EPC Care Planning – Membership of a multidisciplinary team

Questions are asked from time to time regarding the acceptability of specific arrangements to constitute a valid use of the EPC care panning items. Many of these questions relate to who can count as one of the minimum three members of a multidisciplinary team, for example:

- People who may provide services required by a patient, but who do not contribute to the care plan, in some cases providing services on a referral-type basis (examples raised include organisers of walking groups, fitness consultants, driving instructors)
- Allied health or other service providers, in situations where the provision of their service is conditional on external factors, such as the patient being on a particular medication (and thereby having access to eg the services of a dietician, a cognitive behaviour therapy program or to a call centre-based support service, while the patient stays on that medication)
- Access to 'generic' or group-based services that are not individualised for the patient's specific needs (eg group therapy/educational programs)
- Access to services that is time limited, irrespective of the patient's actual needs for the service (eg a set number of appointments with a specified allied health provider)
- Providers who have no ongoing role in the care of the patient (eg provide only one episode of service or treatment to the patient, often on a referral-type basis)
- Providers who are delivering essentially the same type of service as another member of the team (eg two GPs providing general practice services)
- Providers who are actually providing no more than normal services as part of their service to the patient (eg specialists providing services on referral, with no interaction with the other members of the team; pharmacists providing routine dispensing services)

In many of these situations the arrangements adopted may be providing good clinical care for the patient and may work well from the provider's and the patient's perspective. However, they do not meet the requirements for membership as one of the minimum three members required to constitute an EPC multidisciplinary care plan team.

EPC multidisciplinary team care planning is a specific, defined approach to care planning. It does not preclude other care planning approaches to be taken by practitioners to the care of patients, as appropriate to their needs. EPC care planning is multidisciplinary and targeted at patients with chronic (or terminal) conditions and complex needs requiring care from a multidisciplinary team. It involves team-based management of the patient's complex care needs.

The members of an EPC multidisciplinary care plan team should:

- collaborate with the other members of the team, based on interactive communication
- contribute to the development and implementation of the care plan, not only provide a required service
- provide a different kind of care or service to the patient to that provided by the other members of the team
- have an ongoing role in the care of the patient
- provide a service that is individualised to the patient's needs – one that is capable of establishing and responding to that patient's individual needs

- provide a service that is not restricted by conditions such as continuing medication usage or arbitrary time limits

Relevant Medicare EPC Care planning guidance
The Medicare Benefits Schedule explanatory notes (May 2002 MBS supplement, similar wording in previous editions) state:

A.21.11 A multidisciplinary care plan team includes a medical practitioner and at least two other members who collaborate with the medical practitioner in the development of the plan and contribute to the implementation of the plan. Each of the members of the multidisciplinary care plan team must provide a different kind of care or service to the patient. One of the members of the team may be another medical practitioner (normally a specialist or consultant physician).

EPC multidisciplinary care planning involves team-based management of the patient's complex care needs. In preparing the care plan the practitioner must collaborate with all of the other members of the multidisciplinary care plan team. Collaboration is required to identify the patient's needs, the management goals that should be documented in the plan, the ongoing care and services to be provided by each member of the team, and any other services that may be required from other health and care providers to achieve the management goals in the plan.

The process of developing an EPC multidisciplinary care plan may identify that the patient needs other treatment or services in addition to those to be provided by the members of the team. The plan should identify any such required services and document the arrangements for them to be provided. The providers of such services would not count as one of the members of the team, unless they are contributing to the plan in their own right and providing ongoing care and service to the patient.

The MBS notes do not address the issue of what level of expertise or training is required by a member of an EPC multidisciplinary team, nor do they specify an exclusive list of such persons (the examples given are not exclusive). This is a matter for the clinical judgement of the person organising the care plan. The key requirement is that as a member of the team they are equipped to contribute to the care plan and provide a different kind of care or service to the patient. This judgement of their ability and capacity is analogous to the requirement for using a third party to assist with the information collection of a health assessment where the explanatory notes specify that the practitioner must be satisfied they have the necessary skills, expertise and training to do so.

To be a member of an EPC multidisciplinary team, a provider must be able to actually contribute to the plan as a member of the team. It is not sufficient for a provider to just deliver a required service with no interaction with the other members of the team, nor to deliver a service that is not individualised to the specific health and care needs of the patient.