**QI Action Plan- \*add practice name\***

**Health Assessments for patients**

**75 years and over QI Activity**

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| **Ask-Do-Describe** | |
| **Why do we want to change?** | |
| **Gap** | Uptake and completion of Health Assessments for our patients 75 years and over could be improved. |
| **Benefits** | Improved patient health outcomes, reduce risk, increase efficiency, promote healthy lifestyle. Activity may support meeting PIP QI requirements. |
| **Evidence** | General practice is at the forefront of healthcare in Australia and in a pivotal position to deliver preventive healthcare. More than 137 million general practice consultations take place annually in Australia and 85% of the Australian population consult a general practitioner (GP) at least once a year. Preventive healthcare is an important activity in general practice. It includes the prevention of illness, the early detection of specific disease, and the promotion and maintenance of health. The partnership between GP and patient can help people reach their goals of maintaining or improving health. Preventive care is also critical in addressing the health disparities faced by disadvantaged and vulnerable population groups.  Prevention of illness is the key to Australia’s future health – both individually and collectively. About 32% of Australia’s total burden of disease can be attributed to modifiable risk factors. [(RACGP, Guidelines for preventative activities in general practice, 2021)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/guidelines-for-preventive-activities-in-general-pr/preamble/introduction#ref-num-1)  The purpose of a >75 health assessment is to help identify any risk factors exhibited by a patient that may require further health management. In addition to assessing a person’s health status, a health assessment is used to identify a broad range of factors that influence a person’s physical, psychological and social functioning ([MonREN, What is the Effectiveness of the MBS Health Assessment for People Aged 75 Years and Older?, 2023](https://www.monash.edu/__data/assets/pdf_file/0010/3446326/75-plus-health-assessment-evidence-brief-july-2023.pdf)). |
| **What** do we want to change? | |
| **Topic** | Increased completion rates of Health Assessments for patients 75 years and over for regular patients of \*practice name\* |
| **How much** do we want to change? | |
| **Baseline**  *Baseline data is the % of*  *your current performance.*  *Add your practice performance percentage.* | *Baseline data for QI activities can be obtained from multiple sources e.g.:*   * *Data analytic tools- e.g., Primary Sense.* * *Clinical information systems using the “search” function/patient registers.*   **Example:**   * *Baseline data can be obtained from Primary Sense – Health Assessments Report third table down (number of patients eligible can be identified in exported Excel spreadsheet).* * *\*XX patients aged 75 years and over eligible for a Health Assessment.* |
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| **Target**  *Target is the number of Health Assessments for patients aged 75 years and over to be completed to meet your goal.* | **Example:** *Initial target is to reduce the number of patients with missing Health Assessments to \*XX.* |
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| **Sample**  *Sample is the number of patients that are eligible for a 75 year and over Health Assessment to meet your target.*  *Add your practice sample.* | **Example:**   * *Sample could be determined from a Primary Sense report– Health Assessments Report.* * *XX patients aged 75 years and over who have not had a Health Assessment OR* * *Sample is XX patients to reduce the number of patients with missing Health Assessments to XX.*   *Tip (if the list is large) - consider narrowing down your sample size by focusing on:*   * *Specific age groups. e.g., 76–78-year age group /patients who have just turned 75.* * *Existing appointment to allow discussion and rebooking of Health Assessment appointment.* * *ACG Score – e.g., 4 & 5 moderate to high complexity* |
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| **Who** is involved in the change? | |
| **Contributors**  *Add names of the practice team involved* | **Practice Manager:**  **GPs:**  **Practice Nurses:**  **Receptionists:**  **GCPHN QI Project Officer:** |
| **When** are we making the change? | |
| **Deadlines**  *Add key dates here for this activity.* | **Baseline data report generated:**  **Implementation between (from/to):**  **Review meeting/s:**  **Final evaluation meeting:** |
| **How** are we going to change? | |
| **Implement**  *List some improvement strategies in order of implementation.*  ***(see Appendix 1 for suggestions).*** | **1.**  **2.**  **3.** |
| **STOP: The next section is to be completed after implementation has already commenced.** | |
| **Monitor**  *A minimum of one QI*  *activity review /touchpoint is required.*  *You can include multiple reviews/touchpoints – list by date.* | **Review 1 - Date:**  *What is working/not working?*  *Has there been a change in your performance? If not, why not?* |
| **STOP: The next section is to be completed at the end/closure of activity.** | |
| **How much** did we change? | |
| **Performance**  *Question: Did you*  *achieve your target?*  *If not, reflect on why not* | **Example:**   * *Number of patients due for a 75-year-old Health Assessment has decreased from baseline XX to XX.* * *This was an \*increase/decrease\* from our baseline data.* * *Our Health Assessments**\*increased/decreased\* due to \*XX\*.* |
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| **Worthwhile**  *Was the effort to complete the improvement activity worth the outcome?*  *Did the team value the improvement activity?* | **Example:**   * *We believe the effort to complete the activity* ***was worthwhile*** *as we decreased the number of patients due for a 75 year and over Health Assessment.*   ***OR***   * *We believe this activity* ***was not worth*** *the effort required, as we did not significantly reduce the number of patients due for a 75 year and over Health Assessment.* |
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| **Learn**  *What lessons learnt*  *could you use for other improvement activities?*  *What worked well, what could have been changed or improved?* | **Example:**   * *Sending SMS reminders resulted in higher bookings than phone calls.* |
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| **What next?** | |
| **Sustain**  *Implement new processes and systems into business as usual - which parts of this activity, if any, will you incorporate into business as usual at your practice?* | **Example:**   * *Nurses/Doctors will continue to add in reminders for patients due for a Health Assessment.* |
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| **Monitor**  *Review target measure quarterly and initiate corrective measures as required.* | **Example:** *Review Primary Sense – Health Assessments Report once a month to track performance over time.* |
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| **Appendix 1 – Potential solutions** | |
| ***Review suggested implementation strategies listed below. You do not have to implement all options that are brainstormed/listed.***   * Identify eligible patients. For example, using Primary Sense - Health Assessments Report   + Staff to add a reminder and follow up with patients - could be by letter, SMS, secure email or phone call.   + Identify and flag patients with existing appointments (could focus on high-risk patients first), identify if staff has capacity to complete on the day, if not flag to be offered at time of visit and rebooked.   + If clinical staff do have time to complete at existing appointment, reception/ nurse to contact patient to ensure it is agreeable with them. * Consider implementing a process for new patients to add in reminders to ensure Health Assessments are completed (new patient questionnaire). * Consider implementing a process so that driver’s license renewal requests are linked with Health Assessment appointment. * Consider implementing this [Cycle of Care – over 75 years](https://gcphn.org.au/practice-support/support-for-general-practice/practice-based-population-health-management-program/#cycles-of-care) for complex patients. * Consider if your patient may be a suitable candidate for [My health for life,](https://www.myhealthforlife.com.au/) which is an evidence-based behavior change initiative for people at risk of developing chronic disease. Access the [Health Professional Toolkit here](https://gcphn.org.au/wp-content/uploads/2023/11/MH4L-Health-Professional-Toolkit-1.pdf). More information how to refer patients is found on the [GCPHN website here.](https://gcphn.org.au/patient-care/prevention/my-health-for-life/#my-health-for-life-information-and-resources) * Potential ways to promote Health Assessments for patients with their usual GP may include:   + practice webpage, newsletter, and social media pages   + during care plan and other routine appointments   + phone out of hours and on hold messages   + SMS alerts   + online booking system messaging * Review the [GCPHN Health Assessment QI Toolkit](https://gcphn.org.au/practice-support/support-for-general-practice/quality-improvement/qi-toolkits/#prevention) for further ideas. * Consider reviewing the [GCPHN Frailty Management QI Toolkit](https://gcphn.org.au/practice-support/support-for-general-practice/quality-improvement/qi-toolkits/#patient-populations) and implementing a process to assess patients for frailty within Health Assessments. Such as updating Health Assessment templates. * Monitor participation using excel spreadsheet and/or Primary Sense report. | |