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Practice Assistance Support Service

Annual Health Assessments

Not applicable to in-patients of hospital or nursing home resident

	In Consulting Room	Not at consulting Room, hospital or nursing home
Others 75 and over	Item 700	Item 702
Aboriginal and Torres Strait Islanders 55 and over	Item 704	Item 706
Full (DVA)	$146.25	$206.85
85%	$124.35	$175.85

Care Plans **

Patient with multi-disciplinary care needs and medical condition that has been or is likely to present for at least 6 months or that is terminal.

Preparation of a Care Plan	
Not on Discharge Not more than once every 6 months	Item 720
On Discharge (Private patients only) Not more than once every 6 months	Item 722
Full & DVA	$188.05
85%	$159.85
75%	$141.05

Review	
Item 724	
Not within 3 months of Item 720 or 1 month of Item 722	
Full & DVA	$94.05
85%	$79.95
75%	$70.55

Contribution to a Care Plan or Contribution to a	
Not on Discharge (not within 6 months of Item 720)	Item 726
On Discharge	Item 728
In Residential Aged Care Facility	Item 730
Full & DVA	$37.90
85%	$32.25
75%	$28.45

Case Conferences **

Patient with multi-disciplinary care needs and medical condition that has been or is likely to present for at least 6 months or that is terminal.

Organise and Coordinate			
Time	15 to < 30 min	30 to < 45 min	45 min or more
Not on Discharge (not in-patient of hospital or day hospital or nursing home)	Item 740	Item 742	Item 744
On Discharge *(Private patients only)* 1 per hospital	Item 746	Item 749	Item 757
In Aged Care Facility	Item 734	Item 736	Item 738
Full & DVA	$73.15	$109.70	$146.25
85%	$62.20	$93.25	$124.35
75%	$54.90	$82.30	$109.70

Participate			
Time	15 to < 30 min	30 to < 45 min	45 min or more
Not on Discharge (not in-patient of hospital or day hospital or nursing home)			Item 726
On Discharge			Item 728
In Aged Care Facility			Item 730
Full & DVA	$52.20	$83.55	$114.90
85%	$44.40	$71.05	$97.70
75%	$39.15	$62.70	$86.20

**VMOs are not able to claim Care Planning and Case Conferencing items if they are acting under arrangements as a VMO.

*Items 722, 746, 749 and 757 do not apply to public hospital patients on discharge as the coordinating activities are the role of the hospital. (This is not applicable to DVA patients, where this role may be undertaken by the patients own GP)

Developed by PASS at Knox Division of General Practice November 2000

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Practice Assistance Support Service

Annual Health Assessments

A health assessment (not for in-patients of hospital, day hospital or nursing home resident) is the assessment of the patient's health and physical, psychological and social function and whether preventative health care and education should be considered. It includes:

- Measurement of blood pressure, pulse rate and rhythm;
- Medication review, (inc. OTC's, prescriptions from others);
- Continence assessment;
- Immunisation status (influenza, tetanus & pneumococcus);
- Physical function (including ability to transfer between bed, chair & toilet, bathe, dress, shop, etc.) and whether or not patient has had a fall in the last 3 months;
- Psychological function, including cognition & mood (which should be measured with a recognised tool);
- Social function (including availability and adequacy of paid and unpaid help), & if patient is caring for another person.

Medical literature and consensus medical opinion support the following additional components: multi-system review, fitness to drive, hearing, vision, oral health, diet and nutritional status, smoking, foot care, sleep, need for community services, home safety, cardio-vascular risk factors and alcohol use.

The **information collection component may be rendered by a nurse or other assistant in accordance with accepted medical practice, acting under supervision**, the other components **must include a personal attendance by a medical practitioner.**

The annual health assessment should not take the form of a health screening service, generally should not include category 5 (diagnostic imaging) or category 6 (pathology) services, however they may be ordered if clinically relevant.

The assessment must also include keeping a written record of assessment, signed by patient, and provision of a written report to the patient with recommendations about matters covered.

Care Plans

A **multi-disciplinary** care plan or multi-disciplinary discharge care plan is a **written plan** describing:

- Assessment of health care needs;
- Assessment of treatment, health services, health care, & community services the patient is likely to need;
- Arrangement for provision of those services & treatment;
- Management goals with which the patient agrees;
- Arrangements to review the plan by a specified date.

Preparation must include:

- Discussion of the plan with the patient, including who will be in the team;
- Recording the plan and the patient's agreement;
- Providing copies of relevant parts of the plan to those who will provide services or treatment under the plan;
- Providing a copy of the plan, and each team members contribution, to the patient; &
- Providing copy to Dept. of Veterans' Affairs, if appropriate.

Care Plans may be 'on discharge', or 'not on discharge' (in community), however only a contribution to a care plan or a contribution to a review can be conducted in a residential aged care facility.

A care plan team includes a medical practitioner and **at least 2 other contributing members***, each providing a different kind of care (one of whom may be a medical practitioner).

While the patient must be present for a needs assessment by the medical practitioner to develop the plan, the patient need not be present while documentation is prepared and members of the team are contacted for input. **Members of the team do not have to be communicating at the one time** (as they do for a *case conference*).

Review must include review of previous plans, record of patient's agreement to review, provision of revised plans to appropriate participants, and provision of copy to DVA, if applicable.

If another person is preparing the plan, a **contribution to a care plan** or **contribution to a care plan review** would include preparation of the parts of the plan relevant to the treatment provided by the medical practitioner. It is expected that this would take at least 10 minutes and may be made either face to face, by telephone, fax, email, or written correspondence. The medical practitioner contributing should request a copy of the plan, or the part of the plan applicable to services he/she will provide. In preparing a contribution the medical practitioner should inform the patient that their medical history, diagnosis and care preferences will be discussed with other providers, and provide an opportunity for them to specify what may be conveyed or withheld from others.

Patients should be informed that they will incur a charge for this service, for which a Medicare rebate will be payable.

Case Conferences

A case conference is a **discussion** by which a **multi-disciplinary** team carries out the following activities:

- Discuss patient's history;
- Identify patient's multi-disciplinary care needs;
- Identify outcomes to be achieved by members of the case conference team giving care to the patient;
- Identify tasks that need to be undertaken in order to achieve outcomes and allocate tasks to team members
- Assess whether previously identified outcomes have been achieved.

Case conferences may be conducted on discharge, not on discharge or in an Aged Care Facility.

A case conferencing team includes a medical practitioner and at least 2 other contributing members*, each of whom provides a different kind of care (one of whom may be a medical practitioner providing a different kind of care).

The minimum 3 care providers **must be communicating at the one time for the whole of the conference**, either face-to-face, by telephone, video link, or a combination.

Organise and coordinate the case conference involves explaining to the patient the nature of the conference, obtaining and recording consent, recording day, times, names of participants, recording all matters mentioned and providing a summary to patient and team members.

When **participating** in a case conference organised by another, the medical practitioner should inform the patient that his/her medical history, diagnosis and care preferences will be discussed with other providers, and provide an opportunity for them to specify what may be conveyed or withheld from others. Patients should be informed that they will incur a charge for this service, for which a Medicare rebate will be payable.

It is expected that a patient would **not require more than five case conferences in a 12 month period**.

***May include Aboriginal health care workers, audiologists, dental therapists, dietitians, occupational therapists, optometrists, orthoptists or prosthetists, pharmacists, physiotherapists, podiatrists, psychologists, registered nurses, social workers, speech pathologists. May also include home and community care providers, education providers, "meals-on-wheels", personal care workers, etc. Patient and his/her personal carer is not included in the minimum of 3.*

This document is based on the Medicare Benefits Schedule.