

What is the Australian Primary Care Collaborative?

The Australian Primary Care Collaborative is an **improvement** programme. The APCC uses a methodology based upon small cycles of change and this methodology has been used successfully in healthcare settings across Australia, Scotland and England. The programme is focussed on improving COPD patient care and improving prevention & self management. These improvements will be made through the sharing of knowledge locally and throughout the country. Funding of \$7500 is given practices at two stages of the program to help with possible costs associated with making the improvements, e.g. locum cover or admin support. Throughout your practice involvement with the program you will be supported by your locally based Collaborative Project Manager.

The APCC Improvement Model and PDSAs

Before attempting to implement any change, it is essential to answer the following questions:

1. What are we trying to accomplish?
 - *Know exactly what improvements are desired*
2. How will we know that change is an improvement?
 - *Without measurement, it is impossible to tell whether there has been an improvement*
3. What changes can we make that can lead to an improvement?
 - *Decide exactly what changes will bring about the improvements*

After These Decisions Are Made We Can Use The Small Cycles of Change:

PDSA is **Plan, Do, Study, Act** – breaking down improvement ideas into manageable chunks and testing changes on a small scale. If the change doesn't work a return to the way it was does not have any major impact. If it does work, one PDSA invariably leads on to another and, because they are so small, they reduce the anxiety to change. A PDSA can never be too small. Anybody can carry out a PDSA and the whole practice team can become involved, so team members can take ownership of PDSAs and ideas, which ensures that the improvements can take place as a team endeavour.

Improving COPD Patient Care

We recognise that some practices may have undertaken significant work on improving care for patients with COPD. The APCC has distilled both expert and practical learning on changing and improving practice based systems for COPD care. This has been developed into a set of change principles and associated change ideas to further enhance that work.

Monthly Measures (Recorded throughout the 18 Months)

Monthly data is submitted via our online reporting system to the Collaborative to assess the effect of the changes that you are trying out.

COPD (Chronic Obstructive Pulmonary Disease)

- **COPD Register:** The number of people within the clinical database that are coded with a diagnosis matching the COPD definition
- **Smoking Status:** The percentage of people on the COPD Register whose recorded smoking status indicates they are a Non Smoker (Never Smoked OR Ex Smoker)
- **Smoking Status Assessment:** The percentage of people on the COPD Register whose smoking status is recorded as Current Smoker OR Ex Smoker AND who have had their smoking status assessed within the previous 12 months
- **Spirometry:** The percentage of people on the COPD Register with a recorded Spirometry at any time.
- **Influenza vaccine:** The percentage of people on the COPD Register who are recorded as receiving an Influenza vaccine within the previous 12 months
- **Pneumococcal Vaccine:** The percentage of people on the COPD Register with a recorded Pneumococcal vaccination Chronic

CDPSM (Chronic Disease Prevention and Self Management)

- **Non-Smoking:** The % of adults on the clinical data base that are recorded as not currently smoking.
- **Smoking Status Assessment:** The percentage of adults on the clinical database whose recorded smoking status indicates they are a Current Smoker OR Ex Smoker AND who have had their smoking status assessed within the previous 12 months
- **Absolute Risk Assessment:** The % of patients that are aged greater than or equal to 45 years of age AND less than or equal to 74 years of age, OR are recorded as ATSI AND aged greater than or equal to 35 years of age AND less than or equal to 44 years of age, AND currently without a diagnosis CVD who have had an Absolute Risk Assessment
- **Diabetes Risk Assessment:** The % of patients aged ≥ 40 , currently without a diagnosis of diabetes, who have had a Diabetes Risk Assessment Modifiable Risk Factors
- **Prevention (PRV):** The % of modifiable risk factors that meet, or are better than, their recommended target for patients equal to or greater than 35 years of age without a specified chronic disease
- **Modifiable Risk Factors – Self Management (SM):** The % of modifiable risk factors that meet, or are better than, their recommended target for patients equal to or greater than 35 years of age with a specified chronic disease Modifiable Risk Factors - PRV – Recorded The % of modifiable risk factors that have been recorded for patients equal to or greater than 35 years of age without a specified chronic disease
- **Modifiable Risk Factors - SM – Recorded:** The % of modifiable risk factors that have been recorded for patients equal to or greater than 35 years of age with a specified chronic disease
- **Waist Circumference:** The percentage of adults with waist circumference less than or equal to the recommended circumference
- **BMI:** The percentage of adults with a recorded BMI of less than or equal to 28

- **GP Management Plans:** The % of the defined chronic disease population with a GP Management Plan (includes any plan established over the last two years)
- **Patient Locus of Control:** The average score of patient responses to questions within the Ultra Feedback Patient Satisfaction Survey relating to Locus of Control
- **Health Literacy:** The average score of patient responses to questions within the Ultra Feedback Patient Satisfaction Survey relating to Health Literacy

PDSAs

- Practices also submit at least one PDSA per month on each topic

Practice Commitment

The main commitment is for practices to engage and work with the collaborative to improve over the 18 months of the programme. The individual components are:

- Improving Monthly Measures
- Monthly PDSAs
- Local Project Steering Group Meetings
- Local or National Workshops

Summary

- 18 Month quality improvement programme
- Support of local Project Manager throughout
- Practice Funding of \$7500 over 18 months
- 40 Cat 1 points per workshop
- Sharing of ideas and experiences between local/national APCC practices
- Two main focus areas – Improving COPD Patient Care & Chronic Disease Prevention & Self management

Throughout this programme, your local project manager, dedicated to collaborative work, will support you.

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Australian Primary Care Collaborative Wave 5

Information