Health assessments and chronic disease management:

Finding your way through the maze

phn EASTERN MELBOURNE
An Australian Government Initiative

Is your patient eligible for any health assessments?

- If your patient is over 75 years… → Do an over 75 health assessment every 12 months
- If your patient has an intellectual disability… → Do an intellectual disability assessment every 12 months
- If your patient resides in an aged care facility… → Do a comprehensive medical assessment every 12 months
- If your patient is 40–49 years or 15–54 years (inclusive) for Aboriginal and Torres Strait Islander people and at 'high risk' of developing diabetes as defined by ausdrisk… → Do a type 2 diabetes risk evaluation once every 3 years. Eligibility: health.gov.au/resources/apps-and-tools/the-australian-type-2-diabetes-risk-assessment-tool-ausdrisk
- If your patient is 45–49 years with no diagnosed chronic condition… → Do a one-off 45–49 health check
- If your patient is a refugee or humanitarian entrant… → Do a one-off refugee or humanitarian entrant assessment
- If your patient was a serving member of the Australian Defence Force (ADF)… → Do a one-off Australian Defence Force post-discharge GP health assessment

- Brief health assessment of less than 30 minutes **item 701**
- Standard health assessment lasting more than 30 minutes but less than 45 minutes **item 703**
- Long health assessment lasting more than 45 minutes but less than 60 minutes **item 705**
- Prolonged health assessment lasting more than 60 minutes **item 707**

If your patient is of Aboriginal and/or Torres Strait Islander descent…

Do an Aboriginal and Torres Strait Islander Health Assessment item 715 or video telehealth **item 92004**.

For children <15yo; adults 15-55 yo and older adults >55 yo every 9 months

- → Utilise 10x **item 10987** or telehealth **items 93200/93202** per year for follow-up by PN or Aboriginal and Torres Strait Islander Health Worker
- → 10 allied health services can be accessed annually following either Health Assessment **item 715** or GPMP/TCA **items 721/723** using M11 referral form

If patient has a chronic or terminal illness, initiate a GP Management Plan **item 721** or video telehealth **item 92024** and Team Care Arrangement **item 723** or video telehealth **item 92025** as appropriate

If your patient has a mental health issue…

Prepare a GP Mental Health Treatment Plan **item 2700** or video telehealth **item 92112** (if no MH skills training) or **item 2715** or video telehealth i**tem 92116** (if MH Skills Training) and review with **item 2712** or telehealth **items 92129/92114**. For ongoing management of mental health issues **item 2713** or telehealth **items 92127/92115**

If patient has an additional chronic illness, initiate a GP Management Plan **item 721** and Team Care Arrangement **item 723** as appropriate

If your patient has a chronic condition that has been or will be in place for six months, or has a terminal illness…

Do a GP Management Plan **item 721** or video telehealth **item 92024**. Review after 3–6 months using **item 732** or video telehealth **item 92028**

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If your patient also has complex care needs necessitating the involvement of at least two other health or care providers

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Do a TCA item 723 or video telehealth **item 92025**. Review after 3–6 months using **item 732** or video telehealth **item 92028**

→ Utilise 5x **item 10997** or telehealth **items 93201/93203** per year for follow-up by PN or Aboriginal and Torres Strait Islander Health Worker if patient has a GP Management Plan or TCA in place

→ **Your patient is eligible to access 5 subsidised allied health visits per year**

→ Aboriginal and Torres Strait Islander patients are eligible for a total of 10 allied health services annually following either Health Assessment **item 715** or GPMP/TCA **items 721/723.** They can be a combination of:

- up to 5 services using a chronic disease management referral form
- up to 10 services under MBS Group M11 using M11 referral form People of Aboriginal or Torres Strait Islander descent – Referral form for allied health services under Medicare | Australian Government Department of Health and Aged Care

If your patient has diabetes…

Do a GP Management Plan **item 721** and **Team Care Arrangement item 723** as appropriate

Annual Diabetes Cycle of Care recommendations available at www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/diabetes/introduction

Could your patient benefit from a Home Medication Review (HMR)?

Patient must be a current Medicare or DVA cardholder living in a community setting. Organise a HMR **item 900** for patients at risk of medication-related harm due to:

- multiple chronic conditions or comorbidities
- age
- social circumstances
- characteristics of their medicine
- complexity of their medication regimen
- limited knowledge and skills to use their medicines effectively and safely

HMR and RMMR Fact sheet for GPs (psa.org.au)

Case conferencing

Organise and coordinate a Case Conference **item 735, 739, or 743**

Participate in a Case Conference **item 747, 750, or 758** with two other health care providers.

Consider contributing to multi-disciplinary care plan if requested by another health provider **item 729** or video telehealth **item 92026**

If your patient resides in an aged care facility…

Contribute to RACF Care Plan or to a review after 3–6 months **item 731** or video telehealth **item 92027**

If your patient also has complex care needs necessitating the involvement of at least 2 other health or care providers

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Your patient is eligible to access allied health

Could your patient be at 'high risk of developing type 2 diabetes? Should your patient be referred to a lifestyle modification program?

1. If your patient is of Aboriginal and/or Torres Strait Islander descent and aged 15–54 years, do an Aboriginal and Torres Strait Islander Health Assessment—use ausdrisk tool
2. If your patient is 45–49 years with no diagnosed chronic condition, do a 45 year health check—use ausdrisk tool
3. If your patient is 40–49 years, use ausdrisk tool to determine diabetes type 2 risk. If patient is at 'high risk' do a diabetes type 2 risk evaluation

If your patient is found to be at 'high risk' of developing type 2 diabetes, Life! program eligibility criteria: lifeprogram.org.au/learn-about-life/

GPs and nurses refer patients to: lifeprogram.org.au/for-health-professionals/

This resource must be used in conjunction with the item descriptor and explanatory notes for all items as set out in the Medicare Benefits Schedule (MBS) as claiming conditions apply.
MBS online - https://www.mbsonline.gov.au

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