A.21 *EPC Multidisciplinary Care Planning(Items 720 to 730)*

A.21.1 EPC multidisciplinary team care planning is a specific, defined approach to care planning. An EPC multidisciplinary team care plan is a written, comprehensive, longitudinal plan for the care of patients with one or more chronic conditions and complex care needs, developed and managed by a multidisciplinary team comprising the patient's GP and other health and care providers. EPC multidisciplinary care planning involves team-based management of the patient's complex care needs.

A.21.2 The development or review of an EPC multidisciplinary team care plan involves collaboration by the members of the team. Each of the members of the team must contribute to the development or review of the plan and not simply provide a service specified in the plan to the patient.

Chronic conditions and complex care needs

A.21.3 To be eligible for a Medicare rebate EPC multidisciplinary team care plans and case conferences may only be provided for patients with one or more chronic, or terminal, conditions and complex care needs requiring multidisciplinary care from a team of health and care providers, including the patient's GP.

A.21.4 A chronic medical condition is a medical condition that has been, or is likely to be, present for at least 6 months. EPC multidisciplinary team care plans and case conferences have been found to be most useful for patient's with complex care needs, *for example*, where routine management of the condition is compounded by the presence of one or more of the following: unstable or deteriorating condition; increasing frailty and/or dependence; development of complications, including falls or incontinence; co-morbidities; significant change in social circumstances (eg death, illness or 'burnout' of carer); or two or more hospital admissions in the past six months.

Items 720 – 730: Application

A.21.5 Items 720, 724 and 726 apply only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal, and IS NOT an in-patient of a hospital, day hospital facility, or a care recipient in a residential aged care facility.

A.21.6 Items 722 and 728 apply only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal, and IS an in-patient of a hospital or day hospital facility, and IS NOT a care recipient in a residential aged care facility.

A.21.7 Item 730 applies only to a service in relation to a care recipient in a residential aged care facility who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal.

A.21.8 For the purposes of items 720 to 730 a medical practitioner should generally be the medical practitioner or a practitioner working in the medical practice that has provided the majority of services to the patient over the previous 12 months and/or will provide the majority of services to the patient over the coming 12 months.

Preparation of an EPC multidisciplinary care plan

A.21.9 For items 720, 722, 724, 726, 728 and 730 preparation of an EPC multidisciplinary team care plan means the preparation of a written plan in collaboration with all of the members of a multidisciplinary care plan team, describing the following matters:

(a) an assessment of the patient that considers their current and future health and care needs (refer to note A.21.4); and
(b) management goals with which the patient agrees; and
(c) an assessment of the kinds of treatment, health services and health care that the patient is likely to need; and
(d) an assessment of any other kind of services and care that the patient is likely to need (for example, home and community care services); and
(e) arrangements for giving the treatment, services and care referred to in paragraph (b); and
(f) arrangements to review the plan by a day specified in the plan (if this review is to be claimed as an EPC care plan review item it must be done in collaboration with all of the other members of the EPC multidisciplinary care plan team; if the review is undertaken by the GP alone it should be claimed as a normal consultation item).

A.21.10 Preparation of the plan must also include:
(a) a meeting with the patient (and the patient's carer, where appropriate in the practitioner's view and with the patient's agreement) to discuss the preparation of the plan; and
(b) telling the patient who will be included in the multidisciplinary care plan team; and
(c) collaborating with all of the other members of the multidisciplinary care plan team 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;
(d) recording the plan and the patient's agreement to the preparation of the plan; and
(e) giving copies of relevant parts of the plan to the other members of the multidisciplinary care plan team and to any other persons who, under the plan, will give the patient the treatment, service and care mentioned in the plan; and
(f) offering a copy of the plan (and evidence of the contribution made to the plan by members of the team) to the patient (and, if appropriate and with the patient's agreement, to the patient's carer).

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).

Example
Examples of persons who, for the purposes of care planning and case conferencing may be included in an EPC multidisciplinary care plan team are allied health professionals such as, but not limited to: Aboriginal health care workers; asthma educators; audiologists; dental therapists; dentists; diabetes educators; dieticians; mental health workers; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; speech pathologists.

A team may also include home and community service providers, or care organisers, such as: education providers; "meals on wheels" providers; personal care workers (workers who are

paid to provide care services); probation officers; where they are contributing to the plan and not simply providing a service identified in the plan.
The involvement of a patient's carer in an EPC multidisciplinary care plan team can provide significant benefits in terms of input to the development of the plan and coordination of care for the patient. Where the patient has a carer, the practitioner should consider inviting the carer to be an additional member of the EPC multidisciplinary care plan team, with the patient's agreement and having regard to:

- the patient's circumstances;
- the degree of support provided by the carer for the patient; and
- the capacity of the carer to provide ongoing support to the patient and contribute to the work of the team.

Where the patient's carer is not a member of the EPC multidisciplinary care plan team, the practitioner should involve the patient's carer and provide information to the carer where appropriate and with the patient's agreement.

The patient's informal or family carer may be included as a formal member of the team in addition to the minimum of three health or care providers. The patient and the informal or family carer do not count towards the minimum of three.

A.21.12 The development or review of an EPC multidisciplinary team care plan involves collaboration between the members of the team. Collaboration should be based on communication between the members of the team, preferably either in person, by telephone or by videoconferencing. Where it is not practicable to communicate by these means, communication in the development or review of an EPC care plan may be by two-way exchange of e-mails or faxes.

A.21.13 In making arrangements for implementation of the plan, the medical practitioner, in collaboration with the other members of the EPC multidisciplinary care plan team, should specify the type of care to be provided and ascertain the availability of care from other providers, taking into account any care and support provided by the patient's carer and the carer's capacity to provide ongoing support. Additional responsibilities should not be assigned to the patient's carer without the carer's agreement. The documentation of the care plan should note the agreement of the other providers specified in the plan. This may be in the form of the medical practitioner's note of a face-to-face meeting, telephone conversation, videoconference, or two-way exchange of e-mails or faxes.
A.21.14 While the patient must be present for a needs assessment by the medical practitioner in order to develop the care plan, the patient need not be present while collaboration and consultation is undertaken with the other members of the EPC multidisciplinary care plan team and formal documentation is prepared.
A.21.15 When discussing the preparation of the plan with the patient, practitioners should:

- Inform the patient that his or her medical history, diagnosis and care preferences will be discussed with other care providers; and
- Provide an opportunity for the patient to specify what medical and personal information he or she wants to be conveyed to, or withheld from, the other members of the EPC multidisciplinary care plan team;
- Inform the patient that he or she will incur a charge for the service provided by the practitioner for which a Medicare rebate will be payable;
- Inform the patient of any additional costs he or she will incur.

A.21.6 While no standard format for the care plan is mandated, practitioners should consider a recognised care-planning tool, for example those developed by the Royal Australian College of General Practitioners (RACGP) or Divisions of General Practice.

A.21.17 It is recommended that a community care plan be prepared only once per year. However, a new plan may be prepared if in the judgement of the patient's usual medical practitioner there have been significant changes in the patient's clinical condition or in the patient's care support arrangements which have significantly affected their clinical condition since the previous plan, but not within 6 months of the previous plan. Any changes to the plan required after 3 months of the plan being prepared would attract a benefit under the review item 724 (see paragraphs A.21.21 and A.21.22).

A.21.18 Ongoing implementation and maintenance of the plan by the medical practitioner will be covered under normal consultation items.

EPC Multidisciplinary Discharge care plans

A.21.19 For items 722 and 728 an EPC multidisciplinary discharge care plan is a multidisciplinary care plan that is prepared for a patient with a chronic condition and complex care needs before the patient is discharged from a hospital.

A.21.20 Preparation of a discharge care plan (item 722) may be provided for private in-patients only, and must be prepared by the medical practitioner who is providing in-patient care (in most cases this should be the patient's usual medical practitioner). Medical practitioners may contribute to a discharge care plan (item 728) for public in-patients.

Review of care plans

A.21.21 For item 724, review of an EPC multidisciplinary care plan means a process by which the medical practitioner who prepared the care plan, in collaboration with the other members of the EPC multidisciplinary care plan team:

(a) reviews a community care plan or discharge care plan prepared under item 720 or 722 including reviewing the matters mentioned in A.21.9; and

(b) considers whether the arrangements for treatment, service and care have been carried out; and

(c) collaborates with each of the other members of the EPC multidisciplinary care plan team to consider whether different arrangements need to be made to achieve the management goals mentioned in the plan; and

(d) if different arrangements need to be made, prepares a revised EPC multidisciplinary care plan, stating those arrangements.

A.21.22 The review of the plan must also include:

(e) discussing the review of the plan with the patient (and the patient's carer, where appropriate); and

(f) recording the patient's agreement to reviewing the plan; and

(g) offering a copy of relevant parts of the revised EPC multidisciplinary care plan (if any) to the patient (and, if appropriate and with the patient's agreement, to the patient's carer), and giving copies to the other members of the EPC multidisciplinary care plan team and to any other persons who, under the revised plan, will give the patient the treatment, service and care mentioned in the plan.

Contribution to EPC multidisciplinary care plans

A.21.23 For items 726 and 728, a contribution to a care plan must be at the request of the person who prepares the plan, and may include preparation of a part of the plan that relates to

the treatment, service or care that the medical practitioner will give to the patient and giving advice to the person who prepares the plan.

A.21.24 Contribution to a care plan does not include preparation of an EPC multidisciplinary ***community*** care plan, a multidisciplinary discharge care plan or a care plan in a residential aged care facility, but can include contribution to a review of a care plan organised by another provider.

A.21.25 A medical practitioner's contribution to a ***community*** care plan, a discharge plan or a care plan in a residential aged careshould involve collaboration based on two-way communication between the GP and the person organising the care plan. This communication should preferably be either in person, by telephone or by videoconferencing. Where it is not practicable to communicate by these means, a GP's contribution to a care plan may be by two-way exchange of e-mails or faxes.

A.21.26 The medical practitioner should request a copy of the completed plan, or an extract of the plan relating to the medical practitioner's contribution, for the patient's medical record. The medical practitioner must include a record of his or her contribution in the patient's medical record.

A.21.27 For item 730, a contribution to an EPC multidisciplinary team care plan in a residential aged care facility must be at the request of the residential aged care facility. It is expected that a medical practitioner would not normally be required to contribute to an individual care plan in a residential aged care facility more than four times in a 12 month period. The medical practitioner's contribution should be documented in the care plan maintained by the residential aged care facility and a record of the contribution included in the care recipient's medical record.

General requirements

A.21.28 In circumstances where the patient's usual medical practitioner, as defined in A21.8, is not a member of the EPC multidisciplinary care plan team, a copy of the care plan should be forwarded to that medical practitioner (subject to patient's agreement).

A.21.29 Before commencing an EPC multidisciplinary team care plan, the medical practitioner should ascertain whether the patient currently has another active care plan and if so, should not duplicate that plan.

A.21.30 The benefit is not claimable (and an account should not be rendered) until all components of these items have been provided (see general notes section 7).