Policy Issues Paper no. 17: discussion paper for VACGP
June 2002

PCPs and general practice

This paper describes some of the issues arising in the Victorian Department of Human Services' Primary Care Partnerships (PCP) Strategy with implications for State and/or Commonwealth policy. It was developed in preparation for a meeting in March 2002 of the Victorian Advisory Committee on General Practice (VACGP), convened by the Commonwealth Department of Health & Ageing (DoHA).[1]

This paper, which we revised after the VACGP meeting in light of discussion, is for divisions but is not designed to give GPs an overview of the PCP Strategy. We believe it is most likely to be of interest to those CEOs, board members or staff who have already had significant involvement with the PCPs as it assumes detailed knowledge of the PCP Strategy. We are very interested to hear what you think about our description, analysis and suggestions so we can continue to build a fuller picture of divisions and PCPs, across Victoria. Please contact Sonya Tremellen (s.tremellen@gpdv.com.au) or Louise Willis (l.willis@gpdv.com.au) with any comments.

This paper is in 4 parts: introduction; service coordination model; different contexts of primary care; and involvement of divisions with PCPs. The paper's introduction argues that state and commonwealth programs can create competing demands on divisions that may hinder coordination and integration of primary and community care. The next section, about the PCP service coordination model, argues that a greater focus is needed by DHS on design of the model and implementation plans for persuading general practice uptake. The third section seeks to describe the different contexts of primary care and some work by GPDV to increase the mutual understanding between primary health and community care programs and general practice. The final section argues that the inconguence between division and PCP boundaries, while not preventing significant involvement by divisions in PCP structures, highlights resource issues for divisions. It also argues that maintaining and extending their involvement into implementation would be facilitated by targeted allocation of additional resources. Most sections include some suggested solutions for consideration by the VACGP and an indication of the outcome of their meetings held in March and May, 2002.

1. State & Commonwealth: competing demands on divisions?

The PCP Strategy is important to divisions of general practice as it provides a mechanism through which general practice can link with other primary health care providers, and offers the potential for improved coordination of patient or client services, regional health planning, better referral and information sharing processes. It is central to the business of divisions of general practice, whose main aim is to "improve health outcomes for patients by encouraging GPs to work teogether and link with other health professionals to upgrade the quality of health services delivery at the local level."[2]

[1] As well as representatives of State and Commonwealth health departments responsible for primary care, the VACGP also includes representatives from the Rural Doctors Association Victoria (RDAV), Rural Workforce Agency Victoria (RWAV), Royal Australian College of General Practitioners (RACGP), Australian Medical Association (AMA), General Practice Divisions Victoria (GPDV) and the Health Issues Centre. The VACGP provides an opportunity for State and Commonwealth to consider together the way the policies of the two levels of government are played out at the level of general practice, through divisions.

[2] Department of Health & Aged Care, May 1999, *Divisions of General Practice Program Implementation Guide for Outcomes Based Funding*, p.4; re-stated in Portfolio of Health & Aged Care Budget Statement, 2001-2002, Budget Related Paper No. 1.11, Part C, Outcome 4: Quality Health Care, p.135.

But it draws attention to some of the contradictions of our State/Commonwealth health system which hinder coordination and integration. The Commonwealth makes statements (from the AHMAC level to the state office level) about the importance of State and Commonwealth integration, but in a world of finite resources, and an increasing number of Commonwealth initiatives that look to divisions to improve the quality of general practice, the division experience can be one of managing competing priorities. Divisions of general practice tend to focus their attention on the national programs of their Commonwealth funders.

Unlike its predecessor, the PHACS Strategy, which intended to effect change through altering the fragmented funding arrangements, the PCP strategy rests on a philosophy of effecting change through organisational partnerships. DHS can more directly influence the agencies it funds (even if couched in terms of partnership and collaboration) than it can influence general practice. Persuading divisions of general practice, whose attention tends to be focused on their national, funded programs, that there are benefits to practices in conforming with the PCP's protocols, is therefore crucial. Concrete benefits, or at least no disincentives, for general practice need to be demonstrated if the divisions' support is to be secured, across the board.

2. SERVICE COORDINATION MODEL

Background

The overall goal of PCP service coordination is "functional integration in the primary care sector".[3] This means that "agencies will retain their organisational autonomy, while agreeing to conduct particular functions in a common way." Each PCP needs to "develop common practices, processes, protocols and systems" (PPPS) to manage the way in which consumers come into contact with the system; the way their needs are identified and assessed; and the way care is planned and managed.

This "functional integration" (ie coordination at the local level) is to occur across 6 key areas, defined in the Better Access to Services (BATS) policy and operational framework[4]. They are:

- ✶ Initial contact
- ✶ Initial needs identification
- Service specific assessment
- Specialist assessment
- Comprehensive assessment
- ✶ Care planning

Those marked ✶ are the priority areas.

DHS have completed the development and piloting of tool templates to support the implementation of these common functions across PCPs. Following an evaluation of a pilot of the tool templates, DHS has decided to make some changes to the information that will be collected and to what the different categories of information will be called. There will now be five components.[5]

1. Consumer information template (patient information – name, contact details etc). – *universal requirement*

[3] The information in this paragraph is taken from Information Resource: Primary Care Partnerships: Service Coordination: Development of tool templates for Initial Needs Identification and Care Planning , July 2001

[4] DHS, June 2001, *Better Access to Services: A Policy and Operational Framework*

[5] This information is based on DHS presentations following release of the PCP Strategy: Service Coordination: PCP Initial Needs Identification & Care Planning Tools Template Development: Evaluation Report, February 2002 prepared by the Australian Institute of Primary Care, La Trobe University.

2. Summary and referral information template (relevant health summary & referral) – *required* for provision of referral information
3. Consent form for sharing consumer information and consumer information brochure – *universal requirement*
4. Supplementary profiles - which may include *required* 'living arrangements' and 'functional profiles' for HACC referrals – others that have been developed to be released as *optional* templates
5. Service coordination template (care plan)– to be released for *recommended use*

An implementation plan for how and when these tool templates will be mandated for use by specific types of services ie HACC, Community Health etc, has recently been described by DHS.[6]

In summary, the service coordination work is highly relevant to general practice, as it is about what the GP sector would call assessment, referral and EPC care planning. There are tools being developed by DHS, but it is at the local level that the processes for using them will be decided. Processes and protocols may therefore vary between PCPs.

Division engagement in design of service coordination model

There are some key issues affecting the ongoing development of divisions' engagement with PCPs. Some problems include:

- Resources for ongoing negotiation with local PCPs. Strain on resources is exacerbated by the fact that some divisions work with more than one PCP. (For further discussion, see section 3 of this paper, boundary issues.)
- Local development of the service coordination model without sufficient statewide consultation & definition of the GP role to support divisions.
- Perceived inadequacy of the tools for GP use which may risk the level of uptake in general practice.
- Lack of sufficient software development to underpin uptake of PCP tools etc by GPs.

Local development or statewide consistency?

A core set of tool templates has been developed by DHS. As described above, DHS recommends the different core templates for universal, optional or recommended use. Additions to the core set can be implemented by local PCPs. The processes for ***how*** tool templates are used will be decided by each PCP. (This is what DHS calls the PPPS or practice process protocol systems work.) Allowing flexibility to meet different needs in different localities appears to be a sound rationale, but in practice it could mean that slightly different instructions and expectations are given out to general practitioners (and other agencies that work across PCP catchments) about how they should be used. Divisions have advised GPDV that they would welcome more statewide consistency, which was recommended by the RACGP representative at the VACGP meeting (8th May 2002).

Additionally, it would be helpful to have more clarity about what divisions should persuade their members to do when using the tool templates. Who will decide what is 'optional' or 'recommended' or 'required' for GP use? Should this be decided by divisions as a whole, by each division and PCP locally, by each practice, etc? (bearing in mind that individual GPs each need to be persuaded and cannot be required to use the tools).

[6] Information Resource: Primary Care Partnerships: Service Coordination Implementation, May 2002, DHS. Please note that this document indicates that the Supplementary Profiles will be released for recommended use, not optional use as had been indicated in previous communications.

If tool templates become part of GP medical software, this may partly solve the potential problem for those practices that are fully computerised for all their functions. It is likely to mean that one set of templates will be available for all practices in Victoria, but we need to remember that although computers are used in many general practices, they are by no means used for all the patient-related work a GP does, so software development alone will not totally solve the problem in the short-medium term.[7]

Tools for a GP target

Divisions have concerns that the tools are not based on evidence that is relevant to the general practice setting, either through existing widely-accepted standards and research bodies in general practice (RACGP, academic departments of general practice) nor through consultation with GPs at a statewide level at regular enough intervals, in enough detail. The one-off consultations and intensive support to divisions for involvement in technical piloting that have occurred (organised by GPDV and with DHS), have been useful for conveying GP concerns about the practicality of the tools in a general practice setting, and for identifying the high level of information development, training and resources needed to ensure that the technical pilots included at least a few GPs who work in private general practice clinics. GPs have welcomed some of the changes made (e.g. inclusion of "referral" in the title of one of the tool templates) as they have reflected the needs of general practice, but more ongoing, frequent and planned mechanisms would be useful to tailor the tools so that they can be widely used in general practice.

IMIT and service coordination

The lack of statewide consistency of, and compatability between, medical software used by PCPs and their agencies is a major barrier to sharing information. Different IMIT systems underpinning PCP work will prevent ease of communication across the state, and will be an obstacle to general practice participation, given that a practice will have only one IMIT system, which should be able to communicate with the rest of the health sector (including hospitals as well as primary care).

GPDV welcomes the convening of a second meeting of representatives of DHS, DoHA state office, GPDV and GP Computing Group to consider the GP interface with PCPs' IMIT issues specifically. We support continuation of this discussion through regular PCP/GP IMIT meetings.

Carelink

The development of the service directory component of service coordination must take into account the Commonwealth Carelink system. There is some involvement at the local level, but no statewide, systematic development that we know of. Clearly this issue is wider than general practice and it is necessary for the State and Commonwealth to work together to coordinate the two initiatives.

POSSIBLE SOLUTIONS

- ***Mechanisms to facilitate increased division input to design of service coordination systems that have statewide consistency and local utility and meaning*** e.g. establishment of a general practice working group (perhaps of the existing DHS PCP service coordination reference group), to address the interface with general practice, including some of the issues described in this paper; and ongoing PCP-GP IMIT meetings.

[7] The national BEACH study suggests that 67.4% of GPs use computers for some clinical purposes (this may not include referral), while 81.4% use computers for administration purposes. L Valenti, H Britt, *Current rates of computer use in Australian general practice*, conference presentation at RACGP 11th computer conference, August 2001.

Subsequent to the March VACGP meeting, DHS has agreed to convene a GP engagement working group and nominations will be called for in July. In the meantime GPDV has arranged for DHS to chair an interim group comprising division, GP and staff representatives on local PCP committees, DHS and DoHA state office, to draft terms of reference.

- ***State and Commonwealth to consider ways to coordinate Commonwealth Carelink initiative and the PCP service coordination initiative***

3. DIFFERENT CONTEXTS OF PRIMARY CARE

The lack of understanding between the publicly funded primary and community health sector and the general practice sector is a recurring theme in coordination and integration work that involves the whole health sector. This can be a barrier to forming and maintaining good local relationships, and can make it difficult to identify the areas of common interest.

Divisions tend to focus on the general practice, first and foremost. Although they sit within a local area and have signficant links with their community, their strategies for enhancing the quality of general practice generally involve visits to the practice, targeting GPs working there as well as practice managers, practice nurses and others. Visits are kept short and resources provided to practices are carefully targeted so that they fulfil a practice need and do not simply contribute to 'information overload', given that general practice work is structured around a succession of consultations, with little time for meetings, reflection and planning. Additionally, divisions' focus is on nationally-funded programs designed to improve the quality of general practice (e.g. immunisation, chronic disease management, etc.)

On the other hand, other primary care agencies may be structured quite differently, include time for more proactive work, service planning within a context that embraces a social model of health. Funding may be based on throughput, but wages are not necessarily driven by consultations in the same way as general practice. All parts of the health sector need to better understand the context in which the other operates in order to work together effectively.

The difference in language is one indicator of this issue. Although differences in language can appear a minor point, they can have far-reaching consequences, impeding common understanding. Language has been an alienating factor in attempting to secure general practice involvement in the PCP strategy, as policies and implementation plans have been couched in highly bureaucratic language, whose meaning is not always clear, nor consistent. Some of the terms adopted do not have clear meanings in general practice (e.g. initial needs identification), and some terms which are widely understood by general practice, and other health professionals, have not been included in this activity (e.g. assessment). We welcome the recent decision to change the term for the tool template from 'INI Summary & Action Plan' to 'Summary & Referral Information'. It will be important for DHS to settle on terminology – as well as key messages – before embarking on the planned wider communication strategy to PCPs and divisions of general practice about implementing the tool templates in general practice.

Another important difference between divisions and other primary care agencies is that divisions do not generally deliver health services, but are relatively small, member-based organisations. Divisions cannot require changes to general practice via mechanisms such as contracting or employing providers. Although divisions are structurally equivalent to agencies in the PCP in that they are members of the partnership, in another sense, it is the practices that are equivalent to agencies because they provide health services.

SOME SOLUTIONS: CURRENT WORK UNDERTAKEN BY GPDV

GPDV has developed a *Working with Divisions of General Practice* workshop for DHS staff (both Central and Regional Offices) and for staff and agency representatives within Primary Care Partnerships. The workshop aims to provide an understanding of the work of divisions in the context of systems for change, how divisions work with GPs to achieve change, and what the issues and tensions are when engaging with general practice on primary care integration. Six workshops have been held to date. Evaluation indicates that they have been very well received, and offer a sound basis for strengthening GP engagement.

GPDV convened a statewide workshop on GP service coordination on 27th March. 25 PCPs and 21 divisions attended. This is the first of 3 workshops to be held in 2002 bringing together divisions and PCP staff with the following goals:

- To illustrate the work currently being undertaken between divisions and PCPs to achieve quality care planning and effective referral between GPs and other service providers as a basis for service coordination
- To provide an overview of current issues, challenges and response options for division and PCP staff to consider in their joint work
- To enable participants to identify successful strategic approaches to their joint work.

4. INVOLVEMENT OF DIVISIONS IN PCPs

Boundaries of the 31 Victorian divisions of general practice and the 32 Primary Care Partnerships (PCPs) bear no relation to each other. Some divisions participate in several PCPs, and some PCPs have significant involvement by several divisions in their area, while other PCPs have very little division involvement. The incongruent boundaries mean some divisions are expected to negotiate, meet and build collaborative relationships with two or more PCPs, which puts pressure on their resources and capacity and also may result in less general practice involvement in some PCPs.

The table at the end of this paper provides a statewide picture of which divisions and PCPs work together, brought about by their different boundaries. Rather than simply describing the physical overlap between PCPs and divisions, we have attempted to define the number of PCPs each division is 'functionally' involved with – i.e. where the division regularly participates in committee and working group meetings and provides ongoing advice and input about GP issues. We have also indicated where more than one division shares the functional relationship with the same PCP; and where a significant part of a division's catchment area is covered by a PCP that functionally (and primarily) relates to a different division.

At one end of the spectrum, there is a PCP (Outer Eastern PCP) with which 4 divisions are functionally involved. At the other end, there are 4 rural divisions that are functionally involved with 2 PCPs each and where, if each of those divisons withdrew their involvement from one PCP, that PCP would be left with no division of general practice involved.

At its May meeting, the VACGP considered the desirability of re-aligning division boundaries to match those of local government and decided not to pursue the matter.

All 31 divisions are actively involved with at least one PCP. In November 2001, GPDV provided Victorian divisions with a self-audit to assist them with reviewing and reporting on the extent of their relationship with their communities and consumers. The audit shows that a representative

sample of Victorian divisions use a wide variety of strategies to involve themselves in health planning within their local communities and to involve other stakeholders in the design and delivery of division programs. Linkages with PCPs have been established across all 23 divisions responding to the survey, and in 15 of those divisions there was more than one linkage reported[8]. 65% of divisions had dedicated at least one hour per week to their PCP relationships, with 35% dedicating at least 3 hours per week. Division staff were involved in all division-PCP relationships; in 65% of divisions the CEO was involved; in 52% GPs were involved; and consumer representatives were involved in one divisions.

91% of divisions responding reported that relationships with their affiliated PCP/s were still developing and 87% reported that both organisations were better informed as a result of their collaboration. There has been joint action in 65% of divisions surveyed - divisions reported that this led to 39% of affiliated PCPs modifying their practices in some way as a result, and 17% of divisions also reported that GPs had modified their behaviour in some way as a result.

Resource issues

Divisions negotiate for GP payments from their PCP, and protocols for GP payment are now in place in most PCPs. Additionally, funding arrangements that enhance the liaison between divisions and PCPs have included: contracting divisions to write the PCP GP engagement strategy; PCPs contracting staff already employed part-time in divisions to undertake PCP projects; and one PCP has funded a GP-liaison position. But one of the barriers to continuing and extending division involvement is a perception by divisions that involvement in the PCPs is extremely resource-intensive (compounded by the boundary issues described above) with few concrete outcomes relevant to general practice. The lack of specific and quantified resource allocations from divisions is also a barrier to their consistent involvement across the state.

The Commonwealth's commitment to national programs and the State's commitment to regional planning based on local needs through PCPs, place competing demands on divisions. Commonwealth and State need to articulate a clear, joint message, backed up by resources and requirements, if divisions' involvement is to be maximised.

POSSIBLE SOLUTIONS FOR VACGP CONSIDERATION

- ***Specific resource allocations for divisions' involvement in PCPs***

Experience shows that when divisions and PCPs are able to allocate specific resources to joint work they make better progress. This suggests that the greater involvement of divisions and GPs in PCP activity would be facilitated by the targeted allocation of additional resources.

> At its May meeting, the VACGP agreed that divisions should be adequately resourced to work with PCPs, and decided to produce a submission to the [national] Divisions Standing Committee [which reports to GPPAC] that specific resources be provided to divisions of general practice in order to enable divisions to work with PCPs.

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[8] In many cases, this is because divisional and PCP boundaries are not aligned, so that divisions have to establish relationships with anywhere from one to four PCPs. In other cases, divisions reported linkages with planning/program groups within PCPs: for example, health promotion sub-committees or IM/IT working groups.