SYDNEY NORTH Health Network

WELCOME

MBS Item Numbers for Older Persons in the Community Including Case Conferencing

Presented by Wendy O'Meara Primary Health Education Consultant

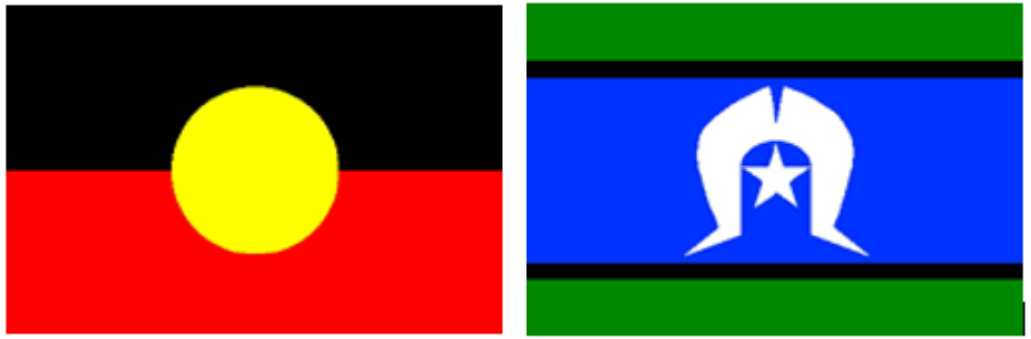
Wednesday 19 October, 2022

ACKNOWLEDGEMENT OF COUNTRY

SYDNEY NORTH Health Network

The Sydney North Health Network wishes to acknowledge Australia's Aboriginal peoples – the traditional custodians of the land on which we meet and work.

We pay our respects and recognise their continued connection to land, water and community and honour their ancestors, Elders past, present and emerging.



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HOUSEKEEPING

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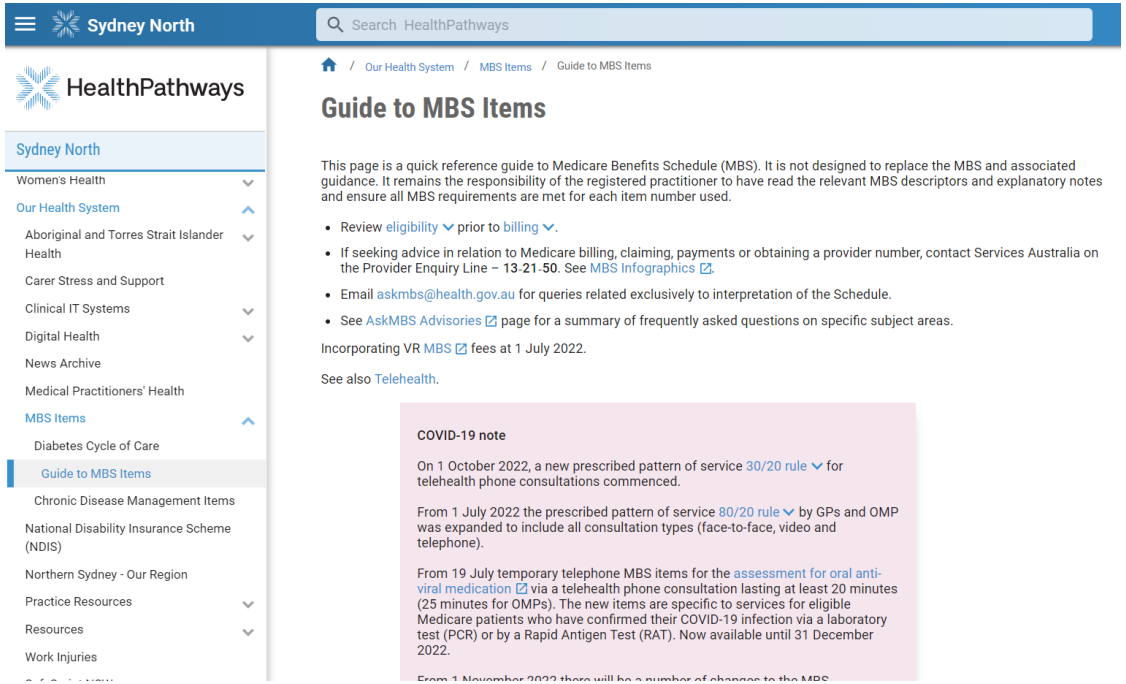
  Your microphone and video will be disabled during this webinar.
- **Interact with each other and submit questions via the chat box -** In your controls at the bottom window, click Chat If you are on a mobile device, tap Participants, then Chat. Select who you would like to send the message to by clicking on the drop down next to "To" e.g. All Panelists and Attendees
- **Please be respectful** of other participants and behave as you would at a face-to-face meeting.
- **If your screen freezes** during the presentation, it could be your WiFi connection is limited – try moving closer to your WiFi router
- **Evaluation** – This will be available via QR code at the completion of this webinar. Please ensure that you submit this to ensure that we can adhere to our RACGP reporting requirements

HealthPathways

A WAY FORWARD

HealthPathways is an online health information website which supports GPs, Hospital Doctors, Nurse Practitioners, Pharmacists, Allied Health And Other Clinicians.



VIEW LIVE PATHWAY

WATCH VIDEO

NSW GOVERNMENT Health Northern Sydney Local Health District

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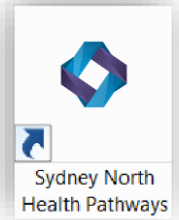
NEXT STEPS

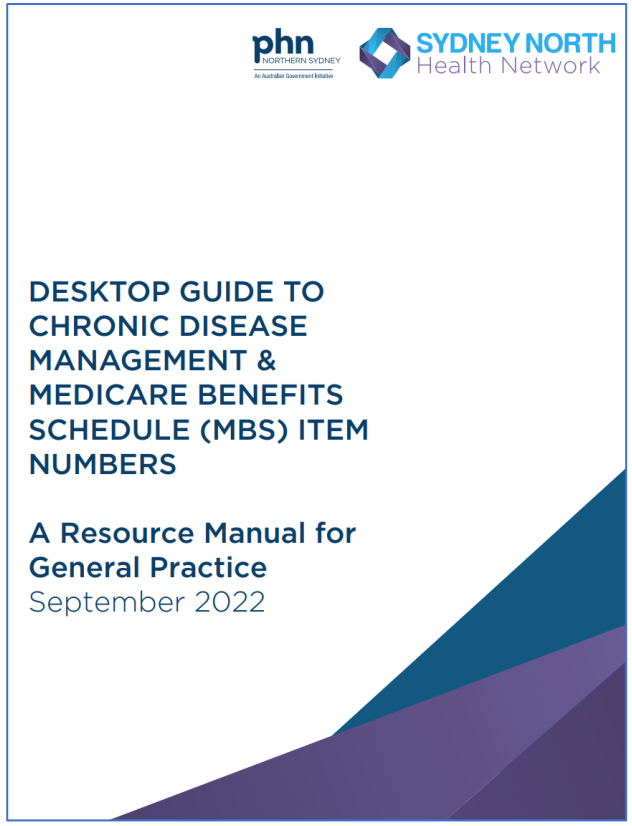
- Login to the HealthPathways website and available localised pathways
- Install the HealthPathways desktop icon 

- Start using HealthPathways in your practice
- Use the floating feedback button 

- For more information contact healthpathways@snhn.org.au

MBS ITEM GUIDE

https://sydneynorthhealthnetwork.org.au/wp-content/uploads/2022/10/Desktop-Guide-Sep-2022.pdf



SUPPORT SERVICE FOR PATIENTS

	Non Urgent					
	Health Navigators Information And Navigation For Services	**Geriatrician Outreach to Primary Care Service** Clinical Input Into Patient Care	**Care Coordination Service**	**Coordination Support For Complex Patients**	**DBMAS** Dementia Support And Management	**Sydney Home Nursing Service**
When Best To Use The Service	When a health professional looking to quickly identify local health and social care services.	When a GPs wishes to have Geriatrician input into patient care	For patients that require assistance with health and social care coordination. Requiring assistance with transport, health service access, MyAgedCare etc.	For patients that are at very high risk of deterioration/have complex needs.	Where a person is experiencing severe and extreme BPSD, DBMAS can refer them to the Severe Behaviour Response Teams for additional support.	General nursing care e.g. comprehensive assessment, wound management, help with medication, pain management and short term care.
Eligibility Of Referrals	For patients generally aged 75+ years. Referrals made only by health professionals.	Patients that are at risk of deterioration in the next 3 months with issues relating to ageing and those mentioned above.	For patients that are enrolled in the Keeping Well And Independent Program.	For patients that are complex and have a high risk of representing to hospital.	Patients with Dementia	• Support to the aged and or disabled or those with a chronic illness • Counselling, support and palliative care to terminally ill people and their families/carers • Chronic disease management support.
Contact details, Referral Details and Locations	Contact: 1800 271 212	**Lower North Shore Area** 0434 579 132	**Willougby, Lane Cove, Mosman, North Sydney, Northern Beaches LGA** Contact: 1300 002 262	Contact: 1300 732 50	Contact: 1800 699 799 Referral Form	Referrals: 1300 732 503 https://www.nslhd.health.nsw.gov.au/pach/Pages/NSHNS.aspx
	District Wide	**Ryde/Hunters Hill Area** 0451 829 527	**Ryde, Hornsby, Ku-rung-gai LGAs** Contact: 02 9477 8700	**District Wide**	**District Wide**	**District Wide**
		Hornsby-Ku-Ring-Gai 0478 784 215				

SUPPORT SERVICE FOR PATIENTS

	Urgent	
	Hospital In the Home (HiTH) Previously APAC	**Geriatric Outreach Service** Rapid Response Services
When Best To Use The Service	For patients that require assistance with any of the below and at a point where there is a sense of urgency.	Urgent referrals will be home visited within 1-24 hours and Non-urgent referrals will be seen within 1 week.
Eligibility Of Referrals	• Cellulitis, • Community Acquired Pneumonia • COPD/Brochiectasis • UTI/ Pyelonephritis • Thromboembolic disease • Subcutaneous fluid rehydration (RACF) • Allied health sensitive conditions (elderly at-risk of hospitalisation)	Patients in their own home and living in RACFs
Contact details, Referral Details and Locations	Contact: 1300 732 503 + option 1 or fax: 9887 5518 Referral form: NSLHD-HCC@health.nsw.gov.au	**Lower North Shore Area** AART (Aged care rapid response team) 0408 546 907
		Ryde/Hunters Hill AART (Aged care rapid response team) 0409 460 419
		Hornsby-Ku-Ring-Gai Geriatric Rapid Aged Care Evaluation (GRACE) 02 9485 6552
		Northern Beaches Beaches Rapid Access Care for the Elderly (BRACE) 02 9998 6111

LEARNING OUTCOMES

- Identify and manage a patient or group of patients that are making recurrent presentations to hospital (ED) by utilising available data and establishing team-based care through use of available resources
- Utilise appropriate MBS item number/s to ensure provision of support through referrals to allied health services appropriate to the patients' needs
- Identifying health concerns within the elderly through better understanding of MBS item numbers
- Outline effective referral pathways and options to ensure continuity of patient care

SPEAKER INTRODUCTION

SYDNEY NORTH Health Network

Wendy O'Meara | Primary Health Education Consultant

- Over the last 23 years, Wendy has worked in all aspects of General Practice including Reception, Practice Nurse and Practice Manager, and have a strong, comprehensive understanding of all facets surrounding each area.

- Wendy currently manages 15 reception and admin staff, 5 chronic disease nurses, and is responsible for IT, daily operations and induction and mentoring of new GP's and medical students, along with accreditation preparation for her current practice.

- Wendy has developed a strong interest in Medicare interpretation and chronic disease, and has an excellent understanding of the guidelines, and how to maximize it within a general practice setting.

SYDNEY NORTH Health Network

Thank you for participating in todays training.

Please remember to use your phone to complete the evaluation by QR code

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MBS item numbers for Older Persons in the Community

Presented by
Wendy O'Meara

LEARNING OBJECTIVES

At the end of this workshop, the participant should be able to:

- Identify and manage a patient or group of patients that are making recurrent presentations to hospital (ed) by utilising available data and establishing team-based care through use of available resources
- Utilise appropriate MBS item number/s to ensure provision of support through referrals to allied health services appropriate to the patients' needs
- identifying health concerns within the elderly through better understanding of MBS item numbers
- outline effective referral pathways and options to ensure continuity of patient care

What does the data tell us?

Australian population

Australia's Population Is Ageing

June 2020

4.2 Million Over 65

More Than Half Were 65-74

2 In 10 Were Aged 75-84

1 In 8 Were Over 85

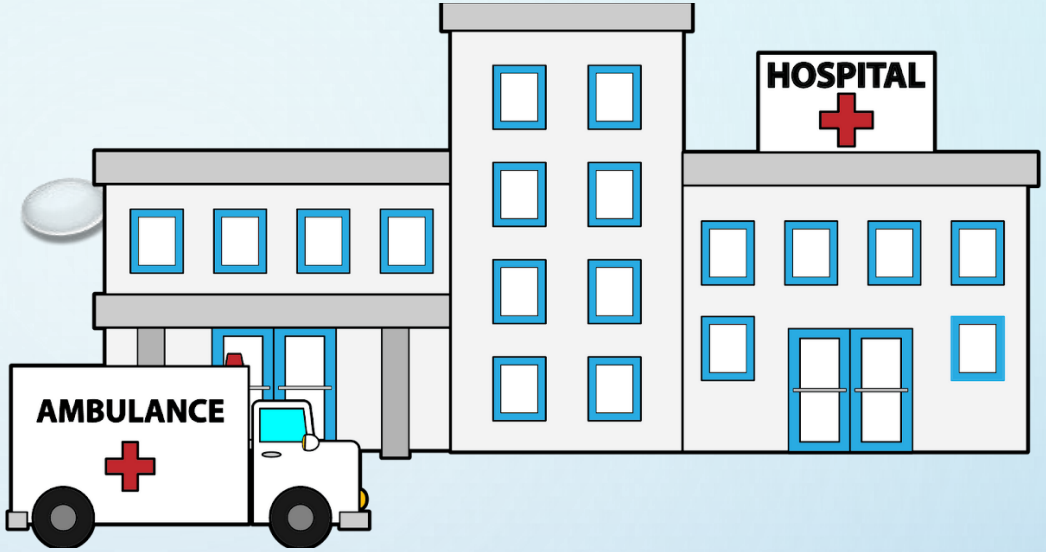
By 2066

8 Million Over 65

https://www.aihw.gov.au

Some statistics

- Older Australians are presenting as an increasing percentage of the population
- More women than men
- NSW 17% of population is over 65
- Over 65yo accounted for 16% of all hospital admissions and 53% of extended stay episodes



Potentially preventable hospitalisation

Northern Sydney-
Sydney North Health Network

2017-2018

- 22,021 PPH (potentially preventable hospitalizations)
- 2062 per 100,000
- Chronic Disease and falls main presenting condition
  - Medication mismanagement

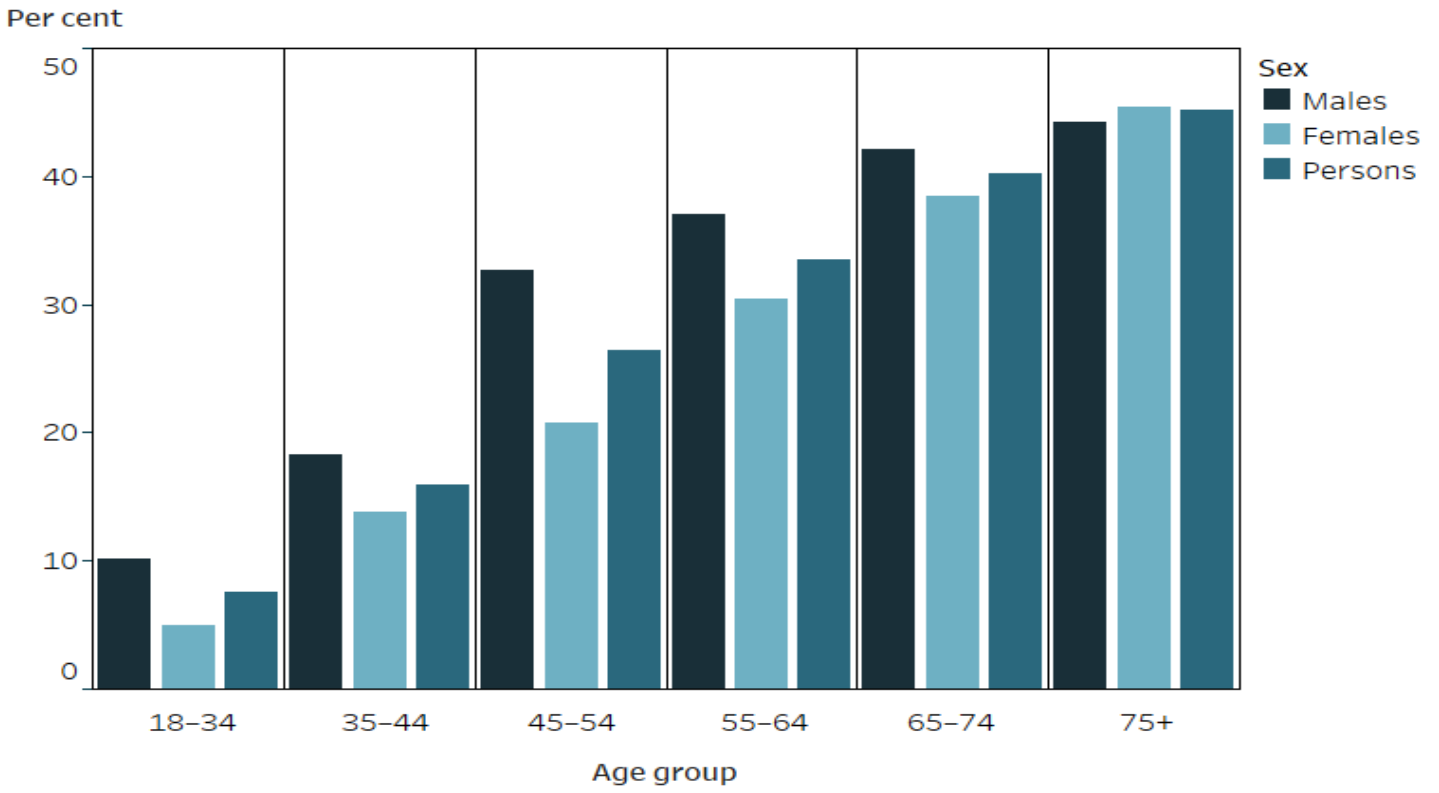
Appendices

Appendix 1: Conditions included in the potentially preventable hospitalisations indicator

Conditions included in the potentially preventable hospitalisations health performance indicator, as per the specifications for the National Healthcare Agreement in 2016, are listed below.[2]

Vaccine-preventable conditions	
• Pneumonia and influenza	• Other vaccine-preventable conditions
Chronic conditions	
• Asthma • Congestive cardiac failure • Diabetes complications • COPD • Bronchiectasis	• Angina • Iron deficiency anaemia • Hypertension • Nutritional deficiencies • Rheumatic heart diseases
Acute conditions	
• Pneumonia (not vaccine-preventable) • Urinary tract infections, including pyelonephritis • Perforated/bleeding ulcer • Cellulitis • Pelvic inflammatory disease	• Ear, nose and throat infections • Dental conditions • Convulsions and epilepsy • Eclampsia • Gangrene

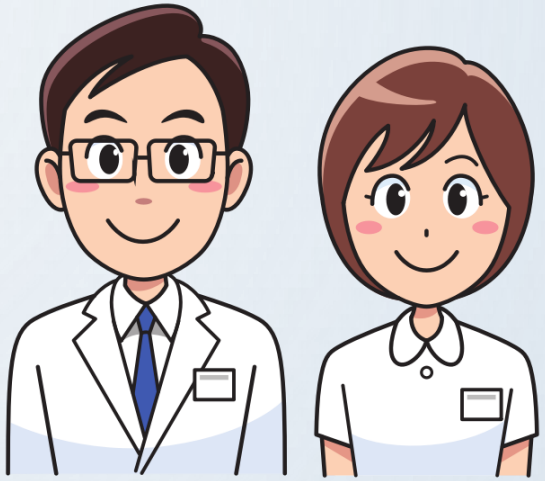
Figure 3C.2: Percentage of Australians with measured high blood pressure by age group and sex, 2017–18



Notes
1. 'Measured high blood pressure' is defined as measured systolic blood pressure of 140 mmHg or more, or diastolic blood pressure of 90 mmHg or more, whether or not they were taking blood pressure medication.
2. 'Older Australians' refers to people aged 65 and over.

Source: ABS 2018b.
http://www.aihw.gov.au/

How can General Practice prevent hospital admissions



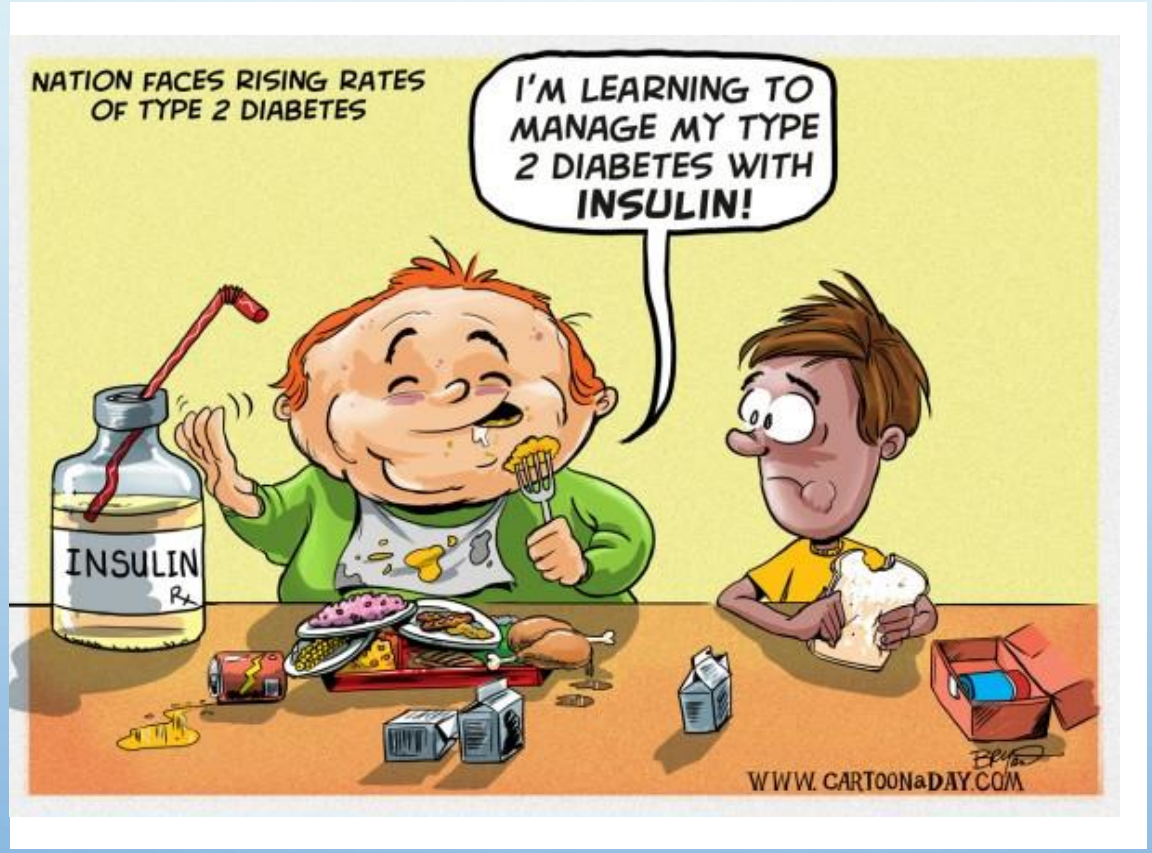
- GP are front line of Australian health care
- Critical in reducing number of PPH
- 95% of all elderly people regularly see GP

2018-2019 Australian Bureau of Statistics

- Falls and Chronic Disease are the largest contributor to hospital admissions
- 2019-2020
  - 42% of hospital admissions and 40% of deaths due to falls

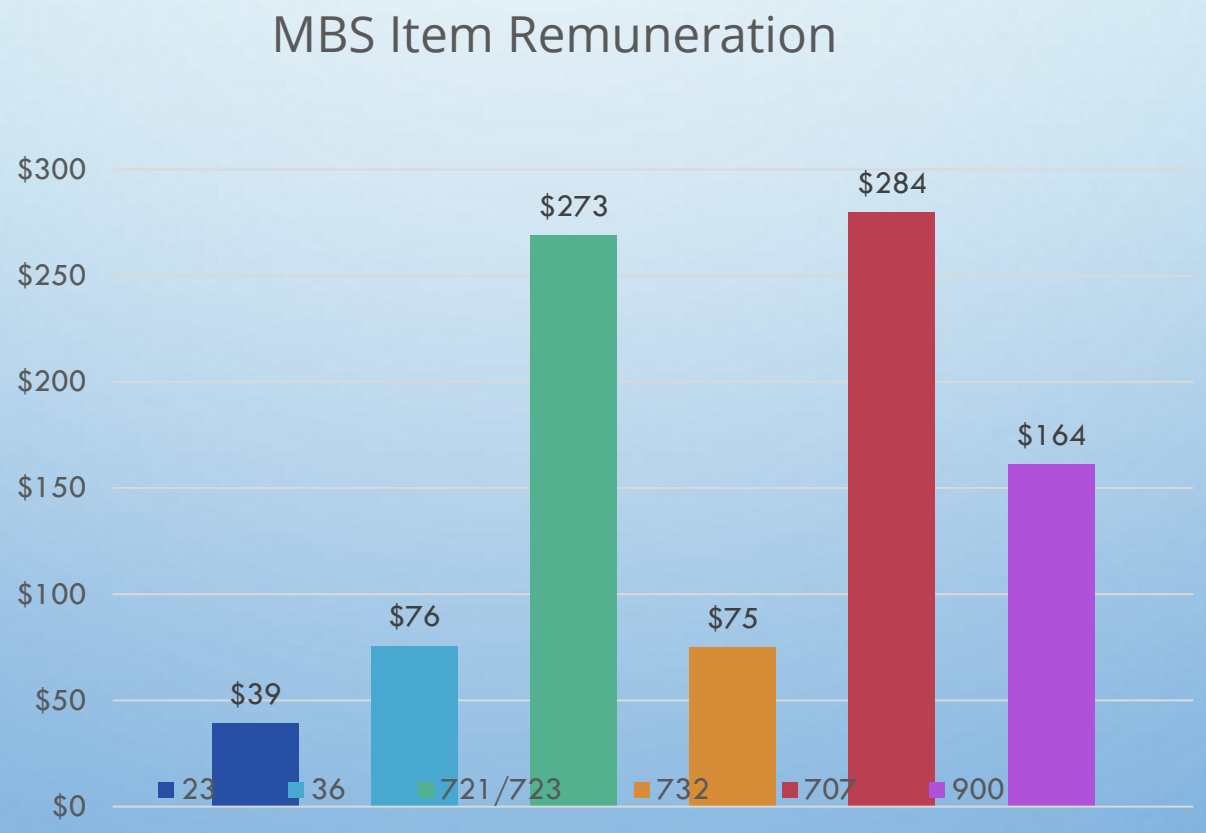
- Prevention is the key
- Managing our patients Chronic Conditions and risk factors
- Multidisciplinary team communication
- Aim-Improve the quality of life and independence of Elderly Australians

Chronic Disease In General Practice

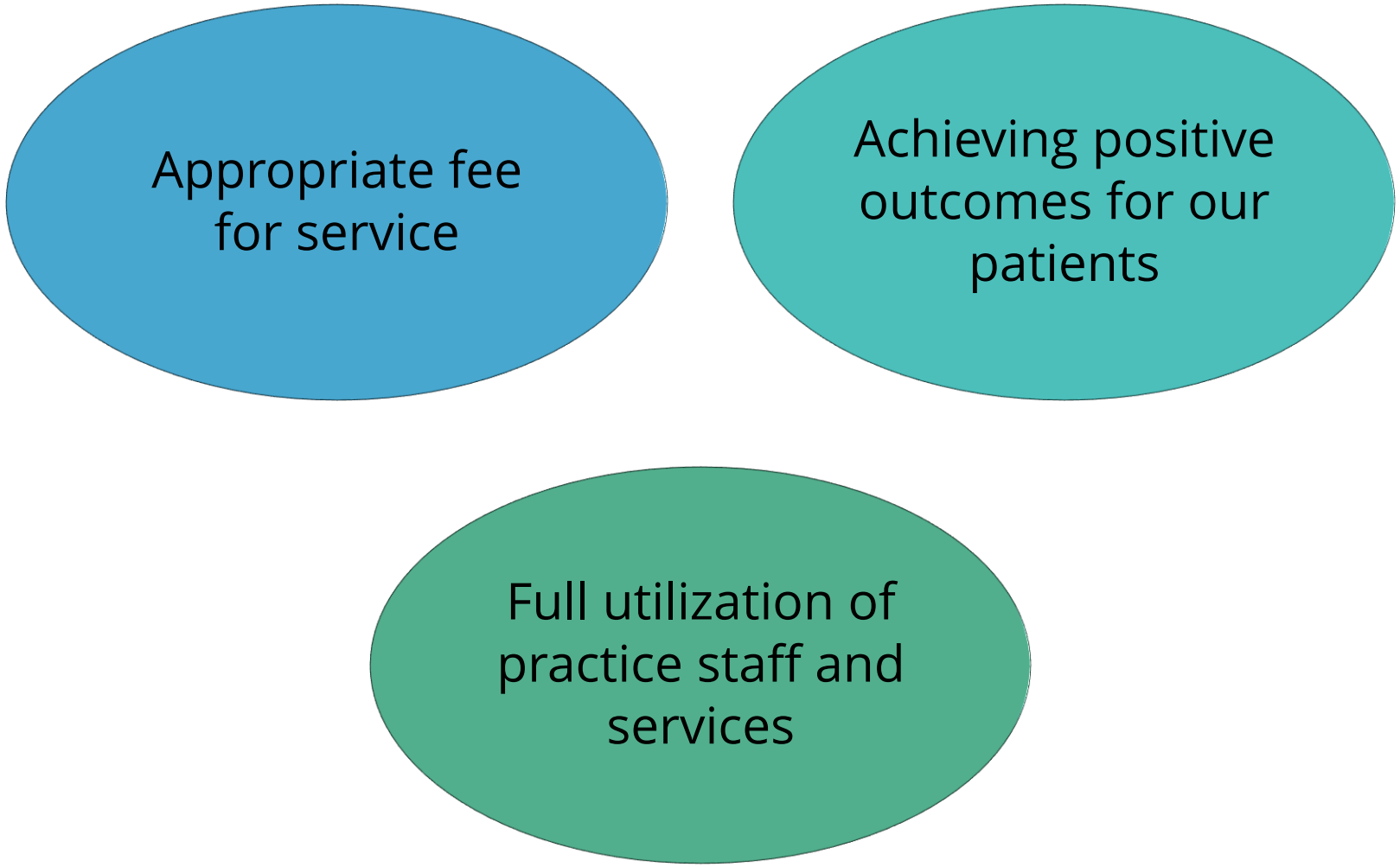


What's available for general practice

- Other MBS items remunerate practices significantly more for planned, proactive care



A GENERAL PRACTICE 'SWEET SPOT'



What's the average MBS $ for a complex patient with chronic illness?

- AAPM modelling (2021) indicates the average MBS revenue for a patient with chronic illness and complex care needs = $905.00

What might this look like in MBS items?					
	Care plan	Care plan review	H/assess (60+ mins)	Other standard consults	Total
Jan	$273.05		$284.20		
Apr		$76.15			
Jul		$76.15		$39.75	
Sep				$39.75	
Oct		$76.15			
Dec				$39.75	$904.95

Health Assessments

Health Assessments

- By far, the most valuable tool available to General Practitioners
- Encompasses all factors of a patient's general health
  - Physical
  - Psychological
  - Social
  - Consideration for preventative health care and education

Type & frequency of MBS health assessment

Type of assessment	Pt. eligibility	Frequency
75 years or older	75+ years old	Annual
Comprehensive medical assessment – residents of aged care facilities	Permanent resident of a residential aged care facility	Annual
Intellectual disability	Intellectual function 2 standard deviations below the average IQ, and would benefit from assistance with daily living activities	Annual
Aboriginal & Torres Strait Islander	Self-identifies as Aboriginal and/or Torres Strait Islander	9 monthly
Type 2 diabetes risk evaluation (40-49)	40-49 years old, identified as 'high risk' through AUSDRISK tool	Once every 3 years
45-49 health check	At risk of developing a chronic disease (specific risk factor identified)	Once only
Refugees & other humanitarian entrants	Within 12 months of arrival or grant of visa 200-204, 070, 695, 786, 866	Once only
Australian Defense Force personnel	Former serving members of permanent or reserve forces	Once only
Healthy Heart Check	Any age- at risk of developing Cardiovascular disease	Annual

MBS Rebates for Health Assessments

Name	Item	Medicare Fee (100%)
Brief Health Assessment less than 30 minutes duration	701	$62.75
Standard Health Assessment more than 30 minutes but less than 45 minutes	703	$145.80
Long Health Assessment more than 45 minutes but less than 60minutes	705	$201.15
Prolonged Health Assessment more than 60 minutes duration	707	$284.20
Aboriginal and Torres Strait Islander peoples health assessment	715	$224.20
Healthy Heart Check- duration minimum 20 minutes	699	$76.95

Elements of a Health Assessment

- Obtain consent
- Collection of information
  - Taking a history
  - Undertaking or arranging investigations and examinations
  - Making an overall assessment
  - Recommending appropriate actions
  - Providing advice and information to the patient
  - Keeping a record and offering a written report to the patient

Medicare benefits schedule Jan 2022

Criteria for a Health Assessment

- Assessment of a patient's health and physical, psychological and social function, with the goal of improving all aspects.
- Consideration of whether preventative health care and education should be offered
- Must be living in the community
- Patient must have the process explained along with the benefits prior to commencing.

Aboriginal/Torres strait islander health assessment

- Conducted every 9 months
  - No age restriction
- Aim to ensure that care is provided to meet individual needs
  - Early detection, diagnosis and intervention of chronic conditions
- Referral to up to 10 additional PN or AHW services
- Enrolment in closing the gap PBS Scheme

Closing the Gap + PBS

- The closing the gap PBS co-payment program is available to Aboriginal and Torres strait islander people of **any age** who are registered with Medicare
- No requirements i.e. Chronic disease
- Registration through PRODA
- PIP sign on payment $1000.00
- Ongoing yearly payments- tiered

Closing the Gap

Eligibility:

"In the opinion of a prescriber or aboriginal health practitioner would:"

- "Experience setbacks in the prevention or ongoing management of a condition if the person did not take the prescribed medicine; and
- Are unlikely to adhere to their medication regime without assistance through the program."
- Provision of either
    - Subsidized or Free medication

Health Assessments

Nurses time is counted towards time spent

- Allows yearly benchmarks for the patient to be measured against
  - Detects early change

- When conducted properly
  - Rewarding experience for patient
  - Valuable source of information for the GP

CARE PLANNING MBS ITEMS

Why care planning?

- Multidisciplinary care planning in general practice has been associated with improved outcomes for patients with chronic conditions, especially where there is follow-up". (Harris et all 2013)

- Important elements
  - Planned framework of care
  - Regular review
  - constant monitoring of patient
  - patient understanding important

(Martin et al 2008,zwar na,hermiz o,comino EJ, et al 2007,segal L, 2007)

Why care planning?

- GP care plans significantly and substantially increased likelihood of increased **regularity** of GP contact (gibson et al 2012)

- Patients *feel* they are getting better quality care (cheong et al 2013) and report increased knowledge of their conditions and how to manage them (mcdonald et al 2006)

Barriers to care planning

- GP time constraints and not having a motivated or skilled nurse to assist or lead programs
- Confusion about Medicare rules and fear of audit
- Don’t believe in the MBS care planning items- to much $, system rorting by others
- Complexity of the process
- Insufficient space for nurses consulting or computer access

Enablers to Care Planning

- Having motivated and skilled practice nurses
- Efficient systems- templates in software, communication protocols and roles for admin staff
- Systems for quality- quality recall system
- Teamwork- communication and understanding of what other disciplines can realistically contribute
- Use of just a few MBS item numbers

Practice Nurse Contribution

Service provided to a person with a chronic disease by a practice nurse or an aboriginal and Torres strait islander health practitioner if:

- The service is provided on behalf of and under the supervision of a medical practitioner; and
- The person is not an admitted patient of a hospital; and
- The person has a GP management plan, team care arrangements or multidisciplinary care plan in place; and
- ***The service is consistent with the GP management plan, team care arrangements or multidisciplinary care plan***

Claiming Frequency

Name	Item	Medicare Fee (100%)	Recommended Frequency	Minimum Claiming period
GPMPs	721	$152.50	2 yearly	12 Months
TCAs	723	$120.85	2 yearly	12 Months
Review a GPMP *Or TCA*	732	$76.15	6 monthly	3 months
Contribution to or review of another provider's care plan	729	$74.40	-	3 months
Contribution to a care plan in residential aged care facility	731	$74.40	-	3 months

General Practice Management Plan (GPMP)

- Patient is living in the community, with a chronic or terminal medical condition (6 months)
    - Asthma
    - Cancer
    - Cardiovascular disease
    - Diabetes
    - Musculoskeletal conditions
    - Stroke
- Between GP and patient
- Agree on and manage long term goals

Team Care Arrangements (TCA)

- GP coordination for a patient who has a chronic or terminal medical condition **and also** requires ongoing care from a multidisciplinary team of at least three health or care providers.
  - Involves the GP collaborating with the other participating providers on required treatment/services
  - Agreeing to arrangements with the patient, documenting the arrangements and a review date in the patient's TCA's
  - Providing copies of the relevant document to the collaborating providers.

Practice nurse monitoring and support funded through #10997

- Follow up services for patients on a care plan, 5 per calendar year (#10997) $12.50
- Checks on clinical progress
- Medication compliance
- Self management advice
- Collect information to inform reviews

Billing Restrictions

- Since 1 November 2014, a GP can't claim a care planning item and a general consultation item for the same patient on the same day. Specifically:
  - When you claim #721 (GPMP), #723 (TCA) or #732 (review of GPMP and TCA), you cannot also claim a general consultation item on the same day
  - General consultation items are
    - Standard consultations
    - After hours consultations

However, it's still fine to

- Bill care plans and health assessments together
- Bill care plans and mental health treatment plans together
- Bill health assessments and mental health treatment plans together

	Standard consults Incl AH	Health Ass	Mx Plan & TCA	MH Plan	MH consult	Procedure Dressings excisions	Medicine Review	Ante Natal	Diagnostic ECG/ABI/ spirometry	Smoking Cessation	Covid Vaccine
Health Assessments 701-707	X		√	√	√	√	√	√	√	√	√
Management Plans and Team Care Arrangements 721/723/732	X	√		√	√	√	√	√	√	√	√
Mental Health Plan and review (2701-2717)	√	√	√			√	√	√	√	√	√
Mental Health consult (2713)	√	√				√	√	√	√	√	√
Minor Surgical Procedures	√	√	√	√	√	√	√	√	√	√	√
Ante-Natal Service	√	√	√	√	√	√	√	√	√	√	√
Diagnostic services ABI/ECG/Spirometry	√	√	√	√	√	√	√	√	√	√	√
Smoking Cessation	√	√	√	√	√	√	√	√	√	√	√
Covid Vaccines	√	√	√	√	√	√	√	√	√	√	√
Case Conference	√	√	x	√	√	√	√	√	√	√	√


MENTAL
HEALTH

Mental Health Plans

- The purpose of the better access initiative is to improve treatment and management of mental illness within the community
- Aims to provide patients with access to mental health professionals and team based mental health care

- Medicare benefits are available to patients for selected mental health services provided by:
  - GP's
  - Psychiatrists
  - Clinical and registered psychologist
  - Appropriately trained socials workers and OT

Mental Health Plans

Services under better access are available to:

- Patients in the community
- Private in patients including residents of RACF being discharged from hospital
- Patients in RACF

Mental Health Plans

- To be eligible patient must be assessed and diagnosed with a mental health disorder
- Referring health professional responsible for determining eligibility and that their condition will benefit from a mental health plan and allied health services
- Temporary covid-19 telehealth services are available
  - Include both telephone and telehealth (only used when established clinical relationship)

Mental Health Plans

- No standard referral- signed and dated letter is sufficient
- Should include patients' symptoms, number of referred services
- Copy of mental health plan
- Initial referral for up to 6 sessions
- Review and then additional 4
- 10 initial individual services

Mental Health Plans

- 10 additional services (different item number)
  - COVID-19 until 31/12/22

- 10 group services

- These limits are per person, per calendar year
- (1st January to 31st December)

- Completion of first 6 sessions, written report must be provided to referring practitioner.

Other MBS programs available in General Practice

Home Medication Reviews

- The patient is living in a community setting
- The patient is at risk of, or experiencing, medication misadventure
- 5 or more medications
- 12 or more doses
- Significant change in medication
- Recent hospital admission

DVA treatment cycles

- Introduced in October 2019
- One treatment cycle equals 12 visits, or 12 months, whichever comes first
- Can have as many treatment cycles as clinically necessary
- Can have multiple treatment cycles concurrently
- Initial consult must create patient care plan
- Final consult must complete end of cycle report
- RACF eligibility based on care level classification

CVC Program

- Gold card holders
- Risk of hospital admission
- Practice nurse led- relationship building
- Monthly phone calls
- UP01- $448.05 and UP03- $467.55
- 3 monthly billing

CASE CONFERENCING

Case Conferencing

- Valuable tool in communication with multi-disciplinary team
- Informative for all
- Convenient
- No travel required
- Organise or participate
- Allied Health renumeration

Case Conferencing-MBS

- Eligibility
  - Patients with chronic or terminal conditions that have complex needs
  - At least 2 other providers (minimum of 3)
    - Allied health
    - Specialist
    - Community services
    - Another general practitioner or Practice Nurse providing alternative services
    - Family/carer can be present but does not count towards minimum number
    - Patient does not have to be present

Case Conferencing-MBS

Organising Case Conference

- **Item 735**: organise and coordinate a case conference of **at least 15 and less than 20 minutes**.
- **Item 739**: organise and coordinate a case conference of **at least 20 and less than 40 minutes**.
- **Item 743**: organise and coordinate a case conference of **at least 40 minutes**.

Case Conferencing-MBS

Participating in a case conference:

- **Item 747**: participate in a case conference of **at least 15 and less than 20 minutes**.
- **Item 750:** participate in a case conference of **at least 20 and less than 40 minutes**.
- **Item 758**: participate in a case conference of **at least 40 minutes**.

Case Conferencing Process

- The process is the same for all categories of case conferences
- Discuss a patient's history; and
- Identify the patient's multidisciplinary care needs; and
- Identify outcomes to be achieved by each team member; and
- Identify tasks that need to be undertaken to achieve these outcomes, and allocate those tasks to members of the case conference team; and
- Assess whether previously identified outcomes (if any) have been achieved.

Case Conferencing-Process

- When participating in a case conference, a GP must:
- explain the nature of the conference to the patient; and
- Obtain and record the patient's agreement to the GP participating in the conference; and
- Record the details of the teleconference (date, duration, names of participants) and all matters discussed by the team; and
- Put a copy of that record in the patient's medical records.

Case Conferencing

- When organising and coordinating a case conference, a GP must do all the above and:
- obtain and record the patient's agreement to the conference taking place; and
- Offer the patient (and their carer if appropriate) a summary of the conference and provide this summary to other team members; and
- Discuss the outcomes with the patient (and their carer if appropriate).

Case Conferencing-claiming

- Can be co-claimed with
  - Health assessments
  - Standard consult
    - Provided both MBS requirements are met

- Cannot be claimed with CDM numbers

Allied health

- 1st November 2021- 3 item numbers for allied health to participate in case conferencing
- Managed under multidisciplinary care plan
- Instigated by GP
- No “existing relationship” rule
- Every 3 months
- 2 additional providers
- Can be telephone/telehealth

MBS rebates

MBS ITEM NUMBER	TIME SPENT	ORGANISE OR PARTICIPATE	MBS REBATE
735	15-20 mins	GP organise	$74.75
739	20-40 mins	GP organise	$127.85
743	40mins plus	GP organise	$213.15
747	15-20mins	GP Participate	$54.90
750	20-40 mins	GP Particpate	$94.10
758	40 mins plus	GP Participate	$156.95
10955	15-20 mins	Allied Health-Participate Only	$43.95
10957	20-40 mins	Allied Health-Participate Only	$75.30
10959	40mins plus	Allied Health-Participate Only	$125.30

Barriers to Case Conferencing

- Reluctance to bill patients for items of service not involving contact.
- GP work practice issues/Unpredictable workload.
- Perception that face-to-face consultations have higher priority than case conferences.
- Differing work practices (e.g., relating to preferred times for meetings).
- Success or otherwise dependent on personality of specialist.

Benefits of Case Conferencing

- Improved coordination of patient care.
- Provision of potentially efficient means of briefing all professionals.
- Minimal travel required
- Continuity of care
- Reduction in mis-management
- Beneficial to patient to have GP present

Integrating Case Conferencing

- Identify Need
- Book session
- Patient consent
- Modality
  - Face to face
  - Video
- Reminder
- Who will facilitate

Suggestions to improve uptake

- Simplify MBS procedures and item numbers.
- Introduce items for phone consultations with other health professionals.
- Introduce items for specific complex situations (e.g., palliative care).
- Consult GP's before making revisions to the program.
- Organise conferences in a way that is efficient but flexible.
- Have clear objectives and procedures.
- Make the process flexible enough to take account of GP operational difficulties.
- Seek GP input in organising conferences.

SYDNEY NORTH COLLABORATIVE

Northern Sydney Collaborative

- Provide proactive, timely and connected support tailored to each persons needs
- Gives choice with where care is provided
- 2 services available (still in development)
  - Geriatrician outreach program
    - Increase specialist input into GP led planning and care for frail and elderly in the community
  - Health Navigator
    - Support for health care professionals to trouble shoot and co-ordinate community-based care

Health Navigator

- Free 1800 phone line dedicated to helping health professionals and community members find the right local service
- Available to the general public
- Find local health, aged care and social services (public and private)

Geriatric Outreach Program

- Available to patients at risk of deterioration in next 3months with
- 3 regions
  - Lower North Shore
  - Ryde/Hunters Hill
  - Hornsby-Ku-Ring-Gai
- Contact PHN for more details

Summation

General Practice is in a unique position to support elderly Australians by:

- Preventing avoidable hospitalization's with a planned, structured and multi-disciplinary approach to their healthcare
- Actively engage other care providers to link appropriate services that will enhance both their quality of life and continued independence.

Questions?

Resources and References

- Https://www1.Health.Gov.Au/internet/main/publishing.Nsf/content/mbsprimarycare-caseconf-factsheet.Htm
- https://sydneynorthhealthnetwork.org.au/programs/northern-sydney-health-navigators/#:~:text=What%20is%20this%20service%3F,available%20to%20the%20general%20public.
- https://www1.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement
- https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/health-aged-care-service-use/health-care-gps-specialists

Thank you