Care Plans. What is a Care Plan? How can it help?

A care plan refers to a General Practitioner Management Plan (GPMP) or a Team Care arrangement (TCA). Both types of care plans are used by GP's to help manage patients living with Chronic diseases, complex medical needs and/or terminal illnesses.

Am I eligible for a Care Plan?

Patients who have at least one chronic medical condition, or complex medical care needs, are eligible for a care plan.

A chronic medical condition is broadly defined as an illness or disability that is present for at last six months.

There is no concrete eligibility criteria for a care plan. The decision plan is based upon whether it will benefit your medical management, and is a shared decision made by you and your doctor.

Examples of common conditions that require care plans

- Heart disease
- Asthma
- Chronic Obstructive pulmonary disease
- Diabetes
- Cancer
- Stroke
- Arthritis
- Kidney disease
- Mental ill-health

Patients who are either in-patient in a public hospital or are already on a care plan package due to living in a residential aged care facility are not eligible.

What are the benefits of a Care Plans

Organised, structured and planned approach to your healthcare

Active participation of patients in their own healthcare

Ease of coordination between your GP, your specialist, and any allied health providers.

Building rapport between patients and their GP's

Who makes a Care Plan for me?

A care plan will be made by usual medical practitioner. This is the doctor who you have seen most often within the past 12months, and who will be the doctor you are going to see most in the following 12 months, and who will be the doctor you are going to see most in the following 12 months, to manage your health.

For the majority of patients, this is their GP.

What is the difference between a General Practitioner Management Plan and Team Care Arrangement?

A general Practitioner Management Plan (GPMP) sets out a plan of action to manage your medical condition. The plan is agreed upon by you and your GP, giving you an active role in your healthcare. A GPMP will include:

- Your diagnosed medical condition (s), and any other relevant health information, such as prescribed medications
- The goals of your management, as agreed upon by you and your GP
- A list of services and treatment you will need, who will be providing the services, and arrangements for each service
- A list of actions that you can take to actively help manage your condition (s)
- Clear arrangements for reviewing the plan

A Team Care Arrangement (TCA)

Is generally used for patients with complex medical needs that requires multidisciplinary management.

For example, a patient who is recovering from a stroke can require all of a GP, rehabilitation physician, dietician, speech pathologists, physiotherapist, podiatrist, exercise physiologist, and occupational therapist if their needs are very complex!

Due to this, a TCA is also more complex than a GPMP to set up for a patient as it requires:

- The patient's usual medical practitioner (most often their GP)
- At least two other health practitioners that are involved in the patients care
- Each practitioner must be providing a different service
- Family members and/or informal carer's are not regarded as health practitioners

Discussion between the multidisciplinary team members regarding:

- Goals of the treatment and services provided to the patient
- Actions the patient can take to help manage their condition's
- Arrangements/appointment to made for the review dates
- Clear understanding amongst team members about their role in the patients care

What happens once a Care Plan has been made for me?

- Once a care plan has been made by your GP, it should be regularly reviewed and changes made accordingly. Regular reviews, generally every six months, allows you and your medical team to access whether your goals of treatment are being met
- Your care plan may be changed if goals of treatment change, which can be due to various reason such as an improvement or deterioration of your condition and/or overall health.

Do I have to pay for a Care Plan?

- All aspects of a Care Plan are funded by Medicare through specific “item numbers” that are listed in the Medicare Benefits Scheme (MBS). This means that you are able to claim for all of the following
- Preparation of a GPMP
- Coordinating the development of a TCA
- Reviewing a GPMP and/or TCA
- Contributing to a multidisciplinary team care plan provided by different provider
- Contributing to a multidisciplinary team care plan provided by residential aged-care facility

.

Our practice Bulk Bills our Care Plans for both the GPMP and the TCA

YOUR GPMP CARE PLAN APPOINTMENT

Appointment with the Nurse:

On_____At_____

Appointment with the doctor:

Dr_____

FOLLOW UP APPOINTMENT FOR CARE PLAN REVIEW

On_____At_____

Appointment with the doctor:

Dr_____

Practice contact details –
Bay Village Medical Centre
3-5 Farrar Road
Killarney Vale NSW 2261

Bay Village Medical Centre

Care Plans

Last Reviewed March 2024