phn BRISBANE SOUTH
An Australian Government Initiative

Heart Foundation

Quality Improvement Toolkit for General Practice

Conditions

Cardiovascular Disease (CVD)

MODULE

Version 3

November 2021

CARDIOVASCULAR DISEASE (CVD)

Introduction

The Quality Improvement (QI) toolkit

This QI toolkit is made up of modules that are **designed to support your practice to make easy, measurable and sustainable improvements to provide best practice care for your patients.** The toolkit will help your practice complete QI activities using the Model For Improvement (MFI).

Throughout the modules you will be guided to explore your data to understand more about your patient population and the pathways of care being provided in your practice. Reflections from the module activities and the related data will inform improvement ideas for you to action using the MFI.

The MFI uses the Plan-Do-Study-Act (PDSA) cycle, a tried and tested approach to achieving successful change. It offers the following benefits:

- A simple approach that anyone can apply
- Reduced risk by starting small
- It can be used to help plan, develop and implement change that is highly effective.

The MFI helps you break down your improvement change into manageable pieces, which are then tested to ensure that the change results in measurable improvements. There is an example of how to increase GPMPs on patients with CVD using the MFI at the end of this module.

If you would like additional support in relation to quality improvement in your practice please contact Brisbane South PHN on support@bsphn.org.au.

This icon indicates that the information relates to the ten Practice Incentive Program Quality Improvement (PIP QI) measures.

Due to constant developments in research and health guidelines, the information in this document will need to be updated regularly. Please contact Brisbane South PHN if you have any feedback regarding the content of this document.

Acknowledgements

We would like to acknowledge that some material contained in this toolkit has been extracted from organisations including the Institute for Healthcare Improvement; the Royal Australian College of General Practitioners (RACGP), the Australian Government Department of Health, Best Practice, MedicalDirector, CAT4, and Train IT. These organisations retain copyright over their original work and we have abided by licence terms. Referencing of material is provided throughout.

While the Australian Government Department of Health has contributed to the funding of this material, the information contained in it does not necessarily reflect the views of the Australian Government and is not advice that is provided, or information that is endorsed, by the Australian Government. The Australian Government is not responsible in negligence or otherwise for any injury, loss or damage however arising from the use of or reliance on the information provided herein.

Brisbane South PHN would like to acknowledge the contribution of the Heart Foundation in the production of this QI toolkit. The Heart Foundation has provided statistics, resources, program framework and publications to assist general practice to manage people at risk or diagnosed with CVD.

Brisbane South PHN, 2021

How to use this toolkit

There are checklists included below that will guide you and your practice.

- Identify a sample group of patients (between 50-100 patients) by reviewing data measures from your practice population.
- Use this toolkit to guide you along the journey.
- Set yourselves timelines to achieve your goals.
- Consider potential internal or external factors that could impact the activity and factor these into your planning e.g. accreditation preparation, staff leave (planned or unplanned), global pandemic, influenza vaccination season.
- Review your progress regularly.
- If you find your process is not working and you are not seeing improvements, then review your process and start again.

For more support


support@bsphn.org.au


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CONTENTS

Cardiovascular disease (CVD)

What is CVD?

Cardiovascular diseases are a group of disorders of the heart and blood vessels, including coronary artery disease, cerebrovascular disease, peripheral artery disease, congenital heart disease and deep venous thrombosis and pulmonary embolism. [1]

- Cardiovascular disease (CVD) is a major cause of death in Australia, with 42,300 (25%) deaths attributed to CVD in Australia in 2019. Cardiovascular disease kills one Australian every 12 minutes.[2][3]
- CVD is one of Australia's largest health problems, and includes heart, stroke and blood vessel diseases. Despite improvements over the last few decades, it remains one of the biggest burdens on our economy.
- key risk factors that contribute to cardiovascular disease are largely preventable, including high blood pressure, poor diet, high cholesterol, lack of activity, tobacco and alcohol excess. Additionally, most people don't associate these key risk factors with their heart health
- two in three Australian adults are overweight or obese, which is among the leading risk factors for heart disease.[4]

What are the risk factors for CVD?

There are multiple modifiable and non-modifiable risk factors that increase the risk of cardiovascular disease.

CVD risk factors that people can change include:

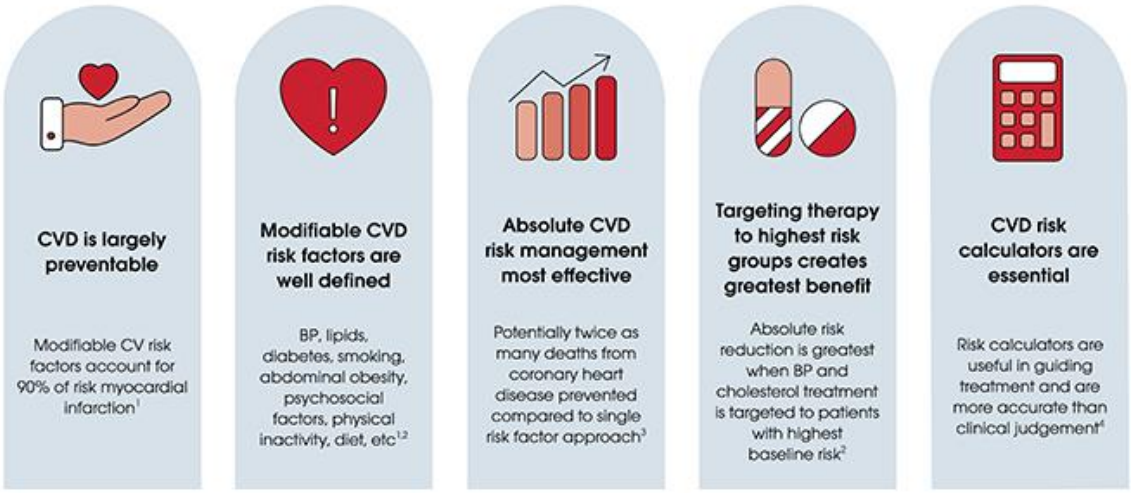
- unhealthy eating
- being physically inactive
- being overweight or obese
- smoking and passive smoking
- diabetes
- high blood pressure
- high cholesterol
- lack of good social support
- alcohol excess.

CVD risk factors that people can't change:

- family history of CHD
- getting older
- ethnicity (Māori, Pasifika people and those from South Asian countries are at higher risk of heart disease)
- being male
- being a post-menopausal woman
- severe mental illness. [5]

[1] https://www.who.int/news-room/fact-sheets/detail/cardiovascular-diseases-(cvds)
[2] https://www.aihw.gov.au/reports/heart-stroke-vascular-diseases/hsvd-facts/contents/about - accessed Nov 2021
[3] https://www.heartfoundation.org.au/Activities-finding-or-opinion/key-stats-cardiovascular-disease - accessed Nov 2021
[4] https://www.heartfoundation.org.au/About-us/Australia-Heart-Disease-Statistics -accessed Nov 2021
[5] https://www.heartfoundation.org.au/conditions/coronary-heart-disease - accessed Nov 2021

Absolute CVD risk principles



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Aim of this QI toolkit

General practice is the first point of contact for treatment, coordination, access to medications, additional tests and referrals to providers in the primary and secondary management of CVD

Toolkit aim - To identify in your practice who has cardiovascular disease and how these patients are being managed.

To achieve this, you will need to extract patient data and establish a valid patient list or register.

The following activities will help guide you through the process at your own pace. There are additional activities to find any patients who may have been missed in the initial data extraction activity and to ensure they are then coded correctly. These activities will improve the accuracy of the register and maintain the system for the future.

Once you have an accurate register you will be able to easily identify how your patients are being managed for their disease and what needs to happen within the practice to optimise patient care.

[6] https://www.heartfoundation.org.au/Conditions/CVD-risk-assessment-and-management - accessed Nov 2021.

Activity 1 - Understanding your CVD patient population

Activity 1.1 – Data collection from CAT4

The aim of this activity is to collect data to determine the number of patients coded with cardiovascular disease. This will include patients with hypertension, hyperlipidaemia, heart failure, cardiovascular disease, coronary heart disease, stroke, myocardial infarct, atrial fibrillation, carotid stenosis, renal artery stenosis and peripheral arterial disease.

Complete the below tables by collecting data from your CAT4 Data Extraction Tool to gather information on your **current** patient population with cardiovascular disease.

Note - Instructions on how to extract the data are available on the CAT4 website: Conditions OR active patients.

	Description	Total number of active patients as per RACGP criteria (3 visits in 2 years)	Total number of active patients
1.1a	Active patient population		
1.1b	Active patients coded with cardiovascular *(covers all subgroups)*		
1.1c	Active patients coded with hypertension		
1.1d	Active patients coded with heart failure		
1.1e	Active patients coded with coronary heart disease		
1.1f	Active patients coded with stroke		
1.1g	Active patients coded with myocardial infarct		
1.1h	Active patients coded with carotid stenosis		
1.1i	Active patients coded with renal artery stenosis		
1.1j	Active patients coded with peripheral arterial disease (PAD)		
1.1k	Active patients coded with hyperlipidaemia (*from other conditions tab*)		
1.1l	Active patients coded with atrial fibrillation (AF) (*from other conditions tab*)		

Please note: the RACGP defines active as 3 visits in 2 years. This does not capture those patients who may come in for screening every 2 years, or twice in 2 years (e.g. flu vaccine), hence the option to look at all active patients.

Another note: Hypertension and hyperlipidaemia are risk factors. Patients coded with these conditions may not necessarily have a diagnosis of cardiovascular disease.

Activity 1.2– Understanding your practice CVD profile

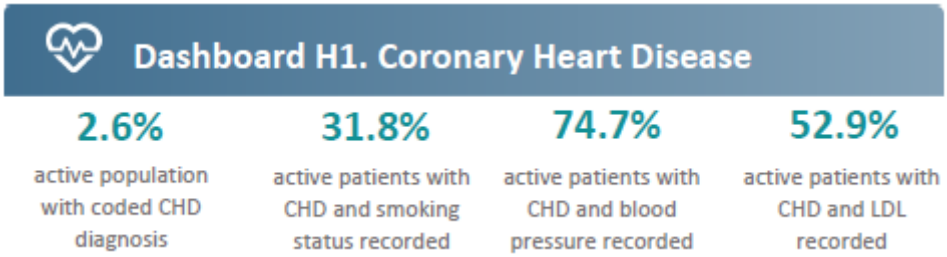
The aim of this activity is to increase your understanding of the active patient with CVD.

Description	Status	Action to be taken
After completing **activity 1.1**, are there any unexpected results with your practice's CVD patients?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. higher number of patients with myocardial infarct than expected, practice has a low population of patients with hypertension*). How will this information be communicated to the practice team?
Is your practice CVD profile similar to other practices in the Brisbane south region (after comparing information from benchmark report)?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Outline the differences – could it be due to *BP recording, specific medications, MBS item claiming?* How will this information be communicated to the practice team?
After reviewing your patient CVD profile, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes, **see action to be taken to help set your goals**. ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 1.3 – Coronary Heart Disease (CHD) measures on benchmark report

The aim of this activity is to review your practice's data dashboard on the monthly benchmark report provided by Brisbane South PHN.

You will need your practice's benchmark report to complete this information. Refer to instructions on how to access this from Sharefile.



	Description	Number
1.3a	Active population with coded CHD diagnosis	
1.3b	Active patients with CHD and smoking status recorded	
1.3c	Active patients with CHD and blood pressure recorded	
1.3d	Active patients with CHD and LDL recorded	

Activity 1.4– Reviewing your practice CHD profile

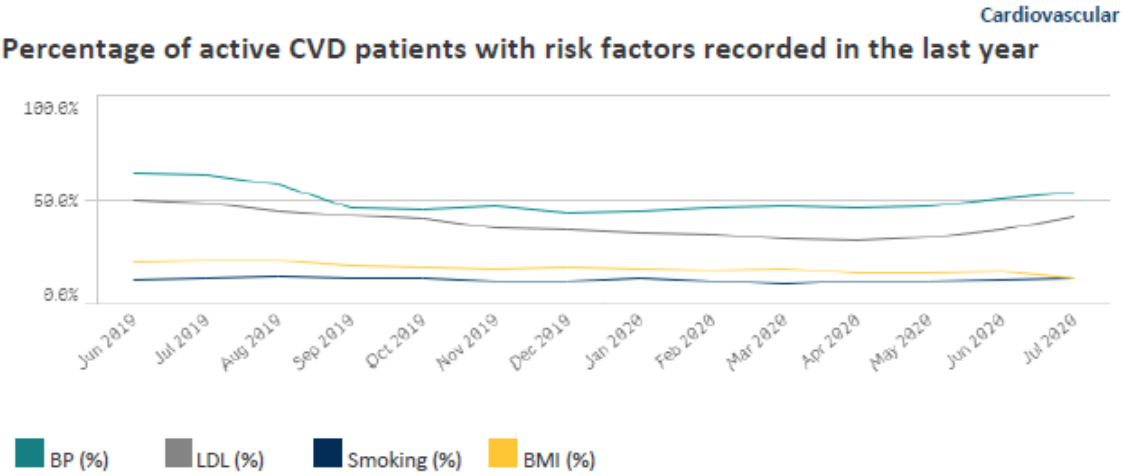
Complete the checklist below which reviews your practice's CHD profile from your benchmark report.

Description	Status	Action to be taken
After completing **activity 1.3**, are there any unexpected results with your practice's CHD profile?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. a low number of patients with CHD and smoking status recorded).* How will this information be communicated to the practice team?
After reviewing your practice's CHD profile, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes, **see action to be taken to help set your goals**. ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 1.5 – Percentage of patients with CVD with risk factors recorded trend report

The aim of this activity is to review your practice's latest trend report provided by Brisbane South PHN.

You will need your practice's trend report to complete this information. Refer to instructions on how to access this from Sharefile.



	Description	Percentage
1.5a	Active CVD patients with BP recorded across the last 12 months	
1.5b	Active CVD patients with LDL recorded across the last 12 months	
1.5c	Active CVD patients with smoking recorded across the last 12 months	
1.5d	Active CVD patients with body mass index (BMI) recorded across the last 12 months	

Activity 1.6– Reviewing your practice CVD profile

Complete the checklist below to review your practice's CVD prevention profile from your trend report.

Description	Status	Action to be taken
After completing **activity 1.5**, are there any unexpected results with your practice's CVD prevention profile?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. trend line is decreasing on the number of patients with CVD and blood pressure recorded in the past 12 months).* How will this information be communicated to the practice team?

Description	Status	Action to be taken
After reviewing your practice's trend line for CVD patients and prevention activities, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes, **see action to be taken to help set your goals**. ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 2 - Identifying patients with CVD and other chronic medical conditions

Activity 2.1 –Data collection from CAT4

The aim of this activity is to collect data to identify patients with CVD and at least one other chronic medical condition

Complete the below table by collecting data from your CAT4 Data Extraction Tool. Note - Instructions on how to extract the data is available from the CAT4 website. Co-morbidities OR Chronic Conditions.

	Description	Total number of active patients as per RACGP criteria (3 visits in 2 years)	Total number of active patients
2.1a	Number of patients with CVD and 1 other chronic medical condition		
2.1b	Number of patients with CVD and 2 other chronic medical conditions		
2.1c	Number of patients with CVD and 3 other chronic medical conditions		
2.1d	Number of patients with CVD and 4 other chronic medical conditions		
2.1e	Number of active patients with CVD & diabetes *(select diabetes 'yes' & cardiovascular disease 'yes' and recalculate)*		
2.1f	Number of active patients with CVD and chronic kidney disease (CKD) *(select cardiovascular disease 'yes' & renal impairment 'yes' and recalculate)*		

Please note: You can search lists by individual providers and provide to them to identify patients with multiple chronic conditions.

Activity 2.2– Reviewing your patients with multiple chronic medical conditions

Complete the checklist below to review your patients with multiple chronic medical conditions.

Description	Status	Action to be taken
After completing **activity 2.1**, are there any unexpected results with your patients' comorbidities?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. higher number of patients with 3 chronic medical conditions).*

Description	Status	Action to be taken
		How will this information be communicated to the practice team?
After completing **activity 2.1,** make note of the patients with CVD & diabetes. Do you need to review your process for managing these patients?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Refer to Brisbane South PHN's QI Toolkit – Chronic Conditions – Diabetes.
After completing **activity 2.1**, make note of the patients with CVD & CKD. Do you need to review your process for managing these patients?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Consider a medication review. Consider recalling the patient to check if they are meeting treatment goals. Refer to Brisbane South PHN's QI Toolkit – Chronic Conditions – CKD.
After reviewing your practice's comorbidities profile, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes, **see action to be taken to help set your goals**. ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 3 - Prevention of CVD

The aim of this activity is to review patients with CVD risk factors and assist the practice to ensure measures are taken to prevent progression to CVD.

Absolute CVD risk calculator

The Australian absolute cardiovascular disease risk calculator has been produced by the National Vascular Disease Prevention Alliance for the information of health professionals. Absolute CVD risk assessment should be performed for all adults aged 45 years and above, or 30 years and above for Aboriginal and Torres Strait Islander peoples, who are not known to have CVD or to be at clinically determined high risk. To use the calculator, you will need the patient's age, gender, blood pressure, smoking status, total and hdl cholesterol, diabetes status and ECG LVH if known. It is also included in Best Practice and MedicalDirector.

Adults who do not require absolute CVD risk assessment

Adults with any of the following do not require absolute CVD risk assessment using the absolute risk calculator, because they are already known to be at clinically determined high risk of CVD:

- diabetes and >60 years of age
- diabetes with microalbuminuria (>20 µg/min or urine albumin-to-creatinine ratio (UACR) >2.5 mg/mmol for males, >3.5 mg/mmol for females)
- moderate or severe chronic kidney disease (CKD; persistent proteinuria or estimated glomerular filtration rate [eGFR] <45 mL/min/1.73 m
- previous diagnosis of familial hypercholesterolaemia (FH)
- systolic blood pressure (SBP) ≥180 mmHg or diastolic blood pressure (DBP) ≥110 mmHg
- serum total cholesterol >7.5 mmol/L
- Aboriginal or Torres Strait Islander peoples aged >74 years.

Risk management summary

The risk management summary helps healthcare professionals identify the right steps, depending on whether their patient has a low, moderate or high risk of having a CVD event in the next five years. Use the table below from the Guidelines for the Management of Absolute Cardiovascular Disease Risk to develop a management plan for your patients.

CVD risk	Lifestyle	Pharmacotherapy	Targets	Monitoring
High risk Clinically determined or calculated using FRE as >15% absolute risk of CVD events over 5 years	Frequent and sustained specific advice and support regarding diet and physical activity. Appropriate advice, support and pharmacotherapy for smoking cessation. Advice given simultaneously with BP and lipid lowering drug treatment.	Treat simultaneously with lipid lowering and BP lowering unless contraindicated or clinically inappropriate. Aspirin not routinely recommended. Consider withdrawal of therapy for people who make profound lifestyle changes.	BP: ≤140/90 mmHG in general or people with CKD; ≤ 130/80 mmHg in all people with diabetes; ≤ 130/80 mmHG if micro or macro albuminuria (UACR > 2.5mg/mmol in men and >3.5 mg/mmol in women). Lipids:	Adjust medications as required. Review of absolute risk according to clinical context.

CVD risk	Lifestyle	Pharmacotherapy	Targets	Monitoring
Moderate risk Calculated using FRE as 10-15% absolute risk of CVD events over 5 years	Appropriate, specific advice and support regarding diet and physical activity. Appropriate advice, support and pharmacotherapy for smoking cessation. Lifestyle advice given in preference to drug therapy.	Not routinely recommended. Consider BP lowering and/or lipid lowering in addition to lifestyle advice if 3-6 months of lifestyle intervention does not reduce risk or: BP persistently ≥ 160/100mmHG Family history of premature CVD Specific population where the FRE underestimates risk e.g. Aboriginal and Torres Strait Islander people, South Asian, Maori and Pacific Islander, Middle Eastern. Consider withdrawal of therapy for people who make profound lifestyle changes.	TC <4.0 mmol/L; HDL-C ≥ 1.0 mmol/L; LDL-C <2.0 mmol/L; Non HDL-C <2.5 mmol/L; TG <2.0 mmol/L. Lifestyle: Smoking cessation (if smoker); consume diet rich in vegetables and fruit, low in salt and saturated and trans fats; at least 30 mins moderate intensity physical activity on most or preferably every day of the week; limit alcohol intake.	Adjust medication as required. Review absolute risk every 6-12 months.
Low risk Calculated using FRE as <10% absolute risk of CVD events over 5 years	Brief, general lifestyle advice regarding diet and physical activity. Appropriate advice, support and pharmacotherapy for smoking cessation	Not routinely recommended. Consider BP lowering therapy in addition to specific lifestyle advice if BP persistently ≥ 160/100mmHg. Consider withdrawal of therapy for people who make profound lifestyle changes.		Adjust medication as required. Review absolute risk every 2 years. Blood test results within 5 years can be used.[7]

CVD risk factors

There are many different risk factors that increase the likelihood of developing CVD.

Medical risk factors

High blood pressure

Hypertension is widely recognised as the leading risk factor for CVD. One third of adults have high blood pressure; however, only 5 per cent of adults nominate high blood pressure as a key risk factor for heart disease. From 1st November 2021, a new MBS item (11607) is available for the diagnosis of hypertension through ambulatory blood pressure monitoring.

[7] https://www.heartfoundation.org.au/conditions/fp-absolute-cvd-risk-clinical-guidelines - accessed Nov 2021.

High cholesterol

High blood cholesterol is a significant risk factor for developing CVD.

- two in five adults are living with high cholesterol
- only 8% of adults nominate high cholesterol as a key risk factor for heart disease

Type 2 diabetes

Having diabetes increases the chance of developing CVD. Over time, high blood sugar levels from diabetes can damage the blood vessels in the heart, making them more likely to develop fatty deposits. The longer patients have diabetes, the higher the chance that they will develop heart disease. Around 30 per cent of people with type 2 diabetes also have CVD.[8]

Chronic kidney disease (CKD)

CVD, type 2 diabetes and CKD share many common risk factors. These diseases often arise from similar underlying causes, have similar features and share a number of management and treatment strategies. They are also largely preventable. Modifying and controlling risk factors for these diseases not only reduces the risk of onset of disease but also has a favourable impact on disease progression and the development of complications, with the potential for large health gains in the population.[9]

Lifestyle risk factors

Modifiable risk factors (e.g. weight, cigarette smoking, physical inactivity, excess alcohol and poor diet) contribute significantly to the risk of CVD.

Being overweight or obese

A person is classified as overweight if their body mass index (BMI) is 25 or over.

- two in three adults are overweight or obese
- three in ten adults believe that being overweight is a key risk factor in heart disease.

Smoking

The smoking statistics below are in regards to 'current smokers', which is defined as people who smoke daily, weekly, or less than weekly.

- almost 3 million people over 15 years old are current smokers
- smoking rates are down overall but increasing in males aged 25 to 34 years
- 37% of adults believe that smoking is a key risk factor in heart disease.

Physical inactivity

Physical inactivity refers to a combination of inactivity based on reported exercise and workplace activity.

- four in five adults do not meet national guides for physical activity, including exercise
- one in seven do no form of physical activity, and this is rising
- slightly more than two in five adults believe that being inactive is a key risk factor in heart disease.

Alcohol consumption

- more than 3 million adults exceed alcohol consumption guidelines
- men are twice as likely to exceed the guidelines
- only 13% of adults believe that alcohol consumption is a key risk factor in heart disease.

[8] https://www.heartfoundation.org.au/heart-health-education/diabetes-and-heart-disease - accessed Nov 2021
[9] https://www.aihw.gov.au/reports/heart-stroke-vascular-disease/cardiovascular-diabetes-chronic-kidney-risk-factor/contents/table-of-contents - accessed Nov 2021

Diet

- adults not meeting the recommended intake for vegetables has increased over the past two decades to 92 per cent
- improving vegetable intake to meet the recommended 5 serves per day is estimated to reduce the risk of CVD (CVD) by 16% [10].

Activity 3.1 – Data collection from CAT4

The aim of this activity is to collect data to identify patients with CVD risk factors.

Complete the below table by collecting data from your CAT4 Data Extraction Tool.

Note - Instructions on how to extract the data is available from the CAT4 website: BMI OR Physical activity OR smoking status OR alcohol status recorded OR blood pressure OR no BP recorded OR lipids.

	Description	Total number of active patients
3.1a	Number of active patients with BMI classified as overweight and obese	
3.1b	Number of active patients who have had a physical activity assessment completed	
3.1c	Number of active patients who are daily smokers	
3.1d	Number of active patients who have had an alcohol assessment completed	
3.1e	Number of active patients with a blood pressure recording > 130/80 mmHg	
3.1f	Number of active patients with no BP recorded	
3.1g	Number of active patients with cholesterol result > 6.5 recorded	

Activity 3.2 - Reviewing your patient's CVD risk factors

Complete the checklist below which reviews your patient's CVD risk factors.

Description	Status	Action to be taken
After completing **activity 3.1**, are there any unexpected results with your patient's CVD risk factors?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. larger number of people who are overweight and obese than expected).* How will this information be communicated to the practice team?

[10] https://www.heartfoundation.org.au/activities-finding-or-opinion/key-statistics-risk-factors-for-heart-disease - accessed Nov 2021

Description	Status	Action to be taken
After reviewing your patient's CVD risk factors, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes, **see action to be taken to help set your goals**. ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 3.3 - PIP QI measures

As part of the PIP QI measures, practices are to report on risk factors for CVD assessment. A snapshot of how your practice is progressing with reporting this information is available in your latest benchmark report provided by Brisbane South PHN. Refer to instructions on how to access this from Sharefile.

	Description	Percentage
3.3a	Percentage of active patients aged 45 to 74 years with information available to calculate their absolute CVD risk	

Activity 3.4 – Review PIP QI measure for risk factors for CVD assessment

The aim of this activity is to review your PIP QI risk factors for CVD assessment.

Description	Status	Action to be taken
After reviewing your PIP QI measures from your latest benchmark report, are you happy with your results?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Please explain: (*e.g. we have a low % of patients with absolute CVD risk recorded*). How will this information be communicated to the practice team?

Description	Status	Action to be taken
After reviewing your PIP QI measures, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes: **see action to be taken to help set you goals**. ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 3.5 – Recording risk factors & smoking status in your clinical software

The aim of this activity is to review where risk factors are being recorded in your clinical software.

Description	Status	Action to be taken
Are all the CVD risk factors being recorded in the correct fields in your clinical software? (*e.g. BP; height, weight and BMI; LDL; HDL; total cholesterol; ethnicity; smoking; alcohol; and physical activity status*)?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Review how and where your CVD risk factor information is being recorded in your practice software. See instructions on entering information in Best Practice or MedicalDirector. Ensure all relevant team members are aware of how to record CVD risk factor information. Document in practice policy.
Do relevant team members understand the importance of using drop down lists provided with your clinical software program?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Provide training to all team members on importance of data entry (Refer to the Quality Patient Records QI Toolkit).
After reviewing where your patient's CVD risk factors are being recorded, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes: **see action to be taken to help set you goals**. ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

CVD risk factors and *My health for life*

Brisbane South PHN have a *My health for life* QI toolkit that can help:

- to effectively identify people at high risk of developing chronic disease and provide them with an appropriate behaviour modification program
- to increase health literacy levels and the capacity of program participants to adopt and maintain positive health behaviours to manage their health risk factors
- to improve community awareness, knowledge and attitudes about chronic disease risk factors and how to make positive health behaviour choices.

Activity 4 - CVD & Heart Health checks

Modifiable CVD risk factors are responsible for up to 90% of the risk of myocardial infarction, providing evidence CVD is largely preventable. [11]However, people at high risk of CVD are not receiving guideline-recommended blood pressure and lipid lowering preventive therapy. [12]The federal government introduced a MBS item number, **699 (177 for non VR**), for GPs to conduct a comprehensive cardiovascular health assessment utilising the Australian Absolute CVD Risk calculator.[13] These MBS items support the ongoing assessment and management of absolute CVD risk in primary care for eligible patients.

Who is eligible for a Heart Health Check?

The intention of this item is to identify CVD in people not known to have CVD including:

- Aboriginal or Torres Strait Islander persons who are aged 30 years and above
- adults aged 45 years and above, who have not claimed a health assessment in the previous 12 months.

For full details about the criteria, review the MBS descriptor.

Activity 4.1 – Data collection from CAT4

Complete the below table by collecting data from your CAT4 Data Extraction Tool.

Note - Instructions on how to extract the data is available from the CAT4 website.

The aim of this activity is to collect data to determine the number of patients eligible for a Heart Health Check and identify those who have not had a Heart Health check completed.

	Description	Total number of active patients as per RACGP criteria (3 visits in 2 years)	Total number of active patients
4.1a	Number of active patients aged 45 years and older		
4.1b	Number of active patients aged 45 years and older WITHOUT CVD		
4.1c	Number of active patients aged 45 years and older WITHOUT CVD and no health assessment completed in the past 12 months		
4.1d	Number of active Aboriginal & Torres Strait Islander patients aged 30 years and older		
4.1e	Number of active Aboriginal & Torres Strait Islander patients aged 30 years and older WITHOUT CVD		
4.1f	Number of active Aboriginal & Torres Strait Islander patients aged 30 years and older WITHOUT CVD and no health assessment completed in the past 12 months		
4.1g	Number of active patients with a Heart Health Check completed (you may need to check the number completed on your practice's billing software)		

[11] Lancet, 2004, 364(9438):p. 937-52

[12] https://www.heartfoundation.org.au/conditions/fp-absolute-cvd-risk-clinical-guidelines - accessed Nov 2021.

[13] http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&qt=ItemID&q=699 – accessed Nov 2021.

Activity 4.2– Reviewing your patients who may be eligible for a Heart Health check

Complete the checklist below to review your patients who may be eligible for a Heart Health check.

Description	Status	Action to be taken
After completing **activity 4.1**, are there any unexpected results with your patients who may be eligible for a Heart Health Check?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. high number of patients aged over 45 with a Heart Health Check completed).* How will this information be communicated to the practice team?
After reviewing your practice's Heart Health Check eligible profile, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes: **see action to be taken to help set you goals**. ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Heart Health Check resources

Guidelines

- Guidelines for the management of absolute cardiovascular disease risk
- Quick reference guide for health professionals - Absolute cardiovascular disease risk management
- Guide to management of hypertension in adults 2016 (PDF)

Tools

- Australian absolute cardiovascular disease risk calculator
- Heart Online: Heart Education Assessment Rehabilitation Toolkit

Training and information:

- Aboriginal Health - information and resources for health professionals
- Heart Online - Supporting behaviour change
- APNA - Cardiovascular disease risk assessment and management - Free 2 hour course for nurses

How to adopt an absolute risk approach in your practice (5 short interviews with leading experts)

- Absolute risk and what it means in practice *(05:24)*
- Reducing barriers to using an absolute risk approach *(04:17)*
- Engaging patients to think about absolute risk *(04:58)*

- Absolute risk assessment in Aboriginal and Torres Strait Islander populations *(02:13)*
- other issues in absolute risk assessment *(03:53)*

For more video presentations and other professional/clinical information

- Heart Foundation
- HotDoc Webinar: Calculating Absolute Cardiovascular Risk & Relevant Health Assessments in General Practice
- For professionals: Heart Health Checks
- Heart Foundation Webinar: Heart Health Checks: the critical role of the practice nurse
- Heart Foundation Webinar: Absolute CVD risk assessment practical update

Information for patients:

- Know your risks
- Heart health check brochure (PDF)
- Guide to healthy eating for adults brochure
- Quitline - for smoking cessation tools, information and resources
- Heart Foundation Shop (health professionals can order patient information)
- St Vincent's Heart Health and Heart Foundation Aboriginal heart health information

RACGP family history screening questionnaire

The use of a simple family history questionnaire can help identify individuals who may require a more detailed assessment of their family history of cancer, heart disease or diabetes.

Activity 5 - Managing patients with CVD

GPs provide a critical role in the long-term management of patients with CVD. Ongoing assessment by a GP or specialist is recommended. There are many different ways of managing and treating CVD.

Despite overwhelming evidence of the effectiveness of secondary prevention therapies, surveys indicate poor adherence to medical treatments and lifestyle recommendations after an acute coronary syndrome.[14] Compliance can be around 50%. Patients can be selective with their medications due to cost or just because they have no symptoms they feel they do not need tablets.

Activity 5.1 – Data collection from CAT4

The aim of this activity is to collect data to identify patients with CVD.

Complete the below table by collecting data from your CAT4 Data Extraction Tool.

Note - Instructions on how to extract the data is available from the CAT4 website: stroke or TIA not on BP medication OR stroke or TIA not on antiplatelet therapy OR stroke or TIA – cholesterol medication OR CHD patients not on cholesterol medication OR CHD not on antithrombotic OR CHD not on ACE or ARB OR type II diabetes and CVD not on statins OR lipid lowering medication HDL <1 & cholesterol > 6.5mmol/L.

	Description	Total number of active patients
5.1a	Number of active patients with stroke or TIA not on BP medication	
5.1b	Number of active patients with stroke or TIA not on antiplatelet therapy	
5.1c	Number of active patients with stroke or TIA not on cholesterol medication	
5.1d	Number of active patients with CHD not on cholesterol medication	
5.1e	Number of active patients with CHD not on antithrombotic medication	
5.1f	Number of active patients with CHD not on ACE or ARB medications	
5.1g	Number of active patients with type II diabetes and CVD not on Statins	
5.1h	Number of active patients not on lipid lowering medication with HDL <1 and cholesterol >6.5mmol/L	

[14] https://onlinelibrary.wiley.com/doi/full/10.5694/mja14.01157

Activity 5.2 - Reviewing your patient's with CVD

Complete the checklist below which reviews your patient's with CVD.

Description	Status	Action to be taken
After completing **activity 5.1**, are there any unexpected results with your patient's with CVD?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. larger number of patients with a stroke not on cholesterol medication than expected).* How will this information be communicated to the practice team?
After reviewing your patient's with CVD, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes, **see action to be taken to help set your goals**. ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 6 - Medicare item numbers for patients with CVD

Patients with CVD ***may be eligible*** to access chronic disease item numbers within the Medicare Benefit Schedule (MBS). These are dependent on patient age, ethnicity and co-morbidities. Conditions apply to each item number. Please ensure the GP understands these prior to claiming the item number/s. Brisbane South PHN has a comprehensive toolkit looking at MBS items, however, a summary of the item numbers include:

MBS items

- GP Management Plans (GPMP)
- Team Care Arrangements (TCA)
- Nurse chronic disease item number
- Mental health items
- Health assessment
- Aboriginal and Torres Strait Islander health assessment
- Home medication review
- MBS telehealth fact sheet
- Ambulatory blood pressure monitoring

TIP: GPs are required to make sure each patient meets the MBS criteria prior to claiming each item number.

Activity 6.1 – Data collection from CAT4

The aim of this activity is to collect data to determine the number of MBS claims made for patients with CVD over the past 12 months.

Complete the below table by collecting data from your CAT4 Data Extraction Tool.

Note - Instructions on how to extract the data is available from the CAT4 website. Number of people eligible for a Home Medication Review OR Number of people eligible for GPMP/TCA OR Number of patients eligible for Health Assessment OR Number of patients eligible for a Diabetes Cycle of Care OR Number of people eligible for an Aboriginal and Torres Strait Islander health assessment OR Number of people eligible for a mental health treatment plan.

	Description	Total number of active patients
6.1a	Number of active patients with CVD who **may be** eligible for a GPMP &/or TCA plan (*ensure you select cardiovascular under Conditions*)	
6.1b	Number of active patients with CVD who **may be** eligible for a Health Assessment (*ensure you select cardiovascular under Conditions*)	

	Description	Total number of active patients
6.1c	Number of active patients with CVD who **may be** eligible for a HMR (*ensure you select cardiovascular under Conditions*)	
6.1d	Number of active patients with CVD who **may be** eligible for a diabetes cycle of care (*ensure you select cardiovascular under Conditions*)	
6.1e	Number of active patients with CVD who **may be** eligible for an Aboriginal and Torres Strait Islander assessment (*ensure you select cardiovascular under Conditions*)	
6.1f	Number of patients with CVD who ***may be*** eligible for a mental health treatment plan (*ensure you select cardiovascular under Conditions*)	

Please note: not all patients with CVD are eligible for MBS item numbers. Please make sure that each patient meets the criteria prior to claiming.

Activity 6.2 – Checklist for reflection on MBS claiming

Complete the checklist below to review your practice's MBS claiming for patients with CVD.

Description	Status	Action to be taken
Are there any patients with CVD without a HMR completed in the past 12 months? (*note: not all patients with CVD will be eligible for a HMR. Refer to MBS criteria).*	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: What action will you take? How will you use this information to increase the number of HMRs completed?
Are there any patients with CVD without a GPMP &/or TCA plan completed in the past 12 months? (*note: not all patients identified in the search will be eligible for a GPMP or TCA e.g. not regular GP. Refer to MBS criteria*).	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: What action will you take?

Description	Status	Action to be taken
		How will you use this information to increase the number of management plans completed?
Do relevant staff know where to find appropriate templates for GPMP/TCA?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	See templates available here.
Are there any eligible patients with CVD without a health assessment completed in the past 12 months? (*note: please ensure that MBS criteria are met).*	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: What action will you take? How will you use this information to increase the number of health assessment completed?
Do you know the contact details for any MBS related questions?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Email: askMBS@health.gov.au. Provider Enquiry Line - 13 21 50.
Do relevant staff know that Medicare provides online training modules?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	More information can be obtained from Medicare Australia e-learning modules.
After reviewing the MBS claiming for patients with CVD, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes: **see action to be taken to help set you goals**. ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

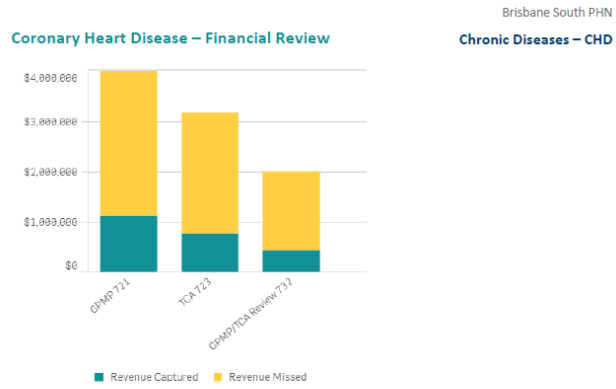
Activity 6.3 – Data Collection - Chronic Disease Management claiming for CVD patients

The aim of this activity is to review your practice's claiming of chronic disease management plans for CVD patients.

Note – Information to complete this activity is available from your latest benchmark and trend reports from Brisbane South PHN. Refer to instructions on how to access this from Sharefile.

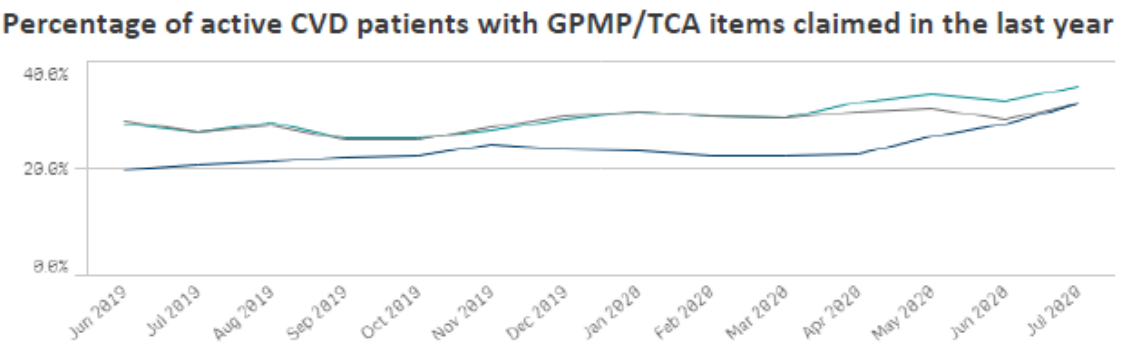
Example images from benchmark report:

CHD Management*	-	- %	BSPHN	BSPHN %
Active patients with CHD	27,706	-	27,706	-
Blood Pressure Recorded	20,964	76%	20,964	76%
BMI Recorded, Age >= 15	12,729	46%	12,729	46%
LDL Recorded	14,576	53%	14,576	53%
Smoking Rates Recorded	10,266	37%	10,266	37%
GPMPs (721) claimed	7,779	28%	7,779	28%
TCAs (723) claimed	6,714	24%	6,714	24%
GPMP/TCA Reviews (732) claimed	5,981	22%	5,981	22%



MBS Billing Item*	GPMPs (721)	TCAs (723)	GPMP/TCA Reviews (732)
Captured Revenue	$1,122,121	$767,410	$430,931
Potential Missed Revenue	$2,874,470	$2,399,386	$1,565,286

Example image from Trend report:



	Description	Number	Percentage
6.3a	Number of patients with CVD		
6.3b	Number of patients with CVD with a GPMP claimed		
6.3c	Number of patients with CVD with a TCA claimed		
6.3d	Number of patients with CVD with a GPMP/TCA review claimed		

Activity 6.4– Review Chronic Disease Management claiming for CVD patients

The aim of this activity is to review your Medicare item number claiming for patients with CVD.

Description	Status	Action to be taken
After completing **activity 6.3**, are there any unexpected results with your practice's chronic disease claiming for CVD patients?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. low % of patients with a GPMP or we are doing well at claiming GPMP/TCA reviews*). How will this information be communicated to the practice team?
Is your practice's chronic disease claiming for CVD patients similar to other practices in the Brisbane south region (compare information from benchmark report)?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Outline the differences – (*e.g. our practice has claimed fewer GPMP than other practices).* How will this information be communicated to the practice team?

Description	Status	Action to be taken
Have you seen a change in the trend line for claiming of GPMPs, TCA & reviews? (compare information from trend report)	☐ Yes: **see action to be taken**. ☐ No: continue with activity**.**	Trend line is: □ improving □ maintaining □ decreasing How will this information be communicated to the practice team?
After reviewing your chronic disease claiming for CVD patients, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes: **see action to be taken to help set you goals**. ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 7 - Establishing appropriate care pathways using evidence-based guidelines

Activity 7.1 – Identify roles for managing CVD patients within your practice

Consider how best to use your practice staff to provide optimum care, and the impact this will have on the workload and appointment system. This involves systematically determining if your practice is set-up and equipped to provide evidence-based CVD assessment and management.

Activity	Nurse	GP	Admin
Organise blood tests as appropriate			
Conduct ECG			
Monitor blood pressure			
Complete cardiovascular risk assessment (if not known to be at clinically determined high risk)			
Update patient reminders for regular monitoring (frequency depends on patient's condition)			
Review diet/healthy eating			
Review physical activity and exercise tolerance			
Review smoking & alcohol intake			
Check mental health status and offer support services			
Provide self-care education			
GPMP			
Consider comorbidities (diabetes, anxiety, depression, CKD)			
Review medications			
HMR			
Assess need for specialist referral			
Consider advanced care planning			

Practice teams QI toolkit

Brisbane South PHN have a practice teams QI toolkit that you may wish to refer to. One of the goals of this toolkit is to assist practices to identify roles and responsibilities for completing QI activities.

Activity 8 - Recalls and Reminders

As part of the RACGP accreditation standards, it is a requirement that practices provide health promotion, illness prevention, preventive care and a reminder system based on patient need and best available evidence. Brisbane South PHN have a comprehensive toolkit to assist you to review your practice recall and reminder systems, however, the aim of this activity is to assist with CVD specific recall and reminders. You can also access other QI tools via medical software modules that will assist your practice to merge duplicate recall/reminder lists in your practice's clinical software. These modules are:

- Module 7 – Recalls, Reminders and Screening using MedicalDirector
- Module 8 – Recalls, Reminders and Screening using Best Practice

You can access these modules via DiscoverPHN**.**

Activity 8.1 – Reminder system

The aim of this activity is to review the practice's reminder system.

Question to consider	Status	Action to be taken
Does your practice have a routine reminder for appropriate CVD tests?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to instructions from Best Practice or MedicalDirector.
Is there a system for ensuring patients recently diagnosed with CVD are incorporated into the reminder system	☐ Yes, policy is working. ☐ Yes, policy is not working, see action to be taken. ☐ No policy, **see action to be taken.**	Revise policy. Practice policy on reminders to be implemented.
Does the recall and reminder system take into consideration patients with low English proficiency?	☐ Yes, policy is working. ☐ Yes, policy is not working, **see action to be taken**. ☐ No policy, **see action to be taken.**	Revise or implement practice policy. Letters and voice phone messages can be confusing for patients with limited or no English. Using the Translating and Interpreting Service to call the patient or sending text messages can be more effective. Consider using the online Appointment Reminder Translation Tool**.**
After reviewing your practice's recall and reminder system, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes, **see action to be taken to help set your goals**. ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 9 - Referral pathways

The aim of this activity is to ensure that practice staff have access to the relevant information and understand pathways for referral of patients to specialists and allied health staff as deemed clinically appropriate.

Engaging other medical services (e.g. diagnostic services; hospitals, consultants; allied health; social, disability and community services) assist the practice to provide optimal care to patients whose health needs require integration with other services.

SpotOnHealth HealthPathways

SpotOnHealth HealthPathways provides clinicians in the greater Brisbane South catchment with web-based information outlining the assessment, management and referral to other clinicians for more than 550 conditions.

It is designed to be used at point of care primarily by general practitioners but is also available to specialists, nurses, allied health and other health professionals.

Health Services Directory

Health Services Directory is a joint initiative of all Australian governments, delivered by HealthDirect Australia, to provide health professionals and consumers with access to reliable and consistent information about health services.

My Community Directory

My Community Directory lists organisations that provide services that are free or subsidised to the public in thousands of locations across Australia. These services are organised into various community directories.

Refer Your Patient

Metro South Health is the major provider of public health services, and health education and research, in the Brisbane south side, Logan, Redlands and Scenic Rim regions. Refer Your Patient Website helps health professionals to access public health services for patients. It provides a single point of entry for all new referrals.

The website outlines available health professionals, criteria to access appointments, expected wait times and all the information required in the referral.

Activity 9.1 – Referral Pathways

Complete the checklist below in relation to referral pathways.

This activity is designed to raise your awareness of local referral options available for you and your patients to facilitate co-ordinated and therefore optimal care.

Description	Status	Action to be taken
Do all GPs and nurses have login details for SpotOnHealth HealthPathways?	☐ Yes: continue with activity. ☐ No: see **action to be taken.**	Obtain access.
Do all GPs and nurses know how to access SpotOnHealth HealthPathways via Topbar?	☐ Yes: continue with activity. ☐ No: see **action to be taken.**	See instructions**.** Or contact BSPHN Digital Health Team via email: ehealth@bsphn.org.au.

Description	Status	Action to be taken
How will you communicate information so clinicians know where to access details on referring a patient to specialist services?	What is the practice plan for communicating referral information?	
After reviewing your practice referral system, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes, **see action to be taken to help set your goals**. ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 10 - Resources for general practice team and patients with CVD

Brochures and fact sheets are important additions to providing efficient/effective patient care. They provide the patient with something tangible they can refer to if they forget or misunderstand the information that is provided to them within their session with the nurse and/or GP. This helps with understanding and information retention, which are important aspects of self-management.

Simply providing education might not improve a person's health literacy, since it also depends on other factors like socioeconomic status and social support, and is influenced by the provider and healthcare system. This is why it is also important to be aware of external, community support services.[15]

Resources for health professionals

- Heart failure toolkit – a targeted approach to reducing heart failure readmissions
- Heart online - Supporting behaviour change
- Heart online - Monitoring of heart failure medicines
- Heart attack action plan
- Heart Foundation - Lipid management for Health Professionals
- RACGP - SNAP guide
- Brisbane South PHN – GP Psychiatry support line.

Guidelines for GPs

- Heart Foundation - Guidelines for the management of absolute cardiovascular disease risk
- Heart Foundation - Cardiac Rehabilitation and Heart Failure Management tool kit
- Heart Foundation - Absolute cardiovascular disease risk management quick reference guide
- Heart Foundation - Guideline for the diagnosis and management of hypertension in adults
- Heart Foundation - clinical guidelines
- CVD GPMP &/or TCA templates
- NPS - Blood pressure: measure, manage & monitor case study
- NPS – continuing professional development
- ECG Interpretation course for all health professionals

Resources for patients

- Heart Foundation - Atrial fibrillation – Understanding abnormal heart rhythm
- Manage your heart and stroke risk – A 3 step guide to better health
- Heart Foundation – My heart, my life app
- Heart Foundation - Action Plans
- Heart Foundation - Heart disease resources for Aboriginal & Torres Strait Islander patients
- Brisbane South PHN - First Nations health focus
- Translated heart health information
- Health translations.

[15] https://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/health-literacy/

Example PDSA for the management of patients with CVD

See below for suggested goals related to CVD you may wish to achieve within your practice:

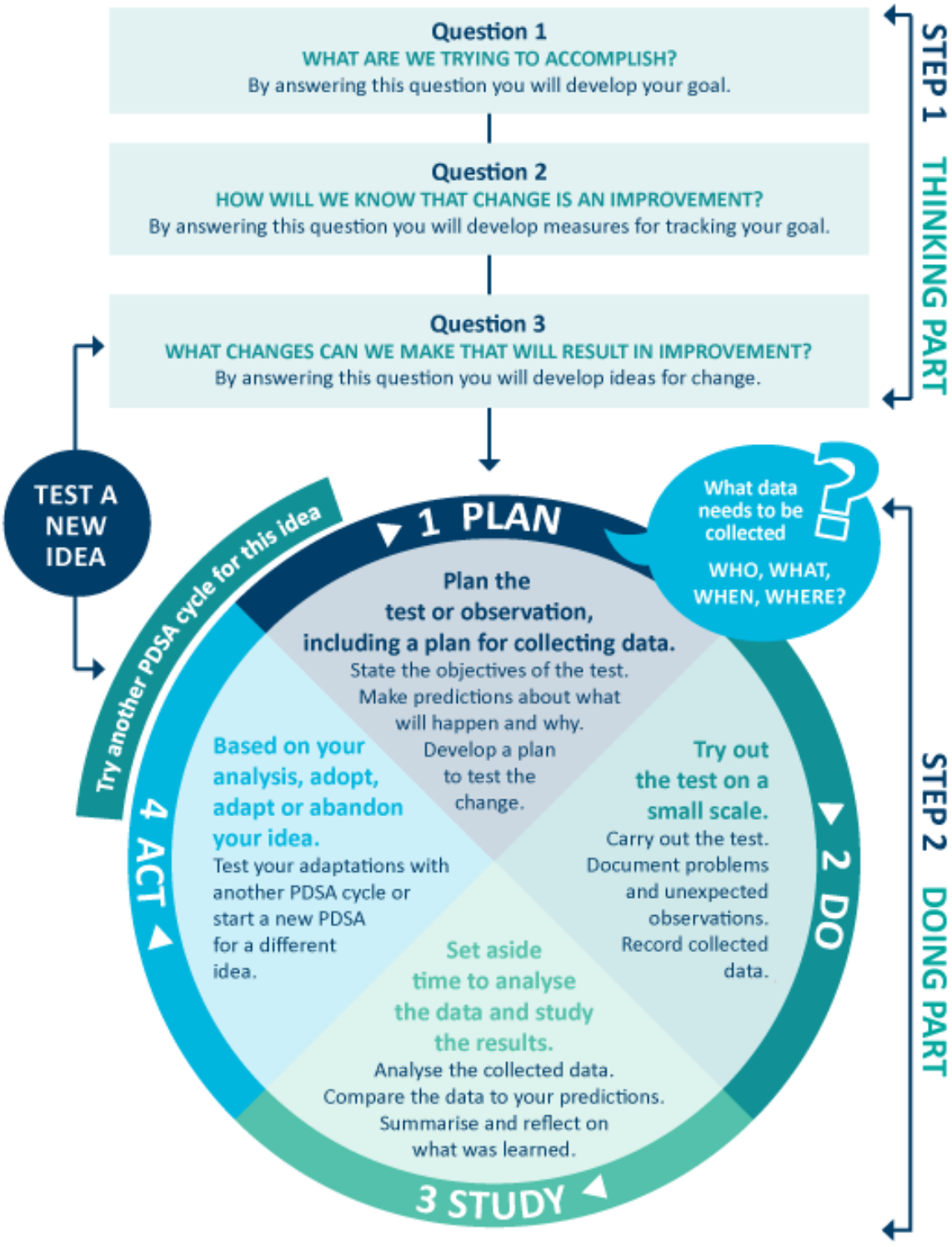
Goal	How you may achieve the goal
Increase BP recordings on patients with CVD by 15%	Refer to CAT4 recipe: CVD patients with no BP recorded.
Increase adult smoking and alcohol status for patients with CVD recorded in clinical software to 75%.	Refer to CAT4 recipe: increase adult smoking and alcohol status for patients with type 2 diabetes. *(select CVD instead of diabetes in conditions).*
Ensure 90% of patients with diabetes and CVD are prescribed a Statins.	Refer to CAT4 recipe**:** identify patients with diabetes and CVD not on statins.
Increase the number of flu injections given to CVD patient over the past 15 months by 10%.	Refer to CAT4 recipe**:** identify the number of diabetes patients who have not received a flu injection in the past 15 months. *(select CVD instead of diabetes in conditions).*
Increase the number of Heart Health Checks completed on eligible patients by 10%.	Refer to CAT4 recipe: Identify patients eligible for the Heart Health Check who are low, moderate, and high risk of CVD.
Increase by 10% the number of patients aged 45 to 74 years to enable CVD risk assessment with the following: • Smoking status • Blood pressure • Total cholesterol and HDL levels (you may wish to do this as part of a heart health check MBS item 699).	Refer to CAT4 recipe: • Identify patients with no allergy or smoking status recorded • Identify patients with no BP recorded • Identify patients with elevated CV risk *(select excluded and incomplete tab).*

Other ideas for improving CVD measures

It is suggested that you meet in your practice team to discuss how at your practice you can improve the recording of CVD measures. Some suggestions you may consider include:

- asking the practice nurse to opportunistically see patients prior to their GP appointment to obtain height, weight, waist measurements, BP, smoking and alcohol status
- asking patients to complete a summarised new patient form with their height, weight, waist measurements, BP, smoking and alcohol status and also check their address, contact details, NOK and emergency contact details
- actively contacting patients who are do not have measures recorded e.g. proactively contact patients with CVD who have not yet had their flu injection in the past 15 months
- ensuring Topbar is installed on every workstation and fully operational.

Model for Improvement diagram



Source: http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx

MFI and PDSA template EXAMPLE

Step 1: The thinking part - The 3 fundamental questions

Practice name:	**Date:**
Team members:	

Q1. What are we trying to accomplish? (Goal)

By answering this question, you will develop your GOAL for improvement.
Record this as a S.M.A.R.T. goal (**S**pecific, **M**easurable, **A**chievable, **R**elevant, **T**ime bound).

Our goal is to: Increase the number of GPMPs completed on patients with CVD.

This is a good start, but how will you measure whether you have achieved this goal? The team will be more likely to embrace change if the goal is more specific and has a time limit.

So, for this example, a better goal statement would be:

Our S.M.A.R.T. goal is to: Increase the number of GPMPs completed on patients with CVD by 10% by 8th July.

Q2. How will I know that a change is an improvement? (Measure)

By answering this question, you will determine what you need to MEASURE in order to monitor the achievement of your goal. Include how you will collect your data (e.g. CAT4 reports, patient surveys etc.). Record and track your baseline measurement to allow for later comparison.

We will measure the percentage of active patients with CVD who have a GPMP completed in the past 12 months. To do this we will:

A) Identify the number of active patients with CVD.

B) Identify the number of active patients with CVD and a GPMP completed in the past 12 months.

B divided by A x 100 produces the percentage of patients with CVD and GPMP completed in the past 12 months.

BASELINE MEASUREMENT: 46% of active patients with CVD have a GPMP completed in the past 12 months.

Q3. What changes could we make that will lead to an improvement? (List your IDEAS)

By answering this question, you will generate a list of IDEAS for possible changes you could implement to assist with achieving your S.M.A.R.T goal. You will test these ideas using part 2 of this template, the 'Plan, Do, Study, Act (PDSA)' cycle. Your team could use brainstorming or a driver diagram to develop this list of change ideas.

IDEA: Identify active patients with CVD who do not have a GPMP recorded in the past 12 months.

IDEA: Update the reminder criteria on the practice software to ensure the GPMP reminder interval is set at the appropriate time.

IDEA: Clinical team develop a system for flagging eligible patients and addressing completing opportunistically.

IDEA: Review practice GPMP templates to ensure there is consistency for all patients with CVD.

IDEA: Source and provide endorsed patient education resources (in waiting rooms, toilets etc.).

Note: Each new GOAL (1st Fundamental Question) will require a new MFI plan.

Source: Langley, G., Nolan, K., Nolan, T., Norman, C. & Provost, L. 1996, The Improvement Guide, Jossey-Bass, San Francisco, USA.

MFI and PDSA template EXAMPLE

Step 2: The doing part - Plan, Do, Study, Act

You will have noted your IDEAS for testing when you answered the 3rd fundamental question in step 1. You will use this template to test an idea. Ensure you communicate the details of the plan to the entire practice team.

IDEA	Record the change idea you are testing
Which idea are you going to test? *(Refer to Q3, step 1 above)*	
Identify active patients with CVD who have not had a GPMP completed in the past 12 months.	
PLAN	**Record the details of how you will test your change idea**
Plan the test, including a plan for collecting data	What exactly do you plan to do? Record who will do what; when they will do it (day, time etc) and for how long (1 week, 2 weeks etc); and where (if applicable); the data to be collected; and predictions about the outcome.
WHAT: Lucy (office manager) will set aside an hour on a Tuesday afternoon to conduct a search on CAT4 of all active patients with CVD and no GPMP recorded. Lucy will organise with each GP to review their list of patients and provide feedback on suitable patients to have a GPMP completed. Lucy will then generate an invitation letter to patients asking them to book an appointment. Tom the nurse will check the software template to ensure all the measures for CVD are included. Jane the practice manager will monitor the practice's monthly benchmark report to review any changes with CVD data. WHO/WHEN/WHERE: Who: Lucy, Tom & Jane When: Begin 1st May. Where: Practice. DATA TO BE COLLECTED: Number of active patients with CVD and number of active patients with CVD who have not had a GPMP completed in the past 12 months. PREDICTION: 56% of the active CVD patient population will have had a GPMP completed in the past 12 months.	
DO	**Run the test, then record your actions, observations and data**
Run the test on a small scale	What did you do? Were there any deviations from the original plan? Record exactly what you did, the data collected and any observations. Include any unexpected consequences (positive or negative).
Done – completed 8th July – Lucy (office manager) conducted a search on CAT4 of all active patients with CVD and no GPMP recorded. Lucy organised a meeting with each GP to review their list of patients and provide feedback on suitable patients to have a GPMP completed. Lucy created a letter for each patient and sent it to them. Tom the nurse checked the software template to ensure all the measures for CVD are included. Jane the practice manager monitored the practice's monthly benchmark report to review any changes with CVD data.	

STUDY	Analyse the data and your observations
Analyse the results and compare them to your predictions	Was the plan executed successfully? Did you encounter any problems or difficulties? What worked/didn't work? What did you learn on the way? Compare the data to your predictions. Summarise and reflect on what was learned.

At the end of the focus on GPMP for patients with CVD, 52% of patients with GPMP recorded. This has resulted in a 7% increase in results which 3% lower than our goal.

Results have been shared with the whole practice team.

ACT	Record what you will do next
Based on what you learned from the test, record what your next actions will be	Will you adopt, adapt or abandon this change idea? Record the details of your option under the relevant heading below. *ADOPT: record what you will do next to support making this change business as usual*; ADAPT: *record your changes and re-test with another PDSA cycle; or ABANDON: record which change idea you will test next and start a new PDSA.*

ADOPT:

ADAPT: The practice has identified that this is beneficial for the patient and the practice, however, we have decided that we will no longer send letters to patients as this is a costly, time consuming method. We are going to trial sending secure SMS messages to patients.

ABANDON:

Repeat step 2 to re-test your adapted plan or to test a new change idea

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bsphn.org.au | ABN 53 151 707 765

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