

# Health assessment for people aged 40 to 49 years with a high risk of developing type 2 diabetes, and lifestyle modification programs



Australian Government  
Department of Health and Ageing

## Questions & Answers

**This question and answer sheet should be read in conjunction with the following**

### **Medicare Benefits Schedule (MBS) Fact Sheets:**

- 'Health assessment for people aged 40 to 49 years with a high risk of developing type 2 diabetes'
- 'Health assessment for people aged 45 to 49 years who are at risk of developing chronic disease'
- 'Health assessment for Aboriginal and Torres Strait Islander People (MBS Item 715)'
- 'Health Assessments MBS items 701, 703, 705, 707, 715 and 10986'

### **Who is eligible for a type 2 diabetes risk evaluation?**

The type 2 diabetes risk evaluation is available to people aged 40 to 49 years (inclusive) who are at high risk of developing type 2 diabetes. 'High risk' is determined following the patient's completion of the Australian type 2 diabetes risk assessment tool.

### **What is the Australian type 2 diabetes risk assessment tool (AUSDRISK)?**

The AUSDRISK has been developed to provide a basis for both health professionals and health consumers to assess the risk of type 2 diabetes. It consists of a short list of questions that, when completed, provides a guide to a patient's current level of risk of developing type 2 diabetes over the next five years.

The AUSDRISK can be obtained from [www.health.gov.au/preventionoftype2diabetes](http://www.health.gov.au/preventionoftype2diabetes)

### **Who should administer the AUSDRISK?**

The AUSDRISK can be completed by the patient with or without the assistance of a health professional or practice staff.

### **Is use of the AUSDRISK mandatory in conjunction with a type 2 diabetes risk evaluation?**

**Yes.** The completion of the AUSDRISK is mandatory for patient access to a type 2 diabetes risk evaluation and the subsidised lifestyle modification programs.

### **What is a lifestyle modification program?**

Eligible patients who have attended a type 2 diabetes risk evaluation with their GP may be referred to a subsidised lifestyle modification program as one of a number of possible intervention strategies.

The intention of a lifestyle modification program is to help people modify their risk factors to delay or prevent the onset of type 2 diabetes. A typical program will be a series of group motivational and educational sessions supporting lifestyle changes and adoption of healthy lifestyle choices.

Relevant resources on lifestyle modification, including information for patients who may not wish to attend or are unable to participate in a formal subsidised lifestyle modification program are available at:

- [www.healthinsite.gov.au](http://www.healthinsite.gov.au); and
- [www.health.gov.au/lifescrpts](http://www.health.gov.au/lifescrpts)

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### **Who will provide the subsidised lifestyle modification programs?**

The Divisions of General Practice Network will purchase or provide subsidised lifestyle modification programs. The programs meet nationally agreed standards covering the content and delivery of lifestyle modification programs.

### **How is access given to the subsidised lifestyle modification programs?**

The patient's GP will complete a lifestyle modification program GP referral form. The patient will present this to the provider of the program for registration. A GP referral form can be obtained from [www.health.gov.au/preventionoftype2diabetes](http://www.health.gov.au/preventionoftype2diabetes)

### **How much will it cost for a patient to participate in a subsidised lifestyle modification program?**

A co-payment of up to \$50 may be collected by the subsidised lifestyle modification program provider at the time of patient enrolment in a program. No co-payment will be collected from patients who are identified by the GP as having a health care card or a concession card. It is important for the GP to indicate if this is the case when completing the lifestyle modification program GP referral form.

### **Do GPs need to use the lifestyle modification program GP referral form?**

**Yes.** The referral form contains basic information required by the subsidised lifestyle modification program provider. It is a requirement for patient participation and program accountability.

### **What if a patient does not provide consent?**

A completed referral form is a mandatory requirement for patient participation. If a patient does not agree to the provision and use of their personal information they will not be able to participate in a subsidised lifestyle modification program. The GP will need to discuss other appropriate options available to the patient.

### **How do GPs know what subsidised lifestyle modification programs are locally available?**

GPs can contact their local Division of General Practice to identify what subsidised lifestyle modification programs are available locally and for further information.


### **What other intervention strategies are available for patients with a high risk of developing diabetes?**

The patient's GP may wish to discuss other suitable intervention strategies available to the patient as part of a type 2 diabetes risk evaluation. Information on prevention and other relevant resources for patients who may not wish to attend or are unable to participate in a formal subsidised lifestyle modification program are available at:

- [www.healthinsite.gov.au](http://www.healthinsite.gov.au); and
- [www.health.gov.au/lifescrpts](http://www.health.gov.au/lifescrpts)

### **What needs to be done following a type 2 diabetes risk evaluation?**

Following a type 2 diabetes risk evaluation the patient's GP may review and adjust treatment of the patient as necessary, as part of normal medical care. Feedback on patient goals and progress will be provided by the subsidised lifestyle modification program provider to inform ongoing care.



### **Are people who have been diagnosed with existing diabetes eligible for a type 2 diabetes risk evaluation?**

**No.** Patients with newly diagnosed or existing diabetes are not eligible for this health assessment.

For patients with existing diabetes, the Diabetes Annual Cycle of Care and Chronic Disease Management (CDM) items (721, 723, 729, 731, 732) provide a suite of items for the management and review of diabetes.

### **Are people with a care plan for an existing chronic condition eligible for a type 2 diabetes risk evaluation?**

**Yes.** Patients with a care plan for a non-diabetes condition are able to access a type 2 diabetes risk evaluation if they meet the patient eligibility requirements.

### **Are Aboriginal and Torres Strait Islander people eligible for a type 2 diabetes risk evaluation?**

**Yes.** Aboriginal and Torres Strait Islander people aged 40 to 49 years (inclusive) may access a type 2 diabetes risk evaluation if they meet the patient eligibility requirements. However Aboriginal and Torres Strait Islander people aged 15 to 54 years (inclusive) are also able to access a specific health assessment under the Health Assessment for Aboriginal and Torres Strait Islander People (MBS item 715). GPs are encouraged to use item 715 where appropriate because it covers a broad range of health issues including diabetes. Under item 715, GPs can refer patients found to be at 'high risk' of diabetes as measured by the AUSDRISK, aged 15 to 54 years (inclusive) to a subsidised lifestyle modification program.

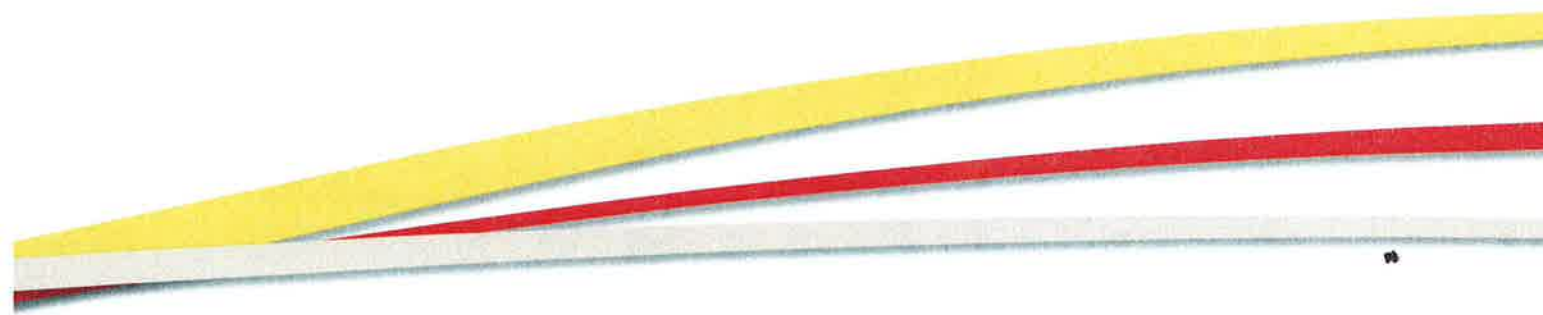
### **Are people who have had a health assessment for those at risk of developing chronic disease also eligible for a type 2 diabetes risk evaluation?**

**Yes.** People who have had a health assessment for 45 to 49 year olds who are at risk of developing chronic disease may also receive a type 2 diabetes risk evaluation if they are at 'high risk' of developing type 2 diabetes and meet the eligibility criteria.

If they are found to be at 'high risk' of diabetes as measured by the AUSDRISK, the GP is able to refer the patient to a subsidised lifestyle modification program, along with other possible strategies to improve the health status of the patient.

### **What other information is available to GPs to assist in the screening and management of type 2 diabetes?**

NHMRC endorsed guidelines covering the diagnosis of type 2 diabetes and its ongoing management are available from the NHMRC website at <http://www.nhmrc.gov.au/publications/synopses/di16to19syn.htm>



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### What is the role of other health professionals?

Practice nurses, registered Aboriginal Health Workers and other health professionals may assist GPs in performing a type 2 diabetes risk evaluation, in accordance with accepted medical practice and under the supervision of the GP.

This may include activities which:

- identify eligible patients through examination of patient records, patient information systems, and risk assessment tools used within the practice;
- collect information such as measuring height and weight (body mass index), waist circumference and blood pressure; and
- provide patients with information about recommended interventions and actions the patient could take (at the direction of the GP) to encourage good health.

### What are the restrictions on providing a type 2 diabetes risk evaluation?

A Medicare rebate is payable for each eligible patient once every three years. The rebate is not payable in conjunction with another attendance item on the same day, except where it is clinically required. The type 2 diabetes risk evaluation is not available to admitted patients of a hospital or day-hospital facility.

### Where can I find information and resources?

For more information visit the Department of Health and Ageing's website at [www.health.gov.au/preventionoftype2diabetes](http://www.health.gov.au/preventionoftype2diabetes) or [www.health.gov.au/mbsprimarycareitems](http://www.health.gov.au/mbsprimarycareitems) or phone the Medicare Australia provider enquiry line on 132 150. Your local Division of General Practice will also be able to provide further information and support.

Other relevant resources include:

- Lifescrpts – providing general practice with tools and skills to help patients address the main lifestyle risk factors for chronic disease: smoking; poor nutrition; alcohol misuse; physical inactivity; and unhealthy weight at [www.health.gov.au/lifescrpts](http://www.health.gov.au/lifescrpts)
- Measure Up – aiming to reduce the prevalence of lifestyle risk factors for some chronic diseases, limit the incidence and the impact of these diseases and reduce morbidity and mortality rates. Visit [www.australia.gov.au/MeasureUp](http://www.australia.gov.au/MeasureUp) for practical resources to assist with healthy eating and increasing physical activity.
- SNAP (Smoking, Nutrition, Alcohol and Physical Activity) – a population health guide to behavioural risk factors in general practice available at [www.racgp.org.au/guidelines/snap](http://www.racgp.org.au/guidelines/snap). RACGP guidelines for preventive activity in general practice at [www.racgp.org.au/guidelines](http://www.racgp.org.au/guidelines) red book and/or green book.