Chronic Disease Program Development

Chronic Disease Management

Aboriginal Health Conference 2019

3hrs…

Medicare Regulations

Patient Identification

How to / health coaching

History of Care Planning

Care plans were introduced in Australia in 1999:

- changing general practitioners' management of chronic illness
- enable GPs to shift from short-term, episodic fragmented care to whole person care that is integrated with other health care providers.

History of Care Planning

In July 2005, in response to GPs' concerns, the Australian Government split the care plan program in two.

Medicare Review Taskforce

- Minimum 40 mins
- Combining GPMP and TCA
- Increased rebate for Reviews
- Patient enrollment

GPMP's and TCA's

GP Management Plans (GPMPs) could be undertaken by GPs alone, and Team Care Arrangements (TCAs) were instituted to cover cases where the GP needed to involve other health care providers.

Why the hesitancy to undertake GP Management Plans or Health Assessments?

Why the hesitancy?

- Fear of a Medicare audit
- Limited time & ***resources***
- Don’t see the value to the patient
- Don’t see the value to the clinic
- Waste of Medicare funding

GPMP's – MBS Item 721

The CDM Medicare items are for GPs to manage the health care of people with chronic or terminal medical conditions and/or complex care needs.

GPMP's – MBS Item 721

A chronic medical condition is one that has been (or is likely to be) present for six months or longer, for example, asthma, cancer, cardiovascular disease, diabetes, musculoskeletal conditions and stroke.

GPMP's – MBS Item 721

MBS does not list all possible medical 'conditions' that are or are not regarded as chronic medical conditions for the purposes of the CDM items.

GPMP's – MBS Item 721

Whether a patient is eligible for a CDM service or services is essentially a matter for the GP to determine, using their clinical judgement and taking into account both the eligibility criterion and the general guidance.

GPMP's – MBS Item 721

MBS has received queries about whether the following are chronic medical conditions: alcohol or other substance abuse; smoking; obesity; unspecified chronic pain; hypertension, hypercholesterolemia, or syndrome X; impaired fasting glucose tolerance or impaired glucose tolerance; pregnancy…

GPMP's – MBS Item 721

MBS recognises that conditions such as these can occur across a wide spectrum of severity and in a broad range of circumstances.

In these cases, the GP should satisfy themselves that their peers would regard the provision of a CDM service as appropriate for that patient, given the patient's needs and circumstances.

GPMP's – MBS Item 721

TCA's - MBS item 723

TCAs are for patients who have a chronic or terminal medical condition and complex needs requiring ongoing care from a multidisciplinary team.

TCA's - MBS item 723

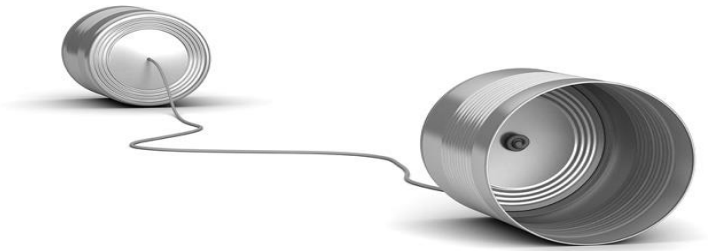
Medicare funding for the service is not aimed at patients with straightforward needs requiring 'standard treatment' from one consultation only.

TCA's - MBS item 723

It is designed for patients who require care from at least three collaborating health or care providers, each of whom provides a different kind of treatment or service and at least one of whom is a medical practitioner.

TCA's - MBS item 723

Communication must be two-way, preferably oral or, if not practicable, in writing (including by exchange of faxes or email).



It should relate to the specific needs and circumstances of the patient. The communication from the collaborating providers must include advice on treatment and management of the patient.

TCA's - MBS item 723

Australian Government
Department of Health

Referral Form for Individual Allied Health Services under Medicare for patients with a chronic medical condition and complex care needs

Note: GPs can use this form issued by the Department of Health or one that contains all of the components of this form.

To be completed by referring GP:

Please tick:

☐ Patient has GP Management Plan (item 721) AND Team Care Arrangements (item 723) OR

☐ GP has contributed to or reviewed a multidisciplinary care plan prepared by the patient's aged care facility (item 731)

Note: GPs are encouraged to attach a copy of the relevant part of the patient's care plan to this form.

GP details

Provider Number ☐☐☐☐☐☐☐☐☐☐

Name

Address Postcode

Patient details

Medicare Number ☐☐☐☐☐☐☐☐☐☐ Patient's ref no. ☐ Patient's DOB._____/_____/_____

First Name Surname

Address Postcode

Allied Health Provider (AHP) patient referred to: (Please specify name or type of AHP)

Name

Address Postcode

Referral details – Please use a separate copy of the referral form for each type of service

Eligible patients may access Medicare rebates for a maximum of 5 allied health services (total) in a calendar year. Please indicate the number of services required by writing the number in the 'No. of services' column next to the relevant AHP.

No of services	AHP Type	Item Number
	Aboriginal Health Worker/Aboriginal and Torres Strait Islander Health Practitioner	10950
	Audiologist	10952
	Chiropractor	10964
	Diabetes Educator	10951
	Dietitian	10954

No of services	AHP Type	Item Number
	Exercise Physiologist	10953
	Mental Health Worker	10956
	Occupational Therapist	10958
	Osteopath	10966
	Physiotherapist	10960

No of services	AHP Type	Item Number
	Podiatrist	10962
	Psychologist	10968
	Speech Pathologist	10970

Referring General Practitioner's signature Date signed

The AHP must provide a written report to the patient's GP after the first and last service, and more often if clinically necessary.

Allied health providers should retain this referral form for record keeping and Department of Human Services (Medicare) audit purposes.

This form may be downloaded from the Department of Health website at www.health.gov.au/mbsprimarycareitems

THE FORM DOES NOT HAVE TO ACCOMPANY MEDICARE CLAIMS

CD Program Developm

TCA's - MBS item 723

A team might also include home and community service providers, or care organisers such as: education providers; 'meals on wheels' providers; personal care workers (workers who are paid to provide care services); and probation officers where they are contributing to the plan and not simply providing a service identified in the plan.

TCA's - MBS item 723

Similarly, persons such as a Workcover Rehabilitation Case Manager, fitness instructor and personal trainer could be members of a TCAs team if they are contributing to the plan.

TCA's - MBS item 723

Only one specialist or consultant physician can be counted towards the minimum of two contributing team members who, with the coordinating GP, make up the core TCAs team.

Review's - MBS item 732

Item 732 is for patients who have a current GP Management Plan (GPMP) and Team Care Arrangements (TCAs) and require a review of one or both of these care plans.

Claiming frequency

Name	Item no.	Recommended frequency	Minimum claiming period*
Preparation of a GP Management Plan	721	2 yearly	12 months
Coordinate the development of Team Care Arrangements	723	2 yearly	12 months
Review of a GP Management Plan and/or review of Team Care Arrangements	732	6 monthly	3 months
Contribution to a multidisciplinary care plan prepared by another provider	729	6 monthly	3 months
Contribution to a multidisciplinary care plan prepared by a residential aged care facility	731	6 monthly	3 months

Health Assessments

There are four time based Health Assessment MBS Item numbers:

701 – Brief
(lasting less than 30 minutes)
703 – Standard
(lasting between 30-45 minutes)
705 – Long
(lasting between 45-60 minutes)
707 – Prolonged
(Lasting 60 minutes or more)

ATSI Health Check – MBS Item 715

This health assessment is available to all people of Aboriginal and Torres Strait Islander descent and should be used for health assessments for the following age categories:

- An Aboriginal or Torres Strait Islander child who is less than 15 years.
- An Aboriginal or Torres Strait Islander person who is aged between 15 years and 54 years.
- An Aboriginal or Torres Strait Islander older person who is aged 55 years and over.

Aboriginal Health *Practitioner* MBS Item Numbers

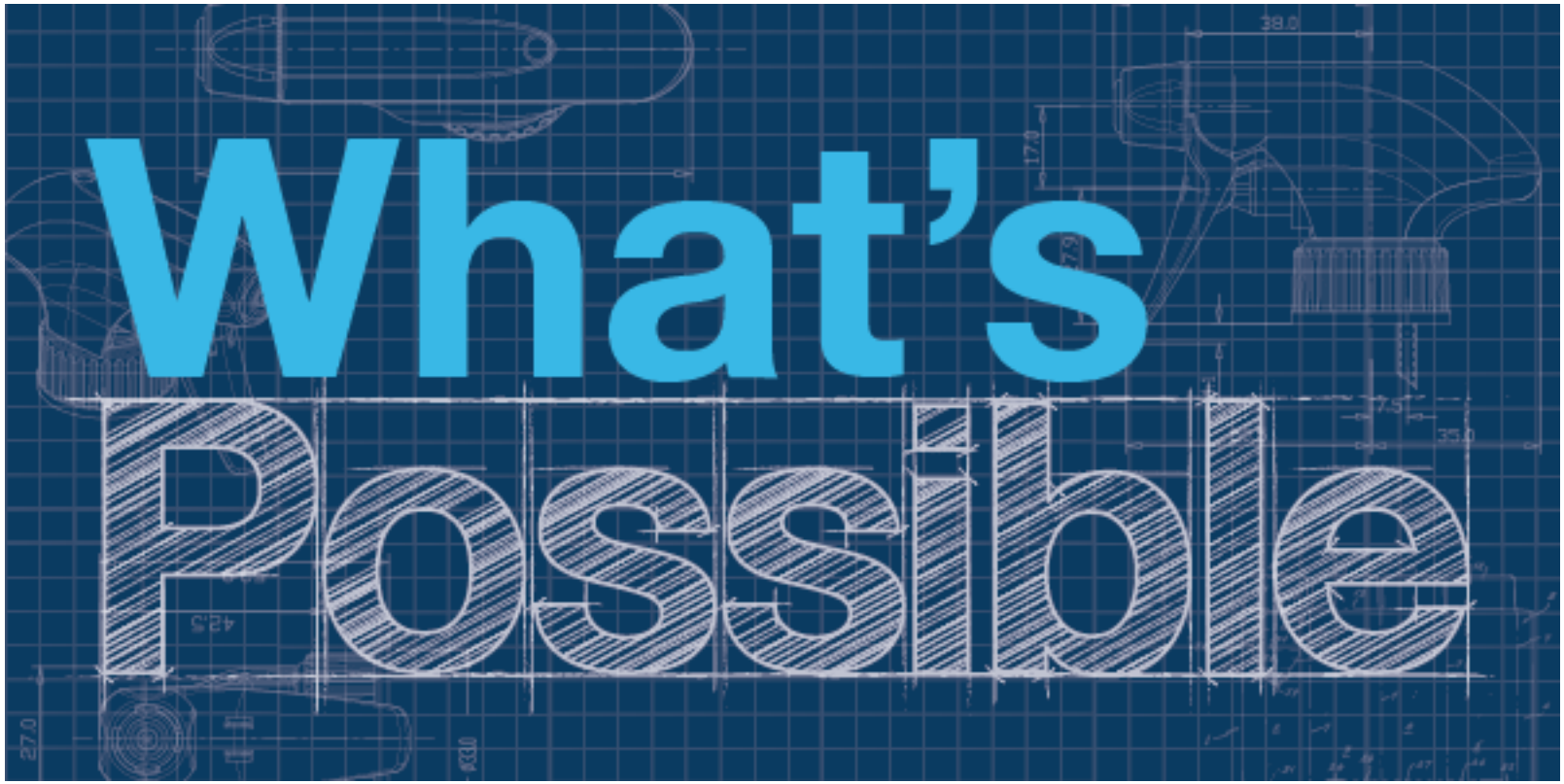
Service	What's Possible		MBS Item Number for *AHP to Claim*	Referral Needed?	Amount during Calendar Year?	Documentation Needed?
Medication Delivery	If visit ***less than*** 20mins	- Dropping of Medication - Brief chat/advocacy - Script Reminders	10987, or 10997	No No	10 5	Short progress note using clinical item
	If visit ***greater than*** 20mins	- Provide education - BP, BGL, advocacy	10950 (Care Plan) 81300 (Health Check)	Yes GP or Nurse to generate	As per referral	AHW-Follow Up Template
Clinic Triage	If contact ***less than*** 20mins	- Measurements including BP, Pulse etc	10987, or 10997	No No	10 5	Short progress note using clinical item
	If contact ***greater than*** 20mins	- Measurements including BP, Pulse etc - History taking - Education	10950 (Care Plan) 81300 (Health Check)	Yes GP or Nurse to generate	As per referral	AHW-Follow Up Template
Home or Community Visit	If visit ***less than*** 20mins	- Dropping of Medication - Brief chat/advocacy - Recall, appt making, liaising between services	10987, or 10997	No No	10 5	Short progress note using clinical item
	If visit ***greater than*** 20mins	- Dropping of Medication - Brief chat - Recall, appt making, liaising between services	10950 (Care Plan) 81300 (Health Check)	Yes GP or Nurse to generate	As per referral	AHW-Follow Up Template
Retinal Screening	Contact to be ***greater than*** 20mins	- Retinal Screening - Education	10950 (Care Plan) 81300 (Health Check)	Yes GP or Nurse to generate	As per referral	AHW-Follow Up Template
Clinical Services	Could be conducted as part of 'Outreach Clinic' as well as Clinic Triage.	- HbA1c POC - Hb - ACR POC - Pregnancy Test - ECG - Spirometry - Immunisation - Wound Care - Antenatal Check	73840 73802 73844 73806 11700 11506 10988 10989 16400	No No No No No No No No No	1 x 3 monthly Unlimited 12-monthly Unlimited Unlimited Unlimited Unlimited Unlimited 10x per pregnancy	***Must be attached to a GP for claiming***

Aboriginal Health *Worker* MBS Item Numbers

Service	What's Possible		MBS Item Number	Referral Needed?	Amount during Calendar Year?	Documentation Needed?
Medication Delivery	If visit ***greater than*** 20mins	- Provide education - BP, BGL, advocacy, - Script Reminders	10950 (Care Plan) 81300 (Health Check)	Yes GP or Nurse to generate	As per referral	AHW-Follow Up Template
Clinic Triage	If contact ***greater than*** 20mins	- Measurements including BP, Pulse etc - History taking - Education	10950 (Care Plan) 81300 (Health Check)	Yes GP or Nurse to generate	As per referral	AHW-Follow Up Template
Home or Community Visit	If visit ***greater than*** 20mins	- Dropping of Medication - Brief chat - Recall, appt making, liaising between services	10950 (Care Plan) 81300 (Health Check)	Yes GP or Nurse to generate	As per referral	AHW-Follow Up Template
Retinal Screening	Contact to be ***greater than*** 20mins	- Retinal Screening - Education	10950 (Care Plan) 81300 (Health Check)	Yes GP or Nurse to generate	As per referral	AHW-Follow Up Template
Clinical Services		- HbA1c POC - ACR POC - Pregnancy Test - ECG - Spirometry	73840 73844 73806 11700 11506	No No No No No	1 x 3 monthly 12-monthly Unlimited Unlimited Unlimited	***Must be attached to a GP for claiming***

Practice Nurse MBS Item Numbers

Service	What's Possible		MBS Item Number	Referral Needed?	Amount during Calendar Year?	Documentation Needed?
Clinical Services		- HbA1c POC - Hb - ACR POC - Pregnancy Test - ECG - Spirometry - Antenatal Care	73840 73802 73844 73806 11700 11506 16400	No No No No No No No	1 x 3-monthly Unlimited 12-monthly Unlimited Unlimited Unlimited 10x per pregnancy	***Must be attached to a GP for claiming***
Chronic Disease Management		- Chronic Disease follow-up	10997	Pt needs a current GP Management Plan	5x Calendar Year	Short progress note using clinical item ***Must be attached to a GP for claiming***
Health Assessment		- Health Assessment follow-up	10987	Pt needs a current Health	10x Calendar Year	Short progress note using clinical item ***Must be attached to a GP for claiming***



CD Program Development

Chronic Disease Program Development

Chronic Disease Management

Nurse-Led Clinics

Chronic Disease Management – The Nurses, AHW, AHP Role…

There are approximately 12,322 nurses working within general practice (AIHW Nursing and Midwifery Workforce Report 2014).

Approximately 1600 Aboriginal Health Workers (Australian Industry and Skills Committee).

Chronic Disease Management – The Nurses, AHW, AHP Role…

The potential of health care organisations to improve outcomes of chronic illness will depend on their ability to provide collaborative care services to the many chronically ill patients that they serve.

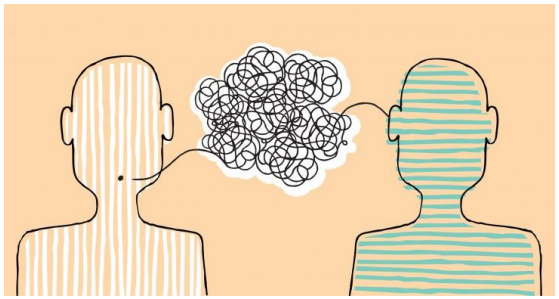
A study looking at collaborative management identified four elements of health care that can enhance collaborative management.

Collaborative Management of Chronic Illness
Michael Von Korff, ScD; Jessie Gruman, PhD; Judith Schaefer, MPH; Susan J. Curry, PhD; and Edward H. Wagner, MD, MPH
http://annals.org/aim/article/711027/collaborative-management-chronic-illness

Chronic Disease Management – The Nurses, AHW, AHP Role…

1. Collaborative Definition of Problems

Providers usually define problems in terms of diagnosis, or poor compliance with treatment.



Patients are more likely to define problems in terms of pain, symptoms, interference with functioning, emotional distress, or fears about unpredictable health consequences of illness.

Chronic Disease Management – The Nurses, AHW, AHP Role…

2. Targeting, Planning and Goal Setting

Focusing on a specific problem, establishing realistic objectives, and developing an action plan for attaining those objectives are beneficial steps in managing chronic illness.

Chronic Disease Management – The Nurses, AHW, AHP Role…

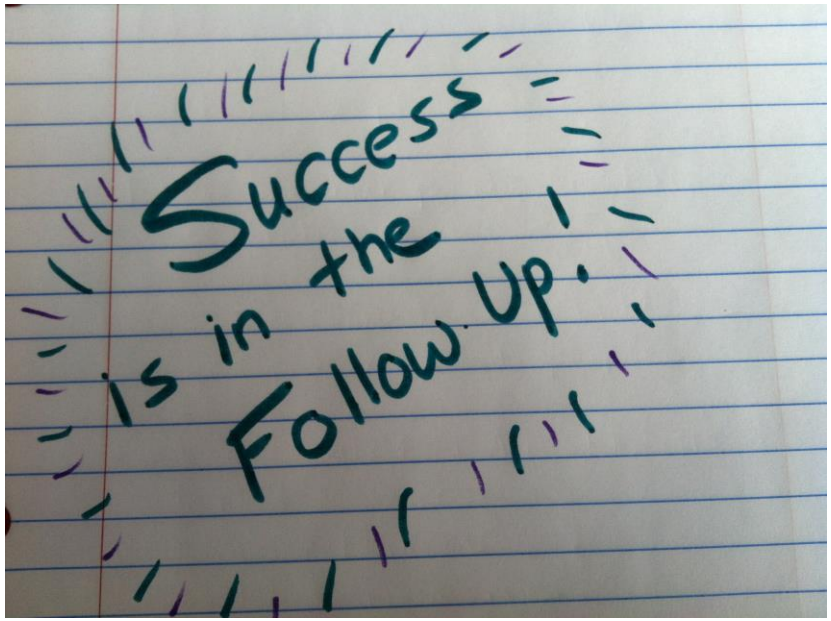
3. Creating a Continuum of Self-Management Training and Support Services

Patients' abilities to care for themselves are enhanced by services that teach skills needed to carry out medical regimens, guide health behavior change, and provide emotional support.

Chronic Disease Management – The Nurses, AHW, AHP Role…

4. Active, Sustained Follow-up

Contact with health care providers that is planned and sustained over time improves patient outcomes.



Chronic Disease Management - The Nurses, AHW, AHP Role…

Where do we start?

Nurse, AHW, AHP - Led Clinics

Who – do we see, who do we target?

What – do we do with them?

Where – do we see them?

When – we do see them, how many can we see?

Why – are we doing this, what is the point?

How – do we make this financially viable?

Who do we see?

- **23 490 700 - Australian Population** as at June 2014[1]
- About **half (11 745 350) of all Australians** have a chronic disease[2]

Who do we see?

Questions to Ask:

- Who are our patient population?
- What is impacting our community/region?
- What are we good at?
- What do we want to achieve?

What do we do with them?

What is the desired outcome of this initiative?

Do we have the resources to manage these patients?

- Allied Health Care Providers
- Education materials (paper vs internet)
- Skills – e.g. foot check

Where do we see them?

Do we have room availability?

Can we offer privacy?

How often do we have access to a suitable space?

When do we see them, how many can we see?

When do we see them, how many can we see?

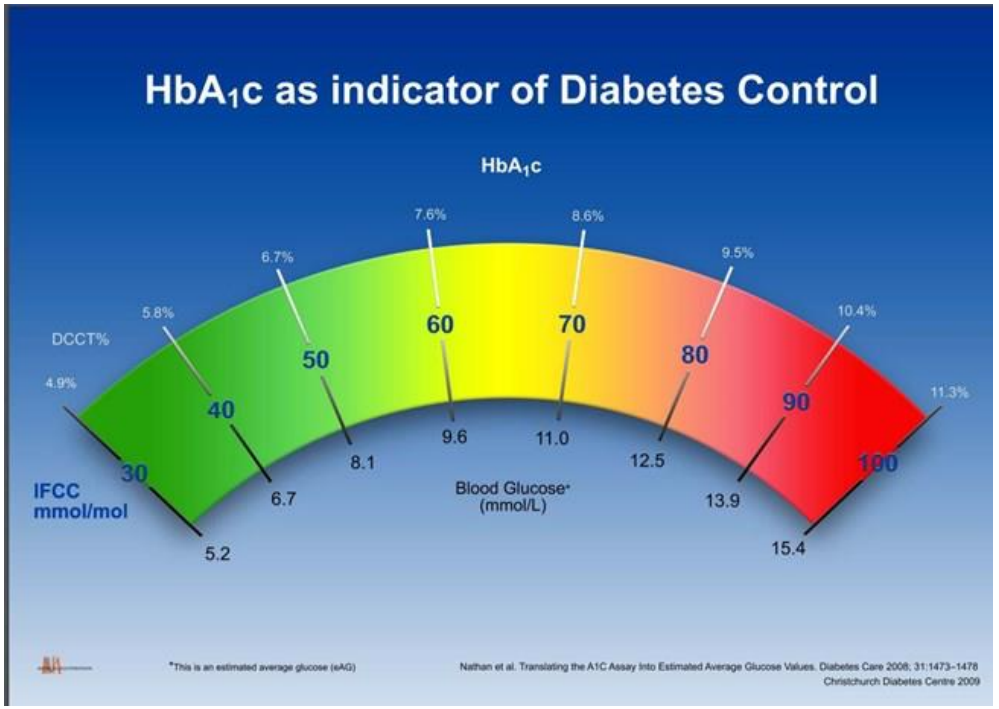
Take into account:

- Staff availability
- Room availability
- ***Who is in most need?***

When do we see them, how many can we see?

Who is in most need?

Example:
With limited time and availability, choosing patients with a higher HbA1c…



Why are we doing this, what is the point?

Improve Patient Outcomes

Increase the Nurse role in GP

Financial benefits

Why are we doing this, what is the point?

Improve Patient Outcomes

- Clinical indicators
- Improved medication compliance
- Improved understanding or disease state
- Ability to self-manage

Why are we doing this, what is the point?

Increase the Nurse, AHW, AHP role in Patient Care

- Clinical leadership
- Proactive role in patient management
- Development of policies and procedures or improved patient management

CD Program Development

Why are we doing this, what is the point?

Financial benefits

- Increase revenue through Medicare billings, for the participating GP's as well as ownership
- Ability to build a business model for future initiatives

Why are we doing this?

Improve Patient Outcomes

Increase the Nurse, AHW, AHP role in patient care

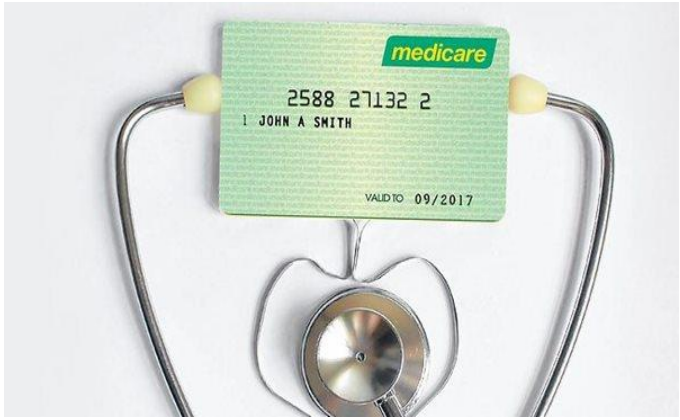
Financial benefits

Why are we doing this?

New Care Plan:
721 + 723 - $258.55

Review:
732 + 732 + 10997 - $156.10

Additional Items:
11700 ECG - $26.60
11506 Spiro - $17.50
11610 Doppler - $54.20
2517 Diabetes COC - $37.05



Why are we doing this?

1 Diabetic patient seen over 2 years for:

Initial care plan, plus
Review every 4 months (5 reviews), plus
Nurse review numbers (10x10997), plus
Yearly ECG (2)

$1,152.25 per patient / 2 yearly

Questions?

Chronic Disease Program Development

Chronic Disease Management

Health Coaching

Health Coaching

There is an enormous gap between wanting to be well and the everyday reality of living with the physical and mental health consequences of overeating, under-exercising and having no down-time to recharge…

What is Coaching?

"The art of creating an environment, through conversation and a way of being, that facilitates the process by which a person can move toward desired goals in a fulfilling manner" W. Timothy Gallwey.

What is Coaching?

While most of us long for better physical and mental well-being, evidence suggests that we're moving in the opposite direction.

Despite continuous media attention devoted to healthy lifestyles, there are now more overweight people worldwide…

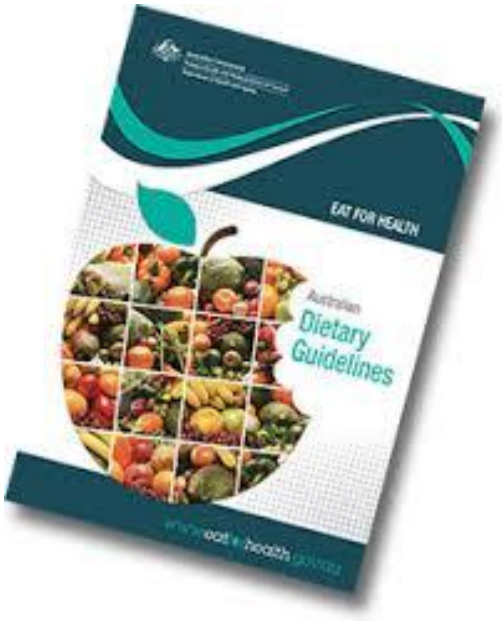
What is Coaching?

Factors affecting healthy choices?

Demands on everyday life, which have never been more

Factors affecting healthy choices?

Wellness guidelines, products, and services making it difficult to create a personal formula



Factors affecting healthy choices?

Obstacles to Change, including confusion, resistance and ambivalence

Factors affecting healthy choices?

Histories of repeated failure, most do not believe they can master their weight and wellness

Reality Check!

You are not a full-time Health Coach!

How can we take Coaching principles and make these a part of out everyday interactions with patients…

Core Coaching Skills

Unconditional Positive Regard

“Being completely accepting toward another person”

Core Coaching Skills

Show Empathy

"A respectful understanding of another person's experience, including his or her feelings, needs and desires"

Core Coaching Skills

Be a Humble Role Model

“Walking the talk” without being boastful, arrogant, or rude.

Core Coaching Skills

Slow Down

“Being in a hurry to “get down to business” will compromise or lose trust and rapport”

Core Coaching Skills

Pay Full Attention

“Trust and rapport are not built through multi-tasking. Distractions, whether physically, intellectually, emotionally, or spiritually will disrupt trust and rapport”

Core Coaching Skills

Confidentiality Is Crucial

Core Coaching Skills

Be Honest

”Through honest inquiries and reflections, an authentic and meaningful relationship is built”

Open-Ended Inquiry

Open-Ended Inquiry

Open-ended questions require long, narrative answers.

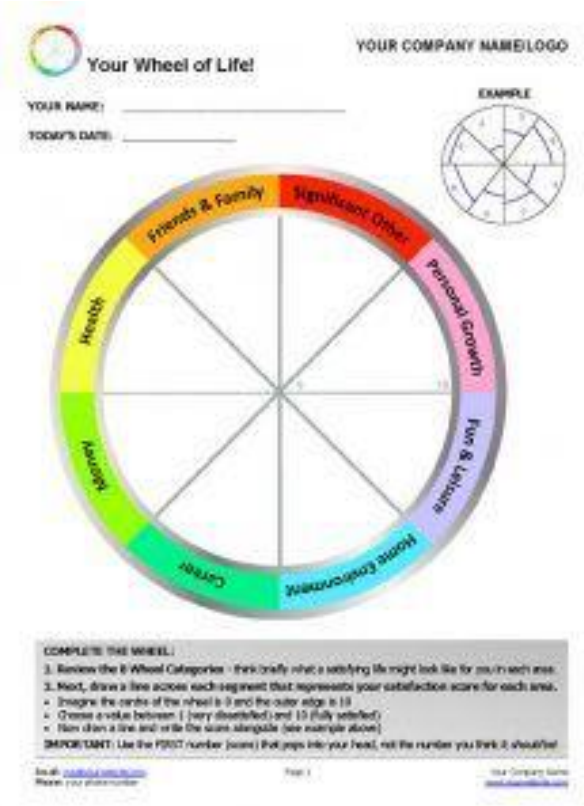
Closed-ended questions require short, “sound-bite” answers

Positive Reframing

People have a natural tendency to look at, focus on, and talk about problems/ failures.

- “I blew my diet”
- “I didn’t exercise like I said I would”
- “I had a cigarette”

Wheel of Life



CD Program Development

What Makes My Heart Sing

What Makes My Heart Sing? YOUR COMPANY NAME/LOGO

CD Program Development

Questions?