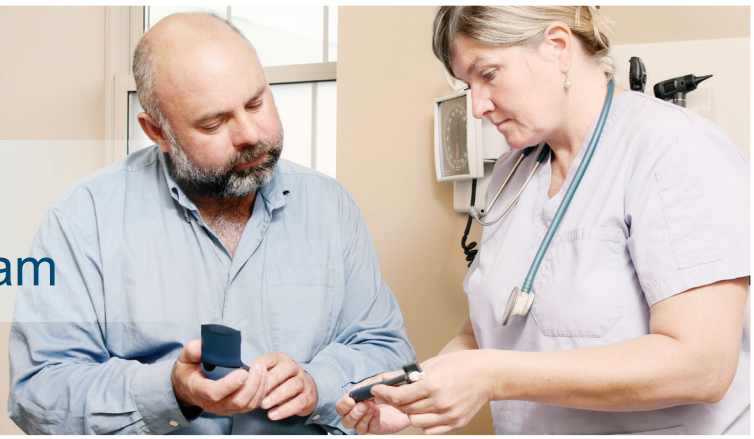
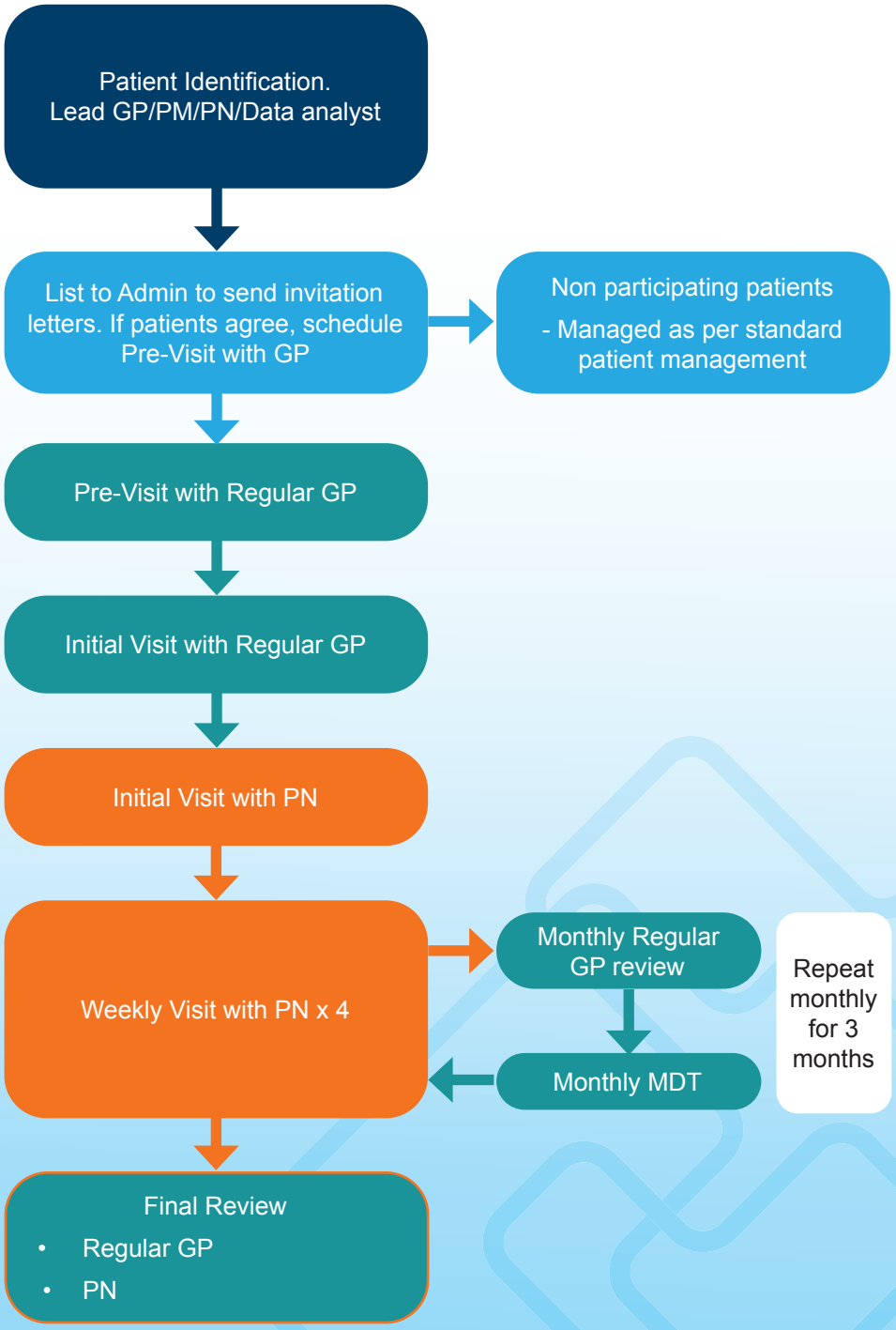
MODEL OF CARE

Weight management program





Potential Funding options for this model:

- A *no out of pocket* program whereby the funding for the visits is provided by the Medicare Item numbers for Care Planning (721) and Team Care Arrangements (723) for the initial visit.
  - PN visits x 5 to utilise the 10997-item number
  - Referral for allied health services provided by the EPC visits.
  - GP reviews to utilise the 3 monthly Care plan reviews 732
  - If additional visits required – bulk bill these as per visit
- A minimal cost program whereby the initial visit is as per the above (721 & 723)
  - PN visits are subsidised by the patient paying a fee for each visit on top of the 10997 item number
  - Referral for allied health services provided by the EPC visits with out of pockets as per the provider.
  - GP reviews to utilise the 3 monthly Care plan reviews 732
  - If not due for a 3 monthly review and require a doctor visit, to be billed as reduced fee if weight management related visit or full fee if unrelated

COORDINARE acknowledges the work done by Bulli Medical Practice in developing this model of care

MODEL OF CARE

Weight management program

LEAD GP/ PM / PN / CLINICAL DATA ANALYST

1. Identify target population using search features of your Electronic Medical Records program.
2. Refine patient list to identify patients e.g. BMI > 30 (target TBC by Practice)
3. Prepare format for Nurse Led Health Review Appointment and template to be used for each review appointment.
4. Prepare Patient Invitations, Consent & Survey.

ADMIN TEAM

5. Mail out invitations.
6. If they don't get a response, phone calls made to patients 2 weeks after mail out
7. If they do get a response and:
   a. If Patient does not want to participate let them know they can choose to book an appointment at another time if they choose to participate.
   b. If patient does want to participate book appointment for GP Pre-visit.

REGULAR GP

8. Pre-program visit – Discuss program with patient (incl goal setting).
9. Initial Visit
   - Care plan development
   - Referral for pathology as required
   - Referral to allied health
10. Monthly Review
    > Review progress
    - Repeat pathology as required
    - Refer as required
    - Participate in MDT meeting
11. Final review
    > Review progress
    - Repeat pathology as required
    - Refer as required

DEDICATED PRACTICE NURSE

12. Pre-program visit – Discuss program with patient (incl goal setting).
13. Initial Visit - Initial measures – Wt, Waist, BP, SF8 survey
14. Weekly visits - Topics incl: Food & exercise diary, Meal Planning, Food labels, Physical activity, takeaway meals/eating out, alcohol, Healthy snacks
15. Final Review
    - 3 month measures – Wt, Waist, BP, SF8 survey
    - Next steps

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