

**QI Action Plan- add practice name**

## Winter Wellness Strategy – Care of patients with cardiovascular disease (CVD)

**Green- Instructions**  **Yellow- add practice detail**  **Teal- examples**

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| **Ask-Do-Describe** | |
| **Why do we want to change?** | |
| * Gap | Patients with CVD will require their care to be reviewed and optimised particularly during the winter. A seasonal, person centred care delivery process may assist and provide a systematic and evidence-based approach to comprehensive care. |
| * Benefits | Every winter there is a surge in both community and hospital healthcare demand. Proactive care planning and delivery by general practices for patients with CVD may help to prevent hospital admissions, increase patient wellness and quality of life.  Chronic care management is incentivised through MBS item numbers and can meet PIP QI practice requirements.  Practice staff will become aware of their more complex patients, proactively inviting and allocating time for patient assessments, which may increase staff satisfaction with their work.  Focusing on patients with CVD ensures efficient use of resources, may reduce avoidable hospital admissions and ultimately improves the health service experience for all consumers. |
| * Evidence | Australia has one of the highest life expectancies in the world and most Australians consider themselves to be in good health, however not all Australians are as healthy as they could be. Chronic diseases are the leading cause of ill health and death in Australia [(AIHW – Australia’s Health 2016)](https://www.aihw.gov.au/reports/australias-health/australias-health-2016/contents/chapter-3-leading-causes-of-ill-health). Chronic diseases are long lasting conditions with persistent effects, including social and economic consequences which may have a significant impact on peoples quality of life [(AIHW – Chronic disease)](https://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/chronic-disease/overview).  An estimated 1.2 million (6%) of Australian adults have 1 or more conditions related to heart, stroke or vascular disease. Prevalence is higher in men (6.5%) than women (4.8%) and increases with age, with more than 1 in 4 of those aged 75+ diagnosed with heart, stroke or vascular disease. However, CVD can be preventable, and many risk factors are modifiable [(AIHW – Cardiovascular Disease)](https://www.aihw.gov.au/reports/heart-stroke-vascular-disease/cardiovascular-health-compendium/contents/how-many-australians-have-cardiovascular-disease). People with cardiovascular disease are more susceptible to severe complications if infection with COVID-19, including intensive care admission and death ([Heart Foundation – COVID-19 & Cardiovascular disease](https://www.heartfoundation.org.au/your-heart/covid-19-and-heart-disease-risks)).  The growing burden of chronic disease means that effective treatment for patients with chronic conditions and complex health care needs is vitally important. Development and implementation of new and innovative methods for early disease detection and treatment, including coordinated care planning, patient self-management and chronic disease management is a key role delivered by general practices [(AIHW – Australia’s Health 2016)](https://www.aihw.gov.au/reports/australias-health/australias-health-2016/contents/chapter-3-leading-causes-of-ill-health).  This risk of illness and disease may be experienced across the lifecycle, with older people at an increased risk of multiple chronic conditions that may impair their function and quality of life [(RACGP – Guidelines for preventive activities in general practice, pg. 66 & 85)](https://www.racgp.org.au/FSDEDEV/media/documents/Clinical%20Resources/Guidelines/Red%20Book/Guidelines-for-preventive-activities-in-general-practice.pdf). An annual cycle of care model with a [seasonal focus](https://gcphn.org.au/practice-support/support-for-general-practice/practice-based-population-health-management-program/) can assist with targeted, cost-effective and high quality care delivery and monitoring by general practice. Implementing a seasonal focus model in primary health care can ensure all critical elements of health care management for at risk patients can be achieved. |
| **What** do we want to change? | |
| * Topic | Identifying and managing vulnerable patients with CVD for regular patients of the practice. |
| **How much** do we want to change? | |
| * Baseline | **Baseline data is your current performance**, baseline data for QI activities can be obtained from multiple sources e.g.:   * Data analytic tools- e.g., Primary Sense. * Clinical information systems using the “search” function/patient registers.   Example: Baseline data can be determined from the Primary Sense– COVID-19 – Vulnerable Patients Report - Table 1 (number of patients eligible can be identified in exported Excel spreadsheet, Filter by Diagnosis – Cardiovascular)   * XX patients with CVD diagnosis recorded. |
| * Target | **Target is the number or percentage of patients with CVD invited for care plan/review or missing care items**  Example:   * 100% of sample patients with CVD invited for care plan/review or missing care items * 40 patients with CVD invited for care plan/review or missing care items |
| * Sample | **Sample is the number or percentage of patients with CVD invited for care plan/review or missing care to meet your target.**  Example:  All patients identified with Cancer (COVID-19 – Vulnerable Patients Report)  Identify CVD patients with missing care items   * Narrow down list by targeting patients with:   + ACG score of 4 or 5   + Missing vaccinations   + No visit in last 3 months   Identify eligibility for Fluvax, Pneumovax, Telehealth review and other missing items of care |
| **Who** are involved in the change? | |
| Contributors | *Remove/change/add names as required*  Practice Manager  GPs/Practice Nurses/Receptionists  GCPHN QI Project Officer |
| **When** are we making the change? | |
| * Deadlines | Baseline data report generated (date)  Implementation between (date range)  Review meeting (date)  Final meeting (date) |
| **How** are we going to change? | |
| * Potential solutions | *These are some options you could implement. Please note you can choose 1 or more or amend/add your own as appropriate for your practice. You do not have to implement all options that are brainstormed/listed.*  **Identification:**   * As per baseline sample above   **Service delivery options:**   * Review eligibility for care plan or review (add your usual process here) * Consider most appropriate service delivery option (in practice or telehealth) * If in practice, consider social distancing requirements, types of patients booked in at the same time (consider only “well patients”)   **Management:**   * Consider a person centred, seasonal approach to support comprehensive, evidence-based care delivery for patients with CVD * [**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 Cardiac Rehabilitation, cancer and other disease screening and allied health providers referrals. Review psychosocial factors and mental health support requirements as appropriate.  Review clinical measures and guidelines and order tests as appropriate  Refer to patient support such as [My Heart, My Life.](https://www.heartfoundation.org.au/recovery-and-support/my-heart-my-life)   * [**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 |
| * Implement | *List your chosen solutions in order of implementation*  1.  2.  3. |
| * Monitor | *A minimum of one QI activity review/touchpoint is required. You can include multiple reviews/touchpoints – list by date. If you have only one review during the activity, remove secondary review dates/information that do not apply.*  Review 1 - Date:  · What is working/not working?  · Has there been a change in your performance? If not, why not?  Review 2 - Date:  · What is working/not working?  · Has there been a change in your performance? If not, why not? |
| **How much** did we change? | |
| * Performance | *This section is to be completed at end/closure of activity.*  *Remove/change/edit as required for your practice*  Did you achieve your target?  Example: Number of patients with CVD due for a fluvax has decreased from baseline XX to XX |
| * Worthwhile | Did the activity provide the outcome expected?  Did this process provide patients with the required information and services?  *Please choose an option or add your own. More detail can be included as required*  *e.g. – we believe the effort to complete the activity was worthwhile as we decreased the number of patients with CVD due for a fluvax.*  *OR*  *We believe this activity was not worth the effort required, as we did not significantly reduce the number of patients with CVD due for a fluvax.* |
| * Learn | *What lessons learnt could you use for other improvement activities?*  *What worked well, what could have been changed or improved?* |
| **What next?** | |
| * Sustain | *Implement new processes and systems into business as usual - which parts of this activity, if any, will you incorporate into business as usual at your practice*  Update processes and inform staff to ensure integration into usual business.  *Examples:*   * *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* |