

New Chronic Disease Management (CDM) Items Questions and Answers

What are the new CDM items?

They are new care planning items which replace the existing EPC multidisciplinary care planning items. They apply to a wider range of patients and make it easier for GPs to manage the care of patients with chronic medical conditions, including patients needing multidisciplinary care.

These new Medicare items have been developed in consultation with GP representatives. They are a significant response to the findings of the Red Tape Taskforce review of the EPC items and have been welcomed by GP organisations.

How are the new CDM items different from the EPC care planning items?

GPs will be able to choose between items for GP care planning or team-assisted care planning (or use both), depending on the needs of their patients.

GPs will be able to use their practice nurse, Aboriginal Health Worker or other health professional to assist them in chronic disease management using the new items.

Patients with a chronic or terminal condition without multidisciplinary care needs will be eligible for the GP Management Plan items able to be provided by their GP.

Patients with a chronic or terminal condition **and** complex care needs will be eligible for both the GP Management Plan items and the add-on Team Care Arrangements items (provided by the GP in collaboration with at least two other providers). This maintains access to the allied health and dental care items introduced in July 2004 as one of the Government's measures to strengthen Medicare.

Restrictions on who can review a care plan have been relaxed, so that a GP Management Plan can be reviewed by a GP from the same practice or, if the patient has changed practices, their new GP.

While time limits on services have been specified, GPs can provide care planning or review services within these minimum time limits if there have been significant changes in the patient's condition or care circumstances.

Are GP Management Plans available to more patients than the current EPC multidisciplinary care plans?

Yes. GP Management Plans are available to all patients with a chronic medical condition – they do not need to have complex care needs (as required for the current EPC care planning items).

Patients with chronic conditions and complex needs are eligible for GP Management Plans and the additional Team Care Arrangements item.

What are the new items and fees for the CDM services?

Patients with a chronic or terminal medical condition are eligible for a GP Management Plan item. Patients who also have complex needs requiring care from a

New Chronic Disease Management (CDM) Items Questions and Answers

multidisciplinary team are eligible for a Team Care Arrangements item. For these patients, a GP Management Plan and Team Care Arrangements, together, broadly equate to an EPC multidisciplinary plan.

The Medicare fees for the new items have been settled in consultation with GP organisations and have their unanimous agreement.

| Name | Item No | Medicare Fee (100%) | Recommended frequency | Minimum Claiming Period* |
|---|---------|---------------------|-----------------------|--------------------------|
| Preparation of a GP Management Plan | 721 | \$120 | 2 yearly | 12 months* |
| Preparation of Team Care Arrangements | 723 | \$95 | 2 yearly | 12 months* |
| Review of a GP Management Plan | 725 | \$60 | 6 monthly | 3 months* |
| Coordination of Review of Team Care Arrangements | 727 | \$60 | 6 monthly | 3 months* |
| Contribution to a multidisciplinary care plan or Team Care Arrangements | 729 | \$41.65 | 6 monthly | 3 months* |
| Contribution to a multidisciplinary care plan by an Aged Care Facility | 731 | \$41.65 | 6 monthly | 3 months* |

**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 circumstances (such as development of co-morbidities or complications, deteriorating condition, illness/death of carer etc), that require a new GP Management Plan, Team Care Arrangements or review service.*

Are the new CDM items eligible for 100% Medicare and bulk billing incentives?

Yes, the new items attract a rebate at 100% of the MBS schedule fee (except where the patient has been admitted to a hospital and the service is provided in the hospital).

Where CDM services are bulk-billed for eligible patients (ie Commonwealth concession card holders or children aged under 16), the services also attract the relevant bulk-billing incentive payment.

When do the new CDM items begin?

The items will be available from July 2005, subject to formal approval processes for new Medicare items.

How do these changes affect access by patients to allied health and dental care items?

New Chronic Disease Management (CDM) Items Questions and Answers

Access to allied health and dental care items (Medicare Items 10950 to 10977) will be available to patients who have both a GP Management Plan and Team Care Arrangements in place. A GP Management Plan and Team Care Arrangements together broadly equate to an EPC multidisciplinary care plan.

Similarly, residents of aged care homes whose GP has contributed to a care plan prepared by the aged care home (item 730 or new item 731) will continue to have access to the allied health and dental care items.

This maintains current access arrangements whereby Medicare rebates for certain allied health and dental care services will continue to be targeted to patients with multidisciplinary care needs. No other changes have been made to the Medicare requirements for the allied health and dental care items.

What are the steps in the GP Management Plan Service (Item 721)?

Preparing a GPMP includes:

- assessing the patient to identify and/or confirm their health care needs, problems and relevant conditions;
- agreeing management goals with the patient for the changes to be achieved by the treatment and services identified in the plan;
- identifying any actions to be taken by the patient;
- identifying treatment and services that the patient is likely to need, and making arrangements for provision of these services and ongoing management; and
- documenting the patient's needs, goals, patient actions, treatment/services and a review date i.e. completing the GPMP document.

The patient's progress against the plan should be periodically reviewed using the GP Management Plan Review items, and ongoing management and care provided through normal consultation items.

What are the steps in the Team Care Arrangements Service?

Coordinating TCA for a patient includes:

- identifying and confirming with the patient which other treatment or service providers will be involved in completing the TCA and what information can be shared with them;
- collaborating with the participating providers to discuss potential treatment/services they will provide to achieve management goals for the patient; and
- documenting the goals, the collaborating providers, the treatment/services they have agreed to provide, patient actions and a review date i.e. completing the TCA document.

The patient's progress against the GPMP and TCA should be periodically reviewed using either the GP Management Plan or TCA Review items as appropriate, and ongoing management and care provided through normal consultation items.

What does collaboration with the other health and care providers mean when developing Team Care Arrangements?

New Chronic Disease Management (CDM) Items Questions and Answers

Collaboration means communicating with the other providers to discuss potential treatment or services they will provide. Communication must be two-way - preferably oral communication, or, if not practicable, communication in writing (including by exchange of faxes or email). It should relate to the specific needs and circumstances of the patient. The communication from the collaborating providers must include advice on treatment and management of the patient.

It is not necessary to ‘case-conference’ with the collaborating providers (ie talk with all of the providers at the same time).

When is it appropriate to coordinate Team Care Arrangements for a patient?

Team Care Arrangements are designed for patients with complex health and care needs, who are seeing or need to see at least three health or care providers (including their GP) and who need team-based care.

Team Care Arrangements are likely to be indicated where a patient has complex health care needs and one or more of the following:

- little or no capacity to access or receive needed services by the usual referral process
- an unstable or deteriorating condition and/or co-morbidities;
- increasing frailty and/or dependence;
- increasing incidence and/or complexity of health problems;
- complications, including falls or incontinence;
- significant change in social circumstances (eg death, illness or ‘burnout’ of carer);
- two or more hospital admissions for their chronic condition in the past six months;
- inability to comply with required treatment without ongoing management and coordination; and/or
- a need to see other providers on regular, frequent and ongoing basis to manage the chronic condition (as distinct from one or two visits for one specific treatment).

How can practice nurses, Aboriginal Health Workers and other health professionals assist with CDM items?

A practice nurse, Aboriginal Health Worker or other health professional can assist a GP in preparing or reviewing a GPMP or TCA, for example, in assessing the patient, identifying the patient’s needs and making arrangements for services. This assistance is provided on behalf of the GP, not as part of a separate Medicare item. The GP must review and confirm all assessments and elements of the service and must see the patient as part of the service.

While it is not mandatory for a practice nurse or other health professional to assist a GP with these services, the new items should help free up GPs’ time by encouraging an expanded role in EPC care planning for practice nurses/other health professionals. The new items give maximum flexibility to the GP in deciding how best to use their practice nurse/other health professional to assist in chronic disease management.

What are the benefits of care planning?

New Chronic Disease Management (CDM) Items Questions and Answers

Care planning helps in coordinating the services and treatment that a patient requires. It can be used as a tool for organising all of the care a patient needs and can help reduce the need for ad hoc, episodic consultations. It both enables and legitimises GPs in taking a proactive role managing the health care required by their patients, including through regular reviews.

A care plan is a useful mechanism for recording comprehensive, accurate and up to date information about the patient's condition and all of the treatment they are receiving. Development of a care plan can also help encourage the patient to take some responsibility for their care, including by identifying any actions the patient might take to help achieve the goals of treatment.

New research (see recent report in *Medical Observer*, 20 May 2005) has showed that care plans have a positive impact on patient care and outcomes. Research conducted by the Centre for General Practice Integration Studies, University of NSW, found more patients were managed in line with national diabetes care guidelines in the year following a care plan. It also found there was a significant improvement in HbA1c, blood pressure and total cholesterol levels where a care plan was implemented and where there were at least two other providers involved in the patient's care.

What happens to the existing EPC care planning items?

The new CDM items replace the existing EPC items for multidisciplinary care planning services – items 720, 722, 724, 726, 728 and 730, which will cease to be available from 1 November 2005. GPs should use the new items when preparing, reviewing or contributing to chronic disease management plans from July 2005.

Where patients have existing care plans it is not necessary to prepare a new chronic disease management plan using the new items until required by the patient's circumstances.

What about patients who already have an EPC multidisciplinary care plan in place?

Their care plans remain in place. They continue to have access to the allied health and dental items. Where patients have existing care plans it is not necessary to prepare a new chronic disease management plan using the new items until required by the patient's circumstances.

A GP who proposes to review an existing EPC multidisciplinary care plan can use either a GP Management Plan Review item, item 725 (for review by a GP without team input) or a Team Care Arrangements review item, item, 727 (for review with input from a multidisciplinary team).

What about EPC multidisciplinary care planning services that have been started before July 2005 but not completed?

If an EPC care planning service of any sort was commenced before July 2005, but not completed and claimed by that date, the service should be completed and claimed for using the relevant pre July EPC item number (up to 1 November 2005).

New Chronic Disease Management (CDM) Items Questions and Answers

Will the current Service Incentives Payments (SIP) under the Practice Incentives Program (PIP) continue?

Current SIP payments for best practice care of patients with asthma, diabetes or mental health will continue to be available. The new CDM items offer an additional and alternative funding mechanism to the SIPs for providing best practice care of patients with chronic conditions, including patients with asthma, diabetes and mental health conditions.

As the new CDM items bed down over the next few years, their impact on management of chronic disease will be assessed, including on the continued need for separate disease specific items. Any change to the current SIP items as a result would be considered in consultation with GPs and other key chronic disease stakeholders.

How can patients with asthma, diabetes or mental health benefit from the new items?

Patients with these or other chronic medical conditions are eligible for a GP Management Plan and review items. A GP Management Plan includes an assessment of the patient and the development of a written/printed plan and can be undertaken in one consultation. Progress against the GP Management Plan can be assessed through regular reviews.

This is a simple model of care that is easy to use for both GP and patient. The CDM items will be available across all general practice, not restricted to practices participating in the PIP that have signed up for the SIPs.

Patients who also have complex needs requiring team-based care are eligible for Team Care Arrangements, where the GP collaborates with the other providers to identify the treatment and services to be provided to the patient. Progress can be assessed through regular reviews, with the GP able to choose between GP or team-based reviews, depending on the patient's needs.

As Medicare items, incentives for chronic disease management using the new items are built directly into the Medicare fee, are transparent to the patient, and are paid 'up-front' as part of the Medicare system.

Can I use the new CDM items and also claim a Service Incentive Payment (SIP) for the same patient?

The SIPs for asthma and mental health incorporate the development of a plan to help the patient manage their condition. It would not be appropriate to claim both the SIP and an item for preparation of a GP Management Plan for the same patient – GPs should choose which of these two services to provide and claim only one.

Patients with diabetes may benefit from a GP Management Plan. They are likely to also benefit from the best practice annual cycle of care for patients with diabetes (as set out in the guidelines distributed to GPs under the National Integrated Diabetes Program). When completing the annual cycle of care GPs should choose to use either

New Chronic Disease Management (CDM) Items Questions and Answers

the relevant diabetes SIP 'trigger' item, or the GP Management Plan review item, but not both.

Where a patient has complex, multidisciplinary needs that extend beyond the management of their asthma, diabetes or mental health condition as part of the three step process or cycle of care, it may be appropriate to develop a GP Management Plan and a Team Care Arrangements for the patient. In this case, these items can be claimed in addition to the relevant SIP, provided the requirements of both services are met.

Will the CDM items be reviewed?

Yes, there will be a review of the items after an initial period of operation (2 years), and a full evaluation after around 4 years. The initial review will include assessing links between the CDM items and the allied health items, and the SIPs.

What information will be available to help GPs with the new items?

Copies of the Medicare item descriptors, explanatory notes and a fact sheet are available on the Department's web site at www.health.gov.au (and use the A-Z Index tool to go to Chronic Disease Management). GPs can also contact the Department of Health and Ageing for these materials on (02) 6289 8735. Questions about the new items can be sent to epc.items@health.gov.au

Additional information on the new items will be available before the items commence in July 2005, including Q&A's, checklists and forms that can be adapted for use by GPs. Medical software providers have been notified of the changes and encouraged to consider incorporating the new items into GP medical software products. Other information and support initiatives are being developed.