General practice and the management of chronic conditions

Where to now?

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BACKGROUND
As of 1 July 2005, the Medicare Benefits Schedule includes additional chronic disease management (CDM) item numbers offering general practitioners more options for managing patients with chronic conditions, including those requiring multidisciplinary care. The new item numbers are not a substitute for normal medical care but expand the possibilities for GPs and their patients.

OBJECTIVE
This article provides a practical overview of the use of the CDM item numbers.

DISCUSSION
A GP management plan (GPMP) if undertaken with team care arrangements (TCA) largely equates to the previous Enhanced Primary Care plan. The role of a practice nurse assisting in preparation of both a GPMP and TCA is now clearer and more inclusive. There is also increased flexibility in who can be involved in the review of these patients.

The new chronic disease management (CDM) item numbers represent an alternative way of funding best practice care for people with chronic medical conditions, including those conditions targeted by the asthma, diabetes and mental health Service Incentive Payments.

Australia is facing an increasing economic and social burden due to chronic diseases. By 2016, an estimated 16% (3.5 million) of the Australian population will be experiencing the effects of chronic disease.[1] Addressing this rising problem will require the development of a systematic and coordinated approach to health care.

The Enhanced Primary Care (EPC) package, introduced in 1999, included new Medicare Benefits Schedule (MBS) item numbers for general practitioners to undertake health assessments and care planning for patients with chronic conditions. Barriers to uptake included undeveloped practice systems and lack of education at the division of general practice and health service level.[2,3] Many GPs found the EPC item numbers difficult to use due to competing demands of acute and episodic care, uncertain roles for practice nurses, and the additional paperwork required.[4]

Following consultation with GP representative groups, changes to the EPC item numbers were recommended and came into effect on 1 July 2005. The new CDM item numbers offer GPs alternatives in the management of chronic and complex conditions and are now available to a wider group of patients.

What is involved in a GP management plan?

The GP management plan (GPMP, item 721) is developed between a GP and a patient with a chronic (or terminal) condition living in the community, or a private in-patient on discharge from hospital, including residents of aged care facilities. The steps in preparing a GPMP are:

- check the patient does not have an existing GPMP

(or EPC plan) and determine eligibility
- discuss the process, including any costs involved, with the patient and record consent in the patient's notes
- assess the patient
- identify ongoing care needs
- agree with the patient on the ongoing management goals
- identify actions to be taken by the patient and GP
- document treatment and continuing management.

Collaboration with other providers to prepare the GPMP is not required. Plans can now be reviewed by the same GP who prepared the management plan, a GP from the same practice, or, if a patient has moved to another practice, by a GP from the new practice. In most cases, past history should already be part of the patient's comprehensive medical record. If not, or the patient is new to the practice, the practice nurse can carry out a full assessment. The GP would then review and confirm with the patient ongoing care needs, management goals, and any action required.

When do I use team care arrangements?

If a patient has a chronic medical condition and complex care needs, poor compliance with treatment or is at risk of further complications, they may require interventions from a multidisciplinary team (see *Case study 1*). In this case they would be eligible for a team care arrangement (TCA, item 723) involving a GP and at least two other health or community care providers. The steps in preparing a TCA are:
- check the patient does not have an existing TCA (or EPC plan) and determine eligibility
- discuss the process, including any costs involved, and develop management goals with the patient
- confirm the patient's consent, including agreement to share relevant information with other providers, and record consent in the patient's notes
- contact the other providers to gain their agreement to be involved in the TCA and to discuss potential treatment/services
- document this information in the TCA, including a review date
- give a copy to all contributors, including the patient, and file in patient's notes.

The CDM item numbers are also available for review of GPMPs and TCAs and for a GP to contribute to a multidisciplinary care plan prepared by another provider (eg. hospital/allied health staff) or an aged care facility (*Table 1*).

Case study 1 – GP management plan and team care arrangement (item 721 and 723)

Paula, 52 years of age, has a moderate intellectual disability and cerebral palsy. She lives in supported accommodation and works in a local factory. Over the past 6 months she has been uncomfortable after eating and has had a cough at night. She has been taking Mylanta after meals but the problem has not resolved. The GP does a full assessment that reveals a weight loss of 3 kg over 3 months (BMI 19) and haemoglobin of 98 g/L (n=115–165 g/L) with low iron levels and microcytic picture. The GP prepares a GP management plan and completes a team care arrangement after collaborating with a dietician to review nutrition, a speech therapist to review swallowing, and a gastroenterologist to review possible severe reflux oesophagitis.

Table 1. Summary of CDM Medicare item numbers

	Item no.	Medicare rebate (100%) from 1/11/2005	Recommended frequency period	Minimum claiming
Preparation of GPMP	721	$122.40	2 yearly	12 months*
Preparation of TCA	723	$96.90	2 yearly	12 months*
Review of GPMP	725#	$61.20	6 monthly	3 months*
Coordination of review of TCA	727#	$61.20	6 monthly	3 months*
Contribution to a multidisciplinary care plan	729	$42.50	6 monthly	3 months*
Contribution of a multidisciplinary care plan from aged care facility	731	$42.50	6 monthly	3 months*

* These services can also be provided more frequently in exceptional circumstances, ie. a significant change in the patient's clinical condition or care circumstances

To review an existing EPC plan (item 720 or 722) a GP can use item 725 (GPMP review) or TCA (item 727)

Source: Australian Government Department of Health and Ageing

Access to allied health and dental item numbers

To access allied health and dental care Medicare item rebates, a patient must have both a GPMP and TCA in place (or a current EPC plan, item 720 or 722) or a GP contribution to a care plan prepared by a residential aged care facility (item 730). Patients are then eligible to claim a maximum of five allied health, and three dental care services in a 12 month period.

Service Incentive Payments

The new CDM item numbers do not significantly alter access to, and usage of, the Service Incentive Payments (SIPs), however commonsense should be used. For example, a patient with diabetes may have the details of care recorded in a GPMP. The GP could also claim a

diabetes SIP as an incentive for the provision of best practice should the annual cycle of care be completed over the previous 12 months (see *Case study 2*). However, a review of GPMP and the SIP should not be claimed within 3 months for the patient as the services overlap (*Table 2*).

In contrast, both the asthma and mental health SIPs and GPMP involve assessment, planning and review, therefore a GP must choose which service to use (unless the patient has another coexisting chronic condition). Both a GPMP and SIP for asthma and mental health conditions should not be used within the same 12 months (*Table 2*).

Role of practice nurses and Aboriginal health workers

Establishing a system within the practice is important and checklists and templates are available to streamline the process. Unlike the previous EPC Medicare item numbers, the role of the practice nurse or Aboriginal health worker in the preparation of both a GPMP and a TCA is now clearer and more inclusive, depending on internal practice arrangements and individual competencies. While the GP must see the patient and confirm all assessments and

Case study 2 – GP management plan (item 721) and diabetes SIP

George, 69 years of age, has type 2 diabetes, hypertension and high cholesterol. He recently moved to the area. George tells the GP that after years of good control of his diabetes, his weight has increased over the past 6 months (BMI now 29) and he has recently been hospitalised for an episode of cellulitis affecting his left leg. His most recent HBA1c was 7.2. The GP discusses with George the benefits of a GP management plan and begins the process. The problems identified with the patient are type 2 diabetes requiring improved metabolic control, overweight and an increase in risk factors for CVD. The goals of the GPMP are weight reduction, better monitoring of blood sugar and an increase in physical activity. The GP also arranges for George to see a diabetes educator at the local hospital. George attends for regular follow up, including a review of the GPMP at 6 months. Having completed an annual diabetes cycle of care at 12 months, the GP then claims the diabetes SIP.

Table 2. Access to CDM item numbers and SIPs for asthma, diabetes and mental health conditions

Patient	CDM and SIP items	Diabetes	Asthma	Mental health conditions
Patient with chronic condition (not requiring team based care)	GPMP	✓	✓ (1)	✓ (1)
	GPMP review	✓	✓	✓
	SIP	✓	✓ (2)	✓ (2)
	SIP with GPMP	✓	Usually not (2)	Usually not (2)
	SIP with GPMP review (3)	Not both at same time	Not both at same time	Not both at same time
Patient with chronic condition and complex needs (requiring team based care)	GPMP with TCA	✓	✓	✓
	GPMP or TCA review	Either, as appropriate	Either, as appropriate	Either, as appropriate
	GPMP and TCA plus SIP	✓	✓	✓
	SIP plus GPMP or TCA Reviews (3)	Not both at same time	Not both at same time	Not both at same time

Notes: 1) The GPMP item should not be claimed within 12 months of an asthma or mental health SIP, other than in exceptional circumstances (eg. where the patient has/develops a separate chronic condition); 2) The asthma and mental health SIPs should not be claimed within 12 months of a GPMP, unless clinically indicated that a SIP is required, as opposed to ongoing management under the GPMP and review items, and normal consultation items; 3) The SIP item and the CDM/TCA review items should not be claimed within 3 months of each other

Source: Australian Government Department of Health and Ageing

arrangements, the practice nurse could assess the patient, assist with preparing a GPMP, identify the patient's needs, facilitate communication between the GP and other health providers, discuss costs with the patient, and provide patient education and self management information.

Conclusion

The CDM item numbers represent an opportunity to improve chronic disease management through general practice and offer eligible patients access to allied health services. They also provide a system to remunerate GPs for the time and effort required to plan and coordinate care of patients with a chronic illness.

The GPMP and TCA have been well received by GPs, but it remains to be seen whether they will overcome the difficulties experienced with EPC multidisciplinary care plans. Their impact on the quality of care provided and longer term health outcomes for patients with chronic illness will also need to be evaluated.

Resources

Contact your local division of general practice for assistance. A comprehensive list of notes, descriptors and electronic templates can be found at the following websites:

- Department of Health and Ageing www.health.gov.au/chronicdisease
- ADGP www.adgp.com.au

Conflict of interest: none declared.

References

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