# 45-49 YEAR OLD CARDIOVASCULAR DISEASE PREVENTION CLINIC

## COFFS MEDICAL CENTRE

Coffs Medical Centre, located on the mid-north coast of NSW, is a privately owned general practice offering a wide range of services to the local community, including family planning, men's and women's health, skin cancer screening, travel medicine, and chronic disease management.

Building on their strong background in chronic disease management and in response to an identified need in the community, Coffs Medical Centre established the 45-49-year-old cardiovascular disease prevention clinic in July 2022. The clinic was implemented and is run by an experienced Enrolled Nurse with Registered Nurse supervision. The clinic takes a structured approach to engage with and support patients at risk of developing cardiovascular disease.

Coffs Medical Centre participated in APNA's 2022 – 2023 Building Nurse Capacity Program.

> "Definitely the nurse clinic has added value, not only have there been better health outcomes but, from a business perspective, the increase in revenue we've been able to gain from performing the 45-49 year old health assessments. (Kayley Meredith, Lead Nurse, Coffs Medical Centre)."

apna
Supporting nurses in primary health care

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## MODEL

The overarching aim of the cardiovascular disease prevention clinic is to increase patient awareness and prevent cardiovascular disease in the 45-49-year-old age group. Clinic patients at risk of developing cardiovascular disease were Identified using a clinical software search and then were invited to attend the nurse-delivered, team-based clinic. The clinic nurse spends one hour with the patient during the initial consult, developing rapport, conducting an initial assessment, discussing cardiovascular health, utilising health coaching skills, and assisting the GP with any required tests such as an ECG. Patients then have an appointment with the GP for any further tests, treatment or referrals required. Following the initial appointment, patients who consented were booked in for a follow-up appointment if required and were placed on the recall system.

## OUTCOME

There were over 40 clinic attendances during the project period, with some patients attending the clinic multiple times for review appointments. As part of the clinic assessment - patients who would benefit from additional support were referred to appropriate specialists and allied health professionals for improved health outcomes. Patients reported high levels of satisfaction with their experience at the clinic.

## FUNDING (*refer to MBS online for full claiming descriptors and eligibility)

| MBS Item No* | Descriptions | Frequency |
|---|---|---|
| 707 | Professional attendance by a general practitioner to perform a prolonged health assessment (lasting at least 60 minutes) | Varies.<br>Check patient eligibility. |
| 11707 | Performing ECG test | Varies.<br>Check patient eligibility |
| 721 | Attendance by a general practitioner for preparation of a GP management plan for a patient (other than a service associated with a service to which any of items 735 to 758 apply) | Minimum claiming period is 12-months |
| 723 | Attendance by a general practitioner to coordinate the development of team care arrangements for a patient (other than a service associated with a service to which any of items 735 to 758 apply) | Minimum claiming period is 12-months |
| 732 | Review of a GP Management Plan or coordination of a Review of Team Care Arrangements | Minimum claiming period is 3-months. |
| 10997 | Service provided to a person with a chronic disease by a practice nurse or an Aboriginal and Torres Strait Islander Health Practitioner. | Maximum of 5 services per patient in a calendar year.<br>GPMP, TCA or MCP in place. |
| 10987 | Follow-up service provided by a practice nurse or an Aboriginal and Torres Strait Islander Health Practitioner, on behalf of a medical practitioner, for an Indigenous person who has received a health assessment | Maximum of 10 services per calendar year |

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| MBS Item No* | Descriptions | Frequency |
|---|---|---|
| 93203 | Phone attendance by a practice nurse or an Aboriginal and Torres Strait Islander Health Practitioner, if the service is provided on behalf of and under the supervision of a medical practitioner and the person, has a GP management plan, TCA, or multidisciplinary plan in place and the service is consistent with the plan or arrangements | Maximum of 5 per calendar year. (Can substitute 10997 where clinically appropriate and safe to do so)<br>GPMP, TCA or MCP in place |
| 93202 | Follow-up phone call attendance provided by a practice nurse or Aboriginal and Torres Strait Islander Health Practitioner, on behalf of a medical practitioner, for an Indigenous person who has received a health check, if the service is provided on behalf of and under the supervision of a medical practitioner and the service is consistent with the needs identified through the health assessment | Maximum of 10 services per calendar year (Can substitute 10987 where clinically appropriate and safe to do so) |
| *To ensure MBS item claiming criteria is current, visit www.mbsonline.gov.au | | |

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## PATIENT FLOW CHART

### Patient eligibility

- Aged 45-49 years
- Identified as at-risk of developing CVD using CVD risk assessment tool
- Data extracted from practice software
- GP's given lists of identified eligible patients
- Patients were invited to attend the clinic and were given a brochure explaining what was involved

### Initial Visit

- One-hour consultation with clinic nurse and then follow-up with their GP
- 45-49-year-old Health Assessment conducted:
  - Information collection
  - Overall assessment, including ECG if required
  - Initiating appropriate interventions
  - Providing advice and information

### Follow up visits

- Follow-up appointments made for 3-4 months' time as appropriate
- Chronic disease management plans and team care arrangements initiated with consent, and if eligible
- Appropriate biometric data collected at follow-up appointment for comparision with baseline observations, and for quality improvement purposes.
- Continued health coaching provided at follow-up appointment
- Patient experience measures collected

### Documentation

- Document nursing interventions
- Arrange follow-up care
- Ensure recall reminders are in place, if required

**For further reading on MBS descriptors and EN supervision requirements, please see links below:**

http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Home

https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ/Enrolled-nurses-and-medicine-administration.aspx#

https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ/Enrolled-nurse-standards-for-practice.aspx#

https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Frameworks.aspx

https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ/Fact-sheet-scope-of-practice-and-capabilities-of-nurses-and-midwives.aspx