phn
EASTERN MELBOURNE
An Australian Government Initiative

Identifying patients at risk of Hospitalisation

Quality Improvement Toolkit for General Practice

Acknowledgement of Country

Eastern Melbourne PHN acknowledges the Wurundjeri people and other peoples of the Kulin Nation on whose unceded lands our work in the community takes place. We pay our respect to Aboriginal and Torres Strait Islander cultures; and to Elders past and present EMPHN is committed to the healing of Country, working towards equity in health outcomes, and the ongoing journey of reconciliation.

Recognition of lived experience

We recognise and value the knowledge and wisdom of people with lived experience, their supporters and the practitioners who work with them and celebrate their strength and resilience in facing the challenges associated with recovery. We acknowledge the important contribution that they make to the development and delivery of health and community services in our catchment.

Disclaimer and Recognition

Where to get help?

EMPHN general practice improvement & digital enablement: digitalhealth@emphn.org.au

EMPHN practice support: practicesupport@emphn.org.au

HealthPathways Melbourne: info@healthpathwaysmelbourne.org.au

About this activity – Hospitalisation Risk

This quality improvement toolkit will guide general practice teams through the steps to identify **ten patients** at urgent risk of hospitalisation that are eligible for a GPMP or review of GPMP.
Ideas and activities in this toolkit provide a simple and practical guide to enhance continuity of care, improve patient outcomes, and increase practice efficiency through a move from unplanned episodic care to planned or preventative care.

Outcomes of this activity	• Identify patients at urgent risk of hospitalisation. • Increase number of completed GP Management Plan (GPMP) or review of GPMP for identified patients at urgent risk of hospitalisation. • Support continuity of care for identified patients at urgent risk of hospitalisation by offering MyMedicare registration and uploading Shared Health Summaries.

How to use this toolkit

The following steps in this toolkit are examples of practical ideas to assist your practice team:

Starting point	Identify your activity goal, activity measurement, QI team and QI activity communication processes.
Step 1	Update your team on Hospital Avoidance Tool (HAT) Report, GPMP, MyMedicare and Shared Health Summaries.
Step 2	Prepare your clinic for undertaking GPMP and review of GPMP.
Step 3	Identify patients at urgent risk of hospitalisation and implement strategies for increasing completed GPMP or review of GPMP.
Step 4	Supporting MyMedicare registration and Shared Health Summary uploads for identified patients at urgent risk of hospitalisation.
Finishing point	Sustainability check list

Recording your improvement for this activity

It is recommended to review each improvement step and select what may be appropriate for your general practice to consider undertaking and test using Plan Do Study Act (PDSA) cycles to make sustainable changes. Use the following template to record your practice team activities and key learnings.

PDSA Template: Model for Improvement and PDSA template

Starting point:

Goal of this QI activity

Defining the goal of this activity provides your practice team with a statement of what you are trying to accomplish. Review the goal below and adjust the timeline if needed according to your general practice requirements.

QI Activity Goal Example:
For **ten identified** patients at urgent risk of hospitalisation, our team will aim to increase to 100% completed GPMP or review of GPMP within the next 3 -6 months*.

Secondary aims (for participating practices in MyMedicare and MyHealth Record):

1. For the identified **ten** patients at urgent risk of hospitalisation, our team will aim to register 100% for MyMedicare.
2. For the identified **ten** patients at urgent risk of hospitalisation, our team will aim to upload 100% for a Shared Health Summary.

*This is a sample goal. Practices can choose the number of patients and length of time to complete this QI activity based on their practice requirements. We recommend a minimum of 5 patients to be identified for this activity.

Measure – How will you measure the change for this activity?

Regular review of improvement activity measurement enables your practice team to assess progress and track whether the change(s) you are testing is leading to an improvement. It is best to measure at the beginning of the activity (baseline) and then at regular (monthly) intervals throughout.

Hospitalisation Risk Activity Measure: Use the following measurements to track your improvement activities.

QI Measure	Measure Description	Data report to use to capture measurement
Hospitalisation risk and GPMP	Number of the **ten patients** identified as urgent risk of hospitalisation with a completed GPMP or review of GPMP (in the last 3 months)	Refer to Hospitalisation risk topic specific POLAR Walkthrough resources on EMPHN website: POLAR Walkthroughs
MyMedicare patient registration	Number of the **ten patients** identified as urgent risk of hospitalisation who are registered for MyMedicare	
Shared Health Summary uploads	Number of the **ten patients** identified as urgent risk of hospitalisation who have an updated Shared Health summary uploaded to their MyHealth Record	

Use the template Activity Measurement and Tracking Table (Appendix A) to record your measurement for each of your identified **ten patients**. This will provide a straightforward way to capture your baseline and end of activity measurement for this activity.

Identify your QI team and QI activity communication processes

Identify your change team	• Identify the lead and practice team members to drive quality improvement work • Assign roles and responsibilities according to staff skill, interest and position. • Allocate protected time for the QI team to perform required tasks in staff calendar e.g. 1hr per week • Plan frequency and book meetings for QI team. • Provide access to project files and related policy and procedures
Communication with the practice team	• Identify who will need to be kept informed. • Identify the method(s) that will be used to inform and update all staff of any changes resulting from this QI activity e.g. staff/Clinical/Admin/Nurse meetings, email, noticeboard, group chat. • Ensure all staff are advised of the chosen communication(s) method. • Provide monthly updates to all staff of ongoing changes e.g. add QI to staff/Clinical/Admin/Nurse meetings. • Allow staff to contribute ideas and provide opportunities for staff feedback. • Distribute minutes/action points following any meetings held and ensure staff are aware of any follow-up needed. • Celebrate your successes

Undertaking regular meetings helps to maintain momentum and keep the team on track to successfully complete the QI activity. Completed PDSA activity templates can be used as evidence for PIP QI, and accreditation purposes.

Step 1: Update your team on hospitalisation risk, GP Management Plan, MyMedicare and Shared Health Summaries

Tasks to complete this activity:

Learn the essential steps on identifying patients at urgent risk of hospitalisation using the Hospital Avoidance Tool (HAT) Report and GP Management Plan by watching our specialised EMPHN training videos:

1. Identifying patients at risk of hospitalisation – Quality Improvement webinar (34 min length) https://www.youtube.com/watch?v=oXRIMWR63WI

Team meeting resources

Information and links to resources that can be reviewed by your practice team to inform your QI implementation activities.

Topic	Key resources
GP Management Plan	• Services Australia – Chronic Disease GPMP • MBS Online - Chronic Disease Management item requirements • Preparation of a GPMP (Item 721) • Review of GPMP (Item 732)

MyMedicare – for healthcare professionals	• About MyMedicare here • MyMedicare practice registration checklist here. • Adding GPs as providers to the Organisation Register in PRODA here. • Providing practice staff with relevant delegations to view and manage patient registration here. • Educating non-clinical staff on the steps involved in patient registration with your practice and preferred GP here.
MyMedicare – patient registration	• Patient facing resources to formalise the relationship between patient, general practice, and preferred GP here. • Patient eligibility and methods of registration here. • MyMedicare Patient Registration Form here. • Patient registration benefits here. • MyMedicare GP and community stakeholder kit here.
Shared Health Summaries	• Digital Health Agency: Shared health summaries

Step 2: Prepare your clinic for undertaking GPMP and review of GPMP

Before starting the activity to identify your **ten patients** at urgent risk of hospitalisation eligible for a GPMP or review of a GPMP and invite to attend the clinic for an appointment, as a team consider the following:

Data Cleansing

Before you start to identify people at urgent risk of hospitalisation, it is important to review and perform data quality activities.

Review your policy and procedure for deactivating past patients (non-attending and deceased) to ensure it is appropriate and being used routinely.

It is good practice to inactivate patients regularly (the inactivation timeframe they haven't been seen for is a clinical decision, but commonly it can be 2 or 3 years). Commonly this task is done 3-6 monthly by the Practice Manager or Practice Nurse. It should go into their calendar and their job description, so if there is staff turnover, it gets handed on to the new staff member and it is not forgotten. Remind reception staff to always check "all patients" when they are looking for patients.

You may consider archiving or inactivating patients one-by-one who do not fit within the practice's active patient definition. This may include:

- Archiving deceased patients.
- Merging duplicate patients.
- Archiving patients with a postcode not relevant to your areas/state.
- Archiving patients that have moved away or no longer attend the clinic.
- Archiving patients that have never attended the clinic e.g. those patients that have registered for an appointment but have never turned up (online bookings).

Resource: Bulk inactivating patients in Best Practice
Resource: Bulk inactivating patients in Medical Director

Implementation

- What is the GPs capacity for appointments?
- Consistent use of templates for GPMP and review of GPMP in clinical software.
- Review consistent recording of patient consent to a GPMP being performed in the patient's clinical record.
- Review current recall and reminder system to ensure a well-defined and effective system is implemented to support GPMP and review of GPMPs. For further information, refer to EMPHN recall and reminder Audit

Patient Bookings

- Consider how long to allocate for each appointment based on GPMP or review GPMP (for GP and nurse time).
- How is the booking recorded in the appointment book to notify practice team the nature of the appointment?
- When will you schedule appointments?

Inviting patients to undertake a GPMP or review of GPMP

- How many of the ten patients will you be offering the GPMP or review of GPMP to at a time?
- How will you send out invitations? SMS, email or personalised letter to each of the ten patients?
- Will your team follow up with phone calls and who will be responsible for this task?

Step 3: Identify patients at urgent risk of hospitalisation and implement strategies for increasing completed GPMP or review of GPMP.

The POLAR Hospital Avoidance Tool (HAT) Report has been developed to calculate a risk score for identified chronic and complex patients based upon a modified Western Harp model. The report highlights a patient cohort that are at risk of hospitalisation within a 12-month period from the time the report is generated. Only active patients that have had at least one visit in the previous 12 months will have a risk score calculated for them.

Tasks to complete this activity:

Developing a list of patients using POLAR

1. Using POLAR Hospital Avoidance Tool (HAT) Report, identify the patients that are at urgent risk of hospitalisation.

Data report to use to identify target cohort	Refer to Hospitalisation Risk topic specific POLAR Walkthrough resources on EMPHN website: **POLAR Walkthroughs** **Note:** This report will provide steps how to identify patients at urgent risk of hospitalisation and those that are eligible for a GPMP or review of GPMP.

2. GP/s and clinical team review the list of patients at urgent risk of hospitalisation and agree on the **ten patients** that are a priority for a recall and that you will focus on to complete a GPMP or review of GPMP.
   To identify your ten patients, consider the following:
   - Identifying ten patients with the highest urgent risk score (refer to POLAR HAT report).
   - Working with one GP and ten of their identified patients.
   - Patients that may have had a recent hospital admission.
   - Patients with multiple comorbidities
   - Patients that have had a change to medications.
   - Patients that have had a significant change to personal circumstances.
   - Patients on your urgent risk list that whose care you are less familiar with.

3. Check list of identified patients to ensure that a GPMP or review of GPMP has not been performed at another clinic.
    - Review patient's My Health Record or My Health App for evidence of previous claims.
    - Log in to PRODA and use the MBS items online checker in HPOS to review claim records. See MBS for HPOS (eLearning)

    If they have already had a completed GPMP or review of GPMP, update relevant patient files and review the urgent risk of hospitalisation patient list again with the team to identify more priority patients.
4. Check the appointments schedule to see if any of the identified eligible patients have any future appointments booked and notate on their record to speak to the patient at time of appointment.
5. Agree on method to contact any remaining patients inviting them to attend the practice for a GPMP or review of GPMP. Note you may want to stagger these to avoid appointment issues.
6. Once all **ten patients** have been reviewed, complete an overall reflection. Consider:
    a. Presenting the overall results with your clinical and non-clinical colleagues at a practice meeting including identified successes and barriers.
    b. Practice-based discussion to be held on how to minimise the barriers and agreement on practice processes to be implemented/amended including actions to improve completed GPMP or review of GPMPs for patients at urgent risk of hospitalisation.
    c. Plan to implement change

Next steps: Consider your next ten patients you will identify and repeat tasks 1-6 above.

Opportunistic engagement with identified patients at urgent risk of hospitalisation

1. Once you have completed your first QI activity with **ten patients**, consider how you can opportunistically identify patients at urgent risk of hospitalisation as an ongoing activity.
2. As a team, identify what tools can be used to identify patients for:
    a. checking the appointments schedule to see if any of the identified eligible patients have any future appointments booked and notate on their record to speak to the patient at time of appointment.
    b. Identification of patients at point of care

Activity Check in

Did you complete any of these activities? If yes, document your completed activity using the PDSA template.

Step 4: MyMedicare registration and My Health Record Shared Health Summary uploads

MyMedicare is designed to strengthen the patient – practice relationship and ensure continuity of care. By having patients register with your practice, you can gain a clearer understanding of your regular patients and improve care coordination, which is especially useful for managing chronic conditions and providing preventative healthcare.

Changes to Chronic Disease Management is coming July 2025 and will be linked to MyMedicare. This gives your practice a great opportunity to start preparing now by:

- Encouraging those patients with a chronic condition or other vulnerable cohorts such as those identified as urgent risk of hospitalisation to register for MyMedicare
- Ensuring current information is uploaded to MyHealth Record, such as Shared Health Summaries

Tasks to complete this activity

For your **ten** identified patient at urgent risk of hospitalisation:

1. Check the list of identified patients in HPOS (MyMedicare tile) or My Health Record to ensure they are not already registered for MyMedicare with the practice or with another practice.
2. Of those patients not registered for MyMedicare, flag in patient management software for a discussion and follow up during their next appointment (this may be the practice nurse, GP or administration staff).
3. During the patient's appointment for a GPMP or review of GPMP, provide sufficient information regarding MyMedicare and registration process including MyMedicare express App and the registration process either through sharing website links and digital leaflets /resources or through hard copies.
4. For those patients that would like the practice to register them for MyMedicare on their behalf, ask the patient to fill out and sign the consent form.
5. For practice led registrations, ensure a copy of the registration form is uploaded to the patient's medical file and complete registration in HPOS (MyMedicare tile, search for the patient and indicate they are registering)
6. At the time of the patient's appointment to complete a GPMP or review of GPMP, upload an updated Shared Health Summary to the patients MyHealth record.

Activity Check in
Did you complete any of these activities? If yes, document your completed activity using the PDSA template

Finishing point

Sustainability check list – maintaining the change

Cyclical nature of PDSAs- Adopt, adapt, abandon	• Adopt: excellent work, embed that change. • Adapt: determine if a change is needed to the plan and start a new PDSA. • Abandon: Rethink the next PDSA • Lessons can be learned from PDSAs that are abandoned. Keep a record of learnings.
Document your improvement activity: Record your competed QI activities to meet PIP QI guidelines	• Record your completion. • Documentation must be kept for 6 years for evidence of PIP QI if your practice is audited by the Department of Health and Aged Care.
Sustaining project outcomes. Consider which practice documentation may need to be updated to include the change:	• Updates to Policy and Procedure manual. • Specific task procedures. • Local signs or instructions. • Staff work practices. • Position descriptions. • Staff induction. • Staff skills development or education.
Communication is key to finishing a successful project. Consider:	• QI project outcome feedback to staff. • Present project strengths and challenges. • Feedback to patients, where appropriate.

	• Consider Incorporating this as part of your practice preventative health care promotion activities.
Celebrate success	• Celebrate your outcomes and achievements by sharing a with a morning tea with your team. • Consider sharing your practice improvement activity efforts with your patients through practice newsletters, website or waiting room. E.g. displaying 'run charts' to demonstrate change over time.
Review and reflect	• Discuss project strengths and challenges. • Annually review the PDSA outcomes to ensure activities are still being adhered to and completed • Annually review and audit your at-risk patients to identify any new urgent risk patients to take through the process • Where to next on your continuous QI journey? review the patients categorises as high risk and determine which ones will be actioned. • Consider potential topics for a new CQI activity, and how your experience with this activity can help you to be more efficient and effective

Appendix A: Activity Measurement and Tracking Table

Baseline measurement:	***Baseline Measurement***	**End of activity measurement:**
Total number of patients at urgent risk of hospitalisation at your practice	Number: Date:	Number: Date:
Total number of patients at urgent risk of hospitalisation that are eligible for a GPMP at your practice	Number: Date:	Number: Date:
Total number of patients at urgent risk of hospitalisation that are eligible for a review of GPMP at your practice	Number: Date:	Number: Date:

Patient	**Prior to patient engagement**				**Engagement**	**Post engagement**		
	Is patient classified as urgent risk of hospitalisation (Y/N)	Has had a completed GPMP or review of GPMP in past 12 months? (Y/N)	Is registered for MyMedicare? (Y/N)	Has had a Shared Health Summary uploaded in the past 12 months? (Y/N)	Has patient been contacted? (Y/N)	Has had a completed GPMP or review of GPMP? (Y/N)	Is registered for MyMedicare? (Y/N)	Has had a Shared Health Summary uploaded? (Y/N)
Patient 1								
Patient 2								
Patient 3								
Patient 4								
Patient 5								
Patient 6								
Patient 7								
Patient 8								
Patient 9								
Patient 10								
TOTAL								