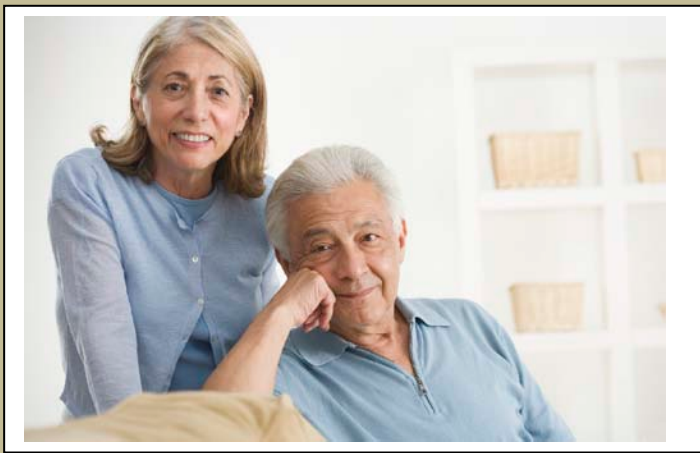




**ILLAWARRA
DIVISION OF
GENERAL
PRACTICE**

BELONGING



Shell Cove Family Health

Objectives

In designing Shell Cove Family Health we had three objectives:

1. devise an innovative model of general practice conducive to team based general practice care,
2. provide a high quality general practice service to the local community, and
3. offer younger GPs a view of a broader career pathway to choose from.

Competition

Our first task was to find an area that would not place us in competition with other GPs. Not only does Shell Cove have no GPs but neither do surrounding suburbs Flinders and Shellharbour Village.

Name

Shell Cove Family Health (SCFH) was the name chosen by our Shell Cove community committee.

Location

SCFH is being constructed at the corner of Cove Boulevard and Shallows Drive, Shell Cove. The Shell Cove residential area is a large new suburb bordering natural grass lands. It has views out to the beach, over land set aside for the Shellharbour Marina. The area has a rich Aboriginal heritage.

Around the area of SCFH is a series of walking/cycle tracks which explore the large tracts of remaining uncleared areas.

From local high points it is possible to see Killalea State Park, Bass Point Reserve, Shellharbour Golf Course, Minnamurra River leading into Mystics Beach, and the Pacific Ocean.

The vision of the Shell Cove Super Clinic is to be a centre of clinical excellence. It will be a place where teamwork between health professionals, students and patients will facilitate excellent health care provision. This clinic will be another example of the Illawarra taking the lead in innovative health care provision.

**Russell Pearson
Chair IDGP**

Design

We then sought to design modern and attractive premises that would blend in with the community of Shell Cove. The eastern section of the building is double storied to allow for the construction of a Lifestyle Centre for local residents and staff members to improve their health.



Innovation

The theme of SCFH is *belonging*. That applies equally to our community, our staff and our students and all of them will belong to one of three teams; Dharawal, Wodi Wodi and Moondar (names to be confirmed by the Shellharbour Aboriginal Community).

Each team will be led by a senior GP and will include another GP, a GP Registrar, medical student, team nurse, exercise physiologist (EP) and dietician. The role of the nurse will be central to the workings of SCFH.

Acute care

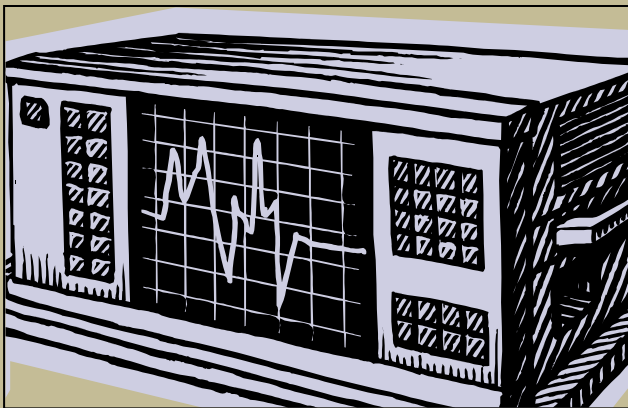
Although all patients will be allocated to a team, most of the time they will just see their usual GP (or GP Registrar or Medical Student) for episodic care.

Chronic care

All patients with complex chronic illnesses will have a GP Management Plan and, where appropriate, Team Care Arrangement prepared in conjunction with the team nurse. This will form the basis of a patient case conference which will involve all team members concerned in the patient care.

The general conduct of case conferences will be overseen by the Senior Practice Nurse (SPN). The case conference will be lead by the team nurse and, where possible,

The case presentation will be done by the team medical student. The outcome is the Patient Care Plan (PCP), written by the nurse but based on the GP management Plan. The PCP indicates to the patient which team members will be treating them and when, and what each person’s role is, including that of the patient themselves.



Preventative Care

SCFH will emphasise prevention with a view to avoid or delay disease progression, lifestyle risk factors and hospital admissions where possible. Patients will be screened for lifestyle and mental health risk factors and

subsequently referred to our in-house exercise, dietetic and/or psychology services for support. Our mental health nurses will work with patients to help support them from presenting to hospital.

Quality

General Practice has long struggled to provide quality care with most studies indicating that best care is applied on less than 50% of occasions. To overcome this problem, evidence based guidelines will be used at the case conference to remind clinicians of the evidence for care.

Many patients with chronic disease will be referred from the case conference, as part of the PCP, to specific clinics (heart failure, coronary artery syndrome and hypertension; chronic obstructive pulmonary disease (COPD) and asthma;

¹ Glasgow NJ, Silthorne B, Dean A. Primary Health Care Position Statement: A synthesis of the evidence. The Australian Primary Health Care Research Institute. The Australian National University.

osteoporosis and Diabetes). An evidenced based holistic approach to care means that a patient with multiple morbidities will only attend one clinic type.

The clinics are review-only services with recommendations being made for the treating GP.

Patients will be screened for all the conditions that are important but not urgent. These screens may include Smoking, Nutrition, Alcohol, Mental Health, Dementia and Physical Activity as relevant. The patient will also be reviewed for specific targets (eg blood pressure or physical activity targets) or screened for specific co-morbidities (such as sleep arousal, gastro-oesophageal reflux disease or osteoporosis in patients with COPD).

The Clinics will be run under direction of the Senior Practice Nurse and staffed by the team nurse and medical student. The medical student or nurse will brief the GP Educator (GPE) as part of the clinical teaching experience.

Quality care is also enhanced by systematic care. All patients will have diseases coded and patients will be recalled according to their PCP. Patients with PCPs who give permission will be SMS'd to remind them of their appointment.

“Best practice includes the notion of valuing all team members, community involvement, communication and cooperation, incentives and practice support.”

APHCRI ¹

Careers

SCFH offers a number of career pathways to its clinicians and staff. The practice is led by the Director who is supported by the Senior Practice Nurse. Each of the three teams is led by a CGP (Consultant GP); an experienced GP whose role it is to lead the team as well as to review the complex patient and make treatment recommendations back to the treating GP, much as the old general physician once did.

SCFH is committed to providing staff with professional development opportunities that are satisfying and rewarding and that help grow the overall capability of SCFH.

GPs

The team GP will work closely with the Team Nurse in the care of team patients. The GP will participate in case conferences, seeking advice from the spectrum of allied



health providers. The GP accepts final responsibility for all patient treatment and will be willing to seek evidence-based advice for patient care.

The GP Registrar (GPR) will see their own patients as well as assisting the medical student in clinical matters. There will be one position available for a GPR Researcher. GPRs wishing to specialise in

adolescent health or occupational health will be encouraged.

The GPE (GP Educator) is a specialist GP who will take responsibility for teaching the medical students as well as the GP Registrars and other clinical staff.

The SSGP (Special Skills GP) will make an appearance monthly to undertake treatment rounds on patients, teaching skills in areas that include skin excisions, chronic airways disease and acupuncture.

All GP positions will be part time. We will assist GPs seeking full time hours to find complementary positions which may include working in another general practice, in ED at Shellharbour Hospital, with Illawarra Occupational Health, with **headspace** Illawarra, or with the Graduate School of Medicine.

GPs will be able to hold concurrent positions as CGP and GPE, GP and GPE; CGP and SSGP or GP and SSGP.

At the completion of selected sessions, each GP will have time set aside to debrief from that session with a senior clinician.

We need to be sure that our staff are not struggling with difficult patients and that the resources we provide are adequate for the task at hand. GPs at **headspace** Illawarra value this support.

Nursing staff

The role of the Team Nurse (TN) is the heart of chronic disease management at SCFH. Apart from the roles described above in coordinating the Case Conference and the Patient Care Plan, the TN's day is divided into blocks. Blocks consist of Skills (Spirometry, ECG, Immunisation and well-women's



checks), Enhanced Primary Care and Chronic Disease Management (GP Management Plan, etc), Screening (health assessments, 4 year old checks, Diabetes Risk Evaluation, 45 year old health check), as well as Clinics and Case conferences as previously referred to.

The Senior Practice Nurse (SPN) carries much of the responsibility for quality improvement. The SPN ensures that case conferencing is successful, that the clinics are well-attended and achieve their health targets, that the patient recall and reminder system is comprehensive and effective. The SPN will take responsibility for diabetes, asthma, cervical screening and immunisation service incentive payments (SIPs) and for quality prescribing practice incentive payments (PIPs). The SPN will monitor patient feedback and maintain the compliments/ complaints register as well as support the nursing staff generally. The SPN will be responsible for the monitoring of unstable patients with complex conditions and will have a clinical role when possible.

The Floating Nurse (FN) will assist in the Treatment Room and interchange roles with TNs to support patient flow and enable skill mix.

Administration staff

Administration staff are the backbone of any practice. All administration staff will be responsible to the Practice Manager.

The Practice Manager (PM) will advise the Director on operational risk and opportunities. The PM will oversee relationships between administration staff members and implement and monitor an internal communications strategy. The PM will be responsible for practice accreditation and will monitor access to the electronic record log.

Receptionists will have an important role in patient care. Apart from normal reception duties they may assist patients to make external appointments, encourage patients to complete Health Risk Assessments and other forms. At least one receptionist will be an Aboriginal person to ensure a culturally sensitive welcome. One receptionist will oversee workers' compensation patient flow, billing and will liaise with their employers and insurers.

Allied Health Staff

Allied health staff will include dietitians and exercise physiologists working within teams. We will also be utilising the services of clinical psychologists and mental health nurses, however their deployment is yet to be finalised. Also uncertain at this stage is the utilisation of a diabetic educator.



Working at SCFH

SCFH is owned and managed by the Illawarra Division of General Practice which itself has a very strong and supportive team based culture. We are a not for profit company which is owned by our general practice members. We employ GPs, clinical psychologists and mental health nurses. We operate a successful **headspace** site, **headspace** Illawarra.

The clinicians who work at SCFH will feel comfortable working in a team. They will be willing to learn from each other and will view the patient as having an important role in the maintenance of their own well-being. Staff at SCFH need to be dynamic team players who are committed to delivering quality care, can contribute to a

success culture and can embrace the ever-changing nature of a modern general practice. SCFH is committed to providing staff with professional development opportunities that are satisfying and rewarding and that help grow the overall capability of SCFH.

Working in the not for profit sector brings certain advantages. For example, a GP working part time and earning \$90000 per annum is able to take salary packaging to the additional value of \$9,210. On top of that significant advantages relate to the purchase of motor cars, meals and even accommodation.

Working for a company also means guaranteed superannuation on top of a salary. Then there's the holiday pay, sick leave and long service leave....



IDGP will employ its clinicians working in SCFH. GP sessions are of four hours duration. In that time, the average patient load per GP should not exceed 14 and a time slot is scheduled for morning or afternoon tea.

Rostering

As a Division of General Practice we believe in quality of life for our members. Accordingly, after hours care will be contracted to the Wollongong Radio Doctor Service.

SCFH will be open Saturday morning and, when fully functional, two GPs (including CGPs and GPRs) will be rostered to work these mornings.

SCFH will open at 8:00 am and close at 6:00pm, although the Lifestyle Centre will be open from 6:30 am.

IT support

SCFH will use a common electronic health record, *Best Practice*. Therefore, subject to patient consent, the patient record will be available to all clinical staff treating a patient within the team.

Helpdesk support for the practice will be provided by the Division's helpdesk service, OTIIS (Operational, Technical and Information Services). The availability of a leading clinician-focused technical support service means that frustrating down times will be kept to a minimum. Staff are also able to purchase heavily discounted branded computer hardware through OTIIS.

Facilities

We want our staff to feel more than comfortable working at SCFH. Staff will have a kitchen downstairs and another area upstairs. Staff toilets and showers are available on the ground floor. Consulting rooms are air conditioned with individual controls and most consulting rooms enjoy their own patio. The facility will have two clinic rooms for parallel teaching and chronic disease Clinics.

A three-bed treatment room will allow us to handle emergencies and acutely sick patients and provide an area for team nurses to undertake ECGs and spirometry.

Nurses will also have their own room to manage patients with chronic conditions according to care protocols agreed with the GP.

The exercise area is large with panoramic views to the escarpment and to the ocean.

Pathology services will be provided on site and a pharmacist is applying for a licence to be co-located and to engage in medication reviews on behalf of the GPs.

Opening

SCFH is expected to open to the public in June, 2011. We hope to open with two complete clinical teams, moving to three teams in February 2012. GPRs and medical students will be joining us in July 2011.

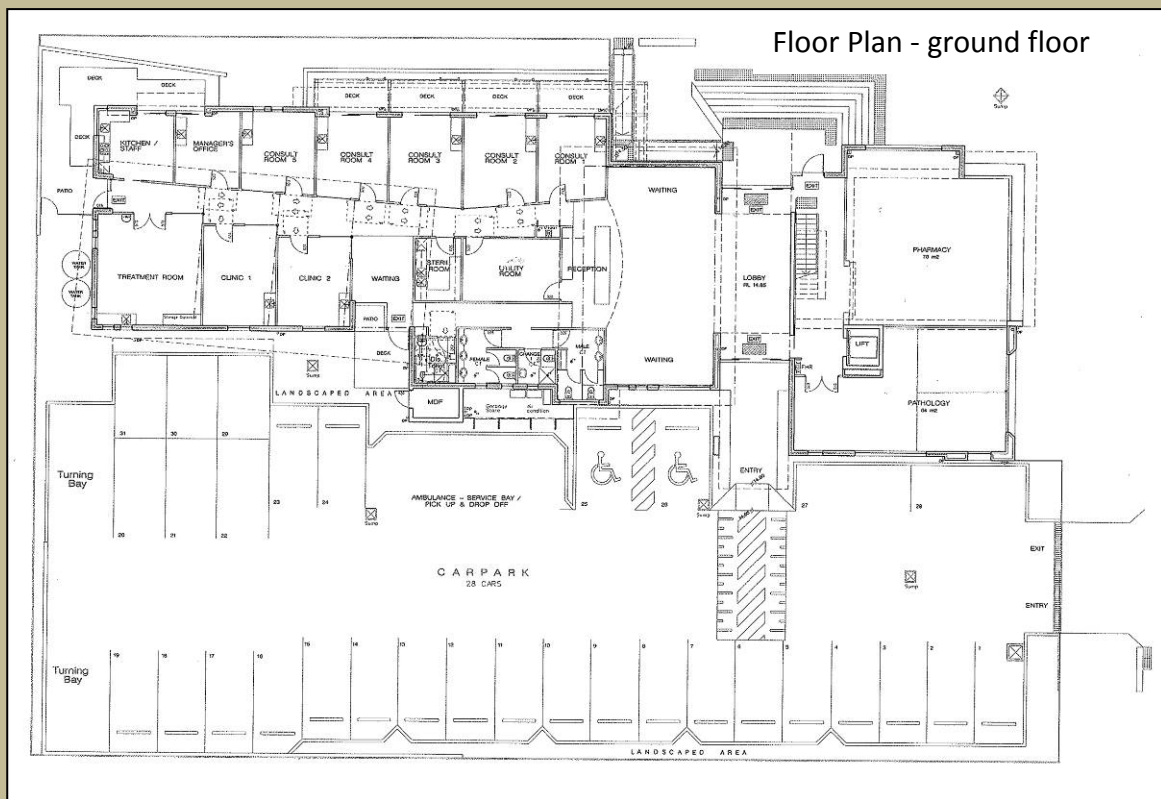
Conclusion

The Illawarra Division of General Practice is investing in an innovative model of care to deliver high quality, comprehensive health services to residents of the Shellharbour LGA. Our model supports the belief that young GPs prefer a flexible career structure and that

many senior GPs prefer not to have to cope with the burden of managing a practice. It is our main priority to increase the number of GPs to this area.

The model we have produced is unashamedly team based and relies heavily on nursing support for good on-going care of patients.

We are able to offer a high quality service because we will enjoy a rent-free environment and because systems will exist to optimise income opportunities offered by government funded incentives. The model has been tested at **headspace** Illawarra where it is highly valued by GPs and patients alike who feel happy to belong to our community of care.



GP superclinics

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For further information about **Shell Cove Family Health**, please contact the

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Supporting the local community through general practice