phn BRISBANE SOUTH
An Australian Government Initiative

Quality Improvement Toolkit for General Practice

Business

Chronic disease

Medicare Benefit Schedule (MBS) item number

MODULE

Version 2

August 2021

CHRONIC DISEASE MEDICARE BENEFIT SCHEDULE (MBS) ITEM NUMBER TOOLKIT

Introduction

The Quality Improvement (QI) toolkit

This QI toolkit is made up of modules that are **designed to support your practice to make easy, measurable and sustainable improvements to provide best practice care for your patients**. The toolkit will help your practice complete QI activities using the Model For Improvement (MFI).

Throughout the modules you will be guided to explore your data to understand more about your patient population and the pathways of care being provided in your practice. Reflections from the module activities and the related data will inform improvement ideas for you to action using the MFI.

The MFI uses the Plan-Do-Study-Act (PDSA) cycle, a tried and tested approach to achieving successful change. It offers the following benefits:

- A simple approach that anyone can apply
- Reduced risk by starting small
- It can be used to help plan, develop and implement change that is highly effective.

The MFI helps you break down your change improvement into manageable pieces, which are then tested to ensure that the change results in measurable improvements, and that minimal effort is wasted.

There is an example of completing GP management plan on patients with diabetes using the MFI at the end of this module.

If you would like additional support in relation to quality improvement in your practice please contact Brisbane South PHN on support@bsphn.org.au.

Due to constant developments in research and health guidelines, the information in this document will need to be updated regularly. Please contact Brisbane South PHN if you have any feedback regarding the content of this document.

This icon indicates that the information relates to the ten Practice Incentive Program Quality Improvement (PIP QI) measures.

Acknowledgements

We would like to acknowledge that some material contained in this toolkit has been extracted from organisations including the Institute for Healthcare Improvement; the Royal Australian College of General Practitioners (RACGP); the Australian Government Department of Health; Best Practice; MedicalDirector, CAT4; and Train IT. These organisations retain copyright over their original work and we have abided by licence terms. Referencing of material is provided throughout.

While the Australian Government Department of Health has contributed to the funding of this material, the information contained in it does not necessarily reflect the views of the Australian Government and is not advice that is provided, or information that is endorsed, by the Australian Government. The Australian Government is not responsible in negligence or otherwise for any injury, loss or damage however arising from the use of or reliance on the information provided herein.

Brisbane South PHN, 2021

CONTENTS

How to use this toolkit

There are checklists included below that will guide you and your practice.

- Use this toolkit to guide you along the journey.
- Set yourselves timelines to achieve your goals.
- Consider potential internal or external factors that could impact the activity and factor these into your planning – e.g. accreditation preparation, staff leave (planned or unplanned), global pandemic, influenza vaccination season.
- Review your progress regularly.
- If you find your process is not working and you are not seeing improvements, then review your process and start again.

For more support


support@bsphn.org.au


1300 467 265

MBS ITEM NUMBER TOOLKIT

The aim of this toolkit is to assist practices to identify the number of chronic disease items being claimed versus the number of eligible patients at your practice. This may help with:

1. chronic disease patient management
2. consistent patient management systems
3. multi-disciplinary approach to patient care
4. identify the number of nursing staff/hours required
5. increase practice revenue.

This activity is to complement the Brisbane South PHN monthly benchmark and trend reports you already receive.

Chronic disease MBS item numbers

The following MBS item numbers will be used as part of this toolkit. Practices may choose to add to or delete any of the item numbers.

- management plan item numbers including GP management (GPMP) and team care arrangements (TCA)
- nurse chronic disease item number
- health assessments
- heart health check
- Aboriginal and Torres Strait Islander health assessments
- domiciliary medication management review
- mental health treatment items.

Maximising nurse led clinics in general practice

Australian primary health care nurse association (APNA) have a webinar and excel spreadsheet you can use to develop a budget and structures for establishing nurse led clinics.

Learning objectives:

1. Improve your understanding of MBS items - what can be claimed for a nurse clinic model?
2. Increase confidence in developing a budget for your nurse clinic
3. Putting it into practice - how to fund a diabetes clinic

Online Train IT learning modules to complement this toolkit

There are a number of online learning modules from Train IT that will assist with understanding this section of the QI Toolkit. To access these resources, you will require access to the online learning and collaborative portal DiscoverPHN. The learning modules include:

Train IT module number	Topic with learning objectives	Length	Target audience

9	Improving quality and revenue in General Practice using data extraction tools including Pen CS CAT4 and Topbar
	• Develop skills to improve data quality
	• Use Pen CS Clinical Audit Tool (CAT4) to:
	  ○ improve patient care
	  ○ meet practice accreditation requirements
	  ○ identify additional revenue opportunities
	• Use Topbar for continual improvements
	• Optimise use of MBS item numbers
	• Enable customised prompts
		45 mins	All staff

27	Reporting and advanced searches with MedicalDirector and Pracsoft • Generate financial reports using Pracsoft • Discuss the importance of collecting and analysing data for measuring practice efficiency and improvements • Develop an understanding of inbuilt searches with MedicalDirector Clinical • Explore additional data extraction tools including MD Insights • Design a practice system for data analysis and planned improvements	34 mins	PM and Principals
28	Reporting and advanced searches with Bp Premier • Generate financial reports using Bp Premier – Management reporting • Discuss the importance of collecting and analysing data for measuring practice efficiency and improvements • Develop an understanding of inbuilt searches with Bp Premier • Explore additional data extraction tools • Design a practice system for data analysis and planned improvements	32 mins	PM and Principals

ACTIVITY 1 - IDENTIFY THE NUMBER OF CHRONIC DISEASE CLAIMS TO MEDICARE THAT HAVE BEEN MADE AT YOUR PRACTICE

Activity 1.1 – Data collection from billing software package

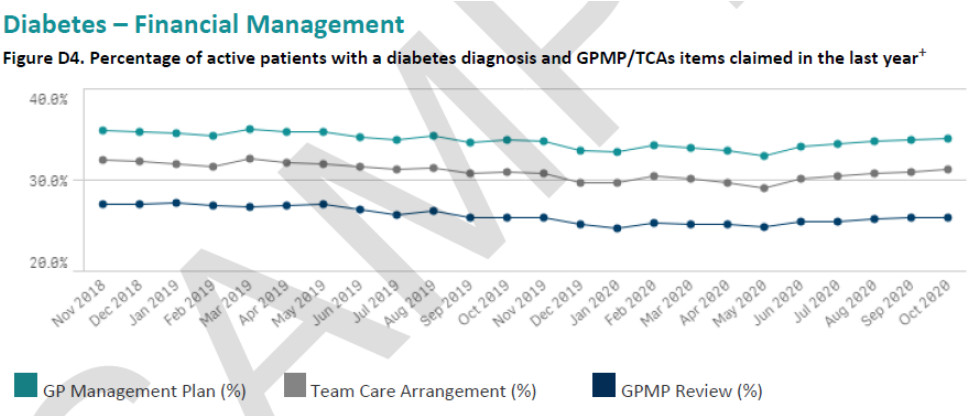
Complete the below table by collecting data from your billing software package. Instructions are available for Pracsoft, Best Practice or CAT4. Use the appropriate item numbers that are relevant for your practice from the list above.

The aim of this activity is to collect data to determine the number of claims made for chronic disease patients at your practice over the past 12 months.

Item	Description	July to Sept	Oct to Dec	Jan to Mar	Apr to June	12-month total
1.1a	Number of GPMP claimed					
1.1b	Number of TCA plans claimed					
1.1c	Number of management plan reviews claimed					
1.1d	Number of nurse chronic disease item numbers claimed					
1.1e	Number of health assessments claimed					
1.1f	Number of Aboriginal and Torres Strait Islander health assessments claimed					
1.1g	Number of home medication reviews claimed					
1.1h	Number of mental health item numbers claimed					

Please note: You may wish to change the dates of your searches to compare previous years and/or different time frames.

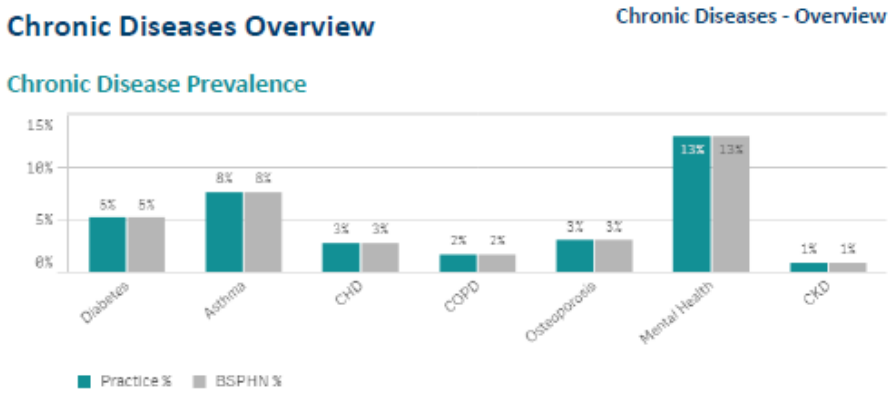
Trend report from Brisbane South PHN: You will also have access to your practice's trend report that you can use to input your data for some of the item numbers listed in activity 1.1. Use the line graphs to celebrate your achievements, set goals and targets for the upcoming 12 months and conduct dedicated chronic disease clinics.



Activity 1.2 – Identify the number of eligible patients from benchmark report

Complete the below table by collecting data from your practice benchmark report provided by Brisbane South PHN

The aim of this activity is to collect data to determine the number of patient's eligible for chronic disease patients at your practice.



Coded diagnosis*	-	- %	BSPHN	BSPHN %
Total Active Population	1,023,548	-	1,023,548	-
Patients with >1 chronic condition & >5 current medications	155,670	15%	155,670	15%
Diabetes**	52,838	5%	52,838	5%
Asthma	77,689	8%	77,689	8%
CHD	27,706	3%	27,706	3%
COPD	16,503	2%	16,503	2%
Osteoporosis	30,876	3%	30,876	3%
Mental Health***	132,420	13%	132,420	13%
CKD	8,469	1%	8,469	1%

Item	Description	Total
1.2a	Number of active asthma patients	
1.2b	Number of active diabetes patients	
1.2c	Number of active patients eligible for a GPMP (*add the total patients with diabetes, asthma, CHD, COPD, osteoporosis and CKD together)*	
1.2d	Number of active patients eligible for a 45-49 years health assessments	
1.2e	Number of active patients eligible for a 75+ years health assessment	
1.2f	Number of active patients eligible for an Aboriginal and/or Torres Strait Islander health assessment	
1.2g	Number of active patients with a mental health condition	

***Please note**: not all patients on the list will be eligible for the MBS item numbers. This can be due to item number being claimed elsewhere, not regular GP etc.*

Activity 1.3 – Numbers completed vs eligible patients

Complete this activity by obtaining information from your practice trend and benchmark reports or by comparing numbers completed in **Activity 1.1** and **Activity 1.2**

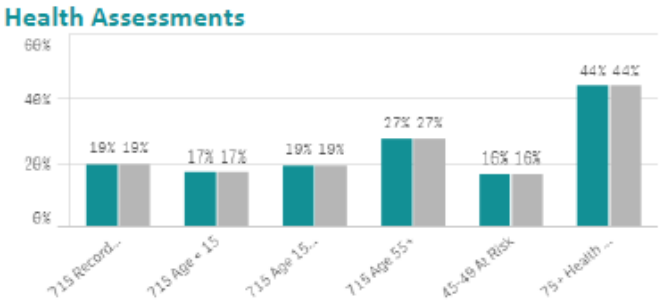
*The aim of this activity is to compare the number of patients who **may** be eligible for a chronic disease item number versus the number completed.*

Example trend report

Active mental health patients with MBS items claimed in the last year

MONTH	MAR 2018	APR 2018	MAY 2018	JUN 2018	JUL 2018	AUG 2018	SEP 2018	OCT 2018	NOV 2018	DEC 2018	JAN 2019	FEB 2019
2700, 2701, 2715, 2717 %	0.00	0.00	0.00	0.00	0.00	13.14	13.81	14.25	14.31	14.87	14.69	15.70
2700, 2701, 2715, 2717	0	0	0	0	0	93	99	103	104	109	108	116
2712 %	0.00	0.00	0.00	0.00	0.00	6.36	6.42	6.92	6.60	6.68	6.67	7.31
2712	0	0	0	0	0	45	46	50	48	49	49	54
2713 %	0.00	0.00	0.00	0.00	0.00	0.99	1.12	1.52	1.79	1.77	1.77	1.89
2713	0	0	0	0	0	7	8	11	13	13	13	14

Example benchmark report



Health Assessments*	-	- %	BSPHN	BSPHN %
Aboriginal and/or Torres Strait Islander Population	20907	-	20,907	-
All Aboriginal and/or Torres Strait Islander Health Check (715) claimed	4032	19%	4,032	19%
~~Age >=15 years Aboriginal and/or Torres~~ Strait Islander Health Check (715) claimed	1072	17%	1,072	17%
Age 15-54 years Aboriginal and/or Torres Strait Islander Health Check (715) claimed	2274	19%	2,274	19%
Age 55 years+ Aboriginal and/or Torres Strait Islander Health Check (715) Health Check claimed	686	27%	686	27%
At Risk Population between 45-49**	35999	-	35,999	-
Age 45-49 at risk health assessment (701, 703, 705, 707)*** ever claimed	5908	16%	5,908	16%
Population Aged 75+	62714	-	62,714	-
Age 75+ health assessment (701, 703, 705, 707)*** ever claimed	27470	44%	27,470	44%

Item	Description	Eligible patients	Number of MBS items claimed
1.3a	Number of active asthma patients and the number of asthma MBS items claimed		
1.3b	Number of active diabetes patients and the number of diabetes MBS items claimed		
1.3c	Number of patients with a chronic medical condition and the number of GP management plans claimed		
1.3d	Number of patients aged 45-49 years and the number of health assessments claimed		
1.3e	Number of patients aged 75+ years and the number of health assessments claimed		
1.3f	Number of Aboriginal and Torres Strait Islander patients and the number health assessments claimed		
1.3g	Number of patients with a mental illness and the number of mental health item numbers claimed		

Activity 1.4 – Reviewing your practices eligible vs actual item number claiming

The aim of this activity is to review the number of patients eligible for MBS item numbers versus the number of actual item numbers claimed for chronic medical conditions.

Description	Status	Action to be Taken
After completing **activity 1.3** are there any unexpected results with your practice's eligible versus completed MBS item numbers?	☐ Yes, **see action to be taken.** ☐ No, continue with activity.	Please explain: (*e.g. not many of our patients with diabetes have had a GPMP completed).* How will this information be communicated to the practice team?
After reviewing your patient eligible versus claimed for MBS chronic disease item numbers, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes, **see actions to be taken to help set you goals.** ☐ No, you have completed this activity	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 1.5 – Comparing your practice data with other practices in the Brisbane South PHN region

Complete this activity by obtaining information from your practice benchmark reports.

The aim of this activity is to compare the percentage of patients with a chronic disease at your practice with other practices in the Brisbane South PHN region.

Coded diagnosis*	-	- %	BSPHN	BSPHN %
Total Active Population	1,023,548	-	1,023,548	-
Patients with >1 chronic condition & >5 current medications	155,670	15%	155,670	15%
Diabetes**	52,838	5%	52,838	5%
Asthma	77,689	8%	77,689	8%
CHD	27,706	3%	27,706	3%
COPD	16,503	2%	16,503	2%
Osteoporosis	30,876	3%	30,876	3%
Mental Health***	132,420	13%	132,420	13%
CKD	8,469	1%	8,469	1%

Item	Description	Practice %	BSPHN %
1.5a	Number of active asthma patients		
1.5b	Number of active diabetes patients		
1.5c	Number of active CHD patients		
1.5d	Number of active COPD patients		
1.5e	Number of active osteoporosis patients		
1.5f	Number of active patients with a mental illness		
1.5g	Number of active CKD patients		
1.5h	Number of active Aboriginal and Torres Strait Islander patients		
1.5i	Number of active patients aged between 45 and 49 years		
1.5j	Number of active patients aged 75+ years		

Activity 1.6 – Reviewing your practices benchmark and trend reports

The aim of this activity is to review the percentage of patients with a chronic disease at your practice with other practices in the Brisbane South PHN region.

Description	Status	Action to be Taken
After completing **activity 1.5** are there any unexpected results with your practice's patient conditions comparing with other practices in the Brisbane south region?	☐ Yes, **see action to be taken.** ☐ No, continue with activity.	Please explain: (*e.g. low number of patients with diabetes compared to others or high number of patients with COPD*). How will this information be communicated to the practice team?
Are your practice patient measures similar to other practices in the Brisbane south region?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Outline the differences: (*e.g.: our number of patients with asthma is much higher than other practices in the region*). How will this information be communicated to the practice team?
Are you noticing a difference in your practice's trend report?	☐ Yes, **see action to be taken.** ☐ No, continue with activity.	Are trend lines: □ improving □ maintaining □ decreasing Please explain the reason for the outcomes of the trend lines: (*e.g. practice is working to improve recording of diabetes cycle of care measures or the practice has lost our chronic disease nurse so numbers are declining)*

Description	Status	Action to be Taken
		How will this information be communicated to the practice team?
After reviewing your patient benchmark and trend reports, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes, **see actions to be taken to help set you goals.** ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

ACTIVITY 2 - REFLECTION ON CURRENT MBS CLAIMING FOR CHRONIC DISEASE PATIENTS

The aim of this activity is to review your practices Medicare claiming for chronic disease patients and to identify if any changes will be made.

Activity 2.1 – Checklist for reflection of claiming

Complete the checklist below which will assist you to identify any gaps in your chronic disease patient claiming and to review if any changes need to be implemented.

Description	Status	Action to be taken
After reviewing your patient claiming history are there any unexpected results?	☐ Yes**, see action to be taken.** ☐ No, continue with activity.	Please explain: (*e.g. low claiming of health assessments or practice is doing well GPMP*). How will this information be communicated to the practice team?
Does the practice have a system for ensuring the correct MBS item numbers are claimed?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Can GPs review their day sheet of billings? ☐ Yes ☐ No Does the GP communicate the item number to bill to reception? ☐ Yes ☐ No
Does the practice have a system for tracking MBS item number claiming?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Review reports from billing software on a regular basis – develop a system that works for you and your practice. Set reminders in your system to regularly check this.
Do you know the contact details for any MBS related questions?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Email: askMBS@health.gov.au Provider Enquiry Line - 13 21 50
Do relevant staff know that Medicare provide online training modules?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	More information can be obtained from Medicare Australia e-learning modules.

Description	Status	Action to be taken
Do you have a proactive reminder system?	☐ Yes, continue with activity. ☐ No - **document action to be taken.**	See Brisbane South PHN recall/reminder QI toolkit. See Train IT recall/reminder resources.
Is your current reminder system working effectively? How do you know?	☐ Yes, continue with activity. ☐ No - **document action to be taken.**	Identify what part of your system is not working effectively. How can the team use this information to improve your system?
After reviewing your patient MBS claiming, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes, **see actions to be taken to help set you goals.** ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 2.2 – Developing plan for MBS claiming

The aim of this activity is to develop a plan for completing MBS item numbers over the next 12 months.

[Example General Practice]

Date range of report: [insert date range]

MEDICARE ITEM NUMBERS

Medicare Item Name	Eligible patients	Number completed	Goal to complete	Number per week for the practice	Proposed income
Health assessments (Age 45-49 and 75+)	945	330 (35%)	472 (50%)	9	$89,821.60 (Item 705 – MBS fee)
GPMP	1,741 **	717 (41%)	1044 (60%)	20	$112,908.60 (50% new plan; 50% reviews MBS Fee)
Heart health check	422	68 (16%)	168 (40%)	3	$12,230.40
Aboriginal and Torres Strait Islander health assessments	74	8 (10%)	45 (60%)	0.8	$9,551.25
Home medication reviews	2,001 *	28 (1.3%)	400 (20%)	8	$61,920.00
Totals for the 12 months	5,183	1,151	2,129 (39%)	41	$286,431.85

* Home medication review eligibility based on patients on five or more medications

** GPMP conditions include: diabetes, asthma, CHD, COPD, osteoporosis and CKD. Please note: team care arrangement plans are not included in the above calculations.

Disclaimer: it is the responsibility of each individual GP to ensure that prior to claiming an MBS item number that each patient meets the criteria as outlined by Medicare.

[Insert practice name]

Date range of report: [insert date range]

Medicare item name	Eligible patients	Number completed	Goal to complete	Number per week for the practice	Proposed income
Health assessments (Age 45-49 and 75+)					
GPMP**					
Heart health check					
Aboriginal and Torres Strait Islander health assessments					
Home medication reviews*					
Totals for the 12 months					

* Home medication review eligibility based on patients on five or more medications

** GPMP conditions include: diabetes, asthma, CHD, COPD, osteoporosis and CKD.

Activity 2.3 – Reviewing Medicare claiming at your practice

After completing **Activity 2.2** note if your practice has a low (less than 20%), medium (between 21% and 50%) or high (51% or above) rate of claiming. (*Obtain this information from the number completed column).*

Item description			
Health assessments	☐ Low	☐ Medium	☐ High
GPMP	☐ Low	☐ Medium	☐ High
Healthy heart check	☐ Low	☐ Medium	☐ High
Aboriginal and Torres Strait Islander health assessments	☐ Low	☐ Medium	☐ High
Home medication reviews	☐ Low	☐ Medium	☐ High
Is there an explanation as to these results? ☐ Yes ☐ No	Please explain: (*e.g. loss or gain of GP/s, influx of patients, data entry, lack of understanding of the Medicare criteria etc., no nurse.*):		
Is there a similar trend with all assessments? ☐ Yes ☐ No	Please explain:		
After reviewing your percentage of patient MBS claiming, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes, **see actions to be taken to help set you goals.** ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.	

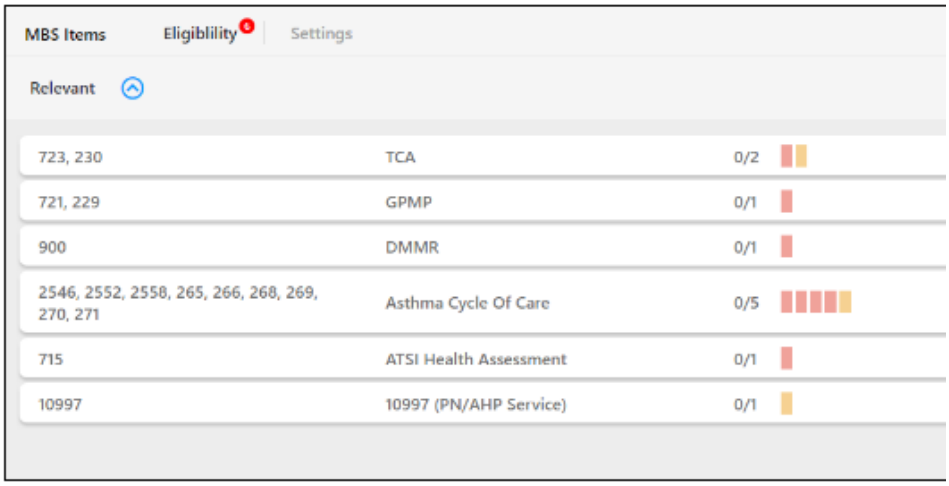
ACTIVITY 3 – TOOLS TO ASSIST AND IMPROVE MBS CLAIMING AT YOUR PRACTICE

Medicare item numbers and Topbar

Pen CS Pty Ltd (PEN CS) have developed Topbar as an adjunct to the GP Clinical Desktop System to deliver useful tools and decision support information for the primary care sector at the point of care. Currently Topbar works with Best Practice, MD3 and the latest version of Zedmed.

The MBS app can assist in determining which MBS item is relevant for the patient currently open in the clinical system. Topbar looks at the billing history of the patient at the clinic only - Medicare currently does not allow third party access to information about billing elsewhere.

For each patient that is open on the clinical system, you will be able to view the list of Medicare item numbers for which the patient is eligible.



MBS online checker

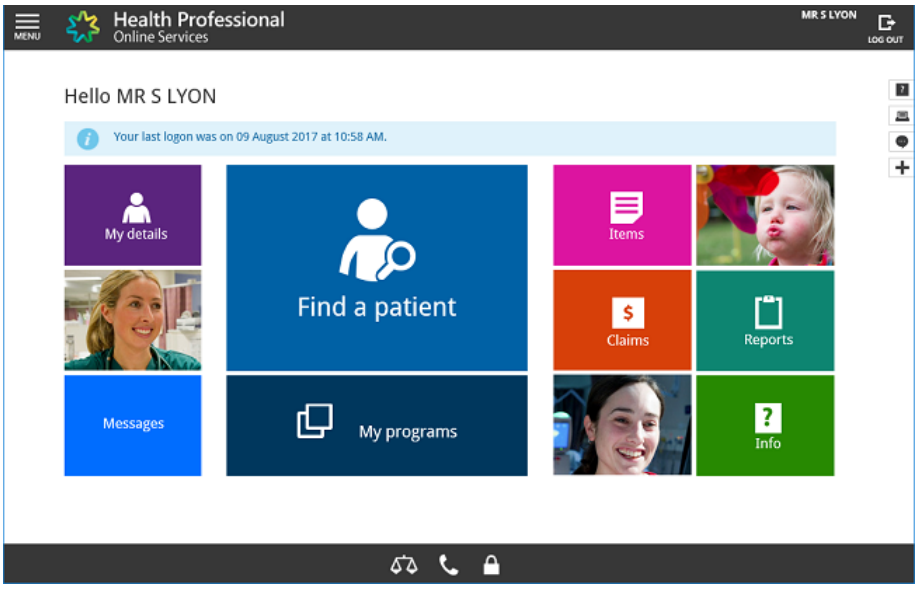
The MBS online checker available via HPOS enables you to:

- view and check patient eligibility based on their MBS history
- check the eligibility of the GP for claiming the MBS item number
- check claiming conditions for MBS items.

Provider digital access (PRODA)

PRODA is an online authentication system used to securely access certain online services including HPOS, Australian Immunisation Register (AIR), Medicare claiming, NDIS and My Health Record. A PRODA account needs to be set up for an individual, not an organisation.

Designed as a two-step verification process, it requires a username, password and verification code to login. Practice staff can use PRODA to search for previous MBS item number billing and to check eligibility. Refer to information on what you can access from PRODA.



For more information about Topbar or PRODA:

Brisbane South PHN have some instructions to assist with registration and using the portal.

- Topbar flip guide
- PRODA login
- HPOS education resources
- Health professionals online learning modules.

Activity 3.1 – Using PRODA in General Practice

The aim of this activity is to ensure the relevant staff in your practice know how to use PRODA.

Description	Status	Action to be taken
Are all GPs in your practice registered to use PRODA?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	See instructions on how to use PRODA.
Are relevant team members given access to PRODA as a delegate of a GP, to be able to check Medicare numbers?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	See instructions on how to use PRODA.

Description	Status	Action to be taken
Are relevant team members aware of all the categories available via HPOS?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	See instructions on how to use each program here. How will this information be distributed to team members?
Does your practice require assistance setting up PRODA?	☐ Yes, **see action to be taken.** ☐ No, continue with activity.	Contact your Regional Support Coordinator at Brisbane South PHN or the Digital Health team on ehealth@bsphn.org.au.
After reviewing your practice PRODA access, are there any changes you would like to implement in the practice, to help using practice software, over the next 12 months?	☐ Yes, **see actions to be taken to help set you goals.** ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

ACTIVITY 4 – MEDICARE ITEM NUMBERS

The aim of this activity is to outline some of the MBS item numbers that you may use in general practice for eligible patients. Instructions are also included on how to complete the templates in Best Practice and MedicalDirector. It is important that prior to claiming any item numbers that GPs have a full understanding of the criteria and to ensure that the individual patient meets the criteria.

Chronic disease management plans (MBS items 721, 723, 732)

There are two types of plans that can be prepared by the patient's regular General Practitioner (GP) for Chronic Disease Management (CDM): GP Management Plans (GPMP); and Team Care Arrangements (TCAs).

These plans are for:

- A patient with a chronic (or terminal) medical condition, (i.e. condition has been present or likely to be present for six months) – GPMP (GP only care planning)
- If the patient has complex care needs and requires treatment from two or more other health care providers - GPMP and TCA (GP and multidisciplinary team care planning).

If the patient has both a GPMP and TCAs prepared, they may be eligible for Medicare rebates for certain allied health services.

The practice nurse can provide support and monitoring between visits via MBS item number 10997.

A chronic medical condition is one that has been (or is likely to be) present for six months or longer, for example, asthma, cancer, heart disease, diabetes, arthritis and stroke. There is no list of eligible conditions. However, these items are designed for patients who require a structured approach and to enable GPs to plan and coordinate the care of patients with complex conditions requiring ongoing care from a multidisciplinary care team.

GPMP (MBS item 721)

A GPMP can help people with chronic medical conditions by providing an organised approach to care. A GPMP is a plan of action agreed between the regular GP and the patient. This plan:

- identifies the patients' health and care needs
- sets out the services to be provided by the GP
- lists the actions the patient can take to help manage their condition.

TCA (MBS item 723)

If the patient has a chronic medical condition and complex care needs requiring multidisciplinary care, the regular GP may also develop a TCA. These will help coordinate more effectively the care the patient needs from their GP and other health or care providers.

TCAs require the GP to collaborate with at least two other health or care providers who will give ongoing treatment or services.

Review of GPMPs and TCAs (MBS item 732)

Once a plan is in place, it should be regularly reviewed by the GP. This is an important part of the planning cycle, where the GP and patient check that the goals are being met and agree on any changes that might be needed.

Exceptional circumstances exist for a patient if there has been a significant change in the patient's clinical condition or care requirements that necessitates the performance of the service for the patient.

Description	Item number	Minimum claiming period
Preparation of a GPMP	721	12 months
Coordination of TCAs	723	12 months
Review of a GPMP or coordination of a Review of TCAs	732	3 months

Referrals for allied health services

If the patient has both a GPMP and TCA prepared, they may be eligible for Medicare rebates for specific individual allied health services that the GP has identified as part of patient care. The need for these services must be directly related to the chronic (or terminal) medical condition. If the patient has type 2 diabetes and their GP has prepared a GPMP, they can also be referred for certain allied health services provided in a group setting.

Management plans and advanced care planning

As part of the Brisbane South Older People's Health and Wellness Strategy 2019-2024 it is suggested that GPs initiate conversations with patients aged 60 years and older who have a GPMP or TCA. An advance health directive is a document that states the wishes or directions regarding patient's future health care for various medical conditions. It comes into effect only if the patient is unable to make their own decisions.

- RACGP – Advance Care Planning
- Advance health directive Queensland.

Temporary chronic disease management telehealth item numbers

During the COVID-19 outbreak, the Australian Government have provided temporary item numbers to manage patients. Refer to the MBS fact sheet.

Completing chronic disease templates in practice software

To create a GPMP, TCA or to review either of these plans refer to instructions from Best Practice or MedicalDirector. You can also customise goals and tasks in the Best Practice template.

You may also choose to use health specific template Please just keep in mind, that if the patient has more than one chronic condition, they only have one management plan with all conditions included, not separate plan for each condition.

Nurse chronic disease item number (MB item 10997)

Item 10997 may be claimed by a medical practitioner, where a monitoring and support service for a person with a chronic disease care plan (GPMP and/or TCA) is provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of that medical practitioner. This item can be claimed up to five times in a calendar year.

Resources for chronic disease plans

- MBS online – all the details about the Medicare item number criteria are available here. (Please note: always click on the explanatory notes for full details)
- Q&A on chronic disease plans
- Medicare chronic disease management resources including case studies.

Chronic disease management

- GP Management Plans (GPMP)
- Team Care Arrangements (TCA)
- Allied Health Initiative (AHI) for GPs
- Multidisciplinary Case Conferences.

Chronic disease management case studies

- GPMP case study - asthma (adult)
- GPMP case study - asthma (child)
- GPMP case study - diabetes
- GPMP case study - osteoarthritis

- GPMP case study - psoriasis
- GPMP case study - tendonitis
- TCA case study - breast cancer
- TCA case study - diabetes
- TCA case study - chronic obstructive airways disease
- TCA case study - heart failure
- TCA case study - osteoarthritis
- TCA case study - osteoarthritis, osteoporosis and Parkinson's disease
- TCA case study - pelvic leiomyosarcoma
- AHI case study - diabetes
- AHI case study - osteoarthritis, hypertension and early dementia.

Health assessments (MBS items 701-707)

There are time-based MBS health assessment items: 701 (brief), 703 (standard), 705 (long) and 707 (prolonged). If you are a non-vocationally registered GP, the following item numbers can be claimed: 224 (brief), 225 (standard), 226 (long) and 227 (prolonged). The following categories of health assessments may be undertaken by a medical practitioner under these items:

- People aged 40 to 49 years (inclusive) with a high risk of developing type 2 diabetes as determined by the Australian type 2 diabetes risk assessment tool.
- People between the age of 45 and 49 (inclusive) who are at risk of developing a chronic disease.
- People aged 75 years and older.
- Permanent residents of a residential aged care facility.
- People who have an intellectual disability.
- Humanitarian entrants who are resident in Australia with access to Medicare services, including refugees and special humanitarian program and protection program entrants.
- Former serving members of the Australian Defence Force including former members of permanent and reserve forces.

Completing health assessment templates in practice software

To create a health assessment template refer to instructions from Best Practice or MedicalDirector.

There are other health assessment templates available that can be incorporated into your practice letter writer template. This is usually a preference of GPs and nurses as to what they would like included in the templates. Central and Eastern Sydney Network have templates available to download.

Health assessments and *My health for life*

Patients identified during a health assessment as having a high risk of chronic disease such as stroke, heart disease, diabetes may be eligible for the My health for life program. To investigate eligible patients for the *My health for life* program, Brisbane South PHN has a QI toolkit to assist you.

Health assessments and advance care planning

An advance health directive is a document that states the wishes or directions regarding a patient's future health care for various medical conditions. It comes into effect only if the patient is unable to make their own decisions.

- RACGP – Advance Care Planning
- Advance health directive Queensland.

To identify older patients at your practice, Brisbane South PHN has a QI toolkit to assist you.

Health assessments and dementia screening

During an annual health assessment, patients can be assessed for dementia via a mini mental state or GPCog examination. They can also be assessed for depression via the Geriatric Depression Scale. Access to these assessments maybe available in your practice clinical software package. Dementia Australia provides more information about cognitive screening.

Additional Health assessment resources

- An education guide is available from Department of Human Services
- RACGP – Guide for prevention in General Practice (Red Book)
- The Department of Health – Medicare Health Assessment Resource Kit
- RACGP – Conducting quality health assessments in General Practice.

Heart Health Check (MBS items 699 and 177)

Medicare has item number 699 (177 for non VR) for GP's to conduct a comprehensive cardiovascular health assessment utilising the Australian Absolute Cardiovascular Disease Risk calculator.[1] The Heart Health Check includes an absolute cardio vascular disease (CVD) risk assessment followed by development of a lifestyle management plan. This plan may include referral to My Health for Life or other available lifestyle support programs such as Heart Foundation Walking, Get Healthy Coaching, Quitline or 10,000 Steps.

It is also beneficial to record physical activity status of the patient and generate a physical activity prescription. Instructions are available from Best Practice and MedicalDirector.

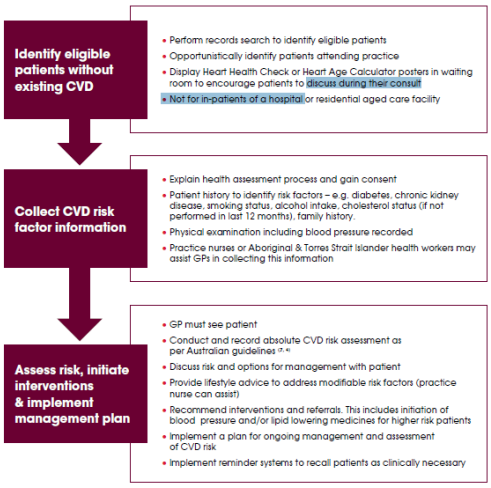
Who is eligible for a Heart Health Check?

The intention of this item is to identify cardiovascular disease (CVD) in people not known to have CVD including:

- Aboriginal or Torres Strait Islander persons who are aged 30 years and above;
- Adults aged 45 years and above, who have not claimed a health assessment in the previous 12 months.

Heart Health Check and the Heart Foundation

The Heart Foundation have a number of resources available to assist general practice to identify and complete Heart Health Checks for eligible patients including a toolkit. Another resource is a suggested approach to implementation of the check in general practice. [2]



Completing Heart Health Check templates in your practice software

The Heart Health Check Risk Assessment template and My Healthy Heart Plan (management template) are now integrated into Bp Premier. **If you are not a Bp user**, you can still download the editable PDF and RTF versions of these templates from the Heart Health Check toolkit and use them to help streamline your processes. MedicalDirector users can access a Healthy Heart Check template from the supplied list in letter writer.

---

[1] *Heart Foundation Australia*

[2] https://www.heartfoundation.org.au/images/uploads/main/For_professionals/190415_MBS_Factsheet_FINAL.pdf

Aboriginal and Torres Strait Islander health assessment (MBS item 715)

Indigenous health refers to the physical, cultural, social and emotional wellbeing of Aboriginal and/or Torres Strait Islander peoples (Indigenous Australians). Many indigenous Australians experience poorer health than other Australians, often dying at much younger ages. Indigenous Australians are more likely than non-Indigenous Australians to have respiratory diseases, mental health problems, cardiovascular disease, diabetes and chronic kidney disease. [3]

Who is eligible for an Aboriginal and Torres Strait Islander health assessment

The Aboriginal and Torres Strait Islander Peoples health assessment is available to:

- Children between ages of 0 and 14 years
- Adults between the ages of 15 and 54 years
- Older people over the age of 55 years.

Aboriginal and Torres Strait Islander assessment and Medicare

MBS item 715 must include the following elements:

- Information collection, including taking a patient history and undertaking examinations and investigations as required.
- Making an overall assessment of the patient.
- Recommending appropriate interventions.
- Providing advice and information to the patient.
- Keeping a record of the health assessment, and offering the patient, and/or patient's carer, a written report about the health assessment with recommendations about matters covered by the health assessment; and
- Offering the patient's carer (if any, and if the general practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

Completing health assessment templates in practice software

To create a health assessment template refer to instructions from Best Practice or MedicalDirector.

Patient populations QI toolkit and Aboriginal and Torres Strait Islander Peoples

Brisbane South PHN have a patient populations QI toolkit that has more information about Aboriginal and Torres Strait Islander patients including:

- reviewing your patient population to identify the number of Aboriginal and Torres Strait Islander patients
- practice incentive payment information
- Closing the GAP
- cultural awareness training.

Temporary health assessment telehealth item numbers

During the COVID-19 outbreak, the Australian Government provided temporary item numbers to manage patients. Refer to the MBS fact sheet.

[3] https://www.healthdirect.gov.au/indigenous-health#:~:text=Many%20Indigenous%20Australians%20experience%20poorer,dying%20at%20much%20younger%20ages.&text=There%20is%20also%20a%20continued,in%20the%20non%2DIndigenous%20population.

Aboriginal and Torres Strait Islander health assessment resources

- Brisbane South PHN Aboriginal and Torres Strait Islander resources
- RACGP - National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people.

Home medication reviews (MBS item 900)

The Home Medication Review (HMR) is a service to patients living in their own home. The goal of an HMR is to maximise an individual consumer's benefit from their medication regimen and prevent medicine-related problems. HMR is based on a team approach that involves the consumer's general practitioner and preferred community pharmacy. Please note: this requires two consultations with the GP, the first to generate the referral to the community pharmacist and secondly to complete a medication management plan after receiving a report from the pharmacist.

Who is eligible for an HMR?

To be eligible for an HMR, the patient must be living in their own home and:

- have a chronic medical condition or a complex medication regimen; and
- are not having their therapeutic goals met and

following that assessment:

- refers the patient to a community pharmacy or an accredited pharmacist for the HMR; and
- provides relevant clinical information required for the HMR; and
- discusses with the reviewing pharmacist the results of the HMR including suggested medication management strategies; and
- develops a written medication management plan following discussion with the patient; and
- provides the written medication management plan to a community pharmacy chosen by the patient.

Completing HMR in practice software

To create a health assessment template refer to instructions from Best Practice or MedicalDirector (to complete the pharmacist referral and medication management plan, you can access templates in the letter writer section).

HMR resources

- Department of Health – Medication management reviews
- Pharmacy Guild - Find a registered pharmacist
- Australian Family Physician – Understanding a HMR from a patient's perspective
- NPS – Understanding your medicines – for patients
- Veterans Mates - 8 reasons to have a HMR.

Mental health MBS item numbers

Mental illness is very common. One in 5 (20%) Australians aged 16 to 85 experience a mental illness in any year. The most common mental illnesses are depression, anxiety and substance use disorder. [4] There are a number of MBS item numbers available for GPs to claim for mental health related consultations. Always refer to the MBS for full details. The item numbers include:

Item description	Medicare criteria	Frequency of claiming
Mental health consultation (MBS item 2713).	Mental health consultation lasting at least 20 minutes. To claim this, the patient does not need to be on a mental health plan.	No limits to the amount of times this item number is claimed
Mental health treatment plan (MHTP) MBS items (2700, 2701, 2715 or 2717).	The MHTP must include documenting the results of assessment, patient needs, goals and actions, referrals and required treatment/services, and review date.	A new plan may be completed after 12 months if clinically required and if the person meets eligibility criteria. After plan has been completed, the patient is entitled to Medicare subsidised visits with a psychologist.
Review mental health plan (MBS item 2712)	The review item is a key component for assessing and managing the patient's progress once a GP MHTP has been prepared. A plan should be reviewed at least once.	Can be claimed every three months or at least four weeks after claiming the MHTP item number.

More information about item numbers is available at Education guide – better access to mental health care for eligible health professionals.

Completing MHTP in practice software

To access assessments such as geriatric depression scale, postnatal depression, K10 refer to instructions from Best Practice or MedicalDirector.

To create a MHTP access the templates supplied in the letter writing section.

Temporary mental health telehealth item numbers

During the COVID-19 outbreak, the Australian Government provided temporary item numbers to manage patients. Refer to the MBS fact sheet.

Additional mental health resources

- MBS education for health professionals
- Family history screening questionnaire.

  The use of a simple family history questionnaire can help identify individuals who may require a more detailed assessment of their family history of cancer, heart disease or diabetes.
- Medicare Benefit Schedule
- Mental health skills training
- Mental health first aid training

[4] Black Dog Institute – Facts and Figures about Mental Health

ACTIVITY 5 – RECALLS AND REMINDERS

As part of the RACGP accreditation standards, it is a requirement that practices provide health promotion, illness prevention, preventive care and a reminder system based on patient needs and best available evidence.

Reminders, recalls and prompts (flags)

Reminders are used to initiate prevention, before or during the patient visit. They can be either opportunistic or proactive. Recalls are a proactive follow up to a preventive or clinical activity. Prompts are usually computer generated and designed to opportunistically draw attention during the consultation to a prevention or clinical activity needed by the patient. Using a recall system can seem complex, but there are some steps you can take:

- be clear about when and how you want to use these flags (including reminder priorities – high, medium and low)
- identify and agree who is responsible for what actions
- identify all the people who need to be recalled and place them in a practice register. This will help to ensure that the recall process is both systematic and complete.

Explore systems used by other practices, your PHN, and information technology specialists to ensure you get the correct system.

Train IT Medical – Recall and reminder resources for MedicalDirector

Train IT Medical have a number of resources available for practices to use to assist managing their recall and reminder systems. These include:

- Bulk recall cleanup
- MedicalDirector learning resources
- Sample quality improvement activity
- Train IT Medical 'Recalls, Reminders & Screening' using MD presentation
- MedicalDirector clinical Top 5 'Recalls & Reminders' tips.

Train IT Medical – Recall and reminder resources for Best Practice

Train IT Medical have a number of resources available for practices to use to assist managing their recall and reminder systems. These include:

- Reminders quick reference guide
- Creating a reminder template
- Sending SMS reminders to patients
- Recall and reminders – why it's so hard.

You can also access other QI tools via medical software modules that will assist your practice to merge duplicate recall/reminder lists in your practice's clinical software. These modules are:

- Module 7 – Recalls, Reminders and Screening using MedicalDirector
- Module 8 – Recalls, Reminders and Screening using Best Practice

You can access these modules via DiscoverPHN.

Activity 5.1 – Reminder system

The aim of this activity is to review the practice's reminder system.

Description	Status	Action to be taken
Do clinicians know how to initiate a patient reminder within clinical software? How does the practice record if a patient **DOES NOT** wish to be contacted offering reminder appointments?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to instructions from Best Practice or MedicalDirector.
Is there a system to identify in the appointment book when a patient is coming in for a reminder appointment?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Use of a symbol in the appointment book to identify type of appointment.
Is there a process for acting on or removing outstanding reminders? (E.g. patients fail to attend, reminder no longer needed).	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	GP education on removing reminders. Document practice process on removing reminders.
Is there a practice policy on how reminders are to be implemented? (E.g. *entering all reminders for the upcoming 12 months to ensure all tests are performed*?)	☐ Yes, policy is working. ☐ Yes, policy is not working, see action to be taken. ☐ No policy, **see action to be taken.**	Revise policy. Practice policy on reminders to be implemented.
Does the recall and reminder system take into consideration patients with low English proficiency?	☐ Yes, policy is working. ☐ Yes, policy is not working, **see action to be taken**. ☐ No policy, **see action to be taken.**	Revise or implement practice policy. Letters and voice phone messages can be confusing for patients with limited or no English. Using the Translating and Interpreting Service to call the patient or sending text messages can be more effective. Consider using the online Appointment Reminder Translation Tool.
After reviewing your practice recall and reminder system, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes, **see actions to be taken to help set you goals.** ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

ACTIVITY 6 – MBS EDUCATION MODULES FOR HEALTH PROFESSIONALS

There are a number of MBS education modules available for health professionals. The modules relevant to this QI toolkit include:

- Better Access to mental health care for eligible practitioners and allied health professionals
- Chronic disease individual allied health services Medicare items 10950-10970
- Chronic disease management – GP services
- Health assessments and your record keeping responsibilities
- Medicare reason codes and reducing claim rejections
- Your guide to Medicare for Indigenous health services.

Links to other QI toolkits

After completing this toolkit, you may benefit from choosing one of the following:

- Quality records – this toolkit is designed to assist practices to review their practice data to ensure data accuracy.
- Patient populations – this toolkit is designed for practices to review demographics of the patients to identify if the practice has a higher population of age group or ethnicity.

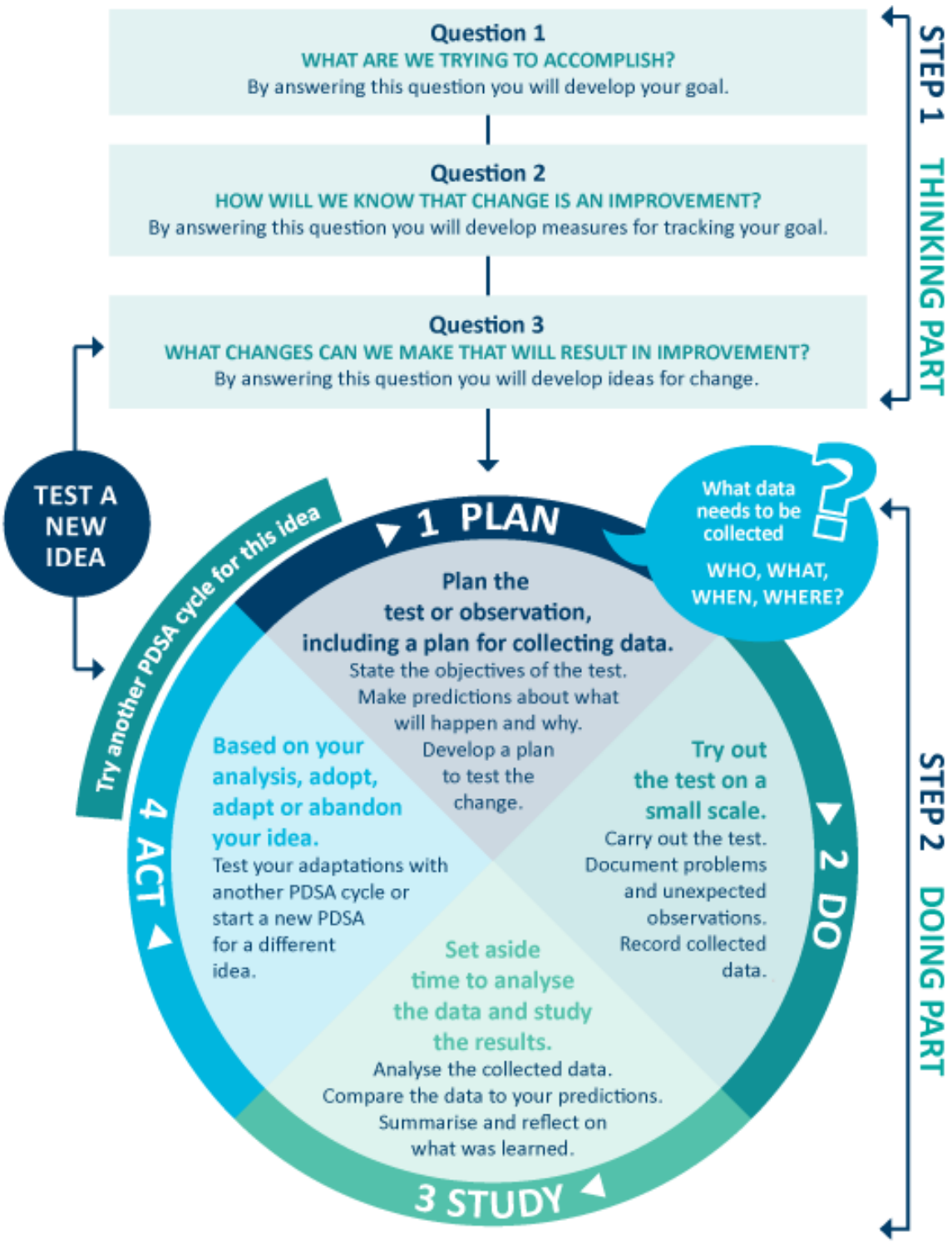
The full suite of toolkits are available on Brisbane South PHN's website.

Example PDSA for MBS items

See below for suggested goals related to the cancer screening you may wish to achieve within your practice:

Goal	How you may achieve the goal
Increase by 10% the number of patients aged 45 to 74 years to enable CVD risk assessment with the following: Smoking status Blood pressure Total cholesterol and HDL levels (You may wish to do this as part of a **heart health check** MBS item 699).	Refer to CAT4 recipe: Identify patients with no allergy or smoking status recorded Identify patients with no BP recorded Identify patients with elevated CV risk (select excluded and incomplete tab).
Increase the number of GPMP completed on patients with diabetes by 10%.	Refer to CAT4 recipe: identify patients with a chronic medical condition eligible for a GPMP or TCA.
Identify home medication review candidates and increase the number of referrals to pharmacists by 5%.	Refer to CAT4 recipe: identify home medication review candidates.

Model for Improvement diagram



Source: http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx

MFI AND PDSA TEMPLATE EXAMPLE

Step 1: The thinking part - The 3 fundamental questions

Practice name:	**Date:**
Team members:	

Q1. What are we trying to accomplish? (Goal)

By answering this question, you will develop your GOAL for improvement.
Record this as a S.M.A.R.T. goal (**S**pecific, **M**easurable, **A**chievable, **R**elevant, **T**ime bound).

Our goal is to: Ensure all active patients with diabetes have a GPMP completed.
This is a good start, but how will you measure whether you have achieved this goal? The team will be more likely to embrace change if the goal is more specific and has a time limit.
So, for this example, a better goal statement would be:
Our S.M.A.R.T. goal is to: Increase the proportion of our active patients with diabetes to have a GPMP completed by 15% by 17th April.

Q2. How will I know that a change is an improvement? (Measure)

By answering this question, you will determine what you need to MEASURE in order to monitor the achievement of your goal. Include how you will collect your data (e.g. CAT4 reports, patient surveys etc.). Record and track your baseline measurement to allow for later comparison.

We will measure the percentage of active patients with diabetes and a GPMP completed. To do this we will:
A) Identify the number of active patients with diabetes.
B) Identify the number of active patients with diabetes and GPMP recorded in the past 12 months.
B divided by A x 100 produces the percentage of patients with diabetes who have a GPMP recorded in the past 12 months.

BASELINE MEASUREMENT: 63% of active diabetes patients have an GPMP recorded in the past 12 months.

Q3. What changes could we make that will lead to an improvement? (List your IDEAS)

By answering this question, you will generate a list of IDEAS for possible changes you could implement to assist with achieving your S.M.A.R.T goal. You will test these ideas using part 2 of this template, the 'Plan, Do, Study, Act (PDSA)' cycle. Your team could use brainstorming or a driver diagram to develop this list of change ideas.

IDEA: Identify active patients with diabetes who do not have a GPMP recorded in the past 12 months.
IDEA: Update the reminder criteria on the practice software to ensure the GPMP reminder interval is set at the appropriate time.
IDEA: Complete diabetes cycle of care on an annual basis for all active patients with diabetes.
IDEA: Adjust the practice nurse roster to allow for extra nursing hours to assist with getting the GPMPs completed.
IDEA: Update templates on the practice software to ensure appropriate templates are available.

Note: Each new GOAL (1st Fundamental Question) will require a new MFI plan.
Source: Langley, G., Nolan, K., Nolan, T., Norman, C. & Provost, L. 1996, The Improvement Guide, Jossey-Bass, San Francisco, USA.

MFI and PDSA template EXAMPLE

Step 2: The doing part - Plan, Do, Study, Act

You will have noted your IDEAS for testing when you answered the 3rd fundamental question in step 1. You will use this template to test an idea. Ensure you communicate the details of the plan to the entire practice team.

IDEA	Record the change idea you are testing
Which idea are you going to test? *(Refer to Q3, step 1 above)*	
Identify active patients with diabetes who do not have a GPMP recorded in the past 12 months.	

PLAN	Record the details of how you will test your change idea
Plan the test, including a plan for collecting data	What exactly do you plan to do? Record who will do what; when they will do it (day, time etc) and for how long (1 week, 2 weeks etc); and where (if applicable); the data to be collected; and predictions about the outcome.
WHAT: Lucy will set aside an hour on a Tuesday afternoon to conduct a search on CAT4 of all active patients with diabetes and no GPMP recorded. A Topbar prompt will then be created to ensure these patients are booked in for their management plan at their next appointment. WHO/WHEN/WHERE: Who: Practice Manager When: Begin 19th January. Where: Practice manager's office. DATA TO BE COLLECTED: Number of active diabetes patients and number of active diabetes patients who have not had a GPMP completed in the past 12 months. PREDICTION: 78% of the active diabetes patient population will have had a GPMP completed in the past 12 months.	

DO	Run the test, then record your actions, observations and data
Run the test on a small scale	What did you do? Were there any deviations from the original plan? Record exactly what you did, the data collected and any observations. Include any unexpected consequences (positive or negative).
Done – completed 17th April – on investigation it was identified that there were 5 different reminder categories for GPMP in the practice software. It took longer to do the check as categories needed to be merged, so there was only 1 category to choose from. The PHN staff provided some great instructions on merging reminder categories. A Topbar prompt was created which assisted the practice team identify diabetes patients who did not have a GPMP recorded when they attended for an appointment. Lucy contacted patients via SMS who did not have a GPMP results recorded, which resulted in 17 people making an appointment to see their GP.	

STUDY	Analyse the data and your observations
Analyse the results and compare them to your predictions	Was the plan executed successfully? Did you encounter any problems or difficulties? What worked/didn't work? What did you learn on the way? Compare the data to your predictions. Summarise and reflect on what was learned.
At the end of the focus on GPMP for patients with diabetes, 72% of patients with diabetes had a result recorded. This has resulted in a 9% increase in results which is 6% lower than our goal. Results have been shared with the whole practice team. Whilst we didn't achieve our goal, we can see the benefit in discussing this with eligible patients. Lucy has been commended for her work in identifying eligible patients. *Communicate the results of your activity with your whole team. Celebrate any achievements, big or small.*	

ACT	Record what you will do next
Based on what you learned from the test, record what your next actions will be	Will you adopt, adapt or abandon this change idea? Record the details of your option under the relevant heading below. *ADOPT: record what you will do next to support making this change business as usual*; ADAPT: *record your changes and re-test with another PDSA cycle; or ABANDON: record which change idea you will test next and start a new PDSA.*

ADOPT:

ADAPT:
The practice will continue to increase the number of GPMPs completed, however, we are going to give our nurses an extra 4 hours a week to dedicate to completing GPMPs.

ABANDON:

Repeat step 2 to re-test your adapted plan or to test a new change idea

First floor, Building 20, Garden City Office Park, 2404 Logan Road, Eight Mile Plains QLD 4113
PO Box 6435, Upper Mt Gravatt QLD 4122 T: 3864 7555 or 1300 467 265
bsphn.org.au | ABN 53 151 707 765

phn BRISBANE SOUTH
An Australian Government Initiative