



Western Health Chronic Disease IMPACT

Quick Reference Guide

Version 4.5.1 – April 2017



smart. secure. connected.   

About this Guide

The Chronic Disease Detection and Management module is an initiative of Western Health, Victoria University and Melbourne University under the umbrella of the Western Chronic Disease Alliance. It aims to further enhance the primary care software to aid detection and management of chronic vascular diseases such as CKD, CVD, and T2DM and to help identify patients at risk of these diseases by identifying and managing risk factors such as Familial Hypercholesterolemia (FH).

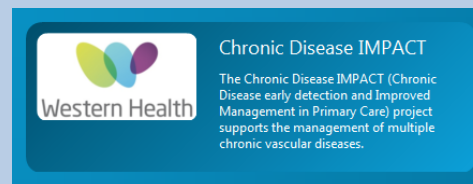
Patients with chronic disease often have co-morbidities and software tools need to support the management of multiple conditions rather than management of conditions in isolation. The key risk factor tests and management items that are common across the chronic vascular diseases are part of this module.

Accessing the module

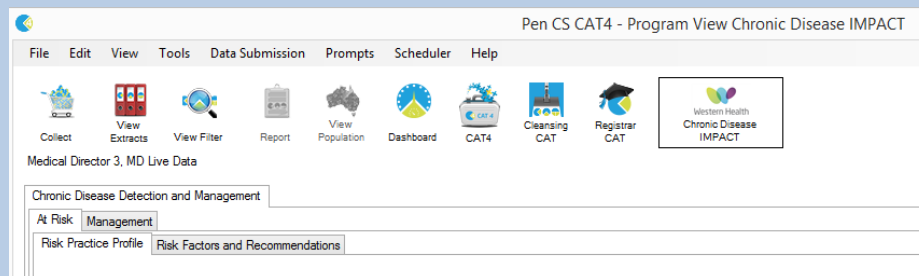
1. From the CAT Dashboard click the Programs



2. Click the Chronic Disease IMPACT tile



3. The module 'At Risk' and 'Management' tabs will be displayed



There are 2 main tabs within the module and each has sub-tabs that displays the graphs:

- **At Risk**
 - **Risk Practice Profile** – The Venn diagram displays the prevalence of chronic vascular disease risk within the practice and the prevalence of the risk of patients developing co-morbidities for chronic vascular diseases.
 - **Risk Factors and Recommendations** – The graph displays the risk factors and associated recommendations for the selected chronic vascular diseases with their legend items.
- **Management**
 - **Diagnosis Practice Profile** – The Venn diagram displays the prevalence of diagnosed chronic vascular disease within the practice and the prevalence of patients with co-morbidities for chronic vascular disease.
 - **Diagnosis Management Items** – The graph displays the management items with their legend items for selected chronic vascular diseases.

The **eligible patient population** for each graph is summarised here.

At Risk > Risks Practice Profile

Eligible Population: Patients 18 years and over that have one or more risk factors for a chronic disease (CVD (including stroke, HF, CHD, PAD), T2DM or CKD).

At Risk > Risk Factors identification

Eligible Population: Patients 18 years and over that have one or more risk factors for a chronic or related disease (CVD (including stroke, HF, CHD, PAD), T2DM, CKD or FH).

Management > Diagnosis Practice Profile

Eligible Population: Patients 18 years and over that have a diagnosis of one or more chronic diseases (CVD (including Ischaemic stroke, HF, CHD, PAD), T2DM or CKD).

Management > Diagnosis Management Items

Eligible Population: Patients 18 years and over that have a diagnosis of one or more chronic or related diseases (CVD (including Ischaemic stroke, HF, CHD, PAD), T2DM, CKD, FH or AF).

For any questions you may contact the following:

- Christine Chidgey – Pen CS Business Development and Operations
 - +61 410 472 600
 - christine.chidgey@pencs.com.au
- Natalie Lumsden – Western Health Chronic Disease Impact
 - +61 0466 418 183
 - natalie.lumsden@wh.org.au

For more detailed information on the Chronic Disease IMPACT module you may refer to the User Manual (please request from Natalie Lumsden if already provided).

Tips for using the Pen CS CAT Chronic Disease IMPACT Module for quality improvement activities by your practice

Worksheets listing patients that have **not undertaken risk testing** as per national guidelines can be recalled by the following method:

1. Go to 'Risk and Recommendation Graph' located under the 'At Risk' tab, tick to select one or more disease tick boxes. Click 'Risk Factor not recorded' bar section (yellow) for Smoking, Obesity, Lipids bars.
2. Click worksheet tab to see list of patients where risk factor is not recorded (e.g. smoking status)

Reidentify Report [patient count = 869] - Reidentify Worksheet
Selected: Risk Factors and Recommendations (Smoking: Not recorded)

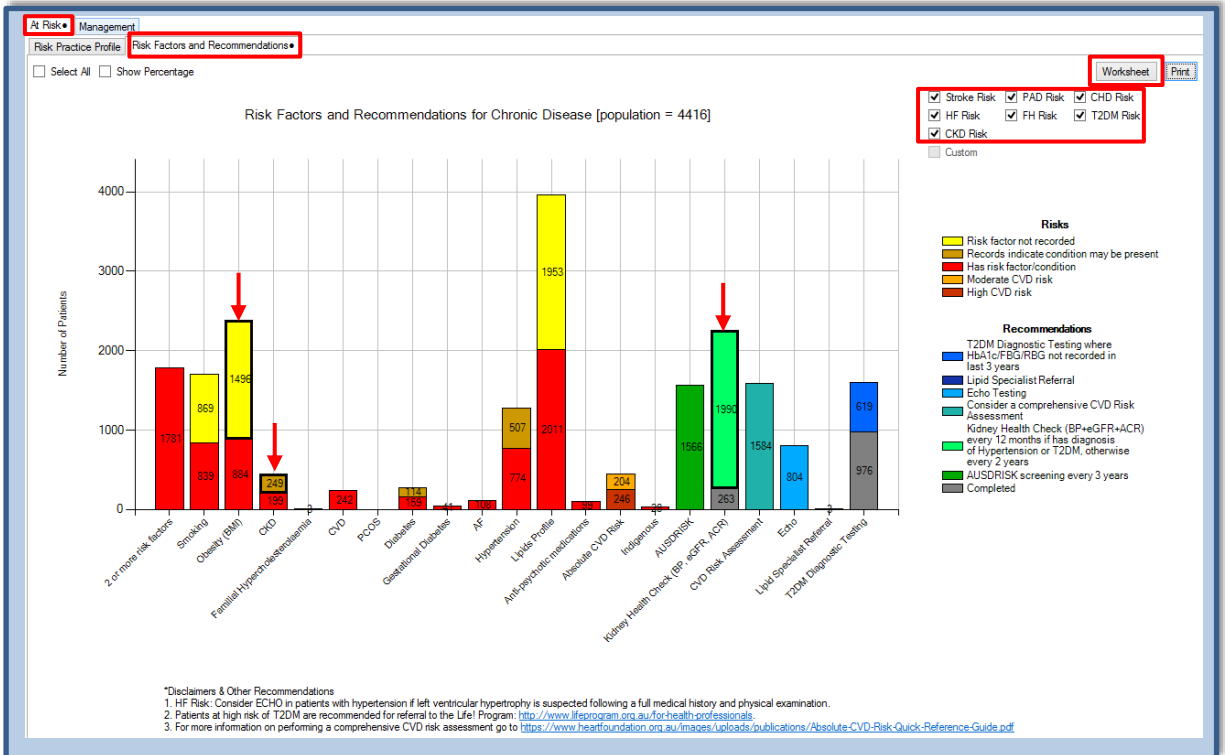
ID	Surname	First Name	Sex	D.O.B	Smoking	BMI	Diagnoses	Indicated
9	Surname	Firstname_1381	F	24/01/1962		29.8		
17	Surname	Firstname_3103	M	24/01/1950		37.8*		

Worksheets listing patients that are **indicated for disease (due to a pathology result) but no coded diagnosis has been entered into your clinical system** can be recalled by the following method:

1. Go to 'Risk and Recommendation Graph' located under the 'At Risk' tab, click on tick box(es) to select one or more disease, click on brown bar section for either CKD, FH, Diabetes and HTN 'Records indicate the condition may be present'.
2. Click worksheet tab to see list of patients indicated for disease (e.g CKD)

Reidentify Report [patient count = 249] - Reidentify Worksheet
Selected: Risk Factors and Recommendations (CKD: May be present)

ID	Surname	First Name	Sex	D.O.B	Smoking	BMI	Diagnoses	Indicated	BP	HbA1c % (mmol/mol)
20	Surname	Firstname_1566	F	24/01/1951			Hypertension*	CKD*	132/74 (15/12/2016)	5.3 (34) (19/04/2016)
28	Surname	Firstname_7953	F	24/01/1981	Never Smoked	24.5		CKD*	112/80 (23/06/2016)	4.8 (29) (21/03/2016)
106	Surname	Firstname_2678	F	24/01/1948	Never Smoked	30.5*	T2DM*, Hypertension*	CKD*	118/67 (22/12/2014)	7.6 (60) (12/12/2014)



Worksheets listing patients for either of the following recommendations as per national guidelines: 'T2DM diagnostic Testing every 12 months', 'lipid specialist referral', 'Echo testing', 'Kidney Health Check every 12 months', 'Consider a comprehensive CVD risk assessment' can be recalled by the following method:

1. Go to 'Risk Factors and Recommendations Graph' located under the 'At Risk' tab, tick to select one or more disease tick boxes. Click any Recommendation bar (e.g. Kidney Health Check green) (do not click 'Completed')
2. Click worksheet tab to see list of patients for who the recommendation pertains

Reidentify Report [patient count = 1990] - Reidentify Worksheet
Selected: Risk Factors and Recommendations (Kidney Health Check (BP, eGFR, ACR); Kidney Health Check (BP, eGFR, ACR))

ID	Surname	First Name	Sex	D.O.B	Smoking	BMI	Diagnoses	Indicated	BP	HbA1c % (mmol/mol)	Lipids	eGFR	ACR	FBG	RBG	Anti-psychotic meds	Statin	Abs CVD Risk	ATSI	Age	Recommendations	
1	Surname	Firstname_8336	F	24/01/1966	Never Smoked	48.4*			130/60 (4/11/2016)		Chol=6.8 (14/04/2016), LDL=3.7 (14/04/2016), HDL=1.4 (14/04/2016), Trig=1.6 (14/04/2016)	38/17 (14/04/2016)			4.8 (14/04/2016)						51*	AUSDRISK, Kidney Health Check (BP, eGFR, ACR)
4	Surname	Firstname_7781	M	24/01/1948	Ex Smoker		Hypertension*		125/68 (24/09/2015)		(NO LDL*), (NO Chol*)							High*		69*	AUSDRISK, Kidney Health Check (BP, eGFR, ACR), Echo	
8	Surname	Firstname_1891	F	24/01/1956	Never Smoked	21.8	Hypertension*		140/60 (10/11/2016)	5.4 (36) (7/11/2016)	Chol=9 (7/11/2016), LDL=2.8 (7/11/2016), HDL=1.70 (7/11/2016), Trig=1.8 (7/11/2016)	*90 (7/11/2016)	1.2 (6/05/2015)	5.2 (31/01/2014)	5.8 (7/11/2016)					61*	AUSDRISK, Kidney Health Check (BP, eGFR, ACR), Echo	

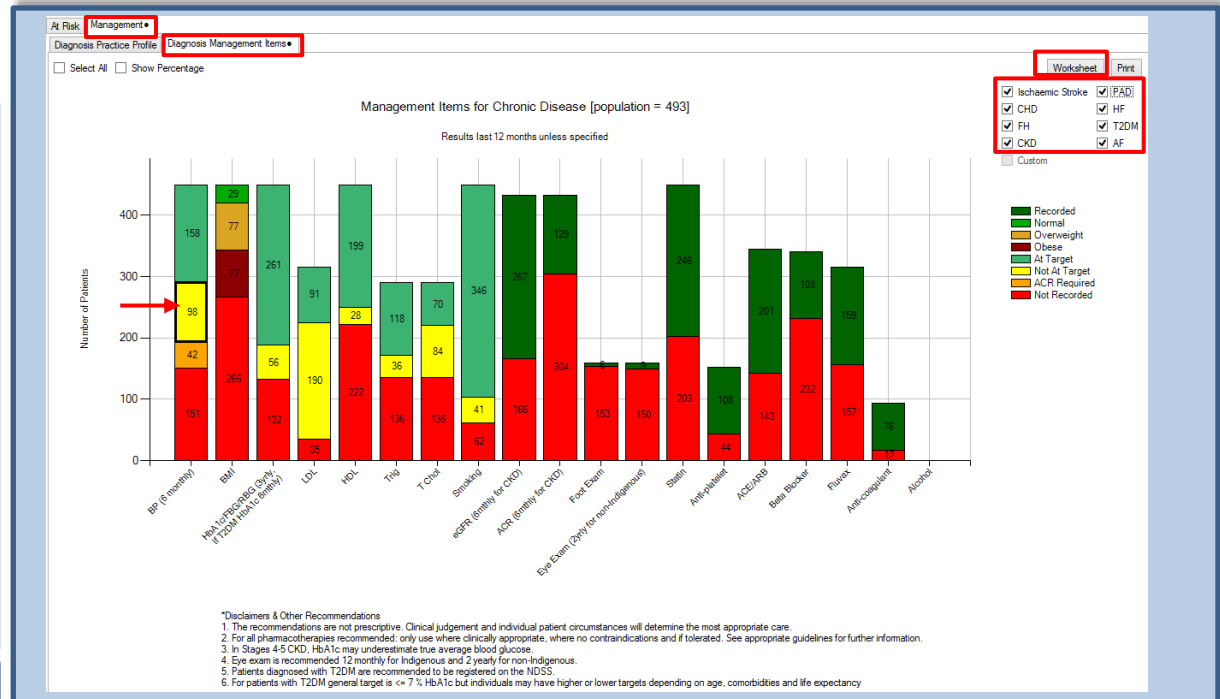
Tips for using the Pen CS CAT Chronic Disease IMPACT Module for quality improvement activities by your practice

Worksheets listing patients that are diagnosed with a disease but management items are not at target or is not recorded can be recalled by the following method:

1. Go to 'Diagnosis Management Items Graph' located under the 'Management' tab, click on tick box(es) to select one or more disease, click on yellow bar section for 'Not at Target' or red section 'not record' management items
2. Click worksheet tab to see list of patients Not at target or 'not recorded' management items

Reidentify Report [patient count = 98] - Reidentify Worksheet
Selected: Diagnosis Management Items (BP (6 monthly): Not At Target)

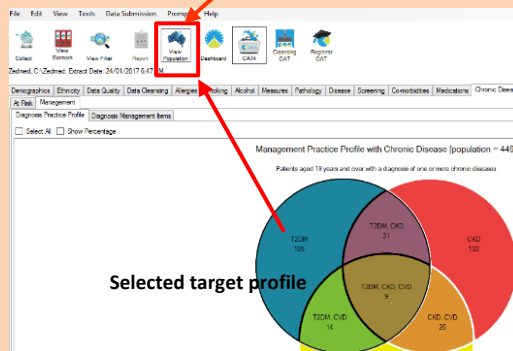
ID	Surname	First Name	Sex	D.O.B	Diagnoses	BP	BMI
60	Surname	Firstname_3013	M	24/01/1955	T2DM, CKD	138/70* (15/11/2016)	27*
119	Surname	Firstname_798	F	24/01/1932	CKD	154/58* (25/11/2016)	33*
126	Surname	Firstname_1116	F	24/01/1954	T2DM	99/70* (23/01/2017)	31*



Other Tips:

- Selecting a target profile in the Risk Practice Profile tab or Diagnosis Practice Profile tab will select the same profile in Risk Factors and Recommendations tab and Diagnosis Management items tab respectively.
- If you are interested to see the assigned provider and when the patient was last seen by the provider – after you have selected your target profile in either Risk Practice Profile tab or Diagnosis Practice Profile tab you may click View Population.

View Population button



Other Tips:

Instead of clicking a bar one by one you may click the legend to select all related bars. For example, clicking 'Has risk factor/condition' in the Legend will select all red bars.

