

PHO Performance Programme

New indicators announced

DHBNZ has announced the new performance indicators for the PHO performance management programme. Implementation of indicators is from 1 July 2008, with measurement of targets to begin on the 1 January 2009. These indicators have been developed in consultation with an expert advisory group and the PHO performance programme governance group.

The programme indicators are confirmed as:

- Breast cancer screening coverage
- Cervical cancer screening coverage
- Ischaemic cardiovascular disease detection
- Cardiovascular disease risk assessment
- Diabetes detection
- Diabetes follow up after detection
- 65 years + influenza vaccine coverage
- Age appropriate vaccinations for 2 year olds
- GP referred laboratory expenditure
- GP referred pharmaceutical expenditure

The indicators focusing on CVD and diabetes are new indicators for this phase of the programme. In this and future editions of the BPJ we'll be promoting practical strategies to support you in achieving the goals of the programme.

In this issue we begin looking at cardiovascular risk assessment.

The CVD risk assessment indicator focuses on ensuring people at risk of cardiovascular disease have had a CVD risk assessment and will be measured by comparing the number of people eligible against the number of people who have had their CVD risk recorded in the past five years.

Cardiovascular risk factors

- Family history of cardiovascular disease (father or brother CVD < 55 years old, mother or sister <65 years old)
- Family history of diabetes (parent or siblings with diabetes)
- Smoking (current smoker or have stopped smoking in the last 12 months)
- High blood pressure (prior blood pressure > 160/95 mmHg)
- Adverse lipid profile (especially low HDL, high triglycerides)
- Increased BMI and/or central obesity
- Diabetes or family history of diabetes or are at risk of developing diabetes (known impaired glucose tolerance or impaired fasting glucose)
- Polycystic ovary syndrome

Cardiovascular risk assessments – who should be screened?

	Males	Females
Māori, Pacific peoples and people from the Indian subcontinent	Age 35 years	Age 45 years
People with known cardiovascular risk factors or at high risk of developing diabetes	Age 35 years	Age 45 years
Asymptomatic people, without known cardiovascular risk factors	Age 45 years	Age 55 years

Age to begin cardiovascular risk assessment (NZGG, 2003)

GPs experiences of CVD risk assessment

Occasionally bpac^{nz} surveys primary care providers to help inform the development of our various programmes. One such recent survey asked GPs about their experiences undertaking cardiovascular risk assessments. This is of particular relevance to primary care with confirmation that the PHO Performance Programme will include ischaemic CVD detection and CVD risk assessment as performance indicators.

The results of the survey showed that 90% of respondents currently offer CVD risk assessments. While the benefits of CVD risk assessments were widely accepted, the ability to undertake them was often limited by the demands of day-to-day practice. Time and patient priorities were the most commonly cited barriers.

“ I try to! Time is always a barrier, and I sometimes feel that my patients think I am not addressing their presenting concerns when I start talking about CVD if it is unrelated to their presentation. ”

Patient priorities were also seen as a key issue in engaging the so called “hard to reach” patients. Many respondents commented that these patients appeared to lack interest in, or did not prioritise preventative healthcare.

“ Preventative health care is not in the patient’s top ten list of priorities in their lives. ”

This is understandable, because for most people, accessing healthcare is associated with experiencing symptoms, and many of the factors which contribute to cardiovascular risk are “silent”.

There were also a number of comments on the barriers to accessing primary care such as cost and accessibility during working hours. These barriers, along with the fact that practices are always busy, raises the question as to what extent some people are “hard to reach” as opposed to primary care services being difficult for some people to access.

The ability to engage patients in managing their cardiovascular risk was a concern for a number of respondents. Again competing priorities were cited as the most common barrier. This is a problem worldwide and the literature in this area suggests that the most significant contributing factors are a poor understanding by patients of the condition and difficulty in contextualising the risk.

Finally almost three quarters of respondents indicated they would like extra tools and resources to help them undertake CVD risk assessments, communicate risk and engage their patients in managing their risk of cardiovascular disease.

In the following articles we explore what we hope are practical strategies for helping to communicate risk and engage patients. We hope to explore this issue further in the future and so would be interested in your feedback, in particular strategies, tools and interventions you have found work well in daily practice.

What approach to CVD risk screening is best for your practice?

To decide which approach to CVD screening is best for your practice, consider your patient demographics, unmet needs and the resources your practice can make available to meet these needs.

Practices may use one, or a combination, of the following approaches:

Opportunistic assessment

- Initiate risk assessment when someone attends for any reason.
- Consider using a decision support tool.
- Previous (within last 12 months) cholesterol and HDL measurements can be used.
- Non-fasting cholesterol and HDL levels can also be used (e.g. point-of-care testing).
- Consider setting up an alert on your patient management system to remind yourself that the patient is due for an assessment when they next attend for an appointment.

Formal assessment

- Schedule an appointment dedicated to a cardiovascular risk assessment.
- Use fasting blood tests.
- Consider using formal assessment if opportunistic testing or estimates from clinical records show a patient is at high risk of cardiovascular disease.

Estimate of risk from clinical records

- Initial estimate from clinical records with those estimated to be at high risk called in for formal cardiovascular risk assessment.
- Consider using a decision support tool to enter values and calculate risk.

Resources for calculating cardiovascular risk

- Risk tables (found in BNF, NZGG, MIMS etc)
- Decision support tools
- Online calculators e.g.
 - www.riskscore.org.uk
 - www2.everybody.co.nz/Heart/Risk-Calculator/index.htm
 - <http://cvrisk.mvm.ed.ac.uk/calculator/framingham.htm>