



## Q.I. RECIPE

## COPD

### Why improve this area?

- Improved patient outcomes and quality of life
- Improved patient self-management and education
- Reduce risk or better manage complications
- Provide multi-disciplinary care
- Burden of disease is high
- Precursor to other chronic disease
- Adherence to evidence based guidelines
- Enhanced systems aligned with Quality PiP (2019)
- Up-to-date MHR
- Evidence to support accreditation requirements

### QI ideas

1. Establish team roles
2. Undertake data cleansing
3. Identify target population/s
4. Collect baseline data
5. Monitor progress
6. Implement recall and reminder system
7. Set goals for no. of patients treated to target
8. Schedule staff training
9. Schedule internal meetings
10. Schedule COORDINARE meetings
11. Design service delivery model
12. Prepare and send patient invitations
13. Implement service delivery model
14. Create relevant patient action plans
15. Updates at team meetings
16. Benchmark report in team meeting/s
17. Speak to your Health Coordination Consultant for additional QI ideas

### MBS items

- GP Management Plan (GPMP) item 721
- Team Care Arrangements (TCA) item 723
- GPMP RACF item 731
- Review of GPMP &/or TCA item 732
- Health assessments (701,703,705,707,715)
- Spirometry item 11505, 11506
- Immunisation item 10993
- Allied Health item 10950-10970
- PNIP items 10987 & 10997
- Home Medicines Review (item 900)
- [MBS Flowchart - COPD Diagnosis and Management](#)

### Clinical and QI Resources

- [COORDINARE SPDS resources:](#)
- Data cleansing manual and supplementary manual.
- CQI Facilitation Tool and CQI Tracking Tool.
- [HealthPathways Illawarra-Shoalhaven](#) and
- [HealthPathways ACT-Southern NSW](#)
- [Guidelines for General Practice Management of COPD](#)
- [COPD Education and training](#)
- [COPD toolkit](#) and [Resources and COPD Action Plan](#)
- [CVD absolute risk calculator](#)
- Refer Aboriginal and Torres Strait Islander patients to the [ITC program](#)