

**QI Action Plan- add practice name**

**Health promotion QI activity with a**

## focus on Winter Wellness Strategy – Care of patients with Asthma

**Green- Instructions**  **Yellow- add practice detail**  **Teal- examples**

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| **Ask-Do-Describe** | |
| **Why do we want to change?** | |
| * Gap | The COVID-19 pandemic has impacted health system service delivery on the Gold Coast. Patients with Asthma will require their care to be reviewed and optimised particularly during the Winter. A seasonal, person-centered care delivery process may assist and provide a systematic and evidence-based approach to comprehensive care. |
| * Benefits | Every winter there is a surge in both community and hospital healthcare demand. Proactive care planning and delivery by general practices for patients with Asthma may help to prevent hospital admissions, increase patient wellness and quality of life.  Chronic care management is incentivised through MBS item numbers and can meet PIP QI practice requirements.  Practice staff will have opportunities to identify their asthma patients, proactively inviting and allocating time for patient assessments, which may increase staff satisfaction with their work.  Focusing on patients with asthma ensures efficient use of resources, may reduce avoidable hospital admissions and ultimately improves the health service experience for all consumers.  A written asthma action plan is a preventative measure prepared for patients with asthma by a GP to assist in managing their condition and reduce the severity of acute asthma exacerbation [(AIHW – Asthma, 2019)](https://www.aihw.gov.au/reports/chronic-respiratory-conditions/asthma/contents/treatment-management). |
| * Evidence | Australia has one of the highest life expectancies in the world and most Australians consider themselves to be in good health, however not all Australians are as healthy as they could be. Chronic diseases are the leading cause of ill health and death in Australia [(AIHW – Australias Health 2016)](https://www.aihw.gov.au/reports/australias-health/australias-health-2016/contents/chapter-3-leading-causes-of-ill-health). Chronic diseases are long lasting conditions with persistent effects, including social and economic consequences which may have a significant impact on quality of life [(AIHW – Chronic disease)](https://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/chronic-disease/overview).  Approximately 2.7 million Australians (11% of the total population) have asthma [(AIHW, 2019)](https://www.aihw.gov.au/getmedia/20a62b89-e44e-4dab-bcee-63461f4f74d3/Asthma.pdf.aspx?inline=true).  Peaks for asthma among children occur in late summer and autumn. Among adults, hospitalisations for asthma are highest in winter and early spring. The common cold is the reason for approximately 4 out of 5 bad asthma attacks [(National Asthma Council Australia, 2020)](https://www.nationalasthma.org.au/living-with-asthma/resources/patients-carers/factsheets/asthma-winter-checklist)  This coincides with the annual winter ‘flu’ season and may reflect the rise in respiratory infections observed then [(AIHW, 2019)](https://www.aihw.gov.au/getmedia/20a62b89-e44e-4dab-bcee-63461f4f74d3/Asthma.pdf.aspx?inline=true)  Asthma is associated with poorer quality of life, with disease severity and the level of control both having an impact. Asthma has varying degrees of impact on the physical, psychological and social wellbeing of people living with the condition [(AIHW, 2020).](https://www.aihw.gov.au/reports/chronic-respiratory-conditions/asthma/contents/asthma)  People with asthma often have other chronic diseases and long-term chronic conditions. Asthma in adults is associated with obesity, mental disorders, arthritis and cardiovascular disease [(AIHW, 2019)](https://www.aihw.gov.au/reports/chronic-respiratory-conditions/asthma-associated-comorbidities-risk-factors/contents/about-asthma-and-associated-comorbidities) |
| **What** do we want to change? | |
| * Topic | Identifying and managing vulnerable patients of the practice with Asthma |
| **How much** do we want to change? | |
| * Baseline | **Baseline data is your current performance,** baseline data for QI activities can be obtained from multiple sources e.g.:   * Data analytic tools- e.g., Primary Sense™ * Clinical information systems using the “search” function/patient registers   Example: Baseline data can be determined from the Primary Sense™ Chronic Lung Disease and Asthma report – Table 1  Identify Asthma patients with missing care items   * Export list to excel * Filter by Diagnosis – Asthma   Identify eligibility for Fluvax, Pneumovax, Telehealth review and other missing items of care   * XX of patients have Asthma   Example: current baseline performance is 150 patients with Asthma and a care plan |
| * Target | **Target is the number of patients who have Asthma**  Example: initial target is to increase the number of patients with Asthma invited for a care plan/review or missing care items to 200 |
| * Sample | **Sample is the number of patients with Asthma that are eligible for a care plan to meet your target**   * XX patients who do not have a care plan   Example: Sample is 50 patients to reduce the number of patients with missing care plans/items to 200  Tip (consider narrowing down your sample size by focusing on):   * Specific age groups * ACG score of 4 or 5 * Missing vaccinations * No visit in last 3 months * Current smoking status * Existing appointment to allow discussion and rebooking for Care Plan * ACG Score – e.g., 4 & 5 moderate to high complexity |
| **Who** are involved in the change? | |
| Contributors | *Remove/change/add names as required*  Practice Manager  GPs/Practice Nurses/Receptionists  GCPHN QI Project Officer |
| **When** are we making the change? | |
| * Deadlines | Baseline data report generated (date)  Implementation between (date range)  Review meeting (date)  Final meeting (date)  Tip: Consider your sample size and how long it will take to complete care plans |
| **How** are we going to change? | |
| * Potential solutions | *These are some options you could implement to increase care plans for Asthma patients. Please note you can choose 1 or more or amend/add your own as appropriate for your practice. You do not have to implement all options that are brainstormed/listed*   * Identify eligible patients. For example, using Primary Sense™ - Chronic Lung Disease and Asthma   **Identification:**  As per baseline sample above  **Service delivery option:**   * Review eligibility for care plan or review * Consider most appropriate service delivery option (in practice or telehealth) * If in practice, consider social distancing requirements, types of patients booked in at the same time (consider only “well patients”   **Management:**   * Consider a person centred, seasonal approach to support comprehensive, evidence-based care delivery for patients with Asthma * [**Autumn – Prevention**](https://gcphn.org.au/practice-support/support-for-general-practice/practice-based-population-health-management-program/seasonal-focus-autumn/)   Prevention activities such reviewing and updating vaccinations, referral to Pulmonary Rehabilitation, cancer and other disease screening and AHP referrals. Review psychosocial factors and mental health support requirements as appropriate.  Review clinical measures and guidelines and order tests as appropriate  [National Asthma Council Australia – Asthma Action Plan.pdf](http://s3-ap-southeast-2.amazonaws.com/nationalasthma/resources/341-NAC-Written-Asthma-Action-Plan-2015_Colour.pdf)  [National Asthma Council Australia – Asthma Action Plans](https://www.nationalasthma.org.au/health-professionals/asthma-action-plans/asthma-action-plan-library)   * [**Winter – Burden of Care**](https://gcphn.org.au/practice-support/support-for-general-practice/practice-based-population-health-management-program/seasonal-focus-winter/)   Review current referrals and specialist and allied health appointments with patient and/or carer to assess which ones are necessary or relevant. Reduce referrals, visits and unnecessary tests if appropriate. Coordinate any relevant tests and/or appointments to meet patient’s medical and personal requirements.  [National Asthma Council Australia – Winter Checklist](https://www.nationalasthma.org.au/living-with-asthma/resources/patients-carers/factsheets/asthma-winter-checklist)  [National Asthma Council Australia – Asthma Score (Asthma Control Test)](https://www.asthmahandbook.org.au/resources/tools/control-questionnaires)  Review clinical measures and guidelines and order tests as appropriate   * [**Spring – Clinical Coding and Data Management**](https://gcphn.org.au/practice-support/support-for-general-practice/practice-based-population-health-management-program/seasonal-focus-spring/)   Develop an agreed process for the practice for clinical coding and data entry that will support data extraction. Revise current patient consent processes and implement processes and systems to capture patient consent to share data. Update patient contact details including next of kin and emergency contact. Consider uploading SHS to My Health Record. Review medications and consider HMR.  Review clinical measures and guidelines and order tests as appropriate   * [**Summer – Advance Care Planning**](https://gcphn.org.au/practice-support/support-for-general-practice/practice-based-population-health-management-program/seasonal-focus-summer/)   Discuss and promote Advance Care Planning and encourage patient or family member to upload to My Health Record.  Review clinical measures and guidelines and order tests as appropriate  NB: patients may enter the seasonal cycle at any point |
| * Implement | List your chosen solutions in order of implementation  1.  2.  3. |
| * Monitor | *A minimum of one QI activity review/touchpoint is required. You can include multiple reviews/touchpoints – list by date. If you have only one review during the activity, remove secondary review dates/information that do not apply.*  Review 1 – Date:   * What is working/not working? * Has there been a change in your performance? If not, why not?   Review 2 – Date:   * What is working/not working? * Has there been a change in your performance? If not, why not? |
| **How much** did we change? | |
| * Performance | *This section is to be completed at end/closure of activity.*  *Remove/change/edit as required for your practice*  Did you achieve your target?  Example: Number of patients with Asthma with a care plan has increased from baseline XX to XX |
| * Worthwhile | *Please choose an option or add your own. More detail can be included as required*  Example: we believe the effort to complete the activity was worthwhile as we decreased the number of patients with Asthma due for a care plan  OR  We believe this activity was not worth the effort required, as we did not significantly reduce the number of patients with Asthma with a care plan |
| * Learn | *What lessons learnt can you use for other improvement activities?*  *What worked well, what could be changed or improved?*  *Example: SMS reminders result in higher bookings than phone calls* |
| **What next?** | |
| * Sustain | *Implement new processes and systems into business as usual – which parts of this activity, if any, will you incorporate into business as usual at your practice*  *Example:*  *Reception to confirm/update personal details at each visit*   * *Confirm/update social/family history/allergies/smoking and alcohol status regularly* * *Ensure new reminder in place for review of care plan/medication reviews* * *Consider any other new changes identified during the activity* |
| * Monitor | *Review target measure quarterly and initiate corrective measures as required*  *Consider monthly data review of eligible at-risk groups and invite to attend services etc.* |