General Practice

Quality Improvement Toolkit

The Advance Care Planning Toolkit

A practical guide to implement Advance Care Planning in general practice as a CQI activity and for PIP QI and CPD purposes

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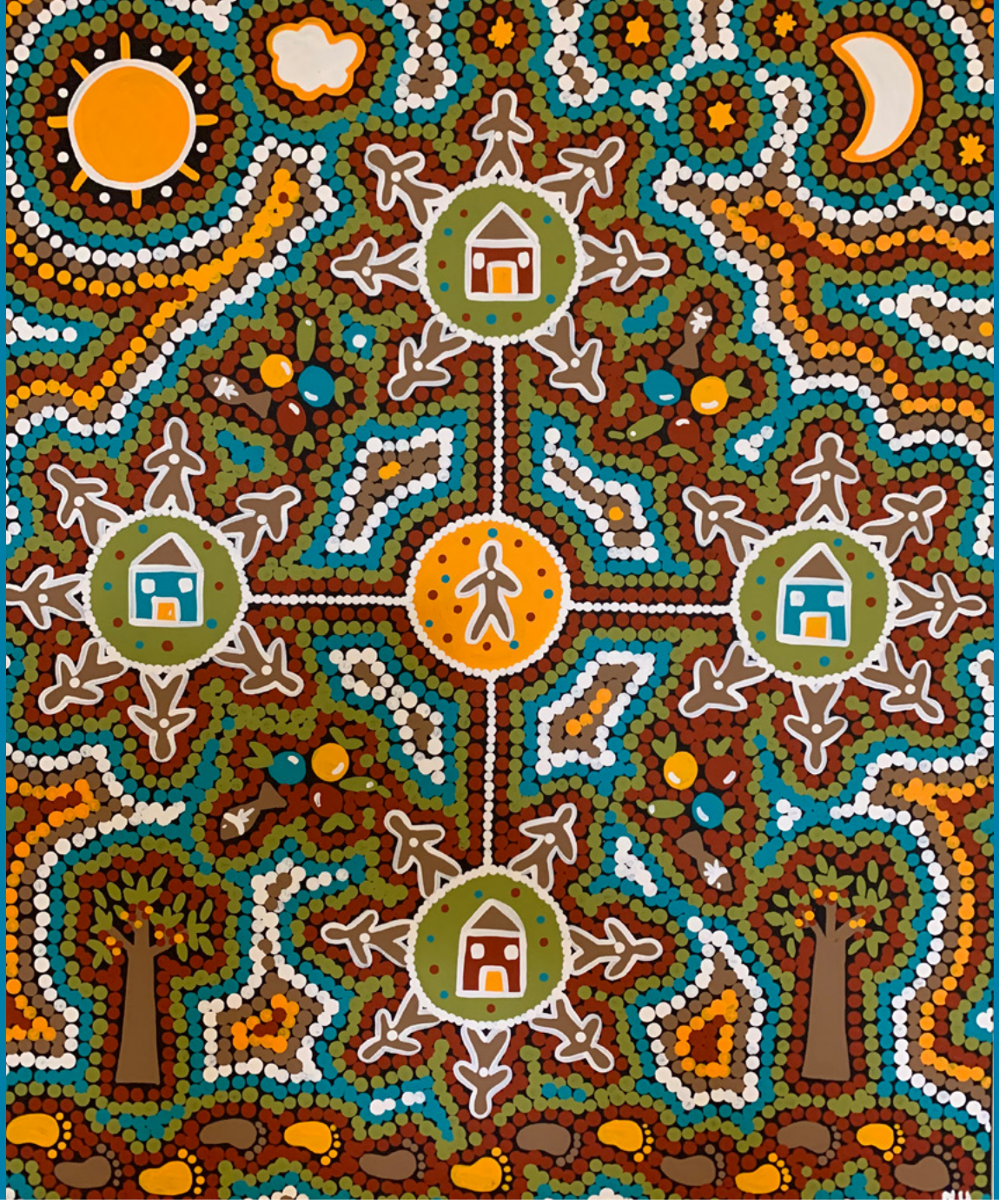

Gold Coast Primary Health Network would like to acknowledge and pay respect to the land and the traditional practices of the families of the Yugambeh Language Region of South East Queensland and their Elders past, present and emerging.

Artwork: Narelle Urquhart. Wiradjuri woman.
Artwork depicts a strong community, with good support for each other, day or night. One mob.

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About The Advance Care Planning Toolkit

Advance Care Planning (ACP) is a person-centred approach that aims to guide current and future decision making about a person's treatment and care that it is consistent with their goals, preferences, and values. The ACP process is proactive, ongoing and should be integrated into routine care. It involves ongoing communication and collaboration between patients, their families or people closest to them and health professionals.[1,2]

The ACP process has different iterative steps and can result in an individual's preferences and values being recorded in Advance Care Directives (ACDs). Advance Care Directives forms a subset of ACP documents. As there is no national Advance Care Directive legislation in Australia, each state and territory determines their own legislation and ACDs/ ACP documents to use.[3] In Queensland there are three ACP documents that an individual can complete to record their choices for future health care.These are Enduring Power of Attorney (EPOA), Advance Health Directive (AHD) and Statement of Choices (SoC).

General Practice is an important setting for initiating and promoting ACP, as planning future health care is best discussed with patients at the time when their health is stable.[4] Evidence suggests that ACP achieves successful outcomes, reducing unnecessary and aggressive treatments at the end of life, higher satisfaction with quality of care and reduces unnecessary hospitalisations for patients at the end of life.[5]

This Toolkit provides a practical guide for general practice teams to assist patients to navigate the advanced care planning process. It describes how to successfully implement advance care planning in a practice as a CQI activity, and for PIP QI and CPD purposes.

Aim of the toolkit

To provide a simple and practical guide for general practices to increase the number of advance care planning documents* completed with patients as a CQI activity.

* EPOA, AHD and/or SoC

The Toolkit supports general practice teams to:

- successfully implement Advance Care Planning in general practice as a CQI activity
- make best use of practice data
- document Advance Care Planning as a CQI activity
- use the CQI activity for PIP QI and CPD purposes
- make measurable and sustainable improvements in a feasible manner to patient care
- increase knowledge of CQI principles and practical application

1 Queensland Government, 2020 https://clinicalexcellence.qld.gov.au/priority-areas/service-improvement/improving-care-end-life-queensland/advance-care-planning/advance

2 Commonwealth of Australia, 2019 https://agedcare.royalcommission.gov.au/sites/default/files/2019-12/background-paper-5.pdf

3 AJGP, 2018 https://www1.racgp.org.au/ajgp/2018/november/advance-care-decision-making-and-planning

4 RACGP, 2012 https://www.racgp.org.au/download/documents/Policies/Clinical/advancedcareplanning_positionstatement.pdf

5 Queensland Health, 2018 https://www.health.qld.gov.au/__data/assets/pdf_file/0037/688618/acp-guidelines.pdf

How to use the toolkit

There are six steps to implement advance care planning in general practice CQI activity

STEP 1 Planning and preparation

STEP 2 Use data to set goals and identify suitable patient

STEP 3 Implement improvement actions

STEP 4 Regularly review your CQI activity

STEP 5 Sustain and maintain improvements

STEP 6 Document your CQI activity

Benefits of using the toolkit

The toolkit provides:

- A structured, easy and quick approach to implement quality improvement activities.
- A step by step guide.
- Suggestions to identify suitable patients using data extraction tools.
- Links to prefilled templates and resources.
- Flexibility: activities can be started at any time of the year, and practice teams decide whether to implement a single improvement intervention, or a bundle of interventions.
- This Toolkit is especially relevant to the Gold Coast context, because it was developed by GCPHN staff, in consultation with the Primary Health Care Improvement Committee.

Step 1 Planning and preparation

1.1 Team meetings

- To meet PIP QI requirements, you must demonstrate that you have undertaken your CQI activity as a team.
- It is important at the beginning of the CQI activity to arrange a practice meeting to agree, plan and prepare for its implementation. If it is not be possible to have the whole team meet, each staff group should be represented. As a minimum, this would include a GP, the practice manager, a member of the administrative team and a practice nurse. In smaller practices, the same individual may have more than one role.
- You should continue to meet regularly to plan and review your CQI activities. It is especially important to meet at the conclusion of the activity and finalize the documentation.
- Meetings can be virtual or in person and can be scheduled at any time that suits the team, i.e. during or outside normal working hours.

***TIP** - Regular meetings help to maintain momentum and keeps the team on track to successfully complete the CQI activity.*

- Practical considerations for your meetings:
  - You could add CQI as a standing agenda item on your usual team meetings; or you could set up specific meetings for this purpose.
  - Schedule meetings with advance notice to ensure key team members can attend
  - Examples of practice meetings and templates are available online.
  - Ensure that you have access to CAT4, Primary Sense™ or other practice data during meetings to inform your discussions and to support your planning and review of your CQI activity.
  - Consider using a CQI activity template during meetings to help guide the discussion and to document your plan, progress and learning. There is also a guide to assist completing this.

1.2 Agree CQI roles and responsibilities

- It is important to define and delegate specific roles and responsibilities in the team. Potential roles for different team members are included as an Appendix.
- Consider in your team who has the skills and ability to complete each task. You could ask staff to gauge their confidence out of 10 to complete an allocated task- this can help identify learning needs.
- Ensure all team members have access to Primary Sense™ desktop or CAT4 to allow development of prompts for care action items.
- Identify and meet the training and education requirements of team members to fulfil their CQI role.
- Ensure all relevant team members understand what ACP is. Refer to training modules and health professionals' resources. These are included in the Advance Care Planning resources section of the toolkit.
- Remember to share your CQI plan (template) with the whole practice team to ensure that everyone is aware of the activity and their roles and responsibilities.

*Training resources for **Primary Sense** and **CAT Plus** are available online.*

1.3 Set realistic timelines

- It is important to specify the steps of your ACP CQI activity and estimate how long each one will take to complete. It is also important to agree dates in advance when progress will be reviewed.
- Allow some flexibility with the timelines and expect and plan for delays. Some of the factors to consider when you set your timelines include:
  - where you are in the cycle of accreditation
  - staff leave and capacity
  - seasonal priorities and anticipated workload, i.e. the winter period tends to be particularly busy

Internal factors you control:

Develop a calendar of known periods of specific activity to align with CQI focus to support proactive planning. Examples are: Advance Care Planning Week held at the end March every year; National Palliative Care Week held in May every year, Queensland Seniors Week usually held between August and October every year.

External factors and factors outside your control:

Ensure disaster management plans and business continuity plans are up to date and all staff are aware of their roles and responsibilities.

Step 2 Use data to set goals and identify suitable patients

2.1 Current performance and future goals

- Ask the following questions to assess current and future performance using your practice data:
  - What is the current level of performance in the practice?
  - If there is an opportunity to improve performance? If so, by how much? Express your goal or target as a number or percentage.
  - Is your target realistic? It is seldom possible to achieve 100% performance; most practice teams can achieve a 25 to 50% improvement in performance or reduce the gap between their current and desired performance by 25 to 50% with concerted effort.
  - How long will it take to achieve this goal?
- A CQI activity is simply a structured, focused and co-ordinated attempt to close the quality gap between your current, baseline performance and a desired outcome or level of performance in the future.
- Practice teams that set SMART goals are more likely to be successful. The acronym SMART describes some of the desired characteristics of a goal: specific, measurable, achievable, relevant and timed.
- Two examples are provided to illustrate the difference between SMART and non-SMART goals.

SMART goal example

Practice A decides to increase the proportion of ACP discussions completed during 75+ health assessments from baseline (if cannot measure 0%) to 30% (goal) over a 12 week period.
To achieve this the practice will need to complete at least 50 75+ health needs assessments for eligible patients during this period. Practice A will achieve this by completing 5 health assessments a week (this provides a small buffer of time).
Expected result of this activity will be an increase in proportion of completed ACP documents (i.e. AHD or SoC).
Practice team agrees to review progress every four weeks.

Non-SMART goal example

Practice B decides to increase the proportion of ACP discussions completed.
Expected result of this activity will be an increase in proportion of completed ACP documents (i.e. AHD or SoC).
The practice team agrees that their GPs and practice nurse will identify eligible patients during their routine work and see how they go in a few weeks.

2.2 Data extraction and analysis tools (CAT4 /Primary Sense™)

- The two data tools that are available in the Gold Coast are CAT4 and Primary Sense™. GCPHN subsidises the licences for Gold Coast general practices to access CAT4 and /or Primary Sense™ data tools at no cost to the practice.
- The quality of your practice data, and whether the data is used to inform improvement, are more important considerations than which tool you use.
- Using a data extraction and analysis tool helps you to use your practice data in a meaningful manner. The main applications of data tools in CQI activities are to:
  - establish your performance baseline
  - compare your performance with the performance of your peers (optional)
  - identify specific groups of patients – also referred to as samples of patients – who may benefit from being included in a CQI. The best data tools have the capability to generate lists with the names and information of all the patients in your sample
  - track your progress towards your goal over the course of the CQI activity

TIP** - collecting, analysing and sharing aggregated practice data are **PIP QI requirements

2.3 Select a sample of patients

- CAT4 or Primary Sense™ can provide you with an overview of your practice performance and the characteristics of your practice population. It also enables you to select and focus on a specific group or sample of patients.
- It is important to direct your improvement efforts at those patients who are most likely to benefit from them. The next step is therefore to identify a suitable group (sample) of patients to discuss advance care planning with or who require completion of documents as part of their health assessments.
- Potential patient groups could include patients:
  - over 70 years with chronic conditions
  - at high risk of dementia
  - with diabetes, CVD, or CKD
  - eligible for 75+ health assessment
  - eligible for 45-49 years Aboriginal or Torres Strait Islander health assessment
  - turning 50 and eligible for bowel and/or breast screening
- For CAT4 users, the following recipes can be used as a guide to assist practices in identifying the appropriate sample group.
  - patients 70-74 with three chronic conditions
  - patients aged 75 and older, with chronic conditions associated with higher risk of death
  - patients at high risk of dementia
  - patients with diabetes, CVD, or CKD who have never had a GPMP/TCA claimed
  - patients eligible for an annual 75+ Health Assessment
  - patients eligible for annual 715 Aboriginal or Torres Strait Islander Health Assessment
  - patients aged 45-49 who have lifestyle and biomedical risk factors
  - patients turning 50 in the next 3 months eligible for bowel and/or breast screening
- Feasible samples are typically between 50 and 100 patients. Larger and more ambitious practice teams may opt to increase the size of their sample further. Smaller sample sizes are acceptable if the practice is implementing bundles of interventions, and interventions are particularly intensive.

- Selecting a suitable sample and picking the right sample size can be challenging decisions for many practice teams. Contact your GCPHN Primary Health Care Improvement Team if you would like to discuss this further.
- GCPHN has developed a prefilled template, practical examples and resources that explain how to use data tools to select samples of patients to implement advance care planning CQI activities and provide examples of which patients may be particularly suitable for inclusion.
- Practices may focus on any sample group to increase completed documents. You can also identify a sample group or patients to focus on by identify the triggers for ACP discussions[6].
- Triggers for ACP can include if a patient:
  - raises ACP with a member of the general practice team
  - has a life limiting illness (e.g. dementia or advanced cancer)
  - is a resident of, or is about to enter, an aged care facility or is at risk of losing competence (e.g. the person has early dementia)
  - has a new significant diagnosis (e.g. metastatic disease or transient ischemic attack)
  - is at a key point of illness trajectory (e.g. recent or repeated hospitalisation or commenced on home oxygen)
  - does not have anyone (such as family, caregiver or friend) who could act as substitute decision maker
  - has a carer

***TIP - sample** and **sample size** are the number of patients you select for a CQI activity.*
***Sampling** is the process of selecting suitable patients.*
***Sampling strategy** is how you choose patients; this is your decision*

Step 3 Implement improvement actions

3.1. Agree specific improvement actions

- It is important to set a SMART goal and identify a sample of patients. It is equally important to decide what improvement actions or interventions will be required to reach your goal. In other words, what is it that needs to be done for every patient in your sample?
- Identify how you will upskill practice team members and ensure all relevant team members understand how to implement ACP in general practice. Refer to health professional resources and information on how to begin the ACP conversation as required.
- Ensure your general practice team understands ACP and ACP documents use in Queensland (Enduring Power of Attorney (EPOA), Advance Health Directive (ADH) and Statement of Choices (SoC)).
- Identify and order any resources or publications required. Refer to list of factsheets in the Advance Care Planning Australia and resources available in the Queensland Government My Care, My Choices website.
- Decide whether your CQI activity requires a single intervention or multiple interventions.
- Consider creating Top Bar prompts to automatically flag patients in the sample.
- Consider patient engagement/experience and activation (communication and feedback). A practical example of this is to add questions to your accreditation survey and offer survey participation to the patients in the CQI sample.

***TIP -** A **care bundle** is a set or number of interventions that, when used together, synergistically improve patient outcomes.*

6 https://www.advancecareplanning.org.au/understand-advance-care-planning/starting-the-conversation#for_HP

TIP - choose one distinct area to start, for example ACP discussion or Advance Health Directives completed as a component of over 75-year-old health assessments.

3.2 Examples of improvement actions for implementing Advance Care Planning (ACP) as a CQI activity

It is suggested that when you meet with your practice team, you discuss how at your practice you can initiate ACP and increase the number of documents completed by patients.
Examples of improvement actions implementing ACP in general practice as a CQI activity.

- Use data to identify patients to start the ACP conversation with or complete advance health directives e.g. patients due to 75+ health assessment, patients with multiple chronic conditions.
- Find and promote consumer information on advance care planning, you may consider posters and brochures in waiting room. The GCPHN has developed a simple guide, Planning Your Future Care Today, with easy-to-understand information about advance care planning for consumers. It is available as a booklet for printing or as an online resource. Other consumer resources or posters can be found on the Advance Care Planning Australia and My Care My Choices websites.
- Use your practice reminder system to 'flag' patients with missing or outstanding ACP documents. Whenever possible, reminders should also be added during patient appointments.
- CQI activity examples for CAT4 users:
  - Care of patients with multimorbidity
  - Care of patients aged 70-74 with 3 or more conditions
  - Aboriginal and Torres Strait Islander MBS item 715 health assessment
  - 75+ Health assessment
  - Pen CS Palliative Care recipes
- Review if advance care planning is included in all health assessment templates including Aboriginal and Torres Strait Islander, 45-49-year-old, and 75+ year old. Refer to ACP resources for Aboriginal and Torres Strait Islander people to find information and resources to help you address ACP with Aboriginal and Torres Strait Islander patients.
- Include advance care planning as part of GP Management Plan and review templates.
- Ensure relevant team members undertake ACP training for general practice.

MBS items to support implementation GP management plan

There is no dedicated MBS item for advance care planning. Several MBS items can support ACP as part of other health interventions. Discussing ACP can be incorporated whilst completing patient's health assessments or management plans.

- GP management plan
- Team care arrangements
- GPMP/TCA review x 3 times per year
- Nurse chronic disease item number
- Health assessment
- Aboriginal and Torres Strait Islander health assessment
- Home medication review

TIP - GPs are required to make sure each patient meets the MBS criteria prior to claiming each item number.

Step 4 Regularly review your CQI activity

- It is important to monitor your progress regularly.
- During the planning and preparation step you would have identified the timelines and activity review points which should now be implemented.

Practical considerations:

- Set the frequency of CQI progress reviews according to the timeline of your activity. For example, it would be reasonable to check the progress of a 12-week activity every fortnight.
- Use your practice data at each checkpoint (review) to determine your progress towards your goal. Remember to check that the data corresponds with the period being reviewed. Some data extraction tools have a lag between current and past performance.
- Identify the barriers or challenges (if any) to your progress during the review. Consider whether any corrective actions are required.
- The following questions may be helpful to work through during your CQI activity reviews:
  - Successes- what has worked well so far?
  - What were the challenges and barriers?
  - Were you able to overcome the challenges and barriers?
    If not, what do you need to do next?
  - If you were able to overcome challenges or barriers, what did you learn, and how can you use that in future?
- During the final review meeting, when you conclude your CQI activity, it is important to consider and document:
  - What worked well?
  - What could have worked better?
  - What were your learning points, learning needs and were learning needs met?
  - What changes did you make to your practice policies and procedures or systems because of this CQI activity (if any)?

Step 5 Sustain and maintain improvements

- Once performance has been improved, it usually requires regular reviews to maintain the gains.
- It is therefore important to establish a reliable procedure to ensure your improved performance is sustained.
- New processes that are developed need to be documented and communicated to the wider team to ensure ongoing implementation is achieved.
- Agree the intervals at which you will review your performance relating to this activity, decide who will be responsible for the review, and the actions that will be taken if performance falls short of your new standard.
- Consider potential topics for a new CQI activity, and how your experience with this activity can help you to be more efficient and effective.
- Share your CQI activity, its successful outcomes and learning points with everyone in the practice team.

***TIP** - Speak with GCPHN if you would like support to showcase your work and share with your Gold Coast peers.*

Step 6 Document your CQI activity

- Ensure you document your CQI activity to meet the PIP QI guidelines. Documentation is also a requirement for CPD purposes.
- Documentation must be kept for 6 years for evidence of PIP QI.
- It is especially important to document your baseline and improved performance, and list improvement actions and learning points.
- If your CQI activity has resulted in changes to your policies and procedures, they can be included in the documentation as attachments and evidence for accreditation purposes.
- There is no single 'right way' to document a CQI activity. The types of documents and templates we provide in this Toolkit are intended as examples. Practice teams can modify them to suit their own needs.
- There are three main types of documents that are required for a CQI activity. The fourth type of document is desirable but not essential. All documents are 'living' in the sense that they can be updated throughout the CQI process. The four types are:

1. Documents about meetings. A CQI activity requires at least two team meetings – one at the beginning and one at its conclusion. It is strongly recommended to also record your review meetings or 'check points'.

2. Documents about data. This type of documents could include reports from Pen CS or Primary Sense with aggregated performance data. It can also include lists of patient names that were sampled. These documents are not routinely shared and should be managed according to data privacy and governance procedures.

3. Documents about the CQI activity. GCPHN developed a CQI activity template that enables practice teams to document any CQI activity from beginning through to its conclusion. The template is suitable for PIP QI and CPD purposes. The template can be found here under "resources")

4. Documents about practice policies and procedures. Practice policies and procedures- changes can be saved as evidence for PIP QI

Primary Sense™ users:

*Templates can also be located in Primary Sense™ Desktop. The Guide for these can be found **here***

Additional support and information

PIP QI

- For your Advance Care Planning CQI activity to be suitable for PIP QI purposes, you must ensure that all the requirements have been met.
  - See details of the PIP QI requirements on GCPHN webpage
- GCPHN Primary Care Improvement Team can provide virtual/face to face meetings or access to recorded webinars that will provide:
  - Resources or training on the use of data extraction tools to assist with identification of a patient sample.
  - Worked examples of CQI action plans to support implementation and meet PIP QI requirements.
  - Tips to support CQI implementation.

CPD

- If general practitioners would like to be eligible for CPD points for participating in the advance care planning CQI activity, further information can be found on RACGP and ACRRM webpages.

Email practicesupport@gcphn.com.au or phone (07) 5612 5408

Advance Care Planning resources

Below there is information and links relevant to the ACP and its process, including forms to be completed.

Advance care planning process:

- Queensland Health has developed an Advance Care Planning six-step process for clinicians and the ACP Quick Guide to help clinicians identify patients who may benefit from advance care planning.
- Advance Care Australia has information about ACP process in general practice. Including ACP health care professionals' roles and responsibilities and starting the ACP conversation in general practice.

Statutory forms (legally binding documents in Queensland)

- Advance Health Directive (AHD)
- Enduring Power of Attorney (EPOA) Long Form
- Enduring Power of Attorney (EPOA) Short Form
- Revocation of an Enduring Power of Attorney (EPOA)

Non-Statutory forms (not legally binding but accepted in Queensland public hospital and health care facilities, and residential aged care services)

- Statement of Choices (SoC)

The Office of Advance Care Planning (OACP) is a state-wide service that receives, reviews and upload advance care planning documents to a patient's Queensland Health electronic hospital record and can be accessed via the ACP Tracker in The Viewer. GPs can register for access to the Health Provider Portal (and The Viewer)

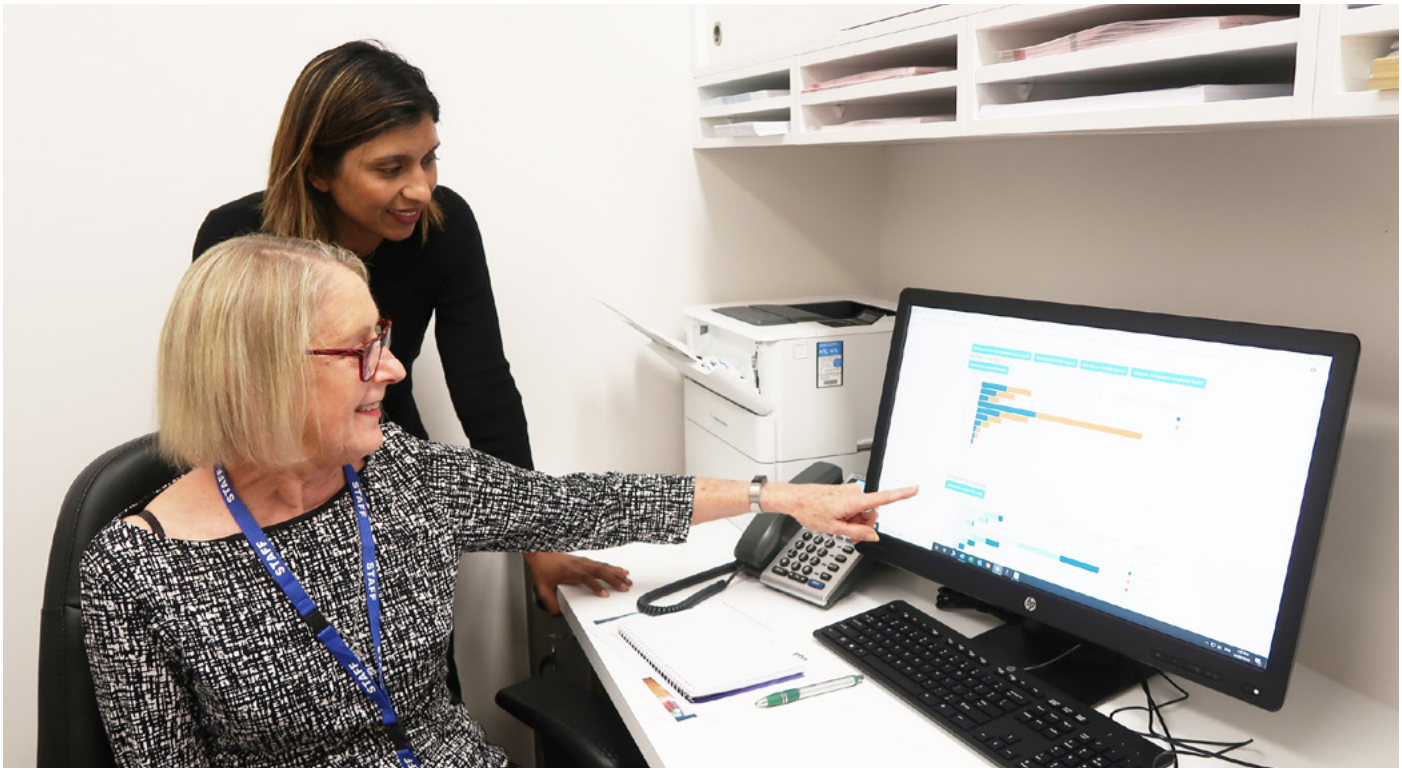
Don't forget to send a copy of your patient's ACP forms/documents to the OACP or remind your patients to send a copy to the OACP. This will ensure their forms are available to all health professionals across Queensland via The Viewer.

Additionally, remind patients to upload ACP forms to My Health Record

For more resources and training about Advance Care Planning for clinicians working in general practice visit our website.

There are other documents or registrations to consider when discussing advance care planning with your patients. These are:

- Wills
- Registration with myGov
- Registration to My Aged Care
- Organ donation



Other GCPHN CQI Toolkits

GCPHN has developed a range of toolkits which are available on the GCPHN website.

Appendix

Potential CQI roles and responsibilities of practice team members

General Practitioners

- Provide clinical oversight and governance of the activity

Practice Nurses

- Support the implementation of the activity
- Provide support to generate data reports
- Identify patients to provide opportunistic interventions

Practice Manager

- Maintain up to date patient registers
- Analyse practice data
- Identify and support implementation of training for the CQI and practice team
- Establish and oversee recall/reminder systems
- Monitor progress against CQI activity
- Review and update new systems to ensure sustainable change
- Document policy and procedures and support implementation across the team

Reception Staff

- Order and maintain supplies of resources (eg patient information)
- Add flags or clinician reminders for patients in the activity
- Support the practice team to identify patients eligible for relevant reminders and contact patients either via letter, text message, phone call etc

Medical and Nursing students (if relevant)

- Consider tasks that medical or nursing students could implement during clinical placements to support your CQI activities

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