GP requirements from the Victorian Reform of Outpatient Systems
Endorsed by GPDV Board February 2007

Background:

In response to the Victorian Auditor General's Report 'Access to Specialist Medical Outpatient Care' (June 2006) DHS has established an Outpatient Improvement and Innovation Strategy with a 2-3 year timeframe. An advisory committee has been established with a number of subcommittees. GPLO representatives have been appointed to these committees and GPDV is playing a support role to these representatives. We also have a GPDV representative on the Expert Advisory Group for the Outpatient Collaborative being run by DHS.

These GP and GPLO representatives wanted advice on what GPs wanted from Outpatients so they could give a consistent message in the meetings in which they participated. To develop these requirements we consulted chairs of divisions in the November 2006 teleconferences and 13 GPLOs who participated in a meeting in December 2006.

GPs require

General:

1. Outpatient clinics as a consultative service to general practice;

Involvement:

2. Divisional representation at hospitals to develop local responses to the new DHS Outpatient Initiatives;

Information:

3. Listing of clinics, days/hours of operation, attached specialists, areas of expertise, eligibility criteria, MBS status;
4. GP accessible web-site that outlines clinic waiting times for each urgency rating and informs on referral pathways;

Notifications:

5. Acknowledgement of receipt of GP referral and estimation of probable waiting time to appointment for individual;
6. Notification of appointment time/date for patient and with whom;
7. Notification of 'No shows';
8. Prompt reports back to GPs, including assessment, tests, progress reports, management plan from specialists (within 7 days);

Communication pathways:

9. Clinical person with whom to clarify, negotiate, and discuss urgency;
10. Streamlined referral pathways i.e. not multiple ways/forms;
11. Compatible electronic communication between outpatients and GP practices;

Access:

12. Consistent agreed urgency criteria for ED, inpatient, and GP referrals;
13. GPs to be credentialed to "triage" patients directly onto waiting lists according to appropriate indicators;
14. Scheduling of "routine" tests without having to schedule specialist appointment E.g. stress tests, MRI knee etc;
15. Clear agreed discharge protocol from outpatient services.