

Better Access Initiative

QUALITY PSYCHOLOGY REFERRALS

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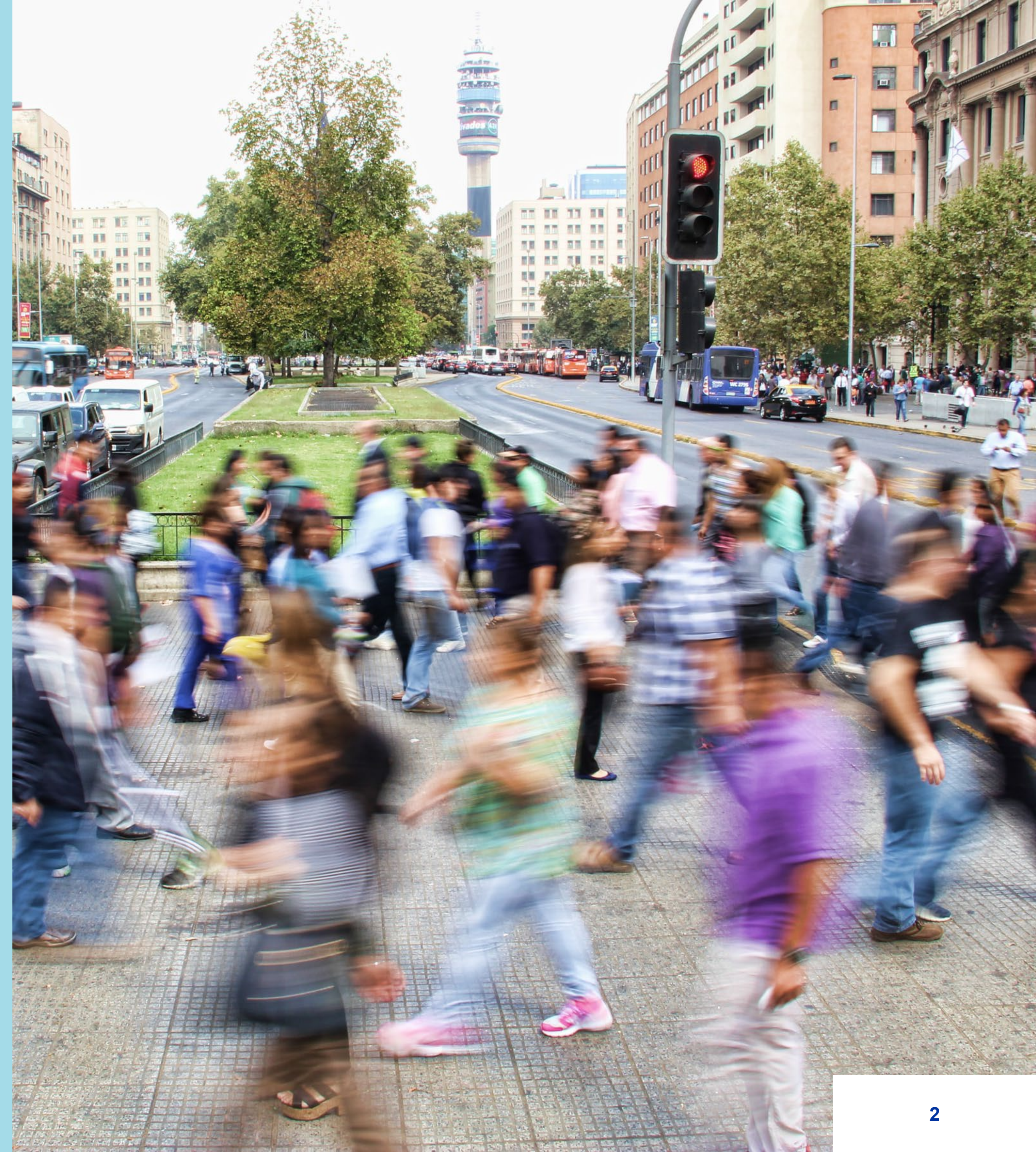
July 2021

WE ACKNOWLEDGE THE TRADITIONAL OWNERS & CUSTODIANS OF THE
LAND THAT WE LIVE & WORK ON AS THE FIRST PEOPLE OF THIS COUNTRY.



CONTENTS

1. Referrals & the Better Access Initiative
2. Where to refer young people and when – a stepped-care approach
3. How GPs can assist in service demand management
4. Quality Improvement ideas



MBS BILLING FOR GENERAL PRACTICE

GP Mental Health Treatment Plan

GP without Mental Health Skills Training

GP Mental Health Treatment Plan (GPMHTP)

- Face to face – 2700 or 2701
- Telehealth – 92112 or 92113
- No telephone items available

GP with Mental Health Skills Training

GP Mental Health Treatment Plan (GPMHTP)

- Face to face – 2715 or 2717
- Telehealth – 92116 or 92117
- No telephone items available

[MBS descriptor link](#)

Training

- GPs who complete the requirements of [Mental Health Skills Training](#) may be eligible to claim at a higher MBS rebate.
- GPs who take on additional training are eligible to provide [Focused Psychological Strategies](#) (2721, 2729, 2725 and/or 2731. Telehealth and telephone equivalent available).

Mental Health Treatment Plan Review (Face to face – 2712 | Telehealth – 92114 | Telephone – 92126)

The review item is a key component for assessing and managing the patient's progress once a GP Mental Health Treatment Plan has been prepared, along with ongoing management through the GP Mental Health Treatment Consultation item and/or standard consultation items. **A patient's GP Mental Health Treatment Plan should be reviewed at least once.**

Mental Health Treatment Consultation (Face to face – 2713 | Telehealth – 92115 | Telephone – 92127)

The GP Mental Health Treatment Consultation item is for an extended consultation with a patient where the primary treating problem is related to a mental disorder, including for a patient being managed under a GP Mental Health Treatment Plan. This item may be used for ongoing management of a patient with a mental disorder. This item should not be used for the development of a GP Mental Health Treatment Plan.

BETTER ACCESS INITIATIVE FOR GPS

About

- **Billing the item 2700, 2701, 2715 or 2717 number ‘unlocks’ the subsidised allied mental health billing.**
- Support is available from variety of health professionals.
- Eligible people can receive up to 10 individual and 10 group allied mental health services each year.
- Extra support is available until 30 June 2022 for people who have a mental health treatment plan in place. People experiencing severe or enduring mental health impacts from the COVID-19 pandemic can access an extra 10 sessions.



Why it is important

- Living with mental ill-health has a huge impact on people’s lives and can be overwhelming. For people experiencing mental ill-health, getting the right support and treatment strategies early is critical.
- Better Access helps cover the cost of this support, giving people easier access and more choice.
- People in rural and remote areas, where mental health services can be scarce, particularly benefit from being able to access video consultations.

BETTER ACCESS INITIATIVE PROCESS FOR GP AND ALLIED HEALTH PROVIDERS

1. The Mental Health Care Plan (MHCP)
2. Referral
3. The Session Numbers
4. Initial Course of Mental Health Treatment Complete
5. Re-Referral
6. Expiry of Referrals
7. Expiry of Mental Health Care Plans
8. Subsequent Courses of Mental Health Treatment
9. Discharge



“Services under the Better Access initiative are different to the services that an eligible patient can access under their Chronic Disease Management Plan.”

DEPARTMENT OF HEALTH STEPPED CARE APPROACH FOR MENTAL HEALTH

The Stepped Care Model aims to:

- Offer a variety of support options for people with different levels and types of need, from low intensity to high intensity
- Provide clear pathways between these care options as individuals' needs change
- Improve collaboration and integration between services
- Connect to other community, health and clinical mental health services available in the local area. Care may range from using a digital app, to brief non-intensive interventions initiated by a GP, to interventions requiring the coordinated, ongoing efforts from a range of professionals on a range of conditions.

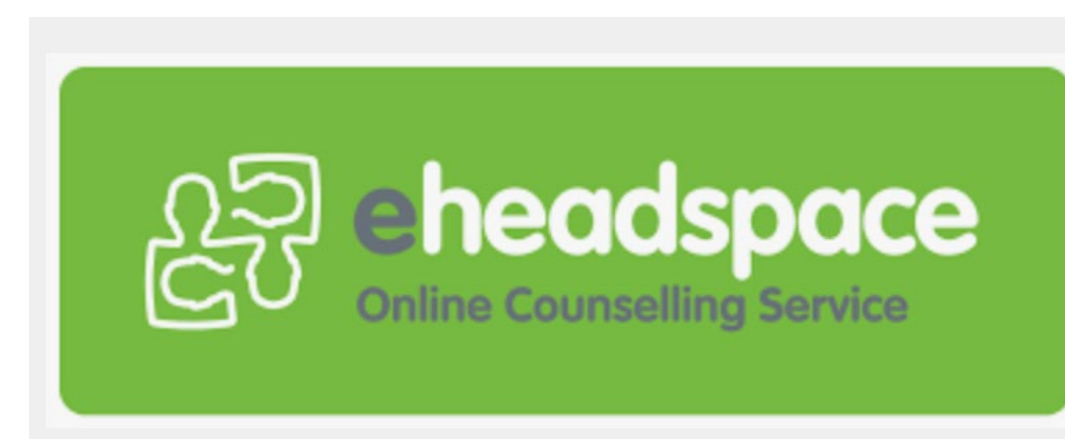


Working with the Stepped Care Model: Mental health services through general practice 2019 RACGP

WHAT IS THE ROLE OF THE GP IN STEPPED CARE?

- GP counselling of patient without the structure of formal psychological therapy
- Referral to digital mental health treatment programs
- GP assessment and diagnosis, with option of prescription medication
- GP delivering face-to-face focused psychological therapy (for appropriately trained GP)
- Referral to an allied health professional such as a psychologist, occupational therapist, social worker or a specialist psychiatry service through a GP Mental Health Treatment Plan (GPMHTP)
- Support to access disability services
- Engagement with families and carers

Tip - General Practice Mental Health Standards Collaborations provides GP MFTP templates in [Rich Text Format](#)



YOUTH MENTAL HEALTH – K10 ASSESSMENT AND SCORE

- K10 Score 0-35 = Low/Mild to Moderate Intensive Services
- K10 Score 35-45 = High Intensity Services
- K10 Score 45-50 = Acute and Specialist Mental Health Services



REFERRING TO HEADSPACE – A LOW TO MODERATE INTENSITY SERVICES

Inclusion	Exclusion
<ul style="list-style-type: none">• The young person is experiencing or at risk of, mild or moderate mental health difficultiesAND• The young person is suitable for short - medium term intervention (up to 10 sessions) AND• There is at least a 6 week period of nil suicide attempts or serious self-harm, as well as an absence of intent to act on thoughts of suicide at the date of referral.• Includes presenting issues such as: Bullying; interpersonal issues; family issues; adjustment disorder; stress; grief & loss; anger; forensic issues; engagement barriers; vocational; drug & alcohol; anxiety; depression; noncomplex trauma – relating to recent, discrete event; self-Harm – Mild to Moderate, without suicidal intent; BPD traits; autism spectrum traits,	<ul style="list-style-type: none">• Risk – If young person has level of risk high enough to warrant entry to a secondary service or poses an unacceptable risk to staff / clients: e.g. within the past 6 weeks at time of referral has had suicide attempts, serious self-harm, suicidal intent; homicidal ideation or attempt.• Moderate to Severe OCD• Eating disorder specifically Anorexia Nervosa• Schizophrenia• Psychosis• Sexual Assault as the main presenting issue• Complex child protection concerns requiring multi-agency coordination

REFERRALS

SeNT eReferrals – electronic headspace referrals

SeNT Referral

Dr A PractitionerSend feedback

PATIENT NAME: Ms Sasha ANDREWS DOB: 12 Jul 2007

Referral information

Referral date

9 Jul 2021

Referral length

12 monthsIndefinite

Referral type

New ReferralOther

Referral recipient

Specialty and condition

Psychology - Other Psychology Concern

Priority

UrgentNon Urgent

Facility type

PrivatePublic

Geographic location

Lower Hunter/ Maitland/ Cessnock/ Dungog

Provider name

Please select

headspace Maitland - Maitland

headspace Cessnock - Cessnock

Central Access and Referral - PRIMA

Referral address

Date patient consented to referral

Patient will consider telehealth?

YesNoNot stated

Are you the patient's usual GP?

YesNo

Standard clinical information

Patient information

Insurance information

Referring GP's information

Attachments

To refer to headspace Maitland or Cessnock in SeNT:

1. enter the relevant condition in the Specialty and Condition search bar (see separate list) and choose either Psychology + relevant condition OR Mental Health + relevant condition

2. select the Priority either Urgent or Non Urgent

3. select Facility Type as 'Public'

4. select Geographic location as Lower Hunter/ Maitland / Cessnock / Dungog

5. select provider name as headspace - Maitland or headspace - Cessnock

6. complete the remainder of the referral including the Speciality Clinical Information form and submit the referral.

NOTE: referrals for headspace Maitland and Cessnock are delivered directly to the secure Referral Manager portal. Once the GP submits a SeNT eReferral, headspace Maitland/ Cessnock receive an email notification that a referral is in the portal. headspace Maitland / Cessnock will then access, triage and manage the referral.

This additional service information iHover appears when the mouse is hovered over the provide name in the drop down list.

Specialist: Psychologist

Site: headspace Maitland

Service Name: headspace Maitland

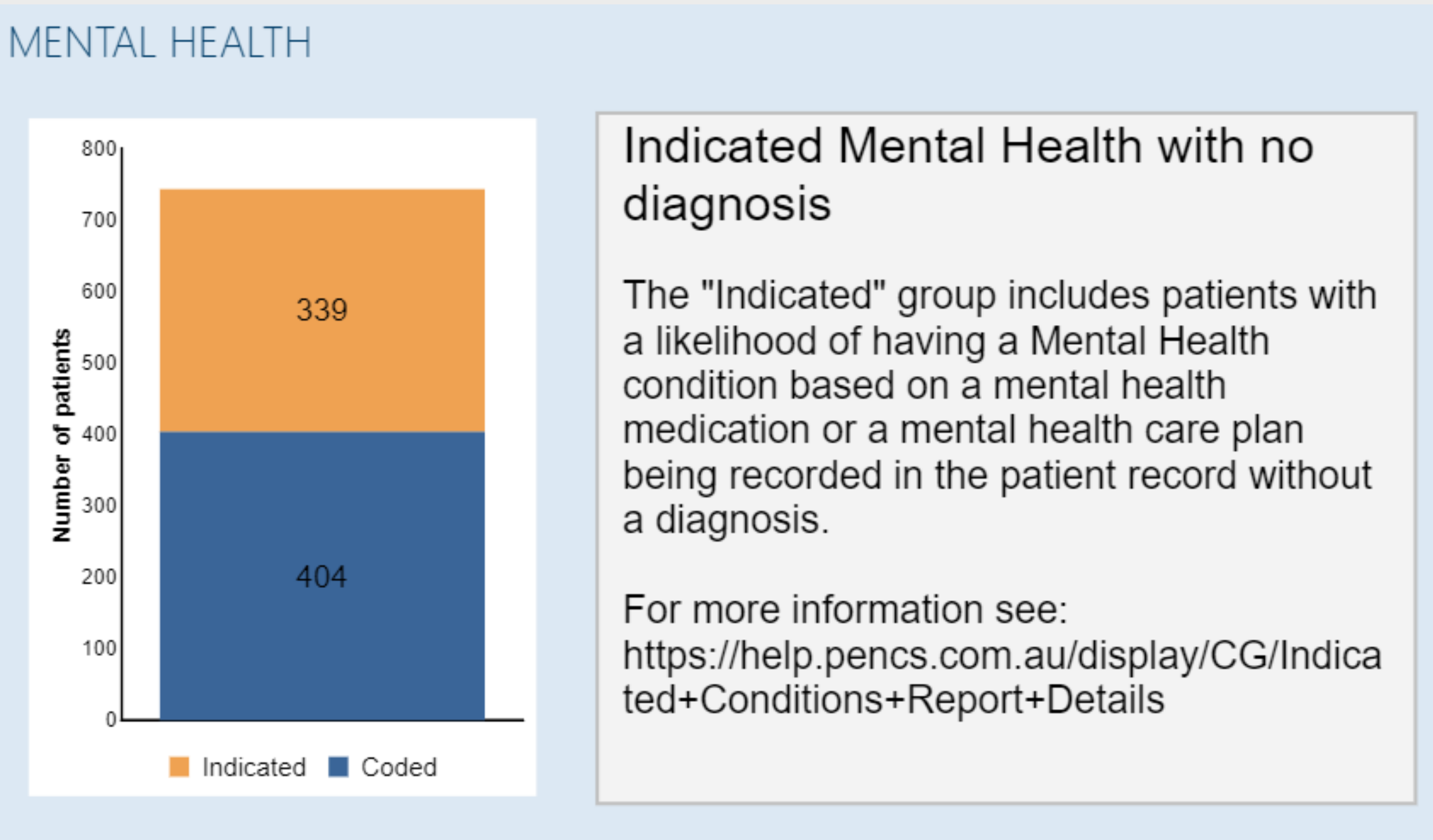
Additional Information: This program is for young people aged 12-25 years old with mild to moderate mental health concerns that can be managed within a primary care setting. GP's to indicate the number of sessions required within the referral

Telehealth Enabled: Yes

PHN © 2020 Editable Document Title

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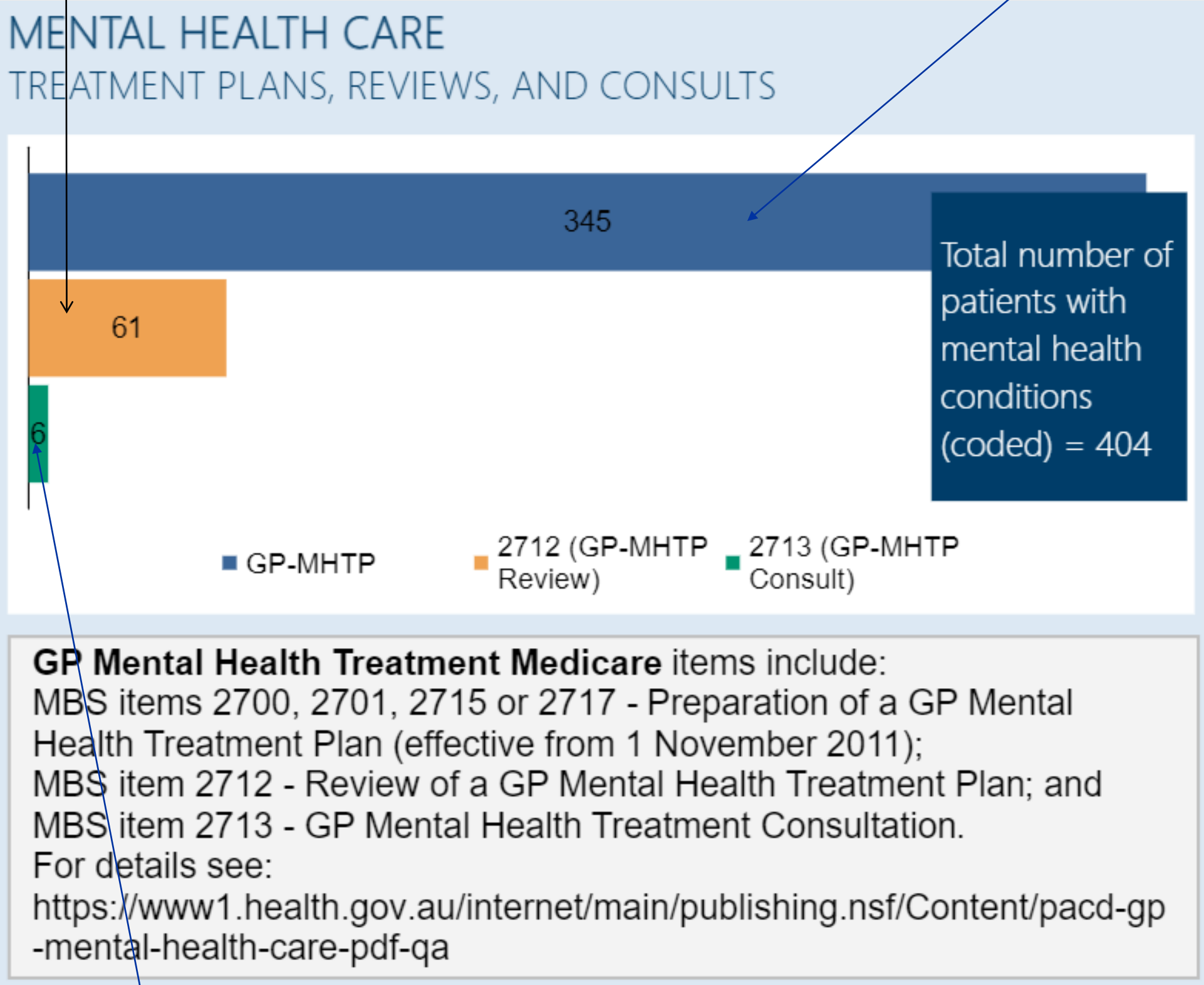
GENERAL PRACTICE COMPREHENSIVE DASHBOARD



[Indicated Conditions Report Details - CAT GUIDES](#)

Mental Health Treatment Plan review

Mental Health Treatment Plan



Mental Health Treatment Consultation

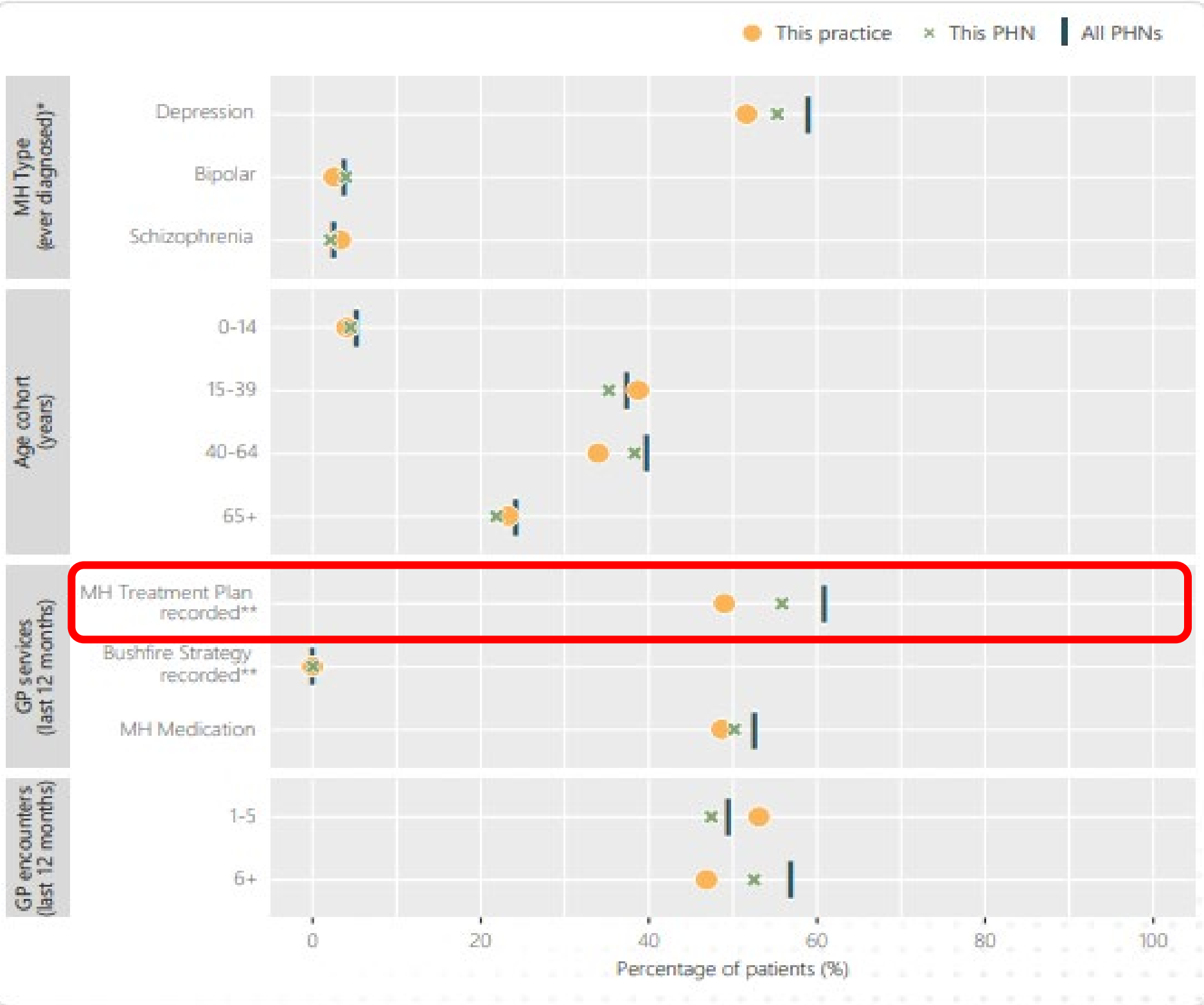


Condition in focus: Mental Health

Patients diagnosed with selected mental health conditions at your practice

Among patients who had encounters with your practice in FY19-20, 271 (15.9%) patients were coded as having ever been diagnosed in your practice with one of the following mental health conditions: anxiety, bipolar disorder, depression or schizophrenia. This compares to 16.1% among Lumos participating practices in this PHN. This page provides a deeper insight into this cohort.

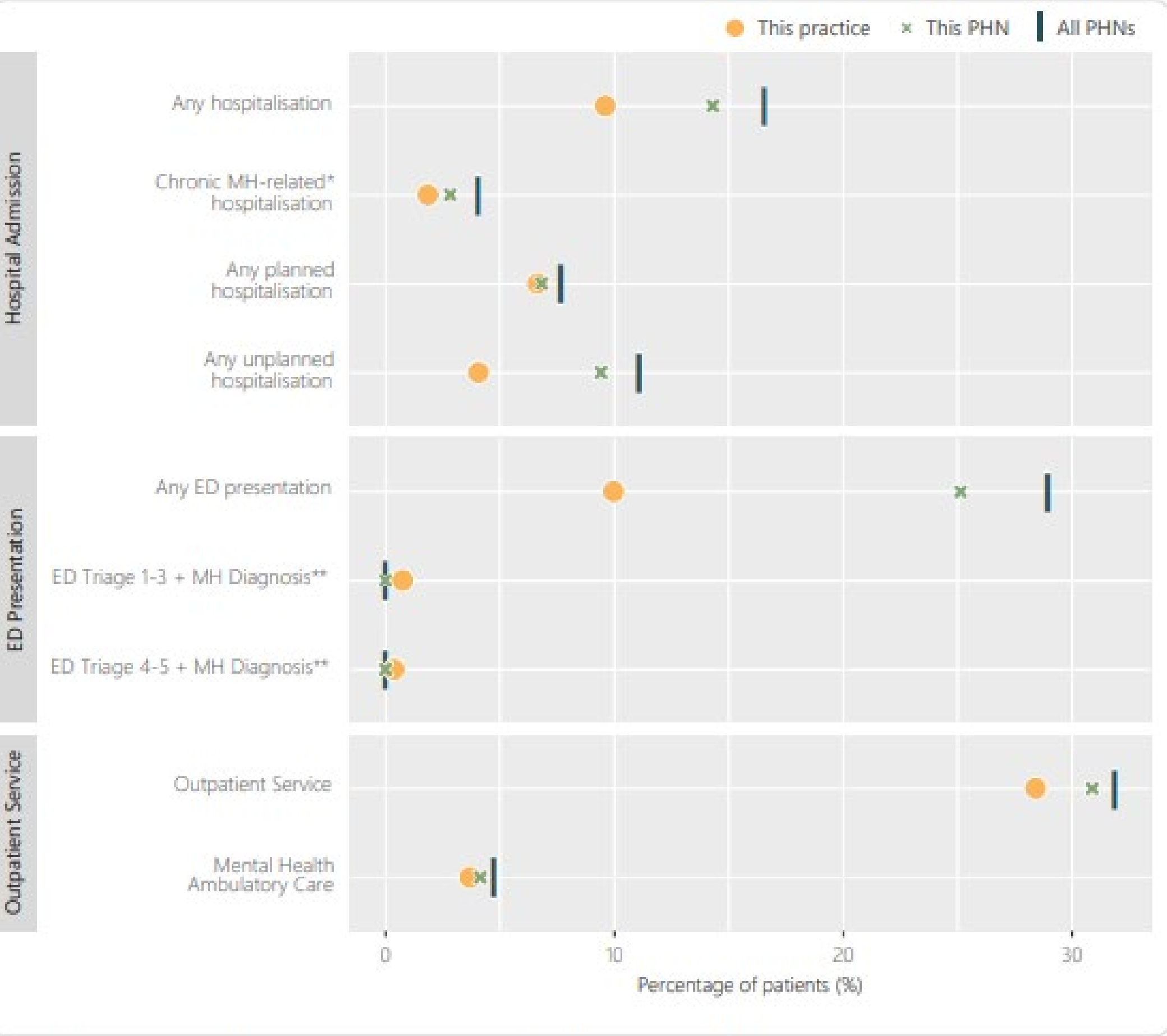
The following graph shows the distribution of your patients with mental health conditions by condition type, age cohort, frequency of GP encounters and selected GP services recorded.



*Note that totals may not add up to 100% because 1) anxiety cannot be shown separately and 2) some people may have more than one condition.
** These GP services were only included from practices where MBS item codes were available.

NSW Health service use among patients with selected mental health conditions

Among patients coded as having the selected mental health conditions at your practice and who had encounters with your practice in FY19-20, the following proportion used other NSW health services in the same 12 month period.



Note that some patients have used multiple health services, and therefore will appear multiple times in this chart.
*Chronic mental health related hospital diagnosis as the main or additional diagnosis in hospital records.
** Any mental health diagnosis as the principal diagnosis in ED records

Of those patients who had encounters with your practice in FY19-20 who were not coded as having one of the selected mental health conditions, 1 (0.1%) had a mental health related hospitalisation.

MODEL FOR IMPROVEMENT

Mental Health Quality Improvement Toolkit are available on our [website](#).

GOAL SETTING

NOTE: This document can be used for ONE "Practice Incentive Payment Quality Improvement (PIP QI)" Quarter

This record can also be used to assist with preparation for RACGP Accreditation

Practice name:	PIP QI Quarter:
Record completed by:	Date:

Focus Area & Aim | What are you trying to achieve? | What is your goal?

Use **Specific, Measurable, Achievable, Relevant, Time-based, Agreed (S.M.A.R.T.A)** goals.

Example: Our practice would like to increase clinical coding/recording of smoking status, weight, alcohol intake and physical activity in each patient's clinical record within the next 3/6/9/12 months.

Increase the proportion of patients who have a mental health diagnosis recognised by the [PenCS](#) software in their patient file. |

What are the ways that you can review and measure the activity?

Example: The practice nurse can use the Primary Health Network practice dashboard (or run a CAT 4 report in PEN CS) to observe the baseline data. This can be reviewed at monthly intervals and at the end of the PIP QI Quarter.

**PCIO TIP* insert image of baseline data or scan dashboard report and attach to this document. Your PCIO can help with this if you need.*

Decrease in number of patients listed in the 'indicated mental health with no diagnosis' report in Cleansing CAT4 so that the number is 0 within 6months time. Review PHN dashboard.

IDEAS | What activities and changes can you make to help you reach your GOAL?

Develop ideas that you would like to test towards achieving your goal. Use the **S.M.A.R.T.A** approach when developing your ideas.

Example: By August 2021, record 100% allergy status for all active patients.

Idea 1.	Review Cleansing CAT4 per GP to create list of patients that have indicated mental health with no diagnosis. Print off 10 patients per GP per fortnight to review starting from <insert date here>. Continue until list completed. Alternatively, can use Topbar prompt. Tip - search 'indicated conditions report details' on the PenCS website to find more information. To find out more information on using Topbar prompts in recipes please search Topbar prompts on the PenCS website .
Idea 2.	Turn off free text in medical software to ensure all diagnoses are picked up by the CAT4 software by <insert date here>. Configure user options to help maintain data quality.
Idea 3.	Clinical team member to complete a bulk clean up of free text diagnosis by <insert date here> Tip - search 'bulk clean up' on the PenCS website to find more information.

MODEL FOR IMPROVEMENT

Plan, Do, Study, Act (PDSA) Cycle

IDEA <i>(From page 1)</i>	Review Cleansing CAT4 per GP to create list of 10 patients that have indicated mental health with no diagnosis. List to be distributed and acted upon prior to the next clinical meeting.
PLAN <i>Who is going to undertake this activity? When are they going to do it? What resources/software will they need?</i>	<p>Who: Practice nurse and/or practice <u>manager</u></p> <p>When: <insert date here></p> <p>Where: Practice computer with CAT4 installed</p> <p>Data to be collected: Number of patients, per GP, in Cleansing CAT4 with 'likely indicated mental health with no <u>diagnosis</u>'.</p> <p>Data predictions: Predict that approximately 30patients will have indicated mental health but no diagnosis.</p>
DO (DID) <i>Was the plan executed? Were there any unexpected events or problems? Record data.</i>	<p>Clinical meeting was held on <insert date here> and GPs were informed of the plan to review patients with indicated mental health with no diagnosis. GPs were invited to propose number of patients they could review per fortnight.</p> <p>Cleansing CAT4 was used to print list of 10 patients per GP with 'likely indicated mental health with no <u>diagnosis</u>'.</p> <p>Lists were given to each GP on Monday <insert date here> to be reviewed and completed prior to the next meeting. Outcome was discussed at the following clinical meeting.</p>
STUDY <i>Review actions and reflect on outcome. Compare to predictions</i>	4/6 GPs were able to completely review their list, and the remaining 2, were able to partially review their list.
ACT <i>What now? What will you take forward? What is the next step?</i>	At clinical meeting it was decided that a <u>Topbar</u> prompt would be used to create reminder for GPs to review for likely mental health diagnosis when in a patients file. All other <u>Topbar</u> prompts were turned off so they could focus on this one activity.

Thank you!

Hannah Jenkins & Alicia Southwell
July, 2021



Access to free counselling
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