

Adolescent Health GP Resource Kit

Practice Points

section two - chapter thirteen

Collaborative Care and Medicare

Multidisciplinary Care

GPs are in a unique position to coordinate the multidisciplinary care of a young person's health problems by:

- ◆ providing shared care in collaboration with allied health professionals, youth services and specialists
- ◆ formulating care plans and case conferencing using the **Medicare item numbers** to coordinate collaborative, multidisciplinary care
- ◆ facilitating referral to other services
- ◆ providing case management – coordinating the input of other professionals and facilitating the young person's access to health services

Referral to Other Services *see page 139*

Referring an adolescent patient to other health providers needs to be handled in a sensitive manner:

- ◆ Explain why each referral is necessary, including why specialised skills are required to deal with their problem
- ◆ Plan the referral/appointment in collaboration with the young person
- ◆ Support the young person if they are anxious – make the 'handover' as smooth as possible
- ◆ If possible, give them the name of a contact person at the other service
- ◆ Explain if you need to provide information to other professionals and obtain their consent to do so
- ◆ Plan for a follow up appointment after the patient has seen the other provider

Using the Medicare Item Numbers *see page 140*

A range of Medicare item numbers are now available to enable GPs to:

- ◆ be better remunerated when dealing with chronic and/or complex adolescent health conditions
- ◆ facilitate the delivery of multidisciplinary health care to adolescents
- ◆ target nationally identified health and screening priorities

Medicare Item Numbers for Use with Young People

Examples of Medicare items that can be used in the provision of health care and services to young people include:

- ◆ The Practice Incentives Payments (PIP), Service Incentive Payments (SIP) and Service Outcomes Payments (SOP)
- ◆ Bulk-billing incentive for concession card holders and children under 16 years
- ◆ Enhanced Primary Care (EPC) Chronic Disease Management (CDM) Program
- ◆ Allied Health Chronic Disease Management
- ◆ Case Conferencing
- ◆ Better Access to Mental Health Care

Better Access to Mental Health Care see page 144

- ◆ The revised **Better Access to Mental Health Care Program** provides GPs with item numbers to assist in the multidisciplinary management of young people's mental health problems
- ◆ It provides improved access to psychologists, psychiatrists and other allied health professionals for patients with mental disorders
- ◆ This program also provides for the assessment and preparation of a **GP Mental Health Care Plan** – to facilitate diagnosis and referral for treatment
- ◆ Patients that have a **GP Mental Health Care Plan** may be referred to a psychologist, or other mental health professional, for rebatable treatment services

The Medicare schedule is dynamic – general practice staff and practitioners should keep abreast of changes to item numbers by checking the **Medicare Australia** and **MBS On-line websites**:

Medicare Australia: www.medicareaustralia.gov.au/providers

MBS On-line: <http://www9.health.gov.au/mbs/search.cfm?type=item&go=browse>

chapter thirteen

Collaborative Care and Medicare

Adolescent health problems can be complex and multidimensional, requiring both time and specialist skills. GPs are often both the facilitator and coordinator of multi-disciplinary care, working with the patient to involve other health professionals. This ensures a sustainable, coordinated approach and continuity of care.

Multidisciplinary Care

GPs are in a unique position to coordinate a young person's health care. They can:

- ◆ Initiate and coordinate shared care in collaboration with allied health professionals, youth services and specialists
- ◆ Formulate plans with young people for their care including plans for the involvement of other health care providers
- ◆ Make referrals and provide important health information to other services
- ◆ Advocate for a young person and their family in dealing with the health system
- ◆ Receive input into a young person's care from other health care providers and help the patient understand and access the care and advice of other providers

Referral to Other Services

Complex problems usually require involvement of a multidisciplinary team. Referring an adolescent patient to other health service providers needs to be handled in a sensitive manner¹:

- ◆ Explain the GP's role as coordinator of and referrer to other care providers
- ◆ Explain why each referral is necessary, including why specialised skills are required to deal with their problem
- ◆ Plan for a follow up appointment after the patient has seen the other provider

Example: "I want to make sure that you get the best possible health care and to do that, we need other health care providers with specialised skills to be involved in your care"

- ◆ Plan the referral/appointment in collaboration with the young person
- ◆ Support the young person if they are anxious – make the 'handover' as smooth as possible
- ◆ If possible, give them the name of a contact person at the other service
- ◆ Explore logistics of travelling to and meeting additional costs of referred services
- ◆ Explain if you need to provide information to other professionals (reassure confidentiality) and obtain their consent to include their health information in the referral
- ◆ Tell them that you are available to see them again if they need help or are unhappy with the new service
- ◆ Provide follow-up support and care where needed

Multidisciplinary Resources

To ensure that a young person receives optimal care, GPs need to establish a referral network of available local services. Some services that may be involved in provision of care to adolescents include:

- ◆ Youth workers
- ◆ Adolescent mental health service
- ◆ Psychiatrists
- ◆ Psychologists, mental health nurses, Social Workers and other counsellors
- ◆ Drug and alcohol service
- ◆ Community health centre
- ◆ School nurses or counsellors; student welfare coordinators
- ◆ Youth accommodation services
- ◆ Department of Community Services
- ◆ Family planning/sexual health service
- ◆ Transcultural Mental Health Centre
- ◆ Bilingual Counsellors in mental health teams
- ◆ Other CALD-specific services
- ◆ Aboriginal health services

See also Section 4 – for contact details of other service providers

Using The Medicare Items

Medicare items currently available to general practice can be utilised in the provision of health care and services to young people.

Australian Medicare provides targeted incentive payments to GPs and practices separate and additional to standard Medicare Rebates. Medicare items assist GPs to meet nationally identified health priorities and remunerate general practice to provide comprehensive, quality and/or collaborative care to patients².

- ◆ All Medicare items have eligibility requirements and specific criteria attached to their use. GPs and general practices wishing to utilise these payments must familiarise themselves with the item and comply with the associated guidelines
- ◆ Many of the guidelines revolve around:
 - the need to work from a practice that has met or is working towards meeting the Royal Australian College of General Practitioners (RACGP) Accreditation Standards for General Practice
 - strict patient eligibility criteria
 - a plan or cycle of care, collaboration with other care providers and practitioner registration with the initiative²
- ◆ Medicare items are influenced by a variety of factors including – emerging evidence, national health priorities and the political health landscape to name a few
- ◆ The Medicare schedule is dynamic – general practice staff and practitioners can keep abreast of changes to item numbers by visiting:

Medicare Australia website:

www.medicareaustralia.gov.au/providers

MBS On-line website:

<http://www9.health.gov.au/mbs/search.cfm?type=item&go=browse>

You can use the **Adolescent Health Check** template to document the data you gather about the young person, services referred to and any Medicare item numbers used.

See Adolescent Health Check template – Appendix 1

In summary, some Medicare items have been introduced to enable GPs to:

- ◆ be better remunerated when dealing with chronic and/or complex health conditions
- ◆ deliver multidisciplinary health care to patients of all ages and
- ◆ target nationally identified health and screening priorities

resources

- ◆ For quick reference to Medicare items available for use with young people – see the 'Ready Reckoner' table (see facing page)
- ◆ These items are explained in more detail in the following pages

General Practitioner General Attendance Items – 3, 23, 36, 44

- ◆ General GP attendance items involving individual patient interactions (i.e. episodic care). There are 4 levels (Levels A – D) of complexity for GP attendance items, and the surgery consultation fee varies depending on the level of complexity and/or time

Practice Incentives Payments (PIP), Service Incentive Payments (SIP) And Service Outcomes Payments (SOP)

Practice Incentive Payments (PIP)

- ◆ Paid to RACGP accredited general practices to register and set-up administrative systems to support practice infrastructure, capacity building and best practice
- ◆ They are generally a one-off or quarterly payment to the practice
- ◆ Examples include information management, after hours care, rural status loadings, practice nurse employment, quality prescribing and chronic disease management for registered practices participating in the Commonwealth such as asthma, diabetes and cervical screening programs

Service Incentive Payments (SIP)

- ◆ Paid to the GP following the completion of a series of requirements for that item
- ◆ SIPs are paid for completion of medical care provided by the individual general practitioner under the Commonwealth asthma, diabetes and cervical screening programs

PATIENT NAME: REFERENCE NO:		DOCTOR/NURSE NAME:			
CHARGE		PRACTICE NURSE	ITEMS	ASTHMA	ITEMS
Private		Immunisation	10993 <input type="checkbox"/>	B Surgery	2546 <input type="checkbox"/>
Bulk Bill	<input type="checkbox"/>	Wound Care	10996 <input type="checkbox"/>	C Surgery	2552 <input type="checkbox"/>
Work Cover	<input type="checkbox"/>	Pap smear & preventive check	10994 <input type="checkbox"/>	D Surgery	2558 <input type="checkbox"/>
T.A.C.	<input type="checkbox"/>	Pap smear & preventive check (women aged 20-69yrs old & no smear in last 4yrs)	10995 <input type="checkbox"/>	DIABETES	ITEMS
CONSULTATION	ITEMS	Pap smear only	10998 <input type="checkbox"/>	B Surgery	2517 <input type="checkbox"/>
Short Consultation	3 <input type="checkbox"/>	Pap smear only (women aged 20-69yrs old & no smear in last 4yrs)	10999 <input type="checkbox"/>	C Surgery	2521 <input type="checkbox"/>
< 20 Minutes or complex	23 <input type="checkbox"/>	TEST/PROCEDURE	ITEMS	D Surgery	2525 <input type="checkbox"/>
20 - 40 Minutes	36 <input type="checkbox"/>	Pregnancy test	73806 <input type="checkbox"/>	GENERAL	ITEMS
> 40 Minutes	44 <input type="checkbox"/>	Foreign Body Removal	30061 <input type="checkbox"/>	GPMP	721 <input type="checkbox"/>
Antenatal initial consultation	16500 <input type="checkbox"/>	Implanon Implantation	14206 <input type="checkbox"/>	Review GPMP	725 <input type="checkbox"/>
Bulk-billing concession	10990/10991 <input type="checkbox"/>	Implanon Removal	30061 <input type="checkbox"/>	TCA	723 <input type="checkbox"/>
After 8pm (=Item 23)	5020 <input type="checkbox"/>	Standard sutures	30026 <input type="checkbox"/>	Review TCA	727 <input type="checkbox"/>
After 8pm (=Item 36)	5040 <input type="checkbox"/>	OTHER:		CP Assessment & Plan	132 <input type="checkbox"/>
VACCINATION				DMMR/HMR	900 <input type="checkbox"/>
Hep-A adult	<input type="checkbox"/>			MENTAL HEALTH	ITEMS
Avaxim (Hep A)	<input type="checkbox"/>	CERVICAL	ITEMS	GP MH Care Plan	2710 <input type="checkbox"/>
Hep-B adult	<input type="checkbox"/>	B Surgery	2501 <input type="checkbox"/>	GP MH Care Plan Review	2712 <input type="checkbox"/>
Meningococcal C	<input type="checkbox"/>	C Surgery	2504 <input type="checkbox"/>	GP MH Consultation	2713 <input type="checkbox"/>
Meningococcal (ACWY)	<input type="checkbox"/>	D Surgery	2507 <input type="checkbox"/>		
Gardasil	<input type="checkbox"/>				

Asthma Cycle of Care – 2546, 2552, 2558

- ◆ SIP paid for patients with moderate to severe asthma to receive quality management to avoid acute exacerbation of the condition
- ◆ At a minimum the Asthma Cycle of Care must include:
 - at least 2 asthma related consultations within 12 months for a patient with moderate to severe asthma (at least 1 of which i.e. the review consultation, is a consultation that was planned at a previous consultation)
 - documented diagnosis and assessment of level of asthma control and severity of asthma
 - review of the patient's use of and access to asthma related medication and devices
 - provision to the patient of a written asthma action plan (if the patient is unable to use a written asthma action plan - discuss with the patient about an alternative method of providing an asthma action plan, and documentation of the discussion in the patient's medical records)
 - provision of asthma self-management education to the patient
 - review of the written or documented asthma action plan

- ◆ SIP can be claimed for completion of a minimum of 2 visits and an Asthma plan

Diabetes Annual Cycle of Care – 2517, 2521, 2525

- ◆ SIP paid for all patients with diabetes to receive minimum national standards of diabetic care to prevent complications
- ◆ SIP can be claimed on completion of annual cycle of care: HbA1c test, lipids, micro albuminuria, weight, BMI, foot check, diet review, eye check, self care, physical activity, smoking status and medication review

Cervical Screening

- ◆ SIP paid when a pap test is conducted for females aged between 20-69 years who have not had a cervical screen within the last 4 years
- ◆ SIP can be claimed on completion of cervical screen
- ◆ Pap tests can be conducted by GPs or accredited and appropriately trained Practice Nurses (PNs)

Service Outcomes Payments (SOPs)

- ◆ SOPs are paid to the practices similar to PIP payments when Commonwealth regulated patient care targets are met by a practice

Cervical Screening

- ◆ SOP paid for females aged between 20-69 years who have received a cervical screen in the last 24 months

Diabetes Annual Cycle of Care

- ◆ SOP paid when 20% of all patients with diabetes have their annual cycle of care completed and claimed within last 12 months

Bulk-billing Incentive for Concession Card Holders and Children Under 16 years - 10990, 10991

Bulk-billed services provided by GPs to a person who is under the age of 16 or has a Commonwealth concession card attract a bulk-billing incentive payment:

- ◆ Depending upon the location of the practice (i.e. 10990 metropolitan or 10991 rural, regional or remote, Tasmania or in an area of workforce shortage) as specified by the Medicare guidelines
- ◆ This incentive item is added to each item number claimed during the patient's visit

Enhanced Primary Care (EPC) Chronic Disease Management (CDM) Program – 721, 723, 725, 727, 729

The Enhanced Primary Care (EPC) Chronic Disease Management (CDM) items provide funding for best practice care to patients with chronic and terminal conditions

- ◆ These items rebate all GPs to manage chronic disease by preparing, coordinating, reviewing or contributing to CDM plans
- ◆ Under these items, patients with chronic or terminal conditions are eligible to receive a GP management Plan (GPMP). Patients with chronic conditions and multidisciplinary care needs can also have a Team Care Arrangement (TCA)
- ◆ To be eligible for the GPMP, patients must have a chronic or terminal medical condition, one that has been or is likely to be present for ≥ 6 months
- ◆ To be eligible for a TCA, a patient must have a chronic or terminal medical condition, one that has been or is likely to be present for ≥ 6 months, and who requires on-going care from a multidisciplinary team of at least 3 health or care providers (at least one non doctor)

Eligibility and requirements of items must be checked against the business rules before claiming – <http://www9.health.gov.au/mbs/search.cfm?type=item&go=browse>

Examples of chronic conditions in young people likely to last longer than 6 months which qualify for the items include:

- ◆ depression*
- ◆ psychotic disorders*
- ◆ anxiety/panic disorders*
- ◆ drug addiction
- ◆ eating disorders*
- ◆ learning disabilities
- ◆ trauma (past history of physical or sexual abuse)
- ◆ chronic medical conditions such as asthma and diabetes
- ◆ HIV, Hepatitis C and Hepatitis B
- ◆ cancer
- ◆ musculoskeletal problems

* **See also mental health items 2710**

There are 5 CDM items that provide a rebate to GPs and can be used in the care of young people (i.e. Items 721, 723, 725, 727, 729, see below)

Preparation of a GP Management Plan (GPMP) – 721

GPMPs are a plan of care developed by GPs in consultation with their patient who has a chronic or terminal medical condition and does not require the input and assistance of other health care professionals.

Review of a GPMP – 725

GPMP Reviews are a review of an existing GPMP and are recommended once every 6 months or less if clinically required. GPs may be assisted by a PN in reviewing the patients GPMP, documenting any relevant changes and setting the next review date.

Where GP coordinates the preparation of Team Care Arrangements (TCA) – 723

TCAs can be made for patients with chronic (or terminal) medical conditions and complex needs and require ongoing care from a multidisciplinary team consisting of their GP and at least two other health or care providers (one must be a non doctor). The Medicare guidelines recommend TCAs are to be completed once every 2 years and GPs can be assisted by a PN in the development of a TCA.

Review of Team Care Arrangements (TCA) – 727

TCA reviews are a review of the existing TCA and are usually expected to be done 6 monthly. GPs can be assisted by a PN and must collaborate with the team on progress against treatment/service goals and document progress and changes to the TCA.

Where a patient has a multidisciplinary care plan prepared or reviewed by a care provider other than their usual GP – 729

The GP is involved in collaborating with care providers in the preparation and review of the plan and including their contribution with the patient's records.

Allied Health Chronic Disease Management

The allied health items were introduced to complement the suite of EPC CDM items by expanding the CDM item numbers to allied health professionals.

- ◆ Patients that have a GPMPs and TCAs, can receive a rebate for access to 5 allied health visits per calendar year. Allied health services can be used in any combination (i.e. 3 visits to the Dietician and 2 visits to the Diabetes educator)
- ◆ In order for the Allied Health items to be claimed, **a GPMP and TCA must be claimed first.** Patients can access up to 5 allied health services per calendar year for a service of at least 20 minutes

Allied Health Care Providers must be registered with the EPC CDM initiative and be classified under one of the following categories:

- ◆ Aboriginal health workers
- ◆ Audiologist
- ◆ Dietician
- ◆ Diabetes educator
- ◆ Mental health worker
- ◆ Occupational therapist
- ◆ Physiotherapist
- ◆ Podiatrist/Chiropodist
- ◆ Chiropractors
- ◆ Osteopath
- ◆ Psychologist
- ◆ Speech pathologist
- ◆ Exercise physiologist

Consultant Physician (CP) Items – 132, 133

- ◆ This item (132) requires referral to the Consultant Physician from a GP or specialist specifically asking for one of these items to be completed
- ◆ Patients with at least 2 morbidities, including complex congenital, behavioural or developmental conditions, are eligible
- ◆ The CP will conduct an assessment and provide a treatment and management plan to the referring GP
- ◆ A second item (133) can be billed by the CP for a review consultation following a 132
- ◆ Where the patient is being managed under an Enhanced Primary Care (EPC) GPMP and or TCA, the action taken by the CP should be used to augment the plans
- ◆ The CP can make suggestions regarding the EPC care plan if, in his or her judgement, the plan needs to be modified

Case Conferencing - 740, 742, 744, 759, 762, 765

A case conference is a process by which a GP organises and coordinates or participates as part of a case conference team to carry out the following activities:

- ◆ discussing a patient's history; and
- ◆ identifying the patient's multidisciplinary care needs; and
- ◆ identifying outcomes to be achieved by members of the case conference team giving care and service to the patient; and
- ◆ identifying tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the case conference team; and
- ◆ assessing whether previously identified outcomes (if any) have been achieved

Where a case conference is organised and coordinated by the GP, the GP must ensure the patient consents to the case conference taking place and to the people attending the conference.

- ◆ The GP must also record:
 - the details of the day on which the conference was held; and the times at which the conference started and ended
 - the names of the participants
 - the outcomes of the conference in the patient's medical records

- ◆ A summary of outcomes should be provided to attendees and the outcomes should be discussed with the patient and/or patient's care giver
- ◆ All providers must be present for the whole time that the item is claimed for

When a GP participates in a case conference it must be at the request of the person who organises and coordinates the case conference and includes ensuring that the above activities are completed and documented in the patient's medical records including the relevant consent given.

- ◆ GP Community Case Conference:
Organise and Coordinate 15 – 30 minutes – 740
- ◆ GP Community Case Conference:
Organise and Coordinate 30 – 45 minutes – 742
- ◆ GP Community Case Conference:
Organise and Coordinate > 45minutes – 744
- ◆ GP Case conference:
Participate 15 – 30 minutes – 759
- ◆ GP Case conference:
Participate 30 – 45 minutes – 762
- ◆ GP Case conference:
Participate >45 minutes - 765

The case conference cannot be a service associated with items 721 (GP Management Plan) to 731.

Contact your local Area Health Service or Division of General Practice – for information regarding local service providers who could participate in Care Plans/Case Conferences.

See Section 4 – for list of services and contact details

Better Access To Mental Health Care – 2710, 2712 & 2713

- ◆ The revised **Better Access to Mental Health Care Program**, came into effect in November 2006
- ◆ Items under the initiative provide GPs with more support and improved remuneration to undertake intervention, assessment and management (both current & continual) of patients with mental disorders, as well provide improved access to general practice, psychologists, psychiatrists and other allied health professionals for patients with mental disorders

- ◆ Eligibility for this item refers to **patients with a mental disorder** who would benefit from a structured approach to the management of their care needs
- ◆ Mental disorder is a term used to describe a range of clinically diagnosable disorders that significantly interfere with an individual's cognitive, emotional or social abilities (refer to the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD10 Chapter V Primary Care Version)
- ◆ **Note** – *Dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders for the purposes of the GP Mental Health Care items*

The items available to GPs using this program include:

Developing a GP Mental Health Care Plan – 2710

This item covers both the assessment and preparation of the **GP Mental Health Care Plan**

- ◆ The item cannot be paid within 12 months of a previous claim for the same item, or within 12 months of a claim for a former 3 Step Mental Health Process except where there has been a significant change in the patient's clinical condition or care circumstances that requires the preparation of a new GP Mental Health Care Plan
- ◆ An assessment of a patient must include:
 - Recording the patient's agreement for the GP Mental Health Care Plan service
 - Taking relevant history (biological, psychological, social) including the presenting complaint
 - Conducting a mental state examination
 - Assessing associated risk and any co-morbidity
 - Making a diagnosis and/or formulation, and
 - Administering an outcome measurement tool, except where it is considered clinically inappropriate
- ◆ In addition to assessment of the patient, preparation of a GP Mental Health Care Plan must include:
 - Discussing the assessment with the patient, including the mental health formulation and/or diagnosis
 - Identifying and discussing referral and treatment options with the patient, including appropriate support services

- Agreeing goals with the patient - what should be achieved by the treatment - and any actions the patient will take
- Provision of psycho-education
- A plan for crisis intervention and/or for relapse prevention, if appropriate at this stage
- Making arrangements for required referrals, treatment, appropriate support services, review and follow-up; and
- Documenting this (results of assessment, patient needs, goals and actions, referrals and required treatment/services, and review date) in the patient's GP Mental Health Care Plan

◆ **Treatment options can include:**

- referral to a psychiatrist
- referral to a clinical psychologist for psychological therapies
- or to an appropriately trained GP or allied mental health professional for provision of focussed psychological strategy services
- pharmacological treatments
- and coordination with community support and rehabilitation agencies, mental health services and other health professionals

Conducting a GP Mental Health Care Plan Review – 2712

- ◆ Conducting a GP Mental Health Care review of the existing GP Mental Health Plan, that is prepared by that same medical practitioner (or an associated medical practitioner)
- ◆ The review must include:
 - Recording the patient's agreement for this service
 - A review of the patient's progress against the goals outlined in the GP Mental Health Care Plan
 - Modification of the documented GP Mental Health Care Plan if required
 - Checking, reinforcing and expanding education
 - A plan for crisis intervention and/or for relapse prevention, if appropriate and if not previously provided; and
 - Re-administration of the outcome measurement tool used in the assessment stage, except where considered clinically inappropriate
- ◆ The item cannot be paid within 3 months of a previous claim for a review item, or within 4 weeks following a claim for the associated GP Mental Health Care Plan – except where there has been a significant change in the patient's clinical

condition or care circumstances that requires the preparation of a new review of a GP Mental Health Care Plan

- ◆ The recommended frequency for the review service is an initial review, which should occur between 4 weeks to 6 months after the completion of a GP Mental Health Care Plan and if required, a further review can occur 3 months after the first review
- ◆ In general, most patients should not require more than 2 reviews in a 12 month period, with ongoing management through the GP Mental Health Care Consultation and standard consultation items, as required

Exceptional Circumstances

- ◆ There are minimum time intervals for payment of rebates for GP Mental Health Care items (as detailed above) – with provision for claims to be made earlier than these minimum intervals in exceptional circumstances
- ◆ 'Exceptional circumstances' apply where there has been a significant change in the patient's clinical condition or care circumstances that requires a new GP Mental Health Care Plan or a new Review, rather than, for example, amending the existing GP Mental Health Care Plan
- ◆ Where a service is provided in exceptional circumstances, the patient's invoice or Medicare voucher should be annotated to briefly indicate the reason why the service involved was required earlier than the minimum time interval for the relevant item (eg annotated as clinically indicated, discharge, exceptional circumstances, significant change etc.)

GP Mental Health Care Consultation (ongoing management) – 2713

- ◆ GP Mental Health Care Consultation by the GP involves:
 - taking relevant history, identifying presenting problem(s), providing treatment, advice and/or referral for other services or treatments
 - and documenting the outcomes of the consultation, on a patient in relation to a mental disorder and lasting at least 20 minutes as a separate consultation to the development and review of the patient's mental health plan

Access to Allied Mental Health Services

- ◆ Patients that have a **GP Mental Health Care Plan (2710)** may be referred by their GP to a clinical psychologist providing psychological therapies; or an appropriately trained GPs or allied mental health professionals providing **Focussed Psychological Strategy (FPS)** services for 6 + 6 rebatable sessions in a calendar year
- ◆ A further referral for up to an **additional 6 services** can be made in exceptional circumstances within the calendar year
- ◆ In the case of exceptional circumstances – both the patient's mental health care plan and referral should be annotated to briefly indicate the reason why the service involved was required in excess of the 12 services permitted within a calendar year
- ◆ In addition to the above services, patients will also be eligible to claim up to 12 separate services for the provision of **group psychotherapy**
- ◆ Patients can also be referred for FPS services under Access to Allied Psychological Services (ATAPS), available through Divisions of General Practice
- ◆ Where a patient's services are not used during the calendar year in which they are referred, the unused services may be used in the next calendar year – where they will count towards the maximum number of services able to be received during that year
- ◆ For example – if a GP prepared a GP Mental Health Care Plan for a client in November 2007 and referred the client for 6 allied mental health services but only 2 of these services were provided by 31 December 2007, the remaining 4 referred services would still be valid into 2008
- ◆ The remaining 4 services could be provided in 2008 using the original referral but would count towards the client's 2008 calendar year limit for allied mental health services
- ◆ Patients who are being managed by their GP under a GP Mental Health Care Plan who need to access further referred services during a new calendar year do not need to have a new MH Care Plan prepared (unless required by the client's clinical condition, needs or circumstances)
- ◆ All consultations conducted as part of the GP Mental Health Care items must be rendered by the GP. A specialist mental health nurse, other allied health practitioner or Aboriginal Health Worker with appropriate mental health qualifications and training may provide general assistance to GPs in provision of mental health care

Claiming GPMPs and MHCPs

- ◆ Where a patient has a mental health condition as identified by an ICD10 classification they can be managed under the new GP Mental Health Care items
- ◆ If a patient has a separate chronic medical condition and a mental health condition, or where a patient has a mental health condition as well as significant co-morbidities and complex needs requiring team-based care, the GP is able to use both the CDM items and the GP Mental Health Care items

Other MBS Items

Practice Nursing

- ◆ Practice Nurses (PNs) provide a valuable resource to the provision of care patient within the general practice setting through contributing to MBS item numbers as appropriate within the Medicare guidelines
- ◆ PNs can assist the GP and provide some of the care in asthma and diabetes SIPs and can assist GPs with developing GPMPs and liaising with allied health professionals as part of the TCA
- ◆ In addition to performing these roles, there are a number of Medicare items that can be claimed by a GP for work undertaken by a PN working on their behalf
- ◆ These items can generally be claimed in addition to the bulk billing item (10990) plus any relevant SIP payments, and any associated GP attendance items

PN Wound Management - 10996

- ◆ A practice claims this item when a PN provides a wound management on behalf of a GP

PN Immunisation - 10993

- ◆ A practice claims this item when a PN provides an immunisation service on behalf of a GP

PN Cervical Screening – 10994, 10995, 10998 and 10999

- ◆ A practice can claim this item when a PN provides a pap test on behalf of and under the supervision of a GP. The PN needs to be a RN Division 1 nurse who is a credentialed pap test provider

PN Preventative Care - 10997

- ◆ The GP can claim this item when a PN provides ongoing monitoring, support and education of the management goals of the GPMP on behalf of the claiming GP

PN Antenatal Care- 16400

- ◆ The practice can claim this item when a suitably trained practice nurse who works in an eligible practice located in a regional, rural, and remote area provides antenatal care to patients on behalf of and under the supervision of a GP

Non-directive Pregnancy Support Counselling – 81000, 81005, 81010 and 4001

- ◆ Provision of a non-directive pregnancy support counselling service to a woman who is concerned about a current pregnancy or a pregnancy that occurred in the preceding 12 months, by a pregnancy support credentialed GP or credentialed mental health nurse – where the service may be used to address any pregnancy related issues for which non-directive counselling is appropriate
- ◆ The consultation must last at least 20 minutes
- ◆ A maximum of 3 non-directive pregnancy support counselling services per patient, per pregnancy can be claimed from any of the following items – 81000, 81005, 81010 and 4001

Home Medicines Review (HMR) or Domiciliary Medication Management Review (DMMR) – 900

- ◆ HMRs are available for any patient living in the community who the GP feels could benefit from this service
- ◆ Patients receive a review of their medication management preferably in their home by an accredited pharmacist
- ◆ Patients that may benefit may include: patients with suspected non-compliance, recent hospital discharge, or a patient who is currently taking 5 or more medications
- ◆ The item can be claimed when the GP and patient review the feedback from the pharmacist and agree on a medication management plan

Health Assessment Items

ATSI Child Health Check – 708

- ◆ The ATSI Child Health Check Item has been developed for patients who are of Aboriginal or Torres Strait Islander descent and aged between 0 – 14 years inclusive

ATSI Adult Health Check – 710

- ◆ The ATSI Adult Health Check Item has been developed for patients who are of Aboriginal or Torres Strait Islander descent and aged at least 15 years old and less than 55 years old

Health Assessment for Refugees and other Humanitarian Entrants – 714

- ◆ The payments for health assessment for refugees and other humanitarian entrants are payable for a service provided to a patient within 12 months of them arriving in Australia or receiving residency (whichever is the later)

Health Assessment of a Patient with an Intellectual Disability – 718, 719

- ◆ A GP can conduct a health assessment on a patient with an intellectual disability in their practice (718) or at home (719) provided the item hasn't been claimed in the preceding 12 months

NOTE:

This chapter highlights a number of key Commonwealth initiatives and incentives currently available to general practice, which can be utilised in the provision of health care and services to young people. All items are subject to MBS guidelines and changes. It is not an exhaustive list and has been produced in good faith. Practitioners and practices making clinical and business decisions resulting from information contained in this chapter should consult the MBS guidelines before making any changes to their current practice and to ensure the accuracy of information presented.

resources

- ◆ Information on MBS guidelines can be found on the **MBS Online website** which contains news updates, the current Medicare Benefits Schedule (MBS) and a listing of the Medicare services subsidised by the Australian government: <http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Medicare-Benefits-Schedule-MBS-1>

practice points

- ◆ GPs are in a unique position to initiate and coordinate shared care in collaboration with allied health professionals, youth services and specialists
- ◆ Complex problems require a multidisciplinary approach
- ◆ Referral to other health service providers needs to be handled in a sensitive manner – plan the referral in collaboration with the young person
- ◆ Monitor the young person's progress and provide follow-up support and care where needed

Examples of Medicare items that can be used in the provision of health care and services to young people include:

- ◆ The Practice Incentives Payments (PIP), Service Incentive Payments (SIP) and Service Outcomes Payments (SOP)
- ◆ Bulk-billing incentive for concession card holders and children under 16 years
- ◆ Enhanced Primary Care (EPC) Chronic Disease Management (CDM) Program
- ◆ Allied Health Chronic Disease Management
- ◆ Case Conferencing
- ◆ Better Access to Mental Health Care
- ◆ The Medicare schedule is dynamic - general practice staff and practitioners should keep abreast of changes to item numbers by checking the **Medicare Australia** and **MBS On-line websites**

Medicare Australia website:

www.medicareaustralia.gov.au/providers

MBS On-line website:

<http://www9.health.gov.au/mbs/search.cfm?type=item&go=browse>

Case Study 1 - Collaborative Care

Eve is a 15 year old young woman with audible wheeze who presents to your clinic with her single mother that she lives with. Eve has a history of mild Asthma since early childhood which was treated inhalers during periods of exacerbation. Eve's mother very worried that her daughter's Asthma has become uncontrolled. She expressed frustration at her inability to communicate the seriousness of her condition to her daughter. Eve used to swim competitively but quit a year ago as she no longer wanted to train on Saturday mornings and before school. She has recently started work at a local fast food restaurant where she is often asked to work night shifts. Eve's mother is also angry as she discovered Eve has lied to her about some of her evening shifts and has been attending parties with much older peer group from work instead. Her mother wants her to quit her job due to this and because it is interfering with her school grades and creating tension in the house. She is also worried as Eve now sleeps most of the day on the weekend and has become overweight and defensive.

After asking her mother for some time alone with Eve, you learn that Eve gave up swimming as she felt that she would never reach her goal of swimming in the national championships like her mum. She also feels that she can't talk to her mother anymore who was very disappointed with her decision to quit and enjoys the freedom of not having to watch her weight and constantly train, which she has done since she was eight. Eve has found a new group of older friends at work that she smokes marijuana and binge drinks with twice a month at parties. She said that there have been other drugs at these parties but she hadn't tried them yet. Eve thinks that the smoking has brought on her asthma but worries that her new friends will reject her if she stops. After questioning Eve you learn that she has little knowledge about her asthma and medication use and is constantly losing her inhalers.

You suspect that Eve might be suffering from anxiety with a panic disorder.

Management Approaches

Consult 1

- ◆ As it seemed apparent that Eve was only attending the clinic due to the coercion of her mother, your first consideration is to build rapport and gain Eve's trust
- ◆ After seeing Eve on her own, discussing confidentiality and commencing your **HEEADSSS** screen and physical assessment, you begin to discuss with her a plan for her care and fill in your **Adolescent Health Check** template

See Adolescent Health Check template – Appendix 1

- ◆ You take Eve and introduce her to your practice nurse who is an asthma educator who familiarises herself with Eve's psychosocial assessment – the nurse also works to develop a rapport with Eve, conducts a spirometry, shows Eve how to conduct and record her peak flows and starts some basic asthma education
- ◆ You review Eve's results and discuss with Eve and her mother about commencing an Asthma cycle of care and a DMMR/HMR referral. You explain the process and obtain consent
- ◆ You record **MBS item numbers: 23, spirometry and 2 x 10990/1**
- ◆ A pharmacist visits Eve at home and discusses the importance of taking her medications, how her preventatives work, administration and storage of medication, asthma triggers in Eve's lifestyle and at home
- ◆ He also discusses the impact of her smoking and marijuana use and a plan for Eve to remember to carry and locate her puffers with contingencies

Consult 2 – 2 weeks

- ◆ You see Eve and her mother in 2 weeks, assess Eve's peak flows and review the completed DMMR/HMR having previously communicated with the accredited pharmacist that visited Eve
- ◆ You discuss Eve's asthma medication plan with Eve and with Eve's permission, her mother
- ◆ The practice nurse completes Eve's asthma education, reinforces key concepts and discusses any management concerns that Eve has
- ◆ You record **MBS item numbers: 23 and 900 claimed and 2 x 10990/1**

Consult 3 – 4 weeks

- ◆ The following week you work collaboratively with your practice nurse, Eve and Eve's Mother to develop an asthma action plan with Eve
- ◆ You record **MBS item numbers: Asthma cycle of care which is conducted as part of a standard consultation 2546; spirometry claimed with 2 x 10991**

Consult 4 - 6 weeks

- ◆ You see Eve and complete her HEEADSSS check
- ◆ An **ICD-10 MH** diagnosis for anxiety with panic disorder is confirmed and documented
- ◆ **MHCP** completed and referral to psychologist actioned
- ◆ You record **MBS item numbers: 23 and MHCP 2710 and 2 x 10990/1**

Case Study 2 - Collaborative Care

Kate is 17 years old young woman who has come to visit you in tears as she suspects she is pregnant. She had unprotected sex on several occasions with her 19 year old ex boyfriend who broke off their relationship and she no longer has contact with. Kate dropped out of school and left home to live with her then boyfriend a few months ago after heated arguments with her parents over the relationship. She is currently living with several friends and has no fixed address. Kate feels that she cannot go back to living at her parent's house as they are very religious and will not support her now that she has left home and had a boyfriend.

Kate also has Chron's disease and is currently experiencing a flare-up of her condition.

Management Approaches

Consult 1

- ◆ You reassure Kate about patient confidentiality and affirm her attendance at your clinic
- ◆ You complete your **HEEADSSS** screen, do a pregnancy test and physical assessment and fill in your adolescent health check template

- ◆ After speaking with Kate you discuss her positive pregnancy test and & physical exam – Kate indicates that she wants to keep pregnancy; and you refer her to the family planning centre and the youth worker at your local community health centre to organise accommodation and further support
- ◆ Kate also mentioned that she would like to go back to school to become an art teacher but would need to catch-up on her subjects
- ◆ You order blood tests and ask Kate if she would like to come back for an STI screen and pap test
- ◆ You commence a GP Management Plan to coordinate Kate's care which includes seeking the support of Kate's school welfare coordinator, youth worker and family planning
- ◆ You also speak to an adolescent-friendly dietician about Kate's pregnancy and Chrone's disease and refer her for 5 allied health visits
- ◆ You ask Kate to come back and see you if she is unhappy with her referrals and that you would like to continue seeing her in the future to look after her on-going health
- ◆ You record **MBS item numbers: 23, 721, pregnancy test 73806, urine test 73805 and 10990/1**

Consult 2 – 1 week

- ◆ When Kate returns for a second visit, you discuss her blood results having communicated with family planning, the dietician, the youth worker and the school welfare coordinator
- ◆ You assess that there is a need to refer Kate to a Gastroenterologist and for a TCA between the Gastroenterologist, Dietician and Obstetrician
- ◆ You record **MBS item numbers: 23 and 10990/1**

Consult 3 – 2 weeks

- ◆ You assess, coordinate, discuss management issues with Kate and finalise her plan of care
- ◆ You ask Kate to come back and see you if she is unhappy with her referrals and that you would like to continue seeing her in the future to look after her on-going health
- ◆ You record **MBS item numbers: 723 and 10992** (possibly with a level B consultation item 23 and 10990/1 depending if any work separate to the TCA was conducted at the same consultation)

References:

- 1 Sanci, L. (2001). *Adolescent Health Care Principles*. Centre for Adolescent Health. The Royal Australian College of General Practitioners. Melbourne.
- 2 Newnham, V. Gregory, T. Caruana, S. and Seymour, J. (2007). *A PARTY Project Training Guide: Medicare Funding Supporting Adolescent Health Services in General Practice*. Primary Care Research Unit. University of Melbourne.
- 3 Commonwealth Department of Health and Ageing. (2007). *Medicare Benefits Schedule Book: Operating from 1 November 2007*. Australian Government. Canberra.