ACI NSW Agency for Clinical Innovation

LEADING BETTER VALUE CARE

CHECKLIST

Osteoporotic Refracture Prevention

Assessment Tool

Musculoskeletal Network

Collaboration. Innovation. Better Healthcare.

The Agency for Clinical Innovation (ACI) works with clinicians, consumers and managers to design and promote better healthcare for NSW. It does this by:

- *service redesign and evaluation* – applying redesign methodology to assist healthcare providers and consumers to review and improve the quality, effectiveness and efficiency of services
- *specialist advice on healthcare innovation* – advising on the development, evaluation and adoption of healthcare innovations from optimal use through to disinvestment
- *initiatives including guidelines and models of care* – developing a range of evidence-based healthcare improvement initiatives to benefit the NSW health system
- *implementation support* – working with ACI Networks, consumers and healthcare providers to assist delivery of healthcare innovations into practice across metropolitan and rural NSW
- *knowledge sharing* – partnering with healthcare providers to support collaboration, learning capability and knowledge sharing on healthcare innovation and improvement
- *continuous capability building* – working with healthcare providers to build capability in redesign, project management and change management through the Centre for Healthcare Redesign.

ACI Clinical Networks, Taskforces and Institutes provide a unique forum for people to collaborate across clinical specialties and regional and service boundaries to develop successful healthcare innovations.

A priority for the ACI is identifying unwarranted variation in clinical practice and working in partnership with healthcare providers to develop mechanisms to improve clinical practice and patient care.

www.aci.health.nsw.gov.au

AGENCY FOR CLINICAL INNOVATION

Level 4, Sage Building
67 Albert Avenue
Chatswood NSW 2067

PO Box 699 Chatswood NSW 2057
T +61 2 9464 4666 | F +61 2 9464 4728
E aci-info@health.nsw.gov.au | **www.aci.health.nsw.gov.au**

Prepared by: NSW Agency for Clinical Innovation

Further copies of this publication can be obtained from
the Agency for Clinical Innovation website at **www.aci.health.nsw.gov.au**

Version: 1 **Trim:** ACI/D17/4533
SHPN (ACI) 170445, ISBN 978-1-76000-700-3.

Date Amended: August 2017

Glossary

ALBP	acute low back pain
CALD	culturally and linguistically diverse
CNC	clinical nurse consultant
CNS	clinical nurse specialist
DXA	dual-energy x-ray absorptiometry
FLS	fracture liaison services
eMR	electronic medical record
GP	general practitioner
ORP	Osteoporotic Refracture Prevention
FTE	full time equivalent
IT	information technology
KPIs	key performance indicators
LHD	local health district
MDT	multidisciplinary team
OA	osteoarthritis
OT	occupational therapist
RN	registered nurse
SLA	service level agreement
VMO	visiting medical officer

Contents

1. Introduction

Osteoporotic Refracture Prevention

The Osteoporotic Refracture Prevention (ORP) model of care was designed to guide best practice coordinated, multi-disciplinary care to improve outcomes for people with minimal trauma fracture, reducing refracture rates and the resultant health usage, morbidity and mortality that refracture causes. The key requirement is the development of Fracture Liaison Services (FLS) and the allocation of a health professional – often a senior nurse or physiotherapist – to coordinate the activities of the patient group, and access to a medical officer who can undertake the medical needs of the patients. This ORP assessment tool has been developed to assist with the implementation of the ORP model of care.

To support the implementation of the Osteoarthritis Chronic Care Program, a toolkit has been developed including:

- model of care
- site manual
- assessment tool
- evaluation package.

2. About the Assessment Tool

Purpose of the Assessment Tool

The purpose of conducting the implementation assessment is to help ORP services to identify current alignment with the model of care and to assist with the preparation and planning to implement or improve the delivery of the model of care.

This assessment tool has been designed to:

- generate awareness and understanding of the Osteoporotic Refracture Prevention model of care including underlying principles and elements of care delivery
- assist in developing a comprehensive and shared understanding of what currently exists for Osteoporotic Refracture Prevention at a local level
- help plan for service delivery in sites without an existing ORP service
- help identify current strengths and weaknesses in relation to implementation of the model of care
- identify the current gaps between what exists now and best-practice care as described in the model of care
- inform the development of local solutions to address identified gaps and issues
- highlight areas to target for improvement
- assist in the prioritisation and planning for action and improvement
- track implementation progress over time and report back to peer mentoring workshops
- identify health system changes required to support implementation.

When to use the Assessment Tool

- For sites where there is no current provision of an Osteoporotic Refracture Prevention service, the Assessment Tool can be used to aid the planning process for new service development.
- For sites that are already providing an Osteoporotic Refracture Prevention service (or elements of that service) this tool should be completed quarterly to identify progress made and priority areas for action.
- In order to identify implementation enablers and barriers and to facilitate discussions across LHDs, each site will be requested to submit their assessment two weeks prior to the quarterly peer mentoring workshops.

How to use the Assessment Tool

1. Read and become familiar with the model of care- this is the service model with which you are comparing your service.
2. Read the accompanying site manual. This is a practical interpretation of the model of care developed through prior experiences of implementing the model of care.
3. Read the monitoring and evaluation plan.
4. Complete the self-assessment tool.
    - It is recommended that a broad and diverse range of views are considered when completing the assessment as it is not expected that any one person will have a complete and accurate understanding of what is currently in place. This is achieved by having multiple stakeholders (e.g. Fracture Liaison Coordinators and ORP team members, clinical leads and executive) completing the assessment from their perspectives, individually or completing the assessment as a group.
    - The tool is divided into two components- the assessment tool to fill in and the supplementary information following. The supplementary information should be used to guide your decision making and provides examples of the types of evidence you can use to justify the rating chosen.
    - A four point rating scale is used to assess the level at which **current practice** meets each service component.
        i. **Not met**: Many of the requirements for successful implementation are not in place nor planned to commence
        ii. **Planned**: Planning is underway to progress with requirements identified for successful implementation.
        iii. **Partially met**: Most requirements identified for successful implementation are in place
        iv. **Met**: All requirements identified are successfully implemented and embedded as business as usual.
    - This tool references both core elements and key resources described in the model of care.
    - When using the tool, include comments on the evidence used to determine how you met or did not meet each component of care.

5. Prioritise action.
    - Foundational components are the minimum requirements for an operational ORP and should be prioritised highest and addressed first. These include governance and workforce resources and assessment, medical care, management plan and review elements.
    - Once the foundational components have been met, prioritisation is based on the local context taking into consideration the following examples:
        i. risk/ safety
        ii. resources
        iii. ease of implementation
        iv. local environment.
    - A maximum of five priorities should be addressed at any one time to ensure efficient and effective implementation.

3. The Assessment Tool

Element or resources	Components of care	Your rating of local achievement				Rationale (comment about how you measured your achievement)	Priority
		Not met	Planned	Partially met	Met		
Governance	**1 Osteoporotic Refracture Prevention is based on chronic care principles**	☐	☐	☐	☐		**Foundational** Low Medium High
	The ORP service is governed by a shared understanding, clear vision and strategies supporting the delivery of chronic care services to reduce the risk of refracture and to promote effective management of bone health.						
	2 There is collaborative decision making for planning, implementation and evaluation	☐	☐	☐	☐		**Foundational** Low Medium High
	A musculoskeletal steering committee responsible for the governance of ORP, consists of representation of all key stakeholders and promotes the achievement of the vision and strategies to achieve program outcomes.						
Workforce	**3 Dedicated fracture liaison coordinator who is skilled to support the chronic care needs of individuals**	☐	☐	☐	☐		**Foundational** Low Medium High
	The fracture liaison coordinator has a dedicated role in leading ORP service delivery and is appropriately skilled in the management of bone health. There is a dedicated FTE with the capacity to successfully meet the cohort need of each ORP service site and achieve full coverage of the local health district's geographical area.						

Element or resources	Components of care	Your rating of local achievement				Rationale (comment about how you measured your achievement)	Priority
		Not met	Planned	Partially met	Met		
Workforce	**4 Multidisciplinary team access is facilitated to support the individual's chronic care needs** The local ORP service delivery model provides access to multidisciplinary support to meet the chronic care needs of participants and for efficient and effective service delivery including administrative support.	☐	☐	☐	☐		**Foundational** Low Medium High
	5 A medical officer is allocated to provide medical management and support for the ORP Service Engagement of a medical officer to address the medical needs of the patients and provide clinical governance and leadership for the ORP service.	☐	☐	☐	☐		**Foundational** Low Medium High
IT	**6 IT functionality supports efficient and effective service delivery** IT infrastructure supports the identification of eligible individuals, captures and monitor outcomes, supports care coordination, sharing of the personalised management plan and the extraction and analysis of data for reporting and quality improvement activities.	☐	☐	☐	☐		Low Medium High
Access	**7 There is equitable access to the service** The ORP service model has appropriate reach and access for local community and priority population groups.	☐	☐	☐	☐		Low Medium High

Element or resources	Components of care	Your rating of local achievement				Rationale (comment about how you measured your achievement)	Priority
		Not met	Planned	Partially met	Met		
Access	**8 Easy identification of eligible individuals** Effective and efficient processes for the identification of people sustaining minimal trauma fractures and requiring refracture prevention.	☐	☐	☐	☐		Low Medium High
Assessment	**9 Undertake a comprehensive assessment based on the holistic needs of the individual** A comprehensive assessment is completed for those identified that is holistic and patient centred, using validated clinical and patient reported measures and in consideration of physical, social, psychosocial and co-morbidity needs of the person.	☐	☐	☐	☐		**Foundational** Low Medium High
Medical Care	**10 Access to investigations** Clinical investigations including bone mineral density scanning are available and utilised to support the assessment of poor bone health and future fracture risk.	☐	☐	☐	☐		**Foundational** Low Medium High
	11 The initiation of medication is facilitated by the ORP medical officer The medical officer initiates the required medical therapy.	☐	☐	☐	☐		**Foundational** Low Medium High

Element or resources	Components of care	Your rating of local achievement				Rationale (comment about how you measured your achievement)	Priority
		Not met	Planned	Partially met	Met		
Health Education	**12 Health education builds understanding, engagement and empowerment for self-management** Health education is provided to all people within the ORP service on their condition and effective treatments and interventions to facilitate active and informed decision making.	☐	☐	☐	☐		Low Medium High
Self-management support	**13 All individuals are supported to engage in treatments, interventions and identified health behaviour changes** There is access to and behavioural support to promote a healthy lifestyle, physical activity, nutrition and treatments and interventions that enhance bone health, reduce fracture risks and address psychosocial and co-morbidity needs.	☐	☐	☐	☐		Low Medium High
Development of a personalised management plan	**14 Collaborative personalised management plans cover the persons' holistic needs** There is collaborative development of a personalised management plan that addresses both the physical and psychosocial needs with their specific goals and actions plan.	☐	☐	☐	☐		Foundational Low Medium High

Element or resources	Components of care	Your rating of local achievement				Rationale (comment about how you measured your achievement)	Priority
		Not met	Planned	Partially met	Met		
Development of a personalised management plan	**15 Personalised management plans are shared with all relevant stakeholders** The personalised management plan is provided to the individual as well as being available to all care providers.	☐	☐	☐	☐		Low Medium High
Reviews	**16 There is ongoing care through planned reviews** Care includes a planned review of long term lifestyle changes and compliance with treatment and interventions.	☐	☐	☐	☐		**Foundational** Low Medium High
Reporting and evaluation	**17 Data systems support quality and timely evaluation and reporting** Appropriate reporting and evaluation capabilities exist allowing for quarterly reporting, service review by the steering committee and use in quality improvement activities.	☐	☐	☐	☐		Low Medium High
Quality improvement	**18 Improved quality of care is driven by patient outcomes and experiences and staff and stakeholder feedback** Quality improvement activities are embedded in ongoing practice and related to patient reported measures as well as staff and stakeholder feedback.	☐	☐	☐	☐		Low Medium High

4. Supplementary information

4.1 Resource: governance

A governance structure provides clear strategic direction and leadership, promoting and enabling use of the chronic care principles for the prevention of osteoporotic refracture within the LHD. A steering committee is responsible for the governance of ORP with representatives from all key stakeholders and meets to drive ORP service establishment and delivery, provide advice, and to advocate or escalate issues.

Components of care

1. **Osteoporotic Refracture Prevention is based on chronic care principles**

   The ORP service is governed by a shared understanding, clear vision and strategies supporting the delivery of chronic care services to reduce the risk of refracture and to promote effective management of bone health.

EXAMPLES OF HOW TO MEET THIS COMPONENT

- Senior leaders visibly participate and show commitment (dedicate resources) to allow utilisation of **chronic care principles** in musculoskeletal services.
- Documented local service delivery model (structure, content, locations) complying with elements of care.
- Formal arrangements for delivery of services (e.g. contracts for external allied health providers, VMOs or GPs).
- Structures are in place for clinicians to provide evidence based guideline recommended care (e.g. professional development, quarantined administrative support time, room or clinic space).

2. **There is collaborative decision making for planning, implementation and evaluation**

   A musculoskeletal steering committee responsible for the governance of ORP consists of representation of all key stakeholders and promotes the achievement of the vision and strategies to achieve program outcomes.

EXAMPLES OF HOW TO MEET THIS COMPONENT

- Executive and clinical lead identified.
  - Executive Sponsor: someone who authorises, legitimises and demonstrates ownership by driving the change. They must have sufficient power in the organisation to initiate and reinforce the resource commitment.
  - Clinical Lead(s): clinicians with local credibility and ability to influence a range of people.
  - Site specific clinical champions: clinician who believe in and want the change to happen.

- Identification and allocation of a medical officer to provide clinical governance and champion the program.
- Formalised service or clinical governance framework: ORP service is referred to in local operational or clinical services plans.
- Engaged and active ORP service delivery team.
    - Service Lead – CNC2 or senior allied health 4.
    - Service Coordinator – CNS, RN8, Allied health professional 3.
- Inclusion and engagement of all key stakeholders in an initial round table discussion.
- A musculoskeletal steering committee.
    - Membership and representation of all key stakeholders.
    - This group will be responsible for governance of ORP, OACCP and (ALBP if that model of care is implemented locally).
    - Documented terms of reference (including clear definition and understanding of roles, responsibilities and expectations of members).
    - Minutes and actions for steering committee meetings.
- Clinicians are supported in their delivery of evidence-based guideline recommended care (e.g. professional development, quarantined administrative support time, room or clinic space).

4.2 Resource: workforce

A skilled workforce with expertise and capacity to deliver evidence based and person centred chronic disease management for people sustaining minimal trauma fractures in order to reduce the risk of refracture and promote bone health. The provision of care should include care coordination, medical interventions, a multidisciplinary team approach, health education, collaborative personalised management planning and self-management support.

Components of care

3. **Dedicated fracture liaison coordinator is skilled to provide care coordination and case management with the capacity to successfully meet the need of each ORP service site.**

   The fracture liaison coordinator has a dedicated role in patient identification, assessment, education and referral in order to achieve early access to appropriate interventions and community support services to reduce risk of refracture and promote bone health. There is a dedicated FTE with the capacity to successfully meet the cohort need of each ORP service site and achieve full coverage of the LHD's geographical area.

EXAMPLES OF HOW TO MEET THIS COMPONENT

- Recruitment of a suitably qualified and experienced dedicated program coordinator for each ORP service site.
    - Service Coordinator – CNS, RN8, Allied health professional 3.
- There may be a Service Lead to oversee the program coordination across the LHD.
    - Service Lead – CNC2 or senior allied health 4.
- Current position descriptions for coordinator roles.

4. **Multidisciplinary team access is facilitated to support the individual's chronic care needs**

   The local ORP service delivery model provides access to multidisciplinary support to meet the chronic care needs of individuals and for efficient and effective service delivery including administrative support.

EXAMPLES OF HOW TO MEET THIS COMPONENT

- Formal documentation of staffing resource allocation for ORP service delivery.
- Access to multidisciplinary team (MDT) members (may include physio, nurse, OT, dietician etc.).
- Formalised and structured referral pathways to MDT care.
- Dedicated administrative support for efficient ORP service delivery.
- ORP is fully staffed with capacity to meet requirements of the SLA /KPIs and quality standards.
- Clinicians delivering care should be appropriately skilled to deliver best practice chronic care principles.
- Staff have attended training programs to support program delivery (e.g. Health Change Training, Peer Mentoring).

5. **A medical officer is allocated to provide medical management and support for the ORP Service**

   Engagement of a medical officer to address the medical needs of the patients and provide clinical governance and leadership for the ORP service.

EXAMPLES OF HOW TO MEET THIS COMPONENT

- Position descriptions for medical officer role
- Staff Specialist or Visiting medical officer with expertise in the management of osteoporosis (e.g. Rheumatology or Endocrinology Specialist) provides medical management.

4.3 Resource: technology

Information Technology (IT) and electronic communication is utilised to support efficient access and sharing of information across the continuum of care, and to enable continuous improvement of the ORP service through more effective recording and reporting of health outcome information.

Components of care

6. **IT functionality supports efficient and effective service delivery**

   IT infrastructure supports the identification of eligible individuals, captures and monitor outcomes, supports care coordination, sharing of the personalised management plan and the extraction and analysis of data for reporting and quality improvement activities

EXAMPLES OF HOW TO MEET THIS COMPONENT

- All staff involved in the ORP service have unhindered access to electronic patient records (eMR).
- eMR integrated assessment and outcome forms are available and in use.
- Data extraction functionality from eMR is used.
- There is electronic access to patient records when care is delivered across multiple sites.
- Access to and utilisation of digital tools to support the identification of eligible patients (i.e. development of an automated patient identification and screening tool).
- Data collection tools are utilised to enable timely and efficient reporting.
- Automated and electronic communication is utilised between providers within the LHD and community and primary health.
- Electronic referral processes are available and in use between the LHD and community and primary health.
- Discharge letter functionality within eMR is available and used.
- Access to alternative tools to provide care delivery (telehealth, web based tools, phone support, internet/phone supported care models, etc.).

4.4 Core element: access to care

People aged 50 years or more, sustaining minimal trauma fractures will be actively identified across acute, outpatient, community and primary healthcare settings. Contact from the fracture liaison coordinator will initiate their access to secondary fracture prevention through health education promoting the importance of optimising bone health.

Components of care

7. **There is equitable access to the service**

   The ORP service model has appropriate reach and access for local community and priority population groups.

EXAMPLES OF HOW TO MEET THIS COMPONENT

- Provision of care that is wherever possible close to home and location of the ORP service is appropriate for those accessing it (shorting walking distance from car park/public transport, lift access etc.).
- Clear identification of priority populations within the LHD (Aboriginal Australians, CALD groups).
- Provision of culturally appropriate services (as well as ongoing self-management opportunities) for Aboriginal people and locally relevant culturally and linguistically diverse group.
- Resources to support and enable access and appropriate interventions for local community and priority population groups (i.e. interpreter, aboriginal health workers, telehealth).
- Written information about the program and eligibility is available in a variety of languages and appropriate formats (i.e. literacy, language and cultural needs).
- Communication regarding access to the ORP includes the involvement of a carer, friend or family as preferred by the individual.
- There are documented systems (electronic if possible) for auditing access to the ORP service.

8. Easy identification of eligible individuals

Effective and efficient processes for the identification of people sustaining minimal trauma fractures and requiring refracture prevention.

EXAMPLES OF HOW TO MEET THIS COMPONENT

- Clear and documented eligibility criteria and referral pathways.
- Automated electronic identification tools are used by staff to identify eligibility for the ORP service (i.e. automated patient identification and screening tool).
- Targeted engagement with the key stakeholders responsible for identifying/referring individuals regarding eligibility and purpose of the ORP.
- There are standard processes for:
    - communication received by the referrer, patient and GP regarding outcomes of identification/referrals to ORP
    - managing ineligible referrals/identification
    - when individuals decline the ORP service
    - managing out of area referrals/identification.
- There are documented systems (electronic if possible) for auditing eligibility and identification processes.

4.5 Core element: comprehensive assessment

All patients who are eligible for the ORP receive a comprehensive assessment that is holistic and patient centred, using validated clinical and patient reported measures. This allows for a better understanding of the individual's specific needs and circumstances and for all factors that impact on their wellbeing to be considered when planning their management.

Components of care

9. Conduct a comprehensive assessment based on the holistic needs of the individual

A comprehensive assessment is completed for those identified that is holistic and patient centred, using validated clinical and patient reported measures and in consideration of physical, social, psychosocial and co- morbidity needs of the person.

EXAMPLES OF HOW TO MEET THIS COMPONENT

- There is a standardised assessment process used across the LHD.
- There is a documented process for engagement of appropriate professionals/services such as an Aboriginal health worker or health interpreters as part of the comprehensive assessment.
- Patient reported measures are included as part of the comprehensive assessment process (i.e. Patient-Reported Outcomes Measurement Information System (PROMIS-29).
- Validated tools are used to assess patient reported or clinical outcomes (e.g. Visual Analogue Scale, DASS-21).
- The assessment resources are available in appropriate formats for low literacy, language and cultural needs.
- A comprehensive assessment is completed by all staff which covers the physical, social, psychological and comorbidity needs of the patients including:
    - bone health (i.e. osteoporosis) and future fracture risk
    - clinical investigations (DXA, x-rays, pathology)
    - falls risk
    - co-morbidities
    - psychosocial assessment.
- The comprehensive assessment is accessible to all health professionals involved in care.
- The comprehensive assessment is documented in the medical record.
- When assessment is completed outside of the ORP service, the coordinator documents the encounter and updates the medical record as required.

4.6 Core element: medical care

A medical officer dedicated to ORP allows the service to facilitate bone mineral density scanning and other investigations (typically blood testing and urine studies) to support the comprehensive assessment of poor bone health (i.e. osteoporosis) and future fracture risk. The medical officer will also initiate medical therapy. This includes the prescription of osteoporosis medication as an addition to conservative care measures such as vitamin D and calcium supplementation.

Components of care

10. Access to investigations

Clinical investigations including bone mineral density scanning are available and utilised to support the assessment of poor bone health and future fracture risk.

EXAMPLES OF HOW TO MEET THIS COMPONENT

- Use of bone densitometry, also called dual-energy x-ray absorptiometry (DXA) as the mode of choice to measure bone density.
- Formalised access and referral processes to bone density scanning, other imaging and pathology departments.

11. The initiation of medication is facilitated by the ORP medical officer

The medical officer initiates the required medical therapy.

EXAMPLES OF HOW TO MEET THIS COMPONENT

- Medical regimes (prescription of osteoporosis medication as an addition to conservative care measures such as vitamin D and calcium supplementation) are initiated as part of ORP services.
- The provision medication regimes through of sub-cutaneous and intravenous delivery methods is available

4.7 Core element: health education and self-management support

Health education and self-management support is an integral part of a chronic disease management program. The ORP provides health education about osteoporosis and promotes the necessary treatment, interventions and a healthy lifestyle for bone health and reduce risks. Behaviour change methodology facilitates the person's lifestyle and behaviour changes.

Components of care

12. Health education builds understanding, engagement and empowerment for self-management

Health education is provided to all people within the ORP service on their condition and effective treatments and interventions to facilitate active and informed decision making.

EXAMPLES OF HOW TO MEET THIS COMPONENT

- There is a flexible and tailored person-centered approach to information and education.
- Health education is delivered in a variety of different formats to meet the needs and preferences of the individual, including written, one to one, group and digital options.
- Health education given is documented within the medical record.
- Health education includes disease management, effective treatments and interventions.
- Education is based on evidence based care.
- The principles of adult learning, behavior change methodologies and health literacy are considered in the delivery of health education.

13. All individuals are supported to engage in treatments, interventions and identified health behaviour changes

There is access to and behavioural support that promote a healthy lifestyle, physical activity, nutrition and treatments and interventions that enhance bone health, reduce fracture risks and address psychosocial and co-morbidity needs.

EXAMPLES OF HOW TO MEET THIS COMPONENT

- Information and communication practices consider the principles of adult learning, behavior change methodologies and health literacy.
- Self-management support is provided by clinical staff and designed to empower the individual and support engagement in behaviour change activities.
- Staff have undergone training in behaviour change methodologies (e.g. Health Change Australia).
- Care pathways and community resources are available to support self-management (e.g. MDT support, community exercise classes).
- Available list of information and self-management resources.

4.8 Core element: development of a personalised management plan

A management plan is developed to address the person's physical and psychosocial needs, bringing together all the management options and self-management support offered. Self-management and action plans are developed in collaboration with the individual, their carer, friends or family. The personalised management plan will include relevant personal details and disease outcomes, clinical and medication management plans, list of service providers and referrals and their self-management goals. This should be shared with all care providers, their GP and/or referrer and the individual. Management options should aim to address the fundamentals of refracture prevention and osteoporosis management.

Components of care

14. Collaborative personalised management plans cover the individual's holistic needs

There is collaborative development of a personalised management plan that addresses both the physical and psychosocial needs with their specific goals and actions plan.

EXAMPLES OF HOW TO MEET THIS COMPONENT

- All people attending the service have a personalised management plan developed.
- There is a standardised template for the management plan including personal details and diagnosis, list of service providers and referrals, clinical and medication management plans and self-management goals.
- Management options and self-management support are offered for:
    - health education
    - diet and lifestyle (i.e. adequate calcium and protein intake, adequate but safe exposure to sunlight as a source of vitamin D, maintenance of a healthy weight and body mass index, cessation of smoking, avoidance of excessive alcohol consumption)
    - reducing the risk of falls
    - exercise
    - calcium and vitamin D supplementation
    - pharmacologic approaches to prevention and treatment
    - psychosocial and comorbidity management.
- The personalised management plan is person centred and user friendly in terms of language, literacy and format.
- The personalised management plan demonstrates collaboration, active involvement and ownership of the individual in their plan (e.g. specific goals and action plans, written in 'their' language, signature/tick box).

15. Personalised management plans are shared with all relevant stakeholders

The personalised management plan is provided to the individual as well as being available to all care providers.

EXAMPLES OF HOW TO MEET THIS COMPONENT

- The personalised management plan is able to be shared, reviewed and updated by all relevant stakeholders and is integrated within the eMR if available.
- A copy of the personalised management plan can be viewed by all health professionals involved in care.
- A copy of the personalised management plan is provided to the individual and/or carer.
- A copy of the personalised management plan is provided to the individual's referrer/GP.
- Communication uses safe and secure electronic transfer platforms for delivery of the personalised management plan.

4.9 Core element: planned reviews

Planned reviews of refracture prevention and the management of bone health are conducted to assess an individual's progress, provide ongoing self-management support and to evaluate, follow up and make adjustments to treatment and management based any changing needs or requirements.

Components of care

16. There is ongoing care through planned reviews

Care includes a planned review of long term lifestyle changes and compliance with treatment and interventions.

EXAMPLES OF HOW TO MEET THIS COMPONENT

- There are planned reviews as part of ORP service delivery.
- There are flexible options for reviews based on an individual's needs (e.g. availability, time, location).
- Responsibility for completion of the review is clearly defined.
- Reviews are conducted and documented using a standardised template (within the eMR if available).
- The review uses the same patient reported measures and clinical outcomes as in the comprehensive assessment.
- Management plans are reviewed and updated with outcomes and actions.
- The planned review includes self-management support to celebrate progress, problem solve barriers and reinforce empowerment of the individual as actively involved in their care.
- There are flexible systems in place for further support as required by the individual i.e. further falls or fractures.
- Procedures and guidelines for the planned review include documentation and communication processes, protocol for additional reviews/informal support (e.g. telephone follow-up).

4.10 Core element: reporting and evaluation

Reporting and evaluation of the ORP service is necessary to assess and monitor key outcomes including service access, patient reported outcome and experience measures, health service utilisation and fidelity to the model of care. The ORP service should use appropriate tools and data systems to efficiently collect, record, analyse and report on interventions and outcomes and use this data to inform ORP service improvements.

Components of care

17. Data systems support quality and timely evaluation and reporting

Appropriate reporting and evaluation capabilities exist allowing for quarterly reporting, service review by the steering committee and use in quality improvement activities.

EXAMPLES OF HOW TO MEET THIS COMPONENT

- Data collection systems and tools exist to capture relevant patient reported outcomes and ORP service provision data.
- Patient reported outcomes are measured (PROMIS 29).
- Patient reported experience measures (PREMs) are used to provide direct feedback about care received.
- Health service utilisation data.
- KPIs and clinical indicators.
- A minimum data set is completed for all individuals and recorded electronically.
- There is a formalised system for analysis and reporting that utilises a standard format for the quarterly reports.
- Data tools and/or resources are provided to enable timely reporting and identifying quality improvement needs.
- There is an embedded audit schedule that includes analysis and reporting processes.

4.11 Core element: quality improvement

Regular reviews are conducted to ensure the quality of the ORP service delivery. This may be achieved by obtaining feedback sought from individuals, staff and key stakeholders; audit of the ORP service and clinical data; or the analysis of systems and processes. Effective information technology systems allow efficient collection and analysis of data. There is a structure in place for teams to reflect on service outcomes and processes and identify opportunities to make changes and quality improvements.

Components of care

18. Improved quality of care is driven by patient outcomes and experiences and staff and stakeholder feedback

Quality improvement activities are embedded in ongoing practice and related to patient reported measures as well as staff and stakeholder feedback.

EXAMPLES OF HOW TO MEET THIS COMPONENT

- Patient reported measures and experiences are routinely collected and analysed to identify, inform and review quality improvement activities.
- Staff and stakeholder feedback is routinely collected to inform or review quality improvement activities.
- Resources (data tools and/or staff time) are provided to enable identification and reviews of opportunities to make changes and quality improvement.
- There is a proactive review of care pathways and community services available to support management and where gaps are identified, plans developed to address the need.

Osteoporotic Refracture Prevention Implementation Assessment Tool

AGENCY FOR CLINICAL INNOVATION

Level 4, 67 Albert Avenue
Chatswood NSW 2067

PO Box 699 Chatswood NSW 2057
T +61 2 9464 4666 | F +61 2 9464 4728
E aci-info@health.nsw.gov.au |
www.aci.health.nsw.gov.au