

Managing Chronic Heart Failure in a rural Primary Care setting using Medicare Chronic Disease Management item funding: A collaborative approach

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Chronic Disease in Elmore, Victoria

- Elmore is small rural community approx 40km north of Bendigo in Central Victoria
- Sits within Bendigo Health catchment region
- Demographic includes:
 - a significant population of people over 60 years
 - low socio-economic status
 - high incidence/prevalence of individuals with diagnosed Chronic Heart Failure (CHF) compared to other small communities in Loddon Mallee region of Central Victoria¹

1. Murray Plains Division of General Practice, 2003; Victorian Ambulatory Care Sensitive Conditions Study



Why set up a Nurse-led CHF Clinic in Elmore?

- Due to over representation of patients from Elmore and region presenting with exacerbation of cardiac related conditions to Bendigo Health.
- Introduction of Medicare Chronic Disease Management (CDM) items by Federal Government in 2005 (replacing the Enhanced primary care multi-disciplinary care planning items).
- This then enabled patients to be referred on to allied health providers as required with little or no cost to the patient. Given Elmore's low socio-economic demographic, this was regarded as essential to enable patient access to these providers.



Primary Care Clinic - Elmore

- General Practitioners x3
- Practice Nurse x2
- Weekly visiting allied health from Community Health Services:
 - Dietician
 - Physiotherapist
 - Psychologist
 - Diabetes Educator



Monthly CHF clinic

- Patients with known or newly diagnosed CHF referred to Bendigo Health HARP-CDM (CHF nurse) program by Elmore GP
- 1 hour Appointment booked with patient to see CHF nurse. Alternate months to see new/review patients.
- Patient assessed by nurse for level of understanding of management of CHF and clinical status. Education given accordingly.
- Case conference scheduled on the same day with GP to discuss treatment options and formulation of multi-disciplinary care plan



Monthly CHF clinic (continued)

- Multi-disciplinary care plan formulated
 - Referrals made to other health providers as identified at the patient assessment (with agreement from the GP and patient). Patient payment is covered by CDM item numbers 721 (team care arrangement) and 723 (GP management plan). Items are charged to Medicare together.
- Patients are then able to see eligible providers for up to 5 visits which are billed as CDM items.
- Patient was booked in for review at next monthly clinic. If follow up was required sooner, CHF nurse could follow up the patient out of clinic time by phone or appointment made for patient to see GP
- Copy of care plan given to patient. Master remains in patient's clinic record



Benefits of Rural CHF Clinic

Patients

- Patients can attend CHF clinic and have access to GP in same visit
- Do not have to travel to regional centre for assessment
- Seen in a safe and trusted environment
- Billing via CDM item means full Medicare rebate to patient and no 'gap'

Clinic

- 'Several' rather than 'one' seen at clinic
- CHF nurse has ready access to patient's GP during time of patient visit
- Complex patients can be managed by team
- Greater communication between health team members



Allied Health Providers most commonly referred to in Elmore by CHF Nurse

- Physiotherapist
- Psychologist (in response to depression screening tool)
- Podiatrist
- Diabetes Educator



Challenges faced

- GP often unavailable for case conference at time of clinic
- Initially many referrals from GP's at Elmore for HARP CDM CHF Clinic. These referrals stopped after approx 10 months.
- Many 'inappropriate' referrals despite clear guidelines for referral
- Clinic continued for 18 months but now 'on hold' as HARP-CDM staffing level is down



To date

- 18 CHF patients seen at nurse-led HARP CHF clinic in Elmore over 18 month period from June 2005. All are NYHA class II or III.
- None of these patients admitted to Bendigo Health with exacerbation of CHF since being seen in CHF clinic in Elmore.



Where to now?

- Aim to re-establish the clinic when HARP CDM returns to full EFT (late 2007)
- New GP's at the clinic – reintroduce the concept by demonstrating a successful HARP clinic in a nearby rural town.
- Potential for Physician involvement?



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