

Health assessments and chronic disease management:

Finding your way through the maze.

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

Do an Aboriginal and Torres Strait Islander Health Assessment **item 715**

Utilise **item 10987** 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 **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**

Utilise **item 10997** for follow-up by PN or Aboriginal and Torres Strait Islander Health Worker if patient has a GP Management Plan or TCA in place

Do a TCA **item 723**. Review after 3-6 months using **item 732**

Your patient is eligible to access allied health

If your patient has **diabetes**...

Commence a Diabetes Annual Cycle of Care and claim **item 2517, 2521, or 2525** (or similar) at end of cycle

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

If your patient has type 2 diabetes and has a GPMP in place, they may be eligible for referral for group diabetes education

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

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

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

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

If your patient is over 75 years...

Do an over 75 health assessment

If your patient was a serving member of the Australian Defence Force (ADF)...

Do an Australian Defence Force post-discharge GP health assessment

If your patient is 45-49 years with no diagnosed chronic condition...

Do a 45-49 health check

If your patient is 40-49 years and at 'high risk' of developing diabetes as defined by **ausdrisk**...

Do a type 2 diabetes risk evaluation

If your patient has an intellectual disability...

Do an intellectual disability assessment

If your patient resides in an aged care facility...

Do a comprehensive medical assessment

If your patient is a refugee or humanitarian entrant...

Do a refugee or humanitarian entrant 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 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

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

Could your patient benefit from a **medication review**?

Organise a **home medication review item 900**

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**

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, provide advice and information such as *My health for life* program and/or information and strategies to achieve lifestyle and behaviour changes.