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 1

Introduction

The Quality Improvement Toolkit

This Quality Improvement (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 Quality Improvement (QI) activities using the Model for Improvement.

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 Model for Improvement.

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

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

The Model for Improvement 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 Model for Improvement 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 optimalcare@bsphn.org.au.

This icon indicates that the information relates to the ten Practice Incentive Program (PIP) Quality Improvement (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; Medical Director, 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, 2020

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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.

There is an association between diagnosis of mental health disorders and a physical disorder, often referred to as a 'comorbid' disorder. From the 2007 Australian national survey of mental health and wellbeing of adults, 1 in 8 (12.0%) of people with a 12-month mental disorder also reported a physical condition, with 1 in 20 (5.0%) reporting 2 or more physical conditions.[1]

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

[2]

[1] https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary-of-mental-health-services-in-australia/prevalence-impact-and-burden

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

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.[3] 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.[4]

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

[5]

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.

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.

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

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[6]. 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[7]. 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.

[6] https://www.aihw.gov.au/getmedia/656f6d35-a7e6-49ee-8130-ebe34f1a3fb6/ah02.pdf.aspx?inline=true
[7] https://www.who.int/nmh/events/ncd_action_plan/en/

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

	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 patient population		
1.1b	Number of active patients (i.e.: 3 x visits in 2 years) See instructions in link below. **Identify active patients with at least 3 visits in the last 2 years**		
1.1c	Number of patients with a mental illness		
1.1d	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.*

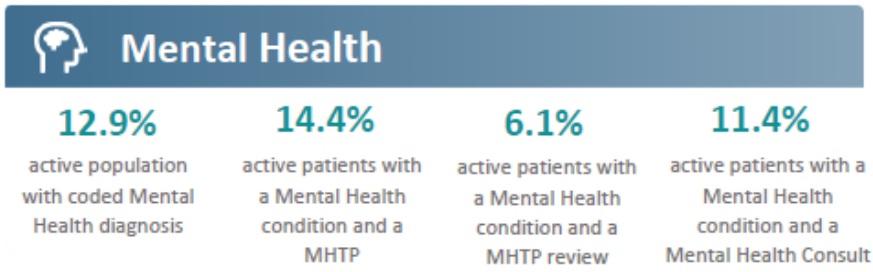
Reflection on Activity 1.1:

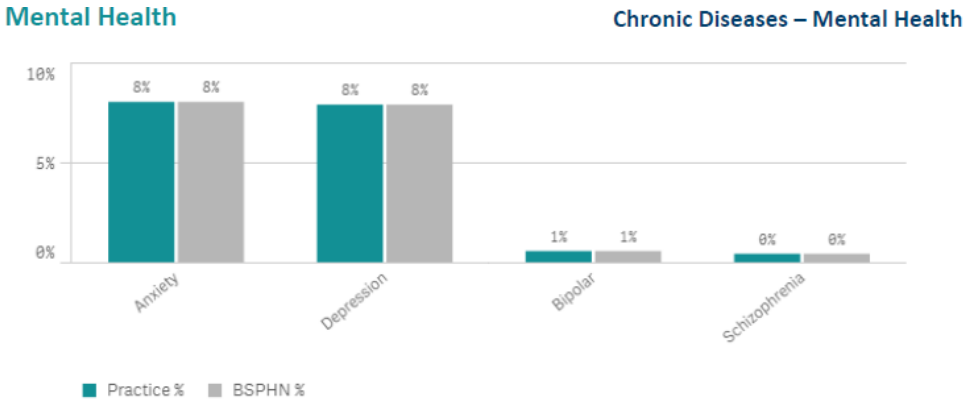
Practice name:	Date:
Team member:	

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 mental health treatment plan	
1.2c	Active patients with a mental illness and a mental health treatment plan 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	

Reflection on Activity 1.2:

Practice name:	Date:
Team member:	

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. [8]

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.[9] 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.[10]

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.[11] 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 are interesting as 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.[12]

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. [13] 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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[8] https://www.healthdirect.gov.au/exercise-and-mental-health

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

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

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

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

[13] 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.

Sometimes, families are not listened to by health professionals. 'Patient confidentiality' may be given inappropriately as a reason for this. Yet families are often the main support for people affected by mental illness, and have a right to be treated as 'partners in care'. They need information about the illness and treatment provided, and about training and support to help themselves as well as the person who is ill.[14]

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.

There are instructions below for how to record this data correctly

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 x 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 active patients with a mental illness aged 15+ years with smoking status recorded as current smoker		

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

	Description	Total number of active patients as per RACGP criteria (3 x visits in 2 years)	Total number of active patients
2.1d	Number of active patients with a mental illness aged 15+ years with an alcohol consumption status recorded		
2.1e	Number of active patients with a mental illness aged 15+ years who have had a BMI recorded as 'overweight' in the previous 12 months		
2.1f	Number of active patients with a mental illness aged 15+ years who have had a BMI recorded as 'obese' in the previous 12 months		
2.1g	Number of patients with a mental illness and their blood pressure recorded in the previous 6 months		

Reflection on Activity 2.1:

Practice name:	Date:
Team member:	

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 actions to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. higher number of patients with mental illness who are obese than expected or only a low number of patients with mental illness have their physical activity recorded)* How will this information be communicated to the practice team?

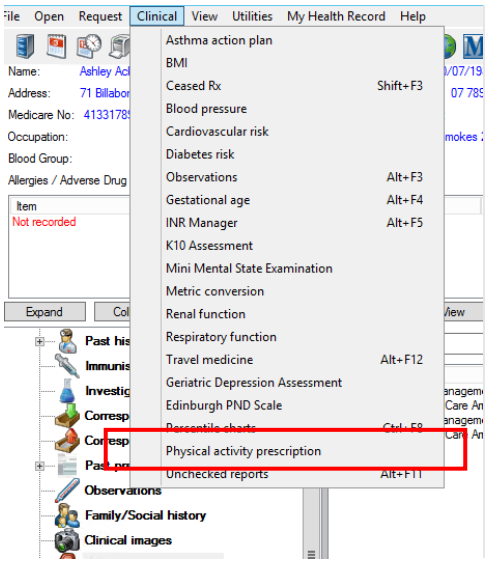
Description	Status	Action to be taken
Do all clinicians know how to enter physical activity status in your practice's clinical software?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	See instructions on how to enter into Best Practice or Medical Director.
Do all clinicians know how 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 Medical Director.
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. See instructions on entering information in Medical Director. Ensure all relevant team members are aware of how to record risk factor information. Document in practice policy.
After reviewing your practices 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.** ☐ No: you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

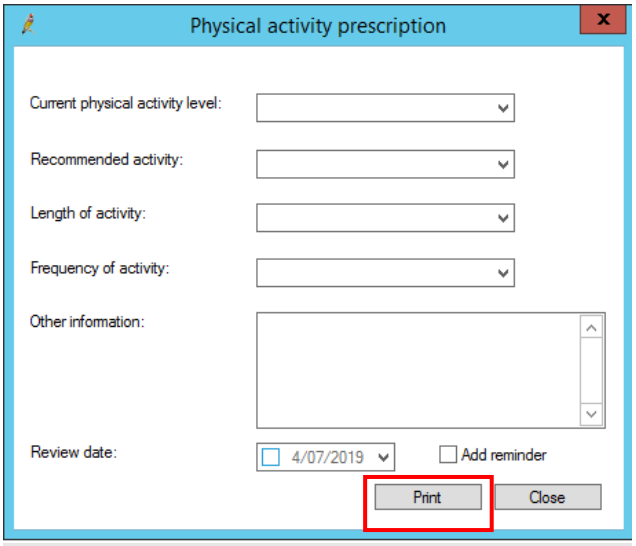
Reflection on Activity 2.2**:**

Practice name:	Date:
Team member:	

Entering physical activity information in the patient file in Best Practice

1. Open the patient file.
2. Select '**Clinical**' and '**Physical Activity Prescription'.**

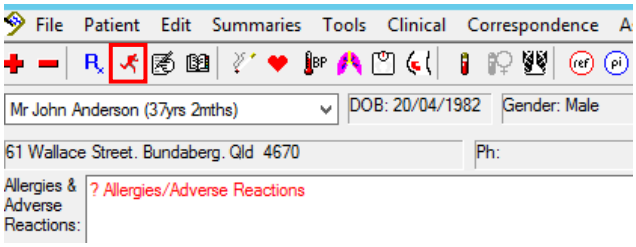




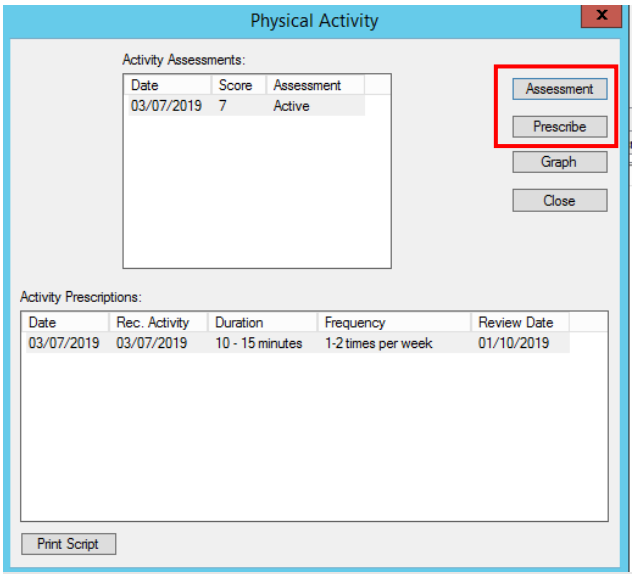
3. Complete the physical activity by using the drop-down menu options.
4. Click '**Print**' to save.

Entering physical activity information in the patient file in Medical Director

1. Open the patient file.
2. Click on the Physical Activity Prescription (red person running) on the toolbar.

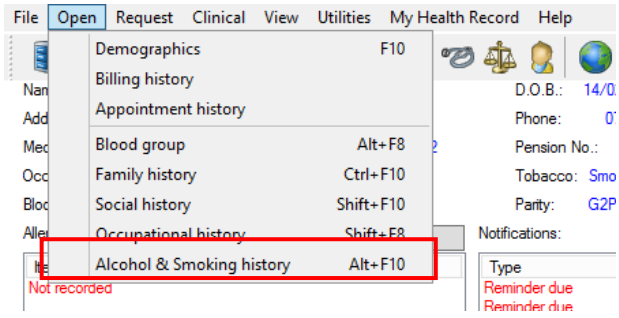


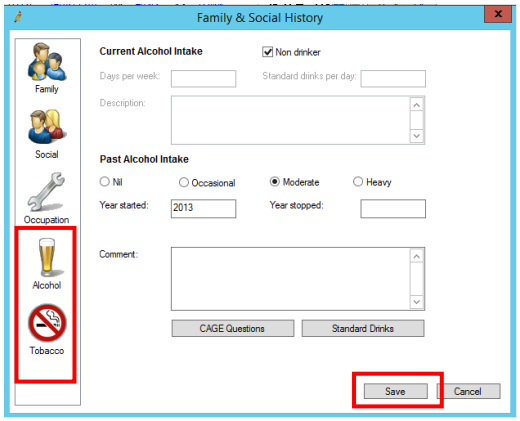
3. You can then complete an assessment or prescribe the patient a physical activity prescription.



Instructions for entering alcohol and smoking status in Best Practice

1. While the patient file is open, select **Open** and **alcohol & smoking history.**

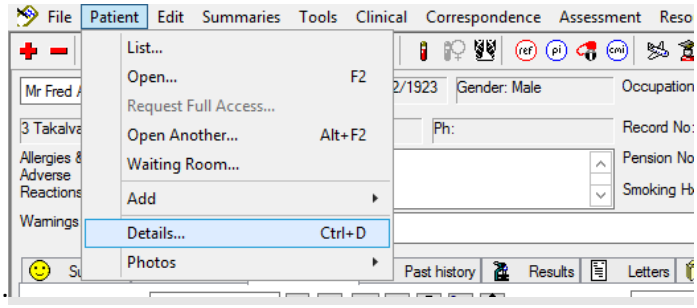




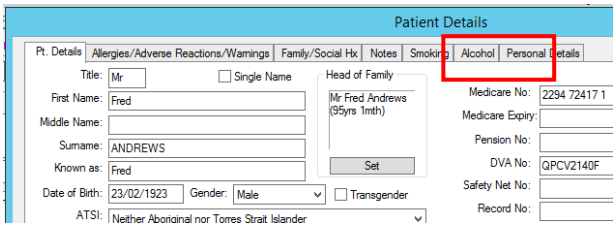
2. Select **Tobacco** on the left-hand side menu.
3. Once you have entered the information, select **alcohol.**
4. Select **Save** to complete.

Instructions on entering alcohol and smoking status into Medical Director

1. Open the patient file.
2. From the '**patient'** menu select '**details**'.



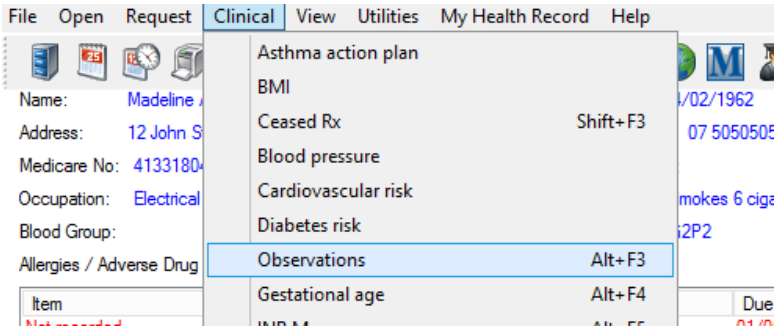
3. This will open a screen where you can enter patient details, allergy/reactions, family/social history, smoking, alcohol and personal details.
4. Select **Smoking.**

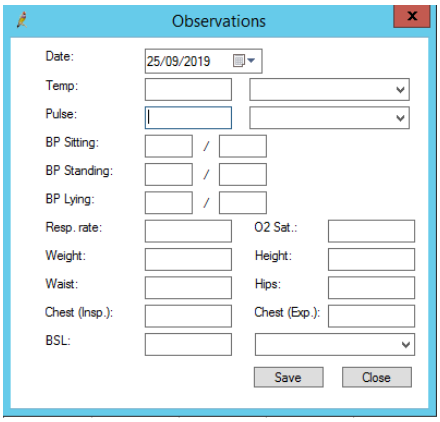


5. Once you have entered the details, select **Alcohol.**
6. Once all details have been completed select **save**.

Instructions on entering measurements into Best Practice

1. Open the patient file.
2. From the top menu, select **Clinical** and then **Observations.**

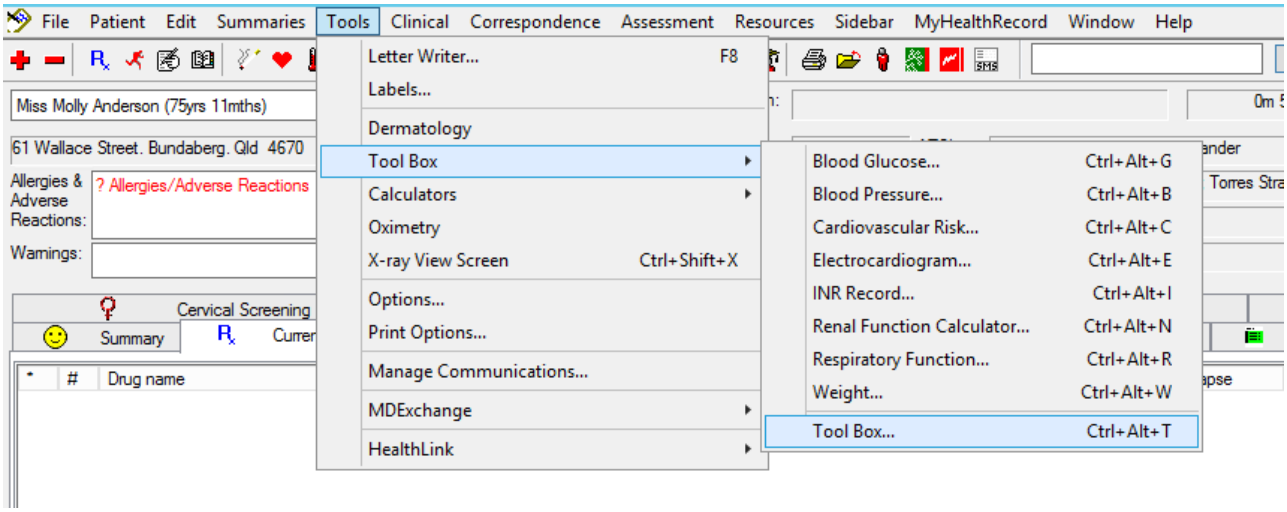




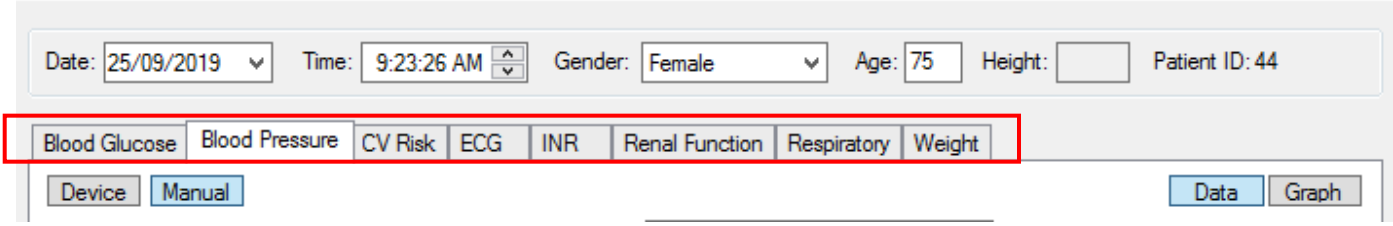
3. Enter the appropriate information.
4. Click **save** to complete.

Instructions on entering measurements into Medical Director

1. Open the patient file.
2. From the top menu select **Tools**, **Tool Box** & **Tool Box.**



3. Select the appropriate tab and enter the relevant information.



4. Click **save** to complete.

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:

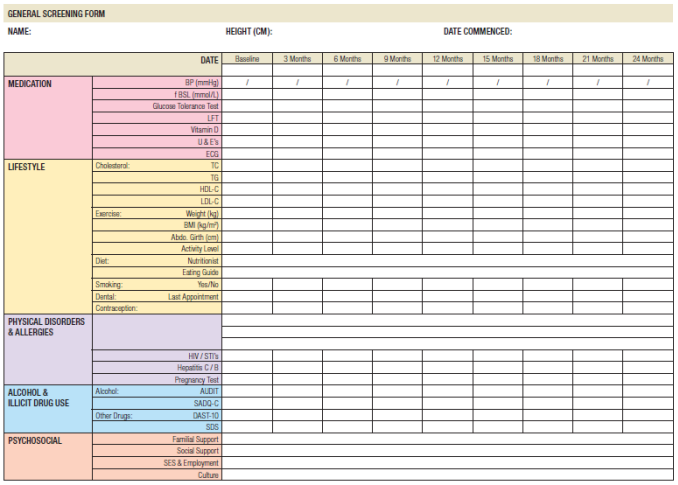
- a holistic, person centred approach to physical and mental health and wellbeing
- effective promotion, prevention and early intervention
- equity of access to all services
- improving quality of health care
- care coordination and regional integration across health, mental health and other services and sectors which enable a contributing life
- monitoring of progress towards improved physical health and wellbeing[15]

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									

[15] 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.[16] 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. [17] 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.

[16] https://www.nice.org.uk/guidance/qs80/chapter/Quality-statement-6-Assessing-physical-health
[17] 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.[18]

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.

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. [19]

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.

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

[19] 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 actions to be taken.** ☐ No: continue with activity.	See instructions from CAT4 on how to identify patients who do not have an ECG recorded *(ensure you select schizophrenia under conditions).* 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.

Description	Status	Action to be taken
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.** ☐ No: you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection on Activity 3.1:

Practice name:	Date:
Team member:	

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
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 GP Management Plan and Team Care Arrangement (if eligible)		

Reflection on Activity 3.2:

Practice name:	Date:
Team member:	

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 actions 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

Description	Status	Action to be taken
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.** ☐ No: you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection on Activity 3.3**:**

Practice name:	Date:
Team member:	

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.[20] 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.

Mental illness and diabetes

Up to 50% of people diagnosed as having diabetes are also thought to have a mental illness.[21]

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.[22]

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.[23]

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.[24] 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. [25]

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. [26]

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

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

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

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.[27]

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.[28]

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, making a plan, putting affairs in order, giving away possessions, preparing a note etc.
- For young people, the HEADS 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 Mental Health Act.

ThinkGP has more information about training options.

[27] https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(19)30414-6/fulltext
[28] https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/red-book/psychosocial/suicide

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.

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 x 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 GP Management Plan claimed in the past 12 months		

	Description	Total number of active patients as per RACGP criteria (3 x visits in 2 years)	Total number of active patients
4.1e	Number of active patients with a mental illness and coronary heart disease who have not had a GP Management Plan 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.*

Reflection on Activity 4.1:

Practice name:	Date:
Team member:	

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 actions to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. higher number of patients with mental illness and diabetes than expected)* How will this information be communicated to the practice team?

Description	Status	Action to be taken
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.** ☐ No: you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection on Activity 4.2:

Practice name:	Date:
Team member:	

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.

Temporary mental health telehealth item numbers

During the COVID-19 outbreak, the Australian Government has provided temporary item numbers to manage patients with a mental illness. These numbers are available from March 2020 to September 2020. More information is available on the MBS fact sheet.

Service	Existing Items *face to face*	Telehealth items *via video-conference*	Telephone items *– for when video-conferencing is not available*
Mental Health Services			
GP without mental health skills training, preparation of a GP mental health treatment plan, lasting at least 20 minutes, but less than 40 minutes	2700	92112	92124
GP without mental health skills training, preparation of a GP mental health treatment plan, at least 40 minutes	2701	92113	92125
Review of a GP mental health treatment plan or Psychiatrist Assessment and Management Plan	2712	92114	92126
Mental health treatment consultation, at least 20 minutes	2713	92115	92127
GP with mental health skills training, preparation of a GP mental health treatment plan, lasting at least 20 minutes, but less than 40 minutes	2715	92116	92128
GP with mental health skills training, preparation of a GP mental health treatment plan, at least 40 minutes	2717	92117	92129

Chronic Disease Management plans

Holistic team-based care of both physical and mental health is critical to achieve the best possible outcomes for people living with both mental illness and chronic physical disease.

There are two types of plans that can be prepared by the patient's regular General Practitioner (GP) for Chronic Disease Management (CDM): GP Management Plans (GPMP); and Team Care Arrangements (TCAs)

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.[29]

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

Temporary telehealth item numbers

During the COVID-19 outbreak, the Australian Government has provided temporary item numbers to manage patients. These numbers are available from March 2020 to September 2020. More information is available on the MBS fact sheet.

Service	Existing Items *face to face*	Telehealth items *via video-conference*	Telephone items *– for when video-conferencing is not available*
Chronic disease management			
Preparation of a GP management plan (GPMP)	721	92024	92068
Coordination of Team Care Arrangements (TCAs)	723	92025	92069
Contribution to a Multidisciplinary Care Plan, or to a review of a Multidisciplinary Care Plan, for a patient who is not a care recipient in a residential aged care facility	729	92026	92070
Contribution to a Multidisciplinary Care Plan, or to a review of a multidisciplinary care plan, for a resident in an aged care facility	731	92027	92071
Review of a GPMP or Coordination of a Review of TCAs	732	92028	92072

Mental health patients and Heart Health Checks (MBS item 699)

People with mental illness are at an increased risk of cardiovascular disease. In addition, anxiety, stress and depression may exacerbate coronary heart disease[30]. Cardiovascular disease (CVD) is a leading cause of death in Australia, with more than 43,000 deaths attributed to the disease in 2017. Modifiable CVD risk factors are responsible for 90% of the risk of myocardial infarction, providing evidence CVD is largely preventable. Unfortunately, studies suggest many people at high risk of CVD are not receiving guideline recommended blood pressure and lipid lowering therapy. The federal government introduced an MBS item number, **699 (177 for non-VR**), for GPs to conduct a comprehensive cardiovascular health assessment utilising the Australian Absolute Cardiovascular Disease Risk calculator.[31]

[29] https://www1.health.gov.au/internet/main/publishing.nsf/Content/pacd-gp-mental-health-care-pdf-qa#7_1
[30] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6016051/
[31] *Heart Foundation Australia*

Who is eligible for a Heart Health Check?

The intention of this item is to identify cardiovascular disease (CVD) in people not known to have CVD including:

- Aboriginal or Torres Strait Islander persons who are aged 30 years and above;
- adults aged 45 years and above, who have not claimed a health assessment in the previous 12 months.

More information is available on MBS online

Mental health patients and Diabetes Cycle of Care (if relevant)

The annual Diabetes Cycle of Care incentivises quality diabetes care (e.g. through MBS items 2517 & 2521). However, the scope of the annual Cycle of Care recommendations is narrower than the guidelines' recommendations. Completion of an annual Diabetes Cycle of Care requires assessment of the following:

- taking a patient history
- performing a clinical examination
- arranging any necessary investigation
- implementing a management plan
- providing appropriate preventative care.

Patients and practitioners need to discuss desired outcomes and agree on goals to achieve.[32]

Full details about diabetes cycle of care can be found at MBS Online.

Aboriginal and Torres Strait Islander Peoples Health Assessment (MBS 715) (if relevant)

Aboriginal and Torres Strait Islander peoples are estimated to have a life expectancy 10 years lower than other Australians, with an even greater gap for those living with mental illness.[33] Conducting a health assessment provides an opportunity to ensure a thorough health check is completed and a holistic treatment plan is developed.

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.

See MBS descriptor for more information.

Temporary telehealth item numbers

During the COVID-19 outbreak, the Australian Government has provided temporary item numbers to manage patients. These numbers are available from March 2020 to September 2020. More information is available on the MBS fact sheet.

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[32] https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/management-of-type-2-diabetes

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

Service	Existing Items *face to face*	Telehealth items *via video-conference*	Telephone items *– for when video-conferencing is not available*
Health Assessment for people of Aboriginal or Torres Strait Islander descent			
Health assessment	715	92004	92016

Mental illness and Health Assessments (MBS item 701-707)

Some patients with a mental illness may be eligible for a health assessment. A health assessment is the evaluation of an eligible patient's health and wellbeing. General practitioners use it to help decide if a patient needs:

- preventive health care
- education to improve their health and wellbeing
- a recommendation for appropriate interventions.

There are time-based MBS health assessment items: **701 (brief), 703 (standard), 705 (long)** and **707 (prolonged)**. If you are a non-vocationally registered GP, the following item numbers can be claimed**: 224 (brief), 225 (standard), 226(long)** and **227 (prolonged)**.

More information available from MBS online.

Mental health patients and electrocardiographs (ECG – MBS item 11700)

Medicare has an item number available for GPs to claim for twelve-lead electrocardiography, tracing and report. More information is available from MBS online.

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 MH treatment plan claimed in the past 12 months		
5.1d	Number of patients with a mental illness and an MH treatment plan review claimed in the past 12 months		

	Description	Number of eligible patients	Number of MBS items claimed
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 Home Medication Review 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 GP management plan completed in the past 12 months *(please note: patient must have another chronic medical condition)*		

Reflection on Activity 5.1:

Practice name:	Date:
Team member:	

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 Home Medication Review? (*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 Home Medication Reviews 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 actions to be taken.**	Follow the instructions to complete this.
Do relevant staff know what the criteria is for completing Mental Health treatment plans, Home Medication Reviews and Health Assessments through Medicare?	☐ Yes, continue with the activity. ☐ No, **see actions to be taken.**	Refer to MBS criteria at: Mental Health treatment plans Home Medication Review Criteria Health Assessments

Description	Status	Action to be taken
Does the practice have a system for tracking Medicare item number claiming?	☐ Yes, continue with the activity. ☐ No, **see actions to be taken.**	Do GPs have access to their day sheets to identify MBS item numbers claimed? Does the practice nurse check that any assessments completed have the correct billing? Are item numbers checked against appointment diary prior to batching?
Do you know the contact details for any MBS related questions?	☐ Yes, continue with the activity. ☐ No, **see actions 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 actions 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.** ☐ No, you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection on Activity 5.2:

Practice name:	Date:
Team member:	

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.

Reminders, recalls and prompts (flags)

Reminders are used to initiate prevention, before or during the patient visit. They can be either opportunistic or proactive. Recalls are a proactive way to follow up on a preventive or clinical activity. Prompts are usually computer generated, and designed to opportunistically draw attention to a prevention or clinical activity needed by the patient during the consultation. Using a recall system can seem complex, but there are three steps you can take:

- be clear about when and how you want to use these flags
- explore systems used by other practices, your PHN, and information technology specialists to ensure you get the correct system
- identify all the people who need to be recalled and place them in a practice register. This will help to ensure that the recall process is both systematic and complete.

You need to ensure that patient consent is obtained prior to including them in the practice reminder system. Some examples specific to mental illness may include review of GP mental health plan due, medication monitoring due, or depot injection due.

Train IT Medical – recall and reminder resources for Medical Director

Train IT Medical has a number of resources available for practices to use to assist in managing their recall and reminder systems. These include:

- Sample Recall Management Protocol/Flowchart
- MedicalDirector learning resources
- Sample Quality Improvement Activity
- Train IT Medical 'Recalls, Reminders & Screening' using MD Presentation
- Read our MedicalDirector Clinical Top 5 'Recalls & Reminders' Tips

Train IT Medical – recall and reminder resources for Best Practice

Train IT Medical has a number of resources available for practices to use to assist in managing their recall and reminder systems. These include:

- Reminders quick reference guide
- Creating a reminder template
- Sending SMS reminders to patients
- Recall & reminders – why it's so hard

Activity 6.1 – Reminder system

<table>
<tr><th></th><th colspan="2">Status</th><th>Action to be taken</th></tr>
<tr><td>Does your practice have a routine reminder for appropriate follow up of physical health checks for people with mental illness? (e.g. cancer screening, diabetes review, ECG, depot injection is due etc.)</td><td colspan="2">☐ Yes, continue with activity.

☐ No, see action to be taken.</td><td>Instructions for creating a reminder in Best Practice.

Instructions for creating a reminder in Medical Director.</td></tr>
<tr><td>Is consent obtained from patients, family members or carers to be included in the practice's reminder system?</td><td colspan="2">☐ Yes, how is this done?

☐ No, see action to be taken.</td><td>Include a section on the new patient information sheet about consent to participate in reminder system.

Clinicians ask patients prior to placing them on reminder system.</td></tr>
<tr><td>How does the practice record if a patient DOES NOT wish to be contacted offering reminder appointments?</td><td colspan="3"></td></tr>
<tr><td>Do clinicians know how to initiate a patient reminder within clinical software?</td><td colspan="2">☐ Yes, continue with activity.

☐ No, see action to be taken.</td><td>Clinician education on setting up patient reminders.</td></tr>
<tr><td rowspan="2">How regularly are reminder lists generated for each doctor/nurse?</td><td>Doctor</td><td>Practice nurse</td><td rowspan="2">Create a practice policy for frequency of generating lists.

Nominate a practice member to generate reminder lists.</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Is there a system for reviewing and actioning reminder lists? i.e.
all posted
all telephoned
wait for patient to attend
GPs review lists and classifies reminders.</td><td colspan="2">☐ Yes, continue with activity.

☐ No, see action to be taken.</td><td>Create policy for activating reminders due.

Nominate a practice member to activate reminders due.</td></tr>
<tr><td>Is there a system to identify in the appointment book when a patient is coming in for a reminder appointment?</td><td colspan="2">☐ Yes, continue with activity.

☐ No, see action to be taken.</td><td>Use of a symbol in the appointment book to identify type of appointment.</td></tr>
</table>

	Status	Action to be taken
Is there a process for acting on or removing outstanding reminders? E.g. patients fail to attend, reminder no longer needed.	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	GP education on removing reminders. Document practice process on removing reminders.
Is there a practice policy on how reminders are to be implemented? (e.g. *entering all reminders for the upcoming 12 months to ensure all tests are performed*)	☐ 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.
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.
After reviewing your practice 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 actions to be taken.** ☐ No, you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

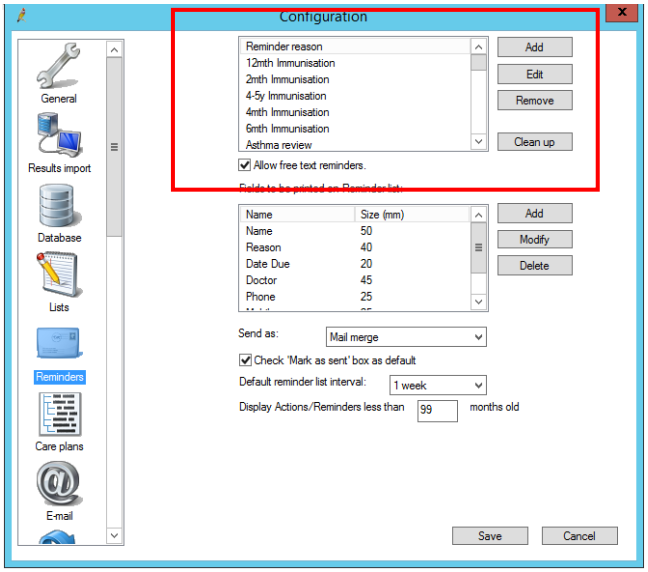
Reflection on Activity 6.1:

Practice name:	Date:
Team member:	

Creating reminder category for monitoring in Best Practice

To create a reminder category for monitoring patients with mental health in Best Practice: (*please note: always check the reminder list prior to creating a category as it may already be included)*

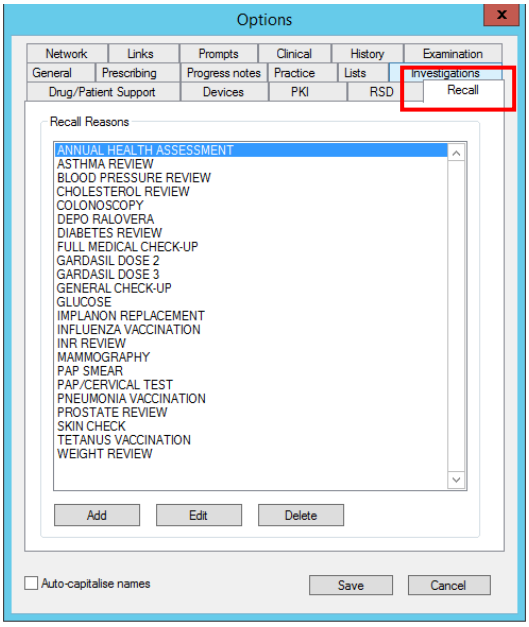
1. Select **Setup > Configuration** from the main Best Practice screen.
2. Scroll down on the left-hand side to find the Reminders icon.
3. The top section of the screen shows the Reminder Reason list — this is the full list of reminder reasons available when reminders are being created within the patient record.
4. Choose **Add.**



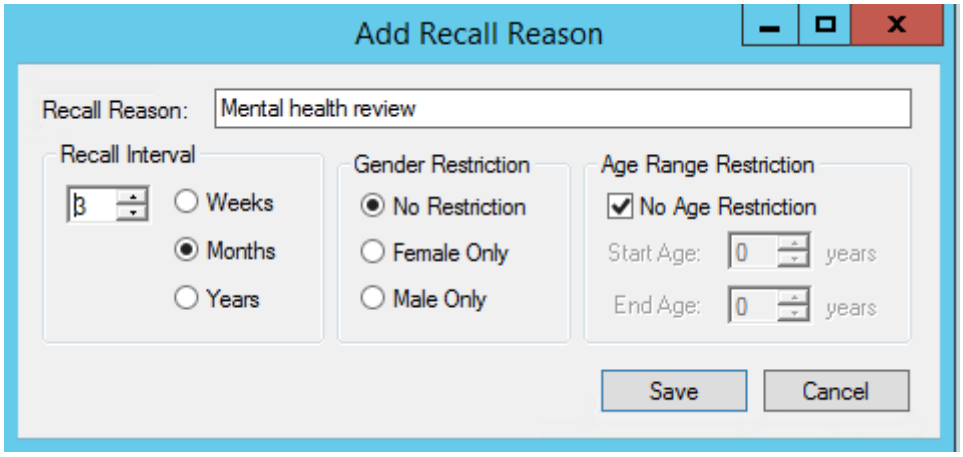
5. Type in the reason as appropriate (e.g. mental health review) and then the interval.
6. Click Save and Save.

Creating reminder category for monitoring in Medical Director

To create a reminder category for monitoring mental health patients in Medical Director: (*please note: always check the reminder list prior to creating a category as it may already be included)*



1. Select **Tools > Options**. Medical Director options will appear.
2. Select the **Recall tab**. The list of recall reasons is presented.
3. Select **Add.**
4. Enter a **name/description** for the recall reason you wish to add.
5. Modify other settings as desired. Note that these settings are simply the defaults for this recall reason, which can be overridden when you go to create a new recall for the patient.



- **Recall Interval:** How often the recall should occur, when it is used for recurring recalls (as opposed to once-off recalls).
- **Gender Restriction**: Whether the recall reason's availability is limited to a specific gender.
- **Age Range Restriction:** Whether the recall reason's availability is limited to a specific age group.

6. Click **Save** to confirm. You will be returned to the **Recall tab**, where your new recall reason is now listed.

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.[34]

Potential members of the multidisciplinary mental health team

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

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.

Metro South Health provide a number of services to patients with a variety of mental illness.

Services

- Acute Mental Health Inpatient Services
- Addiction Services
- Child and Youth Mental Health Services
- Consultation Liaison Psychiatry Services
- Deafness and Mental Health Statewide Consultation and Liaison Service
- Logan-Beaudesert Perinatal Wellbeing Service
- Mood Services
- Older Adult Mental Health Services
- Psychosis Services
- Rehabilitation Services
- Resource and Access Services
- Transcultural Mental Health Service

Under each section, referral requirements are listed to assist with the smooth transition of care. This is an example of the requirements for older adult mental health services.

Referrals

To ensure your service needs are met in a timely manner we would request the following information at time of referral:

- Self or carer referrals: Our triage clinicians will guide you through any additional information that may be required. It is essential to know about active Guardianship or Power of Attorney arrangements.
- For health practitioners: Key assessment findings, treatment interventions provided or proposed, and current General Practitioner/other service providers.
- For General Practitioners: Key assessment findings including physical examination and current medications. Suggested pathology ELFT, FBE, TSH MSU, serum levels of medication (if applicable) and cognitive test scores and neuroimaging (if relevant).
- For residential aged care facilities: General Practitioner review prior to referral (see GP requirements above), Psychogeriatric Assessment Scale (PS), Neuropsychiatric Inventory (NPI) and Cornell Scale for Depression results if available.
- Emergency services (Ambulance or Emergency Departments): These services can facilitate access for individuals in an acute crisis.
- What if the person won't agree to be seen? The *Mental Health Act 2016* provides for the involuntary assessment and treatment, and the protection, of persons with mental illness. Our triage service can advise you about this.

More information about referral criteria can be found at Metro South Health

SpotOnHealth HealthPathways

SpotOnHealth HealthPathways provides clinicians in the greater Brisbane South catchment with web-based information outlining assessment, management and referral to other clinicians for more than 550 conditions.

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.

To access SpotOnHealth Health Pathways you will need to log in.

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 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).

The PHN also provides information on assistance 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.

	Status	Action to be taken
Do all GPs and Nurses have login details for SpotOnHealth HealthPathways?	☐ Yes, continue with the 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 the 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 the activity. ☐ No, see **Action to be taken.**	Refer to Brisbane South PHN website. Refer to the FAQs page.
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?	

	Status	Action to be taken
After reviewing your referral pati 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.** ☐ No, you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection on Activity 7.1:

Practice name:	Date:
Team member:	

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
- RANZCP - Physical health of people with 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

Quality improvement activities using the model for improvement and PDSA

After completing any of the workbook activities above, you may identify areas for improvement in the management of physical health for patients with a mental illness. Follow these steps to conduct a quality improvement activity using The Model for Improvement and PDSA. The model consists of two parts that are of equal importance.

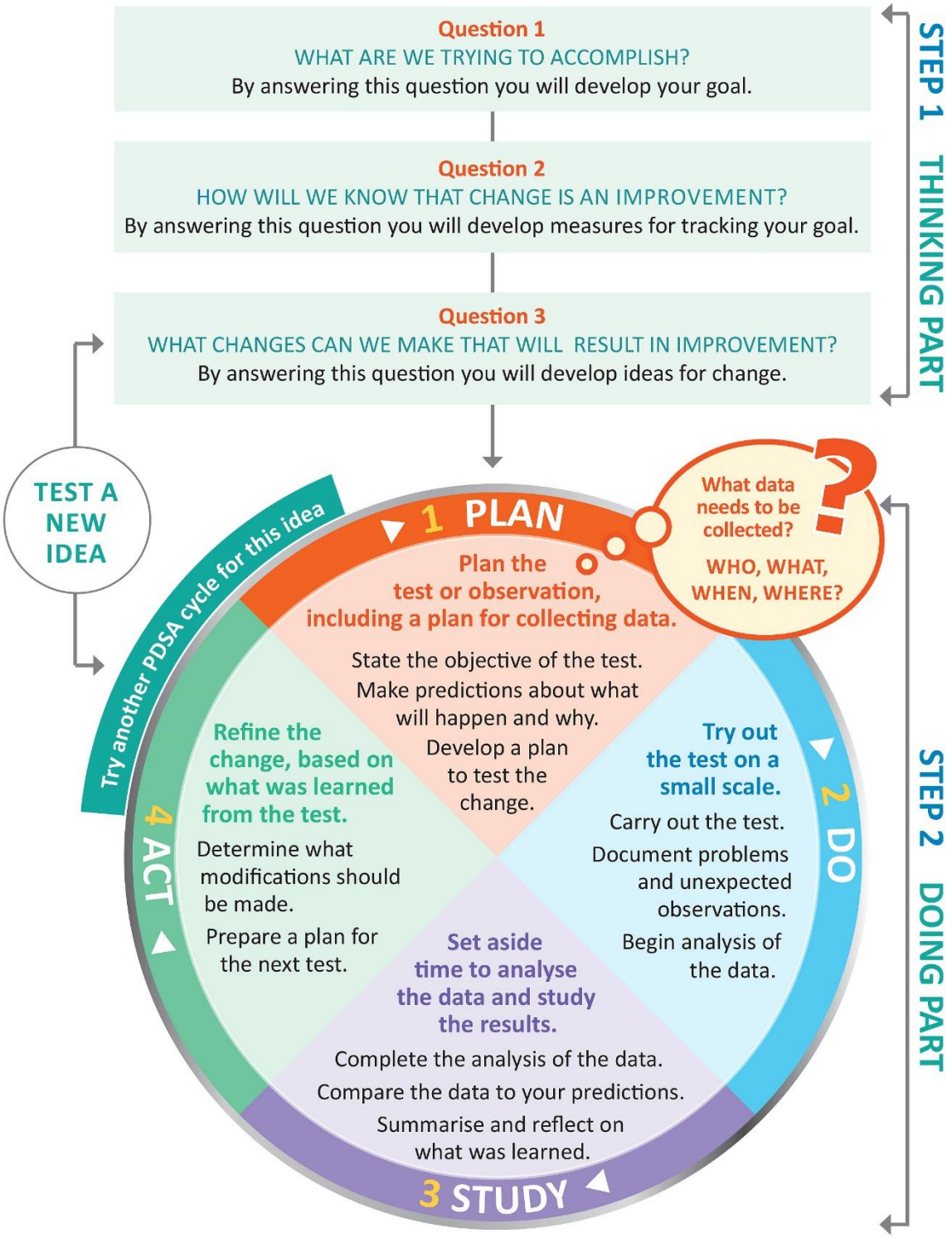
Step 1: The **'thinking'** part consists of three fundamental questions that are essential for guiding improvement work:

- 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.

The model for improvement diagram



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

Model for Improvement and PDSA worksheet EXAMPLE

Step 1: The Thinking Part - The 3 Fundamental Questions

Practice name:	Date:
Team member:	

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

By answering this question, you will develop your goal for improvement

Our goal is to:

- Ensure all active patients with a mental illness 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 14 Feb.

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

By answering this question, you will develop MEASURES to track the achievement of your goal.
E.g. Track baseline measurement and compare results at the end of the improvement.

We will measure the percentage of active patients with a mental illness who have height, weight and BMI recorded.

To do this we will:

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

B) Identify the number of active patients with a mental illness with height, weight and BMI recorded.

B divided by A x 100 produces the percentage of patients with 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 develop the IDEAS that you can test to achieve your CHANGE goal.
You may wish to BRAINSTORM ideas with members of our Practice Team.

Our ideas for change:

1. Using CAT4, identify active patients with a mental illness with height, weight and BMI recorded.
2. Identify patients from list exported from CAT4 and ensure TopBar prompts are working.
3. Ensure the whole of practice team is aware of the goal and encourage all team members to enter missing information.
4. Organise a campaign targeted at patients aged 65 years to 74 years to attend for a heart health check.

The team selects one idea to begin testing with a PDSA.

Note: Each new GOAL (1st Fundamental Question) will require a new Model for Improvement Guide

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

Model for Improvement and PDSA worksheet EXAMPLE

Step 2: The Doing Part - Plan, Do, Study, Act

You will have noted your IDEAS for testing when you answered the third Fundamental Question in Step 1
You will use this sheet to test an idea.

PLAN	Describe the brainstorm idea you are planning to work on. (Idea)
Plan the test, including a plan for collecting data	*What exactly will you do? Include what, who, when, where, predictions and data to be collected.*
Idea: The practice nurse will opportunistically gather patients each day from the waiting room to obtain measures What: Mary the receptionist will search patients with a mental illness and identify who is missing their height, weight and BMI. Lucy the nurse will see these patients when they arrive at the practice. Who: Receptionist (Mary) and Nurse (Lucy) When: Begin 4 January. Where: at the practice. Prediction: 60% of the active patient mental health population will have height, weight and BMI recorded. Data to be collected: Number of active patients with a mental illness and number of active patients with a mental illness with height, weight and BMI recorded.	
DO	**Who is going to do what? (Action)**
Run the test on a small scale	*How will you measure the outcome of your change?*
Completed 20 May – the receptionist contacted Brisbane South PHN for support with the PenCS CAT4 search and the export function. The data search was conducted very quickly, and the receptionist was upskilled to conduct further relevant searches.	
STUDY	**Does the data show a change? (Reflection)**
Analyse the results and compare them to your predictions	*Was the plan executed successfully?* *Did you encounter any problems or difficulty?*
A total of 327 active mental health patients (57%) 15 years and older have had their height, weight and BMI recorded. = 3% lower than predicted.	
ACT	**Do you need to make changes to your original plan? (What next)** **OR Did everything go well?**
Based on what you learned from the test, plan for your next step	*If this idea was successful you may like to implement this change on a larger scale or try something new* *If the idea did not meet its overall goal, consider why not and identify what can be done to improve performance*

1. Create a PenCS Topbar prompt to ensure all patients aged 15 years and older with an active mental illness have height, weight and BMI recorded. Review this by 31 July (in 2 months' time) to determine if there has been an increase in the % of patients recorded.
2. Ensure the clinical team know how to enter height, weight and BMI in the medical software.
3. Remind the whole team that this is an area of focus for the practice.

Repeat Step 2 for other ideas – What idea will you test next?

Model for Improvement and PDSA worksheet template

Step 1: The Thinking Part - The 3 Fundamental Questions

Practice name:	Date:
Team member:	

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

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

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

By answering this question, you will develop MEASURES to track the achievement of your goal.

E.g. Track baseline measurement and compare results at the end of the improvement.

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

By answering this question, you will develop the IDEAS that you can test to achieve your CHANGE goal.

You may wish to BRAINSTORM ideas with members of our Practice Team.

Idea:

Idea:

Idea:

Idea:

Note: Each new GOAL (1st Fundamental Question) will require a new Model for Improvement plan.
Source: Langley, G., Nolan, K., Nolan, T., Norman, C. & Provost, L. 1996, The Improvement Guide, Jossey-Bass, San Francisco, USA.

Model for Improvement and PDSA worksheet template

Step 2: The Doing Part - Plan, Do, Study, Act cycle

You will have noted your IDEAS for testing when you answered the third Fundamental Question in Step 1
You will use this sheet to test an idea.

PLAN	Describe the brainstorm idea you are planning to work on. (Idea)
Plan the test, including a plan for collecting data.	*What exactly will you do? Include what, who, when, where, predictions and data to be collected.*
DO	**Who is going to do what? (Action)**
Run the test on a small scale.	*How will you measure the outcome of your change?*
STUDY	**Does the data show a change? (Reflection)**
Analyse the results and compare them to your predictions.	*Was the plan executed successfully?* *Did you encounter any problems or difficulty?*
ACT	**Do you need to make changes to your original plan? (What next)** **OR Did everything go well?**
Based on what you learned from the test, plan for your next step.	*If this idea was successful, you may like to implement this change on a larger scale or try something new.* *If the idea did not meet its overall goal, consider why not and identify what can be done to improve performance.*

Repeat Step 2 for other ideas - What idea will you test next?

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