

Chronic Disease Management

What is Chronic Disease?

Chronic diseases and conditions are generally defined as those which are long term (lasting more than 6 months), non-communicable, involving some functional impairment or disability and are usually incurable. They can affect people of all ages and contribute to the disease burden in our society.

Chronic Diseases such as: Diabetes, Cancer, Cardiovascular Disease, Asthma and certain Mental Health conditions are among the most significant contributors to morbidity and mortality in Australia and as such have been recognised as National Health Priority Areas.

How can General Practice help in Chronic Disease Management?

Chronic Disease Management (CDM) in General Practice involves appropriate prevention, early identification and best practice management strategies.

As general practitioners are usually the first point of contact in the health system they have a key role to play in the primary intervention, prevention, diagnosis and management of chronic disease in the community.

What support is there for General Practice?

A number of government initiatives have been introduced that support population health approaches to chronic disease management in General Practice. These build on earlier initiatives focusing on enhancing primary care and increasing access to allied health services.

For example, incentives are available for General Practice for the early diagnosis and effective management of people with diabetes, early detection of cervical cancer, improved health outcomes for people with asthma and better outcomes in mental health care. In some cases this includes more funding for longer consultations, medication reviews, practice nurses and Aboriginal Health Workers.

How can Divisions assist in CDM?

Divisions of General Practice are well placed to support the implementation of these initiatives because of their experience in:

- Supporting General Practice in CDM through education and training with general practitioners, practice nurses, general practice staff and other providers in the community.
- Promoting, developing and maintaining partnerships/relationships between general practice, other service providers and consumers, at the local level to improve patient access to quality, timely and coordinated care.
- Keeping abreast of relevant state and national initiatives to enable the identification of future directions in primary care and potential opportunities for collaborative programs and resource sharing at national, state and local levels.
- Structured shared care programs, focussing on the person as an individual and the group of Chronic Disease patients as a Practice Population.

How can Information Management help in CDM?

Information Management will play an important role in the successful implementation of these chronic disease initiatives through tools such as: age, sex, disease registers; recall and reminder systems; electronic health care plans together with other decision support tools

which can assist general practice in the systematic approach to chronic disease management.

Information Management can also assist CDM in General Practice through improving the availability and exchange of secure electronic clinical and patient data, such as: online pathology/radiology ordering and reporting; use of electronic referrals; and discharge summaries.

Who can I contact regarding Chronic Disease Management in General Practice?

You can contact the Division on 9389 0874 for information, support and practice visits.

Asthma

<http://www.nationalasthma.org.au/> Link to the National Asthma Foundation

ASTHMA INCENTIVE

Requirements of the Asthma 3+ Visit Plan

At a minimum this must include:

At least 3 Asthma related consultations in the previous 4 weeks (minimum) to 4 months (maximum) for a patient with moderate to severe asthma

At least 2 of these consultations to have been planned recalls

Diagnosis and assessment of severity

Review of asthma related medication, and

Provision of written asthma action plan and education of the patient. (If the patient is unable to use a written action plan, alternative patient education may be provided and documented in the medical record.)

The patient's medical record should include documentation of each of these requirements and the clinical content of the patient held written action plan.

Definition of moderate to severe asthma - 'symptoms on most days OR use of preventer medications OR broncho dilator used at least 3 times per week OR hospital attendance OR admission following an acute exacerbation of asthma'.

GROUP	TYPE OF CONSULTATION	ASTHMA ITEMS
Group A18 General Practitioner Attendances	Level B - surgery consultation	2546
	Level B - out-of-surgery consultation	2547
	Level C - surgery consultation	2552
	Level C - out-of-surgery consultation	2553
	Level D - surgery consultation	2558
	Level D - out-of-surgery consultation	2559
	Standard Consultation - surgery consultation	2664
	Standard Consultation - out-of-surgery	2673

Group A19 Other Non- Referred Attendances	consultation	
	Long Consultation ? surgery consultation	2666
	Long Consultation ? out-of-surgery consultation	2675
	Prolonged Consultation ? surgery consultation	2668
	Prolonged Consultation ? out-of-surgery consultation	