GPSA
GENERAL PRACTICE SUPERVISION AUSTRALIA

FAQ

FREQUENTLY ASKED QUESTIONS

PODCAST WEBINAR

Teaching your Registrar about Chronic Disease Management: How to complete a Care Plan

What are the different types of Chronic Disease Management ("CDM") appointments to teach registrars?

1. Care Plans
   a. GP Management Plans ("GPMPs"); and
   b. Team Care Arrangements ("TCAs")
2. Care Plan Reviews
   a. GPMP Review and/or
   b. TCA Reviews
3. Health Assessments
4. Mental Health Treatment Plans & Reviews

What is the definition of a Care Plan?

- Attendance by a GP **for preparation of a GP Management Plan** for a patient; and/or
- Attendance by a GP **to coordinate the development of Team Care Arrangements** for a patient.

What is the best approach to teaching CDM to registrars?

Chronic conditions require long-term management. When your registrar sees a patient with a chronic condition, they need to build a mental picture of the care that patient will require over the next 12 months. Breaking this plan into "Today" (short-term goals/activities) and "Next Appointment" (longer-term goals/activities) helps to keep things manageable for you/the registrar as well as the patient.

Booking the next appointment at each appointment further serves to increase patient engagement.

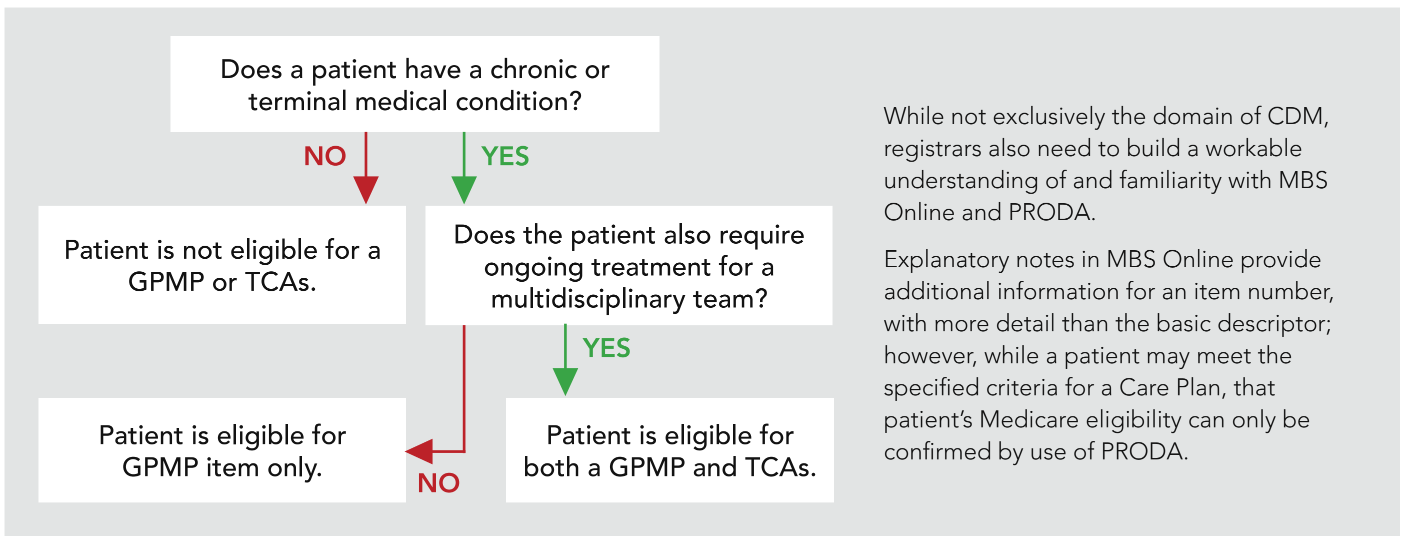
As a subject for teaching and review with your registrars, Chronic Disease Management should be broken into multiple teaching sessions, namely:

- Care Plans (GPMPs and TCAs)
- Care Plan Reviews
- Time Based Health Assessments
- Aboriginal & Torres Strait Islander Health Assessments
- Cycles of Care.

Eligibility of patients

Patients with a chronic medical condition such as these may be eligible for a Care Plan (GPMP and/or TCA):

- Asthma
- Cancer
- Cardiovascular Disease
- Diabetes
- Kidney Disease
- Musculoskeletal Conditions
- Stroke



While not exclusively the domain of CDM, registrars also need to build a workable understanding of and familiarity with MBS Online and PRODA.

Explanatory notes in MBS Online provide additional information for an item number, with more detail than the basic descriptor; however, while a patient may meet the specified criteria for a Care Plan, that patient's Medicare eligibility can only be confirmed by use of PRODA.

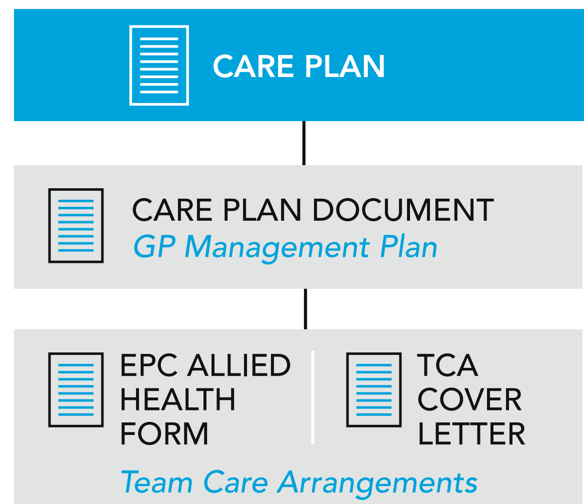
Documenting the Care Plan

It is crucial for your registrars to understand that a successful Care Plan needs both the patient's involvement and contribution to the process by the Practice Team. For it to be sustainable, it cannot rely on just one or two individuals in the practice.

Care Plan = Patient + Practice Team + Process

In the same way, development of an effective CDM template within your practice software should be a team effort, something that comes under regular review by all the members of your team to ensure uniformity in its application. All templates can be edited to create a streamlined whole-of-practice documentation process for Chronic Disease Management, such as Progress Notes, Investigations, Observations, Family/Social History etc.

Since customisation to incorporate the below-listed items is relatively easy, however, it is important to check for duplicates or continued use of outdated templates on your system before introducing your registrars to this aspect of the documentation process.



Useful tip: *Save time by combining the TCA Cover Letter & EPS Allied Health Form into a single document*

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What should the CDM template include?

	Nurse Progress Notes	GP Progress Notes
GPMP (Medicare Item 721)	• Preparation of GPMP for (list conditions/problems) • Last GPMP • GPMP process explained to the patient and/or carer, patient eligible and consents to same • Patient details and smoking/alcohol updated • Family, medical and social history updated • Observations recorded • Medication • Bloods • Specialist • Allied Health/Other • Prevention and Early Detection • Patient Needs & Goals • Patient Actions • Recommendations • Next Appointments - GPMP Review in 3 months • Patient offered copy of plan • SB Dr	• Preparation of GPMP for (list conditions/ problems) • GPMP process explained to the patient and/or carer, patient eligible and consents to same • Treatments & Services • Patient Needs & Goals • Patient Actions • Next Appointments - GPMP Review in 3 months • Patient offered copy of plan
GPMP/TCA	• Preparation of GPMP/TCA for (list conditions/ problems) • Last GPMP/TCA • GPMP/TCA process explained to the patient and/or carer, patient eligible and consents to same • Patient details and smoking/alcohol updated • Family, medical and social history updated • Observations recorded • Medication • Bloods • Specialist • Allied Health/Other • Prevention and Early Detection • Patient Needs & Goals • Patient Actions • Recommendations • Next Appointments - GPMP/TCA Review in 3 months • Patient offered copy of plan • SB Dr	• Preparation of GPMP/TCA for (list conditions/ problems) • GPMP/TCA process explained to the patient and/or carer, patient eligible and consents to same • Collaborating Providers • Treatments & Services • Patient Needs & Goals • Patient Actions • Next Appointments - GPMP Review in 3 months • Patient offered copy of plan

Other things to include	Observations	Prevention and Early Detection Activities
	• Height/Weight/BMI/Waist	• Observations (Peak flow, BGL, Urinalysis)
	• Blood Pressure and Heart Rate	• Immunisations
	• Blood Glucose Level	• Health Assessments
	• Visual Acuity	• Cancers
	• ECG (Annual Chronic Disease)	• AUSDRISK tool
	• Peak Flow (Respiratory Disease)	• Cardiovascular Risk
	• Spirometry (Annual patients >8yrs old with Respiratory Disease)	• K10
	• Oxygen Saturation (Respiratory Disease)	• COPD Screening/Spirometry
	• Respiratory Rate (Respiratory Disease)	• CKD Screening tool
	• Urinalysis (Chronic Disease)	• Cognitive Screening
		• Sexual Health

Other things to include: Care Team Members	Specialist	Allied Health	Other
	• Cardiologist	• Podiatrist	• Community Nurses
	• Endocrinologist	• Audiologist	• Optometrist
	• Respiratory Physician	• Aboriginal Health Worker	• Hospital Programs:
	• Rheumatologist	• Dietitian	– Falls prevention and balance
	• Neurologist	• Physiotherapist	– Cardiac Rehabilitation
	• Ophthalmologist	• Exercise Physiologist	– Pulmonary Rehabilitation
	• Gastroenterologist/Hepatologist	• Psychologist	– Musculoskeletal
	• Nephrologist	• Social Worker	– Neurology
	• Dermatologist	• Chiropractor	– Pain and Chronic Fatigue
	• Haematologist	• Osteopath	• Pharmacist
	• Geriatrician	• Speech Pathologist	• Another GP
	• Psychiatrist	• Diabetes Educator	• Drug & Alcohol Services
	• Pain Specialist	• Occupational Therapist	• ITC
	• Paediatrician		• Dentist
	• Urologist		
	• Oncologist		
	• Immunologist		
	• Obstetrician/Gynaecologist		
	• ENT Specialist (Ear, Nose, Throat)		

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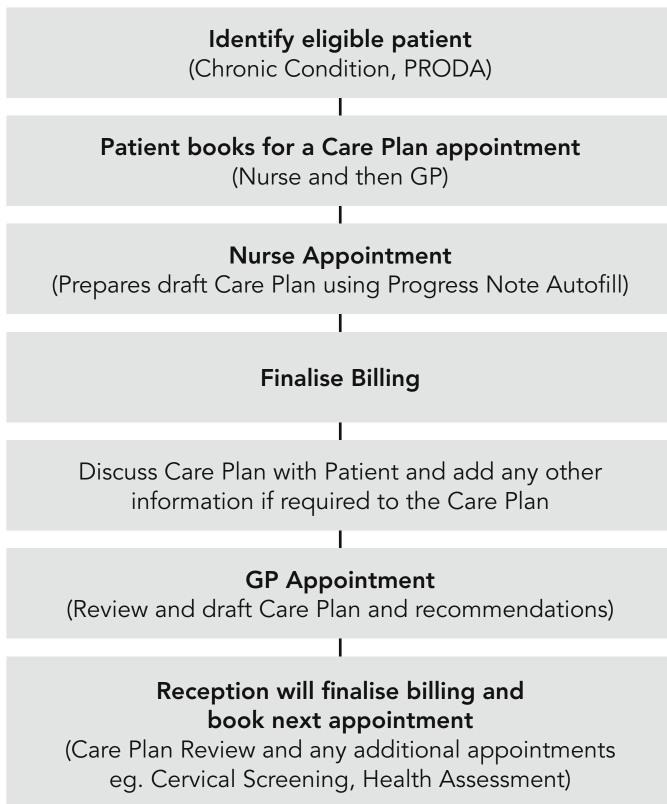
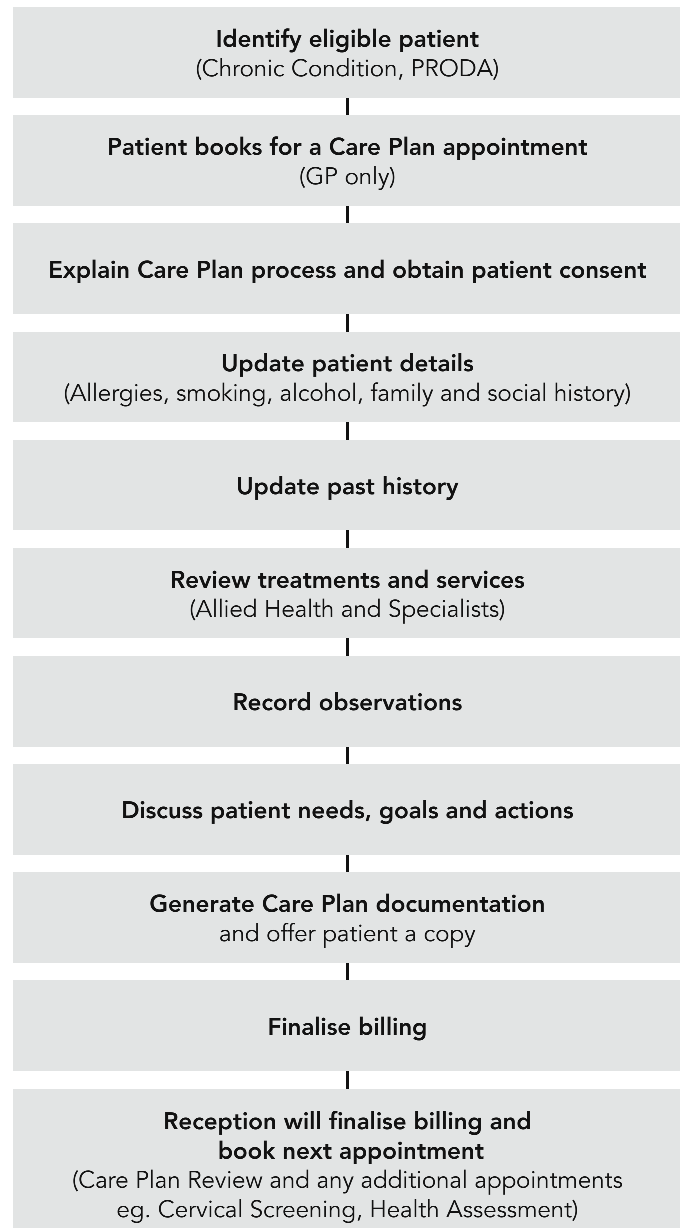
How to explain CDM appointments as a step-by-step process:

NURSE & GP



GP ONLY



More information

Education Guide Chronic Disease GP Management Plans and Team Care Arrangements

Chronic Disease Management (formerly Enhanced Primary Care)

Questions & Answers on the Chronic Disease Management Items

MBS Online

Chronic Disease training

Does this resource need to be updated? Contact GPSA: P: 03 9607 8590, E: admin@gpsa.org.au, W: gpsa.org.au

GPSA is supported by funding from the Australian Government under the Australian General Practice Training Program 22/01/23