

## Continuous Quality Improvement (CQI)

## Example: High Cardiovascular Risk and My Health for Life (CAT4)

Original resource created in collaboration with Anna D’Arcy My Health for Life provider

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| **CQI steps** | | **Ask-Do-Describe** | |
| **Data report 1 - baseline** | **First CQI meeting** | **Why do we want to change?** | |
| * Gap | Some patients eligible for cardiovascular disease (CVD) risk assessment have not had all the risk factors measured to allow a calculation of CVD risk and would benefit from completion of an assessment.  Some patients have a high cardiovascular risk (>15% absolute risk of CVD events over 5 years) and diagnosed hypertension but have not been offered referral to a multiple lifestyle intervention to reduce total mortality and a future cardiovascular event. These patients require identification and appropriate referral for lifestyle support. |
| * Benefits | **Patients:** Early identification of CVD risk and the offer of support and opportunity to improve individual modifiable risk factors will reduce the incidence of preventable CVD events and the resulting disability, morbidity or mortality.  **Practice**: Regular assessment of a patient’s CVD risk is the foundation to identifying patients with modifiable risk factors and supports implementation of an appropriate monitoring and management plan.  **Practitioner:** An up to date list of patients with a high CVD risk will provide practitioners the opportunity to provide early and effective management of modifiable risk factors. |
| * Evidence | It has been estimated that 64% of Australians have three or more modifiable risk factors. Approximately 90% of the risk of myocardial infarction (MI) observed worldwide can be attributed to blood lipid abnormalities, smoking, raised BP, diabetes, abdominal obesity, psychosocial factors, physical inactivity and inadequate intake of fruits and vegetables. ([INTERHEART study 2004)](https://www.ncbi.nlm.nih.gov/pubmed/15364185)  A Cochrane review of 55 trials using lifestyle change interventions to improve cardiovascular outcomes, education or counselling with or without pharmacotherapy to reduce CVD risk factors were assessed. These trials were more than 6 months in duration using counselling or education to modify more than one CVD risk factor in adults from general populations and involved people over 40 years with no evidence of CVD at baseline. The interventions show benefits in total mortality and combined fatal and non-fatal cardiovascular events in people with hypertension (16 trials) (OR 0.78, 95% CI 0.68–0.89). ([Ebrahim S etc al 20111](https://www.ncbi.nlm.nih.gov/pubmed/21249647))    Adults at high absolute risk of CVD should be simultaneously treated with lipid and blood pressure-lowering pharmacotherapy in addition to lifestyle advice unless contraindicated or clinically inappropriate. [(RACGP endorsed clinical guidelines: Recommendations for assessing and managing absolute CVD risk in adults)](https://www.racgp.org.au/clinical-resources/clinical-guidelines/guidelines-by-topic/endorsed-guidelines/guidelines-for-the-management-of-absolute-cardiova)  Much of the decline in cardiovascular deaths over the past four decades is attributable to primary and secondary prevention, including the treatment of elevated blood pressure (BP) and dyslipidaemia. Both BP and lipid lowering therapy have been shown to reduce the risk of cardiovascular events in patients at all levels of risk. [(RACGP)](https://www.racgp.org.au/afp/2012/october/prioritising-cvd-prevention-therapy/) |
| **What** do we want to change? | |
| * Topic | Increasing completion of CVD risk assessments and identification of patients who would benefit from early intervention and management of modifiable risk factors  The aim is to increase the number of eligible patients who have a CVD risk assessment and those with high risk are referred to appropriate lifestyle intervention program/s |
| * Scope | All patients eligible for a CVD risk assessment |
| **How much** do we want to change? | |
| * Baseline | PEN CS software will be used to generate a baseline number of patients with high CV event risk. *E.g. Baseline 72%*  Cat4 recipe – [Find patients eligible for My health For Life with High CV Event risk](https://help.pencs.com.au/display/CR/Find+patients+eligible+for+My+Health+For+Life+with+high+CV+Event+risk) |
| * Sample | Number of people with high CV event risk:  *(Enter practice number here with a buffer for patients that decline assessment)* |
| * Target | *% result of proposed improvement (e.g. 2% per month for 3 months)* |
| * Preparedness | The practice team have the knowledge and confidence to participate in a continuous quality improvement (CQI) project and further develop CQI skills.  **Consider using the** [**Heart Health Check Toolkit.**](https://www.heartfoundation.org.au/Bundles/Heart-Health-Check-Toolkit/) |
| **Who** are involved in the change? | |
| * Leads   Contributors | GP lead:  Practice Nurses/Manager/Admin Staff: |
| * External | My Health for Life facilitators – can provide support for information on My Health for Life program  PHN Practice Support – can provide assistance on downloading referral templates for My Health for Life |
| **When** are we making the change? | |
| * Deadlines | The practice is allocating 3 months to complete the project |
| **How** are we going to change? | |
| * Potential solutions | Utilise [Heart Health Check Toolkit](https://www.heartfoundation.org.au/Bundles/Heart-Health-Check-Toolkit/toolkit-contents) for QI steps and guidance.  Review data and create reports with individual patients listed  Add alerts on clinical software system for those with upcoming appts and discuss/provide CVD risk assessment  Recall patients eligible for review of a GP Management Plan, review of Team Care Arrangements, Health Assessment or Heart Health checks  Utilise TopBar to assess CV risk  Complete referrals for allied health and My Health for Life |
| * Select | CAT4 data will be used to generate a list of patients with high CV event risk and invite for Heart Health check |
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| * **Implementation** | | * Implement | 1. Generate list of patients - Cat4 recipe – [Find patients eligible for My health For Life with High CV Event risk](https://help.pencs.com.au/display/CR/Find+patients+eligible+for+My+Health+For+Life+with+high+CV+Event+risk) 2. RN or PM to check HPOS for eligibility for Heart Health Check 3. Invite eligible patients for Heart Health Check 4. GP role here 5. Refer eligible patients to My Health for Life program. |
| * Record, share | *Add to monthly team meeting agenda* |
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| **Data Report 2**  **Comparison** | **Final CQI meeting** | **How much** did we change? | |
| * Performance | *Did you achieve your target?*  *If not, consider new activity to test* |
| * Worthwhile | *Was the effort to complete worth the outcome?*  *Did the team value the activity?* |
| * Learn | *What lessons learnt could you used for other activities?*  *What worked well, what could have been changed or improved* |
|  | **What next?** | |
| * Sustain | *Implement new processes and systems into business as usual* |
| * Monitor | *Review patients eligible for My Health for Life with High CV Event risk quarterly and initiate corrective measures as required* |