Appendix B. Structured patient-centred care plan – Example of a General practice management plan and Patient care plan

[Insert practice letterhead]

General practice management plan (GPMP) (MBS item number 721 – Diabetes)	
Patient name:	Date of birth:
[Full name]	[Date of birth]
Contact:	Medicare or private health insurance:
[Address]	[Medicare number]
[Telephone]	[Private health insurance number]
Date of last GPMP (if done): [Date]	

This diabetes care plan was developed by staff at the [insert practice name]. While it specifically relates to the management of your diabetes, your other health problems will also be considered. This care plan uses the skills of many health professionals to help you to have the best of healthcare and for you to manage your diabetes.

This plan focuses on proven therapies that, with support and care, may help prevent complications. Diabetes is best treated early and some difficulties of management can occur when complications arise. The management goals in this plan are set by national diabetes expert bodies. Your diabetes will be monitored against these goals.

This plan encourages you to be actively involved in your care. It is important that you and your healthcare team monitor your diabetes and report anything that is untoward.

We particularly urge you to report any chest pains, unexplained weakness, foot problems, visual changes, or any symptom that concerns you. Report if you feel that you cannot cope or manage, and if you feel distressed or sad by living with your illness.

Emergency contact at [insert practice name] for diabetes – [name] [contact number]

This document should be brought along with you to each visit to the dietitian, diabetes educator, practice nurse, other health professional and to the doctor when your review is due.

Management plan outcomes

Patient needs	• To become educated regarding diabetes • To understand the role of diabetes 'goals' – glucose management, minimising heart risks and individually appropriate preventive activities • To appropriately manage medication for diabetes and other supportive therapies • [Insert individual patient needs]
Management goals	• To lead a happy, healthy lifestyle • To progress toward/achieve recognised goals for diabetes care • To prevent onset or progression of cadiovasular disease or its complications • To remain free of serious side effects from medication • To minimise the burden of diabetes management and care • To overcome barriers to self management including psychological and social factors
Treatment services	• To participate in structured care system at the [insert practice name] • To involve other health service providers • To provide holistic, person-centred care • [Insert individualised patient treatment services] to assist in provision of services
Patient actions	• To undertake appropriate lifestyle measures if needed (eg quit smoking, regular exercise, dietary changes) • To participate in this management plan and be aware of the impact of illness • To become educated regarding diabetes • [Insert individualised patient actions]
Monitoring and review	• The first review will usually be at one to four weeks – to monitor impact of any initial or ongoing therapy medication and other strategies • Every three to six months a major review of the management plan goals will occur • Thereafter, reviews will depend on response to therapy and complexity of all health issues • A recall will be instituted at least every three months to monitor progress
Review date	• [Insert review date]

Past medical history

Family history
[Clinical details of family history]
Medications
[Clinical details – medication list]
Allergies
[Allergy details]
Social history
Alcohol intake
Cigarette smoking history

Patient name: [Full name]

GPMP (MBS Item 721, Diabetes)			
Patient problems/ needs/relevant conditions	**Goals – changes to be achieved**	**Required treatments and services including patient actions**	**Arrangements for treatments/services (when, who, contact details)**
1. General			
Patient's understanding of diabetes and self-management	Patient to have a clear understanding of diabetes and their role in managing the condition	Patient education	GP/nurse/diabetes educator
	Patient to understand the psychological and social impact of living with type 2 diabetes	Patient education	GP/nurse/ diabetes educator/ psychologist
	Patient to understand the role of self-monitoring of glucose (SMBG) if this is required	Patient education	GP/nurse/diabetes educator

GPMP (MBS Item 721, Diabetes)			
Patient problems/ needs/relevant conditions	**Goals – changes to be achieved**	**Required treatments and services including patient actions**	**Arrangements for treatments/services (when, who, contact details)**
2. Lifestyle			
Nutrition	Eating according to *Australian dietary guidelines* (www.nhmrc.gov.au/guidelines-publications/n55) with attention to quantity and type of food If concerns regarding cardiovascular disease risk, advise dietary review	Patient education OR As per Lifescripts action plan	GP to monitor Accredited Practising Dietitian (APD)
Weight/body mass index (BMI)	Your target: [insert patient target] kg/m^2 Therapeutic goal is 5–10% loss for people who are overweight and obese with type 2 diabetes With BMI >35 kg/m^2 and comorbidities or BMI >40 kg/m^2, greater weight loss measures should be considered	Monitor Review six monthly OR As per Lifescripts action plan	Patient to monitor GP/nurse to review APD when appropriate BMI >35 kg/m^2 – consider specialist referral and bariatric options
Physical activity	Your target: [insert patient target] minutes/week At least 30 minutes of moderate physical activity on most if not all days of the week (total ≥150 minutes/week)	Patient exercise routine OR As per Lifescripts action plan	GP/Accredited Exercise Physiologist (AEP) Patient to implement
Smoking	Complete cessation	Smoking cessation strategy: • Consider: – quit – medication OR • As per Lifescripts action plan	Patient to manage GP to monitor

GPMP (MBS Item 721, Diabetes)			
Patient problems/ needs/relevant conditions	**Goals – changes to be achieved**	**Required treatments and services including patient actions**	**Arrangements for treatments/services (when, who, contact details)**
Alcohol intake	Your target: <[insert patient target] standard drinks/day Healthy: ≤2 standard drinks/day (adults)	Reduce alcohol intake Patient education OR As per Lifescripts action plan	Patient to manage GP to monitor
3. Biomedical			
Cardiovascular disease risk calculation			
Cholesterol/lipids Blood pressure (BP)	Cholesterol level to accepted national target BP to accepted national target	Initiation of pharmacotherapy is dependent on the assessment of absolute cardiovascular disease risk (Australian absolute CVD risk calculator) This requires using multiple risk factors, which is considered to be more accurate than the use of individual parameters Once therapy is initiated, the specified targets apply; however, these targets are somewhat arbitrary and should be used as a guide to treatment, and not as a mandatory requirement Check every six months	GP GP/nurse

GPMP (MBS Item 721, Diabetes)			
Patient problems/ needs/relevant conditions	**Goals – changes to be achieved**	**Required treatments and services including patient actions**	**Arrangements for treatments/services (when, who, contact details)**
Glycated haemoglobin (HbA1c)	Your target: <[insert patient target] mmol/mol Healthy: ≤53 mmol/mol (range 48–58 mmol/mol) ≤7% (range 6.5–7.5%)	Needs individualisation according to patient circumstances Check every there to six months or as advised by your GP	GP/nurse
Blood glucose level	Advise 6–8 mmol/L fasting and 8–10 mmol/L postprandial Ongoing self-monitoring of blood glucose is recommended for people with diabetes using insulin, people using sulphonylureas or other medicines that may cause hypoglycaemia, hyperglycaemia arising from illness, with haemoglobinopathies, pregnancy or other conditions where data on glycaemic patterns is required Routine self-monitoring of blood glucose in low-risk patients who are using oral glucose-lowering drugs (with the exception of sulphonylureas) is not recommended	Monitoring is dependent on individual circumstances	Patient/GP/nurse Diabetes educator when required
4. Medication			
Medication review	Targeted and careful use of medications to maximise benefit and minimise side effects	Patient education Review medications	GP/Credentialled Diabetes Educator (CDE) to review and provide education Pharmacist when required/home medicines review
Vaccinations	Influenza Pneumococcal and diphtheria-tetanus-acellular pertussis (dTpa) vaccine	Annually At appropriate intervals	GP/nurse
5. Complications of diabetes			

GPMP (MBS Item 721, Diabetes)			
Patient problems/ needs/relevant conditions	**Goals – changes to be achieved**	**Required treatments and services including patient actions**	**Arrangements for treatments/services (when, who, contact details)**
Eye complications	Early detection of any problems	Eye check every two years Retinal photography or referral by GP	GP/optometrist/ ophthalmologist
Foot complications	Optimal foot care and avoidance of ulceration and amputation by: • patient education on foot care and self-check • professional check feet every six months • early detection and management of complications	Stratify the risk of developing foot complications: • low/intermediate/ high risk • the intensity of monitoring and review increases according to level of risk	GP/podiatrist/nurse Patient GP referral to specialist foot clinic if high risks detected
Kidney damage	Avoid kidney complications urine albumin-to-creatinine ratio (UACR): <3.5 mg/mmol women <2.5 mg/mmol men	Test for microalbuminuria annually	GP
Sexual dysfunction	Maintain sexual function	To be discussed with patient where applicable	GP
6. Psychosocial/psychological			
Mood and distress from diabetes	Minimise distress and depression Minimise social isolation, support positive advocacy against social stigma		GP/nurse Psychologist when required
Licence assessment	Maintain safe driving to road authority standards		GP/nurse/ endocrinologist/ specialist
7. Register with National Diabetes Services Scheme (NDSS)			
	Provide access to best practice consumer resources to support self-management	Provision of self-management information and consumer support and advocacy	GP/nurse/ CDE Diabetes Australia

Patient monitoring

Measurements	Target		Progress
Glycated haemoglobin (HbA1c): This is a measure of how well your blood glucose has been controlled over the last three months	48–58 mmol/mol or 6.5–7.5% Individualised, as low as reasonably possible without side effects		
Cardiovascular disease (CVD) risk assessment: This is your risk of having a heart attack or stroke in the next five years			
Systolic blood pressure (SBP): The highest reading in blood perssure (BP), is more closely related to poor outcomes.	<130–140	Initiation of drug therapy depends on the assessment of absolute CVD risk Targets should be used as a guide to treatment, and not as a mandatory requirement	
Low-density lipoprotein-cholesterol (LDL-C): This is the 'bad' cholesterol implicated in causing CVD	<2.0		
High-density lipoprotein-cholesterol (HDL-C): This is the 'good' cholesterol associated with protection against CVD	≥1.0		
Triglycerides	<2.0		
Renal function: Estimated glomerular filtration rate (eGFR) is an indicator of overall kidney function Microalbuminuria Microalbuminuria is a sign of kidney stress. Identification at an early stage can prevent kidney problems and/or progression to kidney failure	eGFR Reduce albuminuria by decreasing BP and blood glucose levels		
Foot examination: To identify potential and active foot problems (eg presence of ulcers, infection, corns, calluses, fissures)	Foot risk = low/intermediate/high Today's examination		

Vision: This is to aid detection of early cataract formation Ophthalmology review – to detect small vessel changes in your eyes	Visual care Full eye review every two years					

Copy of GPMP offered to patient? [_____]

Copy/relevant parts of the GPMP supplied to other providers? [_____]

GPMP added to the patient's records? [_____]

Date service completed: [_____]

Proposed review date: [_____]

I have explained the steps and costs involved, and the patient has agreed to proceed with the service. [Steps and costs explained, patient agreed]

GP signature:_____ Date: _____