PRIMARY CARE IMPROVEMENT

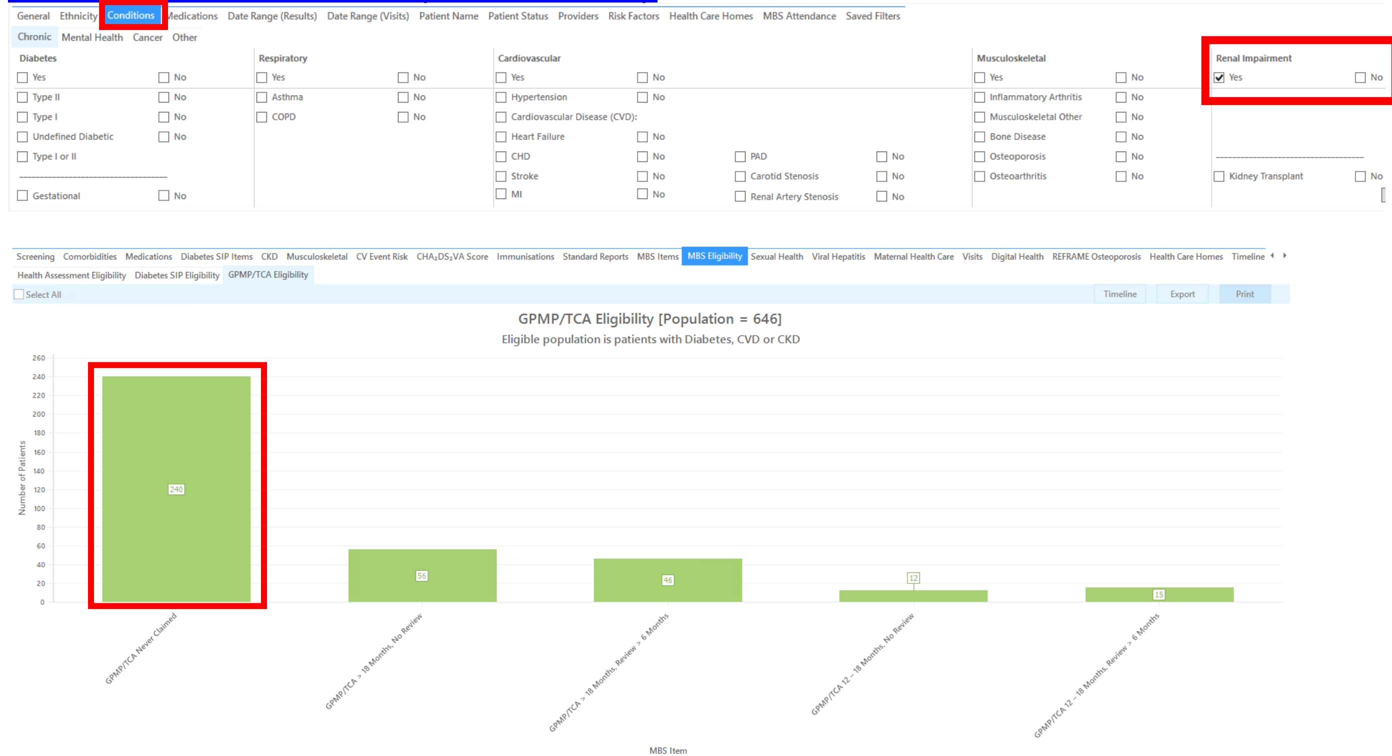
phn HUNTER NEW ENGLAND AND CENTRAL COAST
An Australian Government Initiative

PRIMARY HEALTH NETWORK

Quality Improvement Scenario 3: Chronic Disease Management

Using **Chronic Disease Management** enablers assists practice health professionals to provide appropriate care to patients with Chronic Kidney Disease. **Medical Benefit Schedule (MBS) items** such as GP Management Plan (GPMP), Team Care Arrangement (TCA), Reviews of both, Allied Health Consultations and Nurse Monitoring & Support are beneficial to the management of a patient's Chronic Kidney Disease.

PenCS CAT4 Report "Identify Patients with Chronic Kidney Disease who never had a GP Management Plan (721) claimed" will determine the number of patients with Chronic Kidney Disease who are eligible for a GPMP or TCA. Identify patients with CKD who never had a GPMP/TCA claimed - CAT Recipes - PenCS Help



The Practice's Quality Improvement Team pick this topic and create a **Model for Improvement** for the commencing PIP QI Quarter. The **SMART goal** is 100% of patients with a Chronic Kidney Disease will have a current GPMP and/or TCA by end of quarter. Once patients' GPMPs are in place, Nurse and Aboriginal Health Practitioner attendances can increase.

Data Baseline: 1 May 2021

Numerator: Number of Patients with Chronic Kidney Disease without a GPMP
Denominator: Number of Patients with Chronic Kidney Disease
Example: 240/600 = 33%

Review Date: End of July quarter.

PLAN:

Idea 1: Add a **Reminder** to patient file **(BP)** Add a Clinical Reminder to a patient (bpsoftware.net) or a **Recall (MD)** MedicalDirector Online Help for new GPMP, TCA, Reviews and Nurse and Aboriginal Health Practitioner attendances. Establish a Reminder/Recall system for practice staff to contact the patient. Consider sending to patient using a SMS Reminder Application software vendor.

Idea 2: Use **PenCS TopBar MBS Application** to find patients in real time opportunistically. MBS App Eligibility Tab - USER GUIDES TOPBAR - PenCS Help

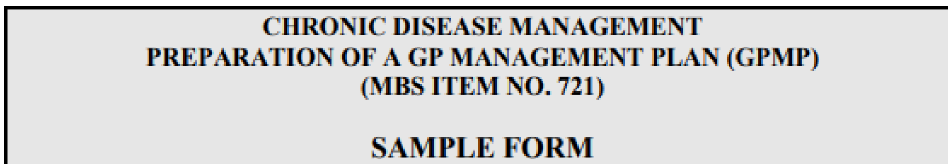
MBS Items | Eligiblility | Settings

Relevant

723, 230	TCA	0/2
721, 229	GPMP	0/1
900	DMMR	0/1
2546, 2552, 2558, 265, 266, 268, 269, 270, 271	Asthma Cycle Of Care	0/5
715	ATSI Health Assessment	0/1
10997	10997 (PN/AHP Service)	0/1

Idea 3: Design practice **Workforce Opportunities** to provide Nurse, Aboriginal Health Practitioner and Medical Practice Assistant monitoring and support to patients in between structured Reviews and to contribute to GPMP, TCA and Reviews. Homepage - APNA informationsheet-medicalassistants.pdf (racgp.org.au)

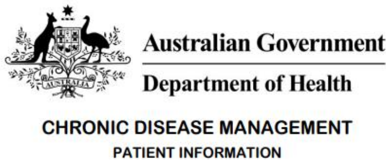
Idea 4: Use the **DOH templates** in the Clinical Information System. Microsoft Word - 353DD223.rtf (health.gov.au)



CHRONIC DISEASE MANAGEMENT
PREPARATION OF A GP MANAGEMENT PLAN (GPMP)
(MBS ITEM NO. 721)

SAMPLE FORM

Idea 5: Provide the Patient with the **Chronic Disease Management Information Sheet.** Fact Sheet - CDM - Patient Info - Feb 2014.pdf (health.gov.au)



By end of July quarter, the Quality Improvement Team complete the Improvement Cycle:

DO: **What did you do?**

STUDY: **What were the reviewed results?**

ACT: **What can be added, continued, and/or removed from process?**