



45-49 YEARS HEALTH ASSESSMENT TOOLKIT

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INTRODUCTION

HNECC PHN 45-49 years Health Assessment Strategy

HNECC PHN is committed to delivering innovative, locally relevant solutions that measurably improve the health outcomes of our communities. Age-specific health assessments lead to early detection of chronic disease in asymptomatic individuals, diagnosis and treatment at earlier stages of disease, and subsequent reduction in illness and mortality.

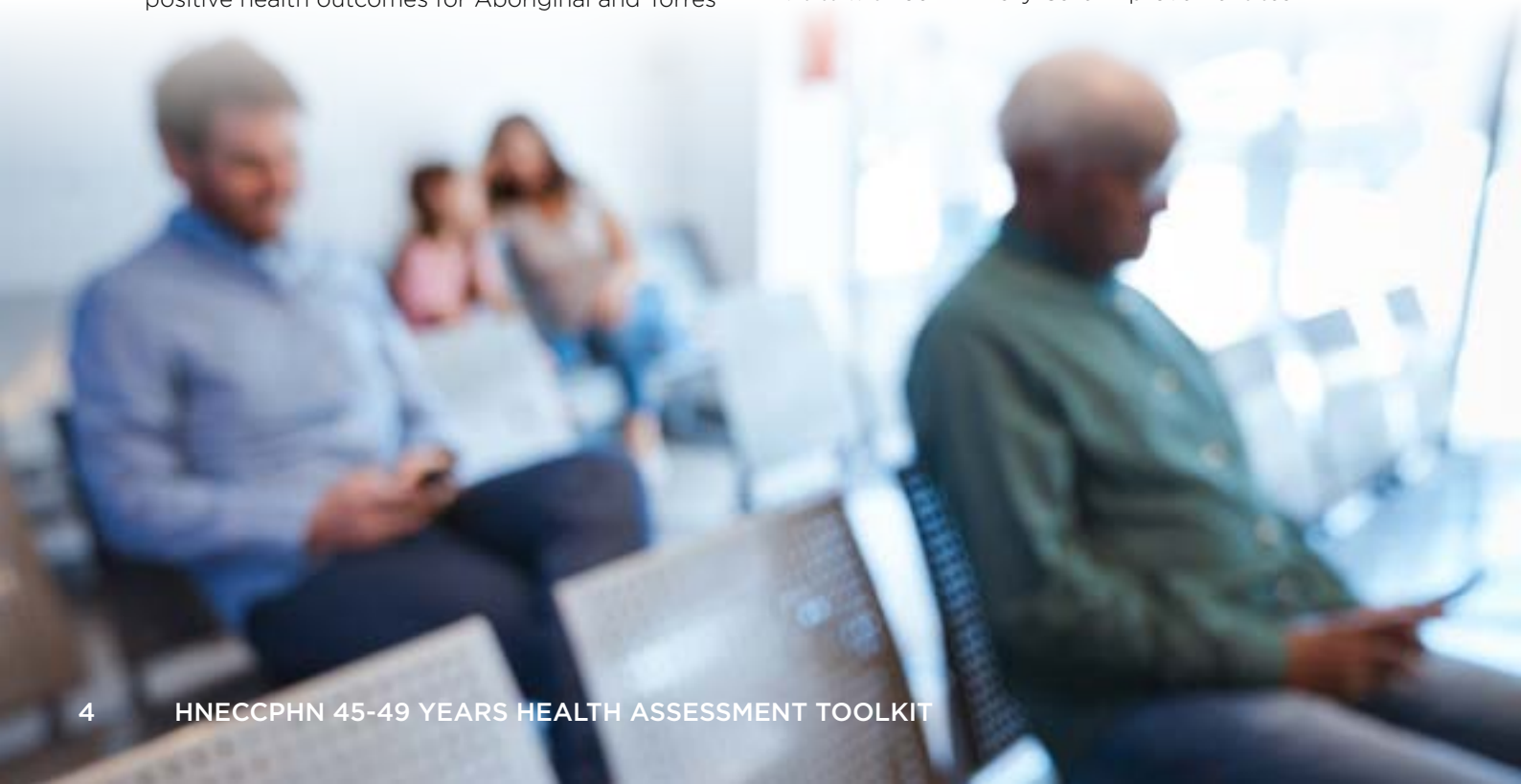
With chronic disease prevention and preventative health care being an area of focus for Primary Health Networks, Hunter New England and Central Coast PHN (HNECC PHN) has developed programs for increasing cancer screening rates and supporting timely diagnosis and management of dementia, as well as drug and alcohol treatment services, funded primary health care services, and helps drive the Diabetes Alliances. There is strong evidence of direct associations between selected chronic diseases and biomedical and behavioural risk factors. Increasing participation in 45-49 years health assessments can assist patients to make the necessary changes to delay or prevent the onset of chronic disease.

HNECC PHN recognises the critical role that primary care plays in chronic disease prevention and encourages and supports General Practice to consider quality improvement activities around increasing participation in 45-49 years health assessments as a means of increasing patient-centred care, providing better management of chronic disease and co-morbidities, reducing potentially preventable hospitalisations, increasing positive health outcomes for Aboriginal and Torres

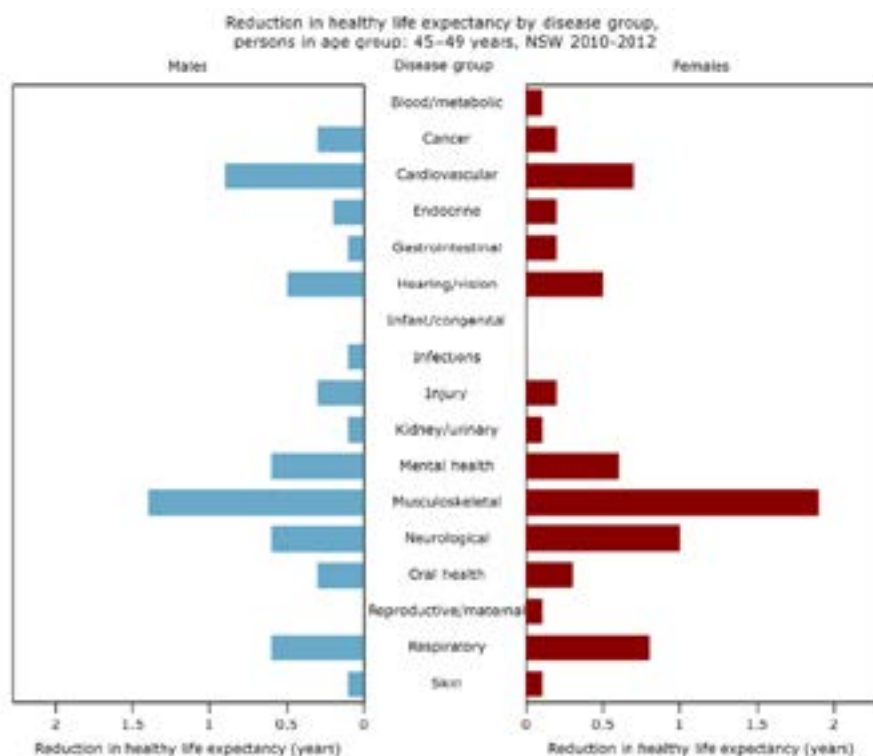
Strait Islander people and providing a collaborative and integrated approach to patient care. The 45-49 years health assessment toolkit has been developed acknowledging these key focus areas, and as a guide for General Practice to assist in improving participation rates of health assessments of people 45 – 49 who are at risk of developing chronic disease. The GP decides whether a patient is at risk of developing a chronic disease, however at least one risk factor must be identified. Factors that may be considered include:

- Lifestyle risk factors: smoking, alcohol misuse, poor nutrition, physical inactivity
- Biomedical risk factors: high blood pressure, high cholesterol, impaired glucose metabolism or obesity
- Family history of chronic disease.

In addition to the toolkit, there is a commitment from HNECC PHN to provide support to General Practice to address participation in 45-49 health assessments through the provision of resources, information and education as well as face to face visits with our Primary Care Improvement team.



At a glance: Reduction in healthy life expectancy by disease group, 45-49 year age group, NSW, 2010-2012



Based on Australian Burden of Disease Study 2011, Australian Institute of Health and Welfare; Life Tables, States, Territories and Australia, 2010-2012, Australian Bureau of Statistics. Prepared by the Centre for Epidemiology and Evidence, NSW Ministry of Health.

Reduction in healthy life expectancy is highest in females for musculoskeletal (1.9 years) and males (1.4 years), followed by cardiovascular for males (0.9 years) and neurological for females (1.0 year).

Burden of disease analysis measures the combined impact in the entire population of living with illness and injury (non-fatal burden) and dying prematurely (fatal burden). More than merely counting deaths and disease prevalence, it considers age at death and severity of disease. The summary measure 'disability-adjusted life years' (or DALY) is used to count the total years of healthy life lost from death and illness in the whole population.

Smoking, high risk alcohol consumption and excess weight are major risk factors for death and disease in Australia. Smoking is linked to numerous health problems, including coronary heart disease, stroke, peripheral vascular disease, and cancer. High risk alcohol consumption is linked to cirrhosis of the liver, cancer, stroke, inflammatory heart disease, hypertension, road accidents, memory lapse, falls, suicide, and drowning.

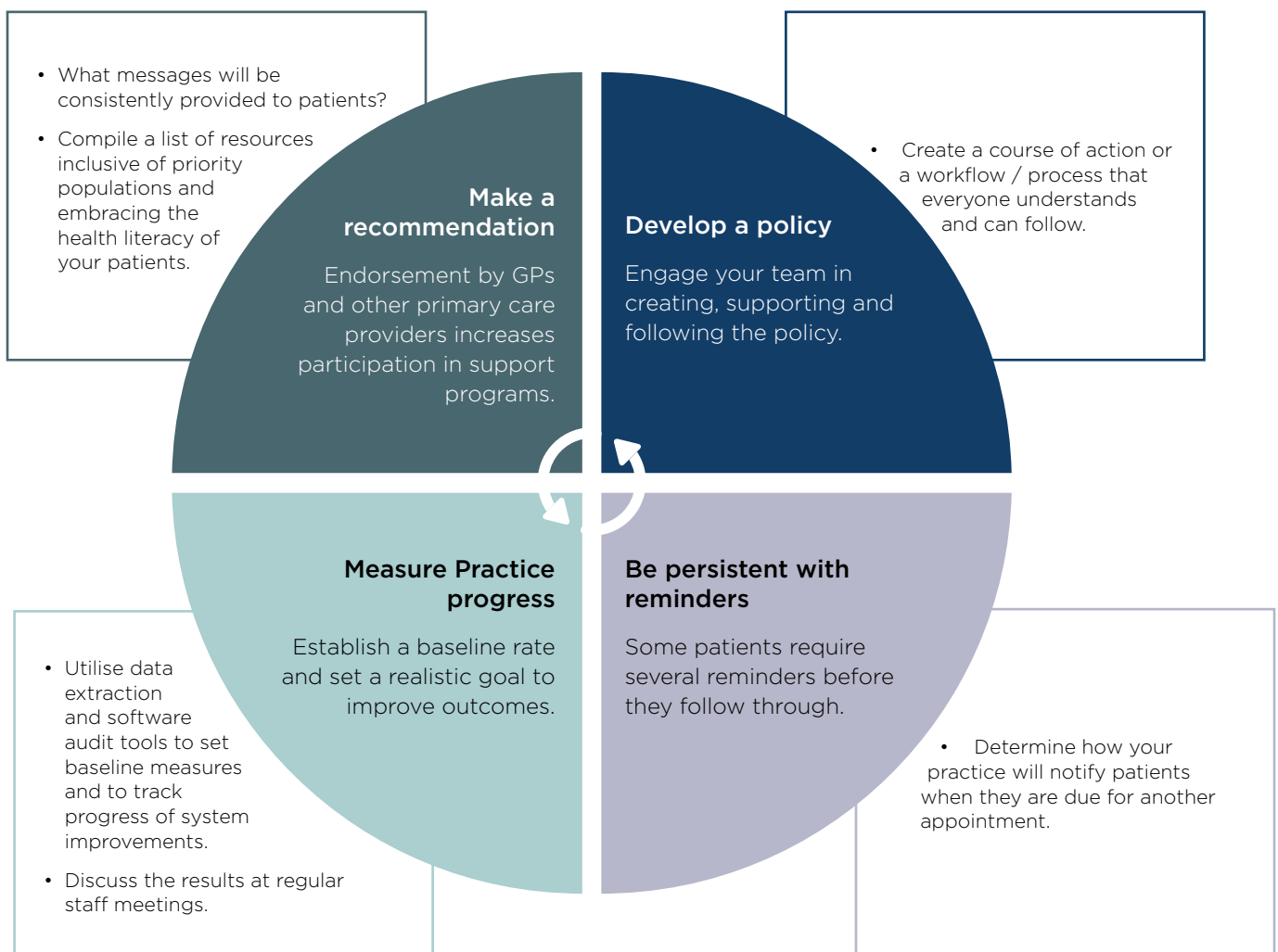
Obesity increases the risk of developing diseases such as cardiovascular disease, Type 2 diabetes, musculoskeletal conditions, and cancer, the risk of which increases with weight gain. Lifestyle risk factors are associated with poorer health outcomes and the development of diseases which can lead to premature death.

Diabetes is a chronic disease characterised by high levels of blood glucose. This is due to either an inability to produce insulin or to use insulin effectively. Type 1 diabetes is a lifelong autoimmune disease affecting approximately 15% of diabetes sufferers. Type 2 diabetes accounts for an estimated 85% of diabetes cases and can generally be prevented by maintaining a healthy lifestyle. Risk factors that can lead to Type 2 diabetes include high saturated fat intake, obesity, insufficient physical activity, and tobacco smoking. Diabetes can result in health complications such as kidney disease, lower limb amputation, blindness and heart disease.

There is a need for prevention in the community, and facilitation of early screening and detection within the primary health care setting.

Four essentials to improving 45-49 years health assessments in Primary Care

1. Implement practice changes.
2. Take a person-centred approach.
3. Involve staff and put office systems in place.
4. Follow a continuous improvement model to develop and test the changes.



DEVELOPING A SYSTEMATIC APPROACH

Data cleansing

The information available in clinical software is invaluable when developing streamlined practice systems and providing quality patient care. For practice data to be useful, information within your clinical database must be accurate and up to date.

Ensuring electronic results are received correctly is key to providing effective and efficient patient care.



HELPFUL TIPS

- Regularly mark patients as 'inactive'
- Merge duplicate patient records
- Ensure pathology results are received in the correct format
- Develop and agree on processes to ensure data quality is maintained
- Clean up reminder lists: Ask your Primary Care Improvement Officer for instructions on 'Bulk Reminder Clean Up'
- Document processes clearly in your Policy and Procedure Manual
- Regularly discuss clinical coding in team meetings to develop clear standards and requirements for patient files.

Workflow

Workflow is defined as a series of steps, frequently performed by different staff members that accomplishes a task. Workflows represent how work gets done, not the protocols that have been established to do the work.

Workflow mapping is a way of making the invisible "visible" to a practice to improve processes to increase efficiency, reduce errors and improve outcomes.

Workflow mapping is the process of documenting the specific steps and actions that take place in completing a task. Creating a workflow map allows the opportunity to see what is currently happening, identify opportunities for improvement or change, and design new, more effective processes. It is helpful to consider workflows associated with the following three processes:

1. Perceived process (what we think is happening).
2. Reality process (what the process actually is).
3. Ideal process (what the process could be).



HELPFUL TIPS

Important rule of mapping: the person who controls the process controls the pen. Meaning whoever carries out the process, maps the steps.

- Be realistic: map what is happening not what is desired.
- Identify each step of the activity and person responsible.
- Communicate: ensure all involved team members understand how the activity is executed.



HELPFUL LINKS & RESOURCES

Train IT Medical have sample workflows for:

[Correspondence Management](#)

[Inbox Management](#)

[Train IT Medical Practice Management resources](#)



Implementing robust recall and reminder systems

The RACGP Standards for General Practice view a **reminder** as an offer to provide patients with systematic preventative care. A **recall** is when it is paramount for a patient to attend the clinic, usually in the instance of an abnormal result. A recall is further defined as a system to make sure patients receive further medical advice on matters of clinical significance.

Clinical significance is determined by:

- the probability that the patient will be harmed if further medical advice is not obtained; and
- the likely seriousness of the harm.

It will be up to each practice to design a system which effectively differentiates between their general preventive reminders and their true recalls (RACGP, 2017).



HELPFUL TIPS

- Ensure there is a written policy which is communicated to the practice team which outlines a consistent and validated process for recording results, entering recalls and sending reminders
- Define roles and responsibilities for individual team members
- Review systems for managing overdue patient recall and reminders.



HELPFUL LINKS & RESOURCES

Speak to your Primary Care Improvement Officer to gain access to best practice resources:

[Medical Director: Recall, Reminders Action Fact Sheet](#)

[The Dos and Dont's of Patient SMS](#)

[AMA Recall Systems and Patient Consent](#)

It is recommended that GPs who are coordinating patient-centred care should not assume that clinically significant test results ordered by others have been adequately followed up.

Clear and agreed systems for receiving and following up on test results are needed to ensure safe and effective continuity of patient care. For further information regarding RACGP's position on non-GP initiated testing [click here](#).

How can PEN CS support patient-based outcomes in General Practice?

When leading change in a General Practice, you will require data to help guide your thinking, discussions and planning.

PEN Clinical Audit Tool (PenCAT) is a user-friendly software tool that interrogates the data contained within GP clinical and management software. The extracted data can be then filtered to select a specific target group and viewed through a range of clinically relevant patient reports to support quality improvement.

PEN CS and your Practice

A significant number of General Practices across the HNECC PHN already use PenCAT to investigate and report against their patient data. Using PenCAT to extract relevant data provides practices a range of benefits including:

- Improving the quality of patient care by identifying patients requiring periodic screening and ensuring the appropriate treatment or referral is delivered proactively; and
- Identifying patients at risk of developing certain diseases or conditions and offering preventative treatment.



HELPFUL TIPS

- Use current data by performing monthly data collection
- Ensure correct coding principles are implemented to ensure data can be extracted
- Upskill; participate in PenCAT and [TopBar webinars](#) and speak with your Primary Care Improvement Officer to assist in understanding your practice data.



HELPFUL LINKS & RESOURCES

PEN CS has developed 'recipes' which are simple step by step guides to extract meaningful data correctly.

Visit www.pencs.com.au to source recipes identifying patients eligible for a 45-49 years health assessment with lifestyle or biomedical risk factors.

WHAT IS QUALITY IMPROVEMENT?

The RACGP Standards for General Practice describe quality activity undertaken within a general practice where the primary purpose is to monitor, evaluate or improve the quality of health care delivered by the practice. The Standards recommend practices engage in quality improvement activities that review structures, systems and processes to aid the identification of required changes to increase the quality of healthcare delivery and safety of patients.

Quality improvement consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups.

Engaging in quality improvement activities is an opportunity for the GPs and other staff in the practice to come together as a team to consider quality improvement. Quality improvement can relate to many areas of a practice and achieving improvements will require the collaborative effort of the practice team.

Standards for General Practice - 5th Edition

The RACGP 5th Edition Standards have been released with a new module specifically identified for Quality Improvement. Criterion QI 1.1 identifies four indicators that relate to Practice based activity around Quality Improvement and reference a team-based approach. The criterion recommends having at least one team member responsible for leading quality improvement in the practice, which establishes clear lines of accountability. Please refer to the guidelines.

Criterion QI 1.3 relates to improving clinical care, specifically practice use of relevant patient and practice data to improve clinical practice. Establishing and utilising robust reminder and recall systems could be a focus under this criterion.

[RACGP Standards for General Practice 5th Edition](#)

The Quality Improvement process is divided into two manageable parts: thinking and doing. This process allows ideas to be broken down into manageable sections which can be tested and reviewed to determine whether improvement has been achieved prior to implementing on a larger scale.

The 'Thinking' part

The thinking part consists of three fundamental questions that are essential for guiding improvement.

1. What are we trying to accomplish?

By answering this question, you will develop your aim for the activity.

Consider exactly what it is you are seeking to change.

- Define the problem. Success comes through preparation, understanding what the problem is and thinking about why there is a problem helps in developing your aim.
- Set realistic objectives which are specific, have a defined timeframe and are agreed (SMARTA). Use plain language and avoid jargon so that the meaning is clear to everyone.
- Include information that will help keep the team focused.

2. How will we know that change is an improvement?

By answering this question, you will develop measures for tracking your goal.

Without measuring, it is impossible to know whether the change you are testing is an improvement.

- Communicate to the team what you are measuring, how, when and who is responsible (see 'Measuring Success')
- Make the measurement as simple as possible
- Only collect the data that is required.

3. What changes can we make that will result in an improvement?

By answering this question, you will develop ideas for change.

Encourage the whole team to contribute ideas. Be creative. Think outside the box.

- You know your General Practice and your patients best. Keep this in mind and use your knowledge and experiences to guide your ideas
- Adapt from others
- Think small and test. Think about testing a change with one GP or a select group of patients. This will assist in determining if the change had the desired effect and is suitable for wider implementation.

FOR EXAMPLE - your General Practice may decide to focus on identifying patients eligible for a 45 - 49 Health Assessment with lifestyle or biomedical risk factors.

You may have an aim like this: To increase the number of health assessments completed and claimed for 45-49-year-old patients attending our practice by 15% by December 2019.

Your response may be:

We will measure through PenCAT:

- The number of 45-49-year-old patients in our practice
- The number of those patients who have had health assessments in the past 12 months

Your outcome may include:

- Use PenCAT to extract the number of active patients aged 45-49 years.
- Provide training to ensure both clinicians and non-clinicians have the necessary skills and confidence to discuss chronic disease prevention – weight management, smoking cessation, risky drinking, mental health and cancer screening.
- Ensure patients' family history, weight, waist circumference, BMI, cancer screening results are recorded in the correct location in Clinical Software (no free text).
- Send 45-49 years health assessment invitation letters to eligible patients.

The 'Doing' part

The doing part is made up of rapid, small Plan, Do, Study Act (PDSA) cycles to test and implement change in real work settings.

Not every change is an improvement, but by making small changes you can test the change on a small scale and learn about the risks and benefits before implementing change more widely. Several PDSA cycles may be required to achieve your improvement goal.

You will find through PDSA cycles some changes lead to improvements. If so, these improvements can be implemented on a wider scale. You may also find that some improvement ideas are not successful. Analyse why they didn't work and learn from this. By carrying out small tests in PDSA cycles, you have avoided implementing unsuccessful change on a wider scale.

Step One: Plan

A well-developed plan includes what, who, when, where and your predictions and what data is to be collected.

Make your plan as clear and as detailed as possible:

- What exactly will you do?
- Who will carry out the plan?
- When will it take place?
- Where will it take place?
- What do you predict will happen?
- What data/information will we collect to know whether there is an improvement?

Step Two: Do

Write down what happens when the plan is implemented (both negative and positive) and other observations.

Collect any data you identified in the plan phase.

Step Three: Study

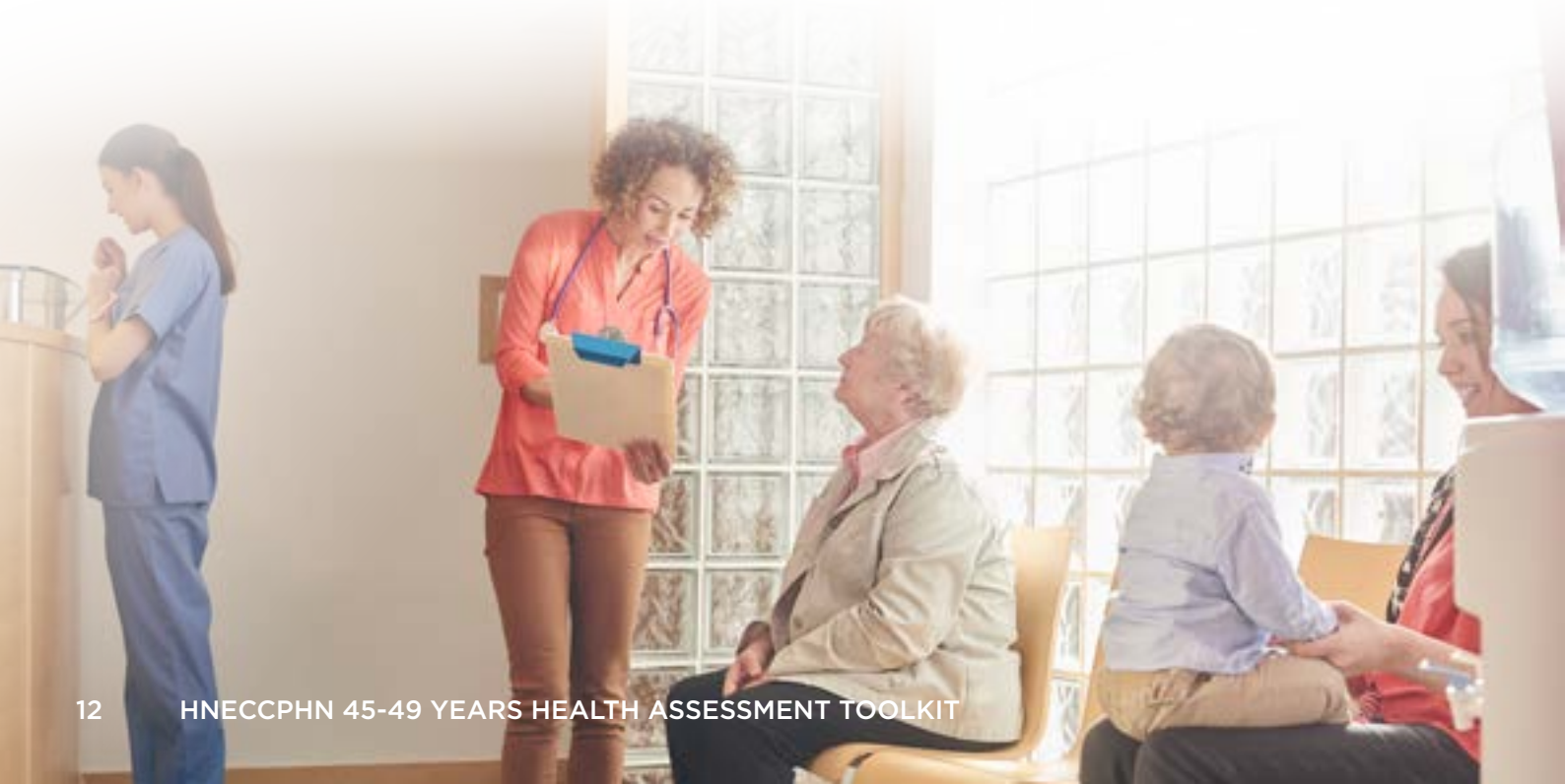
Reflect on what happened.

Think about and summarise what you have learnt. Analyse the data collected and compare with your initial predictions. If there is a difference in the data and predictions, consider what happened and why.

Step Four: Act

Considering the results from your tests; will you implement the tested change or amend and test or try something else?

Write down the next idea you will test. Be sure to start planning the next cycle early to keep up the momentum of change.



FOR EXAMPLE - your General Practice may decide to focus on chronic disease prevention and increasing participation in 45-49 years health assessment.

Idea Use PenCAT to extract the number of patients aged 45-49 who are at risk of developing chronic disease who do not have a 45-49 years health assessment recorded

Plan

What: Use PenCAT to extract data
Who: Practice Manager
When: Wednesday 3 June 2019
Where: General Practice

Data to be collected: Extract or record the number of patients 45-49 who are at risk of developing chronic disease with no 45-49 years health assessment recorded

Prediction: Expect 67% of patients 45-49 to not have a 45-49 years health assessment recorded

Do Practice Manager extracted data as planned using PEN CAT Recipe to ensure correct data was extracted.

PEN CAT recipe:

Identify patients eligible for a 45 - 49 years Health Assessment with lifestyle or biomedical risk factors

Study Percentage of patients 45-49 at risk of developing chronic disease with no 45-49 years health assessment recorded was as expected.

Act Data presented to practice team to discuss chronic disease prevention management strategies that could be implemented within the practice. Data presented to practice team to discuss current health assessment rates and how to increase the number of health assessments for 45-49-year-old patients by implementing a reminder system for 45-49-year-old assessment.



HELPFUL TIPS

- Practices need to engage in quality improvement activities to improve quality and safety for patients in areas such as practice structures, systems and clinical care
- Decisions on changes should be based on practice data (PEN CS and clinical database audits, near misses and patient and/or staff feedback)
- Achieving improvements requires the collaborative effort of the practice team and all members of the team should feel empowered to contribute
- Utilise the Readiness Tool to assist identify ideas and areas for improvement.
- No PDSA cycle is too small; keep it simple
- You may complete a series of PDSA cycles to achieve your goal. Results will be achieved through building on previous cycles
- Set aside protected time to complete the agreed upon tasks
- Document your PSDA cycles and present findings at team meetings
- Improvement is a team effort.

See Criterion C4.1 - [Health Promotion and Preventative Care RACGP 5th Standards](#)

READINESS TOOL

There are many ways to improve patients' participation in the 45-49 years health assessment.

This Readiness Tool is designed as a starting point to encourage General Practice to generate ideas and strategies in chronic disease prevention that may be applied to a quality improvement activity. This may assist with the 'thinking part' of the quality improvement cycle.

In working through the Readiness Tool, start by identifying if the practice or clinicians are undertaking activity in the identified area. In the action column you could document any ideas or processes that may need to be introduced or changed.

45-49 years Health Assessment Quality Improvement Readiness Tool

General Practice Name:	
Completed by:	
Staff involved in change process:	

AREA: Quality Improvement Change Readiness	Yes/No	Action/Comment (what, when, who)
1. Our surgery has engaged leadership at all levels of the organisation and our staff share an active focus on Quality Improvement.		
2. We recognise the value of team-based care and empower all staff to take an active role in quality improvement activities within their scope of practice.		
3. We reserve appointments for all our clinicians to allow our patients prompt access to care from their regular GP and care team as much as possible.		
4. We obtain consent from our patients to participate in recall and reminder systems and for sharing relevant information with other providers actively involved in their team care in line with our privacy policy.		
5. Our Doctors are aware of Closing the Gap Initiatives and all prescriptions for registered Aboriginal and Torres Strait Islander patients are annotated with 'CTG' to increase affordability and compliance.		
6. There is an active focus on Prevention or Management of Patient Care (Chronic Disease Management, Indigenous Health, Cancer Screening).		

AREA: Information Systems and Data Driven Improvement	Yes/No	Action/Comment (what, when, who)
1. Our staff are confident in using our clinical software and all other computer programs required to fulfil the duties of their role (e.g. Excel, Word).		
2. Our staff recognise the importance of clinical coding and use of clinical software functions in facilitating data collection. We actively avoid free text diagnoses as much as possible.		
3. We regularly complete data cleansing activities to ensure accurate and current registers of patients. This role is allocated to one or more staff members in their position description to ensure consistency and accountability.		
4. Our clinical staff upload and view shared health summaries/event summaries to My Health Record to ensure accurate information is available to all providers involved in the team care of our patients.		
5. Our staff have access to clinical audit tools and are trained in using CAT filters effectively and efficiently to create patient registers.		
AREA: General Practice Systems	Yes/No	Action/Comment (what, when, who)
1. We record Allergies and Adverse Reactions for our patients and update these lists regularly.		
2. We have policies and procedures for reminders and recalls. Staff follow these established protocols to ensure consistency and accuracy in their role.		
3. Protected time is scheduled to ensure staff have capacity and resources to accurately complete their tasks within allocated timeframes.		
4. We utilise a standard Family History template inclusive of cancer and other disease history.		
5. The "New patient form" requests consent for recalls (including cancer screening and SMS). The practice sends targeted reminders to patients (e.g. letters, SMS, email or phone calls) for routine patient care follow-up.		
6. Practice software is utilised for actions/prompts for the GP/Nurse to ask about routine cancer screening.		
7. The policy for recalls/reminders has been developed/reviewed		

8. The practice sends targeted reminders to patients (e.g. letters, SMS, email or phone calls) for routine patient care follow-up.

9. Clinicians access HealthPathways and Patient Info for clinical guidelines, assessment, management and referral information and patient information.

AREA: Patient-Centred Care	Yes/No	Action/Comment (what, when, who)
1. Participation in 45-49 years health assessment is opportunistically discussed in general consultations.		
2. Our patients are engaged in shared decision making that respects their personal goals to facilitate the patient-team partnership.		
3. We undertake health promotion and health coaching activities that consider the health literacy of our patients.		
4. Our staff know how to access resources in languages other than English and ways to provide non-written information for patients who require it.		
5. We routinely identify Indigenous patients to ensure culturally appropriate care is provided.		
6. We routinely identify patients who may require assistance to communicate and we utilise Telephone Interpreter or Relay Services where appropriate. All clinicians are registered and familiar with the use of these programs.		
7. We support people with disabilities and physical or cognitive conditions to maintain capacity, dignity and independence by considering assistive devices such as dosing aids and appropriate medications tailored to individual patient requirements.		
8. Our patients are invited to share their experience of 45-49 years health assessment activities to enable us to measure and refine our patient-centred programs and develop a template for future activities.		

AREA FOR ACTION (Go to PDSA template in your toolkit or see suggested PDSA activities)

1.

2.

45-49 HEALTH ASSESSMENT PRACTICE TEAM

Clinical lead (GP):

Administrative lead (PM/PS):

Clinician involvement (GP/PN):



CHANGE IDEAS TO CONSIDER

These ideas are suggestions only, with the concept adaptable across the 45-49 years health assessment.

Idea: Encourage person-centred care by encouraging patients to discuss chronic disease prevention with their GP.

- Display Chronic Disease Management promotional material in the waiting room. This could incorporate posters, newsletters, signs etc.
- Have the reception team give eligible patients a flyer asking them when they were last assessed. The patient can then take the flyer into their appointment with them, opening the door for a discussion with their Doctor or Nurse about relevant programs to assist.

Idea: Engaging the General Practice Team- Develop and maintain an effective recall and reminder system: staff education.

There is often a lot of work that needs to be done to improve how practices use software to maintain effective recall and reminder systems. Staff education is the first step towards improvement. Ask your Primary Care Improvement Officer to provide a short information session to staff and provide reminder and recall resource manuals.

Idea: Appoint a staff member who is responsible for creating and maintaining a 45-49 years health assessment register; add this role to their job description.

This staff member may become the Practice Champion for 45-49 yr=Health Assessments. Providing professional development opportunities to this staff member will assist with rewarding and recognising this person's contribution to the team.

Idea: Have a team meeting to brainstorm how recall and reminder systems could improve income generation and patient care.

(eg by linking together multiple recalls such as GP Management Plans, Health Assessments etc.)

Dedicate some time at a staff meeting to discuss how health assessments can be increased.

Idea: Draft a written procedure for recall and reminder systems.

If your Practice has a policy/procedure for recalls and reminders, check that there is a process for 45-49 years health assessment. If there is not a current policy, contact GPA or AGPAL as a starting point to generate conversation and development of a policy.

Idea: Send 45-49 years health assessment reminder letter to eligible patients.

- Following the establishment of your 45-49 years health assessment patient register, identify patients due for assessment.
- The 45-49 years health assessment initiative suggests two key times where Practice reminders can really add value:
 1. For patients who have never been assessed
 2. On a patient's actual re-screen due date.
- Utilise the suggested template reminder letter available through your Primary Care Improvement Officer.

RESOURCES FOR UNDERTAKING QUALITY IMPROVEMENT

Quality Improvement Goal Setting

1. What are we trying to accomplish?

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

2. How will we know that a change is an improvement?

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

3. What changes can we make that can lead to an improvement?

List your ideas for change. By answering this question, you will develop the ideas you would like to test towards achieving your goal.

IDEA 1.

IDEA 2.

IDEA 3.

IDEA 4.

Quality Improvement Action Worksheet

PLAN, DO, STUDY, ACT

Please complete a new worksheet for each change idea you have documented on the previous page.

Where there are multiple change ideas to test, please number the corresponding worksheet(s).

Describe the idea you are testing.

IDEA

Must include what, who, when, where, predictions & data to be collected.

What:

Who:

PLAN

When:

Where:

Data to collect/record:

What do we think will happen?

Was the plan executed? Document any unexpected events or problems.

DO

Record, analyse and reflect on the results.

Extract same data to measure for improvement:

STUDY

What will you take forward from this cycle (next step or next PDSA cycle)

ACT



Measuring Success

The overall aim of undertaking a chronic disease prevention Quality Improvement activity is to increase participation in 45-49 years health assessment for people aged 45-49 years who are at risk of developing chronic disease.

Choosing an activity or idea to explore will have its own measure of success. It is important to identify in each activity what you are wanting to change and how you will know when the change has occurred. This is identified in Question 2.

Applying a SMARTA (Specific, Measurable, Attainable, Realistic, Timebound and Agreed) goal setting process will assist you.¹

SMARTA Goal Setting

- Specific. Goals that are too vague and general are hard to achieve, for example 'be a better parent'. Goals that work include specifics such as 'who, where, when, why and what'.
- Measurable. Ideally goals should include a quantity of 'how much' or 'how many', for example drinking 2 litres of water per day. This makes it easy to know when you have reached the goal.
- Achievable. Goals should be challenging, but achievable. Goals work best when they are neither too easy or too difficult. In many cases setting harder goals can lead to better outcomes, but only if the person can achieve it. Setting goals which are too difficult can be discouraging and lead to giving up altogether.
- Relevant. The goal should seem important and beneficial to the person who is assigned the goal.
- Time-related. 'You don't need more time, you just need a deadline.' Deadlines can motivate efforts and prioritise the task above other distractions
- Agreed.

Reflect on the 45-49 years health assessment activity identified on page 11. Here you have undertaken a data analysis utilising PenCAT and this has shown the percentage of active patients who do have 45-49 years health assessment recorded. This forms your baseline measure.

The next step is to decide on an activity and set a goal. For this example, you may like to set a goal to increase participation in 45-49 years health assessments by 15%. When this has been implemented within a set time frame, you can then repeat the data analysis to see the change in status has increased.

¹Health Direct November 2016 <https://www.healthdirect.gov.au/smart-goals>

An Example of Measuring Success

Practice X has 600 male and female patients aged between 45-49 years. PenCAT analysis identifies that 120 males and females in this age group have lifestyle or biomedical risk factors that puts them at risk of developing a chronic disease.

Numerator: The number of male and female patients aged 45-49 years, with 3 or more visits in the previous 2 years, who have lifestyle or biomedical risk factors

Denominator: The number of active male and female regular clients aged 45-49 years

$$[\text{Numerator of 120}] \div [\text{Denominator of 600}] = 20\%$$

Practice X then decides as a QI activity to undertake a data cleansing and improvement activity for chronic disease prevention. The measurement of change will be the increase in recording of 10%. This could be a measure after 3 months as this is a measurement of data management and system change.

Measurement for 45-49 years Health Assessment

Lifestyle Risk Factors

NUMERATOR	The number of male and female patients aged 45 – 49 years, with 3 or more visits in the past 2 years, who are smokers and/or excessive alcohol use, and/or low physical activity recorded.
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DENOMINATOR	The number of active male and female regular patients aged 45-49 years.
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Elevated Cholesterol

NUMERATOR	The number of active male and female patients aged 45-49 years who have had a diagnosis of familial hypercholesterolaemia recorded and/or are on cholesterol lowering medication.
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DENOMINATOR	The number of active male and female regular patients aged 45-49 years.
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Type II Diabetes

NUMERATOR	The number of male and female patients aged 45-49 years diagnosed with type II diabetes who are overweight or obese, with 3 or more visits in the previous 2 years.
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DENOMINATOR	The number of active male and female regular patients aged 45-49 years.
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Low Physical Activity

NUMERATOR	The number of active male and female patients aged 45-49 years who have family history of chronic disease recorded.
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DENOMINATOR	The number of active male and female regular patients aged 45-49 years.
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