

# PART C: CLINICAL AUDIT

## Know Your Numbers Worksheet (optional)

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Welcome to the Healthy Ageing Quality Improvement program.

The program has been designed to assist you in leading change in your practice to deliver better care for older people.

The program consists of:

- Viewing a short, animated video of case study “Mrs Andrews story”.
- Reviewing the evidence for better care for older people living in the community.
- Reviewing deidentified data from your medical software records on a range of selected project measures for people aged 65+.
- Auditing 15 medical records for patients who have had a 75+ health assessment at your General Practice in the previous 15 months.
- Reflecting upon any gaps in care that your audit has detected.
- Documenting plans to make improvements in your General Practice system to reduce the likelihood of these ‘care gaps’ occurring in future.
- Auditing the original 15 medical records for patients who have had a 75+ health assessment at your General Practice and comparing the changes.
- Reflecting upon the improvements or persisting gaps that your audit has detected.

The program provides opportunities to gain skills and knowledge to improve leadership within your practice and the healthcare system. Leaders aspiring to run sustainable and innovative general practices can benefit by focused data analysis. In other words, “know your numbers”. Using this data to drive improvements is a leadership activity and can improve team engagement, patient safety, financial performance, and quality of care. This supports practice sustainability, clinical governance, accountability, and professional satisfaction.

You have access to a data extraction tool called Primary Sense. Using this tool allows you to build reports which assist you to “know your numbers” and can be used to identify opportunities for improvements. If you are unfamiliar with how to use Primary Sense, please contact your PHN who can provide support to your team.

Australians aged 65+ have increased from 12% to 16% of the overall population according to the 2021 census when compared to 2016. The Gold Coast region has around 17% of its overall population aged 65+.

# Know Your Numbers Activity

A range of project measures have been developed to evaluate the outcomes of this activity. You will be provided with the data reports (similar to the one pictured below), supplied by Gold Coast PHN, detailing performance on selected project measures on three occasions - at baseline, mid-point, and at conclusion of the audit.

As part of the Healthy Ageing Program, your data can also be benchmarked against other participating practices, *if you wish to better understand how you compare.*

<a href="#">Project Measures – Baseline (May 2024)</a>		
Total patient population = 4202		
	No.	% (within relevant age group)
1. Number and % of patients in the practice aged 65-74	565	13.4%
2. Number and % of patients in the practice aged 75+	422	10.0%
3. Number and % of active patients in the practice aged 65+	987	23.5%
4. Number and % of patients aged over 65 who have had an influenza vaccination in past 15 months	719	72.8%
5. Number and % of patients aged 75+ who have had a pneumococcal vaccine (either 23 or 13)	304	72.0%
6. Number and % of patients aged 65+ who have had the shingles vaccine	491	49.7%
7. Number and % of patients aged 75+ who have had a medication review in past 2 years	3	0.7%
8. Number and % of patients aged 75+ who have had a health assessment in the past 15 months	335	79.9%
9. Number and % of patients aged 75+ with weight recorded in past 12 months and a height record	337	79.9%
10. Number and % of patients aged over 75+ with a frailty diagnosis	1	0.2%
11. Number and % of patients aged 65-74 with a GPMP in past 15 months	235	41.6%
12. Number and % of patients aged 75+ with a CKD diagnosis	32	7.6%
13. Number and % of patients aged 75+ with implied CKD	88	20.9%
14. Number and % of patients aged 75+ with a diagnosis of Dementia	33	7.8%

NB: All data is based on RACGP definition of an active patient

The following pages describe the importance of monitoring performance on selected project measures and offer some ideas for reflections and discussions following the review of practice data at each touch point.

## Practice Demographics

### *Why is this Important?*

Ensuring the accuracy of numbers of your active patient population can make a difference to the services you provide, the skills your GPs and nurses require, and the ancillary services you may wish to co-locate in your practice.

Please note that counts of patient population considered in these data reports use the RACGP definition of active is a patient who visits the practice 3 times in 2 years.

### *Project Measures:*

- How many active patients does your practice have?
- Number and % of active patients aged 65-74?
- Number and % of active patients aged 75+?

*Reflection:*

- Do you have a process for identifying and removing inactive or deceased patients?
- Is the size and % of your older persons' population higher or lower than you expected?
- What is the significance of the size of the group of people aged 65-74 compared to the 75+ group?

## Chronic Conditions

*Why is this Important?*

- 79% of people in Australia aged 65+ have at least 1 long term health condition and 50% of people aged 65+ have at least 2 long term health conditions.
- Chronic conditions monitored during this activity are among the most prevalent in older adults: around 15% of people aged 75+ have dementia and 40% have CKD, and 20% of Australians aged 65+ have frailty.
- Attention to coding of chronic conditions is important not only to help proactively review the care across the practice population, but also from a patient safety perspective as there are many medications which can cause deterioration of both kidney and brain function.
- Having the correctly coded diagnoses in the medical software can mitigate the risk as the software alerts the prescriber if any prescribed medications can cause harm to older people with these conditions.

*Project Measures:*

- Number and % of people aged 75 with coded diagnosis of chronic kidney disease (CKD)
- Number and % of people aged 75 with coded diagnosis of Dementia
- Number and % of people aged 75 with a coded diagnosis of Frailty

*Reflection:*

- If the results are not what you expected, please consider potential reasons.  
There may be an issue with:
  - o coding,
  - o using free text to record diagnoses, or
  - o diagnostic process used to identify people with these long-term conditions.

## Immunisations and Proactive Care

### *Why is this Important?*

Proactive care provided by a 75+ health assessment in a General Practice is an opportunity to stand back and look at the whole person from a physical, psychological and functional perspective. The evidence is strong that a health assessment performed using the right assessment tools, can improve an older person's function.

A decline in immune function with ageing increases the impact of infectious diseases in older people. Infectious diseases contribute significantly to morbidity, ongoing functional decline and mortality in older people. Shingles, Influenza, and pneumococcal disease are preventable by vaccination, but vaccine coverage is suboptimal for all of these. Understanding the vaccine coverage among people aged 65 years and over in your practice will assist in you improving the practice systems to enable more people to receive the age-appropriate vaccines made available through the National Immunisation Program (NIP).

With 50% of people aged 75+ being prescribed 5 or more medications (the definition of polypharmacy), medication reviews are an important proactive care element for this group. Regular medication reviews can prevent or minimise polypharmacy-related adverse effects and related hospitalisations, by helping older people, carers and caregivers to better understand how to use the medications correctly, and how to manage potential adverse effects. By working in partnership with a skilled consultant pharmacist, General Practices can make an impact for older people.

### *Project Measures:*

- Number and % of people aged 75+ with a weight recorded and a height recorded in past 12 months
- Number and % of people aged 65 who have had an influenza vaccination in past 15 months
- Number and % of people aged 75 who have had a home medication review (item 900) in past 2 years
- Number and % of people aged 75+ who have had a 75+ health assessment in the past 15 months?
- Number and % of people aged 75 who have had a pneumococcal vaccine (either 23 or 13)
- Number and % of people aged 75 who have had a shingles vaccine (either Shingrix or Zostavax)

### *Reflection:*

- What could be done to improve the immunisations rates?
- What could be done to improve the height/weight recording?
- What could be done to improve the number of Home Medication Reviews?
- What could be done to improve the number of people having a 75+ Health Assessment?

## Care Systems and Appropriate MBS Utilisation

### *Why is this Important?*

Aging adults face unique challenges to their well-being, not only by having high prevalences of chronic diseases, but also of having to manage more than one chronic condition at a time. Care planning using MBS item 721 allows the opportunity for GPs and nurses to work with patients to create a “plan of wellness” which emphasises the adoption of healthy behaviours, disease self-management and assessment for any gaps in their care. These three areas have the potential to prevent or delay the occurrence and consequences of multiple chronic conditions, and their complications. This opportunity to provide proactive care contrasts to the usual reactive care required by patients during usual 10–15-minute consultations.

### *Project Measures:*

- Number and % of people aged 65-74 who have had a care plan (item 721) prepared in the past 15 months?

### *Reflection:*

- What are your reflections on your practice performance in this area?

## Session #1 Questions

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When reviewing your data for the first time, ask the following 6 questions and use the [worksheet](#) for your answers:

- What looks odd or inaccurate?
- What could be the reasons for this?
- Where are the biggest gaps in the data?
- What did you learn about your practice?
- What surprises you most about the data?
- What would you like to change?

After reflecting on the data, and answering the 6 questions, the next exercise is about the **BIG picture!**

- When leading an improvement, what area do you need to focus on initially in the practice?
- What data will tell you that a change has been made?
- What else will have the biggest impact for your patients and your business over the next 6 months?
- What do you and your team need to be doing in order to make this happen?

### Actions after Session #1:

1. In conjunction with your team, write a plan to focus on leading improvement in one area. Describe the steps required, the timelines and who can be delegated to do the work (a template for a plan will be provided after Workshop 1).
2. Review the plan every month and check on progress.

*PRACTICE TIP: Discuss the change every day in the practice with at least one person. This is called 'socializing the change' and gives a message to everyone that this matters. If it only gets discussed every 3 months, then everyday work will suffocate the message you are trying to give, and the change is less likely to be sustainable.*



