Continuous Quality Improvement

WORKBOOK FOR GENERAL PRACTICE

End-of-life Care

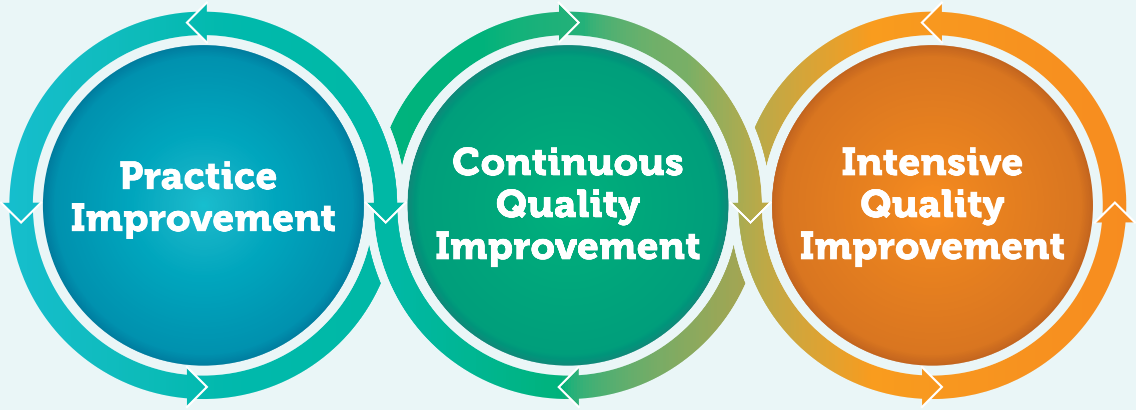
EDITION 1 | MAY 2020

phn
NORTH WESTERN
MELBOURNE

An Australian Government Initiative

A new model for general practice improvement

Our aim is to strengthen primary care to deliver integrated person-centred care that is comprehensive, accessible, safe and coordinated. Our new model has three modules of engagement. Your level of engagement will depend on your needs.



Focused on developing systems for quality improvement.

Focused on data-driven improvement. For accredited practices that share data and are new to quality improvement, or confident to implement quality improvement at their own pace.

A time-limited intensive facilitated quality improvement project for practices who want to further improve patient, clinical and whole of practice outcomes.

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Acknowledgements
North Western Melbourne PHN acknowledges the peoples of the Kulin nation as the Traditional Owners of the land on which our work in the community takes place. We pay our respects to their Elders past and present.

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Acknowledgements

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Some material contained in this workbook has been extracted from organisations including IHI, RACGP, the Australian Government Department of Health, Best Practice, Medical Director, Pen CS and Train IT. These organisations retain copyright over their original work, and we have abided by licence terms. Referencing of material is provided throughout.

The information in this workbook does not constitute medical advice and neither BSPHN nor NWMPHN accept any responsibility for information in the way this workbook is interpreted or used.

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Contents

From little things, big things grow

This workbook will show you how to do the 'little' on the way to achieving the 'big'.

It's a clear, four-step guide that draws on a proven approach, the Model for Improvement, with activities and resources for end-of-life care.

The four steps are:

Step 1: Understand end-of-life care and chronic complex illness

Step 2: Analyse data, set goals and brainstorm potential improvements

Step 3: Create a plan and act on it, following the 'plan, do, study, act' cycle

Step 4: Evaluate and celebrate.

These steps are complemented by links to resources and a comprehensive set of Appendices (p.54) covering:

- chronic complex illness
- best-practice tools to support early identification of end-of-life patients
- important conversations and advance care planning
- assistance for patients to live at home longer
- palliative care teams
- Medicare Benefit Schedule (MBS) items
- 'Plan, do, study, act': worksheet sample and template.

Using the Model for Improvement, you'll learn how to start small with your changes to end-of-life care. You will then systematically review, refine and re-test your ideas as necessary before broader implementation. You'll find a sample for this system in Appendix 10: PDSA worksheet sample.

It's a low-risk, high-return approach, and you'll have solid data to prove your achievements. But be warned – it's likely the process won't end there for your practice. Quality improvement can be a hard habit to shake.

Quality improvement workbooks

This workbook is part of a collection created by North Western Melbourne Primary Health Network (NWMPHN) to help general practices undertake self-directed quality improvement in a particular area of work, type of clinical practice or population group.

The workbooks have been created **by** general practice, **for** general practice, with input from NWMPHN teams and subject matter experts, and through consultation with the community and the broader primary care sector.

They are designed to meet the particular needs of providers, patients and priority populations in the NWMPHN area. Links to appropriate local referral pathways are also included.

For a full list of workbooks, go to nwmphn.org.au/quality-improvement

Before you start

The workbooks are designed to supplement the Quality Improvement Guide and Tools, **which we recommend reading first**. We've also included a primer below about the Model for Improvement (MFI), to refer back to while using the workbook.

About this workbook

This workbook is created as an interactive PDF. You can complete the tables in the book for your Priority 1 activity. Templates in the Appendix can be used for subsequent Priorities.

To complete this workbook, you will ideally use Adobe Acrobat or a similar compatible program to fill out the forms. If you add more content than what will fit in the text box, the text box will allow scroll for additional content to be added. Additional text will be shown with a + on the bottom of the panel. Please note that this additional content will not appear, however, if you print the document.

Your answers use only simple text formatting. You can paste into the text areas.

The Model for Improvement (MFI)

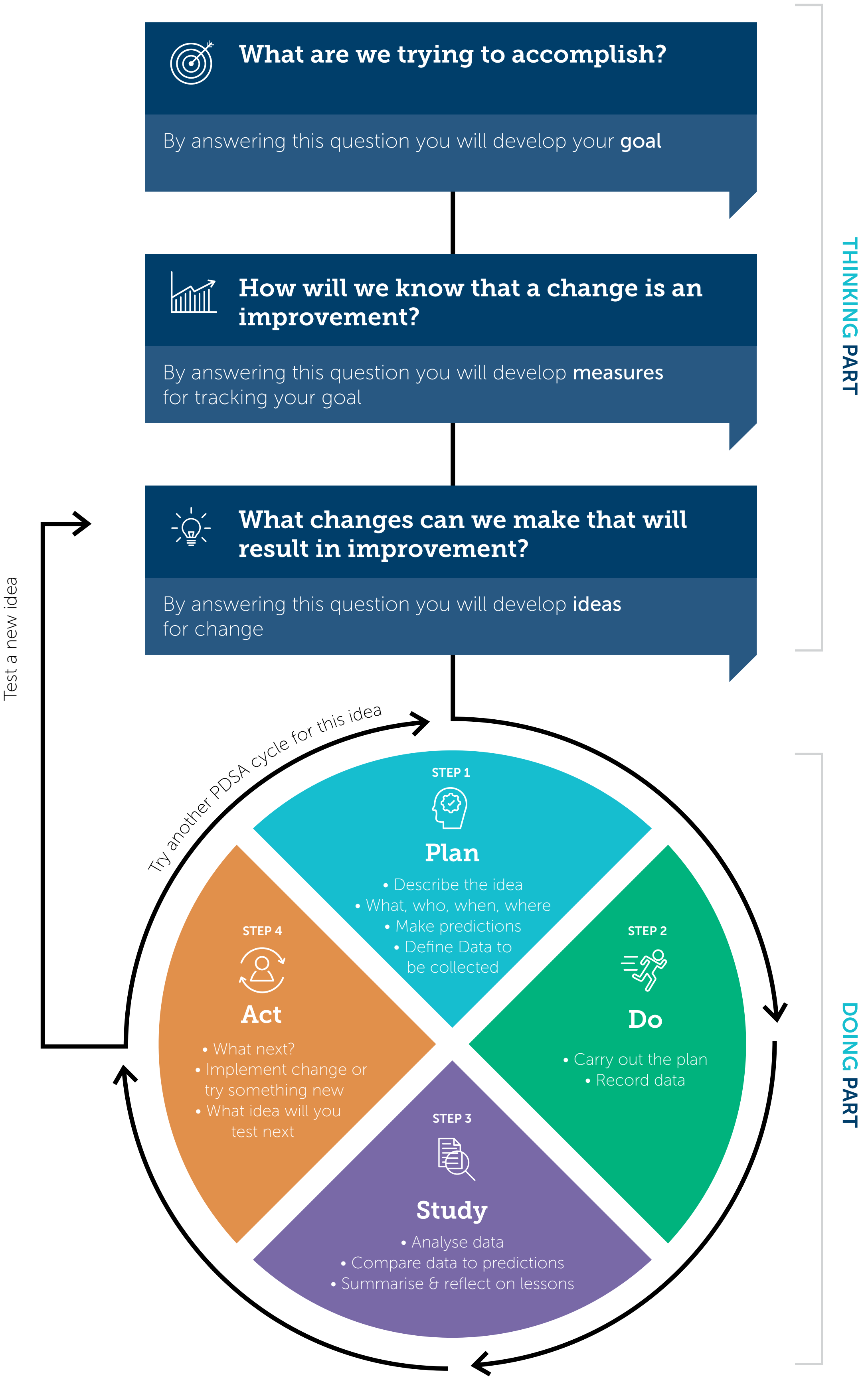
This is an evidence-based approach endorsed by leading health bodies, including the Royal Australian College of General Practitioners (RACGP) and the Institute for Healthcare Improvement (IHI).

It's easily applied and requires no specialist skills or training. It also has the advantage of encouraging both individual creativity, and collegiality and collaboration.

Starting small is key, with change broken down into manageable pieces. This not only helps to reduce risk, but also to foster unity and avoid resistance to change. Proven changes can then be implemented more widely, while refined or new ideas can also be run through the mill.

As illustrated in Figure 1, MFI comprises a 'thinking part' and a 'doing part'. In the 'thinking part', you step through 'Goal', 'Measure' and 'Idea' (GMI). The 'doing part' consists of the 'Plan, Do, Study, Act' (PDSA) cycle. It's not a linear process—the idea is to cycle back and forth through both parts as often as required. (See Videos on the Model for Improvement in this workbook.)

Figure 1: The Model for Improvement and the Plan, Do, Study, Act cycle



What are we trying to accomplish?

By answering this question you will develop your **goal**

How will we know that a change is an improvement?

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

What changes can we make that will result in improvement?

By answering this question you will develop **ideas** for change

THINKING PART

Test a new idea

Try another PDSA cycle for this idea

STEP 1

Plan

- Describe the idea
- What, who, when, where
- Make predictions
- Define Data to be collected

STEP 2

Do

- Carry out the plan
- Record data

STEP 3

Study

- Analyse data
- Compare data to predictions
- Summarise & reflect on lessons

STEP 4

Act

- What next?
- Implement change or try something new
- What idea will you test next

DOING PART

General practice considerations

Quality improvement in general practice can address one or more of the following:

- **Safety** – Avoiding harm to patients
- **Effectiveness** – Providing evidence-based care and only providing services likely to be of benefit
- **Patient-centricity** – Providing care that is responsive to individual patient's preferences, needs and values
- **Timeliness** – Reducing waiting times for care and avoiding harmful delays
- **Efficiency** – Avoiding waste
- **Equity** – Providing care of the same quality regardless of personal characteristics such as gender, ethnicity, location or socio-economic status.

Benefits and outcomes of QI in general practice are often categorised into four areas, as shown in Figure 2. Change that results in benefits across all four areas are said to have met the 'quadruple aim' – a useful target to keep in mind when developing your ideas.

Figure 2: The 'Quadruple Aim'

Improved Patient Experience

Better care: safe, quality care

Timely and equitable access

Patient and family needs met

Improved Provider Experience

Increased clinician and staff satisfaction

Leadership and teamwork

Quality improvement culture in practice

Population health

Better health outcomes

Reduced disease burden

Improvement in physical and mental health

Sustainable Cost

Efficient and effective services

Increased resources for primary care

PIP, accreditation and professional development

This workbook can be used by practices and individual professionals as evidence for:

- Practice Incentive Payment Quality Improvement (PIP QI)
- RACGP accreditation standards
- Continuous professional development points.

Appendix 1 has detailed information about how quality improvement activities included in this workbook can be used as evidence for CPD points for GP's and RACGP accreditation, including requirements relating specifically to end-of-life care.

Support from NWMPHN

For further support on implementing continuous quality improvement activities at your practice, contact your relationship manager at NWMPHN on (03) 9347 1188 or email primary.care@nwmphn.org.au

Your four steps to improvement

Step 1 Understand end-of-life care

End-of-life care is the care given to people who are likely to die within the next 12 months and approaching their end-of-life, to help them live as well as possible.

Palliative care aims to improve the quality of life of patients with life-limiting illnesses. Improving end-of-life care is now an Australian Government priority: visit the Australian Institute of Health and Welfare palliative care page for details.

With the growth and ageing of Australia's population, and an increase of chronic and life-limiting illnesses, the types of patient groups requiring palliative care has widened.

Palliative care is often linked to the care of people with cancer. However, patients with non-cancer end-stage chronic or complex conditions also have significant needs. The burden of symptoms and care needs for patients with end-stage, non-malignant illnesses are similar to those of patients with advanced cancer. These patients benefit from a palliative approach, comprising management of the underlying condition and attention to symptoms, psychosocial needs and carer support. Advance care planning provides an opportunity to prepare for future illness episodes, including provision of end-of-life care.

GPs are well-placed to provide end-of-life care for patients with advanced non-cancer illnesses.[1] We recommend reviewing Appendix 2: Chronic complex illness before moving to the next step.

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[1] *Palliative care for the patient without cancer, Nov 2018, Mounsey, Ferrer & Eastman*

HealthPathways Melbourne

HealthPathways Melbourne (visit melbourne.healthpathways.org.au) is an online resource that gives clinicians up-to-date, localised clinical and referral information.

HealthPathways Melbourne provides clear, concise guidance for assessing and managing patients with particular symptoms or conditions, as well as outlining the most appropriate referral pathways.

There are HealthPathway pages relating to advance care planning, palliative care, voluntary assisted dying as well as other related pathways listed below.

We recommend reading the following pages in relation to end-of-life care before you start your quality improvement program:

- Advance care planning
- NWMPHN website
- Palliative care
- GP palliative care resources
- Voluntary Assisted Dying (VAD).

How do I access HealthPathways Melbourne?

You will need a username and password. Request access online or complete this form to request automatic login. To receive the monthly HealthPathways Melbourne Bulletin, email info@healthpathwaysmelbourne.org.au

Access is limited to health professionals in the North Western and Eastern Melbourne PHN catchments.

Care pathway for advance care planning

A patient may only create an advance care directive if they have decision-making capacity in relation to each statement in their advance care directive. An advance care directive must be witnessed by two adults, one of whom is a medical practitioner.

There are two forms of statement. A patient may include either or both in their advance care directive. Advance care directive forms are available at the health.vic webpage, advance care directive for adults. See over page for information included in this pathway.

HealthPathways provides guidance to assist clinicians to participate in advance care planning, including the creation of new legal documents called 'advance care directives'.

The pathway includes:

- information about the process of advance care planning and the steps involved (develop, review, activate)
- information and contacts for further advice and assistance
- documents and forms
- explanations and definitions of important terms.

A useful resource in the pathway is 'Advance care planning: Roles and responsibilities in advance care planning'. It outlines:

- how advance care planning can be undertaken across different health and care settings (general practice, residential aged care, hospitals, medical deputising, domiciliary nursing, community health, primary health network)
- the importance of relationships between individuals, their families and carers, and their health professionals
- the roles that different people and organisations can play in the advance care planning process.

The resource also provides tips on systematically incorporating advance care planning within an organisation. More information can be found at nwmphn.org.au

Care pathway for palliative care

This pathway provides guidance about clinical management for palliative care. It also has information about local specialist palliative care services and how to contact these or make a referral.

The pathway provides an overview of palliative care, including descriptions of types of service delivery options and providers, and an explanation of the role of providers (generalist palliative care versus specialist palliative care).

It offers information for clinicians about:

- caring for a dying patient at home
- caring for a dying patient in a residential aged care facility
- pain management in palliative care
- pain medications in palliative care
- symptom control in palliative care.

The pathway has information for services about:

- referral for immediate palliative care assessment
- referral to specialist palliative care services
- how to access further palliative care advice.

Care pathway for voluntary assisted dying

This pathway provides a range of information, resources and guidance to assist in understanding or participating in voluntary assisted dying.

As well as introducing and explaining the voluntary assisted dying model, it offers information about:

- participation by health practitioners and services in voluntary assisted dying (including guidance on the roles for health practitioners and services, and considerations for participation)
- guidance and support for voluntary assisted dying requests (including contacts for the voluntary assisted dying care navigators, and support for patients)
- the request and assessment processes (including guidance on the process of voluntary assisted dying and the steps involved)
- application, permit and prescription, and supply of voluntary assisted dying medications (including guidance on steps involved in this process)
- after-death support (including guidance on notification of death, and available support services).

Other care pathways

There are up to 40 palliative care related pathways in HealthPathways Melbourne including:

- 🔗 Certification of death
- 🔗 Bereavement, grief and loss
- 🔗 Caring for dying patient at home
- 🔗 Guide to Medicare Benefit Schedule (MBS).

Step 2

Work as a team to collect data and develop goals

Now you've done your background research, it's time to establish a brains trust and start examining ideas. By the end of this section, you'll be able to answer these key questions:

Goal
What are we trying to accomplish?

Measure
How will we know that a change is an improvement?

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

Team up

Evidence shows that improvement is most likely when all staff support change – so adopt a whole-of-team approach from the outset.

Use the NWMPHN Team Health Check PDSA and Improvement Foundation's Team Health Check Score Sheet to help you assess your team culture and identify roles and responsibilities. Along the way, you might also identify team members who might resist change, as well as potential issues or matters to address before your project begins.

Form a QI project team

Your project team should include representatives from your whole-of-practice team. It might include your practice manager, reception and other administrative staff, nursing staff, GPs and allied health practitioners.

For each project, you will need at least two project leads:

1. A lead GP to inform any clinical content
2. Another person in your team capable of managing the project, who will be given protected time to complete the work required.

Collect baseline data

There is a saying that 'what gets measured gets done'. So collect and collate as much relevant data as you can. This will help you accurately assess the current situation and pinpoint exactly where you want to improve. It will also give you a 'baseline' against which success (and failure) can be measured objectively. You will collect data in relation to:

- your patients
- MBS claims
- your practice's skills and knowledge.

Ensure you review the relevant appendix (cited next to each activity) before you start each activity.

Collect patient data

The first round of data you will need to collect, in Activity 1, Activity 2 and Activity 3 , will help you understand the needs of your patient population.

We also recommend reviewing [Appendix 3: Best-practice tools to support early identification of end-of-life patients](#).

Activity 1: Collect CAT4 data (patients with a complex medical condition)

Complete the table below with data from your CAT4 data extraction tool. For step-by-step instructions, known as 'recipes', access the links provided in the table, or see the 'CAT4 recipes' tab on the Pen CS website at www.pencs.com.au

The aim of this activity is to collect data to determine the number of patients with a complex medical condition.

Activity Table 1: Collect CAT4 data (patients with a complex medical condition)

** RACGP defines 'active' patients as those visiting three or more times in two years. The searches below do not capture those patients who may come in for screening every two years, or twice in two years. We have therefore provided a column to capture all patients with complex medical conditions. To capture **all** patients in recipe provided, DO NOT select the 'Active (3x in 2yrs)' tick-box.*

Item	Description	Total no. active patients	Total no. patients
1a	**Number of patients** CAT4 recipe: Identify active patients with at least three visits in the last two years		
1b	**Number of patients with congestive heart failure** CAT4 recipe: Identify all active patients with at least one chronic condition who are eligible for a medication review (follow instructions to the disease tab count)		
1c	**Number of patients with COPD** CAT4 recipe: Identify all active patients with at least one chronic condition who are eligible for a medication review (follow instructions to the disease tab count)		
1d	**Number of patients with dementia** CAT4 recipe: Dementia patients and carers		
1e	**Number of patients with chronic renal failure** CAT4 recipe: Identify all active patients with at least one chronic condition who are eligible for a medication review (follow instructions to the disease tab count)		
1f	**Number of patients with cancer** CAT4 recipe: Identify all active patients with at least one chronic condition who are eligible for a medication review (follow instructions to the disease tab count and select 'cancer')		
1g	**Number of patients with a BMI above the healthy range** CAT4 recipe: QIM 3 BMI		

Activity Table 1: Collect CAT4 data (patients with a complex medical condition) (continued)

Now reflect on the data and record any comments here. Does anything surprise you? Is this what you expected?

Activity 2: Collect CAT4 data (comorbidities)

Complete the table below with data from your CAT4 data extraction tool. For step-by-step instructions, known as 'recipes', access this link, or see the 'CAT4 recipes' tab on the PenCS website at www.pencs.com.au

The aim of this activity is to collect data to determine the number of active patients with more than one chronic medical condition.

Activity Table 2: Collect CAT4 data (comorbidities)

Item	Description	✍ Total number
2a	Active patients with one chronic condition	
2b	Active patients with two chronic conditions	
2c	Active patients with three chronic conditions	
2d	Active patients with four chronic conditions	
2e	Active patients with more than four chronic conditions	

✍ **Now reflect on the data and record any comments here:**

Activity 3: Summarise patient data collected

Summarise what you learned about your active complex chronic disease patient population by answering the following questions.

Activity Table 3: Summarise patient data collected

Item	Question
3a	**Were there any unexpected results from Activity 1 in relation to your practice's complex chronic disease patient population?** ○ Yes ○ No

If your answer is YES, detail your unexpected results. (For example, 'higher diabetes population than expected' or 'practice has a low population of people with cardiovascular disease'.) How will this information be communicated to the practice team?

If your answer is NO, continue to the next question.

Item	Question
3b	**Were there any unexpected results from Activity 2 in relation to your practice's comorbidities population?** ○ Yes ○ No

If your answer is YES, detail any unexpected results. For example, 'high number of people with three or more chronic conditions'. How will this information be communicated to the practice team?

If your answer is NO, continue to the next question.

Activity Table 3: Summarise patient data collected (continued)

Item	Question
3c	**After reviewing your patient population for chronic disease and comorbidities, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?** ○ Yes ○ No

If your answer is **YES**, write down your ideas for change. You'll use these in the next step, Compile and prioritise areas for improvement.

If your answer is **NO**, you have completed this activity.

Activity 4: Collect CAT4 data about MBS claims

Complete the table below with data from your CAT4 data extraction tool. For step-by-step instructions, known as 'recipes', access this link on MBS items, or this link on MBS attendance filter, or view the 'CAT4 recipes' tab at www.pencs.com.au

The aim of this activity is to collect data to determine the number of MBS claims made for the specific items at your practice over the past 12 months.

Review Appendix 8: Medicare Benefit Schedule (MBS) items before you start.

Activity Table 4: Collect CAT4 data about MBS claims

Item	Description	Total
4a	Number of Health Assessments claimed	
4b	Number of Home Medication Reviews claimed	
4c	Number of Residential Medication Reviews claimed	
4d	Number of GP Management Plans claimed	
4e	Number of Team Care Arrangement plans claimed	
4f	Number of nurse chronic disease item numbers claimed	
4g	Number of mental health item numbers claimed	

Activity Table 4: Collect CAT4 data about MBS claims (continued)

Now reflect on the data and record any comments here:

Activity 5: Summarise your practice's MBS claiming

The aim of this activity is to increase your understanding of the MBS item-number claiming at your practice.

Activity Table 5: Summarise your practice's MBS claiming

Item	Question
5a	**After completing Activity 4, are there any unexpected results in relation to the number of MBS items claimed at your practice?** ○ Yes ○ No

✍ If your answer is **YES**, detail your unexpected results – for example, 'low number of health assessments completed' or 'higher rate of General Practice Management Plans (GPMP) than expected'. How will this information be communicated to the practice team?

If your answer is **NO**, continue to the next question.

Item	Question
5b	**Is your practice utilising MBS claims as you expected?** ○ Yes ○ No

✍ If your answer is **NO**, outline the differences – are they in relation to active population, age group, male/female populations? How will this information be communicated to the practice team?

If your answer is **YES**, continue to the next question.

Activity Table 5: Summarise your practice's MBS claiming (continued)

Item	Question
5c	**After reviewing your MBS claims are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?** ○ Yes ○ No

If your answer is **YES**, write down your ideas for change. You'll use these in the next step. Compile and prioritise areas for improvement.

If your answer is **NO**, you have completed this activity.

Now reflect on the data and record any comments here:

Collect data about your practice's skills and knowledge

Time now to assess the skills and knowledge of staff at your practice in relation to end-of-life care. Your practice may wish to complete Activities 6, 7 and 8 together. For example, you could either discuss them at a team meeting or via a team survey, or in discussion with individuals.

Activity 6: Your practice's knowledge of advanced care documentation

The aim of this activity is to assess whether relevant people in your practice know the importance of end-of-life conversations and planning.

Review Appendix 4: Important conversations and advance care planning before you start.

Activity Table 6: Your practice's knowledge of advanced care documentation

Item	Question
6a	**Do all relevant practice team members know where to locate advance care planning documentation?** ○ Yes ○ No

If your answer is NO, how will this information be communicated to the relevant practice team members? Access the advance care planning website for advance care planning forms or visit the Victorian Government website www2.health.vic.gov.au and search 'advance care planning forms'.

If your answer is YES, continue to the next question.

Activity Table 6: Your practice's knowledge of advanced care documentation (continued)

Item	Question
6b	**Do all relevant practice team members understand how to identify patients' illness trajectories?** ○ Yes ○ No

If your answer is NO, how will this information be communicated to the relevant practice team members? The three main trajectories of patients' illness including a diagram and the description is available at RACGP Palliative Care and End-of-Life Care General Principles website. See the diagram for the different illness trajectories.

If your answer is YES, continue to the next question.

Item	Question
6c	**Do any of the practice team require training/assistance on having end-of-life conversations?** ○ Yes ○ No

If your answer is YES, how will this information be communicated to the practice team? Training is available via End of Life Essentials website and CareSearch Palliative Care Network website. Also see Guides to education and training in end-of-life care.

If your answer is NO, continue to the next question.

Activity Table 6: Your practice's knowledge of advanced care documentation (continued)

Item	Question
6d	**After reviewing your end-of-life conversations and documentation processes, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?** ○ Yes ○ No

If your answer is **YES**, write down your ideas for change. You'll use these in the next step. Compile and prioritise areas for improvement.

If your answer is **NO**, you have completed this activity.

Now reflect on the data and record any comments here:

Activity 7: Your practice's knowledge of assistance for patients to live at home longer

The aim of this activity is to assess whether relevant people in your practice know who to refer patients to for assistance to live in their own home longer.

Review Appendix 5: Assistance for patients to live at home longer before you start.

Activity Table 7: Your practice's knowledge of assistance for patients to live at home longer

Item	Question
7a	**Do all relevant practice staff know how to refer patients who are over 65 to get assistance to live in their own home longer?** ○ Yes ○ No

If your answer is NO, how will this information be communicated to relevant practice staff? Refer to the myagedcare website at www.myagedcare.gov.au

If your answer is YES, continue to the next question.

Item	Question
7b	**Do all relevant practice team members know how to refer patients who are 65 years and younger?** ○ Yes ○ No

If your answer is NO, how will this information be communicated to relevant practice staff? Refer to the home and community care page on the Victorian Government website www2.health.vic.gov.au

If your answer is YES, continue to the next question.

Activity Table 7: Your practice's knowledge of assistance for patients to live at home longer (continued)

Item	Question
7c	**Do all relevant practice team members know how to refer patients to NDIS?** ○ Yes ○ No

If your answer is NO, how will this information be communicated to the practice team? Refer to the Carer Pathways website.

If your answer is YES, continue to the next question.

Item	Question
7d	**Do all relevant practice team members know how to identify the appropriate type of care to support patients, carers and families?** ○ Yes ○ No

If your answer is NO, how will this information be communicated to the practice team? Refer to the Carer Pathways website.

If your answer is YES, continue to the next question.

Activity Table 7: Your practice's knowledge of assistance for patients to live at home longer (continued)

Item	Question
7e	**After reviewing your processes for providing assistance for patients to live at home longer, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?** ○ Yes ○ No

If your answer is **YES**, write down your ideas for change. You'll use these in the next step. Compile and prioritise areas for improvement.

If your answer is **NO**, you have completed this activity.

Now reflect on the data and record any comments here:

Activity 8: Knowledge of local palliative care teams

The aim of this activity is to ensure relevant people in your practice know how to access palliative care teams.

Review Appendix 6: Palliative care teams before you start.

Activity Table 8: Knowledge of local palliative care teams

Item	Question
8a	**Do all relevant practice team members know how to refer a patient for palliative care services?** ○ Yes ○ No

✍ **If your answer is NO, how will this information be communicated to the relevant practice team members?** Refer to the health.vic webpage Assessing Palliative Care or Palliative Care Victoria. Translated resources can also be found on the Pallcare website.

If your answer is YES, continue to the next question.

Item	Question
8b	**Do all relevant practice team members know how to access HealthPathways Melbourne end-of-life/palliative care resources?** ○ Yes ○ No

✍ **If your answer is NO, how will this information be communicated to the practice team?** See this workbook's section on HealthPathways Melbourne.

If your answer is YES, continue to the next question.

Activity Table 8: Knowledge of local palliative care teams (continued)

Item	Question
8c	**Do all relevant practice team members have an understanding of anticipatory prescribing and where to access palliative medicines, including in the after-hours period?** ○ Yes ○ No

If your answer is NO, refer to health.vic websites:

- anticipatory medicines
- anticipatory medicines guidelines
- Victorian Supercare Pharmacies

If your answer is YES, continue to the next question.

Item	Question
8d	**After reviewing your practice's referral process, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?** ○ Yes ○ No

If your answer is YES, write down your ideas for change. You'll use these in the next step. Compile and prioritise areas for improvement.

If your answer is NO, you have completed this activity.

Activity Table 8: Knowledge of local palliative care teams (continued)

Now reflect on the data and record any comments here:

Summary of Activities 1-8: Identify your priority areas

Now that you have completed Activities 1 to 8 you can review what you have learned and determine the priority areas for your practice. Compile and assign priorities to all your areas for improvement (identified in the final questions of Activity Table 3, Activity Table 5, Activity Table 6, Activity Table 7, and Activity Table 8). Use the following table.

Activity Table 9: Compile and prioritise areas for improvement

Item	**Identified area for improvement**	**Priority for improvement (What comes first?)**
1		
2		
3		
4		
5		
6		

Completed by:

Date:

Set a goal

Now that you have identified the top priority area for your practice, the next step is to work together to set a goal for this area. Goals should be 'SMART', so ask yourself if each goal is:

- **Specific** – Does the goal say exactly what we want to achieve?
- **Measurable** – Have we included a measurable target, such as 'increase cervical screening rates among appropriate women by 50 per cent', or 'achieve 100 health checks'?
- **Achievable** – Is it likely our practice will be able to accomplish the goal?
- **Relevant** – Does the goal accord with our practice's broad vision and aims?
- **Time-based** – Do we have a clear deadline for achieving our goal? (Deadlines should be challenging but realistic.)

Activity Table 10: Set a goal for the top priority area

Our priority for improvement is:

Our target population is:

Our goal is to:

Check that the goal is:

☐ Specific ☐ Measurable ☐ Achievable
☐ Relevant ☐ Time-based

We will use the following measures to know if we've been successful:

Measure:
Source:

Measure:
Source:

Measure:
Source:

Measure:
Source:

Etc. (Add more as appropriate)

We want to achieve our goal by:

We will collect our measures every:

e.g. 1st of the month, two months, quarter, six months.

Brainstorm activities for achieving your goal

Now use Activity Table 11, below, to list activities that your practice can undertake to achieve your goal or goals. Activities might include, but are not limited to:

- staff training and education
- system changes
- workplace/environmental changes
- regular reviews/audits/meetings.

There is no minimum or maximum number of activities. We have provided room to record 6 as a guide.

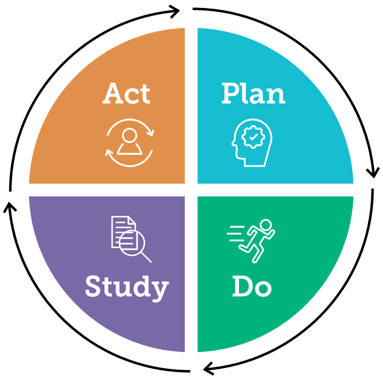
Activity Table 11: Brainstorm of ideas for implementing change

Idea no.	Activity	Expected outcomes
1		
2		
3		
4		
5		
6		

Completed by:	**Date:**

Step 3 Plan, Do, Study, Act – time to get 'cycling'

You're now ready to take action, using a 'Plan, Do, Study, Act' (PDSA) cycle for each activity you've decided to implement.



To get started, take the activities you've listed and prioritised in Activity 11 and assign a responsible person/persons, and intended due dates, to keep the activities moving along. Use the table below and regularly check in on your team's progress. These activities are for your first priority; complete these before tackling the next priority. We have provided room to record six as a guide, however complete as many of these activities as you require.

See the explanation of PDSA under The Model for Improvement heading in the introduction to this workbook.

Activity Table 12: Timeframes and responsibilities

1	**Activity**	
	Person responsible	**By when**
	Expected outcomes	

Activity Table 12: Timeframes and responsibilities (continued)

2

Activity

Person responsible

By when

Expected outcomes

3

Activity

Person responsible

By when

Expected outcomes

4

Activity

Person responsible

By when

Expected outcomes

Activity Table 12: Timeframes and responsibilities (continued)

5	**Activity**	
	Person responsible	**By when**
	Expected outcomes	
6	**Activity**	
	Person responsible	**By when**
	Expected outcomes	

This will help inform the 'plan' part of the PDSA cycle in Activity Table 13: PDSA cycle template.

Create copies of this PDSA table and fill one out for **each activity**. This helps to break your project down into manageable chunks, allocate responsibilities more easily, and accurately assess what's working and what's not. Ensure that each PDSA table includes details of who is doing what, and by when, to keep your project on track.

Note that you can run more than one PDSA at a time. This will depend on the change you're making, and the time it's likely to take before any measurable improvement. If results are likely to take longer (more than a month, for example, or a year), running separate, sequential PDSAs for each activity would mean the project would take too long.

You do not have to complete this table immediately, the plan and do part are pre-implementation and the study and act part are completed after.

Activity Table 13: PDSA cycle template

Priority area number	**Priority area topic**
Activity number	**Staff member responsible**
Date started	**Date completed**

Part 2: The doing part – Plan, Do, Study, Act

Plan	**Describe the brainstorm idea you are planning to work on. (Idea)**
Plan the test, including a plan for collecting data	What exactly will you do? Include what, who, when, where, predictions and data to be collected.

Do	**Who is going to do what? (Action)**
Run the test on a small scale	How will you measure the outcome of your change?

Part 2: The doing part – Plan, Do, Study, Act (continued)

Study	**Does the data show a change? (Reflection)**
Analyse the results and compare them to your predictions	Was the plan executed successfully? Did you encounter any problems or difficulty?

Act	**Do you need to make changes to your original plan? (What next) OR Did everything go well?**
Based on what you learned from the test, plan for your next step	If this idea was successful, you may like to implement this change on a larger scale or try something new. If the idea did not meet its overall goal, consider why not and identify what can be done to improve performance.

Repeat Step 2 for other ideas. What idea will you test next?

Tip: Do your first lot of activities for your first priority then proceed to manage and monitor your progress/success. Begin again on page 34 (setting a goal section) when you're ready to tackle the process again for your next priority area.

Manage and monitor your project

Now you're in the swing of things, ensure you monitor the project regularly, with an eye on your 'baseline data'.

Ensure each PDSA template for each project activity is completed as the activity is completed. As soon as practicable, reflect on how the activity went, and any obstacles, and decide whether to continue with the change, or amend it and try it again.

Look back at the data you collected in Activity 1, as well as any other measures you decided to collect as part of your project.

Now collect the same data again and complete Activity Table 14, below. As you do, assess whether there's any improvement since the last measurement. If not, consider why not. Is it too early to see change, or is an extra effort needed to push performance along? And what might be the best activity to tackle next?

Manage and monitor – tips for successful PDSA

- Allocate 'protected time' so that those responsible can effectively implement the changes.
- Set dates in the project team's calendars now for reviewing the project. Use the PDSA due dates as a guide, and also set regular review periods (perhaps monthly or quarterly). Regular monitoring is important so that the team can support and encourage each other to complete activities.
- Keep your project team and other practice staff well-informed.
- Catch-up with staff about their PDSAs, and offer support where needed.
- Conduct regular check-ups, both to help encourage staff, and to iron-out issues.

Activity Table 14: Measure and monitor

1

Measure

Source of data

6 months before project	3 months before project	Start of project	3 months into project	6 months into project

Activity Table 14: Measure and monitor (continued)

2

Measure

Source of data

6 months before project	3 months before project	Start of project	3 months into project	6 months into project

3

Measure

Source of data

6 months before project	3 months before project	Start of project	3 months into project	6 months into project

4

Measure

Source of data

6 months before project	3 months before project	Start of project	3 months into project	6 months into project

Activity Table 14: Measure and monitor (continued)

5

Measure

Source of data

6 months before project	3 months before project	Start of project	3 months into project	6 months into project

6

Measure

Source of data

6 months before project	3 months before project	Start of project	3 months into project	6 months into project

Step 4 Evaluate and celebrate

Evaluation is, of course, a regular and integral part of the PDSA process. But it's also important to conduct broader evaluations of the project.

Now that you have completed all of your activities for this priority area, it's the perfect time to reflect on how the process went. Complete Activity Table 15 on the next page with your team members.

Share your achievements

By recognising your 'wins', you'll engage your practice team more deeply with your quality improvement project, enhance morale and foster a culture where striving for improvement is as integral as payroll—or lunch.

You could share results at staff meetings, hold a celebratory lunch, post your achievements in the waiting area, or even engage local media.

Has your practice completed a quality improvement activity or project that you'd like to share?

Submit your case study, resources or photos to primarycare@nwmphn.org.au

What's next?

Now that you have completed these activities for priority one, it is time to tackle your next priority. Head back to Activity Table 9 on page 34 to identify the next priority area for your practice and work through the activities again.

Activity Table 15: Evaluate achievements

Did you achieve your goal?

What are you most proud of?

What were the things that helped you?

Were there any barriers?

How did you overcome these?

What were the changes for: • Patients • Staff/Clinicians • Population • Business?

What would you have done differently?

What are your next steps for the changes that were made?

Education and training in end-of-life care

Voluntary assisted dying

Medical practitioners must complete voluntary assisted dying training, via the health.vic website, before conducting an eligibility assessment for voluntary assisted dying.

RACGP

The RACGP aged care clinical guide (Silver Book) Part A and B are guidelines on supporting GPs in Advance care planning, Palliative and end-of-life care, and Palliative care approach.

Therapeutic Guidelines (eTG complete)

Therapeutic guidelines are written principally for prescribers, providing them with clear, practical and up-to-date therapeutic information and recommendations for patient management at the point of care. Access this link for Therapeutic Guidelines: Palliative Care (Version 4).

Australian Government programs and resources

The Australian Government also provides funding for a range of training and education programs and resources to build capacity for end-of-life care.

There are various types of education and training courses. Many can be tailored to the needs of individuals or workplaces. Materials are developed based on evidence and best-practice guidelines.

Courses and other training can be undertaken as a continuing professional development activity, or ‘embedded’ into organisational activities for staff professional development training, or in staff induction or orientation sessions.

Table 16 details available government-funded programs and resources. Also visit the Department of Health webpage ‘What we’re doing about palliative care’.

Table 16: Programs and resources for end-of-life education and training

Program	Description
Advance Care Planning Australia BE OPEN | BE READY | BE HEARD	ACPA (Advance Care Planning Australia) is a national program, supported by funding from the Australian Government, for health professionals, care workers and the general public. It encourages people to consider their values, beliefs, and current and future health goals. The program offers a range of educational support about advance care planning, including online courses, webinars and other online learning resources (visit ACPA’s ‘learning’ page), as well as face-to-face workshops. The program also offers a free national advisory service that provides personalised advice, resources and information on advance care planning, for both health care professionals and individuals. **Phone:** 1300 208 582 **Hours:** 9am–5pm, Monday to Friday **More information:** Visit Advance Care Planning Australia’s education and training page
The Advance> Project Better primary health care through team-based initiation of advance care planning and palliative care	The Advance Project is a national program funded by the Department of Health to support general practices to integrate advance care planning and palliative care with everyday clinical practice. The program offers a range of tools and types of educational support for GPs, practice managers and practice nurses, including: • a practical, evidence-based toolkit that includes screening and assessment tools • e-learning or online learning modules • post e-learning options such as one-on-one professional telephone mentoring and coaching support. It’s designed to support Australian general practices to integrate a team-based approach to initiating advance care planning and palliative care with everyday clinical practice. **More information:** Visit the Advance Project website

Program	Description
ACP Talk ADVANCE CARE PLANNING	ACP Talk, funded by the Department of Health, supports health professionals to have conversations with people from different religions and cultures about advance care planning. It also raises community awareness about related issues. Its online search function allows users to search a religion and denomination (if appropriate) to potentially find out more about a person's background, beliefs and practices; how to disclose medical prognosis; and the type of language to use and advice to offer when having an advance care planning conversation. **More information:** Visit CareSearch's ACP talk page
PEPA Program of Experience in the Palliative Approach Funded by the Australian Government Department of Health	PEPA (Program of Experience in the Palliative Approach) is an education and training program funded by the Department of Health. It aims to build the capacity of health professionals to deliver a palliative approach. The program offers free education and training support through placements, workshops and online learning. It also offers financial support for health professionals to participate in a clinical placement of up to three days with a local palliative care specialist service. **More information:** pepaeducation.com
Centre for Palliative Care Informing Choice. Enabling Care.	The Centre for Palliative Care is part of St Vincent's Hospital, and is a Collaborative Centre of The University Melbourne. It offers educational support for health professionals including: • the Victorian Palliative Medicine Training program (VPMTP) – funded by the Department of Health to provide a coordinated statewide palliative medicine training program for palliative specialists and GPs • the Victorian Palliative Care Nurse Practitioner Collaborative (VPCNPC) • the Program of Experience in the Palliative Approach (PEPA) • masterclasses for advance practice nurses • customised training, online courses and short courses for all disciplines • multidisciplinary University of Melbourne graduate programs (Specialist Certificate in Palliative Care and Graduate Certificate in Palliative Care). **More information:** Visit the centre's education webpage

Program	Description
CARESEARCH palliative care knowledge network	CareSearch is a national program funded by the Department of Health to provide online access to evidence and evidence-based guidance on palliative care. It offers educational support for different disciplines, including: • postgraduate formal qualification programs in palliative care, in partnership with universities (for health professionals) • conferences, short courses, workshops, e-learning, and 'my learning' modules, which demonstrate how to find relevant evidence (for health professionals) • courses and training for care workers, carers, volunteers and the community • resources for managers and educators about workforce development. **More information:** Visit CareSearch's education webpage
palliAGED PALLIATIVE CARE AGED CARE EVIDENCE	palliAGED is funded by the Department of Health and managed by CareSearch. It provides palliative care evidence and practice resources for aged care. It offers tools and educational supports for health professionals including: • apps for GPs and nurses that provide easy, convenient access to information about end-of-life care • an online learning and a course selection tool • postgraduate formal qualification programs. **More information:** Visit palliAGED's practice centre webpage
ELDAC End of Life Directions for Aged Care	ELDAC (End of Life Directions for Aged Care) is a national specialist palliative care and advance care planning advisory service, funded by the Department of Health. The service comprises a comprehensive website and a telephone advisory service. ELDAC has several toolkits to assist care providers who work in aged care to participate in palliative care and advance care planning: • the Home Care Toolkit • the Primary Care Toolkit • the Residential Aged Care Toolkit • the Legal Toolkit • the Working Together Toolkit. Each toolkit offers personal learning and online training, as well as information about conferences, short courses, workshops and clinical experiences. The ELDAC website also has a list of the common clinical tools used for recognising end-of-life patients, and for assessing palliative care needs. **More information:** Access the ELDAC toolkits

Program	Description
PCOC palliative care outcomes collaboration	PCOC (Palliative Care Outcomes Collaboration) is a national palliative care project funded by the Department of Health. Its role is to assist care providers to embed standardised clinical assessment tools for palliative care into routine practice. PCOC also helps to capture clinically meaningful information, such as patients' disease trajectories, to measure and benchmark patient outcomes for palliative care. The service provides educational support about the PCOC assessment tools, implementing PCOC and patient outcome reports, including how to use data to make improvements. Educational support for clinicians and managers includes: • online essential courses • workshops • a self-directed education package. PCOC also provides tools and resources including: • a clinical assessment and response form • a quality and change toolkit • data collection tools and guidance • data reports for patient outcome and benchmarking. **More information:** Visit the PCOC for Clinicians and Service Managers page, hosted by the University of Wollongong.
caring @home Symptom management for palliative patients	Caring@home supports people to be cared for and to die at home, if that is their choice. The service is funded by the Department of Health. It supports health professionals to train carers to give subcutaneous medicines safely to their family member, to help manage 'breakthrough' symptoms to improve symptom control. Training is via online education modules, webinars and podcasts. **More information:** Visit the Caring@home health professionals webpage
PALLIATIVE CARE Online Training ahha	Funded by the Department of Health, this program is designed to educate health professionals and care providers about palliative care approach for people receiving care in a community setting. The Palliative Care Online Training portal offers six free, online, self-learning modules, as well as a discussion forum and knowledge base. **More information:** Visit www.pallcaretraining.com.au
Talking End of Life ...with people with intellectual disability	Funded by the Department of Health, TEL (Talking End of Life) provides disability support professionals or workers with resources to teach people with intellectual disability about end-of-life. Resources include 12 online learning modules with case studies, videos, resources and links. **More information:** Access the TEL modules

Program	Description
ELLC End of Life Law for Clinicians	ELLC (End of Life Law for Clinicians) is a program funded by the Department of Health to address gaps in clinicians' knowledge of end-of-life law, including helping to understand the challenging issues that can arise with end-of-life decision-making, including the law, and individual's rights and duties. The program offers an online course for medical specialists, including GPs and trainee specialists. **More information:** Visit the ELLC website
Quality of Care Collaborative Australia Delivering education in Paediatric Palliative Care	QuoCCA (Quality of Care Collaborative Australia) is a program funded by the Department of Health to deliver paediatric palliative care education to health professionals who may care for children and young people with life-limiting conditions, or with end-of-life care needs. The program offers a range of support including: • education sessions and workshops • 'pop-up' visits by a team of specialist paediatric palliative care teams and educators for education for the child, family and local health team • an online learning module. **More information:** Visit the QuoCCA webpage
end-of-life ESSENTIALS	End-of-Life Essentials provides online learning opportunities and practice resources for doctors, nurses and allied health professionals. Funded by the Department of Health, it aims to improve the quality and safety of end-of-life care in hospitals. The program offers: • free online education (see link) • 'My Toolkit', which brings together tools, resources, promotional materials and evidence to assist change in practice. **More information:** Visit the End-of-Life Essentials website
The Palliative Care Bridge Supporting living to the end	The Palliative Care Bridge is a statewide palliative care education program coordinated and delivered by the HammondCare consortium. The consortium comprises HammondCare, Sacred Heart Health Service and Calvary Healthcare Sydney. The program has a website that provides a series of free, online educational videos delivered by experts and specialists in different fields of end-of-life care. **More information:** Visit the Palliative Care Bridge website
Palliative Care Education & Training Collaborative	A GP online learning module accessed through PEPA's free learning management system. Modules cover: • principles of palliative care • communicating with people with life-limiting illnesses • advance care planning • assessing and managing symptoms • assessing and managing pain • awareness of self-care. **More information:** Visit the Palliative Care Education & Training Collaborative website.

Tools and resources to build your confidence and skills

Other palliative care resources

- The End-of-life care in residential aged care facilities toolkit aims to improve resident, family and staff satisfaction with care, and increase the number of residents dying in their place of choice.
- About palliative care in 17 community languages
- MBS remuneration to support planned palliative care for patients

General resources

Videos on the Model for Improvement

Short videos are available at IHI website. In particular, see:

- Model for Improvement – Part 1 (2 min. 54 sec.) – IHI – MFI – Part 1
- Model for Improvement – Part 2 (3 min.) – IHI – MFI – Part 2
- Plan Do Study Act – Part 1 (4 min. 45 sec.) – IHI – PDSA – Part 1
- Plan Do Study Act – Part 2 (3 min. 48 sec.) – IHI – PDSA – Part 2.

RACGP

- Standards for general practices 5th edition general feedback guide
- Patient feedback requirements

Case studies

Local examples of quality improvement success, including example PDSA cycles can be found at the NWMPHN primary care hub.

Some case studies of GPs' and doctors' experience of managing end-of-life are available on ausdoc.com.au. You may need a log in to read the full article.

- 7 things GP learnt from dying patients
- Australia's first euthanasia doctor tells his story of ending the lives of patients.

Appendices

Appendix 1: Quality Improvement and RACGP accreditation

RACGP's Standards for general practices (5th edition) now includes several QI requirements. Undertaking a QI activity helps demonstrate that a practice can meet or exceed the following:

Criterion QI1.1: Quality improvement activities

Indicators

QI1.1>A Our practice has at least one team member who has the primary responsibility for leading our quality improvement systems and processes.

QI1.1>B Our practice team internally shares information about quality improvement and patient safety.

QI1.1>C Our practice seeks feedback from the team about our quality improvement systems and the performance of these systems.

QI1.1>D Our practice team can describe areas of our practice that we have improved in the past three years.

The Standards also include a range of requirements relating to end-of-life care. Undertaking end-of-life care QI activities will help demonstrate that a practice can meet or exceed the following indicators:

NOTE: Indicators marked with the > symbol are mandatory, which means that your practice must demonstrate that you meet this Indicator in order to achieve accreditation against the Standards. Indicators that are not marked with the mandatory symbol are aspirational Indicators. The RACGP encourages you to meet the aspirational Indicators, but they are not essential to achieve accreditation.

Claiming RACGP Continuing Professional Development Points

GPs who complete activities in this workbook may be eligible to accumulate CPD Accredited Activity points. Speak to one of our Workforce, Education and Training team members regarding requirements prior to commencing your activities.

For more information email education@nwmphn.org.au or call (03) 9347 1188.

Quality Improvement 1 – Quality Improvement

Criterion QI2.2 – Safe and quality use of medicines

QI2.2>A Our patients are informed of the purpose, importance, benefits, and risks of their medicines and treatments.

QI2.2>B Our patients are made aware of their role in their own treatment.

QI2.2>C Our clinical team accesses current information on medicines, and reviews our prescribing patterns, in accordance with best available evidence

QI2.2 D Our clinical team ensures that patients and other health providers to whom we refer receive an accurate and current medicines list.

GP standard 1 Access to care

Criterion GP1.2 – Home and other visits

GP1.2>A Our patients can access home and other visits when safe and reasonable

Criterion GP1.3 – Care outside of normal opening hours

GP1.3>A Our patients are informed about how they can access after-hours care.

GP1.3>B Our patients can access after-hours care.

GP standard 2 Comprehensive care

Criterion GP2.1 – Continuous and comprehensive care

GP2.1>B Our practice provides continuity of care and comprehensive care.

Criterion GP2.2 – Follow-up systems

GP2.2>A Pathology results, imaging reports, investigation reports, and clinical correspondence that our practice receives are:

- reviewed
- electronically notated, or, if on paper, signed or initialled
- acted on where required
- incorporated into the patient health record.

GP2.2>B Our practice recalls patients who have clinically significant results.

GP2.2>C Our patients are advised of the practice's process for follow-up of tests and results.

GP2.2 D Our practice initiates and manages patient reminders.

GP2.2>E High-risk (seriously abnormal and life-threatening) results identified outside normal opening hours are managed by our practice.

Criterion GP2.3 – Engaging with other services

GP2.3>A Our practice collaborates with other health services to deliver comprehensive care.

GP2.3>B Our practice's referral letters are legible and contain all required information.

Appendix 2: Chronic complex illness

Chronic diseases are long-lasting, often life-limiting conditions that warrant end-of-life planning.

End-of-life planning should occur before conditions progress, when a person's ability to make end-of-life choices can be impeded.

Chronic diseases are becoming increasingly common and are a priority for action in the health sector.

The Australian Institute of Health and Welfare commonly reports on eight major groups of illnesses: arthritis, asthma, back pain, cancer, cardiovascular disease, chronic obstructive pulmonary disease, diabetes and mental health conditions (visit the Chronic disease page on the AIHW website).

Chronic diseases also dominate the leading causes of death in Australia, as shown in Figure 3.

Figure 3: Leading causes of death, by sex (2016)

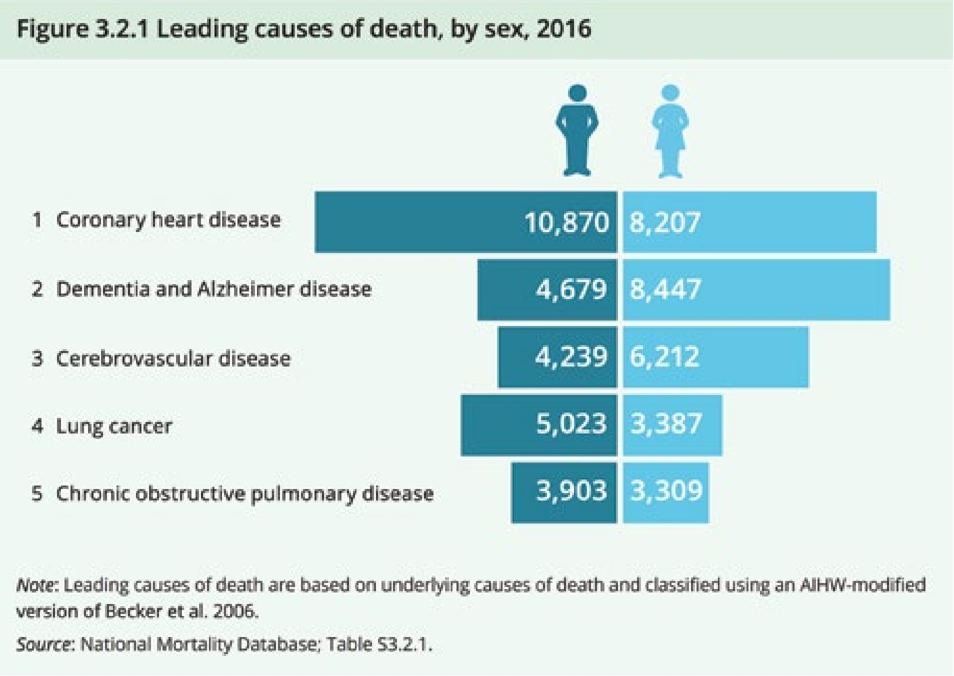


Figure 3.2.1 Leading causes of death, by sex, 2016

Note: Leading causes of death are based on underlying causes of death and classified using an AIHW-modified version of Becker et al. 2006.

Source: National Mortality Database; Table S3.2.1.

Stages of a chronic condition

The stages for chronic conditions are:

- well (no condition)
- at risk of developing
- undiagnosed
- diagnosed
- high-risk and complex
- advanced.

Prevalence of chronic conditions

Chronic conditions range from minor conditions (such as short-sightedness and minor hearing loss) to debilitating and restrictive complaints (such as musculoskeletal conditions) to potentially life-threatening illnesses (such as cancer and coronary heart disease).

According to the 2014–15 National Health Survey, in which people self-reported conditions, one in every two Australians had at least one prominent chronic condition. (That is, arthritis, asthma, back pain, cancer, cardiovascular disease, chronic obstructive pulmonary disease, diabetes or a mental health condition).[2] More information can be found at the Australian Bureau of Statistics website.

The AIHW report 'Australia's Health 2016' found chronic conditions were responsible for about three-quarters of the total non-fatal burden of disease in Australia. The risk factors causing the most burden were tobacco use, high body mass, alcohol use, physical inactivity and high blood pressure.[3] About a third of this burden could be prevented by reducing exposure to modifiable risk factors (including both behavioural and biomedical risk factors).

Aboriginal and Torres Strait Islander people experience poorer health and have worse health outcomes than other Australians, with a burden of disease two to three times greater than the general Australian population. In addition, they are more likely to:

- die younger (death rates are about five times that for non-Indigenous people in the 35–44 age group)
- experience disability
- report their health as fair.[4]

An ageing population and improved treatments have contributed to people living longer with chronic conditions.

Meanwhile, the increasing prevalence of chronic conditions has been attributed to early detection and improved treatments for diseases that previously caused premature death.

Earlier intervention for behavioural factors, such as smoking or poor diet, that increase the risk of developing chronic conditions, has also meant fewer premature deaths, but more people living with chronic conditions.

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[2] *Australian Institute of Health and Welfare 2016. Australia's health 2016. Australia's health no. 15. Cat. no. AUS 199. Canberra: AIHW.*

[3] *Australian Institute of Health and Welfare 2016. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2011. Australian Burden of Disease Study series no. 3. Cat. no. BOD 4. Canberra: AIHW.*

[4] *Australian Institute of Health and Welfare 2014. Australia's health 2014. Australia's health series no. 14. Cat. no. AUS 178. Canberra: AIHW.*

Comorbidity

Chronic complex conditions cannot be cured. It is estimated that many people living with chronic complex conditions have more than one 'comorbidity' – that is, the occurrence of two or more diseases in a person at once.

According to the AIHW report Australia's Health 2016, 23 per cent of Australians, or 5.3 million people, had two or more chronic conditions in 2014–2015.[5]

People aged **65 and over (60%)** compared with people aged 0–44 (9.7%).

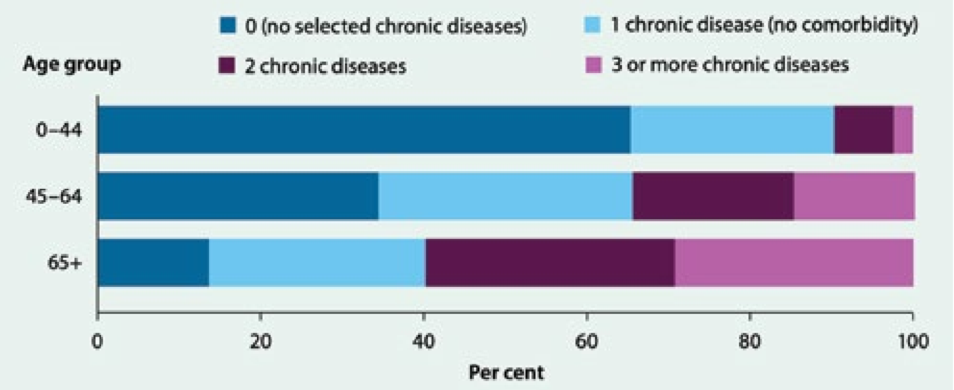
Females (25%) compared with males (21%).

People living in the lowest **socioeconomic areas (30%)** compared with the highest socioeconomic areas (19%).

People living in **regional and remote areas (28%)** compared with major cities (21%).

Figure 4 shows how the rate of comorbidity and the number of chronic diseases experienced increases with age: almost 29 per cent of those over 65 reported having three or more chronic diseases, compared to 2.4 per cent of those under 45.

Figure 4: Comorbidity of selected chronic diseases by age groups (2014–15)



Note: The selected chronic diseases are: arthritis, asthma, back pain and problems, cancer, cardiovascular disease, chronic obstructive pulmonary disease, diabetes, and mental health conditions.

Sources: ABS 2015 (Table 18.3); Table S3.3.2.

For more information about comorbidities in Australia, visit the AIHW document 'Australia's health 2016: Chronic disease and comorbidity'.

Complex health needs

Complexity is comorbidity combined with any number of other social, support, mental or other problems. 'Complex patients' are usually defined as patients with complex care needs, with a combination of multiple chronic conditions, mental health issues, medication-related problems, and social vulnerability.

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[2] *Australian Institute of Health and Welfare 2016. Australia's health 2016. Australia's health series no. 15. Cat. No. AUS199. Canberra AIHW.*

Appendix 3: Best-practice tools to support early identification of end-of-life patients

Surprise Question

The surprise question is a simple trigger that prompts clinicians to ask themselves: 'Would I be surprised if this patient died in the next year or next few months, weeks or days?'

This is to help clinicians to be able to:

- recognise whether or not their patients are at risk of deteriorating and dying, and
- consider whether or not to offer and discuss advance care planning, or revisit their advance care plan, and
- consider whether or not to refer earlier their patients to specialist palliative care for a thorough assessment, **OR**
- consult the specialist palliative care for advice.

More information refer to the health.vic webpage, The last twelve months of life and Australian Government Department of Health page, GP best practice research project.

Supportive and Palliative Care Indicators Tool (SPICT™)

SPICT is a free, online and evidence-based clinical tool used in many countries to help clinicians identify people at risk of deteriorating due to advanced, progressive or life-threatening conditions.

The tool has three domains that provide guidance on:

1. identifying the type of general indicators for poor or deteriorating health
2. identifying clinical signs for the different type of life-limiting conditions
3. prompting for review and assessment of people's needs and care planning earlier.

The tool can help clinicians decide when it is time to start a conversation with people about their health and care, including what is important to them and the available treatment and care options. Access SPICT guides for communication tips.

The tool is designed to look at health status, not prognostic time-frame, because it is not possible to know exactly when a person will deteriorate or die. It is important to refer everyone who is at risk of deterioration for early assessment and care planning.

For more information, visit the SPICT website.

Appendix 4: Important conversations and advance care planning

Important conversations

It's important to offer to discuss what's likely to occur early in the patient's diagnosis or illness. Patients can then plan their health care and what they want from the rest of their life. The amount of information a patient will want to hear will vary.

Having a conversation just as someone is dying is much harder than starting earlier on. Some patients or patients' relatives may initiate discussions with you, and it's best to be prepared.

Important conversations with non English-speaking patients

For patients who don't speak English, use the Translator and Interpreter Services. This tool is available online and allows you to translate appointment details into your patient's language. It is equally important to consider the cultural and safety consideration for non-English-speaking patients. For information and training visit the ceh.org.au website.

Refer to translated resources in Appendices.

Trajectories of patients' illness

It is important to be able to recognise a patient's stage of deterioration, as either:

- at-risk of dying within the next 12 months
- likely to die within the next weeks to months
- dying within days and wanting to go home.

For people who are likely to die in the short term such as within days to weeks, it is likely that their clinical deterioration is irreversible.

For people who are likely to die in the next 12 months, they may experience rapid changes and fluctuations in their condition which may be reversible.

The experience of end-of-life care for people who faces a sudden death is not the same for people who gradually dies from a chronic or ageing condition.

The three main trajectories of illness for people facing towards end-of-life are:

- Cancer trajectory – short decline
- Organ failure trajectory – intermediate with acute episodes
- Dementia and frailty trajectory – gradual dwindling.

Refer to the illness trajectories diagram and the description on the RACGP website of Palliative Care and End-of-Life care General Principles.

Advance care planning

Advance care planning involves thinking and making choices now to guide the future of the patient’s health care. It is also a process of the patient communicating their wishes. If they have strong beliefs about what they want to happen in the future, it is particularly important for the patient to make their plans and wishes known now. This can be done by having a conversation and writing down the individual’s preferences.

Advance care planning documents are only to be used if a person is unable to make or communicate their decisions. People can change their mind, their plans, their Statement of Choices and legal documents at any time while they have decision-making capacity to do so.

Access advance care planning forms on the health.vic website or visit the following NWMPHN advance care planning links (note that all forms under the *Medical Treatment Planning and Decisions Act 2016* are free to download and may be completed without seeking legal advice or assistance):

- Roles and responsibilities in advance care planning (NWMPHN)
- Advance care planning in residential aged care (NWMPHN)
- Advance care planning in community health
- Advance care planning in domiciliary nursing services
- Advance care planning brochure: other languages order form
- Advance care planning MBS item numbers

NWMPHN: translated resources

- Arabic
- Chinese, Simplified
- Chinese, Traditional
- English
- Greek
- Italian
- Macedonian
- Turkish
- Vietnamese

Advance Care Planning

Roles and responsibilities in Advance Care Planning

Ai sẽ đưa ra các quyết định y tế cho quý vị nếu quý vị không thể tự làm điều đó?

Hãy nghĩ về Advance Care Planning ngay ngày hôm nay

Vietnamese

Appendix 5: Assistance for patients to live at home longer

myagedcare

Most people want to live as independently as they can in their own home as they age. Sometimes this means providing help with daily tasks, such as home maintenance, dressing or preparing meals. People may also need aids or equipment.

myagedcare is a service for people aged 65 years and older that can provide:

- help at home
- short-term care in an aged care facility (respite)
- permanent placement at an aged care facility.

To access these services, patients need to be assessed in their home (book assessments via myagedcare). For more information visit HealthPathways Melbourne.

NDIS

National Disability Insurance Scheme (NDIS) is a service available to Australians aged under 65. It can provide people with disability with information and connections to services in their communities, such as doctors, sporting clubs, support groups, libraries and schools, as well as information about what support is provided by each state and territory government. For more information visit HealthPathways Melbourne.

Home and Community Care program

Those under 65 (or Indigenous clients under 50) who are not eligible for the NDIS will continue to be eligible for services under Victoria's HACC Program for Younger People (HACC PYP). The program will continue to provide the same types of services that were provided under the former HACC Program over the period that the NDIS rolls out in Victoria. These services can include help with housework, personal care, meals, social support and group activities, nursing care and home maintenance. The program provides low-level support and maintenance to eligible people and their carers.

Activities of daily living – health assessments

Under the MBS, GPs and nurses can complete these health assessments for any patient 75 or older (or any Aboriginal or Torres Strait Islander patient 55 or older). As part of this assessment, GPs and nurses are to assess the patient's physical function, including the patient's activities of daily living, and whether or not the patient has had a fall in the past three months.

For more information on health assessments, please refer to the MBS criteria, myagedcare national screening and assessment form and RACGP's Silver Book.

Appropriate type of care to support patients, carers and families

Carer Pathways is a free, online resource available for access from the CarerHelp website.

The resource helps to identify the type of care, resources and information that may be useful to support patients, carers and families when identifying someone who is approaching end-of-life.

The resource provides five pathways that includes relevant resources, tools and information to support patients, carers and families:

- Pathway 1: When someone needs care
- Pathway 2: Caring when death is a possibility
- Pathway 3: Preparing for dying
- Pathway 4: When the person is dying
- Pathway 5: After caring guides.

Other resources that are useful for carers are:

- Carer Gateway website that provides advice and telephone counselling support to carers
- Palliative Care Victoria website that provides a resource on Help for families and carers
- Shannon's Bridge that provides an end-of-life care pack for carers and families
- Payments for carers on the servicesaustralia.gov.au website.

Appendix 6: Palliative care teams

No individual health professional has all the skills and knowledge needed to address and manage end-of-life needs for patients and families. Effective teamwork is crucial in strengthening against moral distress and is enabled when patients and families are a central part of health care teams.

Effective teamwork encompasses leadership, clear goals, clear roles, trust, respect and a cultural readiness to allow patients to steer care. Everyone in the team can learn about the best way to approach conflict.

Effective end-of-life care requires you to speak up – to advocate. Feeling safe to speak up is a key to effective teams.

Palliative care team members

Palliative care is provided by a team of health care professionals with a range of skills. The palliative care team works together to meet the physical, psychological, social, spiritual and cultural needs of the patient. It also helps the family and carers.

The members of the palliative care team may include:

- doctors
- nurses
- allied health professionals
- volunteers
- carers.

Access more information about palliative care services available in the North Western Melbourne region visit HealthPathways Melbourne, Health Vic website or the Palliative care services website, which also offers translated resources.

The role of general practices to support patients with dying well

Almost every health professional will encounter patients at or approaching end-of-life, patients with progressive or symptomatic illness, and bereaved families.

It is now recognised that end-of-life care is an integral part of the standard clinical practice of most health professionals.

Specialist palliative care is provided by clinicians, such as doctors, nurses or allied health professionals, who have a specialist palliative care qualification and accreditation.

Generalist palliative care refers to end-of-life care provided by non-specialist palliative care clinicians, such as GPs, practice staff and aged care workers.

A range of specialist palliative care services are available to support general practices to provide end-of-life care for patients and their families or carers. These include:

- community palliative care services
- inpatient palliative care services
- outpatient palliative care clinics
- day hospices
- consultancy teams.

Figure 6 shows the relationship between general practice and specialist palliative care and other health services in providing end-of-life care.

Figure 6: Role of general practice and specialist palliative care for end-of-life patients living in the community (Source: DHHS)

End of life care

- Use the palliative approach to care
- Assess, identify, plan, deliver and review care
- Determine if advance care plan in place
- Commence advance care planning process if required
- Occasional or regular interventions with people at the end of life
- Share care with specialist palliative care as required

Specialist palliative care

- Care for people with complex palliative care needs
- Can occur at any time from diagnosis
- Share care with other healthcare providers
- Bereavement and psychosocial support including after death
- Consultation and advice to other services, healthcare and support teams
- Education and training on palliative care and end of life
- Research about caring for the dying, their families and carers

For more details, see the health.vic webpages on the palliative care service capability framework, referring to community services, and guidance for GPs. You can also view a list of specialist palliative care services in Victoria.

Anticipatory prescribing

It is important that patients identified at risk of deterioration or dying are provided with timely access to medication management support.

This includes anticipating patients' needs and their deterioration, and being proactive in prescribing medicines that are commonly used to manage symptoms during the terminal phase.

This is to ensure that the medicines are in-place for carers or community nurses to manage symptoms for the patient, if and when something happens.

A list of medicines that are commonly used to manage symptoms for terminal phase, also known as the Core Palliative Care Medicines List, are:

- Clonazepam 1 mg/mL Injection – for anxiety and terminal restlessness
- Haloperidol 5 mg/mL Injection – for terminal illness and nausea
- Hyoscine butylbromide 20 mg/mL Injection – for noisy breathing
- Metoclopramide 10 mg/2mL Injection – for nausea
- Morphine 10 mg/mL Injection – for pain and dyspnoea.

Guidance for anticipatory prescribing, and more information on anticipatory medicines are available on the health.vic website, and Medication management in palliative care on the RACGP website.

The Palliative Care Schedule in the Pharmaceutical Benefits Scheme (PBS) is specific for prescribing palliative medicines.

Medicines that are listed in this schedule can be prescribed and supplied in a larger quantity suitable for palliative care use, such as increased number of repeats. The listings are presented as Authority Required (Streamlined) or Restricted Benefits.

This can help reduce the number of doctor's visits required for patients and their families to obtain prescriptions for continuing therapy, and reduce patient co-payment costs to ensure palliative medicines are affordable and accessible for patients and their families. GPs can be supported by community palliative care teams at this time.

More information on access to medicines for palliative care and the guidance for prescribing for palliative care is available at pbs.gov.au.

Access to medicines

A list of the standard medicines used to treat or manage symptoms in palliative care are available from the Supercare Pharmacies.

The Supercare Pharmacies are open 24 hours a day and seven days a week, and provide round-the-clock access to pharmacists for advice, supply of medicines and dispensing prescriptions.

The location and contact details of Supercare Pharmacies in Victoria are available from health.vic.

Pharmacist-medication review

Home Medicines Review (HMR), Residential Medication Management Review (RMMR) and MedsCheck give patient and carer the opportunity to:

- rationalise the patient's need for medicines, to deprescribe and simplify their medication regimen
- discuss any concerns, beliefs or questions about medicines
- educate patient and carer on where and how to access palliative medicines.

For more information, refer to Pharmacists supporting patients with palliative care needs on the Australian Pharmacist website, and the Palliative Care Essential CPE on the Pharmaceutical Society of Australia website.

Appendix 7: Voluntary assisted dying

On 19 June 2019, the *Voluntary Assisted Dying Act 2017* came into effect. The law allows people who are at the end of their life, and who meet strict eligibility criteria, the opportunity to end their life at a time and in a manner they choose.

Medical practitioners who are considering supporting patients to access voluntary assisted dying should consider completing the voluntary assisted dying training. A medical practitioner must complete this training before conducting an eligibility assessment for voluntary assisted dying.

The request for voluntary assisted dying can only be made by the person (patient), and they must meet strict criteria to be eligible. The person must:

- have an incurable, advanced and progressive condition
- be experiencing suffering that they find intolerable
- be expecting to die within six months, or within 12 months for certain people with neurodegenerative condition
- have capacity in decision-making
- be an Australian citizen or permanent resident who is 18 years or over, and who has lived in Victoria for at least 12 months.

Two doctors must separately confirm the person's eligibility to access voluntary assisted dying, after which the coordinating doctor can apply for a permit to prescribe the medication. The role of the doctors are:

1. **Coordinating doctor:** conducts a first assessment of the person and accepts their request for voluntary assisted dying.
2. **Consulting doctor:** conducts a second assessment of the person and their request for voluntary assisted dying.

If the person is physically unable to take the medication, their doctor may provide assistance. There are strict guidelines to adhere to if doctor assistance is required. (Refer to Care pathway for voluntary assisted dying information in this workbook.) Otherwise the person must self-administer.

No health care provider is obliged to participate in voluntary assisted dying. Visit HealthPathways Melbourne or health.vic for more information on voluntary assisted dying.

Appendix 8: Medicare Benefit Schedule (MBS) items

The Australian Government has changed the way it cares for Australians with chronic diseases and complex conditions – aiming to keep them out of hospital and living happier and healthier lives at home. This has been done via the Healthier Medicare package.

The following Medicare item numbers **may be used** for palliative/end-of-life patients.

Health Assessments (items 701–707, 715)

A health assessment is the evaluation of a patient’s health and wellbeing. Eligible practitioners use it to help decide if a patient needs:

- preventive health care
- education to improve their health and wellbeing.

Refer to the MBS Online for more information on 75+ Health Assessments and Aboriginal and Torres Strait Islander Health Assessments.

Home Medication Reviews (item 900)

According to the Quality use of medicines to optimise ageing in older Australians resource, as our population ages, more people are living with multiple chronic diseases with an associated increase in polypharmacy (multiple medicines use). Medicines use is a complex balance between managing disease and avoiding medicine-related problems.

GPs can claim a Medicare item number to complete a Home Medication Review in conjunction with a community pharmacist. Please refer to Home Medication Reviews.

Chronic Disease Management Plans (items 721, 723 and 732)

Older people experience complex diseases that are dynamic in nature, requiring a range of interventions and support approaches at different times. One approach is to complete a GP Management Plan and/or Team Care Arrangement. Refer to MBS online for more information.

Practice nurse chronic disease (item 10997)

This item may be claimed by a medical practitioner, where a monitoring and support service for a person with a chronic disease care plan (GPMP and/or TCA) is provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of that medical practitioner. This item can be claimed up to five times in a calendar year. Certain criteria must be met: search MBS Online.

Case conferences (item 739)

This item is available to provide the opportunity for a holistic, informed approach to ongoing care for providers, carers and family. The case conference needs to:

- be organised by the GP
- be 20–40 minutes long
- include the GP and at least two other health care providers.

Case conferences (items 735 to 758)

These items provide rebates for GPs to organise and coordinate, or participate in, multidisciplinary case conferences for patients in the community, or patients being discharged into the community from hospital, or people living in residential aged care facilities. Certain criteria must be met.

Mental Health treatment plan (if relevant)

Medicare item numbers available for GPs to claim for mental health related consultations are listed in Table 15. Always refer to the Medicare Benefit Schedule for full details.

Table 17: Medicare item numbers and descriptions for mental health related consultations

Item name and number	Medicare criteria	Frequency of claiming
Mental health consultation 2713	Mental health consultation lasting at least 20 minutes. To claim this, the patient does not need to be on a Mental Health Plan.	No limits to the amount of times this item number is claimed.
Mental Health Plan: Item 2715: 20–39 min. consult with a GP **with** mental health skills training Item 2717: 40+ min. consult with a GP **with** mental health skills training Item 2700: 20–39 min. consult with a GP **without** mental health skills training Item 2701 (40+ min. consult with a GP **without** mental health skills training	'Mental disorder' is a term used to describe a range of clinically diagnosable disorders that significantly interfere with an individual's cognitive, emotional or social abilities. The Mental Health Plan must include documenting the results of assessment, patient needs, goals and actions, referrals and required treatment and/or services, and review date, in the patient's GP Mental Health Treatment Plan.	A new plan can be completed every 12 months and at least three months after claiming an item 2712 (review Mental Health Plan). After the plan has been completed, the patient is entitled to up to 10 Medicare-subsidised visits with a psychologist per calendar year.
Review Mental Health Plan	The review item is a key component for assessing and managing a patient's progress once a GP mental health treatment plan has been prepared, along with ongoing management through the GP mental health treatment consultation. A patient's GP mental health treatment plan should be reviewed at least once.	Can be claimed every three months or at least four weeks after claiming the mental health plan item number.

More information is available at Education guide for Mental Health Care.

Medicare item numbers for patients in a residential aged care facility

Patients in a residential aged care facility may be eligible for the following Medicare item numbers.

Comprehensive medical assessments (item 701–707)

This health assessment is available to new residents on admission into a residential aged care facility. It is recommended that new residents should receive the health assessment as soon as possible after admission, preferably within six weeks following admission into a residential aged care facility. The item number can then be claimed every 12 months.

More information can be found at MBS Online.

Care plan contribution (item 731)

GPs can be requested to contribute to an eligible multidisciplinary care plan, prepared by RACF or other provider.

GPs' contribution is to give advice, prepare part of the plan or amendments to the plan, and add a copy to the resident's medical records.

Where clinically indicated, on submission of an item 731 claim, residents may be eligible to access five allied health services in addition to those funded by RACF.

This item number can be claimed every three months (but is recommended every six months.

More information can be found at MBS Online.

Residential Medication Management Review (RMMR) (item 903)

A RMMR is a review of medications in collaboration with the pharmacist report, for residents at risk of medication-related problems or significant change in medical condition.

A GP initiates RMMR with an accredited pharmacist for permanent residents (new or existing). This item number can be claimed once every 12 months.

More information can be found at MBS Online.

Appendix 9: PDSA worksheet sample

Activity Table 13: PDSA Cycle Template

Priority area number	**Priority area topic**
1	Chronic Disease
Activity number	**Staff member responsible**
2	
Date started	**Date completed**

Part 2: The doing part – Plan, Do, Study, Act

Plan	**Describe the brainstorm idea you are planning to work on. (Idea)**
Plan the test, including a plan for collecting data	What exactly will you do? Include what, who, when, where, predictions and data to be collected.

Idea: Increase the number of our active patients over the age of 75 to have a current annual 75+ Health Assessment recorded by 10% by 30 October.

What: Collect information on CAT4 on the number of patients over the age of 75 with and without a current annual 75+ Health Assessment

Who: Receptionist (Sally)

When: Begin 1 October for 4 weeks

Where: In Dr Brown's office on Wednesday afternoons

Prediction: 10% increase in the number of our patients, who visit the practice over this time period, over the age of 75 with a current annual 75+ Health Assessment recorded. Predicted the practice would have 50% of these already in place.

Data to be collected: Number of active patients over the age of 75 and the number of active patients over the age of 75 with no current annual 75+ Health Assessment recorded.

Do	Who is going to do what? (Action)
Run the test on a small scale	How will you measure the outcome of your change?

Completed 15 October – the receptionist contacted **NWMPHN** for support with the PenCS CAT4 search and the export function. The data search was conducted very quickly, with the receptionist being upskilled to conduct further relevant searches.

Study	Does the data show a change? (Reflection)
Analyse the results and compare them to your predictions	Was the plan executed successfully? Did you encounter any problems or difficulty?

A total of 87 active patients (32%) over the age of 75 have an annual 75+ Health Assessment recorded this year = 18% lower than predicted. The lower predicted percentage was suspected to be due to change in nursing staff.

Act	Do you need to make changes to your original plan? (What next) OR Did everything go well?
Based on what you learned from the test, plan for your next step	If this idea was successful, you may like to implement this change on a larger scale or try something new. If the idea did not meet its overall goal, consider why not and identify what can be done to improve performance.

1. Need to identify which GPs are not completing an annual 75+ Health Assessment on eligible patients over the age of 75 and help increase the % completed
2. Need to monitor monthly data collection report data from PENCS to ensure recording rates continue to increase.
3. Ensure the clinical team know how to complete an annual 75+ Health Assessment in medical software.
4. Ensure process is embedded to include discussions about Advance Care Planning (when appropriate) in all new annual 75+ Health Assessments
5. Ensure Advance Care Plans are noted in patient records

Remind the whole team that this is an area of focus for the practice.

Repeat Step 2 for other ideas. What idea will you test next?

Appendix 10: PDSA worksheet template

Activity Table 13: PDSA cycle template

Priority area number	**Priority area topic**
Activity number	**Staff member responsible**
Date started	**Date completed**

Part 2: The doing part – Plan, Do, Study, Act

Plan	**Describe the brainstorm idea you are planning to work on. (Idea)**
Plan the test, including a plan for collecting data	What exactly will you do? Include what, who, when, where, predictions and data to be collected.

Do

Run the test on a small scale

Who is going to do what? (Action)

How will you measure the outcome of your change?

Study

Analyse the results and compare them to your predictions

Does the data show a change? (Reflection)

Was the plan executed successfully?

Did you encounter any problems or difficulty?

Act	**Do you need to make changes to your original plan? (What next) OR Did everything go well?**
Based on what you learned from the test, plan for your next step	If this idea was successful, you may like to implement this change on a larger scale or try something new. If the idea did not meet its overall goal, consider why not and identify what can be done to improve performance.

Repeat Step 2 for other ideas. What idea will you test next?

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