# Health assessments and chronic disease management:

Finding your way through the maze



An Australian Government Initiative

#### Is your patient eligible for any health assessments? Do an over 75 health assessment If your patient is over 75 years... every 12 months If your patient has an intellectual Do an intellectual disability assessment every 12 months disability... If your patient resides in an aged care Do a comprehensive medical assessment every 12 months facility... If your patient is 40-49 years or 15-54 Do a type 2 diabetes risk evaluation years (inclusive) for Aboriginal and once every 3 years. Eligibility: Torres Strait Islander people and at health.gov.au/resources/apps-and-'high risk' of developing diabetes as tools/the-australian-type-2-diabetesdefined by ausdrisk... risk-assessment-tool-ausdrisk If your patient is 45-49 years with no Do a one-off 45-49 health check diagnosed chronic condition... If your patient is a refugee or Do a one-off refugee or humanitarian humanitarian entrant... entrant assessment If your patient was a serving Do a one-off Australian Defence Force member of the Australian post-discharge GP health assessment Defence Force (ADF)... $\Psi$ $\mathbf{\Psi}$ Long health assessment lasting more Brief health assessment of less than than 45 minutes but less than 60 30 minutes item 701 minutes item 705 Standard health assessment lasting Prolonged health assessment lasting more than 30 minutes but less than more than 60 minutes item 707 45 minutes item 703 If your patient is of Aboriginal and/or Torres Strait Islander descent... Utilise 10x item 10987 or telehealth items Do an Aboriginal and 93200/93202 per year for follow-up by PN or Torres Strait Islander Health Aboriginal and Torres Strait Islander Health Worker Assessment item 715 or video telehealth item 92004. For children <15yo; adults 15-55 10 allied health services can be accessed annually yo and older adults >55 yo following either Health Assessment item 715 or every 9 months 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

item 92025 as appropriate

video telehealth item 92024 and Team Care Arrangement item 723 or video telehealth

## 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 item 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

If your patient also has complex

care needs necessitating the

other health or care providers

involvement of at least two

Do a TCA item 723 or video

telehealth item 92025. Review

or video telehealth item 92028

after 3–6 months using **item 732** 

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

Utilise 5x item 10997 or telehealth items 93201/

93203 per year for follow-up by PN or Aboriginal

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

## f vour 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 <a href="www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/diabetes/introduction">www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/diabetes/introduction</a>

## 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
- timited 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



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?

- 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/