## Continuous Quality Improvement (CQI)

## Management of COVID-19 high-risk and vulnerable patients using CAT4

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| **CQI steps** | **Ask-Do-Describe** |
| **Data report 1 - baseline** | **First CQI meeting**  | **Why do we want to change?** |
| * Gap
 | Currently there is a gap in the practice system to advise high risk and vulnerable patients of services, resources, updates and availability of health care options accessible during the COVID-19 pandemic.  |
| * Benefits
 | Proactively manage high-risk and vulnerable patients of contracting COVID-19 to minimise poor health outcomes.  |
| * Evidence
 | There are a significant number of patients in the practice population that are at increased risk of poor health outcomes should they contract COVID-19[Health Direct – Groups at higher risk of developing COVID-19](https://www.healthdirect.gov.au/coronavirus-covid-19-groups-at-higher-risk-faqs)[Department of Health – What you need to know know about COVID-19](https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/what-you-need-to-know-about-coronavirus-covid-19) |
| **What** do we want to change? |
| * Topic
 | Increased awareness and proactive support provided to vulnerable and at-risk patient target groups  |
| * Scope
 | All at risk and vulnerable patients identified at the practice contacted (Tip: could choose one population target group at a time to test process then implement more broadly)  |
| **How much** do we want to change? |
| * Baseline (%)
 | To be determined from selected report (dependent on which population target group is identified)  |
| * Sample (Number)
 | All vulnerable and high-risk patients who will be targeted (e.g. how many patients 70 years and above, how many patients with a Cancer diagnosis) |
| * Target (%)
 | 100% of identified at risk and vulnerable patient target group contacted and offered appropriate care  |
| * Preparedness
 | All staff provided training as per the Pandemic and Business Continuity Plan  |
| **Who** are involved in the change? |
| * Leads

Contributors | Lead by Practice Manager and Principal GPAll staff  |
| * External
 | PHN/DoH/QLD Health/Patients  |
| **When** are we making the change? |
| * Deadlines
 | Immediate start – ongoing as advised  |
| **How** are we going to change? |
| * Potential solutions
 | * Triage appointment requests and optimise [telehealth](https://gcphn.org.au/practice-support/digital-health/telehealth-services/) item numbers where clinically appropriate
* Postpone non-essential consultations and consider completing care plans and reviews required to develop exacerbation plans for chronic disease patients
* Offer special vaccinations clinics **only** for target group as predetermined times (consider when is the best time depending on the age of group) refer to individual population groups immunisation examples – [Gold Coast Immunisation Clinics](https://www.goldcoast.health.qld.gov.au/our-services/immunisation/free-community-immunisation-clinics)
* Consider how to manage influenza vaccination clinics that minimise number of vulnerable patients waiting for general population immunisation program (given that there is expected to be a higher uptake this year)
* Send SMS/emails to select group to advise of opening hours, how to see a GP, access to updates and advice on COVID-19, special clinics etc (*consider the “recall” function to keep in touch with patients)*
* For older populations, consider a practice newsletter with COVID-19 advice and relevant information
* Display information in waiting room (including videos), on doors, noting particularly **access to afterhours support**
* Update on hold telephone and answering machine messages to reflect changes and processes
* Update practice webpage and keep patients informed using social media (if available)
* Consider promoting Mental Health services [Lifeline – Mental Health and Wellbeing During the COVID-19 Outbreak](https://www.lifeline.org.au/get-help/topics/mental-health-and-wellbeing-during-the-coronavirus-covid-19-outbreak)
* Where appropriate promote completion of Advance Care Plan[Advance Care Planning Australia](https://www.advancecareplanning.org.au/#/)
* Ensure Health Summaries and Event Summaries (where appropriate) are uploaded to My Health Record for all patients
* *Consider other options that might be applicable in the practice*
 |
| * Select
 | *Choose potential solutions that will work well in your practice and meet the needs of your patients and team.* |
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| * **Implementation**
 | * Implement
 | *Describe the steps, staff responsible and time frames* *1. Generate baseline measure/target patient list of vulnerable and high-risk patients (Reports, depending on target population) from CAT4 -* <https://help.pencs.com.au/display/CR/COVID-19>*2. Patient list discussed at team meeting* *3. Recall and/or flag high risk and vulnerable patients and offer reviews/clinically indicated immunisations* |
| * Record, share
 | *Regular whole team meetings to evaluate, review planning and implementation. Optimise team meeting minutes as a record of your activities.* [*CQI practice meeting template*](https://gcphn.org.au/wp-content/uploads/2020/02/CQI-Practice-Meeting-Template.docx) |
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| **Data Report 2****Comparison** | **Final CQI meeting**  | **How much** did we change? |
| * Performance
 | *Did you achieve your target?* |
| * Worthwhile
 | Did the activity provide the outcome expected?Did this process provide patients with the required information and services? |
| * Learn
 |  What lessons learnt can you use for other activities, what worked well, what could be changed or improved?  |
|  | **What next?** |
| * Sustain
 | *Implement new systems and processes into business as usual* |
| * Monitor
 | *Consider monthly data review of eligible at-risk groups and invite to attend services etc*  |