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**PDSA Worksheet**

**Heart Health (February 2025)**

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# Heart Health Checks and GPMPs

## Maximising Patient Care Through Heart Health Checks and GP Management Plans

Heart Health Check is an assessment to identify individuals at risk of cardiovascular disease (CVD). It's available under MBS item 699 for GPs and MBS item 177 for Aboriginal Medical Services. These checks are billable once every 12 months for patients aged 30+ without a CVD diagnosis and with risk factors, including chronic conditions. The Medicare rebate is $85.60 for each of these items. The Heart Health Check detects CVD risk early, enabling preventive measures like lifestyle modifications or medical interventions.

GP Chronic Disease Management Plan (GPMP) helps patients with chronic conditions manage their health through coordinated care. Key MBS item numbers include:

* 721 (GPMP Preparation)
* 732 (GPMP Review)

The GPMP provides structured, multidisciplinary care, improving chronic disease management and patient outcomes.

Combining both ensures comprehensive management of cardiovascular risk and related chronic conditions, improving long-term health outcomes and preventing complications.

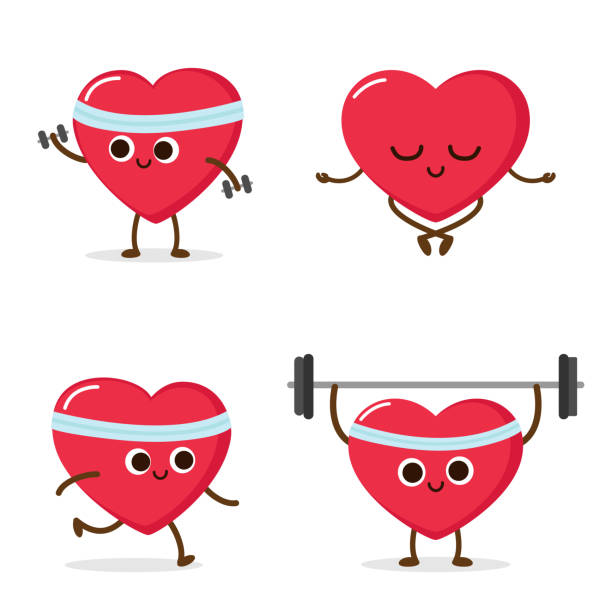
A close-up of a computer screen

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# QI Activity

## Outline Your QI Activity

|  |  |
| --- | --- |
| **QI Activity Name:** | Identify at risk patients who have a chronic condition and are eligible for both a Heart Health Check and a GP Chronic Disease Management Plan. |
| **Rationale:** | Various chronic conditions are often linked with increased risk of heart disease1. It is therefore important to conduct absolute CVD risk assessments (Heart Health Checks) for patients with chronic diseases. This recipe will identify patients who are eligible for both a Heart Health Check and a GP chronic disease management plan.  *1. National Vascular Disease Prevention Alliance. Guidelines for the management of absolute cardiovascular disease risk. 2012.* |
| **Target:** | Patients aged 30 and over with no diagnosis of CVD and any of the following conditions:   1. Diabetes 2. Respiratory conditions 3. Chronic renal failure 4. Musculoskeletal diseases 5. Cancer   Target patients must also not have claimed a Heart Health Check, GP chronic disease management plan, or any other health assessment in the previous 12 months. |



# Pen CS

## CAT4 Recipe

On the General tab enter age criteria (start age 30) and active status:

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On the Conditions tab select the 'No' for existing CVD:

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On the MBS Attendance tab, exclude all patients with health assessments, GPMPs or heart health checks claimed in the past 12 months. Make sure you exclude all items for a GPMP to this filter. Currently the relevant items are: 721, 229, 92024, 92068, 92055, 92099. You will only see items that have been claimed in your practice, so if you don't see the item 177 it might be because it has never been claimed at your practice.

A screenshot of a computer

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Now all filter criteria have been set, please click on 'Recalculate' to apply the filter:



To see the full report, first minimise the filter panel by clicking on the  A black and white text

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**Part 1 - Find patients with chronic conditions (excluding cancer)**

Now that we have applied the above filter, we need to find those patients with any of the specified chronic conditions. To find those patients use the Disease report and click on the bars as shown below to select any of those conditions.

A screenshot of a graph

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Click in the 'Export' icon in the top right to see the patients with the selected conditions. All of them will have no GPMP/Heart Health Check or Health Assessment claimed in the last 12 months as well as the other filter criteria.

A screenshot of a computer

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**Part 2 - Find patients with cancer**

If you haven't done so already, please clear the selected conditions from the 'Disease' filter. Then click on the 'Cancer Conditions' report tab and then click on 'Select All' to add those patients to our search:

A screenshot of a graph

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Click on the 'Export' button in the top right to see a list of all patients with cancer.

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Click on the drop-down arrow next to the Floppy Disc ‘Save’ Icon. This is where you will select how you would like to save the file. Alternatively, you can select the ‘Print’ icon to print a hardcopy.

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**Note:** Please ensure your PDSA reflects the filters and reports you select so that it accurately identifies your patient cohort. It is also worth noting, if your cohort is MBS claim related, that CAT4 will only consider MBS items claimed/not claimed at your practice. You may find that some patients have had the item billed at another clinic. However, as we have filtered for ‘active’ regular patients, these sorts of assessments should, ideally, be completed at your clinic.

Ensure that the patient count is manageable. Your practice staff will need to have the capacity to receive x number of calls and be able to book x number of appointments. Smaller more manageable numbers are recommended as the total number of recalls (if you choose to recall) is irrelevant to fulfilling PIP QI quarterly activity requirements.

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## Topbar - MBS App

To access the [MBS App](https://help.pencs.com.au/display/TUG/MBS+App), click on the 'MBS' title in Topbar. This will display guidelines for eligible patients. Apps in Topbar are by default only displayed when there is any activity indicated for the patient open in the clinical system.

A screenshot of a video game

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The [Heart Health Check Item](https://help.pencs.com.au/display/TUG/Heart+Health+Check+Item) was added to the MBS app and will show if the patient is eligible for the item based on age, existing CVD conditions and billing history at your practice. The item shows all mandatory components and their status:

A screenshot of a computer

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In the example above, the patient record already contains a systolic blood pressure taken in the last 12 months, a total cholesterol (in the last 5 years) and a smoking status (also in the last 5 years). This can help the clinician to decide if there is an opportunity to complete the remaining items during the current patient consult. The orange colour indicates that an item can't be entered manually. This colour code varies, as some clinical systems allow users to manually enter a lipid result for any patient, but Best Practice doesn't allow this. The red colour indicates a missing item that is linked to your clinical system, and a click on the red dot will open the corresponding screen in your system, in this case the CV Event Risk calculator.

If your clinic would prefer a more specific notification, you can create a CAT Prompt.

**CAT Prompts**

[CAT Prompts](https://help.pencs.com.au/display/CP/Topbar) are created in CAT4 (on the practice level). Prompts created in CAT4 in the practice are effective immediately and don't need any further activation in Topbar to be displayed.

A screenshot of a phone

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If you would like some assistance creating a CAT Prompt for your Topbar notifications, please contact the PHN via [practicesupport@ddwmphn.com.au](mailto:practicesupport@ddwmphn.com.au)

# PHN Exchange

PHN Exchange is an innovative, web-based quality improvement tool that benchmarks your practice data against the PHN catchment average, offering valuable insights to identify areas for improvement. By supporting your practice in influencing and enhancing health outcomes, PHN Exchange aids in data-driven decision-making. Practices sharing data with us can access PHN Exchange via [PHN Exchange Portal](https://phnexchange.com.au/home.html?phn=304). Use benchmarking reports to track progress, align with PIP QI activities, and strategically plan for proactive practice management.

## GP (General Practice) Data Reports

Your practice can view trends over a 12-month period via your ‘GP Hub’.

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**How to use this information**

|  |  |
| --- | --- |
| **Step** | **Action** |
| **1. Benchmarking Performance** | Compare your practice’s percentage to the PHN average to see how well you are doing. Identify months where your practice is above or below the PHN average. |
| **2. Identifying Trends** | Look for patterns or trends, such as whether your practice’s percentage is increasing or decreasing over time. Use this data to inform your quality improvement activities. |
| **3. Setting Goals** | Set realistic goals for your practice based on the PHN average. Aim to meet or exceed the PHN average to improve patient care. |
| **4. Planning Interventions** | Use the data to identify when interventions might be needed to make an improvement. Monitor the effectiveness of any changes by observing subsequent data points. |

If you require assistance logging into your practice’s PHN Exchange, please email [practicesupport@ddwmphn.com.au](mailto:practicesupport@ddwmphn.com.au)

**NEXT STEP…**

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Identify at-risk patients with a chronic condition and are eligible for Heart Health Check and GPMP

**NOTE:** This is an example of how you may wish to complete your PDSA template. Please update to align with your goals, findings, and reflections.



|  |  |
| --- | --- |
| **Practice name:** | **Date:** |
| **Team member:** | |
| **Q1. What are we trying to accomplish? (Goal)** | |
| *By answering this question, you will develop your GOAL for improvement* | |
| Our goal is to:   * Increase the identification of regular (active) patients aged 30 years and over, with specific chronic conditions and no diagnosis of CVD, who are eligible for both a Heart Health Check and a GP Chronic Disease Management Plan and have not claimed a Heart Health Check, GP Chronic Disease Management Plan, or any other health assessment in the previous 12 months.   **This is a good start, but how will you measure whether you have achieved this goal? The team will be more likely to embrace change if the goal is more specific and has a time limit.**  *Example - Our S.M.A.R.T. goal is to:*   * Increase the proportion of active eligible patients identified for Heart Health Checks and Chronic Disease Management Plans by [insert percentage] % by the end of the PIP quarter. | |
| **Q2. How will you know that a change is an improvement? (Measure)** | |
| *By answering this question, you will develop MEASURES to track the achievement of your goal.*  *E.g., Track baseline measurement and compare results at the end of the improvement.* | |
| The measures we will use are:   * Record the baseline number and percentage of regular patients aged 30 years and over with specific chronic conditions (diabetes, respiratory conditions, chronic renal failure, musculoskeletal diseases, cancer) who have no diagnosis of CVD and have not claimed a Heart Health Check or GP Chronic Disease Management Plan in the last 12 months. * Compare results at the end of the PIP quarter. * Aim to achieve our SMART goal target (refer to Q1.).   **Baseline Measurement:** [Insert Baseline]  - Date: [Insert Date]  **Results Measurement:** [Insert Results]  - Date: [Insert Date]  **Difference:** [Insert % Difference]  **Was there an improvement?** Yes/No | |
| **Q3. What changes could we make that will lead to an improvement? (List your IDEAS)** | |
| *By answering this question, you will develop the IDEAS that you can test to achieve your CHANGE goal.*  *You may wish to BRAINSTORM ideas with members of our Practice Team.* | |
| **Our ideas for change:** *Examples of what you might wish to include listed below.*   1. *Conduct a team meeting to ensure all relevant team members are aware of the PIP QI focus for the quarter and highlight the importance of identifying this patient cohort.* 2. *Complete a CAT4 search for patients aged 30 years and over with no diagnosis of CVD and at least one of the specified chronic conditions (diabetes, respiratory conditions, chronic renal failure, musculoskeletal diseases, cancer) who have not claimed a Heart Health Check or GP Chronic Disease Management Plan in the previous 12 months.* 3. *Regularly use Pen CS CAT4 and/or Topbar to track and report the percentage of eligible patients in this cohort and monitor progress throughout the PIP quarter.* 4. *Use health promotion materials and patient communication (e.g., SMS, phone calls, letters) to inform patients about Heart Health Checks and Chronic Disease Management Plans and encourage them to book appointments.* 5. *Utilise PHN Exchange to track trends in GPMP claims over time.* 6. *Consider creating a specific CAT Prompt Topbar notification to flag this patient cohort during consultations.* [*https://help.pencs.com.au/display/CP/Topbar*](https://help.pencs.com.au/display/CP/Topbar) | |



You will have noted your IDEAS for testing when you answered the third Fundamental Question in Step 1.

You will use this sheet to test an idea.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| PLAN | | | Describe the brainstorm idea you are planning to work on. (Idea) | |
| *Plan the test, including plan for collecting data* | | | *What exactly will you do? include what, who, when, where, predictions, and data to be collected* | |
| A diagram of a plan  Description automatically generatedIdea: Increase % of patients by the end of the current PIP quarter [insert date]  What: QI staff will complete the CAT4 search for patients aged 30 years and over with no diagnosis of CVD, with specified chronic conditions, and without Heart Health Check or GP Chronic Disease Management Plan claims in the last 12 months.  Who: QI Staff - [List names of QI staff involved]  When: Start [insert date] [insert PIP quarter]  Where: Within the practice  Prediction: *Example - The practice has not specifically focused on identifying patients eligible for both a Heart Health Check and a GP Chronic Disease Management Plan. The baseline number of identified patients will likely be [low]. The campaign is expected to raise awareness and improve patient identification by the end of the improvement period.* | | | | |
| DO | **Who is going to do what? (Action)** | | | |
| *Run the test on a small scale* | *How will you measure the outcome of your change?* | | | |
| Data collection as outlined in Q2. Record the percentage of eligible patients at the beginning and end of the PIP QI quarter. This will establish the outcome of the QI activity, indicating whether it was successful. The awareness campaign will be run within the practice, with QI staff responsible for communicating the importance of identifying patients eligible for both Heart Health Checks and GP Chronic Disease Management Plans to practice staff. | | | | |
| STUDY | | **Does the data show a change? (Reflection)** | | |
| *Analyse the results and compare them to your predictions* | | *Was the plan executed successfully?*  *Did you encounter any problems or difficulty?* | | |
| Date Completed: [Insert Date]  Results: [Insert Baseline, Results, and Difference]  [List if plan was executed successfully and any problems of difficulties encountered]  *Example - [Insert start date] Approx. 150 patients appeared in the CAT4 search as eligible for both a Heart Health Check and GP Chronic Disease Management Plan. At the end of the QI activity [insert results date], there were 120 eligible patients remaining. This showed a 20% improvement. Some difficulties arose as some patients did not respond to the clinic's outreach efforts. We needed to implement a more targeted patient recall system and increase clinician involvement in discussing these assessments during regular consultations.* | | | | |
| ACT | | | | **Do you need to make changes to your original plan? (What next)**  **OR did everything go well?** |
| Based on what you learned from the test, plan for your next step | | | | *If this idea was successful, you may like to implement this change on a larger scale or try something new. If the idea did not meet its overall goal, consider why not and identify what can be done to improve performance* |
| If this idea was successful: *Examples of what you might wish to include listed below.*   1. Implement the change on a larger scale. 2. Consider additional strategies to target patients more effectively, such as using automated patient reminders, SMS campaigns, or outreach programs.   If the idea did not meet its overall goal:   * Identify what can be done to improve performance, such as improving patient recall processes or engaging clinicians to actively promote the Heart Health Check and Chronic Disease Management Plan during routine consultations. | | | | |

# Digital Health

**Digital Health Tools to Assist with QI**

**HealthPathways**

A local online portal for GPs and health professionals, providing clinical assessment, management information, and referral pathways to local services. Developed by experienced local GPs, HealthPathways is intended as the primary tool for consultations and decision-making. DDWMPHN supports two portals: Darling Downs and West Moreton.

* Access: [DDWM HealthPathways](https://www.ddwmhealthpathways.com.au/)

**Smart Referrals**

Smart Referrals streamlines the creation and management of referrals to Queensland specialist outpatient services, enhancing patient journey management, safety, and reducing wait times. GPs can submit electronic referrals via practice software.

* Learn more: [Queensland Health](https://www.health.qld.gov.au/clinical-practice/innovation/smart-referrals)
* Installation and additional resources: [Smart Referrals](Smart%20Referrals)

**The Viewer (Queensland Health)**

The Health Provider Portal (HPP) offers read-only access to Queensland Health’s “The Viewer” system, allowing GPs to see public hospital records such as appointments, radiology results, and discharge summaries.

* Access: [The Viewer](https://www.health.qld.gov.au/clinical-practice/database-tools/health-provider-portal/gps-resources/support)
* Support: [connectingqld@health.qld.gov.au](mailto:connectingqld@health.qld.gov.au)

**My Health Record**

Uploading a Shared Health Summary (SHS) for chronic/complex patients ensures continuity of care and meets ePIP requirements.

* Learn More: [Digital Health Agency](https://www.digitalhealth.gov.au/healthcare-providers/initiatives-and-programs/my-health-record)
* How to upload SHS videos: [Best Practice](https://www.youtube.com/watch?v=CO0TW3P9DRU) | [Medical Director](https://www.youtube.com/watch?v=RlcjR9EBD1w)
* RACGP info: [My Health Record Resources](My%20Health%20Record%20Resources)
* Register for My Health Record: [Registration Overview](http://www.myhealthrecord.gov.au/for-healthcare-professionals/howtos/registration-overview)

**Electronic Prescriptions**

Electronic prescriptions enhance medicine safety and provide patients with convenient, digital alternatives to paper PBS prescriptions. They allow for the prescribing, dispensing, and claiming of medicines electronically, while maintaining the option for paper prescriptions. Patients can choose their pharmacy and decide between paper or electronic prescriptions, with no change to existing processes.

* Learn more: [Digital Health Agency](https://www.digitalhealth.gov.au/get-started-with-digital-health/electronic-prescriptions/for-prescribers)



# Resources

## Resources for Clinicans

**Pen CS and PHN Exchange**

Pen CS [Vimeo Training Videos](https://vimeo.com/pencs)

Pen CS Support: Email: [support@pencs.com.au](mailto:support@pencs.com.au)

Phone: 1800 762 993

Live Support (Available via website) <https://www.pencs.com.au/support/>

Pen CS [GP Resources Portal](https://www.pencs.com.au/gp-resources-portal/)

Pen CS [CAT4 Recipes](https://help.pencs.com.au/display/CR)

Pen CS [Topbar User Guide](https://help.pencs.com.au/display/TUG/TOPBAR+GENERAL+USER+GUIDE)

Pen CS [CAT Plus User Guide](CAT%20Plus%20User%20Guide)

Pen CS [Webinars](https://www.pencs.com.au/support/webinars/)

PHN Exchange [Login Portal](Login%20Portal)

Requesting PenCS and PHN Exchange Training: [practicesupport@ddwmphn.com.au](mailto:practicesupport@ddwmphn.com.au)

**PIP**

QI PDSAs: [practicesupport@ddwmphn.com.au](mailto:practicesupport@ddwmphn.com.au)

PRODA (Direct Contact): Phone: 1800 700 199

Services Australia (PIP): Email: [pip@servicesaustralia.gov.au](mailto:pip@servicesaustralia.gov.au)

Phone: 1800 222 032

Website: <https://www.servicesaustralia.gov.au/practice-incentives-program>

**General**

* [Heart Foundation - Downloaded Resources incl. Clinical Software Templates](https://www.heartfoundation.org.au/heart-health-check-toolkit/downloadable-resources)
* [Australian Centre for Heart Health](https://www.australianhearthealth.org.au/)
* [Healthdirect - Heart and Cardiovascular Conditions](https://www.healthdirect.gov.au/heart-and-cardiovascular-conditions)

## Resources for Patients

**General**

* [Heart Foundation - Keeping Your Heart Healthy](https://www.heartfoundation.org.au/healthy-living/keeping-your-heart-healthy)
* [Heart Foundation - Heart Health Check Toolkit](https://www.heartfoundation.org.au/heart-health-check-toolkit)
* [Queensland Government - Heart Health](https://www.qld.gov.au/health/staying-healthy/men-women/men/heart)
* [DVA - Heart Health Program](https://www.dva.gov.au/get-support/health-support/work-and-social-life-programs/heart-health-program)

# Acknowledgements

We would like to acknowledge that some material contained in this PDSA Worksheet has been extracted from organisations including, but not limited to, the Institute of Healthcare Improvement, the Australian Government Department of Health, and Pen CS.

The information in this PDSA Worksheet does not constitute medical advice and Darling Downs and West Moreton PHN accept no responsibility for how information in this PDSA Worksheet is interpreted or used.

Should the document require updating or if any errors are identified please contact your PHN Primary Care Liaison Officer or email [practicesupport@ddwmphn.com.au](mailto:practicesupport@ddwmphn.com.au)



