GPDV GENERAL PRACTICE DIVISIONS VICTORIA

# Prevention and Chronic Disease Management Incentives in General Practice

Better Capacity Better Care

**Acronym Key**
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ACH - Aged Care Home
ATSI - Aboriginal and Torres Strait Islander
EPC - Enhanced Primary Care
FT - Full Time
MBS - Medicare Benefits Schedule
RRMA - Rural Remote and Metropolitan Area
SIP - Service Incentive Payment
SWPE - Standardised Whole Patient Equivalent

| | GP Management Plan (GPMP) | Health Assessment | | | Asthma | Diabetes | Mental Health (MH) | Cervical Screening | Practice Nurse/ Aboriginal Health Worker (AHW) | Medication Reviews | | Multidisciplinary Team Work Items | | |
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| | | Annual Health Assessment | ATSI Adult Health Check | Comprehensive Medical Assessment (CMA) | | | | | | Home Medicines Review (HMR) | Residential Medication Management Review (RMMR) | Case Conferencing | Team Care Arrangements (TCA) | Allied Health Item Numbers |
| **Patient Care Returns** | Patient with a chronic medical condition present or likely to be present for 6 mths or longer or a terminal illness receives a structured management plan. | Over 75s and over 55s ATSI living in the community receive an annual Health Assessment for early detection and prevention of health problems. | ATSI people aged 15 to 54 receive a health check for early detection, diagnosis and intervention for common treatable conditions. | All permanent residents of C'wlth funded ACH receive a full systems review inc physical & physiological function from their 'usual GP' on entry or for existing residents where required (max 1 per 12 mths). | Patients with moderate to severe asthma receive quality management to avoid acute exacerbations of the condition. | All patients with established diabetes receive minimum national standards of diabetic care to prevent complications. | Patients with a mental health condition (ICD 10-PHC version) receive an assessment, plan and review from a trained GP. | Women 'at risk' receive cervical screen to enable early intervention where required. | Increased service in areas of high workforce need, by Practice Nurse/AHW supporting the GP role in providing care to patients. | Any patient living in the community who has or may have difficulty managing their medications receive a review of the use of their medicines in their home. | All permanent residents of C'wlth funded ACH can have a collaborative review of medicines on admission and than as required. | Patients with a chronic medical condition present or likely to be present for 6 mths or longer or a terminal illness & complex care needs recieve planned, multidisciplinary, team based care.<br>Patient's GP can be involved in real time discussion with other (min 2) team members. | Patient receives a care plan jointly developed by the GP & other (min 2) team members. | Patient with EPC Care Plan/review or GPMP & TCA or item 731 can receive access to 5 MBS AH & 3 dental services p/cal yr. |
| **Practice Nurse (PN)/ Aboriginal Health Worker (AHW) Role** | PN/AHW can assist GP to assess patient, identify patient needs, set goals and arrange for treatment/ services. GP must review plan & see patient. | The 'information collection' component can be delegated to PN/AHW. | The 'information collection' component can be delegated to PN/AHW. | PN can assist the GP in obtaining information relevant to the CMA for the GP's consideration, but cannot replace the GP's involvement. | PN/AHW may assist GP in undertaking most aspects of the Asthma 3 + Visit Plan. GP must review plan and see patient. | PN/AHW may assist GP in undertaking most aspects of the Diabetes Cycle of Care. | PN/AHW can support GP in clarifying patient eligibility and timely referral to approved MH providers. | PN can undertake the pap smear if appropriately qualified and can also manage the recall and reminder process. | Clinical nursing services; coordination of patient services; health promotion and education activities. | PN can support GP in identifying eligible patients and referral to Community Pharmacist. | PN can support GP in liaising with ACH re coordination with scheduled medication reviews. | PN/AHW can liaise with other providers to facilitate their involvement in the case conference. | PN/AHW can liaise with other providers to facilitate their collaboration with the GP in the develop-ment of the TCA and arrange for services to be provided. | PN/AHW can assist with these items by identifying & liaising with allied health providers to whom patients can be referred. |
| **Practice Expertise Invested** | Patient's GP or GP from same practice develops plan, sets review date and documents in GPMP or patient file. | The patient's GP undertakes an in-depth assessment of the patient's health including; physical, psychological and social function. | The patient's GP undertakes an in-depth assessment of the patient's health including; physical, psychological and social function. | The resident's usual GP undertakes an in-depth assessment of the patient's health including; medical, physical, & psychological. CMA provides patient summary for Aged Care Home which documents diagnoses and medication lists. | Patients with moderate to severe asthma, receive a min. of 3 asthma related consultations. Includes severity diagnosis, medication review, 2 planned recalls, written plan for action & patient self management education. | Practice sets up a diabetes register/recall system. Diabetic population identified by HbA1c test in previous 2 years. Annual patient care cycle implemented-reflects RACGP diabetes guidelines. | GP undertakes familiarisation & MH skills train-ing to register with HIC. GP provides patient with '3 step' MH process, inc. assessment, MH plan & review. GP can refer to MH provider for low or no cost 6 + 6 Focussed Psychological Strategies sessions. | Provide paps smears for at-risk women aged 20 to 69 ie. not tested in last 4 yrs. Practice to manage recall & reminder to ensure 70% of women screened every 2 yrs. Practice provides details to & gains info. from State/ Territory cervical screening registers | Practice needs to determine if eligible by postcode, determine number of sessions by number of EFT GP ie 2 sessions funded per EFT GP (up to max 5 GPs). | The HMR is organised through the community pharmacy in partnership with the GP. The GP determines eligibility, refers to the pharmacy and conducts final consult for plan agreement. | RMMR is a collaborative item for the GP to liaise with the Accredited Pharmacist undertaking the resident's medication review. It is recom-mended that a CMA precedes the RMMR so to inform the review. The GP & the reviewing Pharmacists discuss recommendations & the GP adjusts the medication plan accordingly. | Practice arranges GP involvement in real time Case Conference via telephone, video conference or face to face with other health or care providers to discuss & plan patient care. | Practice identifies other health or care providers to discuss potential treatment/service for patient to achieve goals, set review date & document in patient file. GP may also contribute to a Care Plan for a patient in an ACH (item 731), community or on discharge. | Practice identifies Medicare Australia registered health professionals liaising re referral/feedback preferences and processes for eligible patients to access MBS rebates. |
| **Practice Income/ Resource Returns** | Scheduled fee $122.40. GPMP Review $61.20.<br>Rec. frequency GPMP = 2 yrs (review 6 mths) Min claim period = 12 mths if required (Review 3 mths). | Scheduled fee $164.00 (in practice) $232.00 (in patient's home).<br>Min claim period = 12 mth | Scheduled fee $195.50.<br>Min claim period = 18 mth | Scheduled fee $183.80.<br>Min claim period = 12 mth if significant change. | ★ Practice sign-on payment ~ $250 per FT GP plus $100 to GP per patient pa for completion of Asthma 3+ Visit Plan additional to MBS standard consultation fee. | ★ Practice sign-on payment, ~$1000 per FT GP for patient register/ recall + $40 to GP per patient pa for care cycle + $20pa per SWPE + MBS standard consultation fee if 20% diagnosed diabetics receive care cycle. | ★ GP sign-on payment of $150 per GP; plus $150 to GP per patient per annum for the '3 step' MH process, additional to MBS standard consultation fee. | ★ Practice sign-on payment ~ $250 per FT GP plus $35 to GP per at risk woman screened, plus $3 per WPE for 50% of target women screened every 30 mths. *Note: If claiming Nurse MBS item use 10999 for at risk women.* | ★ Practice payment of ~$7 per SWPE to employ a PN/AHW for all practices in RRMA 3-7 and $~8 for practices in RRMA 1-2 eligible areas of workforce shortage. | Scheduled fee $131.35. | Scheduled fee $89.95. | Scheduled fee range from $58.55 – 164.00. | Scheduled fee $96.90 TCA Review = $61.20.<br>Recommended frequency TCA = 2yrs (review 6mths) Min claim period = 12 mths if required (Review 3 mths). | Nil |

MBS GP Item Payments are accurate as of November 2005 and are subject to yearly indexation and:

- 100% (115% DVA) rebates of scheduled fee apply to all GP attendances.
- Additional bulk billing incentive apply for eligible # patients:
  - Items 10990, 64990, 74990 — $5.15
  - Items 10991, 10992, 64991, 74991 — $7.85 (rural areas, Tasmania & eligible metropolitan areas)

# Commonwealth Concession Card Holders & Children under 16years.

★ Requires Practice to be eligible for Practice Incentive Payment

www.hic.gov.au/providers/index.htm www.medicareaustralia.gov.au