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1. The purpose of this guide

An ongoing challenge for the Department of Human Services is to successfully collaborate with general practice. The resources in this guide are designed to assist and support departmental staff in developing and maintaining the strong partnership required for successful collaboration. It brings together:

- the department's position, vision and guiding statements
- practices that support successful partnership with general practice
- a simple checklist for getting started
- a range of case studies demonstrating how the department, State-funded services sector and general practice have worked together for better client outcomes
- additional background information on general practice and Divisions of General Practice.

Who should use this guide?

This guide is designed to be used in conjunction with the department's position statement: *Working with general practice*.

It was developed for people working within Department of Human Services' programs and regions that currently or potentially work with general practice. It also serves as a valuable resource guide for State-funded agencies and the general practice sector.

2. Department of Human Services position and vision

Working with general practice—the Department of Human Services position statement outlines in detail the department’s framework for interactions with general practice.

The vision and guiding statements below are drawn from this document and constitute the department’s position on working with general practice.

The vision

A strengthened collaborative interface between the Department of Human Services, State-funded services and general practice, resulting in integrated service delivery and better health outcomes for Victorians

The guiding statements

- As a key Victorian Government department with State level responsibilities for health and human services, the Department of Human Services recognises the centrality of general practice as the first point of contact for primary medical care in the Australian health system.
- The Department of Human Services, wherever practicable, will seek to bring departmental and general practice developments together to promote and enhance effectiveness and efficiency in the integration of health care in Victoria. General practice and State-funded services cannot provide the most effective health care in isolation.¹
- Achieving complementarity between Victorian Government and Commonwealth Government directions in health system development is integral to achieving better health for all Victorians.
- The Department of Human Services recognises that both sectors are primarily interested in the coordination of care and provision of services. Both are committed to working in a spirit of ongoing consultation, cooperation and partnership to achieve better patient outcomes.

The resources in this guide provide the tools for translating these statements into practice.

¹ Australian Government Department of Health and Ageing, *Future Directions (Toolkit for Implementation) Implementing a national quality and performance system for the Divisions of General Practice* Commonwealth of Australia, Canberra 2005

3. Supporting successful general practice engagement

As discussed in the position statement, general practice is an integral part of our health system; no one sector is going to be able to best meet the health needs of the community on its own.

The list of practices in this guide (section 6) has been developed to assist department staff when working with general practice. These build on the information provided in *A Guide to General Practice Engagement in Primary Care Partnerships* (Department of Human Services, July 2001). The points made in this document remain relevant today. In most instances, a relevant case study is provided and web resources for those looking for additional information.

What is general practice engagement?

General practice engagement can be defined as the process of informing, consulting, collaborating and empowering general practitioners (GPs) and practice staff to change practice, policies and programs to improve the quality of general practice for improved clients' health and/or improved health system efficiency for improved patient health.²

The aim of general practice engagement from the department's perspective is to develop a well-coordinated, comprehensive and quality health system in which general practice plays a significant part. General practice engagement results in benefits to all parties: patients, GPs and other service providers, and will result in improved access to services and better patient outcomes.

From the perspective of the Department of Human Services central office and regional staff, general practice engagement often means working with General Practice Victoria (GPV) and, through that body, with individual divisions and general practices. The department also works with a range of other general practice organisations as required. The role of these organisations is explained in more detail on page 5.

At the service provider level where implementation takes place, general practice engagement means the participation of general practice in projects, programs and provision of care to shared clients. Effective participation at agency level may be subject to factors such as general practice workload and time constraints, but will also depend on the relevance of the program to GPs and availability of remuneration. It is also critical that the general practice role in the initiative is clear.³

Department and State-funded services will invariably work with Divisions in their attempts to access GPs, and it is Divisions that have the task of engaging individual general practices and GPs.

² Bensberg, M., Sutherland, J., & Crosbie, C., 'It takes more than a practice visit—effective general practice engagement', *Australian Journal of Primary Health*, vol. 13, no. 3, pp. 17–21. 2007

³ Department of Human Services *A guide to general practice engagement in primary care partnership* DHS, Melbourne, July 2001

4. Getting started checklist

Following is a quick and easy step-by-step guide to support general practice engagement.

Step One—Quick Audit


1. Does the outcome of your work involve any change processes or action in general practice?
 Yes No Unsure
2. Will informing & involving general practice improve the quality and outcomes of your work and that of general practice?
 Yes No Unsure
3. Is there a current Commonwealth initiative or program in Divisions of General Practice that is relevant to your work?
 Yes No Unsure—check the DoHA website:

www.health.gov.au/internet/main/publishing.nsf/Content/programs-initiatives-all

If still unsure, then check with:

- General Practice Partnerships Team in Primary Health Branch
- Your Department of Human Services Divisional representative on the DHS General Practice Policy Coordination Group (*webpage under development*)


Please note, the DHS Senior Medical Advisors may be able to assist you with further information.

 If you answer **Yes** to any of these questions proceed to Step Two

Step Two—Environment Scan

1. **Check the DHS General Practice Register (accessible only by DHS staff via the DHS intranet)**
http://intranet_2.csv.au/rrhacs/gp_register.htm
The register will be made more widely available to external stakeholders on the internet during 2008. Until then, contact GPV for advice www.gpv.org.au
 - Look for similar projects and have a conversation with the relevant contacts
 - Identify any Department of Human Services project partners
 - Are there opportunities for a combined approach?
2. Look for best practice evidence relevant to your project, including case studies.
3. Consider Commonwealth initiatives that may complement your work
www.phcris.org.au
4. Identify the most appropriate general practice organisation to work with—see page 5 for list of organisations

In most instances, this will be GPV www.gpv.org.au or your local Divisions of General Practice

 **Make contact with the most appropriate general practice organisation**

Step Three—Implement in partnership with general practice

Use the Practices that Support Collaboration (section 6) to guide your planning

Use the case studies (section 7) as a guide

While GPV and individual Divisions of General Practice provide a representative role for general practice for service development at the local level, other peak organisations also represent general practice from different perspectives.

5. General practice organisations in Victoria

The Department of Human Services recognises that there is a variety of organisations with important roles in the general practice sector. It is important for the department to use a range of consultation mechanisms and build a strong working relationship with GPs, their practices, and the various general practice representative bodies. No one group has 'responsibility' for all GPs in Australia.

Divisions of General Practice are predominantly funded by the Commonwealth Government to provide services and support to general practice at the local level to achieve health outcomes for the community. GPV supports divisions in their endeavours to ensure a skilled, viable and effective general practice workforce.

Formal arrangements currently exist between the Department of Human Services and GPV. The department also successfully works with other peak organisations that represent general practice from different perspectives. For example, the RACGP has a role in education and setting standards, the Australian Medical Association (AMA) has an industrial and advocacy role.

The key general practice organisations in Victoria are listed below.

General Practice Victoria (GPV)

As the peak body for Divisions of General Practice in Victoria, GPV (previously known as General Practice Divisions Victoria) supports divisions in their endeavours to ensure a skilled, viable and effective general practice workforce, to improve the health and wellbeing of the people of Victoria.

www.gpv.org.au

Royal Australian College of General Practitioners Victoria (RACGP)

RACGP is the professional body engaged in setting and maintaining the standards of quality practice, education and research in Australian general practice. At the State level, RACGP Vic (co-located with the national body in South Melbourne) has responsibilities reflecting the national body's role in training and standards, including its implementation, as well as local interests.

www.racgp.org.au/vic See also www.racgp.org.au

Australian College of Rural and Remote Medicine (ACRRM)

ACRRM is the peak professional organisation for rural medical education and training in Australia. The college has around 2,500 members, comprising fellows, registrars, practitioners and students who practise in regional, rural and remote communities throughout Australia. The college's core function is to determine and uphold the standards that define and govern competent unsupervised rural and remote medical practice.

www.acrrm.org.au

Australian Medical Association Victoria (AMA)

The AMA represents GPs and medical specialists and plays a pivotal role in influencing health policy and regulation impacting on medical practice in the State.

www.amavic.com.au See also www.ama.com.au

Rural Doctors Association of Victoria (RDAV)

RDAV is concerned with the needs of rural doctors and their patients. It advocates for highly skilled and motivated rural medical practitioners who are adequately trained, remunerated and supported, both professionally and socially.

www.rdav.com.au

Rural Workforce Agency, Victoria (RWAV)

RWAV was established in 1998 to overcome the shortage of rural doctors and improve access to medical services for rural Victorians.

www.rwav.com.au

Australian Practice Nurses Association (APNA)

APNA is the peak body for nurses working in general practice. It provides responsive and effective professional development, support and services, representation and advocacy.

www.apna.asn.au

Australian Association of Practice Managers (AAPM)

AAPM represents practice managers and the profession of practice management. The AAPM has a national board, state branches and regional groups.

www.aapm.org.au

Department of General Practice, The University of Melbourne

This department promotes excellence in general practice through teaching and learning, research and research training, and knowledge transfer to GPs at all stages of their careers ranging from undergraduate medical students to vocational trainees, practising clinicians, emerging researchers and experienced academics across metropolitan, regional and rural settings.

www.gp.unimelb.edu.au/about

The School of Primary Health Care, Monash University

This school incorporates the Departments of General Practice, Community Emergency Health and Paramedic Practice, Health Science, Occupational Therapy, Physiotherapy and Social Work, together with the National Research Centre for Prevention of Child Abuse (NRCPA). It provides leadership in the delivery of high quality education, research and community to GPs as undergraduates and postgraduates.

www.med.monash.edu.au/general-practice

Deakin University Medical School

This school will be established in western Victoria in 2008.

www.deakin.edu.au/giving/medicalschoo.php?print_friendly=true

Regional training providers

A regional training provider is an organisation created to deliver education and training within a specific geographical region. Funded by General Practice Education and Training (GPET), regional training providers are accredited every three years according to RACGP, GPET and, if applicable, ACRRM standards.

There are currently 21 accredited regional training providers throughout Australia. Below is a list of currently accredited regional training providers in Victoria.

- Bogong Regional Training Network
Bright, VIC
www.bogong.org.au
- Gippsland Education and Training for General Practice (GETGP)
Traralgon West, VIC
www.getgp.net.au/public/getGPhome.asp
- Greater Green Triangle GP Education and Training
Warrnambool, VIC
www.gtgpet.com.au
- Victoria Felix Medical Education
Bendigo, VIC
www.vicfelix.com.au
- Victorian Metropolitan Alliance
Collingwood, VIC
www.vma.com.au

6. Practices that support collaboration with general practice

The following practices have been developed to guide collaboration with general practice.

Decide which representative body is right for your project

Bearing in mind the various representative interests outlined, decide which best serves the current purpose. See pages 5–7 for a list of general practice organisations in Victoria. In most cases, this will be GPV.

Case Study 4: Preparing of an influenza pandemic (page 20)

Be clear about the purpose of engagement

This will dictate who from the general practice sector needs to be engaged. Although GPs tend to be clinically focused and therefore better placed to contribute to developing a service response, many have experience in planning and system design and would be able to play a valuable role in this type of work.

Case Study 7: Joint care planning for SRS clients (page 25)

Consult early

The capacity to do this will depend on the area of work, but generally early consultation ensures a better level of collaboration and goodwill.

Case Study 2: Strengthening the role of general practice in palliative care (page 16)

Gain formal agreement from the organisation to work in partnership

It is important to seek formal agreement from the CEO or chairperson of the organisation with whom you are working. This provides endorsement at a senior level within the organisation and authority for your work. Agreement can include written endorsement of a work plan, a contract, partnership agreement or a memorandum of understanding (MOU).

Case Study 3: General Practice Victoria—Primary Health Care Consultant position (page 18)

Agree on how you will work together and define expectations and responsibilities

At the start, agree how you will approach working together. Take time to define the expectations and responsibilities of all parties.

Case Study 8: Diabetes Coordination and Assessment Service (page 27)

Consider the plan-do-study-act approach

The Plan-Do-Study-Act (PDSA) methodology is a suitable change management process to follow when working with general practice and may be a useful model for department staff. The PDSA cycle is well recognised by general practice.

The Improvement Model is a simple yet effective tool for improvement. It consists of two parts:

1. The first, 'thinking part', consists of three fundamental questions to guide improvement work:
 - What are we trying to accomplish?
 - How will we know that a change is an improvement?
 - What changes can we make that will result in an improvement?
2. The 'doing part' is made up of rapid, small PDSA cycles to test and implement change in real work settings. The PDSA cycle guides the test of a change to determine if the change is an improvement.⁴

The PDSA approach may be useful to support the implementation of many initiatives. For more information, go to the National Primary Care Collaboratives website www.npcc.com.au/Improvement_model.html

Case Study 10: Whitehorse CHS Diabetes Prevention study (page 33)

Build the links between 'like' initiatives

This relates to building links between department branches implementing initiatives with similar goals, audience and timeframes and to building on Commonwealth initiatives. This presents the department with opportunities to develop consistency and coordination across the organisation. For DHS Staff, the 'DHS Register of General Practice Engagement' is an online intranet resource that staff can use to see what work other parts of the organisation are doing in relation to general practice and to maximise the opportunity to use common agendas across the department. This will be made more widely available on the internet in 2008.

An important consideration in all of this work is to consolidate and, where possible, rationalise the engagement between Department of Human Services, State-funded services and the general practice sector. This is with a view to maximising the effort and achieving constructive and worthwhile engagement.

Case Study 5: Establishing an Integrated Primary Mental Health Service in north east Victoria (page 21)

Recognise the business environments of general practice

Given that GPs operate in a small business environment, the timing of meetings and the time involved in meetings for practice staff and GPs needs to be considered. Reimbursement for time should also be considered. Sufficient notice needs to be provided for any meetings.

⁴ National Primary Care Collaborative www.npcc.com.au/Improvement_model.html

Employees within divisions may not have the same constraints, but have to work within the priorities of their division. While most divisions own the objective of working with all levels of government, their principal goal is implementing the division's strategic plan. Therefore, for division staff, demands on time need to be considered. GPV also aims to work with the department on common agendas and is funded, in part, for this purpose.

Case Study 12: Supporting the GP Role in Shared Care Maternity Services (online at www.vic.health.gov.au)

Be aware of the time and resources required to build effective relationships

It is important to recognise the time and resources (both staff commitment and financial) to build effective partnerships.

Case Study 6: Frankston Community Health Service GP liaison role (page 23)

Develop work plans and performance measures appropriate to the level of funding

Expectations need to be realistic and match the level of funding available. Take the time to develop a realistic work plan that clearly sets out what is to be achieved and by whom. At the start, think about setting performance measures that reflect what is trying to be achieved.

Case Study 3: General Practice Victoria—Primary Health Care Consultant position (page 18)

GPV and Divisions of General Practice are the best means through which to reach GPs in their practices

Divisions generally communicate with all GPs in their catchment, irrespective of membership status. Divisions do, however, make a judgement about the initiative, its relevance to GPs, and the interest that it is likely to generate. Divisions need to do this as their credibility relies heavily on their member GPs finding the division activity useful to them. Divisions would therefore attempt to interpret where the GP 'fits in'.

Case Study 4: Preparing for an influenza pandemic (page 20)

Use the GPV protocol to select a GP

If GP representation is being sought through GPV, there is an established protocol. The program contacts GPV directly and provides information about the proposed committee or working group, the expertise needed, and the frequency and duration of meetings. GPV will then seek a representative through divisions.

Allow for remuneration

Divisions remunerate GPs in various ways. Boards or committees of management may be paid a stipend or an hourly rate for work done on behalf of the division. Commonly an hourly rate is paid to GPs for involvement on subcommittees, working groups, as program advisors and representatives of their division at forums/meetings and with

other stakeholders. Generally GPs are compensated for time lost in their practice but, more importantly, for their expertise, experience and clinical knowledge. GPs at local, state and federal levels provide input into planning, strategy, health reform and decision making.

Similarly, practice nurses also represent their divisions, provide advice, and participate on subcommittees and working groups. Remuneration to cover practice nurse time out of a practice should also be taken into account.

Divisions will communicate and consult with other elements of the health sector about any matters relating to general practice. However, if some level of practice change is sought, practice detailing may be needed. Given that is resource intensive, divisions are unlikely to be in a position to do this without additional resources.

Clearly identify the role for the GP

Divisions need to be able to see the role of the GP in order to market the initiative. This clinical role needs to be aligned within current DoHA initiatives, and in consideration of the Medical Benefits Schedule (MBS) and practice incentives. While the MBS provides for GP Management Plans and Team Care Arrangements (TCAs) (formerly EPC Care Plans), the uptake of TCAs by GPs has not been strong. There are a number of reasons for this including the fact that general practices need additional systems, processes and protocols in place to facilitate allied health referrals within an effective business model.

GPs tend to be clinically focused and are better placed to contribute to developing a service response and ensuring access pathways, rather than focusing on systems development. However, general practices are being encouraged to think more systematically by their divisions and by DoHA. Divisions are more likely to be able to respond on system issues.

Case Study 7: Joint care planning for SRS clients (page 25)

Hold meetings at GP friendly times

Depending on the time required and location, lunchtime, early morning before 8.30 am or early evening are often preferable times for meetings. Remuneration should always be considered. Consider also arranging to meet at the general practice location in some cases.

Be conscious of the fact that the nature and the structure of general practice is changing

In recent years, general practices have made increasing use of practice managers and practice nurses. Depending on the issue under discussion, both these positions are influential additional contact points within a practice. Divisions should be able to advise on the best point of contact in any given instance.

Be aware of cultural factors

Cultural differences, generally reinforced by different financing mechanisms, remain a barrier to working across sectors, both here and overseas. Such differences persist even in the UK where the system itself is 'integrated' to a far greater extent than it is in Australia. Here, the split in health financing mechanisms may lead to a sense of competition between the general practice sector and, for example, the community health sector. General practice remains dominant in the primary care sector both in terms of its size and its utilisation.

Over the last decade, the workforce pressures in general practice, together with changed community expectations, mean that there is plenty of work for GPs. Nevertheless, GPs may be concerned that the multidisciplinary team within a community health service may draw patients away from private general practice. The State-funded sector is concerned about the limited leverage it has with general practice. The issue of competition therefore may arise in the course of interaction. This paper advocates maintaining the ultimate aim of optimising patient care as a way of bridging sectoral and cultural differences.

7. Case studies

These case studies demonstrate how the Department of Human Services, State-funded services and general practice, including GPV, other representative organisations, Divisions of General Practice and individual GPs work collaboratively.

The case studies provide a snapshot of what has been achieved and what practices were used to promote successful outcomes. They are a sample of the good work that is happening across Victoria.

The case studies following are:

1. GP collaboration with HARP at St Vincent's Hospital
2. Strengthening the role of general practice in palliative care
3. General Practice Victoria—Primary Health Care Consultant position
4. Preparing for an influenza pandemic—an information kit and work plan for general practice
5. Integrated primary mental health services in North East Victoria
6. Frankston Community Health GP liaison role
7. Joint care planning for Supported Residential Services (SRS) clients—collaboration between Brunswick Community Medical Centre and Moreland Community Health Service
8. Diabetes Coordination and Assessment Service
9. Review and redevelopment of the General Practice Liaison (GPL) Program
10. Whitehorse Community Health Service Diabetes Prevention Study
11. Disability Services Division's introduction of the Comprehensive Health Assessment Program

Additional case studies are available online:

12. Supporting the GP role in maternity services
13. Review of Drugs, Poisons and Controlled Substances Regulations (1995)—general practice input
14. Southern Managed Health Network Project
15. Refugee Health Services Project—developing a Refugee Health Kit for general practice
16. Diabetes Co-Management Service—using Diabetes Nurse Educators in general practice
17. Developing a clozapine program in Geelong
18. Docs in Schools—youth friendly mental health program

New case studies will be regularly available online at www.health.vic.gov.au

Key learnings

Diversity in styles and capacity in general practice can be challenging but not insurmountable.

Collaboration requires frank and respectful analysis of many different perspectives so that creative, innovative and transparent solutions can be developed to resolve mutual problems.

Case study 1

GP collaboration with HARP at St Vincent's Hospital

The Hospital Admission Risk Program (HARP) projects at St Vincent's Hospital focus on chronic disease management for a range of conditions and for patients with complex social needs including homelessness and mental illness. The aim was to prevent admission or re-admission to hospital, which required relationship-building and clinical collaboration with the patients' GPs.

The hospital's GP Liaison Unit led the development of effective communication systems across the interface between the hospital-run HARP projects and GPs.

The drivers

The aim of HARP at St Vincent's was to prevent admission or re-admission to hospital. This required relationship-building and clinical collaboration with the patients' GPs.

The players

- St Vincent's GP Liaison Unit
- Key HARP managers
- Four local Divisions of General Practice
- Several GPs working in the field

Practices promoting successful outcomes

- Establishment of a HARP GP Working Group.
- Joint problem solving.
- Access to an expert advisory group to guide the communication style and articulate GP needs in clinical care was invaluable in finding the right balance and building credibility for the programs from the GP perspective.
- Changing of program terminology from acronyms like 'HARP' and 'ALERT' to more GP-friendly 'Chronic Disease Management' in communication sent to GPs.
- Using good news stories in GP newsletters.
- Continuing professional development programs (CPD) for GPs and practice nurses on medical conditions managed under HARP.
- Forums conducted for HARP staff on how to engage GPs and potential use of the Enhanced Primary Care item numbers to remunerate time spent in HARP liaison.

The challenges

- The diversity in styles and capacity in general practice can make relationship-building in this area difficult.

The results

- The relationship between general practice and HARP at St Vincent's has been improved through the collaboration with general practice via the HARP GP Working Group.
- There is improved, relevant information sharing and liaison when patients receive HARP outreach or attend specialist clinics. This could not have been achieved without the work with general practice.
- Unexpected benefits of the collaboration in HARP have been an ongoing liaison and consultation role for the GP Working Group, which meets regularly on broader, non-HARP issues such as improving outpatient referral and discharge, aged care and electronic referral and communication between the hospital and GPs.
- A forum with local divisions provides a simple pathway for the dissemination of information to GPs about new initiatives in the health service and for GP update sessions.

For more information

www.svhm.org.au/gp or David.ISAAC@svhm.org.au

Key learning

Consult and respond to the advice of general practice organisations such as GPV.

Case study 2

Strengthening the role of general practice in palliative care

The Cancer and Palliative Care Unit of the Department of Human Services worked closely with GPV to develop a Program of Experience in the Palliative Approach (PEPA 2), a program of clinical placement for GPs within State-funded palliative care services. To do this, the department and GPV refined a program that had been developed originally for nurses and allied health. The Chairs of Divisions of General Practice were consulted, with metropolitan and rural divisions differing in their response to the initial proposal. The department reviewed the responses and, in consultation with GPV, a final statewide approach was agreed upon.

The department worked closely with palliative care services to make sure that those offering placements were aware of the program requirements. Through GPV, local Divisions of General Practice were supported to recruit GPs. The DHS PEPA 2 Project Manager worked with the GPs and palliative care services to ensure that the GPs were placed in services appropriate to their individual learning goals. The department and GPV met monthly until all the placements had been filled.

The drivers

The Cancer and Palliative Care Unit had developed a PEPA for nurses and allied health and in discussion with GPV decided to take up an opportunity to extend the program to GPs.

The players

- Department of Human Services Cancer and Palliative Care Unit
- GPV
- Divisions of General Practice
- General practitioners
- Palliative care services

Practices promoting successful outcomes

- The Department of Human Services and GPV identified a common purpose to develop the capacity of general practice in palliative care.
- Funding was available to support the common purpose.
- Both organisations committed staff time and resources.
- Funds were available for divisions' administrative costs and GPs were remunerated for participating.
- From the start, the department worked closely with GPV, GPs and palliative care services.
- The Department of Human Services and GPV consulted and responded to the advice of general practice.
- GPV built on strong relationships with divisions to promote the program and support implementation.

- Divisions were used as ‘trusted’ advisors to recruit GPs.
- The Department of Human Services and GPV monitored progress and the department funded GPV to evaluate the outcomes.

The results

The PEPA 2 provides an example of the development and implementation of a program that was relevant to GPs. All 75 places in Victoria were filled, which was an outstanding achievement. The success of the PEPA 2 clinical placements has been attributed to the ability to communicate with GPs through GPV and Divisions of General Practice and the close working relationship between the Cancer and Palliative Care Unit and GPV on this project.

This program was implemented in the period 2005–06. The Department of Human Services is being refunded by the Commonwealth for palliative care clinical attachments for the next three years and has committed to work with GPV and divisions to achieve the desired outcomes.

For more information

GPV Tel: (03) 9341 5200

www.gpv.org.au

Department of Human Services Cancer and Palliative Care Unit

www.health.vic.gov.au/palliativecare

Key learning

Collaboration requires an investment in time and effort to provide better value services and efficiencies.

Case study 3

General Practice Victoria—Primary Health Care Consultant position

The Primary Health Branch of the Department of Human Services first funded a Primary Health Care Consultant position at GPV in 1999. Key activities of the position are to provide:

- advice and assistance to the Primary Health Branch about how best to achieve general practice engagement in various policy and program approaches
- assistance to the primary care health sector on how to work with divisions, and what are realistic mechanisms for achieving GP engagement
- assistance to divisions on particular aspects of their work with PCPs (this changes over the years as priorities change, for example, the focus at present is on small grants implementation and early intervention in chronic disease implementation)
- assistance in identifying and disseminating achievements in service coordination that is meaningful to GPs.

This full-time funded position has been occupied by the same GPV staff member since 2001.

The drivers

The ongoing need for involvement of Divisions of General Practice and, through them, the general practice sector, in State Government primary care reform.

The players

- Director, Primary Health Branch
- Senior staff, Primary Health Branch, including Senior Medical Advisor
- GPV—CEO, Integration Team Leader and Primary Health Care Consultant

Practices promoting successful outcomes

- The Department of Human Services and GPV working in partnership to achieve a common goal.
- Strong leadership by the department for general practice engagement as a central requirement of PCP development and activity.
- Commitment from both organisations to the valuable role provided by this position.
- GPV's effective relationship with members has facilitated robust participation by divisions in activities and discussions.
- Maintaining strong working relationships via regular meetings.
- Statewide workshops that bring together divisions and State-funded primary care providers to showcase collaborative work.
- Finding shared 'business' and good alignment with national programs that are delivered through divisions. As PCPs become more involved in support for chronic disease management and prevention, the alignment between outcomes sought by State-funded primary care organisations and by divisions is increasing.

The challenges

- Division capacity to be involved in all aspects of PCP activity has been limited.

The results

- Recurrent departmental funding to GPV for the staff position.
- Department of Human Services program guidelines requiring divisions to be involved in governance of PCPs (member of MOUs). Likewise requiring implementation and reporting on a local general practice engagement strategy.
- Funding PCPs for divisional participation to support general practice engagement.
- 100 per cent involvement of divisions in local governance of PCPs.
- 75 per cent of PCPs report that their work in GP engagement is at advanced or routine implementation.
- Victorian Statewide Referral Form is a medical software template usable by general practice for referral in primary care—consistent with the Service Coordination Tool Template.
- *Statewide service coordination practice manual* includes realistic and meaningful messages about GP referral and feedback, and care planning with GPs.
- Victorian Division and PCP/member agencies work very well together in common approaches to chronic disease management, and most have attracted State funding for joint activity.
- Expanding range of projects and programs where divisions are involved with other primary care and hospital services.
- GPV has earned the trust of the department as an advisor on the GP sector.
- GPV has a strengthened understanding of State Government policies and imperatives.

For more information

- Primary Health Branch, Department of Human Services, Manager, Primary Health Integration email: Sylvia.Barry@dhs.vic.gov.au
- GPV, Primary Health Care Consultant, phone: (03) 9341 5200

Key learnings

Divisions of General Practice have the ability to reach GPs.

Using a GP champion to deliver the information is a valuable strategy.

Case study 4

Preparing for an influenza pandemic—an information kit and work plan for general practice

The Department of Human Services Public Health Branch, in partnership with a range of general practice organisations, developed an information kit and work plan for general practice to support preparation for an influenza pandemic.

Along with the kit, all divisions were offered a presentation on pandemic planning as well as guidance on writing a practice plan.

The drivers

While a number of Divisions of General Practice were putting together resource kits, it was decided that the Department of Human Services should take the lead on delivering consistent and accurate messages to all GPs.

The players

- Whitehorse Division of General Practice and Melbourne Division of General Practice
- Australian Medical Association—Victoria
- General Practice Victoria
- Royal Australian College of General Practitioners
- Australian Practice Nurse Association
- The Department of Human Services—Public Health, Primary Health and Emergency Management Branch
- One rural and one metropolitan GP

Practices promoting successful outcomes

- Partnerships between the peak bodies ensured that the kit was appropriate and well accepted by GPs.
- Use of a GP champion to deliver the information to general practice.
- Ability of Divisions of General Practice to reach GPs.
- The work arose from a specific identified need by general practice.

The challenges

- GPs were after a single plan and information to assist them.
- Getting agreement by all was a challenge, but was achieved in the end.

The results

- Along with the kit, the department offered to deliver a talk on pandemic planning as well as guidance on writing a practice plan to divisions. The majority of divisions accepted this offer.
- This approach is being used by other states.
- On occasions, meetings with divisions and GPs provided an opportunity to discuss broader infectious diseases issues.

For more information

www.health.vic.gov.au/pandemicinfluenza/general_practice.htm

Key learning

The current Commonwealth and State health reform agendas can provide opportunities to implement an integrated service.

Case study 5**Integrated primary mental health services in North East Victoria**

The North East Victoria Division of General Practice (NEVDG) and Northeast Health Wangaratta saw the opportunity to combine State and Commonwealth funding for primary mental services in order to provide an integrated mental health service for the community in north eastern Victoria. The service would comprise:

- mental health clinicians co-located in and aligned to 29 GP practices
- geographical coverage of 33,000 km²
- referrals via GP
- GPs, mental health clinicians and clients have input into client plans
- clinicians working with the GP's client management system
- an operational integrated health records system (with consent)
- GP assessment and Mental Health Plan document as clinician referral document
- appointments via practice reception.

The drivers

There was similar timing in the rollout of State and Commonwealth initiatives in mental health—primary mental health care teams funded by the Department of Human Services and various mental health programs through divisions, funded by DoHA. At the time, there was a high risk of failure of one or more initiatives if they were not implemented together in an effective way. For instance, they may have developed different processes for GP referral and risked confusion or poor uptake. The NEVDG board made a strategic commitment to work in partnership with other primary care services.

The players

- North East Victoria Division of General Practice
- Northeast Health Wangaratta
- Other regional primary care service providers

Practices promoting successful outcomes

- Built on existing good relationships.
- Management and executive/board involvement.
- Formal MOU between partners.
- Trust between partners.
- Clear demonstration of good intent at all levels.
- Division program manager was experienced mental health professional with long term relationships with GPs.
- Co-location and co-management by partners.

The results

The external evaluation has shown:

- high client satisfaction
- high clinician satisfaction and morale
- high GP satisfaction with model and mental health clinicians
- reduced stigma for clients accessing services via GP clinics
- better health outcomes (pre and post outcome assessment)

Agreed benefits by all participating parties:

- reduced duplication of similar services
- reduced competition for the same clinicians
- simplification of processes and referral pathways
- all GPs are eligible to refer and able to ensure patients can access the service
- a coordinated and higher level of service across the entire region
- the development of a specific integrated service
- economies of scale
- delivery of equitable services across 33,000 km²
- demonstrated application of mixing Commonwealth and State government policy
- service delivered as per Commonwealth and State government objectives
- transferability of model
- service expansion (additional Commonwealth funding)
- enhanced future partnerships
- built a sound base for further developments and partnerships.

For more information

Integrated Primary Mental Health Service North East Victoria www.ipmhs.org.au

Mr David Dart, CEO at North East Vic Division of General Practice

davidd@nevicdgp.org.au

Note: The role of State-funded Primary Mental Teams is being re-examined in response to the Commonwealth's mental health MBS items initiative.

Key learnings

Never underestimate the importance of developing clear strategic directions and action plans.

Care plans and care planning have different connotations for GPs and community health services. There is a need to agree on a shared language to define and communicate the issue.

Case study 6

Frankston Community Health GP liaison role

Peninsula Health—Frankston Community Health Service (FCHS) received funding as part of the Early Intervention in Chronic Disease (EliCD) program. The model developed for EliCD requires close linkages with general practice, initially for referral but also in the development and maintenance of care plans for patients with chronic disease.

A steering committee established for the EliCD program within the Frankston Community Health Service included representatives from the Frankston Mornington Peninsula Primary Care Partnership and the Mornington Peninsula Division of General Practice (MPDGP).

Implementation of this GP liaison work has increased joint planning and implementation. A strategic plan and action plans were developed by the GP Liaison Working Group. Subsequent to this, a GP engagement project has been initiated to enhance the scope with relevant stakeholders including the Peninsula Complex Care Program (HARP). On the ground, significant service system and access issues are being addressed, which is leading to increased referrals from GPs and requests for assistance from other EliCD programs in developing their GP liaison roles.

The drivers

- It was vital for the success of the program to develop close links and viable working relationships with general practice.

The players

- Frankston Community Health Service
- Frankston Mornington Peninsula Primary Care Partnership
- Mornington Peninsula Division of General Practice
- Working Group

Practices promoting successful outcomes

- Work built on established relationships.
- Used the expertise of MPDGP in developing the role and supporting the GP Liaison worker.
- Senior management representatives from all partners were involved in the working group.
- Planning together and looking for solutions when approach was not working initially.
- Funding commitment provided by partnering agencies to support a full-time position.
- Additional small grants funding to support specific projects, such as E-referral.

The challenges

- Recruiting a suitable worker.
- Significant system issues impacting on clear referral pathway for GPs into FCHS.
- Care plan and care planning have different connotations for GPs and EliCD program.
- Incompatibility of IT programs.

The results

- Referrals have increased from GPs
- Enhanced continuum of care for people with chronic disease.
- The opportunity to jointly plan with the MPDGP has enhanced and strengthened the work across both organisations—much greater than was envisaged.
- A number of valuable activities for the PCP were created to support the program.
- There is a strong working group to support a coordinated approach to effectively and efficiently using MBS item numbers for care plans and allied health services.
- A strong platform to produce evaluation and evidence of the impact of the EliCD program in chronic disease services and management.

For more information

Carolyn Marshall, Program Manager, Stay Healthy: Frankston Community Health Service, Peninsula Health. Telephone: 9784 8168. Email: cmarshall@phcn.vic.gov.au

Case study 7

Joint care planning for Supported Residential Services (SRS) clients—collaboration between Brunswick Community Medical Centre and Moreland Community Health Service

Key learning

A shared commitment to meeting the needs of highly disadvantaged people in the local area was the fundamental factor in motivating staff to bear with the 'slow and tedious process' of trying to make two very different organisations interact.

The Hume Moreland Primary Care Partnership (HMPCP) received funding via the 2004–05 GP Service Coordination Small Grants round to create, document, implement and disseminate a good practice model of service coordination between general practice and community health. The project built upon service coordination and integration activities undertaken by Moreland Community Health Service (MCHS) and the co-located Brunswick Community Medical Centre (BCMC).

The project explored development of an integrated care planning system for a specific group of people, namely the residents of Stewart Lodge, a large Supported Residential Service (SRS) in Brunswick, to meet both client and service provider needs.

The drivers

- The introduction in July 2005 of new Medical Benefits Schedule (MBS) Chronic Disease Management items, especially Team Care Arrangement (TCA) items.
- Outcomes of the Interagency Care Planning Protocol Pilot Project undertaken by PCPs in the North and West Metro Region which identified the existence of two care planning systems that did not interface.
- Small grants funding which allowed the agencies to focus on this work.

The players

- Brunswick Community Medical Centre (BCMC)
- Hume Moreland Primary Care Partnership (HMPCP)
- Moreland Community Health Service (MCHS)
- Stewart Lodge—an 80 resident SRS
- GPV
- North West Division of General Practice
- Melbourne Division of General Practice

Practices promoting successful outcomes

- Deliberately built on existing relationships and experiences of working together.
- The project sought a solution to an agreed problem.
- Joint planning and agreement on the implementation plan.
- Coordination of key roles across MCHS and BCMC and a team approach.
- Availability of practice staff to manage the administrative aspect, reducing direct time the GP needed to implement the TCA.
- Adopting a sustainable systemic approach.
- IT systems at the practice were well developed and supported the full range of MBS items, auto population of GP Management Plans and TCAs and a patient recall system.
- Client access was supported by MCHS staff.
- Fast tracked access to private allied health and dental care using MBS.

The challenges

- Significant investment of time was required by the medical practice and divisions to understand and integrate new MBS items into existing practices and systems.
- IT compatibility problems.
- Waiting lists for publicly funded services.
- Identification of private allied health professionals registered for Medicare rebate who were appropriate to use for the project.
- Availability of affordable dentistry.

The results

- Improved health care provision for the Stewart Lodge residents.
- Increased motivation for BCMC and MCHS to collaborate in providing services to the Stewart Lodge client group.
- Enhanced relationship between local providers, including general practice.
- Development of sustainable systems to undertake and record care planning.
- Privacy and consent protocols to ensure client confidentiality and informed consent when care planning.
- Increased awareness and appropriate use of MBS Chronic Disease Management Items.
- Better understanding of the role Divisions of General Practice and PCPs can play in assisting development of care planning protocols.
- Understanding benefits of maximising current resources (for example, practice nurses) in GP Management Plan and TCA process.
- Increased understanding of process for development of GP Management Plans and TCA items for chronic conditions across the participating agencies.

For more information

Brunswick Community Medical Centre: Virginia Rogers (03) 9380 4297
virginia.rogers@svhm.org.au

Moreland Community Health Service: Michelle Marazita (03) 9355 9916
michellem@mchs.org.au

Hume Moreland PCP: Bruce Watson (03) 9300 3082
bwatson@moreland.vic.gov.au

Key learning

A test of collaboration is whether front line staff are empowered and resourced to work flexibly across agency boundaries so services are customised to meet client and community needs.

Case study 8**Diabetes Coordination and Assessment Service**

The Integrated Disease Management Project was a Department of Human Services funded initiative that promoted integrated disease management programs within the context of partnerships across the primary care setting. There was clear recognition that if the partnership with GPs and community health services was to succeed, an innovative strategy was needed to bridge the cultural gap and address the linkage and interface issues. It was also clear that it would take time to build the levels of confidence and knowledge necessary to bridge the gaps.

Early planning identified that:

- a cultural gap existed between GPs and community health services
- GPs lacked confidence in community health services, particularly in relation to long waiting lists, lack of communication regarding referral status and patient progress, poor history of sustainable programs, and issues with availability and access to services
- community health services overall had low rates of GP referrals
- consumers wanted a more cohesive service experience

The notion of a central ‘hub’ was born out of the idea of facilitating communication and activity at the service system interfaces. This hub became known as the Diabetes Coordination and Assessment Service (DCAS).

The drivers

- Integrated Disease Management project and subsequent HARP funding.
- Bridging the cultural gap and addressing the linkage and interface issues was critical for the project’s success.

The players

- South East Primary Care Partnership (SEPCP)
- Dandenong District Division of General Practice
- Southern Health: Cardinia Casey and Greater Dandenong Community Health Services
- Consumers
- GPs

Practices promoting successful outcomes

- Using the SEPCP as an independent facilitator between GPs and community health.
- Understanding the key issues that underpinned the relationships of the key stakeholders.
- Involving key stakeholders in the design, planning and implementation phases.
- A clear and agreed communication strategy.
- Being located within the Division of General Practice, project personnel had access to a broader knowledge and skill base.

- Commitment and trust of key stakeholders in the leadership of the project.
- Locating DCAS within the Division of General Practice. This was a critical strategy in ‘positioning’ as GPs trusted and felt connected to the division. An added benefit was that DCAS staff members were able to access the infrastructure of the division and tap into the broad knowledge, skill and experience of division program staff.
- Building a reputation as ‘GP friendly’ meant that staff understood the context in which general practice operated and were provided assistance in a manner that was appropriate and appreciated by general practice.
- Accepted and acknowledged referrals and health assessments
- Planned an appropriate service mix in consultation with the client
- Clients triaged to the appropriate services as well as tracked and followed as they moved through the service system.
- Ability to identify issues and concerns from GPs and respond in a timely manner that was perceived to be ‘GP friendly’. Often the GP Engagement Project Officer would follow up with a visit to the practice to ‘close the loop’.
- Quickly identifying and addressing consumer or community health service staff issues.

The results

- To date, DCAS has accepted in excess of 2,000 referrals from GPs with an average of 1,000 referrals per annum.
- Waiting lists at local community health services have been significantly reduced for diabetes services.
- There is greater integration, cohesion and linkage across the primary care sector for diabetes services. Currently there is a ‘flow on’ effect for the acute sector as well with the expanded role of DCAS involving the HARP Chronic Disease Management Program.
- Access to diabetes self-management education for consumers has improved.
- DCAS has facilitated and supported the role of GPs as the ‘care coordinator’ in type 2 diabetes care.
- Relationship between GPs, community health and the acute service system has improved.
- DCAS has been proven as a successful model for engaging GPs and is currently being considered as a model for other chronic diseases.
- External stakeholders recognise the importance of involving the Division of General Practice when a link with GPs is desired.
- This experience has continued to build confidence in a cooperative and integrated approach to service delivery by all stakeholders.

- In 2004, the acute sector entered the partnership with the advent of subsequent funding through the HARP Chronic Disease Management Program. The ongoing value of DCAS was acknowledged and it was agreed to build on this success. DCAS was further extended in 2006 with the establishment of the Diabetes Prevention Program.

For more information

Christine Crosbie, Senior Program Manager, Dandenong Casey General Practice Association c.crosbie@dddgp.com.au or (03) 9706 7311

Key learning

Involve key stakeholders from the beginning.

This approach to collaboration improves the understanding of all players and provides clear steps forward in the development of the program.

Case study 9

Review and development of the General Practice Liaison (GPL) program

In 2001–02, HARP funding was made available to expand Victoria’s acute/primary care liaison activities. Consequently, general practice liaison services were significantly expanded and mainstreamed. The Statewide Emergency Program retains responsibility for the General Practice Liaison (GPL) program. Consistent with the *Better Faster Emergency Care* policy framework, a review of the GPL program was undertaken in March 2006 to identify breadth of practice and develop recommendations for the future of the program.

The review was completed in August 2006 and identified the need to develop a service framework to ensure:

- consistency in structure and function of the program across the state
- a formal coordination structure to support GPL services, promote accountability and ensure GPL services were aligned with government and health policy directions
- extension of service partnerships and progressive development of GPL services to provide strategic, cross-health service function focusing on systems change and improvements.

The recommendations of the review were endorsed by the Department of Human Services and provided a basis for strengthening and developing the GPL program by:

- establishing a GPL Program Coordination Service provided by GPV
- preparing a service framework
- implementing a three-year planning process
- funding additional services.

The drivers

There was a timely opportunity to undertake the review and follow this with the development of the GPL program.

The players

GPL program review:

- Emergency Access Reference Committee—Primary Care sub-committee
- GPV and Divisions
- GPL program services
- health services
- Primary Health Branch
- PCPs
- HARP project managers
- peak GP bodies, RACGP and RWAV

Development of the GPL program framework, GPL Program Coordination Service and three-year planning process:

- Emergency Access Reference Committee (EARC)—Primary Care sub-committee
- GPV and Divisions
- GPL Program services
- health services

Practices promoting successful outcomes

- Involving service providers and key stakeholders from the start as part of the review, which secured support from the field and facilitated the development of agreed directions for future development of the program.
- Being responsive to the views of stakeholders.
- Collaboration with GPV and utilising the EARC Primary Care sub-committee as a reference group.

The challenges

- Establishing a planning process that coincided with the Department of Human Services financial year and regular health service budget and planning cycles was challenging.

The results

Review provided an opportunity to:

- engage service providers and key stakeholders
- identify breadth of practice and value of GPL services
- identify future directions for the GPL program.

Collaboration with GPV and using the EARC Primary Care sub-committee as a reference group resulted in:

- development of the role and functions of the GPL Program Coordination Service, which facilitated development and implementation of the service
- development and implementation of planning process for GPL Program Service, including a workshop for GPL services and preparation of a resource document, *General Practitioner Liaison Program planning process 2007–10*
- development of statewide strategic goals and Department of Human Services strategic directions for the GPL Program Service, which support the development of annual action plans at the health service level, give consistency to work undertaken by the GPL program and facilitate accountability
- development of the *Framework for the Victorian GPL program* to promote consistent program development and support continued service improvement.

This collaboration has improved understanding of the program and provided clear steps in the development of the program for all stakeholders and participants.

The identification and presentation of key department priorities from program areas (emergency care, elective surgery, outpatients, sub-acute care, mental health, maternity services and primary health) was well received by GPL services.

The GPL network has been strengthened and the work of the GPL program has a higher profile within the department and health sector.

For further information

www.health.vic.gov.au/emergency

Key learning

Invest in sustainable change through system redesign.

Case study 10**Whitehorse Community Health Service Diabetes Prevention Study**

The Whitehorse Community Health Service (WCHS) Diabetes Prevention study ran over 18 months. The study had high recruitment targets requiring a number of recruitment strategies to be used, including:

- case finding within GP practices
- GP education and practice change to facilitate GP referral
- community marketing
- referral from other health professionals.

The most successful recruitment strategies were those involving the targeting of a number of GPs. The case finding approach taken by the division was successful in achieving the short-term outcomes of participant identification, screening and referral of patients to the study. In participating in the study, many of the GPs identified some patients with diabetes that they would not normally have identified without this screening process. This has encouraged those GPs to change their practice to be more in line with best practice guidelines.

The study has now become a mainstream program, which has been important for ongoing GP buy-in and referral into the program.

The drivers

- GP role—diagnosis of clients with pre-diabetes and referral of eligible clients into the diabetes prevention study run by the WCHS.
- WCHS role—provision of a diabetes prevention program (including assessment, a healthy living course, evaluation and follow-up).

The players

- Whitehorse Division of General Practice (WDGP)—key staff
- GPs within the local government areas of Whitehorse and Manningham
- WCHS—project manager and key staff
- Inner East Primary Care Partnership (IEPCP)—project staff

Practices promoting successful outcomes

- Establishing a working group to oversee the project and developing key performance indicators (KPIs) that were reported on at working group meetings. Each agency was responsible for delivering on the KPIs and accountable to the partnership.
- Regularly involving the staff from WDGP, WCHS and IEPCP to discuss implementation and deal with issues as they arose. This was very effective in ensuring that the development of new systems worked well for all agencies and staff involved.

- Recruitment strategies involving GPs. Of these, the most successful strategy with long term outcomes and sustainability was GP education and practice change. The WDGP worked with a targeted number of GPs to:
 - promote practice change
 - screen early for diabetes based on known risk factors (as per best practice guidelines)
 - collect and enter clinical indicators consistently into their electronic data management systems
 - refer to the WCHS using the Victorian Statewide Referral Form (VSRF)
 - forward clinical indicator data with the referral
 - communicate with WCHS as required.

The challenges

- Where GPs did not have medical software, they were required to complete a paper-based referral modelled on the VSRF.
- Building sustainable change in general practice to identify, screen and refer patients to the community-based program takes time, and the GPs must have confidence that the program is not short lived.

The outcomes

Qualitative information was gathered from two GPs referring into the program. Both GPs were positive about the program, and reported that:

- they believe the program offers a high and consistent standard of pre-diabetes care
- they are willing to continue referring patients to the program
- most of their clients have been receptive to and enthusiastic about the program
- their perception is that patients are benefiting from attending and seem to be making lifestyle changes.

When asked about the recruitment process, both GPs reported that there are two major factors in their decision of whether or not to refer patients to WCHS:

- the quality of the information and activities provided
- the ease of the recruitment process. If the recruitment process fits well with standard practice, is clearly explained to the GPs, and does not require a large amount of time to be spent filling in forms, or if there is a financial incentive for GPs to participate in the recruitment, then the GPs will be more inclined to participate.

It was noted that recruitment may be more fruitful in small single-practitioner practices as opposed to large practices where there are many GPs working shorter hours. As the smaller practices tend to have more continuity of care, it is more likely that the referral will be followed up on subsequent visits.

GPs have become champions for referral to the ongoing diabetes prevention program at WCHS. Practice changes within GP clinics are sustainable and new systems (for example, use of VSRF) can be generalised across other programs.

There have been significant improvements in communication between GPs and health service providers at WCHS. The emphasis of GPs as referrers to WCHS has increased the focus on communication with and feedback to GPs from WCHS health service providers. Importantly, formal processes for written feedback to the GP (at four weeks and six months) have been established.

Clinical data is shared between the GP and WCHS, with client consent. This supports the delivery of services as per good practice guidelines.

Of the 240 clients referred from GPs to WCHS, just over half were referred via the VSRF.

For further information

Better Health Team Leader (WHCS): (03) 9890 2220

Key learning

Learning about the constraints of the environment in which each party works leads to more effective intersectoral collaboration.

Case study 11

Disability Services Division's introduction of the Comprehensive Health Assessment Program

In 2007, the Department of Human Services' Wellbeing and Practice Improvement Unit, Disability Services Division, sought advice from General Practice Victoria (GPV) and the Primary Health Branch, Rural and Regional Health and Aged Care Services Division, in developing a communication strategy to inform GPs about the planned introduction of the Comprehensive Health Assessment Program (CHAP) for people with an intellectual disability living in government managed supported accommodation.

The drivers

People with an intellectual disability have poorer health than the rest of the population. The annual health review with a GP has been a long-standing practice in disability accommodation services but barriers existed, including:

- the person may have communication difficulties and be unable to provide an adequate medical history
- support staff attending the appointment may be unfamiliar with the person's full medical history
- the GP may be restricted by time and may be unfamiliar with the health needs of people with an intellectual disability.

The CHAP is a health assessment, advocacy and education process that has been shown to improve health promotion, disease prevention, case finding and management activities for people with an intellectual disability in the general practice setting. CHAP was developed by Dr Nicholas Lennox, the Director of the Queensland Centre for Intellectual and Developmental Disability, and is being used in three other states in Australia.

CHAP comprises three sections:

- The first part is completed by support staff to provide a thorough medical history for the GP.
- The second part prompts for specific areas that should be considered by practitioners in the annual health review.
- The final part prompts the GP and support staff to prepare a management plan based on the findings of the annual health review.

The planned introduction of CHAP is supported by two new Medicare items to provide rebates for GPs undertaking a comprehensive health assessment for a person with an intellectual disability.

The players

- Department of Human Services' Wellbeing and Practice Improvement Unit, Disability Services Division
- GPV
- Centre for Developmental Disability Health Victoria
- Department of Human Services, Primary Health Branch

Practices promoting successful outcomes

- Open communication and joint problem solving with all parties.
- Seeking advice from trusted advisors and experts.
- Implementing strategies to overcome existing barriers based on the advice from GPV.

The challenges

Limited understanding by some parties regarding the issues facing people with an intellectual disability, and the issues regarding the service environment of general practice.

The results

Department of Human Services staff developed a greater understanding of the small business environment of the general practice, the workforce shortage in general practice and the growing role of practice nurses and nurse practitioners.

GPV learned about the poor health of people with an intellectual disability, qualifications of support staff and the disability accommodation services environment.

Input from the Primary Health Branch and GPV helped the Disability Services Division develop a communication strategy, which included practice instructions for staff and a letter to GPs to be given to them by support staff at the time of the appointment, describing:

- the department's residential services
- the role of department support staff
- consent issues
- MBS items
- CHAP tool
- where to get clinical support for working with a person with an intellectual disability.

For more information

[http://nps718.dhs.vic.gov.au/ds/disabilityimages.nsf/images/wpi_prac_manual_sections_5-7_29112007/\\$file/wpi_prac_manual_sections_5-7_29112007.doc](http://nps718.dhs.vic.gov.au/ds/disabilityimages.nsf/images/wpi_prac_manual_sections_5-7_29112007/$file/wpi_prac_manual_sections_5-7_29112007.doc)

8. What is the Department of Human Services connection with general practice?

Those Department of Human Services programs and State-funded services that have a relationship with the general practice sector are described below:

- **Acute services and sub acute health services**
Public hospitals including emergency departments, sub-acute ambulatory care services, regional integrated cancer services, palliative care, post acute care, hospital admissions risk program, transitional care program, maternity services
- **Aged care services**
Community and residential based aged care services
- **Children, youth and family services**
Services broadly include juvenile justice and youth services and child safety and family service, including adoption, child protection, out-of-home care, family violence, sexual assault.
- **Primary health services**
Primary Care Partnerships, community health services, public dental services, rural integrated health services, HACC service providers including local governments, drug and alcohol treatment services
- **Mental health services**
Area mental health services—inpatient/community mental health services covering adult mental health services including primary mental health teams, child and adolescent mental health services and aged persons mental health services
- **Disability services**
Community residential facilities, residential institutions and respite facilities
- **Public health**
Immunisation, influenza pandemic planning, anaphylaxis management, Blood Borne Virus and Sexually Transmitted Infections education for general practice, population health and health promotion
- **Office of Housing**
The Office of Housing manages or provides funds for the Victorian social housing portfolio of over 76,000 properties, including long term community, public and Aboriginal housing, short-medium term crisis and transitional housing, and assistance with bond loans for private rental.

Department of Human Services and State-funded services are currently working with general practice in a variety of ways and some strong relationships have already been established.

The mechanisms for collaboration include:

- mandating that service providers engage with general practice, and funding the resulting collaboration—PCPs
- establishing formal protocols for communicating with Divisions of General Practice—Public Health Branch
- linking into the divisions' network to implement initiatives—Mental Health Discharge Planning Protocols
- securing general practice representation and leadership on committees—Emergency Access Review Committee
- obtaining general practice sector advice as part of policy and service development—General Practice Liaison Program
- coordinating and exchanging information within the Department of Human Services—DHS GP Policy Coordination Group

‘High community expectations and the increasing number of patients with chronic complex problems continues to put pressure on GPs’ workload and limit their availability of non-patient time.’⁵

‘Whether the small business general practice model will eventually disappear is open to debate, but one thing is certain—it will change.’¹¹

9. General practice realities

Diversity of general practice

The size and structure of private general practices throughout Australia are quite diverse. They range from solo GPs to large purpose built clinics with 15 plus GPs, practice nurses, practice managers and allied health professionals. In Victoria, just over one third are solo, 45 per cent are in 2–5 GP practices and 21.7 per cent in practices with 6+ GPs.⁶ Just under 2 per cent EFT⁷ GPs deliver medical services in community health services.

GPs may work as partners, associates or employees. Sometimes they work independently of each other with no standardised or consistent approach to systems within the one practice. On the other hand, more general practices are moving to a whole of practice approach, as the need for multidisciplinary teams becomes a necessity. Structured chronic disease management in general practice is becoming more prevalent, supported by initiatives such as the National Primary Care Collaboratives (NPCC) Program⁸ and the Lifescripts⁹ program.

In rural Victoria particularly, GPs play a significant role in providing the majority of care in local rural health services and a significant amount of medical care in district rural services. There are approximately 1,200 rural GPs, with about half of these relating to smaller rural hospitals.

GPs, in the majority of cases, operate as small businesses, earning most of their income on a fee-for-service basis. The Commonwealth Government supports consumers to attend GPs through the Medicare Benefits Schedule (MBS)¹⁰ and funds GPs and general practice directly via a blended payment system. A blended payment is a model of payment that includes both fee-for-service and other funding arrangements for the provision of services defined by the Commonwealth Government, such as Service and Practice Incentive Payments.

The profile of GPs is changing. Clearly there is an increase in female GPs with females comprising most of the graduate and registrar numbers. There is also a growing trend towards part-time work, not only due to the feminisation of the workforce. Both males and females tend to be seeking more diversity and increasingly elect to work only part-time in clinical consulting roles. This trend helps achieve a better work–life balance and, hopefully, greater retention in general practice, however, community access to GPs continues to decrease.

⁵ RACGP (C2205) *GPs and General Practice Teams (Draft) Position Statement*, Melbourne 2005

⁶ PHCRIS www.phcris.org.au/products/asd

⁷ Department of Human Services, *General Practitioners in Community Health Services Strategy*, DHS, Melbourne, May 2004

⁸ NPCC www.npcc.com.au

⁹ Lifescripts <http://health.gov.au/lifescrpts>

¹⁰ *Medical Benefits Schedule* Australian Government Department of Health & Ageing

¹¹ Martin, CM & Sturmberg, JP *General Practice—chaos, complexity and innovation* MJA 2005; 183 (2); 106–109

*'The general practice workforce is likely to face continued chronic shortages, necessitating innovative policy responses to ensure that the community's need to primary medical care is met.'*¹²

Workforce

Australian general practice is under pressure with an inadequate workforce and an increasing prevalence of chronic disease and patient complexity. Current practice is more time consuming, with unattractive remuneration as compared to more lucrative areas of medicine. New models of team care require infrastructure investment in consulting rooms, information technology and staffing. Smaller general practices, in particular, are uncertain where their future lies and there is little indication that the increased number of doctors graduating from 2010 onwards will enter general practice.¹³

GPs play a pivotal role in providing services and referral to people who need primary care, and are critical to effective chronic disease management strategies. GPs also provide an interface between the acute, residential and community support systems.¹⁴ Data from DoHA indicates that GPs undertake over 20 million consultations across Australia each year. The number of GPs¹⁵ providing medical care in metropolitan and rural Victoria is approximately 3,500 and 1,225 respectively. These GPs are critical to the provision of comprehensive health care. The ratio of FTE (full time equivalent) GP to population in Victoria ranges from 1:2,000 plus in rural/remote areas, 1:1500 in outer metropolitan and 1:690 in inner urban areas.¹⁶

Practice nurses are becoming core members of the general practice team. The benefits of employing a nurse include improved outcomes in chronic disease; an increased range of services available at the practice, including patient education, improved integration and referral to services; and enhanced consumer satisfaction. The National Practice Nurse Survey Report 2006 revealed a 23 per cent increase in the number of practices employing a practice nurse between 2003–05, with currently over 57 per cent of general practices nationally employing nurses.¹⁷

Practice managers play a pivotal role in general practice and are well supported by divisions and organisations such as the Australian Association of Practice Managers (AAPM).¹⁸

¹² Joyce, CM, McNeil, JJ & Stoelwinder, JU, More doctors, but not enough: Australian medical workforce supply 2001–2012, *MJA* 2006; 184 (9): 441–446

¹³ Jackson, CL, General Practice in Australia 2020; 'robust and ready' or 'rudderless and reeling'? *MJA* 2006; 185(2): 125–127

¹⁴ Department of Human Services, *A guide to general practice engagement in Primary Care Partnerships*, Victorian Government, Melbourne 2001

¹⁵ Department of Human Services, *Medical Labour Force Survey Victoria*, 2004. Estimate calculated April 2005, based on respondents identifying themselves as clinicians, and scaled to Medical Registration Board information on the total number of medical practitioner registrants. Estimates are subject to revision.

¹⁶ PHCRIS GP:population ratios

¹⁷ *National Practice Nurse Survey Report 2006*

¹⁸ www.aapm.org.au

'Everybody seems to want a piece of the consultation time—I sometimes feel totally overwhelmed.' (GP)

The general practitioner

GPs are required to be up-to-date with wide-ranging changes, including those in the local service system (for referrals), Medicare (for payment) and medications (for prescribing)—for the benefit of the clients' health and the GPs' business. Pharmaceutical companies, state and federal governments, community and acute health care providers, Divisions of General Practice and other specialist agencies compete to engage GPs and influence their clinical behaviours.¹⁹

As a small business, general practice has the added efficiency burden and costs related to government regulations and legislative requirements, for example, Drugs, Poisons and Controlled Substances Regulations (2006). General practice administration and compliance costs²⁰ were highlighted in the Productivity Commission report published in 2003.

In its submission to the Productivity Commission on the General Practice Compliance Costs Study October 2002,²¹ ADGP highlighted that the greatest concern for GPs regarding the increasing burden of paperwork and compliance with bureaucratic requirements is the extent to which it detracts from the delivery of patient care.

Experience from initiatives including PCPs and HARP projects demonstrates that GPs in private practice can be successfully engaged through highly targeted, practical proposals that have an immediate, tangible benefit to their clients or that reduce their workload.²²

Provision of best practice in both prevention and chronic illness would take the average GP 9–10 hours per day; therefore it would be difficult to provide high levels of prevention outside a partnership approach. Partnerships and collaboration operate at different levels: between the GP and patient, GPs and practice staff, and between the practice, the local Division of General Practice and/or the broader community and the health system.²³

Many GPs remind Divisions of General Practice that patients with chronic disease take up a larger proportion of their time in relative terms but the majority are not complex with chronic conditions. In its submission to the ADGP Primary Health Care Position Statement September 2005,²⁴ GPV pointed out that the main work of GPs is in individual consultations that do not involve referral to others.

¹⁹ Bensberg, M., Sutherland, J., & Crosbie, C., 'It takes more than a practice visit—effective general practice engagement', *Australian Journal of Primary Health*, vol. 13, no. 3, pp. 17–21. 2007

²⁰ Productivity Commission, General Practice Administration and Compliance costs. Research Report. Canberra, 2003 www.pc.gov.au/study/gpcompliance/docs/finalreport

²¹ ADGP Submission to the Productivity Commission on the General Practice Compliance Costs Study

²² Department of Human Services, *General Practitioners in Community Health Services Strategy*, DHS, Melbourne, May 2004

²³ RACGP Green Book *Putting Prevention into Practice: Guidelines for the implementation of prevention into the general practice setting*. 2nd edition 2006

²⁴ GPV Submission September 2005 ADGP'S Primary Health Care Position Statement

The BEACH Report 2003–2004 states that just over one third of all problems managed were of a chronic nature.²⁵ This means that two thirds of problems managed in general practice are not related to chronic illness. GPV states that: ‘what takes place in the consultation is the key for effective individual and population health. A core role of the divisions’ network should always be to support GPs and practices to enhance the effectiveness of the consultation’.

Maintaining vocational registration places further demand on GPs. The RACGP provides the Quality Assurance and Continuing Medical Education program²⁶ that requires GPs to gain a specific number of CPD points over a triennium.

Involvement with State-funded services

GPs have direct and indirect involvement with State-funded services and the Department of Human Services in a variety of ways. Referral of patients to community health services, hospitals, HACC services and other services is certainly almost a daily occurrence. Consistently, GPs draw attention to the significance of quality care at the interface with hospitals and the need to continually improve communication processes.

Contact will occur from time to time with the Drugs and Poisons Unit, Children’s Services and the Public Health Branch in the reporting of communicable diseases. GPs may represent their Division of General Practice on various committees, boards, working groups and in an advisory capacity to contribute towards governance, planning and strategies of primary care partnerships, hospitals, community health services and other health care providers.

²⁵ Britt, H, Miller GC, Knox S, Charles J, Valenti L, Pan Y, Henderson J, Bayram C, O’Halloran J & Ng A 2004 *General Practice activity in Australia 2003–04. IHW Cat.No.GEP 16, Canberra: Australian Institute of Health and Welfare (General Practice Series No 16)* p 24

²⁶ www.racgp.org.au/Content/Navigationmenu/Advocacy/RACGPpositionstatements/policy23021995.htm

10. Divisions of General Practice and their role

Divisions of General Practice are local organisations, funded primarily by DoHA to improve health outcomes for patients by encouraging GPs to work together and link with other health professionals.

Divisions are supported by state-based organisations and the AGPN. There are currently 119 Divisions of General Practice covering all of Australia, and divisions vary greatly in geographical size, number of GPs and population in their areas, as well as in resources, infrastructure and their range of activities.

Divisions of General Practice were designed to:

- enable GPs to work together and within the wider health care system
- meet local health needs
- promote preventive health care.

Divisions have a role in helping general practices and individual GPs to work more collaboratively with other health professionals. They advocate and negotiate on behalf of their members with governments, hospitals, other health care providers, and organisations that provide services to general practices.

Divisions of General Practice will differ in their priorities, capacity and philosophy.

Divisions are independent organisations incorporated as companies or associations. Just as there is diversity in general practice itself, there are differences between the individual Divisions of General Practice. They vary in their philosophy, organisational structure, areas of expertise, membership categories, funding level and level of membership participation. Many are moving away from the name 'Division of General Practice' to be known as networks or associations. The AGPN, for example, was formerly the Australian Division of General Practice (ADGP).

GP roles in Divisions

GPs at local, state and federal levels provide input into planning, strategy, health reform and decision-making. They serve on boards or committees of management, have involvement on sub-committees and working groups, or act as program advisors and representatives of their division at forums and meetings, where their expertise, experience and clinical knowledge are invaluable. Divisions remunerate GPs in various ways; generally, they are recompensed for time lost in their practice.

Each Division generally factors into their budget an allocation for GP payments within each program area. Again, the allocation and the overall budget for a particular program, for example integration, will differ from division to division. If GP input is required by external agencies at focus groups, meetings or forums, payment will often need to be negotiated as the divisions have limited capacity to stretch beyond their core funding. It is likely a division can provide representation via a staff member, however it is recognised by the divisions that in certain areas, direct GP input is essential.

'The divisions network has a secure place in the health system and GPs are involved at all levels of health reform and decision making. This capacity in the divisions has facilitated multiple health reforms, including immunisation and information technology, leading to improved health outcomes for the Australian community.' ²⁷

General practice engagement is the logical function of Divisions of General Practice. Divisions' longstanding relationships and established trust with practices creates a firm foundation for effective engagement.

Market research

General practice routinely receives a barrage of information from numerous sources. Divisions of General Practice are proven to be ideal 'market researchers' for any organisation wanting to engage general practice, whether for participation in a project, research, raising awareness, education or referral to a service. Once a division understands the value/benefit to general practice and the community, generally it will assist in the delivery of the message to its membership. This filtering and dissemination function is critical to the retention of trust that general practice or more specifically the membership has in the division. If information is received under the division logo and/or from trusted division personnel it is more likely to be received positively.²⁷

The peak body for the 30 divisions in Victoria is General Practice Victoria (GPV). The Commonwealth Government provides the core funding for both GPV and divisions, however GPV and a number of divisions also receive significant funding from the State to support GP integration in specific Department of Human Services' initiatives.

GPV maintains the same role as divisions in filtering information through to the 30 individual organisations as well as providing coordination and support at all levels.

Funding of Divisions of General Practice

It helps to understand a little about how Divisions of General Practices are funded and why capacity, priority and overall philosophy can differ from one to another.

The Australian Government, via DoHA, provides the main funding to Divisions of General Practice. The Australian Government funds divisions to provide services and support to general practice at the local level to achieve health outcomes for the community that would not otherwise be achieved on an individual GP basis.

The first 10 Divisions of General Practice were funded in 1992 as trials to link general practice with the rest of the health system. The Divisions of General Practice Program today comprises the AGPN, eight state based organisations and 119 Divisions of General Practice. There are 30 Divisions in Victoria.

The Australian Government has provided funding of \$302.4 million from 2004–05 until 2007–08 as core funding for the Divisions Program. Earlier this year, the Government announced continued funding for the program of \$243 million for three years from 2008–09.

The Australian Government provides divisions with core funding to support basic infrastructure and administrative needs and to undertake a range of activities based on local needs and priorities. Divisions can allocate the core funding to a range of activities, according to their priorities. Divisions do this under the National Priority Areas.

In any initiative that is going to impact on general practice, ensure that Divisions of General Practice are involved at an early stage to provide input into planning and strategy.

²⁷ Bensberg, M., Sutherland, J., & Crosbie, C., 'It takes more than a practice visit—effective general practice engagement', *Australian Journal of Primary Health*, vol. 13, no. 3, pp. 17–21. 2007

Divisions also receive Australian Government funding to undertake specific programs, such as More Allied Health Services, Aged Care GP Panels Initiative, Workforce Support for Rural Practitioners Program, General Practice Immunisation Incentive Scheme, After Hours Primary Medical Care and Better Outcomes in Mental Health.

Increasingly, the divisions network is building links with State and Territory Governments which are funding divisions for local level service planning and integration of primary care with state and territory health services. Additional funding would be required from states and territories where divisions are being asked to undertake expanded activities.

Core funding is provided according to a formula based on population with a range of weightings (such as socioeconomic status and rurality indices). Overall, the total population in divisions ranges from approximately 19,000 to more than 515,000. The number of practising GPs in divisions also ranges from around 10 to more than 800.²⁸ Consequently, the level of funding available varies significantly from division to division.

While all divisions are required to address the nine National Priority Areas, they vary in their selection of priorities, budget allocation and strategies for each area, having regard to local need. For example, workforce support issues may have greater focus and greater budget allocation in rural and outer metropolitan divisions. Others may invest significantly in integration through involvement with Primary Care Partnerships (PCPs) and/or collaboration with hospitals. This level of engagement may be for specific projects or chronic disease areas. Overall, this results in a broad range of activities undertaken by divisions.

Every financial year, divisions negotiate an annual plan and budget with DoHA, which are based on local needs and priorities identified by the division. Once approved by DoHA, the plan and budget are locked in for a 12-month period and further approval from DoHA is required to change the budget or strategic directions.

²⁸ Department of Health and Ageing, Report of the review of the Outcomes Based Funding formula for the Divisions of General Practice, Canberra, 2002, page 25

Divisions of General Practice National Performance Indicators List

This outlines the National Priority Areas and Domains for Divisions of General Practice planning and reporting as at 2007–08.

National Priority Areas	National Domain <i>Mandatory</i>	Funding allocation	Local Domain <i>Optional</i> (determined by individual Division) Examples provided	Funding allocation
Prevention & early intervention	Immunisation	Fixed	Health promotion	Determined by Division
Access	Residential Aged Care	Fixed	Refugee health, Aboriginal health, youth	Determined by Division
Integration	GPs and hospitals	Determined by Division	Working with PCPs	Determined by Division
Chronic disease	Diabetes or Asthma or Mental Health (only 1 is mandatory)	Determined by Division	Working with area mental health service	Determined by Division
General practice support	N/A	Determined by Division	Practice teams/ practice nursing support	Determined by Division
Quality support	N/A	Determined by Division	Practice accreditation support	Determined by Division
Consumer focus	N/A	Determined by Division	Consumer involvement	Determined by Division
Workforce support	N/A	Determined by Division	Provision of locum in rural areas Specific network/support for OTDs	Determined by Division
Governance	Performance improvement culture Effective external engagement Financial compliance and risk management	Determined by Division	Structural efficiency	Determined by Division

For more on Commonwealth priorities, for example, interest in focusing on a specific disease area, see website www.health.gov.au/internet/main/publishing.nsf/Content/Home and Division national performance indicators www.phcris.org.au/divisions/reporting/div/list.php

11. Contacts and resources

Victorian Divisions of General Practice—website addresses

Division	Website
Ballarat and District Division of General Practice	www.bddgp.org.au
Central Victoria General Practice Network	www.bgodivgp.org.au
Albury Wodonga General Practice Network	www.bordergp.org.au
Central Bayside General Practice Network	www.centralbayside.com.au
Central Highlands General Practice Network	www.chdgp.com.au/division
Central West Gippsland Division of General Practice	www.cwgdogp.com.au
Dandenong Casey General Practice Association	www.dddgp.com.au
East Gippsland Division of General Practice	www.egdgp.com.au
Eastern Ranges General Practice Association	www.ergpa.com.au
General Practice Association of Geelong	www.gpageelong.com.au
Goulburn Valley Division of General Practice	www.gvgp.com.au
Greater Monash General Practice Network	www.gmgp.org.au
Inner Eastern Melbourne Division of General Practice	www.iemdgp.com.au
Knox Division of General Practice	www.knoxdiv.com.au
Mallee Division of General Practice	www.malleedgp.com.au
Melbourne General Practice Network	www.mgpn.com.au
Monash Division of General Practice	www.monashdivision.com.au
Peninsula GP Network	www.pgpn.org.au
Murray Plains Division of General Practice	www.mpdgp.com.au
North East Valley Division of General Practice	www.nevdgp.org.au
North East Vic Division of General Practice	www.nevicdgp.org.au
North West Melbourne Division of General Practice	www.nwmdgp.org.au
Northern Division of General Practice	www.ndgp.org.au
Otway Division of General Practice	www.otway.asn.au
General Practice Alliance South Gippsland	www.gpasouthgippsland.com.au
Southcity GP Services	www.southcitygpservices.com.au
West Vic Division of General Practice	www.westvicdiv.asn.au
Western Melbourne Division of General Practice	www.westerngp.com.au
Westgate General Practice Network	www.wgpn.com.au
Whitehorse Division of General Practice	www.wdgp.com.au

Key reports and references

- 2008** Britt H, Miller GC, Charles J, Bayram C, Pan Y, Henderson J, Valenti L, O'Halloran J, Harrison C, & Fahridin S. General Practice Activity in Australia 2006–2007
Published 30 January 2008; ISSN 1442-3022; ISBN-13 978 1 74024 7528; AIHW cat. no. GEP 21; 254pp Canberra
General practice series no. 21
 This publication is the 21st in the General Practice Series produced by the Australian General Practice Statistics and Classification Centre, a Collaborating Unit of the Australian Institute of Health and Welfare and the University of Sydney. It reports the results of the ninth year of the BEACH program, April 2006 to March 2007. Data reported by 930 general practitioners on 93,000 GP-patient encounters are used to describe aspects of general practice in Australia: the general practitioners and their patients; the problems managed and the treatments provided. Changes that have occurred over the last nine years of the BEACH study, from 1998–99 to 2006–07 are investigated. In addition, changes in the management of type 2 diabetes and depression from 1998–99 to 2006–07 are considered in light of changes in policy. The contribution of practice nurses to the GP-patient encounters in terms of their clinical activities, the problems they assist with and the Medicare items claimed are described in this report. Information on body weight to height ratio, smoking status and alcohol use for a subsample of patients is provided. Abstracts and research tools used in other BEACH substudies from 2006–07 are also included.
www.aihw.gov.au/publications/index.cfm/title/10574
- 2007** Britt H, Miller GC, Charles J, Pan Y, Valenti L, Henderson J, Bayram C, O'Halloran J, & Knox S. General Practice Activity in Australia 2005–2006
Published 17 January 2007; ISSN 1442 3022; ISBN-13 978 1 74024 641 5; AIHW cat. no. GEP 19; 200pp Canberra
General practice series no. 19
 This publication is the 19th in the General Practice Series produced by the Australian General Practice Statistics and Classification Centre, a collaborating unit of the Australian Institute of Health and Welfare and the University of Sydney. It reports the results of the eighth year of the BEACH program, April 2005 to March 2006. Data reported by 1,017 general practitioners on 101,700 GP-patient encounters are used to describe aspects of general practice in Australia: the general practitioners and their patients; the problems managed and the treatments provided. The contribution of practice nurses to the GP-patient encounters, in terms of their clinical activities, the problems they assist with and the Medicare items claimed, are described for the first time in this report. Information on body weight to height ratio, smoking status and alcohol use of a subsample of patients is also provided. Changes that have occurred since 1999–00 are investigated. Data for each of the last 5 years of BEACH are summarised in the appendixes to this report.
www.aihw.gov.au/publications/index.cfm/title/10377

2007	<p>Hordacre, AL., Howard, S., Moretti, C., Kalucy, E. (2007). <i>Making a difference. Report of the 2005-2006 Annual Survey of Divisions of General Practice</i>. Adelaide: Primary Health Care Research & Information Service, Department of General Practice, Flinders University, and Australian Government Department of Health and Ageing.</p> <p>Results of the 2005–06 Annual Divisions Survey (ASD)</p> <p>The Primary Health Care Research and Information Service (PHC RIS) conducts the Annual Survey of Divisions (ASD) on behalf of the Australian Government Department of Health and Ageing. As part of their contractual obligations, all Divisions of General Practice are required to complete the Survey which includes questions about their membership, activities (including population health) and infrastructure for the previous financial year. Consequently, the results provide a comprehensive overview of Divisions and summarise the broad range of activities that they are involved in.</p> <p>www.phcris.org.au/products/asd/results/05_06.php</p>
2006	<p>Gawaine Powell Davies, Professor Mark Harris, Dr David Perkins, Professor Martin Roland, Ms Anna Williams, Ms Karen Larsen, Ms Julie McDonald (2006) <i>Coordination of care within primary health care and with other sectors: a systematic review</i></p> <p>Australian Primary Health Care Research Institute</p> <p>UNSW Research Centre for Primary Health Care and Equity (CPHCE) at the University of New South Wales in Association with the University of Manchester (UK)</p>
2004	<p>Australian Government Department of Health and Ageing (2004) <i>Divisions of General Practice: Future Directions</i> Canberra</p> <p>Government response to the Report of the review of the role of Divisions of General Practice</p>

Online resources

Current as of February 2008. Please note many of these web pages are currently under review and will be updated regularly online at www.health.vic.gov.au/communityhealth/gps/position_statement.htm.

45 Year Old Health Check

www.health.gov.au/internet/main/publishing.nsf/Content/Enhanced+Primary+Care+Program-1

Aged Care GP Panels

Guidelines for the Aged Care GP Panels Initiative August 2007

www.health.gov.au/internet/main/publishing.nsf/content/aged-care-gp-toc

Allied Health (Individual) Services under Medicare

www.health.gov.au/internet/main/publishing.nsf/Content/Allied+Health+and+Dental+Care+initiative

Allied Health Group Services under Medicare for patients with type 2 diabetes

www.health.gov.au/internet/main/publishing.nsf/Content/health-pacd-epc-ahgs-diabetes.htm

Asthma Cycle of Care

www.medicareaustralia.gov.au/provider/incentives/pip/files/asthma-cycle-of-care.pdf

Australian Primary Care Collaboratives Program

www.health.gov.au/internet/main/publishing.nsf/Content/health-pcd-programs-apccp-index.htm

Calculating PIP payments

www.medicareaustralia.gov.au/provider/incentives/pip/payment-formula/index.shtml

Cancer screening

www.cancerscreening.gov.au

Cardiovascular health

www.health.gov.au/internet/main/publishing.nsf/Content/pq-cardio

Chronic Disease Management (CDM) Medicare Items (new from 1 July 2005)

www.health.gov.au/internet/main/publishing.nsf/Content/pcd-programs-epc-chronicdisease

Dental services under Medicare

www.health.gov.au/internet/main/publishing.nsf/Content/Dental+Care+Services

Department of Health and Ageing—Divisions of General Practice Program

Multi Program Funding Agreement 2005–08 Information (including FAQs)

www.health.gov.au/internet/main/publishing.nsf/Content/health-pcd-programs-divisions-overview

Department of Health and Ageing—Information about the Divisions of General Practice Program

Please note that information about the Divisions of General Practice National Quality and Performance System 2008–09 to 2010–11 will be added to this website in the first half of 2008.

www.health.gov.au/internet/main/publishing.nsf/Content/health-pcd-programs-divisions-overview

Department of Health and Ageing—Publications

www.health.gov.au/internet/main/publishing.nsf/Content/health-publicat.htm

Enhanced Primary Care Program

www.health.gov.au/internet/main/publishing.nsf/Content/Enhanced+Primary+Care+Program-1

General Practice Immunisation Incentives (GPII) Scheme

Department of Health and Ageing information about GPII

www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/providers#gpii

Medicare Australia information about GPII

www.medicareaustralia.gov.au/provider/incentives/gpii/index.shtml

General Practice Victoria (GPV) Statistics Package

This package includes updated MBS and PIP/SIP data from Medicare Australia and general practice accreditation data from Accrediting bodies (AGPAL and GPA Plus). The data is collated and shown by all Victorian divisions.

www.gpv.org.au

GP Mental Health Care Medicare Items

www.health.gov.au/internet/main/publishing.nsf/Content/health-pcd-gp-mental-health-care-medicare

Home Medicines Review (HMR)

See Medication Management Reviews

How does Medicare Work

www.medicareaustralia.gov.au/provider/medicare/index.shtml

Information for health practitioners e.g. provider number eligibility

www.health.gov.au/internet/main/publishing.nsf/Content/work-pr

Institute for Healthcare Improvement

www.ihl.org/ihl

Lifescrpts

www.health.gov.au/internet/main/publishing.nsf/Content/health-publth-strateg-lifescrpts-index.htm

MBS—Medicare Benefits Schedule Project (Department of Human Services)

Resources on a range of MBS Items

www.health.vic.gov.au/communityhealth/gps/mbs_gp

MBS items for services provided by a practice nurse on behalf of a medical practitioner

www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=M.2&qt=noteID&criteria=practice%20nurse

MBS Online

www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Medicare-Benefits-Schedule-MBS-1

MBS publications

www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Medicare-Benefits-Schedule-mbs-publications

MBS Items for Health Assessments for Refugees and other Humanitarian Entrants

www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A.27&qt=noteID&criteria=refugee%20health

MBS Items for Health Assessments for people aged 75 + over (55 + over for Aboriginal and Torres Strait Islander people in recognition of their specific health needs)

www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A.23&qt=NoteID

MBS Health Checks (Child and Adult) for Aboriginal and Torres Strait Islanders

www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A.24&qt=NoteID

Medicare Australia—programs and services

www.medicareaustralia.gov.au/about/index.shtml

Medication Management Reviews

www.health.gov.au/internet/main/publishing.nsf/Content/Medication+Management+Reviews

More Allied Health Services Program (MAHS)

www.health.gov.au/internet/main/publishing.nsf/Content/health-pcd-programs-mahs

Multidisciplinary case conferencing

www.health.gov.au/internet/main/publishing.nsf/Content/health-epc-caseconf.htm

National Chronic Disease Strategy

www.health.gov.au/internet/main/publishing.nsf/Content/pq-ncds

New Medicare Initiatives 2005

www.medicareaustralia.gov.au/provider/incentives/medicare-initiatives.shtml

Nursing in general practice program

www.health.gov.au/internet/main/publishing.nsf/Content/work-temp-prog-nigp

Practice Incentives Program (PIP)

www.medicareaustralia.gov.au/provider/incentives/pip/index.shtml

PIP—Diabetes Annual Cycle of Care

www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A.38&qt=notelD&criteria=service%20incentive%20payment

PIP—Information Management/Information Technology (IM/IT)

www.medicareaustralia.gov.au/provider/incentives/pip/payment-formula/it.shtml

PIP—Payment for rural and remote procedural GPs

www.medicareaustralia.gov.au/provider/incentives/pip/index.shtml

Primary Health Care Research and Information Service

PHC RIS works in partnership with the Divisions of General Practice Network, primary health care researchers and policy advisors.

www.phcris.org.au

SWPE (practice size)

www.medicareaustralia.gov.au/provider/incentives/pip/payment-formula/index.shtml

Abbreviations

ACRRM	Australian College of Rural and Remote Medicine
AGPN	Australian General Practice Network (<i>previously Australian Divisions of General Practice</i>)
AMA	Australian Medical Association
APNA	Australian Practice Nurses Association
CDM	Chronic Disease Management
CME	Continuing Medical Education (<i>now CPD, see below</i>)
CPD	Continuing Professional Development (<i>previously CME</i>)
DHS	Victorian Department of Human Services
DoHA	Commonwealth Department of Health and Ageing
EPC	Enhanced Primary Care
GP	General Practitioner
GPV	General Practice Victoria
GPII	General Practice Immunisation Incentives
HARP	Hospital Admission Risk Program—Chronic Disease Management
HMR	Home Medicines Review (<i>previously DMMR</i>)
IM	Information Management
IT	Information Technology
MBS	Medicare Benefits Schedule
MOU	Memorandum of Understanding
OTD	Overseas Trained Doctor
PCP	Primary Care Partnerships (<i>formerly PHACS</i>)
PHCRIS	Primary Health Care Research and Information Service
PIP	Practice Incentives Program/Payment
QA	Quality Assurance
RACGP	Royal Australian College of General Practitioners
RDAV	Rural Doctors Association of Victoria
RVS	Relative Value Study
RWAV	Rural Workforce Agency Victoria
RWSA	Rural Workforce Support Agency (<i>in Victoria, RWAV</i>)
WHO	World Health Organization

Getting started checklist

Step One—Quick Audit

1. Does the outcome of your work involve any change processes or action in general practice?
 Yes No Unsure
2. Will informing & involving general practice improve the quality and outcomes of your work and that of general practice?
 Yes No Unsure
3. Is there a current Commonwealth initiative or program in Divisions of General Practice that is relevant to your work?
 Yes No Unsure—check the DoHA website:
www.health.gov.au/internet/main/publishing.nsf/Content/programs-initiatives-all
If still unsure, then check with:
 - General Practice Partnerships Team in Primary Health Branch
 - Your Department of Human Services Divisional representative on the DHS General Practice Policy Coordination Group (*webpage under development*)Please note, the DHS Senior Medical Advisors may be able to assist you with further information.



If you answer **Yes** to any of these questions proceed to **Step Two**

Step Two—Environment Scan

1. **Check the DHS General Practice Register (accessible only by DHS staff via the DHS intranet)**
http://intranet_2.csv.au/rrhacs/gp_register.htm
The register will be made more widely available to external stakeholders on the internet during 2008. Until then, contact GPV for advice www.gpv.org.au
 - Look for similar projects and have a conversation with the relevant contacts
 - Identify any Department of Human Services project partners
 - Are there opportunities for a combined approach?
2. Look for best practice evidence relevant to your project, including case studies.
3. Consider Commonwealth initiatives that may complement your work
www.phcris.org.au
4. Identify the most appropriate general practice organisation to work with—see page 5 for list of organisations
In most instances, this will be GPV www.gpv.org.au or your local Divisions of General Practice



Make contact with the most appropriate general practice organisation

Step Three—Implement in partnership with general practice

Use the Practices that Support Collaboration (section 6) to guide your planning
Use the case studies (section 7) as a guide

