

Expanding the network of care in general practice

Beres CA Wenck and Prue A Lutton



Dr Beres Wenck (GP), Ms Alison Nason (Practice Nurse Milton Clinic) and Ms Jenny Bostock (Community Health Nurse)

The increasing prevalence of chronic conditions requires general practitioners to implement structured care with their patients. This care is often multidisciplinary. Our experience through two coordinated care trials has shown that GPs often have a network of private allied health care providers, but have limited knowledge of the complete range of services available in the community and how to gain access to these services.

We suggest that there are three key elements essential for GPs to improve multidisciplinary care systems in their practice:

- Find the GP champion in your practice with an interest in chronic disease management who can encourage behaviour change. Appoint a member of the practice staff to be the link with your local community nursing agency. These organisations have an enormous knowledge of the breadth and depth of patient services available, and can help you find appropriate services for your patients. Invite community health nurses to your practice, or meet with them at their centre. Learn to use their expertise by forming and building a relationship. The

Beres Wenck, a GP for 30 years, has played a significant role in the recent EPC item number reform. She is Medical Director of Team Care Health II, Chair of the RACGP National Standing Committee — GP Advocacy and Support, Chair of the Aged Care Coalition Queensland, Member of the Federal AMA Aged Care Committee and Councillor MDA National. In 2002, she was appointed the Co-Chair of the Reference Group on the "Continuum between preventative, acute, chronic and primary care" to inform the Medicare agreement. She was President of Brisbane North Division of General Practice from 1996 to 1999 and President of Queensland AMA in 1999–2000.

Prue Lutton has worked at the Brisbane North Division of General Practice for the past 6 years and believes GPs are uniquely positioned to drive key changes in primary health care through strategic alliances with other providers. She has completed a Master of Scientific Studies and a Bachelor of Applied Science, and has experience in project management, cardiac rehabilitation, corporate health and health promotion.

Brisbane North Division of General Practice, Brisbane, QLD.
 Beres CA Wenck, MB BS, FAMA, Medical Director, Team Care Health II;
 Prue A Lutton, MScSt, BScApp(HMS), Operations Manager,
 Team Care Health II. Reprints will not be available from the authors.
 Correspondence: Dr Beres C A Wenck, Brisbane North Division of
 General Practice, 520 Lutwyche Road, Lutwyche, QLD 4030.
 bwenck@optushome.com.au

collaboration has to be two-way, with community nurses equally committed to liaison. Such a change is likely to not only benefit GPs, but also enhance community nursing awareness of local general practice issues.

- Develop team-building and educational strategies for GPs and practice staff, as this will maximise team efficiency and productivity and boost staff morale. Have a meeting with all practice staff (not just the GPs), and encourage all present to contribute. This will result in knowledgeable and resourceful practice staff who will complement patient management. Use the chronic disease modules developed by Brisbane North Division of General Practice¹ to set up a structured clinical education program. This can be based either within a single small group practice or within a locality, to provide the opportunity for GPs, staff, and, when appropriate, allied health care providers, to discuss evidence-based medicine and practice-based issues relating to chronic disease management.¹

- Involve your practice staff in care planning to help improve patient understanding and care. Medicare Benefits Schedule (MBS) item numbers allow access to five allied health private services a year for those with complex, chronic conditions.² The new MBS Chronic Disease Management item numbers replacing previous Enhanced Primary Care items include a Management Plan and Team Care component, and were developed from our Team Care Health II learnings. They allow practice staff to assist GPs in planning care, and will facilitate service coordination, especially if the practice has established links with community agencies.

These elements need to be put in place at the practice level, but Divisions of General Practice should develop collaborative relationships with community stakeholders for linkages at the local level. Furthermore, to recognise the time-consuming nature of implementing the necessary changes within general practices, there should be appropriate innovative financial incentives for GPs and practices to make this approach a viable option.

With the increasing prevalence of chronic conditions, we need to move our focus from a reactive health care model to a proactive service delivery model. Get the incentives right, get the support right, and you might be surprised at the difference you make.

Competing Interests

None identified.

References

- 1 Brisbane North Division of General Practice. Chronic disease modules, 2004. Available at: http://www.bndgp.com.au/tch_modules.htm (accessed Jun 2005).
- 2 New Medicare Chronic Disease Management items replace Enhanced Primary Care (EPC) care planning items from 1 July 2005. Available at: [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/648DE4B114E3370BCA257019007DB5C3/\\$File/factsheet.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/648DE4B114E3370BCA257019007DB5C3/$File/factsheet.pdf) (accessed Jun 2005).

(Received 24 May 2005, accepted 16 Jun 2005)