Care Coordination – Patient Care Plan example (Diabetes Mellitus Type 2):
A combined GPMP and TCA document with an Action Plan, After Hours arrangements and social/lifestyle goals.

Purpose of the Document:
The following template provides General Practice staff with an example of a Care Plan for The Care Coordination Program that includes the key components required.
This template has been designed to include a GPMP, TCA, Action Plan, After Hours arrangements and social/lifestyle goals. This provides the Patient and Family/Carer with a 'living document' that is individualised to the person's chronic condition and goals.
This resource should be utilised as a guide only and is not exhaustive.

Patient Summary:
Margaret Campbell is a 61-year-old woman with Diabetes Mellitus Type 2. Margaret recently visited her GP complaining of nausea and dizzy spells. During the consultation Margaret explained she was struggling to manage her diet and exercise, resulting in weight gain. She expressed how she felt overwhelmed with the amount of available information on Diabetes available online, and "didn't know what to do" to manage her symptoms. Dr Johnson explained that Diabetes was a difficult condition to manage alone and that Margaret would benefit from enrolling in the care coordination program and would be supported with managing her symptoms and chronic condition in a sustainable way.

CHRONIC DISEASE MANAGEMENT – A COMBINED GP MANAGEMENT PLAN (GPMP) AND TEAM CARE ARRANGEMENTS (TCAs) (MBS ITEM NO. 721 AND 723)

Date service was provided:	25/11/2020
Patient's name and address:	Margaret Campbell 123 Smith Street, Faketown, VIC, 3987
Date of Birth:	17/04/1960
Contact Details:	**Phone: (M)** 0412 345 678 ; **(H):** (03) 9876 5432
Medicare No.	1234567891 / 2
Private health insurance details, if applicable:	No

Details of the patient's usual GP:
Dr Neil Johnson
987 Robert Street,
Pearltown, VIC, 3897
Provider No.: JT672387

Details of the patient's carer (if applicable):
Name: N/A
Relationship to Patient:
Phone:

Contact details for Patient:

- **GP:** Dr Neil Johnson – 9785 1463
- **Care Coordinator:** Melissa Franks – 9785 1463

If the patient has a previous or existing care plan, when was it prepared and what were the outcomes:
Margaret's last care plan was in 2019 and 1 visit was used to see the podiatrist. No visits to the dietitian were claimed.

Medications:
Metformin 1g tablet, extended release. Take 1 tablet twice a day with meals
Panadeine Forte 500mg/30mg. Take 1-2 tablets every 6 hours if required.
Ostelin Vitamin D 1000IU Gel Capsule. Take 1 capsule daily.

Allergies:
No Known Allergies

GOALS – Combined GP Management Plan and Team Care Arrangements (GPMP and TCA)				
Patient's Name:	Margaret Campbell			**Date Care Plan Developed:** 25/11/2020
People Involved:	Patient: Margaret Campbell GP: Dr Neil Johnson Care Coordinator: Melissa Franks Diabetes educator: Michael Victors Dietician: Laura Christianson Exercise Physiologist: Julian Hewitt Physiotherapist: Joanna Granger Endocrinologist: Dr Allison Ainsworth			**Date for Review:** 26/02/2021
Problems identified/ condition/ concerns	**Patient's Goals**	**Actions to complete by the patient**	**Person responsible and team care arrangements**	**Timeframe and next review**
	What would they like to achieve?	*Treatment and service goals for the patient/ changes to be achieved*	*Treatment and services that collaborating providers will provide to the patient*	
1. Diabetes Mellitus Type 2	To improve their day-today blood sugar reading	To consistently test blood sugars on a daily basis and record results Blood tests every 6 months as directed by GP To keep track of daily food intake and increase exercise by walking 20-30 minutes each day	To see a diabetes educator to further understand the condition, how to improve blood sugar levels and what medication to take as directed by GP and Endocrinologist. To check in with the PN once a month to monitor progress. Enrol on the Nellie dietary and exercise SMS protocol	To attend a diabetes educator session in the next month. To be reviewed by GP in 3 months. To book an app with the PN in a month and observation check. To start Nellie SMS protocol today until next GP review.
2. Weight gained	To lose weight	To review diet and work with the dietician to make sustainable changes. To increase movement by walking each day and attending training at the local gym.	To see a dietician to review current diet and discuss food groups that are beneficial for diabetics. To see an exercise physiologist for an initial assessment and consider group training (8 MBS additional visits). Review by physiotherapist if there are any muscle or joint injuries.	To attend a dietician assessment in the next two weeks. To attend the initial session with the Exercise Physiologist in the next month. To start walking from tomorrow and this will be reviewed at next GP appointment.

3. Feeling lonely	Feel connected to others.	Attend social support activity.	Care Coordinator has a discussion with the patient to decide on choice of activities the patient is interested in. Refer patient to the most appropriate local social group based on discussion with the patient.	Care Coordinator to provide details to patient within 2 business days. Care Coordinator to follow-up with patient in 1 week to see if the activity/arrangements were acceptable and if they are now committed to continue this activity.
4. Struggling with access to nutritious meals	Access to regular nutritious meals	Establishing consistent mealtimes	Care Coordinator to link patient to Meals on Wheels local service	Care Coordinator to follow up with patients around the suitability of the meals and the service.

Care plan and TCA provided to:			
Family / Carer	Yes / No	Yes	Name/s: Patient has a copy for home
Other Staff	Yes / No	Yes	Name/s: TCA sent to relevant HCP
Other Services	Yes / No	Yes	Care Coordination program, Nellie

ACTION PLAN and AFTER HOURS				
Patient's Name:	Margaret Campbell			
Worsening condition:	The GP and Care Coordinator should individualise all action plans. Please consult the Professional Body for the Chronic Condition for further advice. (See Chronic Disease Goal Planning document) Example: Diabetes Action plan form Diabetes Victoria/Australia			
Patient's Concern	**For tomorrow?**	**For tonight?**	**For right now? (EMERGENCY)**	**Unsure?**
1. Low blood sugar ('Hypo'= Hypoglycemic) **Symptoms:** Sweating Tiredness Dizziness Feeling shaky Irritable/ mood changes	N/A – go to Tonight actions Note: Only if condition improves and blood sugars remain stable wait for appointment when the practice is open again.	Treat the low blood sugar ASAP. Please follow these steps: If conscious and you are safe to swallow: - Drink a glass of sugary drink such a fruit juice or non-diet fizzy drinks. - Stay seated in an upright position during the hypo. - Once you have	If you are feeling severely unwell and potential falling unconscious OR a family member finding Margaret unconscious or severely unwell PLEASE CALL 000 – emergency ambulance	If you are unsure if you have a low blood sugar, you must: - Eat or drink a sugary product to raise your blood sugar. - Check your blood sugar. - Follow the "for tonight" action plan.

		finished the drink and you feel better, try and eat a slice of toast to maintain your blood sugar levels. THEN If the practice is closed, please call for assessment: • Ring nurse on: NURSE-ON-CALL • Ring the on-call GP: on 13 SICK or 13 7425		

After Hours: If in the event of a non-emergency medical episode(s) the patient should work through their action plan.		
Contact Numbers - If after hours care support is needed call the relevant numbers below: • **Ring nurse on: NURSE-ON-CALL** • **Ring the on-call GP: on 13 SICK or 13 7425** • **Ring Ambulance: 000 (EMERGENCY)** • **1300 366 313 (Non-Urgent patient transport)**		
Action plan and After Hours has been discussed with the patient and/or family/carer?	Yes / No	
Patient and/or family have been given the opportunity to ask question?	Yes / No	
Provided patient with an easy to understand the document that explains their after-hours arrangements?	Yes / No	
Discussed and patient understands should they need a locum service or hospital care, they will arrange an appointment with their usual GP in the following week.	Yes / No	

I have explained the steps and costs involved, and the patient has agreed to proceed with the service

GP's Signature: _____ Date: