

Primary Health Care

Chronic Obstructive Pulmonary Disease (COPD)

Quality Improvement Toolkit

A practical guide to enhancing patient COPD management in primary care as a QI activity.

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Gold Coast Primary Health Network would like to acknowledge and pay respect to the land and the traditional practices of the families of the Yugambeh Language Region of South East Queensland and their Elders past, present and emerging.

Artwork: Narelle Urquhart. Wiradjuri woman.
Artwork depicts a strong community, with good support for each other, day or night. One mob.

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Where to get help?

Gold Coast Primary Health Network

07 5612 5408 | practicesupport@gcphn.com.au

About Chronic Obstructive Pulmonary Disease (COPD)

What is COPD?

Chronic Obstructive Pulmonary Disease (COPD) is a lung condition marked by ongoing respiratory symptoms, including shortness of breath, coughing, and sputum production, resulting from airway abnormalities that lead to persistent and worsening symptoms over time. While COPD is a progressive and (currently) incurable disease, with the right diagnosis and treatment there are many things that can be done to improve symptom control, prognosis and quality of life (Lung Foundation Australia).

What causes COPD?

COPD results from a complex interaction between genes and the environment and there are certain risk factors which may contribute to the development of COPD. These risk factors include:

- **Tobacco smoking:** both active smoking and passive exposure to smoking. Although cigarette smoking is the most well studied COPD risk factor, it is not the only risk factor and there is consistent evidence from epidemiologic studies that non-smokers may also develop chronic airflow limitation.
- Genetic factors: a small number of people have a form of emphysema caused by a protein disorder called alpha-1antitrypsin deficiency (AATD).
- Lung growth and development factors: any factors that affect lung growth during gestation and childhood have the potential for increasing an individual's risk of developing COPD, such as low birthweight, early childhood lung infections, abnormal lung growth and development.
- Environmental factors: working or living in areas where there is dust, gas, chemical agents and fumes, smoke or air pollution.
- Other chronic conditions: such as asthma and chronic bronchitis (Australian Institute of Health and Welfare, AIHW).

What are the symptoms of COPD?

The first symptoms of COPD tend to come on slowly and can be very mild. People often mistake their symptoms as signs of ageing, lack of fitness or asthma. Common symptoms of COPD include:

- shortness of breath, especially on exertion
- a repetitive or chronic cough
- increased phlegm or mucus production
- feeling tired
- more frequent chest infections
- longer recovery from cold or chest infection

These symptoms often worsen over time and lead to functional impairment, social isolation and decreased quality of life (Lung Foundation Australia).

In the Gold Coast region, COPD is one of the leading causes of burden of disease, accounting for 4.2% of all deaths in 2019 and was the sixth leading chronic disease contributing to potentially preventable hospitalisations in 2022. The below figures show the current prevalence of active COPD patients living on the Gold Coast:

2.1% Gold Coast First Nations people with a COPD diagnosis	**2.4%** All Gold Coast patients with a COPD diagnosis

Gold Coast PHN Health Needs Assessment (GCPHN HNA), 2023

About this toolkit

General practice is the ideal setting to address identified care gaps for the prevention, diagnosis and treatment of COPD. It is also an ideal setting for primary and secondary prevention and is often the first point of contact for treatment coordination, access to medications, additional tests and referrals to other providers.

This toolkit has been developed to support primary health care services with quality improvement activities including tips, examples and templates to improve outcomes for people living with COPD. This toolkit does not set out to provide a clinical resource for the management of COPD. Such information can be found in the COPD guidelines produced by relevant clinical advisory organisations such as:

- Chronic Obstructive Pulmonary Disease Clinical Care Standard by the Australian Commission on Safety and Quality in Health Care
- COPD-X Handbook by the Lung Foundation

Outcomes of this toolkit

- Enhance patient care and identify measurable and sustainable improvements for COPD management in the practice.
- Gain a clear understanding of your COPD patient population and care pathways for COPD through effective data exploration.
- Successfully implement a COPD Quality Improvement (QI) activity guided by data from the Primary Sense Chronic Lung and Asthma report or other data extraction tools.
- Identify eligible people due for spirometry testing to ensure precise COPD diagnoses
- Increase clinician knowledge and patient awareness of pulmonary rehabilitation for active COPD patients.

Relevance to primary health care

This activity will assist primary health care with:

- Meeting Practice Incentive Program (PIP) Quality Improvement (QI) activity requirements for:
  - QIM 2 – Proportion of patients with a smoking status
  - QIM 6 – Proportion of patients with COPD who were immunised against influenza
- RACGP Standards for general practices 5th edition include a range of requirements relating to QI such as:
  - Criterion QI 1.1 – Quality improvement activities
  - Criterion QI 1.3 – Improving clinical care
  - Criterion QI 2.1 – Health summaries
  - Criterion QI 2.2 – Safe and quality use of medicines
- Meeting the requirements of the COPD Clinical Care Standards

Quality Improvement Activity Summary

This toolkit utilises the Model for Improvement (MFI) framework to plan the activity goal, activity measurement, and improvement ideas.

Weblink: How to Improve: Model for Improvement | Institute for Healthcare Improvement

The improvement ideas in this toolkit are examples only of practical steps to assist with improving primary health care management for people living with COPD. It is recommended to review each activity and select what may be appropriate for your primary health care service to consider undertaking and test using Plan Do Study Act (PDSA) cycles to make sustainable changes and record key learnings for your team.

Example: PDSA Example COPD on page 15
Template: Plan, Do, Study, Act (PDSA) template

Goal of COPD Quality Improvement Activity

Defining the goal of this activity provides your primary health care team with a statement of what you are trying to accomplish. Review the goal below and adjust according to your primary health care service starting point and requirements.

QI Activity Goal:
Our clinic will aim for 90% of patients with COPD to have a spirometry result and GP Management Plan accurately recorded in their medical records within the next 6 months.

Measure – How will you measure the change for this activity?

Regular review of activity measurement enables your primary health care team to assess progress and track whether the change(s) you are testing is leading to an improvement. It is best to measure at the beginning of the activity (baseline) and then at regular intervals throughout.

Example QI Activity Measure:
Use the following measurements to track your improvement activity for this focus area at your primary health care service.

QI Measure	Measure description	Detail
Measure 1: COPD risk factors	% of active patients with COPD who have NOT received an influenza vaccine for the year.	Numerator: # of active patients with COPD who do not have an influenza vaccine recorded for the year. Denominator: # of active patients with COPD.
Measure 2: Spirometry Testing	% of active patients with COPD who have NOT completed spirometry within the past 12 months.	Numerator: # of active patients with COPD who do not have spirometry results recorded within the past year. Denominator: # of active patients with COPD.
Measure 3: Care planning	% of active patients with COPD who have a GP management plan (GPMP) within the last 12 months.	Numerator: # of active patients with COPD who have a GPMP claimed within the last 12 months. Denominator: # of active patients with COPD.

*RACGP defines an active patient as a patient who has attended the practice three or more times in the past two years.
Note: Refer to the next section on how to collect data for this measurement

Quality Improvement Building Blocks

Step 1: Identify your QI team and establish QI activity communication processes

Identify your change team	• Identify the lead and practice team members to drive quality improvement work (e.g. one nurse, GP, admin, PM). Consider allied health, visiting clinicians and others that may form part of the team. • Allocate protected time for the QI team to perform required tasks e.g. 1hr per week. • Ensure that you have identified the "why" as some team members may not see QI as important or necessary. • Plan frequency of planning meetings for QI team • Provide access to project files and related policy and procedures • Schedule a whole team practice meeting to: o Identify QI team members o Agree on the QI plan and prepare for implementation o Demonstrate a team-based approach to meet PIP QI requirements
Consider the roles of the team members	• Ask yourself the question, what motivates a team member to want to be part of sustaining change and making improvements? This is an important step as team members have different skill sets, interests, scope of practice and levels of authority. • Assign roles and responsibilities according to staff skill, interest and position. • Required QI team members for should include: • General Practitioner (GP) • Practice Manager • Administrative team representative • Practice Nurse ** For smaller practices, staff may fulfill multiple roles*
Communication with the practice team	• Identify who will need to be kept informed. • Identify the method(s) that will be used to inform and update all staff of any changes as a result of the QI activity e.g. staff/Clinical/Admin/Nurse meetings, email, noticeboard, group chat. • Ensure all staff are advised of the chosen communication(s) method. • Provide monthly updates to all staff of ongoing changes e.g. add QI to staff/ Clinical/Admin/Nurse meetings. • Allow staff to contribute ideas and provide opportunities for staff feedback.

Step 2: Establish your improvement activity baseline data

Track your improvement over time

Decide how often you will monitor your quality improvement activity (e.g. monthly) and how you will share this data with your team (team newsletters, lunchroom display, team meetings).

What data report to use?

- Primary Sense Chronic Asthma and Lung Report
- Search function in clinical information system

Steps to collect baseline data in Primary Sense

Video: Primary Sense Chronic Asthma and Lung Report

Record your baseline, monthly and completion measurement of your improvement activity here:

Baseline measurement	Monthly measurement	Completion measurement
Baseline percentage:	Month 1:	Activity completion percentage:
	Month 2:	
Baseline date:	Month 3:	Activity completion date:

Get ready to use your data

- Ensure you are on the latest version of clinical software.
- Ensure data extraction tool is functioning correctly.
- Check that team members can log in and are familiar with using Primary Sense or other data extraction tools.

Help: Contact Gold Coast PHN for support: practicesupport@gcphn.com.au

Improvement Idea 1: Identify areas for improvement

The aim of improvement idea #1 is to visually document your current care pathways for patients with COPD and identify any areas for improvement with the goal of effectively managing patients with COPD.

1.1 COPD patient journey

Get together with your practice team and map your general practice workflows and/or patient journey for COPD to identify practice processes and opportunities for improved patient care. This allows everyone to contribute to defining their role in the practice and pinpointing any obstacles or issues that the team can then address as areas for improvement.

This activity will guide you to map your COPD patient's journey to identify gaps and areas for improvements:

- Organise a session with your practice team to map out the patient's journey and practice workflows for managing patients with COPD.
- Start mapping the process by considering who, when and how you diagnose and manage the care of patients with COPD.
- Identify your practice processes and systems to support patients with COPD e.g initial diagnosis, ongoing monitoring, medication management, and acute exacerbation responses.
- Highlight barriers to managing patients with COPD and what steps are needed to address these barriers.

Illustrate each team members roles and responsibilities by creating a map using rows that represents each team member (e.g. Admin, PN, PM, GP, Pharmacist). Allocate each step into the relevant team member row to demonstrate the process workflow between team members.

1.2 Review COPD roles and responsibilities of the general practice team

Now that you have mapped with your team to identify workflows, reflect on the roles and responsibilities of the general practice team for effective management of patients with COPD. Refer to Appendix A for examples of role-based activities.

Improvement Idea 2: Getting your data ready

The aim of improvement idea #2 is to prepare your patient database to enable you to understand your current active COPD patient population.

Before starting any quality improvement project, it is important to review and refine your patient database to ensure health records are accurate, up-to-date, and support the delivery of reliable data.

2.1 Data cleansing

To prepare your patient database, consider the following data cleansing tips:

- Regularly review and update your policy and procedure for deactivating patients (non-attending or deceased) to ensure it is appropriate and consistently applied.
- Establish a routine for inactivating patients, commonly every 3-6 months, based on a clinically determined timeframe (e.g., 2-3 years without attendance). Assign this task, and schedule it in their calendar to maintain continuity during staff transitions.
- Remind reception staff to always search "all patients" when looking up records.
- Consider archiving or inactivating patients individually if they no longer meet the practice's active patient criteria, such as:
    - o Deceased patients.
    - o Duplicate records.
    - o Patients with irrelevant postcodes or out-of-state addresses.
    - o Patients who registered but never attended (e.g., from online bookings).
    - o Patients who have moved away or no longer attend the clinic
- For information on data quality processes including a readiness checklist view the Data Quality and Cleansing Toolkit.

2.2 Accurate recording of COPD diagnosis

There are multiple ways clinical staff enter a patient's diagnosis in clinical information system. Some will type this information directly into the patient progress notes or enter this information as free text in the 'reason for encounter' or 'diagnosis field'. This process is called free texting or un-coded diagnosis which is not easily searchable in any database or third-party software (e.g. extraction tools) and is therefore not the preferred process.

The recommended process is to use the COPD diagnosis from the drop-down boxes provided in the clinical information system, which is classified as a coded diagnosis. This will enable efficient and reliable recall of patients with COPD and make your reporting more reliable. It is important to ensure your coding is consistent and agreed upon by all clinical staff in the practice, so that diagnostic criteria for COPD are uniform.

Consider the following prompts:

Are relevant practice team members aware of the importance of quality data including using consistent coding (avoiding free text)?

Have you agreed on accepted terminology of COPD codes from the drop-down lists in your practice software?

Are practice team members aware of how to enter diagnosis in clinical information system using agreed COPD terminology?

Do you need to clean up un-coded COPD conditions in your practice software?

After reviewing your practices clinical coding guidelines, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?

2.3 Creating a register for patients with COPD

A patient register can be an effective and efficient method to easily identify your COPD patients and how your patients are being managed. To establish a valid patient register you will need to extract patient data from either your clinical information system, or a third-party software by using an extraction tool after you have conducted a database cleansing. Clinical information system and data extraction tools include:

- Practice management software such as Best Practice or Medical Director
- Data Extraction Tools such as Primary Sense, Pen CS Suite, POLAR or Cubiko

2.4 Identify and understand your COPD patient register

Complete the below table by collecting data from your Primary Sense data extraction tool:

Item	Description	Current total	Post QI activity
2.4a	Number of patients with a COPD diagnosis		
2.4b	Number of patients with COPD who have **NOT** completed spirometry within the past 12 months		
2.4c	Number of patients with COPD who have completed spirometry within the past 12 months		
2.4d	Number of patients with COPD who are smokers		
2.4e	Number of patients with COPD who identify as Aboriginal or Torres Strait Islander status		
2.4f	Number of patients with COPD who have **NOT** received an influenza vaccine		
2.4g	Number of patients with COPD who have received an influenza vaccine		
2.4h	Number of eligible patients with COPD who have **NOT** received a pneumococcal vaccine		
2.4i	Number of eligible patients with COPD who have received a pneumococcal vaccine		

Please note: if patient's have not been coded with COPD, then they will not be included in this report.

2.5 Reviewing your practice COPD patient register

Based on the data identified in 2.4, consider the following questions below and what actions would need to be taken:

- Are there any unexpected results with the identified patients with COPD in your practice?
- Are all the COPD measures being recorded in the correct fields in your clinical information system? (e.g.: spirometry results, smoking status, influenza vaccination)
- Are there any patients with indicated COPD but no diagnosis or do not have a spirometry recorded in the past 12 months?
- Are there any patients with COPD who have not received an influenza vaccination this year?
- Are there any eligible patients with COPD who are not up to date with their pneumococcal vaccination?
- Please note how many patients with COPD are smokers from **activity 2.4d**. Does the practice have a plan to review smoking status for these patients' and offer cessation?
- After reviewing your practices COPD profile, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?

Improvement Idea 3: COPD assessment and diagnosis

The aim of improvement idea #3 is to review and improve your current processes for spirometry testing for patients with COPD.

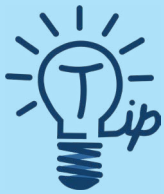
Spirometry is essential to confirm COPD diagnosis. It assesses airflow obstruction and determines the severity of the disease. A formal COPD diagnosis is made through clinical assessment and presence of fixed airway obstruction detected via spirometry.

3.1 Spirometry testing in your practice or externally

During the pandemic, lung function testing infection controls were updated for general practice, including requirements for spirometry testing. In some cases, patients who were required spirometry testing for diagnosis or due for annual testing may not have had a spirometry test conducted. Therefore, these patients may not have any spirometry results recorded.

Consider the following steps to identify patients who are due for spirometry testing and flag them to receive an offer for spirometry testing:

1. Identify if any clinicians including general practitioners or nurses require further education and training in conducting spirometry testing.
2. Identify active COPD patients who do not have a current spirometry test date recorded for the past year from the COPD register created in improvement idea 2.3.
3. Review identified patients records in the clinical information system and check to see if there are any spirometry test results under the 'in-correspondence/results' section as a PFD or image.
    - o Record any results from an image or PDF in the appropriate fields in the clinical information system. See step 3.2 below on how to do this.



Spirometry testing is accessible to patients on the MBS item number 11506

4. Recall patients to the practice who require a spirometry test to book in a spirometry test at the practice or for a referral to an external spirometry service provider. For practices who refer patients to external spirometry service providers, consider the following:
    - What are the current referral pathways you use for spirometry testing?
    - Do these pathways provide timely and reliable results for your patients?
    - Have you encountered challenges or barriers in accessing spirometry services for your patients?
        - o If so, identify these barriers (cost, availability, patient readiness)
    - How do you currently communicate with spirometry service providers to ensure coordinated care?
    - How do you educate your patients about the importance of spirometry testing and ensure their compliance?
    - How will you communicate this information, so clinicians know where to access details on referring a patient to specialist services?

External Spirometry Services on the Gold Coast

- Essential Respiratory & Sleep Australia*
- Queensland Respiratory Services – Pindara* or Gold Coast Private Hospital*
- Respiratory – Lung Function Laboratory – Gold Coast Health
- John Flynn Respiratory Lab*
- Gold Coast Respiratory & Sleep Clinic*
- Gold Coast Lung & Sleep*

** Fees associated*

3.2 Recording spirometry results

In some practice software (e.g. Best Practice and Medical Director), spirometry results are imported from the spirometer's software as an image or PDF rather than as specific coded data (similarly to pathology results). This can mean that information on spirometry results will not be able to be extracted by the Primary Sense extraction tool.

Therefore, it is important that someone in the practice manually enters spirometry results in the appropriate fields in the clinical information system. This information can be useful if you would like to look at whether your patients with COPD have spirometry results in or out of target ranges according to COPD clinical guidelines.

Consider the following questions below and what actions would need to be taken when recording spirometry results in the clinical information system:

- Do relevant team members know where to enter spirometry results in your clinical information system?
- Are spirometry results recorded as values in your clinical information system (not just an uploaded image)?
- Do any team members require training in spirometry? *Applicable to general practices who conduct spirometry
- Do all relevant team members know the MBS item number 11505 and 11506 criteria for completing spirometry?
- After reviewing your practices spirometry use, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?

For further instructions on how to enter spirometry results into Best Practice and Medical Director, refer to Appendix B.

Improvement Idea 4: Establishing appropriate care pathways

The aim of improvement idea #4 is to review your current care pathway processes for patients with COPD and establish new care pathways using evidence-based guidelines.

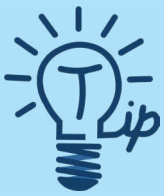
Establishing care pathways for patients with COPD is fundamental for positive long term health outcomes for the patient. These pathways ensure coordinated care between general practices and specialists, reducing hospitalisations and enhancing efficiency. They also promote patient-centred interventions like smoking cessation and pulmonary rehabilitation, improving quality of life, supporting patient self-management via COPD action plans, and addressing key risk factor of COPD.

4.1 Identify patients who are due or missing a current General Practice Management Plan (GPMP)

Patients with COPD are eligible to access subsided chronic disease management care plans under the Medicare Benefits Schedule (MBS). Chronic disease management care plans for COPD include General Practice Management Plans (GPMP) or Team Care Arrangements (TCA).

A GP Management Plan (MBS items 721, 732, 229) can provide an organised approach to care for people with COPD by addressing their specific health needs. A GPMP is a collaborative plan developed between a patient and their GP that identifies the patient's health and care needs, outlines the services the GP will provide, and specifies actions the patient can take to better manage their condition.

For patients with COPD, a GPMP facilitates Medicare-subsidised access to allied health services, such as pulmonary rehabilitation, physiotherapy, and exercise physiology, which are crucial for improving lung function, physical activity, and overall quality of life. When combined with Team Care Arrangements (TCAs), patients may also benefit from coordinated care with other healthcare providers, ensuring a holistic approach to managing their chronic condition.



Consider uploading the Lung Foundation GP Management Plan/Team Care Arrangement template into your clinical information system for consistency and streamlined care planning.

Follow these steps to identify current COPD patients who are due or missing a GPMP:

1. Practice managers or nurses to identify eligible patients via your clinical information system by searching for patients diagnosed with COPD using diagnostic codes or keywords.
2. Filter patients who have not had a GPMP (MBS item 721) created in the last 12 months or a GPMP review (MBS item 732) in the past 6 months.
    a. Focus on patients with frequent GP visits, recent hospital admissions, or exacerbations related to COPD.
    b. Include patients with co-morbidities (e.g., diabetes, cardiovascular disease) that may benefit from coordinated care.
    c. During routine appointments, opportunistically identify patients with unmanaged COPD who could benefit from a GPMP.
3. Highlight identified patients in the COPD patient register to prioritise those at higher risk or with complex needs.
4. Recall identified patients to book in an appointment with the GP and explain the benefits of a GPMP, including access to Medicare-subsidised allied health services such as physiotherapy, pulmonary rehabilitation, or exercise physiology.
5. Ensure that the patient register is maintained to streamline the process of identifying those due for a GPMP or review in the future.



Other MBS items numbers for patients with COPD include

- Nurse chronic disease item number
- Mental health items
- Aboriginal and Torres Strait Islander health assessment
- Home medication review
- Case Conferencing
- 75+ Health Assessment
- MBS telehealth fact sheet

4.2 Create a process for referral pathways to pulmonary rehabilitation

Pulmonary rehabilitation is a six-to-eight-week evidence-based program combining supervised exercise, education, and support to help people with chronic respiratory conditions, such as COPD to improve their physical and emotional well-being. It teaches safe exercise practices, breathlessness management, and strategies for energy conservation, while also improving exercise tolerance, making daily activities easier and increasing independence. Research highlights its effectiveness in reducing COPD exacerbations, keeping patients out of hospital, and fostering long-term lifestyle changes.

On the Gold Coast, there are several pulmonary rehabilitation services available for patients with COPD, with referral information on HealthPathways. To ensure appropriate, timely, and effective care for active patients with COPD, consider implementing the following steps to create a streamline process for referral pathways to pulmonary rehabilitation:

- Identify local services that provide pulmonary rehabilitation on the Gold Coast.
- Ensure relevant clinicians have access to referral pathways such as HealthPathways and ensure they understand how to locate, use information about local pulmonary rehabilitation services and know the minimum referral criteria for referrals.
- Ensure your clinical staff are aware of the benefits of pulmonary rehabilitation and the referral process, emphasising criteria for eligibility and service availability.
- Contact services to confirm referral pathways and eligibility criteria on an annual basis and regularly update practice staff about changes to local pulmonary rehabilitation services or referral requirements.
- Evaluate the referral process periodically to identify and address any gaps or inefficiencies.



This Pulmonary Rehabilitation Referral Form template can be uploaded into your clinical information system and used to refer COPD patients to ocal pulmonary rehabilitation programs.

4.3 Identify patients eligible for referral to pulmonary rehabilitation

After you have identified a strong process for referral pathways to pulmonary rehabilitation, it is important to identify eligible COPD patients. Consider the followings steps to Identify patients eligible for referral to pulmonary rehabilitation:

- Based on clinical guidelines, use the COPD patient register to review and identify patients' who would benefit from rehabilitation. When reviewing the COPD patient register consider patients that have:
  - o poor spirometry results such as spirometry-confirmed airflow limitation,
  - o patients experiencing functional limitations, breathlessness or
  - o patients with reduced quality of life due to COPD or recent hospitalisations for exacerbations.
- Recall identified patients to the practice or engage with them during consultations to educate them on the importance of pulmonary rehabilitation. Highlight its benefits, including improved lung function, enhanced physical capacity, and better quality of life.
  - o Address any barriers with the patient such as transport or scheduling difficulties, to facilitate attendance.
- Complete the referral form required by the rehabilitation provider and include relevant clinical information, such as diagnosis, spirometry results, medications, and any recent exacerbation history and submit via preferred method.

Video: Refer patients via Gold Coast HealthPathways

- Confirm that the patient has been contacted by the pulmonary rehabilitation service and has scheduled an initial appointment by following up with the patient via SMS or phone call one week after referral.
- Request feedback from the rehabilitation provider to assess patient engagement and outcomes.
- Review progress during follow-up consultations and adjust care plans as needed.

Gold Coast pulmonary rehabilitation services available

- Gold Coast Health Pulmonary Rehabilitation Education and Exercise program
- Lungs in Action - City of Gold Coast*
- Gold Coast Community Health - Robina
- Respiratory (Program) (Service) Refer Your Patient – Queensland Health
- Gold Coast Community Health – Helensvale
- Self Management of Chronic Conditions (SMoCC) service

**** Fees associated***



You can incorporate the referral into a GPMP or Team Care Arrangement (TCA) for Medicare-subsidised access to allied health services.

PDSA Examplars

PDSA Exemplar 1: Patients due for spirometry testing
PDSA Exemplar 2: COPD Patients and Influenza
PDSA Exemplar 3: Importance of a COPD Action Plan

Finishing points

Sustainability check list – maintaining the change

Cyclical nature of PDSAs- Adopt, adapt, abandon	• Adopt: excellent work, embed that change. • Adapt: determine if a change is needed to the plan and start a new PDSA. • Abandon: Rethink the next PDSA • Lessons can be learned from PDSAs that are abandoned. Keep a record of learnings.
Document your improvement activity	**Record your competed QI activities to meet PIP QI guidelines:** • Record your completion. • Documentation must be kept for 6 years for evidence of PIP QI if your practice is audited by the Department of Health and Aged Care.
Sustaining project outcomes.	**Consider which practice documentation may need to be updated to include the change:** • Updates to Policy and Procedure manual. • Specific task procedures. • Local signs or instructions. • Staff work practices. • Position descriptions. • Staff induction. • Staff skills development or education.
Communication is key to finishing a successful project	**Consider:** • QI project outcome feedback to staff. • Discuss project strengths and challenges. • Feedback to patients, where appropriate. • Consider Incorporating this as part of your practice preventative health care promotion activities.
Celebrate success	• Celebrate your outcomes and achievements by sharing a with a morning tea with your team. • Consider sharing your practice improvement activity efforts with your patients through practice newsletters, website or waiting room. E.g. displaying 'run charts' to demonstrate • change over time.
Review and reflect	• Discuss project strengths and challenges. • Annually review the PDSA outcomes to ensure activities are still being adhered to and completed. • Annually review and audit your data related to this activity. Identify gaps, areas for improvement and set new targets if needed. • Where to next on your continuous QI journey? • Consider potential topics for a new CQI activity, and how your experience with this activity can help you to be more efficient and effective.

Appendices

Appendix A - Roles and reposibilites of pratice team members

- Your practice team being aware of their roles and responsibilities in relation to vaccinations is critical.
- Create a list of roles and responsibilities for each person involved.
- Communicate this information to the whole team in a team meeting.

General Practitioners

- Provide clinical oversight and governance of the activity.
- Confirm COPD diagnosis through spirometry and clinical assessment
- Develop, implement, and review a personalised COPD management plans including GPMP and TCA.
- Prescribe and adjust medications, including bronchodilators and corticosteroids, as needed.
- Refer to specialists such as respiratory specialists, pulmonary rehabilitation or allied health professionals when necessary.
- Monitor disease progression and comorbidities, ensuring regular follow-ups.

Practice Nurses

- Support the GP in creating and implementing care plans, such as GP Management Plans (GPMPs) and Team Care Arrangements (TCAs).
- Teach patients about medication use (e.g., inhaler techniques), symptom management, and lifestyle changes (e.g., smoking cessation, physical activity).
- Conduct spirometry tests under the GP's guidance to aid diagnosis and monitor lung function.
- Administer influenza and pneumococcal vaccinations to reduce the risk of respiratory infections.

Practice Manager

- Ensure the QI Team have access to Primary Sense desktop to review relevant reports.
- Analyse practice data.
- Identify the best way to share and monitor the QI PDSA's with the whole practice team.
- Identify and support implementation of training for the QI and practice team.
- Establish and oversee recall/reminder systems.
- Monitor progress against QI activity, adjust approach if progress towards goal is not being achieved.
- Review and update new systems to ensure sustainable change.
- Document policy and procedures and support implementation across the team.
- Provide protected time for nursing staff to complete free online CPD accredited training.
- Provide protected time for the quality improvement lead team to completed activities.

Reception Staff

- Order and maintain supplies of resources (e.g. patient information, COPD programs and community resources).
- Display brochures and posters in high visibility areas within the practice
- Support the implementation of the activity.
- Provide support to generate data reports.
- Support the practice team to identify patients eligible for relevant reminders and contact patients either via letter, text message, phone call, etc.
- Schedule regular follow-ups and long appointments
- Provide information on available.

Medical and Nursing students (if relevant)

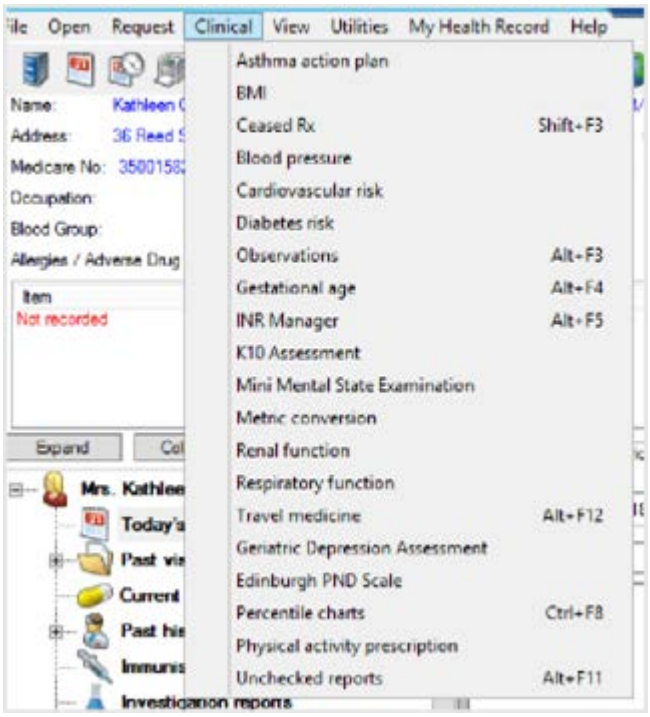
- Consider tasks that medical or nursing students could implement during clinical placements to support your QI activities.

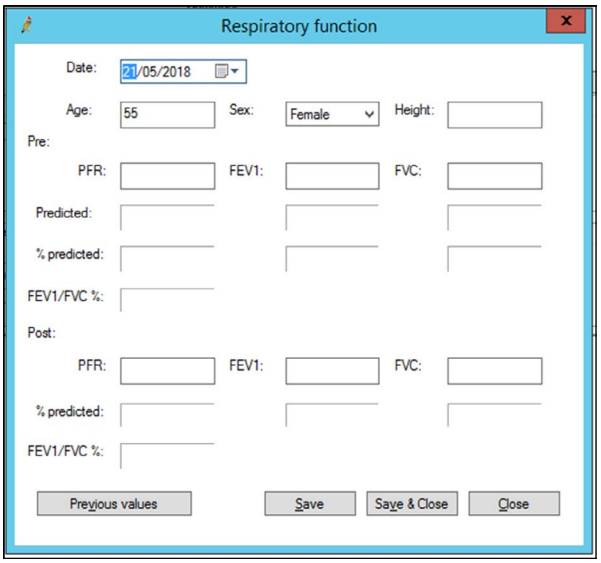
Appendix B - Instructions on entering spirometry results

In Best Practice

To enter patient spirometry results in Best Practice:

1. Open patient file.
2. Select **Clinical** from the menu and select **Respiratory Function.**
3. The Respiratory function screen will then appear. Enter the values in as appropriate. Save and close once complete.

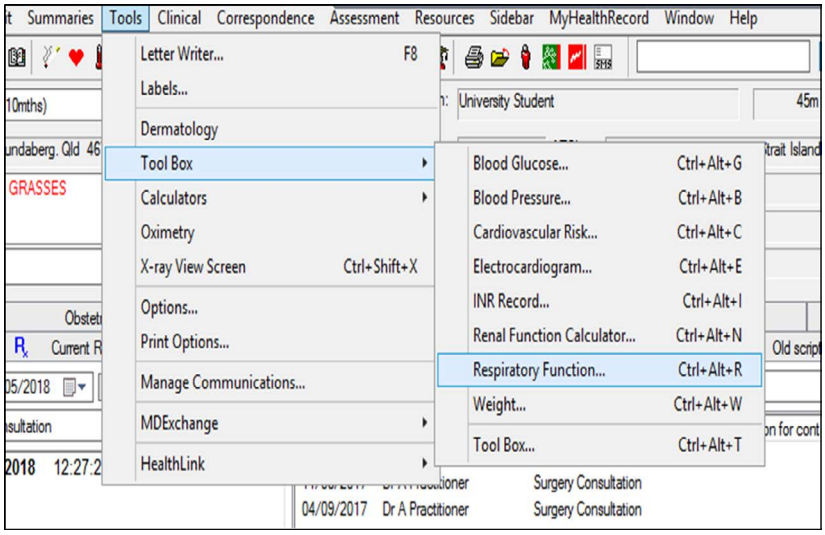


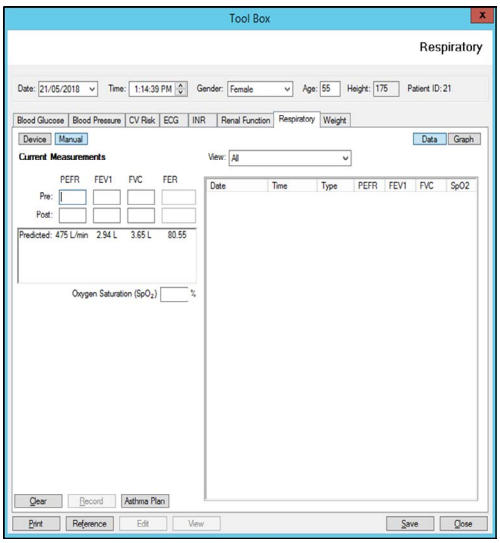


In Medical Director

To enter patient spirometry results in Medical Director:

1. Open the patient's file.
2. From the menu select Tools, Tool Box & Respiratory Function.
3. The Respiratory Tool Box will appear. Enter the patients results from the spirometry result
4. Click Save.





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NATIONAL IMPROVEMENT NETWORK COLLABORATIVE

An Australian Government Initiative

Level 1, 14 Edgewater Court Robina QLD 4226 | PO Box 3576, Robina Town Centre QLD 4230
P 07 5635 2455 | E ninco@gcphn.com.au | W www.ninco.com.au

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