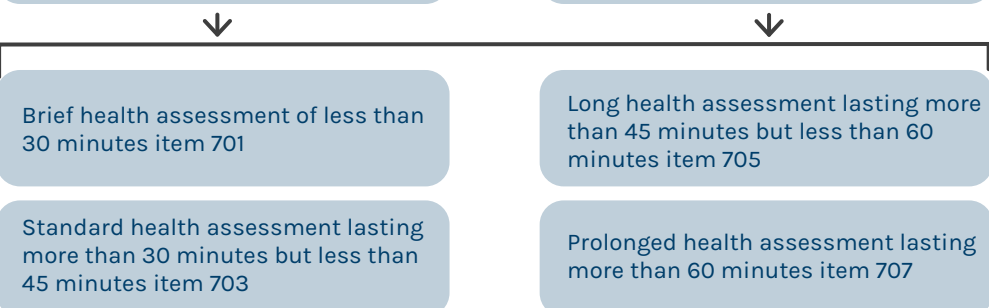
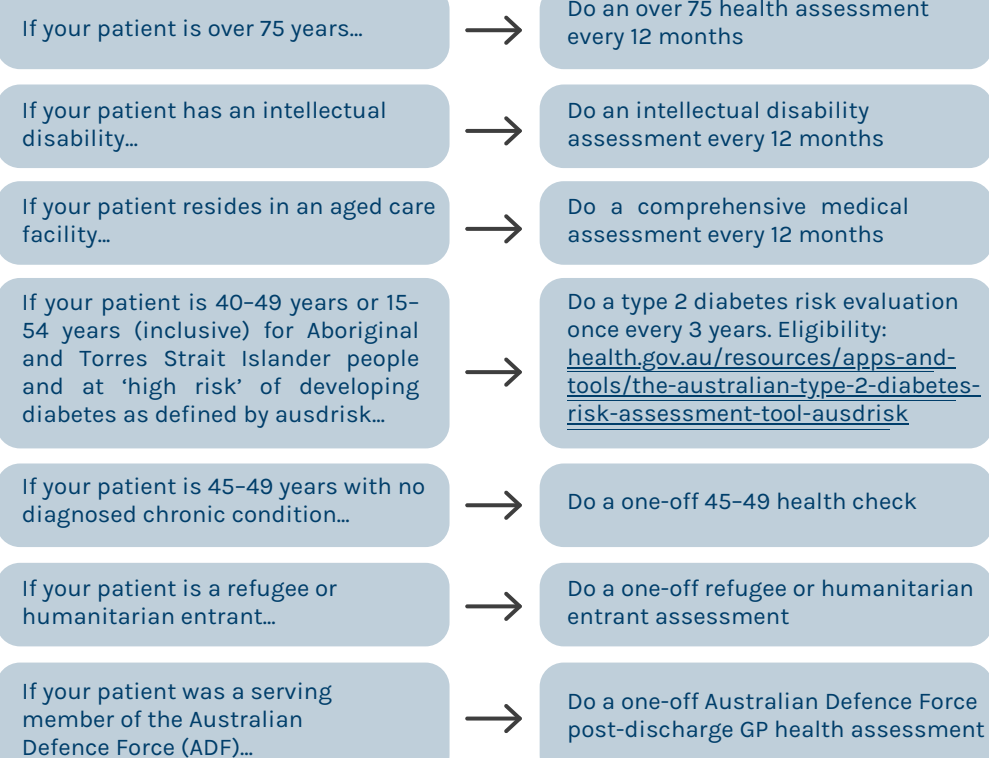


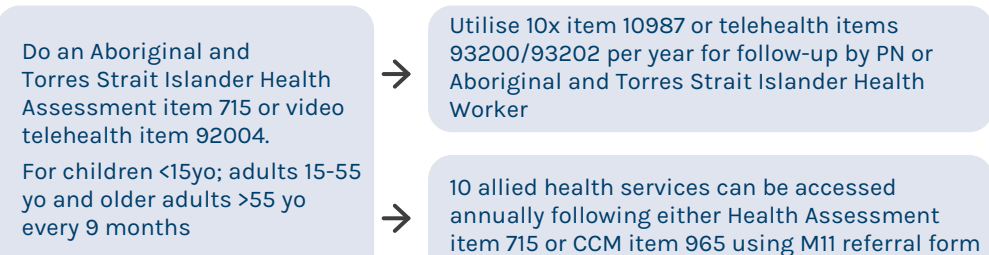
# Health assessments and chronic conditions management:

## Finding your way through the maze

### Is your patient eligible for any health assessments?



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



If a patient has a chronic or terminal illness, initiate a GP Chronic Conditions Management Plan (GPPCMP) item 965 or video telehealth item 92029. Review after 3–6 months using item 967 or video telehealth item 92030

### 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 GPPCMP item 965

### 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 GPPCMP item 965 or video telehealth item 92029

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

Review of GPPCMP can be undertaken every 3–6 months item 967 or video telehealth item 92029. For patients to access allied health services under the GPPCMP, a review must be undertaken a minimum of every 18 months

Aboriginal and Torres Strait Islander patients are eligible for a total of 10 allied health services annually following either Health Assessment item 715 or GPPCMP item 965. They can be a combination of:

- Up to 5 services using an Allied Health referral letter
- 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...

Initiate a GPPCMP item 965 or video telehealth item 92029 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](https://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 \(psa.org.au\)](https://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 RACH Care Plan or to a review after 3–6 months item 731 or video telehealth item 92027

A range of MBS-supported multidisciplinary services may be available to patients with a multidisciplinary care plan, where those services are consistent with the plan

### 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/](https://lifeprogram.org.au/learn-about-life/)

GPs and nurses refer patients to: [lifeprogram.org.au/for-health-professionals/](https://lifeprogram.org.au/for-health-professionals/)

For those not eligible for a timed Health Assessment consider a Healthy Heart Check item 699 or a Menopause and Perimenopause Health Assessment item 695