DEPARTMENT OF
**HEALTH**

# Chronic Conditions Management Plans PHC Remote Information Sheet

The Chronic Conditions Management Plan is a multidisciplinary management care plan for clients diagnosed with a chronic condition/s. These Management Plans assist staff to provide a standardised approach to the care and management of clients with chronic condition/s. The implementation of the Chronic Conditions Management Plan requires the agreement and active participation of the client to help promote health and wellbeing; to identify risk factors; personalise the issues that pose greatest concern to the individual and to develop goals that are meaningful.

Engaging with the client during a Chronic Conditions Management Plan consultation also presents an opportunity for timely brief interventions / health care interventions against the SNAPE[1] risk factors (PCIS / EACS).

This document is to be read in conjunction with the Atlas document - Preventable Chronic Conditions Program.

## 1. Cardio Vascular Risk (CVR) Assessment

Prior to commencing any chronic condition care plan a Cardio Vascular Risk (CVR) Assessment must be completed. The selection of applicable components of a CDMP is based on the assessment of the client's CVR and review of the client's problem list, pathology and other investigations. Cardio Vascular Risk can be calculated by utilising the CARPA CVR Assessment Tool. The CVR may also be calculated by using the Analyse function – **CVR Assessment – CVRA (Calculator)* within the Primary Care Information System (PCIS).

## 2. Initiating a Chronic Conditions Management Plan

PCIS care plans are described as either 'Primary' or 'Secondary'. Each client should have only one Primary Care Plan + one or more Secondary Care Plans as required. EACS provides a Chronic Condition Review template to document the health practitioner to provide appropriate care. A client is to be commenced on an appropriate Management Plan in line with their condition and guidelines in the CARPA STM. This will prompt an initial recall for the client where the clinician can discuss recommended care and recall in the Management Plan and obtain their consent and participation.

*Note: in the event a client declines a Management Plan and/or refuses to have the recall functions, this is to be discussed with the PHCM and Medical Practitioner. Also see Client Recall Systems for further information on Refusal to Attend Recall or Cancellation of Recall.*

Chronic Conditions Management Plans align with the Northern Territory Chronic Conditions Prevention and Management Strategy (CCPMS) as detailed in the CARPA STM[2]. The Management Plans provide an evidence-based approach for the management of chronic conditions, standardised

[1] **SNAPE:** an acronym for **S**moking, **N**utrition, **A**lcohol/Other Drugs, **P**hysical Activity and **E**motional well-being and **O**ther Drug Intake Information.

[2] **CARPA STM:** an acronym for **C**entral **A**ustralian **R**ural **P**ractitioners **A**ssociation **S**tandard **T**reatment **M**anual.



Approved Date: 30/10/2013, Version: 2.0

Doc ID: HEALTHINTRA-1880-12800

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documentation format and a recall functionality for ongoing and follow up care. It is acknowledged that completion of the Management Plan may occur over several visits.

In consultation with the Primary Health Care Manager, any member of the clinical team can initiate a Chronic Conditions Management Plan. To assist in the selection and development of an appropriate Management Plan, clinicians should use the:

- CVR Care Planning Reference (PCIS / EACS) which provides information on the selection of an appropriate care plan
- Chronic Conditions Management Plans Checklist (PCIS / EACS) which assists in the creation of a comprehensive CDMP. This checklist can be used as a worksheet to assist in tailoring a Management Plan for an individual client.

Once the appropriate Management Plan is initiated and information is entered into the client's EHR, the system provides the recall function regarding ongoing management for a client with a chronic condition/s. A Management Plan should be reviewed annually at a minimum and/or when a client's health status changes. Follow up care is provided as prompted by the EHR recall functionality. Documentation of interventions and follow up management must be made in the client's EHR (PCIS / EACS). Also see Health Records Documentation.

To improve client care it is more effective to have routine test results available prior to a Medical Practitioner review.

## 3. Women's / Men's Health Check

Clients with a chronic condition/s also require a Women's / Men's Health Check to be completed. Clients may find it difficult to have a Chronic Conditions Management Plan, including the Women's / Men's Health Check completed during a single consultation. To provide a comprehensive service, clinical staff should be aware that a Chronic Conditions Management Plan may be completed over the course of several consultations. For further details see Information Sheet – Women's & Men's Health Checks.

## 4 Adult Health Checks

In the absence of a chronic condition/s the Adult Health Check Care Plan (PCIS / EACS) should be initiated as the client's Primary Care Plan. See Information Sheet – Adult Health Checks.

## 5. Medicare Claims – for Chronic Disease Management Plan (CDMP)

A Medicare claim can only be submitted when a Medical Practitioner completes the relevant sections of the CDMP. Subsequent to completion of the initial CDMP, a Medicare claim can be made for a service related to the CDMP provided by a RAN or ATSIHP and for a Medical Practitioner CDMP review. It should be noted that for some Medicare Items it may not be possible to make a claim for each presentation of the client due to the absence of a Medical Practitioner. Also see Medicare - Overview.

Whilst Medicare claims are important, the opportunity to review the client when they present and the management of their chronic condition, is the priority. Further information regarding Medicare claimable conditions are explained in Section 5.

Medicare has a suite of Chronic Disease Management items that can be claimed using the EHR system. Any member of the health team can initiate a CDMP, however only a Medical Practitioner can claim items 721, 723 or 732.

### 5.3.1 Item 721 – CDMP Preparation: GP Only

There must be a minimum period of 12 months between item 721 claims for the individual client, and a minimum period of 3 months since the last item 732 was claimed.

### 5.3.2 Item 723 – CDMP Preparation: Team Care Arrangement

This Medicare item can be done in conjunction with Item 721 and may be claimed simultaneously. The Team Care Arrangement may consist of any combination of three health professional positions e.g. RAN, ATSIHP, Allied Health Professional or Medical Practitioner. However it is compulsory that one team member is the claiming Medical Practitioner. There must be a minimum period of 12 months between Item 723 claims for the individual client, and a minimum period of 3 months since the last item 732 was claimed.

### 5.3.3 Item 732 – Review of a GP Management Plan, or, Coordinate a Review of Team Care Arrangements

To claim item 732, **Review of a GP Management Plan**, the review must be undertaken by a Medical Practitioner. To claim this item, there must be a minimum interval of 3 months between either item 721 or 732.

To claim item 732, **Coordinate a Review of Team Care Arrangements,** the review must be undertaken by a Medical Practitioner. The Team Care Arrangement may consist of any combination of three health professional positions e.g. RAN, ATSIHP, Allied Health Professional or Medical Practitioner. However it is compulsory that one team member is the claiming Medical Practitioner. To claim this item, there must be a minimum interval between either items 723 or 732 of 3 months.

Item 732 can be claimed twice on the one day for an individual client – once as review of item 721, and once as a review of item 723. If this is the case, then it must be noted on the Medicare claim that these are two separate services.

### 5.3.4 Item 10997 – RAN & ATSIHP Care Plan Service

As per the CDMP in the EHR, RANs or ATSIHPs can claim a review using item 10997

Item 10997 can only be claimed as per the review schedule stipulated in the client's CDMP, and after the Medical Practitioner has claimed a GP CDMP Preparation (item 721) and/or a CDMP Team Care Arrangement Preparation (item 723). Item 10997 may be claimed to a maximum of 5 services per client in a calendar year.

## 6. References

Client Recall Systems

Health Records Documentation

Preventable Chronic Condition Program

Medicare - Overview

Information Sheets: Adult Health Checks
Women's & Men's Health Checks

Remote Primary Health Care Manuals

Central Australian Rural Practitioners Association (CARPA) Standard Treatment Manual

Medicare Australia

- Northern Territory Chronic Conditions Prevention and Management Strategy
- CARPA CVR Assessment Tool
- Primary Care Information System (PCIS) website:
  - Basic Steps - Care Plans
  - Tips:
    - Adult Health Check Care Plans
    - GP Annual Review
  - User Reference Guides:
    - Preventable Chronic Disease CVR Care Plans
    - CVR Care Planning Reference
  - PCD Care Plan Checklist
- East Arnhem Communicare System (EACS) website:
  - Tips
  - User Reference Guides:
    - Diagnosis linked to the Chronic Conditions Review