Development of the Healthy Hearts, Healthy Minds Program

Summary of findings from consumer and stakeholder engagement

May 2025

Report outline

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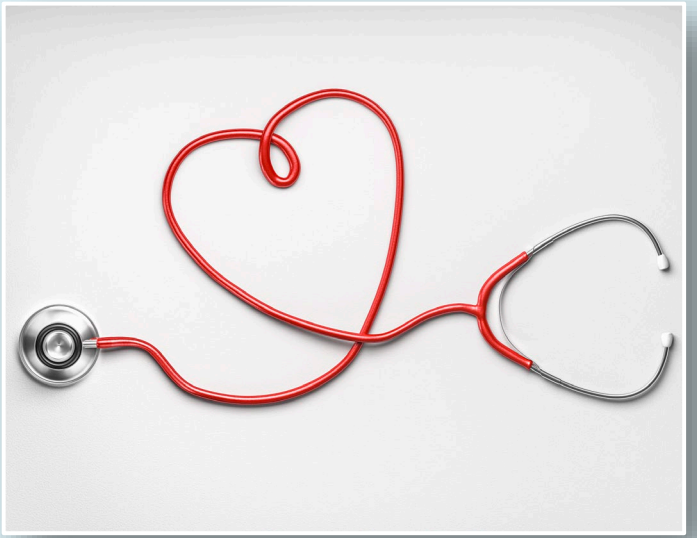

Introduction

- COORDINARE is commissioning the Healthy Hearts Healthy Minds program to address cardiovascular disease (CVD), a priority health condition in South Eastern NSW.
- The Program is being funding through the “PHN commissioning of Multidisciplinary teams” funding stream, announced as part of the Building a Stronger Medicare package in the 2023-24 budget.
- Healthy Hearts Healthy Minds involves a nurse-led intervention for people who are at risk of CVD and is delivered in the general practice setting. The program will initially involve nine general practices who will host a practice nurse employed and managed by an external provider.
- Cardiovascular disease is a priority health condition in South Eastern NSW — some practices record up to 45% patients with high blood pressure and 43% with high cholesterol.
- There are high rates of hospitalisation and mortality related to CVD in the region.
- COORDINARE is in the process of commissioning nurse-led multi-disciplinary clinics in selected general practices through the ‘Healthy Hearts Healthy Minds’ program. The program has been developed to respond to:
    - regional inequity in the practice nurse workforce distribution in SENSW
    - existing evidence that RNs, as part of an MDT approach, can positively impact the identification and management of CVD risks in a general practice setting
    - potential benefits for GPs (workflow, scope of practice), allied health practitioners (coordination), and patients (holistic and integrated care).

Purpose of the Engagement

- This engagement aimed to test and refine the Healthy Hearts Healthy Minds service model by involving consumer representatives and general practices contracted to deliver the model.
- The objectives of the engagement activities were to:
  - introduce the current 'model of care' for the *Healthy Hearts Healthy Minds* program and understand how it addresses the needs and preferences of the target population
  - collect insights and suggestions that can strengthen the design and delivery of the program, relating to what the program offers, who it reaches, and how it is delivered.
  - analyse and summarise key considerations to inform ongoing commissioning and establishment of the program.
- Our engagement included:
  - 2 x focus groups with consumer representatives (14 participants), plus one online survey response from a consumer
  - 1 x focus group with participating practices/expert partners (8 participants).

Overview of Key findings – Intake and Participant Selection

Targeting the right participants

Participants identified the importance of having identification approached and suitability criteria that ensure the program reach those most likely to benefit. This includes people with risk factors with CVD, and those who typically face barriers to accessing services and self-management.

Using data to identify participants

The use of practice-level data tools (i.e. SPDS) to run reports to identify potential patients was supported as one method to identify participants. However, this should occur alongside clinical judgement.

Effective outreach strategies

Participants highlighted the importance of personalised, compelling invitations to join the program. The program should avoid one-off engagements (e.g bulk SMS) which are generic or could be perceived as spam.

Access beyond general practice

There was concern about relying solely on GPs for referrals due to time constraints and cost barriers. Alternative access points like urgent care clinics, pharmacies, and workplaces were recommended for consideration as part of the model.

Overview of Key findings – Getting Started

Building trust with practice nurses

A consistent, trusted relationship with the nurse was identified as key to program engagement. Participants stressed the importance of recruiting staff with relatable life experience and a holistic approach. “You want to make sure it’s the same nurse for the duration of the program. I don’t want to come back and talk to a different person each time” noted one consumer representative.

Holistic assessment

Practice nurses take a holistic approach to initial assessment to understand the patient’s holistic life context. Assessments should cover both clinical and non-clinical factors. “The nurse needs to ask the right questions to understand the connections between the issues in your life,” said one consumer representative.

Behaviour change approach

The practice nurse approach should centre around behaviour change, recognising that protective/risk factors relating to CVD are largely behaviour related. This involves a mix of assessing, coaching, and coordinating.

Structured tools

Tools like the ‘My Healthy Heart Management Plan’ were seen as helpful for setting goals and tracking progress. Participants valued having a plan that supports consistent follow-up and reinforces commitment. Consumers identified that care plans should help patients focus on what to tackle first, especially when managing multiple risks or conditions.

Overview of Key findings – Working Towards Goals

Flexible engagement

Participants felt that high risk patients may need more frequent contact than what is currently in the model. Engagement could be maintained through regular check-ins by phone or video, and follow-up on referrals “Maybe continuity doesn’t actually need someone to go see the GP more frequently. Maybe there are other things that can be done to keep people engaged” said one consumer.

Wraparound supports

Participants suggested enhancing the model with tools like apps, diaries, online portals, pharmacy checks, and group activities. “Some of those kinds of supports might already be there… people just need to be linked with [them],” noted a consumer.

Tailored approach

The program should use personalised strategies that reflect what motivates each individual. This includes recognising that behaviour change is not one-size-fits-all and requires flexibility in delivery.

Social connection

Social and green (nature) prescriptions were seen as powerful motivators to engage with the program. Participants supported linking people with peer groups, walking clubs, or shared activities. “Sometimes when you’re trying to do something it’s better to do it with other people… it creates accountability,” said a consumer.

Overview of Key findings – Transition/Discharge

Reframing discharge as transition

Participants stressed the importance of viewing program exit as a transition to continued care, or a springboard, rather than an endpoint. “Rather than calling it a discharge, what you should actually get is a ‘continuing care plan’… even if we can’t keep supporting you,” said a consumer. Participants valued the idea of being able to reconnect with the program if needed.

Transition care plan requirements

The care plan at the 12-month mark should guide the next stage of self-management, be shareable with GPs and other providers, and include follow-up referrals and a longer-term (e.g. 5-year) health outlook.

Post-program support

Participants recommended providing access to curated local resources and scheduling follow-ups once their time in the program has ended, especially for high-risk individuals.

Peer networks

Participants valued the opportunity to create a community of program graduates. This could include newsletters, group check-ins, and shared resources

Other Consumer Considerations

Cost

Out-of-pocket costs for services like GP visits, allied health, or gym could limit adherence to care plans if not covered. Participants suggested that if these costs are covered, this could be used to reframe the program's value: "Am I really going to get all that stuff for free? That's amazing!" said one consumer.

Workforce

Ensuring nurses are well-trained and equipped for the program's broad scope was seen as essential. "If they really put the call out for great nurses with enough life experience to be a 'super nurse', it could work," noted a consumer. To ensure long term success of the program, it will be critical to address limited allied health workforce availability in rural areas and the need for tailored support for 'at-risk' groups (e.g. culturally diverse communities, men)

Participant voice and quality improvement

Participants supported mechanisms for sharing their experiences to inform ongoing improvements, ensuring the program evolves based on consumer feedback. A formal evaluation after the first year was recommended to assess effectiveness, equity of access, and areas for refinement.

Program/Practice Level Considerations

Nurse onboarding

Practices requested a checklist outlining expectations for onboarding the program nurse, covering areas like site orientation, WHS, system access, referral pathways, introductions to colleagues, and using practice software.

Practice readiness

Ensuring practices are well-prepared to host the nurse and integrate the program into their workflow is essential for long-term success and sustainability.

Continuity of nurse

Maintaining the same nurse at each practice was seen as critical for building trust and consistency. Practices emphasised that nurse retention should be a priority for the program provider.

Availability of Allied Health professionals

Will be an issue in some regional locations, potentially restricting access or adding to the cost of access

Program exclusion criteria

It will be important to ensure program eligibility and exclusion criteria are transparent

Feedback from non-participants

People who decline to participate should be a source of feedback about the program

Next Steps

- The feedback generated from these engagements will be used to improve the model of care for the Healthy Hearts, Healthy Minds Program.
- This service will be implemented from July 2025 until June 2027.
- The program model will evolve over time in response to feedback from involved GP practices, practice nurses, and program participants.
- An independent evaluation will be undertaken prior to the end of the program in 2027.