



7. Chronic Disease Management

7.1 Chronic Disease

The national chronic disease strategy:

<http://www.health.gov.au/internet/main/publishing.nsf/Content/pq-ncds>

- is a national approach to chronic disease prevention and management
- includes information about national service improvement frameworks for particular chronic diseases and the Blueprint for nation-wide surveillance of chronic diseases.

National health priority areas

Seven health areas which contribute significantly to the burden of illness and injury, and which have potential for health gains and reduction in the burden of disease, have been identified as national health priority areas:

- arthritis and musculoskeletal conditions
- asthma
- cancer control
- cardiovascular health
- diabetes mellitus
- injury prevention and control
- mental health

The Chronic Disease Management (CDM) Medicare items on the Medicare Benefits Schedule (MBS) enable GPs to plan and coordinate the health care of patients with chronic or terminal medical conditions, including patients with these conditions who require multidisciplinary, team-based care from a GP and at least two other health or care providers. The items are designed for patients who require a structured approach to their care.

A 'chronic medical condition' is one that has been or is likely to be present for at least six months including but not limited to asthma, cancer, cardiovascular disease, diabetes mellitus, musculoskeletal conditions and stroke.

Whether a patient is eligible for CDM services is a clinical judgement for the GP, taking into account the patient's medical condition and care needs, as well as the general guidance set out in the MBS.

GP Mental Health Treatment Plans apply to patients with mental disorders.

Patients who have a chronic medical condition and complex care needs and are being managed by their GP under a GP Management Plan (item 721) and Team Care Arrangements (item 723) are eligible for Medicare rebates for certain allied health services on referral from their GP.

7.2 GP Management Plans (GPMP) – item 721

GP Management Plans are written comprehensive plans for the care of an individual patient of any age, with a chronic or terminal condition. The recommended frequency is once every two years, supported by regular review services. The practice nurse can assist in preparing or reviewing a GPMP on behalf of the GP. The GP must review and confirm assessments conducted by the nurse and must see the patient as part of the service.

The practice nurse role may include to:

- identify eligible patients who would benefit from a GP Management Plan
- assess the patient
- develop agreed management goals for the patient
- identify actions to be taken by the patient
- identify treatment and ongoing services to be provided and make arrangements for these services.

7.3 Team Care Arrangements (TCA) – item 723

Team Care Arrangements are team assisted care planning for patients with a chronic or terminal condition **and** who require ongoing care from a multidisciplinary team of **at least two** other care or service providers. The recommended frequency is once every two years, supported by regular review services.

The practice nurse role may include:

- identify eligible patients who would benefit from a Team Care Arrangement
- assess the patient
- agreed management goals for the patient
- identify actions to be taken by the patient
- identify treatment and ongoing services to be provided and make arrangements for these services by collaborating with the participating providers.

Interactive templates for GP Management Plans, Team Care Arrangements and the review of these plans have been developed by **gpns**. These templates can be downloaded from **www.gpns.org.au** and installed in Medical Director. If you have trouble installing or using these templates please email **gpns@gpns.org.au** and request IT support.

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For comprehensive information about the Chronic Disease Management item numbers visit www.gpns.org.au . Click on Practice Support, then *Chronic Disease Management* and see the section on *Recent News and resources*. Here you will find general information and fact sheets, MBS explanatory notes, frequently asked questions, case scenarios, and interactive templates for Medical Director, proformas and checklists, allied health and dental referral forms.

Your **gpns** Chronic Disease Management Coordinator can also assist you with the Chronic Disease Management Item numbers. Please contact **gpns** for further information.

7.4 Case Conferencing

This is a meeting of the general practitioner and **at least two** health care providers to plan care for individual patients with chronic and complex conditions and multi-disciplinary care needs. They may either be undertaken for patients in the community or in a residential aged care facility, or patients being discharged into the community from a hospital. Case conference meetings can be face to face, via telephone or video conference.

A case conference usually involves immediate management plans to develop short term or urgent solutions and must be at least fifteen minutes in duration. A practice cannot claim more than five case conferences for a patient in a twelve month period.

Item payments vary depending on:

- the length of the conference
- whether the GP organised or co-ordinated the conference or was a participant
- the location of the conference.

The practice nurse role may include:

- identify eligible patients who would benefit from a case conference
- understand and promote the process of a case conference
- assist with the organisation and facilitation of the case conference
- assist in the implementation of the short term management plan.

Familiarise yourself with the MBS requirements for case conferences by reading the explanatory notes in the MBS. For more information visit www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Medicare-Benefits-Schedule-MBS-1

Chronic Disease Management MBS Items

Item	Name	Description/Eligibility	Frequency
721	GP Management Plan (GPMP)	Chronic or terminal condition lasting more than 6 months	Recommended 2 yearly (not less than 12 months)
723	Team Care Arrangement (TCA)	Pt with complex care requiring ongoing care from multi-disciplinary team. Need contribution from two other providers, pt entitled to 5 rebated allied health services per calendar year	Recommended 2 yearly (not less than 12 months)
732	Review (r/v) of GPMP or TCA	Claimable twice on same day for review of GPMP and TCA	Recommended 6 monthly (not less than 3 months)
731	GP contribution to Care Plan by RACF	Contribution to, or review of a care plan prepared by a Residential Aged Care Facility, at the request of the facility	Not less than 3 months
2517(B) 2521(C) 2525(D)	Diabetes Annual Cycle of Care	For accredited practices. Claimed once all components of cycle of care are met over previous 11-13 months. Replaces usual attendance item	Between 11-13 months
2546(B) 2552(C) 2558(D)	Asthma Cycle of Care	For accredited practices. For patients with moderate to severe asthma	Not less than 12 monthly
10997	Chronic Disease Management	Monitoring and support by Practice Nurse for patients with GPMP in place.	5 visits per calendar year
10987	ATSI Health Assessment follow up	Monitoring and support by Practice Nurse or Aboriginal Health Worker for Aboriginal or Torres Strait Islander patients who have had a H/A	10 visits per calendar year