Improving Physical Health Monitoring in the Community (CPA Patients)

Project lead: Kaz Iwata

Project team: Kaz Iwata, Iyas Assalman, Iris Gibson, Thembi Mahlangu, Marian Cassidy.

Project sponsor: Dudley Manns

Background

- Why you chose this project

Patients with severe mental illness have a substantially higher morbidity and mortality rates compared to their counterparts in the community, and metabolic syndrome (which is linked with antipsychotic use) is strongly associated with premature death.

Monitoring of these patients can get missed by both primary and secondary care, and effective systems need to be in place to identify these patients and ensure they do not fall between services. Preventative measures need to be instituted.

Initial audit of CPA documents showed 0% documented physical health data.
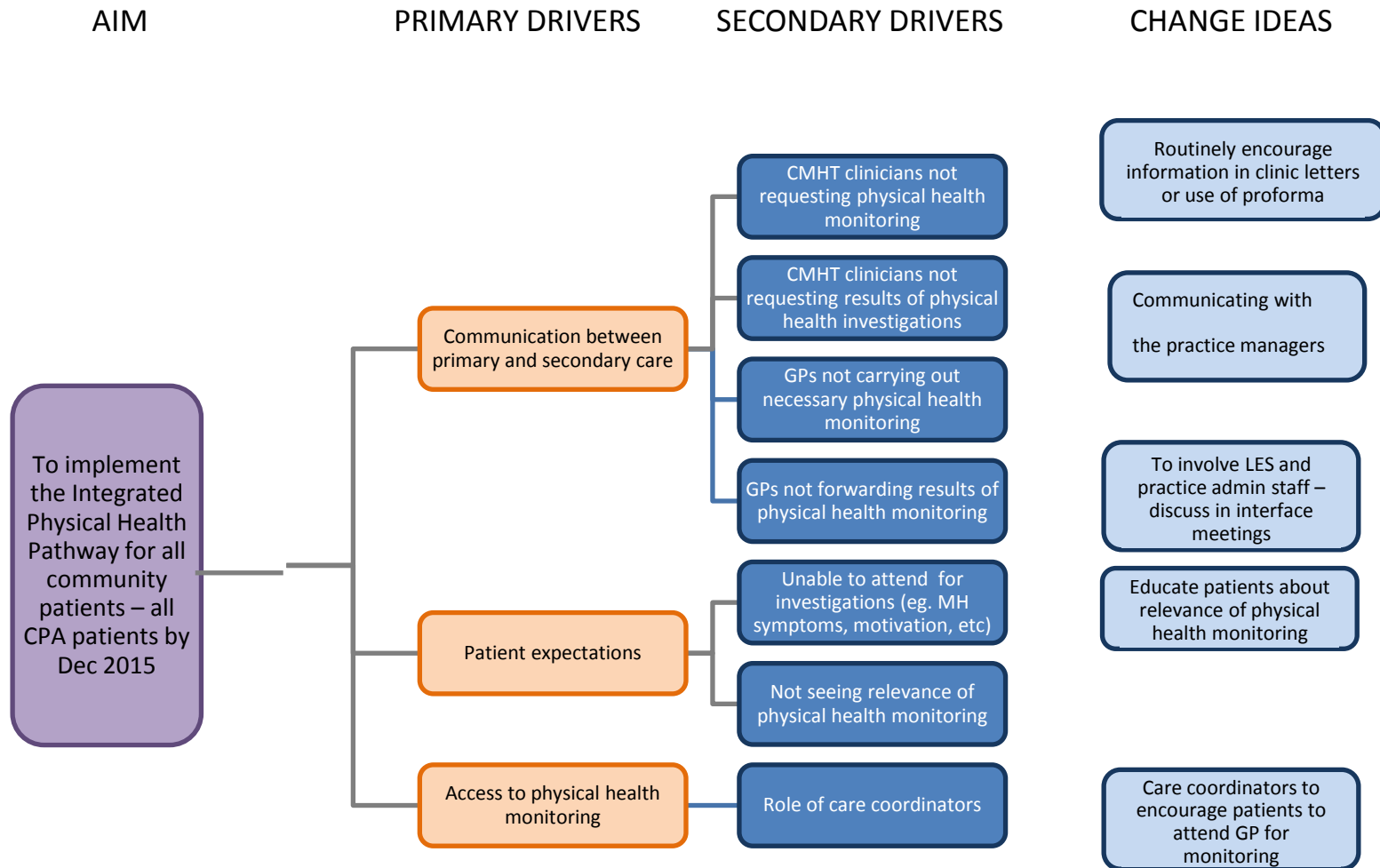
- What was the problem?

Physical Health is currently not routinely monitored or documented in the CPA document.

- Project aim

To implement the Integrated Physical Health Pathway for all CPA patients by Dec 2015.

Improving Physical Health Monitoring in the Community (CPA Patients)

AIM | PRIMARY DRIVERS | SECONDARY DRIVERS | CHANGE IDEAS

To implement the Integrated Physical Health Pathway for all community patients – all CPA patients by Dec 2015

Communication between primary and secondary care

- CMHT clinicians not requesting physical health monitoring
- CMHT clinicians not requesting results of physical health investigations
- GPs not carrying out necessary physical health monitoring
- GPs not forwarding results of physical health monitoring

Patient expectations

- Unable to attend for investigations (eg. MH symptoms, motivation, etc)
- Not seeing relevance of physical health monitoring

Access to physical health monitoring

- Role of care coordinators

Change Ideas:

- Routinely encourage information in clinic letters or use of proforma
- Communicating with the practice managers
- To involve LES and practice admin staff – discuss in interface meetings
- Educate patients about relevance of physical health monitoring
- Care coordinators to encourage patients to attend GP for monitoring

PDSA cycles

- Change ideas for testing and data collection:

1) Designed an addendum to CPA document to facilitate recording of physical health data/ information.

2) Writing to GP Practice' managers in comparison to writing to GPs requesting physical health data/information.

What next?

Physical Health Monitoring		
Baseline Patient Summary from GP	Date Requested:	Date Received:
Physical Health Notes		

GP Request Date		**GP Request Date**		**GP Request Date**		**GP Request Date**	
Result date		Result date		Result date		Result date	
Weight or BMI		Weight or BMI		Weight or BMI		Weight or BMI	
Blood pressure		Blood pressure		Blood pressure		Blood pressure	
Fasting glucose or HbA1C		Fasting glucose or HbA1C		Fasting glucose or HbA1C		Fasting glucose or HbA1C	
Cholesterol		Cholesterol		Cholesterol		Cholesterol	
LDL		LDL		LDL		LDL	
HDL		HDL		HDL		HDL	
Trig		Trig		Trig		Trig	
Smoking status		Smoking status		Smoking status		Smoking status	

GP Request Date		**GP Request Date**		**GP Request Date**		**GP Request Date**	
Result date		Result date		Result date		Result date	
Weight or BMI		Weight or BMI		Weight or BMI		Weight or BMI	
Blood pressure		Blood pressure		Blood pressure		Blood pressure	
Fasting glucose or HbA1C		Fasting glucose or HbA1C		Fasting glucose or HbA1C		Fasting glucose or HbA1C	
Cholesterol		Cholesterol		Cholesterol		Cholesterol	

Learning

- ## What did you learn?

challenges

- Apparently simple aim has proved more complex to make happen
- Finding time to meet regularly.
- Encouraging care coordinators/Team to embrace changes in practice. For this to be effective need – admin, cc's and Drs working together.

Positives

- Accepting the project will take time
- Looking at achieving aims in different ways

What next?

- <u>What will you be doing in your project next?</u>

Further consultation with QI team.

Continue to carry out test mentioned .

Involve primary care liaison nurses

Thank You