phn BRISBANE SOUTH

An Australian Government Initiative

QUALITY IMPROVEMENT TOOLKIT FOR GENERAL PRACTICE

Advance Care Planning

Version 3

November 2021

Advance Care Planning

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 minimal effort is wasted. There is an advance care planning example using the MFI at the end of this module.

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

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.

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

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

What is advance care planning (ACP)?

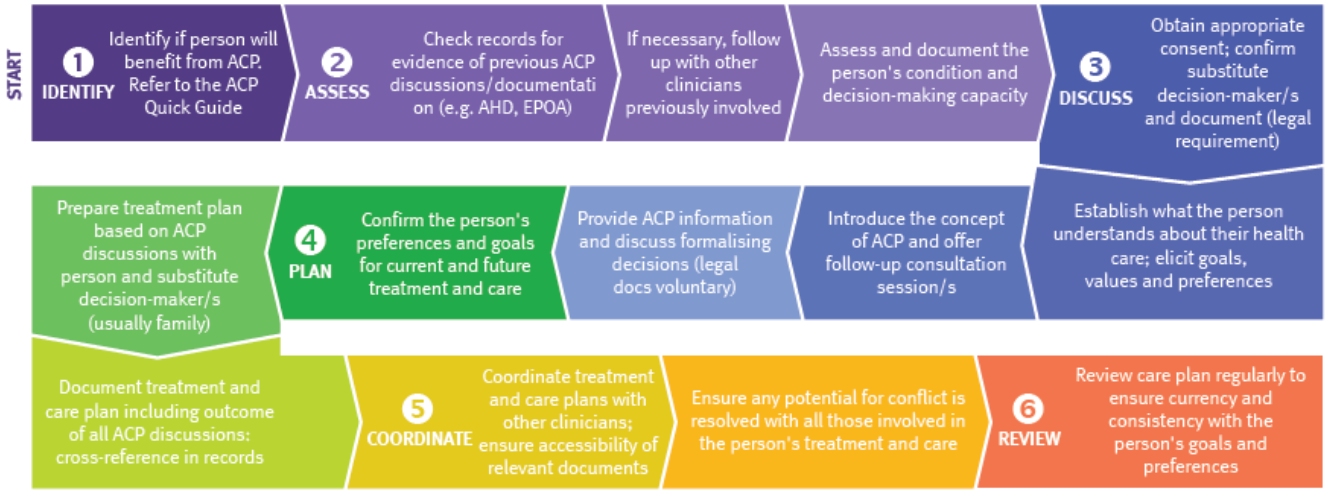
Advance care planning (ACP) is a person-centred approach for planning current and future health and personal care that reflects the person's values, beliefs and preferences. The ACP process is collaborative and coordinated. It aims to develop an understanding of the person's treatment and care goals in order to assist health professionals to better meet their needs.

Effective ACP involves ongoing communication between the person, those closest to them, and a multidisciplinary health care team to optimise the person's current treatment, care, and quality of life. ACP can be carried out at any time and will be driven by the person's care needs and their willingness to participate.

ACP is an iterative process and should be integrated into clinical practice and routine care. ACP plans should be reviewed regularly to ensure plans remain consistent with the person's values, beliefs and preferences for health and personal care.

ACP process

ACP is an accepted process and can commence at any stage. Repeat stages as required. Carefully document to ensure all clinicians can access patient information.



[1]

[1] https://www.health.qld.gov.au/__data/assets/pdf_file/0031/688261/acp-process.pdf

What are the triggers for ACP?

Serious illness or injury can happen to anyone, so it is recommended that everyone has an advance care directive. Making an advance care directive, and discussing it with loved ones and doctors can offer everyone peace of mind. Planning is particularly important in several scenarios. Triggers for ACP can include if a person:

- raises ACP with a member of the general practice team
- has an advanced chronic illness (for example: chronic obstructive pulmonary disease (COPD) or heart failure)
- has a life limiting illness (for example: dementia or advanced cancer)
- is aged 75 years or older, or 55 years or older if they are an Aboriginal and/or Torres Strait Islander person
- is a resident of, or is about to enter, an aged care facility or is at risk of losing competence (for example: has early dementia)
- has a new significant diagnosis (for example: metastatic disease or transient ischemic attack)
- is at a key point in their illness trajectory (for example: recent or repeated hospitalisation, or commenced on home oxygen)
- does not have anyone (such as a family, caregiver or friend) who could act as substitute decision-maker
- may anticipate decision-making conflict about their future health care
- if the person has a carer

ACP relies on the patient having testamentary capacity.[2] A person does not have to be ill to start advance care planning. Healthy people are encouraged to think about their health and care preferences and discuss them with their family, friends, carer and/or health care team.

What are the benefits of ACP?

ACP benefits everyone: the person, their family, carers, health professionals and associated organisations.

- It helps to ensure people receive the care they actually want.
- It improves ongoing and end of life care, along with personal and family satisfaction.
- Families of people who have an ACP have less anxiety, depression, stress and are more satisfied with care.
- For health care professionals and organisations, it reduces unnecessary transfers to acute care and unwanted treatment.[3]

Aim of this QI toolkit

To increase the number of advance care directives completed with patients to ensure their end of life preferences are document and respected

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The following checklists and activities will help guide you to achieve the toolkit aim and allow you to work through the process at your own pace. The toolkit is designed to assist practices to meet the PIP QI incentive.

[2] https://www.advancecareplanning.org.au/for-health-and-care-workers
[3] https://www.advancecareplanning.org.au/for-family-friends-carers/understanding-advance-care-planning

How to use this toolkit

There are checklists included below that will guide you and your practice in assisting patients to meet their ACP needs. This includes how to:

- Identify a sample group of patients (between 50-100 patients) by reviewing data measures from your practice population. (suggestions from the Greater Choices for at Home Palliative Care Project Phase 2 final report) include:
    - Heart failure patients with CKD and COPD
    - Heart failure patients with CKD
    - Heart failure patients with diabetes
    - Lung cancer
    - Patients taking warfarin
    - Aboriginal and Torres Strait Islanders ≥ 55 years old with asthma
    - Patients with no COVID vaccination recorded.
- 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

1300 467 265

Activity 1 – Advance care planning (ACP)

Aspects of ACP

There are a number of aspects to consider when discussing end of life care with patients. These include:

Wills and testaments

A will is a legal document that says what individuals would like to happen with their money, belongings and other assets when they pass away. The will outlines to whom people want to give their estate and who they would like to administer the estate when they pass away.

The Public Trustee of Queensland provides a free will-making service to all Queenslanders.

Registration with myGov

myGov is a secure way to access government services online with one login and one password. Some of the services people can link to their myGov account include:

- Australian Taxation Office (ATO)
- Centrelink
- Department of Veterans' Affairs (DVA)
- Medicare
- My Aged Care
- My Health Record (MHR)
- National Disability Insurance Scheme (NDIS).

Enduring power of attorney

An enduring power of attorney is a formal document giving one person the authority to make personal and/or financial decisions on another person's behalf. Personal decisions relate to an individual's care and welfare, including health care. Financial decisions relate to the management of finances (e.g. paying bills and taxes, selling or renting the home, using income to pay for an individual's needs or invest their money).

Individuals can complete an enduring power of attorney form at any stage.

Statement of choices

The statement of choices allows a person to record their personal values and preferences for health care, which assists family and health care professionals to decide on medical care when that person is unable to make or communicate decisions. There is a form for those who have decision-making capacity (Form A), and those without decision-making capacity (Form B).

Advance care directives

Advance care directives are a set of directives stating an individual's wishes for the future health care of their various medical conditions. These directives come into effect only if a person is unable to make their own decisions.

Registration with 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.

Organ donor

Individuals can list their decision to donate organs and tissues for transplants. Read more about organ donation on the DonateLife website.

Activity 1.1 – ACP patient checklist

The aim of this activity is to guide the practice to ensure that each patient is informed about all options in relation to advance care planning and how this can be incorporated when completing health assessments and management plan reviews.

Checklist for ACP	Completed
Does the patient have a will?	☐
Is the patient registered with myGov?	☐
Does the patient have an enduring power of attorney?	☐
Has the patient completed a statement of choices?	☐
Does the patient have an advance care directive?	☐
Is the patient registered with My Aged Care?	☐
Has the patient considered being an organ donor?	☐
Has the patient or carer provided copies of ACP documentation to the Office of Advance Care Planning?	☐

Medicare Benefits Schedule (MBS) items and ACP

Discussing ACP may be incorporated when completing specific health assessments and chronic disease management plans. 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.

Please note: Brisbane South PHN has a comprehensive toolkit looking at MBS items.

MBS item	Completed
GP management plan	☐
Team care arrangements	☐
GPMP/TCA review x 3 times per year	☐
Nurse chronic disease item number	☐
Health assessment	☐
Aboriginal and Torres Strait Islander health assessment	☐
Home medication review	☐

Activity 2 – Planning your QI activity

Activity 2.1 –QI checklist

The aim of this activity is to work through the suggested steps to support the successful implementation of advance care planning.

Stage	Steps	Details	Completed
Plan your activity	Arrange a practice meeting for practice team members to discuss a potential focus group of patients for advance care planning.	QI activity could be added as a standing agenda item on your usual team meetings; OR Form a QI team within your practice and schedule meetings to discuss options and strategies.  *TIP: To meet PIP QI requirements, you must undertake QI as a team.*	□
	Identify and establish key practice team members to implement this QI activity.	Suggested team members include: 1. General practitioner (GP) 2. Practice manager 3. Practice nurse 4. Receptionist Refer to the practice team roles and responsibility for ideas.  *TIP: Specify roles and delegate responsibilities for each team member and ensure these are documented in the PDSA.*	□
	Identify who will be the QI Lead at your practice.	Who is this person? _____ Do they understand their role? □ Yes □ No  *TIP: The QI Lead provides day to day leadership to support ongoing activity, maintain progress, delegate tasks and ensure QI processes are embedded into routine over time.*	□

Stage	Steps	Details	Completed
	Conduct searches on CAT4 to identify an appropriate sample group of patients to focus on. (*You may wish to conduct your searches prior to holding a practice meeting).*	Practices may focus on any QI area that is informed by your clinical information system data that meet the needs of your practice population. Alternatively, the following recipes can be used as a guide to assist practices in identifying achievable QI activities. • Identify patients at high risk of dementia • Identify patients with diabetes, CVD, or CKD who have never had a GPMP/TCA claimed • Identify patients eligible for an annual 75+ health assessment • All patient aged 75+ with existing chronic conditions • Identify patients eligible for an Aboriginal or Torres Strait Islander health assessment • Palliative care recipes  *TIP: You may have already identified your sample group of patients from previously prepared CAT4 recipe reports.* *TIP: Reviewing and analysing data is a PIP QI requirement.*	☐
	Confirm sample group of patients.	Identify your patients. It is suggested that you start with 50 -100 patients initially.  *TIP: You need to generate a list with individual names who are identified as most appropriate for discussing advance care planning.*	☐
	Upskill practice team members (if required).	Ensure all relevant team members understand what an advance care directive is. Refer to training modules, health professional resources or information on beginning the conversation as required.	☐

Stage	Steps	Details	Completed
	Discuss and document your practice approach, targets and expected outcomes as a result of completing your QI activity. PDSA examples are available in each QI toolkit.	Document agreed strategies, actions, baseline data, timeframes and targets in PDSA template.  *TIP: Consider potential factors that may negatively impact the activity and factor these into timelines. (e.g. accreditation, staff leave, global pandemic, influenza vaccination season).* Refer to the PDSA blank template. Use the PDSA example below as a guide: • increase the number of patients with advance care directives  *TIP: Completing a PDSA template will form **part** of the evidence that is required to ensure your practice meets the criteria and is eligible for the PIP QI payment.* *TIP*: *Refer to ideas to increase the number of Advance Care Directives completed in your practice.*	☐
	Identify and order any resources or publications required.	Refer to the list of resources available from Advance Care Planning Australia, including resources available in languages other than English.	☐
Implement your activity	Communicate details of the focused QI activity to the whole practice team.	Share the updated PDSA with the whole practice team to ensure everyone is aware and knows their role to support implementation of the activity.	☐
	Hold meetings and document minutes and outcomes as you progress through the activity.	Holding regular meetings will help the practice maintain momentum and keep people on task to achieve QI targets. *TIPS:* • *Minutes of meetings form part of the PIP QI documentation* • *a PDSA can be edited and updated as you progress the activity.* • *Plan meetings in advance to ensure availability of key members.*	☐

Stage	Steps	Details	Completed
	Contact Brisbane South PHN for support (if required).	Brisbane South PHN can assist your practice to achieve its activity goals. Contact the team on support@bsphn.org.au to assist with using data extraction tools, suggest QI strategies and tips.	☐
Review your activity	Review PDSA and targets to assess progress or success.	You may wish to duplicate your data search on CAT4 to assist you to report on any improvements. Consider: • What worked? • What needs more work? • What did you learn on the way? • What have you updated or changed to support this activity? *TIPS:* • *Conducting a review of your process and data forms part of the requirements for PIP QI.* • *Ensure you document your findings to continue to meet the PIP QI guidelines.* • *If you have changed your systems and processes ensure these are documented in your practice policy & procedure manual.*	☐
	If outcome not achieved.	Review QI plan and propose a new strategy.	☐
	Hold a whole of practice meeting.	Communicating the results of your QI activity with your whole team is important.	☐
	Completion is a success whether outcome is achieved or not.	Celebrate all achievements, big or small. Use learnings to inform your next activity or repeat this one with a different plan.	☐
Next steps	Determine if this activity needs to continue as is, or requires changes.	If you have achieved your outcomes, ensure this activity continues within your usual processes. Consider options for a new activity.	☐

Activity 3 – Strategies for improving ACP in your practice

Ideas to increase the number of advance care directives completed in your practice

When you meet with your practice team, it is suggested that you discuss how your practice can initiate conversations and increase the number of advance care directives completed for patients. You may consider the following strategies:

- Ensure ACP is included in all health assessments including Aboriginal and Torres Strait Islander, 45-49-year-old and 75+ year old
- Include ACP as part of the GP Management Plan and review templates
- Conduct a search on CAT4 to identify patients with a chronic condition and send them a letter about ACP (examples include: patients with heart failure and CKD and COPD, OR patients with heart failure and CKD, OR patients with heart failure and diabetes, or patients with lung cancer, or patients prescribed warfarin, or Aboriginal and Torres Strait Islanders ≥ 55 years old with asthma, or patients without a COVID vaccination).
- Identify an area of care where advance health directive conversations can be initiated while patients are in the treatment room with the nurse (e.g. completing an ECG, wound care, immunisations)
- Set up a display table in your practice waiting room with resources and information about end of life care
- Ensure your practice website has a link to up to date ACP forms
- Put a note on clinical teams monitor reminding them to talk to patients about ACP
- Include information in the practice newsletter and social media about ACP
- Ensure relevant team members attend an education session on ACP.

Successful teams

Engaged and effective practice teams are the foundations for achieving sustainable improvements.

To achieve sustainable improvement, consider how your team currently operates. Is your team working together effectively and efficiently? Improving PIP QI measures requires a whole of team approach.

Documented role clarity is important to ensure efficiency and accountability. Below is an example of how responsibilities could be shared across the team. As there is a great deal of diversity between practices, consider what will work best for your team.

General Practitioners (GP)

- Respond to recall/reminder systems and engage in opportunistic discussions to encourage participation with eligible patients
- Perform a clinical review on each patient
- Support eligible patients to finalise advance care documentation, including addressing potential barriers (e.g. lack of knowledge, access etc)
- Maintain RACGP Standards for General Practice - Criterion GP2.2 - Follow up systems

Practice Nurses

- Work with reception staff to promote end of life care
- Respond to recall/reminder systems and engage in opportunistic discussions to encourage participation with eligible patients
- Initiate conversations with patients in relation to advance care planning documentation.

Practice Manager

- Maintain up to date patient registers
- Establish and oversee recall/reminder systems
- Support GPs with the flow of information in relation to PIP QI
- Support/manage reception staff responsibilities
- Manage succession planning
- Document policies and procedures
- Monitor progress against PIP QI improvement measures

Reception Staff

- Order and maintain supplies of resources, ensuring information is available in multiple languages
- Display brochures, flyers, posters and statement of choices forms
- Respond to recall/reminders opportunistically when a patient phones for an appointment and/or by handing relevant resources to patients in the waiting area
- Send GP signed recall/reminder letters (and/or text messages and phone calls) to eligible patients to encourage participation.

Medical and Nursing students (if relevant)

- Consider any of the above tasks that Medical and Nursing students may be able to complete and delegate. Ensure training is provided.

Activity 3.1 – Practice team roles in ACP

Based on the example above, identify the person responsible for each part of the process required to increase the number of advance care directives completed. Document each person's responsibilities in the table below.

Tasks for (insert QI Activity Name)		
	Name	**Responsibilities**
GP 		
Practice Nurse 		

Practice Manager 		
Receptionist 		

Resources

- RACGP – Advance care planning
- Queensland Government – Advance health directive
- Office of Advance Care Planning – Improving end of life care
- Advance health directive forms
- Advanced Care Planning Australia
- The Advance Project
- Training modules: Office of Advance Care Planning OR The Advance Project OR Palliative Care online training
- Statement of choices form

Links to other QI toolkits

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

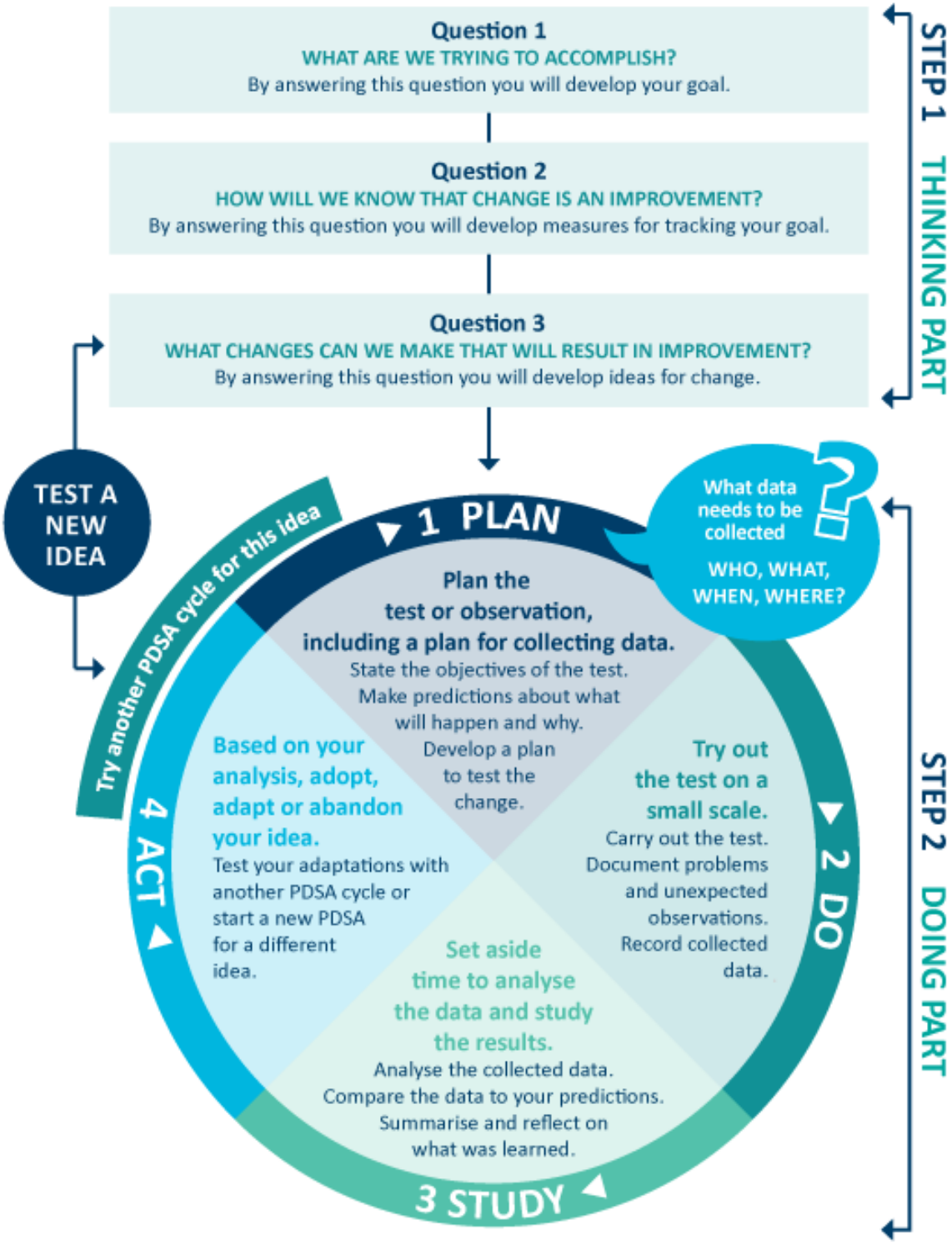
- improve patient care and outcomes
- help practices fulfil their quality improvement requirements under PIP QI
- be available so that you choose your own adventure – you choose which topic/toolkit you would like to work on.

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

- Quality patient records– this toolkit assists you to review your practice data to ensure your patient records are maintained at the highest quality. It also includes activities to ensure your practice is meeting the e-health PIP criteria and another activity on PRODA.
- MBS items – this toolkit assists you to review your practice's use of MBS item numbers. You can also generate reports to identify the number of eligible patient's vs the number of MBS item numbers claimed.
- Older people population - this toolkit is designed to assist you to manage your older patient population. Key topics include health assessments (75+ and Aboriginal and Torres Strait Islander), medication reviews (via a Home Medication Review), management plans (for patients with a chronic medical condition), advance care planning, dementia screening, falls prevention, vaccinations including influenza, pneumococcal and shingles, smoking, alcohol & physical activity, osteoporosis and cancer screening.

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

Model for Improvement diagram



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

MFI and PDSA template EXAMPLE

Step 1: The thinking part - The 3 fundamental questions

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

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

By answering this question, you will develop your GOAL for improvement.
Record this as 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 active patients aged 75+ years with a health assessment and ACP completed. 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.M.A.R.T goal. You will test these ideas using part 2 of this template, the 'Plan, Do, Study, Act (PDSA)' cycle. Your team could use brainstorming or a driver diagram to develop this list of change ideas.

IDEA: Identify active patients 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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