

# Western Sydney Cardiology Toolkit

## Continuous Quality Improvement

The aim of the WentWest, the Western Sydney Primary Health Network, Continuous Quality Improvement (CQI) **Cardiology Toolkit** for Primary Care is to build capability and capacity by equipping primary care providers with practical resources and strategies to effectively manage, support, and improve cardiology care while implementing sustainable CQI practices.

WentWest - the Western Sydney Primary Health Network, acknowledges the First Nations peoples of Australia as the Traditional Custodians of the land on which we work and live. We pay our respect to Elders past, present and future and extend that respect to all Aboriginal and Torres Strait Islander peoples within Western Sydney



## Acknowledgements

*This QI toolkit has been developed by WentWest - Western Sydney PHN, Western Sydney Local Health District and the Heart Foundation. We acknowledge that some resources used or referenced within this toolkit are from organisations including the Department of Health, Disability and Ageing (DOHDA), Heart Foundation, Services Australia, Royal Australian College of General Practitioners (RACGP); Pen CS; TrainIT Medical; HeartBug; Kardia; Best Practice; and Medical Director. These organisations retain copyright over their original work. Referencing of material is provided throughout.*

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**Where to  
get help?**

**Western Sydney Primary Health Network**  
**E: [support@wentwest.com.au](mailto:support@wentwest.com.au)**  
**P: (02) 8811 7117**  
**[www.wentwest.com.au](http://www.wentwest.com.au)**

# Introduction

## Why focus on Cardiology?

Cardiovascular disease (CVD) is Australia's leading cause of death and healthcare costs, with chest pain being a major and growing reason for emergency department visits and hospitalisations<sup>1</sup>.

Atrial fibrillation (AF) significantly increases the risk of stroke, dementia, heart failure, and death.

**One Australian has a heart attack or stroke every four minutes<sup>2</sup>**

**Modifiable CVD risk factors account for 90% of risk of heart attack, reinforcing the fact that CVD is largely preventable.<sup>3</sup>**

## Western Sydney Cardiology

The **Western Sydney Cardiology program** The Western Sydney Cardiology (WSC) program aims to prevent serious illness and reduce the need of hospitalisation for patients with heart conditions. The program works to improve the early detection of cardiovascular diseases (CVD) and support the management of heart conditions such as atrial fibrillation (AF).

This initiative connects primary care with specialists, pharmacists and various health care tools to ensure that cardiology care is delivered at the right time, in the right place, the first time.

## Never Miss a Beat by Taking Part

CVD is a problem that many parts of the community have an interest in solving. Working together, through the WSC program, we can create a range of strategies in Western Sydney that focus on the prevention and management of CVD.

As part of the Continuous Quality Improvement (CQI) transformational journey, health professionals have access to the following tools and enablers.

## Navigating this toolkit

This toolkit includes practical, flexible activities that are **not sequential**. We recommend starting with **Section One – Practice Readiness** to assess your current state.

Use the **links below** to navigate directly to each activity section.

### Introduction

#### Module 1: Leadership – Preparing your practice

- 1.1 Activity – Practice Cardiology Readiness Checklist
- 1.2 Activity – Practice Cardiology QI Plan
- 1.3 Activity – Cardiology Patient Journey & Pathways
- 1.4 Activity – HeartBug workflow

#### Module 2: Data-Driven Improvement

- 2.1 Activity – Patients eligible for Health Health Check
- 2.2 Activity – Patients eligible for care plans and HHC
- 2.3 Activity – Supporting Physical Health in CVD care
- 2.4 Activity – Other Pen CS recipes

#### Module 3: Patient Registration & Engagement

- 3.1 Activity – GoShare and Cardiology
- 3.2 Activity – Heart Awareness Days
- 3.3 Activity – Patient Invitation Templates
- 3.4 Activity – Heart Foundation Walking groups

#### Module 4: Team-based care approach

- 4.1 Activity – Cardiology MBS & PIP Optimisation
- 4.2 Activity – Cardiology Team Roles & Responsibilities
- 4.3 Activity – Practice Nurse workflow
- 4.4 Activity – AF Risk – Patient Questionnaire

### Appendices

- 5.1 Model for Improvement and PDSA cycles
  - PDSA – Increasing Heart Health Checks
  - PDSA – Overdue Cholesterol Results
  - PDSA – Co-Claiming HHC and Care plans
- 5.2 Measuring Outcomes – Audit Worksheet
- 5.3 Group reflection – after completing activities
- 5.4 HeartBug Procedure
- 5.5 KardiaMobile Procedure
- 5.6 Autofill AF patient symptom questionnaire

Use the **Model for Improvement** and **Plan-Do-Study-Act (PDSA) cycles**, to test changes, drive progress, and embed high-quality cardiology care.



<sup>1</sup> Australian Bureau of Statistics. 'Causes of Death, Australia, 2022'. 2023

<sup>2</sup> Australian Institute of Health and Welfare. [National Hospital Morbidity Database \(NHMD\)](#). 2020.

<sup>3</sup> Yusuf S, Hawken S, Ounpuu S, et al. Effect of potentially modifiable risk factors associated with myocardial infarction in 52 countries (the INTERHEART study): case-control study. *Lancet*. 2004;364(9438):937–952. doi:10.1016/S0140-6736(04)17018-9.

# Cardiology Tools and Enablers

At WentWest, we are investing in the best tools and enablers to help health professionals drive CQI. For user access, contact us [support@wentwest.com.au](mailto:support@wentwest.com.au) or call 8811 7117

<b>Pen CS Suite and QI Dashboard</b>	<b>Pen Computer System (CS) suite</b> , including CAT4 and Topbar, enhances clinical data accuracy and decision-making, with WentWest funding access for all Western Sydney practices. Our <b>Data Dashboard and Reports</b> support QI through data-driven initiatives, risk stratification, and predictive modelling
<b>HealthPathways</b>	Developed by local GPs, specialists, nurses and allied health providers, <b>Western Sydney HealthPathways</b> supports health professionals by providing local, relevant information on managing medical conditions and referral options for their patients. <i>A login is required.</i>
<b>GoShare</b>	<b>GoShare</b> is a free patient education platform that allows general practices to share tailored and up-to-date resources (including videos and fact sheets) with patients. There are specific <b>Heart Health Check GoShare bundles</b> that can help increase health literacy and enhance patient awareness and engagement.
<b>Pharmacist in General Practice</b>	The <b>Western Sydney Pharmacist in General Practice Program</b> integrates non-dispensing pharmacists into general practices to provide clinical and educational services as part of a collaborative, patient-centred care team.
<b>Heart Foundation Walking Groups</b>	The <b>Heart Foundation Walking Groups</b> are free and are effective in encouraging people to increase their physical activity which can help prevent and manage diabetes, cardiovascular, mental health and their weight. <b><u>Join a walking group and make every step matter.</u></b>
<b>Care Navigation</b>	<b>InTouch Care facilitator</b> at the Local Health District can support people with chronic conditions and complex needs who may be at risk of unplanned hospitalisation in the next 12 months. For more information or referrals, call 1800 113 644
<b>Remote Monitoring and Screening Devices</b>	Continuous Monitoring: <b>HeartBug ECG</b> is a single led ECG allows real-time remote monitoring of patients with suspected arrhythmia. While the <b>Kardia Mobile</b> allows quick (30secs), accurate ECG ideal for screening and enabling early detection of Atrial Fibrillation, a key risk factor for stroke.

# Module 1

## Leadership – preparing your practice

### On completion of this module, you will:

- Evaluate your practice's readiness to implement MyMedicare and Chronic Condition Management
- Engage the entire practice leadership team to confirm MyMedicare registration status and ensure readiness for the transition

### Activity Navigation

[1.1 Activity – Practice Readiness Checklist](#)

[1.2 Activity – Practice Cardiology QI Plan](#)

[1.3 Activity – Patient Journey & Pathways](#)

[1.4 Activity – HeartBug workflow](#)

**Western Sydney Cardiology Aim:** To improve identification of people at risk of cardiovascular disease, with a focus on integrated and coordinated care for the management of CVD and heart conditions such as AF.

### Target Cohort:

- Patients aged 45\* or over that are at risk of cardiovascular disease (CVD)
- Patients aged 75 and over that are at risk of atrial fibrillation

\***CVD risk assessment** recommends Adults without known CVD aged **45 to 79** years, people with diabetes **35–79**, and First Nations people **30–79**. Consider CVD reclassification factors: Ethnicity; Family History and other considerations.

### Objectives:

- 1** Strengthen participation, screening and assess CVD risk and AF risk factors by undergoing screening and/or **heart health checks** including pulse check and ECG (where required)
- 2** Enhance the treatment and ongoing management through **WSC tools** (HeartBug remote monitoring, care planning and **GoShare** interactive bundles) to help patients engage with their own care.
- 3** Actively encourage patients to join the Heart Foundation **Walking group and the 2kg Challenge** - lifestyle programs designed to help patients reduce their risk factors
- 4** Connect patients with **high risk** of hospitalisation with **InTouch Care Facilitator** to provide care coordination services by **calling 1800-113-644**

### Heart Health Toolkit

#### Conducting Heart Health Checks

- [What is a Heart Health Check?](#)
- [Templates for assessment and management](#)
- [Building a case for the Heart Health Check](#)
- [Promoting the Heart Health Check in your practice \(checklist\)](#)
- [Referral programs](#)

### Resources

- [Western Sydney HealthPathways](#) including
  - [Atrial Fibrillation \(AF\)](#)
  - [CVD Risk Assessment](#)
  - [Heart Failure](#)
  - [Long QT Syndrome](#)
  - [Cardiology Referrals](#)
- [RACGP - Chronic disease](#)
- [RACGP – Preventive Activities \(the Red Book\)](#)

# Module 2

## Data-Driven Improvement

On completion of this module, you will:

- Use CAT4 to drive proactive care and **Identifying patients eligible for the Heart Health Check**
- Apply data-driven strategies to plan, implement, and review quality improvement (QI) activities.

### Screening 'at risk' Patients

Identifying patients through opportunistic or targeted screening who are:

- Active over 45 years (30 years or over for Aboriginal and Torres Strait Islander people)
- have no history of CVD
- have no history of AF
- have the following lifestyle risk factors and comorbidities

⚠ **Note:** Opportunistic screening for AF with pulse palpation followed by an ECG is now **recommended** for all patients aged 65 years or older.

#### Risk factors

- Obesity (BMI >30)
- Smoking
- Alcohol consumption
- Hypertension
- Diabetes
- Chronic Kidney Disease
- Hyperlipidaemia
- Family History

### Before You Begin

- Ensure **CAT4** is installed and staff are trained - use **CAT4 guide** or **videos**
- Clean your data** using **CAT4** (e.g. inactive records, remove duplicates).
- ensure diagnoses are **coded, not free text** – use **CAT4 condition mapping**
- Filter by doctor**, condition, or age to create a smaller patient list.



#### Measuring Outcome CPD

**Tip:** Collaborate as a team to generate a **CAT4 list of patients per GP.**

### Use CAT4 recipes to identify patients:

- 2.1 Activity – Patients eligible for Heart Health Check**
- 2.2 Activity – Patients eligible for care plans and HHC**
- 2.3 Activity – Supporting Physical Health in CVD care**
- 2.4 Activity – Other Pen CS recipes**

### Track & Reflect

- Download the **audit worksheet** or run **chart** template
- Run a PDSA** on a change idea and record your baseline
- As a team, reflect on What worked? What didn't? **Completed QI documentation for CPD**

For opportunistic screening use Topbar **MBS app** and **PIPQI app** to notify you of any presenting patients who are eligible for the Heart Health Check and missing

#### Need support?

PEN CS Support 1800 762 993  
[support@pencs.com.au](mailto:support@pencs.com.au)  
WentWest (02) 8811 7117  
[support@wentwest.com.au](mailto:support@wentwest.com.au)

#### HHC Toolkit – QI and Data:

- **Getting your data ready**
- **Identifying eligible patients**

# Module 3

## Patient Registration & Engagement

On completion of this module, you will:

- Identify and use MyMedicare, GoShare, and awareness days to engage patients in Heart Health Checks.
- Apply patient invitation scripts and promote walking groups to support preventive care.

### Activity Navigation

[3.1 Activity – GoShare](#)

[3.2 Activity – Heart Awareness Days](#)

[3.3 Activity – Invitation Templates](#)

[3.4 Activity – Walking groups](#)

### MyMedicare and Cardiology: Enabling Person-Centred Care

MyMedicare supports a person-centred approach to cardiology care by strengthening the relationship between patients, their GPs, and care teams.

Grounded in the principles of dignity, compassion, coordination, personalised care, and self-management, MyMedicare helps ensure care reflects what matters most to the patient—not just what is the matter with them.

This is especially important in Heart related conditions, where continuity, trust, and shared decision-making lead to more effective and meaningful support.

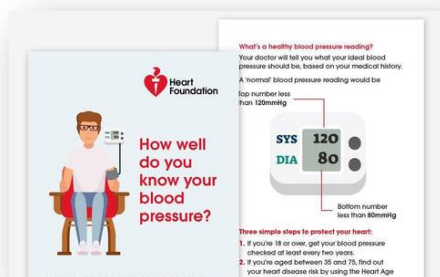
Programs like [MyMedicare](#) and the [Patient Centred Medical Home \(PCMH\)](#) embed these values into everyday practice, enhancing engagement, improving access, and delivering better cardiology outcomes through truly coordinated care.

### MyMedicare Patient Resources:

- [MyMedicare - Poster 1](#)
- [MyMedicare - Poster 2](#)
- [MyMedicare - First Nations](#)
- [Our MyMedicare Patient Guide](#)
- [MyMedicare - DL Brochure](#)
- [Introducing MyMedicare Video](#)
- [Registering in MyMedicare Video](#)

### HHC Toolkit - Risk factor management

- [Practical guide to pharmacological lipid management](#)
- [Lipid modifying medicines comparison table](#)
- [Blood pressure and heart disease \(animation\)](#)
- [Blood pressure information card](#)
- [Blood pressure measuring guide and diary](#)
- [Building blocks of a healthy heart \(brochure\)](#)
- [Lifestyle management](#)
- [Cholesterol and heart disease \(animation\)](#)
- [Personal walking plans](#)
- [Eating well to protect your heart \(info sheet\)](#)



### HHC Toolkit – Engaging your patients

- [What is a heart health check? \(animation\)](#)
- [Know your risk \(waiting room poster\)](#)
- [Building blocks of a healthy heart \(brochure\)](#)
- [What is a Heart Health Check? \(brochure\)](#)
- [Heart age calculator \(waiting room poster\)](#)
- [Blood pressure \(waiting room poster\)](#)
- [Heart age calculator](#)
- [Get a heart check \(animation\) for Aboriginal and/or Torres Strait Islander peoples](#)
- [MyHeart MyLife](#)



# Module 4

## Team-based Care

On completion of this module, you will:

- Identify and allocate team roles to deliver coordinated, efficient cardiovascular care using evidence-based pathways, templates, and screening tools.
- Apply a multidisciplinary approach to improve patient outcomes through structured care plans, proactive recall systems, and patient-centred service design.

### Activity Navigation

- [4.1 Activity – MBS & PIP Optimisation](#)
- [4.2 Activity – Roles & Responsibilities](#)
- [4.3 Activity – Practice Nurse workflow](#)
- [4.3 Activity – AF Risk Questionnaire](#)

### Team-Based Cardiovascular Care: Integrating Pharmacists in General Practices

The integration of a [Pharmacist in General Practice \(PIGP\)](#) offers a unique opportunity to strengthen patient care through a team-based, patient-centred approach. As non-dispensing clinicians, PIGPs work alongside GPs, nurses, and other healthcare professionals in general practice to improve health outcomes—particularly in the prevention and management of chronic diseases such as cardiovascular disease.

By delivering patient education, monitoring and when necessary, medication reconciliation and reviews, PIGPs play a pivotal role in addressing cardiovascular risk factors. Practices can further benefit from MBS optimisation, as, when appropriate, item 900 medication reviews can be co-claimed with Heart Health Checks to enhance both clinical outcomes and financial sustainability.

Having a PIGP in practice not only strengthens the quality of care delivered but also supports a more efficient and sustainable healthcare model aligned with the principles of the [Patient Centred Medical Home](#).



Refer [WentWest MBS guide](#) for the frequently used items including Care Planning and incentives This guide links item number to MBS criteria, descriptor and fact sheets.

### Heart Health Check Toolkit links:

#### A team approach

- [Team roles and responsibilities](#)
- [Challenges and solutions](#)
- [Receptionist's guide to the Heart Health Check](#)
- [Patient invitation templates](#)
- [Examples from primary care colleagues](#)

#### Team member roles

Central role e.g. general practitioner	▼
Essential role e.g. practice nurse	▼
Additional essential role for Aboriginal health workers	▼
Facilitator role e.g. practice manager	▼

### Assessment and Management Templates:

#### CVD risk assessment form

- [Best Practice\\* – RTF file](#)
- [Medical Director – RTF file](#)

#### My Healthy Heart plan

- [Best Practice\\* – RTF file](#)
- [Medical Director – RTF file](#)

\*BPs CVD risk and My Healthy Heart templates are integrated to autofill with patient data.

**Heart Health Check risk assessment**

Practice name: \_\_\_\_\_

Practice address: \_\_\_\_\_

State: \_\_\_\_\_ Postcode: \_\_\_\_\_ Phone: \_\_\_\_\_

GP name: \_\_\_\_\_

GP prescriber No: \_\_\_\_\_ GP provider No: \_\_\_\_\_

Assessment date: / /

# Module 5

## Appendices

- Start by documenting **your practice QI team** and define your problem and specified a robust **Problem Statement**.
- Next, move onto the **Model for Improvement (MFI)**, the 'Thinking Part' focuses on the overall improvement strategy, while the 'Doing Part' implements changes through the **Plan-Do-Study-Act (PDSA) cycle**.
- This model uses PDSA cycles to test changes, ensuring measurable and sustainable improvements. **Watch short video on MFI and PDSA's**.

Downloadable PDSA cycle templates – pre-filled example PLUS blank template available

**The Model for Improvement (template)**

**Step 1: The three fundamental questions**

1. **What are we trying to accomplish?**  
This will help you to develop your GOAL for improvement.

2. **How will we know that a change is an improvement?**  
Develop MEASURES to track the achievement of your goal.

3. **What changes can we make that will lead to an improvement?**  
Get your ideas. This will help you develop IDEAS that you can test to help you achieve if that fundamental question will require a completed Model for Improvement template.

**Step 2: PDSA cycle**

You will have noted your IDEAS for testing when you answered the third fundamental question in Step 1. You can use this template to test an idea.

**IDEA | Describe the idea you're testing.**

Refer to the first fundamental question:

#3 Recall eligible patients identified via Pen CAT and monitor for an increase in the number of Heart Health Checks being conducted over a three month period.

PDSA cycle number: 1

**PLAN | What will you do?**

Know your idea

1. Communicate PDSA detail to practice staff.  
2. Use Pen CAT to extract the number of non-Indigenous active patients aged 45 and over.  
3. Filter for patients without a CVD diagnosis and those who haven't claimed any health assessment.

who will carry it out  
Practice manager/practice nurse to complete the search. Reception staff to send out reminders and make appointments. GP and practice nurse to conduct the checks. Practice manager to report then CAT and billing data.

When will it take place? when?  
March to May

What do you predict will happen?  
15% increase in the number of Heart Health Checks conducted. The current baseline is 20 per month.

What data/information will you collect that will help you measure improvement?  
Number of appointments, number of Heart Health Checks completed, number of referrals to a lifestyle management program e.g. Life!

Notes

5 simple steps to promoting the Heart Health Check in your practice

**Running a Heart Health Check promotion in your practice**  
5 simple steps to success

- 1 What are your goals and measures of success?**
  - How many people are you targeting?
  - What would you consider a success?
  - Can this contribute to a PIP QI activity?
  - Does your activity meet accreditation QI standards?
- 2 Who will be involved?**
  - Identify roles and responsibilities.
  - Appoint a champion.
- 3 What kind of promotion?**
  - Use patient data to identify your most appropriate target group.
  - Partner with another health care provider or collaborate with your PHN.
  - Link the Heart Health Check activity to the PIP QI.
- 4 When will it be?**
  - Choose a day and time that best suits your patient group.
  - Link to heart health related campaigns.
  - Coordinate with other relevant clinics e.g. flu vaccination.
- 5 How will you promote it?**
  - Invite eligible patients via phone, letter, email or SMS.
  - Advertise on your practice website and phone on-hold message system.
  - Advertise locally through newsletters, social media or community radio stations.
  - Provide information in your waiting room.
  - Partner with local primary health care providers.

**Tip:** Personalising invitations from a patient's regular health provider may improve participation in a Heart Health Check.

### HHC Toolkit – QI:

- [Model for improvement and PDSA cycle](#)
- [QI incentives and the Heart Health Check](#)



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