Care Coordination – Patient Care Plan example (Osteoporosis): 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:
Susan Wade is an 81 year old woman diagnosed with osteoporosis. Susan feels quite anxious about her condition after a recent fall which resulted in a sprained wrist. After discussing her concerns with Dr Freeman, it was suggested Susan would benefit from enrolling in the care coordination program which would support Susan with her goals to remain independent and mange her chronic condition.

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

Date service was provided:	28/02/2020
Patient's name and address:	Susan Wade 456 Hutchinson Avenue, Ascotbay, VIC, 9876
Date of Birth:	02/02/1941
Contact Details:	**Phone: (M)** N/A ; **(H):** (03) 9778 6554
Medicare No.	1234567891 / 2
Private health insurance details, if applicable:	Better Health Member #: 106874

Details of the patient's usual GP:
Dr Erika Freeman
222 Delilah Street,
Ascotbay, VIC, 9876
Provider No.: GT6563456

Details of the patient's carer (if applicable):
Name: Lucia Ray
Relationship to Patient: Daughter
Phone: 0412345678

Contact details for Patient:
- **GP:** Dr Erika Freeman – 9485 1426
- **Care Coordinator:** Harry Siddall – 9485 1426

If the patient has a previous or existing care plan, when was it prepared and what were the outcomes:
Susan is due a new GPMP and TCA. The previous visits allocated to the physiotherapist were not used.

For enrolment to the Care Coordination program, the following has been completed:
- The Care Coordination Checklist has been completed with the patient to determine

eligibility for enrolment.

- A full explanation of the goals of the Care Coordination program has been explained.
- The patient and/or family members have consented to enrol in the Care Coordination program.

Medications:
Atacand Plus 32mg/12.5mg, Take one tablet in the morning.
Atorvastatin 20mg. Take one tablet in the evening.
Panadol Osteo SR tablet 665mg. Take two tablets twice a day (morning and evening) if required.
Prolia 60mg. To attend practice every 6 months for sub cut injection by Practice Nurse

Allergies: N/A

GOALS – Combined GP Management Plan and Team Care Arrangements (GPMP and TCA)				
Patient's Name:	Susan Wade			**Date Care Plan Developed:** 28/02/2020
People Involved:	Patient: Susan Wade GP: Dr Erika Freeman Care Coordinator: Harry Siddall Exercise Physiologist: Jen Jones Physiotherapist: Andrew Foote			**Date for Review:** 28/05/2020
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. Osteoporosis	To improve functionality.	To walk for 20 minutes each day. To attend classes twice a week	Exercise physiologist to assist with strength and resistance training twice a week. To see a physiotherapist if condition worsens or to review areas of pain/discomfort	To complete these activities over the next three months. For GPMP review in >3 months.
2. Risk of falls	To prevent injury from falling over and to feel more confident on their feet.	To complete falls education training. To review hazards in the home and wear sensible footwear	To complete a review with the physiotherapist to assess walking and any areas of weakness. For nurse review for observation and if appropriate a health assessment.	To complete these activities in the next month.

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	Name/s: Yes, Susan's daughter was provided with a copy as directed by Susan
Other Staff	Yes / No	Name/s: Yes the HCP involved in the TCA were provided with a copy
Other Services	Yes / No	Name/s: N/A

ACTION PLAN and AFTER HOURS				
Patient's Name:	Susan Wade			
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)			
Patient's Concern	**For tomorrow?**	**For tonight?**	**For right now? (EMERGENCY)**	**Unsure?**
1. Flare up of Osteoporosis.	Triage by PN to determine whether Patient B requires an urgent appointment for assessment. Book an appointment with GP for follow up. Continue to take pain relief as directed by GP. To request for a repeat prescription	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	IF symptoms are worsening: - Seek a friend or family to drive to the Emergency Department if it is safe to do so. OR - call 000	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
	If no injury has been sustained: To telephone in	If the practice is closed, please call for assessment:	IF symptoms are worsening: - Seek a friend or	If the practice is closed, please call for assessment:

2. Fall	the morning to inform PN and GP of fall and request a telephone triage.	• Ring nurse on: NURSE-ON-CALL • Ring the on-call GP: on 13 SICK or 13 7425	family to drive to the Emergency Department if it is safe to do Call 000: Excessive pain or trauma or immobility	• 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: