

## QI Action Plan – add practice name

## Winter Wellness Strategy – Care of patients with chronic obstructive pulmonary disease (COPD)

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

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| **Ask-Do-Describe** |
| **Why do we want to change?** |
| * Gap
 | Patients with COPD require their care to be reviewed and optimised, particularly during the Winter. A seasonal, person centred 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 COPD 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 COPD patients, proactively inviting and allocating time for patient assessments, which may increase staff satisfaction with their work.Focusing on proactive care for patients with COPD ensures efficient use of resources, may reduce exacerbations and avoidable hospital admissions, ultimately improving the health service experience for all consumers. Management of COPD through exacerbation prevention can assist with reducing further deterioration, maintaining lung function and quality of life ([AIHW – COPD, 2019)](https://www.aihw.gov.au/reports/asthma-other-chronic-respiratory-conditions/copd-chronic-obstructive-pulmonary-disease/contents/deaths).  |
| * 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 – Australia’s 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 people's quality of life [(AIHW – Chronic disease)](https://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/chronic-disease/overview).  COPD is a major leading cause of death in Australia [(AIHW – COPD, 2019)](https://www.aihw.gov.au/reports/asthma-other-chronic-respiratory-conditions/copd-chronic-obstructive-pulmonary-disease/contents/deaths). COPD is a serious, progressive condition that limits airflow in the lungs, which can lead to mild or severe shortness of breath that is not fully reversible even with the use of medication [(AIHW, 2019)](https://www.aihw.gov.au/getmedia/15a9e731-fad6-4d01-9bea-65f8667736fa/Chronic%20obstructive%20pulmonary%20disease%20%28COPD%29.pdf.aspx?inline=true). COPD is the most common cause of potentially preventable hospitalisations. Preventing a flare-up is important because an untreated flare-up can mean hospitalisation and each flare-up does long-term damage to the lungs, it’s vital for COPD patients to be prepared each winter [(Lung Foundation Australia, 2020)](https://lungfoundation.com.au/health-professionals/conditions/copd/management/) COPD can be associated with other chronic conditions such as asthma, respiratory cancers, diabetes and diseases of the heart and blood vessels due to shared risk factors and the effect of COPD on other parts of the body [(AIHW, 2019)](https://www.aihw.gov.au/getmedia/15a9e731-fad6-4d01-9bea-65f8667736fa/Chronic%20obstructive%20pulmonary%20disease%20%28COPD%29.pdf.aspx?inline=true). |
| **What** do we want to change? |
| * Topic
 | Identifying and managing vulnerable patients with COPD in the practice.  |
| **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* XX patients with COPD eligible for a care plan.

Example: current baseline performance is 50 patients with COPD with a care plan not recorded |
| * Target
 | **Target is the number of patients with COPD invited for care plan/review or missing items of care complete your goal**Examples: * 100% of sample patients invited for care plan/review or missing items of care
* Initial target is to reduce the number of patients with missing care plans to 30
 |
| * Sample
 | **Sample is the number or percentage of patients with COPD which are invited for care plan/reviewed for missing items of care** **to meet your target*** XX patients with COPD who have not had a care plan

Example: * Sample is 20 patients to reduce the number of patients with missing Health Assessments to 30.
* All patients identified with Asthma (Chronic Lung Disease and Asthma Report)
* Identify COPD patients with missing care items

Tip (consider narrowing down your sample size by focusing on):* Export list to excel
* Filter by Diagnosis – COPD
* ACG score of 4 or 5
* Missing vaccinations
* No visit in last 3 months
* Current smoking status

Could also consider identifying eligibility for Fluvax, Pneumovax, Telehealth review and other missing items of care |
| **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)  |
| **How** are we going to change? |
| * Potential solutions
 | *These are some options you could implement. 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.* **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 COPD
* [GCPHN – COPD Cycle of Care](https://gcphn.org.au/wp-content/uploads/2020/05/updated-COPD-cycle-of-care-wheel-1.pdf)
* [**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 allied health professional referrals. Review psychosocial factors and mental health support requirements as appropriate. [Lung Foundation Australia – COPD Action Plan](https://lungfoundation.com.au/resources/copd-action-plan/)[Department of Health – How to Quit Smoking](https://www.health.gov.au/health-topics/smoking-and-tobacco/how-to-quit-smoking?utm_source=quitnow.gov.au&utm_medium=redirect&utm_campaign=digital_transformation)Review clinical measures and guidelines and order tests as appropriate * [**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. Review clinical measures and guidelines and order tests as appropriate [Lung Foundation Australia – Lung Health Checklist](https://lungfoundation.com.au/checklist/)[Lung Foundation Australia – My COPD Checklist](https://lungfoundation.com.au/resources/my-copd-checklist/)* [**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?e.g. Number of patients with COPD due for a care plan has decreased from baseline XX to XX |
| * Worthwhile
 | *Did the activity provide the outcome expected?**Did this process provide patients with the required information and services?**Please choose an option or add your own. More detail can be included as required* *e.g. – we believe the effort to complete the activity was worthwhile as we decreased the number of patients with COPD 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 COPD due for a care plan.* |
| * Learn
 | *What lessons learnt could you use for other improvement activities?* *What worked well, what could have been changed or improved?* *e.g., 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* *Maintenance - (example below):** *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
 | *Consider monthly data review of eligible at-risk groups and invite to attend services etc*  |