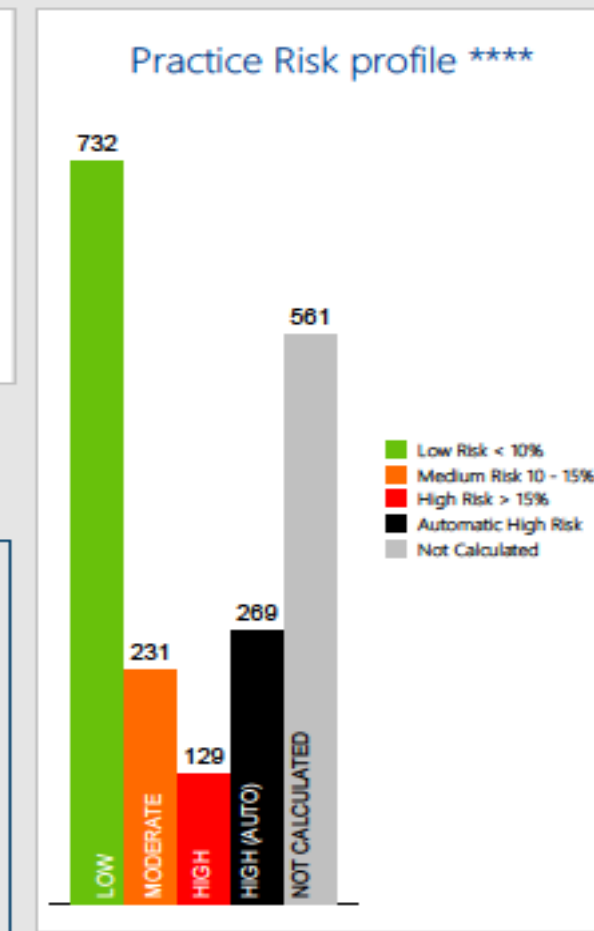
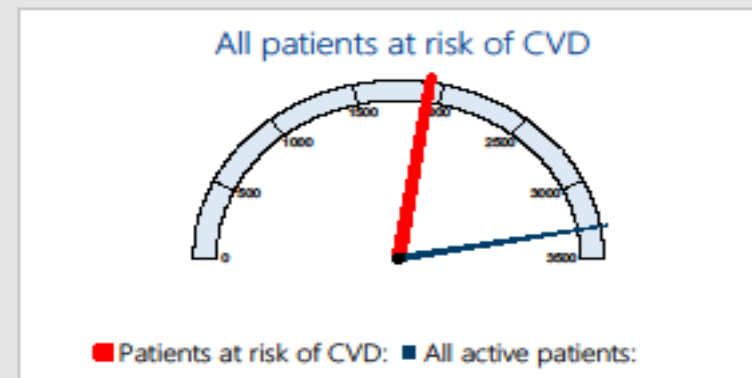


CVD DASHBOARD REPORT - PRODUCED 6 MONTHLY

Summary of active patients

(Values and rates in this dashboard are based on numbers of total active patients**)

1,922 (58.3 %)
Patients at risk of CVD *
3,298
Total active patients **
560
Incomplete data ***

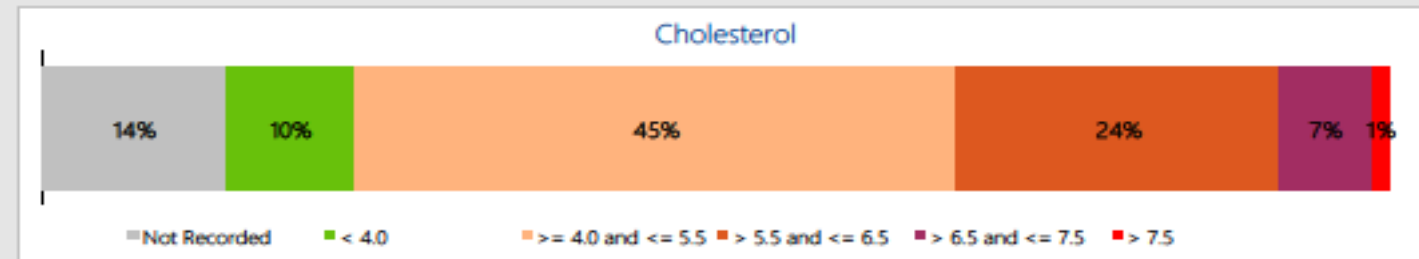
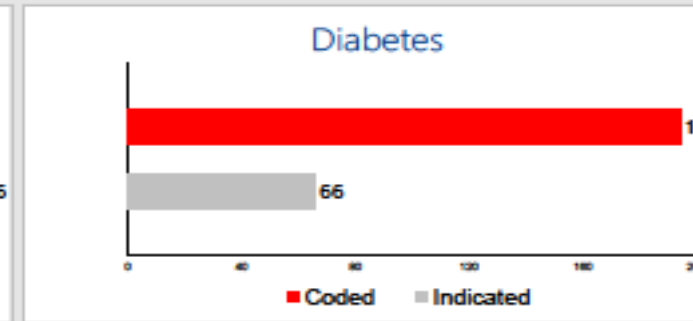
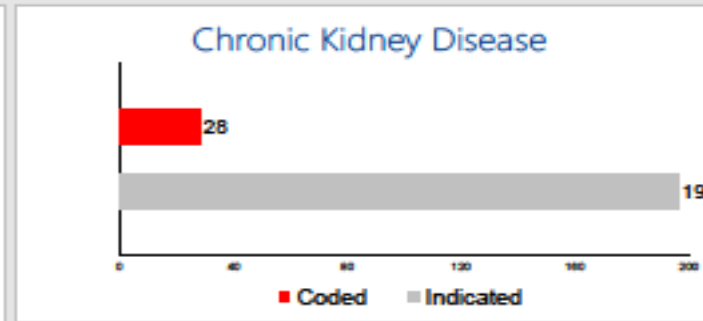
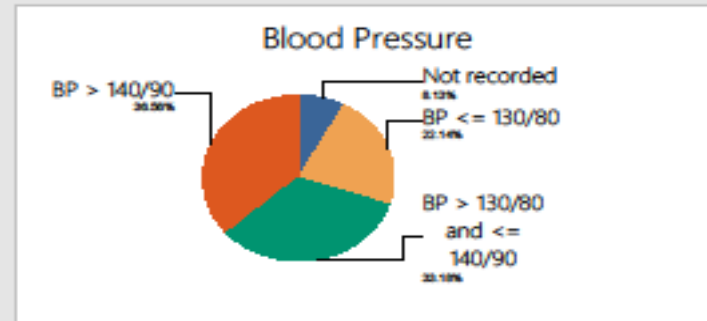


* Based on the Absolute Cardio-vascular Disease Risk Assessment & Management Guidelines.
 ** Active patients, as defined by the RACGP, are patients seen 3 or more times within the past two years
 *** Total number of eligible patients where CVD risk could not be calculated due to incomplete data. Eligible patients include indigenous patients aged over 35 years, non-indigenous patients aged over 45 years, who have not been previously diagnosed with CVD.

Age, ethnicity, and gender of all active patients

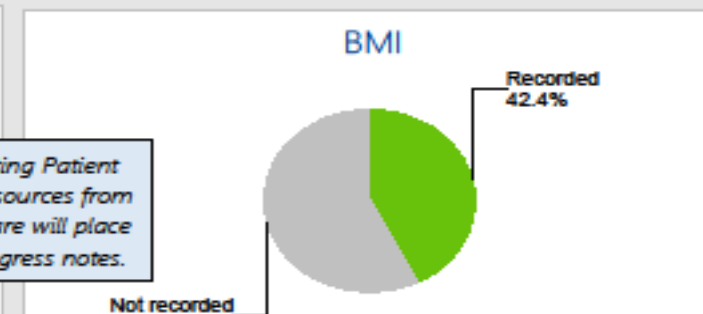
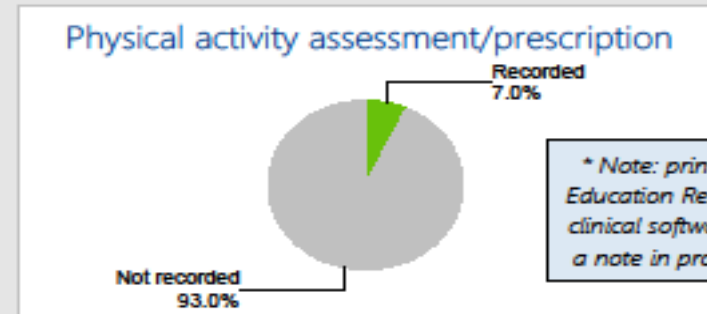
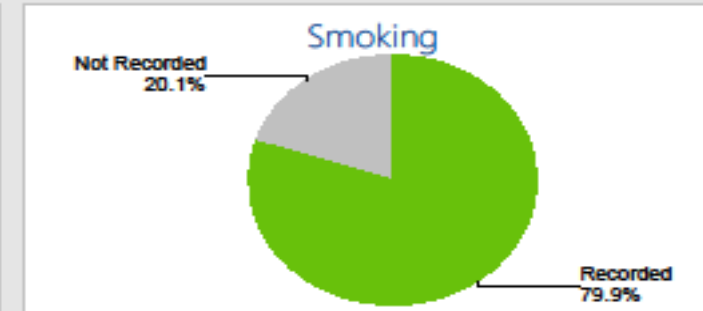
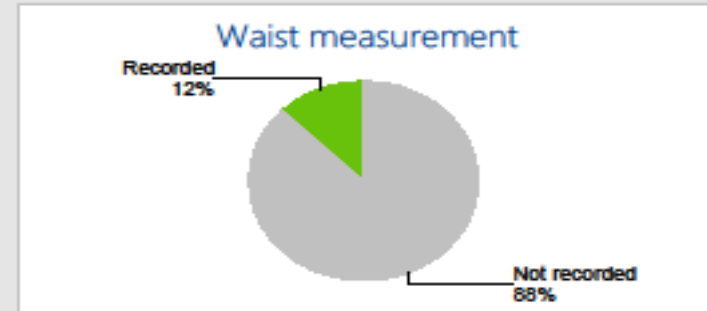
	Female	Male	Total patients
All active patients			3298
All Aboriginal patients			195
Aboriginal patients aged >35 years	54	25	79
All Non-indigenous patients			2911
Non-indigenous patients aged >45 years	967	939	1906
Ethnicity not recorded			189

Related conditions of patients at risk of CVD (including patients with incomplete data)



'Indicated' numbers above represent patients where results and/or medication indicate the possibility of each diagnosis. The possibility may be likely, possible, or requiring review. For more information see the PEN CS CAT4 User Guide at: <https://help.pencs.com.au/display/CG/Indicated+Conditions+Report+Details>

Modifiable risk factors of patients at risk of CVD (including patients with incomplete data)



* Note: printing Patient Education Resources from clinical software will place a note in progress notes.

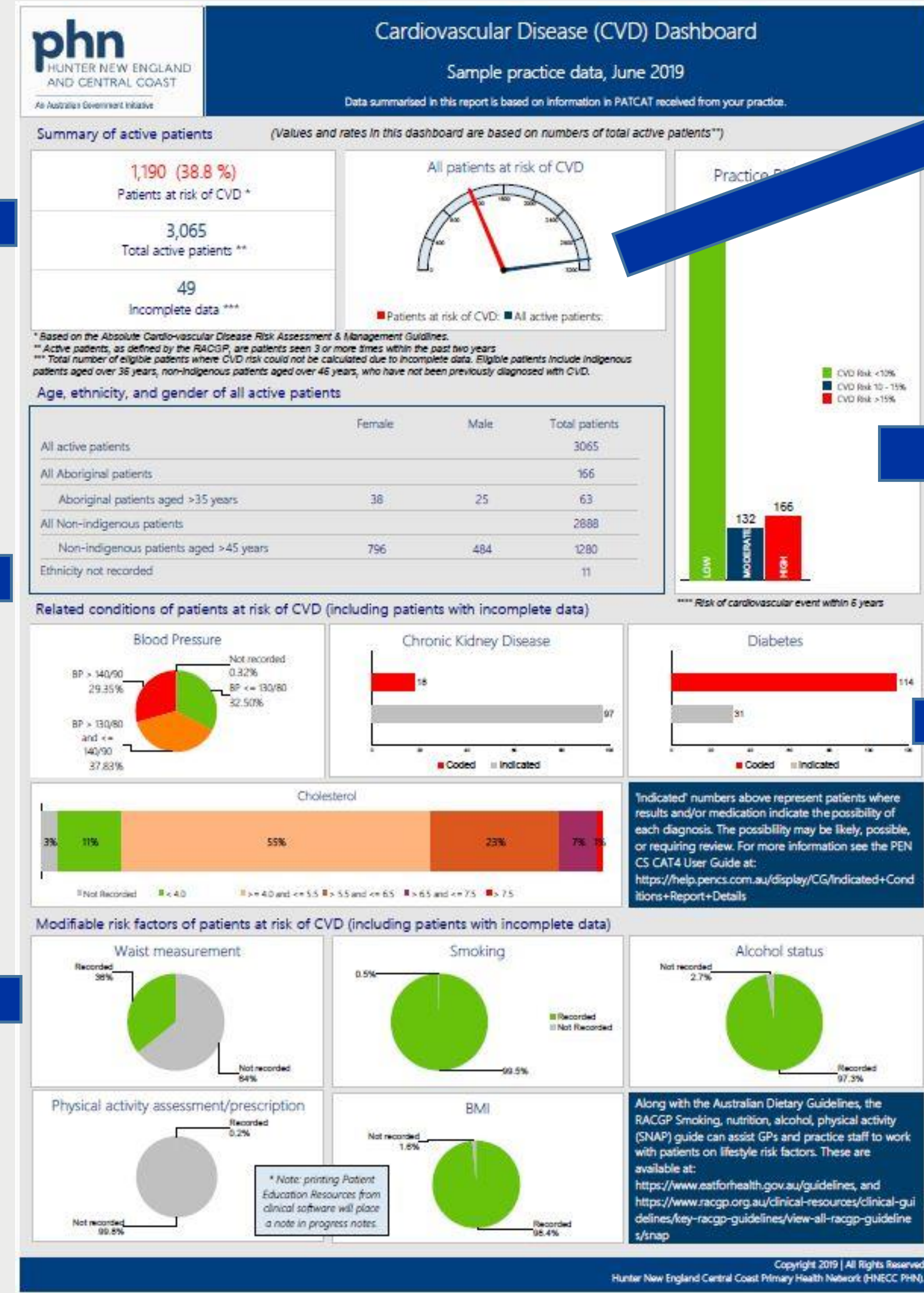
Along with the Australian Dietary Guidelines, the RACGP Smoking, nutrition, alcohol, physical activity (SNAP) guide can assist GPs and practice staff to work with patients on lifestyle risk factors. These are available at: <https://www.eatforhealth.gov.au/guidelines>, and <https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/snap>



ACTIVE PATIENTS: The top number in red highlights the number of active patients that are at risk of Cardiovascular Disease using the [Framingham Risk Equation](#). (eligible patients are described below as part of the ***).
The number of incomplete data indicates patients that have not got a coded ACR score in the medical software.

PATIENT DEMOGRAPHICS: The grey shaded area is a break down of the patient demographics by age, gender, and ethnicity. It also highlights the number of patients without an ethnicity recorded.

MODIFIABLE RISK FACTORS: The modifiable risk factors feature the number of patients at risk of Cardiovascular Disease who have modifiable risk factors. The green in the pie graphs demonstrate the number of those patients who have a coded status of these risk factors. The grey shade illustrates the number of patients who have not had their risk factors recorded e.g., smoking status. This is key in ensuring that the patient details are current and identifying risk factors that are relevant to the patient to then create targeted goals e.g., smoking cessation. These modifiable risk factors are part of the “SNAP” Data/Guidelines as per the [RACGP Guidelines](#).



NUMBER OF AT RISK PATIENTS: This is a visual representation of the numbers in the top left-hand corner. It visually represents the number of eligible active patients that are at risk of Cardiovascular disease.

LEVEL OF RISK: The column graph breaks down the number of eligible active patients at risk of Cardiovascular Disease into levels of risk (Low, Moderate, and High). This can assist in identifying priority population groups.

CO MORBIDITIES: The related conditions section highlights the number of patients that are at risk of CVD who have another chronic disease i.e., Diabetes, Chronic Kidney Disease, and Hypertension. These graphs also highlight in grey an “indicated diagnoses”. The [indicated diagnoses](#) are to do with clinical coding and data cleansing. It is the software suggesting based on pathology, and other clinical factors that the patient may have that diagnoses but it is not coded as that under the patients diagnoses/history. This is common with free texting in the clinical software as opposed to selecting a coded diagnosis. It could also identify a patient’s diagnosis that has been missed or overlooked. It is a great quality check feature.

QUALITY IMPROVEMENT: GOAL SETTING

Ask the three questions:

1. What are we trying to accomplish?

By answering this question, you will develop your goal for improvement.

Identify and reduce Cardiovascular Risk in patients over a 12-month period by:

- Increasing screening for CVD.
- Cleansing practice data to identify patients that may have been missed.
- Assessing modifiable risk factors.
- Looking at the treatment efficacy.

2. How will we know that a change is an improvement?

By answering this question, you will develop measures to track the achievement of your goal.

The practices data which identifies the number of patients at risk of CVD, will have reduced and/or lowered in severity and be reflected in the CVD Dashboard Report.

QUALITY IMPROVEMENT – QI PIP # 8

3. What changes can we make that can lead to an improvement? List your ideas for change. By answering this question, you will develop the ideas you would like to test towards achieving your goal. Use the SMART approach when developing ideas (specific, measurable, attainable, realistic, timebound). E.g. By March 2020, complete 100% of HbA1c tests for all eligible (have not had a test in the past 6 months) active patients.	
Idea 1.	<p><u>Use of Absolute Cardiovascular Risk Score (Screening)</u></p> <p>To increase the use of the Absolute Cardiovascular risk score as part of a screening measure by % by <insert date>.</p>
Idea 2.	<p><u>Indicated Diagnoses (Cleansing)</u></p> <p>To identify and then reduce the number of indicated diagnoses by % by <insert date> through the Pen Cat data cleansing tool.</p>
Idea 3.	<p><u>Modifiable Risk Factors (Clinical Coding)</u></p> <p>To increase the recording of modifiable risk factors (i.e., smoking alcohol, physical activity, BMI) into the clinical software by % by <insert date>.</p>
Idea 4.	<p><u>Reducing CVD Risk- Looking at treatment efficacy</u></p> <p>To identify patients whose response to lifestyle and pharmacological treatment has not reduced modifiable CVD risk factors to recommended target from% to% by <inset date>, for example, patients with hypertension receiving anti-hypertensive medication but not meeting recommended target.</p>