

Using the MBS to expand the range of service for your clients

Market Stalls

You have the option of attending 4 out of 6 "market stall" presentations

<p style="text-align: center;">Option 1 Western District Health Service Contact person: Adam Taylor</p> <p>WDHS have developed an integrated, proactive and sustainable chronic disease service, working with local private GPs, allied health and community health providers. This has included</p> <ul style="list-style-type: none">• employing a chronic disease management nurse to see clients and coordinate systems and services• establishing an electronic referral system from the GPs to community health through Argus promoting the VSRF• working with private and public allied health• linking the client into allied health services located at WDHS through a GP care plan• providing training for local practice nurses to make the model sustainable.	<p style="text-align: center;">Option 2 Hesse Rural Health Service Contact person: Andrea Dunlop</p> <p>From 2007, HRHS has taken over the management operations of the Winchelsea Medical Centre to maintain GP services for the community. During this time HRHS has:</p> <ul style="list-style-type: none">• focused on recruiting GPs and linking to other HRHS services• recruited a part-time practice manager/practice nurse to enhance the viability and services offered by the clinic• found the recruitment of GP Registrars a useful strategy, not only to enhance workforce but to assist with change management.
<p style="text-align: center;">Option 3 Doutta Galla Community Health Service Contact person: Janina De Silva</p> <p>DGCHS received a grant to enhance the breadth and viability of its GP clinic based in Kensington, Melbourne. This has included:</p> <ul style="list-style-type: none">• employment of a practice manager• a new approach to recruitment / retention of GPs• strengthening links with local division• enhancement of the roles of nurses and administrative staff• focusing on teamwork in the clinic including the reception team, as their contributions are often undervalued (especially in the area of triage). They have been included in all practice development and enhancement activities and this has in turn increased the income of the medical practice• employment of a mental health nurse through a Commonwealth initiative• establishment of MBS billing targets for "new" MBS item numbers and a strategic approach to delivering services through "new" MBS item numbers• analysis of client data through the Pen Clinical Audit tool and PracSoft.	<p style="text-align: center;">Option 4 Banyule Community Health Contact person: Meni Stefanovski</p> <p>BCH have focused on strengthening business systems and practices in its GP clinic to improve coordination of care, particularly for clients with a chronic disease, and to improve its workforce capacity. This has involved BCH:</p> <ul style="list-style-type: none">• implementing a continuous quality improvement process using the Pen Clinical Audit tool to improve the quality of clinical data• using the Practice Health Atlas to gain a better understanding of the chronic disease profile of patients• using this information to target resources to better coordinate services for clients with chronic disease and mental health problems through employment of an assessment and chronic care nurse, and a credentialed mental health nurse,• undertaking more planned and proactive care, particularly health assessments, care plans, home medication reviews, and more recently mental health care plans. <p>This work is being supported through the Medicare Benefits Schedule. HRHS are now focused on a more effective use of the MBS.</p>

**Option 5
Hepburn Health Service
Contact person: Erin Richardson**

HHS has developed a sustainable model of integrated health care, supported through the MBS, with a focus on care planning and multidisciplinary care, to improve the health outcomes of people with type 2 diabetes mellitus in Daylesford. HHS has collaborated with two local general practices to plan and coordinate access to a mix of public and private services for the client population group.

This work has involved:

- the GPs, with support from primary care nurses, developing GPMPs and TCAs for clients identified as having Type 2 diabetes with complex care needs
- nurses managing the recall/reminder system so that care plans are regularly reviewed
- two AH practitioners (including an exercise physiologist) working in a private capacity at HHS
- the general practices having electronic access to the appointment calendars of these providers
- each client having a "diabetes hand-held" record
- standardised referral and communication processes including electronic transfer of care plans between the general practices and private practitioners
- sharing of GPs' client/group health outcomes data with HHS-CHS practitioners.

**Option 6 (morning only)
Greater Dandenong
Community Health Service
Contact person: Sue Willey**

GDCHS has worked for many years to enhance access to culturally appropriate GP services for newly arrived refugees to the area. The refugee health nurse works with a range of providers to improve the capacity of individuals to access and receive quality health services. This has involved work with a GP employed within GDCHS, as well as external care providers including private GPs and Dandenong Hospital. This work has involved:

- working with key referral partners (such as the Australian Multicultural Education Services settlement case workers) to ensure clients from a refugee background are connected with GDCHS
- support to local private general practices that have a particular interest in refugee health and are prepared to offer health assessments
- provision of health assessments, supported by the MBS, by the GDCHS GP & private GPs
- as a result of the health assessments, further needs are addressed (eg through referral).

GDCHS has grappled with some of the challenges of providing a health service to people from a refugee background. They are also looking to their next steps, such as investigating a model to build further rapport with refugees settling in the area by co-locating allied health staff in GPs' practices for sessions.