

Increasing General Practice Frailty Screening

*Toolkit for
age group 40-70*

A practical guide to identify patients with or at risk of frailty in primary care and to support healthy ageing initiatives as a CQI activity and for PIP-QI and CPD purposes.



An Australian Government Initiative

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As the global population ages, the prevalence of frailty is increasing, leading to increased demands on healthcare systems. Frailty is a state of increased vulnerability to adverse health outcomes, including disability, falls, hospitalisation, and death. Early detection and intervention for frailty can improve health outcomes and reduce costs to the healthcare system. This toolkit provides GPs and practice nurses with an approach to support the case finding, assessment and management of people living with, or at risk of frailty.

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While the Australian Government helped fund this material, it has not reviewed the content, and neither it nor the Adelaide PHN are responsible for any injury, loss or damage however arising from the use of or reliance on the information provided herein.

The Toolkit has been developed by Bollen Health as part of the Early Identification of Frailty project commissioned by Adelaide Primary Health Network 2023-24. This project has a focus on people aged 40-70 years, but the approach is also applicable for people aged over 70.

Aim

The aim of the Early Identification of Frailty project is to increase the screening for frailty in people aged 40-70 years in a general practice setting. The project is a quality improvement sprint over 90 days and will involve a series of activities designed to raise awareness of frailty, increase the capacity of general practitioners and primary care nurses to identify and manage frailty, and support patients to make lifestyle changes that can reduce the impact of frailty on their health.

This project is also supporting the participants working in General Practices to recognise their own healthy ageing trajectory, and to understand their own barriers to “living younger longer”.

The Scenario

There is an increase in chronic conditions and ageing across the community a general practice serves. GPs, nurses, and practice administration staff see the impact of what happens to people aged 75-105. The trajectory of ageing varies, and the impact for some is worse than others. However, the onset of frailty and pre-frailty can occur many years earlier, and is frequently not recognised, not treated and consequently the frailty complications of falls, fractures and early loss of independence will occur.

This project is about the early identification of people aged 40-70 at risk of or living with frailty in your general practice population. The Asia-Pacific Clinical Practice Guidelines for the Management of Frailty¹ describe the evidence now available which shows earlier interventions can change the trajectory of decline. Identification of frailty at late stage makes it harder to support improvements.

The University of Adelaide Centre of Research Excellence in Frailty and Healthy Ageing has developed Australian local area frailty maps showing current and projected frailty prevalence. Review the prevalence of frailty in your practice area using the online maps:

<https://health.adelaide.edu.au/frailty-healthy-ageing/research/geography-of-frailty>

Project Methodology

1. Training and education

GPs and Practice Nurses will receive training and education on the importance of frailty screening, and how to identify and manage frailty in their patients.

2. Selfcare

Introduction to the role of participants own frailty self-assessment using an online test: <https://www.benetas.com.au/pat>

3. Continuous Quality Improvement

Review and improvement of key data collected in medical software linked to frailty risk factors will occur over the project with a fortnightly PDSA cycle occurring.

4. Screening and assessment

GPs and Practice Nurses will be provided with tools and resources to help them screen for frailty in their patients. The screening will involve a simple assessment, asking questions about physical function, and other factors that can suggest frailty. Objective measures to assess function and risk of sarcopenia, a key determinant of physical frailty, will be described and demonstrated for practical everyday use in a General Practice.

5. Follow-up and management

For patients who are identified as frail, GPs and practice nurse will provide support and advice to help them make lifestyle changes that can reduce the impact of frailty on their health. This may include social prescribing, referrals to other healthcare professionals, such as dietitians, psychologists, physiotherapists, exercise physiologists, or the provision of information and resources to support self-management. The expansion of each practice's Local Healthcare/ Medical Neighbourhood directory is a key output from the project.

6. Evaluation

The project will be evaluated by a team from Flinders University to assess its impact on the screening and management of frailty in general practice. This will involve collecting data on the number of patients screened, the number of patients identified as frail, and the outcomes achieved through the project. Each practice is required to identify and code in the medical software a minimum of 20 patients living with frailty over the 90 days.

Frailty Definition

There is no current “gold standard” definition of frailty, but it is generally recognised as a condition that meets three of five criteria, as described in 2001 by Dr Linda Fried et al². These criteria are:

1. **Low physical activity**
2. **Weak grip strength**
3. **Low energy**
4. **Slow walking speed**
5. **Non-deliberate weight loss**

The first workshop will discuss in more detail the concepts of frailty, its consequences, and complications. In preparation for the first workshop a suggested reading is Chen et al³, “Approach to frailty in the elderly in primary care and the community”, accessed online <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5966632/>

Healthy ageing and being robust and resilient, is the opposite of frailty. Another way of discussing this is our “intrinsic capacity”. Intrinsic capacity is defined as the sum of individual physical and mental abilities⁴. It contains 5 domains:

- **Locomotor**
- **Psychological**
- **Sensory**
- **Cognitive**
- **Vitality**

The determinants of successful ageing are now increasingly recognised and early intervention in improving the intrinsic capacity between ages 40-70 can make a difference for changing the trajectory. Traditionally the recognition of frailty has been linked to a person’s chronological age. As more research into ageing is

occurring, the concept of biological age vs chronological age is now better understood. This has an important bearing on when and in whom we should be recognising frailty.

According to the RACGP aged care clinical guide (Silver Book),⁵ frailty is ‘a syndrome of physiological decline that occurs in later life’, and is associated with ‘vulnerability to adverse health outcomes’ – but age alone ‘does not define frailty, and frailty is not an inevitable consequence of ageing’. The RACGP Silver Book recommends frailty is best assessed annually using a validated measurement tool.

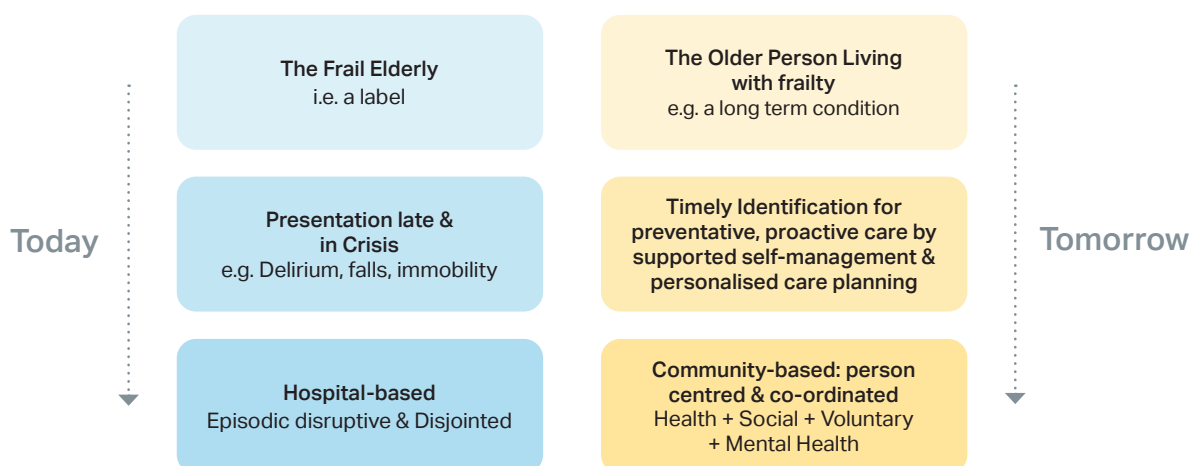
And while undernutrition is among the factors associated with increased frailty, the Silver Book also identifies that obesity may be a factor due to its contribution to a ‘pro-inflammatory state’. The increased inflammatory capacity of fat cells and their infiltration into muscle cells can enhance naturally occurring age-related decline in muscle mass and strength, also plays a role.

The loss of muscle mass is called sarcopenia. When this decline in muscle mass and strength occurs in conjunction with BMI > 30, it is known as “sarcopenic obesity”, which is linked to an increased risk of frailty and disability.

In 2015 frailty was described as a long-term condition by Professor John Young et al⁶. As a result, frailty should be managed like common chronic conditions such as diabetes (see figure 1). The concepts of chronic condition management have been well documented by several models such as the Flinders and Stanford models of chronic disease self-management and the Wagner model of chronic condition management⁷. Using the core concepts of these models, screening for, identification, early intervention, patient education and self-management can prevent frailty progression and potentially reverse frailty if identified early enough.

Care Paradigm for Older People & Frailty

Figure 1. Frailty is a long term Condition



How to use the toolkit

During the healthy ageing- frailty early intervention quality improvement sprint there are 12 weeks of activity with five cycles of quality improvement using the Plan-Do-Study-Act approach. (see detailed description of the sprint in separate handout).

The toolkit outlines the steps for improving care in your general practice based upon the following

Improving the formal screening for frailty in people aged 40-70

Improving the use of objective measures for assessing sarcopenia in people aged 40-70

Improving the number of people aged 40-70 with a coded diagnosis of frailty

Improving the risk factor identification data in the age group 40-70

Improving the documentation of height/weight

Improving collection of waist measurements

Improving the documentation of smoking status

Improving the documentation of physical activity

Improving the whole person care of people aged 40-70 with psychosocial distress/mental illness

Improving the whole person care of people aged 40-70 who are at high risk of hospital admission

Step 1 Planning and preparation

All General Practices should commence planning improvement based upon a focus on the Quintuple Aim objectives, which are:

- Improving the patient experience
- Improving the quality of care of the practice population
- Improving the General Practice financial sustainability
- Improving the daily “joy in work” experience / sustainability of the hardworking General Practice team exhausted by the chaos of COVID.
- Improving the overall practice care system to support health equity (This is often difficult to focus on when the practice survival is paramount. In this project, remember health inequalities persist into old age.).

To support sustainability of the team in this project we encourage all participants to reflect on their own health and ageing trajectory! Self-assess your own frailty risk using the Benetas online tool

<https://www.benetas.com.au/pat>

Improvement in your general practice requires an understanding of two clear components.

The science and technology elements which includes:

- Tools such as the “Model for Improvement”
- The data
- The workflow
- IT systems
- Guidelines

The relational elements which include:

- Leadership
- Meeting structures and agendas
- Engagement with the team
- Communication quality
- Teamwork
- Motivation
- Dealing with resistance to change

Dr Neil Baker⁸, consultant in Quality Improvement recommends the following:

“80% of your time for improvement does require to be spent on the relational elements, and 20% on the science and technology elements”.

In quality improvement, the people who do the work need to be the ones to change the work in order to improve their day as well as improve the patient outcomes. This requires an interdisciplinary improvement team with a representative from GPs, nurses and admin/reception, as well as support from practice leadership to empower the changes across the practice. Involve the whole team in the planning stages for creating a shared purpose and long-term sustainability.

Steps for planning and preparation

Practice mapping

- Identify the stakeholders who can affect your QI project at an early stage.
- Who will be supporters of change?
- Who will be resisters of change?
- Brainstorm and list the stakeholders. What’s the relationship between the groups?
- What are the stakeholder motivations which may act as facilitators or barriers?
 - Patient care
 - Finances
 - Process efficiency
 - Staff satisfaction
 - Staff recognition

GPs have the most influence on variation in healthcare outcomes, so time spent on supporting them to understand the benefits of the improvement will reduce resistance to changes.

Strategies to improve engagement of GPs include:

- Data transparency (put everyone’s data on the tearoom wall)
- Strong organisational commitment to QI
- Showing GPs how QI can lead to more time in the day for direct patient care.
- Make QI easy!
- Having common purpose
- Remuneration
- Incentives

What about the role of patients in improvement projects?

- Identifying improvement opportunities
- Creating a sense of urgency for change with storytelling
- Acting as an outlet to discuss other patient experiences.
- Offering change ideas to redesign systems of care
- Persuading GPs and nurses that quality of care problems exist and need to be addressed.
- Challenge the assumptions that the current level of care is acceptable.
- Lending credibility to system changes by showing that the proposed improvements are likely to be well received by patients and care givers
- Providing self-assessment tools like the Patient Assessment Tool from Benetas
<https://www.benetas.com.au/pat>

For the early intervention in frailty project, the preworkshop worksheets support the practice team to answer the following questions:

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in an improvement?

Not all change is an improvement, but all improvement requires change.

The PDSA model relies on the content knowledge of GP, nurses and reception/administration staff to identify changes that are predicted to lead to an improvement. Your improvement team, to be effective, must contain a member from each of these groups in the practice who is committed to be actively involved.

The focus in the improvement sprint is the rapid cycle, every 2 weeks where the practice team develops a habit of immediate and sequential changes to learn which interventions in which contexts produce improvements.

Model for improvement teaches teams to avoid starting without thoughtful planning. The baseline data, and questions which are being asked in this sprint are designed to trigger discussion about the cause of a quality-of-care problem or a change idea.



Step 2

Using data to set goals and identify suitable patients

In the frailty screening improvement sprint the concept of SMART goals is important. The goals should be:

- **Specific**
- **Measurable**
- **Achievable**
- **Realistic**
- **Timed**

Example of a SMART goal

Practice A decides to focus on screening for frailty all patients aged 40-70 having a care plan over a 2-week period. There are currently on average 10 patients per week being seen for care plans in this group. The goal will be to assess 20 patients and report back in 2 weeks.

Example of a Non-SMART goal

Practice B decides to focus on screening for frailty all patients aged 40-70 being seen in the practice for any reason. The GPs and nurses will identify patients during their routine work and see how they go in a few weeks.

Measures

How will we know a change is an improvement?

Measuring for improvement focuses on monitoring the outcomes of a practice system over time to learn if the processes are effective.

The emphasis is on learning how potential interventions have affected processes and outcomes, so subsequent improvement steps can be taken.

Areas to consider

- **Clinical outcomes**
- **Patient experience**
- **Smart resource usage**
- **Increased use of item numbers**
- **Clinician feedback**

Examples of Measures

Outcome measures

Evaluate the effect of the system on patients such as rates of hospitalisation, rates of falls. This data is currently difficult to capture, but by discussing this with Bollen Health there are ways to be provided with information about your patients who attend public hospitals across South Australia.

Other outcomes can be measured by changes in the following:

- Improvement in patient assessments for sarcopenia such as sit to stand times, grip strength, timed up and go, and/or walking speed.
- The % of patients aged 40-70 coded with a diagnosis of frailty.
- Patient reported outcome measures (PROMs) such as the PROMIS-29 https://aci.health.nsw.gov.au/__data/assets/pdf_file/0006/632859/Patient-Reported-Outcome-Measures-Information-System-PROMIS-29-Profile.pdf

Process Measures

Evaluate system performance and potential changes such as:

1. Use of assessments (such as, height/weight/waist measures/smoking status/physical activity status/ K10)
2. Improved care plan/health assessment templates which have the frail screen tool, and sarcopenia assessment tools
3. Number of referrals to exercise physiologists, physiotherapists, Strength For Life programs, psychologists, and/or dieticians
4. Number of patient education sheets distributed on protein and exercise.
5. Use of MBS item numbers such as health assessments, care plans, heart health checks for people aged 40-70.
6. The % of people aged 40-70 who had an assessment using a FRAIL screening tool.
7. The number of assessment tools in the practice which incorporate a FRAIL screening tool eg:
 - Care plans
 - Mental health care plan assessment
 - Care plan review
 - Health assessments for:
 - Veterans health
 - Intellectual disability
 - Refugee health
 - Intellectual disability
 - 45-49 yo
 - 40-49 yo diabetes risk assessment
 - Heart health checks
8. The % of patients aged 40-70 assessed as frail or prefrail referred to make a change in their lifestyle which may include at least one of the following:
 - Resistance muscle exercise
 - Medication review
 - Social support
 - Lifestyle counselling
 - Dietary Protein advice
 - Assessment of fatigue

Balancing Measures

Whenever changes are made to a practice system, it is important to record the balancing measures which track the unintended consequences of your chosen intervention.

Remember the Quintuple Aim!

Examples

- adding another step to a proactive care visit what effect does this have on the dynamics of the practice?
- longer appointments... what's the impact?
- more complicated discussions
- change in nurse satisfaction.
- change in GP satisfaction.
- change in patient satisfaction.

How will you offset this?

Anticipating, understanding and accounting for these factors will allow you to construct a practice delivery system which is more robust in meeting the needs of your patients and ensuring participation of the practice team.

When selecting any measures, convenience of data collection needs to be considered. Readiness to capture data impacts the success of the improvement project.

- Who will do this? (delegation task)
- Is it able to be extracted easily in electronic format?
- Or is it recorded on paper?

Baseline data is required before commencing the sprint otherwise it's impossible to ascertain that a problem exists or that an improvement has occurred. (see the worksheets provided by Bollen Health which describe the required baseline data)

Usually, 3-5 measures is sufficient. The measures should be simple to collect, accurate and reproducible. The goal is not perfect measurement but rather to determine whether the changes have improved the practice system. It is important when selecting these measures to recognise what needs to be captured, by whom and how.

Example A practice decides that the Timed 5 sit to stands assessment is to be measured. It is both a process measure (the physical act of doing the initial assessment) and an outcome measure (reassessment after 6-12 weeks to assess change in time, which is a function of muscle strength). The primary care nurse is doing the timed sit to stands in the new health assessment/care plan for 40-70 yo. The nurse is delegated to record the number of sit to stand tests, and the individual times can be entered into a spreadsheet (paper or electronic) at each patient encounter and reviewed each week/fortnight.

It is important to define, document and delegate specific roles and responsibilities in your practice sprint team to ensure every team member has a clear understanding of their role and responsibility to achieve the shared sprint goal.

Step 3 Implement improvement actions

What changes can we make that will result in Improvement?

This has two parts:

1. Identify the changes...ideas from colleagues, evidence, theory or experience.
2. Test the idea using PDSA...it's not supposed to be perfect...it's about trying ideas in a low-risk environment that may encounter resistance, and encouraging buy in as success is shown on a small scale before widespread implementation ideas... it requires planning, practice and a systematic approach.

Examples of improvement actions in a frailty screening improvement sprint for 40–70-year-olds

- Embed the FRAIL screening tool into processes for health assessments, care plans, mental healthcare plans and care plan reviews using an autotext (such as /FRAIL) or edit the templates.
- Embed prompts for assessing sarcopenia such as grip strength, timed sit to stand test, Timed Up and Go, into processes for health assessments, care plans, mental healthcare plans and care plan reviews using an autotext or edit the templates.
- Identify patients aged 40-70 with two or more risk factors for frailty such as:
 - BMI > 30, and who smoke
 - a diagnosed mental illness and BMI > 30
 - Increased waist measurement and low physical activity
- Invite these identified patients to attend the practice to have a health assessment or care plan or heart health check (Check MBS eligibility criteria).

Targeted Intervention for identified frailty

Once a person has been assessed as prefrail (score 1-2 on FRAIL screening tool) or frail (score 3+), a management plan that addresses the relevant deficits of the persons FRAIL scale should be developed. A frailty management and decision tool can be utilised to support the plan.

Example https://sydneynorthhealthnetwork.org.au/wp-content/uploads/2019/06/Frail-SNHN-DL-Brochure_6.0-6.pdf

A targeted approach could include:

- The patient's own goals. What do they want to be doing more of? What can they not do...what is their barrier to doing this?
- Healthy eating which includes an increase in protein rich foods and a decrease in carbohydrate and sugar rich foods. (a patient handout on protein rich foods is available)
- Discussion about simple resistance exercises to build muscle strength at home (a patient handout on sit to stand exercise program is available)
- Referral to a resistance exercise class such as Strength for Life
- Referral to an appropriate allied health professional such as physiotherapist, exercise physiologist, dietician, or psychologist.
- Reviewing medications and consider deprescribing or referral for Home Medication Review (HMR item 900)
- Referral for social prescribing from your practice's Local Healthcare Neighbourhood directory
- Further assessment of fatigue to assess for medical causes such as anaemia, diabetes, heart failure, medication side effects, or depression.

Step 4

Regularly review the improvement activity

This healthy ageing frailty screening sprint project has huddles programmed for the practice every 1-2 weeks in order to review the practice's improvement activities.

Each PDSA cycle yields the results which inform the next, and so on, towards the eventual goal. This rapid cycle change can be thought of as building a wall out of bricks rather than pouring a concrete floor. In the case of a wall, each brick's placement can be examined and used to decide where the next brick should go⁹. The weekly huddles help to maintain momentum and keep the team on track to successfully make improvements over time and discuss any obstacles to progress. It also adds accountability to the program to support effective and sustainable improvement.

What happens at the weekly 45-60-minute huddles?

This is an opportunity to review the practice improvement activity. During the planning phase the practice team would be aware of the 2 weekly timelines for each PDSA activity. The huddle times are marked in the practice diary for each of the 12 weeks of the sprint.

At these huddles the following is likely to occur:

- Review the overall progress
- Review the data which is being measured (who is delegated to prepare and present the data?)
- How is progress towards the goal?
- What is working well?
- What could have worked better?
- Document these points as learning from your failures is just as important...if not more than your successes.
- Identify any barriers or challenges to the progress. Discuss these with the team as well as utilise Bollen Health's expertise during the huddle to come up with solutions to overcome the barriers.



Step 5 Sustain and Maintain improvements

To achieve sustainable change, quality improvement initiatives must become the new way of working rather than something added on to routine clinical care. However, up to 70% organisational change is not maintained according to Beer and Nohria¹⁰. To better understand this, your practice will need to consider strategies to sustain and support quality improvement. Threats to sustainability may be identified both at the beginning of a project and when it is ready for implementation.

Tools to help sustain improvement include:

- performance boards showing the practice data
- standard work check lists
- improvement huddles

These tools are a way of socialising the change across the practice. It requires communication to all practice team members and leadership. Standard work has a check list for a task and provides a framework to ensure that changes that have improved patient care are consistently and reliably applied to every patient encounter.

Improvement huddles are short regular meetings amongst the General Practice team to anticipate problems, review performance, and support a culture of improvement.

It's important that these tools are highly visible and are embedded in your practice system... examples:

- a huddle is marked on the booking board for all involved
- a what's app group is formed for the topic
- the progress is in colour pictures on the tearoom wall, or even better on a wall for patients plus the practice GPs and nurses to see
- the project is on the agenda for every practice meeting
- training for any software changes occurs
- education about the changes for patients
- SMS to patients to inform of any changes including a survey pre/post appointment to get their feedback

Even when quality improvement methods are correctly applied, the success of your project still depends on contextual factors. What are these?

- Leadership support
- Competing interests such as accreditation, focus on MyMedicare etc
- Data infrastructure such as PENCAT and practice software
- Team engagement and motivation.
- Team performance.

For these reasons, the same project in one practice may thrive in a supportive context and fail in another due to the different context.



Step 6

Document the improvement activity

Document the activities using the supplied worksheets and QI action plans. If you are using this activity to meet your practice PIP-QI activity or for logging specific CPD hours (reviewing performance and measuring outcomes) the documents will require to be saved, and potentially uploaded (eg a GP's RACGP CPD portal) as evidence of participation.

Documentation must be kept for 3 years and may be audited by RACGP or Department of Health and Aged Care.

Documents for this improvement activity include:

- Worksheets for data collection prior to workshops 1, 2 and 3
- Huddle meeting minutes.
- Frailty screening QI action plan template
- Practice policies and procedure documents- reminder that changes can be saved as evidence for PIP-QI

Process mapping for improving the assessment of frailty in people aged 40-70

Another way of improving care is creating a process map¹¹ of a current assessment or task. Process mapping is a well know approach to understanding practice systems and getting feedback on areas of waste, where waste may be:

- Time (patient, GP, nurse, reception)
- Duplication of effort
- Use of Resources
- Money

What's the current system in your practice for assessing the health of a person aged between 40-70 years old?

- Identify the steps in the current practice process.
- How does this vary across the practice?
- Understand the inner workings of a relationships of processes.
- Enables the identification of differences between how a process actually works and how it is thought to work.
- Clarifies responsibility for work performed in a process.
- Uncovers potential problems, bottle necks and waits, unnecessary /low value steps, duplication, omission or unnecessary complexity.

Map the actual process not the ideal process. And also include the patient action (or lack of) in any steps.

Development of change concepts:

1. Eliminating waste

- Understanding the waste
 - Recognise which patients to focus on as not every person aged 40-70 needs a frail screen, and many frail/pre-frail patients do not get recognised easily without a screening tool.
 - Big question ...is what we currently doing making a difference?
- Role of the team vs the individual clinician
- Eliminate steps ...eg can patient complete questionnaires, surveys, use SMS reminders before attending the practice

2. Designing systems to avoid mistakes and omissions.

3. Changing the work environment

- Improving education about frailty and what can be done.
- Training staff appropriately on practice systems
- More communication about the issue. Socialise the change.
- Provide patient education on healthy ageing.

Brainstorming of ideas

- Mental benchmarking- how would another industry solve this problem?
- Theory of inventive problem solving (TRIZ)¹²
 - ask a team member how to ensure the problem continues eg Ask what can be done to ensure no patients are screened for frailty?
 - collate the maladaptive activities
 - How many of these ideas are currently being practiced?
 - What can be changed to improve care?

Why visually present the information?

Making data of an improvement more visible across the practice supports socialising the change. Invisible data leads to less discussion, less focus and less accountability in a general practice. The saying "what gets measured, matters" remains true, but even more powerful, is displaying the measures and the progress visually to show more people what matters.

Worksheet for Pre-Workshop #1 Data collection

The first set of data to be collected is found on the **Healthy Ageing Early Intervention Frailty project: Practice Worksheet #1 which is distributed as a separate document.**

This data should be collected before the first workshop and will be discussed at the workshop and the first huddle.

Please allocate time for the PENCAT extractions and at least 60 minutes for the team discussion to identify gaps. Please involve the GP champion in the discussion.

(Please note: if a GP or RN is involved in discussing this data, self logging of time for "reviewing performance" CPD hours can occur)

For more details on the required PENCAT extraction steps, please refer to the Bollen Health "How to Guide".

Telling the story of frailty risk in your practice!

When embarking on a quality improvement project, it is important to understand the size of the potential problem. Please use your PENCAT tool to research and discuss the following questions.

1. What is the current population (number and %) of your active patients aged 40-70? (RACGP definition of active is having had clinical encounter at least 3 times in the past two years (this includes telehealth, in surgery consultation or home visit))
2. Break the group up into 10-year age groups and review the active patient numbers for each group.
3. List the potential "touch points" in your practice for each of these age groups. (ie what sort of clinical encounters trigger the patients to be seen at the practice?)
4. PENCAT can be used to show the overall practice performance in the past 12 months of utilising specific item numbers for the active patient group aged 40-70. (remember to use the MBS date range in the top PENCAT filter!) What have you noticed about the item number usage?

In the age group 40-70, the following risk factors for developing physical frailty are recognised:

- BMI >30 and/or Increased waist measurement
- Smoking
- Low levels of physical activity
- Having Diabetes Mellitus (type 1 or type 2)
- Psychosocial distress/mental illness

The following questions are useful to trigger discussion amongst your team.

- What are the current ways you recognise people living with frailty in the group aged 40-70?
- How else could you recognise frailty in this group?
- If your practice team (GPs, nurses and admin) does not easily recognise frailty risk factors in the age range 40-70, what would you need to be doing to change this?

As part of this early intervention project, your aim is to help your practice improve its performance in this area.

Review the patients seen over a 4-week period for all doctors and nurses and complete the following data extraction tasks:

- a. Calculate the number and % of patients aged 40-70 seen in your practice over a 4-week period.
- b. What % of these patients aged 40-70 are booked for care plans, mental health care plans, heart health checks or health assessments?
- c. What % of these types of patient encounters are seen only by GPs? What % are also seen by practice nurses? (estimate only)

Please answer the following questions:

- a. Which templates are used for the care plans/health assessments?
- b. How many templates exist across the practice for each assessment type?
 - a. Health assessment 40-49
 - b. Health assessment 45-49
 - c. ATSI health assessment
 - d. Refugee health assessment
 - e. Heart Health Check
 - f. Veterans' Health Check
 - g. Mental Health Care Plan
 - h. Chronic Disease Care Plan 721
 - i. Chronic Disease Care Plan Review 732
- c. How have the team been educated on each of the templates' use?
- d. How is average weekly physical activity quantity and type captured in your care plans and health assessments?
- e. How is nutritional status captured in care plans and health assessments?
- f. Is weight/height measured in all care plans and health assessments?

- g. Is waist measured in care plans and health assessments?
- h. How is mood status captured in care plans and health assessments?
- i. How do the practice templates currently assess a person for risk of frailty?
- j. Who in the practice can redesign or update these templates?
- k. How are "care gaps" or management recommendations identified for the patients when using the templates?
- l. How are these recommendations or care gaps communicated between health professionals in your practice?
- m. How are these recommendations or care gaps communicated to the patient?

Next will be an audit of the quality of the health assessment/care plan items being performed for people aged 40-70 during the same 4-week period using the following measures: (refer to the Bollen Health "How to guide" to find the data using PENCAT)

1. Height and weight being done at time of the care plan or health assessment. This report will tell you if the group aged 40-70 having care plans and health assessments during the 4-week period had a height and weight measurement during the time of the visit for the health check. Click on the "incomplete data" button to show any gaps.

Discuss the following questions with your team:

- **What are your gaps?**
 - **Why may this be occurring?**
2. Next review **waist measurements** being done for this group of people. Change the date range for the "Date range (results)" tab only. This will tell you if the group aged 40-70 having care plans and health assessments during the 4-week period have had a waist measurement in the past 12 months including the time of the visit for the health check.

Discuss the following questions with your team:

- **What are your gaps?**
 - **Why may this be occurring?**
3. Next audit step is to review the **physical activity**. No need to again change the date range for the "Date range (results)" tab as it was done for the waist measurement. This screen will tell you if the group aged 40-70 having care plans and health assessments during the 4-week period have had their exercise quantity, frequency and type documented during this visit.

Discuss the following questions with your team:

- **What are your gaps?**
 - **Why may this be occurring?**
4. Next review height and weight being done in the past 12 months for this same group of patients. No need to again change the date range for the "Date range (results)" tab as it was done for the waist measurement. This screen will tell you if the group aged 40-70 having care plans and health assessments during the 4 week period have had a height and weight measurement in the past 12 months including the time of the visit for the health check. (Please tick the "Incomplete data" button to review the gaps for this group.)

Discuss the following questions with your team:

- **What are your gaps?**
 - **Why may this be occurring?**
5. **Smoking status.**
You will again need to change the "Date range (results) tab". Tick the "All" dates button. This screen will tell you if the group aged 40-70 having care plans and health assessments during the 4-week period have had their smoking status ever documented.

Discuss the following questions with your team:

- **What are your gaps?**
- **Why may this be occurring?**



Overall review

What did you learn about your health assessment and care planning quality for people aged 40-70?

- **What could be an improvement?**
- **What needs to be done for improvements?**
- **Who needs to do it?**
- **When will it be done by?**

Why this data?

This data reflects your practice's current performance and assists setting your future goals and your initial "plan-do-study-act" (PDSA) cycle. The regular review and reporting of this data will be required during the sprint. This data is currently the best proxy measure available that is easily captured from General Practice software to use for assessment of frailty risk in the 40–70-year-old age group.

Key practice point Update Smoking Status

The BEACH study 2015–2016 found 1 in 5 people (20%) in the 40-70 age group smoke. This is higher than the 15% overall rate for Australians aged over 18.¹³

Key practice point Waist Measurements

As a result of losing muscle > fat tissue with ageing, it is important to understand that if someone is retaining their body weight after age 60, they are not necessarily retaining their lean muscle mass. What is occurring is a gain in fat tissue and a loss of skeletal muscle. After age 70 when weight loss is occurring, the older person is losing muscle instead of fat. Measuring waist circumference can be a better predictor of assessing risk of frailty than purely BMI.

World Health Organization guidelines¹⁴ define a waist circumference of ≤94cm for men and ≤80cm for women as 'normal', and 'high' for men with >102cm and women with >88cm.

World Health Organization guidelines			
	Normal	Moderately high	High
Men	≤94 cm	>94-102cm	>102
Women	≤80 cm	>80-88cm	>88cm

The long term Tromsø study¹⁵ reviewed a group of people aged 60-70 who were robust at baseline. Over 3 years 30% became prefrail, and 13% became frail. On average over the longer-term time of the study, 4% of people aged 60-70 progress to develop frailty each year.

Waist measurements are an important predictor of risk of not only cardiovascular events but also of predicting the risk of developing frailty. People with a 'moderately high' waist circumference were 57% more likely to be pre-frail or

frail than those with a 'normal' waistline, while those people recorded with a 'high' waist circumference were twice as likely to fall into the frail categories in the longer term.

The waist measurements also need to be reviewed in the context of different ethnic backgrounds, as other guidelines also now link waist measurement to Cardiovascular Risk, diabetes risk and metabolic syndrome. African Caribbean, South Asian, Chinese and Japanese people tend to carry more fat and less muscle at the same weight as a white European descended people. And the risk of diabetes and heart and circulatory disease starts to increase at a lower weight gain than white Europeans.¹⁶

Key practice point Physical Activity Recording

2021 ABS Census data¹⁷ showed one in five (22.4%) adults aged 18–64 years met the physical activity guidelines in 2022, an increase from one in six (17.0%) in 2017–18. More than half of this group (56.4%) completed 30 minutes of activity on five or more days. One in four (26.6%) undertook strength or toning exercises on two or more days in the last week. Overall, males were more likely to meet the physical activity guidelines (24.9% compared to 19.9%).

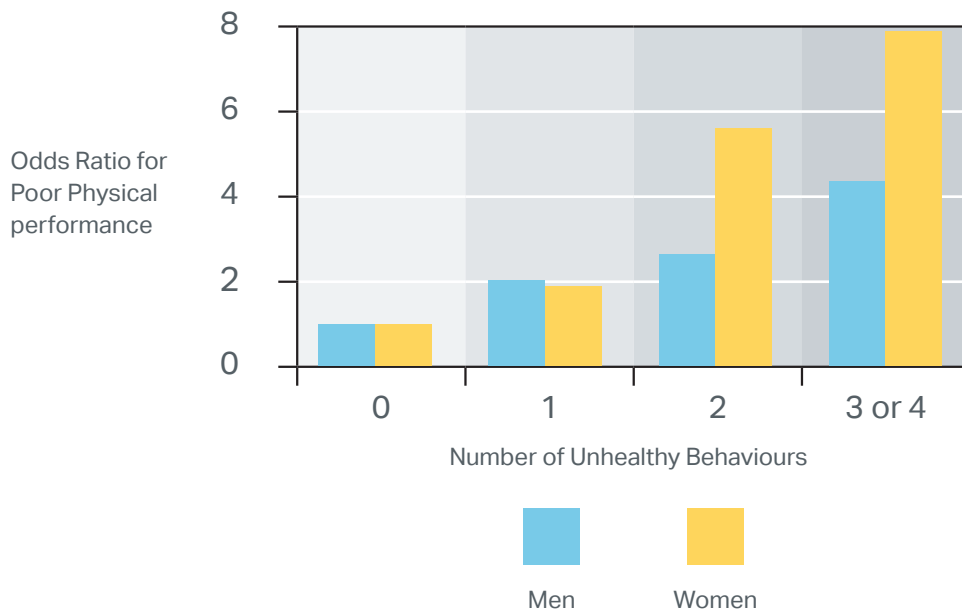
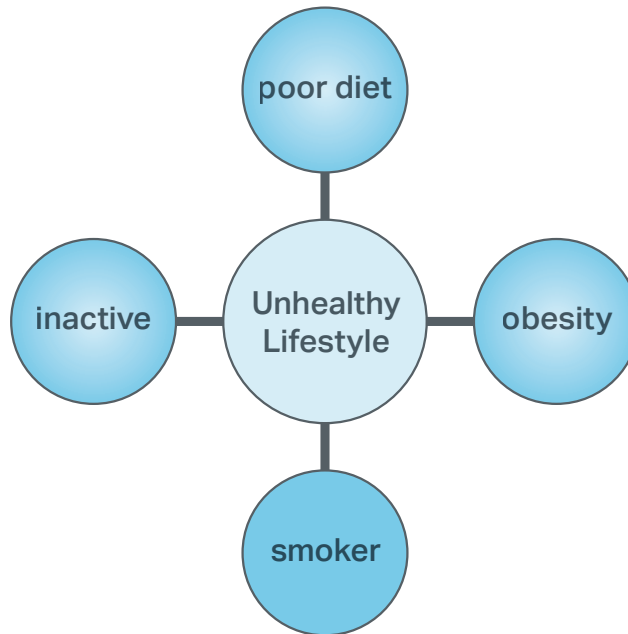
Many General Practices are not recording physical activity in their medical records¹⁸. Do you know how to do this? Refer to the "How to guide" which Bollen Health has prepared to support this activity in Medical Director and Best Practice.

Further reading on frailty risk for age group 40-70 is available in the results of the Hertfordshire Cohort Study¹⁹ and also from Gordon et al's South Australian study²⁰. Figure 3 summarises the risk factors. Other risk factors, such as psychosocial distress/poor mental health will be discussed in workshop 2.

Using the PDSA cycle for your practice's improvement of this data can be explained to your doctors and nurses as an application of the scientific method. A clinician requires the right data to make better clinical decisions.

Unhealthy lifestyle in later life related to worse physical performance

Figure 2. Risk factors for physical performance in later life¹⁹



Worksheet for Pre-Workshop #2 Data collection

Frailty in the 40–70-year-old group is more likely to be found in people with 2+ long term health conditions. Diabetes Mellitus (DM) has been noted as a risk for frailty. It is estimated that the prevalence of frailty is 3-5 fold higher among people with DM than those without²¹.

Task 1

The age group 45-64 years was studied in the BEACH survey 2015-2016¹³. This group makes up 24.6% of the population, and 27% of Australian General Practice encounters.

- 59.7% of this age group have at least one long term conditions.
- 21.2% have 3+ long term conditions.
- 6.4% have 5+ long term conditions.
- 6% have Type 2 Diabetes

How many active patients aged 40-70 in your practice have the following:

- Diabetes mellitus (T1, T2 and undefined)
- 3+ long term conditions
- 5+ long term conditions

You will need to review the data cleansing tab in PENCAT (middle toolbar) and review the active practice population of 40-70 with "indicated diabetes but no diagnosis". This group of patients will be suggested as having diabetes based on results of hba1c, and if a blood glucose level of >7.0 is detected in the atomic data of routine blood tests in a patient file. If a patient has a free text diagnosis, they will also appear on the list.

Discuss the following questions with your team:

- **How big is this group?**
- **Why is diabetes not being coded for this group?**
- **How many of this group aged 40-70 have health assessments and/or care plans?**
- **What needs to be done to improve?**

Frailty risk in all age groups is increased with psychosocial distress²².

Task 2

Review your active patient group aged 40-70 to identify people with higher levels of psychosocial distress.

As a proxy way of finding this group, look for anyone with:

1. A mental health diagnosis such as:
 - Dementia
 - Bipolar disorder
 - Schizophrenia
 - Anxiety
 - Depression
2. Alternatively, if coding of diagnosis is not complete, look for anyone who has been prescribed medications associated with mental health conditions such as
 - Typical antipsychotics
 - Atypical antipsychotics
 - Antidepressants
 - Antianxiety medications (includes benzodiazepines prescribed for insomnia)

Use the PENCAT data cleansing tab and review the group indicated by: "on mental health medications but no diagnosis".

Discuss the following questions with your team:

- **How big is this group in your practice?**
- **How many of this group aged 40-70 have had health assessments and/or care plans?**
- **What needs to be done to improve?**

Worksheet for Pre-Workshop #3 Data collection

Why risk stratify your practice population?

Most General Practice work has a focus on level 4 patients in the pyramid shown in Figure 2. This is the group which actively presents with symptoms for treatment. The work in the frailty sprint aims to enhance care in your practice at levels 2 and 3.

Practices can systematically use patient risk levels to make care management decisions, such as providing greater access and resources to patients in higher risk levels. Risk stratification helps practices to better focus on their sickest patients, reduce costs, and improve care. This will be a topic in workshop 3, and you will be introduced to the CSIRO tool for risk assessment of hospitalisation²³. PENCAT uses this tool to calculate based upon coding of diagnoses, demographics, medications and clinical data such as blood pressure and BMI. Reducing hospital admission risk is also a feature of the new MyMedicare program. (details to be released in 2024)

The aim of this data collection is to assess the group aged 40-70 who are at higher risk of hospital admission and whether the practice is providing a whole patient approach to care with adequate prevention, early intervention and review occurring.

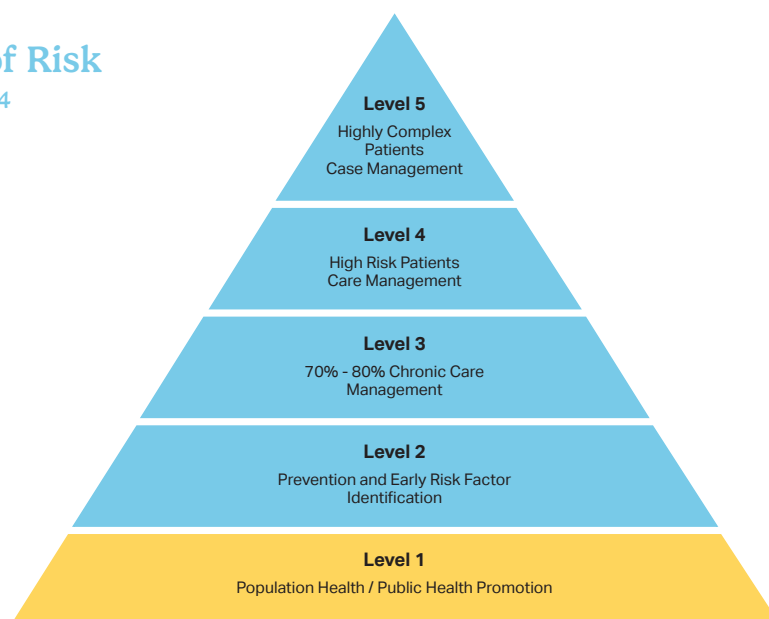
Task 1

Review the active patient population aged 40-70 who are in the hospital admission risk groups:

- 50-100%
- 40-49%
- 30-39%

The Pyramid of Risk in Healthcare²⁴

Figure 3



Discuss the following questions with your team:

- How many people do you have for each of these groups?
- How many of each group aged 40-70 have had health assessments and/or care plans in the past 12 months?
- How many of this group have been assessed for risk of frailty?
- What needs to be done to improve?
- Which group will you focus on first?

Task 2

Review the number of active 40-70yo patients coded with frailty

Search for patients with a coded diagnosis in the Best Practice or Medical Director search **NOT PENCAT**.

This will be giving you an indicator of how many patients you have on your "frailty register". The aim of the project is to have diagnosed (and coded in the Medical Software) at least 20 people aged 40-70 with frailty based upon the FRAIL screening tool and the objective measures of sarcopenia.

Coding for frailty helps create a practice register of people with a long-term condition. They can be reviewed, and this information will also be sent with referral letters alerting others to the risks of medication and surgery impacted by frailty.

Discuss the following questions with your team:

- How many people in your group are coded with a diagnosis of frailty?
- If at least 20 have not been identified, what needs to be done to improve?

Local Medical Neighbourhood and the Healthy Ageing Sprint

Your local medical neighbourhood for this sprint involves more than just health professionals. In workshop 2 the topic of social prescribing will be discussed, explored and actively engaged with!

What is social prescribing?

According to the Consumers Health Forum²⁵ which has partnered with RACGP to focus on this topic, social prescribing is the practice where health professionals, including GPs, have the resources to link patients with social services or even social groups in a bid to address the social determinants contributing to poor health and stave off the epidemic of loneliness and social isolation.

One task for the practice team over the duration of the sprint project is to identify all potential options for improving the care of people living with frailty or who are at risk of frailty. Think about local services and supports who can make a difference in the following areas:

- Mental health
- Social isolation and loneliness
- Nutrition
- Physical activity
- Reducing medication burden

Some examples are:

- The SA Community website <https://sacommunity.org/> Find dance groups, Poetry groups, Choir, Scrabble clubs and much more
- Local library and local councils...these have a large number of underutilised resources. Review the Onkaparinga Council as an example <https://www.onkaparingacity.com/Community-facilities-support>
- Strength for Life <https://cotasa.org.au/programs-and-services/strength-for-life>
- Community Gardens https://sacommunity.org/az/15532-Community_Gardens and Men's Sheds <https://mensshed.org>
- COTA (membership of Council for the Aged is for people aged 50+) <https://cotasa.org.au/about-us>

Create a directory for your practice as part of the Local Medical/Healthcare neighbourhood activity.

Readings, Videos and Podcasts as Resources

Book "Outlive. The Science and Art of Longevity"

<https://peterattiamd.com/outlive/> This website also allows free subscription to a regular newsletter from Dr Peter Attia MD

Model for improvement video

<https://www.youtube.com/watch?v=nPysNaF1oMw&t=147s>

Two videos from IHI to watch on PDSA approaches

- https://www.ihl.org/resources/pages/tools/plandostudyactworksheet.aspx?PostAuthRed=/resources/_layouts/download.aspx?SourceURL=/resources/Knowledge%20Center%20Assets/Tools%20-%20Plan-Do-Study-ActPDSAWorksheet_2f9145ee-2203-49c6-be19-7dcda98b31c5/QIToolkit_PDSAWorksheet.pdf
- Process Mapping <https://www.ihl.org/insights/5-steps-creating-value-through-process-mapping-and-observation>

A frailty management and decision tool

<https://sydneynorthhealthnetwork.org.au/programs/aged-care/#1692076570401-c3bf9086-46dd>

Article on the topic of why risk stratify your practice

<https://www.aafp.org/pubs/fpm/issues/2019/0500/p21.html#:~:text=Practices%20can%20systematically%20use%20patient,reduce%20costs%2C%20and%20improve%20care.>

The frailty self-assessment tool from Benetas

<https://www.benetas.com.au/pat>

An app for assessing frailty has been designed.

See article accessed

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7360669/>

Podcasts on Health Ageing for all people

- <https://www.booming.net.au/pages/podcasts>
- <https://www.theagingproject.com.au> (For women)
- <https://midlifemale.com> (for men)

Patient reported outcome measure PROMIS-29

https://aci.health.nsw.gov.au/_data/assets/pdf_file/0006/632859/Patient-Reported-Outcome-Measures-Information-System-PROMIS-29-Profile.pdf

John Morley's FRAIL scale

<https://sydneynorthhealthnetwork.org.au/wp-content/uploads/2018/12/PDF-Frail-scale.pdf>

Gait speed test

<https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/frailty-gaitspeed.pdf>

Timed up and Go test

https://www.cdc.gov/steady/pdf/TUG_test-print.pdf

Sit to stand testing / 30 second testing

<https://www.cdc.gov/steady/pdf/STEADI-Assessment-30Sec-508.pdf>

5 sit to stands

<https://mobilemeasures.org/2020/09/04/5-time-sit-stand-test/>

Protein information sheet

<https://hneccphn.imgix.net/assets/src/uploads/resources/Protein-information-for-improving-health.pdf>

Home exercise program sheet

https://hneccphn.imgix.net/assets/src/uploads/resources/MEC0026-Sit-to-stand-handout_Hannah-Lane.pdf

Muscle picture

[https://pilates.simaburgin.com/pilates-for-seniors-2/?lang=en#lightbox\[ad723d5a9b992654d7e\]/0](https://pilates.simaburgin.com/pilates-for-seniors-2/?lang=en#lightbox[ad723d5a9b992654d7e]/0)

How to guides

- Using PENCAT to find the data required for the project (contact Bollen Health for these)
- Recording of physical activity in medical software (Best Practice and Medical Director)

https://www.medicaldirector.com/help/topics-clinical/Physical_Activity.htm

<https://www.youtube.com/watch?v=3rcBnx60csA>

Finding a coded diagnosis of frailty in medical software

https://www.medicaldirector.com/help/topics-clinical/Patient_Search.htm

<https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEw-jXzfL13oOEaxVBRmwGHSMDBq8QFnoE-CA4QAw&url=https%3A%2F%2Fgcphn.org.au%2Fwp-content%2Fuploads%2F2021%2F03%2F-CQI-toolkit-Children-and-Young-People-in-Care-How-To-Resource-for-practice-software.docx%23%3A~%3Atext%3DIn%2520the%2520Diagnosis%2520box%2520enter%2Cthe%2520specific%2520diagnosis%2520will%2520appear.&usg=AOvVaw1R4DO6XFIKFcypC4Y2NM-&opi=89978449>



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