HYPOTHETICAL
GENERAL PRACTICE SERVICE IN A COMMUNITY HEALTH SERVICE

Location: based in an urban fringe area of Melbourne

Staff and roles

- 4 GPs, all vocationally registered.
  - 2 full time males (1 with special interest in care of the elderly and diabetes); the other is part time head of clinical team (practice development, accreditation)
  - 2 at 0.5 EFT – 1 male, 1 female (special interest in refugee health)
- Practice Nurse full time (mainly clinical support, some billable treatments like dressings, minimal EPC Health Assessments, accreditation, stock control, health promotion)
- Receptionist 0.5 EFT dedicated to medical clinic (general reception, booking and most billing).
- The clinic does not currently have a Practice Manager so these roles are shared across GP, nurse and reception (and some don't get done).

What MBS items and PIP payments do they access and how systematically are they accessing them?

- Accredited as a general practice two and a half years ago. Due for reaccreditation in six months.
- PIP - IMIT tier 1, after hours tier 1, teaching of medical students.
- Standard consultations are understood and managed well
- Low uptake of diabetes, asthma, cervical screening and mental health incentives
- Low use of EPC Health Assessments, Care Plans and Case Conferences
- Home medication reviews not accessed. No formalised relationship with pharmacist in the area.
- Are accessing the practice nurse MBS items for wound management and immunisations.

Use of computerised health records, electronic resources?

- Appointment and billing computerised (Pracsoft). Hard copy client records used (want to transition to electronic)
- Medical Director available
- Have access to internet and email on one computer, but do not utilise regularly

Use of IM systems for recall and reminder?

- Manual system for immunisation, not working very well, managed by the nurse. Want an electronic system when transition over to electronic client records.

Referral patterns and communication with other providers from the CHS ie diabetes education, podiatrist, counselling service etc etc

- Do not use Initial Contact or Statewide Referral Form. Referrals to CHS allied health providers/programs by fax or dropping around and talking to the allied health practitioner. Don't always know when a patient is also seeing another provider at the CHS.

Practice population

- Between them the 4 GPs perform 19,500 consultations per year, and have a stable patient load of 3000 SWPEs
- The practice patient profile includes 300 WPEs aged over 65 years
- Ageing population generally with some new families moving to the area. Large housing estates in the local area and hence high numbers of socio-economically disadvantaged people, mental illness and newly arrived refugees, and aboriginal people.