Healthy Ageing

Quality Improvement (HAQI) Collaborative

2025-2026

phn
NEPEAN
BLUE MOUNTAINS
An Australian Government Initiative

Wentworth Healthcare
Blue Mountains | Hawkesbury | Lithgow | Penrith

Contents

Introduction

Welcome to the Nepean Blue Mountains Healthy Ageing Quality Improvement (HAQI) Collaborative. This handbook has been developed to support your participation in the HAQI Collaborative. Healthy ageing is defined by the World Health Organization (WHO) as “the process of developing and maintaining the functional ability that enables wellbeing in older age”.[1]

The Nepean Blue Mountains region population is ageing. In 2024, 16.43% of the population was aged 65 years and older. The proportion of the Nepean Blue Mountains population aged 65 years and older is projected to increase to 22.33% by 2041.[2]

Primary Health Networks (PHNs) are receiving funding to support the Australian Government’s response to the Royal Commission into Aged Care Quality and Safety. The aim of this project is to support older adults to live at home for longer through the commissioning of early intervention initiatives that promote healthy ageing, support the ongoing management of chronic conditions, and reduce functional decline.

The HAQI Collaborative will work with general practices across the Nepean Blue Mountains region to support older people to manage chronic health conditions by applying a simple, powerful and evidence-based framework. Systematically applying the 5M Framework ‘What Matters, Medication, Mobility, Mentation and Malnutrition’ to assess older people and guide actions will assist with the process of developing and maintaining the functional capacity enabling wellbeing in our older community. It will also assist preventing potentially avoidable hospital admissions and support patients to live at home for longer. This program will focus on quality improvement measures that support the implementation of improved pathways for the care of older patients.

The HAQI Collaborative will run from 1 October 2025 to 30 June 2026. A collaborative follows a wave timeline with participating practices attending learning opportunities, undertaking activity periods, and submitting data to track improvement. Practices participating in the HAQI Collaborative will engage with other general practices through peer-to-peer learning led by clinicians and quality improvement experts by applying the 5M Framework to support improved management of the health of older people.[3] In recognition of the time taken to attend workshops and implement changes, participation payments will be made available to practices.

Prior to the commencement of this HAQI Collaborative, foundation work was undertaken through an Expert Reference Panel (ERP) workshop facilitated by Dr Paresh Dawda and Angelene True from Prestantia Health. The ERP consisted of representation from a local general practitioner, practice nurse/health connector, consultant pharmacist, exercise physiologist, dietitian, care finder service manager/dementia expert and consumer representative. The panel actively discussed various measures, outcomes and what is achievable for this Collaborative. Contributions from panel members was key to the development of this Handbook.

To support the design and delivery of the HAQI Collaborative, we are working with Prestantia Health utilising their expertise focused on clinical leadership, quality and safety in healthcare, high performing primary care and digital health.

We look forward to working closely with participating general practitioners, practice nurses and other practice staff throughout the duration of this initiative. While participating in the HAQI Collaborative will mean additional work for practices, this initiative is also an exciting opportunity for general practices to improve outcomes for the older population in our region.

Healthy Ageing in Australia

The Nepean Blue Mountains region consists of 391,809 residents with 16.43% of those residents being over 65 years of age, which is expected to increase. The prevalence of diagnosed chronic conditions among patients aged 65 and older is notably high. In the Australian population, 90% of this older age group had at least one chronic condition, the majority (57%) had three or more. Furthermore, 26.1% are managing five or more chronic conditions, and 9.4% are coping with an even higher burden, specifically seven or more diagnosed chronic conditions. This data underscores the significant impact of chronic health issues on the older population in Australia.[4]

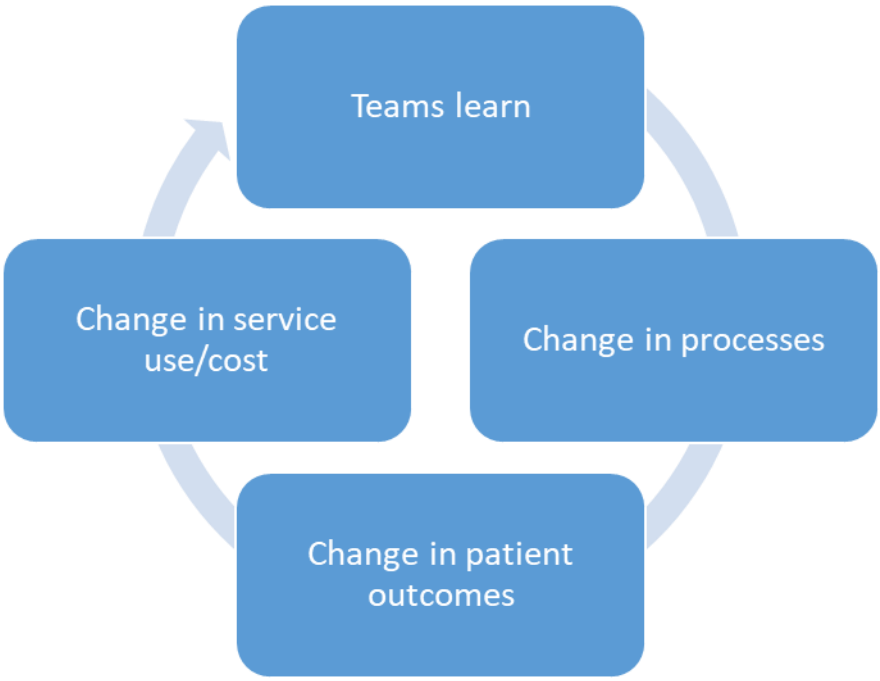
The 5M Framework can help clinicians approach healthy ageing in a holistic manner, by considering ‘What Matters Most’ to the patient, followed by systematically assessing and acting on the other domains of a patient’s ‘Medication, Mobility, Mentation and Malnutrition' needs. By exploring each of these ‘M’ domains, clinicians can assess various aspects of the identified patient’s healthcare needs. Clinicians consider individual patient preferences through understanding what matters most to our patients, whether that be independence, spending time with family, continuing to engage with certain activities, or something directly related to their healthcare. The subsequent actions and care plan will then be delivered through a set of evidence-based interventions, which include known and established pathways of care as well as other interventions such as social prescribing.[5]

A recent survey conducted by the McKinsey Health Institute (MHI) involving over 21,000 older adults (aged 55 and older) in 21 countries, reveals a broad consensus on the significance of key elements such as having a sense of purpose, stress management, meaningful connections with others, maintaining independence and living at home for longer.[6] Early intervention can allow people to stay active and healthy longer, keeping them in their homes and out of hospital.[7] Interventions such as exercise, nutrition, social connectiveness and supports can all help improve older people’s quality of life, enabling them to maintain independence, reducing preventable hospital presentations and early admissions into residential aged care homes.

About the Healthy Ageing Quality Improvement Collaborative

What is a Quality Improvement Collaborative?

A Quality Improvement Collaborative is a simple and powerful approach for quality improvement. It involves groups of professionals coming together to learn from and motivate each other to improve the quality of health services. Collaboratives often use a structured approach, such as setting common aims and undertaking rapid cycles of change leading to meaningful improvements. Broadly, Collaboratives work together and compare practice, which motivates professionals and teams to do things differently, which in turn improves patient outcomes and ultimately improves service use and costs.



The approach is underpinned by:

1. A focus on a specific topic using a structured and evidence-based framework to assess and guide actions for older people.
2. Clinical experts and experts in quality improvement provide ideas and support for improvement – including the expert reference panel.
3. Multi-disciplinary teams from multiple practices participate in building a culture of trust, peer learning and support with the engagement of clinical leaders.
4. A model for improvement, setting targets, collecting data, testing changes and inspiring and motivating others.
5. A collaborative process involving a series of structured activities with experiential learning by doing and using data to drive improvement.

We will provide practical support throughout via your Primary Care Engagement Officer and/or HAQI Project Lead.

Mission of the HAQI Collaborative

The overall mission for the HAQI Collaborative is to foster a process of developing and maintaining the functional capacity that enables wellbeing in older age. In practice this means:

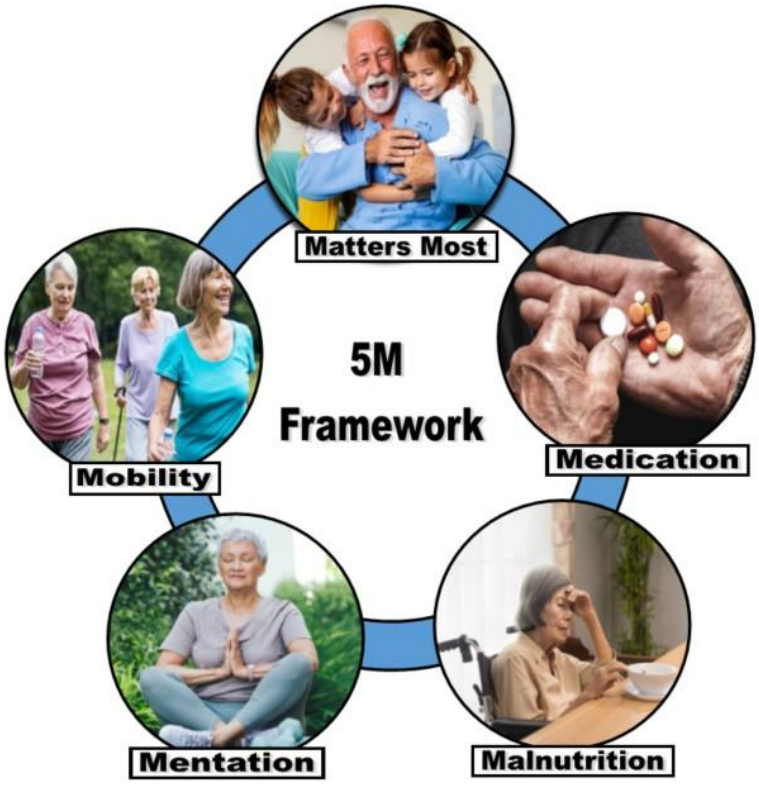
- Improving the management of older patients living with a long-term health condition
- Improving the quality of life for older patients participating in the program
- Maintaining and/or improving function of daily living to remain at home for longer.
- Reducing inappropriate polypharmacy and increasing health literacy to assist older people to better manage their own medication
- Improving the clinical team's knowledge of non-clinical community services available.

Aim of the HAQI Collaborative

A clear aim that strives to resolve the issues or potential gaps in care is critical for a successful collaborative effort. The aim of the HAQI Collaborative was agreed by an Expert Reference Panel in early February 2024, which included representatives from general practice, allied health and community within the Nepean Blue Mountains region.

The aim of the HAQI Collaborative is to:

Improve the care of older people living in the community, which will be guided by the 5M Framework utilised by participating general practices across the Nepean Blue Mountains region.



5M Framework

What Matters Most:

- Making sure that a person's individual, personally meaningful health outcomes, goals and care preferences are reflected in treatment plans
- Coordinating advance care planning
- Helping manage meaningful goals of care measured using patient report measures

Medications:

- Consider referral for a Home Medication Review, particularly after a hospital admission to reduce polypharmacy
- Prescribing treatments specific to an older person
- Helping patient to build awareness of harmful medication effects
- Supporting team-based care

Mobility

- Maintaining muscle tone with simple exercises/activities
- Maintaining the ability to walk and/or maintain balance
- Preventing falls and other types of common injuries such as bone fractures
- Maintaining independence

Mentation

- Maintaining mental stimulation
- Helping manage memory decline and dementia risk
- Helping prevent and treat delirium
- Identifying and treating mood related conditions such as depression and anxiety

Malnutrition

- Maintaining a healthy weight with no unexplained weight loss
- Providing information on healthy foods and access to services including social support groups[8]

The HAQI Collaborative Framework

The HAQI Collaborative will run over a period of up to twelve months and will consist of activity periods, data collection and a series of face-to-face learning workshops. The workshops will be interspersed with activity periods, in which participating practices will submit monthly data, testing and implementing changes within and across their systems.

Baseline data collection

Baseline data is collected at the beginning of the HAQI Collaborative. This provides a snapshot of your general practice's position before making improvements and enables the team to see their starting point.

Learning workshops

Learning workshops provide you with evidence-based information, the opportunity to share knowledge and experiences with peers and build on knowledge gained from previous workshops. You will hear others' ideas and generate new ideas that will translate into improvements within your practice. You will also benefit from protected 'team time' sessions at learning workshops, where you can formulate plans for action. These plans for action may involve multiple teams where changes are required across multiple points of the healthcare system, to bring about an improvement.

Activity periods

Activity periods are the periods of time between and after learning workshops. They enable your team to test their improvement ideas, with progress measured through ongoing monthly data collection. A vital component of an activity period is the proactive and practical assistance we provide via your Primary Care Engagement Officer and/or HAQI Project Lead.

Rules of Improvement

Researchers identified 10 key challenges for those involved in quality improvement. These challenges may be opportunities, so we need to adapt some simple rules and strategies.[9]

From	To
Convincing peers that there is a problem	Humble inquiry to identify the pain points for colleagues and teams
Convincing peers that the solution chosen is the right one	We find our way to the solutions together
Getting data collection and monitoring systems right	Data is important – we start somewhere and get going – it can be stories and numbers
Excess ambitions – treating the intervention as a discrete, time-limited project, rather than as something that will be sustained as part of standard practice	We are going to work in new ways so what we do today is better than what we did yesterday; and what we do tomorrow is better than what we do today
The organisational context, culture, and capacities	Improvement is everyone's business – we start somewhere and keep going
Tribalism and lack of staff engagement	Maybe we need to approach engagement differently
Leadership	Focus on the habits of improvers for all (refer to graphic 1)
Balancing carrots and sticks – harnessing commitment through incentives and potential sanctions	Focus on intrinsic motivation – purpose, autonomy and mastery
Securing sustainability	Apply the five lenses – me, my team, our practice, our patients, the system
Considering the side effects of change	Anticipate and monitor for these potential unintended consequences but not let it stop us improving

Graphic 1

How Will the HAQI Collaborative work?

The HAQI Collaborative will be implemented in a way that will build on positive mindsets for improvement, utilising the quality improvement tools with fidelity. Your practice will be supported to:

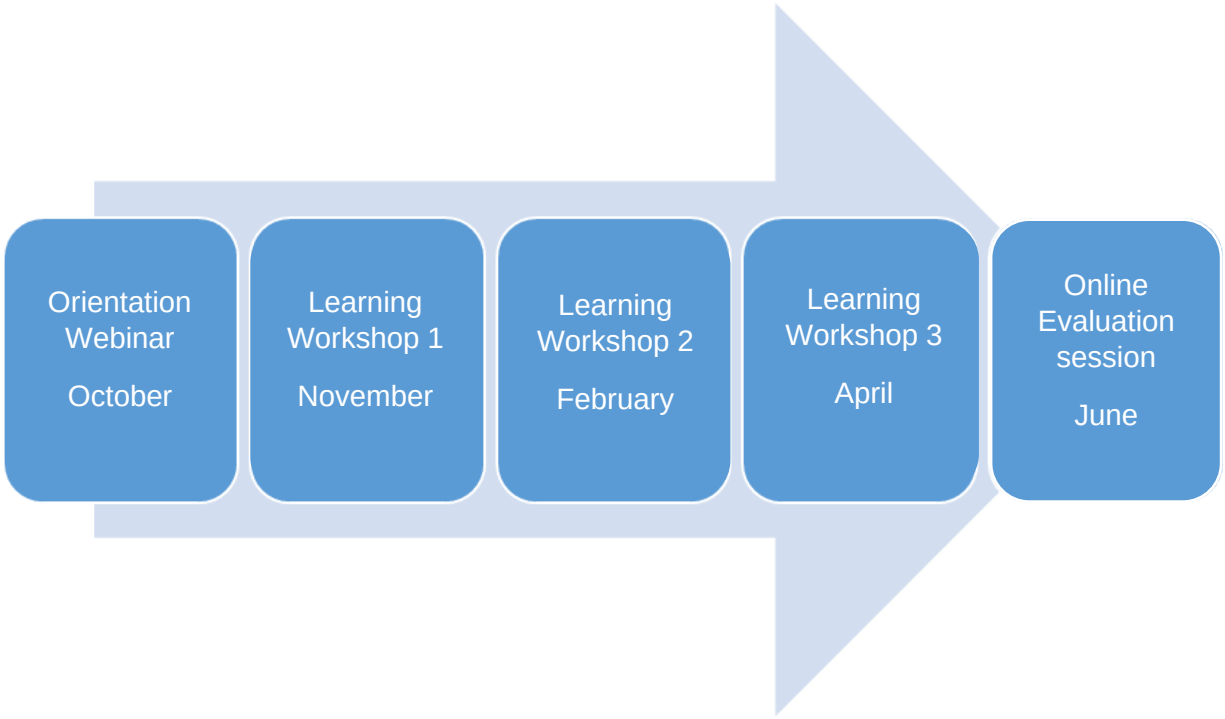
- Work out your starting point by understanding your patient population and segmenting to help prioritise, eg. people who may have frailty or two or more chronic health conditions.
- Learn, think and share with your peers through a series of learning workshops and webinars. The workshops and webinars will include a mix of expert and local speakers to build the group's understanding of the evidence and issues relating to care of patients with two or more chronic health conditions, such as frailty. There will also be time for group work for you to develop ideas for action.

The HAQI Collaborative commences with an Orientation Webinar. This provides an overview of:

- The HAQI Collaborative methodology.
- The HAQI Collaborative aims, measures, change principles and change ideas.
- Key dates and links to resources.

Throughout the HAQI Collaborative, three **Learning Workshops** will be held. Practices must send at least two representatives (ideally one practice nurse and one GP) to each workshop, as each workshop builds on learnings and teamwork developed in previous sessions/workshops. Venues for each learning workshop will be confirmed closer to the date of the learning workshop.

Learning Workshop Timeframe



Three learning workshops will be held face-to-face at locations to be confirmed closer to the event dates and two online workshops will be held at commencement and at the end of the collaborative. All event locations will be within the Nepean Blue Mountains region, based on the spread of participating practices.

The overall progress of all practices participating in the HAQI Collaborative will be discussed at the Learning Workshops. Please be reassured that only aggregated, de-identified practice level data will be shared. To support the spread of good ideas, practices that are meeting or exceeding targets may be asked to share learnings on what they have implemented at the learning workshops.

Making a simple plan is important for turning an idea into action. Documenting your plan and the results of implementation is important so that you can quickly identify and share changes that are worth making permanent. We will provide a template for you to document your goals, ideas and plans for action using the very simple 'Model for Improvement' (sometimes referred to as the Plan-Do-Study-Act or PDSA cycle).

To support you with progressing in your improvement journey we will ask you to:

- Submit a reflective template every month
- Submit a data collection and reporting template.

Reflective Template

Our reflective template takes a very simple approach and ask you to reflect on What, So What and Now What?

Question	Questions for you to consider
What?	What improvement activities have you done in the last month? How may PDSA cycles have you done?
So What?	What worked well? What could we have been done differently?
Now What?	What are we going to do next month in how we approach quality improvement, our measurement and the PDSA cycles?

Data Collection and Reporting

We will provide you with data collection and reporting templates that can be used to track improvement measures. Some measures may be extracted from Primary Sense, other measures may require self-reporting.

De-identified data collected will be collated into a data audit report which will be provided per activity period so that you can track your progress against the HAQI Collaborative measures.

The purpose of collecting and reporting data against the program measures is to help everyone see if what they are doing is working - *it is not for judging participants' performance or for research.*

How We Will Support You

Throughout the HAQI Collaborative we will provide proactive and practical support.

The following representatives will support your practice throughout the duration of the HAQI Collaborative:

- Your Primary Care Engagement Officer (PCEO) will be your first point of call for all matters related to the HAQI Collaborative. This will include providing practices with benchmark reports, assisting with implementing the PDSA cycles and regular feedback and support to guide quality improvement.
- The HAQI Collaborative Program Officer will review your PDSA cycles as part of the activity periods to ensure they meet the minimum requirements and provide you with feedback. They will also process invoices and co-facilitate the Learning Workshops.

CPD Hours

Practices participating in the HAQI Collaborative will be eligible for self-reporting CPD hours for the 2025-2026 triennium.

Change Drivers, Ideas, Tools and Resources

This section provides ideas for action with case studies and helpful tips to assist you. There are drivers that will help us achieve our aim. Each driver will have many change ideas associated with it. The table below helps to represent the relationship of all our change ideas, the drivers and our aim.

There are many change ideas associated. Can you think of any you would like to add?

The below change principles and ideas are based on evidence of what works to improve the care of patients with chronic health conditions in the primary care setting.

Change Driver	Change Ideas (How)
1. Know your patient population	• Accuracy of information by using a consistent definition of which patients in our clinical database are 'active' to assist in selecting eligible patients. • Enhance relationship with the older patient cohort by taking time to listen to what matters most to them about their health. Spending the first five minutes talking to the patient about what their goals are. • Look at patient demographics to better understand the patient profile of the older patient cohort and whether or not they are a high hospital risk or at risk of developing a chronic condition. • Does our practice request feedback from patients about their experience of care?

2. Team based care	• Coordinated care:
	  ○ Shared Health Record
	  ○ Shared Care Plan
	  ○ My Health Record (MHR) including Events Summary
	• Knowledge about and referral to local non-clinical social and support groups.
	• Included patients/carers in decisions around their care and ensure patients/carers understand terminology used in appointments.
	• Collaboration with allied health professionals and social and support groups to inform patient shared care plans.
	• Involve the Health Connector with patient care planning.

3. Proactive assessments	• Care planning:
	  ○ Referrals – utilise appropriate care pathways eg. does the practice use HealthPathways
	  ○ Social Prescribing – what is already available, use of My Health Connector online directory
	  ○ Advance care planning
	• Awareness of measurable activities such as the timed up and go test.
	• During 75+Health Assessment, introduce useful equipment such as hand grips.

4. Patient self-management	• Record patient identified goals and monitor progression. • Establish clear definitions of self-management and what self-management supports are available including non-clinic activities and social groups for patients to attend.
5. Capability building, education and training	• Attendance at regular HAQI Learning Workshops hosted by us with Prestantia Health. • Sharing learnings and information with fellow practices to build on knowledge and skills.

Case studies

A 76-year-old patient living on her own was attending regularly for appointments often not with very specific aspects. During a coffee break, the new practice nurse spoke with the doctor and suggested the patient may need a 75+Health Assessment as she had not had one and is over 75. During the health assessment, the practice nurse asked the patient what matters to her in her life, and what is important. They also used a patient report tool that measures loneliness in older people. The outcome of the tool suggested the patient was experiencing a high level of loneliness. The tool acted as a trigger for the practice nurse to explore this further with the patient. The practice nurse used the My Health Connector website and found some community supports.

A patient made an appointment to see the Health Connector (specially trained practice nurse) at his usual practice hoping to improve his physical health and social connections. The Health Connector discussed what was important to the patient and what he was interested in and then suggested he try a local exercise class. The patient has since attended the classes several times a week and has stated in his follow-up appointment that he enjoys socialising with the other attendees. The patient feels that without attending this class he would have declined in his physical and mental health. He also advised he has made a new friend at the exercise class and they now catch up regularly over coffee.

Keeping Score - Measure your Progress

HAQI Collaborative Measures

It is important to have clear measures that track progress towards achieving the objective/s of the HAQI Collaborative.

The following HAQI Collaborative measures were previously selected by the Expert Reference Panel.

5Ms	Measure
What Matters	• Three patient nominated goals listed in the care plan • Number of nominated goals in the patients' care plan
	• Number of conversations recorded around advance care planning • Number of Advance Care Directives uploaded to My Health Record
	• Has the patient been supported by a Health Connector for more social connections? • What social activity was recommended and did the patient attend the social activity?
Medication	• Number of patients eligible for home medication review (HMR) or Domiciliary Medication Management Review (DMMR) • Number of patients who have completed HMR or DMMR
Mobility	• Number of referrals to My Aged Care for an occupational therapist to undertake a home visit for home modifications • Number of patients receiving an in-home assessment if required • Strength and fitness activity - timed up and go test • Number of patients participating in regular exercise • Record type of exercise patient participating in
Mentation	• Patient score from PROMIS10 to measure self-reported physical, social and mental health • Patient score from WHO-5 Well-being index • Mini-Mental State Examination (MMSE) may be used as a screening test for cognitive impairment eg. dementia (if clinically determined)
Malnutrition	• Is patient within a healthy weight range? • Number of nutritional assessments completed

Templates and Guides

The Model for Improvement is a tool for developing, testing and implementing change. The Model consists of two parts that are of equal importance:

1. The ‘thinking part’ consists of three fundamental questions that are essential for guiding improvement work
2. The ‘doing’ part is made up of Plan-Do-Study-Act (PDSA) cycles that will help you to test ideas and implement change

Step 1: The Three Fundamental Questions

Note: Each new GOAL (first fundamental question) will require a new Model for Improvement form to be completed using Template 1.

Step 2: Plan-Do-Study-Act Cycle

You will have noted your ideas for testing when you answered the third fundamental question in Step 1. You will use this PDSA cycle to test one of those ideas using Template 2.

Template 1

Date: _____

The Model for Improvement

The Model for Improvement is a tool for developing, testing and implementing change, and consists of two parts:

STEP 1: The ***'Thinking Part'***

Consists of three **Fundamental Questions** that are essential for guiding improvement work

Fundamental Question 1: What are we trying to accomplish?

*By answering this question, you will develop your **S.M.A.R.T. GOAL** for improvement*

Goal	

Fundamental Question 2: How will we know that a change is an improvement?

*By answering this question, you will develop your **MEASURES** for tracking your goal*

Fundamental Question 3: What changes can we make that will lead to an improvement?

*By answering this question, you will develop **IDEAS** you can test to achieve your goal*

IDEA 1: .....

IDEA 2: .....

IDEA 3: .....

Template 2

Date: _____

Plan-Do-Study-Act Cycle #1

STEP 2: The ***'Doing/Testing Part'***

Consists of **Plan-Do-Study-Act (PDSA) Cycles** that will help you test and implement the ideas you have developed in Step 1

IDEA: Choose an idea from **Fundamental Question 3**

PLAN: What exactly will you do? Include who, what, when, where, predictions & data to be collected

*By answering this question, you will further develop the **IDEAS** you can test to achieve your goal*

Who:

What:

When:

Where:

Predictions:

Data to be collected:

DO: Was the plan executed? Document what happened (expected or unexpected events)

STUDY: Record, analyse and reflect on results

ACT: What will you take forward from this cycle? What is your next step or PDSA Cycle?

Tools and Resources

https://www.nbmphn.com.au/Health-Professionals/Services/Older-Persons-Health/Compassionate-Communities/Social-Connectedness

https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/silver-book/part-a

https://www.safercare.vic.gov.au/best-practice-improvement/improvement-projects/Older-people-palliative-care/creating-age-friendly-health-systems

https://aci.health.nsw.gov.au/projects/consumer-enablement

What Matters

https://bcpsqc.ca/wp-content/uploads/2018/05/ConversationsMatterFINAL.pdf

https://www.advancecareplanning.org.au/create-your-plan/create-your-plan-nsw

https://aci.health.nsw.gov.au/statewide-programs/prms

https://www.choosingwisely.org.au/assets/CW2189_Conversation_Starter_Kit_v9.pdf

https://med.stanford.edu/letter.html

Medication

https://www.healthdirect.gov.au/home-medicines-review

https://my.psa.org.au/servlet/fileField?entityId=ka10o000000U2N7AAK&field=PDF_File_Member_Content__Body__s

https://www.nswtag.org.au/deprescribing-tools/

https://www.primaryhealthtas.com.au/resources/deprescribing-resources/

https://www.digitalhealth.gov.au/initiatives-and-programs/electronic-prescriptions

Mobility

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

https://www.mdcalc.com/calc/3912/barthel-index-activities-daily-living-adl

Mentation

https://gpcog.com.au

https://www.nursing.psu.edu/cgne/readi/

https://www.racgp.org.au/FSDEDEV/media/documents/Clinical%20Resources/Guidelines/Diabetes/Appendix-D.pdf

Malnutrition

https://www.mna-elderly.com/sites/default/files/2021-10/mna-guide-english-sf.pdf

References

1. World Health Organisation (2020); Healthy ageing and functional ability. Available from https://www.who.int/news-room/questions-and-answers/item/healthy-ageing-and-functional-ability
2. Wentworth Healthcare Nepean Blue Mountains Primary Health Network; Healthy Ageing. Available from https://www.nbmphn.com.au/Community/Services/Older-Persons-Health
3. National Library of Medicine (2019); Optimizing geriatric care with the GERIATRIC 5Ms. Available from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6347324/
4. Wentworth Healthcare Nepean Blue Mountains Primary Health Network (2023); Nepean Blue Mountains Primary Health Network Needs Assessment 2023. Available from https://www.nbmphn.com.au/Resources/About/NBMPHN-Needs-Assessment-2023
5. National Library of Medicine (2023); Optimizing Medications with the Geriatrics 5Ms: An Age-Friendly Approach. Available from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10092911/
6. McKinsey Health Institute (2023); Age is just a number: How older adults view healthy aging. Available from https://www.mckinsey.com/mhi/our-insights/age-is-just-a-number-how-older-adults-view-healthy-aging#/
7. Hunter New England and Central Coast Primary Health Network (2024); Healthy Ageing and Frailty. Available from https://thephn.com.au/what-we-do/care-for-older-people/healthy-ageing-and-frailty
8. Health in Aging Foundation; The 5Ms of Geriatrics. Available from https://www.va.gov/covidtraining/docs/HIA_TipSheet_Geriatric_5Ms_19.pdf
9. The Health Foundation (2021); Quality improvement made simple, What everyone should know about health care quality improvement. Available from https://www.health.org.uk/sites/default/files/QualityImprovementMadeSimple.pdf

Wentworth Healthcare
Level 1, Suite 1, Werrington Park Corporate Centre,
14 Great Western Highway,
Kingswood NSW 2747

(02) 4708 8100

POSTAL ADDRESS
Wentworth Healthcare,
Blg BR, Level 1, Suite 1,
Locked Bag 1797,
Penrith NSW 2751

This report can be found at:
nbmphn.com.au/library

For more information about Wentworth Healthcare, provider of the Nepean Blue Mountains PHN, visit:
nbmphn.com.au

Wentworth Healthcare Limited (ABN 88 155 904 975) provider of the Nepean Blue Mountains PHN.

phn NEPEAN BLUE MOUNTAINS
An Australian Government Initiative

Wentworth Healthcare
Blue Mountains | Hawkesbury | Lithgow | Penrith