INFORMATION SHEET

Asthma Cycle of Care

Patient Eligibility

Patients must have moderate to severe asthma:

- Frequency of episodes
- Use of preventer medication
- Bronchodilator use >3 x week
- Hospital attendance following an acute attack

Completion of the Asthma Cycle of Care

- At least 2 asthma related consultations in 4 weeks (min) to 12 months (max)
- At least one of these consultations should be a review consultation that was planned at a previous consultation

These visits must include:

- Diagnosis and assessment of severity
- Review of medication
- Written asthma action plan and education of the patient

Sign-on payment	N/A	$0.25 (per FTE GP)	One-off payment only Practice must be registered for PIP Incentive payable with quarterly PIP payments
Asthma Cycle of Care - Completion of 2nd visit	Level B – 2546 & 2547 Level C – 2552 & 2553 Level D – 2558 & 2559	$100 per patient PLUS consultation fees	These item numbers should be used in place of the usual attendance items, when a consultation completes the minimum requires for the Asthma Cycle of Care. The Asthma Cycle of Care targets patients with *moderate* to *severe* asthma.

Utilising a practice nurse for the Asthma Cycle of Care

A practice nurse can be used to assist GPs with the Asthma Cycle of Care. A nurse can provide patient education, record peak-flow or Spirometry results; take detailed patient and medication history; and review device techniques.

The following is an example of a general practice utilising practice nurses for the best implementation of the Asthma Cycle of Care:

Visit 1 - Practice nurse and GP

- Spirometry (where available) or peak flow; asthma history, symptoms and medications documented, device use, education
- GP review results; medication review, oversees patient education requirements and completes written Asthma Action Plan for patient
- GP reinforces need for next visit and follow up appointment booked

Visit 2 – Practice nurse and GP

- Spirometry (where available) or peak flow, review of symptom diary; medication review, follow-up education
- GP review of Asthma Action Plan
- GP reinforces need for next visit and follow up appointment booked

Asthma may be treated in General Practice using either the **Asthma Cycle of Care** or the **GPMP**. Both schemes **should not be claimed in the same twelve months** for the same patient due to overlap in the services provided.
For patients with complex needs **GPMP and TCA** and **Asthma Cycle of Care** can be provided.

Suggestions for Asthma Cycle of Care visit structure

Visit 1 – Date

This will often be the visit at which your patient presents with an unrelated problem and doesn't mention asthma until the end of the consultation

- Manage the issue that caused the asthma to be discussed e.g. asthma symptoms, request for a script
- Introduce the concept of a contract of care and the reasons for review.
- reinforce need for next visit and follow up appointment booked

Visit one should be billed under normal MBS items (23/36 or 44)

Visit 2 – Date **Approx. 2 weeks later**

New Patient - ascertain status, including history, medication and management

Existing Patient - assess present situation, including review of medical records and consolidation/collection of information on history, medication and management

- What do they know and what do they need to know? (Knowledge)
- How do they feel about their asthma? (Perception)
- What do they want from you their GP?
- Review medication devices technique
- Perform physical examination (including Spirometry)
- Grade asthma severity and level of control
- Consider 2 weeks of peak expiratory flow rate (PEFR) recording and charting
- Is a change in medication required?
- Consider if clinically appropriate for Home Medicines Review, write referral
- Complete Asthma Action Plan for consumer to follow till next visit
- Identify triggers; consider RAST and skin prick testing

Visit two should be billed under MBS items in Group A18 or A19 (2546, 2552 or 2558).
Include item 11506 if Spirometry performed

(optional) Visit 3 – Date **Approx. 1 month later**

- Review patient and his/her PEFR record
- Perform Spirometry (if not already done or consider redoing)
- Assess progress, review medication devices and techniques
- Review and complete written asthma action plan
- Discuss results of RAST and skin-prick testing
- Is a change in medication required?
- Check on, reinforce and expand education
- Answer any questions
- Place patient on twelve-month recall for Asthma Cycle of Care
- Complete HMR Medication Management Plan (Finalise MBS Item 900 claim)

Visit three should be billed under normal MBS items (23/36 or 44).
Include item 11506 if Spirometry performed

ACTION PLANS can be located as below

In Best Practice: Enter **patient name**, click **Clinical**, click **Asthma action plan.**
In Best Practice v. 3.via **Assessment** or the **respiratory calculator** tool

In Medical Director: In Medical Director v. 3. Enter **patient name**, click **Asthma action plan.** via **Assessment** or the **respiratory calculator** (Under TOOLS/ Tool box)