|  |
| --- |
| Practice: |
| Lead GP/PN: |
| Date plan to be implemented:  |
| Date plan to be reviewed: |

Title

Overview of the project. For instance: we will review and enhance team work within the practice / clean clinical data of patients with chronic disease / improve management of patients with COPD / target patients at risk of diabetes, increase number of encounters with. And the purpose of the project, what we wish to achieve or change. For instance, provide interventions that improve biometric measures / increase patients’ capacity to self-manage lifestyle factors / meet accreditation standard / maximise income from MBS, etc.

Rationale

Evidence of the need for this project in our practice. For instance: state or national or local data showing prevalence of disease or problem / Pen CAT data shows need for improved recording or management of the target group / special interest of provider or practice team members / opportunity offered by funding grant.

Goal *Sample only – adapt wording to suit*

1. Improve the quality of our data on patients at risk of XX, through consistent coding of clinical values and using appropriate tools such as assessment templates provided by MD / BP.
2. Improve our capacity to identify patients at risk of XX, evaluate their level of risk and offer lifestyle interventions.
3. Provide best practice care for patients at risk of XX and maximise MBS and incentive payments.

Target patient population [tick as applicable] *Sample only – adapt wording to suit*

[ ]  All patients presenting opportunistically aged XX years

[ ]  Active patients on the database aged XX years

[ ]  Active patients on the database aged XX years who smoke

[ ]  Patients identified and flagged by GP lead

Method

* Adapt and amend the suggested plan (over) to suit your practice.
* Decide how long to work on the project (e.g. 9-12 months).
* Decide when to review the project (e.g. mid-way / 6 months).
* Break the project into small tasks and use a PDSA (see over) or similar template to: describe each task in turn
* decide how to measure if the task is successful / completed (e.g. data / feedback)
* allocate who / when / where to the task
* undertake the task, measure and assess it
* repeat if necessary or progress to the next task

|  |  |  |
| --- | --- | --- |
| **Actions and tasks**  | *Sample only – adapt wording to suit* | **Responsible** |
| 1. Clean patient data
 | * Establish baseline data and enter on review sheet overleaf:

Use software or Pen CAT to generate the number of patients aged XX years, who do not have XX condition, and who have not had a XX Assessment in the past XX years, i.e. not claimed MBS item XXUse software or Pen CAT to generate the number of MBS item XX claims made for patients aged XX years, who do not have … condition, and who have had a XX Assessment in the past XX yearsUse Pen CAT “recipes” available at [http://help.pencs.com.au/display/CR/CAT+RECIPES](http://help.pencs.com.au/display/CR/CAT%2BRECIPES) Agree on a protocol for using clinical software and keeping data consistent and accurate. Write and add this protocol to the practice manual. | Admin PM / PN |
| 1. Resources for waiting & treatment rooms
 | * Conduct a ‘campaign’ from time to time on this topic and encouraging patients to discuss (lifestyle interventions) with the PN / GP.
* Order the (relevant posters, brochures, surveys, assessment tool) from website XX
* Apply practice stamp / action note to resources
* Order free waiting room resources from Diabetes Australia Vic to promote the Life! program: [www.lifeprogram.org.au](http://www.lifeprogram.org.au)

Order relevant PHN resources | Admin / PM |
| 1. Identify target patients

(e.g. patients aged XX years, with NO diagnosed XX) | *Opportunistic Approach** Review appointment list and flag patients in target group; provide patients with assessment form to complete while waiting. Patient to hand form to GP / PN for discussion or put name on form and place in tray for follow up as below.

GP / PN to identify patients at-risk during consultation and complete assessment in clinical record and flag for follow up. | PN / GP |
|  | *Planned Approach** Allocate a staff member and time to search clinical database or Pen CAT for target patients; mail letter of offer, with brochure, assessment form, signed pathology etc as relevant. Make follow-up calls; invite patients with high score to attend practice.
 | Admin / PN / GP |
| 1. Assessment follow up
 | * If the result is XX advise patient to repeat in 3 years; if XX then provide lifestyle advice and recall in 12 months.
* If score risk is high (or whatever applicable) arrange XX. And undertake MBS initiative XX

Arrange next step according to XX results.  | PN / GP |
| 1. Undertake (eg health assessment)
 | * This assessment is available to (eligibility criteria)
* Discuss risk with pt, provide information, discuss lifestyle and behaviour changes (flag next step); initiate interventions and/or referrals (see below). See Fact sheet and pt resources at (link)

Claim MBS item XX depending on XX | PN / GP |
| 1. Provide (eg Lifestyle Modification advice)
 | * Recommend (for example) pt attends a lifestyle modification program costs:

*Life!* Program: free group sessions or phone coaching. See [www.lifeprogram.org.au](http://www.lifeprogram.org.au) for eligibility and referral procedure. HEAL program or similar at patient’s local community health centre. See also [www.healthylivingnetwork.com.au](http://www.healthylivingnetwork.com.au)Or provide ‘in-house’ lifestyle modification education. See resources at [www.healthinsite.gov.au](http://www.healthinsite.gov.au) or your clinical software or [SNAP](http://www.racgp.org.au/your-practice/guidelines/snap/). | PN / GP / allied health |
|  |  |  |
|  |  |  |

|  |
| --- |
| Practice: |
| Lead GP/PN: |
| Date plan to be implemented:  |
| Date plan to be reviewed: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Actions / tasks review** | **6 months prior to project** | **6 months into project** | **Comments / Progress / changes** ***(time allocated vs time used; success in identifying and targeting patients; ability to keep track of patient progress; uptake of templates & tools, etc.)*** | **Who / When** |
| Number of x interventions completed (as per Action 1) |  |  |  |  |
| Number of forms/surveys etc completed (add paper and online) |  |  |  |  |
| Number and/or percentage of MBS items claimed |  |  |  |  |
| Increased income generated (MBS / other) if applicable |  |  |  |  |
| GP role in XX strategy and level of satisfaction |  |  |  |  |
| Nurse role in XX strategy and level of satisfaction |  |  |  |  |
| Patient uptake of assessment / LMP referrals / interventions |  |  |  |  |
| Other |  |  |  |  |

Plan Do Study Act (PDSA)

PDSA Title:

|  |  |
| --- | --- |
|  | **Goal** *What are we trying to accomplish?* |
|  |
|  | **Measure** *How will we know that a change is an improvement?* |
|  |
|  | **Idea** *What can we do to achieve the goal?* |
|  |
|  | **Plan** *Who? When? Where? Predictions? Data to be collected.* |
|  |
|  | **Do** *Was the plan executed? Any unexpected events or problems?* |
|  |
|  | **Study** *Analysis of actions and data. Reflection on the results* |
|  |
|  | **Act** *What will we take forward; what is the next step or cycle?* |
|  |

We acknowledge the peoples of the Kulin nation as the Traditional Owners of the land on which our work in the community takes place. We pay our respects to their Elders past and present.

