

# Guide to developing an optimal business model for general practice in community health

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## Contents

<b>Glossary</b>	<b>iv</b>
<b>1 Introduction</b>	<b>1</b>
How to use this guide	1
Acknowledgements	2
<b>2 Background</b>	<b>3</b>
Role of general practice	3
<b>3 The business model outline</b>	<b>5</b>
Definitions	6
<b>4 Key influencing factors</b>	<b>7</b>
<b>5 Guide to developing an optimal business model</b>	<b>8</b>
1 Patients and demand	8
2 Strategic imperative	10
3 Operations	10
4 Outcomes	19
<b>Appendix 1: Using the MBS appropriately to support quality care for patients and practice viability</b>	<b>21</b>
<b>Appendix 2: GP arrangements</b>	<b>25</b>
<b>Appendix 3: Resources to support implementation</b>	<b>27</b>
<b>Appendix 4: Supporting change management</b>	<b>29</b>
<b>Appendix 5: Basis of the information for this guide</b>	<b>30</b>
<b>Bibliography</b>	<b>32</b>

## Glossary

AAPM	Australian Association of Practice Managers
AGPN	Australian General Practice Network (formerly Australian Divisions of General Practice)
APCC	Australian Primary Care Collaboratives
CHS	Community health service
CDM	Chronic disease management
DHS	Department of Human Services
DNA	Did not attend
EPC	Enhanced Primary Care
FTE	Full time equivalent
GP	General practitioner
GPMP	GP Management Plan
GPV	General Practice Victoria
IM	Information management
IT	Information technology
MBS	Medicare Benefits Schedule
N&WMR	Northern and Western Metropolitan Region
NPS	National Prescribing Service
PIP	Practice Incentive Payment
RACGP	Royal Australian College of General Practitioners
RCNA	Royal College of Nursing Australia
RWAV	Rural Workforce Agency Victoria
SIP	Service Incentive Payment
SOP	Service Outcome Payment
TCA	Team Care Arrangement

# 1 Introduction

This guide has been developed as a tool to assist in business planning for community health services (CHSs) that have an existing general practice service or are considering establishing a new general practice service.

The basis of the information provided in this guide was a detailed review of the general practices at Darebin Community Health, Dianella Community Health, North Richmond Community Health Centre and North Yarra Community Health, undertaken by Paxton Partners in 2007 and 2008.

From this review and from other consultations with many CHSs, the components that make up a complete business model for general practice in community health were identified. The key influencing factors that impact on the development of a business model for each CHS were also identified. From this information a business model outline was created to assist CHSs to develop their own business model. Given the substantial differences between CHS general practice clinics, there is no single business model that will be best for every CHS.

The business model outline comprises four components that need to be considered when developing a business model for a specific setting. The four components are:

1. patients and demand
2. strategic imperative
3. operations
4. outcomes

The components are described in detail in section 5, and the descriptions are supported by examples from general practices in the community health setting and links to resources.

A number of additional resources are provided in the appendices, including:

- examples of how appropriate use of MBS items can improve practice income and patient outcomes
- information to support change management
- a number of options for arrangements with general practitioners (GPs)
- additional information about resources that support implementation.

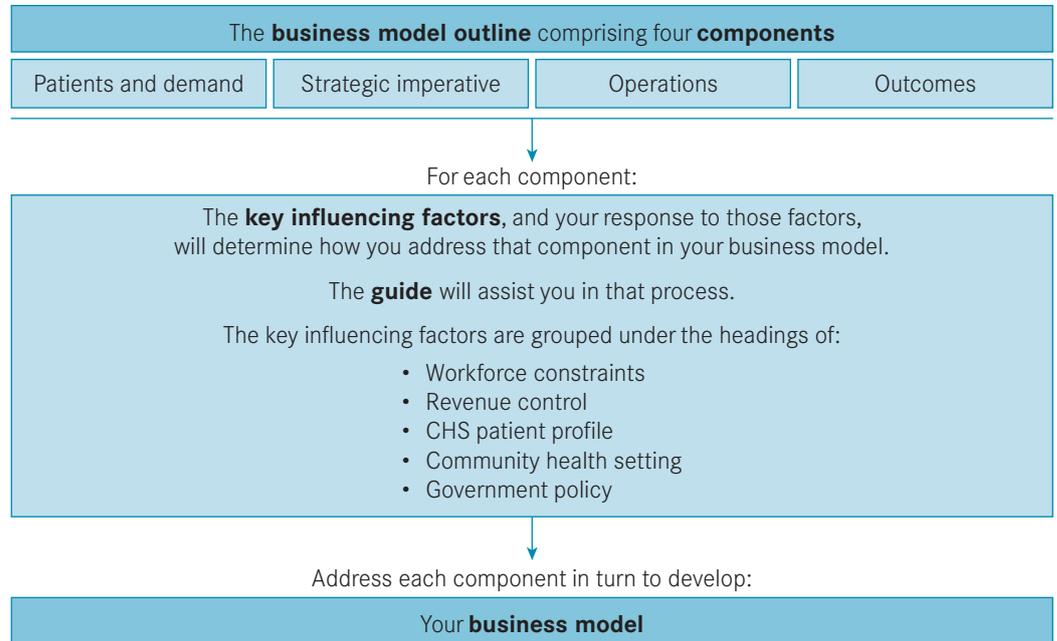
## How to use this guide

This guide has been developed to support the business planning, implementation and change management required to develop a sustainable business model for general practice in the community health setting. It also provides useful background information for CHSs that may be considering provision of general practice services where there is a lack of local services in the private sector.

A starting point for existing CHS general practices is to determine the response to each component that is appropriate for their particular circumstances. For example, for the component of 'operations', it is important to consider recruitment. In this consideration, some CHSs may have constraints such as lack of space to recruit more GPs, and local workforce shortages.

Section 4 lists the key influencing factors that CHSs will take into account as they develop their business model. How each factor affects a particular CHS, and how the CHS responds to that factor, will determine the specifics of their business model. Generally, CHSs will readily identify which influencing factors are relevant to each component, so these relationships are not explicitly detailed in this guide. However, they are implicit in the consideration of the components in section 5.

**Figure 1.1 Using the business model outline to develop your business model**



This guide does not provide all the answers. While there is a range of information and practices that can be shared across agencies, it is expected that each CHS will use this guide in different ways to meet their individual needs.

There are many other resources available to support this work, including: *Client services through Medicare: Opportunities and considerations for community health services* ([www.health.vic.gov.au/communityhealth/gps/mbs.htm](http://www.health.vic.gov.au/communityhealth/gps/mbs.htm)); and *Working with general practice: Department of Human Services resource guide* ([www.health.vic.gov.au/communityhealth/gps/position\\_statement.htm](http://www.health.vic.gov.au/communityhealth/gps/position_statement.htm)). Other resources are referenced throughout the document.

In addition, divisions of general practice offer a number of services that support all general practices with business planning and business development. The programs and services that are particularly relevant to this type of work include:

- support for practice planning and review
- assistance with the recruitment and retention of practice staff
- the Australian Primary Care Collaboratives program
- support in enhancing access to general practice for high needs communities through assisting existing private sector general practices, where there is the workforce and willingness to do so. For example, the Better Outcomes in Mental Health program provides access to bulk-billed MBS mental health services. Divisions may also have programs focused on specific marginalised communities, for example programs providing services to refugee communities.

## Acknowledgements

The information provided in this guide has been developed from a detailed review of the general practices at Darebin Community Health, Dianella Community Health, North Richmond Community Health Centre and North Yarra Community Health, undertaken by project partners Paxton Partners in 2007 and 2008. This guide could not have been developed without significant investment of time from staff within these organisations. We would also like to thank all the agencies that have provided case studies for this guide.

## 2 Background

### Role of general practice

General practice is the primary point of initial health care for most of the community and, as such, is the gateway into the broader health system.<sup>1</sup> Eighty per cent of Victorians visited one or more GPs in 2004–05,<sup>2</sup> and general practice provides the majority of care to patients with chronic illness, especially those with mild to moderately severe disease.<sup>3</sup> The principal roles of general practice are to prevent illness, identify risk, offer early intervention, provide care for episodic illness and for chronic disease, and diagnose, refer and coordinate care for patients with acute and serious illness.<sup>4</sup>

GPs play a pivotal role in providing services and referral to people who need primary care, and are critical to effective chronic disease management strategies. GPs also provide an interface between the acute, residential and community support systems.<sup>5</sup> GPs are the key providers of primary care in Australia. Data from the Department of Health and Ageing indicate that GPs undertake over 20 million consultations across Australia each year. These GPs are critical to the provision of comprehensive health care. The number of GPs providing medical care in Victoria is approximately 4,725.<sup>6</sup> However, GPs are not distributed equally across the state; for example, there is a significantly higher ratio of GPs to population in inner metropolitan Melbourne than in outer metropolitan and rural Victoria. The ratio of full time equivalent (FTE) GP to population ranges from 1:690 in inner urban areas down to 1:2,000 in rural and remote areas.<sup>7</sup>

GPs face a range of pressures in their daily practice. They are required to be up to date with constant changes, including but not limited to those in the local service system (for referrals), Medicare (for payment), medications (for prescribing), and evidence (for the benefit of the patients' health and the GPs' practice). Pharmaceutical companies, state and federal governments, community and acute health care providers, divisions of general practice and other specialist agencies compete to engage GPs and inform their practice.<sup>8</sup>

Practice nurses are becoming core members of the general practice team. Practice nurses assist GPs by contributing to a range of services, including:

- clinical care (e.g. clinical procedures)
- clinical coordination (e.g. recall and reminders and population health approaches)
- practice administration (e.g. quality and accreditation support)
- integration (e.g. liaison with other providers and patient advocacy).

<sup>1</sup> Department of Human Services, 2007

<sup>2</sup> Medicare Australia, 2006

<sup>3</sup> Pegram R, Daniel J and Harris M, *General practice in Australia 2004*, Australian Government Department of Health and Ageing, Canberra 2005

<sup>4</sup> Harris M F and Harris E, 2006

<sup>5</sup> Department of Human Services, 2001

<sup>6</sup> Department of Human Services, Medical Labour Force Survey Victoria, 2004. Estimate calculated April 2005, based on respondents identifying themselves as clinicians, and scaled to Medical Registration Board information on the total number of medical practitioner registrants. Estimates are subject to revision.

<sup>7</sup> PHCRIS GP:population ratios

<sup>8</sup> Bensberg M, Sutherland J and Crosbie C, 'It takes more than a practice visit – effective general practice engagement', *Australian journal of primary health*, vol. 13, no. 3, pp. 17–21, 2007

In some practices, practice nurses also manage or contribute to nurse-led clinics to which GPs can refer patients.<sup>9</sup> The practice nurse role is diverse and influenced by factors such as the practice population and location, nurses' qualifications, practice structure, professional standards and national incentives and programs.<sup>10</sup>

The benefits of employing a nurse can include improved outcomes in chronic disease; an increased range of services available at the practice, including patient education, improved integration and referral to services; and enhanced consumer satisfaction. The National Practice Nurse Survey Report 2006 revealed a 23 per cent increase in the number of practices employing a practice nurse between 2005 and 2007. Currently over 57 per cent of general practices nationally employ nurses.<sup>11</sup>

Practice managers also play a pivotal role in general practice and are supported by divisions and organisations such as the Australian Association of Practice Managers (AAPM).<sup>12</sup> Practice management can be defined as covering all those practical aspects related to the proper, efficient and financially viable management of a medical practice. It includes an understanding of health needs, the community's medical resources and the duties of the profession.<sup>13</sup>

### General practice in the community health setting

Forty percent of CHSs in Victoria offer general practice services. A high proportion of patients of these practices come from disadvantaged sections of the community.<sup>14</sup> In April 2005 Primary Health Branch commissioned the Australian GP Statistics and Classification Centre, University of Sydney, to undertake a study that provided an evidence base to accurately describe GP practice and patient characteristics within CHSs.<sup>15</sup> The key findings were that, in comparison to GPs generally, GPs in CHSs:

- **Provide longer consultations.** The longer consultation time of GPs in CHSs reflects the high numbers of problems managed in each consultation, including the management of chronic conditions, drug use and psychosocial issues. These issues impact both on the model of care provided to the patient and the financial viability of the practices.
- **Service disadvantaged populations.** GPs in CHSs are seeing a more disadvantaged group of patients than GPs in private clinics.
- **Provide the majority of their services to young and middle-aged adults.** Patients of GPs in CHSs are predominantly aged between 25 years and 65 years. This is not reflective of the population which attends CHSs for other services, who are more likely to be older people and children. It is also not reflective of the population that attends GPs in private practice, who are more likely to be people aged over 65 years.
- **Make less use of care plans, including the claiming of relevant Medicare items.** Only 34 per cent of CHS patients that met the current Enhanced Primary Care (EPC) eligibility guidelines for an EPC GP initiated care plan actually had a care plan.

<sup>9</sup> The UNSW Centre for Primary Health Care and Equity's Practice Capacity for Chronic Disease Management project found that in practices in which nurses ran chronic disease management (CDM) clinics, the quality of diabetes assessment was significantly better than in practices where there were no nurse-led CDM clinics. Assessment of diabetes, asthma and general risk factors for chronic disease, and overall care of patients with diabetes, asthma or cardiovascular disease, was significantly better in practices where nurses were responsible for managing disease registers and recall systems. [www.cphce.unsw.edu.au/CPHCEWeb.nsf/resources/Prac+Cap+Summaries/\\$file/Practice+capacity+research+summary+OVERVIEW+FINAL+20060424.pdf](http://www.cphce.unsw.edu.au/CPHCEWeb.nsf/resources/Prac+Cap+Summaries/$file/Practice+capacity+research+summary+OVERVIEW+FINAL+20060424.pdf)

<sup>10</sup> Department of Human Services, 2007

<sup>11</sup> National Practice Nurse Survey Report, 2007

<sup>12</sup> [www.aapm.org.au](http://www.aapm.org.au)

<sup>13</sup> Fabb WE, 1969

<sup>14</sup> Department of Human Services, 2007

<sup>15</sup> Britt H, Bayram C, Ng A and Fitzgerald J, *The clinical activities of general practitioners in Victorian community health services*, University of Sydney 2006.

### 3 The business model outline

The four components of the business model outline for general practices operating in the community health setting are:

1. patients and demand
2. strategic imperative
3. operations
4. outcomes

Each component of the business model outline comprises a number of sub-components that encompass the total operation of the general practice clinic. They are identified in the box below and discussed in more detail in section 5.

**Figure 3.1: The business model outline, showing the four components and the sub-components**

<b>1. Patients and demand</b>	<b>2. Strategic Imperative</b>
<ul style="list-style-type: none"> <li>Understand the patient profile</li> <li>Capacity to manage demand and accept new patients</li> <li>Appropriate appointment lead time</li> </ul>	<ul style="list-style-type: none"> <li>CHS commitment to the provision of a general practice service and to the financial viability of the GP clinic</li> </ul>
<b>3. Operations</b>	
<p><b>Practice structure</b></p> <ul style="list-style-type: none"> <li>An efficient practice structure that supports quality service and practice viability</li> <li>Consistent reporting lines that improve workflow within the general practice</li> </ul> <p><b>GP relationships</b></p> <ul style="list-style-type: none"> <li>Optimal number of GP FTE per clinic required to support the infrastructure investment</li> <li>Optimal GP employment arrangements</li> <li>Provision of opportunities to specialise</li> <li>Innovative approach to recruitment and retention</li> <li>Active registrars training program</li> </ul> <p><b>Practice administration</b></p> <ul style="list-style-type: none"> <li>Appropriate ratio of practice managers to GPs</li> <li>Appropriate practice manager roles and responsibilities</li> <li>Appropriate ratio of practice nurses to GPs</li> <li>Appropriate practice nurse roles and responsibilities</li> <li>The administration team has appropriate expertise and skills to fully support the clinical team</li> <li>Appropriate medical reception support</li> </ul>	<ul style="list-style-type: none"> <li>Medical receptionists' roles are appropriate</li> <li>GP attendance at CHS management and administrative meetings</li> <li>Interpreting services managed at CHS level and used in the most cost- and time-effective manner</li> <li>Effective use of interpreter services which are available without charge to the CHS</li> </ul> <p><b>Information technology and information management</b></p> <ul style="list-style-type: none"> <li>Reliable information management and communication systems implemented and maintained</li> <li>Electronic medical records accessible between multiple locations</li> <li>Full use of functionality of clinical information management and communication systems</li> </ul> <p><b>Patient flow</b></p> <ul style="list-style-type: none"> <li>Systematic approach to patient flow to maintain sustainable throughput and appropriate MBS claiming</li> <li>Targets are set to monitor the take-up of new MBS items</li> <li>The impact of 'did not attends' (DNAs) is minimised and there is an appropriate process to reduce them</li> </ul>
<b>4. Outcomes</b>	
<p><b>Quality</b></p> <ul style="list-style-type: none"> <li>Systems that link quality practice with MBS item use</li> <li>Participation in RACGP accreditation process</li> <li>Use of National Prescribing Service audits</li> <li>Patient satisfaction surveys conducted regularly</li> <li>Effective relationships with universities and local divisions of general practice</li> </ul>	<p><b>Financial</b></p> <ul style="list-style-type: none"> <li>Financial performance is sustainable and consistent with the agreed position of the CHS board</li> <li>The CHS and the general practice are supported by a strong financial framework</li> <li>All staff understand the value of using incentives to improve on current practice</li> </ul>

## Definitions

**General practice** – general practice refers to the practice in its entirety including GPs, practice managers, practice nurses, receptionists and other health professionals who may operate within the practice.

**Business model** – in this guide, business model means a model that addresses the entire operation of the clinic (as encompassed by the four components). It is not used in its more restricted meaning of a model for GP employment arrangements, although this issue is addressed as part of the business model outline.

**Efficient** – achieving the best outcomes in a resource-constrained environment (i.e. using available resources in the best way).

**Effective** – achieving an intended outcome (e.g. financial outcome, patient outcome).

**Optimal** – an ‘optimal’ business model is one that achieves the best outcomes regarding the financial viability and sustainability, efficiency and effectiveness of general practice services.

**Viable** – a viable general practice meets the particular needs of the community by providing appropriate services in a way that takes account of the financial and other costs to the GP, the CHS and the community at large. Practice viability is dependent primarily on supply of appropriately trained general practitioners, adequate rewards for practitioner skills, responsibility and workload, and provision of quality infrastructure and management to support professional practice and quality care. Changes in general practitioner profiles, career expectations, practice structures and arrangements also impact on practice viability.<sup>16</sup>

**Sustainable** – capable of being continued with minimal long-term negative effect.

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<sup>16</sup> RACGP Quality Framework Gap Analysis

## 4 Key influencing factors

The review of the four CHS general practice clinics identified a number of key factors that have an impact on the operation of general practice services in community health. It is necessary to take these into account when using the business model outline developed for general practices operating in the community health setting.

These factors are identified below.

### Workforce constraints

- An ageing GP workforce within community health and in private general practice is resulting in growing workforce shortages.
- There are difficulties recruiting and retaining GPs, nurses and support staff to the general practices in CHSs.
- The perception among GPs that there are lower levels of GP remuneration within CHSs in comparison with the private sector makes working in CHSs less attractive.

### Revenue control

- CHSs are committed to bulk-billing most patients; this limits CHSs' sources of revenue.
- Revenue is therefore directly linked to patient throughput and the use of the appropriate MBS items to support service provision and is not supplemented by co-payments as in private general practice.
- Practice revenue is decreased when GPs do not take up new models of care that are able to earn more for the practice, or when GPs do take up the new models of care but do not claim the appropriate MBS items.

### CHS patient profile

- There is a high prevalence of chronic conditions, and patients present with these conditions at a younger age than in private general practice.
- Patients have a greater prevalence of psychosocial and other issues, resulting in increasing complexity.
- Patients are from a lower socioeconomic background and present with higher levels of complexity when compared with private general practice.

### Community health setting

- Most general practices operated by CHSs in Victoria are reporting some level of deficit.
- There are opportunities to receive additional support regarding business practices from divisions of general practice.
- The CHS setting offers the potential for integration of a range of services for patients with complex needs.
- There is a high demand for services offered by CHSs.
- General practices operating within CHSs must compete for funding, management and administration support with other areas of the agency.
- CHSs have varied support structures, with some having very simple data support systems (i.e. IT/IM, monitoring and reporting) in comparison with private general practices, which makes practice improvement work more difficult.

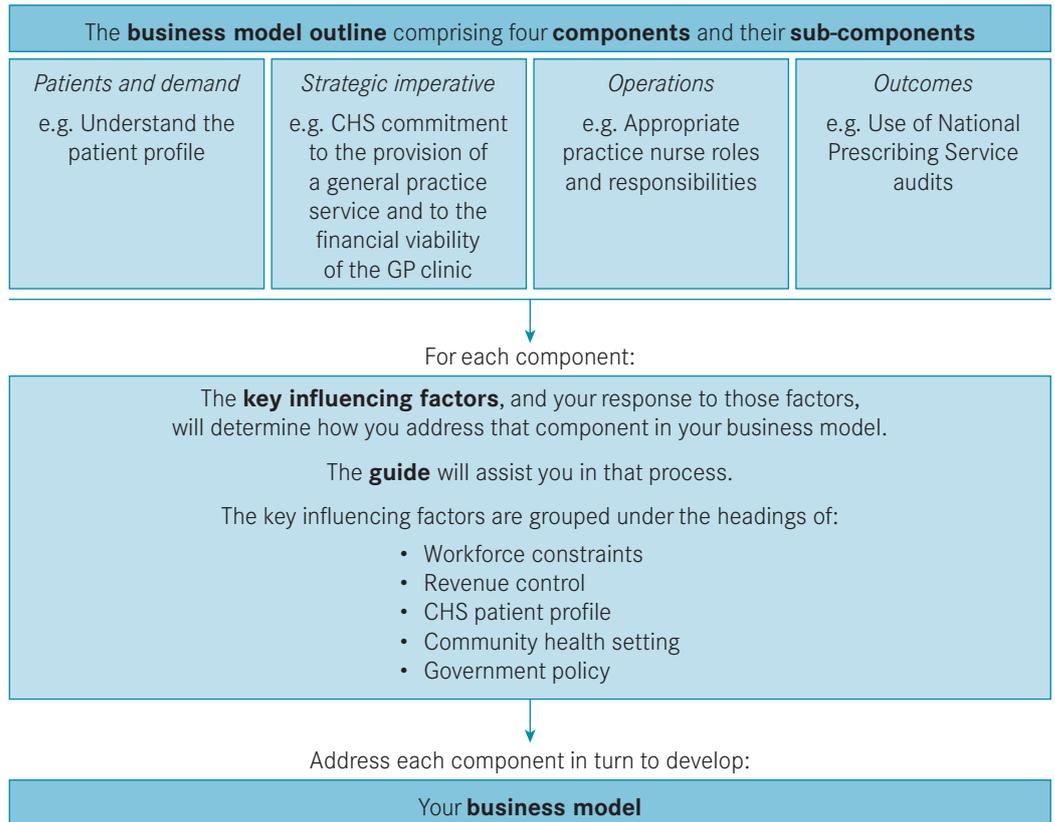
### Government policy

- Since 1999 new Medicare items, including EPC items, have been progressively introduced which now provide rebates for services from a broader range of health professionals.
- Commonwealth and state governments continue to encourage primary care service providers to develop collaborative models of care for patients.
- The Commonwealth has recently commenced a major review of primary health care and this may impact on the operation of CHS general practices in the future.

## 5 Guide to developing an optimal business model

This section provides a detailed consideration of the four components that make up the business model outline. For each component, there is a description of the sub-components, together with suggestions, examples and resources to support CHSs in developing their individual business models.

**Figure 5.1: Using the business model outline to develop your business model**



### Guide to developing an optimal business model for your general practice

#### Component 1: Patients and demand

##### *Understanding the patient profile*

An understanding of the clinic’s patient profile is imperative. This has implications for:

- setting a target for the number of patients seen per hour
- understanding the opportunities for use of MBS items such as the diabetes annual cycle of care and enhanced primary care items
- the level and types of supporting resources required (e.g. interpreters)
- the types of services provided as part of the general practice clinic (e.g. specialised clinics such as diabetes or men’s health).

**Example:** Dousta Galla Community Health administrative staff used an electronic data extraction tool – the PEN Clinical Audit Tool (offered free of charge by their local division of general practice) – to better understand their patient profile. The practice now has a systematic approach to identifying patients that are due for follow up, for example testing of HbA1C levels or review of GP Management Plans (GPMPs).

**Example:** Banyule Community Health Service has now completed their second Practice Health Atlas. This provides them with detailed information about their patient profile and characteristics. Using this information has allowed the practice to target resources to better coordinate services for patients with chronic illnesses and complex care needs and mental health conditions.

**Resource:** Your local division of general practice can provide you with advice about accessing tools to support this type of work: [www.gpv.org.au/content.asp?cid=33&t=Division's-Network](http://www.gpv.org.au/content.asp?cid=33&t=Division's-Network)

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### **Capacity to manage demand and accept new patients**

Clinics need to develop a scheduling system that gives them the capacity to accept new patients. The RACGP standard 1.1.1 recommends that practices have a flexible system that enables them to accommodate patients with urgent, non-urgent, complex, planned chronic care and preventive health needs.<sup>17</sup>

A starting point is to review patient scheduling and consider appropriate use of practice staff other than GPs, such as practice nurses and CHS counselling services. This may provide an opportunity to increase the number of patients seen by the GP.

**Example:** Both North Yarra Community Health and Dianella Community Health have structured their appointments schedule so they have the ability to accept new patients. North Yarra Community Health has introduced a system which allows for 'on-the-day' and 'review' appointments. The 'on-the-day' appointments are not available for general use and are only released first thing in the morning each day. The 'review' appointments are available for the GPs to use for review of a patient within the following week. Where appropriate, patients are referred to CHS counselling services, and case conferencing is used regularly by the GPs and other CHS staff.

**Resource:** *RACGP standards for general practice*, 3rd edition, is accessible at [www.racgp.org.au](http://www.racgp.org.au). The Dandenong Casey General Practice Association's *Policy and procedures manual* is also designed to assist practices meet the RACGP standards for general practice and is accessible at: [www.dcgpa.com.au/resources/General\\_Practice\\_Support/Policy\\_Procedure\\_Manual](http://www.dcgpa.com.au/resources/General_Practice_Support/Policy_Procedure_Manual)

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### **Appropriate appointment lead time**

An appropriate lead time for appointments is 1–2 days; however, the RACGP quality guidelines and the Australian Primary Care Collaboratives recommend that general practice clinics also have some same-day appointments available for patients with urgent needs. A systematic approach to managing bookings is required to support this.

**Example:** North Yarra Community Health has a booking system which breaks up the day into regular appointment times and other times for patients presenting only for repeat prescriptions and short walk-up appointments.

**Resource:** Information about the Australian Primary Care Collaboratives is available at [www.apcc.org.au](http://www.apcc.org.au). General Practice Victoria has a dedicated collaboratives project officer, and some local divisions of general practice have experience in the collaboratives methodology.

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<sup>17</sup> *RACGP standards for general practice*, 3rd edition, 2007

## Component 2: Strategic imperative

### *CHS commitment to the provision of a general practice service and to the financial viability of the GP clinic*

The strategic position of the CHSs in relation to the provision of general practice services is fundamental. Practices must seek a commitment from the board and senior management to the provision of general practice services as a means by which access to services and health outcomes for disadvantaged people is improved. A CHS that is providing general practice services must determine whether it wishes to continue to provide these services (taking into consideration the needs of the local community and the organisation's strategic plan) and, if the GP service is making a loss, whether the CHS is prepared to continue to support the clinic.

It is important to be aware that providing access to the most disadvantaged people, who often present with complex health needs, may impact negatively on the financial profitability of the practice. This is because the MBS rewards high throughput while the complexity of CHS patients may make high throughput difficult to achieve. However, losses can be minimised through effective use of a range of MBS items.

Some CHSs may choose not to provide an in-house general practice service; instead they may work with local clinics to support access for their clients to general practice.

**Example:** Hesse Community Health purchased a local general practice to ensure general practice services continued to be offered in their local community. They now employ a number of GPs on a percentage split contract arrangement, and general practice services remain available to the local community. (For additional information on GP employment arrangements see appendix 1.)

**Example:** Moreland Community Health Service has operated its general practice clinic for around 20 years. In 2002, after a prolonged period during which deficits were recorded, the board agreed to outsource the GP clinic, which was sold to St Vincent's Health. This decision was supported by the local members of Parliament and the Department of Human Services. The outcomes were:

- The clinic remained a bulk-billing clinic, the location was unchanged and the GPs were unchanged.
- From the patients' point of view there was no significant difference in the service.
- GPs were ultimately satisfied with the transfer.
- The broader community initially reacted quite negatively to the transfer as they were concerned about potential changes to service.
- The local community has continued to use the practice.

## Component 3: Operations

### Practice structure

#### *An efficient practice structure that supports quality service and practice viability*

This includes:

- employing an appropriate number of GPs to meet patient demand and generate sufficient revenue to meet operating costs (for more details see GP relationships, p. 13)
- appropriate and flexible GP arrangements, which might include contractors, employees and private collocation options (additional information is available in appendix 2)
- employing a range of practice staff, including practice managers, practice nurses and dedicated receptionists (all practice staff require clearly defined and appropriate roles – more details are available in the practice administration section, pp. 16–18)

- supportive practice information management and communication infrastructure that allows information to be shared across the agency and allows analysis of practice population information for planning purposes (see pp. 18–19 for more details).

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### *Consistent reporting lines that improve workflow within the general practice*

Consistent reporting lines are established for all disciplines involved with the provision of general practice services, including non-clinical staff. The benefits include more effective communication amongst staff, enhanced team cohesion, and improved team performance. As the general practice exists as a subset of the CHS rather than as a standalone business as would be the case in non-CHS environments, the reporting structure needs to balance the business needs of the clinic and its staff with the needs of the overall organisation.

**Example:** The general practice staff at Dousta Galla (including the receptionists, nurses, GPs and practice manager) all work together in a team with a direct reporting line to the Primary and Mental Health Manager. These reporting arrangements were implemented in order to build a team approach across all staff working within the general practice and across other health service teams in the organisation.

## **GP relationships**

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### *Optimal number of GP FTE per clinic required to support the infrastructure investment*

A GP FTE of 5 was identified by Paxton Partners as the optimal number of GPs for a viable clinic.

**Example:** During consultation for this project, Inner East Community Health Service management indicated that 5 GP FTE is optimal as it provides an appropriate revenue base that can support overheads of approximately \$300,000–\$350,000, which brings the practice close to a break-even financial position.

However, determination of the 5 FTE figure was based on the assumption that increased throughput and numbers of GPs are the key drivers to practice viability. Viability can also be supported by:

- maximising the role of other support staff (such as practice managers, practice nurses and administration staff)
- improving MBS claiming and developing new models of care – particularly those that use practice nurses – which address the complex needs of community health patients.

Adopting this approach may mean that the optimal number of GPs to support viability is less than 5 FTE (see appendix 1 for more information).

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### *Optimal GP employment arrangements*

There is a range of GP employment options available to community health centres, including:

- 100 per cent contractors (CHS bills MBS activity for and on behalf of GPs, and contractors pay CHS a percentage of total MBS revenue)
- sessional, collocated (GPs bill MBS activity and pay the CHS a sessional rate)
- fully outsourced, collocated (GPs are fully privatised, and the CHS receives rental income)
- 100% in-house (hourly and incentivised remuneration)
- 100% in-house (hourly remuneration)
- mixed model (in-house and contractors).

For further discussion of the advantages and disadvantages of the options for GP arrangements refer to appendix 2.

Paxton Partners recommended that GPs should have some level of financial incentive in their arrangements with the CHS in order to build the level of ownership of the financial outcome of the practice. This is a win-win situation whereby practices are able to encourage GPs to practise in an evidence-based way and increase income through the use of higher earning MBS items. This can take place in a number of ways. For example GPs are paid a retainer or base rate and then a bonus payment is negotiated based on an agreed level of MBS billing. The CHS may need to negotiate different arrangements with individual GPs to provide additional incentives for taking the time to provide care in accordance with evidence-based practice. For example, the agreement could specify what is required from GPs and what the GPs require from the CHS, both in terms of patient care and MBS claiming. In private general practice it is common for sessional GPs to negotiate a percentage of their MBS income to be paid to the practice to cover the costs incurred by the practice. For example the GP may agree to pay 30 per cent of their MBS income to the general practice, while for services such as diabetes annual cycle of care items, which attract a Service Incentive Payment (SIP) (paid to the practice), the practice may agree to pay that income in full to the GP.

**Example:** Dianella Community Health has recently negotiated a new enterprise bargaining agreement with their GPs where the GP receives an incentive payment of 10 per cent of the value of all EPC items they claim.

**Example:** Inner East Community Health Service has a mix of employment arrangements – in-house GPs on a salaried model and contracted GPs. The contracted GPs pay 25–30 per cent of their total MBS billing to the CHS. The mix of contracted and in-house GPs is seen as an advantage as the contracted GPs are keen to achieve certain productivity levels, and the salaried GPs tend to consequently work to similar targets as their contracted colleagues.

**Resources:** The *Summary of new Medicare Benefit Schedule (MBS) item numbers: General practice and allied health* ([www.health.vic.gov.au/communityhealth/gps/mbs](http://www.health.vic.gov.au/communityhealth/gps/mbs)) and online case studies ([www.health.vic.gov.au/communityhealth/publications/gp\\_forum.htm](http://www.health.vic.gov.au/communityhealth/publications/gp_forum.htm)) provide information about MBS items that are particularly relevant to CHS patients and that support multidisciplinary care, initial needs identification, prevention and early intervention.

More detailed information about individual MBS items can be found at [www.health.gov.au/MBSonline](http://www.health.gov.au/MBSonline)

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### **Provision of opportunities to specialise**

A useful recruitment and retention approach is offering GPs the opportunity to develop specialist clinics in areas of professional interest to them, when this coincides with a priority need of the local community, such as refugee health or children's health. Similarly, offering GPs the opportunity to participate in research can also assist with recruitment and retention. These opportunities are rare in private practice;

**Example:** Bendigo Community Health Service has grouped a range of CHS services together to offer clinics based on the interests of individual GPs that also meet the CHS and local community needs. They describe it as 'wrapping the service around the GP'. For example they offer a women's health clinic in partnership with the local women's health service. They also offer a diabetes clinic which brings together general practice and other allied health staff from the CHS to provide a specialised clinic.

**Example:** Dianella Community Health offers GPs opportunities to undertake research activities such as involvement in the Victorian Primary Care Practice Based Research Network and the PEACH study (Patient Engagement and Coaching for Health: an intensive treatment intervention for patients with type 2 diabetes in disadvantaged communities).

**Resource:** The RACGP *Quality Framework for Australian General Practice* companion guide is a useful decision-making tool for practices to use when thinking about setting up a specialist practice.

[www.racgp.org.au/Content/NavigationMenu/Advocacy/AqualityframeworkforAustralianGeneralPractice/20060210qualityframe\\_companionguide.pdf](http://www.racgp.org.au/Content/NavigationMenu/Advocacy/AqualityframeworkforAustralianGeneralPractice/20060210qualityframe_companionguide.pdf)

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### ***Innovative approaches to recruitment and retention***

Recruiting GPs in a highly competitive market requires innovative approaches. For example, undertaking joint recruitment strategies with other closely located CHS GP clinics or closely located bulk-billing clinics can bring economies of scale. Other recruitment techniques to consider are the use of mainstream advertising (internet, mainstream publications), and adopting language to make the practice more attractive to potential recruits.

Resources to assist with recruitment and retention are available from the Rural Workforce Agency Victoria (RWAV), General Practice Victoria and local divisions, and the Workforce Planning Branch of the Department of Human Services.

**Example:** In order to address GP shortages, Bendigo Community Health Service established a successful partnership between the Monash Clinical School (Bendigo), the Bendigo Primary Care Clinic, Victoria Felix (a general practice education and training consortium) and the Central Victoria General Practice Network. The challenge they faced was to attract new GPs to work in or alongside the community health setting, against a backdrop of existing GP shortages within the City of Greater Bendigo.

The partnership resulted in the shared employment of one GP between Bendigo CHS and the Bendigo Primary Care Clinic, and facilitated working arrangements that enabled two additional GPs to practise at both sites. This arrangement has proved to be very successful in creating employment flexibility for GPs who enjoy practising in a range of settings, or have a particular focus they wish to pursue through sessional arrangements such as conducting a family planning clinic. Additional benefits include the increased GP capacity available to contribute to a shared after-hours roster, the development of consistent practice policies and procedures, and some shared professional development. In addition, the two practices shared the placement of undergraduate medical students and GP registrars with Bendigo Primary Care Clinic, increasing the GP supervision capacity and the number of students they could support, and giving students exposure to a community health setting.

**Resources:** The RWAV website: [www.rwav.com.au](http://www.rwav.com.au)

A presentation on a range of initiatives and programs that are available to support rural general practice is available from the Department of Human Services General Practice Partnerships web page: [www.health.vic.gov.au/communityhealth/publications/gp\\_forum.htm](http://www.health.vic.gov.au/communityhealth/publications/gp_forum.htm)

Information is also available from General Practice Victoria ([www.gpv.org.au](http://www.gpv.org.au)) and from the Service and Workforce Planning Branch of the Department of Human Services ([www.health.vic.gov.au/workforce](http://www.health.vic.gov.au/workforce)).

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### ***Active registrars training program***

Participation in the GP registrars training program may assist with future recruitment and retention. A CHS offering a registrars training program does incur a range of costs, and there is some contention regarding cost versus benefits of participation in the program. However, Flinders University has developed an innovative model to show how the training can be set up to operate in the most cost-effective manner. Participation in the registrars training program should be aligned with clinic and CHS objectives

**Example:** Dianella Community Health is an accredited provider of GP registrar training and employs basic, advanced and subsequent registrars. Registrars provide an invaluable opportunity to contribute to the productivity and sustainability of a service; however the number of patients that can be seen by registrars is dependent on their level of experience.

**Example:** Hesse Community Health participates in the registrars training program managed through Greater Green Triangle GP Education and Training. Hesse Community Health has found that one of the benefits of participating in the training program is that the registrars provide an effective way of getting information to the other GPs about new MBS items.

**Resources:** The registrars training program is supported by RWAV, and General Practice Education and Training fund regional training providers. Information about the training program can be found at [www.rwav.com.au/rews/rews\\_meo.asp](http://www.rwav.com.au/rews/rews_meo.asp)

## Practice administration

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### *Appropriate ratio of practice managers to GPs*

A target ratio of between 0.1 and 0.2 practice manager FTE per GP FTE is suggested by the Australian General Practice Network's (AGPN) *Nursing in general practice business case models*.

**Resource:** *Nursing in general practice business case models* is available online: [www.generalpracticenursing.com.au/client\\_images/137701.pdf](http://www.generalpracticenursing.com.au/client_images/137701.pdf)

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### *Appropriate practice manager roles and responsibilities*

Evidence suggests that the practice manager role is fundamental to improving clinic efficiency as well as contributing in many other areas such as legislative compliance, staff management, quality improvement and recruitment. The practice manager role can also have a substantial influence on workplace culture. It is important that the work of the practice manager becomes accepted and embraced by all clinic staff. Practice managers can actively promote and encourage greater involvement of non-GP staff (e.g. practice nurse and reception staff) in improving productivity and ensuring GP time is being used appropriately. The success of this role is dependent upon receiving appropriate organisational support, and ongoing communication with all stakeholders.

Whilst the practice manager role is invaluable in improving the operations of a general practice clinic, a practice manager position may not be self-funding in the short term, and it may take 12 to 24 months before the position becomes cost-neutral.

Alternatively, there are a number of companies offering consultant practice managers who can be used by practices as a short-term measure.

Note: The practice manager role can be taken on by a practice nurse (if there is FTE capacity).

**Example:** North Yarra Community Health created the position of practice manager in 2006. The position has been very effective in increasing recruitment of GPs over all sites. The position is designed to ensure the ongoing viability of the medical practice and ensure that the reception services provided to the whole organisation are of high and consistent quality. The position is part of the senior management team of the organisation and takes responsibilities for a range of quality improvement and operational initiatives, including participation in setting the strategic direction of the organisation. Reporting to the CEO and board of management on a regular basis has been invaluable in raising the profile of the general practice and ensuring support for the work of the practice manager.

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### **Appropriate ratio of practice nurses to GPs**

The AGPN *Nursing in general practice business case models* recommended a ratio of 0.2 FTE practice nurses per GP FTE. This was developed from a two-year study that aimed to provide resources to support a discussion about the benefits and implications of employing a practice nurse. While this ratio provides a benchmark for staffing levels, the appropriate ratio for each practice is dependent on the nature and requirements of the practice.

Calculation of the nurse to GP ratio could include other nursing staff such as refugee health nurses funded via the CHS or mental health nurses funded through Medicare.

**Resource:** The AGPN *Nursing in general practice business case models* is available at: [www.generalpracticenursing.com.au/client\\_images/137701.pdf](http://www.generalpracticenursing.com.au/client_images/137701.pdf)

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### **Appropriate practice nurse roles and responsibilities**

The work of practice nurses has been defined as:

- Clinical support, which involves undertaking clinical duties as the delegate of the GP, with the purpose of increasing the numbers of services delivered to patients and liberating GP time. Examples of duties under this role are wound care, immunisations, cardiograms, spirometry.
- Administrative and management, which involves managing clinical systems, recall and reminder systems, stock control, equipment maintenance, infection control, sterilisation and accreditation.
- EPC and PIP, which ranges from providing home health assessments to managing the EPC system with patient audit and recruitment, recall registers, diabetic registers, assisting with patient education and chronic disease management.
- Enhanced or primary care, where practice nurses run clinics for conditions such as weight loss, women's health, incontinence, diabetes, asthma, antenatal care and baby health checks.
- Integration, including working with other primary care providers to improve care coordination.<sup>18</sup>

Funding support for practice nurses is available to all rural clinics and some urban clinics through the Medicare Australia PIP program.

**Example:** Dousta Galla Community Health Service has developed a role for their practice nurses to undertake Older Aged Health Assessments. A list of patients that are due for a health assessment is prepared by the administrative team for the nurses. A nurse contacts the patient, seeks their consent and then arranges the assessment. Once the assessment is completed, the patient sees the GP for a 15-minute follow-up. Dousta Galla receives \$175.10 for each Older Aged Health Assessment; this contributes to the funding of the practice nurse position. For Dousta Galla, this use of the practice nurses provides an effective and economical way to commence health assessments for eligible patients. The benefit to the patients is that they now receive regular health assessments and comprehensive health care.

**Resources:** The report *General practice nursing in Australia* produced by the Royal College of Nursing Australia provides detailed information on the roles of practice nurses. [www.rcna.org.au/Default.aspx?PageID=1216914&A=SearchResult&SearchID=471117&ObjectID=1216914&ObjectType=1](http://www.rcna.org.au/Default.aspx?PageID=1216914&A=SearchResult&SearchID=471117&ObjectID=1216914&ObjectType=1)

In addition the *Nursing in general practice information sheet* developed by the AGPN provides a range of information about the benefits and implications of employing practice nurses.

[www.generalpracticenursing.com.au/client\\_images/137701.pdf](http://www.generalpracticenursing.com.au/client_images/137701.pdf)

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<sup>18</sup> The AGPN *Nursing in general practice business case models* and the 2004 study *General practice nursing in Australia*, undertaken by the Royal Australian College of General Practitioners (RACGP) and the Royal College of Nursing Australia (RCNA), define the roles of practice nurses.

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### ***The administration team has appropriate expertise and skills to fully support the clinical team***

It is important that administrative staff can perform all administrative tasks to the high standard expected by the clinical staff. When this is not the case, GPs will perform some administrative tasks themselves, reducing the time they have available for their clinical role.

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### ***Appropriate medical reception support***

An appropriate level of medical reception support is dependent upon the size and nature of the clinic, and the services which are being supported.

The AGPN *Nursing in general practice business case models* provides benchmarks for medical reception staff levels and costs, which are also referenced in the Practice Health Atlas. Example benchmark ratios are: for two GPs, 1.9 FTE of medical reception support; and for five GPs, 4.8 FTE of medical reception support.

**Resource:** AGPN *Nursing in general practice business case models*:  
[www.generalpracticenursing.com.au/client\\_images/137701.pdf](http://www.generalpracticenursing.com.au/client_images/137701.pdf)

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### ***Medical receptionists' roles are appropriate***

Medical receptionists should be fully utilised to perform as many non-clinical tasks as practicable. The role should include all administrative tasks, including faxing, management of appointments, updating patient details, and collection of accurate patient information. Medical receptionists support the work of the GP and free up GP time for clinical care. They should be empowered to feel they are part of the clinic team and contributing to its performance and success.

Ideally, clinics should be supported by medical receptionists with appropriate medical reception training. Appropriately trained medical receptionists are a vital component of a well functioning general practice because of the specialised knowledge required to effectively claim MBS items.

**Example:** Dousta Galla Community Health Service has focused on building the role of their general practice receptionists. This includes providing them with a lead role in information management, managing non-attendance, and building relationships with other local providers. This has led to greater job satisfaction and increased trust between general practice team members.

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### ***GP attendance at CHS management and administrative meetings***

Conducting CHS management and administrative meetings outside of the general practice consultation hours, and compensating GPs for the time involved, will enable GPs to attend these meetings. This will assist in building strong team relationships, understanding of team roles and trust in team members. Benefits also include the maximisation of GPs' consultation hours, engagement of the GPs in practice change, and recognising and rewarding GPs' attendance and commitment to non-clinical activities. These meetings must be relevant to the GPs and may work well if one GP is nominated as the practice leader and attends the meetings on behalf of the other GPs. However, time must also be made for some whole-of-practice meetings, bringing together all GPs and other practice staff.

It is also possible to look for opportunities to combine management meetings with activities that earn continuing professional development (CPD) points, for example small group learning activities that assist GPs to gain category 1 CPD points. Divisions of general practice can assist in establishing these.

**Example:** Dousta Galla Community Health Service uses whole-of-practice meetings to build a team approach and build trust between team members.

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***Interpreting services managed at CHS level and used in the most cost- and time-effective manner***

Use of interpreters should be coordinated for the CHS as a whole (including the general practice clinic). Techniques for the better management of interpreter resources could include block bookings of patients requiring common languages, and the use of a dedicated resource for the proactive management of interpreters (for example having one person in the CHS be responsible for booking and managing interpreters)

**Example:** North Richmond Community Health Centre uses a language services coordinator who manages all interpreter services across the CHS.

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***Effective use of interpreter services which are available without charge to the CHS***

CHSs should make effective use of services funded by third parties such as the Translating and Interpreting Service (for individual GPs) and the Victorian Interpreting and Translating Service.

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**Information technology and information management**

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***Reliable information management and communication systems implemented and maintained***

The CHS has a strategic approach to information management and communication systems that assists rather than hinders productivity. The general practice needs to be sufficiently resourced to support a well interfaced IT system that is capable of meeting all the needs of the organisation.

**Example:** Banyule Community Health has dedicated significant time and resources to developing an effective information management and communication system for their two GP sites. This has included undertaking a continuous quality improvement process using the PEN Clinical Audit Tool to improve the quality of clinical and demographic data and the Practice Health Atlas to gain a better understanding of the practices' chronic disease profiles and to target resources to plan patient care accordingly. For example, practices are able to identify all patients with diabetes and to check if they have had the appropriate care to meet the requirements of the diabetes annual cycle of care SIP.

Banyule uses electronic patient records; this is enabled by the Medical Director 3 clinical software package, paper scanning facilities for medical correspondence and documents, Prac Soft 3 for all administrative functions, and the Argus encrypted software package.

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***Electronic medical records accessible between multiple locations***

Electronic medical records are accessible at multiple sites. The benefits include completeness of records, improved clinical risk management, and access to disease registers between sites.

**Example:** Banyule Community Health has all patient records accessible via a citrix network system (a secure-web based system). This allows full access to all records at both its general practice sites.

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***Full use of functionality of clinical information management and communication systems***

An example is the use of a clinical application that supports quality care and practice viability by incorporating diagnostic lists, investigations, and accessible pathology and radiology ordering, as well as providing access to tools to support the use of new MBS items including EPC items.

**Example:** Banyule Community Health uses online diagnostic reports (e.g. pathology, radiology, and cytology), online access to the ACIR, and secure electronic communication with the after-hours deputising medical locum service. The Victorian Statewide Referral Tool (found in Medical Director 3) is used to refer patients to allied health practitioners within the community health service. Patient registers, recall and reminder systems and various templates are used for the assessment, planning and review of patients with chronic and complex care needs and for preventative care.

## Patient flow

### *Systematic approach to patient flow to maintain sustainable throughput and appropriate MBS claiming*

In order to balance quality of care, access and viability, an appropriate appointment schedule needs to be developed. This schedule should allow for a mix of standard (15-minute), long (30-minute) and emergency consultations. The schedule could include time for repeat prescriptions and allowance for some walk-up appointments each session. It is essential that all consultations are billed appropriately so that, for example, long and prolonged consultations, as well as procedures, nurse items and bulk-billing incentives under the MBS, can be claimed correctly.

Rostering of GP sessions can also be done in a way that will optimise the GP to nurse ratio. Ensuring that GP sessions correlate with nursing sessions so as to best approximate the ideal GP to nurse ratio will support practice viability in practices with smaller GP numbers.

**Example:** North Yarra Community Health split up the day so that, in addition to standard appointments, time is allowed for short walk-up appointments and repeat prescriptions for regular patients.

### *Targets are set to monitor the take-up of new MBS items*

Targets should be determined with reference to the clinical, operational and strategic objectives of the practice. Clinical audit tools are available to assist with determining appropriate EPC targets. This could include measuring the numbers of patients with diabetes and setting targets for the practice around the use of GPMPs, TCAs or completion of the diabetes annual cycle of care.

### *Impact of 'did not attend' (DNAs) is minimised and there is an appropriate process to reduce them*

Each CHS will determine an acceptable level of DNA rates. All clinics will be working to minimise DNAs, although it can be difficult to make improvements in this area.

There is a range of approaches currently used by CHSs to manage DNAs, including:

- SMS reminders
- reminder calls to some groups of patients
- double-booking appointments for patients with a history of not attending appointments, and using non-clinical staff, such as case workers or receptionists, to manage DNAs and to fill any free appointments as needed
- keeping a list of patients who are able to attend at short notice.

**Example:** Dousta Galla Community Health Service proactively manages patients that regularly do not attend. The refugee health nurse or receptionists call patients the day before to remind them of their appointment.

## Component 4: Outcomes

### Quality

#### *Systems that link quality practice with MBS item use*

It is important to ensure the practice team understands that quality practice and appropriate MBS item use are linked. For example, there is evidence that demonstrates that when general practice works in collaboration with specialists and multidisciplinary teams, the quality of care for a number of mild to moderate chronic diseases (including diabetes, hypertension and musculoskeletal conditions) can be improved and there is greater capacity for the continuity and breadth of care required to manage multiple and complex conditions.

**Resource:** Harris MF and Zwar NA, 'Care for patients with chronic disease: The challenge for general practice', *MJA*, 2007, vol. 187, no. 2, pp. 104–107.

#### *Participation in RACGP accreditation process*

Accreditation supports quality and best practice service. It also allows practices to access the PIP items which attract additional funding.

**Resources:** Dandenong Casey General Practice Association *Policy and procedures manual*, RACGP *Standards for general practice*.

#### *Use of National Prescribing Service (NPS) audits*

The NPS offers general practices an audit of their prescribing practices. The clinical audits are free quality improvement activities that help GPs to review their current prescribing practices for patients with certain conditions compared to current best practice guidelines. The number of audits available to each practice is based on the number of MBS claims per GP FTE. Participating in the audits attracts a Practice Incentive Payment (PIP) and earns CPD points.

**Example:** Banyule Community Health participates in three NPS audits per year.

**Resource:** For detailed information on the NPS audits visit [www.nps.org.au/health\\_professionals/activities/clinical\\_audits\\_for\\_gps](http://www.nps.org.au/health_professionals/activities/clinical_audits_for_gps)

#### *Patient satisfaction surveys conducted regularly*

Patient satisfaction surveys should be conducted regularly to provide consumer feedback on services provided.

**Example:** North Yarra Community Health Service undertakes consumer satisfaction surveys on a regular basis. The results from the survey inform the future direction of the agency and allow the agency to address concerns raised by patients. From time to time additional surveys are conducted that have a particular focus; for example, the general practice staff recently devised and conducted a patient survey as part of a review of the appointment system.

#### *Effective relationships with universities and local divisions of general practice*

Strong relationships with local divisions of general practice are essential. The divisions offer a range of services to general practices within their catchments, including training and information in relation to practice setup, information on new initiatives and legislative changes (e.g. in relation to the MBS), assistance to access clinical audit tools, and IT/IM support.

Universities are able to assist with teaching, training, research opportunities for GPs, and recruitment and retention of GPs.

**Example:** Banyule Community Health has a strong relationship with the North East Valley Division of General Practice. The division has supported the CHS by providing it with ongoing IT/IM support and expertise; assisting in the initial implementation and progressive use of the PEN Clinical Audit Tool; providing the Practice Health Atlas which is used by Banyule as a decision support tool across both its practices; providing Medical Director training for new staff; and providing ongoing professional development.

Banyule Community Health also participates in other quality improvement activities such as small group learnings and case studies facilitated by their local division of general practice. These take place on site at the practices to save GPs travel time.

Banyule also has a strong relationship with the University of Melbourne School of Medicine and provides teaching and supervision to third and sixth year medical students on clinical placement at Banyule.

**Example:** Bendigo Community Health Service and La Trobe University have worked together for a number of years. Recently they developed a general practice training consortium which includes private clinics. This relationship has assisted Bendigo CHS in attracting and retaining GPs.

## Financial

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### *Financial performance that is sustainable and consistent with the agreed position of the CHS board*

Practices should aim to adopt models of care which support financial viability. Any loss incurred needs to be commensurate with the value the CHS places on the community benefit of the service.

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### *The CHS and the general practice are supported by a strong financial framework*

The expenditure profile of the general practice is understood and controlled. Costing practices are clearly understood by all staff.

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### *All staff understand the value of using incentives to improve on current practice*

All practice staff understand that the introduction of incentives offers a strategy for improving current practice by promoting better patient care and supporting practice viability.

**Example:** The Doutta Galla Community Health Service practice staff are involved in the setting of targets for MBS items; for example, they understand that setting targets for the number of patients identified as eligible for a health assessment supports quality care for the patient as well as assisting in practice viability.

## Appendix 1: Using the MBS appropriately to support quality care for patients and practice viability

This appendix provides a number of scenarios that demonstrate how the use of the MBS impacts both on the financial outcome for the practice and the type of care that is provided for patients. Part one shows how claiming standard and long consultations will impact on practice revenue. Part two shows how the use of the EPC items and other quality improvement items impact on the type and amount of care provided to patients and as well as on practice revenue.

### Part one: Standard consultation MBS items

The following scenarios are examples of a range of MBS billing mixes using standard and long consultations. For each scenario it is assumed that each GP is undertaking two 3.5-hour sessions a day and is working 5 days a week, 42 weeks of the year. All visits attract the \$5.55 bulk-billing incentive (please note that in rural and some outer urban areas the bulk-billing incentive is at the higher rate of \$8.35).

#### Scenario A: Standard consultations

Assumes all patients have standard consultations (item 23). Each GP sees 28 patients a day.

MBS revenue		1 GP	2 GPs	3 GPs
Daily	28 × \$39.10	\$1,094.80	\$2,189.60	\$3,284.40
Weekly	5 × \$1,094.80	\$5,474.00	\$10,948.00	\$16,422.00
Annual	42 × \$5,474.00	\$229,908.00	\$459,816.00	\$689,724.00
Hourly	\$1094.80 ÷ 7	\$156.40	\$312.80	\$469.20

#### Scenario B: Standard and long consultations

Assumes one patient in four needs a long consultation. Each GP sees 24 patients a day, consisting of 20 standard consultations (item 23) and four long consultations (item 36).

MBS revenue		1 GP	2 GPs	3 GPs
Daily	(20 × \$39.10) + (4 × \$69.30)	\$1,059.20	\$2,118.40	\$3,177.60
Weekly	5 × \$1,059.20	\$5,296.00	\$10,592.00	\$15,888.00
Annual	42 × \$5,296.00	\$222,432.00	\$444,864.00	\$667,296.00
Hourly	\$1,059.20 ÷ 7	\$151.31	\$302.63	\$453.94

#### Scenario C: Standard and long consultations

Assumes three out of four patients need long consultations. Each GP sees 16 patients a day, consisting of four standard consultations (item 23) and 12 long consultations (item 36).

MBS revenue		1 GP	2 GPs	3 GPs
Daily	(4 × \$39.10) + (12 × 69.30)	\$988.00	\$1,976.00	\$2,964.00
Weekly	5 × \$988.00	\$4,940.00	\$9,880.00	\$14,820.00
Annual	42 × \$4,940.00	\$207,480.00	\$414,960.00	\$622,440.00
Hourly	\$988.00 ÷ 7	\$141.14	\$282.28	\$423.43

### Scenarios D: Long consultations

Assumes all patients need long consultations (item 36). Each GP sees 14 patients a day.

MBS revenue		1 GP	2 GPs	3 GPs
Daily	14 × \$69.30	\$970.20	\$1,940.40	\$2,910.60
Weekly	5 × \$919.52	\$4,851.00	\$9,702.00	\$14,553.00
Annual	42 × \$4,597.60	\$203,742.00	\$407,484.00	\$611,226.00
Hourly	\$970.20 ÷ 7	\$138.60	\$277.20	\$415.80

These scenarios provide comparisons of the revenue implications of different ways of working using only the MBS consultation items. This type of analysis can be used to project likely revenue given the expected patient needs of a GP practice. It can also be used to calculate the optimal utilisation (against cost) of nursing staff in each scenario.

In addition to the mix of short and long consultations, financial projections should consider the level of use of the chronic care MBS items. This is demonstrated in the scenarios in part two below.

### Part two: Enhanced Primary Care (EPC) MBS items

The following scenarios demonstrate the amount of care patients can receive using EPC items and the revenue available to the practice through appropriate claiming of these items.

There is evidence that demonstrates that when general practice works in collaboration with specialists and multidisciplinary teams, the quality of care for a number of mild to moderate chronic diseases can be improved and there is greater capacity for the continuity and breadth of care required to manage multiple and complex conditions.<sup>19</sup>

**Resource:** Harris MF and Zwar NA, 'Care for patients with chronic disease: The challenge for general practice', *MJA*, 2007, vol. 187, no. 2, pp. 104–107.

Note that these scenarios are examples only and are intended to demonstrate the flexibility of the MBS EPC items of care for patients with chronic and complex needs. Individual GPs have responsibility to ensure that MBS items claimed match the service provided.

#### Scenario A: Providing care to a patient with complex care needs without using EPC items

A patient with diabetes and complex care needs requires a consultation with a GP every two months. The GP uses item 36 (long consultation) for each visit.

Care over 12 months	Time with patient (minutes)	MBS revenue
6 × item 36 (each \$69.30)	180	\$415.80
Practice revenue per hour		\$138.60

**Outcomes:** The patient sees the GP for a total of 180 minutes (3 hours) during the year and the practice revenue related to this care equates to \$138.60 per hour of GP time.

<sup>19</sup> Harris MF and Zwar NA, 'Care for patients with chronic disease: The challenge for general practice', *MJA*, 2007, vol. 187, no. 2, pp. 104–107.

### Scenario B: Providing care to a patient with complex care needs using EPC items (general practice management plan), standard consultations and the diabetes annual cycle of care service incentive payment (SIP)

The same patient as above is still seen by the GP six times over the year; however the GP undertakes a GP Management Plan (GPMP) at the start of the 12 months, reviews the GPMP every third month, and the patient's remaining two consultations are billed as standard consultations.

Care over 12 months	Time with patient (minutes)	MBS revenue
1 GPMP (item 721)	45	\$136.20
3 reviews of GPMP (item 725)	120	\$212.55
2 standard consultations (item 23)	30	\$78.20
Diabetes annual cycle of care SIP		\$40.00
Total	195	\$466.95
Practice revenue per hour		\$143.68

**Outcomes:** The patient sees the GP for 195 minutes (3 hours and 15 minutes). This is 15 minutes more than Scenario A. In addition, the practice revenue is increased by \$5 per hour of GP time in relation to this care.

### Scenario C: Providing care to a patient with complex care needs using EPC items (GPMP, TCA) and allied health items

The same patient as above is managed by the GP using a GPMP and Team Care Arrangements (TCA). Use of these items allows the patient to also receive MBS-rebateable services from the practice nurse and other allied health providers.

Care over 12 months	Time with patient (minutes)	MBS revenue
GPMP (item 721)	45	\$136.20
TCA (item 723)	30	\$109.05
Allied health, psychology services		
Practice nurse (item 10997)	15	\$16.65
Allied health, psychology services		
GP standard consultation (item 23)	15	\$39.10
2 practice nurse reviews (item 10997)	30	\$33.30
Review of GPMP (item 725)	30	\$70.85
Diabetes annual cycle of care SIP <sup>†</sup>		\$40.00
Total	165 (plus 150 allied health)	\$445.15
Practice revenue per hour		\$161.87

\* The Commonwealth provides eligible patients with access to up to five MBS-rebateable allied health providers sessions. These sessions must be of a minimum of 20 minutes and can be provided by a range of allied health services. In this example it is assumed that this patient accesses all five allied health sessions, that these sessions are of 30 minutes duration and that the services are provided externally to the practice.

† Use of TCA allows the practice nurse to undertake some of the subsequent care using a chronic care nursing item. This frees up GP time to undertake other work.

‡ The diabetes annual cycle of care SIP rewards evidence-based care for patients with diabetes. This can be claimed annually if all requirements are met.

**Outcomes:** The patient has a total of 315 minutes (5 hours and 15 minutes) of service, 150 minutes of which is provided by allied health professionals (e.g. dietician, diabetes educator, exercise physiologist). The practice revenue is \$161.87 per hour of service provided by them, which is the highest hourly rate of remuneration of all the scenarios, and which (unlike scenarios A and B) is earned from a combination of GP and practice nurse time.

**Table 1: Comparison of chronic and complex care model scenarios**

Scenario	Patient care	Practice MBS revenue	Practitioners providing care
Scenario A: Long consultations only	The patient sees the GP for a total of 3 hours over the year, consisting of six 30-minute consultations.	\$138.60 per hour	GP
Scenario B: GPMP, annual cycle of care and standard consultations	The patient sees the GP for a total of 3 hours and 15 minutes.	\$143.68 per hour	GP
Scenario C: GPMP, TCA, annual cycle of care and MBS allied health	The patient sees the GP for 2 hours. The practice nurse provides 45 minutes of care. The patient also receives 2.5 hours of allied health care provided outside of the practice. The use of practice nurses is an efficient use of staff as a practice nurse costs the practice less per hour than a GP.	\$161.87 per hour	GP, practice nurse and allied health providers

## Appendix 2: GP arrangements

The table below outlines the advantages and disadvantages of the various GP arrangements options available to CHSs. The selection of a particular GP arrangement should be made with consideration for the strategic imperatives and other priorities of the organisation.

GP arrangements option		Advantages	Disadvantages
1	100% contractors <i>(CHS bills MBS activity on behalf of GPs, and contractors pay CHS a percentage of total MBS revenue)</i>	<ul style="list-style-type: none"> <li>Encourages a productivity-oriented culture.</li> <li>CHS shares the risk regarding the revenue generation of the GPs with the contracted GPs.</li> <li>CHS has greater influence over the interaction between GP clinic and other CHS services.</li> </ul>	<ul style="list-style-type: none"> <li>Successful integration and ongoing management of contracted GPs requires strong relationships between CHS management and the contracted GPs.</li> <li>CHS bears the risk regarding financial performance of the GP clinic.</li> <li>May encourage a focus on throughput rather than quality of patient care.</li> </ul>
2	Sessional, collocated <i>(GPs bill MBS activity and pay CHS a sessional rate)</i>	<ul style="list-style-type: none"> <li>Reduces CHS exposure to risk regarding financial performance of the GP clinic.</li> <li>Reduces CHS exposure to risk relating to clinical issues and accreditation.</li> <li>Reduces administrative obligations for CHS as they are not responsible for MBS billing.</li> </ul>	<ul style="list-style-type: none"> <li>Successful ongoing interaction between the CHS and the GPs requires strong relationships between CHS management and the contracted GPs.</li> </ul>
3	Fully outsourced, collocated <i>(GPs are fully privatised, and CHS receives rental income)</i>	<ul style="list-style-type: none"> <li>Reduces CHS exposure to risk regarding financial performance of the GP clinic, clinical issues and accreditation.</li> <li>GP services continue to be available to the local community.</li> <li>Reduces administrative obligations for CHS as they are not responsible for Medicare billing.</li> <li>If the CHS had a general practice that was previously operating at a financial deficit, a change to this arrangement may allow the CHS to fund other services for the community.</li> </ul>	<ul style="list-style-type: none"> <li>Becomes more difficult for the CHS to successfully influence the interaction between the GP clinic and other CHS services.</li> <li>Transition to privatised, collocated clinic may not be attractive for the current in-house GPs and it may be difficult to attract other GPs.</li> </ul>
4	100% in-house <i>(hourly remuneration)</i>	<ul style="list-style-type: none"> <li>CHS can determine up front the involvement of GPs in practice management and accreditation activities, rather than pay for these separately.</li> <li>CHS has greater influence over the interaction between GP clinic and other CHS services.</li> </ul>	<ul style="list-style-type: none"> <li>CHS responsible for all clinical- and accreditation-related risks.</li> <li>CHS bears the risk regarding financial performance of the GP clinic.</li> <li>No remuneration-linked incentives available to encourage productivity increases.</li> <li>CHS must use other techniques to encourage improvements in productivity (i.e. cultural shifts).</li> </ul>

GP arrangements option		Advantages	Disadvantages
5	100% in-house <i>(hourly and incentivised remuneration)</i>	<ul style="list-style-type: none"> <li>• Introduction of incentives allows partial retention of status quo (at clinics which currently have in-house GPs).</li> <li>• Provides a mechanism for encouraging and rewarding increased productivity of GPs.</li> <li>• CHS gains a financial benefit from an increase in GP productivity.</li> <li>• CHS determines strategic and operational priorities of the clinic.</li> <li>• CHS has greater influence over the interaction between GP clinic and other CHS services.</li> </ul>	<ul style="list-style-type: none"> <li>• CHS responsible for all clinical- and accreditation-related risks.</li> <li>• CHS bears the risk regarding financial performance of the GP clinic.</li> <li>• May encourage a focus on throughput rather than quality of patient care.</li> </ul>
6	Mixed model <i>(in-house and contractors)</i>	<ul style="list-style-type: none"> <li>• CHS shares the risk regarding the revenue generation of the GPs with the contracted GPs.</li> <li>• CHS has greater influence over the interaction between GP clinic and other CHS services.</li> <li>• Contracted GPs will be more focused on productivity. Performance of contracted GPs sets a benchmark of revenue earned and patients seen. Ideally, in-house GPs work to the same targets.</li> <li>• Encourages a more productivity-oriented culture.</li> </ul>	<ul style="list-style-type: none"> <li>• May encourage a focus on throughput rather than quality of patient care.</li> <li>• Successful integration and ongoing management of contracted GPs requires strong relationships between CHS management and the contracted GPs.</li> <li>• CHS bears the risk regarding financial performance of the GP clinic.</li> </ul>
7	Cessation of GP service <i>(general practice services no longer offered)</i>	<ul style="list-style-type: none"> <li>• CHS bears no financial-, quality- or accreditation-related risks in relation to GP services.</li> <li>• If GP clinic was previously operating with a financial deficit, cessation of services may allow the CHS to redirect the funds used to cover the deficit to provide other services for the community.</li> </ul>	<ul style="list-style-type: none"> <li>• Reduction in bulk-billing GP services available to the local community.</li> <li>• May be at odds with goals and objectives of the CHS regarding access to health services and health of the local community.</li> <li>• Reduction in bulk-billing GP services available to the local community may increase demand for other CHS services (e.g. allied health, nursing services), due to chronic conditions not being medically managed.</li> <li>• Increases burden on remaining bulk-billing GPs and public hospital emergency departments to provide services.</li> </ul>

## Appendix 3: Resources to support implementation

### Department of Human Services website

A range of information relevant to CHS general practices is available online at [www.health.vic.gov.au/communityhealth/gps](http://www.health.vic.gov.au/communityhealth/gps)

This includes:

#### Medicare Benefits Schedule Project

These pages provide information and resources to support evidence-based models of care that incorporate recently introduced Medicare Benefit Schedule (MBS) items for community health and general practice.

[www.health.vic.gov.au/communityhealth/gps/mbs.htm](http://www.health.vic.gov.au/communityhealth/gps/mbs.htm)

#### Community health

[www.health.vic.gov.au/communityhealth/gps/mbs](http://www.health.vic.gov.au/communityhealth/gps/mbs)

#### General practice

[www.health.vic.gov.au/communityhealth/gps/mbs\\_gp](http://www.health.vic.gov.au/communityhealth/gps/mbs_gp)

#### Resources and links

This page provides basic information for community health services who wish to start a general practice service or expand an established service.

[www.health.vic.gov.au/communityhealth/gps/rscs\\_links.htm](http://www.health.vic.gov.au/communityhealth/gps/rscs_links.htm)

#### General Practitioners in Community Health Services Strategy

These pages explain the 2004–08 strategy, and provide resources from the Strategy Projects Review Forum held in August 2007.

[www.health.vic.gov.au/communityhealth/gps/chs.htm](http://www.health.vic.gov.au/communityhealth/gps/chs.htm)

#### Other Primary Health Branch work related to GPs

This page describes the work of the Primary Health Branch that supports GPs working in or with CHSs.

[www.health.vic.gov.au/communityhealth/gps/other.htm](http://www.health.vic.gov.au/communityhealth/gps/other.htm)

### Divisions of general practice

Local divisions of general practice offer a range of resources and support services for general practice in the CHS environment. These include:

- training materials targeting accreditation-related matters and new initiatives (e.g. EPC items)
- practice structure-related training (for practice managers and practice nurses)
- support for the uptake of practice nurses and the application of the *Nursing in general practice recruitment and orientation guide*, available via the Australian General Practice Network (AGPN): [www.agpn.com.au/nigprecrut](http://www.agpn.com.au/nigprecrut)
- support for new approaches and technologies (Australian Primary Care Collaborative, Practice Health Atlas, PEN Clinical Audit Tool).

More detailed information on the role of divisions of practice is available at [www.gpv.org.au](http://www.gpv.org.au) and [www.phcris.org.au](http://www.phcris.org.au).

### **Australian Primary Care Collaboratives (formerly National Primary Care Collaborative)**

The Australian Primary Care Collaboratives (APCC) program is designed to assist GPs and primary health care providers to work together to improve patient clinical outcomes, reduce lifestyle risk factors, help maintain good health for those with chronic and complex conditions and promote a culture of quality improvement in primary health care.

The APCC program involves the collection of data and its analysis via clinical audit tools. The program goes beyond data analysis to include the integration of practice nurses and the fostering of a team care approach in order to improve health outcomes related to chronic disease management. The result of team-based care is better quality care for patients, an appropriate increase in EPC items and a resultant increase in revenue for the practice.

The APCC is run in some divisions of general practice. For information on this program contact your local division or go to [www.apcc.org.au](http://www.apcc.org.au).

## Appendix 4: Supporting change management

There are many change management models available to CHSs. The following information was developed by Paxton Partners to support the implementation of a new business model.

A successful change management process will likely require the following:

- Appointment or nomination of a project manager (with executive support) for the change management process.
- Identification of a clinical champion from the general practice team.
- Preparation of a project timetable, including project milestones, to ensure the timeliness and progress of change, and to ensure problems are identified and managed.
- Preparation of a detailed communication plan. Communication should be regular and honest, and targeted to reach all team members (including a specific focus on GPs). Communication should cover the objectives, drivers and targeted outcomes of the proposed change.
- Commitment of an appropriate period of time (e.g. at least 12 months) for the change management process.
- Organisational understanding that changes of this nature will not be achieved easily, and will require time and effort. This may require a financial commitment by the organisation in the short term (i.e. the organisation should confirm its commitment to the change management process, and understand and commit to the costs associated with the process, which may include additional operating deficits for GP services).
- Undertaking a process to understand team members' concerns (particularly GPs) about the proposed change. Where appropriate, actions should be taken to address these concerns. It may be necessary to modify the project timetable or communication plan to incorporate the identified concerns. Any actions taken in response to team members' concerns should be highly visible to team members.
- Identification of opinion leaders from within the GP team who are both well respected and likely to support the process of change. These opinion leaders should be approached and briefed individually, to elicit their engagement in and support of the process.
- Identification of GP team members who will most likely resist the proposed change, and are likely to have a degree of influence amongst the team. Consider a targeted approach and communication process for these individuals, aimed at obtaining some level of engagement. It may be necessary for the organisation to no longer offer employment to team members who will not ultimately embrace or work to achieve change.
- A review of physical and logistical aspects to identify factors which might assist change management (for example, in order to encourage greater interaction between GPs and allied health staff, it may be appropriate to physically locate the team together).
- A review and redevelopment of relevant policies, processes and procedures to ensure they are aligned with the targeted change.
- The determination of KPIs to monitor the status of the change management progress.
- Periodic feedback to assess progress to maintain team engagement. This would include feedback from management to practice staff as well as seeking feedback from practice staff about the change process.
- Use of clinically and philosophically relevant indicators of success to reinforce change.
- A period of stability at the end of this process during which the organisation makes no additional major changes, so the completed changes can become established.

## Appendix 5: Basis of the information for this guide

In early 2007 the Primary Health Branch, in conjunction with the Northern and Western Metropolitan Region and four CHSs (Darebin Community Health, Dianella Community Health, North Richmond Community Health Centre and North Yarra Community Health), agreed to explore the viability of their general practices and develop an optimal business model for general practice within a CHS.

The objectives of the project were:

- to undertake an investigation of efficient and effective business models for CHS general practices
- to provide background information on efficient and effective practices in the operation and management of business models currently in place in the four CHSs, including optimising MBS claiming
- to develop tools that will assist CHSs in developing an optimal business model for their general practice.

The project was undertaken by Paxton Partners Pty Ltd.

The starting point for this guide was the information from the project conducted by Paxton Partners Pty Ltd with the four CHSs, including:

- their analysis of financial, activity and practice administration data (for three financial years if available) and background information
- meetings with agency staff, including CEOs, GPs, practice nurses and other nursing staff, chief financial officers and finance managers, practice managers, and reception and other administration staff
- a review of background literature regarding innovative CHS general practice clinics in Victoria and Australia, and previous Department of Human Services reports
- interviews with management of CHSs operating general practice clinics that were identified as innovative by their peers and by the department
- a review of relevant literature regarding business rules in health service settings
- consultation with local divisions of general practice (Melbourne General Practice Network, North West Melbourne Division, Northern Division) regarding assistance available to CHS general practice clinics
- consultation with IT vendors regarding the availability of software to assist GP clinics with their take-up of EPC items.

This guide has been developed by summarising the information generated in the original study. A range of other information relevant to CHS general practice, including additional examples and links to resources, has been added by the Primary Health Branch.

### Characteristics of the four CHS general practices that participated in the study

#### Darebin Community Health

Darebin Community Health operates one GP clinic (East Reservoir) and two pharmacotherapy clinics (Northcote and PANCH). In 2006–07, the GP FTE of the GP clinic was 2.6, and the GP FTE of the pharmacotherapy clinics was 1.5. The GPs are employees of the agency.

Darebin's patient profile is predominantly long-term Greek and Italian immigrants and more recent immigrants from the Horn of Africa. A high proportion of patients are from low socioeconomic backgrounds and have chronic and complex needs.

### **Dianella Community Health**

Dianella Community Health operates two GP clinics (Broadmeadows and Meadow Heights). In 2006–07, the GP and paediatrician FTEs for Broadmeadows were 7.6 GP FTE and 0.6 paediatrician FTE, and for Meadow Heights they were 0.7 GP FTE and 0.2 paediatrician FTE. The GPs are employees of the agency.

Dianella's patient profile is predominantly Turkish immigrants, with a high proportion of older patients.

### **North Richmond Community Health Centre**

North Richmond Community Health Centre operates a GP clinic in Richmond. In 2006–07, the GP FTE of the clinic was 3.0. North Richmond's GPs are contractors, paying a sessional fee to North Richmond for the use of rooms, consumables and medical records. North Richmond's patients come from the nearby high-rise public housing; a high proportion are refugees and asylum seekers.

### **North Yarra Community Health**

North Yarra Community Health operates two GP clinics (Collingwood and Fitzroy) and a pharmacotherapy clinic (Smith St, Fitzroy). In 2006–07, the GP FTE was 9.57 for the GP clinics combined and 0.47 FTE for the pharmacotherapy clinic. The GPs are employees of the agency.

North Yarra's patients are a mix of public housing residents, homeless people, long-term Greek and Italian immigrants, and an increasing number of people from the somewhat higher socioeconomic areas in Carlton and Clifton Hill.

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