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OLDER PERSON'S HEALTH

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An Australian Government Initiative

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Contents

QI FOR OLDER PERSON'S HEALTH

This toolkit is intended as a guide for how quality improvement can be used to improve outcomes, and the experience of care, for older people. General practices and health services are complex environments. Therefore, you should test any system changes that you are planning to make using the Model for Improvement, which includes Plan, Do, Study, Act (PDSA) cycles.

This toolkit does not set out to provide a clinical resource for the care of older people. Such information can be found in guidelines produced by relevant clinical advisory organisations, as noted below.

POSITION STATEMENTS AND GUIDELINES FOR OLDER PERSON'S HEALTH

The Australian Medical Association (AMA) has developed a position statement titled ‘Health and care of older people – 2018’[1]. This statement includes principles, recommendations and information on a range of topics, including the following:

- health promotion and prevention
- consent and decision-making
- health systems for older people
- dementia
- palliative care
- elder abuse
- research related to the care of older people.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) has developed a guideline to assist clinicians with improving the care of people with cognitive impairment, titled ‘A better way to care. Safe and high-quality care for patients with cognitive impairment or at risk of delirium in acute health services - second edition’[1]. These guidelines include a step-by-step approach and associated case studies relating to the following:

- being alert to delirium and the risk of harm for patients with cognitive impairment
- recognising and responding to patients with cognitive impairment
- providing safe and high quality care tailored to the patient’s needs.

The UK’s National Institute for Health and Care Excellence (NICE) updated their 2017 Guideline ‘Dementia: assessment, management and support for people living with dementia and their carers’[2] in 2018 to include a flowchart and supporting tools and resources for implementation on the following:

- health promotion and prevention
- involving people living with dementia in decisions about their care
- assessment and diagnosis

[1] https://ama.com.au/position-statement/health-and-care-older-people-%E2%80%93-2018
[2] https://www.safetyandquality.gov.au/sites/default/files/2019-06/sq19-026_acsqhc_bwtc_d21.sk_june-3_accessible_pdf.pdf
[3] https://www.nice.org.uk/guidance/ng97

- interventions to promote cognition, independence and wellbeing
- pharmacological interventions
- managing non-cognitive symptoms
- supporting carers
- staff training and education.

For older Aboriginal and Torres Strait Islander peoples, a briefing paper has been prepared by Sharon Wall and the Koori Growing Old Well Study Project Team at Neuroscience Research Australia, in partnership with The Benevolent Society, titled ‘Working with older Aboriginal and Torres Strait Islander people’[1]. This briefing paper summarises research evidence to assist organisations and health care providers on partnering with Aboriginal and Torres Strait Islander peoples in a respectful and culturally safe way.

The material in some of these guidelines has been succinctly captured in HealthPathways point-of-care resources.

Planning for Improvement

Ideally, before embarking on your quality improvement journey, you will have engaged your team and there is agreement to focus on a particular area (e.g. older person's health) for a period of time. This is best documented in a Quality Improvement Plan.

A Quality Improvement Plan is a valuable document for guiding your quality improvement work and keeping your effort focused. If you have not already developed a Quality Improvement Plan, refer to the 'Continuous Quality Improvement Fundamentals' module.

Example Aims for Older Person's Health

An example management aim for older person's health in a Quality Improvement Plan might be:

> 'Within one year, 70% of eligible Active Patients*, aged 75 years or over, will have a GP Management Plan (GPMP) review completed.'

An example prevention aim for older person's health in a Quality Improvement Plan might be:

> 'Within one year, 60% of Active Patients*, aged 75 years or over, will have a health assessment completed.'
>
> Active Patient Definition: A patient who has attended the practice/service three or more times in the past two years.

These aims (or goals as they are sometimes referred to) are at a high level and ideally present a reasonable challenge for the team over a period of 12 or 18 months. The target set in the aim needs to reflect your organisation's population and your current performance. If you set the target too high or too low, the aim may not resonate with the team and you could lose engagement.

As primary care is a very busy and complex environment, it is recommended that your plan has one area of focus for the period. The above examples are provided as examples for the prevention of disease and management of older person's health. While it is possible to attempt both together, it is not recommended.

Example Measurement for these Aims

Management Measurement

- GP Management Plan and Reviews

  Description: The proportion of Active Patients, aged 75 years or older with a GP Management Plan (MBS Item 721), or a GP Management Plan Review (MBS Item 732), claimed in the past 6 months.

  Numerator = The number of Active Patients aged 75 years or older with a GP Management Plan (MBS Item 721), or a GP Management Plan Review (MBS Item 732), claimed in the past 6 months.

  Denominator = The number of Active Patients aged 75 years or older.

This measure should respond to early process work and has the following assumptions:

- A high proportion of Active Patients 75 years or older are eligible for a GPMP
- There is an effective plan review process in place where either a GMPM Review, or a GPMP is claimed within a six month period
- when a GP Management Plan or a GMPM Review are claimed, elements of care detailed in the plan are being delivered.

You could use the Active Patient, aged 75 years or older definition, and use other measures, such as blood pressure recorded in the past 6 months, immunisation status, recording of a carer in the software, eGFR recorded, etc

Prevention Measurement

Health Assessments

- Description: The proportion of Active Patients, aged 75 years or older, with a health assessment claimed within the past year.
- Numerator = The number of Active Patients, aged 75 years or older with a:
-
  - MBS item number 701, OR
  - MBS item number 703, OR
  - MBS item number 705, OR
  - MBS item number 707

  claimed within the past year.
- Denominator = The number of Active Patients, aged 75 years or older.

This measure may not be available in your clinical software, in which case a manual calculation may be required.

This measure is a direct measure of the example prevention aim and will allow monitoring of progress over time. However, this measure is unlikely to respond quickly and to early process changes, therefore, additional measurement is recommended. This will depend on where you choose to start and the following are examples of additional measurement.

- Carer Identified
  - Description: The proportion of Active Patients, aged 75 years or older, with a carer / responsible person recorded in the clinical software.
  - Numerator = The number of Active Patients, aged 75 years or older, where an emergency contact is recorded in the clinical software.
  - Denominator = The number of Active Patients, aged 75 years or older.

Quality Improvement Plans

Your Quality Improvement Plan should already have established an understanding of your population and your organisation's performance. Following this, a decision to focus on improving older person's health and establishing an aim and measures will provide a framework for you to monitor improvements over time and report progress to your team.

This document provides example activities. Although they are presented in a linear fashion, knowledge of your organisation's performance with regard to the management of older person's health should guide where you will start and the activities you choose to undertake.

The below activities are detailed in the following pages, with example Model for Improvement cycles (where relevant) to stimulate thinking:

1. Know your patient population
2. Recall patients or clients for health assessments
3. Ensure influenza and pneumococcal immunisations are provided
4. Complete GPMPs and Team Care Arrangement (TCAs) and eligible reviews
5. Support patient self-management.

Making Changes to your Systems

At this stage, you should have established an aim for your improvement work and decided how you will measure your progress over time. In this toolkit, we'll principally be focusing on management of older person's health as this is where most of the system change opportunity exists. Later in this tool kit we'll look at prevention using an idea relating to increasing the proportion of patients aged 75 and over who have Sick Day Action Plans completed.

KNOW YOUR PATIENT POPULATION

Before commencing your improvement work, you will need to fully understand your older patient population. While some of this work may have been done to guide your decision to focus on this topic area, a more detailed understanding of your organisation's population is now needed to help inform your early improvement activities.

Some of the questions that you may want to answer are:

- How many Active Patients, aged 75 years or older are included in the register and does this seem about right, taking into account the demographics in your catchment area?
- What proportion of Active Patients, aged 75 years or older have not had their blood pressure recorded in the past 6 months?
- What proportion of Active Patients, aged 75 years or older have who have not had their lipids recorded in the past12 months?
- What proportion of Active Patients, aged 75 years or older have not had their glucose regulation recorded in the past 6 months?
- What proportion of Active Patients, aged 75 years or older do not have a current influenza vaccination?
- What proportion of Active Patients, aged 75 years or older have not had a pneumococcal vaccination within the recommended timeframe?
- What proportion of Active Patients, aged 75 years or older have not had a GPMP or GPMP Review claimed within the past 6 months?
- What proportion of Active Patients, aged 75 years or older do not have a carer recorded?

Once you have a good understanding of how your organisation is performing with regard to older person's health, you will be able to consider where to start your work.

Data Quality and Clinically Coded Diagnosis

Coding is critical to quality and safety, and your computer systems cannot perform at their best without it. While there is a place for contextual notes using free text, these notes should be in addition to appropriate coding. By clinically coding diagnoses you can produce a register which allows you to more easily monitor pathology testing, vaccinations, care planning, and referrals to relevant specialists and allied health providers.

Achieving and Maintaining Data Quality

Data quality is more than just coding. It means that data, relevant to the patient's care needs, are accurate, complete and up-to-date.

A team approach is critical. Every person on your team has a responsibility to ensure that data quality is maintained. If each person is doing their part, your organisation will have a sustainable process in place resulting in the achievement and maintenance of quality data. If not, inevitably, data quality will not improve and if you undertake once off data cleaning, over time data quality will erode in the absence of a sustainable process.

Once off Data Cleaning

There is a place for once off data cleaning, but this should be done after the team has developed an agreed approach to maintaining data quality. If not, your cleaning efforts will be eroded over time.

As you are focusing on older person's health, there are specific data cleaning exercises you can undertake in your clinical software, PenCS CAT4 and Cleansing CAT.

1. Demographics

   - Disease prevalence in older patients

2. Data quality

   - Identify older patients who do not have height/weight recorded
   - Identify older patients who have uncoded diagnoses
   - Identify older patients who do not have a carer recorded
   - Identify older patients who do not have physical exercise recorded

3. Risks and diagnoses

   - Identify older patients who are obese or overweight
   - Identify older patients who have not had a BP recorded in the previous 12 months
   - Identify older patients who have not had lipids recorded in the previous 12 months
   - Identify older patients who have not had glucose regulation recorded in the previous 12 months

4. Medications

   - Identify older patients who are on 5 or more prescriptions

5. Management

   - Identify older patients who have not had a GPMP/TCA review in the recommended timeframe
   - Identify older patients who do not have a shared health summary (SHS) uploaded

Where to start your improvement activities

By this stage you should have in place:

- commitment from your team to be involved in quality improvement
- Quality Improvement Plan with:
  - a clear aim
  - measures (about 3) to guide your work over the next year
  - high level strategies, ideas or tactics for change
  - identified members of the quality team or at least a coordinator for the Quality Improvement Plan
- protected time to carry out essential coordination activities.

System Changes vs Tasks

Some of your change ideas will be task-based in nature, whereas others will relate to system change.

Tasks

These are generally actions that can be undertaken, such as data cleansing activities, which are not really a change to a system. In this example, the system change will come after you have a current and accurate register of older patients.

System Change

System change (or process change) is where you will seek to change the way people (staff, patients, or suppliers) routinely behave. For example, the way your organisation/staff routinely ensures that all older patients have health assessments undertaken within the recommended timeframes.

Identifying which of the change ideas (as they come up) is a task and which is a system change will help you determine whether to use the Model for Improvement (to test a system change) or if it's a task, undertaking it at the appropriate time.

Change Ideas

When making changes to your systems, it is advised that you make small changes over time in a planned and coordinated way.

Your quality plan should include high level strategies, ideas or tactics for change. You can commence by selecting one of these change ideas and if it is stated at a high level, break the idea down into smaller working parts and then chose one of these.

The change ideas are not intended to be implemented at once, or necessarily in the listed order. It would be best to start on just one change idea that is most suited to your team and organisation.
The following are examples of high level strategies, ideas or tactics for change that may have been documented in the quality plan:

Where to start your improvement activities

- Ensure that all older patients receive a health assessment annually
- Ensure that all older patients, where eligible, have a GP Management Plan
- Ensure that older patients are fully immunised
- Ensure that all older patients have an Advance Care Directive
- Ensure that all older patients have a My Health Record
- Ensure that all older patients have their record in the clinical system up-to-date, including emergency contacts
- Ensure that all older patients that require such have a Sick Day Action Plan
- Ensure that the general practice is full accessible for older patients
- Ask older patients or their carers for ideas on how we can improve services.

The above list of ideas proposes quite a lot of work and would be extremely difficult to implement all at once. Therefore, it is recommended that you and your team commence work in one area and at a small level, and work on one change idea for a couple of months to introduce small iterative change.

Model for Improvement examples are provided to help you understand how to break change down into small incremental steps and ensure the change is an improvement before scaling or implementing.

Systematic and Proactive Care for Older Patients

Managing care efficiently and consistently across a general practice or health service requires a planned, systematic and proactive approach. Delivering health care services to older patients can be a planned and systematic approach and not reactive.

Nurse clinics offer an alternative model of care delivery where the nurse is the primary provider of care for the patient. In the general practice or health service setting, nurse clinics support a team based approach to care delivery, which involves GPs and other members of the practice team. Accountability and responsibility for patient care and professional practice remains with the nurse.

Nurse clinics can provide holistic and patient centred care by:

- developing ongoing relationships with patients, their carers and families
- spending the time needed to create individualised care plans with patient-determined goals, as well as coordinating requests for pathology and referrals to relevant specialists and/or allied health providers
- supporting patients with strategies to enhance self-management and undertaking risk assessments for co-morbid conditions and/or assessing patients' health literacy.

There is no one model for a nurse clinic. Several factors need to be considered, including:
- the size of the practice and available treatment rooms
- available resources including the number of practice nurses employed in the practice and their skill set(s)
- business planning, including sources of finance
- governance frameworks

[1] https://www.apna.asn.au/nursing-tools/nurse-clinics

- the ability of practice nurses to form collaborative working relationships with GPs and/or form micro teams with other staff in the practice, as well as health and social care providers in the community.

With the recent introduction of the Medical Practice Assistant role, there is a need to reconsider roles within the general practice to ensure that people's skills are used in the most appropriate and efficient manner. You can achieve this by focussing on your change ideas in a systematic manner using the Model for Improvement.

Model for Improvement - Health Assessments for Older Patients

One of ideas listed in the QI plan was to “Ensure that all older patients receive a health assessment annually”. The higher level goal is stated as “…all older patients…” which is ambitious as its 100% but often how these statements can be made. Using the Model for Improvement you can break this aim down into a smaller piece of work to test how your system is working and identify opportunities for improvement. Therefore, your Model for Improvement goal is almost certainly going to be different to what is stated in the QI plan.

Goal

Over the next two months, increase the proportion of patients aged 75 years or over, who are regular patients of Dr Jones, who have received a health assessment to 60%.

In the goal example above, the scope has been reduced to working with one GP and focussing on their regular older patients. The goal set at 60% is an example and your goal should be an attainable goal taking into account local factors. Working with a GP that has as a strong interest in older patients is recommended in the first instance.

Measurement

In this example the goal can be directly measured by:

- The proportion of Active patients who are regular patients of Dr Jones aged 75 or older who had a health assessment claimed within the past year (A divided by B below).
- A (Numerator): The number of Active patients who are regular patients of Dr Jones aged 75 and older who have had a health assessment claimed within the past year
- B (Denominator): The number of Active patients within the clinical database aged 75 and older who had a health assessment claimed within the past year

You have now developed a clear goal at a small test level and measurement that will directly measure your progress. The Model for Improvement now asks, ‘What changes can we make that will result in an improvement?’ Remember that ideas generated now need to be within the context of this test.

Ideas

- Identify older patients of Dr Jones and whether they have had a health assessment or not
- Recall patients who have not had a health assessment
- Work with Dr Jones and the practice nurse to streamline the assessment process
- Identify older patients of Dr Jones who are booked to attend at the clinic over the next two weeks and seek to undertake a health assessment
- Provide reception with a list of Dr Jones’ patients that need a health assessment to pro-actively book them into an appointment if they call.

PDSA Cycles

So far, we have established the first part of the Model for Improvement (the goal, measurement and ideas for change).

The next step is to test one of the ideas using a PDSA cycle or cycles. You will need to consider your ideas and decide which one to start working on. Ideally the PDSA cycle will help you understand what changes you can make to your systems and/or processes that will improve on the current result and be sustainable over time.

Some of the ideas above may not be suitable for PDSA cycles, such as identifying older patients of Dr Jones and determining whether they have had a health assessment or not. This is a task that can be completed by someone and then checked with Dr Jones. This task will help identify (1) all older patients that have not had a health assessment in the past year and then (2) those patients that are regular clients of Dr Jones. This activity is important but can be undertaken as a straightforward task.

When considering where to start, and using the examples above, you might begin by working with Dr Jones and the practice nurse to streamline the assessment process and then recalling 5 patients to test the new process and recall system. Subsequent PDSAs can help refine the process and recall system before scaling by including patients that are regular clients of other GPs.

It’s important to keep PDSA cycles small tests that can be completed over a very short period of time.

Patient Self Management

To provide comprehensive care, integrate self-management support into the care delivery system. Self-management support includes a range of initiatives for patients that are delivered via different modes, including consultations, action plans, brochures, online videos, TV, telephone, support groups or mobile phone apps.

Develop written action plans for relevant chronic conditions in consultation with your patients. Consider the severity of the disease and the unique circumstances of each patient prior to commencing the plan. Supporting patients to undertake monitoring of conditions (such as diabetes) will help them to continually focus on their self-management and will likely reduce their risk of hypoglycaemia and/or hyperglycaemia.

Adherence with the Action Plan will require patients to be able to understand what they need to do when they become unwell. Check their health literacy, especially in older, frail and cognitively impaired patients.

Action plans should not replace comprehensive self-management plans that incorporate patient goals, ongoing education and regular reviews of the patient's health and wellbeing.

Model for Improvement Example - Sick Day Action Plans

Goal:

Over the next two months, increase the proportion of Active patients aged 75 years or over who have an action plan from 20% to 30%.

Measures:

- The number of Active patients aged 75 years or over in the clinical software (A)
- The number of Active patients aged 75 years or over who have an action plan completed (B)
- The proportion of Active patients aged 75 years or over who have a completed action plan (B divided by A).

Ideas:

- Recall patients for specific appointments to develop action plans
- Develop a tracking sheet to monitor the completion of action plans and inform all clinical staff of this sheet
- Source and utilise appropriate resources and templates (e.g. from the ADEA[1], Lung Foundation Australia[2], Heart Foundation[3])
- Involve the whole team in developing plans and allocate roles and responsibilities.

[1] https://www.adea.com.au/wp-content/uploads/2015/12/sick-day-booklet-type-2-single-pages-final.pdf

[2] https://lungfoundation.com.au/wp-content/uploads/2018/12/Information-paper-COPD-Action-Plan-Kit-Feb2019.pdf

[3] https://www.heartfoundation.org.au/after-my-heart-attack/heart-attack-recovery/action-plans

PDSA Cycles

So far, we have established the first part of the Model for Improvement (the goal, measurement and ideas for change).

The next step is to test one of the ideas using a PDSA cycle or cycles. You will need to consider your ideas and decide which one to start working on. Ideally the PDSA cycle will help you understand what changes you can make to your systems and/or processes that will improve on the current result and be sustainable over time. The logical first step is to use your clinical software to identify all Active patients aged 75 years or over and then determine which of these patients has a current action plan. This may already have been done in your QI planning stage, but if not, needs to be completed.

While you can use the PDSA framework to undertake this activity, it could also be done as a task by a person with the appropriate skill. Once you have this list, you can calculate the current proportion of Active patients aged 75 years or over who have a completed action plan (in the example stated as 20%).

In this example, a starting point would be to test recalling a small number of patients for the completion of an action plan. Starting with a small number will help you test your recall system and also the process you use to complete the action plans. Following the first PDSA cycle, you can study the results and consider any barriers or issues identified. Subsequent PDSA cycles should seek to improve on the process and overcome any barriers and issues until you are comfortable that your process is efficient and sustainable.