**Quality Improvement Activity**

**Start date: End date:**

Identify patients with a high BMI eligible for a Health Assessment

**Practice/team name:**

**Specific**

Provide a clear description of what needs to be achieved.

**Measurable**

Include a metric with a target that indicates success.

**Achievable**

Set a challenging target but keep it realistic.

**Relevant**

Keep your goal consistent with higher-level goals.

**Time-Bound**

Set a date for when your goal needs to be achieved.

**QI Activity Lead:**

Increase recording of BMI for patients in practice clinical information system

Ensure proper assessments undertaken for patients with high BMI

Identify patients who are at risk for obesity related complications

**Goal:**

What are we trying to accomplish?

**Change Ideas:**

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

Health coaching and care plans for patients with a high BMI to improve coordination of care, patient engagement and encourage patients to make lifestyle changes to improve their health and wellbeing.

Engage with local allied health professionals to ensure patients receive holistic coordinated care that is aimed at improving their health

**QI Activity Team:**

Using practice data, we can see that XX% patients with a high BMI are eligible for a Health Assessment

**Benchmark:**

What is our current data saying?

* Name/Role
* Name/Role
* Name/Role
* Name/Role
* Name/Role

Compare baseline data using data extraction tool benchmarking reports for active patients aged 15+ years who have had their BMI classified as obese, overweight within the last 12 months to post QI activity data and seen an increase in recording and an increase in health assessments.

**Measures:**

How will we know that a change is an improvement?

What data will we use to track our improvement?

**ACT**

*Review or extend activity?*

*Implement the plan and record observations*

**DO**

**PLAN**

**STUDY**

*Develop a plan and the steps involved*

Consult with the WVPHN practice facilitator, develop a plan of action and present it at staff meetings.

Form a QI team, discuss workflow and allocate roles & responsibilities. [ideally – practice manager (can include WVPHN practice facilitator) and at least one GP, nurse and admin staff.]

QI lead to extract baseline data from practice software using data extraction tool

Consult with the GP and set up appointments for health assessments and chronic disease follow-ups for eligible patients. Implement a reminder system and support its use

Send invitation letters to eligible patients

*Analyse and learn from the results*

**ACT**

*Review or extend activity?*

*Implement the plan and record observations*

**DO**

**PLAN**

**STUDY**

*Develop a plan and the steps involved*

Engage with PHN Practice Facilitator to: request access to GoShare for patient facing resources for healthy living and other nutrition based information

Request access to HealthPathways for information on management and treatment of patients with obesity

Ensure recall visits are scheduled for follow-up appointments as required after health assessments.

Use clinical assessment tools to track progress on health assessments.

Develop a progress chart for the activity and display updates in the tea-room / kitchen.

At completion of QI period, measure change by repeating reports using software. Compare to baseline.

*Analyse and learn from the results*