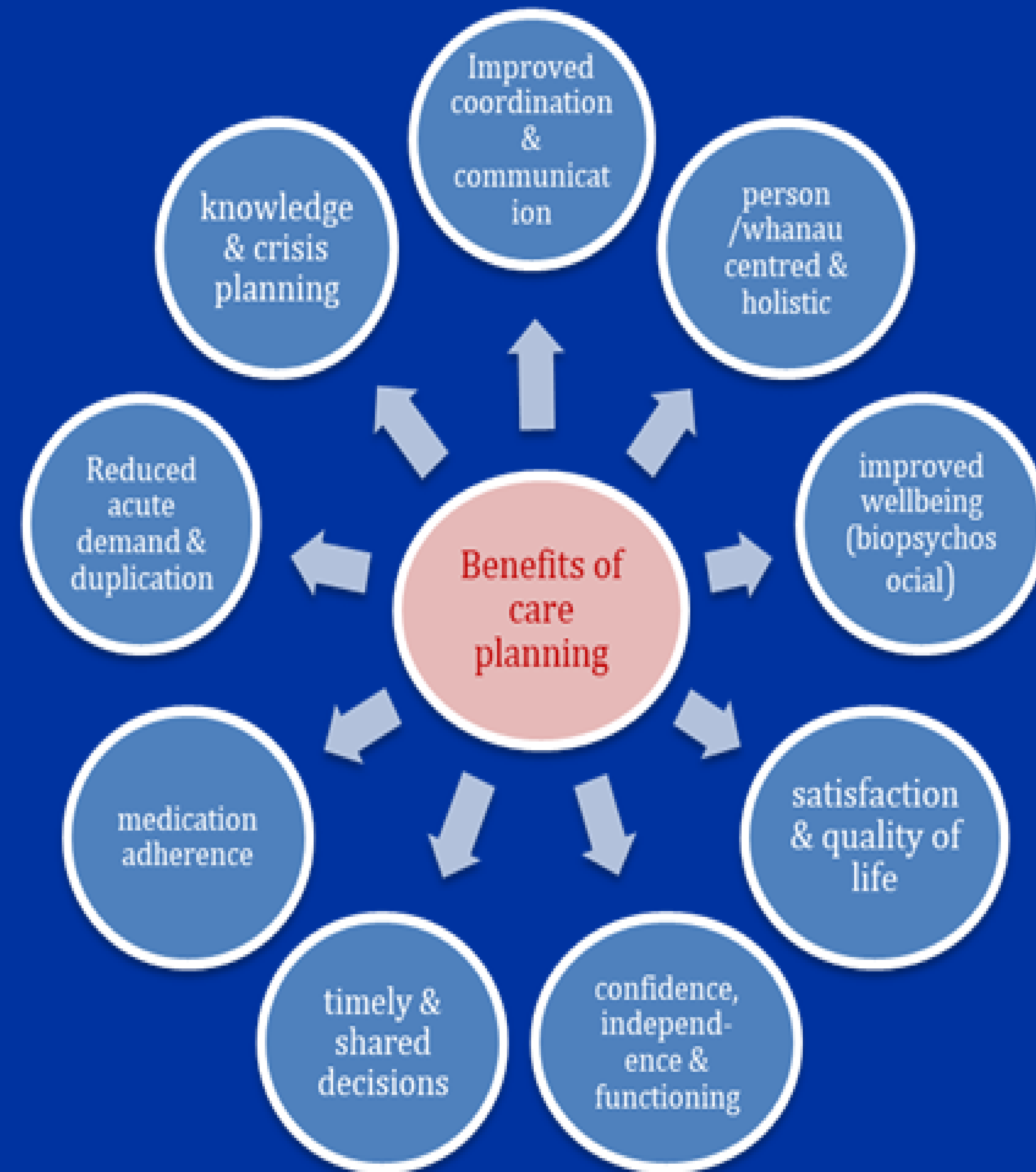
PRIMARY HEALTH NETWORK

CREATING QUALITY CARE PLANS TO IMPROVE PATIENT OUTCOMES

Sarah Hoolihan

11th May 2022

WE ACKNOWLEDGE THE TRADITIONAL OWNERS & CUSTODIANS OF THE LAND THAT WE LIVE & WORK ON AS THE FIRST PEOPLE OF THIS COUNTRY.



Learning Objectives

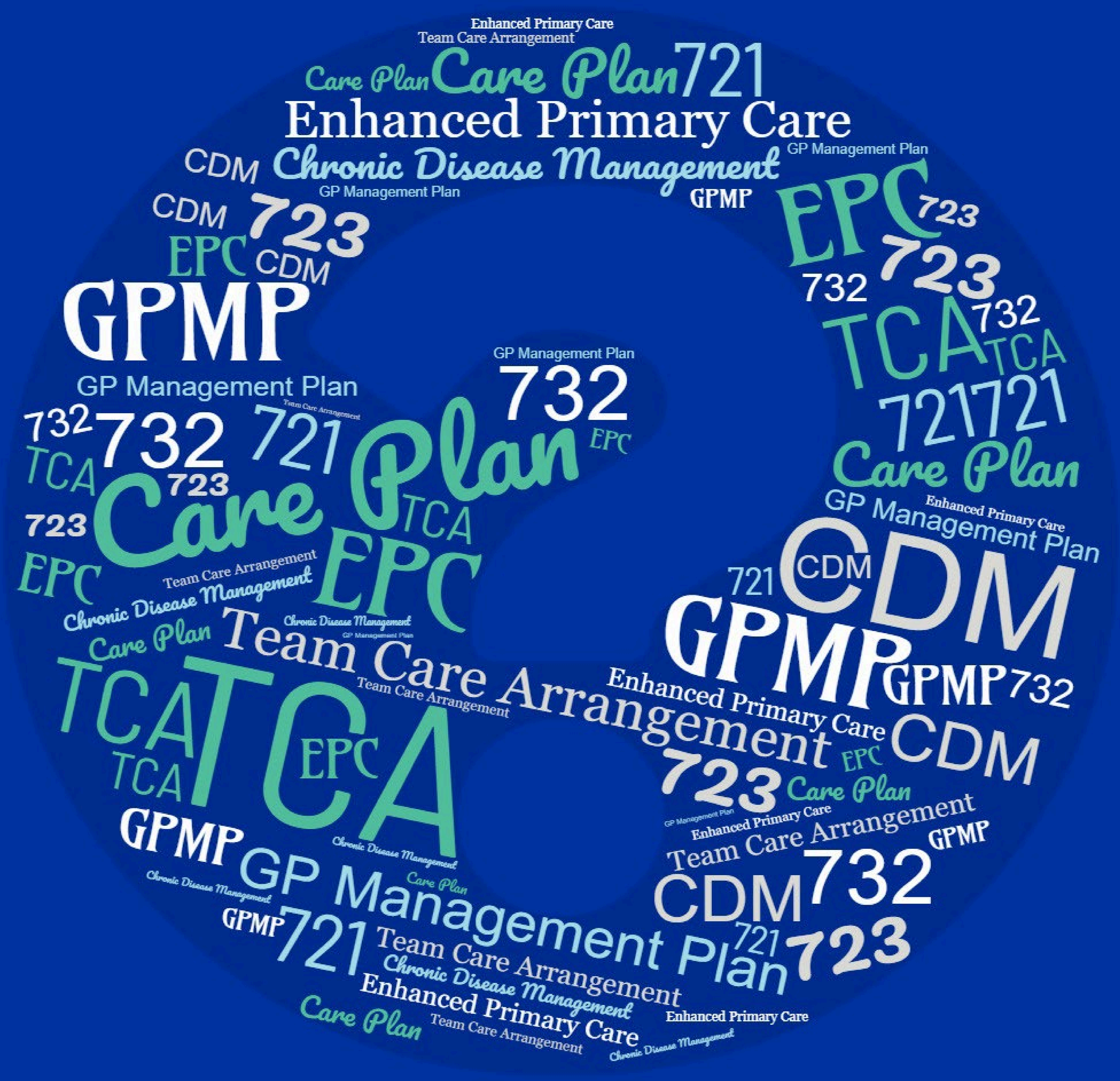
Identify eligibility and Medicare requirements

Recognise what's involved in developing a comprehensive plan

Additional considerations regarding care planning for First Nations people

Complementary care for chronic disease management

Tools to assist you with care planning



Enhanced Primary Care
Team Care Arrangement
Care Plan
Care Plan
721
Enhanced Primary Care
GP Management Plan
CDM
Chronic Disease Management
GP Management Plan
GPMP
CDM
723
EPC
723
EPC
CDM
723
732
GPMP
TCA
732
TCA
GP Management Plan
732
GP Management Plan
721721
732
732
721
Team Care Arrangement
EPC
TCA
Care Plan
Care Plan
723
Enhanced Primary Care
723
TCA
GP Management Plan
EPC
CDM
Team Care Arrangement
721
CDM
EPC
Chronic Disease Management
Chronic Disease Management
GPMP
Care Plan
Team Care Arrangement
GPMP
732
TCA
TCA
Team Care Arrangement
Enhanced Primary Care
CDM
EPC
723
TCA
EPC
Care Plan
GPMP
Enhanced Primary Care
Team Care Arrangement
GPMP
GP Management Plan
Chronic Disease Management
732
Care Plan
CDM
Chronic Disease Management
GPMP
721
721
723
Team Care Arrangement
GP Management Plan
Chronic Disease Management
Enhanced Primary Care
Enhanced Primary Care
Care Plan
Team Care Arrangement
Chronic Disease Management

Eligibility for chronic disease management

A chronic medical condition is one that has been (or is likely to be) present for six months or longer

There is no age restriction on eligibility for chronic disease services

Patients are eligible for a total of 5 Allied Health services per calendar year, regardless of when their plan starts or is reviewed. Allied health services provided through TCA referrals must be directly related to the management of the patient’s chronic condition/s

The patient’s regular GP is considered by Medicare to be the GP or Practice who has provided majority of care for the past 12 months, or in the case of a patient joining your practice – the GP likely to provide majority of care for the next 12 months

Medicare requirements for a GP Management Plan

A comprehensive written plan must be prepared describing:

- the patient's health care needs, health problems and relevant conditions;
- management goals with which the patient agrees;
- actions to be taken by the patient;
- treatment and services the patient is likely to need;
- arrangements for providing this treatment and these services; and
- arrangements to review the plan by a date specified in the plan.

Explanatory Notes AN.0.47 - Chronic Disease Management MBS Items

Medicare requirements for a Team Care Arrangement

When coordinating Team Care Arrangements, the GP must:

- consult with at least two collaborating providers, each of whom will provide a different kind of treatment or service to the patient, and one of whom may be another medical practitioner,
- document the treatment and services that collaborating providers will provide to the patient;
- discuss with the patient the collaborating providers who will contribute to the development of the TCAs and provide treatment and services to the patient under those arrangements; and
- give copies of the relevant parts of the document to the collaborating providers

Explanatory Notes AN.0.47 - Chronic Disease Management MBS Items

Other providers that might be involved in the patient's care:

- Dentist
- Pharmacist
- Pathology or radiology services
- Complementary medicine therapists
- Home care providers
- Teachers Aide or Education support
- Residential respite care
- Optometry
- Assisted fertility or IVF clinic
- Housing support services
- Drug and Alcohol services
- Phone services (e.g Quitline, Get Healthy)
- Disability service providers
- Social work or counselling
- Gym, Personal trainer or weight loss clinic
- Meal preparation/delivery services
- Equipment supply and maintenance
- Employment support services
- Transport services
- Community and social groups

Questions about billing or eligibility?

[Department of Health Questions and Answers on the Chronic Disease Management (CDM) items]

3.3 What does collaboration with the other health and care providers mean when developing Team Care Arrangements (TCAs)? ....

3.4 Can a 'blanket' agreement form be sent by a GP if the patient is in need of straightforward treatment or monitoring? ....

3.5 Is a fax form an acceptable form of communication for collaboration between GPs and providers on a Team Care Arrangements (TCAs) service? ....

3.12 Under what circumstances can a nurse/practice nurse, Aboriginal and Torres Strait Islander health practitioner or Aboriginal health worker be one of the three minimum members of a multidisciplinary Team Care Arrangements (TCAs) team? ....

Why does the quality of a plan matter?

Effectiveness

Safety

Timeliness

Equity

QUALITY

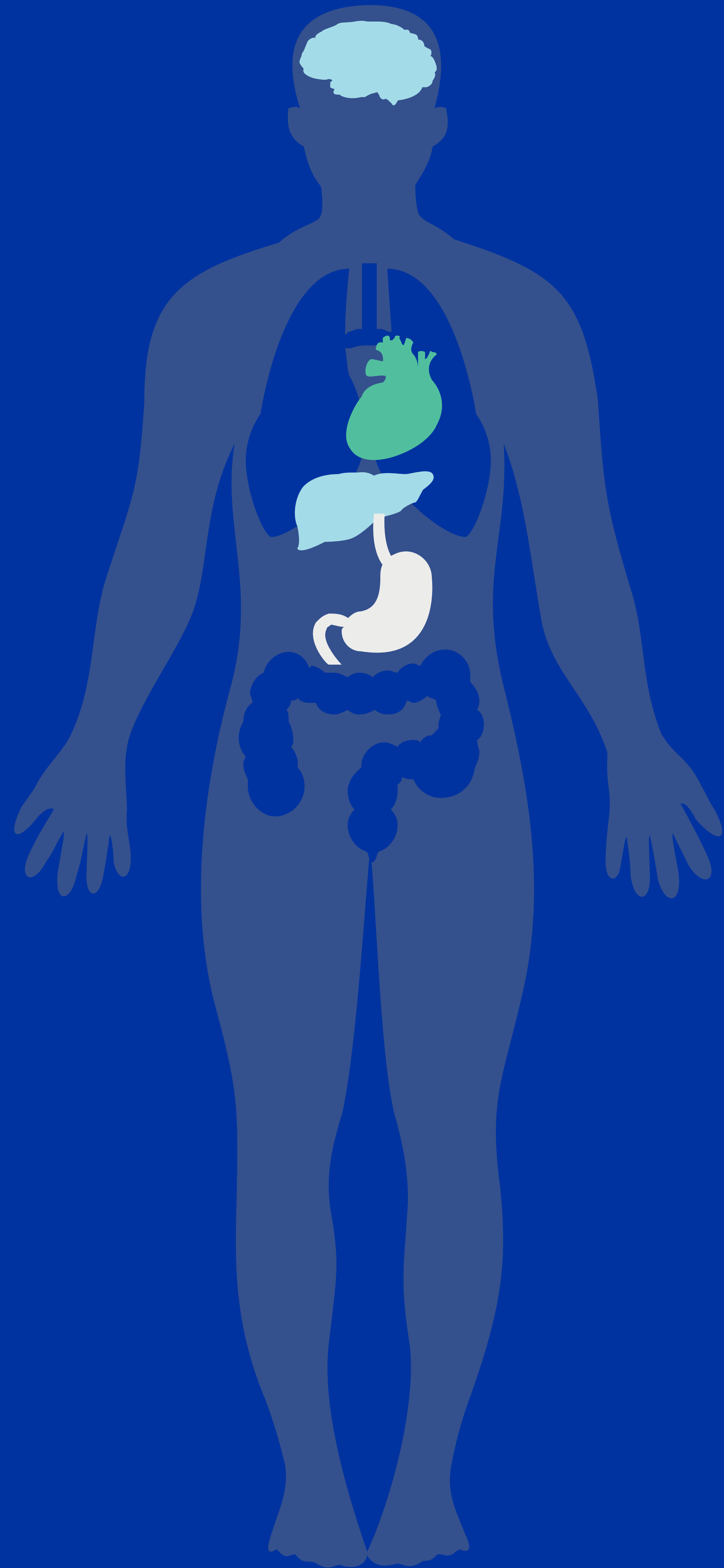
Integration

People-
centredness

Efficiency

World Health
Organization

Developing a quality plan with the patient



Ascertain what’s most important to the patient:

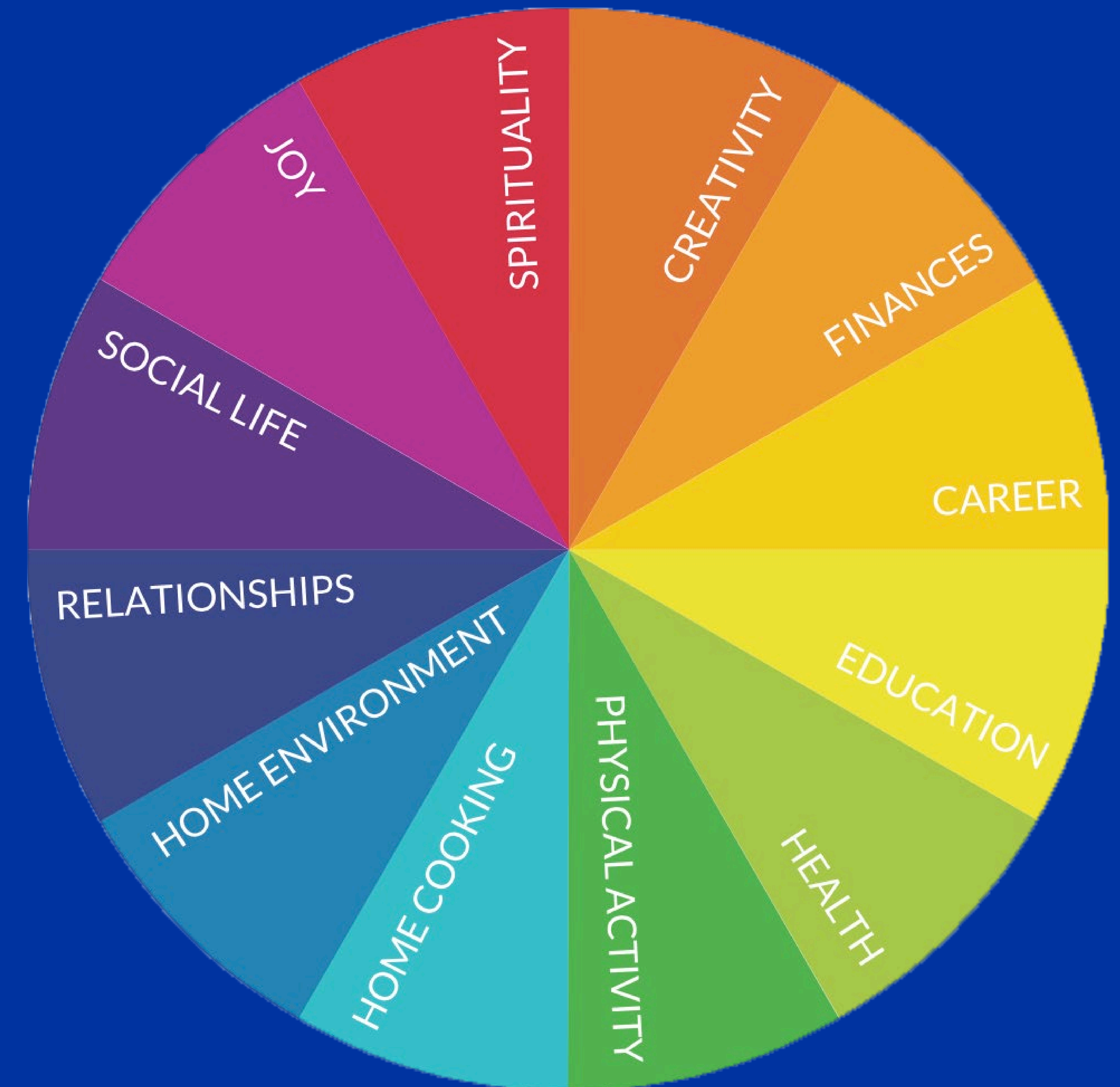
- Their health goals
- The activities and lifestyle that is important to them
- What defines success or failure to them

Include all health issues requiring active management in the plan:

- What services the patient needs
- Why the patient needs that service
- Who will provide each service
- When each service will be provided
- How the effectiveness of services will be measured

Actions to be taken by the patient

- Involve the patient in goal setting
- Patient goals may be broader than health
- Consider the patient's level of health literacy
- Use the opportunity for health coaching
- Confirm the patient understands and agrees
- Use S.M.A.R.T goals:



Basic Care plan

Sample Practice

GP MANAGEMENT PLAN - MBS ITEM No. 721

Patient's Name: Miss Ann Smith

Date of Birth: 24/4/1957

Contact Details:
1 Smith St
WYONG NSW 2259

Medicare or Private Health Insurance Details:

Details of Patient's Usual GP:
Dr A Practitioner
205 Bourbong Street
BUNDABERG QLD 4670
Tel (work): 1300 788 802

Details of Patient's Carer (if applicable):
Name: Sandra Presson
Relationship to Patient: Daughter
Tel: 0415172179

Date of last GP Management Plan (if done): Monday, 28 January 2019

PAST MEDICAL HISTORY

Active:

Date	Condition -- Comment
1992	Asthma
2000	Diabetes Mellitus - Type II
2001	Cervical spondylosis
2004	Hypercholesterolaemia
2015	Hypertension
2016	Charcot's joints
2016	Neuropathic pain
2017	Osteopenia
2019	GORD (Gastro-oesophageal Reflux Disease)
2020	Thiamine deficiency

MEDICATIONS

Drug Name	Strength	Dosage	Reason
ALLEGRON Tablet (Nortriptyline (as hydrochloride))	25mg	1 nocte	Charcot's joints
ATORVACHOL Tablet (Atorvastatin (as calcium trihydrate))	20mg	daily	Hypercholesterolaemia
BETAVIT Tablet (Thiamine hydrochloride)	100mg	mane	Thiamine deficiency
CELEXI Capsule (Celecoxib)	200mg	daily	Cervical spondylosis
EXFORGE Tablet (Amlodipine (as besylate)/Valsartan)	5mg/80mg	1 daily	Hypertension
FENOCOL Tablet (Fenofibrate)	145mg	1 mane	Hypercholesterolaemia
NOVORAPID FLEXPEN Injection (Insulin aspart)	100 units/mL	12 units b.d. a.c.	Diabetes Mellitus - Type II
OZMEP EC Tablet (Omeprazole)	20mg	1 mane	GORD (Gastro-oesophageal Reflux Disease)
PREGABALIN AMNEAL Capsule (Pregabalin)	300mg	1 nocte	Charcot's joints
PREGABALIN Capsule (Pregabalin)	150mg	1 mane	Charcot's joints
PROLIA Syringe (Denosumab (rch))	60mg/1mL		Osteopenia
RYZODEG FLEXTOUCH Injection (Insulin degludec/insulin aspart)	70 units - 30 units/mL (100 units/mL)	daily m.d.u.	Diabetes Mellitus - Type II
TRAMAL SR Tablet (Tramadol hydrochloride)	50mg (12h)	1 b.d.	Charcot's joints
VENTOLIN CFC-FREE Inhaler (Salbutamol (as sulfate))	100mcg/dose (with dose counter)	2 puffs q.i.d. p.r.n.	Asthma
VITAMIN D3 [EAGLE] Capsule (Colecalciferol)	1,000 units (25mcg)	1 daily	Osteopenia

ALLERGIES/ADVERSE REACTIONS

No known allergies/adverse reactions.

Patient problems / needs / relevant conditions	Goals - changes to be achieved	Required treatments and services including patient actions	Arrangements for treatments/services (when, who, contact details)
Patient's understanding of their condition	Patient to have a clear understanding of their condition and patient's role in management.	Patient education	GP / Nurse
Nutrition	Maintain healthy diet	Patient education	Patient to implement GP to monitor
Weight	BMI ≤ 25 kg/m^2	Monitor Review 6 monthly	Patient to monitor GP to review
Physical activity	Exercise at least 30 minutes walking or equivalent 5 or more days per week	Patient exercise routine	Patient to implement Exercise Physiologist Mr Jon Jones
Blood pressure	< 130/80 mm Hg	Check every 6 months	GP / Nurse
Medication review	Correct use of medications, minimise side effects	Patient education Review medications	GP to review and provide education
Diabetes	Specialist monitoring and advice	3 monthly review	Endocrinologist Dr Wakill
Foot care	Manage existing ulcer and prevent deterioration	Foot and nail care	Podiatry Wyong Hospital

Copy of GP Management Plan offered to patient? Yes

Copy / relevant parts of the GP Management Plan supplied to other providers? Yes

GP Management Plan added to the patient's records? Yes

Date service was completed: Tuesday, 29 March 2022 **Proposed Review Date:** Friday, 30 September 2022

I have explained the steps and any costs involved, and the patient has agreed to proceed with the plan. Yes

GP's Signature: x______________________ Date: 29/3/2022

GP Name: Dr A Practitioner

Comprehensive and patient centred plan

Patient problems / needs / relevant conditions
Diabetes Mellitus, Type 2
Charcot's joints
Osteopenia
Hypercholesterolaemia
Cervical spondylosis
Hypertension
Neuropathic pain
Asthma
Chronic Kidney Disease, Stage 3

Goals - changes to be achieved.
Most important goal to patient is to reduce deterioration of health and maintain independence safely at home

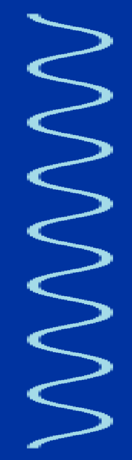
Required treatments and services.

Task	Provider	Due
Charcot joint arthropathy foot care, monthly - monitoring of peripheral neuropathy progression, management of existing diabetic foot ulcer, prevention of further foot ulcers via custom orthotics	Wyong Hospital High Risk Foot clinic	18/04/2022
Diabetic foot care, monthly - skin and nail management, annual toe doppler measurement for circulatory monitoring, Education regarding appropriate footwear	CCLHD Podiatry	29/03/2022
Foot self care - wear appropriate footwear as advised, use soap free cleansers, moisturise feet daily, attend booked appointments with Podiatry and high risk foot clinic, use a mirror to inspect all aspects of feet daily	Patient	29/03/2022
Foot wound care, twice weekly - Community Nurses to attend home visits for dressing changes. Record observations of foot and wound, escalate any concerns to GP via patient	CCLHD Community Nurse	29/03/2022
Diabetes pathology monitoring and medication advice, 3 monthly - Endocrinologist to provide pathology request form and review results with patient. Provide specialist advice to GP as relevant	Dr Wakil	29/03/2022
Diabetic dietary advice, annually as required	Mrs. Nancy Drew	29/03/2022
Diabetes Education, monthly phone check in - review BGL's and advise Insulin regime as required	CCLHD Diabetes Education	29/03/2022
Diabetes self management - daily BGL monitoring and recording, take medications as prescribed, follow diabetic diet recommendations	Patient	29/03/2022
Prolia Injection biannually - Nurse to administer	Practice nurse	29/03/2022
Osteopenia self management - patient to participate in weight bearing exercises as able. Maintain calcium rich diet. have blood tests and scans as advised by medical team	Patient	29/03/2022
Falls risk - My Aged Care home assessment for bathroom modifications and other safety considerations	My Aged Care	29/03/2022
Neck pain, Physiotherapy for chronic pain management via stretching and possible hydrotherapy once foot wound has healed	Mr. Mark Jones	29/03/2022
Hospital avoidance - seek medical advice early if any concerns or changes to your health	Patient	29/03/2022
Medication prescribing and monitoring	G.P.	29/03/2022
Medication webstar packs prepared for ease of use, medication compliance and to reduce risk of medication errors	Village Pharmacy	29/03/2022
Home support and transport, 3 visits weekly for 1 hour. Showering assistance, basic cleaning, transport to appointments when informal carer unavailable	ADSSI	29/03/2022
Asthma management - follow asthma action plan and sick day plan. Take puffer as directed. Seek medical help early if you develop any change in your breathing or development of a cough or other respiratory concerns	Patient	29/03/2022
Annual Optometry review to monitor sight and progression of retinopathy	SpecSavers Lake Haven	29/03/2022
Carer (Daughter Sandra) provides assistance with meals, shopping, laundry, home maintenance, transport, provision and maintenance of walking frame and wheelchair	Patient	29/03/2022
Disabled parking permit form completed	G.P.	29/03/2022
Domiciliary medication review as appropriate	Village Pharmacy	29/03/2022
Exercise group program to meet individual needs of patient	Mr. Jon Jones	29/03/2022
Imaging investigations - BMD testing as clinically indicated, Radiology guided steroid injections as clinically required	ACE Radiology	29/03/2022
Prevention of influenza - annual flu vaccination	Practice nurse	29/03/2022
Pathology investigations as requested by GP and/or Specialist	Laverty Pathology	29/03/2022
Annual heart health check with ECG monitoring for early detection of CVD issues	G.P.	29/03/2022
Blood pressure, weight, height, waist measurement monitoring	Practice nurse	29/03/2022

Arrangements for treatments/services.

Provider	Phone	Fax
Wyong Hospital High Risk Foot clinic	0243907015	
CCLHD Podiatry	02 43948523	
CCLHD Community Nurse	02 43942106	
Dr Wakil	02 43945217	
Mrs. Nancy Drew	0415248967	
CCLHD Diabetes Education	02 43202158	
My Aged Care	1800365974	
Mr. Mark Jones	0243963548	
Village Pharmacy	02 43568249	
ADSSI	1300258697	
SpecSavers Lake Haven	02 43687521	
Mr. Jon Jones	0425698317	
ACE Radiology	02 43562891	
Laverty Pathology	1300426957	

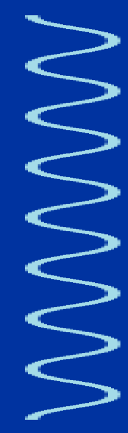
Copy of GPMP offered to patient? Yes	**Copy / relevant parts of the GPMP supplied to other providers?** No
GPMP added to the patient's record? Yes	
Date service was completed: 30/03/2022	**Review Date:** 30/09/2022



Financial considerations for comprehensive plans

Description	Item No.	Remuneration
GP Management Plan	721	$112.60
Team Care Arrangement	723	$89.25
GPMP Review	732	$56.25
TCA Review	732	$56.25
Nurse follow up x5	10997	$62.50
	TOTAL	$376.85
	PLUS BB incentives	$58.95 - $112.50

*MBS rebate amounts current as at 11/5/22



Chronic disease management for First Nations people

Identify your First Nations people by asking all patients about their ethnicity using the appropriate language

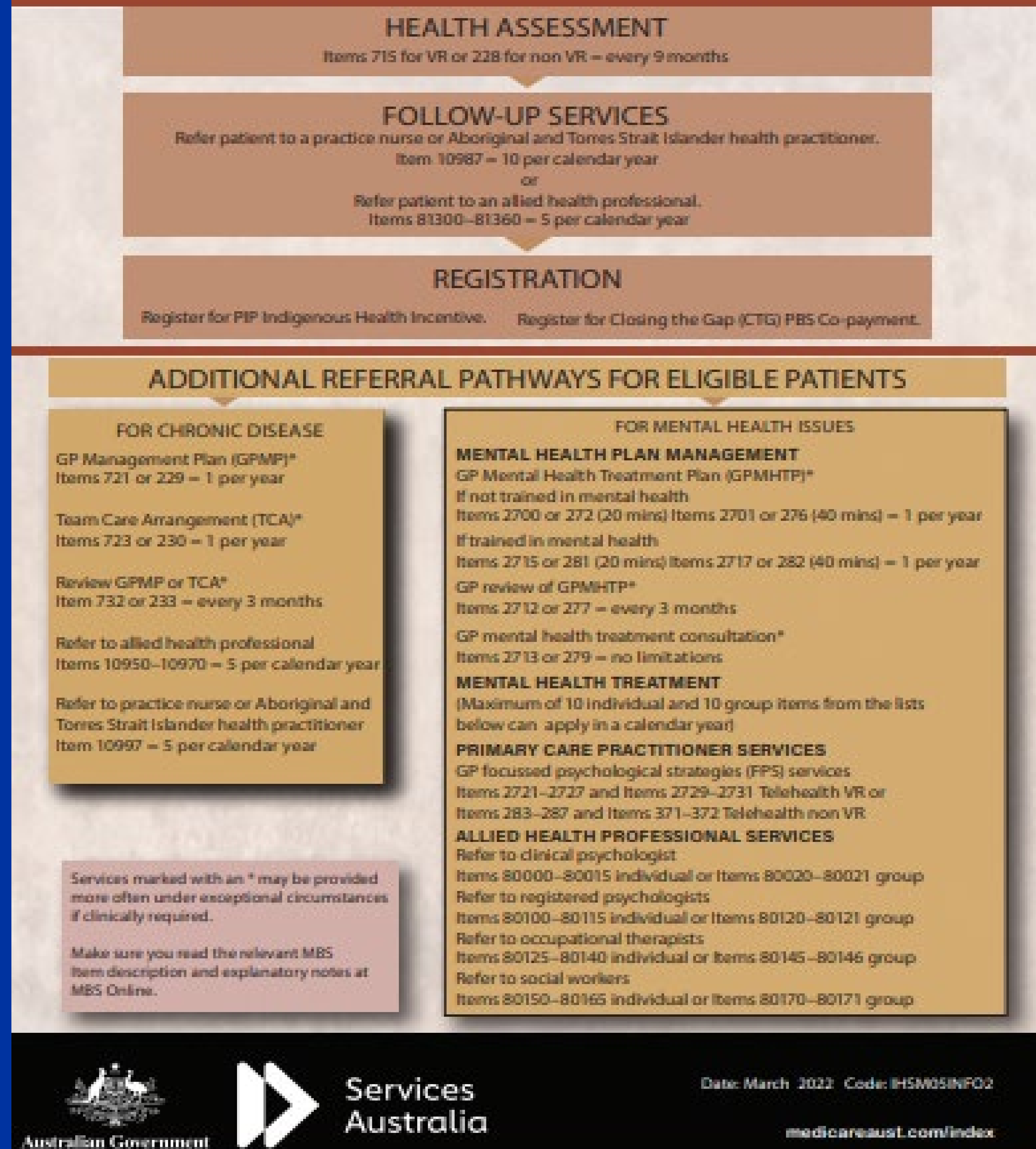
Consider a GPMP and/or TCA for First Nations patients with chronic or complex health issues and utilise the 5x Allied Health referrals and 5x Nurse follow up items

Offer patients of all ages to be registered for PBS Closing the Gap (CTG) to reduce cost of prescriptions as a potential barrier to chronic disease self management

Offer First Nations patients an annual 715 health assessment and utilise the 5x Allied Health referrals and 10x Nurse follow up items attached to a 715 health assessment

https://thephn.com.au/programs-resources/aboriginal-health

Questions about chronic disease management for First Nations people?



GP led primary care planning for Indigenous patients

HEALTH ASSESSMENT
Items 715 for VR or 228 for non VR – every 9 months

FOLLOW-UP SERVICES
Refer patient to a practice nurse or Aboriginal and Torres Strait Islander health practitioner.
Item 10987 – 10 per calendar year
or
Refer patient to an allied health professional.
Items 81300–81360 – 5 per calendar year

REGISTRATION
Register for PIP Indigenous Health Incentive.
Register for Closing the Gap (CTG) PBS Co-payment.

ADDITIONAL REFERRAL PATHWAYS FOR ELIGIBLE PATIENTS

FOR CHRONIC DISEASE

GP Management Plan (GPMP)*
Items 721 or 229 – 1 per year

Team Care Arrangement (TCA)*
Items 723 or 230 – 1 per year

Review GPMP or TCA*
Item 732 or 233 – every 3 months

Refer to allied health professional
Items 10950–10970 – 5 per calendar year

Refer to practice nurse or Aboriginal and Torres Strait Islander health practitioner
Item 10997 – 5 per calendar year

Services marked with an * may be provided more often under exceptional circumstances if clinically required.

Make sure you read the relevant MBS Item description and explanatory notes at MBS Online.

FOR MENTAL HEALTH ISSUES

MENTAL HEALTH PLAN MANAGEMENT
GP Mental Health Treatment Plan (GPMHTP)*
If not trained in mental health
Items 2700 or 272 (20 mins) Items 2701 or 276 (40 mins) – 1 per year
If trained in mental health
Items 2715 or 281 (20 mins) Items 2717 or 282 (40 mins) – 1 per year
GP review of GPMHTP*
Items 2712 or 277 – every 3 months
GP mental health treatment consultation*
Items 2713 or 279 – no limitations

MENTAL HEALTH TREATMENT
(Maximum of 10 individual and 10 group items from the lists below can apply in a calendar year)

PRIMARY CARE PRACTITIONER SERVICES
GP focussed psychological strategies (FPS) services
Items 2721–2727 and Items 2729–2731 Telehealth VR or
Items 283–287 and Items 371–372 Telehealth non VR

ALLIED HEALTH PROFESSIONAL SERVICES
Refer to clinical psychologist
Items 80000–80015 individual or Items 80020–80021 group
Refer to registered psychologists
Items 80100–80115 individual or Items 80120–80121 group
Refer to occupational therapists
Items 80125–80140 individual or Items 80145–80146 group
Refer to social workers
Items 80150–80165 individual or Items 80170–80171 group

Australian Government
Services Australia
Date: March 2022 Code: IHSM05INFO2
medicareaust.com/index

www.servicesaustralia.gov.au/indigenous-health-education-for-health-professionals

Diabetes annual cycle of care

GP Management Plan +/- Team Care arrangement: include goals and interventions for all aspects of the patient's health, including diabetes

Nurse follow up visit 1: confirm services as referred have been accessed, patient is on track with their self management goals. Provide nurse interventions per care plan

Nurse follow up visit 2: Diabetes focus, check education and understanding. Offer Type 2 Diabetes group services (if not already referred). Consider multidisciplinary case conferencing for patients not meeting clinical targets

Nurse follow up visit 3: Provide nurse interventions per care plan. Eg Immunisations, ECG monitoring, ABPI doppler, Review action plans

GPMP +/- TCA Review: review and update goals and interventions for optimal care

Nurse follow up visit 4: check in on patient progress with self management goals. Ensure patient has required forms for pathology etc ahead of diabetes review at next visit. Provide nurse interventions per care plan

Nurse follow up visit 5: Diabetes focus. Review and complete Nurse aspects of DACC.
GP completion of annual cycle of care. MBS DACC as appropriate

Review or renew the GP Management Plan +/- Team Care Arrangement: include goals and interventions for all aspects of the patient's health as clinically appropriate

- Nurse follow up visits
- Diabetes group services
- Heart health checks
- Coordinated Veterans Care
- Mental Health Treatment Plan
- National Disability Insurance Scheme
- Asthma cycle of care
- Ambulance Care plans
- Kidney Health Checks
- Multidisciplinary case conferencing
- Medication management review
- My Aged Care

Tools to assist you with care planning

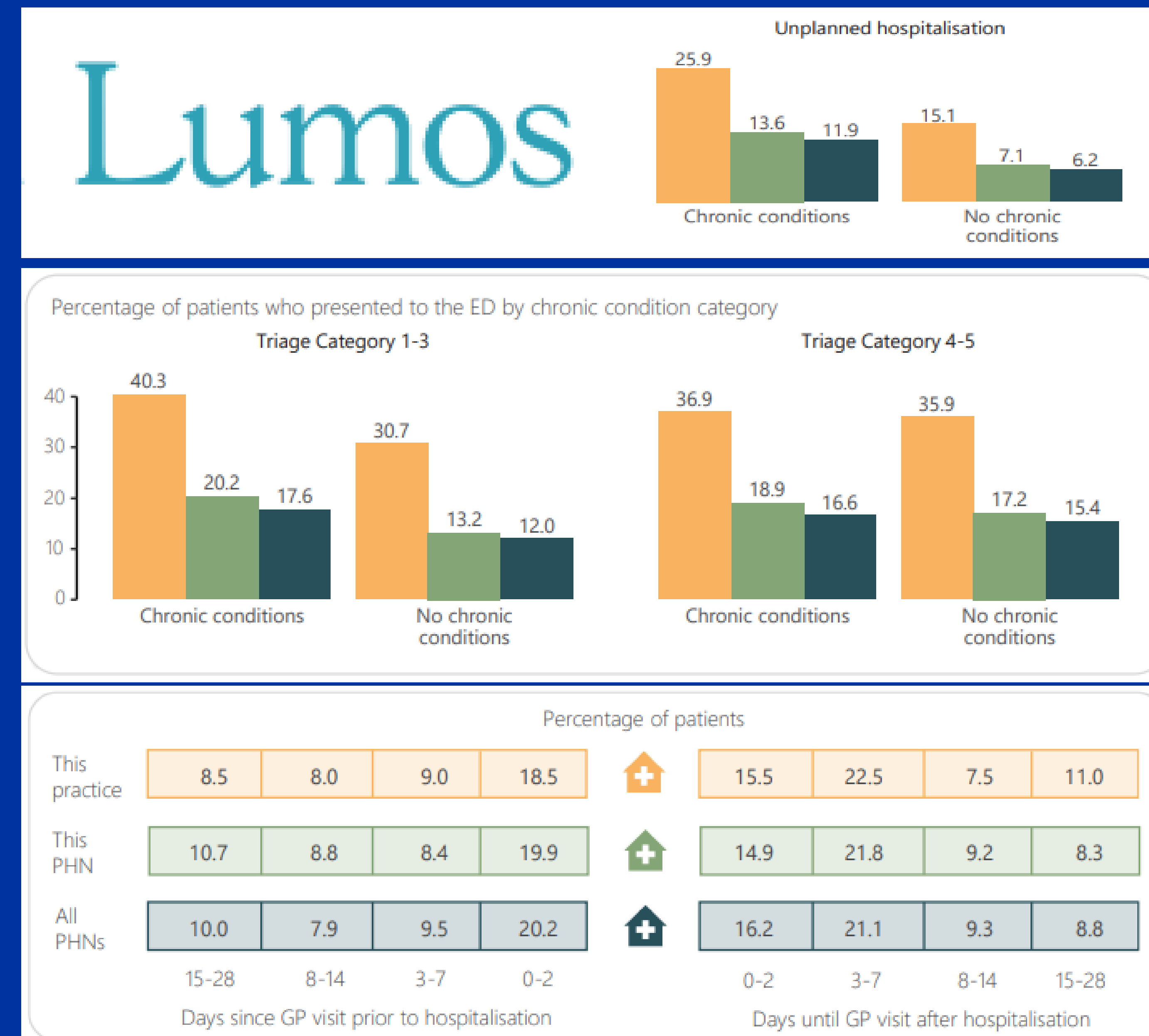
MBS ELIGIBILITY SETTINGS

Relevant hide

The following recommendations have been identified as relevant for this patient

	TITLE	UP TO DATE
	TCA	✗ 2/2
721	GPMP	✗ 1/1
900	DMMR	✗ 1/1
2517, 2521, 2525	Diabetes CoC	✗ 4/13
2546, 2552, 2558	Asthma Cycle Of Care	✗ 3/5
10997	10997 (PN/AHP Service)	✗ 0/1

topbar



Pen CS CAT4 - CAT4

CAT4

File Edit View Tools Data Submission Prompts Help Support

Collect | Report | View Population | CAT 4 | Cleansing CAT | Registrar CAT | Daily CAT | Programs | Clear Filters | Recalculate

Show Extracts

Filter

General | Ethnicity | Conditions | Medications | Date Range (Results) | Date Range (Visits) | Patient Name | Patient Status | Providers | Risk Factors | Health Care Homes | MBS Attendance

Chronic | Mental Health | Cancer | Other

Diabetes: Yes / No; Type II / No; Type I / No; Undefined / No; Type I or II; Gestational / No

Respiratory: Yes / No; Asthma / No; COPD / No

Cardiovascular: Yes / No; Hypertension / No; Cardiovascular Disease (CVD):; Heart Failure / No; CHD / No; PAD / No; Stroke / No; Carotid / No; MI / No; Renal Artery / No

Musculoskeletal: Yes / No; Inflammatory / No; Musculoskele / No; Bone Disease / No; Osteoporosis / No; Osteoarthritis / No

Renal Impairment: Yes / No; Chronic Renal / No; Acute Renal / No; Dialysis / No; Kidney / No

Clear Conditions

NURSES
A VOICE TO LEAD

INVEST IN NURSING AND RESPECT RIGHTS TO SECURE GLOBAL HEALTH