Quality Improvement Toolkit

for General Practice

phn
NEPEAN
BLUE MOUNTAINS
An Australian Government Initiative

Wentworth Healthcare
Blue Mountains | Hawkesbury | Lithgow | Penrith

Contents

SECTION 1: Introduction

Purpose

This toolkit is designed to help your practice undertake Quality Improvement (QI) activities. You are welcome to use and adapt any tools that you find on in this resource. If this does not contain what you are looking for, please contact us on 47 08 8100.

Our Commitment to Quality Improvement

To support Quality Improvement in our region NBMPHN has developed a strategic approach which can be seen on our website.

We are committed to supporting general practices and primary care through a step by step process to identify areas for improvement, implement change and develop a quality improvement plan that addresses a priority area specific to your general practice or primary care setting. Our Practice Support Team can provide your practice with advice and resources that will help you plan, implement and review QI activities in your practice.

In this toolkit you will find:

- Strategies to build your internal QI culture
- Templates for QI activities
- Example QI goals and ideas
- Access to tools and support for your QI activities

SECTION 2: Quality Improvement

What is Quality Improvement?

Quality improvement is a system of monitoring and refining processes in order to improve coordination of care and deliver better health outcomes for patients. The RACGP defines continuous quality improvement as an ongoing activity undertaken within a general practice. The primary aim is to monitor, evaluate and improve the quality of healthcare delivered to patients.

PIPQI

The new PIP QI incentive aims to recognise and support those practices that commit to improving the care they provide to their patients. A practice can utilise the clinical information they have about their own communities and their knowledge of the particular needs of their own patients to develop innovative strategies to drive improvement.

Engaging in quality improvement activities is an opportunity for the practices' GPs and other staff members to come together as a team to consider quality improvement. Quality improvement can relate to many areas of a practice and achieving improvements will require the collaborative effort of the practice team as a whole.

Accreditation

The RACGP 5th Edition Standards for General Practice describes Quality Improvement as an activity undertaken within a general practice where the primary purpose is to monitor, evaluate or improve the quality of health care delivered by the practice. The Standards encourage quality improvement so that you can identify opportunities to make changes that will improve patient safety and care.

This toolkit will assist General Practices to meet or exceed the RACGP Standards for General Practice 5th Edition Core Module: ***Quality Improvement***:

QI Standard 1

Criterion QI1.1 - Quality Improvement Activities

Indicators

- ***QI1.1 A*** - Our practice has at least one team member who has the primary responsibility for leading our quality improvement systems and processes.
- ***QI1.1 B*** - Our practice team internally shares information about quality improvement and patient safety.
- ***QI1.1 C*** - Our practice seeks feedback from the team about our quality improvement systems and the performance of these systems.
- ***QI1.1 D*** - Our practice team can describe areas of our practice that we have improved in the past three years.

Why undertake quality improvement activities?

Practices need to engage in quality improvement activities to improve quality and safety for patients in areas such as practice structures, systems and clinical care. Achieving improvements requires the collaborative effort of the whole practice team and all members of the team should feel empowered to contribute.

Improving all aspects of your practice helps you deliver better care and health outcomes.

The benefits of quality improvement activities would affect each of the four areas below and therefore achieve the Quadruple Aim.

- ***Patient Experience:*** Improving patients' access to care; quality and safety; and outcomes.
- ***Care Team Wellbeing:*** Improving staff satisfaction, morale, team-work, and workforce sustainability.
- ***Population Health*****:** Reducing the burden of disease and health inequalities across your region.
- ***Reducing Costs*****:** Reducing unnecessary hospital admissions; improving the return on innovative investments; and managing the cost of providing care to the population.

When an improvement affects all the four areas listed above, we say that is has achieved the ***'Quadruple Aim'***. When developing ideas for QI in your practice, you should identify how each proposed improvement would affect each of the four areas below, and whether it would affect all four and therefore achieve the Quadruple Aim.

Steps to undertaking Quality Improvement

Step 1 – Build your Quality Improvement team

Step 2 – Introducing your practice to QI

Step 3 – Deciding on a focus

Step 4 – Start your QI Journey

Step 5 – Document your QI efforts

Step 1: Build Your Quality Improvement Team

Identify your Improvement Champion

Identifying an 'Improvement Champion' in your practice is pivotal when implementing quality improvement initiatives and engaging the whole team in the activity. The role of an improvement champion can be exercised by **anyone in the practice**, either individually or in partnership with others. This person does not need to be a Manager or key decision maker but it is important that there is active involvement and support from senior leaders within your practice. High performing practices have leadership at all levels of the practice. Shared leadership is essential to the co-creation of health outcomes.

Being an Improvement champion involves:

- Modelling enthusiasm for the process.
- Fostering an environment of open communication by encouraging the views and opinions of all team members
- Ensuring appropriate resources, systems and support are in place
- Clear and regular communication

Build your team

Having an effective team at your practice is a necessary foundation on which to begin any quality improvement work. You will be more successful in implementing quality improvement if your whole team is engaged and participates in the journey.

Building an effective team is an ongoing process and an evolving journey.

Points to consider:

- Attempting any Quality Improvement Activity without building and engaging the whole team is unlikely to lead to substantial change.
- Providing continuous feedback on what the quality improvement team is currently working on will result in less resistance to change as the whole team will understand the reason for change.
- By assigning small responsibilities to different staff members, they can take ownership of that task and become more involved and valued by the team.

The team will work together to:

- Share ideas.
- Test changes before implementing them within the whole practice.
- Monitor improvement.
- Celebrate successes.

Step 2: Introducing your practice to QI

Getting started is easy. Have a QI 'launch' within your practice to introduce the concept of QI and engage the team.

Quality Improvement Activity #1
The steps suggested in **Appendix 1 – Building teams QIA**, can be used as your first Quality Improvement Activity on your PIPQI journey. Completing this template will support you to start building your team and define what Quality Improvement looks like in your practice.

By completing this activity you will:

- Identify the lead QI team
- Assign roles and responsibilities
- Allocating resources (including protected time), systems and training
- Define your practices communication method and frequency
- Design the review and reflect process for your practice

Step 3: Deciding on a focus

Quality Improvement can be applied to any aspect of enhancing patient care including but not limited to:

- Data quality and cleansing
- Increasing cancer screening rates
- Improving immunisation rates
- Chronic disease management
- Lifestyle modification
- Preventive health.

How do you choose what to focus on?

Your practice has the flexibility to decide what your focus will be. Some options can be seen below:

- Utilise your Data Quality Improvement Report (provided by the PHN) to identify one of the 10 Improvement Measures to work on.
- Utilise your baseline report to identify other areas for improvement within your population health data.
- Utilise your own Cat4 data in practice to identify other areas for improvement within your population health data.
- Join a formal Quality Improvement Program with the PHN. See **here** for details of programs currently available.
- Focus on a particular cohort of patients based on your patient profile/needs.
- Focus on an area of improvement as identified in your practices recent accreditation survey.
- Focus on the health interests of your staff, practitioners and clinical staff.
- Ask your team at a team meeting. Giving staff an opportunity to share ideas and come up with suggestions may assist with practice engagement and a whole of practice approach.
- Patient feedback via surveys and suggestion boxes

Appendix 2 shows some examples of Smart Goals related to the PIPQI Improvement Measures.

Step 4: Start your QI activity

A Quality Improvement (QI) Activity is any activity your practice undertakes as part of your QI process.

What are the different ways to undertake QI?

There is no one way to conduct a quality Improvement. Below are some suggestions on how you may want to do this:

1. Use the Model for Improvement, PDSA cycles
2. Develop simple Quality Improvement Activity Plans to tackle focus areas.
3. Use simple workplans
4. Build QI registers for qualitative improvements
5. Keep track of your data with clinical audit reports

1. The Model for Improvement (PDSA)

The Model for Improvement (MFI) is an internationally recognised tool used to guide improvement work and is the approach many peak health bodies prefer including RACGP and The Improvement Foundation. The MFI helps you to break down your change into manageable pieces, which are then tested to ensure that the change results in measurable improvements, and that minimal effort is wasted.

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 you've come up with the thinking part
- Helping you assess whether you are achieving your desired objectives
- Enabling you to confirm which changes you want to adopt permanently.

The Plan-Do-Study-Act (PDSA) cycle is a useful tool for documenting a test of change. Running a PDSA cycle is another way of saying testing a change —you develop a plan to test the change (Plan), carry out the test (Do), observe, analyse, and learn from the test (Study), and determine what modifications, if any, to make for the next cycle (Act).

Please see a PDSA Cheat Sheet on the next page and Appendix 3 for a PDSA template.

Model for Improvement (MFI) / PDSA Cheat Sheet

Thinking part	**GOAL** What are we trying to accomplish?	Have a **SMART** goal: **In this space put ONE goal only.** Specific: Make it clear what you want to achieve. Measurable: How will you know a change has occurred? Achievable: Being ambitious is good, but what if the goals aren't completed and people lose motivation? Relevant: Everybody will lose interest if they can't see the point. Timely: Include a date or timeframe (e.g. by 31/05/17, next 3 months).
	MEASURE How will we know that a change is an improvement?	There can be one or more of these. What will you see in the results to know you have achieved an improvement? • Use data that is easily obtained. • Use a combination of process and outcome measures. • Use both qualitative (descriptive) and quantitative (numerical) data. • Use only the data you need.
	IDEAS What changes can we make that will result in improvement?	In this section, list some ways you might be able to achieve your goal. What can you actually do in practice that will assist with the goal? Ideally these will be new ways of doing this that you will 'test' before implementing in your practice. List as many as you need to
Doing part (PDSA cycle)	**IDEA**	Choose an idea from 'Ideas' on the previous page – this is the idea you will 'test'. Write it in this space
	Plan	**What:** Choose an idea from 'Ideas' on the previous page – this is the idea you will 'test'. Write it in this space **Who:** Who will do this? i.e. Practice Manager **When:** Include specific date (e.g. on the 21/05/19, by 21/05/19). **Where:** Location (in the clinic, another location). **Prediction:** What the practice thinks will be the result of this test? **Data to be collected:** • What will you need to collect after to know it happened? • Include a measure, where possible (e.g. number of patients on the register, number of staff attending meeting)?
	Do	**Was the plan executed?** Yes/No **Unexpected events/problems:** Anything that may have occurred (e.g. two days late due to staff shortage, discovered chosen staff member didn't have skills to use clinical audit tool and needs more training).
	Study	**Review and reflect on results:** Must include reflections/observations of what occurred and a review of the data: • Did this system change idea work well? • If not, why didn't it work well? • What does the data indicate?
	Act	**What will you take forward?** What did you learn from this? If the idea was not successful, go back to 'Ideas' on page 1 and pick a new idea and complete this page again for that idea. If it works, you adopt this as a part of your new processes. As a result, your next PDSA will involve a NEW goal and NEW ideas (both pages completed again).

2. Simple Quality Improvement Activities (QIA)

Quality Improvement Activity Plans can also be used to document what your practice is doing in terms of Quality Improvement. These are less detailed that The Model For Improvement and consist of a set of tasks to complete in order to achieve a goal.

Please see Appendix 4 for a QI Activity template and Appendix 5 of an example QIA.

3. Workplans

Workplans are similar to simple QIA's. They are just a different way to plan out what you are trying to achieve. Please see Appendix 6 for a template.

4. QI registers

QI registers are a great way to track your qualitative improvement. Qualitative relates to measuring, or being measured by the quality of something rather than its quantity. For example, you could collect information from satisfaction surveys, suggestion boxes, minutes from meetings, and staff feedback. This type of data may help you to identify patterns and gauge patients' level of satisfaction with the care they have received and staff satisfaction. See Appendix 7 for a QI Register.

5. Clinical Audit Reports

Clinical Audit Reports can be used to track progress over time. You can run reports through Cat4 or your clinical software and plot measures over time. An example of this can be found in Appendix 8.

SECTION 3: Tools to support your QI journey

When starting a quality improvement activity, it is sometimes difficult to pin point where to begin. By using quality improvement tools, it can help your team understand the problem, think laterally and make decisions. By clearly defining the problem that you wish to improve, it can assist the team to identify an area of focus and ideas to implement.

Tools include:

- NBMPHN Quarterly Data Quality Improvement Report as seen in Appendix 9
- Your clinical software
- PenCS tool – Cat4 and Topbar
- The accreditation process
- Formal QI programs with NBMPHN https://www.nbmphn.com.au/Health-Professionals/Practice-Support/Quality-Improvement/Quality-Improvement-Program-Opportunities
- PHN education and training https://www.nbmphn.com.au/Events

The PENCS suite

CAT4 and Topbar are provided at no cost to the practice. The benefits of using these tools include:

- Enhance the quality of patient information in your practice to:
    - Support more coordinated, comprehensive care.
    - Increase quality and safety
    - Meet accreditation standards
    - Increase practice revenue
    - Monthly benchmarking reports that your practice can use to reflect on and gain insights into opportunities for quality improvement
    - Contributing to enhancing understanding of population health needs in the Nepean Blue Mountains region.

To find out more about CAT4 tools, please contact the practice support team on 47 08 8100.

Useful links for data quality with PenCS:

- Webinars: https://www.pencs.com.au/support/webinars/
- Recorded training
- PIPQI Training Manual: https://files.constantcontact.com/1fa03709001/8ee68a8e-492c-44f3-b98b-510c57be0191.pdf
- PIPQI 'How To' recipes: https://help.pencs.com.au/display/CR/PIP+QI+Improvement+Measures
- Cat4 'How To' guides

Presenting evidence of the improvement

Practices are required to show evidence of quality improvement activities in areas which meet the needs of their practice population.

Presenting evidence of an improvement is also an effective way of:

- Informing your team about the project.
- Demonstrating outcomes through graphs and diagrams (easily accessed from CAT4).
- Providing relevant evidence if you are participating in a QI activity that is being facilitated by another organisation.

The following are examples of documentation which can be kept as evidence:

- QI Activity Workplans
- PDSA's
- QI registers
- Cat4 reports
- NBMPHN Quarterly Data Quality Improvement Reports
- Notes from team meetings
- Putting a Practice Improvement Dashboard up in the practice in communal areas such as the lunch room. An example of this can be seen in Appendix 10.

Nepean Blue Mountains PHN will provide your practice with quarterly Data Quality Improvement Reports that will assist you to:

- Identify room for improvement and gaps.
- Monitor progress for QI activities.
- Evaluate and demonstrate success.

These reports, combined with your supporting documentation around what QIA you are undertaking, should be kept in a safe place and be accessible to anyone involved in QI in your practice.

SECTION 4: Summary

For your Quality Improvement Activities to be successful, you need to plan, implement and review thoroughly and systematically. Using the methodology and processes in this guide means you are more likely to achieve this goal and meet the Quadruple Aim.

Set up your practice for success:

- Ask us about how we can help you
- Identify and consider several ideas for improvement.
- Set SMART-A goals that are realistic
- Consider the effect of the change on patient experience, population health, care team wellbeing, costs (does the change achieve the Quadruple Aim?)
- Implement small changes first and work up to large changes

Collect useful, accurate and varied data:

- Collect feedback from your patients and team members
- Collect baseline data and progressive data
- Collect qualitative and quantitative data
- Keep stakeholders informed, involved and engaged
- Involve your staff, keep them informed, and acknowledge their contributions and successes
- Involve some of your patients in Quality Improvement activities
- Display information visually (e.g. graphs, charts and tables).

Review your outcomes and learn from them:

- Monitor and assess the outcomes honestly, so you can improve your processed and achieve real improvement
- Document your process and outcomes, including how the process could be improved, so you can learn from them.

Appendix 1 – QI Activity: Team Building

Having an engaged and supported practice team is key to achieving successful implementation of any program within your practice. The following activity is just one example which may help you to identify change champions and leaders, set realistic goals and increase communication within your practice with regards to continuous quality improvement. It also sets the scene of what QI looks like in your practice

RACGP Standards – 5th edition	C3.4 – Practice communication and teamwork QI 1.1 – Quality Improvement activities
PIPQI measure alignment	

Goal			
What are you trying to accomplish?			
To create a lead team to drive quality improvement activities and embed continuous quality improvement processes by (insert date).			
Measure			
How will you know that a change is an improvement?			
Select the measure appropriate to your building teams activities: • Number of times QI is added to the staff monthly meeting agenda. • Number of hours allocated for protected time for lead team to implement QI activities now (at baseline) and the number after the improvement activity. • Number of QI team meetings now (at baseline) and the number after the improvement activity.			
Ideas			
What changes can we make that will lead to an improvement? – small steps/ideas			
Assign roles and responsibilities		**Date Completed**	**Notes**
☐	Identify the lead team to drive quality improvement (QI) work (e.g. one nurse, GP, admin, PM).		
☐	Allocate protected time for the QI team each month to perform required tasks.		
☐	Assign roles and responsibilities according to staff skill, interest and position. Your practice may need to update or assign new roles and responsibilities across your team in order to participate in QI activities. When people are assigned to roles, it authorises them to carry out certain actions.		

☐	Update all staff position descriptions to include these new roles and responsibilities. Ensure quality improvement roles and training are incorporated into new staff orientation processes.		
Communicate with the practice team			
☐	Identify the method that will be used to inform and update the practice team on any changes as a result of QI activities that affect different staff at the clinic e.g. staff meetings, email, noticeboard.		
☐	Ensure all staff are advised of the chosen communication method.		
Undertake regular staff meetings			
☐	Create a monthly schedule of meetings and invite all staff.		
☐	Create/review an agenda for each meeting including an update on quality improvement work.		
☐	Allow for staff to contribute ideas on agenda items.		
☐	Distribute minutes following meetings and ensure staff are aware of any follow up needed.		
☐	Invite guest speakers to staff meetings on priority areas to build staff knowledge and awareness.		
Review and reflect			
☐	Ensure regular review of changes are made to ensure a successful transition to new workflows: - What is working well and what is not? - What should we do more/less of? - Is there anything that we should stop doing?		
☐	Involve the team in developing and implementing ideas for change related to the QI activities.		
☐	Allow opportunities for staff feedback.		

Appendix 2: PIP QI Goal examples

Goal	How you may achieve the goal
Ensure all active patients with diabetes are coded correctly and have a HbA1c recorded in the past 12 months	**Refer to PENCS to** identify patients with diabetes with no HbA1c recorded in the past 12 months
Ensure 90% of active patients aged 15 years and older have smoking status – current smoker, ex-smoker or never smoked	**Refer to PENCS to** identify patients with no allergy or smoking status recorded
Ensure 75% of active patients aged 15 years and older have BMI classified as obese, overweight, healthy or underweight within the previous 12 months	**Refer to PENCS –** adding, height, weight and waist measurements to patients records
Increase the number of flu injections given to active patients aged 65 years and over the past 15 months by 10%	**Refer to PENCS to** identify the number of active patients 65 years and over who have not received a flu injection in the past 15 mont**hs**
Increase the number of flu injections given to diabetes patient over the past 15 months by 10%	**Refer to PENCS to** identify the number of diabetes patients who have not received a flu injection in the past 15 months
Increase the number of flu injections given to patients with COPD over the past 15 months by 5%	**Refer to PENCS to** identify the number of COPD patients who have not received a flu injection in the past 15 months
Ensure 90% of active patients aged 15 years and older have their alcohol status recorded	**Refer to PENCS to identify the** list of patients who do not have their alcohol status recorded
Increase by 10% the number of patients aged 45 to 74 years with the following: Smoking status Blood pressure Total cholesterol and HDL levels (YOU MAY WISH TO DO THIS AS PART OF A healthy heart check MBS ITEM 699)	**Refer to PENCS:** identify patients with no allergy or smoking status recorded
Increase the cervical screening of the number of eligible female patients aged 25 to 74 years by 10%	**Refer to PENCS to find patients** eligible for cervical screening
Ensure that 90% of active diabetes patients have their blood pressure recorded	**Refer to PENCS to** find diabetes patients with no BP recorded

Appendix 3 : PDSA template

Practice:_____

Date:_____

PDSA Cycle # :_____

The Model for Improvement (MfI) is a tool for developing, testing and implementing change. 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 your improvement work.
- Step 2: The '*doing'/'testing*' part is made up of Plan, Do, Study, Act (PDSA) cycles that will help you test and implement change.

Step 1: Three Fundamental Questions	
1. **What are we trying to accomplish?** By answering this question you will develop your **GOAL** for improvement. *Each new GOAL (1st Fundamental Question) will require a new Model for Improvement*	
2. How will we know that a change is an improvement? By answering this question you will develop **MEASURES** to track the achievement of your goal	
3. What changes can we make that will lead to an improvement? List the ways you can achieve your goal. By answering this question you will develop the **IDEAS** that you can test to achieve your goal	
Idea 1	
Idea 2	
Idea 3	
Idea 4	
Idea 5	
Idea 6	

Step 2: Plan-Do-Study-Act (PDSA) cycle
Idea Pick one of your ideas
Plan What exactly will you do? Include what, who, when, where, predictions & data to be collected
Who: **When:** **Where:** **Predictions:** **Data to be collected:**
Do Was the plan completed? Document any unexpected events or problems
Yes or No?
Study Record, analyse and reflect on the results
Act What will you take forward from this cycle? What is your next step / PDSA cycle?

Appendix 4 –Simple QI Activity template

Relevant RACGP Standards – 5th edition	
PIPQI measure alignment	

Goal			
What are you trying to accomplish?			
Measure			
How will you know that a change is an improvement?			
Ideas			
What changes can we make that will lead to an improvement? – small steps/ideas			
Assign roles and responsibilities		**Date Complet**	**Notes**
☐			
☐			
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Action/s to take as a result of findings of QIA

☐			
☐			
☐			
☐			
☐			

Appendix 5 –
Example QI Activity: Data Cleansing

Goal			
What are you trying to accomplish?			
To create an accurate and up to date clinical system of active patients within 3 months.			
Measure			
How will you know that a change is an improvement?			
% of active patients			
Ideas			
Data quality steps			
Assign data quality roles		**Date Complet**	**Notes**
☐	Allocate a person to be responsible for data quality (data quality manager) to oversee all data quality activities.		
☐	Provide protected time for the data quality manager to complete data		
☐	Include data cleansing as part of a job description and articulate expectations.		
Communicate with the practice team			
☐	Include data cleansing topics as agenda items to team meetings.		
☐	Support the team with required clinical software training and regular updates to ensure data collection and cleansing is a routine and consistent task.		
☐	Does the clinic have a data cleansing policy on inactivating patients? If no, consider developing a policy.		
☐	Develop a procedure to archive inactive patients on a regular basis. You may consider different timeframes for different age groups		
☐	Agree on a definition of active patients for the practice		

☐	Archive inactive patients that do not fit within the practice's active patient definition. This may include: • Archive deceased patients. • Merge duplicate patients. • Archive patients with a postcode not relevant to your areas/state. • Archive patients that have moved away or no longer attend the clinic. • Archive patients that have never attended the clinic e.g. those patients that have registered for an appointment but have never turned up (online bookings).		
	• Develop procedure to archive inactive patients on a regular basis e.g. every 3 months.		

Appendix 6 – Quality Improvement Work plan

Name of Practice: Date:

Name of the Quality Improvement Activity:

Which area of your practice might benefit from a QI Activity – Administrative or Clinical?	
QI Activity Description – What is your SMART Goal?	
What will a successful outcome look like?	
How will you measure success?	
What is your initial benchmark?	
Who will be leading this activity?	
Who will be on the team?	
How long will the activity need?	
What additional resources will be required?	

Tasks Associated with the activity			
Step	***What***	***Who***	***When***
1			
2			
3			
4			
5			
6			
Reflection			
What are the lessons learnt from this Quality Improvement Activity?			
Do we need to review or extend the activity?			
Is this Quality Improvement Activity completed?			

Appendix 7 – Quality Improvement Register for General Practice

Practice name: _____

QI Activity #	Date	Lead staff member	QI Activity Description	Measures Used	Completion Date	Outcomes of QI Activity	Next Steps for Continuous QI
001							
002							
003							
004							
005							
006							
007							
008							
009							
010							
011							
012							

Quality Improvement Register

Practice Name:
Last updated:

Month	Activity	Outcome

Future Quality Improvement initiatives

Activity	Status/Progress

Appendix 8 – Clinical Audit Report template

PRACTICE PATIENT POPULATION PROFILE

The figures recorded below are as recorded in <insert either CAT4 or Clinical Software)

- Focus area:
- Active patients:
- Enter other filters:

Active Patients	Baseline		Audit 1		Audit 2		Audit 3	
	n	(%)	n	(%)	n	(%)	n	(%)

Appendix 9 – Sample Quality Improvement Report

Partnering with your Practice for Data Quality Improvement
Example Practice

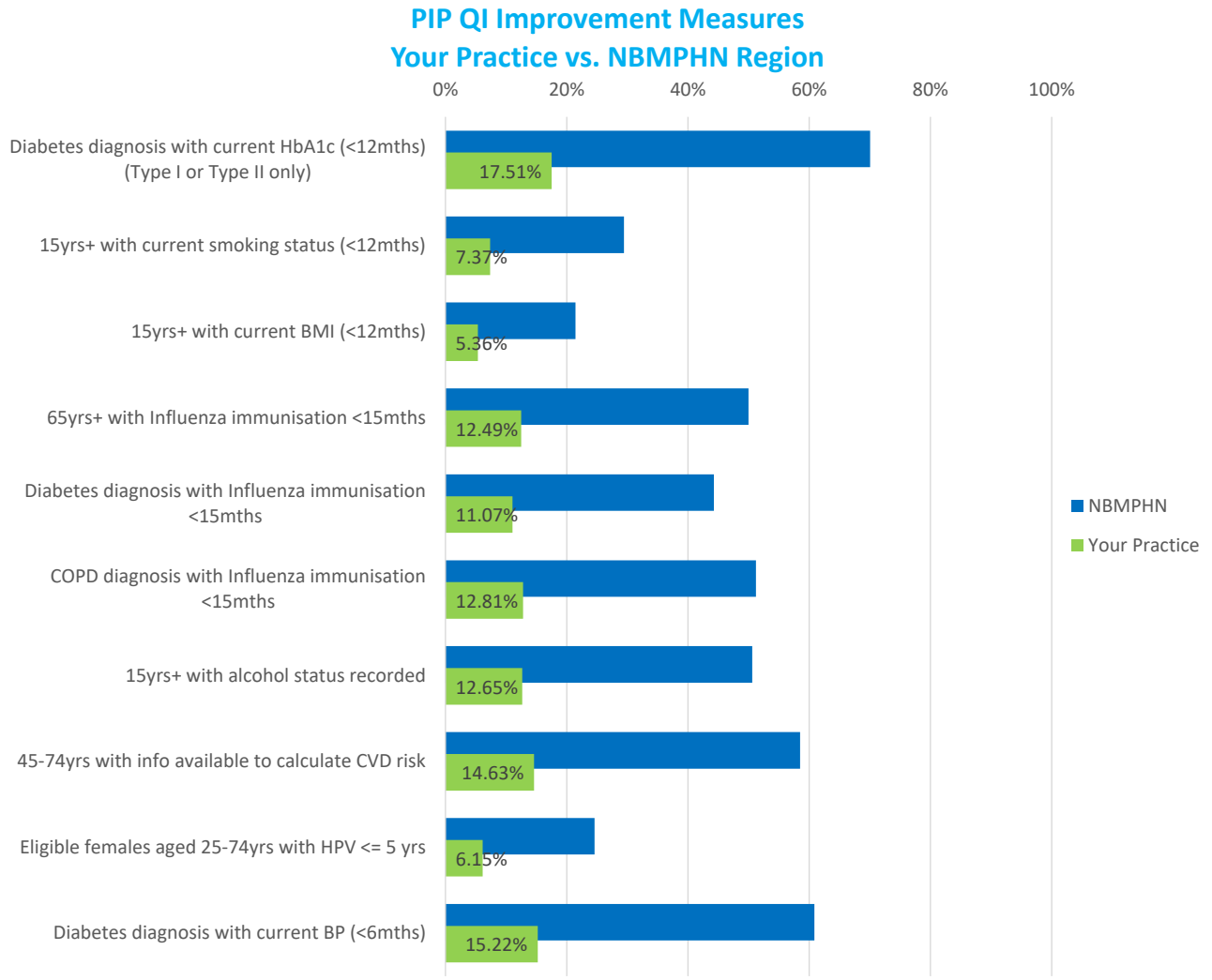
Wentworth Healthcare
Blue Mountains | Hawkesbury | Lithgow | Penrith

Practice Support Officer: Example Practice Support Officer

QUICK FACTS ABOUT YOUR PRACTICE - As at 31 December 2019

38540	16484	599	324	1518
TOTAL PATIENTS	ACTIVE PATIENTS	INDIGENOUS PATIENTS	PATIENTS LIVING WITH COPD	PATIENTS HAVE A SHARED HEALTH SUMMARY

PIP QI - CURRENT SNAPSHOT



Need further information about PIP QI?
For further information about the PIP QI requirements, FAQs and key contacts, please speak with your Practice Support Officer or visit the Department of Health's website.

This report shows de-identified patient data sent to Nepean Blue Mountains PHN (NBMPHN) via your PenCS software, and is intended for the addressed practice only. Please note that regional figures include only those practices sharing data with NBMPHN and is not representative of the entire NBM population.

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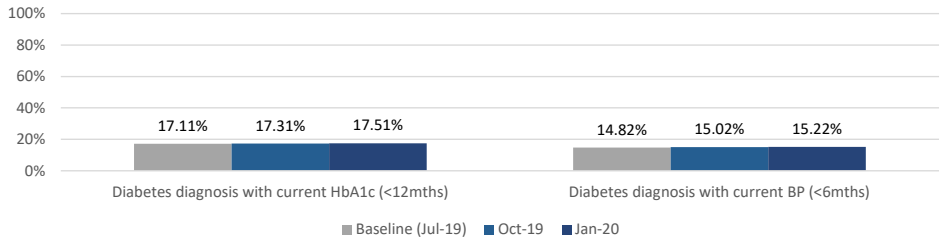
PIP QI - How are you tracking?

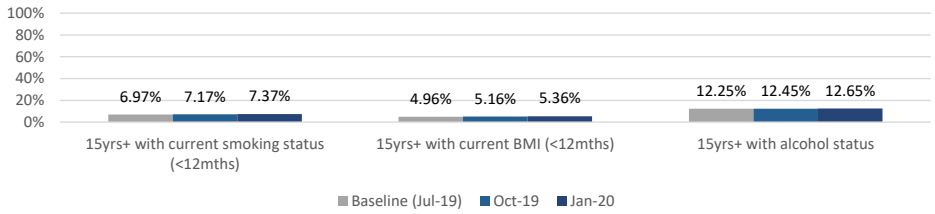
QIMs 1 & 10
Proportion of Diabetes patients with current HbA1c and BP recordings



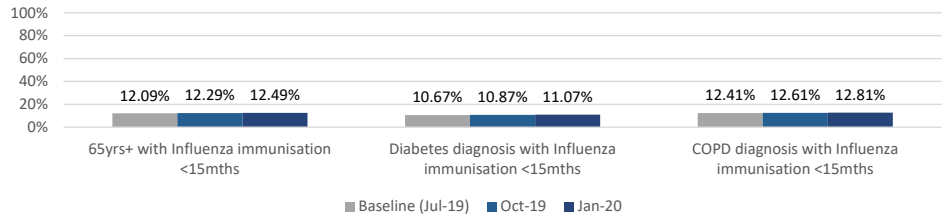
Ensure all diabetes patients are coded with the correct diagnosis in your clinical software system. For further help, follow this **link** to find CAT recipes on how to perform a bulk clean-up of free text diagnoses in your clinical software system.

QIM 2, 3 & 7
Proportion of eligible patients aged 15yrs+ with smoking, BMI and alcohol recordings

Follow this **link** to find CAT recipes related to Smoking, BMI and Alcohol status recordings for your patients.



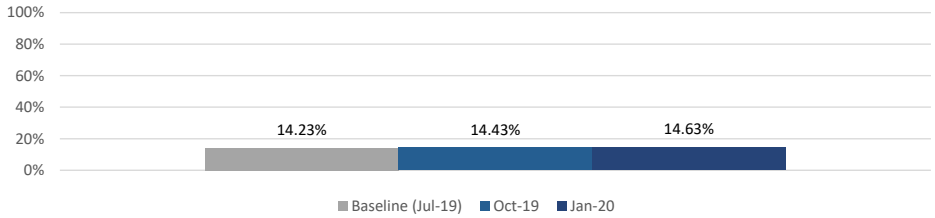
QIM 4, 5 & 6
Proportion of eligible patients with Influenza Immunisation recorded <15mths



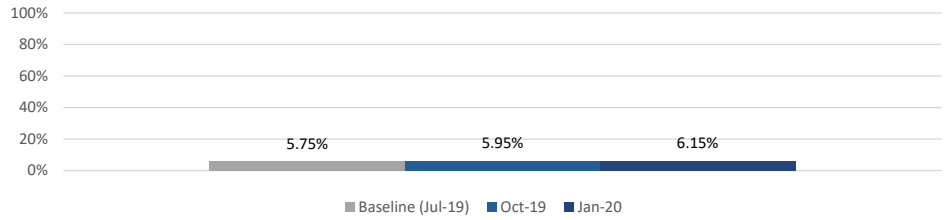
It is important to identify patients in your practice who are at risk for influenza. Follow this **link** to find CAT recipes to identify patients within your practice who may be at risk.

QIM 8
Proportion of patients aged 45-74yrs with info available to calculate CVD risk

Follow this **link** to find CAT recipes to identify patients within your practice who may not have all the relevant information available in their clinical record to calculate CVD risk.



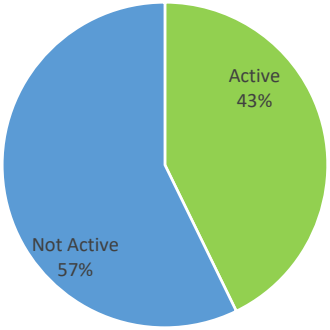
QIM 9
Proportion of eligible female patients aged 25-74yrs with HPV recorded in past 5 years



Follow this **link** to find CAT recipes to identify age eligible female patients within your practice who are not up to date with their cervical screening.

KNOW YOUR POPULATION

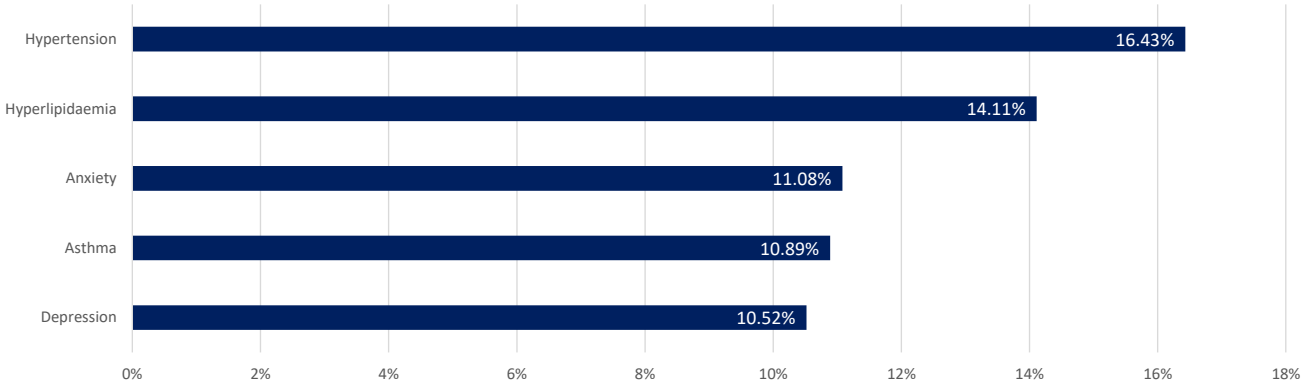
Active vs Not Active Patients



4.36% CODED DIAGNOSIS **vs** **0.64%** UNCODED DIAGNOSIS

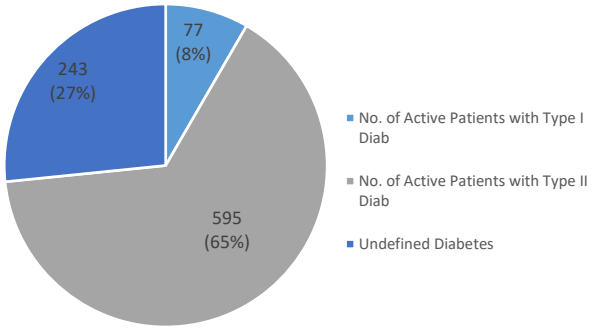
If you need further information about how to archive in your clinical software system, please speak with your Practice Support Officer.

Disease Prevalence for Active Patients (top 5 items only)



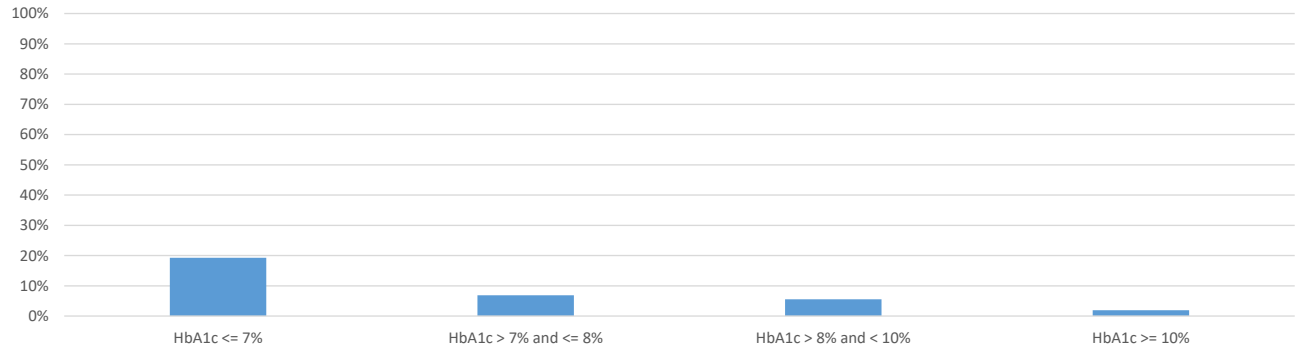
DIABETES PATIENT SNAPSHOT

Diabetes Patient Breakdown

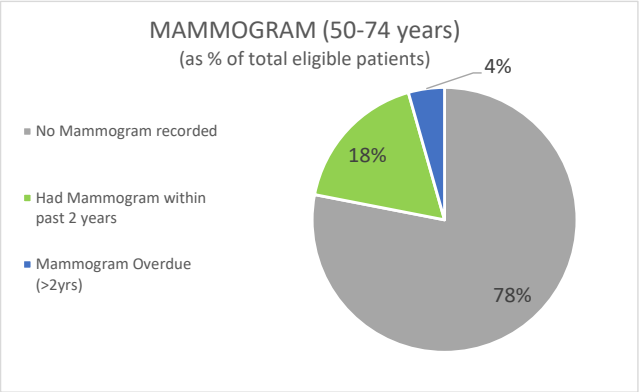


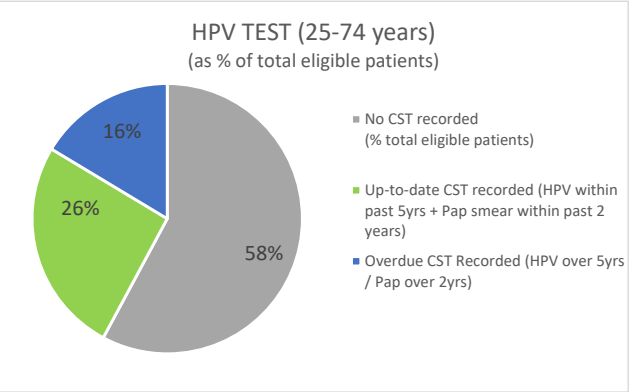
Proportion of recorded key indicators for active diabetes patients		
GPMP (15 mths)	✗	1.85%
TCA (15 mths)	✗	1.63%
Annual Cycle of Care	✗	0.75%
HbA1c (12 mths)	!	3.41%
Eye Exam (24 mths)	✗	0.42%
BMI (6-12 mths)	✗	1.63%
BP (6-12 mths)	!	3.02%
Foot Exam (6-12 mths)		0.31%
Cholesterol (12 mths)	!	3.15%
Smoking	✓	4.50%

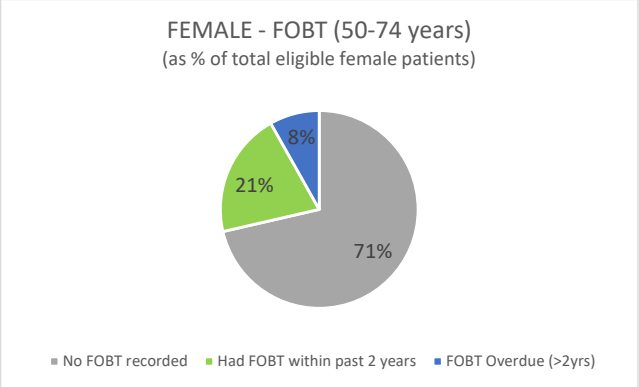
HbA1c in Active Diabetes Patients (as % of Active Diabetes patients)

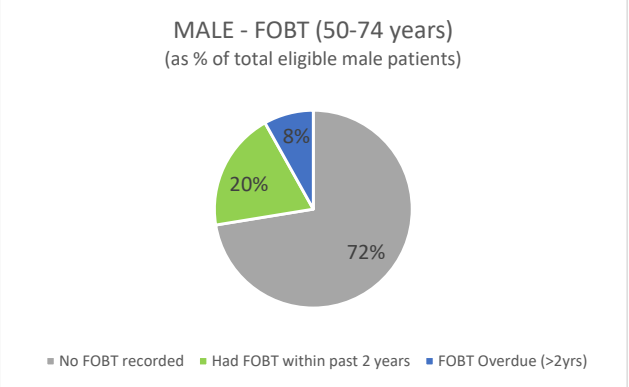


CANCER SCREENING



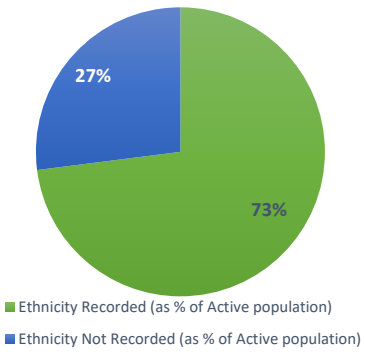




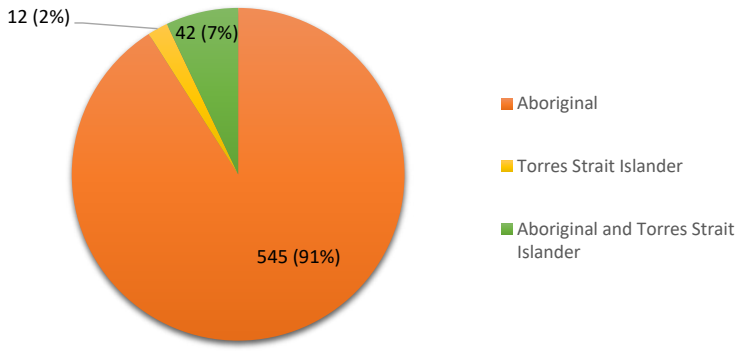


ABORIGINAL AND TORRES STRAIT ISLANDER PATIENT SNAPSHOT

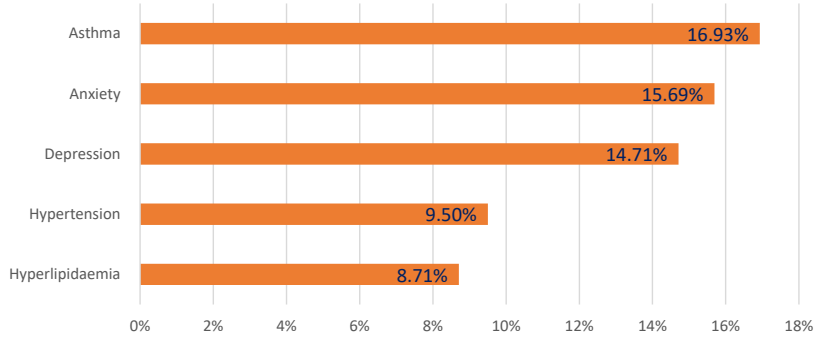
Ethnicity Recordings



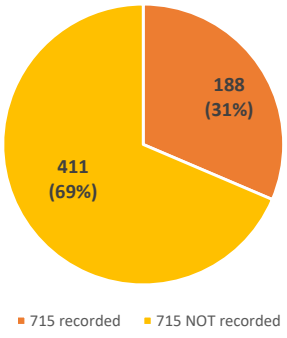
Indigenous Population



Disease Prevalence for Indigenous Patients (top 5 items only)



715 recordings for Indigenous patients



ACCREDITATION

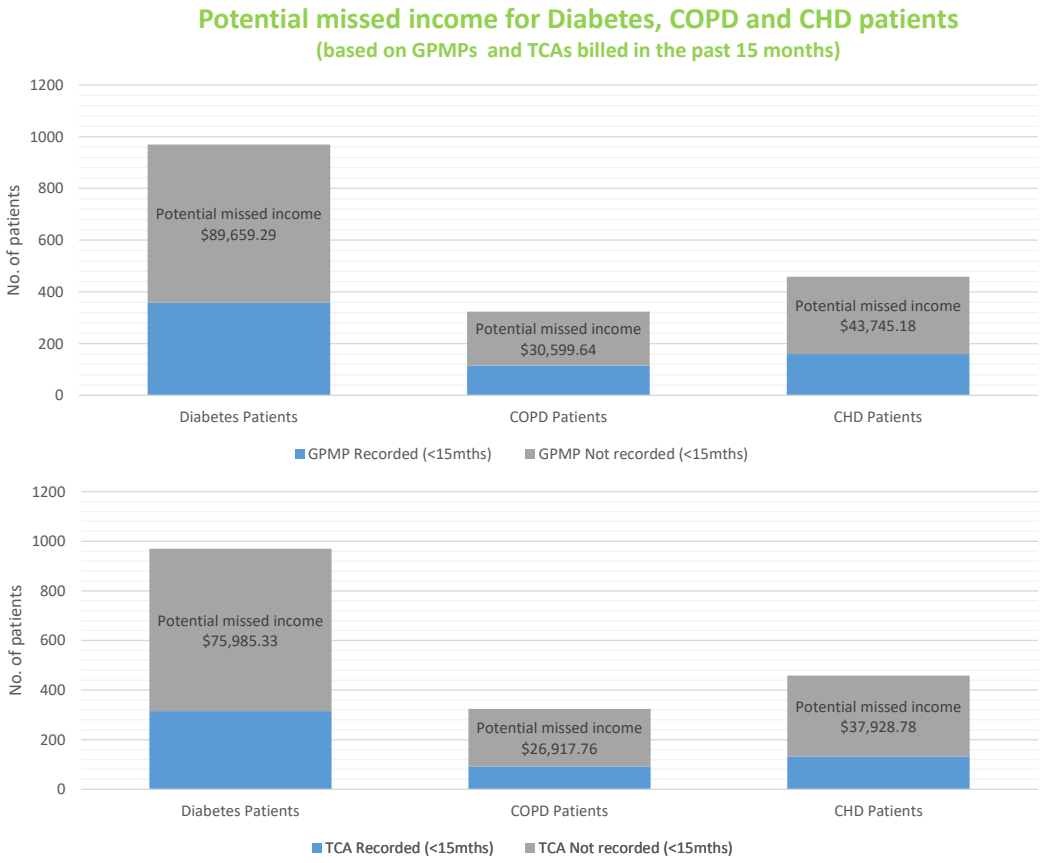
RECORDED MEASURES	TARGETS	LAST QTR	CURRENT QTR
Allergy Status	90%	4.00%	4.80%
Ethnicity	75%	3.00%	3.65%
Age	75%	5.00%	5.00%
Waist Measurement	75%	0.30%	0.48%
Height	75%	2.30%	2.35%
Weight	75%	2.80%	2.81%
Alcohol	75%	2.80%	2.80%
Smoking Status	75%	3.60%	3.75%
Physical Activity	75%	0.12%	0.13%

The **RACGP 5th edition Standards** for general practices encourages practices to work towards having a current health summary for all active patients which includes a record of health/lifestyle risk factors (*Criterion QI2.1 & Criterion C7.1).

To satisfy this Criterion, practices must have:

- A record of known allergies for at least 90% of active patient health records.
- A current health summary (smoking, alcohol, age, height and weight) for at least 75% of active

BUSINESS CASE



HOT TIP

Use the PenCS Topbar MBS Eligibility App to help you identify potentially billable items. Visit the PenCS website or contact your Practice Support Officer for training.

Please note that MBS data is only available for those practices who have billing systems compatible with PenCS CAT4. Practices with non-compatible billing software systems should not rely on this business case. Follow this link for information on CAT4 Clinical and Billing System Compatibility.

Appendix 10 – Practice Improvement Dashboard

PRACTICE IMPROVEMENT DASHBOARD

phn NEPEAN BLUE MOUNTAINS
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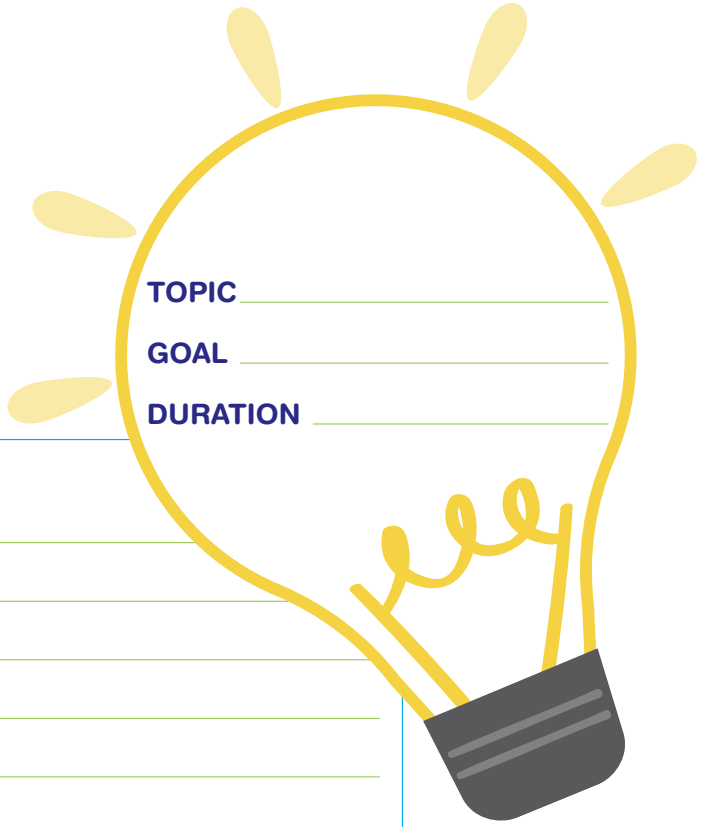
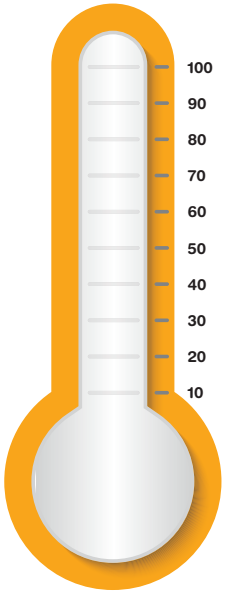


TOPIC _____

GOAL _____

DURATION _____

STEPS



THE QI TEAM

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This report can be found at
www.nbmphn.com.au/library

For more information about Wentworth Healthcare
or Nepean Blue Mountains PHN visit
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