What is a Care Plan - GP Management Plan ?

A care plan is a written health plan which outlines goals for the management of your health and the treatments, services and care which will help to achieve those goals. The plan includes time lines and reviews. In general practice there are two kinds of care plans for people with chronic disease: a GP Management Plan, and a Team Care Arrangement.

What is a Chronic Disease?

A chronic disease is one that has been present for 6 months or is likely to last 6 months more or longer. Examples are: asthma, diabetes, heart disease, mental illness or arthritis. Palliative care is included in this category.

What is the Chronic Disease Management Clinic?

As part of our ongoing commitment to ensure a high standard of care for our patients, the practice has established a weekly Chronic Disease Management Clinic.

Each patient attending the clinic will spend **<< ?? Minutes>>** with our Practice Nurse and during that time your current health and care needs will be assessed.

The practice nurse will record all relevant information in your clinical file and undertake some of the initial work on behalf of your regular GP.

There is no charge for attending the Chronic Disease Management as part of the preparation of your Management Plan.

Following your attendance at the Care Plan Clinic a follow up appointment **(within ?? days)** will be made for you to see your doctor and finalise your Management Plan.

GP Management Plan (GPMP).

A GP Management Plan is for patients of any age with one or more chronic diseases. It outlines the treatment you will receive from your GP to manage your condition. It is for patients living at home, or private patients being discharged from hospital.

First the doctor or clinic nurse will explain the purpose of the plan and obtain your consent. Then they will assess your current health and care needs. Your medical, physical, psychological and social needs will all be considered.

You will be asked about your personal goals and what results you would like from the plan. The doctor will also look at any other health care services you are using or need. (See *Team Care Arrangements*.) This will normally be done at the Chronic Disease Management Clinic.

Once the plan has been finalised your doctor will discuss the recommendations with you, obtain your agreement and give you a copy of the plan. This will be done at your follow up appointment.

If you would like a carer, another family member or someone else to be present for the appointment, please tell the practice beforehand.

The initial appointment at the Chronic Disease Management Clinic will take about **??** minutes and the follow up appointment, with your GP, will take ?**??** minutes of your time.

The plan should be reviewed every 6 months to see how you are progressing and the practice will send you a reminder letter at the appropriate time. Your plan can be rewritten every 2 years – unless your circumstances change significantly, in which case a new plan can be written before this.

Team Care Arrangements (TCA).

If you would benefit from seeing any other health care providers your GP will recommend appropriate services, discuss care and goals with them, and draw up a plan called a 'Team Care Arrangement'.

This may mean setting up a plan between services you already use.

The doctor or nurse will explain the plan to you and obtain your consent before sharing information about you with others. *If there are aspects of your health that you do not want discussed with other providers, let the doctor or nurse know.*

You will be consulted about your personal needs and goals and what results you would like from the plan.

As with GP Management Plans, the Team Care Arrangement is for patients of any age with a chronic disease, who are living at home, or are private patients being discharged from hospital.

Should your doctor feel that you would benefit from having a Team Care Plan, you will need to attend for a further follow up appointment.

Who is a Health Care Provider?

Any health worker or community care service, such as a physiotherapist, medical specialist, community nurse, home help service, occupational therapist, dietician, diabetes and asthma educators, pharmacists, etc.

What will it Cost?

Normal practice fee applies for initial consultation and *reduced fees will apply for subsequent visits for those patients being reviewed as part of their disease management plan.*

Medicare Rebates are paid for GP Management Plans , Team Care Arrangements and Reviews.

Medicare Benefits for Private Allied Health Services.

Most Team Care Arrangements involve specialists or community services. However, sometimes a referral to a private service is necessary.

You can now receive Medicare rebates for some of these services. Only certain types of service are eligible and only for a total of 5 rebates per year per patient.

These rebates are only available to patients who are being managed for chronic disease by their GP.

If both a GP Management Plan and a Team Care Arrangement are in place, the doctor may then give you a referral for the allied health service.

Eligible services include:

* aboriginal health workers
* audiologists
* chiropractors
* diabetes educators (credentialed)
* dieticians
* exercise physiologists
* mental health workers
* occupational therapists
* osteopaths
* physiotherapists
* podiatrists / chiropodists
* psychologists
* speech therapists.

In addition to the 5 allied health services, Medicare rebates are also available for dental care **BUT only** where the dental problem significantly affects your chronic illness or has been caused by your illness.

How can I arrange for my GP Management Plan?

You should discuss with your doctor whether a Chronic Disease Management Plan would benefit your ongoing health and well being.

After discussing it with them, they can organise an appointment for you at the Chronic Disease Management Clinic.

Thank you ……

For choosing the << practice name >>, for your health care needs.

We trust that you will find the services here of the highest quality.

This information brochure is to assist you to obtain maximum benefit from the services, personnel and facilities available.

By informing you about our policies, services, procedures and methods of our practice, we will be better able to serve you.

It is practice policy that accounts are
FULLY paid on the day of consultation.

Clinic Name

Details.

Managed Care Plans

A Patient's Guide.