



PRINCIPLES FOR GENERAL PRACTICE ENGAGEMENT

*A guide to meeting requests from DHHS and the GP Community
for input into service review, planning and policy
development in matters of common interest*

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WHY WE NEED THE GUIDE

This guide contains practical advice to support improved collaboration between the Department of Health and Human Services (DHHS), Tasmanian General Practitioners and Divisions of General Practice. It has been developed jointly between DHHS and General Practice Tasmania to support the aims of the Memorandum of Understanding between the parties.

In the past, interfaces between the parties have been variable in terms of the roles, responsibilities and expectations of representatives on committees and working groups and in relation to other mechanisms used to support joint efforts. The principles contained in this guide are intended to serve as a practical checklist to improve the clarity, efficiency and effectiveness of future collaboration.

It seeks to foster a greater understanding of the range of issues facing GPs and the other parties in order to inform processes and assist decision-making.

THE BENEFITS OF ENGAGEMENT BETWEEN DHHS, GPS AND DIVISIONS

The MoU has the following aims:

1. To work collaboratively to improve individual patient care and community health outcomes;
2. To involve general practitioners in the planning and development of Tasmanian health services at a local level and in statewide planning;
3. To improve communication between Tasmanian public health services and general practitioners;
4. To recognise the role of GPs in improving health outcomes for all Tasmanians.

Effective engagement between the parties provides a means of meeting these aims, and can provide the following benefits:

- Clinical and practical expertise in the development of primary care policies, processes and protocols, and whole of health system planning and reform.
- Experience with medical case management and continuity of care for people with chronic, complex or intensive needs.
- Expertise in prevention of chronic disease and promotion of healthy lifestyles.
- Links to GPs interface with the acute and aged residential sectors, for example through GP participation in discharge planning and referral to allied health providers.
- Expertise in information technology to support improved communication between health care providers.

GP engagement is at times on an ad hoc basis without clear expectations of the roles of invited participants. The decision as to who should be involved in particular working groups or committees at any given time should be based on mutual agreement and discussion at either the State or the local level.

In general, where issues relate to governance, broad system reform or information technology, Division staff are likely to have the appropriate expertise whereas a GPs major contribution is generally likely to be related to their clinical expertise.

If the request is from DHHS, the responsible officer should contact:

- Their local Division of General Practice if it is a matter specific to the local area – for example redevelopment of a service or a project within a particular geographic area.
- The TGPD if it is a statewide or whole of health system matter.

If the request is from a GP or a Division of General Practice, they should contact DHHS through Divisional Support Units, to ascertain the appropriate contact officer.

PRINCIPLES FOR ENGAGEMENT BETWEEN THE PARTIES

1. UNDERSTAND THAT GENERAL PRACTICE IS A SMALL BUSINESS

General practices operate as small businesses, earning most of their income on a fee-for-service basis. As such, time out of the practice and not in patient consultation for a GP will involve a loss of income and compensation for this needs to be considered. In contrast, most DHHS staff are remunerated on a salaried basis where time at meetings during their normal working hours would be covered.

2. BE CLEAR ABOUT WHY GP REPRESENTATION ON THE COMMITTEE/GROUP IS REQUIRED

There are two aspects to this principle:

First, is the consideration about whether a committee or group is required in the first place. The most common form of interface between the parties is through committees and working groups. It is important that the parties give thought to alternatives, rather than assuming that committees/meetings are necessarily the most effective mechanism for engagement.

Second, is the consideration of whether a GP is required or whether another representative such as a Divisional staff member would be more appropriate. In general, where issues relate to governance, process, system reform, or information technology, Division staff are likely to have the appropriate expertise. A GPs major contribution is generally likely to be related to their clinical expertise and experience.

3. CONSULT EARLY IN THE PROCESS

Both parties should consider the other's need for involvement early in the process and if unsure should seek guidance from the CEO TGPD, or Manager Policy Unit CPRH DHHS. Depending on the nature of the project or area of work, General Practice involvement may be desirable from the first scoping stages, or not until later when the relevant group has determined its terms of reference and governance. An early discussion may clarify some of these issues.

4. RECOGNISE DIFFERENCES

It is important to recognise cultural and professional differences, and work towards addressing them – or work with them, recognising the skills and attributes of the various parties and appropriate complementary roles. For example, we tend to assume that others attribute the same meanings to words as we do or that certain aspects of our work are of a same importance to others as they are to us. This is often not the case and can be the source of misunderstanding and sometimes frustration.

In general, a GPs decision to participate in activities and processes will tend to be primarily clinically driven, based on a wish for better patient outcomes and improved service delivery. Most will adopt new approaches (for example, tools, protocols, service directories) only when there is a clear benefit to their practice and their patients.

5. BE CLEAR ABOUT PURPOSE AND ROLE

It is critical to be clear about what type of advice or representation is being sought, as this will guide the decision about who is the appropriate person from which to source that advice or seek representation. For example, is clinical expertise and experience required to fulfil the role or not?

6. BE CLEAR ABOUT RESPONSIBILITIES AND EXPECTATIONS

It is also important to be clear about the expectations of individuals fulfilling these roles and the parties should have considered the following questions in advance of any requests:

- What are the expectations of representatives of general practice (for example, time commitments, workload, nature of contribution)?
- What is the intended frequency of meetings?
- What is the expected duration of the Committee/Process?
- If an existing group, are their Terms of Reference already in place? Has the Division / General Practice been previously represented? If so by whom?
- In those circumstances where the representatives are GPs, are they representing the Division, or themselves as individuals? If the former, what arrangements are made for reporting back to the Division?
- Will the representative be required to input into decision-making processes at the meeting or will he/she be given the opportunity to consult with his/her constituency pre and post meetings?

7. BE CLEAR ABOUT WHETHER THE GP IS TO BE PAID

Decisions about payment of GP time spent on committee work need to be clarified as part of the process of negotiating between the parties.

The principle is that a GP will be remunerated, although there are some instances in which the GP may be volunteering his or her input into particular processes.

In general, it is expected that if GPs are to be remunerated, DHHS will pay in some circumstances, and Divisions will pay in others. Divisions receive Commonwealth funding for some areas of work, and they will therefore remunerate the GP whom they nominate to participate in those areas.

Decisions need to be made about whether payment is for the duration of the meeting time only, or whether it extends to travelling time and/or meeting preparation/feedback.

DHHS will not usually pay for extensive travel costs, or meeting preparation or any costs incurred by the GP in reporting back to their colleagues, but this should be assessed on a case-by-case basis. DHHS will remunerate GPs where there is clearly a need for GP input, there is no Divisional funding, and the extent of the GP input has been scoped and costed.

In order to make decisions about remuneration, the person requesting General Practice input into a particular area of work should first consult the checklist provided in these guidelines. When confirmed that GP input is needed, DHHS personnel should contact the DSU Manager in their Division, and GP Division staff should contact their CEO. The relevant DSU Manager and Division of General Practice CEO should then negotiate the remuneration issue.

8. TRY TO ARRANGE MEETINGS IN GP FRIENDLY TIMES

Where GPs are invited to attend meeting, they may find it difficult to attend during normal business hours:

- GPs may prefer to attend meetings at either end of the day, or around lunchtime.
- If possible, try linking into an existing meeting.
- Avoid Mondays and Fridays when there tends to be high demand from patients.
- Consider teleconferencing, and videoconferencing, particularly in rural areas.

9. BE ORGANISED

For both parties it is of significant benefit if meetings are well organised and processes and protocols are agreed to in advance and adhered to in practice.

Meeting papers need to be prepared and distributed with sufficient time for people, many who have a range of competing priorities, to have the opportunity to read them. If there is a requirement or need to gather input from a wider constituency in advance, sufficient time must be allowed to do this.

Papers must be clear, concise and make explicit where decisions or recommendations are to be made. There should also be alternate methods of distribution for meeting papers (eg email distribution of papers is not always appropriate, nor is the expectation that the recipient will have the resources to enable the papers to be printed).

10. BE MINDFUL OF THE ROLES OF OTHER GP ORGANISATIONS

It may be that, instead of communication with Divisions of General Practice, that another organisation concerned with the business of general practice, e.g. the Royal College of General Practice or the Australian Medical Association, is more appropriate. While this guide does not relate specifically to consultation with those organisations, many of the principles will still apply. Annex A provides details of roles and responsibilities of other key GP organisations.

KEY QUESTIONS CHECKLIST

(Parties should be clear on the answers to the following questions prior to any requests being made)

1.	Is representation on a Group and attendance at meetings considered to be the most effective mechanism for engagement?	
2.	Are there other forums/committees already in place that could be used to serve this purpose?	
3.	Are there other mechanisms for gaining input that would be more efficient or effective eg Focus Groups, invited attendance at selected meetings, consultation forums?	
4.	Is this a role for the Divisions of General Practice or does it relate more closely to the role of another GP organisation?	
5.	Is the other party likely to be fully appraised of the context and language involved in this process? If not, what would be helpful to them?	
6.	What type of role is envisaged?	<input type="checkbox"/> Clinical <input type="checkbox"/> Advisory <input type="checkbox"/> Governance
7.	What type of knowledge and experience is considered necessary for effective representation?	
8.	Given this, what type of representation is being requested?	<input type="checkbox"/> General Practitioner <input type="checkbox"/> Management <input type="checkbox"/> Program Officer
9.	What are the expectations of the representatives?	<input type="checkbox"/> Frequency and duration of meetings <input type="checkbox"/> Expected duration of the Committee/Process? <input type="checkbox"/> Workload (eg pre-reading)
10.	In those circumstances where the representatives are GPs, are they representing the Division, or themselves as individuals?	
11.	If the former, what arrangements are made for reporting back to the Division?	
12.	Will the representative be required to input into decision-making processes at the meeting or will he/she be given the opportunity to consult with his/her constituency pre and post meetings?	
13.	Is this a Regional or Statewide group?	<input type="checkbox"/> Regional <input type="checkbox"/> Statewide
14.	Is the GP to be remunerated for their time?	
15.	Who is the appropriate party to provide remuneration?	

16. What meeting protocols will be put in place? eg How and when will meeting papers be distributed? Please consider sending papers to the relevant Division of General Practice as well as the nominated GP.
17. If it is an existing group, are their Terms of Reference already in place? Has the Division / General Practice been previously represented? If so by whom?
18. Can/will meetings be organised at GP friendly times?

ABOUT DHHS

- The Department brings together a wide range of services - providing health care and support services in hospitals and the community, promoting better health, maintaining services for elderly people and those with disabilities, and providing housing programs.
- As a consequence of the diverse range of services, there are opportunities to ensure that services are planned and integrated in a way that maximises health and well being outcomes for the Tasmanian community. Therefore the Department fosters networks and partnerships with the community and other providers such as with GPs and the Divisions of General Practice.
- The Department's vision is improved health and wellbeing for Tasmanians. Its mission is to ensure access to quality health and human services.
- The Department strives to achieve the following four outcomes:
 - Health and wellbeing status which compares favourably with the best in Australia;
 - Quality of life maintained and improved for those who experience illness, injury or disability and those in need of personal or social support;
 - Enhanced capacity and increased opportunities for Tasmanians of all ages to contribute to their own health and wellbeing;
 - A strong, dynamic organisation that leads the health and human service industry and is responsive to the external environment.
 - Engaging with GPs offers a valuable mechanism for achieving these outcomes, especially in responding to primary health care needs of Tasmanians.
- DHHS employs some GPs on contract, often to provide services in rural hospitals and community centres. These GPs can provide valuable input into planning and service design, particularly at the local level, and their expertise should be considered when seeking GP input into planning processes.

ABOUT GENERAL PRACTICE

- General practitioners are the first point of contact in the health and community support system for most people.
- General practitioners play a pivotal role in providing services, information and referral to people who need primary care, and are critical to effective health promotion and early intervention.
- General practitioners have a central role to play in service coordination in the primary care system and in ongoing community-based treatment and support. GPs also provide an interface between the acute, residential, primary care and community support systems.
- General practitioners role is central to integrated disease management and treatment, health promotion and population health.
- While general practitioners are central to the health system, most work as private practitioners, either individually or in group practices, operating as businesses that provide health care.

- The demands of running a practice limit GPs' ability to engage in meetings with other service providers for issues not immediately related to patient care.
- GPs operate predominantly on a fee for service basis with their services remunerated through payments for seeing individual patients, either by billing their patients, who then recover a rebate through the Commonwealth Medicare Benefits Schedule (MBS), or by bulk billing to Medicare. The fee for service model provides little incentive for activities outside patient consultations.

ABOUT DIVISIONS OF GENERAL PRACTICE

The main aim of the Divisions program is to improve health outcomes for patients by encouraging GPs to work together and link with other primary care providers to improve the quality of health care service delivery at the local level.

Divisions provide:

- A structure to enable peer support and to advocate for the needs of general practice.
- A means for fostering communication between GPs, the community, and the wider health system.
- A resource for GPs and other health care providers regarding general practice, primary health care and primary health research.
- Support services to GPs and general practice staff in a range of program areas including GP/patient care and whole of practice support.
- Continuing professional development for GPs and training for their staff.
- A vehicle for contributing to general practice participation in policy development.
- An interface with general practice at the local level for consumer and community representatives.

OTHER BODIES REPRESENTING GENERAL PRACTICE

The Royal Australian College of General Practitioners (RACGP) is the professional body engaged in setting and maintaining the standards for quality practice, education and research in Australian General Practice.

The Australian Medical Association (AMA) is the medical industrial body representing GPs as well as medical specialists. The AMA, a peak health advocacy organisation, exists to advance the professional interests of doctors and the health of the community.

Rural Workforce Agencies operate in each State and Territory to provide support and assistance in the attraction, recruitment and retention of GPs in rural and remote areas. In Tasmania, this task is the responsibility of the Rural Workforce Support (RWS) unit within Tasmanian General Practice Divisions (TGPD).

The Rural Doctors Association of Tasmania (RDAT) was formed to advance the needs of rural doctors and their patients. It is one of seven State and territory members of the Rural Doctors Association of Australia. RDAT advocates for highly skilled and motivated rural medical practitioners who are adequately trained, remunerated and supported, both professionally and socially.

The Australian College of Rural and Remote Medicine (ACRRM) is the peak professional organisation for rural medical education and training in Australia. ACRRM aims to support and represent the rural medical profession to improve health services for rural and remote communities. The key to achieving this is training skilled, caring and well-prepared doctors and allied health professionals.

General Practice Training Tasmania (GPTT) is the sole provider of general practice vocational training in Tasmania. Its program covers both urban and rural locations. It provides quality training, with its teaching and administrative staff having many years of experience within the former RACGP Training Program. It has a reputation of being 'registrar friendly' with attention given to individual training needs.

KEY CONTACTS

General Practice Tasmania

Ms Sarah Male
Chief Executive Officer
Telephone: 6224 1114
Mobile: 0409 438 207
Facsimile: 6224 3384
Email: smale@tgpd.com.au

General Practice South

Ms Judy Broad
A/Executive Officer
Telephone: 6234 4230
Mobile:
Facsimile: 6234 4780
Email: smoir@southtasdgp.com.au

General Practice North

Mr Phil Edmondson
Chief Executive Officer
Telephone: 6331 9296
Mobile: 0407 332 770
Facsimile: 6334 2443
Email: pedmondson@gpnorth.com.au

General Practice North West

Ms Elvie Hales
Executive Officer
Telephone: 6432 1440
Mobile: 0408 370 784
Facsimile: 6431 7827
Email: elviehales@nwtasdgp.com.au

General Practice Workforce

Mr Peter Barns
Chief Executive Officer
Telephone: 6334 2355
Mobile:
Facsimile: 6334 3851
Email: pbarns@gpworkforce.com.au

Department of Health and Human Services (Community Population and Rural Health)

Sally Williams

Manager, Divisional Support Unit

Telephone: 6233 3784

Mobile: 0417395887

Facsimile: 6233 4949

Email: sally.williams@dhhs.tas.gov.au

Department of Health and Human Services (Hospitals and Ambulance Services)

Nick Goddard

Manager, Divisional Support Unit

Telephone: 6233 3247

Mobile: 0438341903

Facsimile: 6233 2909

Email: nick.goddard@dhhs.tas.gov.au

Department of Health and Human Services (Children and Families)

Caroline Brown

Manager, Divisional Support Unit

Telephone: 6233 4931

Mobile:

Facsimile: 6233 2883

Email: caroline.brown@dhhs.tas.gov.au