

MBS Allied Health Chronic Condition Management Review

Prepared for the Department of Health, Disability
and Ageing, September 2025



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Background, objectives and methodology



Review Background

On 20 August 2024, the [Medicare Benefits Schedule Review Advisory Committee \(MRAC\)](#) commenced a [review of MBS allied health chronic condition management services](#). The purpose of the review is to assess whether allied health chronic condition management (CCM) items should be amended to better support management of chronic conditions for eligible patients.

Data from the Australian Bureau of Statistics (2022) indicates that half of the Australian population (49.9%) have at least one chronic condition, equating to 12.6 million people.

To be eligible for a GP Chronic Condition Management Plan (GPCCMP) and referral to allied health services, a patient must have one or more medical conditions that have been (or are likely to be) present for at least 6 months, or terminal condition(s).

Concerns about the effectiveness of GPCCMP items have been raised triggering the review. Particularly in relation to the current annual service cap per patient (a maximum of 5, or a maximum of 10 for First Nations Australians). A common concern has been raised, highlighting that this service cap leads to insufficient care for many patients, especially those with co-morbid conditions.

In 2023, MBS data indicated that 35% of allied health GPCCMP patients claimed their maximum number of 5 allied health services in that calendar year. This demonstrates that over a third of eligible patients cannot receive further MBS rebates for ongoing allied health treatment to manage their chronic condition(s) unless they are a First Nations Australian.

This research will contribute to the review of MBS allied health chronic condition management services to ensure allied health chronic condition management services adequately support patients with chronic conditions.

Overview of Research Objectives

Assess whether current MBS allied health chronic condition management services are adequately supporting patients with chronic conditions.

Explore whether individual and group MBS allied health services could be improved to better support eligible patients.



This research will support the MRAC working group to respond to the following questions

What should the **calendar year limit** be for individual allied health services?

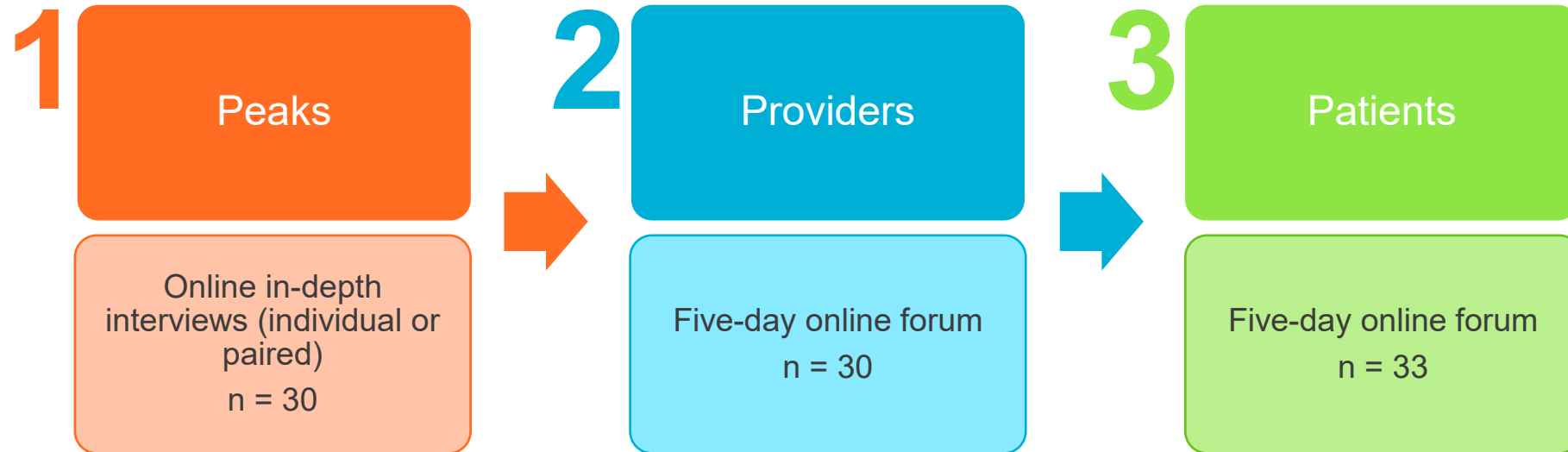
Should the existing individual allied health **service 'floor' of 20 minutes be increased?** If so, **what is an appropriate 'floor'** and **should this vary** (e.g., longer initial consult or time-tiering)?

Should the existing condition specific restriction on **group allied health services be expanded** beyond type 2 diabetes? If so, **which conditions** would benefit from group therapy, and which of the existing **eligible individual allied health provider services** are appropriate for group therapy?

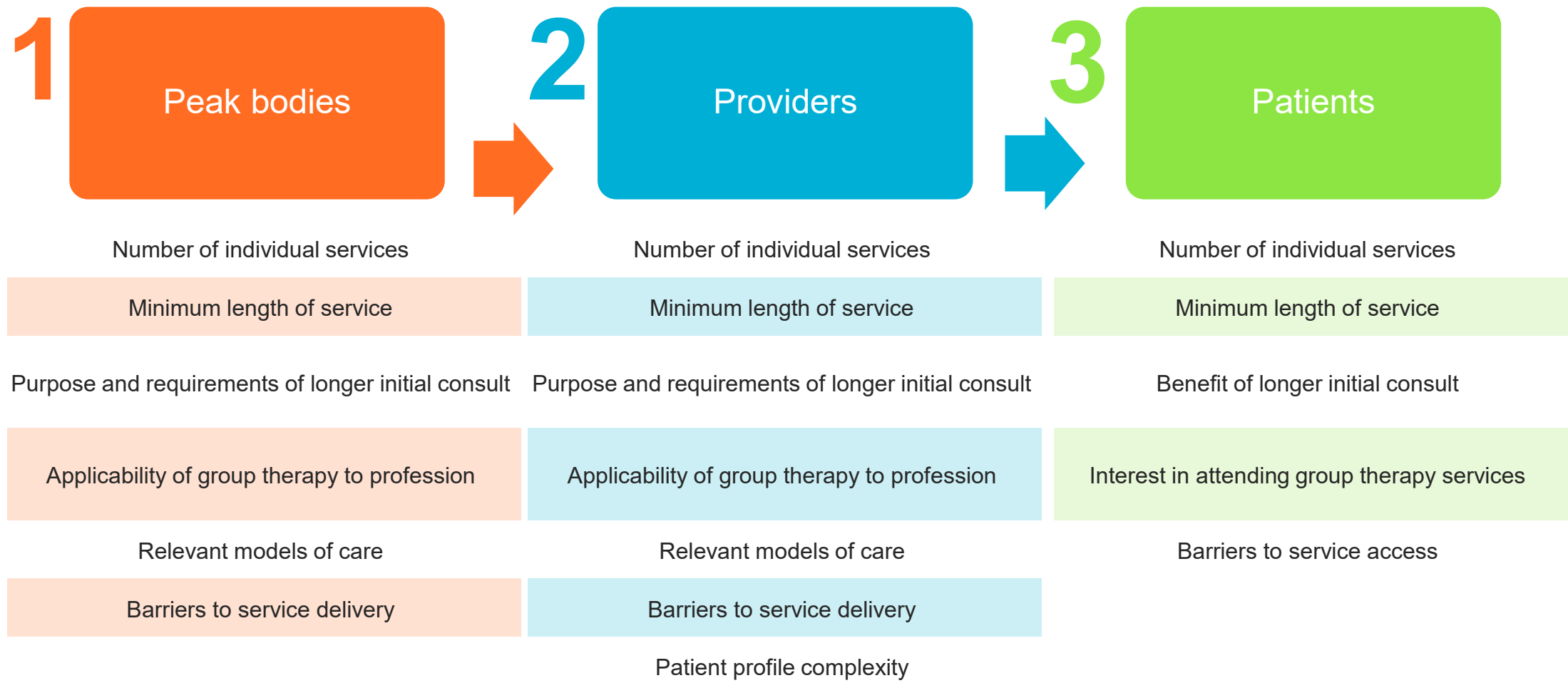
Should **the list of eligible individual allied health providers be expanded?** If so, **which allied health professions** should be added?

Research Approach

An iterative, qualitative research approach was developed. The research approach included three stages of consultation with eligible peak bodies, providers, and patients as identified by the MRAC working group.



Stage-specific research objectives



Qualitative methodology:

Peak bodies



n = 30 online in-depth or paired interviews conducted with representatives from peak bodies through Microsoft Teams.



Fieldwork commenced on July 7th 2025 and ran throughout August and early September to accommodate peak bodies' availability and scheduling preferences.



In-depth and paired interviews ran for 60 minutes.



Peak bodies were approached by the MBS Primary Health Care Team to nominate representatives to take part in an in-depth interview. Once nominated the peak representatives were contacted by the QMR team.
No incentivisation was offered to these bodies for their participation in the research

The project was carried out in line with the Market Research International Standard, AS ISO 20252. This report is based on qualitative research. The research participants were recruited to represent a range of individuals in the target population rather than a strictly representative sample of the target population, and as such the prevalence of views amongst participants cannot be extrapolated to the broader target population.

Australian Association of Social Workers
Australian Association of Psychologists Inc (AAPI)
Australian Podiatry Association (APoDA)
Australian Chiropractors Association (ACA)
Chiropractic Australia
Dietitians Australia
Exercise & Sports Science Australia (ESSA)
Osteopathy Australia
Occupational Therapy Australia
Australian Psychological Society
Australian College of Mental Health Nurses
Audiology Australia
Australian Physiotherapy Association
Speech Pathology Australia
Australian Diabetes Educators Association
National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners
Diabetes Australia
Arthritis Australia
Painaustralia
Lung Foundation
Kidney Health Australia
National Alliance for Self-Regulating Professions
Gastroenterological Society of Australia
Allied Health Professions Australia
Indigenous Allied Health Australia
Services for Australian Rural and Remote Allied Health
Neurological Alliance Australia
Australian Cardiovascular Alliance
Australian Primary Health Care Nurses Association (APNA)*
Royal Australian College of General Practitioners

*Did not respond

Qualitative methodology: Providers



A 5-day online forum using Recollective software was held. Providers responded to daily activities and discussions, which were moderated by QMR team.



The forum was hosted from the 4th to the 8th of August 2025.



Providers were asked to contribute 20 minutes per day to the forum.



n=10 providers were recruited through our third-party recruitment provider, EKAS. The remaining n=20 were recruited using a snowball approach to recruitment from Stage 1.



All providers were offered an incentive in the form of a \$450 pre-paid gift voucher.

The project was carried out in line with the Market Research International Standard, AS ISO 20252. This report is based on qualitative research. The research participants were recruited to represent a range of individuals in the target population rather than a strictly representative sample of the target population, and as such the prevalence of views amongst participants cannot be extrapolated to the broader target population.

Health Professionals	Number of interviews
Aboriginal and Torres Strait Islander Health Worker	2
Aboriginal and Torres Strait Islander Health Practitioner	2
Audiologist	1
Chiropractor	2
Diabetes Educator	1
Dietitian	2
Exercise Physiologist	2
Mental Health Nurse	1
Occupational Therapist	2
Osteopath	2
Podiatrist	2
Physiotherapist	2
Psychologist	2
Social Worker	4
Speech Pathologist	2
Total	30

Qualitative methodology: Patients



A 5-day online forum using Recollective software was held. Providers responded to daily activities and discussions, which were moderated by QMR team.



The forum was hosted from the 18th to the 24th of August 2025, the forum remained open for an additional 2 days to allow patients time to respond at a time and location suitable to them.



Patients were asked to contribute 20 minutes per day to the forum.



n=32 patients were recruited through our third party recruitment provider EKAs, who specialise in recruitment for healthcare research.



All patients were offered an incentive in the form of a \$150 pre-paid gift voucher .

The project was carried out in line with the Market Research International Standard, AS ISO 20252. This report is based on qualitative research. The research participants were recruited to represent a range of individuals in the target population rather than a strictly representative sample of the target population, and as such the prevalence of views amongst participants cannot be extrapolated to the broader target population.

Health Professionals	Number of interviews
Cancer	4
Cardiovascular Disease - Hypertension	4
Cardiovascular Disease - Coronary Heart Disease	
Cardiovascular Disease - Heart Failure	
Chronic Kidney Disease	2
Chronic Pain	2
Chronic Respiratory Disease – chronic obstructive pulmonary disease	3
Chronic Respiratory Disease - bronchiectasis	
Chronic Respiratory Disease - asthma	
Diabetes - Type 1	1
Diabetes - Type 2	1
Gastrointestinal Disorders - Inflammatory bowel disease	3
Gastrointestinal Disorders - Crohn's disease	
Gastrointestinal Disorders - ulcerative colitis	
Gastrointestinal Disorder - coeliac	2
Musculoskeletal Conditions - osteoarthritis	
Musculoskeletal Conditions - osteoporosis	
Neurological Conditions - Parkinson's	4
Neurological Conditions - epilepsy	
Neurological Conditions - stroke	
Obesity	2
Paediatric Conditions - stuttering	2
Paediatric Conditions - childhood apraxia of speech	
Total	32

Executive Summary



Executive Summary

1.

Unanimously there is desire to increase the number of individual sessions per calendar year

Peak bodies, providers and patients all believe the current maximum of 5 individual sessions per calendar year is inadequate for delivering effective long-term condition management to patients. It also leads to unintended consequences; providers opting to not provide care to abide by their ethical standards or changing the care provided to focus on short-term relief and education. However, multiple approaches to increasing the number of services offered per year were recommended across the three audiences. At a minimum, it is recommended that the current program increase to 10 individual sessions per year. Importantly, while these increases are recommended, the unintended consequences of increased demand on allied health provides needs to be considered, including potential provider burnout and lack of availability of appointments for patients.

2.

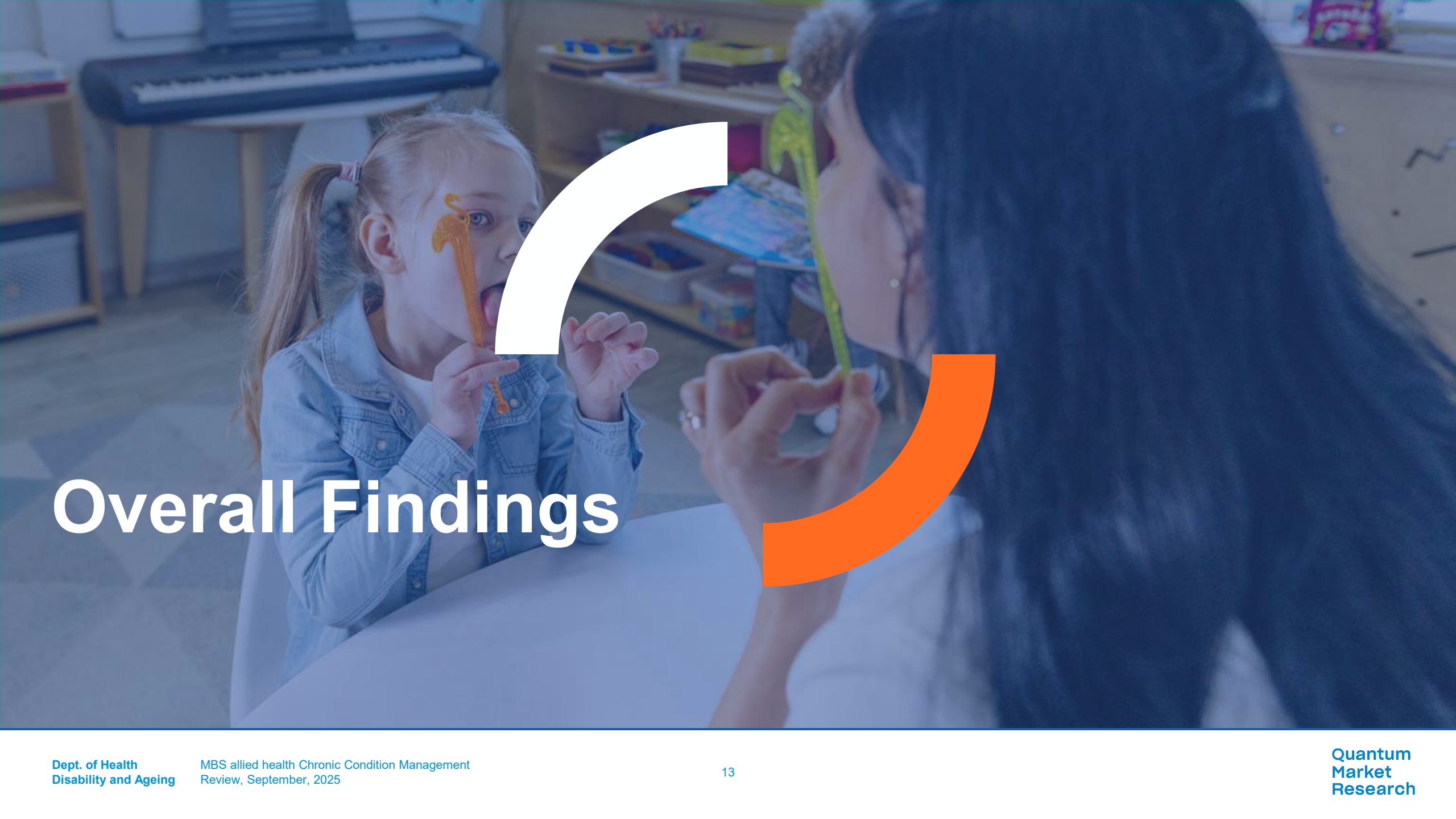
Increasing session length (initial and subsequent) has strong support

While time tiering is preferred as an overall approach, increasing session length (with subsequent provider rebate) is recommended from all audiences. Most allied health professionals (chiropractors and podiatrists aside) are unable to provide effective care in 20 minutes and are often charging a gap co-payment from patients making it less accessible to continue treatment. Initial appointments were recognised as being longer than follow-up appointments and therefore a time tiered approach would cover all bases. Longer initial appointments are seen as critical in delivering positive outcomes for patients, with the extended time needed to understand history, psychosocial factors impacting treatment and building a plan for treatment at a minimum.

3.

There's potential for group therapy to provide support and skills to better self-manage conditions

The potential for wider application of group therapy services under MBS CCM is welcomed by patients and providers with the key benefits focussing on education, socialisation, and peer support for patients. Several opportunities for further expansion of group services were highlighted including group services for dietitians, diabetes educators, speech pathologists, exercise physiologists and social workers. Aboriginal and Torres Strait Islander health workers and practitioners highlighted the potential for group services to include broader health education as part of yarning circles. However, there are barriers for patients (anxiety and fear of treatment/education in a group setting) and providers (cost to them vs. rebates received) which need to be understood, and in the case of providers, resolved to encourage uptake.



Overall Findings

GP Chronic Condition Management Plans are unanimously viewed as a welcome step forward in managing chronic conditions

Peak bodies, providers and patients all spoke positively of the existence of GP Chronic Condition Management Plans (GPCCMP) and acknowledged that it is a positive step forward in the management of chronic conditions, driven by three core reasons:

1. Recognises that pharmacological interventions aren't the only management tool

While many patients we spoke to were using pharmacological interventions to manage some of their conditions (in cases of co-morbidity). The majority rely on allied health services to maintain their ability to engage in day-to-day activities.

2. Highlights the role of allied health

The GPCCMP acknowledges and highlights the key role that the allied health providers play in the health of Australia's population and acts as a tool to encourage GPs to incorporate allied health services in their care plans.

3. Recognises the longevity of chronic conditions

While there are critiques of the current GPCCMP and its effectiveness, the Medicare Benefits Scheme Chronic Condition Management (MBS CCM) still acknowledges the longevity of these conditions and patients' ongoing need for management and support to self-manage their condition(s).

The findings presented in the remainder of this report are designed to address the key objectives of this review and aim to build upon these positive aspects of the GPCCMP as highlighted to us by the peak bodies, allied health providers, and patients that we spoke to.



Objective 1: *Number of individual services*

Effective condition management is not achievable under the current cap of 5 services per annum, driven by

CO-MORBIDITIES

Patients often present **with multiple coexisting chronic conditions** complicating treatment or having competing priorities.

PATIENT CIRCUMSTANCE

Each patient has **unique psychosocial factors, health literacy and patient motivation** creating additional complexities.

MUTIPLE SERVICES

Patients could **often benefit from more than one type of allied health service**, needing to split their sessions or prioritise one service above another.

GP ENGAGEMENT

GP knowledge of allied health services, **understanding** of GPCCMPs, **patient relationship** all feed into how appropriately managed the plan is.

EVOLVING NEEDS

Chronic conditions and patient **needs evolve over time** resulting in variations to treatment plans.

Co-morbidities require multi- disciplinary care

Patients often present with multiple coexisting chronic conditions.

These patients often require comprehensive, multidisciplinary care plans.

These requirements cannot be met within a 5-service limit, meaning the program cannot live up to its potential and deliver strong patient outcomes.

- For patients, this often means that they're having to prioritise one element of their condition over another (for example pain management over mobility).
- For allied health providers, it means compromising their treatment plan, and potentially their ethics by agreeing to treat a patient knowing that they're not going to complete treatment nor get to significantly positive outcomes in the five sessions available on the plan.



*"We rarely see clients with only one presenting condition...
A rebate for 5 sessions across all allied health disciplines
at a fraction of the total cost is a drop in the ocean of what
these clients actually need."*

- Speech Pathologist, Queensland



Individual circumstances impact treatment options

Each patient has unique psychosocial factors, health literacy and patient motivation creating additional complexities.

- **Psychosocial factors** such as limited support networks and transport availability impact accessibility for several patients. This means they're not always able to maintain consistency in appointments and treatment.
- **Health literacy** is another key factor in the ability for GPCCMPs to have a positive impact on patients. Those with lower health literacy often have greater scepticism to some allied health treatments (for example chiropractic for pain management) and require more education up front impacting treatment time within the five sessions.
- **Individual patient attitude, existing behaviours and stage of chronic condition** (early vs. late) impact the motivation to implement recommendations from providers, particularly continuing care at home in between, or after, treatments. This ultimately reduces the long-term impact that allied health can have on these patients, with providers often instead focusing on addressing acute symptoms.



"Many of the clients I see... present with high levels of complexity. A common thread is not just the presence of multiple conditions, but also the psychosocial and environmental challenges that affect their ability to engage in care."

- Exercise physiologist, Queensland



Multiple allied health services often needed

Patients could often benefit from more than one type of allied health service, needing to split their sessions or prioritise one service above another.

Complex and ongoing conditions benefit from a multi-disciplinary team over an extended period of time. This team could include several allied health professionals with different specialities, either at the same time or consecutively over the year (or longer).

An example of this would be a patient with chronic pain who could benefit from:

- A physiotherapist to offer physical relief in the form of manual therapies and guidance on how to stretch
- An occupational therapist who can help the patient modify their home to reduce movements that impact mobility and/or result in pain
- A psychologist to help with the mental health challenges that come with continued pain and assist in providing some techniques for managing pain mentally
- A social worker may help them access services available for things like cleaning which they may not be able to do due to their pain.



“I feel 5 is not sufficient especially if you need multiple service providers' help.”

**- Patient, Gastrointestinal Disorders –
Inflammatory Bowel Disease.**



Conditions change and patient needs evolve over time

Chronic conditions are frequently changing and evolving over time, with patients often being diagnosed with additional challenges over time.

This means that treatment plans also need to evolve to meet the changing needs of patients. Not only does this result in providers needing to redesign the treatment plan but often includes reassessment of patients.

Further, patients then need to invest extra time in their own treatment and depending on their motivation will sometimes cease engagement with a provider as it's 'too hard'.



“As mentioned before, health needs change throughout a year so it would be good to make them more often than yearly. It would be better if you get more sessions included but could do the plans more often. My needs for a physio will often pop up throughout the year but I have already allocated all my sessions to the podiatrist, so I have to use my health insurance and pay privately instead to see the physio. If I was able to do a new CCM plan half-way through the year, then I could change my allocation and give some to physio instead (particularly if we got more than 5 a year).”

**- Patient, Gastrointestinal Disorders
– Chron’s Disease.**



General Practitioner (GP) engagement and knowledge impacts CCM approach

GP knowledge of allied health services, understanding of the GPCCMPs, patient relationship all feed into how appropriately managed the plan is.

How GPs set patients up on the program can significantly impact patient outcomes. Those that have a highly engaged GP, who understand what a GPCCMP is, what allied health services are covered, how these connect to the condition and then also knows not only the medical context of the patient, but their broader context (psychosocial factors etc.) tend to have a greater chance of success.

These GPs are able to set patients up with the appropriate allied health professional, tap into an existing network and discuss the GPCCMP with their patient so they know what to expect.

GPs who aren't as well acquainted with GPCCMPs and/or allied health services often leave the approach up to patients or send a patient off to a professional without explanation over what they're seeing them for. This often means that patients don't know what to expect and providers spend more time getting patients on board with their treatment or even sending them to a different (more appropriate) practitioner.

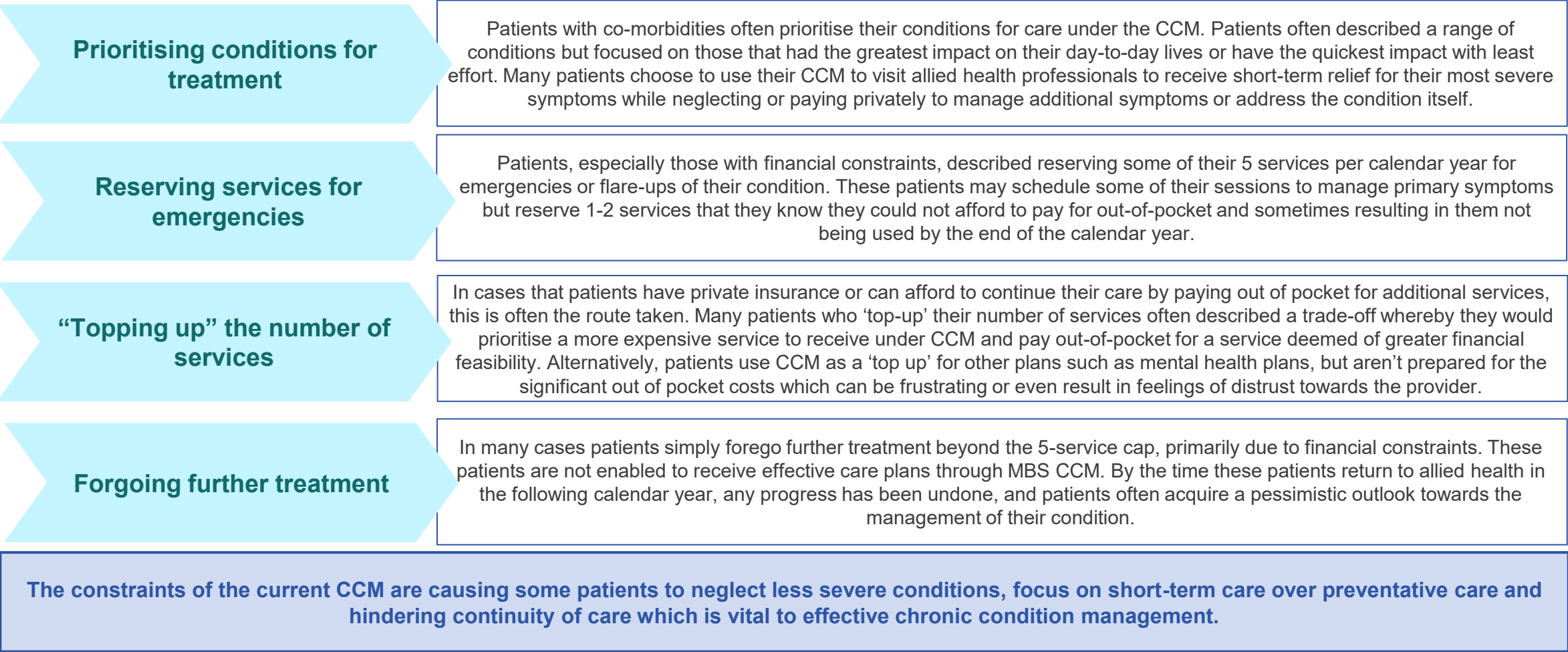


“Some GPs may lack knowledge of the full range of allied health options, leading to suboptimal referrals.”

- Exercise Physiologist, VIC



As a result, patients note they're not achieving desired outcomes and, in many cases, experiencing negative consequences



Current cap also creates barriers and additional difficulties for providers when it comes to working with CCM patients

Ethical considerations for allied health providers

A number of peak bodies and providers highlighted the ethical considerations allied health professionals face when providing care under the constraint of the 5-service cap. Some allied health professionals consider it unethical to provide care under MBS CCM, as providers, they know they cannot provide effective care plans in 5 services and therefore do not offer services under MBS CCM. This is further compounded by indications that patients typically have low levels of knowledge about MBS CCM, service caps and associated rebates.

Symptomatic treatment > long-term management

For allied health providers who can effectively provide care under MBS CCM, they aim to focus on symptomatic care plans that provide relief to patients in the short-term. These can be effective and helpful for patients but fail to effectively address the long-term management of chronic conditions or to provide effective preventative care for patients.

Prioritising education

To address concerns related to continuity of care and long-term management of conditions, many providers report trying to prioritise education during the 5-sessions they are limited to with MBS CCM patients. In doing this, they aim to equip patients with the knowledge and tools to continue their care once they reach the cap but often patients struggle to continue their management plan without the support of allied health professionals.

Some allied health providers described how the service cap constraints lead them to adapt the services they provide, with the intention of being as effective as possible in a short space of time as opposed to providing best practice care.

Unanimously, there was recognition that the session cap needs to be increased to improve patient outcomes

Across all three participant groups, recommendations for how the minimum number of individual services should be increased could be divided into two broad approaches:



Approach 1: Expanding the number of allied health sessions to improve efficacy of MBS CCM

As highlighted at the top of the report, providers and patients recognise strengths of the current MBS CCM. Patients are grateful that a GPCCMP provides them access to rebated allied health services (regardless of caps), relieves some financial burden and recognises the longevity of chronic conditions.

Compared to peak bodies and providers, patients more frequently made recommendations that aligned with the approach of expanding the number of services currently offered. This may be a result of patients having lower levels of health literacy, a sense that it was unrealistic to recommend a high or unlimited number of services (regardless of needs) or simply being constrained by the number of services offered under the current MBS CCM framework.

There were two primary recommendations for expanding the number of services under the current framework. Both assume the individual service cap would be increased at an overall level, for all patients on a GPCCMP.

Increasing the number of sessions in a calendar year would provide better access for patients to get the comprehensive care they need to achieve better outcomes.

Recommendation 1
10-12 Individual sessions per calendar year

- Increasing the number of individual sessions offered per calendar year to at least a cap of 10 services.
- Alternatively, increasing to a cap of 12 sessions per calendar year roughly equating to 1 session per month.

Recommendation 2
5-10 Individual sessions per allied health service per calendar year

- Expanding the current framework by allowing patients to access 5-10 individual sessions per allied health per calendar year.
- If necessary, this could involve a cap on the number of allied health. For example, access to up to 3 allied health per year with 10 sessions per allied health, equating to 30 sessions in total per calendar year.

Approach 2: Adopting a patient-centered approach to chronic condition management

Peak bodies and allied health providers emphasised best practice approaches for patients on GPCCMPs when recommending an ideal number of sessions to be offered per calendar year. Considering the high incidence of comorbidities and other patient complexities, these best-practice recommendations rarely fit within the parameters of the current MBS CCM framework.

Peak bodies and providers frequently stated there should be no 'one size fits all' approach to the number of allied health services offered. Instead, the number of allied health services offered should be decided taking into consideration several factors including:

- a patient's condition(s),
- comorbidities,
- severity of symptoms,
- psycho-social factors (such as social supports, mental wellbeing, cognitive capacity)
- any additional complexities.

A key component of these recommendations is that individual GPCCMPs are continually reviewed, outcome focused, and the number of sessions can be extended as necessary.

A shift toward patient centered GPCCMPs to identify an ideal number of allied health sessions per calendar year would allow GPCCMPs to adequately address patient needs and allow providers the opportunity to provide best-practice care plans under MBS CCM .

Recommendation 3 **'No one-size fits all' approach**

- The number of individual sessions offered under allied health CCM should be decided and reviewed by a GP working in a multidisciplinary team with allied health.
- A 'test' for severity could be included in this to create a tiered option.
- The plans should include a set number of sessions and time period for improvement based on a conditions(s) and complexity.
- Plans should be reviewed frequently.

Recommendation 4 **Development of condition-specific GPCCMPs**

- Desire among peak bodies and providers for condition-specific care plans to be provided to GPs for chronic conditions with wide empirical evidence bases.
- These would help improve allied health referral pathways and facilitate access to effective care.
- GPCCMPs would recommend number of sessions, type of allied health, time frames and expected outcomes.



However, there are considerations to factor in when increasing session caps

Increasing the number of individual sessions per year was welcomed as a necessary change by peaks, patients, and providers. Regardless of the approach taken to increasing sessions, there are some considerations to take into account:

- Increased demand on allied health providers needs to be acknowledged, with demand already increasing due to the general population relying more on allied health services as private health insurance costs increase. Changes to other schemes such as NDIS have also diverted patients towards MBS CCM and allied health more generally.
- Patients should not be responsible for keeping track of the number of sessions used and remaining. Patients and allied health professionals are struggling to keep track of the number of sessions accessed under the current system. If the number of sessions is increased or stratified, there is a risk that accounting for the number of sessions becomes more complex – this needs to be avoided and the process streamlined for all parties.

While there are some considerations towards increasing the number of allied health sessions per calendar year, the benefits outweigh the concerns, and an increase is viewed as necessary for MBS CCM to achieve its intended purpose.

“The exact number could be decided by one or both practitioners depending on the chronicity or previous history... anymore than 10 might lead to overtreatment and burdening the system.”
- Chiropractor, NSW

Key learnings: GPCCMPs aren't living up to their potential, opportunity exists to increase sessions to better serve patients

1.

Current limit of five allied health sessions per calendar year is inadequate

The current maximum of 5 individual sessions per calendar year is inadequate for delivering effective long-term condition management to patients. It also leads to unintended consequences; providers opting to not provide care to abide by their ethical standards or changing the care provided to focus on short-term relief and education.

2.

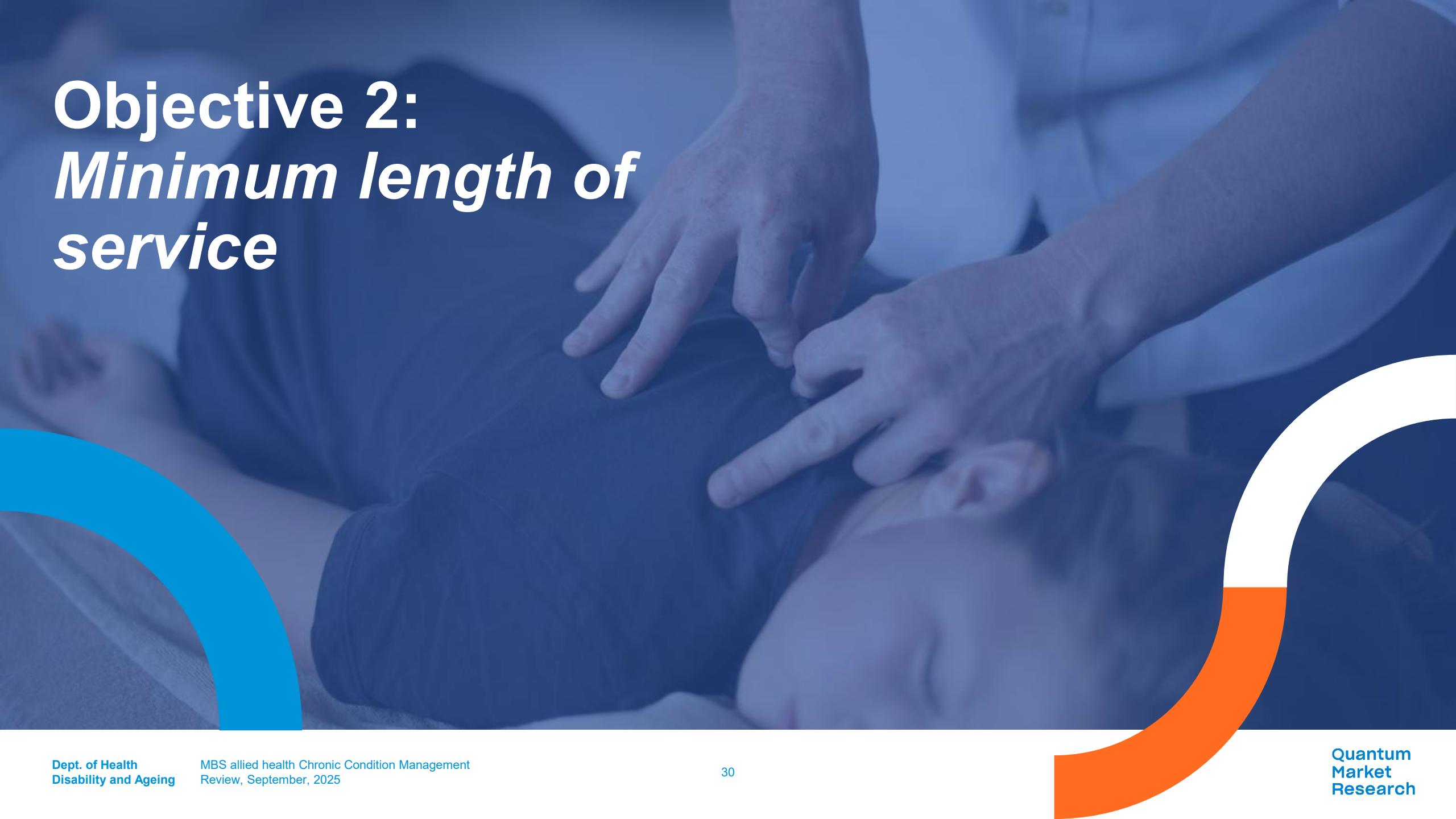
Multiple recommended approaches to increasing the number of services offered per year

Recommendations for increasing sessions can be divided into expansion and redevelopment approaches. The minimum recommended expansion of the current program is an increase to 10 individual sessions per year. The best practice approach as recommended by peak bodies and providers is the development of condition-specific care plans.

3.

Potential for increased demand on allied health providers to be considered

Allied health providers have already experienced increased demand for their services as the rising cost of private health insurance has left the general population seeking alternative pathways. Similarly, changes to other schemes such as NDIS have diverted patients towards MBS CCM and allied health.



Objective 2: *Minimum length of service*

Current minimum session length (20 minutes) is too short for effective treatment as providers need to:



Most allied health professionals are already providing CCM sessions beyond the 20-minute duration (typically 40-60 minutes), leaving most patients with a gap fee that contributes to the financial burden of health care costs, or the provider wearing the cost of the extended session impact their financial viability.

“The current benefit covers a minimum session of 20 minutes, but for patients with chronic or complex needs, this often isn’t long enough to properly assess, treat, and provide education.”
Diabetes Educator, TAS



“A 20min session is pretty useless for Speech Pathology and Occupational Therapy for any of the conditions covered by a GPCCMP – the research evidence indicates 60min sessions are more appropriate for complex/chronic conditions.”
Speech Pathologist, QLD

Some allied health professions cannot treat in only 20 minutes



Occupational therapists often need extended time to conduct in-home assessment, modify set-ups, as well as educating the patient and their support network.



Speech pathologists noted that some assessments take several hours and therefore a 20-minute session was completely impractical. While paediatric treatments tended to be shorter due to attention span, sessions often involve educating parents and caregivers requiring extra time.



Mental health professionals (psychologists, mental health nurses, social workers) noted that a standard session is 50 minutes, with the extended time needed to build trust and rapport along with engaging in meaningful dialogue and treatment.

Under the current minimum length of service, a range of allied health treatments can be deemed inaccessible under GPCCMPs for financial vulnerable patients who cannot afford the co-payment.

However, some providers can provide care, albeit compromised, while others are confident in treating within 20 minutes

COMPROMISED CARE

- Some practitioners noted that they were able to provide *some* treatment in 20 minutes, but would be able to provide better, more complete care in a longer session.
- For example, an **exercise physiologist** could talk through an exercise prescription but may not be able to demonstrate or review form on all exercises.
- Other professions that can provide some, but often compromised treatment in 20 minutes included **dietitians, physiotherapists, osteopaths, audiologists, Aboriginal and Torres Strait Islander health workers/practitioners** and **diabetes educators**.

“Longer sessions wouldn’t negatively impact our caseload at all. In fact, they would improve the quality of care and reduce clinician burnout.”
Exercise Physiologist, QLD

COMPLETE CARE

- **Chiropractors and podiatrists** can provide effective and immediate (although at times short term) relief for chronic conditions they’re working with, provided a comprehensive (and extended) initial session was completed.
- For example, a chiropractor can complete an adjustment for those with chronic back pain in 20 minutes.
- Extended sessions may help with paperwork or educating patients, but otherwise, may be unnecessary.
- Further, these professionals noted shorter sessions allowed them to see more patients in a day, including a balance between private patients and those on GPCCMPs (or other plans) to ensure practice viability.

“Sessions in our practice are 15mins, 30mins, 45mins and 1 hour. Therefore, we spend 30 mins per patient. However, 20 mins with a patient would allow time for consultation and treatment for the patient.”
Chiropractor, QLD

Consideration should be given to whether length of allied health sessions under MBS CCM are extended universally, or some allied health professions left at 20 minutes.



“Our practice currently only offers 60–90min assessments and then 60 minute follow up reviews... this allows for more quality time with clients and less clients over the day, preventing burnout.”
dietitian, NSW

Short session times also increases risk of provider burnout

To keep their practices financially viable some allied health professionals balance shorter sessions with high patient caseload.

The high number of patients means providers can have increased administrative loads, fatigue from being ‘on’ for each patient, additional programs to write etc. which can lead to burnout in the long run.

In worst cases, providers have left their professions due to burn out, impacting availability of allied health professionals and increasing demand for services.

However, peak bodies and professionals tended to agree that increased session lengths would allow for improved quality of care, greater ability to build rapport with clients and fewer clients each day. This, in turn, would reduce burnout among allied health, ensuring that a strong and stable workforce remains to meet the growing demand.

Some practices that exclusively offer longer services have already seen the benefits of this to improved patient care and reduced provider burnout.

Increased session length has the potential to reduce burnout among allied health providers while also improving quality of care for patients.

Time tiering is the preferred approach to session length

Time tiering (including 20, 40 and 60 minute sessions) would provide the flexibility that providers are looking for to give patients the treatment needed for best possible outcomes.

This would allow professionals who provide effective care within 20-minutes to continue to provide this service and maintain their current business model, while also allowing longer service times for those who needed it.

Importantly it was noted that rebates would need to increase proportionally to the minimum service length to ensure patients weren't financial impacted.

Further, there was a preference for the decision for which time tier to use to be made collaboratively with GPs and allied health professionals, rather than a blanket option provided for specific allied health professions.

Flexible time tiers would allow providers (in consultation with GPs) to better meet the evolving needs and challenges of patients with chronic conditions.



"40-60minutes is the length of time required to be effective with complex clients. It would allow us to carefully assess, treat and leave the client with something to work on. We are often pushing our 30min sessions and running late to ensure we can be effective but this is not sustainable for our practice."

- Physiotherapist, VIC



Longer initial consultations are already happening, but patients pay the price



- **Peaks and providers report typically providing initial consultations of up to 60 minutes.** However, this could increase to up to 80 minutes for allied health such as occupational therapists or 90+ minutes for speech pathologists who need to administer lengthy tests during their initial consult.
- Allied health professionals agreed that GP referrals are often not a sufficient basis for allied health providers to build their care plan from.
- Not only do allied health providers need to collect their own medical history and conduct specific assessments relating to their profession, but often patient history isn't included or lack the detail needed.



- **These reports of longer initial consults were also echoed by patients.**
- This indicates that even under the current framework longer initial consults are known to be a necessary component to treating chronic conditions that the MBS CCM framework doesn't allow for.
- Consequently, patients are again having to pay a co-payment to ensure they have the appropriate initial assessment.
- This is all while still using one of their 5 services, leaving only 4 services available for subsequent treatment (assuming a patient is seeing only one allied health provider).

"I think the initial session should be 45 minutes to an hour, because you need time to go through everything properly. Follow-ups could be shorter."
Patient, Thyroid Cancer

"I need a long first appointment — 60 minutes minimum — to explain all my conditions. The short ones just don't cut it."

- Patient, Musculoskeletal Conditions – Osteoarthritis

Longer initial consults help set treatment up for success

Longer initial consults are necessary to allow allied health to understand their patient and develop an effective care program for them.

The initial consultation requires the provider to conduct the following, before or in addition to commencing treatment or providing care

- Build rapport with their patient
- Gather a full patient history
- Understand previous approaches to condition management and what does/doesn't work.
- Examination or assessments/tests.
- Clinical impression / working diagnosis.
- Provide advice, explanation or discussion related to treatment plan.
- Education on condition management.

Often providers also have to educate patients on the GPCCMP, how it works, what is available under the plan and associated rebates when this has not been explained by a patient's GP.

A longer initial consult allows time for allied health to build rapport with their patient, and to prepare and explain a throughout treatment plan to their patient.



“Initial appointments absolutely need to be longer. That’s where we gather a detailed complex medical history, understand the client’s goals and barriers, conduct safety screening, and assess their functional capacity”

- Exercise Physiologist, QLD

Patients deserve the respect and time required during initial consults to share their condition history

Initial consultations can be burdensome for patients who may visit numerous practitioners, specialists and allied health each year.

- At each initial consultation patients reiterate their medical history, how they manage their condition(s), their symptoms over time and their support systems etc.
- This practice is fatiguing for patients, even when granted the necessary amount of time to discuss their history with allied health.

The expectation that patients need to condense their medical history into under 20 minutes can be distressing.

- There is also the risk that patients leave their consultation feeling unheard or misunderstood, or that in due to time pressures and shortening their story, they leave out critical information or prioritising information.
- This ultimately means they are placed on a treatment plan that often does not meet their needs.



Increased initial consults would provide patients with the time needed to share the history of their condition(s), feel comfortable with a provider and explain the support they require – leading to improved overall health outcomes.

Key learnings: Increasing service length has strong support, particularly when paired with longer initial consults

- 1. Time tiered approach to service length is recommended**

The majority of allied health professionals cannot provide effective care within a 20-minute session length and are either opting to not provide care under MBS CCM or providing 40-60+ minute services with a gap fee. Time-tiered options would address allied health providers ethical concerns about condensing care and reduce financial burden on patients. Podiatrists and chiropractors can provide effective care in 20 minutes and do not support an overall extension to the minimum length of service, as this would be of a disadvantage to their business models.

Implication: Time-tiered model should be introduced with 20, 40, and 60-minute consults tiers and proportional rebates
- 2. Longer initial consults of up to 60 minutes are necessary for effective condition management**

Longer initial consults already occur in practice, with patients paying gap fees as necessary. Initial consultations typically last up to 60 minutes and can be longer for certain allied health services (e.g. occupational therapists, speech pathologists). Peak bodies, providers, and allied health patients agreed that an increased initial allied health consult length is necessary under MBS CCM.

Implication: A longer initial consultation with allied health should be provided under MBS CCM
- 3. Longer initial consults benefit the provider and the patient**

Longer initial consults allow providers the time needed to build rapport and develop an effective care plan that meets the patient's individual needs. This includes conducting examinations/assessments, collecting full medical history, and providing education on condition management – in addition to treatment. For patients, longer consults allow them to benefit from the rapport built with allied health professionals and have greater potential to improve their health outcomes under MBS CCM.

Implication: Longer initial consults can improve the effectiveness of MBS CCM and improve condition management in the long-term



Objective 3: *Applicability of group therapy*



High levels of interest from both providers and patients indicate that group therapy should be further explored, but only applied with the correct resources, evidence and support.

Providers are excited about the potential for group therapy under MBS CCM, but concerned about financial viability for them

BENEFITS

- Potential to provide greater support and education to patients who are constrained by financial means.
- Provide care to patients in rural and regional areas who typically have fewer local services by travelling to them for group sessions.
- Can provide socialisation and peer support for patients as they navigate the management of their condition(s).

"We love group therapy – it combines capacity building with social engagement, education and normalisation of patient's condition. It is the most cost effective way to build capacity and reduce chronic health burden and we'd love to roll more of it out in our business." - dietitian, NSW

BARRIERS

- Rebate on attendance only means that providers take a financial risk engaging in group therapy, sometimes only getting paid for the one or two patients who turn up.
- Providers cited a lack of patient commitment due to the 'free' service which resulted in a lot of no-shows.
- Administrative time developing content and facilitating any co-facilitators. This is compounded by a lack of understanding that an initial assessment would have already taken place prior to being eligible for group treatment and providers believing they need to understand the individual patient needs in their own time.
- Financial overheads driven by lack of access to a space further complicate viability.
- **Ultimately, the time and overhead investment of group therapy is too great for the return when there's no guarantee on actual payments.**

"We cannot provide groups under this model of funding. There is not sufficient rebate for clients to choose to come to groups... any kind of individualisation or detailed recording cannot be done with \$39–\$152 per session, including wages and overheads."

- Chiropractor, NSW



While patients are interested in the idea of group therapy, they express some hesitation and fear

BENEFITS

- Opportunity to meet others who are managing the same (or similar) chronic conditions.
- Learning strategies, potential therapies, access to new funding, from others.
- Support and not feeling so alone. This was evident from the enthusiasm in which they participated in the research and wanted to see other's responses.

"I would like to try group therapy so you can hear how other people manage their pain and what treatments help them."

– Patient, Musculoskeletal Conditions - Osteoarthritis

BARRIERS

- Fear of sharing their condition history with others, largely due to the fatigue they have of sharing experiences and medical history repeatedly.
- Many also fear potentially being judged by others, a fear that they experience frequently in the 'real world'.
- For some, there's also concern that their needs may be overshadowed by other patients in a group setting, meaning they won't get the same level of care they could in one-on-one treatments or sessions.
- **Importantly, these fears are all heightened when patients believe that group therapy would *replace* their individual treatment. It's important that if group therapy is considered, it's communicated clearly that it's *in addition* to their individual sessions.**



"I really don't find group allied health services appealing as I have an unusual set of medical conditions and would rather not have to be dealing with the thought of other people judging me who have no idea what I am going through."

- Patient, Gastrointestinal Disorders – Chron's Disease

Group therapy may only be applicable for certain allied health services and specific programs

The broader application of group therapy was perceived as a **positive and effective approach to providing care, education and support to a higher number of patients**. However, peak bodies and providers were divided on whether group therapy was applicable to their profession.



- Allied health professionals who were supportive of the applicability of additional allied health sessions to their profession primarily highlighted how group services could be a mechanism through which to provide education and external supports.
- A separate benefit to this is that allied health professionals would then have more time to focus on treatment in their services as education could be provided through these additional group services.



- Allied health professionals that did not believe there to be any known applicability of group therapy to their profession included chiropractors, podiatrists and psychologists.
- For psychologists, ethical and patient confidentiality concerns mean group therapy options are inappropriate for most patients.
- Chiropractors and podiatrists work directly one-on-one with patients and treat physical pain or ailments; this type of care was deemed inaccessible through group therapy.

There is potential for group sessions support to be expanded to other allied health services, with particular focus on education, social and exercise or physical activity-based programs.

“Group therapy could work well in my current practice, particularly for clients with shared goals such as social communication development in children or language rehabilitation in adults post-stroke.”

Speech Pathologist, Vic

Support for group therapy differs across profession, with some more supportive than others

Strongly Supportive

- **Osteopathy:** physical movement, falls prevention, pilates, strengthening and movement classes
- **Exercise Physiology:** supervision of people completing individualised programs, group classes for specific conditions such as osteoporosis etc.
- **Speech Pathologists:** group practice allows for pragmatic language practice, turn taking etc. also helps children with social communication challenges. Note, there was a preference for slightly longer group sessions 60-120 minutes
- **Physiotherapy:** group programs for people with specific condition – e.g. balance program for people with Parkinson's, group program for chronic pain etc.; would like to see how this could also be applied to things like water based sessions
- **Aboriginal and Torres Strait Islander Health Workers and Practitioners** (see slide 46)

Strongly Supportive (cont)

- **Social workers:** depended on what they were delivering – chronic pain, health education, group support programs, but still wanted to see individual therapy as needed
- **Chiropractors:** GLA:D model for group exercise training for stretch/posture classes and possible condition education classes
- **Occupational Therapy:** unsure how education programs would apply in chronic conditions, but could see it working examples of other programs are school readiness, exploring neurodivergence etc.
- **Psychologists:** in conjunction with other practitioners who are running more practical group programs such as exercise etc., however, can see how it would make group therapy more affordable if there's a way to talk through effective therapy

Somewhat Supportive

- **Mental Health nurses:** support group and education
- **Diabetes educators:** if from a GP clinic and combined with other practitioners vs. solely on their own
- **Dietitians:** education, support groups

Limited Support

- **Audiology:** highly individualised program, however, may work with speech therapy
- **Podiatry:** alongside other therapists for specific programs such as diabetes educators etc. as part of an education program vs. hands on treatment

Group therapy has proven to work for First Nations people

Both Aboriginal and Torres Strait Islander Health Workers and Professionals interviewed and associated peak bodies discussed group programs that had already worked and could imagine both these and other programs could be included under MBS CCM.

Previous programs have included:

- Good Quick Tikka sessions including demonstration no how to make healthy meals, how to adapt meals, share this information and support others to engage in healthier eating
- Work It Out program: education and physical activity sessions. This included discussions about chronic conditions as well as social and emotional wellbeing
- Individual clinics often run men's education sessions, sometimes as walking groups and discuss various topics. This could be adapted to include condition specific education such as diabetes etc.

Importantly, all group programs need to ensure there's time given for acknowledgements, introductions of each person and time taken to understand what it is that people want covered in the group. This includes open discussion at the end of each session to allow for broader conversation and suggestions for future topics or areas to cover.





"I've been part of something like this before with diabetes patients. There were several different practitioners, a GP, a nurse, dietitian and various others. It worked really well."
Social Worker, NSW

Allied health professionals can see how they may co-facilitate sessions

Among allied health providers who are supportive of the application of group therapy to their profession, some expressed an interest in the possibility of working alongside other allied health professionals from different services in these group sessions.

- Physiotherapists were interested in working alongside psychologists and social workers to address the psychosocial factors that impact some patient's progression.
- Dietitians, exercise physiologists, diabetes educators, and podiatrists may be able to provide group services well for diabetic patients (e.g. a comprehensive education program).
- Speech pathologists and audiologists may also work well together.

However, the applicability of this option is more limited than the applicability of group services more generally, particularly when providers come from different practices vs. being co-located.

More broadly, allied health professionals suggested that the introduction of allied health assistants could improve the quality of care provided under group services. This would take pressure off allied health providers in group service settings and make group services a more financially viable option for practitioners.

Opportunities for allied health professionals to work together in group service settings are limited but have the potential to be effective if supported in the correct way. The introduction of allied health assistants could make the applicability of group services more feasible for practitioners.

Key learnings: Group therapy may be a viable path for improving social support, boosting education and prolonging self-led management of conditions

1.

Patients and allied health providers are excited by the potential that group services offer to MBS CCM

The potential for wider application of group therapy services under MBS CCM is welcomed by patients and providers with the key benefits focussing on education, socialisation, and peer support for patients.

Implication: Expansion of group service applicability should be explored further

2.

There are some opportunities for the expansion of group services

Several opportunities for further expansion of group services were highlighted including group services for dietitians, diabetes educators, speech pathologists, exercise physiologists and social workers. Aboriginal and Torres Strait Islander health workers and practitioners highlighted the potential for group services to include broader health education as part of yarning circles.

Implication: Applicability of group services under these health professionals should be further explored in direct consultation

3.

Hesitancy exists in the form of financial risk for providers and fear of judgement among patients

Allied health providers raised concerns surrounding financial feasibility as a result of the high costs related to running group services. Patients expressed hesitancy towards group services because they value their privacy or fear sharing information about their condition with others, some also feared that the quality of care would be lower compared to individual services.

Implication: If group services are expanded the fears and concerns of providers and patients must be addressed.



Objective 4:

Explore expansion of eligible allied health services



"It would be great to include holistic health practitioners as I benefit from having acupuncture but not covered by plan."
- MBS CCM patient, Gastrointestinal Disorders – Ulcerative Colitis

The range of allied health services under MBS CCM is well received by all

Patients were the most supportive of further expansion to the current list of eligible allied health services, particularly as there has been a recent expansion in what's covered by private health insurance. However, the majority are satisfied with the current eligible list. Recommendations of additional allied health professions from patients included prosthetists and acupuncturists.

Peak bodies and providers were satisfied with the current range of eligible allied health services available under MBS CCM. Some peak bodies expressed a hesitancy to support further expansion. Particularly related to the inclusion of acupuncturists citing concerns related to a lack of empirical evidence to support their inclusion in the management of chronic conditions. This resistance comes despite the fact many patients are accessing these providers outside of MBS CCM and rely on these providers for the management of their conditions.

A point of expansion recommended by both **providers and patients** was for pain educators to be included under MBS CCM. Pain educators and pain clinics have been effective in helping patients manage their conditions but currently educators can be difficult to access. The inclusion of pain educators under MBS CCM and potentially in group services could aid the efficacy of the program.

Prosthetists, acupuncturists and pain educators were recommended additions to the eligible list of allied health services. Though these additions may need to be supported with empirical literature highlighting their effectiveness for condition management.

Additional barriers to service delivery



“The administrative burden has definitely increased and more has been shifted over to allied health professionals from GPs with the latest changes.”

Peak organisation

Providers are additionally burdened by unclaimable administrative work

A significant challenge to the ability for professionals to provide excellent care for their patients/clients is the unclaimable administration that accompanies the GPCCMP.

Regardless of the type of patient or the type of care, professionals noted that they don't have the same support, and some even believe respect, as other medical professionals but just as much administration. They need to:

- Plan treatment
- Take notes
- Make adjustments to the treatment plan
- Report back to the GP
- Engage other professionals as and when required
- Provide their client with notes/advice for what to do in between or after sessions
- Help manage the number of sessions used etc., book patients in and stay on top of how the CCM is working

GPs' and specialists' administrative hours are believed to be accounted for, while allied health professionals are expected to absorb the time and financial losses associated with administration related to GPCCMP. This pain point is exasperated by a sense that most patient GPCCMP reports go unread and unacknowledged by GPs.

Poor referral pathways and communication between GP and allied health professionals creates difficulties

- The current referral mechanism, while an improvement upon previous systems, leaves patients in charge of remembering what sessions have been used and where, often resulting in over or under utilisation of the program which can then make multidisciplinary models of care an increased challenge to implement.
- Often patients are referred to one specific professional or service, with little to no back up options if that one is unavailable. Further, referrals don't often set expectations for patients (what to expect, out of pocket costs, what the service will address etc.) meaning that allied health professionals are starting at a disadvantage.
- This has resulted in many professionals and some peaks questioning whether GPs are the best person to manage GPCCMPs.
- At the very least, there's a strong belief and recommendation for GPs to be better educated on GPCCMPs, what allied health services can do and how they can work together.
- Allied health professionals and peak bodies reported GPs referring patients to multiple services because they didn't know which would work, resulting in 'wasting' sessions.



Discussion arose over the potential for case managers

Some peak bodies felt that a case manager should be implemented to manage GPCCMPs. This case manager could liaise between GPs, patients, and allied health providers closing the feedback loop and allowing more efficient service provision.

In this case, allied health service providers may also be able to suggest other allied health service referrals to the GP where they feel that their patient could benefit from accessing another service and also ensure sessions are used and managed appropriately.

The DVA care plan was frequently mentioned as an effective version of this care management model. However, the NDIS referrals model was deemed to be ineffective and not suitable for the referral of MBS allied health services.

However, for most providers, while GPs aren't always ideal, they could see the need to have one person who is responsible for the patient and is across medication and any other medical issues the patient has.

Ultimately, there is recognition that GPs have the most holistic view of the patient, however there is a strong desire for GPs to be given the tools and education to understand the role that allied health can play in chronic conditions.



“For some conditions there could be an allied health professional, for example, who could be the coordinator or ‘case manager’ because they are the key relationship that the person will have and will spend the most time with them. It’s not always the GP. However, GPs will always have to be heavily involved because they play an important role, particularly for decision making, given they are a medical professional.”

Peak organisation

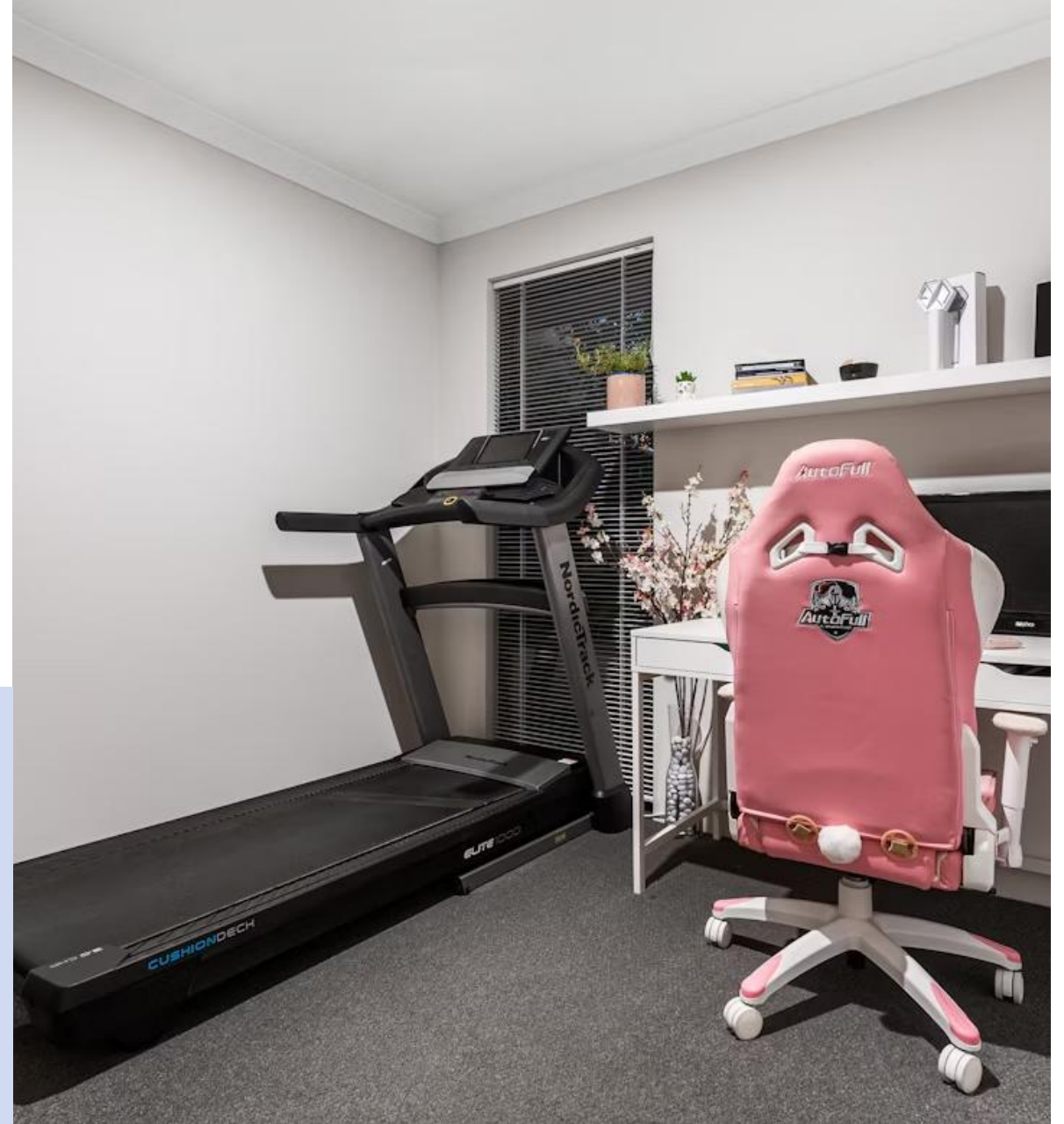
Reminding of telehealth availability will help more people access services

Accessibility is a key challenge for regional, rural and remote patients to get the care they need. Patients did appear to know that telehealth services were available; encouraging uptake of telehealth will enable those that have these access issues.

Similarly, those with transport limitations and mobility issues will benefit from telehealth services, ensuring they don't miss out on care that will deliver positive outcomes.

“ A challenge I face is being able to find an affordable specialist in the area. The solution I found was to have online telehealth appointments, particularly with the dietitian because they were cheaper and I could still see a specialist for my issue.

- Patient, Musculoskeletal Conditions,
Osteoporosis



Cost of living has increased the challenges patients experience accessing allied health services

Private health costs increasing

Fees for private health insurance means people are changing their level of care. Some are removing extras completely from their cover resulting in full fees needing to be paid once the allied health sessions under their GPCCMP have been used up.

Rebates not matching fee increases

Both Medicare rebates and health fund rebates haven't kept pace with the increases practitioners have been making.

Changes in NDIS impact access

Additional restrictions in NDIS and other programs such as Mental Health Care Plans means more people are turning to GPCCMPs as a way to continue to get the sessions they need.

Compounding this is the fact that many people no longer have a 'family GP' or regularly see GPs due to increasing cost and lack of availability, particularly of a bulk billing practitioner.

Critically, patients need a way to track number of sessions used

“

I used to just use three so that I could have two spare in case I needed them for an emergency, but I ended up wasting those visits. Now I try and schedule four and have one spare, but it's hard to keep track.

- Patient, Cardiovascular Disease - Hypertension



Patients had a poor understanding of how the GPCCMP works, with many often not knowing how many sessions had been used, feeling 'caught out' when they reach their cap or having to pay the full fee for a service they expected to have a rebate.

This can impact their confidence and trust in the allied health provider and allied health professions more broadly, reducing their likelihood to commit to and continue treatment.

Patients need transparency in session usage and a way to be able to track and monitor the progress of their GPCCMP allied health sessions.

Models of care

Peaks and providers are eager to move towards multidisciplinary models of care

A key message from peak bodies and providers was a request for a greater focus on multidisciplinary models of care. These are models that are patient-centered, allow the healthcare team (including GPs, practice nurses, multiple allied health etc.) to collaborate and provide coordinated, holistic care.

Currently, some peaks and providers view the MBS CCM framework as one-directional, with GPs deciding referral pathways for allied health. Certain allied health providers expressed concerns that GPs do not understand their role in care plans and therefore the correct referral pathways are not always followed. Increased collaboration between healthcare teams could improve the effectiveness of care provided.

Under the current MBS CCM, allied health professionals experience minimal two-way communication with GPs which adds to their frustration and inability to coordinate with GPs. Many allied health providers feel that their patient reports are not read by GPs or at the least, are not responded to.

While most allied health professionals still recognise that a GP is best placed to manage and prepare a GPCCMP, there is a desire for greater collaboration between the general practice teams (GPs, nurse practitioners), patient and multiple allied health simultaneously.

Peak bodies and providers would like to see a greater focus on collaborative, coordinated, and comprehensive models of care.



“GP awareness gaps: Some GPs may lack knowledge of the full range of allied health options, leading to suboptimal referrals.”
- Exercise Physiologist, VIC

A few existing Australian schemes and models were referenced frequently



Australian Government
Department of Veterans' Affairs

- The National Disability Insurance Services (NDIS) scheme was referenced frequently by peak bodies and providers throughout the review. Peak bodies and providers advised that they do not want GPCCMPs to evolve to follow the same structure as NDIS.
 - However, they did commend the NDIS scheme for individualising care plans, involving patients in the plan development and decentralising GP's from being the key decision makers.
-
- The Department of Veteran's Affairs (DVA) allied health treatment cycle was considered the current gold standard approach to allied health treatment plans within Australia.
 - The cycle puts patients at the center of care, allowing for plans to be individualised and are coordinated by a GP. The treatment plan allows for up to 12 sessions; multiple allied health treatment areas can occur at the same time and there is no limit to the number of cycles that are clinically necessary.
 - However, it was recognised that this is an expensive model of care and would be difficult to roll out for Medicare due to numbers of patients and funding requirements.
-
- Eating disorder care plans were also referenced frequently by providers, particularly those who worked with patients managing psychological disorders.
 - The care plans are designed and tailored for specific conditions and allow for multiple releases of treatment blocks that include 10 sessions each, following review and sign-off on further releases of sessions. A similar approach to GPCCMPs could be considered.

Providers highlighted strengths that MBS CCM could incorporate but cautioned to avoid mistakes that make the NDIS inefficient

Strengths		Caution
NDIS 1. Time-based funding 2. Accounts for travel and admin costs 3. Individual care plans 4. Allows patients to be involved in developing their care plan	<i>“The NDIS is not perfect but the fact that it’s time based funding, covers travel and admin is worth looking at.”</i> - Physiotherapist, VIC	NDIS deemed overly complex and administratively burdensome, ultimately making the scheme inefficient.
DVA Scheme 1. Higher number of sessions (12) per treatment cycle 2. Allows multiple health treatment cycles to occur together 3. No limit on the number of cycles clinically necessary	<i>“The Department of Veterans’ Affairs scheme shows what happens when you properly fund chronic care – patients stick with treatment, they don’t ration out sessions like they have to under CCM.”</i> - Exercise Physiologist, QLD	An expensive model of care that would be difficult to roll out for Medicare due to numbers of patients and funding requirements.
Eating Disorder Care Plans 1. Higher number of sessions (10) per block 2. No limit on the number of cycles clinically necessary 3. Plans developed to treat specific conditions	<i>“The eating disorder care plans work well, in that they have multiple ‘releases’ of 10x sessions in blocks that require different sign-offs... Perhaps a similar set-up can be applied to GPCCMs.”</i> - Occupational therapist, NSW	

In addition to multidisciplinary models, providers highlighted the need for patient affirming models of care

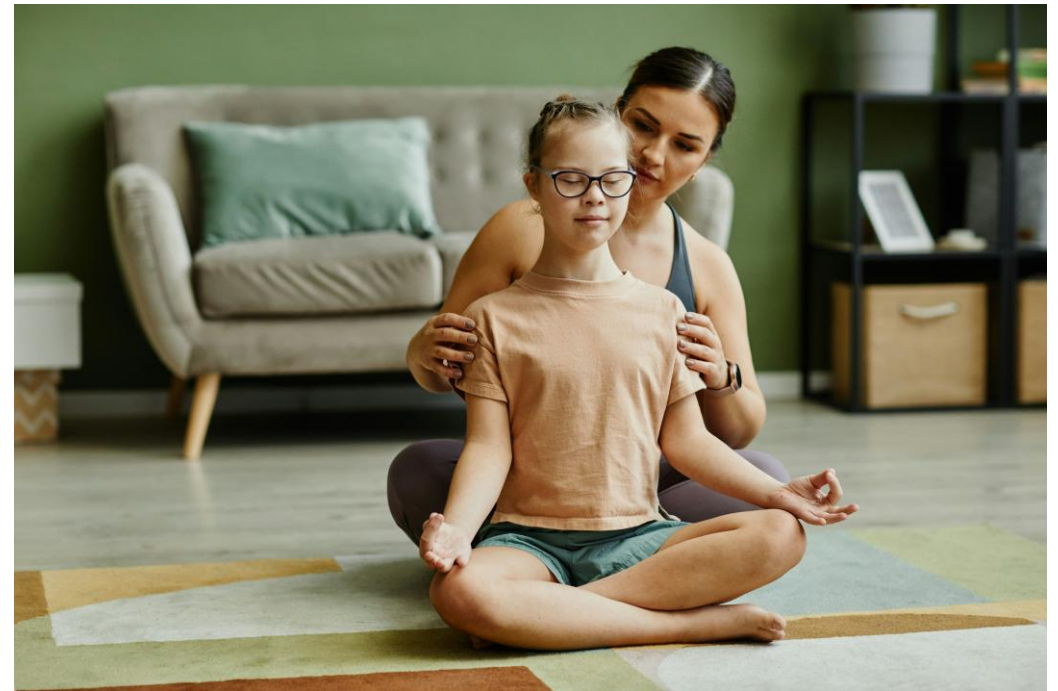
Some providers emphasised that patients need their care to be adaptable to a patient's context and circumstances.

“The main model of care affecting the cohort I support would be a neurodivergent affirming model. Trying to force them to comply with neurotypical ways is resulting in long term trauma, harm and autistic burnout.”

- Occupational therapist, VIC

“Family-centred models of care should be prioritised – often the patient isn’t managing alone, they’re part of a family unit, and bringing carers or family into sessions makes the intervention more effective and sustainable.”

- Physiotherapist, VIC



Further, there are some models that applied to specific conditions that were suggested for consideration under MBS CCM

Osteoarthritis

- GLA:D - <https://gladaustralia.com.au/>
- PEAK - <https://pubmed.ncbi.nlm.nih.gov/38461844/>
- Peak Training - <https://healthsciences.unimelb.edu.au/departments/physiotherapy/chesm/clinician-resources/peak-training>

Chronic back pain

- WalkBack - [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(24\)00755-4/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(24)00755-4/fulltext)
- RESTORE - <https://pubmed.ncbi.nlm.nih.gov/37146623/>
- RESOLVE - <https://pubmed.ncbi.nlm.nih.gov/27939089/>

Chronic obstructive pulmonary disease (COPD)

- Pulmonary rehab for COPD based on an existing 8-week program running in hospitals.

General models for consideration

- Falls prevention models
- Pain management models
- Mental health care plans



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