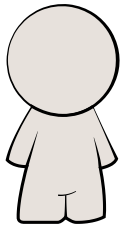
TEAM CARE ARRANGEMENT (TCA) 723

CDMPLUS®



PATIENT

Attendance by a General Practitioner for the Preparation of a GP Management Plan (GPMP) for a patient.

If your patient has a chronic medical condition, they may be eligible for services under either a:

- General Practitioner Management Plan (GPMP)
- Team Care Arrangement (TCA)

To be eligible for a GPMP, your patient must have a chronic or terminal medical condition. If they need ongoing treatment from a multidisciplinary team, they're also eligible for TCAs. While many patients will be eligible for both a GPMP and TCAs, you can provide the services independently.

Source: Services Australia

Chronic medical conditions are those that have been, or are likely to be, present for at least 6 months. This includes:

- Asthma
- Cancer
- Cardiovascular disease
- Diabetes
- Kidney Disease
- Musculoskeletal conditions
- Stroke

These care plans help you to coordinate care and reduce the need for ad hoc consultations. They're useful for recording comprehensive, accurate and up-to-date information about a patient's condition and treatment.

Developing a care plan can also help encourage your patient to take responsibility for their care. Patients may be able to identify things they could do to achieve the goals of the treatment.

Description	Item No	Minimum claiming period*
Preparation of a GP Management Plan (GPMP)	721	12 months
Coordination of Team Care Arrangements (TCAs)	723	12 months
Contribution to a Multidisciplinary Care Plan, or to a Review of a Multidisciplinary Care Plan, for a patient who is not a care recipient in a residential aged care facility	729	3 months
Contribution to a Multidisciplinary Care Plan, or to a review of a multidisciplinary care plan, for a resident in an aged care facility	731	3 months
Review of a GP Management Plan or Coordination of a Review of Team Care Arrangements	732	3 months

CDM services may be provided more frequently in the exceptional circumstances defined below. Exceptional circumstances exist for a patient if there has been a significant change in the patient's clinical condition or care requirements that necessitates the performance of the service for the patient.

Source: Medicare Benefits Schedule

Items 721, 723, 729, 731 and 732 provide rebates to manage chronic or terminal medical conditions by preparing, coordinating, reviewing or contributing to chronic disease management (CDM) plans. They apply for a patient who suffers from at least 1 medical condition that has been present (or is likely to be present) for at least 6 months or is terminal.

Items 721-732 should generally be undertaken by the patient's usual General Practitioner. The patient's "usual GP" means the GP, or a GP working in the medical practice, who has provided the majority of care to the patient over the previous twelve months and/or will be providing the majority of GP services to the patient over the next twelve months. The term "usual GP" would not generally apply to a practice that provides only one specific CDM service.

TEAM CARE ARRANGEMENT (TCA) 723

CDMPLUS®

RECEPTION

Action

1. Confirm patient appointment the day before via phone or SMS

2. Use MBS Online to check eligibility for GP and/or Medical Practitioner MBS Item Numbers

3. Document eligibility and MBS Item Numbers in Appointment Notes

   Example format:
   DD/MM/YY ELG 721, 723, 732

   CDM items example format:
   Last 721/723 DD/MM/YY
   Last 732/732 DD/MM/YY

4. Update Patient Details on arrival

Additional Information

GP MBS Item Numbers

Care Plans & Review 721, 723, 732
Health Assessments 701, 703, 705, 707
ATSI Health Assessment 715
Home Medicine Review (HMR) 900, 903
Mental Health 2700, 2701, 2712, 2715, 2717
Source: Medicare Benefits Schedule

Medical Practitioner MBS Item Numbers

Care Plans & Review 229, 230, 233
Health Assessments 224, 225, 226, 227
ATSI Health Assessment 228
Home Medicine Review (HMR) 245, 249
Mental Health 272, 276, 277, 281, 282

Appointment Notes

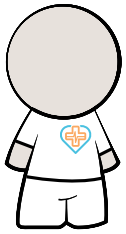
- By documenting here, all the staff can quickly identify if the patient is eligible for any CDM items.
- It is also helpful for clinical staff to know when the last CDM items took place at your clinic, as the clinical record is not always an accurate picture of what was actually billed. For example, the patient record shows GPMP completed on a certain date but this may not reflect in the billing (omitted or rejected).

Patient Details

- Address/Phone/NOK/Emergency Contact
- Medicare
- Pension
- Healthcare Card

TEAM CARE ARRANGEMENT (TCA) 723

CDMPLUS®



NURSE/AHW

Action

5. Review patient Eligibility for TCA and consider other additional CDM item numbers (use MBS Billing Combinations)

6. Use CDMPLUS® shortcut for your progress notes

7. Review clinical record Before you see the patient

Document:
- Date of last TCA
- Reason for the management plan list the chronic or terminal condition eg Diabetes

8. Explain the steps in preparing the Team Care Arrangement and document patient Consent

Example format:
TCA for diabetes.
Last GPMP billed DD/MM/YY, no TCA, eligible and consents to same.

Additional Information

Eligibility

- Is the patient eligible for any other CDM Item Numbers?
- Is the patient eligible for a Health Assessment?
- Is the patient eligible for a Home Medicines Review?

- Consider completing activities on the day such as HMR referral. Patients may be rebooked for activities that need more time such as Health Assessments.

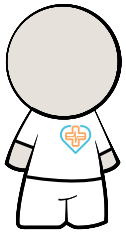
Before you see the patient

- Take a few minutes before calling your patient in from the waiting room to get to **know your patient** and start completing your progress notes.

- Reviewing the clinical record will let you know what is missing and guide the time you have with the patient. It will also make sure you give the patient your full attention (which can help increase patient engagement).

TEAM CARE ARRANGEMENT (TCA) 723

CDMPLUS®



NURSE/AHW

Action

9. Update Patient Details in clinical software (not in progress notes)

10. Record relevant Observations for patient age and conditions

Additional Information

Patient Details

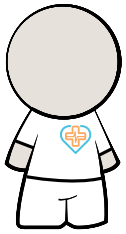
Allergies	Review and update Allergies	
Smoking	Complete all sections in smoking assessment Document increase or decrease	
Alcohol	Complete all sections in alcohol assessment Document increase or decrease	
Ethnicity	Update Ethnicity	
Australian Defence Force	Update Australian Defence Force status	
Family History **Example format:** Father died aged 55yr-AMI, Diabetes Mother alive aged 65yr-Asthma **Example format:** 1 Brother & 1 Sister 1 Brother died aged 23yr-MVA 1 Sister alive aged 35yr-Breast Cancer	Parents Alive or Deceased (cause of death if known) Age and Medical Conditions	Siblings Number of Siblings Alive or Deceased (cause of death if known) Age and Medical Conditions if any
Social History **Example format:** Married lives with wife Mary 3 children	Married/Single/De-facto /Widowed/Separated/Divorced Lives with husband/wife/defacto/partner/children Number of Children Funding or other programs	
Medical/Surgical History	Update Medical History (Coded Diagnoses only) Update Surgical History (Coded Diagnoses only)	

Observations

- Height/Weight/BMI/Waist
- Blood Pressure and Heart Rate
- Blood Glucose Level
- Visual Acuity
- ECG
- Urinalysis
- Peak Flow
- Spirometry
- Oxygen Saturation
- Respiratory Rate
- Point of Care Testing (HbA1c/ACR)

TEAM CARE ARRANGEMENT (TCA) 723

CDMPLUS®



NURSE/AHW

Action

11. Review Current Medication and consider a Home Medicines Review (see HMR steps to generate a referral)

Example format:
Medication-Stopped taking blood pressure medication 2 weeks ago due to side effects

12. Review Recent Bloods

Example format:
Bloods- Last bloods DD/MM/YY

Additional Information

Current Medication

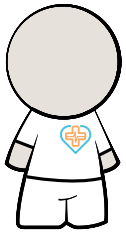
- Medications taken by the patient that are not listed
- Possible side effects
- Discrepancies in medication, dose or frequency
- Any over the counter (OTC) medication/medications not listed
- Issues identified such as dispensing
- Device use or absence eg spacer or glucometer

Recent Bloods

- Patients with chronic disease may require more frequent blood monitoring due to certain medications they are taking and medical conditions.
- Drug categories that may require monitoring include:
  - Cardiac drugs
  - Antibiotics
  - Antiepileptics
  - Bronchodilators
  - Immunosuppressants
  - Anti-cancer drugs
  - Psychiatric drugs

TEAM CARE ARRANGEMENT (TCA) 723

CDMPLUS®



NURSE/AHW

Action

13. Document date of last visit, outcome and next visit for Specialist, Allied Health & Other

Example format:
Cardiologist-Last seen by Dr Heart DD/MM/YY
-changes to BP medication, next review in 6 months
Podiatrist-Last seen by podiatrist DD/MM/YY
-low foot risk, visits every 12 weeks under EPC

14. Discuss Patient Needs and Goals with your patient

Additional Information

Specialist, Allied Health and Other

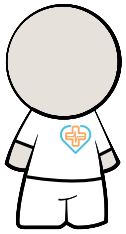
- It is important to know which other health care professionals are involved in your patient's care
- Take time to review correspondence to and from other providers (Before you see the patient) to minimise unnecessary referrals and/or duplication of services
- A patient that has complex care needs requiring care from a multidisciplinary team may be eligible for a Team Care Arrangement
- Consider referral to **Allied Health** under GPMP/TCA referral **(5 x visits per calendar year)**

Specialist	Allied Health	Other
Cardiologist	Podiatrist	Community Nurses
Endocrinologist	Audiologist	Optometrist
Respiratory Physician	Aboriginal Health Worker	Hospital Programs:
Rheumatologist	Dietitian	- Falls prevention and balance program
Neurologist	Physiotherapist	- Cardiac Rehabilitation
Ophthalmologist	Exercise Physiologist	- Pulmonary Rehabilitation
Gastroenterologist / Hepatologist	Psychologist	- Musculoskeletal
Nephrologist	Social Worker	- Neurology
Dermatologist	Chiropractor	- Pain and Chronic Fatigue
Haematologist	Osteopath	Pharmacist
Geriatrician	Speech Pathologist	Another GP
Psychiatrist	Diabetes Educator	Drug & Alcohol Services
Pain Specialist	Occupational Therapist	Integrated Team Care (ITC) Program
Paediatrician		Dentist
Urologist		
Oncologist		
Immunologist		
Obstetrician / Gynaecologist		
ENT (Ear, Nose, Throat)		

Patient Needs and Goals

- Remember to ask your patient for their input and document their specific needs/goals

CDMPLUS®



NURSE/AHW

Action

15. Document Prevention, Detection and Management activities

Example format:
Immunisation-Flu injection in YYYY,
no documented pneumovax
Mammogram-Last mammogram DD/MM/YY,
recommended screening 2 years, recall in place

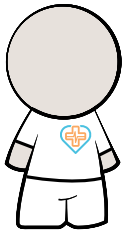
Additional Information

Prevention, Detection and Management

Immunisations	Australian Immunisation Handbook
Cancer Screening	Cervical Screening, Mammogram/Breast Awareness, FOBT/Colonoscopy, Skin Examination/Protection/Self-examination Guidelines for preventive activities in general practice
Lifestyle Modifications	Smoking, Nutrition, Alcohol, Physical Activity (SNAP), Australian Dietary Guidelines, QUIT Smoking, Tackling Indigenous Smoking, Height/Weight/BMI, Waist, Other Substance Use
Musculoskeletal Conditions	Management of Knee and Hip Osteoarthritis, Osteoporosis Risk Assessment
Cardiovascular Disease	Absolute Cardiovascular Risk, Blood Pressure, Heart Rate, ECG, Ankle Brachial Index (ABI), Cholesterol
Social & Emotional Wellbeing	Abuse and Violence, Domestic Violence Safety Assessment Tool (DVSAT), Edinburgh Postnatal Depression Score (EPDS), Depression Anxiety Stress Scales (DASS), K10, Social support
Respiratory Conditions	Australian Asthma Handbook, COPD-X Plan, COPD Screening Tool & Device, Obstructive Sleep Apnoea (OSA), Asthma Control Test, Asthma Action Plan, Oxygen Saturation, Peak Flow, Respiratory Rate, Spirometry
Chronic Kidney Disease	CKD Management Handbook, CKD Screening Tool, CKD Risk Test, Urinalysis, Blood Pressure, Height/Weight/BMI, ACR
Cognitive Impairment	MMSE, GPCOG, Kimberly Indigenous Cognitive Assessment (KICA), Rowland Universal Dementia Assessment Scale (RUDAS), Mini-Cog, MoCA Test
Diabetes	Management of Type 2 Diabetes, AUSDRISK Tool, Blood Glucose Level, HbA1c, ACR, Height/Weight/BMI, Waist
Sexual Health	STI Screening, Safe sex discussion

TEAM CARE ARRANGEMENT (TCA) 723

CDMPLUS®



NURSE/AHW

Action

16. Document any Recommendations in your notes and handover any urgent concerns to the GP before seeing the patient

17. Generate TCA document, EPC forms and cover letters and save as a draft

18. Add/Adjust Recall for GPMP/TCA and GPMP/TCA review (using Next Appointment resource)

19. Write in appointment notes/mark on billing sheet Next Appointments to be booked by reception

20. Finalise visit in software using relevant GP MBS Item Numbers (or Medical Practitioner MBS Item Numbers) for review (or note relevant MBS Item Numbers on billing sheet)

Additional Information

Recommendations

- Referrals to Specialist, Allied Health and Other
- CDM Activities such as GPMPs, TCAs, Reviews, HMR, Health Assessment
- Prevention, Detection and Management activities such as Immunisations and Cancer Screening
- Applications for CAPS, Disability Parking and other paper based referrals

Recall

- Review current recalls and adjust dates if needed
- Add recalls for Preventive Health such as Skin Check, Mammogram and Cervical Screening

Next Appointments

- GPMP/TCA
- Reviews of GPMP/TCA
- Health Assessments
- GP Mental Health Treatment Plans
- Spirometry, ECG, Cervical Screening, Immunisations
- Appointments with GP for results or follow up
- Internal Allied Health Services
- Internal Specialist Services

GP MBS Item Numbers

- Care Plans & Review 721, 723, 732
- Health Assessments 701, 703, 705, 707
- ATSI Health Assessment 715
- Home Medicine Review (HMR) 900, 903
- Mental Health 2700, 2701, 2712, 2715, 2717

Source: Medicare Benefits Schedule

Medical Practitioner MBS Item Numbers

- Care Plans & Review 229, 230, 233
- Health Assessments 224, 225, 226, 227
- ATSI Health Assessment 228
- Home Medicine Review (HMR) 245, 249
- Mental Health 272, 276, 277, 281, 282

TEAM CARE ARRANGEMENT (TCA) 723

CDMPLUS®

GP

Action

21. Review and action Recommendations from Nurse/AHW/AHP

22. Review and update Current Medication

23. Review draft TCA and make any changes needed

24. Offer patient a copy of the TCA

25. Create and upload a Shared Health Summary (SHS)

26. Review Next Appointments noted by Nurse/AHW/AHP and advise patient to book at reception

27. Finalise visit in software using relevant MBS Item Numbers (or note relevant MBS Item Numbers on billing sheet)

Additional Information

When coordinating the development of Team Care Arrangements (TCAs), the General Practitioner must:

- consult with at least two collaborating providers, each of whom will provide a different kind of treatment or service to the patient, and one of whom may be another Medical Practitioner, when making arrangements for the multidisciplinary care of the patient
- prepare a document that describes:
  - treatment and service goals for the patient
  - treatment and services that collaborating providers will provide to the patient
  - actions to be taken by the patient
  - arrangements to review by a date specified in the document
- explain the steps involved in the development of the arrangements to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees)
- discuss with the patient the collaborating providers who will contribute to the development of the TCAs and provide treatment and services to the patient under those arrangements
- record the patient's agreement to the development of TCAs
- give copies of the relevant parts of the document to the collaborating providers
- offer a copy of the document to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees)
- add a copy of the document to the patient's medical records

One of the minimum 2 service providers collaborating with the GP can be another Medical Practitioner. The patient's informal or family carer can be included in the collaborative process but does not count towards the minimum of 3 collaborating providers.

The document described above must be retained for 2 years.

Restriction of Co-claiming of Chronic Disease and General Consultation Items

Co-claiming of GP consultation items 3, 4, 23, 24, 36, 37, 44, 47, 52, 53, 54, 57, 58, 59, 60, 65, 585, 588, 591, 594, 599, 600, 5000, 5003, 5020, 5023, 5040, 5043, 5060, 5063, 5200, 5203, 5207, 5208, 5220, 5223, 5227 and 5228 with chronic disease management items 721, 723, or 732 is not permitted for the same patient, on the same day.
Source: Medicare Benefits Schedule

TEAM CARE ARRANGEMENT (TCA) 723

CDMPLUS®

RECEPTION

Action

28. Complete billing for TCA and any additional GP MBS Item Numbers (or Medical Practitioner MBS Item Numbers)

29. Book Next Appointment for TCA Review and any other appointments noted by GP/Nurse/ AHW/AHP (use Next Appointment resource)

Additional Information

GP MBS Item Numbers

- Care Plans & Review 721, 723, 732
- Health Assessments 701, 703, 705, 707
- ATSI Health Assessment 715
- Home Medicine Review (HMR) 900, 903
- Mental Health 2700, 2701, 2712, 2715, 2717

Source: Medicare Benefits Schedule

Medical Practitioner MBS Item Numbers

- Care Plans & Review 229, 230, 233
- Health Assessments 224, 225, 226, 227
- ATSI Health Assessment 228
- Home Medicine Review (HMR) 245, 249
- Mental Health 272, 276, 277, 281, 282

Next Appointment

- GPMP/TCA
- Reviews of GPMP/TCA
- Health Assessments
- GP Mental Health Treatment Plans
- Spirometry, ECG, Cervical Screening, Immunisations
- Appointments with GP for results or follow up
- Internal Allied Health Services
- Internal Specialist Services