**QI Action Plan- \*add practice name\***

**Care of Patients with Diabetes QI Activity**

|  |  |  |
| --- | --- | --- |
| **Ask-Do-Describe** | | |
| **Why do we want to change?** | | |
| **Gap** | Patients with diabetes 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** | * Proactive care planning and delivery by general practices for patients with diabetes may help to prevent hospital admissions, improved patient wellbeing and quality of life. * Improved patient self-management, health literacy and education. * Provide multi-disciplinary care. * Having diabetes is a precursor to other chronic disease. * Chronic care management is incentivised through [MBS item numbers](https://www.servicesaustralia.gov.au/chronic-disease-gp-management-plans-and-team-care-arrangements#a3) and can meet PIP QI and accreditation practice requirements. |
| **Evidence** | The number of people with type 2 diabetes is growing, most likely the result of rising overweight and obesity rates, lifestyle and dietary changes and an ageing population. Within 20 years, the number of people in Australia with type 2 diabetes may increase from an estimated 870,000 in 2014, to more than 2.5 million.   The early identification and optimal management of people with type 2 diabetes is therefore critical. [(RACGP, 2020)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/management-of-type-2-diabetes)  An annual cycle of care model with a [seasonal focus](https://gcphn.org.au/practice-support/support-for-general-practice/practice-based-population-health-management-program/) can assist with targeted, cost-effective and high quality care delivery and monitoring by general practice. Implementing a seasonal focus model in primary health care can ensure all critical elements of health care management for at risk patients can be achieved. |
| **What** do we want to change? | | |
| **Topic** | Identifying and managing vulnerable patients with diabetes in \*Practice Name\* |
| **How much** do we want to change? | | |
| **Baseline**  *Baseline data is the % of*  *your current performance.*  *Add your practice performance percentage or number.*  *Baseline data from QI activities can be obtained from multiple sources e.g; Clinical information systems using the search function, Primary Sense, using the Diabetes Mellitus Report – Table 3 - patients with diabetes who may be eligible for chronic care occasions of service.* | **Example:** *\*XX patients with diabetes eligible for a care plan.* |
|  |
| **Sample**  *Sample is the number or percentage of patients with diabetes which are invited for care plan/reviewed for missing items of care to meet your target.*  *Add your practice sample.*  *This number could be determined from a Primary Sense – Diabetes Mellitus Report.* | ***Example:*** *Our sample is ALL patients with diabetes eligible for a care plan (if the list of patients eligible is large, consider narrowing this down using filters in Excel).*  *Identify eligibility for influenza vaccine, microalbumin test, blood pressure, review, and other missing items of care.* |
|  |
| **Target**  *Your target is the planned % result of the improvement.*  *Target is the number of patients with Diabetes to be invited for care plan/review or missing items of care to meet your goal.* | **Example:** *Target is to reduce the number of patients with diabetes with missing care plans to \*XX.* |
|  |
| **Who** is involved in the change? | | |
| **Contributors**  *Add names of the practice team involved* | **Practice Manager:**  **GPs:**  **Practice Nurses:**  **Receptionists:**  **GCPHN QI Project Officer:** |
| **When** are we making the change? | | |
| **Deadlines**  *Add key dates here for this activity.* | **Baseline data report generated:**  **Implementation between (from/to):**  **Review meeting/s:**  **Final evaluation meeting:** |
| **How** are we going to change? | | |
| **Implement**  *List some improvement strategies in order of implementation.*  ***(see Appendix 1 for suggestions).*** | **1.**  **2.**  **3.** |
| **STOP: The next section is to be completed after implementation has already commenced.** | | |
| **Monitor**  *A minimum of one QI*  *activity review /touchpoint is required.*  *You can include multiple reviews/touchpoints – list by date.* | **Review 1 - Date:**  *What is working/not working?*  *Has there been a change in your performance? If not, why not?* |
| **STOP: The next section is to be completed at the end/closure of activity.** | | |
| **How much** did we change? | | |
| **Performance**  *Question: Did you*  *achieve your target?*  *If not, reflect on why not* | **Example:**  *Number of patients with diabetes with a missing care plan/review or missing items of care has decreased from baseline \*XX to \*XX.*   * *This was an \*increase/decrease\* from our baseline data.* |
|  |
| **Worthwhile**  *Was the effort to complete the improvement activity worth the outcome?*  *Did the team value the improvement activity?* | **Example:**   * *We believe the effort to complete the activity* ***was worthwhile*** *as we as we decreased the number of patients with diabetes due for a care plan/review.*   ***OR***   * *We believe this activity* ***was not worth*** *the effort required, as we did not significantly reduce the number of patients with diabetes who were due for a care plan/review.* |
|  |
| **Learn**  *What lessons learnt*  *could you use for other improvement activities?*  *What worked well, what could have been changed or improved?* | **Example:** *A focus on data quality should have occurred before this activity as many patients were indicated as having diabetes but were not coded correctly as having Diabetes.* |
|  |
| **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.* |
|  |
| **Monitor**  *Review target measure quarterly and initiate corrective measures as required.* | **Example:** *Review Primary Sense – Diabetes Mellitus Report monthly to identify at-risk groups and invite to attend services etc. and to track performance over time.* |
|  |

|  |
| --- |
| **Appendix 1 – Potential solutions** |
| ***Review suggested implementation strategies listed below. You do not have to implement all options that are brainstormed/listed.***  Review patients for their eligibility for care plan or review (could be your usual process).  Consider a person centred, seasonal approach to support comprehensive, evidence-based care delivery for patients with diabetes:   * [**Autumn – Prevention**](https://gcphn.org.au/practice-support/support-for-general-practice/practice-based-population-health-management-program/seasonal-focus-autumn/)   + Prevention activities such as reviewing and updating vaccinations, referral to cancer and other disease screening and allied health professional referrals.   + Review psychosocial factors and mental health support requirements as appropriate.   + 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. * [**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 this to their My Health Record.   + Review clinical measures and guidelines and order tests as appropriate.   NB: patients may enter the seasonal cycle at any point |