

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
P: (02) 8811 7117
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 hospitalisations¹.

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

One Australian has a heart attack or stroke every four minutes²

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

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 and this icon** to navigate directly to each activity section.



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



¹ Australian Bureau of Statistics. 'Causes of Death, Australia, 2022'. 2023

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

³ 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 or call 8811 7117

Pen CS Suite and QI Dashboard	Pen Computer System (CS) suite , including CAT4 and Topbar, enhances clinical data accuracy and decision-making, with WentWest funding access for all Western Sydney practices. Our Data Dashboard and Reports support QI through data-driven initiatives, risk stratification, and predictive modelling
HealthPathways	Developed by local GPs, specialists, nurses and allied health providers, Western Sydney HealthPathways supports health professionals by providing local, relevant information on managing medical conditions and referral options for their patients. <i>A login is required.</i>
GoShare	GoShare 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 Heart Health Check GoShare bundles that can help increase health literacy and enhance patient awareness and engagement.
Pharmacist in General Practice	The Western Sydney Pharmacist in General Practice Program integrates non-dispensing pharmacists into general practices to provide clinical and educational services as part of a collaborative, patient-centred care team.
Heart Foundation Walking Groups	The Heart Foundation Walking Groups 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. Join a walking group and make every step matter.
Remote Monitoring and Screening Devices	Continuous Monitoring: HeartBug ECG is a single led ECG allows real-time remote monitoring of patients with suspected arrhythmia. While the Kardia Mobile allows quick (30secs), accurate ECG ideal for screening and enabling early detection of Atrial Fibrillation, a key risk factor for stroke.
Care Navigation	InTouch Care facilitator 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

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 Improve access to the **Rapid Access and Stabilisation Services** (RASS) and enhance stabilisation of patients via calling **GP support line 1300-972-915**
- 5 Connect patients with **high risk** of hospitalisation with **InTouch Care Facilitator** to provide care coordination services by **calling 1800-113-644**

Heart Health Check Toolkit links:

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 \(the Red Book\)](#)

1.1 Activity - Practice Cardiology Readiness Checklist

Essential preparations for delivering high-quality, team-based Heart Health Checks, supported by engaged leadership, structured planning, and data-driven continuous improvement.

Change Principle (What)	Change Ideas (How - Actions)	Assigned to (who)
1. Engaged leadership – preparing your practice	<ul style="list-style-type: none"> <input type="checkbox"/> Appoint a QI lead or Heart Health Check champion. <input type="checkbox"/> Brief the practice team (GPs, nurses, admin) on QI plan. <input type="checkbox"/> Define team roles (e.g., patient identification, bookings, follow-ups). <input type="checkbox"/> Schedule regular team meetings to monitor progress <input type="checkbox"/> Review the tools and enablers available and prepare a Practice QI plan <ul style="list-style-type: none"> <input type="checkbox"/> Kardia screening device <input type="checkbox"/> HF Walking Groups <input type="checkbox"/> GoShare campaign credits <input type="checkbox"/> Heartbug remote monitoring <input type="checkbox"/> HF printed resources <input type="checkbox"/> 2kg Challenge <input type="checkbox"/> Install and test Heart Health Check templates in BP or MD software 	<p><i>Need help? contact your</i></p> <p>WentWest Primary Care Facilitator</p>
2. Data driven improvements,	<ul style="list-style-type: none"> <input type="checkbox"/> Get your data ready – conduct data cleansing <input type="checkbox"/> Use Pen CAT or your preferred audit tool to identify eligible patients: <ul style="list-style-type: none"> o Aged 45–79, 35–79 with diabetes or 30–79 First Nations peoples. o No prior CVD diagnosis. o No MBS Heart Health Check (or other Health Assessments) billed in the past 12 months. <input type="checkbox"/> Flag patients in your clinical system (Topbar or Cubiko Care Prompts) for opportunistic identification. <input type="checkbox"/> Maintain the accuracy of the patient register by using consistent coding. 	
3. Patient Registration and Engagement	<ul style="list-style-type: none"> <input type="checkbox"/> Establish recall/reminder systems (use GoShare). <input type="checkbox"/> Use the Heart Foundation’s promotional toolkit: <ul style="list-style-type: none"> o Posters in waiting areas. o Website banners and social media posts. o On-hold phone messages. o SMS/email templates. <input type="checkbox"/> Tailor materials to the needs of your patient population (i.e. translated). <input type="checkbox"/> Align activities with upcoming heart-related awareness events <input type="checkbox"/> Promote or start a Heart Foundation Walking Group 	
4. Team Based Care	<ul style="list-style-type: none"> <input type="checkbox"/> Allocate dedicated appointments (approx. 20 mins). <input type="checkbox"/> Utilise HealthPathways for assessment, management and referrals <input type="checkbox"/> Confirm staff are trained in: <ul style="list-style-type: none"> o Absolute CVD risk calculator <ul style="list-style-type: none"> o Practitioner: webinar on Aus CVD Risk calculator o Nurses: APNA’s CVD risk learning module o ECG interpretation (if needed). o Use of Heart Health Check templates. <input type="checkbox"/> Discuss CVD risk results and provide a personalised plan. <input type="checkbox"/> Claim MBS item HHC (699) with CCM items when eligible if appropriate. 	
5. Monitor, Reflect, and Celebrate	<ul style="list-style-type: none"> <input type="checkbox"/> Track weekly/fortnightly progress (e.g., number of checks completed). <input type="checkbox"/> Use PDSA (Plan-Do-Study-Act) cycles to test change ideas and improve workflows. <input type="checkbox"/> Gather patient feedback to refine promotion and care delivery. <input type="checkbox"/> Celebrate team efforts and share outcomes in team meetings. 	



1.2 Activity – Practice Cardiology QI Plan

Please complete the following table to outline your plan to complete the goal.

Engaged Leadership	Goal	Increase CVD risk assessments via Heart Health Check (HHC) MBS 699 billed in the past 12months from ##% (## patients) to ##% (## patients) by DD/MM/YYYY.		
	Measure/s	No. of Heart Health Check billed, monthly	Search criteria	i.e. CAT4 filters
	QI Lead and Team	Who will need to be involved?	Period	Start date - end date

	Actions <i>Tip: Use PDSA cycles to test change ideas</i>	Resources	Who	Period	Update
Data-Driven Improvement	Conduct data cleansing to identify and review the 'Indicated CVD and not diagnosed' patient list	<ul style="list-style-type: none"> CAT4 Data Cleansing Archiving BP MD 		Start date - end date	Allocated a usual care provider to patients
	Patient register: Extracting list of active patients with no CV and risk factors recorded to enable CVD Risk Assessment (PIP QIM 8)	<ul style="list-style-type: none"> CAT4 QIM 8 			
	Conduct Heart Health Checks for patients aged 50–74 years , targeting those who are not eligible for other health assessments.	<ul style="list-style-type: none"> 			
	Find eligible patients that are due for HHC and care plan/ review	<ul style="list-style-type: none"> CAT4 GPMP/TCA CAT4 QIM 8 			Used Topbar prompt
Patient Registration	Ensure recall and reminder system is established for HHC	<ul style="list-style-type: none"> BP Reminder MD Recalls 			Upskill staff in recalls and reminders TrainIT -Course
	Educating patients HHC proactively via GoShare	<ul style="list-style-type: none"> GoShare Heart Health Check 			Trained team on GoShare
	Enrol eligible to MyMedicare during HHC appointments	<ul style="list-style-type: none"> Hotdoc, Healthengine or AutoMed 			
	Refer patients to lifestyle programs	<ul style="list-style-type: none"> Walking groups, 2kg Challenge 			
	Team to host Heart Awareness Week in May and conduct population screening through Heart Age Calculator	<ul style="list-style-type: none"> 			
Team-Based Care	Upskill team in HHC through Heart Foundation toolkit				
	Allocate roles and responsibilities				
	Engage Pharmacist in General Practice	<ul style="list-style-type: none"> Pharmacist in General Practice 			
	Ensure staff can access HealthPathways for the latest Cardiology assessment, management and referral information	<ul style="list-style-type: none"> Western Sydney HealthPathways 	All		
	Utilise Kardia single lead Screen patients. <i>Disclaimer: Limited device availability. The device is available for loan for up to 6 months based on usage.</i>	<ul style="list-style-type: none"> Kardia single lead 	RN		
	Implement HeartBug remote monitoring for suspected arrhythmia	<ul style="list-style-type: none"> HeartBug 	RN		

Reflection	Outcomes Summary	As a team, what did you learn? What changes would you make to your practice as a result?
		RACGP CPD Tip: utilise the self-reporting feature on Quick Log mycpd.racgp.org.au to document reflection.

1.3 Activity - Cardiology Patient Journey and Pathways



Identify patient eligible

Patient Engagement
Proactive OR Opportunistic

Risk Assessment



AF Patient Symptoms Questionnaire

Health Assessment

Pulse Check and Kardia* or 12-lead ECG

- 75+ health assessment**
- Heart health check**
- Other health assessments**

DIAGNOSIS

INCONCLUSIVE RESULTS

If the ECG is inconclusive, or the patient has identified experiencing AF symptoms in the risk questionnaire, the GP can:

- Call the local hospital **Cardiology advice** line
- Use the following to investigate further:
 - Holter Monitor
 - HeartBug (single lead ECG)*
 - Kardia (single lead ECG)*
 - Other devices/tools

The device/tools used are at the discretion of the GP and should be considered on a case-by-case basis.

CVD / AF DETECTED IN ECG

If the ECG is conducted and shows the patient has CVD / AF

REFERRAL

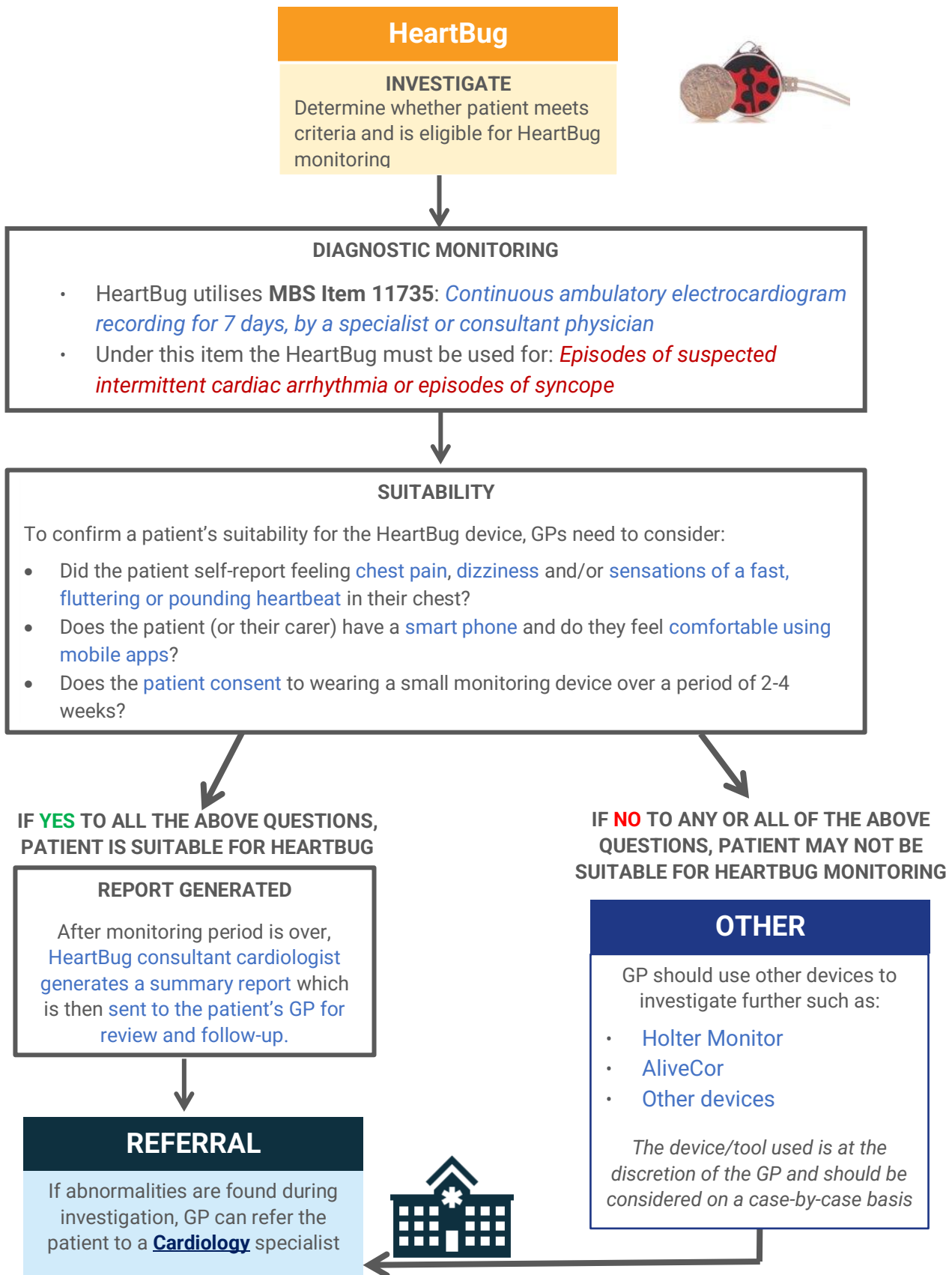
If abnormalities are found during investigation, GP can refer the patient to a **Cardiology** specialist



**HeartBug and Kardia are available through WentWest. To access, refer to the relevant onboarding procedures.*

1.4 Activity - HeartBug workflow

To access HeartBug, your clinical team must be onboarded by HeartBug. Refer to 5.4 HeartBug Procedure or contact us via support@wentwest.com.au



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
WentWest (02) 8811 7117
support@wentwest.com.au

HHC Toolkit – QI and Data:

- [Getting your data ready](#)
- [Identifying eligible patients](#)

2.1 Activity – Patients eligible for Heart Health Check

Identify active patients aged ≥45 years with no diagnosis of atrial fibrillation (AF), and no existing cardiovascular conditions, as they are at increased risk of AF and CVD and may benefit from targeted recall and intervention through programs like WSC program, in line with guidelines recommending intensive weight management to reduce risk⁴.

Screen all patients aged 65+ opportunistically for AF during clinic or community visits.

➤ **Starting point:** Log into Pen CS **CAT4** → Show Extracts → load latest data extract → Hide Extract

➤ In Filter Panel

1. General tab → **Age** → **Start Age** = 45
2. Choose either **Active** or **MyMedicare** status:
 - Optional 1: Under 'General' tab → Activity → Select 'Active (3 x in 2 yrs)'
 - Optional 2: Under 'Patient Status' tab → tick 'Registered with MyMedicare'
3. **Conditions** tab → **Chronic** → **Cardiovascular** tick "No" boxes for **heart failure, CHD, stroke, MI, PAD, carotid stenosis and renal artery stenosis**.
4. **Conditions** → **Other** → **Atrial Fibrillation** tick **No** box.

Atrial Fibrillation

Yes No

Cardiovascular

Yes No

Hypertension No

Cardiovascular Disease (CVD):

Heart Failure No

CHD No PAD No

Stroke No Carotid Stenosis No

MI No Renal Artery No

5. **MBS attendance** → select **12months** → **MBS Item Numbers** = **No 699, 701, 703 705**

General Ethnicity Conditions Medications Date Range (Results) Date Range (Visits) Patient Name Patient Status Providers Risk Factors **MBS Attendance** Saved Filters

Patient with selected MBS Item(s) in Date Range MBS Item Categories

Any None

Claim Date Range

All ≤ 6 Months

≤ 12 Months ≤ 24 Months

≤ 36 Months ≤ 48 Months

Data Range (from - to)

All of selected Any of selected

MBS Item Numbers	
<input type="checkbox"/> 177	<input checked="" type="checkbox"/> No
<input type="checkbox"/> 2100	<input type="checkbox"/> No
<input type="checkbox"/> 224	<input type="checkbox"/> No
<input type="checkbox"/> 228	<input type="checkbox"/> No
<input type="checkbox"/> 23	<input type="checkbox"/> No
<input type="checkbox"/> 245	<input type="checkbox"/> No
<input type="checkbox"/> 2517	<input type="checkbox"/> No
<input type="checkbox"/> 2546	<input type="checkbox"/> No
<input type="checkbox"/> 2664	<input type="checkbox"/> No
<input type="checkbox"/> 2700	<input type="checkbox"/> No
<input type="checkbox"/> 2712	<input type="checkbox"/> No
<input type="checkbox"/> 272	<input type="checkbox"/> No
<input type="checkbox"/> 36	<input type="checkbox"/> No
<input type="checkbox"/> 699	<input checked="" type="checkbox"/> No

6. **Optional:** save Filter for quick next time you do your search Saved Filters

7. **Recalculate**



➤ In Report Panel

8. **CV Event Risk** → **CAT Calculated** → Excluded and Incomplete → Select all Incomplete'

CAT Calculated CIS Calculated

Select All Incomplete

Count Excluded and Incomplete

9. **Optional:** Select **Export** → **XLS File** → **Save** (e.g. Create a folder C:/ClinicalAudit/CAT Patient FollowUp)

10. **Optional:** **filter patient list by provider** (select → Visits → Assigned Provider → Report button)

11. **Optional:** **create a Topbar prompt** (Daily CAT button → CV Event Risk → Export → Topbar Prompt button)



Ask patients to complete a **cholesterol blood test** before their **Heart Health Check** to avoid delays.

⁴Atrial fibrillation clinical guidelines [https://www.heartlungcirc.org/article/S1443-9506\(18\)31778-5/fulltext](https://www.heartlungcirc.org/article/S1443-9506(18)31778-5/fulltext)

2.2 Activity – Patients eligible for care plans and HHC

Identify patients with one or more chronic conditions eligible for the care plan / review (MBS 965 or 967) who are also eligible for heart health check (MBS 699).

⚠ Note: Item 699 or 177 can be **co-claimed with other items** to enhance patient management. For examples Chronic Conditions management (CCM): For Heart Health Check patients who have a chronic condition and require a CCM plan, 699 may be claimed in conjunction with the suite of **CCM items** available where eligible. You will need to include a 'not related' notations

➤ **Starting point:** Log into Pen CS **CAT4** → Show Extracts → load latest data extract → Hide Extract

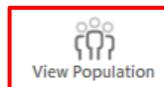
➤ In Filter Panel

1. General tab → **Age** → **Start Age** = 45
2. Choose either Active or MyMedicare status
 - Optional 1: Under 'General' tab → Activity → Select 'Active (3 x in 2 yrs)'
 - Optional 2: Under 'Patient Status' tab → tick 'Registered with MyMedicare'
3. **Conditions** tab → **Chronic** → **Cardiovascular** tick "No" boxes for **heart failure, CHD, stroke, MI, PAD, carotid stenosis and renal renal artery stenosis.**
4. **Conditions** → **Other** → **Atrial Fibrillation** tick **No** box.
5. **MBS attendance** → **select 12months** → **MBS Item Numbers = No to 699, 701, 703 705 and 965 (CCM plan) 967 (CCM review)**

6. **Recalculate**



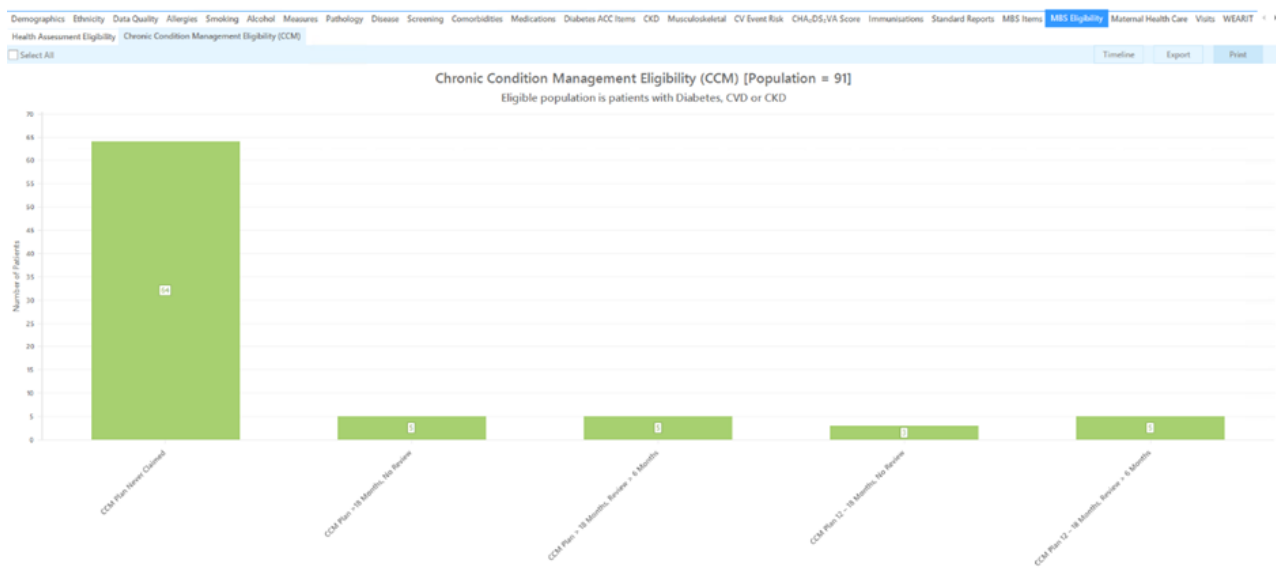
7. **View Population**



➤ In Report Panel

8. **Optional:** Export → XLS File → Save (e.g. Create a folder C:/ClinicalAudit/CAT Patient Follow-up)
9. **Optional:** **filter patient list by provider** (select → Visits → Assigned Provider → Report button)
10. **Optional:** **create a Topbar prompt** (Daily CAT button → CV Event Risk → Export → Topbar Prompt button)

Alternatively, you can filter by **MBS attendance** → **no to 699** and in Report panel use **MBS Eligibility** → **Chronic Condition Management Eligibility (CCM)**



2.3 Activity – Supporting Physical Health in Cardiovascular Care

Looking after physical health is essential for everyone, but people at risk of or living with cardiovascular disease (CVD) and heart-related conditions often face additional challenges.

These may include medication side effects, lifestyle-related risks such as smoking, poor nutrition, low physical activity, and comorbidities like obesity and diabetes. Physical health needs can sometimes be overlooked when care focuses solely on managing acute cardiac events or single risk factors.

As part of a whole-person approach, it's important for care teams to assess and address modifiable lifestyle risks using the **SNAP framework: Smoking, Nutrition, Alcohol, and Physical Activity**.

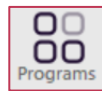
Refer to **Australian guideline and calculator for assessing and managing cardiovascular disease risk**.

Practice Measures and Monitoring

To assess and monitor lifestyle risk factor recording in your practice, complete the following steps in **Pen CS CAT4**:

1. **View Extracts**

- Select the latest data extract
- Click the **Programs** icon
- Select **PIPQI**



2. **Optional: View Filter** (by default this is selecting Active patients)

- Choose **MyMedicare** enrolled: Under '**Patient Status**' tab → tick '**Registered with MyMedicare**'
- Under **Conditions**, set **Cardiovascular** = '**Yes**'
- Click **Recalculate**

3. Choose from the following **Quality Improvement Measures (QIM)**:

- **QIM 1 – HBA1C status for patients with diabetes**
- **QIM 2 – Smoking Status**
- **QIM 3 – BMI**
- **QIM 7 – Alcohol status recording**
- **QIM 8 – Cardiovascular Risk**
- **QIM 10 – Blood pressure for patients with diabetes**

Programs and Resources to Support Physical Health

- **Heart Foundation Walking Groups** are free walking groups in your local area.
- **The 2kg Challenge**: A free 8-week lifestyle program to help lower the risk of diabetes, CVD, improve physical and mental health, boost social wellbeing, and increase energy.



Useful Resources & Local Programs

- **Live Life Get Active** – Free fitness classes in parks and online
- **Out and About Directory** – Outdoor activity and facility finder (Western Sydney Diabetes)
- **Department of Health, Disability and Ageing** – National activity guidelines
- **NSW Health** – Tips for getting started and staying active for mental wellbeing
- **Active Parramatta** – Free in-person and online activities (City of Parramatta)
- **Community Programs** – Collective Leisure local group programs
- **Get Healthy Service** – free phone health coaching service focused on patient's health goals.
- **MyHeart MyLife** free support program for people living with heart disease and those who care for them.

2.4 Activity – Other Pen CS recipes

Due to recent updates, these recipe links may no longer be current.
For the latest information, please contact our team or Pen CS Support.



- [Eligible for the Heart Health Check who are low, moderate, and high risk of CVD](#)
- [High risk patients eligible for the Heart Health Check due to hypertension or hyperlipidaemia](#)
- [At risk patients who are eligible for a Heart Health Check and a GPMP](#)
- [Female patients who are eligible for the Heart Health and have had a diagnosis of gestational diabetes.](#)
- [Eligible for the Heart Health Check who have missing data for an absolute CVD risk assessment](#)

- [CVD Patients with no BP recorded \(NB: change CVD to CHD\)](#)
- [Identify patients not on Lipid lowering medication with HDL<1 and Cholesterol >6.5mmol/L](#)
- [Identify elevated CV risk - Part A](#)
- [Identify elevated CV risk - Part B](#)

- [Finding patients with Coronary Heart Disease \(CHD\) not coded for CHD](#)
- [Identifying Coronary Heart Disease \(CHD\) patients not on lipid modifying medication](#)
- [Identifying the smoking status of coronary heart disease \(CHD\) patients](#)
- [Identifying Coronary Heart Disease \(CHD\) patients not on ACE or ARB medication](#)
- [Identifying CHD patients not on antithrombotic](#)
- [Identifying Coronary Heart Disease patients with high BP recorded in the last 12 months](#)

- [Identifying Home Medication Review candidates: Heart Failure patients who are not on ACE inhibitors](#)
- [Identify all active stroke/TIA patients who are eligible for a GPMP \(NB: change TIA to CHD\)](#)
- [Identify patients with a chronic disease eligible for a GP Management Plan and/or Team Care Arrangement](#)
- [Identify patients with diabetes, CVD or CKD who never had a GPMP/TCA claimed](#)
- [Find patients eligible for GPMP/TCA - cross tabulated](#)
- [Adding Provider Details to a Report](#) (Tip: to help create reports for individual GPs)

**Need
support?**

PEN CS Support 1800 762 993
support@pencs.com.au

WentWest (02) 8811 7117
support@wentwest.com.au

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.

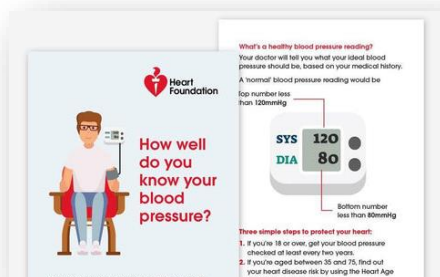
Programs like [MyMedicare](#) and the [Patient Centred Medical Home \(PCMH\)](#) embed these values into everyday practice, enhancing engagement, improving access, and delivering better cardiology outcomes through truly coordinated care.

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](#)



GoShare

patient
education
platform

GoShare is a free* patient education platform enabling health professionals to send tailored, trusted resources—such as videos and fact sheets—via email or SMS to help patients manage their health, improve **health literacy, and boost engagement**.

GoShare **Heart topics** including patient stories, information sheets, animations & more.

- [Cardiomyopathy](#)
- [Coronary Heart Disease](#)
- [Heart Failure](#)
- [Heart Health Check](#)
- [Heart Surgery](#)
- [Living with Heart Disease](#)

To get started or request access, please contact our team
support@wentwest.com.au

Quick Instructions

For Best Practice (BP) Users Using GoShare BP PSI Integration

1. **Install & Access:**
 - Ensure GoShare PSI is installed and activated in Best Practice. [GoShare PSI download instructions](#)
 - Log into GoShare PSI.
2. **Create Campaign**
 - Choose eligible patients by selecting a pre-built query from the GoShare PSI library.
3. **Send Bundle**
 - Choose SMS or email delivery.
 - Review and send to patients (you can stagger the sending in batches).

All Users – Web-Based Using GoShare Portal

1. **Log In:**
<https://goshare.realtimehealth.com>
2. **Build a Bundle**
 - Find Heart Health Check resources (videos, fact sheets).
 - Click “Add to bundle”, then ★ (star icon) to save.
3. **Send to Patients**
 - Click “Send bundle to list”.
 - Download CSV template.
 - Populate with patient details (Name, Phone, Email).
 - Upload, review, and send.
 - Direct Sends (Optional).
 - Click “Send bundle” → “New Recipient” → enter details → “Done”.

For Medical Director /Zedmed Users Using CAT4 & GoShare Plus

1. **Extract Patient List**
 - Open CAT4, apply filters:
 - i. ≥2 visits in 24 months
 - ii. No CVD conditions
 - iii. Eligible for 699 HHC
 - Export selected patient list as CSV file.
2. **Upload to GoShare Plus**
 - Log into GoShare Plus.
 - Select MyMedicare or CCM bundle.
 - Upload CSV via “Send bundle to list”.
 - Match fields and send via SMS or email.
 - Follow Up.

3.2 Activity - Heart Awareness Days

Use these dates to run targeted promotions, social media posts, clinics, or patient education campaigns:

Date	Awareness Day/Event	Opportunity
February (Whole Month)	<u>Redfeb (Heart Disease)</u>	Run a full-month campaign on CVD prevention.
March 3-16	<u>Seniors' Week (NSW) Festival</u>	Conduct Kardia screening for AF detection.
March 4	<u>World Obesity Day</u>	Invite patients to sign 2kg Challenge
April	<u>April Falls Month</u>	Educate eligible patients to the Steps Up or other Falls prevention program
May 6-12	<u>Heart Health Week</u>	Promote heart health checks
May 17	<u>World Hypertension Day</u>	Promote blood pressure checks and link to Heart Health Checks.
July	<u>Dry July</u>	Alcohol consumption campaign and link to Heart Health Checks.
August 4 -12	<u>National Stroke Week (Australia)</u>	Promote links between CVD risk and stroke prevention.
September 29	<u>World Heart Day</u>	Host a community event or clinic around heart health.
November 11-17	<u>Cholesterol awareness week</u>	Encourage lipid profile testing and CVD risk assessment.

Interested in viewing a full calendar year of Health Awareness events click [here](#).



3.3 Activity - Patient Invitation Templates

Letter / Email Invitation

Dear <patient's first name>,

Your heart health is very important. Sometimes the heart can beat in an irregular way. This is called *atrial fibrillation (AF)*. If AF is not found and treated, it can cause serious problems like stroke or heart failure. The good news is that many of these problems can be prevented if we check your health early.

Our records show that you may have some risk factors for AF. We would like to invite you for a **free Health Assessment (or Heart Health Check)** at our practice.

This check takes about **20 minutes** and is done by your doctor or nurse. During the visit we will:

- talk with you about your health and family history
- check your blood pressure, weight, and other simple measures
- discuss your lifestyle, like food, exercise, and smoking
- work with you on a care plan to keep your heart healthy

If you are enrolled in **MyMedicare** with our practice, your doctor and healthcare team will be able to provide you with more personalised, continuous care.

Please call us on <practice number> to book your free Health Assessment (or Heart Health Check).

Yours sincerely,
<Doctor's name>

SMS Invitations

Version 1 (1x SMS credit): Hi <patient's first name>. Please book a free Health Assessment (or Heart Health Check) with your doctor and healthcare team at <practice name>. Call us on <practice number>.

Version 2 (2x SMS credits): Hi <patient's first name>. Our records show you may have risk factors for heart disease (like Atrial Fibrillation). Please book a free Health Assessment (or Heart Health Check) with your doctor and healthcare team at <practice name>. Call <practice number>.

Staff Call Script

When calling patients, staff may say:

1. Invitation

"Hello <patient's name>, I'm calling from <practice name>. Your doctor has asked me to invite you to book a free Health Assessment (or Heart Health Check). This is because you may have risk factors for heart disease or stroke."

2. If patient asks what happens in the check-up

- "During the check-up, your doctor or nurse will:
- talk with you about your health and lifestyle
- check your weight, blood pressure, and maybe blood sugar
- calculate your risk of heart disease or stroke
- order tests, like blood tests or an ECG, if needed
- make a plan with you to help lower your risk."

TIP: For any questions about risk factors, refer the patient to the practice nurse or GP.

3. Extra details

"The check-up takes at least 20 minutes. It is fully covered by Medicare.

If you are enrolled in **MyMedicare** with our practice, your doctor and team can give you more ongoing and personalised care."

3.4 Activity - Heart Foundation Walking groups

Walking is a great way to be **social, stay active** and **feel connected** to your community! Take the first step and join a **FREE** Heart Foundation Walking group in your area:

Scan the QR code or visit walking.heartfoundation.org.au/walking to find a group, register, and start walking!



Blacktown area

Walking Group	Meet Spot	Contact - Walk Organiser	Walk Times
KRMC Walking Group	Francis Park, Blacktown Showground	Ann 0431 222 798	7am Mon, Wed & Fri
ECQ Walking Group	Live Well Health Club, Eastern Creek Shopping Centre	Rio 02 9767 2840 marketing@easterncreekquarter.shopping	9am Wed
Filipino Walkers	Dyanmila picnic shelter Bungarabee Park	Imelda 0425 284 851 filipinowalkers@gmail.com	8am Sat
HEALTHICARE	Blacktown Exercise Sports and Technology, Rooty Hill	Camelia 1800 828 828 camelia.najjar@healthicare.org.au	10am Fri
Rooty Hill Multicultural Group	Plumpton Park	Gladys gpanoncillo@bigpond.com	10am Mon -Sat
Too Deadly	Emerton Post Office	Bev Beverley.Donovan@health.nsw.gov.au	5am Tues, Wed & Thurs
Mt Druitt Medical Centre Walking Group	Car park, Mount Druitt Medical Centre	Maureen m.wan56@gmail.com	9am Wed & Fri
Blacktown and Surrounds Walkers	A different walk every week - contact Walk Organiser	David 0426 880 646	10am Thurs

Cumberland, Hills and Parramatta areas

Walking Group	Meet Spot	Contact - Walk Organiser	Walk Times
Stockland Merrylands	Food Court Entrance (near Baked & Co Coffee) Merrylands, Shopping Centre	Brian bcd1220@gmail.com	7.45am Tues, Thurs, Fri & Sun
Let's Walk	Les Shore Reserve, Glenorie	Andrea 0460 353 542	9.30am Thurs
Rouse Hill Warrior Walkers	Hills Centenary Park Commercial Rd, Rouse Hill	Irene irene@graphicdesignoz.com.au	7am Mon, Wed & Thurs
The Winston Walkers	Main entry of Winston Hills Mall (Outside Cafe Els)	Stephen machong@optusnet.com.au	9.15am Mon
Friday Frolic in Parramatta Park	Gate House Tea House, Pitt street entrance	Stephen machong@optusnet.com.au	9.15am Fri
Parramatta Park Walking Group	Pitt/Macquarie Street park gate	Stephen machong@optusnet.com.au	8am Sat
Westmead Parramatta Park Walkers	Queens Road entrance, Parramatta Park	Ruth ruth49@tpg.com.au	9am Sat
North Rocks Stratford Medical Practice	North Rocks Stratford Road Medical Practice	Belinda belinda@nrsurgery.com.au	9.30am Wed
WentWest Walkers	Leaf Cafe Westmead Westmead	Maha 0433 117 836 Maha.sedhom@wentwest.com.au	12pm Mon
Holistic Walkers	Holistic Exercise Physiology Clinic, Wentworthville	Hassan Hassan@holisticep.co	10am Wed
The Easy	Salt & Butter Cafe, Ermington (bottom of the stairs)	Katie 0413 147 338	9am Mon

Start a group

Take the lead for better health

Contact your **Western Sydney Coordinator**
 Aruni Ratnayake 0428 681 983 Aruni.Ratnayake@health.nsw.gov.au
 More info: <https://walking.heartfoundation.org.au/start-group/>



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
- 4.4 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: / /

4.1 Activity – Cardiology MBS and PIP Optimisation

This quick guide outlines key Medicare Benefits Schedule (MBS) items for CVD risk assessment and management. Each item number is **linked** to its criteria, descriptor, and fact sheets. Click [here](#) for a full list of MBS items.

HEALTH ASSESSMENTS (HA)	ELIGIBLE GROUPS			
Heart Health Check 20-min CVD risk check for eligible patients 30+ (ANNUALLY)		699		
<ul style="list-style-type: none"> Comprehensive Medical Assessment (CMA) for Residents of RACFs (ANNUALLY) People with an Intellectual Disability (ANNUALLY) One-off Veterans' Health Check (ONCE ONLY) Refugees with Medicare access (ONCE ONLY) 	<ul style="list-style-type: none"> 75 Years or Older (ANNUALLY) 45 to 49 Years at risk of developing chronic disease (ONCE ONLY) 40 to 49 Years at High Risk of Diabetes following AUSDRISK Tool (3 YEARLY) 	701 703 705 707	< 30 mins 30-45 mins 45 - 60 mins ≥ 60 mins	
	OTHER HEALTH ASSESSMENTS		Face to Face	Telehealth*
	NEW Menopause and Perimenopause Health Assessment		695	
	Aboriginal and Torres Strait Islander Peoples Health Assessment (EVERY 9 MONTHS)		715	92004
Patients <25 with eligible disability: assessment, diagnosis & plan (≥45mins) (ONCE)		139	92142	

CHRONIC CONDITIONS MANAGEMENT (CCM)	Face to Face	Telehealth*
NEW GP chronic condition management plan** (EVERY 12 MONTHS if clinically relevant)	965 [†]	92029 [†]
NEW GP chronic condition management plan Review** (EVERY 3 MONTHS if clinically relevant)	967 [†]	92030 [†]
Practice Nurse /AHW follow-up services for a patient with a chronic condition (5 PER YEAR)	10997 [^]	Phone 93203 Video 93201
Practice Nurse/AHW follow-up services for Indigenous Patients (10 PER YEAR)	10987 [^]	Phone 93202 Video 93200
Domiciliary Medication Management Review (DMMR) (ANNUALLY) Note: From 1 July 2027, a GP chronic condition management plan will be required to access domiciliary medication management reviews	900	
GP contribution to multidisciplinary plan – Community (EVERY 3 MONTHS)	729	92026
GP contribution to multidisciplinary plan (MCP) – RACF (EVERY 3 MONTHS)	731	92027
Case Conference GP organises (MAX. 5 TIMES PER PATIENT PER CALENDAR YEAR)	735 , 739 , 743	
Case Conference GP participating (MAX. 5 TIMES PER PATIENT PER CALENDAR YEAR)	747 , 750 , 758	
**Patients with a General Practitioner Chronic Disease Management Plan (GPCCMP) can access the following MBS services: <ul style="list-style-type: none"> Allied Health Services: Up to 5 individual sessions per year (10 for Aboriginal or Torres Strait Islander patients). Nurse or Health Practitioner Services: Up to 5 services annually, provided on behalf of a doctor. Type 2 Diabetes Care: If eligible, up to 8 yearly group sessions for dietetics, education, or exercise. The current allied health referral form will be replaced by referral letters , aligning with referrals to medical specialists.		

DIAGNOSTIC PROCEDURES	
12-Lead Electrocardiography - tracing only	11707
24-hr BP for suspected hypertension (patient not treated), including report and treatment plan (ONCE ANNUALLY if criteria met)	11607

ICON NAVIGATION	BULK BILLING INCENTIVES (BBI)
† Only available MyMedicare enrolled patients at the practice * Telehealth (Video Consults) and * Telephone (Phone Consults) available to Medicare-eligible patients with an established practice relationship who have attended in-person within the past year can access services. (Exceptions apply)	BBI (MBS MN.1.1) can be claimed when you bulk bill a child under 16 or a Commonwealth Concession Card holder. MyMedicare enrolled patients only at their enrolled practice <ul style="list-style-type: none"> Level C, D, E (Telehealth*) 75880[†] Level C, D (Telephone*) Level B, C, D, E (Face to Face) 75870 Level B (Telehealth*, Telephone*) All other eligible services not covered above 10990

Practice Incentive Program (PIP)



The **Practice Incentives Program (PIP)** supports general practices in improving quality care, capacity, and health outcomes. Accredited practices receive quarterly payments across three streams.

For more details, visit the [Services Australia website](#), email pip@servicesaustralia.gov.au or call the PIP enquiry line on 1800 222 032.

Incentive	Activity	Payment amount
MyMedicare	MyMedicare is a new voluntary patient registration model. It aims to formalise the relationship between patients, their general practice, general practitioner and primary care teams.	
Bulk Billing Incentive	From 1 November 2025, the Australian Government will expand eligibility for bulk billing incentives to all Medicare-eligible patients and introduce the Bulk Billing Practice Incentive Program , which requires participating practices to be MyMedicare registered and bulk bill all eligible patients.	
eHealth	eHealth requirements to qualify for payments	\$6.50 per SWPE capped at \$12,500 per practice per quarter
Indigenous Health	Sign-on Payment	\$1,000 per practice
	Patient Registration Payment	\$250 per patient per year
	Outcomes Payment Tier 1	\$100 per patient per year
	Outcomes Payment Tier 2	\$150 per patient per year
Quality Improvement (PIP QI)	Payment to practices to undertake quality improvement through the collection and review of practice data, and to share de-identified data with their PHN.	\$5 per SWPE capped at \$12,500 per quarter

MBS optimisation tips:

- Once per patient in a 12-month period. **Cannot be claimed with other health assessments** e.g. items 701, 703, 705, 707 & 715
- Heart Health Check/CVD risk calculation can be incorporate with other Health Assessment (e.g. 45-49) to **prolong the duration**. See [Heart Foundation more info](#).
- Item 699 or 177 can be **co-claimed with other items** to enhance patient management. Here are some examples of how you can co-claim.
 - Bulk-billing: Like other health assessments, 699 can be co-claimed with item 10990 or 10991, where eligible.
 - Chronic Conditions management (CCM): For Heart Health Check patients who have a chronic condition and require a CCM plan, 699 may be claimed in conjunction with the suite of [CCM items](#) available where eligible. You will need to include a 'not related' notations
 - Consider if patients eligible for a **medication management review and 699**.
- Patients aged **50–74 have no other Health Assessment**, and the Heart Health Check can be done every 12 months if clinically relevant.
- Use the workforce incentive program (WIP) to increase the support services of your nurses, Aboriginal and Torres Strait Islander health workers, and eligible allied health professionals.
- For every Heart Health Check or Health assessment upload a Shared Health Summary to My Heart Record to meet eHealth Incentive.

More info, visit [Heart Foundation - What is a Heart Health Check?](#) Or email askMBS@health.gov.au

MBS ONLINE

- [Search for Item Number](#)
- [Fact Sheets](#)
- [Updates \(XML Files\)](#)
- [MBS News](#)

Eligibility

- Ensure patient meets billing criteria.
- [HPOS MBS checker](#)
 - [My Health Record](#)
 - [Topbar MBS app](#)

More information

- www.mbsonline.gov.au
- Contact MBS 13 21 50
- askMBS@health.gov.au
- [Western Sydney HealthPathways - MBS Items](#)

Whilst all care has been taken in preparing this document, this information is a guide only and is subject to change without notice. Printed copies of this document are uncontrolled. Last updated August 2025

4.2 Activity - Identify team roles within your practice

Use these example **team roles and responsibilities** to consider how best to use your practice staff to provide optimum care, and the impact this will have on the workload and appointment system.

Activity	Example role allocation	Nurse	GP	Practice Manager	Admin / MPA	Pharmacists in General Practice	Other
monthly data extraction and review QI measures	<i>admin</i>						
Write up PDSAs and document QI activities	<i>Practice manager</i>						
Identify patients to recall	<i>Practice manager</i>						
Coordinate patient appointments	<i>admin</i>						
Monitor blood pressure	<i>Nurse</i>						
Review BMI	<i>Nurse</i>						
Review diet/healthy eating	<i>dietician</i>						
Review smoking & alcohol intake	<i>Nurse</i>						
Monitor physical activity	<i>Nurse</i>						
Conduct ECG	<i>Nurse</i>						
Monitor ECG remotely (if applicable)	<i>PIGP</i>						
Enrol patient on Topbar CIC app	<i>Admin</i>						
Organise blood tests as appropriate	<i>GP</i>						
Complete cardiovascular risk assessment (if applicable)	<i>GP</i>						
Update patient reminders for regular monitoring	<i>Admin</i>						
Check CVD status and offer support services	<i>GP</i>						
Provide self-care education	<i>Nurse</i>						
GP Management Plan (if applicable)	<i>GP</i>						
Review medications (if applicable)	<i>PIGP</i>						
Contact InTouch Facilitator for care coordination (if applicable)	<i>Nurse</i>						
Referral to RASS for stabilisation (if applicable)	<i>GP</i>						

4.3 Activity - Practice nurses workflow

Assessment template available in Heart Health Check Toolkit

2. Patient history

Medical history

Diabetes: Type 1 Type 2 Gestational

Hypertension: During pregnancy

Familial hypercholesterolaemia:

Moderate or severe chronic kidney disease:

Albuminuria: mcg/min Urine protein:

Urinary albumin:creatinine ratio: mg/mmol

Atrial fibrillation:

Left ventricular hypertrophy (LVH):

Mental illness:

Allergies:

Other relevant history:

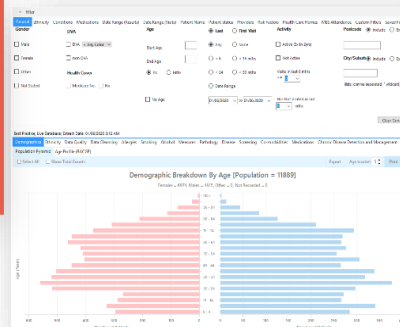
02

Practice nurse collects CVD risk factor info – BMI, BP, history, etc

01

Practice nurse performs records search and actively recalls eligible patients + opportunistic identification

Recall templates and recipes
Refer to Module 2 Data-Drive Improvements or HHC toolkit



03

GP completes risk assessment and recommends interventions

04

Practice nurse provides lifestyle advice + assists with management plan

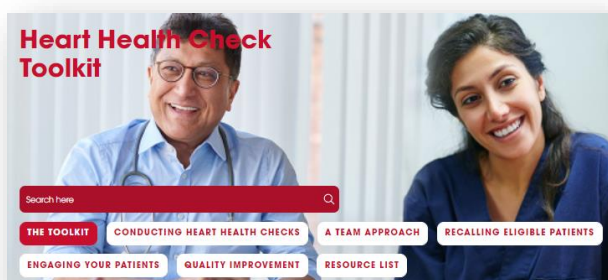
05

Patient recalled 6, 12, 24 months later

06

Follow up monitoring of risk +/- meds

More risk assessment and management (lifestyle and pharmacological) resources for GPs available in Heart Health Check Toolkit



4.4 Activity - AF Risk – Patient Questionnaire

Practice team to ask patient the following Atrial Fibrillation (AF) questions:

Do you experience any of the following?	
Sensations of a fast, fluttering or pounding heartbeat in your chest	<input type="checkbox"/>
Pain and pressure in your chest	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>
Tired, Fatigued, or Sleepy during the daytime*	<input type="checkbox"/>
Light Headedness	<input type="checkbox"/>
Snore loudly or difficulty breathing during sleep*	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>

*Recommend conducting [Obstructive Sleep Apnoea \(OSA\) questionnaire](#) if patient reports these symptoms

Conduct a Pulse Check

Pulse Palpation	<input type="checkbox"/> Irregular Pulse
	<input type="checkbox"/> Regular Pulse
	<input type="checkbox"/> Inconclusive

Conduct an ECG

ECG	<input type="checkbox"/> Irregular ECG
	<input type="checkbox"/> Regular ECG
	<input type="checkbox"/> Inconclusive

Request HeartBug ECG monitoring

Digital Literacy, Monitoring & Consent		
Does the patient (or their carer) have a smart phone and do they feel comfortable using mobile apps	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you consent to wearing a small monitoring device over a period of 2-4 weeks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
no planned hospitalization or overseas trips in the next month	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How long you want the patient to wear the device?	<input type="checkbox"/> 14 days	<input type="checkbox"/> 28 days
What do you want to investigate?	<input type="checkbox"/> AF (Stroke, TIA) – detection and/or management	
	<input type="checkbox"/> Syncope/light-headedness/dizziness (pauses, heart blocks, tachy and bradyarrhythmias)	
	<input type="checkbox"/> Symptom-Rhythm correlation i.e. palpitations (SVT, VT, ectopic beats)	
	<input type="checkbox"/> Monitoring the effectiveness of medications and interventions	
	<input type="checkbox"/> Pre and post-operative heart monitoring – (TAVR, ablation, PFO Closure, EP study)	
	<input type="checkbox"/> Longer term outpatient ECG monitoring	

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



Activity Navigation

- 5.1 PDSA cycles
 - PDSA – Heart Health Checks
 - PDSA – Overdue Cholesterol
 - PDSA – HHC and Care plans
- 5.2 Audit Worksheet
- 5.3 Group reflection
- 5.4 HeartBug Procedure
- 5.5 KardiaMobile Procedure
- 5.6 Autofill AF questionnaire

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](#)

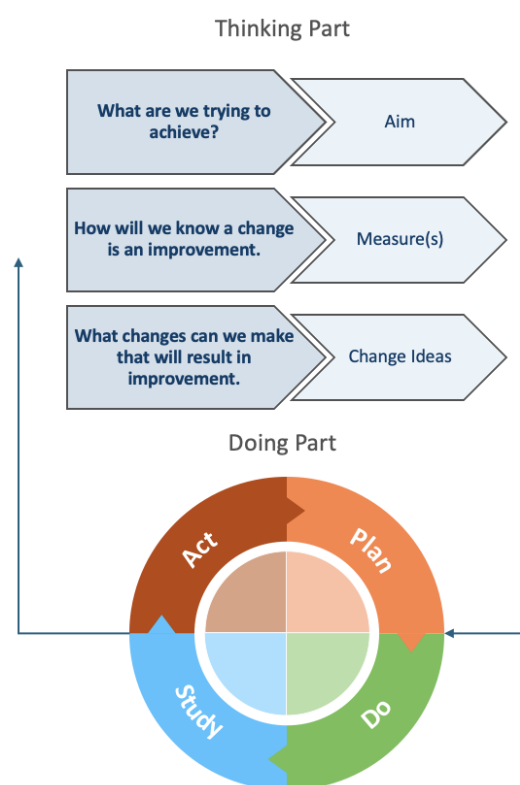
5.1 Model for Improvement and PDSA cycles

Start by documenting **your practice QI team** and define your problem and specified a robust **Problem Statement**.

Practice name:	Add your primary healthcare service name here	Date:	Start date
QI team:	List the team members involved		
Problem:	Describe why this work is strategically important. What problem is the team addressing? What does our data indicate about it, and what are the causes?		
Problem Statement:	Document your succinct problem statement here		

Step 1: Model for Improvement (Thinking Part)

- Goal / Aim:** What are we trying to accomplish? Develop a S.M.A.R.T. (Specific, Measurable, Attainable, Realistic, Time-bound) and people-crafted Aim Statement.
- MEASURE:** How will we know that a change is an improvement? Identify what good looks like and develop a measure(s) of success.
Tip: Use a [Run Chart](#) to plot trends.
- CHANGE IDEAS:** What changes can we make that will result in an improvement? Engage the whole team in formulating change ideas using [Institute for Healthcare Improvement QI tools](#) such as brainstorming, [driver diagrams](#) or [process mapping](#). **Each change idea may involve multiple small rapid PDSA cycles.**



Step 2: Plan-Do-Study-Act (PDSA) (Doing Part)

- PLAN:** Describe the change idea (what, who, when, where). Predict outcomes and define the data to collect.
- DO:** Carry out the plan. Collect data. Consider what worked well and why? Document any unexpected observations, events or problems.
- STUDY:** Analyse results, compare them to predictions, and reflect on what you learned.
- ACT:** Based on what you learned from the test, consider what you will do next (e.g., adopt, adapt or abandon)? How does this inform the plan for your next PDSA?

For [guidance](#), download [template](#) or for support on conducting quality improvement in your primary healthcare services, please contact the WentWest Primary Care Delivery team on support@wentwest.com.au

Source: Langley, G., Nolan, K., Nolan, T., Norman, C. & Provost, L. 1996, The Improvement Guide, Jossey-Bass, San Francisco, USA

AIM	1. What are we trying to accomplish?
Increase the number of MBS 699 or 177 Heart Health Checks billed for eligible patients aged 50–74 years (not eligible for other health assessments) from X% to Y% by [insert date].	
MEASURE(S)	2. How will we know that a change is an improvement?
<ul style="list-style-type: none"> • Number of MBS 699 claims per month • % of eligible patients with completed CVD risk recorded 	
CHANGE IDEAS	3. What changes can we make that will result in improvement?
Idea 1	Identify eligible patients using CAT4/Topbar filters.
Idea 2	Use nurse-led workflows for pre-assessment
Idea 3	Send our reminders using GoShare patient education resources
Idea 4	Flag patients for opportunistic HHCs
Idea 5	Promote Heart Health Week to boost awareness and bookings
Next steps:	<i>Each idea may involve multiple short and small PDSA cycles.</i>

Plan-Do-Study-Act (PDSA)

Idea	Plan	Do	Study	Act
1.1	Use CAT4 to extract a list of active patients aged 50–74 with no previous HHC or other health assessments in the past 12 months. Who: Practice manager When: Week 1 Where: at practice	Send SMS invitations (via GoShare or BP recalls) to 50 eligible patients.	<ul style="list-style-type: none"> • 40% of patients responded to SMS within 5 days. • Admin staff found CAT4 filters easy to use but wanted clarity on eligibility criteria. • 3 patients were booked but not eligible due to recent GPMP/HA. • Staff appreciated having a clear recall scrip 	<ul style="list-style-type: none"> • Refine CAT4 filters to exclude patients with recent MBS claims. • Use staff transcript for admin/reception to increase bookings. • Expand SMS recall to the next 100 patients with eligibility flag in Topbar.
2.1	Trial a workflow where nurses conduct pre-checks (BP, BMI, history), and GPs complete the risk assessment and plan. Who: Practice nurse When: Week 2 Where: at practice	Implement this workflow for 10 patients over one week using HHC templates.	<ul style="list-style-type: none"> • Nurses were confident using the HHC template but unsure when to escalate findings. • GPs found pre-filled templates reduced consult time by ~5 mins. • 8 out of 10 patients completed full checks, but 2 needed ECG rescheduling. • Team liked the role clarity and smoother flow. 	<ul style="list-style-type: none"> • Add a nurse-GP handover checklist to the workflow. • Provide ECG training refresher for nurses. • Standardise HHC appointments to 30 minutes with nurse-GP split.
2.2	Deliver a short in-practice session to upskill nurses and admin on HHC eligibility, template use, and GoShare. Who: PHN Primary Care Facilitator When: Week 3 Where: staff meeting/lunch room	Hold a 30-minute lunchtime training session with 6 staff using Heart Foundation and toolkit resources.	<ul style="list-style-type: none"> • Team showed interest but had questions about patient eligibility and enrolment. • Some team members unaware of how it aligns with the practice’s current strategy. • Quick post-meeting feedback collected showed 80% of attendees found the session useful. 	<ul style="list-style-type: none"> • Plan a follow-up FAQ session. • Add a MyMedicare summary to the practice resource folder. • Ensure key updates are emailed post-session.
3.1	Use GoShare to send HHC video bundles to improve understanding and increase uptake of booked checks. Who: Practice nurse When: Week 2–3 Where: at practice	Send GoShare SMS with videos to 20 patients scheduled for an HHC next week.	<ul style="list-style-type: none"> • 75% of patients watched at least one video prior to their appointment. • Nurses reported patients were more informed and asked fewer basic questions. • Admin noted a few bounce-backs from outdated numbers. 	<ul style="list-style-type: none"> • Clean and verify mobile numbers as part of the recall process. • Incorporate GoShare into all HHC recalls. • Monitor whether informed patients reduce consult time.

PDSA – Overdue Cholesterol Results

AIM	1. What are we trying to accomplish?
Increase the proportion of active patients with CVD who have a cholesterol result recorded in the past 12 months by from X% to Y% by [insert date].	
MEASURE(S)	2. How will we know that a change is an improvement?
Number of active patients with CVD and cholesterol result <12 months	
CHANGE IDEAS	3. What changes can we make that will result in improvement?
Idea 1	Identify active CVD patients without cholesterol recorded in the past 12 months using CAT4
Idea 2	Update cholesterol reminder settings in practice software
Idea 3	Flag eligible patients for opportunistically via Topbar
Idea 4	Send GoShare educational resources to engage patients

Idea	Plan	Do	Study	Act
1.1	Lucy to conduct a CAT4 search on 25/09 to identify active CVD patients with no cholesterol recorded <12 months. List to be reviewed by GPs. Who: Practice manager When: Week 1 Where: at practice	Search completed.	<ul style="list-style-type: none"> 5 inactive patients, 2 RACF patients, 30 patients with cholesterol result documented in free-text. 175 patients flagged. Actions added to clinical files. Data clarified gaps in clinical coding and patient status. High volume of patients needing follow-up. CAT4 was effective in identifying gaps. 	<ul style="list-style-type: none"> Schedule WSPHN training session on coding standards. Begin quarterly monitoring using PIPQI reports. Use this list to guide future recalls.

PDSA – Co-Claiming HHC and Care plans

AIM	1. What are we trying to accomplish?
Increase the number of eligible patients who have both a Heart Health Check (MBS 699) and a Care Plan or Review (MBS 965 or 967) completed and claimed by from X% to Y% by [insert date].	
MEASURE(S)	2. How will we know that a change is an improvement?
Number of patients identified as eligible for both MBS 699 and 965/967	
CHANGE IDEAS	3. What changes can we make that will result in improvement?
Idea 1	Use CAT4 to identify patients with chronic conditions eligible for both HHC and CCM plan /review
Idea 2	Flag these patients in the clinical system (Topbar) for opportunistic co-claiming
Idea 3	Train nurses/admin to bundle bookings for HHC + CCM plan in one session
Idea 4	Create a 'co-claim checklist' for clinicians to streamline documentation and ensure correct billing

Idea	Plan	Do	Study	Act
1.1	Identify active patients aged 45–74 with one or more chronic conditions who have no CCM plan or review in the last 12 months and are also eligible for a Heart Health Check . Use CAT4 and Topbar to flag these patients. Train admin staff to offer a bundled appointment when recalling or booking patients. Who: Practice manager When: Week 1 Where: at practice	Pilot the process over 2 weeks. 20 patients are contacted. Admin staff offer a combined HHC and CCM plan /review appointment. Clinicians use a co-claim checklist to ensure both services are delivered appropriately and note 'not related' when billing.	<ul style="list-style-type: none"> 15/20 patients accepted the bundled appointment. 13 completed both items in one session. 3 patients required a follow-up due to incomplete pathology. Staff reported time savings and better continuity. One incorrect claim due to missing 'not related' note. 	<ul style="list-style-type: none"> Update the checklist to include a billing reminder for 'not related'. Add prompt in patient notes to suggest co-claim when eligible. Expand the approach to the next cohort of 50 patients. Present results and lessons learned at next team meeting.

5.2 Measuring Outcomes – Audit Worksheet

- Enter a practice baseline for QI activity measure in the table below
- Track your progress over time by entering a result for reporting period. You can also use funnel charts to process.



SCREENING

Identifying active patients (> 45 years old) who have the following comorbidities (hypertension, diabetes) and lifestyle risk factors (obesity, smoking and alcohol) that put them at risk of AF and stand to benefit from the WSC program.

PEN CS Filters:

- **Active Patients** (3 visits x 2 years)
Note: Per RACGP, an active patient has 3+ visits in 2 years. This filter may exclude patients who don't visit regularly
- Age: **>45 years**
- Risk factors: **Obesity** (BMI of 30 +)
- **Condition/s:** No Atrial Fibrillation and No CVD conditions (i.e. heart Failure, AF, PAD, Stroke, Carotid Stenosis, MI, Renal Artery Stenosis)

Report/measure	Baseline		Audit 1		Audit 2		Audit 3		PHN* %
	MM/ YY		MM/ YY		MM/ YY		MM/ YY		
	n	%	n	%	n	%	n	%	
Obesity Patients over 45yrs with <u>no</u> diagnose of AF and CVD									0%
45-49									
50-74									
75>									
Risk Factors									
BMI: Morbid (40+)									
BMI: Obese (30 to 39.9)									
BP: > 140/90									
Alcohol: Drinker High Risk**									
Smoking: Daily									
CVD Risk: High Risk (>15%)***									
Co-morbidities									
Patients with 3 or more co-morbidities									
Diabetes Type II									
Hypertension									
Hyperlipidaemia									
Renal Impairment									
Chronic Kidney Disease (CKD)									
Patient with 8+ Medications									
MBS not recorded in the past 12month									
Heart Health Check									
HA 75+									
HA 45-49									
GCCMP									
GCCMP Review									
10997 (PN/AHP Service)									
DMMR									

*PHN can be used as a accumulative percentage of Western Sydney practices or AHIW

** 2 or more drinks on a regular occasion or more than 4 drinks on any occasion

***Framingham Risk Equation (FRE)

5.3 Group reflection – after completing activities

As a team, analysis and review **baseline** data results and discuss change ideas and actions.
Use **PDSA cycles** to test and measure change ideas

The degree to which the learning needs were met:

- Not met
- Partially met
- Entirely met

To what degree this activity was relevant to your practice:

- Not met
- Partially met
- Entirely met

What did you learn? What changes would you make to your practise as a result?

What did you learn?

- Has the clinical team completed key HHC training?
- What did your CAT4 search reveal about undiagnosed or uncoded CVD conditions?
 - Was your CVD register:
 - Higher than expected
 - About what you expected
 - Lower than expected
 - What might explain this? (e.g. coding issues, clinician uncertainty about where to enter diagnoses, or incomplete records)
- Are all relevant team members aware of:
 - How to correctly code CVD diagnoses in your clinical software?
 - The need to mark conditions as active/inactive or confidential?
 - Using consistent terminology from the system's drop-down list?

What changes will you make?

- Clean and update your CVD register:
 - Remove or recode any uncoded CVD conditions. Refer to **[Best Practice](#)** or **[Medical Director](#)**
 - Use the CAT4 clinical coding guide specific to **[Best Practice](#)** or **[Medical Director](#)**.
- Ensure the team understands:
 - How to accurately enter alcohol use, smoking status, BMI, and physical activity in the system.
 - *alcohol and smoking:* **[Best Practice](#)** or **[Medical Director](#)**
 - *BMI (weight and height):* **[Best Practice](#)** or **[Medical Director](#)**.
 - *physical activity:* **[Best Practice](#)** or **[Medical Director](#)**.
 - How to support patients with **[SNAP \(Smoking, Nutrition, Alcohol, Physical Activity\)](#)** advice and referrals.
- Enhance patient engagement:
 - Use **[GoShare](#)** to send tailored health CVD education and resources.
 - Use Topbar to identify missing clinical and demographic data, including "indicate" rather than diagnose prompts.

5.4 HeartBug Procedure

⚠ Note: HeartBug is strictly for monitoring patients where arrhythmia is suspected. It is not intended for general screening.

Onboarding

This onboarding procedure is specifically for practices interested in using HeartBug to support patients with suspected arrhythmia.

1. Complete the **Continuous Quality Improvement Cycle - Expression of Interest (EOI) Form** and indicate your clinical team's availability to be onboarding process.
2. WentWest Primary Care Support Officer will book a training session **with a HeartBug Representative (Linda)** at your preferred time (as indicated in the EOI). ➤ *All clinical staff must complete training before devices can be provided.*
3. **Device Allocation Based on Practice Size**
 - **Large Practices:** A HeartBug device rack will be supplied by HeartBug.
 - **Smaller Practices:** Devices will be mailed directly to your practice through the WentWest HeartBug system - please check availability of WentWest HeartBug by contacting WentWest Reception on 02 88117100, or email reception@wentwest.com.au. HeartBug will be posted on **Tuesdays and Thursdays. Please allow 3-4 days for delivery.**

⚠ Note: Do not send patient details to our reception as this may be concerned a data breach.

Using HeartBug via WentWest

1. Check Eligibility

Confirm the patient qualifies for HeartBug under **MBS item 11735** (this is item is only available to HeartBug, not the GP). **Note:** HeartBug is strictly for monitoring patients where arrhythmia is suspected. It is not intended for general screening.

2. Smartphone Access

Patient must have a smartphone to download the HeartBug app via QR code or the following links: [iOS App](#) or [Android App](#)



3. Order HeartBug (if needed)

Smaller practices should email reception@wentwest.com.au to order the device **1 week** before the appointment.

4. Enrol Patient and App Login

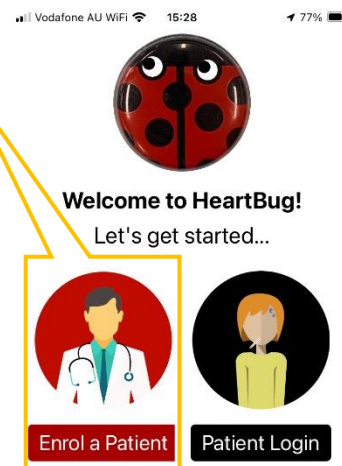
Register the patient on the [Heartbug portal](#) and follow the app instructions. For technical or patient concerns, contact HeartBug: **1800 529 275 (Mon-Fri, 9am-5pm)**.

5. Return Device

After monitoring ends, the patient will get a message. They must post the device and leads back using the **ReplyPaid envelope** provided.

6. Results & Follow-Up

HeartBug sends the report to the doctor (within 1-3 weeks). Reception will then contact the patient to book a follow-up appointment.



Questions? Contact HeartBug Support 1800 529 275
www.heartbug.com.au

5.5 KardiaMobile Procedure

Onboarding kardiaMobile

Access to Kardia devices is limited to the first 100 practices that completed CQI EOI form – This device focused on Atrial Fibrillation (AF) screening. Follow these steps to onboard:

1. Complete the **Continuous Quality Improvement Cycle (CQI) - Expression of Interest (EOI) Form** and indicate your clinical team's availability to be onboarding process.
2. **Device Activation in Your Practice:** Your Primary Care Support Officer will guide your team through activation, including unboxing and connecting to the Kardia software/app to your practice mobile phone – using the below instructions.

⚠ Important: A mobile phone with Bluetooth capability is required to use the Kardia device. Screening results will be stored in the Kardia app and can be exported for clinical use.

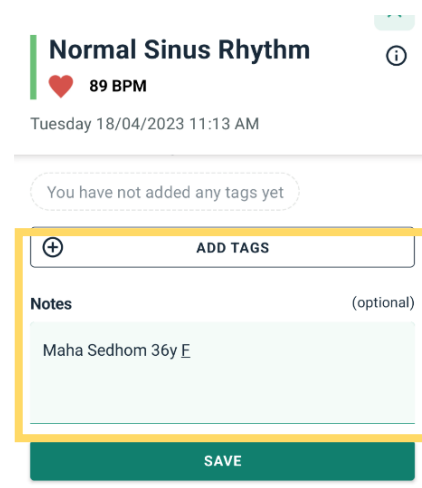
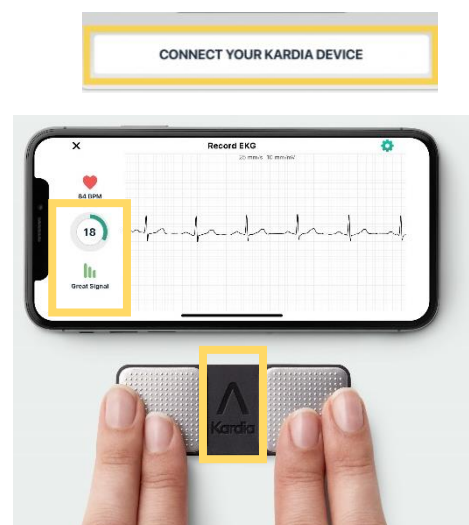
Setting up KardiaMobile

1. Download App via **Kardia App for iOS®** or **Kardia App for Android®**
2. Create **Account > Next >**
3. Enter your **Practice email and password** would like used for your Kardia account (not patients).
4. Select **Country > Create Account > Setup your Profile** (not patient*) > Complete

Using KardiaMobile

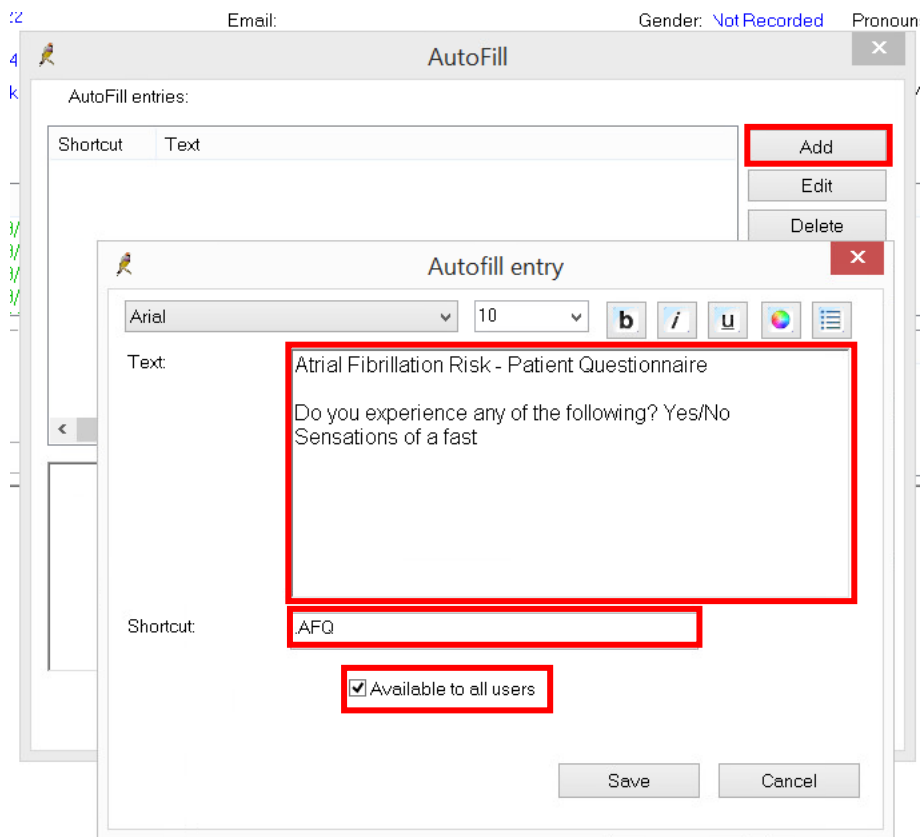
5. Recording **Results on KardiaMobile app**
6. **Kardia app > Connect Your Kardia Device > KardiaMobile > Next > Grant access to microphone.**
7. **Record Your ECG >** selected device.
8. Place smartphone/tablet and KardiaMobile in front of you (close proximity) with **"A" logo facing up.**
9. Place **index and middle fingers on each electrode.**
10. KardiaMobile will turn green to indicate stable connection** and countdown from **30 seconds.**
11. Saving results with patients details and sharing PDF
12. Select **Tag and Notes>** in Notes add **Patient's Name, Age and Gender > Save**
13. Recommended Next Step> **Download PDF>** skip or create a shareable password > email to assigned GP or practice email

Disclaimer: Limited device availability. The device is available for loan for up to 6 months based on usage.



5.6 Autofill AF Patient Sympton Questionairre

1. From **Today's Notes**, click **Autofill**.
2. Select **Add**, copy Atrial Fibrillation Risk – Patient Questionnaire below and label shortcut .AFQ. Make sure you tick “Available to all users”.
3. Click the Save button to confirm.



Atrial Fibrillation Risk – Patient Questionnaire

Practice team to ask patient the following questions:

- Do you experience any of the following? Yes / No
- Sensations of a fast, fluttering or pounding heartbeat in your chest? Yes / No
- Pain and pressure in your chest? Yes / No
- Dizziness? Yes / No
- Tired, Fatigued, or Sleepy during the daytime*? Yes / No
- Light Headedness? Yes / No
- Snore loudly or difficulty breathing during sleep*? Yes / No
- Shortness of Breath? Yes / No

*Recommend conducting Obstructive Sleep Apnea (OSA) questionnaire if patient reports these symptoms

Digital Literacy & Consent

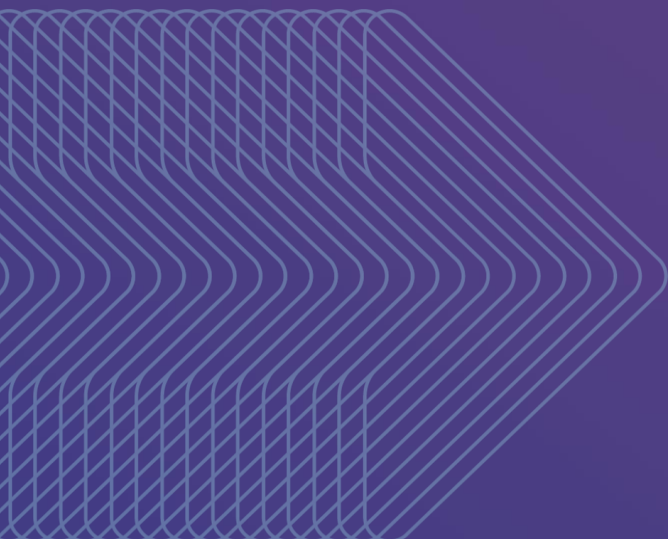
Do you have a smart phone? Yes / No

Do you feel comfortable using mobile apps? Yes / No

Do you consent to wearing a small monitoring device over a period of 2-4 weeks? Yes / No

Conduct a Pulse Check [] Irregular Pulse [] Regular Pulse [] Inconclusive.

Conduct an ECG [] Irregular ECG [] Regular ECG [] Inconclusive



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