Model for Improvement

Step 1: Thinking Part - Three Fundamental Questions
Complete the Model for Improvement (MFI) as a whole team.

AIM	**1. What are we trying to accomplish?**
*By answering this question, you will develop your **GOAL** for improvement. It important to establish a S.M.A.R.T (Specific, Measurable, Achievable, Relevant, Time bound) and people-crafted aim that clearly states what you are trying to achieve.*	
Our practice aims to increase the proportion of active patients with COPD to have a documented COPD action plan from 40% to 80% by 30 May 2025.	
MEASURE(S)	**2. How will we know that a change is an improvement?**
*By answering this question, you will develop the **MEASURE(S)** you will use to track your overarching goal. Record and track your baseline measurement to allow for later comparison.* *Tip: Use a Run Chart to plot trends.*	
Outcome Measure: % of active patients with COPD without a current documented COPD Action Plan. **Source:** Clinical Information System search **Frequency:** Fortnightly **Numerator:** # of active patients coded with COPD who have a COPD Action Plan (A) **Denominator:** # of active patients coded with COPD in the clinical information system (B) The proportion of active patients with COPD with a documented COPD action plan (A divided by B).	
Baseline:	20% of active patients with COPD have a documented COPD action plan
Baseline date:	13/01/2025
CHANGE IDEAS	**3. What changes can we make that will result in improvement?**
*By answering this question, you will develop **IDEAS** for change.* *Tip: Engage the whole team in formulating change ideas using tools such as brainstorming, driver diagrams or process mapping. Include any predictions and measure their effect quickly.*	
Idea 1	Develop a standardised workflow for creating and documenting COPD action plans.
Idea 2	**Identify and increase number of patients with COPD who don't have a COPD action plan**
Idea 3	**Introduce a COPD action plan reminder in the clinical information system.**
Idea 4	Conduct patient education sessions on the benefits of COPD action plans.
Next steps:	*Each idea may involve multiple short and small PDSA cycles.*

PDSA (Plan-Do-Study-Act)

Step 2: Doing Part - Plan-Do-Study-Act
Once you have completed the Model for Improvement (MFI), use the template below to document and track your PDSA cycles (i.e. small rapid tests of change).

Idea	Plan		Do	Study	Act
#	**Plan the test**	**Prediction**	**Do the test on small scale**	**Analyse the results**	**Make a plan for next step**
	__How__ will we run this test? __Who__ will do it and __when__? __What__ will we measure?	*__Prediction__ or hypothesis on what will happen.*	*Was the plan completed? Yes or No. Collect data. Consider what worked well and why? Document any unexpected observations, events or problems.*	*Analyse results, compare them to predictions, and reflect on what you learned.*	*Based on your learnings from the test, what will you do next (e.g., adopt, adapt or abandon)? How does this inform the plan for your next PDSA?*
Change idea 2.1	The practice nurse will use the clinical information system to identify active patients with COPD who do not currently have a COPD action plan. When: 13 February 2025 Patients will be contacted by phone or SMS and encouraged to book an appointment for a review and for GP to initiate a COPD action plan. If eligible GP's can incorporate COPD action plan as part of MBS item numbers 721, 723 or 732.	We predict that 50% of contacted patients will schedule an appointment within a month.	• 60 out of 100 patients were identified using the clinical information system via a '*COPD action plan'* template search. • 20 identified patients were sent SMS reminders and follow-up calls were made over two weeks to schedule patients in for a COPD action plan. • Patients responded well to the phone calls instead of the SMS as staff were able to explain why they needed a COPD action plan. • 12 out of 20 patients scheduled appointments from the phone calls (60%).	Our prediction was correct, as we had 50% of patients schedule an appointment. **Key observation:** Phone call was more effective than SMS in prompting responses. **Unexpected issue:** 2 patients declined due to difficulty attending during business hours.	Adopt: Expand this approach to the next 20 patients. For next change idea: Consider offering extended appointment times for patients unable to attend during regular hours.

Change idea 3.1	Using the report from change idea 2.1, the practice nurse will add alerts in the clinical information system for all active patients with COPD who do not have a COPD action plan. When: End of March Practice Manager to train reception staff to notify the nurse/GP when flagged patients check in. When: End of February	We predict that 30% of flagged patients will have an action plan initiated during their next visit within two months.	• Process changes of admin staff notifying nurse/GP of patient without a COPD action plan when checked-in took longer than anticipated. More supportive training was required during busy period. • 10 out of 40 flagged patients had an action plan initiated (25%).	Our prediction was close, but we did not achieve the 30% we were aiming for. **Observations:** Staff engagement was high; however, time constraints during busy clinic hours limited action plan initiation as reception staff did not have capacity to notify nurse/GP when a patient checked in. **Feedback:** Clinicians requested a pre-visit review process to identify suitable patients.	Adapt: Implement a weekly review of flagged patients to prepare COPD action plan documents in advance. Patients are identified via the pre-visit review conducted by the nurse. Practice Manager to monitor staff feedback during team meetings to streamline processes further.
Summary of Results	• Proportion of COPD patients with an action plan increased from 40% to 60% within the first two months. • Recall systems and opportunistic flagging proved effective but revealed areas for improvement in scheduling flexibility and pre-visit preparation. • Next steps include scaling successful strategies and piloting additional change ideas such as a pre-screening highlighted in change idea 3.1 Act.				