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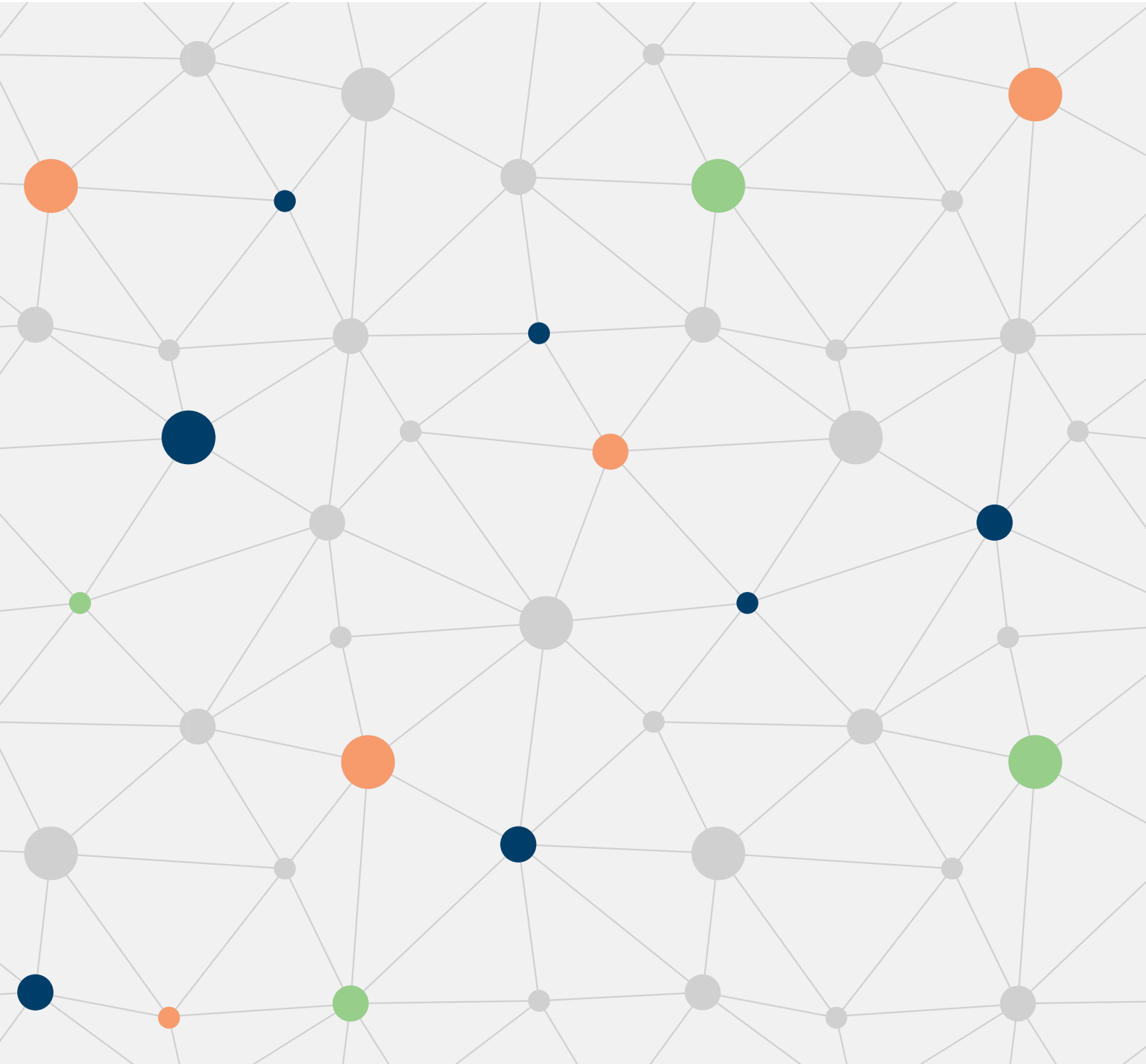
An Australian Government Initiative

Quality Improvement Toolkit



This Quality Improvement Toolkit has been developed as an initiative of the Latrobe Health Innovation Zone (LHIZ), funded by the Victorian Department of Health and Human Services.

The information included within this toolkit was developed by Murray PHN, Western Victoria PHN and North Western Melbourne PHN for the Community led cancer screening project.

Gippsland PHN acknowledges original work designed by the Improvement Foundation (UK), with permission from the Cancer Institute of NSW and additional content formulated by the North Coast Primary Health Network.

Version: 2.6
Publish Date: October 2019

For more information about the Community led cancer screening project visit *www.vtphna.org.au/community-led-cancer-screening*

Quality Improvement Toolkit

Contents

What is Quality Improvement?

Quality improvement (QI) in healthcare is based on the concept that health care is a system. Unlike a manufacturing line, which can be micron perfect, healthcare is about people (often one person at a time), but it is a system. On any day, in Australia, many thousands of people visit a Health Service. Most people will return to their Health Service of choice and the Health Service will have considerable information (data) about them. This data provides a powerful insight into the person's current health state and potential future health state.

QI is the use of this information, at a health service level, combined with the use of QI tools and techniques by a health care team. This activity changes the health service's systems and processes to ensure that sustainable improvement is achieved.

Within health care, quality has been defined as *the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge*[1].

QI is defined as a systematic approach that uses specific techniques to improve quality. It involves continuous efforts to implement systematic change and achieve stable and predictable results.

"Health Service" in this toolkit is a defined term and means any primary healthcare organisation that delivers services with a general practitioner, such as a general practice, Aboriginal Community Controlled Health Organisation, Aboriginal Medical Service or community health service.

Quality Assurance vs Quality Improvement

QI is sometimes confused with quality assurance. Quality assurance assesses whether health care services meet a set of requirements by comparing them to a set of pre-defined criteria. Quality assurance often involves a retrospective approach, which may include inspections. QI, on the other hand, is proactive and involves purposeful efforts and teamwork to improve processes, systems or outcomes.

What can QI achieve?

Effective standard operating procedures

Improved outcomes for patients

Improved outcomes for health care organisations[2]

What are the aims of QI?

Make healthcare safe and effective

Make healthcare person centred

Make healthcare timely, efficient and equitable[2]

Why is Quality Improvement important?

For most Australians, primary care is their first point of contact with the health care system. In mid 2015, it was reported that approximately 20% of the Australian population has two or more chronic conditions[3]. Patients with multiple chronic conditions often receive treatment from a number of health providers, many of whom work in different locations and often in different parts of the health system. As a result, effective communication between the health care team can be challenging, leading to gaps in the quality and safety of patient care[4].

Generally, the primary health care system performs well and most health care is associated with good clinical outcomes. However, some people do not receive all the care that is recommended to them; there is considerable variation in access to health care around the country and the outcomes of this care. Additionally, preventable adverse events continue to occur across the entire health care system[5 6]

In order to frame improvement in the primary health care setting, Health Services can adopt the Quadruple Aim, an approach to optimise health system performance by:

- Pursuing improvements in population health
- Enhancing patient experience of care
- Reducing per capita costs to the health care system
- Improving the work life of health care providers[7]

When working in any of the four Quadruple Aim areas, it's important to remember that improving patient care remains at the core.

If Health Services use the four areas of the Quadruple Aim to guide the development of QI initiatives, as a result should collectively achieve significant improvements.

There is real opportunity for health care services to:

- Build a whole of team approach
- Improve patient outcomes via early detection and intervention, and
- Contribute towards reducing burden of disease and associated costs to the healthcare system.

Figure 01

The Quadruple Aim Method

Improving the work life of health care providers

Benefits

Improves employee satisfaction and turnover

Improves patient satisfaction and reduces workplace injuries

Enhancing the patient care experience

Benefits

Reduced spending for workers' compensation claims, employee injuries and medical error litigation

Benefits

Less patient suffering through reduced medical errors, healthcare acquired infections and injuries

Benefits

Reduced readmission

Reduced error-related complications

Reducing the per capita cost to the health care system

Pursuing improvements in population health

Quality Improvement Planning

How to plan for Quality Improvement

To drive your improvement work, it is important to develop and implement a Quality Improvement Plan (QIP).

A QIP clearly identifies priority area(s) and "sets the scene" for what you and your team hope to achieve through your improvement work. It provides the team with a document to focus their efforts on your chosen QI priorities over time. In this example, cancer screening will be the focus, however, your QIP can be expanded to include other areas over time.

Ideally, the QIP you use will include:

- An overview of the plan and how the team will approach the improvement work
- The overarching aim(s) of the plan
- The principal measures to track progress against the aims
- The change areas that will guide the improvement work.

Developing your Quality Improvement Plan

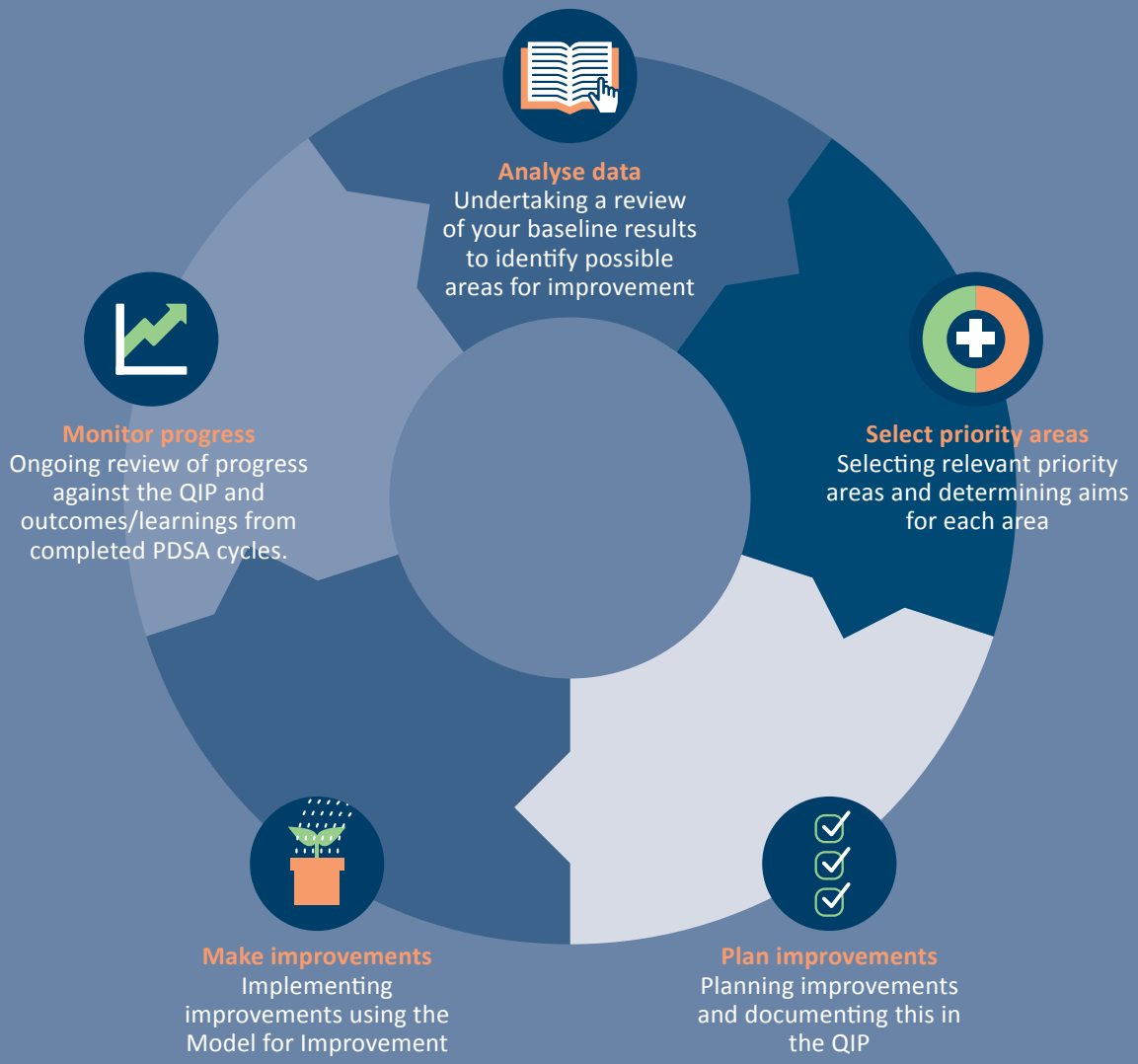
The first step is to clearly define why you would like to make improvements to the selected priority area for your Health Service's population and to share the reasons with the whole team. Consider what benefits you may realise both during, and as a result, of undertaking quality improvement work. For example, you could enhance teamwork and communication within the team, while making improvements to specific internal processes and systems.

To effectively determine the most important areas for improvement, it is essential to understand whether there are issues with patient outcomes or satisfaction, business processes, financial outcomes or organisational capacity. Analysing the data you currently have will help to determine the type and the extent of the issue(s). Understanding what the issues are, and thinking about why these issues are occurring, will assist you with the selection of your priority areas.

Next, select the individuals and/or team who will be responsible for developing, implementing and monitoring the QIP. The initial development may be undertaken by a small team or subset of the Health Service team. However, the whole team should be engaged in the QIP development so they're aware of the overall goals and how these will be brought about. Over time it's likely that the whole team will be involved.

Figure 02

How to develop and implement a Quality Improvement Plan



Reviewing your Quality Improvement Plan

It is extremely important that you regularly monitor, review and record progress in meeting your aims. Sometimes, the aim, measures or change areas that were initially chosen are not leading to the intended improvement and amendments to the QIP are required.

When undertaking your QIP reviews, make sure you have all relevant information at hand so that you can objectively determine your progress.

Monitor the target dates for achieving the overarching aim(s). If it has not been possible to achieve an aim by the anticipated date, document the progress achieved so far and set new strategies and a new target date. The aim may need to be rewritten so that it is realistic and achievable.

Once an aim has been reached, document this and move on to the next aim.

Consider scheduling regular reviews of the QIP at team meetings so that progress can be shared and everyone stays focused on what needs to be completed. Reviewing your QIP does not need to be time consuming; discussing progress as a group is a time efficient strategy. The insights and input of other team members will enhance this process.

You may also wish to consider the following questions in your review process:

Has there been a change in staffing? New staff may require upskilling and often bring new ideas and different experiences that could be included.

Has new research and/or resources become available to support assessment of your current processes against best practice?

Can you delegate identified actions to other staff to build leadership skills and share the knowledge across the whole team?

The Royal Australian College of General Practitioners (RACGP) Standards for General Practices —5th Edition

RACGP standards include a range of requirements relating to QI. This toolkit, if followed correctly, will help Health Services demonstrate that the Health Service can meet or exceed the indicators documented by the RACGP for quality improvement activities.

The RACGP standards set the benchmark for quality care and risk management in Australian general practices. They support general practices in identifying and addressing any gaps in their systems and processes.

For more information on the Standards for General Practices—5th Edition
racgp.org.au/running-a-practice/practice-standards/standards-5th-edition

Refer to the RACGP Resource Guide for supporting information to help meet indicators in the Standards 5th edition
racgp.org.au/running-a-practice/practice-standards/standards-5th-edition/resource-guide

Criterion QI1.1
Quality improvement activities —Indicators[8]

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

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

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

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

Model for Improvement

The Model for Improvement (MFI)[9] provides a framework for developing, testing and implementing changes in any setting or system, and on any scale. It involves choosing specific and measurable goals, selecting objective measures of improvement that can be tracked over time, and identifying key change ideas that will result in an improvement. The change effort is broken down into manageable steps, which are tested to determine whether improvement is being achieved.

Overview of the Model

The Model for Improvement consists of two equally important parts:

For an overview of the Model for Improvement, take a look at the video on YouTube
youtube.com/watch?v=lZAx-69Vn_Y

1—The 'thinking' part

This consists of three fundamental questions that are essential for guiding your improvement work:

Identify the goal. What are we trying to accomplish?

Identify the measures. How will we know that a change is an improvement?

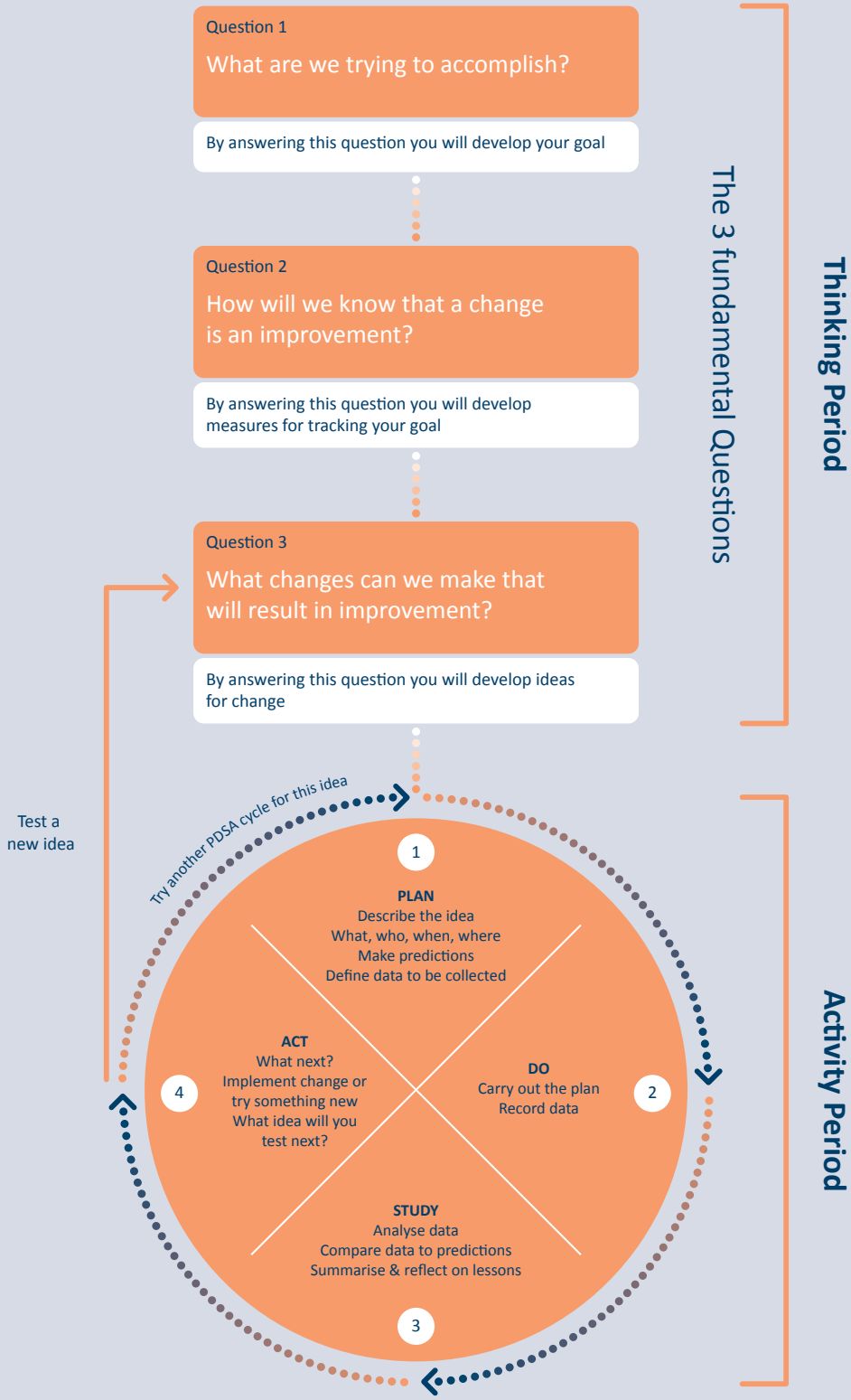
Identify an idea change. What changes can we make that will result in an improvement?

2—The 'doing'/'testing' part

This part is made up of Plan, Do, Study, Act (PDSA) cycles that will help you test and implement change.

Not every change is an improvement. By making small, incremental changes, you have the opportunity to test the change on a small scale and learn about the risks and benefits before implementing the change more widely. A number of PDSA cycles will be required to achieve your improvement goal.

Figure 03


Question 1
What are we trying to accomplish?
By answering this question you will develop your goal
Question 2
How will we know that a change is an improvement?
By answering this question you will develop measures for tracking your goal
Question 3
What changes can we make that will result in improvement?
By answering this question you will develop ideas for change
The 3 fundamental Questions
Thinking Period
Activity Period
Test a new idea
Try another PDSA cycle for this idea
1
PLAN
Describe the idea
What, who, when, where
Make predictions
Define data to be collected
2
DO
Carry out the plan
Record data
3
STUDY
Analyse data
Compare data to predictions
Summarise & reflect on lessons
4
ACT
What next?
Implement change or try something new
What idea will you test next?

Question 1:
What are we trying to accomplish?

We often launch into change without stopping to think about what we are trying to achieve. The first question provides an opportunity to consider exactly what it is you are seeking to change.

Once you and your team have agreed on the goal, it will guide you, keep you focused and motivate the team. To answer the first of the three Fundamental Questions, you will need to write a clear and concise goal for improvement.

Helpful Tip
Use the SMART principle as a guide: an effective goal is: Specific, Measurable, Achievable, Relevant and Time-bound. Your goal will be less effective if it is vague, hard to measure, unrealistic, irrelevant or open-ended.

Begin by:

Defining the problem. Success is all in the preparation! Understanding the problem and its root cause will help you with developing your goals.

Setting bold but realistic goals that are specific and have a defined timeframe. Use plain language and avoid jargon, so that the meaning is clear to everyone.

Including information that will help keep the team focused (for example, the location of the test and a focus on certain patient populations).

Question 2:
How will we know that a change is an improvement?

Without measuring, it is impossible to know whether the change being tested is leading to improvement. Measures should be collected before you make the change (baseline data), and at regular intervals as you test changes.

Try to find measures that show progress towards the goal; however, you may have to accept that your measures are not perfect. Spending too much time trying to create the perfect measurement system is a common pitfall.

Helpful Tip
Consider choosing a combination of *process measures* (measures that tell you whether the actions you have chosen are actually happening) and *outcome measures* (measures that show you the effects of your actions).

Remember:

Don't collect more measures than you need

Make measure collection as simple as possible. If you choose a measure that must be collected manually, create a simple data collection form and ensure someone is made responsible for completing the form.

Everyone in your team needs to know what you are measuring, how, when, and who is responsible for collecting the data.

Use diagrams and charts to show your measures to the team. Presenting data in a simple format helps with communicating this information to the whole team.

Question 3:
What changes can we make that will result in improvement?

By the time you answer this question, you should know your goal and how you will measure progress towards achieving it. Here's when you can become creative and encourage the whole team to contribute ideas. After answering this question, you will have a range of useful ideas, which can be tested in PDSA cycles.

You know your own healthcare service best, so keep your goal in mind and use your knowledge and experience to guide you to the ideas that suit your unique situation.

Adapt ideas from others. Ask your Gippsland PHN support officer to share successful change ideas that other practices have trialed and implemented.

Use creative QI tools to help your team generate ideas that may be able to influence a positive change

Achieving your goal may take successful testing (and implementation) of more than one idea generated by your team

Following this step, you should have several ideas that may contribute to achieving your goal. You will need to select one to test and generally there are some ideas that have greater support from the team.

Helpful Tip

Consider generating ideas by:

Running brainstorming sessions with the team

Chatting informally when you have the chance (e.g. during lunch)

Asking for ideas during a team meeting

Setting up a suggestion box for staff (or even one in the waiting room for patients)

Emailing everyone in the team

Considering the steps normally taken to complete a task and removing one to see what happens. For example, if you couldn't use the telephone to contact patients, how would you communicate with them? If the nurse left, how would you run your clinics?

Figure 04

Example: Effective Goal Setting using the three fundamental questions

Question 1: What are we trying to accomplish?

Your team has decided to work on Bowel Cancer Screening. You might state your goal like this:

Our goal is to: Increase the number of people who undertake bowel cancer screening

This is a good start, but how will you measure whether you have achieved this goal? Your team will be more likely to embrace change if the goal is more specific and has a time limit. So, for this example a better goal statement would be this:

Our goal is to: Increase participation in bowel cancer screening by 15% for patients aged 50 (first timers) by 31 May 2019

Question 2: How will we know that a change is an improvement?

Continuing with our example on Bowel Cancer Screening, your answer to the Second Fundamental Question might be this:

We will measure:

Number of patients aged 50 and over on our clinical database

The percentage of patients aged 50 who have a FOBT result recorded

Question 3: What changes can we make that will result in improvement?

Using the Bowel Cancer Screening example, your answer to the Third Fundamental Question might be this:

Ideas for change:

Audit patients aged 49 and send letter encouraging participation in the NBCSP

Audit patients aged 50 and send letter to those who have not yet had an FOBT

Create an ongoing system for sending a letter to people aged 49 to encourage their participation in the screening program

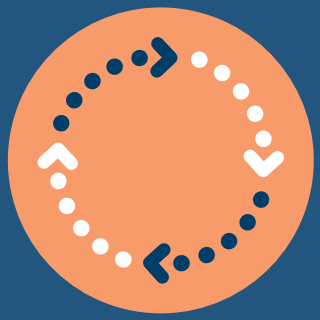
Clinicians to discuss and encourage screening opportunistically

Add bowel cancer screening to templates for CDM and 45-49 Health Assessments

Source and provide endorsed patient education resources in waiting rooms, toilets and distribute demo kits

Run an awareness campaign for bowel cancer awareness month

Please see Appendix for a template on quality improvement goal setting



Plan, Do, Study, Act Cycles (PDSA)

The Three Fundamental Questions will prepare you for the next stage, during which you will use PDSA cycles to test the ideas for change that you developed to answer the third Fundamental Question. By testing ideas, you will find that some changes lead to improvements, while others aren't successful. Analyse why they didn't work and learn from this. By carrying out small tests, you can avoid implementing unsuccessful changes on a wide scale.

Think big and test small. The idea could involve quite a large change, however, the test needs to be on a small scale. Think about testing a change with one GP, or one health worker, or a select group of patients over a short period of time. The knowledge gained from this small test will help you determine if the change had the desired effect and is suitable for wider implementation, or whether adjustment(s) to the idea may be required. In some cases the idea may fail and therefore you will need to try another idea and test this in the same way.

Please see Appendix for a template to help you complete your PDSA cycles

Helpful Tips

No PDSA cycle is too small. Making them too big is a more common problem. Keep it simple and just do it (e.g. Think 'what can we do by next Tuesday?'). A PDSA cycle that is too large can usually be broken down into two or three individual PDSA cycles.

You should expect to complete a series of PDSA cycles to achieve your goal – don't expect complete success the first time. It is by building on your previous cycles that you achieve results.

Make sure you involve the right people in your work as improvement is nearly always a team effort.

Set aside protected time to do the work and don't try to squeeze it into a busy schedule.

Documenting your PDSA cycles is a great way of motivating the team, by sharing what you've learned with other people.

Don't be discouraged if an idea doesn't work. You will learn as much from something that did not go well as you can from something that did.

Figure 05

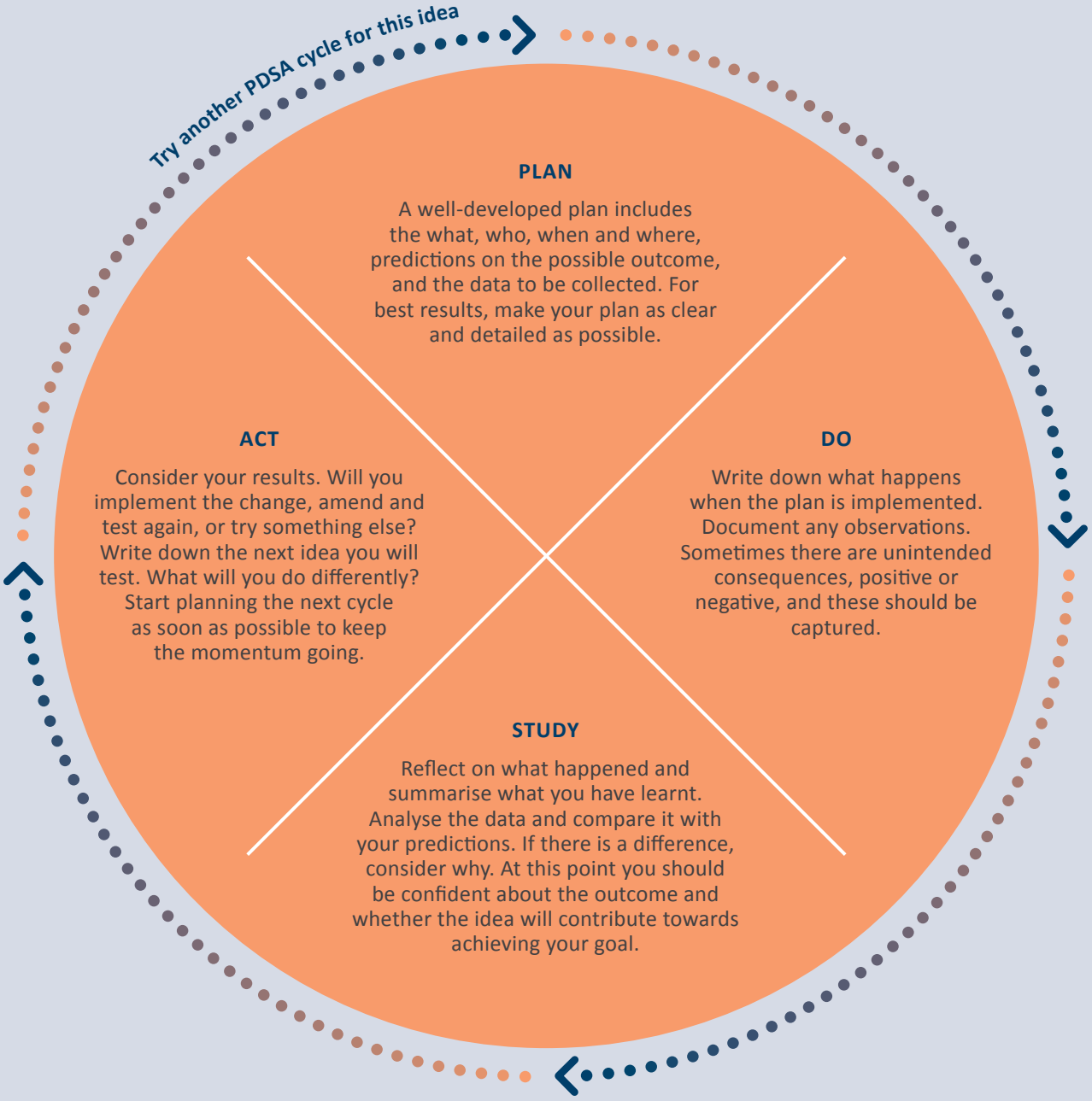

Try another PDSA cycle for this idea
PLAN
A well-developed plan includes the what, who, when and where, predictions on the possible outcome, and the data to be collected. For best results, make your plan as clear and detailed as possible.
DO
Write down what happens when the plan is implemented. Document any observations. Sometimes there are unintended consequences, positive or negative, and these should be captured.
STUDY
Reflect on what happened and summarise what you have learnt. Analyse the data and compare it with your predictions. If there is a difference, consider why. At this point you should be confident about the outcome and whether the idea will contribute towards achieving your goal.
ACT
Consider your results. Will you implement the change, amend and test again, or try something else? Write down the next idea you will test. What will you do differently? Start planning the next cycle as soon as possible to keep the momentum going.

Figure 06

Example: Effectively using PDSA Cycles

IDEA 1

Audit patients aged 50-74 years who have not had a FOBT result recorded.

PLAN

What: John to use Sue's office to conduct an audit and identify active patients aged 50-74 years who have not had an FOBT result recorded.

Who: John, Practice Manager, Sue, Practice Nurse

When: 17 March

Where: At the practice

Prediction: 30% of these patients will have an FOBT result recorded

Data to be collected: number of active patients aged 50-74 years who have had an FOBT result recorded

DO

Done: scheduled protected time on 17 March. Completed data cleaning prior to conducting the audit in POLAR, all completed 17 March.

STUDY

36 out of 152 of patients aged 50-74 years have had an FOBT (24%). This is lower than predicted.

ACT

Next PDSA Cycle: Flag all active patients aged 50-74 years (116) who do not have a FOBT result recorded in medical software for follow up activities.

IDEA 2

Flag all active patients aged 50-74 years (116) who do not have a FOBT result recorded in medical software for follow up activities.

PLAN

What: Mary to flag all active patients identified in the audit as aged 50-74 years with no FOBT result recorded, John to communicate with all GPs that flagged patients without FOBT results need to be followed up and recorded

Who: Mary, Administration, John, Practice Manager

When: Mary - 24 March, John – 26 March

Where: At the practice

Prediction: 100% (116) of all identified patients without a FOBT result recorded will be flagged, John to send email to 13 GPs regarding flagged patients

Data to be collected: number of active patients aged 50-74 who have been flagged as having no FOBT result recorded

DO

Done: Mary scheduled protected time on 24 March to conduct flagging of all 116 patients without a FOBT result recorded. John drafted and sent email to all 13 GPs informing them of flagged patients and resources on how to code FOBT in medical software on 26 March.

STUDY

100% of all identified patients without a FOBT result recorded have a flagged message of their bowel screen status

ACT

Next PDSA Cycle: Send a letter to patients aged 50-74 years (116) who do not have a FOBT result recorded.

IDEA 3

Send a letter to patients aged 50-74 years (116) who do not have a FOBT result recorded.

PLAN

What: Sue to draft a letter template and John to post letters to patients aged 50-74 years who have not had a FOBT result recorded

Who: Sue, Practice Nurse, John, Practice Manager

When: Sue - by 7 June, John - by 10 June

Where: At the practice

Prediction: 116 letters sent, with 0 letters sent back

Data to be collected: number of patient letters sent, number of letters received back

DO

Done: Sue scheduled protected time on 7 June, completed letter template. John scheduled protected time on 8 June and 9 June and finalised letters, all 116 letters sent on 10 June.

STUDY

116 letters sent to identified patients, 4 letters received back. Letters received back were unexpected, addresses no longer correct.

ACT

Next PDSA cycle: SMS patients aged 50-74 years who received a letter and provided no response.

IDEA 4

SMS patients aged 50-74 years who received a letter and provided no response.

PLAN

What: John to run a report of those aged 50-74 years without a FOBT result recorded in the medical software, and who have provided no response to the letter. Send out a reminder SMS to those eligible.

Who: John, Practice Manager

When: 31 July

Where: At the practice

Prediction: 90 patients identified as no FOBT result recorded and no response, 90 SMS sent out.

Data to be collected: number of eligible patients, number of SMS sent out

DO

Done: John scheduled protected time on 31 July to run the report and sent out SMS to patients identified on the report.

STUDY

98 patients identified with no FOBT result recorded, 98 SMS sent out, 6 bounced back, invalid phone numbers.

ACT

Next PDSA cycle: Follow up with patients who had no response to letter or SMS with a phone call.

New MFI: Apply this process of engaging under screened, non-screened patients to other cancer forms.

Implementing a Change

Once you have tested a change, determined that it is effective, and your team supports this new way of working, you will need to implement the change.

Implementing a change means making it a sustainable process within the organisation. For simple changes, implementation will be relatively straightforward. For other changes, effective implementation will require training and on-going monitoring to ensure that the team does not return to the old way of doing things.

When considering implementation, ask yourself these questions:

What other changes are needed to support implementation of this change long term?

Your new way of working may require an alteration in support structures such as job descriptions or standardised procedures, as well as updating your policy and procedures manual. For example, you could add regularly reviewing the accuracy of patient registers as a part of the Practice Nurse's role to ensure routine coding by staff is maintained.

Does the wider team need to be involved in the implementation of the change?

Testing a change may have involved a small group of people. However, implementing the change may affect others that were not involved in the testing process. You will need to consider how to engage these individuals, identify any resistance and promote the benefits of the new way of working. You may find that the data you collect through testing provides valuable information to convince the wider team about the benefits of the proposed change. For instance, you could print monthly graphs showing the improvement achieved after implementing the ideas tested in your PSDA cycles and display them in the staff room or present them at staff meetings.

Will a regular review process be needed to make this change permanent?

You may consider that a bi-annual audit of the new system or process is needed. This could be a component of the standardised procedures that are developed to support the new system. For example, an audit of whether the patient registers are being appropriately maintained.

Notes

Measuring your progress through data

Quality Improvement and Measurement

How do you know if the changes you are making are leading to improvement? The only way is to measure. Successful measurement is a cornerstone of QI.

Measurement allows a team to demonstrate current performance, set goals and monitor the effects of changes made.

It also enables teams to:

- Identify performance gaps and safety issues
- Understand patterns and trends
- Make decisions and undertake planning
- Understand unintended consequences

In addition, measurement allows for benchmarking against others, which is often a great motivator for change.

As you start the Quality Improvement journey, it is important to understand that not all measurement is the same.

You will typically need to conduct measurement at different times in an improvement project and at different levels, outlined in Figure 07.

Measurement does not need to be difficult or time-consuming. The key is to pick the right measures so that you can see results quickly and are able to adapt your actions accordingly, putting less strain on your resources and a greater focus on outcomes.

Figure 07

The Three Basic Levels of Measurement

Population Topic Measures
Measures that provide consistent data to track your progress over time ie. cancer screening or diabetes

Goal Measures
Measures that answer the Second Fundamental Question: *How will we know that a change is an improvement?*

PDSA Measures
Measures at the PDSA cycle level which help you assess the idea being tested in the PDSA cycle.

Introduction to Data and Measurement for QI

Measurement is a fundamental part of QI and business in general. To produce sound and reliable measurement you will need well defined measures and good data quality.

Data is talked about a lot in QI. “Data” is information in raw or unorganised form (such as alphabets, numbers or symbols) that refer to, or represent, conditions, ideas, or objects. Data are transformed into measures using a set of rules and often these rules will not be visible as they are coded into software. For example, the proportion (or percentage) of women who have received a cervical screen is an existing measure within clinical software.

In some cases, the “rules” can be quite complex and if you refer to the user guides of the software, you will be able to find these rules explained. In this toolkit, we will refer to POLAR GP Software as a tool to help with measurement and data cleaning. This is an ‘in practice’ software product for GPs, Practice Managers and other staff to use within their practice to support internal operations, patient-centred care, quality improvement and business development. Measurement can only be reliable if your Health Service has good quality data.

In this section, we’ll work through how your Health Service can ensure that it has good quality data, and then we’ll talk about how to produce measurement for QI.

Example

The result produced by the software is filtered in a number of ways, such as:

Including only women within the age range that is recommended

Excluding women with a coded condition of Hysterectomy, or where the Health Service has ticked the check box to exclude

Whether the woman is considered a “Regular Client” and/or an “Active” client can often play a part in measurement.

POLAR GP Software Support

For further information and support on how to use POLAR GP Software please contact your practice support team at Gippsland PHN.

Cleaning your data for Quality Improvement

Data cleaning refers to a process where staff at a Health Service specifically work on ensuring that the data within the clinical information system are complete, correct and coded properly.

Data quality in this context refers to the completeness, accuracy and consistent coding of data in the clinical information system.

To ensure quality data you need to consider the following:

- Identify missing or inaccurate data
- Correct and add missing data
- Remove corrupt or inaccurate data

Your team is critical to ensuring that your Health Service's data is clean. A clear understanding of each team member's responsibility to ensure the data collection, recording and maintenance process remains robust.

Data collection and coding

To minimise data cleaning efforts and the need to significantly correct poor work practices such as missing or inaccurate data, it is important to implement a robust and consistent data collection, recording and maintenance process.

Coding data wherever the system allows is paramount. If you do not code, for example conditions or allergies, then data will not be considered "clean" and the clinical information system cannot function in the way it is intended. For example, when uploading a Shared Health Summary, if conditions and allergies are not coded, they will not be included in the upload.

Your Health Service should have an agreed approach to the collection and recording of data including:

- A process to ensure that patient demographic, contact and billing details are complete and current
- An agreed approach to coding conditions and ensuing that the patient's clinical record is complete
- Ensuring that all pathology providers are supplying results electronically in an atomic format such as HL7 (not a scanned PDF)

Example: Data cleaning for cancer screening

Identifying people for cancer screening and communicating with them relies on:

- Accurate patient contact and demographic information, such as sex, ethnicity, date of birth, address, mobile phone number
- Coded conditions so that the software can exclude people with certain conditions, for example exclusions for FOBT include bowel cancer, cancer of the colon, carcinoma of the colon and 20 other coded conditions
- Test results recorded, and data (any text) recorded in the result area of the test record.

For cancer screening to be effectively measured, all of these data elements must be accurate and recorded in the correct place within the clinical information system.

Auditing your data

Your Health Service should have a regular audit process in place to assess the completeness and accuracy of data. This should be done at least quarterly to monitor your process to ensure that it remains robust and reliable. If not, your data quality will reduce over time and your hard work in this area will be wasted.

An "audit" in this context is the process of evaluation or analysis in the clinical information system to assess its accuracy and completeness. POLAR can assist with this process, however, POLAR cannot determine whether some data are correct, such as ethnicity, phone number, address. Some data are sensitive to change over time and therefore, your audit process should include testing the accuracy of data that POLAR cannot help with.

This does not need to be an onerous process and can simply be calling 20 patients that have recently visited the Health Service (as their data should be up-to-date) and asking them to confirm a few details. If you find any gaps, then it's likely that your data maintenance process is not effective, and correction is required.

Measuring your progress

Now you have confidence in your Health Service's data quality, you can have confidence in the measurement produced from the data.

You can start measuring straight away. Just be aware that as your data quality improves over time, there may be changes to the measurement results that are due to data cleaning and not your quality improvement work.

Polar GP Software Support

For further information and support on how to use Polar GP Software please contact your practice support team at Gippsland PHN.

For a summary on the benefits of Polar GP Software
gphn.org.au/programs/data-analysis-extraction-tool-polar-gp

To login to POLAR
polarexplorer.org.au/Account/Login

Determining your Health Service's population

It is important that you take time to determine your Health Service's population. The approach to determining your Health Services population is likely to vary between Health Services due to the local context and patient demographics of your Health Service.

Consider the "RACGP Active Patient" concept, including the Indigenous National Key Performance Indicators (nKPIs). In POLAR The Regular Patient is generally defined as a person that visits the Health Service three or more times in any two year period. This concept is useful to filter on patients that are regularly visiting the Health Service.

For major rural Health Services in popular holiday destinations, it may be appropriate to limit the population by post codes that your Health Service would primarily service. Consider a policy to mark people outside this as inactive so that they are not included as a regular patient within your Health Services population.

Ensure consistency when archiving patients. Consider a policy that outlines an agreed approach for archiving patients, such as specific period of time that patients have not visited your Health Service.

Working with your team, decide how to determine the population of your Health Service. Once you have done this, you can search for Health Service Population in POLAR to establish your baseline data and measure your quality improvement progress. Saving these searches means they remain consistent over time and you can reliably measure your Health Service's progress.

POLAR GP Search Criteria

To start your quality improvement measurement journey, you will need to establish these POLAR searches and save these so that they can be used routinely and remain consistent across the journey.

These searches will measure the high-level change measures of your quality improvement and will be based on your Health Service's definition of the population.

Checklist 01

Approach to sustainable quality data

- ◯ To ensure sustainable quality data consider implementing a sustainable collection, recording and maintenance process
- ◯ Use POLAR to gain an understanding of how clean and complete your clinical database is and understand where there may be missing or inaccurate data
- ◯ Work with your team and discuss any missing or inaccurate data you've found and then identify gaps in the collection, recording and maintenance process
- ◯ Determine your strategy to approach data cleaning
- ◯ Work with your team on retrospective data cleaning
- ◯ Agree on an archiving approach that is consistent and suitable for your Health Service. Ensure that someone is responsible for archiving on a regular basis
- ◯ Ensure that you include a regular audit as part of the process, so you can monitor data quality over time
- ◯ When the process is sound, document the process and include roles and responsibilities in relevant position descriptions
- ◯ Make sure that your clinical software system is configured appropriately and that you are receiving pathology electronically in HL7 format wherever possible. You will need to contact pathology providers and check the delivery preference set for your Health Service. All software is different so please consult your vendor for assistance or Gippsland PHN practice support staff
- ◯ Use the Model for Improvement to improve your processes. You could also map the patient journey through your Health Service, specifically as it relates to data collection, recording and maintenance

Change principles for Quality Improvement

Engaging the practice team

Engaged and effective general practice teams are the absolute foundation for achieving sustainable improvements. Experience has shown that building the team's engagement and commitment to quality improvement work is often overlooked, and it becomes a weakness that impacts the ability for practices to achieve sustainable change.

If you want to change the outcomes for your practice, you will need to change what you are doing.

This will require some change management; it's important not to assume that the benefits of these changes will be understood or accepted by everyone. Facts are usually not enough, you need to get the "hearts and minds" onside for making changes.

The 'Engage and Support the Practice Team' checklist, and other tools and resources provided in this toolkit, will help you take the right steps to build an integrated, team-based and sustainable approach to quality improvement in your general practice.

Roles and Responsibilities of the Health Service Team

Consider how your Health Service team currently operates. Is your team working together effectively and efficiently? It's not unusual for Health Service teams to be working in silos, which can lead to gaps, errors, assumptions, duplication and other inefficiencies. To achieve sustainable improvement, you will likely need to do some work on achieving a whole of team approach to quality improvement.

There are a range of responsibilities for effective quality improvement within a Health Service. Documented role clarity is of high importance to ensure efficiency and accountability.

On the following page are examples of how responsibilities could be shared across the Health Service team. As there is a great deal of diversity between Health Services, consider what will work best for your team.

On the following pages we've listed examples of role based activities related to cancer screening. However, it is important that your team discusses the range of actions or tasks that are needed to make sure that your Health Service population receives appropriate cancer screening. Then, based on comparative advantage, which role(s) in the team is best placed to undertake which action(s).

Checklist 02

Working with your Health Service Team

Educate and build the capacity of your team to support quality improvement activities

- ◯ Does our team have a good understanding of RACGP standards?
- ◯ Does our team have a good understanding of our systems and processes to support quality improvement?
- ◯ Does our Health Service have a good understanding of the target populations of how to determine your health services target population?

Involve the whole team

- ◯ Can we give the whole team opportunities to generate ideas for improving quality improvement systems during team meetings or in other ways?
- ◯ Do we have both clinical and non-clinical leaders (eg. Clinician and Practice Manager)?
- ◯ Have we assigned roles, responsibilities and timeframes for carrying out tasks?
- ◯ Do our team members have the skills they need, or is more training required?

Ensure team members have protected time to complete tasks

- ◯ Does the way in which we assign roles make efficient use of our entire team?
- ◯ Have we assigned people realistic tasks in light of any resource or time constraints?
- ◯ Have team members been given “protected” time to regularly complete tasks?

Set realistic goals and use data to drive improvement

- ◯ Will our whole team be involved in setting our Health Service’s goals for this work?
- ◯ Are our goals SMART: Specific, Measurable, Attainable, Realistic and Time-bound?
- ◯ Do we have tools to measure progress against our goals?
- ◯ Are we using data to frequently review progress against our goals?

As a team, regularly reflect, review and adjust what you are doing

- ◯ Is reviewing progress, goals and new ideas part of our regular team meeting agenda?
- ◯ Are we regularly reviewing our progress and adjusting our goals and strategies?
- ◯ Are we rewarding and acknowledging success and working as a team to problem-solve any challenges?

General Practitioners

Respond to recall/reminder systems and engage in opportunistic discussions to encourage healthcare outcomes with relevant patients

Support relevant patients to participate in healthcare outcomes, including addressing potential barriers (eg. fear, embarrassment, lack of knowledge, access etc.)

Perform opportunistic tests in consultation with Practice Nurses

Assess and support patients with follow up care after a positive result. Additionally, assist by referring to appropriate pathways

Work in accordance with clinical guidelines:

—NHMRC approved Guidelines

—The Royal Australian College of General Practitioners (RACGP) Standards for General Practices Criterion GP2.2 — Follow up systems

Practice Nurses

Work with reception staff to promote the health programs within the Health Service

Respond to recall/reminder systems and engage in opportunistic discussions to encourage healthcare outcomes with relevant patients

Support relevant patients to participate in healthcare outcomes, including addressing potential barriers (eg. fear, embarrassment, lack of knowledge, access etc.)

If self collection or care is appropriate, demonstrate to patients how to use the equipment or kits

Perform opportunistic tests in consultation with General Practitioners

Refer patients of any age with symptoms or family history of concern to a GP for further investigation

Enter any results received, and an appropriate reminder, into the clinical software

Contact and provide support to patients following a positive result and arrange a GP appointment

Follow up patients who did not attend GP or other appointment(s), addressing potential barriers to participation (e.g. fear, embarrassment, lack of knowledge, access etc)

Practice Managers

- Maintain up to date data
- Undertake screening audits of Health Service records to identify lapsed patients as well as targeting those never screened, under screened and/or specific vulnerable groups
- Establish and oversee recall/reminder systems
- Support GPs with the flow of information to and from the Program Register
- Manage payments from relevant incentives
- Support/manage reception staff responsibilities
- Manage succession planning
- Document policy and procedures for health outcomes
- Monitor progress against goals and measures

Reception Staff

- Promote the healthcare programs within the Health Service
- Order and maintain supplies of program resources
- Display brochures, flyers and posters
- Respond to recall/reminders opportunistically when a patient phones for an appointment and/or by handing relevant resources to patients in the waiting area
- Send GP signed recall/reminder letters (and/or text messages and phone calls) to relevant patients to encourage participation.
- Provide resources and support information in alternative languages as needed.

Develop a systematic approach to quality improvement

A systematic approach to quality improvement requires the practice team to review the existing system, processes and current practice to identify barriers and opportunities for change. This process can determine where improvements can be made.

When developing a systematic approach for conducting quality improvement within your Health Service it is important to consider the following:

Ongoing development of sustainable and quality data

Ensure consistent use of recall and reminder systems

Engage the entire practice team throughout the process

Maintain clear and up to date processes and policies

Ensure clinical staff are familiar with local referral pathways

Embed regular and consistent communication with target population

The ‘Systematic approach to quality improvement’ checklist is designed to help your practice establish this approach and prioritise areas for improvement.

Checklist 03

Systematic approach to quality improvement

Considering your priority area and determine you target population

- ◯ Does our Health Service have a clear idea of when and how information is communicated to patients (ie. during health checks, as part of routine appointments, during specific information sessions, via written information)?
- ◯ Have we documented when and how information is communicated to patients?
- ◯ Do our team members have an understanding of the target population and the skills to conduct required tests or outcomes?
- ◯ Have our staff undertaken cultural awareness training?
- ◯ Have our staff undertaken health literacy training?

Undertake awareness raising

- ◯ Does our Health Service display health promotion materials?
- ◯ Do we regularly review the health promotion materials available and order posters or pamphlets relevant to our Health Service?
- ◯ Is our team aware of the most up-to-date health information?
- ◯ Does our Health Service participate and raise awareness of relevant health initiatives?

Identify at risk individuals and provide them with additional support

- ◯ Has our health service reviewed our data to determine the target population?
- ◯ Has our Health Service used the “Deliver person centred” checklist to identify actions that will strengthen engagement with individuals at-risk?
- ◯ Does our Health Service consider the diversity of the health services population and adapt approach to patient care accordingly?

Support individuals who have a positive test

- ◯ Do we use appropriate pathways for people who require further investigation after a positive test or diagnosis?
- ◯ Does our Health Service have resources and a team to support individuals with a positive or subsequent diagnoses?
- ◯ Does our Health Service use HealthPathways Gippsland and Optimal Care Pathways?

Delivering person centred care

The health needs of individuals is often complex and include a range of social, cultural, individual and environmental factors.

In a person centred health system the individual, as well as their families and carers, are at the core of how care is designed, planned, communicated and delivered. This is because ultimately, it is the values, resources and actions of the person and their carers that are the key determinants of health outcomes.

The following checklist, tools and resources are designed to help you take a person centred approach to delivering and promoting screening services.

Did you know?
A person centred approach will not only help you connect with 'hard-to-reach' groups but will also improve the experience for individuals who are screening regularly at your practice.

All general practices have 'hard-to-reach' groups who will not readily respond to invitations to attend screening or may be difficult to contact. Access to services may be limited by service restrictions, geographical or social reasons.

Hard to reach groups include:

- Aboriginal and Torres Strait Islander peoples
- People living with a disability
- People who identify as part of the LGBTQI community
- People from culturally and linguistically diverse (CALD) backgrounds
- People with mental health issues
- Homeless people

For patients with disabilities

To support those with disabilities, consider:

- Familiarising yourself with guidelines for the provision of preventative health care to patients with disabilities and creating summaries of these guidelines for clinicians
- Acknowledging the individual's lived expertise in managing their disability
- How you can improve physical access
- Using alternative positions and instruments if appropriate
- Working with residential care facilities to provide care with the patient's place of residence
- Be mindful that carers, clinicians and family can falsely assume patients with a disability have not had sexual contact, and may not require certain services
- Accessing available resources that will assist with educating patients with intellectual disabilities

For CALD patients

To support culturally and linguistically diverse patients, consider:

- Providing resources in appropriate languages
- Using interpreter services
- Working with health promotion officers targeting CALD groups
- Conducting workshops to educate and motivate CALD groups to perform desired action
- Understand cultural barriers
- Offer self collection where appropriate if patient is eligible
- Having community presentations and displays. For example, these could focus on women who are, or will soon be, eligible for breast or cervical cancer screening and provide a reminder for others on the importance of regular screening. Displays promoting screening can be presented at suitable CALD community events, such as a multicultural day.

Health literacy for clinicians

Health Literacy is the degree to which a person has the capacity to obtain, communicate, process, and understand health information and services to make appropriate health decisions.

Health Literacy is important as it shapes peoples long-term health outcomes and the safety and quality of the care they receive.

The infrastructure, policies, processes, materials, people and relationships that make up the health system have an impact on how information is received.

Health literacy also involves the ability of general practice to “make it easier for people to navigate, understand, and use information and services to take care of their health” Health literacy is an important area for us to address if we want to improve health outcomes.

For more information on health literacy for clinicians
safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/health-literacy/tools-and-resources-for-health-service-organisations

So, what can you do?

Develop a list of ideas for action from the checklist in this handbook and use the Model for Improvement to test your ideas.

Review your current patient information resources to ensure they are appropriate, e.g. they use plain language.

Ask specific cohorts of patients, their families or carers, to review your information resources.

Consider asking a group of individuals to form a Health Literacy Advisory Group.

Ensure the entire practice team have undertaken Health Literacy training

Figure 09

How can I help my patients understand their health better?

Checklist 04

A person centered approach to quality improvement

Understand individual's perspectives, and design and deliver your services accordingly

- ◯ Has our team mapped the care pathway from the individual's point of view to understand which aspects of the "patient journey" may be difficult to access, inconvenient, unclear or psychologically distressing for our patients?
- ◯ Does our Health Service co-design service delivery with patients and incorporate their perspectives into our delivery of care?

Work in partnership to address environmental, cultural and other barriers

- ◯ Does our Health Service partner with community organisations or leaders to better engage hard to reach groups and support referrals to other healthcare services?
- ◯ Does our Health Service use interpreter services appropriately?
- ◯ Is our Health Service a safe place for Aboriginal or culturally diverse people?
- ◯ Have our staff members read the Cultural Safety Factsheet? *aida.org.au/wp-content/uploads/2018/07/Cultural-Safety-Factsheet_08092015.docx.pdf*
- ◯ Have our team members undertaken cultural awareness training?
- ◯ Are our patient resources culturally appropriate?
- ◯ Do we offer patient resources in other languages?

Improve your organisation's health literacy

- ◯ Does our whole team understand the components of health literacy?
- ◯ Have our staff members (including reception staff) undertaken health literacy training?
- ◯ Does our Health Service display health promotion materials designed for specific cohorts of patients?
- ◯ Do we ask and record all new patients about their language preferences, and offer and use appropriate language services? (Accreditation: RACGP Core Standard 1, criterion C1.1, C1.3, C1.4, C1.5)
- ◯ Has our Health Service developed, or do we use audio-visual materials to support patients in better understanding their health care?
- ◯ Do our team members have the interpersonal skills to support all individuals in making informed choices about their healthcare?
- ◯ Does our Health Service have a clear process for communicating positive results with individuals in a way that helps them make an informed decision on treatment?
- ◯ Do our team members understand this process? Can they explain it?
- ◯ Use patient reported measures to drive improvement
- ◯ Does our Health Service request feedback from patients about their experience of care? (Accreditation: RACGP criterion QI1.2)
- ◯ Do patient reported measures form part of how we assess our Health Service's performance?

Patient centred care links and resources

The Australian Commission on Safety and Quality in Health Care (ACSQHC) and RACGP online module, *Helping patients make informed decisions: communicating benefits and harms*
racgp.org.au/education/courses/activitylist/activity/?id=40869&q=keywords%3Dinformed%2Bdecisions

The Royal Australian College of General Practitioners (RACGP) motivational interviewing techniques
racgp.org.au

NSW Agency for Clinical Innovation, *Patient Reported Measures – Outcomes that matter to patients*
aci.health.nsw.gov.au/make-it-happen/prms

Australian Indigenous Doctors, *Cultural Safety Factsheet*
aida.org.au/wp-content/uploads/2018/07/Cultural-Safety-Factsheet_08092015.docx.pdf

Preventative Women's Health Care for Women with Disabilities, *Guidelines for General Practitioners*
wwda.org.au/wp-content/uploads/2013/12/nswguidelines2.pdf

Health literacy links and resources

Guide on creating plain language resources
ipchealth.com.au/wp-content/uploads/Health-literacy-guide-for-client-resources-Final-2017.pdf

For more information, tools and resources from Australia Commission on Safety and Quality in Healthcare (ACSQHC)
safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/health-literacy/tools-and-resources-for-health-service-organisations

Health Literacy Checklist from Central West Gippsland Primary Care Partnership
centralwestgippslandpcp.com/health-literacy

Becoming a Health Literate Organisation
centralwestgippslandpcp.com/projects/becoming-a-health-literate-organisation

Undertake further health literacy learning
centralwestgippslandpcp.com/health-literacy/vicpcp-online-health-literacy-course

Readability tools from Department of Health and Human Services Tasmania
dhhs.tas.gov.au/publichealth/health_literacy/health_literacy_toolkit/assessing_readability

Readability tools from SA Health
sahealth.sa.gov.au/wps/wcm/connect/f8d1d0004e454788aa0caf8ba24f3db9/Guideline_Guide_for_Engaging_Consumers_Community_v1.2_29.11.18.pdf

Continuous Quality Improvement

The Ten Sustainability Factors

Embedding a culture of Continuous Quality Improvement

Continuous Quality Improvement (CQI) involves creating a system to reflect on and refine improvement efforts that aim to provide a better experience of care, improve population health, minimise per capita health care costs and improve the working life of health care providers. This requires teams to create a culture that supports a constant review by your team of the health service's processes and systems in order to meet these aims.

The UK National Health Service's Institute for Innovation and Improvement developed a sustainability model (and accompanying guide) that helps health care providers to implement and maintain successful improvement initiatives.[10]

The model consists of ten sustainability factors relating to processes, staff and the organisation. The team selects the description that best represents the improvement initiative for each factor. The model uses a weighted scoring system to obtain an overall score, and outlines strengths and weaknesses for each factor. The ten sustainability factors are briefly described on this page.

This model can be used by teams to identify the current state of readiness for undertaking and implementing continuous quality improvement work and to identify the areas the team most needs to work on.

Process Considerations

01
Benefits beyond helping individuals
Reducing waste or avoiding duplication; improving working life

02
Credibility of the benefits
Identifying the benefits of improvement; communicating the evidence of the benefits

03
Adaptability of the new processes
Meeting needs; succession planning

04
Ability of the new system(s) to monitor effectiveness
Measuring for improvement; feedback processes; whole of team involvement

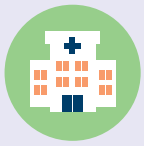
Staff Considerations

05
Involvement and training
Creating a culture of involvement with all staff; training and development infrastructure

06
Behaviour towards sustaining change
Engaging with staff for change ideas; giving staff training in, and responsibility for, testing change ideas

07
Senior leadership engagement and support
Influencing change; taking personal responsibility

08
Clinical leadership engagement and support
Influencing change; taking personal responsibility



Organisation Considerations

09
Alignment with business vision and goals
Aligning the change aims with overall strategic aims

10
Infrastructure
Aligning roles and job descriptions with the new processes; communicating effectively; resourcing appropriately

Core requirements for Quality Improvement

Aligning with the sustainability model, there are several features that health care health outcomes need to ensure are in place to support an ongoing focus on quality improvement work.

These have been listed as[11]:

Improvement leadership

A culture supportive of improvement

Knowledge of improvement methods

Motivation to change

Team diversity

Physician involvement

Subject matter expertise

Team familiarity and experience.

To support the spread and sustainability of CQI in your health service, consider how you will:

Develop a new approach to leadership that moves away from the imposition of solutions from top down to recognise that team members are often better placed to make improvements through a process of discovery

Provide the required resources and time to enable ongoing improvement activity

Ensure that patients, families and carers are involved in improvement activities

Enable team members to take ownership of the improvement process and to celebrate successful initiatives, and

Commit to making continuous quality improvement central to the way care is provided[12]

There is no single way to ensure that the benefits achieved by QI initiatives last. Developing a culture of CQI requires a commitment to maintaining an innovative approach to change, consistently measuring for improvement, and re-evaluating processes regularly to identify what does and does not work. Team members need the knowledge, resources and time to undertake improvement work and to be supported by skilled leaders who enable and empower their teams[13].

HealthPathways Gippsland

HealthPathways Gippsland is an online portal, designed to be used by general practice at the point of care. HealthPathways aims to guide best-practice assessment and management of common medical conditions, including when and where to refer patients. It is also available to medical specialists, nurses, allied health, and other health professionals, for use within their scope of practice within the Gippsland region.

The aim of HealthPathways Gippsland is to assist health services and providers build a more sustainable and integrated health system for Gippsland. The name HealthPathways reflects the referral pathways that assist in connecting patients to the right care, at the right place, and with the right healthcare provider.

HealthPathways are designed for use during consultation and are jointly developed by consensus and collaboration between hospital clinicians and general practice teams. Implementation of HealthPathways will assist clinicians navigate patients through what can be a complex primary, community and acute health care system and enable a more seamless patient journey.

The HealthPathways portal presents a synopsis of current evidence and clinical guidelines, along with information about local referral options for a range of specific conditions in the one, easy to use place. HealthPathways does not replace clinical decision making, it supports it.

The HealthPathways Gippsland portal assists GPs to refer only as required, specialists and hospital outpatient departments are better able to focus on patients most in need of their expertise.

Template 01

Goal Setting for Quality Improvement

QUESTION 1

What are we trying to accomplish?
By answering this question, you will develop our goal for improvement.

QUESTION 2

How will we know that a change is an improvement?
By answering this question, you will develop measures to track the achievement of your goal.

QUESTION 3

What changes can we make that will result in improvement? List your ideas for change.
By answering this question, you will develop the ideas you would like to test towards achieving your goal.

Idea 1

Idea 2

Idea 3

Idea 4

Template 02

Completing your
Plan, Do, Study, Act (PDSA) Cycles

IDEA

Describe the idea you are testing.

PLAN

What

Who

When

Prediction

Data to be collected

DO

Was the plan executed? Document any unexpected events or problems.

STUDY

Record, analyse and reflect on the results.
Extract same data to measure for improvement.

ACT

What will you take foreward from this cycle (next step or the next PSDA cycle)?

Abbreviations

ACSQHC	*Australian Commission on Safety and Quality in Health Care*
NBCSP	*National Bowel Cancer Screening Program*
CALD	*Culturally and linguistically diverse*
CSC	*Cancer Screening Collaborative*
CST	*Cervical Screening Test*
CQI	*Continuous Quality Improvement*
FOBT	*Faecal Occult Blood Test*
GP	*General practitioner*
HPV	*Human Papillomavirus*
LGBTQI	*Lesbian, gay, bisexual, transgender, queer, intersex*
NCSP	*National Cervical Screening Program*
PDSA	*Plan, Do, Study, Act cycle*
PHN	*Primary Health Network*
QI	*Quality Improvement*
QI&CPD	*Quality improvement and continuing professional development points*
RACGP	*Royal Australian College of General Practitioners*
SLA	*Statistical Local Area*
SMS	*Secure messaging service*

References

1 — Institute of Medicine, 1990, Crossing the quality chasm: a new health system for the 21st century, Washington DC: National Academy Press, p.244.

2 — The Health Foundation, 2016, Quality improvement made simple: What everyone should know, *https://www.health.org.uk/sites/health/files/QualityImprovementMadeSimple.pdf*

3 — Australian Institute of Health and Welfare, (AIHW), 2015, Chronic Disease Web Update, *https://www.aihw.gov.au/reports-statistics/health-conditions-disability-deaths/chronic-disease/overview*

4 — Primary Health Care Advisory Group, 2016, Final Report: Better Outcomes for People with Chronic and Complex Health Conditions, *http://www.health.gov.au/internet/main/publishing.nsf/Content/76B2BDC12AE54540CA257F72001102B9/$File/ Primary-Health-Care-Advisory-Group_Final-Report.pdf*

5 — Australian Institute of Health and Welfare, 2014, Australia's Health 2014: Australia's Health Series, *https://www.aihw.gov.au/getmedia/d2946c3e-9b94-413c-898c-aa5219903b8c/16507.pdf.aspx?inline=true*

6 — National Health Performance Authority, March 2013, Healthy Communities: Australians' experiences with primary health care in 2010-11, *https://www.myhealthycommunities.gov.au/our-reports/australians-experiences-with-primary-health- care/march-2013*

7 — Bodenheimer T, and Sinsky C, 2014, From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider, Annals of Family Medicine, Vol. 12, No. 6, pp. 573-576, *http://www.annfammed.org/content/12/6/573.full*

8 — The Royal Australian College of General Practitioners, 2017, Standards for general practices, 5th edn., East Melbourne, Vic: RACGP, 2017, p.89, *https://www.racgp.org.au/download/Documents/Standards/RACGP-Standards-for-general-practices-5th-edition.pdf*

9 — Langley GL, Nolan KM, Nolan TW, Norman CL & Provost LP, 1996, The improvement guide: a practical approach to enhancing organisational performance, San Francisco: Jossey-Bass

10 — National Health Service Institute for Innovation and Improvement, 2010, Sustainability Model and Guide, *https://improvement.nhs.uk/resources/Sustainability-model-and-guide/*

11 — Silver SA, McQuillan R, Harel Z, Weizman AV, Thomas A, Nesrallah G, Bell CM, Chan CT & Chertow GM, 2016, How to Sustain Change and Support Continuous Quality Improvement, *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4858491/*

12 — The King's Fund, 2017, Embedding a culture of quality improvement, *https://www.kingsfund.org.uk/sites/default/files/2017-11/Embedding-culture-QI-Kings-Fund-November-2017.pdf*

13 — NHSScotland Quality Improvement Hub, The Spread and Sustainability of Quality Improvement in Health care, 2014, *http://www.qihub.scot.nhs.uk/media/596811/the%20spread%20and%20sustainability%20ofquality%20improvement%20in%20healthcare%20pdf%20.pdf*