

Coronary heart disease (CHD) management care model

This is a joint project between the Heart Foundation (Victoria) and Northern Division of General Practice to develop an effective coronary heart disease (CHD) model of care for Victorian general practice. This flowchart and additional resources support the implementation of best practice cardiovascular care and demonstrate that it is feasible and achievable to implement CHD models of care in general practice.

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For more information on this project, please contact the Heart Foundation in Victoria on (03) 9321 1530 or email cvhvic@heartfoundation.org.au

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Underpinned by the set of Heart Foundation 'key messages' developed to address the most pressing clinical treatment gaps:

- establishing practice systems for coronary heart disease (including registers and recall mechanisms)
- facilitating lifestyle risk factor modification for all CHD patients
- treating to target for biomedical risk factors
- diagnosing chronic heart failure early and titrating ACE inhibitor and beta-blocker therapy to the maximal dose (or as close to maximal dose as tolerated).



Adopt an integrated team approach with clear roles and responsibilities

Targets

BP: <130/80 mmHg. For adults with proteinuria >1g/day: <125/75 mmHg

Lipids: HDL > 1.0 mmol/L LDL < 2.0 mmol/L TG < 1.5 mmol/L

Smoking: complete cessation & avoidance of secondhand smoke

BMI: 18.5-24.9 kg/m²

Waist circumference: \leq 94 (M), \leq 80 (F)

Physical Activity: >150mins/week

Refer to current Heart Foundation guidelines for all targets and recommendations

Coordinated Referrals

Heartmoves

Heart Foundation Walking

Heart Foundation Health Information Service 1300 36 27 87

Smoking cessation e.g. Quitline 13 78 48

Allied Health Professionals e.g.

- Dietitian
- Podiatrist
- Physiotherapist
- Pharmacist
- Exercise physiologist

Medical Specialists

Cardiac Rehabilitation & Secondary Prevention programs

Community Health Services (See: www.humanservicesdirectory. vic.gov.au)

Nurse on Call 1300 60 60 24

Develop and maintain a CHD practice register/database

- Clean data
- Use clinical decision support and audit tools to analyse practice data (speak to your local Division of General Practice)
- Develop a system to support identification of Aboriginal and Torres Strait Islander people
- Develop practice specific protocols to ensure that there is consistency across your practice in identifying patients with CHD (Agree on a clear definition of CHD)

Identifying patients who would benefit

Target group = patients with CHD (Applies to acute coronary syndromes, myocardial infarction, coronary angioplasty with/without stenting, bypass surgery, angina, and MI-related heart failure).

- 1. Patients with known CHD
- 2. Patients with known risk factors who are at high risk of CHD (use absolute CVD risk assessment www.cvdcheck.org.au)
- 3. New events: patients diagnosed with ACS in hospital

Provide best practice care (by the general practice team) to improve patient outcomes

Initial and ongoing assessment	Disease risk: diabetes, hypertension & dyslipidaemia, obesity, family history, age, ethnicity, post menopausal, age Lifestyle & behavioural risks: BMI, waist circumference, smoking, alcohol, nutrition, physical activity (SNAP) Psychosocial risk: assess for depression & social isolation	g realistic goals e patient.
Develop care and self- management plan	Pathology/Tests: echocardiogram (ECG), electrocardiogram (ECHO), stress testing, blood profile	Implement a patient-centred approach, setting realistic goals and time frames in consultation with the patient.
	Medical plan: antiplatelet agents (aspirin), statins, beta- blockers, ACE-inhibitors (and or other) with assessment of dosing, titration and compliance	
	 Lifestyle & behavioural interventions: Consider strategies to support self-management, assess readiness for change and explore barriers Interventions based on Lifescripts program Psychosocial needs Social supports (e.g. patient support groups) Self care Warning signs of heart attack action plan If heart failure suspected consider referral for ECG, chest x-ray and ECHO 	

Utilise chronic disease management (CDM) Medicare Benefits Schedule (MBS) item numbers to support CHD management (see case study resources)

-eedback/Follow-up/Recall and review (according to clinical context) Ongoing management

