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

**Frailty Management and Healthy Ageing QI Activity**

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| **Ask-Do-Describe** | |
| **Why do we want to change?** | |
| **Gap** | Early recognition of frailty and appropriate interventions commenced.  *"Frailty is the most significant challenge to 'ageing well' in Australia. More than 20% of people become frail as they age.” Professor Ruth Hubbard* |
| **Benefits** | Registering in MyMedicare helps strengthen the relationship between patient, practice, GP, and healthcare team.  Increased understanding of the concept of frailty and its impact on ageing.  Increased use of the [frailty screening tool](https://gcphn.org.au/wp-content/uploads/2023/08/PHN011_Healthy-Ageing-Frailty-Brochure_INTERACTIVE_FINAL.pdf) to recognise older people with or at risk of frailty, which in turn supports treatment options and referral pathways for frailty which can assist with reducing further decline and supporting an older person to live at home independently for as long as possible reducing early entry into RACHs. |
| **Evidence** | Frailty is a common syndrome which occurs due to a combination of de-conditioning and acute illness on a background of existing functional decline that is often under recognised.  People with frailty have 2 to 3 times the health care utilisation of their non-frail counterparts and experience higher morbidity, mortality as well as lower quality of life.  Frailty can increase functional decline, increase the risk of falls, contribute to longer length of hospital stay and increased chance of institutionalisation and death [(RACGP aged care clinical guide (Silver Book))](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/silver-book/part-a/frailty).  Many of the causes of frailty can be managed and, in some cases reversed, to create better health outcomes and quality of life. It is therefore important to identify older people who are living with frailty. |
| **What** do we want to change? | |
| **Topic** | Identifying and managing patients at \*practice name\*  with frailty indicators that may require review or confirmation of their frailty status. |
| **How much** do we want to change? | |
| **Baseline**  *Baseline data is the % of*  *your current performance.*  *Baseline data for a Frailty Care QI activity can be found using for example the following Primary Sense report:* | **Example:**   * *\*XX\* patients have 1 or more frailty indicators and require review.*   ***Primary Sense User Tips (if needed - consider narrowing sample down by):***  *Frailty Care Management report*   * *Offer to patients with an existing appointment.* * *Focus on patients with lower complexity scores initially (*[*Adjusted Clinical Groups (ACG) category*](https://www.youtube.com/watch?v=QvUQeu36k78) *2-3). Specific age groups. e.g 65- 75 –year olds.* * *Focus on patients with a hospital risk score of 80% or more.* * *Focus on particular frailty indicators e.g falls, lives alone.* |
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| **Target**  *Your target is the planned % result of the improvement.* | **Example:**   * *Our practice aims to review (\*insert goal\*) patients that have one or more frailty indicators, using the frailty assessment tool. Confirmation of their frailty status has been made and intervention plan has been developed.* |
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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 project.* | **Baseline data report generated:**  **Implementation between (from/to):**  **Review meeting:**  **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:**   * *50 patients (100%) were identified on the Frailty Care Management Report and a frailty assessment was completed (50 patients had a FRAIL assessment completed). An intervention plan was then developed.* |
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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 completed an assessment of all patients found on the Frailty Management report and completed an intervention plan if needed.* |
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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:** *Patients are more engaged to creating a plan that is focused on their goal and what matters to them.* |
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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:**   * *Ensure frailty assessments and objective measures are incorporated into 75-year-old health assessment and 65-year-old chronic condition care plan templates.* * *Schedule a follow up appointment to discuss risk factors and make a frail management plan with the patient if you cannot complete all frailty management activities associated with the FRAIL scale in one appointment.* * *Continue to add reminders to re-do FRAIL scale in 12 months when a patient has a FRAIL scale assessment score of 0.* |
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| **Monitor**  *Review target measure quarterly and initiate corrective measures as required.* | **Example***: Review target measure quarterly and initiate corrective measures as required.* |
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| **Appendix 1 – Potential improvement strategies** |
| ***Review suggested improvement strategies listed below. You do not have to implement all options that are brainstormed/listed.*** **Be Aware of Frailty**   * All staff to be aware of what frailty is and how to recognise the concept of frailty and its complications.  **Early Identification**   * Identify patients with 1 or more frailty indicators using the Primary Sense report - Frailty Care Management. * Clinical staff to become aware of the [FRAIL Scale](https://gcphn.org.au/wp-content/uploads/2023/08/PHN011_Healthy-Ageing-Frailty-Brochure_INTERACTIVE_FINAL.pdf) and how to use it, to recognise older people with or at risk of frailty. * Increase the use of a frailty assessment tool by incorporating into regular encounters with older people, for example by integrating into 75 years and over health assessment and 65 years and over chronic condition care plan templates. * Consider integrating the following into health assessments: * [Measuring walking speed.](https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/frailty-gaitspeed.pdf) * Grip strength to indicate weakness. * [Mini nutrition assessment (MNA)](https://www.mna-elderly.com/). * Consider linking this activity with a health assessment QI activity concurrently to increase the number of health assessments completed and thus FRAIL assessments. Review the [Health Assessment QI Toolkit here.](https://gcphn.org.au/practice-support/support-for-general-practice/quality-improvement/qi-toolkits/#prevention)  **Targeted Intervention**  * Once a person has been [assessed](https://aci.health.nsw.gov.au/networks/frailty-taskforce/resources/frailty-screening-and-assessment-tools) as pre-frail (i.e. score of 1-2) or frail, (i.e. score > 3) using the FRAIL Scale Risk Assessment Tool, a management plan that addresses the relevant deficits of the person’s FRAIL scale should be developed. A [Frailty Management and Decision tool](https://gcphn.org.au/wp-content/uploads/2023/08/PHN011_Healthy-Ageing-Frailty-Brochure_INTERACTIVE_FINAL.pdf) can be utilised to support the plan. The targeted approach could include for example: * Patients own goals. * [Healthy eating to stay strong and independent](https://aci.health.nsw.gov.au/__data/assets/pdf_file/0010/724483/ACI-Healthy-eating-to-stay-strong-and-independent.pdf) (protein in the diet). * Discussion about simple resistance exercises to build muscle. * Referral to appropriate allied health professional (e.g. a physiotherapist, exercise physiologist or dietitian). * Managing weight loss. * Exercise classes (e.g. [Active & Healthy Program classes](https://www.goldcoast.qld.gov.au/Things-to-do/Active-Healthy-program) (Active Ageing section)). * [Reviewing medications, consider deprescribing and or/ refer to a Pharmacist for a Home Medicine Review (HMR)](https://aci.health.nsw.gov.au/networks/frailty-taskforce/resources/medication-review). * Focus on the [Older Persons Quality Care 5Ms](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6347324/#:~:text=In%202017%2C%20Canadian%20and%20US,matters%20most%20(Table%201).) – What matters most; Mobility, Mentation, Medicines and Malnutrition. * Consider affordability and provide options suitable for the patient. For example: Some patients might prefer to pay to attend group classes which have a social element. Others might prefer or require one-on-one consultation (e.g. with a physiotherapist or exercise physiologist). * Review the [Frailty Management in Primary Care QI Toolkit](https://gcphn.org.au/practice-support/support-for-general-practice/general-practice-quality-improvement-incentive-pip-qi-incentive/#frailty-and-healthy-ageing) for further examples. |