Did you know?
A 30-minute case conference can reduce the average HbA1c level by 0.9% and this is sustained for up to three years.

General Practice MBS Item Numbers for JGPSCC

<table>
<thead>
<tr>
<th>Description</th>
<th>Conference time</th>
<th>Item no.</th>
<th>Medicare fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance by a medical practitioner (including a General Practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to organise and coordinate a case conference in a Residential Aged Care Facility OR a Community case conference OR a discharge case conference (not being a service associated with one to which items 721 to 732 apply)</td>
<td>At least 20 minutes and less than 40 minutes</td>
<td>739</td>
<td>$122.90</td>
</tr>
</tbody>
</table>

General Practice MBS Item Numbers for Care Plans

<table>
<thead>
<tr>
<th>Description</th>
<th>Item no.</th>
<th>Recommended frequency</th>
<th>Minimum claiming period</th>
<th>Other CDM item numbers that can/not be claimed in conjunction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation of a GP Management Plan</td>
<td>721</td>
<td>2 yearly</td>
<td>12 months</td>
<td>723, 735, 739, 743</td>
</tr>
<tr>
<td>Coordination of Team Care Arrangements</td>
<td>723</td>
<td>2 yearly</td>
<td>12 months</td>
<td>721, 735, 739, 743</td>
</tr>
<tr>
<td>Review of a GP Management Plan or Coordination of Review of Team Care Arrangements/Multidisciplinary Community Care Plan/Multidisciplinary Discharge Plan</td>
<td>732</td>
<td>When the GP determines this is clinically appropriate</td>
<td>3 months</td>
<td>732, 735, 739, 743</td>
</tr>
<tr>
<td>Contribution to a Multidisciplinary Care Plan or Team Care Arrangements</td>
<td>729</td>
<td>6 months</td>
<td>3 months</td>
<td>735, 739, 743, 721, 723, 732</td>
</tr>
</tbody>
</table>
Frequently Asked Questions

Q: Who needs to be present at a JGPSCC?
A: The General Practitioner, Endocrinologist plus another allied health professional (either a Diabetes Educator, Dietitian, Exercise Physiologist or Practice Nurse) and the patient – who may like to bring a support person, such as a spouse or family member, with them.

Q: Will the Endocrinologist be taking over the patient’s overall diabetes care and management going forward?
A: No. The case conference will not replace normal diabetes management in the practice; it is a learning session to discuss management issues and treatment options.

Q: How long will each case conference take?
A: Each case conference will take approximately 30 minutes

Q: Will there be any cost to the practice?
A: There is no cost to the practice. The GP can bill a case conference item number that is time based. As most consults last for approximately 30 mins, this item number is 739.

Q: Will there be any cost to the patient?
A: No. The practice will usually bulk bill the patient using the appropriate Item Number shown on the first page. The Endocrinologist will also bulk bill the patient for his/her time.

Q: What is the planned follow-up?
A: Following a JGPSCC, the GP will manage the care and assess the efficacy of any suggested change in the patient’s diabetes management.

Q: What if the patient already has an Endocrinologist?
A: The Endocrinologist involved in a JGPSCC works closely with colleagues within the Western Sydney Local Health District. They are aware of the program and support the principle that a patient with diabetes can be best supported in the primary care setting. All recommendations provided by the Endocrinologist in regards to the patient’s ongoing management are based on current clinical best practice indicators. No patient management will be changed unless all health practitioners involved in the case conference, including the patient, agree.

Q: Can the Allied Health Professional (AHP) and Practice Nurse (PN) sit in on the case conference?
A: Absolutely. The case conference is an opportunity for learning and sharing knowledge and encouraging a team approach. We welcome involvement from the AHP and PN.

Q: How do I access this service and set up appointments?
A: Your Practice Development Coordinator from Western Sydney Primary Health Network will act as a liaison between your practice and the specialist team. They will assist you with bookings and preparing and sending referrals.

Q: Does the patient need to be complex?
A: For maximum learning, select a minimum of four patients whose conditions vary in complexity (ie from pre-diabetes to complex type 2 cases).

How do I book a JGPSCC?
Contact your Western Sydney Primary Health Network Practice Development Coordinator, the WentWest Help Desk on 02 8811 7117 or email support@wentwest.com.au

For more information about Western Sydney Diabetes, visit www.westernsydneydiabetes.com.au