



Northern Queensland Primary Health Network

Continuous quality improvement toolkit





Purpose of the guide:

This toolkit has been compiled to help you and your practice complete quality improvement (QI) activities.

It has been designed to support your practice in making easy, measurable and sustainable improvements to provide best practice care for your patients.



NQPHN acknowledges the Aboriginal and Torres Strait Islander peoples as Australia's First Nation Peoples and the Traditional Custodians of this land. We respect their continued connection to land and sea, country, kin, and community. We also pay our respect to their Elders past, present, and emerging as the custodians of knowledge and lore.



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What is quality improvement?

Quality improvement is an activity with the main purpose of improving the quality of care delivered to your patients through regular monitoring, evaluating and refining of current processes and practices.

Quality improvement helps to identify problems caused by processes, not people. By using various measurements, you are able to identify gaps and demonstrate improvement. It includes team-based approaches, peer review, reflective practice, best practice, and data analysis.



Quadruple aim



Improved patient (individual and family) experience

- » Care is individualised to meeting the needs of the individual and/or family.
- » Coordinated and comprehensive care.
- » Safe and effective care.
- » Timely and equitable.
- » Increased skills and confidence to manage own care.



Improved health care provider experience

- » Increased clinician and staff satisfaction.
- » Increased flexibility and scope for innovation.
- » Evidence of leadership and team-based approach.
- » Quality improvement culture in place.



Improved health outcomes for the population

- » Reduced disease burden.
- » Increased focus on prevention.
- » Improved quality of care.
- » Improvement in individual behavioural and physical health.
- » Improvements for individuals, families, and communities.



Improved cost efficiency and sustainability in health care

- » More efficient and effective service delivery.
- » Increased resourcing to primary care.
- » Improved access to primary care, reducing demand on hospitals within a defined region.

Bodenheimer's quadruple aim - Northern Queensland Primary Health Network (NQPHN) CQI program guidelines have identified four elements that align with the quadruple aim and are important for practice transformation.

- » Effectiveness is about improving the outcomes of care for populations.
- » Patient experience is about enhancing the experience of care received by patients.
- » Efficiency aims to reduce the per capita cost of healthcare.
- » The above three may risk increasing burnout amongst the care providers and hence the fourth aim of enhancing the provider experience recognises the need for a motivated workforce as a prerequisite to achieve the other three aims.



Why do quality improvement?

Why are we doing this? What difference will it make?

- » Improve health outcomes for your patients.
- » Reduce burden of disease and health inequalities.
- » Enhance patient experience—improve access of care, quality and safety.
- » Improve work life for your health care providers.
- » Strengthen your practice team.
- » Improve clinical data quality.
- » Reduce hospital admissions and help manage costs of providing care.
- » Meet the [Practice Incentive Program Quality Improvement \(PIPQI\)](#)
- » Meet the [Accreditation Standards for Quality Improvement \(5th Standard\)](#).

Accreditation

A quality improvement module is included in RACGP Standards for General Practice – 5th edition. The improvement needs to be based on the practice's data and information.

Some suggested sources are:

- » response to patient or staff feedback;
- » day to day operations that are not working (e.g. record keeping processes);
- » auditing clinical databases; and/ or
- » safety concerns.

[RACGP - Standards 5th edition](#)

PIPQI

The aim of the Practice Incentives Program Quality Improvement (PIPQI) is to improve detection and management of chronic conditions through identifying specific issues relevant to your practice population.

This payment replaces five of the 11 Practice Incentives Program (PIP) payments. To be eligible, general practices are required to provide de-identified data to demonstrate improvements in patient care.

Eligibility requirements:

The general practice must:

- » Be accredited or registered for accreditation.
- » Register for PIPQI.
- » Electronically submit data to NQPHN.
- » Undertake quality improvement activities in partnership with NQPHN.

[PIPQI Incentive Guidance](#)



Where do I start?

Getting started—quick start guide

a) Nominate your team

Effective, sustainable change requires an engaged team.

Ideally your team would include:

- » **Practice manager/senior administrator**—CQI lead who will oversee the system improvement work.
- » **General practitioner**—clinical champion providing clinical advice.
- » **Practice nurse**—patient education, data cleaning and supporting the improvements.
- » **Reception**—raising awareness of cancer screening and important role in reminder systems.

Minimum requirement for successful change—practice manager/senior administrator and a GP to lead and champion the work.

b) Be familiar with the CQI goals

- » understand what needs to be done
- » set goals
- » create “shared” accountability
- » keep on track.

Decide with your team, how you will:

- » Get together to discuss each module of work as it is received.
- » Review monthly progress against the module.
- » Report progress to the greater practice team.

The practice team will want to know how the program will impact on the day to day functioning of the practice.

c) Use the CQI readiness tool

This tool has been adapted from one developed by the Hunter New England and Central Coast Primary Health Network and is available in the NSW Cancer screening toolkit.

This will help you identify areas for improvement.

Adapted from Cancer Institute NSW/Cancer screening toolkit 2019.



CQI readiness tool

Accreditation standards	Yes/No/Unsure	Action/Comment
Our practice is currently accredited against the RACGP Standards for General Practice (5th edition) where available.		
We currently participate in, or are prepared to participate in the NQPHN data program.		
Our practice has at least one team member who has the primary responsibility for leading our CQI systems and process.		
Our practice team internally shares information about CQI and patient safety.		
Our practice seeks feedback from the team about our CQI systems and the performance of these systems.		
Our practice team can describe areas of our practice that we've improved in the last three years.		
General practice systems	Yes/No/Unsure	Action/Comment
We use a standard family history template .		
Our New patient form requests consent for reminders.		
Our practice uses a standard list for coding/labeling that all staff comply with.		
We regularly perform data cleaning activities to establish up-to-date patient lists to identify those eligible for screenings, immunisations or review.		
Our practice uses data to identify under-reported/recorded demographics and at-risk patients.		
TopBar prompts/actions have been enabled in the practice software for the GPs and nurses.		
Policies and procedures are in place including reminders and recalls.		
We currently provide recall and reminders as per clinical guidelines.		
Targeted reminders are being sent to patients for routine follow-up and care; for example, cancer screening (ie. letter, SMS, email or phone call).		
Reminders are compliant with health literacy principles.		



We have an active focus on continuous quality improvement (CQI). Eg. discussed at practice meetings, reminder/recall systems.		
A documented workflow and allocation of roles to manage and monitor the selected CQI exists in our practice.		
Clinicians know how to access guidelines, assessment, management and referral information (including patient information).		
IT & computer capabilities	Started/ progressing/ achieved	Action/Comment
System can collect coded data for CQI activities.		
Enables secure electronic communication with both internal and external providers.		
Has a recall and reminder system for ongoing patient review.		

Adapted from Cancer Institute NSW/Cancer Screening Toolkit 2019 & Northern Queensland Primary Health Network/ Quality Improvement Toolkit 2019.





General data management health check

Systematically perform basic clean up functions:

- » deactivating patients
- » deceasing patients
- » checking for missing dates of birth or gender
- » merging duplicate patient files.

Use the links to help you carry out any of the above that may have been overlooked.

Activity	
Deactivate patients	Performed Y/N
Best Practice—mark a patient inactive. Marking patients as inactive Medical Director—deactivating patients Deactivating patients Genie—marking patient records as inactive Marking patient records as inactive	
Mark patient as deceased	Performed Y/N
Best Practice—mark patient as deceased Marking patients as deceased Medical Director—flagging patients as deceased Flagging patients as deceased Genie—marking patient records as inactive Marking patient records as inactive	
Check for missing dates of birth and gender	Performed Y/N
Best Practice—searching the database Database search Medical Director—editing a patient’s details Editing patient’s details from within their record Genie custom reports	
Merging duplicate files	Performed Y/N
Best Practice Merge patient records Medical Director Merge patient records Genie Merging patient records	





Genie custom reports

.....

Missing gender

1. From the **Open** menu, select **Patients**.
2. Then **cancel** out of the search box which appears.
3. From the **Records menu**, select **Search**.
4. From the **Available Fields** column, **expand** the [Patient] table.
5. Locate and highlight **Sex**.
6. From the **Comparisons** column, choose **is equal to**
7. Leave the **Value** box **blank**.
8. Choose **Query**.
9. A list of patients with no gender entered will then be shown in the patient list.

Missing date of birth

1. From the **Open** menu, select **Patients**.
2. Then **cancel** out of the search box which appears.
3. From the **Records menu**, select **Search**.
4. From the **Available Fields** column, **expand** the [Patient] table.
5. Locate and highlight **DOB**.
6. From the **Comparisons** column, choose **is equal to**
7. In the **Value** box, enter **00/00/0000**.
8. Choose **Query**.
9. A list of patients with no date of birth entered will then be shown in the Patient list.



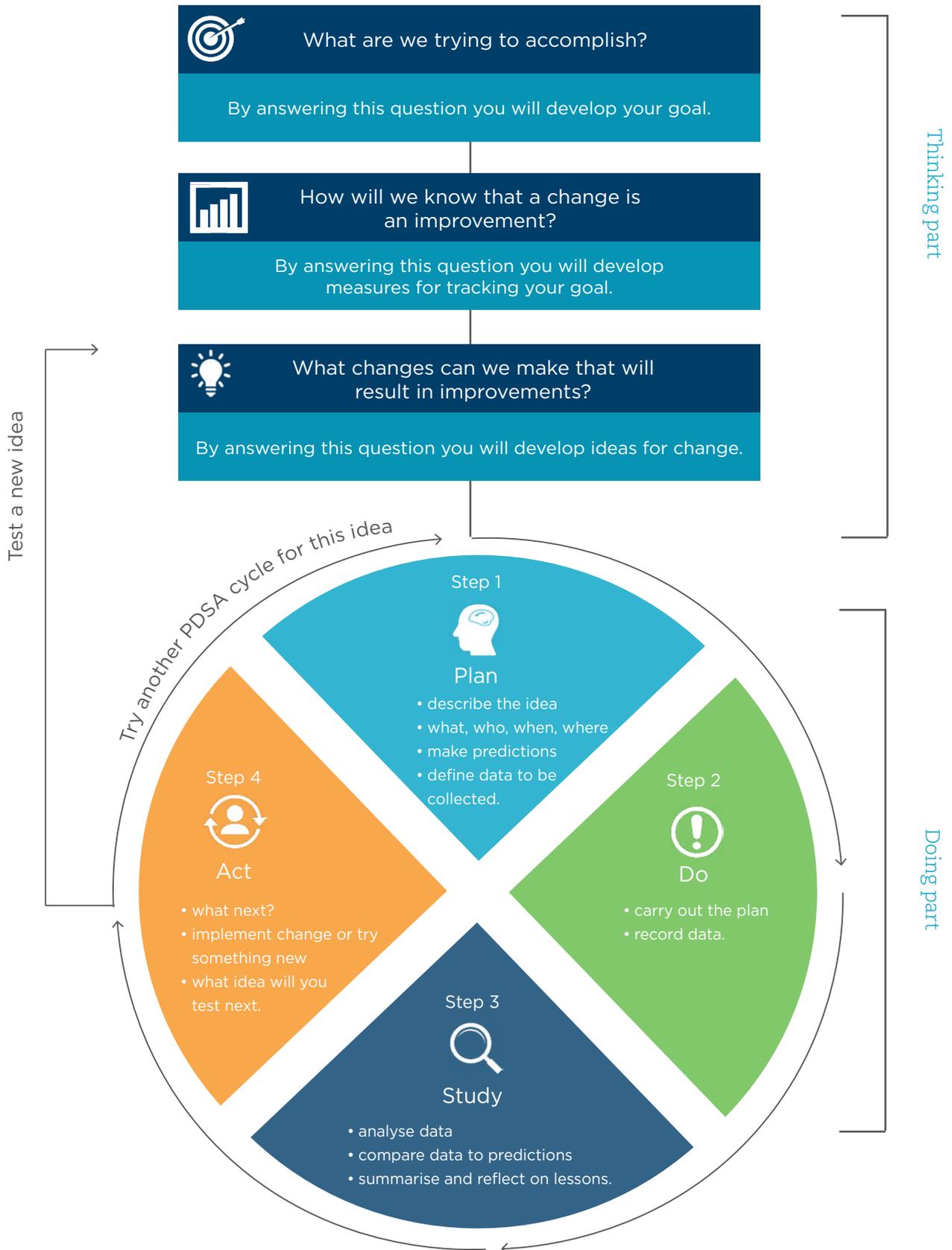
Baseline data

- » Refer to your monthly data reports.
- » Use CAT4 recipes available under [Topics/Projects](#).



How?

Plan, Do, Study, Act (PDSA)





PDSA template

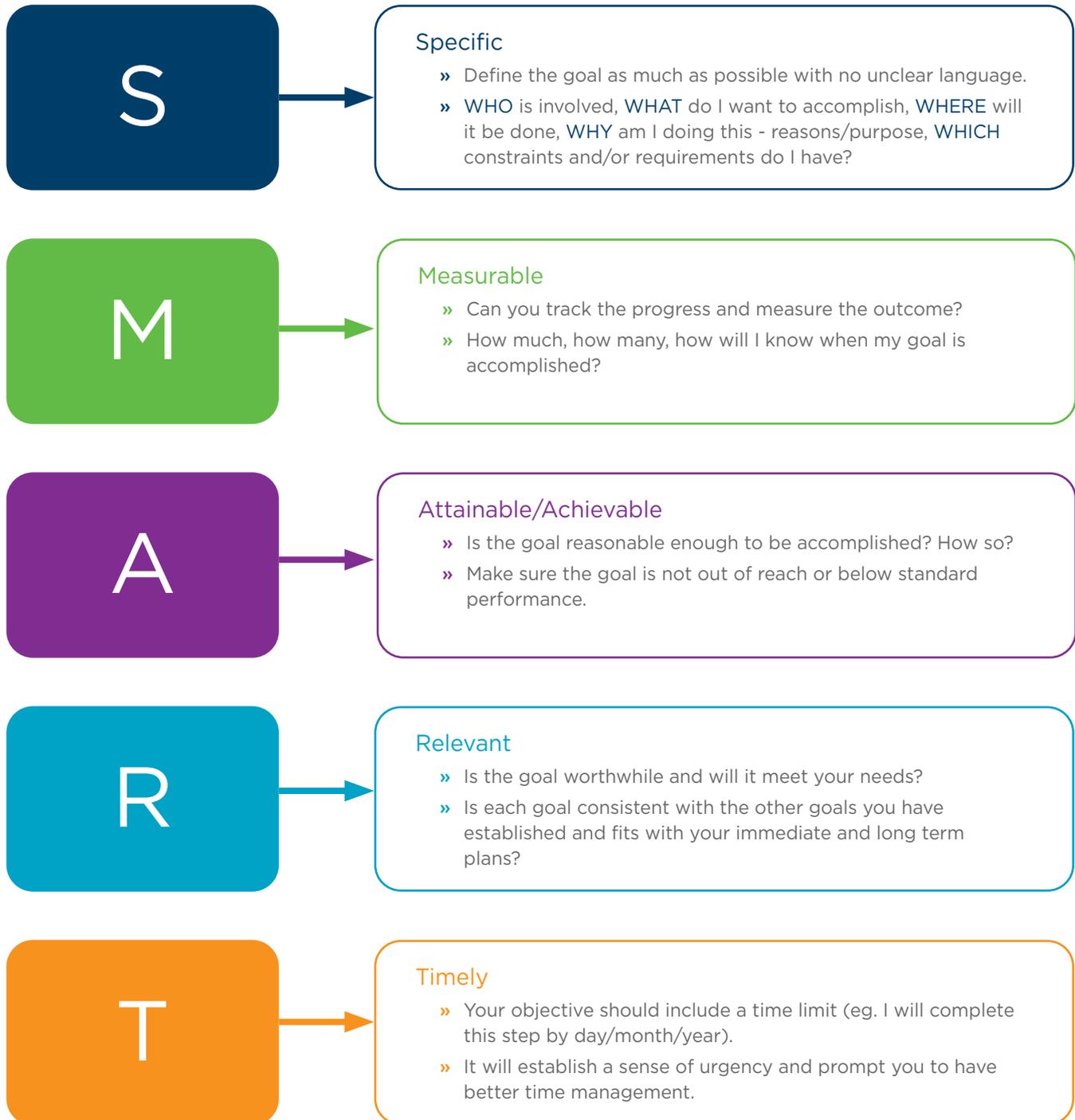
PDSA Title:

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

SMART goals

The thinking part

Now that you have identified a need, you need to identify a goal. What are we trying to accomplish?
Your goal needs to be SMART.





SMART example

Q1. What are we trying to accomplish? (Goal)

Our SMART goal is to:

- » Increase the proportion of our active patients with COPD who have an influenza vaccine by 20% by 31 July.

Q2. How will you know that a change is an improvement? (Measure)

eg. Track baseline measurement and compare results at the end of the improvement.

We will measure the percentage of active patients with COPD who have had a flu vaccine.

To do this we will:

- a) Identify the number of active patients with COPD.
- b) Identify the number of active patients with COPD who have had a vaccine.

b) divided by a) x 100 produces the percentage (%) of patients with COPD who have had a flu vaccine.

Q3. What changes could we make that will lead to an improvement? (List your ideas)

You may wish to BRAINSTORM ideas with members of our Practice Team.

Our ideas for change:

- » Identify active patients with COPD who have not had a flu vaccine this year, using CAT4 recipe.
- » You can double check AIR information through the Medicare Overview section in the My Health Record window, if your patient has a My health Record.
- » Send SMS recall/reminder via hot docs to identified patients.
- » Check vaccine stock. Reorder if necessary.
- » Have patient education resources on flu vaccination available in waiting room etc.
- » Run an awareness campaign for COPD.
- » As a team, select which idea(s) to begin testing with a PDSA cycle.



Action plan template

Download printable version of template [here](#).

CQI action plan

What Actions for improving selected areas.	Who Who is responsible to get this done?	When When should this be done?	Support Who else needs to help? Does a clinician need to help?	Complete Date completed	Comments
Action 1					
Action 2					
Action 3					
Action 4					
Reporting back to your team—how and when?					



Topics/Projects

PIPQI improvement measures (CQI activities)

1. [Proportion of patients with diabetes with a current HbA1c result.](#)
2. [Proportion of patients with a smoking status.](#)
3. [Proportion of patients with a weight classification.](#)
4. [Proportion of patients aged 65 and over who were immunised against influenza.](#)
5. [Proportion of patients with diabetes who were immunised against influenza.](#)
6. [Proportion of patients with COPD who were immunised against influenza.](#)
7. [Proportion of patients with an alcohol consumption status.](#)
8. [Proportion of patients with the necessary risk factors assessed to enable CVD assessment.](#)
9. [Proportion of female patients with an up-to-date cervical screening.](#)
10. [Proportion of patients with diabetes with a blood pressure result.](#)

Other CQI activities

11. [Proportion of CVD patients with Blood Pressure recorded.](#)
12. [Proportion of CVD patients with Cholesterol recorded.](#)
13. [Proportion of patients with Hypertension with Blood Pressure recorded.](#)
14. [Proportion of patients with Hypertension with Cholesterol recorded.](#)
15. [Proportion of patients with COPD with Spirometry recorded.](#)
16. [Proportion of patients with Allergy Status recorded.](#)
17. [Proportion of patients with BMI recorded.](#)
18. [Proportion of patients with Waist Measurement recorded.](#)
19. [Proportion of patients with Ethnicity recorded.](#)
20. [Proportion of fully immunised Indigenous children.](#)
21. [Proportion of patients 75+ with current Health Assessment.](#)



PIPQI improvement measures

1. Proportion of patients with diabetes with a current haemoglobin A1c (HbA1c) result

Improve recording of HbA1c results.

- » Gold standard for assessing glycaemic control.
- » Helps clinicians set treatment goals and monitor control accurately.

Goal	<ul style="list-style-type: none"> » Increase recording of HbA1c results.
Measure	<ul style="list-style-type: none"> » Percentage of patients with diabetes with an HbA1c result recorded.
Starting point	<ul style="list-style-type: none"> » quick start guide » CQI readiness tool » data management health check » recording HbA1c status for patients with Diabetes—CAT4 recipe » brainstorm ideas with the team.
Possible improvement ideas	Goal 1: <ul style="list-style-type: none"> » Staff know the correct location in the software to look for the result. » Routinely check results are being recorded appropriately.
	Goal 2: Setup appropriate recall/reminder systems <ul style="list-style-type: none"> » merging and locking lists » recalls & reminders. Katrina Otto—recall & reminders (BP) Katrina Otto—recall & reminders (MD)
Plan, Do, Study, Act	<ul style="list-style-type: none"> » PDSA template » action plan template.
What now?	<ul style="list-style-type: none"> » sustainability checklist » quality improvement register (to be developed).



2. Proportion of patients with a smoking status

Improve recording of **smoking** status.

Goal	» Increase recording of smoking status.
Measure	» Percentage of patients with smoking status recorded.
Starting point	<ul style="list-style-type: none"> » quick start guide » CQI readiness tool » data management health check » smoking status—CAT4 recipe » brainstorm ideas with the team.
Possible improvement ideas	<p>Staff know the correct location in the software to place the status</p> <ul style="list-style-type: none"> » entering smoking status—Best Practice » entering smoking status—Medical Director » routinely check status is being entered.
Plan, Do, Study, Act	<ul style="list-style-type: none"> » PDSA template » action plan template.
What now?	<ul style="list-style-type: none"> » sustainability checklist » quality improvement register (to be developed).





3. Proportion of patients with a weight classification

Improve recording of **weight** classification

Goal	» Increase recording of weight classification.
Measure	» Percentage of patients with weight classification recorded.
Starting point	<ul style="list-style-type: none"> » quick start guide » CQI readiness tool » data management health check » recording BMI—CAT4 recipe » brainstorm ideas with the team.
Possible improvement ideas	<p>Staff know the correct location in the software to place the status</p> <ul style="list-style-type: none"> » entering measurements—Best Practice » entering measurements—Medical Director » routinely check results are being recorded appropriately.
Plan, Do, Study, Act	<ul style="list-style-type: none"> » PDSA template » action plan template
What now?	<ul style="list-style-type: none"> » sustainability checklist » quality improvement register (to be developed).



4. Proportion of patients aged 65 and over who were immunised against influenza

Improve recording of, and the number of patients aged 65 and over immunised against influenza.

Goal	<ol style="list-style-type: none"> 1. Improve recording of influenza immunisation for patients aged 65 and over immunised against influenza. and/or 2. Increase the number of patients age 65 and over receiving influenza immunisation.
Measure	<ul style="list-style-type: none"> » Percentage of patients aged 65 and over with influenza vaccine recorded.
Target group	<ul style="list-style-type: none"> » Patients aged 65 years and over.
Starting point	<ul style="list-style-type: none"> » quick start guide » CQI readiness tool » data management health check » influenza immunisation for patients aged 65 and over—CAT4 recipe » brainstorm ideas with the team.
Possible improvement ideas	<p>Goal 1:</p> <ul style="list-style-type: none"> » Staff know the correct location in the software to place the status. » Routinely check results are being recorded appropriately.
	<p>Goal 2: Set-up appropriate recall/reminder systems</p> <ul style="list-style-type: none"> » merging and locking lists » recall & reminders. <p>Katrina Otto—recall & reminders (BP) Katrina Otto—recall & reminders (MD)</p>
Plan, Do, Study, Act	<ul style="list-style-type: none"> » PDSA template » action plan template.
What now?	<ul style="list-style-type: none"> » sustainability checklist » quality improvement register (to be developed).





5. Proportion of patients with diabetes who were immunised against influenza

Improve the number of patients with **diabetes immunised** against **influenza**.

Goal	<ol style="list-style-type: none"> 1. Increase recording of, and the number of patients with diabetes immunised against influenza. and/or 2. Increasing the number of patients with diabetes receiving influenza immunisation.
Measure	<ul style="list-style-type: none"> » Percentage of patients with diabetes with influenza vaccine recorded.
Target group	<ul style="list-style-type: none"> » Patients with recorded diagnosis of diabetes.
Starting point	<ul style="list-style-type: none"> » quick start guide » CQI readiness tool » data management health check » influenza immunisation and diabetes—CAT4 recipe » brainstorm ideas with the team.
Possible improvement ideas	<p>Goal 1: Staff know the correct location in the software to place the status</p> <ul style="list-style-type: none"> » Routinely check results are being recorded appropriately. <p>Goal 2: Set-up appropriate recall/reminder systems</p> <ul style="list-style-type: none"> » merging and locking lists » recalls & reminders. <p>Katrina Otto—recall & reminders (BP) Katrina Otto—recall & reminders (MD)</p>
Plan, Do, Study, Act	<ul style="list-style-type: none"> » PDSA template » action plan template.
What now?	<ul style="list-style-type: none"> » sustainability checklist » quality improvement register (to be developed).



6. Proportion of patients with COPD who were immunised against influenza

Improve the number of patients with COPD immunised against influenza.

Goal	<ol style="list-style-type: none"> 1. Improve recording of influenza immunisation for patients with COPD. and/or 2. Increasing the number of patients with COPD receiving influenza immunisation.
Measure	<ul style="list-style-type: none"> » Percentage of patients with COPD with influenza vaccine recorded.
Target group	<ul style="list-style-type: none"> » Patients with recorded diagnosis of COPD.
Starting point	<ul style="list-style-type: none"> » quick start guide » CQI readiness tool » data management health check » influenza immunisation for patients with COPD—CAT4 recipe » brainstorm ideas with the team.
Possible improvement ideas	<p>Goal 1 Staff know the correct location in the software to place the status</p> <ul style="list-style-type: none"> » Routinely check results are being recorded appropriately. <p>Goal 2 Set-up appropriate recall/reminder systems</p> <ul style="list-style-type: none"> » merging and locking lists » recalls & reminders. <p>Katrina Otto—recall & reminders (BP) Katrina Otto—recall & reminders (MD)</p>
Plan, Do, Study, Act	<ul style="list-style-type: none"> » PDSA template » action plan template.
What now?	<ul style="list-style-type: none"> » sustainability checklist » quality improvement register (to be developed).





7. Proportion of patients with an alcohol consumption status

Improve recording of alcohol consumption.

Goal	» Increase recording of alcohol consumption.
Measure	» Percentage of patients with alcohol consumption recorded.
Starting point	<ul style="list-style-type: none"> » quick start guide » CQI readiness tool » data management health check » alcohol status recoding—CAT4 recipe » brainstorm ideas with the team.
Possible improvement ideas	<ul style="list-style-type: none"> » staff know the correct location in the software to place the status » entering alcohol status—Best Practice » entering alcohol status—Medical Director » follow steps as for smoking » routinely check results are being recorded appropriately.
Plan, Do, Study, Act	<ul style="list-style-type: none"> » PDSA template » action plan template.
What now?	<ul style="list-style-type: none"> » sustainability checklist » quality improvement register (to be developed).



8. Proportion of patients with the necessary risk factors assessed to enable CVD assessment

Improve recording of **risk factors** to enable **CVD** assessment.

Goal	» Increase recording of risk factors to enable CVD assessment.				
Measure	» Percentage of patients with necessary risk factors recorded to enable CVD assessment.				
Target group	» Adults aged >45yrs without known history of CVD. » Aboriginal and Torres Strait Islander peoples aged >35yrs.				
Starting point	» quick start guide » CQI readiness tool » data management health check » cardiovascular risk —CAT4 recipe. Considerations for comprehensive CVD risk assessment.				
	<table border="1"> <tr> <td> Modifiable factors » smoking » BP » waist circumference » BMI » alcohol. </td> <td> Non-modifiable factors » age & sex » family history CVD » social history. </td> </tr> <tr> <td colspan="2"> Related Conditions » diabetes » chronic kidney disease » familial hypercholesterolaemia » atrial fibrillation. </td> </tr> </table>	Modifiable factors » smoking » BP » waist circumference » BMI » alcohol.	Non-modifiable factors » age & sex » family history CVD » social history.	Related Conditions » diabetes » chronic kidney disease » familial hypercholesterolaemia » atrial fibrillation.	
	Modifiable factors » smoking » BP » waist circumference » BMI » alcohol.	Non-modifiable factors » age & sex » family history CVD » social history.			
Related Conditions » diabetes » chronic kidney disease » familial hypercholesterolaemia » atrial fibrillation.					
» Brainstorm ideas with the team.					
Possible improvement ideas	Staff know the correct location in the software to place the status » entering measurements—Best Practice » entering measurements—Medical Director » routinely check results are being recorded appropriately				
Plan, Do, Study, Act	» PDSA template » action plan template.				
What now?	» sustainability checklist » quality improvement register (to be developed).				



9. Proportion of female patients with an up-to-date cervical screening

Improve number of patients with up to date **cervical screening**.

Goal	<ol style="list-style-type: none"> 1. Increase recording of up to date cervical screening. and/or 2. Increase the number of patients participating in cervical screening.
Measure	<ul style="list-style-type: none"> » Percentage of patients aged 25-75 with an up to date cervical screen recorded.
Target group	<ul style="list-style-type: none"> » ALL patients aged 25-75 who have a cervix.
Starting point	<ul style="list-style-type: none"> » quick start guide » CQI readiness tool » data management health check » cervical screening—CAT4 recipe » brainstorm ideas with the team.
Possible improvement ideas	<p>Goal 1: Staff know the correct location in the software to place the status</p> <ul style="list-style-type: none"> » Routinely check results are being recorded appropriately. <p>Goal 2: (additional step) Set-up appropriate recall/reminder systems</p> <ul style="list-style-type: none"> » merging and locking lists » recalls & reminders. <p>Katrina Otto—recall & reminders (BP) Katrina Otto—recall & reminders (MD)</p> <p>It is important to capture all people with a cervix, consider:</p> <ul style="list-style-type: none"> » transgender or intersex patients » registration of transgender or intersex patients. <p>Recording Cervical Screening Results</p>
Plan, Do, Study, Act	<ul style="list-style-type: none"> » PDSA template » action plan template.
What now?	<ul style="list-style-type: none"> » sustainability checklist » quality improvement register (to be developed).



10. Proportion of patients with diabetes with a blood pressure result

Improve recording of **blood pressure** for patients with **diabetes**.

Assists clinicians to develop appropriate care to lower risk of macro vascular and micro vascular complications

- » stroke
- » heart failure
- » heart attack
- » kidney disease
- » peripheral neuropathy
- » glaucoma.

Goal	» Increase recording of blood pressure results.
Measure	» Percentage of patients with diabetes with blood pressure recorded.
Starting point	<ul style="list-style-type: none"> » quick start guide » CQI readiness tool » data management health check » BP for patients with diabetes—CAT4 recipe » brainstorm ideas with the team.
Possible improvement ideas	<p>Staff know the correct location in the software to place the status</p> <ul style="list-style-type: none"> » entering measurements—Best Practice » entering measurements—Medical Director » routinely check results are being recorded appropriately.
Plan, Do, Study, Act	<ul style="list-style-type: none"> » PDSA template » action plan template.
What now?	<ul style="list-style-type: none"> » sustainability checklist » quality improvement register (to be developed).





Other measures

11. Proportion of CVD patients with blood pressure recorded

Improve number of patients diagnosed with CVD who have blood pressure (BP) recorded.

Goal	» Increase % of CVD patients with blood pressure recorded.
Measure	» Percentage of patients diagnosed with CVD who have blood pressure recorded.
Starting point	<ul style="list-style-type: none"> » quick start guide » CQI readiness tool » data management health check » CVD patients with no BP recorded—CAT4 recipe » brainstorm ideas with the team.
Possible improvement ideas	Staff know the correct location in the software to place the status <ul style="list-style-type: none"> » entering measurements—Best Practice » entering measurements—Medical Director » routinely check results are being recorded appropriately.
Plan, Do, Study, Act	<ul style="list-style-type: none"> » PDSA template » action plan template.
What now?	<ul style="list-style-type: none"> » sustainability checklist » quality improvement register (to be developed).



12. Proportion of CVD patients with cholesterol recorded

Improve number of patients diagnosed with CVD who have cholesterol recorded.

Goal	» Increase % of CVD patients with cholesterol recorded.
Measure	» Percentage of patients diagnosed with CVD who have cholesterol recorded.
Starting point	<ul style="list-style-type: none"> » quick start guide » CQI readiness tool » data management health check » CAT4 recipe - CVD patients, no cholesterol recorded » brainstorm ideas with the team.
Possible improvement ideas	Staff know the correct location in the software to place the status <ul style="list-style-type: none"> » Routinely check results are being recorded appropriately.
	Goal 2: Set-up appropriate recall/reminder systems <ul style="list-style-type: none"> » merging and locking lists » recalls & reminders. Katrina Otto—recall & reminders (BP) Katrina Otto—recall & reminders (MD)
Plan, Do, Study, Act	<ul style="list-style-type: none"> » PDSA template » action plan template.
What now?	<ul style="list-style-type: none"> » sustainability checklist » quality improvement register (to be developed).





13. Proportion of patients with hypertension with blood pressure recorded

Improve number of patients with hypertension (HT) who have blood pressure recorded.

Goal	» Increase % of HT patients with blood pressure recorded.
Measure	» Percentage of patients diagnosed with HT who have blood pressure recorded.
Starting point	<ul style="list-style-type: none"> » quick start guide » CQI readiness tool » data management health check » CAT4 recipe - identifying hypertension patient » brainstorm ideas with the team.
Possible improvement ideas	<p>Staff know the correct location in the software to place the status</p> <ul style="list-style-type: none"> » entering measurements—Best Practice » entering measurements—Medical Director » routinely check results are being recorded appropriately.
Plan, Do, Study, Act	<ul style="list-style-type: none"> » PDSA template » action plan template.
What now?	<ul style="list-style-type: none"> » sustainability checklist » quality improvement register (to be developed).



14. Proportion of patients with Hypertension with cholesterol recorded

Improve number of patients with Hypertension who have **cholesterol** recorded.

Goal	» Increase % of HT patients with cholesterol recorded.
Measure	» Percentage of patients diagnosed with HT who have cholesterol recorded.
Starting point	<ul style="list-style-type: none"> » quick start guide » CQI readiness tool » data management health check » CAT4 recipe - identifying hypertension patients, no cholesterol recorded » brainstorm ideas with the team.
Possible improvement ideas	Goal 1 Staff know the correct location in the software to place the status » Routinely check results are being recorded appropriately.
	Goal 2: Set-up appropriate recall/reminder systems » merging and locking lists » recalls & reminders. Katrina Otto—recall & reminders (BP) Katrina Otto—recall & reminders (MD)
Plan, Do, Study, Act	<ul style="list-style-type: none"> » PDSA template » action plan template.
What now?	<ul style="list-style-type: none"> » sustainability checklist » quality improvement register (to be developed).





15. Proportion of patients with COPD with spirometry recorded

Improve number of patients with COPD who have **spirometry** recorded.

Goal	» Increase % of COPD patients with spirometry recorded.
Measure	» Percentage of patients diagnosed with COPD who have spirometry recorded.
Starting point	<ul style="list-style-type: none"> » quick start guide » CQI readiness tool » data management health check » CAT4 recipe - COPD, no spirometry » brainstorm ideas with the team.
Possible improvement ideas	Goal 1 Staff know the correct location in the software to place the status » Routinely check results are being recorded appropriately.
	Goal 2: Set-up appropriate Recall/Reminder systems » merging and locking lists » recalls & reminders. Katrina Otto—recall & reminders (BP) Katrina Otto—recall & reminders (MD)
Plan, Do, Study, Act	<ul style="list-style-type: none"> » PDSA template » action plan template.
What now?	<ul style="list-style-type: none"> » sustainability check list » quality improvement register (to be developed).



16. Proportion of patients with allergy status recorded

Improve number of patients with **allergy status** recorded.

Goal	» Increase recording of allergy status.
Measure	» Percentage of patients with allergy status recorded.
Starting Point:	<ul style="list-style-type: none"> » quick start guide » CQI readiness tool » data management health check » allergy status not recorded—CAT4 recipe » brainstorm ideas with the team.
Possible Improvement ideas	<p>Staff know the correct location in the software to place the status</p> <ul style="list-style-type: none"> » Best Practice - Allergy recording » recording allergy—Medical Director » routinely check status is being entered.
Plan, Do, Study, Act	<ul style="list-style-type: none"> » PDSA template » action plan template.
What Now?	<ul style="list-style-type: none"> » sustainability checklist » quality improvement register (to be developed).





17. Proportion of patients with BMI recorded

Improve number of patients with **Body Mass Index (BMI)** recorded.

Goal	» Increase % of patients with BMI recorded.
Measure	» Percentage of patients who have BMI recorded.
Starting point:	<ul style="list-style-type: none"> » quick start guide » CQI readiness tool » data management health check » identifying-no weight or height—CAT4 recipe » brainstorm ideas with the team.
Possible improvement ideas	Staff know the correct location in the software to place the status <ul style="list-style-type: none"> » entering measurements—Best Practice » entering measurements—Medical Director » routinely check results are being recorded appropriately.
Plan, Do, Study, Act	<ul style="list-style-type: none"> » PDSA template » action plan template.
What Now?	<ul style="list-style-type: none"> » sustainability checklist » quality improvement register (to be developed).



18. Proportion of patients with waist measurement recorded

Improve number of patients with **waist measurement** recorded.

Goal	» Increase % of patients with waist measurement recorded.
Measure	» Percentage of patients who have waist measurement recorded.
Starting Point:	<ul style="list-style-type: none"> » quick start guide » CQI readiness tool » data management health check » identifying-no waist measurement—CAT4 recipe » brainstorm ideas with the team.
Possible Improvement ideas	<p>Staff know the correct location in the software to place the status</p> <ul style="list-style-type: none"> » entering measurements—Best Practice » entering measurements—Medical Director » routinely check results are being recorded appropriately.
Plan, Do, Study, Act	<ul style="list-style-type: none"> » PDSA template » action plan template.
What Now?	<ul style="list-style-type: none"> » sustainability checklist » quality improvement register (to be developed).





19. Proportion of patients with ethnicity recorded

Improve number of patients with **ethnicity** recorded.

Goal	» Increase % of patients with ethnicity recorded.
Measure	» Percentage of patients who have ethnicity recorded.
Starting point:	<ul style="list-style-type: none"> » quick start guide » CQI readiness tool » data management health check » CAT4 recipe - identify patients with no ethnicity status » brainstorm ideas with the team.
Possible improvement ideas	Staff know the correct location in the software to place the status <ul style="list-style-type: none"> » Routinely check results are being recorded appropriately.
Plan, Do, Study, Act	<ul style="list-style-type: none"> » PDSA template » action plan template.
What Now?	<ul style="list-style-type: none"> » sustainability checklist » quality improvement register (to be developed).



20. Proportion of fully immunised Indigenous children

Improve number of Indigenous children who have received all childhood immunisations.

Goal	» Increase the number of fully immunised Indigenous children.
Measure	» Percentage of fully immunised Indigenous children.
Starting point:	<ul style="list-style-type: none"> » quick start guide » CQI readiness tool » data management health check » CAT4 recipe - Indigenous childhood immunisation » brainstorm ideas with the team.
Possible improvement ideas	Set-up appropriate recall/reminder systems <ul style="list-style-type: none"> » recalls & reminders. Katrina Otto—recall & reminders (BP) Katrina Otto—recall & reminders (MD)
Plan, Do, Study, Act	<ul style="list-style-type: none"> » PDSA template » action plan template.
What Now?	<ul style="list-style-type: none"> » sustainability checklist » quality improvement register (to be developed).





21. Proportion of patients 75+ with current Health Assessment

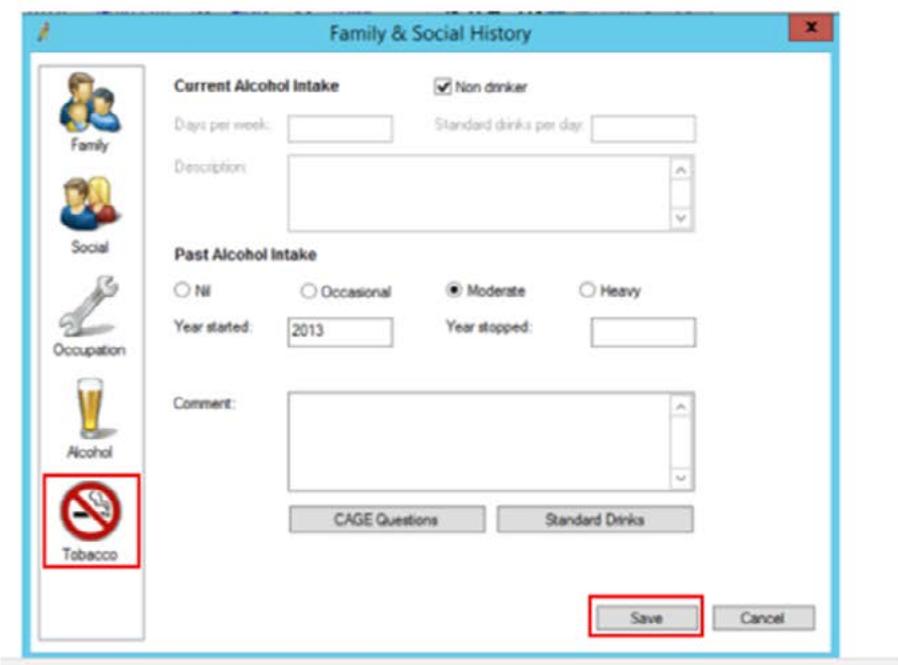
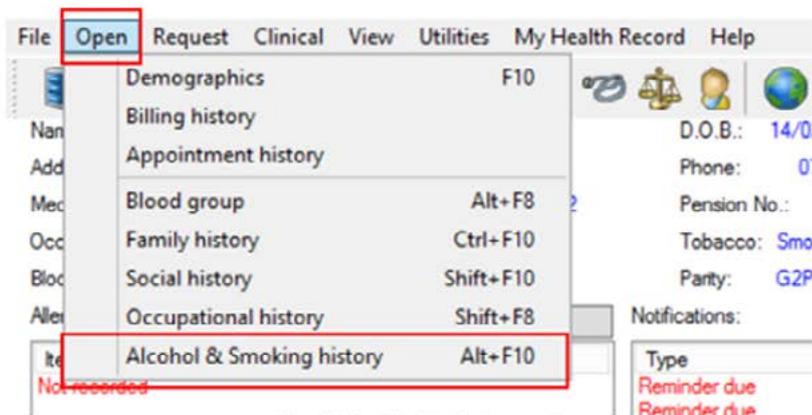
Improve number of patients with current 75+ Health Assessment.

Goal	» Increase % of patients >75 with a current Health Assessment.
Measure	» Percentage of patients 75 years and over with a current Health Assessment.
Starting point:	<ul style="list-style-type: none"> » quick start guide » CQI readiness tool » data management health check » CAT4 recipe - Identify patients eligible for an annual 75+ Health Assessment - Pen CS Help Centre (zendesk.com) » brainstorm ideas with the team.
Possible improvement ideas	Goal 1 » Routinely check results that 75+ Health Assessment are being performed and recorded.
	Goal 2 Set-up appropriate recall/reminder systems » merging and locking lists » recalls & reminders. Katrina Otto—recall & reminders (BP) Katrina Otto—recall & reminders (MD)
Plan, Do, Study, Act	<ul style="list-style-type: none"> » PDSA template » action plan template.
What Now?	<ul style="list-style-type: none"> » sustainability checklist » quality improvement register (to be developed).

Entering smoking & alcohol status - Best Practice

Instructions for entering smoking status in Best Practice

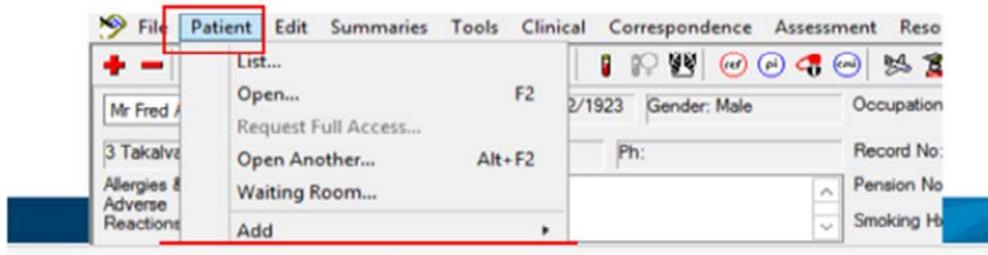
1. While the patient file is open, select **Open** and **Alcohol & Smoking history**.
2. Select **Tobacco** on the left-hand side menu.
3. Once you have entered the information, select **Save**.



Entering smoking & alcohol status - Medical Director

Instructions for entering smoking status in Medical Director

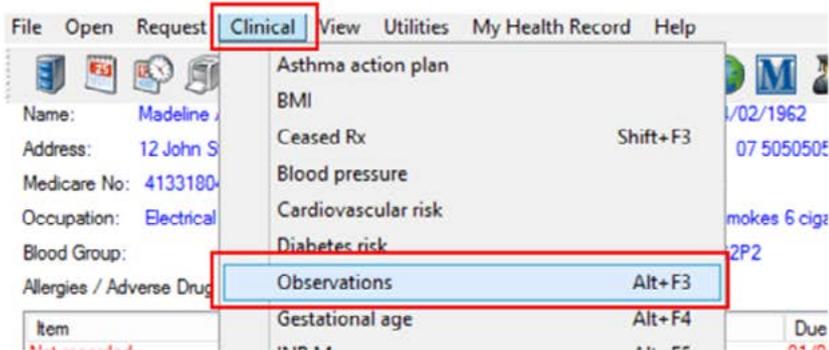
1. Have the patient file open.
2. From the patient menu select **Details**.
3. This will then open a screen where you can enter patient details, allergy/reactions, family/social history, smoking, alcohol, and personal details.
4. Select **Smoking**.
5. Once you have entered the details, select **Save**.

A screenshot of the 'Patient Details' form in the Medical Director software. The 'Smoking' tab is selected and highlighted with a red box. The form contains various fields for patient information, including name, date of birth, gender, ethnicity, contact details, and insurance information. The patient's name is 'Mr Fred Andrews' and his date of birth is '23/02/1923'. The 'Smoking' tab is currently empty, indicating that the user is about to enter the smoking status.

Entering measurements - Best practice

Instructions for entering measurements in Best Practice

1. Have the patient's file open.
2. From the top menu, select **Clinical** and then **Observations**.
3. Enter the appropriate information.
4. Click **Save** to complete.



A screenshot of the 'Observations' form. The form has a title bar with a close button. The fields are as follows:

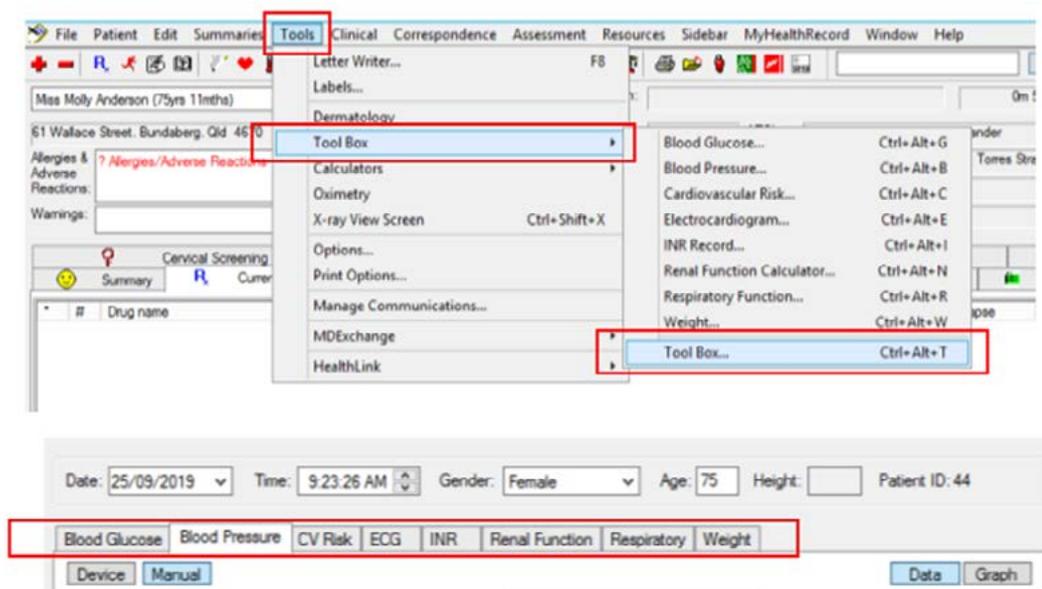
Date:	25/09/2019	
Temp:	<input type="text"/>	<input type="text"/>
Pulse:	<input type="text"/>	<input type="text"/>
BP Sitting:	<input type="text"/> / <input type="text"/>	
BP Standing:	<input type="text"/> / <input type="text"/>	
BP Lying:	<input type="text"/> / <input type="text"/>	
Resp. rate:	<input type="text"/>	O2 Sat.: <input type="text"/>
Weight:	<input type="text"/>	Height: <input type="text"/>
Waist:	<input type="text"/>	Hips: <input type="text"/>
Chest (Insp.):	<input type="text"/>	Chest (Exp.): <input type="text"/>
BSL:	<input type="text"/>	<input type="text"/>

Buttons: Save, Close

Entering measurements - Medical Director

Instructions on entering measurements into Medical Director

1. Have the patient's file open.
2. From the top menu, select **Tools**, **Tool Box**, and then **Tool Box**.
3. Select the appropriate tab and enter the relevant information.
4. Click **Save** to complete.





Merging old labels/codes into the new list

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Links below will assist you in merging existing lists into the new agreed lists.

Best practice	Set up reminder reasons and defaults Cleaning up uncoded and free text data
Medical Director	Merge clinical lists
Genie	N/A





Locking recall and reminder lists

- » This option is **only** available in **Best Practice**. See link below if applicable.
- » This prevents practitioners from adding new free-text labels/codes.

Best Practice ONLY - [Set up reminder reasons and defaults](#).

Recalls and reminders

An accurate recall/reminder system depends on using consistent labels/codes for the recall reason.

Discuss Code Options

Teams are more likely to use a set of codes/labels if they have been involved in deciding what they should be.

Discussion Point	Benefit
Why using consistent coding is important? What are the benefits of using standard codes?	<ol style="list-style-type: none"> 1. It is easier to extract accurate recall/reminder lists (nobody is missed). 2. Screening participation rates are more accurate. 3. Assess practice performance. 4. Easier to identify under screened patients.
Table of options (see below). Adoption of agreed codes.	<ol style="list-style-type: none"> 1. Opportunity to offer input. 2. Chance to provide feedback.
Options for access of codes <ul style="list-style-type: none"> » printouts » where to place them. 	<ol style="list-style-type: none"> 1. Accessibility of codes. 2. Consistent use of codes.

Examples of multiple labels/codes

Breast screening	Breast	Mam	Mammography	Breast screen
Bowel screening	FOBT	iFOBT	CRC screening	Bowel screen
Cervical/Pap	HPV	Pap smear	Cervical screen	Cervical screening



Transgender and intersex patients

It is important to capture information regarding patients who identify as transgender, gender diverse or intersex, so that they are not overlooked in data, and when developing recall and reminder systems.

For example, ALL patients aged 25 to 74 years, who have a cervix and have been sexually active, should have a cervical screen. This includes people who were assigned the gender of female at birth but no longer identify as such, even if they have had the HPV vaccination.

Understanding the meaning of intersex, transgender and gender diversity

Intersex

Intersex is a term that relates to a broad range of congenital physical traits or variations that lie between ideals of male and female. Intersex people are born with physical, hormonal or genetic features that are neither wholly female nor wholly male, or a combination of female and male. Many forms of intersex exist; it is a spectrum or umbrella term, rather than a single category. At least 30 or 40 different variations are known to science. Intersex differences may be apparent at birth. Some common intersex variations are diagnosed prenatally. Some intersex traits become apparent at puberty, or when trying to conceive, or through random chance.¹

According to Intersex Human Rights Australia, intersex clients need the following:

- » Clear messages that a service welcomes intersex people, and an awareness that intersex status is about variations of biology, not gender identity or sexual orientation.
- » To know that confidentiality will be respected.
- » Services that understand intersex health and wellbeing concerns.

Printable version of [Making your service Intersex friendly.](#)

Transgender and gender diverse

Transgender and gender diverse are described as individuals who identify to a different gender than that assigned to them at birth (ACON).

Gender diverse people may identify outside of the male and female binary. Identities may include; non-binary, gender-fluid, gender non-conforming, trans masculine and trans feminine, etc.

Transgender is independent of sexuality, meaning they will also have a sexual orientation which could be heterosexual, lesbian, gay, bisexual, etc.

¹ <https://ihra.org.au/>





Gender categories – data audit tools and practice software

CAT4 gender categories

- » male
- » female
- » other (gender other/diverse)
- » not stated/inadequately described.

Register for Transgender and intersex patients

Maintaining a register of patients who identify as transgender, gender diverse, or intersex could be utilised to cross check lists.

This type of register can help to ensure that only patients who are clinically eligible to participate in specific screening programs receive reminder notifications, or are not overlooked as in the example above.

Consideration of changing patient information forms

Patient information forms give your patients the opportunity to tell you:

- » how they identify themselves
- » if they are transgender, gender diverse or intersex
- » how you should address them.

Questions for consideration (taken from ACON's checkout clinic registration form):

1. What is your current gender identity?
<ul style="list-style-type: none">» Female» Male» Non-binary» Different identity (open field here)
2. What sex were you assigned at birth?
<ul style="list-style-type: none">» Female» Male
3. Were you born with a variation of sex characteristics (this is sometimes called 'intersex')?
<ul style="list-style-type: none">» Yes» No» Prefer not to say
4. What are your pronouns? (you can select more than one)
<ul style="list-style-type: none">» She/Her/Hers» He/Him/His» They/Them/Theirs» Other (open field here)



What now?

Sustainability checklist

Does your practice do the following?				
Organisational culture	Yes	No	Unsure	Action
The practice team is aware of the work that has been done.				
The team understand their role in the CQI activities.				
The team is supportive of the changes.				
Our team is regularly updated about: <ul style="list-style-type: none"> » changes being implemented & why » achievements and highlights of the work undertaken. 				
Organisational structure	Yes	No	Unsure	Action
We have implemented a team-based approach to the ongoing delivery and management of our CQI activities.				
Roles and functions of team members are documented.				
If particular members of the team left, the CQI activities could continue (ie. contingency plan in place).				
Policy & process	Yes	No	Unsure	Action
Reminder workflow is documented.				
Agreed reminder labels have been documented.				
A process exists to ensure annual 'cleaning' of data.				
Good practice health literacy is part of your policy and processes.				
Revisiting the 'quality improvement readiness tool' you completed in the beginning of your CQI can help you: <ul style="list-style-type: none"> » assess the changes and improvements you have made » identify any further actions you may wish to take. 				

Adapted from the Cancer Institute NSW, Cancer screening toolkit 2019.

