



A Guide to General Practice Engagement

IN PRIMARY CARE PARTNERSHIPS

July 2001

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in Primary Care Partnerships

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For further information or to obtain copies of this publication please contact:

Bruce Watson,
Manager, Integrated Care
11/555 Collins Street, Melbourne, 3000
tel: (03) 9616 6131
fax: (03) 9616 84168680
email: bruce.watson@dhs.vic.gov.au

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Photograph: A family meeting to discuss the care of the grandparents both of whom receive services from Dr Terry Ahern, GP, Coburg and Mr Ari Nimorakiotakis, podiatrist, Moreland Community Health Centre.

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Foreword

The Victorian Government released the document *Primary Care Partnerships: Going Forward* in April 2000, outlining the Primary Care Partnership Strategy. The strategy encourages collaboration between providers with the aim of strengthening service planning partnerships and coordination within localities.

The main goals of the Primary Care Partnership Strategy are to:

- Improve the experience and outcomes for people who use primary care services.
- Reduce the preventable use of hospital, medical and residential services through a greater emphasis on health promotion programs and by responding to the early signs of disease and/or people's need for support.

General practitioners and Divisions of General Practice are central to the success of the Primary Care Partnership Strategy. They have an important role to play in service coordination, health promotion, integrated disease management, integrated service planning and in the delivery of primary care services in Victoria.

A key success factor for the Primary Care Partnerships will be the creation of effective integration between general practice and the broader primary care system.

The Primary Care Partnerships Strategy is Victoria's vehicle for achieving greater collaboration and integration of the health care system, and the aims of better service coordination and disease prevention. These aims are also consistent with the Commonwealth's Enhanced Primary Care agenda. In particular, the Enhanced Primary Care items of the Medicare Benefits Schedule provide a mechanism for achieving this integration. The items provide rebates for general practitioners for conducting health assessments for older persons, and for participating in multidisciplinary care for people with chronic and complex needs. Importantly, the multi-disciplinary care planning and case conferencing items apply both in the community and in relation to discharge from hospital.

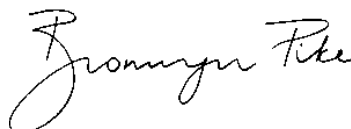
Primary Care Partnerships provide a structured approach to the meaningful integration of general practitioners with other primary care services, while at the same time preserving the independence and integrity of each. A great deal of progress has been made over the last year across Victoria in the development of partnerships between general practitioners and primary care providers. This Guide builds on the experiences gained over this time.

The Guide draws heavily on many of those examples of good work in the field, both through a series of case studies, as well as through the *hint boxes* which provide some very practical ideas to help in developing effective working relationships. These ideas have been suggested through the extensive consultations which occurred in the development of this Guide.

Thank you to all those who have contributed to this Guide.



Hon John Thwaites MP
Minister for Health Hon



Bronwyn Pike MP
Minister for Housing and Aged Care
Minister Assisting the Minister for Health

Acronyms used in this Guide

BATS	Better Access To Services
CCT	Coordinated Care Trials
DHS	Department of Human Services
EPC	Enhanced Primary Care (Commonwealth Government initiative)
GP	General practitioner, general practice
GPDV	General Practice Divisions Victoria
HACC	Home and Community Care
IM	Information Management
IT	Information Technology
MBS	Medicare Benefits Schedule
PCP	Primary Care Partnership
PHKB	Primary Health Knowledge Base (Department of Human Services)
RACGP	Royal Australian College of General Practitioners

The Case Studies

The case studies contained in this Guide provide a few illustrative examples of engagement of general practice by some Primary Care Partnerships and Divisions are. They cover a range of stages in the development of Partnerships. There are many more examples of innovation occurring in the field. These will be posted on the Primary Health Knowledge Base. If you wish to submit a case study, please contact either Silvana Scibilia or Bruce Watson:

Silvana Scibilia,
Project Manager, GP and Commonwealth Integration
11/555 Collins Street, Melbourne, 3000
tel: (03) 9616 8907
fax: (03) 9616 8416
email: silvana.scibilia@dhs.vic.gov.au

Bruce Watson,
Manager, Integrated Care
11/555 Collins Street, Melbourne, 3000
tel: (03) 9616 6131
fax: (03) 9616 84168680
email: bruce.watson@dhs.vic.gov.au

Summary of Key Points

The following key points highlight the critical role that general practitioners and Divisions of General Practice play in the successful development of Primary Care Partnerships (PCPs). Whilst acknowledging that barriers exist, this Guide provides examples of developing Partnerships through projects. It also proposes practical strategies to assist Primary Care Partnerships, Divisions and general practitioners (GPs) to develop positive Partnerships.

- Collaboration between GPs and the broader primary care sector should produce a range of benefits for consumers, general practitioners, Divisions of General Practice and other primary care providers.
- General practitioners are integral to the success of the PCP strategy.
- While general practitioners are central to the health system, they tend to be culturally and structurally separate from other primary care providers due to the way their practices are organised and funded. This can hinder effective communication between GPs and other service providers and restrict their involvement in the wider service system.
- A number of parallel initiatives and influences are leading to a major change in general practice. The Practice Incentives Program, the Enhanced Primary Care Package, and a range of collaborative projects and programs are promoting greater integration between GPs and other providers of primary care, and promoting greater integration between the acute and primary care sectors.
- The main aim of the Divisions of General Practice program is to improve health outcomes for patients by encouraging GPs to work together and link with other primary care providers to improve the quality of health care service delivery at the local level.
- The Primary Care Partnerships Strategy is a State initiative which aims to achieve greater collaboration and integration of the health care system, and better service coordination and prevention. These aims are also consistent with the Commonwealth's Enhanced Primary Care agenda. Involvement in Primary Care Partnerships is a key strategy for Victorian Divisions to meet their objective of improved links between general practice and other elements of the health sector.
- It takes time, commitment and trust to reap the benefits of successful collaboration, and its development typically involves a series of stages, building on the many local achievements that have occurred to date across Victoria.
- The engagement of Divisions and general practitioners in PCPs will involve two key stages: engagement with Divisions of General Practice and engagement with individual GPs.
- To date, as part of the development of Primary Care Partnerships, Divisions have played a leading role in representing general practice.

- The decision as to who should be involved in particular PCP working groups at any given time should be based on mutual agreement and discussion at the local level. In general, where issues relate to governance, broad system reform or information technology, Division staff are likely to have the appropriate expertise. The major contribution of GPs is likely to be related to their clinical expertise in patient care.
- Once PCP processes and practices have developed to the point where tangible benefits can be offered to local GPs, the focus of engagement should shift to individual general practitioners within the PCP catchment. Increasing numbers of GPs are likely to adopt changes in their practice as they see direct benefits to their patients, but this will take time.
- It is important to recognise cultural and professional differences and work towards addressing them – or work with them, recognising appropriate complementary roles, and recognising time constraints.
- Each PCP has been resourced to support the process of formally engaging providers, consumers, carers and community in the development of sustainable and democratic alliances. However, the Department of Human Services has not prescribed how this is to be achieved, nor determined a policy on payment to individual providers to reimburse participation. Where GPs wish to be reimbursed for time spent on PCP activities, Partnerships should seek to come to a mutually acceptable arrangement with Divisions.
- Research shows that a major barrier to GPs engaging with other elements of the primary health and community support sector is their lack of knowledge of relevant services. The local primary care service directory, to be developed and maintained by each PCP, will help address this.
- Divisions of General Practice have substantial knowledge and experience to assist Partnerships in the development of their information management strategy.
- A major component of GP engagement in PCPs will be through the Better Access To Services framework. Effective GP engagement will be a key success factor for the framework.
- The Enhanced Primary Care (EPC) MBS items provide a crucial means for GPs to develop closer working relationships with other primary care providers. In combination with the PCP structure, the items provide an ideal basis for the enhancement of multi-disciplinary approaches. Partnerships will be able to develop Better Access To Services (BATS) protocols which incorporate GP involvement through the EPC MBS items.
- The Department of Human Services will conduct a series of local workshops and other support strategies in 2001 to assist practitioners, including GPs and other primary care practitioners, in utilising the EPC MBS items. These activities will build on what has already been done locally.

- Divisions of General Practice can make a valuable contribution to Community Health Plans through their work on Strategic and Business Plans and their knowledge of general practice and population health issues.
- Primary Care Partnerships provide an excellent opportunity to improve coordination between the health promotion efforts of GPs and Divisions with those of other primary care providers. Their engagement in the development of PCP health promotion strategies is critical.
- Four Primary Care Partnerships have been selected as pilots to develop integrated disease management strategies. GP involvement will be critical to their success.

Introduction

The Purpose of the Guide

This Guide is intended to be a resource for those involved in primary care. It identifies issues facing GPs and other primary care providers and aims to provide strategies to assist in developing stronger relationships through Primary Care Partnerships.

The Guide also provides background information, practical advice and useful references and resources, particularly for members of Primary Care Partnerships, including Divisions of General Practice, responsible for developing their local *Primary Care Partnership – General Practice Engagement Strategy* (See Part 2) as part of their PCP's Community Health Plan.

Who Should Read the Guide?

The Guide's primary audience is Primary Care Partnerships. It should be useful to:

- Members of Primary Care Partnerships, in developing their local *Primary Care Partnership – General Practice Engagement Strategy*.
- Members of PCP committees or working groups working on a range of PCP activities.
- Practitioners involved in activities which bring together GPs and other primary care providers.
- Staff and members of Divisions of General Practice who are developing EPC training programs, Business Plans or other Division programs.

How to Use the Guide

The Guide is a starting point for developing a *Primary Care Partnership – General Practice Engagement Strategy* at the local level. It is not a prescriptive set of guidelines, but is intended as a reference and a resource to be used as required.

Each part of the Guide is self-contained.

- Part One** Provides **background information on Primary Care Partnerships and general practice**, and outlines the benefits of working together effectively.
- Part Two** Provides options and **practical advice for working together** in the context of the Primary Care Partnerships Strategy.

Part One: Primary Care

Partnerships and General Practice

Part One outlines the benefits of Primary Care Partnerships and general practice working together effectively, and provides background information on Primary Care Partnerships and general practice.

The Benefits of Engaging General Practice

Collaboration between GPs and the broader primary care sector should produce a range of benefits for consumers, general practitioners, Divisions of General Practice and other primary care providers.

Benefits to Consumers

People often see their GP first when seeking help with their health, so closer links between GPs and other primary care providers have the following potential advantages:

- Easier access to information from the GP through the local primary care services directory, which will be useful in rural areas where services are limited and metropolitan areas where there are multiple services.
- Increased likelihood of being referred to an appropriate primary care provider in their area.
- Less duplication of services.
- Greater continuity of care, particularly for people with complex or chronic conditions.
- Better health outcomes.

Benefits to General Practice

Participation in PCPs should produce the following benefits, leading to better patient outcomes:

- A clear point of contact for GPs to use in arranging services.
- A current local services directory, providing easier and more efficient GP access to information on service availability, eligibility, and other details.
- Expansion of the referral and information network with less duplication of needs identification, assessment and care planning.
- Timely feedback from other primary care providers following referral.
- Opportunities to inform other stakeholders about issues facing GPs in linking with other primary care providers.
- Opportunities to secure active support from other primary care providers to achieve specific, agreed population health goals through general practice, for example, increased influenza and pneumococcal vaccination rates, increased number of people with diabetes receiving regular health checks.
- Facilitation of GPs' involvement in multi-disciplinary care planning and case conferencing.

- Common assessment tools and protocols, which will result in improved coordination of patient care, integrated service planning and integrated disease management.
- Opportunities to apply expertise in population health, integrated disease management and health promotion across the local area.

Benefits to Other Primary Care Providers

Partnership with GPs can provide the following benefits for other primary care providers, leading to better consumer outcomes:

- A significant source of referral, particularly of people who may need, but are not linked to, wider primary care services.
- Medical expertise about their patients for assessment, multi-disciplinary care planning and case conferencing.
- A point of delivery for one-on-one health promotion messages, including behavioural change and patient self management strategies.
- Clinical and practical expertise in the development of PCP processes and protocols.
- Medical case management and continuity of care for people with chronic, complex or intensive needs.
- Links to GPs' interface with the acute and aged residential sectors, for example, through GP participation in discharge planning, and referring patients to allied health providers through the EPC Care Planning item (see Appendix 1).

Divisions can provide the following benefits:

- A point of contact for broad consultation with their GP members.
- Experience and practical strategies in working with their GP membership.
- Experience in developing and implementing activities to promote GP participation in population health, integrated disease management, health promotion, IM/IT, care co-ordination and integration.
- Data relevant to, and a general practice perspective on, Integrated Service Planning.
- Expertise in project management involving GPs.

Primary Care Providers Funded by the State Government

Agencies involved in Primary Care Partnerships deliver a range of primary care services funded by the Victorian Government, including Home and Community Care and aged care services, community health (including a range of allied health) services, services for women, ethnic and indigenous people, community mental health services and community district nursing services.

The roles of these agencies include:

- Supporting and maintaining people with functional disabilities in their own home.
- Preventing or minimising health problems through health promotion.
- Diverting people from more intensive and intrusive health care settings or residential care.
- Treating illness and other complaints.
- Restoring optimal health following an episode of ill health.

State-funded primary care services generally care for people on low incomes and people who have chronic and complex conditions.

Many of these services have eligibility criteria. Where demand is greater than the available resources, services need to determine priorities regarding service access.

General Practice

Why is General Practice Engagement Important?

General practitioners are integral to the success of the PCP strategy. They are the first point of contact in the health and community support system for most people.

General practitioners play a pivotal role in providing services, information and referral to people who need primary care, and are critical to effective health promotion and early intervention. According to data from the Commonwealth Department of Health and Aged Care, in Victoria general practitioners undertake over 20 million consultations each year and over 80 per cent of people see their GP at least once a year.

General practitioners have a central role to play in service coordination in the primary care system and in ongoing community-based treatment and support. GPs also provide an interface between the acute, residential, primary care and community support systems. Their role is central to integrated disease management and treatment, health promotion and population health.

General Practice Links with Other Primary Care Providers

While general practitioners are central to the health system, they tend to be culturally and structurally separate from other primary care providers due to the way their practices are organised and funded. This can hinder effective communication between GPs and other service providers, and restrict their involvement in the wider service system.

A recent Victorian study: *Community Health and General Practitioners: Partnerships in Care* identified a 'cultural gap' between general practice and community health. Barriers included a mutual suspicion that each may attract patients away from the other; GPs' lack of knowledge of, and confidence about using other primary care services; a lack of awareness of what these services do; and concerns regarding the relationship between general practice and other primary care services, particularly those with a case management function. The report stressed the need to develop trust and common understanding, encouraging partnerships in planning services responsive to community needs.

Most GPs work as private practitioners, either individually or in group practices, operating as businesses which provide health care. A small number are located in community health centres or in association with public hospitals.

A major factor affecting GPs' involvement in the wider service system relates to how their services are remunerated. GPs receive payments for seeing individual patients, either by billing their patients, who then recover a rebate through the Commonwealth Medicare Benefits Schedule (MBS), or by bulk billing to Medicare. GPs consider their primary contractual relationship to be with their patients. This focus on individuals and a fee for service model provides little incentive for activities outside patient consultations. The demands of running a practice limit GPs' ability to engage in meetings with other service providers for issues not immediately related to patient care.

A number of parallel initiatives and influences are leading to a major change in general practice. The Practice Incentives Program, the Enhanced Primary Care Package, and a range of collaborative projects and programs are promoting greater integration between GPs and other providers of primary care, and promoting greater integration between the acute and primary care sectors.

General practice is changing. For example, the Practice Incentives Program, introduced in 1998, supplements fee for service payments. It remunerates practices for a range of quality related activities, including information management and information technology, after-hours care, immunisation and quality prescribing programs.

Research published by the Consumers' Health Forum indicates that people want a more active partnership with their GPs, want their GPs to be aware of the range of health and community support services available, and they want their GPs to refer them appropriately to these services.

The MBS introduced Enhanced Primary Care (EPC) items for health assessments, care planning and case conferencing in 1999. These items provide an opportunity for GPs to work in multi-disciplinary teams with other primary care providers, both in the community, and in discharge planning. They provide a platform for GPs to move from acute, episodic and reactive care towards providing long-term coordinated, pro-active and preventative care (see Part 2 and Appendix 1).

While some GPs have had little exposure to collaborative working arrangements, many have been involved in post-acute care, shared care and other community-based programs.

For example, many GPs played a key role in the first round of Coordinated Care Trials (CCTs). The Interim National Evaluation of the Trials indicated that participating GPs were generally very supportive of coordinated care. They saw care planning as a way of formalizing how they treated people with chronic and complex needs. Coordinated care was seen as strengthening the key role they played and saw themselves as ideally positioned to undertake a care coordination role. Most found the holistic approach of coordinated care to be beneficial to their patients. They saw the coordinated care approach as rewarding, and enhancing the comprehensiveness of their patient care. Trial clients valued the service coordination and reported improvements in well-being. Nurses and a range of other professionals worked closely with GPs and other providers in care coordination.

With the introduction of Primary Care Partnerships and a second round of Coordinated Care Trials, many GPs will be working in areas where both co-exist. It is important that processes and tools are consistent between these models. The Department is working closely with the potential Trials and with PCP providers, including representatives of general practice, to attain such consistency.

Divisions of General Practice

Overview and Role

The main aim of the Divisions program is to improve health outcomes for patients by encouraging GPs to work together and link with other primary care providers to improve the quality of health care service delivery at the local level.

The establishment of Divisions of General Practice in 1992 signalled a significant change to general practice. Divisions have been the major vehicle for implementing general practice reforms.

Divisions provide:

- A structure to enable peer support and to promote the identity of general practice.
- A means for fostering communication between GPs, the public, and the wider health system.
- A resource for GPs and other health care providers regarding general practice, primary health care and primary health research.

- Support services to GPs and general practice staff in program areas such as IM/IT, immunisation, health promotion and disease management.
- Continuing medical education for GPs and training for their staff.
- A vehicle for contributing to general practice participation in policy development.
- An interface with general practice at the local level for consumer and community representatives.
- A mechanism to assist GPs in providing enhanced services to their patients.

While all Divisions perform similar functions, they vary in their priorities and strategies for addressing them. For example, workforce issues have greater focus in rural Divisions.

There are 31 Divisions in Victoria. Divisions are constituted by their member GPs. Their membership varies from several hundred GPs to as few as 50. Rural Divisions cover larger areas. Their populations vary from 250,000 to 60,000. At the time of their formation, GPs negotiated Division geographical areas based on communities of interest. This has continued to be the basis of their boundaries. Appendix 2 contains maps showing the relationship between Division boundaries and PCP catchments.

Membership of Divisions is voluntary, and a Division has no authority to impose a decision or view on its member GPs. Victorian Divisions have, on average, 90 per cent membership. Not all members are actively involved.

Divisions are governed by a management committee or board of directors elected by the membership. They employ staff; usually a manager, administrative staff and several program officers.

Divisions are generally not providers of services in the same way as other PCP member agencies.

Links to each Victorian Division's website can be found at www.gpdv.com.au.

Divisions and Integration

The Primary Care Partnerships Strategy is a State initiative which aims to achieve greater collaboration and integration of the health care system, and better service coordination and prevention. These aims are also consistent with the Commonwealth's Enhanced Primary Care agenda.

Involvement in Primary Care Partnerships is a key strategy for Victorian Divisions to meet their objective of improved links between general practice and other elements of the health sector.

Divisions are funded by block grants to achieve specified objectives that are contained within a three-year strategic plan, developed by the Division and based on local need. Each Division identifies its own objectives within the Commonwealth's from a framework which encourages general practice to improve links with other elements of the health sector, to focus on population health and to improve health outcomes.

Divisions are core member agencies of each PCP. All PCPs include at least one Division as a formal partner.

Other Bodies Representing General Practice

General Practice Divisions Victoria (GPDV) represents all Victorian Divisions of General Practice. GPDV works to improve the link between Commonwealth and State policy and program initiatives as they involve general practice, for example, the use of IM/IT by GPs; Enhanced Primary Care; Primary Mental Health; More Allied Health Services; GP roles in population health and chronic illness management. In consultation with Divisions, GPDV develops policy positions and provides representation on key committees.

Representatives from Divisions regularly attend GPDV forums to update them on issues, including the Primary Care Partnerships strategy, from a general practice perspective.

The Department of Human Services funds GPDV to employ a Primary Care Consultant who is a resource for PCPs on general practice issues.

The Royal Australian College of General Practitioners (RACGP) is the professional body responsible for standards and accreditation of general practice.

The Australian Medical Association (AMA) is the medical industrial body representing GPs as well as medical specialists. The Rural Workforce Agency Victoria (RWAV), the Rural Doctors Association of Victoria (RDA) and the Australian College of Rural and Remote Medicine (ACRRM), are concerned with rural GP issues.

It takes time, commitment and trust to reap the benefits of successful collaboration, and its development typically involves a series of stages, building on the many local achievements that have occurred to date across Victoria.

Collaboration across the health and primary care system can be difficult due to differences in goals, priorities, values, language, information management and technology capacity, resources and service practices and culture.

The costs of collaboration, in time and other resources, tend to be immediate. The benefits tend to be seen in the longer term. Therefore, the benefits need to be clearly identified and appreciated in order to overcome the short-term barriers. It is critical to develop shared understanding of problems and goals, and to recognise differences.

While it is important to recognise the difficulties in developing Partnerships, it is also critical to acknowledge what has been achieved locally. Many of the case studies in this Guide and in the Department's *Primary Health Knowledge Base* highlight the fact that there have been many valuable achievements which can be built on.

The development of collaborative arrangements involves consideration of the needs of all players. The Department's information resource on *Partnership Issues* is designed to assist in this process.

GPs are more likely to become involved where activities are practical and will improve patient care processes. Some of the case studies and hints found throughout this Guide provide examples of how this can be done.

A Local PCP–GP Engagement Strategy

The PCP–GP Engagement Strategy component of each Community Health Plan should address the two key stages of engagement with general practice in Primary Care Partnerships:

- Engagement with Divisions of General Practice.
- Engagement with individual GPs.

By June 2001, each PCP will have developed a local PCP–GP *Engagement Strategy* as part of its Community Health Plan. It will include:

- Clear roles and responsibilities for general practice representation on steering group and working parties, including where Division and PCP boundaries do not align (see Hint Boxes 2, 3 and 4).
- A shared understanding of the issues involved in developing a collaborative approach. This should include an understanding of differences in work culture and practice, and in the use of language (see Hint Box 5).
- Mechanisms for involvement of general practice in the development and delivery of service coordination mechanisms (Better Access To Services, information management strategies, local services information); disease prevention; integrated planning and health promotion.

HINTS 1

Involving Consumers

Many Divisions of General Practice include consumer involvement in their program planning and implementation.

PCPs should consult with local Divisions about their arrangements for consumer involvement and what they have learnt from such involvement. Division staff may be able to facilitate consumer involvement in the development of their PCP–GP Engagement Strategy.

Consumers from a Division consumer group may wish to become involved on the PCP Consumers and Carers Reference Group.

HINTS 2

Ways Divisions Can Link in with PCPs

Divisions can link in with PCPs by:

- *Being active members of the PCP management group.*
- *Becoming members of relevant sub-committees or working groups.*

Divisions can also link by sharing their knowledge and expertise in:

- *Developing Integrated Service Planning for the PCP's Community Health Plan using Divisions' Strategic and Business plans as a resource.*
- *Providing support in developing and implementing the PCP IM strategy.*
- *Consumer involvement.*
- *Sharing communication strategies to maximise GP involvement.*
- *Inviting other primary care providers, through the PCP, to attend training and information sessions for the EPC (see Appendix 1) and relevant Continuing Medical Education programs.*

- Identification of assessment and referral pathways, and development of communication protocols, as part of service coordination.

Your local *PCP–GP Engagement Strategy* should take into account needs of GPs, Divisions and other primary care providers. It should include examples of existing and planned collaborative activities and projects involving general practice and other primary care providers.

Initially, it may be useful to focus on piloting projects which address identified needs and involve a relatively small number of general practitioners. Examples might include discharge planning, use of EPC items, communication, shared care in mental health, the Active Script program or falls prevention. Where these produce positive results, other general practitioners are likely to be more motivated to become involved for the benefit of their patients.

As with other aspects of the Primary Care Partnerships strategy, it is important to involve consumers in the development and implementation of your local *PCP–GP Engagement Strategy* (See Hint Box 1). Consumers can:

- Help to ensure that the strategy focuses on consumer based improvements and outcomes.
- Identify service gaps.
- Provide ideas about how access to services can be improved.
- Assist in developing strategies for consumer participation.

How Divisions and PCPs Can Work in Partnership

To date, as part of the development of Primary Care Partnerships, Divisions have played a leading role in making the link with general practitioners. General practitioners are likely to become increasingly involved in PCP development activities as clinical issues come to the fore. For example, some GPs will be involved in the development of an Initial Needs Identification tool. Broader involvement will come later, as tangible benefits can be offered to local GPs.

In working with Divisions, members of Primary Care Partnerships should be aware that:

- Many Divisions are actively looking for ways to engage PCPs, for example with their immunisation, youth programs and projects. Integration with the primary care sector is one of the priorities and tasks of Divisions.
- Most Divisions have experience and expertise in areas such as information technology; strategic planning integrated disease management and population health planning.
- Divisions have developed links with hospitals and the primary care sector, particularly in relation to hospital discharge, integrated disease management, and shared care protocols.

- Divisions have an explicit role as change management agents for general practice.
- All Divisions address population health in their Strategic Plans.
- Some Divisions have developed service directories.
- Divisions are participating in other major systemic changes and projects, such as Coordinated Care Trials, chronic disease self-management projects, and a range of programs linked to the Commonwealth's Enhanced Primary Care Package.
- Rural Divisions are funded under the Commonwealth's More Allied Health Services program for additional allied health services. The Commonwealth's guidelines for this program require Divisions to use an integrated approach with existing providers.
- Most, but not all, GPs are members of the Division.
- Divisions vary in their philosophy, organisational structure, areas of expertise and membership.
- Divisions may be involved in more than one PCP, due to non-alignment of boundaries. This may have resource implications for Divisions (See Hint Box 3, and Appendix 2).

Case Study 1: The Challenges of Partnership

The Central Bayside Division has been an active participant in the PCP reform from the beginning. The Division participated for the following reasons.

1. The reform meets four of our strategic planning goals – medical case management, integration, health promotion and IT.
2. The Division has a high aged care population. Their clinical complexity has led to close relationships between GPs and the primary care sector, and an interest in improving the interface.
3. We have established relationships between the Division and other primary care agencies as a result of implementing several projects in recent years.
4. We identified a number of benefits for GPs, including: a directory of service providers; expansion of existing referral protocols to all GPs and agencies; development of an email-based referral system; GP involvement in the development of common assessment tools and in planning and service coordination.
5. PCP policy material stipulates involvement of Divisions, as it is not possible for a PCP alliance to work with GPs without a structure such as Divisions.

Not all GPs see the relevance of PCPs to their day-to-day practice with few of their patients referred to, and even fewer receiving, a service from primary care. GPs and Divisions have been involved in a number of reforms over the years and some have become sceptical. Also, Divisions, like many primary care agencies, are resource constrained. It can be very difficult to find GPs and staff who can attend meetings and contribute to the development of initiatives.

Integration of health care services is complex and change is difficult to achieve. The PCP reform will be very challenging due to the high number of agencies, the number of small agencies, resource constraints and very differing organisational

HINTS 3

When PCP and Division Boundaries Do Not Align

If boundaries do not align, the following strategies could be considered:

- *One Division, could take the lead role, with arrangements for keeping others informed.*
- *One Division could coordinate involvement for all relevant Divisions, so that greatest expertise can be drawn on.*
- *There could be a functional split between Divisions, for example, one on Management Committee, one on IM working group.*

HINTS 4

Clarifying Roles and Responsibilities for General Practice Representation on PCP Committees and Working Groups

In establishing clear roles and responsibilities, the following issues should be clarified:

- *Who represents general practice in which forums (GP, or Division staff, or both)?*
- *What are the expectations of representatives of general practice (for example, time commitments, workload, nature of contribution)?*
- *In those circumstances where the representatives are GPs, are they representing the Division, or themselves as individuals? If the former, what arrangements are made for reporting back to the Division?*
- *Are there agreed processes for PCP contact with local GPs regarding GP participation in such groups? (This would usually be through Divisions.)*

and professional cultures. In short, expect a lot of frustration. It is important to ensure that decisions are based on an objective analysis of the data rather than agency self-interest.

Our experience in this reform process has been rewarding despite the difficulties. There has been a spirit of collaboration, a willingness to embrace change – and scepticism of government bureaucracy that GPs would find appealing.

Central Bayside Division of General Practice

Case Study 2: The Challenges of Partnership

Whitehorse Division is linked with two PCPs. As the style of these PCPs varies, there are benefits to development and standardisation from knowing what is happening in both.

Ensuring that a Division representative is available at PCP alliance meetings and any sub-committees or working groups is essential to raise awareness of the role of general practice in the primary and community support health system.

GP attendance is valuable in meetings where specific elements of communication, referral assessment, and disease management are being developed.

Regular communication with local GPs regarding what PCPs are offering for improved communication and understanding of roles and responsibilities is also helpful.

While the PCP work is essential for an improved system of health service delivery, it is very time-consuming and demanding on all participants. It can also be very challenging for some agencies.

Whitehorse Division of General Practice

Working with General Practitioners

Should Representatives on PCP Working Groups be GPs or Division Staff?

The decision as to who should be involved in particular PCP working groups at any given time should be based on mutual agreement and discussion at the local level.

In general, where issues relate to governance, broad system reform or information technology, Division staff are likely to have the appropriate expertise.

GPs major contribution is generally likely to be related to their clinical expertise, for example, in the development of shared management protocols for patient care.

A survey conducted by GPDV in early 2001 indicated that a similar number of GPs and Division staff were participating in PCPs. Divisions vary in regard to their preference for GP participation in, and representation on, groups dealing with non-clinical activities.

Divisions aim to maximise the ownership and commitment that GPs have to the changes that the Division negotiates or promotes, while at the same time minimising the demands on GPs' time and utilising their skills and expertise effectively.

When GP involvement is appropriate, Divisions provide the best method of identifying those with the relevant expertise and skills to make a valuable contribution. Divisions will also be able to provide practical advice regarding mutually acceptable arrangements for GP participation, including meeting times and payments for GPs' time.

Initially GP engagement is likely to primarily involve Division staff and a small number of GPs.

Over time, PCPs should start involving more GPs in PCP processes as they develop service coordination strategies, such as a local service directory, that will provide a tangible benefit to GPs in their practice (See *Working Together to Improve Local Service Coordination*, pages 17–23, and *Working Together to Improve Local Service Planning*, pages 24–26).

Recognising Differences

It is important to recognise cultural and professional differences, and work towards addressing them – or work with them, recognising appropriate complementary roles, and recognising time constraints.

General practitioners and primary care service agencies share many interests and concerns and are usually keen to benefit from each other's expertise. However, they may approach issues from different perspectives arising from their different roles, structures and cultures. The use of technical terms may differ (see Hint Box 5).

For example, the Primary Care Partnership strategy aims to build a population health and well-being approach into primary care, whereas GPs' main focus is usually on individual patient care. However, GPs do undertake many population health activities, such as immunisation, screening, health and lifestyle advice and counselling.

Both GPs and others may have strong views as to their relative importance or effectiveness in the health care system. Experience shows that as professional interaction increases, so does understanding and appreciation of the other's role. Many initiatives linked to the PCP strategy are designed to help this occur.

For example, many state-funded primary care services have eligibility criteria for access to services, and may need to determine priorities regarding service access. GPs referring patients to such services need to be aware of this. The local primary care service directory, to be developed by Partnerships, will inform GPs of such matters.

General Practice as a Small Business

Most general practices operate as small businesses, earning most of their income on a fee-for-service basis. Their decision to participate in PCP activities and processes will tend to be primarily clinically driven, based on a wish for better patient outcomes and improved service delivery. Most will adopt new approaches (for example, tools, protocols, service directory) only when there is a clear benefit to their practice and their patients.

HINTS 5

Same Words, Different Meanings

We tend to assume that others attribute the same meanings to words as we do. This is often not the case and can be the source of misunderstanding and even conflict.

An important task for general practitioners and other primary care practitioners is to identify differences and work towards a shared understanding.

In most cases these differences need to be clarified when GPs and other practitioners work together in supporting and treating a patient. Some key terms, which may arise, include:

- Initial contact
- Comprehensive assessment
- Screening
- Care planning
- Risk assessment
- Case management
- Initial needs identification
- Care coordination
- Needs assessment
- Case conference
- Comprehensive assessment
- Primary care
- Medical assessment
- Patient/Consumer/Client
- Service specific assessment
- Self-management
- Specialist assessment
- Disease management
- Functional assessment
- Shared care
- Bio-psychological assessment
- Home help

*Definitions of many of these terms can be found in the document, *Better Access To Services: A Policy and Operational Framework*. (Appendix One: Common Terms and Acronyms).*

HINTS 6

Arranging Meetings with GP Participation

Where GPs are invited to attend meeting, they may find it difficult to attend during normal business hours:

- GPs may prefer to attend meetings at either end of the day, or around lunchtime.
- Try linking into an existing meeting.
- Avoid Mondays and Fridays when there tends to be high demand from patients.
- Consider teleconferencing, particularly in rural areas.

HINTS 7

Communicating with GPs

Consider the following points when communicating with GPs:

- Practice managers can be an effective first point of contact.
- GPs place an absolute premium on time: in meetings, including case conferences, get straight to the point.
- Organise a mutually convenient, possibly regular, time to involve GPs in meetings, care plans and case conferences.
- Provide sufficient notice.
- Link into current meetings, if possible, for example, activities hosted by Divisions.
- Many GPs are already engaged in PCPs, and highly motivated. Consider using them as 'champions' within the local general practice community.
- Vary messages according to whether GPs are in solo or group practice, or according to their attitudes to integration with other primary care service.
- Consider conducting short, 10-15 minute, and face-to-face meetings with individual GPs at their practice, highlighting practical benefits to their patients and practices. This is a familiar method to GPs, and can be very effective. It could be used with those GPs who are most likely to be receptive.

It is important to recognise that their resources are likely to be limited, especially in small practices and in rural areas.

There is currently a trend towards corporatisation of general practice. Large corporate entities are purchasing general practices and co-locating GPs into purpose-built clinics. This adds a new layer of complexity in terms of the organisational environment in which GPs work.

Communicating with General Practitioners

The strategies outlined in Hint Boxes 6, 7 and 8 should help engage GPs in PCP activities, such as working groups, and in multi-disciplinary care planning or case conferencing organised by other primary care providers.

Funding GP Participation

Each PCP has been resourced to support the process of formally engaging providers, consumers, carers and the community in the development of sustainable and democratic alliances. However, the Department has not prescribed how this is to be achieved, nor determined a policy on payment to individual providers to reimburse participation.

Where GPs wish to be reimbursed for time spent on PCP activities, Partnerships should seek to come to a mutually acceptable arrangement with Divisions.

A major aim of Commonwealth Government funding for Divisions is improved links between general practice and other primary care providers. Involvement in PCPs may help Divisions achieve the objectives specified in their annual Business Plans and triennial Strategic Plans.

Although existing Strategic Plans may not have funds allocated for PCP activities, now that PCPs have commenced operation, Divisions have the flexibility to vary their Business Plans to include funding to support Division and GP involvement in PCP activities. In some cases, Divisions have already indicated that their next Business and/or Strategic Plans will include funding to reflect a commitment to GP involvement in Primary Care Partnerships activities and processes.

The Department of Human Services has allocated funds to support the participation of GP Trainers in proposed workshops to assist practitioners, including GPs and other primary care practitioners, in utilising the Enhanced Primary Care MBS items (See page 23.) The Department also funds GPDV to employ a Primary Care Consultant who is a resource for PCPs on general practice issues.

Hint Box 9 outlines some issues to be addressed when considering payment of GPs for participation in PCP activities.

How Have GPs Been Involved in PCP Activities to Date?

GPs are already involved in a range of ways in PCP activities, for example:

- Through their Division:
 - Participating on PCP management committees and working groups.
 - Involvement in developing a service directory.
 - Expanding existing referral protocols to all GPs and agencies.
 - Developing an email-based referral system.
 - Involvement in planning and service coordination.
 - Participating in GP focus groups.
 - Developing the *PCP–GP Engagement Strategy*.
- Contacting primary care agencies to support the development of a care plan, under the EPC MBS items, for individual patients.
- Participating in care plans and case conferences organised by other providers.
- Improving the interface between general practice and other primary care providers, such as immunisation programs and activities that are planned through local committees.

Other specific examples are outlined in the case studies in this Guide and in the Primary Health Knowledge Base.

Working Together to Improve Local Service Coordination

Once PCP processes and practices have developed to the point where tangible benefits can be offered to local GPs, the second key stage of PCP–GP Engagement should commence. The focus of engagement should shift to individual general practitioners within the PCP catchment.

Increasing numbers of GPs are likely to adopt changes in their practice as they see direct benefits for their patients, but this will take time.

The remainder of this Guide surveys a number of specific PCP initiatives which aim to deliver those tangible benefits to GPs and their patients. These include:

- Improved service coordination through the provision of local service information, information management, and better access to services (discussed in this section).
- Improved local service planning through integrated service planning, health promotion and disease management (see pages 24–26).

HINTS 8

Communicating with GPs on the Telephone

Telephone calls are a very convenient and efficient way of communicating with GPs. If you use the telephone, it is worth bearing the following points in mind:

- *Keep conversations brief.*
- *Identify the issue briefly.*
- *Identify what you are requesting the GP to do.*
- *'Faxback' is commonly used with GPs: consider faxing a clear, brief message to the general practice, indicating that you would like to speak with the GP about the issue. Follow the fax immediately with a telephone call to the practice staff to (1) ensure they received the fax and (2) to ascertain when the GP is likely to be available.*
- *Some GPs will take calls while consulting with patients, others prefer to call back.*

HINTS 9

Payment of GPs

When determining issues around payment of GPs for participation in PCP activities PCPs and Divisions could consider the following:

- *Can part of the PCPs funds be used to support GP involvement?*
- *Does the Division have funds to support GP involvement?*
- *Where more than one Division relate to the same PCP, could one represent the others?*
- *Is a GP the most appropriate representative, or would Division staff be more appropriate?*
- *If the Division cannot find funds in their current budget, is there an opportunity to negotiate on this matter in relation to future budgets?*
- *Are meetings set up at a time and location, which minimises costs?*
- *Could teleconferences or videoconferences be a more efficient use of time?*
- *Is there a clear, shared understanding of the outcomes and contribution expected from GPs receiving payment from PCPs?*
- *Is there clarity regarding the pay structure for GP participation? Divisions will have a set of pay rates, with different rates depending on whether the meeting is in clinical hours or out of hours.*

Information about Local Services: Local Primary Care Service Directory

Research shows that a major barrier to GPs engaging with other elements of the primary health and community support sector is their lack of knowledge of relevant services. The local primary care service directory, to be developed and maintained by each PCP, will help address this.

At a recent forum a GP described an experience of phoning 20 different services over two weeks seeking an appropriate referral. While he was given plenty of advice about where to try next, no real assistance was provided.

The implementation of the BATS strategy and the local primary care service directory should avoid this type of situation; providing an information and referral source, and helping GPs to increase their knowledge of other primary care service providers. More importantly, a local service coordination model will ensure the PCP provides a single point of coordination for GPs.

The core information in local service directories (such as contact details, opening hours, eligibility criteria) will be the same across PCPs. Each PCP will also have the flexibility to add local level information to their own service directory, as they deem appropriate.

The use of a standard dataset for PCPs will make it easier for GPs working across PCP boundaries. It also means that information on local PCP service directories can be incorporated into a statewide service directory (through the Better Health Channel) and will be consistent with Commonwealth data such as Carelink Centres. This aims to avoid duplication and inconsistency of information.

Some Divisions of General Practice have already developed service directories. They will be able to contribute to PCP local service directory development in terms of hosting systems, software development, support and content.

The Department's *Services Directory Discussion Paper* contains more information.

Information Management

Divisions of General Practice have substantial knowledge and experience to assist Partnerships in the development of their information management strategy.

The Department's *Information Management Strategic Directions Paper* outlines how Primary Care Partnerships will develop an information management strategic plan that addresses the information needs of the primary care providers, including:

- Client information management, to support better access to services.
- Service information management, to support consumer access, navigation and referral.
- Professional decision support information.

Divisions will be able to provide valuable assistance to this work, resulting in an information management strategy which will enhance integration between all providers of primary care, including GPs.

Commonwealth initiatives have led to a major increase in general practice electronic communication capacity for patient registration, patient billing, prescribing and clinical records. Most prescriptions are now computer-generated. The General Practice Computing Group has provided coordination at a national level and has led the way in the developments of standards.

Better Access To Services (BATS) Framework

A major component of GP engagement in PCPs will be through the Better Access To Services framework. Effective GP engagement will be a key success factor for the framework.

The document *Better Access To Services: A Policy and Operational Framework* outlines a strategy to support improving practice within and linkages between current assessment processes, including the establishment of consistent processes for needs identification and care planning.

The BATS framework aims to deliver a number of tangible benefits to GPs:

- The basis for a common statewide referral platform through the Initial Needs Identification Tool and Care Planning Tool.
- Timely feedback on referrals.
- Clearly articulated models for service coordination with clear and defined roles and responsibilities for each provider. A single point of access to the broad range of services.

Divisions should be involved in developing the BATS model at the local level, involving GPs where appropriate. The next stage, implementation, needs to involve individual GPs.

Using the Enhanced Primary Care MBS Items to Implement the BATS Framework

The Enhanced Primary Care Package MBS items provide a crucial means for GPs to develop closer working relationships with other primary care providers. In combination with the PCP structure, the items provide an ideal basis for the enhancement of multi-disciplinary approaches.

Partnerships will be able to develop BATS protocols which incorporate GP involvement through the EPC MBS items.

In November 1999 the Commonwealth Government introduced several new MBS items as part of the Enhanced Primary Care (EPC) Package. These items provide Medicare rebates, for the first time, for general practitioners to work with other providers in planning multi-disciplinary care for people with chronic and complex needs. There are specific requirements and circumstances that must be met before a GP will be eligible to claim a Medicare rebate for these services.

HINTS 10

GP Involvement in Better Access To Services

Partnerships can actively encourage GP involvement in BATS by:

- *Involving Divisions on PCP sub-committee or working party for BATS and IM.*
- *Consulting GPs through Divisions in the development of tools and other better access models and projects. Developing processes and protocols which are inclusive of GPs and which build on the Enhanced Primary Care MBS items (see Hint Box 11), for example:*
 - *Conducting Initial Needs Identification using the Partnership's tool and in accordance with its protocols.*
 - *Care planning and case conferencing utilising the relevant MBS items and the Partnership's care planning tool.*
 - *Undertaking Comprehensive Assessment consistent with the protocols of the Partnership for older people eligible under the Health Assessment MBS item, or for others through a long consultation.*
- *Forwarding necessary information about the referred patient to other providers, consistent with agreed protocols.*
- *Giving GPs access to Partnerships' service directory. This will assist GPs by providing knowledge of local service providers.*
- *Identifying, through Divisions, local GPs interested in participating as 'partner providers' in assessment, care coordination or case management.*
- *Negotiating clear roles and responsibilities for shared care arrangements with any participating general practitioners.*
- *Providing information and training to general practitioners through Divisions about the PCP's assessment protocols and practice.*
- *Including formal processes for feedback between GPs and other providers about treatment or care resulting from referrals in either direction.*
- *Building on relevant good practices that aim at enhancing service quality for shared clients between GPs and other services in the Partnership.*

The EPC items provide payment to GPs for:

- Health assessments of older persons.
- Preparation of or contribution to a multi-disciplinary care plan (in the community or on discharge) for people of any age with complex health conditions.
- Organising or participation in multi-disciplinary case conferencing (in the community or in preparation for discharge) for people of any age with complex health conditions.

A detailed summary of these items is found in Appendix 1.

Further information on the EPC MBS Items should be sought from Divisions.

The EPC items can be used to foster collaboration between PCPs and GPs and to ensure GP participation in care planning and case conferencing. This also applies to GPs participating in Integrated Disease Management programs.

The table opposite sets out the relationship between the service coordination elements of the BATS framework, the potential GP roles, and the potential means of MBS remuneration for GPs. Partnerships could use the table to assist them in developing models and processes for service coordination between general practitioners and other providers.

Engaging GPs in Service Coordination: Remuneration and Tools

Service Coordination Element	Potential GP Role	GP Remuneration through MBS	PCP Tools and Processes
Initial Contact	<ul style="list-style-type: none"> Refer patients to PCP Initial Contact point Use PCP Initial Contact arrangements as entry point Act as an Initial Contact point for PCP 	<ul style="list-style-type: none"> As part of Level B (Standard), Level C (Long) or Level D (Prolonged) Consultation 	<ul style="list-style-type: none"> Service Directory Coordinated referral and feedback
Initial Needs Identification (INI)	<ul style="list-style-type: none"> Refer patients to PCP INI process and pass client information to PCP provider to use in INI process Conduct INI for the PCP 	<ul style="list-style-type: none"> Level B (Standard), Level C (Long) or Level D (Prolonged) Consultation 	<ul style="list-style-type: none"> Initial Needs Identification Tool (Statewide) Service Directory Coordinated referral and feedback
Service Specific Assessment	<ul style="list-style-type: none"> Undertake medical assessment, diagnosis and treatment Build on information gathered via Initial Contact and Initial Needs Identification Referral to other service agencies such as local government, allied health staff and nursing services, consistent with PCP arrangements 	<ul style="list-style-type: none"> Level B (Standard), Level C (Long) or Level D (Prolonged) Consultation 	<ul style="list-style-type: none"> Service Directory Coordinated referral and feedback
Specialist Assessment	<ul style="list-style-type: none"> Undertake medical assessment, diagnosis and treatment in specialist areas of sport, travel, reproductive health where required Build on information gathered via Initial Contact and Initial Needs Identification Referral to other specialist service providers such as mental health, sexual assault and drug treatment, consistent with PCP arrangements 	<ul style="list-style-type: none"> Level B (Standard), Level C (Long) or Level D (Prolonged) Consultation 	<ul style="list-style-type: none"> Service Directory Coordinated referral and feedback
Comprehensive Assessment	<ul style="list-style-type: none"> Refer patients to PCP provider for comprehensive assessment Build on information gathered via Initial Contact and Initial Needs Identification Share record of EPC Health Assessment with PCP providers Sub-contract Health Assessment to PCP provider Conduct Comprehensive Assessment consistent with PCP arrangements 	<ul style="list-style-type: none"> EPC Health Assessment Level C (Long) or Level D (Prolonged) Consultation <i>NOTE: Level C or D Consultations can be used for Comprehensive Assessments when a patient is not eligible for an EPC Health Assessment.</i> 	<ul style="list-style-type: none"> Comprehensive Assessment Tool (PCP) Service Directory Coordinated referral and feedback
Care Planning	<ul style="list-style-type: none"> Refer patients to PCP provider for care planning arrangements Develop care plan with PCP provider Build on information gathered via Initial Contact and Initial Needs Identification Contribute to a care planning prepared by a PCP provider Undertake care planning consistent with PCP arrangements Conduct or participate in case conferences with PCP providers as part of preparation of care plan Discharge Planning 	<ul style="list-style-type: none"> EPC Care Plan EPC Case Conference Level B (Standard), Level C (Long) or Level D (Prolonged) Consultation 	<ul style="list-style-type: none"> Care Planning Tool (Statewide) Service Directory Coordinated referral and feedback

Notes:

MBS Consultation items are broken down into four levels for Vocationally Registered GPs:

Level A: less than 5 minutes. For very brief encounters, not for patients with complex problems requiring service coordination.

Level B: 5 to 20 minutes. A standard consultation.

Level C: 20 to 40 minutes. A long consultation for patients with more complex problems.

Level D: longer than 40 minutes. For patients with multi-system problems, psychosocial problems, requiring in depth attention.

(For the minority of GPs who are not Vocationally Registered, the corresponding consultations are: Brief, Standard, Long and Prolonged.)

It is important to note that several of the Service Coordination elements can occur simultaneously within the one consultation (for example, Initial Contact, Initial Needs Identification and Service Specific or Specialist Assessment).

Note that when a GP uses the regular consultation items, they need to see the patient. When using the EPC Health Assessment Items the assessment can be delegated to another health professional e.g. nurse (see Appendix 1). GPs can do health assessments on younger people with complex conditions, and claim Medicare rebates for standard, long or prolonged consultations. However, the Medicare rebates for these consultations are considerably lower than for the EPC Health Assessment items.

HINTS 11

Making the EPC MBS Items Work for You

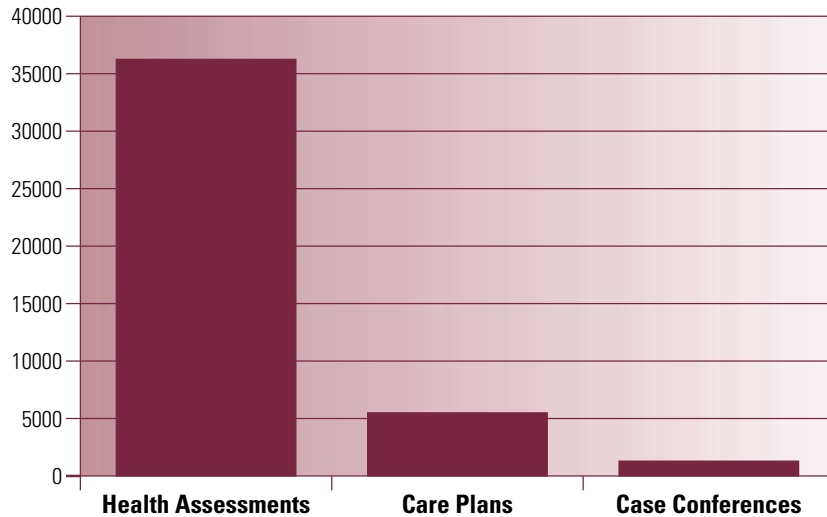
It is very important to make sure that what a primary care provider refers to as 'care planning' and 'case conferencing' correspond to what the EPC MBS items define as 'care planning' and 'case conferencing'. Once this is ensured, the EPC MBS items will provide a basis for working together.

While the items remove the financial disincentive to GPs working in multi-disciplinary teams, they do not on their own facilitate practice change to make this happen.

- *Case conferences are currently common practice for many primary care providers, but not for many GPs.*
- *Many GPs may be willing to participate in case conferences, but less willing to initiate them.*
- *When you encounter eligible consumers who would benefit from care planning, a case conference or health assessment, do not hesitate to contact their GP.*
- *Where case conferences are already occurring, invite the person's GP to participate. This may be easier where cases conferences occur at a regular time, so that GPs can plan to be available at that time.*
- *GPs may attend cases conferences in person or by telephone or video link.*
- *Providers such as ACAS could consider conveying to GPs that they would find a health assessment valuable when there is a GP referral to them.*
- *Discuss with relevant Division(s) the extent of take up of the care planning and case conferencing EPC items within their area, and how to approach practices (for example, focussing on those GPs who are using the item to some extent).*
- *When discussing potential arrangements for case conferencing, consider initially contacting practice managers.*

To date, there has been a reasonably high uptake of the Health Assessment item, with around 36,200 performed in Victoria. However, there have been far fewer care plans completed (around 5,500) and even fewer case conferences involving GPs (around 1,300).

Total Takeup Rate in Victoria of Health Assessments, Care Plans and Case Conferences to March 2001



Source: Health Insurance Commission (http://www.hic.gov.au/statistics/dyn_mbs/forms/mbs_tab4.shtml)

While the lower uptake of care planning and case conferencing items is partly due to the small eligible population, there are also greater complexities in the using them. GPs need the infrastructure, time, knowledge of other services, and experience or perceived skills. Other practitioners, who may be more experienced in organising care plans and case conferences should be aware that they can initiate them, and the GP can now be reimbursed through MBS for participation.

Divisions of General Practice are actively engaged in the provision of information and training sessions on the EPC MBS Items for GPs. A number of Divisions are including the wider primary care sector in these sessions. GPDV is providing education and training for a GP in each Division to train their peers at the local level, around the use of these Items (see Case Studies 3 and 4).

The Department of Human Services is currently working with GPDV to ensure that GP education and training in the EPC MBS items is complemented by information for the wider primary care sector. The Department will conduct a series of local workshops and other support strategies in 2001 to assist practitioners, including GPs and other primary care practitioners, in utilising the EPC MBS items. These activities will build on what has already been done locally.

The workshops and other activities will provide State-funded primary care providers with information about the items and how they can use them to support the BATS framework. They will also be designed to practically address some of the barriers identified in this Guide to the participation of GPs in a multi-disciplinary approach, in the context of the specific needs of each Partnership.

Case Study 3: Introducing GPs to Care Planning

Central Bayside Division of General Practice has, through a number of projects, identified barriers, enablers and determining factors that influence GP uptake of multi-disciplinary care planning. These include:

- The fee for service funding system
- Local arrangements for collaboration
- Capacity to manage/ time
- Practice infrastructure (for example, recall systems)
- Local knowledge of services
- GP interest and experience in the area
- Patient profile in the practice
- The GP's knowledge of the new MBS items

Completing a care plan or assessment takes 45 minutes to 1 hour. The ability to spend this amount of time requires an overall change in GP traditional practice style. This involves more than just changing the appointment system. It requires moving from 'reactive' problem solving to 'pro-active' planning, and more extensive collaboration with other primary care providers. Establishing such lasting change takes time.

The experience from the Division's projects also suggests that GPs do see the benefits in a more longitudinal approach to care planning and that documenting the plan has benefits for planning and patient care.

In recognition of the importance of multi-disciplinary care planning Central Bayside Division has created a care planning staff position that incorporates involvement with PCPs.

Central Bayside Division of General Practice

Case Study 4: Division Workshops on the EPC MBS Items

The North East Victorian Division of General Practice has conducted two workshops around the Enhanced Primary Care MBS items.

Ten GPs and 30 representatives of other organisations, including hospitals, Community Health, Local Government, the Department of Human Services Regional Office and Self-Help Groups, attended the first workshop. Many were managers in their organisations. GPDV facilitated the three-hour meeting. The workshop was mainly information sharing, GP training to use the items, and implications for other agencies. Participants generated a list of issues and barriers for other organisations.

A follow-up workshop targeted practitioners. It included a presentation by a GP on his experience with care plans and case conferences, how they have worked and the barriers. The workshop identified strategies for working together and overcoming the barriers.

North East Victoria Division of General Practice

Working Together to Improve Local Service Planning

Integrated Service Planning

Divisions of General Practice can make a valuable contribution to Community Health Plans through their work on Strategic and Business Plans and their knowledge of general practice and population health issues.

As part of their Community Health Plan, each Partnership is developing an Integrated Service Plan. These will identify the priority health and well-being needs of the community-based on a range of information such as population data, service information, and consumer, carer and community participation. The agreed priorities will be the basis for ongoing collaborative work.

In developing their Integrated Service Plan, Partnerships are encouraged to build on and link with other relevant needs analyses and plans in the area.

Divisions' strategic plans include:

- An analysis of the community's health needs using sources such as demographic information, GP information and statistics, and consumer involvement.
- The specific activities Divisions will undertake relating to population health.
- The identification of unmet needs and service access problems, and often identification of specialist medical services available or needed.

Linking and rationalising planning processes will build a more coordinated approach across the service system to addressing community needs. This will help to achieve the goals of the PCP strategy and help Divisions of General Practice implement their Strategic Plans.

Further details can be found in *Integrated Service Planning: Interim Guidelines*.

Health Promotion

Primary Care Partnerships provide an excellent opportunity to improve coordination between the health promotion efforts of GPs and Divisions with those of other primary care providers. Their engagement in the development of PCP health promotion strategies is critical.

The Department is funding Partnerships to plan integrated health promotion activities based on collaboration between agencies and with other sectors. It has developed the *Primary Care Partnerships Draft Health Promotion Guidelines* and the *Health Promotion Funding Guidelines for Primary Care Partnerships* documents to assist PCPs develop their health promotion strategies as part of their community health plans. A number of workforce development activities will also be provided to support integrated health promotion practice.

Divisions have undertaken many health promotion projects. Evaluation of these projects has shown that:

- GPs can have a significant role in health promotion, and will readily participate.
- Divisions have a vital role in supporting GPs in this.

All Divisions address population health through their Strategic and Business Plans, focussing on national goals and targets. The RACGP has produced guidelines on *Prevention and Health Promotion in General Practice*.

General practitioners make a major contribution to health promotion and disease prevention through attention to risk factors (such as smoking, diet, alcohol intake and exercise), adherence to recommended screening and immunisation protocols for various risk groups and provision of health promotion advice and material to patients. GPs understand that consideration of disease prevention, health education and health promotion should form part of every clinical consultation.

Disease Management

Four Primary Care Partnerships have been selected as pilots to develop integrated disease management strategies. These will aim to improve the health and well-being and reduce preventable admissions to hospital for people with chronic illness. General practitioner involvement will be critical to the success of these projects.

In order to improve the likelihood that medical professionals will be involved integrated disease management in a meaningful way, Primary Care Partnerships should consider:

- involving GPs early in program development to promote 'ownership' and commitment.
- informing GPs about the potential benefits of disease management programs for their patients, and to themselves, in having support from a multi-disciplinary team.
- exploring with GPs how they can use the EPC MBS items for care planning to support their participation in the pilot projects.

Linking GP engagement with integrated disease management projects should also be considered in the development of BATS/IM strategies, as these components are all inter-related.

Further details can be found in *Integrated Disease Management: Interim Policy Directions and Guidelines*.

Appendix 1: Enhanced Primary Care

Medicare Benefits Schedule Items

Annual Health Assessments

Eligibility: Patients aged 75 years and over (55 years and over for Aboriginal and Torres Strait Islander people) living in the community (not for hospital in-patients or nursing home residents).

A health assessment is the assessment of the patient's health and physical, psychological and social function and whether preventative health care and education should be considered. It includes:

- Measurement of blood pressure, pulse rate and rhythm.
- Medication review, (inc. OTC's, prescriptions from others).
- Continence assessment.
- Immunisation status (influenza, tetanus & pneumococcus).
- Physical function (including ability to transfer between bed, chair and toilet, bathe, dress, shop, etc.) and whether or not the patient has had a fall in the last three months.
- Psychological function, including cognition & mood (which should be measured with a recognised tool).
- Social function (including availability and adequacy of paid and unpaid help), and if the patient is caring for another person.

Medical literature and consensus medical opinion support the following additional components: multi-system review, fitness to drive, hearing, vision, oral health, diet and nutritional status, smoking, foot care, sleep, need for community services, home safety, cardio-vascular risk factors and alcohol use.

The information collection component may be rendered by a nurse or another assistant in accordance with accepted medical practice, acting under supervision. The other components must include a personal attendance by a medical practitioner.

The assessment should not take the form of a health screening service, and generally should not include diagnostic imaging or pathology services, but they may be ordered if clinically relevant.

The assessment must also include keeping a written record of the assessment, signed by the patient, and provision of a written report to the patient with recommendations about any matters covered.

Care Plans

Eligibility: Patients with a medical condition that has been or is likely to be present for at least six months or that is terminal. Care plans may be conducted in the community, on discharge (GPs may contribute to care plans for private or public patients on discharge, but can initiate care plans of private patients only), or in a residential Aged Care Facility (only for contribution to a care plan review).

A multi-disciplinary care plan or multi-disciplinary discharge care plan is a **written plan** describing:

- Assessment of health care needs.
- Assessment of treatment, health services, health care, and community services the patient is likely to need.
- Arrangement for provision of those services and treatment.
- Management goals with which the patient agrees.
- Arrangements to review the plan by a specified date.

Preparation must include:

- Discussing the plan with the patient, including who will be in the team.
- Recording the plan and the patient's agreement.
- Providing copies of relevant parts of the plan to those who will provide services or treatment under the plan.
- Providing a copy of the plan, and each team member's contribution, to the patient.
- Providing copy to Department of Veterans' Affairs, if appropriate.

A care plan team includes a medical practitioner and **at least two other contributing members***, each providing a different kind of care (one may be a medical practitioner).

While the patient must be present for a needs assessment by the medical practitioner to develop the plan, the patient need not be present while documentation is prepared and members of the team are contacted for input. **Members of the team do not have to be communicating at the one time** (as they do for a *case conference*).

Review must include review of previous plans, record of the patient's agreement to review, provision of revised plans to appropriate participants, and provision of copy to DVA, if applicable.

If another person is preparing the plan, a **contribution to a care plan or to a care plan review** would include preparation of the parts of the plan relevant to the treatment provided by the medical practitioner. It is expected that this would take at least 10 minutes and may be made face-to-face, by telephone, fax, email, or written correspondence. The medical practitioner contributing should request a copy of the plan, or the part of the plan applicable to services he/she will provide. In preparing a contribution the medical practitioner should inform the patient that their medical history, diagnosis and care preferences will be discussed with other providers, and provide an opportunity for them to specify what may be conveyed or withheld from others.

Patients should be informed that they will incur a charge for this service, for which a Medicare rebate will be payable.

* *May include Aboriginal health care workers, audiologists, dental therapists, dietitians, occupational therapists, optometrists, orthoptists or prosthetists, pharmacists, physiotherapists, podiatrists, psychologists, registered nurses, social workers, speech pathologists, Home and Community Care providers, education providers, 'meals-on-wheels', personal care workers, etc. The patient and his/her personal carer are not included in the minimum of three.*

Case Conferences

Eligibility: Patients with a medical condition that has been or is likely to be present for at least six months or that is terminal. Case conferences may be conducted in the community, on discharge, or in an Aged Care Facility.

A case conference is a **discussion** by which a multi-disciplinary team carries out the following activities:

- Discuss the patient's history.
- Identify the patient's multi-disciplinary care needs.
- Identify outcomes to be achieved by members of the case conference team giving care to the patient.
- Identify tasks that need to be undertaken in order to achieve outcomes and allocate tasks to team members.
- Assess whether previously identified outcomes have been achieved.

A case conferencing team includes a medical practitioner **and at least two other contributing members***, each of whom provides a different kind of care (one may be a medical practitioner providing a different kind of care).

The minimum three care providers **must be communicating at the one time for the whole of the conference**, either face-to-face, by telephone, video link, or a combination.

To **organise and coordinate** the case conference involves explaining to the patient the nature of the conference, obtaining and recording consent, recording day, times, names of participants, and all matters mentioned, and providing a summary to patient and team members.

When **participating** in a case conference organised by another, the medical practitioner should inform the patient that their medical history, diagnosis and care preferences will be discussed with other providers, and provide an opportunity for them to specify what may be conveyed or withheld. Patients should be informed that they will incur a charge for this service, for which a Medicare rebate will be payable.

It is expected that a patient would **not require more than five case conferences in a 12-month period**.

* *May include Aboriginal health care workers, audiologists, dental therapists, dietitians, occupational therapists, optometrists, orthoptists or prosthetists, pharmacists, physiotherapists, podiatrists, psychologists, registered nurses, social workers, speech pathologists, Home and Community Care providers, education providers, 'meals-on-wheels', personal care workers, etc. The patient and his/her personal carer are not included in the minimum of three.*

Appendix 2: Maps – Divisions of General Practice and Primary Care Partnerships

The map opposite shows the geographical relationship between Primary Care Partnership catchments and boundaries for Divisions of General Practice.

The numbers for the Divisions of General Practice on the map correspond to the following names:

- 301 – Melbourne Division of General Practice
- 302 – North East Valley Division of General Practice
- 303 – Inner Eastern Melbourne Division of General Practice
- 304 – Southcity GP Services
- 305 – Westgate Division of General Practice
- 306 – Western Melbourne Division of General Practice
- 307 – North West Melbourne Division of General Practice
- 308 – Northern Melbourne Division of General Practice
- 310 – Whitehorse Division of General Practice
- 311 – Greater South Eastern Division of General Practice
- 312 – Monash Division of General Practice
- 313 – Central Bayside Division of General Practice
- 314 – Knox Division of General Practice
- 315 – Dandenong Division of General Practice
- 316 – Mornington Peninsula Division of General Practice
- 317 – General Practitioners Association of Geelong
- 318 – Central Highlands Division of General Practice
- 319 – North East Victorian Division of General Practice
- 320 – Lilydale and Yarra Valley Division of General Practice
- 321 – Sherbrooke and Pakenham Division of General Practice
- 322 – South Gippsland Division of General Practice
- 323 – Central West Gippsland Division of General Practice
- 324 – Otway Division of General Practice
- 325 – Ballarat and District Division of General Practice
- 326 – Bendigo and District Division of General Practice
- 327 – Goulburn Valley Division of General Practice
- 328 – East Gippsland Division of General Practice
- 329 – Border Division of General Practice
- 330 – West Victoria Division of General Practice
- 331 – Murray Plains Division of General Practice
- 332 – Mallee Division of General Practice

Primary Care Partnerships with Divisions of General Practice

Key:

BOUNDARY LINES:
Primary Care Partnerships

SHADED AREAS:
Divisions of General Practice



Appendix 3: References and Websites

Listed below are publications and websites referred to in this Guide, or drawn on during its preparation:

Department of Human Services

Useful references and resources can be found on the Primary Care Partnerships page of the Department of Human Services' website at, www.dhs.vic.gov.au/acmh/ph/pcp/index.htm, and its *Primary Health Knowledge Base* (PHKB), <http://www.dhs.vic.gov.au/phkb>.

The following documents can be found on the PHKB:

Going Forward

Services Directory Discussion Paper

Information Management Strategic Directions Paper

Integrated Service Planning: Interim Guidelines

Primary Care Partnerships Draft Health Promotion Guidelines

Health Promotion Funding Guidelines for Primary Care Partnerships

Integrated Disease Management: Interim Policy Directions and Guidelines

Better Access To Services: A Policy and Operational Framework

Other Publications

Community Health and General Practitioners: Partnerships in Care,

http://www.dhs.vic.gov.au/acmh/ph/publications/downloads/gp/gp_doc.pdf

Prevention and Health Promotion in General Practice (RACGP), <http://www.racgp.org.au/>

Walker, R., *Collaboration & Alliances: A Review for Vic Health, (2000)*, Unpublished paper, National Stroke Foundation.

Victorian Healthcare Association Ltd, www.vha.org.au, *Backgrounder, November 1999, Number 3, Working Effectively with General Practitioners,*

Commonwealth Department of Health and Aged Care, *The Australian Coordinated Care Trials Interim National Evaluation*, September 1999.

Commonwealth Department of Health and Aged Care, *General Practice in Australia, 2000.*

Websites

Commonwealth Department of Health and Aged Care, <http://www.health.gov.au/>

Consumers' Health Forum, <http://www.chf.org.au/>

Enhanced Primary Care, <http://www.health.gov.au/hsdd/gp/epc>.

General Practice Divisions Victoria, <http://www.gpdv.com.au>

Health Insurance Commission, <http://www.hic.gov.au/statistics/index.htm>

Royal Australian College of General Practitioners, <http://www.racp.org.au/>

Victorian Healthcare Association, <http://www.vha.org.au/>

