phn BRISBANE SOUTH
An Australian Government Initiative

QUALITY IMPROVEMENT TOOLKIT FOR GENERAL PRACTICE

Mental health

Improving physical health for people living with mental illness

MODULE

Version 2

November 2021

Introduction

The Quality Improvement (QI) toolkit

This QI toolkit is made up of modules that are **designed to support your practice to make easy, measurable and sustainable improvements to provide best practice care for your patients.** The toolkit will help your practice complete QI activities using the Model For Improvement (MFI).

Throughout the modules, you will be guided to explore your data to understand more about your patient population and the pathways of care being provided in your practice. Reflections from the module activities and the related data will inform improvement ideas for you to action using the MFI.

The MFI uses the Plan-Do-Study-Act (PDSA) cycle, a tried and tested approach to achieving successful change. It offers the following benefits:

- A simple approach that anyone can apply.
- Reduced risk by starting small.
- It can be used to help plan, develop and implement change that is highly effective.

The MFI helps you break down your change into manageable pieces, which are then tested to ensure that the change results in measurable improvements, and that minimal effort is wasted. There is an example of how to record height, weight and BMI using the MFI at the end of this module.

If you would like additional support in relation to quality improvement in your practice please contact Brisbane South PHN on support@bsphn.org.au.

This icon indicates that the information relates to the ten Practice Incentive Program Quality Improvement (PIP QI) measures.

Due to constant developments in research and health guidelines, the information in this document will need to be updated regularly. Please contact Brisbane South PHN if you have any feedback regarding the content of this document.

Mental illness and physical health QI toolkit goals and objectives

This toolkit is to be used in general practice to:

- identify those patients in your practice with a mental illness and ensure physical health measures are recorded
- develop a register of patients living with a mental illness to facilitate better continuity of care inclusive of physical health checks (reminders, recalls)
- better manage the physical health and comorbidities of patients living with a mental illness
- identify patients eligible for MBS item numbers and other funding streams.

How to use this toolkit

There are checklists included below that will guide you and your practice.

- Identify a sample group of patients by reviewing data measures from your practice population.
- Use this toolkit to guide you along the journey.
- Set yourselves timelines to achieve your goals.
- Consider potential internal or external factors that could impact the activity and factor these into your planning e.g. accreditation preparation, staff leave (planned or unplanned), global pandemic, influenza vaccination season.
- Review your progress regularly.
- If you find your process is not working and you are not seeing improvements, then review your process and start again.

For more support

support@bsphn.org.au

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Mental illness and physical health

Looking after physical health is important for everyone, but it can be an extra challenge for those living with a mental illness. Unfortunately, people living with mental illness experience disproportionately poorer physical health outcomes when compared to those not living with a mental illness. Poorer physical health may be related to the symptoms of the condition or the side effects of medication. It may be because of smoking, not getting enough exercise, or other lifestyle factors. Physical health problems can also be overlooked when the clinician's primary focus is assisting patients to manage their mental illness.

Many factors can contribute to these poorer health outcomes, as illustrated in the figure below:

[1]

The factors identified include:

- People living with mental illness are more at risk of weight gain, high blood pressure, high cholesterol and high blood glucose levels.
- People living with mental illness are twice as likely to have cardiovascular disease, respiratory disease, metabolic syndrome, diabetes or osteoporosis. They are also 65% more likely to smoke, six times more likely to have dental problems and comprise around one third of all avoidable deaths.

People living with severe mental illness e.g. moderate to severe depression, bipolar disorder, schizophrenia and other psychotic disorders generally have a life expectancy of 10-20 years shorter than the general population.[2] Around 80% of this higher mortality is due to physical illnesses such as cardiovascular and respiratory diseases and cancer. This is linked to lifestyle factors, side effects of medications and a lack of adequate physical healthcare. [3]

[1] https://www.equallywell.org.au/wp-content/uploads/2018/12/Equally-Well-National-Consensus-Booklet-47537.pdf
[2] https://www.who.int/
[3] https://www.ranzcp.org/home

Unfortunately, people living with severe mental illness are particularly at risk as illustrated in the figure below:

4

As a result, it is critical that management for people with mental illness is holistic and focuses on improving mental and physical wellbeing. Effective mental health care, alongside quality physical health care provided early, can significantly improve long term outcomes and overall wellbeing.

Role of general practice in mental health care

The role of primary care, and particularly general practice, in managing people's mental health care is significant. The majority of mental health care is delivered through general practice and other primary care services, with GPs providing mental health care to 75% of those seeking such help[5]. Many people who have been seriously affected by their mental illness manage this with only the support of a GP. For others, the GP will form an essential part of a wider multidisciplinary team of mental health service clinicians and community-based organisations.

Healthy eating behaviours, regular physical activity, safe alcohol consumption, and smoking cessation can help decrease the burden of chronic disease[6]. When incorporated with evidence-based psychological and clinical treatment, other interventions such as diet and exercise can provide a range of physical, social and mental health benefits for people living with a mental illness.

[4] https://www.equallywell.org.au/wp-content/uploads/2018/12/Equally-Well-National-Consensus-Booklet-47537.pdf
[5] https://www.aihw.gov.au/getmedia/656f6d35-a7e6-49ee-8130-ebe34f1a3fb6/ah02.pdf.aspx?inline=true
[6] https://www.who.int/nmh/events/ncd_action_plan/en/

Pre-activity checklist

Complete the checklist below to identify any pre-activities you may wish to complete.

Description	Status	Action to be taken
Has your practice completed data cleansing activities recently including: • missing patient demographics • un-coded diagnosis • indications of mental health conditions without a diagnosis.	☐ Yes: continue with activity. ☐ No, **see action to be taken.**	Refer to instructions from CAT4 **or** refer to activity 2 of the mental health introduction QI toolkit **or** quality patient records QI toolkit.
Have you agreed on accepted mental health terminology from the drop-down lists in your practice software?	☐ Yes: continue with activity. ☐ No, **see action to be taken.**	Refer to activity 2 of the mental health introduction QI toolkit.
Are practice team members aware of how to enter diagnosis in clinical software using agreed conditions?	☐ Yes: continue with activity. ☐ No, **see action to be taken.**	Refer to instructions from Best Practice or MedicalDirector.
Do you have a reminder system that is set up and working to ensure patients with a mental illness receive continuity of care?	☐ Yes: you have completed this activity. ☐ No, **see action to be taken.**	Refer to Brisbane South PHN recall and reminder QI toolkit.

Activity 1 – Introduction to understanding your patient's mental health profile

Activity 1.1 – Data collection from CAT4

The aim of this activity is to collect data to identify patients diagnosed or indicated as living with a mental illness from your practice to facilitate subsequent activities.

Complete the below table by collecting data from your CAT4 Data Extraction Tool.

Note - Instructions on how to extract the data is available from the CAT4 website: Number of patients with a mental health condition **or** Indicated mental health with no diagnosis **or** identify active patients with at least 3 visits in the last 2 years

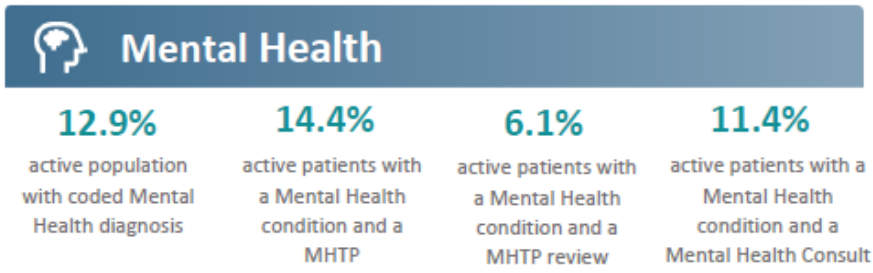
	Description	Total number of active patients as per RACGP criteria (3 visits in 2 years)	Total number of active patients
1.1a	Number of active patient population		
1.1b	Number of patients with a mental illness		
1.1c	Number of patients with indication of mental illness but no diagnosis		

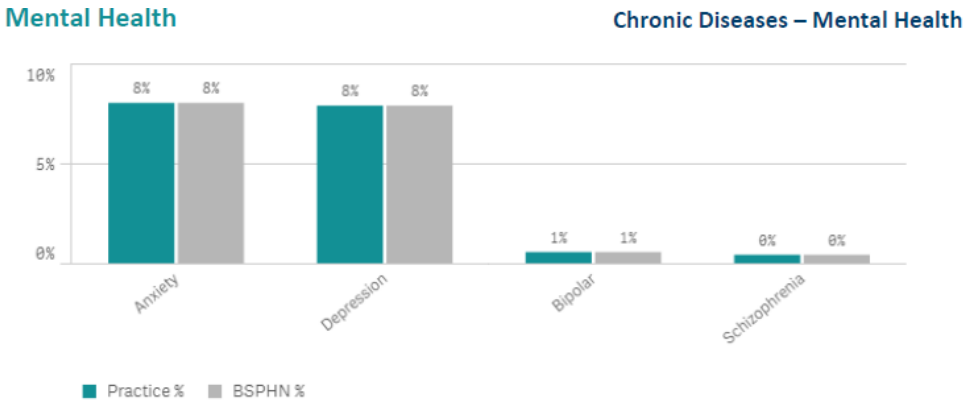
Please note: *the RACGP defines active as 3 x visits in 2 years. This search criteria does not capture those patients who may come in for screening every 2 years, or twice in 2 years e.g. flu vaccine, hence the option to look at all active patients.*

Activity 1.2 – Mental health measures on benchmark report

The aim of this activity is to review your practice's data dashboard on the monthly benchmark report provided by Brisbane South PHN.

You will need your practice's benchmark report to complete this information.





Mental Health Diagnosis*	-	- %	BSPHN	BSPHN %
Active Patients with a Mental Health diagnosis**	132,420		132,420	
Anxiety	82,115	8%	82,115	8%
Depression	80,736	8%	80,736	8%
Bipolar	5,710	1%	5,710	1%
Schizophrenia	4,297	0%	4,297	0%

	Description	Percentage
1.2a	Active population with coded mental health diagnosis	
1.2b	Active patients with a mental illness and a MHTP	
1.2c	Active patients with a mental illness and a MHTP review	
1.2d	Active patients with a mental illness and a mental health consult	
1.2e	Active patients with a diagnosis of anxiety	
1.2f	Active patients with a diagnosis of depression	
1.2g	Active patients with a diagnosis of bipolar	
1.2h	Active patients with a diagnosis of schizophrenia	

Activity 1.3 – Reviewing your practice mental health profile

Complete the checklist below to review your practice's mental health patients 'at risk' and diagnosed.

Description	Status	Action to be taken
After completing **activity 1.1 and 1.2**, are there any unexpected results with your practice's mental health profile?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. higher percentage of patients with a diagnosis of anxiety than other practices in the region.)*

Description	Status	Action to be taken
		How will this information be communicated to the practice team?
After reviewing your practice's mental health profile, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes, **see actions to be taken to help set you goals.** ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 2 - Understanding the lifestyle risk factors of your patients living with a mental illness

Physical activity

Regular exercise can reduce stress and symptoms of mental illness such as depression and anxiety. It also reduces the risk of illnesses such as heart and respiratory disease, obesity and cancer. Assessing physical activity levels amongst people living with mental illness is important to aid in incorporating an exercise program into part of their overall treatment plan. [7]

Smoking, alcohol and other drugs

There is a complex relationship between mental health and alcohol and other drug use. A mental illness may make a person more likely to use drugs to provide short term relief from their symptoms, while for others drug or alcohol problems may trigger the first symptoms of mental illness.[8] Smoking and alcohol use are significant contributors to the poorer physical health outcomes experienced by people with mental illness.

In Australia, while the prevalence of smoking is declining in the general community, it remains high among people living with a mental illness. Compared with the general population, people living with mental illness have higher smoking rates, higher levels of nicotine dependence, and a disproportionate health and financial burden from smoking.[9]

Alcohol can also have a major impact on mental and physical health. Studies suggest people who exceed the recommended alcohol intake are more likely to have higher levels of psychological distress and that the diagnosis of a mental illness is 1.2 - 1.3 times higher among those who drink at risky levels.[10] It is important to identify those with mental illness who are smokers or drink excessive amounts of alcohol in order to be able to help with smoking cessation and alcohol reduction. This can lead to improved mental and physical health.

Drugs and alcohol affect the chemical messaging processes in the brain, so it's difficult to predict how people respond to them. Everyone is different. Every drug is different. Illegal drugs contain unidentified contents and it's never possible to tell exactly what's in them. If people are taking prescribed medication for anxiety or depression alcohol, most illegal drugs interact with these medications and can reduce their effectiveness or increase the chance of side effects.[11]

Weight and BMI

People living with a mental illness may be at a higher risk of being overweight or obese. There is a complex relationship between weight and mental health. Weight gain may in some situations lead to poorer mental health and, conversely, some mental illness (and certain medications) may lead to weight gain. An Australian study found that three-quarters of people with a long-term psychotic illness were overweight or obese. [12] Identifying people who have a mental illness and who are also overweight or obese allows for tailored support for weight management to improve long-term health.

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[7] https://www.healthdirect.gov.au/exercise-and-mental-health

[8] https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/people-with-mental-health-conditions

[9] https://www.tobaccoinaustralia.org.au/chapter-7-cessation/7-12-smoking-and-mental-health

[10] https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/people-with-mental-health-conditions

[11] https://www.beyondblue.org.au/the-facts/drugs-alcohol-and-mental-health

[12] https://journals.sagepub.com/doi/10.1177/0004867412453089

Mental health and the effects on families

Mental illness often has a 'ripple effect' on families, creating tension, uncertainty, troubled emotions and big changes in how people live their lives. Different family members are likely to be affected in different ways. These effects on the family are sometimes not acknowledged by health professionals.

Families may also take on the role of day-to-day care. This often happens with little training or support, or acknowledgment of their own needs and mental health. When families are accepted as partners in care and do receive training and support, there is strong evidence that this leads to better outcomes for everyone involved.[13]

It is important to be receptive to concerns raised from family or carers as this additional information is helpful in managing a patients mental illness.

My health for life QI toolkit

Support for lifestyle improvements are available for eligible people through the *My health for life* program. Brisbane South PHN has a *My health for life* QI toolkit.

Activity 2.1 – Data collection from CAT4

The aim of this activity is to identify patients living with a mental illness and review their lifestyle factors that impact upon physical health.

Complete the below table by collecting data from your CAT4 Data Extraction Tool & your latest Benchmarking report provided by Brisbane South PHN.

Note - Instructions on how to extract the data is available from the CAT4 website: Number of patients with a mental health condition **or** Number of patients with smoking & alcohol status *(change condition to Mental Health)* **or** Number of patients with BMI recorded **or** Number of patients with BP recorded *(change condition to Mental Health)* **or** Physical activity status available on your benchmarking report.

	Description	Total number of active patients as per RACGP criteria (3 visits in 2 years)	Total number of active patients
2.1a	Number of patients with a mental illness *(from activity 1.1c)*		
2.1b	Number of patients with a mental illness and physical activity recorded		
2.1c	Number of patients with a mental illness with no physical activity recorded		
2.1d	Number of active patients with a mental illness aged 15+ years with smoking status recorded as current smoker		
2.1e	Number of active patients with a mental illness aged 15+ years with no smoking status recorded		
2.1f	Number of active patients with a mental illness aged 15+ years with an alcohol consumption status recorded		

[13] https://www.sane.org/information-stories/facts-and-guides/families-friends-carers

	Description	Total number of active patients as per RACGP criteria (3 visits in 2 years)	Total number of active patients
2.1g	Number of active patients with a mental illness aged 15+ years with no alcohol consumption recorded		
2.1h	Number of active patients with a mental illness aged 15+ years who have had a BMI recorded as 'overweight' in the previous 12 months		
2.1i	Number of active patients with a mental illness aged 15+ years who have had a BMI recorded as 'obese' in the previous 12 months		
2.1j	Number of active patients with a mental illness aged 15+ years with no BMI recorded in the previous 12 months.		
2.1k	Number of patients with a mental illness and their blood pressure recorded in the previous 6 months		

Activity 2.2 – Reviewing your practice mental illness and physical health profile

Complete the checklist below which reviews your practices patients living with a mental illness and their physical health status.

Description	Status	Action to be taken
After completing **activity 2.1** are there any unexpected results with your practice's physical health profile?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. high number of patients with a mental illness who do not have their smoking and alcohol status recorded).* How will this information be communicated to the practice team?
Do all clinicians know how to enter physical activity status in your practice's clinical software?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	See instructions on how to enter into Best Practice or MedicalDirector.

Description	Status	Action to be taken
Do all clinicians know how to enter alcohol and smoking status in your practice's clinical software?	☐ Yes: continue with activity. ☐ No: **see action to be taken**.	See instructions on how to enter into Best Practice or MedicalDirector.
Are all the risk factors being recorded in the correct fields in your clinical software? (e.g.: BP, BMI, waist circumference etc.)	☐ Yes: continue with activity. ☐ No, **see action to be taken.**	Review how and where your risk factor information is being recorded in your practice software. See instructions on entering information in Best Practice or MedicalDirector. Ensure all relevant team members are aware of how to record risk factor information. Document in practice policy.
After reviewing your practice's physical health profile, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes: **see actions to be taken to help set your goals.** ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 3 – Physical health care and monitoring for people with mental illness

Improving quality of health care

The Equally Well National Consensus on improving the physical health and wellbeing of people living with mental illness in Australia recommends the following criteria:

- a holistic, person centred approach to physical and mental health and wellbeing
- effective promotion, prevention and early intervention
- equity of access to all services
- improving quality of health care
- care coordination and regional integration across health, mental health and other services and sectors which enable a contributing life
- monitoring of progress towards improved physical health and wellbeing[14]

The following standards of care should also be met:

- Mental health care should also include documented physical health care checks as part of the routine care of people living with mental illness.
- Health assessments should be part of an integrated physical and mental health care plan developed together with the person living with mental illness, their family, carers and supporters.
- Assessments should consider the risk of developing conditions such as obesity, cardiovascular disease, respiratory illness, osteoporosis, diabetes and metabolic syndrome.
- Assessments should include a review of lifestyle, e.g. physical activity, nutrition, alcohol and drug use, treatment and medication effects.
- Impacts of medication (both positive and negative) should be regularly assessed.

Template for monitoring physical health amongst people with mental illness

To assist with ensuring patients receive optimal treatment in line with clinical guidance, teams can access a general patient screening template from the University of Western Australia.

GENERAL SCREENING FORM

NAME: **HEIGHT (CM):** **DATE COMMENCED:**

		DATE	Baseline	3 Months	6 Months	9 Months	12 Months	15 Months	18 Months	21 Months	24 Months
MEDICATION		BP (mmHg)	/	/	/	/	/	/	/	/	/
		f BSL (mmol/L)									
		Glucose Tolerance Test									
		LFT									
		Vitamin D									
		U & E's									
		ECG									
LIFESTYLE	Cholesterol:	TC									
		TG									
		HDL-C									
		LDL-C									
	Exercise:	Weight (kg)									
		BMI (kg/m²)									
		Abdo. Girth (cm)									
		Activity Level									
	Diet:	Nutritionist									
		Eating Guide									
	Smoking:	Yes/No									
	Dental:	Last Appointment									
	Contraception:										
PHYSICAL DISORDERS & ALLERGIES											
		HIV / STI's									
		Hepatitis C / B									
		Pregnancy Test									
ALCOHOL & ILLICIT DRUG USE	Alcohol:	AUDIT									
		SADQ-C									
	Other Drugs:	DAST-10									
		SDS									
PSYCHOSOCIAL		Familial Support									
		Social Support									
		SES & Employment									
		Culture									

[14] https://www.equallywell.org.au/wp-content/uploads/2018/12/Equally-Well-National-Consensus-Booklet-47537.pdf

People with psychosis or schizophrenia

Life expectancy for adults with psychosis or schizophrenia is between 15 and 20 years less than the general population.[15] Unfortunately, a significant portion of this reduced life expectancy is due to poorer physical health such as an increased risk of cardiovascular disease, metabolic disorders and type 2 diabetes. Up to 90% of people with schizophrenia have a chronic physical illness. [16] Antipsychotics, while forming an essential part of treatment, can exacerbate metabolic risk factors. As a result, it is important to comprehensively assess and manage the physical and mental health of people with psychotic disorders.

Suggested physical health monitoring in Australian general practice for people with schizophrenia or on long term antipsychotics

Description	Frequency	Reason/Intervention
Smoking Status	Baseline, every visit.	Motivational interviewing or QUIT program.
Weight	Baseline, every 3 months for first year, then every 6 months.	Intervene if body mass index >25 kg/m^2.
Waist circumference	Baseline, every 3 months for first year, then every 6 months.	Intervene if >94 cm for males and >80 cm for females.
Blood pressure	Baseline, every 3 months for first year, then every 6 months.	Intervene if systolic blood pressure is >130 mmHg and diastolic blood pressure is >85 mmHg.
Fasting glucose	Baseline, every 3 months for first year, then every 6 months.	If fasting blood sugar levels 5.6–7 mmol/L then glucose tolerance test.
Fasting cholesterol and lipids	Baseline, every 3 months for first year, then every 6 months.	Intervene if triglycerides >1.7 mmol/L, high-density lipoprotein <1.03 mmol/L in male and <1.29 mmol/L in female.
Prolactin	Baseline, then annually.	If high and symptomatic, refer to endocrinologist.
ECG	Baseline, then annually in additional to at each change of antipsychotic dose.	If QTc prolonged, refer to cardiologist.
Liver function tests	Baseline, then annually.	Antipsychotic induced transaminitis.
Neurological examination	Baseline, then annually.	Movement disorder.
Eye examination	Biannually.	Detection of cataracts, especially if on quetiapine and chlorpromazine.
Contraception review (women only)	Annually.	Counselling for prevention of unwanted pregnancy.

[15] https://www.nice.org.uk/guidance/qs80/chapter/Quality-statement-6-Assessing-physical-health
[16] https://www.racgp.org.au/afp/2015/november/chronic-schizophrenia-and-the-role-of-the-general-practitioner/#27

Medication safety monitoring

Many people with mental illnesses take medication as an essential part of their treatment plan. GPs prescribe the majority (86%) of psychotropic medications, and the use of medications to treat mental illness has increased significantly over the last 20 years. Unfortunately, people with severe mental illness have between four and eight medication-related problems per person on average, including drug interactions and adverse drug reactions. Regular monitoring of the benefits and possible side effects of long-term psychotropic medications is an important part of an overall treatment plan.

Some people with mental illness may be treated with long acting (depot) medications. It is important to ensure practices have a reminder system in place for regular depot administration.[17]

Some people with mental illness will be eligible for a home medication review by a pharmacist. Details on eligibility are included in the MBS toolkit. Some medication changes may require review or input from a psychiatrist. Refer to GP Psychiatry support line.

Certain psychotropic medications may also require additional monitoring. For example, there are detailed guidelines on the management and monitoring of people taking the antipsychotic Clozapine. It is important that all practitioners involved in the care of people taking psychotropic medications are familiar with the guidelines for monitoring medication safety.

Monitoring for people taking lithium

Lithium is often used as part of treatment for people with bipolar disorder and may also be used as a mood stabiliser for people with other mental illnesses. Lithium requires regular monitoring of serum levels to ensure the dose is adequate and not too high to cause toxicity which can be life threatening. Lithium also requires long term monitoring as it can affect kidney and thyroid function. Unfortunately, audits consistently show that monitoring for people on lithium is suboptimal. [18]

Recommendations for monitoring patients on lithium:

Description	Frequency
Lithium plasma levels	3-6 months.
Renal function (eGFR)	Baseline, then every 3-6 months.
Thyroid function (TFTs)	Baseline, then every 6-12 months.
Calcium	Baseline, then annually.
Weight	Baseline, then annually.

[17] https://www.safetyandquality.gov.au/sites/default/files/migrated/Medication-Safety-in-Mental-Health-final-report-2017.pdf

[18] https://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/WATAG/WAPDC/Bipolar-disorder-pharmacological-treatment-October-2009.pdf

Activity 3.1 – Reviewing management of patients with psychotic illness and bipolar disorder

Complete the checklist below to review the management of patients at your practice with psychotic illnesses and bipolar disorder

Description	Status	Action to be taken
Do you have any patients at your practice with schizophrenia who do not have an ECG recorded in the past 12 months?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Identify patients with schizophrenia and review their status of ECG recorded. Include a reminder for patients who are missing an ECG. How will this information be communicated to the practice team?
Do you have a system for ensuring regular monitoring and reminders are in place for people on long term antipsychotics? (*e.g. depot injection, ECG, blood tests*)	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to recall and reminders section.
Do you have a system for ensuring regular blood tests and monitoring is occurring for people on lithium?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to recall and reminders section.
Are healthcare providers familiar with guidelines on managing and monitoring psychotropic medications?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to the guidelines.
After reviewing your practice's system for managing patients with psychotic illnesses and bipolar disorder, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes: **see actions to be taken to help set your goals.** ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 3.2 - Identify roles for managing physical health assessment for people with mental illness

Consider how best to use your practice staff to provide optimum care.

Activity	Nurse	GP	Admin
Organise investigations (as appropriate)			
Monitor blood pressure			
Height, weight & BMI			
Complete cardiovascular risk assessment			
Update patient reminders for regular monitoring			
Review diet/healthy eating			
Review physical activity and exercise tolerance			
Review smoking & alcohol intake			
Review substance and drug use			
Complete ECG (particularly for those on antipsychotics, mood stabilisers and certain antidepressants)			
Assess support from family, carers or other support people			
Offer support services			
Provide self-care education			
Complete mental health assessment			
Consider comorbidities (CKD, diabetes, cardiovascular disease, lung cancer)			
Review medications			
Complete mental health treatment plan and review			
Home medication review (if appropriate)			
Assess need for referral to other mental health providers			
Consider advanced care planning			
Complete risk assessments			
Consider GPMP and TCA (if eligible)			

Activity 3.3 – Reviewing your practice assessment process for managing physical health assessments for people with mental illness

Complete the checklist below to review your systems on completing physical assessments for people living with mental illness.

Description	Status	Action to be taken
Do you have a system to ensure all patients with mental illnesses have regular physical health assessments?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	□ *System working well.* □ *System in place, but needs reviewing.* □ *System needs developing.* Refer to the assessment guidelines. How will this information be communicated to the practice team?
Do relevant team members understand their role in completing physical assessments for patients living with mental illness?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to activity 3.1 – Identify roles for managing physical health assessments
Do relevant team members know how to set-up a Topbar prompt to improve recording of data in patient's medical records?	☐ Yes: continue with activity. ☐ No, **see action to be taken.**	See Topbar instructions.
After reviewing your practice's physical health assessment processes, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes: **see actions to be taken to help set your goals.** ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 4 – Mental illness and comorbidities

People living with a mental illness have an associated higher risk of obesity, diabetes, respiratory disease and cardiovascular disease.[19] Four out of every five people living with mental illness have a co-existing physical condition. Identifying this comorbidity allows for more effective holistic management of their physical and mental health. Chronic health problems can also increase the likelihood of a mental health problem, or confound efforts to better manage a physical health problem e.g. lack of motivation or ability to participate in enjoyable activities.

Mental illness and diabetes

Up to 50% of people diagnosed as having diabetes are also thought to have a mental illness.[20]

Research shows that having diabetes more than doubles the risk of developing depression. Living with a chronic condition like diabetes, coping with biological and hormonal factors, plus needing to manage the condition on a daily basis may increase the risk of depression. People may find it harder to deal with everyday tasks and over time, managing their diabetes can take its toll. This may in turn lead to their usual diabetes care being neglected.[21]

People with severe mental illness such as schizophrenia and bipolar disorder are between 2 to 3 times more likely to have diabetes. Antipsychotic medications, while often essential, are linked with weight gain and a rise in blood sugars.[22]

It is critical to identify diabetes in people with mental illness to allow treatment of both conditions and improve long term outcomes.

Brisbane South PHN has a diabetes QI toolkit to assist with managing patients with diabetes and identify patients at risk.

Mental illness and cardiovascular disease

Coronary heart disease (CHD) and mental illness are among the leading causes of morbidity and mortality worldwide. Research has suggested several links between CHD and mental illness, and that each may cause the other.[23] For example, depression can be as big a risk factor for CHD as smoking, high cholesterol levels and high blood pressure. Depression can also affect the recovery of people with coronary heart disease and increase their risk of further complications.

People with severe mental illness including schizophrenia, bipolar and severe depression have a 53% higher chance of cardiovascular disease than people living without these conditions. Cardiovascular disease is one of the major contributors to the reduced life expectancy amongst people with severe mental illness. [24]

For people with depression, the risk of developing cardiac disease, hypertension, stroke, diabetes, metabolic syndrome or obesity is around 40% higher than the general population. Conversely, the Heart Foundation recommends all people with cardiovascular disease have mental health screening. [25]

Identification of mental ill health amongst people with CVD allows for the optimisation of treatment of patients' physical and mental illness to improve long-term outcomes.

Brisbane South PHN has a cardiovascular QI toolkit to assist with managing patients with CVD.

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[19] https://www.thelancet.com/pdfs/journals/lanpsy/PIIS2215-0366(19)30132-4.pdf
[20] https://www.diabetesaustralia.com.au/depression-and-mental-health
[21] https://www.diabetesaustralia.com.au/depression-and-mental-health
[22] https://care.diabetesjournals.org/content/early/2018/05/14/dc18-0425
[23] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6016051/
[24] https://www.bmj.com/content/357/bmj.j2339
[25] https://www.mja.com.au/journal/2013/198/9/screening-referral-and-treatment-depression-patients-coronary-heart-disease

Mental illness and cancer screening

People living with a mental illness are also less likely to participate in cancer screening. They are also more likely to die from cancer, which highlights the importance of ensuring regular screening.[26]

Brisbane South PHN has a cancer screening toolkit to assist with identifying under screened patients.

Mental illness and suicide risk factors

GP involvement in suicide assessment

Research shows that quality mental health care can reduce suicidal thinking and prevent suicidal behaviour. It is important that clinicians are equipped with skills to discuss suicide and suicide risk with their patients. This involves a comprehensive psychosocial assessment and assessment of suicidality.[27]

It is important to be aware of risk factors for suicide and evaluate the risk of suicide through the following steps:

- Assessment of suicide risk involves enquiring into the extent of suicidal thinking and intent. This includes assessing the following; suicidal thinking (if present, how frequent and how persistent?), plan (if present how detailed and realistic is it?), lethality (what method has been chosen and how lethal is it?), means (does the person have the means to carry out the method?), past history (has the person ever planned or attempted suicide?), history of suicide of family member or peer.
- Also consider risk and protective factors, mental state (e.g. hopelessness, despair, psychosis, agitation, shame, anger, guilt, impulsivity), substance use, strengths and supports.
- For all people with suicidal ideation, enquiry should be made about preparatory activities e.g. obtaining a weapon, planning, putting affairs in order, giving away possessions, preparing a note etc.
- For young people, the HEADSSS tool has questions that can assist in assessing suicide risk.

Responding to suicide risk

It is important that clinicians are equipped to discuss and develop a suicide safety plan. Safety planning has been shown to reduce suicide risk and increase engagement with health services when used in combination with evidence-based therapy. It is important to involve the patient in treatment planning and to have a recovery-oriented focus. For people at a high and immediate risk of suicide, it is important that GPs and practice staff are aware of how to access immediate assistance if required. This may involve the local hospital or acute mental health service. Occasionally, for those at immediate danger to themselves or others, this may require calling 000 and using the acute mental health assessment.

ThinkGP has more information about training options.

Mental illness and physical disability

Living with a disability, physical or intellectual, affects many parts of a person's overall wellbeing. Mental health is no exception.

In Australia, almost one in five people have a disability of some kind. The Royal Children's Hospital defines an intellectual disability as "a significant impairment of cognitive and adaptive functions, with age of onset before 18 years." Around three per cent of the Australian population live with an intellectual disability.

A physical disability refers to a condition that limits bodily function in some way. It can be the result of a medical issue you were born with, or an accident/illness later in life. Physical disability is common in Australia:

- Every week, five people sustain a spinal cord injury.
- Every week, 10–15 people sustain a severe brain injury.
- Every 13 hours, a child is born with cerebral palsy.
- One in six people are affected by hearing loss.
- Approximately 575,000 people are blind or vision-impaired.

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[26] https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(19)30414-6/fulltext

[27] https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/red-book/psychosocial/suicide

Activity 4.1 – Reviewing your practice profile of people with both mental illness and chronic physical illness

The aim of this activity is to identify people within your practice who have both a mental illness and chronic physical illness, to allow for optimising holistic team-based care of both conditions.

Complete the below table by collecting data from your CAT4 Data Extraction Tool.

Note - Instructions on how to extract the data are available from the CAT4 website: Number of patients with a mental health condition **or** condition filtering **or** identify patients eligible for a GP Management Plan (*select yes for mental health and diabetes in the conditions and mental health and cardiovascular disease in conditions).*

	Description	Total number of active patients as per RACGP criteria (3 visits in 2 years)	Total number of active patients
4.1a	Number of active patients with a mental illness *(from activity 1.1c)*		
4.1b	Number of active patients with a mental illness and diabetes		
4.1c	Number of active patients with a mental illness and coronary heart disease		
4.1d	Number of active patients with a mental illness and diabetes who have not had a GPMP claimed in the past 12 months		
4.1e	Number of active patients with a mental illness and coronary heart disease who have not had a GPMP claimed in the past 12 months		

Please note: *the RACGP defines active as 3 x visits in 2 years. This search criteria does not capture those patients who may come in for screening every 2 years, or twice in 2 years e.g. flu vaccine, hence the option to look at all active patients.*

Activity 4.2 – Reviewing your practice mental illness and chronic physical health profile

Complete the checklist below to review your practice's patients with a mental illness and their chronic physical health status.

Description	Status	Action to be taken
After completing **activity 4.1**, are there any unexpected results with your practice's chronic physical health profile?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. higher number of patients with mental illness and diabetes than expected).*

Description	Status	Action to be taken
		How will this information be communicated to the practice team?
After reviewing your practice's chronic physical health profile, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes: **see actions to be taken to help set your goals.** ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 5 – Medicare item numbers, mental illness and physical health

Patients with a mental illness ***may be eligible*** to access item numbers within the Medicare Benefit Schedule (MBS). These are dependent on patient age, ethnicity and co-morbidities. Conditions apply to each item number: please ensure the GP understands these prior to claiming the item number/s. Brisbane South PHN has a comprehensive toolkit looking at MBS items, however, a summary of the item numbers include:

MBS items

- Mental health consultation (MBS 2713)
- Mental health treatment plan (MHTP)
- Mental health treatment plan (MHTP) review
- Aboriginal and Torres Strait Islander health assessment
- Health assessments
- Home medication review
- ECG
- Heart Health Check
- MBS telehealth fact sheet

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

Mental health and chronic disease plans for the same patient

The Chronic Disease Management (CDM) Medicare items continue to be available for patients with chronic medical conditions, including patients needing multidisciplinary care.

Patients with a mental disorder only, who require a treatment plan to be prepared, should be managed under the GP Mental Health Treatment items (MBS items 2700, 2701, 2712, 2713, 2715 and 2717).

Where a patient has a mental disorder as well as significant co-morbidities and complex needs requiring team-based care, the GP is able use both the CDM items (for team-based care) and the GP Mental Health Treatment items.[28]

Please note: GPs should always ensure they fully understand the criteria from Medicare before claiming the item number.

[28] https://www1.health.gov.au/internet/main/publishing.nsf/Content/pacd-gp-mental-health-care-pdf-qa#7_1

Activity 5.1 – Data Collection from CAT4

The aim of this activity is to review your practices claiming of MBS item numbers for patients with mental illness.

Complete the below table by collecting data from your CAT4 Data Extraction Tool.

Note - Instructions on how to extract the data is available from the CAT4 website.

	Description	Number of eligible patients	Number of MBS items claimed
5.1a	Number of patients with a mental illness *(from activity 1.1)*		
5.1b	Number of patients with a mental illness and an MH consult claimed in the past 12 months		
5.1c	Number of patients with a mental illness and an MHTP claimed in the past 12 months		
5.1d	Number of patients with a mental illness and an MHTP review claimed in the past 12 months		
5.1e	Number of patients with a mental illness and a health assessment claimed in the past 12 months *(please note: patient must meet the criteria for the health assessment)*		
5.1f	Number of patients with a mental illness and an Aboriginal and Torres Strait Islander health assessment claimed in the past 12 months *(please note: patient must meet the criteria for the health assessment)*		
5.1g	Number of patients with a mental illness who have had a HMR completed in the past 12 months *(please note: patient must meet the criteria for home medication review)*		
5.1h	Number of patients with a mental illness who have had a GPMP completed in the past 12 months *(please note: patient must have another chronic medical condition)*		

Activity 5.2 – Checklist for reflection on MBS claiming

Complete the checklist below to review your practice's MBS claiming for patients with a mental illness.

Description	Status	Action to be taken
After completing **activity 5.1** are there any unexpected results with your practice's mental health profile?	☐ Yes, **see action to be taken.** ☐ No, continue with the activity.	Please explain. What action will you take?

Description	Status	Action to be taken
Are there any patients with mental illness who would benefit from a health assessment? *(note not all patients are eligible for a health assessment).*	☐ Yes, **see action to be taken.** ☐ No, continue with the activity.	Please explain. What action will you take? How will you use this information to increase the number of health assessments on people living with mental illness?
Are there any patients with mental illness who may benefit from a HMR? (*note: not all patients with mental health will be eligible for an HMR, refer to MBS criteria).*	☐ Yes, **see action to be taken.** ☐ No, continue with the activity.	Please explain. What action will you take? How will you use this information to increase the number of HMR's completed?
Have you created a TopBar prompt on all patients with mental illness who may be eligible for a health assessment?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Follow the instructions to complete this.
Do you know the contact details for any MBS related questions?	☐ Yes, continue with the activity. ☐ No, **see action to be taken.**	Email: askMBS@health.gov.au Provider Enquiry Line - 13 21 50
Do relevant staff know that Medicare provides online training modules?	☐ Yes, continue with the activity. ☐ No, **see action to be taken.**	More information can be obtained from Medicare Australia e-learning modules.
After reviewing the MBS claiming for patients with a mental illness, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes: **see actions to be taken to help set your goals.** ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 6 – Recall and reminders

As part of the RACGP accreditation standards, it is a requirement that practices provide health promotion, illness prevention, preventive care and a reminder system based on patient need and best available evidence. Brisbane South PHN have a comprehensive toolkit to assist you to review your practice recall and reminder systems, however, the aim of this activity is to assist with mental illness specific recall and reminders. You can also access other QI tools via medical software modules that will assist your practice to merge duplicate recall/reminder lists in your practice's clinical software. These modules are:

- Module 7 – Recalls, Reminders and Screening using MedicalDirector
- Module 8 – Recalls, Reminders and Screening using Best Practice

You can access these modules via DiscoverPHN**.**

Activity 6.1 – Reminder system

The aim of this activity is to review the practice's reminder system.

Question to consider	Status	Action to be taken
Do clinicians know how to initiate a patient reminder within clinical software?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to instructions from Best Practice or MedicalDirector. Arrange education on setting up patient reminders for relevant team members.
Is there a system for ensuring patients recently diagnosed with a mental illness are incorporated into the reminder system	☐ Yes, policy is working. ☐ Yes, policy is not working, see action to be taken. ☐ No policy, **see action to be taken.**	Revise policy Practice policy on reminders to be implemented
Does the recall and reminder system take into consideration patients with low English proficiency?	☐ Yes, policy is working. ☐ Yes, policy is not working, **see action to be taken**. ☐ No policy, **see action to be taken.**	Revise or implement practice policy. Letters and voice phone messages can be confusing for patients with limited or no English. Using the Translating and Interpreting Service to call the patient or sending text messages can be more effective. Consider using the online Appointment Reminder Translation Tool.
After reviewing your practice's recall and reminder system, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes, **see action to be taken to help set your goals**. ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

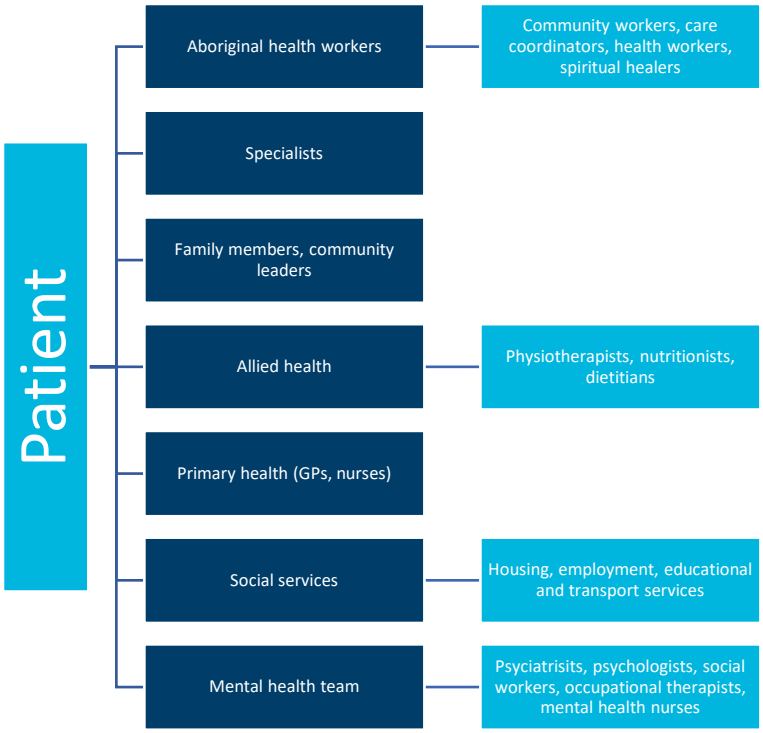
Activity 7 - Referral pathways

The aim of this activity is to ensure that practice staff have access to the relevant information and understand pathways for referral of patients to specialists and allied health staff as deemed clinically appropriate.

Engaging other medical services (e.g. diagnostic services; hospitals and consultants; allied health; social, disability, financial, housing, training, supported employment, alcohol and drug treatment and community services) assist the practice to provide optimal care to patients whose health needs require integration with other services.

Multidisciplinary teams convey many benefits to both service users and the mental health professionals working on the team, such as continuity of care, the ability to take a comprehensive, holistic view of the service user's needs, the availability of a range of skills, and mutual support and education.[29] Refer to interdisciplinary care to enhance mental health and social and emotional wellbeing to obtain more information about specific roles and responsibilities.

Potential members of the multidisciplinary mental health team



Essential referral information for mental health patients

Metro South 24-hour phone support

The Metro South community can access local mental health services for information and assistance in times of mental health crisis 24 hours a day via a centralised phone number: 1300 MH CALL (1300 64 22 55).

Refer Your Patient

Metro South Health is the major provider of public health services and health education and research in the Brisbane south side, Logan, Redlands and Scenic Rim regions. The Refer Your Patient Website assists health professionals with access to public health services for patients and provides a single point of entry for all new referrals. The website outlines available health professionals, criteria to access appointments with the health professionals and expected wait times, as well as all the information required in the referral.

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29 https://www.researchgate.net/publication/260125071_Interdisciplinary_Care_to_Enhance_Mental_Health_and_Social_and_Emotional_Wellbeing

SpotOnHealth HealthPathways

SpotOnHealth HealthPathways provides clinicians in the greater Brisbane south catchment with web-based information outlining the assessment, management and referral to other clinicians. It is designed to be used at point of care primarily by general practitioners but is also available to specialists, nurses, allied health and other health professionals.

Primary Mental Health and Wellbeing Initiatives

Brisbane South PHN commissions mental health, suicide prevention, and alcohol and other drug services designed to provide flexible support that is best suited to an individual's needs. There are three sub-regions:

- Brisbane (Princess Alexandra Hospital catchment area)
- Logan/Beaudesert (Logan Hospital catchment area)
- Redlands (Redlands Hospital catchment area)

Assistance is available for GPs to link to Brisbane South PHN commissioned mental health services.

Health Services Directory

Health Services Directory is a joint initiative of all Australian governments, delivered by HealthDirect Australia, to enable health professionals and consumers to access reliable and consistent information about health services.

My Community Directory

My Community Directory lists organisations that provide services that are free or subsidised to the public in thousands of locations across Australia. These services are organised into various Community Directories.

Other services

If you can't find a service that suits your needs, these may help:

- Alcohol and Drug Information Service
- Ask Izzy
- Head to Health
- Lifeline
- Metro South Health
- Suicide Call Back Service

Activity 7.1 – Referral pathways

Complete the checklist below in relation to referral pathways.

This activity is designed to raise your awareness of local referral options available for you and your patients to facilitate co-ordinated and therefore optimal care.

Question to consider	Status	Action to be taken
Do all GPs and nurses have login details for SpotOnHealth HealthPathways?	☐ Yes, continue with activity. ☐ No, see **action to be taken.**	Register on the login page to request access.
Do all GPs and nurses know how to access SpotOnHealth HealthPathways via Topbar?	☐ Yes, continue with activity. ☐ No, see **action to be taken.**	Follow the instructions. Or contact BSPHN Digital Health Team via email: ehealth@bsphn.org.au.
Do all GPs and nurses know how to refer to Brisbane South PHN commissioned mental health, suicide prevention and alcohol and other drug services?	☐ Yes, continue with activity. ☐ No, see **action to be taken.**	Refer to Brisbane South PHN.

Question to consider	Status	Action to be taken
How will you communicate information so clinicians know where to access details on referring a patient to specialist services?	What is the practice plan for communicating referral information?	
After reviewing your referral pathways for patients with a mental illness, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes, **see action to be taken to help set your goals**. ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 8 – Resources

- Brisbane South PHN Primary Mental Health & Wellbeing initiatives
- Collaborative handbook recommendation for monitoring people with serious mental illness
- RANZCP – Physical health and mental illness
- WHO guidelines – Physical health and severe mental disorders
- The Lancet – Physical health in mental illness
- RACGP – Chronic schizophrenia and the role of the general practitioner
- NPS – Managing the metabolic adverse effects of antipsychotic drugs in patients with psychosis
- Equally well - Improving the physical health and wellbeing of people living with mental illness in Australia
- Graylands hospital - drug bulletin - Using lithium safely
- Medication safety in mental health
- Safe and quality use of clozapine therapy in mental health services
- Clinical Guidelines for the Physical Care of Mental Health Consumers
- First Nations Health Focus
- GP Psychiatry support line
- Wellbeing First Report (Queensland Alliance for Mental Health).

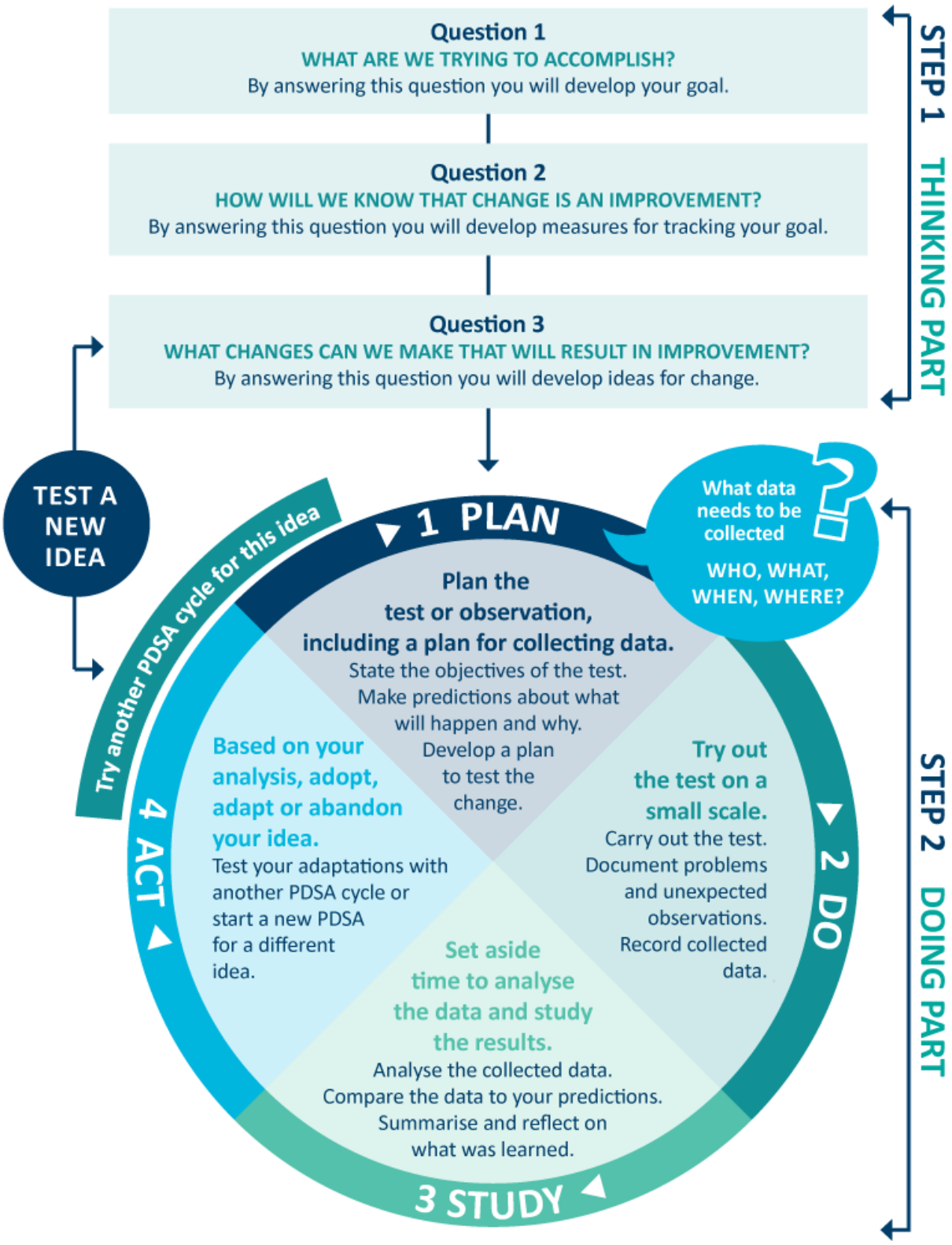
Links to other QI toolkits

After completing this toolkit, you may benefit from choosing one of the following:

- Anxiety and depression – this toolkit is designed to assist practices to review their patients who may be affected by a anxiety and depression.
- Alcohol and other drugs — this toolkit is designed to identify patients, develop a register of patients to facilitate better continuity of care and better manage the physical health and comorbidities of patients experiencing problematic substance use and/or dependency.
- Eating disorders – this toolkit can assist to identify patients with and at risk of an eating disorder, including screening and assessment of those with relevant comorbidities or presentations. It also includes prevention, early identification, appropriate intervention including referral pathways and identifying eligible MBS eating disorder and other funding streams.

The full suite of toolkits are available on Brisbane South PHN's website.

Model for Improvement diagram



Source: http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx

MFI and PDSA template EXAMPLE

Step 1: The thinking part - The 3 fundamental questions

Practice name:	**Date:**
Team members:	

Q1. What are we trying to accomplish? (Goal)

By answering this question, you will develop your GOAL for improvement.

Record this as an S.M.A.R.T. goal (**S**pecific, **M**easurable, **A**chievable, **R**elevant, **T**ime bound).

Our goal is to:

Ensure all patients with a mental health diagnosis have a height, weight and BMI recorded.

This is a good start, but how will you measure whether you have achieved this goal? The team will be more likely to embrace change if the goal is more specific and has a time limit.

So, for this example, a better goal statement would be:

Our S.M.A.R.T. goal is to increase the proportion of our active patients with a mental illness who have a height, weight and BMI recorded by 10% by 14th February.

Q2. How will I know that a change is an improvement? (Measure)

By answering this question, you will determine what you need to MEASURE in order to monitor the achievement of your goal. Include how you will collect your data (e.g. CAT4 reports, patient surveys etc.). Record and track your baseline measurement to allow for later comparison.

We will measure the percentage of active patients who have their alcohol consumption recorded. To do this we will:

A) Identify the number of active patients with an active mental illness.

B) Identify the number of active patients with an active mental illness who have had their height, weight and BMI recorded.

B divided by A x 100 produces the percentage of patients who have had their height, weight and BMI recorded.

BASELINE MEASUREMENT: 57% of active patients with a mental illness have their height, weight and BMI recorded.

Q3. What changes could we make that will lead to an improvement? (List your IDEAS)

By answering this question, you will generate a list of IDEAS for possible changes you could implement to assist with achieving your S.M.A.R.T. goal. You will test these ideas using part 2 of this template, the 'Plan, Do, Study, Act (PDSA)' cycle. Your team could use brainstorming or a driver diagram to develop this list of change ideas.

IDEA: Identify active patients with a mental illness with no height, weight and BMI recorded.

IDEA: Create a Topbar prompt for eligible patients who do not have their information recorded.

IDEA: Ensure the whole of practice team is aware of the goal and encourage all team members to enter missing information.

IDEA: Organise a campaign targeted at patients with a mental illness aged 65 to 74 years to attend for a heart health check.

Note: Each new GOAL (1st Fundamental Question) will require a new MFI plan.

Source: Langley, G., Nolan, K., Nolan, T., Norman, C. & Provost, L. 1996, The Improvement Guide, Jossey-Bass, San Francisco, USA.

MFI and PDSA template

Step 2: The doing part - Plan, Do, Study, Act

You will have noted your IDEAS for testing when you answered the 3rd fundamental question in step 1. You will use this template to test an idea. Ensure you communicate the details of the plan to the entire practice team.

IDEA	Record the change idea you are testing
Which idea are you going to test? *(Refer to Q3, step 1 above)*	
Organise a campaign targeted at patients with a mental illness aged 65 to 74 years to attend for a heart health check.	
PLAN	**Record the details of how you will test your change idea**
Plan the test, including a plan for collecting data	What exactly do you plan to do? Record who will do what; when they will do it (day, time etc) and for how long (1 week, 2 weeks etc); and where (if applicable); the data to be collected; and predictions about the outcome.
WHAT: Charlie will conduct a search on CAT4 to identify active patients with an active mental illness aged 65 to 74 years who have not had a heart health check (MBS item 699) claimed. A Topbar prompt will be created for eligible patients to update information. WHO/WHEN/WHERE: Who: Practice manager. When: 1st October. Where: Practice manager's office. DATA TO BE COLLECTED: Number of active patients with an active mental illness and their height, weight and BMI recorded and number of active patients aged 65 to 74 years with a mental illness who have had a heart health check.	
DO	**Run the test, then record your actions, observations and data**
Run the test on a small scale	What did you do? Were there any deviations from the original plan? Record exactly what you did, the data collected and any observations. Include any unexpected consequences (positive or negative).
Done – completed 14th February – Charlie conducted a search on CAT4 and identified patients with a mental illness aged 65 to 74 years who have not had a heart health check completed back in October. He also conducted a search on all active patients with a mental illness with no height, weight or BMI recorded and created a Topbar prompt to ensure the practice team members were alerted to this when the patient arrived for their next appointment. Charlie generated an individual report for each GP and asked if they could identify 20 patients who would benefit from having a heart health check completed. Charlie included at the practice meeting some time to discuss the criteria of the heart health check, how to complete on the practice software and as a team they discussed roles and responsibilities. Once the GPs identified eligible patients, Charlie contacted the patients to offer them an appointment to have their health check completed.	

STUDY	Analyse the data and your observations
Analyse the results and compare them to your predictions	Was the plan executed successfully? Did you encounter any problems or difficulties? What worked/didn't work? What did you learn on the way? Compare the data to your predictions. Summarise and reflect on what was learned.

A total of 70% of patients with a mental illness have their height, weight and BMI recorded This exceeded our goal by 3%. We identified that GPs can be time poor and patients attend with a number of issues they would like to discuss, having the Topbar prompt assisted all the clinical team to improve the recording of height, weight & BMI.

During the 6 months focus on this project, the practice completed 140 heart health checks, which resulted in an increase of $10,605 in MBS claiming.

Results have been shared with the whole practice team.

ACT	Record what you will do next
Based on what you learned from the test, record what your next actions will be	Will you adopt, adapt or abandon this change idea? Record the details of your option under the relevant heading below. *ADOPT: record what you will do next to support making this change business as usual*; ADAPT: *record your changes and re-test with another PDSA cycle; or ABANDON: record which change idea you will test next and start a new PDSA.*

ADOPT:

ADAPT:

The practice will regularly monitor height, weight and BMI stats to ensure the rates are increasing.

Charlie will ensure a Topbar prompt for BMI has been created for all patients with an active mental illness. Instead of focusing on heart health checks, the practice will change the criteria for patients aged 45 to 49 years with no health assessment completed.

ABANDON:

Repeat step 2 to re-test your adapted plan or to test a new change idea

Acknowledgements

We would like to acknowledge that some material contained in this toolkit has been extracted from organisations including the Institute for Healthcare Improvement; the Royal Australian College of General Practitioners (RACGP); the Australian Government Department of Health; Best Practice; MedicalDirector, CAT4; and Train IT. These organisations retain copyright over their original work and we have abided by licence terms. Referencing of material is provided throughout.

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Brisbane South PHN, 2022

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