



Referrals for allied health services

If you have both a GPMP and a TCA prepared for you by your GP, you may be eligible for Medicare rebates for specific allied health services that your GP has identified as part of your care. If you have type 2 diabetes and your GP has prepared a GPMP, you can also be referred for certain allied health services provided in a group setting.

How a GP Management Plan worked for Joan

Joan has returned to her GP to obtain the results of her recent tests. Her GP confirms that she has diabetes. As a newly diagnosed patient, her GP considers she would benefit from a structured approach to her care and suggests a GP Management Plan.

Joan agrees to the GPMP and her GP begins documenting her investigations and assessment of Joan's health and care needs.

Joan and the GP agree on the management goals of controlling the diabetes by managing her blood sugar levels and preventing complications. Joan will do regular blood tests at home, exercise more regularly and improve her diet. The GP will organise regular pathology tests. All this is written in the management plan.

The GP gives a copy of the GPMP to Joan and makes another appointment in six months' time to review the plan.

If you have any questions, ask your GP or practice nurse

How Team Care Arrangements worked for Jack

Jack is 67 years old and has chronic obstructive pulmonary disease. He is a heavy smoker and becomes short of breath when walking up one flight of stairs. He had four extended periods in hospital in the last year, and lives at home by himself.

Jack already has a GP Management Plan but his GP suggests that they now develop Team Care Arrangements to involve a respiratory nurse from the community health centre, who already organises his home oxygen equipment. The GP would also like Jack to have a home assessment from an occupational therapist who could, if necessary, arrange mobility aids. Jack agrees, and he and the GP also discuss things that Jack could do to obtain home help.

Before Jack's next visit, the GP contacts the respiratory nurse and occupational therapist and obtains information on services they can provide Jack. These actions are written into the Team Care Arrangements.

Jack returns to the GP and discusses the Team Care Arrangements. He is given a copy of the plan and a referral to the occupational therapist.

Jack visits his GP and practice nurse regularly to check his condition and the GP reviews his care plan after six months.

More information is available at www.health.gov.au (and follow the A-Z links to 'C' for Chronic Disease Management Medicare items) and on the Medicare Australia Patient Enquiry Line – 13 20 11.

GP CHRONIC DISEASE MANAGEMENT

for people with a chronic medical condition

Planning your health care

FAST FACTS

- There are two types of plans:
 - GP Management Plans (GPMP)
 - Team Care Arrangements (TCA).
- If you have a chronic medical condition, your GP may suggest a GP Management Plan.
- If you also have complex care needs and require treatment from two or more other health care providers, your GP may suggest Team Care Arrangements as well.
- Your GP or practice staff must obtain your agreement before providing these plans.
- A written, structured approach to health care can help you and your GP manage your condition by identifying your needs and planning what should be done.
- If you have both a GPMP and a TCA prepared for you by your GP, you may be eligible for Medicare rebates for specific allied health services.
- The practice nurse can provide support and monitoring between visits to your GP.
- Your GP will offer you a copy of your plan.
- GPMPs and TCAs are intended to be provided by your usual GP or practice; the one that you attend most often.
- You and your GP should regularly review your plan.

Chronic medical conditions

A chronic medical condition is one that has been (or is likely to be) present for six months or longer. It includes conditions such as asthma, cancer, heart disease, diabetes, arthritis and stroke.

Your GP will assess whether a plan is appropriate for you.



GP Management Plan

A GP Management Plan (GPMP) can help people with chronic medical conditions by providing an organised approach to care.

A GPMP is a plan of action that you have agreed with your GP.

A GPMP

- identifies your health and care needs
- sets out the services to be provided by your GP
- lists the actions you can take to help manage your condition.

Team Care Arrangements

If you have a chronic medical condition *and* complex care needs, your GP may also develop Team Care Arrangements (TCA). These will help coordinate more effectively the care you need from your GP and other health care providers.

A TCA requires your GP to collaborate with at least two other health care providers who will give ongoing treatment or services to you.

Let your GP or nurse know if there are aspects of your care that you do not want discussed with other health care providers.

Review of GPMPs and TCAs

Once a plan is in place, it should be regularly reviewed by your GP. This is an important part of the planning cycle, where you and your GP check that your goals are being met and agree on any changes that might be needed.

Payment arrangements

If your GP bulk bills, there will be no charge for these services. If not, you can claim a rebate, as for other Medicare services.

Developing a GPMP or TCA is likely to take more time than normal GP consultations. Your GP may ask you to return on another occasion to complete your plan, but you will only be billed once for the plan.