EXAMPLE: 12 Month | Quality Improvement Record

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| **GOAL SETTING**  **NOTE:** This document can be used as a template for “Practice Incentive Payment Quality Improvement (PIP QI)” or is suitable for a **12-month** strategic approach  **This record can also be used to assist with preparation for RACGP Accreditation**  \*\*\* This PDSA/12 Month Quality Improvement Record is to be used as a guide and can be adjusted appropriately to suit your practice. The content provided is an example only, and information can vary depending on individual circumstances. If you would like assistance in how to tailor this to your practice, please contact your local PHN. | | |
| Practice name: | | PIP QI Quarter/s: |
| Record completed by: | | Date: |
| **Focus Area & Aim…. What are you trying to achieve? What is your goal?**  Use**Specific, Measurable, Achievable, Relevant, Time-based, Agreed (S.M.A.R.T.A)** goals. | | |
| Identify and reduce Cardiovascular Risk in patients over a 12-month period by:   * Scheduling a regular time for CVD screening * Cleaning practice data to identify patients yet to be assessed for CVD risk * Assessing patient CVD modifiable risk factors * Reviewing the treatment efficacy. | | |
| **What are the ways that you can review and measure the activity?** | | |
| |  | | --- | | The practice can use the Primary Health Network practice dashboard (or run a CAT 4 report in PEN CS) to observe the baseline data. This can be reviewed at monthly intervals and at the end of the PIP QI Quarter. |   . | | |
| **IDEAS…. What activities and changes can we make to help you reach your GOAL?**  Develop ideas that you would like to test towards achieving your goal. Use the **S.M.A.R.T.A** approach when developing your ideas. | | |
| **Idea 1.** | Use of Absolute Cardiovascular Risk Score (Screening)  To increase the use of the Absolute Cardiovascular risk score as part of a screening measure by …. % by <insert date>. | |
| **Idea 2.** | Indicated Diagnoses (Under data cleansing in software)  To identify and then reduce the number of indicated diagnoses by …. % by <insert date> through the Pen Cat data cleansing tool. | |
| **Idea 3.** | Modifiable Risk Factors (Clinical Coding)  To increase the recording of modifiable risk factors (i.e., smoking alcohol, physical activity, BMI) into the clinical software by …. % by <insert date>. | |
| **Idea 4.** | Reviewing treatment efficacy in high-risk patients  To identify all patients prescribed treatments for (insert condition here) in the last 12 months who are not yet meeting recommended risk factors targets. | |

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| **IDEA 1** | Use of Absolute Cardiovascular Risk Score (Screening) | |
| **PLAN**  *Who is going to undertake this activity?*  *When are they going to do it? What resources/software will they need?* | (Example Below)  **Who:** (For example)   * Practice Staff: Identify list of eligible patients for all GPs with patients aged between (insert age range). * GPs to screen list. * Practice staff to make appointments.   **When:** (For example) Appointments scheduled in 4-hour blocks on the last Friday of every month.  **Where:** Practice premises.  **Data to be collected**:  A CAT 4 extraction looking at the number of ACR scores recorded and the risk severity. The recipe for this extraction can be found on the PenCS website under [QIM 8- Cardiovascular Risk](https://help.pencs.com.au/pages/viewpage.action?pageId=47317156).  **Data predictions**: There will be (insert prediction here) percentage of having a cardiovascular event in the next 5 years.  **Resources needed:**   * Practice staff to generate list of eligible patients * Software for generating list * Time in schedules available for appointments with GP and PN. | |
| **DO (DID)**  *Was the plan executed?*  *Were there any unexpected events or problems? Record data.* | (Example Below)  (insert number) of patients were screened for Cardiovascular Disease using the Absolute Cardiovascular Risk Assessment tool between (insert date) and (insert date).  Deviations from plan:   * Pts unable to attend time slot designated * Urgent appointments for (insert reason) were recorded in (insert number) instances during the time designated. * Staff on leave during (insert date) delayed appointments for (insert month/time-period). | |
| **STUDY**  *Review actions and reflect on outcome. Compare to predictions* | (Example Below)  According to the Dashboard report this was a (insert number) increase/decrease compared to the previous Dashboard Report.  Training in using the clinical software to record the ACR will be useful to the GPs and Nurses to encourage screening.  Clinical reminders can be used as a friendly prompt for clinical staff to conduct an ACR score. | |
| **ACT**  *What now?*  *What will you take forward?*  *What is the next step?* | (Example Below)  Continue to monitor and measure CVD Risk through CAT 4 extractions and the CVD Dashboard report available through the PHN. This will achieve continual improvement and ensure that there is no decrease in screening. The practice will also continue to identify the level of risk Cardiovascular risk and aim to reduce the level of risk through pharmacotherapy and lifestyle modifications. | |

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| **IDEA 2** | Indicated Diagnoses (Cleansing) | |
| **PLAN**  *Who is going to undertake this activity?*  *When are they going to do it? What resources/software will they need?* | (Example Below)  **Who:**   * Practice staff: Identify list of patients with an indicated diagnosis for chronic diseases that will contribute to an increase in Cardiovascular risk i.e., Diabetes and Chronic Kidney Disease. * GP’s: Review list of patients and confirm diagnoses in the software and ensure there is correct clinical coding. Identify patients from list that need a review. * Practice staff to make appointments for patients needing a review.   **When:** Review appointments scheduled with the patient’s regular GP within timeframe indicated by GP.  **Where:** Practice premises  **Data to be collected:**  A CAT 4 extraction of patients with an indicated diagnosis of Diabetes and/ or Chronic Kidney Disease.  The way to access this is explained on the PenCS website under [Cleansing View](https://help.pencs.com.au/display/CG/Cleansing+View) and [Data Cleansing](https://help.pencs.com.au/display/CG/Data+Cleansing).  **Data predictions:** The initial collection of data will have a high number of indicated diagnoses. When crossed checked to the patient file it was due to incorrect clinical coding.  **Resources needed:**   * Practice staff to generate list of eligible patients * Software for generating list * Time in schedules available for appointments with GP and PN. | |
| **DO (DID)**  *Was the plan executed?*  *Were there any unexpected events or problems? Record data.* | (Example Below)  GPs reviewed the patient’s files that were identified to have an indicated clinical diagnosis and reviewed the patient if indicated. Any indicated diagnoses that were identified due to clinical coding were amended by the GP.  Deviations from plan:   * Pts unable to attend time slot designated | |
| **STUDY**  *Review actions and reflect on outcome. Compare to predictions* | (Example Below)  There were (insert number) of patients with an indicated diagnosis that had the diagnoses in their file, but it was not coded. For example, free texting NIDDM Type 2 Diabetes, rather than selecting the coded diagnoses of Type 2 Diabetes.  Training on how to appropriately use clinical coding in the software would be beneficial to the staff. | |
| **ACT**  *What now?*  *What will you take forward?*  *What is the next step?* | (Example Below)  Identify the indicated diagnoses every (insert timeframe here). Review this list at the staff meetings every month and book review appointments as required. | |

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| **IDEA 3** | Modifiable Risk Factors (Clinical Coding) | |
| **PLAN**  *Who is going to undertake this activity?*  *When are they going to do it? What resources/software will they need?* | (Example Below)  **Who:**   * Practice staff: Identify list of patients that have a modifiable risk factors such as smoking and alcohol. Identify if there are a high number of patients with certain modifiable risk factors. * GPs to review list and analyse the number of patients that have modifiable risk factors and identify patients that may require a review for assistance in lifestyle modifications such as smoking cessation. * Practice staff: Book in patients for review as requested by GP. * GPs and Nurses to ensure modifiable risk factors are being updated in the software.   **When:** Review appointments scheduled with the patient’s regular GP within timeframe indicated by GP.  **Where:** Practice premises  **Data to be collected:**  A CAT 4 extraction looking at the number of patients in the practice with modifiable risk factors.  How to do this is on the PenCS website under [Risk Factors Filtering](https://help.pencs.com.au/display/CG/Risk+Factors+Filtering).  **Data predictions:** Our practice will have a high patient population that are current smokers.  **Resources needed**:   * Practice staff to generate list of eligible patients * Software for generating list * Time in schedules available for appointments with GP and PN. | |
| **DO (DID)**  *Was the plan executed?*  *Were there any unexpected events or problems? Record data.* | (Example Below)  There was a high population of patients that are current smokers so the practice staff organised patient resources around smoking cessation and found a local program that patients could access. Patients that required a review with their GP as indicated were offered an appointment.  Deviations from plan:   * Pts unable to attend time slot designated * Pts not interested in participating in the program | |
| **STUDY**  *Review actions and reflect on outcome. Compare to predictions* | (Example Below)  According to the Practice’s Dashboard Reports there was an (insert number) increase in recording modifiable risk factors. There was also a (insert number) increase/decrease in patients who are current smokers.  Training around reducing lifestyle factors such as smoking cessation, increase in physical activity leading to weight loss, and reduction in consumption of alcohol would be beneficial for the staff. | |
| **ACT**  *What now?*  *What will you take forward?*  *What is the next step?* | (Example Below)  Continue to monitor the modifiable risk factors in the Practice’s Dashboard Reports. Look into renting a room at the practice for Allied Health that the patients can access for assistance in smoking cessation, reduction in alcohol consumption, and weight management. | |

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| **IDEA 4** | Reducing CVD Risk- Looking at treatment efficacy. | |
| **PLAN**  *Who is going to undertake this activity?*  *When are they going to do it? What resources/software will they need?* | (Example Below)  **Who:**   * Clinical staff: Perform a CAT 4 extraction using a cross tabulation report to identify patients that have (insert condition here e.g., Hypertension) that are currently on an (insert medication here e.g., antihypertensive medication), that is not yet meeting recommended targets (e.g., has a blood pressure over recommended target). * GP’s: Review list of patients from the cross-tabulation report and identify patients that need a review * Practice staff: Book in appointments requested by GP.   **When:** Review appointments scheduled with the patient’s regular GP within timeframe indicated by GP.  **Where:** Practice premises  **Data to be collected:** A cross tabulated report for cohort of patients with a prescribed treatment that are not yet meeting recommended targets. Further information on how to do this is available on the PenCS website under [Cross Tabulation Report.](https://help.pencs.com.au/display/CG/Cross+Tabulation+Report)  **Data predictions**: There will be a low number of patients who are on a prescribed treatment that are not meeting recommended targets.  **Resources needed**:   * Practice staff to generate list of eligible patients * Software for generating list * Time in schedules available for appointments with GP and PN. | |
| **DO (DID)**  *Was the plan executed?*  *Were there any unexpected events or problems? Record data.* | (Example Below)  The GP’s reviewed patients that were on a prescribed treatment which were not meeting recommended targets. If required and indicated there were further investigations, changes to treatment plans, and/or referrals to specialists made.  Deviations from plan:   * Pts unable to attend time slot designated * Urgent appointments for (insert reason) were recorded in (insert number) instances during the time designated. * Staff on leave during (insert date) delayed appointments for (insert month/time-period). | |
| **STUDY**  *Review actions and reflect on outcome. Compare to predictions* | (Example Below)  According to a cross tabulation report conducted (insert timeframe) after the initial report, there was improvement in treatment efficacy. | |
| **ACT**  *What now?*  *What will you take forward?*  *What is the next step?* | (Example Below)  Continue to look at the PenCat extractions for treatment efficacy as a quality check and as part of the practices’ clinical meetings every month. | |