

## Continuous Quality Improvement (CQI) – Patients eligible for Heart Health Check using CAT4.

Based on the Heart Foundations [Heart Health Check Toolkit.](https://www.heartfoundation.org.au/Bundles/Heart-Health-Check-Toolkit/toolkit-contents)

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| **CQI steps** | | **Ask-Do-Describe** | |
| **Data report 1 - baseline** | **First CQI meeting** | **Why do we want to change?** | |
| * Gap | Absolute CVD (cardiovascular disease) risk assessment performed during a Heart Health Check brings together multiple risk factors to give an estimate of an individuals combined risk of heart attack or stroke in the next five years.  However, there is still suboptimal assessment of risk factors and 70% of high-risk individuals aged 45-74 years are not receiving guideline-recommended blood pressure and lipid lowering therapy. |
| * Benefits | Identifying patients eligible for a Heart Health Check (comprehensive CVD risk assessment) can lead to assessment and management of CVD risk, lifestyle advice to address modifiable risk factors, interventions and referrals to support lifestyle changes.  Proactive identification and planning for patients with CVD risk factors may help prevent hospital admissions, increase patient wellness and quality of life.  CVD risk assessment is incentivised through MBS item numbers and a QI focus in this area can support practices to meet PIP QI requirements. CVD risk assessment is also listed as one of the [10 PIP QI measures](https://www1.health.gov.au/internet/main/publishing.nsf/Content/46506AF50A4824B6CA25848600113FFF/$File/Practice%20Incentives%20Program%20Quality%20Improvement%20Measures.pdf) that form the PIP Eligible Data Set. |
| * Evidence | The burden of CVD remains high. Cardiovascular disease (CVD) in Australia:   * causes one in four of all deaths * claims the life of one person every 13 minutes * accounts for 1,600 hospitalisations per day.   Two-thirds of Australian adults are living with at least three CVD risk factors, such as elevated blood pressure, cholesterol and diabetes.  It is estimated that one-fifth of Australian adults aged 45 to 74 years – or 1.4 million people – are at high risk of having a heart attack or stroke in the next five years. Modifiable CVD risk factors such as those mentioned above account for 90% of risk of heart attack, reinforcing the fact that CVD is largely preventable. |
| **What** do we want to change? | |
| * Topic | Identification and management of patients eligible for the Heart Health Check |
| * Scope | Eligibility criteria for Heart Health Check:   * Be 45 years or over (30 years or over for Aboriginal and/or Torres Strait Islander people) * Have no history of CVD, and * Have not had another health assessment in the last 12 months |
| **How much** do we want to change? | |
| * Baseline | To be determined from:  [CAT4 Recipes – Identifying patients eligible for the Heart Health Check](https://help.pencs.com.au/display/CR/Identifying+patients+eligible+for+the+Heart+Health+Check)  Add other potentials indicators to further narrow data (if needed). For example:   * Identify ‘High Risk’ (5-year risk of cardiovascular event) patients using sort/filter * Identify older patients using sort/filter for age * Identify patients with other chronic conditions (e.g., diabetes, COPD) |
| * Sample | All patients identified in the baseline report |
| * Target | 100% of sample patients eligible for CVD risk assessment |
| * Preparedness | All staff believe this is a priority activity for their practice and patient population. |
| **Who** are involved in the change? | |
| * Leads   Contributors | Practice Manager  GPs/Practice Nurses/Receptionists |
| * External | PHN / Heart Foundation/ Patients |
| **When** are we making the change? | |
| * Deadlines | Baseline data report generated (date)  Implementation between (date range)  Review meeting (date) |
| **How** are we going to change? | |
| * Potential solutions | **Identification:**   * As per baseline sample above   **Service delivery options:**   * Review eligibility for Heart Health Check (add your usual process here) * Consider process for service delivery (i.e. number of appointments booked per week, length of appointments) * Consider method for recalling patients including [phone](https://www.heartfoundation.org.au/Bundles/Heart-Health-Check-Toolkit/Receptionist-s-guide-to-the-Heart-Health-Check), [letter/email or SMS](https://www.heartfoundation.org.au/Bundles/Heart-Health-Check-Toolkit/Patient-invitation-templates). * Consider [patient resources](https://www.heartfoundation.org.au/Bundles/Heart-Health-Check-Toolkit?selectedfilter=%5e4%5eEngaging%20Your%20Patients) that can be displayed.   **Management:**   * Consider steps/actions after CVD risk assessment including a seasonal approach to supporting patients: * [**Autumn – Prevention**](https://gcphn.org.au/practice-support/support-for-general-practice/practice-based-population-health-management-program/seasonal-focus-autumn/)   Prevention activities such reviewing and updating vaccinations, referral to lifestyle programs such as [My Health for Life](https://www.myhealthforlife.com.au/) and allied health professional referrals. Review psychosocial factors as appropriate.  Review clinical measures and guidelines and order tests as appropriate.   * [**Winter – Burden of Care**](https://gcphn.org.au/practice-support/support-for-general-practice/practice-based-population-health-management-program/seasonal-focus-winter/)   Review current referrals and specialist and allied health appointments with patient and/or carer to assess which ones are necessary or relevant. Reduce referrals, visits and unnecessary tests if appropriate. Coordinate any relevant tests and/or appointments to meet patient’s medical and personal requirements.  Review clinical measures and guidelines and order tests as appropriate.   * [**Spring – Clinical Coding and Data Management**](https://gcphn.org.au/practice-support/support-for-general-practice/practice-based-population-health-management-program/seasonal-focus-spring/)   Develop an agreed process for the practice for clinical coding and data entry that will support data extraction. Revise current patient consent processes and implement processes and systems to capture patient consent to share data. Update patient contact details including next of kin and emergency contact. Consider uploading SHS to My Health Record. Review medications and consider HMR.  Review clinical measures and guidelines and order tests as appropriate.   * [**Summer – Advance Care Planning**](https://gcphn.org.au/practice-support/support-for-general-practice/practice-based-population-health-management-program/seasonal-focus-summer/)   Discuss and promote Advance Care Planning and encourage patient or family member to upload to My Health Record.  Review clinical measures and guidelines and order tests as appropriate.  NB: patients may enter the seasonal cycle at any point |
| * Select | *Choose potential solutions that will work well in your practice and meet the needs of your patients and team.* |
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| **Implementation** | | * Implement | *Develop plan to suit practice processes (example below). Ensure task allocated to appropriate role.*   1. *Team meeting to discuss plan and confirm roles* 2. *Generate baseline measure from selected report* 3. *Recall patients and schedule appointments* 4. *Progress the most appropriate service delivery option*   *Book Practice Nurse appointment time prior to GP appointment* |
| * Record, share | *Documentation of plan to meet PIP QI requirements. Use team meeting minutes as a record of your activities or document meetings in* [*PIP QI Meeting template.*](https://gcphn.org.au/wp-content/uploads/2020/02/CQI-Practice-Meeting-Template.docx) *Plan date for review meeting to assess progress.* |
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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 as above* |
| * Worthwhile | *Did the activity provide the outcome expected?*  *Did this process provide patients with the required information and services?* |
| * Learn | *What lessons learnt can you use for other activities, what worked well, what could be changed or improved?* |
|  | **What next?** | |
| * Sustain | ***Maintenance*** *(Business as Usual):*   * *Reception to confirm/update personal details at each visit* * *Confirm/update social/family history/allergies/smoking and alcohol status regularly* * *Ensure new reminder in place for review of care plan/medication reviews* * *Consider any other new changes identified during the activity* |
| * Monitor | *Consider monthly data review of eligible at-risk groups and invite to attend services etc* |