6 Operations Aspect

The GP Super Clinics Program objectives provide a framework for the model of care which was expected to be delivered by the GP Super Clinics.[2] While these objectives are not prescriptive it was expected that each GP Super Clinics demonstrate or progress strategies towards the elements described in the Program objectives.[2]

This component of the evaluation aimed to assess the extent to which these elements have been demonstrated from the perspectives of a range of stakeholders in each of the seven operational clinics. This chapter presents an overview of the sample of participants, key themes from analysis of interviews, results of surveys of patients and clinicians, and information collected in the self-assessment forms completed by GP Super Clinic Directors.

6.1 Overview of Participants

The following section provides an overview of participants for each of the evaluation methods for the operations aspects.

6.1.1 GP Super Clinic Directors

The self-assessment form was completed by six GP Super Clinic Directors. Fourteen Directors participated in the interviews at the site visit. This was greater than the number of GP Super Clinics (7) in this aspect of the evaluation, as some clinics had multiple Directors, some of whom actively chose to participate in interviews.

6.1.2 Patients

Patient Survey

Of the 1050 individuals invited to participate in the study, 710 provided data, with numbers per GP Super Clinic ranging from 9 to 146.

Table 3 provides socio-demographic characteristics of the sample. Almost two-thirds of the patients were female, and approximately half were aged 45 years or over, with 17% aged 65 or over. Fifty-nine percent were married or in a de facto relationship, and only 4% of the sample were Aboriginal or Torres Strait Islander. While 84% of the sample were born in Australia, 11% spoke a language other than English.

These data were compared to GP encounters with Bettering the Evaluation And Care of Health (BEACH) data. Relative to the population of general practice patients from BEACH data, the GP Super Clinics' patient sample had a slightly higher proportion of females, were younger, and had a higher proportion of Aboriginal and / or Torres Strait Islanders.[26]

Table 3: Demographic Characteristics of Patient Participants in Survey

Patient Characteristic	Patient Survey Data	
	Number	Proportion of Sample (%)
Gender		
Male	253	36
Female	457	64
Age Group		
18-24	73	10
25-34	134	19
35-44	141	20
45-54	140	20
55-64	95	13
65-74	67	9
75+	60	8
Relationship Status*		
Never married	149	21
Widowed	42	6
Divorced	58	8
Separated	38	5
Married (registered and de facto)	417	59
Other Characteristics		
Aboriginal person	31	4
Non-English speaking background	74	11
Born in Australia	593	84

* Data missing for 6 observations

Table 4 provides an overview of the employment status and health insurance characteristics of the patients who completed the survey in this evaluation.

Table 4: Employment and Health Insurance Characteristics of Patient Participants in Survey

Patient Characteristic	Patient Survey Data	
	Number	Proportion of Sample (%)
Employment Status		
Employed full-time	273	38
Employed part-time	158	22
Unemployed	78	11
Not in the labour force	201	28
Health Insurance Characteristics		
Health Care, Veterans Affairs or Pensioner Concession Card	172	24
Private health insurance	148	21
No insurance or card	389	55

Sixty percent of patients were in either full- or part-time employment. Over half of patients (55%) did not have either private insurance or a health concession card (Health Care Card, Pensioner Concession Card or Veterans Affairs Card).

An overview of the characteristics of patients completing the survey in relation to attendances at the GP Super Clinic is provided in Table 5.

Table 5: Overview of GP Super Clinics Attendances of Patient Participants in Survey

Patient Characteristic	Patient Survey Data	
	Number	Proportion of Sample (%)
Attendances		
Usual GP Practice	645	91
Changed from another practice	343	52
See GPs at another practice	162	23
Expecting to see usual doctor	460	67
Clinicians other than GP seen in last year at GP Super Clinic		
Seen Nurse	344	50
Seen Allied health clinician	188	27
Seen medical specialist	36	5
Frequency of Attending GP in Last Year*		
1 time	43	6
2-3 times	166	24
4-5 times	159	23
6-7 times	113	16
8-9 times	45	7
More than 10 times	165	24
Main Reason for Attending GP Super Clinics		
New problem	164	24
Existing or chronic problem	221	32
Work related problem	18	3
Treatment/procedure	17	2
Medication problem or prescription	83	12
Get results	86	12
General check up	40	6
Referral	13	2
Vaccination	7	1
Other	42	6

* Contains Missing data

Six hundred and forty-five patients (91%) considered the GP Super Clinics as their usual GP practices. Of all patients who participated in the survey, 343 (52%) reported that they changed practice to attend the GP Super Clinics. Two-thirds of patients (67%) indicated that they were expecting to see their usual doctors at the visit. In relation to the other clinicians that patients had seen at the GP Super Clinics in the last twelve months, 50% had seen nurses, 27% had seen allied health clinicians and 5% had seen medical specialists.

Nearly one quarter (24%) of all patients reported attending the GP Super Clinics more than 10 times in the last twelve months. Twenty-four percent of patients were attending the GP Super Clinics on the day of survey completion for new problems, with 32% attending for existing or chronic problems.

Patient Interviews

Twenty-four patients at the seven GP Super Clinics consented to participate in the semi-structured interviews. Of those patients interviewed, 75% were female, with age range from 25 to 78 years, and all but one patient had visited the GP Super Clinics a number of times.

6.1.3 Clinicians

Clinician Survey

Email addresses for 131 clinicians were provided by the GP Super Clinic Directors. Ten email addresses were automatically returned to the sender as being incorrect or "out of office" for the period of the web-based survey. A total of 53 clinicians completed the web-based survey, a response rate 44 per cent. The profile of the clinicians is outlined in Table 6.

Table 6: Demographic Characteristics of Clinician Participants in Survey

Clinician Characteristic	Clinician Survey Data	
	Number	Proportion of Sample (%)
Gender		
Male	27	51
Female	26	49
Age		
18-24	2	4
25-34	9	17
35-44	21	40
45-54	15	28
55-64	6	11
65+	0	0
Discipline		
General practitioner	29	55
PGPPP*	1	2
Non GP Medical specialist	1	2
Nurse	4	8
Psychologist	7	13
Physiotherapist	4	8
Podiatrist	2	4
Other allied health**	4	8
Manager	1	2

* Prevocational General Practice Placements Program

** Other Allied Health includes Social Worker, Diabetes Educator, Dietician, and Occupational Therapist

Approximately equal proportions of male (51%) and female (49%) clinicians completed the clinician survey. The majority (68%, n=36) were between 35 and 54 years. Over half (55%, n=29) of the survey participants were GPs, four (8%) were nurses and 17 (33%) were allied health clinicians. The majority (75%) were employed on a contractual basis and 13% were employed by the GP Super Clinics.

Clinician Interviews

A total of 75 staff involved in management (including GP Super Clinic Directors) and clinicians from a range of disciplines, participated in the semi-structured interviews during the seven site visits. A discipline profile of the participating clinicians is outlined in Table 7.

Table 7: Gender and Discipline Profile of Participants in Clinician Site-visit Interviews

	Clinician Interview Data	
Discipline	**Number**	**Proportion of Sample (%)**
General practitioner	22	29
Nurse	13	17
Psychologist	4	5
Dietician	2	3
Physiotherapist	4	5
Other allied health*	5	7
Managers**	23	31
Students (medical and nursing)	2	3
	75	100

* Other included Occupational Therapist, Welfare, Social Worker, Exercise Physiologist and Podiatrist

** Included GP Super Clinic Directors, Practice Managers and Administrative staff managers

The majority of those interviewed were clinicians (66%) with managers (31%), and general practitioners (29%), nurses (17%) and allied health staff (20%) accounting for specific disciplines. GP Super Clinics Directors, who were GPs providing a clinical and management role, for the purposes of these data, were classified as managers. Similarly practice managers who were nurses and also provided a clinical role were classified as managers.

6.1.4 Community Stakeholders

Community stakeholders who were engaged in consultation with the GP Super Clinics and were identified in the Project Plans were contacted to participate in either a face-to-face or semi-structured interviews. Twenty-one community stakeholder names were provided and 11 participated in the interview. Of the 11, two were from another general practice, two were from a university, one was from a Division of General Practice, one was from an Aboriginal Community Controlled Health Service, two were Indigenous Elders, and three were from local state or non-government organisation health services.

6.2 Multi-disciplinary and Integrated Care

6.2.1 Multi-disciplinary Care

Older patients (>65 years) represented 17% of the patient survey sample with 32% (n= 221) of patients identifying as having a chronic illness. All GP Super Clinic Directors indicated when interviewed and through the self-assessment form that the GP Super Clinics were providing high quality multi-disciplinary care.

A total of 170 clinicians provided services at the six GP Super Clinics completing the self-assessment form; this equates to 94 full-time equivalents (FTEs). These numbers do not include information from one of the GP Super Clinics that did not complete the self-assessment form. An overview of the disciplines involved and their employment status (FTEs) is provided in Table 8. The GP Super Clinic which did not respond to the self-assessment survey reported 6 GPs providing services at the clinic.

Multi-disciplinary care occurred mainly through mechanisms such as the shared health record and the provision of multiple disciplines under one roof, thus facilitating referral, access and

communication about patient care. Access to Medicare Items such as those for Team Care Arrangements or Chronic Disease Management items was also identified as facilitating multi-disciplinary care. Care planning was mostly undertaken by a specific discipline such as a practice nurse or allied health staff, following assessment and clinical treatment advice by a GP. In most instances this occurred with the patient attending multiple appointments with the different disciplines.

Table 8: Overview of Numbers and Employment Status of Clinicians*

Clinician Characteristic	Clinician Interview Data	
	Number	FTEs
Discipline		
General practitioner	60	39
Nurse	32	20
Psychologist	13	6
Dietician	6	4
Physiotherapist	13	8
Occupational therapist	3	2
Social worker	3	3
Podiatrist	6	3
Dentist	1	1
Non GP Medical specialist	21	4
Other	12	4
Total	170	94

* Missing data from one clinic

Clinicians in interviews commonly reported that multi-disciplinary care was in place and was providing significant benefits for patients. Further, 83% of patients surveyed indicated agreement or a strong level of agreement that the reason they attended the GP Super Clinics was that they could see a range of other health professionals in the one location.

Table 9 reports the proportion of clinicians who rated elements of care as important or very important (Level 4 or 5), and the proportion who rated the same elements as extensively or fully implemented (Level 4 or 5). The elements of care are listed in the table in order of perceived decreasing level of importance.

The three elements of care ranked by the most participants as being important are Multi-disciplinary model of service delivery for people with chronic illness (96%; 95% CI 87%-100%), recruitment of a range of clinicians (94%; 95% CI 84%-99%) and preventative care (92%; 95% CI 82%-98%). These elements of care were considered to have been extensively or fully implemented by 87% (95% CI 75%-95%), 70% (95% CI 56%-82%) and 79% (95% CI 66%-89%) of clinicians respectively (ranked 3rd, equal 4th and equal 5th). Participation in research was ranked as least important (45%; 95% CI 32%-60%) and most poorly implemented (25%; 95% CI 14%-38%). After hours care was considered second least important element, but considered as being implemented reasonably well (62%; 95% CI 48%-75%).

While the extent of implementation was comparable to ratings of importance for multi-disciplinary model of care (87%), the proportions indicating extensive or full implementation for recruitment of a range of clinicians (70%) and preventative care (79%) was much less than

importance ratings. The biggest difference in ratings for importance (72%) compared to implementation (47%) was for training opportunities for clinicians.

Table 9: Clinicians Ratings of Importance and Extent of Implementation of Key Elements of GP Super Clinics in Providing High Quality care

	Importance^			Implementation#		
	%	95% Confidence Interval		%	95% Confidence Interval	
Multi-disciplinary model	96	87	100	87	75	95
Recruitment of a range of clinicians	94	84	99	70	56	82
Preventative care	92	82	98	79	66	89
Enhanced sharing of patient information	89	77	96	91	79	97
IT systems to support multi-disciplinary care	87	75	95	89	77	96
Retention of clinicians	85	72	93	70	56	82
Self-management for patients with chronic illness	83	70	92	66	52	78
Engagement with local community	81	68	91	62	48	75
Multi-disciplinary involvement in clinical governance	79	66	89	64	50	77
Multi-disciplinary involvement in development of service models	79	66	89	55	40	68
Meeting health needs of Aboriginal and Torres Strait Islanders	74	60	85	60	46	74
Physical infrastructure to support training	74	60	85	79	66	89
Training (professional development) opportunities for clinicians	72	58	83	47	33	61
Shared planning with external health services	70	56	82	55	40	68
Training opportunities in multi-disciplinary care	70	56	82	55	40	68
Meeting health needs of older Australians	64	50	77	70	56	82
Multi-disciplinary involvement in organisational governance	64	50	77	57	42	70
After-hours care	58	44	72	62	48	75
Participation in research	45	32	60	25	14	38

^ Percentage of clinicians who rated this aspect as importance level 4 or 5

Percentage of clinicians who rated this aspect as being implemented at level 4 or 5

Clinicians were asked about their perceptions about factors which support multi-disciplinary care at their GP Super Clinics (Table 10).

Table 10: Clinicians' Perception of Factors which Support Multi-disciplinary Care

	%^	95 % Confidence Interval	
Management commitment	94	84	99
Respect for the contribution of all disciplines	94	84	99
Communication systems within this GP Super Clinic	94	84	99
IT systems	94	84	99
Clinical protocols and guidelines	91	79	97
Clinical leadership from all clinical leaders	85	72	93
Data collection systems which support understanding of performance and outcomes	79	66	89
Time availability for provision of multi-disciplinary care planning	79	66	89
Funding for all aspects of multi-disciplinary care	75	62	86
Processes for involvement of all disciplines in clinical governance approaches	74	60	85
Processes for involvement of all disciplines in organisational governance approaches	64	50	77

^ Percentage of clinician agreeing or strongly agreeing that the factors support multi-disciplinary care at this GP Super Clinic

Management commitment, respect for the contribution of all disciplines, communication systems within the GP Super Clinics and IT systems were all considered by almost all clinicians to support multidisciplinary care at GP Super Clinics (94%; 95% CI 84%-99%). The factor considered by the least number of clinicians as supporting multi-disciplinary care in the GP Super Clinics was processes for involvement of all disciplines in organisational governance approaches (64%; 95% CI 50%-77%).

6.2.2 Integrated Care

All of the GP Super Clinics Directors demonstrated awareness of the importance of ensuring care was integrated across aspects of their service delivery model. They indicated that they had achieved extensive or full implementation of integrated care within their practices. However, most indicated that the integration within the GP Super Clinics was more reliant on corridor conversations and on shared health records, than on more systematic approaches supported by multi-disciplinary clinical guidelines.

Of the patients completing the survey, 66% agreed or strongly agreed that the GP Super Clinic staff coordinated all aspects of their care. These data suggest the majority of patients believe that their care is well-integrated within the GP Super Clinics.

6.2.3 Factors Impacting on Provision of Multi-disciplinary and Integrated Care

Clinicians indicated a number of factors either positively or negatively impacted on the provision of multi-disciplinary and integrated care within the GP Super Clinics. First, clinical and

organisational leadership which provided direction and support was considered critical in driving the model of care. In most interviews this was reflected in comments by GP Super Clinic Directors and clinicians. This reflects evidence of the importance of clinical and organisational leadership in most clinical settings.[27,28] Many clinicians indicated that the Directors had a clear vision of the model of care which drove a range of strategies to support the model. In GP Super Clinics where this leadership was less evident or where there was uncertainty in the clinical leadership roles, the model of multi-disciplinary care appeared to be one dependent on co-location of disciplines and on a "business as usual approach" rather than a vision of integrated multi-disciplinary teams..

Second, the model of care where multiple disciplines provide care under one roof, was considered critical to the success of the GP Super Clinics. This enabled access to and immediacy of information-sharing among different disciplines which, under other models, were reliant on varying forms of communication between disciplines. Most clinicians were positive about co-location.

> I have worked in a private practice before with other [allied health disciplines]. I had little communication with GPs other than through referrals or summaries of interventions. I did not know many of them [GPs] other than at the end of a phone. Here I can catch them in the corridor to discuss a client, as well as having the shared health record. It works brilliantly and I think the clients are getting better care because of these informal corridor conversations."
> Allied health professional – interview

This was further reflected in patient comments in surveys and in interviews.

> ....This practice offers a range of services all in the one place
> Patient - survey
>
> [Moved to this GP Super Clinic] Because of the multi-disciplinary service this clinic gives
> Patient - survey
>
> We moved here to be near this clinic. It has a range of service which [spouse] needs and they are all here in one spot. So we don't have to travel to different spots. And they all know what's going on with [spouse] as it is all on the record.
> Patient - interview

Third, the shared health record was seen by clinicians as a key factor in enabling the sharing of information to support multi-disciplinary care. The record was seen as an efficient and effective tool which resulted in better care for patients. In particular, allied health clinicians commented on the importance of the shared health record in supporting coordination of care, a system which they had not experienced when working in separate locations. The majority of clinicians (88%) in the survey rated IT systems to support multi-disciplinary care as important, with 89% indicating that such IT was in place in their GP Super Clinic. This was reinforced by many patients who indicated that they were happy with the shared health record as it meant that all the clinicians were aware of their clinical information and they did not have to repeat the information when seeing a range of clinicians at the GP Super Clinics.

Fourth, the culture of and team-work within most of the GP Super Clinics were conducive to multi-disciplinary care. Evidence for factors impacting on teamwork in relation to multi-

disciplinary care align with elements of the model within the GP Super Clinics, such as co-location and shared electronic health records.[29] However, evidence also supports the need for shared planning and protocols. The extent to which these were effectively in place in most GP Super Clinics was not able to be determined accurately. To maintain a positive culture and team-work, more attention to shared planning and protocols may be required.

Fifth, the differences in organisational models including not-for-profit, community owned, private for profit and third party contractual arrangements, did not appear to impact on the provision of multi-disciplinary and integrated care. Rather the flexibility in models provided for under the GP Super Clinics Program allowed resources to be used to suit local needs and contexts. Problems in relation to organisational models occurred where there were third party contractual arrangements requiring reporting at multiple levels and attempts to align sometimes disparate objectives.

Lastly, access to and equity in the Medicare Benefits Schedule (MBS) was raised consistently as a barrier to optimising multi-disciplinary care. In particular, clinicians raised the inconsistency in access for all disciplines and the inequity in remuneration across disciplines for participating in multi-disciplinary teams and in particular for case management. The MBS items 735 to 758 provide rebates for medical practitioners (not including specialists or consultant physicians) to organise and coordinate, or participate in, multi-disciplinary case conferences for patients in the community or patients being discharged into the community from hospital, or people living in residential aged care facilities.[30] These items were recognised as supporting some aspects of multi-disciplinary care but the inequity in remuneration was perceived to be a barrier.

GP Super Clinics doctors frequently identified a feeling of guilt in case management as they were able to bill for these services, whereas allied health were unable to bill under the MBS item. In many instances, allied health staff reported willingness to participate in case conferences in the interest of patient care and their professional learning.

6.2.4 Clinical Governance

The inclusion of clinical governance aimed to enhance quality as part of the multi-disciplinary approach to care. Clinical governance in acute settings has traditionally focused on monitoring and addressing adverse events and risks.

Approaches to clinical governance in the GP Super Clinics were variable at best with some clinics formalising approaches to clinical governance through policies, clinical protocols and mechanisms such as clinical review meetings. Only one of the GP Super Clinic Directors reported full implementation of formal clinical governance approaches. Only one of the Directors reported involvement of multiple disciplines in clinical governance. This was aligned to views of clinicians who reported less than optimal approaches to clinical governance, and in particular, multi-disciplinary involvement.

The majority of clinicians (79%) rated multi-disciplinary involvement in clinical governance as important. However, only 64% of clinicians indicated that this had been fully implemented. In contrast, a number of the GP Super Clinics appeared to have a more informal and reactive approach which included dealing with issues as they arose.

6.2.5 Self-management

Self-management is an important approach to supporting patients with chronic and complex conditions.[31] All Directors reported extensive or full implementation of self-management approaches. Clinicians mostly reported that they included self-management approaches to patient care as part of consultations. In addition, some clinicians provided specific self-management programs. The extent of planned approaches to self-management as part of care coordination, apart from where specific group programs were run, was not as evident. Almost two-thirds of patients (65%) indicated that their GPs or other health professionals discussed with them ways of better managing their health.

6.3 Responsiveness to Local Community

Most GP Super Clinics reported using processes, usually including consultation, to determine community needs. This occurred most commonly in the phase leading up to the construction of the GP Super Clinics. Examples were provided of engagement with community members, Divisions of General Practice, aged care facilities and Aboriginal Medical Services.

One GP Super Clinic reported specific engagement approaches with members of the Aboriginal community in the local area. This was not a formal consultation strategy. Rather, it was an attempt to meet and get to know members of the Aboriginal community and build relationships that would support Aboriginal engagement. This has been ongoing, and there was evidence of significant impact, with 600 patients identifying as Aboriginal at this one GP Super Clinic. This approach has been further supported by participation in the Australian Government's Closing the Gap Collaborative.

> [Director] came and met me a few years ago to talk about what he wanted to do and asked what we needed. We still talk regularly. Everything he committed to he has done..... We meet regularly and the word has got around about this clinic. Indigenous people here get great service.
>
> Indigenous Elder - interview

Another GP Super Clinic provided examples of engagement with the local Aboriginal community through Elders and the Aboriginal Medical Service. As a result, programs targeting local Aboriginal young people have been developed.

Many of the community stakeholders reported positive experiences in relation to the engagement processes with the GP Super Clinic Directors in the early phase of development. Some had developed clinical relationships with the GP Super Clinic since their inception.

The extent of ongoing involvement in part depended on the organisational structure of the GP Super Clinics. Where Boards existed, members had often been involved in engagement in the early phases of the GP Super Clinics. While Board membership was mostly skills-based this was viewed as important in the GP Super Clinics' infancy. As a consequence, the members did not necessarily reflect community views. Rather, they brought specific and needed skills to the Boards for the stage of development of the GP Super Clinics.

6.4 Accessible Primary Health Care

Access to primary health care is fundamental to a high-performing health system.[9] Ability to get appointments and financial costs associated with reduced bulk billing rates have been cited in many studies in Australia as barriers to access to primary care.[9]

All GP Super Clinic Directors had some arrangements for either extended or after-hours medical care. The format this took depended on perceived demand and other local arrangements, such as advising patients of the GP Super Clinic's arrangement with an agreed after-hours provider. Where extended and after-hours care was provided, demand was mostly seen as greatest between 6.00 p.m. and 10.00 p.m. Some GP Super Clinics had successfully provided weekend clinics. Some GP Super Clinics provided and others were examining the opportunities for out-of-normal-hours allied health appointments.

Just over half (58%) of clinicians indicated that the provision of after-hours care was important. Some clinicians perceived that demand for after-hours care had decreased because of greater availability of appointments during normal business hours. This aligned with the views of some patients who indicated they could access appointments without having to wait for weeks.

> At [previous] clinic I had to wait for about a week to get an appointment. If urgent, you had to try to the local after-hours which wasn't great. Here I can usually get an appointment within a day.

In the survey, just over half of all patients (52%) reported they had changed from another practice to attend the GP Super Clinics. Results from the survey also indicated that patients rated access issues regarding availability and costs as important determinants of reasons to attend the GP Super Clinics. The majority (67%) of the patients participating in the survey also indicated that they were there on the day to see their usual doctors.

Table 11 describes the reasons patients report attending the GP Super Clinics, defined as the proportion strongly agreeing or agreeing with each statement. These are presented in decreasing order, with the most commonly specified reasons reported first.

Table 11: Percentage of Patients Agreeing with Reasons for Attending GP Super Clinic*

Reason for attending	Percentage Agreeing*	95% Confidence Interval[&]		Design Effect
Hours clinic opens suits need	87	81	92	2.9
Close to home/work	85	76	90	4.2
See range of health professionals	83	74	90	5.3
Access to GP of choice	79	64	89	11.3
Clinic bulk bills	75	52	89	22.9
Staff understand health needs	72	58	83	8.5
Staff communicate well with external providers	68	53	80	10.2
Clinic coordinates all aspects of care	66	51	78	9.9
Do not wait more than 1 day for appointment	65	52	77	8.3
Staff understand cultural needs	57	44	70	8.2
After hours services available	52	38	65	9.0

Reason for attending	Percentage Agreeing*	95% Confidence Interval[&]		Design Effect
Drop in appointments available	42	30	55	7.8
Can't get appointment at other practice	30	21	41	5.1

* Percentage agreeing or strongly agreeing with each reason

& Standard error adjusted for correlation of patients within clinics using the jack-knife method for the survey tabulate option in Stata

The three most commonly cited reasons for attendance at the GP Super Clinics were: the suitability of the GP Super Clinics opening hours (87%; 95% CI 81%-92%), although only half of the patients (52%; 95% CI 38%-65%) considered after hours opening as important; the location of the GP Super Clinics, i.e. that is they were close to the patients' home or work (85%; 95% CI 76%-90%); and that patients could see a range of health professionals within the same location (83%; 95% CI 74%-89%).

The opportunity to see the GP of their choice, the fact that the GP Super Clinics bulk-billed and the fact that the staff understand the patients' health needs were also rated highly by 79% (95% CI 64%-89%), 75% (95% CI 52%-89%) and 72% (95% CI 58%-83%) of patients respectively.

The least important reasons for attending the GP Super Clinic were that it offered drop-in appointments (42%; 95% CI 30%-55%) or because the patient could not get an appointment at another local GP clinic (30%; 95% CI 21%-41%).

The design effects for reasons for attendance ranged from 2.9 for clinic opening hours to 22.9 for bulk-billing. The high value for bulk-billing is not unexpected given that this is a GP Super Clinic feature, i.e. although the importance of this may vary among patients within the same GP Super Clinic, whether or not patients are bulk-billed is determined at the clinic level.

Many patients made comments in the survey as to the reasons for changing to the GP Super Clinics with most providing multiple reasons. These comments were coded with the top six reasons patients changed from another practice reported in Table 12.

Table 12: Top Six Reasons for Changing to the GP Super Clinic – Survey Comments

Reasons	Number of Mentions
Access to appointments	64
Quality of care	62
Convenience of location	59
Moved to area	52
Followed a GP	50
Cost	50

The reasons for changing were made in either a positive or negative sense. For example, reasons such as "easier to get an appointment" or "had to wait weeks to get an appointment at other clinic" were both coded as access to appointments. Similarly, comments such as "heard the doctors here provide good care" and "dissatisfied with quality of care at other clinic" were both coded as quality of care. Availability of appointments was the most common reason for changing practice, with 64 mentions, followed by those about quality of care (62 mentions) and

convenience of location (59 mentions). Comments from surveyed patients about reasons for change, such as those outlined below, were common.

Patient Comments – Reasons for Change – Patient Survey

"Quicker access to doctors. Unsatisfied with medical care. Unsatisfied with attitudes of reception staff"

"Doctor more professional and get appointment most of time"

"I lost confidence in the doctor and was too expensive"

"More availability plus all services under one roof"

These results corresponded to common themes in patient interviews, where these were the top reasons for moving to the GP Super Clinics. In particular, during interviews patients reported that wait times of up to two weeks were not uncommon at previous practices and expressed frustration about lack of availability of appointments even when they were sick. Concerns about the quality of care as reasons for changing clinics were also common in patient interviews.

All GP Super Clinics provided bulk-billing for some of their patients. Mostly, this was for children less than 16 years, and pensioners and/or people with health concession cards. In one GP Super Clinic all patients were bulk-billed. While it was acknowledged that bulk-billing was desirable, most espoused the view that financial viability was impossible with total bulk-billing. Allied health disciplines seeing clients under MBS-rebatable items bulk-billed in line with GP Super Clinic arrangements. This had in most instances been negotiated as part of the contract for service engagement.

Cultural appropriateness is also an important element of access. Two of the GP Super Clinics had participated in the national Closing Gap the Gap Primary Care Collaborative. A further two GP Super Clinics had undertaken specific training for staff, including reception staff, with respect to cultural appropriateness for Aboriginal and Torres Strait Islander peoples. The majority of patients (57%) indicated that the GP Super Clinics met their cultural needs. The focus on cultural appropriateness as an important element of access appeared to be related to the commitment of the GP Super Clinic Directors to rate this as important. This was evident in GP Super Clinics which had participated in the Closing the Gap Collaboratives. However, these were in the minority, and greater engagement of Aboriginal people and where relevant, refugee or other Culturally and Linguistically Diverse (CALD) groups could be considered in GP Super Clinics in the future.

6.5 Preventative Care

In interviews, when asked about their role in preventative health care, most clinicians reported activities related to chronic disease management. It was only when prompted about their role in primary prevention, preventative health care in patients with risk factors but without disease, that they considered other strategies.

Table 13 reports the percentage of patients in the surveys reporting that their clinicians either sometimes or always discussed aspects of preventative care with them.

Table 13: Percentage Patients Reporting Discussion with Clinicians about Preventative Care

Reason for attending[#]	Percentage agreeing* %	95% confidence interval[&] %		Design Effect
Discussion about lifestyle risks	59	48	69	5.2
Advice about changing lifestyle risks	55	40	69	9.7
Advice about better management of health	65	49	78	10.6

* Percentage reporting issue sometimes or always discussed

Reasons are not mutually exclusive

& Standard error adjusted for correlation of patients within clinics using the jack-knife method option of the survey tabulate command in Stata

Less than two-thirds of patients reported that their GPs or health care workers discussed any of the specified aspects of health or health care, such as ways of managing their health (65%; 95% CI 49%-78%), lifestyle risks (59%; 95% CI 48%-69%) and advice about changing lifestyle risks (55%; 95% CI 40%-69%). In comparison, in another Australian study focusing on prevention advice about obesity, only one-third of over-weight or obese patients recalled receiving dietary and/or exercise advice from their GPs in the past 12 months.[32]

Clinicians were asked the same questions in relation to preventative care. Table 14 reports the results from these questions for clinicians.

Table 14: Percentage Clinicians Reporting Discussion with Patients about Preventative Care

	Percentage agreeing ^ %	95 % Confidence Interval	
Lifestyle risks (e.g. smoking) that might impact on their health	98	89	100
Advice about changing lifestyle risks (like doing more exercise)	98	89	100
How to better self-manage their health conditions	98	89	100

^ Percentage of clinician who reported sometimes or always discussing each aspect of health care

Most clinicians reported that they sometimes or always discussed with their patients lifestyle risks, advice about changing lifestyle risks and how to better manage their health conditions (98%, 95% CI 89%-100% for all aspect of preventive care). Patient report of these discussion was much lower: with 65% reporting that their GP or health worker provided advice about better management of their health; 59% reporting receiving discussion and 55% reporting advice about lifestyle risks was lower than the proportion of health workers reporting discussing those aspects of care.

6.6 Effective Use of Information Technology

The seven GP Super Clinics used electronic health record products for access by all clinicians, subject to agreed permission levels. All seven GP Super Clinics were consistent in their approach to compliance with privacy regulations for shared electronic health records. Most had privacy policies and had provided staff training in confidentiality. These policies were usually aligned with requirements under the accreditation process. The majority of GP Super Clinics had permission levels for discipline type in relation to sharing of information. These were most commonly applied for psychologists and/or social workers.

All GP Super Clinics had some type of consent form for patients for sharing of records: these mostly included opportunities for exclusion of sharing. The majority of patients interviewed indicated the use of electronic health records as positive. None of the patients expressed concern about sharing of records. Rather, the majority perceived that it was valuable when they saw another clinician in the practice that access to their history was available.

> Sometimes I see another doctor. My records are all on the computer so I don't have to repeat everything about me – they can just access it.
>
> Patient - Interview

None of the GP Super Clinics had implemented systems for sharing of electronic health records with external health care providers. However, two had indicated that plans were in place to trial an approach of shared electronic records with an external provider, in both instances with an aged care facility. The GP Super Clinic Directors indicated that the planning and processes required for this to occur were time-consuming to ensure both accuracy in shared information and compliance with privacy regulations.

6.7 Recruiting and Retaining the Primary Care Workforce

Net Increase in Access to GPs in Local Areas

To date across these seven GP Super Clinics, it is estimated that there has been a net increase of 19 GPs. This figure is derived from the total number of GPs at each of the GP Super Clinics, minus the number of GPs reported by the Directors as having moved from a local practice.

Model of Care

Most of the GPs interviewed indicated that the models of care applied in the GP Super Clinics was a major factor in retention. In particular, many GPs indicated that the delineation of duties within the practices allowed them to focus on "their medical work" and allowed other disciplines to undertake other aspects of primary care such as chronic disease management. This aligns with evidence from the United Kingdom where GPs reported positive experiences with the delineation of workloads among disciplines, enabling them to focus on more complex patients.[33]

> "I feel this is what I have been trained for. I can efficiently use my medical skills....and allow others such as the Chronic Disease Nurse to spend more time in developing and monitoring care plans....Working under this model is the most professionally fulfilled that I have been."
> GP - Interview

Clinicians were asked in the survey to indicate their levels of agreement with reasons for working in the GP Super Clinic (Table 15).

Table 15: Percentage of Clinicians Reporting Reasons for Working at GP Super Clinics

	%^	95 % Confidence Interval	
Commitment to provision of integrated care	92	82	98
Commitment to the provision of multi-disciplinary care	89	77	96
Opportunity to work with a range of disciplines	87	75	95
Strong approach to ensuring and monitoring quality	81	68	91
Service models meet the health needs of the community	77	64	88
Commitment to supporting and retaining staff	75	62	86
Multidisciplinary involvement in clinical governance	70	56	82
Flexible hours	68	54	80
Opportunity to participate in teaching/training of students/new graduates	57	42	70
Multidisciplinary involvement in organisational governance	57	42	70
Opportunity to participate in research	26	15	40

^ Percentage of clinician agreeing or strongly agreeing with each reason for working in clinic

The most important reason for participants working at the GP Super Clinics was commitment to provision of integrated care (92%; 95% CI 82%-98%), followed by commitment to provision of multidisciplinary care (89%; 95% CI 77%-96%) and opportunity to work with a range of disciplines (87%; 95% CI 75%-95%). The opportunity to participate in research was considered to be the least important reason for working at the GP Super Clinics (26%; 95% CI 15%-40%).

Teaching and Training

Many of the clinicians interviewed indicated that the opportunity for participating in teaching and training was a facilitator in commencing and maintaining their positions in the GP Super Clinics. This appeared to be related to a philosophical commitment to teaching and training, and the capacity to influence future graduates in their particular disciplines in the model of care. In addition, the inclusion of suitable space was a factor in their willingness and capacity to provide training.

There was a common perception that the model under which students and graduates would be trained at the GP Super Clinics would be substantially different from that experienced in other practices where clinicians had worked. In particular, it was expected but not totally realised that the opportunities for partnership approaches to teaching and training would be available in GP Super Clinics. In this way the GP Super Clinics could provide placements under a multi-disciplinary model and universities in return could align their teaching programs with this model of care.

Business Model and Financial Viability

The majority of GPs and other clinicians provided services at the GP Super Clinics under a contract based on a negotiated proportion of all patient-derived income. The majority of GPs interviewed indicated that the business model was a key element in their recruitment and retention. While not all indicated that the financial viability was optimal, they were positive that this would be reached within time. The business model allowed them to develop a sense of autonomy, albeit within a care team which provided the necessary clinical support.

A number of the GPs indicated that they had left profit-driven corporate models of General Practice where they perceived that salary differentials were inequitable and the model of care did not reflect their expectations for high quality primary care. In these instances, GPs expressed views that GP Super Clinics provided a balance between financial viability and their beliefs about high quality care which was not available in the corporate models in which they had worked.

Administrative support provided by the GP Super Clinics was also a factor in recruitment and retention. This was provided as part of the contractual arrangements for the clinicians. It was perceived as representing value-for-money for clinicians and ensured they could focus on clinical rather than administrative duties. Indeed, some who had been in practice as sole practitioners and/or business owners indicated that the administrative load in private practice was a factor in their decisions to seek alternative arrangements.

Misinformation

One issue which was unexpectedly raised as a barrier to recruitment, but not to retention, was the misinformation and adverse media coverage about GP Super Clinics at start-up. Many of the GP Super Clinic Directors reported they spent significant time, especially in the early stages, countering misinformation in the media and among the community about GP Super Clinics and the models of care. A number of clinicians also reported their initial concerns about commencing at the GP Super Clinics, given the negative media coverage. Indeed, some clinicians at a number of sites reported active campaigns run locally against GP Super Clinics, and the clinicians, usually by other doctors. This was perceived as due to threats about the GP Super Clinics providing unfair competition locally, in spite of many patients who indicated a reason for changing to the GP Super Clinics was inability to get timely appointments at other clinics.

The situation was reinforced by some patients indicating an initial feeling of wariness about the GP Super Clinics, given negative local media coverage. However, patients who raised this also indicated that their experiences at the GP Super Clinics differed from their expectations.

> I'd read in the [local paper] about the clinic....I thought it was going to be like a big production factory....But after coming here now a few times it could not be further from the truth. I can get an appointment where at [previous clinic] I had to wait weeks. I can usually see a doctor that I want to see. Everyone is friendly. The service is much better...you are actually treated like a person, not a number. This is so what this area needed and I am not sure what all the fuss was about.
>
> Patient - Interview

Some GP Super Clinic Directors also reported that they were now receiving calls from GPs expressing interest in working at the GP Super Clinic. Most commonly, the Directors reported

that the interest of these GPs was based on a desire to work under the model of multi-disciplinary care provided at the GP Super Clinics.

6.8 High Quality Best Practice Care

Approaches to high quality best practice care in the seven GP Super Clinics were evident. Most of these related to quality improvement approaches such as collaboratives or quality assessment approaches such as through accreditation. Patient satisfaction surveys and data collection in the context of specific collaboratives had also been undertaken.

All of the GP Super Clinics had participated or were about to participate in accreditation processes. A number of GP Super Clinics cited participation in a number of accreditation processes beyond systems such as Australian General Practice Accreditation Limited (AGPAL). Training practices are accredited according to Royal Australian College of General Practitioners (RACGP), and the Australian College of Rural and Remote Medicine (ACRRM) standards, depending on location and range of experiences available for GP Registrars.

All GP Super Clinics had developed or adapted clinical policy and protocols for some conditions with reliance on RACGP guidelines. These guidelines may be clinically appropriate for general practitioners but do not always reflect the multi-disciplinary care model applied by the GP Super Clinics.

Some of the GP Super Clinics have participated in the national Primary Care Collaboratives. Two GP Super Clinics reported participation in the *Closing the Gap - Improving Indigenous Access to Mainstream Primary Care Program*. Another GP Super Clinic had participated in a Diabetes Primary Care Collaborative. Other local initiatives evident in most GP Super Clinics were clinical meetings and clinical review meetings.

Aligned with evidence, approaches to quality in general practice tend to be project-based.[34] There was limited evidence of the extent to which these were embedded as part of the culture of the workforce in the GP Super Clinics. Delivering high-quality care in a multi-disciplinary environment requires new models of shared care to be developed in collaboration with a range of disciplines within and external to the GP Super Clinics. It was common for GP Super Clinics to adopt but not tailor RACGP clinical guidelines to their settings regardless of the context in which they provided services. Given that these do not necessarily reflect the evidence of multiple disciplines, their relevance could be questioned and ownership, and hence compliance by disciplines, reduced

Barriers to embedding approaches to quality identified through interviews with clinicians were numerous. First, in this early stage of maturation, the priorities of the GP Super Clinics were on other issues. This is not to say there was not a commitment to quality, with numerous examples provided. However, it was evident that other organisational priorities had been addressed. Second and related to the first barrier of relative priorities, is that embedding quality as part of the culture requires leadership, which at this stage had been directed towards other priorities in the GP Super Clinics. Third, it was evident that the knowledge of and skills in approaches to embedding quality was at best variable. Last, as identified in the evidence, in the absence of a systematic approach to quality across the primary care sector, approaches to quality which measure and allow comparison of performance are not possible.

6.9 Viable, Sustainable and Efficient Business Models

All GP Super Clinics had a strong focus on the viability and sustainability of business models. While not all GP Super Clinics were presently financially viable, most indicated they were optimistic about achieving this within the first three years of operation. In the main, the approach to achieving viability was a combination of MBS-refundable items with patient appointment times. This "price and volume" approach was common among the GP Super Clinics. To achieve patient volume, appointment times for GPs were allocated usually at either ten or fifteen minute intervals, with a focus on the medical assessment component, leaving other aspects of patient management to other disciplines. Where possible, appointments for other disciplines were arranged following or prior to those with general practitioners.

The business model was also supported by contractual arrangements between clinicians and the GP Super Clinics. These contracts commonly provided a proportional component of MBS items to the clinicians, with the remaining proportion contributing to the overall income for the GP Super Clinics supporting administrative and other staff to provide the required functional aspects. Forty (75%) of clinicians in the survey indicated that they contracted to provide services by the GP Super Clinics, with the remaining indicating a mix of arrangements.

Bulk-billing for all patients for MBS items was only available in one GP Super Clinic. This GP Super Clinic allocated appointments at ten-minute intervals to achieve the volume required to ensure viability. Most GP Super Clinics indicated that their initial projections under-estimated the proportion of clients who would be bulk-billed, thus necessitating a review of the business model. The majority of clinicians commented positively on the financial viability of the business model for them as individuals. Many indicated that they saw the balance between the model of care and professional satisfaction and the financial viability as critical. Indeed, some indicated they had left previous clinics where income may have been greater but professional satisfaction under the model of care provided made their position untenable.

> I am happy with the business model….. I think my earnings will grow as the clinic grows but it is a balance between money and job satisfaction. Here is a much better environment [than previous] roles and I feel I am doing what I was trained to do…medicine. And the other [disciplines] can do what they need to do. This is a much more efficient way to work than I have had before because of that.
>
> General Practitioner - Interview

GP Super Clinics where most concerns were expressed about the viability of the model identified patient volume as the main contributor to these concerns. In these instances, concerns about the location of the GP Super Clinics, combined with significant negativity from local practices, were suggested as factors impacting on patient volume.

6.10 Support for Future Primary Care Workforce

Placements for under-graduate students had been provided at six of the seven GP Super Clinics, and most also had GP registrars. While the focus of this training, at this stage of maturation, had been on medical practitioners, four of the GP Super Clinics had also provided training for nurses or allied health students.

Students, or their supervisors, commented that the experiences of students in this multi-disciplinary environment were positive and educationally beneficial. However, concerns were expressed that while the placements provided experience of multi-disciplinary care, the teaching at their respective universities was still provided in discipline-specific silos.

Even in those GP Super Clinics with universities as partners, there was no evidence of the teaching reflecting multi-disciplinary approaches. Even problem-based learning, which some clinicians perceived provided an ideal opportunity to be undertaken across student disciplines, was conducted in silos.

Patients commented positively about students being involved in care at the GP Super Clinics. None of the patients interviewed indicated any problems with the presence of students in consultations. Indeed, all interviewed commented on the importance of students in this setting in relation to the future health care workforce.

> [Doctor] often has a student with him. He always asks if I mind but I don't. It's important that they are here because they have to learn and the best way to do that is with real patients. Sometimes I have even seen a student first and then [Doctor] comes in and checks them because he is in the room next door.
>
> Patient - Interview

The space provided for teaching and training in most GP Super Clinics was viewed positively by most clinicians. In particular a number of GP Super Clinics had designed spaces to allow for parallel consulting thus supporting placements for multiple students with ease of access by medical clinicians.

6.11 Integration with Local Programs and Initiatives

Only a limited number of GP Super Clinics in this evaluation demonstrated proactive approaches to developing partnerships with other health care settings. Where they had occurred they were mostly with aged care settings and focused predominately on the provision of medical care to residents. This operational focus may have been necessary given other priorities for GP Super Clinics in the first 12 months of operation. The impact on the level of integration of care under these approaches was limited, in part because of lack of shared health records between the different facilities. There was even less demonstration of integrated approaches with acute hospitals or in planning for the health needs of local communities.

Non GP medical specialists were also providing services at the GP Super Clinics. These specialists provide services at the GP Super Clinics in a range of specialties, enabling access for patients locally.