



Understanding and Working with General Practice

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Primary Health Care Reform

Affordable health care

- Hospital avoidance
- Greater efficiencies (duplication and gaps)
- Sharing costs (public/private/personal)
- Cost saving technologies (e.g. point of care testing)

Federal / State Agreement

- August 2nd 2011 - all states and territories sign a new *National Health Reform Agreement*
- States remaining public hospital system managers
- Additional \$16.4 billion nationally for efficient growth funding for hospitals from 2014-15 to 2019-20
- New performance targets for elective surgery and emergency department access, plus deliver increased subacute capacity
- Establishment of Medicare Locals
- Commonwealth takeover of responsibility for Home and Community Care (HACC) services (except Vic)

Federal reforms

National Health Governance Agencies

- National Preventive Health Agency
- Australian Commission on Safety and Quality in Health Care (made a permanent entity)
- National Health Performance Authority
- Independent Hospital Pricing Authority to set a national efficient price for hospital services

Details on how the national governance agencies will work together to deliver improvements in the Australian health system are yet to be released.

Federal reforms

GP Super Clinics

- Each Super Clinic will bring together a range of health care providers which may include general practitioners, nurses, visiting medical specialists, allied health professionals and other health care providers to deliver better health care, tailored to the needs and priorities of the local community.
- They will open for extended hours and have significant capacity for inter-professional clinical training and education.

Federal reforms

Telehealth

- Since 1 July 2011, Medicare and DVA rebates have been available to patients for video consultations across a range of medical specialties.
- Telehealth facilities located in general practices, aged care facilities, Aboriginal Medical Services and some other, non-medical facilities, will be able to videolink patients in rural, remote and outer metropolitan areas with specialists (eligible specialists, consultant physician or psychiatrist).
- *Telehealth Eligible Areas* are geographical areas where patients can receive telehealth services.

Federal reforms

Electronic Health Record

- The Personally Controlled Electronic Health Record (PCEHR) program is working towards an electronically **interoperable health care system** to underpin the establishment of a personally controlled health record to provide an electronic summary of a patients' health information and secure access for patients and healthcare providers to eHealth records.
- A PCEHR will include a **health summary showing a patient's medical conditions, allergies, and demographic information, and an index summary of a patient's health information and medical history such as consultations, referrals, procedures, prescriptions, test results, personal health diaries and care plans.**

Federal reforms

After Hours GP helpline

- A commonwealth funded After Hours GP Helpline commenced operation on July 1st 2011.
- Medibank is the operator of the after-hours line which has enlisted large numbers of General Practitioners and nurses to take calls (this will be an add-on to the nurse triage, information and advice services currently provided by the National Health Call Centre Network trading as *healthdirect Australia*).
- Calls are first triaged by a registered nurse who, if necessary, transfers the call to a GP.

Federal reforms

Lead Clinician Groups

- Structures purposely established through Commonwealth government funding to improve clinical engagement in health care practice and system design with a priority to promote evidence based clinical practices and standards, safety and quality improvements, and more effective (and efficient) care processes.
- By working across the primary, acute, ambulatory and aged care sectors Lead Clinicians Groups are designed to contribute to achieving better integrated or coordinated patient-centred care.

Federal reforms

Practice Nurse Incentive Program

- The Practice Nurse Incentive Program (PNIP) starts 1st Jan 2012 and provides incentive payments to eligible practices to support an expanded role for nurses working in gp.
- The commencement of the program comes with the removal of six Medicare Benefit Schedule (MBS) practice nurse items where practice nurses provide a range of specific services on behalf of a GP without the patient having to see the GP such as immunisation and wound management services; Pap smear services; preventive health checks; provision of monitoring and support for a person with a chronic disease on a GP Management Plan, Team Care Arrangement or MBS Multidisciplinary Care Plan; Antenatal services; and Healthy kids checks.

Federal reforms

Coordinated Care for Diabetes

- A pilot of prepaid funding for care of patients with diabetes in general practice is about to commence.
- The pilot of the *Coordinated Care for Diabetes* reform will see patients register with a practice that coordinates their care and manages pre-allocated funds to provide services instead of billing Medicare.
- The purpose of the pilot is to assess the effectiveness of the key elements of the measure (i.e. voluntary patient enrolment, flexible funding arrangements, and pay for performance incentives) to inform future policy considerations regarding arrangements for chronic disease management in the primary care setting.

General Practice Public Policy

- The Divisions of General Practice Program has been part of the Australian Governments General Practice Strategy
- Original aim of the Divisions - *to improve health outcomes for patients by encouraging general practitioners to work together and link with other health professionals to upgrade the quality of health service delivery at the local level* (Commonwealth Department of Health & Family Services 1998b).

Medicare Locals

- Improving coordination and integration of primary health care in local communities, and addressing service gaps where necessary.
- Facilitating allied health care and other support for people with chronic conditions.
- Working with LHNs and aged care services to identify the best pathways between services.
- Delivering health promotion and preventive health programs.
- Undertaking population level planning.

Medicare Locals

- Established in 3 tranches over the next 12-18 months.
- Nineteen MLs were successful in the 1st tranche and will commence from July 2011.
- Invitations to apply for next 2 tranches close 19 July.
- A further 15 will commence in January 2012 and the remainder from July 2012.
- The first tranche was drawn from high performing Divisions of General Practice. The subsequent two tranches are open to other primary health care organisations and service providers.

Medicare Locals

- There will be 62 Medicare Locals across Australia.
- Medicare Locals are consistent with Local Health District boundaries (though not always identical).
- There will be 18 Medicare Locals covering NSW, and a single Medicare Local covering the ACT.
- NSW Medicare Locals from 1st July 2011:

Western Sydney	<i>WentWest Division</i>
Hunter Urban	<i>Hunter Urban Division</i>
New England	<i>New England, North West Slopes, Barwon</i>
Murrumbidgee	<i>Riverina and Murrumbidgee</i>

yourhealth website: <http://www.yourhealth.gov.au>

Medicare Locals

- The Commonwealth will fund Medicare Locals in place of Divisions of General Practice. All core funding under the Divisions of General Practice Program will cease on 30 June 2012.
- Total annual core funding for the Medicare Local network will be approximately \$171 million.
- Medicare Locals will reflect their local communities and health care services in their governance, including consumers, doctors, nurses, allied health and State-funded community health providers.

Medicare Locals

- MLs will be managed by a **skill based board** and largely operate under an organisational membership model with members such as local health services and community groups.
- Medicare Locals will reflect the range of organisational expertise needed to deliver an **expanded suite of PHC programs and services**. The actual make-up of Medicare Locals will vary and reflect the needs and nature of the local community.

Medicare Locals

General characteristics of applicants successful in the first round included:

- Proposals to expand and enhance current activities.
- Evidence of regional support and strong collaborations.
- Models of governance and operational arrangements that involved the broader primary health care sector.
- Evidence of community engagement.
- Clear transition/implementation strategies.

Medicare Locals

- From 2012-13, each ML will be provided with funding to plan and ensure the availability of face-to-face after-hours services for their region. These services will be integrated with the new after-hours telephone-based GP medical advice service.
- From 2013, MLs will also be provided with a flexible funding pool to target gaps in primary health care services for aged care recipients.

A GUIDE TO UNDERSTANDING AND WORKING WITH GENERAL PRACTICE IN NSW



General Practice Overview

“A combination of features set general practice apart from other health care providers including its whole-person focus, its complex funding arrangements and its generalist nature which requires broad education, information and support”

Facts

- GPs outnumber any other medical specialist group.
- Compared to hospital and specialist care, general practice consultations are the most cost-effective medical consultations.
- As the gatekeeper to a range of other health services, general practice is a significant driver of health care activity in Australia.
- Its reach into each community and ongoing relationships with patients/families is unparalleled.
- Failures in ensuring access to primary care have fundamental rebound effects on the entire health care system.

Facts

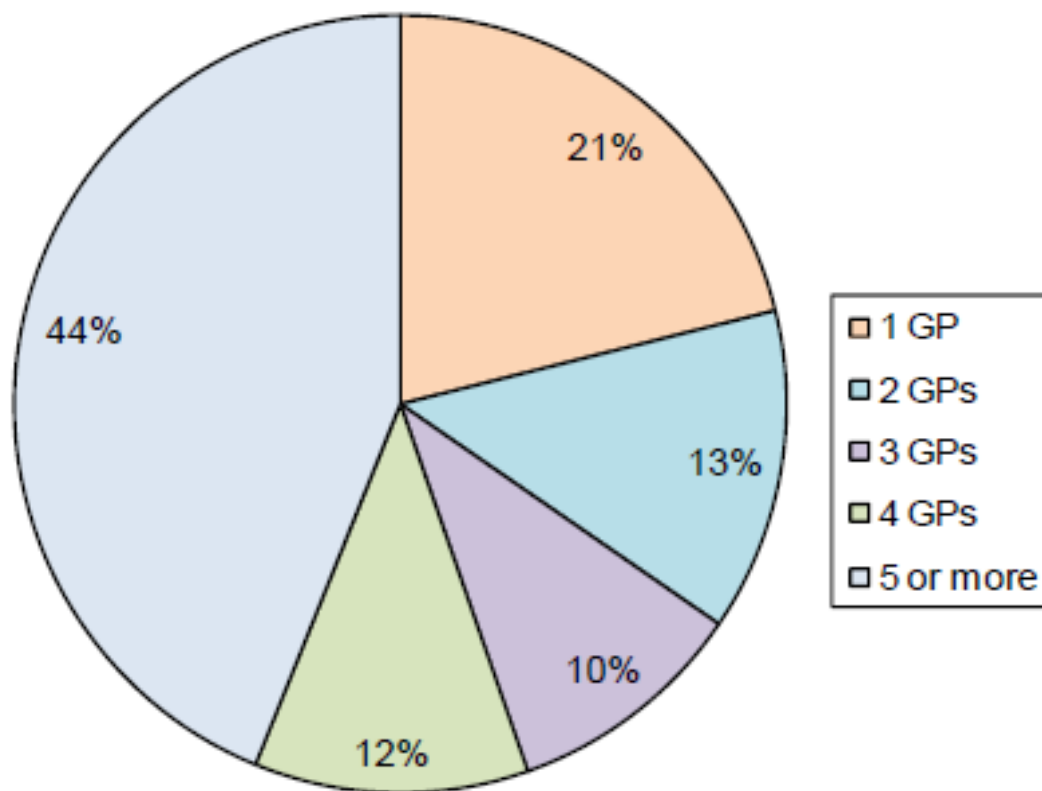
- Almost 23,000 GPs in Australia
- Practice arrangements vary from solo, small or large, in a variety of settings – rural, remote, urban, metropolitan
- The practice workforce composition is often unique to each practice – solo GP, employee doctors, nurses, allied health staff, registrars, medical and nursing students, practice managers, receptionists
- About 2600 General Practices in NSW (over 7,000 GPs)

Facts

- The majority of GPs work in private practice
- Practice ownership is becoming less attractive
- The average age of the GP population is 50
- Younger practitioners are attracted to the larger practices
- Approximately 40% of GPs are women
- Approx 58% of practices in NSW employ one or more practice nurses (either an RN or EN)
- 1700+ Practice Nurses in NSW

Facts

GPs per Practice 2007 NSW



- Almost half of all GPs work in practices with more than 5 GPs
- Approximately 20% work in solo GP practices
- Over the age of 60 years there are more GPs in solo practice than larger practices

Facts

- Most frequent point of entry into the health system
- 87.5% (↑ 20 million) of population visit a practice at least annually (118 mil GP consultations in 08/09)
- Average 5.2 visits/year/person in NSW
- GPs manage 1.5 problems per encounter (number ↑ with patient age)
- Arrange appointments based on a min. 4-6 pts /hour
- The majority of GPs average approx 36 pts/day
- Over 60% Aust say they have a 'medical home'
- GP consultations with NESB patients account for around one in 10 patient presentations

Facts

- General practice is able to provide all the care needed for around 90% of health problems presented.
- Chronic illness account for around 36% of all problems managed by general practice each year and this number is steadily increasing.
- For every 100 problems managed there are around nine referrals to other health care providers, most often to medical specialists (six referrals per 100 problems) with three referrals per 100 problems to allied health professionals.

Facts

- Over the past decade general practice has increasingly:
- Managed ↑ newly diagnosed chronic conditions and patients with multiple chronic conditions (>30% pts)
 - Spent a greater % of time servicing older patients
 - Performed more check-ups and provided more lifestyle advice than ever before
 - Undergone a steady series of changes to MBS item numbers, accreditations standards, continuing professional development requirements, incentive funding arrangements, billing and medical records technologies that has resulted in variable degrees of change fatigue.

Facts

- Many small towns do not have a general practice while other areas have far fewer practices than they need. Many practices have closed their books to new patients.
- Continued reliance on IMGs to support the GP workforce. In 2008, 41% of doctors in rural and remote areas of Australia were IMGs
- Up to 75% of ED patients cite lack of access to a GP as their reason for attending emergency departments and 40% of ED patients could be more appropriately cared for in general practice if it were accessible.

Implications/Recommendations

- Significant variation exists in the size, workforce, context and capacity of individual practices which often makes the discipline difficult to fully comprehend and/or apply a one-size-fits-all approach to collaborative projects/other initiatives.
- General practice faces a range of daily pressures not the least of which is maintaining a viable small business. Overwhelming practice workloads often force general practice to focus on core business making it difficult to participate in external programs.

Implications/Recommendations

The provision of cost free short or long term human resource support including practice nurses, care coordinators and others that have an agreed role and where space and time for training by the Division is available, have been found to be valuable to practices that are at risk of, or are overwhelmed by, patient demand.

Implications/Recommendations

- Systems and software that provide efficiencies in quality care provision are useful when adequate training, ongoing support and maintenance is available.
- Ensuring information resources such as lists of the available local public and private acute, community, preventive and screening services in the area (inc. wait times and costs) will assist general practices and patients.

Questions?
Comments?

General Practice Funding

General Practice Funding

- Medicare Australia (formally the Health Insurance Commission) is an Australian government agency that works in partnership with the Department of Health and Ageing.
- The programs administered by Medicare Australia include Medicare Benefits and Pharmaceutical Benefits Schemes, Australian Childhood Immunisation Register, Australian Organ Donor Register, General Practice Immunisation Incentives Scheme and the Practice Incentives Program.

General Practice Funding

Fee for Service

- Medicare – universal health insurance scheme provides free or subsidised health care access to doctors' services and certain pathology, psychiatry and optometry services (patient subsidy).
- Bulk Billing - GP accepts the Medicare benefit payable to the patient as full payment for the service and does not charge a patient a co-payment.
- Bulkbilling is not distributed evenly around the nation (47% to 99%). Market drivers, business costs, lack of competition in rural areas blamed (child, pensioners generally bulk billed).

General Practice Funding

Patient Fee (private billing)

- A Medicare rebate (fee-for-service) does not determine the amount a health professional can charge for providing the service (no cap but professional body guidelines).
- The difference between the Medicare rebate and the fee charged to the patient is referred to as an 'out-of-pocket cost' (patient co-payment).
- Found to be used as a new patient disincentive where pt load already high.
- Significant constraint to health care for many.

General Practice Funding

Level A - \$15.70	Used for obvious and straightforward cases – reflected in the patients notes
Level B – \$34.30	<p>Professional attendance by a general practitioner lasting less than 20 mins</p> <ul style="list-style-type: none"> a) taking a history; b) undertaking clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; <p>in relation to one or more health related issues</p>
Level C - \$66.45	<p>Professional attendance by a general practitioner lasting at least 20 mins</p> <ul style="list-style-type: none"> a) taking a detailed history; b) undertaking clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; <p>in relation to one or more health related issues</p>
Level D - \$97.80	<p>Professional attendance by a general practitioner lasting at least 40 mins</p> <ul style="list-style-type: none"> a) taking an extensive history; b) undertaking clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care;

General Practice Funding

Medicare item claim example

Reason/s for presentation	Medicare claimable services	Non-Medicare claimable services include:
<p>Check if pregnant and complete forms for welfare system</p>	<p>Professional attendance by a general practitioner at consulting rooms lasting less than 20 minutes - level B consultation - \$34.30 (+ \$9.00 bulk billing incentive payment), including any of the following:</p> <ul style="list-style-type: none"> • taking a patient history; • performing a clinical examination; • arranging any necessary investigation; • implementing a management plan; • providing appropriate preventive health care; <p>in relation to 1 or more health-related issues, with appropriate documentation.</p>	<ul style="list-style-type: none"> • Reading blood test results • Any phone consultation with a patient e.g. explaining test results • Recording blood test results in clinical notes (<i>only clinical details recorded at the time of the attendance count towards the time of consultation. It does not include information added at a later time, such as reports of investigations</i>) • Completing forms i.e. service access, patient programs etc • Reporting a child at risk

General Practice Funding

Blended payment arrangements

- Fee for service - obstacle to achieving effective and coordinated chronic disease care - doesn't adequately support the 'behind the scene' work required to support comprehensive care and care coordination.
- Practice and other incentive payments in parallel with fee-for-service and patient fee producing a blended payments scheme
- Specific eligibility criteria and restrictions / conditions on accessing these arrangements.

General Practice Funding

Health Assessments

- Healthy Kids Check
- 45-49 Health Assessment
- Type 2 Diabetes Risk Evaluation
- Older Persons Health Assessment
- Comprehensive Medical Assessment for permanent residents of an aged care facility
- Health Assessment for person with an intellectual disability
- Health Assessment for a person under the Government humanitarian program

General Practice Funding

Health Assessments

Target Groups	Frequency
Children aged at least 3 years and less than 5 yrs of age, who have received or who are receiving their 4 yr old immunisation	Once only to an eligible patient
People ages 40-49 yrs (inclusive) with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool	Once every 3 yrs to an eligible patient
People aged 45-49 yrs (inclusive) who are risk of developing chronic disease	Once only to an eligible patient
People aged 75 yrs and older	Provided annually to an eligible patient
Permanent residence of Residential Aged care Facilities	Provided annually to an eligible patient
People with an intellectual disability	Provided annually to an eligible patient
Refugees and other humanitarian entrants	Once only to an eligible patient

General Practice Funding

Health Assessments

Item Number	Item Names	New Fee
701	Brief – will be used to undertake simple and straightforward health assessment. HA shouldn't take longer than 30 mins.	\$55.00
703	Standard – Health assessment lasting more than 30 minutes but less than 45 minutes	\$127.00
705	Long - Health assessment lasting more than 45 minutes but less than 60 minutes	\$176.30
707	Prolonged - Health assessment lasting more than 60 minutes	\$249.10
715	Aboriginal and Torres Strait Islander peoples health assessment	\$196.65
10986	Healthy Kids Check – provided by a practice nurse or registered Aboriginal Health Worker	\$55.00 ₃

General Practice Funding

MBS Chronic Disease Management items:

- Preparation of GP Management Plan (GPMP)
- Review of GP Management Plan
- Coordination of Team Care Arrangements (TCA)
- Coordination of a review of TCAs
- Contribution to a multidisciplinary care plan prepared by another health provider
- Case Conferencing services by a GP

General Practice Funding

GP Management Plan (GPMP) - item 721

- For patients with a chronic or terminal medical condition who will benefit from a structured approach to the management of their care needs.
- A chronic medical condition is one that has been or is likely to be present for six months or longer, including to asthma, cancer, cardiovascular illness, diabetes mellitus, musculoskeletal conditions, stroke.
- GPMP review

General Practice Funding

Team Care Arrangements (TCAs) - item 723

- TCAs are suitable for patients with a chronic or terminal condition, who need ongoing care from a multidisciplinary team including their GP and **at least two** other health or care providers.
- One of the two other service providers collaborating with the GP may be another medical practitioner (normally a specialist or consultant physician but not usually another GP)
- TCAs review

General Practice Funding

For the purposes of care planning and case conferencing who may be included in a multidisciplinary care team:

Aboriginal health workers	asthma educators
audiologists	dental therapists
dentists	diabetes educators
dieticians	mental health workers
occupational therapists	orthoptists
optometrists	prosthetists
orthotists	pharmacists
podiatrists	physiotherapists
psychologists	registered nurses
social workers	speech pathologists

General Practice Funding

Allied Health Items

- Medicare benefits are available for some services provided by eligible allied health professionals to people with chronic medical conditions and complex care needs who are being managed by a GP using specific CDM items.
- The allied health services must be recommended in the patient's management plan/s.
- Patients must have received a GP Management Plan – MBS item 721 (or review) AND Team Care Arrangements – MBS item 723 (or review)

General Practice Funding

Contributing to a multidisciplinary care plan

Steps:

- Gaining or confirming the patient's agreement for the GP to contribute to the care plan and to share relevant information with the other providers;
- Collaborating with the person preparing the care plan to set goals and specify services to be provided by the GP;
- Adding to the patient's records a copy or notation of the GP's contribution to the plan (either the services to be provided by the GP or the GP's advice to the person preparing the plan)

General Practice Funding

Case study

- Mr Chung Woong is 76 years of age and lives at home by himself
- His daughter who works lives half an hour away with her children
- He smoked heavily all his life and has chronic obstructive pulmonary disease (COPD)
- He had four extended periods in hospital in the last year for COAD and related conditions.
- Chung presents to his GP with a discharge letter from the hospital following his most recent admission for treatment of COAD

General Practice Funding

Case Conference

- The case conferencing team must include a GP and at least two other health or community care providers. Each team member should provide a different kind of care or service to the patient.
- Education providers, “meals on wheels” providers, personal care workers, probation officers, patient’s carer can be included as a formal member of the team, but **does not count** towards the minimum of three service providers.
- The patient does not have to be present.

General Practice Funding

- **PIP** scheme recognises practices that contribute to quality care, such as provision of after hours care, student teaching, better prescribing, employment of practice nurses, servicing RACFs, use of a patient register to recall patients with diabetes etc
- Cannot access PIP unless are accredited or working towards **accreditation** (RACGP Standards for General Practices)

General Practice Funding

Item descriptors and explanatory notes are available at www.mbsonline.com.au

Fact sheets available at www.health.gov.au/mbsprimarycareitems

Implications/Recommendations

- It may not be feasible for patients to be offered additional advice or services beyond their original reason for presentation unless a reliable strategy is negotiated and agreed.
- Working with Divisions of General Practice and adequately resourcing the establishment and funding of nurse clinics (in practices with adequate infrastructure) and off or on-site group education courses (where GPs can refer relevant patients) have proven very successful in instances where sustainability of the add-on services can be assured.

Implications/Recommendations

- More GPs utilise the MBS incentive payments when given support to do so, including appropriate item identification, clear summaries of the conditions to be met to claim the item, the provision of templates that satisfy any necessary patient information collection, billing instructions and comparative summaries of evidence based benefits of providing the services to patients relative to usual general practice care.

Questions?
Comments?

General Practice Education and Training

“A General Practitioner is not a failed heart surgeon or a failed anything but a fully trained and competent medical practitioner with their own crucial 'generalist' role to play in the provision of excellent high quality health care”

General Practice Education



Vocational registration

- Australia was one of the last developed countries to recognise that General Practice is a specific and defined discipline in Medicine.
- Vocational recognition of general practitioners by government in 1989 resulted in a realisation of the enormous potential of the role of general practice in the delivery of health care in Australia.

General Practice Education

Vocational registration

- Approximately 90% of GPs in Australia are vocationally registered, meaning that they have completed the Royal Australian College of General Practitioners' Fellowship Examination (**or** are fellows of the College by virtue of their year of graduation)
- The major practical significance of the distinction is that the service provided by a non-VR GP attracts a lower Medicare rebate compared with those who are registered.

General Practice Education

Quality Improvement and Continuing professional Development (QI&CPD)

- The primary aim of the RACGP QI&CPD Program is to assist all GPs maintain and improve the quality of care they give to patients through participation in continuing medical education, quality assurance and professional development.
- Divisions are the major providers of QI&CPD activities.

General Practice Education



Implications/Recommendations

- There is no shortage of accredited educational activities for GPs and investigating those available may eliminate the need, cost and time to develop another.
- Expertise as a GP includes the need for knowledge of a large body of information and procedural skill across a wide range of areas.
- Education is more likely to be of value if GPs are given sound evidence based rationale for the need to know or be update on a particular topic.

General Practice Education

Implications/Recommendations

- Involve GPs in diagnosing their own educational needs and in planning the delivery methods and content of CPD activities.
- Ensure GP education is properly constructed and targeted, general overviews attract less interest and lectures alone are unlikely to change professional practice. Facilitate learning through interactive workshops and other methods (e.g. small group learning).

Questions?
Comments?

Evolving role of nursing in General Practice

*In 2004 MBS Items first introduced
for practice nurses to provide a
service on behalf of GPs*

Nursing in General Practice

- A general practice nurse (PN) is a registered or enrolled nurse who is employed by, or whose services are retained by, a medical general practice.
- > 57% of NSW practices employ at least one PN.
- 25% of practices employ one nurse, while 7% employ more than five.
- The majority of PN are registered nurses, aged over 40 years and employed part time.
- Around 30% PNs are employed in at least one other nursing job.

Nursing in General Practice

- Around half of practice nurses are employed in major Australian cities. Nearly 20% in regional practices.
- 14% of PNs are located in remote and very remote Australia.
- Practice nursing is better suited to a work-life balance than nursing in hospitals or other settings that may require shift work, overtime and on-call demands.
- Federal pay award a barrier.

Nursing in General Practice



Source: Primary Health Research and Information Service www.phcris.org.au

Medicare Items for Practice Nurses

Immunisation given by a nurse on behalf of GP

Cervical smear and preventative checks provided by practice nurse

- with preventative health check
 - without preventative health check
-

Wound management by a nurse on behalf of GP

Chronic disease: monitoring and support

- checks on clinical progress
 - monitoring medication compliance
 - self management advice
 - collection of information to support GP review of care plans
-

Antenatal checks

Healthy Kids check

Items where nurses can assist GPs

45 Year old health check

Health assessments

- at consulting rooms
 - at home
-

EPC Care Planning

- GP Management Plan (GPMP)
 - Team Care Arrangements (TCA)
 - reviews of GPMP and TCA
-

Asthma cycle of care

Diabetes cycle of care

Cervical Smear: unscreened women

Implications/Recommendations

- Care provided in general practice will more and more require greater levels of health promotion, chronic disease monitoring and care of older patients. This will involve the innovative use of existing resources including other health professionals, particularly practice nurses.
- Practice nurses will be called on to undertake a greater range of functions including working outside the practice with external care and other service providers who are able to support practice patients.

Implications/Recommendations

- PNs are an important link between the patient and the GP, and between requests made from external groups and the GP.
- Nurses have access to practice systems and data that may support the development and evaluation of local population health and other initiatives.
- General practice nurses can be supported by external groups through the design and certification of primary care relevant, cost free professional development opportunities that are accessible after hours.

Questions?
Comments?

General Practice Accreditation

The activity of preparing and undergoing accreditation has been shown to promote change in health care organisations through detailed reflection on organisational practices.

Accreditation

- Accreditation is an accepted and important element in quality improvement activities in health care systems throughout Australia.
- Accreditation in general practice is a voluntary process of organisational assessment.
- The Royal Australian College of General Practitioners' sets the accreditation Standards for General Practices.
- The standards are designed to ensure compliance with legal, safety and other requirements of general practice and provide a mechanism for feedback and quality improvement support.

Accreditation

	Number	NSW Practices %
Total General Practices in NSW	2782	100.00
Fully accredited practices	1528	54.92
Practices registered or accredited	1793	64.45
Practices registered for accreditation	265	9.53
Practices not registered and not accredited	989	35.55

Implications/Recommendations

With around 65% of NSW practices either accredited or working towards accreditation, focusing on the requirements outlined in the RACGP Standards provides opportunities for working with general practice across areas such as health promotion, evidence based practice, chronic disease management and training provision.

Implications/Recommendations

- General practice can be supported with training and workforce capacity development associated with accreditation requirements.
- There is a need for the costs associated with practice accreditation to be sufficiently acknowledged and managed through mechanisms such as grants for practices to meet the administrative and equipment costs of compliance and free training and support for practice staff.

Questions?
Comments?

Computerisation and eHealth in General Practice

WHO defines ehealth as *“the use, in the health sector, of digital data - transmitted, stored and retrieved electronically - in support of health care, both at the local site and at a distance”*

Computerisation and eHealth

- Nearly 89% of GPs have access to a computer in their major practice address.
- A range of different management and clinical systems are used by Australian general practices.
- Administrative tasks remain the most common use of computers in general practice including the issuing bills/receipts, and word processing.
- Other uses include prescribing medications, clinical data storage, patient history and progress notes, allergy alerts and accessing the Internet.

Computerisation and eHealth

Overall, comprehensive computer use is more likely in a large multi GP practice rather than a smaller or solo GP practice; when the GPs have recently graduated or are female, and in large rural centres and other regional areas compared to urban areas.

Computerisation and eHealth

- 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/misconduct investigation.
- Aggregating individual clinical data up to the level of the practice population has been used to add a population focus to the work of many practices.

Computerisation and eHealth

- General practice generates around 13 million referrals yearly
- The majority of these (approx 12 million) go to specialists and allied health providers.
- GPs are also the dominant receivers of reports from referred-to clinicians, with approximately 7 million post referral reports received per annum.
- The proportion of GP referrals that are computer generated paper from clinical systems is estimated to be up to 66% (compared to only around 10-20% for specialist referrals)
- Handwritten (or dictated and typed up by the practice's office staff) is estimated to be at least 33%.
- Electronically transmitted (e-referral) is estimated to be only between 1-2%.

Computerisation and eHealth

Main Barrier

- Low level of Information Technology use 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 information technology investment has also been relatively low.

Computerisation and eHealth

Implications/Recommendations

- Target practices with systems already in place.
- Practices are more likely to be interested in working with external groups if they design programs that align with the general practice environment. For example, external care providers and services can utilise existing or work with and/or fund Divisions of General Practice to develop relevant electronic referral templates that are compatible with and can be uploaded into existing clinical software.

Implications/Recommendations

- A level of desensitisation to electronic alerts that are of little immediate clinical significance or inappropriate for a particular patient has been reported by GPs.
- Reliable electronic directories of health and welfare services that may be suitable and affordable for patients with chronic conditions are becoming increasingly important to general practice.
- Always seek Division advice when considering initiatives that rely on patient electronic record and/or clinical system changes in general practice.

Questions?
Comments?

General Practice as an Information Target

General Practice as an Information Target

General Practitioners and practice staff have a diverse range of information needs:

- New developments in family medicine
- Routine patient care
- Drug alerts
- Government policy and regulations relating to health care
- Practice organisation and management
- Communicable disease-specific information
- Professional development
- New medical equipment

General Practice as an Information Target

- The common assumption that simply developing and making even important information both relevant and available to general practice can lead to understanding, uptake and application is naive.
- Barriers to accessing and using information of any kind include lack of awareness of available information resources or forgetting about their availability, reimbursement concerns, lack of relevancy and transferability of research to clinical practice, distrust of available information, and disruption of established work-flow patterns.

General Practice as an Information Target

Information sources currently referred to frequently by general practice include systems such as Medical Director, on-line and print text books, clinical literature search engines such as PubMed, locally produced journals such as Australian Doctor, Australian Family Physician, Medical Observer and Australian Prescriber; electronic and/or print newsletters from GP, Nursing and Practice Manager professional bodies and medical education experts such as ThinkGP, and organisations such as Divisions of General Practice, and the daily on-line update - *6minutes*.

Implications/Recommendations

- Information is more likely to be perceived as relevant to general practice if it is seen as responding to its particular circumstances, is matched to its business environment, offers needed support to understand and/or contribute to better patient care or practice management and includes a website that can be accessed for further information.
- Relevant information will take into account questions that are important to practices including: *Is the issue common to my practice, and is the intervention feasible in this setting? Does the information focus on an outcome that my patients care about?*

Questions?
Comments?

Responsible Partnering

Partnerships are more likely to be sustained if they have a clear mission with realistic expectations, are patient centred, provide regular communication, share responsibility for decision making, have rules for management and good leadership, and acknowledge the successes of all involved

Responsible Partnering

- General practice is routinely asked by a range of different groups to partner for a variety of purposes.
- The difference in structure, role and funding of private general practice, hospitals and public allied health services can make partnering difficult.
- Collaboration between general practice and other health care providers gives each a better understanding of the services of the other.
- Studies have shown that when a general practice has a good understanding of those they may work with, they are more likely to engage with them.

Responsible Partnering

- GPs face numerous demands such as high practice workload, administrative burden etc.
- These factors force GPs to focus on the core business of the practice and may make them reluctant to participate in any additional activities.
- The fee for service payment structure in general practice makes it difficult for practices to participate in much of the “behind the scenes” work that is required to communicate and engage in partnerships and take the time to understand its value and expectations.

Responsible Partnering

Implications/Recommendations

- Put time into gaining knowledge about general practice, what it does, how it works, its context, its funding arrangements, the challenges it faces etc.
- Express commitments early through practical support for the partnership in terms of resources, staff and/or other support.
- Medicare and other incentive payments are generally not enough to ensure effective collaboration with general practice.
- More pro-active facilitation, in-kind support and resourcing of partnerships are often required.

Implications/Recommendations

- Minimise the time burden and paper work requirement of practice staff and GP.
- Recruit or finance the recruitment of a staff member in the local Division to be specifically responsible for relationship management and program support. This helps to coordinate communication between the partners and ensure effective implementation of ground rules and protocols for working together. It also ensures that relationship management is given focused time and attention to gauge and track the health of the partnership over time.

Questions?
Comments?

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