

## Continuous Quality Improvement (CQI)

## Health Assessments > 75 years (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 | Uptake and completion of Health Assessments for our patients > 75 years could be improved |
| * Benefits | Improved Health outcomes, Meet PIP QI requirements, reduce risk, increase efficiency, promote healthy lifestyle. |
| * Evidence | RACGP: [Guidelines for preventive activities in general practice 9th Edition](https://www.racgp.org.au/FSDEDEV/media/documents/Clinical%20Resources/Guidelines/Red%20Book/Guidelines-for-preventive-activities-in-general-practice.pdf) - Preventive activities in older age (page 45).  Focusing on patients in the vulnerable age group ensures efficient use of resources, may reduce avoidable hospital admissions and ultimately improves the health service experience for all consumers.  Health Assessments is incentivised through MBS item numbers and can meet PIP QI practice requirements. |
| **What** do we want to change? | |
| * Topic | Completion of Health Assessments for over 75-year-olds |
| * Scope | Patients aged 75 years or over who have not had a health assessment billed in the past 12 months. |
| **How much** do we want to change? | |
| * Baseline (%) | To be determined from:  [CAT4 Report - % of Health Assessments 75+ in past 12 months.](https://help.pencs.com.au/display/CG/MBS+Items)  Tip:   * Consider using Active (3x 2 years) filter in CAT4 to ensure current patients. * Ensure use [date range (results) <12 months filter](https://help.pencs.com.au/display/CG/Date+Range+%28Results%29+Filtering) as Health Assessments for over 75yrs can be billed annually. |
| * Sample (number) | [CAT4 Recipe - Identify patients eligible for an annual 75+ Health Assessment](https://help.pencs.com.au/pages/viewpage.action?pageId=179700458)  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 consider using select age groups (e.g. 75-78yrs). |
| * Target (%) | 50% of eligible patients on list *(n =?)* |
| * Preparedness | Practice team involved in decision making  Current appointment scheduling will accommodate increase in appointments for this activity |
| **Who** are involved in the change? | |
| * Leads   Contributors | Practice Manager  GPs/Practice Nurses/Receptionists |
| * External | Consider support required here from external companies  PHN/DOH/QLD Health/Patients |
| **When** are we making the change? | |
| * Deadlines | Start date dd/mm/yyyy End Date dd/mm/yyyy  Consider your sample size and how long it will take to invite/complete HAs  Baseline data report generated (date)  Implementation between (date range)  Review meeting (date) |
| **How** are we going to change? | |
| * Potential solutions | To implement a process for new patients to add in reminders to ensure health assessments are completed (new patient questionnaire)  Driver’s license renewal requests are linked with Health Assessment appointment as planned care  Printing CAT4 report which indicates who has missing Health assessment item numbers that are over 75 years - [CAT4 Recipe - Identify patients eligible for an annual 75+ Health Assessment](https://help.pencs.com.au/pages/viewpage.action?pageId=179700458)  Recall or add appointment reminder as per selected process  Consider implementing this [Over 75 Cycle of Care](https://gcphn.org.au/wp-content/uploads/2020/05/NEW-Over-75-Cycle-of-Care-linked.pdf) for complex patients |
| * Select | *Choose potential solutions that will work well in your practice and meet the needs of your patients and team.* |
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| * **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.* |
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| **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* |