SESSION 1: USING PARTNERSHIPS TO ADDRESS INEQUALITIES

Building the trust – Using community networks to improve Aboriginal health outcomes.

Presenters

- Susie Latham, Program Manager Population Health, Central Highlands Division of General Practice
- Debbie Pepper, Berry Street Victoria & Committee member, Jaambie Neighbourhood House

Description

This presentation will outline the experience of Central Highlands Division of General Practice in locating and working with an Aboriginal community with significant unmet health and other needs. The Aboriginal community in Seymour wants to establish an Aboriginal co-operative and the Division has worked with them and other agencies towards this goal. The relationships that have developed over time have laid the groundwork for better health outcomes in the future.

Mobile Integrated Health Program – Low-cost accommodation.

Presenters

- Dr. Ron Korman, Peninsula Community Health Service
- Ms. Joanne Fitzgerald, Peninsula Community Health Service

Description

In 2000, the Peninsula Community Health Service via the M.I.Health program received state and federal funding to establish an outreach program to people living in low cost and insecure accommodation. 12 months later the program expanded to include funding for a visiting GP program into Pension only Supported Residential Services in the City of Frankston and Mornington Peninsula Shire.

The presentation will highlight the strategic partnership between the Community Health Service, two local GP's and the proprietors of the residential services. The program recognises the diversity of partnership backgrounds and meeting the needs of complex care residents. It will speak of the previous glaring inequalities for residents of SRS's in accessing medical and nursing care management. The presentation will also inform participants of the establishment of the program, how the program was implemented, some of the lessons learnt and the health outcomes for residents.

How successful are divisions of general practice in forming partnerships with others to address inequalities in health care?

Presenter

- Dr John Furler, senior lecturer, Department of General Practice, University of Melbourne

Description

Divisions of General Practice should be a "base where general practitioners (GPs) can work with their community and other health professionals to improve local health outcomes". Improving local health outcomes remains their core purpose.

Internationally, GPs working in groups such as Primary Care Trusts in the UK, and Primary Health Organisations in NZ, are charged specifically with not only improving the health of their populations but also reducing health inequalities.

Australian Divisions receive infrastructure funding weighted for, inter alia, the rural and remote location, socio-economic status, and Indigenous population of their community but are not charged specifically with reducing health inequalities. Nevertheless in the Annual Survey of Divisions, many report activities aimed at improving access to GP services and in delivering outreach or designated services to particular population groups, such as Aboriginal groups. In our analysis of a sample of Division strategic plans and first year business plans we looked for evidence of partnership approaches to addressing the needs of socioeconomically disadvantaged groups.

Most plans included discussion of the socioeconomic mix of the community, but few discussed the unequal burden of disease experienced within their communities. No needs assessments explicitly addressed equity issues.

Divisions were widely linked to other agencies, providers, community groups and bureaucracies within their communities, often through membership of committees. There was a strong emphasis on process (e.g. representational activity). A significant percentage of plans included an intention to collaborate with other community agencies (especially Indigenous community organisations) and health care providers to improve access to care locally, and a small number planned joint advocacy on behalf of disadvantaged communities. While nearly all plans mentioned intent to collaborate with consumers, only one, through a Consumer Health Advocacy Group focused on this as a strategy to address inequity or disadvantage.

The implications of these findings will be discussed.

1. Furler J, Harris E, Harris M, Powell Davies G, Traynor V, Rose V, et al. Do Divisions of General Practice have a role and the capacity to tackle health inequalities? Australian Family Physician 2002;31(7):681-3.

SESSION 2: COORDINATION AND COLLABORATION IN PRIMARY CARE

A framework for analysing primary care provider relationships

Presenter

- Lucio Naccarella, Department of General Practice, University of Melbourne

Description

Introduction

The General Practice Strategy Review emphasized the need for primary health care integration. Terms such as 'integrated care', 'collaborative care', 'shared care' and 'teamwork' describe GPs work with primary health care providers. However, such terms provide limited insights into *how linkages function/operate.*

General practice is an 'organizational system' consisting of professionals interconnected via networks, interpreting, sharing and acting on information and knowledge to get their job done. General practice research would benefit from ***Social Network Analysis*.** Methods. These are specifically designed to describe and measure organisational systems or the patterns of interactions among people. This paper presents the underpinning methodology and findings of a study designed to trial data collection methods based on a social network approach with the goal of understanding how GPs work together with other primary health care providers.

Objectives

The overall study aims to develop a measurement approach to understand patterns of interaction between GPs and other primary health care providers. Patterns of interactions will be described, as will what has contributed to these relationships and the consequences of these relationships.

Methods

Due to the exploratory nature of the study, a qualitative approach (semi-structured interviews) will be conducted with GPs plus GP Clinic Staff. Primary health care providers with whom GPs interact with will also be interviewed to explore their perceptions of their interactions with GPs.

So What?

For policy makers, program funders and managers the study will inform the future development, implementation and evaluation of policies, structures, programs designed to encourage GPs to work with other primary health care providers.

Getting ACROSS Dementia – A Collaborative Primary Care Education and Management Project.

Presenters:

- Dr Sam Scherer; Southcity GP Services; Prahran. Victoria
- Elizabeth Rand; Alzheimer's Association of Victoria; Hawthorn, Victoria
- Pru Ingram Cognitive, Dementia and Memory Service; Caulfield General Medical Centre

Description

Background
Dementia is strongly age-associated and we are currently experiencing a major increase in cases, predicted to peak at up to one million by the middle of this century. GPs play a pivotal role in recognising, assessing and managing patients with dementia and their carers.

The complex and multidimensional issues involved in high calibre care of people with dementia offer a potential laboratory for the development of a model of integration of general practice, other elements of primary care, consumer and carer organisations and secondary referral and specialist services.

Program Outline
In 2000, outside the framework of funded coordinated care trials, Southcity GP Services independently initiated a collaborative 2-year project with the Alzheimer's Association of Victoria (AAV); the Cognitive, Dementia and Memory Service (CDAMS) at Caulfield General Medical Centre; other local agencies; and consumer representatives, with the aim of improving the management of people with dementia in the Inner South Eastern suburbs of Melbourne.

An education and information kit was distributed to all 120 Division practices, with the offer of personal delivery and introduction by an AAV counsellor, and the kit was later placed on the Division website. It covering the educative elements of the program:

1) Knowledge for coordination of dementia diagnosis and management
2) A focus on the carer role and the needs of the carer
3) A referral and resource information directory.

Follow-up teaching forums included seminars on dementia diagnosis and management and multidisciplinary interactive workshops focussing on case studies.

Program Evaluation
A total of 102 GP's participated in elements of the program, which brought them into contact with representatives of primary and aged care services including councillors, consumer representatives, nurses, social workers, occupational therapists speech pathologists, neuropsychologists, geriaticians, and psychogeriatricians.

Qualitative and quantitative pre and post program data on GP attitudes, skills, knowledge, and referral patterns indicated that the program resulted in a significant change toward a greater intention to refer dementia patients and their carers to AAV and CDAMS; an increased recognition of the benefits of multidisciplinary collaboration; as well as more confidence in diagnosis and management. The results suggest that the program provides a model for successful high quality primary care coordination and collaboration.

Integrated Disease Management (Diabetes): Breaking through the Barriers.

Presenters

- Dr Graeme Downe, Dandenong Division of General Practice
- Ms Christine Crosbie, South East Primary Care Partnership

Description

This presentation will describe a model of diabetes care that successfully 'integrates' private practice GPs with the state-funded sector, in particular with community health and the acute sector. The Integrated Disease Management (Diabetes) Project is a DHS-funded project of the South East PCP. Major partners include Dandenong District Division of General Practice (DDDGP), Southern Health & City of Greater Dandenong. A unique feature of this model, The Diabetes Coordination & Assessment Service is located at the DDDGP site. The model aims to improve service coordination and achieve an integrated approach to diabetes care between primary health care providers.

While evaluation is not yet complete, preliminary data demonstrates at least three crucial outcomes:

- Establishment of an effective referral pathway for GPs;
- Implementation of processes to ensure higher quality communication between GPs and other health professionals, and
- Delivery of a self-management program that provides greater access for patients/consumers to evidence-based, best practice care.

As at November 2002, more than 100 eligible patients have been referred into the program by their GPs since July. These patients have received timely, quality services designed to achieve optimal health outcomes. Ways in which the model has addressed the key consideration of sustainability of this innovative approach will be discussed.

SESSION 3: HOSPITAL SYSTEMS THAT PROMOTE COORDINATION OF CARE

Enhanced Primary Care – An Asset To Hospitals

Presenter

- Dr Linda Danvers (Ballarat & District Division of General Practice & GPLO Ballarat Health)

Description

The trial

In mid 2000, an identified priority of the Ballarat and District Division of General Practice was to encourage the up-take of the new EPC item numbers within hospitals. This trial was undertaken by the General Practitioner Hospital Liaison Officer which is a joint position between Ballarat Health Services and BDDGP. The purpose of the trial was to introduce Ballarat Health Services to the involvement of GPs in discharge and post-discharge case conferences, where the defined criteria were met. (RACGP "Enhanced Primary Care" page 73-74). The key objectives of the project were to:

- improve communication between GPs, hospital staff and other care-givers;
- decrease hospital readmission rates
- enhance patient confidence & understanding
- increase the profile of GPs in the hospital

The implementation plan for this trial was to engage 10 patients and their General Practitioners from the Ballarat Health Services, Gandarra Palliative Care Unit. The Medical Director of Gandarra Palliative Care Unit took responsibility for identifying patients who met the eligibility criteria, contacting the GP regarding attendance at a case conference, obtaining patient consent, organizing and conducting the case conference and providing the requisite case conference summary and patient management plan

All GPs in the BDDGP were notified of the trial and requested to formally consent to involvement. In all 22 replies were obtained – 18 giving consent and 4 withholding consent. A package of paperwork was developed to aid the organisation of the case conferences, and this included:

- GP request form for participation in Case Conference (to be faxed to the GP)
- Patient consent form and list of Case Conference attendees
- Aims and Outcomes of Case Conference
- GP information – Case Conferencing
- Patient Information – Case Conferencing

This paperwork was based on that developed independently by the Epworth Hospital and the Austin and Repatriation Hospital, but was individualized to suit the needs of the trial.

The proposed conference presentation will provide an overview of achievements against the project objectives allowing question time to give consideration to barriers to uptake of EPC in the Hospital environment.

St Vincent's Hospital Enhanced Primary Care Project

Presenters

Rebecca Power, Chief Social Worker, St Georges Hospital
Renae O'Toole, Nurse Unit Manager, St Vincent's Hospital – Caritas Christi, Fitzroy

Description

The Enhanced Primary Care (EPC) project operated throughout St Vincent's Health Aged Care Services during 2002. The initial brief of the project was to improve continuity of care for patients with chronic and complex care needs being discharged home. Improving two-way communication with GPs was a central focus of the project.

To begin the project, St Vincent's identified patients with complex care needs. A new process ensured that GPs were contacted at admission, during care planning and on discharge. GPs were given the option of contributing to the discharge conference and plan. In recognition of the complex issues facing this patient group, a multidisciplinary 'discharge summary' template was introduced. The summary gave GPs a holistic account of patients' issues and subsequent interventions in a clear, easy-to-read format.

The enthusiasm with which staff embraced this initiative, along with a positive response from GPs, spurred on the development and extension of the project. The breadth and scope of the EPC concept was widened and its application revised. As a result, St Vincent's Health Aged Care Service now has a discharge database for all patients using the service. The database enables the provision of an advanced multidisciplinary referral system; it records case conferences and provides personalized patient information brochures. It represents improved integration across St Vincent's Aged Care Services and the beginnings of a coordinated approach across the continuum of care.

The application of the EPC concept within St Vincent's Aged Care has been very positively evaluated. Staff, patient and GP surveys and comments have highlighted encouraging outcomes. The information produced by the database is patient friendly, and GPs appreciate the holistic and readable nature of the summaries. The system has improved accountability of staff to all involved in the patient care system and it encourages integration across service providers. The capacity of the database to produce reports on trends, performance and quality provides excellent opportunities for service development and research.

The database application will continue to evolve taking into account our expanding experience, evaluation and initiatives. It forms a springboard for us to realize the dream of fully integrated care across the continuum.

Aspects of a communication audit to shared maternity care affiliates at three Melbourne hospitals.

Presenters

- Dr Susan Nicolson, Mercy Hospital for Women
- Dr Jenny Gore, Sunshine Hospital
- Dr Ines Rio, Mercy Hospital for Women

Description to follow

There are approximately 1100 GPs accredited with the Mercy Hospital for Women, The Royal Women's Hospital and Sunshine Hospital to undertake shared maternity care. Our experience as General Practice Liaison Officers and Shared Care Coordinators has been that communication between the hospital and community providers in the provision of shared maternity care is of concern.

As part of a DHS-funded project between the 3 hospitals and 5 Divisions of General Practice, we evaluated communication between our hospitals and community providers of shared maternity care. Audits were conducted in January 2001 and September 2002 and examined a number of indicators designed to measure communication. These included: letter of enrolment being sent to GPs; GPs being informed of results of a range of investigations performed at the hospitals; GPs being informed of Emergency Department presentations, unscheduled admissions, cessation of shared care and birth of the baby. Interesting lessons learnt from these audits will be discussed.

SESSION 4: THE GP LIAISON OFFICER: A REVIEW OF THE ROLE

Bringing the GP perspective to a hospital…a heroic tale of myths, too much coffee and one IT person.

Presenter

- Dr Sharon Monagle, GP Consultant to Southern Health, Member of Central Bayside Division.

Description

I intend to reflect on almost 12 months of GP liaison at Southern Health, a role I commenced in May 2002, and a new role for this organisation. I will describe the cultural barriers that stand between hospitals and GPs, how these barriers can be addressed (evidence and anecdote), why we should bother and what the roles are of the GP, GPLO and the hospital. In particular, I will emphasize the need for all providers to take a whole-of-health-system approach to looking for solutions both in the acute and the primary care sectors.

This is a work in progress, as I am still in the process of discovery! However, I feel that an interesting picture which will emerge, and I will be keen to share the experience.

Eastern Health GP Liaison Project

Presenter

- Alina Tooley, Knox Division of General Practice

Description

This presentation will present an overview of the recently commenced GP Liaison Project that has been funded as part of the Victorian Department of Human Services HARP initiative.

The model involves a GP Liaison Team (GPLT) and a Project Reference Group. The GPLT consists of:

- Three part time GP Liaison Officers for Knox, Eastern Ranges and Whitehorse Divisions of General Practice. They have been recruited from their respective Divisions and are engaged for 4 hours per week.
- Two full time Project Officers covering the four Eastern Health Hospitals and the Peter James Centre. Whilst each project Officer covers specific hospitals, the positions function as a flexible team developing standardised resources and common frameworks across campuses. The Project Officer is shared between Knox and Eastern Ranges Divisions and the other Project Officer is based at Whitehorse Division of General Practice.

The role of GPLT includes:

- Participating in planning for and evaluation of initiatives that Impact on GPs related to:
- Discharge planning
- Informing Divisions and their members or initiatives and engaging GP participation.

- Developing policy frameworks supporting effective relationships with GPs and the hospitals at all levels and on particular issues and practices eg discharge planning, communication issue.
- Contributing to the development of initiatives or Project specific policy and procedures related to the role of GPs
- Identifying and supporting opportunities to enhance relationships between GPs and other local providers in working with high risk and high need clients
- Identifying and communicating GP concerns
- Linking specific patients to GPs and, as necessary, facilitating communication and issue resolution on specific patient matters
- Preventable ED attendances
- The development of diversion programs
- Tertiary prevention programs

The GP Liaison Project Reference Group consists of representatives from each of the Divisions, Eastern Health representatives including Hospital Managers and those involved with HITH, HDM and HARP initiatives and community provider representatives including PCP representatives.

The broad role of the Reference Group is to ensure effective communication and coordination around initiatives relevant to the Project.

Mobile Assessment and Treatment Service (MATS): GP liaison by stealth

Presenters

- Dr Netta Duggan, The Alfred, Melbourne

Description

Mobile Assessment and Treatment Service (MATS), based at The Alfred in Melbourne, is an innovative ambulatory medical service charged with providing advanced medical care to nursing home patients. The service aims to provide appropriate treatment for elderly patients in their places of residence and to avoid transfer to a tertiary facility. It also facilitates early discharges for elderly inpatients, and aims to substitute community visits for outpatient appointments. The key focus to the management of patients is to involve all players – family, Nursing Staff and the GP.

During the 12 months the service has been in operation we have noted many areas of concern in relation to a smooth interface for patients between tertiary and primary care. In particular we identify the information flow between GPs and hospital teams as problematic, impacting significantly on the successful management of the patient in both settings. In these instances MATS has been able to provide a GP liaison role.

The presentation will use patient examples to illustrate areas where MATS has identified a need for improvement or where MATS has had some success in bridging the gap.

SESSION 5: EFFECTIVE INTEGRATION: SOME KEY COMPONENTS

Sustaining integration: it's how we do things round here

Presenter

- Gawaine Powell Davies, Centre for General Practice Integration Studies, University of NSW

Description

For the last ten years or so there has been a continuing focus on improving integration between general practice and other health services, both vertical (GPs and hospitals/specialists) and horizontal (GPs and other primary health care services). More recently there has been a move from purely local initiatives such as shared care programs to state and national programs which try to bring about change on a larger scale. In spite of the effort that has gone into this work, the results to date are still somewhat patchy. Some areas have extensive arrangements for sharing care where others have none. Many programs have problems with reach and sustainability. The limits to what we have been able to achieve reflect the real difficulties of working across sectors, each of which is in its own way under-equipped for sharing care.

This workshop will address one of the key issues for sustaining integration of care and ensuring broad reach at local level: making integrated care part of normal practice - 'the way we do things round here'. It will review the options for building it into management systems and processes of care, and highlight both the costs and the benefits of different approaches.

The workshop will draw on the experience of the audience.

Not By Education Alone…Stages Of Change And System Reform

Presenter

- Dr Larry Osborne, Dandenong Division of General Practice

Description

The work conducted through a multi-divisional project on the role of the General Practitioner in the management of patients with both substance abuse and mental health issues, emphasised the role of education and training in encouraging GP's to become more involved in the care of these patients and their families. A sophisticated model of training needs was developed which recognised that different educational interventions were relevant to the particular knowledge, attitudes and skills of GPs. While broader systems issues were considered, no attempt was made to intervene at a "macro" level. It seems that the outcome of this project is that there has not been a significant increase in interest by the majority of GPs in these patients. Clearly this is of concern given current initiatives to engage GPs in the management of more complex mental health issues.

This paper presents an expanded model for GP engagement in system reform in the care of patients chronic and complex illnesses in the light of earlier Dual Diagnosis work. The approach advocated is to take the well known "Stages of Change" model and build into that framework some of the psychological issues likely to be experienced by GPs when they are asked to modify their clinical work to manage new clinical problems. The model could help broaden the understanding of the specific educational and training requirements of GPs as they move into the relatively unknown clinical situations.

Further data will be collected regarding the particular issues involved in GP care of these patients through a Primary Health Care Research Fellowship in order to provide evidence for the model.

Hospital & GP Integration – The establishment of integrated and supported medical services

Presenter

- Dr Peter Goodwin, Logan Area Division of General practice

Description

The Logan Area Division of General Practice is collaborating with its local Public Hospital and Community Health Services to achieve integrated and supported medical services to patients with diabetes, CVD, obesity, and asthma/COPD based on innovative changes in clinical pathways and home-based care. Hospital specialist staff will have protected time to consult with GPs on treatment plans, both one-on-one with respect to complex problems, and in small groups, with potential to use small group learning and case conferencing. Community Health Nurses will have 'in-reach' into the hospital, allowing contact with patients in the emergency ward, as inpatient, or in outpatients. A single point of triage will allow maximum efficiency of allocation of resources, both in hospital and in home care.

The expected outcomes are:

- A lower admission rate to hospital
- Fewer and more critical outpatient referrals
- More quality in-home primary care
- A win for GPs with better home care resources leading to reduced need for frequent at the surgery service
- Improved support for GP practices to enable the GP to comfortably continue the care of more complex medical problems
- Improved communication between the tertiary and primary sector, ultimately resulting in reduced duplication of services