Primary Sense Reports – CVD Risk Screening, Recall and Treatment Report

Report - release 2.46

Overview

This report was developed as part of the **PHASES project** in Queensland, a statewide initiative to reduce cardiovascular disease (CVD) by improving primary care. It stands for **Preventing Heart Attacks and Stroke Events through Surveillance** and uses digital tools like Primary Sense, practice support, and community campaigns to empower general practices to identify, prevent, and manage CVD risks earlier. The project's aim is to strengthen primary care's role in preventive healthcare and improve long-term health outcomes for Queenslanders. PHASES with Primary Sense: Project Overview

Primary Sense can assist with the project success by providing data-driven insights to general practitioners (GPs) at the point of care and facilitating early intervention by helping GPs and other primary care providers identify patients at high risk for CVD, enabling proactive guidance on lifestyle and behaviour modifications before conditions become severe.

This report has 4 tables. Due to the criteria for each table, patients should only appear in 1 table. Where patients are automatic high risk but also have CVD, CVD is used to determine which guideline therapy and targets are applied

Table 1:

Intermediate and high CVD risk patients without prior CVD not on guideline therapy
This table lists patients who face a significant risk of developing cardiovascular disease within the next five years and are currently missing one or both of the recommended medications to help manage that risk.

Table 2:

Patients with prior CVD not on guideline-recommended therapy
This table lists patients with CVD who are missing one or more of the three recommended medications to reduce the risk of another cardiovascular event.

Table 3:

Patients at high CVD risk (including prior CVD) on guideline therapy but treatment targets not met
Patients listed are receiving appropriate medications, but their risk factors—such as smoking—remain unmanaged.

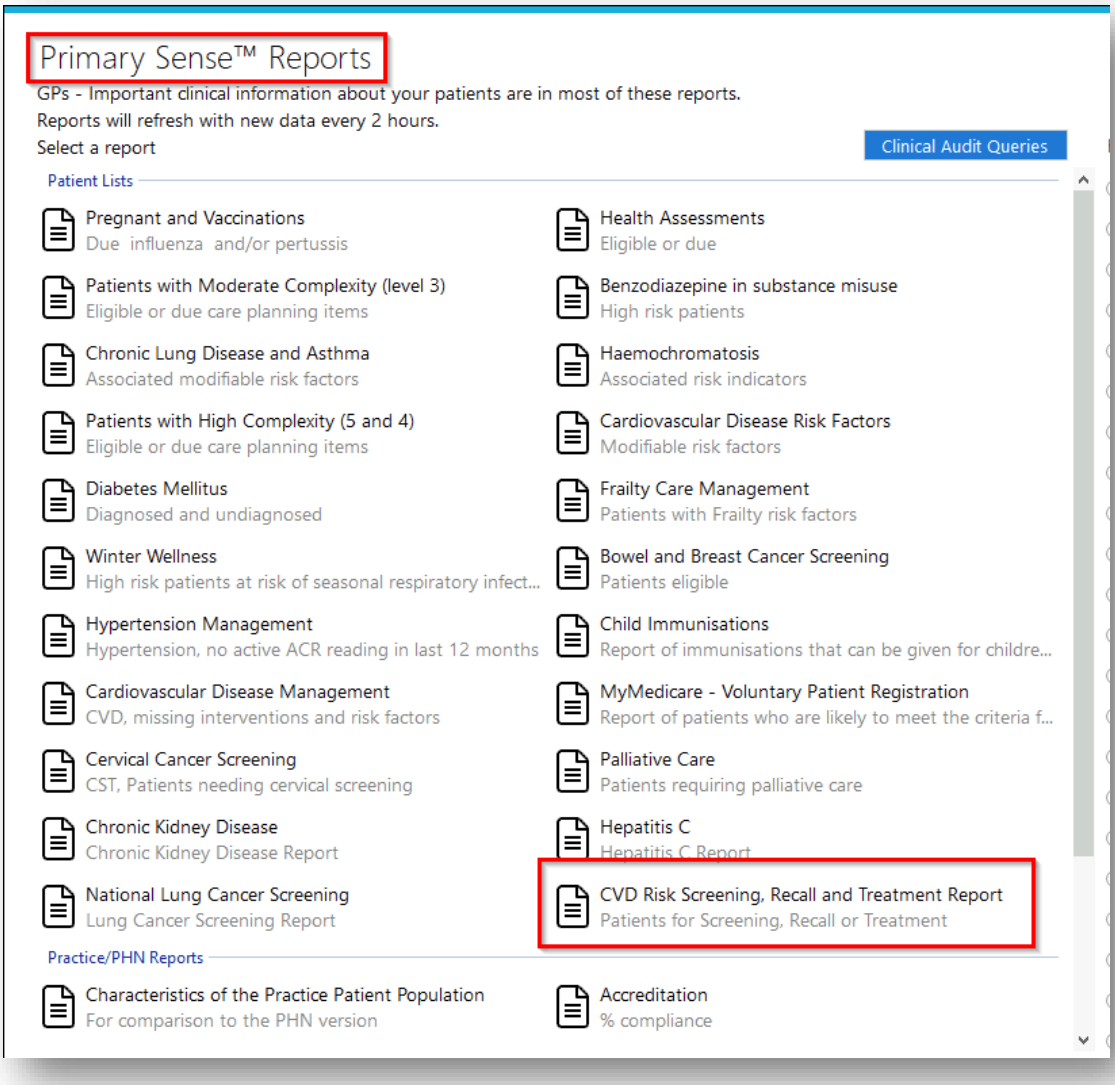
Table 4:

Patients likely to be at high CVD risk - incomplete/outdated risk factors (priority screening)
Patients in this table do not have the metrics to calculate CV risk but are likely at high risk of a CV event due to other modifiable (e.g. blood pressure) and non-modifiable factors (e.g. age).

Using the report

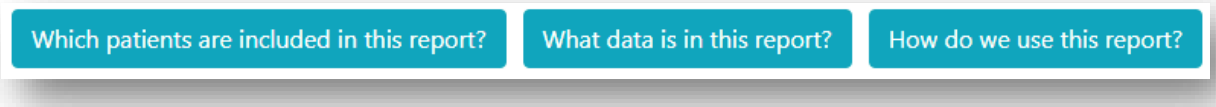
To open the report, click on the 'Reports' tile in the desktop app.

Double click 'CVD Risk Screening, Recall and Treatment Report 'under the 'Patient Lists' section.



General Information

- The tabs at the top of the page can be clicked to bring up relevant information.

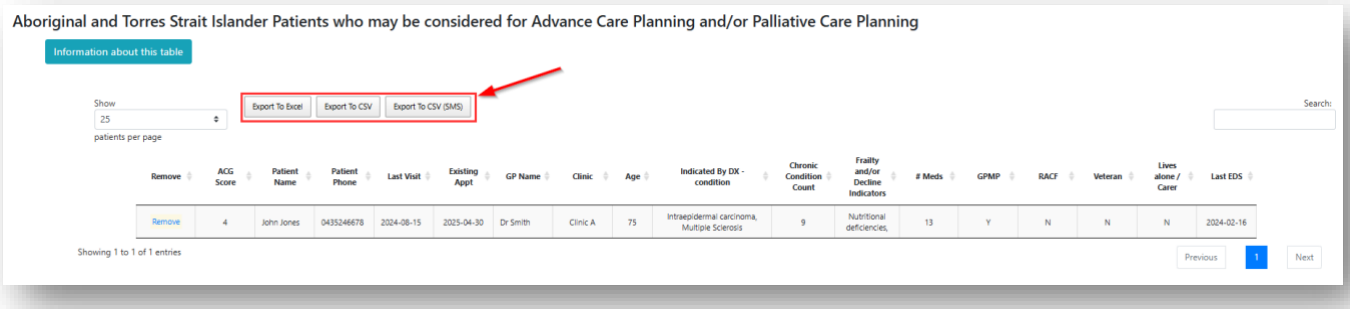


- The results can be filtered by clicking on each column. Clicking on columns will rearrange the results alphabetically, chronologically or from high to low or low to high.

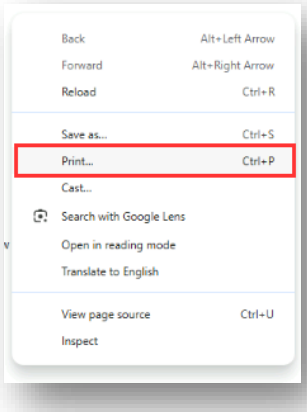
- The 'Search' function can help you find specific content

Try searching by a month or year e.g. '08' or '2023' to find a last visit dates in a particular range, or by 'GP name' to bring up patients with a specific regular GP.

- Patients can be removed from the report for 12 months, by clicking 'Remove.' This action cannot be reversed.
- The table can be exported to Excel or CSV for further analysis. 'Export To CSV (SMS)' will create a patient recall list for use with HotDoc© or other compatible applications.
- Applications such as Google Sheets or Libre Office can be used to view and filter the export if Excel is unavailable.

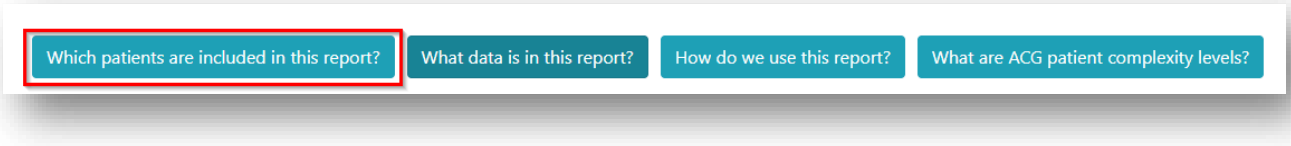


- Any filters applied to the data at the time, will be carried over when exported.
- All reports that are generated are automatically saved to a folder on your practice computer.
- The report can be printed by right clicking the mouse button while hovering the cursor over the report and selecting the 'Print' option.



Report Content

Which patients are included in this report?

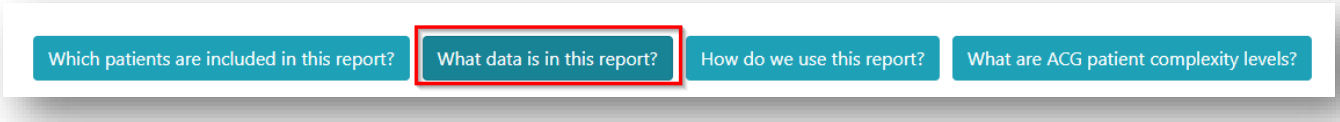


- All people aged 45-79 years.
- People with diabetes aged 35-79 years.
- First Nations people aged 30-79 years (assess individual risk factors 18-29 years).
- Patients at intermediate and high risk of a CVD event (according to 2023 Australian CVD risk tool and/or 2012 Framingham-based tool), not on guideline-recommended therapy.
- Patients with prior CVD not on guideline-recommended therapy.
- Patients at high CVD risk on guideline-recommended therapy but not meeting treatment targets.
- Patients with prior CVD on guideline-recommended therapy but not meeting treatment targets.
- Patients likely to be at high CVD risk who have insufficient risk factors to enable risk score measurement including those not recorded or out of date.
- Patients with a documented reason for a visit in the past 18 months.
- Patients with billed Residential Aged Care Home MBS items or recorded as palliative are excluded.

Example of data returned in the table for patients with CV risk not on dual therapy **Note:** Patient and clinic data is test data.

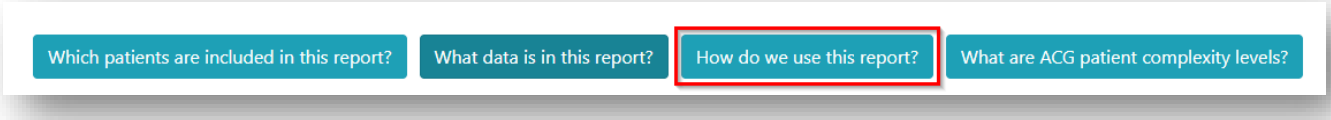
Remove	ACG Complexity	Patient Name	Patient Phone	Last Visit	Existing Appt	GP Name	Clinic	Age	Sex At Birth	ATSI	Familial Hyper chol	Moderate Severe CKD	CVD Score%	Total Cholesterol	Age Of TC Result	LDL	HDL	TC/HDL Ratio	SBP	Age Of SBP Result	Diabetes	Smoking Status	On Lipid Lowering	On Antihypertensive	On Lipid Antihypertensive Combo	Last Heart Health Check	Last Care Plan Date	Last Care Plan Review Date
Remove	1	Nguyen, U	0401 234 567	2024-11-04	Nil	Dr C Lee		65	M	N				8.1 mmol/L	33 months		1.0 mmol/L	7.9	162	33 months		Non						
Remove	3	Taylor, C	0401 234 567	2024-10-23	Nil	Dr C Lee		72	F	N				7.8 mmol/L	3 months		1.1 mmol/L	7.2	160	18 months		Ex	rosuvastatin					
Remove	3	Smith, R	0401 234 567	2024-12-30	Nil	Dr C Lee		73	F	N		Y		7.7 mmol/L	3 months	5.7 mmol/L	0.9 mmol/L	8.2	117	81 months		Non					2024-07-30	2025-02-10
Remove	2	Ryan, D	0401 234 567	2024-07-26	Nil	Dr C Lee		66	F	N				7.6 mmol/L	36 months		1.2 mmol/L	6.4	181	75 months		N/A		telmisartan and diuretics				
Remove	3	Lee, D	0401 234 567	2024-05-08	Nil	Dr C Lee		69	F	N	Y			7.5 mmol/L	18 months		1.6 mmol/L	4.9	154	18 months		Non						

What data is in this report?



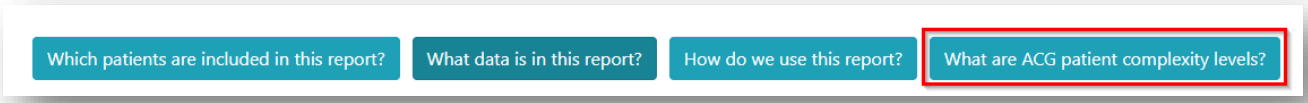
- Patient demographics including age, sex at birth, Aboriginal and Torres Strait Islander status, smoking and diabetes status (where available).
- Select CVD related pathology results (e.g. Lipids, Cholesterol, Renal).
- Names of CVD related Medications prescribed in the past 18 months.
- Observations including last blood pressure recording and time since recorded.
- Dates of MBS items for CVD and CCM services completed in the last 12months.
- Date of last visit.
- Existing appointment date.
- GP/clinic.
- 2023 Australian CVD risk tool score.
- Date of last Heart Health Check (MBS item 699).
- Date of last Care Plan (MBS items 721 or 965).
- Date of last Care Plan Review (MBS item 732 or 967).
- Where a field is blank, no record has been found.

How do we use this report?



- This report can be used to identify the different patient groups that may require screening, recall, intervention or clinical management.
- The report also identifies those patients likely to be at high CVD risk who have insufficient risk factors to enable risk score measurement (including those not recorded or out of date) and are recommended for priority screening.
- All results can be sorted by clicking on each column, to rearrange the results alphabetically, chronologically or from high to low/low to high.
- A date range filter is provided so that only risk factors measured within specified time frames are displayed.
- The date of the last MBS billed item are provided.
- The 'Search' function can help you find specific content.
- The ‘Existing appt’ column displays patient appointments that have been booked for dates beyond the report.
- The 'Last Visit' column displays the date the patient last had an appointment at the practice.
- The 'Remove' column provides the option to selectively remove individual patients from this type of report for the next twelve months.
- The report can be exported as an Excel or CSV file by clicking the 'Export to Excel' or 'Export to CSV' tabs.
- All reports that are generated are automatically saved to a folder on your practice computer.
- The report can be printed by clicking the right mouse button while hovering the cursor over the report and selecting the 'print' option.

What are ACG Complexity Levels?



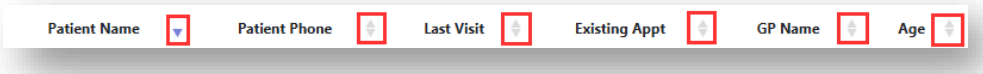
- There are five complexity levels, ranging from 1 to 5. For data analysis purposes, there is a sixth level, level 0. Level 0 is for those patients with no recorded diagnoses or significantly incomplete or missing data.
- Level 1 indicates a very low level of complexity with no known risks for poor health outcomes, level 5 is the highest complexity. Patients with level 5 complexity typically have significant multi-morbidity and polypharmacy and are at greatest risk of poor health outcomes.
- Levels overview:
    - Level 5: High complexity, characterized by instability, multimorbidity, polypharmacy or patients requiring end-of-life care.
    - Level 4: High to moderate complexity, characterized by multimorbidity.
    - Level 3: Moderate complexity. Patients typically have at least 1 chronic condition and are at risk of progressive deterioration.
    - Level 2: Low to moderate complexity. Patients typically have one risk factor.
    - Level 1: Low complexity. Patients are generally healthy and only present because of acute, time-limited conditions or minor issues.
    - Level 0: no or only invalid diagnosis.
- Patients with higher levels of complexity are more likely to be hospitalized than those with lower levels. However, complexity is not directly related to the risk of being hospitalized. Many Primary Sense reports therefore include both estimates.
- If the complexity of a patient is calculated from results that are more than 12 months old, the level will be displayed in brackets, e.g. (3), rather than 3.
- If there is insufficient information to calculate a complexity level, the result will be displayed as ‘N/A’.
- The complexity levels of patients in this report were calculated with the Johns Hopkins ACG tool. The ACG is underpinned by a robust evidence base of >30 years of practical application. The tool is used in 20 countries and has been validated in different healthcare settings, including general practice.

Information about these tables

The report includes 4 tables.
Diagnosis/Conditions referenced from patient Clinical Information System (CIS) are:

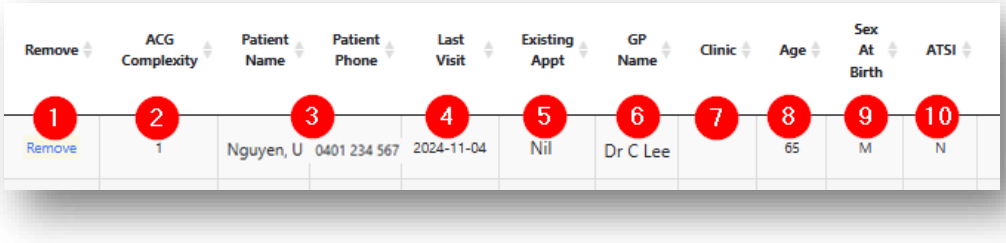
- CVD
- Diabetes
- Familiar hypercholesterolemia
- CKD (References eGFR/ACR results)

Arrows at the top of each column can be used to reverse the ordering.



Columns Returned

Standard across all tables:

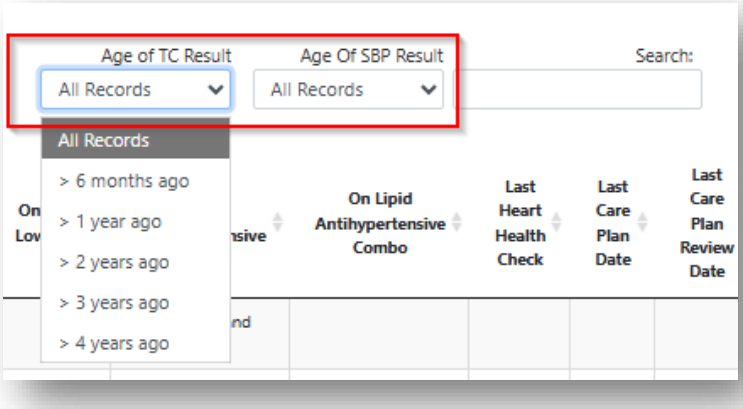


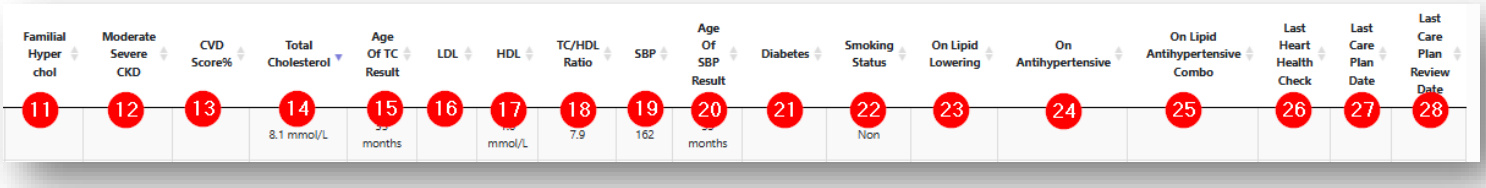
1. **'Remove'** - Patients can be removed from the report for 12 months, by clicking 'Remove.' This action cannot be reversed.
2. **'ACG Complexity'** - the complexity bands formed by combining the ACGs to measure overall morbidity burden on a scale of 0-5, with 5 being the most complex/morbidity burden. See *The Johns Hopkins ACG® Version 12.0 User Documentation* for more information on ACG data.
3. Patient demographic data.
4. **'Last Visit'** - displays the date the patient last had an appointment at the practice.
5. **'Existing Appt'** - displays patient appointments that have been booked for dates beyond the report.
6. **'GP Name'** - the GP who has most accessed the patient record. See User Guide for rules.
7. **'Clinic'** - most attended clinic if data is shared.
8. **'Age'** - Patient age at time the report is run (to protect patient confidentiality, the age of all patients older than 90 years are displayed as 90).
9. **'Sex at Birth'** – F = Female, M = Male, O = Other, U = Unknown, N = Not Recorded
10. **'ATSI' -** patients identified as: Aboriginal, Aboriginal/Torres Strait Islander or Torres Strait Islander will display 'Y'. If not, then 'N'

Table 1 - Intermediate and high CVD risk patients without prior CVD not on guideline therapy

- Intermediate and high CVD risk patients without prior CVD not on guideline therapy (includes automatic high CVD risk).
- No prior CVD.
- Age /group band: (Aboriginal and Torres Strait Islander and 30 ≥ age ≤ 79) OR (Diabetes and 35 ≥ age ≤ 79) OR (Neither Aboriginal and Torres Strait Islander nor Diabetes and 45 ≥ age ≤ 79).
- Risk Status: CVD risk category = intermediate to high OR meets automatic high-risk criteria (i.e. Moderate-severe CKD (eGFR <45ml /kg/min/1.73 m2 OR uACR> 25 men, >35 women; OR Recorded Familial hypercholesterolemia).
- Therapy status: Not on any antihypertensive AND not on any lipid-lowering therapy.
- Recency: ≥1 recorded consultation within the last 18 months (reason for visit/diagnosis) OR Any medication prescribed within the last 18 months from report date.

Results can be filtered by time passed since the last Total Cholesterol or Systolic Blood Pressure test to identify those needing review.





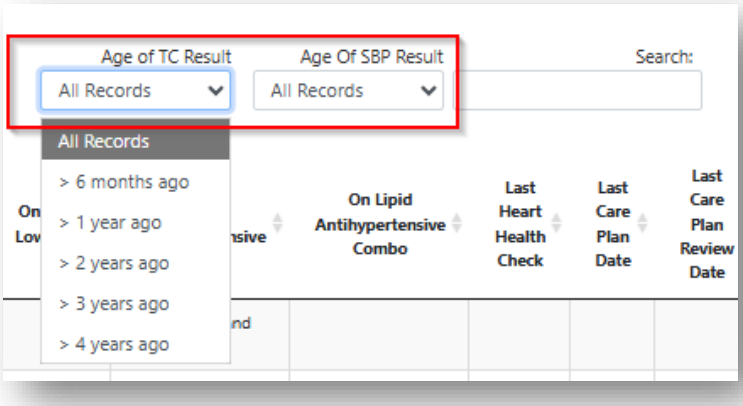
11. **'Familiar hypercholesterolemia'** – Y displayed if diagnosis in CIS
12. **'Moderate Severe CKD'** – Y displayed if diagnosis in CIS (Moderate-severe CKD (eGFR <45ml /kg/min/1.73 m2 OR uACR> 25 men, >35 women)
13. **'CVD Score %' =>5**
14. **'Total Cholesterol'** - Latest Total Cholesterol result
15. **'Age of TC Result'** – Time since last Total Cholesterol result, displays 'this month' or total in months e.g. '33 months'
16. **'LDL' –** latest Low-Density Lipoprotein result
17. **'HDL' –** Latest High-Density Lipoprotein result
18. **'TC/HDL Ratio'** – latest Total Cholesterol to HDL Ratio result
19. **'SBP'** – Latest recorded Systolic Blood Pressure

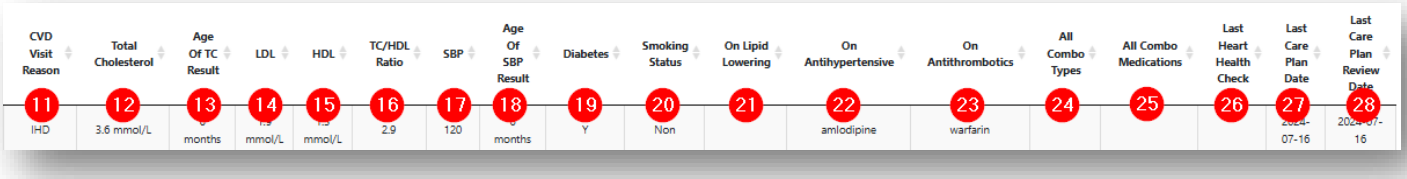
20. **'SBP'** – Time since last recorded Systolic Blood Pressure, displays 'this month' or total in months e.g. '33 months'
21. **'Diabetes'** – Y displayed if diagnosis in CIS (Type 1 and gestational diabetes diagnosis are excluded due to the heart foundation calculation acknowledging overestimates with Type 1 diabetics)
22. **'Smoking Status'** - Smoker, Non = Non-smoker, Ex = Ex-smoker, N/A if no record in CIS
23. **'On Lipid Lowering' –** Displays prescribed medication
24. **'On Antihypertensive' –** Displays prescribed medication
25. **'On Lipid Antihypertensive Combo' –** Displays prescribed medication
26. **'Last Heart Health Check'** - last billed MBS item 699 Heart Health Assessment
27. **'Last Care Plan date'** – last billed 721 GP Management Plan (GPMP) or 965 Prepare GP Chronic Condition Management Plan
28. **'Last Care Plan Review Date' –** last billed 732 Review of GPMP or Team Care Arrangements (TCA) or 967 Review GP Chronic Condition Management Plan

Table 2 - Patients with prior CVD not on guideline-recommended therapy

- Age: 30 ≥ age ≤ 79.
- Condition: prior CVD.
- Therapy status: Missing any one or more of the following therapies:
    - Antiplatelet
    - Antihypertensive
    - Lipid-lowering
- Medication definition: Active therapy requires a prescription within the past 18 months.
- Conditions are used where active or inactive due to risks.

Results can be filtered by time passed since the last Total Cholesterol or Systolic Blood Pressure test to identify those needing review.





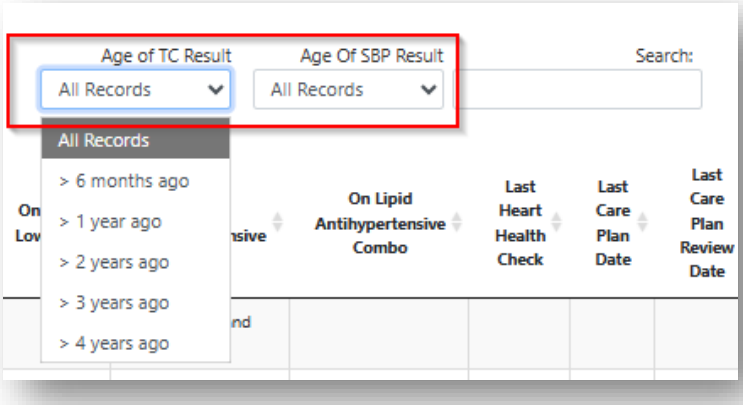
11. **'CVD Visit Reason'** – latest CVD reason for visit / diagnosis in CIS (reason for visit / diagnosis list defined by PHASES Project)
12. **'Total Cholesterol'** - Latest Total Cholesterol result
13. **'Age of TC Result'** – Time since last Total Cholesterol result, displays 'this month' or total in months e.g. '33 months'
14. **'LDL' –** latest Low-Density Lipoprotein result
15. **'HDL' –** Latest High-Density Lipoprotein result
16. **'TC/HDL Ratio'** – latest Total Cholesterol to HDL Ratio result
17. **'SBP'** – Latest recorded Systolic Blood Pressure
18. **'Age of SBP Result'** – Time since last recorded Systolic Blood Pressure, displays 'this month' or total in months e.g. '33 months'
19. **'Diabetes'** – Y displayed if diagnosis in CIS (Type 1 and gestational diabetes diagnosis are excluded due to the heart foundation calculation acknowledging overestimates with Type 1 diabetics)
20. **'Smoking Status'** - Smoker, Non = Non-smoker, Ex = Ex-smoker, N/A if no record in CIS
21. **'On Lipid Lowering' –** Displays prescribed medication
22. **'On Antihypertensive' –** Displays prescribed medication
23. **'On Antithrombotics' –** Displays prescribed medication

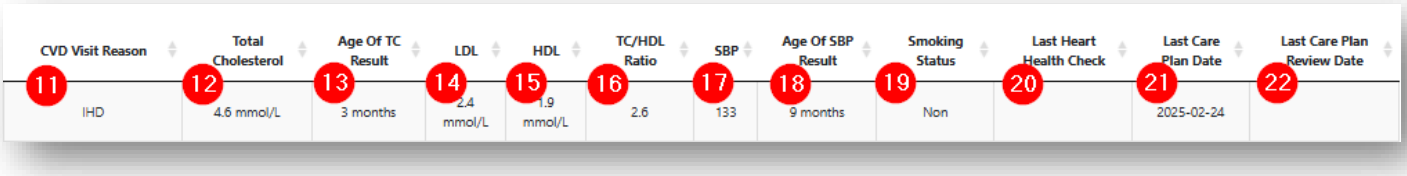
24. **'All Combo Types' –** Displays prescribed medication e.g. statin and lipid lowering and anti-platelet (this field may be empty until some medications come onto the PBS)
25. **'All Combo Medications' –** Displays prescribed medication where medication type is a combination medication
26. **'Last Heart Health Check'** - last billed MBS item 699 Heart Health Assessment
27. **'Last Care Plan date'** – last billed 721 GP Management Plan (GPMP) or 965 Prepare GP Chronic Condition Management Plan
28. **'Last Care Plan Review Date' –** last billed 732 Review of GPMP or Team Care Arrangements (TCA) or 967 Review GP Chronic Condition Management Plan

Table 3- Patients at high CVD risk (including prior CVD) on guideline therapy but treatment targets not met

- Selects patients who meet all of the following:
  - Age /group band : 30 ≥ age ≤ 79).
  - Risk Status: High CVD risk -
    - Includes high CVD risk score.
    - Includes automatic high risk categories.
- Data completeness: Complete set of risk factors recorded for those with a high CVD risk score; not for those who are automatic high risk or prior CVD as not needed.
- Therapy Status: On guideline-recommended therapy (active prescription = within past 18 months) AND who meet at least one of the following 'not at target' criteria:
  - On lipid-lowering therapy AND LDL ≥ 1.8 mmol/L if no prior CVD, or LDL ≥ 1.4 mmol/L if prior CVD.
  - On antihypertensive therapy AND systolic BP ≥ 140 mmHg.
- Current smoker.
- Where the CVD visit reason is blank this means the patient is auto high risk, intermediate or high CV Risk.

Results can be filtered by time passed since the last Total Cholesterol or Systolic Blood Pressure test to identify those needing review.





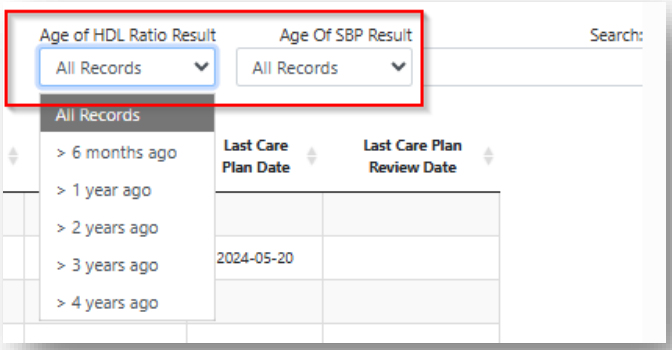
11. **'CVD Visit Reason'** – latest CVD reason for visit / diagnosis in CIS. If blank this means the patient is auto high risk, intermediate or high CV Risk (reason for visit / diagnosis list defined by PHASES Project)
12. **'Total Cholesterol'** - Latest Total Cholesterol result
13. **'Age of TC Result'** – Time since last Total Cholesterol result, displays 'this month' or total in months e.g. '33 months'
14. **'LDL' –** latest Low-Density Lipoprotein result
15. **'HDL' –** Latest High-Density Lipoprotein result
16. **'TC/HDL Ratio'** – latest Total Cholesterol to HDL Ratio result
17. **'SBP'** – Latest recorded Systolic Blood Pressure
18. **'Age of SBP Result'** – Time since last recorded Systolic Blood Pressure, displays 'this month' or total in months e.g. '33 months'

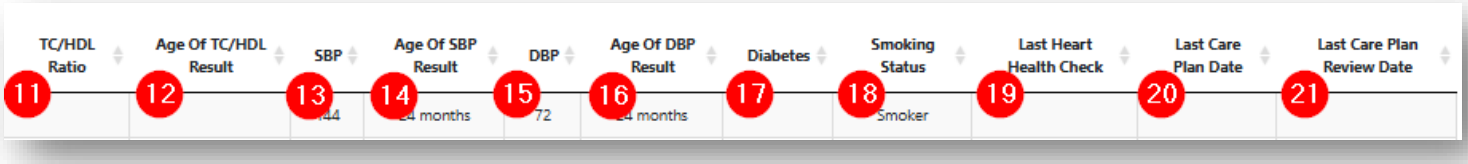
19. **'Smoking Status'** - Smoker, Non = Non-smoker, Ex = Ex-smoker, N/A if no record in CIS
20. **'Last Heart Health Check'** - last billed MBS item 699 Heart Health Assessment
21. **'Last Care Plan date'** – last billed 721 GP Management Plan (GPMP) or 965 Prepare GP Chronic Condition Management Plan
22. **'Last Care Plan Review Date' –** last billed 732 Review of GPMP or Team Care Arrangements (TCA) or 967 Review GP Chronic Condition Management Plan

Table 4 - Patients likely to be at high CVD risk - incomplete/outdated risk factors (priority screening)

- Select patients who meet **all** of the following:
  - Age: Male aged ≥75 years.
  - Male or female aged ≥70 years who is a current smoker.
  - Any person aged ≥70 years with diabetes.
  - Aboriginal and Torres Strait Islander person aged ≥55 years who is a current smoker or has diabetes.
  - Male aged ≥65 years with both
    - Systolic BP ≥150 mmHg AND.
    - Total cholesterol:HDL ratio ≥5.
  - Any person aged ≥60 years with all three of the following:
    - Current smoker
    - Elevated BP (systolic ≥140 mmHg or diastolic ≥90 mmHg)
- Recency: AND have had at least one consultation within the past 2 years.

Results can be filtered by time passed since the last High-Density Lipoprotein (HDL) result or Systolic Blood Pressure test to identify those needing review.





11. **'TC/HDL Ratio'** – latest Total Cholesterol to HDL Ratio result
12. **'Age of TC/HDL Result'** – Time since last Total Cholesterol to HDL Ratio result, displays 'this month' or total in months e.g. '33 months'
13. **'SBP'** – Latest recorded Systolic Blood Pressure
14. **'Age of SBP Result'** – Time since last recorded Systolic Blood Pressure, displays 'this month' or total in months e.g. '33 months'
15. **'DBP'** – Latest recorded Diastolic Blood Pressure
16. **'Age of DBP Result'** – Time since last recorded Diastolic Blood Pressure, displays 'this month' or total in months e.g. '33 months'
17. **'Diabetes'** – Y displayed if diagnosis in CIS (Type 1 and gestational diabetes diagnosis are excluded due to the heart foundation calculation acknowledging overestimates with Type 1 diabetics)

18. **‘Smoking Status’** - Smoker, Non = Non-smoker, Ex = Ex-smoker, N/A if no record in CIS
19. **‘Last Heart Health Check’** - last billed MBS item 699 Heart Health Assessment
20. **‘Last Care Plan date’** – last billed 721 GP Management Plan (GPMP) or 965 Prepare GP Chronic Condition Management Plan
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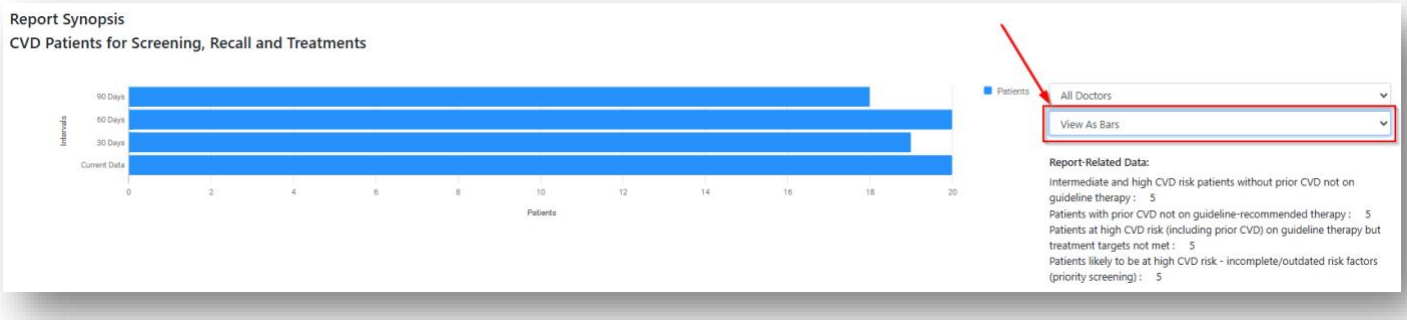
Report Synopsis

- Intermediate and high CVD risk patients without prior CVD not on guideline therapy
- Patients with prior CVD not on guideline-recommended therapy
- Patients at high CVD risk (including prior CVD) on guideline therapy but treatment targets not met
- Patients likely to be at high CVD risk - incomplete/outdated risk factors (priority screening)

- Results can be filtered to a specific GP who has most accessed the patient record.
- Synopsis can be viewed as columns or bars.



Code, Data Field and Table Information

General

Field	Table
ACG Score	ps.acgpatient table

Excluded patients

Palliative Care	Table
A28011 - Palliative care	ICPCCode in ED.VisitReason table
A68004 Referral;palliative care	ICPCCode in ED.VisitReason table
A46020 - Consult;palliative care	ICPCCode in ED.VisitReason table
Nursing Home Patients RACF mbs.MBSItem 731, 90001, 90020, 90035, 90043, 90051, 90092, 90093, 90095, 90096, 90183, 90188, 90202, 90212, 92026, 92070, 92027, 92071	ED.MBSBilledRecord

Diagnosis/Conditions

ICPCCode sourced from in ED.VisitReason or ED.ClinicalHistory table.
ICPC ClassificationID from ref.ICPCCode and ref.icpcClassification .

Diagnosis/Condition	Table ref.ICPC
CVD	ED.VisitReason or ED.ClinicalHistory Ref.ICPCclassification = 11
Familiar Hypercholesterolemia	ED.VisitReason or ED.ClinicalHistory ref.ICPCCode T93020
Diabetes	ED.VisitReason or ED.ClinicalHistory Ref.diabetes where type is 2 or 3

MBS items Heart and Health Checks

MBS – last date if known	Table
699 Heart Health Assessment	ED.MBSBilledRecord
721 GP Management Plan (GPMP), 965 Prepare GP Chronic Condition Management Plan, 732 Review of GPMP or Team Care Arrangements (TCA), 967 Review GP Chronic Condition Management Plan	ED.MBSBilledRecord

Observations

	Table
Systolic BP Diastolic BP	ED.observation
CV risk (BP only as it links to the new Heart Foundation calculator (AusCVD) and result can be written back to the patient record, MD still uses Framingham) CV Score =>5 where recorded 2025-01-01 and onwards CV risk via Framingham is =>15 **High risk: ≥15%**	ED.observation from BP Extracted data only.

Medication

Sourced from ed.medication referencing Ref.ATCCode

Field	Table
Antithrombic – Direct factor Xa inhibitors	ed.medication ref.atcclassification

Direct thrombin inhibitors Platelet aggregation inhibitors excl. heparin Vitamin K antagonists	where level3id = 224
Antihypertensive – calcium channel blockers and diuretics ace inhibitors, plain angiotensin ii antagonists, combinations ace inhibitors, combinations beta blocking agents, other combinations other agents acting on the renin-angiotensin system antiadrenergic agents, centrally acting beta blocking agents and thiazides other antihypertensives arteriolar smooth muscle, agents acting on beta blocking agents and other diuretics beta blocking agents, thiazides and other diuretics antihypertensives and diuretics in combination non-selective calcium channel blockers antiadrenergic agents, peripherally acting selective calcium channel blockers with mainly vascular effects angiotensin ii antagonists, plain selective calcium channel blockers with direct cardiac effects low-ceiling diuretics, thiazides beta blocking agents	ed.medication Ref.atcclassification where level2id = 21, 22, 25, 26, 27
Lipid lowering – Bile acid sequestrants Fibrates HMG CoA reductase inhibitors HMG CoA reductase inhibitors in combination with other lipid modifying agents HMG CoA reductase inhibitors, other combinations Nicotinic acid and derivatives Other lipid modifying agents	ed.medication Ref.atcclassification ID = 28

Combinations of the above drugs are also used. Some may not be available on PBS as yet.

Pathology

Field		Table
ACR	LOINCClassificationID = 22	Ref.loinccode ED.pathologyresult
eGFR	LOINCClassificationID = 10	
Cholesterol	LOINCClassification = 1	
HDLRatio	LOINCClassification =6	
HDL	LOINCClassification = 7	
LDL	LOINCClassification = 20	