PHASES

QI TOOLKIT
FOR GENERAL PRACTICE

Primary Health

High CVD Risk Screening, Recall and Treatment

A practical guide to support primary care providers at improving cardiovascular disease (CVD) outcomes through early identification, intervention, and management as a CQI activity.

In partnership with:

Australian Government

Queensland Government

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An Australian Government Initiative

Acknowledgement

We acknowledge the Traditional Custodians of the lands on which we work and live and recognise their continuing connection to land, waters and community. We pay our respect to them and their cultures and to Elders past, present and emerging.

PHASES is a statewide initiative to transform cardiovascular health in Queensland by empowering primary care to lead preventive, data-driven solutions. Learn more about how PHASES aims to improve health outcomes for individuals and communities at phasesqld.com

Disclaimer and Recognition

While the Australian and Queensland Governments helped fund this document, they have not reviewed the content and are not responsible for any injury, loss or damage however arising from the use of or reliance on the information provided herein.

Clinical judgement remains essential. The PHASES tools and resources are intended to support clinical decision-making and quality improvement. They do not replace the need for individual clinical assessment, professional judgement, or discussion with patients. Clinical judgement, patient preferences, and current clinical guidelines must always guide assessment and management decisions.

We acknowledge the National Improvement Network Collaborative (NINCO) for the template that guided the development of this Quality Improvement Toolkit. NINCO's work has provided a strong foundation to design a practical tool that meets the needs of the PHASES initiative and supports primary care teams to strengthen CVD prevention through quality improvement.

The information in this toolkit does not constitute medical advice.

Due to constant developments in research and health guidelines, the information in this document will be updated as required.

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Where to get help?

Contact the PHASES with Primary Sense team:
phasesqld.com/contact

About this activity

High CVD risk screening, recall and treatment

Cardiovascular disease (CVD) is the second leading cause of death in Australia , but most cases are preventable. Modifiable risk factors account for 80% of heart attack risk, and over half of adults have three or more risk factors , making prevention in primary care essential.

New national guidelines were introduced in 2023 with the new CVD risk calculator and the Heart Health Check to support general practice to assess CVD risk and intervene early. Widespread use could prevent over 76,000 CVD-related events in five years .

This toolkit is specifically designed to increase CVD prevention in primary care. It will help general practices identify key actions to drive early identification, intervention and management, using data-driven strategies.

Why use this Toolkit?

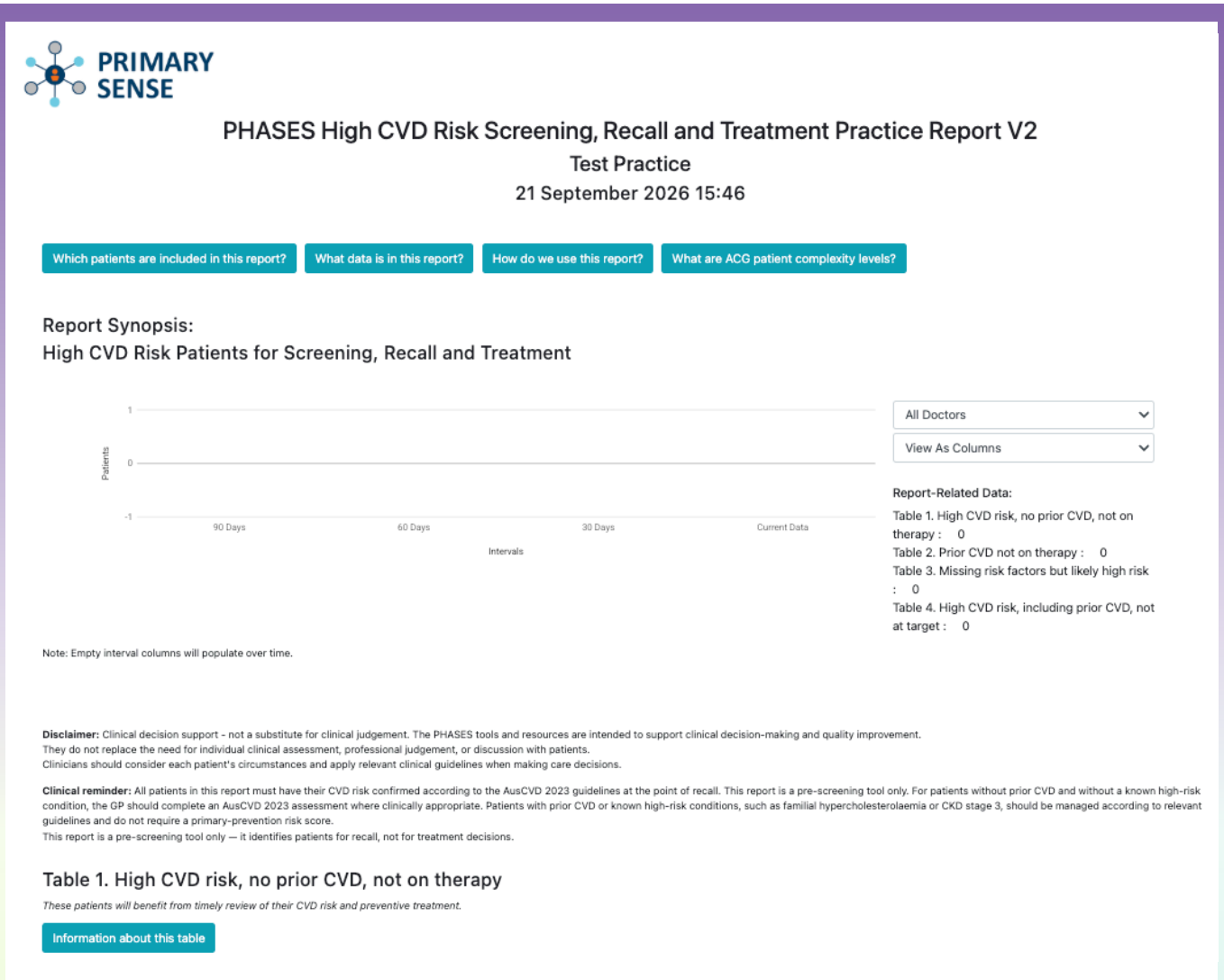
Identify at-risk patients	Use Primary Sense reports to proactively screen cardiovascular risk factors.
Increase Heart Health Checks	Systematically recall eligible patients and use the CVD risk calculator to assess and manage their risk.
Leverage incentives	Maximise use of relevant MBS items and align activities with programs like PIP QI.
Follow best practice	Use HealthPathways and meet RACGP accreditation and CPD requirements.
Access support	Connect with your PHN for training, resources, and ongoing assistance in CVD prevention and management.

1. Australian Institute of Health and Welfare (2024) Heart, stroke and vascular disease: Australian facts: www.aihw.gov.au/reports/heart-stroke-vascular-diseases/hsvd-facts. AIHW, Australian Government, accessed 11 March 2025.
2. 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.
3. Australian cardiovascular disease risk calculator: www.cvdcheck.org.au/calculator. AusCVDRisk accessed 16/12/2025
4. Heart Foundation. About the Heart Health Check Toolkit [Internet]. Melbourne: Heart Foundation; 2024 [cited 2025 Feb 26]. Available from www.heartfoundation.org.au/heart-health-check-toolkit/about-the-toolkit

Toolkit purpose and outcomes

This toolkit helps practices integrate CVD risk assessment into routine care using the specifically designed Report in Primary Sense™ called *PHASES High CVD Risk Screening, Recall and Treatment Practice Report V2*. It also includes suggested improvement activities and simple workflows that will support practices to embed continuous quality improvement in business as usual.

Here is a quick preview of what the report looks like:



PRIMARY SENSE

PHASES High CVD Risk Screening, Recall and Treatment Practice Report V2

Test Practice

21 September 2026 15:46

Which patients are included in this report? | What data is in this report? | How do we use this report? | What are ACG patient complexity levels?

Report Synopsis:
High CVD Risk Patients for Screening, Recall and Treatment

All Doctors

View As Columns

Report-Related Data:

Table 1. High CVD risk, no prior CVD, not on therapy : 0
Table 2. Prior CVD not on therapy : 0
Table 3. Missing risk factors but likely high risk : 0
Table 4. High CVD risk, including prior CVD, not at target : 0

Note: Empty interval columns will populate over time.

Disclaimer: Clinical decision support - not a substitute for clinical judgement. The PHASES tools and resources are intended to support clinical decision-making and quality improvement.
They do not replace the need for individual clinical assessment, professional judgement, or discussion with patients.
Clinicians should consider each patient's circumstances and apply relevant clinical guidelines when making care decisions.

Clinical reminder: All patients in this report must have their CVD risk confirmed according to the AusCVD 2023 guidelines at the point of recall. This report is a pre-screening tool only. For patients without prior CVD and without a known high-risk condition, the GP should complete an AusCVD 2023 assessment where clinically appropriate. Patients with prior CVD or known high-risk conditions, such as familial hypercholesterolaemia or CKD stage 3, should be managed according to relevant guidelines and do not require a primary-prevention risk score.
This report is a pre-screening tool only — it identifies patients for recall, not for treatment decisions.

Table 1. High CVD risk, no prior CVD, not on therapy

These patients will benefit from timely review of their CVD risk and preventive treatment.

Information about this table

Quality Improvement Framework

This toolkit applies the Model for Improvement (MFI) framework to guide the planning of activity goals, measurement strategies, and the development of effective improvement ideas.

For further details on the MFI approach, visit the Institute for Healthcare Improvement website: ihi.org/library/model-for-improvement

The improvement activities outlined in this toolkit are designed to enhance cardiovascular disease (CVD) prevention by supporting early **identification**, timely **intervention**, and ongoing **management**. Each activity is directly aligned with the *PHASES High CVD Risk Screening, Recall and Treatment Practice Report V2* in Primary Sense, ensuring primary care providers have practical tools to embed prevention strategies into routine practice.

Practices do not need to complete every activity.

Select one improvement activity, test a small cohort using the PDSA cycle, review results and either adapt or scale. Completing one full cycle meets CQI, CPD and PIP QI requirements.

Resource:
Record your QI activities
phasesqld.com/PDSA

Planning your Quality Improvement Activity

Step 1: Identify your QI team and assign roles and responsibilities

Actions and guidance		
Identify your change team	1	Select a lead and key practice team members (e.g., nurse, GP, admin, practice manager).
	2	Consider including allied health professionals, visiting clinicians, and others who can contribute.
	3	Allocate dedicated time for QI activities (e.g., 1 hour per week).
	4	Ensure everyone understands the purpose and value of QI — some may need extra motivation.
	5	Schedule regular planning meetings and provide access to relevant project files, policies, and procedures.
Clarify team roles and responsibilities	1	Reflect on what motivates each team member to participate in and sustain improvements.
	2	Assign roles based on skills, interests, scope of practice, and authority. Example roles: • **GPs:** Lead clinical decisions, conduct Heart Health Checks, initiate management plans. • **Practice Nurses:** Support data collection (BP, cholesterol), patient education, follow-up. • **Reception/Admin:** Coordinate recalls, manage bookings, distribute patient info. • **Practice Managers:** Oversee workflow, allocate protected time, monitor progress.
Communicate with the practice team	1	Identify who needs to be kept informed and choose effective communication methods (e.g., meetings, email, noticeboard, group chat).
	2	Ensure all staff are aware of updates and changes.
	3	Provide updates (e.g., include QI in staff meetings).
	4	Encourage staff to contribute ideas and feedback.
	5	Share meeting minutes and action points and clarify any required follow-up.

- Form a QI team to identify key challenges, develop innovative solutions, and align on improvement goals and strategies.
- Explore enablers and barriers to optimal CVD care. Use tools like process maps, flow charts, or driver diagrams to generate change ideas and enhance care processes.
- Review the Heart Foundation Team roles and responsibilities resource: www.bit.ly/hf-resource

Step 2: Get your data ready

Patient Data Cleansing Steps

- Deactivate inactive patients: Remove patients who are no longer regular attendees (fewer than three visits in the past two years) or who are deceased.
- Merge duplicate records: Consolidate duplicate patient entries to ensure data accuracy and prevent loss of information.
- Remove irrelevant addresses: Deactivate patients with out-of-state or invalid postcodes.
- Exclude non-attendees: Remove patients who registered but never attended (e.g., online bookings).

Resources:

NINCo QI Resources
www.bit.ly/ninco-qi

RACGP Quality Health Records in General Practice
www.bit.ly/racgp-qhr

Get ready to use your data:

- Ensure your practice is using the latest version of your clinical software
- Ensure Primary Sense is working, and reports can be downloaded.
- Confirm that Primary Sense is installed on each workstation and that all team members are trained and confident in its use.

Help: Contact your local PHN for support.

Step 3: Setting your quality improvement (QI) activity goal

To establish a meaningful goal for your QI activity, start by running the Primary Sense: *PHASES High CVD Risk Screening, Recall and Treatment Practice Report V2* for your practice.

Review the patient lists displayed in each of the four tables and record the date you generated the report. Assess the number of patients identified in each category and determine how many you can realistically recall and manage over the coming weeks. Based on this assessment, select one QI activity to focus on as your improvement initiative.

High CVD Risk Screening, Recall and Treatment
QI Activity Goal Setting

Example
By [month] 2026, reduce the number of high-risk patients not on guideline therapy by X%

Date report was generated: ___/___/____ **Target patient groups (tables in report)**	**Number of patients (baseline)**	**Number to recall (target)**	**Goal of QI activity**
Table 1, High CVD Risk, no prior CVD, not on therapy			
Table 2. Prior CVD not on therapy			
Table 3. Missing risk factors but likely high risk			
Table 4. High CVD risk, including prior CVD, not at target			

How to use this table:

- Fill in the baseline numbers from your *PHASES High CVD Risk Screening, Recall and Treatment Practice Report V2*. Note the date the report was run as this is your baseline.
- Set realistic recall targets for each category.
- Define a clear, measurable goal for your QI activity (e.g., percentage reduction, improved documentation, increased recall rate).

Step 4: Establish your baseline and track improvement over time

Consistently reviewing your activity measurements empowers your team to evaluate progress and determine whether the changes being implemented are driving meaningful improvement. Once you have confirmed your improvement activity and established the baseline (from Step 3), develop a plan to monitor progress over time.

Decide on a regular review schedule for your quality improvement activity (such as monthly) and choose effective ways to share results with your team—options include team newsletters, lunchroom displays, or updates during staff meetings.

Quality improvement activity progress tracker

Measurement point	Date	Percentage (%) achieved
Baseline	/ / 20	%
Month 1 review	/ / 20	%
Month 2 review	/ / 20	%
Month 3 review	/ / 20	%
Completion	/ / 20	%

How to Use This Table:

- Baseline: Record the starting percentage and date when you begin your QI activity.
- Monthly Reviews: Track progress each month by entering the review date and the percentage achieved.
- Completion: Document the final measurement and completion date to assess overall improvement.

Did you know?

Remember to self-report your QI initiative as a CPD activity: QI is a great tool for measuring tangible outcomes and demonstrating improvement in patient care!

Finishing point

Sustainability checklist: Maintaining the change

Focus area	Key actions and guidance
Cyclical nature of PDSAs Adopt, Adapt, Abandon	• Adopt: Embed successful changes into routine practice. • Adapt: Modify the plan as needed and start a new PDSA cycle. • Abandon: Reconsider and redesign if a change isn't effective. • Learn: Document lessons from all cycles, even those abandoned.
Document your improvement activity	• Record completed QI activities to meet PIP QI guidelines. • Keep documentation for 6 years for audit purposes by the Department of Health, Disability and Ageing.
Sustaining project outcomes	• Update relevant practice documentation (e.g., policy and procedure manuals, task procedures, signage, staff work practices). • Revise position descriptions and induction materials to reflect new roles in CVD risk assessment and Heart Health Check delivery. • Use the Heart Foundation's roles and responsibilities guide. • Support ongoing staff skills development and education.
Communication	• Provide QI project outcome feedback to staff. • Discuss strengths and challenges. • Share feedback with patients where appropriate. • Incorporate outcomes into preventative health care promotion activities.
Celebrate success	• Celebrate achievements (e.g., team morning tea). • Share improvement activities with patients via newsletters, website, or waiting room displays (e.g., run charts to show progress)
Review and reflect	• Discuss project strengths and challenges. • Annually review PDSA outcomes to ensure ongoing adherence. • Audit data annually to identify gaps and set new targets. • Consider new CQI activity topics and apply learnings for greater efficiency and effectiveness.

Improvement Activity Idea 1

Using Primary Sense for CVD Risk Identification and Recall

Early identification of cardiovascular disease (CVD) risk is critical to reducing preventable morbidity and mortality in Australia. Primary care is uniquely positioned to proactively identify patients at risk and intervene early.

This improvement activity supports practices to use Primary Sense to proactively identify patients at intermediate or high risk of CVD, prioritise Heart Health Checks, and embed recall and assessment practices in business as usual.

Step 1: What are we trying to achieve?

AIM

Within 6 months, increase the proportion of eligible patients aged 45–74 years (or 30–74 years for Aboriginal and Torres Strait Islander peoples) who receive a documented Heart Health Check by 20%.

Step 2: How will we know that a change is an improvement?

MEASURE

- How many patients in our practice are potentially at high risk of CVD (baseline)?
- Use the Primary Sense *PHASES High CVD Risk Screening, Recall and Treatment Practice Report V2* > Tables 1 & 3

OUTCOME MEASURES

- Number and proportion of eligible patients who have had a Heart Health Check (MBS item 699) in the past 12 months
- Number of patients newly identified as high CVD risk

PROCESS MEASURES

- Number of patients recalled or flagged using Primary Sense
- Number of completed Heart Health Check appointments
- Proportion of Heart Health Checks with complete risk factor data

Step 3: What changes can we make that will result in this improvement?

CHANGE IDEA

Use Primary Sense to systematically identify, recall and assess patients at high risk of CVD.

Step 4:
PDSA Cycle (Plan, Do, Study, Act)

PLAN

1. Identify priority patients and plan the recall process
2. Run the Primary Sense *PHASES High CVD Risk Screening, Recall and Treatment Practice Report V2*
   - Table 1: High CVD risk, no prior CVD, not on therapy
   - Table 3: Missing risk factors but likely high risk
3. Define scope for this cycle (e.g. recall up to 20 patients)
4. Confirm roles:
   - Who runs the report?
   - Who recalls patients?
   - Who conducts the Heart Health Checks?
   - Confirm recall method(s): SMS, phone, email, letters, GoShare bundles

DO

1. Test the recall and assessment process
2. Check whether MBS item 699 has been billed in the last 12 months to avoid duplication
3. Recall or opportunistically flag selected patients
4. Conduct Heart Health Checks during booked or linked appointments
5. Use the Australian CVD risk calculator (AusCVD) to calculate risk
   - In Best Practice, access via Cardiovascular Risk in the clinical record
   - Otherwise, use the online calculator
6. Document outcomes and management decisions in the clinical record

STUDY

1. At the end of the test period (e.g. 4–6 weeks), review:
   - How many patients were successfully contacted?
   - How many attended a Heart Health Check?
   - Were risk factors complete?
   - Were any workflow barriers identified (e.g. booking issues, time constraints)?
   - Did staff feel clear about their roles?
2. Compare results to baseline measures.

ACT

1. Review findings
2. Adjust recall messaging or methods
3. Modify appointment lengths or workflows
4. Update staff training or prompts
5. Decide whether to:
   - Repeat the cycle with a larger cohort
   - Embed the process as business-as-usual
   - Test a new change idea (e.g. nurse-led checks, opportunistic prompts)

Clinical considerations during Heart Health Assessment

1. Collect and confirm all relevant CVD risk factors:
   - Age, sex at birth, ethnicity
   - Blood pressure, cholesterol
   - Smoking status, physical activity, diet, weight
   - Diabetes, CKD, familial hypercholesterolaemia
2. Use AusCVD risk calculation and apply reclassification factors
3. Do not routinely assess risk in patients automatically classified as high risk, including:
   - Moderate–severe chronic kidney disease
   - Confirmed familial hypercholesterolaemia
4. Follow guideline-based management and referral via local HealthPathways
5. Where appropriate, initiate management plans, referrals, and lifestyle support

Equity and access

Ensure recall and engagement strategies are culturally safe and accessible, particularly for:

- ✔ Aboriginal and Torres Strait Islander peoples
- ✔ South Asian, Middle Eastern, Māori, Pacific Islander communities
- ✔ Refugee and priority populations

Improvement Activity Idea 2

Using Primary Sense to Optimise Treatment and Management of CVD

Patients at high cardiovascular disease (CVD) risk or with established CVD benefit most when treatment is optimised and care is reviewed regularly. However, variation in medication use, monitoring, follow-up, and documentation can result in missed opportunities for prevention and secondary prevention.

This improvement activity supports practices to use Primary Sense to systematically identify patients with high or established CVD risk, test proactive review and recall workflows, and optimise treatment and long-term management using a continuous quality improvement approach.

Step 1: What are we trying to achieve?

AIM

Within 6 months, increase the proportion of patients at high CVD risk or with established CVD who are receiving guideline-recommended therapy and appropriate follow-up by 20%.

Step 2: How will we know that a change is an improvement?

MEASURE

- How many patients in our practice, who we already know have high CVD risk or have an existing CVD diagnosis (baseline)?
- Use Primary Sense report *PHASES High CVD Risk Screening, Recall and Treatment Practice Report V2* > Tables 2 & 4

OUTCOME MEASURES

- Number of patients with established CVD not receiving guideline-recommended therapy (Table 2)
- Reduction in the number of patients not meeting treatment targets (e.g. BP, LDL cholesterol)

PROCESS MEASURES

- Number of proactive clinical reviews completed
- Number of medication reviews or adjustments made
- Number of GP chronic condition management plans (GPCCMPs) initiated
- Number of patients recalled or reviewed opportunistically

Why we measure "patients not meeting targets?"

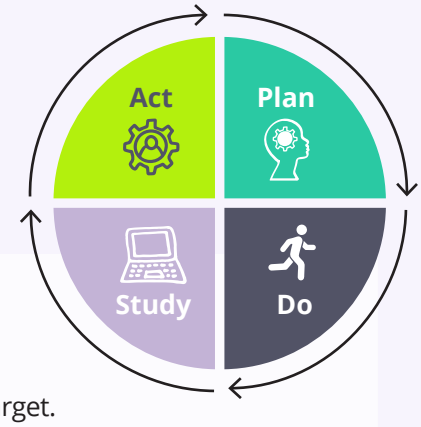
Primary Sense reports highlights gaps in care rather than all treated patients. For this reason, improvement is measured by a reduction in the number of patients identified in these gap reports over time.

Step 3: What changes can we make that will result in this improvement?

CHANGE IDEA

Use Primary Sense reports to systematically identify patients with high or established CVD risk, and test proactive review, optimisation and follow-up to improve treatment and long-term management.

Step 4:
PDSA Cycle (Plan, Do, Study, Act)



PLAN

1. Run the *PHASES High CVD Risk Screening, Recall and Treatment Practice Report V2*:
   - Table 2. Prior CVD not on therapy
   - Table 4: High CVD Risk, including prior CVD, not at target. (e.g. BP, LDL)
2. Select a small test cohort (e.g. 10–20 patients)
3. Identify common gaps:
   - Missing lipid lowering, lipid-lowering, antihypertensive, or antiplatelet therapy
   - Uncontrolled blood pressure or cholesterol
   - No structured follow up or care plans
4. Define roles:
   - Who will conduct reviews (GP, nurse, team based approach?)
   - How patients will be reviewed (recall vs opportunistic)?
   - Confirm use of relevant MBS items (eg. GPCCMP, chronic disease items)

DO

1. Test the planned workflow with the selected cohort.
2. Recall or opportunistically review selected patients during existing appointments
3. Conduct structured medication and lifestyle reviews including:
   - Medication optimisation in line with guidelines
   - Lifestyle counselling and risk factor management
4. Initiate or update GP chronic condition management plans where appropriate
5. Document treatment changes, targets, and follow-up plans
6. Book follow-up appointments or monitoring as clinically indicated

STUDY

Review what happened during the test period (e.g. 4–6 weeks).

1. How many patients were reviewed?
2. How many had medication changes or care plans initiated?
3. Were treatment targets addressed?
4. Did the workflow fit within routine practice?
5. What barriers or enablers were identified (time, patient engagement, systems)?
6. Compare results with baseline measures.

ACT

Refine and scale the approach based on learnings.

1. Adjust:
   - Recall methods or messaging
   - Review templates or prompts
   - Appointment lengths or team roles
2. Decide whether to:
   - Expand to a larger patient cohort
   - Embed the workflow into routine care
   - Run a new PDSA cycle focused on adherence, follow-up, or patient education

Clinical considerations

1. Use local HealthPathways to confirm guideline-based management and referral pathways
2. Ensure patients with established CVD are prioritised for secondary prevention
3. Promote healthy lifestyle changes alongside pharmacotherapy
4. Use Primary Sense prompts (e.g. missing CV risk medication) to support point-of-care decision-making

Equity and access

Adapt engagement and follow-up approaches to ensure equitable access for priority populations, including:

- ✔ Aboriginal and Torres Strait Islander peoples
- ✔ South Asian, Middle Eastern, Māori, Pacific Islander communities
- ✔ Refugee and priority populations

Additional Resources

Access factsheets, webinar recordings, HealthPathways and FAQs to help your practice, make the most of Primary Sense™ and strengthen proactive CVD risk assessment.

phasesqld.com/resources

PHASES is being delivered by Country to Coast Queensland in partnership with Queensland Primary Health Network (PHNs) and is co-funded by the Australian and Queensland Governments.

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