Improving chronic disease management in your general practice

Call 1800 194 319 for technical assistance
Why is there an increasing focus on chronic disease management?
Chronic disease management in context

Patients’ needs are changing

Australians and chronic disease

1 in 3 Australians have a chronic disease

2 in 3 Australians have risk factors for heart disease, diabetes or chronic kidney disease

Australians aged over 65

In 2012, 1 in 7 people were aged over 65

By 2060, this will increase to 1 in 4 people

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Chronic disease management in context

• The care of people with chronic disease has become a major requirement of and role for the health system:
  • In Australia $60 billion is spent annually on caring for people with chronic diseases
• General practice is usually the patient’s first point of contact with the medical profession
  • It plays a key role in early diagnosis and care of people with chronic disease in the community.

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Requirements for chronic care

The model of care for people with chronic disease requires:

• Support for patient self-management
• Longitudinal, planned care
• Collaboration with a multidisciplinary care team
• Regular follow up and review
• Systematic application to all chronically ill patients

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Current care of people with a chronic disease

• Only 25% of patients with chronic disease have a documented general practitioner management plan (GPMP)

• Only 20% patients who have a GPMP or TCA is regularly followed up and reviewed

• Care plans may on occasions be incomplete for a multitude of reasons

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Key problems

• Healthcare involves silos of care with no-one having overall responsibility for care co-ordination
• The processes of care delivery can at times be inefficient
• Current care plan focus is often on data documentation as opposed to improving patient outcomes
• Agreed actions are not always monitored
Implementing a system for follow up and review is important.

“Improvements in administration, team functioning, data collection and data accuracy underpin all other clinical care improvements”

(Improvement foundation 2011)
On going review of patients:

- Improves patient health outcomes
  - thoroughly checking that all tasks in the care plan are being actioned and
  - all care team members are actually doing what is in the plan and
  - ensuring that GPMPs and the TCAs are current and up to date

- Reviews increase adherence to actions on the plan

- Improves clinical measures
  - Eg. HbA1c, Lipids in diabetes
  - enhances patient sense of being cared for by your practice
  - provides reassurance patients understand what they need to know and do

- Requires a system for ensuring regular and ongoing follow up
MBS item numbers intended specifically to support care of people with chronic disease
The MBS definition of a chronic disease is one that has been (or is likely to be) present for six months or longer.

Chronic disease management items are designed for patients who:
- would benefit from a structured approach
- would benefit from ongoing care from a multidisciplinary team (Department of Health).
MBS item numbers

The MBS item numbers exist to support CDM via:

- #721 GP Management Plan (GPMP)
- #732 Review of GP Management Plan
- #723 Coordination of Team Care Arrangements (TCA)
- #732 Coordinate a Review of Team Care Arrangements
- #10997 Practice nurse (PN) and Aboriginal health worker (AHW) provision of monitoring and support

There are a number of the compliance requirements for each of these MBS item numbers that are all available via www.mbsonline.gov.au
<table>
<thead>
<tr>
<th>Service</th>
<th>Item</th>
<th>Medicare Benefits schedule ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation of a GPMP</td>
<td>721</td>
<td>$144.25</td>
</tr>
<tr>
<td>Review of a GPMP to which 721 applies</td>
<td>732</td>
<td>$72.05</td>
</tr>
<tr>
<td><strong>Team care arrangement</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coordinate</td>
<td>723</td>
<td>$114.30</td>
</tr>
<tr>
<td>a) Review of a GPMP to which a 721 applies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Coordinate a review of team care arrangements to which 723 applies</td>
<td>732</td>
<td>$72.05</td>
</tr>
<tr>
<td><strong>Multidisciplinary care plan</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contribute to a review</td>
<td>729</td>
<td>$70.40</td>
</tr>
<tr>
<td><strong>Multidisciplinary care plan prepared by another provider</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contribute to a review</td>
<td>731</td>
<td>$70.40</td>
</tr>
<tr>
<td><strong>Medication management review</strong></td>
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<td></td>
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<tr>
<td>Residential</td>
<td>903</td>
<td>$106.00</td>
</tr>
<tr>
<td>Domiciliary medication review</td>
<td>900</td>
<td>$154.80</td>
</tr>
</tbody>
</table>
It is the responsibility of the practitioner in whose name the MBS care planning items are being claimed to ensure compliance with the MBS requirements.
Access to Allied Health Items

- Patients who have both a GPMP (item 721) and TCA (item 723) are eligible for the individual allied health services that they need on the MBS.

- Patients can claim up to five allied health services per calendar year (MBS items 10950-10970)

- Indigenous Australians are eligible for up to 10 services per calendar year

- Patients can claim for services from the following:
  - Aboriginal health workers
  - Aboriginal and Torres Strait Islander health practitioners
  - audiologists
  - chiropractors
  - diabetes educators
  - dieticians
  - exercise physiologists
  - mental health workers
  - occupational therapists
  - osteopaths
  - physiotherapists
  - podiatrists
  - psychologists
  - speech pathologists
  - asthma educators
  - orthoptists
  - orthotists or prosthetists

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Evaluation by practices of their own data, and the RACGP Clinical indicators
Quality health records in Australian primary healthcare: A guide

This guide assist GPs to work towards having high quality health records that provide for:

• safe clinical decision making
• good communication with other health professionals
• trustworthy partnerships with patients
• effective continuity and systematic patient care

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**RACGP Clinical Indicators**

- The RACGP Clinical Indicators have been developed to improve the quality of clinical services and improve and monitor the health and wellbeing of patients.

- The RACGP is currently developing a clear link between the indicators and the new Quality Improvement requirements in the current QI&CPD triennium.

- The RACGP will work with software providers to encourage the automation of data collection within existing software packages.

- The RACGP Clinical Indicators will be released later this year.

- By completing the clinical indicators, GPs will be able to complete their Plan Do Study Act (PDSA) and gain 2 QI&CPD points per indicator.

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Managing chronic disease in your general practice

or

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What is systemisation

- Involves a set of detailed methods, procedures and routines created to carry out a specific activity, perform a duty or solve a problem.
- All aspects of a practice can and should be systemised
- It’s about a process not an individual
- Maximises productivity and doctor/staff satisfaction
- Reproducible
- Same way every day
Benefits of developing a CDM business process for General Practitioners

Well managed and effective CDM business process:

• Increase quality of care
• Increase consistency, reliability and thoroughness of care
• Increases the range of services
• Increases capacity and expertise within the practice
• Improves efficiency in the use of team time
• Shared responsibility
• Increased numbers of completed GPMPs and TCAs and of reviews of these

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The general practice team

Effective management of patients with a chronic disease usually requires a multi-disciplinary team based approach.

Within general practice, a team may include:

- the GP
- a Practice Nurse
- other health professionals eg Dietitian, Podiatrist, Optometrist
- Practice Managers

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The Practice Nurse Role

- organising the chronic condition management systems and processes in the practice
- assist with the identification of patients in the target group
- assist the GP in preparing or reviewing a care plan (provided on behalf of the GP)
- assist with the provision of CDM under the general practitioner’s supervision.

Research also shows that the inclusion of practice nurses in CDM can improve patient care and outcomes and reduce GP workload.
The roles of the practice manager and reception staff

• Contribute to the development of the practice’s
  • CDM governance framework
  • Policies and procedures
• Oversee the practice’s CDM operational process including:
  • Clinic services
  • Team member responsibilities
  • Appointment structure
  • Reminder systems
• Periodically review and analyse the practice’s CDM activity including:
  • Clinical outcomes
  • Billing profiles
  • Opportunities for improvement

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Using technologies to assist with chronic disease management
How can electronic systems help?

- Improved quality-of-care and better health outcomes
- Easier access to care for existing patients
- Reduction in administrative time, allowing greater time for patients
- More efficient processes and communication

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Data extraction and analysis

- Most clinical software packages have limited capabilities for the extraction and analysis of information for the entire patient population. This makes them difficult to use for systematic management of patients.

- There is a range of data extraction tools on the market that enable you to extract patient population information from your clinical and administrative databases.

- This allows the practice to review the care that it is providing and enables it to use this information for quality improvement for a range of different patient populations within the practice.
Some available data extraction and audit tools

Canning Data Extraction Tools

Doctors’ Control Panel

Pen Clinical Audit Tool

Topbar

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A care planning tool

cdmNet – care planning and care co-ordination that tracks and helps all tasks to be followed up

http://precedencehealthcare.com/cdmnet/
Data cleansing (steps to improve data)

- Protected time
- Policies and procedures to ensure quality of information
- Agreed use of standardised clinical coding and terminology
- Use of clinical audit tools
  - Data extraction
  - Identify and exclude invalid data
  - Undertake data analysis
Data analysis: What can you do with the data?

For example:

- You can use a data extraction and analysis tool that will show which of your patients with diabetes do not have a GPMP and a TCA.
- A prompt can be generated to remind the next GP who sees them to arrange for these to be done.
- You can also generate a list of patients who have a GPMP and or a TCA that has **not been reviewed** within the last six months and **schedule a review**.

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Electronic clinical systems can help us during consultations

They can alert GP or practice team about whether:

• the patient has a chronic illness and is eligible for a GPMP and TCA
• the patient is due for a GPMP or TCA Review
• the patient is due for a Diabetes or Asthma Annual Cycle of Care
• there are any new notes or documents about the patient from other care providers on patient’s care team
• In CDM structured templates may be of assistance

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Improved care planning

Software packages are able to provide structured care plans that identify:

- goals, targets, actions that
  - are based on existing recorded data, personalised and for multiple morbidities
- display current information
- evolve and are constantly added to by the whole care team

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More effective care management

Digital systems can:

- **track appointments, actions and progress** across the entire care team, compare these with the care plan, and generate an instant snapshot of what has been planned, done, and not done.

- automate time-consuming collaborative processes, such as team agreements and follow-up reports, reducing phone tag, fax follow-up, and document scanning.

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Support for patient self-management

Digital products and services can support patient self-management, including:

- targeted reminders to help patients adhere to their plan,
- mobile applications for patients to record and transmit observations and measurements
- social networks for sharing patient experiences and providing peer support.

Some CDM services integrate with these applications and have the potential to improve quality of care.
Reduced red tape and administration

CDM, and the use of the current MBS care planning and coordination item numbers in particular, involve considerable administrative overheads.

Digital products and services can help alleviate this administrative burden by:

• automating administrative tasks
• ensuring Medicare requirements are met
• reducing the risk of negative compliance audits
• automating the creation and distribution of documentation.

Call 1800 194 319 for technical assistance
1. Establish a system for your business process
2. Define the roles within the practice
   • Who is doing what? Including the GP, PM, PN and reception
   • Map the workflow from the GP initiating the idea of a plan, to the plan being completed and reviewed
3. Run an initial clinical data extraction report
4. Analyse the practice’s data:
   • how many patients with chronic disease does each GP have, how many care plans does each GP do now, how many reviews and how often
5. Plan the practice’s chronic disease targets and use of MBS item numbers
Webinar summary

6. Maximise practice nurse efficiency
   • ensure there is protected time allocated to CDM

7. Ensure there is a system for red-flagging
   • For patients that need extra attention (overdue review, overdue annual cycle of care, out of range measures)

8. Use available electronic tools

9. Develop an annual strategy with key measurable

10. Review periodically

11. Provide feedback to the practice team
Supporting our members

RACGP NFSI eHealth network
The aims of the network are to provide:

• a discussion forum
• a collective point of contact for the RACGP on topical
• a forum for innovation and advocacy
• a forum for knowledge exchange, development, presentation and dissemination of research

This is the end of the education part of the webinar.

Here is a word from our sponsors
**cdmNet**

This is an online service that makes it easier for GPs, practice nurses and other healthcare providers to plan, manage and coordinate the care of their patients with chronic disease.

It tracks all the tasks/actions in a plan as they happen so that at least 50% of the review process is complete when the patient comes in.

The RACGP has endorsed cdmNet as a product that can support quality improvement in general practice. The RACGP recognises that cdmNet could be a useful tool for helping general practitioners in managing patients with chronic disease.

More information on cdmNet can be found at [http://precedencehealthcare.com/cdmnet/](http://precedencehealthcare.com/cdmnet/)

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**RACGP**

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Evidence: improved quality care

• A study conducted by Monash University of the effect of cdmNet, for patients with diabetes found improvements in quality of care.
  
• 577 patients with diabetes were managed with a GPMP created using cdmNet.

• Patients using cdmNet were 4x more likely to have their GPMP or TCA followed up through regular reviews than the national average.

• 85% of Patients with regular reviews had greater improvements in the proportion of annual cycle of care clinical tests completed (85% vs 59%)
Improved Clinical Outcomes

Patients initially >53mmol/mol (P<0.001)

Patients with regular reviews (p<0.05)

Call 1800 194 319 for technical assistance
To contact cdmNet or to register

Email: cdmnet@precedencehealthcare.com

Phone: 1300 236 638 or 03 9023 0800

To register your interest for cdmNet:
http://precedencehealthcare.com/cdmnet/welcome/
Additional Links

- RACGP Consultation paper – Vision for a sustainable health system – April 2015

- The Chronic Care Model MacColl Institute


- For more information and a breakdown of the MBS item numbers and their requirements, go to


