PDSA: Increasing the number of patients over 75 years who have had a Health Assessments in the past 12 months.

Clinic:	Date:
Title:	Number:

Goal: What is the overall goal you wish to achieve?
Increase the number of patients who are over 75 years that have had an Over 75 years Health Assessment in the previous 12 months.

Idea:
A health assessment of an older person is an in-depth assessment of a patient aged 75 years and over. It provides a structured way of identifying health issues and conditions that are potentially preventable or amenable to interventions in order to improve health and/or quality of life.

PLAN:

List the tasks necessary to complete this test (what)	Person responsible (who)	When	Where
Run POLAR search for baseline data number of patients who have had an over 75 years HA. (see attached walkthrough)			
Discuss the implementation at a practice meeting: Do you have the resources? Do you have the room availability?			
Run POLAR search to find patients who are eligible for an over 75 years Health Assessment (see walkthrough)			
Check the appointments schedule to see if any of the identified eligible patient's have any future appointments booked and notate on their record to speak to the patient to book.			
Send a reminder SMS or ring patients needing assessments. Note you may want to stagger these to avoid appointment issues.			
Follow up Patients			
Run baseline reports monthly to check progress. (See attached walkthrough and table)			

3) What do you predict will happen?
The number of patients needing an over 75 years HA will decrease.

DO: Was the cycle carried out as planned?   Yes   No, if not why?

STUDY: Record, analyse and reflect on results.   Did the results match your predictions?

ACT: Decide to Adopt, Adapt or Abandon.

	Select		Describe
	Adopt	Select changes to implement on a larger scale and develop an implementation plan and plan for sustainability.	
	Adapt	Improve the change and continue testing plan. What will be next PDSA cycle?	
	Abandon	Discard this change idea and try a different one.	

WALKTHROUGH: Health Assessments for patients over 75 years.

Patient Cohort:
Patient Status Active
Patient Status RACGP Active
Are over the age of 75years
Have not had an Over 75 Years Health Assessment in the past 12 months.

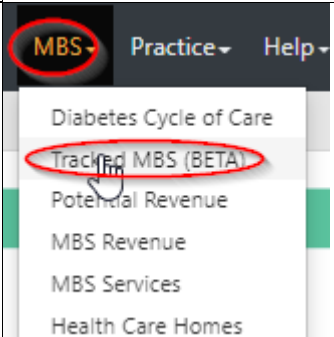|	
1.Open POLAR and Select Clinic Summary Report from Reports	**Clinic Summary** Clinic Summary report including CLINICAL INDICATORS
2. Select the RACGP & Practice Active Patients shortcut on the top right hand side.	RACGP & Practice Active Patients CURRENTLY SELECTED ☑
3. From the dark ribbon select MBS drop down list then select Tracked MBS	MBS ⏷ Practice ⏷ Help ⏷ Diabetes Cycle of Care Tracked MBS (BETA) Potential Revenue MBS Revenue MBS Services Health Care Homes

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4. In the table at the top select 75+ Health Assessment from the Tracked MBS Item column	Focus **Tracked MBS Item** Q Eligibl GPMP TCA GP Mental Health Plan Indigenous Health Assessment Indigenous Nurse Assessment Chronic Disease Nurse Assessment MBS Items: 701, 703, 705, 707, 224, 225, 226, 227 75+ Health Assessment
5.You can now see how many Active 75+ Health Assessments you have currently. (This is your baseline data) Following the table along you can see How many you have to Action & How many have Expired	 | Focus	Tracked MBS Item	Eligible Cohort	Active	Active Review	To Action	Expired	Never Had
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	GP Mental Health Plan	1,400	1,574	47	739	0	742
	Indigenous Health Assessment	93	6	Not Applicable	87	12	75
	Indigenous Nurse Assessment	18	0	Not Applicable	18	2	16
	Chronic Disease Nurse Assessment	2,011	19	Not Applicable	1,996	397	1,599
	45-49 Health Assessment	505	63	Not Applicable	455	0	455
	75+ Health Assessment	1,175	196	Not Applicable	979	234	745	 Baseline Data

6. Moving to the middle of the report to the Red To Action section you can either select the expired button (patients that have had one in the past but this item has now expired) or use the Select Combined button this will give you a list of any patients that are eligible for a 75+ Health Assessment.	**To action** **for 75+ Health Assessment** **979** ⓘ Select Never Had Select Expired Select Combined
7. The table at the bottom will load with the patient cohort. To print the list of patients eligible go to Patient List and then export to excel. You may need to sort by provider and addresses to eliminate patients living in RACF. Record your baseline data to measure progress.	Patient List

Measure	Practice Target	Baseline Data Date: _____	Month/PIP Quarter											