

The EPC MBS items at a glance:

Health Assessments

(Items 700 – 706)

Purpose of health assessment	<i>An opportunity for an in-depth assessment of the health of older patients in the context of their social and physical environment</i>
Improvements for your patients	<i>Minimisation of potential health risks and improved health outcomes such as quality of life and efficiency of care</i>
Who is eligible?	<ul style="list-style-type: none">➤ 75+ in general community; 55+ in Aboriginal and Torres Strait Islander communities➤ Not applicable to in-patients of hospital/day hospital or people in residential aged care facilities
How often?	<ul style="list-style-type: none">➤ Repeated annually
How long does it take?	<ul style="list-style-type: none">➤ Approximately 60-90 minutes
Where is it done?	<ul style="list-style-type: none">➤ At patient's home or at GP's surgery or combination of home and surgery
Who can assist?	<ul style="list-style-type: none">➤ Information may be gathered by an appropriate professional acting under supervision of the GP (eg home safety assessment) but the GP must still attend the patient in person for the medical components
Before beginning a health assessment	<ul style="list-style-type: none">➤ Refer to the detailed step by step approach to health assessments in the guidelines➤ Check for existing health assessment➤ Check eligibility➤ Identify and discuss benefits of a health assessment with patient➤ Obtain consent from patient➤ Prepare for health assessment appointment<ul style="list-style-type: none">- Identify the place of consultation (home or surgery or combination)- Identify professional responsible for home assessment- Make appointment for patient (and carer); ensure adequate time (at least an hour)- Arrange trained interpreter if necessary- Check supplies of equipment and assessment scales/tools needed
Undertaking the assessment	<ul style="list-style-type: none">➤ Complete a comprehensive biopsychosocial assessment of the patient

What MUST be included?

- ∅ **Assessment of physical, psychological and social health must include:**
 - **ADLs, physical function, falls within last 3 months**
 - **BP, pulse rate and rhythm,**
 - **Continence**
 - **Medication review**
 - **Psychological function (mood, cognition)**
 - **Social function, support required, carer status**
 - **Vaccinations (influenza, pneumococcus, tetanus)**

What else should be considered?

- ∅ **Multi-system review**
- ∅ **Fitness to drive**
- ∅ **Hearing and vision**
- ∅ **Oral health, diet and nutrition, foot care, sleep**
- ∅ **Cardiovascular risk factors, postural hypotension, smoking and alcohol intake**
- ∅ **Home safety**

What should NOT be done in a health assessment?

- ∅ **Radiology**
- ∅ **Pathology**

What documentation MUST I keep with patient's record?

- ∅ **A detailed record of the assessment, signed by the patient, including recommendations**
- ∅ **Evidence that outcomes and recommendations have been communicated to the patient and carer**
- ∅ **Evidence that a copy of the written report and recommendations has been given to the patient.**

What should I do next?

- ∅ **Consider the need for a care plan and or case conference for the patient**
- ∅ **Consider putting the patient on a recall / reminder schedule**
- ∅ **Finalise MBS claim.**

Source: Adapted from RACGP 'Standards and Guidelines for the Enhanced Primary Care Medicare Benefits Schedule Items.'