phn
CENTRAL AND
EASTERN SYDNEY
An Australian Government Initiative

Quality improvement Toolkit

For General Practice

Advance Care Planning

Introduction

This Quality Improvement (QI) toolkit comprises modules specifically crafted to assist your practice in achieving straightforward, quantifiable, and sustainable enhancements to deliver optimal care for your patients. Utilizing the Model For Improvement (MFI), the toolkit facilitates the completion of QI activities.

As you progress through the modules, you'll receive guidance on exploring your data to gain deeper insights into your patient population and the care pathways within your practice. Insights gathered from module activities and related data will shape improvement ideas, which you can implement using the MFI.

The MFI employs the Plan-Do-Study-Act (PDSA) cycle, a proven method for effecting successful change. It presents several advantages:

- A straightforward approach applicable to anyone
- Reduced risk through starting with small-scale changes
- Effectiveness in planning, developing, and implementing impactful changes.

The MFI assists in breaking down the implementation of changes into manageable components. These components are then systematically tested to ensure that the changes lead to measurable improvements, minimizing wasted effort.

If you would like additional support in relation to quality improvement in your practice, please contact practicesupport@cesphn.com.au

As research and health guidelines continually evolve, the information in this document will need to be updated. If you have any feedback on the content of this document, please reach out to Central and Eastern Sydney PHN.

Acknowledgements

We wish to acknowledge that some content contained in this toolkit has been sourced from various organisations including Advanced Care Planning Australia; the Royal Australian College of General Practitioners (RACGP); the Australian Government Department of Health; NSW Health; Brisbane South PHN, MedicalDirector, and Pen CAT. These organisations maintain copyright over their original work, and we have adhered to license terms. Referencing of material is provided throughout.

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Contents

What is advance care planning?

Advance Care Planning is an important process that helps patients plan for future care. It is based on the fundamental principles of self-determination, dignity, and the avoidance of suffering. Through a process of reflection, discussion, and communication the patient is enabled to plan for their future treatment and other care, for a time when they are not competent to make or communicate decisions for themselves. It is an important way of letting people know your wishes about your healthcare and treatment should you find yourself in a position where you are ill or injured and not able to make decisions.

The process is collaborative and coordinated and involves the person, their families and a multidisciplinary health care team working together to optimize the persons current treatment, care and quality of life and ensuring their needs and wants are met in the future. [1]

What is the Process of developing an advance care plan?

In NSW an advanced care plan can be spoken or written. There is no specific form or template to use for an advance care plan. Advanced care planning can commence at any stage and does not require a terminal illness to begin the process. Ideally these conversations start when a person is well and able.

The process should begin by following the steps below

1. Identify if a person would benefit from an ACP
2. Assess the persons condition and decision-making capacity
3. Discuss health goals, values, and preferences
4. Planning treatment options based on ACP discussions with person and suitable decision-makers (usually family)
5. Coordinate treatment and care plans with other clinicians
6. Review care plan regularly to ensure consistency with the persons goals and preferences[2]

Aim of the toolkit

Provide a user friendly and hands on tool to general practices to facilitate an increase in advance care directives completed with patients while serving as a QI activity

This toolkit supports practices to meet the PIP QI incentive as well as making best use of practice data and simultaneously enhance patient care.

[1] https://www.advancecareplanning.org.au/home

[2] https://www.health.nsw.gov.au/patients/acp/Pages/advance-care-planning.aspx

How to use the toolkit

There are checklists included in this toolkit to guide you and your practice in assisting patients to meet their ACP needs. This includes:

- Planning and preparation
- Identifying a sample group of patients
- Setting timelines to achieve your goals
- Implementing improvement actions
- Documenting your QI activities
- Reviewing your QI activities and evaluate if your process is working

Benefits of using the toolkit

The toolkit provides:

- A structured, easy, and quick approach to implement quality improvement activities.
- A step-by-step guide
- Suggestions to identify suitable patients using data extraction tools.
- Links to prefilled templates and resources.
- Flexibility: activities can be started at any time of the year, and practice teams decide whether to implement a single improvement intervention, or a bundle of interventions.

ACTIVITY 1- ADVANCED CARE PLANNING (ACP)

The following checklist highlights some important considerations when discussing end of life care with patients

ACTIVITY 1.1 ACP Checklist

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

Medicare Benefits Schedule (MBS) items and ACP

While there is no dedicated MBS item for advance care planning, several MBS items can support ACP as part of other health assessments. Discussing ACP can be incorporated whilst completing patient's health assessments or management plans.

GPs are required to ensure that the individual meets the MBS criteria prior to claiming item numbers.

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

ACTIVITY 2 – PLANNING OUT YOUR QI ACTIVITY

Activity 2.1 –QI checklist

STAGE 1: PLANNING YOUR ACTIVITY		
Steps	**Details**	**completed**
Arrange a practice meeting for practice team members to discuss a potential focus group of patients for advance care planning.	Quality Improvement should be completed as a team to meet PIP QI requirements. Arrange a practice meeting to complete QI activities or add it to your regular agenda.	
Identify and establish key practice team members to implement this QI activity.	Suggested team members include: 1. General practitioner (GP) 2. Practice manager 3. Practice nurse 4. Receptionist Refer to QI improvement team planning sheet to help you plan	
Identify who will be the QI Lead at your practice.	The QI Lead provides day to day leadership to support ongoing activity, maintain progress, delegate tasks, and ensure QI processes are embedded into routine over time. who will be this person in your practice? _____	

Conduct searches using Polar or Pen CAT to identify an appropriate sample group of patients to focus on (You may wish to conduct your searches prior to holding a practice meeting).	The following recipes can be used as a guide to assist practices in identifying achievable QI activities • Find all patients 75 and older, with existing chronic conditions which are associated with a higher risk of death • Identify patients at high risk of dementia • Identify patients with diabetes, CVD or CKD who never had a GPMP/TCA claimed • Identify patients eligible for a 715 Aboriginal and Torres Strait Islander Health Assessment • Patients 75 years of age and over with a diagnosis of dementia and a health	
	assessment claimed within the specified time period If your practice uses Polar, use the Polar Education Portal to identify the data required. If you need assistance contact your Digital Health Officer digitalhealth@cesphn.com.au	
Confirm sample group of patients.	Identify your patients. It is suggested that you start with 50 -100 patients initially. Generate a list with individual names who are identified as most appropriate for discussing advance care planning.	
Upskill practice team members (if required).	Ensure all staff understand what advance care planning entails. Refer to online resources if required	
Discuss and document your practice approach, targets and expected outcomes as a result of completing your QI activity.	Consider things like targets, benchmarking data, timeframes, and actions in the PDSA template	

Examples are available for each QI Activity	Refer to the PDSA blank template	
Identify and order any resources or publications required.	A list of resources is available from Advance Care Planning Australia	

STAGE 2: IMPLEMENT YOUR ACTIVITY		
Steps	**Details**	**completed**
Communicate details of the focused QI activity to the whole practice team.	Share the updated PDSA with the whole practice team to ensure everyone is aware and knows their role to support implementation of the activity.	
Hold meetings and document minutes and outcomes as you progress through the activity.	Holding regular meetings will help the practice maintain momentum and keep people on task to achieve QI targets. Make sure to document minutes of meetings as this forms part of the PIP QI documentation.	

STAGE 3: REVIEW YOUR ACTIVITY		
Steps	**Details**	**completed**
Review PDSA and targets to assess progress or success.	Consider • What worked? • What needs more work? • What did you learn on the way? • What have you updated or changed to support this activity? TIPS: • Conducting a review of your process and data forms part of the requirements for PIP QI. • Ensure you document your findings to continue to meet the PIP QI guidelines. • If you have changed your systems and processes ensure these are documented in your practice policy & procedure manual.	
If outcome not achieved.	Review QI plan and propose a new strategy.	
Hold a whole of practice meeting.	Communicating the results of your QI activity with your whole team is important.	
Completion is a success whether outcome is achieved or not.	Use learnings to inform your next activity or repeat this one with a different plan. Here you can determine if the activity needs to continue as is or requires changes	

ACTIVITY 3 – STRATEGIES FOR IMPROVING ACP IN YOUR PRACTICE

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

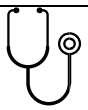
When you meet with your practice team, it is suggested that you discuss how your practice can initiate conversations and increase the number of advance care directives completed for patients.

You may consider the following strategies:

- Ensure ACP is included in all health assessments including Aboriginal and Torres Strait Islander, 45-49yearold and 75+ year old
- Include ACP as part of the GP Management Plan and review templates
- Conduct a search on CAT4 or Practice Sense to identify patients with a chronic condition and send them a letter about ACP
- Identify an area of care where advance health directive conversations can be initiated while patients are in the treatment room with the nurse (e.g completing an ECG, wound care, immunisations)
- Set up a display table in your practice waiting room with resources and information about end-of-life care
- Ensure your practice website has a link to up-to-date ACP forms
- Put a note on clinical teams monitor reminding them to talk to patients about ACP ○ Include information in the practice newsletter and social media about ACP ○ Ensure relevant team members attend an education session on ACP.

Evaluate your team's current operational dynamics—Is it working together cohesively and efficiently? A comprehensive approach involving the entire team is essential for enhancing Performance Improvement Project (PIP) Quality Improvement (QI) measures. Clearly defined roles, documented for efficiency and accountability, play a crucial role.

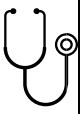
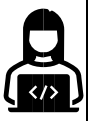
Here's an illustrative example of how responsibilities could be distributed among team members.

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

	• Respond to recall/reminder systems and engage in opportunistic discussions to encourage participation with eligible patients • Initiate conversations with patients in relation to advance care planning documentation.
Practice Manager 	• Maintain up to date patient registers • Establish and oversee recall/reminder systems • Support GPs with the flow of information in relation to PIP QI • Support/manage reception staff responsibilities • Manage succession planning • Document policies and procedures • Monitor progress against PIP QI improvement measures
Reception staff 	• Order and maintain supplies of resources, ensuring information is available in multiple languages • Display brochures, flyers, posters and statement of choices forms • Respond to recall/reminders opportunistically when a patient phones for an appointment and/or by handing relevant resources to patients in the waiting area • Send GP signed recall/reminder letters (and/or text messages and phone calls) to eligible patients to encourage participation.

ACTIVITY 4 – PRACTICE TEAM ROLES IN ACP

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

ROLE	STAFF MEMBER	RESPONSBILITY
General Practitioners 		
Practice Nurses 		
Practice Manager 		
Reception staff 		

Resources

- RACGP- Advanced Care Planning
- Advance Care Planning Australia
- NSW Health Advance Care Planning
- NSW Health Download an Advance Care Directive Form
- Training modules NSW Health Information for Health Professionals
- NSW Appoint an Enduring Guardian
- An interpreter can be arranged via Translating and Interpreting Service (TIS) . For patients who do not speak English the Appointment Reminder Translation Tool (available online) allows you to translate appointment details into your patient's language.

Links to other QI toolkits

Central and Eastern Sydney PHN have a suite of QI toolkits available for general practice. The toolkits are designed to:

- Enhance patient care and outcomes
- Assist practices fulfil their quality improvement requirements under PIP QI
- Allow you to choose the area of work you would like to focus on and enhance.

The full PIP QI and suite of toolkits and is available on Central and Eastern Sydney PHN's website.

Register your completion

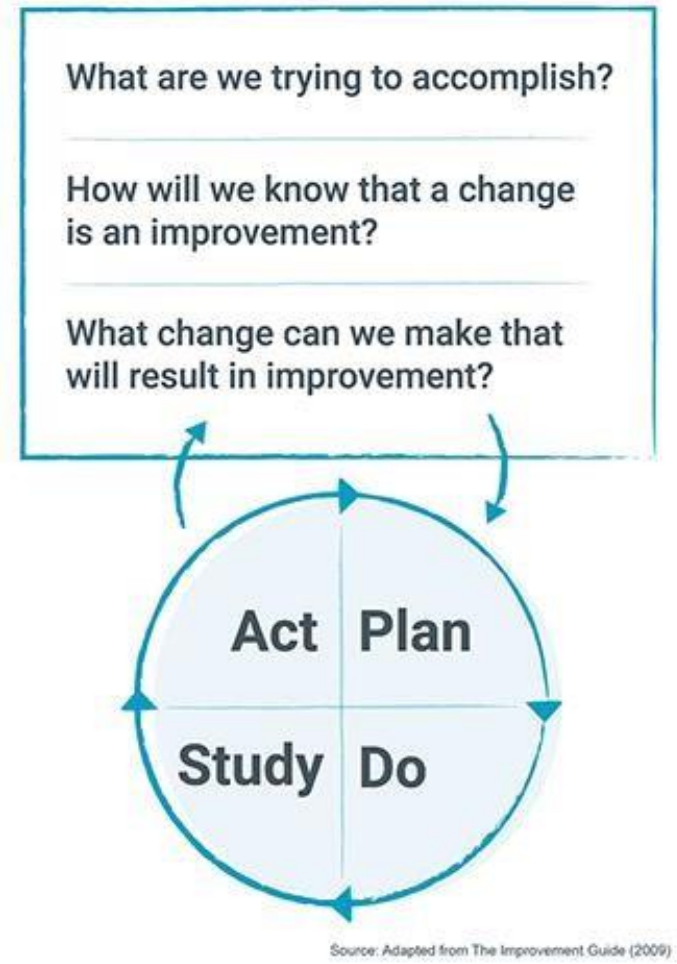
Please use the following form to submit the completion of your activity. Any feedback provided is highly valued and will assist CESPHN in enhancing the quality of these documents for future use. Register your completion

Additional Information

It is recommended that Advance Care Planning documents be uploaded to My Health Record You

can find instructions on digitalhealth.gov.au on how to upload an advance care plan.

Model for improvement diagram



Source: Adapted from The Improvement Guide (2009)

Name of Practice: Date:

Name of QIA:

Quality Improvement Team	
Names	**Roles/Responsibilities**

GOAL (Simple, Measurable, Achievable, Realistic, Timely) What are we trying to accomplish and when?	Our goal is to increase the number of ACP documents completed for patients having a 75+ health assessment by 15% by the end of the calendar year
MEASURES What data will we use to track our improvement?	We will measure the number of active patients aged 75+ years with a health assessment and ACP completed. To do this we will: A) Identify the number of active patients aged 75+ years with a health assessment. B) Identify the number of active patients aged 75+ years with a health assessment who have ACP completed. B divided by A x 100 produces the percentage of patients 75+ with a health assessment and ACP completed.
INITIAL BENCHMARK What is our current data saying?	30% of active 75+ year old patients have a health assessment and ACP
IDEAS What changes will we make that will lead to an improvement? NB: These ideas are not practice specific and are designed to give you some general ideas. The QI Team should develop these ideas together. To assist with clinical decision making, consider using HealthPathways, see: HealthPathways Sydney: https://sydney.communityhealthpathways.org/ Username: connected P/w: healthcare. HealthPathways South East Sydney: https://sesydney.healthpathwayscommunity.org Username: sesydney P/w: healthcare	IDEA: Identify active patients 75+ eligible for a health assessment. IDEA: Ensure all relevant team members have received training on ACP. IDEA: Add ACP checkbox to templates for chronic disease management and health assessments. IDEA: Ask the receptionist to provide all patients 65 years and older with an ACP brochure when they arrive at the practice.

QUALITY IMPROVEMENT ACTIVITY (QIA) PLANNING SHEET

	PLAN How will we do it?			DO Did we do it? Unexpected problems?	STUDY Review/reflect on results Lessons learnt What did/didnt't work well?	ACT Next steps? Review or extend activity?
	What	Who	When			
1	Jane will conduct a search on PenCAT to identify active patients aged 75+ eligible for an annual health assessment. She will then generate individual lists for each GP and highlight the patients who do not have any record of ACP discussions from their medical record. Each GP will identify suitable patients to contact to organise an appointment for their health assessment. Jane will call the patient to organise an appointment time. On arrival at the practice, each patient will see the practice nurse who will complete parts of the health assessment, the GP will then complete the health assessment. Both the nurse and the GP will have discussions with the patients about ACP.	Practice manager	Start of new month	Individual reports were generated using PenCAT to identify patients aged 75 and above eligible for a health assessment. The reports identified patients without any mention of Advance Care Planning (ACP) in their medical records. Each GP highlighted patients to contact, and Jane coordinated appointments with both the nurse and GP to facilitate their assessments. During our team meeting, we recognized a need for upskilling some GPs and Nurses in advance care planning. Team members underwent training, allowing staff to openly discuss ACP with patients. Appointment uptake was high, with the practice nurse noting people's interest in understanding ACP. While some patients expressed willingness to complete forms, the practice lacked a mechanism to track when the forms were submitted.	Of the individuals eligible for a health assessment, only 45% had Advance Care Planning (ACP) documentation in place, which was below our initial expectations. Despite this, we observed improvements in our overall completion rates. It's possible that the percentage could have been higher; however, for certain patients, we lacked a mechanism to track whether they had completed an advanced care plan. The results were shared with the practice team.	The practice has decided to adopt this. The practice manager will focus on generating reports quarterly to identify any active patients aged 75+ who do not have a current health assessment.