# Chronic Obstructive Pulmonary Disease (COPD) Collaborative

COPD Collaborative 2022/2023

HANDBOOK

phn
NEPEAN BLUE MOUNTAINS
An Australian Government Initiative

Wentworth Healthcare
Blue Mountains | Hawkesbury | Lithgow | Penrith

Wentworth Healthcare, provider of the Nepean Blue Mountains PHN

Level 1, Suite 1,

Werrington Park Corporate Centre

14 Great Western Highway, Kingswood NSW 2747

www.nbmphn.com.au

Wentworth Healthcare, provider of the Nepean Blue Mountains PHN, is a not-for-profit organisation that works to improve health for the communities of the Blue Mountains, Hawkesbury, Lithgow and Penrith.



Wentworth Healthcare would like to acknowledge the Improvement Foundation, the other organisations and members of our local community who contributed to the contents of this workbook.

# Table of Contents

# Introduction

Welcome to the Nepean Blue Mountains Chronic Obstructive Pulmonary Disease (COPD) Collaborative. This Handbook has been developed to support your participation in the Collaborative. COPD is a serious, progressive and disabling condition that limits airflow in the lungs, which leads to recurring illnesses and may result in frequent admissions to hospital.[1]

In the Nepean Blue Mountains region, COPD is the second leading cause of potentially preventable hospitalisations.[2]

The Nepean Blue Mountains Primary Health Network (NBMPHN) and the Nepean Blue Mountains Local Health District (NBMLHD) have agreed that COPD is a joint board priority. The development of a COPD Collaborative in the region will support general practices to improve the diagnosis and management of people suffering from COPD with the aim of reducing the number of COPD-related Emergency Department presentations and associated hospital admissions.

The COPD Collaborative and COPD Quality Improvement Initiative will continue to work with general practices across the Nepean Blue Mountains to support earlier diagnosis and improved management of patients with COPD. These initiatives will focus on quality improvement measures that support the implementation of improved pathways of care for patients with COPD across the care continuum. This Collaborative actively recognises the significant role that general practice has in assisting patients to manage symptoms, control exacerbations, enhance exercise capacity, manage comorbidities, and increase health status.

The COPD Collaborative will run from 1 July 2022 to March 2023. A Collaborative follows a wave timeline with participating practices attending learning opportunities, undertaking activity periods and submitting data to track improvement. Practices participating in the Collaborative will learn from other general practices, leading respiratory clinicians and quality improvement experts on topics including spirometry, pharmacological interventions and data cleansing. In recognition of the time taken to attend workshops and undertake changes, participation and outcomes payments will be made available to practices.

Prior to the commencement of the first COPD Collaborative in 2017/18, foundation work was undertaken with representatives from local general practices, the NBMLHD, NSW Ambulance and the Lung Foundation Australia along with a local COPD patient support group. NBMPHN is appreciative of the involvement of these representatives as part of the Expert Reference Panel as well as for contributions to the development of this Handbook.

To support the design and delivery of the COPD Collaborative, the collaborative methodology is used, and will be of immense value to practices participating in the COPD Collaborative to improve work practices and management challenges.

NBMPHN looks forward to working closely with participating general practitioners, practice nurses and other practice staff throughout the duration of this initiative. While participating in the Collaborative will mean additional work for practices, this initiative is also an exciting opportunity for general practices to improve outcomes for patients with COPD in our region and NBMPHN is grateful that your practice has chosen to become involved.

We look forward to hearing about the progress of your practice as well as other practices participating in the Collaborative.

***Lizz Reay,***

***Chief Executive Officer***

# About Chronic Obstructive Pulmonary Disease in Australia

COPD is a serious, progressive and disabling condition that limits airflow in the lungs and is a type of chronic airways disease.[1]

Emphysema and chronic bronchitis are the most common features of the disease. People with COPD are often short of breath and may have frequent coughing.[1] The condition mainly affects older people and the main cause is active smoking or exposure to smoking.[2]

The Australian Institute of Health and Welfare (AIHW) estimates that there are approximately 464,000 Australians aged 45 years and over with COPD, which equates to nearly 1 in 20 (4.8%) people aged 45 years and over.[3] Within the Nepean Blue Mountains (NBM) region, COPD remains one of the leading causes of potentially preventable hospitalisations, resulting in a 6.0 day average length of stay.[4] Furthermore, in the NBM region respiratory disease was the fourth-leading cause of death in 2017.[1]

While the number of COPD hospitalisations for men has decreased over the past 10 years, the cost to the healthcare system remains high. Conversely, COPD female hospitalisation rates have increased and were significantly higher than NSW COPD female hospitalisation rates overall.[5]

COPD is a preventable condition which can be treated through pharmacological and non-pharmacological options.[6]

While there is no cure, there is robust medical evidence to show that diagnosing the condition early combined with disease management programs in the early stages of the disease can lessen the burden of COPD, enhance quality of life, delay disease progression, decrease mortality and reduce hospital admissions.[6]

Key issues driving the burden of this disease remains the under diagnosis of COPD, particularly in the early stage of the disease, and poor utilisation of spirometry.[7]

People with COPD rate their health worse than people without the condition. In 2014-15, 22% of those aged 45 years and over with COPD rated their health as poor, compared to 6% of those aged 45 years and over without it.

# About the Chronic Obstructive Pulmonary Disease Collaborative

## What is a Collaborative?

A Collaborative is a specific method of quality improvement used to distribute and adapt existing knowledge to multiple groups to achieve a common aim. The Collaborative Methodology is user friendly and simple to apply. It promotes rapid change, allowing your team to create results and reap rewards in short time frames. You are supported throughout the Collaborative and provided protected time to solve problems as a team.

The methodology is designed to implement change in small, manageable cycles, and identify where a change actually leads to an improvement.

The Collaborative Methodology is underpinned by:

- The psychology of change, which suggests that knowing and learning from peers who have successfully made a change improves an individual's own motivation to change. In this context, a culture of trust, peer learning and support and the engagement of clinical leaders are important.
- Active clinical engagement in the Collaborative and support from the wider clinical community
- The collection of data at regular intervals, in line with the three data collection principles:
    - Measurement and data collection for improvement rather than judgement or research
    - Use of data to inform activity and identify when a change leads to an improvement
    - Primary care health data sets are owned by the respective bodies and not released beyond participants. These data are used to support the Collaborative infrastructure.

## Key Features of a Collaborative

The key feature of the Collaborative approach, used in the Australian context, consists of the Collaborative Framework and the Model for Improvement (MFI). Furthermore, it includes the following vital elements:

- A framework of practical improvement ideas
- Examples drawn from existing participants
- Use of the Model for Improvement to deliver rapid and sustainable improvements
- Measurement for improvement
- Protected time to plan and carry out changes
- Practical support from the team at Nepean Blue Mountains PHN.

## Objective of the COPD Collaborative

The objective of the COPD Collaborative is to improve the diagnosis and management of patients with COPD within the general practice setting.

## Aims of the COPD Collaborative

The aims of the COPD Collaborative were previously agreed by an Expert Reference Panel (ERP) in 2017 which included representatives from general practice within the NBM region, NBMLHD, NSW Ambulance, Lung Foundation Australia, a local patient support group, along with quality improvement experts from the Improvement Foundation.

In July 2020, the aims of the Collaborative were reviewed by two local GPs who participated in the 2019-2020 COPD Collaborative and agreed by the Primary Care Advisory Committee. The aims are categorised into ‘Diagnosis’ and ‘Management’ and are designed to be ‘stretch’ aims that your practice can continue to work towards over time.

**Diagnosis**

- *Diagnosis Aim:* Increase to 50% the proportion of patients diagnosed with COPD who have spirometry results recorded within participating general practices

**Management**

- *Management Aim*: Increase to 70% the proportion of patients diagnosed with COPD who have a GP Management Plan (GPMP) within participating general practices

# The COPD Collaborative Framework

The Collaborative will run over a period of up to nine months and will consist of activity periods, data collection and a series of face-to-face learning workshops. The workshops will be interspersed with activity periods, in which participating practices will submit monthly data, and test and implement changes within and across their systems.

## Baseline data collection

Baseline data is collected at the beginning of the Collaborative. This provides a snapshot of your general practice's position before making improvements and enables the team to see their starting point.

## Learning Workshops

Learning workshops provide you with evidence-based information, the opportunity to share knowledge and experiences with peers, and to build on knowledge gained from previous workshops. You will hear others' ideas and generate new ideas that will translate into improvements within your organisation. You will also benefit from protected 'team time' sessions at learning workshops, where you can formulate plans for action. These plans for action may include multiple teams where changes are required across multiple points of the healthcare system to bring about an improvement.

## Activity periods

Activity periods are the periods of time between and after learning workshops. They enable your team to test their improvement ideas, and progress is measured through ongoing monthly data collection. A vital component of an activity period is the proactive and practical assistance provided by your General Practice Support Officer from NBMPHN.

# The Six Rules of Improvement

The ‘six rules of improvement’ provide a helpful guide to the key elements of a Collaborative.

**1. Think in systems**

Build practice systems and processes that support individuals to provide reliable care. If you want a different result than you are currently achieving, then you need to adapt your system.

**2. Explicitly state your aim and anticipated benefits**

Often, change is attempted without a clear discussion about what is trying to be achieved. Meaningful and measureable aims are important. During the COPD Collaborative we will use the ‘Model for Improvement’ (MFI) to help us set aims and track progress against small incremental changes that we think will bring us closer to the goal of improving the care provided to patients with COPD.

**3. Keep score - measure your progress**

All improvement requires change, but not all change is an improvement. Measurement determines if a change is leading to a desired improvement. A shared set of measures for this Collaborative have been developed. NBMPHN will support your practice to report progress against the measures as simply and easily as possible.

**4. Make small incremental changes - continually**

Large scale change is difficult to achieve and has potential for large unintended consequences. Progress can be made by small steps made by a few providers, checking the outcomes at every step. Large scale change is achieved from the culmination of continual small steps.

**5. Steal shamelessly**

It’s important to look outside your own practice, or even health, to learn from the experience of others. Collaboratives are designed to help participating practices to improve faster by learning from each other - Collaboratives work better when we are all willing to share our stories generously.

**6. Inspire a culture of falling forward**

Sometimes in health, when we are all very busy, we tend to do things a certain way because that is how we have always done them. The world changes when we give ourselves and our team permission to change.

Whilst our first job is to look after the person in front of us, our second job is to improve so that we can deliver better care for them or the next person. Constant change can be exhausting, but constant improvement is invigorating, and cultivates a culture of always doing things a little bit better.

# How will the Chronic Obstructive Pulmonary Collaborative work?

The COPD Collaborative will be implemented in a way that will turn the principles of improvement into action. Your practice will be supported to:

1. **Work out your starting point** by checking your COPD patient register to see if it is up-to-date and identifying if there are any patients in your practice who may have COPD but who are not diagnosed or coded correctly.

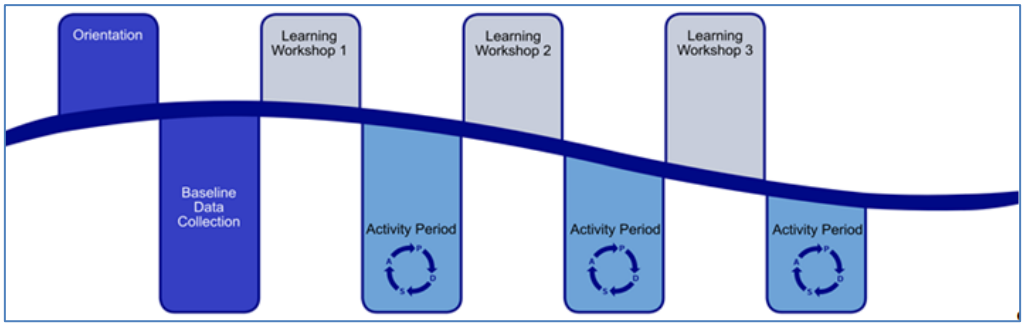
2. **Learn, think and share** with your peers through a series of learning workshops and webinars. The workshops and webinars will include a mixture of expert and local speakers to build the group's understanding of the evidence and issues relating to care of patients with COPD. There will also be time for group work for you to develop ideas for action.

The COPD Collaborative will commence with an **Orientation Webinar**. This will provide an overview of:

- The Collaborative methodology;
- The COPD Collaborative aim(s), measures, change principles and change ideas
- The HealthHub portal
- Key dates and links to resources.

This webinar will be recorded and made available to all participating practices via the online COPD Collaborative HealthHub portal.

Throughout the Collaborative three **Learning Workshops** will be held. Practices must send the same two representatives (1 x practice nurse and 1 x GP, or 2 x GPs if no practice nurse) to each workshop, this is because each workshop builds on learnings and teamwork developed in previous sessions/workshops.



# Learning Workshop Dates

- **Orientation Webinar:**
    - Tuesday 12th July 2022 – 6:30-7:30pm
- **Learning Workshop 1:**
    - Session 1: Tuesday 16th August 2022 – Time: TBD
    - Session 2: Thursday 18th August 2022 – Time: TBD
- **Learning Workshop 2:**
    - Session 1: Tuesday 15th November 2022 – Time: TBD
    - Session 2: Thursday 17th November 2022 – Time: TBD
- **Learning Workshop 3:**
    - Session 1: Tuesday 14th February 2023 – Time: TBD
    - Session 2: Thursday 16th February 2023 – Time: TBD

All workshops will be held online via the video conferencing program called Zoom. Instructions on how to register for the workshops will be distributed closer to the time of each workshop via the online COPD Collaborative HealthHub portal.

In addition to the workshops, you will also be offered access to online continuing professional development (CPD) training delivered by the Lung Foundation. During the Collaborative you will need to nominate two of the following training sessions to attend:

- Manage Exacerbations of COPD
- Inhaler Device Technique Training
- Who Really Has COPD?

These training courses take approximately 30 minutes and can be completed at any point during the Collaborative. The Program Development Officer will register you for your nominated training course when you are ready to complete it.

Making a simple plan is important for turning an idea into action. Documenting your plan and how implementation went is important so that you can quickly identify and share changes that are worth making permanent. A template for you to document your goals, ideas and plans for action using the very simple 'Model for Improvement' (sometimes referred to as the Plan-Do-Study-Act or PDSA cycle) is supplied on page 37 of this Handbook.

To ensure you keep progressing, practices are asked to complete a minimum of 1 MFI/PDSA cycle per month (7 in total) from 1 July 2022 to 31 March 2023.

### 3. Measure, reflect and improve

Using the MFI template to record and reflect on the small-scale changes you make is really important because if your practice sees an improvement in the care provided, it gives you a record of what was done to create the change. This helps to decide on what changes you want to make permanent and helps practices to share and learn from each other. In addition to the MFI cycles, the NBMPHN's Practice Support team will collect relevant COPD improvement measures from all participating practices via the PEN data extraction toll and Topbar. De-identified data collected will be collated and a data audit report will be provided per activity period so that you can track your progress against the COPD Collaborative measures.

The purpose of collecting and reporting data against the program measures is to help everyone see if what they are doing is working - *It is not for judging participants' performance or for research.*

# How Nepean Blue Mountains Primary Health Network will support you

Throughout the Collaborative you will receive proactive and practical support from NBMPHN.

The following representatives will support your practice throughout the duration of the COPD Collaborative:

Your Practice Support Officer will be your first point of call for all matters related to the COPD Collaborative. This will include providing practices with benchmark reports, assisting with implementing the MFI/PDSA cycles and regular feedback and support to guide quality improvement.

The COPD Collaborative Program Officer will review your PDSAs to ensure they meet the minimum requirements and provide feedback to your Practice Support Officer. The COPD Collaborative Program Officer will be the one monitoring the online portal, processing your invoices and who will facilitate the Learning Workshops and other training events

## CPD Points

Practices participating in the COPD Collaborative will be eligible for 40 RACGP CPD points for the 2023-2025 triennium.

## Being part of COPD Collaborative HealthHub will provide you with:

The COPD Collaborative HealthHub will be an invaluable tool throughout the program. The HealthHub is a new online space where clinical and non-clinical staff taking part in the Collaborative can share information and ideas. Practice staff registered on the HealthHub portal will also be able to:

- Access the Document Library to download the latest COPD resources, sample MFI/PDSAs, COPD fact sheets, as well as resources for patients, GPs and practice nurses
- Take part in online discussion forums to share ideas on how they are progressing and create a COPD community of practice with other participating practices in the COPD Collaborative
- Keep track of and register for Learning Workshops and other training events
- Upload completed PDSA cycles and invoices

## Key Support Functions: Practice Support Officer

Practices are required to submit data extracted from their clinical software on a monthly basis to the NBMPHN (1 July 2022 to 31 March 2023). This process will occur automatically if Scheduler has been set up. *If you do not have Scheduler, please ask your Practice Support Officer for assistance.*

Your Practice Support Officer will regularly visit your practice throughout the program to review data audit reports and PDSAs.

Your Practice Support Officer will provide ongoing feedback and support. You can call them at any time for assistance!

## Support to Monitor and Report Progress

Regular data submission is a key feature of a Collaborative. Regular data submission works on a number of levels as it assists:

- General practices to actively engage in the topic areas and deliver rapid and sustainable improvements
- General practices to benchmark against others and track their improvement work
- NBMPHN Practice Support Officers to identify how their practices are tracking, and where they may need additional support and guidance.

Your Practice Support Officer will work to make sure that providing data for measures is as easy and straight forward as possible. The benefit is that reporting against the measures really helps you to see if the work you are doing is making an impact!

## Key Support Functions

You will be able to keep your practice informed about how you are progressing and benchmark your practice against others participating in the Collaborative via data graphs that will be uploaded to the COPD Collaborative HealthHub portal. Your Practice Support Officer will also provide feedback during their practice visits to you.

The overall progress of all practices participating in the Collaborative will be discussed at the Learning Workshops. Please be reassured that only aggregated, de-identified practice level data will be shared. To support the spread of good ideas, practices that are meeting or exceeding targets may be asked to share learnings on what they have implemented at the learning workshops.

# Change Principles, Change Ideas, Tools and Resources

## Change Principles and Change Ideas

This section provides ideas for action with case studies and helpful tips to assist you. The below change principles and ideas are based on evidence of what works to improve the care of patients with COPD in the Primary Care setting. To further assist your practice with making changes, resources and helpful links are available via the Document Library on the COPD Collaborative HealthHub portal.

| Change Principle | Change Ideas (How) |
|---|---|
| 1. *Engage and support the practice team* | • Involve the whole team<br>• Set realistic goals and use data to drive improvement<br>• Ensure team members have protected time to complete tasks<br>• Communicate regularly and systematically<br>• As a team, regularly reflect, review and adjust what you are doing |
| 2. *Improve the accuracy of your clinical database* | • Build a reliable register of patients diagnosed with COPD<br>• Systematically identify patients who have not yet been identified as having COPD but who fit the diagnostic criteria<br>• Build systems to maintain the accuracy of the register over time<br>• Engage your patients to ensure the accuracy of the information you hold about them |

| | |
|---|---|
| 3. *Have a systematic and proactive approach to managing the care of people with COPD* | • Use a multidisciplinary team to facilitate reliable care delivery<br>• Utilise appropriate care pathways – are these outlined anywhere for people with COPD<br>• Use guidelines, protocols and computer templates to support care delivery<br>• Establish proactive recall and reminder systems<br>• Integrate the perspective of patients and carers in the design of services |
| 4. *Support patient self-management* | • Establish clear definitions of self-management and what self-management support involves<br>• Organise internal and external resources to provide patient-centred self-management support<br>• Implement a strategy for self-management support that empowers patients and carers<br>• Implement processes and systems to support patients to adopt self-management plans and those with advance care directives/plans |
| 5. *Ensure patients receive coordinated and integrated care* | • Identify and engage local organisations and other sources of care to provide best care to people with COPD<br>• Analyse the patient journey and redesign where necessary<br>• Support integrated care by improving the relationship between primary, secondary and tertiary care providers<br>• Use Shared Health Summaries (SHS) to coordinate care with other providers in the patients' care team |

# Engage and Support the Practice Team

Engaged practice teams are the foundation of achieving sustainable change.

Experience from past Collaborative programs shows that building the team's engagement and commitment to the works is often an area that practices overlook, and it becomes a weakness that impacts on achieving sustainable change.

If you want to change the outcomes your practice is achieving, you will need to change what you are doing and it's only natural that this will require some change management. It's important not to assume the value of changes will be understood or accepted without some team building. Facts are usually not enough, you need to get 'hearts and minds' on side for making changes.

The following checklist, tools and resources will help you take the right steps to build an integrated team-based and sustainable approach to improve the care of patients with COPD in your practice.

## Getting started is easy

For example, your first goal may be to ensure you have an engaged team to support the work your practice will do. So, your first MFI/PDSA cycle may be to complete the 'Engage your practice team' checklist. Completing the checklist will give your team ideas for areas where you want to make improvements, and one of these improvement ideas can become your next MFI/PDSA cycle.

# CHECKLIST: Engage and Support the Practice Team

- ☐ Involve the whole team
- ☐ Will you reflect as a team on the purpose of the COPD Collaborative, what you want to achieve and who will benefit from the COPD Collaborative?
- ☐ Does the whole team have a motivation for participating in the COPD Collaborative? It doesn't have to be the same motivating factor (e.g. pride in the quality of my work, the business case and financial benefit, competition, prior negative experience such as patient with adverse outcomes).
- ☐ Will we give the whole team opportunity to generate ideas for improving care provision?
- ☐ Do we have a practice leader (e.g. our Practice Manager or Principle Clinician) championing the COPD Collaborative?
- ☐ Does our team have the skills they need, or is more training required? Would undertaking a simple skills audit be helpful to identify training needs?
- ☐ Set realistic goals and use data to drive improvement
- ☐ Was our team involved in setting our practice's own goals for the COPD Collaborative? (These goals will form the basis of your MFI/PDSA cycles and they don't have to be ambitious or complication - start small and go from there).
- ☐ Are our goals SMART: Specific, Measureable, Achievable, Realistic and Time-bound?
- ☐ Will we give the whole team opportunities to generate ideas for improving care provision?
- ☐ Do we have tools to measure progress against our goals?
- ☐ Are we using data to frequently review progress against our goals?
- ☐ Ensure team members have protected time to complete tasks
- ☐ Have we assigned clear roles and responsibilities for carrying out tasks? Is what we have asked people to do realistic?
- ☐ Do team members have 'protected' time to regularly complete tasks? *(This is critical!)*
- ☐ Communicate regularly and systematically
- ☐ Have we established a process for providing and seeking regular feedback to and from the team (e.g. monthly staff meeting, via staff email, using staff notice boards)?

- What importance does our team place on team meetings? What is their frequency? What outcomes are achieved? How does management communicate with the wider team? How will team-time be divided between the COPD Collaborative and other practice business?
- Do we have our COPD Collaborative goals and regular progress updates displayed and accessible to staff?
- Are team members well organised and supported by good processes (agendas, chairing, minutes, action lists, accountability, etc)?
- As a team, regularly reflect, review and adjust what you are doing
- Is reviewing our progress against our COPD Collaborative targets and generating new ideas, part of our regular team meetings agenda?
- Are we regularly reviewing our progress and adjusting our goals and strategies as needed?
- Are we rewarding and acknowledging success and working as a team to problem solve challenges?

**Helpful Tip**

Experience in the Collaborative program has shown that successful teams have demonstrated four key characteristics:

- They are clear about what is required of them, and they have an agreed strategy on how to complete all tasks required to run the practice
- They have enough information, skills and experience to do the job
- They have constructive group dynamics that create and maintain effective and efficient levels of communication
- Members of the team are committed to the practice and to producing high quality responsive patient care

Effective teams communicate well. Good communication saves time, money and eliminates duplicated work.

Poor communication does the opposite. It creates work, causes frustration, costs time and money and compromises patient outcomes.

## Case Studies

### Case Study - Involving the whole team

To engage the reception staff in the Program and help them understand the necessity and importance of data collection, we invited the key contacts from our local and state based support organisations to further explain the Program and their role in it. We had fantastic feedback from staff and they are now proactive in collecting the required measures. The staff members are enthusiastic and are even encouraging and reminding each other to get data collected.

- *Keen Street Private Clinic, Lismore, NSW*

### Case Study - Engaging with patients to check accuracy of information

At Tintenbar Medical Centre the receptionist prints the patient's health summary on yellow paper and asks the patient to check the accuracy of the record whilst in the waiting room. The doctor makes any amendments to the shared health summary then codes the 'reason for visit' as 'health summary. This enables Tintenbar to extract a list of patients who have reviewed their share health summary. The benefits of this approach has been a more conscientious effort in entering data across the practice team, engagement by the patient in their health summary, and improved accuracy of data.

- *Tintenbar Medical Centre, Tintenbar, NSW*

# Improve the Accuracy of your Clinical Database

The first step towards providing evidence-based care for your patients is to have a good understanding of your patient population. You can't be proactive and systematic in the management of your patients if you don't know 'who they are and what they've got'.

Experience in the Collaborative Program has shown that developing and maintaining registers requires involvement of the whole team. You may choose to establish a small, multidisciplinary team (or micro-team) to lead the work. This might include a GP, practice nurse and/or practice manager. It is important that the system designed by the micro-team is communicated to, and adopted by, all staff members

# CHECKLIST: Improve the Accuracy of your Clinical Database

1. **Build a reliable register of people diagnosed with COPD**

- ☐ Do we have a consistent policy to define which of the patients on our clinical database 'active' patients are and to proactively 'inactivate' patients who are no longer under our care?
- ☐ Do we have a current register of patients diagnosed with COPD?
- ☐ Do we have an agreed definition of COPD?
- ☐ Do we have a protocol for coding patient information?
- ☐ Do we have a coding policy to ensure that all GPs are coding consistently using existing search options, and avoiding free text in diagnosis, to ensure that our clinical software can be interrogated to accurately identify all patients with COPD?

2. **Systematically identify patients who have not been identified as having COPD but who fit the diagnostic criteria**

- ☐ Do we have patients who have no formal COPD diagnosis recorded?
- ☐ Do we have patients who are current or ex-smokers with the following symptoms or risk factors:
  - o breathlessness that seems inappropriate
  - o chronic (daily for two months) or intermittent, unusual cough
  - o frequent or unusual sputum production
  - o relapsing acute infective bronchitis, and/or
  - o risk factors such as exposure to tobacco smoke, occupational dusts and chemicals, or a strong family history of COPD
- ☐ Do we have patients who are not diagnosed with COPD but are prescribed bronchildilators, inhaled corticosteroids, oral corticosteroids, and mucolytics?
- ☐ Have these patients been offered/referred for spirometry?

**Helpful Tip**

Experience in the Collaborative program has shown that successful teams have demonstrated four key characteristics:

- They are clear about what is required of them, and they have an agreed strategy on how to complete all tasks required to run the practice
- They have enough information, skills and experience to do the job
- They have constructive group dynamics that create and maintain effective and efficient levels of communication
- Members of the team are committed to the practice and to producing high quality responsive patient care

## Case Studies

**Case Study – Importance of correctly coding COPD in clinical software**

Due to the many lung diseases that fall under the category of COPD, getting GPs to use one consistent disease code in clinical software for COPD can be a challenge. McGraths Hill Medical Centre discovered this when trying to identify the number of patients in their practice with COPD. They used their clinical software's search function for coded diagnosis of COPD however, found that this search function is only useful if a previous diagnosis has been made and entered into the clinical software using the diagnosis coder. The team decided to expand their search to include diagnoses of Asthma, Bronchitis and Emphysema, as well as including a search on COPD medications and inhalers. Patients who were identified through these search terms as indicated COPD, but with no spirometry recorded to confirm the diagnosis, were recalled by the practice via phone. The team made the decision to call rather than send a letter or SMS as they felt it was important to be able to explain why the patient needed to come in for a spirometry test.

- *McGraths Hill Medical Centre, McGraths Hill, NSW*

**Case Study – Entering pre and post spirometry values**

Spirometry testing plays an important role in confirming a diagnosis of COPD and also in managing the disease in the general practice setting. When entering spirometry values into clinical software McGraths Hill Medical Centre found that there was a discrepancy in their data, with only 11 patients showing as having had a spirometry test done, when in fact 14 patients had a recorded spirometry result. The team identified that this was because the 3 patients only had the pre value recorded which resulted in them not being identified in clinical software searches. The team updated their process to ensure that both pre and post values are recorded into the clinical software.

- *McGraths Hill Medical Centre, McGraths Hill, NSW*

# Have a Systematic and Proactive Approach to Managing the Care of People with COPD

Managing care efficiently and consistently across a general practice requires a planned, systematic and proactive approach. It is important your patients are offered appropriate evidence-based and patient-centred interventions.

Some patients have a high risk of exacerbation, leading to presentations and admissions to hospital. By systematically identifying these people, and adopting a proactive approach to risk factor reduction, you can have a large impact on their health outcomes. However, all patients diagnosed with COPD potentially benefit from improvements to their modifiable risk factors, including smoking cessation, referral to pulmonary rehabilitation, regular physical activity, immunisation and referral to local support groups.

There is strong medical evidence to show that early diagnosis, combined with disease management at the early stages of the disease could reduce the burden of COPD, improving quality of life, slowing disease progression, reducing mortality and keeping people out of hospital[5].

# CHECKLIST: Have a Systematic and Proactive Approach to Managing the Care of People with COPD

**Use a multidisciplinary team to facilitate reliable care delivery**

- ☐ Do we have a team based approach to chronic care management?
- ☐ Do the team members* have the appropriate skills and training e.g. spirometry training, to manage the care of patients with COPD?
- ☐ Do we regularly liaise with each other to coordinate patient care?
- ☐ Do we run nurse clinics?
- ☐ Do our patients know who their care team is?
- ☐ *Members of the team may be external private providers e.g. physiotherapists and exercise physiologists. Engaging them within the practice team as part of the 'Team Care Arrangement' is important.

**Utilise appropriate care pathways for people with COPD**

- ☐ Do our patients with COPD have current GPMPs/TCAs and COPD Sick Day Action Plans
- ☐ Do the care plans include information on patients' needs and goals and self-management options?
- ☐ Do our patients receive timely clinical reviews based on recommended guidelines?
- ☐ Do we regularly undertake reviews of our patients care plans?
- ☐ Do we use recommended care pathways as well as NBMPHN HealthPathways?

**Use guidelines, protocols and computer templates to support care delivery**

- ☐ Do our clinicians refer to relevant guidelines such as the COPD-X Guidelines, local guidelines as well as NBMPHN COPD HealthPathways?
- ☐ Do our clinicians have online access to clinical guidelines and templates?
- ☐ Do we review the templates to make sure they're suitable for our general practice and/or our community's needs?
- ☐ Do all our clinicians know how to use the templates?

**Establish proactive recall and reminder systems**

- ☐ Do we have a systematic and proactive reminder system?
- ☐ Do we use prompts in the appointment system or clinical software to identify patients with specific needs e.g. those for whom English is a second language, patients with disabilities?
- ☐ Do we have multiple channels for communicating reminders, depending on the needs and preferences of the patient? (e.g. letter, SMS, phone call, letters translated into other languages)
- ☐ Does our whole team understand our recall and reminder system?
- ☐ Does our practice monitor attendance and have systems to follow up patients who do not attend?

**Integrate the perspective of patients and carers in the design of services**

- ☐ How do we incorporate patients' and their family's perspectives and choices to ensure their knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care?
- ☐ How do we encourage and support patients to participate in care and decision-making at the level they choose?
- ☐ Do we have an agreed process and policy around collaborative goal setting to assist patients to develop written action plans to achieve their own health goals?
- ☐ Does our practice request feedback from patients about their experience of care?
- ☐ Have we involved patients in the design of our resources such as awareness raising literature and health lifestyle guidance?
- ☐ Do we have a patient advisory group?
- ☐ Do patient reported measures form part of how we assess our practice's performance?

**Helpful Tip**

Consider assessing patients who are current smokers for COPD when they present to your practice with a chest infection

Encourage all patients to involve carers and family members in their management (e.g. by attending consultations)

## Case Studies

### Case Study - Smoking cessation program

Tintenbar Medical Centre wanted to reduce the number of their patients who smoked. After successfully receiving a cancer council grant, they ran a project aimed at helping patients quit smoking. The practice identified patients who smoked and mailed them an invitation to attend a smoking cessation meeting. The group that attended was keen to meet twice more to support one another. The practice enlisted the local pharmacist to present at one of the meetings. Although the number of patients that responded to the invitation was small, the quit rate at six months was 40% of those who attended the meetings.

- Tintenbar Medical Centre, Tintenbar, NSW

### Case Study - Integrating patient feedback

My GP invited me to speak to her team about the value of a Care Plan and my involvement was used to support their applications for various Awards - two of which they won and it was also included in their re-accreditation. Whenever I see my GP, she updates me on the innovations and changes in the practice which makes me feel part of the extended team. My involvement with the Improvement Foundation has also grown and developed. I was on the panel at the 21st Century Patient Care and Self-Management workshop on the Gold Coast, and on another panel at the electronic health record workshop - something else I am passionate about as a chronic disease patient. Being fortunate enough to be involved in these workshops, has made me more aware of the need to take ownership and responsibility for my diabetes. I've also been sharing what I've learned with fellow patients and encourage them to self-manage better.

- Julie Sattler - Improvement Foundation Patient Rep & Mentor

# Support Patient Self-Management

We know the real work in managing chronic conditions and reducing risk factors is done by our patients and their families. In a person-centred health system, the person and their families and carers are at the centre 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. Our role as general practices and primary health services is to provide the tools and guidance patients require to take action to improve their health.

Self-management involves 'engaging in activities that protect and promote health, monitoring and managing symptoms and signs of illness, managing the impacts of illness on functioning, emotions and interpersonal relationships and adhering to treatment regimes. Self-management plans are an effective way of actively engaging patients in managing their health.

The 'Support patient self-management' checklist, tools and resources are designed to help you take a person-centred approach to supporting patients to self-manage their conditions to the best of their ability.

## Patient Support Programs

Lung Foundation Patient Support Line 1800 654 301 or visit the webpage for patient education resources and information

https://lungfoundation.com.au/patient-support/

## Patient Support Programs in the Nepean Blue Mountains

**Chronic Airflow Limitation Management (CALM) Pulmonary Rehabilitation Program*:**

- **Chronic Airflow Limitation Management (CALM) Pulmonary Rehabilitation Program*:**
  - Blue Mountains Hospital (02) 4784 6663
  - Nepean Hospital (02) 4734 4276
  - Hawkesbury District Community Health Service (02) 4560 5713

*GP referral form required for patient registration to the CALM program.

- **Lungs in Action** exercise group is currently held in Windsor. Contact Rebecca Hannon on 0404 871 484 or go to the Lung Foundation's Lungs in Action exercise class directory for other locations https://lungfoundation.com.au
- **Nepean Lung Support Group (Nepean Puffers & Wheezers)** Contact: John Ruttle - ruttlej@gmail.com

# CHECKLIST: Support Patient Self-Management

**Establish clear definitions of self-management and what self-management support involves**

- ☐ Do we provide care that builds our patients' and their families' knowledge, skills and confidence?
- ☐ How do we increase our patients' and their families' knowledge about their condition/s?
- ☐ How do we share the needs and preferences of our patients and the families with the team?
- ☐ Do we support our patients and their families in the psychosocial and medical responses to their condition/s?
- ☐ Do we provide evidence-based approaches to enhancing self-management?

**Organise internal and external resources to provide patient-centred self-management support**

- ☐ Does our team have the resources and skills to provide self-management support?
- ☐ Do we have a clinical or administrative champion within the team to drive self-management support strategies?
- ☐ Does our practice display COPD self-management materials?
- ☐ Have we reviewed the health promotion materials available from the Lung Foundation Australia and ordered the resources that are relevant to our practice?
- ☐ Do we provide smoking cessation advice and resources?
- ☐ Does our practice display self-management materials designed for specific cohorts of patients, e.g. Aboriginal and Torres Strait Islander people?
- ☐ Does our practice use events such as World COPD Day or Lung Health Awareness Month to promote lung health initiatives within our practice?

**Implement a strategy for self-management support that empowers patients and carers**

- ☐ Do we have a strategy to identify the patients that would most benefit from self-management support?
- ☐ Does our whole team understand the components of health literacy?
- ☐ Has our team (including reception staff) received health literacy training?
- ☐ Have we put our reminder letter through a health literacy check?
- ☐ Have our clinicians undertaken online Teach-Back training?
- ☐ Do our clinicians use motivational interviewing techniques and/or provide health coaching?

- ☐ Is our practice a safe place for culturally diverse patients?
- ☐ Have our clinicians read the Australian Indigenous Doctors' Association's 'Cultural Safety Factsheets'?

**Implement processes and systems to support patients and adopt self-management plans**

- ☐ Do we a strategy to identify the patients that would most benefit from self-management plans?
- ☐ Do we use self-management plans?
- ☐ Do the plans include shared definitions of our patients' problems, goals, actions and timeframes for managing their health?
- ☐ Do our patients have COPD Action Plans?
- ☐ Do our COPD Action Plans detail what individuals should do in the event of an exacerbation at any time of the day?

**Implement processes and systems to support patients with Advance Care Planning (ACP)**

- ☐ Do we have a strategy to assess which of our patients are suitable for Advance Care Planning?
- ☐ Have we set up a specific recall and reminder system for this process?
- ☐ Do we book long consultations in order to ensure that there is time to discuss ACP in full, answer any questions and discuss the patients' concerns and issues?
- ☐ Do we invite patients' nominated carers, family members or friends to the consult (if appropriate)?
- ☐ Do we book further consultations as ACP is often an ongoing process rather than a "one-off" discussion?
- ☐ Do we discuss Power of Attorney/Enduring Guardianship with patients and their families or carers as required?
- ☐ Do we refer patients to external agencies such as NSW Public Guardian or the NSW Guardianship Tribunal where relevant?

**Helpful Tip**

COPD Action Plans can add recognition of, and response to, exacerbations but they should not replace comprehensive self-management plans that incorporate elements such as education and regular review for suitable patients.

## Case Studies

### Case Study - Nurse clinic to support self-management

Stirk Medical Group in Western Australia established nurse-led clinics with an aim of improving patient self-management. The practice understood the importance of assigning the right staff member(s) to coordinate the clinic.

A practice nurse who was willing to develop the program and understood the concept of self-management was assigned to lead the clinic. By creating a nurse-led clinic, the practice could dedicate the necessary time for patients to be educated and actively involved in making decision about their care.

- Stirk Medical Group, Lesmurdie, WA

# Ensure Patients Receive Coordinated and Integrated Care

General Practice is typically the gateway for patients to access specialised parts of the health system. GP's and care managers play a key role in ensuring patients can access the care they need, while avoiding unnecessary pathways or pathways where risks may outweigh the benefits.

In the Medical Home Model, a person and their family form a partnership with a particular primary care provider and their team, with other services 'wrapping around' this partnership, as required. This model is useful for considering how the wider health system links with the primary health care services in which patients receive the majority of their care, to form an integrated care system.

For more information on the Medical Home Model, visit:

http://medicalhome.org.au/the-person-centred-health-system-and-the-medical-home/

## HealthPathways as a tool for providing integrated care

HealthPathways is an important tool that is designed to ensure Nepean Blue Mountains primary health care providers have the information they need at their fingertips, at the point-of-care, to help patients navigate our health system effectively.

NBMPHN in conjunction with the NBM Local Health District have developed localised and up-to-date HealthPathways for the management of patients with COPD which are available for GPs now.

**Login details for HealthPathways:**

URL: https://nbm.communityhealthpathways.org/

| **Region your practice is based in** | **Username** | **Password** |
|---|---|---|
| Blue Mountains | hpbluemount | hpbmpassword |
| Hawkesbury | hphawkesbury | hphpassword |
| Lithgow | hplithgow | hplpassword |
| Penrith | hppenrith | hpppassword |

# CHECKLIST: Ensure Patients Receive Coordinated and Integrated Care

**Identify and engage local organisations and other sources of care to provide best care in people with COPD**

- ☐ Do we have details of our patients' carers, nominated family members and friends in the patient record?
- ☐ Do we have a list of local allied health professionals/services that we can refer to? Is this information up to date?
- ☐ Can we access an electronic service director which is regularly updated?
- ☐ Do we have contact details for the local hospital discharge planner?
- ☐ Do we know which local support services are available?
- ☐ Do we ask and record all new patients' language preferences and offer and use appropriate language services?
- ☐ Do we use interpreter services appropriately?
- ☐ How do we communicate with local health organisations and support services?

**Analyse the patient journey and redesign where necessary**

- ☐ Do we have details for all the team members involved in the care of our patients with COPD?
- ☐ Has our practice team mapped the patient journey from the person's point of view to try to understand which aspects of the journey may be inconvenient, difficult to access, unclear or psychologically distressing for our patients?
- ☐ Have we involved patients in the mapping exercise?
- ☐ As a result of this, do we need to amend our care pathways?

**Provide integrated care by improving the relationship between primary, secondary and tertiary providers**

- ☐ Do we have established referral processes?
- ☐ Do we utilise localised care pathways?
- ☐ Does our practice partner with community organisations or leaders to better engage hard to reach patients and to support referrals to services?
- ☐ Do we refer our patients to local support groups?
- ☐ Do we use the Nepean Blue Mountains HealthPathways site?

**Use Shared Health Summaries (SHS) to coordinate with other providers in the patients' care teams**

- ☐ Do all of our patients with COPD have a My Health Record?
- ☐ Have we updated Share Health Summaries for all of our patients with COPD?
- ☐ Can we work with the hospital to support improved use of My Health Record?
- ☐ Does our practice partner with community organisation or leaders to inform patients of the benefits of My Health Record and how to use it?

**Medication Management**

- ☐ Are all medications recorded?
- ☐ Does the patient understand how to use their medications including inhalers correctly?
- ☐ Is a Medication Management Review (MMR - MBS 903) required? Has it been reviewed in the last 12 months?

**Helpful Tip**

The Lung Foundation's Information and Support Centre can be contacted for:

- Support group locations
- Pulmonary rehabilitation program locations
- Lungs in Action class locations
- Links to other relevant services
- Clinical and patient resources

FREE CALL 1800 654 301 or via enquiries@lungfoundation.com.au

Consider liaising with your local pharmacies to find out what information, advice and support they provide to people who have respiratory infections/present with respiratory issues.

## Case Studies

### Case Study - Raising awareness of COPD in the community

A Lung Support Group held a COPD Awareness Day outside a local Bunnings store. Nurses were on hand to undertake lung function testing for individuals who attended the store. The group partnered with the local Rotary Club who provided a BBQ, and proceeds from the BBQ were split evenly between the two groups.

### Case Study - Patient journey mapping

In the Townsville Integrated Care Collaborative, Lionel “Tiger” Corrigan undertook the patient journey mapping process with his GP, other health care providers and family members. Tiger was identified as being a patient with complex care needs, with diagnoses including ongoing chest pain, arthritis, back pain, type 2 diabetes and kidney disease. Tiger has many health providers and has had numerous hospital admissions over the years.

The aim of the mapping process was to identify ways to reduce Tiger’s hospital admissions and to understand whether the current service provision was timely and of high quality. The session collectively mapped the journey relating to his latest hospital admission.

The map generated through this process enabled the team to easily identify areas of duplication and gaps in the existing provision of services. Tiger’s health providers and family members were able to visualise how various members of the wider care team fit together. As part of this process, it also offered each health care provider an opportunity to assess how they could improve their systems for other patients with high care needs.

- Strive Health and Physiotherapy, Kirwan, QLD

# Keeping Score - Measure your Progress

## COPD Collaborative Measures

It's important to have clear measures that track progress towards achieving the objective of improving diagnosis and management of COPD.

The following COPD Collaborative measures were previously selected by the Expert Reference Panel.

| **Measure Title** | **COPD Register** |
|---|---|
| Numerator | The number of patients that are coded with a diagnosis matching the COPD definition |
| Denominator | The number of active patients in the total practice register |
| **Measure Title** | **COPD Smoking Status Recorded** |
| Numerator | The number of patients that are coded with a diagnosis matching the COPD definition whose smoking status has been recorded |
| Denominator | The number of active patients that are coded with a diagnosis matching the COPD definition |
| **Measure Title** | **COPD Spirometry Recorded** |
| Numerator | The number of patients that are coded with a diagnosis matching the COPD definition with a Spirometry result recorded at any time |
| Denominator | The number of active patients that are coded with a diagnosis matching the COPD definition |

| Measure Title | COPD Pneumococcal Vaccination Recorded |
|---|---|
| Numerator | The number of patients that are coded with a diagnosis matching the COPD definition with a Pneumococcal vaccination recorded at any time |
| Denominator | The number of active patients that are coded with a diagnosis matching the COPD definition |
| **Measure Title** | **COPD Influenza Vaccination Recorded** |
| Numerator | The number of patients that are coded with a diagnosis matching the COPD definition with an Influenza vaccination recorded in the past 12 months |
| Denominator | The number of active patients that are coded with a diagnosis matching the COPD definition |
| **Measure Title** | **COPD GP Management Plan Recorded** |
| Numerator | The number of patients that are coded with a diagnosis matching the COPD definition with a GP Management Plan claimed within the past 24 months |
| Denominator | The number of active patients that are coded with a diagnosis matching the COPD definition |

# Templates & Guides

The **Model for Improvement** is a tool for developing, testing and implementing change. The Model consists of two parts that are of equal importance.

1. The *'thinking part'* consists of 3 Fundamental Questions that are essential for guiding improvement work
2. The *'doing'* part is made up of Plan-Do-Study-Act (PDSA) cycles that will help you to test ideas and implement change

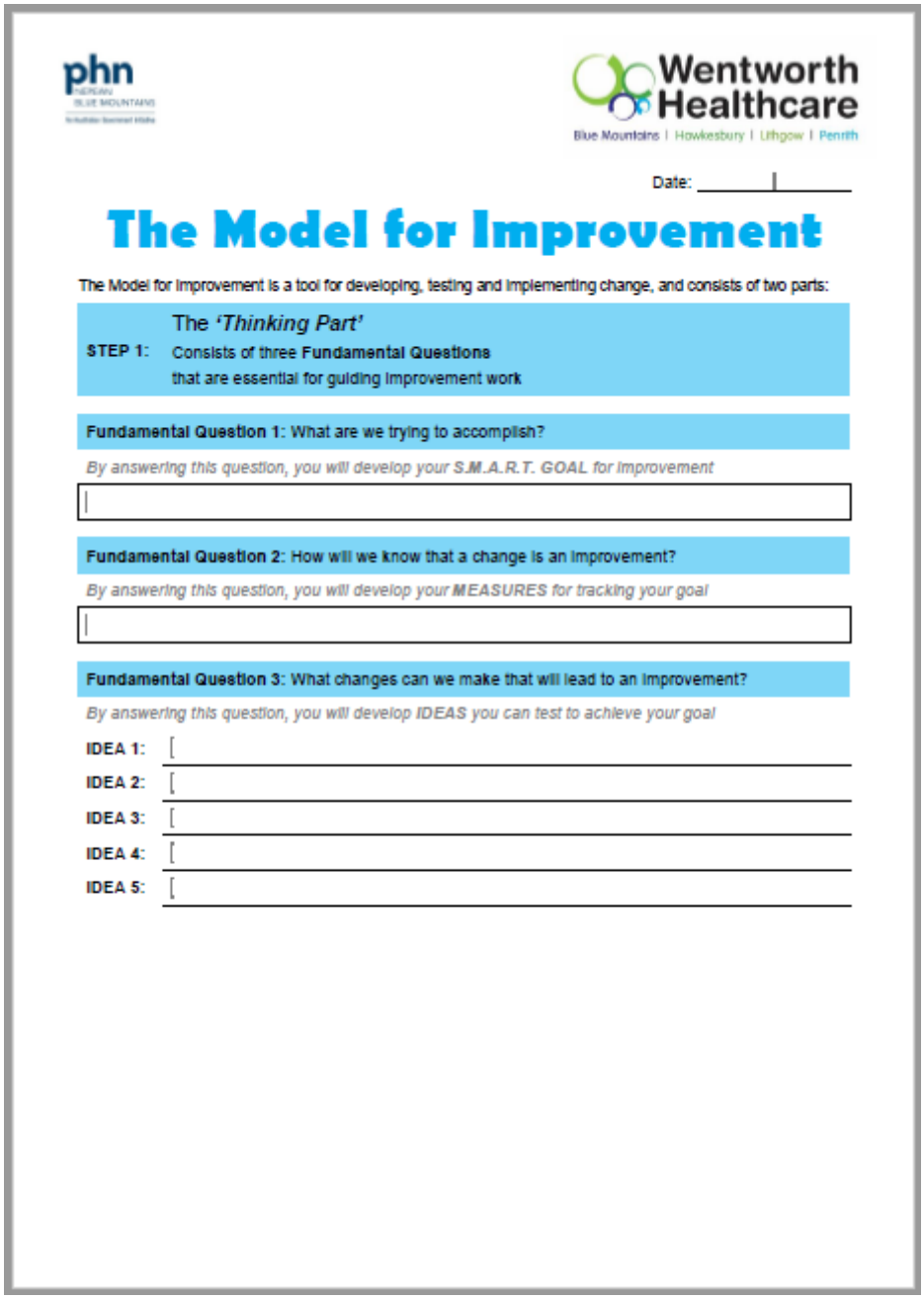
This guide will take you through the following steps:

**Step 1**: The 3 Fundamental Questions

**Step 2**: The PDSA cycle

# Step 1: The 3 Fundamental Questions

**Note**: Each new GOAL (1st Fundamental Question) will require a new Model for Improvement form to be completed.



phn

Wentworth Healthcare

Blue Mountains | Hawkesbury | Lithgow | Penrith

Date: _____

## The Model for Improvement

The Model for Improvement is a tool for developing, testing and implementing change, and consists of two parts:

**STEP 1:** The *'Thinking Part'*
Consists of three **Fundamental Questions**
that are essential for guiding improvement work

**Fundamental Question 1**: What are we trying to accomplish?

*By answering this question, you will develop your **S.M.A.R.T. GOAL** for improvement*

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

*By answering this question, you will develop your **MEASURES** for tracking your goal*

**Fundamental Question 3**: What changes can we make that will lead to an improvement?

*By answering this question, you will develop **IDEAS** you can test to achieve your goal*

**IDEA 1:**

**IDEA 2:**

**IDEA 3:**

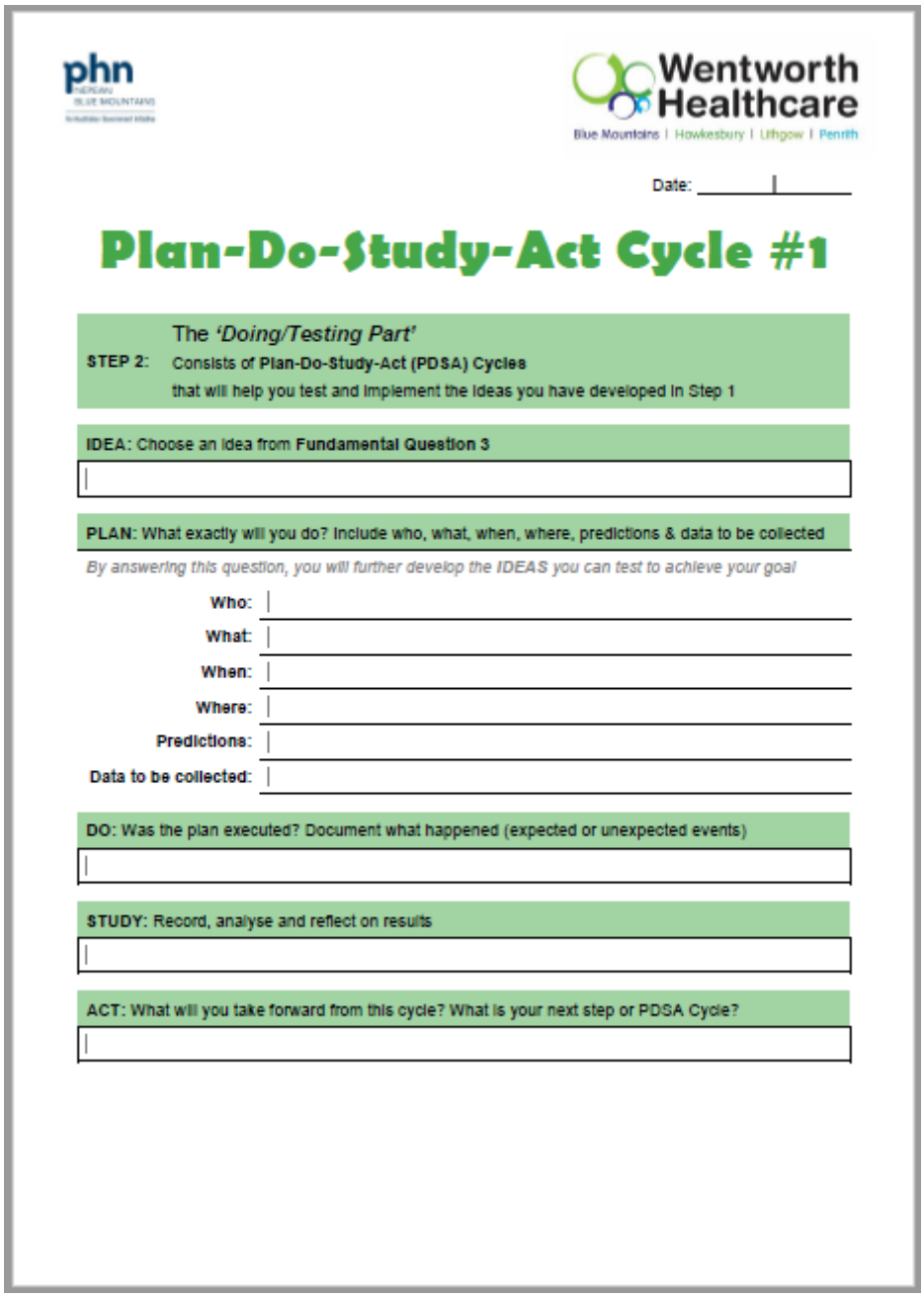
**IDEA 4:**

**IDEA 5:**

Acknowledgement: MFI derived from the Improvement Foundation

# Step 2: Plan-Do-Study-Act

You will have noted your *ideas* for testing when you answered the 3rd Fundamental Question in Step 1. You will use this PDSA cycle to test one of those ideas



phn

Wentworth Healthcare

Blue Mountains | Hawkesbury | Lithgow | Penrith

Date: _____

## Plan-Do-Study-Act Cycle #1

**STEP 2:** The *'Doing/Testing Part'*
Consists of **Plan-Do-Study-Act (PDSA) Cycles**
that will help you test and implement the ideas you have developed in Step 1

**IDEA:** Choose an idea from **Fundamental Question 3**

**PLAN:** What exactly will you do? Include who, what, when, where, predictions & data to be collected

*By answering this question, you will further develop the IDEAS you can test to achieve your goal*

**Who:**
**What:**
**When:**
**Where:**
**Predictions:**
**Data to be collected:**

**DO:** Was the plan executed? Document what happened (expected or unexpected events)

**STUDY:** Record, analyse and reflect on results

**ACT:** What will you take forward from this cycle? What is your next step or PDSA Cycle?

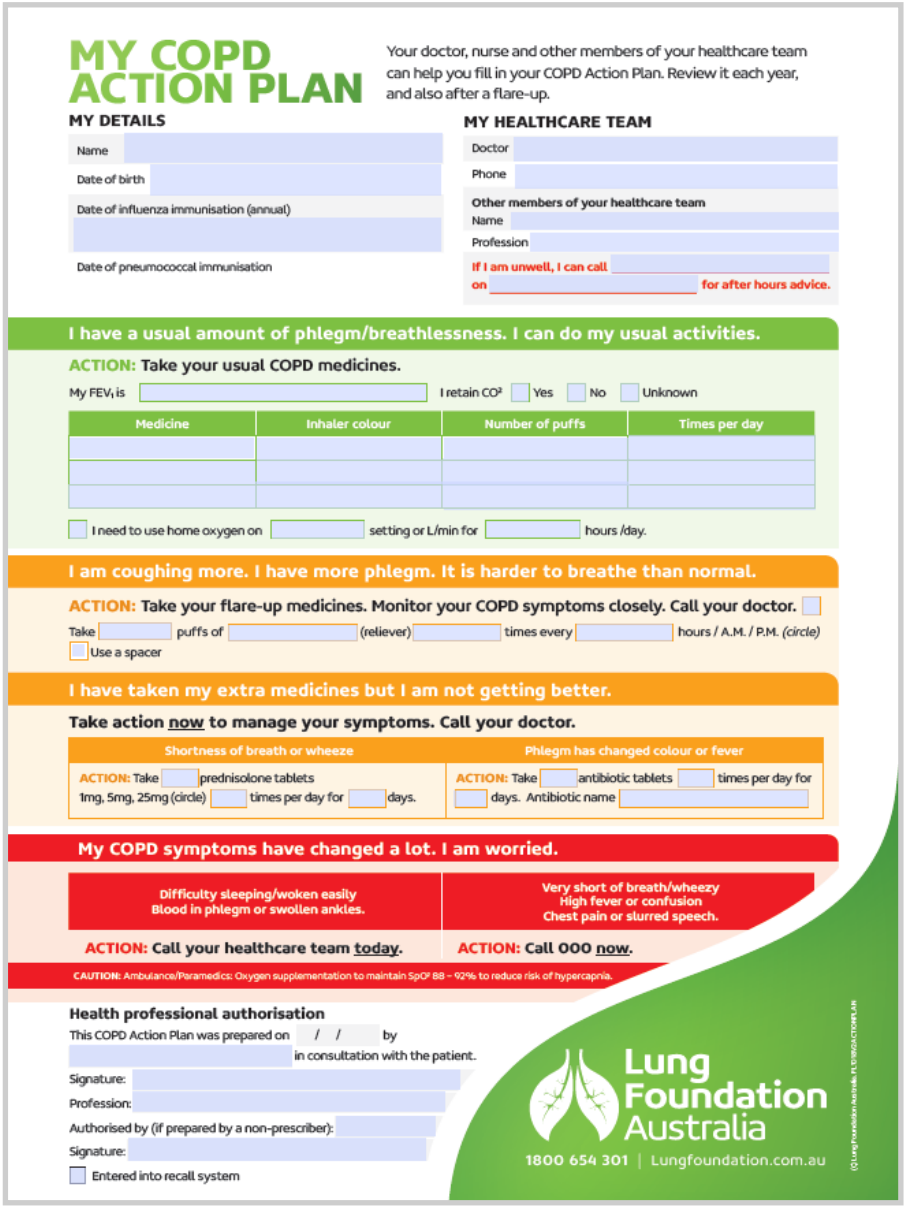
Acknowledgement: PDSA cycle derived from the Improvement Foundation

# COPD Action Plan

The COPD Action Plan Kit is available for download from the Lung Foundation Australia website as an editable PDF.

The COPD Action Plan Kit is also available to download on HealthPathways. Once logged in go to **Medical** > **Respiratory** > **COPD** > **Management** and point 9 includes a link to the COPD Action Plan. On pages 3 and 4 of the COPD Action Plan template there are instructions on the algorithm for managing exacerbations as well as instructions on how to write the action plan.

Alternatively, ask your Practice Support Officer how you can get an RTF version to link in with your clinical software.



MY COPD ACTION PLAN

Your doctor, nurse and other members of your healthcare team can help you fill in your COPD Action Plan. Review it each year, and also after a flare-up.

MY DETAILS

Name

Date of birth

Date of influenza immunisation (annual)

Date of pneumococcal immunisation

MY HEALTHCARE TEAM

Doctor

Phone

Other members of your healthcare team

Name

Profession

If I am unwell, I can call on for after hours advice.

I have a usual amount of phlegm/breathlessness. I can do my usual activities.

ACTION: Take your usual COPD medicines.

My FEV1 is I retain CO2 Yes No Unknown

| Medicine | Inhaler colour | Number of puffs | Times per day |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

I need to use home oxygen on setting or L/min for hours /day.

I am coughing more. I have more phlegm. It is harder to breathe than normal.

ACTION: Take your flare-up medicines. Monitor your COPD symptoms closely. Call your doctor.

Take puffs of (reliever) times every hours / A.M. / P.M. *(circle)*

Use a spacer

I have taken my extra medicines but I am not getting better.

Take action now to manage your symptoms. Call your doctor.

| Shortness of breath or wheeze | Phlegm has changed colour or fever |
|---|---|
| ACTION: Take prednisolone tablets 1mg, 5mg, 25mg (circle) times per day for days. | ACTION: Take antibiotic tablets times per day for days. Antibiotic name |

My COPD symptoms have changed a lot. I am worried.

| Difficulty sleeping/woken easily<br>Blood in phlegm or swollen ankles. | Very short of breath/wheezy<br>High fever or confusion<br>Chest pain or slurred speech. |
|---|---|
| ACTION: Call your healthcare team today. | ACTION: Call 000 now. |

CAUTION: Ambulance/Paramedics: Oxygen supplementation to maintain SpO2 88 - 92% to reduce risk of hypercapnia.

Health professional authorisation

This COPD Action Plan was prepared on / / by in consultation with the patient.

Signature:

Profession:

Authorised by (if prepared by a non-prescriber):

Signature:

Entered into recall system

Lung Foundation Australia

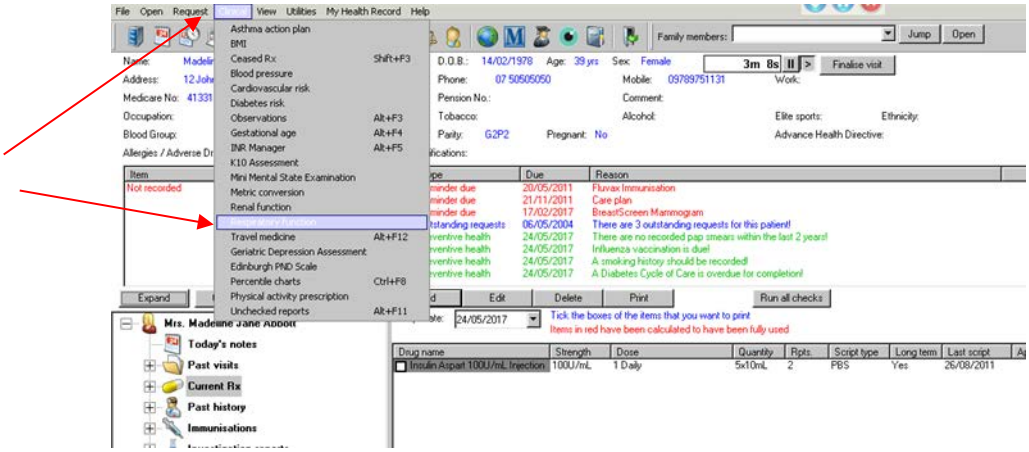
1800 654 301 | Lungfoundation.com.au

# Clinical Software – Best Practice

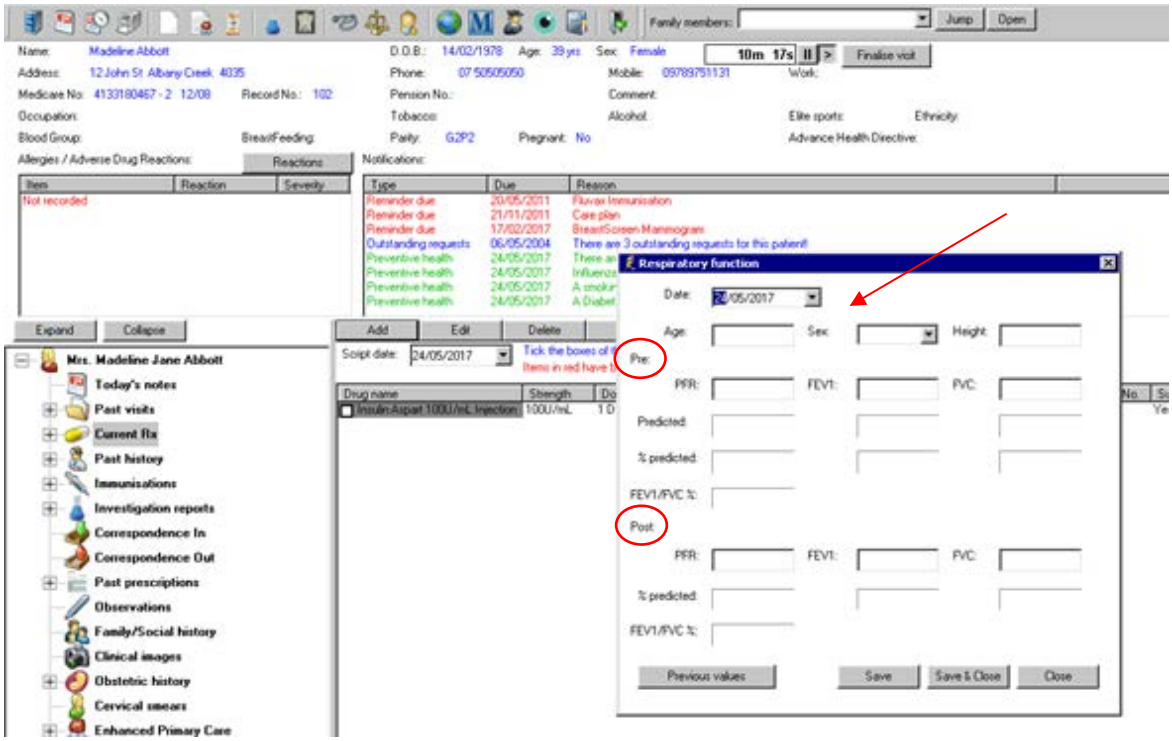
Remember to enter the coded **'Reason for Visit'** so this information can be identified on future visits.

## Entering spirometry results into Best Practice

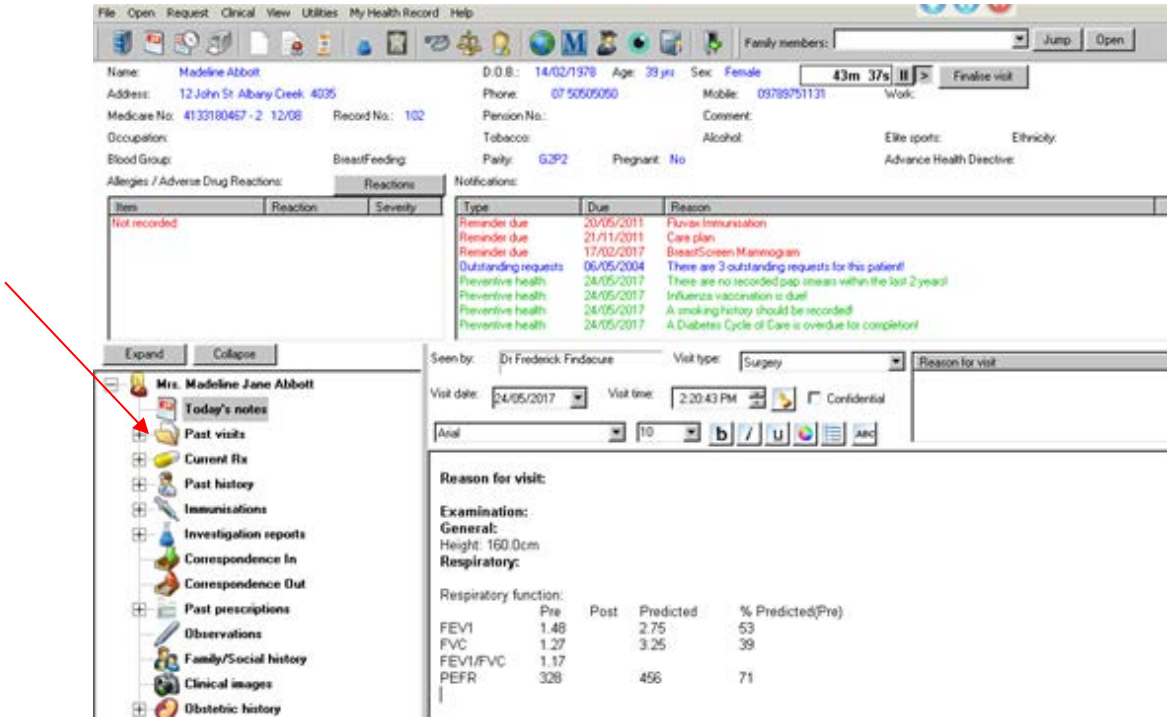
***Step 1*** – Click on the **Clinical** tab. Open **Respiratory Function.**




***Step 2*** – Enter the date and patient details (Age, Sex and Height) and then add the Pre and Post spirometry values. *You must enter both Pre and Post values for CAT4 to pick up that a spirometry result has been recorded.*

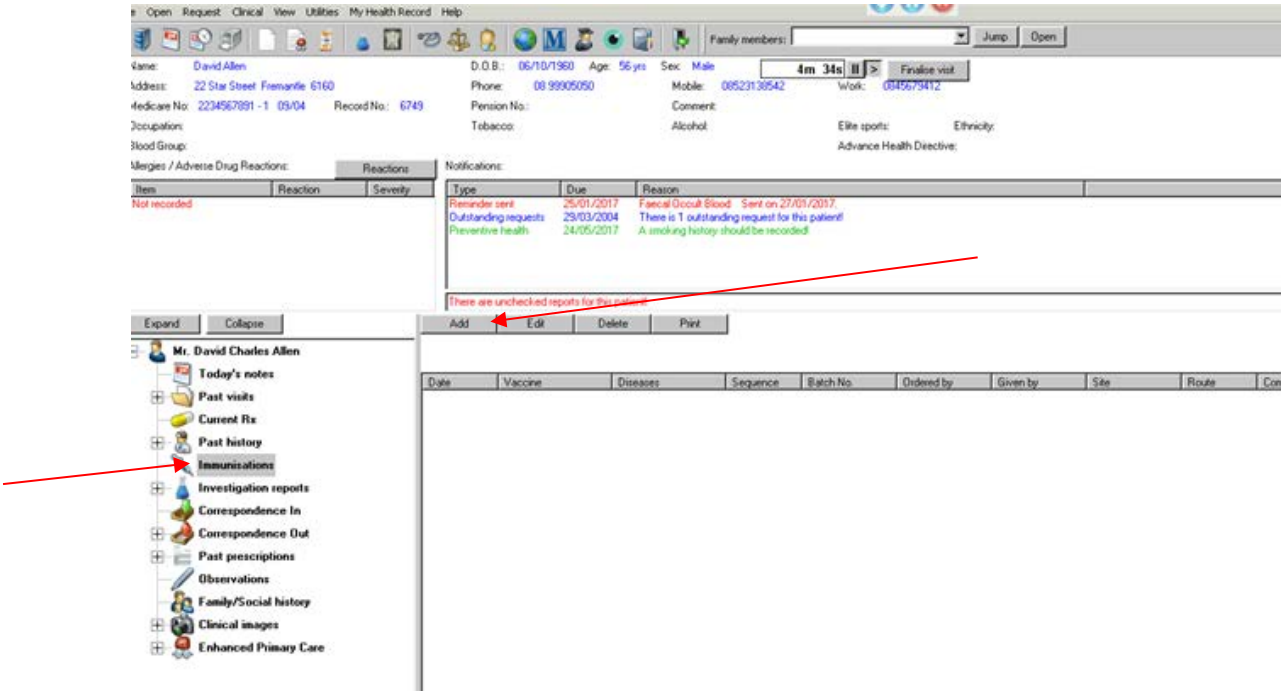


Spirometry results which have been previously entered via this method can be accessed via the **Past Visits** tab.

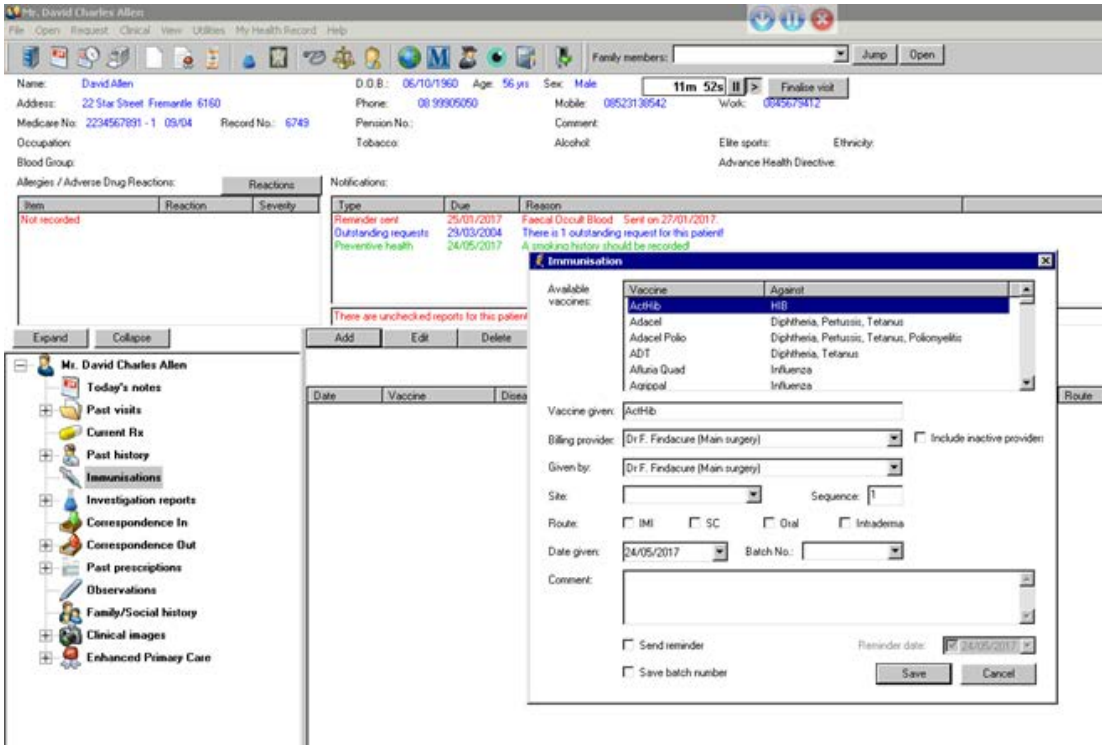


# Entering pneumococcal vaccinations into Best Practice

***Step 1*** – Open the **Immunisations** tab. To enter a new vaccination, click **add**



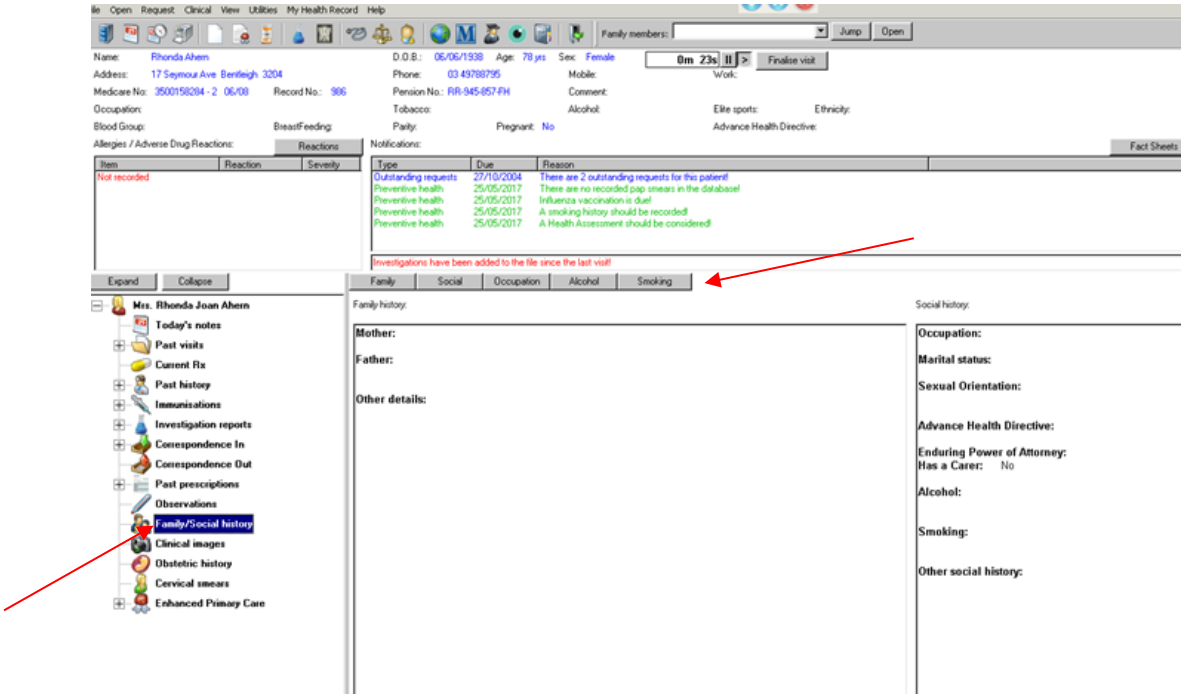

***Step 2*** – Enter the vaccination details




To see current vaccinations entered via this method, open the **Immunisations** tab again

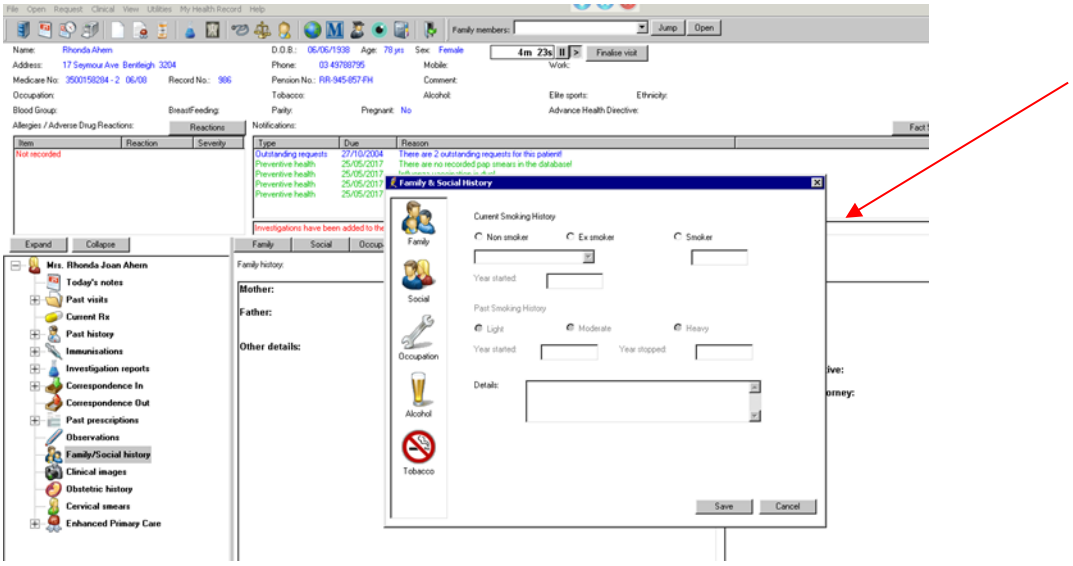
# Entering smoking status into Best Practice

***Step 1*** – Click on the **Family/Social History** tab. The enter smoking history, click on the **Smoking** tab




***Step 2*** – A pop up window will appear where you can enter the patients' smoking history.

To see a patients' smoking history enter via this method, go back to the **Family/Social History** tab.

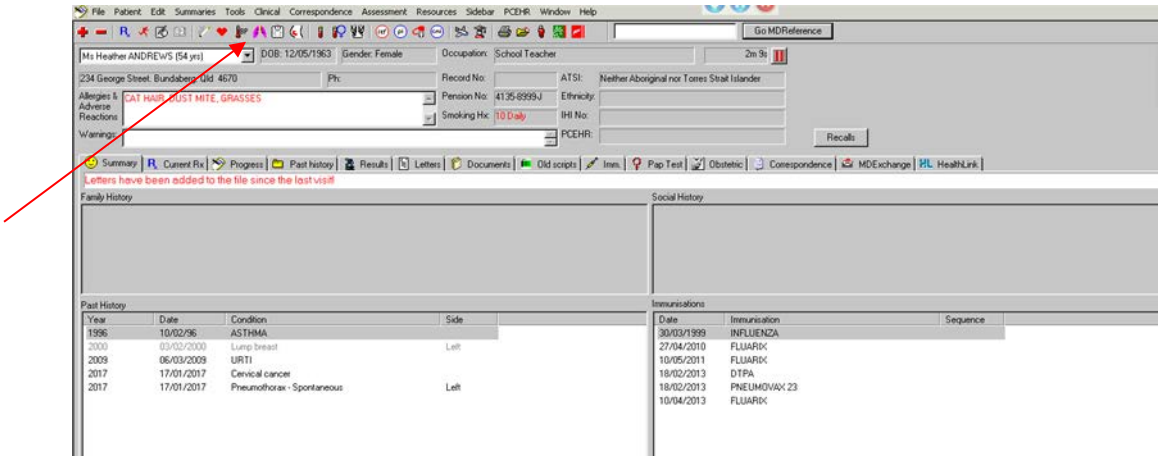


# Clinical Software – Medical Director

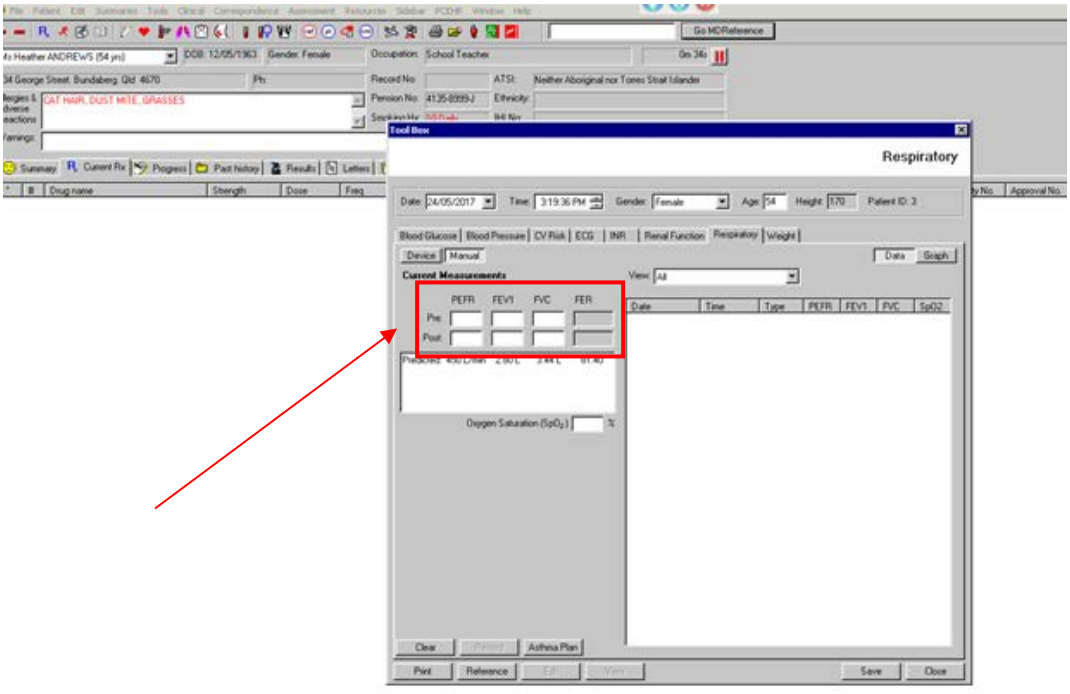
Remember to enter the coded **'Reason for Visit'** so this information can be identified on future visits

## Entering spirometry results into Medical Director

***Step 1*** – Open the Respiratory Calculator by clicking on the **lungs** icon



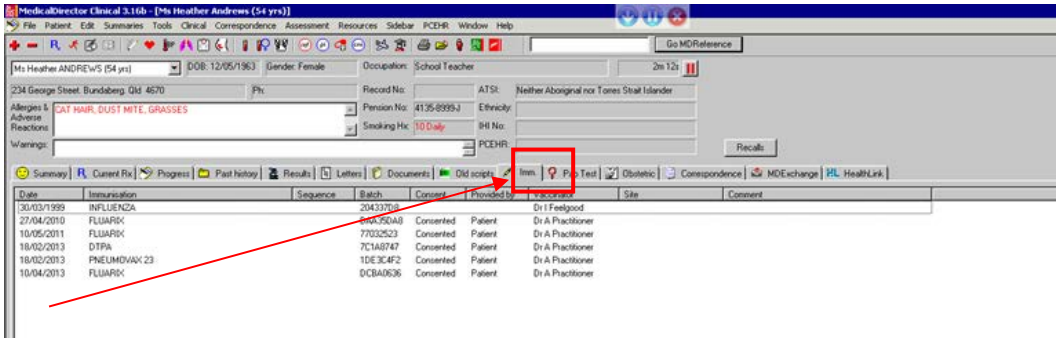
***Step 2*** – A pop up window will open and under the heading Current Measures, enter the spirometry results. *You must enter both Pre and Post values for PENCAT to pick up that a spirometry result has been recorded.*



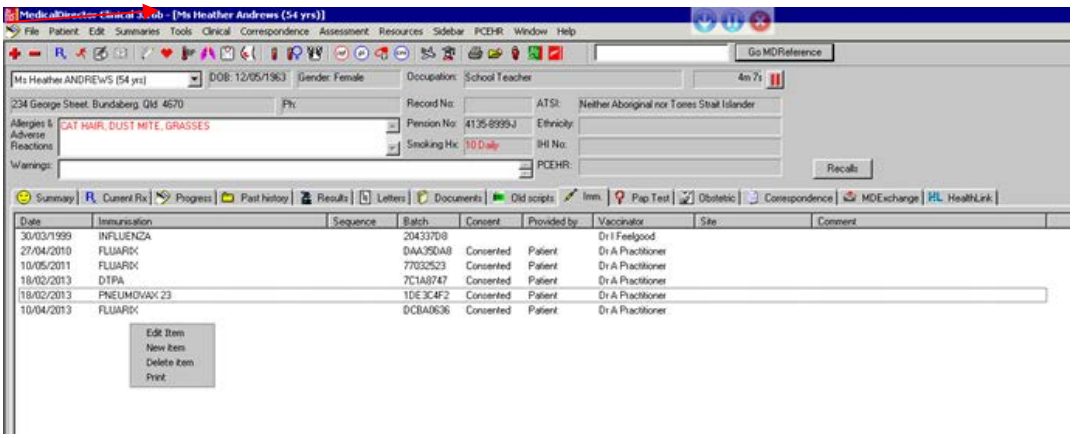

Spirometry results which have been entered via this method can be accessed by clicking on the Respiratory Calculator. The results will be listed by the date they were entered.

# Entering pneumococcal vaccinations into Medical Director

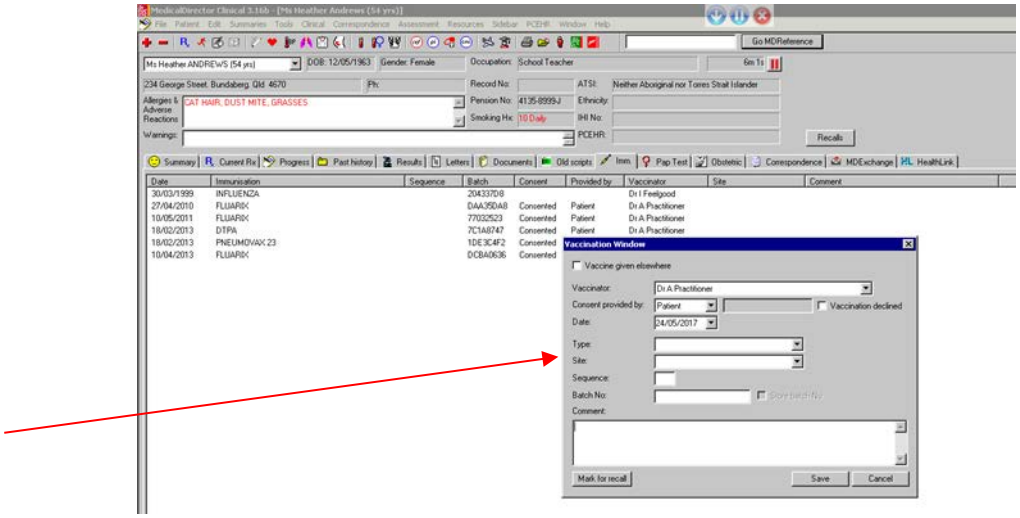
***Step 1*** – Open the **Immunisations** tab



***Step 2*** – On your mouse, right click and open a **New Item**. If using a Mac, press the Control (Ctrl) key when you tab the mouse button to 'right click'



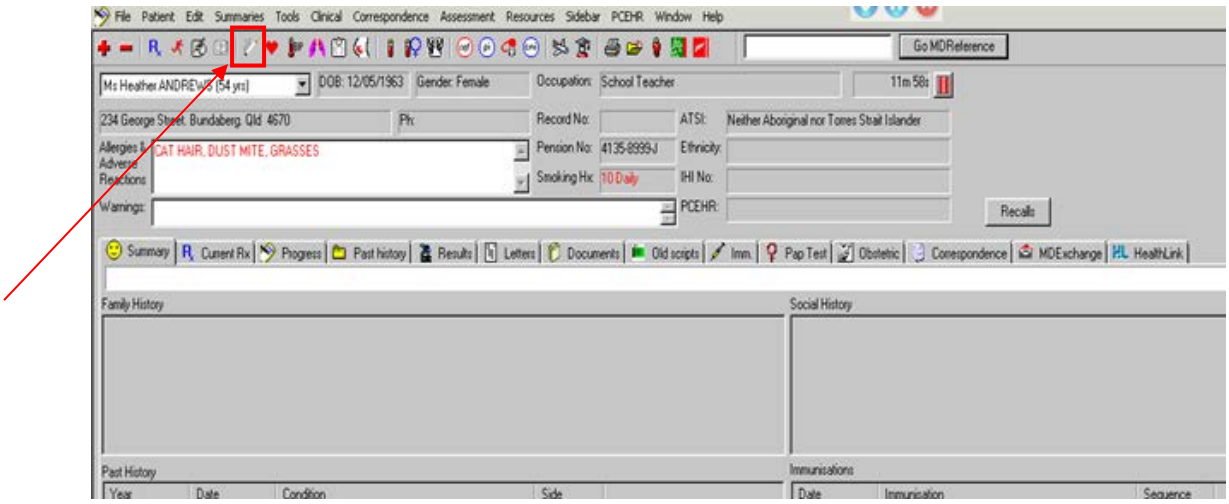

***Step 3*** – A vaccination window will pop up window to enter the vaccination details



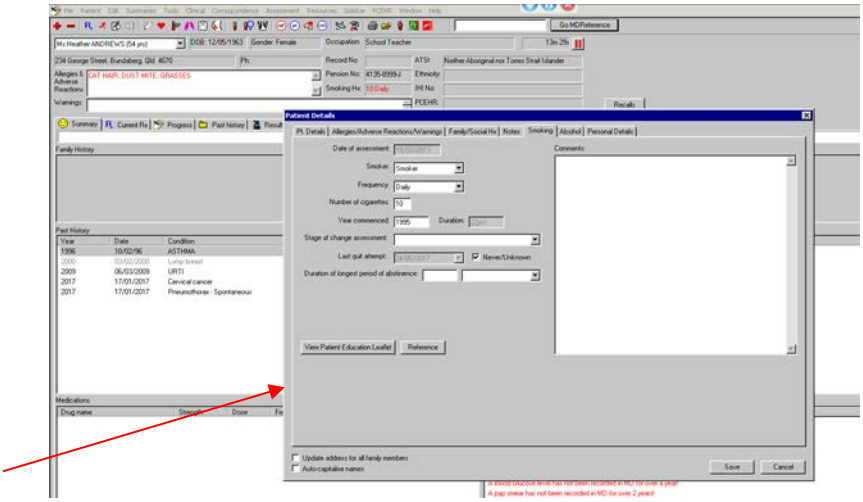

The new vaccination will be saved under the **Immunisations** tab.

# Entering smoking status into Medical Director

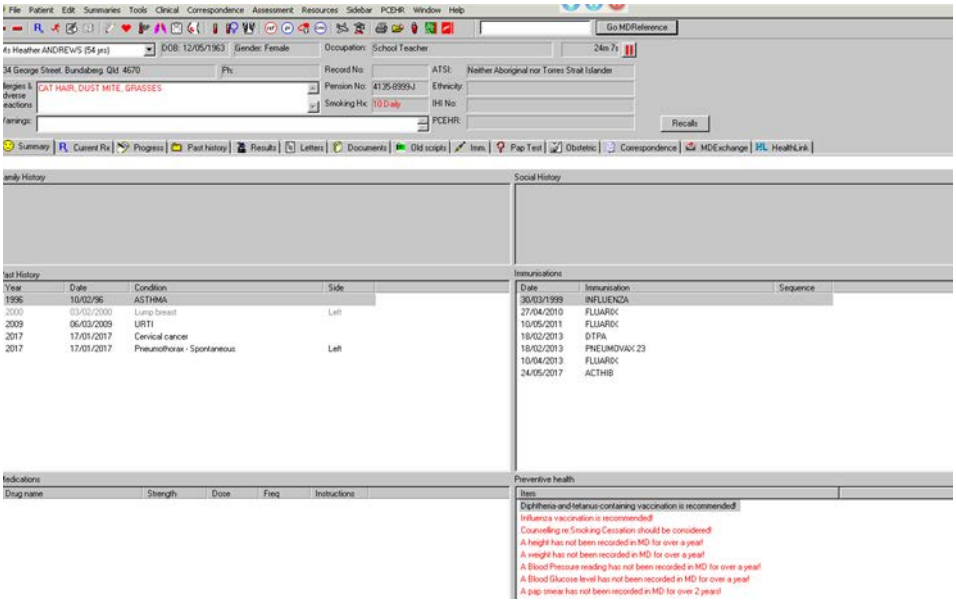
***Step 1*** – Open **Smoking Details** tab




***Step 2*** - Enter the patients smoking details and click save



The current smoking status can also be veiwed in the patient record under Smoking Hx



# Abbreviations

| | |
|---|---|
| **ACP** | Advance Care Planning |
| **ACSQHC** | Australian Commission on Quality & Safety in Health Care |
| **COPD** | Chronic Obstructive Pulmonary Disease |
| **CPD** | Continuing Professional Development |
| **GP** | General Practitioner |
| **GPMP** | GP Management Plan |
| **IF** | Improvement Foundation |
| **MMR** | Medication Management Review |
| **NBMPHN** | Nepean Blue Mountains Primary Health Network |
| **NBMLHD** | Nepean Blue Mountains Local Health District |
| **NSW** | New South Wales |
| **PN** | Practice Nurse |
| **QI** | Quality Improvement |
| **RACGP** | Royal Australian College of General Practitioners |
| **SMART** | Specific, Measureable, Achievable, Realistic, Timely |
| **SHS** | Shared Health Summary |
| **SMS** | Secure Messaging Service |
| **TCA** | Team Care Arrangement |

# References


Australian Institute of Health & Welfare (2017); *Australia's Health;* Canberra: Australian Institute of Health & Welfare - Australian Government

Wentworth Healthcare Limited 2016/2017 (updated in December 2019), Needs Assessment. Kingswood, Australia; 2017, p46. Available from https://www.nbmphn.com.au/Resources/About/Nepean-Blue-Mountains-Needs-Assessment-2019 [Accessed 21 September 2021]

Australian Institute of Health & Welfare (2019). Chronic Obstructive Pulmonary Disease (COPD), Web report [Online]. Available at https://www.aihw.gov.au/reports/chronic-respiratory-conditions/copd/contents/copd [Accessed 9 September 2019]

Australian Institute of Health & Welfare, 2019. Potentially preventable hospitalisations in Australia by geographic areas.

Health Statistics NSW portal – Deaths by category of cause and Primary Health Network, Nepean Blue Mountains PHN, NSW 2017 [Online]. Available at: http://www.healthstats.nsw.gov.au/Indicator/bod_dth_cat/bod_dth_cat_phn_snap?&topic=Overview%20of%20deaths&topic1=topic_dth&code=dth [Accessed 9 September 2019]

Toelle B, Xuan W, Bird T, Abramson M, Burton D, Hunter M, Johns D, Maguire G, Wood-Baker R, Marks G. COPD in the Australian burden of lung disease (BOLD) study. Respirology [Internet] 2011 April 1-6 [cited 2017 May 1]; 16 (Suppl s1): 12. Available from: http://onlinelibrary.wiley.com/doi/10.1111/res.2011.16.issue-s1/issuetoc

Yang IA, Dabscheck E, George J, Jenkins S, McDonald CF, McDonald V, Smith B, Zwar N. The COPD-X Plan: Australian and New Zealand Guidelines for the management of Chronic Obstructive Pulmonary Disease; 2017. Version 2.49, March. Available from: http://copdx.org.au/the-copd-x-plan-pdf/

**Wentworth Healthcare**
Level 1, Suite 1, Werrington Park Corporate Centre,
14 Great Western Highway
Kingswood NSW 2747

T 4708 8100

**POSTAL ADDRESS**
Wentworth Healthcare,
Blg BR, Level 1, Suite 1,
Locked Bag 1797,
Penrith NSW 2751

This report can be found at:
**www.nbmphn.com.au/library**

For more information about Wentworth Healthcare or Nepean Blue Mountains PHN visit:
**www.nbmphn.com.au**

565_0622 

phn NEPEAN BLUE MOUNTAINS
An Australian Government Initiative

Wentworth Healthcare
Blue Mountains | Hawkesbury | Lithgow | Penrith

Wentworth Healthcare Limited (ABN 88 155 904 975) provider of the Nepean Blue Mountains PHN.