

## QI Action Plan – add practice name

## Winter Wellness Strategy – Care of patients

## 70-74 yrs old

**Green- Instructions Yellow- add practice detail Teal- examples**

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| **Ask-Do-Describe** | |
| **Why do we want to change?** | |
| * Gap | The COVID-19 pandemic 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 diseases, 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 in the practice. |
| **How much** do we want to change? | |
| * Baseline | **Baseline data is your current performance,** 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 determined from the Primary Sense COVID-19 Vulnerable Patients report or the Patients with High Complexity (5 and 4) report.  **Patients with High Complexity (5 and 4) report:**   * Export list to excel (filter out all age groups, leaving 70-74yrs)   **COVID-19 Vulnerable Patients report:**  *Patients who* have **not** *had COVID-19 like signs and symptoms or testing done:*   * Export list to excel (filter out all age groups, leaving 70-74yrs)   *Patients who* have **had** *COVID-19 like signs and symptoms or testing done:*   * Export list to excel (filter out all age groups, leaving 70-74yrs) |
| * Target | **Target is the number of 70–74-year-old patients invited for care plan/review or missing items of care complete your goal**  Example: 100% of sample patients invited for care plan/review or missing items of care |
| * Sample | **Sample is the number or percentage of patients aged 70-74 which are invited for care plan/reviewed for missing items of care** **to meet your target**  XX % of patients aged 70-74 are invited for care plan/reviewed for missing items of care to meet your target  Example: could be all patients aged 70-74yrs of age  Tip (consider narrowing down your sample size by focusing on):  **Patients with High Complexity (5 and 4) report:**   * Export list to excel (filter out all age groups, leaving 70-74yrs) * Filtering options: patients with complexity of 5 * Hospital risk * Last medication review * GPMP/TCA due * No visit in last 6 months   **COVID-19 Vulnerable Patients report:**  *Patients who* have **not** *had COVID-19 like signs and symptoms or testing done:*   * Export list to excel (filter out all age groups, leaving 70-74yrs) * Filtering options: * Patients with 2 or more conditions * Missing or overdue influenza and pneumovax vaccines * No visit in last 6 months * ACG risk score of 4 or 5   *Patients who* have **had** *COVID-19 like signs and symptoms or testing done:*   * Export list to excel (filter out all age groups, leaving 70-74yrs) * Filtering options: * Patients with 2 or more chronic conditions * Major risk indicators * Last EDS * Telehealth billed |
| **Who** are involved in the change? | |
| Contributors | *Remove/change/add names as required*  Practice Manager/COVID-19 Team Leader  GPs/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)  Final meeting (date)  Tip: Consider your sample size and how long it will take to invite/complete items of care, such as GPMP/TCA |
| **How** are we going to change? | |
| * Potential solutions | *There are some options you could implement to. Please note you can choose 1 or more or amend/add your own as appropriate for your practice. You do not have to implement all options that are brainstormed/listed. Choose potential solutions that will work well in your practice and meet the needs of your patients and team.*  **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 AHP 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 |
| * Implement | *List your chosen solutions in order or implementation. Ensure task allocated to appropriate role.* |
| * Monitor | *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://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fgcphn.org.au%2Fwp-content%2Fuploads%2F2020%2F02%2FCQI-Practice-Meeting-Template.docx&wdOrigin=BROWSELINK)*. Plan date for review meeting to assess progress.*  *A minimum of one QI activity review/touchpoint is required. You can include multiple reviews/touchpoints – list by date. If you have only one review during the activity, remove secondary review dates/information that do not apply.*  Review 1 – Date:   * What is working/not working? * Has there been a change in your performance? If not, why not?   Review 2 – Date:   * What is working/not working?   Has there been a change in your performance? If not, why not? |
| **How much** did we change? | |
| * Performance | *This section is to be completed at end/closure of activity.*  *Remove/change/edit as required for your practice*  *Did you achieve your target?*  e.g. Number or percentage of patients that are invited for care plan/reviewed for missing items of care has increased from baseline 12 patients to 40 patients |
| * Worthwhile | *Please choose an option or add your own. More detail can be included as required*  Did the activity provide the outcome expected?  Did this process provide patients with the required information and services?  *e.g. – we believe the effort to complete the activity was worthwhile as all patients were invited for care plan/reviewed for missing items of care*  *OR*  *We believe this activity was not worth the effort required, as we did not significantly reduce the number of patients due for a care plan/reviewed for missing items of care* |
| * Learn | *What lessons learnt could you use for other improvement activities?*  *What worked well, what could have been changed or improved?*  *e.g., phone call to older patients resulted in higher bookings than SMS reminders* |
| **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* |