Client services through Medicare

Opportunities and considerations for community health services

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Foreword

Victoria's health system is facing an increasing demand for service. Both the Commonwealth and state governments are developing new strategies and funding mechanisms that aim to meet these demands by strengthening community-based models of care with a particular focus on prevention, early intervention for those diagnosed with a chronic illness, and intensive coordinated care for those with complex care needs.

The Commonwealth government has significantly expanded the breadth of the Medicare Benefits Schedule to resource models of care that help meet these emerging health care needs. These reforms, which include the introduction of Medicare rebates for services provided by a wider range of health service providers including allied health providers and counsellors, present exciting opportunities for community health services and other services in Victoria.

Community health services are well placed to provide leadership in partnership approaches to meet the emerging health needs of local communities. Some have already explored the opportunities and challenges available through the recent reforms to Medicare, and their learnings are incorporated into this paper.

I encourage all community health services and other services to explore the opportunities associated with reforms to the Medicare Benefits Schedule with a view to enhancing client-centred services.

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Greater Dandenong Community Health Service

Hepburn Health Service

Inner East Community Health Service

Western District Health Service

Whitehorse Community Health Service

Wimmera Health Care Group

Contents

Figures

Tables

Key messages

The need for integration

The case for integrated models of care is now stronger than ever, with state and Commonwealth governments having similar priorities for health. Models supporting effective chronic disease care are of particular relevance to the community health sector, because:

- community health clients commonly have chronic disease, complex care needs and/or mental health conditions
- state and Commonwealth governments have identified chronic disease management and mental health as high priorities.
- Research demonstrates that when general practice works in collaboration with specialists and multidisciplinary teams, the quality of care for a number of mild to moderate chronic diseases can be improved, and there is greater capacity for the continuity and breadth of care required to manage multiple and chronic conditions[1].

Additional Medicare item numbers

Additional Medicare item numbers have been introduced over the past decade to support new models of care that focus on client needs. The new items:

- encourage a multidisciplinary approach to health care provision
- provide a catalyst for strengthening partnerships with general practice and other public and private primary health providers through primary care partnerships involving divisions of general practice that have expertise in general practice engagement
- provide impetus for agencies to reconfigure their services to increase client access to services, and to maximise care options.

New models of care

Work by community health services to implement new models of care that involve general practice and incorporate appropriate Medicare item numbers can enhance client access to public and private services. However, it is important to be aware that:

- the implementation of new multidisciplinary models of care that incorporate Medicare Benefits Schedule (MBS) funded services is relevant to all community health services, whether or not they manage medical clinics
- models adopted should not result in a reduction of state-funded public allied health services
- community health services need to seek legal advice to ensure that any new service models are compliant with s19(2) of the *Health Insurance Act 1973 (Commonwealth)*[2] and with other legislation
- services funded through Medicare schedules are in addition to services funded by Primary Health Branch of the Department of Human Services. If an agency is recording a Medicare-funded service in the client management software, the funding source should be recorded as 'MBS-funded service'. As the funding source is different, Medicare-funded services should not be included by community health services as part of their reporting about Primary Health Branch–funded activities.

Community health services, in collaboration with other providers and with clients, should determine which models best suit their clients. These decisions should be based on:

- local analysis of client characteristics and needs
- the prevalence of chronic disease in the community
- the availability of local services and providers with whom models of care can be built
- the likely future impact on client services, the local workforce, and demand management strategies.

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1 Harris MF and Zwar NA, 'Care for patients with chronic disease: The challenge for general practice', *MJA*, 2007, vol. 187, no. 2, pp. 104–107.

2 Available at http://www.austlii.edu.au/au/legis/cth/consol_act/hia1973164/s19.html

1 Introduction

1.1 Rationale and scope

Medicare Benefits Schedule (MBS) item numbers have the potential to lead to more integrated local approaches to health care provision by providing remuneration for GPs, practice nurses and allied health professionals to work together.

The *Victorian community health services – creating a healthier Victoria* policy[3], released in September 2004, sets out the vision for community health services as a key service platform for the management of chronic disease and the delivery of early intervention services and integrated health promotion activities within the broader Victorian health system. The policy also articulates the important role of community health in enhancing client access to general practice. The addition of a range of new MBS item numbers presents opportunities for *all* community health services to closely analyse how they could work to enhance the range of services available to clients through these new funding streams.

This paper:

- provides information about Medicare, including reform to the MBS over the past decade
- assists community health services to determine whether or not new Medicare item numbers present them with opportunities to enhance client access to necessary services, and to plan new service models that incorporate Medicare-funded services
- provides case studies involving community health services that have already undertaken this work
- directs community health services that manage general practice clinics to resources that will help them explore the factors that contribute to financial viability.

Recognising that every community health service has a unique client base, philosophy and methods of providing services, this paper is not able to and does not provide examples of models that apply in all geographical areas, legal advice, detailed costings or staffing mixes associated with particular service models.

1.2 Policy context

This paper has been developed in line with relevant state policies and program initiatives including:

- *A Fairer Victoria*
- *Care in your community: a planning framework for integrated ambulatory health care*
- *Community health services – creating a healthier Victoria*
- *Working with general practice: Department of Human Services position statement and resource guide*
- *Primary care partnerships strategy*
- *Early intervention in chronic disease*
- *Towards a demand management strategy for community health services*
- *Metropolitan health strategy*
- *Rural directions for a better state of health*.

A Fairer Victoria is available at www.dvc.vic.gov.au and other policy and program initiatives are available on the department's website: www.health.vic.gov.au

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3 Department of Human Services, *Community health services – creating a healthier Victoria,* Department of Human Services, Melbourne, 2004.

2 General practice in Victoria

Eighty per cent[4] of Victorians visited one or more GPs in 2005–06. The Department of Human Services is committed to exploring strategies that will strengthen partnerships between state-funded services and general practice, and to providing support to general practice clinics within or collocated with state-funded services.

State-funded services looking to work with general practice or to enhance client services through the MBS are encouraged to read the *Working with General practice: Department of Human Services position statement* and accompanying *Resource guide*[5]. These resources provide detailed information about general practice and divisions of general practice, outline the common drivers for collaboration between general practice and state-funded services, and provide a range of case studies that demonstrate tangible benefits through collaboration at the local level.

4 Medicare Australia, *Annual Report 2005–06,* www.medicareaustralia.gov.au/about/governance/reports/05-06

5 Department of Human Services. *Working with general practice: Department of Human Services position statement* and *Resource guide*, Department of Human Services, Melbourne, 2007, www.health.vic.gov.au/communityhealth/gps/position_statement.htm

3 The Medicare benefits system

3.1 Introduction

The Medicare system was introduced by the Commonwealth in 1984 to provide eligible Australian residents with affordable, accessible and high quality health care. The Commonwealth regularly publishes a list of professional services for which eligible Australian residents can claim a Commonwealth-funded benefit payment under Medicare[6]. Each service is associated with a particular 'item number' which can be claimed against for payment for delivery of the service, provided that the business rules associated with each individual item number are followed. The services, matched with item numbers and associated business rules, are listed in four 'schedules':

- Medicare Benefits Schedule (MBS) – includes benefits for services provided by GPs, and by practice nurses on behalf of GPs
- Allied Health Services Schedule – includes benefits for services provided by a range of allied and mental health professionals
- Optometrical Schedule
- Cleft Lip and Cleft Palate Schedule.

Use of the term 'Medicare Benefits Schedule'

'Medicare Benefits Schedule' is commonly used in the health sector as a collective term to describe all four schedules above. This paper refers to services listed in the Medicare Benefits Schedule and the Allied Health Services Schedule, but uses the term 'Medicare Benefits Schedule' or 'MBS' as a collective term.

Since the introduction of Medicare, a number of Medicare item numbers have been commonly used by GPs to help fund general practice services; namely, items 3, 23, 36 and 44. These item numbers, often referred to as 'standard consultation item numbers', provide remuneration for services provided through general practice, such as taking a client history, examining the client, treating the client, formulating and implementing a treatment plan, and facilitating and analysing further investigations through referral to diagnostic services.

The Commonwealth reviews the types of services it will fund through Medicare annually and releases updated schedules every 1 November. These new schedules may include, for example, new item numbers or amended business rules for existing item numbers. New items are also sometimes introduced at other times[7].

6 These are often referred to as items in the Schedule, with each item assigned a reference number, or 'item number'

7 Medicare Australia lists recent updates, and the dates of future updates, at www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Medicare-Benefits-Schedule-faq

Medicare – some handy hints

While each item number has rules that must be followed in order to claim for the item, there are also some basic ground rules that must be followed when using the Medicare system.

Provider registration

In order to be eligible to provide services that attract a Medicare benefit, a provider must be registered with Medicare Australia. Registration forms are available at the Medicare Australia website at: www.medicareaustralia.gov.au or on request from Medicare Australia on **132 150**.

Client consent

Before a service that attracts a Medicare rebate is commenced, it is a Medicare requirement (and good practice) that the client, or the client and their carer, be given an explanation of the process and its likely benefits, and asked whether they consent to the service being provided. Consent must be noted on the client's medical record.

Use of a practice nurse

It is common for general practices to use the skills of a nurse to assist in completing services that enable an MBS item to be claimed. According to common Medicare rules, this assistance should take place on behalf of, and under the supervision of, a medical practitioner. In almost all cases, where appropriately skilled, a nurse can assist in identifying client need, aspects of client assessment, making arrangements for services, client advocacy through the broader service system, and managing or assisting another team member to manage the client recall and reminder system.

Nurses working in other organisations or as independent consultants can also assist GPs in this way. Often in circumstances such as these, the nurse or their employer enters into a written agreement with the GP about how the service is to be performed and how the nurse is to be remunerated (for example, 70 per cent of the bulk-billed MBS revenue). Such arrangements could be negotiated between an employee nurse of a community health service and a private general practice, for example, to enhance access to medical services for disadvantaged members of the community.

Checking if an MBS service has been delivered previously

Many of the new MBS items can only be used once within a certain time period, or once in a client's lifetime. Some community health services with general practice clinics have reported that often the client is not able to accurately recall whether a particular MBS service (such as a GP Management Plan or allied health) has been delivered by another provider. Medicare Australia may refuse to provide a rebate for a service on the grounds that the service has already been delivered elsewhere and the client is no longer eligible for a rebate.

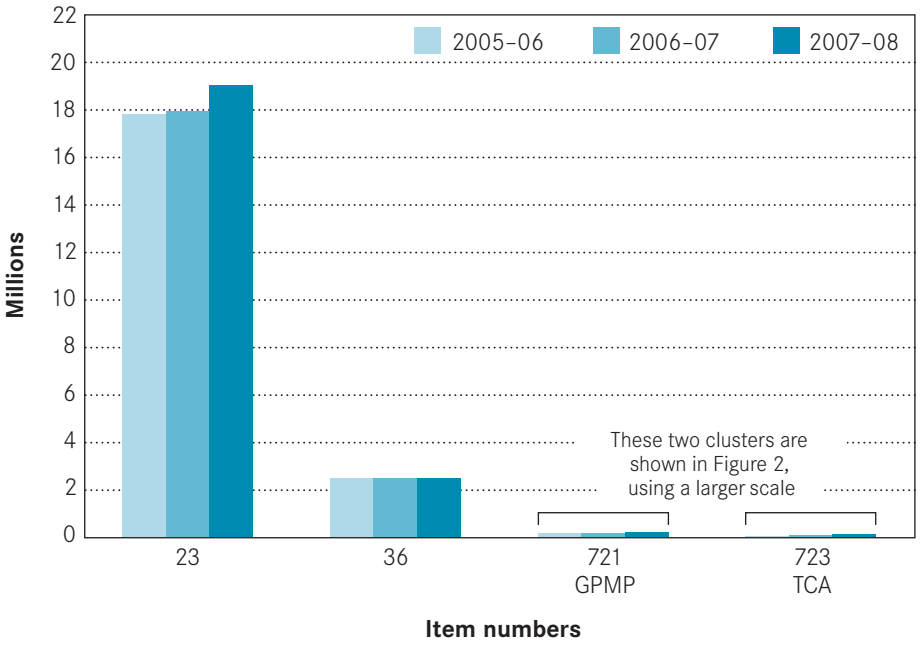
Where it is unclear whether the client has received a particular service, the provider can ring the **Medicare Enquiry Line 13 2011** to verify the date of the payment of a particular item (if any) while the patient (or their representative) is present. Medicare requires patient consent for this information to be released. The patient (or their representative) will also need to provide their Medicare number. The provider can ask Medicare whether a singular item or an item in a particular range (for example, items 721 – 729 for GP care plans) has been paid previously and, if so, when. If a patient is being represented, the representative must have Power of Attorney and must have previously lodged this with Medicare Australia.

3.2 Reforms to the MBS since 1999

New primary health item numbers began to be introduced to the MBS in 1999 under a Commonwealth initiative called the Enhanced Primary Care (EPC) program. The stated aim of this program was to enable GPs and allied primary health care teams to 'provide more preventive care for older Australians and improve coordination of care for people with chronic conditions and complex care needs'[8]. Other items have been progressively added – the number of primary care Medicare item numbers has more than tripled in this time from 66 to 247[9].

Use of the standard consultation item numbers still vastly outnumbers the use of newer item numbers, as shown graphically below. However, use of the newer items is growing strongly. For example, from 2005–06 to 2007–08, claims for items 23 (level 'B' standard consultation) and 36 (level 'C' standard consultation) grew by 7.69% and 1.59% respectively, while claims for GP-led care planning items 721 and 723 grew by 36.74% and 135.43% respectively and reviews of care plan items 725 and 727 grew by 250%.

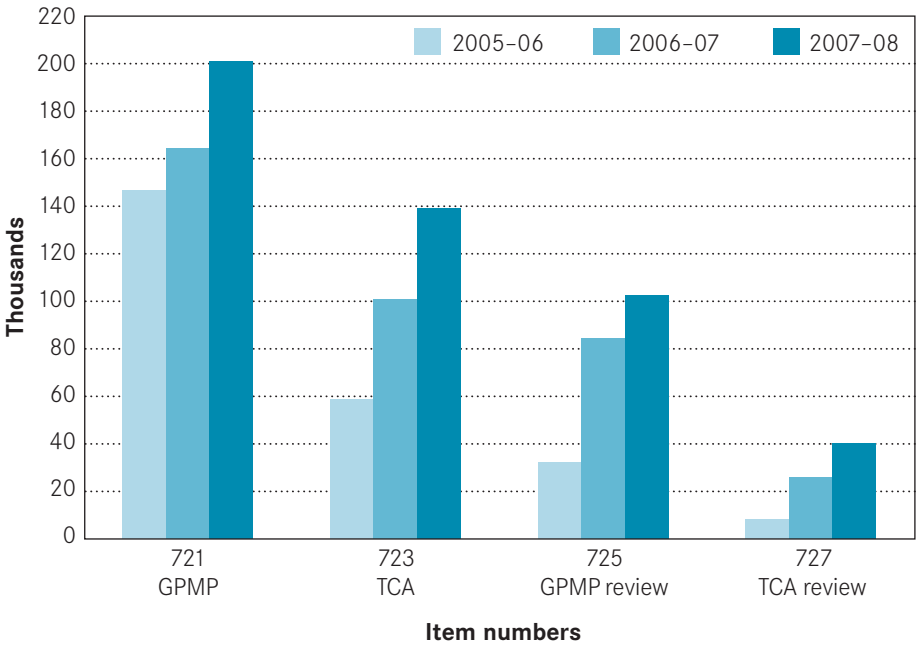
Figure 1: Number of standard consultation MBS item claims in Victoria, 2005–06 to 2007–08



8 See 'Enhanced Primary Care Program', www.health.gov.au/internet/main/publishing.nsf/Content/Enhanced+Primary+Care+Program-1

9 www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr08-nr-nr178.htm

Figure 2: Number of care planning MBS item number claims in Victoria, 2005–06 to 2007–08



Note that the scale in Figure 2 is 100 times greater than in Figure 1 (a range of 220,00 in the y-axis for Figure 2 compared to 22 million for Figure 1).

Medicare rebates are now available for services provided by a broader range of providers in the community setting including a range of allied health providers. These include:

- Aboriginal health workers
- diabetes educators
- audiologists
- exercise physiologists
- dieticians
- psychologists
- paediatricians
- mental health nurses
- occupational therapists
- social workers
- physiotherapists
- podiatrists
- chiropractors
- osteopaths
- speech pathologists.

3.3 More information about the reforms

To assist state-funded services to understand the newer MBS item numbers, Primary Health Branch has categorised the newer MBS item numbers into eight categories:

- health assessments
- prevention
- care planning and case conferencing
- allied and dental health
- better access to mental health
- service incentive payments
- quality use of medicines
- bulk-billing incentives

Summary information about MBS item numbers within these categories and their business rules is provided in the document *Summary of new Medicare Benefits Schedule (MBS) item numbers: general practice and allied health* which is available online at www.health.vic.gov.au/communityhealth/gps/mbs.htm.

Full descriptions of the items, including full business rules for each item, are available in the Medicare Benefits Schedule book. The book can be:

- viewed in its entirety online at www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Medicare-Benefits-Schedule-MBS-1
- viewed by searching for individual item numbers at www9.health.gov.au/mbs/search.cfm
- ordered in hard copy format at www.health.gov.au/internet/mbsonline/publishing.nsf/Content/print-on-demand

Use of the term 'EPC' (Enhanced Primary Care)

The terms 'EPC' and 'EPC care plan' are used in different ways and contexts by different people. EPC properly only refers to the health assessment, health check, care planning, case conferencing, quality use of medicines and allied health MBS item numbers[10].

You may hear that clients being managed under an EPC care plan are eligible for the MBS-funded allied health services. This is correct, and in this context the term EPC care plan refers to circumstances in which a GP has billed the following MBS items for a client within the previous two years:

(a) GP Management Plan – item 721 (or review item 725)

and

(b) Team Care Arrangements – item 723 (or review item 727).

These EPC care plans are also sometimes known as GP-led care plans.

Clients who are permanent residents of an aged care facility can also be said to be managed under an EPC care plan if their GP has contributed to or reviewed a multidisciplinary care plan prepared for them by the aged care facility (item 731).

[10] See www.health.gov.au/epc

4 The MBS and community health services

4.1 Introduction

Community health services have been working with general practices and individual GPs for many years to enhance client access to medical services. Some have directly employed GPs; some have rented rooms to privately practising GPs; some have worked closely with GPs in other organisations or in private practice in the community; and some have colocated with an existing general practice.

Community health staff knowledge of Medicare is important and varies from person to person and from agency to agency depending on experience working with the Medicare system. The importance of enhancing staff knowledge of the MBS is discussed in section 5 Making it happen.

4.2 Opportunities for community health

There are three key opportunities for community health services in response to reforms of the MBS. The first two are relevant to all services; the third is only relevant to services that are managing general practice clinics.

1 Delivering or facilitating new kinds of health services

The broadening of the availability of MBS rebates for specific services by specific providers means that community health services may be able to offer new services where client need is apparent. An example would be a community health service that is not able to attract an additional podiatrist deciding to work with a local podiatrist in private practice to provide additional services to community health clients.

2 Delivery of more services

Community health services may identify opportunities to complement the delivery of existing state-funded services by using MBS funding streams. An example would be a community health service offering existing salaried providers the opportunity to work additional sessions as private providers in a community health setting.

3 Enhancing the viability of general practices managed by community health services

Many of the new MBS item numbers provide a higher level of remuneration than the standard consultation MBS item numbers. Therefore, any focus on improving the viability of general practices managed by community health services would benefit from an analysis of the mix of MBS items being claimed by the practice. A detailed look at these issues and the other factors affecting the viability of community health-based general practices can be found in the Department of Human Services publication *Guide to developing an optimal business model for general practice in community health*[11].

[11] Available at www.health.vic.gov.au/communityhealth/gps/index.htm

4.3 Service model options

There are four key factors that must be considered when preparing a service model attracting MBS benefits:

- **Location:** whether services are provided within **or** outside community health
- **Provider recruitment:** whether providers are recruited from within **or** outside community health
- **MBS revenue flow:** whether the provider keeps the MBS revenue for themselves as remuneration (and may use a proportion of this to pay for services provided by community health eg: room rental, equipment) or the provider donates 100% of the MBS revenue to community health and is remunerated through other means.
- **Management of the provider and billing:** the extent to which community health manages the provider and manages billing processes, both with clients and with Medicare Australia.

These are represented diagrammatically in Figure 3:

Figure 3: Factors to consider for a service model, and the range of possible approaches

Factor	Possible approaches		
Location	Services provided from CHS	**OR**	Services provided outside CHS
Provider recruitment	Recruited from within CHS	**OR**	Recruited from outside CHS
MBS revenue flow	← Provider keeps MBS revenue		Provider donates MBS to CHS and receives remuneration from CHS →
Management of the provider and billing	← Managed by CHS		Provider self-manages →

Decisions made about each of these four factors will determine the look of the service model. For example, when considering location and provider recruitment, there are three key questions:

1. Where do clients currently go to access their other health services?
2. Where are the practitioners currently practising – do they need to be relocated or can the community health service work with them where they are? Does community health need to recruit?
3. Is there enough space? If not, can community health use consulting rooms after hours or is a new location desirable, or should community health look to partner with private providers in their own (private) settings?

To provide additional services to clients who are already attending a specific community health site, it makes sense to deliver the services from that site. However, this is not always possible; for example, it may not be possible to attract private providers into community health due to workforce shortages, or existing salaried staff may not wish to work additional hours as a private practitioner. In some circumstances it may be more practical to partner with existing private providers and refer clients directly to those providers in their settings.

Here are some examples of models:

(a) Rooms for rent'

A community health service offers rooms for rent to a provider to provide MBS-funded services for clients as a private provider. This provider is recruited from outside community health, and has little knowledge of community health at the time of recruitment. In negotiation with the provider, it is agreed that the provider will attract and keep the MBS payment, and then out of their profit will pay community health an amount to cover rent and other costs including administrative support, consumables and utilities. In this model, the provider manages their own billing, agrees to bulk bill all pensioners and concession card holders, and agrees to work on a system to integrate their client notes with the community health service's filing system. They also agree to attend staff meetings and to abide by the policies and procedures manual for community health staff.

(b) Extending the hours of existing salaried practitioners

A community health service offers existing salaried practitioners the opportunity to work additional sessions as private (non-salaried) providers within the community health setting, either after hours or on Friday afternoon as there is a room spare at that time. Two practitioners express an interest to work on the Friday, and agree on times for shifts. They register with Medicare. The community health service works to promote the 'private' sessions to the two local GP practices in partnership with the division, and administrative staff in community health agree to manage the bookings from the GPs for these sessions and to manage the billing with Medicare and the clients.

(c) Contracting new private providers

A community health service contracts with a private provider to work for community health. The private provider attracts the MBS income, but donates 100 per cent of this income to the community health service (keeping none for themselves) and is paid from a separate income stream from within community health. The community health service undertakes the management of the billing.

(d) Linking clients to MBS-funded services provided externally

A community health service in a rural area surveys staff and discovers that most staff are already speaking with clients about how to gain access to Medicare services on referral from their usual GP in the town. It is discovered that some staff do not have a strong knowledge of the MBS, so the local division of general practice is asked to provide additional training to community health staff. It is also agreed with the division that the local GPs should be contacted to discuss the types of clients within community health that could be referred back to their GPs for the provision of MBS-funded services, and how this should occur. Once this is done, the community health service begins to proactively identify clients from their client management software who could be referred to their GPs for additional MBS services.

5 Making it happen

Community health services should consider each of the aspects listed below when looking at opportunities through the MBS. These have been identified as important by community health managers and practitioners who are already well progressed in this work, and through agencies' reports to the department for specific projects such as those funded through the *GPs in Community Health Services Strategy 2004–08*.

5.1 Executive support

Opportunities to use MBS funding streams should be guided in the first instance by the strategic directions of community health services that have been established by their boards and executive management. With reference to these directions, management will need to:

- identify the kinds of health services the target population most needs
- understand which specific services may be funded through the MBS item numbers for their target population (the MBS flipchart *Summary of new Medicare Benefits Schedule (MBS) item numbers: general practice and allied health*[12] may assist)
- match the need with the opportunities through the MBS.

Obtaining board support for any new service model is important, so looking at the strategic directions already set by the board is a good place to begin.

5.2 Analysis of client mix and MBS-funded services

The types of clients eligible for MBS rebates through community-based general practice and allied health services include:

- clients aged 75 years and over (health assessment items)
- Aboriginal and Torres Strait Islander clients (health assessment items):
  - 0–14 years
  - 15–55 years
  - 55+ years
- clients who are refugees or other humanitarian entrants (health assessment items)
- clients with an intellectual disability (health assessment items)
- clients aged 45–49 years inclusive (prevention items)
- clients aged 40-49 years inclusive who are at risk of developing type 2 diabetes mellitus (prevention items)
- clients requiring an immunisation service or a Pap test (prevention items)
- clients with a chronic disease or chronic diseases (care planning, case conferencing items):
  - clients are differentiated by those with a chronic disease only, and those with a chronic disease and complex care needs[13] (those with complex care needs are also eligible for allied health items)

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12 www.health.vic.gov.au/communityhealth/gps/mbs.htm

13 Complex care needs means:
- little or no capacity to access or receive needed services by the usual referral process
- an unstable or deteriorating condition and/or co-morbidities
- increasing frailty and/or dependence
- increasing incidence and/or complexity of health problems
- complications, including falls or incontinence
- significant change in social circumstances (e.g. death, illness or 'burnout' of carer)
- two or more hospital admissions for their chronic condition in the past six months
- inability to comply with required treatment without ongoing management and coordination
- a need to see other providers on regular, frequent and ongoing basis to manage the chronic condition (as distinct from one or two visits for one specific treatment).

  - clients whose dental health is exacerbating their chronic disease (these clients are also eligible for MBS dental items at the time of printing)
- clients with a 'mental disorder'[14] (mental health items)
- clients with type 2 diabetes (additional allied health group services items)
- for the purposes of a Home Medicines Review, all clients:
  - currently taking five or more regular medications
  - taking more than 12 doses of medication per day
  - with significant changes to their medication regimen in the last three months, including recent discharge from hospital
  - taking medication with a narrow therapeutic index or required therapeutic monitoring
  - with symptoms suggestive of an adverse drug reaction
  - having difficulty managing their own medicines because of literacy or language difficulties, or impaired sight
  - attending a number of different doctors, including both GPs and specialists.

The specific items applicable to these categories of clients can be found by looking at the 'client eligibility' rows in the tabs of the MBS flipchart *Summary of new Medicare Benefits Schedule (MBS) item numbers: general practice and allied health*[15].

For CHSs that offer general practice services, new data extraction and analysis tools, such as the Pen Clinical Audit Tool, the Practice Health Atlas and the Canning Tool, can assist in identifying clients who may benefit from services funded specifically through the MBS. These tools are often available through divisions of general practice. Most general practice clinical software programs can also categorise clients, based on their demographics or medication profiles.

5.3 Analysing potential service models

Once the kinds of services that could be funded through the MBS for clients have been established, the next step to consider is how best to construct a service model (see 4.3 above and case studies in 6.1 below).

When considering the four examples of service models listed in section 4.3, agencies should determine, in collaboration with other providers and with the input of clients, which models are likely to be best suited to their clients. These decisions may be based on:

- a local analysis of client characteristics and needs
- the prevalence of chronic disease
- the availability of local services and providers with whom models of care can be built
- the likely future impact on client services, the local workforce, and demand management strategies.

[14] **Includes** chronic psychotic disorders, acute psychotic disorders, schizophrenia, bipolar disorder, phobic disorders, generalised anxiety disorder, adjustment disorder, unexplained somatic complaints, depression, sexual disorders, conduct disorder, bereavement disorders, post traumatic stress disorder, eating disorders, panic disorder, alcohol use disorders, drug use disorders, mixed anxiety and depression, dissociative (conversion) disorder, neurasthenia, sleep problems, hyperkinetic (attention deficit) disorder, enuresis (non-organic), obsessive compulsive disorder, mental disorder, not otherwise specified. **Does not include** dementia, delirium, tobacco use disorder or mental retardation.

[15] www.health.vic.gov.au/communityhealth/gps/mbs.htm

5.4 Developing collaborative relationships

Developing collaborative working relationships with other providers is essential for all community health services; however, this is particularly the case when establishing models of care that involve a mix of Commonwealth and state funding streams. Divisions of general practice can be helpful in connecting with local GPs and other general practice staff, and can be engaged through primary care partnerships.

The historical context for organisations may present opportunities or challenges. For example, state-funded and Commonwealth-funded (or private) services may have no relationship, or even a poor relationship and early work may need to focus on addressing this. It is important in these circumstances to work to overcome these challenges, keeping in mind that failure to do so may adversely affect clients' access to services.

A first step may be a session where local health providers are introduced to each other. At this session clinicians can begin a dialogue to become more aware of each others' discipline and identify opportunities to improve patients' experiences and outcomes. Many community health services have reported that this is a very important step, and that it cannot be taken for granted that health service providers understand what services other providers actually offer (for example, some GPs may not know that a podiatrist can provide a suite of preventive services for a client newly diagnosed with diabetes). Divisions of general practice may help local service providers meet each other and construct new service models through their funded Australian Better Health Inititiave – Primary Care Integration Program (ABHI-PCIP) programs.

Community health services can partner with private providers either in an organisational sense (where all private providers in a particular organisation agree to work with community health in a particular way for particular clients), or on an individual-by-individual basis. Where organisational partnership work is difficult, partnering with individual private providers can provide opportunities for those providers to champion their work with colleagues.

Formalised agreements with either organisations or individual practitioners need to clearly articulate arrangements and processes that pertain to client eligibility for service, service coordination, privacy of and access to client records, and clinical governance. Community health services should refer to information from the Australian Competition and Consumer Commission in regard to agreements about fees[16].

16 www.accc.gov.au/content/index.phtml/itemId/575117

5.5 Governance associated with creation of new service models

Change will always present challenges for health services and there are many factors to consider when looking to use MBS items.

Some community health services have found the establishment of a inter-agency project reference group has been helpful to support implementation, as the various challenges can be worked through inclusively and collaboratively. The group can include a mix of both managers and health service providers.

Careful consideration also needs to be given to the establishment of internal working groups within organisations, so that the various challenges (highlighted below) can be addressed inclusively.

5.6 Understanding the MBS

Understanding the MBS is obviously important yet challenging due to both its breadth and its constant evolution. The MBS is very complex at both the macro level (how the system works) and the micro level (the business rules of individual item numbers). Executive and staff knowledge of the MBS may not be sufficient in order to either employ MBS-funded practitioners or to work successfully in partnership with them.

For example, a recent small survey of the staff of a community health service found that 60 per cent of the staff stated they had some knowledge of the MBS, 30 per cent felt they had no knowledge, and only 10 per cent felt they were well informed. However, each of these staff was advising at least five clients a month to discuss services funded through the MBS with their GP.

Staff of divisions of general practice often have expert understanding of the MBS and can provide or facilitate guidance and training on request, particularly when community health services are looking to enhance engagement with GPs. Division staff funded through the ABHI-PCIP may be an ideal first contact point for community health staff looking for guidance.

The Primary Health Branch has also provided information and support through the MBS project. For example, the Department of Human Services' MBS flipchart summarises the business rules of key MBS item numbers that fund multidisciplinary care and provides some guidance in how the items work in practice. Hard copies of this flipchart were sent to every community health service in Victoria in September 2008 and it is also online in a printable format at www.health.vic.gov.au/communityhealth/downloads/mbs/all_mbs_attachments_for_printing%20.pdf

5.7 Complementing existing services and strategies

Opportunities through the MBS should not be considered in isolation to other service development and quality improvement activities in community health. Indeed, the MBS may be an important driver of reform in other strategic areas. For example, understanding the MBS will help community health service practitioners effectively communicate with clients about how they can access services in the private setting, should this be deemed appropriate. This could also contribute to demand management strategies. It will also help agencies looking to establish systems to enhance the referral of clients from private providers to Early Intervention in Chronic Disease in Community Health (EliCD) services. When communicating with general practices about how to refer to EliCD services, advising practitioners that they could refer patients through a GP care plan and how to do this demonstrates an understanding of general practice processes and financing that is likely to be engaging.

5.8 Capital requirements

A lack of space or equipment may present a barrier for some organisations looking to offer additional, MBS-funded services. Where an organisation faces capacity constraints, they may wish to investigate opportunities to have MBS-funded services delivered from other organisations that they can refer clients to. Or, they could deliver services out-of-hours, when existing rooms are not used, if clients are able to come during these times.

5.9 Legal issues

Community health services considering negotiating service agreements with private Medicare-registered providers who are going to operate from within community health should seek to understand, and comply with, the relevant requirements of the MBS, the *Health Insurance Act 1973 (Commonwealth)*[17] and any other information issued by Medicare Australia.

Agencies looking to deliver MBS-funded services should seek their own legal, financial and industrial advice on the impact of particular models.

5.10 Human resources issues

5.10.1 Workforce

Finding the workforce to progress new models of care is often a challenge, particularly in rural and outer urban areas. In response to this shortage, some agencies have decided not to recruit additional providers but to focus on working with private providers already operating in the community. Other agencies have asked existing salaried staff if they would be willing to work additional hours in a private capacity from within community health. Others have invited private practitioners already operating in the community to set up practice within community health or have placed community health providers in private practice; and others have decided to focus on recruitment.

For agencies looking to recruit additional staff to their region, there is no single solution to the workforce challenges in any particular region. However, there is research available that outlines the factors that are most likely to lead to the recruitment and retention of additional practitioners[18].

5.10.2 Practice management, practice nursing and medical receptionists

Community health services that have implemented new models have found that a strong enabler was employing or working closely with dedicated general practice managers, nurses and receptionists who have experience in the private general practice sector and/or have established working relationships with the local division of general practice.

Though the skills of every practice manager will vary, experienced and qualified practice managers are likely to have a good understanding and working knowledge of the MBS; expertise in managing billing and accounting systems including software systems related to determining client eligibility for MBS services and processing MBS payments; and collegial relationships with other practice managers.

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[17] An example of an unequivocal breach of the Act would be if an employee of a community health service bills Medicare for a particular service **and** does not donate 100% of this revenue back to the community health service **and** is also paid a salary for the time they spent providing the service.

[18] For example: *Recruiting and retaining general practitioners in rural areas* www.rwav.com.au/resources/publications/UniversityofBallarat-EvidenceBasedResearch-execsummary.pdf; *Attracting health professionals into primary care: strategies for recruitment* www.anu.edu.au/aphcri/Domain/Workforce/Thistlethwaite_3_FINAL.pdf*; Overseas trained doctors: recruitment and support* www.rwav.com.au/resources/publications/G12-5Recrtmt&Support.pdf

The roles and skills of practice nurses and medical receptionists also vary considerably, though they may have a good understanding and working knowledge of the MBS and experience in establishing and/or maintaining client recall and reminder systems, both of which are important. Additionally, nurses may have skills to contribute to patient health assessments, self-management approaches to chronic disease management, and care planning. When used as part of delivering services funded by new MBS item numbers, these skills can improve the quality of service provision and enhance the financial viability of general practices.

5.10.3 The 'GP champion'

A GP who is experienced in the use of the MBS item numbers can be an important enabler, both in terms of convincing GP colleagues of the merits of the items and providing leadership in systems development, particularly clinical governance.

5.10.4 Working with staff on proposed reforms

From an organisational perspective, it can be challenging to ensure that staff are aware and supportive of any proposed change to the way an agency does business. In this context it is important that:

- the rationale for the exploration of opportunities available through the MBS is transparent to all staff
- staff believe and can see that new models are in accordance with the stated objectives and philosophies of their organisation
- staff are able to have input into the planning, implementation and evaluation of new service models.

5.10.5 Organisational perspectives of private providers

Where private providers are engaged to provide services in a community health setting, it is important to consider to what extent you expect them to adhere to formal (documented) and informal (conventional) policies, procedures and cultures, and how to ensure this happens. Any expectation of a private provider should be explicitly stated and agreed upon up front – for example, as part of employment contracts or position descriptions. Specifically, agreements may relate to:

- furthering the organisation's mission
- record keeping and privacy, including an agreement regarding access to and use of central client files (electronic or paper-based)
- occupational health and safety
- service coordination principles
- performance review and disciplinary processes
- equal opportunity and harassment in the workplace
- use of facilities and support services – rights and responsibilities
- clinical governance, including participation in organisational quality improvement activities such as accreditation
- infection control
- participation in staff meetings.

This list is not exhaustive.

5.11 Clinical governance

Work on enhancing client services through Medicare should be supported through clinical governance systems. Clinical governance relates to how organisations manage responsibility and accountability for clinical performance. It should focus on the delivery of care arrangements in a team-based care environment and involve clinical performance and evaluation measures. Clinical governance provides a framework through which community health is accountable for continuously improving the quality of service provided to clients and safeguarding high standards of care.

Resources and training supporting clinical governance have been developed through the Department of Human Services Clinical Governance in Community Health Project, available at www.vha.org.au

5.12 Service viability

Some services funded through the MBS can bring full cost recovery or even bring in additional revenue, depending on the model[19]. However, other services financed by the MBS are unlikely to bring full cost recovery if delivered according to best practice clinical guidelines and may or may not be viable (for example, all allied health services attracting a Medicare rebate through a Team Care Arrangements attract a Medicare rebate of $47.95 when bulk-billed, meaning that MBS-funded physiotherapy, for example, is likely to be more viable than MBS-funded occupational therapy because the treatment session is usually shorter in duration for physiotherapy[20]).

It is important to remember that the MBS is only a source of funding for some activities; other funding sources and providers are likely to be needed to care for people with complex health needs. For example, refugee clients with ongoing care coordination needs may greatly benefit from a GP-led refugee health assessment service (MBS item 714 or 716), as well as other MBS-funded services, though only as part of a suite of services involving the client's sponsor, case manager and hospital-based specialist services funded from a variety of sources[21]. Coordinating these services for clients is the challenge for care facilitators and service managers. Similarly, community health services are innovatively using MBS-funded practitioners and State-funded practitioners to fund holistic models of care, with medical input, to clients[22]. Getting the mix right is a challenge both for practitioners and for primary health managers.

Note, however, that general practices are still learning about the new items themselves, and there may also need to be education and support provided to GPs and nurses in private practice to encourage them to participate. Divisions can assist here.

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19 Case studies of the different ways for general practice to use the MBS, and financial outcomes, are detailed in the Primary Health Branch document *Guide to developing an optimal business model for general practice in community health*, 2009.

20 It is important to keep in mind that for many clients a bulk-billing incentive will also be claimable

21 For example, see the Greater Dandenong CHS refugee case study.

22 For example, see the Dianella CHS 'Docs in Schools' program for Koori students case study.

6 Opportunities in specific MBS categories

This section looks at specific MBS item types and the opportunities they present. It also includes case studies to demonstrate how community health serivces have applied particular service models in order to use the MBS to enhance services to clients.

6.1 EPC health assessments

EPC health assessments items[23] can provide funding for a medical practitioner, by themselves or as part of a primary care team, to undertake a comprehensive, holistic assessment of a person. The Commonwealth's introduction of health assessments aimed to improve preventive care and to remove the financial barriers for particular clients associated with seeking comprehensive medical assessments.

Currently, there are items for:

- persons aged 75 years or over, living in the community (item 700, item 702)
- persons self-identifying as of Aboriginal and Torres Strait Islander descent (item 704, item 706, item 708, item 710)
- persons who are refugees or other humanitarian entrants who have arrived in Australia in the last 12 months (item 714, item 716)
- persons with an intellectual disability (item 718, item 719)
- persons who are permanent residents of Commonwealth-funded residential aged care facilities (item 712).

Assessment is an essential element of Victoria's vision for best practice service coordination, as articulated in *Better access to services: a policy and operational framework*[24] (BATS) and the Victorian Service Coordination Practice Manual[25].

6.1.1 Older age health assessment

The Commonwealth's stated aim for the introduction of the older age health assessment was to remove financial barriers that could discourage older Australians from seeking a thorough annual health check-up. The assessments allow GPs and practice nurses to play a proactive role in the health and wellbeing of older patients[26].

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23 The Commonwealth has more recently used the terminology 'health checks' to refer to EPC health assessments. This term is also used within the private health insurance sector and is seen as less threatening for some clients than using the term 'assessment'. Both terms are synonymous with the term 'comprehensive assessment' used in the Victorian *Better Access to Services* (BATS) policy.

24 www.health.vic.gov.au/pcps/publications/access.htm

25 Department of Human Services , *Good practice guide for practitioners: a resource of the Victorian service coordination practice manual,* Department of Human Services, Melbourne, 2007, www.health.vic.gov.au/pcps/downloads/sc_pracmanual.pdf

26 Commonwealth of Australia. Enhanced Primary Care – Medicare Benefits Items: Health Assessments. www.health.gov.au/internet/main/publishing.nsf/Content/mha_700-719.htm

Case study: Older age health assessments
Doutta Galla Community Health Service

Doutta Galla Community Health Service (DGCHS) has increased its focus on improving management systems and on enhancing the roles of nurses and administrative staff within its medical clinic. Over the last 18 months this has led to a marked increase in the number of annual health assessments delivered to clients aged 75 years and over (MBS item 700).

Importance of administrative staff role

The clinic has moved from an ad hoc to a systematic approach to client identification and client information management, with administrative staff taking a lead role. Eligible clients are identified by administrative staff either through a data extraction or opportunistically as clients present for appointments.

A register of all clients aged over 75 years is extracted from the clinic's client billing and management software (PracSoft). This register records client name, date of previous annual health assessment (if any), and consent previously provided for health assessment services (if any). Clients who are due for a health assessment and who have not previously refused to consent for a service are printed onto a new list which is handed to the clinic practice nurse for follow up. Clients who have already received an assessment are placed on a separate 'recall list' and are flagged to be offered their next annual assessment when due.

> 'Nobody had explained to the administrative staff member how crucial their role was … they are now managing all our significant recalls and they have access to Medical Director to monitor the provision of services to clients. There is greater job satisfaction in the team – they know they can talk to the nurses, talk to the doctors, and we are not missing any clients,' says practice manager Janina De Silva.

Teamwork approach by clinical staff

It is the role of the practice nurse to contact clients and seek their consent for DGCHS to proceed with a health assessment. For consenting clients much of the information collection component can be performed by the nurse and in many cases this is done in the client's own home. This workload is sometimes shared with community health nurses, depending on the type of client. For example, if the client is a refugee, the refugee health nurse collects client information; if the person is living in public housing high rise it may be another community health nurse who collects client information. The relevant nurse has access to client records and can check what information has been collected previously and make a note of information needing to be updated or confirmed. Once this part has been completed, the client will then be booked in to see the GP on-site at DGCHS. Following this, the MBS item is claimed.

On average, an assessment usually takes around 45 minutes of the nurses' time in the client's home (plus travel time), followed by 15 minutes with the GP. Doutta Galla receives $171.15 for each assessment. The practice manager believes the service is financially viable and it helps to fund the practice nurse position.

The health assessments have created opportunities for the GPs and the nurse to refer clients to other community health services, such as those provided by Doutta Galla's mental health nurse. If a chronic disease is identified, there are also opportunities to offer the client an Enhanced Primary Care (EPC) care plan remunerated through the MBS – GP Management Plan and Team Care Arrangements items (items 721 and 723).

Data cleansing and analysis

DGCHS' systematic approach to client management led to the discovery that much of its client data was inaccurate or contained 'inactive' clients (clients who had not been to DGCHS for many years or who had deceased). As this made managing recall and reminder lists difficult, DGCHS invested administrative staff time in cleansing client data systems. DGCHS used an electronic data extraction tool offered free of charge by a division of general practice to identify inaccurate data and inactive clients. This tool can also be used to identify clients who require follow up – such as those needing immunisation and those with diabetes whose glycosylated haemoglobin levels are above the desired range.

Enablers

- A strategic and systematic approach to offering health assessment services to eligible clients.
- Developing clear and accountable roles and responsibilities for nurses and administrative staff and embedding these in position descriptions. Each member of the team has responsibility to ensure that clients are offered the services they need, and to ensure that DGCHS is billing services appropriately.
- Phone calls to clients to offer an annual health assessment or remind them of their appointment. DGCHS has found that clients do not respond to posted letters.
- Clients are 'flagged' as eligible for particular MBS services in the billing/client management software. Clients who do not attend or clients who are sometimes difficult to work with are also flagged so that staff are prepared in advance.
- Administrative staff are trained to look at a client's record as the client comes into DGCHS so that services can be offered or reminders given during each interaction.
- The nurses have been given the ability to book their own appointments with clients through the electronic appointments system, which has improved efficiency.
- Outreach workers have been educated about MBS health assessments approach and now often bring clients into the service for a health assessment.
- The practice manager has regular team meetings with staff to monitor and discuss progress against specified targets.

Challenges

- If a client has an existing relationship with an external GP, it is not appropriate under the MBS rules to offer an MBS health assessment at DGCHS.
- Language barriers exist but are overcome by the use of interpreters.
- Clients not showing up for scheduled appointments can be challenging. Administrative staff now print monthly reports showing which clients have not attended and frequent non-attendees are flagged for special reminders. Signs have been erected to remind clients of the importance of attending appointments or at least ringing ahead to cancel. A list of regular clients who are able to attend the clinic at short notice (for example, for repeat prescriptions) is kept and appointments for these clients are sometimes brought forward as a replacement for a 'no show'.

Next steps

DGCHS would like to pursue the delivery of health assessments as an outreach service – this would enable the claiming of item 702 ($242.05) for an older age health assessment delivered off site.

6.1.2 Aboriginal and Torres Strait Islander health checks

A goal of the Victorian Government is to end a situation in which Indigenous citizens die on average 20 years younger than other Victorian citizens and experience a greater concentration of hardship and trauma over the course of their lives. The Victorian Indigenous Affairs Framework[27] stresses the importance of building protective factors to reduce the trauma and risk experienced in Indigenous communities and to promote better alignment and integration of policy and program efforts across sectors.

The Aboriginal and Torres Strait Islander (ATSI) MBS health checks present an opportunity for community health services to further contribute to closing the gap between non-Indigenous and Indigenous health outcomes through preventive measures and early intervention. They provide a clinical framework to assess a person's physical, psychological and social function and to identify treatment or services they may require.

Case study: Koori child annual health assessment
Dianella Community Health

Dianella Community Health (DCH) has built on its existing relationship with the Victorian Prep–12 College of Koori Education (VCKE – Glenroy Campus) to establish a medical and nursing service on campus that aims to provide an annual health assessment to all students aged five to 18 years old.

Need for medical care

Dianella's community health nurse worked with the school for two years on health promotion programs. Teachers identified many health issues that they had to cope with during a needs analysis session held in conjunction with Dianella.

The school reported that efforts to get students to see local private medical practices were not always successful due to appointment times and other issues. Many students reported that they could not recall seeing a GP and therefore had not had a medical examination for many years.

DCH and VCKE agreed that an on-campus clinic would be the best way of enhancing access to primary health services and comprehensive bulk-billed health assessments, while also encouraging students to make use of the ATSI annual health check.

A DCH GP who also worked part-time at the Victorian Aboriginal Health Service (VAHS) in Fitzroy was approached and agreed to work a four-hour session fortnightly in partnership with the nurse and school to provide health assessments, health education and minor treatment to students.

Trust and cultural safety

Students and their families had little contact with the health system and reported they did not feel comfortable approaching existing providers. Ensuring the school-based clinic was culturally safe and youth-friendly was seen as critical. The nurse researched other projects that had placed doctors in schools and discussed plans with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and the VAHS. She also rang the Medicare Aboriginal and Torres Strait Islander Access Line (1800 556 955) to discuss the MBS items.

Before proceeding, a memorandum of understanding with VCKE – Glenroy Campus was agreed and a policies and procedures manual was developed to govern operations and minimise risks.

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[27] Department of Victorian Communities. *Improving the lives of Indigenous Victorians: Victorian Indigenous Affairs Framework*. www.aboriginalaffairs.vic.gov.au/web7/rwpgslib.nsf/GraphicFiles/Vic_IndigenousAffairsFramework/$file/Vic_IndigenousAffairsFramework.pdf

Establishing the clinic in the school was a joint project between the school and DCH, with each contributing ideas, furniture and equipment. Cultural safety was assured through a number of policies and procedures, for example:

- the doctor's door is left open on request of students
- students can attend appointments with siblings or friends so they feel secure
- students were free to walk between the doctor's and nurse's rooms or in and out of the clinic
- parents were encouraged to come to see the clinic and meet the providers
- students' art was placed on the walls and the rooms were decorated with cushions and bright, warm colours
- health information from VACCHO and VAHS is provided in the waiting area
- the community health nurse assists the student in filling out the psychosocial questionnaire.

Services and viability

Thirty-eight health assessments were delivered to students and billed to Medicare from April to December 2007 (item 708: 28, item 710: 10), as well as 35 bulk-billing incentive items (item 10990 – see 6.8 Bulk-billing incentives). Following the health assessments, many students received minor treatment at the school (enabling the clinic to also bill standard GP consultation items) and some students were brought into the community health service for additional services. Community health allied health providers also visited the school to provide services.

Paper-based records are taken back to Dianella to be scanned into client files by administrative staff, who also process Medicare billing.

Dianella estimates that it costs $520.00 per session for the GP, nurse and administrative staff, including on-costs. This means that if three health assessments per session were billed (and bulk-billing incentive items claimed) they would cover all costs, not including the $500 that was spent to decorate the clinic.

Enablers

- A three-year investment into building relationships with the school and the local Koori community and building trust with students and parents.
- The commitment of the school and health providers and administrative staff at Dianella.
- Planning a culturally safe clinic.
- Being able to use health promotion funding to plan the service.
- The MBS items proved financially viable and helped to provide some guidance regarding components of the assessments.
- Finding a GP with experience working with Koori clients.

Challenges

- Establishing trust with the school, students, parents and the wider Koori community.
- Obtaining consent from the appropriate carer (the child's parent, guardian or teacher). A consent form that indicated verbal parental consent accompanied by the signature of a teacher was helpful.
- Not having initial access to computers (including medical software) was inefficient.
- The lack of a practice nurse to support the school clinic in elements of assessment and follow up meant that the role of the community health nurse was stretched.

Next steps

Dianella is now seeking to employ a part-time practice nurse to assist the GP and health promotion nurse at the school. It is believed this will assist in providing more follow up services at the school (including care planning) and enhancing the viability of the service.

6.1.3 Refugee and other humanitarian entrants health check

These health checks were introduced by the Commonwealth in recognition that refugees often arrive in Australia with complex and unusual medical conditions and mental health problems resulting from their area of origin, previous living conditions and experiences.

Indeed, evidence indicates that people of a refugee background tend to suffer a higher incidence of physical and mental health problems than migrants and people born in Australia[28].

Comprehensive health assessments are important for refugees and other humanitarian entrants because:

- humanitarian entrants may have had limited access to health care
- they assist in identifying asymptomatic medical conditions that, left untreated, may have serious long term health consequences (for example, intestinal parasitic infection, adult vitamin D deficiency, hepatitis B)
- they present an opportunity for early intervention for existing conditions
- sensitively administered, a thorough medical examination can contribute to a person's psychological recovery[29].

Comprehensive resources have recently been developed to support care for refugees in primary health care[30].

Case study: Refugee health assessment
Greater Dandenong Community Health Service

The City of Greater Dandenong receives more humanitarian settlers than any other municipality in Victoria. In 2006–2007, Greater Dandenong received 24.6 per cent of Victoria's humanitarian settlers[31]. Greater Dandenong Community Health Service (GDCHS) has worked for many years to enhance access to culturally appropriate services for newly arrived refugees in the area.

Access to MBS-funded refugee health assessments

The appointment in March 2006 of a full-time refugee health nurse under the Victorian Refugee Health Nurse Program has improved the capacity of individuals from refugee backgrounds to access quality health services[32], including GP refugee health assessments for clients. The nurse's central coordinating role complements and enhances work performed by privately practising GPs and that of a GP employed within GDCHS on a part-time basis.

Clients from a refugee background are referred to GDCHS in many ways, including:

- from Australian Multicultural Education Services (AMES) settlement case workers
- through refugee sponsors, who may refer or accompany a refugee client to a GP
- from private general practices in the area
- from The Victorian Foundation for the Survivors of Torture Inc. (Foundation House).

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28 Department of Human Services. *Refugee health and wellbeing action plan 2008–2010,* Department of Human Services, Melbourne, 2008.

29 Foundation House – Victorian Foundation for Survivors of Torture. 2007. *Promoting Refugee Health: A Guide for Doctors and Other Health Care Providers Caring for People from Refugee Backgrounds.* Melbourne.

30 For example, see www.racgp.org.au/guidelines/refugeehealth, www.gpv.org.au/resources.asp?cat=17 and www.foundationhouse.org.au/resources/publications_and_resources.htm

31 Australian Government Department of Immigration and Citizenship, 2007. Quoted from: Kelly, Mary. 2008. *Greater Dandenong Community Health Service Refugee Health Nurse Project*. Melbourne: Refugee Health Research Centre.

32 Ibid.

Generally the refugee health nurse will see clients after an initial GP assessment but then may support the AMES case coordinator in determining whether a client needs a more comprehensive medical assessment or immediate treatment. Referral options include:

- to other GPs in the region who provide health services for refugees
- to the GDCHS GP – useful when a refugee has moved from another area or has already been receiving GDCHS midwifery program services
- directly to the Refugee Health Clinic at Dandenong Hospital.

GDCHS has played an active role in establishing links with local general practices. To increase access to refugee health assessments in the area, the AMES refugee settlement service provided GDCHS with a list of local GPs with a special interest in refugee health. The refugee health nurse offered a practice visit to each of these GPs to determine whether they would be willing to accept referrals. There are at least nine GPs in local general practices who are prepared to provide bulk-billed MBS refugee health assessments for refugee clients.

MBS health assessments provided by the GP within GDCHS are generally completed in two sessions of at least 30 minutes each. The GP is assisted in the collection of information by the refugee health nurse. A copy of the assessment is provided to the client. Assessments often lead to further sessions with the refugee health nurse who is able to coordinate services for clients. Referrals for pathology, chest x-rays, counselling and other specialist services at Dandenong Hospital are common and clients often require assistance to link in with other health service providers.

Enablers

- The structured role of the refugee health nurse, leading to enhanced coordination of services for refugee clients including direct service provision, referrals, and assisting clients with interpreting services and transportation.
- The commitment of GDCHS and the organisations involved to serve refugee clients in the City of Greater Dandenong. GDCHS has developed strong partnerships with Foundation House, AMES, Dandenong Hospital and the Dandenong Casey General Practice Association. These organisations facilitated a refugee health forum in 2007 attended by 130 people[33].
- The tools available to assist in the completion of the item number.
- Sometimes the GDCHS GP assesses each member of a family when they are all in the consulting room together. The ability to claim multiple MBS refugee health assessment item numbers when this occurs enhances the viability of the service.

Challenges

- Medicare allows the provision of only one refugee health assessment per client and it is sometimes difficult to determine whether or not a service has already been provided.
- Clients often require assistance to attend an appointment and sometimes do not attend a scheduled appointment. Strategies used to assist clients to keep scheduled appointments include reminders provided by reception one week before the scheduled appointment and transport assistance from AMES volunteers, from sponsors, through cab vouchers or a personal transport service provided as a last resort by GDCHS.

[33] www.dhs.vic.gov.au/disability/state_disability_plan/

- Language barriers are usually a challenge. The Department of Human Services provides funding through the Refugee Health Nurse Program to purchase sessional interpreting services, and GDCHS also uses professional interpreters booked through interpreting agencies. Telephone interpreting is used when on-site interpreters are not available.

Next steps

GDCHS is investigating a model to build rapport with refugees settling in the area by co-locating allied health staff in GPs' private practices for one or two sessions a week.

GDCHS is also working closely with Dandenong Hospital to begin a general practice service specifically for asylum seekers.

6.1.4 Health assessment for people with an intellectual disability

Victoria's *State Disability Plan 2002–2012*[34] outlines a vision that promotes a shift from the provision of reactive, crisis-driven health services to more proactive planning and support to meet the health needs of people with an intellectual disability. The recent introduction of this health assessment item by the Commonwealth is therefore timely, as it provides remuneration for a comprehensive assessment of the physical, psychological and social function of persons with an intellectual disability and will help to proactively identify any medical intervention, preventative health care and the range of supports and services that may be required.

In Victoria, government managed and owned disability accommodation services have a licence to use the Comprehensive Health Assessment Program (CHAP) tool to assist GPs to conduct an annual health review for people with an intellectual disability. Use of this tool has been shown to improve health promotion, disease prevention and management activities for people with an intellectual disability in the general practice setting.

Disability support staff are able complete the first part of CHAP to provide the GP with the person's medical history. The second part of CHAP provides the GP with prompts for specific areas that should be considered by practitioners in an annual health review of people with an intellectual disability. The final section of CHAP prompts support staff and the GP to work together to develop a plan of action. The completion of CHAP satisfies the requirements of the Medicare rebate for items 718 and 719.

For people with an intellectual disability living outside government managed and owned disability accommodation services, a template to guide GPs through the annual health review for people with an intellectual disability has been incorporated into Medical Director, a commonly used general practice software system.

6.2 Prevention

The MBS has been expanded to fund services that help prevent the onset of chronic and vaccine-preventable diseases. These include immunisation, Pap tests, and preventive health checks for sections of the community deemed to be at risk of developing a chronic illness.

Community health services provide a platform to lead and deliver integrated health promotion, prevention and early intervention programs targeting risk factors and promoting protective factors for people with, or at risk of, Ambulatory Care Sensitive Conditions (ACSCs). The importance of this role is articulated in *Community health services – creating a healthier Victoria*[35].

[34] www.dhs.vic.gov.au/disability/state_disability_plan/

[35] www.health.vic.gov.au/communityhealth/publications/chs.htm

Case study: 45–49 year old health check
Goulburn Valley Community Health Service

Goulburn Valley Community Health Service operated a small medical clinic which was integrated with other community health services and programs. The clinic initiated a strategic approach to offering 45–49 year old health checks to all of its eligible clients after hearing of the new item number from the Goulburn Valley Division of General Practice.

Client recruitment

Eligible clients were identified from the clinic's client register and sent a letter of invitation. The response rate was poor, so the GP and nurse decided to also offer the service opportunistically as eligible clients presented to the clinic for other reasons. This approach proved slightly more successful.

It is believed that the majority of community health clients did not enthusiastically respond to offers of a health check because the potential benefits of the service were seen as less important than addressing current problems in their lives. The notion of prevention and self-responsibility for health was generally not well understood by clients.

Health check and follow up

Clients who did agree to the service first saw the practice nurse for an assessment and draft client action plan. This was followed up with an appointment with the GP who would discuss findings with the client, agree with them on a client action plan, and organise further preventive services or treatment if required. These sessions took approximately one hour per client.

Sometimes the health check uncovered an existing chronic illness that was not known by the client or providers. These clients were offered a GP-led care plan at a subsequent visit. SMS messaging, direct calling and opportunistic face-to-face reminders were used to encourage attendance at follow-up visits, which were sometimes successful. However, prompting clients to come back for a care plan was a 'constant battle' for the practice nurse.

Clients who received a 45–49 year old health check were enthusiastic about the service.

> 'Once you get talking to them regarding their height, weight, blood pressure and habits and say "this is where you are at, and this is where you are heading", some clients are surprised… [however] we have to work hard to maintain their enthusiasm to implement an action plan,' said clinic nurse Chris Flower.

Service viability

Establishing the 45–49 year old health check initiative did not incur significant start-up costs. The local division of general practice provided free education on the item number and the care planning items, as well as templates for providers to use when assessing the client. Administrative costs when identifying and recruiting clients were minimal.

Approximately 98 per cent of clients were bulk-billed for the service, and the bulk-billed MBS remuneration of $102.20 made provision of the service viable for most clients. Viability was enhanced by the contribution of the nurse in assessing the client and drafting an action plan before the client saw the GP. However, time spent trying to convince clients to attend subsequent visits and helping them implement their action plans meant that for some clients the MBS rebate did not fully cover all costs.

The care planning items (such as GP Management Plans and Team Care Arrangements) were viable for every client and raised additional income for the clinic that could be directed towards other services. MBS care planning services were only offered if the GP and nurse were convinced they would make a difference; some clients were also not interested in the service.

Enablers

- Leadership from the practice manager to establish the service and support from the medical administration assistant in billing.
- Leadership from the practice nurse to recruit clients for the service and to perform the majority of tasks associated with the assessment and action plan – the nurse role freed up much of the GP time and made the service viable.
- Support from the local division of general practice regarding fulfilling the requirements of the MBS item.
- Other clinics in the local area gave some advice.
- Monthly clinic meetings with the CEO, team manager, GP, practice nurse, practice manager and administrative assistant allowed the clinic opportunities to innovate, to discuss challenges and to celebrate successes.

Challenges

- Poor client response to recruitment drives was frequently challenging and required persistence and innovation.
- The clients who were not willing to attend follow-up appointments somewhat diminished the benefit of the health check, as the practice could not be sure whether or not clients were following their agreed action plan and could not support them.
- An inability to recruit more GPs to the clinic in an area of acute workforce shortage was challenging. Non vocationally-registered GPs could have been recruited; however, due to the fact that these GPs attract lower Medicare rebates, the financial returns would not have been sufficient to sustain their employment in community health.

6.3 Care planning and case conferencing

Care planning is a process of deliberation that incorporates a range of existing activities such as care coordination, case management, referral, feedback, review, re-assessment and monitoring. Care planning involves the judgement/determination of relative need as well as competing needs, and assists consumers to come to decisions that are appropriate to their needs, wishes, values and circumstances. Care planning forms an essential element of service coordination, as articulated in the *Victorian service coordination practice manual*[36].

The Commonwealth funds a wide range of care planning and case conferencing services through its Enhanced Primary Care Chronic Disease Management (EPC-CDM) Program, which uses Medicare as the funding mechanism. These services may be led by a GP or involve a contribution by a GP. The MBS funds:

- service-specific care plans through general practice (for example, GP Management Plans)
- interagency care plans led by a GP (for example, Team Care Arrangements)
- interagency care plans into which a GP contributes
- practice nurses to monitor client progress against a GP-led care plan.

The GP may involve the community health sector in a partnership approach to care.

Claims for MBS-funded care plans in Victorian general practice are growing over time as GPs and practice nurses come to understand the items and establish systems to participate in care planning.

[36] www.health.vic.gov.au/pcps/publications/sc_pracmanual.htm

Case studies of the development of care plans between general practice and community health are published on the Department of Human Services website at www.health.vic.gov.au/pcps/coordination/care_iniatives.htm. There are also case studies in the allied health services section which pertain to GP care planning.

Medicare also funds GPs to lead and coordinate case conferences or to participate in case conferences organised by another provider. An EPC case conference is a meeting of health and care providers to plan for the health and care needs of an individual patient with at least one chronic medical condition and complex multidisciplinary care needs requiring care from a GP and at least two other health or care providers.

Who can be a member in Team Care Arrangements?

Team Care Arrangements are the GP-led, MBS-funded multidisciplinary care plan. They are specifically for people with a chronic or terminal medical condition and complex care needs, who are seeing or need to see at least three health or other care providers (including their GP) and who need team-based care.

To be a contributing member of Team Care Arrangements, the provider must have been, or will commit to, providing ongoing care to the client in relation to the management of their chronic or terminal illness.

A mix of both publicly and privately funded providers can be members of Team Care Arrangements. According to the Commonwealth, persons who may be included in a team are allied health professionals such as, but not limited to: Aboriginal health workers, asthma educators, audiologists, dental therapists, dentists, diabetes educators, dietitians, mental health workers, occupational therapists, optometrists, orthoptists, orthotists or prosthetists, pharmacists, physiotherapists, podiatrists, psychologists, registered nurses, social workers and speech pathologists.

A team may also include home and community service providers or care organisers such as: education providers, meals on wheels providers, personal care workers (workers who are paid to provide care services) and probation officers where they are contributing to the plan and not simply providing a service identified in the plan. Note that the above list of people is more extensive than the list of allied health professionals to whom a GP can refer patients for the purpose of the five annual allied health rebates under Medicare.

As an example: members of the team for a person may include the GP, a privately practising diabetes educator, a meals on wheels provider and a salaried occupational therapist in community health. The GP may choose to refer to the private diabetes educator using the referral form for allied health services under Medicare – which would enable the client to receive MBS rebates for five visits to the diabetes educator – while using a normal referral letter to the other providers whose services would not be MBS-rebateable.

6.4 Allied and dental health

Improving the health of Victorians by focusing on allied and dental health services has been a strong priority for the Victorian Government, and for community health services. The Government has invested an increasing amount into these services, however there are major opportunities to reorganise the way we manage and deliver allied and dental health care to improve outcomes for Victorians. The MBS is one funding mechanism that can enhance clients' access to private sector services whilst minimising out-of-pocket expenses.

Medicare rebates for allied and dental health services are available for people with chronic conditions and complex care needs on referral from their GP, and for people of Aboriginal and Torres Strait Islander descent who have had a health assessment during which the GP has identified a need for follow up services. Medicare expects that the assessment will be broadly consistent with the Medicare-funded Aboriginal and Torres Strait Islander Medicare health checks.

A list of the types of allied health providers that can attract Medicare benefits, and the requirements for them to be able to become registered with Medicare Australia, is at Attachment 1. Further information and Medicare-mandated referral forms are at www.medicareaustralia.gov.au/provider/incentives/allied-health.shtml and www.health.gov.au/epc

6.4.1 Individual allied health sessions

6.4.1.1 Clients with a chronic or terminal medical condition and complex care needs

Clients with a chronic or terminal medical condition and complex care needs are eligible for up to five MBS-subsidised individual allied health services per calendar year, in any mix of allied health providers (the types of allied health providers who are able to register with Medicare to provide these services are listed in Attachment 1). To be eligible for Medicare rebates for individual services provided by private allied health providers, a client must be managed on a GP-led EPC care plan. Clients are being managed under an EPC plan if their GP has prepared and billed the following MBS chronic disease management items in the previous two years:

(a) GP Management Plan – item 721 (or review item 725)
and
(b) Team Care Arrangements – item 723 (or review item 727).

Clients who are permanent residents of an aged care facility are also being managed under an EPC plan if their GP has contributed to or reviewed a multidisciplinary care plan prepared for them by the aged care facility (item 731).

6.4.1.2 Clients of Aboriginal and Torres Strait Islander descent

Clients of Aboriginal and Torres Strait Islander descent who have had a health assessment during which the GP has identified a need for follow up services are also eligible for up to five MBS-subsidised individual allied health services per calendar year, in any mix of allied health providers. These are in addition to the five MBS-subsidised allied health services available for clients with a chronic or terminal medical condition and complex care needs.

6.4.1.3 Further information

No limit has been placed on gap payments by the Commonwealth. Individual practitioners may choose to bulk-bill, to charge the schedule fee, or to charge a different fee. The consumer is responsible for paying the difference between the rebate and the fee charged. Out-of-pocket expenses, however, do count towards Medicare safety nets. Community health services partnering with privately practising allied health providers may need to negotiate with them to guarantee access for disadvantaged clients, particularly in relation to agreeing to provide low-gap or bulk-billed services.

Uptake of the individual MBS-subsidised allied health item numbers is shown in Table 1.

Table 1: Number of Allied Health MBS item number claims in Victoria, 2005–06 to 2007–08

MBS item number	Description	2005–06	2006–07	2007–08
10950	Aborignal health worker service	0	1	31
10951	Diabetes education	2,530	5,844	10,903
10952	Audiology	174	156	131
10953	Exercise physiology	277	4,726	6,275
10954	Dietetics	13,569	23,081	29,161
10956	Mental health worker service	635	1,052	4,608
10958	Occupational therapy	1,761	2,965	4,608
10960	Physiotherapy	46,345	88,237	131,444
10962	Podiatry	38,826	94,647	146,677
10964	Chiropractic service	6,196	13,239	20,968
10966	Osteopathy	5,566	9,422	16,417
10968	Psychology	13,314	15,249	2,213
10970	Speech pathology	2,273	5,884	13,219

Case study: Care planning and allied health
Wimmera Health Care Group

The Podiatry Department of Wimmera Health Care Group (WHCG) had experienced long waiting lists, creating frustration for clients and staff. A small grant partially funded the employment of an extra podiatrist for clinical work, freeing time for the chief podiatrist to closely analyse demand for podiatry services in the Wimmera and formulate a new demand management plan.

Audit of clients attending the Podiatry Department

An audit of client records was conducted to evaluate the reasons for the current strong demand for podiatry services. The audit showed that while a large percentage had diabetes mellitus and complex health care needs, their lower limbs were not deemed to be at high risk of complications.

Eligibility criteria for entry to the Podiatry Department of WHCG was clarified so that clients with the following would receive priority access:

- history of ulceration/amputation
- loss of protective sensation
- peripheral arterial disease (ABI > 0.8)
- referred for diabetes lower limb assessment (vascular and neurological assessment)
- referred for lower limb wound assessment and management
- referred for biomechanical assessment
- referred for paediatric gait assessment.

Clients not meeting these criteria faced significant financial barriers to accessing private podiatry services in the community. However, given that many still had a chronic disease and complex care needs, they would be eligible for a GP-led care plan (combined GP Management Plan and Team Care Arrangements service) that, upon completion, would render them eligible for five MBS-rebateable podiatry services through private Medicare-registered podiatrists in the local community. It was decided to try to coordinate these services for clients.

Working with local private providers

The WHCG's Director of Medical Services contacted local GPs in private practice to ascertain their willingness to provide care plans for these clients, and to refer them for podiatry services if warranted. At the same time, the Chief Podiatrist contacted local podiatrists in private practice to determine their capacity and readiness to provide MBS-rebateable podiatry services on referral from GPs through care plans. The Director found that local GPs were also frustrated with the barriers to access for podiatry services for their patients and though they had some misgivings about the time it may take and the paperwork associated with GP-led care plans, they agreed to work with their patients to refer them to private podiatrists for MBS-rebateable sessions. The podiatrists were also contacted to discuss this approach and it was noted which podiatrists had the spare capacity to take additional clients through a GP-led care plan referral. This was then communicated back to the GPs.

Clients who had an initial podiatry assessment but did not meet the new medical admission requirements for further podiatry services at WHCG, yet for whom podiatry would assist in the management of their chronic disease, were provided with an information flyer outlining the MBS plan. Clients were asked to discuss the possibility of referral to private podiatry through a GP-led care plan with their usual GP[37]. If their GP agreed, a GP Management Plan and Team Care Arrangements service would be completed and the client referred by the GP through the Medicare referral form to private podiatry.

It is also WHCG policy that all clients with diabetes have an annual comprehensive diabetes lower limb assessment. Clients identified as requiring assistance with periodic foot care were advised about the MBS and encouraged to discuss private podiatry services via GP-led care plans and referrals with their GP.

Costs and outcomes

This project entailed costs for WHCG, including time to review the MBS items, management meetings, GP and private podiatrist engagement and planning processes for promoting the plan to providers and clients. These were funded through the Department of Human Services grant. All MBS revenue funded the care planning and private podiatry services.

Waiting times for podiatry services were reduced from 150 days to ten days, and the number of clients waiting reduced from 366 to 38.

[37] GPs had already agreed with this process.

Enablers

- Strengthening relationships with GPs and gaining their support for the plan was the most essential element. Often, support was gained by clearly demonstrating how their patient would benefit from being on a care plan with referral to private podiatry.
- Ensuring that podiatrists could accept additional referrals, and were Medicare-registered, helped to prevent potential delays.
- Leadership from WHCG and in particular the Medical Director and Chief Podiatrist approaching private providers in the region.
- It was helpful that the majority of WHCG clients not eligible for public podiatry services (according to the new criteria) were eligible for GP Management Plans and Team Care Arrangements.
- The funding grant created additional capacity to help plan the approach.

Challenges

- GPs were initially reluctant to participate in the plan due to concerns about the time it would take to complete GP Management Plans and Team Care Arrangements. [This was sometimes overcome by pointing out that practice nurses could contribute to the care plans and that there are electronic templates on GP software programs that self-populate much of the client information].
- Access to additional appointments with GPs was sometimes difficult due to GP workforce shortages.

Case study: Care planning and allied health
Hepburn Health Service

Hepburn Health Service (HHS) has developed a model of integrated health care with a focus on multidisciplinary care planning and service provision, funded through the MBS, to improve the health status of people living with type 2 diabetes mellitus in Daylesford. The project was initiated with grant funding through the GPs in Community Health Services Strategy 2006–08.

Working in partnership with local general practices

Hepburn Health Service does not provide medical services or co-locate with a general practice, but has nurtured positive working relationships with the two external general practices in Daylesford. If was felt that all three organisations could work together to strategically plan and deliver access to an appropriate mix of 'public' (primarily DHS-funded) and 'private' (primarily Commonwealth/MBS-funded) services for the target population, while keeping out-of-pocket costs for clients to a minimum. The two general practices had already established diabetes registers and were delivering evidence-based care to these clients. Their participation in the National Primary Care Collaboratives program, delivered through the Central Highlands General Practice Network (the local division of general practice), had been the catalyst for this work.

Establishing the model

A steering committee was formed, consisting of local GPs and HHS staff, including a newly appointed project manager, allied health team leaders, a diabetes educator and two general practice nurses working from the local private clinics. The aims of the project were to:

- Maximise the provision of evidence-based care for all people with diabetes mellitus in Daylesford. Evidence-based care would be based on best practice guidelines[38]
- For clients with diabetes and also complex care needs, coordinate team care including GPs and practice nurses in private general practice and a mix of public and private allied health providers at HHS. Planning processes would be driven by the project manager
- Clients would be provided with a record of care plans, care provided and educational material about their condition and be regularly recalled for follow up.

The general practices work with clients identified as having type 2 diabetes with complex care needs to develop a GP Management Plan and seek input from HHS's allied health providers into Team Care Arrangements. The GPs then refer clients to allied health service providers at HHS. These processes are assisted by primary care nurses who discuss clients' care needs with them and help draft care plans before client consultation with the GP. Nurses also manage the client recall/reminder systems so that care plans are reviewed.

The nurses and GPs have electronic access to the appointments calendars of the private allied health providers working from HHS and are able to book appointments for their clients directly without having to go through HHS' reception. These providers are able to view their calendars and make subsequent bookings for those clients. (If the client is seeing a 'public' allied health provider, HHS reception is used). Details of the care plans completed at the general practices would be sent to HHS via an Argus-encrypted secure electronic referral system to some private practitioners – another initiative of the project.

All clients were provided with a 'diabetes hand-held record' containing copies of results, referrals, health education pamphlets and allied health provider consultation notes. Providers would also view the record when the client came in for a consultation, which helped to avoid duplication of service and improved communication between members of the care team.

As well as the steering committee meetings, providers also met separately to discuss clinical aspects of diabetes care, referral processes and appointments management. These meetings helped to standardise referral and communication processes and also helped providers share the kinds of services they could provide to clients with diabetes.

'At one meeting, a GP asked the podiatrist: "Why would I refer a person with diabetes to you, when their feet are healthy?" The podiatrist was able to explain the specialised education and health promotion services they could provide to help prevent complications in the future, so that the GPs could clearly see the potential benefits for these types of clients and would refer them,' explained project manager Erin Richardson.

[38] Diabetes Australia and the Royal Australian College of General Practitioners. 2007. *Diabetes Management in General Practice 2007-08*. www.racgp.org.au/guidelines/diabetes

Private allied health providers working within Hepburn Health Service

A podiatrist and a dietician who were both working in part-time salaried positions at HHS and part-time in private practice agreed to work an extra day each as a private provider at Hepburn. Hepburn's physiotherapist agreed to register with Medicare Australia and also work in a private capacity from rooms within community health. All three providers agreed to see clients referred from GPs through Team Care Arrangements. HHS was also able to attract an exercise physiologist who now works one day a fortnight privately in Hepburn. These new arrangements have resulted in both an increase in the number of clients seen at HHS, a decrease in waiting lists, and reportedly improved health outcomes.

When working in a private capacity at HHS, providers were given a room (with electricity, heating etc.) and a computer with email and an electronic calendar. GPs and general practice nurses would automatically book clients into these calendars. The private allied health providers were responsible for ensuring they were insured privately for the provision of services. Two providers agreed to bulk-bill, while the third asked the client to pay $55 up front from which the client could claim the $47.95 rebate from Medicare. Some clients were initially not comfortable or used to the notion of paying a large amount up front but agreed to proceed on the basis that they would be only $7.05 out of pocket following receipt of their Medicare rebate.

Enablers

- Placing practice nurses to work in general practice clinics with dedicated time to see clients for diabetes care, which allowed a systematic approach to care and freed GP time to see more clients.
- Implementation of the diabetes hand held record for clients.
- Electronic booking systems and electronic e-referral processes helped to minimise the administrative impost, and were efficient.
- Bulk billing of patients by private allied health practitioners was easy and helped enhance access to services for clients.
- Regular steering committee meetings to share progress and make decisions was important in order to progress work in a coordinated and inclusive manner.
- Private general practices participating in the National Primary Care Collaborative (NPCC)

Challenges

- Creating a role for practice nurses in chronic disease management put many pressures on the nurses' time, particularly when they have other tasks to attend to.
- Recruiting patients into the system to see the nurse was challenging. Whether done opportunistically, by phone, by letter or by another method, each has its drawbacks.
- Sometimes the hand held records were not made use of by patients, or practitioners did not remember to write in them.
- The creation of electronic billing, referral and appointments system required time and expertise, and further work is needed in this area.
- Not all allied health practitioners chose to bulk bill patients.
- Recruiting and retaining private allied health

Next steps

HHS is now rolling the model out to improve services for the treatment of other chronic diseases.

6.4.2 Group allied health services

Clients with type 2 diabetes mellitus who have received a GP Management Plan service (item 721) are eligible for an assessment for group services by a diabetes educator, exercise physiologist or dietician on referral from their GP. People living in residential aged care services are also eligible if their GP has contributed to a care plan through item 731. If deemed that group services would be beneficial, a client is then eligible for up to eight MBS-subsidised group allied health services per calendar year.

On completion of both the assessment for group services and the group services program, each allied health provider must provide, or contribute to, a written report back to the referring GP for each patient. After the assessment service, the allied health provider should supply the GP with a written report outlining the assessment undertaken, whether the patient is suitable for group services and, if so, the nature of the group services to be provided. After the group services program, the allied health provider should supply the GP with a written report describing the group services provided for the patient and indicating the outcomes achieved.

6.4.3 Dental health services

Improving Victoria's Oral Health[39] is the Victorian Government's four-year strategic plan for public dental health services and oral health. The Victorian Government provides the vast majority of delivery of public dental care for children and disadvantaged adults in Victoria. Most dental services are provided by private practitioners and funded through private health insurance and/or out-of-pocket fees.

Currently, Medicare subsidises dental treatment and assessment services for clients with a chronic or terminal medical condition and complex care needs, on an EPC care plan, where their oral health is impacting upon, or likely to impact upon, their general health. A client is eligible for up to $4,250 in Medicare Benefits on referral from their GP for dental services over two consecutive calendar years – specific limits apply to some items (for example, time limit on access to benefits for new dentures). However, the Commonwealth has advised that subject to Parliament's agreement, they intend to close this scheme to all clients. For updates, see www.health.gov.au/internet/main/publishing.nsf/Content/Dental+Care+Services

6.5 Better access to mental health care

Clients who are financially and/or socially disadvantaged and have significant multiple and complex mental and social health problems require access to comprehensive and collaborative[40] models of care.

In July 2006, COAG endorsed a *National Action Plan on Mental Health (2006–2011)*[41]. Under the plan, Victoria committed to implementing 23 measures and the Commonwealth to implementing 18 measures to improve services for people with a mental illness, their families and carers.

One of the Commonwealth measures was the Better Access to Psychiatrists, Psychologists and General Practitioners (GPs) through the Medicare Benefits Schedule (MBS) initiative. This initiative allows private psychiatrists to refer patients to psychologists and GPs, encourages early assessment and management of people with a mental illness by GPs, and allows GPs to refer patients to psychologists, allied health professionals and other GPs with special training to deliver focused psychological services. Patients with a GP Mental Health Care Plan, or who are being managed by a GP under a referred psychiatrist Assessment and Management Plan,

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39 www.health.vic.gov.au/dentistry/publications/improve_oralhealth.htm

40 Gilbody S, Bower P, Fletcher J, et al. 'Collaborative care for depression. A cumulative meta-analysis and review of longer-term outcomes'. *Arch Intern Med* 2006; 166: 2314-2321.

41 Council of Australian Governments. 2006. www.coag.gov.au Accessed 1 May 2008.

can claim up to 12 Medicare rebates per calendar year (in two groups of up to six services) for individual services provided by clinical psychologists, appropriately trained GPs and other allied mental health professionals. In exceptional circumstances, patients may receive an additional six individual services, to a maximum of 18 services per patient per calendar year.[42] Eligible patients can also claim up to 12 rebates per calendar year for group services provided by clinical psychologists and other allied mental health professionals. Rebates for these services are also available on referral by a psychiatrist or a paediatrician. No limit has been placed on gap payments. Practitioners may choose to bulk-bill, to charge the schedule fee or to charge a different fee. The client is responsible for paying the difference between the rebate and the fee charged. Out-of-pocket expenses, however, do count towards Medicare safety nets.

A list of the types of mental health providers that can attract Medicare benefits and the requirements for them to be able to become registered with Medicare Australia is at Attachment 2. Further information is at www.health.gov.au/internet/main/publishing.nsf/Content/health-pcd-gp-mental-health-care-medicare

Twenty-eight MBS item numbers are grouped under the initiative and the most frequently claimed items are shown below.

Table 2: Number of Better Access to Mental Health Care MBS item number claims in Victoria, 2006–07 and 2007–08

MBS item number	Description	2006–07	2007–08
296	Consultant psychiatrist, initial consultation on new patient	11,322	20,780
2710	GP Mental Health Care Plan	88,619	142,933
2712	Review of GP Mental Health Care Plan	12,347	48,779
2713	GP Mental Health Consultation	57,809	144,123
2725	GP FPS* 40+ minutes	5,766	6,444
80010	Clinical Psychologist Therapy – Single	53,850	164,980
80100	Clinical Psychologist Therapy – Group	4,994	8,346
80110	Psychologist FPS – Single	140,876	409,745
80120	Psychologist FPS – Group	400	1,881
80135	Occupational Therapist FPS 50+ minutes	598	3,484
80145	Occupational Therapist Group Psychology/FPS	0	12
80160	Social Worker FPS 50+ minutes	4,011	22,736

* Focused Psychological Services

There tend to be more opportunities for community health services to facilitate services funded through the Better Access initiative in areas that private practitioners reside and practice. There may also be financial barriers for socioeconomically disadvantaged clients due to significant out-of-pocket costs. Despite these challenges, there are still opportunities for agencies to provide integrated mental health services that include MBS-funded services through the Better Access program.

[42] Exceptional circumstances apply when there has been a change in the patient's clinical condition or care circumstances, and must be authorised by the referring medical practitioner.

Case study: Mental health
Doutta Galla Community Health Service

Doutta Galla Community Health Service (DGCHS) operates from 11 sites across the cities of Melbourne and Moonee Valley. DGCH's medical clinic in Kensington employs 2.1 EFT GPs, a 0.8 EFT practice nurse and a part-time practice manager. The clinic staff work closely with other community health staff and allied health and nursing staff providing care in collaboration with the GPs and practice nurse.

Provision of MBS-funded mental health GP services

DGCHS has embraced the Better Access item numbers as one method of providing structured psychological assessment and therapy services to clients. Responsibility for Medicare billing and screening clients to ascertain their eligibility for certain MBS-funded services has been embedded into the position description of one of the administrative staff by the practice manager, who then reports monthly on billing targets to enhance the viability of the medical clinic. This role includes screening all clients through the medical billing system to see who is eligible for MBS services such as health assessments, chronic disease care plans and mental health care plans. The practice manager assists by identifying item numbers that may be used to fund clinical work, and these are discussed at fortnightly team meetings. If agreed that the items would assist, eligible clients are identified and a process is established to offer them a service funded through the item number.

DGCHS's analysis of client eligibility for care planning services will be enhanced by a thorough analysis of their client data with use of a software product called Pen Clinical Audit Tool[43], provided through the division of general practice, in conjunction with Pracsoft.

Engaging a mental health nurse

In 2007, DGCHS became aware that the Melbourne General Practice Network (MGPN) was employing a group of nurses through the Commonwealth's Mental Health Nurse Incentive Scheme[44]. Due to the strength of their relationship, DGCHS and MGPN negotiated a model whereby a nurse would be located at DGCHS's Kensington site. In 2007, a mental health nurse began working at DGCHS.

The nurse's role is to support delivery of client services planned through the Better Access MBS-funded mental health care plans. The nurse has been granted access to the medical software system used at DGCHS to help her review clients' progress against their mental health care plans, assisting with medication, helping the client negotiate the health service and welfare systems, liaising with family and carers, helping clients implement non-pharmacological approaches to managing their care, and liaising with community outreach services and other GPs in the area. The mental health nurse also works with other staff to strengthen relationships with case workers and with DGCHS's Mental Health and Complex Needs Program, which provides a range of community mental health services. Referrals to the mental health nurse are also accepted from private GPs.

43 For further information see www.nevdgp.org.au/?content=13

44 This scheme provides non-MBS incentive payments to community-based general practices, private psychiatrist services and other appropriate organisations that engage or retain mental health nurses to assist in the provision of coordinated clinical care for people with mental disorders in the community www.racgp.org.au/mentalhealth/mhnip

Enablers

- Partnership approaches – DGCHS has worked to improve relationships with other organisations and case workers. The relationship with the local division of general practice reached a level of trust whereby the division was prepared to locate one of their staff (the mental heath nurse) on site at DGCHS. Additionally, local case workers are now comfortable to visit DGCHS, often with clients, to link them into services.
- MBS billing – though GPs have always agreed on care plans with clients to improve their mental health, they are now assisted to bill appropriately for these services. For example in the past a GP may have claimed a long consultation item (item #44, $91.70), whereas they are now assisted to bill a GP mental health care plan (item #2710 $153.30). All GPs at the service, and administrative staff, have agreed on appropriate MBS billing targets in their position descriptions as well. 'It's not about throughput…it's about billing appropriately [whilst] also working to ensure that the GPs, nurses and clients are satisfied with the level of care being provided' says practice manager Janina De Silva.
- Working collaboratively – Doutta Galla's GPs, mental health nurse, practice nurse, community health nurse and refugee health nurse meet regularly to discuss client cases where mental health issues are prevalent. This has assisted staff to share effective management techniques for specific clients, to support each other, share the workload and to debrief. It also helps prevent duplication of services.
- Planned approach to ensure client consent for viewing of their records – client consent for the DGCHS GP and mental health nurse to view the client's record is noted in client files in a systematic fashion.

Challenges

- The mental health nurse found it difficult establishing her program because local GPs (external to DGCHS) were not interested in the mental health nurse initiative. The reasons for the lack of interest include the availability of other pathways for clients to access private psychological services, an unwillingness to learn of new programs and referral pathways, and a feeling that their own service provision may be 'under scrutiny'.

Next steps

With the support of the MGPN, Doutta Galla now employs the mental health nurse directly with funding provided through the Commonwealth's Mental Health Nurse Incentive Scheme ($480 a day).

Work continues with the MGPN and DGCHS Mental Health and Complex Needs Program to promote the mental health service and facilitate greater client access. The mental health nurse is now a fully integrated member of DGCHS.

6.6 Service incentive payments

Service incentive payments (SIPs) provide financial rewards for accredited general practice clinics that are participating in the Practice Incentives Program for the provision of systematic care for clients with diabetes and asthma, and for prevention of disease through immunisation and Pap tests. These are 'payments for quality' and are an important component of Australia's blended payments system for general practice.

Community health general practice clinics can access service incentive payments. Detailed information is available at www.health.vic.gov.au/communityhealth/gps/mbs/sip.htm

6.7 Quality use of medicines

The MBS funds services that help ensure the safe and effective use of medicines, both in the community sector (through Home Medicines Reviews) and in Commonwealth-funded residential aged care facilities (through Residential Medication Management Reviews). Medicare business rules stipulate that these services must be coordinated by the client's GP and involve an accredited pharmacist in order for the item to be claimable.

Robust clinical governance programs should include a focus on ensuring the safe and appropriate use of prescribed and over-the-counter medications by clients.

Case study: Home Medicines Review
Goulburn Valley Community Health Service

Goulburn Valley Community Health Service's (GVCHS) commitment to providing quality bulk-billed services led to a partnership approach between its medical clinic and a local pharmacy to deliver home-based medication management review services for clients.

Support from the local division of general practice

The first Home Medicines Review (HMR) service was initiated after a visit to the medical clinic's GP from the Goulburn Valley Division of General Practice's pharmacist project officer, who provided a briefing on the HMR process and informed the GP that a local accredited pharmacist was willing to visit clients in their own homes.

Identification of clients that would benefit

The GP offers an HMR service to clients who may benefit from an HMR, including those who are having trouble managing their medicines, those on more than five medications, those on warfarin, and those expressing difficulties in understanding what their medicines are for and how to take them.

> 'Normally the pharmacist would advise on what kind of medications the patient is on, and provide opinions to the patient and to me… she explains the side effects [to the client] and what the medicines are for' said GVCHS's GP, Dr Satpal Singh. 'We often find that patients need to have blister packs organised by the pharmacy, especially the elderly because they can get easily confused about when to take their medications, or whether or not they already taken them'.

Dr Singh organised more than 20 HMR services for clients of the clinic.

Enablers

- The visit by the local division of general practice was the key to helping the GP understand the HMR process, and to let him know that referrals to the local pharmacies would be acted upon promptly.
- The responsiveness of the local accredited pharmacist and the quality of her reports back to the GP was seen as a positive.
- The key motivation for delivery of HMR was that it is seen as a quality service for clients in the community, fitting in with the philosophy of community health.
- The remuneration of $140.20 (bulk-billed) covered the costs of the two GP consultations and the referral processes required to complete the service.
- Community pharmacies are also remunerated, receiving $187.09 for facilitating a home visit by an accredited pharmacist.

Challenges

- Provision of an HMR service is relatively time consuming, involving a GP consultation, referral, home visit, pharmacist report and second GP consultation.
- Shortages of GPs and pharmacists in Shepparton mean that only the most needy clients are able to receive an HMR service.
- The dissemination of common resources and sharing of administrative support at a regional or state level (for example, common IT templates and rotating staff between community health services) were suggested as initiatives that could increase HMR uptake.

6.8 Bulk-billing incentives

Through Medicare, it is essentially up to the provider to decide whether to bulk-bill or to charge a 'gap' and the level of any gap. However, the Commonwealth provides additional incentive payments every time GPs and practice nurses bulk-bill concessional clients or children aged under 16 years. This involves claiming a separate MBS item (a bulk-billing incentive item) in addition to the relevant MBS item for the service provided to the client. If a client is bulk-billed for more than one MBS item during a visit (for example, a GP service and a practice nurse service), then it is acceptable to claim the bulk-billing incentive more than once.

Case study: Bulk-billed MBS
Inner East Community Health Service

The Inner East Community Health Service (IECHS) has waiting lists of between 1–9 months and through use of private practitioners in community health (GPs and allied health) has been able to provide additional services, funded through bulk-billed MBS items. The MBS bulk-billing items are used for all client consultations. IECHS has been able to effectively link some clients to counselling, alcohol and drug and allied health services funded through the MBS.

Operational considerations

IECHS has assisted allied health staff with their business and MBS claiming practices when they have made the change from a salaried worker to private practitioner. IECHS has also assisted clients by providing information about how to claim MBS entitlements. Clients are recruited to MBS-funded services through GPs (the clinics use clinical audit software), intake systems and self and allied health referral.

The precise start-up costs for the introduction of the MBS items are hard to estimate because IECHS already has business systems in place to support private practitioners. Having said this, there has been considerable staff time in changing business practices and strengthening partnerships to deliver multidisciplinary work. While all services are bulk-billed, the MBS payment does not cover costs to deliver the service in all circumstances.

IECHS have found that a key challenge is working on systems and agreements to guarantee a high quality of care when care is provided by private practitioners. This is because private practitioners are not necessarily obligated to adhere to the same policies and procedures as salaried staff. To address this challenge, IECHS has focused on refining clinical governance systems through which private practitioners have agreed to operate.

Client records

Across the organisation, client records are not shared between IECHS staff and private practitioners. The barriers to shared client records include IT systems that do not seamlessly connect, the challenge of seeking client consent to share records between private and public practitioners, and clarifying who 'owns' the client – the service or the practitioner.

Enablers

- IECHS's organisational philosophy, including a commitment to care planning, self-management and innovation.
- Administrative and business support provided to private practitioners.
- A history of working with contract staff and private practitioners, and in engaging with the community, for example, informing low income clients about MBS items.
- Use of nurses and reception staff is critical to make this work.
- A focus on GP-centred practice in recognition of a strong client demand for GP-centred, multidisciplinary services for people with chronic and complex conditions.

Challenges

- Requires work on systems to ensure organisational expectations regarding quality of care are met when services are delivered by private practitioners. This is because the MBS does not guarantee quality care.
- Requires an investment in administrative and business support for private practitioners.
- Limitations on the number of MBS claims that can be made (for example, five MBS-funded allied health services per calendar year limit).
- They are currently centred around GPs, however not every client requires time with a GP.
- 'No shows' can be an issue. Innovation such as SMS messaging has been introduced, and following up clients who regularly miss appointments.

Next steps

A Commonwealth-funded mental health nurse is being appointed who will work with GPs and state-funded mental health and drug and alcohol services.

Attachment 1

Medicare items for individual allied health services for people with chronic conditions and complex care needs

MBS item numbers	Eligible provider type	Allied Health Provider Eligibility Requirements in Victoria	Medicare benefit*
10950, 81300	Aboriginal health worker	Must have been awarded a Certificate Level III (or higher) in Aboriginal and Torres Strait Islander Health from a registered training organisation that meets training standards of the Australian National Training Authority's Australian Quality Training Framework.	$48.95
10951, 81305	Diabetes educator	Must be a Credentialed Diabetes Educator (CDE) as credentialed by the Australian Diabetes Educators Association (ADEA).	$48.95
10952, 81310	Audiologist	Must be either a full member of the Audiological Society of Australia Inc (ASA), who holds a Certificate of Clinical Practice issued by the ASA; or an ordinary member audiologist or fellow audiologist of the Australian College of Audiology (ACAud).	$48.95
10953, 81315	Exercise physiologist	Must be an accredited exercise physiologist as accredited by the Australian Association for Exercise and Sports Science (AAESS).	$48.95
10954, 81320	Dietician	Must be an accredited practising dietician as recognised by the Dieticians Association of Australia (DAA).	$48.95
10956, 81325	Mental health worker	Includes Aboriginal health workers, mental health nurses, occupational therapists, psychologists, and some social workers. A **social worker** must be a member of the Australian Association of Social Workers (AASW) and be certified by AASW as meeting the standards for mental health set out in AASW's *Standards for Mental Health Social Workers 1999*. A mental health nurse must be a credentialed mental health nurse, as certified by the Australian and New Zealand College of Mental Health Nurses (ANZCMHN). Eligibility requirements for Aboriginal health workers, occupational therapists and psychologists are the same as those covered under their own categories.	$48.95
10958, 81330	Occupational Therapist	Must be a full-time member or part-time member of OT Australia, the national body of the Australian Association of Occupational Therapists.	$48.95
10960, 81335	Physio-therapist	Must be registered with the Physiotherapists Registration Board of Victoria.	$48.95
10962, 81340	Podiatrist or Chiropodist	Must be registered with the Podiatrists Registration Board of Victoria.	$48.95
10964, 81345	Chiropractor	Must be registered with the Chiropractors Registration Board of Victoria.	$48.95
10966, 81350	Osteopath	Must be registered with the Osteopaths Registration Board of Victoria.	$48.95
10968, 81355	Psychologist	Must be registered with the Psychologists Registration Board of Victoria.	$48.95
10970, 81360	Speech pathologist	Must be a practising member of Speech Pathology Australia.	$48.95

* Medicare Benefits Schedule, 1 November 2008 version. When bulk-billed, the Medicare Benefit for services provided by allied health professionals is 85% of the Schedule Fee. Note that MBS schedule fees are usually increased by a small amount by Medicare Australia on 1 November each year.

Attachment 2

Medicare items for provision of focused psychological services for people diagnosed with a 'mental disorder'

MBS item numbers	Eligible provider type	Mental health provider eligibility requirements in Victoria
2721, 2723, 2725, 2727	General practitioners	Must be registered with Medicare Australia as having satisfied the requirements for higher level mental health skills* for the provision of the service. The medical practitioner must provide the service in a general practice participating in the Practice Incentive Programs and/or which is accredited. It is acceptable for a GP who is managing a client through an item 2710 or 2712 to refer to themselves for the provision of focused psychological services if they are registered.
80000, 80010, 80020	Clinical psychologists	Must be eligible for membership of the Australian Psychological Society's College of Clinical Psychologists, and registered with the Psychologists Registration Board in Victoria
80100, 80110, 80120	Psychologists	Must be registered with the Psychologists Registration Board in Victoria
80125, 80135, 80145	Occupational therapists	Must be a member of OT Australia, with a minimum of two years' full-time experience in mental health and must abide by *The Australian competency standards for occupational therapists in mental health*.
80150, 80160	Social workers	Must be members of the Australian Association for Social Workers (AASW), and have certification from AASW as meeting the standards for mental health set out in the *AASW standards for mental health social workers 1999*.

* See www.racgp.org.au/mentalhealth

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