How the new CDM items work for patients

A. Patient with a chronic medical condition (eg diabetes)

1. Mrs Smith is returning to see her usual GP (Dr Jones) after being tested for Diabetes. At the consultation Dr Jones confirms that she has diabetes.

2. Dr Jones suggests Mrs Smith would benefit from a GP Management Plan, as this will outline all the necessary activities that need to be done by both himself and Mrs Smith to ensure she gets the best treatment and management of her Diabetes. He explains what this would involve.

3. After her agreement, her doctor immediately begins the process for a **GP Management Plan.**
   - since Mrs Smith has been seeing Dr Jones for some time, he has a detailed record including past history, social and family history, and is able to quickly complete a thorough assessment of Mrs Smith's needs. If Dr Jones was less familiar with Mrs Smith's history, he might ask his practice nurse to undertake this assessment, which he would then review and confirm with Mrs Smith.
   - they agree that the management goal is to control her diabetes, and this will be measured through a regular blood test done by herself at home and usually with 3 monthly tests done at the pathology laboratory.
   - they discuss the need for her to control her diet, exercise more regularly and monitor her blood sugar level. While Mrs Smith is happy to test her own blood sugar she is unfamiliar with how the testing is done.
   - they agree she should visit a diabetes educator to learn about managing her diabetes, monitoring her sugars and how best to control her diabetes.
   - they agree that they will review the management plan in six months.
   - Dr Jones has used his medical software to document these needs, goals, patient actions, treatment/services and review date, thus completing the GP Management Plan. He prints out a copy for Mrs Smith and either bulk bills or invoices her for the service.
   - If he bulk bills and Mrs Smith has a health care concession card, Dr Jones also claims the relevant bulk billing incentive payment. If the service is not bulk-billed, Mrs Smith goes to the Medicare office and receives **$120**, the rebate for the GP Management Plan.

4. Mrs Smith's diabetes is managed normally through her **usual visits** to the doctor (billed as a normal attendance) and further regular reviews of progress against the GP Management Plan (billed against the item for **review of GP Management Plan**, rebate **$60**).

5. After six months, Dr Jones and Mrs Smith review the Management Plan and the impact it has had on control of her diabetes. They agree that the visit to the diabetes educator had been worthwhile but that ongoing support through Diabetes Australia is probably sufficient now. Dr Jones also provides a referral for an ophthalmological review. They also discuss possible future needs:
   – if Mrs Smith's condition changes dramatically before the six months (eg if she is hospitalised for a related reason), Dr Jones might decide to develop a new GP Management Plan.
   – if Mrs Smith's diabetes becomes poorly controlled and she develops complications from it, Dr Jones might consider undertaking **Team Care Arrangements** (see example B below).

B. Patient with a chronic medical condition and complex care needs (eg poorly controlled diabetes)

1. Ms Pappas visits her GP (Dr Jones). At that consultation, Dr Jones confirms that she has diabetes. He also identifies the fact that Ms Pappas' diabetes has gone undetected for some time and she has complications as a result - leg ulcers and numbness from poor circulation. Ms Pappas is 74 and frail, living alone at home, and therefore at risk of falls.

2. After obtaining her agreement, Dr Jones develops a **GP Management Plan** for Ms Pappas in the same way as for Mrs Smith, but he also suggests to Ms Pappas that it would be more effective if he also works with other health providers to manage her diabetes and complications.

3. Dr Jones explains what developing Team Care Arrangements involves and asks if she is happy for other providers to be involved. She agrees, and he initiates the **Team Care Arrangements** service immediately.
   - they agree that a podiatrist and diabetes educator in the local area will be asked to collaborate with Dr Jones in helping her. Ms Pappas agrees to Dr Jones providing them with relevant information.
   - Dr Jones bills Ms Pappas for the GP Management Plan or bulk bills for the service (he has not yet finished the Team Care Arrangements).
   - Before her next visit, Dr Jones asks the practice nurse to send the podiatrist and diabetes educator Ms Pappas' GP Management Plan and discuss with them what services Ms Pappas might need.
   - Dr Jones reviews this information, emails the podiatrist and calls the diabetes educator to confirm the services they will give Ms Pappas, and then includes the agreed arrangements in a Team Care Arrangements document, which can be attached to her GP Management Plan.

4. Ms Pappas visits her GP the next week, as arranged. Dr Jones explains the Team Care Arrangements to Mrs Pappas and gives her a copy of the document and allied health referrals for the podiatrist and for the diabetes educator. Dr Jones decides to bulk bill the Team Care Arrangements item for Ms Pappas (rebate **$95**). Later, she makes an appointment to see the podiatrist.

5. **Allied health services: At the podiatrist**, Ms Pappas gets her feet checked, advice about the right shoes to wear, and advice about how to monitor the condition of her feet herself.
   - The podiatrist completes the referral form and provides it and an invoice for the relevant Medicare item to Mrs Pappas, and emails a report on the service to Dr Jones.
   - Ms Pappas goes to the Medicare office and receives the rebate for an **allied health service ($44.95)**.
   - Ms Pappas can receive up to 5 allied health services per year as a result of having her condition managed via a GP Management Plan and Team Care Arrangements, so long as Dr Jones completes a referral for the allied health provider. If Ms Pappas had dental problems directly related to that condition, she may also be eligible for up to 3 **dental services** per year.

6. Just as for Mrs Smith, Ms Pappas' diabetes is managed normally through her **usual visits** to the doctor and regular **reviews of progress against the GP Management Plan and (if necessary) the Team Care Arrangements** (rebate $60 for each). If Ms Pappas' condition changes dramatically before the six months (eg if she is hospitalised for a related reason), Dr Jones might decide to develop a new GP Management Plan and/or Team Care Arrangements.