

# General Practitioners in Community Health Services Strategy



# General Practitioners in Community Health Services Strategy

May 2004

*Improving the health, wellbeing and quality of life  
for Victorians through increased access to  
medical services integrated with  
community health services.*

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## Abbreviations

ABN	Australian Business Number
CEO	Chief Executive Officer
CHC	Community Health Centre
CHP	Community Health Policy
CHS	Community Health Service
CHV	Community Health Victoria
CME	Continual Medical Education
CPD	Continual Professional Development
DGP	Division of General Practice
ED	Emergency Department
EPC	Enhanced Primary Care
GP	General Practitioner
GPDV	General Practice Division of Victoria
GPs in CHSs	General Practitioners in Community Health Services
HARP	Hospital Admission Risk Program
HDM	Hospital Demand Management
HIC	Health Insurance Commission
IDM	Integrated Disease Management
KSC	Key Selection Criteria
LGA	Local Government Area
MBS	Medical Benefits Schedule
MHS	Metropolitan Health Strategy
PCP	Primary Care Partnerships
RACGP	Royal Australian College of General Practitioners
RDNS	Royal District Nursing Service
RRMA	Rural, Remote and Metropolitan Areas
SLA	Statistical Local Areas
SRHS	Small Rural Health Services
The department	The Department of Human Services
The strategy	The General Practitioners in Community Health Services Strategy
VHIA	Victorian Hospital Industry Association

## 1. Purpose of this document

This document details the General Practitioners in Community Health Services Strategy ('the strategy'). It is the government strategy for the delivery on their commitment to recruit general practitioners (GPs) and expand general practice services within community health services (CHSs)<sup>1</sup>. The document explains the strategy in the context of Victorian and Australian Government health policy environments. This document should be read in conjunction with the Community Health Policy public consultation draft, *Community Health Services—creating a healthier Victoria* (January 2004), and the Primary Care Partnership (PCP) strategic directions available from [www.dhs.vic.gov.au/phkb](http://www.dhs.vic.gov.au/phkb)

This document includes:

- Victorian and Australian health policy context
- strategy aims, objectives and criteria
- CHS general practice models
- funding models.

Information is provided to assist agencies in preparing submissions for the GPs in CHS Strategy 2004–05 funding round in the *General Practitioners in Community Health Services Strategy Submission Guide 2004–05*. A submission guide will be released for each subsequent funding round.

A separate document will be provided in 2004 as an information resource for delivering general practice services in a CHS setting.

<sup>1</sup> Community health services are defined as multidisciplinary health and support agencies that receive Victorian Community Health program funding and deliver a wide range of primary health and support services to meet local community needs. This includes community health centres and primary health units or divisions of rural and metropolitan health services.

## 2. Introduction and overview

The Department of Human Services *Study of general practitioners in community health services* (June 2002) determined that the role of GPs in CHSs is unclear and that they are inadequately resourced. The study found that GPs in CHSs often delivered integrated services to clients with chronic and complex needs, which is time and resource intensive. The study recommended that the department play a role in strengthening the determination, capacity and viability of CHSs, their GPs and private practice GPs to improve and increase the services they cooperatively provide.

The Government's Healthy Communities policy committed \$2 million per annum for the recruitment of GPs to CHSs. The policy also stated:

*When linked with GP services, CHSs can provide a very broad range of primary care, from doctor consultations to rehabilitation and allied health therapies. Through the Primary Care Partnerships initiative, CHSs will be encouraged to establish relationships with GPs in their areas. In addition incentives will be provided to recruit GPs to CHSs.*

### The GPs in CHSs strategy aims to:

1. **improve access** to general practice, particularly for Victorians experiencing difficulty accessing a GP
2. generate genuine **service integration and coordination** between GPs and CHSs
3. improve **workforce capacity** for CHS medical teams.

### The strategy outcomes will include:

- increased numbers and capacity of GPs and other medical staff in CHSs
- increased quality bulk billing services, including extended hours, new medical sites and specialised medical services
- more financially viable and sustainable CHS GP services
- CHSs that are integrated and coordinated with general practices
- diversion of low triage presentations from hospital emergency departments
- increased CHS access to Medicare and Health Insurance Commission (HIC) payments.

Beginning in 2004–05, funds for the GPs in CHSs strategy are to be allocated at \$2 million per year.

The strategy recognises CHSs as unique settings to deliver general medical services as well as tailored responses. The department supports the development of thriving community-based medical services that have the capacity to respond to the needs of the local community by delivering targeted, often resource intensive, medical services within the general practice.

The strategy has the potential to aid the health sector to increase, complement and strengthen practices, programs and relationships. It will assist coordination of an Australian Government funded activity (general practice through Medicare) in a State-funded setting (CHSs).

During 2003, Department of Human Services and sector-based staff were employed to work with the health sector and State and Australian Government departments to consider how best the resources could be used to achieve GP services in community health settings. The strategy directions are a result of this work.

## Why GPs in community health?

A recent report for the department showed that, on average, GPs working in CHSs did actively focus on working with clients with more chronic and complex conditions<sup>2</sup> (eg mental illness, substance abuse, chronic diseases).

GPs within CHSs are uniquely positioned in the primary health care sector to further develop existing work in a number of key areas including:

- Improved integration between CHS GPs and allied health practitioners to provide improved care planning and health outcomes, particularly for patients with complex needs and chronic illness.
- Responding to the health care needs of children and families, particularly those from socio-economically disadvantaged backgrounds.
- Capacity to prevent hospital admissions and presentations to emergency departments through the targeting of high risk groups and integrating with other community based care.
- Capacity to support ambulatory care that can reduce hospital admissions, including through CHS services co-located with and integrated with ambulatory care services in Superclinic locations.
- The implementation of service coordination to deliver an integrated approach to the way in which people come in contact with the health care system, and have their needs identified and assessed, and their care planning managed.
- Addressing health needs within a social model of health framework in a predominantly bulk billed environment.

CHSs provide an opportunity to deliver primary medical care in existing appropriate primary care environments and in those places and to those communities that have poor access to private general practice. In addition CHSs and private GPs have the capacity to build strong functional relationships to improve the health outcomes for local communities.

Relations between GPs and CHSs have traditionally varied from place to place. Through the Primary Care Partnership strategy, the department has encouraged the building of stronger functional relationships between CHSs, Divisions of General Practice and service providers as part of a strong local primary health system. The interim evaluation of the Primary Care Partnership strategy reported that there is strong evidence ‘...that the PCP strategy is having a positive impact on the activities of health services across Victoria, particularly in the areas of relationship building, health promotion, service coordination and GP engagement.’<sup>3</sup>

2 Primary and Community Health Branch  
define this as ‘those conditions that have been, or are likely to be present for at least six months and require more than one type of service from the same or different service providers.’

3 Bob Burgell, Tim O’Leary & Doris Young,  
*Study of general practitioners in community health services summary report*  
(Department of Human Services,  
June 2002)

### 3. The health policy context

The strategy supports major policy initiatives driving the Victorian Government’s health agenda. It is being implemented in the context of the broader community health policy that emphasises the benefits of strong CHSs within a health care system.

Figure 1 illustrates the policy and strategic framework that the strategy sits within.

#### Growing Victoria Together

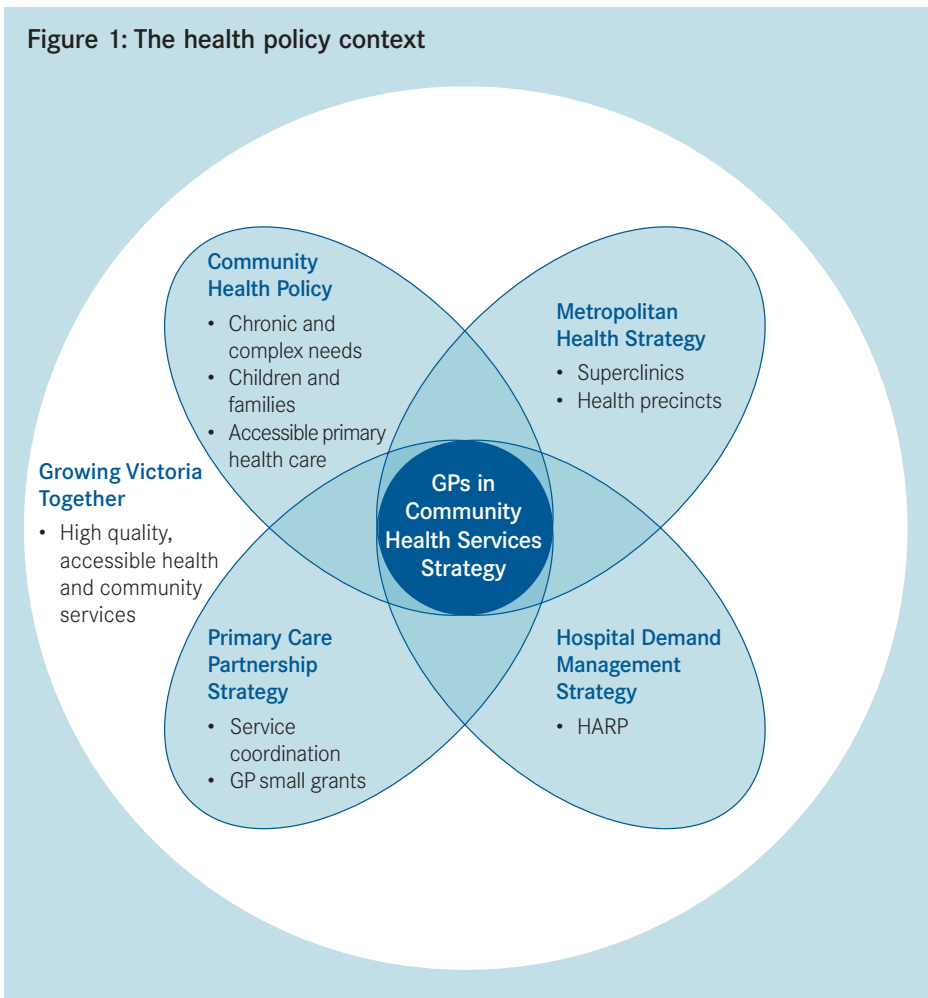
*Growing Victoria Together* articulates the State Government’s broad vision for Victoria across the areas of health, education, employment and justice. The GPs in CHSs Strategy contributes directly to the Growing Victoria Together goal of high quality, accessible health and community services. As a direct contributor to this goal, the strategy works within and alongside a number of policies and strategies aimed at achieving this vision.

#### Community Health Policy

The Minister for Health recently released the draft Community Health Policy (CHP). The draft CHP details how the community health commitments in the State Government’s election platform, ‘Healthy Communities’, will be addressed. The draft CHP recommends strategies that address the health needs of communities, determined through consultation, data collection and analysis. General practice services in conjunction with CHSs are clearly identified as an unmet need and a multi-pronged proposal is detailed.

The draft CHP outlines the vital role of GPs in acute services, care planning, chronic illness management and post-discharge care and illustrates compatibility with CHSs allied health services, health promotion, and experience with clients with chronic and complex needs. The draft CHP recommends greater coordination and cooperation between general practice and community health, with the strategy being a primary response to this issue.

Figure 1: The health policy context



## Primary Care Partnerships Strategy

The PCP Strategy aims to create an effective system within which primary care services operate. It aims to do this by supporting service providers and health professionals to coordinate their work for clients common to their services. PCPs are alliances of primary care providers, including GPs and CHSs, that are working together to address the health needs of local communities. Community health plans developed by PCPs primarily address the implementation of integrated health promotion and service coordination. Integrated health promotion identifies the preventative health needs of the community and strategies to respond to these needs. Service coordination looks at how coordinated local systems and infrastructure can improve quality, effectiveness and efficiency for clients and services.

The GPs in CHSs Strategy supports the goals of the PCP Strategy, in particular that of service coordination. The aims of increasing GP EFT, expanding after hours services, increasing GP sites, strengthening existing GP services within CHSs and encouraging stronger relationships and formal coordination between GPs and CHSs are all complementary goals.

## Metropolitan Health Strategy and Hospital Demand Management Strategy

The Metropolitan Health Strategy (MHS) addresses greater Melbourne's public health system in its entirety. While a large component is public hospitals, the strategy includes the interface with and development of complementary primary health services. The MHS plans future services based on population and health data and traces emerging technology and practices and their potential to strengthen public health systems. Innovative models of service capacity building and delivery are explored in the MHS, including the roles and relationships of GPs, hospitals and CHSs. Superclinics and health precincts are examples of this.

The MHS complements the Hospital Demand Management Strategy and includes continued work through the Hospital Admission Risk Program (HARP) that encompasses continuity of care for people with chronic and complex needs. The GPs in CHSs Strategy is also being pursued jointly with the hospital demand management objective of building partnerships with GPs to provide the most appropriate care to people who might otherwise present at hospital emergency departments.

## Small Rural Health Services

The Small Rural Health Services (SRHS) approach encourages funding and service delivery flexibility with a local focus for small rural health services in towns of less than 5,000 people. It encourages services to be active in planning and management of health service delivery to meet local needs, to involve the community and to be active in collaborative planning and service delivery arrangements with neighbouring health service providers.

The SRHS guide identifies three objectives:

- to improve the health status of Victorians in small rural towns
- to support a sustainable configuration of health and aged care services in these communities that is responsive to local needs
- to facilitate delivery of a locally determined mix of services, with an emphasis on those that are community based and in-home.

The ability to use funding flexibly to provide services supports these objectives. The GPs in CHSs Strategy can value add to SRHS approach in the planning and delivery of GP services in the local community.

## 4. The Australian Government agenda

General practice in CHSs will be strengthened by the proposed changes outlined in the new **MedicarePlus** package (March 2004) that provides an additional \$2.85 billion over four years to the health budget.

The MedicarePlus package offers (but is not limited to):

- incentives to bulk bill Commonwealth concession card holders, with a higher incentive applying in rural areas
- incentives for GPs to provide services to residents in aged care facilities
- grants for GPs to use HIC online services
- private allied health and dental involvement in care planning through the Enhanced Primary Care (EPC) initiative
- a number of incentives to increase initiatives workforce capacity.

These complement the existing Enhanced Primary Care (EPC) program. Within an efficient GP practice there is scope to optimise the benefits of these Australian Government initiatives.

Despite these incentives, public comment suggests that bulk billing rates are still of concern, reducing affordability of services for those most in need and placing further demand on hospital emergency services.

The GPs in CHSs Strategy aims to complement the MedicarePlus incentives to assist CHSs and GPs to offer bulk billing to clients of socioeconomic disadvantage and those with chronic and complex health needs. The strategy will support the planning, development and implementation of new, expanded and integrated GP services with CHSs. The strategy will not duplicate any activity financially supported by the Australian Government, but will support the development of practices and systems to optimise access to Australian Government initiatives and supports. Capacity to access the key elements of MedicarePlus should be taken into account when submitting proposals under the strategy.

The GPs in CHSs Strategy sits within the context of these policies and initiatives. It is not designed to address CHSs and general practice issues in isolation and so will not fund projects that are disengaged from these initiatives and opportunities. For example, a submission addressing service coordination between a CHS and a general practice that has no current connection to or involvement in PCPs will not be considered and a CHS in an area of workforce shortage that is eligible for Practice Nurse hours through MedicarePlus will not be funded for this activity.

### A snapshot of GPs in CHSs

GPs have worked in CHSs within a multidisciplinary environment since their inception in the 1970s. The 1990s saw a decline in the number of GP clinics in CHSs. As a result of this decline the Department of Human Services commissioned a study into the role of GPs in CHSs in 2001.

Included in the findings of the report were some indicators of the differences between CHS GPs and GPs in private practice. GPs in CHSs were more likely to:

- service a greater number of clients with higher levels of complex and chronic conditions
- refer their clients to allied health professionals for a range of problems including reproductive health, drug and alcohol, mental health, obesity and foot problems
- service a great number of people from culturally and linguistically diverse backgrounds
- work within the social model of health, taking into account the social problems facing the client.

These findings form the basis of a rationale to expand the role of GPs and increase access to medical services within a community health setting.

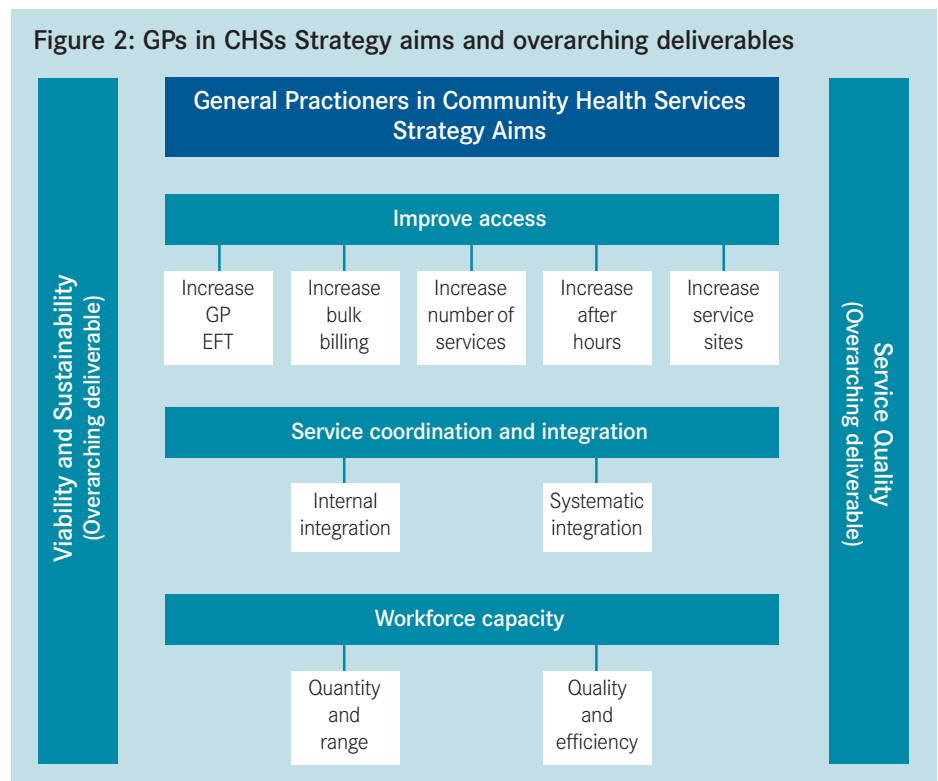
## 5. Aims, priorities and outcomes

The strategy will invest in models that contribute to one or more of the following aims, meet the mandatory requirements and outline the relationship between the proposed project and the strategy outcomes given below. Figure 2: GPs in CHSs Strategy aims and overarching deliverables illustrates these key themes.

### Strategy aims

1. **Improve access** to, and availability of, general practice through:
  - increasing the numbers of GPs working in CHSs
  - increasing access to bulk billing for socioeconomically disadvantaged clients and clients with complex health needs
  - increasing the number of general practice services
  - increasing the number of service sites
  - greater availability of after hours care
  - increased efficiency in CHS general practice systems.
2. Generate genuine **service coordination and integration** improvement between bulk billing GPs and CHSs including:
  - CHS managed general practice clinics
  - private practices co-located within CHSs
  - private practices separate to CHSs.

Figure 2: GPs in CHSs Strategy aims and overarching deliverables



3. Improve **workforce capacity** for CHS medical teams, including:
  - supporting the development of an appropriate mix of medical team staff (including as practice managers and nurses) in CHSs
  - increasing the efficiency and quality of the CHS medical workforce.

### Overarching deliverables

Proposals funded through the strategy must demonstrate:

- **financially viable and sustainable general practices:** proposals must detail plans that demonstrate general practices that will attain financial viability over a set time period and not require recurrent funding (excepting

exceptional circumstances) and that demonstrate systematic and program sustainability within the CHS setting (refer to pages 17–18)

- **high quality GP services** integrated with CHS: proposals must outline how quality of care for clients will be maintained and enhanced (refer to page 19).

### Strategy priorities

Investment through the strategy will prioritise:

- areas of socioeconomic disadvantage<sup>4</sup>
- client populations with chronic and complex health needs

<sup>4</sup> Determined by the ABS 2001 Index of Relative Socio-Economic Disadvantage. Refer to Attachment 1, parts 3 and 4.

- areas of GP workforce shortage<sup>5</sup>
- places and communities whose bulk billing needs and GP numbers are not being adequately met by the private practice model alone
- areas where hospital emergency department demand rates are high.

## Outcomes

Outcomes for clients and the health sector will include:

- increased number of GPs in CHSs under a variety of arrangements, such as salaried, sessional, private co-location
- increased bulk billing services available to the community, including special

focus medical services targeting, for example, children and families, the aged, youth, drug and alcohol clients and refugees

- more patients receiving quality medical services in CHSs through coordinated care between GPs and allied health professionals and through efficient general practice systems, including electronic booking and billing systems
- more financially viable and sustainable CHS GP services
- increased capacity of medical teams within CHSs through, for example, an increase in GPs, practice managers, triage processes, service and system

development, GP non-clinical time, electronic booking and billing systems

- increased after hours GP services
- increased CHS GP service delivery sites
- CHSs that are genuinely integrated and coordinated with general practices (both public and private) and with other services and systems provided by CHSs and external service providers that result in more CHS clients receiving quality and timely care
- diversion of low triage presentations at hospital emergency departments
- increased CHSs access to Medicare and HIC incentive payments.

## GPs in CHS statistics

There are 97 EFT GPs delivering medical services from 29 of the 100 CHSs.

They are delivered from 38 service sites across Victoria (refer to Attachment 1, parts 1 and 2). Ten of the 38 service sites have special focus GPs, with five of these having special focus services only, including adolescent health, family planning and pharmacotherapy services. The remaining 29 service sites deliver general medical services.

Twenty service sites (37 EFT GPs) are located in rural regions and 18 service sites (60 EFT GPs) in metropolitan Melbourne.

Sixteen services have three or more EFT GPs delivering general practice clinics.

The arrangements under which GP services operate within CHSs consist of: salaried GPs (55 per cent), private co-located practices (33.5 per cent), income sharing arrangements (7.5 per cent) and other arrangements (4 per cent).

Analysis of community health client data shows that around 81 per cent reported their main income sources to be from Australian Government benefits. This is contrasted with Centrelink data, which shows that about 30 per cent of the Victorian population aged 15 years and over were Centrelink clients. This data indicates that services provided by CHSs are to a large degree targeted to holders of Commonwealth health care cards<sup>6</sup>. Data collected indicates that the vast majority of CHSs that provide medical services bulk bill all of their clients.

The strategy evaluation framework will include further targeted research into the current and unique CHS general practice environment.

<sup>5</sup> A district of workforce shortage is defined by the Department of Health and Ageing as a geographic area where the doctor to population ratio is less than the national average. At the time of writing the national average is one GP to 1,406 head of population. Refer to Attachment 1, part six.

<sup>6</sup> Community and Women's Health Program, *Annual service delivery report, 2001-02* (Department of Human Services)

## GPs in CHSs example—keeping people out of hospital

Western Region Health Service (WRHS) has a 10 GP (8.57 EFT) medical practice in Footscray. The WRHS keeps people out of hospitals in three ways:

### 1. By providing extended hours of service with appropriate clinical and administrative support

The practice operates from 8 am–8 pm weekdays; to 12 noon on weekends and public holidays; and to 1.00 pm on Saturday.

Registered Nurses Division 1 work with the GPs all hours that the clinic is open. The nurses are experienced in general practice and help to triage clients, support GPs in procedures and care for clients presenting with urgent medical matters.

The medical clinic is equipped to support intervention for urgent matters such as plastering, suture of a laceration and inhalation therapy.

The medical clinic is completely computerised; allowing GPs to easily access patient records across sites, supporting continuum of care and improving the quality of care to patients.

### 2. Through access to diagnostic equipment in the local community

A young man fell off his bike and was brought straight to the medical centre and was diagnosed with a suspected dislocation/fracture of the shoulder. A nurse provided observation until the patient was well enough to be escorted to the nearby x-ray facility. With confirmation of the diagnosis, the patient was strapped up and sent home with pain relief and treatment instructions.

An elderly woman waiting for a bus outside the centre had her bag snatched and experienced chest pain. The woman was seen immediately by a GP and an electrocardiogram was immediately performed. She was assisted with contacting the police and her family and was made comfortable until she felt well enough to leave the clinic.

### 3. Through specialised treatment to at risk groups.

A drug injecting client who was an inpatient in hospital for deep vein thrombosis prematurely released himself as he could not manage the hospital regime and had difficulties managing his pain and drug issues. The patient was a client of the WRHS Health Works program, a special focus program to assist the drug-injecting population. The Health Works team took over the hospital treatment including the daily injections for the deep vein thrombosis and an antibiotic regime, which prevented his readmission to hospital.

## 6. Funding models

### Who will be funded?

It is anticipated that CHSs will be funded by the Department of Human Services in the majority of cases, reflecting their lead role in the strategy. CHSs must demonstrate that they have consulted with relevant Divisions of General Practice (DGPs), private practices and PCP members in the development of submissions.

PCPs may also be funded. Proposals put forward by PCPs should generally have a catchment focus and must include partnerships with CHSs across their area.

Submissions being put forward by a DGP must be developed in partnership with a CHS.

### What will be funded?

The strategy is to be considered in the context of community health policies, initiatives and the range of financial and practical supports available to CHSs and GPs. Project proposals should not be developed in isolation of existing opportunities, for example PCP, General Practice Divisions and Australian Government initiatives, and should complement what is already available.

Funding can be provided to support the functions, staffing and infrastructure that support a medical practice to operate in an effective and integrated way within a CHS setting.

There are a wide variety of service delivery models appropriate to local environments that are delivering aims and objectives consistent with those of

the strategy. A consistent focus is on recognising the unique setting a CHS offers and ensuring integration between GP, nursing and allied health services and systems. Attachment 2 provides several hypothetical models drawn from a range of best practices currently operating in communities.

The following may be funded:

- practice management positions to support medical teams
- nursing positions to increase the capacity of medical teams
- administrative support for medical teams
- workforce capacity building, such as training, development, service/system planning and organisational structures
- non-patient contact GP time to support participation in activities such as case planning, service planning and development, training and development, regional networks and health promotion
- recruitment and retention strategies that have a direct impact on an individual service or that have statewide applicability and benefit
- support for GP registrar placements in CHSs
- support for undergraduate placements
- service development and expansion, including extended hours and establishment of satellite general practice sites
- integration reforms, such as service coordination planning, development and inter-service protocols

- business management reforms, such as electronic client management, booking and billing processes
- minor capital works (buildings and equipment) that enhance medical service delivery
- development and resourcing grants (overheads and operating costs).

Funding will **not** be provided for the delivery of general practice services for which a rebate or other payment can be received through the HIC.

Planning for and demonstrating financial viability and project sustainability of medical services within CHSs is a threshold requirement, except where special circumstances exist requiring recurrent expenditure to support targeted services. All proposals should demonstrate how they would achieve financial viability and sustainability (see pages 17–18 for details).

Attachment 1 provides a range of data and includes:

- GP workforce and current locations of general practice services in CHSs
- GP to population ratios by Statistical Local Area (SLA) (this information will also be provided by Local Government Area)
- Australian Bureau of Statistics (ABS) 2001 Index of Relative Socio-Economic Disadvantage by SLA
- Levels of bulk billing by federal electorate
- Rural, Remote and Metropolitan Area (RRMA) class by SLA.

Agencies should consider this and other local data and planning processes when formulating their submission. Services located in areas of low GP to population ratios, where there are low levels of bulk billing and high levels of socioeconomic disadvantage, are high priorities for investment under this strategy. Neighbourhood Renewal areas will receive priority as they have been selected for their relative disadvantage compared to other parts of Victoria. High priority will also be given to submissions relating to GP services within Superclinics and submissions linked to projects funded under the Hospital Demand Management Strategy objective of building partnerships with GPs to reduce emergency demand.

### What funding will be considered?

Proposals will be considered for one-off, short term (one year), medium term (two years), long term (three years) and, in some cases, limited recurrent funding. Table 2 provides a guide for funding models, timeframes and levels.

A service/consortium could submit for one-off grants each year for three concurrent years, for example, a staged approach to IT development. They could submit several submissions for a range of projects. Alternatively, a submission could encompass a comprehensive range of activities that rejuvenate an existing clinic or establish a new one. The department is open to a range of funding models to respond to local environments.

Projects requiring one-off, short, medium and long term funding must demonstrate plans to achieve sustainable change. Sustainable change is the long-term impact that the change causes. For example, providing for non-patient GP time to participate in organisational and sector development, planning and health promotion will contribute to cultural and systematic improvements, the impacts of which can be measured over time.

Where recurrent costs are identified, submissions should provide justification as to why the project should receive financial support even though the minimum requirements for financial viability cannot be met. For example, if recurrent funding to support the delivery of pharmacotherapy within a CHS general practice is sought, the submission should outline the clear need for the service, the impact it will have and the rationale of why viability is not achievable.

In recognition that there may be significant lead-time in developing a medical practice within a CHS or expanding to extended hours services, seeding grants are available to support the development of proposals for subsequent years. For example, a seeding grant may be useful where projects are centred on the integration of a general practice into CHSs under a corporatised model. Funds for the implementation of proposals developed through seeding grants can be sought in subsequent calls for submission funding rounds.

Submissions should identify where there are agency, consortium and/or other government contributions to projects, including direct funding, capital contributions and in-kind support.

The Department of Human Services will fund activities and initiatives for statewide applicability and strategy development. For example, contracting the strategy evaluation, research projects, employment of industry consultants and special focus advisors may be funded.

**Table 2: GPs in CHS Strategy possible funding models**

The following table provides a guide for models and levels of funding that may be available through the GP in CHS Strategy. The table is not intended to be prescriptive or exhaustive, it is indicative.

1 year	2 years	3 years	extended funding required	project example	funding guide
				Viability study for new GP and/or after hours clinic	Up to \$20K
				Small capital and development grants	Up to \$20K
				Install ICT billing and booking systems across GP clinic and CHS	Up to \$50K
				Integration and coordination between CHS and GP clinic	Up to \$20K
				Fully funded practice manager or practice nurse for one year, then gradual reduction as viability increases	Up to \$75Kpa
				Expand existing CHS GP clinic to after hours	Reducing from max of \$100Kpa
				Establish a new CHS GP clinic or new satellite site, including capital, systems and workforce	Reducing from max of \$250Kpa
				Support continuation of specialist or small rural GP service	\$20-40Kpa

## 7. Major funding objectives

This section sets out the five major objectives for the strategy. These objectives are based on the findings of the study of GPs in CHSs commissioned by the Department of Human Services in 2001<sup>7</sup>. The objectives are dealt with under the following headings:

1. Access and availability
2. Integration and coordination
3. Workforce capacity
4. Viability and sustainability
5. Service quality.

### Access and availability

#### Objective: Improve access to general practice services for community health clients

Improved access for CHS clients to general practice services is a key objective as GPs are often the first point of entry into a broader range of primary acute health services. Additionally, improved access into effectively integrated primary health services, such as those offered at CHSs, is important for clients with chronic and complex conditions. Targeted approaches can provide people with support in a community-based setting and can reduce the risk of hospital admission and preventable presentations to hospital emergency departments.

Access and availability to GP services can be improved by:

- increasing the numbers of GPs and the number of hours of GPs working in CHSs
- increasing the number of bulk billing services
- increasing the number of medical services delivered to those members of the community most in need, which may mean increasing both the number of EFT GPs as well as the number of medical services they deliver and the broader medical team deliver
- increasing the number of medical service sites
- improving patient flow through efficient booking systems and using broader medical team capacity, for example, clinical allocations to a supervised nurse such as immunisations and dressings
- increasing understanding of demand issues and developing appropriate and innovative demand responses, including self-help, patient access via email, telephone and group consultations, flexible appointment management and clear role definition<sup>8</sup>
- varying the medical service hours (including after hours) provided
- changing the way that medical services are accessed (including through initial contact and initial needs identification processes)
- establishing a chronic disease register and proactive follow-up.

CHSs need to carefully consider how increased efficiencies, expansion and/or establishment of a GP service will address issues of access or availability for their clients. CHSs need to be confident that the mix of services they offer, and the way in which the services are accessed, are appropriate to their clients' needs. There may also be scope for CHSs to increase their responsiveness to private GPs, hospitals, aged care services and other service providers. CHSs in general have shown themselves to be willing and flexible in attempting to match service delivery to the emerging activities and trends within the primary health sector.

#### After hours

There are currently few extended hours medical or allied health services offered by CHSs, a situation reflected in the broader medical community. However, as part of a joint strategy for co-location of GP clinics with state funded services (including public hospitals and CHSs), proposals developed for funding under the strategy may attract additional funding through the Hospital Demand Management Strategy to support after hours GP services with a capacity to divert primary care type presentations from emergency departments.

<sup>7</sup> Bob Burgell, Tim O'Leary & Doris Young, *Study of general practitioners in community health services summary report* (Department of Human Services, June 2002)

<sup>8</sup> John Oldham, *Advanced access in primary care*, 2001

## Examples of extended hours service provision in CHSs

### Moe After Hours Medical Service

Latrobe CHS in Moe is operating the Moe After Hours Medical Centre, delivering a model of after hours medical service provision that, with support from the Victorian State Government, is providing medical care that is reducing hospital presentations by 40 per cent.

In this model the local DGP organises a roster of GPs from local private practices to be available on call for 29 hours per week (evenings and weekends). A nurse and receptionist are located at the CHS and contact the GP to come in and see clients if required. Patients are encouraged to call before presenting. The services provided are fully bulk billed.

The Department of Human Services provides approximately \$180,000 per annum inclusive of wages for nurses and reception staff, stores, utilities, advertising and hotel facilities. GPs are funded entirely through the Medicare rebate. The unit cost for each consultation was \$36.00, plus the Medicare rebate to the GP. Rising demand has seen the unit cost fall from \$54.85 in the first year to \$39.58 in the second. This total cost per client of \$58.95 compares favourably with the 1999–2000 unit cost of \$86.91 in public hospital outpatients.

### Dianella CHS

Dianella CHS runs a medical service that operates both day and after hours on weeknights and weekends. Dianella recently completed a survey of the patients who attend their medical service, which indicated that 50 per cent of patients would attend the hospital emergency department if they could not access a bulk billing GP.

## Coordination and integration

### Objective: Improve internal and external (systematic) integration and coordination between medical and allied health services to improve patient health outcomes

Improving integration between providers in the health system leads to improved health outcomes and improved efficiencies in health expenditure. CHSs are uniquely placed to provide a primary health service delivery platform and lead coordination and integration initiatives. CHSs are a part of local service systems that include hospitals, private general

practices, Local Governments and a range of larger (such as Royal District Nursing Service (RDNS)) and smaller non-government agencies. The Government is committed to creating a primary health system that better meets the needs of the community. In Victoria a major strategy to improve service system integration has been the establishment of local PCP and, through these partnerships, a focus on improved service coordination and integrated health promotion.<sup>9</sup> The goal is a health system that is more functionally integrated and exhibiting strong partnerships.

There are two forms of integration relevant to this project:

- the degree to which the medical practice within the CHS is integrated with the allied health professionals within the CHS, (internal integration)
- the degree to which medical practices in CHSs, and other services delivered by CHSs, are integrated into the broader primary health system including external GPs, hospitals and other service providers (systemic integration).

There are some good examples of internal integration between medical practices and allied health services working within CHSs. However, internal

<sup>9</sup> Department of Human Services (2003). *Primary Care Partnerships strategic directions 2004–2006 Better health-stronger communities.*

integration could be better managed in some CHSs and where there are privately co-located GPs within the CHS. The service coordination reforms provide a framework for improved integration.

Funding will support implementation of service coordination initiatives to improve internal integration, integration between CHSs and private GPs and integration between CHS GPs and acute hospitals (including diversion of presentations by triage category 4 and 5 patients at emergency departments). This would include the extension of existing or planned implementation of consistent practice, processes, protocols and systems for:

- initial contact
- initial needs identification (including intake and nurse triage)
- care planning
- effective referral and feedback
- judgements about risk, eligibility and priority of access for services.

Implementation of service coordination through the strategy should result in increased uptake of service coordination tool templates by GPs in CHSs and by private GPs working with CHS clients.

#### **Participation in local PCP service coordination**

The network of PCPs cover Victoria, therefore all CHSs have a local PCP that they should be active members of. Service coordination aims to improve quality, effectiveness and efficiency for clients and services through coordinated local systems and infrastructure and is a key deliverable of PCPs. Participation in the local PCP provides practical support and assistance with improved processes, enabling CHSs to work with other local services to coordinate client care. PCPs also promote better engagement with and participation by GPs in service coordination. The strategy has the potential to build on the work being undertaken through PCPs, particularly at a service delivery level.

#### **Service capacity**

Demand for CHSs currently outstrips supply. The degree to which CHSs can meet the demand for services from GPs (either in community health or in private practice) is, therefore, clearly limited. At the same time, however, there is scope to improve how services are delivered. Service coordination reforms have improved service integration and, in some CHSs where implementation is well advanced, have resulted in efficiencies enabling increased service delivery. The Department of Human Services is currently developing a project that is looking at how CHSs can build on these reforms to improve their demand management capacity. These factors need to be considered when looking at better integrating services.

### **Service coordination—increasing the availability of allied health services**

The podiatry service at Whitehorse CHS is extremely busy with approximately 70 calls per week from people seeking service. In line with best practice in public podiatry, the service is only available to those with a medical condition and not just for nail cutting. This often means that people calling seeking an appointment are ineligible for the service.

Prior to the introduction of service coordination, the podiatrist would need to speak to the person seeking a service to determine eligibility. The volume of enquiries means that people often did not get to speak to the podiatrist for many weeks.

Since introducing service coordination, potential clients receive a response within 24 hours and those that are ineligible are given options such as other podiatry providers and health education opportunities. In addition, the wait time for eligible clients has reduced from three months to 6–8 weeks.

### Working with Divisions of General Practice

The industry consultant engaged to boost practice management capacity for GP services in community health has found that, in general, CHSs do not have strong relationships with DGPs. As a result, many GPs in CHSs may be missing out on the support that DGPs provide to their private practice counterparts including training, improving business systems, IT support, access to Australian Government incentive payments, service integration opportunities, access to practice management, practice nursing and GP networks.

This strategy presents an opportunity to change this situation by including DGPs in the consultation process and attempting to improve systemic integration. In some areas, PCPs are undertaking positive work in this area, which the strategy can build on. This underscores the need to ensure that submissions supported through this strategy are prepared in consultation with DGPs. For this to occur there needs to be a clearer understanding of the role of GPs in relation to CHSs and the ways in which DGPs can support this role. Medical services within CHSs need to clarify their role through improved collection of clinical data, promotion of their unique role, and improved integration across the service system.

### Engaging private practitioners

Opportunity exists under the strategy to improve CHS clients' access to medical services through private GPs and access by patients of private GPs to CHSs. Groundwork has already been laid through engagement of private practitioners in a range of PCP activities, including Integrated Disease Management (IDM) projects and service coordination small grants (aimed at increasing GP uptake of the service coordination tool templates).

Experience from these initiatives 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 (for example, by reducing the time involved in arranging access to allied health services for a client).

Building on lessons learned through the activities, funding provided by the strategy can be used to support specific practical initiatives aimed at engaging GPs.

### Neighbourhood Renewal Strategy

The Department of Human Services' Neighbourhood Renewal Strategy is a new approach that brings together the resources and ideas of residents, governments, businesses and community groups to reduce inequality and build more cohesive communities. To improve the health and wellbeing of selected disadvantaged communities, Neighbourhood Renewal is tackling the key social determinants of health.

Partnerships have been built across government, the community and the service sector. Most importantly, local residents are getting involved and leading change that is creating healthier communities.

Primary and community health services have an important role to play in the renewal of disadvantaged communities. Neighbourhood Renewal presents a unique opportunity for health services to join with other agencies to create better health through stronger communities.

Where a GPs in CHSs proposal involves a Neighbourhood Renewal area, and specifically where the Neighbourhood Renewal Action Plan identifies general practice issues, linkages should be demonstrated.

### Workforce capacity

#### Objective: Improve the workforce capacity of CHS medical teams

Improving workforce capacity can occur through two broad methods: increase the number and range of staff and improve the quality and efficiency of staff teams.

There is generally an inherent lack of efficiency when GPs in CHSs are involved in non-clinical activities due to the loss of clinically derived income. Conversely, it is difficult for CHSs to find the extra resources to engage the appropriate support staff to do this non-clinical work.

There is a range of possible staff roles within a CHS medical practice, including Chief Executive Officer (CEO),

primary health manager, practice manager, practice nurse, receptionist and GP. Understanding of the role of the GP and other staff within a CHS medical practice is variable. GPs are sometimes involved in tasks that could be conducted by other members of a medical practice team.

There are some fundamental differences between private practitioners and GPs within CHSs. GPs in CHSs may not have input into the business model that is adopted in the medical practice within the CHS. The implications of this are that even if GPs are engaged around issues of practice management they may not have the authority or the resources to implement systemic change into the practice. This issue can have an impact on the retention of GPs within a service. GPs need to be well supported to focus on their clinical role, including time allocation for non-patient contact, administrative, educational and practice planning.

There is a range of other workforce capacity issues including:

- patient flow (clinical allocations to a supervised nurse can greatly reduce patient waiting times)
- appropriate staff for each role (for example, initial needs identification must be conducted by qualified staff)
- recruitment and retention of medical staff
- internal and systemic integration (what models of effective integration better meet patient need)

- improved educational frameworks to support registrars and extended skill posts (assists in attracting new medical staff to CHSs)
- information technology to improve patient clinical management and billing
- development of roles for clinical champions and mentors of community health general practice to foster goodwill and career opportunities for GPs in CHSs.

Capacity issues may be addressed with one-off funding that could improve practice sustainability. Funding may be provided to support the establishment or development of appropriate functions to improve workforce capacity. This can include recruitment costs, skill and knowledge development, cost of introducing new business systems, and minor capital works to support specialised roles.

Recurrent salary costs may be sought to support the capacity of a CHS general practice clinic to deliver special focus medical services. However (as noted in the viability and sustainability section below), submissions must provide clear rationale of why the service is of value and why financial viability is not expected.

Submissions that address workforce issues on a wider scale, for example, community, sector and state, will be viewed positively. For example, building on existing workforce initiatives, recruitment strategies that include and benefit other local stakeholders, mentoring programs, participation with university and other student placement bodies are encouraged.

## Viability and sustainability

### Objective: Increase financial viability and sustainability of medical services within CHS

The funding is intended to support financial viability and sustainability of GP practices working in a CHS setting by recognising the costs associated with establishing and maintaining effective integration between GP services and CHSs. GPs in CHSs experience financial viability pressure due to a commitment to provide bulk billed services to disadvantaged populations (80 per cent of CHS clients are health care cardholders), delivering targeted medical services (such as pharmacotherapy) and the need for longer consultations due to client complexity.

Addressing financial viability and sustainability is key to increasing general practice service provision within CHSs as this:

- keeps GP services operating within CHSs
- provides suitable support structures to attract medical staff
- reduces negative impact on other CHSs service delivery.

### Standard minimum requirements of financial viability

Financial viability of GP services operating in a community health setting is dependent upon:

- **Critical mass**—in most circumstances, at least three EFT GPs are needed to generate income to cover costs.

- **Patient consultations**—between 3.5–4 patients per hour on average are generally required to ensure adequate income.
- **Number and clinical skill mix of allied health support staff**—nursing and other allied health staff provide a cost-effective practice integration support role to GPs, which can help sustain higher volume patient throughputs and improve service quality.
- **Efficient business practices**—efficient administrative and clinical systems.
- **Level of charge-out arrangement to the GP service by CHS**—should reflect actual usage levels of corporate services provided by the CHS.

Support to increase viability and sustainability will be considered where GP services are employing business models that make effective use of income generating opportunities (or can demonstrate how they will achieve this over time), but still require additional support to maintain or enhance the provision of integrated services to those clients most in need. In general, a viable business model under this strategy is one that meets the standard minimum requirements of financial viability as outlined above. However, some special focus medical services are highly resource intensive and are unlikely to be financially viable, but are required by the community. Therefore, services that can provide a rationale for the delivery of medical services that do not meet the minimum viability criteria may still be eligible for

funding. This situation could apply in outer metropolitan, remote and rural locations where there are serious workforce issues, general lack of access to services and no capacity to deliver the minimum financial viability model. This could also include the delivery of specialised services, such as pharmacotherapy services, where these could not be otherwise viably delivered.

As a threshold requirement, services need to be maximising income and keeping costs to a minimum to attract additional support. In cases where CHSs wish to start up new medical services there would need to be a strong business case developed in their proposal. Proposals to establish medical practices within CHSs are more likely to be successful in locations with high levels of socio-economic disadvantage (such as Neighbourhood Renewal areas) where there is GP workforce shortage or other practical limitations to integration with local private GP practices (such as very limited access to bulk billing).

#### **Sustainability of change**

Sustainability of change relates to the long-term impact achieved through activities.

For each of the strategy objectives, sustainable change may include:

- Access and availability
  - permanent increase in the EFT of the medical staff team
  - ongoing higher rates of bulk billing
- additional medical services as permanent parts of a generalist CHS medical clinic
- ongoing increased number of CHS clients receiving general practice services
- increase in client satisfaction.
- Integration and coordination
  - ongoing increased number of referrals between CHS GPs, allied health service and external services (including private GPs)
  - decreased wait times for GPs and allied health services
  - increased EPC items for CHS clients
  - reduced administrative time
  - increased participation by GPs in the development and delivery of CHS and sector initiatives.
- Workforce capacity
  - permanent increase in the EFT and satisfaction of the medical staff team
  - greater range in the roles of CHS medical staff teams
  - medical staff teams skilled in all areas relevant to their role
  - increased patient flow
  - increased number of registrars and undergraduate placements in CHSs
  - medical staff satisfaction
  - established networks, mentoring and championing.
- Service quality
  - an increase in CHS general practice clinics accredited to Royal Australian College of General Practitioners (RACGP) standard

- an increase in the number and maintenance of accredited CHSs with GP clinics
- an increase in GPs working with CHSs who are RACGP vocationally registered or working towards registration or other medical practitioners undertaking continual medical education (CME) and continual professional development (CPD)
- increase in client satisfaction.

## Service quality

**Objective: to maintain and enhance the quality of care clients receive through general practice integrated with CHSs**

Ensuring CHS GPs (including private practice partnerships) deliver high quality services is of key importance to the strategy. It is vital to ensure that while GP and clinic efficiencies are increased, and greater patient throughput occurs, that quality of care is not sacrificed but is enhanced. In relation to the strategy, quality will be assessed at the three 'levels' of:

- **Practitioner**

Maintained and increased levels of vocational registration of GPs working with CHSs and GPs who are recognised as working towards registration or other medical practitioners undertaking CME and CPD to a comparable level.

- **General practice clinic**

Increase in achievement and maintenance of CHS general practice clinics accreditation, to RACGP standard.

- **CHS**

An increase in the number of accredited CHSs through the CHS quality accreditation system.

## 8. Evaluation

Program Logic (also known as Program Theory or Theory of Change) is the proposed evaluation framework for the GP in CHS Strategy. Program Logic evaluation frameworks are increasingly being recognised as the preferred approach to the evaluation of complex public health initiatives which aim to create change in complex service systems and involve communities<sup>10, 11, 12, 13</sup>.

Program Logic allows development of clear linkages between aims, objectives and activities, so the how and why a program has a particular observed effect can be measured in a targeted and planned approach. In addition, Program Logic evaluation frameworks provide a high degree of flexibility with respect to the research designs and methods that can be used.

The evaluation will be divided into two sections. The first section will be an internal evaluation of the behind the scenes activities which have occurred in the development, implementation

and ongoing support for this strategy.

The second section will require engagement of an external evaluator to evaluate the impact of the strategy and the contribution of projects to the overall strategy aims and objectives. Finalisation of the exact evaluation plan will be conducted in consultation with Department of Human Services central office and regions, and will involve:

- identification and development of key indicators
- an evaluability assessment
- development of research designs and qualitative and quantitative methods for the collection and analysis of data relevant to key indicators of:
  - access and availability
  - service integration
  - workforce capacity
  - financial viability and sustainability
  - quality
  - analysis of existing and new data to minimise duplication of data reporting through efficient use of current data collection methods
  - ongoing and final reporting of progress against the strategy's aims and objectives.

Finalisation of this evaluation plan will require consultation with and agreement by all key stakeholders.

10 Judge, K. and Bauld, L. (2001) Strong theory, flexible methods: evaluating complex community-based initiatives. *Critical Public Health*, 11(1), 19–38.

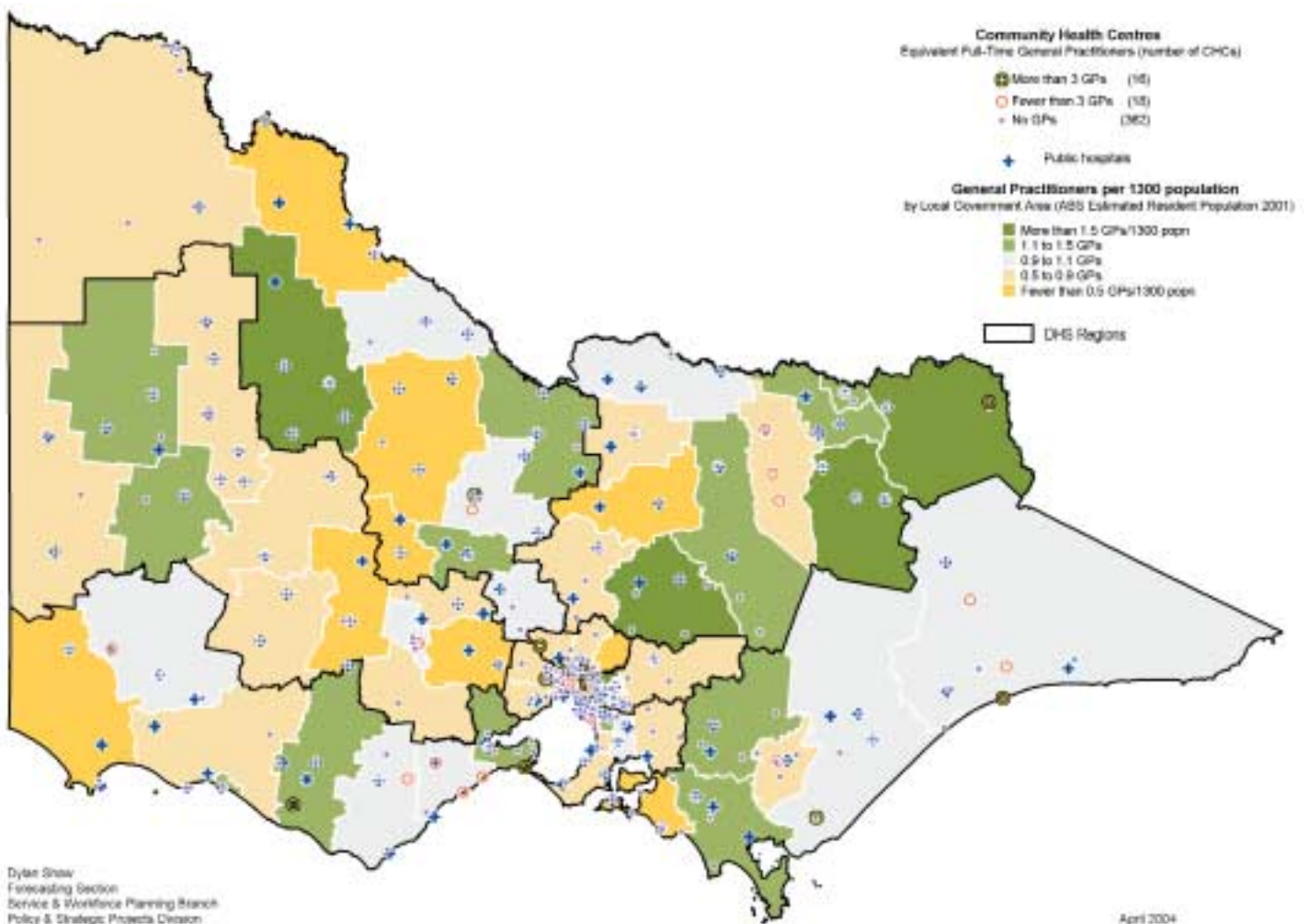
11 Connell, J.P., Kubish, A.C., Schorr, L.B. and Weiss, C.H. (Eds) (1995) *New approaches to evaluating community initiatives volume 1: concepts, methods and contexts*. The Aspen Institute, Washington DC.

12 Fulbright-Anderson, K., Kubisch, A.C. and Connell, J.P. (Eds) (1998) *New approaches to evaluating community initiatives volume 2: theory measurement and analysis*. The Aspen Institute, Washington DC.

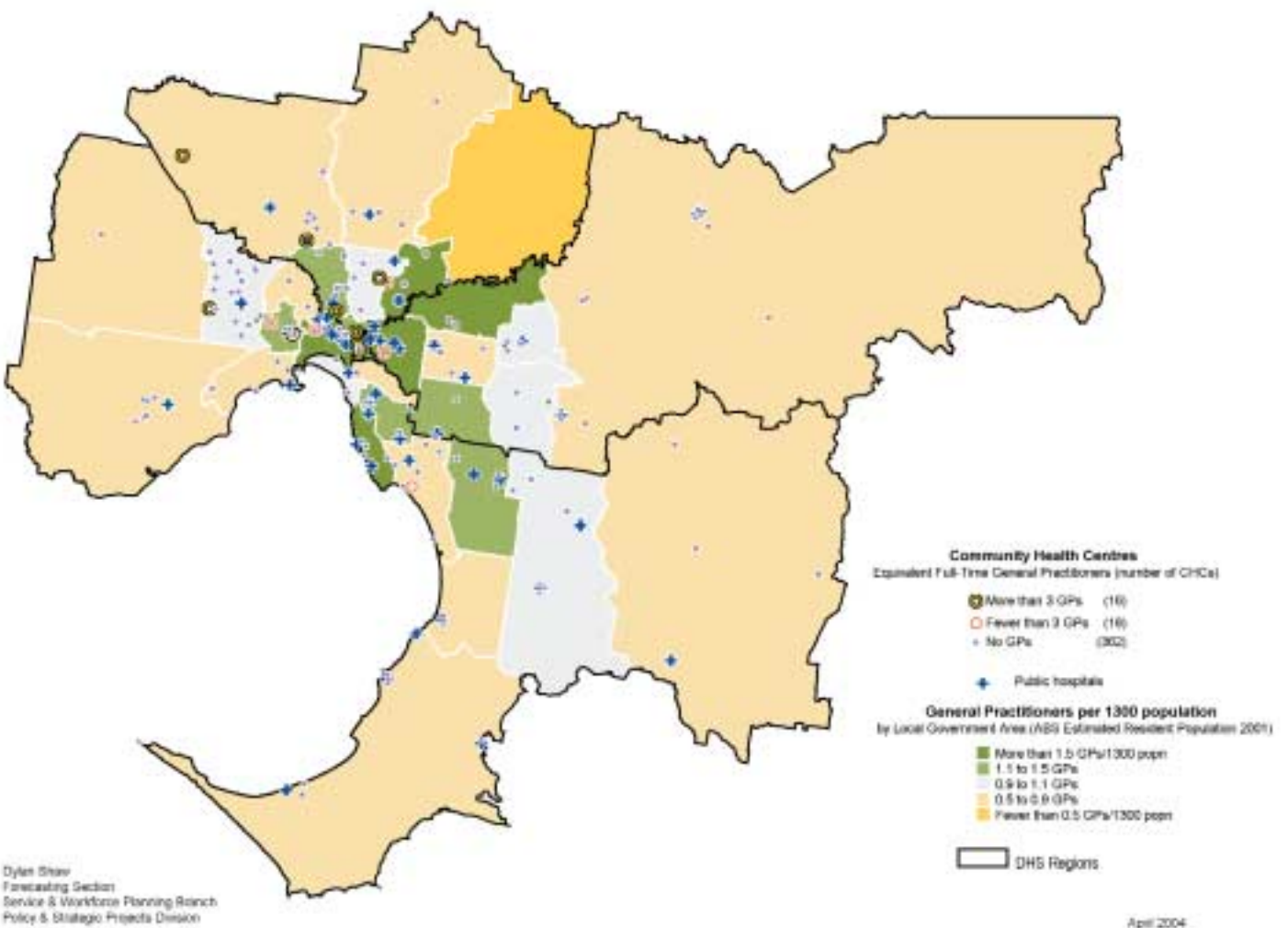
13 Bickman, L. (1996) The application of Program Theory to the evaluation of a management mental healthy care system. *Evaluation and Program Planning*, 19(2), 111–119.

## Attachment 1: Data

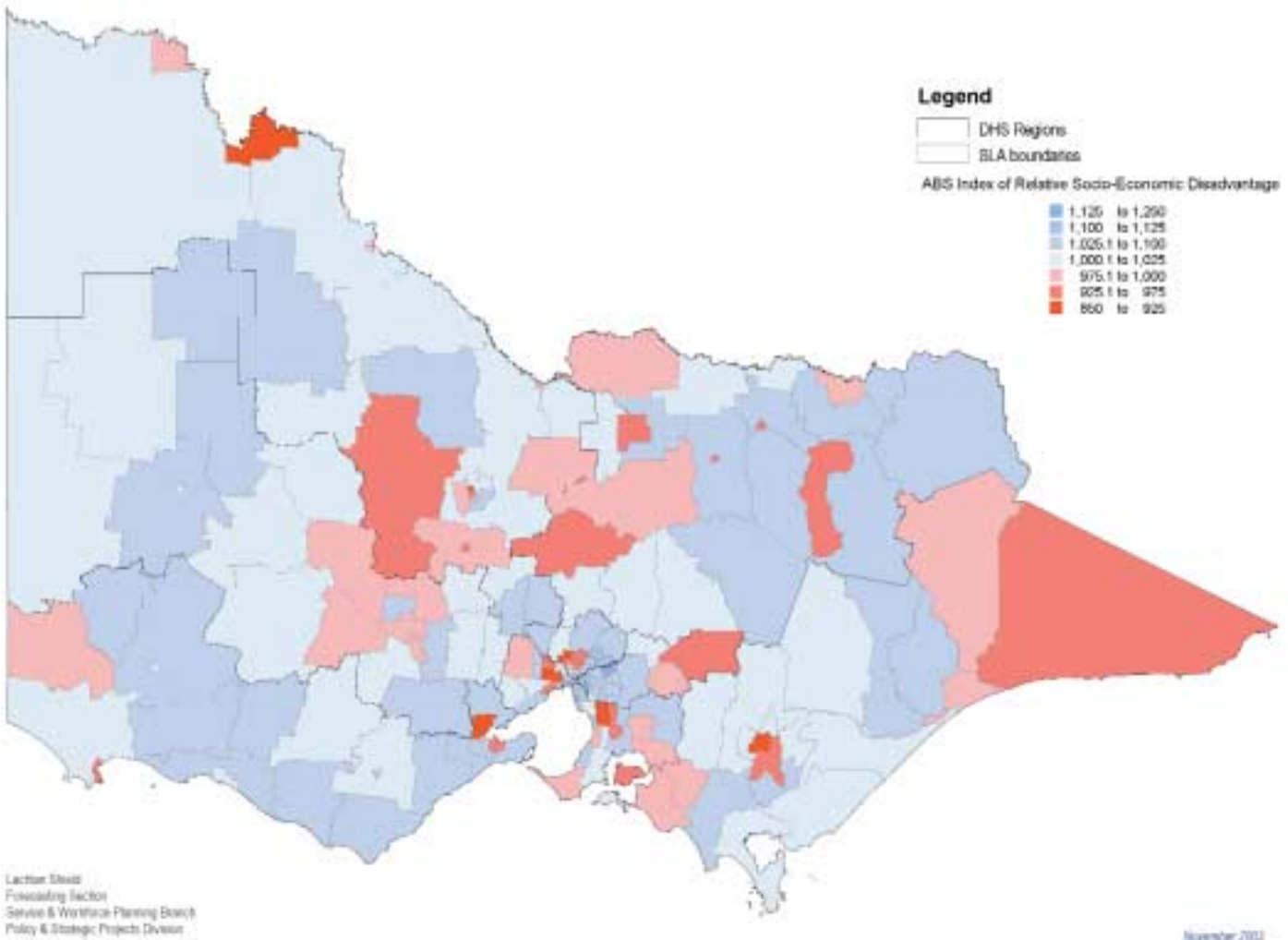
### Part one—General practice workforce and current locations of general practice services in CHSs: Rural Victoria



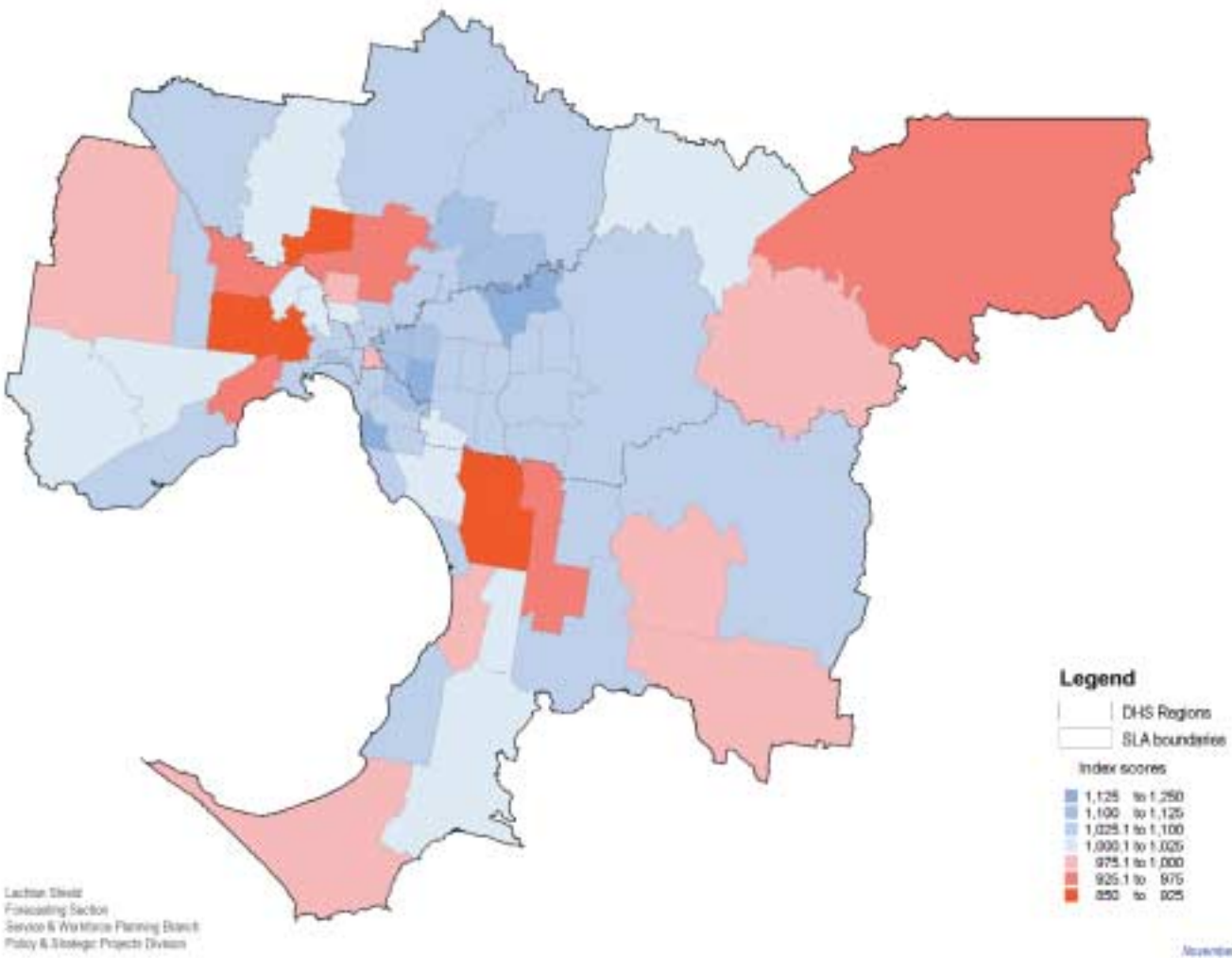
## Part two—General Practice workforce and current locations of general practice services in CHSs: Metropolitan Melbourne



### Part three—ABS 2001 Index of Relative Socioeconomic Disadvantage: Rural Victoria



### Part four—ABS 2001 Index of Relative Socioeconomic Disadvantage: Metropolitan Victoria



## Part five—Bulk billing rates by federal electorate 2002–2003

### Medicare: non-referred (GP) attendances—Percentage of services bulk billed by electorate

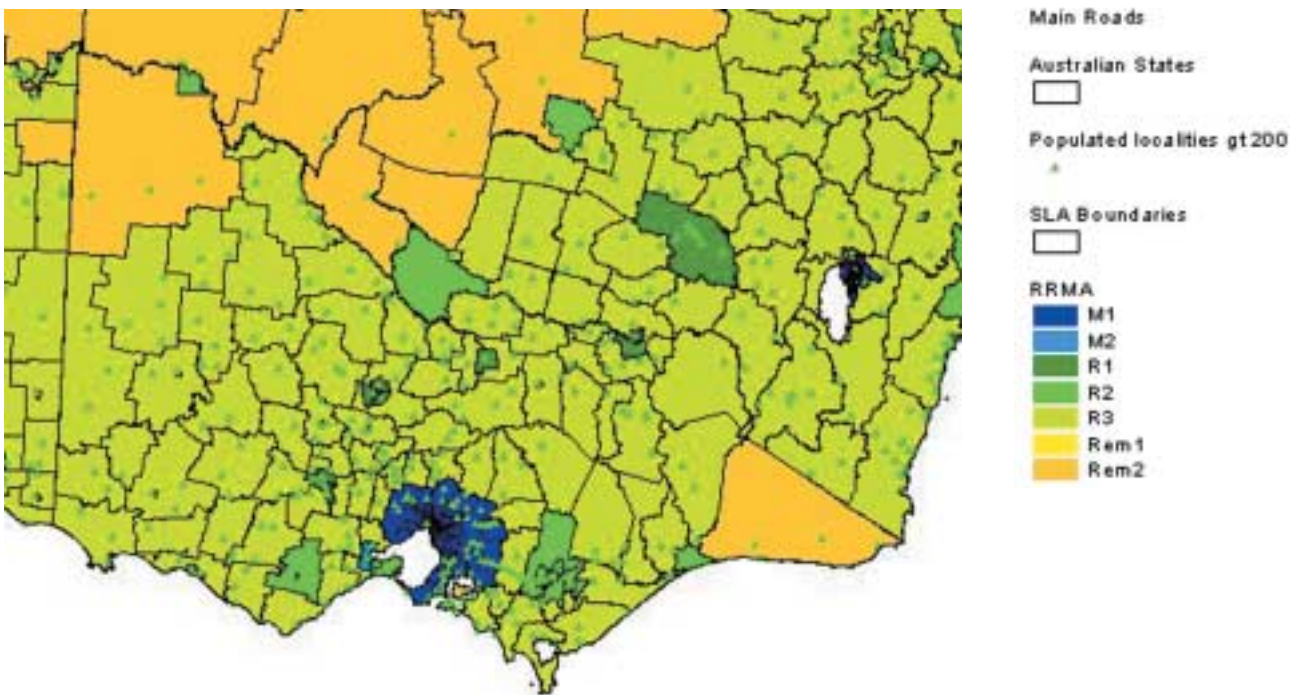
Electorate	12 months ending December	
	2002	2003
Aston	79.2%	71.1%
Ballarat	58.0%	43.2%
Batman	87.1%	83.3%
Bendigo	48.9%	48.2%
Bruce	78.8%	76.0%
Burke	67.2%	59.1%
Calwell	87.7%	81.5%
Casey	68.6%	59.6%
Chisholm	77.7%	72.7%
Corangamite	44.0%	41.8%
Corio	60.3%	57.9%
Deakin	73.5%	64.6%
Dunkley	54.5%	47.6%
Flinders	51.9%	44.5%
Gellibrand	89.1%	85.0%
Gippsland	53.8%	46.1%
Higgins	65.0%	60.5%
Holt	80.0%	76.1%
Hotham	81.1%	76.4%
Indi	34.4%	29.8%
Isaacs	72.8%	65.1%
Jagajaga	72.6%	68.1%
Kooyong	63.2%	58.3%
La Trobe	67.3%	62.4%
Lalor	85.0%	77.2%
Mallee	54.3%	54.1%
Maribyrnong	87.2%	82.4%
McEwen	66.7%	60.9%
McMillan	67.0%	67.6%
Melbourne	83.9%	79.9%
Melbourne Ports	73.6%	70.5%
Menzies	75.3%	70.0%
Murray	33.4%	31.5%
Scullin	87.6%	84.8%
Wannon	51.8%	42.2%
Wills	84.7%	79.0%
<b>Total</b>	<b>72.3%</b>	<b>67.7%</b>

(a) These statistics were compiled using 2001 electoral boundaries.

(b) These statistics were compiled from statistics by Medicare enrolment postcode. Since some postcodes overlap federal electoral division boundaries, data by enrolment postcode were mapped to electorate using data from the Census of Population and Housing showing the percentage of the population of the postcode in each Federal Electoral Division. Excludes statistics for postcodes which could not be mapped to electorate (in particular, Australia Post post box/mail centre postcodes).

For details of suburbs and postcodes within these electorates visit <http://www.aec.gov.au/eseach/main.htm>

### Part six—Rural, Remote and Metropolitan Area class by Statistical Local Area



Source: Commonwealth Department of Health and Aged Care. [www.ruralhealth.gov.au/policy/accessibility.htm](http://www.ruralhealth.gov.au/policy/accessibility.htm)

## Attachment 2: General practice models

The following tables provide examples drawn from ‘best practices’ currently operating in communities. They are not case studies of particular CHSs. It is not a comprehensive list of options nor is it exclusive of the many hybrid or alternative models that may be developed.

### Large CHS general practice

#### CHS/GP description:

A large metropolitan CHS that runs its own general practice. The practice has around 10 GP EFT, a practice manager, practice nurse, community nurse and two receptionists who are shared across all program areas. The clinic is open seven days a week, 8.00 am to 8.00 pm. It has formal links to diagnostic services. It provides bulk billing to all clients and has a philosophy to see all clients who present.

#### GP employment:

The GPs are salaried. There are around 16 GPs that make up the 10 EFT. Some GPs are very general in nature; some have specific interest areas such as women’s health, refugees, pharmacotherapy and homeless people. There are also two GP registrars at any given time. The clinic supports two GP undergraduate placements most years.

#### GP practice:

On average the GPs see four patients an hour—the generalist GPs may have a higher rate, the special focus a lower one. The practice nurses focus on GP support, administration and practices such as dressings and immunisations. The community nurses undertake services like home visits, EPCs and care plans. The registrars see two patients an hour.

#### Integration:

The GPs refer between themselves when a patient’s needs are best met by another GP.

GPs use the GP statewide form to refer to department funded services.

GPs participate in local feedback protocols following patient referral.

The GPs have arrangements with external diagnostic providers for in hours and after hours services and for patients without Medicare cards, for example, refugees, homeless people.

The GP practice has referral protocols with the local hospital emergency department (ED) and through its nursing support, observation capacity and links to diagnostic services is able to effectively divert patients from EDs where appropriate.

GPs have non-clinical hours to participate in service development, planning, staff meetings, GP undergraduate support, external activities and networks.

#### Practice capacities:

The practice manager oversees running the clinic and integration with other service areas. The practice manager is part of the CHS Executive and reports to the CEO.

Staff are resourced and supported with defined roles within a multidisciplinary team.

Efficient electronic booking and billing systems ensure sound financial management and patient flow.

Quality facilities and equipment.

Targeted, planned use of GP time, including non-clinical time.

The practice nurse and community nurse help streamline practices, ensure efficient use of GP time and make a broad range of Medicare payments accessible.

#### Financial viability:

Due to the size, staffing and systems within the practice, it is viable even with the after hours service, special focus GPs, and commitment to all who present including non-Medicare cardholders.

### **Medium CHS managed and integrated general practice**

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#### **CHS/GP description:**

A medium sized CHS\* that runs its own general practice. The clinic has around four GP EFT, 0.5 EFT clinical nurse and a practice manager and receptionist, both of whom are shared with other program areas. The clinic is open five days a week, 9.00 am to 5.00 pm. It provides bulk billing to all clients and has a philosophy to see all clients who present.

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#### **GP employment:**

The GPs are salaried. There are around eight GPs that make up the 4 EFT. Two of the GPs deliver pharmacotherapy. There is also one GP registrar based there at most times. The clinic supports one undergraduate placement per year.

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#### **GP practice:**

On average, the GPs see 3.5 patients an hour. The practice nurse provides GP support and administration and patient services such as dressings, immunisations and occasional health assessments.

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#### **Integration:**

GPs use the GP statewide referral form to refer to department funded services.

GPs participate in local feedback protocols following patient referral.

GPs have some, but limited, non-clinical hours to participate in service development, planning, undergraduate GP support, staff meetings, external activities and networks.

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#### **Practice capacities:**

The practice manager oversees running the clinic, along with the other direct service delivery programs. While this provides across program integration, it also reduces the focus on the general practice. They report to the CEO.

Staff are resourced and supported with defined roles across a multidisciplinary team.

Efficient electronic booking and billing systems ensures sound financial management and patient flow.

Quality facilities and equipment.

Targeted, planned use of GP time including non-clinical time.

The practice nurse helps streamline practices, assists with efficient use of GP time and makes some additional Medicare payments accessible.

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#### **Financial viability:**

The clinic is viable while operating within normal business hours.

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\* This model is also applicable when more than one CHS collectively operates a GP clinic across their sites.

### CHS integrated with a co-located private general practice

#### CHS description:

A medium sized regional CHS. A privately managed general practice\*. The practice has four GP EFT, a part-time practice manager, a clinical nurse and its own receptionist. The practice is open five days a week, 9.00 am to 5.00 pm. It provides bulk billing to CHS clients. The two services cooperatively aim for seamless service delivery to mutual clients.

#### GP employment:

The GPs are employed by the practice on a percentage split arrangement. There are around eight GPs that make up the 4 EFT. The practice has a pharmacotherapy prescribing GP and a GP with particular interest in women's health. There is also one GP registrar based with the general practice at most times and it supports one GP undergraduate placement per year.

#### GP practice:

The general practice is responsible for employment and operations of the practice. On average, the GPs see five patients an hour. The practice and the CHS have financial arrangements that share rent and some operating expenses.

#### Integration:

GPs use the GP statewide referral form to refer to department funded services.

GPs participate in local feedback protocols following patient referral.

GPs have access to non-clinical hours to ensure integration with the CHS.

#### Practice capacities:

The general practice is efficient with electronic booking and billing and efficient use of GP time.

The practice manager works with the CHS management to plan and deliver services.

The practice provides bulk billing to CHS clients\*\*.

#### Financial viability:

The private practice is financially viable.

\* The GP clinic could be a private practice or a non-profit auspiced one

\*\* Bulk billing would ideally be universally available, but may be negotiated to 'targeted' cover of all CHS clients, or to holders of health care and pension cards.

### **CHS and private practice integrated service delivery**

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#### **CHS/GP description:**

A small rural CHS. A separately located private GP practice\*. The CHS and the practice are open five days a week, 9.00 am to 5.00 pm. The practice ideally delivers general practice services at the CHS site or at the practice address.

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#### **GP employment:**

The GPs are employed by the practice, not the CHS.

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#### **GP practice:**

The GP practice is responsible for operations of the practice. Where GP sessions are delivered at the CHS, the CHS provides the room, equipment, utilities, wait room and receptionist services. The GP receives all Medicare income generated during the sessions.

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#### **Integration:**

The CHS and the GP practice have referral protocols (including use of the Victorian statewide referral form) and common assessment tools.

Formal agreement between the CHS and the GP practice ensures accessibility (referrals and prioritised appointments) and affordability (bulk billing) for CHS referrals.

GPs have a small number of non-clinical hours to participate in the development of the partnership.

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#### **Practice capacities:**

The practice provides bulk billing to CHS clients\*\*.

Referral protocols (including use of the Victorian statewide referral form) and common assessment tools.

Streamlined and accessible services for CHS clients.

Communication and joint case planning.

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#### **Financial viability:**

The private general practice is financially viable.

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\* This arrangement could be with one private practice or with several practices.

\*\* Bulk billing would ideally be universally available, but may be negotiated to 'targeted' cover of all CHS clients or to holders of health care and pension cards.

### GP program sessions in a CHS

#### CHS/GP description:

A small outer metropolitan CHS. The CHS runs a specialised service for a particular client group (for example, a pharmacotherapy service)\*. This is the only program area managed by the CHS involving general practice. This model could also apply to delivery of GP services to a small population in a rural area.

#### GP employment:

A local private practice employs the GP and has responsibility for billing and the provision of consumables. The CHS provides the room, equipment, utilities, wait room and receptionist services. The GP receives all Medicare income generated during the sessions.

#### GP practice:

On average the GP sees 2–3 patients per hour, due to the complexity of targeted service client needs.

#### Integration:

The CHS and the GP have referral protocols, including the use of the Victorian statewide referral form.

A formal agreement covers the sessional arrangement under which the GP provides services to CHS clients.

#### Practice capacities:

Referral protocols.

Communication and joint case planning.

#### Financial viability:

The viability of the CHS general practice is possibly dependent on recurrent funding for operating costs and an initial grant to purchase equipment.

It is viable for the GP as they receive all Medicare benefits income and incur limited overheads.

\* The establishment of a 3–4 GP practice in the CHS is not pursued due to the population base, (regional/remote), existing accessibility to a bulk billing general practice in the local area, workforce issues and/or the targeted nature of the GP service (for example, pharmacotherapy).

## Attachment 3: Victorian community health services

### Barwon South Western

Barwon Health  
Bellarine Community Health Inc  
Casterton Memorial Hospital  
Colac Area Health  
Coleraine District Health Services  
Hesse Rural Health Services  
Lorne Community Hospital  
Otway Health and Community Services  
Portland District Health  
South West Healthcare  
Terang and Mortlake Health Service  
Timboon and District Healthcare Service  
Western District Health Service

### Grampians

Ballarat Community Health Centre Inc  
Ballarat Health Services  
Beaufort and Skipton Health Service  
Djerriwarrh Health Service  
Dunmunkle Health Services  
East Grampians Health Service  
East Wimmera Health Service  
Grampians Community Health Centre Inc  
Hepburn Health Service  
Rural Northwest Health  
Stawell Regional Health  
West Wimmera Health Service  
Wimmera Health Care Group

### Loddon Mallee

Bendigo Community Health Services Inc  
Bendigo Health Care Group  
Castlemaine District Community Health Centre Inc  
Cobaw Community Health Service Inc  
Echuca Regional Health  
Gisborne and District Community Health and Hospital Board Inc  
Inglewood and Districts Health Service  
Kyabram and District Memorial Community Hospital  
Maryborough District Health Service  
McIvor Health and Community Services  
Northern District Community Health Service Inc  
Robinvale District Health Services  
Rochester and Elmore District Health Service  
Sunraysia Community Health Services Inc  
Swan Hill District Hospital

**Hume**

Alexandra District Hospital  
 Alpine Health  
 Benalla and District Memorial Hospital  
 Cobram District Hospital  
 Glenview Community Care Inc  
 Goulburn Valley Community Health Service Inc  
 Goulburn Valley Health  
 Mansfield District Hospital  
 Mitchell Community Health Services Inc  
 Murrindindi Community Health Service Inc  
 Numurkah District Health Service  
 Ovens and King Community Health Service Inc  
 Seymour District Memorial Hospital  
 Tallangatta Health Service  
 Upper Hume Community Health Service Inc  
 Upper Murray Health and Community Services  
 Wangaratta District Base Hospital  
 Wodonga Regional Health Service  
 Yarrawonga District Health Service

**Gippsland**

Bairnsdale Regional Health Service  
 Central Gippsland Health Service  
 Ensay Community Health Centre Inc  
 Orbost Regional Health  
 Gippsland Southern Health Service  
 Lakes Entrance Community Health Centre Inc  
 Latrobe Community Health Service Inc  
 Nowa Nowa Community Health Centre Inc  
 San Remo and District Community Health Centre Inc  
 West Gippsland Healthcare Group  
 Yarram and District Health Service

**Western Metropolitan**

Doutta Galla Community Health Service Inc  
 Isis Primary Care Inc  
 Western Region Health Centre Ltd

**Northern Metropolitan**

Banyule Community Health Service Inc  
 Darebin Community Health Service Inc  
 Dianella Community Health Inc  
 Eltham Community Health Centre Inc  
 Moreland Community Health Service Inc  
 North Richmond Community Health Centre Inc  
 North Yarra Community Health Inc  
 Plenty Valley Community Health Services Inc  
 Sunbury Community Health Centre Inc

**Eastern Metropolitan**

Eastern Access Community Health Inc.  
Eastern Health  
Inner East Community Health Service Inc  
Knox Community Health Service Inc  
Manningham Community Health Service Inc  
MonashLink Community Health Service Inc  
Ranges Community Health Service Inc  
Whitehorse Community Health Service Inc

**Southern Metropolitan**

Bayside Health  
Bentleigh Bayside Community Health Service Inc  
Central Bayside Community Health Services Inc  
Inner South Community Health Service Inc  
Peninsula Community Health Service  
Peninsula Health  
Southern Health





