CHAPTER 13

COLLABORATIVE CARE AND MEDICARE

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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 manner:

- 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
- Engage the young person in setting their health goals and developing a care plan that is realistic and owned by the young person
- Plan for a follow up appointment after the patient has seen the other provider(s)

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
- Where multiple providers are involved, make a longitudinal plan of the order and priority of their health issues and the providers they will see
- 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:

- Adolescent primary care services (e.g. youth health clinics, headspace centres with primary care staff, specialist GPs, Nurse Practitioners and Practice Nurses, Physiotherapists, Dentists etc…)
- Adolescent mental health services (e.g., Local Hospital Network or equivalent clinical adolescent mental health and early psychosis services, headspace, etc)
- Access To Allied Psychological Services (ATAPS) providers
- Community mental health services (e.g. Personal Helpers & Mentors Scheme (PHAMS), Day to Day Living program (D2DL), Partners in Recovery program (PIR), State funded services)
- Aboriginal health services
- Psychiatrists
- Psychologists, mental health nurses, social workers and other counsellors
- Youth workers
- Drug and alcohol services
- Community health centres
- School nurses or counsellors; student welfare coordinators
- Youth accommodation services
- State Departments of Community/ Human Services
- Family planning/sexual health services
- CALD-specific services such as transcultural mental/primary health services, bilingual counsellors and translating services
- Consumer organisations with peer support groups and services (e.g., Peer Workers, Carer Consultants, etc.)

See also Section Four – 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 primary care 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 patients.

The Department of Health and Ageing regularly updates the Medicare Benefits Schedule (MBS) which is an itemised list of all of the medical services that attract a Medicare rebate. Each service has a corresponding fee which is considered reasonable for that particular service.

- 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 primary care 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 initiative
- 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 MBS 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 appropriately remunerated when supporting young people 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 below.
- The items most commonly used with adolescents are explained in more detail in the following pages.

PATIENT NAME:				**DOCTOR/NURSE NAME:**	
REFERENCE NO:				**DATE OF BIRTH:**	
CHARGE				**ASTHMA**	**ITEMS**
Private				B Surgery	2546
Bulk-Bill				C Surgery	2552
Work Cover				D Surgery	2558
T.A.C.				**DIABETES**	**ITEMS**
CONSULTATION	**ITEMS**	**TEST / PROCEDURE**	**ITEMS**	B Surgery	2517
Level A: Short Consultation	3	Pregnancy test	73806	C Surgery	2521
Level B: < 20 Minutes	23	Foreign Body Removal	30061	D Surgery	2525
Level C: > 20 Minutes	36	Implanon Implantation	14206	**GENERAL**	**ITEMS**
Level D: > 40 Minutes	44	Implanon Removal	30061	GPMP	721
Antenatal initial consultation	16500	Standard sutures	30026	Review GPMP	732
Bulk-billing concession	10990/10991	**OTHER**		TCA	723
After 8pm (=Item 23)	5020			Review GPMP	732
After 8pm (=Item 36)	5040			CP Assessment & Plan	132
VACCINATION				DMMR/HMR	900
Hep-A adult				**MENTAL HEALTH**	**ITEMS**
Avaxim (Hep A)				GP MH Treatment Plan	2700,2701, 2715,2717
Hep-B adult		**CERVICAL**	**ITEMS**		
Meningococcal C		B Surgery	2501	GP MH Treatment Plan Review	2712
Meningococcal (ACWY)		C Surgery	2504	GP MH Consultation	2713
Gardasil		D Surgery	2507	Better Start for Children with Disability	139

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.
- Consultation items levels B to D can be used for: taking an extensive patient history; performing a clinical examination; arranging any necessary investigation; implementing a management plan and providing appropriate preventive health care in relation to one or more clinically relevant health-related issue(s), with appropriate documentation.

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, cervical screening and Indigenous Health Incentive 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, cervical screening and Indigenous Health Incentive programs

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 two asthma-related consultations within 12 months
  - At least one of these consultations must be planned recalls
  - Documented diagnosis and assessment of severity and level of asthma control
  - Review of the patients use of and access to asthma-related medication and devices
  - Provision of written asthma action plan (if patient is unable to use a written action plant, discuss alternative and record the
  - Discussion in the patient's medical records)
  - Provision of asthma self-management education to the patient, and
  - Review of the written or documented asthma action plan

The patient's medical record should include documentation of each of these requirements and the clinical content of the patient -held written action plan.

- SIP payable once per year per patient with moderate to severe asthma for completion of a minimum of 2 visits & 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

SIX MONTHLY	ANNUALLY	BI-ANNUALLY	MUST ALSO INCLUDE
*Weight, Height, BMI	HbA1c	Eye Examination	Self Care Education
Blood Pressure	Total Cholesterol, Triglycerides & HDL Cholesterol		Review Physical Activity Levels
Foot Examination	Microalbuminuria		Review Diet
	eGFT**		Medication Review
			Smaoking Status

* At initial Consult then weight only required ** From October 2013

- SIP payable when GPs provide the minimum requirements of care outlined below within an 11 to 13 month period. Additional levels of care will be needed by insulin-dependent patients and those with abnormal review findings, complications and/or co-morbidities:

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 payment per year per eligible female where at least 70% of females aged between 20-69 years in the practice are screened in a 30-month period.
- Diabetes Outcome Payment
- An outcomes payment of $20.00 per diabetic SWPE per year is received by practices where at least 2% of practice patients are diagnosed with diabetes mellitus and a diabetes cycle of care has been completed on at least 50% of these patients.

BULK-BILLING INCENTIVE FOR CONCESSION CARD HOLDERS AND CHILDREN UNDER 16 YEARS -, 10991, 10992

Bulk-billed services provided by GPs to a person who is under the age of 16 or has a Commonwealth Pensioner Concession Card, Health Care Card, or Seniors Health Card attract a bulk-billing incentive payment:

- 10991 To be used when a medical practitioner provides a bulk-billed medical service at or from a practice location, including services performed either at the medical practitioner's surgery, or those services performed away from the surgery using the provider number for that surgery (e.g. home visits or RACFs).This incentive item is added to each item number claimed during the patient's visit
- 10992 An after hours unreferred bulk-billed medical service to which Item 597, 598, 599, 600, 5003-5267 applies outside of consulting rooms or hospital.

CHRONIC DISEASE MANAGEMENT (CDM) PROGRAM – 721 (GPMP), 723 (TCA), 732 (GPMP/ TCA REVIEW), 729 (MCP)

The Chronic Disease Management (CDM) items are available to enable GPs to better manage the health care of patients with chronic or terminal medical conditions, including patients with these conditions that require multidisciplinary, team-based care from a GP and at least two other health or care providers. GP Management Plans (GPMPs) and Team Care Arrangements (TCAs) are comprehensive documents that set out a structured approach to a patient's health and care needs. While a GPMP and TCA are able to be provided individually, to access allied health services as part of the TCA, it is necessary to undertake both a GPMP and TCA.

Items 721, 723 and 732 are available to patients in the community and private inpatients of a hospital being discharged. Patients must have a chronic or terminal medical condition to be eligible for a GPMP item. Patients who also have complex needs requiring care from a multidisciplinary team are eligible for a TCA item.

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**

There are 4 main CDM items that provide a rebate to GPs and can be used in the care of young people (i.e. Items 721, 723, 732, 729, see below)

Preparation of a GP Management Plan (GPMP) – 721

GPMPs involve the GP (who may be assisted by primary care nursing staff, Aboriginal health worker or other health professional) assesses the patient, agrees on management goals, identifies actions to be taken by the patient, identifies treatment and ongoing services to be provided, and documents these in the GP Management Plan. Recommended frequency is once every two years, supported by regular review every 6 months.

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/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 a GPMP and TCA – 732

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 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.

CHRONIC DISEASE ALLIED HEALTH SERVICES

Medicare benefits are available for certain services provided by eligible allied health professionals to treat people with chronic conditions and complex care needs who are being managed under certain Chronic Disease Management (CDM) MBS Items (above). The allied health services must be recommended in the patient's plan as part of the management of their chronic condition.

Eligible patients

Patients who have both a chronic medical condition and complex care needs, i.e. both a GP Management Plan (Item 721) or review (Item 732) and a Team Care Arrangement (Item 723 or review Item 732), or who are a permanent Commonwealth funded resident of an aged care facility managed under a Multidisciplinary Care Plan (Item 731) have access to the Allied Health Items under the Medicare Benefits Schedule.

Eligible Allied Health Service Providers

Allied health providers must be registered with Medicare Australia for the purpose of this initiative. Allied health services funded by other Commonwealth or State programs or provided to an admitted patient of a hospital are not eligible for Medicare rebates, except where a subsection 19(2) exemption has been granted. Patients can access up to 5 allied health services per calendar year for a service of at least 20 minutes

Allied Health Items (10950 – 10970)
These cover a range of services from allied health providers:

- 10950 Aboriginal Health Worker
- 10951 Diabetes Educator
- 10952 Audiologist
- 10953 Exercise Physiologist
- 10954 Dietitian
- 10956 Mental Health Worker
- 10958 Occupational Therapist
- 10960 Physiotherapist
- 10962 Podiatrist
- 10964 Chiropractor
- 10966 Osteopath
- 10968 Psychologist
- 10970 Speech Pathologist

CONSULTANT PHYSICIAN (CP) ITEMS – 132, 133

- This item (132) remunerates a Consultant Physician to whom the GP has referred a patient for a 45 minute consultation, initial assessment, and development of a treatment and management plan for the patient and provided to the referring GP.

Patients with at least 2 morbidities, including complex congenital, behavioural or developmental conditions, are eligible

- A second item (133) can be billed by the CP for a review consultation following a 132
- Where the patient is being managed under a GPMP and or TCA, the action taken by the CP should be used to augment the plans

CASE CONFERENCES - 735, 739, 743 AND 747, 750, 758

The case conferencing items are for GPs to organise and coordinate, or participate in, a meeting or discussion held to ensure that their patient's multidisciplinary care needs are met through a planned and coordinated approach. A case conferencing team includes a GP and at least two other contributing members, each of whom provides a different kind of care. Patients with a chronic or terminal medical condition and complex care needs requiring care or services from their usual GP and at least two other health or care providers are eligible for a case conference service.

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:

- Discuss a patient's history and identify the patient's multidisciplinary care needs
- Identify outcomes to be achieved by each team member
- Identify tasks that need to be undertaken to achieve these outcomes and allocate those tasks to members of the case conference team
- Assess whether previously identified outcomes (if any) have been achieved

When organising and coordinating a case conference, a GP must:

- Explain to the patient the nature of a multidisciplinary case conference, and ask the patient for their agreement to the conference taking place
- Record the patient's agreement to the conference
- Record the day on which the conference was held, and the times at which the conference started and ended
- Record the names of the participants
- Offer the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) a summary of the conference and provide this summary to other team members
- Discuss the outcomes of the conference with the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees)
- Record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient's medical records

When participating in a case conference, a GP must:

- Explain to the patient the nature of a multidisciplinary case conference, and ask the patient whether they agree to the medical practitioner's participation in the conference
- Record the patient's agreement to the medical practitioner's participation
- Record the day on which the conference was held, and the times at which the conference started and ended
- Record the names of the participants
- Record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient's medical records

ORGANISE & CO-ORDINATE		
15 - <20 min	20 < 40 min	> 40 min
735	739	743
PARTICIPATE		
15 - <20 min	20 < 40 min	> 40 min
747	750	758

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

Contact your local Area/Community Health Service or primary health network for information regarding local service providers who could participate in CDM Plans/Case Conferences.

MENTAL HEALTH TREATMENT-2700, 2701, 2712, 2713, 2715, 2717; ALLIED MENTAL HEALTH SERVICES 80000 – 80170

- These items define services for which Medicare rebates are payable where GPs undertake early intervention, assessment and management of patients with mental disorders. The GP Mental Health Treatment Plan items incorporate a model for best practice primary health treatment of patients with mental disorders, including patients with both chronic or non-chronic disorders, that comprises assess and plan; provide and/or refer for appropriate treatment and services; review and ongoing management as required.
- 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: ICD 10 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:

GP MENTAL HEALTH TREATMENT PLAN (GPMHTP) 2700, 2701, 2715, 2717

A rebate is paid upon completion of an assessment and preparation of a GP Mental Health Treatment Plan (GPMHTP). From November 2011 there are four GPMHTP MBS items. Access to each item depends on the duration of the GPMHTP and whether a GP has undertaken mental health skills training recognised through the General Practice Mental Health Standards Collaboration.

MENTAL HEALTH SKILLS TRAINING	20<40 MIN	>40 MIN
YES	2715	2717
NO	2700	2701

GPMHTP must include:

Assessment

- Recording the patient's agreement
- Relevant history (biological, psychological, social) including presenting complaint
- Conducting a mental state examination
- Assessing associated risk and any comorbidity
- Making a diagnosis and/or formulation
- Administering an outcome measurement tool, except where it is considered clinically inappropriate.

Preparation

- Discussing assessment with patient
- Identifying and discussing referral and treatment options with the patient, including support services
- Agreeing to goals and actions with the patient
- Provision of psycho-education
- A plan for crisis intervention and/ or for relapse prevention
- Making arrangements for required referrals, treatment, appropriate support services, review and follow-up
- Documentation in the GPMHTP

GP MENTAL HEALTH TREATMENT PLAN REVIEW – 2712

The review item is a key component for assessing and managing the patient's progress once a GPMHTP has been prepared. The recommended frequency for the review service, allowing for variation in patients' needs, is: an initial review, which should occur between four weeks to six months after the completion of a GPMHTP; and if required, a further review can occur three months after the first review. In general, most patients should not require more than two reviews in a 12 month period.

A review must include:

- Recording the patient's agreement for this service
- A review of the patient's progress against the goals outlined in the GPMHTP
- Modification of the documented GPMHTP if required
- Checking, reinforcing and expanding education
- A plan for crisis intervention and/or for relapse prevention, if appropriate and if not previously provided
- Re-administration of the outcome measurement tool used in the assessment stage, except where considered clinically inappropriate

GP MENTAL HEALTH TREATMENT CONSULTATION – 2713

- Consultations associated with this item must be at least 20 minutes duration
- Where the primary treating problem is related to a mental disorder, including for a patient being managed under a GPMHTP
- This item may be used for ongoing management of a patient with a mental disorder. This item should not be used for the development of a GPMHTP

A consultation must include:

- Taking relevant history and identifying the patient's presenting problem(s) (if not previously documented)
- Providing treatment, advice and/or referral for other services or treatment
- Documenting the outcomes of the consultation

A patient may be referred from a GP Mental Health Consultation for other treatment and services as per normal GP referral arrangements (this does not include referral for Medicare rebateable services for focused psychological strategy services, clinical psychology or other allied mental health services, unless the patient is being managed by the GP under a GPMHTP or under a referred psychiatrist assessment and management plan).

ALLIED MENTAL HEALTH SERVICES 80000 – 80170

MBS items are available to patients with a mental disorder (excluding dementia, delirium, tobacco use disorder, mental retardation) who have been referred by a medical practitioner managing the patient under a:

- GPMHTP
- Psychiatrist assessment and management plan; or
- On referral from a psychiatrist or paediatrician
- For up to a maximum of 10 individual and 10 group allied mental health services per calendar year. The 10 services may consist of psychological therapy (80000- 80015); and/or focused psychological strategies- allied mental health services (80100-80115, 80125-80140, 80150-80165) Group therapy services for 6-10 patients are accessible under items 80020 clinical psychologist; and for focused psychological strategies under the items 80120 psychologist 80145 occupational therapist 80170 social worker.

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 Treatment 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 RELEVANT MBS ITEMS AND MEDICARE INITIATIVES

MENTAL HEALTH NURSE INCENTIVE PROGRAM (MHNIP)

General practices currently participating in the Mental Health Nurse Incentive Program (MHNIP) may continue to attract funds from Medicare Australia or services from local primary health care organisations/Medicare Locals to support existing engagement of credentialed Mental Health Nurses under the MHNIP. Mental Health Nurses can assist with the provision of co-ordinated clinical care for people with severe mental health disorders.

A 2012 MHNIP evaluation conducted by the Federal Government resulted in future funding to the MHNIP to be maintained at current service levels while the program is redesigned in accordance with the findings of the review in collaboration with the sector. The 2014 budget maintained finding at the current level for MHNIP for the 2014-15 financial year.

Organisations that do not have an existing MHNIP session allocation are currently unable to receive payment for MHNIP sessions and can be placed on a MHNIP waiting list.

GENERAL HEALTH ASSESSMENT ITEMS

From 1 May 2010, the MBS Review of Medicare primary care items resulted in the reduction of ten health assessment items to four time-based items 701(brief), 703 (standard), 705 (long) and 707 (prolonged)

These health assessment items continue to apply to individual target groups and can be used in the care of young people who fall into the following categories:

- Permanent residents of residential aged care facilities;
- People with an intellectual disability; and
- Refugees and other humanitarian entrants.

Health Assessment Items

- Item 701—BRIEF to undertake SIMPLE health assessments < 30 mins
- Item 703—STANDARD to undertake STRAIGHTFORWARD health assessments >30 but < 45 mins
- Item 705—LONG to undertake EXTENSIVE health assessments >45 but < 60 mins
- Item 707—PROLONGED to undertake COMPLEX health assessments >60 mins

ABORIGINAL AND TORRES STRAIT ISLANDER (ATSI) HEALTH ASSESSMENTS

The Aboriginal and Torres Strait Islander (ATSI) Health Check items for children, adults and older people were merged into one MBS health assessment item 715. This health assessment item is available to all people of Aboriginal and/or Torres Strait Islander descent.

PRACTICE NURSE INCENTIVE PROGRAM

The Practice Nurse Incentive Program (PNIP) commenced on 1 January 2012 to provide incentive payments to practices to support an expanded and enhanced role for nurses working in general practice. The PNIP consolidates funding arrangements under

the Practice Incentive Program (PIP) Practice Nurse Incentive and six of the Medicare Benefits Schedule (MBS) practice nurse items (10993,10994, 10995, 10996, 10998, 10999) and redirects them into a single payment to eligible general practices.

To be eligible to participate in the PNIP, a practice must:

- Meet the RACGP definition of a 'general practice' as defined in the current RACGP Standards for general practices;
- Maintain full accreditation or be registered for accreditation against the RACGP Standards for general practices;
- Achieve full accreditation within 12 months of joining the PNIP and maintain full accreditation thereafter;
- Maintain current public liability insurance;
- Ensure that all practice GPs maintain current professional indemnity cover;
- Ensure that all practice nurses, Aboriginal Health Workers and allied health professionals (where applicable) are covered by appropriate professional indemnity insurance arrangements as required by the Australia Health Practitioner Regulation Agency or by the professional's registration board;
- Employ or otherwise retain the services of eligible practice nurses and/or Aboriginal Health Workers; and
- Employ or otherwise retain the services of a GP. This may include less than one full time GP

Follow up service provided by a Practice Nurse or registered Aboriginal Health Worker 10987

Follow up service to a maximum of 10 services per patient in a calendar year provided by a Practice Nurse or registered Aboriginal Health Worker, on behalf of a GP, for an Indigenous person who has received a health check (Item 715) if:

- The service is provided on behalf of and under the supervision of a medical practitioner; and
- The person is not an admitted patient of a hospital; and
- The service is consistent with the needs identified through the health assessment;

Chronic Disease Management Assistance 10997

Service provided to a maximum of 5 services per patient in a calendar year to a person with a chronic disease by a Practice Nurse or registered Aboriginal Health Worker if:

- The service is provided on behalf of and under the supervision of a medical practitioner; and
- The person is not an admitted patient of a hospital; and
- The person has a GP Management Plan (Item 721), Team Care Arrangements (Item 723) or Multidisciplinary Care Plan in place (Items 729, 731); and
- The service is consistent with the care plans as above.

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, where the service may be used to address any pregnancy related issues for which non-directive counselling is appropriate
- A maximum of 3 non-directive pregnancy support counselling services per patient, per pregnancy can be claimed using the following items:
  - 4001 – provided by a GP (consultation must last at least 20 minutes);
  - 81000 – provided by a psychologist (consultation must last at least 30 minutes);
  - 81005 – provided by a social worker; (consultation must last at least 30 minutes);
  - 81010 – provided by a mental health nurse (consultation must last at least 30 minutes).

HOME MEDICINES REVIEW (HMR) OR DOMICILIARY MEDICATION MANAGEMENT REVIEW (DMMR) – 900

Participation by a general practitioner in a Domiciliary Medication Management Review (DMMR) also known as Home Medicines Review (HMR) for patients living in the community setting, where the medical practitioner:

- Assesses a patient's medication management needs, and following that assessment, refers the patient to a community pharmacy or an accredited pharmacist for a DMMR, and provides relevant clinical information required for the review, with the patient's consent; and
- Discusses with the reviewing pharmacist the results of that review including suggested medication management strategies; and
- Develops a written medication management plan following discussion with the patient.
- Benefits under this item are payable not more than once in each 12 month period, except where there has been a significant change in the patient's condition or medication regimen requiring a new DMMR.

BETTER START FOR CHILDREN WITH DISABILITY INITIATIVE

The Better Start Medicare items are early intervention services that have strict age and disability based criteria. A GP, specialist or consultant physician can refer a child to an eligible allied health provider to assist with diagnosis of the child or for the purpose of contributing to the child's disability treatment and management plan.

Medicare items are available for assessment, diagnosis and the creation of a treatment and management plan by a general practitioner (MBS item 139) or specialist or consultant physician for a child aged under 13 years.

They can be applied for any of the following conditions:

- Sight impairment that results in vision of less than or equal to 6/18 vision or equivalent field loss in the better eye, with correction.
- Hearing impairment that results in:
  - A hearing loss of 40 decibels or greater in the better ear, across 4 frequencies; or
  - Permanent conductive hearing loss and auditory neuropathy.
- Deafblindness
- Cerebral palsy
- Down syndrome
- Fragile X syndrome
- Prader-Willi syndrome
- Williams syndrome
- Angelman syndrome
- Kabuki syndrome
- Smith-Magenis syndrome
- CHARGE syndrome
- Cri du Chat syndrome
- Cornelia de Lange syndrome
- Microcephaly if a child has:
  - A head circumference less than the third percentile for age and sex; and
  - A functional level at or below 2 standard deviations below the mean for age on a standard developmental test, or an IQ score of less than 70 on a standardised test of intelligence.
- Rett's disorder

Children with an eligible disability can be referred by a GP, specialist or consultant physician for the following allied health services:

- Up to four diagnostic/assessment services from psychologists, speech pathologists, occupational therapists, audiologists, optometrists, orthoptists or physiotherapists to assist the referring practitioner with diagnosis or to contribute to a child's treatment and management plan (for a child under 13 years of age).
- Up to twenty treatment services from psychologists, speech pathologists, occupational therapists, audiologists, optometrists, orthoptists or physiotherapists (for a child under 15 years of age, providing a treatment and management plan is in place before their 13th birthday).

THE CHILD DENTAL BENEFITS SCHEDULE

The Child Dental Benefits Schedule (CDBS) commenced on 1 January 2014 to replace the Medicare Teen Dental Plan and provides access to benefits for basic dental services (including; dental examinations, x-rays, cleaning, fissure sealing, fillings, root canals and extractions orthodontic or cosmetic dental work) to children and adolescents aged 2-17 years in a non-hospital setting.

The total benefit entitlement is capped at $1,000 per child over a two calendar year period. The CDBS has a means test, which requires receipt of Family Tax Benefit Part A (FTB-A) or a relevant Australian Government payment.

OUT OF HOME CARE IN NSW

In NSW guidelines exist for the health assessment of young people in out of home care (OOHC). They reflect NSW Health's approach to the implementation of the National Clinical Assessment Framework for Children and Young People in OOHC (2011). They can be found at the following link: http://www0.health.nsw.gov.au/policies/gl/2013/GL2013_010.html

There are a large number of MBS items that are appropriate to the care provided to young people in OOHC. Care includes primary health assessment, comprehensive health assessment, development of a Health Management Plan and ongoing monitoring, assessment and care. MBS items are listed at: http://health.gov.au/internet/publications/publishing.nsf/Content/ncaf-cyp-oohc-toc~ncaf-cyp-oohc-appc.

NOTE:

This chapter highlights a number of key Commonwealth initiatives and incentives 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 to government policy. 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.

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 with inhalers during periods of exacerbation. Eve's mother is 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 instead been attending parties with a much older peer group from work. Her mother wants her to quit her job 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 a psychologist from the local headspace actioned
- You record MBS item numbers: 23 and GPMHTP 2715and 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 Chrohn'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 the pregnancy and you refer her to the local 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 Chrohn'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 work with her on her on-going health goals
- 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

Commonwealth Department of Health and Ageing (2014). *MBS Online Medicare Benefits Schedule*. URL: http://www9.health.gov.au/mbs/search.cfm?pdf=yes [Retrieved 12 April – 12 May 2014]

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