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: www.lifeprogram.org.au/get-involved/join-the-life-program
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** For children <15yo; adults 15-55 yo and older adults >55 yo every 9 months → Utilise 10x **item 10987** per year for follow-up by PN or Aboriginal and Torres Strait Islander Health Worker

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

If your patient has a **mental health issue**…

Prepare a GP Mental Health Treatment Plan **item 2700** (if no MH skills training) or **item 2715** (if MH Skills Training) and review with **item 2712**. For ongoing management of mental health issues **item 2713**

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**
Review after 3-6 months using **item 732**

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

Do a TCA **item 723**. Review after 3-6 months using **item 732** → **Your patient is eligible to access 5 subsidised allied health visits per year**

Utilise 5x **item 10997** 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

If your patient has **diabetes**…

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

Commence a Diabetes Annual Cycle of Care and claim **item 2517, 2521, or 2525** (or similar) at end of cycle. Components of Cycle of care can be completed within 11-13 months

If your patient has type 2 diabetes and has a GPMP in place, they may be eligible for referral for group diabetes education with a dietician, exercise physiologist or diabetes educator (8 extra group sessions above and beyond 5 individual allied health sessions)

If your patient has moderate to severe **asthma**…

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

Commence an Asthma Annual Cycle of Care and claim **item 2546, 2552, or 2558** (or similar) at end of cycle **OR** do a GP Management Plan and TCA if necessary

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

Organise a HMR **item 900**. Patient must be a current Medicare or DVA cardholder and living in a community setting. A HMR could benefit a patient who is 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

https://my.psa.org.au/s/article/HMR-and-RMMR-Fact-sheet-for-GPs

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 - www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Home

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**

If your patient resides in an **aged care facility**…

Contribute to RACF Care Plan **item 731**
Review after 3-6 months using **item 731**

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

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: www.lifeprogram.org.au/get-involved/join-the-life-program
GPs and nurses refer patients to: www.lifeprogram.org.au/health-professionals/gps-refer-your-patients