Evaluating Early Detection: Cardiovascular Disease

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The Problem & The Project

- Untreated patients at high risk of cardiovascular disease
  - Identifiable from information in electronic primary care records
  - Information alone insufficient
- Identify: using Risk Manager module in MSDi software
  - Untreated high risk patients aged 40-74
- Invite
  - letter offering assessment in practice
- Assess
  - Project Nurse undertakes assessment
- Treat (prescribe / advise / refer)
Computer generates list of untreated high risk patients

Review list:
- Exclude if unsuitable

Letter inviting patients for assessment

Check up in own practice

Case-finding

Advise, refer, treat
Evaluation

• Use routine electronic patient records data
  – Number of patients started on statins / antihypertensives
• Randomised rollout
  – 26 practices included in the evaluation
Roll out Practice by Practice

- Randomise order of rollout
- Stepped wedge randomised controlled trial

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<th>Jan-09</th>
<th>Mar-09</th>
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Valuable Experience

- Defining start dates for intervention
- Identifying target population
- Data extraction
- Software changes & data losses
- Priority

“Experience is the name everyone gives to their mistakes”
Lady Windermere’s Fan: Oscar Wilde
Moving on....

Managing Patients with Long Term Conditions
The dilemma of "defining risk" for patients on long-term conditions in primary care

- Is it just the number of registers?
- What about outside QOF: parkinsons, cirrhosis, inflammatory bowel disease….children…. 

Once identified as high risk, then what do you do:
- as an individual team member
- as a team practice
What if we used what we have?

**Metrics**
- HbA1c
- Cholesterol
- BP
- MRC
- eGFR*
- BMI
- Waist circ
- Audit C score
- PHQ9
- Being Housebound
- No of repeat
- Age >75
- Being a smoker

**Long Term Conditions**
- Cancer,
- COPD,
- Asthma,
- Diabetes,
- CKD 3,4,5,
- Hypertension,
- Rh Arthritis,
- AF,
- HF,
- Hypertension,
- Mental Health condition,
- LD,
- Dementia,
- Parkinsons,
- Cirrhosis,
- being on the GSF,
- Inflammatory Bowel Disease,
- Stroke/TIA,
- Osteoporosis
MSDi LTC Module

• The software will allocate a R,A,G, status to patients based on:
  – The number of long term conditions they have
  – Indicators used to define whether those conditions are optimally managed
  – No of visits a patient has made to the surgery over the last 12 m
  – Flexible: to allow for user defined thresholds and weightings to be allocated to each of the above parameters
  – A care plan will be generated for the patient which will include the number of appointments that a patient will have over the following 12 m which are dedicated to the optimal management of that patients conditions.
  – The software is practice based
  – At locality level anonymised data can be aggregated and accessed through a web-based portal, allowing risk to be stratified across a geography.
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<thead>
<tr>
<th>Event Count-based Criteria</th>
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<th>Upper Bound</th>
<th>Use In Scoring</th>
<th>Points</th>
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Overall Red Points Threshold: 15
Overall Orange Points Threshold: 5

Save Current Criteria, Load Default Criteria, Calculate Scores, Cancel