Healthy Hearts Model of Care – V2.3

Contents

Abbreviations and Acronyms

Acronym	Definition
AHP	Allied Health Practitioner
ACCHO	Aboriginal Community Controlled Health Organisation
AHW	Aboriginal Health Worker or Practitioner
APNA	Australia Primary Health Care Nurses Association
BMI	Body Mass Index
CVD	Cardiovascular Disease
EQ-5D-5L	EuroQol Group's 5 Dimension, 5 Level Health-Related Quality of Life Instrument
HHP	Healthy Hearts Program - coordinated Multidisciplinary Team Care (Cardiovascular Disease Prevention and Management) Program
GP	General Practitioner
GPCCMP	General Practitioner Chronic Conditions Management Plan
LGAs	Local Government Areas
LHD	Local Health District
MDT	Multidisciplinary Team
NPS	Net Promoter Score
PREM	Patient Recorded Experience Measure
PHN	Primary Health Network
PROM	Patient Recorded Outcome Measure
RNs	Registered Nurses
RFP	Request for Proposal
SENSW	South East NSW
SPDS	Sentinel Practices Data Sourcing
UOW	University of Wollongong

Background

Program documentation and consumer messaging will consistently use the simplified “Healthy Hearts Program” branding to support recognition and reduce confusion.

The Healthy Hearts Program (HHP) is a service providing multi-disciplinary team (MDT) care in General Practices. HHP has been developed as part of COORDINARE’s implementation of Stream 6 of the Primary Health Networks (PHN’s) Program Core Schedule GO6901, named “PHN commissioning of Multidisciplinary teams”. This funding was announced as part of the *Building a Stronger Medicare* package in the 2023-24 budget and is funded for the period 2024–2027. The purpose of the funding is to strengthen the role PHNs play in commissioning multidisciplinary health care teams to improve the management of chronic conditions and reduce avoidable hospitalisations. The funding objectives are to:

- Design an approach for multidisciplinary team care in the PHN region that will increase the effectiveness of health interventions in primary care.
- Successfully commission MDTs that address a prioritised need in the region, with a focus on supporting small general practices to work in a more multi-disciplinary way.
- Extend PHNs’ existing role in primary health to support allied health, nursing and/or midwifery practices.
- Establish reporting processes supported by data collection and data management practices
- Monitor implementation of the activity.
- The intended outcomes of the funding are to:
- Increase access to Allied Health practitioners, Aboriginal Health Workers/Practitioner, Nurse Practitioners, Nursing and/or Midwifery services to provide person-centred care for Australians that improves health outcomes and reduces avoidable hospitalisations, particularly in relation to chronic disease.

Healthy Hearts Program model

Program Aim

HHP aims to reduce the risk of, and improve the MDT management of, CVD and CVD risk among participating patients by strengthening prevention, early detection, and management of key risk factors within primary care. Through coordinated multidisciplinary teams, data-driven quality improvement, and tailored patient support, HHP seeks to:

- Improve identification and monitoring of CVD risk factors such as hypertension, high cholesterol, and diabetes
- Improve the MDT management of people with diagnosed CVD
- Enhance patient engagement through education, health coaching, and self-management strategies
- Support timely and coordinated care across general practice and allied health providers
- Address barriers to access, particularly in rural and underserved areas

Ultimately, these activities are designed to lower CVD risks and impacts, reduce preventable hospitalisations, and improve the overall health and wellbeing of program participants.

Service Description

HHP is a free service which will be delivered in small practices and/or ACCHOs as a facilitated MDT clinic.

Services will be provided face-to-face and via telehealth, involving HHP staff, GPs, practice staff, and allied health professionals such as dietitians and exercise physiologists.

The initial assessment appointment may be delivered as one longer session or as two shorter contacts (face-to-face or telehealth), to reduce patient burden while maintaining clinical integrity.

Appointment frequency and mode may be adapted to patient need and practice capacity while maintaining the required program milestones across the 12-month period.

In between scheduled appointments, patients will have access to the HHP staff to support self-management, optimise opportunistic health interventions and referral to allied and community health supports as needed.

PROMS (EQ-D5-DL) and PREMS (NPS) will be collected in a format approved by the PHN at the initial and final appointment with the HHP staff and at any other appointment of more than 30 minutes.

Group and shared care options:
Practices and/or ACCHOs may deliver optional group-based sessions- including education, health coaching, or exercise physiology group activities- where capacity and patient preference align. These sessions complement but do not replace scheduled individual appointments.

Figure 1 outlines the overall model including timelines and key interventions. Each patient will participate for up to a year with a soft exit inclusive of ongoing health coaching and care planning as required.

During the program, the HHP staff will work with the patient to develop and maintain a "My Healthy Heart Management" care plan using health coaching techniques. This includes referrals to community-based care including dietitians and exercise physiologists funded through HPP where appropriate. The HHP staff will also make referrals to other community resources such as heart health walking groups and liaise with those providers in providing coordinated care to the patient. This plan will be reviewed and updated as needed with the patient at each scheduled program appointment.

HHP staff will use prescribed program tools and templates to deliver the program to ensure consistency and integrity of model delivery. The Heart Foundations Heart Health Toolkit will support risk assessment and management.

Appendix 1 includes a list of activities that may be undertaken within each appointment.

Referrals and Eligibility criteria

Referrals are based on clinical judgement and patient data, with eligibility determined by age, risk factors and diagnosis. See also **Figure 2**
Eligible client lists will be available within practice software (where the practice is enrolled in SPDS)
Eligible patients include:

- Patients with diagnosed CVD and who are at least ≥1 month post-event or
- Any patients:
    - with diabetes aged 35-44 years
    - aged 45-79
    - with a confirmed diagnosis of family hypercholesteremia
- Aboriginal and/or Torres Strait Islander patients:
    - Aged 30-79 years
    - aged 18-29 with ANY of these risk indicators
- hypertension
- hyperlipidaemia

- diabetes
- family history of hyperlipidaemia
- family history of premature CVD
- CVD medications in the past 6 months
- moderate to severe chronic kidney disease
- history of early onset <34 weeks hypertensive disorders of pregnancy
- history of pre-eclampsia
- history of gestational diabetes
- severe mental illness (requiring specialist treatment in the past 5 years)
- Individuals with moderate-to-severe chronic kidney disease meeting any of these criteria:
    - sustained eGFR <45mL/min/1.73m or
    - men with persistent uACR >25mg/mmol or
    - women with persistent uACR >35mg/mmol
- Other individuals as assessed by their GP who could benefit from HHP

Note: Clinical judgement and flexibility

Eligibility for the Healthy Hearts Program is informed by structured criteria and supported by GP clinical judgement. Individuals with diagnosed cardiovascular disease who are at least one month post-acute event are eligible. GPs may also refer patients who, in their clinical view, would benefit from structured multidisciplinary risk-factor management even when criteria are not fully met.

Table: Eligibility and Referral Decision Support Guide

Scenario	Eligible	Notes
Diagnosed CVD ≥1 month post-event	Yes	Prioritised secondary prevention cohort
Age based eligibility met but incomplete data	Yes	Requires clinical judgement
Multiple risk factors but outside age range	Clinician discretion	GP led decision
Borderline / complex cases	As assessed	Consider MDT discussion

Out of Scope

- HHP staff are not to undertake any work that is outside the scope of HHP noting that the care pathway includes optimised patient care and therefore may include other interventions within their scope of practice that assist the patient to stay well and engaged in managing their health e.g. providing access to vaccinations per practice protocols or support re accessing members of the external care team etc.
- HHP staff and any allied health practitioners brokered by HHP are not to claim any other fee for service including but not limited to - MBS, DVA, NDIA, MAC for treatment and care undertaken as part of the program.
- HHP staff are not to provide care to any patients other than those who are enrolled in, or who are eligible to, and considering enrolling in HHP.

Workforce

Practice induction:
Prior to program commencement, a whole of practice/ACCHO orientation of 1 hour will be undertaken to ensure shared understanding of workflows, communication pathways, documentation processes, and role expectations across the general practice team. Payments to the practice will support this induction time.

HHP will be led by a program staff (usually an RN but may also be a suitably qualified Allied Health Practitioner) supported by practice staff. The HHP staff may also engage Allied Health practitioners (primarily Dieticians and Exercise Physiologists) on a fee for service basis at no cost to the participant using HHP brokerage funds.

The HHP Provider will employ staff to provide HHP for **primary and secondary prevention** on site and via telehealth during the business hours of the practices. They will split their time between the practices, based on the case load of each and in consultation with the PHN. The roles of practice staff and HHP staff are outlined below in Table 1.

To support clarity and consistent delivery, the HHP workforce model includes defined responsibilities for GPs, practice nurses, practice managers, HHP staff, and external allied health providers.

Table 1: Roles of HHP personnel

Personnel	Description
GPs	• Champion the implementation of the HHP • Review the HHP model of care and support the development of new practice workflows to support the model. • Work with the HHP staff to ensure that patients are aware of HHP and its benefits. • GPs are encouraged to identify patients who may be eligible to participate and to suggest enrolment in the program. • Participate in the model of care by providing clinical review to discuss CVD risk with patients and interventions as per the Australian CVD Assessment and Intervention Guidelines and engage in case discussion to help plan ongoing care. • Participate in HHP Community of Practice • Ensure practice data inclusion in SPDS collections
Existing Practice Nurse	• Review the HHP model of care and support the development of new practice workflows to support the model. • Work with the HHP staff to ensure that patients are aware of HHP and its benefits. • Practice Nurses are encouraged to identify patients who may be eligible to participate and to suggest enrolment in the program. • Identify optimised health interventions for patients enrolled in HHP such as vaccinations, wound care, GP Chronic Condition Management Plan etc. and discuss the inclusion of these into the care plan with the HHP staff
Practice Manager	• Implement processes to facilitate the introduction of HHP • Set up systems to identify, recall and follow-up eligible patients • Support clinical team members with data management and reporting • Ensure the CVD risk calculator can be easily accessed • Develop communication and support strategies to keep all staff informed of issues that may impact the HHP. • Ensure practice data is part of SPDS collections
HHP Staff	• Be the central point of contact for the care team working with the patient

	• Appointment scheduling and reminders in practice software
	• Managing program consent processes
	• Health coaching and motivational interviewing
	• CVD risk assessment and heart health planning including observations (where appropriate)
	• Referrals as appropriate
	• Collection of PROMS and PREMS
	• Follow up care as specified in the pathway
	• Build strong connections with other allied health professionals / community resources in the area that can provide additional support of the enrolled patients
	• Facilitate case consultations and reviews with the care team
	• Be certified in APNA's CVD Risk Learning Module and/or Australian Heart Health's Cardiac Rehabilitation and Secondary Prevention Training.
	• Identify quality improvement activities in line with Practice Incentive Program Quality Improvement (PIP QI) incentive requirements for CVD
	• Participate in Community of Practice activities
	• Collect and record data in the Practice EMR and their employers EMR for the purpose of clinical care and data collection
	• Undertake orientation, training, and performance monitoring
	• Implement the eligibility pathway through working with the practices to identify, contact and recruit eligible patients to HHP including through:
	  ○ Use of clinical data
	  ○ Recalls
	  ○ Bulk texts
	  ○ Phone recruitment
	  ○ Direct referrals from practice staff

External Dietitian, Exercise Physiologist and other AHPs	• Provide specialised assessments, interventions and collaborative care planning to patients referred by HHP within the scope of practice. • Provide clinical feedback to the practice using the HHP staff as the central point of connection.

Program implementation

Recruitment strategies:

Recruitment strategies may include opportunistic engagement e.g. through flu clinics, data driven recalls, practice nurse/Aboriginal Health Worker identified candidates, and targeted communication to eligible cohorts.

Equity and cultural safety:

The HHP is available to Aboriginal Community Controlled Health Organisations and will partner with local Aboriginal programs to support culturally safe recruitment and care pathways.

Strengthening chronic condition management workflows within participating practices:

Through the facilitated multidisciplinary approach, practices in the HHP are supported to identify patients who would benefit from chronic disease planning, coordinate timely GP review, and improve alignment between the GPCCMP and the patient's "My Healthy Heart Management Plan."

Regular HHP staff led assessments, structured data capture, and collaborative case reviews enable practices to refine internal workflows related to recalls, monitoring, and follow-up; improve the quality and completeness of GPCCMP documentation; and streamline care across the general practice team. These improvements support more consistent application of national chronic disease management guidelines, enhance continuity of care, and contribute to improved patient outcomes.

By participating in HHP, small practices/ACCHOs can consolidate sustainable, efficient chronic disease management processes using MDT models that can be embedded beyond the life of the program and applied across their broader patient population.

Performance Measures

Clinical outcomes for participating general practices will be tracked through SPDS.

For the HHP staff provider performance is tracked through data reporting. COORDINARE have developed a data collection schema. This schema forms the basis of the HHP staff provider reporting of de-identified unit record data submission to COORDINARE for all service activity, demographic and social profile of clients as well as outcomes and experience measures. Ongoing performance management will be done by authorised users/portfolio managers using COORDINARE's Strategic Technical Analysis and Reporting (STAR) Portal.

Organisational roles and responsibilities

Other responsibilities may be described in contracts and schedules.

General Practices/ACCHOs

- Will identify a designated practice champion (GP, nurse, AHP or practice manager) who will support coordination, communication, and internal problem solving related to HHP.
- Ensure and enable practice data inclusion in SPDS collections
- Review the HHP model of care and support the development of new practice workflows to support the model
- Provide training for HHP staff in the practice's management software
- Provide an appointment profile for the HHP staff and schedule appointments for eligible patients
- Provide a suitable environment and resources for the HHP staff to carry out the requirements of the care pathway
- Work with the HHP staff to ensure that patients are aware of HHP and its benefits
- Identify patients using patient data and clinical and to refer to HHP
- Ensure the necessary program elements including Healthy Hearts Risk Assessment and Healthy Hearts Management Plan can be easily accessed, recorded and updated in practice software
- Develop communication and support strategies to keep all staff informed of issues that may impact the HHP program
- Engage in case discussions to help plan ongoing care and program delivery
- Maintain service level agreement with the HHP provider

Commissioned HHP Provider

- Privacy and Confidentiality provisions agreed in writing with each commissioned GP practice
- Placement of program RNs based on patient demand
- Appropriate onboarding of Nursing staff to practice WHS, EMR, Code of Conduct, policies and procedures etc.
- Necessary program elements including Healthy Hearts Risk Assessment and Healthy Hearts Management Plan can be easily accessed, recorded and updated in practice software
- Agreed workflows within practices consistent with the eligibility and care pathways inclusive of standard appointment profiles
- Maintain service level agreements with the participating GP practices.
- Provision of software for MDS data collection and reporting

- Recruitment and training of qualified staff
- Establish appropriate referral, monitoring, feedback and payment mechanism for approved Allied Health brokerage for patients at high risk of CVD
- Staff are supervised and monitored
- Staff are supported to participate in codesign and community of practice
- Data is monitored and uploaded as specified in the contract
- Activity is monitored and demand management strategies are enacted
- Performance review is undertaken with the PHN including incorporating program design changes if required
- Issues with HHP are monitored and reported including enablers and barriers to patient participation
- Expenditure and demand for allied health brokerage funds are managed and reported
- Opportunities for program enhancement are recorded and reported

SENSW PHN

- Provide ongoing mentoring, phone support, and site visits to commissioned practices and MDT members
- Share eligible patient lists from SPDS data every six months (noting that not all eligible patients will be able to be identified)
- Maintain a secure portal for MDS data uploads, including PROMs and PREMs
- Convene communities of practice
- Monitor and review program delivery
- Lead program evaluation and co-design activities
- Integrate sustainability considerations into program monitoring and redesign processes, focusing on long term feasibility beyond the funding window.

Consultation and Co-Design History

COORDINARE consulted stakeholders including key small general practices, the Clinical Councils, Illawarra Shoalhaven LHD, and Southern NSW LHD as to the feasibility and acceptability of this program. The stakeholders were presented with two options for the funding:

1. Pharmacy in the Practice
2. Nurses in Small Practices with the focus on CVD

The view of the key stakeholders was that the Nurses in Small Practices would provide the greatest outcome for the targeted patients.

Market sounding

In Q4 2024 COORDINARE reached out to third party practice nurse placement agencies inviting them to an industry briefing that covered off on the requirements of HHP and the region in which the practice nurses would be placed. The attendees were required to sign a confidentiality agreement prior to attending the briefing.

Discussions were held with the third-party providers around the barriers that could be faced with the placement of practice nurses in the regional areas and work arounds that the third party would put in place to mitigate the issues. Continuity of practice nurse coverage within the commissioned practices was also discussed.

Consultation regarding MDT was conducted to determine the reasons they do not employ the maximum number of nurses claimable under the Workforce Incentive program. The following key reasons were identified:

- Financial constraints
- Uncertainty regarding role of nurse
- Capacity to recruit and oversee new staff

A co-design process was undertaken with a team comprising of internal PHN subject matter experts, ISLHD and SNSWLHD and nursing SMEs from UoW (total n participants N = 19) over nine meetings held between July 2024 and April 2025.

Further co-design was undertaken by Beacon Consulting through a series of workshops in March and April of 2025. Their report can be accessed on the COORDINARE website.

Redesign

Program enhancement was included in the original program design. Between January and March 2026 co-design activities were undertaken with key stakeholders including:

- COORDINARE CEO and Executive
- Silverchain (HHP provider)
- Illawarra Shoalhaven and Southern NSW Local Health Districts
- University of Wollongong
- Program Consumers
- Tranche 1 General Practices and
- Key COORDINARE stakeholders from across all directorates

The outcome of those codesign discussions is reflected in this document including changes to eligibility criteria, roles, program and session flexibility, enhanced equity lens, inclusion of group

options, enhanced induction, program branding clarity and the decision to go to market for an additional 10 GP practices or ACCHOs in 2026-27.

Population re CVD and Service Needs

Cardiovascular Disease (CVD) is a major health concern in South Eastern NSW (SENSW), with General Practitioners (GPs) playing a critical role in reducing its impact. Despite this, studies such as the BEACH study and National Health Survey[1] reveal that nearly half of high-risk individuals are not properly screened or treated according to guidelines. CVD management is notably poorer in rural areas, leading to higher rates of morbidity and mortality compared to metropolitan regions.

Rates of CVD in SENSW

CVD significantly contributes to hospitalisation and deaths across SE NSW. In 2021–22 the SE NSW CVD death rate was 129.1 per 100,000 population[2]. This was slightly higher in Southern LHD compared to Illawarra Shoalhaven[3]. In 2022–23, there were 1564.9 CVD related hospitalisations[4], with both rate per 100,000 and number higher in the Illawarra Shoalhaven LHD, compared to Southern NSW[5]. Males consistently had higher rates of both hospitalisation and death.

The Local Government Areas (LGAs) in the region with the highest rate of CVD related hospitalisation per 100,000 population are Shellharbour, followed by Wollongong, Shoalhaven, Upper Lachlan, Kiama, and Goulburn Mulwaree[6]. However, actual numbers of hospitalisations (likely due to higher population) are highest in Wollongong LGA, followed by Shoalhaven, Shellharbour, and Eurobodalla[7]. The CVD related death rate per 100,000 in 2021–22 was highest in Eurobodalla, Snowy Monaro, followed by Upper Lachlan, Goulburn Mulwaree, Shoalhaven, and Yass[8].

While CVD prevention is needed across the region, rural and remote areas, particularly Eurobodalla, Snowy Monaro, Upper Lachlan, Goulburn Mulwaree, and Yass, may require greater support due to lower hospitalisation rates but higher death rates.

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[1] BEACH Study

[2] Centre for Epidemiology and Evidence. HealthStats NSW. Sydney: NSW Ministry of Health, Available at: https://www.healthstats.nsw.gov.au/r/119829 Accessed: 19/03/2025

[3] Centre for Epidemiology and Evidence. HealthStats NSW. Sydney: NSW Ministry of Health Available at: https://www.healthstats.nsw.gov.au/r/119850 Accessed: 20/03/2025

[4] Centre for Epidemiology and Evidence. HealthStats NSW. Sydney: NSW Ministry of Health Available at: https://www.healthstats.nsw.gov.au/r/122239 Accessed: 08/07/2025

[5] Centre for Epidemiology and Evidence. HealthStats NSW. Sydney: NSW Ministry of Health Available at: https://www.healthstats.nsw.gov.au/r/119851 Accessed: 20/03/2025

[6] Centre for Epidemiology and Evidence. HealthStats NSW. Sydney: NSW Ministry of Health Available at: https://www.healthstats.nsw.gov.au/r/119833 Accessed: 19/03/2025

[7] Centre for Epidemiology and Evidence. HealthStats NSW. Sydney: NSW Ministry of Health Available at: https://www.healthstats.nsw.gov.au/r/119833 Accessed: 19/03/2025

[8] Centre for Epidemiology and Evidence. HealthStats NSW. Sydney: NSW Ministry of Health Available at: https://www.healthstats.nsw.gov.au/r/119836 Accessed: 19/03/2025

Current supports for CVD Risk Factors in SENSW and service gaps

General Practices play a major role in supporting people to identify, treat and reduce risk factors for CVD.

Data from the Sentinel Practices Dataset (SPDS) across our target cohort of 40-50 practices showed that up to 45% of patients had high blood pressure, and 43% had high cholesterol. These conditions often co-occur, and both conditions are risk factors for CVD.

Data driven improvements in CVD risk assessments

Through the SPDS project[9], COORDINARE has been driving data-driven quality improvement in CVD management and prevention. Participating practices have been working on indicators, including:

- patients of eligible age groups who have comprehensive risk factor profile completed for absolute CVD risk assessment
- frequent blood pressure monitoring for patients with hypertension
- frequent blood pressure monitoring is done for patients with diabetes
- reduction in patients with uncontrolled hypertension

Analysis shows significant improvements across all metrics since baseline data from August 2022. HHP will continue to build on this progress, with all participating practices required to contribute to SPDS data collection.[10]

Bulk Billing

The latest COORDINARE Needs Assessment (2024/25–2026/27) indicates that access to bulk-billing primary care remains a significant challenge across South Eastern NSW, with substantial geographic variation in the availability of bulk-billing services. Bulk-billing distribution was a specific focus of new analysis undertaken for the current needs assessment cycle, which examined patterns of Medicare bulk-billing across the region and the relationship between low bulk-billing availability and areas of higher health need.[11]

Limited access to bulk-billing services continues to present barriers for people with CVD and CVD risk factors, particularly in small practices, rural communities, and areas experiencing higher socioeconomic disadvantage. These barriers may contribute to delays in seeking preventive care,

[9] https://coordinare.org.au/health-professionals/tools-and-resources-for-general-practice/data-quality
[10] STAR Portal SPDS QI Snapshot (ad-hoc backend data analysis), COORDINARE (Internal use Only)
[11] Needs Assessment 2024/25-2026/27

reduced attendance for chronic condition management, and challenges in achieving continuity of care.

The Needs Assessment also highlighted several persistent gaps in chronic condition management across the region, including:

- Poor coordination of care and limited availability of affordable, timely services for referral
- Limited access to affordable prevention programs targeting modifiable risk factors
- Medication management issues contributing to preventable hospitalisations
- Concerns regarding the appropriateness and effectiveness of self managed care plans, including the need for more collaborative, person-centred planning processes

Principles of Primary and Secondary CVD Prevention in the Healthy Hearts Program

- Primary prevention refers to the inclusion of people in the program based on population level risk factors of CVD including age and ethnicity and individual risk factors such as hypercholesteremia or hypertension. HHP assessment and interventions are aimed at preventing the onset of CVD through evidence-based interventions to address modifiable risks. CVD prevention is the focus of care.
- Secondary prevention in cardiovascular disease focuses on reducing recurrent events through evidence based measures, including lipid and blood pressure control, antiplatelet therapy, smoking cessation, cardiac rehabilitation, optimal nutrition, physical activity, and adherence to medications, strengthening long term health and lowering mortality risks for people with established conditions to improve overall clinical outcomes. The focus if care is preventing further cardiac events.
- Health coaching through personalised risk assessment and motivational interviewing enables individuals to make active decisions about their own health and act on those decisions.
- Early intervention in the disease pathway can modify individual risks and delay or prevent the onset of CVD or further cardiac events.
- Self-management is required to enable sustained behavioural changes that will improve health outcomes
- Access to appropriate and timely health interventions including pharmacology, lifestyle interventions and allied health care are enablers of improved health outcomes in the primary care environment

Research

CVD is a leading cause of death and hospitalisation in Australia. CVDs are a group of disorders of the heart and blood vessels and include coronary heart disease, cerebrovascular disease, rheumatic heart disease, stroke and other conditions.

The Australian Government issued the Guideline for assessing and managing CVD risk and Australian CVD risk calculator in 2023**.** [12] The clinical guidelines for the basis of the evidence for the assessment and intervention measures in HHP. The risk factors that indicate the need for assessment of CVD risk are summarised below in Table 2.

Table 2: Risk Factors for CVD

Category	Factors
Socioeconomic Factors	• SEIFA quintiles by postcode • Additional disadvantages for First Nations patients
Lifestyle Factors	• Nutrition • Alcohol use • Obesity • Physical inactivity • Smoking status
Clinical Risk Factors	• Hypertension • Hyperlipidaemia • Diabetes (ages 35–79) • Family history of hyperlipidaemia • Family history of premature CVD • CVD medications in the past 6 months • Moderate to severe chronic kidney disease • History of hypertensive disorders of • pregnancy (<34 weeks) • History of pre-eclampsia • History of gestational diabetes • Menopause

[12] Australian Guideline for Assessing and Managing Cardiovascular Disease Risk, Commonwealth of Australia 2023

The Role of Registered Nurses in CVD Management in Primary Care Settings

While the Healthy Hearts Program is delivered by HHP staff who may be Registered Nurses or suitably qualified Allied Health Practitioners, much of the published evidence relates to nurse-led models of care.

RNs are vital to delivering best-practice care and enhancing general practice performance[13], as supported by Australia's Primary Health Care 10 Year Plan[14]. However, COORDINARE's needs assessment reveals inequities in RN workforce distribution across SENSW[15], with small practices often unable to hire RNs due to financial and governance constraints.

To address this, HHHM will place RN positions into primary care environments to lead MDT care, improving patient outcomes, supporting GPs to optimise their workflow and scope of practice.

For external Allied Health Practitioners, RN-led MDTs offer a single point of contact and more integrated care. For patients, this means more timely, holistic, and coordinated support.

Evidence shows that RN led MDTs significantly improve the management of CVD in a general practice setting, both internationally[16,17,18]and in Australia[19,20,21] Studies that did not involve a

[13] Bodenheimer T, Ghorob A, Willard-Grace R, & Grumbach K. (2014). The 10 building blocks of high-performing primary care. *Ann Fam Med*, *12*, 166-171. https://doi.org/10.1370/afm.1616

[14] Department of Health. (2022). *Future focused primary health care: Australia's Primary Health Care 10 Year Plan 2022-2032*. Commonwealth of Australia. www.health.gov.au/resources/publications/australias-primary-health-care-10-year-plan-2022-2032?language=en

[15] Ghosh, A. (2024). *Population Health Profile: South Eastern NSW*. Wollongong: COORDINARE - South Eastern NSW PHN. www.coordinare.org.au/assets/Population-Health-Profile.pdf

[16] Tideman, P., Taylor, A. W., Janus, E., Philpot, B., Clark, R., Peach, E., Laatikainen, T., Vartiainen, E., Tirimacco, R., Montgomerie, A., Grant, J., Versace, V., & Dunbar, J. A. (2013). A comparison of Australian rural and metropolitan cardiovascular risk and mortality: the Greater Green Triangle and North West Adelaide population surveys. *BMJ Open*, *3*(8), e003203. https://doi.org/10.1136/bmjopen-2013-003203

[17] Connolly, S. B., Kotseva, K., Jennings, C., Atrey, A., Jones, J., Brown, A., Bassett, P., & Wood, D. A. (2017). Outcomes of an integrated community-based nurse-led cardiovascular disease prevention programme. *Heart*, *103*(11), 840-847. https://doi.org/10.1136/heartjnl-2016-310477

[18] Mohammed, M. A., El Sayed, C., & Marshall, T. (2012). Patient and other factors influencing the prescribing of cardiovascular prevention therapy in the general practice setting with and without nurse assessment. *Med Decis Making*, *32*(3), 498-506. https://doi.org/10.1177/0272989X12437246

[19] Stephen, C., Halcomb, E., Fernandez, R., McInnes, S., Batterham, M., & Zwar, N. (2022). Nurse-led interventions to manage hypertension in general practice: A systematic review and meta-analysis. *J Adv Nurs*, *78*(5), 1281-1293. https://doi.org/10.1111/jan.15159

[20] Bulto, L. N., & Hendriks, J. M. (2024). The role of nurse-led interventions to empower patients in cardiovascular care. *Eur J Cardiovasc Nurs*, *23*(2), e17-e19. https://doi.org/10.1093/eurjcn/zvad095

[21] Carrington, M. J., & Stewart, S. (2015). Cardiovascular disease prevention via a nurse-facilitated intervention clinic in a regional setting: the Protecting Healthy Hearts Program. *Eur J Cardiovasc Nurs*, *14*(4), 352-361. https://doi.org/10.1177/1474515114537022

dedicated RN with protected time for CVD assessment and management in a general practice setting were less successful.[22,23]

RN programs are based in the principles of patient centred care, aim to enhance patient understanding of their health and supporting them to develop the skills to manage and make active and informed decisions about their health.

The roles that RNs play in CVD prevention programs can vary. APNA have recently released a suite of resources that highlight the roles of RNs in General Practice. It supports RNs carrying out six core roles.[24]

Allied Health Practitioners in CVD Prevention and Management

There is evidence that Allied Health Professionals including Exercise Physiologists (EPs), and Dietitians have an important role to play in behaviour change coaching and lifestyle modification in reducing CVD risks[25] and mental health disorders[26]. The evidence for health interventions from EPs includes clinical exercise therapy and behavioural modifications[27]. For Dietitians, face-to-face dietetic consultations encompassing behaviour change and education have been found to be effective in improving mental health and reducing lipid levels[28] [29] [30]. Dietitians and Exercise Physiologists will be engaged by HHP RNs to offer evidence-based assessments and interventions for patients within the program.

Self-management in CVD Prevention and Management

"Despite the importance and effectiveness of self-care in preventing and managing CVD, many individuals find it challenging to make enduring modifications in lifestyle behaviours, take care of their mental health, and deal with chronic conditions."[31]

[22] Connolly, S. B., Kotseva, K., Jennings, C., Atrey, A., Jones, J., Brown, A., Bassett, P., & Wood, D. A. (2017). Outcomes of an integrated community-based nurse-led cardiovascular disease prevention programme. *Heart*, *103*(11), 840-847. https://doi.org/10.1136/heartjnl-2016-310477

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[27] The value of accredited exercise physiologists to consumers in Australia Deloitte 2016

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[29] Effectiveness of dietetic consultation for lowering blood lipid levels in the management of cardiovascular disease risk: A systematic review and meta-analysis of randomised controlled trials Ross et al 2019

[30] S A Korenhof, E V Rouwet et al Evaluation of an Intervention to Promote Self-Management Regarding Cardiovascular Disease: The Social Engagement Framework for Addressing the Chronic-Disease-Challenge (SEFAC), International Journal of Environmental Research and Public Health 2022 19 (20) https://doi.org/10.3390/ijerph192013145

[31] AIHW General practice, allied health and other primary care services Web article updated 19 March 2025

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Self-management plays a crucial role in managing cardiovascular disease (CVD) risk by empowering individuals to actively participate in their care, monitor their condition, adhere to treatment plans, and adopt healthy lifestyles, ultimately improving outcomes and quality of life. On average Australians see their GPs 6.2 times per year[32]. This means that the vast majority of management of clinical and lifestyle risk management fall on the patient to self-manage.

"*Self-management education programs are distinct from simple patient education or skills training, in that they are designed to allow people with chronic conditions to take an active part in the management of their own condition. Effective self-management of hypertension and CVD consists of self-monitoring of disease control and symptoms; knowing when blood pressure levels or symptoms indicate a problem; responding with appropriate actions (adjust medications, initiate call to a health care provider); making major lifestyle changes (e.g., stop smoking, reduce alcohol consumption, modify diet, lose weight, and increase exercise); adhere to medication regimens (even in the absence of symptoms), some of which are inconvenient or produce side effects; identify and respond to the psychosocial contributors to chronic disease management; and maintain regular contact with health care provider for monitoring progress. Thus, self-management programs designed to reduce the impact of CVD might include components to address each of the problems listed above by (1) promoting patient-centred care and improving physician-patient communication, (2) increasing patients' adherence to recommended medications and self-care regimens, (3) facilitating greater communication between physicians and patients, (4) making medical care more evidence-based through proven health behaviours, and (5) increase focus on self-monitoring (e.g., weight, blood pressure, glucose levels, etc).*"[33]

HHP will address this through

- Facilitating patient centred care and health literacy through health coaching activities.
- Increasing accountability through monitoring of agreed activities in the "my healthy heart management plan."
- Enhanced MDT communication within the primary care team including regular RN led review of MDT treatment and connection back to the GP and other health and allied health practitioners.
- Enhancing compliance with evidence-based interventions for clinical and lifestyle risk factors.
- Improving self-monitoring activities and help seeking behaviours including referrals to the Get Healthy NSW health Coaching initiative.

Success factors for MDT for CVD

Communication

- For the model to work effectively, it is essential that there is good communication between HHP and the practice staff.
- HHP staff will need to communicate with the practice team via regular meetings and practice management software.
- The HHP staff will work with the GP to conduct a CVD risk assessment, and identify which participants require a chronic disease management plan, team care arrangement or a mental health treatment plan and medication review in line with current guidelines (e.g. NHF hypertension guidelines, statin guidelines).
- The GP will facilitate referrals to a cardiologist or other specialists as necessary.

MDT Management

- CVD risk is often complex and multifactorial, requiring a holistic approach that considers various risk factors and comorbidities. MDT care allows for a more comprehensive assessment and management of these factors. [34]

Improved Risk Factor Control

- MDT interventions have been shown to significantly reduce cardiovascular risk factors like hypertension, hyperlipidaemia, and blood sugar levels. [35]

Better Patient Outcomes

- Studies indicate that MDT care can lead to lower readmission rates, reduced mortality, and improved quality of life for patients with CVD. [36]

[34] Merseburger, A.S., Bakshi, G., Chen, DY. *et al.* cardiovascular disease risk assessment and multidisciplinary care in prostate cancer treatment with ADT: recommendations from the APMA PCCV expert network. *World J Urol* 42, 156 (2024). https://doi.org/10.1007/s00345-024-04852-2

[35] Qiang Tu et al The effects of multidisciplinary collaborative care on cardiovascular risk factors among patients with diabetes in primary care settings: A systematic review and meta-analysis. Primary Care Diabetes Volume 18 Issue 4 pp 381-392

[36] Nieto-Martinez et al Impact of a Multidisciplinary Approach on Cardiometabolic Risk Reduction in a Multiracial Cohort of Adults: A 1-Year Pilot Study. Nutrients 2022 Aug 18:14 (16) 3391

Enhanced Patient Engagement

- A team approach fosters better communication and collaboration between healthcare professionals and patients, leading to improved adherence to treatment plans and self-care practices. [37]

Specialised Expertise

- MDTs bring together specialists with expertise in different areas of CVD risk reduction such as Exercise Physiologists, Dietitians and Mental Health professionals ensuring patients receive the best possible care. [38]

Improved Medication Safety

- MDTs can help optimize medication regimens, reduce the risk of drug interactions, and improve medication adherence. [39]

Focus on Comorbidities

- CVD risk includes chronic conditions, such as diabetes, kidney disease, and mental health issues. MDTs can address these comorbidities effectively, leading to better overall health outcomes.[40]

[37] Hendriks, J. M., Jaarsma, T., (2021), The multidisciplinary team approach in cardiovascular care, European Journal of Cardiovascular Nursing, 20(2), 91-92. https://doi.org/10.1093/eurjcn/zvaa005

[38] Nieto-Martinez et al Impact of a Multidisciplinary Approach on Cardiometabolic Risk Reduction in a Multiracial Cohort of Adults: A 1-Year Pilot Study. Nutrients 2022 Aug 18:14 (16) 3391

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Appendix 1: Appointment inclusions

Each appointment will include a number of activities. These are outlined in the tables below.

Activities
Consent (required at first appointment)
Patient engagement
Patient history taking including CVD risk history e.g. smoking, pre-eclampsia, review of referral documents, GPCCMP etc.
Patient education re CVD risk assessment and treatment including motivational interviewing
Observations incl. weight, height, blood pressure
CVD risk assessment completed via CVD risk Calculator
"Heart Health Risk Assessment" template completed and upload to EMR
Consider interventions including lifestyle/allied health/GP and discuss with the patient and record if recommended
Health coaching and motivational interviewing approaches to lifestyle changes and interventions such as smoking cessation, dietary changes etc.
Agree with the patient on and complete "My Healthy Heart Management Plan" and provide a printed copy to the patient and upload to EMR
Provide referral information +/- warm referral for the patient to support the "My Healthy Heart Management Plan"
Provide or refer for opportunistic health interventions that will optimise patient management and contribute to reduced CVD risk e.g. appropriate immunisations, medication repeat reminders etc.
Consider internal referrals for further GP management such as GPCCMP, Mental Health Treatment Plan, Home Medication Review, Nicotine Replacement Therapy, prescribing appointment etc. and record if recommended
Book next appointment based on clinical decision making or exit from program
Patient completes PROMS (EQ-5D-5L) and PREMS (NPS)
Consider using brokerage for allied health referral especially to an Exercise Physiologist or Dietitian to support "My Healthy Heart Management Plan"

Version control

Version N	Date	Comments
Version 1	8/7/2025	Good Draft, Not for Publication
Version1.1	6/8/2025	Ready for publication. Added link to Beacon consultation document and added menopause as a clinical risk factor
Version 2	20/01/2026	Major changes to services directed by Executive re eligibility and scheduling
Version 2.1	31/02/2026	Version updated to reflect comprehensive stakeholder consultations