

QUALITY IMPROVEMENT TOOLKIT FOR GENERAL PRACTICE

# CONDITIONS

Asthma

MODULE

Version 2

May 2021



## Introduction

### 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.
- Reduced 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.

There is an asthma and spirometry example using the MFI and a blank template for you to complete at the end of this module.

If you would like additional support in relation to QI in your practice please contact Brisbane South PHN on [support@bsphn.org.au](mailto:support@bsphn.org.au).



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

Due to ongoing development 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.

## 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 would like to acknowledge the contribution of Asthma Australia in the production of this QI toolkit.

**Brisbane South PHN, 2021**

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## ASTHMA

Asthma is a serious condition that leads to the deaths of almost 400 Australians each year. But in most cases, asthma is a manageable condition, and people can live a full life unhindered by its symptoms.

Asthma affects people of all ages, from childhood to adulthood, and it can appear at all ages and stages of life.<sup>1</sup>

### What are the symptoms of asthma?

The most common symptoms of asthma are:

- wheezing – a high-pitched sound coming from the chest while breathing out
- a feeling of not being able to get enough air or being short of breath
- a feeling of tightness in the chest
- coughing.

Asthma symptoms can be triggered by different things for different people. Common triggers include:

- viral respiratory infections, such as colds
- exercise
- exposure to specific allergens (if a person is allergic to them) such as:
  - house dust mites
  - pollens
  - mould spores
  - pets and animals
- environmental irritants such as:
  - tobacco smoke and other air pollutants
  - cold/dry air
- medicines such as:
  - aspirin and other non-steroidal anti-inflammatory drugs (NSAIDs)
- occupational exposures to:
  - specific allergens
  - dust
  - fumes.<sup>2</sup>

More information on asthma triggers can be found in the [Australian Asthma Handbook](#).

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<sup>1</sup> <https://asthma.org.au/about-asthma/>

<sup>2</sup> <https://www.aihw.gov.au/reports/chronic-respiratory-conditions/asthma/contents/asthma>

## Asthma management guidelines

The Australian asthma guidelines have recently been updated and include additional treatment options for adults and adolescents with mild asthma.

Mild asthma is not necessarily a benign condition and patients are still at risk of severe flare-ups, particularly if they overuse short-acting beta<sub>2</sub> agonists such as a salbutamol inhaler.

For adults and adolescents with mild asthma, the updated guidelines include as-needed inhaled low-dose budesonide–formoterol as an alternative to daily low-dose inhaled corticosteroid plus as-needed short-acting beta<sub>2</sub> agonist.

The budesonide–formoterol combination should be taken as needed to provide symptom relief and reduce the risk of severe exacerbations.<sup>3</sup>

The Asthma Australia [guidelines](#) recommend patient asthma is classified as:

- good control
- partial control or
- poor control

To assist your practice to identify levels of recent asthma episodes, refer to the following guidelines:

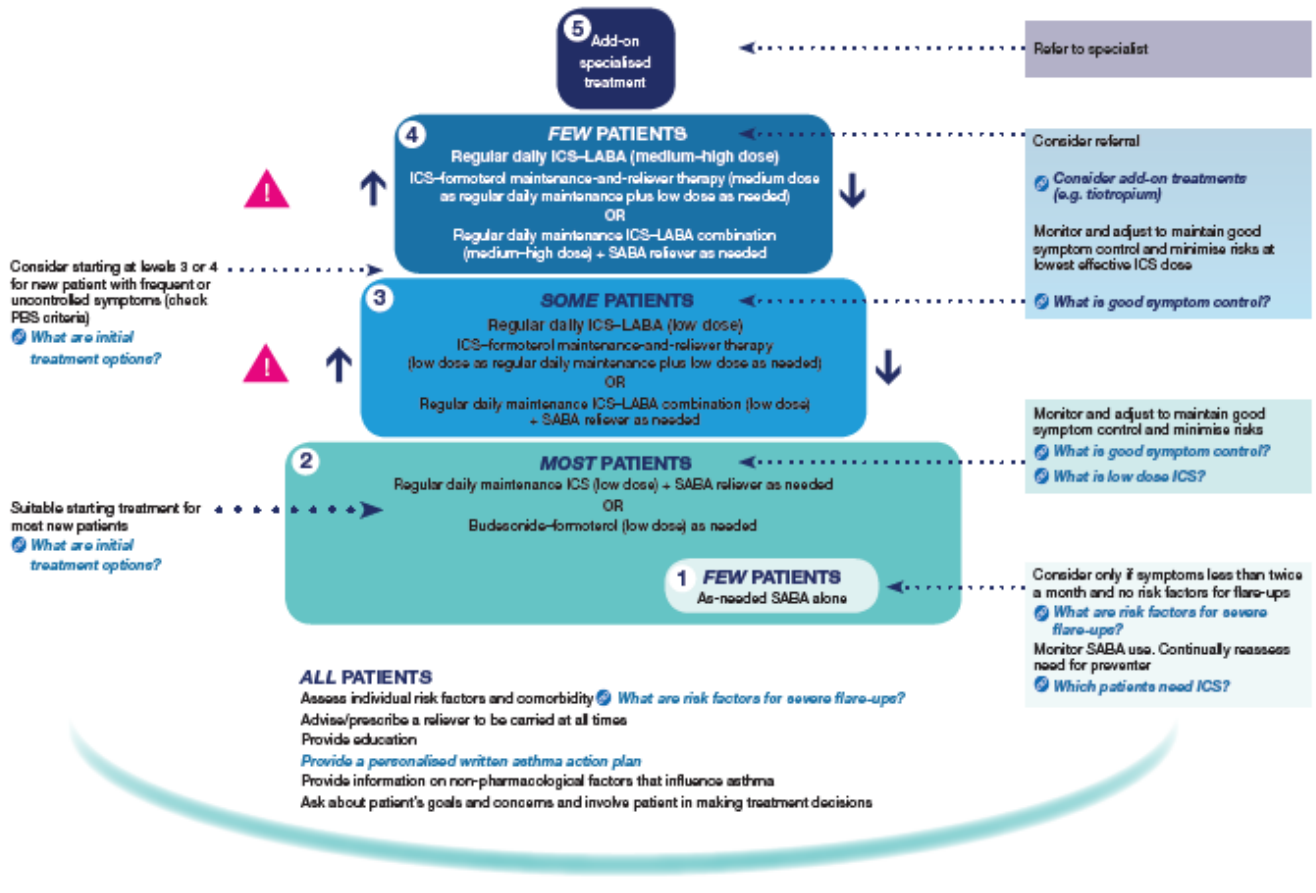
Good control	Partial control	Poor control
<p>All of:</p> <ul style="list-style-type: none"> <li>› Daytime symptoms ≤2 days per week</li> <li>› Need for <u>SABA</u> reliever ≤2 days per week†</li> <li>› No limitation of activities</li> <li>› No symptoms during night or on waking</li> </ul>	<p>One or two of:</p> <ul style="list-style-type: none"> <li>› Daytime symptoms &gt;2 days per week</li> <li>› Need for <u>SABA</u> reliever &gt;2 days per week†</li> <li>› Any limitation of activities</li> <li>› Any symptoms during night or on waking</li> </ul>	<p>Three or more of:</p> <ul style="list-style-type: none"> <li>› Daytime symptoms &gt;2 days per week</li> <li>› Need for <u>SABA</u> reliever &gt;2 days per week†</li> <li>› Any limitation of activities</li> <li>› Any symptoms during night or on waking</li> </ul>

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<sup>3</sup> <https://www.nps.org.au/australian-prescriber/articles/updated-australian-guidelines-for-mild-asthma-whats-changed-and-why>

<sup>4</sup> <https://www.astmahandbook.org.au/management/adults/initial-assessments/control-risk>

FIGURE Selecting and adjusting medication for adults and adolescents



ICS Inhaled corticosteroid  
 LABA long-acting beta<sub>2</sub> agonist  
 SABA short-acting beta<sub>2</sub> agonist

**!** Before you consider stepping up, check that:  
 • symptoms are due to asthma  
 • Inhaler technique is correct  
 • adherence is adequate.

**↑** Consider stepping up if good control is not achieved despite good adherence and correct inhaler technique.

**↓** When asthma is stable and well controlled for 2-3 months, consider stepping down  
 • Stepping down treatment in adults

*Toolkit aim - To identify who in your practice is at risk of or has asthma and how these patients are being managed.*

The toolkit is designed...

- to support medical practices to make easy, measurable and sustainable improvements
- to provide best practice care for their patients
- to assist practices to complete QI activities
- to assist practices to meet PIP QI.

The following checklists and activities will help guide you through the process at your own pace. Once you understand your patients, you will be able to easily identify how your patients are being managed and what needs to happen within the practice to optimise patient care.



## How to use this toolkit

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

- identify a sample group of patients by reviewing data measures from your practice population
- 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
- review your process and start again if you find your process is not working and you are not seeing improvements.

## Asthma & COPD

Asthma and chronic obstructive pulmonary disease (COPD) were once considered to be at opposite ends of the spectrum of airway disease. Asthma was thought to be highly responsive to treatment and essentially reversible, while COPD was characterised by fixed airway narrowing that was unresponsive to treatment. The currently accepted definitions still emphasise these features, even though there may be significant overlap between the two diseases.

Asthma is often described as a fully reversible inflammatory process, whereas COPD is an irreversible disease characterised by progressive airway narrowing.<sup>5</sup>

Brisbane South PHN have a [QI toolkit](#) to assist you to review your patients with COPD.

## For more support



[support@bsphn.org.au](mailto:support@bsphn.org.au)



1300 467 265

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<sup>5</sup> <https://www.mja.com.au/journal/2005/183/1/distinguishing-asthma-and-chronic-obstructive-pulmonary-disease-why-why-not-and>

## Activity 1. Understanding your asthma patient population

### Activity 1.1 – Data collection from CAT4

The aim of this activity is to collect data to determine the number of patients coded with asthma.



Complete the below table by collecting data from your CAT4 Data Extraction Tool to gather information on your current patient population with asthma.

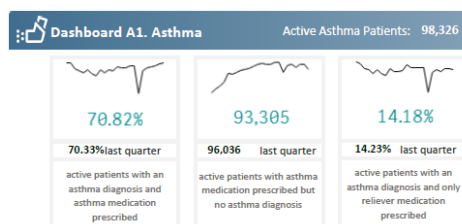
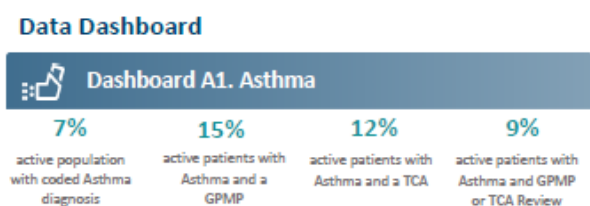
Note - Instructions on how to extract the data are available on the CAT4 website. [Conditions](#) OR [Medications filtering](#)

	Description	Total number of active patients as per RACGP criteria (3 visits in 2 years)	Total number of active patients
1.1a	Identify patient population See instructions in link below. <u>Identify active patients with at least 3 visits in the last 2 years</u>		
1.1b	Number of patients with asthma		
1.1c	Number of patients with asthma on a preventer medication by provider		
1.1d	Number of active patients with asthma who identify as Aboriginal or Torres Strait Islander ( <i>select asthma in the conditions tab &amp; indigenous under the ethnicity tab</i> ).		

*Please note: the RACGP defines active as 3 visits in 2 years. This search criteria does not capture those patients who may come in for screening every 2 years, or twice in 2 years e.g. flu vaccine, hence the option to look at all active patients.*

### Asthma data from your Brisbane South PHN Benchmark report

You may also obtain your practice asthma data from your monthly benchmark and trend reports provided by Brisbane South PHN. You will need your practice’s trend report to complete this information. Information on how to access your practice reports is available on BSPHN [website](#).



### Activity 1.2– Reviewing your practice asthma profile



Complete the checklist below to increase your understanding of active patients with asthma.

Description	Status	Action to be taken
After completing <b>activity 1.1</b> are there any unexpected results with your practice’s asthma patients?	<input type="checkbox"/> Yes: <b>see action to be taken.</b>  <input type="checkbox"/> No: continue with activity.	Please explain: (e.g. <i>higher number of patients with asthma medication but no diagnosis than expected</i> ).  How will this information be communicated to the practice team?
Is your practice’s asthma profile similar to other practices in the Brisbane south region? ( <i>Compare with information from your latest benchmark report</i> ).	<input type="checkbox"/> Yes: continue with activity.  <input type="checkbox"/> No: <b>see action to be taken.</b>	Outline the differences – ( <i>is it patients with asthma, is it risk factors?</i> )  How will this information be communicated to the practice team?
After reviewing your practice’s asthma profile, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	<input type="checkbox"/> Yes, see <b>action to be taken</b> to help set your goals.  <input type="checkbox"/> No: you have completed this activity.	Refer to the MFI and the <a href="#">Thinking part</a> at the end of this document.  Refer to the <a href="#">Doing part - PDSA</a> of the MFI to test and measure your ideas for success.

## Activity 2. Building your practice asthma register

Coding is simply a process of using an agreed standardised descriptor, stored as a series of numbers or letters. You may have identified that there are multiple ways clinical staff may enter a patient’s diagnosis in practice software. Some will type this information directly into the patient progress notes or enter this information as free text in the ‘reason for encounter’ or ‘diagnosis field’. This process is called free texting or un-coded diagnosis. Free text is not easily searchable in any database by the clinical software or third-party software (e.g. extraction tools) and is therefore not the preferred process.

The recommended process is to use a diagnosis from the drop-down boxes provided in the clinical software. This is a coded diagnosis. If all clinical staff within the practice use the same codes to identify a diagnosis then it is easier to search for particular conditions. It also allows the practice software to create automatic prompts e.g. reminders and warnings.

It is important to ensure your coding is consistent and agreed upon by all clinical staff in the practice, and diagnostic criteria for asthma are uniform.

### Activity 2.1 – Determine terms for consistent coding



*Determine which clinicians are currently using clinical codes for asthma and decide what ‘condition coding’ will be used as standard across the practice team.*

Best Practice Clinical Software has the functionality to code asthma severity (mild/moderate/severe) and to record spirometry results. As a result, we recommend that the practice discuss these options for implementation across the practice team.


It is recommended that you meet either in your established micro-team or at a practice clinical team meeting to complete the below clinical coding activities.

*The aim of this activity is for the clinical team to agree on consistent asthma coding to be used within the practice.*

Description	Status	Action to be taken
Are relevant practice team members aware of the importance of quality data including using consistent coding (avoiding free text)?	<input type="checkbox"/> Yes: continue with this activity.  <input type="checkbox"/> No, <b>see action to be taken.</b>	Organise a practice team meeting to discuss how to <a href="#">develop a clinical coding policy for your practice.</a>

Description	Status	Action to be taken
Have you agreed on accepted terminology of asthma codes from the drop-down lists in your practice software?	<input type="checkbox"/> Yes: continue with this activity.  <input type="checkbox"/> No, <b>see action to be taken.</b>	<p>Source list of clinical codes already available in current clinical software.</p> <p>Develop and agree on clinical codes for asthma to be used within practice.</p>
Are practice team members aware of how to enter diagnosis in clinical software using agreed asthma terminology?	<input type="checkbox"/> Yes: continue with this activity.  <input type="checkbox"/> No, <b>see action to be taken.</b>	Refer to instructions from <a href="#">Best Practice</a> or <a href="#">MedicalDirector</a> .
After reviewing your practice’s clinical coding guidelines, are there any changes you would like to implement in the practice to help manage patients, over the next 12 months?	<input type="checkbox"/> Yes, <b>see action to be taken to help set your goals.</b>  <input type="checkbox"/> No, you have completed this activity.	<p>Refer to the MFI and the <a href="#">Thinking part</a> at the end of this document.</p> <p>Refer to the <a href="#">Doing part - PDSA</a> of the MFI to test and measure your ideas for success.</p>

**Activity 2.2 – Recording asthma severity (Best Practice software users)**

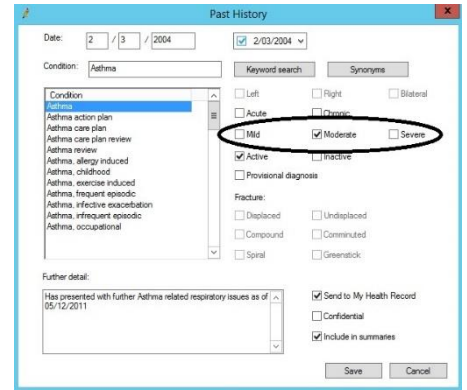
 *Best Practice has an additional functionality to record a patient’s asthma severity (mild/moderate/severe). The below activity aims to raise awareness of this feature and how it can help your practice determine patients that may be eligible for funded vaccines and the asthma cycle of care.*

Description	Status	Action to be Taken
Are your practice team members coding for asthma severity?	<input type="checkbox"/> Yes, continue with activity.  <input type="checkbox"/> No: <b>see action to be taken.</b>	<p>Refer to instructions on <a href="#">coding asthma severity</a> in Best Practice.</p> <p>Ensure all appropriate team members are aware of how to record asthma severity in Best Practice.</p> <p>Document in practice policy.</p>
Have you distributed the patient lists to individual providers to assist with diagnosis and asthma severity (moderate/severe)?	<input type="checkbox"/> Yes you have completed this activity.  <input type="checkbox"/> No: <b>see action to be taken.</b>	Distribute lists to individual providers. (Ensure you follow up a week later to receive lists back).


### Coding of asthma severity in Best Practice clinical software

When entering the asthma diagnosis in Best Practice software, there is an additional function to add a severity code (mild/moderate/severe). See below example.

It is beneficial to add this information into your clinical software for easier determination of patient eligibility for an asthma cycle of care.



### Activity 2.3 – Cleaning up un-coded conditions in your practice software

 The aim of this activity is to identify and clean up any un-coded asthma conditions in your practice software. Cleaning up un-coded items makes it easier to perform database searches and manage third-party clinical audit tools.

#### Identify

Follow the instructions for [Best Practice](#) or [MedicalDirector](#) to identify the number of un-coded asthma conditions.

Date data collected	Number of un-coded asthma conditions

What is a reasonable timeframe to complete this activity: \_\_\_\_\_

Who will be completing this activity: \_\_\_\_\_

#### Results

After you have actioned any un-coded asthma conditions, perform another database search in your practice software and record the number of un-coded conditions to track your results.

Date data collected	Number of un-coded asthma conditions

## Activity 2.4 – Identifying patients with indications for asthma, but no diagnosis recorded in your clinical software

The aim of this activity is to collect data to identify any patients with indication of asthma, but no diagnosis recorded.

Complete the below table by collecting data from your CAT4 to gather information on your current patient population with indications of asthma. **Please note:** these searches may identify patients with COPD.

	Description	Total number of active patients as per RACGP criteria (3 visits in 2 years)	Total number of active patients
2.4a	Number of patients on anti-asthmatic medication with NO asthma diagnosis In <b>Conditions</b> tab. Under <b>Respiratory</b> heading tick <b>No</b> . In <b>Medications – Respiratory</b> tab. Under <b>Antiasthmatic</b> heading tick <b>Yes</b> . Click <b>Recalculate</b> .		
2.4b	Number of patients on inhaled steroids with no asthma diagnosis <ul style="list-style-type: none"> <li>• In <b>Conditions</b> tab.</li> </ul> Under <b>Respiratory</b> heading tick <b>No</b> . In <b>Medications – Respiratory</b> tab. Under <b>Steroids</b> heading tick <b>Yes</b> to Steroid – Inhaler. Click <b>Recalculate</b> .		
2.4c	Number of patients with asthma on preventer medication (by provider) – <ul style="list-style-type: none"> <li>• In <b>Conditions</b> tab.</li> <li>• Under <b>Respiratory</b> heading tick <b>Yes</b> for <b>Asthma</b>.</li> <li>• In <b>Medications – Respiratory</b> tab.</li> <li>• Under <b>Long Acting</b> tick <b>Yes</b>.</li> <li>• Click <b>Recalculate</b>.</li> </ul> To identify individual providers see instructions <a href="#">here</a> .		

**Action:** Distribute patient list to individual providers for review to help identify diagnosis and asthma severity.

### Activity 2.5– Reviewing your patients with indication of asthma but no diagnosis



Complete the checklist below which reviews your practices patients with indications of asthma but no diagnosis.

Description	Status	Action to be taken
After completing <b>activity 2.4</b> are there any unexpected results with the patients with indications of asthma with no diagnosis?	<input type="checkbox"/> Yes: <b>see action to be taken.</b> <input type="checkbox"/> No: continue with activity.	Please explain: (e.g. <i>high number of patients on inhaled steroids with no diagnosis</i> ).  How will this information be communicated to the practice team?
After reviewing your patients with indications of asthma but no diagnosis, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	<input type="checkbox"/> Yes, <b>see action to be taken to help set your goals.</b> <input type="checkbox"/> No: you have completed this activity.	Refer to the MFI and the <a href="#">Thinking part</a> at the end of this document.  Refer to the <a href="#">Doing part - PDSA</a> of the MFI to test and measure your ideas for success.



#### Practice decision point

It is recommended that you have a practice meeting to review the data collection table results and determine any action that needs to be taken.


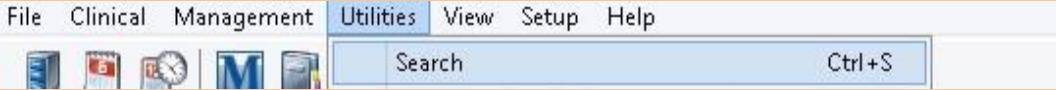
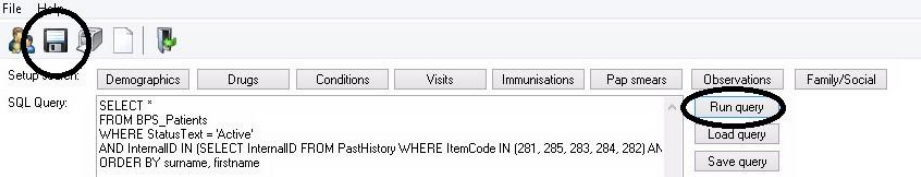

### Activity 2.6 – Create your basic asthma register



Develop a register of active patients with asthma using one of the options listed below.

Asthma register options	Chosen Option
<p><b>Option 1 – Creating a register using CAT4</b></p> <ul style="list-style-type: none"> <li>• In <b>General</b> tab.</li> <li>• Tick <b>Active (3x in 2yrs)</b> (<i>Note: if your practice has been established for less than 2 years do not choose this option</i>).</li> <li>• In <b>Conditions</b> tab.</li> <li>• Tick <b>Asthma</b>.</li> <li>• Click <b>Recalculate</b>.</li> <li>• Under <b>Demographics</b> tab, click <b>Select All</b>.</li> <li>• Click <b>Export</b>.</li> </ul>	<input type="checkbox"/>



Asthma register options	Chosen Option
<ul style="list-style-type: none"> <li>Select  icon and Excel, to export to an excel document for further modification and maintenance.</li> </ul> <p>Now that you have saved this as an excel file you can utilise this document as the basis to create your register. You may wish to include additional columns that may be relevant to the care of your asthma patients.</p>	
<p><b>Option 2 – Creating a register using Best Practice</b></p> <p>In Best Practice</p> <ul style="list-style-type: none"> <li>Select <b>Utilities</b> then <b>Search</b>.</li> </ul>  <ul style="list-style-type: none"> <li>Select <b>Conditions</b>.</li> <li>In Search for Past History pop up type Asthma and ensure Past history is selected.</li> <li>Click <b>Add</b> then <b>OK</b>.</li> <li>Click <b>Run query</b>.</li> </ul>  <ul style="list-style-type: none"> <li>Select  icon to save register as an excel file</li> </ul> <p>Now that you have saved this as an excel file, you can utilise this document as the basis to create your register. You may wish to include additional columns that may be relevant to the care of your asthma patients.</p>	□
<p><b>Option 3 – Creating a register using Medical Director</b></p> <p>Refer to instructions from <a href="#">MedicalDirector</a>.</p> <p>Now that you have saved this as an excel file you can utilise this document as the basis to create your register. You may wish to include additional columns that may be relevant to the care of your asthma patients.</p>	□

Save your asthma patient register for future reference.

### Activity 2.7 – Consider additional information for your asthma register

This is an example of a register that has been exported to an excel spreadsheet with additional fields added. There may be other fields you would like to add to your register to provide an accurate overview of how patients are tracking in their care. Colour coding patients helps to prioritise patients for follow up.



Patient Register - Asthma																		
ID	Provider	number	Surname	First name	Sex	Date of Birth	Address	City	Postcode	Phone (H/W)	Phone (M)	Age	Asthma Severity	Last Asthma Cycle of Care (MBS item claim date)	First visit for ACoC completed	Last GPMP/TCA	Last Spirometry	FEV1/FVC Ratio
Dr1	804	Adams	Jane	F	14/03/1956	12 Sample Street	Suburb	4256 (07) 1234 5678	0412 3456	60	Mild	N/A	N/A	N/A	TBA			
Dr1	327	Baker	John	M	5/10/1970	12 Sample Street	Suburb	4215 (07) 1234 5678	0412 3456	46	Moderate	27/07/2016	N/A	N/A	27/07/2016			0.9
Dr2	350	Brown	Jane	F	22/02/1963	12 Sample Street	Suburb	4698 (07) 1234 5678	0412 3456	54	Moderate	17/02/2016	Due	N/A	17/02/2016			0.7
Dr2	264	Carter	John	M	5/07/1973	12 Sample Street	Suburb	4587 (07) 1234 5678	0412 3456	43	Moderate	TBA		TBA	12/10/2016			
Dr2	546	Doe	Jane	F	6/08/1966	12 Sample Street	Suburb	4256 (07) 1234 5678	0412 3456	50	Mild	N/A	N/A	N/A	TBA			
Dr3	215	Douglas	John	M	1/07/1949	12 Sample Street	Suburb	4951 (07) 1234 5678	0412 3456	67	Severe	1/02/2016	12/11/2016	N/A	12/11/2016			0.7
Dr1	654	Jones	Jane	F	1/10/1942	12 Sample Street	Suburb	4325 (07) 1234 5678	0412 3456	74	Mild	N/A	N/A	N/A	TBA			
Dr3	326	Lane	John	M	1/01/1964	12 Sample Street	Suburb	4125 (07) 1234 5678	0412 3456	53	Moderate	N/A	23/09/2016	23/09/2016	23/09/2016			0.8
Dr2	245	Smith	Jane	F	31/07/1938	12 Sample Street	Suburb	4569 (07) 1234 5678	0412 3456	78	Severe	6/12/2016	N/A	N/A	6/12/2016			0.6
Dr2	845	White	John	M	28/02/1953	12 Sample Street	Suburb	4587 (07) 1234 5678	0412 3456	64	Moderate	TBA		TBA	TBA			

Consider what fields you would like your asthma register to capture in order to have an overview of how patients are tracking in their care. You may like to discuss this with the team.

Suggestions of areas to include:

- Asthma severity (mild / moderate / severe)
- Date of when last Asthma Cycle of Care was claimed
- Date of when the patient attended the first visit of the Asthma Cycle of Care.
- Date of when last GPMP (GP Management Plan) / TCA (Team Care Arrangement) was claimed
- Date of recent spirometry recorded
- Clinical results of recent spirometry recorded (FEV1/FEVC ratio)
- Influenza vaccination status

## Activity 3. Asthma measures, risk factors and co-morbidities

### Common asthma risk factors

Asthma shares a number of risk factors with other chronic conditions, such as:

Non-modifiable risk factors

- genetic predisposition

Modifiable risk factors

- tobacco use (smoking or exposure to cigarette smoke)
- exposure to environmental hazards (for example, exposure to air pollutants)
- overweight/obesity
- sedentary lifestyle

Other risk factors

- allergic rhinitis.

Risk factors may increase the chance of developing asthma in the first place (either in childhood or as an adult), or may increase the chance that a person with asthma will develop additional health problems. Risk factors also vary according to the person's age, and according to the type of asthma that they have. Finding a factor that is associated with asthma, or poor health outcomes in asthma, does not necessarily mean that the risk factor caused these problems, or that they can be prevented.<sup>6</sup>

### Activity 3.1 –Data collection from CAT4








The aim of this activity is to collect data to identify patients with asthma with modifiable risk factors.

Complete the below table by collecting data from your CAT4 Data Extraction Tool. Note - Instructions on how to extract the data is available from the CAT4 website. [Conditions](#) and [Smoking](#) or [BMI](#) or [physical activity](#). (Ensure you select asthma under conditions prior to completing any of these searches)

	Description	Total number of active patients as per RACGP criteria (3 visits in 2 years)	Total number of active patients
3.1a	Number of patients with asthma (from activity 1.1b)		
3.1b	Number of patients with asthma with no smoking status recorded		



<sup>6</sup> <https://www.aihw.gov.au/reports/asthma-other-chronic-respiratory-conditions/asthma-associated-comorbidities-and-risk-factors/contents/risk-factors-associated-with-asthma>

	Description		Total number of active patients as per RACGP criteria (3 visits in 2 years)	Total number of active patients
3.1c	Number of patients with asthma who are daily smokers			
3.1d	Number of patients with asthma who do not have their height and/or weight recorded			
3.1e	Number of patients with asthma and their BMI classified as overweight			
3.1f	Number of patients with asthma and their BMI classified as obese			
3.1g	Number of patients with asthma and their BMI classified as morbid			
3.1h	Number of patients with asthma with no physical activity recorded			
3.1i	Number of patients with asthma with their physical activity recorded as insufficient or sedentary			

Please note: You can search lists by individual [providers](#) and provide to them to review.

### Activity 3.2– Reviewing your patients with asthma and modifiable risk factors



Complete the checklist below which reviews your patients with asthma and modifiable risk factors.

Description	Status	Action to be taken
After completing <b>activity 3.1</b> are there any unexpected results with your patients with asthma and their modifiable risk factors?	<input type="checkbox"/> Yes: <b>see action to be taken.</b>  <input type="checkbox"/> No: continue with activity.	Please explain: (e.g. none of our patients with asthma were classified as overweight).  How will this information be communicated to the practice team?

Description	Status	Action to be taken
Do you have Topbar installed and operating on all workstations?	<input type="checkbox"/> Yes: continue with activity.  <input type="checkbox"/> No: <b>see action to be taken.</b>	Refer to <a href="#">Topbar user guide</a> .
Have you created Topbar prompts for patients with asthma who do not have their modifiable risk factors recorded?	<input type="checkbox"/> Yes: continue with activity.  <input type="checkbox"/> No: <b>see action to be taken.</b>	Refer to <a href="#">instructions</a> .
After reviewing your patients with asthma and their modifiable risk factors, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	<input type="checkbox"/> Yes, <b>see action to be taken to help set your goals.</b>  <input type="checkbox"/> No: you have completed this activity.	Refer to the MFI and the <a href="#">Thinking part</a> at the end of this document.  Refer to the <a href="#">Doing part - PDSA</a> of the MFI to test and measure your ideas for success.

### Asthma and recommended vaccinations

The following patients with asthma are recommended to have the following vaccinations:

- Influenza - People aged ≥6 months with *severe* asthma are strongly recommended to receive annual influenza vaccine.
- Pneumococcal - All children and adults with newly identified *severe* asthma are recommended to receive:
  - 1 dose of 13vPCV at diagnosis (at least 2 months after any previous doses of 13vPCV)
  - 1 dose of 23vPPV 12 months after 13vPCV (2–12 months later is acceptable) or at 4 years of age whichever is later
  - a 2nd dose of 23vPPV at least 5 years later
- COVID – encourage patients with asthma to be vaccinated against COVID-19

For other patients, follow national immunisation [guidelines](#). Advise adults with asthma about potential benefits of influenza and pneumococcal vaccination and offer it, as appropriate, based on individual risk factors.

### Brisbane South PHN QI toolkit

Brisbane South PHN have influenza and pneumococcal QI toolkits available. These are available to assist practices to identify patients of their practice who would benefit from receiving these vaccinations. The toolkits are available from the [website](#).

### Activity 3.3 –Data collection from CAT4



The aim of this activity is to collect data to review immunisation status of patients with asthma.

Complete the below table by collecting data from your CAT4 Data Extraction Tool. Note - Instructions on how to extract the data is available from the CAT4 website. [Conditions](#) and [identify patients at risk of influenza](#). (Ensure you only select asthma under disease count).

	Description	Total number of active patients as per RACGP criteria (3 visits in 2 years)	Total number of active patients
3.3a	Number of patients with asthma who have had an influenza vaccination recorded in the past 15 months		

### Activity 3.4– Reviewing your patients with asthma and their vaccination status



Complete the checklist below which reviews your patients with asthma and their vaccination status.

Description	Status	Action to be taken
After completing <b>activity 3.3</b> are there any unexpected results with your patients with asthma and their vaccination status?	<input type="checkbox"/> Yes: <b>see action to be taken.</b>  <input type="checkbox"/> No: continue with activity.	Please explain: (e.g. low number of patients with asthma have had an influenza vaccination recorded).   How will this information be communicated to the practice team?
After reviewing your patients with asthma and their vaccination status, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	<input type="checkbox"/> Yes, <b>see action to be taken to help set your goals.</b>  <input type="checkbox"/> No: you have completed this activity.	Refer to the MFI and the <a href="#">Thinking part</a> at the end of this document.  Refer to the <a href="#">Doing part - PDSA</a> of the MFI to test and measure your ideas for success.

### Activity 3.5 – Recording Spirometry results

In some practice software (e.g. Best Practice and MedicalDirector), spirometry results are imported from the spirometer’s software as an image or PDF rather than as specific coded data (similarly to pathology results). This can mean that information on spirometry results will not be able to be extracted by the CAT4 Data Extraction Tool. This information can be useful if you would like to look at whether your patients with asthma have spirometry results in or out of target ranges according to clinical guidelines.

**Note** - check your manufacturer’s user guide to determine if your spirometer is capable of importing results directly into your practice software.

Description	Status	Action to be Taken
Are spirometry results recorded as values in your clinical software (not just an uploaded image)?	<input type="checkbox"/> Yes, continue with activity.  <input type="checkbox"/> No: <b>see action to be taken.</b>	<p>Review how and where your spirometry information is being stored in your practice software.</p> <p>Refer to instructions on coding spirometry from <a href="#">Best Practice</a> or <a href="#">MedicalDirector</a>.</p> <p>Ensure all appropriate team members are aware of how to record asthma severity.</p> <p>Document in practice policy.</p>
Do any team members require training in spirometry?	<input type="checkbox"/> Yes, <b>see action to be taken.</b>  <input type="checkbox"/> No: continue with activity.	<p>Refer to <a href="#">spirometry training</a> from National Asthma Council or <a href="#">spirometry training company</a> or training for <a href="#">Aboriginal Health workers</a>.</p>
After reviewing your practices spirometry use, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	<input type="checkbox"/> Yes, <b>see action to be taken to help set your goals.</b>  <input type="checkbox"/> No: you have completed this activity.	<p>Refer to the MFI and the <a href="#">Thinking part</a> at the end of this document.</p> <p>Refer to the <a href="#">Doing part - PDSA</a> of the MFI to test and measure your ideas for success.</p>

### Spirometry and COVID

The [Asthma handbook](#) provides the following guidelines for spirometry and COVID:

- Do NOT perform spirometry or peak expiratory flow on patients who have symptoms consistent with [COVID-19](#), are febrile, have symptoms of a viral illness, or who have an escalating acute respiratory condition.
- Use only spirometers that use inline filters.

- The respiratory plume of exhaled particles contains viruses for several hours and surfaces may retain viruses for several days.

The National Asthma Council also provides spirometry infection control [recommendations for primary care](#).

### Activity 3.6 - Recording asthma measures, smoking status and influenza vaccination in your clinical software

Description	Status	Action to be taken
Are all the asthma measures being recorded in the correct fields in your clinical software? (e.g.: respiratory rate, peak flow, smoking status, influenza vaccination, FEV1/FEVC ratio, height, weight, physical activity levels)?	<input type="checkbox"/> Yes: continue with this activity.  <input type="checkbox"/> No, <b>see action to be taken.</b>	<p>Review how and where your asthma information is being recorded in your practice software.</p> <p>Refer to instructions for <a href="#">Best Practice</a> or <a href="#">MedicalDirector</a>.</p> <p>Ensure all relevant team members are aware of how to record relevant asthma information.</p> <p>Document in practice policy.</p>
After reviewing where your team members are entering data, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	<input type="checkbox"/> Yes, <b>see action to be taken to help set your goals.</b>  <input type="checkbox"/> No: you have completed this activity.	<p>Refer to the MFI and the <a href="#">Thinking part</a> at the end of this document.</p> <p>Refer to the <a href="#">Doing part - PDSA</a> of the MFI to test and measure your ideas for success.</p>

### Asthma and co-morbidities

People with asthma often have other chronic and long-term conditions. Comorbidities are typically more common in older age groups.

- 54% of people aged 45 and over with asthma had 2 or more chronic conditions in 2017-2018.
- Adults with asthma were 1.4 times as likely to be obese as people without asthma.
- 49% of people 45 and over with asthma also had arthritis, 37% had back problems and 33% had mental and behavioural conditions.
- 81% of Australians aged 45 and over with asthma had at least one other selected chronic condition in 2017-2018.<sup>7</sup>

<sup>7</sup> <https://www.aihw.gov.au/reports/asthma-other-chronic-respiratory-conditions/asthma-associated-comorbidities-and-risk-factors/contents/risk-factors-associated-with-asthma>



### Activity 3.7 –Data collection from CAT4



The aim of this activity is to collect data to identify patients with asthma and at least one other chronic medical condition.

Complete the below table by collecting data from your CAT4 Data Extraction Tool. Note - Instructions on how to extract the data is available from the CAT4 website. [Co-morbidities](#) OR [Chronic Conditions](#).

	Description	Total number of active patients as per RACGP criteria (3 visits in 2 years)	Total number of active patients
3.7a	Number of patients with asthma and 1 other chronic medical condition		
3.7b	Number of patients with asthma and 2 other chronic medical conditions		
3.7c	Number of patients with asthma and 3 other chronic medical conditions		
3.7d	Number of patients with asthma and 4 other chronic medical conditions		
3.7e	Number of active patients with asthma & mental illness ( <i>select asthma 'yes' &amp; mental illness 'yes' and recalculate</i> )		

**Please note:** You can search lists by [individual providers](#) and provide to them to identify patients with multiple chronic conditions.

### Activity 3.8– Reviewing your patients with multiple chronic medical conditions



Complete the checklist below to review your patients with multiple chronic medical conditions.

Description	Status	Action to be taken
After completing <b>activity 3.7</b> , are there any unexpected results with your patients' comorbidities?	<input type="checkbox"/> Yes: <b>see action to be taken.</b>  <input type="checkbox"/> No: continue with activity.	Please explain: ( <i>e.g. higher number of patients with 3 chronic medical conditions</i> ).  How will this information be communicated to the practice team?

Description	Status	Action to be taken
<p>After completing <b>activity 3.7</b>, make note of the patients with asthma and mental illness. Do you need to review your process for managing these patients?</p>	<p><input type="checkbox"/> Yes: <b>see action to be taken.</b></p> <p><input type="checkbox"/> No: continue with activity.</p>	<p>Consider completing a GP management plan. Refer to <a href="#">MBS online</a> for criteria.</p> <p>Refer to Brisbane South PHN's <a href="#">mental health QI toolkits</a>.</p>
<p>After reviewing your practice's comorbidities profile, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?</p>	<p><input type="checkbox"/> Yes, <b>see action to be taken to help set your goals.</b></p> <p><input type="checkbox"/> No: you have completed this activity.</p>	<p>Refer to the MFI and the <a href="#">Thinking part</a> at the end of this document.</p> <p>Refer to the <a href="#">Doing part - PDSA</a> of the MFI to test and measure your ideas for success.</p>


## Activity 4. Medicare item numbers for patients with Asthma

The aim of this activity is to outline some of the Medicare item numbers that you may use in general practice for eligible patients.

Patients with asthma **may be eligible** to access item numbers within the Medicare Benefit Schedule (MBS). These are dependent on patient age, ethnicity and co-morbidities. Conditions apply to each item number, please ensure the GP understands these prior to claiming the item number/s. Brisbane South PHN has a comprehensive [toolkit](#) looking at MBS items, however, a summary of the item numbers include:

**MBS items**

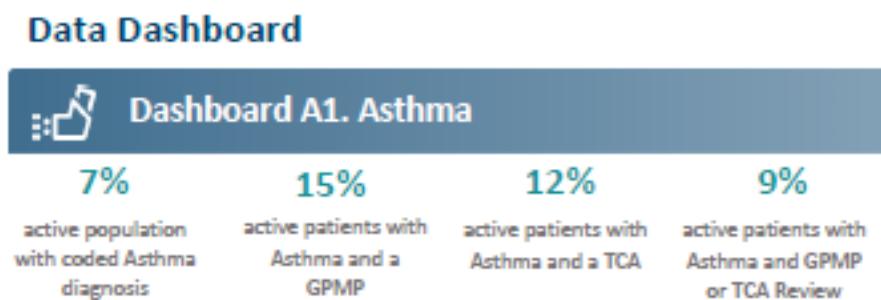
- [Asthma cycle of care](#)
- [Spirometry](#)
- [GP Management Plans \(GPMP\)](#)
- [Team Care Arrangements \(TCA\)](#)
- [Nurse chronic disease item number](#)
- [Mental health items](#)
- [Aboriginal and Torres Strait Islander health assessment](#)
- [Home medication review](#)
- [MBS telehealth fact sheet](#)



*TIP: GPs are required to make sure each patient meets the MBS criteria prior to claiming each item number.*

### Activity 4.1 – Data Collection - Medicare claiming for asthma patients

The aim of this activity is to review your practices claiming of relevant Medicare item numbers for patients with asthma. Note – Information to complete this activity is available from your latest benchmark report from Brisbane South PHN. (Examples of benchmark report below).



Asthma

Chronic Diseases - Asthma

Figure A1. Asthma management graph

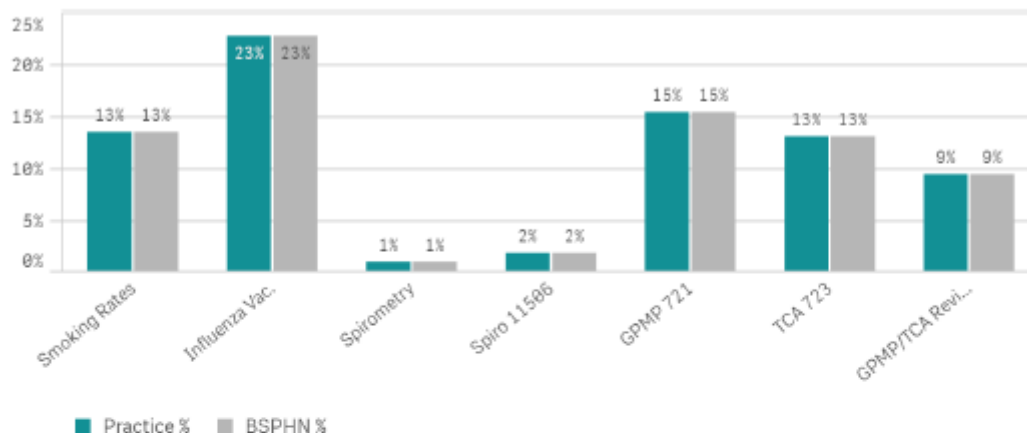


Table A1. Asthma management table

Asthma Management	-	- %	BSPHN	BSPHN %
Active patients with Asthma	102,071	-	102,071	-
Smoking Rates Recorded	13,732	13%	13,732	13%
Influenza Vaccination Recorded *	23,175	23%	23,175	23%
Spirometry Measurement Recorded **	939	1%	939	1%
Spirometry MBS item claimed ***	1,796	2%	1,796	2%
GPMP claimed***	15,691	15%	15,691	15%
TCA claimed ***	13,280	13%	13,280	13%
GPMP/TCA Reviews claimed ***	9,567	9%	9,567	9%

	Description	Number	Percentage
4.1a	Active population with coded asthma diagnosis		
4.1b	Active patients with asthma and a GPMP		
4.1c	Active patients with asthma and a TCA		
4.1d	Active patients with asthma and GPMP or TCA review		
4.1e	Number of spirometry tests claimed		

Please note: you may also wish to search for other MBS item number claiming history for patient with asthma. Instructions are available from [CAT4](#).

Activity 4.2– Reviewing your practice asthma profile



Complete the checklist below which reviews your practices asthma profile from your benchmark report.

Description	Status	Action to be taken
After completing <b>activity 4.1</b> are there any unexpected results with your practice’s asthma profile?	<input type="checkbox"/> Yes: <b>see actions to be taken.</b>  <input type="checkbox"/> No: continue with activity.	Please explain: <i>(e.g. a low percentage of patients with asthma have a GPMP).</i>   How will this information be communicated to the practice team?
Is your practice chronic disease claiming for asthma patients similar to other practices in the Brisbane south region <i>(compare information from benchmark report)?</i>	<input type="checkbox"/> Yes: continue with activity.  <input type="checkbox"/> No: <b>see action to be taken.</b>	Outline the differences – <i>(e.g. our practice is claiming fewer GPMPs than other practices).</i>   How will this information be communicated to the practice team?
Are there any patients with asthma who have not been billed a spirometry in the past 12 months?	<input type="checkbox"/> Yes, <b>see action to be taken.</b>  <input type="checkbox"/> No, continue with the activity.	Please explain. <i>(e.g. COVID pandemic)</i>  What action will you take?   How will you use this information to increase the number of spirometry tests completed?

Description	Status	Action to be taken
Do you know the contact details for any MBS related questions?	<input type="checkbox"/> Yes, continue with the activity.  <input type="checkbox"/> No, <b>see action to be taken.</b>	Email: <a href="mailto:askMBS@health.gov.au">askMBS@health.gov.au</a> .  Provider Enquiry Line - 13 21 50.
Do relevant staff know that Medicare provides online training modules?	<input type="checkbox"/> Yes, continue with the activity.  <input type="checkbox"/> No, <b>see action to be taken.</b>	More information can be obtained from <a href="#">Medicare Australia e-learning modules</a> .
After reviewing the MBS claiming for patients with asthma, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	<input type="checkbox"/> Yes, <b>see action to be taken to help set your goals.</b>  <input type="checkbox"/> No, you have completed this activity.	Refer to the MFI and the <a href="#">Thinking part</a> at the end of this document.  Refer to the <a href="#">Doing part - PDSA</a> of the MFI to test and measure your ideas for success.

## Activity 5. Establishing appropriate care pathways using evidence-based guidelines

### Activity 5.1 – Identify roles for managing patients with asthma within your practice



Complete the checklist below to review your practice’s roles and responsibilities for managing patients with asthma.

Consider how best to use your practice staff to provide optimum care and the impact this will have on the workload and appointment system. This involves systematically determining if your practice is set-up and equipped to provide evidence-based asthma assessment and management.

Activity	Nurse	GP	Admin
Details of patient medication history and completes asthma level of control score			
Height, weight and BMI			
Completes spirometry			
Reviews inhaler device technique			
Provides appropriate education			
Organises allergy tests (if appropriate)			
Updating patient reminders for regular monitoring (frequency depends on patient’s condition)			
Review diet/healthy eating			
Review physical activity and exercise tolerance			
Review smoking & alcohol intake			
Check mental health status and offer support services			
Provide self-care education			
GPMP			
Consider comorbidities (smoking, anxiety, depression, obesity, allergic rhinitis, anaphylaxis)			
Review medications			
HMR (if eligible)			
Assess need for specialist referral			
Consider advanced care planning			
Update and order patient resources			

## Activity 6. Recalls and Reminders

As part of the RACGP accreditation standards, it is a requirement that practices provide health promotion, illness prevention, preventive care and a reminder system based on patient need and best available evidence. Brisbane South PHN have a comprehensive [toolkit](#) to assist you to review your practice recall and reminder systems, however, the aim of this activity is to assist with asthma specific recall and reminders. You can also access other QI tools via medical software modules that will assist your practice to merge duplicate recall/reminder lists in your practice’s clinical software. These modules are:

- Module 7 – Recalls, Reminders and Screening using MedicalDirector
- Module 8 – Recalls, Reminders and Screening using Best Practice

You can access these modules via [DiscoverPHN](#).

### Activity 6.1 – Reminder system



*The aim of this activity is to review the practice’s reminder system.*

Question to consider	Status	Action to be taken
Does your practice have a routine reminder for appropriate asthma care?	<input type="checkbox"/> Yes, continue with activity.  <input type="checkbox"/> No, <b>see action to be taken.</b>	Refer to instructions from <a href="#">Best Practice</a> or <a href="#">MedicalDirector</a> .
Do clinicians know how to initiate a patient reminder within clinical software?	<input type="checkbox"/> Yes, continue with activity.  <input type="checkbox"/> No, <b>see action to be taken.</b>	Clinician education on setting up patient reminders
Is there a system for ensuring patients recently diagnosed with asthma are incorporated into the reminder system	<input type="checkbox"/> Yes, policy is working. <input type="checkbox"/> Yes, policy is not working, <b>see action to be taken.</b> <input type="checkbox"/> No policy, <b>see action to be taken.</b>	Revise policy  Practice policy on reminders to be implemented
After reviewing your practice recall and reminder system, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	<input type="checkbox"/> Yes, <b>see action to be taken to help set your goals.</b> <input type="checkbox"/> No, you have completed this activity.	Refer to the MFI and the <a href="#">Thinking part</a> at the end of this document.  Refer to the <a href="#">Doing part - PDSA</a> of the MFI to test and measure your ideas for success.



## Activity 7. Referral pathways

*The aim of this activity is to ensure that practice staff have access to the relevant information and understand pathways for referral of patients to specialists and allied health staff as deemed clinically appropriate.*

Engaging other medical services (e.g. diagnostic services; hospitals and consultants; allied health; social, disability and community services) assists the practice in providing optimal care to patients whose health needs require integration with other services.

An organised team approach to care for people with severe asthma leads to better outcomes. They help people learn ways to manage and treat their asthma. Specialists in the centre can assess and treat triggers and other medical problems. Multidisciplinary care leads to better quality of life, better asthma control and fewer exacerbations for people with severe asthma.<sup>8</sup>

### Essential referral information for asthma patients – Refer your patient – Metro South health

[Metro South Health](#) is the major provider of public health services, and health education and research, in Brisbane south including Logan, Redlands and Scenic Rim regions. The [Refer Your Patient Website](#) provides health professionals with important information to assist in accessing public health services for patients. It provides a single point of entry for all new referrals.

On the website, it outlines available health professionals, criteria to access appointments with the health professionals, expected wait times plus all the information that is required in the referral.

#### Essential referral information for Asthma referrals

- ▶ Approximate age at diagnosis
- ▶ Duration and severity of symptoms (breathlessness, chest tightness, wheezing and cough)
- ▶ Frequency of exacerbations
- ▶ Management including:
  - ▶ Current medications (including complete list of all patient's medications)
  - ▶ Previously tried respiratory medications
- ▶ Oral prednisolone use
- ▶ Previous hospitalisations for asthma
- ▶ Allergies
- ▶ Spirometry (if available)

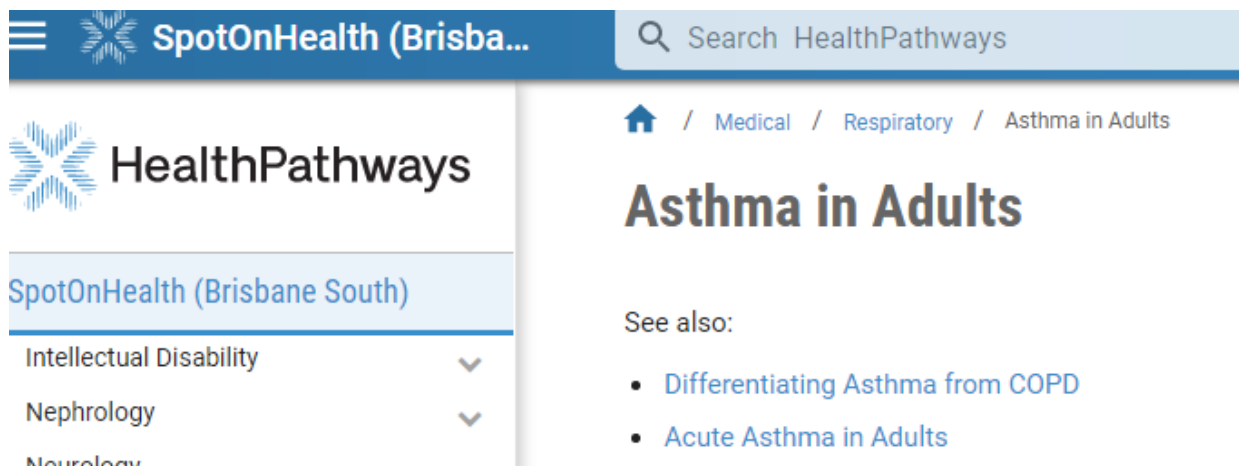
If a specific test result is unable to be obtained due to access, financial, religious, cultural or consent reasons a Clinical Override may be requested. This reason must be clearly articulated in the body of the referral.

<sup>8</sup> <https://toolkit.severeasthma.org.au/establishing-a-clinic/overview/>

### SpotOnHealth HealthPathways

[SpotOnHealth HealthPathways](#) provides clinicians in the greater Brisbane south catchment with web-based information outlining the assessment, management and referral to other clinicians for over 550 conditions.

It is designed to be used at point of care primarily by general practitioners but is also available to specialists, nurses, allied health and other health professionals.



### Health Services Directory

[Health Services Directory](#) is a joint initiative of all Australian governments, delivered by HealthDirect Australia, to enable health professionals and consumers access to reliable and consistent information about health services.

### My Community Directory

[My Community Directory](#) lists organisations that provide services that are free or subsidised to the public in thousands of locations across Australia. These services are organised into various Community Directories.

### Allied health professionals

Allied Health Profession	Contact Details
Chronic Disease Respiratory Nurse	Refer to <a href="#">contact details</a> .
Exercise Physiologist	Refer to <a href="#">contact details</a> .

### Allergy Testing

Asthma Australia recommends consideration of [allergy testing](#) as part of diagnostic investigations if the clinician suspects allergic triggers, or to guide future management. If allergy testing is needed, refer to an appropriate provider for skin prick testing for common aeroallergens. Blood tests can be used if skin prick testing is unavailable, impractical and/or contraindicated.

[Sullivan Nicolaidis](#) and [QML](#) have guides to assist with ordering allergy test.

### Activity 7.1 – Referral Pathways



This activity is designed to raise your awareness of local referral options available for you and your patients to facilitate co-ordinated and therefore optimal care.

Complete the checklist below in relation to referral pathways.

Details	Status	Action to be taken
Do all GPs and nurses have login details for SpotOnHealth HealthPathways?	<input type="checkbox"/> Yes, continue with the activity.  <input type="checkbox"/> No, see <b>action to be taken</b> .	Refer to <a href="#">instructions</a> to obtain access.
Do all GPs and nurses know how to access SpotOnHealth HealthPathways via Topbar?	<input type="checkbox"/> Yes, continue with the activity.  <input type="checkbox"/> No, see <b>action to be taken</b> .	Refer to <a href="#">instructions</a> from Pen CS.  Or contact BSPHN Digital Health Team via email: <a href="mailto:support@bsphn.org.au">support@bsphn.org.au</a> .
How will you communicate information so clinicians know where to access details on referring a patient to specialist services?	What is the practice plan for communicating referral information?	
After reviewing your practice referral system, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	<input type="checkbox"/> Yes, <b>see action to be taken to help set your goals</b> .  <input type="checkbox"/> No, you have completed this activity.	Refer to the MFI and the <a href="#">Thinking part</a> at the end of this document.  Refer to the <a href="#">Doing part - PDSA</a> of the MFI to test and measure your ideas for success.

## Activity 8. Resources and education

### Support options for patients

#### 1800 ASTHMA Helpline

The [1800 ASTHMA Helpline](#) is a free asthma information service that aims to support patient's better managing asthma. More information about asthma management is available by contacting Asthma Educators on 1800 ASTHMA (1800 278 462) or email [helpline@asthma.org.au](mailto:helpline@asthma.org.au).

[Referrals](#) can be made by GP, practice nurse or allied health professional directly via template in Best Practice or MedicalDirector, downloadable template for ZedMed, fax, webform, or self-referral.

#### Quitline (13 78 48)

[Quitline](#) is a telephone service dedicated to helping Queenslanders quit smoking. Referrals can be made by calling the Quitline on 13 78 48 or completing an online request [form](#). Quitline counsellors are available between 8am and 9pm, 7 days a week.

### Asthma Resources for Health Professionals

- [Australian Asthma Handbook](#)
- [Global Initiative for Asthma \(GINA\)](#)
- [Severe Asthma Toolkit](#)
- [Asthma Control Test – Asthma Australia](#)
- [Asthma and COPD Medications \(Poster\)](#) – National Asthma Council Australia
- [Spirometry Quick Reference Guide](#)
- [Spirometry Users and Buyers Guide](#)
- [Spirometry Handbook](#)
- [Asthma: Inhaler Device Checklist](#)
- [Asthma: Inhaler device videos](#)
- [Supporting Smoking Cessation: A Guide for Health Professionals](#) - RACGP
- [Skin prick testing for the diagnosis of allergic disease](#) – A manual for practitioners.

### Education for Health Professionals

- [RACGP e-learning modules](#)
- [Brisbane South PHN education events](#)
- [Asthma Australia Health Professional Training](#)
- [Asthma and Respiratory Workshop Education program](#) - National Asthma Council Australia
- [Spirometry training and tools](#) – National Asthma Council Australia
- [Spirometry Training Professionals](#)
- [Spirometry training for Indigenous Health Workers](#)
- [Think GP - Asthma in Australia: Practical Solutions for Challenges in Primary Care](#)
- [Difficult to treat and severe asthma webinar](#)- NPS Medicinewise
- [Asthma management webinar](#) – APNA.

Resources for Patients

- [Quitnow](#)
- [My health for life](#)
- Asthma Assist [program](#)
- National Asthma Council – [patient resources](#).

Resources for Aboriginal and Torres Strait Islander patients

- [Aboriginal & Torres Strait Islander patients and Asthma](#) – Australian Indigenous Health/InfoNet
- [Aboriginal and Torres Strait Islander Respiratory Resources](#) – Queensland Health.

Activity 8.1 – Education for the general practice team



Complete the table below to identify any required training or education for health professionals within the practice.

Topic	Who would like the education?	What would they like to know?
Asthma Basics		
Spirometry		
Inhalers, spacers and correct technique		
Asthma Action Plan		
Self-management skills/techniques		
Other		

## QI activities using the MFI and PDSA

After completing any of the workbook activities above you may identify areas for improvement in the management of patients with asthma. Follow these steps to conduct a QI activity using the MFI and PDSA. The model consists of two parts that are of equal importance.

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

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

Step 2: The **‘doing’** part is made up of Plan, Do, Study, Act (PDSA) cycles that will help to bring about rapid change. This includes:

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

### Example PDSA for the management of patients with asthma

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

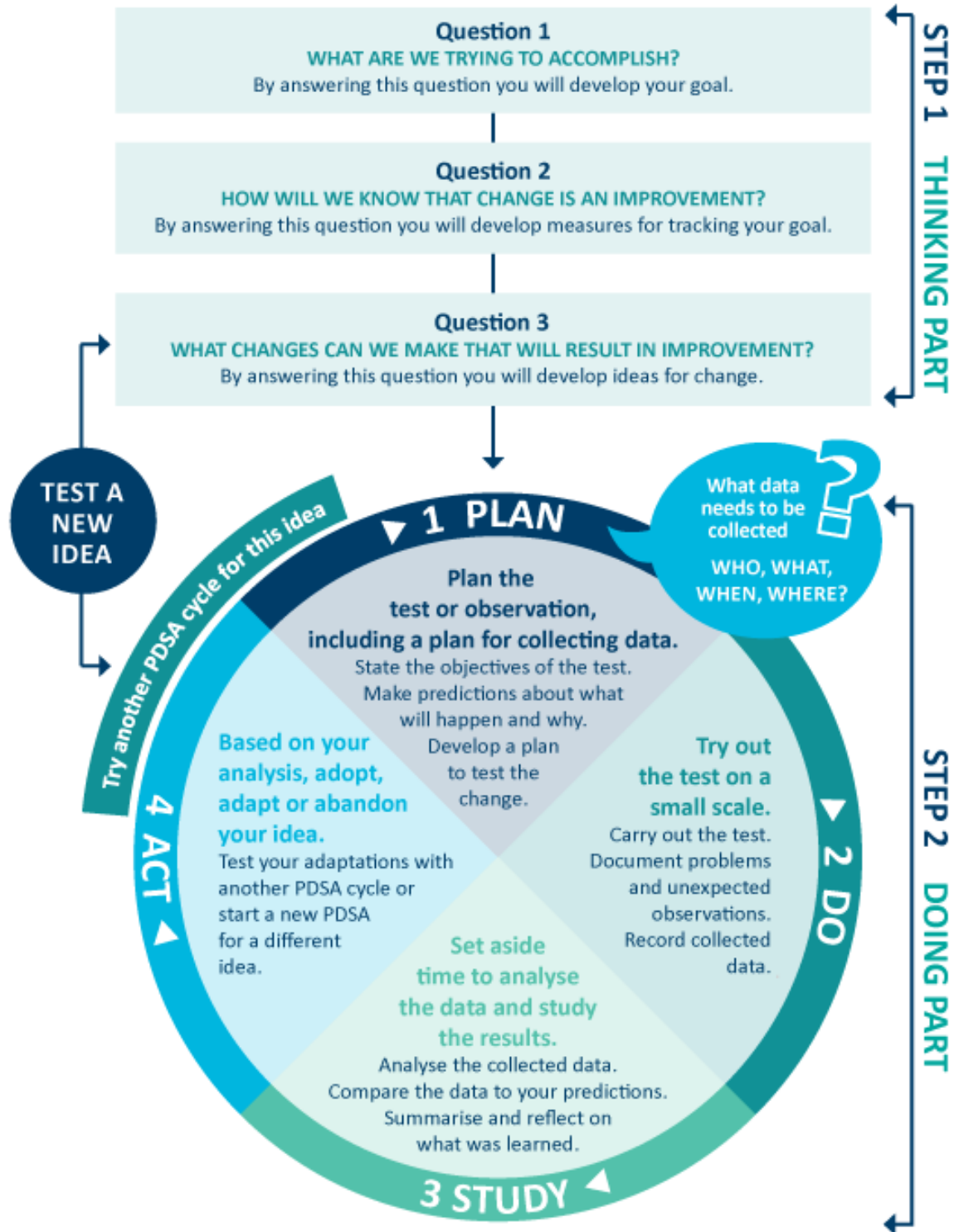
Goal	How you may achieve the goal
Ensure 90% of active patients aged 15 years and older have smoking status recorded (current smoker, ex-smoker or never smoked).	Refer to CAT4 recipe: <a href="#">identify patients with allergy or smoking status not recorded</a> .
Ensure 75% of active patients aged 15 years and older have BMI classified as obese, overweight, healthy or underweight within the previous 12 months.	Refer to CAT4 recipe: <a href="#">add height, weight and waist measurements to patient record</a> .
Increase the number of flu injections given to active patients with asthma aged 65 years and over during the past 15 months by 10%.	Refer to CAT4 recipe: <a href="#">identify patients at risk of influenza based on age, ethnicity or pregnancy</a> .

### Other ideas for improving asthma measures

It is suggested that you meet in your practice team to discuss how at your practice you can improve asthma measures. Some suggestions you may consider include:

- asking the practice nurse to opportunistically see patients prior to their GP appointment to obtain height, weight, waist measurements, BP, smoking and alcohol status
- asking patients to complete a summarised new patient form with their height, weight, waist measurements, BP, smoking and alcohol status and also check their address, contact details, NOK and emergency contact details
- actively contacting patients who do not have measures recorded e.g. proactively contact patients with severe asthma who have not yet had their flu injection in the past 15 months
- ensuring Topbar is installed on every workstation and fully operational.

# Model for Improvement diagram



Source: <http://www.ihl.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:	
<b>Q1. What are we trying to accomplish? (Goal)</b>	
By answering this question, you will develop your GOAL for improvement. Record this as a S.M.A.R.T. goal ( <b>S</b> pecific, <b>M</b> easurable, <b>A</b> chievable, <b>R</b> elevant, <b>T</b> ime bound).	
Our goal is to: increase the number of influenza vaccines recorded on active patients with asthma. <i>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.</i>	
So, for this example, a better goal statement would be: Our S.M.A.R.T goal is to: increase the proportion of influenza vaccinations given on our active asthma patients aged 65 and over by 15% by 25 <sup>th</sup> April.	
<b>Q2. How will I know that a change is an improvement? (Measure)</b>	
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 influenza vaccinations recorded on active patients aged 65 and over. To do this we will:	
A) Identify the number of active patients aged 65 and over with asthma.	
B) Identify the number of active patients aged 65 and over with an influenza vaccination recorded in the past 15 months.	
B divided by A x 100 produces the percentage of patients with asthma who have an influenza vaccination recorded in the past 15 months.	
BASELINE MEASUREMENT:            57% of active asthma patients have an influenza vaccination in the past 15 months.	
<b>Q3. What changes could we make that will lead to an improvement? (List your IDEAS)</b>	
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 active patients with asthma aged 65 and over who have not had an influenza vaccination recorded in the past 15 months.	
IDEA: Ensure relevant team members participate in immunisation training, ensuring a focus on influenza vaccinations.	
IDEA: Clinical team develop a system for flagging eligible patients and vaccinating opportunistically.	
IDEA: Source and provide endorsed patient education resources (in waiting rooms, toilets etc.).	



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 EXAMPLE

### 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)	
Identify active patients with asthma aged 65 and over who have not had an influenza vaccination recorded in the past 15 months.	
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.
<p>WHAT: Megan will set aside an hour on a Thursday afternoon to conduct a search on CAT4 of all patients aged 65 and over with asthma and no influenza vaccination recorded. A Topbar prompt will then be created to ensure these patients are reviewed for eligibility at their next appointment.</p> <p>WHO/WHEN/WHERE:</p> <p>Who: Practice Manager                      When: Begin 19<sup>th</sup> February.                      Where: Practice manager’s office.</p> <p>DATA TO BE COLLECTED: Number of active patients with asthma aged 65 and over and number of active patients with asthma aged 65 and over who have not had an influenza vaccination completed in the past 15 months.</p> <p>PREDICTION: 72% of the active patients with asthma aged 65 and over will have an influenza vaccination in the past 15 months.</p>	
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 10 <sup>th</sup> April – The practice manager conducted searches on CAT4 to identify the number of active patients aged 65 years and older with asthma and the number of active patients aged 65 years and older with asthma who do not have an influenza vaccination recorded in the past 15 months. A Topbar prompt was created which assisted the practice team identify patients eligible for influenza vaccination when they attended for an appointment.	
STUDY	Analyse the data and your observations
Analyse the results and compare them to your predictions	<p>Was the plan executed successfully? Did you encounter any problems or difficulties?</p> <p>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.</p>

At the end of the focus on influenza vaccinations for patients with asthma aged 65 and over, 75% of patients had an influenza vaccination recorded. This has resulted in an 18% increase in results which exceeded our goal.

Results have been shared with the whole practice team. The whole team was congratulated for their efforts.

*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. <i>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.</i>

ADOPT:

As this focus was a success, the practice have decided to review any patients with diabetes who have not received their influenza vaccination in the past 15 months.

ADAPT:

ABANDON:

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

MFI and PDSA template

Step 1: The thinking part - The 3 fundamental questions

<b>Practice name:</b>	<b>Date:</b>
<b>Team members:</b>	
<b>Q1. What are we trying to accomplish? (Goal)</b>	
By answering this question, you will develop your GOAL for improvement.	
Record this as a S.M.A.R.T. goal ( <b>S</b> pecific, <b>M</b> easurable, <b>A</b> chievable, <b>R</b> elevant, <b>T</b> ime bound).	
<b>Q2. How will I know that a change is an improvement? (Measure)</b>	
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.	
BASELINE MEASUREMENT:	DATE:
<b>Q3. What changes could we make that will lead to an improvement? (List your IDEAS)</b>	
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:	
IDEA:	
IDEA:	
IDEA:	

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)	
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 ( <i>if applicable</i> ); the data to be collected; and predictions about the outcome.
<p>WHAT:</p> <p>WHO/WHEN/WHERE:</p> <p>DATA TO BE COLLECTED:</p> <p>PREDICTIONS:</p>	
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).

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.
<p><i>Communicate the results of your activity with your whole team. Celebrate any achievements, big or small.</i></p>	
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. <i>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.</i>
<p>ADOPT:</p>  <p>ADAPT:</p>  <p>ABANDON:</p>	

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

