

Prevocational GP Placement Program (PGPPP)

Information for Practices and Supervisors for 2011 Placements



About PGPPP

PGPPP is an Australian Federal Government initiative that provides Junior Doctors with the opportunity to experience General Practice. In the CCCT region PGPPP posts currently exist in rural (Gundagai – PGY2) and urban (ACT - Interns) settings.

Although the Commonwealth supports posts in outer metropolitan, regional, rural and remote areas, in NSW, placements are currently limited to PGY2/3 posts in RRMA 4-7 in Practices with on call (VMO) components of Practice but as funds become available this will likely change. GSAHS and SESIAHS are very supportive of the PGPPP program with GSAHS (in particular) being keen to grow the number of placements as quickly as possible.

ACT Health is keen to continue supporting PGPPP posts with an emphasis on Interns in Canberra itself and PGY2s in adjacent rural centres (located in NSW).

The PGPPP program offers high quality training in a wide range of clinical situations with the aim of encouraging Junior Doctors to choose General Practice as a career.

Participating Practices are allocated a Junior Doctor on a term by term basis. The term will match that of the feeder hospital and will commence upon the Junior Doctor's rotation into General Practice.

An opportunity for you

CCCT is committed to ensuring that all accredited Practices and Supervisors understand the potential opportunities and challenges that the PGPPP offers to Practices from 2010 and beyond.

Why consider PGPPP?

- A Junior Doctor participating in PGPPP has opted to take part in the program because they are keen to experience General Practice and learn
- A Junior Doctor in your Practice constantly challenges your knowledge and skills contributing to your own personal development
- People often learn much about their area of expertise from a whole new angle when placed in a position to teach others about it
- Because Junior Doctors are being exposed to the latest medical research and techniques during their post graduate training, they impact positively on your Practice
- It is rewarding and satisfying being involved in the process of attracting Junior Doctors to the field of General Practice
- Through interaction with each other, Junior Doctors and Registrars enhance each other's learning experience

Your questions answered

How long is a PGPPP placement?

In NSW and the ACT, PGPPP placement terms are consistent with hospital rotations which are ten weeks long.

What are the hours for a fulltime placement?

Hours for a fulltime placement differ between interns and PGY2 and depending on the location of the post.

Interns (RRMA 1-2) work a normal working week as defined by the feeder hospital.

PGY2 (Rural): Normal work hours vary between 41 and 45 hours with the latter including a weekend (Saturday morning) in Practice. These normal hours include 2-6 hours of overtime.

In 2011 Bowral-based posts will not include mid week on call work but PGY2s will do weekend work in the Bowral Emergency Department with supervision provided by the AHS. A similar arrangement may eventuate for the Shoalhaven, pending appropriate hospital term accreditation.

What about after hours work?

Rural PGPPP posts would include funded hospital rostered overtime and hospital call back components.

Typically a PGY2 doing a weeknight on call would work 4 hours of rostered overtime (1800hrs – 2200hrs) per week plus required hospital call back hours.

A PGY2 working a weeknight and weekend on call would do 6 hours of hospital rostered overtime per week plus required hospital call back hours.

NSW IMET requires that the Supervisor be called for each PGY2/3 hospital call back, until at least the fifth week of the term from which point supervision is at the discretion of the Supervisor.

Page 5 provides a clear breakdown of a rural PGY2's hours for an existing rural post.

What education support should the Practice provide?

NSW IMET Standards are currently being developed for the 2011 program

In CCCT's PGPPP posts, the structure of educational support programs differs between PGY2/3 and Intern posts in terms of who takes responsibility for delivering education. Common to all posts is the need for 1 hour of protected teaching time weekly, in addition to the supervision requirement discussed below.

Common elements include that Practices are required to provide an orientation at the beginning of the placement (CCCT recommends the use of GP Start modules 1-3) and Supervisors are required to help develop a learning plan.

As with Registrar education, structured sessions may take a variety of forms including case discussions, work shadowing, practical skills sessions, meetings, tutorials, video consultations and review.

Practices are particularly encouraged to conduct integrated Registrar/PGPPP/Student education sessions with the delivery of the session being shared between Supervisors, Registrars and other Practice staff as befits the culture of the Practice.

In 2011 IMET's standards will require that the appointed supervisor be accredited by the RACGP or ACRRM, though other doctors participating in the teaching /supervision program need not have this level of accreditation.

How does CCCT support and contribute to the Education Program?

Interns: CCCT develops and manages an in-depth induction program (conducted in the first week of the term) and thereafter coordinates an intensive weekly educational program undertaken in the Practice by a range of Medical Educators, Academic GP Registrars, Division and other staff.

The CCCT model removes pressure from the Supervisor leaving them time to concentrate on the supervision requirement.

PGY2/3: IMET standards will require that a CCCT Medical Educator be appointed as mentor to each JMO undertaking PGPPP terms. In addition to mentoring/supporting as required the mentor will work with the JMO to develop an initial learning plan and discuss the challenges of General Practice relative to hospital based medicine.

Additional Medical Educators will also conduct ECT visits (one per rotation) and JMOs will have the option to attend Registrar education events.

What is the Supervision requirement for Interns and PGY2/3s in General Practice?

Interns: The PGPPP Doctor consults the Supervisor about the management of all patients. The Supervisor takes primary responsibility for individual patients and the PGY1 Doctor takes limited responsibility.

The Supervisor must be physically present or available within 10 minutes to be able to provide physical review at any place where the PGPPP Doctor provides care.

PGY2/3s: The PGPPP Doctor must consult the Supervisor about the management of patients at a frequency determined by the Supervisor and the PGPPP Doctor (eg. after a session or after particularly complex cases, as required).

The Supervisor shares responsibility for individual patients with the PGPPP Doctor.

The structure and frequency of Consultations for Interns

Interns can see two patients an hour, with the Supervisor being called into the consultation once the history has been taken and the Doctor's actions are ready to be checked and signed off.

Feedback indicates that developing an approach to managing the interruption of their own consultations to meet the Intern supervision requirement is initially the most challenging task for Supervisors, and that approaches vary depending on individual consulting styles and the receptiveness of patients.

Given the intensity of the supervision requirement for interns, it is recommended that the Practice use multiple Supervisors.

For more information about the WAVE Consulting Model go to:

www.racgp.org.au/afp/200601/200601dewitt.pdf

A sample weekly roster for Interns is on page 7.

The structure and frequency of Consultations for PGY2/3

The number of patients seen by PGY2/3s will depend on the Supervisor's assessment of each Doctor's capabilities.

To begin with, the expectation is 2-3 patients per hour increasing to no more than 4 per hour during the term – and always at the Supervisor's discretion.

The PGY2/3's patients do not require sign off by the Supervisor.

A sample weekly roster for PGY2/3s is on page 6.

Can PGPPP be set up in any Practice?

It is CCCT Policy that a practice must have a track record of experience in supporting GPT1 and 2 Registrars and/or long term medical students.

What are the additional accreditation requirements?

ACT and NSW Practices must be accredited by IMET. In other words, your Practice is accredited in the same way as any other Hospital term.

The paperwork for accreditation has been simplified and tailored to the general practice setting.

Based on satisfactory completion of paperwork and attendance at a joint meeting with IMET and CCCT your practice will receive interim accreditation. After three JMO rotations a site visit will take place with a view to your practice transitioning from provisional to full accreditation.

Can you opt in and out or are you contracted for so many terms?

Practices are contracted for the number of terms specified in their application on an annual basis.

For some Practices, this might be all five terms in a year, while for others, rotations in terms 2, 3 and 4 might be practical.

Once contracted, the expectation is that you would not opt out before the end of the calendar year.

Are consultations billed to Medicare?

Interns: No. The feeder Hospital continues to pay the Doctor’s salary.

PGY2/3s: Yes. Consultations are billed to Medicare using the provider number of the Junior Doctor.

How are PGY2/3s paid?

The PGY2/3 remains an employee of their feeder hospital and continues to be paid and accrue leave entitlements etc from their hospital.

Because the Junior Doctor comes to the Practice with their salary (for normal hospital hours) paid by the hospital, the PGPPP process requires that Medicare billings to cover salary plus on costs be paid to the AHS. CCCT will invoice the Practice and facilitate these payments.

Practices will be required to provide CCCT with the Medicare Billing data for each rotation

In three years of operation practices have never been out of pocket using this process.

How is the Practice paid?

Practices are paid set amounts to cover supervision, briefing and orientation costs and a further amount for infrastructure development.

Within two weeks of the completion of each 10 week rotation, the Practice is invited to submit an invoice to CCCT for the contracted amount which will vary for PGY2/3 vs Interns and between rural and urban locations.

Payments to Practices consist include the following per 10 week rotation:

Supervisions and Teaching:	\$7,200
Infrastructure and Support	5,800
Briefing and Orientation	\$1000
Total per 10 weeks	\$14,000

The Practice hosting PGY2/3s also retains any billings above that repaid to the AHS and keeps all private billings earned.

What is the financial impact of a PGPPP post on the Practice?

To estimate the financial impact of a PGPPP post on your Practice, Supervisors and Practice Managers can log into CCCT’s *GPrime* system and use the “*PGPPP Ready Reckoner*” (listed under popular documents).

An example of this ready reckoner for a PGY2 seeing 2.5 patients per hour is provided on page 8.

Where to from here?

Please contact CEO Sharon Flynn with general queries and requests for further information about participating in the 2011 PGPPP Program on 6923 5400.

If responding to an expression of interest process, please do so in accordance with the instructions accompanying the email request.

PGY2 Doctor - Working in a rural placement with on call work

Table 1: On Call - No Weekend

Day	Normal Hours		Hospital Rostered Overtime	Hospital Call Back
	Practice Hours	Rostered Overtime (Practice)		
Monday, Tuesday, Thursday, Friday	0830 - 1700 (.5 lunch)	1700 - 1800		
Wednesday	0830 - 1330			
Weeknight on call			1800 - 2200	2200 +

Total hours worked are 4 hours of rostered overtime (hospital) and 41 hours 'Normal Hours' consisting of:

- 39 Practice hours
- 2 rostered overtime hours (Practice)

Total 45 hours plus call back hours

Table 2: On Call - With a Weekend

Day	Normal Hours		Hospital Rostered Overtime	Hospital Call Back
	Practice Hours	Rostered Overtime (Practice)		
Monday, Tuesday, Thursday, Friday	0830 - 1700 (.5 lunch)	1700 - 1800		
Wednesday	0830 - 1630*			
Weeknight on call			1800 - 2200	2200 +
Weekend on call	0830 - 1230		1230 - 1430	1430 + (Including all of Sunday)

Total hours worked are 6 hours of rostered overtime (hospital) and 45 hours "Normal Hours" consisting of:

- 43 Practice hours (including Wednesday pm education session at hospital)
- 2 rostered overtime hours (Practice)
- 6 hours hospital rostered overtime

Total 51 hours plus call back hours

PGY2 Doctor - Weekly Roster of Activities and Supervisors Schedule

NB. Start time is dependent on inpatient numbers	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday		
0800 – 0930	Hospital rounds	Hospital rounds	Hospital rounds	Hospital rounds	Hospital rounds	Weekend Surgery Roster is from 0830am – 12 noon (this day is operated like After Hours with bookings taken on day only) Will do 1:4 weekends in 10 weeks Hospital After Hours is covered by the Visiting Medical Officers. Supervised on call one night per week will be arranged with the VMOs at the commencement of the term.			
0930 – 1230	Consulting	Consulting	Nursing Home Hostel Home Visits	Hospital procedures	Learning Plan Review Consulting Complete and fax weekly Supervisor contact record				
1200 -1330	Lunch Break	Lunch Break	Lunch Break Junior Medical Officer Education WWBH	Lunch break	Lunch Break				
1330 – 1700	Consulting	Consulting	Study Period	Consulting	Consulting				
1730 - 1830 (f/nightly)	<ul style="list-style-type: none"> ▪ Case Presentation ▪ CCCT Tutorial ▪ Practice is open from 8:30am until 5pm (or until the last patient is finished) ▪ Visiting inpatients/nursing home/hostel patients can vary from morning to afternoon ▪ Times may vary due to clinical requirements including emergency presentations at the hospital. 								

Intern - Weekly Roster of Activities and Supervisors Schedule

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
0830 - 1300	Clinic	Clinic	Clinic	GP Education teaching session	Clinic	Leisure	
1300 - 1330	Lunch	Lunch	Lunch	Lunch	Lunch		
1330 - 1500	Clinic	Academic Registrar tutorial	Clinic	Clinic	Clinic		
1500 - 1700		JMO Teaching					
Tuesdays (monthly)	<ul style="list-style-type: none"> GP Grand Rounds 1230-1330pm 						

Education/teaching sessions may include:

- Adverse drug reactions
- Introduction to Medicare
- Adverse drug reactions
- Managing depression and anxiety in General Practice
- Dermatology
- Workers Compensation
- Musculoskeletal medicine
- Cross Cultural Health
- Indigenous Health
- Insomnia and drugs of addiction
- Medical Organizations
- Insomnia and drugs of addiction
- Men's Health Issues
- Chronic Disease in General Practice and Management of Diabetes
- Antenatal Care in General Practice and the Postnatal period
- Sexual Health and Family Planning
- Common Paediatric problems in general practice

Example - Estimate of Practice income and costs under PGPPP for a PGY2

Patients seen per hour by the Supervisor	4.00	
Average fee per patient for the Supervisor	\$44.78	
Patients seen per hour by the RMO	2.50	It is likely that an RMO1 will see two patients an hour for the first half of the term and three patients an hour for the second half. Default figure is 2.5
Average fee per patient for the RMO	\$44.78	This may be the same as for the supervisor or may be different. Default figure is $(\\$33.55 + \\$56.00)/2 = \\$44.78$
Lost room income per annum	\$14400.00	How much income will you actually forgo if a RMO occupies that room all year? Default is \$300pw x 48w
Set up costs	\$2000.00	Do you need to buy additional equipment etc for that room? Default is \$2,000
Admin costs	\$2880.00	How much additional admin time will it take in organising these placements? Default is \$30 ph x 2 hrs/wk x 48 weeks/yr
Marginal practice costs as % of billings	30%	What % of additional billings goes in additional practice costs not counted above? Default is 30%

Assumptions of this model are that:

- RMO works 4 days per week, 6 hours per day seeing patients, the fifth day is teaching and/or workshops
- RMOs effectively see patients for 48 weeks of the year assuming some holiday or leave time

Income

PGPPP infrastructure & support funding	\$29,000	
PGPPP supervision/teaching funding	\$28,800	Based on \$100 per hour for 6 hours per week for 48 weeks per year
Billings (Medicare component capped at 120,000pa)	\$128,966	Fee/pt x Pts/hr x 6hrs/day x 4days/week x 48 weeks/yr

Costs

Reimburse hospital for RMO salary	-\$72,992	Base salary for RMO1 of \$60,827 plus 20% on-costs. NB. Will go to \$63,199 + 20% = \$75,839 from 1/7/09
Lost Room income	-\$14,400	
Lost supervisor income	-\$51,587	Supervisor fee/pt x pts/hr x 6hrs/week x 48 weeks/yr
Set up costs	-\$2,000	
Admin costs	-\$2,880	
Practice cost component of billings	-\$38,690	
Total	\$4,218	

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Comments: _____

