Cubiko

CUBIKO WEBINAR

MONDAY 7 SEPTEMBER 2026

Preparing your practice for Women's Health Week 2026

The clinical picture, the workflows and a resource bundle for 7–11 September

Claire, Roslyn & Bryn

Acknowledgement of Country

In the spirit of reconciliation, Cubiko acknowledges the Traditional Custodians of country throughout Australia and their connections to land, sea and community. We pay our respect to their Elders past and present and extend that respect to all Aboriginal and Torres Strait Islander peoples today.

Gaagal by Miimi and Jiinda

BEFORE WE START

Welcome and housekeeping

We're recording

The session and slides will be shared with you afterwards

Ask as we go

Drop questions in the Q&A panel and we'll answer them before the hour is up

Grab the bundle

A resource bundle will drop in the chat during the session

INTRODUCTIONS

Your speakers today

Dr Claire Mohr

Roslyn Horsfield

Bryn Tardent-Powell

QUICK POLL

Is your practice doing anything for Women's Health Week?

- Yes, a full program
- Yes, a few activities
- Not yet, that's why we're here!
- No plans yet

01 · WHY THIS YEAR

The year to act on women's health

MBS

New items to work with

New women's health MBS items, including the menopause health assessment, put real funding behind proactive care

PBS

New listings for patients

Newly listed menopausal hormone therapies and contraceptive options make treatment conversations easier to have

7–11 Sept

A ready-made focal point

Women's Health Week gives your whole team one week to rally around. We'll give you the day-by-day plan

AGENDA

What we'll cover

01	Welcome and housekeeping	A quick poll and a recap on what’s happening this year
02	A practical update	Three clinical focus areas
03	Finding your patients	Identify → contact→ book → bill, in Cubiko and your PMS
04	The resource bundle	Your Women's Health Week plan
05	Q&A	Your questions answered

WOMEN'S HEALTH IN GENERAL PRACTICE

A Practical Update

Perimenopause, Pelvic Pain and Preventive Care

Dr Claire Mohr MBBS FRACGP

INTRODUCTION

Why this matters

- Women make up the majority of GP consultations, yet menopause, endometriosis and cervical/bone screening are consistently under-assessed in a standard consult
- Perimenopause is frequently missed, misattributed to stress or a primary mental health issue, or “watched and waited” for years
- Today: perimenopause & menopause, endometriosis/pelvic pain/heavy bleeding, and preventive care & screening gaps, each with something concrete to change in your next relevant consult

6–8

years

average time to diagnose endometriosis in Australia

The symptom range, and why it's missed

MORE THAN HOT FLUSHES

- Vasomotor: hot flushes, night sweats
- Sleep: insomnia, independent of night sweats
- Genitourinary: dryness, dyspareunia, UTIs, urgency
- Psychological/cognitive: low mood, anxiety, brain fog
- Musculoskeletal: joint aches, frozen shoulder
- Cycle changes: irregular, heavier or lighter bleeding

WHY IT'S HARD TO CATCH

- No single test confirms it. It's a clinical diagnosis based on age, symptoms and cycle changes
- FSH is unreliable in perimenopause. Levels fluctuate, so don't rely on one blood test to rule it in or out
- Exclude: thyroid dysfunction, anaemia (if heavy bleeding), a primary mood disorder, pregnancy

When does PMS/PMDD become perimenopause?

PMS / PMDD

- Symptoms are cyclical, tied to the luteal phase
- A clear symptom-free window in the follicular phase
- Predictable, tracks tightly with the cycle, month to month

PERIMENOPAUSE

- Symptoms become less predictable, more continuous
- The symptom-free window shrinks or disappears
- New features appear: vasomotor symptoms, changing cycle length, sleep worse independent of luteal phase

Practical tip: a 2–3 cycle symptom diary (symptoms plotted against cycle day) beats a blood test for telling the two apart. Perimenopause can also unmask or worsen pre-existing PMDD. The two aren't mutually exclusive.

What a good structured assessment covers

1	**History**	Menstrual/cycle history, full symptom review across all domains, impact on function and quality of life
2	**Symptom tool**	A structured checklist (e.g. Jean Hailes' symptom checklist) rather than unprompted recall
3	**Exclude differentials**	Thyroid function, iron studies if heavy bleeding, mood disorder screen
4	**Personal risk profile**	Personal/family history of breast cancer, VTE, CVD and osteoporosis risk, which shapes MHT suitability
5	**Shared decision-making**	Discuss MHT, non-hormonal and lifestyle options, not a binary yes/no to HRT
6	**Follow-up**	Review at 6–12 weeks after starting treatment. Don't set and forget

MHT myths worth retiring

Myth	Current evidence
“MHT causes breast cancer”	Absolute risk increase is small and varies by regimen/duration, often smaller than the risk from alcohol or obesity
“The WHI proved MHT is dangerous”	WHI participants averaged 63 years old; the timing hypothesis shows a more favourable risk profile starting MHT under 60 or within 10 years of menopause
“All MHT carries the same clot/stroke risk”	Transdermal oestrogen does not carry the same VTE/stroke risk as oral. It's a real prescribing choice
“Compounded ‘bioidentical’ hormones are safer”	Regulated, TGA-approved body-identical products (estradiol, micronised progesterone) are not the same as unregulated compounded preparations
“MHT is only for hot flushes”	Also indicated for genitourinary syndrome of menopause and bone protection. GSM is common and undertreated

A wide toolkit, not one-size-fits-all

Cyclic combined

Perimenopause, or less than 12 months since the last period *e.g. Femoston tablet, or Estrogel Pro (gel + oral progesterone)*

Continuous combined

12+ months since the last period, no further bleeding expected *e.g. Kliovance, Angeliq, Bijuva tablets, or Estalis patch*

Oestrogen-only

After hysterectomy, or paired with a separate progestogen or Mirena *e.g. Estradot/Estraderm patch, Estrogel/Sandrena gel, Progynova tablet*

Vaginal-only

Genitourinary symptoms alone; a progestogen isn't needed *e.g. Ovestin cream/pessary, Vagifem Low, Intrarosa (DHEA)*

Reference: every category above comes in low, medium and high dose, and the progestogen can be oral or delivered via a Mirena IUD. The AMS Guide to MHT/HRT Doses maps equivalent doses across current Australian brands, useful for tailoring therapy or switching products (Australia only, current November 2024; items marked * are private script).

The diagnostic delay problem

6–8

YEARS

average time to diagnosis in Australia, from symptom onset

WHAT DRIVES THE DELAY

- Normalisation of period pain: the idea that “periods are just meant to hurt”
- Symptom overlap with IBS/bladder conditions sends patients down other pathways
- Pain dismissed or under-investigated at first presentation

The opportunity: years of untreated pain, disrupted work/study and disease progression. The alternative is a short, deliberate set of screening questions at the very first pelvic pain presentation, rather than waiting for pain to become “bad enough.”

A fast screen you can run in one consult

Ask any patient presenting with period pain or pelvic pain:

1. Is the pain bad enough to affect work, school or social activities?
2. Have they needed to take time off because of period pain?
3. Do OTC painkillers not fully control it?
4. Do they have pain with sex (deep dyspareunia)?
5. Cyclical bowel or bladder symptoms: pain opening bowels, bloating, urinary urgency that tracks the cycle?
6. Is there a family history of endometriosis?

A “yes” to any of these, especially more than one, warrants further work-up, not “try the pill and see.”

The care journey

1

Screen positive

Thorough history & exam where appropriate

2

Imaging

TVUS (endo-experienced sonographer) and/or MRI if inconclusive

3

Treat now

Analgesia + hormonal treatment can start before imaging/referral

4

Refer when

Moderate/severe disease, severe symptoms, fertility concerns, or Rx fails

OPTIONAL

Remember: a negative scan does NOT rule out endometriosis. Superficial peritoneal disease is often not visible on imaging.

Contraception as treatment, and better LARC access

CONTRACEPTION AS TREATMENT

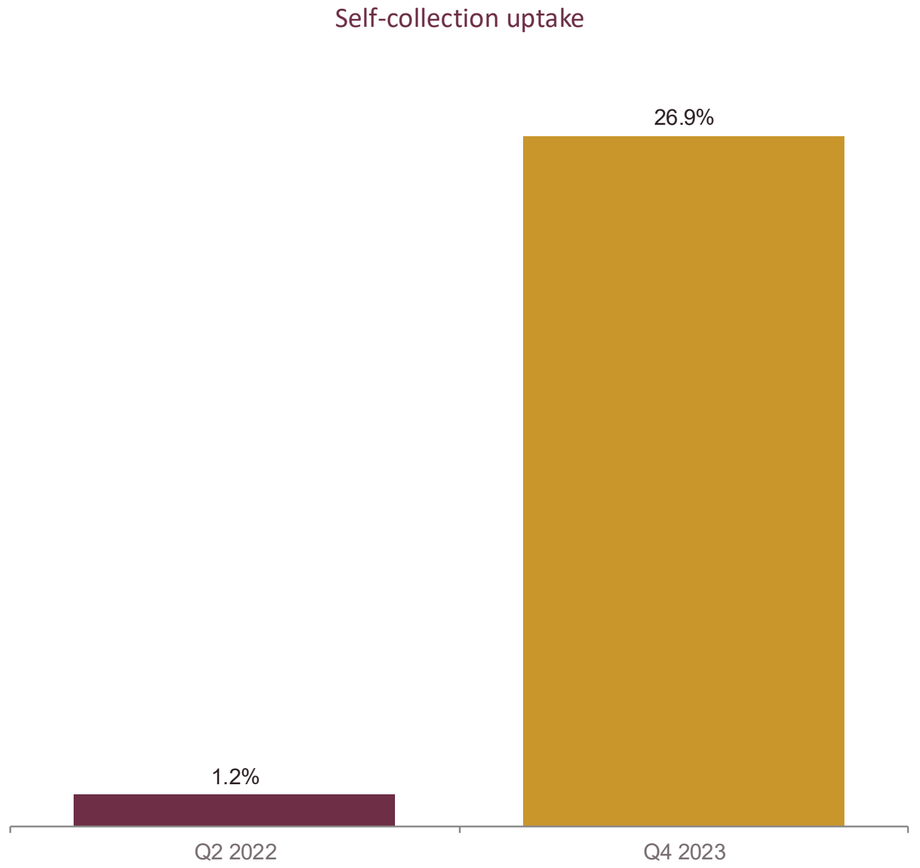
- Reframe hormonal contraception as treatment for pain and bleeding, not only pregnancy prevention. It changes uptake and adherence
- Continuous/extended COCP, POP, and the levonorgestrel IUD: both contraceptive and first-line therapy for endo-associated pain and heavy bleeding
- From 1 March 2025, Slinda, Yaz and Yasmin PBS-listed : ~$126/yr general, ~$31/yr concession

BETTER ACCESS TO LARCs

- From 1 November 2025, MBS rebates for LARC insertion/removal increased, plus a new bulk-billing incentive item
- Lower out-of-pocket cost for a patient getting an IUD or implant inserted or removed
- Worth raising again with patients who ruled LARC out on cost previously

Cervical screening: self-collection is now universal

- Available to ALL screening-eligible women and people with a cervix aged 25–74 since 1 July 2022, no longer restricted to under-screened or never-screened patients
- The gap: many patients, and some clinicians, still think self-collection is a fallback, not a routine, equally valid option
- Practical tip: offer self-collection as one of two equal options at every screening conversation



PART 3 · PREVENTIVE CARE & SCREENING GAPS

Bone health around menopause, and a few other quick wins

CASE-FIND, DON'T UNIVERSALLY SCREEN

Ask about: premature menopause (<45), parental hip fracture, height loss ≥3cm, low BMI (<20), smoking, high alcohol, low calcium/vitamin D, bone-loss medications (glucocorticoids, aromatase inhibitors)

Refer for DXA if: minimal-trauma fracture after 50, height loss ≥3cm, multiple risk factors, or FRAX® ≥10% major fracture risk. Premature/early menopause is a trigger to assess NOW.

A FEW OTHER QUICK WINS

- Cardiovascular risk: recalculate around the menopause transition
- Mood/psychosocial screening: a recognised window of vulnerability
- Keep breast screening & general preventive checks on the agenda

Premature or early menopause

is the one most often missed. It's a clear, actionable trigger for an earlier bone health conversation, well before the standard postmenopausal age bracket.

SUMMARY

Pulling it together

Three things to start doing this week

1

Perimenopause

Structured symptom checklist, stop relying on FSH, and revisit MHT with patients you previously couldn't start on cost grounds

2

Pelvic pain & bleeding

Ask the 6 screening questions at first presentation, treat early, refer if needed, reframe contraception/LARC as active treatment

3

Preventive care

Offer cervical self-collection as a routine, equal option, and flag early menopause as a bone health trigger

THANK YOU

Resources & further reading

Jean Hailes for Women's Health	Perimenopause/menopause symptom checklist and GP education modules (jeanhailes.org.au)
Australasian Menopause Society	MHT prescribing guides and patient fact sheets, incl. “9 myths” (menopause.org.au)
RANZCOG	Australian Living Evidence Guideline: Endometriosis (ranzcog.edu.au)
Healthy Bones Australia / RACGP	Osteoporosis prevention, diagnosis and management guidelines (healthybonesaustralia.org.au)
MBS Online	LARC item changes factsheet, for current item numbers and fees (mbsonline.gov.au)

03

Finding the patients

One repeatable loop, in Cubiko and Best Practice or MedicalDirector:
identify → contact→ book the right appointment type → bill correctly.

QUICK POLL

Which cohorts do you have a systematic recall process for?

- Cervical screening
- Heart health checks
- Menopause and midlife health
- None yet

Pick all that apply, then we'll go and find these patients

03 · THE METHOD

The same loop, every cohort

1

Identify

Build the cohort from your PMS search or report: eligible, active, not yet done

2

Contact

Contact patients from your PMS

3

Book

The right appointment type and length.
A 20-minute assessment isn't a standard consult

4

Bill

The correct item, first time, so the care is funded and the data is clean

03 · WORKED EXAMPLE 1

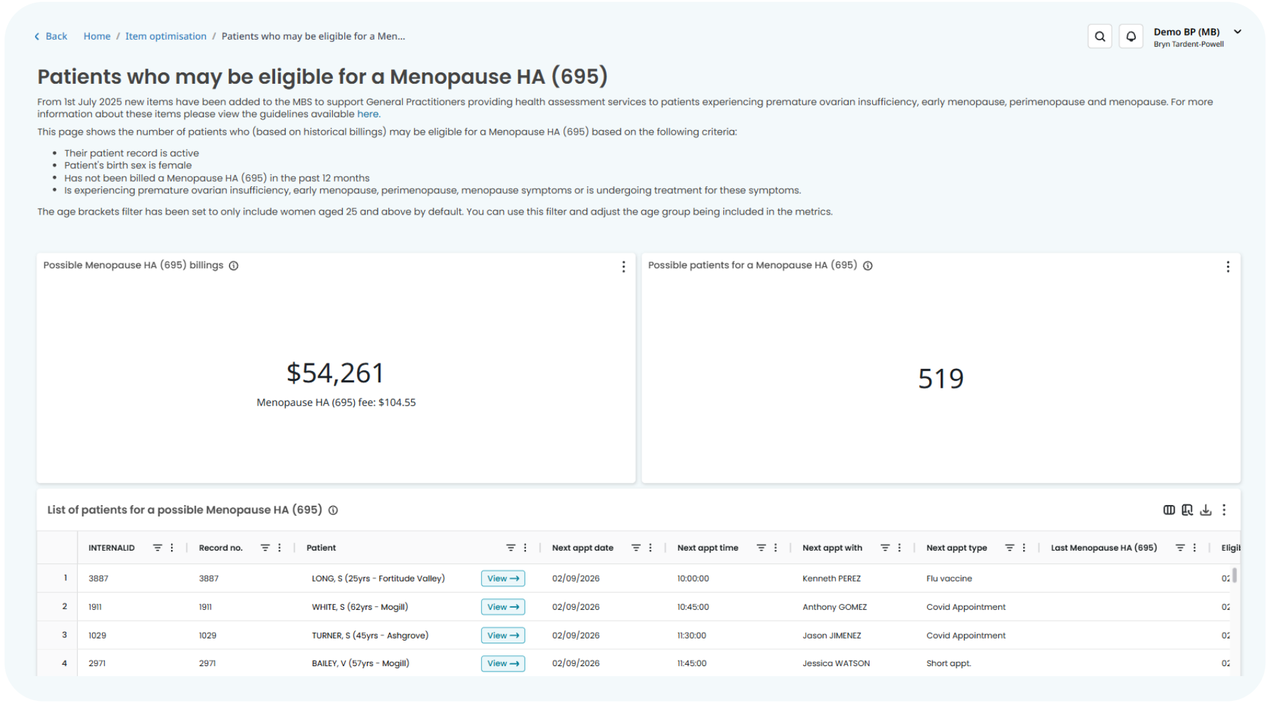
Menopause health assessments

The criteria: active patients (seen 3+ times in 2 years), women around 40–60, no item 695 billed in the last 12 months. Run it as a database search in your PMS, or use a pre-built list in a tool like Cubiko.

$104.55 item 695, minimum 20 minutes, once a year

19000 the equivalent item for prescribing medical practitioners

- Your nurse can assist with the assessment
- Bulk billing incentive eligible
- Add a 20-minute "menopause health assessment" appointment type



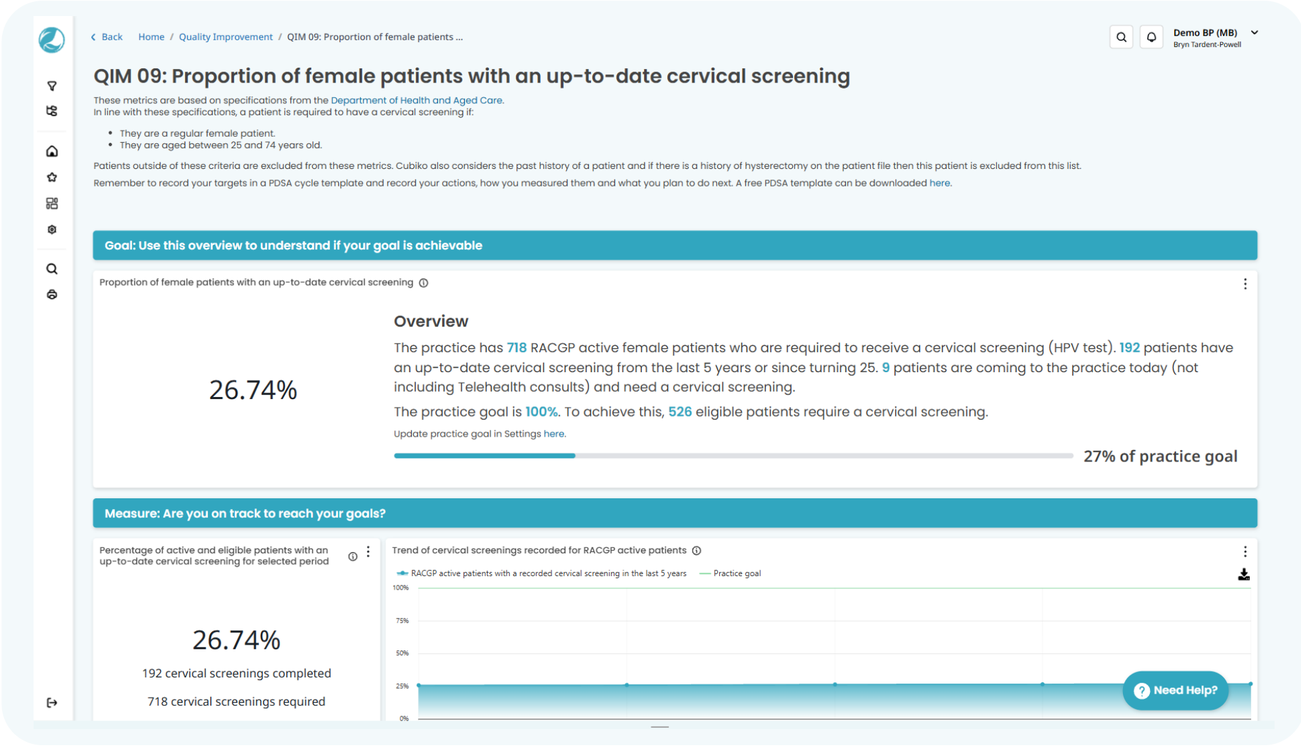
03 · WORKED EXAMPLE 2

Your cervical screening gap list

QIM 09 is one of the ten national quality measures your PMS data already tracks: the share of women 25–74 with an up-to-date cervical screen. Your PIP QI reports or a tool like Cubiko show the percentage, and the patients who could close the gap.

- Check your QIM 09 coverage in your PIP QI reporting, CAT4 or Cubiko
- Cross-check overdue patients against upcoming appointments, and offer a CST while they're in
- Offer self-collection every time for under-screened women

An accreditation win for the practice, and CPD for the team

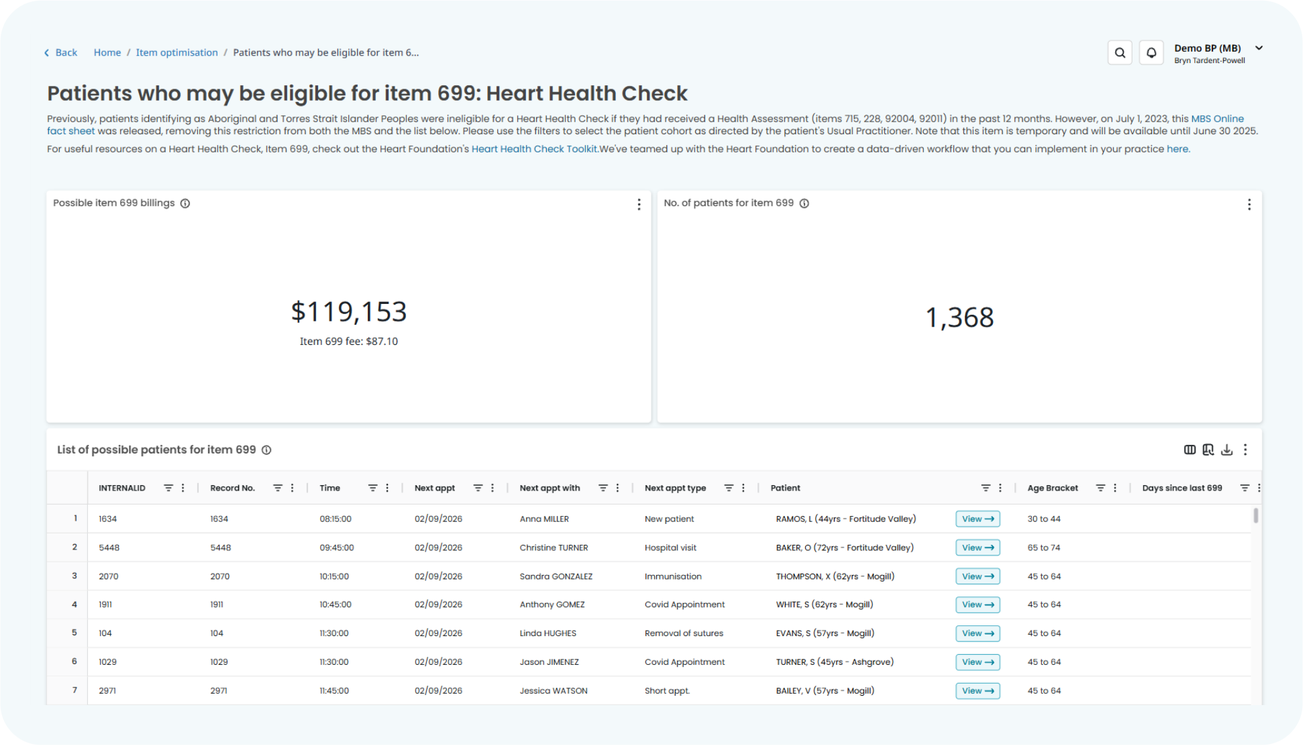


03 · WORKED EXAMPLE 3

Preventive and chronic care

Heart health checks for women 30 years of age or older:

- The criteria: no heart health check (699/177) in the last 12 months, plus risk factors on file, no other health assessments billed (excluding 715) in the last 12 months.
- Search your PMS for eligible patients, or let a tool like Cubiko surface them against upcoming appointments
- The same loop applies: identify, contact, book, bill



03 · PROVE IT WORKED

Measure it in week two

The recall funnel

Sent → Booked → Attended

Track each cohort's recalls through to attendance. The drop-off points show you what to improve next time.

Item volumes vs baseline

4 weeks

Compare 695s, CSTs and heart health checks against your prior four-week baseline and YoY.

04

Proactive workflows for women's health

Four mini workflows to help your practice turn awareness into action, during Women's Health Week and beyond.

YOUR TAKEAWAY

Four mini workflows, one per day or one per owner

1. Menopause and midlife health: identify item 695 opportunities, recall a first 50, make it an everyday conversation
2. Heart and bone health: Heart Health Check opportunities, plus BP and risk-factor updates in visits already happening
3. Mental health and the midlife load: start the conversation, review MHTP opportunities, book follow-up comfortably
4. Cervical screening catch-up: build your gap list, recall a manageable cohort, make screening opportunistic too

Each workflow includes a 15-minute huddle guide and an end-of-day review, plus clinical resource links

GRAB IT NOW

The download link is in the chat

Proactive workflows for women's health: all four workflows step by step, huddle guides, end-of-week reviews and clinical resources courtesy of Dr Claire Mohr.

Check the webinar chat

Also emailed to every registrant with the recording

Cubiko

Thank you, over to your questions

Drop anything we haven't covered in the Q&A panel now.

Claire, Roslyn & Bryn · Cubiko • Recording, slides and the resource bundle will be emailed to all registrants