

APCC PROGRESS SAMPLE REPORT



Team

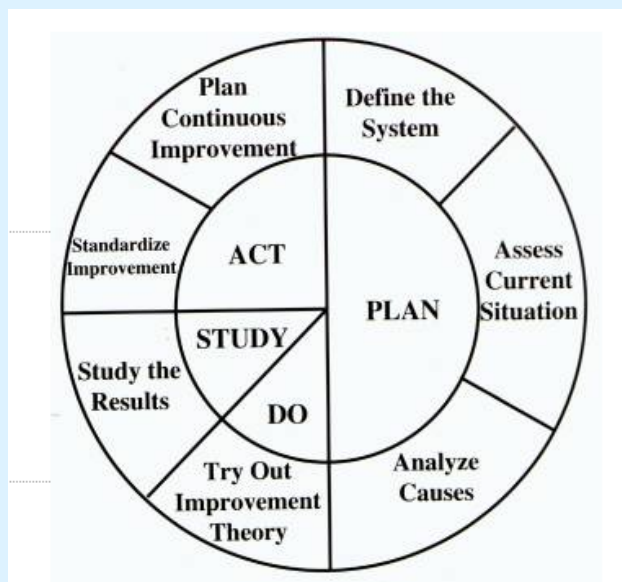
Sample Practice

***Dr. Feelgood
Ms. Practice Manager***

Your Practice & Quality Improvement

Currently your practice is participating in the APCC (Australian Primary Care Collaboratives) program which is the largest Primary Care Improvement program in Australia. Approximately 1100 practices have participated in the APCC program.

The APCC is about improving outcomes for patients with a chronic disease, collaborating and sharing ideas that work and monitor if the practice is on the right track to succeed.



A collaborative is a strategy for achieving rapid improvement in clinical outcomes. This is achieved by using small cycles called PDSAs (Plan, Do, Study, Act).

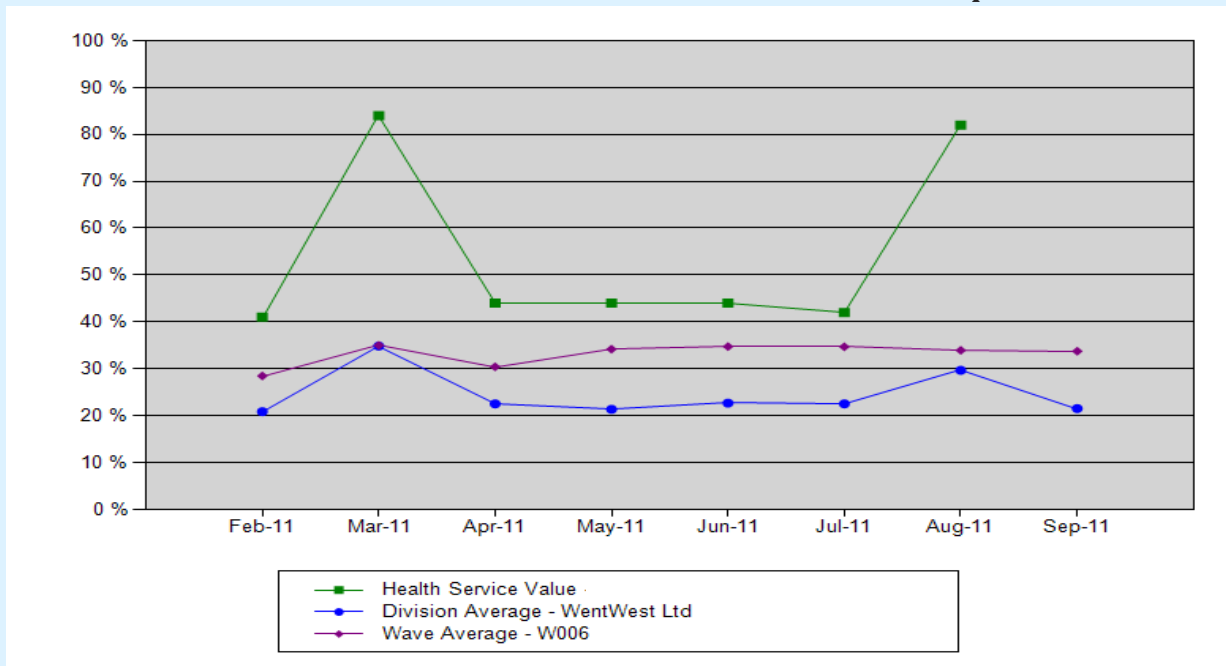
Participant practices apply PDSA cycles to sustain change in small incremental steps. The PDSA cycle allows users to test and implement solutions and processes at a small scale before rolling these out to the rest of the practice.

Practices have applied PDSAs to achieve improvements in:

<ul style="list-style-type: none"> • Systematic processes by which diabetes reviews and plans are accomplished e.g. checklists 	<ul style="list-style-type: none"> • Promoting and maintaining correct coding amongst clinical staff
<ul style="list-style-type: none"> • Identification of patients eligible for AUSDRISK tool health assessment 	<ul style="list-style-type: none"> • Patient identification for referrals
<ul style="list-style-type: none"> • Structured completion of clinical data for every diabetic patient in the practice 	<ul style="list-style-type: none"> • Training GPs on Primary Care Sidebar to maximise efficiency in caring for patients missing information and care (Red flag) particularly for Diabetic patients
<ul style="list-style-type: none"> • Patient education on self blood sugar monitoring 	<ul style="list-style-type: none"> • Running Diabetes clinics

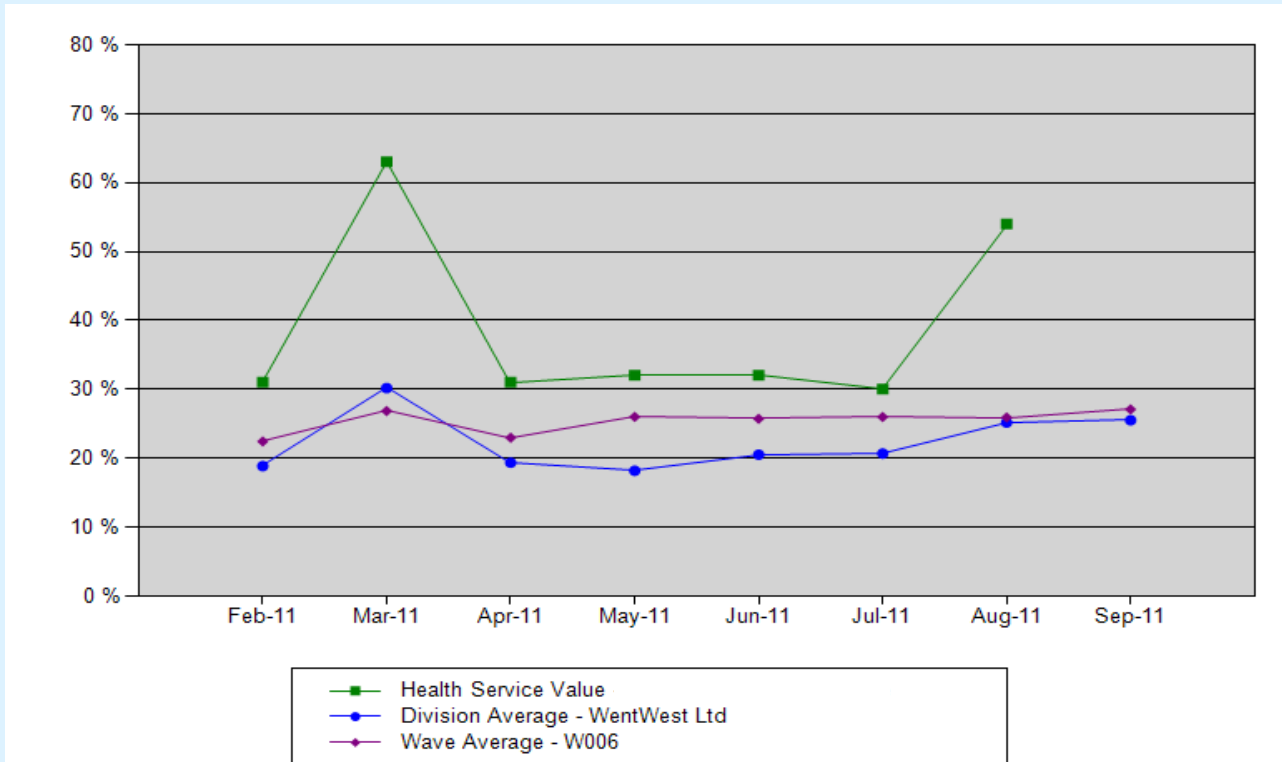
APCC Progress HbA1c

The graph below shows the percentage of patients on the Diabetes Register with a recorded HbA1c within the last 12 months and where the last recorded HbA1C result was less than or equal to 7.0%.



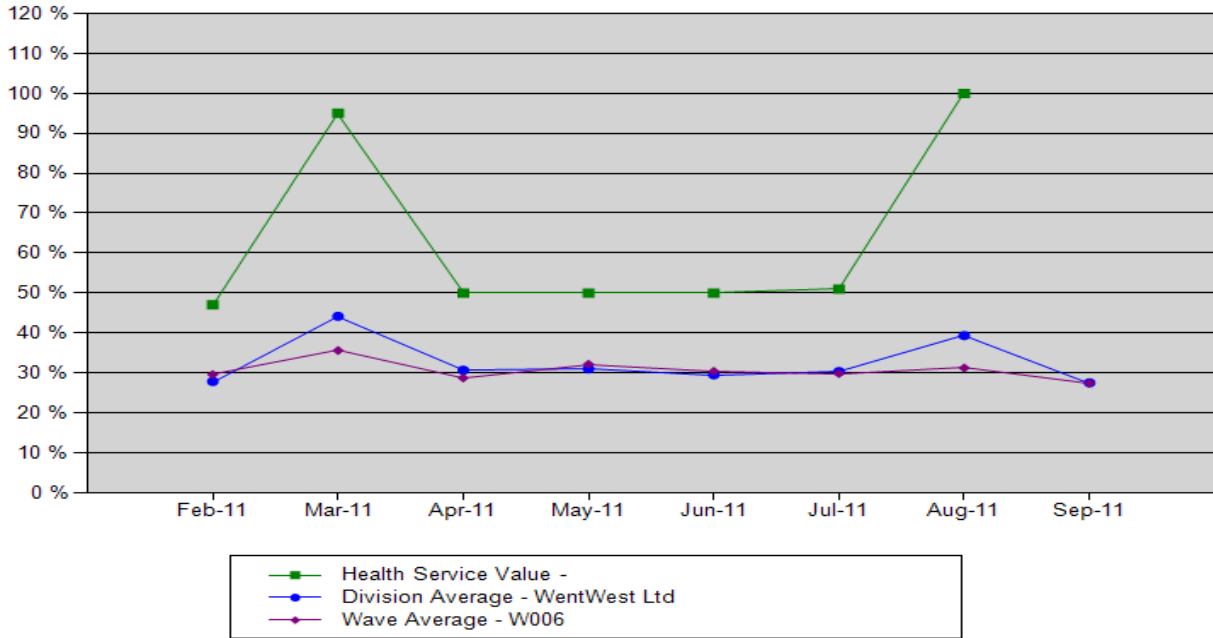
APCC - Cholesterol

The percentage of people on the Diabetes Register whose total cholesterol or Low Density Lipid (LDL) result has been recorded within the previous 12 months and where the last recorded result was less than or equal to 2.0 mmol/L for LDL or where LDL is not recorded less than 4mmol/L for total cholesterol.



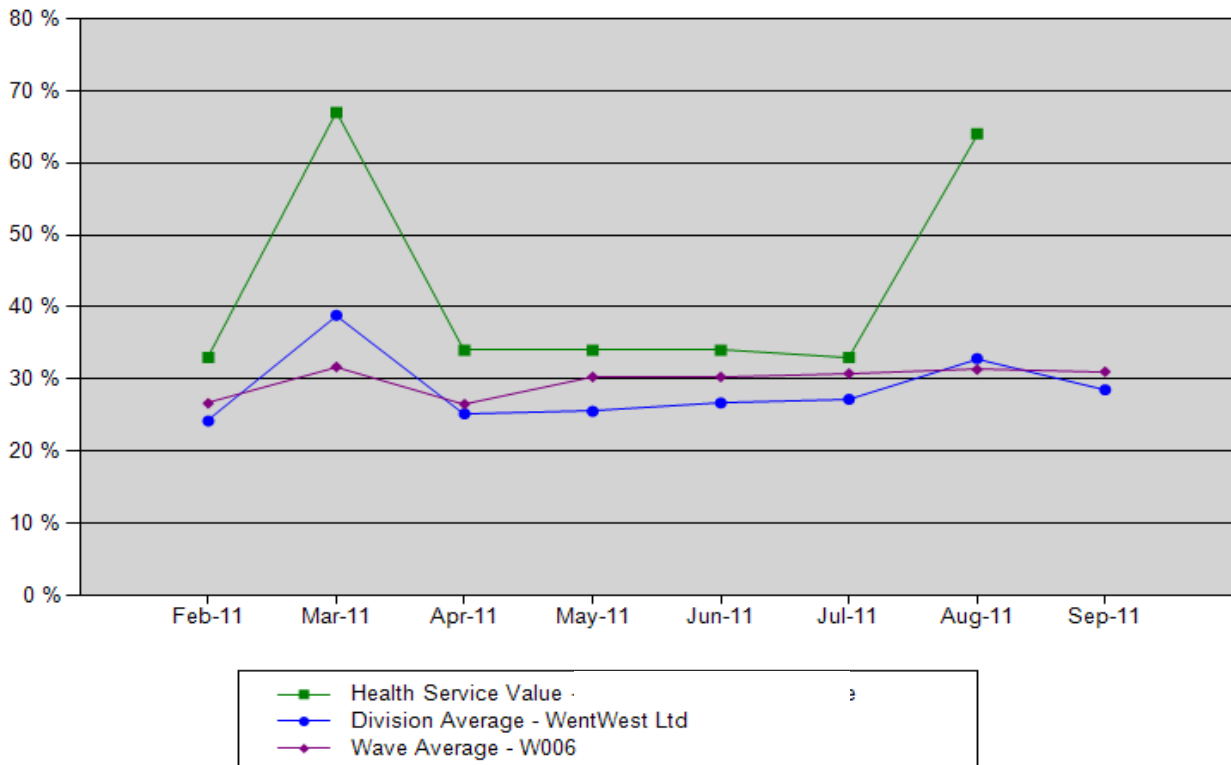
APCC Progress Blood Pressure

The percentage of people on the Diabetes Register whose total cholesterol or Low Density Lipid (LDL) result has been recorded within the previous 12 months and where the last recorded result was less than or equal to 2.0 mmol/L for LDL or where LDL is not recorded less than 4mmol/L for total cholesterol.



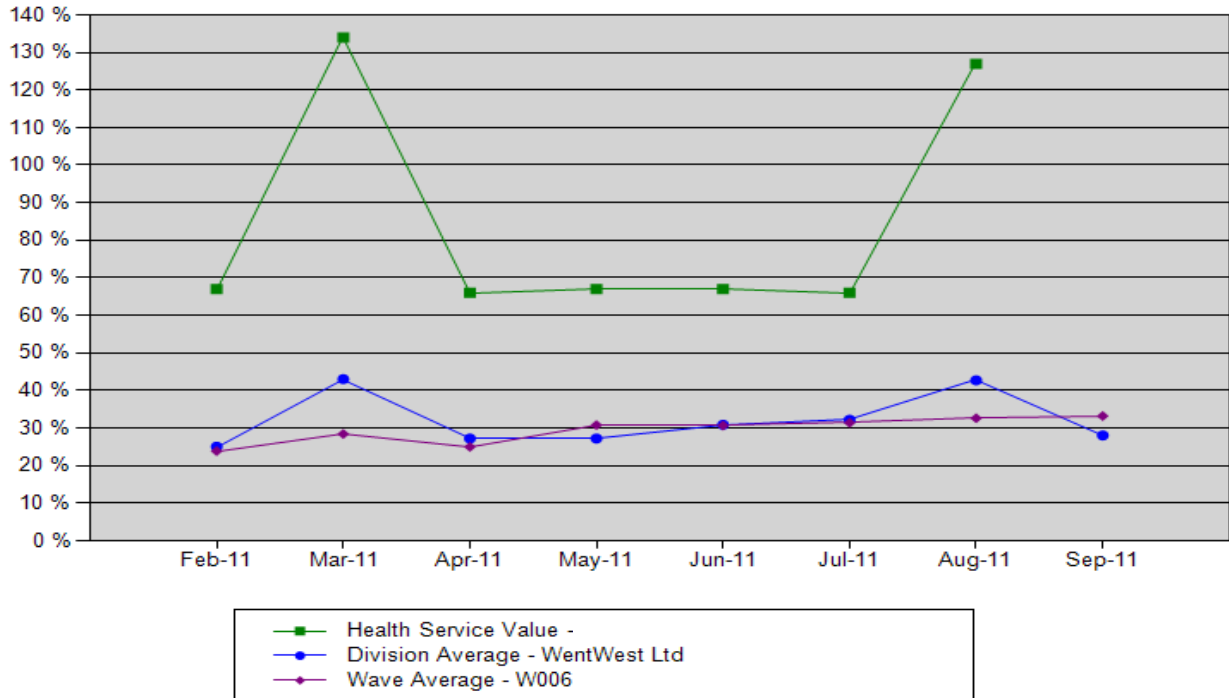
APCC - Diabetes Annual Cycle of Care

The percentage of annual cycle of care elements completed for the people on the Diabetes Register.



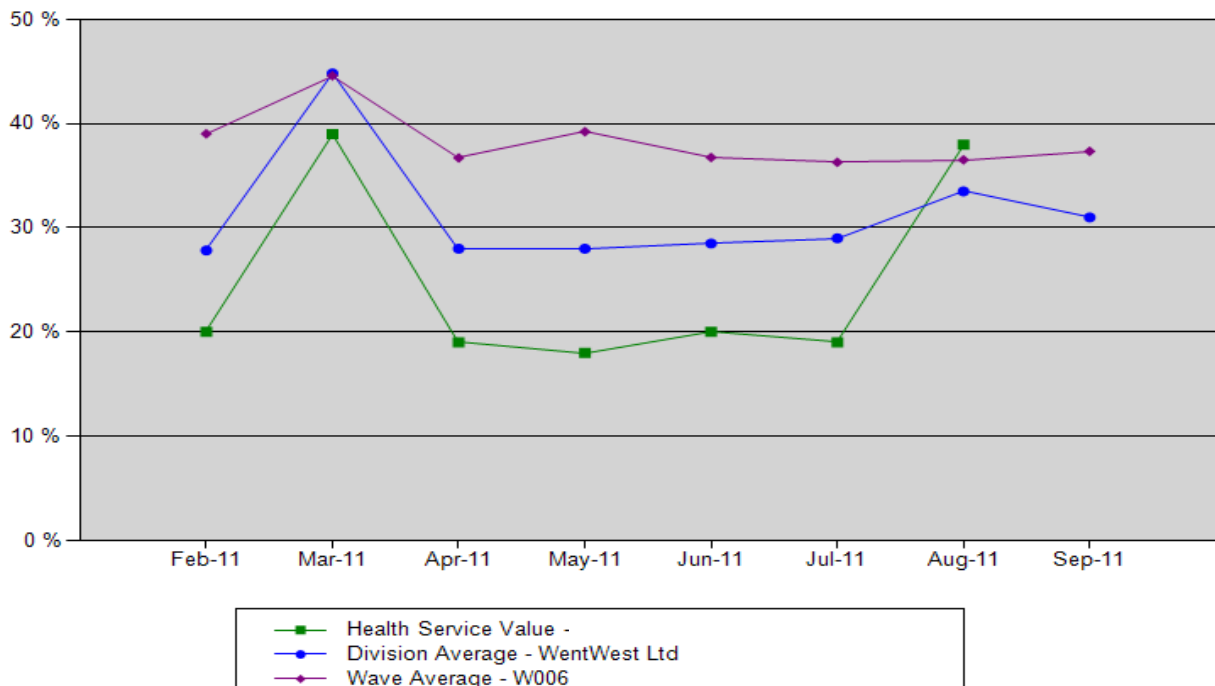
APCC Progress – ACR & eGFR

The percentage of people on the Diabetes Register who have had an Estimated Glomerular Filtration Rate (eGFR) within previous 12 months and urinary ACR OR other urinary Micro albumin test result recorded within the previous 12 months.



APCC - Aspirin

The percentage of patients on the Diabetes Register who are aged greater than or equal to 55 and recorded as being prescribed or taking aspirin



APCC Progress - September 2011

Reflection & Next Steps

Ideas to improve on:

⇒ Diabetes Register	⇒ Blood Pressure
⇒ HbA1c	⇒ Annual Cycle of Care
⇒ Cholesterol	⇒ ACR
⇒ Aspirin	⇒ Access to services e.g. diabetes clinics

After reviewing these graphs, it can be concluded:

Resources needed:

Required resources	Strategy
• Time	
• Staff	
• Training	
•	
•	

Next step for Improvement...



For more information

Visit our website at:

http://www.wentwest.com.au/public/australian_primary_care_collaborative.asp

e-Learning Portal

Online Health Services Directory

Divisional Information System (DIS)

General Practice Training 2012



Australian Primary Care Collaborative



New APCC Program – Registrations now open!

Program	Diabetes Management and Prevention
Aims	Provide skills, tool, strategies and support to improve on goal alignment, service gap identification, responsiveness, care provision, delivery and coordination.
Structure	Two face to face workshops, two online training sessions and one on one mentorship sessions at a mutually convenient time and frequency.
Requirements	Participation of at least one clinician and staff member per health service.
Brochure	Health Service Recruitment Brochure
Hot Tips for Promotion	Recruitment Top Tips
More information	To discuss this program further, contact Alex McLaren at: alex.mclaren@wentwest.com.au .
Registration Link	http://bit.ly/qmSocg

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A collaborative is a strategy for achieving rapid improvement in



"Measurement is the first step that leads to control and eventually to improvement. If you can't measure something, you can't understand it. If you can't understand it, you can't control it. If you can't control it, you can't improve it."

H. James Harrington