WELLNESS CLINIC – THE WELLNESS HOUSE

OVERVIEW

The Wellness House established a self-management Wellness Clinic for patients with identified chronic disease. The region where the practice is located includes a high Indigenous population with a significantly lower life expectancy compared to the rest of NSW. The clinic focused on improving patients' health literacy and encouraging lifestyle changes to allow them to manage their own health more effectively.

MODEL

Comprehensive data cleansing using PENCAT software was undertaken; patients with three or more co-morbidities were identified; and a disease register was created. Brochures introducing the nurse clinic service were handed out to patients by reception staff, boosting patient interest in the new service. Initial 45-minute appointments to discuss health concerns and care planning enabled comprehensive information gathering and ensured patients' individual health needs and goals were understood. Care plan development and GP consultation for identified treatments (medication, pathology, health coaching etc) attracted MBS funding. A follow up 30-minute appointment to check the progress of any referrals to additional services and to track and review patients' care plans was scheduled.

> "Subjectively, I feel patients are happier, their results are improving for the large part. They feel this is a place that helps them achieve what they want from their health rather than a place to go to when they have a problem. Which is a wonderful kind of switching perspective. Yeah, a lot of changes have come about thanks to this Wellness Clinic."
>
> **Dr Alex Hoyle – The Wellness Clinic**

apna
Supporting nurses in primary health care

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FUNDING

All consultations are bulk billed utilising the eligible suite of MBS chronic disease management and health assessment item numbers. There is no out-of-pocket expense to patients visiting the nurse clinic.

OUTCOME

There was a huge uptake in the nurse clinic, with over 200 patient appointments conducted within the first six months and a total of 1164 appointments between January 2019 and May 2020. The development of a Chronic Disease Register kept track of patient numbers. The team approach to patient care is evident and the nurse clinic was heavily supported by lead GP, Dr Alex Hoyle, administrative staff, and the nursing staff.

Dr Hoyle commented that the Wellness House aims to 'focus on health, rather than illness' which is the primary aim for the nurse clinic as it relates to empowering patients to self-manage their chronic disease. He says *'As doctors, we focus a lot on the numbers, on the medication, on the illness because that's our training. Whereas, with nursing, the focus is more on symptoms, activity, and social coordination. Having two sides to the equation really allows us to do a far more integrated assessment for the patients with health plans and (achieve) positive outcomes.'*

The clinic has made care delivery more systematic and financially rewarding for the GPs, evidenced by the following successful outcomes:

- Increased patient requests for this service
- Increased nurse satisfaction
- Increased practice revenue

PATIENT FLOW CHART

Patient eligibility

- Patients with chronic conditions and 3+ co-morbidities

Initial Visit

- The initial visit consisted of a 45-minute appointment to discuss health concerns and care planning. This enabled comprehensive information gathering and ensured patients' individual health needs and goals were understood. Care plan development and GP consultation for identified treatments (medication, pathology, health coaching etc) attracted eligible MBS funding.

Follow up visits

- A follow up 30-minute appointment to check the progress of any referrals to additional services and to track and review patients' care plans was scheduled.
- Further visits according to MBS Chronic Disease Review items or as appropriate to meet patient health needs.

Documentation

- Health Assessment and Chronic Disease Management documentation to meet MBS claiming criteria

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MBS Items

The suite of eligible chronic disease management, health assessment and associated item numbers makes this model financially viable.

MBS item #	Description	Recommended Frequency
701-707	Health Assessment (75+ / 45-49 yrs)	Annual or once only – refer to MBS online*
715	Indigenous Health Assessment	Once every 9 months
721	GP Management Plan	12 months
723	Team Care Arrangement	12 months
732	GPMP and/or TCA Review	3 months
10987	Additional bulk billing payment 10990 or 10991 according to MMM classification	Claimed in conjunction with General Medical Services Table of MBS
10997	Provision of monitoring and support for a person with a chronic disease by a practice nurse or Aboriginal and Torres Strait Islander health practitioner	Maximum of 5 services per patient in a calendar year
900	Medication Management Review – Domiciliary	Once in each 12-month period (unless significant change in patient condition identified)
903	Residential Medication Management Review (RACF)	One claim per resident in a 12-month period (unless significant change in patient condition identified)
2700-2717	GP Mental Health Treatment Plan (MHTP)	Annual Refer to MBS* to determine claiming criteria eligibility
2712	Review GP MHTP	
2713	GP MHTP Consultation	
2517 – 2526 2620-2635	Completion of Diabetes Cycle of Care	Annual
2546 – 2559 2664 - 2677	Completion of Asthma Cycle of Care	Annual
699	Heart Health Check	Once per patient in 12-month period
refer to MBS online claiming criteria to determine eligibility* **http://www9.health.gov.au/mbs/search.cfm?q=&Submit=&sopt=S		