

## **How you can build Enhanced Primary Care into your service**

There are several steps you can take to incorporate EPC items into your service and ensure that the EPC services you provide meet Medicare requirements:

1. Make sure that staff are aware of the EPC services and how they operate by distributing this and other information about them;
2. Encourage staff to read distributed information and adapt it to your local needs and circumstances;
3. Talk to your client groups and patients about EPC services and how they can benefit from them;
4. Promote awareness of EPC services in the community by displaying available posters;
5. Make sure that doctors who work with your service are aware of EPC services, who can benefit from them, and what is involved in providing them;
6. If your service does not have a doctor, you may want to talk to doctors in the area about how you can work together to make sure patients get appropriate care. For example, Aboriginal health workers can be involved by contributing to care plans, taking part in case conferences or helping doctors get information for a health assessment.

## **Annual Older Age Health Assessments**

There are four services on the Medicare Benefits Schedule for older age health assessments: two for Aboriginal and Torres Strait Islander people aged 55 years and over and two for other Australians aged 75 years and over.

Item number 704 is for an older age health assessment conducted for an Aboriginal and Torres Strait Islander person at a GP's consulting rooms. Item 706 is for the same service conducted at somewhere other than a GP's consulting rooms, a hospital or a residential aged care facility.

### **How are Indigenous status and age identified for an annual older age health assessment?**

To be eligible for an older age Indigenous health assessment, a person must identify themselves as being of Aboriginal or Torres Strait Islander descent and state their age. Some patients may give this information without being asked. However, other patients will need to be asked. An appropriate way to ask this question is "Do you identify as an Aboriginal and/or Torres Strait Islander person?"

Information provided by the patient about their Indigenous status and age should be accepted, as stated by the patient, for the purposes of having a health assessment.

### **Who can do an annual older age health assessment?**

An older age health assessment should be done by the patient's usual GP. Providing certain conditions are met, the GP can arrange for another person under his or her supervision to collect information needed for the health assessment, with the patient's agreement. The health assessment must include the GP seeing the patient.

### **What are the steps in an annual older age health assessment?**

There are five main components:

1. seeking and gaining patient agreement to the service;
2. collecting specific information about the patient;
3. assessing the information to make recommendations for care/treatment;
4. talking to the patient about outcomes and recommendations; and
5. placing a copy of the assessment in the patient's record and offering a copy to the patient.

Note that the information collecting part of the check can be done by an Aboriginal Health Worker, nurse or other qualified health professional if certain conditions are met (see the relevant explanatory notes in the Medicare Benefits Schedule Book).

## **What are the benefits of annual older age health assessments?**

Health assessments can help prevent sickness or help the patient and doctor manage a health problem better by finding health or other problems early.

Health assessments give the doctor and health workers up-to-date information about a patient's medical condition and health care needs. This can be very important in deciding how to care for a patient, and may mean better health outcomes.

## **Two-Yearly Aboriginal and Torres Strait Islander Adult Health Check**

There is one service on the Medicare Benefits Schedule for a health check for Aboriginal and Torres Strait Islander people aged 15 to 54 (inclusive) who have not had the check in the previous 18 months. The relevant item number is 710.

### **How are indigenous status and age identified?**

See the answer to this question for older age health assessments (above), noting that age range for the adult health check service is 15 to 54 (inclusive).

### **Who can do an adult health check?**

The patient's usual GP should normally do the adult health check.

### **What are the steps in an adult health check?**

1. deciding whether the patient should have an adult health check;
2. explaining the health check to the patient;
3. gaining and noting patient agreement to the service;
4. taking a patient history;
5. examining the patient (mandatory activities);
6. arranging or undertaking any investigations;
7. assessing the patient's health;
8. initiating interventions;
9. developing a strategy for the good health of the patient;
10. recording the health check;
11. offering the patient a written report (including the simple strategy); and
12. keeping a copy of the health check in the patient record.

Note that the information collecting part of the check can be done by an Aboriginal Health Worker, nurse or other qualified health professional if certain conditions are met (see the relevant explanatory notes in the Medicare Benefits Schedule Book).

### **What are the benefits of an adult health check?**

The adult health check encourages early detection, diagnosis and intervention for common and treatable conditions.

## Comprehensive Medical Assessments (CMAs)

There is one service on the MBS for a Comprehensive Medical Assessment (CMA) for permanent residents of residential aged care facilities who have not had a CMA in the previous twelve months. The relevant item number is 712. This service can be provided to a new resident on admission or to a continuing resident on an “as required” basis (with a maximum of one CMA Per resident in any twelve month period).

### Who can do a Comprehensive Medical Assessment?

The patient’s usual GP should normally do the CMA. However, GPs who provide services on a facility-wide contract basis or who are registered to provide services to residential aged care facilities as a part of aged care panel arrangements may also provide CMAs as part of their services.

### What are the steps in a Comprehensive Medical Assessment?

1. seeking and obtaining consent to the service;
2. taking a detailed medical history;
3. conducting a comprehensive medical examination;
4. developing a list of diagnoses or problems based on the medical history and medical examination; and
5. providing a written summary of the outcomes of the CMA.

### What are the benefits of a Comprehensive Medical Assessment?

Listing diagnoses and problems helps provide better care for the resident. It also assists pharmacists who provide medication management review services for the resident.

## Care Planning (Chronic Disease Management services)

There are six care planning or Chronic Disease Management (CDM) services on the MBS.

The two main services are:

- (a) **preparation by a GP of a GP Management Plan** (Item 721) for a patient with at least one chronic or terminal condition; and
- (b) **coordination by a GP of Team Care Arrangements** (Item 723), involving collaboration with at least two other service providers for a patient who has at least one chronic or terminal condition and complex (team) care needs.

A patient who has at least one chronic or terminal condition and complex (team) care needs will be eligible for both services.

There are two review services:

- (a) **review by a GP of a GP Management Plan** (Item 725); and
- (b) **coordination by a GP of a team review of Team Care Arrangements** (Item 727).

There is a service for a contribution by a GP to a **multidisciplinary care plan** (or to a review of a multidisciplinary care plan) **by another provider**, for example a hospital on discharge (Item 729).

There is also a service for a contribution by a GP to a **multidisciplinary care plan** (or to the review of a multidisciplinary care plan) **for a resident of an aged care facility** (Item 731).

There are restrictions on where the CDM services can be provided, who can provide them and on the frequency of provision. (See the relevant explanatory notes MBS Book.)