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| --- | --- | --- | --- |
| Practice Name  |  | Cycle number |  |
| Staff initiator:  |  | Position title: |  |
| Start date: |  | End date: |  |
| Purpose | What are we trying to accomplish?What do you plan to do? |
| In response to the COVID-19 pandemic temporary MBS items for chronic disease management including care planning have been released for telehealth. To reduce the risk of vulnerable patients coming into the clinic we would like to increase the number of telehealth appointments for all care planning patients. Offer telehealth appointments in place of face to face consults for care planning patients to reduce the social contact for the patients over the COVID-19 pandemic period. |
| How will we know that change is an improvement? What do you hope to achieve? (include measurement/outcome) |
| There will be an increase in number of care planning MBS telehealth item numbers billed over the period, we hope to reduce the number of face to face care planning items billed to XX. |
| What change can we make that will result in improvement? |
| The Practice Nurse will analyse care planning patients already booked in for face to face consults and transfer to telehealth where appropriate. As well as identify eligible patients for care planning MBS items and offer telehealth appointments for their consults. |
| PLAN | By answering this, you will develop the GOAL for improvement. The goal must be SMART - Specific, Measurable, Achievable, Relevant, Time-limited |
| Write a concise statement of what you plan to do, and the steps involved | From the questions/answers above, write your statement or aim of what you are attempting to achieve. |
| Increase in number of care planning MBS telehealth item numbers billed over the period of <<insert dates>> to xx %, the number of face to face care planning items billed to XX. |
| How are you going to do this? (list the steps to be implemented) |
| Steps | By whom | By when |
| Consult with the PHN 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 PHN practice facilitator) and at least one GP, nurse and admin staff.] |  |  |
| Organise protected time for Practice nurse to organise care planning nurse led clinic. |  |  |
| Interrogate and analyse the data to identify patients already booked in as well as eligible patients. |  |  |
| Contact patients currently booked for face to face consults up until XX and transfer to telehealth where appropriate. Carry out recall and reminders for patients that are eligible and book them in with the Practice nurse telehealth care planning clinic. |  |  |
| Review the data to see if there has been an increase in the number of patients accessing care planning telehealth consults and a reduced number of face to face consults. |  |  |
| At completion of QI period, measure change by repeating reports using Pen/clinical software. Recipes and assistance provided by PHN. Compare to baseline. |  |  |
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| DO | This may include how the patients react, how the doctors react, how the nurses react, how it fits in with your system or flow of the patient visit. You will ask, “Did everything go as planned?” |
| **Implement your plan and write down observations you have during your implementation.**  | What did you observe? |
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| Where there any unexpected events? |
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| STUDY | You will ask, “Do I have to modify the plan” |
| **After implementation you will study the results and record how well it worked, if you met your goal and document areas of improvement.**  | What did you learn? |
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| Has there been an improvement? |
|  |
| Did you meet your measurement goal? |
|  |
| What could be done differently? |
|  |
| ACT | If it did not work, what you can do differently in your next cycle to address that. If it did work, are you ready to spread it across your entire practice? |
| **Here you will write what you came away with for this implementation, whether it worked or not.**  | What did you conclude from this cycle? |
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