

**COMPARATIVE TABLE: ENHANCED PRIMARY CARE (EPC)
MULTIDISCIPLINARY CARE PLANNING ITEMS Vs CHRONIC DISEASE MANAGEMENT ITEMS**

The table below compares key elements of the Enhanced Primary Care (EPC) Multidisciplinary Care Planning items (to be phased out by November 2005) against the new Chronic Disease Management (CDM) items (introduced on 1 July 2005). The information is summarised for illustration purposes only and should not be used for providing care planning services. Clinicians should refer to the relevant Medicare items, descriptors and explanatory notes.

Medicare items under Enhanced Primary Care	EPC Multidisciplinary Care Planning Items	Chronic Disease Management (CDM) Items
Eligibility	<p>Medicare items for EPC Multidisciplinary Care Planning to be withdrawn on 1 November 2005:</p> <ul style="list-style-type: none"> • 720 – Preparation of a care plan by a GP. • 722 – Preparation of a discharge care plan by a GP. • 724 – Review of a care plan by a GP. • 726 – Contribution by a GP to a plan or review by another provider. • 728 - Contribution by a GP to a discharge plan or review by another provider. • 730 - Contribution by a GP to a plan or review by another provider for residents of aged care facilities. 	<p>Medicare items for Chronic Disease Management introduced on 1 July 2005:</p> <ul style="list-style-type: none"> • 721 - Preparation of a GP Management Plan by a GP (including on discharge for private patients). • 723 - Coordination of Team Care Arrangements by a GP (including on discharge for private patients). • 725 - Review of a GP Management Plan by a GP. • 727 - Coordination of a review of Team Care Arrangements by a GP. • 729 - Contribution by a GP to a plan or review prepared by another provider (including on discharge). • 731 - Contribution by a GP to a plan or review by another provider for residents of aged care facilities (including on discharge).
Service delivery	<ul style="list-style-type: none"> • Mandatory for GPs to collaborate with other care providers in preparing and reviewing multidisciplinary care plans. 	<ul style="list-style-type: none"> • GPs can now provide a GP Management Plan to patients with chronic or terminal conditions, without needing to collaborate with other care providers. • GPs can still collaborate with other providers if the patient has complex multidisciplinary care needs and would benefit from Team Care Arrangements.

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Frequency of services	<ul style="list-style-type: none"> Permitted claiming frequency is dependent on the service being provided but is fixed. 	<ul style="list-style-type: none"> Minimum time limits apply, but CDM services can also be provided more frequently in 'exceptional circumstances' - where there has been a significant change in the patient's clinical condition or care.
GP assistance	<ul style="list-style-type: none"> GPs required to perform all tasks without assistance from other clinicians in the practice (eg Practice Nurse). Plans had to be coordinated and reviewed by the same GP (patient's usual GP). 	<ul style="list-style-type: none"> GPs can now be assisted by their Practice Nurse, Aboriginal Health Worker or other health professional. Plans can now be reviewed by the same GP, a GP from the same practice or, in the event that the patient has moved practices, by a GP from the new practice.
Reviews	<ul style="list-style-type: none"> GPs could only review patient's progress using multidisciplinary review item, requiring collaboration with team 	<ul style="list-style-type: none"> GPs can choose most appropriate review item for circumstances of patient – GP review if reviewing alone; Team Care review if reviewing with team input.
Access to allied health and dental care services (MBS Items 10950 – 10977)	<ul style="list-style-type: none"> Patients must have a multidisciplinary care plan or, in the case of aged care residents, the GP must have contributed to the resident's multidisciplinary care plan. 	<ul style="list-style-type: none"> Patients can access MBS items 10950 – 10977 after their GP has completed their GP Management Plan <u>and</u> Team Care Arrangements or, after the GP has completed their contribution to an aged care resident's care plan. Access also retained for patients who have an EPC multidisciplinary care plan.
Residents in aged care facilities	<ul style="list-style-type: none"> GPs only able to contribute to a care plan prepared by the aged care facility. 	<ul style="list-style-type: none"> GPs can contribute to aged care facility care plans and also contribute to multidisciplinary discharge care plans for aged care residents (public or private patients) being discharged from hospital. GPs can prepare GP Management Plans or coordinate Team Care Arrangements for aged care residents being discharged as private patients from hospital.
Methods of collaboration with other providers.	<ul style="list-style-type: none"> Collaboration with other providers can be face to face, in writing, by fax, phone, videoconference or email. 	<ul style="list-style-type: none"> Collaboration with other providers for Team Care Arrangement items can be face to face, in writing, by fax, phone, videoconference or email.