



# Chronic Disease Management Resource Manual

Section 1: Introduction to Chronic Disease Management



Current as at January 2012

**GP partners Adelaide**

First Floor 120 Hutt Street, Adelaide SA 5000

PO Box 7293 Hutt Street SA 5000

Phone (08) 8112 1100

Fax (08) 8227 2220

Images on the front cover of this manual are © Queensland Health

**Disclaimer:**

GP partners Adelaide has made every reasonable effort to ensure that the information referred to is accurate and up-to-date at the date of publication. The Division, its agents and employees, will not be liable for any loss or damage arising directly or indirectly from the possession, or use of, or reliance on information obtained from this document. It is provided in good faith without expressed or implied warranty.

*Whilst every effort has been made to ensure that the information in this manual is correct at time of printing, we apologise for any errors or omissions that may occur.*

*Please contact GP partners Adelaide on 8112 1100 or email: [info@gppadelaide.org.au](mailto:info@gppadelaide.org.au).*

*We welcome any suggestions or comments regarding the information presented in this manual.*

# Contents

<b>Acknowledgements</b> .....	1
<b>Chronic Disease Management (CDM)</b> .....	2
<b>Implementing Chronic Disease Management Processes</b> .....	3
Sample checklist to help in setting up processes for systematic approach to CDM.....	3
<b>Quick Guide to MBS Primary Care Items</b> .....	5
<b>Referral Options and Patient Support Services</b> .....	8
Chronic Disease Management & Prevention Referral Pathways.....	8
General Practice Older Persons Service Directory.....	8
<b>The Role of the Practice Nurse</b> .....	9
Disease Specific Clinics.....	9
<b>Clinical Resource List</b> .....	10
General Resources.....	10
Arthritis.....	12
Asthma .....	12
Cardiovascular Disease .....	12
COPD.....	13
Diabetes .....	13
Healthy Eating and Physical Activity .....	14
Culturally & Linguistically Diverse .....	14

# Acknowledgements

GP partners Adelaide would like to thank the Central Coast Division of General Practice and Health Connect SA for providing us with the original basis of this resource.

The information presented in the first part of this folder has been adapted from the *Chronic Disease Resource Manual* from the Central Coast Division of General Practice and was originally produced in August 2006 by Ms J Sadler and Ms M Bradbury.

This resource has been built upon an existing body of knowledge and the tools and resources that have been developed by various Divisions of General Practice, Australian Government departments, the RACGP and other organisations.

Acknowledgements and thanks for the information provided are given to the following:

- Adelaide North Eastern Division of General Practice
- Australian General Practice Network
- General Practice NSW
- Central Sydney GP Network
- Commonwealth Department of Health and Ageing
- Diabetes Outreach -SA Government Department of Health
- Dubbo Division of General Practice
- General Practice South Australia
- Hornsby Ku-ring-gai Division of General Practice
- Hunter Rural Division of General Practice
- Hunter Urban Division of General Practice
- Medicare Australia
- Monash Division General Practice Network
- Morton Bay Division of General Practice
- National Asthma Council
- North East Valley Division of General Practice
- General Practice Network South
- The Murray Clinic-Magill SA
- The Northern Division of General Practice
- Went West Division of General Practice
- Western Melbourne Division of General Practice

## Chronic Disease Management (CDM)

'Over three million Australians, or nearly one in seven, suffer from chronic disease and the problem is likely to be one of the great health challenges for Australia and the world in the 21st Century.

Chronic diseases and conditions are generally defined as those which are long term (lasting more than 6 months), non-communicable, involving some functional impairment or disability and are usually incurable. They can affect people of all ages and contribute to the disease burden in our society.'

(NSW Department of Health, 2008, [www.ncahs.nsw.gov.au/chronic-disease](http://www.ncahs.nsw.gov.au/chronic-disease))

The May 2001 Federal health budget targeted the National Health Priority Areas of asthma, diabetes, mental health, and cancer. The initiative recognised the pivotal role of GPs in prevention, diagnosis and management of chronic diseases in the community and built on previous strategies such as Enhanced Primary Care (EPC).

The Medicare Chronic Disease Management items were introduced in July 2005 aiming to make it simpler for GPs to manage the health care of patients with chronic medical conditions, including those with complex needs requiring multidisciplinary care. The Chronic Disease Management (CDM) items have increased the care planning options for GPs by increasing the patient eligibility criteria and allowing the assistance of practice nurses and others to be involved in preparing the plans. These item numbers offer GPs alternatives in the management of chronic and complex conditions and are now available to a wider group of patients.

GP partners Adelaide can support general practices in the management of their patients with chronic disease by providing:

- Education, support and information for general practice in the detection and management of chronic diseases;
- Linkages between general practice and other health care providers, consumers and local communities, relevant government and non-government organisations to improve access to integrated care.
- Professional development opportunities, quality assurance and clinical audit processes in chronic disease prevention and management;
- Relevant, up to date information on standards, information management/ technology and practice management systems.

Establishing a system within the practice is important and check lists and templates are available to streamline the process. Unlike the previous EPC Medicare item numbers, the role of the practice nurse or Aboriginal health worker in the preparation of both a GPMP and a TCA is now clearer and more inclusive, depending on internal practice arrangements and individual competencies. While the GP must see the patient and confirm all assessments and arrangements, the practice nurse could assess the patient, assist with preparing a GPMP, identify the patient's needs, facilitate communication between the GP and other health providers, discuss costs with the patient, and provide patient education and self management information.

The CDM item numbers represent an opportunity to improve chronic disease management through general practice and offer eligible patients access to allied health services. They also provide a system to remunerate GPs for the time and effort required to plan and coordinate care of patients with a chronic illness.

(J. Newland, 2006, *General practice and the management of chronic conditions*, *Australian Family Physician* Vol. 35, No. 1/2, Jan/Feb, [www.racgp.org.au/afp/200601/200601newland.pdf](http://www.racgp.org.au/afp/200601/200601newland.pdf))

This resource folder has been compiled to assist General Practitioners, Practice Nurses, Practice Managers and Practice staff to take a systematic approach to managing patients with chronic diseases.

# Implementing Chronic Disease Management Processes

Chronic Disease Management processes aim to establish a systematic method to managing patients with chronic diseases. It aims to prevent complications and maintain health through planned regular consultations rather than just ad hoc presentations when unwell or a problem arises.

When systematic processes for chronic disease management are in place in general practice there are benefits for both the patient and the practice with outcomes such as:

- More effective care
- Coordinated care
- Reduced need for ad hoc consultations
- Promotion of multi disciplinary teamwork
- Greater involvement of patients in own care

To implement chronic disease management (CDM) processes the practice needs to focus on:

- A whole practice approach-involve and inform all staff about the process
- The systems needed to facilitate improved care
- The skills and responsibilities of staff
- Practice nurse skills and allocated time to CDM
- Ensuring good communication
- Available resources and community contacts

The following are some considerations that may be taken into account and can be used as a checklist to help the practice in setting up processes for a systematic approach to CDM. *(Adapted from Hornsby Ku-ring-gai Ryde Division of General Practice, February 2004)*

## Sample checklist to help in setting up processes for systematic approach to CDM

Issues	Key questions	✓
Demographic issues	What is the patient profile?	<input type="checkbox"/>
	Are there many patients with specific chronic diseases?	<input type="checkbox"/>
	What can a Practice Health Atlas or Clinical Audit Tool data analysis tell us?	<input type="checkbox"/>
	Can we identify our patients with chronic disease, diabetes etc.?	<input type="checkbox"/>
	Can we identify those asthma patients with moderate to severe asthma?	<input type="checkbox"/>
	Which chronic disease initiatives could be utilised for this practice population?	<input type="checkbox"/>
	Can we identify the patients who may benefit from HMR?	<input type="checkbox"/>
	What one area will we address initially?	<input type="checkbox"/>
Clinical issues For GPs and Nurses	Do I know about the Asthma Cycle of Care?	<input type="checkbox"/>
	Do I know about the Diabetes Annual Cycle of Care?	<input type="checkbox"/>
	Do I know about the Better Access to Mental Health process?	<input type="checkbox"/>
	Can our practice utilise other staff members in managing chronic disease?	<input type="checkbox"/>
	What new roles and skills are required in the practice to improve our CDM?	<input type="checkbox"/>
	Do I know about Medicare Chronic Disease Management (CDM) initiatives?	<input type="checkbox"/>
	Do we know who we can refer to for Team Care Arrangements?	<input type="checkbox"/>
	What Allied Health Professionals do we have onsite?	<input type="checkbox"/>
	Do we need to set aside blocks of time for care planning?	<input type="checkbox"/>
	Am I implementing Quality Use of Medicines / best-practice guidelines in the treatment of patients?	<input type="checkbox"/>
	What is the role of the Practice Nurse in CDM?	<input type="checkbox"/>
What can be claimed through MBS for PN work?	<input type="checkbox"/>	

Issues	Key questions	✓
Administration issues	Is this practice registered for Practice Incentive Payments?	<input type="checkbox"/>
	Do we know when we can claim for PIPS/SIPS?	<input type="checkbox"/>
	Do we have good clinical data and record keeping?	<input type="checkbox"/>
	Is the patient data base “clean”?	<input type="checkbox"/>
	Are active, inactive, deceased, patient details and diagnosis coded correctly?	<input type="checkbox"/>
	Do I have a Diabetes Register of diabetes patients?	<input type="checkbox"/>
	Do I have a patient recall /reminder system?	<input type="checkbox"/>
	Am I registered with Medicare Australia for diabetes, asthma or cervical screening Service Incentive Payments?	<input type="checkbox"/>
	Do we have appropriate templates for care planning on the system?	<input type="checkbox"/>
	Do we know how to import other templates into our system from websites?	<input type="checkbox"/>
	Do we have all the forms required and do we need access to electronic forms?	<input type="checkbox"/>
	Who will be involved in identifying patients who would benefit for care planning and who will send letters to patients and maintain records of responses?	<input type="checkbox"/>
	Does the practice need to consider re-deploying and/or training existing staff and/or employing a Practice Nurse?	<input type="checkbox"/>
	Do staff have appropriate resources to perform duties? Does the Practice Nurse have access to computer and a room to consult patients?	<input type="checkbox"/>
	For HMR – does the practice have access to an accredited pharmacy and pharmacist?	<input type="checkbox"/>
	Does the practice have access to relevant resources/patient information?	<input type="checkbox"/>
Has the practice established links and communication processes with relevant service providers?	<input type="checkbox"/>	
Do staff know how to complete billing and item number process?	<input type="checkbox"/>	
Patient issues	How do we inform the patients that the practice is implementing new chronic disease management processes (e.g. letters, phone calls, posters, hand-outs, practice newsletter)	<input type="checkbox"/>
	Who will decide which patient group to target?	<input type="checkbox"/>
	Booking appointments –check with whom and the amount of time to be allocated?	<input type="checkbox"/>
	Do we want to have specific patient clinics for established diseases?	<input type="checkbox"/>
	Are all missed recall appointments followed up? How is this recorded?	<input type="checkbox"/>
Getting started	<p>Take a continuous improvement approach in implementing CDM within the practice. Use the PDSA approach! Plan, Do, Study &amp; Act.</p> <p><b>Plan:</b> Plan your goals so you know where you are going, What, who, when, where, predictions &amp; data to be collected. Start small.</p> <p><b>Do:</b> Undertake the activities that you have planned. Document any unexpected problems or outcomes.</p> <p><b>Study:</b> Have you achieved your targets and goals? Review and reflect on results. What feedback have you obtained along the way to improve what you do next time?</p> <p><b>Act:</b> What will you take forward from this cycle? Based on the feedback at the “Study” stage, make improvements; reset the goals and targets.</p>	

## Quick Guide to MBS Primary Care Items

For the most up to date information refer to the Medicare Benefits Schedule online at [www.health.gov.au/mbsonline](http://www.health.gov.au/mbsonline) or phone the Medicare Australia Schedule Interpretation Team on 132 150.

	Item Number	Service	Brief Guide	Claim period	MBS Payment 1/1/2012	
Health Assessments	701	Brief Health Assessment of less than 30 minutes duration	<p>These item numbers may be used for the following health assessments:</p> <ul style="list-style-type: none"> <li>• Healthy Kids Check</li> <li>• 45-49 year old health check</li> <li>• Type 2 Diabetes Risk Assessment</li> <li>• Older persons health assessment</li> <li>• Comprehensive Medical Assessment</li> <li>• Health Assessment for people with an Intellectual Disability</li> <li>• Refugee &amp; other Humanitarian Entrants health assessment</li> </ul>	<b>Healthy Kids Check</b> Once only <b>45-49 y.o. Health Check</b> Once only <b>Type 2 Diabetes Risk Assessment</b> 36 months <b>Older persons health assessment</b> 12 months <b>Comprehensive Medical Assessment</b> 12 months <b>Health Assessment for people with Intellectual Disability</b> 12 months <b>Refugee &amp; other Humanitarian Entrants health assessment</b> Once only	\$57.10	
	703	Standard Health Assessment lasting more than 30 minutes but less than 45 minutes		<p>Assessment in GP surgery by practice nurse for four year olds at time of four year old immunisation</p>	Once only	\$57.10
	705	Long Health Assessment lasting more than 45 minutes but less than sixty minutes			Annual (minimum 9 months)	\$204.20
	707	Prolonged Health Assessment lasting more than 60 minutes			2 yearly (minimum 12 months)	\$138.75
	10986	Healthy Kids Check provided by a practice nurse or registered Aboriginal health worker			2 yearly (minimum 12 months)	\$109.95
	715	Aboriginal and Torres Strait Islander peoples health assessment			6 monthly (minimum 3 months)	\$69.35
	Chronic Disease Management	721	Preparation of a <b>General Practitioner Management Plan (GPMP)</b>	Patients with a chronic or terminal medical condition are eligible	6 monthly (minimum 3 months)	\$67.70
723		Coordination of a <b>Team Care Arrangement (TCA)</b>	Patients with a chronic disease who require ongoing care from a multidisciplinary team	6 monthly (minimum 3 months)	\$67.70	
732		Review of a GPMP	Systematic review of the patient's progress against GPMP goals	6 monthly (minimum 3 months)	\$69.35	
		Coordinate a review of TCA	Systematic team-based review of patient's progress against TCA goals			
729		Contribution to care plan or to review care plan being prepared by another provider	Not available to patients of RACF	6 monthly (minimum 3 months)	\$67.70	
731	Contribution to care plan or to review the care plan for patient of RACF	Plan prepared by such a facility	6 monthly (minimum 3 months)	\$67.70		

	139	Assessment, diagnosis and development of a treatment and management plan for a disability	Children aged under 13 years with an eligible disability	Once only	\$127.50
Mental Health	2700	Preparing a GP Mental Health Treatment Plan At least 20 minutes	Preparation by a medical practitioner who has <b>NOT</b> undertaken mental health skills training	12 months	\$69.00
	2701	Preparing a GP Mental Health Treatment Plan At least 40 minutes		12 months	\$101.55
	2715	Preparing a GP Mental Health Treatment Plan At least 20 minutes	Preparation by a medical practitioner who has undertaken mental health skills training	12 months	\$87.60
	2717	Preparing a GP Mental Health Treatment Plan At least 40 minutes		12 months	\$129.00
	2712	Review of a GP Mental Health Treatment Plan	Review of patient's progress once a GP Mental Health Treatment Plan has been prepared	4 weeks to 6 months after completion of GP Mental Health Treatment Plan; further review can occur 3 months after the first	\$69.00
	2713	GP Mental Health Treatment Consultation	Consultation for mental disorder of at least 20 minutes (not associated with items 2700, 2701, 2715 or 2717)	Unrestricted	\$69.00
	2721-2727	Focussed Psychological Strategies	Provided to patients by a Credentialed medical practitioner. Time limited; being deliverable, in up to 12 planned sessions.	Refer to each item in MBS for time required	\$89.25 - \$152.70
	Medication Reviews	900	Domiciliary Medication Management Review (DMMR) for patients living in the community setting.	Assessment, referral to a community pharmacy	12 months Except in circumstances with significant change
903		Residential Medication Management Review (RMMR) for a permanent resident of a residential aged care facility	For new or existing residents of RACFs	12 months Except in circumstances with significant change	\$101.95
Practice Nurse	10987	Follow up by a PN or AHW for indigenous person who has had a health check	Provided by a practice nurse or AHW on behalf of the medical practitioner	Maximum of 10 times per patient per calendar year	\$23.55
	10997	Monitoring and support for a person with a chronic disease	Patient must have GPMP, TCA or multidisciplinary care plan in place	Maximum of 5 times per patient per calendar year.	\$11.80
Practice Incentive Payments	2501 2504 2507	Cervical smear Level B Level C Level D	In Surgery Consultation for pt between the ages of 20 & 69 years inclusive	Patient who has not had a smear in the last 4 years	\$35.60 \$69.00 \$101.55
	2517 2521 2525	Diabetes Annual Cycle of Care Level B Level C Level D	Minimum requirements of care needed to be completed.	Only paid once every 11-13 month period per patient	\$34.90 \$67.65 \$99.55
	2546 2552 2558	Asthma Cycle of Care Level B Level C Level D	Completion of minimum the Asthma Cycle of Care within 12 months for a patient with <b>moderate to severe</b> asthma	One Asthma Cycle of Care for each eligible patient per 12 month period	\$34.90 \$67.65 \$99.55

# Referral Options and Patient Support Services

## Chronic Disease Prevention and Management Referral Pathways

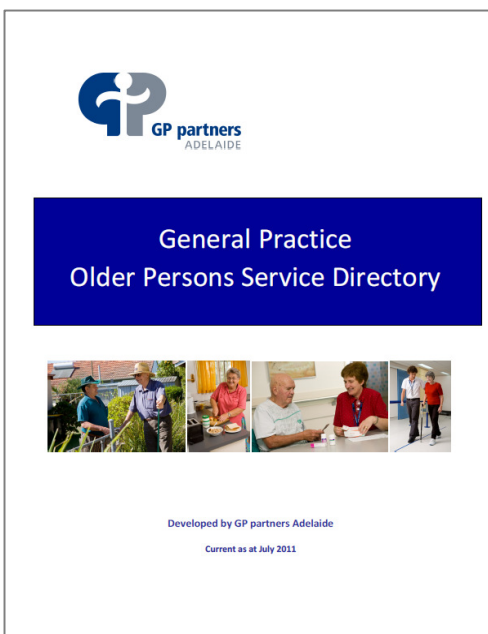


Chronic Disease Prevention and Management Referral Pathways charts have been produced by GP partners Adelaide for type 2 diabetes, coronary artery disease, asthma and COPD, and arthritis and osteoporosis.

The charts aim to assist GPs and practice nurses in identifying local programs and services to support patients who are at risk or diagnosed with the condition. They include the relevant MBS item numbers to be considered as well as support resources. Programs and services are listed as those requiring a GP referral and those to which a patient can self-refer (GP refer not required).

The charts can be viewed and downloaded from the GP partners Adelaide website at the following link:  
[www.gppadelaide.org.au/Programs/ChronicDiseaseManagementPrevention](http://www.gppadelaide.org.au/Programs/ChronicDiseaseManagementPrevention)

## General Practice Older Persons Service Directory



A General Practice Older Persons Service Directory has been developed by GP partners Adelaide to assist general practitioners, practice nurses and practice staff to locate locally available services for people aged 60 years and over living in the community.

The 'Assistance Required' section of the directory provides a list of providers offering the type of service that is required. The 'Service Providers' section of the directory lists each service providers in alphabetical order and provides further information on the service including costs, eligibility, how to access and contact details. Icons are used throughout the directory provide a quick guide to further details on service providers including the types of services offered, costs and if a medical clearance is required.

The General Practice Older Persons Service Directory can be viewed on the GP partners Adelaide website at the link following link  
[www.gppadelaide.org.au/Resources/GPOlderPersonsServiceDirectory](http://www.gppadelaide.org.au/Resources/GPOlderPersonsServiceDirectory).  
A PDF version is also available that can be downloaded and printed.

# The Role of the Practice Nurse

'A practice nurse is a registered nurse or an enrolled nurse who is employed by, or whose services are otherwise retained by, a general practice.'

'Practice nurses work in collaboration with general practitioners providing a range of services, including chronic disease management and population health activities. Their role is diverse and influenced by factors such as the practice population, nurses' qualifications, practice structure, professional standards and national incentives and programs.'

(*Nursing in General Practice: Recruitment and Orientation Resource*, 2009, <http://generalpracticenursing.com.au/recruitment>)

Practice nurses can assist with the provision of quality Chronic Disease Management (CDM). This care must be provided under the general practitioner's supervision.

A practice nurse can assist the GP in preparing or reviewing a care plan for example, in assessing the patient, identifying the patient's needs and making arrangements for services. This assistance is provided on behalf of the GP. The GP must review and confirm all assessments and elements of the service and must see the patient.

Nurses can be involved in organising the chronic disease management systems and processes in the practice, as well as having an on-going role in identifying eligible patients.

Informed patient consent is required when using a practice nurse. If the patient refuses, this needs to be documented in the patient's notes.

(*Department of Health and Ageing*, [www.health.gov.au/internet/wcms/publishing.nsf/Content/pcd-nursing-index](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/pcd-nursing-index))

## Disease Specific Clinics

Practice Nurses can be involved in setting up disease specific clinics such as diabetes or cardiac clinics and allocated sessions to perform assessments and develop care plans with patients. Nurses can be involved in health promotion and patient education aspects within the practice. Some practice nurses may have other qualifications or special expertise to provide specific ongoing care, such as an Asthma Educator.

There needs to be adequate space within practices to support nurses taking on these roles. Patients need to be informed about the practice nurse role. Informed patient consent is required when using a practice nurse. If the patient refuses, this needs to be documented.

See the Practice Incentive Payments section of this manual for information on Setting Up a Diabetic Clinic and more details on nurse led disease specific clinics.

For more information on nursing in general practice contact the Practice Nurse Program Coordinator at GP partners Adelaide on Ph: 8112 1100 or visit: [www.gpplusnurses.com.au](http://www.gpplusnurses.com.au)

## Clinical Resources List

The following pages consist of resources for various diseases and conditions as well as government and community information. The list has been put together to assist general practitioners and practice nurses to find information and best practice guidelines available within South Australia and Australia for asthma, cardiovascular disease, COPD, diabetes, healthy eating and physical activity and culturally and linguistically diverse resources. Information and educational resources for consumers have also been included.

All resources listed are available on the corresponding website in PDF format or printer friendly pages, and are able to be downloaded or printed. Most of these resources may also be ordered (some at a cost) from the corresponding organisation.

**Please Note:** It is advisable that, before printing to check for copyright or permission to download files.

The Australian Government, Department of Health and Ageing website has extensive information and resources for the use of MBS Items for Chronic Disease Management. It is highly recommended that general practice staff involved in Chronic Disease Management check the information on the Department of Health and Ageing website at [www.health.gov.au](http://www.health.gov.au).

### General Resources

<b>Australian Childhood Immunisation Register</b>	<a href="http://www.medicareaustralia.gov.au/provider/patients/acir/index.jsp">www.medicareaustralia.gov.au/provider/patients/acir/index.jsp</a>
<b>Australian General Practice Network</b>	<a href="http://www.agpn.com.au">www.agpn.com.au</a>
<b>Australian Indigenous HealthInfoNet</b> Web-based pages of information on a broad range of health and related issues.	<a href="http://www.healthinfonet.ecu.edu.au">www.healthinfonet.ecu.edu.au</a>
<b>Australian Institute of Health &amp; Welfare</b> Provide information and statistics in various subject areas of health and welfare	<a href="http://www.aihw.gov.au/subjectareas.cfm">www.aihw.gov.au/subjectareas.cfm</a>
<b>Australian Resuscitation Council</b> ARC Guidelines	<a href="http://www.resus.org.au/">www.resus.org.au/</a>
<b>Australian Bureau of Statistics</b>	<a href="http://www.abs.gov.au">www.abs.gov.au</a>
<b>Australasian Cochrane Centre</b> Gateway to the Cochrane Library, providing evidence for healthcare decision making.	<a href="http://acc.cochrane.org">http://acc.cochrane.org</a>
<b>Better Health Channel</b> Health and medical information for consumers	<a href="http://www.betterhealth.vic.gov.au">www.betterhealth.vic.gov.au</a>
<b>Beyond blue</b> Depression & anxiety information for health professional and consumers	<a href="http://www.beyondblue.org.au">www.beyondblue.org.au</a>
<b>Australian Government – Department of Health and Ageing</b>	<a href="http://www.health.gov.au">www.health.gov.au</a>
<b>Chronic Condition Self Management Courses</b> For health professionals or for patients, Arthritis SA	Phone: 1800 011 041
<b>Disability Information and Resource Centre (DIRC)</b>	<a href="http://www.dircsa.org.au">www.dircsa.org.au</a>
<b>Falls Prevention in SA</b>	<a href="http://www.fallssa.com.au">www.fallssa.com.au</a>
<b>Health Insite</b>	<a href="http://www.healthinsite.gov.au">www.healthinsite.gov.au</a>

A <i>healthdirect</i> Australia health information service	
<b>Healthy for Life</b> Program that aims to improve the health of Aboriginal and Torres Straits Islander people	<a href="http://www.health.gov.au/internet/h41/publishing.nsf/Content/home-1">www.health.gov.au/internet/h41/publishing.nsf/Content/home-1</a>
<b>Health Provider Registry</b> A central and authoritative source of healthcare providers' contact details to enable communication of patient information across the state	<a href="http://www.healthproviders.com.au">www.healthproviders.com.au</a>
<b>Health Services Finder</b> Online directory of private and public health related services in South Australia	<a href="http://www.hsfinder.sa.gov.au">www.hsfinder.sa.gov.au</a>
<b>Live Life Well</b> Provides basic information and tools to make healthier changes including quit smoking, eating better and being active	<a href="http://www.livelifewell.nsw.gov.au">www.livelifewell.nsw.gov.au</a>
<b>Living, Caring, Working</b> Improving quality of life for people with a life threatening illness, their families, carers and communities	<a href="http://www.livingcaringworking.com">www.livingcaringworking.com</a>
<b>LungNet Australian Patient Support Network</b>	<a href="http://www.lungnet.com.au">www.lungnet.com.au</a>
<b>myDr</b> A website by MIMS that provides consumer information on a range of diseases, conditions and medications	<a href="http://www.mydr.com.au">www.mydr.com.au</a>
<b>Measure Up</b> Provides tips and guidelines to assist individuals decrease risk of chronic disease by reducing their waist measurement	<a href="http://www.measureup.gov.au">www.measureup.gov.au</a>
<b>Medicare Australia</b>	<a href="http://www.medicareaustralia.com.au">www.medicareaustralia.com.au</a>
<b>MBS Online</b>	<a href="http://www.health.gov.au/mbsonline">www.health.gov.au/mbsonline</a>
<b>Cancer Australia (Australian Government site)</b> Information on data and statistics, clinical best practice, research and education	<a href="http://canceraustralia.nbooc.org.au">http://canceraustralia.nbooc.org.au</a>
<b>National Health &amp; Medical Research Council (NHMRC) – Clinical Practice Guidelines</b>	<a href="http://www.nhmrc.gov.au/guidelines/publications/subject/Clinical%20practice%20guidelines">www.nhmrc.gov.au/guidelines/publications/subject/Clinical%20practice%20guidelines</a>
<b>NHMRC Nutrient Reference Values</b> Set of recommendations for nutritional intake based on currently available scientific knowledge.	<a href="http://www.nrv.gov.au/index.htm">www.nrv.gov.au/index.htm</a>
<b>NPS</b> Practical tools and information about medicines, health conditions and medical tests.	<a href="http://www.nps.org.au">www.nps.org.au</a>
<b>Australian Prescriber</b> Free, independent publication published by the NPS, providing information about drugs and therapeutics.	<a href="http://www.australianprescriber.com">www.australianprescriber.com</a>
<b>Nutrition Australia</b> Not-for-profit organisation that provides nutrition information to encourage all Australians to achieve optimal health through food variety and physical activity	<a href="http://www.nutritionaustralia.org">www.nutritionaustralia.org</a>

<b>Palliative Care Australia</b>	<a href="http://www.pallcare.org.au">www.pallcare.org.au</a>
<b>Clinical Audit Tool (Pen CAT)</b> Information and recipes for using CAT	<a href="http://www.clinicalaudit.com.au">www.clinicalaudit.com.au</a>
<b>The Pharmacy Guild of Australia</b>	<a href="http://www.guild.org.au">www.guild.org.au</a>
<b>Quit SA</b> Resources and support for smoking cessation	<a href="http://www.quitsa.org.au">www.quitsa.org.au</a> Phone: 13 78 48
<b>SA Health</b>	<a href="http://www.health.sa.gov.au">www.health.sa.gov.au</a>
<b>BreastScreen Australia</b> <b>National Cervical Screening Program</b> <b>National Bowel Cancer Screening Program</b>	<a href="http://www.cancerscreening.gov.au">www.cancerscreening.gov.au</a>
<b>RACGP</b> Guidelines to support GPs in their work	<a href="http://www.racgp.org.au/guidelines">www.racgp.org.au/guidelines</a>

## Arthritis & Osteoporosis

<b>Arthritis SA and Osteoporosis SA</b>	<a href="http://www.arthritissa.org.au">www.arthritissa.org.au</a>
<b>Arthritis Australia</b>	<a href="http://www.arthritisaustralia.com.au">www.arthritisaustralia.com.au</a>
<b>Osteoporosis Australia</b>	<a href="http://www.osteoporosis.org.au">www.osteoporosis.org.au</a>

## Asthma

<b>National Asthma Council (NAC)</b> Resources for patients and health professionals including tools for primary care, asthma management handbook, spirometry resources, education and training.	<a href="http://www.nationalasthma.org.au">www.nationalasthma.org.au</a> Ph: 1800 032 495
<b>Asthma Foundation of South Australia</b>	<a href="http://www.asthmasa.org.au">www.asthmasa.org.au</a>
<b>Australasian Society of Clinical Immunology and Allergy</b>	<a href="http://www.allergy.org.au/aer/infobulletins/index.htm">www.allergy.org.au/aer/infobulletins/index.htm</a>
<b>Thoracic Society of Australia and New Zealand</b>	<a href="http://www.thoracic.org.au">www.thoracic.org.au</a>
<b>Australian Centre for Asthma Monitoring</b>	<a href="http://www.asthmamonitoring.org">www.asthmamonitoring.org</a>

## Cardiovascular Disease

<b>Heart Foundation of Australia</b>	<a href="http://www.heartfoundation.org.au">www.heartfoundation.org.au</a> Phone: 1300 36 27 87
<b>Australian absolute cardiovascular disease risk calculator</b> Produced by the National Vascular Disease Prevention Alliance for the information of health professionals.	<a href="http://www.cvdcheck.org.au/">www.cvdcheck.org.au/</a>
<b>National Stroke Foundation - Australia</b>	<a href="http://www.strokefoundation.com.au">www.strokefoundation.com.au</a>
<b>Australian Cardiovascular Health and Rehabilitation Association (ACRA)</b>	<a href="http://www.acra.net.au">www.acra.net.au</a>
<b>Cardiac Society of Australia and New Zealand</b>	<a href="http://www.csanz.edu.au">www.csanz.edu.au</a>
<b>Cardiomyopathy Association of Australia</b>	<a href="http://www.cmaa.org.au">www.cmaa.org.au</a>
<b>Heart Support Australia</b> National, volunteer, consumer based organisation developed to provide support, information and encouragement to people who have a heart condition and their family/carers.	<a href="http://www.heartnet.org.au">www.heartnet.org.au</a>

<b>World Health Organisation</b> Cardiovascular Disease information	<a href="http://www.who.int/cardiovascular_diseases/en">www.who.int/cardiovascular_diseases/en</a>
--	--

## COPD

<b>The COPD-X Plan</b> Australian and New Zealand Guidelines for the management of Chronic Obstructive Pulmonary Disease	<a href="http://www.copdx.org.au">www.copdx.org.au</a>
<b>The Thoracic Society of Australia &amp; New Zealand</b>	<a href="http://www.thoracic.org.au">www.thoracic.org.au</a>
<b>The Australian Lung Foundation - LungNet</b> Australian Patient Support Network	<a href="http://www.lungnet.com.au">www.lungnet.com.au</a>
<b>Global Initiative for Chronic Obstructive Lung Disease (GOLD)</b>	<a href="http://www.goldcopd.com">www.goldcopd.com</a>
<b>International COPD Coalition</b>	<a href="http://www.internationalcopd.org">www.internationalcopd.org</a>
<b>International Primary Care Respiratory Group</b>	<a href="http://www.theipcr.org">www.theipcr.org</a>
<b>World Health Organisation</b> Chronic Respiratory Diseases information	<a href="http://www.who.int/respiratory/en">www.who.int/respiratory/en</a>

## Diabetes

<b>Diabetes Australia</b>	<a href="http://www.diabetesaustralia.com.au">www.diabetesaustralia.com.au</a>
<b>Diabetes SA</b>	<a href="http://www.diabetessa.com.au">www.diabetessa.com.au</a>
<b>Australian Diabetes Society</b>	<a href="http://www.diabetessociety.com.au">www.diabetessociety.com.au</a>
<b>Diabetes Management in General Practice (17<sup>th</sup> edition) 2011/12</b>	<a href="http://www.racgp.org.au/guidelines/diabetes">www.racgp.org.au/guidelines/diabetes</a>
<b>Australian Diabetes Educators Association</b> Includes 'Find a Credentialed Diabetes Educator' search function.	<a href="http://www.adea.com.au">www.adea.com.au</a>
<b>Australasian Paediatric Endocrine Group (APEG)</b>	<a href="http://www.apeg.org.au">www.apeg.org.au</a>
<b>Australasian Diabetes In Pregnancy Society</b>	<a href="http://www.adips.org">www.adips.org</a>
<b>Australasian Podiatry Council</b>	<a href="http://www.apodc.com.au">www.apodc.com.au</a>
<b>Dietitians Association of Australia</b>	<a href="http://www.daa.asn.au">www.daa.asn.au</a>
<b>Diabetes Centre - The Queen Elizabeth Hospital</b>	<a href="http://www.diabetes.org.au">www.diabetes.org.au</a>
<b>Diabetes Outreach (Country Health SA)</b> Professional resources and for patient education	<a href="http://www.diabetesoutreach.org.au">www.diabetesoutreach.org.au</a>
<b>Multilingual Resources (Diabetes Australia)</b>	<a href="http://www.diabetesaustralia.com.au/en/NDSS-Content/Resources/Multilingual">www.diabetesaustralia.com.au/en/NDSS-Content/Resources/Multilingual</a>
<b>National Diabetes Service Scheme (NDSS)</b>	<a href="http://www.ndss.com.au">www.ndss.com.au</a>
<b>Baker IDI Heart and Diabetes Institute</b>	<a href="http://www.bakeridi.edu.au">www.bakeridi.edu.au</a>
<b>Juvenile Diabetes Research Foundation (JDRF)</b>	<a href="http://www.jdrf.org.au">www.jdrf.org.au</a>
<b>Kidney Health Australia</b>	<a href="http://www.kidney.org.au">www.kidney.org.au</a>
<b>Optometrists Association of Australia</b>	<a href="http://www.optometrists.asn.au">www.optometrists.asn.au</a>
<b>Glycaemic Index (The University of Sydney)</b>	<a href="http://www.glycemicindex.com/">www.glycemicindex.com/</a>
<b>Vision Australia</b> Resource materials on diabetic retinopathy, blindness and low vision	<a href="http://www.visionaustralia.org.au/info.aspx?page=1698">www.visionaustralia.org.au/info.aspx?page=1698</a>
<b>International Diabetes Federation</b>	<a href="http://www.idf.org">www.idf.org</a>
<b>World Health Organisation</b>	<a href="http://www.who.int/topics/diabetes_mellitus/en/">www.who.int/topics/diabetes_mellitus/en/</a>

Diabetes information	
----------------------	--

## Health Eating and Physical Activity

<b>Australian Healthy Weight Week</b>	<a href="http://www.healthyweightweek.com.au">www.healthyweightweek.com.au</a>
<b>Be Active (Government of South Australia)</b> Publications, resources and events to encourage South Australians to be more active, more often.	<a href="http://www.beactive.com.au">www.beactive.com.au</a>
<b>Healthy Weight website (Australian Government)</b>	<a href="http://www.health.gov.au/internet/healthyactive/publishing.nsf/Content/healthyweight">www.health.gov.au/internet/healthyactive/publishing.nsf/Content/healthyweight</a>
<b>Live Life Well</b> Tools to make healthier changes including quitting smoking, eating better and being active	<a href="http://www.livelifewell.nsw.gov.au">www.livelifewell.nsw.gov.au</a>
<b>Measure Up</b> Tips to assist individuals to decrease risk of chronic disease by reducing waist measurement	<a href="http://www.measureup.gov.au">www.measureup.gov.au</a>
<b>My Healthy Balance</b> Free, online healthy lifestyle program developed by Diabetes WA	<a href="http://www.myhealthybalance.com.au">www.myhealthybalance.com.au</a>
<b>NHMRC Nutrient Reference Values</b> Set of recommendations for nutritional intake based on currently available scientific knowledge.	<a href="http://www.nrv.gov.au/index.htm">www.nrv.gov.au/index.htm</a>
<b>Nutrition Australia</b> Nutrition information to encourage all Australians to achieve optimal health	<a href="http://www.nutritionaustralia.org">www.nutritionaustralia.org</a>
<b>Swap It, Don't Stop It campaign</b>	<a href="http://www.swapit.gov.au">www.swapit.gov.au</a>
<b>RACGP Guidelines for Preventive Activities in General Practice (Red Book)</b>	<a href="http://www.racgp.org.au/guidelines/redbook">www.racgp.org.au/guidelines/redbook</a>

## Culturally and Linguistically Diverse

### The Health Translations Online Directory

The Health Translations Online Directory, available at [www.healthtranslations.vic.gov.au](http://www.healthtranslations.vic.gov.au), enables health practitioners and those working with culturally and linguistically diverse communities to easily find translated health information. You can search by language and topic. The Directory provides web links to third party sites with translated resources including government departments, peak health bodies, hospitals, community health and welfare agencies. The Directory currently links up to over 7,000 resources in 58 languages. Additional material is progressively being added.

### Doctors Priority Line Ph: 1300 655 820

The Doctors Priority Line is a free telephone interpreting service which helps medical practitioners to communicate with their non-English speaking patients. Medical practitioners can use the Doctors Priority Line when providing services that are:

- claimable under Medicare
- delivered in private practices
- provided to non-English speakers who are Australian citizens or permanent residents.

The Doctors Priority Line is available 24 hours a day, seven days a week. Doctors who are not currently registered for the Doctor's Priority Line can arrange access to the service via telephone or by sending a completed registration form to the Client Liaison and Promotions team.

For further information and to download the 'Doctor's free interpreting registration form' visit [www.immi.gov.au/living-in-australia/help-with-english/help\\_with\\_translating/free-services.htm](http://www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/free-services.htm)