An Introduction to Care Planning in General Practice

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BSPHN
15 March 2018

Agenda

- The Medicare CDM Strategy
- Identifying patients for chronic disease registers
- The CDM Item Numbers for GPs
- Minimum requirements for plan inclusions
- Example templates
- Reviews
- Allied Health Professional referrals
- Group Allied Health sessions
- GP Mental Health Treatment Plans

The Medicare CDM Strategy – history

- Exists to provide structure, guidance and remuneration to GPs for managing complex chronic disease patients
- Formerly known as “Enhanced Primary Care” or “EPC”
- Other names have included “Care Plans”
- Different structures since its inception in 1999
- Current: *Chronic Disease Management*

The Medicare CDM Strategy - current

- A chronic medical condition … six months or longer
- There is no list of eligible conditions; however ….patients who require a structured approach & a multidisciplinary team
- Eligibility for CDM services is a clinical judgement for the GP

Source:
http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement

The Medicare CDM Strategy – 3 essential tools

www.health.gov.au

Search → For Health Professionals
→ Medicare
→ Primary Care

www.mbsonline.gov.au

Search by Item number for rules and notes

Document

This one is paramount to your role assisting the GP

Preparation saves time

- Before you see a CDM patient, collect as much data about them as possible from their chart
- Use of an Assessment cheat sheet is highly recommended …

FYI

- A **practice nurse, Aboriginal and Torres Strait Islander health practitioner, Aboriginal health worker or other health professional** may assist a GP with items 721, 723, and 732 (e.g. in patient assessment, identification of patient needs and making arrangements for services). However, the GP must meet all regulatory requirements, review and confirm all assessments and see the patient.

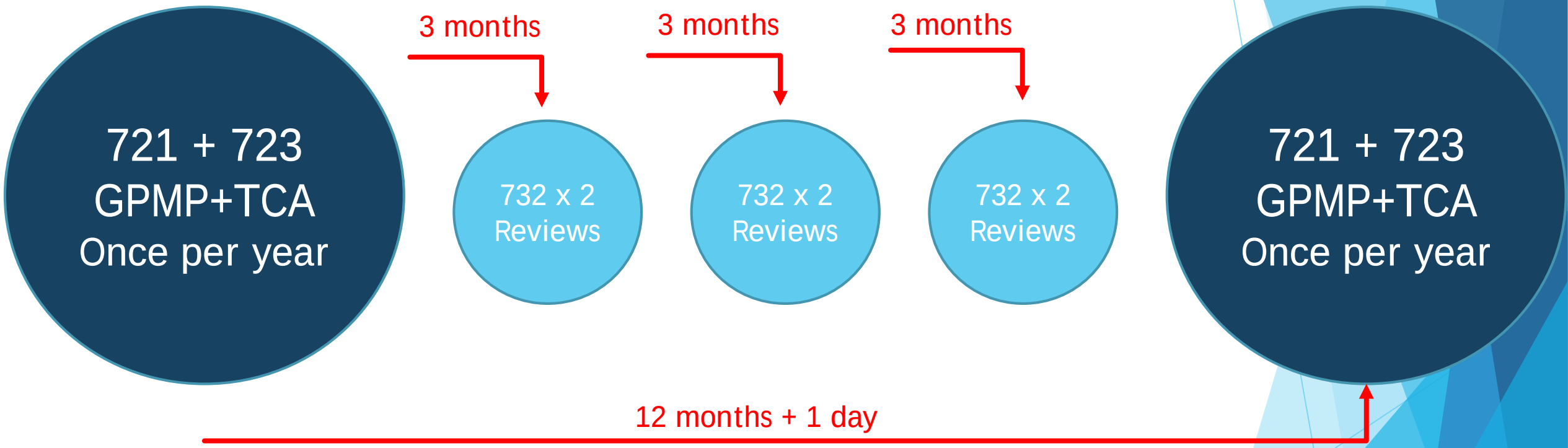
- Ref: Notes Section A36 www.mbsonline.gov.au

CDM Item Numbers – there are 6 for GPs

- 721: Preparation of a GP Management Plan (GPMP)
- 732: Review of a GPMP
- 723: Coordination of a Team Care Arrangement (TCA)
- 732: Review of a TCA

- 729: Contribution to a Multidisciplinary Care Plan being prepared by another health or care provider (hospital discharge)
- 731: Contribution to a Multidisciplinary Care Plan for a resident of an aged care facility

Timeline of a CDM Program – by Medicare billing guidelines



Example:
1 February 2018

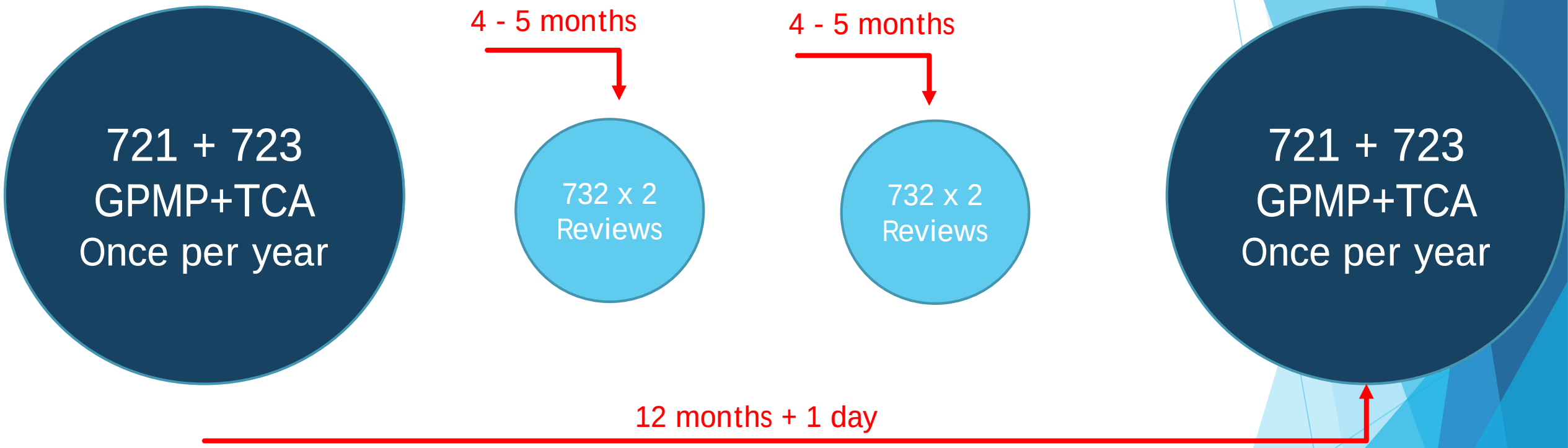
1 May 2018

1 Aug 2018

1 Nov 2018

2 February 2019

Timeline of a CDM Program – more often



Example:

1 February 2018 May 2018 October 2018 2 February 2019

Timeline of a CDM Program – most patients?

Example:
1 February 2018

August 2018

2 February 2019

721
Preparation of a GP Management Plan (GPMP)

- Chronic/terminal disease management, with or without multidisciplinary care needs
- The minimum claiming period is once every twelve months

721 GPMP: minimum inclusions

- A comprehensive written plan must be prepared describing:
  - (a) the patient's health care needs, health problems and relevant conditions;
  - (b) management goals with which the patient agrees;
  - (c) actions to be taken by the patient;
  - (d) treatment and services the patient is likely to need;
  - (e) arrangements for providing this treatment and these services; and
  - (f) arrangements to review the plan by a date specified in the plan.

723
Coordination of a Team Care Arrangement (TCA)

- for a patient who has a chronic or terminal medical condition and also requires ongoing care from a multidisciplinary team of at least three health or care providers.
- In most cases the patient will already have a GPMP in place.
- The minimum claiming period is once every twelve months.

723
Coordination of a Team Care Arrangement (TCA)

- When coordinating the development of Team Care Arrangements (TCAs), the medical practitioner must:
- (a) 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, when making arrangements for the multidisciplinary care of the patient; and
- (b) prepare a document that describes:
- i. treatment and service goals for the patient;
- ii. treatment and services that collaborating providers will provide to the patient; and
- iii. actions to be taken by the patient;
- iv. arrangements to review (i), (ii) and (iii) by a date specified in the document.

Can a Nurse or AHW be one of the 3 members of the TCA team?

Ref: Section 3.12 of the CDM Q&A document (2014)

"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? "

- If a nurse/practice nurse/Aboriginal and Torres Strait Islander health practitioner or Aboriginal health worker is independently providing ongoing treatment or services to the patient, that is:
  - not as part of the general practice medical services provided by the GP;
  - not under the supervision of the GP; and
  - different to the ongoing care provided by the other members of the team; they could constitute one of the minimum three members of the team.
- Where the nurse/practice nurse is:
  - providing general practice services on behalf of the patient's GP (including Medicare items for immunisation, wound management and Pap smears, which must be provided on behalf of and under the supervision of a GP); and/or
  - otherwise providing services under supervision, not in their own independent professional capacity; they could not qualify as one of the three independent members of the team.

Cont'd…

- Within the general guidance above, it is up to the GP to determine in the specific circumstances whether the practice nurse is skilled or qualified to independently provide ongoing treatment or services to the patient that is different to the care provided by the other members of the team.
- If a GP believes that there is a clear case for the practice nurse to qualify as one of the minimum three members of a TCAs team, given the particular needs and circumstances of the patient and the treatment to be provided by the practice nurse, the GP should be clearly satisfied that their peers would regard the involvement of the practice nurse as a member of the TCAs team to be appropriate in the circumstances.

Example of a TCA – please note

1. Try to include as much details as possible: name, address, phone & fax
2. Only 1 Specialist or Consultant Physician can be counted towards the team of 3 making up the core TCA team
3. A patient can see a different AHP at the same location (eg a group Physio practice) but they cannot go to a different Physio practice altogether. A new AHP referral form would be required to change AHP practice

732
Review of a GPMP

- Provides a rebate for a GP to review a GPMP
- The minimum claiming period is once every three months
- Involves reviewing the patient's GP Management Plan, documenting any changes and setting the next review date.

732
Review of a TCA

- Provides a rebate for a GP to review a TCA
- The minimum claiming period is once every three months
- Involves the GP (who may be assisted by their practice nurse or other) collaborating with the participating providers on progress against treatment/services and documenting any changes to the patient's TCAs.

Medicare requirements when item 732 is claimed twice on the same day

- If a GPMP and TCA are both reviewed on the same date and item 732 is to be claimed twice on the same day, both electronic claims and manual claims need to indicate they were rendered at different times

- Ref: Notes Section A36 www.mbsonline.gov.au

Patient Consent

Number of pathways for patient to consent:

- Implied consent (they visit the Practice regularly)
- They respond to letter or phone call
- Your role as Nurse/AHW: ensure patient understands purpose and agrees to assessment prior to commencing

Summary of CDM Item numbers

Item Number	Notes	Recommended Frequency
721 **GP Management Plan**	• Can be just the GP + AHW/Nurse involved in patient care • Set treatment goals and actions • Set a review date • AHW/Nurse can assist the GP to prepare the documentation	Minimum 12 months
723 **Team Care Arrangement**	• Patient has complex care requirements • Patient requires a team of health care providers to manage condition • Minimum of 3 health professionals	Minimum 12 months
732 **Reviews**	• GP + AHW/Nurse review patient progress • Document changes & set next date	Once every 3/12 period

The Medicare Subsidised Allied Health Referral Scheme

- Patient must have a GPMP and a TCA in place
- GP only to refer to AHP
- AHP must write back to GP
- Subsidy for up to 5 sessions per calendar year (total)
- Who is included in the scheme?…

Eligible Allied Health Providers

AHP	Item Number
Aboriginal Health Workers or Aboriginal and Torres Strait Islander Health Practitioners	10950
Audiologists	10952
Chiropractors	10964
Diabetes Educators	10951
Dietitians	10954
Exercise Physiologists	10953
Mental Health Workers	10956
Occupational Therapists	10958
Osteopaths	10966
Physiotherapists	10960
Podiatrists	10962
Psychologists	10968
Speech Pathologists	10970

Referral Form for AHP Services

- Finding the form
- Import it as a template
- Discuss how you utilise it as a table group

http://www.health.gov.au/internet/main/publishing.nsf/Content/Chronic+Disease+Allied+Health+Individual+Services

How to Communicate with AHPs for the Subsidy Scheme

1. Seek their agreement to be a part of the patient's management (phone ideal); document agreement somewhere
2. Include the AHP within the TCA (contact details, treatment/services)
3. Complete an AHP referral form for every provider (but only total of 5 visits)
4. Fax this referral form to the AHP once the Item numbers (721+723) have been billed by GP
5. Send a copy of the GPMP+TCA to the AHP (fax OR via the patient)
6. Include details of progress within the Review document at next visit (3-6/12 later)

Reporting requirements - allied health providers to GP

- A written report is required after the first and last service, or more often if clinically necessary.

Group Allied Health Services for Patients with Type 2 Diabetes

Diabetes Educator	**Exercise Physiologist**	**Dietitian**

Diabetes Educator	Exercise Physiologist	Dietitian

- The patient must have a GPMP in place, but ***does not*** require a TCA
- There are two elements to provision of allied health services under these items:

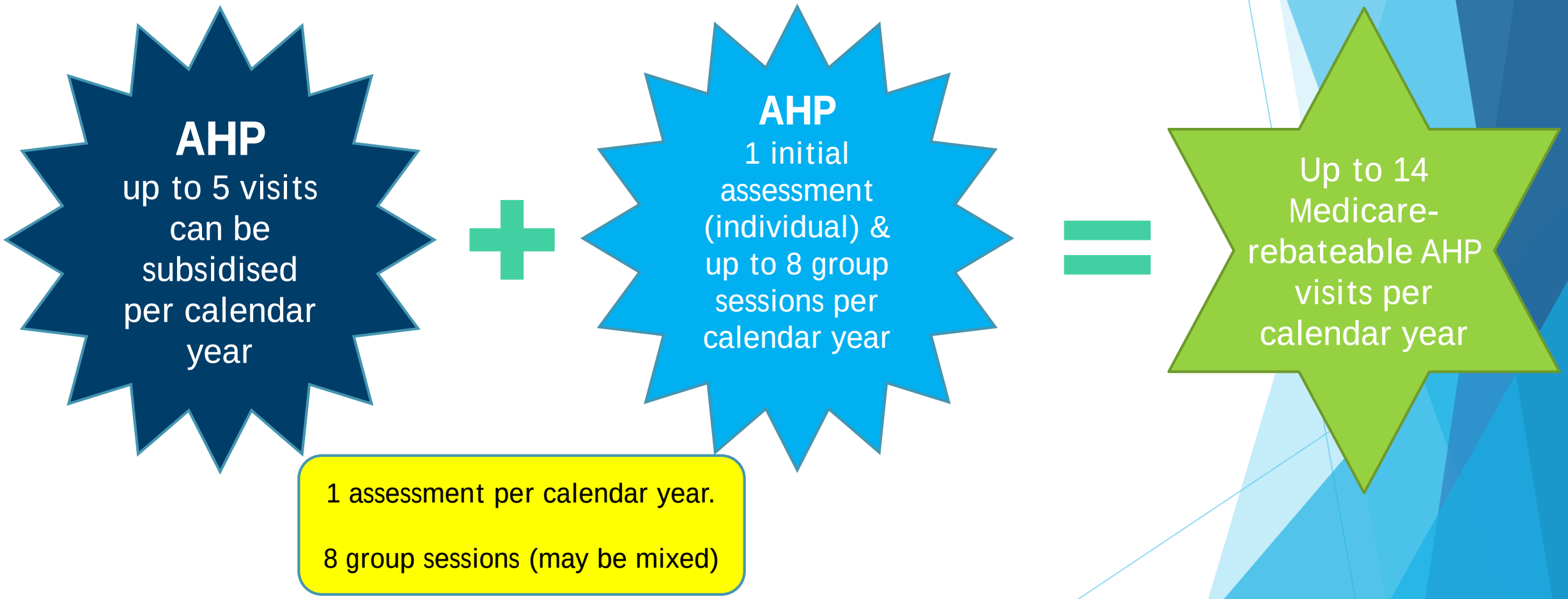
- Group services are ***in addition*** to the 5 individual allied health services available
- GP is required to refer using the specific Group AHP Services referral form

Group Allied Health Services for patients with Type 2 Diabetes

	Diabetes Educators	Exercise Physiologists	Dietitians
Initial Individual Assessment (min. 45 mins)	81100	81110	81120
Group Services (at least 60 mins) 2 – 12 patients	81105	81115	81125

If a provider accepts the Medicare benefit as full payment for the service, there will be no out-of-pocket cost. If not, the patient will have to pay the difference between the fee charged and the Medicare rebate.

Group Allied Health Services for patients with Type 2 Diabetes



GP Mental Health Treatment Plans

- Provided under the “Better Access to Mental Health” framework
- These services are provided only by
  - GPs
  - Psychiatrists
  - clinical psychologists
  - registered psychologists, and
  - appropriately trained social workers and occupational therapists

- Nurses in General Practice cannot assist with these plans, unlike CDM

https://www.humanservices.gov.au/organisations/health-professionals/enablers/education-guide-better-access-mental-health-care-general-practitioners-and-allied-health

GPs can provide the following services under Better Access:

Service	MBS item	Frequency it can be used
Prepare a GP mental health treatment plan (GPMHTP)	2700, 2701, 2715 or 2717	Once every 12 months however not within 3 months of a review under item 2712
Review a mental health treatment plan	2712	Once every 3 months however not within 4 weeks of claiming item 2700, 2701, 2715 or 2717
Manage a patient's mental health condition	2713 or a general consultation item	As often as necessary - no restrictions
*GP focused psychological strategies (FPS) services	2721 - 2727	Up to 10 services every 12 months

https://www.humanservices.gov.au/organisations/health-professionals/enablers/education-guide-better-access-mental-health-care-general-practitioners-and-allied-health

Mental Health Treatment Plans

- All consultations conducted as part of the GP Mental Health Treatment items must be rendered by the GP and include a personal attendance with the patient.
- A specialist mental health nurse, other allied health practitioner, Aboriginal and Torres Strait Islander health practitioner or Aboriginal Health Worker with appropriate mental health qualifications and training may provide general assistance to GPs in provision of mental health care.

- http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&q=2715&qt=ItemID

Mental Health TP and CDM Together?

- It is preferable that wherever possible patients have only one plan for primary care management of their mental disorder. As a general principle the creation of multiple plans should be avoided, unless the patient clearly requires an additional plan for the management of a separate medical condition.
- The Chronic Disease Management (CDM) care plan items (items 721, 723, 729, 731 and 732) continue to be available for patients with chronic medical conditions, including patients with complex needs.
- Where a patient has a mental health condition only, it is anticipated that they will be managed under the GP Mental Health Treatment items.
- Where a patient has a separate chronic medical condition, it may be appropriate to manage the patient's medical condition through a GP Management Plan (+TCA if required), and to manage their mental health condition through a GP Mental Health Treatment Plan. In this case, both items can be used

References

1. Department of Health

www.health.gov.au

2. Provider Information
http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-factsheet-chronicdisease.htm

3. Item Numbers

www.mbsonline.gov.au

4. CDM QnA Fact Sheet

http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement

5. Better Access to Mental Health

www.humanservices.gov.au/organisations/health-professionals/enablers/education-guide-better-access-mental-health-care-general-practitioners-and-allied-health

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