

## QI Action Plan – add practice name

## Winter Wellness Strategy – Care of patients with multimorbidity

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| **Green- Instructions**  **Yellow- add practice detail**  **Teal- examples** **Ask-Do-Describe** |
| **Why do we want to change?** |
| * Gap
 | Patients with multimorbidity 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 with multimorbidity 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 with multiple chronic conditions 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). Comorbidity refers to the occurrence of two or more diseases that a person experiences at one time. The growing burden of chronic disease means that effective treatment for patients with multiple chronic conditions and complex health care needs is vitally important. Development and implementation of new and innovative methods for early disease detection and treatment, including coordinated care planning, patient self-management and chronic disease management is a key role delivered by general practices [(AIHW – Australia’s Health 2016)](https://www.aihw.gov.au/reports/australias-health/australias-health-2016/contents/chapter-3-leading-causes-of-ill-health).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 [(RACGP – Guidelines for preventive activities in general practice)](https://www.racgp.org.au/FSDEDEV/media/documents/Clinical%20Resources/Guidelines/Red%20Book/Guidelines-for-preventive-activities-in-general-practice.pdf). 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 vulnerable patients with multimorbidity of 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 - Patients with High Complexity (ACG 4 & 5) Report COVID-19 Vulnerable Patients Report* XX of patients with multimorbidity’s eligible or due for care plan items

Example: current baseline performance is 100 patients with multimorbidity’s with no care plan |
| Target | **Target is the number of patients with multimorbidity’s with care plans completed to meet your goal**Example: * Initial target is to reduce the number of patients with missing care plans to 80
* 100% of sample patients invited for care plan/review or missing items of care
 |
| * Sample
 | **Sample is the number of multimorbidity patients that are eligible for a care plan to meet your target*** XX patients who do not have a care plan

Example: sample is 20 patients to reduce the number of patients with a missing care plan to 80Tip (consider narrowing down your sample size by focusing on):* ACG Score – Start with patients with ACG Score of 5 with no visit in last 3 months
* All Aboriginal or Torres Strait Islander patients with ACG Score of 5 with no visit recorded in last 3 months
* Specific age groups. E.g., 70+ age group
* Existing appointment to allow discussion and rebooking of Health Assessment appointment
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| **Who** are involved in the change? |
| Contributors | *Remove/change/add names as required* Practice Manager  GPs/Practice Nurses/Receptionists GCPHN QI Project Officer  |
| **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 care plans |
| **How** are we going to change? |
| * Potential solutions
 | *These are some options you could implement. 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.* **Identification:**Identify multimorbid patients: (Tip: target patients with no visit in last 3 months, ACG 5 score, more than 2 chronic conditions)* *Patients with High complexity (ACG 4 & 5) Report*

Eligible for Care plan/Review, PN review, HMR * *COVID-19 Vulnerable Patients Report*
* Identify patients eligible for missing Influenza or Pneumococcal vaccinations
* 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 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 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.
* Potential ways to promote care plans 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

**Service delivery option:*** Review eligibility for care plan or review
* 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 with multimorbidity
* [**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  Monitor participation using excel spreadsheet and/or Primary Sense |
| * Implement
 | List your chosen solutions in order of implementation1. 2.3. |
| * Monitor
 | *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? e.g. Regular whole of team meetings to evaluate, review planning and implementation. Optimise team meeting minutes as a record of your activities. Document meetings. |
| **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?**If not, consider new activity to test as above*e.g. Number of multimorbid patients due for a care plan has decreased from baseline XX to XX |
| * Worthwhile
 | *Did the activity provide the outcome expected?**Did this process provide patients with the required information and services?**Please choose an option or add your own. More detail can be included as required.**Example: we believe the effort to complete the activity was worthwhile as we decreased the number of multimorbid patients due for a care plan**OR**We believe this activity was not worth the effort required, as we did no significantly reduce the number of multimorbid patients due for a care plan* |
| * Learn
 | *What lessons learnt could you use for other improvement activities?* *What worked well, what could have been changed or improved?* *e.g., phone calls and letters result in higher bookings than SMS reminders for older patients* |
| **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* *e.g.,* * *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*
 |
| * Monitor
 | *Review target measure quarterly and initiate corrective measures as required.* *Consider monthly data review of eligible at-risk groups and invite to attend services etc* |