phn BRISBANE SOUTH
An Australian Government Initiative

Quality Improvement Toolkit for General Practice

Patient Population Groups

Older people

MODULE

Version 2

January 2021

OLDER PEOPLE'S HEALTH

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 implementation 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 using the MFI to increase the number of home medication reviews completed and a blank template for you to complete 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.

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, 2021

Contents

OLDER PEOPLE'S HEALTH

Brisbane South PHN and Metro South Health are committed to ensuring that every person can live a long life and in good health. They have jointly developed the Brisbane South Older People's Health and Wellness Strategy 2019-2024.

Definition of an older person

According to the Australian Institute of Health & Welfare older people are people aged 65 years and older and Aboriginal & Torres Strait Islander patients aged 55 years and older.

Older peoples' toolkit for general practice

This toolkit is designed to assist you to manage older people living in their own home and their health needs. Key topics include:

- Health assessments (75+ and Aboriginal and Torres Strait Islander)
- Medication reviews (via a home medication review (HMR)
- Management plans (for patients with a chronic medical condition)
- Advance care planning
- Dementia screening
- Falls prevention
- Vaccinations including:
  - Influenza
  - Pneumococcal
  - Shingles (herpes zoster)
- Lifestyle risk factors including smoking, alcohol and physical activity
- Drivers licence medicals
- Osteoporosis
- Cancer screening (including breast, bowel and cervical).

Goal of this QI toolkit

This toolkit is to be used in general practice to:

- identify older patient populations from your practice
- ensure your practice's older patient population is provided with the most appropriate health care
- Identify funding opportunities available via the Medicate Benefit Schedule (MBS).

This toolkit will specifically assist you to understand your older patient population. (If you would like to review your whole practice population, please refer to the QI Toolkit – Patient Populations).

How to use this toolkit

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

- identify a sample group of patients (between 50-100 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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ACTIVITY 1 – UNDERSTANDING YOUR PATIENT POPULATION

Activity 1.1 – Data collection from CAT4

Complete the below table by collecting data from your CAT4 Data Extraction Tool. You may also refer to your monthly benchmarking report provided by Brisbane South PHN.

Note - Instructions on how to extract the data is available from the CAT4 website: Active patient population OR Demographics OR Ethnicity OR Co-morbidities OR Shared health summaries.

The aim of this activity is to collect data to determine the demographics of your practice's active older patient population.

	Description	Total number of active patients as per RACGP criteria (3 x visits in 2 years)	Total number of active patients
1.1a	Number of active patients		
1.1b	Number of active patients aged 65 to 74 years		
1.1c	Number of active patients aged 75 years and older		
1.1d	Number of active Aboriginal & Torres Strait Islander patients aged 55 years and older		
1.1e	Number of active patients aged 65 years and older with 2–3 co-morbidities		
1.1f	Number of active patients aged 65 years and older with an uploaded shared health summary		

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 – Understanding your practice's older patient population

The aim of this activity is to increase your understanding of the active older patient population.

Description	Status	Action to be taken
After completing **activity 1.1** are there any unexpected findings with your practice's older patient demographics?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: *(e.g. lower older population than expected, practice has no Aboriginal and Torres Strait Islander patients).* How will this information be communicated to the practice team?
Are your practice demographics similar to other practices in the Brisbane south region (compare information from benchmark report)?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Outline the differences – is it active population, age group differences, male/female populations? How will this information be communicated to the practice team?
After reviewing your older patient demographics, 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.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

ACTIVITY 2 - OLDER PEOPLE'S HEALTH AND MEDICARE

The Australian Government has changed the way we care for Australians with chronic diseases and complex conditions – aiming to keep them out of hospital and living happier and healthier lives at home.

The following MBS item numbers *may be* used for older patients. Always refer to the guidelines in the MBS. This can be accessed at MBS online, education guides or eLearning guide. Brisbane South PHN has a MBS claiming toolkit covering the following item numbers.

Older people and health assessments (MBS item 701-707)

A health assessment is the evaluation of an eligible patient's health and wellbeing. General practitioners can use it as an opportunity for an overall medical review to:

- identify preventive healthcare needs
- provide education on health and wellbeing
- recommend appropriate interventions.

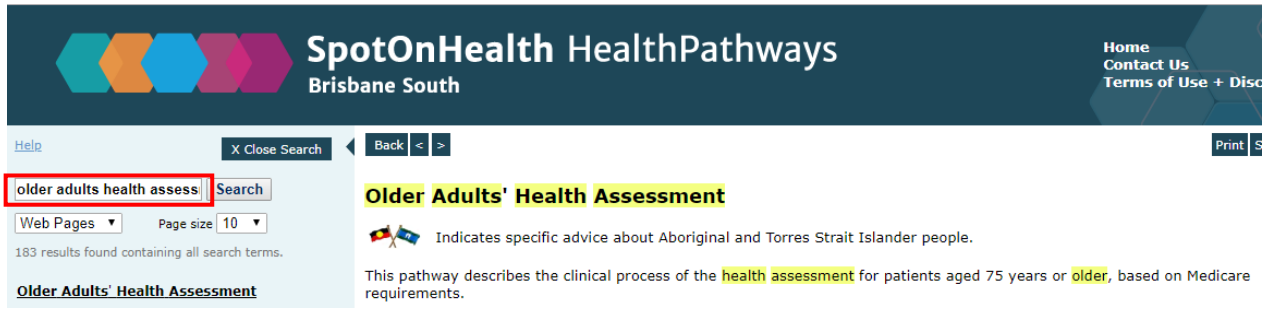
There are time-based MBS health assessment items: 701 (brief), 703 (standard), 705 (long) and 707 (prolonged).

Health assessments and SpotOnHealth HealthPathways

SpotOnHealth HealthPathways provides clinicians in the greater Brisbane south catchment with web-based information outlining the assessment, management and referral of over 550 conditions.

It is designed to be used primarily by general practitioners at point of care, but is also available to specialists, nurses, allied health and other health professionals.

There is a great pathway for Older Adults Health Assessment.



Older people and Aboriginal and Torres Strait Islander health assessments (MBS item 715)

Indigenous health refers to the physical, cultural, social and emotional wellbeing of Aboriginal and/or Torres Strait Islander people (Indigenous Australians).

Many Indigenous Australians experience poorer health than other Australians, often dying at much younger ages. Indigenous Australians are more likely than non-Indigenous Australians to have respiratory diseases, mental health problems, cardiovascular disease, diabetes and chronic kidney disease.[1]

[1] https://www.healthdirect.gov.au/indigenous-health

Who is eligible for an Aboriginal and Torres Strait Islander health assessment

The Aboriginal and Torres Strait Islander Peoples health assessment is available to:

- Children between ages of 0 and 14 years
- Adults between the ages of 15 and 54 years
- Older people over the age of 55 years.

Older people and medication reviews (MBS item 900 – home, item 903 – aged care facility)

According to the Quality Use of Medicines to Optimise Ageing in Older Australians resource, as our population ages, there are more people are living with multiple chronic diseases with an associated increase in polypharmacy (multiple medicines use). Medicines use in older people is a complex balance between managing disease and avoiding medicines related problems.

GPs are able to claim an MBS item number to complete a home medication review (HMR) or residential medication management review (RMMR) in conjunction with a pharmacist for the following:

- Medication reviews are targeted at patients who are:
- currently taking five or more regular medications;
- taking more than 12 doses of medication per day;
- have had significant changes made to medication treatment regimen in the last three months;
- taking medication with a narrow therapeutic index or medications requiring therapeutic monitoring;
- experiencing symptoms suggestive of an adverse drug reaction;
- displaying sub-optimal responses to treatment with medicines;
- suspected of non-compliance or inability to manage medication related therapeutic devices;
- having difficulty managing their own medicines because of literacy or language difficulties, dexterity problems or impaired sight, confusion/dementia or other cognitive difficulties;
- attending a number of different doctors, both GPs and specialists; and/or
- recently discharged from a facility/hospital (in the last four weeks).

Please note: if you have GPs at your practice who have patients in residential aged care facilities, you may wish to review these patients to identify those who may benefit from a RMMR.

Older people and chronic disease management plans (MBS items 721 and 723)

Older people experience complex diseases that are dynamic in nature, requiring a range of interventions and support approaches at different times through the ageing journey. One approach is to complete and then review a GP Management Plan (GPMP) and/or Team Care Arrangement (TCA).

These plans are for:

- patients with a chronic (or terminal) medical condition (i.e. condition has been present or likely to be present for six months) – GPMP (GP only care planning)
- patients with complex care needs and who require treatment from two or more other health care providers - GPMP and TCA (GP and multidisciplinary team care planning)

Prior to claiming any MBS item numbers, it is important that GPs have a full understanding of the criteria to ensure that the individual patient meets that criteria.

Review of GPMPs and TCAs (MBS item 732)

Once a plan is in place, it should be regularly reviewed by the GP. This is an important part of the planning cycle where the GP and patient check that the goals are being met and agree on any changes that might be needed.

Exceptional circumstances exist for a patient if there has been a significant change in the patient's clinical condition or care requirements that necessitates the performance of a service for the patient.

Description	Item number	Minimum claiming period
Preparation of a GPMP	721	12 months
Coordination of TCAs	723	12 months
Review of a GPMP or coordination of review of TCAs	732	3 months

Older people and practice nurse – chronic disease (item 10997)

MBS item number 10997 may be claimed by a medical practitioner, where a monitoring and support service for a person with a chronic disease care plan (GPMP and/or TCA) is provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of that medical practitioner. This item can be claimed up to 5 times in a calendar year.

Older people and heart health check

Modifiable Cardiovascular Disease (CVD) risk factors are responsible for up to 90 per cent of the risk of myocardial infarction, although there is evidence that CVD is largely preventable.[2] However, people at high risk of CVD are not receiving guideline-recommended blood pressure and lipid lowering preventive therapy.[3] The federal government introduced MBS item number 699 for GPs to conduct a comprehensive cardiovascular health assessment using the Australian Absolute Cardiovascular Disease Risk calculator.[4] This MBS item supports the ongoing assessment and management of absolute CVD risk in primary care for eligible patients.

Eligible patients: all adults aged 45 to74 years who are *not known* to have CVD or clinically determined high risk, e.g. only appropriate for those up to age 74 and with no known cardiovascular disease.

Older people and mental health treatment plan (if relevant)

There are a number of Medicare item numbers available for GPs to claim for mental health related consultations. Always refer to the MBS for full details. The item numbers include:

Item description	Medicare criteria	Frequency of claiming
Mental health consultation (MBS item 2713)	Mental health consultation lasting at least 20 minutes. To claim this, the patient does not need to be on a mental health plan.	No limits to the amount of times this item number is claimed

[2] Lancet, 2004, 364(9438): p. 937-52
[3] http://www.cvdcheck.org.au/pdf/Absolute_CVD_Risk_Full_Guidelines.pdf
[4] http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&qt=ItemID&q=699

Item description	Medicare criteria	Frequency of claiming
Mental health plan (MBS Items 2700, 2701, 2715 or 2717)	The mental health plan must include documenting the (results of assessment, patient needs, goals and actions, referrals and required treatment/services, and review date) in the patient's plan.	After plan has been completed, the patient is entitled to up to 10 Medicare subsidised visits with a psychologist per calendar year. A new plan may be completed after 12 months if clinically required and if the person meets eligibility criteria.
Review mental health plan (MBS item 2712)	The review item is a key component for assessing and managing the patient's progress once a plan has been prepared, along with ongoing management. A patient's GP mental health treatment plan should be reviewed at least once.	Can be claimed every 3 months or at least 4 weeks after claiming the mental health plan item number.

More information is available at Education guide for Mental Health Care.

Activity 2.1 – Data Collection from CAT4

Complete the below table by collecting data from CAT4. Instructions on how to do this can be found at: MBS items OR MBS attendance.

Please ensure you select the starting age of 65 years or 55 years for Aboriginal and Torres Strait Islander patients.

Please note: not all patients will be eligible for the following item numbers. Make sure you check the MBS criteria prior to claiming.

The aim of this activity is to collect data to determine the number of MBS claims made for the specific items at your practice over the past 12 months.

	Description	Total	Not recorded
2.1a	Number of health assessments claimed for patients 75 years and older in the past 12 months		
2.1b	Number of Aboriginal and Torres Strait Islander health assessments claimed for patients 55 years and older in the past 12 months		
2.1c	Number of HMRs claimed for patients 65 years and older in the past 12 months		
2.1d	Number of GPMPs claimed for patients 65 years and older in the past 12 months		

	Description	Total	Not recorded
2.1e	Number of TCAs claimed for patients 65 years and older in the past 12 months		
2.1f	Number of GPMP reviews claimed for patients 65 years and older in the past 12 months		
2.1g	Number of nurse chronic disease item numbers claimed for patients 65 years and older in the past 12 months		
2.1h	Number of heart health checks claimed for patients aged 65 to 74 years in the past 12 months		
2.1i	Number of mental health item numbers claimed for patients 65 years and older in the past 12 months		

Please note: *These searches are to include all items claimed, regardless if the patient is active. You may wish to change the dates of your searches to compare previous years and/or different time frames. You may also wish to search by a particular provider.*

Activity 2.2 – Understanding your practice's MBS claiming

The aim of this activity is to increase your understanding of the MBS item number claiming at your practice

Description	Status	Action to be taken
After completing **activity 2.1** are there any unexpected results with the number of MBS items claimed at your practice?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. low number of health assessments completed, higher rate of GPMP than expected*). How will this information be communicated to the practice team?
Is your practice's MBS claiming similar to other practices in the Brisbane south region (compare information from benchmark report)?	☐ Yes: continue with activity.	Outline the differences – is it active population, age group differences, male/female populations?

Description	Status	Action to be taken
	☐ No: **see action to be taken.**	How will this information be communicated to the practice team?
After reviewing your patient MBS claiming, 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 you goals**. ☐ No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

ACTIVITY 3 – OLDER PEOPLE'S HEALTH AND ADVANCE CARE PLANNING

As part of the Brisbane South Older People's Health and Wellness Strategy 2019-2024 it is suggested that GPs initiate conversations relating to advanced care planning with patients aged 60 years and older who have a GPMP or TCA. An advance health directive is a document that states the wishes or directions regarding patient's future health care for various medical conditions. It comes into effect only if the patient is unable to make their own decisions.

The RACGP have a great resource on Advance Care Planning.

In November 2020, the forms for advance health directives and enduring power of attorney were updated. Please make sure you download new forms each time and do not refer to forms you may have previously printed at your practice. The previous versions of the form are no longer legally valid when creating new advance care plans.

The advance health directive form can be obtained here.

Activity 3.1 – Activity – Advance care documentation

The aim of this activity is to ensure relevant people in your practice know the importance of end of life conversations and planning

Description	Status	Action to be taken
Do all relevant practice team members know where to locate advance care planning documentation? Do they know how to upload documents to patient records?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to advance care planning forms. Refer to GP Information from the Queensland Government. How will this information be communicated to the relevant practice team members?
Do any of the practice team require training/assistance on having end of life conversations?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Refer to training modules. How will this information be communicated to the practice team?

Description	Status	Action to be taken
Are advance care documents completed during an annual 75+ year health assessment?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Hold a team meeting to discuss how advance care planning can be included in health assessments.
After reviewing your advance care documentation processes, 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 you goals.** ☐ No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

ACTIVITY 4 - OLDER PEOPLE'S HEALTH AND DEMENTIA

Dementia is the second leading cause of death of Australians. In 2016 dementia became the leading cause of death of Australian women, surpassing heart disease which had been the leading cause of death for both men and women since the early 20th century. In 2017, dementia remained the first leading cause of death of women, and the third leading cause of death of men. Overall, accounting for 13,729 deaths. Females account for 64.5 per cent of all dementia related deaths. In 2020, there is an estimated 459,000 Australians living with dementia.[5]

Three in 10 people over the age of 85 and almost one in 10 people over 65 have dementia.[6]

Activity 4.1 – Data Collection from CAT4

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: Dementia patients.

The aim of this activity is to collect data to determine the number of patients who have dementia, their health assessment, cardiovascular risk, HMR and carer status.

	Description	Total Number of active patients as per RACGP criteria (3 x visits in 2 years)	Total number of active patients
4.1a	Number of active patients with dementia		
4.1b	Number of active patients aged 75 years and older with dementia who have NOT had a Health Assessment completed in the past 12 months		
4.1c	Number of active patients with dementia with a BP and cholesterol or LDL in a healthy range recorded in the last 12 months (*this is important for those patients with vascular dementia)*		
4.1d	Number of active patients with dementia who have a carer recorded		
4.1e	Number of active patients with dementia who had a medication review in the previous 12 months		
4.1f	Number of active patients with dementia who had a shared health summary uploaded in the previous 12 months		
4.1g	Number of active patients who are at high risk of dementia		

[5] https://www.dementia.org.au/statistics
[6] https://dementia.org.au/The-economic-cost-of-dementia-in-Australia-2016-to-2056.pdf

***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 – Review practice dementia population

The aim of this activity is to increase your understanding of the practice's dementia population.

Description	Status	Action to be Taken
After completing **activity 4.1** are there any unexpected results with your practice's dementia patient population?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. only 20% of dementia patients have had a health assessment completed in the past 12 months*). How will this information be communicated to the practice team?
Does the practice have a system for contacting patients who have not had a health assessment completed?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Please explain: How will this information be communicated to the practice team?
Does the practice have a system for ensuring all patients with dementia have carer details recorded?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Identify the patients with no carer details and develop a system of obtaining this information. How will this information be communicated to the practice team?

Description	Status	Action to be Taken
Does the practice have a system for identifying all patients with dementia who would benefit from a home medication review?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Hold a clinical meeting and discuss with relevant team members who would benefit from this service. How will this information be communicated to the practice team?
Have you setup Topbar prompts to assist with managing patients with dementia?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to Topbar instructions.
After reviewing your practice's dementia patients, are there any changes with the management of your patient's you would like to implement over the next 12 months?	☐ Yes, **set goals and outline in action to be taken**. ☐ No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Dementia patients and advance care planning

People with dementia face significant challenges in planning for future care.

As dementia progresses, a person's capacity to make and communicate decisions about everyday life, health and end-of-life care will deteriorate. Complex health and personal decisions will then often require the involvement of family members or carers who may be uncertain about the preferences of their loved one.

Advance care planning is a key way to improve the quality of care delivered to people with dementia. It has been associated with significant reductions in rates of hospitalisation and increased use of hospice services among people with dementia. It can also reduce stress, anxiety and depression in relatives.[7]

[7] https://www.advancecareplanning.org.au/understand-advance-care-planning/advance-care-planning-in-specific-health-settings/advance-care-planning-and-dementia

Activity 4.3 – Data collection from clinical software

Complete the below table by collecting data from Best Practice or MedicalDirector.

The aim of this activity is to collect data to determine the number of patients with dementia who have a completed advance health directive.

	Description	Total number of active patients as per RACGP criteria (3 x visits in 2 years)	Total number of active patients
4.3a	Number of active patients with dementia (from activity 4.1)		
4.3b	Number of active patients with dementia and a completed advance health directive		

Please note: *patients will only appear in these searches if a GP has recorded advance health directives as a condition in the patient's past history.*

Activity 4.4 – Review practice dementia population with advance care plan

The aim of this activity is to increase your understanding of the number of patients with dementia at your practice with an advance health directive.

Description	Status	Action to be Taken
After completing **activity 4.3** are there any unexpected results with your practice's dementia patients with a completed advance health directive?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. only one of our dementia patients had an advance health directive completed*). How will this information be communicated to the practice team?
Do relevant team members know where to find more information about advance health directives?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to advance care planning forms. Refer to GP Information from Queensland Government. How will this information be communicated to the relevant practice team members?

Description	Status	Action to be Taken
Are GPs aware that if they record the advance health directive as a reason for a visit or record it in the patient's past history, it is easier to identify when completing a search on the practice database?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Communicate this information to all GPs as per practice communication policy. Discuss this at the next practice team meeting.
After reviewing your practice's dementia patients with a completed advance health directive, are there any changes with the management of your patients you would like to implement over the next 12 months?	☐ Yes, **set goals and outline in action to be taken**. ☐ No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

ACTIVITY 5 - OLDER PEOPLE AND FALLS PREVENTION

Falls are a major health issue in the community with around 30 per cent of adults over 65 experiencing at least one fall per year. This is set to increase as Australia's population ages with the proportion of people aged over 65 predicted to increase from 14 per cent (3 million people) in 2010 to 23 per cent (8.1 million people) in 2050.[8]

Through the use of appropriate MBS health assessment item numbers and screening tools, you can identify people most at risk of falls. The RACGP has published guidelines for falls prevention in older adults.

There are several measures that an older person can take to help prevent a fall. Simple, everyday measures around the home include:

- using non-slip mats in the bathroom
- mopping up spills to avoid wet floors
- getting help lifting or moving items that are heavy or difficult to lift
- removing clutter and ensuring that all areas of the home are properly lit.[9]

Falls prevention toolkit

The Queensland Stay On Your Feet Toolkit provides anyone working with older people with access to current evidence-based information about falls prevention. It also provides healthy active ageing strategies to use in the organisation and local community. The toolkit will guide you through how to set up and implement an effective falls prevention program using practical strategies, how to evaluate the program's impact and maintain momentum. Initiatives can be undertaken at a community, organisational or individual level, or a combination of all three.

Activity 5.1 – Review practice dementia population

The aim of this activity is to increase your understanding of the practice's dementia population.

Description	Status	Action to be Taken
Is falls prevention included in your practice's health assessment templates?	☐ Yes: continue with activity. ☐ No: **see action to be taken**.	Review practice templates to ensure falls prevention questions are included in health assessment templates.
Do relevant team members record if a patient has a history of a fall in the patient records?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Hold a practice clinical meeting to discuss the importance of recording if a patient has a previous history of a fall.

[8] http://www.anzfallsprevention.org/info/
[9] https://www.healthdirect.gov.au/fall-prevention

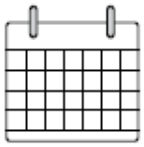
Description	Status	Action to be Taken
Are all relevant team members aware of Queensland Health Stay on Your Feet toolkit?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Access the toolkit. How will this information be communicated to the practice team?
After reviewing your practice's systems to prevent falls, are there any changes with the management of your patient's you would like to implement over the next 12 months?	☐ Yes, **set goals and outline in action to be taken**. ☐ No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

OLDER PEOPLE'S HEALTH AND VACCINATIONS

The Australian Immunisation Handbook provides guidelines for the recommendation for vaccinations for older people. The following activities in this workbook will look in detail at the following vaccinations: influenza, pneumococcal and shingles.

Vaccination for healthy ageing

Adults >50 years old are at increased risk of some vaccine-preventable diseases and of serious complications from these diseases, even if they are otherwise healthy.



Was the person born during or since 1966?

- Check to see if they have received any MMR vaccines.
- Offer 2 doses of MMR vaccine, 1 month apart, if they have not already received them.

Is the person 50 years old or more?

- Check to see if they need any of the following:

Booster doses

Immunity to some diseases can start to wane in older people, and they may need booster doses of some vaccines.

- Offer adults aged 50 years a booster dose of dTpa vaccine to protect against diphtheria, tetanus and pertussis, if their last dose was more than 10 years ago.
- Offer adults aged ≥65 years a booster dose of dTpa vaccine if their last dose was more than 10 years ago.

Herpes zoster (shingles)

The incidence of herpes zoster increases with age, as does the incidence of serious complications such as post-herpetic neuralgia.

- Give adults aged 70–79 years a dose of zoster vaccine if they have not already received one. Do not give zoster vaccine to adults who are immunocompromised. ☑

Pneumococcal disease

Pneumococcal disease is more prevalent in older adults.

- For healthy non-Indigenous adults aged ≥70 years, give 1 dose of 13vPCV if they have not already received a dose. ☑ Give 13vPCV at least 12 months after any previous dose of 23vPPV.
- For healthy Aboriginal and Torres Strait Islander adults aged ≥50 years, give 1 dose of 13vPCV, 1 dose of 23vPPV 12 months later, and a 2nd dose of 23vPPV at least 5 years later. ☑

Influenza

Influenza-associated mortality rates are highest among older adults and Aboriginal and Torres Strait Islander people.

- Each year, give non-Indigenous adults aged ≥65 years a dose of seasonal influenza vaccine. ☑
- Each year, give Aboriginal and Torres Strait Islander adults of any age a dose of seasonal influenza vaccine. ☑

☑ = vaccine funded under the National Immunisation Program

See the Australian Immunisation Handbook for more details.

ACTIVITY 6 - OLDER PEOPLE'S HEALTH AND INFLUENZA VACCINATION

Influenza (flu) is a highly contagious viral infection that spreads easily from person to person through coughing, sneezing and close contact.

Unlike a cold, symptoms such as fever, sore throat and muscle aches develop suddenly with the flu and last about a week. In some cases, severe illness and complications such as pneumonia and bronchitis can develop, which can result in hospitalisation and even death. The flu can also make some existing medical conditions worse.

The flu virus can be especially dangerous for elderly people, pregnant women, Aboriginal and Torres Strait Islander people and very young children, as well as for people with underlying medical conditions and some chronic diseases.[10]

Activity 6.1 – Data Collection from CAT4

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: identify patients at risk of influenza based on age.

The aim of this activity is to identify the number of patients eligible for an influenza vaccination.

	Description	Total Number
6.1a	Number of active patients aged 65 years & older (*obtain from activity 1.1*)	
6.1b	Number of active patients aged 65 years and older who have NOT had an influenza vaccination in the past 15 months	
6.1c	Number of active Aboriginal and Torres Strait Islander patients aged 55 years and older (*obtain from activity 1.1*)	
6.1d	Number of active Aboriginal and Torres Strait Islander patients aged 55 years and older who have NOT had an influenza vaccination in the past 15 months	

[10] https://www.health.gov.au/health-topics/immunisation/immunisation-services/flu-influenza-immunisation-service-0

Activity 6.2 – Understanding your practice's vaccination status in older patients

The aim of this activity is to increase your understanding of the influenza vaccination status of older patients at your practice.

Description	Status	Action to be Taken
After completing **activity 6.1** are there any unexpected results with your practice's influenza vaccination rates?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. only 50% of older patients have their influenza vaccination recorded in the past 15 months*). How will this information be communicated to the practice team?
Does your practice have a system for reminding patients that their influenza vaccination is due?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to the reminder system. How will this information be communicated to the practice team?
After reviewing your practice's influenza vaccination profile, are there any changes with the management of your patients you would like to implement over the next 12 months?	☐ Yes, **set goals and outline in action to be taken**. ☐ No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

ACTIVITY 7 - OLDER PEOPLE'S HEALTH AND PNEUMOCOCCAL VACCINATION

Anyone of any age can contract pneumonia, but those at a higher risk are:

- people aged 70 years and older
- people with medical conditions such as diabetes, cancer or a chronic disease affecting the lungs, heart, kidney or liver
- tobacco smokers
- Indigenous Australians.

It's important to remember that no matter how healthy and active people are, their risk for getting pneumonia increases with age.

Pneumococcal vaccines funded under the National Immunisation Program (NIP)

From 1 July 2020 there are changes to the timing, type and number of pneumococcal vaccines given under the NIP. These apply to the following groups relating to this toolkit:

- all Aboriginal and Torres Strait Islander people aged 50 years and older.
- all non-Indigenous people aged 70 years and older.

The list of conditions associated with an increased risk of pneumococcal disease has been updated. There is now a single list of risk conditions for funded NIP pneumococcal vaccinations.

Pneumococcal disease

Pneumococcal disease is more prevalent in older adults.

- For healthy non-Indigenous adults aged ≥70 years, give 1 dose of 13vPCV if they have not already received a dose. ☑ Give 13vPCV at least 12 months after any previous dose of 23vPPV.
- For healthy Aboriginal and Torres Strait Islander adults aged ≥50 years, give 1 dose of 13vPCV, 1 dose of 23vPPV 12 months later, and a 2nd dose of 23vPPV at least 5 years later. ☑

[11]

Activity 7.1 – Data Collection from CAT4

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: Adult – pneumococcal.

The aim of this activity is to identify the number of patients who are not up to date with their pneumococcal vaccination.

	Description	Total Number
7.1a	Number of active patients overdue for their pneumococcal vaccination	
7.1b	Number of active patients at risk, Indigenous, nothing recorded	

[11] https://immunisationhandbook.health.gov.au/vaccine-preventable-diseases/pneumococcal-disease

	Description	Total Number
7.1c	Number of active patients at risk, non-Indigenous, nothing recorded	
7.1d	Number of active patients at risk, unknown, nothing recorded	

Activity 7.2 – Understanding your practice's pneumococcal vaccination status in older patients

The aim of this activity is to increase your understanding of the pneumococcal vaccination status of older patients at your practice.

Description	Status	Action to be Taken
After completing **activity 7.1** are there any unexpected results with your practice's pneumococcal vaccination rates?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. only 50% of older patients have their vaccination recorded).* How will this information be communicated to the practice team?
Does your practice have a system for notifying patients when their pneumococcal vaccination is due?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to the reminder system. How will this information be communicated to the practice team?
After reviewing your practice's pneumococcal vaccination profile, are there any changes with the management of your patients you would like to implement over the next 12 months?	☐ Yes, **set goals and outline in action to be taken.** ☐ No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

ACTIVITY 8 - OLDER PEOPLE'S HEALTH AND SHINGLES VACCINATION

Shingles (herpes zoster) is a reactivation of the varicella-zoster virus, which is the same virus that causes chickenpox. Shingles develops as a painful rash that can cause nerve pain. You can only get shingles if you have had chickenpox in the past.

Shingles can occur at any age, but it usually affects older adults. About 1 in 3 people will develop shingles at some stage during their lifetime. [12]

Please be aware when completing this activity that shingles vaccine is contraindicated in certain groups of patients related to immune suppression (due to disease or medication).[13]

Shingles and the Australian Immunisation Handbook

Information about herpes zoster (shingles) disease, vaccines and recommendations for vaccination can be found in the Australian Immunisation Handbook.

Activity 8.1 – Data Collection from CAT4

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: Identify patients who are eligible for a shingles vaccination.

The aim of this activity is to identify the number of patients who are not up to date with their shingles vaccine (please be aware of patients that may be ineligible due to allergy, immunosuppression or a recent history of shingles in the previous 12 months).

	Description	Total Number
8.1a	Number of active patients aged 70 to 79 years	
8.1b	Number of active patients aged 70 to 79 years who are NOT up to date with their Shingles vaccine	

[12] https://www.healthdirect.gov.au/shingles
[13] https://www.health.gov.au/resources/publications/zostavax-vaccine-screening-form-for-contraindications

Activity 8.2 – Understanding your practice's shingles vaccine status in older patients

The aim of this activity is to increase your understanding of shingles vaccination status of older patients at your practice.

Description	Status	Action to be Taken
After completing **activity 8.1** are there any unexpected results with your practice's shingles rates?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. only 50% of older patients have their shingles vaccination recorded or 28 patients ineligible due to contraindications*). How will this information be communicated to the practice team?
Does your practice have a system for notifying patients that their shingles vaccination is due?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to the reminder system. How will this information be communicated to the practice team?
After reviewing your practice's shingles profile, are there any changes with the management of your patients you would like to implement over the next 12 months?	☐ Yes, **set goals and outline in action to be taken**. ☐ No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

ACTIVITY 9 - OLDER PEOPLE'S HEALTH AND LIFESTYLE RISK FACTORS

Many serious health issues, including some chronic diseases (such as cardiovascular disease, chronic kidney disease, certain types of cancer, type 2 diabetes, influenza and high blood pressure) can relate to lifestyle factors—particularly lack of physical exercise, poor nutrition, obesity, smoking, excessive alcohol consumption, non-vaccination and psychological distress.[14]

Physical inactivity

In 2014–15, the Australian Bureau of Statistics (ABS) National Health Survey (NHS) reported:

- 35% of people aged 65 and over surveyed were sufficiently active (doing more than 150 minutes of exercise over 5 or more sessions) during the preceding week
- 37% reported were insufficiently active (less than 150 minutes of exercise), and
- 28% reported doing no exercise at all.

Smoking

Rates of smoking have dramatically decreased in Australia since the late 1980s. This may be due to an improved awareness of the negative health effects of tobacco, and a range of control measures aimed at reducing smoking rates. Older Australians tend to have lower rates of smoking than younger people —only 9 per cent of people aged 65–74, and 5 per cent of people aged 75 and over, were daily smokers in 2016.

Obesity

Obesity is a key health issue for older Australians and can increase the risk of developing heart disease, type 2 diabetes and certain cancers, among other things. Based on data from the 2014–15 NHS, 72 per cent of people aged 65 and over (around 2.4 million) were overweight or obese.

Alcohol consumption

Alcohol plays a prominent role in society; most Australians drink at light to moderate levels. However, drinking excessive amounts of alcohol is a health risk, and can contribute to long-term health issues such as liver disease, some cancers, and brain damage.

Older people and My health for life

My health for life (MH4L) is a free behaviour change program designed for people at high risk of developing a chronic disease including cardiovascular disease or diabetes. The program shows participants that making small lifestyle changes can have major health benefits. Participants take part in face to face group programs in the community or the program is delivered over the phone. The program is delivered by trained health professionals via 6 sessions over a six-month period.

The program works in partnership with general practice and is a practical extension of the advice given by GPs and nurses to their patients.

Refer to the *My health for life program* QI toolkit provided by Brisbane South PHN.

[14] https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/healthy-ageing/behavioural-risk-factors

Activity 9.1 – Data collection from CAT4

The aim of this activity is to collect data to lifestyle risk factors. 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: BMI OR Physical activity OR Smoking status OR Alcohol status recorded OR Blood pressure OR Lipids.

	Description	Total number of active patients
9.1a	Number of active patients aged 65 years and older with a BMI classified as overweight and obese	
9.1b	Number of active Aboriginal and Torres Strait Islander patients aged 55 years and older with a BMI classified as overweight and obese	
9.1c	Number of active patients aged 65 years and older who have had a physical activity assessment completed	
9.1d	Number of active Aboriginal and Torres Strait Islander patients aged 55 years and older who have had a physical activity assessment completed	
9.1e	Number of active patients 65 years and older who are daily smokers	
9.1f	Number of active Aboriginal and Torres Strait Islander patients aged 55 years and older who are daily smokers	
9.1g	Number of active patients 65 years and older who have had an alcohol assessment completed	
9.1h	Number of active Aboriginal and Torres Strait Islander patients aged 55 years and older who have had an alcohol assessment completed	
9.1i	Number of active patients 65 years and older with a blood pressure recording >130/80 mmHg	
9.1j	Number of active Aboriginal and Torres Strait Islander patients aged 55 years and older with a blood pressure recording >130/80 mmHg	
9.1k	Number of active patients 65 years and older with cholesterol result >6.5 recorded	
9.1l	Number of active Aboriginal and Torres Strait Islander patients aged 55 years and older with cholesterol results >6.5 recorded	

Activity 9.2 - Reviewing your older patients' lifestyle risk factors

Complete the checklist below which reviews your older patients' lifestyle risk factors.

Description	Status	Action to be taken
After completing **activity 9.1**, are there any unexpected results with your patients' lifestyle risk factors?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. larger number of people who are overweight and obese than expected).* How will this information be communicated to the practice team?
Are all the lifestyle risk factors being recorded in the correct fields in your clinical software? (*e.g. BP; height, weight and BMI; LDL; HDL; total cholesterol; ethnicity; smoking; alcohol; and physical activity status*).	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Review how and where your lifestyle risk factor information is being recorded in your practice software. *(Ensure no free text entries)*. Ensure all relevant team members are aware of how to record lifestyle risk factor information. Document in practice policy.
Do relevant team members understand the importance of using drop down lists provided with your clinical software program?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Provide training to all team members on importance of data entry (Refer to the Quality Patient Records QI Toolkit).
After reviewing your patients' lifestyle risk factors, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes, **set goals and outline in action to be taken**. ☐ No: you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

ACTIVITY 10 - OLDER PEOPLE'S HEALTH AND DRIVERS LICENCE MEDICALS

Driving a motor vehicle is a complex task involving perception, appropriate judgement, adequate response time and reasonable physical capability. A range of medical conditions, as well as certain treatments, may impair any of these factors.

Who is required to have a medical fitness assessment?

Currently people aged 75 years and older and required to have a medical assessment to assess their fitness to drive. The Department of Transport notify patients approximately 6 weeks prior to their licence expiration to ensure adequate time for the assessment to be completed. People of all ages are required to have a medical fitness to drive if they have a medical condition that may affect their ability to drive.

Permanent or long-term medical conditions

People need to have their medical fitness to drive assessed if they develop a permanent or long term medical condition, or an increase in or change to an existing medical condition, that is likely to adversely affect their ability to drive safely.

Health professional role in assessing medical fitness

As a health professional your role is to assess a person's medical fitness to drive based on the medical standards in the publication Assessing Fitness to Drive for commercial and private vehicle drivers.

While it is not compulsory, you are encouraged to use the Private and Commercial Vehicle Driver's Health Assessment form (F3195) as it is a tool that has been developed to guide your medical assessment. A copy of the assessment should be retained by you and form part of the person's medical records.

At the completion of your medical assessment, you will need to complete a medical certificate for motor vehicle driver form (F3712) for the person, where you will be required to provide a recommendation regarding:

- the person's medical fitness to drive
- any conditions and restrictions associated to the person's driver licence
- the medical certificate expiry date.

Activity 10.1 - Drivers licence medicals

Complete the checklist below which reviews your practice's systems for conducting drivers licence medicals.

Description	Status	Action to be taken
Do relevant team members have access either online or hardcopy to the Assessing Fitness to Drive publication?	☐ Yes: continue with activity. ☐ No: **see action to be taken**.	Refer to ordering information.

Description	Status	Action to be taken
Do relevant team members know contact details for the Department of Transport and Main Roads Queensland?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Phone: 1300 753 627 Web: www.tmr.qld.gov.au
Do team members understand their roles and responsibilities in completing a drivers license medical? (*E.g. nurse conduct vision screening etc.*)	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	As a team, review all items required to complete medical and allocate appropriately. Document roles and responsibilities to ensure all team members are aware.
Does the practice ensure a copy of the completed assessment form is scanned into the patient's record?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Ensure all GPs are aware it is a requirement to keep a copy of the completed assessment. Photocopy completed assessment and scan into patient's file.
Does the practice team review to see if patient has had their 75+ health assessment completed when conducting drivers license medical?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Develop a system to encourage the prompting of the completion of 75+ health assessments when completing drivers license medical.
After reviewing your practice's systems for conducting drivers license medicals, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes, **set goals and outline in action to be taken**. ☐ No: you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

ACTIVITY 11 - OLDER PEOPLE'S HEALTH AND OSTEOPOROSIS

Osteoporosis Australia published a burden of disease analysis which estimated that in 2012, 4.74 million Australians older than 50 years of age (66 per cent) had poor bone health, including more than one million with osteoporosis. By 2022, it is estimated that 6.2 million Australians older than 50 years of age will have osteoporosis or osteopenia, a rise of 31 per cent from 2012. A similar increase in the rate of fracture, from 140,882 in 2012 to 183,105 in 2022, is anticipated if action is not taken to improve the diagnosis and management of osteoporosis.[15]

In general practice, early detection can prevent a first fracture. For patients who have already experienced a fracture, investigation and initiation of osteoporosis medication is crucial to reduce the very high risk of subsequent fractures.

Activity 11.1 – Data Collection from CAT4

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: Disease OR Number of people eligible for GP Management Plan (GPMP)/Team Care Arrangement (TCA).

The aim of this activity is to identify the number of patients with osteoporosis eligible for a GPMP and/or TCA.

	Description	Total Number
11.1a	Number of active patients aged 65 years and older with Osteoporosis	
11.1b	Number of active patients aged 65 years and older with Osteoporosis eligible for a GPMP and/or TCA	

Activity 11.2 – Understanding your practice's osteoporosis status in older patients

The aim of this activity is to increase your understanding of older patients at your practice who have osteoporosis, eligible for a GPMP and/or TCA.

Description	Status	Action to be Taken
After completing **activity 11.1** are there any unexpected results with your practice's osteoporosis patients?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. only 5% of older patients with osteoporosis have a GPMP).* How will this information be communicated to the practice team?

[15] https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/osteoporosis

Description	Status	Action to be Taken
Does your practice have a system for reminding patients that their GPMP is due?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to the reminder system. How will this information be communicated to the practice team?
After reviewing your practice's osteoporosis profile, are there any changes with the management of your patient's you would like to implement over the next 12 months?	☐ Yes, **set goals and outline in action to be taken**. ☐ No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

ACTIVITY 12 - OLDER PEOPLE'S HEALTH AND CANCER SCREENING

Cardiovascular disease and cancer were the leading causes of burden for older Australians (contributing 24 per cent each). The rate of cancer was highest for 80–84 year olds.[16]

Activity 12.1 – Data Collection from CAT4

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: Cancer screening (ensure enter start age of 65 years and end age of 74 years)

The aim of this activity is to identify the number of older patients eligible for cervical screening, or who do not have a faecal occult blood test (FOBT) recorded, or have not had a mammogram recorded

	Description	Total Number
12.1a	Number of active patients aged 65 years to 74 years *(from **activity 1.1**)*	
12.1b	Number of active female patients aged 65 years to 74 years eligible for cervical screening	
12.1c	Number of active patients aged 65 years to 74 years who do not have an FOBT recorded	
12.1d	Number of active female patients aged 65 years to 74 years who have not had a mammogram recorded	

Activity 12.2 – Understanding your practice's cancer screening status in older patients

The aim of this activity is to increase your understanding of older patients at your practice who are eligible for cervical screening, or who do not have a FOBT recorded, or have not had a mammogram recorded.

Description	Status	Action to be Taken
After completing **activity 12.1** are there any unexpected results with your practice's cancer screening for older patients?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. only 5% of older patients have cervical screening recorded or 70% of older patients have an FOBT recorded*). How will this information be communicated to the practice team?

[16] https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/health-functioning/burden-of-disease

Description	Status	Action to be Taken
Does your practice have a system for reminding patients when their cancer screening test is due?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to the reminder system. How will this information be communicated to the practice team?
After reviewing your practice's older patients' cancer screening profile, are there any changes with the management of your patient's you would like to implement over the next 12 months?	☐ Yes, **set goals and outline in action to be taken**. ☐ No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

ACTIVITY 13 - OLDER PEOPLE'S HEALTH AND MY AGED CARE

My Aged Care is the main entry point to the aged care system in Australia. My Aged Care aims to make it easier for older people, their families, and carers to access information on ageing and aged care, have their needs assessed and be supported to find and access services.

My aged care is a service available for:

- help at home
- short term care in an aged care facility (respite)
- permanent placement at an aged care facility.

Aged Care Navigator trial

As part of the national Aged Care Navigator trials, Brisbane South PHN is working with community organisations to deliver seminars, phone support, and group and individual sessions across the Brisbane south region to help Australian seniors learn more about Government supported aged care programs and how to access them.

Eligibility criteria for referrals:

People aged 65+ years (Aboriginal and Torres Strait Islander people aged 50+ years) and who meet one or more of the following:

- Aboriginal and Torres Strait Islander people
- Culturally and linguistically diverse backgrounds
- Lesbian, gay, bisexual, transgender and intersex people
- Lives in rural or remote areas
- Limited access to technology or limited computer literacy
- Special website accessibility requirements, such as people who are vision impaired
- Financially or socially disadvantaged
- Socially isolated or at risk of social isolation
- Homeless or at risk of becoming homeless
- Disability
- Complex medical condition/s.

To download a specialist support worker referral form and details on how to send referrals, please **click here**.

More information can be obtained by contacting Brisbane South PHN Aged care team on agedcare@bsphn.org.au.

Activity 13.1 –Assistance for patients to live at home longer

The aim of this activity is to ensure relevant people in your practice know who to refer patients to for assistance to live in their own home longer.

Description	Status	Action to be taken
Do all relevant practice team members know how to refer patients to get assistance to live in their own home longer?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to the My Aged Care. How will this information be communicated to the relevant practice team members?
After reviewing your processes for assisting people live in the home longer, 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 you goals.** ☐ No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Links to other QI toolkits

Brisbane South PHN have a suite of QI toolkits available for general practice. The toolkits are designed to:

- improve patient care and outcomes
- generate increased revenue for GPs
- help practices fulfil their quality improvement requirements under the PIP QI Incentive
- to be completed at your own pace
- be available so that you choose your own adventure – you choose which topic/toolkit you would like to work on.

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

- MBS
- Influenza
- Pneumococcal
- Shingles vaccination
- Osteoporosis
- Cancer screening
- Advance care planning

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

Example PDSA for older patient's

See below for suggested goals related to older patient's you may wish to achieve within your practice: (please ensure you input the relevant age group prior to conducting each search).

GOAL	HOW YOU MAY ACHIEVE THE GOAL
Ensure 90% of active patients aged 65 years and older have smoking status recorded – current smoker, ex-smoker or never smoked.	Refer to CAT4 recipe: Identifying patients with no allergy or smoking status recorded.
Ensure 75% of active patients aged 65 years and older have BMI classified as obese, overweight, healthy or underweight within the previous 12 months	Refer to CAT4 recipe: adding, height, weight and waist measurements to patients records.
Ensure 90% of active patients aged 65 years and older have their alcohol status recorded	Refer to CAT4 data to identify the list of patients who do not have their alcohol status recorded.
Identify patients eligible for a bone mineral test.	Refer to CAT4 data to identify the patients eligible for bone mineral test.
Increase the number of flu injections given to active patients aged 65 years and over the past 15 months by 10%	Refer to CAT4 recipe: QIM4 – Influenza immunisation for patients aged 65 years and over.
Increase by 10% the number of patients aged 65 to 74 years with data recorded to enable CVD risk assessment. (you may wish to do this as part of a heart health check – MBS item 699)	Refer to CAT4 recipe: QIM8 – Cardiovascular risk.
Increase the cervical screening of the number of eligible female patients aged 65 to 74 years by 10%	Refer to CAT4 recipe: QIM9 – cervical screening.

Other ideas for improving PIP QI measures

It is suggested that you meet in your practice team to discuss how at your practice you can assist to improve health outcomes for patients. Some ideas you may consider include:

- asking the practice nurse to opportunistically see patients prior to their GP appointment to obtain height, weight, waist measurements, BMI, BP, physical activity, smoking and alcohol status
- ensuring team members have access to MBS assessment templates
- Ensuring Topbar is installed on every workstation.

QI activities using the MFI and PDSA

After completing any of the workbook activities above you may identify areas for improvement in the management of older patients in your practice. Follow these steps to conduct a QI activity using the MFI and PDSA model. The model consists of two parts that are of equal importance.

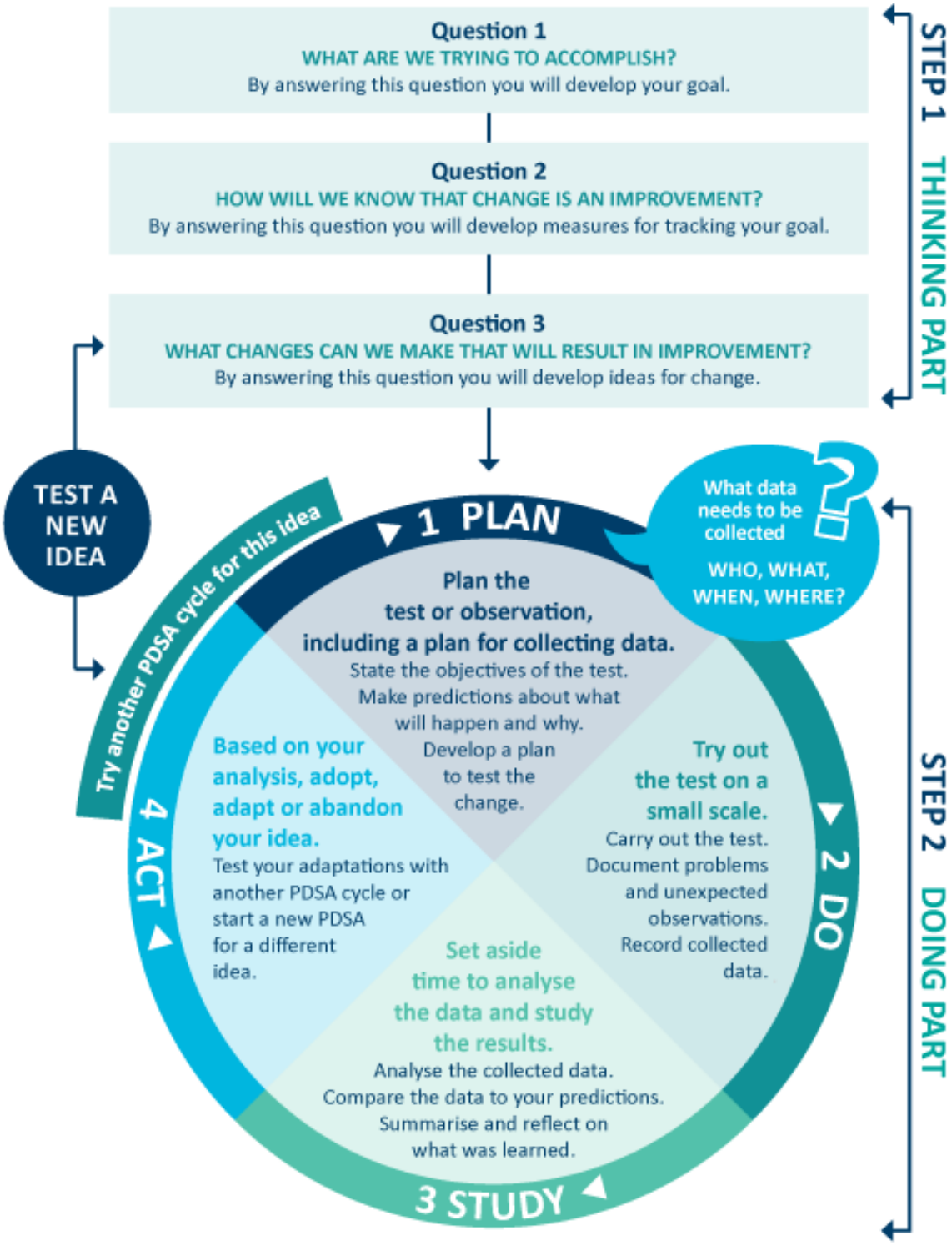
Step 1: The **'thinking'** part consists of three fundamental questions that are essential for guiding improvement work:

- What are we trying to accomplish?
- How will we know that the proposed change will be an improvement?
- What changes can we make that will lead to an improvement?

Step 2: The **'doing'** part is made up of Plan, Do, Study, Act (PDSA) cycles that will help to bring about rapid change. This includes:

- Helping you test the ideas
- Helping you assess whether you are achieving your desired objectives
- Enabling you to confirm which changes you want to adopt permanently.

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 a S.M.A.R.T. goal (**S**pecific, **M**easurable, **A**chievable, **R**elevant, **T**ime bound).

Our goal is to:
Increase the number of people with advance care planning documentation completed.
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 number of ACP documents completed for patients having a 75+ health assessment by 15% by 31st December.

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 number of ACP documents completed on patients 75+. To do this we will:

A) Identify the number of active patients aged 75+ years with a health assessment.
B) Identify the number of active patients aged 75+ years with a health assessment who have ACP completed.

B divided by A x 100 produces the percentage of patients 75+ with a health assessment and ACP completed.

BASELINE MEASUREMENT: 37% of active 75+ year old patients have a health assessment and ACP DATE:

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.MA.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 75+ eligible for a health assessment.

IDEA: Ensure all relevant team members have received training on ACP.

IDEA: Add ACP checkbox to templates for chronic disease management and health assessments.

IDEA: Ask receptionist to provide all patients 65 years and older with an ACP brochure when they arrive at the practice.

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)*	
Identify active patients 75+ eligible for a health assessment.	

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:
Mary will conduct a search on CAT4 to identify active patients aged 75+ eligible for an annual health assessment. She will then generate individual lists for each GP and highlight the patients who do not have any record of ACP discussions from their medical record. Each GP will identify suitable patients to contact to organise an appointment for their health assessment. Mary will call the patient to organise an appointment time. On arrival at the practice, each patient will see the practice nurse who will complete parts of the health assessment, the GP will then complete the health assessment. Both the nurse and the GP will have discussions with the patients about ACP.
WHO/WHEN/WHERE:
Who: Practice manager When: Begin 30th October. Where: Practice manager office.

DATA TO BE COLLECTED: Number of active patients aged 75+ eligible for a health assessment and the number of active patients aged 75+ with a health assessment and advance health directive completed.

PREDICTION: 52% of active patients 75+ eligible for a health assessment will have an assessment and ACP completed.

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 20th December – individual GP reports were generated from CAT4 outlining patients aged 75+ eligible for a health assessment. The reports were highlighted with patients who do not have any mention of ACP in their medical records. Each GP identified patients to contact and Mary arranged appointments with the nurse and GP to have their assessments completed. When we discussed advance care planning at our team meeting we identified that some of the GPs and Nurses needed upskilling in this topic. Team members participated in training which provided an opportunity for staff to freely speak to patients about ACP**.** Uptake of the appointments were high and the practice nurse reported people's interests in understanding ACP. Some patients indicated that they would complete the forms, but there was no way for the practice to know when the forms were 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 47% eligible for a health assessment had ACP documentation in place. This was lower than predicted, but we still had improvements in our completion rates. The percentage may have been higher, but we had no way of tracking for some patients if they had an advanced care plan completed.

Results have been shared with the whole practice team.

Communicate the results of your activity with your whole team. Celebrate any achievements, big or small.

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:
The practice has decided that they will adopt this. Mary will do a quarterly focus on generating reports from CAT4 to identify any active patients aged 75+ who do not have a current health assessment.

ADAPT:

ABANDON:

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

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