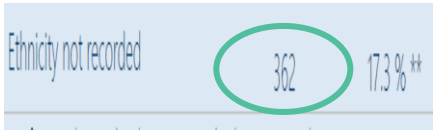
# Dashboard Interpretation from a Practice Management Perspective

## Active Patient Cohort


RACGP definition of 'Active patient' is 3 visits in 2 years. They then can be considered as part of your patient demographic.

## Aboriginal and Torres Strait Island Patients

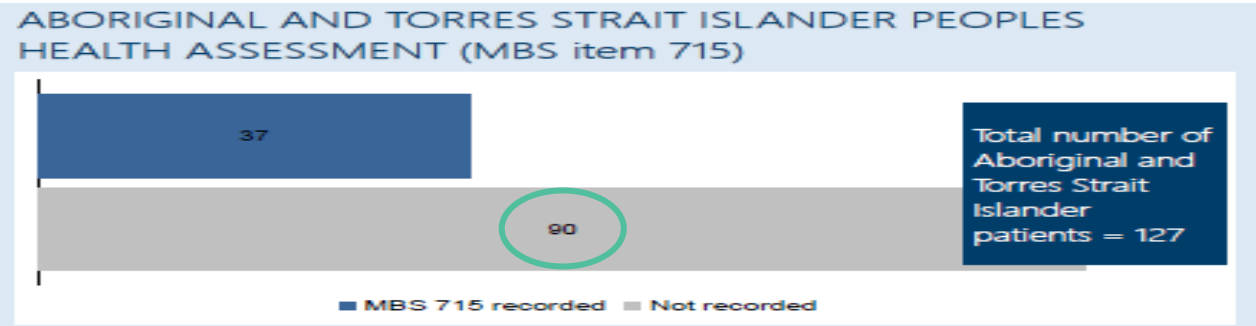




In this example 6.1% equates to 127 active patients identify as Aboriginal or Torres Strait Islander origin.

When we apply the same % to patients without their ethnicity recorded (362*6.1%), we find that there could potentially be another 22 patients who would also identify as being from Aboriginal or Torres Strait Islander origin who could be missing out on a health assessment because we have not been able to offer this service.

22 * $ (715 health assessment) =____?

22* 10 (10987 nurse items) =_____?




The dashboard shows the number of Aboriginal & Torres Strait Islander patients who have not had their health assessment in the practice in the last 12 months.

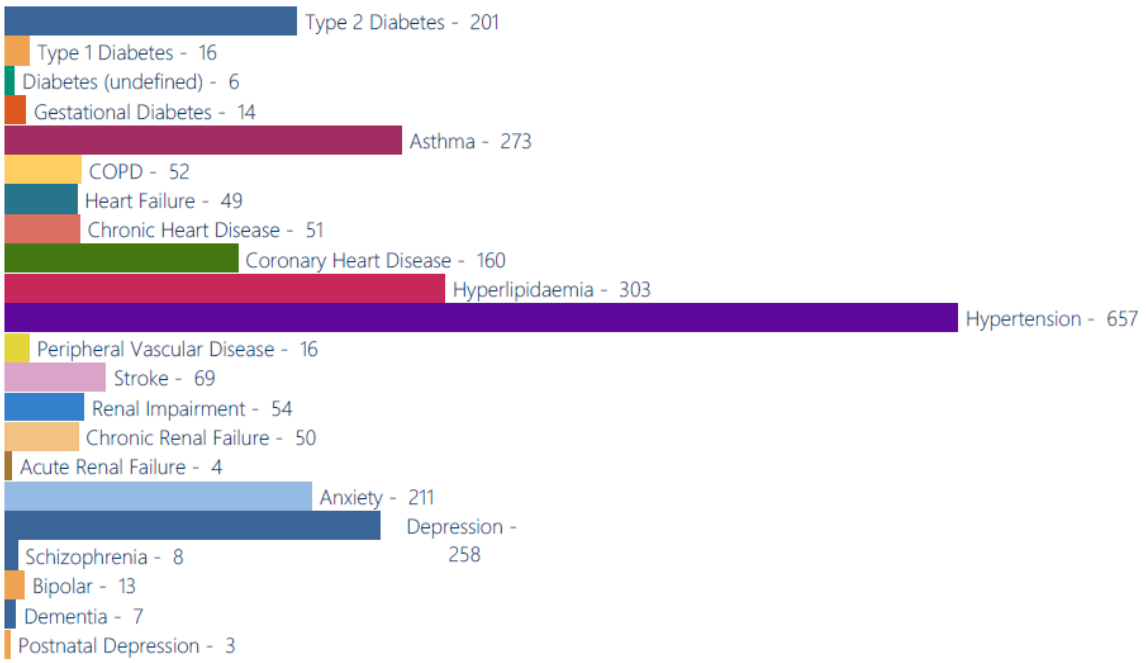
NOTE: Check via PRODA/HPOS for eligibility for billing before proceeding as patient may have had this care attended by another General Practice or Aboriginal Medical Service.

In this example 90 *$ (715 health assessment) = _____? &

90*10*$ (10987 Nurse item number eligible with a 715 completion) = _____?

## Disease Prevalence

Chart indicates numbers of patients at your practice coded with each diagnoses




** Patients may be counted in more than one disease category according to their coded diagnoses*

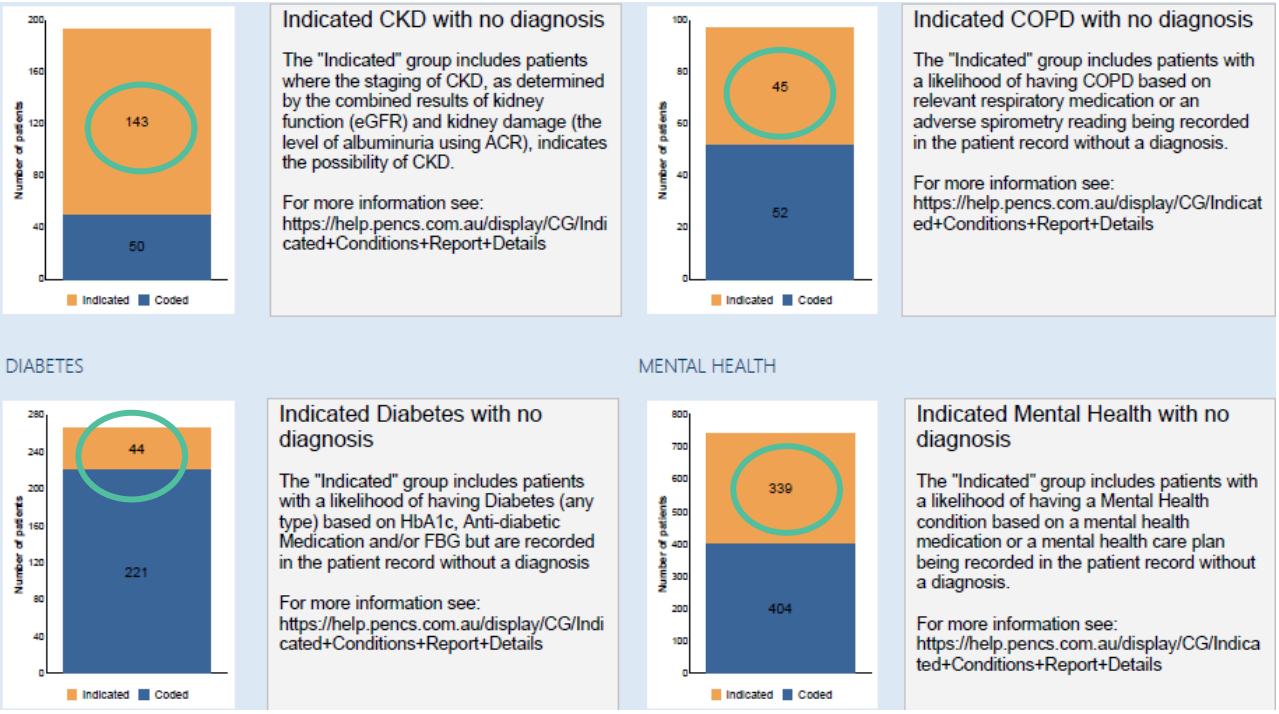
Using a CAT4, find the % of patients for the practice who have at least 1 coded chronic disease diagnosis. Apply the % to the active patient count from page 1 to get to an eligible patient count for comprehensive care or Chronic Disease Management (CDM). CDM item numbers 721+723+732*6+10997*5 over a 12-month period = $_____? Per CDM patient.

Example – If 65% of the active patients had at least 1 identified chronic disease then the practice would have **1361** patients eligible for CDM care.

Patients with a coded diagnosis can be easily identified using CAT4 for comprehensive care.

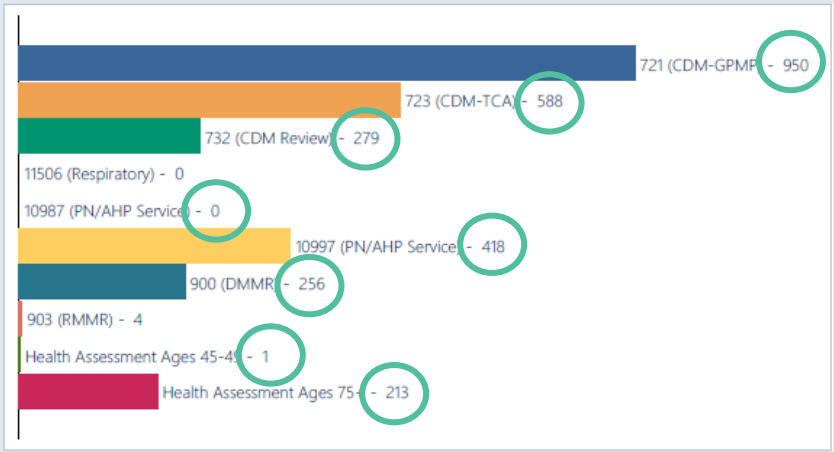
NOTE: It is a GP's decision to manage a patient with GP Management Plans & Team Care Arrangements. The purpose in coding these patients is to provide clinicians with information to make these decisions more easily & support patients who are seriously ill to maintain & possibly improve their health.

## Coded and Indicated Diagnoses




The Coded & Indicated Diagnosis bar graphs reveal patient cohorts who are not visible (gold) in the CDM patient count in the above disease streams. Using CAT4 to clean up the diagnosis for these patients will make them visible for CDM care. CDM item numbers 721+723+732*6+10997*5 over a 12-month period = $_____? per CDM patient.

## MBS Billing




**About MBS data**

For information on how PEN maps MBS data from billing systems, and MBS items included in each category see: http://help.pencs.com.au/display/ADM/MBS+Items+Mapping+All+Systems

In some instances MBS mapping may be incomplete or missing, depending on local billing software. In those instances data in the MBS billing chart on this page may be limited or missing.

* In the chart, numbers represent numbers of MBS items claimed.

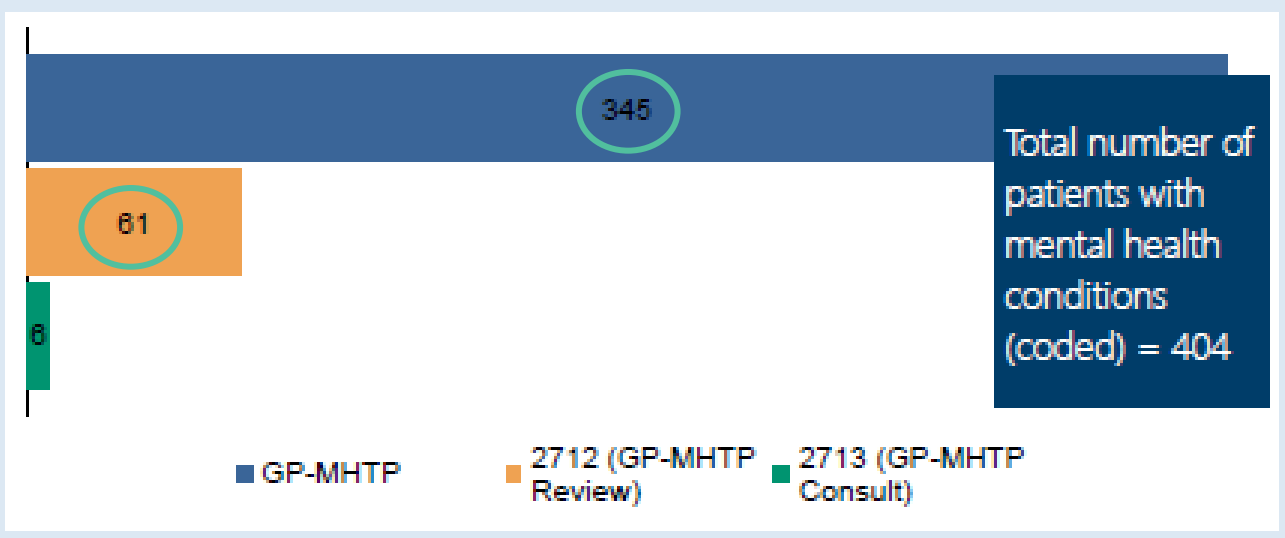
1361 Patients with a coded diagnosis, eligible for CDM care.

- 1361-950 (721 Billed) = 411 without a Care plan (GPMP) = $_____ missed
- 411 without a GPMP means there is a loss of the reviews for those GPMP's *3/year=$_____ missed
- 1361 – 588 (723 Billed) = 773 without a Team Care Arrangement (TCA) = $_____missed
- 773 without a TCA leads to loss of TCA reviews*3/year = $_____missed
- 950 GPMP's - 588 TCA's = 362 patients may not be accessing support from Allied Health/ Specialist care through the co-ordination of the GP =$_____?

GPMP & TCA Reviews are the same item number (732) & are only distinguished at the time of billing by their individual annotation. The maximum number available to complete in a 12-month period is 3*GPMP reviews (732) and 3*TCA reviews (732).

- 950 GPMP's 588 TCA's=1538*3 reviews = 4614 eligible for billing/care – 279 Completed – 4335*$_____missed
- 950 GPMP*5 (10997's)/year = 4750 opportunities of care – 418 completes = 4332 available to bill = $_____missed
- 37  715 health assessment billed*10 – 370* 10987's – NIL billed = $_____missed.
- DMMR can be done as part of a new GPMP, completed by pharmacist over the next 3 months & patient booked for completion – Who – 75 year health assessment and 715 health assessment & all care plan patients who fit the eligibility criteria could benefit from this care - $____ missed.
- CAT4 demographics will provide you with exact numbers of patients in the 45 - 49 year age group – how many patients = $____missing billing is item numbers 701 - 707
- Same search will provide you over 75 year demographic & again missed billing will items 701 - 707= missed $_____?

## Mental Health Care – Treatment plans, reviews and consults




Patients with a GP Mental Health Treatment Plan should have at least one formal review (MBS item 2712). As a general rule, a formal review should occur four weeks to six months after the completion of a GP Mental Health Treatment Plan. In general, most patients should not require more than two reviews in a 12 month period.

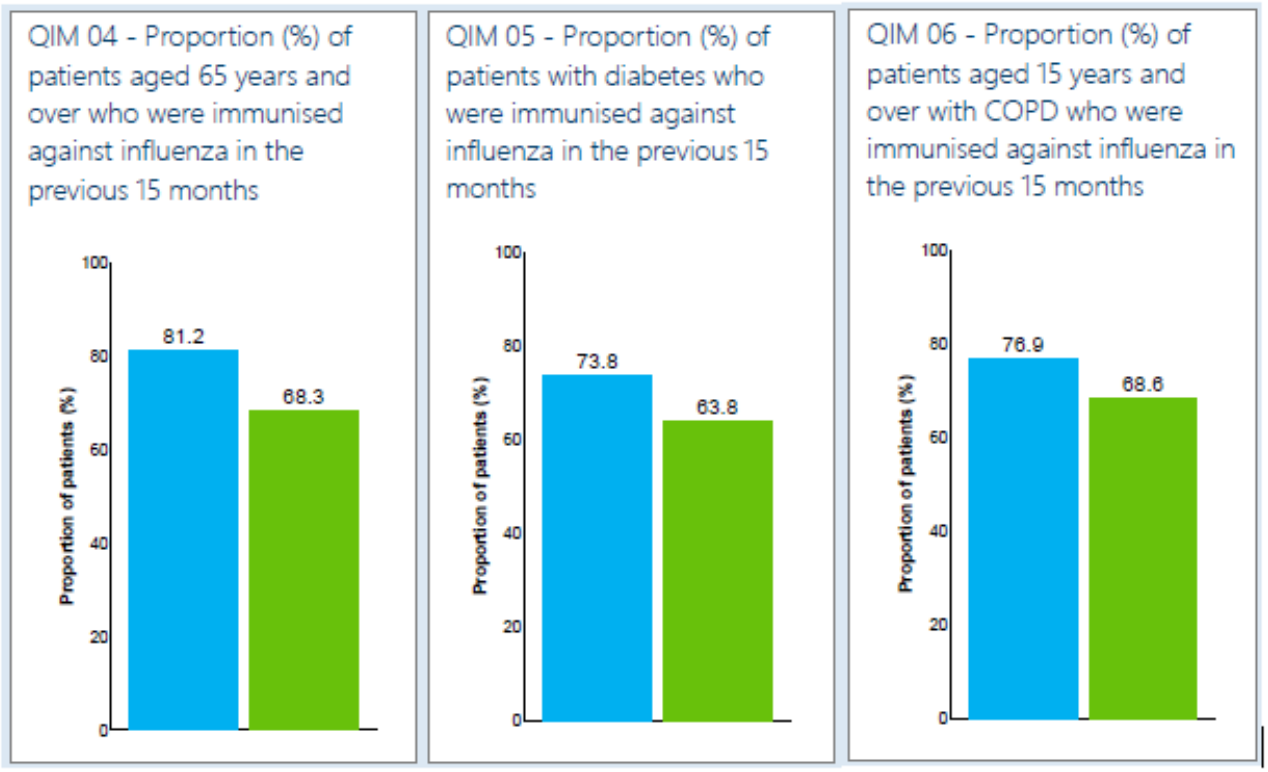
In the example –

- 404 diagnosed patients - 345 with a plan = 59 who may benefit from care.
- 345 plans - 61 reviews = 284 patients needing at least 1 review for compliance & better care $_____

Process for Compliance –

- Day 1– Plan created; patient referred to specialist services (takes approx. 6 weeks)
- Weeks 4-6 – first review
- Week 6 – Onwards - dependant on visits with specialist & their timeframes. Report sent back to GP with request for ongoing referral.
- Patient reviewed again by GP & specialist report discussed – a second review can occur three months after the first review.
- Patient continues under specialist care if needed.
- Mental Health Consults can be used between visits for monitoring & support.
- Day 366 – New plan can be completed as clinically appropriate.

## PIP QI Incentive Improvement Measures




While all the QI Measures are of interest to Practice Managers in checking the performance of their practice, there is also opportunity for financial gain & a focus could be the 3 QI measures for Flu Vaccination.

These are target demographics for Flu Vaccination clinics in the practice to protect seriously ill patients.

This is also an opportunity to work to a repeatable process to gain the best use of Nurse & staff resources and also target other preventative health measures during these clinics.

Example – When conducting flu clinics make a point to check each patient for care plans, reviews, cancer screening & other reminders to ensure patient care stays on track. Use clinics to bring patients pathology up to date & re-engage with the patient if they have not had face to face care in recent times.

## Glossary

**Care Plan**
Generic term used for General Practitioner Management Plan (GPMP)

**CAT4**
Extraction tool in the suite of PenCS to review practice data. Used to assess quality improvement activities

**CDM**
Chronic Disease Management. CDM enables GPs to plan and coordinate the healthcare of patients with chronic or terminal medical conditions. A chronic medical condition is one that has been or likely to be present for six months or longer

**DMMR**
Domiciliary Medication Management Review also know as a Home Medication Review (HMR)

**GP**
General Practitioner

**GPMP**
General Practitioner Management Plan, also known as a care plan, used to provide a rebate for a GP to prepare a management plan for a patient who has a chronic or terminal medical condition with or without multidisciplinary care needs

**HPOS**
Health Professional Online Service. HPOS is an online portal for healthcare providers to interact electronically with Services Australia

**PRODA**
Provider Digital Access. PRODA is an online identity verification and authentication system. It lets you securely access government online services

**QI**
Quality Improvement. Is a system of regularly review and refining general practice processes to enhance patient health and quality of care

**RACGP**
The Royal Australian College of General Practitioners

**TCA**
Team Care Arrangement is used to provide a rebate for a GP to coordinate the preparation for a patient who has a chronic or terminal medical condition and also requires ongoing care from a multidisciplinary team of at least three health or care providers

**MBS**
Medicare Benefits Schedule. The MBS is a listing of the Medicare services subsidised by the Australian Government