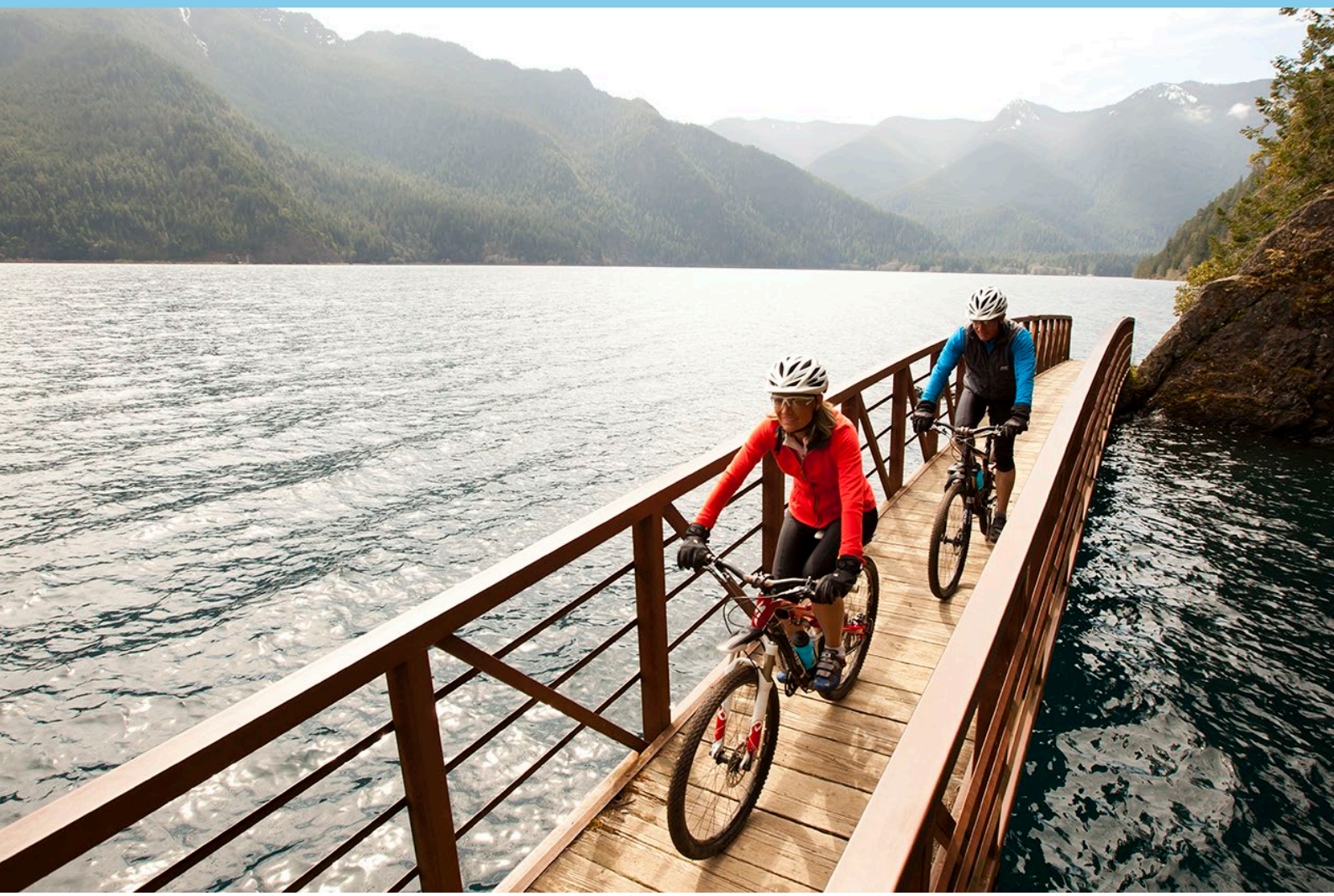
General Practice
Early Intervention Initiatives in Primary Care
Chronic Disease Management QI Toolkit

Toolkit for age group 40-70



SIMPLE HEALTHCARE SOLUTIONS
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About the Toolkit

Introduction

This Chronic Disease Management Toolkit has been developed by Simple Healthcare Solutions (SHS) as part of the Early Intervention Initiatives In Primary Care Project commissioned by Adelaide Primary Health Network (Adelaide PHN) in 2023-24.

This project focused on patients aged 40-70 years and aims to increase awareness, education, screening, intervention, and care for chronic disease. The toolkit is the result of a three-month sprint co-designed and trialled by 10 practices.

Aim

The aim of this toolkit is to provide a comprehensive quality improvement (QI) resource for primary care clinicians on how to improve early identification and management of chronic disease. The toolkit includes information on the role of primary care in early intervention, as well as activities and resources to drive individual practice improvement. Ideas, resources and recommendations from the 10 project practices will be shared throughout this toolkit.

Project methodology

During the project, SHS provided support to each of the practices via weekly huddle meetings (coaching sessions) throughout the chronic disease management sprint. The sprint was divided into three stages commencing with discovery stage to ensure all involved in the project explored the same baseline information and activities before embarking on their own quality improvement interventions. The following highlights the key components and outcomes achieved during the project.

Discovery Stage

The discovery stage incorporated foundational activties such as a practice readiness and reflection surveys, reconciliation and engagement with Local Medical Neighbourhood (LMN) activities to highlight specific and group level areas for improvement. This process of discovery reinforced multiple avenues for 'practice-centered improvement approaches to improve care plans' and the opportunity to 'implement case conferencing' for mutli-disciplinary care. These themes were carried into a change management stage and into 10 separate LMN interventions.

Change Management Stage

In this stage, SHS facilitated both in-person and virtual huddles for practices. These sessions supported practices in addressing their identified areas for improvement using SHS's digital Plan Do Study Act (PDSA) tool. In this sprint, 24 PDSA plans were created, encompassing 70 individual activity cycles, resulting in easily adoptable improvements. These improvements encompassed various changes such as heart health assessments, AusDrisk assessments, nurse support items, GPs completing care plans, health coaching, and prompts for SMART goal setting. All practices had the option to focus on these changes. By providing these activities and tools for implementation, SHS aims to serve as a quality improvement resource, ensuring that the change process becomes deeply embedded and sustained for the benefit of all involved.

Involvement of Local Medical Neighbourhood (LMN)

The third stage relates to LMN trialled interventions of which the ten practices were tasked with incorporating 20 patients through a targeted intervention with their LMN.

Following the conclusion of all discovery activities, all ten practices collectively identified and committed to collaborating with their LMNs to learn and implement case conferencing. Despite lacking any prior experience with case conferencing, the practices accomplished an impressive feat during the final six weeks of the sprint by successfully conducting 155 case conferences. This initiative, although not widely adopted, proved to be exceptionally fruitful, as evidenced by its impact. In the broader context, South Australia only claimed 2.3% (1,206) of GP-led case conferencing items nationwide (out of 53,999) in 2022. Remarkably, this project accounted for 12.8% of the SA total in just six weeks, showcasing its significant contribution and efficacy. Additionally, within this short timeframe, the practices generated substantial revenue, totaling $20,630 for GPs and $24,304 for Allied Health Professionals.

Final word

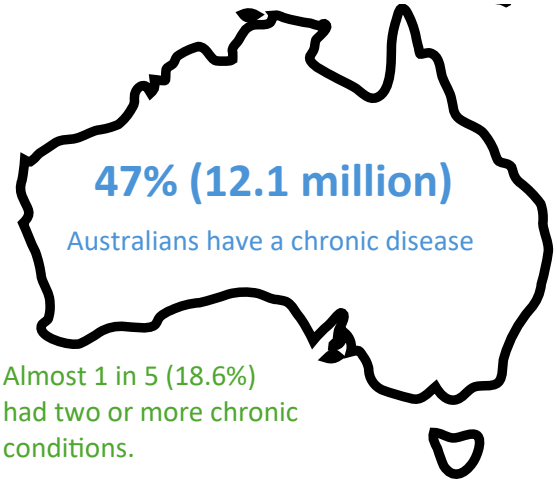
This toolkit builds upon the groundwork of these 10 practices and provides your team with the opportunity to self-identify and incorporate areas of improvement for chronic disease management. By undertaking these activities, you can self-record and meet practice PIP QI and individual GP CPD requirements.

The Impact of Chronic Disease

Australian Institute of Health and Welfare 2021

A chronic condition is an illness that lasts for at least 6 months. Effective management of chronic conditions can help improve overall health and wellbeing. It can prevent or delay complications and slow the progression of disease. Patients with chronic illness will benefit from having a team of health professionals involved in their care.

National Impact



Almost 1 in 5 (18.6%) had two or more chronic conditions.

51% of 2018 hospitalisations were related to chronic disease and 7% of all admissions were avoidable.

Primary Care Impact

1 in 4 (26%) had GP supported Chronic Disease Management Plan.

Less than half received a review over the next 12 months.

35% did not claim any of the Medicare-subsidised individual allied health services.

38% claimed one or more monitoring and support services (nurse item) over the next 12 months.

South Australian impact within 40-70 year-old population

37% of South Australia's population is in this age group.	
51% of this target group have a chronic disease.	HALF
Rates increase with age.	
In 2022, 2% of case conferencing claims were from SA.	

How to Use the Toolkit

The following guide is built from feedback obtained during the chronic disease sprint.

Adjust the order, number of activities and number of improvement cycles to suit your practice needs.

Initiating the Project

Assemble Team: Consisting of a nurse, a manager, and at least one GP.

Meetings**:** Set weekly internal huddle meeting times for 30-60 minutes over next 12 weeks.

Document Management: Implement a shared folder system for centralised access.

Discovery Activities (Weeks 1 – 4)

Complete one or more of the following activities over the first four weeks.

Practice Activation Measure Survey

CDM QI Self-Reflection Survey

CDM Reconciliation Activity

Local Medical Neighbourhood Pre-Work

Each activity has an outline and instruction guide that reinforces the intention behind each activity, how much time should be allocated, when and who should be involved as well as what outcomes you should likely find based on feedback shared through the project.

Upon completion of each activity, record three key ideas for quality improvement. These ideas will be shortlisted for the next section – Change Management.

Change Management (Weeks 5 -12)

Wk.	Activity Description
5	Hold a planning session to shortlist three ideas for quality improvement. *Ideas For Change Table*
6	Set up three PDSA cycles with designated practice champions leading one each. *Plan Do Study Act Template*
7-12	Conduct weekly progress meetings to discuss and advance PDSA cycles.

Local Medical Neighbourhood Quality Improvement Initiatives and Case Conference Implementation (Weeks 5 - 12)

Engage and work with your LMN to drive identified quality improvement-based initiatives.

Explore and implement case conferencing as a sustainable multi-disciplinary model of care.

Trialled Interventions and Examples

View, adopt and continue to improve interventions provided in this section to suit your practice.

Continuing Professional Development (CPD)

If you are using these activities to meet your practice PIP-QI activity or for logging specific CPD hours (reviewing performance and measuring outcomes) the documents will be required to be saved, and potentially uploaded as evidence of participation.

As this is a quality improvement activity, we recommend that your team explore your own ideas rather than trying to fit your findings to the examples provided as the ideas for change may vary between practices based on their capacity and capability.

For accredited education, access to digital versions of activities and/or coaching support please contact Simple Healthcare Solutions.

Adelaide PHN is a not-for-profit organisation predominately funded by the Commonwealth, whose key objectives are to increase the efficiency and effectiveness of primary health care services for individuals. Adelaide PHN provides General Practice with ongoing support, education and resources, please email for further information; practicesupport@adelaidephn.com.au

Practice Activation Measure (PrAM) Survey Outline

Key information

	Link	Activity form
	Staging	Discovery stage
	Who	Practice Champions
	Time	1 – 1.5 hrs
	CPD	Self-recorded RP

Activity overview

The Practice Activation Measure (PrAM) Survey, developed by Simple Healthcare Solutions, is a tool tailored for general practice staff to evaluate their readiness for quality improvement projects focused on healthy aging initiatives.

Practice Activation Measure (PrAM) Survey

Rationale for the activity

The rationale for implementing the PrAM survey activity lies in its ability to assess practice readiness, facilitate benchmarking, stimulate idea generation, and drive action planning for quality improvement initiatives targeting healthy aging. By engaging practices in this structured approach, healthcare organisations can foster a culture of continuous learning and improvement, ultimately leading to enhanced healthcare outcomes for aging populations.

Activity instructions

1. Complete survey within the first week.
2. Collate results and review averages.
3. Discuss strengths & improvement areas.
4. Record three key ideas for change.
5. Optional: Repeat survey at sprint's end for progress comparison.

Insights from the project

When comparing against baseline results:

- Practices showed significant improvement in staff understanding and knowledge regarding healthy aging initiatives, indicating effective education and awareness efforts.
- Significant improvement was made in establishing multidisciplinary teams to enrich feedback and involvement.
- Notable improvement in setting clear goals and designating project leads was observed.
- Practices made strides in staff training and data analysis mechanisms indicating a commitment to continuous learning and evidence-based decision-making.
- Marked improvement in reviewing barriers and encouraging open communication signifies collaborative culture.

'Helped us realise we have more work to do. Highlighted the opportunity for us to review what each of us do so same messages are communicated across the board. This will help us with our continuity of care.'

Tips for best activity outcomes

- Present activity to whole of practice as an opportunity for improvement, not as an assessment of performance.
- Seek practice feedback and brainstorm ideas for improvement following initial results collation.
- Shortlist three ideas for improvement (below) that your team can potentially address using PDSA framework.

What three key ideas for change have you identified?

1.	
2.	
3.	

Chronic Disease QI Self-Reflection Survey Outline

Key information

	Link	Activity form
	Staging	Discovery stage
	Who	Practice Champions
	Time	1 – 1.5 hrs
	CPD	Self-recorded RP

Activity overview

The Chronic Disease QI Self-Reflection Survey, developed by Simple Healthcare Solutions, is a tool tailored for general practice staff to assess assumptions and knowledge regarding service provision, clinical processes, and quality improvement initiatives related to chronic disease management. This reflective exercise aids practices in understanding their strengths and areas for improvement, ultimately enhancing the quality of care delivered to patients.

Chronic Disease QI Self-Reflection Survey

Activity instructions

1. Complete survey within the first month.
2. Collate and review results.
3. Review data to identify actual results.
4. Discuss strengths & improvement areas.
5. Record three key ideas for change.
6. Optional: Repeat survey at sprint's end for progress comparison.

Insights and findings from the project

Identified improvement areas

The survey revealed overestimations in certain metrics, including the rates of patients with recorded care plans and those receiving heart health assessments. These findings pinpoint areas for improvement in documentation, patient outreach, and preventive care efforts.

Setting relevant targets

Practices showed a significant increase, from

Measure	Estimate	Actual
Chronic disease prevalence	68%	58%
Care plan (721) historic	72%	42%
Care plan (721) actual	55%	20%
40-49 Health Assessments	21%	11%
Heart Health Assessments	20%	3%
Case Conference	8%	0%

33% to 70%, in setting relevant targets for providing services to patients with chronic diseases.

Independently searching for answers

The percentage of practices able to independently search and find answers to questions related to chronic disease management increased from 53% to 70%.

Tips for best activity outcomes

- Present activity to whole of practice as an opportunity for improvement, not as an assessment of performance.
- Seek practice feedback and brainstorm ideas for improvement following initial results collation.
- Shortlist three ideas for improvement (below) that your team can potentially address using PDSA framework.

What three key ideas for change have you identified?

1.	
2.	
3.	

Chronic Disease Reconciliation Activity Outline

Key information

	Link	Activity form
	Staging	Discovery stage
	Who	Practice Champions
	Time	1 – 1.5 hrs
	CPD	Self-recorded RP

Activity overview

This activity focuses on enhancing chronic disease management in practices by facilitating a reflective conversation among practice champions to pinpoint and act on improvement opportunities.

It guides practices through a structured process to evaluate and refine their approach to chronic disease management.

Designed to be time-efficient, the activity takes about 1 to 1.5 hours to complete.

Rationale for activity

The 'Chronic Disease Management (CDM) Reconciliation Activity' aligns with Australian

CDM guidelines by:

- Ensuring practices follow the RACGPs' Red Book for Preventative Activities
- Aiming for quality improvement in early chronic disease identification and management.
- Being co-designed with healthcare practices for practicality and relevance.

It is included as a discovery activity to prompt practices to evaluate and improve their CDM care strategies, fostering continuous quality enhancement.

Tips for best activity outcomes

- Practice champions should do this activity together, utilising their collective experiences.
- Discuss and record how to measure performance and improvement actions in the relevant columns.
- Allocate 3 to 5 minutes for each guidance point based on project experience.
- Identify and record top three ideas for improvement.

Insights from the project

- Data Review: Practices recognised the need to spend more time reviewing data at different levels, from overall population to individual patients. They know how many patients might be on care plans have but lack information on outcomes, goal achievement, and meeting clinical targets.
- Realistic Goals: Practices are working to set more realistic treatment goals by aligning templates with guidelines and focusing on patient-specific objectives.
- Medication Management: Practices recognise the need to improve medication management. This includes boosting health literacy, promoting non-drug treatments, and involving pharmacy teams in medication reviews (MBS 900). Practices identified they do not monitor and promote average medication prescriptions and deprescribing rates.

What three key ideas for change have you identified?

1.	
2.	
3.	

Local Medical Neighbourhood (LMN) Activities Outline

Key information

	Link	Activity form
	Staging	Discovery stage
	Who	Practice Champions
	Time	2 hrs
	CPD	Self-recorded RP

Activity overview

LMN Discovery Activities offer a structured approach for practices to assess and improve LMN relationships. Through guided activities, they identify collaboration opportunities and enhance patient care.

Activity information and instructions

LMN Discovery Activities

Activity 1: LMN Discovery Activity

A 10-question survey designed for practices to self-identify who is in their immediate LMN and how well they truly know them.

1. Explain the purpose: self-identify the practice's LMN and assess familiarity with its members.
2. Provide LMN Discovery Activity questions to staff.
3. Encourage honest responses to the 10 questions.
4. Facilitate staff discussion to share insights.
5. Identify strengths and areas for LMN improvement.
6. Capture three insights for potential quality improvements.

Activity 2: LMN Allied Health Providers Table

An activity for General Practices to compile a succinct list of Allied Health Professionals within their LMN.

1. Working together, complete the activity table.
2. Analyse the compiled list with the team to identify patterns and areas for improvement.
3. Capture three key insights for potential quality improvements.
4. Share the completed table with the practice.

Insights and findings from the project

- All practices recognised the potential of the address book for care planning and case conference application.
- Emphasis on networking, face-to-face meetings, and obtaining feedback from providers for enhanced communication and information exchange.
- Acknowledgment of the need for a more structured approach to recognising referred providers.
- Proposed strategies include reinstating morning tea meetings, creating notice boards, and revisiting provider lists.

What three key ideas for change have you identified?

1.	
2.	
3.	

Change Management Stage Outline

Key information

	Link	Activity form
	Staging	Change management Weeks 5 - 12
	Who	Practice Champions
	Time	Variable
	CPD	Self-recorded RP

Stage overview

Over the next eight weeks, it is time to implement your ideas using PDSA Cycles for quality improvement. Check out the trialled interventions for inspiration and guidance.

Rationale

Context of Quality Improvement

Quality improvement is a systematic approach to regularly reviewing and refining processes with the goal of enhancing the quality of care and health outcomes for patients.

Implementing quality improvement activities, particularly through a team-based approach, can lead to positive changes in practices.

Quadruple Aims

The Quadruple Aim focuses on improving primary care practices in four key areas: patient experience, care team well-being, population health, and reducing costs. By undertaking quality improvement initiatives that positively impact all four areas, a practice can achieve better access to care, quality, safety, outcomes, staff satisfaction, population health, and cost management.

PDSA as the change management tool

PDSAs are a systematic approach practices can use for regularly reviewing and refining processes to improve care and health outcomes for patients. By breaking down changes into manageable pieces and testing them, practices can ensure measurable improvements and reduce risk while encouraging creativity and achieving team unity.

You are welcome to utilise the PDSA Template or SHS digital PDSA Tools via our website.

Plan Do Study Act (PDSA) Template

Activity Instructions

Wk.	Activity Description
5	Hold a planning session to shortlist three ideas for quality improvement. *Ideas For Change Table*
6	Set up three PDSA cycles with designated practice champions leading one each.
7-12	Conduct weekly progress meetings to discuss and advance PDSA cycles.

Tips for best activity outcomes

- Brainstorm as a team.
- Discuss and agree on steps together.
- Prepare project leads for implementation.
- Save PDSA templates into shared folder.
- Seek feedback, communicate, improve, and promote.

Shortlisted ideas for change

1.	
2.	
3.	

LMN and Case Conferencing Outline

Key information

	Staging	LMN & Case Conferencing Weeks 5 - 12
	Who	Practice Champions/LMN
	Time	Variable
	CPD	Self-recorded RP

Stage overview

Over the next eight weeks, this stage will see your practice work with your identified Local Medical Neighbourhood to explore and implement case conferencing as a multi-disciplinary model of care for patients with chronic disease management plans.

For accredited training and implementation support, contact Simple Healthcare Solutions.

Rationale

Quality care, particularly for chronic disease, requires a multidisciplinary approach to maximise patient outcomes.

Relevance to General Practice

Case conferencing Medicare items (see below) allow GPs to organise meetings to address patients' multidisciplinary care needs. GPs can claim rebates up to 5 times yearly, and Allied Health can also claim since 2021.

Who	Item	Duration	Value
GP	735	15-20 mins	$77.85
GP	739	20-40 mins	$133.10
GP	739	> 40 mins	$221.90
AHP	10955	15-20 mins	$45.70
AHP	10957	20-40 mins	$78.40
AHP	10959	> 40 mins	$130.45

Project experience

Despite no prior experience, 10 practices completed training, held 155 case conferences, and generated $20,630 for GPs and $24,304 for Allied Health Professionals in just 6 weeks.

Not widely used!

In 2022, South Australia claimed only 2.3% (1,206) of GP-led case conferencing items nationwide (53,999). This project accounted for 12.8% in just 6 weeks.

Activity guidance

1. Engage identified allied health professionals you wish to work with.
2. Organise or coordinate individual or group training.
3. Hold re-occurring planning and implementation sessions utilising PDSA's. Be sure to cover the following:
   - Identification and engagement process for patients
   - Consent process and documentation (modify and upload templates).
   - Scheduling and delivery of conference
   - Facilitation methods (in-person, phone, virtual or hybrid).
   - Conference documentation and claiming of service.
   - Post service requirements and follow-up.

Consent Template (general)

Case Conference Template (general)

Tips

- Consult AskMBS and view all MBS online annotations.
- Remember patients do not need to be present. Patient choice.
- Consider organising back-to-back conferences with the same team members. Book ahead.
- Consider HealthDirect Video Call to host meetings and share documents.

Case conferencing continued..

Key takeaways and benefits

Recognition of patient motivation

Case conferences have highlighted the determination and motivation of some patients in their efforts to address health issues, like weight loss.

Identification of unforeseen health issues

Through collaborative discussions, healthcare providers have uncovered previously undisclosed health issues in patients, including gout, spinal injuries, and neuropathy.

Emphasis on preventative care

The case conferences have underscored the importance of preventative care and early interventions, particularly for high-risk patients, to avoid complications and health deterioration.

Improved understanding of patient needs:

The healthcare team now has a better understanding of the psychosocial, physical, and lifestyle needs of patients, enabling them to provide more targeted support and care.

Enhanced interdisciplinary communication

The case conferences have highlighted the need for improved communication between professionals and to have the right motivated healthcare professionals to work collaboratively in care coordination and planning.

Monitoring and supports provided

In addition to the training, resources and huddle meetings provided, SHS extended additional supports for practices to assist their implementation and monitoring of their goals.

The following supports were extended and utilised:

- Moderation support for several GPs with their first case conference. This support included obtaining additional consent from patients so that SHS could co-facilitate with the GP in a guiding/mentoring role, not a clinical role.
- Technical support for practices setting up and using HealthDirect as the primary video-conferencing tool of choice.
- Engagement and communication with allied health professionals and GPs that were not able to attend training.
- Additional reporting provided for practices to meet their targets.
- Additional face to face and virtual sessions were also extended.

Trialled Interventions

The following are a few examples of the trialled interventions and ideas the project practices explored through their PDSAs.

Please note, not all of these improvement activities and interventions were peer reviewed and may still require further improvements.

PDSA Improvement Ideas

Data-driven improvement

- Develop a recipe for PENCS to identify patients and monitor outcomes.
- Analyse collected data to determine a 5% improvement target and set daily/weekly KPIs.
- Review and trial modified care plan templates.
- Establish a table/survey to assess consistency in care plan creation by providers/nurses.
- Gather patient feedback through questionnaires to enhance the process.

Training and efficiency

- Provide motivational interviewing training for all nurses.
- Measure and set individual efficiency goals for nurses in care plan creation.
- Implement prework procedures with systematic planning and patient coaching.
- Business case for hiring additional part-time nurses.
- Create a table to analyse reasons for care plan variations and understand doctor-nurse interactions.

Engagement and workflow

- Develop an opportunistic engagement strategy for nurses, including diary recall for eligible patients and patient resources.
- Explore forward bookings and same day service options.
- Improve workflow efficiency.
- Establish what percentage of nurse time can be allocated to care plans, health assessments and other duties to avoid burnout.

Patient-centred care

- Improve the patient experience by reducing appointment length.
- Review and discuss templates and processes with the team.
- Gather feedback through surveys and time-in-motion questions.
- Consult doctors on their preferred care plan templates.
- Ask patients about their knowledge, preparation, and experience with care plans.

Better Health Coaching Service

Government of South Australia
Preventive Health SA

https://betterhealth.sa.gov.au/

The Better Health Coaching Service is an evidence based, confidential telephone coaching service funded by Preventive Health SA to support South Australians to be active, eat well and reduce the risk of chronic disease.

The Better Health Coaching Service is free to eligible South Australians aged between 18 and 74 years, with a BMI of 27 or above who are seeking support to build and maintain healthy lifestyle habits.

The program links participants with a qualified health professional who provides up to 10 coaching calls over six months.

Patient Resources

healthdirect

Health Direct is a government-funded service, offering quality, approved health information and advice. Health Direct provides a range of services including a health information website, a symptom checker, and the National Health Services Directory.

Insights from project

- Not all practices and staff were aware of the services provided by Health Direct.
- Patients involved in consumer workshops were not familiar with this either.

Recommendations

- Review chronic disease related link https://www.healthdirect.gov.au/management-of-chronic-conditions
- Promote HealthDirect as quality source of information in waiting rooms, patient resources and on practice website.
- Hyperlink resources into care plan template and communications so that information when accessed is always current.

Practice Activation Measure (PrAM) Survey

#	Question	Score out of 10 (10=High)	Ideas for improvement
1	Our practice staff members understand the importance of healthy ageing initiatives in improving patient outcomes		
2	Our practice staff members are knowledgeable about the specific healthy ageing initiatives being implemented.		
3	Our practice has the necessary resources (e.g., funding, equipment) to support the implementation of healthy ageing initiatives.		
4	Our practice has clear goals and objectives for quality improvements targeting healthy ageing initiatives.		
5	Our practice has designated a project lead or champion for driving quality improvements.		
6	Our practice has an established multidisciplinary team that includes representatives from different roles (e.g., doctors, nurses, administrative staff, allied health professionals etc) to collaborate on our quality improvement initiatives.		
7	Our practice staff members regularly receive training or education opportunities that relate to quality improvement activities.		
8	Our practice has mechanisms in place to collect and analyse relevant data on patient outcomes and satisfaction related to healthy ageing initiatives.		
9	Our practice regularly reviews potential barriers or challenges that may arise during quality improvement implementation cycles and has plans to address them.		
10	Our practice encourages open communication and collaboration among staff members to support the successful quality improvement initiatives.		

Chronic Disease QI Self-Reflection Survey

#	Question	Answer | Practice Average	Comments | Ideas for improvement
1	Without looking, what percentage of your patients have a chronic illness?		
2	Without looking, what percentage of your chronic disease patients have historically had a care plan (GPMP/TCA)?		
3	Without looking, what percentage of your chronic disease patients have an active (within 12 months) care plan?		
4	Without looking, what percentage of these patients with an active care plan receive care plan reviews at least once a year?		
5	Without looking, how many times throughout the calendar year will your nurses support these patients and claim the nurse item (MBS 10997)?		
6	Without looking, what percentage of your patients between the ages of 40-49 have received a health assessment?		
7	Without looking, what percentage of your eligible patients have received a heart health assessment (MBS 699)		
8	Without looking, what percentage of patients with an active care plan receive the same Team Care Arrangement each subsequent care plan? *i.e., continue to see Podiatrist x 3 and Physio x 2.*		
9	To the best of your knowledge, has your practice ever completed an MBS Case Conference for eligible patients with chronic disease?		
10	Without looking, what percentage of patients with a care plan have		

#	Question	Answer | Practice Average	Comments | Ideas for improvement
	received a case conference with their allied health team?		
11	With respect to the questions above, has your practice set relevant targets in providing these services for your patients with chronic disease? [Yes / No]		
12	With respect to the questions above and without looking for instructions, are you able to independently search and find the answers to these questions? [Yes / No]		
13	When was the last time you had an all of practice meeting discussing your quality improvement strategy? • Last 3 months • 3 to 6 months • 6 to 12 months • 12+ months or never		
14	Do you have a Quality Improvement Action Plan in place? [Yes / No]		
15	If I were to walk into your practice and ask each staff member what your current Quality Improvement focus is, would they know and be able to tell me how your practice is working towards it? [Yes / No]		
16	If I were to start as the new practice manager tomorrow, would I have a registry of quality improvement activities and outcomes I could access and continue to support? [Yes / No]		
17	How often do you broadcast your QI activity outcomes to staff? • Weekly • Monthly • Quarterly • Yearly / Never		

#	Question	Answer | Practice Average	Comments | Ideas for improvement
18	Are your QI activity outcomes shared with your patients? [Yes / No]		
19	Do you involve your patients and/or seek feedback for your QI activities? [Yes / No]		
20	When was the last time your practice reviewed and modified templates (i.e., care plans, health assessments) to ensure patient-centred principles, SMART goal setting and outcomes are captured and focussed on? • Last 3 months • 3 to 6 months • 6 to 12 months • 12 months / never		

Chronic Disease Reconciliation Activity

Components	Guidance	Practice Considerations	Ideas for change
1. Initial Assessment			
Perform a comprehensive medical history, including family history, lifestyle factors, and social determinants of health.	How is this captured, documented and communicated. How often is this reviewed? What processes (registration forms) support this process.		
Conduct a physical examination, including measurements of blood pressure, weight, and waist circumference.	How and when do we routinely do this? Consider an audit activity to determine what percentage of patients have these measures?		
Use validated assessment tools, such as the Australian Type 2 Diabetes Risk Assessment Tool or the Australian Absolute Cardiovascular Disease Risk Calculator, where appropriate.	Do we utilise this tool? What other tools come to mind for early identification/ assessments?		

Components	Guidance	Practice Considerations	Ideas for change
2. Diagnosis and Classification			
Establish a definitive diagnosis based on Australian clinical practice guidelines for specific chronic diseases, such as diabetes, hypertension, asthma, etc.	Do we have practice wide agreement on our diagnosis guidelines? How do we know we are capturing and recording the right information?		
Classify the disease severity or stage, if applicable, according to relevant guidelines.	How and where do we all classify this information? Are we consistent?		
3. Treatment Planning			
Develop an individualised management plan based on evidence-based guidelines, patient preferences, and available resources.	Consider reviewing care plan templates. Consider a random sample audit to determine individuality and person-centred reflection.		
Set realistic treatment goals, considering the Australian recommended targets for specific chronic diseases.	Consider reviewing templates. Consider a random sample audit.		
Engage in shared decision-making with the patient, taking into account their preferences and cultural background.	Consider reviewing templates to confirm/add prompts to evidence this. Consider a random sample audit.		

Provide culturally appropriate and patient-centred care.	How do we address different cultures? Are our templates / process flexible?		

Components	Guidance	Practice Considerations	Ideas for change
4. Lifestyle Modifications			
Promote healthy lifestyle behaviours, including regular physical activity, healthy diet, smoking cessation, and reducing alcohol intake.	How well do we engage these conversations and record these measures? Consider reviewing: Use of 5 A's (Red Book)		
Provide resources and referrals to support behaviour change, such as exercise programs, dieticians, and smoking cessation services.	Do we have a of list of resources and referrals available?		
Consider cultural, socioeconomic, and environmental factors when providing lifestyle advice.	How is this captured and shared internally and externally?		

Components	Guidance	Practice Considerations	Ideas for change
5. Medication Management			
Prescribe medications based on the Australian Medicines Handbook (AMH), Therapeutic Guidelines, or specific disease guidelines.	Do we internally monitor and support each prescriber in our practice? Do we raise or identify risks where medications prescribed are questionable?		
Review medications for potential interactions, contraindications, and side effects.	How do we review this information? Have we set-up an audit schedule to review potential risks? Do we have system notifications set up for contradictions?		
Ensure patient understanding of medication instructions, including dosages, frequency, and potential adverse effects.	How do we evidence this? Consider a symptom action plan.		
Regularly review and adjust the medication regimen as necessary.	How often do we review? Do we involve pharmacy? Do we utilise Home Medicines Reviews (MBS item 900)?		

Components	Guidance	Practice Considerations	Ideas for change
6. Regular Monitoring and Follow-up			
Schedule regular follow-up appointments to monitor disease control, treatment response, and adherence to the management plan.	How do we monitor this? Do we monitor disease on a provider or practice level? Consider an audit on patients with MBS item 721 who have not had MBS item 732.		
Perform appropriate laboratory tests, imaging studies, or other diagnostic evaluations based on disease-specific guidelines.	How do our templates and processes support reminders for these measures?		
Use validated assessment tools, such as the Patient Health Questionnaire (PHQ-9) for depression or the Asthma Control Test (ACT) for asthma, to monitor patient outcomes.	Consider use of internal and external tools to monitor outcomes?		

Components	Guidance	Practice Considerations	Ideas for change
7. Patient Support and Self-Management			
Provide patient education on the chronic disease, its management, and the importance of self-care.	What is our approach? How do we know it is effective?		
Support self-management strategies, including goal setting, action planning, and problem-solving.	Do patients have a shared self-management plan including My Symptom Action Plan		
Consider incorporating telehealth services, digital health tools, or chronic disease management programs available in Australia.	Do we record patient preferences/ options/ consents for in-person, phone, video and case conferencing? Do we capture this information for their support personnel or service providers (Aged care | Disability)?		

LMN Discovery Activity (Activity 1)

Guided Questions	Comments	Ideas for change
On a scale of 1 to 10 (10 being absolutely - 1 being no way), Do you have a complete trusted network of local health professionals you can work collaboratively with? • *Are there any gaps in your network that need to be addressed?* • *How would you rate the accessibility and responsiveness of your current network members?*		
Do you currently have an up-to-date list of medical professionals your practice engages frequently? • *How do you ensure the accuracy and currency of this list?* • *Are there any specific criteria for inclusion on this list?*		
How often does this list get reviewed, edited and updated? • *What triggers a review/update of the list?* • *Is there a designated individual or team responsible for this task?*		
How many contacts are on this list? • *We recommend exporting your address book so you can view this database in its entirety*.		

Guided Questions	Comments	Ideas for change
If I was a new GP or Practice Nurse from interstate starting at your practice today, how would I know who to go to? • *Do you have a designated onboarding process for new staff to familiarise them with your network?* • *Is there a resource or documentation available to guide new staff on referral protocols?*		
If I was one of your practices' top 10 LMN referee (receives referrals) and walked through your practice unannounced… - would I know and recognise each of your doctors and/or nurses by name? - would your doctors, nurses and administration team recognise me and know me by name and discipline? • *How do you ensure visibility and recognition for key network members within your practice?* • *Is there a system in place to acknowledge and appreciate top referrers?*		
Do you have a team member responsible for engaging, fostering and maintaining relationships? • *What specific duties or responsibilities does this team member have?* • *How do you measure the effectiveness of their relationship-building efforts?*		
Do you have any existing memorandums of understanding (MOU's), agreements or in-principal agreements with members of your LMN?		

Guided Questions	Comments	Ideas for change
• *How do these agreements benefit both parties involved?* • *Are there any plans to expand or revise these agreements in the future?*		
How do you as a practice monitor the performance and quality of services provided by your LMN? • *What metrics or indicators do you track to evaluate performance?* • *Is there a feedback mechanism in place for patients to provide input on network services?*		
Can you provide an example of a time where you have created additional access to services or introduced a new service for your practice? • *What metrics or indicators do you track to evaluate performance?* • *Is there a feedback mechanism in place for patients to provide input on network services?*		

What three key ideas for change have you identified?

1.	
2.	
3.	

LMN Allied Health Providers Table (Activity 2)

- Using your contacts, add each LMN health professional under their discipline and complete the guidance questions.
- If your practice receives multiple allied health services from one group - list the group/company name under each section or record each name with group in brackets
- Utilise frequency data or apply rough estimates based on how many per month.
- Once entered, rank individuals based on frequency within each discipline.
- Once entered, rank disciplines based on overall frequency.

Discipline / Name	Length of relationship? (Years)	Proximity to practice (Km's)	Individual or Group	Referral Frequency (estimate: how many/month)	Discipline Rank (1 through 12) 1 = Highest Frequency.
Accredited Exercise Physiologist					
1.					
2.					
3.					
Dietitian					
1.					
2.					
3.					
Podiatrist					
1.					
2.					
3.					
Occupational Therapist					

Discipline / Name	Length of relationship? (Years)	Proximity to practice (Km's)	Individual or Group	Referral Frequency (estimate: how many/month)	Discipline Rank (1 through 12) 1 = Highest Frequency.
1.					
2.					
3.					
Physiotherapist					
1.					
2.					
3.					
Psychologist					
1.					
2.					
3.					
Diabetes Educator					
1.					
2.					
3.					
Social Worker					
1.					
2.					
3.					
Speech Pathologist					
1.					
2.					

Discipline / Name	Length of relationship? (Years)	Proximity to practice (Km's)	Individual or Group	Referral Frequency (estimate: how many/month)	Discipline Rank (1 through 12) 1 = Highest Frequency.
3.					
Pharmacist					
1.					
2.					
3.					
Speech Therapist					
1.					
2.					
3.					
Respiratory Therapist					
1.					
2.					
3.					
Optometrist/ Ophthalmologist					
1.					
2.					
3.					
Audiologist					
1.					
2.					
3.					

What key insights did you gain? What activities and actions will you follow up with as a result?

Plan Do Study Act (PDSA)

PDSA Name:			
Project Lead: (Name and role)		**Commencement Date:**	
Core Project Team: (Minimum of three)		**Due Date:**	
Progress Meeting Details: (Day/time/location)		**Total Number of Weeks:** (No longer than eight weeks)	
What are we trying to accomplish? Use Specific, Measurable, Achievable, Relevant and Time (SMART) goals. *Example: Increase our daily care plans by nurse from 4 per day (1 June) to 6 per day by 31 July.*		**Data Collection:** How will we know we have made an improvement? Who, what, where, when, how is the data accessed and collected?	
What ideas/actions and considerations do we have? - Brainstorm and record what ideas/actions your project team has for change. Identify considerations from the ideas/actions generated. - Agree and assign the ideas/actions 1 to 5 as these will order your PDSA activity cycles. - Consider alignment to quadruple aims.	Ideas/actions:	Considerations:	

Table 2: PDSA Activity Summary

ACTION PLAN [Re-write a short action name from the ideas ranked above]	**PLAN** What, who, when, where and how.	**DO** Was the plan executed? Document any unexpected events or problems.	**STUDY** As a team - record, analyse and reflect on the results.	**ACT** What will you take forward form this cycle? (i.e. next steps / next PDSA).
Idea/Action 1:				
Idea/Action 2:				
Idea/Action 3:				
Idea/Action 4:				
Idea/Action 5:				

Idea/Action Activity Cycle Number:	**1**	**Idea/Action:**	
Plan Describe it further. Link it to the objective. What are your predictions? Consider sequence of events / next steps. Plan for collecting data.			
Do Run the test. Describe what happens. Collect data. Use this space to record progress/notes during the 'Do' phase.			
Study Analyse data. Compare outcomes to predictions. Summarise what you learned.			
Act Decide what's next. Make changes and start another cycle.			

Idea/Action Activity Cycle Number:	**2**	**Idea/Action:**	
Plan Describe it further. Link it to the objective. What are your predictions? Consider sequence of events / next steps. Plan for collecting data.			
Do Run the test. Describe what happens. Collect data. Use this space to record progress/notes during the 'Do' phase.			
Study Analyse data. Compare outcomes to predictions. Summarise what you learned.			
Act Decide what's next. Make changes and start another cycle.			

Idea/Action Activity Cycle Number:	**3**	**Idea/Action:**	
Plan Describe it further. Link it to the objective. What are your predictions? Consider sequence of events / next steps. Plan for collecting data.			
Do Run the test. Describe what happens. Collect data. Use this space to record progress/notes during the 'Do' phase.			
Study Analyse data. Compare outcomes to predictions. Summarise what you learned.			
Act Decide what's next. Make changes and start another cycle.			

Idea/Action Activity Cycle Number:	**4**	**Idea/Action:**	
Plan Describe it further. Link it to the objective. What are your predictions? Consider sequence of events / next steps. Plan for collecting data.			
Do Run the test. Describe what happens. Collect data. Use this space to record progress/notes during the 'Do' phase.			
Study Analyse data. Compare outcomes to predictions. Summarise what you learned.			
Act Decide what's next. Make changes and start another cycle.			

Idea/Action Activity Cycle Number:	**5**	**Idea/Action:**	
Plan Describe it further. Link it to the objective. What are your predictions? Consider sequence of events / next steps. Plan for collecting data.			
Do Run the test. Describe what happens. Collect data. Use this space to record progress/notes during the 'Do' phase.			
Study Analyse data. Compare outcomes to predictions. Summarise what you learned.			
Act Decide what's next. Make changes and start another cycle.			

Outcomes and Next Steps Table

Once all of the activity cycles have been completed in the allocated time, complete the outcomes and next steps table.

Summarised Outcomes (In 1-2 sentences, summarise the outcomes of this PDSA.	
Were the original objective(s) achieved? (Yes / No) and if no, why not?	
Measure(s) of success. Describe the outcome measure compared to the baseline. I.e. we improved our rate by 5% or we achieved 50% of our original target.	
Were you able to complete the PDSA within the planned timeframe? (Yes / No) and if no, why not?	
How and when (if needed) will this PDSA topic require review?	
How has this PDSA been communicated with all staff?	
Where has this document and any supporting documents/resource been saved? Consider share drives or network folders with all staff access.	

Ideas For Change Table

Use this document to help record and organise your ideas from each of the discovery activities.

Order and rank the ideas into three ideas you wish to commence with.

Assign different project leads to each of the three ideas.

Activity	Idea	Description	Order/ Rank
Practice Activation Measure Activity	1		
	2		
	3		
CDM QI Self Reflection Activity	1		
	2		
	3		
CDM Reconciliation Activity	1		
	2		
	3		
LMN Activities	1		
	2		
	3		

Case Conference Consent Template

[Your Practice Name]

[Address]

[City, State, Postal Code]

[Phone Number]

[Email Address]

[Website]

PATIENT CONSENT FORM: Case Conferencing

Patient Information

Patient Name: _____

Date of Birth: _____

Address: _____

City: _____ State: _____

Postal Code: _____

Phone Number: _____

Email Address: _____

I, the undersigned, [Patient Name], hereby give my informed consent to participate in MBS Case Conferencing Items of Care at [Your Practice Name]. I acknowledge that I have been provided with the necessary information and understand the purpose, benefits, and potential risks associated with case conferencing. I have had the opportunity to discuss any concerns or questions I may have had with my healthcare provider, and all my queries have been adequately addressed.

Please read the following information carefully before signing this consent form:

1. Purpose and Nature of Case Conferencing:

- Case Conferencing involves the collaboration and discussion of my medical case among healthcare professionals to develop a comprehensive treatment plan.
- Case conferencing aims to enhance the quality of my care by facilitating communication and coordination between healthcare providers involved in my treatment.

2. Benefits of Case Conferencing:

- Improved coordination and continuity of care.
- Enhanced communication among healthcare professionals involved in my treatment.
- Comprehensive and tailored treatment plans.
- Increased efficiency in the delivery of healthcare services.
- Potential for improved health outcomes.

3. Potential Risks and Confidentiality:

- The information shared during case conferencing is subject to strict confidentiality requirements and will be treated with utmost privacy.

- All healthcare professionals involved in the case conferencing are bound by professional and legal obligations to maintain the confidentiality of patient information.
- Efforts will be made to ensure secure transmission and storage of electronic records.
- However, despite these precautions, there is a minimal risk of unauthorised access to my medical information.

4. Voluntary Participation:

- My participation in Case Conferencing is entirely voluntary, and I understand that I have the right to withdraw my consent at any time without affecting my right to receive medical care.
- I have the right to decline participation or limit the information shared during case conferencing without prejudice to my medical treatment.

5. Duration of Consent:

- This consent form will remain valid whilst I am a patient at [Your Practice Name] unless I withdraw my consent.

By signing below, I confirm that I have read and understood the information provided in this consent form. I voluntarily give my informed consent to participate in Case Conferencing at [Your Practice Name].

Patient Signature: _____

Date: _____

Parent/Legal Guardian (if applicable):

Printed Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Please retain a copy of this consent form for your records.

If you have any questions or concerns regarding this consent form or Case Conferencing, please feel free to discuss them with your healthcare provider or contact us at the practice.

Thank you for your cooperation.

[Your Practice Name]

[Signature of Healthcare Provider]

[Printed Name of Healthcare Provider]

[Date]

Case Conference Template

Case conferencing items are for GPs to organise and coordinate, or to participate in, a meeting or discussion held to ensure that their patient's multidisciplinary care needs are met through a planned and coordinated approach.

PATIENT DETAILS

Name:		DOB: Age:	
Carer:		Patient is a carer for:	
Address:			
Contacts:	Home:	Work:	Mobile:
☐ Interpreter Required	If Yes, Language:		

CONSENT

☐ Case conference explained	Date consent obtained:

DATE AND DURATION OF CASE CONFERENCE

☐ Face to Face	☐ Telephone	☐ Other:	
Date:	Start time:	Finish time:	Duration (mins):
MBS Item claimed:			

CASE CONFERENCE PARTICIPANTS

Name	Role	Organisation	Contact

ITEMS DISCUSSED

Patient history and identification of needs

- *GP to lead with brief overview and reason for conducting case conference.*
- *Discuss present risks.*
- *Discuss what is important to the patient (motivation).*

Identifying outcomes to be achieved by members of the team and tasks that need to be undertaken by each member.

Target outcomes

Tasks

Assessing whether previously identified outcomes (if any) have been achieved.

Checklist

☐ Notes placed in patient's medical record	
☐ Copies offered to patient, carer, members of the team	
☐ Appointment arranged to discuss outcomes with the patient	
☐ Book next Case Conference	Appointment date/time:

SIMPLE HEALTHCARE SOLUTIONS
FOCUS ON WHAT MATTERS

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