



75+ YEARS HEALTH CARE ASSESSMENT TOOLKIT

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INTRODUCTION

HNECC PHN: 75+ Years Health Assessment Strategy

Hunter New England and Central Coast (HNECC) PHN is a not-for-profit organisation that is funded by the Commonwealth Government. We support Practices and health professionals to provide high quality, evidence-informed care while maximising the practice's efficiency and sustainability.

Support that can be accessed through the PHN includes: Education and professional development, preventative health, immunisation, workforce support, chronic disease management, quality improvement / accreditation, practice management, as well as digital health.

At a glance:

With over 1.2 million people currently living in our region and with an ageing population, the aim of annual health assessments is to assist medical and non-medical care needs of a patient ranging from acute to chronic. It is widely accepted that a multidisciplinary approach to Aged Care is best drawing from the knowledge and skills of a range of health care professionals to assist individuals reach their highest levels of physical, functional and cognitive health.

With older people at an increased risk of multiple health conditions, the aim of attending a 75+ years health assessment is to identify health issues and conditions that are preventable or amendable to

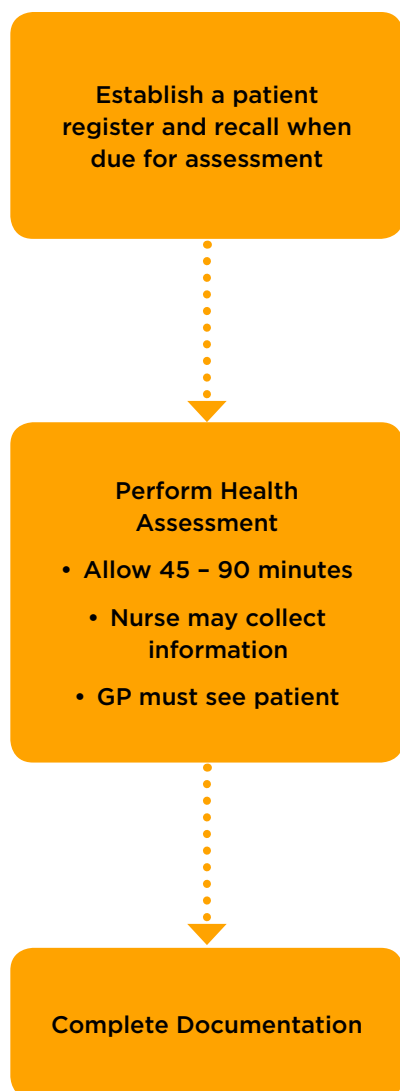
interventions to improve health and/or quality of life. The aim of attending a health assessment is to identify key areas of concern and link the right care, at the right time, by the right people, and at the right location. A health clinician may assist the patient to be able to stay in their own home longer; assist them with accessing services with the aim of promoting independent living; as well as carry out and/or arrange examinations and investigations as required, including risk factors that may require management.

<https://www.swsphn.com.au/agedcare>

(Sydney, 2019)



75+ Years Health Assessment



Eligibility Criteria

- Patients aged 75 years and older
- Patient seen in consulting rooms and/or at home
- Not for patients in hospital or a Residential Aged Care Facility.

Clinical Content

Mandatory:

- Explain Health Assessment process and gain patient's/carer's consent
- Information collection – take patient history; undertake examinations and investigations as clinically required
- Measurement of BP, pulse rate and rhythm
- Assessment of medication, continence, immunisation status for influenza, tetanus and pneumococcus
- Assessment of physical function including activities of daily living and falls in the last 3 months
- Assessment of psychological function including cognition and mood
- Assessment of social function including availability and adequacy of paid and unpaid help and the patient's carer responsibilities
- Overall assessment of patient
- Recommend appropriate interventions
- Provide advice and information
- Discuss outcomes of the assessment and any recommendations with patient.

Non-Mandatory:

- Consider need for community services, social isolation, oral health and dentition and nutrition status
- Additional matters as relevant to the patient.

Claiming

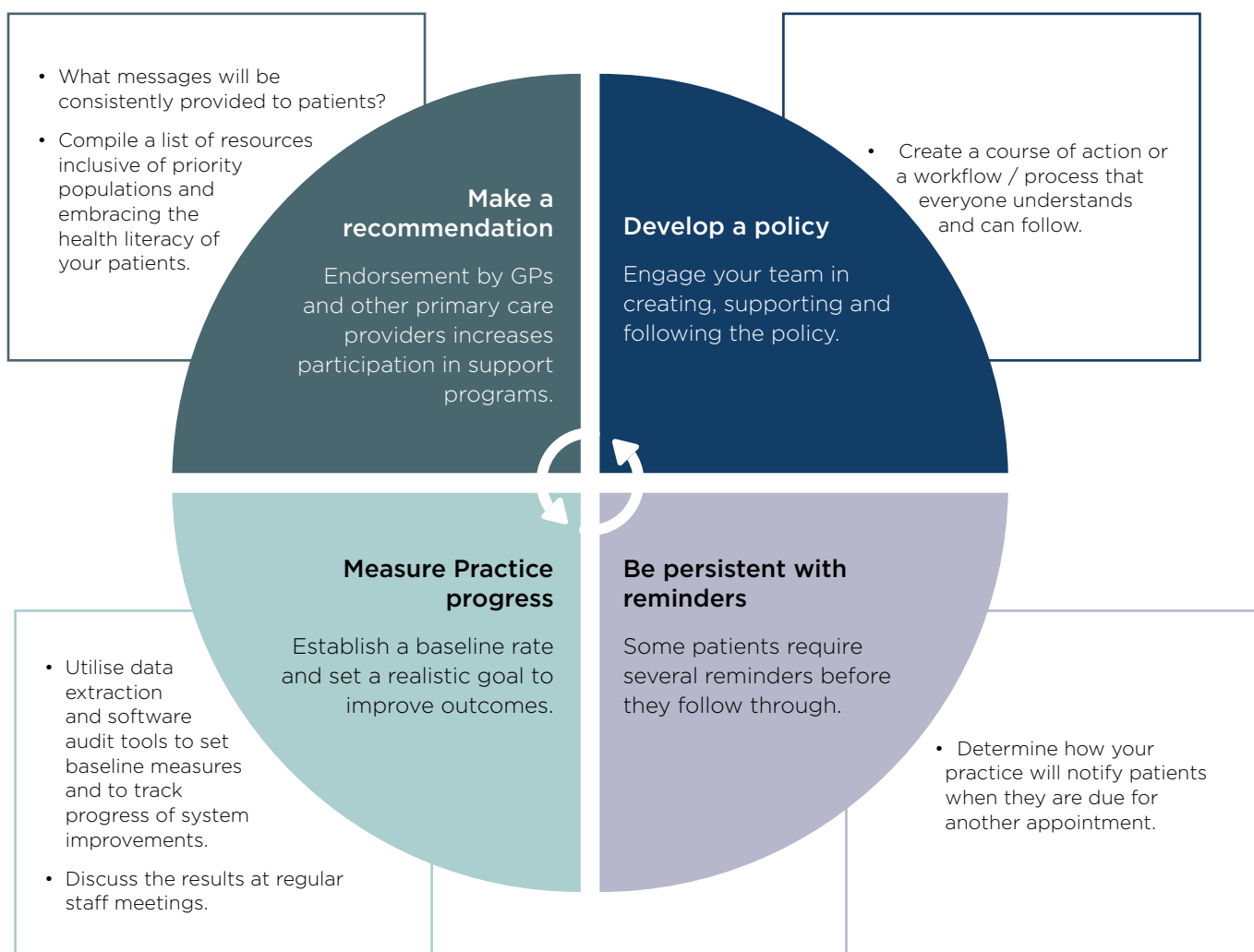
- All elements of the service must be completed to claim
- Requires personal attendance by GP with patient.

MBS item	Name	Age Range	Recommended Frequency
701 / 703 / 705 / 707	Health Assessment – 75 Years and Older	75 years and older	Once every 12 months

MBS item 10991 (bulk billing incentive) may also be claimed for eligible patients.

Four essentials to improving 75+ 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 Do's 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 CS's Clinical Audit Tool 4 (CAT4) 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 CAT4 to investigate and report against their patient data. Using CAT4 to extract relevant data provides practices a range of benefits including:

- Improving the quality of patient care by identify 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 PEN CS 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 75+ Health assessments.



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.

The Quality Improvement process (model for improvement) 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 suitable for wider implementation.

FOR EXAMPLE - your General Practice may decide to focus on 75+ years health assessments

You may have an aim like this: Identify patients that are eligible for a 75+ years health assessment

Your response may be:

We will measure through CAT4:

- The number of eligible patients aged 75 and over in our practice
- The number of patients over 75 that have not had a visit in the last 12 months.

Your outcome may include:

- Use CAT4 to extract the number of patients aged over 75.
- Provide training to ensure both clinicians and non-clinicians have met the MBS guidelines associated with 75+ years health assessments
- Routine Health assessments: identifying if the assessment can be attended in clinic or if it would be more beneficial to the patient to have at home
- Send 75+ years health assessment invitation to eligible patients.
- Review recall and reminder systems for patients aged 75 and over.



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 75+ years health assessments

Idea	Use CAT4 to extract the number of patients aged 75 and over who are at risk of developing chronic disease who do not have a 75+ years health assessment recorded
Plan	<p>What: Use CAT4 to extract data.</p> <p>Who: Admin (nominated person for data extraction)- In collaboration with the practice manager.</p> <p>When: 1 April 2019</p> <p>Where: General Practice</p> <p>Data to be collected: Extract or record the number of eligible patients over the age of 75 years.</p> <p>Prediction: Expect 60% of patients have not had a 75+ years health assessment.</p>
Do	Practice nurse or admin to extract data as planned using PenCS Recipe to ensure correct data was extracted.
Study	Percentage of patients with 75+ years health assessments was as expected.
Act	Data presented to practice team to discuss health assessment management strategies that could be implemented within the practice.ie: it could be your recall and reminders are up to date.



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

Undertaking a 75+ years health assessment is an ideal way to assist your patients by reducing hospital admissions and can assist them to stay in their own home longer by ensuring that any services that the patient may require have been accessed.

It is also a great time to educate patients on lifestyle choices that may have a positive impact on their general health and well-being.

There are many ways to improve patients' participation in 75+ years health assessments.

This Readiness Tool is designed as a starting point to encourage General Practice to generate ideas and strategies in 75+ years health assessments 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 identify any ideas you may like to consider changing.

75+ 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. In our practice we display promotional material within the practice. This ensures patients are aware that a 75+ years health assessment is available as well of the benefits of having the health assessment attended.		
3. 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.		
4. We ensure that all follow up appointments to complete the health assessment are with the patient's regular GP.		
5. 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.		

6. Our staff regularly attend education and training so that they are up to date with best practice and can ensure that the patient is given the most up to date evidenced based information.

7. Our practice endeavours to use an interpreter with patients where English is not their first language.

www.tisnational.gov.au

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. We regularly complete data cleansing activities to establish up to date lists (registers) of eligible patients due for 75+ years health assessment.		
3. 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.		
4. Our staff have access to clinical audit tools and are trained in using CAT filters effectively and efficiently to create patient registers.		
5. Staff are aware and confident in the benefits of utilising TOPBAR.		
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. All prescriptions and medication lists are recorded in our clinical software and regularly updated by the Doctor.		
3. Our practice will ensure that there is accessibility for all patients with a disability or special needs so that they are able to access our practice in ways that maintain their dignity.		
4. We have policies and procedures for reminders and recalls. Staff follow these established protocols to ensure consistency and accuracy in recalling patients at the correct times.		
5. Protected time is scheduled to ensure staff have capacity and resources to accurately complete their tasks within allocated timeframes.		

6. The practice has a protocol for home visit assessments with regular reviews for high risk patients.

7. The practice has adequate staff to be able to attend clinic and home visit health assessments ensuring that all patients can have access to having the health assessment attended.

AREA: Patient-Centred Care	Yes/No	Action/Comment (what, when, who)
<p>1. There is a focus on 75+ years health assessments, with the aim of:</p> <ul style="list-style-type: none"> • Reduction of hospital admissions of patients within the practice. • Assessment and recognition of illness that may lead to subsequent deterioration in the patient's health. • Maintaining current level of mobility. • Ensuring the patient is socially active within their community. • Improved health outcomes. • Providing optimal level of care to patients. 		
2. There is the capacity within the practice to follow up on the frail with regular reviews at home.		
3. Staff are appropriately trained in attending 75+ years health assessments.		
<p>4. Staff are trained to be able to complete a basic nutrition assessment</p> <p>Guide to completing the Mini Nutritional Assessment (MNA®)</p>		
5. Practice Nurses attending the health assessment are skilled in sending appropriate referrals as required and are aware of the pathways for sending referrals.		
6. The nurse reviews SNAP (Smoking, Nutrition, Alcohol and Physical Activity) data on a regular basis to ensure that it is current and up to date.		
<p>7. The nurse has knowledge of My Aged Care and will be able to assist the patient and family with My Aged Care referral as required</p> <p>https://www.myagedcare.gov.au/referral-form</p>		

8. The nurse understands the immunisation schedule and can recommend the most up to date immunisation schedule for the patient

<https://www.health.gov.au/health-topics/immunisation/immunisation-throughout-life/immunisation-for-seniors>

9. The information provided is tailored to the patient's level of understanding and health literacy, so they understand the information and recommendations they receive.

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

1.

2.

75+ YEARS HEALTH ASSISTANCE 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 75+ years health assessments.

Idea: Encourage person-centred care by encouraging patients to discuss 75+ years health assessments management with their GP.

- Display promotional material in the waiting room.
- 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 75+ years health assessment register; add this role to their job description.

This staff member may become the Practice Champion for 75+ years 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 and Health Assessments)

Dedicate some time at a staff meeting to discuss how health assessments can include falls prevention, ROM exercises, Nutrition, social situation and Isolation, home safety, alcohol Issues as well as mental health. Review health assessment templates to ensure that the above questions are included.

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 75+ years health assessments, in home or in clinic. 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 75 + years health assessment reminder letter to eligible patients due for assessment.

- Following the establishment of your 75+ years health assessment patient register, identify patients due for assessment
- The 75+ 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 75+ years health assessment Quality Improvement activity is to increase participation in 75+ years health assessments.

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.

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.**

When reflecting on the 75+ years health assessment activity identified on page 11, you have undertaken a data analysis utilising PenCAT and this has shown the percentage of active patients who have 75+ years health assessments attended. 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 the amount of 75+ years health assessments attended at your practice by 10%. 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 with increasing 75+ years health assessments within your practice

Practice X has 600 active male and female patients aged 75 years and over. CAT4 analysis identifies that 200 males and females have not attended a 75+ years health assessment in the last 12 months.

Numerator: The number of male and female patients aged over 75 years with 3 or more visits in the previous 2 years who have not had a 75+ years health assessment in the last 12 months.

Denominator: The number of active male and female regular clients aged over 75 years on our database.

$$[\text{Numerator of 200}] \div [\text{Denominator of 600}] = 30\%$$

Practice X then decides as a QI activity to undertake a data cleansing and improvement activity for 75+ years health assessments. The goal is to increase the 75+ years health assessment rate by 10%. Results will be reviewed after a 3 month period.

Measurement for 75+ years health assessment

Health Assessments for patients 75 years and over who have not a health assessment in the past 12 months

NUMERATOR No. of patients who have not had a health assessment.

DENOMINATOR Total number of patients eligible for a Health Assessment.

NUMERATOR

DENOMINATOR

NUMERATOR

DENOMINATOR

NUMERATOR

DENOMINATOR

Useful Online Resources to assist with undertaking a 75+ years health assessment

- **PENCAT recipes Data Extraction:** <http://help.pencs.com.au/display/CR/CAT+RECIPES>
Used to optimise patient outcomes in assisting the nurse with extracting data to recall patients that have not had a 75+ years health assessment attended.
- **Translation and Interpreter Service** - <https://www.tisnational.gov.au>
Immediate phone interpreting: Phone: **131450** (within Australia)
Australian Translating and Interpreting Service (ATIS) phone interpreting: **1800 131 450**
Pre-booked phone interpreter: **1300 655 081** or email: tis.prebook@homeaffairs.gov.au
- **Health Translations Directory** - www.healthtranslations.vic.gov.au
To assist with improving communication with your patients from culturally and linguistically communities. It has a broad range of health and well-being information covering over 100 languages. This site is continually reviewed so that the information is current and up to date.
- **Health pathways** - <https://hne.communityhealthpathways.org/> & <https://centralcoast.healthpathways.org.au/>
Local pathways and relevant referrals pathways to assist with attending and completing 75+ health assessments.
- **National Relay Service** - www.relayservice.com.au
To assist patients who have a hearing impediment or who may have a speech impediment to communicate.
Speak and Listen: 1300 555 727
Teletypewriter: 133677
SMS Relay Number: 0423 677 767
This service is a confidential service that uses trained staff to relay information and communicate between patients who are deaf, hard of hearing and/or have a speech impediment and the organisation they are calling.
- **Nutrition Assessment** - https://www.mna-elderly.com/forms/mna_guide_english.pdf
A screening tool to assist with identifying patients that may be at risk of malnutrition.
- **My aged care referral** - <https://www.myagedcare.gov.au/referral-form>
- **Hunter New England Central Coast Primary Health Network (HNECC PHN)** - <https://hneccphn.com.au/>
Information on HNECC PHN programs, resources and education opportunities.
- **Immunisation Schedule** - <https://www.health.nsw.gov.au/immunisation/Pages/nsw-immunisation-schedule.aspx>
- **Falls prevention in older adults** - <https://www.racgp.org.au/afp/2012/december/falls-prevention/>
- **CAPS Continence Aids Payment Scheme Application Form** - <http://bladderbowel.gov.au/assets/doc/caps/CAPSAApplicationForm.pdf>
Phone the **National Continence Helpline** on **1800 33 00 66**.
Go to the **Australian Government's bladder bowel** website.
- **Advanced Care Directive** - <https://www.advancereplanning.org.au>
- **Dementia Australia** - <http://www.dementia.org.au>
- **Elder Abuse Red Flags** - www.elderabusehelpline.com.au
- **Osteoporosis** - <https://www.osteoporosis.org.au/clinical-guidelines>
- **Palliative Care** - <https://palliativecare.nsw.org.au/new/>
- **Palliative Care app for nurses** - <https://apps.caresearch.com.au/palliAGEDnurse/ACP-in-General-Practice>
- **Heart Movers** - to assist with directing to your local area - <https://walking.heartfoundation.org.au/>
- **Heart Foundation Helpline: 13 11 12**
- **Meals on Wheels** - <https://mealsonwheels.org.au/>
- **University of the third age** - newcastleu3a.au@gmail.com

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