



Enhanced Primary Care - Medicare Benefits Items



DEVELOPING PROFORMAS FOR ENHANCED PRIMARY CARE (EPC) MEDICARE ITEMS

General practitioners must keep a written record of a health assessment, a care plan and a report of the outcomes of a case conference. The patient must be offered a copy of the record. This is to ensure the service is properly provided and is a requirement for Medicare benefits to be made. Practitioners may find the easiest way to ensure these requirements are met is by using an appropriate proforma suited to their needs.

The Royal Australian College of General Practitioners developed proformas for health assessments, care plans and case conferencing. Many Divisions of General Practices have used these proformas as a guide in developing their own proformas tailored to the needs of GPs in their Divisions.

Proformas developed for local requirements should support practitioners in the delivery of EPC services and enable them to meet the requirements for the Items. Provided below are checklists covering the basic elements that should be included in proformas for the EPC Items. If one or more of these basic elements are not present on a proforma, then the proforma will not assist a GP to meet the Medicare requirements for the relevant item. To support best practice in the delivery of EPC services, proformas may usefully include optional elements eg recording of carer details, to ensure all the needs of the patient are considered.

HEALTH ASSESSMENT PROFORMAS CRITERIA

Proformas used for health assessments should include:

- Reminder to check for previous health assessments in the last 12 months
- Patient's name, age, nationality and Aboriginal and Torres Strait Islander status
- Patient's consent to health assessment
- Essential Items:
 - Blood pressure
 - Pulse rate and rhythm
 - Medication review
 - Continence assessment
 - Psychological function including mood and cognition
 - Immunisation status:
 - influenza
 - tetanus
 - pneumococcus
 - Assessment of patient's physical function, including:
 - activities of daily living
 - falls in the last 3 months
 - Assessment of patient's social function, including:
 - availability/adequacy of paid and unpaid help
 - whether the patient is responsible for caring for another person
- Additional components as relevant:
 - multi-system review
 - alcohol assessment
 - level of exercise
 - fitness to drive
 - foot care
 - hearing assessment
 - vision
 - weight, height, body mass index
 - sleep
 - need for community services
 - home safety
 - mobility
 - diet and nutritional status
 - cardiovascular risk factors
 - postural hypertension
 - oral health
 - smoking
- Assessment tools – if used must be validated and not modified; practitioner must be familiar with use or seek education/training.
- Patient to be offered a copy of the health assessment, copy (or extracts) offered to carer, with patient's agreement, and copy to be provided to patient's usual doctor (if different)
- Carer details (if the patient has a carer)