##

##### Appendix 8.1 GP Management Plan for HIV

**GP MANAGEMENT PLAN (GPMP-721) for HIV TEAM CARE ARRANGEMENTS (TCA-723)**

Date service provided: Patient’s name: Patient’s address: Date of Birth:

Contact Details:

Medicare No:

Private Health Insurance or Health Care Card details:

Patient’s usual GP: Patient’s carer (if applicable): Date & outcomes of previous/existing care plan:

Other notes or comments relevant to the patient’s care planning (eg. need for translator):

Current problems:

Medications (including OTC):

Allergies:

Social History: Occupation, Marital status, Sexual Orientation, Accommodation, Smoking, Alcohol

**GP Management Plan (Medicare Item: 721)**

Patient’s health problems

**/ health needs / relevant conditions**

**Management goals with which the patient agrees**

**Treatment and services required, including actions to be taken by the patient**

**Arrangements for providing treatment/services (when, who, contact details)**

**HIV education**

Good understanding of HIV Including Undetectable = Untransmissible (U=U) and Treatment as Prevention (TasP)

Patient education: disease prognosis potential transmission treatment options

GP / Nurse/ Treatment educator / Peer navigator

CD4 count and % HIV viral load

Monitor immune function Check every 3 – 6 months GP / Other Specialist

**Interactions** Prevent problems from drug interactions

Check all current medicines at every visit

GP / Other Specialist

Continuing ART treatment

Need to take ART medication regularly once started

Assess adherence at every visit, support as needed

GP / Other Specialist

Side effects of treatment

Reduce side effects Review side effects at every visit

GP / Other Specialist

**Coinfections and vaccinations**

|  |  |  |  |
| --- | --- | --- | --- |
| **Hepatitis A** | Prevent | Vaccination x 2 if at risk | GP / Nurse |
| **Hepatitis B** | Prevent | Vaccination x 3 if at risk | GP / Nurse |
| **Hepatitis C** | Detect and treat | Check HCV Ab baseline, annual if at risk | GP / Nurse |
| **Influenza** | Prevent | Annual vaccination | GP / Nurse |
| **Pneumococcal** | Prevent | Vaccination x 3 | GP / Nurse |
| **Tetanus/pertussis** | Prevent | Vaccination every 10 years | GP / Nurse |
| **HPV** | Prevent | Vaccination x 3 | GP / Nurse |
| **Meningococcal B** | Prevent | Vaccination X 2 | GP / Nurse |
| **Meningococcal ACWY** | Prevent | Vaccination X 1 every 5 years | GP / Nurse |
| **Varicella serology** | Prevent | Vaccination X 2 if needed | GP / Nurse |
| **MMR serology** | Prevent | Vaccination X 2 if needed | GP / Nurse |
| **Zoster vaccination** | Prevent | Vaccination X 1 at 60, note cautions | GP / Nurse |
| **Mpox (monkeypox)** | Prevent | Vaccination x 2 if at risk | GP / Nurse |
| **COVID-19** | Prevent | Vaccination (complex) | GP / Nurse |

**Prevent infections** Prevent opportunistic

infections

If CD4 < 200, seek specialist advice on prophylaxis

GP / Nurse

**STIs** Early detection Depending on risk group (MSM: 3 – 12 monthly) GP / Nurse

**Lifestyle**

|  |  |  |  |
| --- | --- | --- | --- |
| **Smoking current:** | Complete cessation | Opportunistic | Patient / GP /Nurse |
| Nutrition | Healthy diet | Review every 6 – 24 months | Patient / GP / Nurse / Dietitian |

Alcohol intake

Current drinks/day

Physical activity

Target: drinks/day Ideal: max 2 daily

Target:

Review every 2 years Patient / GP /Nurse

Patient / GP / Nurse / Exercise

Current:

Ideal: 30mins of moderate activity on most days

Review every 2 years

Physiologist

**Cardiovascular/metabolic risk**

Weight: Waist: BMI:

Target weight: Ideal weight: BMI ≤ 25

Review every 6 – 24 months

Patient / GP / Nurse/ Dietitian

CV risk calculation

Absolute risk:

Minimise risk Calculate every 2 years Patient / GP / Nurse

Blood pressure

BP:

< 140/90

< 130/80 (DM, Albuminuria)

Lifestyle change, medication if required Check every 6 – 24 months

Patient / GP / Nurse

Lipids

Fasting Lipids:

Glucose

Fasting Glucose:

Target lipids Check fasting cholesterol every year Lifestyle change, medication if required

Glucose <5.5mmol/L Check fasting every year

Lifestyle change, medication

Patient / GP / Nurse/ Dietitian

Patient / GP / Nurse/ Dietitian

Renal

eGFR:

**Urinalysis:**

eGFR > 90

Normal urinalysis

eGFR 3-6 monthly

Urinalysis at baseline, every 6 – 12 months on ART

GP / Nurse

Liver

LFT:

Osteoporosis

Optimise liver function LFT 3-6 monthly (with ART), 6 – 12

monthly (no ART)

Assess risk factors for Osteoporosis

GP /Nurse

Cal, Phos, ALP, vit D FRAX:

Optimise bone health

Females >45, Males >50 Consider BMD

GP / Nurse / Dietitian

**Cancer screening**

**Colon** Early detection FOBT (every 2 years age 50 – 75) or colonoscopy (every 5 years if +ve Fhx)

GP / Nurse

**Skin** Early detection,

|  |  |  |  |
| --- | --- | --- | --- |
|  | prevention | **consider** regular skin checks (high risk > 40) |  |
| **Cervical (female)** | Early detection | HPV every 3 years | GP / Nurse |
| **Breast (female)** | Early detection | Mammogram every 2 years (50 – 69) | GP / Nurse |
| **Prostate (male)** | Early detection | **Consider** PSA from 50 | GP / Nurse |
| **Anal cancer** | Early detection | Annual digital anorectal examination 50 | GP / Nurse |

Sun avoidance and protection,

GP / Nurse

**Psychosocial**

Depression, mental illness

Early detection, treatment

Opportunistic screening GP / Nurse

**Drug use** Early detection, treatment

Opportunistic screening GP / Nurse

Housing, financial, social support

Optimise Opportunistic screening GP / Nurse

Sexual / reproduction

Optimise sexual function, reproductive health

Opportunistic screening GP / Nurse

**Cognitive** Screening questionnaire

As indicates if at risk GP / Nurse

**Other prevention**

**Dental health** Optimise dental health Referral for regular dental care GP / Nurse / Dentist

**Glaucoma / vision** Prevent visual loss Referral if at risk eg FHx, CD4 < 50 GP / Nurse

**Older patients** Detect falls, frailty Regular reviews and care GP/Nurse

**Other Health Problems**

Health problems Goals Treatment and services Arrangements

|  |
| --- |
| **Coordination of Team Care Arrangements (Medicare Item 723)** |
| **Treatment and service goals for the patient / changes to be achieved** | **Treatment and services that collaborating providers will provide to the patient** | **Actions to be taken by the patient** |

|  |  |  |
| --- | --- | --- |
| **Optimise general health** | GP | Attend 3 monthly |
| **Optimise immune function** | HIV specialist | Attend 6 monthly |
| **Optimise dental health** | Dentist | Attend 6 monthly |
| **Optimise vaccinations** | Practice nurse | Attend as needed |
| **Optimise nutritional health** | Dietitian | Attend as needed |
| **Optimise mental health** | Psychologist / counsellor | Attend as needed |

721

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

GP’S SIGNATURE & DATE

 **723**

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

The patient also agrees to the involvement of other care providers and to share clinical information without / with restrictions (identify)

GP’S SIGNATURE & DATE

I give my permission for my GP to discuss my medical history/diagnosis with other service providers. I understand that referral for service can still go ahead if I do not want information about me made know to the service providers.

I understand the above Management Plan recommendations and agree to the outlined goals.

PATIENT/CARER SIGNATURE & DATE

Any information the patient wants withheld:

Copy offered to patient?

YES

Copy added to the patient’s records?

YES

Date GPMP completed: / /

**Date TCA completed:** / /

 **Copy / relevant parts of GPMP/TCA supplied to other providers?** ///////////**(Mandatory for 723)**

Review Date: (6 months) / /

YES /

NO / NA