

# Chronic Disease and Mental Health Care Plan User Pathways

DEVELOPED BY GP AND SPECIALIST COMPLIANCE STRATEGY SECTION  
PART OF THE RECOVERY, HEALTH & BUSINESS COMPLIANCE DIVISION

*ThinkPlace has developed this work on behalf of the Department of Human Services - Medicare*





# From the Sponsor

In late 2010 a decision was made within the Recovery, Health and Business Compliance Division to develop a holistic approach to compliance activities surrounding Chronic Disease Management Plans and/or General Practitioner Mental Health Treatment Plans. One of these activities included the development of user pathways relating to the interactions between health providers treating patients who have a:

- Chronic disease and whose care is being managed under a Chronic Disease Management Plan
- Mental illness and whose care is being managed under a General Practitioner Mental Health Treatment Plan.

It is envisaged that this approach will be developed in consultation with the Department of Health and Ageing, key health bodies and stakeholder groups.

**David Hancock**  
National Manager  
Health Provider Compliance



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# Project Approach

## THE REQUIREMENT

The specific requirement for this project, as presented in this user pathway product was:

- The development of separate user pathways that illustrate the most common experiences and interactions during the treatment of patients who have a:
  - Chronic disease and whose care is being managed under a Chronic Disease Care Plan
  - Mental illness and whose care is being managed under a Mental Health Care Plan.

To develop these user pathways the focus was on the experience of the following key roles:

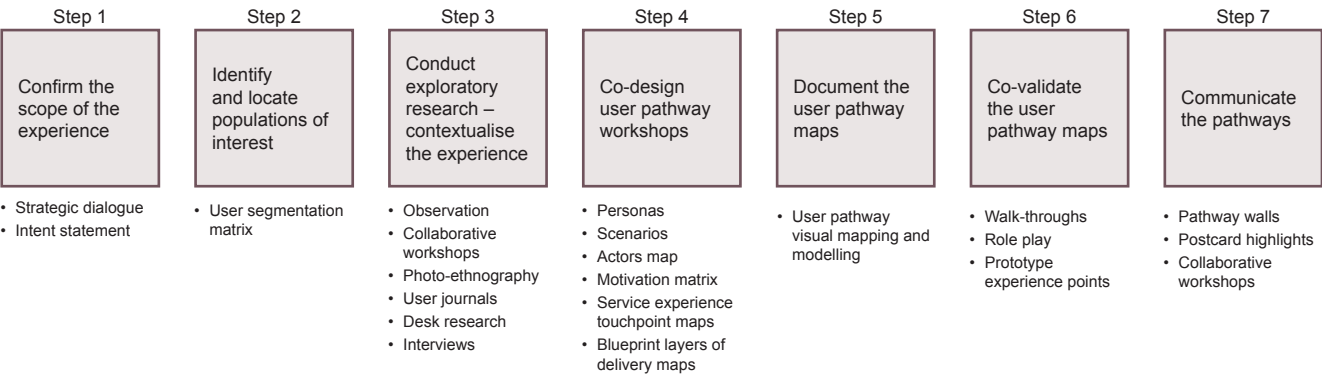
- General Practitioners practicing in Australia in small and large practices
- Allied Health Professionals practicing in Australia within General Practices and in stand-alone practices
- Practice Managers and other administration staff
- Practice Nurses and Credentialed Mental Health Nurses
- Other specialists as appropriate.

## WHAT IS A USER PATHWAY?

A user pathway captures experience from the user perspective as an end-to-end representation of tasks, relationships, needs and what's important to them about their goal or the outcome they're seeking.

The experience is the combination and articulation of what people:

- Do - activities, interactions, routines, processes.
- Use - products, systems, services, messages.
- Think - motivations, perceptions, beliefs, expectations.



All types of interaction should be captured in the user pathway as relevant and may include business processes, online and paper products, IT systems and all forms of communication. Relevant business owners for these interactions need to be identified as well as identifying which employees are involved where relevant.

The user pathway should communicate a sense of time as to when key interactions take place so the document tells the story of the experience for the GP from the first interaction of determining a patient's requirement for establishing a Chronic Disease Care Plan and/or Mental Health Care Plan until such a point after the care plan is reviewed. This information is important to build an understanding of when GPs interact with patients, AHPs, practice managers/administration staff as part of the administration of a Chronic Disease Care Plan and/or Mental Health Care Plan.

## CHRONIC DISEASE AND MENTAL HEALTH CARE PLAN USER PATHWAYS – SPECIFIC APPROACH

Taking into account the methodology for developing user pathways, in this project the following activities were undertaken:

- Confirm intent
  - Worked with the Project Team to define intent
  - Lee Rasmussen, Tino Rizzo, Natalie Andrews and Layla Kemp
- Identify users - using the services of a recruitment agency to identify the following 16 interview targets
  - Four small practice General Practitioners
  - One large practice General Practitioner
  - One small practice Practice Manager
  - One large practice Practice Manager
  - Two Psychologists
  - Two Social Workers
  - One Physiotherapist
  - One Podiatrist
  - Two Credentialed Mental Health Nurses
  - One Practice Nurse
- Conduct interviews in metropolitan (Melbourne) and regional (Ballarat) settings.
- Conduct exploratory user research - asking the following questions in the individual interviews:
  - What goes into a plan?
  - How do you know you are doing it right?
  - What is expected of you and where do you get that information from?
  - What are your key relationships?
  - What is the most important outcome for you?
  - Is the plan sufficient for total health benefits?
- Develop user pathways - synthesising the material and then holding a range of workshops which involved representatives from the user groups outlined above in order to enhance and validate the information gathered in the interview stage.
  - The workshops were held in Brisbane (separate workshops on chronic disease and mental health) and Melbourne (combined validation session).
  - At the workshops, the following framework was used to develop detailed content:
    - Goals and needs – What are the key statements about what success means?
    - Materials used – What are the tools/products used – software, paper, channels?
    - Relationships – Who else is involved? Is there a relationship hierarchy?
    - Barriers and irritants – What makes the process difficult? What hurdles do they face?
    - Medicare Interaction – What specific interactions occur?
    - Ideas – What suggestions are there for improvement?
- The user pathways were then validated with the project team.



# How Care Plans Work - the System in Use

## Medicare

Medicare delivers a broad range of payments and information for health-related and other programs, on behalf of the Australian Government. It plays an integral role in the Australian health sector.

Medicare's objective is to improve the health and wellbeing of Australians through the delivery of information and payment services. Medicare provides the best possible service delivery to increase access and convenience for the public and providers. It does this mainly through electronic channels but also through its national office network.

Medicare's compliance role is to ensure that claims and payments are accurate and to recover any incorrect payments.

## Medicare and its role in Chronic Disease and Mental Health Management

*The following information is sourced from the Department of Health and Ageing Medicare Benefits Schedule (MBS)*

The Chronic Disease Management (CDM) Medicare items on the Medicare Benefits Schedule (MBS) enable GPs to plan and coordinate the health care of patients with chronic or terminal medical conditions, including patients with these conditions who require multidisciplinary, team-based care from a GP and at least two other health or care providers. The items are designed for patients who require a structured approach to their care.

A chronic disease means that a patient has at least one medical condition that has been (or is likely to be) present for at least 6 months or is terminal; and is described in column 3 of Table 2.17.9 of the *Health Insurance (General Medical Service Table) Regulations 2010*.

Whether a patient is eligible for Care Plan services is a clinical judgement for the GP, taking into account the patient's medical condition and care needs, as well as the general guidance set out in the MBS. For patients who have a chronic medical condition and complex care needs and are being managed by their GP under the following MBS items are eligible for Medicare rebates for certain allied health services on referral from their GP:

- MBS Item 721 - Preparation of a GP Management Plan
- MBS Item 732 - Review of a GP Management Plan
- MBS Item 723 - Coordination of Team Care Arrangements
- MBS Item 732 - Coordination of a Review of Team Care Arrangements
- MBS Item 729 - Contribution to a multidisciplinary care plan being prepared by another health or care provider
- MBS Item 731 - Contribution to a multidisciplinary care plan being prepared for a resident of an aged care facility.

GP Mental Health Treatment Plans apply to patients with mental disorders. GP Mental Health Treatment Medicare items were introduced on to the Medicare Benefits Schedule. They are:

- MBS items 2702 or 2710 - Preparation of a GP Mental Health Treatment Plan
- MBS Item 2712 - Review of a GP Mental Health Treatment Plan
- MBS Item 2713 - GP Mental Health Treatment Consultation.

The items provide a structured framework for GPs to undertake early intervention, assessment and management of patients with mental disorders, as well as providing referral user pathways to clinical psychologists, registered psychologists, and appropriately trained social workers and occupational therapists.

Where a patient has a mental disorder only, it is anticipated that they will be managed using the GP Mental Health Treatment items.

## The operation of the system

Health professionals will typically interact with more than one Medicare program on any given day, however, there is little or no coordination of interactions with health professionals across the programs Medicare administers which results in health professionals receiving competing, mixed or at times conflicting messages from Medicare.

At the same time, different programs rely on the interaction of different medical disciplines and professions to deliver care. Some of these professions and roles are mature and understood, some are maturing through incentive programs and evolving accreditation and training.

The roles that work together to manage patients' care under Chronic Disease and Mental Health Care Plans are:

- GPs practicing in Australia
- AHPs practicing in Australia
- Practice managers/administration staff
- Credentialed Mental Health Nurses – specifically for Mental Health Care Plans.

Chronic Disease Care Plans and GP Mental Health Care Plans are established in the Medical Benefits Schedule by regulations. *Health Insurance (General Medical Services Table) Regulations 2010, s.2.17 and s.2.20*.

In late 2010 a decision was made to develop a holistic approach to compliance activities surrounding Chronic Disease Care Plans and/or General Practitioner Mental Health Care Plans.

## Language

It should be noted that the user pathways on the following pages reflect the experience and language of the health professionals involved – as it currently stands.

During the development process a range of issues around language were noted:

- Though now considered obsolete by the Department of Health and Ageing in relation to the MBS, the term 'Enhanced Primary Care', or 'EPC', is consistently used interchangeably with the programs discussed here.
- There was little, if any, reference to 'Chronic Disease Care Plans'. They were referred to as 'GP Management Plans (GPMPs)' and 'Team Care Arrangements'. 'Mental Health Treatment Plans' were also known by the name of GPMPs.

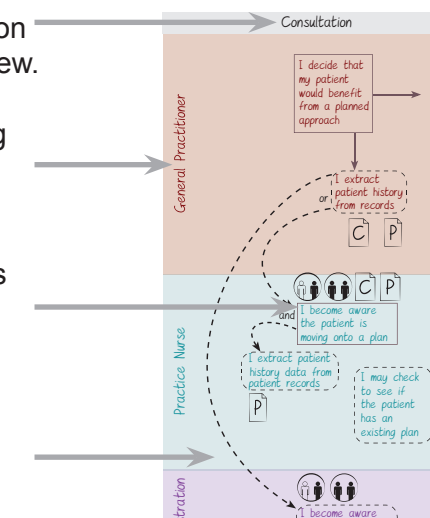


# User Pathways

The two user pathways developed represent a common experience of all the people involved in developing Chronic Disease and Mental Health Care Plans; patients, GPs, practice nurses, allied health professionals, credentialed mental health nurses, practice managers and practice administration staff. The focus of the activities, relationships and touchpoints represented relate to 'red tape' aspects of care plans, not clinical or health outcomes.

The user pathways are constructed as follows:

- Framework for the experience – this groups the common activities across the spectrum from consultation to review.
- Roles represented – these may be by job or a grouping of activities where no single job is responsible (e.g. Practice Manager/Practice Administration).
- Activities – these represent the break-down of activities at a generic level, common to the experience of the users — the wording is also in the voice of the users.
- Dependencies or linkages – these show the interconnectedness of the activities or triggers for activity/response from other users in the pathway.

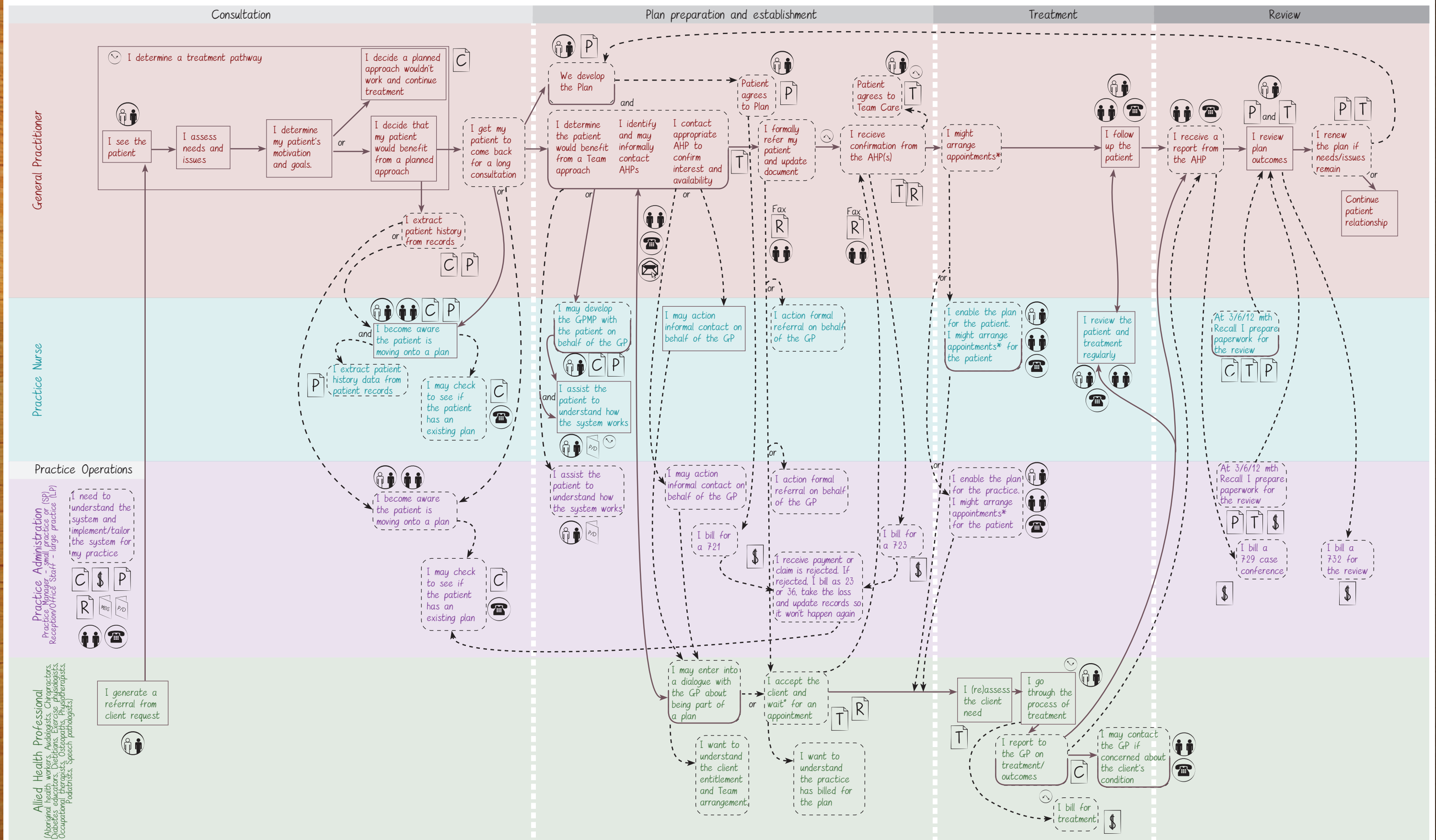
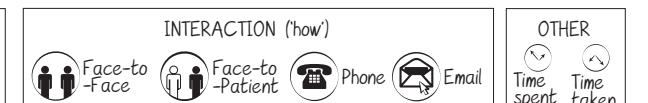
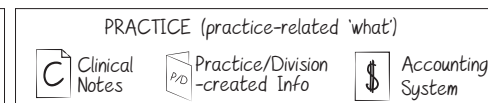
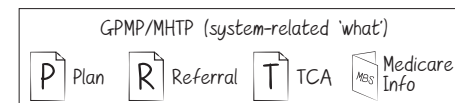
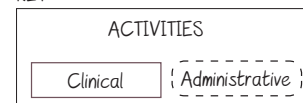




# Chronic Disease Care Plan User Pathway

30 June 2011

KEY



\*If part of practice AHA may proactively make appointments

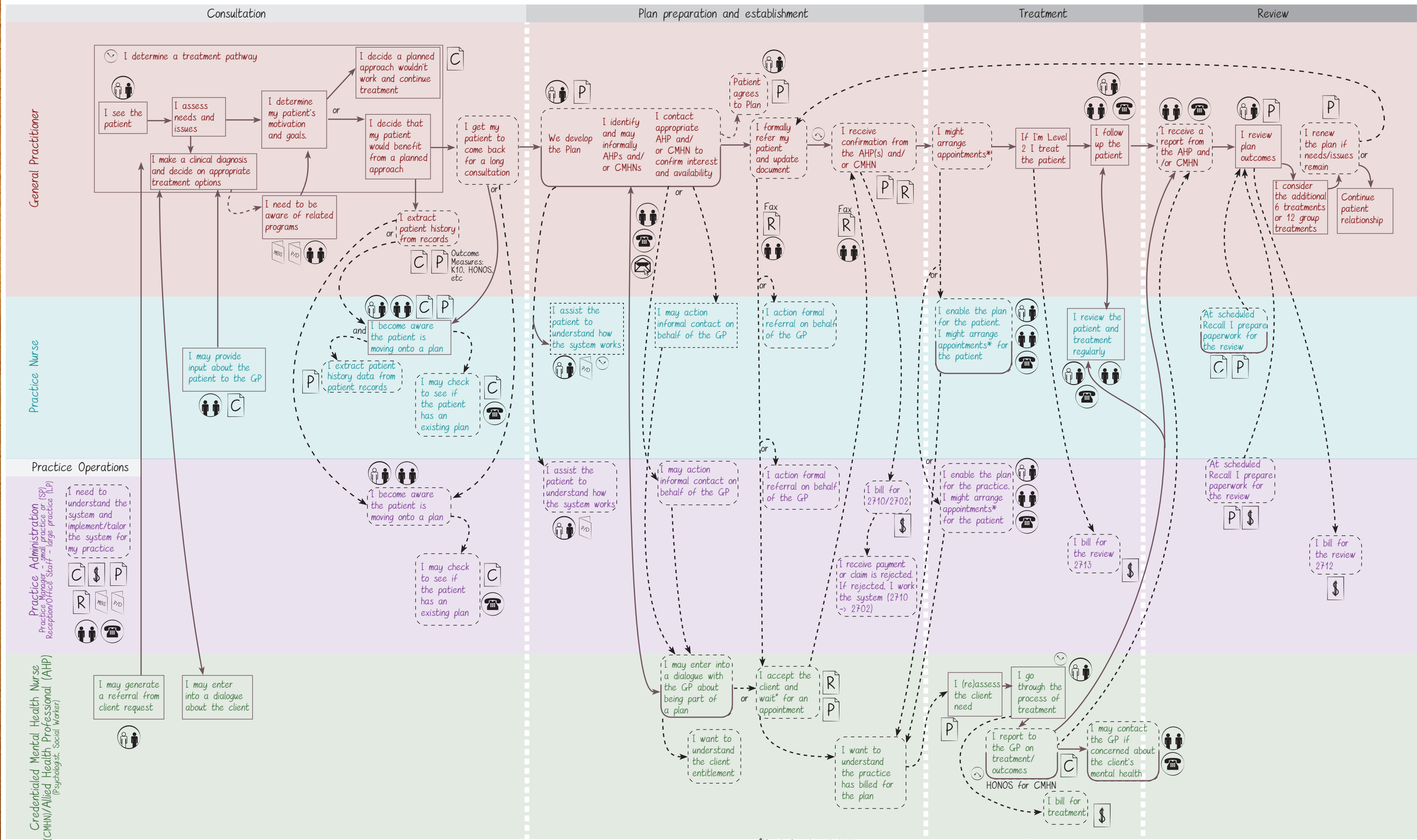
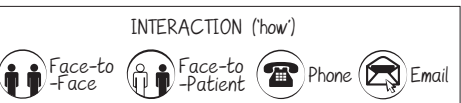
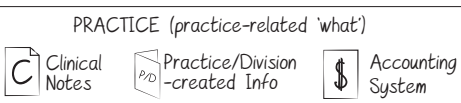
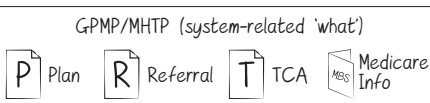
\*If patient doesn't 'like' AHP new referrals and appointments are arranged for remaining treatments



# Mental Health Care Plan User Pathway

30 June 2011

KEY



\*If part of practice AHA/CMHN may proactively make appointments

\*If patient doesn't like AHP new referrals and appointments are arranged for remaining treatments



# Roles within the User Pathways

The following section drills into the detail of the specific users involved in the development of care plans. Specifically:

- General Practitioners practicing in Australia in small and large practices
- Allied Health Professionals practicing in Australia within General Practices and in stand-alone practices
- Practice Managers and other administration staff
- Practice Nurses and Credentialed Mental Health Nurses.

Each role is described at the level of:

- Goal - what it is that drives their activity
- What gets in the way - drawing out what issues, irritants or barriers get in the way of the role achieving their goal.



## General Practitioner

CONSULT	
My goal	What gets in the way?
<p>My goal is to ensure the patient is open to and will benefit from a planned approach plan.</p> <p>I do that by determining:</p> <ul style="list-style-type: none"><li>• If the patient ready for change,</li><li>• Has remediable factors in patients lifestyle/self-care/chronic disease.</li><li>• If the patient will be engaged in their chronic disease management and self care.</li></ul>	<ul style="list-style-type: none"><li>• Misinformation about entitlements – from AHPs, from family and social networks.</li><li>• A care plan is only as good as the knowledge, experience and networks of the GP. This means some GPs don't develop them at all.</li></ul> <p><i>"They're not capable of understanding....and I don't understand the whole process anyway."</i> GP</p> <ul style="list-style-type: none"><li>• Patient goals and health system expectations.</li></ul> <p><i>"If the patient is willing [to pay for treatment] I won't go through the Treatment Plan process because it's only to get funding, but [the patient] usually likes the free sessions – so they drive it."</i> GP</p>
In addition for GPs in the mental health space	
My goal	
<p>My goal is as above, but also to ensure that the patient to have an experience and journey through mental health services as simple and easy as possible as this group, more than any other struggle with financial adversity, marginalisation, inter-personal relationship dysfunction and cognitive challenges that all impact on communication, ability to engage and act.</p> <p>NB: For GPs in the Mental Health space this additional goal informs their activities across all stages of the pathway.</p>	



PLAN PREPARATION AND ESTABLISHMENT

My goal	What gets in the way?
<p>My goal is to set-up a formal care plan to allow my patient to access a range of services.</p> <p>I do that by determining:</p> <ul style="list-style-type: none"><li>Whether team care arrangements would lead to better clinical outcomes</li><li>Whether the patient need would be served by the benefits associated with the care plan set-up (i.e. “free appointments”).</li></ul> <p>I comply with the requirements of the administrative system to the level I perceive is appropriate. This includes:</p> <ul style="list-style-type: none"><li>Determining the patient is clinically eligible</li><li>Co-ordinating the most appropriate team, including roles within my own practice</li><li>Keeping the records I need to keep in case I'm audited later.</li></ul>	<p>“Red tape”</p> <ul style="list-style-type: none"><li>Compliance rather than getting on with consultation. <i>“[the requirements are deliberately vague and I suspect come from] someone who has no idea about general practice and how the real world works is going to keep an eye on what the GPs do.” GP</i></li><li><i>“The plan is meant to be about health, not administration.” GP</i></li><li>Paperwork actually disrupts the interaction with the patient. <i>“You’re filling in forms when all you want to do is treat or refer someone.” GP</i></li><li><i>“I’m familiar with all the item numbers and how they work but to try and integrate where they’re up to and make all the management and clinical decisions is more than one person can reasonably do.” GP</i></li><li>Requirement for the patient to be in the room when preparing the plan can compromise the clinical discussion.</li><li>GP paranoia around compliance leads to over compliance in some instances.</li><li>Time spent calling Medicare and inconsistency of advice. <i>“There is no shortage of information, there’s a shortage of interpretation.” GP</i></li><li>Rebates don’t adequately cover the cost of services, particularly the level of non-face-to-face activity required for patients. Some practices ‘work the system’ to cover costs. <i>“Most of my time is taken up with documenting, rather than treating.” GP</i></li><li>Lack of available AHPs, especially in rural areas.</li><li>Perception that Medicare doesn’t trust GPs. <i>“Having to get permission beforehand like a legal contract to administer healthcare, when there’s an implied permission for me to provide healthcare because that’s why patients come to me.” GP</i></li></ul>
	<p>In addition for GPs in the mental health space</p> <ul style="list-style-type: none"><li>For MH they are cumbersome, repetitive and have redundancies.</li><li>GP guilt factor over doing the plan just to get access to services. <i>“It’s a long drawn out process to fill in all the details – first of all to discuss, then to fill out all the forms...and then develop the plan from there” – this takes multiple sessions.” GP</i></li></ul>

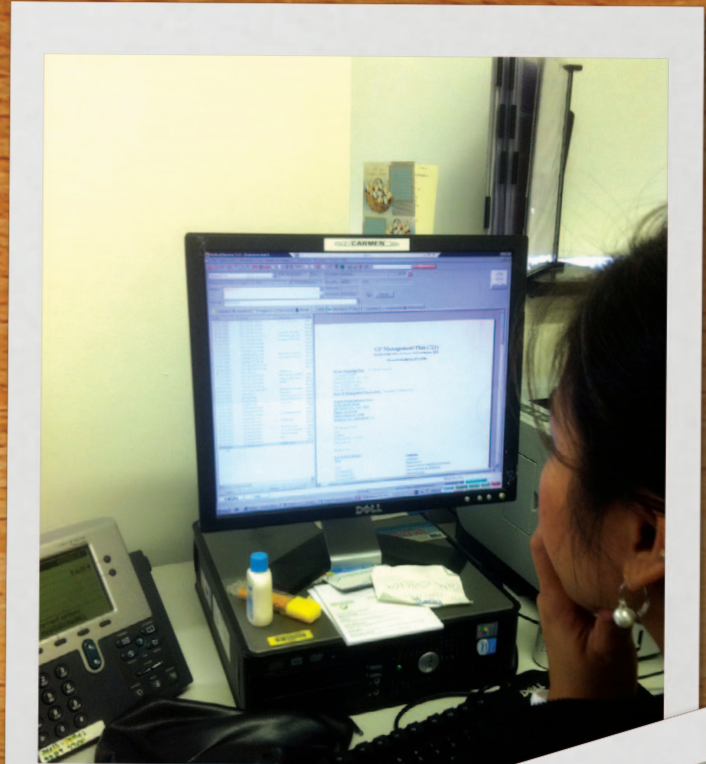
TREATMENT

My goal	What gets in the way?
<p>My goal is to ensure patient and the team members are working towards good clinical outcomes.</p> <p>I do that by:</p> <ul style="list-style-type: none"><li>Maintaining the central role in co-ordinating delivery of the team care services</li><li>Ensuring the patient is engaged and responding appropriately to treatments.</li></ul>	<p>Patient commitment levels to treatment:</p> <ul style="list-style-type: none"><li>Not allowing time for appointments.</li><li>Patients defensiveness about lifestyle issues.</li><li>Socio-economic issues – e.g. affordability of transport. <i>“The nature of patients with a mental health problem is a challenge; [they are] a difficult group to engage, sustain and make a difference for.” GP</i></li><li>Rebates do not adequately reflect the cost of the services.</li><li>Significant amount of clinical work is not face-to-face activity; the MBS items don’t pay for this time.</li><li>Real life care in mental health doesn’t fit neatly within the bureaucratic steps of administration.</li></ul>

REVIEW

My goal	What gets in the way?
<p>My goal is to make a judgement about the outcome of the care plan and next steps for treatment.</p> <p>I do that by determining:</p> <ul style="list-style-type: none"><li>Whether the patient is getting significantly better or at least functioning more appropriately.</li></ul> <p>I comply with the requirements of the administrative system to the level I perceive is appropriate. This includes:</p> <ul style="list-style-type: none"><li>Finalising the records I need to keep in case I'm audited later</li><li>Renewing plan, if appropriate.</li></ul>	<ul style="list-style-type: none"><li>Understanding what constitutes a formal review and getting AHP’s input.</li><li>Delays to second set of referrals for mental health treatments. <i>“Trial and error. And paranoia. So doing more than what you have to; read the Medicare explanations and do a little bit more.” GP</i></li></ul>





# Practice Nurse

## CONSULT — PLAN PREPARATION AND ESTABLISHMENT

My goal	What gets in the way?
Practice Nurse	
<p>My goal is to work corroboratively with the GP for patient and practice outcomes.</p> <p>I do that by supporting:</p> <ul style="list-style-type: none"><li>• The GP through initial development of the plan, co-ordinating AHPs at both an administrative and clinical level (if required)</li><li>• Eligibility clarification directly with Medicare (if required)</li><li>• The patient to understand what is required of them.</li></ul>	<p><b>Consult</b></p> <ul style="list-style-type: none"><li>• Understanding the rules around patient entitlement and team care arrangements for the purposes of educating the patient and assisting the GP.</li><li>• Accommodating activities around different practitioner preferences.</li><li>• Volume of 'unpaid work' (e.g. patient follow-up, attendance).</li></ul> <p><b>Plan preparation and establishment</b></p> <ul style="list-style-type: none"><li>• Identifying appropriate AHPs.</li><li>• Connecting patient preferences with AHP availability.</li><li>• Managing the expectations and needs of the patient within the plan entitlements.</li><li>• Volume of 'unpaid work' (e.g. patient follow-up, attendance).</li></ul>

## TREATMENT — REVIEW

My goal	What gets in the way?
Practice Nurse	
<p>My goal is to support the GP and patient during the treatment process.</p> <p>I do that by continuing to assist:</p> <ul style="list-style-type: none"><li>• In the delivery of team care services</li><li>• Patient engagement in treatment and outcomes</li><li>• Preparing paperwork and provide clinical advice to support review process.</li></ul>	<p><b>Treatment</b></p> <ul style="list-style-type: none"><li>• Identifying appropriate AHPs.</li><li>• Connecting patient preferences with AHP availability.</li><li>• Managing the expectations and needs of the patient within the plan entitlements.</li><li>• Volume of 'unpaid work' (e.g. patient follow-up, attendance).</li></ul> <p><b>Review</b></p> <ul style="list-style-type: none"><li>• Volume of 'unpaid work' (e.g. patient follow-up, attendance).</li></ul> <p><i>"I spend a lot of my time running around making sure patients get to their appointments which I don't mind doing because they need the help." PN</i></p>



Practice Manager – Small Practice

Practice Administration – Large Practice

PRACTICE OPERATIONS	
My goal	What gets in the way?
<b>Small Practice</b> (e.g. Practice Manager, Receptionist)	
My goal is to ensure the financial success and sustainability of the practice.  I do that by: <ul style="list-style-type: none"><li>Understanding the requirements of the Health system</li><li>Understanding our business model</li><li>Implementing the system within my practice, including tailoring systems for GP preferences.</li></ul>	<ul style="list-style-type: none"><li>Understanding of MBS.</li><li>Fear of audit.</li><li>Receiving notification of changes to rules after they come into effect.</li><li>Practitioner preferences – many GPs.</li></ul> <p><i>“I’ve structured myself around these [Medicare and systemic] decisions – I’m employing people based on these structures.” GP</i></p>
<b>Large Practice</b> (e.g. Practice Manager for set-up, Receptionist, Office staff for operational activity)	
As above, plus <ul style="list-style-type: none"><li>By ensuring that the variety of roles involved can implement the system efficiently.</li></ul>	As above

CONSULT — PLAN PREPARATION AND ESTABLISHMENT — TREATMENT — REVIEW	
My goal	What gets in the way?
<b>Small Practice</b> (e.g. Practice Manager, Receptionist)	
My goal is to ensure practice receives payments for services rendered.  I do that by: <ul style="list-style-type: none"><li>Assisting the patient to understand what is required of them</li><li>Co-ordinating the administrative aspects of team care including my GP’s role</li><li>Liaising with Medicare to ensure payment and processing</li><li>Preparing paperwork to support review process</li><li>Maintaining records for potential audit</li><li>Managing the compliance process when audited.</li></ul>	<ul style="list-style-type: none"><li>Tailoring practice around different practitioner preferences</li><li>Maintaining multiple channels to communicate with patient, but also to fulfil compliance requirements (e.g. fax for written signatory).</li><li>Education and management of patients including:<ul style="list-style-type: none"><li>Those who don’t qualify for getting referrals from AHPs</li><li>Those who present but already have a plan</li><li>Those who’s behaviour is effected by their condition (ie mental health).</li></ul></li><li>Another practice “picks up” patient and does a review which means the practice can’t charge for a Review.</li><li>Negotiating with AHP and explaining to the patient the difference between subsidised amount and actual cost of treatment.</li><li>Managing multiple calendars.</li><li>Lack of clarity around item numbers.</li><li>Volume of ‘unpaid work’ (e.g. patient follow-up, attendance) impacts the bottom line.</li><li>Interaction with Medicare:<ul style="list-style-type: none"><li>Managing the impact of the delay in notification if the claim is rejected</li><li>Lack accessible information including verbal advice</li><li>Difficult to navigate MBS</li><li>Inability to prepare for potential audit</li><li>Time staff and materials required for Audit process.</li></ul></li></ul> <p><i>“I always get the impression that the [complexity] of the item numbers – is there to discourage people from abusing the system rather than helping us... that’s the feeling that you get that they’re just trying to put a lid on you.” GP</i></p> <p><i>“Mental health work doesn’t pay and it’s going to be less well-paid on 1 November...so the decision will have to be made how much of this do I want to do – I enjoy it and it creates a balance in pace for me but there’s a limit to what you can do.” GP</i></p>
<b>Large Practice</b> (e.g. Practice Manager for set-up, Receptionist, Office staff for operational activity)	
As above, however, in a large practice the Practice Operations requirement is to manage a large number of roles in the administrative space as well as processes. Practice-specific templates and protocols differentiate it from a small practice.	As above.



# Allied Health Professionals/Credentialed Mental Health Nurse

PRACTICE OPERATIONS	
My goal	What gets in the way?
Allied Health Professionals	
<p>My goal is to implement a course of treatment that will benefit the patient within the constraints of the available time.</p> <p>I do that by understanding:</p> <ul style="list-style-type: none"><li>The requirements of the Health system</li><li>My business model (if outside of a practice)</li><li>Implementing the system within my practice.</li></ul>	<ul style="list-style-type: none"><li>Volume of 'unpaid work' (e.g. patient follow-up, attendance). <i>"It's not really team care - it's co-ordinated care. Collaborating is really difficult for TCA." AHP</i></li></ul>
Credentialed Mental Health Nurse	
<p>As above, plus my goal is to implement and facilitate a course of treatment that will benefit the patient's mental health and make best use of available government programs in order to keep the patient out of hospital.</p>	<ul style="list-style-type: none"><li>As above <i>"Others understanding our role in MHTP. Stakeholders do not tend to understand. They are getting better. Usually what helps them understand is who employs us – when I say I am employed by the general practice." CMHN</i></li></ul>
CONSULT — PLAN PREPARATION AND ESTABLISHMENT	
My goal	What gets in the way?
Allied Health Professionals	
<p>My goal is to implement a course of treatment that will benefit the patient within the constraints of the available time.</p> <p>I do that by:</p> <ul style="list-style-type: none"><li>Responding to referral requests and understand the patients current needs, goals and motivation</li><li>Ensuring, as much as is possible, that taking on the patient won't cost me financially (ie patient eligibility and commitment to treatment).</li></ul>	<ul style="list-style-type: none"><li>Managing the expectations and needs of the patient within the plan entitlements.</li><li>Volume of 'unpaid work' (e.g. patient follow-up, attendance) – particularly in the mental health space due to complex nature of cases.</li><li>Interaction with Medicare:<ul style="list-style-type: none"><li>Lack accessible information including verbal advice</li><li>Difficult to navigate MBS</li><li>Not knowing what an audit involves</li><li>Not knowing how to prepare for an audit</li><li>Inability to prepare for potential audit.</li><li>Time staff and materials required for audit process.</li></ul></li><li>Payment rates are too low.</li><li>Number of available programs adds complexity.</li><li>Quality of mental health plans coming from GPs varies.</li><li>Re-diagnose treatment after the GP has done it already.</li></ul>
Credentialed Mental Health Nurse	
<p>As above plus, my goal is to implement and facilitate a course of treatment that will benefit the patient's mental health and make best use of available government programs in order to keep the patient out of hospital.</p> <p>I do that by:</p> <ul style="list-style-type: none"><li>Responding to referral requests and understanding the patients current needs, goals and motivation</li><li>Providing the primary face-to-face relationship throughout the course of treatment</li><li>Understanding the patient's total life circumstances and supporting them through case management.</li></ul>	As above

TREATMENT	
My goal	What gets in the way?
Allied Health Professionals	
<p>My goal is to implement a course of treatment that will benefit the patient within the constraints of the available time.</p> <p>I do this by:</p> <ul style="list-style-type: none"><li>Supporting the patient to self-manage beyond the treatment activity</li><li>Reporting outcomes of the treatment to the GP/Practice Nurse.</li></ul>	<ul style="list-style-type: none"><li>As per the Consult, Plan and Establishment</li></ul>
Credentialed Mental Health Nurse	
<p>As above plus, my goal is to implement and facilitate a course of treatment that will benefit the patient's mental health and make best use of available government programs in order to keep the patient out of hospital.</p> <p>I do that by:</p> <ul style="list-style-type: none"><li>Supporting the patient to self-manage beyond the treatment activity including introducing the patient to a wider support network</li><li>Undertaking progress measurement and documenting outcomes for reporting to the GP/ or appropriate AHP.</li></ul>	<ul style="list-style-type: none"><li>As above</li></ul>

REVIEW	
My goal	What gets in the way?
Allied Health Professionals	
<p>My goal is to implement a course of treatment that will benefit the patient within the constraints of the available time.</p> <p>I do that by:</p> <ul style="list-style-type: none"><li>Supporting the patient to self-manage beyond the treatment activity</li><li>Reporting outcomes of the treatment to the GP/Practice Nurse.</li></ul>	<ul style="list-style-type: none"><li>Volume of 'unpaid work' (e.g. patient follow-up, attendance) <i>"We are working hard to change our practices so that the client gets a better experience and we also help the GPs. The GPs are so busy and they can't do everything in their sessions, we need to take some of that load." MHN5</i></li></ul>
Credentialed Mental Health Nurse	
<p>My goal is to enable the client's mental health issues to diminish.</p>	<ul style="list-style-type: none"><li>As above</li></ul>



# Relationships and Tools

CONSULT	
Who's involved	Tools used
<ul style="list-style-type: none"><li>GP</li><li>Patient, different types include:<ul style="list-style-type: none"><li>Existing patient to practice – plan is GP-initiated or patient-initiated, or</li><li>New to Practice - plan is GP-initiated or patient-initiated, or</li><li>Existing or new patient is referred by AHP for care plan</li></ul></li><li>AHP</li></ul>	<p>For clinical treatment:</p> <ul style="list-style-type: none"><li>Software:<ul style="list-style-type: none"><li>Recall/review systems</li><li>Clinical software for patient records</li></ul></li></ul> <p>Tailored Templates for Care Plan, Referral and Review - multiple and customisable division-sourced or practice-tailored templates</p> <ul style="list-style-type: none"><li>Fax, email<ul style="list-style-type: none"><li>Practice to practice communication and proof of signature</li></ul></li><li>Face-to-face, phone<ul style="list-style-type: none"><li>Clinical conversation and informal discussion of team care</li></ul></li></ul> <p>For awareness of Care Plan processes:</p> <ul style="list-style-type: none"><li>Patient Education material<ul style="list-style-type: none"><li>Posters and Health-based educational material/social marketing (including TV) to promote readiness to change/engage</li><li>GP-generated Practice Manuals/Brochures for patients to understand how care plans work</li></ul></li><li>GP education material:<ul style="list-style-type: none"><li>Division of General Practice – Seminars, Newsletters</li><li>Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV)</li></ul></li><li>Policy and service delivery agencies<ul style="list-style-type: none"><li>MBS</li><li>medicare.gov.au</li><li>Medicare call centre</li><li>DOHA material</li></ul></li></ul> <p>For payment from Medicare</p> <ul style="list-style-type: none"><li>Manual swipe or online</li></ul>

PLAN PREPARATION AND ESTABLISHMENT	
Who's involved	Tools used
<ul style="list-style-type: none"><li>GP</li><li>Patient</li><li>Peers within practice</li><li>Network of professionals and AHP - Podiatrist, Optometrist, Dietician, Diabetes Educator, Speech Therapy, Occupational Therapist, Chiropractor, Exercise Physiologist, Physiotherapist, Dentists, Psychiatrist, Social Worker</li><li>Practice Nurse</li><li>Practice Manager, Office Administrator, Receptionist</li><li>Division of GP, Professional Associations</li><li>Medicare (for small practices)</li><li>Credentialed Mental Health Nurse</li><li>Other non-clinical administration staff to pull plan components together</li></ul>	<p>As per Consultation</p>

TREATMENT	
Who's involved	Tools used
<ul style="list-style-type: none"><li>GP</li><li>Patient</li><li>Network of professionals and AHP - Podiatrist, Optometrist, Dietician, Diabetes Educator, Speech Therapy, Occupational Therapist, Chiropractor, Exercise Physiologist, Physiotherapist, Dentists, Psychiatrist, Social Worker</li><li>Practice Nurse</li><li>Practice Manager, Office Administrator, Receptionist</li><li>Division of GP, Professional Associations</li><li>Medicare (for small practices)</li><li>Credentialed Mental Health Nurse</li></ul>	<p>For tracking clinical progress:</p> <ul style="list-style-type: none"><li>Fax, email<ul style="list-style-type: none"><li>Practice to practice communication</li></ul></li><li>Face-to-face, phone – with Team<ul style="list-style-type: none"><li>Clinical conversation and informal discussion of team care</li></ul></li><li>Face-to-face, phone, SMS, letter – with Patient<ul style="list-style-type: none"><li>Follow-up with patient to ensure appointments are being attended</li></ul></li></ul> <p>For payment from Medicare</p> <ul style="list-style-type: none"><li>Manual swipe or online</li></ul>

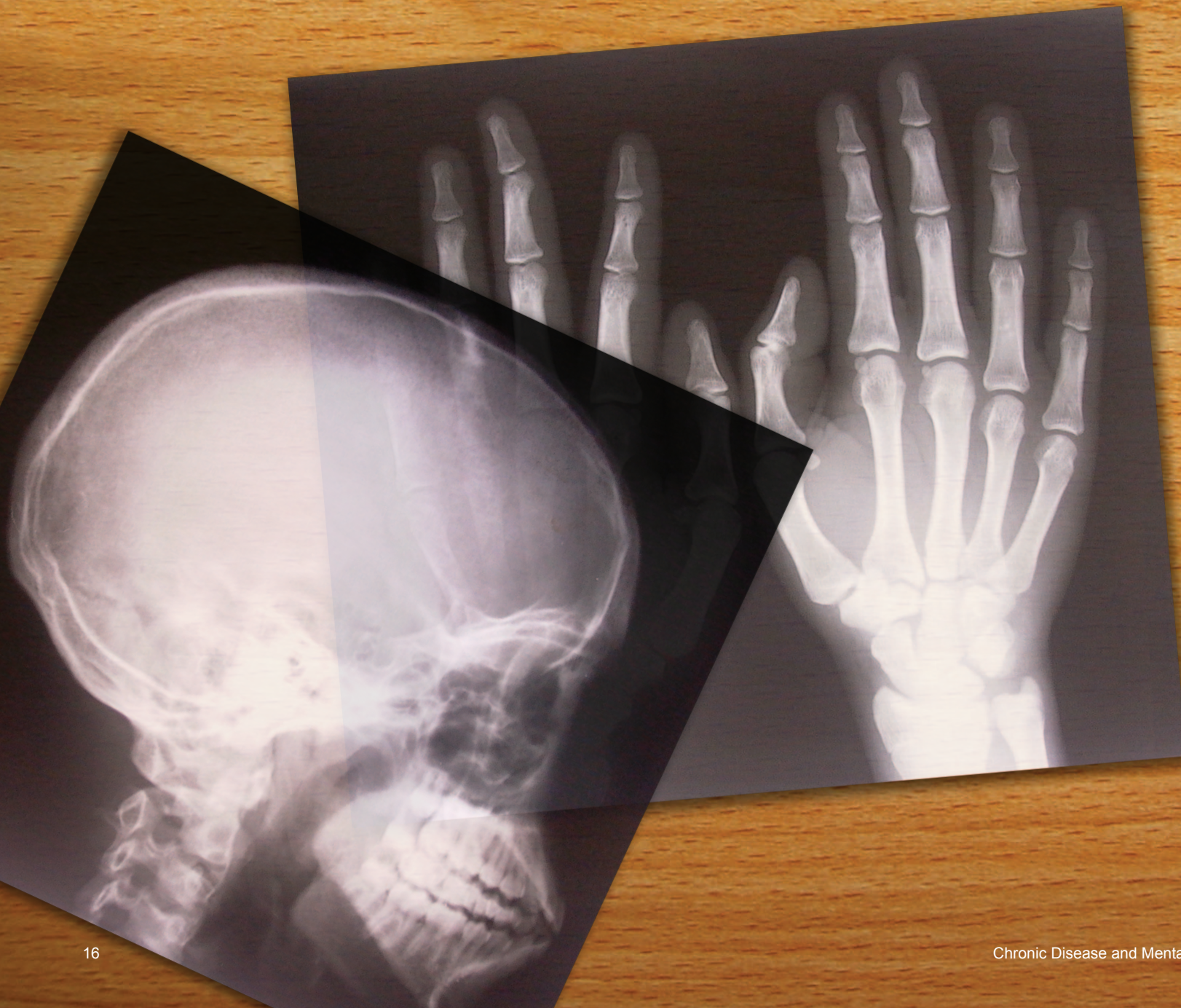
REVIEW	
Who's involved	Tools used
<ul style="list-style-type: none"><li>GP</li><li>Patient</li><li>Network of professionals and AHP - Podiatrist, Optometrist, Dietician, Diabetes Educator, Speech Therapy, Occupational Therapist, Chiropractor, Exercise Physiologist, Physiotherapist, Dentists, Psychiatrist, Social Worker</li><li>Practice Nurse</li><li>Practice Manager, Office Administrator, Receptionist</li><li>Division of GP, Professional Associations</li><li>Medicare (for small practices)</li><li>Credentialed Mental Health Nurse</li></ul>	<p>For reviewing clinical progress:</p> <ul style="list-style-type: none"><li>Software:<ul style="list-style-type: none"><li>Recall/review systems</li><li>Clinical software for patient records</li></ul></li><li>Face-to-face, phone, SMS, letter – review/recall with Patient</li><li>Tailored Templates for the Care Plan</li></ul> <p>For payment from Medicare</p> <ul style="list-style-type: none"><li>Manual swipe or online</li></ul>



# Insights and Ideas

The following section sets out the synthesised results from the research and series of workshops held with health professionals. Features of this section include:

- The four key insights about the experience and the practice of developing care plans.
- A highlighted view of the user pathways which provides context for the four key insights.
- Ideas for improvement sourced directly from the health professionals.
- Conclusions and next steps.





Key Insights

From the research and series of workshops with health professionals the following four key insights about the experience and practice of developing care plans have emerged:

PLAN CONCEPT IS GOOD	PATIENTS ARE A BIG FACTOR IN THE EFFECTIVENESS OF PLANS	PROCESS CLARITY IS LACKING	ADMINISTRATIVE BURDEN COMPROMISES CLINICAL OUTCOMES
<p>The plan concept is considered a positive development and health professionals will make it work because they care about the patient outcome.</p> <p><i>“I think the care plans are generally good – a good thing to do – they have resulted in forcing us to be more organised, and to include practice nurses who are integral and vital to the success – good but a long haul.”</i></p> <p><i>“...coming from a different country, Australia has a really good health system giving the chance for especially marginal population [who] can’t usually afford to have these benefits – the care plan [and] to have these benefits – is really good!”</i></p>	<p>The type of patient, from a non-clinical standpoint (age, motivation, socio-economic status) is a factor in the trigger for, and successful implementation of, a Plan.</p> <p>The role of the patient in participating in the plan from the point of consultation, to making or attending appointments, to ‘liking’ the Allied Health Professional impacts the non-clinical outcomes, and informs the administrative burden on the practices and health professionals.</p> <p><i>“[Patient’s] are not capable of understanding.... and I don’t understand the whole process anyway.”</i></p> <p><i>“The nature of patients with a mental health problem is a challenge; [the patient’s are] a difficult group to engage, sustain and make a difference for.”</i></p>	<p>The level of explicit and easily accessible guidance and instruction on the care plan process and expectations is vague at best – for both health professional and patient alike.</p> <p>While tools and education exist it is pitched at a one-size-fits all view which means practices and Divisions of General Practice come up with interpretations of what is required, what works for the practice business model and styles of individual GPs.</p> <p>In terms of audit, no health professional objected to being audited, but the lack of direction meant that ‘audit fear’ was common and impacted practice — in terms of under- and over-complying.</p> <p><i>“In essence I think the care plan is a good idea but there is a feeling that you’re going to be audited one day and have you ticked all the boxes, and are they going to take all your money off you because you haven’t done this that and the other” - “there’s a big brother feeling that I’m being watched and coerced and not trusted.”</i></p> <p><i>“They give us guidelines [but] I’ve never seen an example of what represents an acceptable written product so we’re left a little bit exposed as to what constitutes a valid care plan.”</i></p>	<p>The volume of administrative requirements (i.e. paperwork, especially with the patient in attendance, or papers requiring signatures when practices operate in an electronic environment), is seen as compromising clinical responsibility.</p> <p>Interaction is also compromised, and often GPs complete the ‘form filling’ outside of the appointment, or delegate it for completion to a Practice Nurse or, in some cases, a non-clinical staff member.</p> <p><i>“Most of my time is taken up with documenting, rather than treating...sometimes I have my back to the patient because I’m filling in the forms.”</i></p> <p><i>“We [Practice Nurse’s] have more time than GPs. We have time to follow up on our clients backgrounds [yet you] can’t charge for the nurses’ time unless GP sees the patient.”</i></p>



## Observations and Insights - Chronic Disease Care Plans

The collection of observations and emergent insights directly sourced during the user pathways development are grouped by the key themes below:

## Red tape



1. From a Medicare perspective compliance falls under plan preparation, establishment and Review. In practice, the pre-preparation activity i.e. 'consultation' and 'treatment' itself represent the clinical activities.
2. The pathway demonstrates why care plans for solo GPs is difficult due to the required trade-off in time spent administering versus treating. *This is also an Education issue.*
3. The regulatory process has been designed from a one-size-fits all perspective. However, there is a difference between large scale practices and solo GPs in terms of how they set-up and run their internal systems.
4. To manage the administrative load some practices 'work the system' to achieve patient outcomes – e.g. delegate paperwork to non-GP staff (nurses, other).
5. It is almost exclusively administrative activity that takes place during plan preparation and review. Proportionally Care Plans are a small part of a practices business, but they represent a significant paper workload when they are enacted.
6. The issue for GPs around referrals is the paperwork (in addition to the plan) and perception of Medicare 'mistrust' that paperwork is of more value than trusting professional relationships.
7. There is confusion as to whether a Team Care Arrangement and a Referral are separate things. Are they both outputs? Is the TCA the activity and the Referral the record?
8. There is a sense from administration staff – particularly nurses from a clinical standpoint but also practice managers and receptionists, that their work is of less value or a burden on the practice because they are not specifically billable for the work they do in assisting the GP and patient to achieve Care Plan outcomes.
9. There is a significant level of 'unpaid' activity for all the health professionals - in particular, non-GPs. This generally comes from paperwork compliance - both required and pre-emptive, patient 'chasing up' and review activities. *This is also a Policy issue.*

## Education



1. Chronic Disease Management Plans are referred to as 'GPMP', or 'GPMP plus a TCA'.
2. There are no guidelines on the time limit of reporting back to the GP. *This is also a Policy issue.*
3. Some AHP's make inappropriate 'reverse referrals' (chronic disease) which means the GP needs to spend time assessing eligibility and/or re-educating the patient.

## Audit



1. 'Audit fear' is common across health professionals, and informs their attitudes towards the process – either by 'over-complying' or assuming they aren't complying and 'just getting on with it' because treating the patient is the priority.

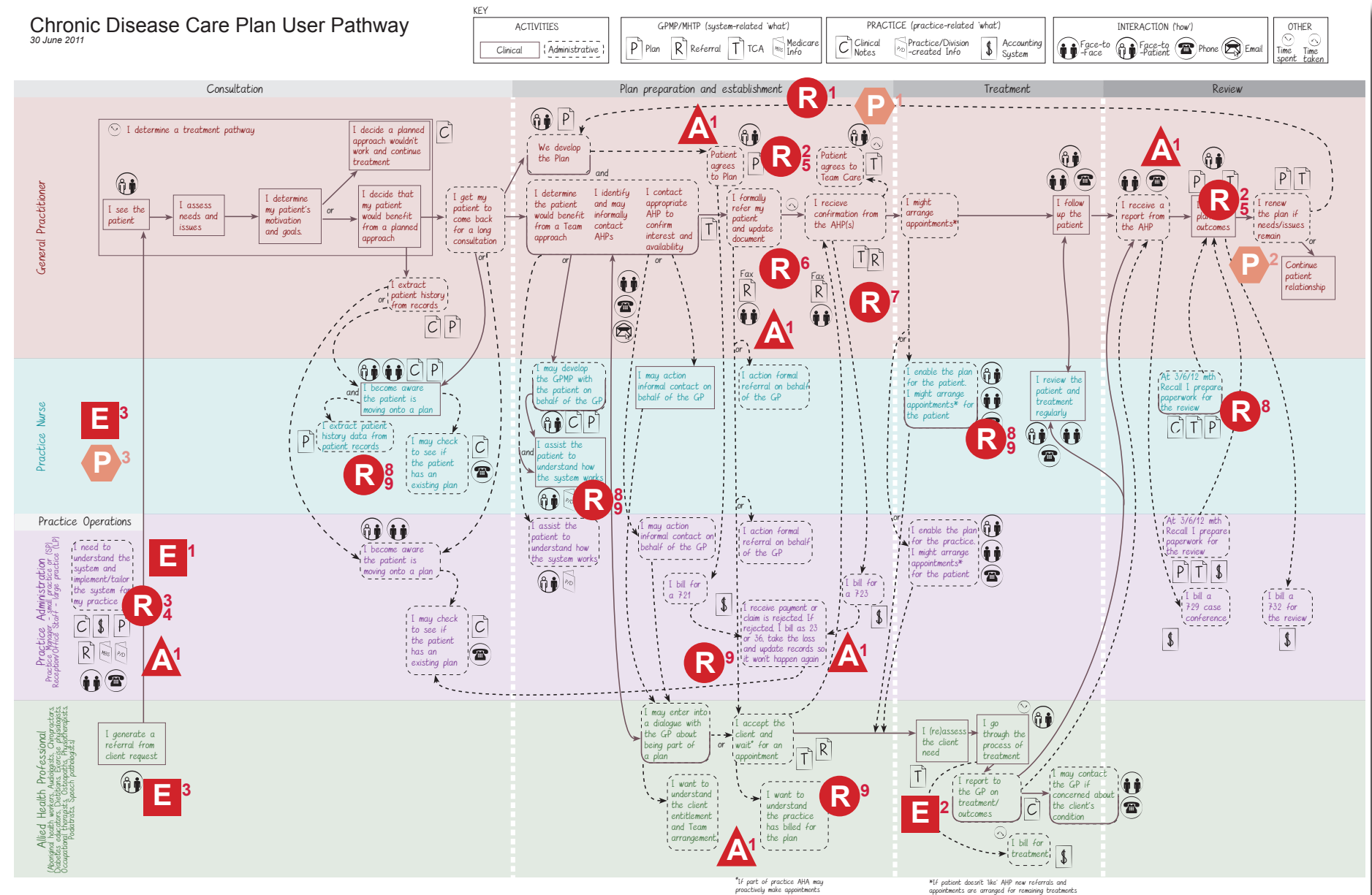
## Policy



1. TCA is not 'team' in the sense of a group of collaborating partners working on the patient treatment and outcome – everyone goes through GP.
2. The nature of a chronic disease means that the allocation of five AHP sessions is not enough.
3. The role of the Practice Nurse is justified by the administrative support they can provide GPs, but the complexity of the topic means practices are challenged in sourcing competent nurses. *This is also an Education issue.*

## Chronic Disease Care Plan User Pathway

30 June 2011





## Observations and Insights - Mental Health Care Plans

The collection of observations and emergent insights directly sourced during the user pathways development are grouped by the key themes below. One significant overarching observation to take into account for mental health care plans are the patients. From both a clinical and non-clinical standpoint the patients themselves represent particular challenges for the health professionals because their issues can manifest in their behaviours and require additional energy and effort on the part of health professionals.

## Red tape



1. From a Medicare perspective compliance falls under plan preparation, establishment and Review. In practice, the pre-preparation activity i.e. 'consultation' and 'treatment' itself represent the clinical activities.
2. The pathway demonstrates why care plans for solo GPs are difficult due to the required trade-off in time spent administering versus treating.
3. The regulatory process has been designed from a one-size-fits all perspective. However, there is a difference between large scale practices and solo GPs in terms of how they set-up and run their internal systems.
4. Not all administration is 'bad' but items such as the Care Plans themselves have been described as 'compendious'.
5. It is almost exclusively administrative activity that takes place during plan preparation and review. Proportionally Treatment Plans are a small part of a practices business, but they represent a significant paper workload when they are enacted.
6. The issue for GPs around referrals is the paperwork (in addition to the plan) and perception of Medicare-mistrust that paperwork is of more value than trusting professional relationships.
7. There is a sense from administration staff – particularly nurses from a clinical standpoint but also practice managers and receptionists, that their work is of less value or a burden on the practice because they are not specifically billable for the work they do in assisting the GP and patient to achieve Care Plan outcomes.
8. There is a significant level of 'unpaid' activity for all the health professionals - in particular, non-GPs. This generally comes from paperwork compliance - both required and pre-emptive, patient 'chasing up' and review activities. *This is also a Policy issue.*

## Education



1. Mental Health Treatment Plans are generally referred to as GPMP or GPMHTP. GPs also refer to them as EPC.
2. There are no guidelines on the time limit of reporting back to the GP. *This is also a Policy issue.*
3. Application of 'exceptional circumstances' are not clearly understood for accessing treatment. *This is also a Policy issue.*

## Audit



1. 'Audit fear' is common across health professionals, and informs their attitudes towards the process – either by 'over-complying' or assuming they aren't complying and 'just getting on with it' because treating the patient is the priority.

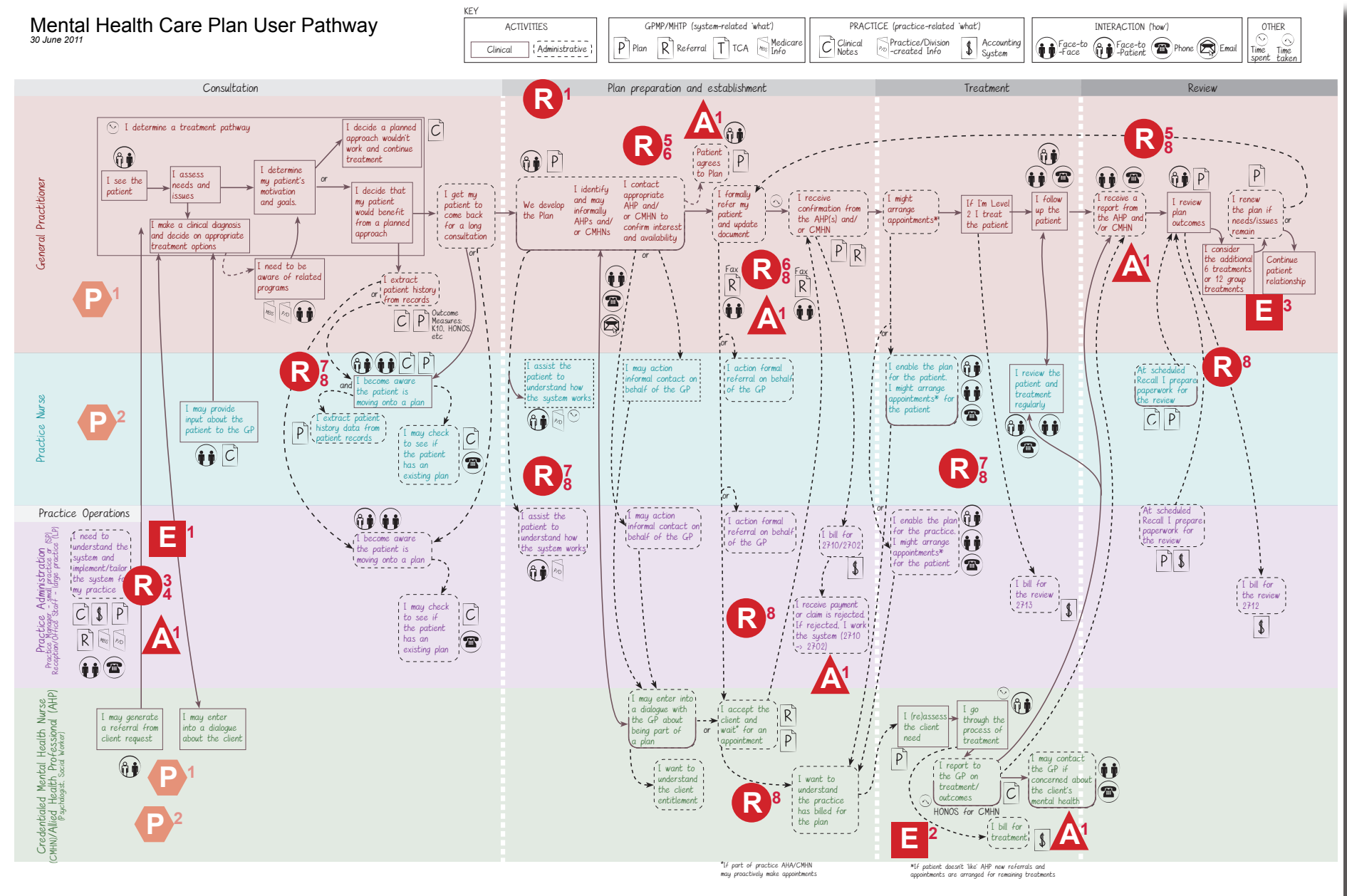
## Policy



1. Whilst outside of scope, in addition to the above, reduced rebates for Mental Health patients is seen as another deterrent to taking on patients with mental health issues due to the volume of 'unpaid' work required to manage the patient. The flow on from this is that some practices are structured around the policy (e.g. having a mental health nurse on staff) and some GPs may reconsider their practice structure.
2. The role of the Practice Nurse/Credentialed Mental Health Nurse is justified by the administrative support they can provide GPs, but the complexity of the topic means practices are challenged in sourcing competent nurses. *This is also an Education issue.*

## Mental Health Care Plan User Pathway

30 June 2011





# Ideas from the Health Professionals

The following ideas were suggested by the health professionals during the research and workshops. The ideas range in scope from large scale change to small scale ‘quick wins’ as defined by the users. In some instances their ideas reflect the confusion about the care plan process and requirements and represent an opportunity for improving the experience through clarifying how the care plans are intended to work.

‘RED TAPE’	EDUCATION/SUPPORT/TOOLS	AUDIT AIDS	POLICY SPECIFIC <i>(out of scope but of note)</i>
<p><b>Simplification of the process</b></p> <ul style="list-style-type: none"><li>Simplify the plan documentation needs and the steps required for completion - e.g.<ul style="list-style-type: none"><li>Ability to refer before developing a plan</li><li>Provide minimum requirements for documentation.</li></ul></li><li>Acceptance of treatment by a patient should be understood as plan acceptance (i.e. no signatory required).</li></ul> <p><b>Referrals</b></p> <ul style="list-style-type: none"><li>Accept a ‘standard agreement with a practice’ that if GP uses an AHP regularly there is an understanding that they will provide treatment, eliminating the need for referral paperwork. Have this agreement status updated once a year to ensure it’s meeting appropriate criteria.</li><li>In-house referrals should be by an agreement – otherwise they double up on paperwork.</li><li>Extend referral for mental health to non-mental health AHP – e.g. dietician. By not doing this it puts GPs in a position of working out if can a patient can fit into both a chronic disease and mental health care plan just so they can send them to a dietician or other appropriate AHP.</li><li>Have a different level of referral for psychologists – to avoid double handling of paper work “allow us to facilitate a referral and get paid an appropriate fee which probably isn’t much more than a standard fee.”</li><li>Have a trust-based system that accepts if a GP recommends an AHP this is as acceptable as a referral.</li><li>Learn from the Department of Veterans’ Affairs (DVA) and Indigenous policies who both have good examples:<ul style="list-style-type: none"><li>DVA Request/Referral form (D904) is a simple model of effective referral processes</li><li>Indigenous has good model for PIP/SIP for non-face-to-face appointments.</li></ul></li></ul> <p><b>Item numbers</b></p> <ul style="list-style-type: none"><li>De-couple MBS Item 2710 from referral process.</li><li>Change the rules for a second referral in mental health space.</li><li>If a MBS Item 2710 rejects, automatically apply MBS Item 2702 at a system level.</li><li>Confusion of the MBS Item 732 means GPs can’t differentiate for their records between review of team care arrangement and a care plan (“we can charge two 732s in a day but Medicare will reject this...so now we can’t differentiate in our software”).</li></ul>	<p><b>Develop more public education</b></p> <ul style="list-style-type: none"><li>Develop a common hand-out to give to patients which explains:<ul style="list-style-type: none"><li>What the plans are</li><li>What the CDMP is about</li><li>What they are entitled to and how it works.</li></ul></li><li>Patients have a card, similar to the Department of Veterans’ Affairs model, to record their plan so they can self-manage their visit quotas.</li><li>Ensure the education to mental health patients understands that they require different information – they need to be comfortable with the process and not have their distress increased.</li><li>Provide a translation service to assist non-English speakers understand the Plans.</li></ul> <p><b>Develop more professional education</b></p> <ul style="list-style-type: none"><li>Explain whose job is it to advise the GP that their referrals are not “chronic enough.”</li><li>Communicate the role of Credentialed Mental Health Nurses to GPs and practices.</li><li>Develop a training tool covering how the Plans work and what can and can’t be done. Suggested sections:<ul style="list-style-type: none"><li>Examples of what is acceptable</li><li>What can and cannot be billed under which plan</li><li>What can’t be done or isn’t covered.</li></ul></li><li>Acknowledge social workers on a plan so that AHPs could keep them informed and they could better assist with the coordination of the plans.</li><li>Clarify the options other than plans (ATAPs, Better Access, etc).</li></ul> <p><b>Tools to facilitate Plan development and deployment</b></p> <ul style="list-style-type: none"><li>Develop a resource/ directory via Medicare for finding AHPs. This would be more efficient for locating and making appointments.</li><li>Provide a register of care plans to be able to look up and see if a patient already has one.</li><li>Have a case manager for each plan.</li><li>HPOS is a good model of a simple and effective online system</li><li>Provide better access to interpretation when ringing Medicare.</li></ul>	<p><b>Provide direction</b></p> <ul style="list-style-type: none"><li>Provide concise direction and some clear written criteria for care plans – for GPs, AHPs and patients.</li><li>Have a single source of truth at a national level.</li><li>Make the process clearer to AHPs:<ul style="list-style-type: none"><li>What the rules are</li><li>What referral date to put on their claim</li><li>How often to write to the GP on progress.</li></ul></li><li>Make the process clearer to GPs for mental health, including:<ul style="list-style-type: none"><li>Billing Focused Psychological Strategy (FPS) for Level 2 trained GPs</li><li>Clarify the difference between MBS Item 2713 is a consultation, MBS Item 2712 is a review</li><li>Eliminate need for documentation for a second referral after the initial six treatments have been used</li><li>Clarifying if a patient have both a Chronic Disease and Mental Health plan at the same time.</li></ul></li></ul> <p><b>Take the ‘fear’ out of the audit process</b></p> <ul style="list-style-type: none"><li>Be more compassionate when applying audit controls and clarify the nature of the audit– don’t come from a place of mistrust.</li><li>Control the details that are audited and empower auditors with judgement ability – i.e. why does every single sheet of paper need to be audited.</li></ul>	<p><b>Access to services</b></p> <ul style="list-style-type: none"><li>Increase the number of AHP treatment sessions from five for chronic disease treatment. The issue is with the ability to prioritise treatment across the range of professions and with giving the AHP enough time to diagnose the best treatment. Five sessions doesn’t adequately cover the reality of dealing with multiple issues.</li><li>Pay the AHP directly to eliminate ‘middle-man status of GP – get AHP to manage the plan without GP involvement</li><li>Have free clinics for certain conditions</li><li>Fix the calendar vs year-to-date dates, i.e. revert to anniversary</li></ul> <p><b>‘Unpaid’ work</b></p> <ul style="list-style-type: none"><li>One session to complete treatment plan isn’t enough — especially mental health care plans. This is envisioned as a three-stage process:<ul style="list-style-type: none"><li>Session 1 with patient</li><li>Session 2 with AHPs</li><li>Session 3 for follow-up.</li></ul></li><li>Follow-up activity should be remunerated as the set-up is i.e. non-face-to-face time.</li><li>Tighten up criteria for eligibility for Chronic Disease Care Plans for those in need.</li></ul> <p><b>Specific mental health ideas</b></p> <ul style="list-style-type: none"><li>Facilitate referral to psychologist without GP necessary – just a double up of paper.</li><li>Mental Health Nurse Incentive Program (MHNIP) is incorrectly titled – it is broader than originally intended and does not cover on-costs (such as phones, cars, travel) to do home site visits.</li><li>Reward GPs for taking difficult clients because they take more time and effort.</li><li>For mental health<ul style="list-style-type: none"><li>Allow more than one appointment a day – some patients may benefit form a morning and afternoon appointment if in a state of distress</li><li>Have an emergency provision to be referred to a Psychologist for at least one consultation before a care plan is developed.</li></ul></li></ul> <p><b>Patient role in plan set-up and deployment</b></p> <ul style="list-style-type: none"><li>Allow flexibility for patient presence at plan set-up - sometimes it’s better for patient to not be there when GP is discussing treatment options with provider.</li><li>Make patients accountable for commitment to Plan.</li></ul>



Conclusion - What the User Pathways reveal

THE CARE PLAN SYSTEM	COMPLIANCE WITHIN THE SYSTEM	ABILITY TO INFLUENCE THE CARE PLAN SYSTEM
<p>The health professionals come from a clinical standpoint, patient outcome is their primary driver and therefore, as defined by one of the GPs: “the drive and passion of clinical team rises above bureaucracy.”</p> <p>The plans themselves generate a disproportionate amount of administrative activity relative to the overall customer base. This is compounded by the lack of direction resulting in practices ‘over-complying’ and generating more paperwork for fear of being audited.</p> <p>Frustration occurs because, for many, care plan regulations are seen as adding a layer of bureaucracy to activity they already used to do prior to Care Plans being introduced.</p> <p>It is the time the red tape takes, as opposed to the red tape itself that is a key issue for the health professionals.</p> <ul style="list-style-type: none"><li>• Time the GPs could otherwise spend treating and interacting with their patients.</li><li>• Time that administration staff could spend focusing on better community and patient care and profitability for the practice.</li></ul> <p>A system that is more clinically-oriented where more time is spent managing than documenting would be better and feel more worthwhile.</p>	<p>From a compliance perspective where there is significant regulatory paperwork required, there is significant audit fear. In many instances this fear is borne out of a lack of clear direction on what is actually required. It manifests in over-compliance.</p> <p>The multiple levels of noncompliance that Medicare has found – which can be characterised by poor administrative implementation (e.g. not capturing a review date) highlight the difference between what health professionals ‘think’ they need to do versus what they ‘actually’ need to do. It’s not that effort to comply is lacking, it’s that the effort is mis-placed.</p> <p>When the users themselves were offered the chance to come up with a new process they largely drew up a similar process, however, the key areas they addressed were:</p> <ul style="list-style-type: none"><li>• Applying a level of flexibility to the entry points for a plan – primarily streamlining the process by allowing a referral prior to determining a plan is appropriate for mental health or simplifying the referral process itself to a verbal confirmation and clinical notes record.</li><li>• The entry points and applying a level of flexibility to the pre-plan state.</li></ul>	<p>Behaviours of the health professionals is varied in relation to:</p> <ul style="list-style-type: none"><li>• Their business model – e.g. bulk-billing, nurse-led, solo-GP</li><li>• Patient interaction and relationship</li><li>• Behaviour within, and structure of the practice</li></ul> <p>This can mean that while practitioners may seek improvements such as generic care plan information or a ‘single source of truth’ the implementation of that information is highly likely to be tailored within the practice or still not quite suit the individual’s needs. Therefore policy and compliance approaches should reflect these varying behaviours.</p> <p>For example:</p> <ul style="list-style-type: none"><li>• In addressing this is a description of ‘what you must include’ versus a care plan template may be a preferable design option.</li><li>• A simple flow chart of the requirements described in the language familiar to those undertaking the activity such as patients, solo or practice GPs – as opposed to language drawn from the Act or regulations.</li></ul>

Next steps

The user pathways developed for Chronic Disease Management Plans and Mental Health Treatment Plans will be used, along with the findings of a range of other compliance activities currently underway and additional research and analysis within the Recovery, Health and Business Compliance Division to co-design a comprehensive strategy for Care Plans (as a suite).