HotDoc

Chronic Disease Management & Care Plans using Telehealth in General Practice

May 2020

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Chronic Disease Management & Care Plans using Telehealth in General Practice

This session will cover:

- Overview of **telehealth items for chronic disease management**
- **Areas to prioritise** when providing **chronic disease care via telehealth**
- **Sample structure of a telehealth care plan or review** consultation
- **Using a team approach**: the role of nurses, GPs and promoting access to allied health
- **Key resources** for a smooth practice process

Telehealth Items for Chronic Disease Management

Service	**Existing Items** *face to face*	**COVID-19 Telehealth items** *video-conference*	**COVID-19 Telephone items** – *for when video-conferencing is not available*
Chronic Disease Management			
GP management plan, prepare	721	92024	92068
GP team care arrangement, co-ordinate development	723	92025	92069
GP contribution to prepare or review a multidisciplinary care plan, prepared by another provider	729	92026	92070
GP contribution to prepare or review a multidisciplinary care plan, prepared by a provider when the patient was admitted or by a RACF	731	92027	92071
GP attendance to coordinate a GP management plan or team care arrangements	732	92028	92072

Source: http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/news-2020-03-29-latest-news-March retrieved 04/05/20

Telehealth Items for Chronic Disease Management - Nurse Items

ATTENDANCES for COVID-19 Services Provided By A Practice Nurse Or Aboriginal And Torres Strait Islander Health Practitioner On Behalf Of A Medical Practitioner

These services are for non-admitted patients

	Existing Items *face to face*	**COVID-19 Telehealth items** *video-conference*	**COVID-19 Telephone items** – *for when video-conferencing is not available*
* Follow up service for an Indigenous person who has received a health assessment	10987	93200	93202
* Service provided to a person with a chronic disease	10997	93201	93203

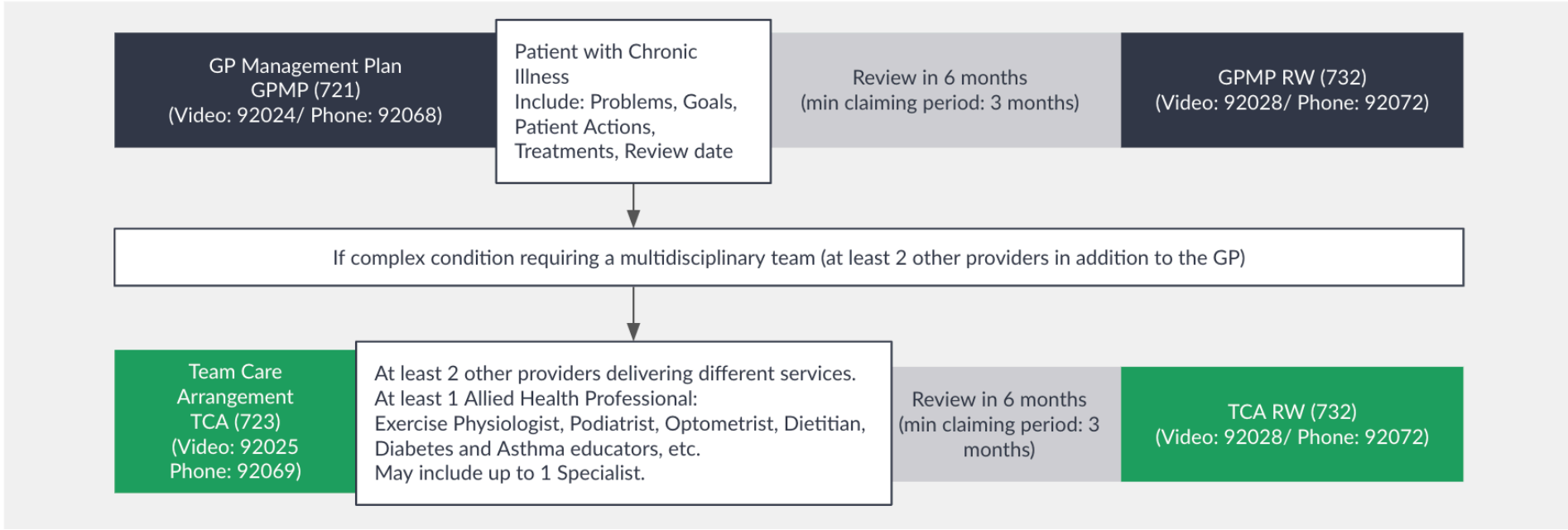
Source: http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/news-2020-03-29-latest-news-March retrieved 04/05/20

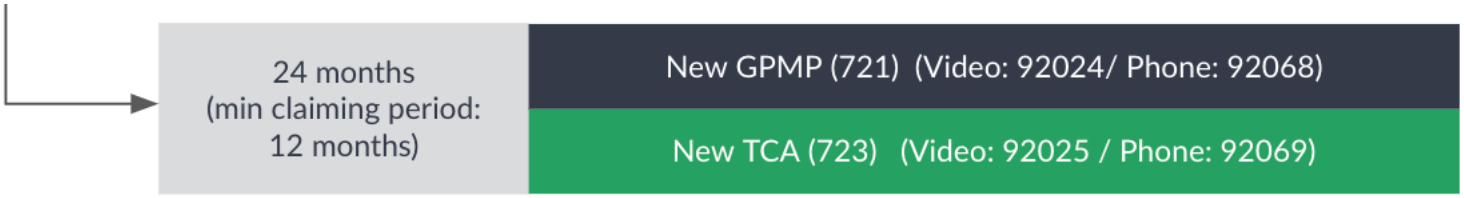
Key things to remember

- These are **GP items. Nurses can help, but** the **GP needs to have a direct consultation with the patient for the date the item is claimed.**
- **No other GP consult item** (eg Level A, B, C, etc.) **should be claimed** at this time.
- **Only the "usual GP" or usual GP clinic** is allowed to create CDM plans. This means:
    - A GP who has provided the **majority of care to the patient over the previous 12 months**; **or**
    - A GP who will be providing the **majority of care to the patient over the next 12 months**; or
    - A GP who is **located at a medical practice that provided the majority of services to the patient in the past or the next 12 months**
- **Patients need to provide inform consent** for a **plan to be created or reviewed** as well as consent **for a bulk billed claim to be made** as a result

Source: http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement-qanda Retrieved 04/05/20

GP Management Plans & Team Care Arrangments





GPMP+TCA Formerly "EPC"
Now "CDM"

5 Nurse support/monitoring services - 10997 (Only GPMP needed)
(Video: 93201 / Phone: 93203)

Allows patient access to: 5 AHP services (in total) in a calendar year

Patient recruitment

Database audit and good Recall/Reminder system

- Use your **recall system** to identify who is **due/overdue for a plan or review**
- **Perform a comprehensive database audit** (PEN CAT/POLAR GP) to identify other eligible patients
- You can **recall patients via SMS, phone or letter**
- **Message focus around:**
  - "It is now just as important, if not ***more*** important than ever before, to check in about your health so we can prevent health problems or detect and manage any issues early."
  - Highlight the **benefits** for them and that **it will not require a practice visit**
- **Book for 20-45min with the nurse** and then standard lenght with the GP after. This **could be same or different day, but only claim the item on completion after the GP has finalised the plan/review.**

Telehealth Priorities for Chronic Disease Management

This is not business as usual. These are unprecedented times.

- We need to **acknowledge this and check how they are coping generally**
- It is more important to **be present and listen**
- **Connect with the person. Don't get bogged down with your to-do list**

Get organised before you start your session

- **Review their file** and to become familiar with the **last issues they were seen** at the practice for
- Check if there's a **record of their flu vaccine being up to date. If not, offer at the end of the consult if you have it in stock**
- Check for **any other relevant vaccines** they might be due for or benefit from Eg **pneumococcal/shingles**
- **Check** any **routine pathology is up to date,** if not flag to discuss with the patient and their GP

Telehealth logistics and tips

- Check they have the **right equipment for video consult** and that they are **relatively comfortable with using this technology**
- **If not**, then simply **do a phone consultation**
- **Check they can see you** (if using video) and **hear you clearly**
- **Check 3 points of identity at the start**
- Ensure they are in a **private, quiet place, and** that they are **comfortable and able to talk right now**
- **Set expectations on length (eg 30min) and that they don't foresee any distractions during this time** (eg. relatives, neighbor, tradesman due to arrive or dropping by)

Sample tructure of a CDM Telehealth consult

Once technology logistics have been dealt with:

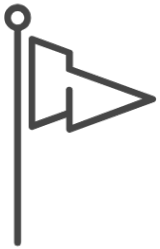
- **Break the ice and connect with the person** (Kim Poyner covers some great tips during our "in conversation" episode available via the FB group)
- **Check they understand the aim/purpose of this plan/review** (and that they **consent** to it)
- **Check "How are you coping generally with it all"**
- **How do you feel your health has been affected by what's going on?** (positively or negatively, be open to both)
- **Any changes to their sleep? Either** to the **amount or the quality** of it (how rested they feel when they wake up)
- **What about energy levels?** Would they say they are **better, worse or same** as before?
- **Do they feel safe at home?** (Domestic violence/elder abuse)
- What **other health professionals are they still seeing or** in contact with or **intending/due to see or overdue for?**

Sample tructure of a CDM Telehealth consult

Looking at their condition and management

- **Consider a basic mood screener** (2 questions) if **yes to either then get GP to do a more comprehensive mental health assessment**
- **Moving onto their chronic condition… "and when it comes to your (diabetes/ashtma/arthritis, etc) how are you managing at the moment?"**
- **Check access to medication**, has **enough at home**, has **access to chemist or delivery service**
- Check **physical activity:** what are they doing and how much of it?
- Check **nutrition:** how **healthy and nutritious** is the food they're eating right now? Any **issues with access to grocery shopping?**
- Check **alcohol consumption**: **Number of drinks** they have and **frequency** at the moment? And **is this more, less or same as usual**
- Check **smoking**, **even if they have quit in the past.** The stress of the current situation may have triggered a relapse

Sample tructure of a CDM Telehealth consult



Any new/concerning symptoms or red flags?

- **Check for symptoms or red flags** related to their chronic condition: "**Have you experienced any new symptoms or anything that's worried or concerned you** (or worried someone you live with or cares for you)?

- **Consider if health coaching and goal setting might be appropriate: "What is one thing you feel you could start doing from today or tomorrow that would help your health during this time?"**

  And as Kim suggests, it can be as little as just 1% more than what you're doing now. Doesn't have to be a massive or drastic change.

- **Check** for **self efficacy: "How confident are you that if I ring you this time next week (or in x Days) you will have started doing that regularly?"** **Rate on a scale of 1 to 10, where 1 is not at all confident and 10 is extremely confident. You'll want a rating of 7+ before you lock it in as a goal.**

- Plan to **use the Nurse Support item** (10997 telehealth equivalents) to **check progress of their self-identified goal**

A Team Approach

Check with allied health providers you usually refer to as some may now be offering Telehealth consultations

Is the patient **perhaps more open to trying a Telehealth consultation** with an allied health? (now that they don't even have to leave the house!)

Measurements are likely the most challenging component to effectively track remotely, however:

Check if the patient has any way of self tracking at home.
For example: Blood pressure machine, Blood glucose monitors, scales, etc.

If not, they may have access via their ***local pharmacy*** *or if essential, a* ***home visit or practice visit could be arranged, but only if absolutely necessary.***

Next steps

- **Confirm or set up the session with the GP** so the **plan/review item can be finalised and claimed**
- Discuss and **set the next review date** (in 3-6 months time) and **add a recall for this**
- **Suggest an interim follow-up date in a few days** or weeks **for nurse support** and to check on progress
- **Coordinate with the GP if any documentation needs to be printed/ signed/forwarded** somewhere eg Pathology slips, scripts, referals, etc.
- **Offer the patient a copy of the plan** (could be sent via post or electronically one finalised)
- **Ensure the correct item number is claimed** (Video or phone Telehealth item)

Key strategies and tools for a smoother process

- Ensure nurses and doctors have **adequate access to patient files** (eg remote access if not working from the practice)
- **Audit tool** (PEN CAT/POLAR GP): **contact your PHN for support** with installation and running queries
- Make good use of your **Recall & Reminder system**
- Decide **priority patient group to target** with your recruitment efforts:
  - New Plans: If first ever, **might be harder to engage. Highest revenue potential.**
  - Due for review: **Might be easier to engage now** that **Telehealth is an option.** Can also **use nurse support item here if relevant.**
  - Not yet due for review: **Check next review is in recall system.** Could do **nurse support follow up** in the meantime. Lowest revenue potential. Though **might highlight need for Mental Health** consultation with the GP

Magali's Checklist for Chronic Disease Management via Telehealth

Without the patient

Prepare the workspace

- Have a basic **checklist** to use as a rough guide/prompt
- Have **notepad and pen** handy
- Have **access to the patient file**

Get up-to-date on care we've provided for this patient:

- Go through the patient file to **check for current and past health conditions**
- Do they have a **previous or current plan already in place?**
- What **other providers** are they seeing? **Last correspondence** received? Or any **referrals we've made**, but don't seem to have any follow up correspondence about
- **Last pathology results** on file and if **any routine bloods** are **due/overdue**
- Any outstanding **recalls**?
- Are they due/overdue for any **immunisations**?
- Based on their condition(s), are there any **measurements** we'd want to track?

With the patient

Start the patient consult

- Initiate the **video** or phone consult
- Check they can **see and hear me** clearly
- Do **3 points of identity check**
- Are they **comfortable**, in a **private**, **quiet** area where they can have this conversation
- Set expectations of **consult length**
- Any foreseeable **interruptions** that will be happening in that timeframe?
- **Cover aim/purpose of this plan/review** (consent to proceed)

Main discussion/assessment

- If I haven't already… **break the ice!**
- Check on **how they're going today**
- Check **"How are you coping generally with it all?"**
- **How do you feel your health has been affected by what's going on?**
- **Any changes to your sleep? amount or quality**
- **Energy levels?**
- **Do you feel safe at home?**

- Any other **health professionals you're currently** in contact with or **due/overdue for?**
- **Mood:** Over the past 2 weeks have you:
  Felt down, depressed or hopeless?
  Felt little interest or pleasure in doing things?
- **"And when it comes to your (chronic condition) how are you managing at the moment?"**
- Access to **medication/pharmacy**
- **Physical activity**: type and how much?
- **Nutrition**: access to grocery shopping?
- **Alcohol** consumption: number of drinks and frequency
- **Smoking**
- **Any new symptoms or anything that's worried or concerned you** (or those around you?
- **Measurements:** Anything overdue or that they can self-check at home?
- Any **condition-specific tasks to perform/arrange/check** (based on pre-consult file review discoveries)
- If appropriate to do **goal setting:**
  "What is **one thing you feel you could start doing** from today or tomorrow **that would help your health during this time**?"

  Self-efficacy: "**How confident are you** that if I ring you this time next week (or in x Days) you will have started doing that regularly?" Self-rate from 1 to 10, where 1 is not at all confident and 10 is extremely confident
- Discuss **next steps** (arrange pathology, scripts, referrals, etc.)

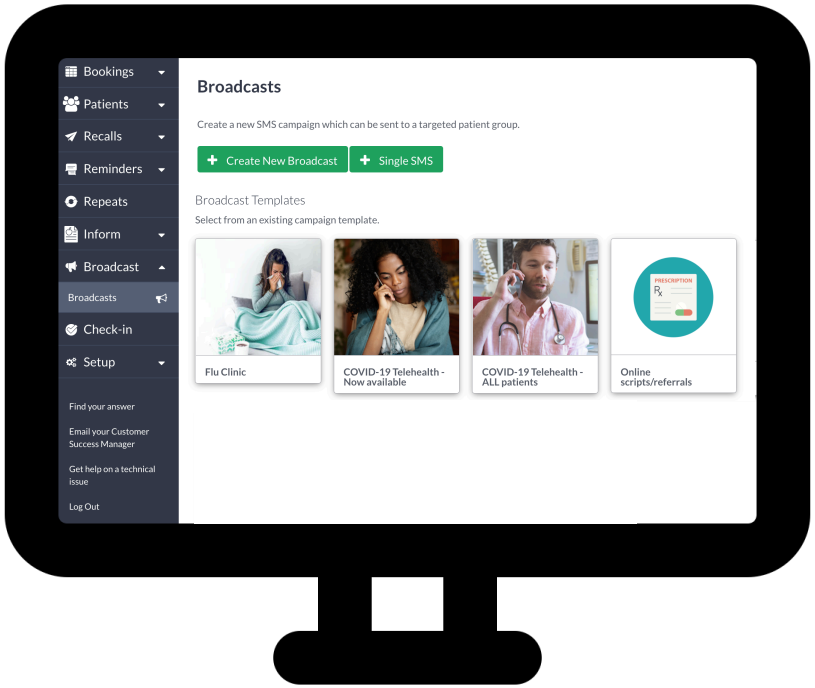
Wrapping up:

- Arrange or confirm **session with the GP** to finalise and claim relevant items
- Confirm **follow up date/time** for nurse support
- Explain what **documentation to expect** electronically/via post (e.g. Copy of the plan, referrals, pathology slips, scripts, etc)
- **Thank you and don't hesitate to reach out** if you have any questions.

Effective tools to help your practice

Broadcast

Dashboard



Filter query by:

Patient age

Gender

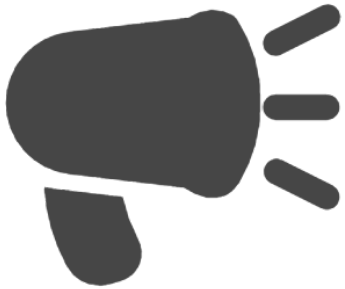
Or

Use a CSV export from
your clinical software or Audit Tool
(eg Pen CAT or POLAR GP)

Contact the HotDoc team: 1300 468 362

Helping practices communicate with patients

- 8c SMS for any other Broadcast campaigns extended to May 31st



Upcoming Special Guest webinar...Register Now!

https://www.hotdoc.com.au/practices/blog/telehealth-future-medicine/

for the love of Healthcare

IN CONVERSATION

Supporting Behaviour Change in a Telehealth World

Host

Magali De Castro - Clinical Director, HotDoc

Special Guest

Kim Poyner - Founder, MediCoach

Join over 2,700+ Healthcare Professionals in our HOT TOPIC post.
Our community is also a great resource & support space during the COVID-19 pandemic

Join our Facebook Group **"For the Love of Healthcare"**
Request to join here https://www.facebook.com/groups/fortheloveofhealthcare