

Annex 8. Proposed assessment indicators

Key Questions:

- What indicators are used to monitor quality of primary and secondary prevention of stroke?

It is important to determine if the fulfillment of the most important recommendations leads to the desired objectives. In order to do this, the assessment of the most relevant process and clinical outcome indicators is suggested. Many of the indicators included in the ischemic cardiopathy strategy of the National Health System (National Quality Plan) are the same as in vascular disease. Therefore, most of the following proposed indicators are the same as those included in the aforementioned Plan. Additionally, the working group has proposed others.

Detection of vascular risk factors

Formula:	$a \times 100 / b$, where: a = Number of people over the age of 14 identified in primary care as presenting one or more vascular risk factors. b = Total number of people over the age of 14 attended in primary care.
Definition/clarifications:	For this assessment, risk factors that are considered major have been included, such as diabetes mellitus, hypercholesterolemia, HT, obesity and tobacco smoking, and the presence of first degree family history of early coronary disease.
Disaggregation:	By risk factor detected, autonomous communities, age and sex groups.
Sources of information:	Intervention programmes and/or portfolio of primary care services in the autonomous communities (local regional governments).

Assessment of vascular risk

Formula:	<p>$a \times 100 / b$, where:</p> <p>a = Number of people over the age of 40 whose primary care clinical history indicates that screening activities for one or more vascular risk factors were performed, and assessment and stratification of their level of vascular risk were carried out.</p> <p>b = Total number of people over the age of 40 without a known vascular disease with one or more identified vascular risk factors that are included in the primary care clinical history.</p>
Definition/clarifications:	<p>For this assessment, risk factors that are considered major have been included, such as diabetes mellitus, hypercholesterolemia, HT, obesity and tobacco smoking, and the presence of first degree family history of early coronary disease.</p> <p>In order to calculate vascular risk, the quantitative model consensuated by the scientific societies should be used.</p>
Disaggregation:	By autonomous communities, age and sex groups
Sources of information:	Intervention programmes and/or portfolio of primary care services in the autonomous communities (local regional governments).

Incidence of ischemic stroke

Formula:	<p>$a \times 100.000 / b$, where:</p> <p>a = Number of patients who have been discharged with the main diagnosis of ischemic stroke in one year.</p> <p>b = Population that year.</p>
Definitions/clarifications:	All discharges with main diagnosis coded using the International Classification of Diseases (ICD) (code 434 of the current ICD9-CM version) will be counted. Of the total number of discharges, re-admittances will be excluded.
Disaggregation:	By autonomous communities, age and sex groups.

Sources of information:	Notification in the hospital discharge. Population projections by the NSI (National Statistics Institute).
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Rates of mortality due to stroke

Formula:	$a \times 100,000 / b$, where: a = Number of people who have died from stroke in one year. b = Population that year.
Definition/clarifications:	Gross and adjusted rates will be calculated.
Disaggregation:	By autonomous community and sex.
Sources of information:	Death statistics by the NSI (National Statistics Institute). Population projections by the NSI.

Rate of potential years of life lost from stroke

Formula:	$a \times 1000 / b$, where: a = Number of years of life lost due to deaths from stroke before 65 years of age and before 75 years of age, in a given year. b = Population aged between 0 and 64 years and between 0 and 74 years, respectively, in that year.
Definition/clarifications:	Gross and adjusted rates will be calculated.
Disaggregation:	By autonomous community and sex.
Sources of information:	Death statistics by the NSI (National Statistics Institute). Population projections by the NSI.

Prevalence of smokers in people over the age of 15

Formula:	$a \times 100 / b$, where: a = Number of people over the age of 15 who have participated in the survey and have reported to smoke tobacco on a daily basis in the interview. b = Total number of people over the age of 15 who have participated in the survey.
Definition/clarifications:	A person is considered a smoker if he/she smokes tobacco daily, regardless of the quantity smoked.
Disaggregation:	By autonomous community, sex and age groups.
Source of information:	National Health Survey.

Prevalence of obesity

Formula:	$a \times 100 / b$, where a = Number of people included in the survey, with a BMI equal to or greater than 30 kg/m ² . b = Total number of people included in the survey.
Definition/clarifications:	BMI is calculated using height and weight data expressed in the following way: <ul style="list-style-type: none"> • In the case of adults, using the standard formula (weight in kg / square of height in meters). • In the case of minors under the age of 18, the cutoff points established for age and sex subgroups published by Cole TJ, et al BMJ 2000; 320: 1-6, are used.
Disaggregation:	By autonomous community, sex and age groups.
Source of information:	National Health Survey.

Prevalence of obesity

Formula:	$a \times 100 / b$, where a = Number of people who exercise included in the survey b = Total number of people included in the survey.
Definition/clarifications:	In individuals aged 18 or less, physical exercise in their spare time is assessed. This same criterion is used in unoccupied adults. All other individuals are assessed both in terms of the time they exercise in their spare time as well as the degree of the physical effort employed while at work.
Disaggregation:	By autonomous community, sex and age groups.
Source of information:	National Health Survey.