



# CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) COLLABORATIVE

## Handbook

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Wentworth Healthcare, provider of the Nepean Blue Mountains PHN, is a not-for-profit organisation that works to improve health for the communities of the Blue Mountains, Hawkesbury, Lithgow and Penrith.

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## Introduction

Welcome to the Nepean Blue Mountains Chronic Obstructive Pulmonary Disease (COPD) Collaborative and to this Handbook developed to support your participation in the Collaborative. COPD is a serious, progressive and disabling condition that limits airflow in the lungs, which leads to recurring illnesses and may result in frequent admissions to hospital [1]. In the Nepean Blue Mountains, COPD is the leading cause of potentially preventable hospitalisations [2]. The Nepean Blue Mountains Primary Health Network (NBMPHN) and the Nepean Blue Mountains Local Health District (NMBLHD) have jointly agreed to develop a COPD Collaborative to improve the quality of life of people suffering from COPD, to reduce the growth in COPD-related Emergency Department presentations and to reduce associated hospital admissions.



*Lizz Reay - CEO NBMPHN*

The COPD Collaborative will work with general practices across the Nepean Blue Mountains to support earlier diagnosis and improved management of patients with COPD. This initiative will focus on quality improvement measures that support the implementation of improved pathways of care for patients with COPD across the care continuum. This Collaborative activity recognises the significant role that general practice has in assisting patients to manage symptoms, control exacerbations, enhance exercise capacity and increase health status.

The COPD Collaborative will run from 1 July 2017 to 31 March 2018. A Collaborative follows a wave timeline with participating practices attending learning opportunities, undertaking activity periods and submitting data to track improvement. Practices participating in the Collaborative will learn from other general practices, leading respiratory clinicians and quality improvement experts on topics including spirometry, pharmacological interventions and data cleansing. In recognition of the time taken to attend workshops and undertake changes, participation and outcomes payments will be available to practices as well as to general practitioners and practice nurses.

Prior to the commencement of the Collaborative, foundation work was undertaken with representatives from local general practices, the NBMLHD, NSW Ambulance, the Lung Foundation Australia along with a local COPD patient support group. NBMPHN is appreciative of the involvement of these representatives as part of the Expert Reference Panel held on 27<sup>th</sup> April 2017 as well as for contributions to the development of this Handbook.

To support the design and delivery of the COPD Collaborative, NBMPHN is working with the Improvement Foundation. The Improvement Foundation is a not for profit organisation that has significant expertise in the design and delivery of quality improvement interventions, in particular using the collaborative methodology, and will be of immense value to practices participating in the COPD Collaborative to improve work practices and management challenges.

NBMPHN looks forward to working closely with participating general practitioners, practice nurses and other practice staff throughout the duration of this initiative. While participating in the Collaborative will mean additional work for practices, this initiative is also an exciting opportunity for general practice to improve outcomes for patients with COPD in our region and NBMPHN is grateful that your practice has chosen to become involved. We look forward to hearing about the progress of your practice as well as other practices participating in the Collaborative.

A handwritten signature in black ink that reads "Elizabeth Reay". The script is cursive and fluid, with the first name "Elizabeth" and the last name "Reay" clearly distinguishable.

Lizz Reay  
*Chief Executive Officer*  
*Wentworth Healthcare Limited provider of the*  
*Nepean Blue Mountains Primary Health Network*

# About Chronic Obstructive Pulmonary Disease in Australia

# Chronic Obstructive Pulmonary Disease in Australia

**COPD is a serious, progressive and disabling condition that limits airflow in the lungs and is a type of chronic airways disease [1]. Emphysema and chronic bronchitis are the most common features of the disease. People with COPD are often short of breath and may have frequent coughing [1]. The condition mainly affects older people and the main cause is active smoking or exposure to smoking [2].**

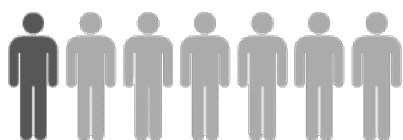
Lung Foundation Australia has estimated from ABS data that there are approximately 1.45 million Australians with COPD [3], which equates to nearly 1 in 7 of the population aged 40 years and over [4].

Within the Nepean Blue Mountains (NBM) region, COPD is the leading cause of potentially preventable hospitalisations, resulting in a 6.1 day average length of stay [3]. In the NBM region in 2010-11, respiratory disease was the third-leading cause of death in the region, accounting for 8.6% of male deaths and 10.6% of female deaths [2].

The number of COPD hospitalisations for men has decreased over the past 10 years, however the cost to the health budget remains significant. Conversely, COPD female hospitalisation rates have increased and were significantly higher than NSW COPD female hospitalisation rates overall [3].

COPD is a preventable condition which can be treated through pharmacological and non-pharmacological options [4]. While there is no cure, there is robust medical evidence to show that diagnosing the condition early combined with disease management programs in the early stages of the disease can lessen the burden of COPD, enhance quality of life, delay disease progression, decrease mortality and reduce hospital admissions [4]. Key issues driving the burden of this disease remains the underdiagnoses of COPD, particularly in the early stage of the disease, and poor utilisation of spirometry [5].

People with COPD rate their health worse than people without the condition. In 2014–15, 22% of those aged 45 years and over with COPD rated their health as poor, compared to 6% of those aged 45 years and over without it.



**1 in 7 people aged 40 years and over are living with COPD.**



**Within the NBMPHN region, COPD is the leading cause of potentially preventable hospitalisations.**

# About the Chronic Obstructive Pulmonary Disease Collaborative

# The Chronic Obstructive Pulmonary Disease Collaborative Objective

The objective of the COPD Collaborative is to improve the diagnosis and management of patients with COPD within the general practice setting.

## Aims of the Chronic Obstructive Pulmonary Disease Collaborative



**Increase to 50% the proportion of patients diagnosed with COPD who have spirometry recorded within participating general practices.**

**Increase to 70% the proportion of patients diagnosed with COPD who are on a GP Management Plan (GPMP) within participating general practices**



The aims of the COPD Collaborative were agreed by an Expert Reference Panel (ERP) that included representatives from general practice within the NBM region, NBM LHD, NSW Ambulance, Lung Foundation Australia, a local Patient Support Group, along with quality improvement experts from the Improvement Foundation.

The aims for the COPD Collaborative are designed to be 'stretch' aims that your practice can continue to work towards over time.

## What is a Collaborative?

Whilst there is evidence about what works to improve the care of patients with COPD, which provides some guidance on the way forward (this information is described in clinical guidelines and is referred to in this Handbook), there isn't a specific pathway s to follow. This lack of a clear map is why a collaborative approach to jointly defining the local processes involved will be supportive to clinicians.

Collaboratives are based on the well-established science of quality improvement, which has been developed over many years in many fields. The benefits of using a collaborative approach to achieve quality improvement in health is well documented.

*"A collaborative brings together groups of practitioners from different healthcare organisations to work in a structured way to improve one aspect of the quality of their service. It involves them in a series of meetings to learn about best practice in the area chosen, about quality methods and change ideas, and to share their experiences of making changes in their own local setting." [7].*

# The Six Rules of Improvement

The 'six rules of improvement' provide a helpful guide to the key elements of a Collaborative.

## 1. Think in systems

Build practice systems and processes that support individuals to provide reliable care. If you want a different result than you are currently achieving, then you need to adapt your system.

## 2. Explicitly state your aim and anticipated benefits

Often, change is attempted without a clear discussion about what is trying to be achieved. Meaningful and measurable aims are important. During the COPD Collaborative we will use the 'Model for Improvement' to help us set aims and track progress against small changes that we think will bring us closer to the goal of improving the care provided to patients with COPD.

## 3. Keep score – measure your progress

All improvement requires change, but not all change is an improvement. Measurement is what will tell if a change is leading to a desired improvement. A shared set of measures for this Collaborative have been developed. NBMPHN will support your practice to report progress against the measures as simply and easily as possible.

## 4. Make small incremental changes – continually

Large scale change is difficult to achieve and has potential for large unintended

consequence. Progress can be made by small steps made by a few providers, checking the outcomes at every step. Large scale change is achieved from the culmination of continual small steps.

## 5. Steal shamelessly

It's important to look outside your own practice, or even health, to learn from the experience of others. Collaboratives are designed to help participating practices to improve faster by learning from each other – Collaboratives work better when we are all willing to share our stories generously.

## 6. Inspire a culture of 'falling forward'

Sometimes in health, when we are all very busy, we tend to do things a certain way because that is how we have always done them. The world changes when we give ourselves and our team permission to change.

Whilst our first job is to look after the person in front of us, our second job is to improve so that we can deliver better care for them or the next person. Constant change can be exhausting, but constant improvement can be invigorating, which is why we should cultivate a culture of always doing things a little bit better.

**How will the Chronic  
Obstructive Pulmonary  
Disease (COPD)  
Collaborative work?**

## How will the Chronic Obstructive Pulmonary Disease (COPD) Collaborative work?

The COPD Collaborative will be implemented in a way that will turn the principles of improvement into action. Your practice will be supported to:

1. **Work out your starting point** by checking your COPD patient register to see if it's up-to-date and identifying if there are any patients in your practice who may have COPD but who are not diagnosed or coded correctly.
2. **Learn, think and share** with your peers through a series of learning workshops and webinars.

The workshops and webinars will include a mixture of expert and local speakers to build the group's understanding of the evidence and issues relating to care of patients with COPD. There will also be time for group work for you to develop ideas for action.

The COPD Collaborative will commence with an **Orientation Webinar**. This will provide:

- An overview of collaborative methodology;
- The COPD Collaborative aim(s), measures, change principles and change ideas; and,
- Key dates and links to resources.

This webinar will be recorded and made available to all participating practices.

Throughout the Collaborative three face-to-face **Learning Workshops** will be held. Practices are encouraged to send the same two representatives to each workshop. This is because each workshop builds on learnings and teamwork developed in previous sessions/workshops.

### Workshop and Webinar Schedule - KEY DATES

	Orientation Webinar	Learning Workshop 1	Learning Workshop 2	Learning Workshop 3
Dates	12 <sup>th</sup> July 2017 12:30pm-1:30pm	12 <sup>th</sup> September 2017 6:00 pm-9:00 pm	14 <sup>th</sup> November 2017 6:00 pm-9:00 pm	13 <sup>th</sup> February 2018 6:00 pm-9:00 pm

In addition to the workshops and webinars, which will be RACGP QI&CPD accredited for the current triennium (2017-19), you will be offered continuing professional development (CPD) training including:

- Spirometry; and
- Clinical topics relevant to COPD screening, diagnosis and management, including inhaler device technique.

The location of the learning workshops along with the dates and locations of the additional CPD training opportunities will be emailed to your practice.

Each practice participating in the Collaborative will be given free enrolments to Lung Foundation Australia's 'COPD Nurse Online' for all practice nurses. This online training will assist nurses to upskill about COPD, identify patients with COPD, manage patients with COPD and develop self-management plans with patients. **All participating practices will also receive a complementary stethoscope.**

To identify if there are other COPD related topics that your practice would benefit from learning about, a short survey has been sent to the contact email supplied for your practice. **Please follow the link supplied, within the introductory email sent to your practice, to complete the survey by 28 July 2017.**

### **3. Take action** by trialing changes in small, manageable cycles.

Making a simple plan is important for turning an idea into action. Documenting your plan and how implementation went is important so that you can quickly identify and share changes that are worth making permanent. A template for you to document your goals, ideas and plans for action using the very simple 'Model for Improvement' (sometimes referred to as the Plan, Do, Study, Act or PDSA cycle) is supplied on pages 45 - 47 of this Handbook.

To ensure you keep progressing, practices are **asked to complete a minimum of 2 'Model for Improvement' cycles per month** from September 2017 to March 2018. **These will need to be emailed to the COPD Collaborative Support Officer on the last working day of the month.**

NBMPHN is here to help you with documenting your 'Model for Improvement' cycles.

The Collaborative Support Officer, Jacquie Millynn, can be contacted via 02 4708 8138 or [jacquie.millynn@nbmphn.com.au](mailto:jacquie.millynn@nbmphn.com.au)

### **4. Measure, reflect and improve**

Using the 'Model for Improvement' template to record and reflect on the small scale changes you make is really important because if your practice sees an improvement in the care provided, it gives you a record of what was done to create the change. This helps to decide on what changes you want to make permanent, and helps practices to share and learn from each other.

In addition to the 'Model for Improvement' cycles, NBMPHN's support team will collect relevant COPD improvement measures from all participating practices via the PEN data extraction tool. De-identified data collected will be collated and monthly reports will be supplied to your practice so that you can track your progress against the COPD Collaborative measures and to see how you are tracking against other participating practices and the region.

The purpose of collecting and reporting data against the measure is to help everyone see if what they are doing is working – it is not for judging participants' performance or for research. **Throughout the COPD Collaborative, you will receive proactive and practical support from NBMPHN's COPD Collaborative Support Officer and your Practice Support Officer.**

**How NBMPHN  
will support you**

The following representatives will support your practice throughout the duration of the COPD Collaborative:

- The **COPD Collaborative Support Officer** will be your first point of call for all matters related to the COPD Collaborative. This will include providing practices with benchmark reports, assistance with implementing the 'Model for Improvement' cycles and regular feedback and support to guide quality improvement activities.
- Your **Primary Care Support Officer (PCSO)** will assist the COPD Collaborative Support Officer where required. Your PCSO will continue to be your first point of contact for all other matters to do with NBMPHN.
- The **COPD Collaborative Wave Chair** will support your practice through clinical guidance and support. The Wave Chair for this Collaborative is Dr Andrew Knight, a local GP with substantial experience in leading Collaboratives.

The COPD Collaborative Wave Chair, Dr Andrew Knight, can be contacted by email [awknight@aapt.net.au](mailto:awknight@aapt.net.au) or phone 0425 298 818.

## Training and learning

By participating in the COPD Collaborative, your practice is eligible to attend RACGP accredited continuing professional development training and learning opportunities led by leading respiratory clinicians and quality improvement experts. Information on workshops and webinar is outlined in the previous section, 'How will the COPD Collaborative Work?'

## QI&CPD points and incentive payments

Practices participating in the COPD Collaborative will be eligible for 40 RACGP Category 1 QI&CPD points for 2017-19 triennium.

RACGP Activity Number for the COPD Collaborative is 98453.

Practices will also be eligible for participation and outcomes payments. Payments will be made according to the following activity structure:

## Payment structure for COPD Collaborative

Stage (dates)	Payment type and amount (ex. GST)	Target area	Description of required participation / performance target(s)
<b>1 July to 31 Aug 2017</b>  <b>12 July 2017</b>  <b>12 Sept 2017</b>	<b>Practice Participation payment #1</b> (\$750)	Visit 1 - Baseline data collection  Orientation Webinar  Learning Workshop #1	Baseline data collection is undertaken and report created (by COPD Collaborative Support Officer) which identifies the number of patients in the Practice patient-population with a coded diagnosis of COPD who have spirometry results, smoking status and pneumococcal vaccinations recorded.  A minimum of two practice staff participate in the orientation webinar  A minimum of two practice staff to attend the first learning workshop.
<b>14 Nov 2017</b>	<b>Practice Participation payment #2</b> (\$750)	Learning Workshop #2  8 x 'Model for Improvement' cycles	A minimum of two practice staff to attend the second learning workshop.  The Practice develops and submits eight 'Model for Improvement' cycles (2 per month from September to December 2017) which outline QI activities the Practice team will implement to improve COPD within the Practice patient-population.
<b>Jan 2018</b>	<b>Practice Performance incentive payment #1</b> (\$750)	Visit 2 - Practice performance target	Practices will be paid \$25 for each patient (up to a maximum of \$750) with a coded diagnosis of COPD who have spirometry results, smoking status and pneumococcal vaccinations recorded in the period 01 September 2017 to 31 December 2017.
<b>13 Feb 2018</b>  <b>Apr 2018</b>	<b>Practice Participation payment #3</b> (\$750)	Learning Workshop #3  6 x 'Model for Improvement' cycles	A minimum of two practice staff to attend the third learning workshop.  The Practice develops and submits six 'Model for Improvement' cycles (2 per month from January 2018 – March 2018) which outline QI activities the Practice team will implement to improve COPD within the Practice patient-population.
<b>Apr 2018</b>	<b>Practice Performance incentive payment #2</b> (\$750)	Visit 3 - Practice performance target	Practices will be paid \$25 for each patient (up to a maximum of \$750) with a coded diagnosis of COPD who have spirometry results, smoking status and pneumococcal vaccinations recorded in the period 01 January 2018 to 31 March 2018.

In addition to payments to practices, outcomes payments are also available for general practitioners and practice nurses. Providers will be paid \$25 for each patient with a spirometry result recorded up to a maximum of \$750 per general practitioner or practice nurse per time-period (see below for time-periods). GPs are required to individually register for the COPD Collaborative to be eligible for Outcome Payments. GPs / practices are encouraged to pass on payments in full to practice nurses that record spirometry results in the Practice.

Payment	Stage	Time-period
#1	January 2018	Results received from 1 September 2017 – 31 December 2017
#2	April 2018	Results received from 1 January 2018 – 31 March 2018

Total participation payment for practices – \$2,250

Maximum incentive payments for practices – \$1500

Maximum outcome payment for general practitioners and practice nurses – \$1500

## Support to monitor and report progress

Regular data submission is a key feature of a Collaborative wave. Regular data submission works on a number of levels as it assists:

- General practices to actively engage in the topic areas and deliver rapid and sustainable improvements;
- General practices to benchmark against others and track their improvement work; and,
- Collaborative support staff to identify how their practices are tracking, and where they may need additional support and guidance.

The COPD Collaborative Support Officer will work to make sure that providing data for the measures is as easy and straightforward as possible. The benefit is that reporting against the measures really helps you to see if the work you are doing is making an impact!

## Key support functions

- Practices are required to submit data extracted from its clinical software on a monthly basis to NBMPHN (July 2017 to March 2018). This process will occur automatically if automatic scheduling has been set-up. You will be supported to do this.
- The COPD Collaborative Support Officer will also visit your practice in July or August 2017 to collect baseline data and in January and April 2018 to collect progress data.
- NBMPHN COPD Collaborative Support Officer and your Primary Care Support Officer will provide ongoing feedback and support – and you can call them at any time.

To keep your practice informed about how you are progressing and to benchmark your practice against others participating in the Collaborative, monthly feedback will be provided to you.

The overall progress will also be discussed at the Learning Workshops. Please be reassured that only aggregated, de-identified practice level data will be shared. Practices that are meeting or exceeding targets may be asked to share suggestions and advice on what they have implemented to support sharing of good ideas.



**Change principles,  
change ideas, tools  
and resources**

## Change principles and change ideas

This section provides ideas for action with case studies and helpful tips to assist you. The change principles and ideas presented here are based on evidence about what works for quality improvement in the Primary Care setting that supports improving the care of patients with COPD. To assist your practice with making changes, resources and helpful links are available via the NBMPHN website: <http://www.nbmphn.com.au/General-Practice/Programs-Services/COPD-collaborative.aspx>

Change Principle	How? (Change Ideas)
<b>Engage and support the practice team</b>	<ul style="list-style-type: none"> <li>• Involve the whole team</li> <li>• Set realistic goals and use data to drive improvement</li> <li>• Ensure team members have protected time to complete tasks</li> <li>• Communicate regularly and systematically</li> <li>• As a team, regularly reflect, review and adjust what you are doing</li> </ul>
<b>Improve the accuracy of your clinical database</b>	<ul style="list-style-type: none"> <li>• Build a reliable register of patients diagnosed with COPD</li> <li>• Systematically identify patients who have not yet been identified as having COPD but who fit the diagnostic criteria</li> <li>• Build systems to maintain the accuracy of these registers over time</li> <li>• Engage your patients to ensure the accuracy of the information you hold about them</li> </ul>
<b>Have a systematic and proactive approach to managing the care of people with COPD</b>	<ul style="list-style-type: none"> <li>• Use a multidisciplinary team to facilitate reliable care delivery</li> <li>• Utilise appropriate care pathways for people with COPD</li> <li>• Use guidelines, protocols and computer templates to support care delivery</li> <li>• Establish proactive recall and reminder systems</li> <li>• Integrate the perspective of patients and carers in the design of services</li> </ul>
<b>Support patient self-management</b>	<ul style="list-style-type: none"> <li>• Establish clear definitions of self-management and what self-management support involves</li> <li>• Organise internal and external resources to provide patient-centred self-management support</li> <li>• Implement a strategy for self-management support that empower patients and carers</li> <li>• Implement processes and systems to support patients to adopt self-management plans</li> <li>• Implement processes and systems to support patients with advance care directives/plans</li> </ul>
<b>Ensure patients receive coordinated and integrated care</b>	<ul style="list-style-type: none"> <li>• Identify and engage local organisations and other sources of care to provide best care to people with COPD</li> <li>• Analyse the patient journey and redesign where necessary</li> <li>• Support integrated care by improving the relationship between primary, secondary and tertiary care providers</li> <li>• Use shared health summaries to coordinate care with other providers in the patients' care teams</li> </ul>

## Getting started is easy

For example, your first goal may be to ensure you have an engaged team to support the work your practice will do. So, your first 'Model for Improvement' cycle may be to complete the 'Engage your practice team' checklist. Completing this checklist will give your team ideas for areas where you want to make improvements, and one of these improvement ideas can become your next 'Model for Improvement' cycle.

## Engage and support the practice team

Engaged practice teams are the foundation of achieving sustainable change.

Experience from past collaborative programs shows that building the team's engagement and commitment to the work is often an area that practices overlook, and it becomes a weakness that impacts on achieving sustainable change.

If you want to change the outcomes your practice is achieving, you will need to change what you are doing and it's only natural that this will require some change management. It's important not to assume the value of changes will be understood or accepted without some team building. Facts are usually not enough, you need to get "hearts and minds" on side for making changes.

The following checklist, tools and resources will help you to take the right steps to build an integrated team-based and sustainable approach to improve the care of patients with COPD in your practice.

## Checklist: Engage and support the practice team

### Involve the whole team

- ☐ Will you reflect as a team on the purpose of the COPD Collaborative, what you want to achieve and who will benefit from the COPD Collaborative?
- ☐ Does the whole team have a motivation for participating in the COPD Collaborative? It doesn't have to be the same motivating factor (e.g. pride in the quality of my work, the business case and financial benefit, competition, prior bad experience with patients having adverse outcomes)
- ☐ Will we give the whole team opportunity to generate ideas for improving care provision?
- ☐ Do we have a practice leader (e.g. our Practice Manager or Principal Clinician) championing the COPD Collaborative?
- ☐ Does the way we assign roles make efficient use of our entire team? (See the 'Assigning Tasks' case study)
- ☐ Does our team have the skills they need, or is more training required? Would undertaking a simple skills audit be helpful to identify training needs?

### Set realistic goals and use data to drive improvement

- ☐ Was our team involved in setting our practice's own goals for the COPD Collaborative? (These goals will form the basis of your 'Model for Improvement' cycles and they don't have to be ambitious or complicated – start small and go from there!)
- ☐ Are our goals SMART: Specific, Measurable, Attainable, Realistic and Time bound?
- ☐ Do we have tools to measure progress against our goals?
- ☐ Are we using data to frequently review progress against our goals?

### Ensure team members have protected time to complete tasks

- ☐ Have we assigned roles and responsibilities for carrying out tasks? Is what we have asked people to do realistic?
- ☐ Do team members have 'protected' time to regularly complete tasks? (This is critical!)

### **Communicate regularly and systematically**

- ☐ Have we established a process for providing and seeking regular feedback to and from the team (e.g. monthly staff meeting, via staff email, using staff notice boards)?
- ☐ What importance does our team place on team meetings? What is their frequency? What outcomes are achieved? How does management communicate with the wider team? How will team-time be divided between the COPD Collaborative and other practice business?
- ☐ Do we have our COPD Collaborative goals and regular progress updates displayed and accessible to staff?
- ☐ Are team meetings well organised and supported by good processes (agendas, chairing, minutes, action lists, accountability, etc.)?

### **As a team, regularly reflect, review and adjust what you are doing**

- ☐ Is reviewing our progress against our COPD Collaborative targets and generating new ideas, part of our regular team meeting agenda?
- ☐ Are we regularly reviewing our progress and adjusting our goals and strategies, as needed?
- ☐ Are we rewarding and acknowledging success and working as a team to problem solve challenges?

## Helpful tips and case studies

### Helpful tip

Experience in the collaborative program has shown that successful teams have demonstrated four key characteristics:

- They are clear about what is required of them, and they have an agreed strategy on how to complete all tasks required to run the practice;
- They have enough information, skills and experience to do the job;
- They have constructive group dynamics that create and maintain effective and efficient levels of communication; and
- Members of the team are committed to the practice and to producing high quality responsive patient care.

### Helpful tip

Effective teams communicate well. Good communication saves time, money and eliminates duplicated work.

Poor communication does the opposite. It creates work, causes frustration, costs time and money and compromises patient outcomes.

### Case Study – Involving the whole team

To engage the reception staff in the Program and help them understand the necessity and importance of data collection, we invited the key contacts from our local and state based support organisations to further explain the Program and their role in it. We had fantastic feedback from staff and they are now proactive in collecting the measures. They have even drawn up their own timetable to track which measures they need to be collecting. The staff members are enthusiastic and are even encouraging and reminding each other to get data collected.

***Keen Street Private Clinic, Lismore, NSW***

### Case Study – Engaging with patients to check accuracy of information

At Tintenbar Medical Centre the receptionist prints the patient's health summary on yellow paper and asks the patient to check the accuracy of the record whilst in the waiting room. The doctor makes any amendments to the shared health summary then codes the 'reason for visit' as 'health summary'. This enables Tintenbar to extract a list of patients who have reviewed their shared health summary. The benefits of this approach has been a more conscientious effort in entering data across the practice team, engagement by the patient in their health summary, and improved accuracy of data.

***Tintenbar Medical Centre, Tintenbar, NSW***

## Improve the accuracy of your clinical database

The first step towards providing evidence based care for your patients is to have a good understanding of your patient population. You can't be proactive and systematic in the management of your patients if you don't know 'who they are and what they've got'.

Experience in the Collaborative Program has shown that developing and maintaining registers requires involvement of the whole team. You may choose to establish a small, multidisciplinary team (or micro-team) to lead the work. This might include a GP, practice nurse and/or practice manager. It is important that the system designed by the micro-team is communicated to, and adopted by, all staff members.



## Checklist: Improve the accuracy of your clinical database

### Build a reliable register of people diagnosed with COPD

- ☐ Do we have a consistent policy to identify which of the patients on your clinical database are 'active' patients', and to proactively 'inactivate' patients who are no longer under your care?
- ☐ Do we have a current register of patients diagnosed with COPD?
- ☐ Do we have an agreed definition of COPD?
- ☐ Do we have a protocol for coding patient information?
- ☐ Do we have a coding policy to ensure that all GPs are coding consistently using existing search options, and avoiding free text in diagnosis, to ensure that our clinical software can be interrogated to accurately identify all patients with COPD?

### Systematically identify patients who have not yet been identified as having COPD but who fit the diagnostic criteria

- ☐ Do we have patients who have no formal diagnoses recorded?
- ☐ Do we have patients who are current or ex-smokers with the following symptoms or risk factors:
  - breathlessness that seems inappropriate;
  - chronic (daily for two months) or intermittent, unusual cough;
  - frequent or unusual sputum production;
  - relapsing acute infective bronchitis; and,
  - risk factors such as exposure to tobacco smoke, occupational dusts and chemicals, and a strong family history of COPD?
- ☐ Do we have patients who are not diagnosed with COPD but are prescribed bronchodilators, inhaled corticosteroids, oral corticosteroids, and mucolytics?
- ☐ Have these patients been offered/referred for spirometry?

### Build systems to maintain the accuracy of these registers over time

- ☐ Do we have a person named as the 'register manager'?
- ☐ Has this person been given 'protected time' to maintain the register?
- ☐ Is maintaining our register part of our practice policy and guidelines?
- ☐ Does our register capture new patients effectively and retire patients effectively?
- ☐ How does the register fit with our care pathways and recall and reminder systems?
- ☐ How often do we routinely check the quality of the information on the register?
- ☐ Do we need to document our system for maintaining the register so the system works when the register manager is away?

### Engage your patients in ensuring the accuracy of the information you hold about them

- ☐ How do we ask patients to review the information we hold about them?
- ☐ What information do we include in the review process, e.g. medical history, allergies and adverse reactions, current medications, immunisations etc.?
- ☐ How often do we ask patients to review their information?
- ☐ How do we update patient records after the review process?

## Helpful tips and case studies

### Helpful tip

Run a search on all patients' diagnoses to produce a list of patients recorded with COPD and asthma. Ask your GPs to assess which patients should be coded with COPD or asthma or both.

### Case Study – Maintaining the register

Maintaining the register in the practice is a continuous, quality improvement process. The practice uses a variety of approaches to encourage doctors to use the diagnosis code when entering a diagnosis:

- The practice manager reminds doctors of the importance of coding at clinical meetings and ensures that the doctors are clear and in agreement on what diagnostic codes are to be used;
- Laminated posters are placed in each doctor's office to remind them to use the diagnostic codes; and
- A staff member is responsible for regularly validating and checking the accuracy of the register.

***Camp Hill Medical Centre, Brisbane, QLD***

### Helpful tip

Ensure all patients on the register have smoking status recorded annually and of these, how many are current smokers.

## Have a systematic and proactive approach to managing the care of people with COPD

Managing care efficiently and consistently across a general practice requires a planned, systematic and proactive approach. It is important your patients are offered appropriate evidence-based and patient-centred interventions.

Some patients have a high risk of exacerbations, leading to presentations and admissions to hospital. By systematically identifying these people, and adopting a proactive approach to risk factor reduction, you can have a large impact on their health outcomes. However, all patients diagnosed with COPD potentially benefit from improvements to their modifiable risk factors, including smoking cessation, referral to pulmonary rehabilitation, regular physical activity, immunisation and referral to local support groups.

There is strong medical evidence to show that early diagnosis, combined with disease management programs at the early stages of the disease could reduce the burden of COPD, improving quality of life, slowing disease progression, reducing mortality and keeping people out of hospital [5].

## **Checklist: Have a systematic and proactive approach to managing the care of people with COPD**

### **Use a multidisciplinary team to facilitate reliable care delivery**

- ☐ Do we have a team based approach to chronic care management?
- ☐ Do the team members\* have the appropriate skills and training, e.g. spirometry training, to manage the care of patients with COPD?
- ☐ Do we regularly liaise with each other to coordinate patient care?
- ☐ Do we run nurse clinics?
- ☐ Do our patients know who their care team is?

\*Members of the team may be external private providers e.g. physiotherapists and exercise physiologists. Engaging them within the practice team as part of the 'Team Care Arrangement' is important.

### **Utilise appropriate care pathways for people with COPD**

- ☐ Do our patients with COPD have current care plans?
- ☐ Do the care plans include information on patient needs and goals and self-management options?
- ☐ Do our patients receive timely clinical reviews based on recommended guidelines?
- ☐ Do we regularly undertake reviews of our patients care plans?
- ☐ Do we use recommended care pathways?

### **Use guidelines, protocols and computer templates to support care delivery**

- ☐ Do our clinicians refer to relevant guidelines such as COPD-X guidelines?
- ☐ Do our clinicians have online access to clinical guidelines and templates?
- ☐ Do we review the templates to make sure they're suitable for our general practice and our community's needs?
- ☐ Do all our clinicians know how to use the templates?

### **Establish proactive recall and reminder systems**

- ☐ Do we have a systematic and proactive reminder system?
- ☐ Do we use prompts in the appointment system or clinical software to identify patients with specific needs e.g. those for whom English is a second language, patients with disabilities?
- ☐ Do we have multiple channels for communicating reminders, depending on the needs and preferences of the patient? (e.g. letter, SMS, phone call, letters translated into other languages)
- ☐ Does our whole team understand our recall and reminder system?
- ☐ Does our practice monitor attendance and have systems to follow up patients who do not attend?

### **Integrate the perspective of patients and carers in the design of services**

- ☐ How do we incorporate patients' and their families' perspectives and choices to ensure their knowledge, values, beliefs, and cultural backgrounds are incorporated into the planning and delivery of care?
- ☐ How do we encourage and support patients to participate in care and decision-making at the level they choose?
- ☐ Do we have an agreed process and policy around collaborative goal setting to assist patients to develop written action plans to achieve their own goals?
- ☐ Does our practice request feedback from patients about their experience of care? (Accreditation: RACGP 1.2.1A, 1.6.1B, 2.1.2A, C, D, E)
- ☐ Have we involved patients in the design of resources, such as awareness raising literature and healthy lifestyle guidance?
- ☐ Do we have a patient advisory group?
- ☐ Do patient reported measures form part of how we assess our practice's performance?

# MBS incentives for Chronic Disease Prevention and management

Incorporating MBS fees as at 01 July 2017

\*The Medicare requirements for each item should be read before any claims are made: see [www.health.gov.au/mbsonline](http://www.health.gov.au/mbsonline) or phone Medicare Australia on 132 150.

CDM Initiative	MBS Item	Benefit	Service	Frequency
<b>Health Assessments</b>	701 <30 mins	701 - \$59.35	Over 75 Health Assessment	Annual
			Healthy Kids/4 year old check, by GP	Once only
			Comprehensive Medical Assessment for aged care resident	Annual
	703 30-45 mins	703 - \$137.90	Diabetes Prevention: 40-49 Year Diabetes Evaluation (following AUDISK)	Every 3 years
			45-49 Year Health Check (people with chronic disease risk factor)	Once only
	705 45-60 mins	705- \$190.30	Refugee/Humanitarian Entrant Health Check (see eligibility criteria)	Once only
			Health Check for Intellectually Disabled Person	Annual
	707 >60 mins	707 - \$268.80	Former Serving Members of The Australian Defence Force	Once Only
	715	\$212.25	ATSI People's Health assessment (all ages). ATSI patients with Health Assessment can be referred for Medicare-rebated allied health services.	9 Monthly
	10987	\$24.00	Nurse Services following an ATSI Health Assessment	10 per year
<b>Case conferences</b>	735, 739, 743, 747, 750, 758	Refer to MBS Online	Case conferences, based on time: items 735, 739 or 743 where GP organises, or items 747, 750 or 758 where GP participates.	5 per year
<b>Chronic Disease Care Planning</b> Patients with a GPMP & TCA can be referred for EPC Medicare-rebated allied health services. Patients with GPMP can be referred for Type 2 Diabetes group courses	721	\$144.25	GP Management Plan for Chronic Disease Management - see MBS online for criteria	12 monthly minimum
	723	\$114.30	Team Care Arrangements (TCA) for chronic disease management	As above
	732	\$72.05	Review of either GPMP or TCA	3-6 monthly
	729	\$70.40	GP contribution to another organisation's care plan	Refer MBS online
	731	\$70.40	GP contribution to Aged Care Facility's care plane	Refer MBS online
	10997	\$12.00	Service provided by a practice nurse - If person has GPMP/TCA or Multidisciplinary Plan in place and service is consistent with GPMP/TCA or Multidisciplinary Plan	5 per year
<b>DMMR</b> Domiciliary Medication Management Review	900	\$154.80	Review of Medications in collaboration with a pharmacist for patients at risk of medication related misadventure. See MBS for full details	12 monthly *refer MBS online
<b>RMMR</b> Residential Medication Management Review	903	\$106.00	For Permanent residents of Residential Aged Care Facilities who are at risk of medication related misadventure. Performed in collaboration with the resident's pharmacist.	12 monthly *refer MBS online
<b>Simple Procedures</b>	11506	\$17.50	Spirometry – before and after bronchodilator	No limit

## Helpful tips and case studies

### Helpful tip

Consider assessing patients who are current smokers for COPD when they present to your practice with a chest infection.

### Case Study – Smoking cessation program

Tintenbar Medical Centre wanted to reduce the number of their patients who smoked. After successfully receiving a cancer council grant, they ran a project aimed at helping patients quit smoking.

The practice identified patients who smoked and mailed them an invitation to attend a smoking cessation meeting that was run at a local hall. The group that attended was keen to meet twice more to support one another. The practice enlisted the local pharmacist to present at one of the meetings. Although the number of patients that responded to the invitation was small, the quit rate at six months was 40% of those who attended the meetings.

***Tintenbar Medical Centre, Tintenbar, NSW***

### Helpful tip

Encourage all patients to involve carers and family members in their management (e.g. by attending consultations).

### Case Study – Integrating patients' feedback

My GP invited me to speak to her entire team about the value of a Care Plan and this presentation and my involvement was used to support applications by the practice for various Awards – two of which they won. This involvement was also included in the practice's re-accreditation. Whenever I see my GP she updates me on the innovations and changes in the practice which makes me feel part of their extended team.

My involvement with the Improvement Foundation has also grown and developed. I've been part of a panel on 21st century Patient Care and Self-Management workshop on the Gold Coast, and I was part of another panel at a workshop on the electronic health record – something else I am passionate about as a chronic disease patient.

I have to say being as involved as I have been and fortunate to be in these workshops, has made me more aware of the need to take ownership and responsibility for my diabetes. I've also been able to share what I have learned with fellow patients and encourage them to self-manage better.

***Julie Sattler – Improvement Foundation Patient Representative and Mentor***

## Support patient self-management

We know the real work in managing chronic conditions and reducing risk factors is done by our patients and their families. In a person-centred health system, the person and their families and carers are at the centre of how care is designed, planned, communicated and delivered. This is because ultimately, it is the values, resources and actions of the person and their carers that are the key determinants of health outcomes. Our role as general practices and primary health services is to give them the tools and teams they need to take action on improving their health.

Self-management involves 'engaging in activities that protect and promote health, monitoring and managing symptoms and signs of illness, managing the impacts of illness on functioning, emotions and interpersonal relationships and adhering to treatment regimes'. Self-management plans are an effective way of actively engaging patients in managing their health.

The 'Support patient self-management' checklist, tools and resources are designed to help you take a person-centred approach to supporting patients to self-manage their conditions to the best of their ability.



## Checklist: Support patient self-management

### **Establish clear definitions of self-management and what self-management support involves**

- ☐ Do we provide care that builds our patients' and their families' knowledge, skills and confidence?
- ☐ How do we increase our patients' and their families' knowledge about their condition(s)?
- ☐ How do we share the needs and preferences of our patients and their families with the team?
- ☐ Do we support our patients and their families in the psychosocial and medical responses to their condition?
- ☐ Do we provide evidenced-based approaches to enhancing self-management?

### **Organise internal and external resources to provide patient-centred self-management support**

- ☐ Does our team have the resources and skills to provide self-management support?
- ☐ Do we have a clinical or administrative champion within the team to drive self-management support strategies?
- ☐ Does our practice display COPD self-management materials?
- ☐ Have we reviewed the health promotion materials available from the Lung Foundation Australia and ordered the resources that are relevant to our practice?
- ☐ Do we provide smoking cessation advice and resources?
- ☐ Does our practice display self-management materials designed for specific cohorts of patients (e.g. Aboriginal and Torres Strait Islander people)?
- ☐ Does our practice use events such as World COPD Day or Lung Health Awareness Month to promote lung health initiatives within our health service?

### **Implement a strategy for self-management support that empower patients and carers**

- ☐ Do we have a strategy to identify the patients that would most benefit from self-management support?
- ☐ Does our whole team understand the components of health literacy?
- ☐ Has our team (including reception staff) received health literacy training?
- ☐ Have we put our reminder letter through a health literacy check?
- ☐ Have your clinicians undertaken online Teach-Back training? (Accreditation: RACGP 1.2.2A, 1.2.2B, 1.3.1)
- ☐ Do our clinicians use motivational interviewing techniques and/or provide health coaching?
- ☐ Is our practice a safe place for Aboriginal or culturally diverse patients?
- ☐ Have our clinicians read the 'Cultural Safety Factsheet'?
- ☐ Do our patients understand the instructions within the COPD Action Plan?

**Implement processes and systems to support patients to adopt self-management plans**

- ☐ Do we have a strategy to identify the patients that would most benefit from self-management planning?
- ☐ Do we use self-management plans?
- ☐ Do the plans include shared definitions of the patient's problems, goals, actions and timeframes for managing their health?
- ☐ Do our patients have COPD Action Plans?
- ☐ Do our COPD action plans detail what individuals should do in the event of an exacerbation at any time of the day?

**Implement processes and systems to support patients with advance care planning**

- ☐ Do we have a strategy to assess which of our patients are suitable for Advance Care Planning (ACP)?
- ☐ Have we set up a specific recall and reminder system for this process?
- ☐ Do we book long consultations in order to ensure that there is time to discuss ACP in full, answer any questions and discuss patients' concerns and issues?
- ☐ Do we invite patients' nominated carers, family members or friends (if appropriate)?
- ☐ Do we book further consultations, as ACP is often an ongoing process, rather than a "one-off" discussion?
- ☐ Do we discuss power of attorney/ enduring guardianship with patients and their carers as required?
- ☐ Do we refer patients to external agencies such as the NSW Public Guardian or the NSW Guardianship Tribunal, where relevant?

## Helpful tips and case studies

### Case Study – Nurse clinics to support self-management

Stirk Medical Group in Western Australia established nurse-led clinics with an aim of improving patient self-management. The practice understood the importance of assigning the right staff member(s) to coordinate the clinic.

A practice nurse, who was willing to develop the program and understood the concept of self-management, was assigned to lead the clinic. By creating a nurse-led clinic, the practice could dedicate the necessary time for patients to be educated and actively involved in making decisions about their care.

***Stirk Medical Group, Lesmurdie, WA***

### Helpful tip

COPD Action plans can aid recognition of, and response to, exacerbations but they should not replace comprehensive self-management plans that incorporate elements such as education and regular review for suitable patients.

### Case study – Reducing ‘no-shows’ by using a health literacy checklist to update appointment letters

A number of practices have improved their appointment letters. The new letters are written in clear language and checked for readability. The appointment time is in 12 hour time not 24 hour time. They included the location of the appointment with a map, public transport and parking options. The letters also provide information about the cost of the appointment, and the option to call the practice ahead of their appointment if the cost is an issue. This way, people can discuss payment in private and know that they will not need to have this conversation in front of others in a waiting room. These changes lowered anxiety about appointments and reduced the number of no-shows for people receiving reminder letters.

***Health Literacy Officer, Northern NSW Local Health District***

## Ensure patients receive coordinated and integrated care

General practice is typically the gateway for patients to access specialised parts of the health system. GP's and care managers play a key role in ensuring patients can access the care they need, while avoiding unnecessary pathways or pathways where risks may outweigh the benefits.

In the medical home model, a person and their family form a partnership with a particular primary care provider and their team, with other services 'wrapping around' this partnership, as required. This model is useful for considering how the wider health system links with the primary care health services in which patients' receive the majority of their care, to form an integrated care system. For more information visit: <http://medicalhome.org.au/the-person-centred-health-system-and-the-medical-home/>.



## Checklist: Ensure patients receive coordinated and integrated care

### Identify and engage local organisations and other sources of care to provide best care to people with COPD

- ☐ Do we have details of our patients' carers, nominated family members and friends in their records?
- ☐ Do we have a list of local allied health professionals/services that we can refer to? Is this information up to date?
- ☐ Can we access an electronic service directory which is regularly updated?
- ☐ Do we have contact details for the local hospital discharge planner?
- ☐ Do we know which local support services are available?
- ☐ Do we ask and record all new patients' language preferences and offer and use appropriate language services? (RACGP criterion 1.7.1C, F)
- ☐ Do we use interpreter services appropriately?
- ☐ How do we communicate with local providers and support services?

### Analyse the patient journey and redesign where necessary

- ☐ Do we have details for all the team members involved in the care of our patients with COPD?
- ☐ Has our practice team mapped the patient journey from the person's point of view to try to understand which aspects of the journey may be inconvenient, difficult to access, unclear or psychologically distressing for your patients?
- ☐ Have we involved patients in the mapping exercise?
- ☐ As a result of this, do we need to amend our care pathways?

### Provide integrated care by improving the relationship between primary, secondary and tertiary providers

- ☐ Do we have established referral processes?
- ☐ Do we utilise localised care pathways?
- ☐ Does our practice partner with community organisations or leaders to better engage hard to reach patients and to support referrals to services?
- ☐ Do we refer our patients to local support groups?
- ☐ Will we use the Nepean Blue Mountains HealthPathways live site when it becomes available?

#### HealthPathways

HealthPathways is an important tool that is designed to ensure Nepean Blue Mountains primary health care providers have the information they need at their fingertips, at the point-of-care, to help patients navigate our health system effectively. NBMPHN in conjunction with the NBM Local Health District will provide localised and up to date HealthPathways for management of patients with COPD later this year.

**Use shared health summaries to coordinate care with other providers in the patients' care teams**

- ☐ Do all our patients with COPD have a 'My Health Record'?
- ☐ Have we uploaded Shared Health Summaries (SHSs) for all our patients with COPD?
- ☐ Can we work with the Hospital to support improved use of the My Health Record?
- ☐ Does our practice partner with community organisations or leaders to inform patients of the benefits of the My Health Record and how to use it?

**Medication Management**

- ☐ Are all medications recorded?
- ☐ Does the patient understand how to use their medications including inhalers correctly?
- ☐ Is a Medication Management Review (MMR) (MBS 903) required?
- ☐ Has a MMR been conducted in the last twelve months?

## Helpful tips and case studies

### Helpful tip

The Lung Foundation's Information and Support Centre can be contacted for:

- Support group locations
- Pulmonary rehabilitation program locations
- Lungs in Action program locations
- Links to other relevant services
- Clinical and patient resources

FREE CALL 1800 654 301 or via [enquiries@lungfoundation.com.au](mailto:enquiries@lungfoundation.com.au).

### Case study – Raising awareness of COPD in the community

A Lung Support Group held a COPD Awareness Day outside a local Bunnings store. Nurses were on hand to undertake lung function testing for individuals who attended the store. The group partnered with the local Rotary Club who provided a BBQ and proceeds from the BBQ were split evenly between the 2 groups.

### Helpful tip

Consider liaising with your local pharmacies to find out what information, advice and support they provide to people who have respiratory infections/present with respiratory issues.

### Case study – Patient journey mapping

In the Townsville Integrated Care Program, Lionel "Tiger" Corrigan undertook the patient journey mapping process with his GP from Strive Health and Physiotherapy. Tiger was identified as being a patient with complex care needs, with diagnoses including ongoing chest pain, arthritis, back pain, type 2 diabetes, kidney disease and depression. Tiger has many health providers and has had numerous hospital admissions over the years.

The aim of the mapping process was to identify ways to reduce Tiger's hospital admissions and to understand whether the current service provision was timely and of high quality. The mapping session involved his GP and the wider health care team, and they collectively mapped the journey related to his latest hospital admission.

The map generated through this process enabled the team to easily identify areas of duplication and gaps in the existing provision of services. Tiger's health providers were able to visualise how various members of the wider care team fit together. As part of this process, it also offered each provider an opportunity to assess how they could improve their systems for other patients with high care needs.

**Health Literacy Officer, Northern NSW Local Health District**

**Keeping Score**  
– **measure your progress**

## COPD collaborative measures

It's important to have clear measures that track progress towards achieving the objective of improving the diagnosis and management of COPD. The following COPD Collaborative measures were selected by the Expert Reference Panel.

Measure Title	COPD Register
Numerator	The number of patients that are coded with a diagnosis matching the COPD definition
Denominator	The number of active patients in the total practice register

Measure Title	COPD Smoking Status Recorded
Numerator	The number of clients that are coded with a diagnosis matching the COPD definition whose smoking status has been recorded
Denominator	The number of clients that are coded with a diagnosis matching the COPD definition

Measure Title	COPD Spirometry
Numerator	The number of clients that are coded with a diagnosis matching the COPD definition with a Spirometry result recorded at any time
Denominator	The number of clients that are coded with a diagnosis matching the COPD definition

Measure Title	COPD Influenza Vaccination
Numerator	The number of clients that are coded with a diagnosis matching the COPD definition with an Influenza vaccination recorded in the past 12 months
Denominator	The number of clients that are coded with a diagnosis matching the COPD definition

Measure Title	COPD Pneumococcal Vaccination
Numerator	The number of clients that are coded with a diagnosis matching the COPD definition with a Pneumococcal vaccination recorded at any time
Denominator	The number of clients that are coded with a diagnosis matching the COPD definition

Measure Title	COPD GPMP
Numerator	The number of clients that are coded with a diagnosis matching the COPD definition with a GP Management Plan claimed within the past 24 months
Denominator	The number of clients that are coded with a diagnosis matching the COPD definition

**Templates & Guides**

## Model for continuous improvement – PDSA Cycle template

The Model for improvement is a tool for developing, testing and implementing change. The Model consists of two parts that are of equal importance.

1. The 'thinking part' consists of three fundamental questions that are essential for guiding your improvement work.
2. The 'doing/testing' part is made up of PLAN – DO – STUDY – ACT (PDSA) cycles that will help you to test and implement change.

This guide will take you through the following steps:

- Step 1: The 3 fundamental questions
- Step 2: The PDSA cycle

### Step 1: The 3 Fundamental Questions

**What are we trying to accomplish?**

*By answering this question you will develop your GOAL for improvement*

**How will we know that a change is an improvement?**

*By answering this question you will develop the MEASURES to track the achievement of your goal*

**What changes can we make that will lead to an improvement?**

List your small steps/ideas

*By answering this question you will develop the IDEAS that you can test to achieve your goal*

Idea:

Idea:

Idea:

Other ideas:

\*Note: Each new GOAL (1st Fundamental Question) will require a new Improvement Model Guide. Acknowledgement: PDSA Cycle form derived from the Improvement Foundation.

**Step 2: Plan-Do-Study-Act Cycle**

You will have noted your IDEAS for testing when you answered the 3rd Fundamental Question in step 1. You will use this sheet to test an idea.

**IDEA - Describe the idea you are testing: refer to the 3<sup>rd</sup> Fundamental Question**

PDSA Cycle Number \_\_\_\_\_

**PLAN** – What exactly will you do? What, who, when, where, predictions & data to be collected.

	Idea / Change #1	Idea / Change #2	Idea / Change #3
What:			
Who:			
When:			
Where:			
Predictions:			
Data to be collected:			

**DO** – Was the plan executed? Document any unexpected events or problems.

**STUDY** – Record, analyse and reflect on the results.

**ACT** – What will you take forward from this cycle? (What is your next step/PDSA cycle)

Repeat Step 2 for other ideas and continuous improvement.

# Clinical software – incentive target guidelines

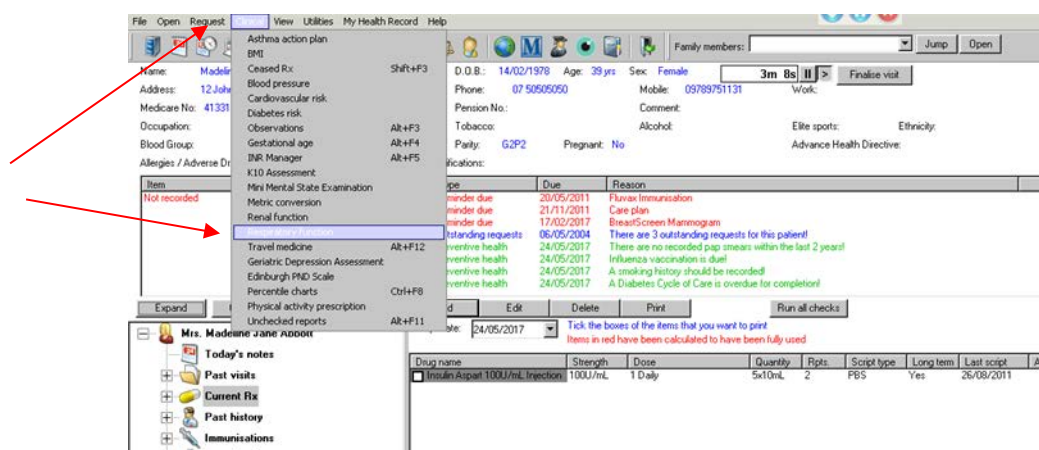
## ‘Best Practice’ software

### Remember

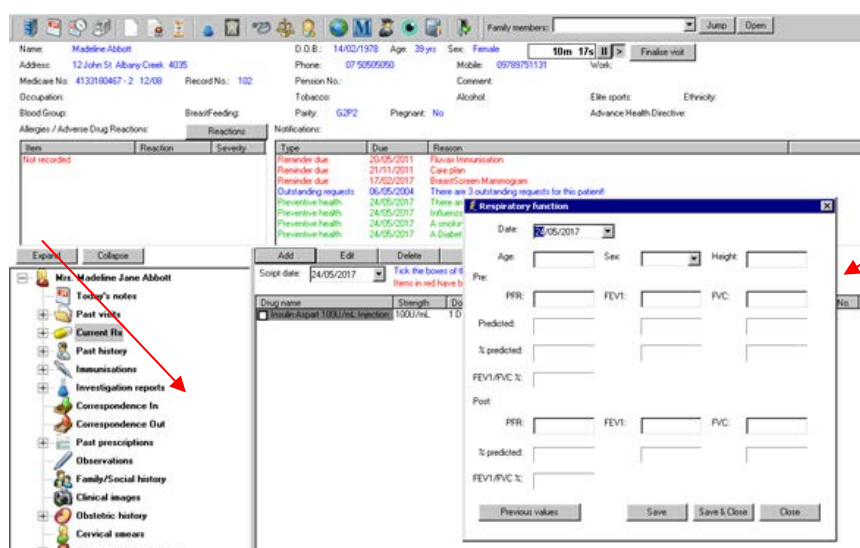
Enter the coded ‘Reason for Visit’ so this information can be identified on future visits!

### Entering spirometry results

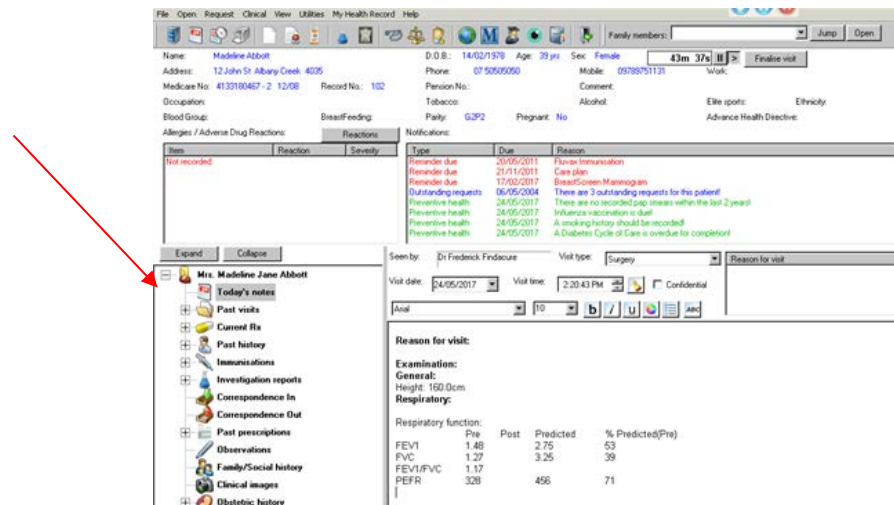
Step 1 – Click on the ‘Clinical’ tab. Open ‘Respiratory Function’.



Step 2 – Enter patient details in the ‘Respiratory function’ box. When results are entered, click ‘Save & Close’.



Spirometry results which have been previously entered via this method can be accessed via the 'past visits' tab



The screenshot displays a medical software interface with a menu on the left and a patient record on the right. A red arrow points to the 'Past visits' tab in the left-hand navigation menu.

**Patient Information:**

- Name: Madeline Abbott
- Address: 12 John St Albany Creek 4035
- Medicare No: 41310467 - 2 12/08
- Record No: 102
- D.O.B: 14/02/1978
- Age: 39 yr
- Sex: Female
- Phone: 07 5505050
- Mobile: 09785751131
- Pension No: [blank]
- Consent: [blank]
- Tobacco: [blank]
- Partly: 6/3/2
- Pregnant: No
- Alcohol: [blank]
- Elle spots: [blank]
- Ethnicity: [blank]
- Advance Health Directive: [blank]

**Reactions:**

Item	Reaction	Severity	Type	Due	Reason
Not recorded					
Reminder due				20/05/2011	Fluoride Immunisation
Reminder due				21/11/2011	Care plan
Reminder due				17/03/2017	BreastScreen Mammogram
Outstanding requests				06/05/2004	There are 3 outstanding requests for this patient
Preventive health				24/05/2017	There are no recorded pap smears within the last 2 years
Preventive health				24/05/2017	Influenza vaccination is due
Preventive health				24/05/2017	A smoking history should be recorded
Preventive health				24/05/2017	A Diabetes Cycle of Care is overdue for completion

**Left-hand navigation menu:**

- Expand
- Collapse
- Mrs. Madeline Jane Abbott
- Today's notes
- Past visits
- Current Rx
- Past history
- Immunisations
- Investigation reports
- Correspondence In
- Correspondence Out
- Past prescriptions
- Observations
- Family/Social history
- Clinical images
- Obstetric history

**Visit Information:**

- Seen by: Dr Frederick Firdaus
- Visit type: Surgery
- Reason for visit: [blank]
- Visit date: 24/05/2017
- Visit time: 2:20:43 PM
- Confidential: [checked]

**Reason for visit:**

**Examination:**

**General:**

Height: 160.0cm

**Respiratory:**

Respiratory function	Pre	Post	Predicted	% Predicted(Pre)
FEV1	1.48	2.75	53	
FVC	1.27	3.25	39	
FEV1/FVC	1.17			
PEFR	328	456	71	

### Entering pneumococcal vaccinations

Step 1 – Open the ‘Immunisations’ tab. To enter a new vaccination, click ‘add’.

The screenshot displays the 'My Health Record' interface. At the top, there's a navigation bar with options like 'Open', 'Request', 'View', 'Utilities', and 'My Health Record'. Below this, patient details for 'David Allen' are shown, including his address, date of birth (06/10/1960), age (56 yrs), sex (Male), and various identification numbers. A 'Family members' section is also visible. The main content area is divided into 'Merges / Adverse Drug Reactions' and 'Reactions' (with a 'Not recorded' status), and 'Notifications' (listing events like 'Painkiller test' and 'Outstanding requests'). A red arrow points to the 'Immunisations' category in the left-hand menu, which is highlighted. Below the menu, there's a table with columns for 'Date', 'Vaccine', 'Diseases', 'Sequence', 'Batch No.', 'Ordered by', 'Given by', 'Site', and 'Route'.

## Step 2 – Enter vaccination details

The screenshot displays the 'David Allen Clinical Notes' application window. The top menu bar includes options like File, Open, Enquiry, Clinical, View, Utilities, My Health Record, and Help. Below the menu is a toolbar with various icons for document management and clinical functions.

**Patient Information:**

- Name: David Allen
- Address: 22 Star Street Fremantle 6150
- Medicare No: 2234567891 - 1 05/04
- Occupation: Blood Group
- D.O.B.: 06/10/1960 Age: 56 yrs
- Phone: 08 99990500
- Pension No: 08523130542
- Tobacco: Alcohol
- Sex: Male
- Comment: There is 1 outstanding request for this patient's smoking history should be recorded!
- Elite spot: Advancing Health Directive.

**Family members:** A dropdown menu showing 'Jump' and 'Open' options.

**Allegies / Adverse Drug Reactions:**

Item	Reaction	Severity
Not recorded		

**Reactions:**

Type	Date	Reason
Painkiller sent	25/01/2017	Faecal Occult Blood Sent on 27/01/2017
Outstanding requests	29/03/2004	There is 1 outstanding request for this patient's smoking history should be recorded!
Preventive health	24/05/2017	

**Immunisation:**

Available vaccines:

Vaccine	Against
Aptivac	HIV
Adact	Diphtheria, Pertussis, Tetanus
Adact Polo	Diphtheria, Pertussis, Tetanus, Poliovirus
ADT	Diphtheria, Tetanus
Allura Quad	Influenza
Asipol	Influenza

**Billing provider:** Dr F. Findacre (Main surgery)

**Given by:** Dr F. Findacre (Main surgery)

**Site:** IMB SC Oral Intradoma

**Date given:** 24/05/2017 **Batch No:**

**Comments:**

☐ Send reminder ☐ Save batch number

**Transfer date:** 24/05/2017

**Buttons:** Save Cancel

To see current vaccinations entered via this method, open the 'Immunisations' tab.

## Entering smoking status

Step 1 – Click on the 'Family/Social history' tab. To enter smoking history, click on the 'Smoking' tab.

The screenshot shows a patient record for Rhonda Ahern. The left sidebar contains a tree view with 'Family/Social history' selected. The main content area has tabs for Family, Social, Occupation, Alcohol, and Smoking. The 'Smoking' tab is highlighted with a red arrow. The top navigation bar also has a 'Smoking' tab highlighted with a red arrow.

Step 2 – In the 'Family & Social History' box, enter patients smoking history.

The screenshot shows the 'Family & Social History' dialog box. The 'Smoking' tab is selected. The 'Current Smoking History' section has radio buttons for 'Non smoker', 'Ex smoker', and 'Smoker'. The 'Past Smoking History' section has radio buttons for 'Light', 'Moderate', and 'Heavy'. There are fields for 'Year started' and 'Year stopped'. A 'Details' field is also present. The 'Save' and 'Cancel' buttons are at the bottom.

To see smoking history entered via this method, open the 'Family/Social history' tab.

## 'Medical Director' software

### Remember

Enter the coded 'Reason for Visit' so this information can be identified on future visits!

### Entering spirometry results

Step 1 – Open the 'Respiratory Calculator'. A pop-up box will open.

The screenshot shows the Medical Director software interface for a patient named Ms Heather ANDREW'S (54 yrs). The patient's details include DOB: 12/05/1963, Gender: Female, Occupation: School Teacher, and Address: 234 George Street, Bundaberg Qld 4670. The 'Allergies & Adverse Reactions' field is highlighted with a red box and contains the text 'CAT HAIR, DUST, MITE, GRASSES'. A red arrow points to the 'Respiratory Calculator' icon in the toolbar. The 'Past History' table lists conditions such as ASTHMA, Lung breast, URTI, Cervical cancer, and Pneumothorax - Spontaneous. The 'Immunisations' table lists various vaccines and their dates.

Year	Date	Condition	Side
1996	10/02/96	ASTHMA	
2000	03/03/2000	Lung breast	Left
2009	06/03/2009	URT	
2017	17/01/2017	Cervical cancer	
2017	17/01/2017	Pneumothorax - Spontaneous	Left

Date	Immunisation	Sequence
30/03/1999	INFLUENZA	
27/04/2010	FLUARIX	
19/05/2011	FLUARIX	
18/02/2013	DTPA	
18/02/2013	PNEUMOVAX 23	
10/04/2013	FLUARIX	

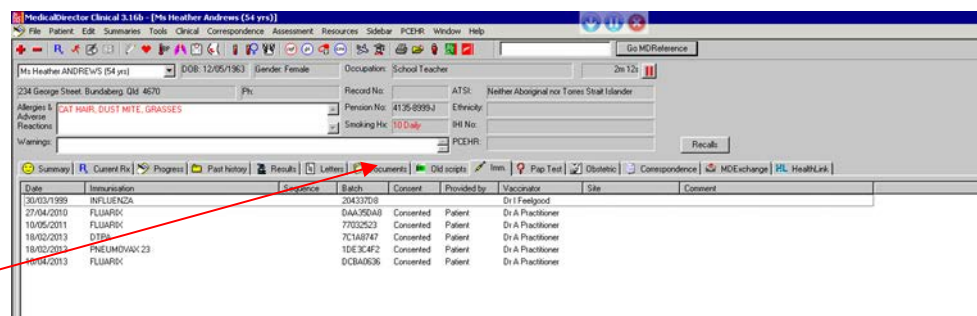
Step 2 – Enter spirometry results under 'current measures'.

The screenshot shows the 'Respiratory Calculator' pop-up box. The 'Current Measurements' tab is selected, and a red arrow points to it. The box contains fields for Date, Time, Gender, Age, Height, and Patient ID. The 'Current Measurements' section includes fields for PEF, FEV1, FVC, and FEV1/FVC. The 'Predicted' values are listed as 400 L/min, 2.05 L, 3.44 L, and 0.40. The 'Oxygen Saturation (SpO2)' field is also present. The 'Respiratory' section includes fields for Blood Glucose, Blood Pressure, CV Risk, ECG, RR, Renal Function, and Respiratory. The 'Data' and 'Graph' buttons are at the bottom right.

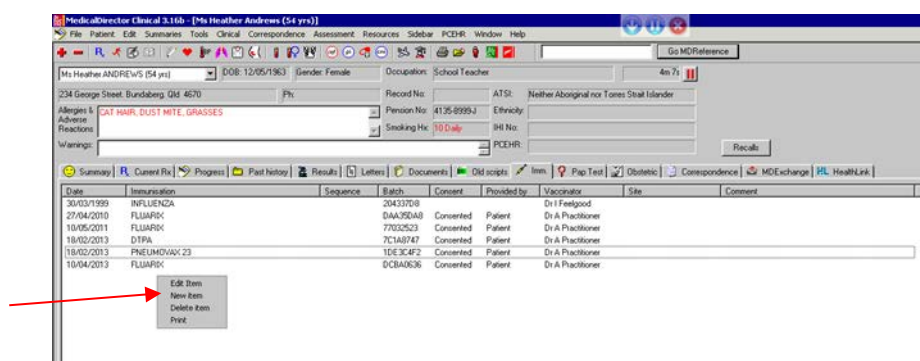
Step 3 – Spirometry results which have been previously entered via this method can be accessed via the respiratory calculator. These will be listed by the date the results were entered.

## Entering pneumococcal vaccinations

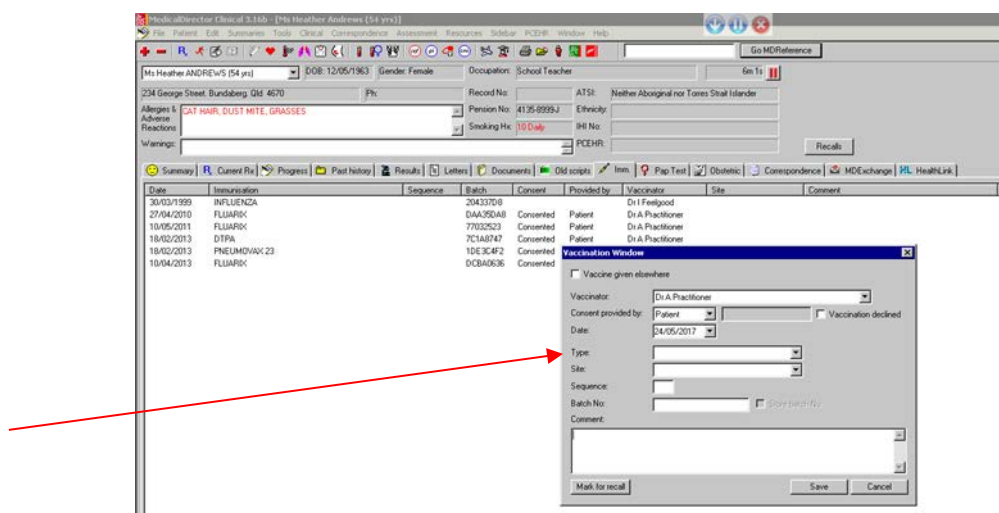
Step 1 – Open 'Immunisations' tab



Step 2 – Right click and open 'New item'. On a Mac computer, press the Ctrl (or Control) key when you tap the mouse button.



Step 3 – In the vaccination window, enter details



The new vaccination will be saved under the 'Immunisations' tab.

## Entering smoking status

### Step 1 – Open 'Smoking Details' tab

The screenshot shows the patient record for Ms Heather ANDREWS (54 yrs). The 'Smoking Details' tab is selected in the top navigation bar. The patient's current smoking status is listed as '10 Daily'.

### Step 2 – Enter details and click save

The 'Smoking Details' dialog box is open, showing fields for Date of assessment, Smoker (Tobacco), Frequency (Daily), Number of cigarettes (10), Year commenced (1995), Duration (20 years), Stage of change assessment, Last quit attempt (11/01/2017), and Duration of longest period of abstinence. The 'Save' button is highlighted with a red arrow.

The current smoking status can also be viewed via:

The screenshot shows the patient record for Ms Heather ANDREWS (54 yrs). The 'Smoking Details' tab is selected in the top navigation bar. The patient's current smoking status is listed as '10 Daily'.

## Abbreviations

<b>ACP</b>	Advance Care Planning
<b>ACSQHC</b>	Australian Commission on Safety and Quality in Health Care
<b>CALD</b>	Culturally and Linguistically Diverse
<b>COPD</b>	Chronic Obstructive Pulmonary Disease
<b>GP</b>	General Practitioner
<b>GPMP</b>	GP Management Plan
<b>IF</b>	Improvement Foundation
<b>MMR</b>	Medication Management Review
<b>NBMPHN</b>	Nepean Blue Mountains Primary Health Network
<b>NBMLHD</b>	Nepean Blue Mountains Local Health District
<b>NSW</b>	New South Wales
<b>PN</b>	Practice Nurse
<b>QI</b>	Quality Improvement
<b>RACGP</b>	Royal Australian College of General Practitioners
<b>SMART</b>	Specific, Measurable, Achievable, Relevant and Timely
<b>SHS</b>	Shared Health Summary
<b>SMS</b>	Secure Messaging Service
<b>TCA</b>	Team Care Arrangement

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