



SMOKING CESSATION IN GENERAL PRACTICE TOOLKIT



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Version dated: JULY 2019

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INTRODUCTION

HNECC PHN Smoking Cessation in General Practice

Hunter New England and Central Coast (HNECC) Primary Health Network (PHN) is a not-for-profit organisation funded by the Australian Government to improve the efficiency and effectiveness of the primary health care system. Our PHN works with General Practitioners (GPs), psychologists, nurses, allied health providers and a broad range of health and community services to develop and deliver services and programs that reflect local needs and focus on safe, effective and person-centred care. For further information on other services we provide please visit our website at www.hneccphn.com.au

Currently 15% of Australian adult (18+) males and 12% of Australian adult (18+) females are daily smokers. This number increases to 42% among the Aboriginal and Torres Strait Islander community and is as high as 50% among some ethnically diverse communities. People living in areas with the lowest socioeconomic status (SES) are three times more likely to smoke than those living in the highest SES areas.

In Australia in 2013, daily smokers were twice as likely to have high/very high levels of psychological distress (18.2% vs 9.0%) and were twice as likely to have been diagnosed or treated for a mental health condition (22% compared with 11.1%) compared with people who had never smoked.

People with a mental illness who smoke die up to 20 years earlier than the general population, not due to their psychiatric condition but mostly due to tobacco-related illness.

There is also an association between smoking habits and suicidal behaviours; compared to non-smokers current smokers are at higher risk of suicide attempts. Other studies have found smoking was significantly associated with an increased risk of suicidality among individuals with a severe mental illness.



The physically damaging effects of smoking are clear. Long-term smokers are at a higher risk of developing a range of potentially deadly diseases including:

- Cancer of the lungs, mouth, nose, throat, oesophagus, pancreas, kidney, liver, bladder, bowel, ovary, cervix, bone marrow and stomach
- Lung diseases such as chronic obstructive pulmonary disease (COPD) which includes chronic bronchitis and emphysema
- Heart disease, heart attack and stroke
- Poor blood circulation in feet and hands, which can lead to pain and, in severe cases, gangrene and amputation.

There are numerous benefits to quitting smoking. In as little as 6 hours stabilising of blood pressure and slower heart rate can be observed. After a day almost all nicotine is out of the bloodstream, carbon monoxide in the body has dropped and oxygen circulates more easily to the heart and muscles. Over time the risk of heart attack and stroke decreases progressively to be close to a person who never smoked (after 15 years) and the risk of lung cancer 10 years after quitting is lower than that of a continuing smoker. Quitting smoking is also associated with mental health benefits. Recent evidence is showing that quitting smoking improves mental health, mood, and quality of life, both among the general population and among people with psychiatric disorders. Quitting is also associated with a decreased likelihood of suicide attempt.

We know that GPs and other health professionals play a key role in providing brief interventions for smoking cessation, as recommended by the RACGP, and evidence suggests this approach helps smokers to quit. You can access the RACGP guide for health professionals [here](#).

One in every 33 conversations will lead to a patient successfully quitting smoking. In the guidelines, the 5A framework is recommended as spending more time (longer than 10 minutes) advising smokers to quit yields higher abstinence rates than minimal advice. However, feedback from GPs and studies indicate that physicians ask their patients, but seldom offer practical cessation support.

The Smoking Cessation Guidelines also acknowledges that offering brief advice (as little as 3 minutes) has been shown to have clear benefits and notes that providing brief advice to most smokers is more effective and efficient than spending a longer time with a few patients.



EVIDENCE

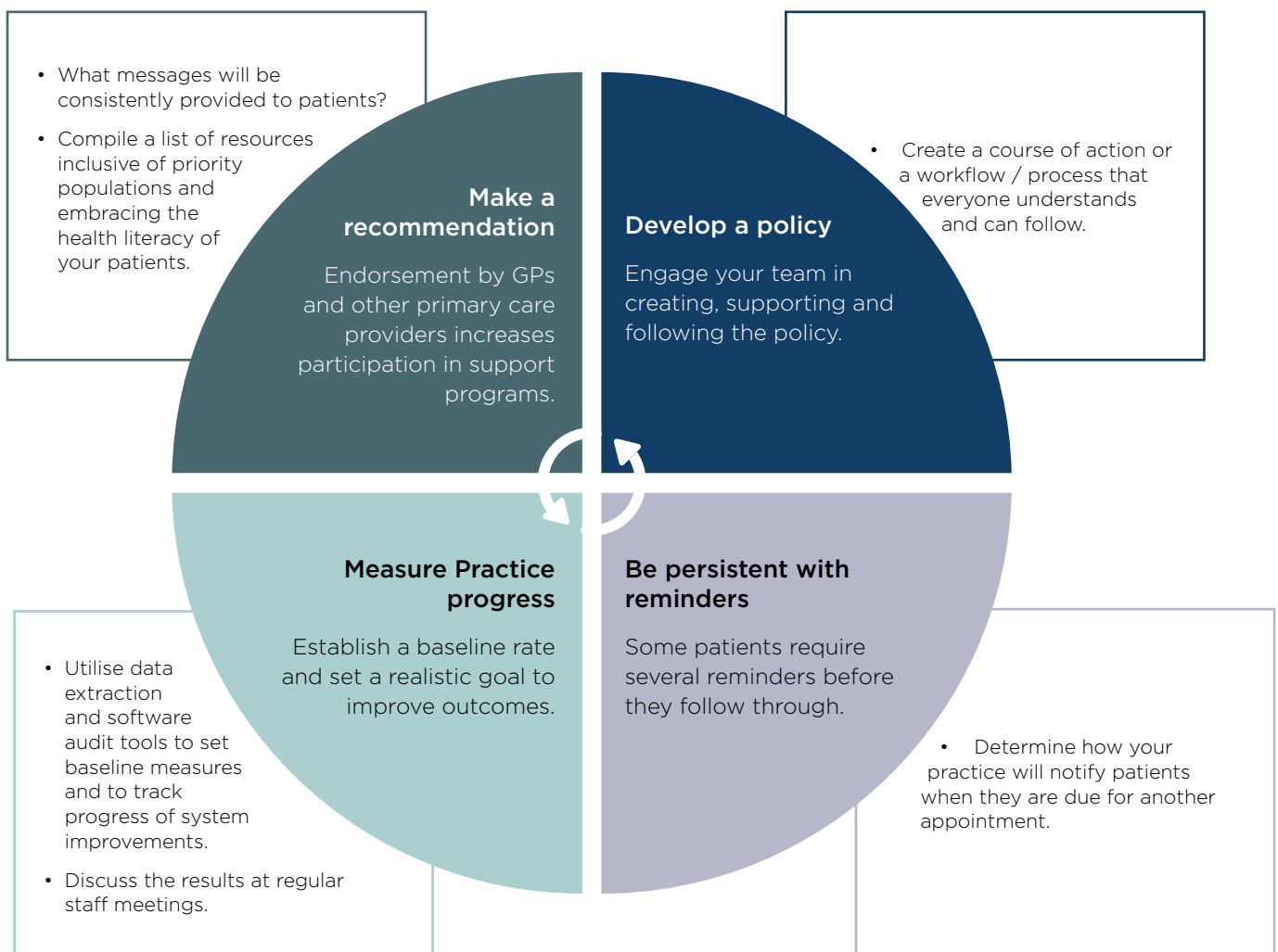
There is clear evidence that simply asking about and documenting smoking status is actually harmful in that it reduces the odds of the patient attempting to quit and sustaining a quit attempt.

A patient seen by a GP but not advised to quit has statistically significantly reduced likelihood of quitting as does a patient advised to quit but not offered any help to do so.

A patient asked, advised to quit and offered help has a statistically significant likelihood of quitting.

Four essentials to improving smoking cessation in Primary Care

1. Implement practice changes.
2. Take a person-centred approach.
3. Involve staff and put office systems in place.
4. Follow a continuous improvement model to develop and test the changes.



DEVELOPING A SYSTEMATIC APPROACH

Data cleansing

The information available in clinical software is invaluable when developing streamlined practice systems and providing quality patient care. For practice data to be useful, information within your clinical database must be accurate and up to date.

Ensuring electronic results are received correctly is key to providing effective and efficient patient care.



HELPFUL TIPS

- Regularly mark patients as 'inactive'
- Merge duplicate patient records
- Ensure pathology results are received in the correct format
- Develop and agree on processes to ensure data quality is maintained
- Clean up reminder lists: Ask your Primary Care Improvement Officer for instructions on 'Bulk Reminder Clean Up'
- Document processes clearly in your Policy and Procedure Manual
- Regularly discuss clinical coding in team meetings to develop clear standards and requirements for patient files.

Workflow

Workflow is defined as a series of steps, frequently performed by different staff members that accomplishes a task. Workflows represent how work gets done, not the protocols that have been established to do the work.

Workflow mapping is a way of making the invisible "visible" to a practice to improve processes to increase efficiency, reduce errors and improve outcomes.

Workflow mapping is the process of documenting the specific steps and actions that take place in completing a task. Creating a workflow map allows the opportunity to see what is currently happening, identify opportunities for improvement or change, and design new, more effective processes. It is helpful to consider workflows associated with the following three processes:

1. Perceived process (what we think is happening).
2. Reality process (what the process actually is).
3. Ideal process (what the process could be).



HELPFUL TIPS

Important rule of mapping: the person who controls the process controls the pen. Meaning whoever carries out the process, maps the steps.

- Be realistic: map what is happening not what is desired.
- Identify each step of the activity and person responsible.
- Communicate: ensure all involved team members understand how the activity is executed.



HELPFUL LINKS & RESOURCES

Train IT Medical have sample workflows for:

[Correspondence Management](#)

[Inbox Management](#)

[Train IT Medical Practice Management resources](#)



Implementing robust recall and reminder systems

The RACGP Standards for General Practice view a **reminder** as an offer to provide patients with systematic preventative care. A **recall** is when it is paramount for a patient to attend the clinic, usually in the instance of an abnormal result. A recall is further defined as a system to make sure patients receive further medical advice on matters of clinical significance.

Clinical significance is determined by:

- the probability that the patient will be harmed if further medical advice is not obtained; and
- the likely seriousness of the harm.

It will be up to each practice to design a system which effectively differentiates between their general preventive reminders and their true recalls (RACGP, 2017).



HELPFUL TIPS

- Ensure there is a written policy which is communicated to the practice team which outlines a consistent and validated process for recording results, entering recalls and sending reminders
- Define roles and responsibilities for individual team members
- Review systems for managing overdue patient recall and reminders.



HELPFUL LINKS & RESOURCES

Speak to your Primary Care Improvement Officer to gain access to best practice resources:

[Medical Director: Recall, Reminders Action Fact Sheet](#)

[The Dos and Dont's of Patient SMS](#)

[AMA Recall Systems and Patient Consent](#)

It is recommended that GPs who are coordinating patient-centred care should not assume that clinically significant test results ordered by others have been adequately followed up.

Clear and agreed systems for receiving and following up on test results are needed to ensure safe and effective continuity of patient care. For further information regarding RACGP's position on non-GP initiated testing [click here](#).

How can PEN CS support patient-based outcomes in General Practice?

When leading change in a General Practice, you will require data to help guide your thinking, discussions and planning.

PEN Clinical Audit Tool (PenCAT) is a user-friendly software tool that interrogates the data contained within GP clinical and management software. The extracted data can be then filtered to select a specific target group and viewed through a range of clinically relevant patient reports to support quality improvement.

PEN CS and your Practice

A significant number of General Practices across the HNECC PHN already use PenCAT to investigate and report against their patient data. Using PenCAT to extract relevant data provides practices a range of benefits including:

- Improving the quality of patient care by identifying patients requiring periodic screening and ensuring the appropriate treatment or referral is delivered proactively; and
- Identifying patients at risk of developing certain diseases or conditions and offering preventative treatment.



HELPFUL TIPS

- Use current data by performing monthly data collection
- Ensure correct coding principles are implemented to ensure data can be extracted
- Upskill; participate in PenCAT and [TopBar webinars](#) and speak with your Primary Care Improvement Officer to assist in understanding your practice data.



HELPFUL LINKS & RESOURCES

PEN CS has developed 'recipes' which are simple step by step guides to extract meaningful data correctly.

Visit www.pencs.com.au to source recipes identifying patients eligible for a 45-49 years health assessment with lifestyle or biomedical risk factors.



WHAT IS QUALITY IMPROVEMENT?

The RACGP Standards for General Practice describe quality activity undertaken within a general practice where the primary purpose is to monitor, evaluate or improve the quality of health care delivered by the practice. The Standards recommend practices engage in quality improvement activities that review structures, systems and processes to aid the identification of required changes to increase the quality of healthcare delivery and safety of patients.

Quality improvement consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups.

Engaging in quality improvement activities is an opportunity for the GPs and other staff in the practice to come together as a team to consider quality improvement. Quality improvement can relate to many areas of a practice and achieving improvements will require the collaborative effort of the practice team.

Standards for General Practice - 5th Edition

The RACGP 5th Edition Standards have been released with a new module specifically identified for Quality Improvement. Criterion QI 1.1 identifies four indicators that relate to Practice based activity around Quality Improvement and reference a team-based approach. The criterion recommends having at least one team member responsible for leading quality improvement in the practice, which establishes clear lines of accountability. Please refer to the guidelines.

Criterion QI 1.3 relates to improving clinical care, specifically practice use of relevant patient and practice data to improve clinical practice. Establishing and utilising robust reminder and recall systems could be a focus under this criterion.

[RACGP Standards for General Practice 5th Edition](#)

The Quality Improvement process is divided into two manageable parts: thinking and doing. This process allows ideas to be broken down into manageable sections which can be tested and reviewed to determine whether improvement has been achieved prior to implementing on a larger scale.

The 'Thinking' part

The thinking part consists of three fundamental questions that are essential for guiding improvement.

1. What are we trying to accomplish?

By answering this question, you will develop your aim for the activity.

Consider exactly what it is you are seeking to change.

- Define the problem. Success comes through preparation, understanding what the problem is and thinking about why there is a problem helps in developing your aim.
- Set realistic objectives which are specific, have a defined timeframe and are agreed (SMARTA). Use plain language and avoid jargon so that the meaning is clear to everyone.
- Include information that will help keep the team focused.

2. How will we know that change is an improvement?

By answering this question, you will develop measures for tracking your goal.

Without measuring, it is impossible to know whether the change you are testing is an improvement.

- Communicate to the team what you are measuring, how, when and who is responsible (see 'Measuring Success')
- Make the measurement as simple as possible
- Only collect the data that is required.

3. What changes can we make that will result in an improvement?

By answering this question, you will develop ideas for change.

Encourage the whole team to contribute ideas. Be creative. Think outside the box.

- You know your General Practice and your patients best. Keep this in mind and use your knowledge and experiences to guide your ideas
- Adapt from others
- Think small and test. Think about testing a change with one GP or a select group of patients. This will assist in determining if the change had the desired effect and is suitable for wider implementation.



The 'Doing' part

The doing part is made up of rapid, small Plan, Do, Study Act (PDSA) cycles to test and implement change in real work settings.

Not every change is an improvement, but by making small changes you can test the change on a small scale and learn about the risks and benefits before implementing change more widely. Several PDSA cycles may be required to achieve your improvement goal.

You will find through PDSA cycles some changes lead to improvements. If so, these improvements can be implemented on a wider scale. You may also find that some improvement ideas are not successful. Analyse why they didn't work and learn from this. By carrying out small tests in PDSA cycles, you have avoided implementing unsuccessful change on a wider scale.

Step One: Plan

A well-developed plan includes what, who, when, where and your predictions and what data is to be collected.

Make your plan as clear and as detailed as possible:

- What exactly will you do?
- Who will carry out the plan?
- When will it take place?
- Where will it take place?
- What do you predict will happen?
- What data/information will we collect to know whether there is an improvement?

Step Two: Do

Write down what happens when the plan is implemented (both negative and positive) and other observations.

Collect any data you identified in the plan phase.

Step Three: Study

Reflect on what happened.

Think about and summarise what you have learnt. Analyse the data collected and compare with your initial predictions. If there is a difference in the data and predictions, consider what happened and why.

Step Four: Act

Considering the results from your tests; will you implement the tested change or amend and test or try something else?

Write down the next idea you will test. Be sure to start planning the next cycle early to keep up the momentum of change.

HELPFUL TIPS



- Practices need to engage in quality improvement activities to improve quality and safety for patients in areas such as practice structures, systems and clinical care
- Decisions on changes should be based on practice data (PEN CS and clinical database audits, near misses and patient and/or staff feedback)
- Achieving improvements requires the collaborative effort of the practice team and all members of the team should feel empowered to contribute
- Utilise the Readiness Tool to assist identify ideas and areas for improvement.
- No PDSA cycle is too small; keep it simple
- You may complete a series of PDSA cycles to achieve your goal. Results will be achieved through building on previous cycles
- Set aside protected time to complete the agreed upon tasks
- Document your PSDA cycles and present findings at team meetings
- Improvement is a team effort.

See Criterion C4.1 - [Health Promotion and Preventative Care RACGP 5th Standards](#).

READINESS TOOL

In Australia, smoking continues to be the behavioural risk factor responsible for the highest levels of preventable disease and premature death. Recording systems that document tobacco use almost double the rate at which clinicians intervene with smokers, leading to higher rates of smoking cessation (PIP QI, DOH, 2019).

There are many ways to improve patients' participation in the 45-49 years health assessment.

This Readiness Tool is designed as a starting point to encourage General Practice to generate ideas and strategies in chronic disease prevention that may be applied to a quality improvement activity. This may assist with the 'thinking part' of the quality improvement cycle.

In working through the Readiness Tool, start by identifying if the practice or clinicians are undertaking activity in the identified area. In the action column you could document any ideas or processes that may need to be introduced or changed.

Smoking Status and Cessation Assessment Readiness Tool (> 15 yo, current, ex, never)

General Practice Name:	
Completed by:	
Date:	

Building Block 1: Engaged Leadership	Implementation Status YES/NO	If No, include as an idea in QI PDSA Cycle
A. Value and allow protected staff time for Smoking Status Assessment and Cessation Continuing Professional Development.		
B. Get involved & give input into Local Government Area smoke-free environments.		
C. Become a member on multi-disciplinary Smoking Cessation Working Groups		
D. Consider presenting yours, your practice's and patients experience at a Health Conference.		
E. Participate in Smoking Status and Cessation Research opportunities. RuralSMOKING Study; Quit Study. Video counselling to quit smoking in rural areas		
F. Lobby State and Commonwealth Government and Opposition Health Ministers for increased Smoking Status and Cessation Assessment health funding.		

G. Value the input of Australian Primary Health Care Nurses Association (APNA) by purchasing Organisational Membership.

[APNA Membership](#)

H. Smoking Status and Cessation Assessment quality improvement has a dedicated PDSA cycle.

I. Quality Improvement in Smoking Status and Cessation Assessment is valued in organisation goals by practice leaders

J. Review of Smoking Status and Cessation Assessment practice data is a Standing Agenda Item at Clinical Meetings

K. Smoking Status and Cessation Assessment quality improvement has infrastructure, such as dedicated resources, such as lead staff and protected time, and data audit tool.

L. Smoking Status and Cessation Assessment quality improvement is a shared responsibility of all practice staff.

M. Consider formal Public Engagement with your patients as consumers in Smoking Status and Cessation Assessment Quality Improvement.

N. Subscribe to membership at [Hunter Postgraduate Medical Institute](#) for CPD education events.

Building Block 2: Data-driven Improvement	Implementation Status YES/NO	If No, include as an idea in QI PDSA cycle.
A. Utilise your practice's HNECC PHN licenced PenCS CAT4 software to illustrate your practices total population, eligible population, count of patients assessed and count of patients not assessed.		
B. Contact your HNECC PHN Primary Care Improvement Officer for assistance		
C. Determine your practice baseline, apply a PDSA cycle, and review the change to baseline.		
D. Have an awareness of regional-level Smoking burden; see HNECC PHN Regional Snapshots. HealthStats NSW, AIHW , AHPC		
E. Have an awareness of practice-level Smoking burden; see HNECC PHN - provided quarterly PenCAT Dashboard.		

F. Utilise PenCS TopBar software to opportunistically identify patients without a Smoking Status.

G. Upgrade practice software versions and utilise Smoking Status and Cessation Readiness fields (BP, MD, Comm, Genie etc).

Building Block 3: Empanelment	Implementation Status YES/NO	If No, include as an idea in QI PDSA cycle.
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A. Assign a provider and nurse to each patient in practice software.

B. Use PenCAT to identify patients in your panel by provider.

C. Know your provider Whole Patient Equivalent.

D. Stratify patients by Smoking Status and Cessation Assessment.

E. Consider reducing your panel size as weighting of a patient with Smoking Risk increases.

F. Know your provider population cohort with Smoking Risk.

Building Block 4: Team-base Care	Implementation Status YES/NO	If No, include as an idea in QI PDSA Cycle
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A. Commence Nurse-led Smoking Risk and Cessation Clinics;

B. For Aboriginal and Torres Strait Islander patients with a 715 and a GPMP, utilise 20 x 10987 Practice Nurse or AHW services, or similar for Allied Health Services eg. dietician.

C. For patients with a GPMP, utilise MBS item 10997 for 5 x Practice Nurse services.

D. Employ a non-prescribing Pharmacist

E. Refer to Cognitive Behavioural Therapy providers.

F. Refer to Complementary and Alternative Therapies.

G. Provide sessional allied health professional care, dietician, exercise physiologist, diabetes educator.

H. Enrol nurses in APNA Smoking Risk Assessment.

I. Enrol clinicians in [Woolcock Institute Nicotine Addiction Smoking Cessation Course](#).

J. Enrol in [Flinders University Motivational Interviewing Training](#).

K. Enrol Nurses in APNA Foundations of General Practice Nursing Workshop.

L. Attend HNECC PHN education events, such as Cardiovascular Quality Improvement; Motivational Interviewing; Physical Activity Prescription Training.

M. Attend [ThinkGP Nicotine Replacement therapy](#) education event.

N. Enrol in [National Prescribing Service \(NPS\) Update on Medicines for Smoking Cessation](#) Training

O. Communicate the patient's Smoking Status and Cessation Stage in referrals, Team Care Arrangements and Multi-disciplinary Case Conferencing referrals.

Building Block 5: Patient-team Partnership	Implementation Status YES/NO	If No, include as an idea in QI PDSA cycle
A. Purchase Smokalyser breath carbon monoxide (Co) monitor bio-feedback equipment for use with patients in practice.		
A. Obtain training in and apply Motivational Interviewing techniques with patients to address Smoking Status and Cessation Readiness.		
B. In presence of patient, assess Smoking Status and Cessation Readiness in conjunction with CVD Risk Assessment in Practice Software to demonstrate modifiable CVD Risk.		
C. Incorporate Smoking Status and Cessation Readiness into Chronic Disease Management Plan, Team Care Arrangements and review MBS items.		
D. Make available print and A/V Smoking Risk and Cessation health promotion materials, eg. Heart Foundation .		
E. Consider the health literacy and cultural & linguistic diversity of your empanelled patients and the literacy-appropriateness of health promotion materials.		
F. Request patient health promotion resources from The Heart Foundation.		
G. Ensure medical practitioner enrolment in Telephone Interpreting Service		
H. Promote patient use of the National Heart Foundation 'Heart Age Calculator'		

I. Inform patient of legislated smoke-free public areas, such as hospitals, restaurants and delineated CBD boundaries

J. Inform patient of expense of continuing to smoke and opportunities to direct funds to other priorities.

K. Encourage continued participation in education, as increasing education has a protective factor against smoking.

L. Provide access to Patient Info for patient information.

Building Block 6: Population Management	Implementation Status YES/NO	If No, include as an idea in QI PDSA cycle
A. Consider the National Drug Strategy		
B. Be aware of the AIHW Australia's Health 2018 report .		
C. Consider the intersection of legislative, educational, economic and health factors for smoking status and cessation readiness.		
D. Access Hunter & New England HealthPathways and Central Coast HealthPathways		
E. Use NSW Cancer Institute Quitline resources including Online Referral Form		
F. Prioritise immunisations for high-risk groups including smokers.		
G. Consider referring for Domiciliary and Home Medication Reviews (900, 903), particularly if prescribed Nicotine Replacement Therapy.		
H. Perform a > 20 minute Heart Health Assessment to assess risk, identify modifiable factors, and create a preventative health care plan. (Indigenous patients > 35years and Non-Indigenous patients > 45years). Associated Note 14.2 MBS Item 699		
I. Apply your colleges guidelines - RACGP, ACCRM, CDE.		
J. Incorporated Smoking Status and Cessation Assessment into Health Assessments (701-707 & Indigenous 715, 40-49years with High Risk AUSDRISK and 45-49years with Lifestyle Risk factor, disability, armed forces, humanitarian, 75+ years and CMA).		
K. Note that Smoking is a factor in AUSDRISK scoring .		

L. Utilise [RACGP preventative health assessment](#) for Aboriginal and Torres Strait Islander people.

M. Consider targeted approach for patients with existing co-morbidities:		
a. Patients with hypertension		
b. Patients with hyperlipidaemia		
c. Patients overweight or obese		
d. Patients with family Hx hyperlipidemia; premature CV death		
e. Patients with Chronic Kidney Disease		
f. Patients with physical inactivity		
g. Patients with evidence of Atrial Fibrillation		
h. Patient's nutrition status/habits (Attend in SNAP)		
i. Utilise RACGP preventative guidelines		
j. Gender of patients		

Building Block 7: Continuity of Care	Implementation Status YES/NO	If No, include as an idea in QI PDSA cycle
A. Use reminders function in software for annual health assessments, reviews of CDM items, pathology requests, etc.		
B. Upload Shared Health Summaries to My Health Record; including prescribed Nicotine Replacement Therapy.		
C. Follow up patient after receipt of Hospitalisation Discharge Summaries in agreed timeliness of practice policy, particularly if commenced NRT in hospital.		
D. Gain patients agreement to see usual, named provider within practice.		
E. Reception encourages patient to see usual, named health professionals.		
F. Chase and review written feedback from Allied Health Professional in a Team Care Arrangement, eg. Exercise Physiology, Diabetes Educator, Dietician.		
G. Install BPAC SeNT eReferral HNECC PHN sponsored licence.		

Building Block 8: Prompt Access to Care	Implementation Status YES/NO	If No, include as an idea in QI PDSA cycle
A. Follow up test results in holding file/inbox in agreed timeliness; contact actions are communicated to team.		

B. Agree on Standing Orders/Protocols provided by clinical team members.

Building Block 9: Comprehensiveness & Care Coordination	Implementation Status YES/NO	If No, include as an idea in QI PDSA cycle
A. Liaise with Outpatient and Acute Settings from Area Health Services.		

B. Refer to Lifestyle Modification Programs eg. Get Healthy NSW, Online Quitline referral form

C. Alcohol Tobacco and Other Drug (ATOD) Counsellors are considered members of the Care Team		
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D. Dental health professionals are considered members of the Care Team

E. Team Care Arrangements refer to Allied Health disciplines		
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F. Team Care Arrangements are followed up by TCA Review Item Number (3-6 monthly).

G. Acknowledge relapse period within days and provide contact support		
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H. Ensure patient is aware they can contact telephone/online support.

Building Block 10: Template of the Future	Implementation Status YES/NO	If No, include as an idea in QI PDSA cycle
A. Apply for Practice Incentive Program Quality Improvement Incentive (PIP-QI) payments		

B. Apply for [Workforce Incentive Program](#) (WIP) reimbursement payments from Jan 2020.

C. Employ a non-prescribing pharmacist		
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D. Use Telehealth consultation [MBS items](#)

E. Use multi-disciplinary Case Conferencing MBS items

F. Use group Allied Health Diabetes Type 2 MBS items for Exercise, Physiology, Diabetes Educator, or Dietician, if eligible.

G. Expand workforce to include emerging classifications such as Medical Practice Assistant.

AREA FOR ACTION (Go to PDSA template in your toolkit or see suggested PDSA activities)

1.

2.

SMOKING CESSATION PRACTICE TEAM

Clinical lead (GP):

Administrative lead (PM/PS):

Clinician involvement (GP/PN):



CHANGE IDEAS TO CONSIDER

Prior to undertaking a Smoking Cessation Quality Improvement project, it is important that clinicians have undertaken smoking cessation training and understand new and emerging literature on tobacco and smoking cessation, including;

- The prevalence of smoking in Australian, including among Aboriginal and Torres Strait Islander and culturally diverse communities
- Evidence for smoking cessation and use of brief interventions to facilitate behaviour change
- Smoking and mental illness
- Consideration of smoking status and Pneumococcal Vaccination

Idea: Extract and examine patient data relating to smoking status.

- Schedule time with your Primary Care Improvement Officer to assist with data extraction utilising PenCAT.
- Utilise the Data Quality Dashboard Report in PenCAT to indicate level of social history recorded across the patient population
- Extract data from Report and provide summary to participating GPs
- Identify total number of active patients
- Identify number and percentage of all practice patients who are current smokers and percentage of patients whose smoking status is 'unknown' smoker, ex-smoker, non-smoker or not specified
- Identify number and percentage of all practice patients who have been prescribed Nicotine Replacement Therapy or another smoking cessation pharmacotherapy (eg varenicline, bupropion)
- Identify number and percentage of patients who are current smokers and have been prescribed Nicotine Replacement Therapy
- Compare and act on the results, implement changes to software and educate other GPs and nurses about recording smoking status and the importance of discussing smoking, benefits of prescribing NRT in combination with counselling as a part of the recommended 5A's.

Idea: Set reminder 'red flags' for smokers and patients with 'unknown status' recorded.

- Schedule a team meeting and as a team plan to reduce the percentage of unrecorded smokers using alerts in clinical software / desktop reminders or any strategy that your practice team think will assist to clean up this data

- Discuss strategies, record and assign team members to implement them
- Compare and act on the results. For strategies that have worked and are going to be implemented long term, write them up in a practice policy or guide for practitioners on the recording of smoking status in your clinic.

Idea: Assess the practice environment ensuring it is conducive to patients making quit attempts.

- Schedule an assessment of your practice to ensure it is conducive to patients (and staff members) making quit attempts
- Project lead to arrange a meeting and allocate specific tasks to each GP/staff member. This is also an opportunity to ensure systems are in place to better undertake smoking cessation such as access to the auto-populating quitline referral form, fact sheets for patients and clinical software address books are up to date and current
- Have each staff member make a list of planned changes and improvements to the practice
- Compare and act on the results. Adopt and make changes to the practice.

RESOURCES FOR UNDERTAKING QUALITY IMPROVEMENT

Quality Improvement Goal Setting

1. What are we trying to accomplish?

By answering this question, you will develop your goal for improvement.

2. How will we know that a change is an improvement?

By answering this question, you will develop measures to track the achievement of your goal.

3. What changes can we make that can lead to an improvement?

List your ideas for change. By answering this question, you will develop the ideas you would like to test towards achieving your goal.

IDEA 1.

IDEA 2.

IDEA 3.

IDEA 4.

Quality Improvement Action Worksheet

PLAN, DO, STUDY, ACT

Please complete a new worksheet for each change idea you have documented on the previous page.

Where there are multiple change ideas to test, please number the corresponding worksheet(s).

	Describe the idea you are testing.
IDEA	
	Must include what, who, when, where, predictions & data to be collected.
	What:
	Who:
PLAN	When:
	Where:
	Data to collect/record:
	What do we think will happen?
	Was the plan executed? Document any unexpected events or problems.
DO	
	Record, analyse and reflect on the results.
	Extract same data to measure for improvement:
STUDY	
	What will you take forward from this cycle (next step or next PDSA cycle)
ACT	



Measuring Success

Through baseline and follow-up data, the number of current and unrecorded smokers will be captured. An improvement will be observed if there is a reduction in the overall percentage of practice smokers (or for singularly participating GPs, a reduction in the percentage of their patients who smoke), or a reduction in the number of unrecorded smokers (as the overall percentage of smokers may increase as a result of improved recording of patient smoking status).

Choosing an activity or idea to explore will have its own measure of success. It is important to identify in each activity what you are wanting to change and how you will know when the change has occurred. This is identified in Question 2.

Applying a SMARTA (Specific, Measurable, Attainable, Realistic, Timebound and Agreed) goal setting process will assist you.¹

SMARTA Goal Setting

- Specific. Goals that are too vague and general are hard to achieve, for example 'be a better parent'. Goals that work include specifics such as 'who, where, when, why and what'.
- Measurable. Ideally goals should include a quantity of 'how much' or 'how many', for example drinking 2 litres of water per day. This makes it easy to know when you have reached the goal.
- Achievable. Goals should be challenging, but achievable. Goals work best when they are neither too easy or too difficult. In many cases setting harder goals can lead to better outcomes, but only if the person can achieve it. Setting goals which are too difficult can be discouraging and lead to giving up altogether.
- Relevant. The goal should seem important and beneficial to the person who is assigned the goal.

- Time-related. 'You don't need more time, you just need a deadline.' Deadlines can motivate efforts and prioritise the task above other distractions
- Agreed. All parties should agree on the approach.

Undertaking data analysis by utilising the PEN Clinical Audit Tool (PenCAT) will assist to identify the smoking status of your active patient population.

¹Health Direct November 2016 <https://www.healthdirect.gov.au/smart-goals>

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- UK Smoking Toolkit Study: <http://www.smokinginengland.info/>
- HNECC PHN Website: <https://hneccphn.com.au/>

Resources:

- Smoking - PenCS: <https://help.pencs.com.au/display/CG/Smoking>
- Identify patients with Allergy or Smoking Status NOT recorded: <https://help.pencs.com.au/display/CR/Identify+patients+with+Allergy+or+Smoking+Status+NOT+recorded>
- Tobacco - Tools for health professionals: <https://www.health.nsw.gov.au/tobacco/Pages/tools-for-health-professionals.aspx>
- Let's take a moment 5A's: <https://www.health.nsw.gov.au/tobacco/Publications/lets-take-a-moment-reference.pdf>
- Tackling Indigenous Smoking: <https://www.ahmrc.org.au/publication/aboriginal-tobacco-resistance-tool-kit/>
- Quit Education: <https://education.quit.org.au/>
- Role of the Primary Health Professional in General Practice: <http://www.tobaccoinaustralia.org.au/chapter-7-cessation/7-10-role-of-general-practice-and-other-hea>
- Video: Alfred Health - consumers and professionals talking about addressing smoking (1 minute 40 seconds): <http://starttheconversation.org.au/patients#Christene>
- Quit Clinical Protocol Sheet: <https://www.gphn.org.au/wp-content/uploads/2017/03/Resource-Quit-Clinical-Protocol-Sheet-2017.pdf>
- Quit Consumer Information Sheet: <https://www.gphn.org.au/wp-content/uploads/2017/03/Resource-Quit-Consumer-Health-Sheet-2017.pdf>
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- Supporting smoking cessation: a guide for health professionals: <http://www.racgp.org.au/your-practice/guidelines/smoking-cessation/>
- Expired Carbon Monoxide Monitor: <https://www.health.nsw.gov.au/tobacco/Factsheets/expired-co-monitor.pdf>
- Smoking and Aboriginal Communities: <https://www.health.nsw.gov.au/tobacco/Pages/aboriginal-communities-smoking.aspx>

HNECC PHN acknowledges the traditional owners and custodians of the lands that we live and work on as the First People of this Country.

This toolkit has been made possible through funding provided by the Australian Government under the PHN Program.

Toolkit published AUGUST 2019