# 12 Month | Quality Improvement Record

**GOAL SETTING**

This document can be used for **one** "Practice Incentive Payment Quality Improvement (PIP QI)" Quarter or is suitable for a **12-month** strategic planning approach.

This record can also be used to assist with preparation for RACGP Accreditation.

| 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.

***Example:*** *Our practice would like to increase clinical coding/recording of smoking status, weight, alcohol intake and physical activity in each patient's clinical record within the next 3/6/9/12 months.*

*Improve the management of patients with Chronic Kidney Disease by assessing risk factors, performing an Annual Kidney Health Check, and diagnosing Chronic Kidney Disease, and performing timely clinical reviews.*

**What are the ways that you can review and measure the activity?**

***Example:*** *The practice nurse 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.*

Insert image of baseline data or scan dashboard report and attach to this document. Your PCIO can help with this if you need.

*This can be measured in patient outcomes which can be accessed in a PenCS CAT4 extraction, and through the MBS billing item numbers for each patient.*

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**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.

***Example:*** *By August 2021, record 100% allergy status for all active patients.*

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| **Idea 1.** | *Provide in house training to all staff (admin and clinical staff) on the billing, minimum MBS requirements, and the use of the clinical information system. This will create a team approach and a structured procedure on identifying and recalling patients for their chronic disease management.* |
| **Idea 2.** | *Use the clinical information system or PenCS CAT4, and/or PRODA/HPOS to identify patients who have Chronic Kidney Disease and are due for MBS Chronic Disease Management items to be completed. This will create a list of patients to focus on.* |
| **Idea 3.** | *Create a list of patients through the clinical software and/or PenCS CAT4 that have Chronic Kidney Disease who have never had a CDM item completed before. This can be cross checked through PRODA/HPOS. This will create another focus group of patients.* |
| **Idea 4.** | *Do a data extraction through the clinical software or through PenCS CAT4 for patients at risk of Chronic Kidney Disease that have not had a Kidney Health Check attended. Use that list of patients as a focus group.* |

# Quality Improvement

## Plan, Do, Study, Act (PDSA) Cycle

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| **IDEA 1** | *Provide in house training to all staff (admin and clinical staff) on the billing, minimum MBS requirements, and the use of the software to complete Chronic Disease Management. This will create a team approach and a structured procedure on identifying and recalling patients for their Care.* |
| **PLAN**<br>Who is going to undertake this activity?<br>When are they going to do it?<br>What resources/software will they need? | **Whom:** *All staff.*<br><br>**When:** *<insert date>*<br><br>**Where:** *Practice premises.*<br><br>**Data to be collected**: *Questionnaire completed by staff to assess training needs.*<br><br>**Data predictions**: *Majority of staff could benefit from the training session.* |
| **DO (DID)**<br>Was the plan executed?<br>Were there any unexpected events or problems?<br>Record data. | *Staff training was held on <insert date>* |
| **STUDY**<br>Review actions and reflect on outcome.<br>Compare to predictions | *Staff gave positive feedback about the training and the team's approach on attending the Kidney Health Check.* |
| **ACT**<br>What now?<br>What will you take forward?<br>What is the next step? | *Continue to discuss the Kidney Health Check in regular clinical meetings*. |

# Quality Improvement

## Plan, Do, Study, Act (PDSA) Cycle

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| **IDEA 2** | *Use the clinical software, or PenCS CAT4, and/or PRODA/HPOS to identify patients who have Chronic Kidney Disease that are due for a GPMP, TCA or Review and Nurse/AHP Monitoring. This will create a list of patients to focus on.* |
| **PLAN**<br>Who is going to undertake this activity?<br>When are they going to do it? What resources/software will they need? | **Whom:** *Admin/Management and Clinical Staff.*<br><br>**When:** *Do the extraction and create list of patients per provider by <insert date>. Book <insert number> of patients in from the list by <insert date>*<br><br>**Where:** *Practice premises*<br><br>**What:** *Do the extraction and create list of patients per provider and make appointments.*<br><br>**Why? Data predictions:** *There will be a large list of patients that are due or overdue for their Chronic Disease Management care.* |
| **DO (DID)**<br>Was the plan executed?<br>Were there any unexpected events or problems? Record data. | *Patients who were in the clinical software reminders system as over-due/due for an GPMP, TCA, Review or Monitoring were identified*. |
| **STUDY**<br>Review actions and reflect on outcome. Compare to predictions | *<insert number> patients were identified as being due/over-due for a Chronic Disease Management item. <insert number> of these patients were booked in and had an CDM item completed.* |
| **ACT**<br>What now?<br>What will you take forward?<br>What is the next step? | *Continue to use the clinical reminders to measure who is due/ over-due for their Chronic Disease management item.* |

# Quality Improvement

## Plan, Do, Study, Act (PDSA) Cycle

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| **IDEA 3** | *Create a list of patients through the clinical software and/or PenCS CAT4 that have Chronic Kidney Disease who have never had a CDM Item completed before. This can be cross checked through PRODA/HPOS. This will create another focus group of patients.* |
| **PLAN**<br>Who is going to undertake this activity?<br>When are they going to do it? What resources/software will they need? | **Whom:** *Admin/Management and Clinical Staff.*<br><br>**When:** *Do the extraction and create list of patients per provider by <insert date>. Book <insert number> of patients in from the list by <insert date>*<br><br>**Where:** *Practice Premises*<br><br>**What:** *Do the extraction and create list of patients per provider and make appointments.*<br><br>**Why? Data predictions:** *There will be a sizeable list of eligible patients for an GPMP and/or TCA.* |
| **DO (DID)**<br>Was the plan executed?<br>Were there any unexpected events or problems? Record data. | *It was more effective using a PenCS CAT4 extraction and cross checking PRODA for eligibility and ensuring the service was not accessed at another practice. This was more time effective using multiple staff.*<br><br>*A list of <insert number> patients were identified as being eligible for a Chronic Disease Management item.* |
| **STUDY**<br>Review actions and reflect on outcome. Compare to predictions | *From the <insert number> of patients, <insert number> of patients were booked in and had a Chronic Disease Management item completed.* |
| **ACT**<br>What now?<br>What will you take forward?<br>What is the next step? | *Ensure that patients who have a new diagnosis of Chronic Kidney Disease have a clinical reminder for an GPMP, TCA or Review in the software so their chronic disease management can be monitored.* |

# Quality Improvement

## Plan, Do, Study, Act (PDSA) Cycle

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| **IDEA 4** | *Do a data extraction through the clinical software or through PenCS CAT4 for patients at risk of Chronic Kidney Disease that have not had a Kidney Health Check done and use that list of patients as a focus group to have a Kidney Health Check completed.* |
| **PLAN**<br>Who is going to undertake this activity?<br>When are they going to do it? What resources/software will they need? | **Whom:** *Admin/Management and Clinical Staff*<br><br>**When:** *Do the extraction and create list of patients per provider by <insert date>. Book <insert number> of patients in from the list by <insert date>*<br><br>**Where:** *Practice Premises*<br><br>**Data to be collected:** *There will be a substantial number of patients identified as not having had a Kidney Health Check in the last 1-2 years.*<br><br>**Data predictions:** *Do the extraction and create list of patients per provider and make appointments.* |
| **DO (DID)**<br>*Was the plan* executed?<br>Were there any unexpected events or problems? Record data. | - *Staff executed this Plan with a list of <insert number> patients who had not had a Kidney Health Check collected in the previous 1-2 years.*<br>- *Staff booked <insert number> of patients for a Kidney Health Check.*<br>- *<number> of patients declined the Kidney Health Check. These patients were booked in with their usual GP for a review of their Chronic Kidney Disease risk.* |
| **STUDY**<br>Review actions and reflect on outcome. Compare to predictions | *There was a larger number of patients then expected without a Kidney Health Check done within 1-2 years, therefore this activity will be repeated to achieve a reduction in that number. <insert number> of the patients on the list had a Kidney Health Check completed.* |
| **ACT**<br>What now?<br>What will you take forward?<br>What is the next step? | *Continue to work through the patient list and aim to have all patients at risk of Chronic Kidney Disease have had a Kidney Health Check in the last 1-2 years.* |