

South Eastern Sydney Division of General Practice Ltd

Conducting the 45 Year Old Health
Check item



Summary of Learning Objectives

- Increase understanding of who is eligible for the 45 - 49 year old health check, what the assessment entails, and who can help with each step of the assessment
- Inform GPs and PNs of the tools, interventions and approaches available to help them bring about behavioural change in their patients



The 45 year old health check

- The health check is a screening process that will identify potential clinical problems and lifestyle factors that may impact upon the long term health and well being of the patient.
- The check is also an opportunity to promote preventative health strategies to your eligible patients



Patient Eligibility

- Health check is for men and women aged 45 - 49 years with at least one risk factor for chronic disease
- Nearly 1 in 7 Australians have a recognised chronic disease and the problem is expected to be one of the greatest health challenges of the 21st century



Patient Eligibility

- The Australian Institute of Health and Welfare estimates that 94% of men and 89% of women in the 45 - 54 age range have at least one risk factor for cardiovascular disease
- Most risk factors are modifiable through strategies such as supporting patients to make behavioural changes



A proportion of patients who may be at risk may not be identifiable by you

- Weight, height, body mass index and waist circumference are only recorded in less than 50% of patients
- Smoking status and alcohol consumption are recorded less than 50% of the time, and
- Diet is recorded in less than 10% of patients
- Most current practice software systems do not have the ability to recall the information required to identify eligible patients in this way



How can you identify eligible patients?

- Through proactive patient management and examination of records:
- Opportunistically during normal visits
- Providing patients within the age range with a simple lifestyle risk factor survey
- Writing to all patients within the age range with known risk factors
- Providing information on the health check in the waiting room



Using the reminder and recall system

- Age, sex and medications are usually reliably recorded by practices, allowing for identification of suitability for this health check
- Patients who have conditions such as diabetes and hypertension can be easily identified from their medications and then sorted by age range
- Staged notification of your identified eligible patients by mail, email or SMS can assist with management of patient numbers i.e. in age increments such as 45 – 47 years and then 48 - 49 years



Risk factors in my patients – Lifestyle factors

- **Smoking** - 19.5% smoke daily*
- **Physical inactivity** - 1 in 2 do not exercise enough*
- **Poor nutrition** - 2 in 3 do not consume adequate fruit and vegetables*
- **Alcohol misuse** - 10% drink at levels considered to be harmful for long-term health*



*In adult Australians

Risk factors in my patients – **Family history**

- Of a chronic disease may indicate a predisposition for that disease in a patient



Risk factors in my patients – Biomedical factors

- High blood pressure - 29% have high blood pressure^{††}
- High cholesterol - 1 in 2 have high cholesterol^{††}
- Impaired glucose - Almost 1 in 4 have diabetes or impaired glucose metabolism[†]
- Excess weight - 60% are overweight or obese ^{††}

• †In adult Australians aged > 25 years. ‡> 5.5 mmol/L

• † † In adult Australians aged > 25 years



Role of the Practice Nurse

- Practice nurses under the supervision of the GP may assist GPs in performing this health check by:
- **Identifying eligible patients** - Through examination of patient records
- **Collecting information from patients** - Such as measuring height, weight and blood pressure
- **Providing patients with information** - About recommended interventions (e.g. details of local community resources, support services and referral options)



The key benefits of conducting the 45 - 49 year health check include:

- Maintaining a focus on wellness and prevention
- The early identification of chronic disease risk factors can prevent or delay the onset of chronic disease
- Can also provide opportunistic benefits in terms of identification of any number of other existing conditions/injuries/illnesses requiring treatment
- Allows for a practitioner to make appropriate referral to other local health services and care



The key benefits of conducting the 45 - 49 year health check include:

- Complements other chronic disease management MBS item numbers, including the GP management plan, Team Care Arrangements, Diabetes/Asthma Cycle of Care and the Type 2 diabetes risk evaluation
- Collecting a patient's social history and updated summary assists practices to meet accreditation standards



What does the 45 - 49 year old health check involve?

- The health check should generally be undertaken by the patient's 'usual doctor'
- The health check can be completed in one consultation however, all parts of the health check must have been undertaken
- If test results are not yet available, the GP may choose either:
 - To defer completion of the health check until the results are available
 - To complete the health check and review the test results and discuss the assessment of the patient in a subsequent, **separately billed** consultation



What does the 45 - 49 year old health check involve?

- The MBS requires:
- **Information collection**, including taking history and performing examinations and investigations as required
- Making an **overall assessment** of the patient
- **Interventions** as indicated
- Providing **advice and information to the patient**



MBS information

- **45 year old health check – item 717**
- Attendance by a medical practitioner (including a general practitioner but not including a specialist or consultant physician) **AT A PLACE OTHER THAN A HOSPITAL** to undertake a health check for a patient between the age of 45 and 49 (inclusive) at risk of developing a chronic disease.
- Benefits are payable on **one** occasion only for each eligible patient.

Fee: \$104.55 Benefit: 100% = \$104.55



Essential Documentation Requirements

- Patient's informed consent for all components
- Document health check including outcomes and recommendations
- Keep copy in patient file
- If required a GP Management Plan (GPMP) item 721 and a Team Care Arrangement (TCA) item 723 can be identified and completed in a **separately billed consultation**



Conducting the health check – Clinical Content

- Information collection, including taking or updating a patient's history and undertaking relevant examinations and investigations as clinically required
- Overall assessment of patient's health, including readiness to make lifestyle changes (SNAP Guide)
- Initiating interventions, referrals as clinically indicated



Conducting the health check – Provide advice and information to the patient

- Strategies to achieve lifestyle and behavioural changes (e.g. Lifescrpts resources)
- Identify appropriate follow up
- Schedule regular GP visits



Assessing a patient's medical history - Smoking

- **Ask** about smoking of cigarettes, pipes or cigars
- 1. Assess readiness to quit smoking and nicotine dependence *SNAP* 10–13
- 2. Offer brief non judgmental advice to quit
- 3. Refer to the Quitline 131 848.



Assessing a patient's medical history - Nutrition

- **Ask** about the number of portions of fruit and vegetables eaten per day and the types of fat eaten
- All patients should be advised to follow the *NHMRC Dietary guidelines for Australian adults SNAP 17–19*



Assessing a patient's medical history - Alcohol

- **Ask** about the quantity and frequency of alcohol intake and number of alcohol free days each week
SNAP 20–23
- Try to reach agreement about the number of drinks per day and the number of alcohol free days
- High risk situations should be identified and avoided and appropriate social support such as friends or family should be enlisted
- Monitor progress at a follow up visit



Assessing a patient's medical history - Physical activity

- **Ask** how many minutes per day of moderate physical activity
- Advise to participate in 30 minutes of moderate activity on most, preferably all days of the week *SNAP* 24–6



Assessing a patient's medical history - Depression

- **Ask** *'Over the past 2 weeks, have you felt down, depressed or hopeless?'* and *'Over the past 2 weeks have*
- *you felt little interest or pleasure in doing things?'*
- 1. Check for suicide risk *Red book 58–9*
- 2. Consider counselling, cognitive behavioural therapy, pharmacotherapy or referral to psychologist



Assessing a patient's medical history - Osteoporosis

- **Ask** about risk factors
- Bone mineral densitometry *Red book 66–7*
- Management of risk factors



Performing a physical examination - Body weight

- **Assess** body mass index and waist circumference
- **Develop** weight management plan *Red book* 29–30



Performing a physical examination - Blood pressure

- **Measure** blood pressure
- **Assess** absolute cardiovascular risk and consider referral or pharmacotherapy based on this *Red book 38*
- The Australian absolute cardiovascular risk calculator available at <http://www.cvdcheck.org.au/> Lifestyle risk factor counselling



Performing a physical examination - Skin cancer

- **Examine** skin if increased or high risk
- Provide preventive advice *Red book 48–9*
- Manage according to risk



Ordering Tests – Lipids

- **Order** fasting blood lipids
- Lifestyle risk factor counselling



Ordering Tests – Diabetes

- **Consider** ordering fasting blood glucose if at risk (use the AUSDRisk tool)
- If diabetes, treat *Red book 41–2*
- If IGT or IFG (pre-diabetes), offer early intervention (LMP referral)
- Lifestyle risk factor counselling



Ordering Tests – Cervical cancer

- **Pap test** every 2 years for women who have ever had sex and still have an intact uterus - if required can be completed in a **separately billed consultation** at another appointment
- Manage according to risk *Red book 49–50*



If you diagnose a chronic disease in your patient?

- Prepare a GP Management Plan
- A new plan may be required every 2 years (Item 721), with regular progress reviews at 6-month intervals (Item 725)
- Initiate patient education
- Refer as necessary



Opportunities for risk factor modification

- Risk factor information can educate patients about lifestyle changes and help GPs decide when and how to intervene (i.e. use the AUSDRisk tool)
- Agreed interventions can be summarised on the GP Management Plan and risk factors referred to in subsequent consultations
- Patients are assisted to exercise autonomy and follow the agreed plan when interventions are jointly planned and negotiated



Providing preventative health advice

- It is important to start where the person is at, with small incremental changes rather than dramatic changes that cannot be sustained
- You can help building the capacity of patients to make further change by increasing their confidence



Providing preventative health advice

- Goal setting is a key part of the approach to managing lifestyle risk factors in general practice
- Goals for lifestyle change need to be realistic and tailored to the patients' level of risk
- This may be less than the ideal targets



An example - weight loss

- It may not be possible at least in the medium term to achieve ideal body weight
- Most of the benefit from weight loss in terms of lowering the risk of cardiovascular disease and diabetes is in the first 10% of body weight
- 10% weight loss is what we should aim for even if that means that patients remain overweight
- It may also be harder to maintain more dramatic changes in lifestyle in the longer term and wild oscillations in weight may be harmful to the patient both physically and mentally



Goals are more likely to be useful in promoting behaviour change if they are SMART:

- **Specific**
- **Measurable**
- **Agreed**
- **Realistic**
- **Time specific**



SMART goals

- Consider the difference between these two goals:
- I will try and be more active (general)
- I will walk the dog for 30 minutes 3 afternoons each week for the next month (SMART)



lifestyle change depends on the patients' willingness

- Our patient's first priority will not always match our own (which will always be smoking if the patient is a smoker)
- However success at making one change may help build confidence to take on more difficult challenges
- One of the strengths of general practice is your ability to tailor interventions to our patients' needs and readiness
- Finding common ground is the most important place to begin



Providing preventative health advice

- Goals that people come up with themselves or at least agree to are much more likely to be adhered to than goals we might recommend
- Once people decide to change, they are often overly ambitious and set unrealistic goals
- A good rule of thumb is to ask patients if they can imagine being able to keep up the goal long term, if the answer is 'no' it is the wrong goal and needs to be modified to make it more realistic



Stages of readiness for change

- **Precontemplation** - people move from being uninterested, unaware or unwilling to make a change
- **Contemplation** - to considering a change
- **Preparation** - to deciding and preparing to make a change
- **Action** - genuine, determined action is then taken
- **Maintenance** - attempts to maintain the new behaviour occur
- **Relapse** - relapses are almost inevitable and become part of the process of working toward life-long change
- The model is circular rather than linear, as people can enter or exit at any point



Stages of readiness for change

- **Expressing empathy** - listening and reflecting the patient's concerns, thoughts and feelings in a non-judgmental manner
- **Developing discrepancy** - highlighting discrepancies between the patient's current behaviour and goals
- **Avoiding argumentation** - rolling with resistance and not arguing when patients are defensive or resistant
- **Using active listening and reflection** - to avoid increasing a patient's resistance to change
- **Supporting self-efficacy** - supporting the person's confidence in achieving the patient's arranged goals



Lifescrpts is a national initiative implemented through your Division

- An extra minute in a consultation using Lifescrpts tools and resources can reduce lifestyle risk factors for chronic disease
- The Lifescrpts Resource Kit provides a framework for:
 - Raising and discussing lifestyle risk factors with patients
 - Giving advice in a written script and associated patient education
 - Organising ongoing review
 - Referral to other providers and services to support healthy lifestyle choices



Lifescrpts

- Lifescrpts tools and resources can help GPs and practices to manage life style risk factors in their patients including:
 - Quitting smoking
 - Eating a healthier diet
 - Reducing alcohol use
 - Increasing Physical activity
 - Managing body weight



Adopting Lifescripts

- Lifescripts is NOT designed as a rigid, one size fits all type of program
- Lifescripts is designed to suit practices at all stages of readiness to integrate prevention into the practice's routine
- Does not have to mean major changes to the practice, staff or systems
- GPs and staff can start using Lifescripts ideas by selecting tools and suggested protocols that will be feasible in the individual practice



For more information

- Lifescripts program: promotes risk factor management in general practice and primary health care services www.agpn.com.au
- Contact your Practice Support Officer at the Division: 9663 5958 & admin@sesdgp.com.au
- RACGP online training modules 'implementing lifestyle change' www.gplearning.com.au



Other resources

- The **National Heart Foundation of Australia** provides resources for patients and clinical practice information for healthcare professionals www.heartfoundation.org.au
- The **RACGP** has developed resources to support you in implementing this health check, including:
 - ***The Red Book*** – Guidelines for preventative activities in general practice
 - ***The Green Book*** – Putting prevention into practice: guidelines for the implementation of prevention in the general practice setting
 - ***The SNAP Guide*** – Smoking, Nutrition, Alcohol and Physical Activity (SNAP): a population health guide to behavioural risk factors in general practice
www.racgp.org.au/clinicalresources/45



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