 50 years and the status of their FOBT result.	
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).
Done – completed 17 November – while the test went smoothly, the receptionist needed to contact PHN for support with the Pen CS search and the export function. A Topbar prompt was created which assisted the practice team identify patients who did not have a FOBT result recorded when they attended for an appointment. John contacted patients via SMS who did not have a FOBT results recorded, which resulted in 5 people making an appointment to see their GP.	
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.
At the end of the focus on FOBT testing, 38% of patients aged 50 years have had a FOBT result recorded. This has resulted in an 11% increase in results which is 4% lower than our goal. Results have been shared with the whole practice team. Whilst we didn't achieve our goal, we can see the benefit in discussing this with eligible patients. John has been commended for his work in identifying eligible patients. *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:

The practice will regularly monitor FOBT rates via the monthly benchmark report supplied by Brisbane South PHN to ensure the rates are increasing.

John will ensure a Topbar prompt has been created for all patients aged 50 years and 6 months who do not have a FOBT result recorded.

ADAPT:

ABANDON:

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

Acknowledgements

We would like to acknowledge that some material contained in this Toolkit has been extracted from organisations including the Institute for Healthcare Improvement; the Royal Australian College of General Practitioners (RACGP); the Australian Government Department of Health; Best Practice; MedicalDirector, CAT4 and Train IT. These organisations retain copyright over their original work and we have abided by licence terms. Referencing of material is provided throughout.

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Brisbane South PHN, 2022

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