

Medicare Locals discussion paper on governance and functions

This submission is a response to the discussion paper on Medicare Locals.

GPV's main points are numbered below, after which we respond to a number of the paper's specific questions. We would be happy to elaborate on any of the points made here in further discussions.

1. Since the 'health reform' consultations began, the discussions and proposals for primary health care organisations have shifted between the idea of a major system reform whereby regional population health planning is undertaken, with more flexible funding to target gaps; and a more limited change where Medicare Locals (MLs) engage with a variety of primary health care providers to improve coordination and implement national programs.

The current discussion paper lists both these objectives: #1 "identifying local area health needs" and #4 "implementing healthcare initiatives." While GPV would support a major reform that put the regional population health approach at the forefront, our reading of the paper suggests that this is not what is really intended. We are therefore making comments in the context of #4 being likely to become the major focus for Medicare Locals.

2. We welcome a greater focus on primary health care. Divisions have long recognised the need to strengthen multidisciplinary care, particularly in the context of an increase in chronic disease, and they implement programs with this aim. One of the overall aims of the Divisions' Program has always been to better connect general practice and the rest of the health system (both primary and acute), for better patient care.
3. We welcome the invitation to divisions of general practice to register their interest in tendering to become a Medicare Local. In Victoria, divisions have already reached agreement on the Medicare Local catchment areas in 7 of the 8 state Department of Health regions (and these catchments are broadly consistent with the state health department's approach) and are leading work with their partners at the local level to prepare for the establishment of Medicare Locals.
4. It is essential to ensure that the knowledge and expertise gained over the last 18 years by the Divisions Network (at local, state and national levels) is not lost in the transition to PHCOs – about what types of approaches work, local relationships, what activities or strategies are needed in certain areas of health, models for the general practice contribution to care for conditions that have low prevalence but affect very high need populations, policy issues that need to be addressed at state and national levels. We need to ensure that the new organisations draw on this information and expertise, particularly as division programs wind up and new ones begin. See below, pp. 11 and 13 for list of programs.
5. The crucial challenge is: how will Medicare Locals bring about any major change in local arrangements when they have no significant levers to do so? This has been the challenge of the Divisions' Program so far – it has accomplished much, but not enough, and the limitations to these achievements are largely because of the lack of levers. Divisions make the rationale clear to providers for taking up any given initiative, offer some support to do so (sometimes not enough due to funding constraints) and general practices choose to engage or not. This appears likely to be the case for Medicare Locals also – except that, in their case, there will be far more primary health care providers and service sites to engage. If Medicare Locals do not have the levers in the form of the allocation of funding, and lack any formal authority to require action, how will the results be different?

6. GPV believes that the appropriate structure should be put in place for the ultimate role proposed for MLs. If the purpose is to create regional health plans and allocate funding to meet needs and fill gaps, as paragraph 5 suggests is necessary, the ML would be allocating large amounts of taxpayer money and would therefore have to be more amenable to government direction than a company limited by guarantee. If an organisation is initially established to fulfil a more modest role, like that of current divisions, it will not simply ‘evolve’ as time goes on; it will create the need for another major restructure in the future.
7. GPV believes that there must be a requirement that Medicare Locals be not-for-profit. (The discussion paper describes this as an expectation rather than a requirement.)
8. The paper makes no reference to the need for a purchaser-provider split. The separation of these roles is a fundamental principle of accountability and good governance
9. GPV welcomes the renewed emphasis in this discussion paper on providing support to clinicians as a crucial area of responsibility for Medicare Locals; and the statement (p.4) that “Medicare Locals will retain, and expand, the functions and activities currently undertaken by the Divisions of General Practice – including general practice support and the delivery of programs”. These roles need to be preserved so that we do not risk the disengagement of general practice, which is crucial for primary health care systems improvement.

It is important to see providing support to clinicians as an area of activity that is inextricably connected to achieving good results in health service delivery – it is often a method, or one strategy for ‘implementing healthcare initiatives’ and/or for gathering good quality local needs data rather than something separate. Population health planning and many health initiatives will need multi-faceted strategies. We outline some of the programs and areas of general practice support below (see pp.5-6) that will need to become part of MLs’ responsibilities. These represent a wider range of programs than is sometimes recognised and it will be important for policy makers and funders, as well as MLs themselves, to be clear about what programs might be included.

10. All the activities and objectives suggested for Medicare Locals require an adequate health workforce if they are to be achieved. Medicare Locals’ engagement with primary care providers in their area will mean they are ideally placed to link with the larger workforce organisations, colleges and training networks to support a range of workforce activities.

GPV supports the statements made by AGPN in its submission stating that Medicare Locals must be able to perform a range of workforce tasks as a way of ensuring their capacity to meet local primary health care needs. Workforce roles include:

- Facilitate workforce attraction and retention in partnership with workforce agencies
- Develop new service models to maximise the efficiency and reach of the available workforce
- Develop and maintain strategic partnerships for workforce development including:
 - Community partnerships for workforce attraction and retention
 - Partnerships with education institutions through regional training networks to be established by Health Workforce Australia.

It is vital to recall that divisions of general practice have already played a substantial role in workforce development and these roles have been documented in the annual PHCRIS reports and in Victoria by a joint RWAV & GPV study on the role of and capacity of divisions to respond to workforce issues.

The executive summary and full report of the RWAV & GPV study are available to download from the GPV website: <http://www.gpv.org.au/resources.asp?cat=86&subcat=105>.

11. The objectives outlined in the discussion paper can only be achieved with investment in practice nursing and the work that MLs can do to build and further develop this workforce.

Practice nurses have increasingly taken on wider roles and practices rely on nurses to co-ordinate population health approaches in practice, including but not limited to immunisation, chronic disease management and women's health. Practice nurses are now the key players in quality development in general practice, initially through refining systems to support practice accreditation, and extending to involvement in Primary Care Collaboratives and Practice Health Atlas activities with their population health focus. Chronic disease management within multi-disciplinary teams will require nurses in general practice to provide systematic care and to bring the team together. Through programs such as Lifescripts, Life! Taking Action on Diabetes and now the Commonwealth Diabetes Prevention Programs practice nurses are involved in identification of suitable patients and support for prevention through appropriate referral and one on one motivational interviewing.

The credit for the development of this population health role sits firmly with the work of the Nursing in General Practice Program, funded over the last few years, but surprisingly not provided for in 2010-2011 until AGPN made vigorous representation to the Department of Health and Ageing and the Minister for Health and Ageing.

The divisions' workforce development role for practice nurses now extends from clinical placements for students in training through workplace training and development, increasingly multi-disciplinary, to support for post-graduate studies.

12. GPV and other SBOs believe that the continuation and further development of work at the state level will be essential to the successful achievement of the Commonwealth's health reform agenda.

Health systems in Australia function at the state level. The management and configuration of hospitals differ in each state and territory, and will continue to do so under the reforms. The Commonwealth's reform objective of an integrated health system cannot be achieved if that system is seen to comprise a Commonwealth-driven primary sector and a state-driven hospital sector. Without substantial capacity for work in primary health care at the state level there is a significant risk that the Commonwealth's assumption of responsibility for all primary health care might result in accentuation of the gulf between primary and hospital care and the reinforcement of barriers to integration.

There needs to be alignment of national initiatives with relevant state-level initiatives to enable their successful implementation. Divisions and SBOs have worked to find common directions and bring them together at the general practice level. This will still be needed with the advent of Medicare Locals.

There are many areas of primary health care for which responsibility will not be transferred to the Commonwealth, but which will remain the responsibility of the state or local government in Victoria. These include disability services, HACC services, maternal and child health and public health. The Departments of Education and Early Childhood Development and Human Services provide funding for programs that will require the engagement of the primary health care sector in Victoria, and consequently there will remain a need for a state-level organisation for the Medicare Locals.

There will continue to be a trend to shift some areas of patient care from current hospital settings to community settings for a range of reasons including better access for patients as well as cost containment. (Just one example is hepatitis – in Victoria there has been a program to enable more care to be provided through general practice which requires a range of training and other supports. One outcome is that country patients do not need to travel to the city for treatment and are

therefore more likely to seek and complete required treatment). These types of initiatives are best organised through a state level organisation. There is not a sufficiently large group of GPs (nor patients) to warrant a Medicare Local addressing the full range of high-need populations with low prevalence conditions; but the national level is too remote, and not so well able to link with the state-based health organisations, specialists and hospitals.

Medicare Locals will also need the services that SBOs have provided for divisions including statewide networks and individual consultancy services to help ensure high and consistent standards of organisation and service delivery. This work is likely to include governance training and development for boards; consultancy services on organisation and management; support and development at the program level, including program-specific networks for MLs and other agencies relevant to their programs; state networks, state forums and other opportunities for sharing and exchange both with MLs and with other agencies and services. These sorts of services are most effectively provided at a state level, by providers with detailed state-specific knowledge or relationships.

Public health will remain a state responsibility. The primary health care response to disease epidemics and disasters needs to be organised at a state level not only with state-funded agencies, but with a range of providers. In Victoria over the past 2 years, there have been division-led responses to swine flu and to providing primary care services immediately following the bushfires. The state based organisation of divisions has enabled general practice input to disaster management and a range of public health strategies, so that they can be implemented when necessary. It also provides the state with an efficient line of communication with the approximately 1700 practices in Victoria. This will still be needed, and indeed will be more complex with MLs extending their focus to all primary health care providers in a catchment.

There will be a need for a state-level entity for the Medicare Locals. In Victoria there are a number of state-level organisations with which a close partnership would make a very strong support system for MLs.

Responses to specific questions

What features will MLs need to have in order to achieve their objectives?

1. Identification of the health needs of local areas and development of locally focused and responsive services

As suggested in point 1 above, we would welcome the MLs having a major regional population health planning role. If that is the intention, then, as our national organisation, AGPN has argued in its submission, success will rely on “the authority, resources and capacity vested in MLs.” If there are no ‘levers’ to enable the ML to collect data from a wide range of players (listed in AGPN’s submission), including the state which has responsibility for health planning and will retain responsibility for public health, and local government, which is required by law to develop municipal health plans, as well as public and private health providers, then the type of health needs analysis done by the MLs will be much more limited in scope and the MLs will have little capacity to influence the development of services and no capacity to implement its plans.

The scope needs to be clear. The relationship of the ML health plan to local government and state plans (including those of a number of departments, including in Victoria DHS, DEECD, Office for Children as well as DH) needs to be clarified. Duplication would be not only inefficient and confusing, but would risk stakeholders being unwilling to provide the data, if they are receiving multiple requests.

The collection of data directly from local providers (rather than through a third party such as the MBS), must be designed in such a way that the benefits of submitting the data are very clear to service providers. Providing data needs to be linked to something valued and needed; otherwise providers are unlikely to devote resources to doing it. (Examples include the Australian Childhood Immunisation Register (ACIR) which gives feedback to general practice to enable them to improve rates of immunisation in their practice population; the Australian Primary Care Collaboratives and the PEN Computer Systems Clinical Audit Tool (PENCAT) and other data extraction tools, described further below.) There needs to be support to set up the systems that allow for data collection and transfer. Divisions and their state based organisations have had some experience of this through encouraging the adoption of tools such as the PEN Clinical Audit Tool and through programs such as the Australian Primary Care Collaboratives. (See Attachment 1 for more information on APCC and PENCAT)

2. Improving the patient journey through developing integrated and coordinated services, including across the transitions between primary and acute and aged care

One of the critical factors leading to improving the patient journey is the extent to which services are integrated. Integration must include the continuity within the primary health care sector, systemic linkages between the primary health sector and the acute and specialist care sectors, and linkages between aged care and primary care and acute/specialist services. For patients to experience improvements in how the health services they access are organised Medicare Locals must address integration at these levels. The paper suggests the development of clinical pathways with LHNs and lead clinician groups. Integration needs to be much broader than just a focus on clinical pathways. The recently completed Australian Better Health Initiative Primary Care Integration Program in Victoria achieved the following:

- Productive collaborations between Divisions, Primary Care Partnerships and state-funded community health services focussing on system changes to improve integrated chronic disease management.
- Building networks between GPs, community health and private allied health providers, increasing awareness and mutual understanding of services available, roles and capacities to contribute to chronic disease management. Flow-on effects were seen in improved consistency and quality of communication between providers and the increased quality and frequency of referrals.
- The implementation and increasing use of system tools in general practice to improve practice data management and analysis to inform planning, quality improvement and the implementation of reminder and recall systems to deliver more proactive, tailored and timely care for people with chronic disease.

The enablers identified for this increase in integration across both the public and private sectors were: parallel state-funded chronic disease management initiatives and having dedicated resources to focus efforts and increase momentum for integrated approaches to chronic disease management. Medicare Locals would need to be resourced to further strengthen the understanding and linkages between the range of health and aged care providers, as this requires concentrated long term attention at local, regional, state and national levels.¹ Such understanding and linkages will improve the patient journey through our complex health and aged care system.

See section below on “How should Medicare Locals and Local Hospital Networks work together?” for points on integration/coordination between general practice and hospitals.

3. Providing support to clinicians

¹ GPV meets six monthly with the state level allied health peak organisations to keep them informed of developments affecting general practice and allied health professions. This has been welcomed by the allied health organisations and led to a much greater mutual understanding between these professions and general practice.

GPV welcomes the renewed emphasis on providing support to clinicians as a crucial area of responsibility for Medicare Locals. As we have advocated in previous submissions, the roles currently fulfilled by general practice networks needs to be preserved, otherwise we will risk the disengagement of general practice. General practice engagement is crucial for primary health care systems improvement, for many reasons, including that 80% of the population access general practice each year. No other service type has this kind of 'reach.'

The following list of Division programs can be characterised as providing support to clinicians. The programs are, in fact, about improving the capacity of general practices and their staff to deliver high quality, better coordinated and accessible care to patients. Such programs include:

- the Primary Care Collaboratives Program, which allows practices to identify areas for improvement and work towards achievable, measurable improvement (e.g. in improving the local community's access to general practice, improving the achievement of clinical measures for diabetes and cardiovascular care);
- implementation of the PEN Clinical Audit Tool and other data extraction tools (as part of e-health programs) which assist practices to take a systematic approach to the health of their practice population, keep track of patient data and clinical outcomes and provide a basis for recall and reminder systems and give a profile of the practice population;
- various programs to assist referral, provide secondary consultation when necessary and allow the person to return to their regular GP for ongoing whole-person care;
- quality use of medicines programs to improve prescribing;
- assistance with use of new MBS items to increase uptake of processes that are thought to improve multidisciplinary and chronic disease care;
- the Nursing in General Practice program, to encourage and assist practices in appointing and training practice nurses that allow for a more appropriate use of skills in delivering good quality services to as many people as possible. (see also point 11 on p.3 above)

This is not an exhaustive list. (More information on the approach and results of the APCC are at Attachment 1.)

It is important to see that providing support to clinicians is an area of activity that is inextricably linked to achieving good results in health services delivery; and that divisions are involved in a wide range of such programs. MLs will need significant resources to continue this work as well as expand and strengthen it.

4. Facilitation of the implementation and successful performance of primary health care initiatives and programs

- GPV welcomes the suggestion that Medicare Locals will expand on the work that has been undertaken so far "including general practice support and the delivery of programs." The range of government programs that divisions have implemented needs to be acknowledged, in order to be clear which aspects Medicare Locals are seeking to build on.

These include: (in no particular order): mental health, youth health, aged care, maternal and child health, immunisation, Aboriginal health, health promotion, chronic disease management, e-health, referral and feedback (to and from primary care services and hospitals), clinical risk management, practice accreditation, implementation and support for new MBS items and enhanced primary care (including diabetes, asthma, cervical screening), practice nurses (education, networking, practice-level support and promotion of financial models and schemes to enable initial employment), Continuing Professional Development for GPs, Primary Care Collaboratives, palliative care, *Active Script*, implementation of PEN Clinical Audit Tool, Practice Health Atlas, quality use of medicines, workforce recruitment, support and retention, providing after hours care, as well as a range of programs on particular health areas e.g. cardiovascular health, diabetes prevention, injury prevention, asthma, COPD, etc.

In government reports and discussions, this breadth sometimes seems to be underestimated in a line that says ‘implementing government programs’ or in a different line that says ‘GP support.’

- This objective will be likely to take priority over some other objectives, such as the identification of local health needs. Divisions have experienced the tension of trying to balance addressing local needs with addressing national priorities, and it tends to be the national priorities that inevitably take precedence. This militates against MLs doing the best job of identifying local needs and filling gaps.
- Medicare Locals should not have to have separate funding contracts for each program they undertake. Different reporting cycles and requirements can be arduous to meet and divert attention from the real program work that needs to be done.
- GPV would be concerned if this objective was translated as a series of short-term projects, which have serious limitations for health improvement. Funding priorities change, and there tends to be relatively high investment in the initial development stages but not necessarily resources to enable sustained effort or improvement, or retention of staff or corporate knowledge. Divisions have many examples of this – the most recent ones being in Mental Health Programs and the Practice Nursing Program, both of which have lost many experienced staff (and therefore the local projects stop) as the funding has either ceased or there has been prolonged uncertainty.
- This objective must not be interpreted as referring only to national priorities or initiatives. There are also likely to be statewide initiatives. For instance, in Victoria GPV and, through our member divisions, GPs, have been involved in training and support re hepatitis B and C, HIV, methadone prescribing, Vitamin D deficiency, alcohol, children in out-of-home care and refugee health. These initiatives have required negotiation between state health and GPV.

Are there other roles and functions Medicare Locals could potentially adopt?

Workforce roles

See point 10 above which outlines the workforce roles that MLs will need to fulfil, building on the role of divisions to date.

The recent RWAV and GPV study on the role of and capacity of divisions to respond to workforce issues found that ‘workforce underpins everything we do’. Divisions have undertaken a wide range of workforce roles including attraction, retention, education support, integration into local communities, support for students, community partnerships to promote workforce, after-hours care to name a few. They have also been involved in improving workforce capacity in general practice, in practice nursing, in mental health, aged care as well as in a number of high-need, low prevalence areas such as care for hepatitis C patients or provision of palliative care.² These roles have been led by statewide and sometimes national programs.

There is also a substantial state-level role

- (a) in supporting workforce data collection and analysis, at present, undertaken for rural areas by rural workforce agencies but unavailable for urban areas.
- (b) Training, development, networking and resource sharing to support the capacity of local workforce development roles.

The statewide role should involve the technical expertise in workforce offered by workforce agencies and the dedicated program support and development role currently provided by SBOs in nationally funded programs such as the highly successful Practice Nursing Program. The statewide role also involves partnerships at statewide level to pave the way and set the framework for local negotiations.

² For a full list of workforce activities undertaken by divisions of general practice see Appendix 1.

For a complete account view the report on Victorian divisions workforce activity at:

www.gpv.org.au/files/downloadable_files/Programs/Workforce/20091104_rpt_Workforce%20Research%20Report%20Final%20-%20low%20res.pdf

It would jeopardise the success of the Medicare Locals if the importance of this role were not recognised and resourced at local and state-wide levels.

(See also p. 3 above, which outlines some of the areas that will remain responsibilities of the state, where MLs would need to play a role – e.g. public health, disability services etc.)

Low-prevalence and high-need

There are many different health issues affecting groups within the community that have very high needs, but because either the group represents only a small proportion of the general population (eg children entering out of home care; refugees) or the clinical condition has relatively low prevalence, even though it may have severe consequences (eg HIV, viral hepatitis), it is difficult to get widespread engagement and sufficient knowledge among all GPs to provide the best quality care. In these situations, where the alternative is usually hospital-based treatment and specialist care, GPV and divisions can offer a way to ensure that sufficient GPs are engaged and supported to undertake the care that is needed. Divisions have worked on a model that:

- a) Maintains focus on general practice as the key provider of medical care because:
 - access to general practice care is greater than access to specialist care – in terms of geographic spread and timeliness
 - people with specific conditions requiring specialist care also require general medical care. General practice is able to provide continuing and comprehensive whole-patient care, rather than care based on only one condition.
 - General practice can provide appropriate medical care, supported by access to medical specialists, secondary consultation advice and multi-disciplinary care providers.

- b) Supports GPs and general practices with a specific interest in developing their capacity for delivery of care to this population group. The types of support tend to include:
 - professional development for GPs, and practice nurses at local level to meet identified needs
 - use of tools and systems in the practice including software templates, clinical tools, patient record tools, etc
 - advice about practice systems development eg appointment design, billing, referral pathways and protocols

(In turn, these GPs and practices with a specific interest can become a source of clinical leadership at the local level and readily accessible to assist with risk management, complex cases, ethical issues, secondary consultation, etc)

- c) Involves the network of divisions of general practice to support implementation and develop capacity for general practice participation, eg:
 - recruit suitable, interested general practices from all catchments across the state (or nationally),
 - facilitate access to support (described above) for the selected practices in their catchment
 - provide input to resource and strategy development at regional or state level including quality improvement and innovation, clinical guideline development, aggregated data collection and so on.
 - work with the range of stakeholders to achieve program aims.

This model would need to be expanded by MLs so that the necessary supports are in place for the other providers that need to be involved – including hospital specialists and private and public allied health providers.

How should Medicare Locals and Local Hospital Networks work together?

- It is more important to look at joint strategies, at what areas of work hospitals and MLs need to focus on to improve patient care and at what policy drivers need to change (e.g. funding hospitals for presentations/admissions rather than prevention, making it difficult to address prevention even though it is crucial in order to reduce hospital demand) than at cross-membership of boards.

In terms of linkage between the MLs and LHNs we need a bridge or boundary spanner to bridge the cultural gap between the sectors. General practice liaison units currently funded in Victoria in 15 hospitals could be located in each LHN. The functions of such a liaison unit are to:

1. Improve relations between primary care providers and hospitals
2. Improve the transitions of care
3. Shift care to the most appropriate location and
4. Reduce the need for acute care

This multipronged approach means that the needs of both the hospital and the primary care sector can be addressed through one unit with a profile in the hospital. Our experience has shown that you cannot get successful outcomes in the more complex areas of shifting care and reducing the need for acute care until you have addressed the issues of relationship and improving communication about the transitions of care.³

There need to be requirements for MLs to engage with LHNs; funding to support it; and state governments need to require hospitals to report on agreed targets, so that they also have an incentive to deliver.

What aspects of clinical governance should Medicare Locals be responsible for?

What is required to ensure appropriate linkages between Medicare Locals' clinical governance and Local Lead Clinician Groups?

The discussion paper suggests (p.11) that 'clinical governance' means both the clinical governance responsibilities of the Medicare Local for the services that it delivers; and also the work that it does to improve quality and safety in primary health care services in its catchment areas. The latter is an important area of work, but the ML is not directly responsible for the quality and safety of those services – the services are completely independent of the ML and will remain so, unless they are contracted by it. The distinction between direct responsibility (i.e. "clinical governance") and work to improve quality and safety in independent health services for which the ML has no responsibility must be clear.

Divisions currently play a valuable role in continuous quality improvement and peer support for clinicians; this area of practitioner support can and should continue under Medicare Locals. One example of a very successful Clinical Risk Management program run through rural divisions in Victoria is the Limited Adverse Occurrence Screening (LAOS) program, funded through the Victorian Department of Health. In this program to address adverse events and medical error medical records from small rural hospitals are screened, and if they meet certain criteria, are forwarded to GP peer reviewers. If a possible adverse event or educational opportunity is found, the record is returned to the treating GP visiting medical officer for comment. If appropriate, the record is discussed by a panel of reviewing GPs who issue recommendations for system improvement.

It is difficult to comment on Local Lead Clinician Groups as these have not been fully described in the discussion paper. In Victoria (and we understand, in Qld, WA, NSW and SA) there are clinical networks which are funded by the state health departments which bring together clinicians from

³ Centre for General Practice Integration Studies (December 2001), GP-Hospital Integration – What have we learnt?

across the continuum of care (including primary care and specialist care) for a particular condition. It will be important not to duplicate these.

What can Medicare Locals do to facilitate stronger community participation in local primary health care service planning and delivery?

What kinds of information would be appropriate to provide in Healthy Communities reports?

The discussion paper describes the Healthy Communities reports in terms of measuring health system performance (e.g. on p.13). This suggests that the reports will need to collect data from all primary health care sites, including, but not limited to, general practices. If this is the case, there will need to be substantial supports in and for the services to enable them to extract and provide data so that it is comparable; there will need to be clear indicators, measured over time; and there will need to be clear benefits (ie for patients) that can be demonstrated to providers to persuade them to devote the necessary time and resources to provide the data.

The discussion paper seems to continue the confusion that arose with the National Health & Hospitals Network Agreement which, as part of reporting on health system performance, commits to the production of new Local Hospital Network reports based on hospital data and Healthy Communities Reports based on “PHCO data” (section 19b). It is not really clear whether what is intended is collection of data from primary health care sites, or only collection of data on services provided by the PHCO, or Medicare Local. The number and type of service sites in MLs make it a far more complex exercise than collection of hospital data. This section and schedule D (3c) suggests that PHCOs will be reporting on their own performance; not that of every primary health care service within their area.

If MLs are to report on primary health care services within their catchment, we would hope that the AIHW is involved in developing the indicators. GPV made a submission to the AIHW in May 2008 on performance indicators in primary care that the institute was then being asked to develop for new health care agreements. This contains more detail on some draft primary care performance indicators. http://www.gpv.org.au/files/downloadable_files/Policy/Submissions/may2008.pdf

Attachment 1: Quality Improvement Initiatives

Australian Primary Care Collaboratives (APCC)

The aim of the Collaboratives is to support general practices to deliver systematic improvements in the management of chronic disease. The program is modeled on the Breakthrough Series Collaborative methodology developed by the Institute for Healthcare Improvement in the United States.⁴

In Australia, divisions of general practice have been key to the implementation of this Commonwealth funded program, both in its first iteration (Phase 1) as the National Primary Care Collaboratives (NPCC), run through Flinders University, and through Phase 2, known as the APCC and run by Improvement Foundation Australia (IFA).

Practices are recruited to participate in the Collaboratives in 'waves.' Both Phase 1 (NPCC) and Phase 2 (APCC) of the Collaboratives program included a focus on three main topic areas:

- diabetes
- secondary prevention of coronary heart disease
- improving access to primary care.

Phase 2 of the Collaboratives started in July 2008 and will finish its current funding on 30 June 2011. Phase 2 is being run as a series of State-based, Local and Virtual waves and includes Waves on Chronic Disease Self Management, Chronic Obstructive Pulmonary Disease (COPD) and Closing the Gap in Indigenous Health Outcomes.

At the end of 2009-10 financial year, GPV had supported 26 of the 29 Victorian divisions to undertake Phase 2 of the Australian Primary Care Collaboratives (APCC) in 172 Victorian general practices, or 10.4% of all practices. Over both phases of the program (which includes Phase 1, run between 2005 and 2007 as the NPCC), 15% of all Victorian practices have been involved in the Collaboratives.

Achievements of the recent APCC Wave 3 in Victoria include:

- Diabetes HbA1C levels below 7% rose from 26% to 39% of patients in participating practices
- Cholesterol of <4mmol per litre improved from 24% to 35% of patients who were meeting targets in participating practices
- Blood pressure of <130/80 improved from 14% to 24% of patients in participating practices

PEN Clinical Audit Tool (PENCAT)

The PEN Clinical Audit Tool (PENCAT) is a software tool that operates with the GP clinical desktop system to present the GPs and practice staff with meaningful information about their patient population. PENCAT is compatible with a range of clinical software commonly used in general practices, including Medical Director V2 and V3, Genie and Best Practice systems.

Use of the PENCAT and other data extraction tools enables practices to take a population health approach to examining their patient population. Once the data has been presented practices are then able to implement the systems to care for cohorts of patients with the same disease, risk factors etc. in a standardised way. In Victoria, all divisions have experience in practice-level support for the PENCAT. 25 of the 29 Victorian divisions reported (in response to a recent survey) that

⁴ Biuso, C and W. Newton (2008) "Supporting Quality Care in General Practice: The Collaboratives Approach", *Australian Journal of Primary Health*, Volume 4, No.2, August 2008, pp. 46-52.

approximately 49.5% of general practices in their catchment areas practices have the PENCAT installed; or 619 of the 1250 practices in those 25 divisions.

In Victoria, many divisions have also used Commonwealth-funded programs including the APCC, ABHI-PCIP, Home Medication Reviews, Cervical Screening or Chronic Disease Management and Prevention Programs as an opportunity to work with general practices in their region to employ the PENCAT as a population health planning and decision support strategy for general practice.

PENCAT aggregates practice data in an easy-to-use way, helping practices to identify patients who need to be monitored, and supporting practices' register, recall and reminder systems. By using PENCAT the capacity of general practice to integrate with other elements of the primary health care sector is enhanced. Patients who will benefit from additional primary health care services can easily be named and referred for multi-disciplinary care. For example, it can help practices determine which of their patients with diabetes are overdue for a foot examination.

From the general practitioner's perspective data analysed using PENCAT is important because:

- Patients have better planning for chronic disease management leading to better quality outcomes
- It identifies patients who may be missing out on services
- It enables GPs to exercise greater control over their practice and service delivery
- It may reduce potential medico-legal concerns.

Attachment 2: Workforce roles

Victorian divisions of general practice collectively have undertaken activities in all of the following areas. No division, even the most active in workforce, undertakes the full potential range of workforce activity. In each activity area at least one division has developed an innovative model that could be disseminated more widely.⁵

1. Support for clinical placement capacity

- a. Partnership with universities and/or regional training networks to support capacity for clinical placement
- b. Practice support to enhance capacity for provision of clinical placements

2. Recruitment to general practice

- a. Supporting students at undergraduate, prevocational and registrar levels
- b. Partnerships with local communities to promote the area to outsiders
- c. Partnerships with local hospitals to recruit hospital-employed IMGs to local general practice
- d. Case management model for the recruitment of IMGs
- e. Establishment (in partnership with university) of an academic centre based in the division to help establish an area of workforce shortage as an attractive and collegiate environment

3. Retention strategies

- a. Induction, orientation and mentoring programs for students, GPs and/or practice nurses
- b. Establishment of continuing education to ensure support for vocational registration, collegiate environment.
- c. Establishment of community support for newcomers to the area
- d. Inclusion of students in division activities
- e. Use of after-hours services to reduce pressure on doctors
- f. GP well-being programs
- g. Educational support for IMGs
- h. Cultural education of community and of IMGs to support mutual understanding and community integration
- i. Various forms of locum service including partnership between rural and urban divisions for locum relief.

4. Improving the efficiency of the workforce:

- a. Supporting the use of other health workers where appropriate, especially through the employment of practice nurses & the provision of cdm by nurses
- b. Development of efficient practice systems to minimise doctor time in red-tape and other unnecessary work
- c. Use of the access collaborative to improve patient flow and to free up doctor time
- d. analysis of GP tasks that could be undertaken by others and reorientation of practice activities accordingly
- e. Support for practices to become accredited as accreditation affects access to relevant incentives to support teamwork.
- f. Support for the development of succession planning models

5. Supporting and developing teamwork in primary care

- a. Professional development for nurses
- b. Practice manager and practice nurse networks
- c. Interprofessional education to support teamwork
- d. Support for access to allied health professionals

⁵ This list is based on comprehensive structured interviews with each Victorian division of general practice. The full report, *Workforce underpins all that we do* is at:

www.gpv.org.au/files/downloadable_files/Programs/Workforce/20091104_rpt_Workforce%20Research%20Report%20Final%20-%20low%20res.pdf