Practice Capacity – 25 August 2005

Martin Mullane

- Items commenced on 1 July 05.
- Key information including MBS explanatory notes and descriptors sent to all GPs in June 05.
- Notes, descriptors, forms, Q&As etc at: www.health.gov.au, (and follow the A-Z to 'chronic disease')
- When GPs are to claim the new CDM Item numbers (721, 723, 725, 727, 729 & 731) they must be able to justify to their peers that the service offered is appropriate.
- Once a GPMP and TCA have been completed for a patient and claimed on Medicare the patient is eligible for access to certain allied health and dental services (items 10950 to 10977 inclusive)
- A TCA can be provided without a GPMP, but a patient must have both a GPMP and a TCA to access allied health and dental care (MBS Items 19050 to 10977)

Questions & Answers:

- Is there the facility for division and practice staff to teleconference in to DoHA for fielding questions?

DoHA have limited resources and recommend approaching HIC. DoHA will take individual queries but suggest checking their webpage first.

- What is the patient's role in the GPMP and TCA?

The patient's role is listed on the checklist and this checklist is a prompt to include the patient to support level of care but it is not mandatory.

- Can you use SIP for mental health instead of the review of GPMP and TCA?

Yes, if the GP has met the requirements for the 3-step plan.

- What are the criteria for claiming a 729?

Refer to Q&A section and explanatory notes of powerpoint on the DoHA website. The patient must be eligible and the team must be multidisciplinary and the GP must clearly document their contribution either as a service or as advice.

- What consent is required by the patient when the GP contributes to the TCA?

The GP must ensure that the patient has consented to their contribution to the plan and to ensure that the patient has agreed to any necessary payment. The patient consent can be gained by other team members on the GPs behalf.

- Can Division 2 nurses assist with the GPMP?

This is an issue for the GP to assess and to be confident of the nurses ability to assist.

- What is the GP contribution to the hospital discharge plan?

The patient's usual GP should contribute to the hospital discharge plan. In the case that the GP is asked to contribute to the plan of an unknown patient then the GP must ensure that the patient meets the criteria of a chronic condition.

- What is the trigger for the Allied Health item?

Both the GPMP and TCA need to be completed and service providers must be registered with HIC. The contributors to a TCA however do not have to be HIC registered.

What do your members need now?	What will they need in the next 6 mths?	What are/can divisions realistically do?	What can GPDV do to help?
Case studies – esp step by step guide for MH & Asthma SIPs (timelines etc) including financial models. Where 721 + 723 are claimed on same day. Case study for: • solo GP • for GP & PN • for GP in multidisciplinary AH practice			Access to current resources that divisions have developed – needs to meet dept chklist & have all correct information
Division Performance indicators – who is feeding back to divs about the data collected and what?			Issue divisions a collation of the division resources – bone fide resource
Need a 'hotline' for answers to difficult questions – number is on DoHA website: 02 6289 8735 or 02 6289 4184			Martin M to place Q & A section in user-friendly format – sub headings
			Flowcharts – similar to AC flowcharts – to step GPs through the process – Wayne Bruton
			PN & practice staff interactions – scenarios: query Trina Gregory & MichaelJannsen
			List of good speakers (but lack of div $$) • 'A Team' type role out – must be a GP • GP champion & PN champion (8 divs w GPs) • Ensure quality speaker • Pool of speakers
			Needs to be done in the next few weeks otherwise it will need to have a different focus
			Patient education/ consumer information

Rosie Fenech

From division staff:

- The information around the new CDM items was needed 3-4 months ago.
- There is already duplication among the resources that divisions have created and division resources are seen to be better than those created by ADGP.
- These comments/discussion is not a criticism of GPDV. This needs to be feedback to DoHA.

Action: GPDV to feedback division staff discontent in writing to the departments – ADGP and DoHA *Also refer to comments from evaluation summary*

Action: GPDV to give divisions where possible monthly updates regarding the uptake

Action: GPDV/ADGP to create/adapt consumer pamphlet

Action: GPDV to update Allied Health providers about the new items

Action: GPDV to revisit assisting divisions in identifying HIC registered Allied Health Professionals.

Action: Rosie to contact Leigh Barnetby and Marg Gordon (Whitehorse) regarding creating business models.

Action: Rosie to contact Wayne Bruton (Western) regarding flowcharts.

Judy Proudfoot

- What is GPAS?

General practice assessment survey (GPAS) – it is a patient survey that has been validated in the UK (hence lots of comparison data). It looks at the patient's perception of the quality of care that they have received.

- If you improve Prac Cap in small practices will they perform better than large practices?

We can't say that from our data as it looks at one point in time – there was one measurement/ snapshot of the practice in 2004. Practice Capacity compensates the quality of care for the practice.

Overall smaller practices have better quality of care but larger practices can compensate by improving their practice capacity. Larger practices are also better at evidence based chronic disease management.

Action: Judy to email PL the subset data that was collected for the administrative classification

Provide specific prac cap elements that have the strongest correlation to quality of care for 1) admin staff functions 2) IMIT clinical 3) Business development

If the quality of the linkage (incl communication) with external agencies is high then the practice capacity is better.

- Does this say that we should tell practices to make their own linkages?

No, the data indicates that there was not a significant association between the availability of local services and the quality of linkages. Educators employed by the practice were not seen as external.

Practices make use of the division linkages and more. Query – it may mean that practices are referring outside of their area.

Merely employing a nurse does not influence the quality of care eg wounds and immunisation. It matters on the role/function of the nurse in the management of Chronic Disease (31/40 prefer reg & recall) eg specialist clinics. Not the admin – patient registers, it's bringing the patient in, taking the patient measurements, following up on patients and recall & reminder (seeing patient). PNs perform at a higher function than admin staff and provide clinical support that includes the ability to identify other ailments eg undertaking diabetes measurements, talking/relationship with patient and PN able to identify a level of depression.

Bottom line: practice capacity does make a difference to quality of care in CDM.

Admin functions – setting up & managing the registers, keeping directory of services up-to-date, sending out recall letters, ordering patient information material, phone calls to other health care providers to include in care plan. Organising, liaison.

Action: Judy to email list of admin functions

Action: Judy to email the different tools used for the findings or how to access these tools

What information from CGPIS research can I apply?	At what level?	What help is needed?
Research findings need to be disseminated • 50% of patients rec'd less than optimal care • Snapshot of findings • Use of PN for Chronic disease care • Admin staff supporting PN • Reflect on the Team Climate	Top down – board level to support concept/ideas and filter down	Summary page – CGPIS (minus PN)
Adapt research tools to be 'user-friendly'	Sell concept at all levels eg at practices to prac staff	Access & training to the tools
	Through tailored practice visits	Development of tools in a realistic time frame
	DoHA to fund division staff	Presentation to CEO's
	Build capacity of divisions infrastructure	Newsletter article
		Why difference between metro/rural (more research). Conjecture: • GP shortage • Higher stress levels
		Business case/ Benefits realisation study – to show financial viability eg CDM item no, who can do it • Freeing up GP time • Patient outcomes