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GENERAL PRACTICE SUPERVISION AUSTRALIA

FAQ
FREQUENTLY ASKED QUESTIONS

PODCAST WEBINAR

Teaching Your Registrar about Chronic Disease Management and Related MBS Items

1 in every 2 Australians has at least 1 of the following chronic diseases:

1. Cancer
2. Cardiovascular Disease
3. Mental Health Conditions
4. Arthritis
5. Back Pain
6. COPD
7. Asthma
8. Diabetes

1 in every 4 Australians is estimated to have 2 or more of these conditions.

What is Chronic Obstructive Pulmonary Disease?

Chronic Disease Management is the term used for delivering long term care for patients with one or more chronic conditions defined by Medicare as having been present "(or is likely to be present) for at least six months or is terminal".

What are the different types of CDM appointments?

1. Care Plans
2. Care Plan Reviews
3. Health Assessments
4. Mental Health

Who is involved in your patient's care?

- Patient
- Patient's family/carers
- GPs
- Nurses
- Aboriginal Health Workers/Practitioners
- Allied Health Providers
- Specialists
- Admin staff
- Other service providers/programs

Which of the practice team members are involved in Chronic Disease Management?

Reception	Nurse/ Aboriginal Health Worker	GP
• Patient Engagement • Booking Appointments • Confirming Appointmnets • Updating details • Checking Patient Eligibility	• Patient Engagement • Collection of information • Prevention & Early Intervention activities • Assisting GP to co-ordinate care	• Patient Engagement • Plans & co-ordinates care • Provides ongoing reviews to monitor progress

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What are the key tips for CDM?

1. **Medicare**

   Get to know your MBS Item Numbers, Descriptions, and MBS Billing Combinations, and review changes regularly.

2. **Efficiencies – Software, Templates, Text Shortcuts and Teamwork**

   Progress notes are important for all health care providers working in primary health care. They increase efficiencies as a tool for communication between team members and are a great way to on-board a new team member to Chronic Disease Management.

   Most Clinical Software will allow you to create your own Progress Note Shortcuts and Templates. Shared access to these shortcuts and templates ensures consistency across the practice team while helping to save time and safeguard against forgetting key components of the CDM activity.

3. **Patient Engagement**

   - CDM is about long-term care
   - Don't overwhelm the patient with lists of clinical tasks to complete (See: Today & Next Appointment)
   - Before you see the patient, review the clinical record
   - Booking the next appointment increases attendance rates
   - Build self-efficacy with smaller achievable goals
   - Remember your goals are not the patient's goals

What are the main practice challenges in CDM within GP practices?

- Staff Training (including the part-time workforce)
- Patient engagement
- Establishing systems and processes
- The health system itself – eg its limitations and the complexity of problems)
- Numbers of patients and Time
- Technology (Computer Literacy, Software, Templates)
- Time

What are the different types of CDM activities?

Care Plans, Care Plan Reviews, and Health Assessments are the three main CDM activities that should be (regularly) performed in your clinic.

What do I need to ensure my registrar covers in a CDM appointment?

Apart from MBS item numbers for patient eligibility (721/723 for Care Plans; 701/ 703/ 705/707 OR 715 if Aboriginal and/or Torres Strait Islander for Health Assessments), the below CDM checklist is identical for Care Plans and Health Assessments:

1. **Check patient eligibility** (admin staff can do this the day before appointment; registrar needs to check it has been done before seeing the patient)
2. **Progress note shortcuts** (bring up shortcut/template)
3. **Before you see the patient** (review clinical record before calling the patient in)
4. **Patient Details** (Family/Social/Medical/Surgical History)

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5. Observations

ALL Conditions and Health Assessments	Specific Conditions	Specific Health Assessments
Blood Glucose Level	Respiratory Rate (Respiratory Conditions)	Heart Rhythm (Aboriginal and/ or Torres Strait Islander 55+/>75yr/ RACF)
Blood Pressure	Oxygen Saturation (Respiratory Conditions)	Audiometry (Aboriginal and Torres Strait Islander15-54 yrs/Intellectual Disability)
Heart Rate	Peak Flow (Respiratory Conditions)	Neonatal Hearing Screening & Audiometry (Aboriginal and/ or Torres Strait Islander 0-14 yrs)
ECG (within last 12 months)	Point of Care Testing (HbA1c/ ACR) (Diabetes/ CKD)	
Visual Acuity (within last 12 months)		
Height/Weight/ BMI/Waist		
Urinalysis		

6. Medications

7. Bloods

8. Specialist, Allied Health and Other

Specialist	Allied Health	Other
Cardiologist	Podiatrist	Community Nurses
Endocrinologist	Audiologist	Optomitrist
Respiratory Physician	Aboriginal Health Worker	Hospital Programs
Rheumatologist	Dietitian	- Falls prevention and balance program
Neurologist	Physiotherapist	- Cardiac Rehabilitation
Ophthalmologist	Exercise Physiologist	- Pulmonary Rehabilitation
Gastroenterologist/ Hepatologist	Psycholgist	- Musculoskelatal
Nephrologist	Social Worker	- Neurology
Dermatologist	Chiropractor	- Pain and Chronic Fatigue
Haematologist	Osteopath	Pharmacist
Geriatrician	Speech Pathologist	Another GP
Psychiatrist	Diabetes Educator	Drug & Alcohol Services
Pain Specialist	Occupational Therapist	ITC
Paediatrician		Dentist
Urologist		
Oncologist		
Immunologist		
Obstetrician/ Gynaecologist		
ENT Specialist (Ear, Nose, Throat)		

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9. Prevention & Early Intervention

- Observations (Peak flow, BGL, Urinalysis)
- Immunisation
- Health Assessments
- Cancers
- AUSDRISK tool
- Cardiovascular Risk
- K10
- COPD Screening/Spirometry
- CKD Screening tool
- Cognitive Screening
- Sexual Health

10. Patient needs & goals – Patient engagement

- Build self-efficacy with smaller achievable goals
- Remember your goals are not the patient's goals

11. Recommendations

- Consistent documentation of care plans across the team – using well-crafted CDM templates – can help registrars articulate their recommendations to another GP's patient with a familiarity and confidence that encourages patient buy-in

12. Recalls

13. MBS Billing (see below).

- To ensure you have a record of advice we recommend that you email questions to askMBS@health.gov.au

14. (Today and) Next Appointment

- Chronic conditions require long-term management. When you see a patient with a chronic condition, you should begin to build a mental picture of the care that patient will require in the next 12 months.
- Try to think in the terms of short-term (Today) and long-term (Next Appointment) activities that your patient will need.
- Keep things manageable for you and your patient.
- Booking the Next Appointment increases patient engagement

What are the different types of Health Assessments available under the Medicare Benefits Schedule?

TIME-BASED HEALTH ASSESSMENTS

There are 7 types of Health Assessments that can be performed using the time-based MBS Item Numbers:

1. People aged 40 to 49 years (inclusive) with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool;
2. People between the age OF 65 and 49 (inclusive) who are at risk of developing a chronic disease;
3. People aged 75 years and older;
4. Permanent residents of a Residential Aged Care Facility;
5. People who have an intellectual disability;
6. Humanitarian entrants who are resident in Australia with access to Medicare services, including Refugees and Special Humanitarian Program and Protection Program entrants;
7. Former serving members of the Australian Defence Force including former members of permanent and reserve forces

These fall under the following MBS items:

- MBS Item Number 701 - A brief health assessment is used to undertake simple health assessments. The health assessment should take no more than 30 minutes to complete;
- MBS Item Number 703 - A standard health assessment is used for straightforward assessments where the patient does not present with complex health issues but may require more attention than can be provided in a brief assessment. The assessment lasts more than 30 minutes but takes less than 45 minutes;
- MBS Item Number 705 - A long health assessment is used for an extensive assessment, where the patient has a range of health issues that require more in-depth consideration, and longer-term strategies for managing the patient's health may be necessary. The assessment lasts at least 45 minutes but less than 60 minutes;
- MBS Item Number 707 - A prolonged health assessment is used for a complex assessment of a patient with significant, long-term health needs that need to be managed through a comprehensive preventive health care plan. The assessment takes 60 minutes or more to complete.

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ABORIGINAL & TORRES ISLANDER PEOPLES HEALTH ASSESSMENTS

An Aboriginal & Torres Strait Islander Peoples Health Assessment is available to 3 separate age groups and is the same MBS Item Number 715:

- Children between ages of 0 and 14 years
- Adults between the ages of 15 and 54 years
- Older people over the age of 55 years

HEART HEALTH ASSESSMENT

- MBS Item Number 699
- ONCE in a 12 month period
- Cannot be claimed if a patient has had a health assessment service (items 701, 703, 705, 707, 715) in the previous 12 months
- Patients not known to have CVD including:
  - Aboriginal or Torres Strait Islander persons 30 and over
  - Adults aged 45 years and over

NOTES:

A. *If patient identifies as Aboriginal and/or Torres Strait Islander, only complete a 715 and incorporate the cardiovascular risk assessment into the 715. If a 699 is billed, a 715 cannot be billed for 12 months and they would lose access to the 5 x EPC Allied Health visits.*

B. *If a non-Aboriginal and/or Torres Strait Islander patient is eligible for a time-based Health Assessment, then complete the time-based Health Assessment and incorporate the cardiovascular risk assessment into this Health Assessment eg the patient is 45-49yrs.*

What are the Medicare Items relevant to CDM in General Practice?

While the below charts are current as at 09/06/2020, it must be noted that Medicare releases updates monthly.

Accordingly, both the clinical and admin team should stay alert to any changes as it may alter day to day processes. A practice team member should be designated to download the monthly update and summary of changes and share these across the team regularly.

GP CDM ITEM NUMBERS

CDM Activity	MBS Item Number
Care Plans	721, 723, 732
Health Assessments	701, 703, 705, 707
Aboriginal and Torres Strait Islander Health Assessment	715
Home Medicine Review (HMR)	900, 903
Diabetes Cycle of Care	2517, 2521, 2525
Asthma Cycle of Care	2546, 2552, 2558
Mental Health	2700, 2701, 2712, 2715, 2717

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Useful Links:

www.cdmplus.com.au

http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=AN.0.47&qt=noteID&criteria=chronic%20disease%20management

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CDM TELEHEALTH ITEM NUMBERS

CDM Activity	Face to Face	Video-Conference	Telephone
Care Plans	721 723 732	92024 92025 92028	92068 92069 92072
Aboriginal and Torres Strait Islander Health Assessment	715	92004	92016
Mental Health	2700 2701 2712 2715 2717	92112 92113 92114 92116 92117	92124 92125 92126 92128 92129

Please note that links to the relevant MBS Online pages are embedded in this document for easy access to the above listed MBS Items. This information was accurate as at 9 June 2020.

Does this resource need to be updated? Contact GPSA: P: 03 9607 8590, E: admin@gpsa.org.au, W: gpsa.org.au
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