





# QUALITY IMPROVEMENT: GOAL SETTING





Ask the three questions:

<b>1. What are we trying to accomplish?</b> By answering this question, you will develop your goal for improvement.	
<p>Improve the management of patients with Diabetes by attending to the Annual Cycle of Care and complying to the MBS minimum requirements.</p>	
<b>2. How will we know that a change is an improvement?</b> By answering this question, you will develop measures to track the achievement of your goal.	
<p>This can be measured in patient outcomes (reduction of HbA1c which can be accessed in a Pen Cat extraction), and through the MBS billing item numbers for an Annual Cycle of Care for each patient.</p>	
<b>3. What changes can we make that can lead to an improvement?</b> List your ideas for change. By answering this question, you will develop the ideas you would like to test towards achieving your goal. Use the SMART approach when developing ideas (specific, measurable, attainable, realistic, timebound). E.g. By March 2020, complete 100% of HbA1c tests for all eligible (have not had a test in the past 6 months) active patients.	
<b>Idea 1.</b>	<p>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 Annual Cycles of Care. This will create a team approach and a structured procedure on identifying and recalling patients for their Annual Cycle of Care.</p>
<b>Idea 2.</b>	<p>Use the clinical software, or Pen Cat, and/or PRODA/HPOS to identify patients who have Diabetes that have had an Annual Cycle of Care previously and are due for another one to be completed. This will create a list of patients to focus on as well.</p>
<b>Idea 3.</b>	<p>Create a list of patients through the clinical software and/or Pen Cat that have Diabetes who have never had an Annual Cycle of Care completed before. This can be cross checked through PRODA/HPOS. This will create another focus group of patients.</p>
<b>Idea 4.</b>	<p>Do a data extraction through the clinical software or through PenCat for patients with Diabetes that have not had a HbA1c done in 12months and use that list of patients as a focus group to have an Annual Cycle of Care completed.</p>





# QUALITY IMPROVEMENT: PLAN, DO, STUDY, ACT CYCLE

<p><b>Idea being tested:</b></p> <p><i>From page 1: Idea 1,2,3 or 4</i></p>	<p>Idea one: 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 Annual Cycles of Care. This will create a team approach and a structured procedure on identifying and recalling patients for their Annual Cycle of Care.</p>
	<p><b>Plan</b>      <i>Who? When? Where? Data predictions? Data to be collected.</i></p> <hr/> <p>Who: All staff          When: &lt;insert date&gt;          Where: Practice Premises          Data predictions: Majority of staff could benefit from the training session.          Data to be collected: Questionnaire completed by staff to assess training needs</p>
	<p><b>Do</b>      <i>Was the plan executed? Any unexpected events or problems? Record data.</i></p> <hr/> <p>Staff training was held on &lt;insert date&gt;</p>
	<p><b>Study</b>      <i>Analysis of actions and data. Reflection on the results. Compare to predictions.</i></p> <hr/> <p>Staff gave positive feedback to the training and a team approach on attending the Annual Cycles of Care was created.</p>
	<p><b>Act</b>      <i>What will we take forward; what is the next step or cycle?</i></p> <hr/> <p>Continue to discuss the Annual Cycle of Care in regular clinical meetings.</p>





# QUALITY IMPROVEMENT: PLAN, DO, STUDY, ACT CYCLE

<p><b>Idea being tested:</b></p> <p><i>From page 1: Idea 1,2,3 or 4</i></p>	<p>Idea two: Use the clinical software, or Pen Cat, and/or PRODA/HPOS to identify patients who have Diabetes that have had an Annual Cycle of Care previously and are due for another one to be completed. This will create a list of patients to focus on as well.</p>
	<p><b>Plan</b>      <i>Who? When? Where? Data predictions? Data to be collected.</i></p> <p>Who: Admin/Management and Clinical Staff</p> <p>When: Do the extraction and create list of patients per provider by &lt;insert date&gt;. Book &lt;insert number&gt; of patients in from the list by &lt;insert date&gt;</p> <p>Where: Practice Premises</p> <p>Date predictions: There will be a large list of patients that are due or overdue for their Annual Cycle of Care.</p> <p>Data to be collected: Do the extraction and create list of patients per provider and make appointments.</p>
	<p><b>Do</b>      <i>Was the plan executed? Any unexpected events or problems? Record data.</i></p> <p>Patients who were in the clinical software reminders system as over-due/due for an Annual Cycle of Care were identified.</p>
	<p><b>Study</b>      <i>Analysis of actions and data. Reflection on the results. Compare to predictions.</i></p> <p>&lt;insert number&gt; patients were identified as being due/over-due for an Annual Cycle of Care that has previously had one. &lt;insert number&gt; of these patients were booked in and had an Annual Cycle of Care completed.</p>
	<p><b>Act</b>      <i>What will we take forward; what is the next step or cycle?</i></p> <p>Continue to use the clinical reminders to measure who is due/ over-due for their Annual Cycle of Care.</p>

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<p><b>Idea being tested:</b></p> <p><i>From page 1: Idea 1,2,3 or 4</i></p>	<p>Idea three: Create a list of patients through the clinical software and/or Pen Cat that have Diabetes who have never had an Annual Cycle of Care completed before. This can be cross checked through PRODA/HPOS. This will create another focus group of patients.</p>
	<p><b>Plan</b>      <i>Who? When? Where? Data predictions? Data to be collected.</i></p> <p>Who: Admin/Management and Clinical Staff</p> <p>When: Do the extraction and create list of patients per provider by &lt;insert date&gt;. Book &lt;insert number&gt; of patients in from the list by &lt;insert date&gt;</p> <p>Where: Practice Premises</p> <p>Date predictions: There will be a sizeable list of eligible patients for an Annual Cycle of Care.</p> <p>Data to be collected: Do the extraction and create list of patients per provider and make appointments.</p>
	<p><b>Do</b>      <i>Was the plan executed? Any unexpected events or problems? Record data.</i></p> <p>It was more effective using a Pen Cat 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.</p> <p>A list of &lt;insert number&gt; patients were identified as being eligible for an Annual Cycle of Care.</p>
	<p><b>Study</b>      <i>Analysis of actions and data. Reflection on the results. Compare to predictions.</i></p> <p>From the &lt;insert number&gt; of patients, &lt;insert number&gt; of patients were booked in and had an Annual Cycle of Care completed.</p>
	<p><b>Act</b>      <i>What will we take forward; what is the next step or cycle?</i></p> <p>Ensure that patients that have recently been diagnosed with Diabetes have a clinical reminder for an Annual Cycle of Care in the software it can then be monitored.</p>

# QUALITY IMPROVEMENT: PLAN, DO, STUDY, ACT CYCLE

<p><b>Idea being tested:</b></p> <p><i>From page 1: Idea 1,2,3 or 4</i></p>	<p>Idea four: Do a data extraction through the clinical software or through PenCat for patients with Diabetes that have not had a HbA1c done in 12months and use that list of patients as a focus group to have an Annual Cycle of Care completed.</p>
	<p><b>Plan</b>      <i>Who? When? Where? Data predictions? Data to be collected.</i></p> <p>Who: Admin/Management and Clinical Staff</p> <p>When: Do the extraction and create list of patients per provider by &lt;insert date&gt;. Book &lt;insert number&gt; of patients in from the list by &lt;insert date&gt;</p> <p>Where: Practice Premises</p> <p>Data Predictions: There will be a substantial number of diabetic patients identified as no having had a HbA1c in the last 12 months.</p> <p>Data to be collected: Do the extraction and create list of patients per provider and make appointments.</p>
	<p><b>Do</b>      <i>Was the plan executed? Any unexpected events or problems? Record data.</i></p> <p>Plan was executed with a list of &lt;insert number&gt; patients who had not had a HbA1c done in 12 months. &lt;insert number&gt; of patients were booked in for an Annual Cycle of Care.</p> <p>Some patients declined the cycle of care- those patients were booked in with GP for a review of blood tests so they could still have the relevant pathology attended to and a review of their Diabetes with the GP.</p>
	<p><b>Study</b>      <i>Analysis of actions and data. Reflection on the results. Compare to predictions.</i></p> <p>There was a larger number of patients then expected without a HbA1c done within 12 months, therefore this activity will be repeated to achieve a reduction in that number. &lt;insert number&gt; of the patients on the list had an Annual Cycle of Care completed.</p>
	<p><b>Act</b>      <i>What will we take forward; what is the next step or cycle?</i></p> <p>Continue to work through the patient list and aim to have all patients with Diabetes to have had at least one HbA1c done in the last 12 months.</p>