Measuring your outcomes for aged care with Dr Anthony Marinucci

Chair, RACGP Specific Interests Aged Care

RACGP Specific Interests

Why should you do measuring outcomes/quality improvement in aged care?

More than one in three general practice patient encounters are with older people aged 65 years and over and number of older people aged 65 years and over in Australia is projected to more than double in coming years.

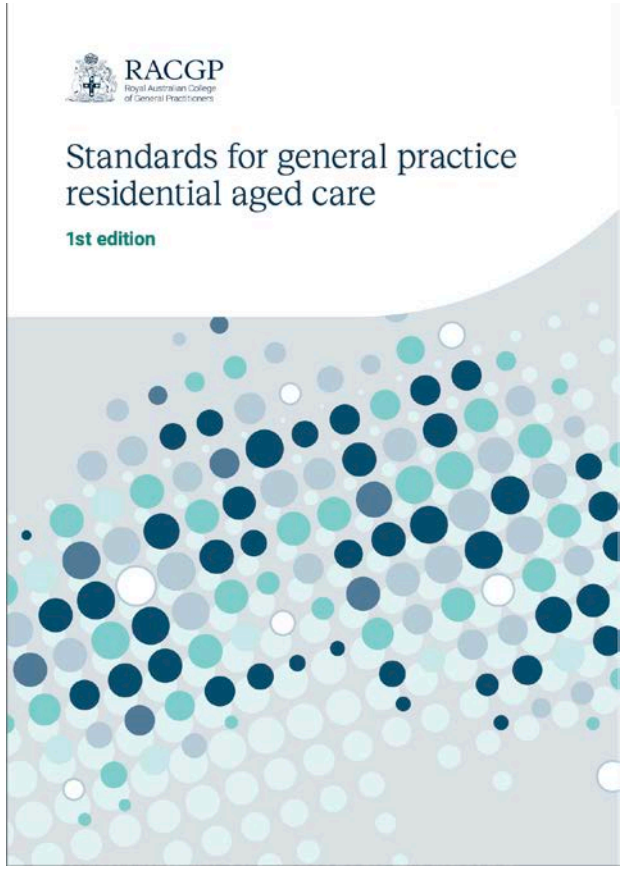
Ref – RACGP Silver Book

RACGP aged care clinical guide (Silver Book)

Available on the RACGP website:

https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/silver-book/

Standards for general practice residential aged care



Available on the RACGP website:

https://www.racgp.org.au/running-a-practice/practice-standards/standards-for-other-health-care-settings/standards-for-gp-residential-aged-care

Types of measuring outcomes CPD activities

Measuring outcomes activities could include:

Individual-focused activities

- audit focused on participant's own practice
- root cause analysis
- incident report
- individual quality improvement project

Group-focused activities

- audit (practice, national or international)
- M&M meetings, case conferences
- quality improvement project
- multi-disciplinary team meetings

Not directly focused on participant's practice

- assessing incident reports
- leading, analysing, writing reports on healthcare outcomes

https://www.medicalboard.gov.au/Professional-Performance-Framework/CPD/Professional-Development-Plans.aspx

RACGP Measuring Outcomes Tool

The Measuring Outcomes (MO) Tool can assist you in obtaining hours.

It helps you describe any changes or improvements you have implemented in your practice as an outcome of a CPD activity you've completed, to claim MO CPD:

- Log-in to myCPD
- At very top of myCPD, click on 'Log'
- From drop-down menu, click on 'Measuring Outcomes Tool'
- Complete the form (we will do some examples together later)

Measuring Outcomes Tool – The Framework

Step 1: Describe an improvement or change you have implemented in your practice (think about what prompted you to make the change)

Step 2: What impact or outcome are you expecting or have seen as a result of the change/s you've implemented?

Step 3: How do you plan to monitor and/or evaluate the effectiveness of these changes

Step 1

Describe an improvement or change you have implemented in your practice and what prompted you to make the change.
(Practice refers to any role in which you are currently employed, e.g., your regular clinical practice, university teaching, research studies, or locum work.)

Step 2

How do you plan to monitor and/or evaluate the effectiveness of these changes?

Step 3

What impact or outcome are you expecting as a result of the change/s you've implemented? If you have already observed an impact or outcome, please describe this below.

How to get started – Step 1

Describe your improvement or change

I have referred all my patients with polypharmacy for a RMMR/HMMR

I have identified patients at high risk of fracture using the Garvin # Risk Calc.

In conjunction with the facility care manager, we have identified all patients with 3 or more chronic conditions to be multi-morbid in a regular monthly clinical meeting

I have participated and actively contributed in a 3-monthly MAC meeting

Step 2- - What are the impacts or outcomes?

What results are you expecting?

By reviewing my patients with dementia for polypharmacy I am expecting “a reduction in falls”

By screening my patients for osteoporosis the outcomes I expect are “a reduction in fractures”

By referring my patients with complex multi-morbidity for comprehensive geriatric assessment I am expecting a “reduction in the amount of hospitalisations”

By reducing use of oral anti-biotics for asymptomatic bacteriuria, I am expecting “a reduction in adverse consequences of antimicrobial use (including antimicrobial resistance, toxicity and unnecessary costs)”

Step 3 – Monitor and evaluate

How do you plan to monitor or evaluate the effectiveness of these changes?

I have set up recall systems with the RACF to perform 3 monthly medication/psychotropic medication reviews to actively initiate medication rationalisation

I have setup an alert on my clinical practice software to prompt for osteoporosis screening on all patients over 70yo and will monitor percentage of those that have had BMD DEXA scans.

I will monitor for a reduction in hospitalisations of those complex patients which are part of a MDT incl. allied health and geriatrician.

Anti-biotic prescribing is reviewed every 3months during the MDT MAC meeting

Falls, Fracture Risk and Osteoporosis

Have you assessed risk for fractures in all your aged care patients?

These fracture risk calculators have been validated and are available for use:

- FRAX score
- Garvan Fracture Risk Calculator

Risk stratification is valid without a BMD test; however, the Pharmaceutical Benefits Scheme (PBS) criteria for antiresorptive drugs require a BMD T-score of <2.5 or evidence of fracture due to minimal trauma

Reference: https://www.racgp.org.au/getattachment/967680a5-404c-4f04-a6d1-4e4df422174a/Osteoporosis.aspx

Consider:

- How many of your patients have had a BMD DEXA scan?
- How many patient have had a minimal trauma fracture?
- How many patients have you assessed fracture risk?
- How many of these patients are receiving treatment?

S8/opioid prescribing and chronic pain

…..the prevalence of chronic pain in residential aged care facility (RACF) residents is challenging to measure but estimated to be around 80%. (RACGP Silver book)

As the population ages, the number of people with chronic pain is expected to increase. The consequences of chronic pain include increased confusion, sleep disturbance, nutritional alterations, impaired mobility, depression, social isolation, worsening pain, slowed rehabilitation and increased risk of falls. (RACGP Silver book)

Consider:

- number of patients prescribed opioids which have had the required 12months review for pbs by another practitioner
- number of patients with a trial reduction/cessation of their narcotic analgesia
- number of patients prescribed opioids or non-opioid psychoactive analgesic agents which have had pain clinic review

https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/silver-book/part-a/pain

Multimorbidity and frailty

Multimorbidity is commonly defined as the presence of two or more chronic medical conditions in an individual, and can present several challenges in healthcare, particularly with higher numbers of coexisting conditions and related polypharmacy. Complex multimorbidity is defined as ‘co-occurrence of three or more chronic conditions affecting three or more body systems within one person, without defining an index condition’.

Frailty is a syndrome of physiological decline that occurs in later life, and is associated with vulnerability to adverse health outcomes.

Aged care patients are often frail and multi-morbid and require multi-disciplinary care.

Consider:

- Number of patients which have been referred for a comprehensive geriatric assessment
- Number of patients which have had an MDT conference

Polypharmacy (5+ medications) and medication rationalisation

Polypharmacy is common in older people due to an increased incidence of chronic conditions requiring multiple medicines to prevent or control symptoms

~2/3's of Australians aged >75 years are taking five or more medicines

Older people are more vulnerable to harms from polypharmacy because of increased frailty and age-related changes that alter the way their bodies respond to medicines

Consider:

- number of patients which have been referred for a pharmacy review (RMMR/HMMR)
- number of patients which have been referred for a comprehensive geriatric assessment

Psychotropic prescribing

Importance of regular review of medications to ensure that they are still the most appropriate treatment

Medication reviews ideally are multidisciplinary and should always involve the person living with dementia and/or their substitute decision-maker

Ref:
https://www.health.gov.au/sites/default/files/documents/2020/01/prescribing-psychotropic-medications-to-people-in-aged-care-information-and-resources.pdf

Table 1. Consider the following at the three-month antipsychotic review

Assessment	Related adverse effect or reason for assessment
Assessment of behaviour	Agitation, anxiety as a side effect of antipsychotics
Adverse effects	Movement disorders (eg rigidity, tremor, abnormal involuntary movements, muscle stiffness), sedation, anticholinergic effects (eg dry mouth, constipation), falls, confusion
Documentation of previous attempts at ceasing the antipsychotic	
Outcome of previous attempt.	
Non-pharmacological methods used that have failed/worked	Guidelines
Bowel actions	Constipation
Sleep assessment	Somnolence, insomnia
Weight measurement	Weight gain or loss
Pain assessment	Extremity pain, headache
Cardiovascular system examination: Consider electrocardiography (ECG)	Bradycardia/QT prolongation
Consider blood tests	Agranulocytosis, lipids, blood glucose levels

RACGP Specific Interests

Healthy Profession.
Healthy Australia.

Dementia care

Incl. management of Behavioural and psychological symptoms of dementia (BPSD)

- number of patients with an up-to-date and appropriate behavioural support plan in place
- number of patients with chemical restraints and when last reviewed
- number of patients for which a trial reduction of their chemical restraint has been made
- number of patients which have been referred for a pharmacy review
- Number of patients which have been referred to DSA/DBMAS service
- number of patients which have been referred for a comprehensive geriatric assessment

Refer to the Dementia Training Australia webinar - *Supporting people living with dementia in primary care – Driving assessments and medication management*

https://www.racgp.org.au/getattachment/af2d2506-9c65-43ab-a442-319a56f12fb7/Dementia.aspx

Antibiotic stewardship

It has been estimated that 40–70% of antibiotic prescribing within an RACF is inappropriate, and antibiotic resistance is increasing. The frequent transfers between healthcare facilities (ie RACF to hospital and back) exacerbates antibiotic resistance. (Ref: RACGP Silver Book)

Consider:

- attendance at RACF MAC meetings
- number of patients with long term or PRN medicated creams charted and when last reviewed
- guideline use of oral antibiotics, example waiting for cultures

https://www.racgp.org.au/getattachment/20aebf68-2ab0-4813-9498-2ecd59e26f0e/Infection-and-sepsis.aspx

Continence related care

- Number of patients with single or dual incontinence
- Optimal nursing/medical management
- Optimal escalation of care for incontinence associated dermatitis/excoriation: eg barrier creams then medicated creams
- Consider relationship between continence care and recurrent UTIs

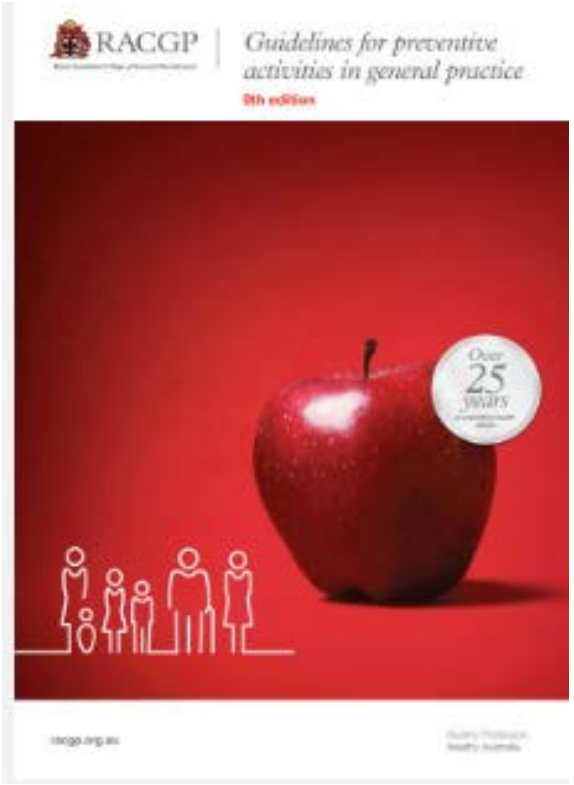
https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/silver-book/part-a/urinary-incontinence

Preventative health

Some considerations (amongst many!):

- number of patients fully up to date with Aus immunisation schedule (COVID/Influenza/Pneumococcal/Shingles)
- number of patients who have not had screening pathology in the last 6months - 1year (Iron deficiency / Vit D deficiency / DM / CKD etc etc)

Please refer to the RACGP Redbook



https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/guidelines-for-preventive-activities-in-general-pr/preamble/introduction

Are you a member of the Aged Care Specific Interest Group?

As an RACGP member you can join now for free at:

https://www.racgp.org.au/the-racgp/faculties/specific-interests/become-a-member

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