Understanding and working with general practice

Agency for Clinical Innovation

The Agency for Clinical Innovation (ACI) works with clinicians, consumers and managers to design and promote better healthcare for NSW. It does this by:

- **service redesign and evaluation** – applying redesign methodology to assist healthcare providers and consumers to review and improve the quality, effectiveness and efficiency of services.
- **specialist advice on healthcare innovation** – advising on the development, evaluation and adoption of healthcare innovations from optimal use through to disinvestment.
- **initiatives including guidelines and models of care** – developing a range of evidence-based healthcare improvement initiatives to benefit the NSW health system.
- **implementation support** – working with ACI Networks, consumers and healthcare providers to assist delivery of healthcare innovations into practice across metropolitan and rural NSW.
- **knowledge sharing** – partnering with healthcare providers to support collaboration, learning capability and knowledge sharing on healthcare innovation and improvement.
- **continuous capability building** – working with healthcare providers to build capability in redesign, project management and change management through the Centre for Healthcare Redesign.

ACI Clinical Networks, Taskforces and Institutes provide a unique forum for people to collaborate across clinical specialities and regional and service boundaries to develop successful healthcare innovations.

A priority for the ACI is identifying unwarranted variation in clinical practice and working in partnership with healthcare providers to develop mechanisms to improve clinical practice and patient care.

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Networking Health NSW was formerly known as General Practice NSW (GPNSW) and has built on that organisation’s longstanding achievements in advancing health reform through strengthening primary care systems and expertise.

Networking Health NSW thanks the NSW Agency for Clinical Innovation for providing the generous financial support and partnership that made the development of this publication possible.
Understanding and working with general practice is broadly accepted as the cornerstone to effective primary healthcare. General practice has a pivotal contribution in delivering better health outcomes and high-performing general health system. It also has the potential to offer support efficiencies and improve equity and access across the healthcare continuum, in collaboration with secondary care and acute health services.

**Context**

NSW has the largest number of general practitioners (GPs) of all Australian states and territories, with more than 8000¹ doctors working in over 2700 general practices.² There are almost 10,700 nurses working in general practices in Australia, with around 2400 in NSW. While 63% of practices in Australia employ at least one nurse, only 47% of NSW practices have nurses. This is the lowest state percentage and compares with over 70% in other states.

Australian GPs provide 127 million patient consultations each year.³ On average, Australians visit a general practice five to six times per year with over 85% visiting a general practice at least once a year.

The evolution of general practice over the past decade has resulted in significant changes to service numbers, focus and activities. This is compounded by the challenges facing the wider health system of ageing populations and increases in the need for long-term management of chronic illnesses.

General practice provides the first point of contact for investigations, diagnostics and referral. General practice manages a very broad range of conditions including minor surgery, trauma care, procedures and management of complex mental healthcare. Chronic disease is the focus of around 40% of all general practice consultations.

**Collaboration between general practice and local health districts**

The focus at both Commonwealth and state level is on improving integration across the broader healthcare system. This will create a more connected health system across primary and acute settings, improve patient outcomes and help to reduce unnecessary hospitalisations and emergency department presentations. Not only does this benefit the individual, it will also create a more financially sustainable health system for the future.

The *NSW state health plan – towards 2021* has two key strategic directions that will be dependent on effective collaboration with general practice. These are *keeping people healthy* (strategic direction 1) and *delivering truly integrated care* (strategic direction 3).

As the first point of contact with the health system for most patients, general practices play a pivotal role in prevention activities to keep people well and out of hospital.

The NSW Government has invested $120 million in an integrated care strategy that focuses on driving integration in communities through partnerships, promoting local health pathways and supporting effective transfer of care. This strategy will also depend on effective working relationships with general practices in local communities.

Integrated, collaborative care requires systemic changes, including:

- a cooperative and combined approach to planning and coordinating services for the community
- a focus on consumers and their experience at the centre of the collaboration

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• standardised approaches, with teams using shared protocols, defined roles and responsibilities and agreed and efficient communication channels
• efficient information exchange, using shared electronic health records or secure messaging wherever possible
• governance structures that promote coordination, collaboration and participation in planning and decision making
• promotion and support of the role of nursing and practice managers in general practice.

Where financial incentives are not available or viable, collaboration needs to offer benefits in terms of improvements to quality of working life and improved care to patients, such as:

• providing opportunities for general practice to formally engage with allied health, other disciplines and local health districts
• providing training opportunities that attract continuing professional development points
• strengthening patient referral pathways
• improving communication channels
• giving support with accessing PIP eHealth incentive funding.

**Purpose of this guide**

The purpose of this guide is to provide background information about general practice and to outline factors for local health districts to consider when engaging with general practice.

This guide has three major components:

• the context of general practice in NSW, including trends and challenges
• effective partnerships with general practice
• supporting organisations and their roles.
General practice is the cornerstone of primary care delivery in NSW, working in varied settings and undertaking diverse diagnostic, clinical and disease prevention activities. It is a specialty in its own right with a growing focus on the provision of primary healthcare: a comprehensive approach to care that includes disease prevention, community empowerment and multidisciplinary collaboration.4

The Royal Australian College of General Practitioners (RACGP) defines general practice as a service that provides patient-centred, continuing, comprehensive and coordinated primary care to individuals, families and communities.

1.1. Key characteristics

General practice is most often the point of first medical contact within the healthcare system, providing unrestricted non-referred access to those seeking care. The features that characterise general practice are that it:5

- manages patients presenting with multiple problems in any one visit
- focuses broadly on managing established conditions, undifferentiated illnesses and problems requiring urgent intervention
- centres on the whole person and deals with the physical, psychological, social and cultural dimensions of health problems
- promotes health, disease detection and self-management tailored to fit the needs of the patient’s social and cultural context
- facilitates comprehensive care, including appropriate and necessary referral, testing, monitoring and follow-up
- plays a key role in supporting patients to navigate the wider complex healthcare system
- allows an awareness of the particular health beliefs of local cultural groups
- undertakes personal advocacy for patients whose capacity to advocate for themselves is reduced due to illness or marginalisation
- plays an increasingly important role in electronic clinical information management
- provides longitudinal continuity of care supported by a comprehensive medical record.

A detailed description of general practice service delivery is provided in the report *A decade of Australian general practice activity, 2004–05 to 2013–14*, by Britt et al.6 A summary of trends published in the report is outlined below.

Over 90% of NSW GPs work in private practices. Around 5% work in hospitals with the remainder working in ‘extended-hours clinics’, corporately managed practices, non-residential health facilities and a range of other settings, including Primary Health Networks (PHNs).7

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4 Starfield B. Basic concepts in population health and health care. *Epidemiol Community Health*. 2001;55:452–454
There has been a steady increase in the number of GPs working in practices with 10 or more practitioners. Currently, over 26% of GPs work in large practices and 9% in solo practice. A larger proportion of GPs aged over 60 years work in solo practices than in the large practices.

Over 60% of NSW general practices have a practice nurse. The percentage has the potential to increase with greater acknowledgement of the efficiency potential of nurses in general practice and government investment in this area.8

Nature of consultations

Australians visit general practices five to six times per year with over 85% visiting at least once a year. General practice provides all the care needed for around 90% of health problems. The average length of Medicare Benefits Schedule or Department of Veterans’ Affairs claimable patient consultations is just under 15 minutes.

Chronic disease is associated with 40% of all GP encounters. The most frequently managed problems are hypertension, immunisation, upper respiratory tract infections, depression, diabetes, anxiety, gastro-oesophageal reflux disease and atrial fibrillation. In the 10 years to 2014, there was a 20% increase in consultations about psychological issues and a 40% increase in consultations related to blood and blood-forming organs.

For every 100 problems managed there are around nine referrals to other healthcare providers, most often medical specialists (six referrals per 100 consultations). Most other referrals to other health professionals are to allied health professionals such as physiotherapists, psychologists, podiatrists and dieticians.

General practice consultations with people from culturally and linguistically diverse backgrounds account for around 1 in 10 presentations.9

The shape of general practice is changing and an increasing number of practice activities are outside a conventional consultation. Funding mechanisms are slow to keep pace with these changes.

Practice administration

The administration of general practice as a medium-sized business is demanding. GPs spend considerable time attending to duties considered to be ‘non-clinical’, meaning no financial recompense is available. This non-clinical time often includes administrative and managerial procedures, such as the authority script approval process, applying for incentive funding, dealing with Medicare queries and rejected payments, being involved in phone consultations and discussing patient matters with the patient’s family and other relevant parties.10

The growing number of medical students and graduates is putting increasing demands on practices to take on students and trainees.11 The Practice Incentive Program, Teaching Incentive and General Practice Infrastructure Grants have established initiatives to support GPs and practices with teaching medical students, pre-vocational doctors and GP registrars.

1.2. General practice roles and responsibilities

The RACGP defines the following roles and responsibilities for general practice:

- providing person-centred healthcare, where the patient’s needs, values and desired health outcomes always remain central to the GP’s evaluation and management processes
- facilitating continuity of care through the continuing patient-doctor relationship and knowledge of the patient, and coordination of clinical teamwork, resources and services
- providing comprehensive care, spanning prevention, health promotion, early intervention and the management of acute, chronic and complex conditions.

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9 Charles J, Britt H and Fahridin S. NESB patients. Australian Family Physician. April 2010; 39, No. 4
• providing whole person care by addressing the interplay between biological, psychological and social contributors to health

• applying diagnostic and therapeutic skill to manage uncertainty, undifferentiated illness and complexity, and applying best-practice evidence in the light of individual circumstances

• promoting coordination and clinical teamwork to deliver accessible, integrated patient care: leading, supporting and coordinating flexibly configured clinical teams, and engaging with diverse specialists and other sector services according to individual patient or family needs.

1.3. The changing face of general practice

Australian general practice provides 127 million patient consultations each year. There have been important changes in its activities over the past decade – between 2003–04 and 2012–13 – in terms of numbers of services provided and the focus of these services. These changes have occurred alongside the ageing of the population and the subsequent rise in need for long-term management of chronic illnesses.

Over the past decade general practice has:

• managed growing numbers of newly diagnosed chronic conditions and patients with multiple chronic conditions or morbidity

• increasingly embraced ICT and new technologies, with over 99% of practices being computerised in recent years

• spent a greater proportion of time servicing the needs of older patients

• increasingly managed multiple problems in a single consultation

• undergone a steady series of changes to Medicare Benefits Schedule item numbers, accreditation standards, continuing professional development requirements, incentive funding arrangements, billing and medical records technologies.

Reflecting a growing proportion of the population, NSW GPs are ageing and have an average age of 50 years, with an increasing number of GPs practicing for more than 20 years. Males aged 65 and over comprise almost 10% of working GPs.

Approximately 28% of GPs in Australia are located in regions classed as rural or remote by the Australian standard geographical classification. There has been a significant increase in the number of GPs working 21–40 hours per week on direct patient care.

As a result of Australian medical workforce shortages, there has been an increase in recruitment of overseas-trained doctors, particularly in regional and rural areas of NSW. Fewer practices are providing after-hours care on their own, or in cooperation with other practices. Instead, more practices use deputising services for after-hours care. In more highly populated areas, there is also a growth of after-hours services, billing through Medicare.

The RACGP defines standards for general practice and updates these regularly to reflect changes influenced by, for example, the health reform agenda, ehealth, changing practice models and quality improvement. Many practices choose to be assessed against the standards by an independent third party to gain formal accreditation against the RACGP Standards. The RACGP promotes peer review where one surveyor must be a GP.


14 Starfield B. Basic concepts in population health and health care. Epidemiol Community Health. 2001; 55:452–454
1.4. Rural practice characteristics

When GPs care for patients in rural and remote areas, additional skills, competencies and professional values are required in order to provide safe and appropriate care.

Rural and remote medicine is typically delivered through private community-based practice facilities and hospitals in NSW. However, it can also be provided in remote clinics, correctional centres and Aboriginal Medical Services, or via telephone or ehealth systems. One of the hallmarks of rural and remote practitioners is an extended skill set, which allows them to safely care for patients in a manner that is not typical in more urban settings. This includes providing specialised care such as surgery or obstetrics, and admitting and caring for adults and children in hospital settings.\(^\text{15}\)

Rural GPs are more likely than urban practitioners to:

- provide in-hospital care
- provide after-hours services
- engage in public health roles
- conduct clinical procedures
- deliver emergency care
- encounter a higher number of complex or chronic health presentations
- treat larger proportions of Aboriginal or Torres Strait Islander people.\(^\text{16}\)

The particular interests and needs identified among rural GPs include:

- healthcare during and following natural disasters
- mobile, telemedicine and ehealth platforms
- online learning and networking
- locum arrangements
- travel time and cost for both GPs and patients
- patient transfer between institutions.\(^\text{17}\)

1.5. Practice structures and service models in NSW

NSW has the largest number of GPs of all Australian states and territories, with more than 8000\(^\text{18}\) doctors in over 2700 general practices\(^\text{19}\). While there are core characteristics of general practice, there are also significant variations in the size, workforce, context and capacity of individual practices across NSW, depending on the nature of the practice location, population demographics, size and corporate structure of practices.

Corporate practices may be owned by or run as public companies, with shareholder interests and with GPs either salaried or contracted.\(^\text{20}\)

General practices are free to vary the extent to which they charge above the Medicare rebate, and therefore in the amount of ‘out-of-pocket’ expenses that need to be paid by the patient.

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\(^\text{16}\) www.racgp.org.au/becomingagp/what-is-a-gp/what-is-rural-general-practice/
1.6. Practice managers

Practice managers play a vital role in general practice and are supported by PHNs and organisations such as the Australian Association of Practice Management.

They are generally responsible for the operational management of a practice, including:

- governance, organisational leadership and development of services
- promotion and marketing
- human resource management – supervision, management of meetings and internal communications, occupational health and safety, and induction of new staff
- financial performance – accounts, financial reporting and payroll
- practice accreditation process
- managing the provision of practice services, such as ordering and purchasing of practice consumables, maintenance of appropriate stock levels, patient filing systems, records integrity and practice manuals
- asset maintenance – registers, maintenance and repairs, IT systems.

1.7. Nursing in general practice

There are almost 10,700 nurses working in general practice in Australia, with around 2400 in NSW general practices. Overall 63% of practices in Australia employ at least one nurse, although NSW has the lowest percentage – 47%, compared with over 70% in other states. There are also a small number of nurse practitioners working in general practice who provide a professional foundation for future growth and development as practice and funding conditions permit.

GPs may delegate aspects of their clinical workload to a practice nurse with appropriate training and qualifications. Clinical roles performed by nurses in general practice are increasingly specialised and include:

- clinical and procedural activities
- running immunisation clinics
- health promotion and maintenance and illness prevention
- chronic disease management, such as monitoring patient health, managing patient recall registers and conducting diabetes assessment and education clinics
- expert clinical nursing specialist services, including diabetes education, asthma management and specialist wound care
- home visits and providing services in other community settings, such as residential aged-care facilities.

Practice nurses are sometimes generalist nurses, who provide nursing care and health management. Increasingly, practice nurses develop specific specialist interests and advanced expertise. Examples include antenatal care, baby and toddler care, health checks, screening assessments, chronic disease management and preventative care.

1.8. General practice funding

General practices in NSW are typically small businesses with an average of three to five GPs. The income of a practice is derived mainly from Medicare fees for service arrangements, patient co-payments and fees, and a small proportion from government incentive payments.

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Although changing, most GPs earn their income either:

- through a share of profits as a partner or owner of the practice
- by taking a contracted percentage of the gross billings they generate
- through a facility fee paid to the practice by the practitioner and a salary per session (half-day).

There are many variations of these three main schemes, which also depend on factors such as how practice incentive payments are handled.23

**Bulk billing**

The availability of bulk billing services varies across NSW. A GP’s willingness to bulk bill can be influenced by the costs of running their practice and the ideological views of the practice. Practice costs vary widely depending on location, patient population, local market conditions, number of staff employed and equipment.

A considerable number of general practices bulk bill pensioners, children and concession card holders but may charge a higher patient contribution for other patients. About 40% of the population holds healthcare concession cards and tends to use a comparatively greater proportion of GP services than those who do not hold a concession card.24

**Incentive funding**

Funding mechanisms that support collaboration between general practice and other health services include:

- Chronic disease management items intended to better enable GPs to manage the healthcare of patients with chronic medical conditions, including patients who need multidisciplinary care.
- Medicare benefits schedule items for general practice mental health plans and psychological therapy items.
- The Practice Incentives Program (PIP),25 which is a part of a blended payment arrangement for eligible general practices. PIP payments go to the practices rather than individual doctors. PIP practice payments are in addition to income earned by GPs and the practice, such as fee-for-service Medicare rebates and patient payments. Currently the PIP is made up of 12 different incentives, including rural, ehealth, disease and population group specific. Other PIP incentives support practices to employ practice nurses and allied health workers.
- Service Incentive Payments (SIPs) are made to practitioners working within a PIP practice for the provision of care to patients meeting specific criteria.26
- Aged-Care Access Incentive is an incentive payment, through PIP, to encourage GPs to provide more services in residential aged-care facilities.
- After Hours Incentive, administered by PHNs, aims to ensure that patients of GPs have access to quality after-hours care. There is also Commonwealth funding to PHNs so they can work with key local stakeholders to improve after-hours healthcare.

The resources required to adopt incentive schemes has resulted in a low uptake with less than 10% of general practice remuneration coming from Medicare Australia’s incentive payments.

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23 GP NSW Expert Reference Group


26 Ibid
Funding for nursing in general practice

The employment and role of nurses in general practice has been supported via the Practice Nurse Incentive Program (PNIP).\(^{27}\) There are a number of Medicare items that apply to a practice nurse undertaking particular tasks. Others allow funding when the practice nurse assists a GP in providing specific care.\(^{28}\)

The changes brought in by the 2012 PNIP allow practices to engage their practice nurses in a more strategic, diverse and less task-oriented way.

ehealth funding

The aim of the PIP eHealth incentive is to ensure general practices are equipped to receive electronic information, including discharge summaries, pathology, reports, referrals and prescriptions, securely. This incentive encourages practices to keep up to date with the latest developments in ehealth. To be eligible for the PIP eHealth Incentive, practices must:

- either be accredited or working towards accreditation for the RACGP Standards for general practices
- have a secure messaging capability, which is provided by an eligible supplier
- have (or have applied for) a location or site Public Key Infrastructure (PKI) certificate for the practice and each practice branch, and ensure that each practitioner has (or has applied for) an individual PKI certificate
- provide practitioners with access to a range of key electronic clinical resources.

General practices are committed to ehealth and there are clear benefits in sharing discharge and clinical information. However, the level of integration is variable across local health districts and the state. It is important to encourage all care providers to register for ehealth initiatives such as the Personally Controlled Electronic Health Record (PCEHR) or secure messaging as benefits are increased when a critical mass of providers and their patients are participating.

1.9. Challenges in the general practice environment

High demand for services and the resulting delays in patient access is a significant challenge for general practice. Many general practices have closed their books to new patients and this is becoming increasingly common in both rural and urban areas. This is due to a combination of factors including the rise of multiple chronic diseases, the need for doctors to contain working hours in the practice to allow adequate time for home and residential aged-care visits, workforce issues and decreasing length of hospital stays, all of which have increased the demand for general practice services.

The pressures on general practice workload have affected both availability and duration of the consultations required to deliver care for more complex patients and those with chronic conditions. This is compounded by financial pressures, limiting the capacity of general practices to participate in the multidisciplinary care that is needed for the comprehensive prevention and management of chronic conditions.

Engaging GPs more effectively in partnerships will support efforts to reduce avoidable hospital admissions. These partnerships can be facilitated by NSW Health and general practice, for example, by working collaboratively on the development and implementation of programs like Health Pathways.


Section 2
Effective partnerships in health

2.1. Collaborating with general practitioners

The relationship between general practice and local health districts is increasingly pivotal to the health system. Effective partnerships can help to ensure patient safety, continuity of care, integration and quality health outcomes.

General practice is the gateway for most people into the broader health system, the contact point for accessing acute and secondary care and for managing patients’ needs on discharge. GPs typically hold the most comprehensive patient health record and this shared information provides a foundation for continuity of care. Given the financial pressures and demand on all health services, establishing effective partnerships between the local health districts and general practice to improve the coordination of care is critical to the achievement of many NSW Health strategies.

In addition, GPs in private practice can be visiting medical officers (VMOs), who provide medical services in public hospitals, particularly in rural centres. This role supports good relationships and collaboration between general practices and hospitals and promotes a good understanding of the needs and challenges of both settings. VMOs are not hospital employees but are contracted by the local health district to provide specific medical services in nominated health facilities.

For GPs to be granted VMO rights in a hospital, their clinical skills must be credentialled by the relevant local health district and they must be granted privileges to provide services in nominated health facilities.

Opportunities for GPs to participate in committees and groups exploring a range of clinical and service issues are growing. GPs collaborate with local health districts through participation on hospital and district clinical councils.

Collaboration offers benefits to patients, to general practice and to the local health districts. These benefits include:

- key general practice stakeholders being better informed on service development and planning, ensuring better professional and patient outcomes
- improved patient safety and continuity of care
- improved patient experiences and a reduction in ‘assessment fatigue’
- better ‘service navigation’, knowledge of and access to services through closer relationships with other providers in the local district, which facilitates referrals and multidisciplinary care for patients where needed
- increased cooperation between GPs and hospitals in planning patients’ discharges improves the transition back to the care of the GP
- improved care planning, decision making and management of patients in the community reduces acute admissions and pressure on hospitals
- use of ehealth to reduce administrative duplication
- reduced waiting times for patients as they navigate the system
- improved health outcomes for patients and better quality of life
- reduction of avoidable or unnecessary hospitalisations
- reduced duplication of pathology and radiology tests through sharing of information
- more effective use of health resources to deliver clinical care.
2.2. Partnering for individual patient care

General practice and LHDs share the objective of ensuring that patients receive the right care, in the right place, at the right time by the right healthcare professional. Ensuring a smooth transition between services is an important priority, but the boundaries between community and hospital care are becoming increasingly blurred. The primary driver for collaboration between local health districts and general practice is to manage the movement of patients between the two in a way that provides an optimal outcome for the patients and streamlines processes for both parties.

CASE STUDY: NSW INTEGRATED CARE STRATEGY

The NSW Health Integrated Care Strategy is investing in innovative initiatives and demonstrator programs with an emphasis on community-based services.

The aim of the strategy is to build a health system that provides seamless care that responds holistically to all of a person’s physical and mental health needs. It will promote connected service provision across different healthcare providers and will place a greater emphasis on community-based services. An integrated health system will better support people with long-term conditions and complex health needs.

The Integrated Care Strategy provides $120 million over the period 2014–17. Funding is provided to local health districts to partner with primary care organisations, such as PHNs, and other local providers, to develop and progress integrated care in their regions.

There are opportunities to enhance these partnerships through joint governance arrangements, shared financial incentives to encourage collaboration, and improved IT systems to facilitate communication between providers from different sectors, such as between a GP and a specialist.

Shared care planning

Where a community health service or hospital identifies chronic disease patients, who they believe could benefit from a general practice-led care plan they should:

- agree on a care planning process that will not add significant time commitments to the GP’s current practices
- understand how care planning activities can be linked to general practice funding initiatives
- collaborate with and consult the patient’s nominated GP, or with practice staff such as practice nurses, to determine if the patient has an existing care plan that is appropriate for the patient’s current condition
- work with the GP to identify requirements for access to allied health and eligibility of the patient for Medicare Benefits Scheme reimbursement.

They should have an agreed position on any medico-legal and governance issues, such as who has responsibility for the transfer, who takes the lead and how deteriorating patients will be managed.

Transfer of care

Appropriate and effective transfer of care arrangements are important for any patient who receives care from their GP, community health, community mental health and other specialists, and in a hospital. Clinicians can provide the best possible care when good communication exists between all treating healthcare practitioners across the continuum of care, starting from the community setting, through to acute or sub-acute care, and subsequent return of the patient to the community for ongoing management.

Effective transfer of care practices can reduce hospital readmissions and adverse events and deliver a more positive experience for both the patient and treating healthcare providers.

2.3. Engaging general practitioners in patient care processes

The following factors should be considered when engaging GPs to improve patient care processes between general practice and other health services.

**Systemic approach**

Integrated, collaborative care requires systemic changes, including:

- a centralised approach to planning and coordination services for the community
- a focus on consumers and their experience at the centre of the collaboration
- standardised approaches with teams using shared protocols, defined roles and responsibilities and agreed and efficient communication channels
- efficient information exchange, using shared electronic health records or secure messaging wherever possible
- governance structures that promote coordination, collaboration and participation in planning and decision making
- promotion and support of the role of nursing and practice managers in general practice
- introducing more proactive strategies, in-kind support and resourcing of partnerships to supplement Medicare and other incentive payments
- promoting an understanding of the Medicare Benefits Schedule items which general practice can use for care planning, for example, the chronic disease management items (MBS item numbers 721 to 732).

**Local relevance**

Collaboration between PHNs, LHDs and GPs can deliver benefits to all participants and their patients. Joint needs analysis and planning will assist parties in understanding the priority healthcare needs of their communities. The development of comprehensive needs assessments will help to identify and address service gaps and prioritise areas for general practice engagement.

These collaboration opportunities can improve outcomes through:

- collaborating on the comprehensive needs assessment for the community, including assessment, planning, implementation and evaluation
- identifying ‘quick wins’ to demonstrate the benefit of collaboration
- programs that require minimal initial investment or change
- opportunities to share investment in initiatives with PHNs
- joint resourcing.

**Resource support**

Practices that are experiencing high patient demands may have difficulty implementing new programs without additional staff capacity. In this situation practices may be able to work with PHNs to access short or long-term support personnel, such as practice nurses or care co-ordinators.

To help drive a reduction in demand for acute care, general practice is increasingly required to deliver greater levels of health promotion, chronic disease monitoring, social support and enhanced care of older patients. Many of these activities could be undertaken by practice nurses and allied health. Practice nurses could also undertake a greater range of functions, including liaising about support of patients with other service providers, such as chronic disease management programs, antenatal shared care, aged-care services or the Department of Veterans Affairs Coordinated Veterans Care Program.
Technology and tools

A key role of the PHNs is to assist practices to understand and make meaningful use of ehealth systems, in order to streamline the flow of relevant patient information across the local health provider community. They could assist general practices to implement and effectively use systems to exchange information with local health districts and facilitate opportunities to improve data quality.

LHDs could facilitate extended access to hospital electronic medical record systems by GPs who are working in joint programs with hospitals (e.g. antenatal shared care programs) through a review of policies and protocols.

The use of directories among local GPs, hospitals, allied health professionals (e.g. community pharmacists) and other relevant agencies should be promoted and steps taken to ensure data is current. The directory should increase the ease with which GPs are able to access hospital services and specialists.

The value of directories for a range of initiatives has been demonstrated through the HealthPathways program. This program provides a one-stop shop for accessing online local health information, agreed localised management protocols and referral options so that patients receive care from the most appropriate health professional. It includes the following useful information:

- listing of each department and service within the hospital or community service, including hours of operation
- listing of specialists working within the hospital
- identification of services for patients with additional needs (e.g. interpreter services)
- listing of community health or outpatient services that can be accessed by GPs
- direct phone numbers for each department or service and where possible for each specialist
- specification of the referral process or patient pre-referral investigations required.

Local health districts can partner with PHNs to provide general practices with access to telehealth facilities or patient pathways where telehealth would be an appropriate vehicle for collaborative patient care.

Business processes and protocols

To improve handovers between hospitals and general practices, collaboration needs to be based on using ehealth systems that support shared individual health records and that build and support referral pathways. Clearly defined roles and responsibilities and common intake and discharge protocols are also required. These processes can leverage the safe clinical handover resources improving the efficiency and outcomes of care processes, especially where the patient has particularly complex needs.

CASE STUDY: COLLABORATION IN CARE: THE ST VINCENT’S HOSPITAL AGED CARE EMERGENCY SERVICE

The St Vincent’s Hospital Aged Care Emergency (ACE) service is a joint initiative between the hospital, NSW Health, St Vincent’s Hospital, residential aged-care facilities and local practitioners involved in the care of residents at Eastern Sydney aged-care facilities. The aim of the initiative is to improve the management of elderly patients suffering from chronic and complex conditions. These patients tend to have a high bed occupancy rate and require a level of supportive care that can be difficult to provide in an emergency department environment. The ACE service facilitates a collaborative working relationship between the hospital, aged-care facilities and visiting GPs. It provides a telephone liaison and consultation service, education and support services and post-discharge follow-up. ACE has implemented a Resident Transfer Hospital Envelope, which includes a checklist of clinical and handover information to support the transitions between hospital and community services.

2.4. **Joint program development and coordination**

Input from general practice is essential when developing new multidisciplinary, preventative health programs to manage chronic disease as well as other programs where GPs will play a key role in delivery.

In LHDs and PHNs, GP liaison staff play an important part in the development of partnerships between hospitals, general practice and primary care providers to ensure patients receive care at the right time from the appropriate care service.

**Engaging general practice in the development and coordination of health programs**

PHNs are a conduit for primary healthcare commissioning, program development and implementation within a geographic area and have an active role in facilitation. Roles vary and may include:

- undertaking comprehensive community health needs assessment, in collaboration with LHDs and other stakeholders, identifying gaps and priorities for future service development and commissioning
- providing feedback to GPs about patients and practices which have benefited from the new program and information on how other practices have embedded changes
- working with doctors to hold general practice education sessions providing targeted information relevant to the local population and client base
- working with practice nurses and practice managers to encourage referrals between new programs or services and general practice
- supporting and brief general practice to understand and adopt policy and funding changes through education, system and practice staff support.

2.5. **Education, training and dissemination of information**

The skills of GPs encompass prevention, pre-symptomatic detection of disease, early and established disease diagnosis and managing other clinical problems such as injury and complications, as well as rehabilitation, palliative care and counselling. Many practitioners also maintain other specialist medical skills and have ‘dual specialties’.

Maintaining registration as a GP requires ongoing professional development accredited by the RACGP or the Australian College of Rural and Remote Medicine (ACRRM). Activities must be undertaken on a three-year cycle to ensure the GP is eligible for vocational registration.

**CASE STUDY: TRAINING PARTNERSHIPS BETWEEN GENERAL PRACTICE AND ABORIGINAL COMMUNITY CONTROLLED HEALTH SERVICES**

The Aboriginal and Torres Strait Islander health training statements of the RACGP and ACRRM advocate a partnership approach with Indigenous educators in all aspects of training, including planning, development and implementation. The aim of training partnerships between GPs, their local ACCHSs and other stakeholders is to:

- promote general practice training in Aboriginal and Torres Strait Islander health issues
- support cultural educators and cultural mentors
- support local ACCHSs and communities to participate in general practice training
- engage local ACCHSs for the purpose of accreditation as general practice training posts.

The training partnership offers the opportunity to work as a member of a multidisciplinary healthcare team, including Aboriginal health workers, in an accredited general practice training post. Participants undertake a range of community health activities, learning about the local culture and the range of physical, social, emotional and spiritual well-being issues experienced by the local Aboriginal and Torres Strait Islander community. Outcomes of the training partnerships are the development of clinical skills and cultural knowledge relevant to Aboriginal and Torres Strait Islander health, increased access to culturally appropriate primary healthcare services for Aboriginal and Torres Strait Islander people and support for initiatives to ‘Close the Gap’.

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Communication requirements
General practitioners and practice staff have a diverse range of information needs, and are regular recipients of information from many sources including the NSW Ministry of Health, Commonwealth Department of Health, PHNs and LHDs. The PHNs have a coordinating role and are well placed to assist with communication with general practice. They also have a key ‘enabling’ responsibility in general practice support and development.

Information of interest to general practice includes:
- new developments in family medicine
- routine patient care
- drug alerts
- government policy and regulations relating to healthcare
- practice organisation and management
- communicable disease-specific information
- professional development opportunities.

2.6. Policy development, planning and research
There are significant benefits in gaining input from general practice in policy development and planning. Collaboration for this purpose could be achieved through general practice representation in governance groups and working parties or through input into policy development and planning through workshops, other consultation and gaining feedback on proposed drafts. This ideally should be initiated through PHNs.

To engage with general practice, LHDs may wish to consider:
- Liaise with the PHN to determine the most appropriate form of engagement and whether there are existing data sources that would support the development of the planned policy or research activity.
- Where possible engage GPs with a particular interest in the area involved to develop relationships and encourage them to be general practice champions.
- Support GPs to understand the value of collaborating by beginning with a small project that has clear benefits for them. Once a relationship has been established and benefits to the general practice are evident it will facilitate increased engagement in service and policy development activity.
- Use patient activity data to identify the most appropriate GPs to participate in the policy development or research activity. For example, if planning research on the effectiveness of a particular program related to childhood obesity, existing data sources can be used to identify geographic locations where there are high rates of obesity. This information can be used to approach GPs practicing in these areas.
- Use tele or video conferences where possible to enable participation around working schedules and minimise the need for travel.

2.7. Governance
Clinical governance provides a systematic approach to maintaining and improving the quality of patient care. It ensures accountability for providing high quality, safe care to patients. Clinical governance occurs within a broader governance context which includes partnership, financial and corporate governance, setting strategic direction, managing risk, improving performance and ensuring compliance with statutory requirements. Corporate governance encompasses the rules, relationships, policies, systems and processes implemented to manage, control and direct the organisation.

The successful implementation of clinical governance requires the identification of clear lines of responsibility and accountability for clinical care and ensuring these are communicated to all participants and stakeholders.

The working relationship between general practice and LHDs will be facilitated if it is underpinned by effective and responsive governance structure and processes. This may include:
• representation of general practice on relevant management committees, such as the Clinical Council and working parties, which will help to improve lines of communication and understanding of the issues and priorities for both services – it will support the development of strategies that support both general practice and acute and community health

• making sure that roles, commitment and responsibilities are clear and expectations are well defined

• defining and implementing standardised and agreed processes where they affect both general practice and the local health district

• implementing formal structures and processes for sharing information

• implementing a process for resolving disputes if they occur

• establishing joint planning in priority areas

• identifying mechanisms for GP appointment and remuneration.

2.8. ehealth programs and opportunities

A range of different management and clinical systems are used by Australian general practices. Clinical systems are used widely for prescribing medications, clinical decision support, accessing clinical evidence, information and patient self-help information sheets, clinical data downloading and storage, recording patient history and progress notes and allergy alerts.

Increasing uptake of the PCEHR, now known as My Health Record, may be one mechanism to further connect general practice and other health services for participating patients.

General practice clinical data is used for a range of purposes, including medical research, disease registries, medical education, public health surveillance, planning patient services, risk management, quality control and medical complaint or misconduct investigation. Aggregating individual clinical data up to the level of the practice population has been used to add a population health focus to the work of many practices. This is a rapidly developing aspect of practice management and PHN interest.

Interoperability between healthcare providers

Across Australia there are a growing number of ehealth implementations in primary and acute care settings. Many are delivering localised benefits such as electronic discharge information or patient recall systems. While steps are being made towards interoperability between providers, this is still fairly limited. For example, while general practice generates around 13 million referrals per year, including approximately 12 million to specialists and allied health providers, only an estimated 1–2% of these are e-referrals.

There are several barriers to electronic communication between providers. These include a focus on improving internal systems over external communication. Additionally there are existing challenges and barriers that would need to be addressed for e-referrals to be successfully implemented. A special challenge is the low level of information and communication technology used in specialist and allied health practices, given the significant volume of referrals involving these groups. A similar situation exists for aged and community care, where investment in information and communication technology has also been relatively low.

Other barriers include use of multiple secure messaging systems across general practice and limitations in system interoperability. Variations also exist in the governance underpinning collection, management and sharing of assessment, history and referral information.


Personally Controlled Electronic Health Record / My Health Record
The PCEHR, or My Health Record, is a national initiative to bring together a summary of important health events into a single record that can be viewed and shared by providers. This will support more integrated and coordinated care by all the healthcare providers who are associated with an individual. It is currently a voluntary system that has been reviewed and relaunched as a patient ‘opt out’ initiative.

HealtheNet – clinical portal
The HealtheNet clinical portal is being rolled out across NSW Health. It aims to support healthcare providers by improving information sharing between health services. In locations where this has been implemented, NSW Health clinicians can use the clinical portal to view information about a patient from facilities in other local health districts that is not available within their existing systems, including:

- e-discharge summaries from other facilities to allow communication, planning and follow-up
- event summaries from community-based health services such as mental health, child health or aged-care to facilitate continuity of care and decision making
- where available, PCEHR primary care event summaries
- allergies or adverse reactions and alerts
- previous admissions, discharge and transfer history for inpatients, emergency departments and outpatients
- radiology images and associated reports.

Engaging general practice in eHealth
When developing electronic information sharing systems or implementing ehealth systems, local context is critical. It will be important to consider the following points:

- One size does not fit all. Understand the individual needs of practices and doctors.
- Consider local population demographics and general practice operation.
- Identify and engage with general practitioners in projects they prioritise. This will develop relationships to support the development of other projects in the future.
- Identify and articulate how the proposed project will impact or benefit the practice, its patients and outcomes.
- Be aware of the resource requirements, including financial and time commitments.

General practice has a pivotal contribution in delivering better health outcomes and a high-performing health system. Utilising the information above to better understand general practice and considering the concepts and engagement suggestions detailed in this guide can assist secondary care and acute health services in developing effective partnerships with primary healthcare, supporting efficiencies and improving equity and access across the healthcare continuum.
Section 3

Organisations supporting general practice

There is a diverse range of general practice support and representative organisations in Australia. Some of these are described below.

3.1. Primary Health Networks
Succeeding Medicare Locals in 2015, the role of PHNs is described below.

- Undertake the comprehensive healthcare needs of their communities, identifying gaps, trends, targets and priorities through analysis, planning and consultation. They will also know what services are available and help to identify and address service gaps where needed, including in rural and remote areas, while pursuing better efficiencies and value for money.
- Provide practice support services so that GPs are better placed to provide care to patients subsidised through the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme, and help patients avoid having to go to emergency departments or be admitted to hospital for conditions that can be effectively managed outside of hospitals.
- Support general practices in attaining the highest standards in safety and quality, through showcasing and disseminating research and evidence of best practice. This includes collecting and reporting data to support continuous improvement.
- Assist general practices in understanding and making meaningful use of ehealth systems in order to streamline the flow of relevant patient information across the local health provider community.
- Work with other funders of services in identifying priorities, commissioning health and medical or clinical services for local groups most in need, including patients with complex chronic conditions or mental health problems.


3.2. Royal Australian College of General Practitioners
The RACGP NSW/ACT Faculty is the professional organisation for GPs, registrars and medical students in NSW that focuses on the safety and quality of general practice. The RACGP sets the standards for general practices, supports ongoing professional development, provides resources and guidelines.

www.racgp.org.au

3.3. Australian College of Rural and Remote Medicine
The Australian College of Rural and Remote Medicine is responsible for setting professional standards for training, assessment, certification and continuing professional development. It also plays an important role in supporting medical students and junior doctors considering a career in rural practice.

www.acrrm.org.au

3.4. Australian Medical Association (NSW)
The Australian Medical Association (NSW) is the state’s peak independent medico-political lobbying body. The Australian Medical Association (NSW) is dedicated to providing its members with representation on a variety of medical issues, professional services and commercial benefits, playing a role in the formation of public health and hospital policy in the state.

www.amansw.com.au
3.5. Australian Indigenous Doctors’ Association
The Australian Indigenous Doctors’ Association (AIDA) is a not-for-profit, non-government organisation dedicated to the pursuit of leadership, partnership and scholarship in Aboriginal and Torres Strait Islander health, education and the workforce.
www.aida.org.au

3.6. Rural Doctors Association NSW
The Rural Doctors Association (RDA NSW) is one of seven state members of the Rural Doctors Association of Australia. RDA NSW identifies, promotes and works with government to ensure appropriate implementation of solutions to the current rural workforce shortage. Activities range from those targeted towards high-school students, through to GP retention grants, including anaesthetic and obstetric incentive grants.
www.rdansw.com.au

3.7. NSW Rural Doctors Network
The NSW Rural Doctors Network (RDN) is a not-for-profit membership organisation of about 700 doctors and is designated by the Australian government as the rural workforce agency in NSW. RDN aims to provide the highest possible standard of healthcare to rural and remote communities through the provision of a competent and continuing medical workforce in rural and remote NSW. It administers the Rural and Remote General Practice Program in NSW, to attract, recruit and retain GPs in rural and remote communities.
www.nswrdn.com.au

3.8. Australian Primary Health Care Nurses Association
The Australian Primary Health Care Nurses Association is the peak professional membership organisation for practice nurses working in general practice. It provides numerous benefits to its members including state-based practice nurse clinical education, conferences, access to free or discounted courses online and regular e-news, advocacy and professional resources.
www.apna.asn.au

3.9. Australian Association of Practice Management
The Australian Association of Practice Management is a non-profit, national association recognised as the professional body supporting effective practice management in the healthcare profession. The organisation represents and unites practice managers; promotes professional development and the code of ethics through leadership and education and provides specialised services and networks to support quality practice management.
www.aapm.org.au
Section 4

Information resources

4.1. Context of Australian general practitioners

4.2. Working with general practice


4.3. Communication and information exchange with general practitioners


4.4. ICT and ehealth

Department of Health, Personally Controlled Electronic Health Record (PCEHR) System. health.gov.au/internet/main/publishing.nsf/content/ehealth-record


### 4.5. Nursing in general practice

Primary Health-Care Research and Information Service. *Introduction to nursing in general practice.*


RACGP. *General practice nurses.*


Royal College of Nursing, Australia. *Nursing in general practice project.*

