If you have a TCA in place you are entitled to up to 5 Medicare sponsored visits to Allied Health Care providers per year which is of great financial benefit to many of our patients. Providers include physios, osteopaths, dieticians, diabetic educators and podiatrists. Some will take the Medicare payment as complete payment and others as partial payment only. That is their decision and is not under our control.

Please note it is 5 visits TOTAL per year. You cannot see a podiatrist 5 times then a physio 5 times. Our doctors will advise you how best to use your allied health payments.

GP Mental Health Care Plans

These are dealt with in our Mental Health brochure but are mentioned here because like having a TCA a Mental Health Care Plan can entitle you to have Medicare subsidised visits to an appropriately qualified social worker or psychologist.

WE LOOK FORWARD TO SEEING YOU AT YOUR ENHANCED PRIMARY CARE APPOINTMENT.

SHOAL BAY & ANNA BAY MEDICAL CENTRES

5 Government Road
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SHOAL BAY & ANNA BAY MEDICAL CENTRES

Health Care Planning for Chronic Conditions

Enhanced Primary Care (EPC)

Chronic Disease Management

"CARE PLANNING"

Over the last 15 or so years the government has introduced a range of measures designed to ensure that more General Practice time is given to the management of chronic disease.

Chronic disease management and prevention have always been a priority of the doctors at Shoal Bay and Anna Bay and we are generally supportive of these measures; though the Medicare system can be needlessly bureaucratic at times. This brochure outlines what is available.

Consultations where a chronic disease management or EPC Medicare item number is charged **have always been bulk billed by our practice**.

As well as helping provide good medical care this saves our patients money. In addition there may be other financial incentives for patients who have a chronic condition which makes having a chronic disease management care plan worthwhile for them.

Chronic Disease Management Plans (Health Care Plans)

Patients suffering from serious chronic (likely to go on for more than 6 months) illness are entitled to a GP management Plan (GPMP).

To prepare a GPMP we note your serious illnesses, decide "what needs to be done" and "when it needs to be done" to best manage them.

We discuss the plan, put it in writing and give it to you for your records. We use Australian and International guidelines to structure your plans but unlike some practices we individualise our plans to patient's individual needs and set goals which are realistic and achievable. Eg. A 120 kg man may have an ideal weight of 75 kg, however, in the real world people rarely lose that much weight and it may be more reasonable to aim for a target of 5-10% weight loss in 1 year.

There are many common conditions which entitle you to a care plan.

These include coronary artery disease, cancer care, osteoarthritis, diabetes, asthma and chronic kidney disease.

Team Care Arrangements

If you have a GPMP and are seeing two or more other health care providers (for example: podiatrist, physio, pharmacist, specialist) for the provision of care related to the plan you may also be entitled to a Team Care Arrangement.

We formulate a plan as for a GPMP then communicate with the other providers involved. They may change or amend the plan then we discuss it with you. Simply put in addition to the "what needs to be done?" and "when does it need to be done?" there is a third element of "who does what". This prevents needless duplication in your health care and also ensures that responsibility is assigned for all aspects of your management.

GPMPS and TCA are normally reviewed by us every 3-6 months and you can have a new plan every 1-2 years dependant on how your health is changing. When you come to discuss your plan or review we may ask you to see one of our sisters first - they perform important measurements for us and may give you preventive and management advice.