**Healthcare Professionals' Insights into Medicare-Rebated Chronic Disease Management Plans on Self-management among Patients with Diabetes: A Qualitative Study**

**Background and Purpose:** Chronic Disease Management (CDM) Plans target the coordination of patient needs. However, patients with chronic conditions are often poorly served by current health delivery arrangements that fail to manage care needs across different service providers. This qualitative study investigates healthcare professionals' perspectives on the effectiveness of CDM plans on self-management among patients with diabetes.

**Methods:** A qualitative study used individual semi-structured interviews with ten healthcare professionals. All participants utilised CDM plans in general practice settings in Australia. Interviews were audio-recorded and transcribed verbatim. Thematic analysis was conducted to identify how healthcare professionals view the effectiveness of CDM plans on patient self-management. The study finding was further analysed using the Andersen Behavioural Model of Health Service Use as an underlying theoretical framework and a modified model is proposed for more efficacy and efficiency of access to the CDM plans.

**Results:** These professionals identified obstacles with patients, individual healthcare professionals, and delivery across the healthcare system, rendering the achievement of optimal patient outcomes challenging. Four major themes were identified in this study: We Acknowledge the burden of diabetes, but we cannot do magic! True empowerment can only be achieved by giving patients some control over their decisions, robust care planning process is not person-centred, and there are limitations within the system at all levels.

**Conclusion:** Medicare-rebated CDM plans are a well-used tool in primary care practice in Australia. Better targeted services based on patient needs, a higher level of coordination between the multidisciplinary team, patient involvement in their shared goals and decision-making, and regular review and follow-up are requirements for improving and reforming the current implementation of CDM plans with consideration of rolling out a blended funding process.

**Keywords:** Chronic disease management plan, primary health care, general practice setting, patient's perspective, patient care planning, patient-centred care, patient with diabetes, self-management, shared goal settings