

## Continuous Quality Improvement (CQI)

## Winter Wellness Strategy – Care of patients with multimorbidity – using Cat 4

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| **CQI steps** | **Ask-Do-Describe** |
| **Data report 1 - baseline** | **First CQI meeting**  | **Why do we want to change?** |
| * Gap
 | The current COVID-19 pandemic has impacted health system service delivery on the Gold Coast. Patients with multimorbidity will require their care to be reviewed and optimised particularly during the Winter. A seasonal, person centred care delivery process may assist and provide a systematic and evidence-based approach to comprehensive care. |
| * Benefits
 | Every winter there is a surge in both community and hospital healthcare demand. Proactive care planning and delivery by general practices for patients with multimorbidity may help to prevent hospital admissions, increase patient wellness and quality of life.Chronic care management is incentivised through MBS item numbers and can meet PIP QI practice requirements. Practice staff will become aware of their more complex patients, proactively inviting and allocating time for patient assessments, which may increase staff satisfaction with their work.Focusing on patients with multiple chronic conditions ensures efficient use of resources, may reduce avoidable hospital admissions and ultimately improves the health service experience for all consumers.  |
| * Evidence
 | Australia has one of the highest life expectancies in the world and most Australians consider themselves to be in good health, however not all Australians are as healthy as they could be. Chronic diseases are the leading cause of ill health and death in Australia [(AIHW – Australias Health 2016)](https://www.aihw.gov.au/reports/australias-health/australias-health-2016/contents/chapter-3-leading-causes-of-ill-health). Chronic diseases are long lasting conditions with persistent effects, including social and economic consequences which may have a significant impact on peoples quality of life [(AIHW – Chronic disease)](https://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/chronic-disease/overview). Comorbidity refers to the occurrence of two or more diseases that a person experiences at one time. The growing burden of chronic disease means that effective treatment for patients with multiple chronic conditions and complex health care needs is vitally important. Development and implementation of new and innovative methods for early disease detection and treatment, including coordinated care planning, patient self-management and chronic disease management is a key role delivered by general practices [(AIHW – Australias Health 2016)](https://www.aihw.gov.au/reports/australias-health/australias-health-2016/contents/chapter-3-leading-causes-of-ill-health).This risk of illness and disease may be experienced across the lifecycle, with older people at an increased risk of multiple chronic conditions that may impair their function and quality of life [(RACGP – Guidelines for preventive activities in general practice)](https://www.racgp.org.au/FSDEDEV/media/documents/Clinical%20Resources/Guidelines/Red%20Book/Guidelines-for-preventive-activities-in-general-practice.pdf). An annual cycle of care model with a [seasonal focus](https://gcphn.org.au/practice-support/support-for-general-practice/practice-based-population-health-management-program/) can assist with targeted, cost-effective and high quality care delivery and monitoring by general practice. Implementing a seasonal focus model in primary health care can ensure all critical elements of health care management for at risk patients can be achieved.  |
| **What** do we want to change? |
| * Topic
 | Identifying and managing vulnerable patients with multimorbidity |
| * Scope
 |  Vulnerable and at-risk groups – to be determined by practice demographics |
| **How much** do we want to change? |
| * Baseline
 | To be determined from [CAT4 Recipe – Identify older patients with two or more chronic conditions](https://help.pencs.com.au/display/CR/Covid-19%3A%2BIdentify%2Bolder%2Bpatients%2Bwith%2Btwo%2Bor%2Bmore%2Bchronic%2Bconditions)  |
| * Sample
 | All patients with 2 or more chronic conditions ORAll Aboriginal or Torres Strait Islander patients with 2 or more chronic conditions |
| * Target
 | 100% of sample patients with 2 or more chronic conditions invited for care plan or review.  |
| * Preparedness
 | All staff believe this is a priority activity for their practice and patient population.  |
| **Who** are involved in the change? |
| * Leads

Contributors | Practice Manager/COVID-19 Team LeaderGPs/Practice Nurses/Receptionists |
| * External
 | PHN/DoH/QLD Health/Patients |
| **When** are we making the change? |
| * Deadlines
 | Baseline data report generated (date)Implementation between (date range)Review meeting (date) |
| **How** are we going to change? |
| * Potential solutions
 | **Identification:*** Identify patients with 2 or more chronic illnesses by practitioner [CAT4 Recipe – Identify older patients with two or more chronic conditions](https://help.pencs.com.au/display/CR/Covid-19%3A%2BIdentify%2Bolder%2Bpatients%2Bwith%2Btwo%2Bor%2Bmore%2Bchronic%2Bconditions) (tip- can target vulnerable age groups first
* Identify patients eligible for GPMP/TCA or review and invite for appointment – time with nurse and GP

**Service delivery option:*** Review eligibility for care plan or review
* Consider most appropriate service delivery option (in practice or telehealth)
* If in practice, consider social distancing requirements, types of patients booked in at the same time (consider only “well patients”)

**Management:*** Consider a person centred, seasonal approach to support comprehensive, evidence-based care delivery for patients with multimorbidity
* [**Autumn – Prevention**](https://gcphn.org.au/practice-support/support-for-general-practice/practice-based-population-health-management-program/seasonal-focus-autumn/)

Prevention activities such reviewing and updating vaccinations, referral to Cardiac or Pulmonary Rehabilitation, cancer and other disease screening and AHP referrals. Review psychosocial factors as appropriate. Review clinical measures and guidelines and order tests as appropriate * [**Winter – Burden of Care**](https://gcphn.org.au/practice-support/support-for-general-practice/practice-based-population-health-management-program/seasonal-focus-winter/)

Review current referrals and specialist and allied health appointments with patient and/or carer to assess which ones are necessary or relevant. Reduce referrals, visits and unnecessary tests if appropriate. Coordinate any relevant tests and/or appointments to meet patient’s medical and personal requirements. Review clinical measures and guidelines and order tests as appropriate * [**Spring – Clinical Coding and Data Management**](https://gcphn.org.au/practice-support/support-for-general-practice/practice-based-population-health-management-program/seasonal-focus-spring/)

Develop an agreed process for the practice for clinical coding and data entry that will support data extraction. Revise current patient consent processes and implement processes and systems to capture patient consent to share data. Update patient contact details including next of kin and emergency contact. Consider uploading SHS to My Health Record. Review medications and consider HMR. Review clinical measures and guidelines and order tests as appropriate * [**Summer – Advance Care Planning**](https://gcphn.org.au/practice-support/support-for-general-practice/practice-based-population-health-management-program/seasonal-focus-summer/)

Discuss and promote Advance Care Planning and encourage patient or family member to upload to My Health Record. Review clinical measures and guidelines and order tests as appropriate  |
| * Select
 | *Choose potential solutions that will work well in your practice and meet the needs of your patients and team.*  |
|  |
| * **Implementation**
 | * Implement
 | 1. *Generate baseline measure via* [*CAT4 Recipe – Identify older patients with two or more chronic conditions*](https://help.pencs.com.au/display/CR/Covid-19%3A%2BIdentify%2Bolder%2Bpatients%2Bwith%2Btwo%2Bor%2Bmore%2Bchronic%2Bconditions)
2. *Recall patients and schedule appointment with patients identified from CAT 4*
3. *Progress the most appropriate service delivery option*
4. *Book Practice Nurse appointment time prior to GP appointment*
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| * Record, share
 | *Regular whole of team meetings to evaluate, review planning and implementation. Optimise team meeting minutes as a record of your activities.* *Document* [*CQI Practice initial and final meeting minutes*](https://gcphn.org.au/wp-content/uploads/2020/02/CQI-Practice-Meeting-Template.docx) *as above* |
|  |
| **Data Report 2****Comparison** | **Final CQI meeting**  | **How much** did we change? |
| * Performance
 | *Did you achieve your target?**If not, consider new activity to test as above* |
| * Worthwhile
 | *Did the activity provide the outcome expected?**Did this process provide patients with the required information and services?* |
| * Learn
 | *What lessons learnt can you use for other activities, what worked well, what could be changed or improved?* |
|  | **What next?** |
| * Sustain
 | ***Maintenance*** *(Business as Usual):** *Reception to confirm/update personal details at each visit*
* *Confirm/update social/family history/allergies/smoking and alcohol status regularly*
* *Ensure new reminder in place for review of care plan/medication reviews*
 |
| * Monitor
 | *Consider monthly data review of eligible at-risk groups and invite to attend services etc* |