DEMENTIA QUALITY IMPROVEMENT PROGRAM

Enhancing Dementia Care in Primary Care

Handbook

Dementia Care
QUALITY IMPROVEMENT PROGRAM

phn
NORTHERN SYDNEY
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Disclaimer
Whilst every effort has been made to ensure that the information in this toolkit is accurate, health professionals must not rely solely on this information to make patient care decisions.

Intellectual Property

This program is funded by the Australian Government Department of Health.

Introduction

Sydney North Health Network (SNHN) is delighted that your practice has decided to participate in the Dementia Quality Improvement Program (DQIP).

The aim of the DQIP is to encourage and support general practices within the Sydney North region to improve practice processes, resulting in better health outcomes for patients and provide sustainable quality improvement for General Practice. This will be achieved by identifying measurable and achievable key indicators within your practice setting. The DQIP will focus on Dementia, addressing the following indicators:

1. Dementia Register (Patients with a diagnosis of dementia - including all subtypes)
2. Dementia – Health Assessments (Over 75 Health Assessment)
3. Dementia – Reducing Cardiovascular Disease Risk (as a form of dementia prevention)
4. Dementia – MyHealth Record Currency (Health Summary Uploaded)
5. Dementia – Carer Identified (Person most responsible and support provided, with contact details recorded)
6. Dementia – Domiciliary Medication Management Review (including anticholinergic load and use of anti-psychotic medication, and assessment of the person's ability to take medication - consider Webster pack)
7. Dementia – High Risk of Dementia (Identify patients and consider diabetes, cardiovascular disease , age, diagnosis of mild cognitive impairment)

The program will provide support to you and your team to analyse current dementia care management and develop individualised plans to deliver improvements in the quality of services you provide to your patients with dementia and other health care needs.
Dementia has a profound life-changing impact - not only on the person with dementia, but their carers, family members and friends.

The Role of the GP

In August 2012, Australian Health Ministers agreed to designate dementia as the ninth National Health Priority Area due to the increased burden of disease and the rising prevalence of dementia in Australia. Recognising dementia as a National Health Priority Area creates opportunities to improve the health status and wellbeing of people with dementia and their carers.

In the absence of a cure there is increasing focus on risk reduction, timely diagnosis and early intervention. Ongoing management, including regular review and supports such as as social prescribing is also important.The Department of Health National Framework for Action on Dementia 2015-2019 states:
"A person's main healthcare provider, their General Practitioner has an important role in recognising, assessing, diagnosing and providing support".

Diagnosing dementia can be difficult owing to the insidious onset of the disease. In response to this and due to the aging population in our region, we need to focus on solutions that meet the needs of people living with dementia through a multi-pronged approach. We aim to build capacity within general practice to better understand the needs of people and their carers, living with dementia to navigate our complex health system. SNHN in collaboration with The Improvement Foundation formed an expert reference panel in 2016 to develop the quality indicators for best practice dementia care in general practice.

The DQIP is based on a similar program, the Australian Primary Care Collaboratives (APCC), which has been running since 2005 across Australia. The APCC program has been very successful in developing the processes involved when delivering services to patients with chronic illnesses. Some of the chronic disease conditions addressed during the APPC programs have included diabetes, chronic heart disease, and chronic kidney disease.

The Primary Care Advancement team at SNHN welcomes your practice to the DQIP and we are confident that this will prove to be a beneficial and worthwhile journey in helping to enhance and develop the management of patients with chronic disease in primary care.

What is a collaborative?

A Collaborative is a way for practices to work together to explore solutions to identifying early interventions for patients with chronic and complex needs. The collaboration involves trialing solutions through small scale rapid changes at the practice level, measuring the success of those trials and sharing what has or has not worked.

The Dementia Quality Improvement Program (DQIP) will help support you and your team to deliver improvements in the quality of services you provide to your patients with dementia and other health care needs.

The ideas included in this handbook are those that we currently know will have the greatest impact on achieving improvements in this program. We acknowledge, however, that you may have practical approaches and examples that can improve on these ideas. As the program progresses, we will work together to enrich the original ideas, add new ideas and update examples from your successes and the experiences of all participating Practice teams.

This resonates with the philosophy behind the Collaborative methodology; of people working together to share, learn, apply and ultimately improve best practice to deliver better patient care. Together we can stimulate innovation and improvement in this area.

We hope you find this handbook to be a practical resource in supporting the work of you and your team, and we look forward to your contribution to future editions of this work.

The impact of dementia in Australia

- Dementia is the second leading cause of death
- It is the leading cause of death of Australian women, surpassing heart disease. Females account for 64.5% of all dementia related deaths
- It is the single greatest cause of disability in older Australians (65 yrs and older)
- an estimated 250 people are joining the population with dementia each day, and is predicted to increase to 318/day by 2025 and more than 650/day by 2056
- in 2020 it is estimated that almost 1.6million people in Australia are involved in the care of someone living with dementia
- it is estimated to cost more than $15billion in 2018 rising to more than $18.7billion by 2020 people with dementia account for 52% of all residents in aged care facilities
- In Northern Sydney 55.9% of people living in residential care (on 30th June 2018) had a diagnosis of dementia. https://www.gen-agedcaredata.gov.au/My-aged-care-region

Ref: Dementia Australia Jan 21 https://www.dementia.org.au/statistics

INTRODUCTION TO QUALITY IMPROVEMENT

What is Quality Improvement?

The RACGP 5th Edition Standards for General Practice describes Quality Improvement as an 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 encourage quality improvement so that you can identify opportunities to make changes that will improve patient safety and care[1].

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 practices' GPs and other staff members 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 as a whole.

THE PROCESS

The Quality Improvement process is divided into two manageable steps, the "thinking" part and the "doing" part. This process allows ideas to be broken down into management sections which can be tested and reviewed to determine whether improvement has been achieved prior to implementing changes 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?
2. How will we know that a change is an improvement?
3. What changes can we make that will result in an improvement?

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.

[1] RACGP Accreditation 5th Edition Standards

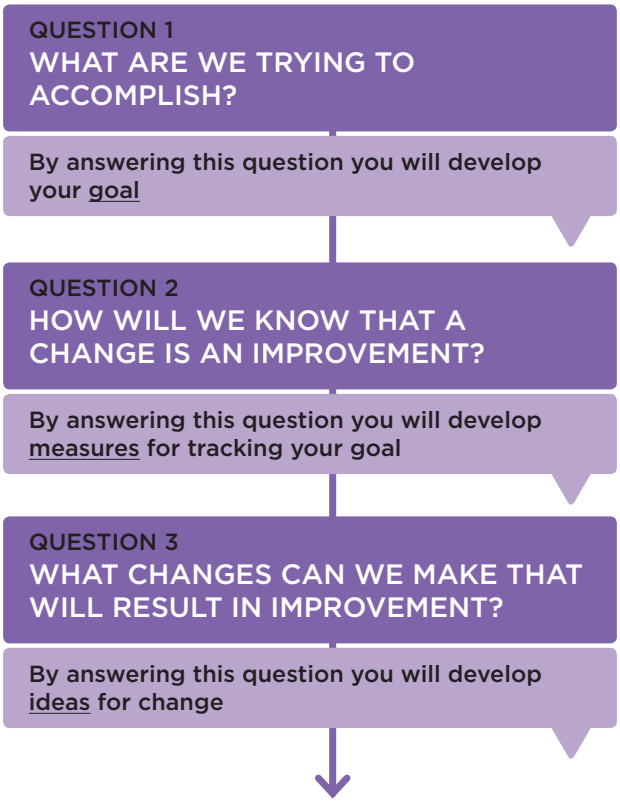
What is Quality Improvement? (continued)

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 (CAT4 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.
- Quality Improvement can be applied to any aspect of enhancing patient care including but not limited to:
  - Data quality and cleansing
  - Increasing cancer screening rates
  - Improving immunisation rates
  - Chronic disease management
  - Lifestyle modification
  - Preventive health.

The "Thinking" Part

THREE FUNDAMENTAL QUESTIONS WHEN UNDERTAKING QUALITY IMPROVEMENT



The "Thinking" Part (continued)

THREE FUNDAMENTAL QUESTIONS

QUESTION 1

What are we trying to accomplish?

Consider exactly what it is you are seeking to change.

- Define the problem. Success comes through preparation. Understanding what the problem actually is and thinking about why there is a problem helps in developing your goal.
- Set realistic goals that are specific and have a defined time-frame (SMART goals). Use plain language and avoid jargon so that the meaning is clear to everyone.
- Include information that will help keep the team focused.

QUESTION 2

How will we know that a change is an improvement?

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.

QUESTION 3

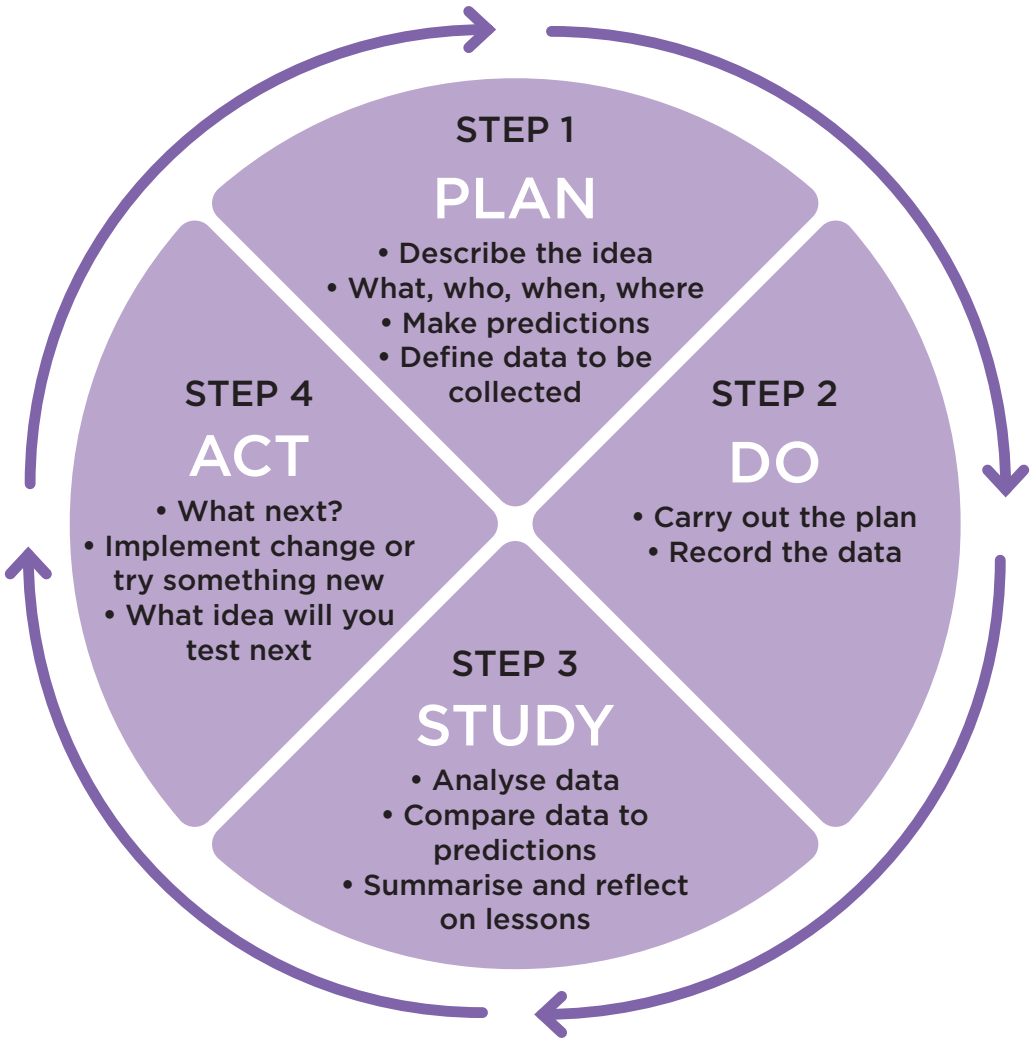
What changes can we make that will result in improvement?

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 resulted in the desired effect and is suitable for wider implementation.

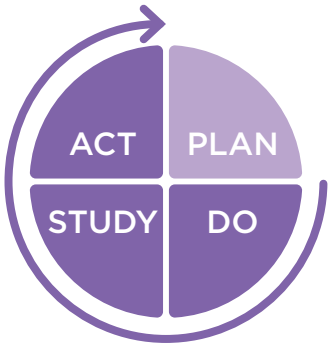
The "Doing" Part

PLAN, DO, STUDY, ACT



You will find through PDSA cycles that 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.

The "Doing" Part (continued)

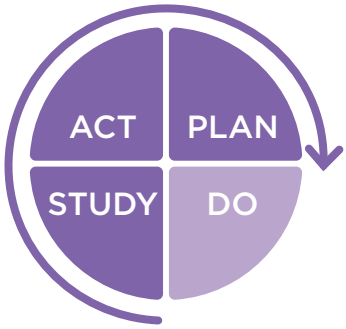


PLAN:

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

Make your plan as clear and detailed as possible:

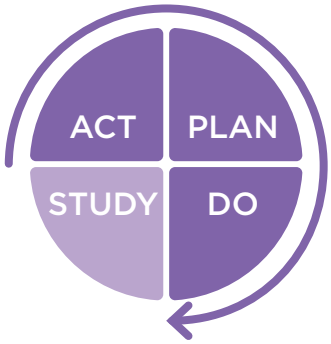
- What exactly will you do?
- Who will carry out the plan?
- When will it take place?
- Where will it take place?
- What do you predict will happen?
- What data/information will you collect to know whether there is an improvement?



DO:

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

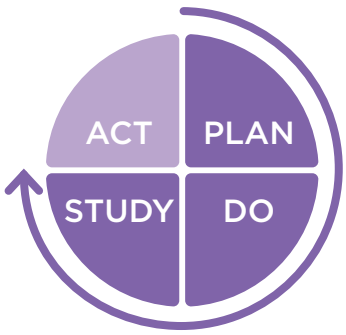
Collect any data you identified in the plan phase.



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.



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.

EXAMPLES

Example 1

YOUR GENERAL PRACTICE MAY DECIDE TO FOCUS ON CREATING A DEMENTIA REGISTER

Thinking Part

What are we trying to accomplish?	To create a register of patients with known dementia and those newly diagnosed, and use the register to review management
How will we know that a change is an improvement?	We will measure through CAT4: ◆ The number of patients with dementia and cognitive impairment
What changes can we make that will result in improvement?	◆ Use free text search in software and convert to coded diagnosis ◆ Review patients identified through CAT searches ◆ Review recall and reminder process in practice

Doing Part

IDEA: Review patients identified through CAT searches

Plan	**What:** Use CAT4 to extract data **Who:** Practice Manager **When:** Wednesday 3 November 2021 **Where:** General Practice **Data to be collected:** Extract or record the number of patients with coded diagnoses of dementia **Prediction:** Expect 5% of population to have a diagnosis of dementia
Do	Practice Manager extracted data as planned using PEN CAT Recipe to ensure correct data was extracted.
Study	Percentage of patients with dementia was significantly lower than expected.
Act	Data presented to practice team to discuss how to identify people with dementia.

EXAMPLES (CONTINUED)

Example 2

IMPROVE 75+ HEALTH ASESSMENT UPTAKE RATES

Thinking Part

What are we trying to accomplish?	To improve number of 75+ patients who have a Health Assessment, and to identify those with any cognitive impairment.
How will we know that a change is an improvement?	We will measure through CAT4: ◆ The number of health assessments conducted each quarter ◆ The number of cognitive impairment diagnoses
What changes can we make that will result in improvement?	◆ Identify eligible patients and invite for health assessment ◆ Follow up with phone call reminder

Doing Part

IDEA: Ideally eligible patients and invite for health assessment

Plan	Use CAT4 to extract data and send invitation for health assessment by text and phone
Do	Practice Manager extracted data as planned using PEN CAT Recipe to ensure correct data was extracted. Invitations sent to this cohort.
Study	Percentage of patients eligible for health assessment was higher than predicted (15%). Number of health assessments booked is 5%.
Act	Continue the process and incorporate follow up reminders Encourage GPs to promote health assessment to appropriate patients

EXAMPLES (CONTINUED)

The PDSA cycles are used to test an idea which may need refining as your team uncovers quality improved methods. Further examples of PDSA cycles:

- Establish a consistent diagnosis coding for dementia, to be used by all GP's
- Incorporate cognitive function test in health assessments for those who have indicators of memory problems
- Increase GPMP's and TCA for patients on dementia register (dementia is a chronic disease)
- Ensure recalls and reminders are added to review GPMP and TCA for people with dementia
- DMMR completed for all patients on register for 5+ medications. This should include a request to identify anticholinergic medications for people with dementia
- Improve vaccination rates for people with dementia (influenza and COVID.) They may forget to book for these
- Review social prescribing needs for patients with dementia eg support groups, dementia cafes, social clubs
- Check that carer/support person is identified in patient record, for those with a diagnosis of dementia, with contact phone number
- Identify and screen patients identified as high risk for dementia
- Agree on a time frame to archive patients, 2-3 years

Did you know?
Out of date GP clinical software can cause recording errors when transmitting data to the Australian Immunisation Register

HELPFUL TIPS

- Utilise the General Practice Quality Improvement Readiness Tool to assist in identifying 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.
- Other examples can be found via the CAT recipes.

SECTION 3: RESOURCES

General Practice Quality Improvement Readiness Tool

EXAMPLES/IDEAS

Area: General Practice Systems	Yes/No	Action/Comment (what, when and who)
1. Have you inactivated your inactive patients as per RACGP guidelines – 3 visits in 2 years?		
2. Does your practice request consent for de-identified patient information to be used for research purposes?		
3. Does the new patient form ask if the person identifies as Aboriginal or Torres Strait Islander?		
4. Regular data cleansing activities are undertaken to establish up to date lists (registers) of patients eligible for screening using CAT4 clinical software.		
5. Practice software is utilised for actions/ prompts for the GP/Nurse to ask about routine screening, immunisation status or chronic illness.		
6. There are policies and procedures in place that include reminders and recalls.		
7. The practice sends targeted reminders to patients (e.g. letters, SMS, email or phone calls).		
8. Have you developed a work-flow to manage and monitor CDM and recalling patients for review?		
9. Does your practice have a formalised team approach to quality improvement?		
10. Clinicians access HealthPathways.		
Areas for Action (Here you can use the PDSA template:)		
1.		
2.		
3.		

Change Ideas to Consider

The following ideas are suggestions only, with the concept adaptable across all areas of quality improvement.

IDEA:

Encourage person centred care by encouraging patients to discuss screening with their GP.

- Display Health Assessment promotional material in the waiting room.
- Have the reception team mention the Health Assessment to eligible patients

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 the PHN for information on how to improve your recall and reminder systems.

IDEA:

Appoint a staff member who is responsible for creating and maintaining Chronic Disease registers, add this role to their job description.

Providing professional development opportunities to this staff member will assist with rewarding and recognising this person's contribution to the team.

IDEA:

Encourage parents to use the 'Save the Date to Vaccinate' app.

Display brochures in the waiting room and/ or promote while a child is having a vaccination.

IDEA:

Have a team meeting to brainstorm how recall and reminder systems could improve income generation and patient care (e.g. by linking multiple recalls such as Cancer screening recall, Immunisations, GP Management Plans, Health Assessments, etc together).

Dedicate some time at a staff meeting to discuss how health assessments can include cancer screening prompts. Review health assessment templates to ensure that breast, bowel and cervical screening 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 management of cancer screening. If there is not a current policy, contact QPA or AGPAL as a starting point to generate conversation and development of a policy.

IDEA:

Send reminder letter to eligible patients for review of GPMP or TCA

- Following the establishment of your dementia patient register, identify patients due for GPMP/ TCA and invite them to see the GP. Schedule regular reviews for these patients

Quality Improvement Goal Setting

Ask the three questions:

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.

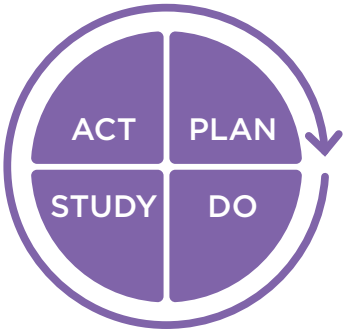
Idea 1	
Idea 2	
Idea 3	
Idea 4	
Idea 5	

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).



Idea	Describe the idea you are testing.
Plan	Might include what, who, when, where, predictions & data to be collected.
Do	Was the plan executed? Document any unexpected events or problems.
Study	Record, analyse and reflect on the results.
Act	What will you take forward from this cycle (next step or next PDSA cycle)

Measuring Success

Choosing an activity/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 SMART (Specific, Measurable, Achievable, Realistic and Time-framed) goal setting process will assist you.

S **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'.

M **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.

A **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 as long as the person has the ability to achieve it. Setting goals which are too difficult can be discouraging and lead to giving up altogether.

R **Relevant:** The goal should seem important and beneficial to the person who is assigned the goal.

T **Time-framed:** 'You don't need more time, you just need a deadline'. Deadlines can motivate efforts and prioritise the task above other distractions.

Reflecting on the Bowel Cancer Screening Activity identified earlier, where you have undertaken a data analysis utilising CAT4. This has shown the percentage of active patients that have a bowel screening participation status (FOBT) recorded. This forms your baseline measure.

The next step is to decide on an activity and set a goal. For the example above, you may like to set a goal to increase recording of bowel screening status participation by 5%. When this has been implemented, within a set time frame, you can then repeat the data analysis to see if the goal has been achieved.