


System Implementation

GENERAL PRACTITIONER GUIDE
for the
Enhanced Primary Care (EPC)
Medical Benefit Schedule Item Numbers

Reference: MBS Book 1 November 2003 – Sections A20, A21 pp 33-39, item 700-730

Guide to implementation
utilising emedilab's simple and effective pro-formas





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INTRODUCTION TO EPC PROCEDURES

emedilab introduces a systematic and simple method for GPs to implement the requirements of the MBS EPC Items.

The GP utilises a sequence of simple-to-follow forms, supported by explanatory notes to effectively implement the EPC requirements.

1 HEALTH ASSESSMENT ITEMS 700 – 706 (Group A20)

Who is entitled?

- 75+ Year Olds
- 55+ Year Olds for Aboriginal and Torres Strait Islanders
- Patients not in hospital or day hospital facility
- Not resident of a nursing home

Frequency

One assessment per year

The requirements for emedilab health assessments are divided into four phases. All four phases need to be completed to claim for rebate.

1.1 COMPUTER SCANNABLE ASSESSMENT I Nurse Completed

emedilab has a simplified assessment procedure. This utilises a computer scannable form:

*the world-best assessment known as the
“Senior Health Questionnaire” – SHQ¹*

1.2 SENIOR HEALTH ASSESSMENT II Nurse completed

For the health assessments it is assumed that the patients are relatively healthy.

Attention is therefore concentrated on the risk factor parts of the SHQ – nutrition, BMI, physical functioning, mental functioning, alcohol, smoking, falls and other lifestyle items of the SHQ.

1.3 NOTES (Form 3) Nurse completed

¹ See – www.emedilab.com website for description of SHQ on computer scannable format.

1.4 PREVENTIVE HEALTH ASSESSMENT PRESCRIPTION (Form 4) GP Completed

- **Items to Prescribe**

The quantified results have been received from the electronic medical laboratory (Emedilab) and the completed senior health assessment II form reviewed. The GP now writes the prescription and gives it to the patient.

This will not be a prescription for drugs (chemical energy) – but will be a prescription for health promotion activities (physical energy). In the case of a health assessment on a healthy senior, the plan is one for preventive treatment.

This is, in effect, a health promotive prescription of educative or lifestyle activities that are to be implemented by the patient.

The GP determines which particular activities are recommended and the frequency, duration and intensity of implementation over a **three-month period**.

This may be a prescription for watching four hours of a video – educational on the benefits of physical activity, it may be a half an hour video on light aerobics, the patient should implement five days a week.

It may be a prescription to spend six hours reading a nominated dietary book, coupled with a prescription to eat two pieces of fruit/day. It may be a prescription to have two tobacco free days per week for the three-month period.

Other suggested “preventive prescriptions” will be available from the Emedilab Website as will further more detailed questionnaires on items such as more detailed Positive Health Indices.

Further information on how to interpret the patient profile report and how to complete the preventive health prescription guide, is found in the master pack, entitled “SHQ Patient Profile Report Explanation and Prescription Guide”.

- **Goals**

The “goal” for a specific patient is to improve a particular health parameter by a score of 10% at the next assessment. This may be their Nutritional Index Score, Physical Functioning Score or Mental Functioning Score. The eventual aim is to return the health parameter to normal.

The prescription will only be effective if adhered to or complied with.

- **Implementation and Supervision Record**

In order to implement the plan, the patient would be assisted by resources; videos, booklets, cassettes, education programs, exercise, relaxation courses etc. and a daily diary.

The patient must be advised where they can obtain these resources and directed accordingly. The patient must decide when, where and how she/he will implement the plan and make the appropriate arrangements. The patient should be able to self-implement the preventive program, obtain the resources and take responsibility for their regular performance.

- **Monitoring/Evaluation/Adherence**

The implementation or adherence to the plan should be monitored.

The patient should be advised to record a daily diary of activities actually performed.

2 COMMUNITY CARE PLANS (CP) – DISCHARGE CARE PLANS CONTRIBUTION TO CARE PLANS ITEMS 720 – 730

2.1 COMPUTER SCANNABLE ASSESSMENT I Nurse Completed

emedilab has a simplified assessment procedure utilising the world-best senior's assessment known as the Care Plan Assessment.

This is the same form used in the Seniors' Health Assessment. Attention is **now** focused on the medical diagnosis and the patient's functional health assessment.

2.2 CARE PLAN ASSESSMENT II Nurse Completed

The Chronic Condition Clinical Review uses the same form as the Senior Health Assessment. Attention here is **now** focused on diagnoses, disabilities and multi-disciplinary care needs.

2.3 NOTES (Form 3) Nurse Completed

2.4 PREVENTIVE HEALTH ASSESSMENT PRESCRIPTION (Form 4) (Part of Care Plan) GP Completed

This should also be completed as for SHA, but as part of a Care Plan.

2.5 CARE PLAN, CONSENT AND PRESCRIPTION (Form 5) (Part of Care Plan) GP Completed

This plan focuses on the involvement of other multi-disciplinary health care providers. The provider groups are to be involved as determined (prescribed) by the GP.

The duration of each session and the frequency of attendances are also set out for the first three months of the plan.

The particular activity, depth and complexity of the involvement of the provider is also prescribed by the GP. This describes which tasks, assistance and education activities the provider should be performing on each visit.

The goals of the CP are also set out. These should include improvements in the results of the Care Plan Assessment Form 1 parameters. A ten percent improvement in the selected parameter is a usual “goal”² in the physical component health status, mental component health status, a quantified reduction in the “PRA”, improvement in nutritional health status and so forth.

This is set out on the ***Care Plan, Consent and Prescription Form***.

² See – Description of SHQ on www.emedilab.com

2.5.1 IMPLEMENTATION & SUPERVISION RECORD

In order to implement the Coordinated Care Plan or Discharge Plan and ensure its appropriate introduction, the GP will nominate a practice coordinator (may be the GP's receptionist or the practice nurse).

The practice coordinators task is to ensure the arrangements are implemented to the prescribed timetable.

This involves:

- Faxing or emailing two providers the care plans
- Providing a covering letter to care plans with the return fax/email
- At review, supervising and verifying patient's have attended the providers

The practice coordinator (receptionist or practice nurse), should create and update a list of local providers, their fax/email addresses, the cost, if any, of their service.

The coordinator should aim to create standing arrangements with local providers, so they are aware, prior to individual patients being referred, they will be utilised regularly as part of the practices usual Care Plan providers.

This will ensure barriers to the successful implementation of the Care Plans are removed.

2.5.2 MONITORING / EVALUATION / ADHERENCE

The implementation or "actual" performance of the plan compared to the prescription must be monitored by the patient as well as the service coordinator. The "actual" goals achieved over a 3-month period must be evaluated against the goals set out in the plan.

The patient should be utilise a daily diary to record daily activities and provider attendances. This diary must be compared to the CP prescription. Evaluation/ Adherence Survey Forms should be completed by the practice coordinator: The "actual" performance of the activities by each provider is evaluated on a Likert scale from ① poor - ② - ③ - ④ - ⑤ excellent³ and the goals achieved are determined by a re-administration of the Form 1 (computer scannable) complete assessment at the appropriate intervals (6-monthly).

³ See – website www.emedilab.com. – General Practitioners/ EPC for guidelines as to ratings of poor, fair, good, very good and excellent.

3 CARE PLAN REVIEW (FORM 6) GP COMPLETED

Who is entitled?

Anyone who has had a previous Care Plan prepared by that medical practitioner and claimed under Item 720 or 722.

Frequency

Once per three months.

Recommended appointment time is 13 weeks from the date of claim of Item 720.

This form serves as the GP's record of performance of this service.

4 ADHERENCE EVALUATION (FORM 7) OPTIONAL PRACTICE COMPLETED

This form is optional. It may be completed by the receptionist, utilising the emedilab Guidelines for Monitoring/Adherence Evaluation Ratings.

This form, it is expected, would be utilised by those practices participating in the GP Divisions or Australian Quality Patient Care Research Unit (AQRU) research projects.