Continuous Quality Improvement

WORKBOOK FOR GENERAL PRACTICE

Closing the Gap

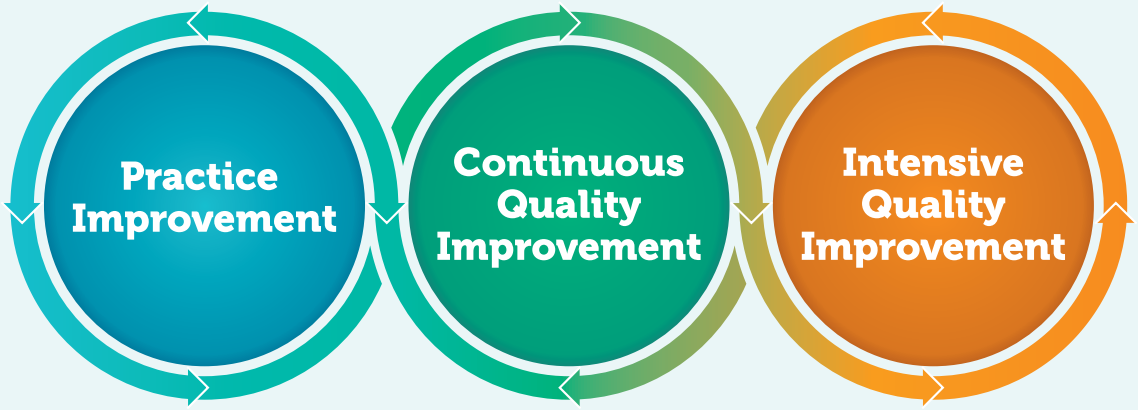
phn NORTH WESTERN MELBOURNE

An Australian Government Initiative

EDITION 1 | OCTOBER 2021

A new model for general practice improvement

Our aim is to strengthen primary care to deliver integrated person-centred care that is comprehensive, accessible, safe and coordinated. Our new model has three modules of engagement. Your level of engagement will depend on your needs.



Focused on developing systems for quality improvement.

Focused on data-driven improvement. For accredited practices that share data and are new to quality improvement, or confident to implement quality improvement at their own pace.

A time-limited intensive facilitated quality improvement project for practices who want to further improve patient, clinical and whole of practice outcomes.

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Illustrations by Sketch Group – pages 3, 5, 7, 10, 12, 20, 26, 32, 40, 44, 47, 48 and 51.

Artwork on page 41 by Lynette Briggs of the Wiradjuri – Yorta Yorta people.
Titled 'Walking together'.

Contents

From little things, big things grow

This workbook will show you how to do the 'little' things on the way to achieving the 'big'.

This workbook will show you how to do the 'little' on the way to achieving the 'big'.

It's a clear, four-step guide that draws on a proven approach, the Model for Improvement, with expert advice and resources specific to Closing the Gap.

The four steps in this Continuous Quality Improvement Workbook are:

Step 1: Understand Closing the Gap

Step 2: Analyse data, set goals and brainstorm potential improvements

Step 3: Create a plan and act on it, following the 'plan, do, study, act' cycle

Step 4: Evaluate and celebrate

These steps are complemented by links to resources and a comprehensive set of Appendices (page 41) covering:

- Quality improvement and RACGP Standards (5th ed.)
- Sample of goals
- Clinical software guides and sample forms
- 'Plan, do, study, act' worksheet sample and template

Using the Model for Improvement, you will learn how to start small, then systematically review, refine and re-test your Quality Improvement ideas as necessary before implementation across the practice. You will find samples in Appendix 5 and a template for this system in Appendix 6.

It is a low-risk, high-return approach, and you will have solid data to prove your achievements. But be warned – it is likely the process will not end there for your practice. Quality improvement can be a hard habit to shake.

Quality improvement (QI) workbooks

This workbook is part of a collection created by North Western Melbourne Primary Health Network (NWMPHN) to help general practices undertake self-directed quality improvement in a particular area of work, type of clinical practice or population group.

The workbooks have been created **by** general practice, **for** general practice, with input from NWMPHN teams and subject-matter experts, and through consultation with the community and the broader primary care sector.

They are designed to meet the particular needs of providers, patients and priority populations in the NWMPHN area. Links to appropriate local referral pathways are also included.

See a full list of CQI workbooks on the NWMPHN website.

Before you start

The workbooks are designed to supplement the Quality Improvement Guide and Tools, **which we recommend reading first**. We have also included a primer below about the Model for Improvement (MFI), to refer back to while using the workbook.

About this workbook

This workbook is created as an interactive PDF. You can complete the tables in the book for your Priority 1 activity. Templates in the Appendix can be used for subsequent Priorities.

To complete this workbook, you will ideally use Adobe Acrobat or a similar compatible program to fill out the forms. If you add more content than what will fit in the text box, the text box will allow scroll for additional content to be added. Additional text will be shown with a + on the bottom of the panel. Please note that this additional content will not appear, however, if you print the document.

Your answers use only simple text formatting. You can paste into the text areas.

The Model for Improvement (MFI)

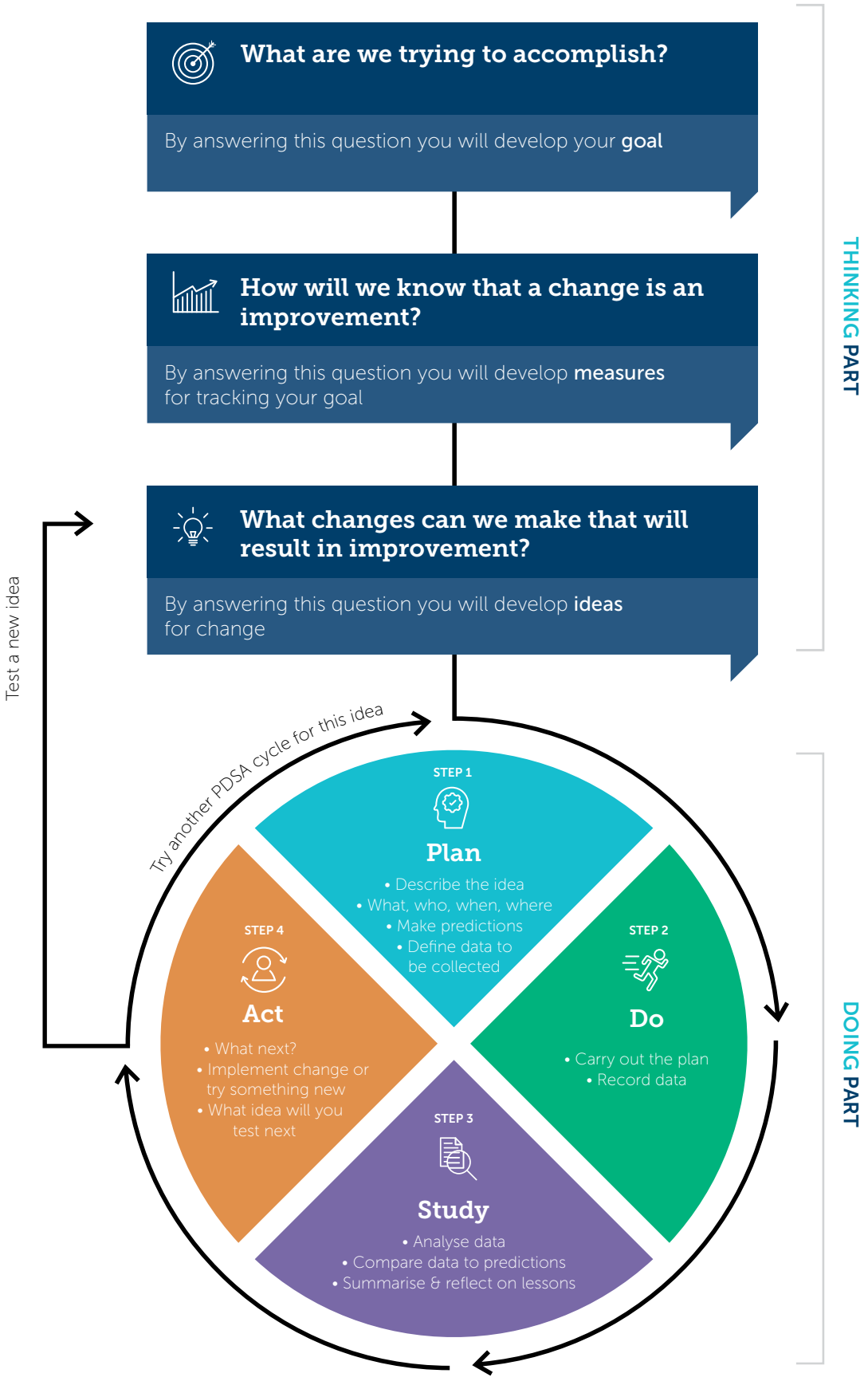
This is an evidence-based approach endorsed by leading health bodies, including the Royal Australian College of General Practitioners (RACGP) and the Institute for Healthcare Improvement (IHI).

It is easily applied and requires no specialist skills or background. It also has the advantage of encouraging both individual creativity, and collegiality and collaboration.

Starting small is key, with change broken down into manageable pieces. Within your practice, this not only helps to reduce clinical and administrative risks, but also to foster unity within the practice team and avoid resistance to change. Proven changes can then be implemented more widely across the practice, while refined or new ideas can also be run through the mill.

As illustrated in Figure 1, MFI comprises a 'thinking part' and a 'doing part'. In the 'thinking part', you step through 'Goal', 'Measure' and 'Idea' (GMI). The 'doing part' consists of the 'Plan, Do, Study, Act' (PDSA) cycle. It's not a linear process – the idea is to cycle back and forth through both parts as often as required.
(See Videos on the Model for Improvement in this workbook.)

Figure 1: The Model for Improvement and the Plan, Do, Study, Act cycle



General practice considerations

Quality improvement in general practice can address one or more of the following:

- **Safety** – Avoiding harm to patients
- **Effectiveness** – Providing evidence-based care and only providing s ervices likely to be of benefit
- **Patient-centricity** – Providing care that is responsive to individual patients' preferences, needs and values
- **Timeliness** – Reducing waiting times for care and avoiding harmful delays
- **Efficiency** – Avoiding waste
- **Equity** – Providing care of the same quality regardless of personal characteristics such as gender, ethnicity, location or socio-economic status

Benefits and outcomes of QI are often categorised into four areas, as shown in Figure 2. Change that results in benefits across all four areas are said to have met the 'Quadruple Aim'' – a useful target to keep in mind when developing your ideas.

Figure 2: The 'Quadruple Aim'' for general practice

Improved Patient Experience

Better care: safe, quality care

Timely and equitable access

Patient and family needs met

Improved Provider Experience

Increased clinician and staff satisfaction

Leadership and teamwork

Quality improvement culture in practice

Population health

Better health outcomes

Reduced disease burden

Improvement in physical and mental health

Sustainable Cost

Efficient and effective services

Increased resources for primary care

Commissioning effectively

Links with PIP, accreditation and professional development

This workbook can be used by practices and individual professionals as evidence for:

- Practice Incentive Payment Quality Improvement (PIP QI)
- RACGP accreditation standards
- RACGP continuous professional development points

Appendix 1 has detailed information about how quality improvement activities included in this workbook can be used as evidence for RACGP continuing professional development (CPD) points for GPs and RACGP accreditation, including requirements relating specifically to Closing the Gap.

Support from NWMPHN

For further support on implementing continuous quality improvement activities at your practice, contact your relationship manager at NWMPHN on (03) 9347 1188 or email primary.care@nwmphn.org.au

The use of the CAT4 data extraction tool

CAT4 is a data extraction tool which extracts and summarises key information about your practice population. It is compatible with a number of medical software systems and NWMPHN provides general practices with free access to the tool. These booklets primarily utilise CAT4 as a main source of data, however you are not precluded from undertaking quality improvement work if you do not have CAT4. There may be opportunities to extract the same data (or a modified version of it) directly from your clinical system. If you need assistance, contact your NWMPHN relationship manager.

Your four steps to improvement

Step 1 Understand Closing the Gap

Closing the Gap began as a response to the significant inequality in health and wellbeing experiences by Aboriginal and Torres Strait Islander people.

It is a call to governments to commit to equality for Aboriginal and Torres Strait Islander people in health and life expectancy within a generation. In order to address these health inequalities there is a need to:

- strengthen and integrate primary healthcare,
- improve identification of Aboriginal and Torres Strait Islander patients,
- improve resource allocation and health service delivery,
- subsidise medication, and
- provide a well-trained and culturally safe health workforce.

Primary care providers have an important role in *Closing the Gap* including patient identification, chronic disease prevention and management, and delivery of culturally appropriate care.

Health and wellbeing

Aboriginal health is more than just the physical wellbeing of an individual. Aboriginal health refers to the social, emotional and cultural wellbeing of the whole community – in which each individual is able to achieve their full potential, bringing about the total wellbeing of their community. Wellbeing may include language, culture and spirituality; belonging and identity; strength of community and family; living conditions and lifestyle; economy; mental health; and empowerment and control.

The ongoing impact of colonisation and the separation of Aboriginal and Torres Strait Islander people from their family and country impacts the individual and collective health and wellbeing.

To approach the health and care of Aboriginal and Torres Strait Islander peoples by only treating illness excludes the promotion and consideration of wellbeing. To improve Aboriginal and Torres Strait Islander health and wellbeing for individuals and communities, patients need to be treated with respect, included in decision making, and supported to understand their illness and treatment and, health/wellbeing should be addressed holistically in a culturally safe manner.

For more information read the Victorian Government's 2017 Aboriginal health, wellbeing and safety strategic plan 2017-2027 – Korin Korin Balit-Djack, or the National Aboriginal and Torres Strait Islander Health Plan 2013-2023.

Use HealthPathways Melbourne to research Closing the Gap

HealthPathways Melbourne (melbourne.healthpathways.org.au) is an online resource that gives clinicians up-to-date, localised clinical and referral information.

HealthPathways Melbourne provides clear, concise guidance for assessing and managing patients with particular symptoms or conditions, as well as outlining the most appropriate referral pathways.

If this symbol is at the top of a HealthPathways it indicates that the pathway contains information specific to Aboriginal or Torres Strait Islander people.

We recommend reviewing the following pages before you start:

- Aboriginal and Torres Strait Islander health
- Closing the Gap – Improving health outcomes for Aboriginal and Torres Strait Islander people
    - Aboriginal and Torres Strait Islander services directory
    - Integrated Team Care Program
    - CTG scripts and allied health services
    - Cultural sensitivity training
    - Health assessment for Aboriginal and Torres Strait Islander people (MBS Item 715)
    - Practice Incentives Program Indigenous Health Incentive (PIP-IHI)
- Principles for care provision for Aboriginal and Torres Strait Islander peoples
- Aboriginal hospital liaison officer

How do I access HealthPathways Melbourne?

HealthPathways Melbourne access requires a username and password. Request access online or complete this form to request automatic login.

To receive the monthly HealthPathways Melbourne Bulletin, email info@healthpathwaysmelbourne.org.au

Access is limited to health professionals in the North Western and Eastern Melbourne PHN catchments.

Step 2 Work as a team to collect data and develop goals

Now you've done your background research, it's time to establish a brains trust and start examining ideas. By the end of this section, you'll be able to answer these key questions:

Goal

What are we trying to accomplish?

Measure

How will we know that a change is an improvement?

Idea

What changes can we make that will result in an improvement?

Team up

Evidence shows that improvement is most likely when all staff support change, so adopt a whole-of-team approach from the outset.

Form a QI project team

Your project team should include representatives from your whole-of-practice team. It might include your practice manager, reception and other administrative staff, nursing staff, GPs and allied health practitioners.

For each project, you will need at least two project leads:

1. A lead GP or nurse to inform any clinical content
2. Another person in your team capable of managing the project, who will be given allocated time to complete the work required

As your practice becomes more experienced with quality improvement, you may consider including an Aboriginal or Torres Strait Islander person in your project team – they can provide great insight from a patient perspective, particularly if the focus of your QI activities includes measuring and improving patient experience. The Quality Improvement Guide and Tools provides more ideas on how to include patients in your QI activities.

Download the NWMPHN Team Health Check PDSA* and Improvement Foundation's Team Health Check Score Sheet* to help you assess your team culture and identify roles and responsibilities. Along the way, you might also identify team members who might resist change, as well as potential issues or matters to address before your project begins.

**Documents will download directly from the links*

Collect baseline data

There is a saying that 'What gets measured gets done'. Collect and collate as much relevant data as you can, this will help you accurately assess the current situation and pinpoint exactly where you want to improve. It will also give you a 'baseline' against which success (and failure) can be measured objectively.

Some baseline data is straightforward, such as clinical data retrieved from CAT4 searches. By contrast, information such as 'staff knowledge' or 'patient experience' is harder to measure but may be no less important.
(See Videos on the Model for Improvement on page 40.)

Activity Table 1 will help you collate your baseline data.

Baseline data may include, but is not limited to:

- CAT4 data
- practice system audits
- environment audits
- measurement of patient experience
- measurement of staff experience
- measurement of current staff knowledge and confidence.

Note too, that NWMPHN will also send quarterly reports to practices on their performance in relation to the Improvement Measures, and in relation to the aggregated performance of other NWMPHN general practices. This information may also be useful in establishing your baseline data.

Stop and 'cleanse' your data

'Clean' data going in means 'clean' data coming out. Guides for undertaking a 'data cleanse' include:

- CAT4: Pen CS Data Cleansing Guide
- Medical Director: Data cleansing in Medical Director (Sydney North Health Network)
- Data cleansing in Best Practice: Best Practice's data clean up guide or Sydney North Health Network's Best Practice Data Cleansing Guide
- A Quality Improvement activity: Data Cleansing QI Activity (North Western Melbourne PHN).

Activity Table 1: Collating baseline data

Item	Question/Measure	Assessment of activity/status Today Date:	3 months ago *(if possible)* Date:	6 months ago *(if possible)* Date:
1	**Is this practice registered for the Practice Incentive Program – Indigenous Health Incentive (PIP IHI)?** Number of staff (GP/other) who have complete cultural awareness training (required within one year of registration of PIP IHI). **Data Source:** HPOS **Best practice/Gold Standard:** Services Australia – Indigenous Health Incentive Guidelines	○ Yes ○ No	N/A	N/A
2	**Does our practice have a welcoming environment for Aboriginal and Torres Strait Islander people?** **Data Source:** NWMPHN – Aboriginal Health HealthWest – Health and Community Services Audit **Best practice/Gold Standard:** Victorian Government – Aboriginal and Torres Strait Islander cultural safety framework	○ Yes ○ No	N/A	N/A
3	**Number of patients who have their Aboriginal and Torres Strait Islander status recorded** **Data Source:** CAT4 Extraction Tool, Topbar **Best practice/Gold Standard:** RACGP – Identification of Aboriginal and Torres Strait Islander people in general practice 75%, see RACGP Standards for General Practice (5th ed.) – Indicator QI 2.1>B			

Activity Table 1: Collating baseline data (continued)

		Assessment of activity/status		
		Today	**3 months ago** *(if possible)*	**6 months ago** *(if possible)*
Item	**Question/Measure**	**Date:**	**Date:**	**Date:**
4	**Number of eligible patients who have a completed 715 Aboriginal Health Assessment in the last 12 months** **Data Source:** CAT4 Extraction Tool, Topbar **Best practice/Gold Standard:** RACGP – National guide to a preventative health assessment for Aboriginal and Torres Strait Islander people			
5	**Number of Aboriginal and Torres Strait Islander patients being followed up by our practice nurse or Aboriginal and Torres Strait Islander health practitioner after a health assessment 715** **Data Source:** CAT4 Extraction Tool **Best practice/Gold Standard:** Maximum 10 services per calendar year, see Australian Government Department of Health Fact Sheet Item 10987			
6	**Number of patients referred to allied health services following from claiming 715 MBS item number** **Best practice/Gold Standard:** Maximum 5 services per calendar year, see Australian Government Department of Health Fact Sheet Item 81300-81360 Follow up referral form		N/A	N/A
7	**Number of Care plans, Team Care arrangements and Reviews for Aboriginal and Torres Strait Islander patients** **Data Source:** CAT4 Extraction Tool, Topbar **Best practice/Gold Standard:** Minimum claiming 12 months, see Australian Government Department of Health MBS Item 721 and Item 723		N/A	N/A

Activity Table 1: Collating baseline data (continued)

		Assessment of activity/status		
		Today	**3 months ago** *(if possible)*	**6 months ago** *(if possible)*
Item	**Question/Measure**	**Date:**	**Date:**	**Date:**
8	**Number of Aboriginal and Torres Strait Islander patients are being followed up by our Practice Nurse or Aboriginal and Torres Strait Islander health practitioner after a health assessment 721 & 723** **Data Source:** CAT4 Extraction Tool, Topbar **Best practice/Gold Standard:** Maximum 5 services per calendar year, see Australian Government Department of Health MBS Item 10997		N/A	N/A
9	**Number of patients referred to allied health services following from claiming 721 & 723 MBS item numbers** **Best practice/Gold Standard:** Maximum 5 services per calendar year, see Australian Government Department of Health		N/A	N/A
10	**Number of Aboriginal and Torres Strait Islander patients referred to the Integrated Team Care (ITC)** **Best practice/Gold Standard:** NWMPHN – Indigenous Australians Health Program – Integrated Team Care		N/A	N/A
11	**Number of patients registered for PBS co-payment measure for chronic patients or at risk** **Data Source:** HPOS **Best practice/Gold Standard:** Services Australia – Closing the Gap, PBS co-payment for health professionals		N/A	N/A

Add any other measures you think are relevant including any patient feedback you already have in hand – this is valuable baseline data!

Reflect on the data

Reflect on the information you've compiled. You might consider the following questions:

- How does your performance compare to Best Practice/Gold Standards (where available above)?
- Does any data surprise you?
- How does the data compare from year-to-year? Can significant differences be explained?
- Are there clear areas for improvement that could form the basis of your QI project?

Based on this discussion, identify and prioritise key areas for improvement using Activity Table 2.

Remember – You don't need to improve in all areas at once. You might decide to concentrate on one measure at a time. How you do this is up to you. You can pick and choose ideas in this workbook to suit the approach that best meets your practice's needs.

Activity Table 2: Analysing baseline data

Item	Identified area for improvement	Number each in order of priority for improvement (i.e. 1, 2, 3, etc.)
1		
2		
3		
4		
5		
6		

Completed by:	Date:

Set a goal

Now that you have identified the top priority area for your practice, the next step is to work together to set a goal for this area. Goals should be 'SMART', so ask if each goal is:

- **Specific** – Does the goal say exactly what we want to achieve?
- **Measurable** – Have we included a measurable target, such as 'to increase annual ACR rates to 75 per cent', or 'to achieve 100 "at risk of diabetes" 40 to 49-year-old health checks'?
- **Achievable** – Is it likely our practice will be able to accomplish the goal?
- **Relevant** – Does the goal align with our practice's broad vision and aims?
- **Time-based** – Do we have a clear deadline for achieving your goal? (Deadlines should be challenging but realistic.)

See Appendix 2: Sample goals for Closing The Gap.

Describe your goal

Once you have established your first goal, describe it in more detail in Activity Table 3.
(This table will also be used for any subsequent goals.)

Activity Table 3: Setting your SMART goal for a priority area

Our priority for improvement is:	**Our target population is:**
Our goal is to:	**Check that the goal is:** ☐ Specific ☐ Measurable ☐ Achievable ☐ Relevant ☐ Time-based

We will use the following measures to know if we've been successful:

Measure:	Source:
Measure:	Source:
Measure:	Source:
Measure:	Source:
Measure:	Source:

*add more as appropriate

We want to achieve our goal by:	**We will collect our measures every:** For example: 1st of the month, two months, quarter, six months.

Brainstorm ways to achieve your goal

Now use Activity Table 4 to list activities that might help your practice achieve its goal or goals. Activities might include, but are not limited to:

- Staff training and education
- System changes
- Workplace/environmental changes
- Regular reviews/audits/meetings

There is no minimum or maximum number of activities. As a guide, we have provided room to record six.

See brainstorming tools for identifying a change idea, recommended by IHI, including:

- Affinity Tool
- Five Whys
- Driver Diagram
- Flow Chart
- Cause and Effect (Fishbone)

Activity Table 4: Brainstorm of ideas for implementing change

Idea no.	Activity	Expected outcomes
1		
2		
3		
4		
5		
6		

Completed by:	Date:

Sample activities for Closing the Gap

Adjust these sample activities to suit your needs, strike-off those you've already done, or develop your own activities.

General

These activities could apply to any goal:

- Discuss the Closing the Gap program at the next all staff meeting including rationale, targets, activities, and roles. Invite ideas for any activities which may help achieve the goal. Add it to regular meeting agendas.
- Discuss the Closing the Gap at the next clinical meeting, to address clinical-specific issues and tactics.
- Add an update to the staff notice board in lunchroom about this project, the aim, our starting position and update on outcomes (use graphs to demonstrate improvement over time).
- Ensure that Aboriginal and Torres Strait Islander status is recorded on new patient registration form. Train staff on how to ask Aboriginal or Torres Strait Islander status in a culturally safe and consistent way, and where to record the answer.
- Create a welcoming environment for Aboriginal and Torres Strait Islander people including your reception and waiting area e.g., local Aboriginal art works, posters and flags, etc.
- Develop a reminder sticker for each GP and nurse's computer to remind them to check if patient ethnicity has been added to clinical software.
- Source Aboriginal specific resources from peak body organisations for example the Heart Foundation, Cancer Council or Diabetes Victoria print out Aboriginal specific information sheets from websites, such as healthinfonet, these resources can be displayed in waiting rooms or given to patients after a GP Management Plan or Health Check.
- Familiarise yourself with services in Melbourne specifically for Aboriginal and/or Torres Strait Islanders or in your local area. See HealthPathways Melbourne for referral and service options.

Indigenous Health Incentive

- Check if the practice is registered for the Indigenous Health Incentive and if not register on HPOS (Health Professional Online Services).
- Ask the team who would like to do the cultural awareness training. It is a requirement as part of the Indigenous Health Incentive guidelines that 2 staff from the practice do the training within 12 months of registering for the incentive – 1 GP and 1 other staff member.
- Recall patients who have not had a 715-health assessment claimed in the past 12 months.

Recording of lifestyle information/preventive health

- Routinely ask all new and returning patients to complete (or update) a brief patient registration form in the waiting room, providing their height, weight, smoking status and weekly alcohol consumption, and to check contact details (address, phone number), including next-of-kin and emergency contact details.
- Change practice procedures so that nurses can take the opportunity to see patients prior to GP appointments to collect height, weight and waist measurements, blood pressure, and smoking and alcohol consumption status.
- Complete health assessments (Health Check) to address risk factors of chronic disease using template and refer to national guide to preventative health assessment for Aboriginal and Torres Strait Islander people.
- For the Aboriginal Health Assessment (715) it is important to use the term "Health Check" instead of Health Assessment when sending letters or discussing with patients, due to the word "assessment" which has negative connotations to Aboriginal people.
- Create a prompt in Topbar so that clinicians are reminded to complete smoking status, weight classification and alcohol consumption for relevant patients during any type of consultation. (See the Pen CS guide on this topic.)

CVD risk-factor assessment (intermediate)

- Prepare information for clinicians about the appropriate referrals and information on the Medicare Benefits Schedule (MBS) Heart Health Item Number 699 to help Aboriginal and Torres Strait Islander patients to improve their lifestyles to reduce CVD risk. (See the Australian absolute cardiovascular disease risk calculator and the Heart Foundation's Heart Health Checks.) Information is also available on Healthpathways Melbourne and refer to The RACGP's National Guide to Preventive health assessment for Aboriginal and Torres Strait Islander People – Chapter 11 Cardiovascular disease prevention.
- Create a list of Aboriginal and Torres Strait Islander patients (in CAT4) with a >15 per cent risk of a CVD event (such as a heart attack or stroke) in the next five years (high risk) and give to GPs to review clinically. Recall these patients by SMS or letter. (See the Pen CS guide on this topic.)
- GPs can consider prevention of other chronic diseases for patients with one chronic condition. Refer to the following National preventive health guidelines under the information tab on HealthPathways Melbourne.

Chronic Disease Management

Aboriginal and Torres Strait Islander patients are at greater risk of chronic disease such as diabetes, cardiovascular disease, chronic kidney disease, and respiratory conditions. Mental Health is also at greater risk for patients.

For each condition you could consider management and coordination through the Integrated Care Team program (ITC). See more information on ITC on HealthPathways Melbourne.

- Ensure all active Aboriginal and Torres Strait Islander patients (See CAT4 Ethnicity Filtering) with the chronic condition are 'coded' correctly. (See the PEN Cat plus quick start guide.)
- Identify Aboriginal and Torres Strait Islander patients with a chronic disease who have never had a Chronic Disease Management Plan (GPMP) or Team Care arrangement before. (See CAT4 Recipe.)
- Send out a recall SMS and/or letter to all Aboriginal and Torres Strait Islander patients missing Chronic Disease Management Plan and/or Team Care Arrangement.
- Send out a recall SMS and/or letter to all Aboriginal and Torres Strait Islander patients missing review of Chronic Disease Management Plan and/or Team Care Arrangement.
- Complete Chronic Disease Management Plan and Team Care Arrangements. Search for any chronic condition on HealthPathways Melbourne to support management of a chronic disease.
- Consider referring Aboriginal and Torres Strait Islander patients to the Indigenous Australians' Health Programme – Integrated Team Care.
- The Integrated Team Care (ITC) program supports Aboriginal and Torres Strait Islander people with complex chronic diseases to effectively manage their conditions, through access to one-on-one assistance by care coordinators. The program aims to assist people to access health services as soon as possible and ensure they have adequate supports to get the care required in a culturally safe way. See more information on HealthPathways Melbourne.
- Identify Indigenous patients eligible for PBS Co-payment Measure using CAT4. (See CAT4 Recipe.)
- Create a prompt in Topbar so that clinicians are reminded to follow up eligible Aboriginal and Torres Strait Islander patients during any type of consultation. (See CAT4 Guide.)

Mental Health

- Ensure all active Aboriginal and Torres Strait Islander patients (see CAT4 Ethnicity Filtering) with Mental Health are "coded" correctly. (See the Pen CS Guide.)
- Using CAT4 or your clinical software extract patients diagnosed with mental health (see CAT4 recipe). See also HealthPathways Melbourne, the RACGP's e-Mental health – A guide for GPs and refer to the RACGP's National Guide to Preventive health assessment for Aboriginal and Torres Strait Islander People – Chapter 17.
- Identify Aboriginal and Torres Strait Islander patients who are eligible for Mental Health Treatment plan. (See CAT4 Recipe.)
- Identify Aboriginal and Torres Strait Islander patients who are eligible for Mental Health Treatment Review. (See CAT4 Recipe.)
- Send out a recall SMS and/or letter to all Aboriginal and Torres Strait Islander patients missing Mental Health Treatment plan and Review.
- Disseminate MBS information to your GP's, see MBS GP Mental Health Treatment Items – (Items 2700 to 2717)
- Consider referring Aboriginal and Torres Strait Islander patients to CAREinMIND™ Mental Health Services.
- Consider referring Aboriginal and Torres Strait Islander patients to the Integrated Team Care Program.

Improving patient experience and seeking patient feedback

Gather patient feedback before and after implementing a change which directly impacts patient care. This may include:

- Creating a culturally safe environment in the clinic (Aboriginal and Torres Strait Islander flags, local Aboriginal artwork, Aboriginal specific resources such as posters, signs to state practice is registered for Closing the Gap).
- All staff to complete cultural awareness training so they can be more culturally competent and include cultural awareness training in the induction process for all new staff members.
- Holding small events or acknowledging Aboriginal specific dates, such as Reconciliation Day and NAIDOC week.

Step 3 Plan, Do, Study, Act – time to 'cycle'

You're now ready to take action, using a 'Plan, Do, Study, Act' (PDSA) cycle for each activity you've decided to implement in the previous activity.

Using Activity Table 5, take the activities listed in Activity Table 4 and assign a responsible person/persons, and intended due dates. Use Activity Table 5 to regularly check in on your team's progress. This will help inform the 'plan' part of the PDSA cycle in Activity Table 6. (You may also want to review the explanation of PDSA under the Model for Improvement heading in the introduction to this workbook.)

Activity Table 5: Timeframes and responsibilities

1	**Activity** **Person responsible** / **By when** **Expected outcomes**
2	**Activity** **Person responsible** / **By when** **Expected outcomes**

Activity Table 5: Timeframes and responsibilities (continued)

3	**Activity** **Person responsible** **By when** **Expected outcomes**
4	**Activity** **Person responsible** **By when** **Expected outcomes**
5	**Activity** **Person responsible** **By when** **Expected outcomes**

Activity Table 5: Timeframes and responsibilities (continued)

6	**Activity** **Person responsible** / **By when** **Expected outcomes**

Next, create copies of the PDSA table (Activity Table 6: PDSA cycle template) and fill one out for **each activity in this priority area**. This will help to break your project down into manageable chunks, allocate responsibilities more easily, and accurately assess what's working and what's not. Ensure that each PDSA table includes details of who is doing what, and by when, to keep your project on track.

Note that you can run more than one PDSA at a time. This will depend on the change you're making, and the time it's likely to take before any measurable improvement. If results are likely to take longer (more than a month, for example, or a year), running separate, sequential PDSAs for each activity would mean the project would take too long.

PDSA cycle template

You've got your plan and are now ready for the 'doing' – that is, to start 'cycling' through PDSAs. Use Activity Table 6. An example of how to complete the PDSA cycle template is in Appendix 5.

Activity Table 6: PDSA cycle template – Step 1

Priority area number	**Priority area goal**
Activity number	**Staff member responsible**
Date started	**Date completed**

Activity Table 6: PDSA cycle template – Step 2

Plan	Describe the brainstorm idea you are planning to work on. (Idea)
Plan the test, including a plan for collecting data	What exactly will you do? Include what, who, when, where, predictions and data to be collected.

Idea (activity)	
What (step-by-step)	
Who	**When**
Where	**Prediction**
Data to be collected	
Baseline	

Activity Table 6: PDSA cycle template – Step 2 (continued))

Do	Carry it out, and describe how you went (Action)
Run the test on a small scale	Was the plan executed successfully? Did you encounter any problems or difficulties?

Study	Does the data show a change? (Reflection)
Analyse the results and compare them to your predictions	What does the data say? Did you meet your predictions, or did you fall short?

Act	Do you need to make changes to your original plan? (What next?) OR Did everything go well?
Based on what you learned from the test, plan for your next step	If this idea was successful you may like to implement this change on a larger scale or try something new. If the idea did not meet its overall goal, consider why not and identify what can be done to improve performance.

Repeat Step 2 for other ideas. What idea will you test next?

Tip: Do your first lot of activities for your first priority then proceed to manage and monitor your progress/success. Begin again on page 20 (setting a goal) when you're ready to tackle the process again for your next priority area.

Manage and monitor your project

Now you're in the swing of things, ensure you monitor the project regularly, with an eye on your 'baseline data'.

Ensure each PDSA template for each project activity is completed as the activity is completed. As soon as practical, reflect on how the activity went, and any obstacles, and decide whether to continue with the change, or amend it and try it again.

Look back at the data you collected in Activity Table 1, as well as any other measures you decided to collect as part of your project.

Now collect the same data again and complete Activity Table 7. As you do, assess whether there's any improvement since the last measurement. If not, consider why not. Is it too early to see change, or is an extra effort needed to push performance along? And what might be the best activity to tackle next?

Manage and monitor – tips for successful PDSA

- Allocate 'protected time' so that those responsible can effectively implement the changes.
- Set dates in the project team's calendars **now** for reviewing the project. Use the PDSA due dates as a guide, and also set regular review periods (perhaps monthly or quarterly). Regular monitoring is important so that the team can support and encourage each other to complete activities.
- Keep your project team and other practice staff well-informed.
- Catch-up with staff about their PDSAs and offer support where needed.
- Conduct regular check-ups, both to help encourage staff, and to iron-out issues.

Copy the relevant data results from Activity Table 1, but note the order of columns is different here.

Activity Table 7: Manage and monitor your activity

1	**Measure**				
	Source of data				
	6 months before project	3 months before project	Start of project	3 months into project	6 months into project
2	**Measure**				
	Source of data				
	6 months before project	3 months before project	Start of project	3 months into project	6 months into project
3	**Measure**				
	Source of data				
	6 months before project	3 months before project	Start of project	3 months into project	6 months into project

Activity Table 7: Manage and monitor (continued)

4	**Measure**				
	Source of data				
	6 months before project	3 months before project	Start of project	3 months into project	6 months into project
5	**Measure**				
	Source of data				
	6 months before project	3 months before project	Start of project	3 months into project	6 months into project
6	**Measure**				
	Source of data				
	6 months before project	3 months before project	Start of project	3 months into project	6 months into project

Step 4 Evaluate and celebrate

Evaluation is, of course, a regular and integral part of the PDSA process. But it's also important to conduct broader evaluations of the overall project, which is what Step 4 is all about.

Once you have completed all activities for a priority area, reflect on the process and complete Activity Table 8 as a team.

Celebrate and share

Celebrating your success doesn't just feel good – it will help you capitalise on your quality improvement efforts. Under the Model for Improvement, quality improvement is a 'virtuous cycle'. Each benefit has a positive effect on the next, leading to a 'snowball' of improvement.

By celebrating your 'wins', you'll engage your practice team more deeply with your QI project, enhance morale and foster a culture where striving for improvement is as integral as payroll – or lunch!

Depending on the stage and scale of your success, you could share results at staff meetings, hold a celebratory lunch, post your achievements in the waiting area, or even in local media or online.

Has your practice completed a quality improvement activity or project that you'd like to share?

Submit your case study, resources or photos to primary.care@nwmphn.org.au

Activity Table 8: Evaluate achievements

Did you achieve your goal?

What are you most proud of?

What were the things that helped you?

Were there any barriers? How did you overcome these?

Activity Table 8: Evaluate achievements (continued)

What were the changes for: • Patients • Staff/Clinicians • Population • Business?

What would you have done differently?

What are your next steps for the changes that were made?

Completed by:	**Date:**

What's next?

Now that you have completed these activities for priority one, it is time to tackle your next priority. Head back to Activity Table 2 on page 19 to identify the next priority area for your practice and work through the activities again.

Resources and training to build your skills and confidence

General practice resources

Welcoming environment for Aboriginal and Torres Strait Islander people

RACGP's The 5 Steps resources is a suite of resources that provide a clear and concise summary of the programs and funding options available to support care for Aboriginal and Torres Strait Islander patients. These resources were developed to provide busy GPs and practice teams with practical advice on working towards the delivery of excellent Aboriginal and Torres Strait Islander healthcare.

See Appendix 3 for more ideas about making your practice a welcoming place.

Practice Incentive Program – Indigenous Health Incentive (PIP IHI)

- Services Australia's Indigenous Health Incentive guidelines provides information about the practice incentive payments, eligibility, and requirements.
- This CAT4 Recipe to Identify Indigenous patients eligible for PBS Co-payment Measure can extract who is identified as Aboriginal and Torres Strait islander in your clinical software. This recipe also goes on to see who is eligible for the PBS Co-payment measure.

Identification of Aboriginal or Torres Strait Islander people in general practice

- The RACGP's guide Identification of Aboriginal or Torres Strait Islander People in General Practice provides support to practice staff on how to ask all patients about their Aboriginal and Torres Strait Islander status, including patient family members.
- The CSIRO provide education materials to add Aboriginal and Torres Strait Islander identification in medical director, best practice, communicare clinical and billing software.
- The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) has developed a video that covers the quality improvement cycle for recording Aboriginal and/or Torres Strait Islander status.

Cultural Awareness Training

To meet the Indigenous Health Incentive, it is a requirement, at least two staff members from the practice (one must be a GP) must complete appropriate cultural awareness training within 12 months of the practice signing on to the incentive. HealthPathways Melbourne includes more information about the RACGP Cultural Sensitivity training and ACRRM's Cultural Awareness training.

Health Assessments for Aboriginal and Torres Strait Islander patients

- The Medicare Benefits Schedule – Item 715 provides the details/requirements for the Aboriginal and Torres Strait Islander Peoples Health Assessment. See also the RACGP Health check resources for MBS Item 715.
- The RACGP's National Guide is a practical resource intended for all health professionals delivering primary healthcare to Aboriginal and/or Torres Strait Islander peoples. Its purpose is to provide health professionals with an accessible, user-friendly guide to best practice in preventive healthcare for Aboriginal and Torres Strait Islander patients.
- This referral form from the Department of Health is to be completed following a health assessment by an allied health service.
- Medicare has an online module on Indigenous health assessments.

Patient information

- Australian Indigenous Health*InfoNet* provides patient resources and workforce information to health providers.
- Resources from the Healing Foundation are for GP's working with the stolen generations: understanding trauma. See the GP Fact Sheet.

General resources

Patient feedback requirements

- RACGP Patient Feedback Requirements
- RACGP Standards for general practices (5th ed.) – general feedback guide

Videos on the Model for Improvement

Short videos are available at IHI website. In particular, see:

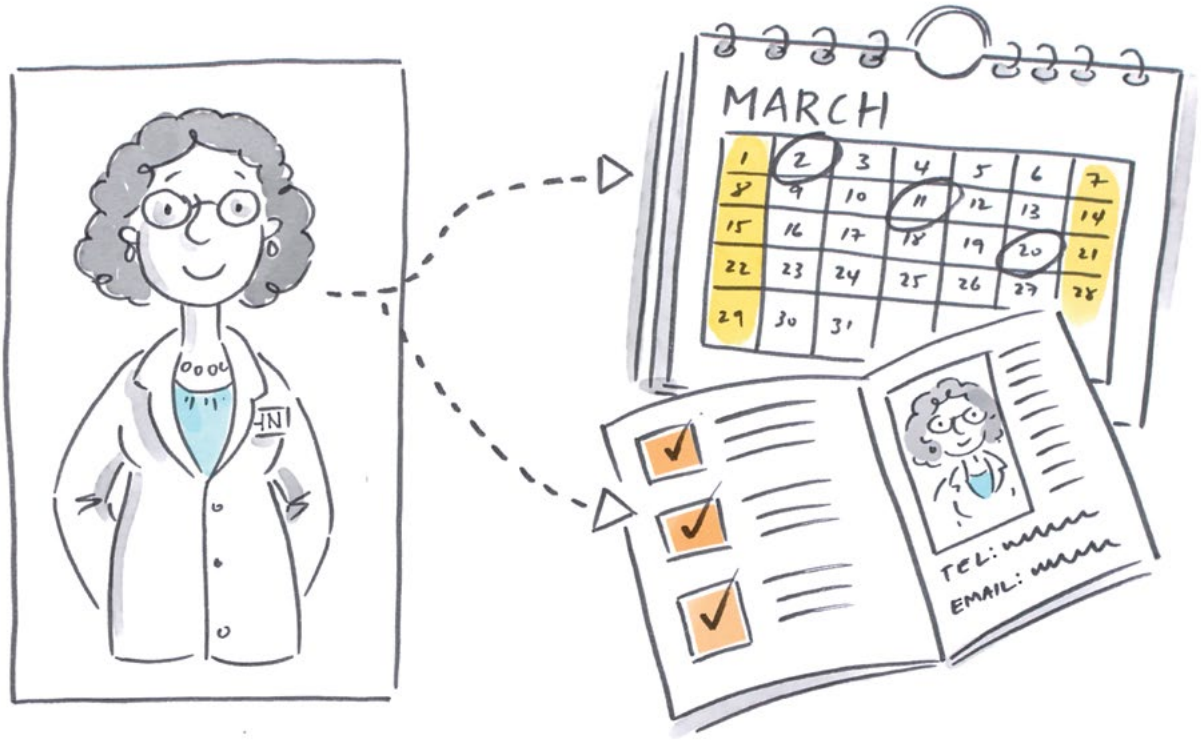
- Model For Improvement Part 1 (2 min. 54 sec.) – IHI – MFI – Part 1
- Model For Improvement Part 2 (3 min.) – IHI – MFI – Part 2
- Plan Do Study Act Part 1 (4 min. 45 sec.) – IHI – PDSA – Part 1
- Plan Do Study Act Part 2 (3 min. 48 sec.) – IHI – PDSA – Part 2

Australian Bureau of Statistics

Access this page for questionnaire design advice.

Case Studies

Local examples of quality improvement success, as well as sample PDSA cycles, can be found at the NWMPHN primary care hub.



Appendices

Appendix 1: Quality Improvement and RACGP accreditation

RACGP's Standards for general practices (5th edition) now includes several QI requirements. Undertaking a QI activity helps demonstrate that a practice can meet or exceed the following:

*Indicator (> Denotes indicator is mandatory)

Criterion QI1.1: Quality improvement activities

Indicators

QI1.1>A Our practice has at least one team member who has the primary responsibility for leading our quality improvement systems and processes.

QI1.1>B Our practice team internally shares information about quality improvement and patient safety.

QI1.1>C Our practice seeks feedback from the team about our quality improvement systems and the performance of these systems.

QI1.1>D Our practice team can describe areas of our practice that we have improved in the past three years.

Claiming RACGP Continuing Professional Development Points

GPs who complete activities in this workbook may be eligible to accumulate 40 RACGP CPD Accredited Activity points as a Practice Audit. Speak to one of our Workforce Development Team members about requirements before starting your activities. For more information email education@nwmphn.org.au or call (03) 9347 1188.

The Standards also include a range of requirements relating to Closing the Gap. Undertaking Closing the Gap QI activities will help demonstrate that a practice can meet or exceed the following indicators:

Criterion C1.3: Informed patient decisions

Indicators

C1.3>A Our patients receive information about proposed investigations, referrals and treatments, including their purpose, importance, benefits, and risks.

C1.3>B Our patients receive information to support the diagnosis, treatment, and management of their conditions.

Criterion C1.4: Interpreter and other communication services

Indicators

C1.4>A Our practice endeavours to use an interpreter with patients who do not speak the primary language of our practice team.

C1.4>B Our practice endeavours to use appropriate communication services to communicate with patients who have a communication impairment.

C1.4C Our patients can access resources that are culturally appropriate, translated, and/or in plain English.

Criterion C2.1: Respectful and culturally appropriate care

Indicators

C2.1>A Our practice, in providing patient healthcare, considers patients' rights, beliefs, and their religious and cultural backgrounds.

Criterion C3.4: Practice communication and teamwork

Indicators

C3.4>B Our practice encourages involvement and input from all members of the practice team.

C3.4>C Our clinical team discusses the practice's clinical issues and support systems.

Criterion C3.6: Research

Indicators

C3.6>C Our practice only transfers identified patient health information to a third party for quality improvement or professional development activities after we have obtained the patient's consent.

The Australian Institute of Aboriginal and Torres Strait Islander Studies has produced Guidelines for ethical research in Australian Indigenous studies.
You could refer to these guidelines if your patient sample includes Aboriginal and Torres Strait Islander peoples.

Criterion C4.1: Health promotion and preventive care

Indicators

C4.1>A Our patients receive appropriately tailored information about health promotion, illness prevention, and preventive care.

Criterion C5.1: Diagnosis and management of health issues

Indicators

C5.1>A Our clinical team is able to access relevant current clinical and other guidelines that help diagnose and manage our patients.

C5.1>B Our clinical team supports consistent diagnosis and management of our patients.

Criterion C7.1: Content of patient health records

Indicators

C7.1>E Our practice routinely records the Aboriginal or Torres Strait Islander status of our patients in their patient health record.

C7.1>G Our patient health records contain, for each active patient, lifestyle risk factors.

Criterion C8.1: Education and training of non-clinical staff

Indicators

C8.1>A Our non-clinical staff complete training appropriate to their role and our patient population.

Criterion QI1.2: Patient feedback

Indicators

QI1.2>A Our practice collects feedback from patients, carers and other relevant parties in accordance with the RACGP's Patient feedback guide.

QI1.2>B Our practice analyses, considers and responds to feedback.

QI1.2>C Our practice informs patients, carers and other relevant parties about how we have responded to feedback and used feedback to improve quality.

Criterion QI1.3: Improving clinical care

Indicators

QI1.3A Our practice team uses a nationally recognised medical vocabulary for coding.

QI1.3>B Our practice uses relevant patient and practice data to improve clinical practice (e.g. chronic disease management, preventive health).

Criterion GP2.1: Continuous and comprehensive care

Indicators

GP2.1>A Our patients can request their preferred practitioner.

GP2.1>B Our practice provides continuity of care and comprehensive care.

Criterion GP2.2: Follow-up systems

Indicators

GP2.2D Our practice initiates and manages patient reminders.

Criterion GP2.3: Engaging with other services

Indicators

GP2.3>A Our practice collaborates with other health services to deliver comprehensive care.

GP2.3>B Our practice's referral letters are legible and contain all required information.

Criterion GP3.1: Qualifications, education and training of healthcare practitioners

Indicators

GP3.1>A Members of our clinical team actively participate in continuing professional development (CPD) relevant to their position and in accordance with their legal and professional organisation's requirements.

Appendix 2: Samples SMART goal for Closing the Gap

Sample goal #1: Increase the number of Health Assessments (715) for Aboriginal and Torres Strait patients

Our goal is:

To increase the number of Health Assessments (715) for Aboriginal and Torres Strait patients by 10% by 30th November.

**Practices to amend the percentage/the priority population*

Our target population is:

Active Patients who identified as Aboriginal and Torres Strait Islander eligible for Health Assessment (715).

Check that the goal is:

- ☑ Specific
- ☑ Measurable
- ☑ Achievable
- ☑ Relevant
- ☑ Time-based

We will use the following measures to know if we've been successful:

Measure A:	Source:
The number of active Aboriginal and Torres Strait Islander patients.	CAT4 data extraction tool CAT4 Ethnicity Filtering
Measure B:	**Source:**
The number of active Aboriginal and Torres Strait Islander patients who have not had a health assessment (715) in the past 12 months.	CAT4 data extraction tool (See Appendix 4 or go to CAT4 Recipe online)

We want to achieve our goal by:

30th November 2021

We will collect our measures every:

1st of the month

Sample goal #2: Increase the number of GP Management Plans (GPMP) completed for patients with diabetes who identify as Aboriginal and/or Torres Strait Islanders

Our goal is:

To increase by 10% the number of GP Management Plans completed for patients with diabetes who identify as Aboriginal and/or Torres Strait Islander patients by 30th June 2020.

**Practices to amend the percentage / the priority population*

Our target population is:

Active Aboriginal and/or Torres Strait Islander patients with diabetes eligible for GP Management Plan.

Check that the goal is:

- ☑ Specific
- ☑ Measurable
- ☑ Achievable
- ☑ Relevant
- ☑ Time-based

We will use the following measures to know if we've been successful:

Measure A: The number of active Aboriginal and/or Torres Strait Islander patients with diabetes.	Source: CAT4/medical software CAT4 Ethnicity Filtering
Measure B: The number of active Aboriginal and/or Torres Strait Islander patients with diabetes who have never had a GP Management Plan.	Source: CAT4 /medical software 1st CAT4 Ethnicity Filtering 2nd CAT4 Conditions Filtering 3rd CAT4 MBS Attendance Filter
Measure C: The number of active Aboriginal and/or Torres Strait Islander patients with diabetes who have not had a GPMP in the last 2 years.	Source: CAT4/medical software CAT4 Recipe
We want to achieve our goal by: 30th June 2021	**We will collect our measures every:** 1st of the month

Appendix 3: Creating a welcoming environment in your practice

Using Aboriginal artwork, welcoming and inclusive signage and displaying appropriate posters in your practice that are relevant to Aboriginal, or Torres Strait Islander people can make it a much more welcoming environment.

Here are some ideas to get you started:

- A range of posters, flyers and postcards can be downloaded from the NWMPHN Aboriginal Health page of our website, this includes a Closing the Gap poster to display that your practice is a registered provider under the Closing the Gap program.
- Displaying the Aboriginal and/or Torres Strait Islander flags is also a welcoming sign in our outside your practice.
- Acknowledgement of Traditional Custodians plaque are a display that acknowledge the Aboriginal land, people and culture, where your practice is located. Artwork and plaques can be found at Kinya Lerrk, and Antar Victoria.
- Provide culturally appropriate health resources and reading materials in your patient waiting room, such as the Koori Mail.

Appendix 4: Using Clinical software to improve Aboriginal and Torres Strait Islander Health

Adding Aboriginal or Torres Strait Islander status in your software using Train IT Medical:

- Adding Aboriginal and/or Torres Strait Islander status in your clinical software MD
- Adding Aboriginal and/or Torres Strait Islander status in your clinical software BP

Identify patients eligible for an annual health assessment (See CAT4).

Appendix 5: PDSA worksheet sample

You will have noted your ideas for testing when you worked through earlier activities.
You will use this sheet to test an idea.

PDSA worksheet sample – Step 1

Priority area number	**Activity number**
1	2
Goal	
To ensure that at least 40% of our Aboriginal and Torres Strait Islander active patients have a health assessment (MBS Item 715) by 30th October.	
Staff member responsible	
Date started	**Date completed**

Continued on next page.

PDSA worksheet sample (continued)

PDSA worksheet sample – Step 2

Plan	Describe the brainstorm idea you are planning to work on. (Idea)
Plan the test, including a plan for collecting data	What exactly will you do? Include what, who, when, where, predictions and data to be collected.

Idea

Recall Aboriginal and Torres Strait Islander patients who have not had a Health Assessment in the past 12 months.

What (step-by-step)

1. Extract CAT4 list of Aboriginal and Torres Strait Islander patients without a Health Assessment.
2. Recall those patients.
3. Re-check the list within 3 weeks.
4. Send text reminder to those who haven't had an Aboriginal and Torres Strait Islander Health Assessment in the past 12 months.

Who:

Receptionist (Sonia)

When:

Begin 1st September for eight weeks

Where:

Dr Grey's office on Wednesday afternoons.

Prediction:

At least 40% of Aboriginal and Torres Islander patients will have a health assessment by the end of this work.

Data to be collected:

Number of active patients who have not had an Aboriginal and Torres Strait Islander Health Assessment recorded.

Baseline:

120 active Aboriginal and Torres Strait Islander patients. 100 have not had a health assessment in 12 months (84%). 20 have a health assessment (16%).

Continued on next page.

PDSA worksheet sample (continued)

PDSA worksheet sample – Step 2 (continued)

Do	Who is going to do what? (Action)
Run the test on a small scale	Was the plan executed successfully? Did you encounter any problems or difficulties?

Completed 15th September. The receptionist contacted NWMPHN for support with the Pen CS CAT4 search and the export function. The data search was conducted very quickly, with the receptionist being upskilled to conduct further relevant searches.

Study	Does the data show a change? (Reflection)
Analyse the results and compare them to your predictions	What does the data say? Did you meet your predictions? If you fell short, suggest why.

At the end of October, a total of 44 active Aboriginal and Torres Islander patients (37%) have now had a Health Assessment (715). We did not reach our aim of 40% (which would have been 48 patients). Despite falling short, it is encouraging that we were able to improve by 21% in two months.

We may not have allowed ourselves enough time to achieve our goal.

We did have one main GP on sick leave this month which may have reduced our ability to reach our goal.

We also may have GPs who are not completing Aboriginal and Torres Strait Islander Health Assessment appropriately, or not claiming them properly through MBS items.

Act	Do you need to make changes to your original plan? (What next) OR Did everything go well?
Based on what you learned from the test, plan for your next step	If this idea was successful, you may like to implement this change on a larger scale or try something new. If the idea did not meet its overall goal, consider why not and identify what can be done to improve performance.

1. Need to identify which GPs are not completing Aboriginal and Torres Strait Islander Health Assessment (715) and help increase the percentage completed.
2. Need to monitor monthly data collection report data from CAT4 to ensure recording rates continue to increase.
3. Ensure the clinical team know how to complete Aboriginal and Torres Strait Islander Health Assessment 715 templates in medical software and know how to claim the right MBS item number.
4. We could put a Topbar reminder in, so that GPs can discuss with a patient opportunistically.

Remind the whole team that this is an area of focus for the practice.

Repeat Step 2 for other ideas. What idea will you test next?

Appendix 6: PDSA worksheet template

This is a blank PDSA worksheet that you can use to test each new idea.

Note: Each new goal (first fundamental question) will require a new Model for Improvement plan.

PDSA worksheet template – Step 1

Priority area number	**Activity number**
Goal	
Staff member responsible	
Date started	**Date completed**

Continued on next page.

PDSA worksheet template (continued)

PDSA worksheet template – Step 2

Plan	Describe the brainstorm idea you are planning to work on. (Idea)
Plan the test, including a plan for collecting data	What exactly will you do? Include what, who, when, where, predictions and data to be collected.

Idea

What (step-by-step)

Who:	**When:**
Where:	**Prediction:**

Data to be collected:

Baseline:

Continued on next page.

PDSA worksheet template (continued)

PDSA worksheet template – Step 2 (continued)

Do	Who is going to do what? (Action)
Run the test on a small scale	Was the plan executed successfully? Did you encounter any problems or difficulties?

Study	Does the data show a change? (Reflection)
Analyse the results and compare them to your predictions	What does the data say? Did you meet your predictions? If you fell short, suggest why.

Act	Do you need to make changes to your original plan? (What next) OR Did everything go well?
Based on what you learned from the test, plan for your next step	If this idea was successful, you may like to implement this change on a larger scale or try something new. If the idea did not meet its overall goal, consider why not and identify what can be done to improve performance.

Repeat Step 2 for other ideas. What idea will you test next?

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