

# Winter Wellness Quality Improvement Guide

## Aim of this guide

This quality improvement guide has been designed to support practices to keep their most vulnerable patients well and reduce their likelihood of being hospitalised this winter.

Each winter the demand for healthcare increases due to the increased prevalence of seasonal conditions and infectious diseases as well as the exacerbation of existing conditions due to seasonal changes. Older patients and patients with existing chronic and complex conditions are especially vulnerable during this time. During the COVID-19 pandemic, it is especially important that these patients are provided with regular, proactive care.



This guide outlines a simple approach your practice can take to identify your vulnerable patients and provide them with proactive support during the winter period. To further support your practice with these quality improvement activities, a snapshot of annual hospitalisation data in your region has been provided in this guide. For more specific data to your region please contact your PCLO.

## Step 1. Identify patients

The first step is to identify patients that would benefit from enhanced support during winter. 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
- would not be surprised if this patient were to go to hospital in the next six months.

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 winter care

Review and update patients' existing care and plan for the winter using Sick Day Action Plans. Adoption of these Action Plans can be supported by regular patient check-ins over the winter period.

[www.brisbanenorthphn.org.au](http://www.brisbanenorthphn.org.au)

Level 1, Market Central  
120 Chalk Street, Lutwyche QLD 4030  
PO Box 845 Lutwyche QLD 4030  
t 07 3630 7300 f 07 3630 7333

Level 2, 10 Endeavour Boulevard  
North Lakes QLD 4509  
PO Box 929 North Lakes QLD 4509  
t 07 3490 3490 f 07 3630 7333

## 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 during winter 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	<a href="#">National Asthma Council Australia – Asthma Action Plan</a>	<a href="#">MD</a>	<a href="#">BP</a>
Anaphylaxis	<a href="#">ASCIA – Action Plan for Anaphylaxis</a>	<a href="#">MD</a>	<a href="#">BP</a>
Chest Pain	<a href="#">Heart Foundation – Heart Attack Action Plan</a>	<a href="#">MD</a>	<a href="#">BP</a>
Chronic Kidney Disease	<a href="#">Chronic Kidney Disease Action Plan</a>	<a href="#">MD</a>	<a href="#">BP</a>
COPD	<a href="#">Lung Foundation Australia – COPD Action Plan</a>	<a href="#">MD</a>	<a href="#">BP</a>
COPD for Indigenous patients	<a href="#">Lung Foundation Australia – Indigenous COPD Action Plan</a>	<a href="#">MD</a>	<a href="#">BP</a>
Delirium	<a href="#">Delirium Action Plan</a>	<a href="#">MD</a>	<a href="#">BP</a>
Heart Failure	<a href="#">Queensland Health – Heart Failure Action Plan</a>	<a href="#">MD</a>	<a href="#">BP</a>
Type 1 Diabetes	<a href="#">Sick Day Action Plan</a>	<a href="#">MD</a>	<a href="#">BP</a>
Type 2 Diabetes	<a href="#">RACGP – Sick Day Action Plan</a>	<a href="#">MD</a>	<a href="#">BP</a>
General	<a href="#">General Action Plan</a>	<a href="#">MD</a>	<a href="#">BP</a>

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 planning for winter with 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 winter: 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  
HEALTH<sup>1</sup>

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

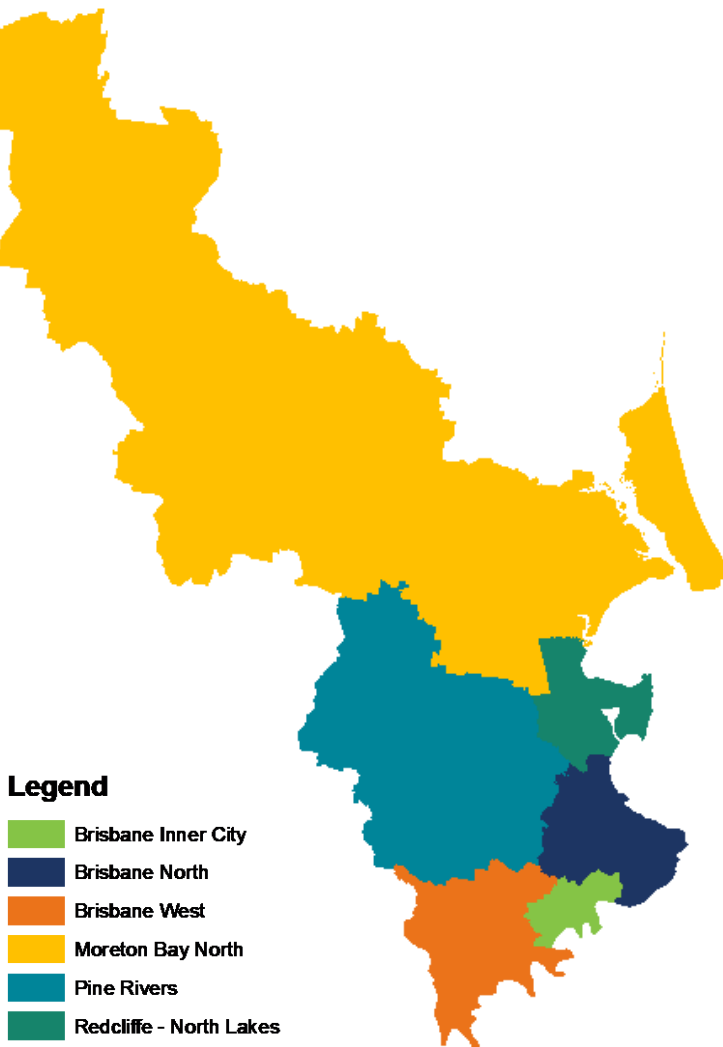


ALL  
POTENTIALLY  
PREVENTABLE  
HOSPITALISATIONS

3,100 preventable hospitalisations per 100,000 people

<sup>\*</sup>All rates above are average age-standardised rates – this means the differing age distributions between regions have been accounted for.

<sup>1</sup>Mental 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 <sup>1</sup>	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
<b>All Potentially Preventable Hospitalisations</b>	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.”