Australian Divisions of General Practice

Frequently Asked Questions

Edition One

Better Access

Will better Access items be accessible by GPs in non accredited practices?

Yes

Do referrals to psychologist have to be made by the persons 'usual GP'? If so ... what is the definition of the Usual GP by Medicare standards? This is a specialist practice that treats women with multiple problems including mental health issues – therefore they want to be able to refer the patients to specialist mental health providers under Better Access

Under the new items a patient should generally be referred for allied mental health services (eg. a psychologist or other appropriate mental health provider) by the GP who has completed the patient's GP Mental Health Care Plan. It is the profession's expectation, consistent with the EPC and CDM items, that this would generally be the patient's usual doctor.

This is not a mandatory or enforceable provision for the EPC or CDM items but is set out as guidance in the relevant MBS explanatory notes. The MBS explanatory notes for the new GP Mental Health Care items do not specify that a patient's GP Mental Health Care Plan must be completed by the patient's usual GP, however, it is anticipated that this would generally be the case.

The MBS explanatory notes for the EPC items define 'usual doctor' as the doctor (or practice) that has provided the majority of services to the patient over the previous 12 months, and/or that will provide the majority of services over the coming twelve months. This is not designed to be an enforceable provision and takes account of the patient's right to choose their own doctor.

If a patient is referred for allied health services by a psychiatrist or paediatrician and the GP is unaware of this and then does a GP Mental Health Care Plan and refers the patient for allied health services, will the patient be able to access rebates for these additional allied health services?

A patient is eligible to access Medicare rebates for up to 12 individual and/or 12 group services from a clinical psychologist or other allied mental health professional in a calendar year, regardless of whether they have been referred from one provider or many (i.e. a psychiatrist/paediatrician and a GP). Referral from another provider (eg psychiatrist, paediatrician or another GP) does not generate a new entitlement for additional clinical psychology or other allied mental health services.

If a patient is referred for these new items by a psychiatrist or paediatrician and the GP is unaware of this and then does a GPMP&TAC,

etc will that be rejected by Medicare and along with that any Medicare AH referrals?

It is preferable that wherever possible, patients have only one plan for primary care management of their mental disorder. As a general principle the creation of multiple plans should be avoided, unless the patient clearly requires an additional plan for the management of a separate medical condition.

Where a patient has a mental disorder as well as significant co-morbidities and complex needs requiring team-based care, the GP is able to use both the CDM items (for team-based care) and the GP Mental Health Care items.

Similarly, where a patient has been referred for allied mental health services available under the new mental health items by another health professional (eg a psychiatrist or paediatrician), the GP is able to use the CDM items for team-based care where the patient meets the MBS requirements for these services, ie where the patient requires team-based care using the CDM items to manage their chronic medical condition and complex needs.

Does the GP need to get patient consent for the GP MH Consultation item? (This relates to all the issues around confidentiality and insurance, etc).

There is no separate and specific requirement around the issue of patient consent for the GP Mental Health Care Consultation, other than the requirements that apply to consent for normal medical care using standard consultation items. As a matter of good practice, the nature of the service being provided should be explained to the patient including that it is a mental health consultation and the patient should be fully informed of their treatment options.

Is the GP required to check whether the patient has had a referral to an AHP in the past calendar year for group and/or individual therapy under Better Access before they refer? If so, how would they check this?

A patient is eligible to access Medicare rebates for up to 12 individual and/or 12 group services from a clinical psychologists or other allied mental health professional in a calendar year. A further 6 services can be accessed in exceptional circumstances, following a review by the referring practitioner. If the patient exceeds this limit they will not be eligible to claim the Medicare rebate.

A GP is not required to check a patient's eligibility, however, if a GP is concerned that a patient may have had a Mental Health Care plan from another GP, or have already accessed allied mental health services up to the yearly limit, they can ask the patient to check their eligibility for services with Medicare Australia, as is the case with the CDM items and referrals to allied health services.

Education & Training

Will GPs, particularly those who have not been involved with the BOIMHC Program, be provided with information and examples of templates of the GP Mental Health Care Plan similar to the Familiarisation Training manual? If yes, will the Division's be required to provide GPs this type of information? Will Division's be funded to do this?

Can GPs just use the BOiMHC Assessment/Plan/Review templates?

Do you have a Care Plan template for GP's to use?

The better access program mirrors the better outcomes program, in many ways. There are no prescribed templates for GPs for either program, but Divisions may choose to support their GPs in understanding the best practice examples that have been developed with better outcomes. This also means that GPs could be encouraged to use the assessment careplan and review templates that are able to be uploaded into medical director.

GPs are members of the Divisions, and it is *core business* to support their members with accurate and user friendly information about changes and processes like Better Access in Mental Health care. ADGP is committed to supporting to Divisions in getting information out to GPs in a user friendly way. To date we have worked closely with DoHA to develop three key documents all available on the ADGP Website www.adgp.com.au for Divisions use:

- A patient referral pathways document
- A GP and Patient rebates under Better access for GP Mental Health care plan and review and consultation
- A Flow chart explaining the Better Access pathways

In addition we are working closely with the Department to continue to develop tools and resources for Divisions supporting the uptake of the Better Access program. ADGP will launch this package of information at a workshop at the National Primary Mental Health Care Symposium on the 25th of November 2006. To register for this free event please visit the website www.adgp.com.au

Will Divisions be funded to coordinate, organise and/or provided mental health education and training to GPs, psychiatrists and allied health professionals?

ADGP continues to advise DoHA of the capacity needs for Divisions to support the uptake of these measures under better access. Any developments will be conveyed through the National Primary Mental Health Care Network and the DLOs.

ATAPS / Better Outcomes

Given that GPs do not need to complete a specific form to refer patients on to eligible allied mental health professionals for treatment, GPs, are unlikely to complete the ATAPS referral forms which will impact on Division's ability to meet its data reporting obligations from the 1 November 2006. Given that it is a requirement of the Divisions ATAPS funding Agreement, how do you propose the Division's meet its reporting obligations?

Better Outcomes and the ATAPs component has funding until 2009. The new pathways under Better Access will open up opportunities for all GPs to undertake mental health work and make it easier for all patients to be referred to appropriate providers under a structured mental health care process. Local providers will require some form of referral process – but this will be locally

determined, and Divisions have the opportunity to try to stream line this for their GPs. It does not need to be more complex than the ATAPs referral process. There is also the chance for Divisions to streamline the referral paperwork for their ATAPs programs as well.

It is likely that the new measures will serve to *improve* the current demand pressures on the ATAPs programs – where community need outweighs demand. There will be lots of reasons for GPs to choose the appropriate patient pathway for referral. ATAPs has provided low cost or no cost treatment options for patients, and this will remain unchanged. Divisions will have the opportunity to consider how their local models of ATAPs programs work to compliment the new measures, and align to the new measures. Divisions may consider revising their referral criteria to recognize at risk or target patient groups (eg youth mental health 12 – 25 Year olds) or to target those of lower socioeconomic groups

Divisions are required to complete the MDS for their ATAPs referrals only. If there is an increase or a decrease in the numbers of ATAPs referrals – this will be reflected in the MDS that is completed. It should not change the way the Divisions meet this reporting obligation.

Divisions will shortly be receiving a letter from the Department advising them that they should be thinking flexibly how the models of care for ATAPS will work with Better Outcomes.

What will be the incentive for BOIMHC GPs to continue referring to the ATAPS psychologists, when some private psychologists will accept the Medicare rebate as their full fee i.e. the service will not come at a cost to the patient.

Divisions will be asked to align their ATAPs models to complement the Better Access measures. This could mean that a Division in collaboration with its reference group chooses to change their referral criteria to be more specific – eg young people or ATSI or co-morbid populations or CALD. This could serve to encourage increased service levels from these groups. This approach might be useful where a Division is part of a CYS under headspace, as this could provide the service provision component of the CYS.

The underpinning message is *accessibility* of mental health care for all the patients and the carers. There will be enough need out there for all providers.

What will be the incentive for BOIMHC GPs to continue referring to the ATAPS psychologists, when the mental health conditions being treated under /Better Access /include all mental health conditions and many Division's ATAPS projects have been limited to specific mental health conditions?

Divisions need to consider how their local models will work with the new measures to provide better access to mental health care for all Australians. Where there is a locally defined client group for ATAPS Divisions should think about whether this is the right target group – or will there need to be a change in their model to best meet the needs of the community and complement the other mental health programs that they are undertaking (eg youth mental health under headspace)

What will be the incentive for BOIMHC GPs to maintain their registration?

Education is not mandatory – but will be encouraged. GPs already are required to complete ongoing education and training to maintain their practicing status. Mental health education and training that has been accredited will count as CPD for GPs and can be marketed in this way.

There has been a commitment from DoHA that they strongly encourage training and education for mental health skills. Divisions are in a good position to continue to provide education and training that involves the entire practice team (allied health professionals, practice nurses, mental health nurses, practice managers and reception staff). There have been some excellent examples of this training like *teams of two* in NSW, and the Takeaway mental health package developed by QDGP as well as the national program *Managing the Mix: Your mental health and alcohol.*

GPs who choose to undertake mental health skills based training will have a better grasp of techniques and skills required to undertake a structured 3 step mental health process, and adhere to the necessary rules under Medicare. This is another motivating factor for GPs to undertake this kind of training.

Flexible Fund Blending approach: Can Divisions use new Better Access to employ appropriate allied health providers, or increase the hours of their employed ATAPS providers (clinical psychologists, psychologists, OTs and SW) and use the medicare billing to finance salaries and on costs?

No. The new Mental Health Care MBS items for services by clinical psychologists and other allied mental health professionals are for practitioners working in private practice or covered by specific exemptions to access MBS items (eg for AMS's).