

## Continuous Quality Improvement (CQI)

## Winter Wellness Strategy – Care of patients

## 70 - 74yrs old – using CAT4

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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 in the vulnerable age group of 70-74yrs old 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 in the 70-74yrs vulnerable age bracket 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 in the vulnerable age group 70-74yrs old 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 – Australia’s 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). People aged in the 70-74yr age bracket are in the vulnerable age group, susceptible to chronic disease, polypharmacy, falls risk and depression. [RACGP-Preventative activities over the lifecycle-Adults](https://www.racgp.org.au/FSDEDEV/media/documents/Clinical%20Resources/Guidelines/Red%20Book/Lifecycle-chart.pdf)It is important to ensure that this age group has good support systems in place to maintain overall good health - [Health Direct - Managing your health in your 70s](https://www.healthdirect.gov.au/manage-your-health-in-your-70s-and-older) 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. 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 patients in the vulnerable age group of 70-74yrs old.  |
| * Scope
 |  Vulnerable age group 70-74yrs |
| **How much** do we want to change? |
| * Baseline
 | To be determined from:[Cat4 Recipe – 70-74yr Cross Tabulation Report](https://gcphn.org.au/wp-content/uploads/2021/03/70-74yrs-Cross-Tabulation-Report_Updated-Feb21.pdf)Your patient list should ideally have between 50-100 patients. If your patient list has a higher number, consider the following:Optional: To further narrow down your patient list, please include one or more of the following:* No Cholesterol recorded
* No Blood Pressure
* Medications Not Printed in last 6mths

NB: A total of 5 items only can be used in a cross-tabulation report |
| * Sample
 |  All patients identified in cross tabulation report |
| * Target
 | 100% of sample patients invited for care plan/review or missing items of care |
| * 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:*** As per baseline sample above

**Service delivery option:*** Review eligibility for care plan or review (add your usual process here)
* 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 aged 70-74yrs
* [**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 allied health professional 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 NB: patients may enter the seasonal cycle at any point  |
| * Select
 | *Choose potential solutions that will work well in your practice and meet the needs of your patients and team.* |
|  |
| * **Implementation**
 | * Implement
 | *Develop plan to suit practice processes (example below). Ensure task allocated to appropriate role.* 1. *Team meeting to discuss plan and confirm roles*
2. *Generate baseline measure from selected report*
3. *Recall patients and schedule appointments*
4. *Progress the most appropriate service delivery option*
5. *Book Practice Nurse appointment time prior to GP appointment*
 |
| * Record, share
 | *Documentation of plan to meet PIP QI requirements. Use team meeting minutes as a record of your activities or document meetings in* [*PIP QI Meeting template.*](https://gcphn.org.au/wp-content/uploads/2020/02/CQI-Practice-Meeting-Template.docx) *Plan date for review meeting to assess progress.*  |
|  |
| **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*** *- Update processes and inform staff to ensure integration into usual business (example below).* * *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*
* *Consider any other new changes identified during the activity*
 |
| * Monitor
 | *Consider monthly data review of eligible at-risk groups and invite to attend services etc* |