GP care planning

Summary of explanatory notes and web links

	Care planning prepared by a GP				Practice nurse (PN) and Aboriginal health worker (AHW) provision of monitoring and support #10997
	GP Management Plan (GPMP) #721	Review of GP Management Plan #725	Team Care Arrangements (TCA) #723	Review of Team Care Arrangements #727	
Steps that must be taken to claim the Medicare item	• Assessing the patient to identify and/or confirm needs, problems and conditions • Explaining the service and any associated costs with the patient, and gaining and recording consent to proceed • Agreeing on management goals with the patient for changes to be achieved by the treatment and services identified in the plan • Identifying required patient actions • Identifying treatment and services that the patient is likely to need, and making arrangements for them • Services and ongoing management • Preparation of a comprehensive written plan describing the patient's needs, goals, patient actions, treatment / services and a review date • Offering a copy of the plan to the patient and adding it to medical records	• Explaining the service and any associated costs with the patient, and gaining and recording consent to proceed • Reviewing the patient's needs and goals, patient actions and treatment/ services • Making relevant changes to the documented GPMP • Adding a new review date • Offering a copy of the plan to the patient and adding it to medical records	• Explaining the service and any associated costs with the patient, and gaining consent to proceed • Discussing with the patient which providers should collaborate with the GP (each of whom must provide a different kind of ongoing care), gaining patient consent to share information • Contacting the proposed providers, obtaining their agreement to participate, and providing them with relevant information or allowing time for them to see the patient, if necessary • Collaborating with the other providers to discuss potential treatments/services to be provided to achieve patient goals • Preparing a document that describes treatment and service goals, providers involved, patient actions and that nominates a review date • Providing copy of the TCA document to other providers (with consent), offering a copy to patient/carer, and adding it to the medical records	• Explaining the service and any associated costs with the patient, and gaining and recording consent to proceed • Discussing with the patient which providers should be asked to collaborate in the review • Collaborating with the providers to establish patient progress against care plan goals and reviewing the plan • Documenting any changes to the plan • Providing a copy to other providers (with consent), offering a copy to patient/carer, and adding it to the medical records	• Assisting patients on an EPC Care Plan who require access to ongoing care, routine treatment and ongoing monitoring and support between the more structured reviews of the care plan by the patient's usual GP. • Note: Cannot be claimed at the same time as GP Care Planning items #721, #723, #725, #727, #729 or #731.
Medicare rules relating to frequency of service	Maximum of once per patient in a 12–month period. The recommended frequency is one #721 every 2 years (if required) with 6–monthly reviews.	Maximum of once per patient in a 3–month period. The recommended frequency is every 6 months.	Maximum of once per patient in a 12–month period. The recommended frequency is one #723 every 2 years (if required) with 6–monthly reviews.	Maximum of once per patient in a 3–month period. The recommended frequency is every 6 months.	A maximum of 5 services per patient per calendar year.
Role of the GP	• The GP has ultimate responsibility for delivery of the service, which must include a personal attendance by a single medical practitioner with a single patient (the consultation may include the patient's carer or representative as necessary)				• The GP retains responsibility for the outcomes
Roles that can be performed by practice nurses (PNs) or Aboriginal health workers (AHWs) on behalf of and under the supervision of a GP	• Assist in aspects of patient assessment, identification of patient needs, and making arrangements for services • Managing review appointments system • Assistance to patients as per #10997	• Recalling the patient for the care plan review • Other tasks as per GPMP column	• Assist in aspects of patient assessment, identification of patient needs, and making arrangements for services • Managing review appointments system • Assistance to patients as per #10997	• Recalling the patient for the care plan review • Other tasks as per TCA column	• All tasks • Check web link for examples of specific services
Main information web links	GP items: www.health.gov.au/internet/main/publishing.nsf/Content/pcd-programs-epc-chronicdisease PN item: www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=M2.1&qt=noteID				

All information is current as at September 2008. Health professionals intending to use these items should refer to the Medicare Benefits Schedule (MBS) book for more comprehensive information, including the MBS requirements for each item. Alternatively, they can search for specific items at www9.health.gov.au/mbs or telephone Medicare Australia on 03 9605 7964 or contact the local Division of General Practice.

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