Appendix 8.5
Example of a shared care GP case

- Hugh is a 50-year-old gay male, HIV +ve 1995, attending your practice for 12 years
- Presents with 1-month history of shortness of breath at the gym
- HIV managed by specialist, well controlled on ARVs, HIV viral load <20, CD4 = 570, three years mild hypertension - perindopril 5 mg daily
- Normal EUC, LFTs, glucose and lipids, normal FBC
- Smoking intermittently, currently 10 a day
- Examination normal, BP = 128/74
- 177 cm, 86 kg, BMI = 27
- Chest XR, spirometry, resting ECG normal
- Referred for stress echocardiogram which is abnormal, referred to cardiologist who detects coronary artery disease and stents the left anterior descending artery
- Patient discharged to your care on atorvastatin, aspirin and clopidogrel

This patient qualifies for a GPMP / TCA. The plan is written by the GP and forwarded for comment to Hugh's HIV specialist along with the covering letter. The specialist copies recent results to the GP.

721 GP MANAGEMENT PLAN (GPMP) for HIV
723 TEAM CARE ARRANGEMENTS (TCA) (if applicable)

Date service provided: 2 April 2023

Patient's name: Hugh

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):**

If the patient has a previous or existing care plan, when was it prepared and what were the outcomes:

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

Current problems:
HIV infection 1995: ARVs since 2005
Ischaemic heart disease: LAD stented 2019
Smoking: 10 /d
Overweight: BMI 27

Medications (including OTC):
ARVs
Aspirin
Clopidogrel
Atorvastatin
Perindopril

Allergies: nil

Social History: Occupation, Marital status, Sexual Orientation, Accommodation, Smoking, Alcohol: 10 cigs /d

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:			
HIV education	Good understanding of HIV	Discuss 2/4/23	GP / HIV clinic nurse
CD4 = 570 - 4/3/15 HIV viral load <20	Monitor immune function	Check every 3-6 months	Specialist HIV clinic
Drug Interactions	Prevent	Checked 2/4/23	GP / Specialist
Continuing ART	Adherence	Misses 1-2 doses / month	GP / HIV clinic nurse
Side effects	Reduce side effects	Nil reported 2/4/23	GP / Specialist
Coinfections and vaccinations:			
Hepatitis A	Prevent	HAV Ab +ve 2/5/18	Specialist / HIV clinic nurse
Hepatitis B	Prevent	HBsAb = 830 2/5/18	Specialist / HIV clinic nurse
Hepatitis C	Detect	HCV Ab –ve 4/3/23	Specialist / HIV clinic nurse
Influenza	Prevent	Vaccination 2023	GP / Practice nurse
Pneumococcal	Prevent	Vaccination 2018	Specialist / HIV clinic nurse
Tetanus/pertussis	Prevent	Vaccination 2018	GP / Practice nurse
Mpox (monkeypox)	Prevent	Patient considering	GP / Nurse
COVID-19	Prevent	Vaccination 2023	GP / Practice nurse
HPV	Prevent	Patient considering	GP / Nurse
STIs	Early detection	Full screen 4/3/23	Specialist / HIV clinic nurse
Prevent infections	N/A as high CD4	Nil	Nil
Lifestyle:			
Smoking 10 /d	Complete cessation	Supportive counselling	Patient / GP / Practice Nurse
Weight, 86 kg, bmi = 27 on 2/4/15	Target weight: 80 kg	Review every 6 – 24 months	Patient /GP / Nurse / Dietician
Nutrition	Healthy diet	Review every 6 – 24 months	Patient /GP / Nurse / Dietician
Physical activity Current: gym 3 d/wk	Target: inc walking	Review every 2 years	Patient GP / Nurse / Exercise Physiologist
Alcohol 2 drinks 2 days /wk	Target: at target	Review every 2 years	Patient / GP / Nurse

Cardiovascular / metabolic:			
CV risk calculation High as had event	Minimise risk	Optimise CV risk factors	Patient / GP /Nurse
Blood pressure 128/74 - 2/4/15	< 130/80 post event	Annual check	Patient / GP / Nurse
Lipids TC = 5.3, HDL = 1.1, LDL = 2.6 4/3/15	Optimise lipids – LDL < 1.8 post event	Annual check	Patient /GP / Nurse Dietician
Glucose fasting glucose = 5.1 4/3/15	Fasting glucose <5.5 mmol/L	Annual check	Specialist HIV clinic
Renal eGFR > 90 – 4/3/15 urinalysis n 4/3/15	eGFR > 90 normal urinalyses	eGFR 6 monthly Urinalysis annual	Specialist HIV clinic
Liver normal 4/3/15	Optimise liver function	LFT 6 monthly	Specialist HIV clinic
Osteoporosis	Optimise bone health	Booked in for DEXA at hospital	Specialist HIV clinic

Cancer screening:			
Colon	Early detection	-ve FOBT at 50	GP / Nurse
Skin	Early detection, prevention	Sun avoidance and protection, consider regular skin checks	GP / Nurse
Prostate (male)	Early detection	Patient not wanting after counselling	GP / Nurse
DARE	Early detection	DARE attended, NAD	GP / Nurse

Psychosocial:			
Depression, mental illness	Early detection, treatment	Opportunistic screening	GP / Nurse
Drug use	Early detection, treatment	Nil of concern	GP / Nurse
Housing, financial situation, social support	Optimise	Nil of concern	GP / Nurse
Sexual / reproduction	Optimise sexual function, reproductive health	Regular HIV –ve partner, uses condoms Knows about PEP /PrEP. Regular testing of partner (eg 6 monthly)	GP / Nurse

Other prevention: see RACGP Redbook https://www.racgp.org.au/clinical-resources/clinical-guidelines			
Dental health	Optimise dental health	6 monthly care	Dentist
Glaucoma / vision	Prevent visual loss	n/a	GP / Nurse

Other Health Problems			
Health problems	Goals	Treatment and services	Arrangements
Ischaemic heart disease	Prevent progression or complications	Optimise risk factors as above	Cardiologist in 6 months

Coordination of Team Care Arrangements (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 cardiovascular health	Cardiologist	Attend 6 monthly
Optimise dental health	Dentist	Attend 6 monthly
Optimise vaccinations	Practice nurse	Attend as needed
Optimise nutritional health	Dietician	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:	2 April 2023
Date TCA completed:	2 April 2023
Copy / relevant parts of GPMP/TCA supplied to other providers? (Mandatory for 723)	☐ YES / ☐ NO / ☐ NA
Review Date: (6 months)	2 October 2023