Introduction

General Practice Divisions Victoria (GPDV) is seeking applications from qualified persons or organisations to evaluate the rollout of the Enhanced Primary Care (EPC) Medicare Benefits Schedule (MBS) items in Victoria through the Victorian implementation of the GP Education, Support and Community Linkages (henceforth GP-ESCL) component of the EPC.

GPDV is the contracted agency for the implementation of the GP-ESCL in Victoria.

A national evaluation of the new MBS items and the GP-ESCL has been contracted to a consortium, which is headed by Professor David Wilkinson at the SA Centre for Rural and Remote Health. This state evaluation is expected to link with the national evaluation in all relevant respects and to add value in terms of understanding the Victorian experience and dissemination model. GPDV is currently negotiating with the National Evaluators to undertake component 3 of the State Evaluation. Tenderers are invited to submit a proposal for components 1 & 2.

A limited budget of a maximum of $40,000 has been assigned for this evaluation.

The purpose of this evaluation

The GP Education, Support and Community Linkages Program (GP ESCL) is a national program implemented through State Based Organisations (SBOs) to provide education to GPs about the new MBS items that are part of the governments enhanced primary care package and to support them with its implementation. While primarily focused on education of GPs the program also involves SBOs working with other organisations to inform them and to develop opportunities for collaboration. Further background information is provided in the attached extract for the Request fro Tenders prepared by the Commonwealth for the national evaluation of the new items and the GP ESCL (p9).

A national evaluation of the GP ESCL has been commissioned. The purpose of the state evaluation will be to supplement the national evaluation and answer questions related particularly to the Victorian model of implementation. A major theme is to understand the variability of uptake between Divisions and between GPs grouped according to other criteria.

The Victorian model

The Victorian model for the GP ESCL was designed around a train-the-trainer approach in that a GP from each Division was given training about the new EPC items and resourced to educate other GPs regarding their use. GPDV has provided the 31 member Divisions of General Practice with 65% of $1.6 million that was allocated for the Program for this purpose. This model was not used in all states but was chosen in Victoria because it was felt that this approach would:

- build capacity in the Divisions in a way that was sustainable beyond the life of the program;
- establish change-leaders and advocates within the Division;
- allow Divisions to adopt approaches suitable to their own context, history and current workplan.

From now on this model will be referred to as the local GP trainer model. Initially GPDV offered Divisions an option whereby GPDV would provide the training directly. As it happens no divisions took up this option.

Implicit in the adoption of this model, rather than a centrally implemented education model, is a high value placed on diversity and flexibility. The potential dangers are that essential education messages may not be delivered to all GPs because of idiosyncratic issues associated with the particular Division of the particular GP nominated to do the training.

The expected diversity of approaches has been borne out in fact, with Divisions adopting both varied education/support strategies and varied ways of marketing the items and creating opportunities for their implementation. For example some Divisions have chosen to emphasise ease-of-use and that the items are little different from what GPs have been doing anyway, while others have chosen to emphasise potential benefit and the establishment of joint programs where the items can be used in ways where the expected benefit to patients is clear. It is a principle of this framework that the evaluation should in some ways judge the achievements of Divisions in terms of their own understanding of what they were trying to achieve and the values that guided these choices.

In summary the Victorian model was chosen in order to maximise capacity building and local flexibility and responsiveness. The diversity of ways in which implementation occurred creates an opportunity to learn about many diverse aspects of implementation and to inform the values that should guide further initiatives to promote the use of the items. This opportunity should be taken up in the evaluation.

Existing data

Divisions have been completing a proforma report to GPDV quarterly. The report states the number of GPs, practice nurses and practice managers that have received training and the training strategies the division has used. It asks divisions to state which of the EPC items have received major emphasis and whether this has occurred in the context of particular division programs. It also asks which other organisations the division has been involved with either to inform them about the items or to plan how they can be used. The detail provided in the reports is highly variable with some Divisions offering detailed descriptions of their activities and the issues they face while others have provided little beyond the basic quantitative information.

National evaluation

In the Commonwealth Government's request for tenders for the national evaluation they state that the objectives for the evaluation are to describe, assess and provide recommendations for improvement on:

1. Strategies to promote awareness, use and uptake of the items among the target groups;
2. Provider and consumer satisfaction with the items;
3. The impact of the items on changes in practice by all targeted health and community care providers, and on changes to systems of health care delivery;
4. The impact of the items on the quality of health care and responsiveness to the needs of consumers (to the extent possible in the timeframe of the evaluation); and
5. The contributions of these two components to achievement of policy priorities in primary health care development.

The state evaluation should complement rather than compete with the national evaluation and address issues related to the education and support strategy pursued by GPDV. The background information and guidelines for the national evaluation are provided as an attachment to this framework.

Evaluation questions

The evaluation framework that follows has been developed to address three main evaluation questions. Related sub-questions are identified within the framework itself.

The three primary evaluation questions are:

1. What have been the effects of the train the trainer model? How has the training been implemented by Divisions with what effects?
2. In what ways are divisions working with other agencies and providers to use the items in addressing specific clinical and service delivery problems?
3. Are there any groups of GPs (perhaps based on division, culture, SES, rurality etc.) where uptake has been low? Are there individuals within these groups who have had high uptake from whom lessons can be learnt on behalf of the whole group?

Of these questions the first relates primarily to the past and the evaluation of GPDV's strategy for providing GPs with initial training in the use of the items. The second question relates somewhat to the past but more to the future, as divisions work with others to give GPs the opportunities to utilise the items for specific purposes where there is a reasonable expectation of clinical benefit. The third question is descriptive and focuses on identifying limitations to the diffusion of change to date and strategies for overcoming these limitations in the next year.

Main components of the evaluation

In relation to these main questions the proposed evaluation framework has three main components.

> Component one focuses on the implementation and effects of the local GP trainer model.
> Component two focuses on the way in which divisions are working with others to develop specific areas of use for the new MBS items.
> Component three focuses on understanding variations in uptake and the development of strategies to facilitate use in-groups of GPs where uptake is low. (For example, by identifying outstanding examples within the group.) **This component will be undertaken by the national evaluators and is not included in the Victorian evaluation for GPDV.**

The following section gives a rationale for each component and outlines the questions GPDV would like to see addressed. Brief comments are given on appropriate data collection and analysis strategies. Suggested timeframes for each component are provided.

Component one: Evaluation of the local GP trainer model

Rationale

This is considered the most important component of the three and focuses on the effectiveness of GPDV's chosen strategy of education and support. The model is different to that adopted in some other states for reasons outlined above. An important question for this component is whether the hypothesised benefits of allowing divisions to customise their own

strategies were in fact realised or if the loss of standardisation that this approach entails was in any way problematic. In seeking to inform members about the items and promote their use divisions varied widely in a number of dimensions, for example:

- the educational strategies used;
- beliefs about what the items can and should achieve;
- the values underlying efforts at promotion;
- linkages with existing division programs;
- concepts of change management and diffusion;
- emphasis on practice capacity building;
- emphasis on creating collaborative opportunities to address known problems.

It has not been possible for any division to cover all possible ground in relation to these and all the other relevant dimensions. Divisions have chosen varied strategies guided by varied values to achieve varied goals. The purpose of this component is to synthesise what has been learnt in regard to the various strategy-value-outcome configurations utilised by divisions and to come up with a relatively complete description of the possible orientations and what has been found effective in relation to each. Negative or unintended consequences of this varied implementation also need to be considered.

It is expected that the evaluation will lead to recommendations about how GPDV can better initiate and support these varied implementation processes in the future and identify areas where a greater level of standardisation (eg of resources) might be desirable.

Evaluation questions

Key evaluation questions for this component include the following.

1. How have divisions gone about educating and supporting GPs in their use of the items?
   - How have they seen their role?
   - What have been their objectives?
   - What have been their beliefs about their purpose? eg
     - Increase GP income,
     - Inspire,
     - Change the nature of general practice,
     - Provide options.
   - What educational and change management strategies were used to realise these objectives and values? Were they appropriate?
   - What was the impact of the announcement of the practice incentive payment?
2. Has the local GP trainer model had broader consequences for divisions and how they function? What has happened in the few divisions that have chosen to use non-GP trainers?
3. Has the experience had other consequences for the GP trainer?
   - Has it been a positive experience?
   - What have they learned as regards their own practice and professional development?
   - What would they do differently if they were to do it again?
   - How adequately were they resourced and supported? What else would have been of value?

Appropriate methods

The main methodological consideration is to adequately reflect the diversity of what has been attempted, implemented and achieved; therefore strategies that might produce an homogenised picture are inappropriate. In particular group interviews are not considered appropriate. It is considered that the main elements of the evaluation will include:

1. A review of collected data, reports on workshops and discussions with an evaluation steering group to identify the important dimensions on which the divisions activities have varied. (See for example the list presented in the rationale for this component);
2. Interviews with the GP trainer and the most relevant staff worker in each division;
3. Presentation of the resulting synthesis and a discussion of key issues at one or more workshops.

Analysis strategies and products

As with the data collection methods the main analytic concern is to preserve and value diversity and to achieve an understanding of the achievements of each division in its own terms, that is the way in which values/beliefs, desired outcomes, strategies and actual outcomes match up and interact. It is essential that the analysis achieve an understanding of each division's approaches and achievements. For this reason simple cross-tabulations are likely to be less important in the analysis than the development of descriptive and ideal 'types' illustrating the strategies that are most likely to be successful in producing particular outcomes that the division might value. For example strategies used by divisions emphasising "ease of use" and attempting to maximise the number of GPs who "give it a go" could be described separately from divisions emphasising "relevance and quality of use" and attempting to help GPs to use the items to address known problems and priorities (this will be fairer than a simple quantitative comparison). The product of this approach is likely to be a number of synthesised case studies illustrated by reference to real case studies.

The analysis should make clear the implications of various value and strategic positions. At present there is insufficient evidence to say that one value position or approach is preferable or is likely to be most successful in the long-term. It is inappropriate, therefore, for the analysis to assume a best position, rather it is hoped that the evaluation will provide some preliminary evidence and a basis for further debate. It is for this reason that the workshop(s) at the conclusion are proposed.

Time frame

It is hoped that interviews and analysis could be completed by mid January 2002 with the workshop(s) to be conducted in February 2002. An interim report is required by January 30th 2002.

Component two: Development of collaborative applications in Divisions

Rationale

Increasingly divisions are moving beyond simple education about the items and starting to develop collaborative projects to identify particular health or health system problems. In many cases these are being initiated by other agencies as they see the opportunity to achieve greater involvement of GPs. There are two major foci for these developments. The first involves the interface between general practice and the acute sector particularly around discharge from hospital. The second involves the relationship between general practitioners

and other community based providers in the management of specific diseases or health problems (eg diabetes, falls in the elderly). In the context of these programs the items are usually not being seen as an end in themselves but as a possible solution to long-known, endemic problems.

GPDV has been engaging with a range of organisations, particularly the state government, to inform them about the items and develop areas for their application. This activity, and supporting divisions in similar activities, will be a major element of GPDV's rollout program in the coming year. Divisions have already requested that GPDV begins documenting and sharing experiences in these areas.

Evaluation questions

1. What programs and applications are divisions developing or participating in?
   - What programs are occurring as a response to initiatives of other organisations?
   - How and to what extent are the items being used within divisions' own programs?
   - How has GPDV contributed to these programs either directly or through its discussions with the government and other agencies?
2. How successful are these initiatives?
   - To what extent are the items being used for the intended purpose?
   - Are the programs and the approaches/tools being used by GPs for assessment and care-planning based on evidence or a strong rationale related to the particular need being addressed?
   - How valuable do GPs, patients and other providers feel the items are within these programs?
   - To what extent is success determined by concurrent influences (eg hospital funding for discharge planning, PIP funding for diabetes)?
   - Are the programs being separately evaluated? With what results?
3. Are there any common patterns or thoughts about best practice emerging from these programs?
4. Are there any of these areas that are suitable for development as state or national programs?
5. Do divisions continue to promote and support the use of the items after the cessation of funding at the end of 2001? If so in what ways is it accommodated within their programs?

Appropriate methods

This component will be largely descriptive and will need to draw on data from a variety of sources. A new reporting proforma for divisions could provide an overview, while the interviews conducted as part of component one will provide some more detailed information. Programs are likely to have there own evaluations and division programs will provide reports to the Commonwealth. Web or e-mail based forums could provide valuable vehicle for divisions to share information but also as a source of information to the evaluators.

There would be substantial advantages in this component being conducted by the same evaluators who conduct component one.

Analysis strategies and products

The analysis will seek to describe the diversity of applications of the new MBS items while identifying some common types of activity within this diversity. For major types of activity the evaluation will describe uptake, the rationale and factors affecting success. For the most

part it would not be appropriate to try and determine the clinical effectiveness of the item usage, rather adequacy of service delivery, compliance with accepted best practice and subjectively reported benefits will need to serve as proxies for clinical benefit (see comments below).

Time frame

Some data collection will need to be complete before specific funding for rollout ceases at the end of 2001. The focus of this component goes beyond this time, however, and begins to address sustainability issues. The final report for this component would be expected by 30th March 2002

Component three: Sub-group analysis and identification of exceptional cases

(NB This component will be undertaken by National Evaluator. The description is included here for information)

Rationale

The purpose of this component is to describe the limits of uptake of the items and to identify strategies for promoting their use in GP groups where uptake has been low. It is considered that this approach may best be handled as part of the national evaluation involving over-sampling of particular groups as the national Evaluators go about conducting individual or group interviews with GPs, patients and other providers.

Evaluation questions

Key evaluation questions for this component include the following.

1. What factors make a difference in uptake? eg
    - Practice type
    - Ethnicity
    - Patient profile
    - Socio-economic
    - Role in practice
    - Bulk billing or not
    - What are the trends in relation to these factors?
    - Where/who are the exceptions to these trends?
        - What are the positive factors that have influenced them?
        - What solutions and strategies have they used to overcome issues that are an impediment to others?
2. What do consumers think of the items?
    - How does acceptability to consumers affect uptake (eg being assessed by someone other than the doctor)?
    - How do acceptable are different models of doing assessments/plans (eg in clinic, at home, subcontracted)?
3. How are other service providers using the items?
    - How much do they know about them?
    - To what extent is the initiative taken by other providers a determinant of GP uptake?

Appropriate methods

The questions outlined above are questions being addressed by the national evaluator who will have a responsibility to interview a sample of GPs, patients and other providers. It is proposed that GPDV negotiate with the national evaluators to increase their sample in several key areas. These areas will be identified by reviewing uptake data, data from the divisions and input from the support network workshops. The areas will be identified in conjunction with the national evaluators and will use the approaches used within the overall national evaluation. Interviews with individual GP who are exceptions to prevailing trends may not be something that would otherwise have been done within the national evaluation.

Analysis strategies and products

The general analytic strategy involves using qualitative data from individual or group interviews to interpret and explain quantitative trends. The products will include descriptions of barriers affecting uptake by certain groups and examples of how these barriers can be overcome.

Expressions of Interest

GPDV seeks expressions of interest from suitably qualified persons or organisations to undertake **Components 1 and 2** of the research detailed in this brief.

The tenderer is required to;

- Detail the organisation's experience in undertaking research and evaluation.
- List name/s and relevant experience of individuals who will be undertaking the project.
- Detail the methodology that will be undertaken.
- Submit a budget of all anticipated costs in undertaking this work (including cost of interviewing GPs).
- Submissions are required to be no longer than 2 pages.

Time frame

- Applications for tender close at 5pm on Wednesday October 31st.
- GPDV requires the successful consultant to meet with the VACGP EPC Sub Committee on Tuesday November 13th.
- An interim report to be submitted by the 31st of January 2002.
- Final report to be submitted by the 30th of March 2002.

Attachment: background and guidelines from the request for tenders for the national evaluation

Part C – Statement of Requirement

C1. INTRODUCTION

The Commonwealth Department of Health and Aged Care is seeking applications from qualified persons or organisations to evaluate the following two components of the Enhanced Primary Care Package. These components are:

- *Enhanced Primary Care (EPC) Medicare Benefits Schedule (MBS) Items.*
- *GP Education, Support and Community Linkages;*

Collaboration between individuals or organisations with relevant expertise as part of joint tender proposals will be well regarded.

A limited budget has been assigned for this purpose.

C2. Background

The Enhanced Primary Care Package was announced in the 1999/2000 Budget as a way of improving the health care and well being of older Australians and people with chronic conditions and multidisciplinary care needs. $210 m has been provided over 4 years for the overall package including:

- $110 m over 4 years for 21 new MBS items relating to:
    - annual voluntary health assessments for people over 75 and for Aboriginal and Torres Strait Islander people over 55;
    - the development of multidisciplinary care plans for people with chronic conditions and complex care needs; and
    - involvement in multidisciplinary case conferencing;
- $41.2 m over 4 years for Commonwealth carelink centres - a single point of access for information and referral to community care services;
- Integration of health information systems to support better delivery of care;
- $14.4 m over 4 years for Chronic Disease Self Management initiatives;
- $6.6 m over 4 years for a national Falls Prevention Program;
- $33.2 m over 4 years for ongoing and additional Co-ordinated Care Trials; and
- $8.1m over 4 years for the *GP Education, Support and Community Linkages* component associated with new MBS items.

A full description of the components of the EPC Package can be found at the following web address:

http://www.health.gov.au/hsdd/primcare/enhancpr/enhancpr.htm

C3. CONTEXT

EPC Package

The Enhanced Primary Care Package is designed to promote a more integrated approach to service delivery among health professionals and other service providers. The overall goal of the EPC Package is:

> ***"to improve the health outcomes and quality of life of older Australians and people with complex and chronic conditions".***

To achieve this, the overall objective of the EPC Package is "to advance substantially the quality of health care for older Australians and people with chronic and complex conditions." All components of the EPC Package contribute in different ways and to differing degrees to achieving this objective.

The *Enhanced Primary Care (EPC) Medicare Benefits Schedule (MBS) Items* and the *GP Education, Support and Community Linkages* components are part of the EPC Package. The EPC MBS Items consist of the following services:

- Health Assessments for people aged 75 and over (and 55 and over for Aboriginal and Torres Strait Islander people);
- Multidisciplinary care plans for people of any age with chronic conditions and multidisciplinary care needs; and
- Multidisciplinary case conferences for people of any age with chronic conditions and multidisciplinary care needs.

Information on the new EPC MBS Items, including the formal item descriptors and explanatory notes from the MBS book, may be found at the following Internet addresses:

http://www.health.gov.au/hsdd/primcare/enhancpr/enhancpr.htm

The implementation and appropriate use of the new items is supported by the roll-out of the *GP Education, Support and Community Linkages* component, communication strategies and information products directed to the target groups. The provision of training and resources to assist GPs and other health and community care providers via the *GP Education, Support and Community Linkages* component is intended to have a positive impact on the use and uptake levels of the EPC MBS items.

A combined evaluation of the *EPC MBS Items* and the *GP Education, Support and Community Linkages* components is being undertaken in recognition of the close relationship between these two components.

New EPC MBS Items

The new EPC MBS items came into effect from 1 November 1999 and are intended to contribute to the overall goal of the EPC package by improving the quality of health care available to older Australians and to Australians of any age with chronic conditions and multidisciplinary care needs. The items are designed to contribute to

this goal by enabling a more preventative approach to patient care for older people, and by facilitating GP involvement in multidisciplinary teams to provide better coordinated care for people with chronic conditions.

The EPC MBS items are primarily focused on the community setting, but also include items for GP involvement in discharge care planning and case conferencing for patients leaving hospital, and for contributing to care planning and case conferencing for people receiving care in residential aged care facilities.

GP Education, Support and Community Linkages component

The *GP Education, Support and Community Linkages* component was allocated $8.1, most of which will be expended in 2000 and 2001 to ensure it meets its primary objective that by 2002 all GPs have had the opportunity to participate in an education and training program around the use of the new MBS items.

There are three main strategies associated with the *GP Education, Support and Community Linkages* program which will be taken into account in the evaluation. These are:

- Implementation of Education, Support and Community Linkages through the Divisions program coordinated by Australian Divisions of General Practice (ADGP) and implemented through EPC coordinators in each State Based Organisation (SBO) of Divisions
- RACGP Standards and Guidelines
- Clinical Audit Package

C4. OBJECTIVES

The objectives of the evaluation are to describe, assess and provide recommendations for improvements on:

1. Strategies to promote awareness, use and uptake of the items among the target groups;
2. Provider and consumer satisfaction with the items;
3. The impact of the items on changes in practice by all targeted health and community care providers, and on changes to systems of health care delivery;
4. The impact of the items on the quality of health care and responsiveness to the needs of consumers (to the extent possible in the timeframe of the evaluation); and
5. The contributions of these two components to achievement of policy priorities in primary health care development.

C5. REQUIREMENT

General

The Department of Health and Aged Care is seeking the services of suitably qualified persons or organisations to undertake an evaluation at the national level of the *EPC MBS Items* and the *GP Education, Support and Community Linkages* components of the EPC package.

The evaluation will provide information and feedback on the implementation and performance of the two components in terms of the evaluation objectives set out above. The evaluation should also assist in providing a better understanding of how GPs' use of the new MBS items contributes to achievement of the overall objective for the EPC Package.

Methodology

The successful tenderer will be expected to provide the Commonwealth with a detailed proposal that outlines a clear and coherent methodology and process for evaluating the *EPC MBS Items and GP Education, Support and Community Linkages* components.

The methodology must clearly outline how the evaluation will assess the performance of the components in meeting the evaluation objectives. Tenderers may include innovative approaches to meeting specific evaluation requirements (for example, in assessing impact on quality of health care and responsiveness to consumer needs, to the extent possible in the timeframe of the evaluation).

For each of the evaluation objectives, the methodology must clearly outline how the evaluation will describe, assess, make findings and provide recommendations for improvements.

1. **Strategies to promote awareness, use and uptake of the items among the target groups:**

   - Levels of awareness and understanding about the items, and any impact on access to or use of the items among the target groups (consumers, medical practitioners, allied health and community care professionals, nurses, etc)
   - The levels of uptake, and barriers to accessing or using the EPC MBS items by the target groups. This should include assessing the impact of activities undertaken as part of the two components.

2. **Provider and consumer satisfaction with the items**

   - The level of satisfaction of consumers and carers with the new items and the services they receive, and the level of satisfaction of GPs and other health and care providers with the new items, including:
     - ease of use
     - coverage of patients, and
     - remuneration.
   - The level of satisfaction of GPs and other health and care providers with activities provided by SBOs and the Divisions of General Practice under the *GP Education Support and Community Linkages* component.

3. **The impact of the items on changes in practice by all targeted health and community care providers, and on changes to systems of health care delivery**

   - How GPs and other health and community care services changed their practice and service delivery systems in using the EPC items, including:
     - levels of integrated multidisciplinary service provision and barriers to same
     - levels of use of third party service providers for data collection for health assessments
     - time required for different activities in using the EPC items
     - whether other GP, allied health or community care provider activities have been reduced or otherwise changed
   - Factors affecting integration and coordination of services delivered to target populations, including barriers to coordinated service delivery.

4. **The impact of the items on the quality of health care for consumers (to the extent possible in the timeframe and scope of the evaluation)**

   - Changes in quality of care for the target populations, including for people with chronic conditions that fall under the National Health Priority Areas
   - Capacity of health assessments in detecting health needs and risk factors in the target population
   - Capacity of EPC items in addressing the needs of consumers
   - Appropriateness of cost of EPC services for consumers
   - Where possible, any health outcomes that can be attributed the use of the EPC items in the target populations.

5. **The contributions of these two components to achievement of policy priorities in primary health care development**, including:

   - Access to appropriate health care, including preventative health care, for older Australians
   - Building closer integration of GPs with other health and care providers
   - Developing the role of general practitioners in care coordination
   - Encouraging multidisciplinary care, and
   - Impact on access and equity in health services, for different priority population groups (such as Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, people in rural and remote communities and from lower socio-economic groups).

In assessing the areas outlined in 1 to 5 above, the evaluator(s) must describe, assess and make recommendations on the strategies and processes used for implementing the *EPC MBS Items* and *GP Education, Support and Community Linkages* components. This necessitates an assessment of the effectiveness of communication strategies to various stakeholder groups, and the implementation processes used by SBOs and GP Divisions for each individual State and Territory.

Key points to address in this analysis are:

- relationships between the strategies developed at the national, State/Territory and local (Divisional) levels;
- the strengths/weaknesses/gaps in the education methodologies used by each SBO to promote the involvement of GPs and other health professionals in multidisciplinary care, and facilitate the provision of quality care using the new MBS items; and
- the effectiveness of the development and promotion of community linkages at the local or divisional level to assist in the development and implementation of multidisciplinary care.

Data requirements

In order to make the above assessments, the consultant(s) will need to collect and assess information on provider and patient experience in using the new items.

C6. TIMEFRAME

The evaluation will run over an approximately 18 month period to mid-2002.

C7. REPORTING REQUIREMENTS

The successful tenderer will be required to provide reports at agreed intervals to the Contract Management Team. The Contract Management Team will be established once the contract has been signed with the successful tenderer. The membership will be the same as for the Tender Evaluation Steering Committee, currently consisting of representatives from the GPPAC Enhanced Primary Care Taskforce and the Commonwealth Department of Health and Aged Care (see D1).

An initial report on the scope and program of work for the evaluation, and any preliminary views must be provided to the Contract Management Team one month after notification of selection as preferred tenderer.

Progress reports on the evaluation are to be provided to the Contract Management Team on the following dates:

- 22 June 2001
- 7 December 2001

The evaluation consultants will be expected to also provide ongoing advice and feedback to the Contract Management Team on the performance of the two components, and any identified changes required.

Reports and feedback should contain sufficient detail and be sufficiently timely to allow for progressive fine tuning of the implementation strategies, guidelines and standards, and the EPC MBS items, during the period of the evaluation.

The final evaluation report must be provided by 21 June 2002.

An outline of each of the evaluation's progress and final reports must be provided to the Contract Management Team at least one month prior to the due date for that report.

Information and feedback from the evaluation, including from the progress reports, will be provided to the SBOs, ADGP and Central and State Offices of the Department of Health and Aged Care on the roll-out of the various State/Territory strategies.

Regular consultation with the General Practice and Medicare Benefits Branches of the Department of Health and Aged Care will be required during the term of the contract.

C8. COMMUNICATION AND CONSULTATION

In developing the evaluation strategy and conducting the evaluation, the successful tenderer will be expected to consult with key stakeholders including:

- Australian Division of General Practice, SBOs, Divisions of General Practice and the Royal Australian College of General Practitioners;
- Policy officers responsible for the implementation of the Enhanced Primary Care package in the Department of Health and Aged Care in both the Central Office and State and Territory Offices;
- The Enhanced Primary Care Taskforce (a subcommittee of General Practice Partnership Advisory Council [GPPAC]);
- Peak bodies representing allied health professionals, nurses and community care providers;
- Peak bodies representing rural and remote health professionals (eg RDAA, NRHA, CRANA), health consumers/ carers (CHF), aged care providers (COTA, ACAT), and Indigenous health care providers and consumers (NACCHO); and
- Academics and professional groups (such as the Australian Medical Association, the Royal College of Nursing and the Centre for GP Integration).

C9. CULTURAL, COMMUNITY OR ORGANISATIONAL ISSUES

In the development of your proposal, attention should be given to

- Issues of cultural sensitivity for both Indigenous Australians and people from different cultural and linguistic backgrounds;
- Specific challenges posed by rural, remote and metropolitan situations; and
- Health consumers' and carers' perspective.

C10. CONFIDENTIALITY ISSUES

There are no confidentiality issues associated with this tender, other than normal confidentiality requirements associated with provision of medical services to individuals and access to patient medical records.