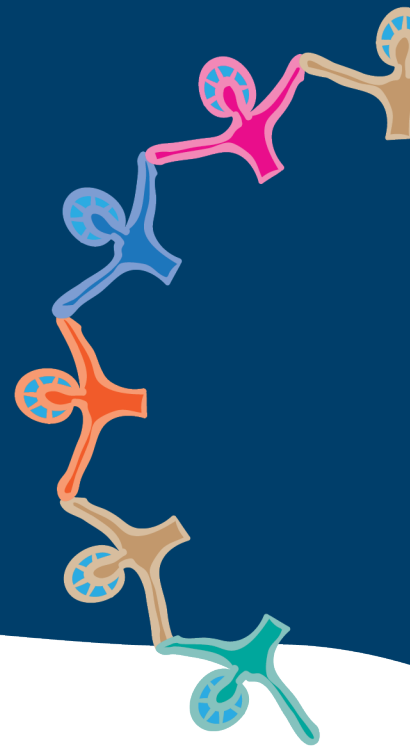


Welcome to general practice in northern Queensland

A guide for overseas trained doctors



NQPHN acknowledges the Aboriginal and Torres Strait Islander peoples as Australia's First Nation Peoples and the Traditional Custodians of this land. We respect their continued connection to land and sea, country, kin, and community. We also pay our respect to their Elders past, present, and emerging as the custodians of knowledge and lore.



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Acknowledgement of Country

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We respect their continued cultural and spiritual connection to country, waters, kin, and community.

We also pay our respect to their Elders past, present, and emerging as the custodians of knowledge and lore.

We are committed to making a valued contribution to the wellbeing of all Aboriginal and Torres Strait Islander peoples of northern Queensland.

NQPHN's offices are proudly on Gimuy-Walubara, Yidinji, and Yirrganydji Country (Cairns), Bindal and Wulgurukaba Country (Townsville), and Yuwibara Country (Mackay).



For questions or practice support, contact NQPHN's Primary Care Engagement team at pce@nqphn.com.au or visit our website www.nqphn.com.au to access helpful resources and updates.

Welcome to general practice in northern Queensland

A guide for overseas trained doctors (and anyone transitioning into general practice in the region)

A message to overseas trained doctors

Welcome to general practice in northern Queensland – we are genuinely glad you're here.

Whether you trained overseas, worked in another health system, or are transitioning from a different clinical environment, choosing to work in this region is a meaningful step. Your knowledge, skills and perspectives strengthen the communities you serve, from coastal cities to rural and remote towns across the north.

It's normal if some parts of the Australian system feel unfamiliar. Many doctors describe their first months as exciting, busy, and occasionally overwhelming – especially when navigating Medicare, communication styles, community expectations, and the unique culture of the north.

This guide has been created to walk alongside you. It offers practical insights, everyday examples and supportive advice drawn from doctors who have stood exactly where you are now.



Why this guide was created

This resource was informed by conversations with overseas trained doctors, rural and regional GPs, educators, and practice teams across northern Queensland. Common themes emerged:

- The culture and pace of general practice in the north can differ from many other health systems.
- Medicare and MBS billing are new concepts for many doctors.
- Navigating referral pathways while still building local knowledge can be challenging.
- Communication styles, accents, and colloquial language can be difficult early on.
- Working with Aboriginal and Torres Strait Islander peoples involves new learning and cultural considerations.
- Geography, weather, and resource availability shape clinical practice.

This guide aims to make your first months clearer and better supported.



About NQPHN

Northern Queensland Primary Health Network (NQPHN) connects, funds, and supports primary healthcare services and providers so all northern Queenslanders can access the care and information they need to live healthier lives.

We do this through our core functions:

- **Commissioning** targeted services that respond to local health challenges and opportunities.
- **Capacity building** to strengthen the primary healthcare workforce and support innovation, data and quality improvement, business sustainability, and reform.
- **Coordinating** and connecting care across the system to improve access, as well as patient and provider experiences.

Partnerships are central to NQPHN's approach. We work collaboratively with Members, the health workforce, and health and community partners, to identify and address local needs and priorities. NQPHN is committed to strengthening these partnerships to achieve better health outcomes for northern Queensland communities.

Our strategic priorities are healthy communities, health equity, healthy system, healthy workforce, healthy intelligence, and healthy organisation, as defined in our [Strategic Plan 2025-28](#).

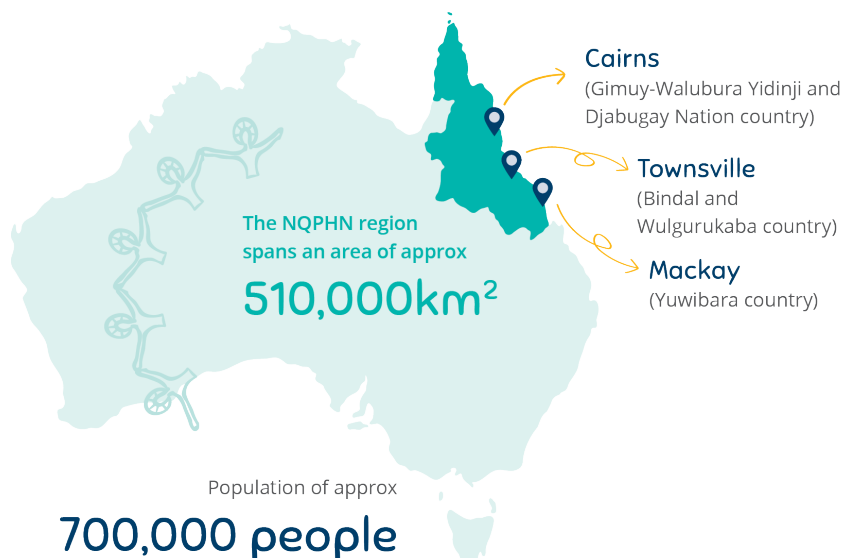
Our region

The NQPHN region is home to approximately 700,000 people, and extends from St Lawrence in the south coast, up to the Torres Strait in the north, and west to Croydon and Kowanyama.

We have over 90 staff operating across three offices in:

- **Cairns** (Gimuy-Walubura, Yidinji, and Djabugay Nation country)
- **Townsville** (Bindal and Wulgurukaba country)
- and **Mackay** (Yuwibara country).

NQPHN is one of 31 regional and independent PHNs established nationally by the Commonwealth Department of Health, Disability and Ageing.





Who this guide is for

Overseas trained doctors new to northern Queensland

For doctors who are:

- new to Australia
- transitioning from overseas systems
- moving from hospital roles into general practice.

Doctors transitioning from other settings

This guide is also helpful for:

- doctors moving from hospital medicine
- doctors returning to general practitioner (GP) work
- doctors entering rural/remote practice.

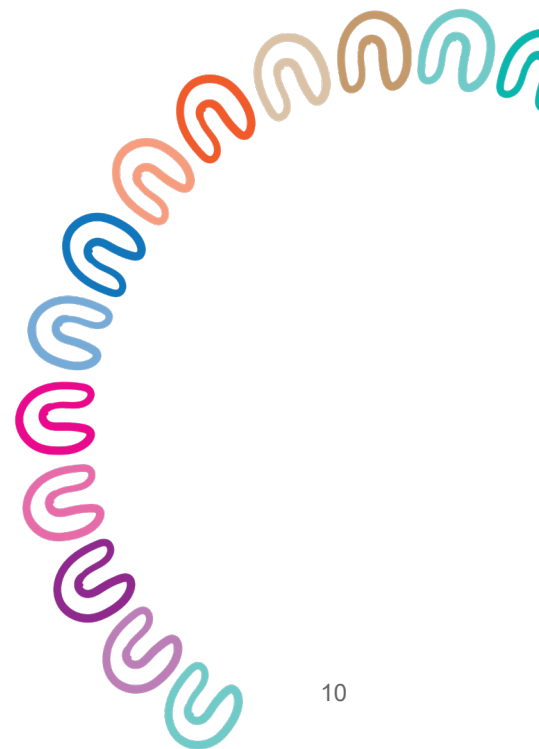
What this guide covers – and what it doesn't

This guide does aim to:

- introduce you to the northern Queensland GP environment
- introduce the NQPHN region
- explain everyday workflows
- support communication and cultural understanding
- cover the basics of MBS billing
- provide practical scripts, scenarios, and tools.

This guide isn't designed to:

- replace RACGP/ACRRM training
- provide legal, visa, or employment advice
- offer detailed clinical guidelines
- give advanced billing interpretation.





Communication, language, and colloquial speech

Communication is one of the most important, and most challenging, parts of transitioning into general practice in northern Queensland. Many overseas trained doctors say this is where they notice the biggest differences compared to previous health systems.

This section focuses on practical, everyday communication: how consultations tend to flow, how patients describe symptoms, and how to build rapport while still managing time, boundaries, and expectations.

Communication style in northern Queensland general practice

In northern Queensland, communication in general practice is often:

- **informal but respectful.**
- **warm and conversational.**
- **patient-led**, with stories rather than short summaries.
- focused on **shared decision-making.**

Patients may use humour, minimise symptoms, or tell their story in detail. Taking a moment to listen before redirecting the consult can help build trust quickly.

A helpful mindset is to aim for:

Friendly, clear, and professional – rather than formal or distant.

Small gestures matter – greeting patients by name, brief small talk, and showing interest in their daily life or work often strengthen rapport. Body language should reflect empathy and that the clinician is attentive to the concerns of the patient.

Understanding colloquial language and slang

Patients in northern Queensland frequently use everyday language, slang, or regional expressions to describe symptoms. This can feel confusing at first, especially when words do not directly match to medical terms.

The below table includes some common phrases you may hear early on, along with their likely meaning and helpful clinical follow-up questions.

Colloquial phrase	Likely meaning	Helpful follow-up question
“I’m feeling crook”	Generally unwell	“What symptoms are bothering you most today?”
“My back’s gone bung”	Acute back pain or spasm	“When did it start, and what were you doing at the time?”
“I’ve had the runs”	Diarrhoea	“How long has it been going on? Any fever or dehydration?”
“I need a sickie”	Request for medical certificate	“What symptoms are stopping you from working today?”
“I’m feeling wobbly”	Dizziness or light-headedness	“Do you feel faint, spinning, or unsteady on your feet?”
“My chest feels tight”	Possible chest pain or shortness of breath	“Is the discomfort sharp, heavy, or spreading anywhere?”
“I’m just worn out”	Fatigue	“How long have you been feeling this tired?”
“The asthma’s playing up”	Worsening asthma symptoms	“Have you been using your reliever more often than usual?”
“It’s flared up again”	Recurrence of a known condition	“What usually triggers it when this happens?”

Rather than guessing, it is always appropriate to **clarify meaning**. Patients generally appreciate careful listening and follow-up questions.


Over time, you will naturally learn the patterns and rhythm of how people speak in your local community.

Strategies when you don’t understand a patient

Not understanding something is normal – even for Australian-trained general practitioners. What matters is how you respond.

Helpful clarification phrases include:

- “Just to make sure I understand you correctly...”
- “Can you describe what that feels like for you?”
- “When you say ‘wobbly,’ what do you notice happening?”
- “Could you show me where it hurts?”



If a patient speaks very quickly, mumbles, or has a strong accent, it is appropriate to say: “Would you mind slowing down slightly so I don’t miss anything important?”

Summarising back what you have heard (“Let me check I’ve got this right…”) also helps structure the consult and demonstrates active listening.

Making your English easier to understand

You do not need to change your accent. Patients in northern Queensland are used to hearing many accents. What helps most is clear structure and simple language.

Practical strategies include:

- using short sentences
- explaining one idea at a time
- choosing plain language over medical terms
- breaking explanations into clear steps.

A useful structure is:

- What you found.
- What it means.
- What the next step is.
- Checking understanding using teach-back (“Can you tell me what the plan is after today?”) helps identify confusion early and supports safe care.
- Visual aids, written instructions, and printed resources are also helpful – particularly for patients managing chronic disease or multiple medications.
- Your supervisors or colleagues should be able to provide you with a list of resources to turn to for reliable patient information and to assist with complex clinical decisions.

Common tricky conversations

Some conversations occur frequently in general practice and can feel uncomfortable at first.

Examples include:

- patients expecting antibiotics for viral illness
- requests for medical certificates that are not clinically indicated
- discussions about mental health, sexual health, substance use, or domestic violence
- managing multiple issues within a short appointment.

Clear, calm language and early boundary setting are key. You do not need to be abrupt – simply explain your reasoning and focus on patient safety and care. Over time, most doctors develop a small set of phrases they return to again and again.



Working with interpreters and multilingual patients

Northern Queensland is culturally and linguistically diverse. Some patients speak English as a second or third language.

Professional interpreters should be used when:

- a patient requests one
- misunderstanding could affect safety or consent
- complex diagnoses or management plans are discussed.

Family members should not be used as interpreters for sensitive or clinical conversations.

When working with interpreters:

- speak directly to the patient
- use short, clear sentences
- pause regularly.

Check understanding at the end of the consult.

Building confidence over time

Confidence with communication grows steadily. In the early months, it is common to feel mentally tired after full clinic days.

Helpful habits include:

- briefly reflecting after challenging consults
- discussing tricky conversations with your supervisor
- borrowing phrases or approaches you hear colleagues use
- observing your colleague consult patients, with the consent of the patient, is a useful learning tool that can help you learn more directly.

Miscommunication happens to everyone. Patients usually respond well when you show care, curiosity, and willingness to clarify.

With time, the language, pace, and expectations of general practice in northern Queensland will feel increasingly natural.

Cultural care reminder: Respectful care starts with listening, asking permission, and working at the person's pace.



Getting started with MBS and billing (essentials only)

This section provides a **calm, practical introduction** to Medicare billing for doctors who are new to the Australian system. It focuses on what you need to know in your **first months of practice**, without overwhelming detail.

What is the Medicare Benefits Schedule (MBS)?

The **Medicare Benefits Schedule (MBS)** is Australia's national list of medical services that can be claimed through **Medicare**. It provides the practice and practitioner with a payment for delivering a particular service. Each service has an **MBS item number**, which determines whether Medicare will pay a rebate, and how much that rebate will be.

In everyday practice, the MBS connects:

- **Patients**, who rely on Medicare to access affordable care
- **You**, the GP, providing the clinical service
- **The practice**, which submits claims and receives payments
- **The Australian Government**, which funds the system

Some services are covered entirely by the Medicare rebate (so the patient has no out-of-pocket cost). Practices can also choose to charge more than the rebate; in that case, the patient pays the difference (often called a *gap* or *gap fee*).

Incorrect billing of **Medicare** could make you liable to pay back the incorrect claims. You cannot bill **Medicare** unless you have seen the patient.

Think of the MBS as a **shared language** between your clinical care and the health system. Learning the basics early makes daily practice much smoother.

You can access information about the MBS online at www.mbsonline.gov.au

Your responsibilities as a doctor

Clinical responsibility vs billing responsibility

As the doctor, you are responsible for:

- providing appropriate clinical care
- selecting the correct MBS item
- documenting your assessment and management clearly and in a timely fashion.

Practice staff (reception, admin, practice managers) usually handle the **technical submission** of claims – but they rely on **your documentation and item selection**.



Why documentation matters

Your notes do not need to be long, but they must clearly show:

- why the patient attended
- what you assessed or examined
- your clinical decision-making
- what management or advice you provided
- the **time spent**, if using time-based items
- any other details which may reflect specific requirements of the item number

Good documentation protects:

- **patients**, by supporting safe, ongoing care
- **you**, if billing is ever reviewed
- **the practice**, by ensuring claims are appropriate
- your colleagues, by providing clinical reasoning for diagnosis and management

A reassuring note on compliance and audits

You may hear others talk about Medicare billing audits early on. For most doctors, audits never occur. The safest approach is simply to build **good habits**:

- choose the item that genuinely reflects the consult
- document clearly and honestly
- ask questions whenever you are unsure
- Billing compliance is about accuracy — not perfection
- Artificial intelligence tools are useful to help compile clinical notes. Discuss appropriate use of AI assistance with a senior doctor in your practice.

Common GP items you'll meet early on

Standard time-based consultation items

Most of your early billing will involve time-based consultation items, often referred to as:

- Level A (item 3): <5 minutes
- Level B (item 23): 6–19 minutes
- Level C (item 36): 20–39 minutes
- Level D (item 44): 40+ minutes.

In practice, it is the **time spent and complexity** that guide item choice – not the diagnosis alone. Practices may also have local preferences or fee structures, which your supervisor or practice manager can explain.



Chronic disease management and care plans (high-level overview)

Chronic disease item numbers are common in North Queensland due to higher rates of conditions such as diabetes, cardiovascular disease and respiratory illness.

These consultations coordinate surveillance of chronic disease to monitor severity, ensure allied health and specialist care continues, and ensure preventive care is up to date.

These items:

- support structured, planned care
- are often completed with practice nurse involvement
- require specific documentation and templates,

You do not need to master these immediately – your practice team will guide you through the process.

Health assessments and preventive care

Health assessments support preventive care for eligible groups, including:

- Aboriginal and Torres Strait Islander patients
- older adults
- patients with identified risks

These items often involve longer appointments and multidisciplinary input. The government incentivises prevention by linking these consultations to subsidised allied health access, and for the doctor, they often attract higher billing rates.

They can generally be combined with standard time-based consultation MBS item numbers.

Telehealth items

If your practice uses telehealth, specific MBS items apply for telephone or video consultations. Telehealth use may be higher in rural or remote areas and during severe weather events.

Telehealth items – key regulations to be aware of

- When using Medicare telehealth items, the same clinical standards apply as for face-to-face care.
- Telehealth items are intended to safely substitute an in-person consultation where this is clinically appropriate, not to lower documentation or decision-making requirements.¹

Key rules to understand early include:

- Email or text-only consultations are **not eligible** for MBS claiming.

¹ Services Australia 2026



Patient eligibility matters

For most GP telehealth items, the patient must either:

- have an **established clinical relationship** with the practitioner (generally having attended the practice face-to-face within the previous 12 months), **or**
- be **registered with the practice under MyMedicare**, in which case ongoing telehealth may be provided by that registered practice even if the patient has not attended in person recently.

There are specific exemptions to these requirements.^{2 3}

Important exemptions apply, including for:

- patients living in areas affected by a **declared natural disaster**
- children under 12 months
- patients attending Aboriginal Medical Services
- patients experiencing homelessness
- certain public health, mental health, sexual health and urgent after-hours services
In these situations, telehealth items may be used even if the usual eligibility rules are not met.⁴

Both the doctor and the patient must be in Australia at the time of the telehealth consultation for Medicare benefits to apply.⁵

Time-based rules still apply

For time-tiered GP items, the **total consultation time must be met and documented**, just as it would be for face-to-face care. For some telephone items, additional claiming limits (such as daily service caps) may apply.

Telehealth cannot be used for all settings

Most MBS telehealth items **cannot be claimed for admitted hospital patients or hospital-in-the-home services**, with limited specialist exceptions.⁶

Local practice policies still apply

Practices may have specific workflows around which telehealth items are used, who is eligible, and how appointments are booked and billed. Always clarify local processes with your practice manager or supervisor.

² Australian Government Department of Health, Disability and Ageing 2025

³ The Royal Australian College of General Practitioners 2026

⁴ Australian Government Department of Health, Disability and Ageing 2025

⁵ MBS Online 2025

⁶ Services Australia 2025

Practical tip for new doctors

If you are unsure whether a telehealth item is appropriate, **check before the claim is submitted**. Telehealth rules change more often than standard GP items and asking early prevents compliance issues later.

Bulk billing, private billing, and mixed billing

What these terms mean in everyday practice

- **Bulk billing:** the patient pays nothing; Medicare pays the rebate directly to the practice
- **Private billing:** the patient pays a fee upfront and receives a Medicare rebate
- **Mixed billing:** some patients are bulk billed, others are privately billed

How billing choices affect patients and practices

Billing approaches influence:

- patient access to care
- practice sustainability
- appointment lengths and availability
- There is no single “right” model – approaches vary across northern Queensland.

What to clarify with your supervisor early

Ask questions such as:

- Who do we bulk bill?
- How do we decide consult levels?
- Do I need to flag item changes to reception?
- What is our approach to after-hours or telehealth billing?

Putting it together in real consults.

Short acute consult (23)

Scenario: Sore throat, uncomplicated presentation.

- Brief history and exam.
- Simple management and advice less than 20 minutes.

Likely item: Short consult item 23.

Longer or complex consult (36 or 44)

Scenario: Diabetes review plus new joint pain and medication review.

- Multiple issues addressed.
- Clinical reasoning documented.

Likely item: Longer consult item 36.



Chronic disease management with care planning (GPCCMP 965)

Scenario: Routine chronic disease review supported by nurse involvement

- Structured review.
- Documented goals and follow-up.

Likely billing: Relevant chronic disease items 965.

You are not expected to match items perfectly on day one. Checking with a supervisor is encouraged.

Getting support with billing in your first months

Questions to ask your practice manager

- Which items are used most often here?
- How do we document time-based consults?
- Who initiates care plans or health assessments?
- What should I do if I think the wrong item was used?

Using your supervisor or colleagues

- Review real consult examples together.
- Confirm documentation is sufficient.
- Talk through item selection decisions.

Further education and billing links for future reference

Additional billing education is available through:

- professional colleges
- PHN-supported education
- webinars and workshops.

You do not need all of this immediately – start with the basics.

Healthcare professional useful resources

- **MBS and DVA billing:** A guide on how to bill Medicare Benefits Schedule (MBS) and Department of Veterans' Affairs (DVA) item numbers
www.servicesaustralia.gov.au/mbs-and-dva-billing
- **MBS Online**
www.mbsonline.gov.au
- **Bulk Billing Practice Incentive Program: eligible services**
www.health.gov.au/resources/publications/bulk-billing-practice-incentive-program-eligible-services
- **Better Billing, MBS Online: What is the MBS?**
<https://www.betterbilling.com.au/mbsonline>

- **RACGP, Medicare Benefits Schedule / Medicare compliance - Summary of useful links**
www.racgp.org.au/running-a-practice/practice-resources/medicare/medicare-benefits-schedule-medicare-compliance

- **Department of Veterans' Affairs, Fees & claims**
www.dva.gov.au/providers/fees-claims

WorkSafe, Fees

www.worksafe.qld.gov.au/service-providers/fees

Common early pitfalls and how to avoid them

Pitfall: Not documenting enough detail.

Tip: Document clearly what you assessed and decided.

Pitfall: Assuming others will fix billing errors.

Tip: Ask early and correct habits quickly.

Pitfall: Trying to learn everything at once.

Tip: Focus first on common consult items, then add complexity gradually.

Building steady billing habits early will save you significant stress later.

Helpful reminders

- It is normal to ask questions every day at the beginning.
- Good documentation protects you, your patients, and your practice.
- Billing accuracy improves with **routine**, not pressure.
- You are not expected to know everything immediately.

Tip: If unsure, check early – correcting habits is harder than asking questions now.





HealthPathways and Smart Referrals

Navigating local care and referrals in northern Queensland

Starting general practice in a new region can feel challenging – especially when referral processes, service availability, and local expectations differ from what you are used to. **HealthPathways** and **Smart Referrals** are two key digital tools designed to help you navigate **how things are done locally** and support safe, timely referrals.

What is HealthPathways?

HealthPathways is a web-based clinical and referral support tool designed to be used at the point of care by GPs and primary care clinicians. Each pathway provides locally agreed guidance on how to assess, manage and refer patients with a particular symptom or condition. Clinicians will need to register with each individual HealthPathways site to access the tool and its features.

HealthPathways in the NQPHN region

The Northern Queensland Primary Health Network region has three HealthPathways, designed to support each of our four regions.

- **Far North Queensland HealthPathways** (Torres and Cape and Cairns and Hinterland regions): <https://fnq.communityhealthpathways.org>
- **Townsville HealthPathways**: <https://townsville.communityhealthpathways.org>
- **Mackay HealthPathways**: <https://mackay.communityhealthpathways.org>

You can locate all local HealthPathways sites online at <https://communityhealthpathways.org/#AustraliaHealthPathways>

Benefits of HealthPathways


- Combine **clinical guidance** with **local referral information**.
- Reflect **local service availability, referral criteria, and processes**.
- Developed collaboratively by **local GPs, specialists, hospitals, and PHNs**.
 - Help clinicians understand “**how things work here.**”⁷

How HealthPathways helps in everyday practice

HealthPathways can support you to:

- decide **what can be safely managed in general practice**
- identify **when specialist referral is required**

⁷ General Practice Registrars Australia 2026

- 
- understand **local referral criteria** before submitting a referral
 - find **patient information resources** to support shared decision-making
 - reduce referral delays and rejected referrals.^{8 9}

Many IMG general practitioners find HealthPathways particularly helpful during their first months, as it provides clear, practical guidance aligned to the **local health system**, not just national guidelines.

What are Smart Referrals?

Smart Referrals is a **secure electronic referral system** used to send referrals directly from general practice software to **Queensland public hospitals and community services**. It is a Queensland Health initiative and is widely used across hospital and health services in northern Queensland.¹⁰

Smart Referrals:

- integrate with common GP software systems
- use **condition-specific referral templates**
- ensure required clinical information is included
- support faster triage and processing by hospital services.

How HealthPathways and Smart Referrals work together

HealthPathways and Smart Referrals are designed to be used **together**:

- **HealthPathways** helps you decide **whether** and **where** to refer, and what information is required.
- **Smart Referrals** is the tool used to **send** a referral electronically to the appropriate service.

Many HealthPathways include direct links or instructions for using Smart Referrals which are directed at the specific health condition or service.

Practical tips for new doctors

- **Use HealthPathways during the consult**, not just after.
- Check referral criteria **before** promising a referral to a patient.
- Ask your supervisor or practice manager which referral system your practice uses.
- If unsure, **document your reasoning** and seek advice early.

Helpful mindset

HealthPathways supports clinical decision-making – it does not replace your judgement. It is there to guide, not restrict, your care.

⁸ General Practice Registrars Australia 2026

⁹ The Royal Australian College of General Practitioners 2026

¹⁰ Queensland Health 2025



Cultural capability and culturally safe practice

Practising medicine in northern Queensland means working alongside Aboriginal and Torres Strait Islander peoples, communities, and cultures that are diverse, resilient, and deeply connected to Country. In the NQPHN region, cultural capability is not an optional skill but a core requirement of safe, effective, and professional general practice.

This section outlines key principles that support culturally safe care in northern Queensland, recognising that strong, respectful relationships, cultural humility, and ongoing reflective practice are essential to improving health outcomes and delivering care that genuinely aligns with Closing the Gap priorities.

Cultural capability, cultural safety, and closing the gap

Cultural capability is a core professional skill in general practice and is essential to delivering safe, high-quality care for Aboriginal and Torres Strait Islander people. Within the Integrated Team Care (ITC) model, cultural capability underpins how care is planned, delivered, and sustained over time. Cultural capability goes beyond awareness of culture. It involves ongoing self-reflection, learning, and adaptation, recognising that health is shaped by social, cultural, historical, and community contexts as well as clinical factors.

What cultural capability means for IMG doctors

For general practitioners working in ITC, cultural capability means:

- Practising with cultural humility, recognising that patients and communities are the experts in their own lives.
- Understanding the impact of colonisation, intergenerational trauma, racism, and inequity on health and engagement with services.
- Delivering care that is patient-led, relationship-based, and respectful of cultural identity and community connection.
- Recognising the importance of family, Country, community obligations, and lived experience when planning care.
- Cultural capability is not about having all the answers. It is about being open to learning, asking appropriate questions, and working respectfully alongside others.

The role of the team in cultural safety

ITC strengthens cultural safety by embedding care within a multidisciplinary team, particularly through the involvement of Aboriginal and Torres Strait Islander health workers and practitioners. These team members bring critical cultural knowledge, community connection, and trust that support patient engagement and continuity of care.

For general practitioners, this means:

- valuing Aboriginal health workers and practitioners as essential clinical and cultural partners
- seeking their input when planning care or addressing engagement challenges
- sharing decision-making and responsibility rather than working independently.

This team-based approach supports safer care for patients and a more sustainable model for clinicians.



Cultural capability in everyday clinical practice

In practice, culturally capable care may include:

- Taking time to build trust through consistent, respectful interactions.
- Using clear, plain language and checking understanding.
- Allowing space for patients to express their priorities and concerns.
- Respecting that patient goals may differ from purely biomedical goals.
- Being flexible with appointment structure, follow-up, and communication where possible.
- Reflecting on one's own assumptions and seeking guidance when unsure.

Cultural safety is determined by the patient's experience of care, not the clinician's intent.

Alignment with Closing the Gap

ITC aligns with Closing the Gap Priority Reforms, particularly those focused on:

- Improving access to culturally safe health services.
- Strengthening partnerships between communities and healthcare providers.
- Supporting coordinated care that reflects patient priorities and strengths.

For IMG doctors, developing cultural capability within ITC supports both professional standards and meaningful contribution to health equity.

A lifelong professional skill

Many general practitioners report that working within ITC:

- deepens their understanding of holistic, relationship-based care
- strengthens their cultural capability over time
- improves patient engagement and continuity
- enhances professional satisfaction and confidence.

Cultural capability is not a one-off competency – it is a lifelong professional responsibility, developed through reflection, relationships, and respectful practice.



Supporting Integrated Team Care for Aboriginal and Torres Strait Islanders

Working in ITC

Integrated Team Care (ITC) supports Aboriginal and Torres Strait Islander people with **complex and chronic conditions** to navigate the health system and access coordinated care.

As a general practitioner, you work within a team-based model that may include Aboriginal and Torres Strait Islander health workers and practitioners, care coordinators, allied health providers, specialists, hospitals, and community-controlled and mainstream services.

Your role includes providing **continuity of clinical care**, chronic disease management, care planning, prescribing, medication review, and referrals, while collaborating with the broader team to deliver **holistic, patient-centred care**.

Cultural safety and team-based care

ITC requires a strong commitment to **cultural safety, respect, and relationship-building**. Trust is developed over time through consistency, listening, and partnership. Many general practitioners find this approach rewarding, as it supports care that reflects patients' social, cultural, and community contexts and aligns with **self-determination and Closing the Gap**.

General practitioners are well supported through:

- care coordinators managing complex care needs
- clear referral pathways
- clinical and cultural support resources
- learning opportunities in chronic disease management and culturally responsive care.

You are not expected to work in isolation – **shared responsibility is central to ITC**.


What cultural safety looks like in practice

Cultural safety focuses on **how care is delivered**, including:

- building trust through consistency and listening
- respecting patient priorities
- working closely with Aboriginal health workers and care coordinators
- using clear, plain language
- recognising social, cultural, and historical influences on health
- practising cultural humility.

Chronic conditions supported through ITC

ITC commonly supports patients with **diabetes, cardiovascular disease, chronic respiratory disease, chronic kidney disease, musculoskeletal conditions, and multiple long-term**



conditions. Care coordination improves access to services, reduces duplication, and strengthens follow-up, with a focus on **long-term wellbeing and self-management**.

Case studies for IMG doctors (RACGP/ACRRM-aligned)

Regional practice case

Dr Patel, an IMG GP under supervision, cares for **Mary**, an Aboriginal woman with multiple chronic conditions. Through ITC, a **Care Coordinator** and **Aboriginal Health Worker** support appointments, follow-up, and culturally safe care. Dr Patel delivers care within scope, using shared decision-making and coordinated planning.

Outcome: Improved engagement, fewer hospital admissions, and sustainable team-based practice.

Remote practice case

Dr Nguyen, an IMG GP visiting a remote community and works with **Tom**, an Aboriginal man with complex chronic disease and access barriers. ITC supports coordination across distance, specialist visits, and follow-up, with strong involvement from a local Aboriginal Health Worker.

Outcome: Improved continuity, reduced fragmentation, and safe, sustainable remote practice.

Key takeaways for IMG doctors

Across regional and remote contexts, Integrated Team Care:

- supports **continuity of care**
- enables culturally safe, patient-centred practice
- shares responsibility within a multidisciplinary team
- operates within structured systems that support safe supervision and escalation
- improves patient outcomes and supports sustainable general practice.

The setting may change, but the principles remain the same: team-based, culturally safe care that meets professional standards and community needs.



Health assessments and MBS billing

Health assessments are structured consultations that support preventive care, early intervention, and coordinated follow-up. They are distinct from standard consultations and have specific eligibility, documentation, and billing requirements.

The correct use of Medicare Benefits Schedule (MBS) items is part of safe clinical practice and Medicare compliance. You can access information about the MBS online at www.mbsonline.gov.au

In many practices, eligible health assessments are **bulk billed** to reduce cost barriers and support preventive care – particularly for patients with higher needs. If your practice bulk bills health assessments, make sure eligibility is confirmed and the correct bulk billing steps are followed (including patient consent), and always work within local practice policy.

Aboriginal and Torres Strait Islander health assessments

MBS Item 715 – Aboriginal and Torres Strait Islander Peoples Health Assessment

- Applies to patients of Aboriginal or Torres Strait Islander descent.
- Available across the lifespan.
- Generally claimable once every nine (9) months.
- Supports access to follow-up services, allied health, and ITC pathways.

This assessment takes a holistic approach, considering physical, psychological, and social wellbeing, and should be informed by patient priorities. Involvement of Aboriginal Health Workers or Practitioners is strongly encouraged where available.

Follow-up services

- **Item 10987:** Follow-up services provided by Practice Nurses or Aboriginal Health Workers under GP supervision.
- Enable structured education, monitoring, and engagement following a completed health assessment.

Non-indigenous health assessments (general population)

Health assessments for non-Indigenous patients are cohort-specific and time-based.

Common GP health assessment items

- Item 701.
- Item 703.
- Item 705.
- Item 707.

The above item numbers are used for eligible patient groups such as:

- adults aged 45–49 years at risk of chronic disease
- older people (75 years and older)
- people with intellectual disability

- refugees and humanitarian entrants
- other specified cohorts.

Each item has minimum time requirements and specific eligibility criteria. Eligibility must be confirmed before billing.

Key billing principles for IMG doctors

- Health assessments are not standard consultations; eligibility must be confirmed before claiming.
- Clarify your practice's approach to bulk billing health assessments (who is eligible, when it applies, and the workflow for obtaining and recording patient consent)

Full documentation is required, including:

- Assessment findings
 - identified risks and needs
 - outcomes, referrals, and follow-up plans.
- Billing should align with practice policy and supervision guidance.
 - When unsure, check first with your supervisor or practice manager.
 - Safe billing is part of professional accountability and good clinical governance.

Health assessments and supervision (RACGP/ACRRM)

Under RACGP and ACRRM frameworks:

- health assessments should be completed within your approved scope of practice
- supervisors should be consulted if eligibility or item selection is unclear
- practice nurses and Aboriginal health workers may assist under GP supervision
- clear documentation supports continuity, handover, and audit readiness (Services Australia).

Health assessments and ITC

Aboriginal and Torres Strait Islander health assessments (Item 715) often:

- identify patients suitable for Integrated Team Care (ITC)
- enable access to coordinated allied health and follow-up services
- support long-term, team-based chronic disease management.

Key takeaways for IMG doctors

- Use Item 715 for Aboriginal and Torres Strait Islander health assessments.
- Use time-tiered items (70 to 707) for eligible non-Indigenous cohorts.
- Always confirm eligibility, timing, and documentation requirements.
- When uncertain, escalate early – do not guess.

Good billing supports good care.



Looking after yourself and thriving

Managing the transition

Common feelings you may experience when managing the transition can include overwhelm, fatigue, homesickness, and imposter syndrome. Remember, these are all normal.

Wellbeing strategies

An important step of maintaining your wellbeing is establishing healthy strategies.

- Set realistic expectations.
- Maintain work-life boundaries.
- Rest deliberately.
- Enjoy the northern Queensland lifestyle.
- Watch for burnout signs and seek help.

Staying connected

There are several ways you might consider building connections, which may include:

- maintaining cultural and family contacts
- joining local GP groups
- peer networks (including locum communities and local GP groups)
- workshops and education
- informal peer meetings
- clinical societies.

Regional clinical societies, where available, can be a great way to stay connected. They bring clinicians together for local continuing professional development (CPD), peer support, and mentoring, shared problem-solving about “how things work here,” and advocacy for sustainable services in rural and regional areas.

- **Professional colleges:** Offer ongoing education, standards, and professional guidance.

Tip: Asking questions early is a strength – it supports patient safety, good habits, and confidence.

Networking with other GPs

Meeting, connecting, and sharing experiences locally

Starting work in a new health system and community can feel isolating at first – especially if you are new to Australia or rural practice. Connecting with other GPs can make a significant difference to your confidence, learning, and wellbeing.

Ways IMG doctors commonly connect with other GPs in northern Queensland include:

- **Your own practice team** – informal conversations with supervisors and colleagues are often the most valuable learning moments.
- **Local GP groups and peer networks**, including informal coffee catch-ups or WhatsApp groups.
- **Education events, workshops, and CPD sessions**, which provide both learning and networking opportunities.
- **Primary Health Network (PHN) supported activities**, including forums, training, and community engagement events.
- **Rural and regional education sessions**, where many doctors share similar transition experiences.

Many doctors find that simply hearing “I’ve had that experience too” helps normalise challenges early on. Sharing experiences, asking questions, and learning from others is part of safe, professional practice – not a sign of weakness.

Tip: You do not need a large network. A few trusted peers you can talk things through with can make a big difference.

Continuing professional development (CPD)

What you need to know as a GP in Australia

All medical practitioners in Australia who are engaged in any form of practice are required by the **Medical Board of Australia** to participate in **continuing professional development (CPD)** to maintain registration with AHPRA.

CPD is designed to support **safe practice, lifelong learning, and professional confidence**. It is not intended to be burdensome, and many everyday activities in general practice contribute to CPD.

Annual CPD requirements (AHPRA)

To meet the CPD registration standard, **each calendar year** you must:

- Be enrolled in an **AMC-accredited CPD Home** that is appropriate to your scope of practice.
- **Develop a written annual professional development plan.**
- **Complete a minimum of 50 hours of CPD**, relevant to your scope of practice, made up of:
 - at least **12.5 hours in educational activities** (such as learning activities, courses, or workshops)
 - at least **25 hours in activities that review performance and measure outcomes**, including a minimum of five hours in each category
 - the remaining hours across any CPD activity type
 - record and reflect on your CPD activities
 - **retain CPD records for three years** in case of audit.

You will be asked to **declare your CPD Home when renewing your registration with AHPRA** each year.



Reassurance for IMG doctors

Most doctors meet CPD requirements gradually across the year through:

- education sessions and workshops
- supervision discussions
- reflective practice
- quality improvement activities
- peer learning and case discussions.

You are **not expected to manage CPD alone**. Your supervisor, practice manager, or CPD Home can help you understand what counts and how to record it appropriately – particularly in your first year of practice.

Northern Queensland is home to **two regional universities** with strong academic outputs and flexible upskilling options (including **short courses, graduate certificates, and graduate diplomas**). Where appropriate, consider local/regional university offerings to support these providers while building your own capability for practice in the north – an added bonus, if any adult children are also looking to study or upskill.

Additional support for rural and regional doctors

Doctors working in rural and regional Queensland may be eligible for **training support or grants** to assist with further education and professional development.

For example, **Health Workforce Queensland (HWQ)** has historically offered funding opportunities for rural doctors to undertake training courses and upskilling activities. Availability and eligibility can change, so it is worth exploring current options and discussing this with your practice manager or regional workforce organisations.

Helpful mindset: CPD is part of looking after yourself professionally – building confidence, capability, and long-term sustainability in practice.

Quick reference resources

This section contains short, practical tools you can return to during busy clinical days – particularly in your first few months.

Glossary of common general practice terms

A quick reference for terms and acronyms commonly used in Australian general practice.

Term	Definition
Bulk billing	When the practice bills Medicare directly and the patient pays no out-of-pocket cost.
Care Plan (GPCCMP)	Structured planning for patients with chronic disease, often involving the practice nurse and allied health.
Health Assessment	A preventive health check for eligible patient groups (e.g. Aboriginal and Torres Strait Islander health assessments).
Item number	The MBS number used to describe and bill a service.
MBS (Medicare Benefits Schedule)	The list of medical services subsidised by the Australian Government.
MBS item number	The number used to describe and bill a service under the Medicare Benefits Schedule.
Mixed billing	A combination of bulk billed and privately billed patients.
Practice nurse (PN)	A nurse working within the general practice team who supports clinical care, recalls and care planning.
Private billing	When the patient pays a fee and claims a Medicare rebate.
Supervisor	An experienced GP who provides clinical and professional support, particularly for doctors new to practice.

Where to seek help

You are never expected to manage things alone – support is part of safe general practice.

- **Practice manager:** Your first point of contact for billing processes, workflows, appointment types, and practice policies.
- **GP supervisor or senior GP:** For clinical guidance, documentation review, and help with complex consults or decision-making.
- **Practice nurse team:** There to support you with care plans, health assessments, recalls, and chronic disease workflows.
- **Primary Health Network (PHN):** A central hub for education, practice support, resources, and connections to local services.

Tip: Asking questions early is a strength – it supports patient safety, good habits, and confidence.



One-page quick reference: Go-to consult phrases

Practical, respectful phrases you can use in everyday consultations.

These phrases are commonly used by GPs in Australian general practice to support clarity, rapport, and shared decision-making – especially helpful in your first months.

Opening the consult

- “What’s been happening for you today?”
- “How can I help you today?”
- “What’s the main thing you’d like us to focus on?”

Clarifying and exploring symptoms

- “Can you tell me a bit more about that?”
- “When did you first notice this?”
- “What makes it better or worse?”
- “How is this affecting your day-to-day life?”

Managing multiple issues

- “We might not get to everything today – what’s the most important thing to start with?”
- “Let’s focus on the most urgent issue first, and we can book another appointment for the rest.”

Explaining findings or plans

- “Based on what you’ve told me, this is what I’m thinking...”
- “What this means is...”
- “The next step I’d suggest is...”

Checking understanding (teach-back)

- “Just so I know I’ve explained that clearly, can you tell me what the plan is from here?”
- “Does that make sense? Is there anything I should explain differently?”

Setting boundaries gently

- “I understand why you’re asking – at the moment this isn’t something I can safely recommend.”
- “I’m not able to prescribe that today, but we can talk about other options.”

Closing the consult

- “Before you go, is there anything else you wanted to ask?”
- “If things change or don’t improve, please come back and see us.”
- “We’ll organise a follow-up to check how you’re going.”

One-page quick reference: Common colloquial phrases

Printable handout for new starters – suitable for desks or clinic rooms

How to use this page

When a patient uses informal or unfamiliar language, pause and clarify. These phrases do not replace clinical assessment – they help you quickly translate everyday language into focused follow-up questions.

What the patient says	What they may mean	Useful clinical follow-up
“I’m feeling crook”	Feeling generally unwell	“What symptoms are bothering you the most today?”
“My back’s gone bung”	Acute back pain or spasm	“When did it start, and what were you doing at the time?”
“I’ve had the runs”	Diarrhoea	“How long has this been happening? Any fever or dehydration?”
“I need a sickie”	Request for medical certificate	“What symptoms are stopping you from working today?”
“I’m feeling wobbly”	Dizziness / light-headedness	“Do you feel faint, spinning, or unsteady?”
“My chest feels tight”	Possible chest pain or SOB	“Is it heavy, sharp, or spreading anywhere?”
“I’m just worn out”	Fatigue	“How long have you been feeling this tired?”
“The asthma’s playing up”	Worsening asthma control	“Have you needed your reliever more often?”
“It’s flared up again”	Recurrence of known issue	“What usually triggers it for you?”

Helpful reminders

- Clarifying language builds rapport – it does not reduce confidence.
- It is always appropriate to ask patients to describe symptoms in their own words.
- Many phrases have different meanings for different people – avoid assumptions.

Tip for new doctors: If unsure, summarise back what you’ve heard: “Let me check I’ve understood this correctly...”



One-page quick reference: Telehealth eligibility exemptions (MBS)

Usual telehealth requirement

Most GP telehealth items require the patient to have:

- a face-to-face visit in the last 12 months, or
- MyMedicare registration with the practice.

When these requirements do *not* apply

Patient-based exemptions

Telehealth **may be used without prior face-to-face attendance or MyMedicare registration** if the patient:

- Lives in an area affected by a declared natural disaster (e.g. cyclone, flooding, severe weather)
- Is a **child under 12 months of age**
- Is **experiencing homelessness**
- Is attending an **Aboriginal Medical Service (AMS)** or receiving Aboriginal and Torres Strait Islander primary care

Service-based exemptions

Eligibility rules are also relaxed for:

- Urgent after-hours GP services
- Public health services
- Mental health care, including Better Access services
- Sexual and reproductive health services.

Rules that always apply

Even when an exemption applies:

- Doctor and patient must both be in Australia.
- Video is preferred; telephone may be used when video is not clinically appropriate.
- Email or text-only consultations are not MBS-eligible.
- Time-based requirements still apply and must be documented.
- Local practice policies and workflows must be followed.

Words of wisdom from other IMGs and practice managers

The weather!
Commonality of certain conditions in the community that are related to lifestyle and culture.

The biggest challenges were navigating paperwork, accreditation, and unfamiliar systems, rather than clinical work. Understanding referral pathways, billing, documentation standards, and local expectations took time. A positive surprise was how supportive colleagues and nursing staff were once I reached out, and how willing people were to help when asked.

Ask questions early and often – no one expects you to know everything. Focus first on learning the systems and workflows, not just clinical guidelines. Keep copies of all documents, stay organised, and don't delay paperwork. Build connections with colleagues, supervisors, and admin staff – they are invaluable. Most importantly, be kind to yourself during the adjustment.

Challenges
Following and finding referral pathways.
Documenting notes in an efficient way.

Working on the communication skills.
Putting some time to check the HealthPathways website.

I wish I had known how much administrative and system-related paperwork is involved, especially around Medicare, RACGP requirements, supervision, and local processes. Clinically, the work is manageable but understanding how the health system functions day-to-day would have reduced stress early on. I also wish I had known how important it is to establish early professional networks and ask for help sooner.

Many northern Queensland patients do not hear the word 'fat' as a diagnosis – they hear it as a judgement. Sensitive, permission based conversations support trust and better outcomes.

Perseverance.
Positivity.



Self-reflection

Prompts:

- What still feels confusing?
- Who can I ask?
- What will I try next week?
- Wins to celebrate.

Practice-specific notes

Sections for:

- Billing rules.
- Key contacts.
- Referral pathways.
- Workflow reminders.

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