

Better Cardiac Care

Robina Health precinct



What is Better Cardiac Care

- BCC is a specialized, culturally appropriate service designed to improve cardiovascular outcomes for Aboriginal and Torres Strait Islander peoples.
- Operating within Gold Coast health since October 2022
- A Multi-disciplinary team supports patients from hospital to community care, offering education, medication management, and better access to specialist treatment.
- The MDT team also supports A&TSI clients in the community with identified cardiovascular risk factors or diagnosed cardiac conditions.
- Working to close the gap in mortality within the A&TSI population.

How does BCC benefit clients?

- Early cardiovascular risk assessment and management (clients that received a Medicare benefits schedule health assessment) 4% 2006-7 --> 24% 2021-2022
- Timely diagnosis of heart disease and heart failure- in 2021 25% of First Nations people with suspected or confirmed cardiac disease were reviewed by a cardiologist
- Guideline based therapy for acute coronary syndrome. In 2020 First Nations people were about 14% less likely than non- Indigenous Australians to receive PCI.
- Optimization of health status and provision of ongoing preventative care- chronic disease management post inpatient admission rose from 42% in 2010 to 64% in 2018.
- Strengthening the diagnosis, notification and follow up of RHD
- Hospitalization and mortality- 205 per 100,000 2006 to 134 per 100,000 in 2021. In 2021 the age standardized mortality rate for First Nations people was 1.5 times the rate on non- Indigenous Australians.



How do we improve health outcomes for clients transitioning from hospital to community?



- BCC provide support to clients in the hospital through to community. Seamless transitions prevent gaps in care, crucial for managing chronic illnesses and reducing emergency department revisits.
- Building trust and equity. Effective communication and collaboration fosters trust in healthcare and reduces health disparities.
- GP briefing documents post-acute admission
- Ensuring clients have discharge medication with FNS and CTG registration
- Timely medical follow up
- Advocating for clients to engage in cardiac rehab and access other community supports.

How do we improve health outcomes for our clients from the community?



- We support clients referred from the community to improve their health outcomes by providing culturally safe clinical assessments and coordinating appropriate care.
- This includes linking clients to internal services to better manage their medical conditions, such as A&TSI-specific programs like Mungulli Gym and Yarn & Walk.
- We also assist with managing cardiovascular risk factors, including providing smoking cessation support, referring clients to chronic disease clinics (e.g. diabetes and chronic kidney disease MDT clinics), conducting thorough medication reviews, and working together with their GP by liaising and preparing GP letters with clinical recommendations.

Who can be referred?

Have risk of developing;

Ischemic heart disease

Heart attack

Heart failure

Abnormal heart rhythm

Rheumatic heart disease or history of rheumatic fever

Diabetes

HTN

Smoking

Obesity

High cholesterol
Family history
heart disease

Out of Scope Services

The following conditions are out of scope for this service:

- Residents of an aged care facility
- Patients experiencing diagnosed cognitive impairment
- Patients under the age of 18
- Patients who do not identify as Aboriginal and/or Torres Strait Islander

How to refer to our service

GP Smart referrals: contact Gold Coast Health's General Practice Liaison Unit for any support/issues/concerns with GP smart referrals & assistance with access to non-urgent specialist outpatient advice or general service enquiries (GCGPLU@health.qld.gov.au or phone 1300 004 242 available from 8am to 4pm weekdays)

For Practices that are unable to use GP smart referral, they can use secure messaging through (Medical Objects ID – GQ42150009Z, HealthLink EDI – qldgchsd, [Kiteworks](#)).

Emailing is not typically accepted, as it is considered unsecure and the last back up option is the central fax number for referrals which is: (07) **5687-4497**



Patient name: Ruby MACKAY DoB: 1 Jan 1980

Request information

Request date

24 Oct 2022

Request type

New referral

Update

Continuation

Request for advice

Reason for referral

- New condition requiring specialist consultation
- Deterioration in condition, recently discharged from outpatients < 12 months
- Other

Priority

Urgent

Routine

Provider

QHSR

Private

Consents

Date patient consented to request

24 Oct 2022



Patient is willing to have surgery if required?

Yes

No

Not applicable

Condition and Speciality

Start typing condition or speciality

[HealthPathways](#)

Suitable for Telehealth?

Yes

No

Are you the patient's usual GP?

Yes

No

Unit Name	Condition & Specialty (GPSR search term)	GPSR Service Location
Better Cardiac Care - Aboriginal and Torres Strait Islander Service	Cardiology	Better Cardiac Care - Aboriginal and Torres Strait Islander Service - ROBINA HEALTH PRECINCT

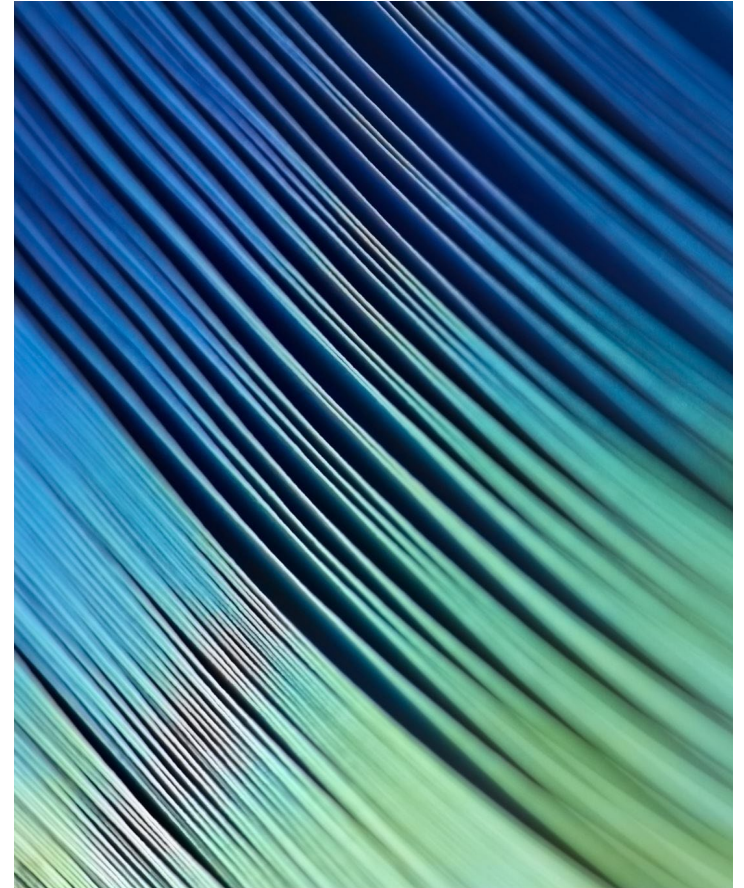
715 health check

Aboriginal and/or Torres Strait Islander people of all ages can get their free 715 health check at Aboriginal Medical Services and bulk-billing clinics.

This health check helps identify whether someone is at risk of illnesses or chronic conditions. It's much easier to prevent these than to treat them, so catching them early can make a big difference. **Fee:** \$247.65 **Benefit:** 100% = \$247.65

After the health check, and with client agreement, the Doctor can refer the client to up to 10 free follow-up services if needed; a specialist or another health service/ a mental health service and/or a service that works to prevent chronic conditions.

[RACGP - Resources to support health checks for Aboriginal and Torres Strait Islander people.](#)



Pharmacy: FNS as inpatient and CTG PBS co- payment in the community.

- FNS provides a fee waiver for prescriptions written as part of episode of care while inpatient or outpatient for First Nation people and must be dispensed by the hospital pharmacy to be dispensed free of charge.
- CTG PBS Co-payment Program for prescribed PBS medicines for First Nations people in the community.

The **full general PBS co-payment amount pay the concessional rate** when obtaining their PBS medicines from an CTG PBS Co-payment Program approved supplier.

The **concessional rate receives their prescribed PBS medicines for free**, without having to pay a co-payment, from an approved CTG PBS Co-payment Program supplier.

- Any PBS prescriber or A&TSI health practitioner registered with Ahpra & Medicare can register First Nations people for the CTG PBS Co-payment Program.
- Registration of eligible First Nations people is completed via the Services Australia [Health Professional Online Services \(HPOS\)](#) portal and is a one-off registration process. Alternatively, the CTG PBS Co-payment Program registering practitioner can authorise a HPOS delegate to act on their behalf. A delegate will need to register for their own [PRODA \(Provider Digital Access\)](#) account before being linked to a CTG PBS Co-payment Program registering practitioners HPOS account
- [PBSM08 1-How to register a patient for Closing the Gap \(CTG\) Pharmaceutical Benefits Scheme \(PBS\) Co-payment](#)