

## Continuous Quality Improvement (CQI)

## Project Example – Identifying eligible patients aged 75+ for health assessment and advance care planning discussions.

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| **CQI steps** | **Ask-Do-Describe** |
| **Data report 1 - baseline** | **First CQI meeting**  | **Why do we want to change?** |
| * Gap
 | Low number of advance care documents completed and sent to Office of Advance Care Planning (OACP) for patients having a 75+ Health assessment.  |
| * Benefits
 | Increase the opportunity to discuss end of life care wishes with patients aged 75+. Aiming to reduce future inappropriate health interventions and hospitalisations and increasing the likelihood for patients to die in their place of choice.  |
| * Evidence
 | [RACGP](https://www.racgp.org.au/download/documents/Policies/Clinical/advancedcareplanning_positionstatement.pdf) position statement on ACP, suggests that General Practice is an important setting for initiating and promoting Advance Care Planning (ACP), as planning for future health care is best discussed with patients at the time when their health is stable. [QLD Health](https://www.health.qld.gov.au/__data/assets/pdf_file/0037/688618/acp-guidelines.pdf) ACP Guidelines also suggests that ACP achieves successful outcomes reducing unnecessary and undesired interventions and treatments at the end of life, higher satisfaction with quality of care (increasing quality of life) and reduces unnecessary hospitalisations for patients at the end of life.[[1]](#footnote-1) |
| **What** do we want to change? |
| * Topic
 | Increase the number of ACP discussions to start the completion of advance care documents\* for active patients having a 75+ Health assessment. \* Advance Health Directive (AHD) form or Statement of Choices (SoC) form  |
| * Scope
 |  Patients eligible for 75+ Health assessment |
| **How much** do we want to change? |
| * Baseline
 | Unknown. This activity will ensure 75+ Heath assessments patients are provided with the opportunity to discuss their future health care needs. |
| * Sample
 | Patients eligible for 75+ Health assessments. You will need to generate a list with individual names who are identified as most appropriate for ACP discussions (refer to [ACP QI toolkit](https://gcphn.org.au/practice-support/support-for-general-practice/general-practice-quality-improvement-incentive-pip-qi-incentive/#advance-care-planning-toolkit) for possible sample groups) |
| * Target
 | Assess number of patients eligible for a health assessment (using data) to define what is a reasonable and achievable number in a specified time  |
| * Preparedness
 | All relevant practice team must undertake [ACP training.](https://gcphn.org.au/patient-care/advance-care-planning/advanced-care-planning/#education-and-training) [Order](https://metrosouth.health.qld.gov.au/acp/acp-resources/acp-information-packs) and/or [print](https://metrosouth.health.qld.gov.au/acp/queensland-advance-care-planning-forms) ACP forms. Source endorsed patient education [resources](https://metrosouth.health.qld.gov.au/acp/acp-resources) ([brochures](https://metrosouth.health.qld.gov.au/sites/default/files/acp-brochure.pdf) in waiting rooms, posters in toilets, etc) |
| **Who** are involved in the change? |
| * Leads

Contributors | RN and PMGP and other general practice staff (e.g., reception staff) |
| * External
 | Consider support required from external organisations and other stakeholders. For example:[Office of Advance Care Planning (OACP)](https://metrosouth.health.qld.gov.au/acp/about-us)[Advance Care Planning Australia](https://www.advancecareplanning.org.au/) |
| **When** are we making the change? |
| * Deadlines
 | Define start date dd/mm/yyyy and end date dd/mm/yyyy Consider your sample size and how long it will take to complete advance care directives and to submit to the OACP |
| **How** are we going to change? |
| * Potential solutions
 | * To implement a process for new patients to add in reminders to ensure ACP is discussed when 75+ Health assessments are completed (new patient questionnaire).
* To identify 75+ eligible patients for health assessment in CAT4.
* Contact patients via letter or SMS to encourage participation in the health assessment and ACP.
* Use Primary Sense™ *Health Assessments report* to support identification of the target group
 |
| * Select
 | Define target group, approach and roles and responsibilities  |
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| * **Implementation**
 | * Implement
 | 1. PM to implement a process for new patients to add in reminders to ensure ACP is discussed when health assessments are completed (new patient questionnaire).
2. Receptionist to print lists from Cat 4 for active patients > 75 years with health assessment item number not billed in last 12 months. [CAT4 Recipe - Identify patients eligible for an annual 75+ Health Assessment](https://help.pencs.com.au/pages/viewpage.action?pageId=1479270)
3. Recall eligible patients or add appointment reminder as per selected process.
4. Ensure Health Assessment template in clinical software includes discussion on ACP
5. Some clinical software systems have a field to record when ACP documents are completed. Ensure a team member is responsible for adding this as part of the process

Note: The 75+ health assessment includes a list of activities and investigations, there may not be time to complete all Advance Care Planning activities (including recording details of any existing documents, start the conversation and [provide information about advance care planning](https://metrosouth.health.qld.gov.au/acp/acp-resources), assisting person to document their plan, etc). It is an opportunity, to start the conversation and offer printed information and organise a follow up consultation. |
| * Record, share
 | * Number of active patients aged 75+ eligible for health assessment.
* Number of active patients aged 75+ with a health assessment with ACP discussion completed.
* [CQI Practice initial and final meeting minutes](https://gcphn.org.au/wp-content/uploads/2020/02/CQI-Practice-Meeting-Template.docx)
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| **Data Report 2****Comparison** | **Final CQI meeting**  | **How much** did we change? |
| * Performance
 | *Was the plan executed successfully?* *Did you achieve your target? If not, identify why not.* |
| * Worthwhile
 | *Was the effort to complete the improvement activity worth the outcome?* |
| * Learn
 |  *What lessons learnt could you use for other improvement activities?**What worked well, what could have been changed or improved?* |
|  | **What next?** |
| * Sustain
 | *Implement new processes and systems into business as usual* |
| * Monitor
 | *Review CAT4 data report monthly/quarterly and initiate corrective measures as required* |

1. [↑](#footnote-ref-1)