

Staying well with chronic conditions

Aim of this guide

This quality improvement guide is designed to support practices to keep their most vulnerable patients well and reduce their likelihood of adverse outcomes.

Vulnerable patients including older patients and patients with chronic and complex conditions benefit from regular, proactive care throughout the year. This guide outlines a simple approach your practice can take to identify your vulnerable patients and provide them with proactive support through the implementation of Sick Day Action Plans.



To further support your practice with these quality improvement activities, a snapshot of annual hospitalisation data in your region is provided in this guide. For more specific regional data please contact your PCLO.

Step 1. Identify patients

The first step is to identify patients that would benefit from enhanced support. Some considerations when identifying these patients may include:

- one or more chronic condition/s
- complex treatment regimes
- frequent hospital/ED presentations in the previous 12 months
- escalation/deterioration of condition/s
- measurable physical limitations
- measurable mental limitation
- poor social connectedness
- patient would benefit from integrated care intervention

You may also consider identifying areas of improvement in your Health Data Reports available on the [Practice Portal](#) and search for certain patient groups using [CAT4 Recipes](#).

Step 2. Implementation of proactive care

Review and update patients' existing care and plan using Sick Day Action Plans. Adoption of these Action Plans can be supported with regular patient check-ins.

www.brisbanenorthphn.org.au

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Sick Day Action Plans

Sick Day Action Plans enable patients to make well-informed and guided decisions about their own health care with better health outcomes. When personalised and regularly reviewed, these plans are associated with an increase in patient self-efficacy, fewer unplanned hospitalisations and timely contact with a GP or health professional when they need it.

The following Action Plan templates are available for GPs to personalise with their patients. Use these action plan templates to support patients to:

- identify new or increasing symptoms and intervene quickly, decreasing the chance of their health significantly deteriorating
- manage their condition better and know who to contact if they become acutely unwell or just feel sicker.

Detailed Description	Action Plan PDF	Medical Director Template	Best Practice Template
Asthma	National Asthma Council Australia – Asthma Action Plan	MD	BP
Anaphylaxis	ASCIA – Action Plan for Anaphylaxis	MD	BP
Chest Pain	Heart Foundation – Heart Attack Action Plan	MD	BP
Chronic Kidney Disease	Chronic Kidney Disease Action Plan	MD	BP
COPD	Lung Foundation Australia – COPD Action Plan	MD	BP
COPD for Indigenous patients	Lung Foundation Australia – Indigenous COPD Action Plan	MD	BP
Delirium	Delirium Action Plan	MD	BP
Heart Failure	Queensland Health – Heart Failure Action Plan	MD	BP
Type 1 Diabetes	Sick Day Action Plan	MD	BP
Type 2 Diabetes	RACGP – Sick Day Action Plan	MD	BP
General	General Action Plan	MD	BP

The [Ten Questions to ask in a Chronic Care Review](#) guide has been provided with this guide to support in reviewing and updating patients' existing care and implementing Sick Day Action Plans.

Step 3. Document and share learnings

Document quality improvement activities you are undertaking as part of this approach using the Plan Do Study Act (PDSA) approach. Use Brisbane North PHN's [PDSA template](#) to document these activities and share learnings with your team.

Your region: Your wellness

The potentially preventable hospitalisations (PPH) indicator is a proxy measure of primary care effectiveness.

PPH are specific hospital admissions that potentially could have been prevented by health care accessed in the community.

To the right, are rates for 2017-18 of select health conditions in the Brisbane North PHN region



ASTHMA

168 preventable hospitalisations per 100,000 people



COPD

277 preventable hospitalisations per 100,000 people



DIABETES

197 preventable hospitalisations per 100,000 people



CONGESTIVE
CARDIAC
FAILURE

205 preventable hospitalisations per 100,000 people



MENTAL
HEALTH¹

1,202 overnight admitted hospitalisations per 100,000 people



ANGINA

159 preventable hospitalisations per 100,000 people



PNEUMONIA &
INFLUENZA

268 preventable hospitalisations per 100,000 people

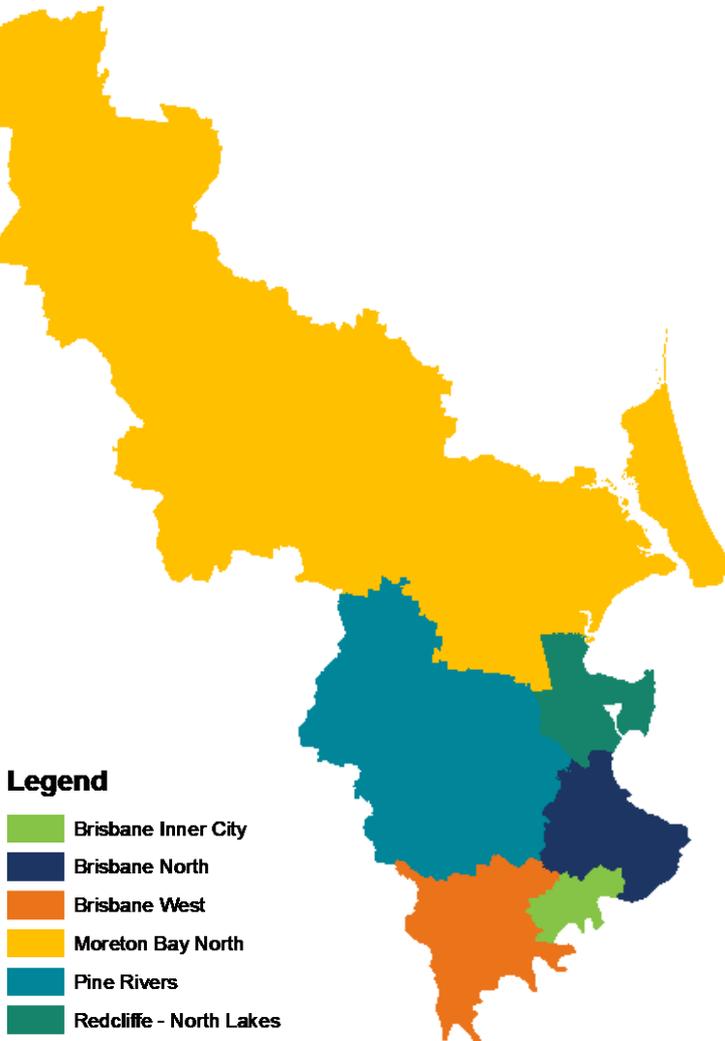


ALL
POTENTIALLY
PREVENTABLE
HOSPITALISATIONS

3,100 preventable hospitalisations per 100,000 people

^{*}All rates above are average age-standardised rates – this means the differing age distributions between regions have been accounted for.

¹Mental health refers to average number of overnight admitted mental health-related separations and may not necessarily be considered preventable. This is a crude rate and age distribution has not been accounted for.



Legend

- Brisbane Inner City
- Brisbane North
- Brisbane West
- Moreton Bay North
- Pine Rivers
- Redcliffe - North Lakes

Source:

Australian Institute of Health and Welfare 2020. Disparities in potentially preventable hospitalisations across Australia, 2012-13 to 2017-18. Cat. no. HPF 50. Canberra: AIHW.

Australian Institute of Health and Welfare 2020. Mental health services in Australia. Canberra: AIHW.

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How does your area compare to the greater PHN region, state or country?

	Brisbane North PHN Region	Queensland	National
Asthma	169 per 100,000	166 per 100,000	134 per 100,000
COPD	277 per 100,000	333 per 100,000	267 per 100,000
Diabetes	197 per 100,000	222 per 100,000	187 per 100,000
Congestive cardiac failure	205 per 100,000	225 per 100,000	206 per 100,000
Mental Health ¹	1,202 per 100,000	1,115 per 100,000	1,078 per 100,000
Angina	159 per 100,000	153 per 100,000	110 per 100,000
Pneumonia and Influenza (vaccine – preventable)	268 per 100,000	262 per 100,000	207 per 100,000
All Potentially Preventable Hospitalisations	3,100 per 100,000	3,409 per 100,000	2,793 per 100,000

= Highest rate
 = Lowest rate

What is a potentially preventable hospitalisation?

Below is an explanation of potentially preventable hospitalisations published by the AIHW.

Link: <https://www.aihw.gov.au/reports/primary-health-care/potentially-preventable-hospitalisations/contents/overview>

“The term PPH does not mean that a patient admitted for that condition did not need to be hospitalised at the time of admission. Rather the hospitalisation could have potentially been prevented through the provision of appropriate preventative health interventions and early disease management in primary care and community-based care settings (including by general practitioners, medical specialists, dentists, nurses and allied health professionals). PPH rates are indicators of the effectiveness of non-hospital care. The rate of PPH in a local area may reflect access to primary health care, as well as sociodemographic factors and health behaviours (Falster & Jorm 2017).

There are 22 conditions for which hospitalisation is considered potentially preventable across 3 broad categories: vaccine-preventable conditions, acute conditions and chronic conditions.

This local-level information can be used as an indicator of patients’ access to primary health care services and the appropriateness or effectiveness of care, as well as preventive health interventions. It is intended to assist local health professionals to develop strategies for change where needed, in the context of their local area.”