

Better
Capacity

Better
Care



A resource kit for assisting general practice to achieve quality outcomes for chronic disease management.



General Practice Divisions - Victoria

- **2001/02- Commissioned state evaluations of EPC & GPII**
 - **Found practice support as key to helping general practice change**
 - **Produced resource for divisions under the direction of ‘experts’ from divisions**
- Rosemary Fenech**

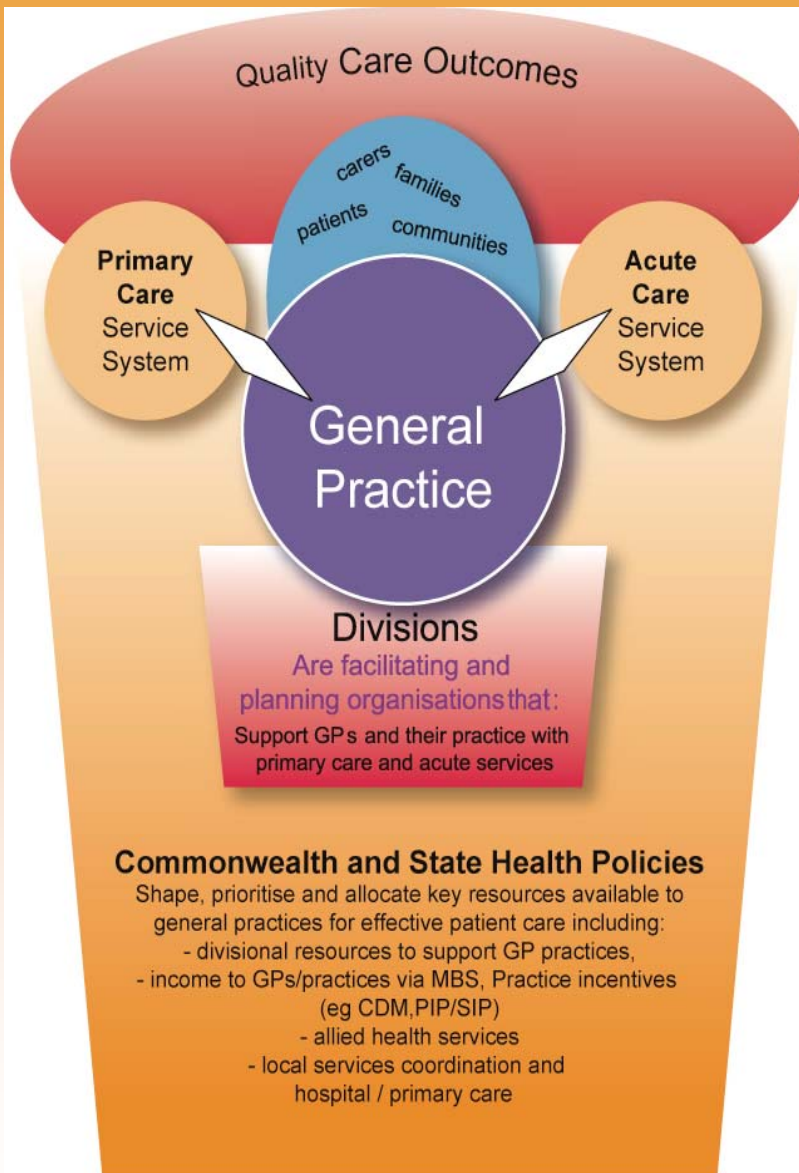
Team Work is a feature of new initiatives



MBS funding has always valued the GP / Patient Relationship

Commonwealth funding for General Practice has always recognised that the creation of positive relationships and effective communication between GP and patient are essential pre conditions for achieving quality patient care.

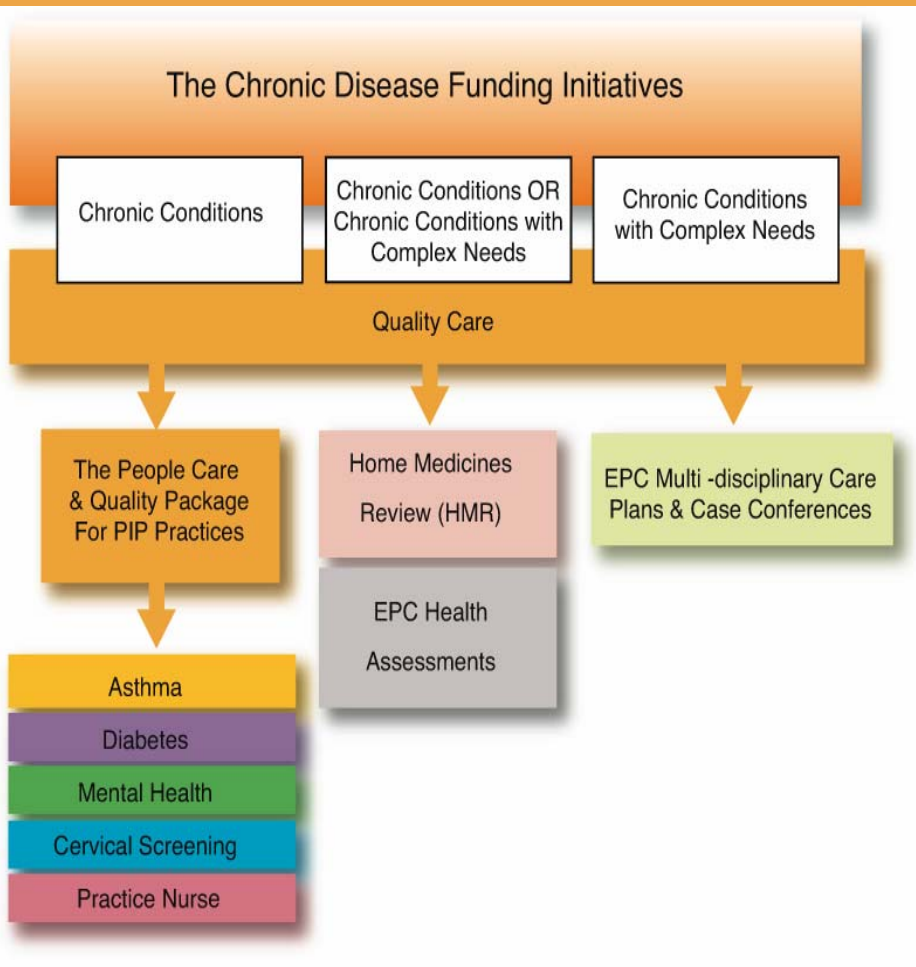




**Division's work
is focused in
general practice**

Better Capacity, Better Care

Embraces the suite
of Commonwealth
Preventative and
Chronic Disease
incentives



The Commonwealth Department of Health and Ageing Chronic Disease and Preventative Health Incentives

	EPC Annual Health Assessment	Asthma	Diabetes	Mental Health	Cervical Screening	Practice Nurse	Home Medicines Review (HMR)	EPC Multidisciplinary Careplan / Case Conference
Patient Care Returns	All over 75s and over 55s ATSI people living in the community can have an annual Health Assessment for early detection and prevention of health problems.	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 disorder can 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 supporting the GP role in providing care to patients.	Any patient living in the community, who has or may have difficulty managing their medications can receive a review of the use of their medicines in their home.	Patients of any age with a chronic medical condition(s) or terminal illness and complex care needs receive planned, multidisciplinary, team based care.
Practice Expertise Invested	The patient's usual GP undertakes an in-depth assessment of the patient's health including: medical, physical, psychological and social function. The 'information collection' component can be delegated to a nurse.	Patients with moderate to severe asthma, receive a min. of 3 asthma-related consults. 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 & mental health skills training. GP provides patient with '3 step' MH process, inclusive of assessment, mental health plan and review.	Cervical smears for women aged 20 to 69 years not tested in the last 4 years. Practice provides details to and gains information from State / Territory cervical screening registers.	Nurses undertake their roles within a framework of agreed functions, including clinical nursing services; coordination of patient services; health promotion and education activities.	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.	EPC activities reflect steps & standards set by MBS/RACGP & require active multidisciplinary collaboration. Billing is triggered by the GP achieving a sequence of set tasks.
Practice Income* Resource Returns	MBS GP item payments ranging from: (@ 85 % rebate) \$153.65 - \$217.30	★ Practice sign-on payment - \$250 per EFT GP plus \$100 per GP pa per patient for completion of Asthma 3+ Visit Plan additional to MBS standard consultation fee.	★ Practice sign-on payment, - \$1000 per EFT GP for patient register/recall system + \$40 to GP per patient pa for care cycle + \$20 pa per SWPE additional to MBS standard consultation fee if 20% diagnosed diabetics receive care cycle.	★ Practice sign-on payment of \$150 per GP; plus \$150 to GP per patient per annum for the '3 step' MH process, additional to MBS service consultation fee.	★ Practice sign-on ~ \$250 per EFT GP plus \$35 to each GP pa for each patient screened, plus \$2 per SWPE for 70% of target women screened every 2 years additional to MBS standard consultation fee.	★ Practice payment of -\$8 per SWPE to employ a nurse for practices in RRMA 3-7, (some in RRMA 1-2) & to employ a AHW in Aboriginal Medical Services.	MBS GP item payment (@ 85% rebate) of \$123 for HMR	MBS GP item payments ranging from: (@ 85 % rebate) Care plans: \$39.80-\$187.55 Case conferences: \$54.85-\$120.70

* Payments are accurate as of November 2002 MBS, which are subject to yearly indexation

★ Requires Practice to be eligible for Practice Incentive Payment

Systems of a General Practice

All systems work in harmony

to strengthen practice capabilities for achieving

- quality care of chronic conditions
- business viability



Core systems of GPBA



Additional systems which support CDM

Better Capacity, Better Care

Provides detailed descriptions of systems within general practice that support...

Quality care of chronic conditions & general practice business viability

GP Practice Systems Goal Setting Problem Solving Template for CDM

The template incorporates aspects of the GPBA goal setting approach and applies resources mapped in the Kit. It involves a 4 step problem solving process for addressing how systems in a general practice may need to change or better adapt in order to ensure quality care and business viability for CDM patient services. At each step decision-making is supported through access to resources.



Problem Solving Template

Step 1 - Scope the Issues

Step 2 - Set a SMART goal

Step 3 - Identify Key actions

Step 4 - Allocate Actions to people

Web Based Resource Directory

The screenshot shows a web browser window displaying the GPDV website. The page title is "Better Capacity, Better Care Resources". The main heading is "Systems of a General Practice" with the subtext "All systems work in harmony" and "to strengthen practice capabilities for achieving" followed by a list: "- quality care of chronic conditions" and "- business viability". A diagram below shows five interconnected systems: 1. strategic planning system, 2. human resources system, 3. patient services system, 4. (partially visible), and 8. financial system. A central red circle contains the text "quality care of chronic conditions". The left sidebar contains a navigation menu with links like "What's New!!", "About GPDV", "Contact Divisions", "Programs", "Issues", "Policy", "Publications", "Consumers and Community", "Details of Events", "Links", "GP Register", and "GPDV Conference 2003". Contact information for GPDV is provided, including phone, fax, and email. The footer shows "Last modified: 08 October 2003", "Privacy Policy | Website Statement", and a visitor count of 84647.

Better Capacity, Better Care Resources

Systems of a General Practice

All systems work in harmony
to strengthen practice capabilities for achieving

- quality care of chronic conditions
- business viability

1 strategic planning system

2 human resources system

3 patient services system

4

8 financial system

quality care of chronic conditions

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Last modified: 08 October 2003

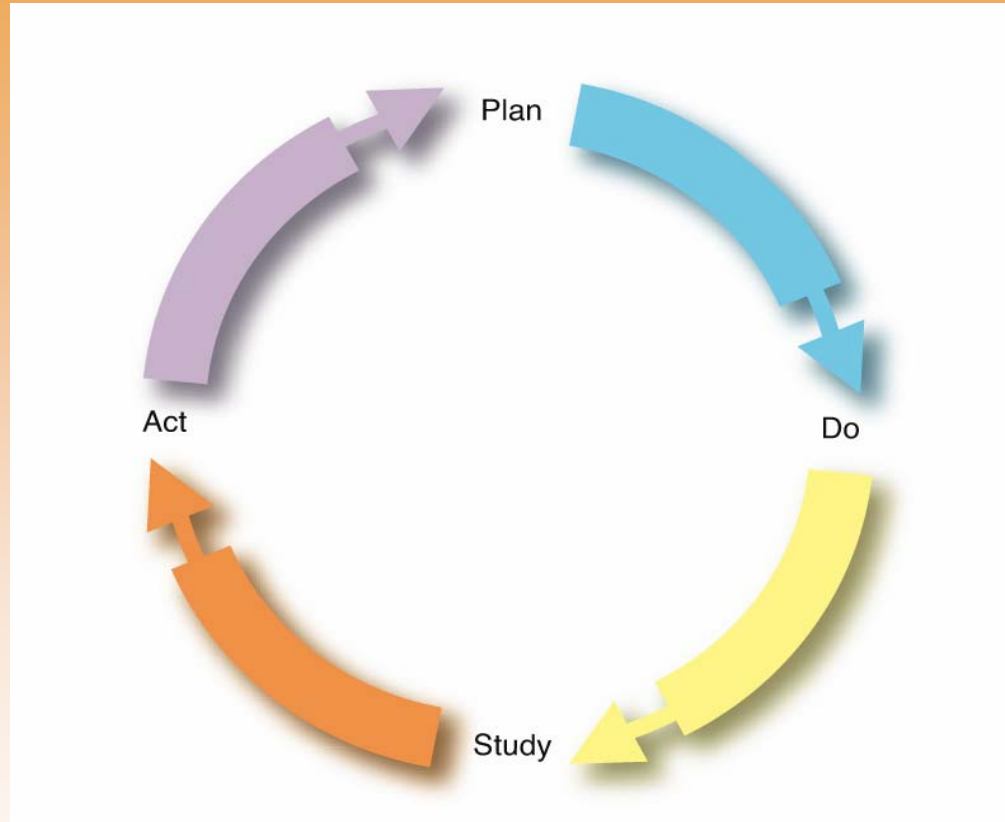
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www.gpdv.com.au/ChronicDisease/BetterCapacity



GPDV is committed to Quality



We welcome your feedback, suggestions & contributions

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