CENTRE FOR HEALTH
PROGRAM EVALUATION

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An evaluation of the Victorian rollout of the new MBS items for GPs: GP Education, Support and Community Linkages

FINAL REPORT
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The University of Melbourne
Department of General Practice, School of Medicine, Dentistry and Health Sciences
& The Centre for Health Program Evaluation, School of Population Health

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Executive Summary

The GP Education, Support and Community Linkages Program (EPCESCL Program) has supported implementation and appropriate use of the MBS items since the beginning of 2000. The provision of training and resources to assist GPs and other providers was intended to have a positive impact upon the usage and uptake levels of the EPC MBS items. General Practice Divisions– Victoria Ltd. commissioned this evaluation to assess the implementation of education, support and community linkages via the divisions program in Victoria. At national level, an evaluation of the EPC MBS items and the EPCESCL program is also currently underway.

Semi-structured interviews took place with the CEO, EPC Coordinator and GP Trainer from each Victorian Division of General Practice. These personnel provided feedback on how the EPCESCL program had operated at state and divisional level. The perspectives of GPs and other health providers who received education as part of the program were obtained for triangulation purposes.

The interviewees noted achievements in the uptake of the MBS items during the course of the program's operation. This trend had occurred in spite of some concurrent changes within the divisions, notably staff turnover, which could have influenced optimal implementation of the program. Due to the complexity of the EPC items and the systems and cultural changes their usage required, EPC co-ordinators who commenced mid-way through the program felt at a considerable disadvantage.

The interviewees acknowledged the support that GPD-V had provided to assist program implementation. The 'train the trainer' model was seen as a valuable approach to adopt, although there were some reservations about its actual operation.

Multiple strategies were used in the program's education component. Large CME events were mainly used for awareness raising, for trainees to understand the EPC concept and broad parameters of the items' use. Practice visits, and in some divisions, small group training, were used for imparting detailed information and delivering the proformas and the technical support necessary to use the items. The practice visits appeared to be the key vehicle for removing the barriers to GPs using the items, rather than the large CME events. Essentially, it had been the technical and practical systems support rather than the awareness raising and education of GPs that were the main success factors behind the uptake of the items.

There was much higher uptake of the health assessment than the care planning items and very limited usage of the case conferencing items. Many divisions reported that the extent of culture change underpinning the items' usage had been underestimated . Usage required a shift from 'problem based consultations' to 'population health and preventative health based consultations'.

GPs have traditionally tended to work independently rather than in conjunction with allied health professionals, which may explain the poor case conferencing uptake. Some divisions considered case conferencing 'too hard' and chose to focus their attention on health assessments. The use of case conferencing was chiefly limited to GPs who already worked in some way with allied health professionals. The EPC items seemed to formalise and enhance existing relationships, with limited impact on GPs who did not already have a relationship with other providers. Considerably more work and effort is needed to promote sustainable culture change amongst GPs.

The items also required significant systems change at the practice level. The use of the items required the assistance and active participation of a range of practice staff in addition to the GP. The EPC items required a re-think of how a practice is organised and operated. Practices needed to have the capacity to access and recall particular types of patients, for example patients who are over 75, or who have chronic diseases such as diabetes. Thus, the EPCESCL program complemented other divisional initiatives such as IT support, and chronic diseases programs.

A number of respondents highlighted that the EPC program was too focused on the 'numbers'. The quality of item usage appeared variable. Many respondents suggested that the quality of conducting the EPC item activities needed to be assessed. In addition to the uptake statistics, there needed to be success criteria that measured other indicators, such as systems and cultural changes.

Sustainability and capacity building were the final components assessed in this evaluation. Overall, there was considerable agreement and corroboration amongst and within divisions' CEOs, EPC Coordinators, and GP Trainers that the EPCESCL program had contributed to divisions' capacity (i.e., workforce development, organisational development, resources) to support GPs to use the EPC items. Several key strategies emerged by which divisions intended to sustain the EPCESCL program including:

- actively transferring EPC knowledge and skills to all divisional staff;
- integrating EPC into existing practice support programs;
- incorporating EPC into divisional business and strategic plans; and
- providing ongoing support and resources

The EPCESCL program had been hampered by limited funding, its short-term timeframe and a lack of continuity in the support provided. The model adopted in Victoria of centralised support and local delivery had inherent advantages such as increased ownership and program integration. However, the flexibility also had disadvantages, related to variable quality of implementation at both division and practice level.

The lack of timely, centrally developed proformas, tools and templates resulted in considerable duplication and resource wastage as each division developed their own material. Whilst there was some sharing of information between divisions, this could have been done in a more strategic and co-ordinated manner.

Several tentative patterns emerged regarding the implementation of EPC support. For example, for divisions that had existing related initiatives/projects the EPCESCL program appeared to provide a platform for further building capacity. In divisions that were in the process of reviewing organisational structures and directions the EPCESCL program acted as a catalyst for clarifying capacity building dimensions.

It is important to recognise that there appeared to be limited understanding of the concept of capacity building and overall, interviewees did not necessarily conceptualise the GPD-V program as a capacity building program.

These results need to be interpreted with caution. They have emerged predominantly from self-report data (semi-structured interviews). Furthermore the context within which the EPCESCL program has been implemented needs consideration. To a certain extent capacity building and item usage may have been influenced by factors beyond the direct control of the program including: the dynamic status of General Practice; specific providers of EPC education, training and support; the current evidence base; perspectives of other service providers; and the heterogeneity of GPs.

Key Messages Emerging from the Evaluation

Specifically for the EPCESCL program

1. Items will continue but need more work for systematic use

In one sense, EPC item usage will continue so long as the items can be claimed and GPs receive payment. However, much more work is needed to promote and ensure that the items are being used as intended and on a systematic basis, rather than in the current, seemingly ad hoc manner.

2. Significant culture change to way GPs operate

EPC item usage requires significant culture and organisational change. Further work is needed to support GPs provision of 'health promotion and preventative focused' consultations as opposed to 'problem centred' consultations. GPs also need to work more closely with allied health professionals for case conferencing item usage to increase. These changes will 'value add' to practice level changes such as the use of IT systems, and well as the chronic diseases initiatives.

General recommendations for future statewide GP education and support programs

1. Program rationale needs to be clear

The rationale for the initiative itself and the rationale for the way it is being supported in each State and division needs to be clear to all players. This message needs to be repeated often during initiative. Staff change and people can often lose sight of the overall objectives whilst focusing on the strategies.

2. A range of criteria for success

There needs to be several criteria for 'success' to take into account quality issues. Other criteria can relate to the causal factors identified. This serves two functions: firstly progress can be monitored for critical factors and enablers; and secondly divisions can have additional indicators and shorter term successes. The uptake of the EPC items required significant culture and organisational change. Many divisions considered that the sole success criteria of item usage did not reflect their achievements in addressing some of the barriers to the EPC item use. It would seem advantageous to have additional criteria for success to measure shorter term successes in promoting enablers and addressing barriers.

3. Coordinated development of materials

There needs to be a coordinated approach to the development of materials relevant to the different audiences. Timely and centrally developed material is needed. Two sets of materials are generally required:

- Brief summary material, written in a language GPs can relate to.
- Proformas, tools and templates, both paper and IT versions.

Translated material also needs to be centrally developed for a range of patient (and GP) information needs.

4. Supporting late starters

Programs need to be able to meet the needs of Divisions with a changing workforce. A Statewide approach should take into account the support needs of GP trainers and other staff starting later in a program's cycle.

5. Explicit aim of capacity building

A Statewide and division explicit commitment to capacity building has more chance of achieving a sustainable adoption of change in GP practices than an education approach alone. Although capacity building was an aim of the EPCESL, many divisions did not operationalise the project with this in mind.

6. Timeframe of program tailored to size of task

The size and complexity of the cultural shift needed to achieve the required change should determine the length of time allowed for the education and support program.

7. A range of models and stages are needed

The 'Train the Trainer' approach and the use of GP advocates were important strategies in the program's awareness raising stage. However, practice and systems level support were also needed to impart the detailed information and help establish systems to enable the items to be used.

Introduction

The Commonwealth Government in its 1999/2000 budget introduced the Enhanced Primary Care (EPC) Package. Its purpose was to improve the health and well being of older Australians and people with chronic conditions and multidisciplinary care needs. One component of the Package was a range of 21 MBS items to enable health assessments for older people and multidisciplinary care planning and case conferencing for people with chronic, complex care needs. A budget of $110 million over four years was provided to fund the item usage. A further $8.1 million was allocated to support the uptake of these items via the GP Education, Support and Community Linkages Program (EPCESCL).

The EPCESCL program has supported implementation and appropriate use of the MBS items since the beginning of 2000. The provision of training and resources to assist GPs and other providers was intended to have a positive impact upon the usage and uptake levels of the EPC MBS items. Three main strategies were associated with the program:

- Implementation of education, support and community linkages via the Divisions program, coordinated by ADGP and auspiced via EPC coordinators in each SBO
- RACGP Standards and Guidelines
- Clinical Audit Package

The evaluation reported here was commissioned by General Practice Divisions – Victoria Ltd. to assess the first of these strategies, as executed in Victoria. At national level, an evaluation of the EPC MBS items and the EPCESCL program is currently underway.

The report contains eight sections. The first outlines the methodology used. The second provides contextual data about the divisional personnel who were responsible for implementing the Victorian EPCESCL program. It incorporates their feedback on the support they received to assist their role. The third section gives a description of the implementation of the program's components.

The fourth section considers the effects of the train the trainer model and whether it assisted the program's implementation. The fifth section gives closer analyses of the program's achievements and the extent to which they were met. The sixth section focuses upon the ways divisions worked with other agencies. It provides the other health providers' perspective on the effectiveness of the linkages and reviews strategies for future collaboration. The seventh section reviews the extent to which the program had built capacity in the divisions. The final section uses the RE-AIM model to summarise the program's evaluation. It highlights the stages that have been critical to achieving an increase in EPC item usage.

Methodology

The evaluation had four phases:

- Phase 1 Planning: The quarterly reports from the divisions to GPD-V and from the SBO's EPC Coordinator to the Commonwealth were reviewed, along with the EPC MBS item uptake statistics. Data collection tools were developed. All Victorian divisions were contacted, requesting their participation in the project.
- Phase 2 Data collection: Telephone interviews with EPC Coordinators, GP trainers and Division CEOs were arranged. Ethical approval for the recruitment of trainees (GPs, Practice nurses, practice managers) was sought.
- Phase 3 Analysis: data analysis to produce an overview of the GPD-V model and to identify case studies.
- Phase 4 Dissemination: of report and case studies via existing networks and statewide workshops.

Data collection

The evaluation methodology has been implemented as per the table below. Telephone interviews with all GP trainers, EPC coordinators and Divisional CEOs were completed by mid-March. (CEOs, N=19, EPC Coordinators N=26, GP Trainers N=19). The second phase of interviews engaged a sample of trainees and other providers, selected to reflect the diversity of implementation approaches, to provide supplementary data and representative case study illustrations. Following ethical approval from the University of Melbourne Human Research Ethics Committee, data was obtained from two main sources:

- A sample of multi-disciplinary providers who attended one of the workshops facilitated by Cathy Sutherland for the Department of Human Services (DHS)
- A sample of multi-disciplinary providers who attended a workshop facilitated by one of the Divisions of General Practice (DGP).

Purposive sampling was employed to meet the evaluation objectives. With regard to the DHS trainees, we focused upon a rural location where a broad range of providers, including GPs, was represented. A similar sample was obtained from an urban fringe DGP.

Finally, to supplement the information obtained from primary and secondary data sources, formal face-to face interviews with the GPD-V EPC Coordinator and the DHS facilitator were conducted.

Data analyses

Data was entered onto Access databases. Reports were compiled of the interviewees' responses to the questions (The interview schedules used appear as Appendices). The key themes arising were explored using content analysis techniques.

Hypotheses regarding factors associated with item uptake at division level were generated and tested across the four quartiles of item uptake. Attempts to obtain adjusted data from the National Evaluators for this purpose were unsuccessful.

Dissemination

Once GPD-V have approved this final report, arrangements for a final workshop for GP trainers and EPC coordinators to feed back the findings for discussion will be arranged in liaison with the GPD-V EPC Coordinator. We also intend to dissemination findings to the

National Evaluators. A summary of the evaluation will be presented at the Annual General Practice & Primary Health Care Research Conference at the end of May.

Table 1. Summary of the evaluation methodology

Key Themes	Information source	Evaluation process
1 Variability of uptake of EPC	GPD-V proforma, EPC coordinators, service providers	Interpretation of 2y data Stakeholder interviews
2 Diversity of training	GP trainers and trainees Divisions protocols	Assess achievement of core educational objectives against standardised framework
3 Impact of training	EPC coordinators, trainees	Survey of purposive sample from each group
4 Reach of training	GPD-V proforma, EPC coordinators	EPC coordinator interviews to assist interpretation of proforma data. Schedule to focus on GP and structural barriers and enablers
5 Sustainability of EPC activities	GPD-V EPC Coordinator Divisional staff	Stakeholder interviews
6 Interagency collaborations	GPD-V proforma, EPC coordinators, service providers	Triangulation of 2y data with that from service provider interviews
7 National evaluation objectives addressed at State level	GPD-V EPC coordinator, national evaluators	Evidence base led analysis and interpretation of all collated data

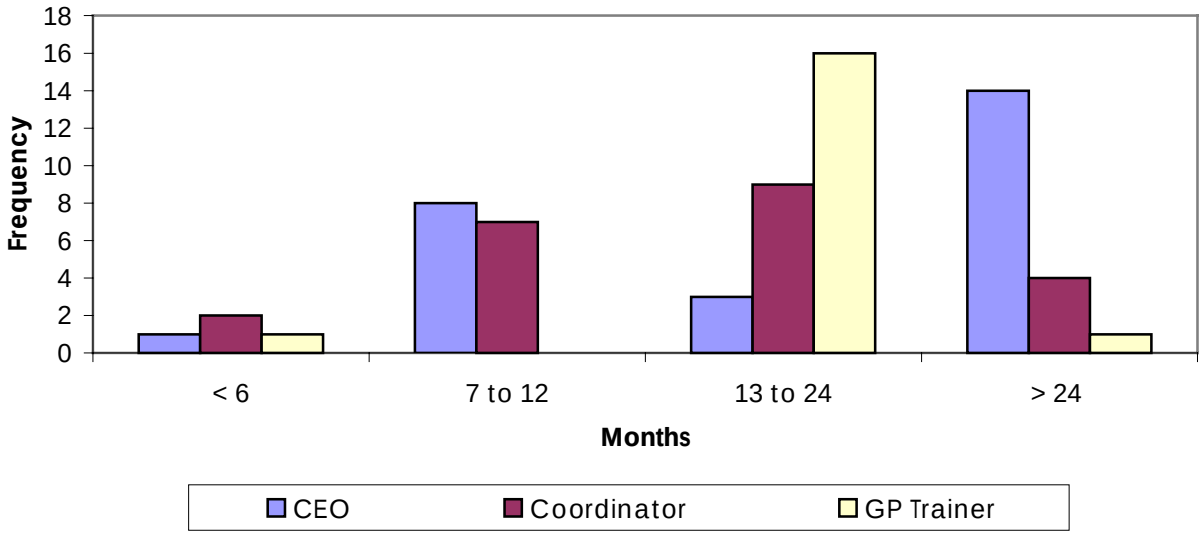
Background

We asked interviewees contextual questions regarding their involvement in the EPCESCL program. This section also explores the level of support each of the CEOs, EPC Coordinators and GP Trainers reported receiving, both from GPD-V and other sources.

Employment of Divisional Program Staff

The duration that the interviewees reported being involved in the EPCESCL program ranged from less than six months to over two years. Notably a minority of interviewees reported that they had been in their position for less than six months. Figure 1 describes the duration of interviewees' involvement in the EPCESCL program. Clearly the majority of GP Trainers (84%) were involved in the EPCESCL program from the initial implementation stage. Approximately half that number of EPC Coordinators (41%) reported being involved in the program for 13 to 24 months and less than half were involved in the program for greater than 12 months.

Figure 1. Duration of time on EPCESCL program



Roles/responsibilities with regard to the EPCESCL program

Both the EPC Coordinators and the GP Trainers were asked how they were recruited and what percentage time fraction they worked on the EPC ESCL program. The majority of the EPC Coordinators interviewed advised that they had existing positions within the division, with several stating that their existing roles linked well with the EPC ESCL program initiative and that they were therefore most appropriately placed to implement the program for the division. Similarly, most of the GP Trainers interviewed reported having an existing appointment or active association with their respective division, ranging from positions such as board membership, GP mentor, CME Coordinator, to other advisory roles.

'(I was appointed) by default as I was already working as an immunization advisor, running CME events...the division thought I would be an ideal person to sell CME.'(GP Trainer)

Both the EPC Coordinators and GP Trainers interviewed reported proportionally similar time fractions per week spent actively involved in working on the EPCESCL program. Most were appointed between 1 to 2 days on the program, with most GP Trainers quoting more intense involvement during the earlier stages of the program.

' I was the division CME Coordinator, it was only appropriate…but I also had an interest. I work on an 'as required' basis. It was busy in the first instance but now it is quiet.' (GP Trainer)

' EPC is full of peaks and troughs in terms of time…I am also involved in Koori Health and am also the IT Coordinator.' (EPC Coordinator)

Most CEOs reported their role in the EPC ESCL program as indirect, with responsibility mainly for overseeing, supervising and monitoring the program as well as management of the program staff. A small number of CEOs reported an advisory role with regards to the program implementation.

' My role was indirect, I was kept up-to-date, and any issues arising were discussed with the (EPC) Coordinator.' (CEO)

However certain CEOs reported a more active role. They were mainly CEOs with additional appointments and tended to be from smaller divisions.

' Because I'm also the division's IT/IM officer, I have been involved in teaching GPs about recall reminders.' (CEO)

'..Overseeing program's organization and management. Supervision of staff, and advice giving.' (CEO)

Reported responsibilities of the EPC Coordinators were consistent across the divisions. Overall the EPC Coordinators described their roles as being to develop and disseminate information to GP Members and allied health professionals, to organize associated CME events, to answer queries, undertake practice visits, report on program progress and practice support. Interviewees often reported a role in integrating these activities in other division project areas.

' To organise education and information events, coordinate within other program areas, "help line" for GP practices, practice visits, collect information on EPC, develop and distribute resources.' (EPC Coordinator)

'…organisation of CME activities on EPC related topics. Liaison with GPs, allied and community health workers. Reporting to GPD-V.' (EPC Coordinator)

'I am the 'help desk', the first port of call for GPs wanting assistance. I have also been involved in MAHS, division planning, accreditation support, CVD and Koori health, and involvement in the practice management network.' (EPC Coordinator)

All GP Trainers reported their initial role with the program as being to deliver and support EPCESCL program CME related events. A number of GP Trainers also mentioned their involvement in the development of resources. Generally, other roles included practice visits, responding to GP queries, advising the division, training division staff, and liaising with Primary Care Partnerships (PCPs).

'Being familiar with the EPC process I was able to develop material, become involved in marketing, to participate in educational events, to support the EPC Coordinator and to advise her and the board.' (GP Trainer)

'Planned staff engagement and infrastructure support in the division. Planning development and delivery of educational events. Academic detailing. Organised divisional staff training program to upskill them about the EPC items.' (GP Trainer)

Education/training

Both the EPC Coordinators and GP Trainers were asked about the training they had received to assist their role. Almost half of the EPC Coordinators interviewed said that they had no training whilst the remaining half mentioned having attended the GPDV workshop and/or self-education using the reading material provided. The majority of the GP Trainers mentioned that they had attended the Train the Trainer workshop run by GPD –V, with only a small number having undertaken any other additional training for their role.

' I only attended the GPD-V training session, and attended Network meetings' (EPC Coordinator)

' I attended the GPD-V EPC workshop and reading all the material. When EPC was first introduced, all staff read up on EPC.' (EPC Coordinator)

'Difficult because I came into the position late, missed the initial training session and program was well underway. Rosemary's initial site visit was the main source of education, otherwise I learned on the job. ' (EPC Coordinator)

Support by GPD-V

Each division CEO, EPC Coordinator, and GP Trainer was asked to describe the support they received from GPD-V to assist in implementing the program initiatives. Information and resource provision were the most commonly cited types of support, then the Train the Trainer workshop and direct assistance provided by the GPD-V EPC Coordinator through answering queries, site visits and keeping them informed about any relevant changes or materials related to the EPC items. The EPC Coordinators explicitly mentioned the value of the GPD-V workshops. However one rural based EPC Coordinator commented about the lack of support from the GPD-V Coordinator to assist in the workshop that they ran, adding that they were aware that the GPD-V Coordinator had attended other rural divisions' workshops.

Considering the range of responses regarding the level of support received from GPD–V, clearly the divisions had differing levels of expectation. Whilst a number were satisfied with the amount of support they received, others commented that the support was insufficient, and limited.

'Excellent. Provided resources upon request. Rosemary visited the division 4-5 times, she was always available for CME events.' (CEO)

' ….. GPD-V Coordinator was a resource for queries, information, they tended to highlight resources available from other divisions.' (EPC Coordinator)

'the EPC Coordinator has been very good. She was able to assist with queries and always came back with the answers. She has been very supportive, attending three education sessions to assist facilitation. She is very approachable.'(EPC Coordinator)

'My concern with GPDV is whether their role is to work with divisions or just to police the budget.' (CEO)

'Support has been very poor. The initial session with Rosemary was good, but since then it has been poor. No response to emails and phone calls, so the majority of support was from other divisions.' (EPC Coordinator)

Furthermore, we asked the EPC Coordinators to comment on whether they felt their needs were met when they approached GPD-V with requests for support. A reflection of the range of quotes are listed below.

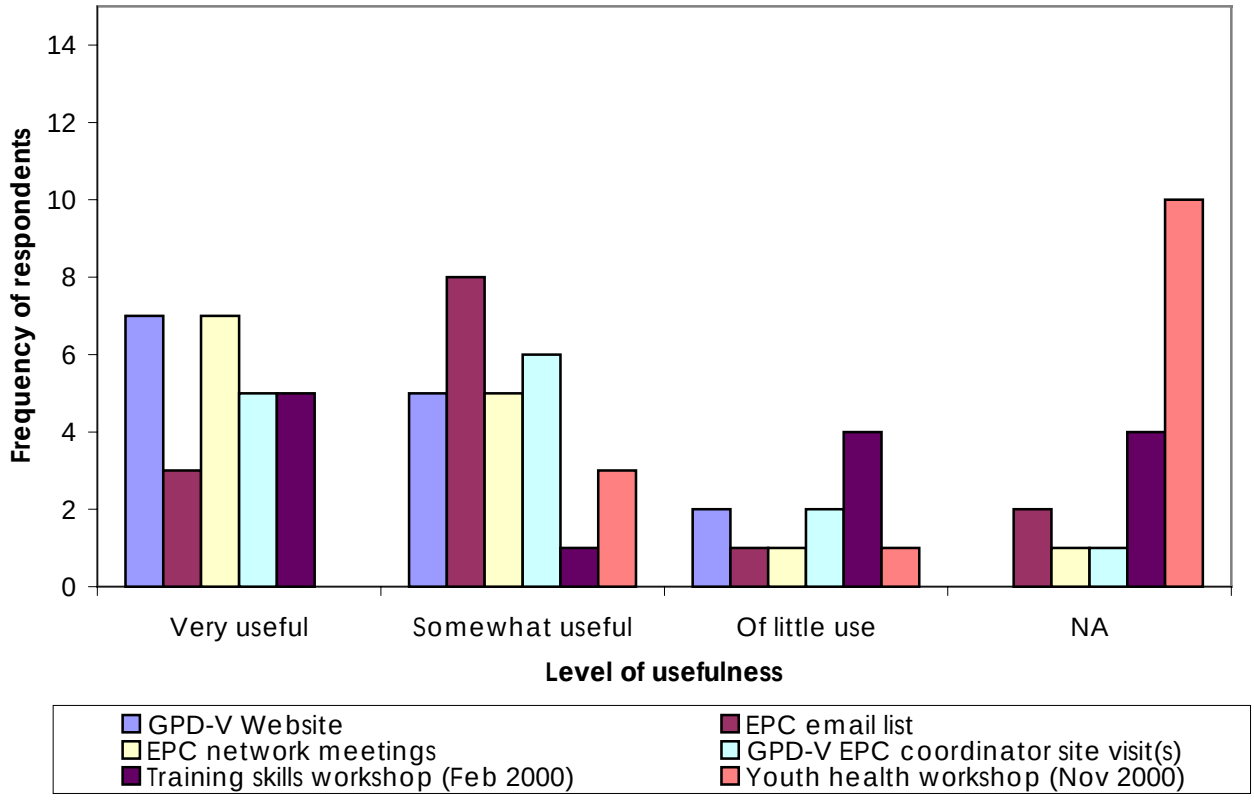
'GPD-V has provided excellent support. The only area we felt that support may have been improved was in liaising/communicating information to state bodies such as ACAS, Local Government, Community Health Services, RACF, which might have assisted local linkages.

'Useful in sending resources via email but not useful in providing support to local areas in the format of on-site visits to CME activities.'

'Generally my requests have been met. However I think GPD-V could have acted as more of a depository of template Care Planning, e.g. a GP asks me what does a Care Plan look like for somebody with asthma. I have to go to other division sites to find their examples for their members.'

We asked each EPC Coordinator to rate the usefulness of specific support the division received from GPD-V. The responses from those who responded are shown in Figure 2.

Figure 2. Usefulness of specific GPD-V support



Other Sources of Support

Other commonly reported sources of support included local Primary Care Partnerships, Department of Human Services, Health Insurance Commission, Royal Australian College of General Practitioners, Medical Director, and other divisions who provided additional sources of information and/or support. Of these, assistance from other divisions was the most frequently cited form of 'other support' mentioned by both the CEOs and EPC Coordinators. GP Trainers also mentioned receiving most additional support from staff within their own division. Publications including Australian Doctor, Medical Observer, and Prescriber were also mentioned as useful sources of information regarding current topical information about EPC.

'...(We used) the HIC hotline for information, financial support from sponsors of workshop, collaborated to work closely with the local PCP...' (EPC Coordinator)

Interviewees were asked whether there were any changes within the division that had impacted on the implementation of the EPCESCL program. Respondents discussed both positive and negative factors. Most commonly interviewees reported staff changes and staff movement as the major divisional change impacting on the implementation of the EPCESCL program.

'...Six months of no coordinator in place, most objectives were in place however it was difficult finding someone to take over with relevant experience.' (CEO)

Restructuring of division programs was also cited as impacting upon the implementation of the program. However, many commented that in fact the restructuring facilitated the integration of the EPC program.

'Our divisions' greater focus on integration activities, participation in coordinated health care, primary mental health teams, and the big focus on collaborative nature – all of which provide a vehicle for EPC.' (CEO)

Views on the promotion and implementation of the EPCESCL in the Division

Interviewees were asked to reflect upon the diversity, impact and reach of the program within their division. The program's three components- education, support and community linkages - were discussed in turn.

Education

In line with the evidence base (Davis et al., 1995[1]), divisions used a range of strategies to train personnel. The between division variation in strategies was greater than that within divisions. That is, most divisions chose a limited range of activities, with the type(s) of approach chosen generally based upon prior divisional experience of members' needs. All divisions held at least one CME event. No explicit mention was made of the use of self-education or satellite broadcasts. In the following discussion, a distinction is made between educational events that were formally announced and open to a wide constituency and educational activities that occurred on a more opportunistic basis. Education is also considered more broadly under the other program component headings.

Formal education- to whom, by whom and by what means?

Three main types of audience were obtained for educational events. First, only GPs were invited and CME points were available. Second, the session was open to both GPs and their staff to attend. Third, the session was aimed at other health providers. In the third category, some divisions intentionally invited both GPs and other health professionals to assist in relationship building. This strategy was also used in the educational program facilitated by the Department of Human Services during the last eight months. Evaluation of these events occurred immediately post session and has been largely positive.

Most divisions disseminated information to practice staff as well as GPs. Several divisions invited practice staff to CME events. The items were also discussed at practice manager/ practice nurse/practice support network meetings. Practice staff were also targeted via practice visits.

Education sessions were the most commonly mentioned means of raising other providers' awareness. The reach of the training amongst other local providers (e.g. DHS, hospitals, health agencies, aboriginal health services, Local Government Organisations, private practitioners, Primary Care Partnerships, Royal District Nursing Services) has been good overall. (Further discussion appears in the Community Linkages section).

The events were usually organised by the EPC coordinator. The GP trainer and/or the EPC coordinator facilitated the events. On some occasions, GPD-V staff also assisted. At events where the main topic was a particular condition e.g. diabetes, other divisional staff were involved and relevant health professionals gave presentations. Whilst divisions used both trained and untrained personnel to provide education, the GP trainer and/or the EPC coordinator, the majority of whom had attended the GPD-V 'Train the Trainer' workshops, facilitated most of the EPC associated training.

[1] Davis DA Thompson MA Oxman AD Haynes RB 1995 Changing physician performance. A systematic review of the effect of continuing medical education strategies JAMA 274: 700-705.

'We involved the OT Association and had speakers at an education session on osteoarthritis.' (EPC Coordinator)

Throughout the divisions, education was provided about all the EPC items. The trend was for the health assessments to be discussed in early sessions, with the care planning and case conferencing items receiving explicit coverage at later events. This trend reflected the respective item uptake: divisions recognised the need to promote the latter items more widely. Most divisions acted strategically to address uptake of the care planning (CP) and case conferencing (CC) items. It was found to be useful to incorporate information on these items within education sessions dealing with other divisional programs, e.g. diabetes care.

The main source of the education material used was the RACGP EPC kit. The divisions also made use of edited versions of this core material. Several divisions used resources developed by the Whitehorse Division of General Practice. Most EPC coordinators modified existing material to make it user friendly for their members. Education materials did not need to refer to local circumstances e.g. services available and waiting times, since participant providers were already familiar with these issues. Some divisions had tailored their activities to address the needs of Non-English Speaking Background patient groups.

A third of the divisions explicitly mentioned using case studies/examples at their educational events. These gave participants 'real life scenarios', providing meaning to the information by showing how the items could be used. Several divisions also used role-playing to strengthen the learning experience.

' *We use case examples and try and pitch it [the educational level] at the midway. If we set the bar too high it will put people off, but we try to raise the bar incrementally as the opportunity arises. In questions and answers we use realistic experiences and set a good standard of practice'.* (EPC Coordinator)

Practice visits

Practice visits were a popular strategy. Two patterns of practice visit occurred. In the first, GPs and practice staff were upskilled by the EPC coordinator and/or the GP trainer. In the second, upskilling occurred as part of a practice visit to discuss broader practice support matters. For example, an IT program officer could be assisting the practice to install a reminder system and would discuss the opportunities for using the EPC items.

Two coordinators referred to 'academic detailing' (one to one education with the GP). The commoner approach was to involve several practice staff, both GPs and employees. Eight divisions particularly mentioned focusing upon or including practice managers and six referred to practice nurses. A limited number of divisions strategically targeted particular practices. One division focused upon larger practices to begin with, before moving to assist solo practitioners. The rationale was to assist those who already had the necessary infrastructure capacity. This would need to be addressed in other practices before they could readily use the items.

'To begin with we had no specific targets. In recent times we have focused on those more capable (in terms of systems and/or attitudes) practices'. (EPC Coordinator)

'We've worked with practices already using the items'. (EPC Coordinator)

'*We targeted three practices in the MAHS program who hadn't been claiming the items, although they had been doing the work.' Sometimes we visited at the practice's request.* ' (EPC Coordinator)

In general, the divisions reported practice visits to be most useful. However, several divisions chose not to conduct practice visits, as they did not have sufficient capacity to do so. Most undertook practice visits as part of other divisional programs. One division reported only conducting practice visits on request. Practices were able to contact the division should they require further support, but there was no evidence of systematic follow-up of these visits. That is, GP follow up to reinforce promotion of EPC item usage has not proactively occurred. Rather, coordinators had answered practices' queries as they arose.

Support

A number of strategies were used to promote the EPCESCL program within the Division. Six coordinators explicitly referred to the endorsement that the Board and/or the Chief Executive Officer afforded the program. The most common approach has been to incorporate the goals of the EPCESCL program within existing divisional programs. Whilst some divisions did this throughout, others had only done so since the funding had ceased. Beyond the educational activities mentioned in the previous section, this integrative approach seemed to have been the most productive. However, this is based upon anecdotal evidence: none of the divisions had conducted any internal evaluation of this approach.

Targeting and reinforcement

Whilst educational input had been subsequently reinforced, there appears to have been no strategic follow-up of GPs to support item uptake. Three divisions reported providing follow-up on request. One division reported providing additional education sessions at the members' request. Most said that follow-up had occurred via other divisional programs, such practice support visits.

' *There was some academic detailing by the coordinator following a practice visit. Queries post visit were followed up. We reinforce item usage via midweek faxes and newsletters. The computer training (at the practices) has incorporated the EPC template for GPs to use.'* (EPC Coordinator)

'*A questionnaire was sent to those who had practice visits to invite feedback'.* (GP Trainer).

As noted above, divisions tended not to target their efforts at any particular type of GPs. They consistently noted solo GPs as being hard to reach, given their lack of infrastructure capacity. Other types of GP who were less likely to use the items were part time and older GPs. Practices that bulk billed, had workforce shortages or were situated in rural or socioculturally disadvantaged areas were mentioned by one or two respondents.

'Older GPs and solo GPs don't change'. (EPC Coordinator)

'Solo GPs need much more support. We have followed them up, both pro- and reactively. We have educated several solo GPs together and that has worked really well for discussion of the issues.' (EPC Coordinator)

'We found no difference between solos and others, although we found with part time female GPs that they had no energy, time nor motivation'. (EPC Coordinator)

'Generally slow with solo GPs. We have explained delegation e.g. to practice nurses to assist them'. (EPC Coordinator)

'Solo GPs are the most difficult to engage. There has also been slow uptake in Community Health Centres. Perhaps this is due to resistance from other providers who see GPs getting more money'. (GP Trainer).

Resources

Interviewees were asked whether protocols and similar tools had been used to support GPs uptake of the EPC items. Beyond the development of flowcharts to aid understanding of the processes, a limited number of approaches were mentioned. One division had produced tailored lists of other service providers for their members.

Information needs

The majority of divisions provided a 'helpline' service to assist members. GPs had largely requested proforma/templates to assist item usage. Several divisions had supported practices by transferring the forms onto Medical Director. Some GPs needed more specific details on the regulations underpinning item usage. Specific queries about care planning had been raised. One person mentioned PIP queries, another requests for referral forms. Two respondents noted the need for a service directory. On most occasions, the EPC Coordinators had been able to answer the queries. Some issues had been forwarded to GPD-V's EPC Program Coordinator or to the HIC, where answers were successfully obtained. In some areas discussions had occurred with Indigenous community agencies and attempts had been made to address cultural issues related to the items' uptake.

Community linkages

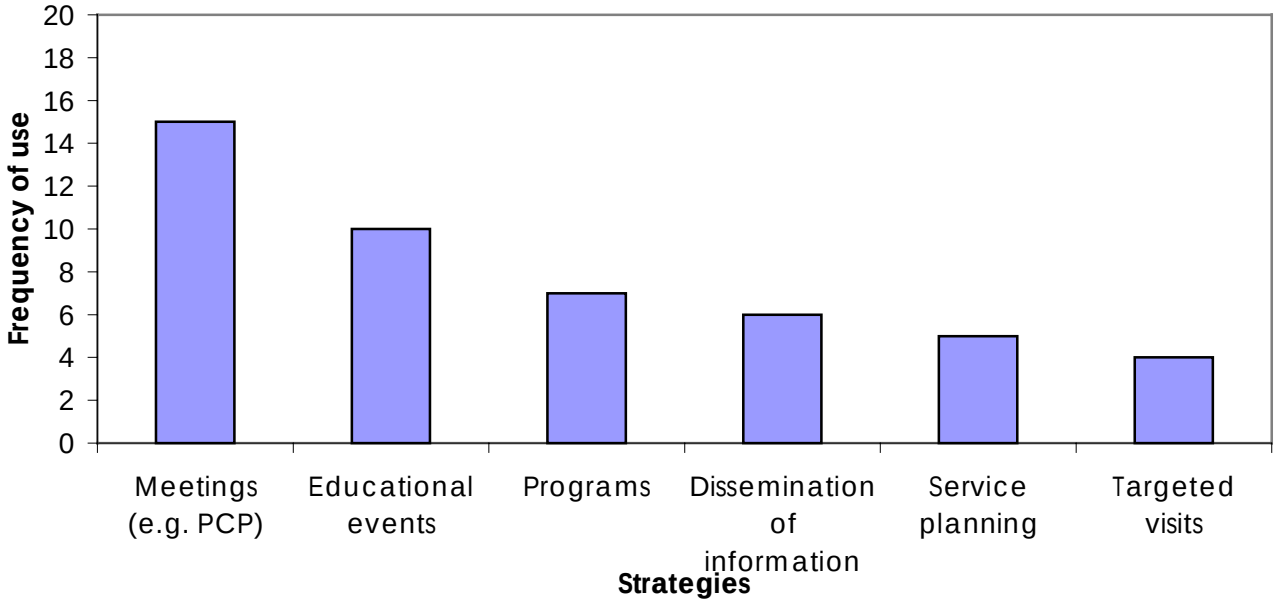
The majority of divisions ensured that other local community providers were informed about the items. The extent to which this occurred ranged from passive dissemination of materials through to engagement of health professionals in both education and subsequent service planning. Several interviewees commented that there had been missed opportunities to educate GPs and other providers together. However, it was not always practicable to do so.

'Joint sessions engaged around 80 people per session. We targeted towns systematically. There has been good reach and representation and it has been worthwhile.' (EPC Coordinator)

'The division and the PCP are currently educating allied health providers via a roadshow. The DHS program may be too late'. (EPC Coordinator)]

A range of strategies had been employed to develop linkages between GPs, the Division and other providers. Apart from educational events, meetings, particularly PCP meetings, had provided opportunities for discussing EPC items in service planning and delivery. A few divisions had simply sent agencies information about the items, whereas others had visited local providers e.g. hospitals, community and Indigenous health centres to raise awareness.

Figure 3. Strategies for creating linkages between general practice and other service providers



'We spoke to the Carers Association directly'. (CEO)

Where provision of information to other services had occurred, the outcome had been valuable, not only in awareness raising, but also in building support and trust across the sector. Health providers were encouraged to be proactive in initiating these activities with GPs. The interviewees remarked that the other health agencies generally welcomed this opportunity.

'Our strategy is to ensure that other providers are aware so that they prompt GPs to use the items. I think this has been successful. Providers are requesting GP involvement in case conferencing and care planning.' (EPC Coordinator)

'I sent letter to every nursing home and visited many. I acted as the liaison and gave the nursing homes details of the local GPs and encouraged them to develop a relationship with a GP'. (EPC Coordinator)

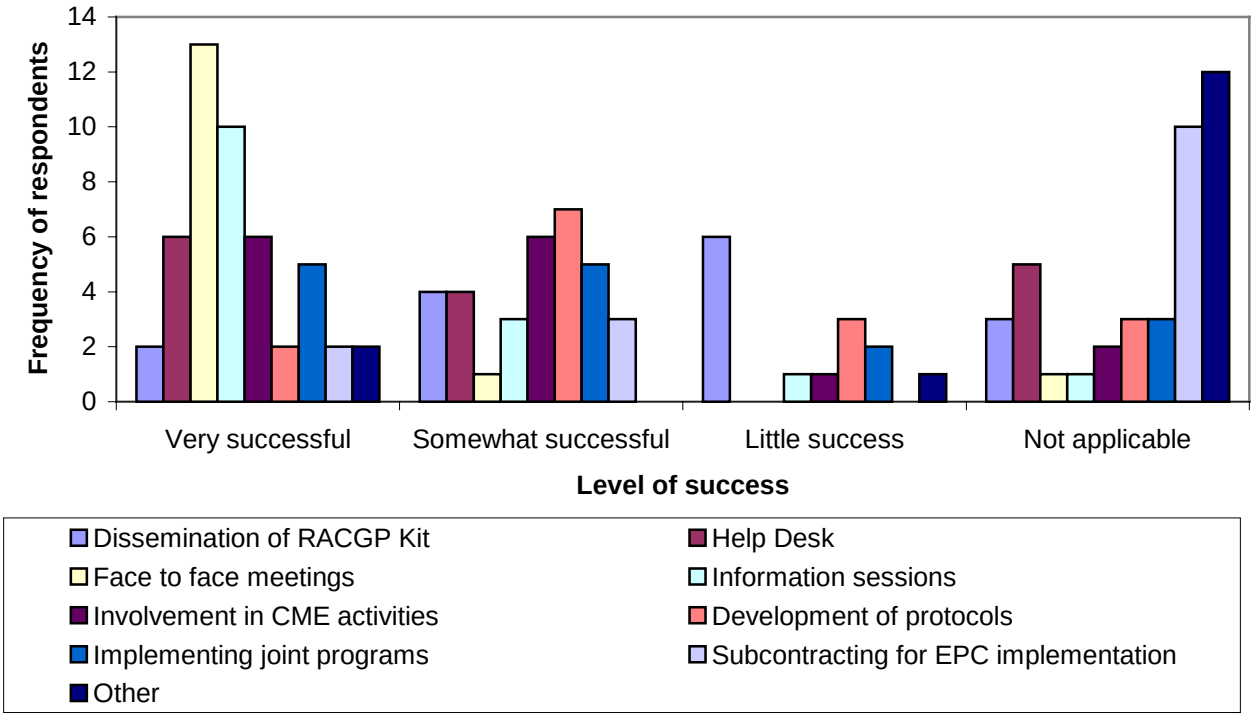
In certain divisions, communication across the community had previously been limited: the EPCESCL program acted as a catalyst for the development of networks. Several divisions had forged links with other service providers via specific programs such as those funded by the More Allied Health Services initiative and the Older Persons' Tracking Project. One division had established a specific group to consider EPC item usage. Another used an existing Community Reference Group.

'The division has used MAHS funding for welfare and social wellbeing under the care facilitation project, whereby staff work with practices, the Aboriginal Coop and drug and alcohol services'. (EPC Coordinator)

'The MAHS project officer and the EPC coordinator worked in conjunction to market the program to this group (other service providers)'. (CEO)

'An MBS sub-committee has been set up consisting of both GPs and other providers'. (CEO)

Figure 4. Success of community linkage activities in supporting EPC item usage



Protocols and other resources

Several divisions had worked with other agencies to produce protocols for services that included opportunities for EPC usage. These included MAHS programs (chiefly related to diabetes and mental health), palliative care, drug withdrawal and youth services. A smaller proportion had developed EPC specific joint protocols, primarily with the RDNS to assist health assessments and to a lesser extent with hospitals to aid discharge planning.

We had input into PCP template development; the 'Initial Needs Identification tool' and the 'Care Planning Proforma'. (EPC Coordinator)

One respondent qualified their reason for not negotiating protocols:

' Agencies have their own protocols and are mindful of general practice requirements.' (EPC Coordinator)

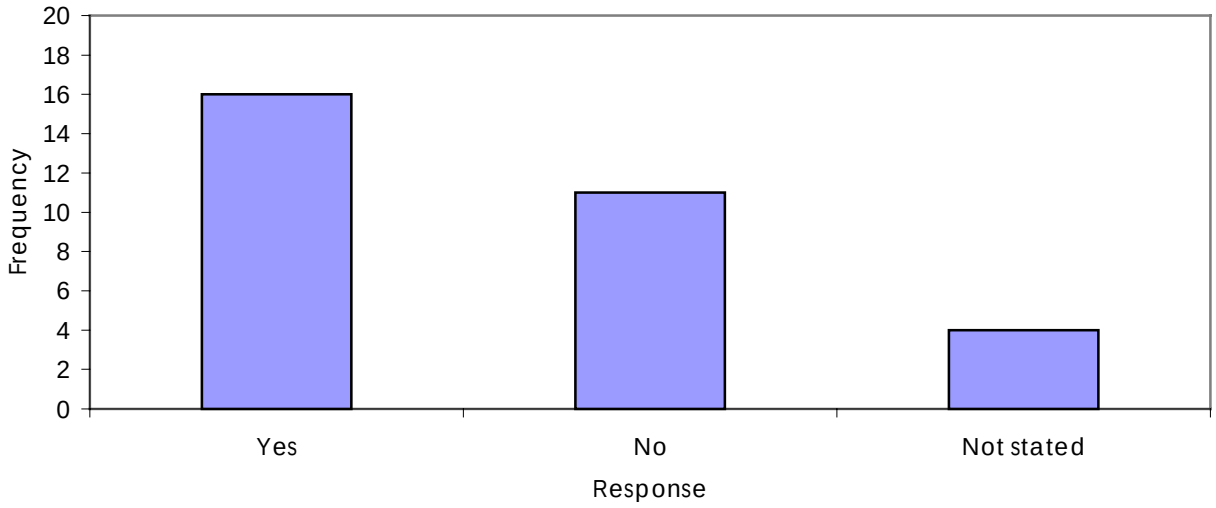
Others noted the challenge of protocols being properly implemented:

' You can get the appreciation (of the value of protocols) from the CEOs of different organizations, but to get staff to use them is another matter'. (CEO)

'A uniform proforma has been discussed for youth services, but I don't know whether it can be achieved.' (EPC Coordinator)

Several divisions organised for the services of other providers, chiefly nurses, to be made available to practices to assist them in the conduct of health assessments.

Figure 5. Protocols negotiated with local agencies to promote item use



Support from other agencies

The majority (70%) of divisions acknowledged support from other agencies towards assisting EPC item promotion and usage. The State Department of Human Services was the commonest source of support, with Primary Care Partnerships (PCPs) acting as the main source of policy, training or financial support to the divisions. In several divisions the EPC Coordinators have taken on PCP funded positions to assist the GP Engagement Initiative. Additional sources discussed included: local service providers, other divisions, Department of Health and Ageing, Royal District Nursing Service and a pharmaceutical company.

'DHS has provided some funding for hospitals but it has resulted in minimal use and had no real impact. A lot of work is needed from DHS'. (CEO)

'No. 'There has been some antagonism, with comments about all the money going to GPs, but no allied health support' (EPC Coordinator)

'The PCP have funded network meetings and the production of a service providers document on how to contact GPs.' (CEO)

'The care facilitation project arose from an EPC event facilitated by DHS. It has followed up on the issues raised. It is making GPs more aware of how they can contact services and provides practice systems assistance to aid item usage'. (EPC coordinator)

Effectiveness of linkages to other providers

Just over a third of divisions (39%) thought that effective linkages had been made with other service providers. A similar number (32%) acknowledged some successes, but noted the variability of effectiveness. Sixteen percent of divisions thought that success had been limited and that engaging other providers had been a slow process.

Consistent barriers to networking cited were: waiting lists, service availability, and the lack of required structural and systems integration. One person referred to GPs reticence to liaise with other providers. Enablers included: personal relationships and trust, awareness raising via the educational events and collaboration on a specific program of work.

'PCPs got there in the end - two years after items introduced. The local government staff have no idea about EPC… In hospitals, like other state funded organizations, there was a lack of knowledge about EPC and they do different sorts of care planning'. (EPC Coordinator)

'Strong willingness in principle, but poor outcome delivery. Every level of the hospital is enthusiastic especially higher up. But there are no runs on the board. It is difficult to implement. ' (GP Trainer)

' It's too early to assess impact of linkages upon item use'. (EPC Coordinator)

'Personal links and the associated trust helps. Where services have sustained staffing, GPs are more likely to use them, compared to where there is staff turnover'. (CEO)

'The items helped the division develop a better relationship with agencies such as hospitals and PCPs. Have just applied for a joint tender.... overall very successful: without these support and arrangements, item usage would have been much lower'. (EPC coordinator)

In summary, there has been much variability across divisions in the approaches used and no clear picture of what is the 'best' approach has emerged. A series of case studies are given below to illustrate some general trends.

EPCESCL Case Studies

Background

In general case studies are the preferred strategy when "how" and "why" questions are being posed, and when the investigator has little control over events, and when the focus is on contemporary phenomena in some real life context" (Yin, 1994)

In the context of the EPCESCL program, the use of a case study approach provides both *descriptive* material about the processes and practices involved in implementing the EPC program, and *explanatory* material about the complex causal links between policy, structures, processes and practices in implementing the EPC program.

We are ultimately interested in *'What makes the EPCESCL program model work'?* Case studies will be used to provide illustrations of the way the EPCESCL program has been implemented by Divisions using five dimensions:

- Structure of the program in Division
- GPD-V support
- Education, Support and Community Linkages;
- Sustainability of the program; and
- Key lessons

Methodology

Selection of Cases
The cases were selected on the basis that they would provide an opportunity to learn from a variety of models. Specific selection criteria included known organisational/structural features (e.g., inter-divisional collaborations) , division-specific factors (eg., structures in place; existence of related programs and location (eg., geographical- rural, urban, regional).

The cases are not meant to be representative rather illustrative of the ways the EPCESCL program was implemented. Nor are the cases illustrative of high implementers and low implementers.

The selected cases are de-identified in keeping with ethical clearance of the evaluation of the EPCESCL program.

Data sources

Two data sources were utilised including:

- Semi-structured interviews with CEOs, EPC Coordinator and GP Trainers
- Divisional Quarterly EPC reports

The case studies have been formatted so that they provide the reader with an overview of four areas that illustrate the way the EPC has been implemented.

Case Study 1: Existing Practice Support Structure

This case study provides an illustration of a division that implemented the EPC Program via an existing practice support structure that utilises divisional staff to promote, educate and support GPs in using the EPC Items.

Structure of EPCESCL program in Division

The EPC program was implemented by a Divisional EPC Coordinator on 3 days per week as part of their role as a member of a practice support program team. As such the EPC program was perceived as an integrated program in the Division.

GPD-V Support

The EPC education and training provided by GPD-V was seen as not useful, as it was seen as not relevant as the Division was already supporting GPs via its existing practice support program. The GP Trainer model was also seen as not useful, as the practice support program did not utilise GPs but staff. The GPD-V support was perceived as limited and not responsive to requests in a timely fashion.

Education, Support and Community Linkages

Practice visits was the main strategy used to educate and support GPs using the items, as practice visits are a feature of the practice support program as the most appropriate to GPs work style and to get GPs not just aware but using EPC items. The Division uses a whole of practice approach involving Practice Managers and Practice Nurses. The Division has strong links to PCPs and is involved in MAHS, to enable the further development of community linkages.

Sustainability of EPCESCL program

The EPCESCL program was reported as not contributing to workforce development, organisational development and resource allocation predominantly due to existence of the practice support program.

Lessons Learnt

The existence of an established and recognised GP practice support program maximises the potential uptake of EPC items at the GP level

The existence of an established and recognised Division wide practice support structure limits the ability of an external support initiative being incorporated

Case Study 2: Inter-Divisional Collaboration

This case study provides an illustration of an inter-Divisional collaboration aiming to econmise funding available, staffing resources and coordinate educational activities across a defined geographical area.

Structure of EPC program in Division

Three divisions formally agreed to work together to implement the EPC Program. The Divisions have a history of working together in various initiatives. In order to provide economies of scale in terms of funding, education and support provision support, the three divisions sought to work together. One divisions held the funding and housed the EPC Coordinaotor, whose role was to organise CMEs, support the three Divisions, conduct practice visits, and establish links with community providers. The CEOs ensured that the structural arrangement was in place- (i.e., terms of reference, roles and fundholding etc).
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Overall there were mixed views about how well the inter-divisional model had worked. Two Divisions reported that it had been successful as it had enabled pooling of resources. Whereas, the third Division (a small Division that has a large proportion of negative GPs and has experienced staff changes) reported that it had not worked, as they received an inequitable provision of support from the EPC Coordinator.

GPD-V Support

All three divisions attended the initial GPD-V workshop, and adopted the GP Trainer model and selected GP Trainers to educate other GPs to use the EPC Items. Overall Divisions reported that the GPD-V support was hard to access (personal support and electronic- website etc), and that more face to face support was required. The Divisions also accessed other support from Divisions who had already developed tools and resources,

Education, Support and Community Linkages

The main education and support strategies used included CMEs and Practice Visits. PCPs were the main vehicle to develop linkages with other service providers.

Sustainability of EPC program

All three Divisions reported that the EPC program had a limited contribution to building the capacity of the Division, for several reasons. In terms of workforce development – there was insufficient knowledge and skill transfer. With regard to organisational development, overall it was reported that EPC did not compare to other similar programs in terms of timeframe and resource to impact on Divisional policies and strategic directions. Similarly, the short-timeframe and limited resources were perceived as barriers to obtaining real change in GP practices and culture.

Lessons Learnt

- Collaborative arrangements to implement programs can potentially work, but require clarity and transparency in the roles, responsibilities and location of support provision
- The specific size, profile of GPs and staffing issues in Divisions need to be considered when contemplating inter-divisional collaborative arrangements
- The existence of prior working relationships may not be the best indicator of future collaborative arrangements

Case Study 3: Existing EPC Related Projects: Metropolitan perspective

This case study provides an illustration of a Division that implemented the EPC program by building upon previous divisional practice support initiatives (decision support and GP readiness project)

Structure of EPC program in Division

The EPC program was perceived as a core program as it was a goal in the Division Strategic Plan, and the program was being integrated across other projects/programs. The Division contributed financial resources to complement the GPD-V funding to enable a full-time EPC position.

GPD-V Support

The Division CEO and EPC co-ordinator participated in the GPDV network meetings, however no commentary was provided as to how useful this was.

Education, Support and Community Linkages

The EPC program was incorporated into program area, and predominantly used practice visits as the main strategy to provjde education and support to GPs. With regard to developing linkages with community service providers, the Division commented and recognised that it had started in this areas, but that the issue of an integrated health care system was beyond the scope of the Division.

Sustainability of EPC program

Overall the EPC program was perceived as having contributed to building the capacity of the Division as the EPC Coordinator had transferred knowledge and skills to other divisional staff. In terms of organisational development the Division was committed to EPC as it now featured in the Divisions business and strategic plan and in specific program areas such as Mental Health. The EPC program had contributed to Divisional resources, however, the funds were perceived as too small, and that it had required the Division to have the EPC in its broad strategic direction.

Lessons Learnt

- The existence of relevant initiatives can provide a platform and maximise the potential for EPC to be taken up at the GP and Division level
- The potential of the EPC is maximised if it fits into the broad strategic direction of the Division and if the Division commits to EPC in its business and strategic plan
- The development of community linkages to assist GP use of EPC items needs to be seen within the broader context of the need for an integrated health care system which is beyond the scope of Divisions.

Case Study 4: Participation in related State-wide Initiatives

This case study provides an illustration of a Division that was previously involved in an EPC related state-wide initiative (e.g., Coordinated Care Trial)

Structure of EPC program in Division

The EPC program was perceived as integrated with other programs, and all staff were encouraged to deliver EPC information as part of their programs. The Division CEO took up EPC as a priority issue.

GPD-V Support

The Division participated in the initial and subsequent EPC training provide by GPD-V, the EPC network, and accessed the EPC section on the GPD-V website. The Division commented that the support extended beyond information provision, and quality assurance to providing a liaison between Divisions in Victoria. The Division was also involved in a discharge planning project which was complementary to the EPC program.

Education, Support and Community Linkages

The Division utilised CME and practice visits to provide education and support to GPs. With regard to the development of community linkages the division had worked on several levels including: working with the local PCP; participating on PCP project specific steering committees; negotiating MoUs with health services; and negotiating "GP payment: related contracts with service providers.

Sustainability of EPC program

Overall the Division saw intrinsic value in the EPC program, however there were mixed views about whether the EPC program had contributed to the Divisions capacity to support GPs. Responses ranged from the EPC program facilitating the strategic and business plan development process to the realisation that GPs will need ongoing resourcing.

Lessons Learnt

- The success of EPC is maximised if the Division is committed to EPC at several levels: CEO, staff and Divisional programs
- A multi-faceted approach to developing community linkages is essential

Case Study 5: Existing EPC Related Projects: Rural Perspective

This case study provides an illustration of a rural Division that implemented the EPC program by building on previous Divisional initiatives/projects in the older persons area, Commonwealth funding initiatives such as the MAHS and working with the Department of Veterans Affairs (DVA).

Structure of EPC program in Division

The EPC Program was initially viewed as peripheral, however it is now seen as a core Divisional program. Specifically, the EPC was seen as core business for the Divisions practice managers group. Furthermore the EPC program is being integrated into other programs such as the MAHS and practice support programs.

GPD-V Support

Overall the Division reported being well supported from the start by GPD-V, particulary the EPC coordinator who was able to assist with queries and always came back with the answers and facilitating educational sessions etc.

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Education, Support and Community Linkages

The Division utilised various approaches to inform promote, educate and support GPs to use the EPC items. For example pharmaceutical company sponsorship was secured for training events. Local allied health services were targeted as were GPs who participated in the DVA trial. In terms of community linkages the Division targeted allied health professionals via the MAHS initiative and PCPs.

Sustainability of EPC program

Overall the EPC program had contributed to building the capacity of the Division. In terms of workforce development the EPC had provided a good grounding for staff. However, there appeared to be limited flexibility to sustaining the EPC Coordinator in the Division. With regard to organisational development, the EPC program had created the impetus for the Division to ensure that the EPC would be integral to the continuing work of the Division. In terms of Divisional resources, the resources were seen as helpful, but insufficient to provided the one-to-one assistance needed at the GP practice level.

Lessons Learnt

- Previous experience in Commonwealth initiatives/project appeared to facilitate the implementation of the EPC program
- The use of alternative funding sources and recruitment sites facilitated EPC education and support
- The existence of related Divisional programs eg., MAHS maximises community linkages efforts

Potential of the GP' train the trainer' model

A key evaluation question was 'What have been the effects of the 'train the trainer' model?' The previous section described the programs' implementation at divisional level and gave some indication of its effects. Here we consider the extent to which the 'train the 'trainer' model assisted the programs' implementation. Since respondents perspective on the value of the model was influenced by their views on the delivery of GPD-V's 'train the trainer' education, these views are initially outlined, followed by feedback on the model's underpinning tenets. The model's potential future use is then discussed.

Training provided by GPD-V

GPD-V conducted two workshops early in the EPC roll out which were aimed at supporting the EPC coordinators and GP trainers. The first workshop was content based and the second held six months later was more focused on presentation skills. The first workshop seemed to be hampered by the lack of clarity in the use and detail of the items that was inherent in the early phase of the EPC items' introduction. The lack of centrally developed tools, templates and proformas at the start of the program hampered the training and was a significant barrier to the program's early implementation.

'There were some inadequacies in the training program, e.g. lack of information available for trainers. This impacted on their confidence to pass on information'. (EPC Coordinator)

As was found in the divisional education events, people attending the GPD-V training workshop valued the more interactive, case study methods rather than the didactic approach to teaching.

'Needed less didactic content and more case examples.' (GP Trainer)

One difficulty associated with GPD-V's training was the variability in the experience and skill level of the participants. Some of the respondents were long term, experienced division staff who felt that the training was too basic for their needs, although there was acknowledgment of the variance in people's experience.

'...GPD-V training is often aimed at lowest common denominator ...and too basic for our staff ...we could have been out the front rather than them teaching' (CEO).

Over the course of the EPCESCL program, there were staff changes in the EPC coordinator position. Staff who were not on board at the commencement of the program missed the introductory workshops and commented that they had needed more assistance than they initially received.

'Because I wasn't there from the start, perhaps I missed some input at the outset, so I felt like sink or swim. I was unsure of the model and what proformas there were'. (EPC coordinator)

Allied to this, some respondents felt that it would have helped to have a series of trainer workshops throughout the program, rather than just at the start. However, EPC coordinators valued the subsequent networking, email and phone support received from GPD-V.

Suggestions for improvements to the delivery of the GPD-V training included: - more regular updates and provision of advice regarding improvements divisions could make; the provision of marketing information and training and assistance with engaging the support of other providers. These latter issues were related to the skills and tasks needed to increase the use of the items.

Views regarding the 'train the trainer' model

A core tenet of the model was the use of a GP trainer as a peer educator. Many divisions used a GP trainer for the large CME events and used project staff for practice visits, although a small number also used GPs to conduct practice visits. Another approach involved small discussion groups held at lunchtime for 6-8 GPs. Some divisions did not use a GP trainer at all, using division staff to implement the program.

There was a very mixed response regarding the usefulness and applicability of the GP trainer model. Some divisions were very strong advocates for the GP trainer model and considered that it was a major success factor to have a peer trainer that the GPs could relate to. There was also the rationale of GP participants reflecting that 'if they (the trainer) can use the EPC items, then maybe I should give it a go'.

'Train the trainer works especially well where the GP is local and knows the context for the item's implementation' (CEO)

'Whenever a GP talks to their peers in most cases it works' (EPC coordinator)

'The advantage of the model is that you are telling your peers – you are a part of it rather than an outsider. There is poor attendance unless there is a peer educator or the person is well known' (GP trainer)

'Superb model. The GP has good credibility with their peers and this enables a freer, franker discussion. It is worth the money to encourage the change' (GP trainer)

A number of divisions did not use a GP to conduct the EPC training: they believed that an analysis was needed of the appropriateness of the GP trainer model on a case-by-case basis, depending on the level of clinical knowledge required.

'…The GP trainer model makes assumptions regarding GP presentation, educational and interpersonal skills which are sometimes unfounded.' (CEO)

It was highlighted that presentation and adult learning skills are a different skills set to those required of a GP. Divisions who did not use GP trainers also cited two other considerations for using project staff: reduced cost and increased availability. It was much cheaper to use project staff rather than GPs for the training, plus they had greater flexibility and more time available than GPs.

'We don't use the train the trainer, it's the philosophy of the division. GPs are good doctors but they don't have the business management and administrative skills. We are not trying to teach them medical skills. You can't assume GPs have adult education and training skills. Project officers are cheaper and a lot more available.. The division does not have to pay for every minute of the project officer's time' (EPC coordinator)

'Need to analyse on a case by case basis depending upon the level of clinical knowledge required. There are assumptions made that GPs possess good presentation, educational and interpersonal skills, when sometimes these are at a low level.' (CEO)

'GPs may not be the best population health educators, GPs receive little training on peer, consumer and staff education' (GP trainer)

'[Train the trainer] works in the short term but the cost factor makes it unsustainable' (CEO)

'In principle, it's the best approach. However, using GPs to deliver is debatable on the ground, given the time and financial constraints' (EPC coordinator)

The GP 'champion'

Whilst the role of the GP as a formal educator was not wholly endorsed, the importance of a senior credible GP who was known locally and supported the EPC item usage was mentioned by nearly all of the divisions. This was noted as a driver for the success of the program, whilst the absence of a GP advocate was noted as a barrier to the success of the program. This was true regardless of whether the GP trainer model was used.

'The GP mentor was important to the trial. He was very good and interested. He had a practice in the area for 20 years, he had a local history and credibility.' (CEO)

'The use of a trusted local GP who can say I've done it and it works' (CEO)

'We did not use the train the trainer model, ... what we lack here is converted GPs to champion EPC' (EPC coordinator)

'GP trainer model only works well if you have an inspirational and interested GP trainer. We don't have too many GP leaders that have all of the skills. They may have the knowledge but not the presentation skills. The initial GP Trainer was not a suitable selection; he was a locum and external. So he did not have the reputation and was not the best change agent' (EPC coordinator)

The relationship that the GP trainer had with the division staff was also raised.

'If the GP has a good working relationship with the Division staff it can be effective' (GP trainer).

Where there was a good relationship, the GP and project staff worked as part of team who supported each other and were both integral to achieving the result of increased item usage.

The contribution of the 'train the trainer' model to the program's implementation

The 'train the trainer' model was seen as only one facet of the program's implementation. Indeed, the education events, where the GP trainer was mainly used, served as only one part of the equation in increasing the use of the items - to raise awareness and potential interest in using the items. More detailed information and systems change at the practice level were needed for the items to be actually used. GPs needed access to tools and information and to be shown how to use them. Information and guidance is also required for the wider practice staff. In nearly all divisions, the division project staff provided the practice level information and systems support.

'Multiple educational strategies are needed, you can't just use the one strategy' (CEO)

'GP trainer model was excellent but also need one-to-one academic detailing' (CEO)

'Peer education draws GPs closer to the policy expectation. It improves their understanding and gets GPs closer to the policy direction. Then the program officers can more readily develop activities with GPs' (CEO)

'It works well with GPs, but not in isolation. Practice staff- nurses and administration also require training, as do other stakeholders such as allied health staff.' (CEO)

'Staff know the practical but not the clinical. GP trainers are seen as the key people to conduct the CME and group training.' (EPC Coordinator)

'*The training was useful but there have been no overall systems changes'* (GP Trainer).

Finally, as noted elsewhere, many respondents referred to the significant change in culture, attitude and practice that are required for GPs to use the EPC items.

'Train the trainer is a small part of the change process, and is only enough to raise awareness. There was not real recognition that change happens slowly' (EPC Coordinator)

Conclusion

In summary, the main benefit and use of the GP 'trainers' was as local 'champions' and promoters of the EPC items, rather than providing all of the training. The use of a GP advocate or 'champion' of EPC seemed as critical as the training in promotion of EPC items, regardless of whether this GP advocate was the trainer.

One of the difficulties in evaluating the GP 'train the trainer' model and making recommendations regarding its use for future programs is that it was interpreted and implemented very differently across divisions. It was not possible to associate one particular approach with higher uptake of EPC. However, the consistent theme was that the training, whether by GP trainer or division staff, was only one small part of the equation of successful uptake of EPC items. The systems information and support at the practice level remain an additional core component in promoting uptake of EPC items.

How successful has the Victorian EPCESCL program been?

We have outlined how the program was implemented across the divisions. In this section we consider the program's achievements, what contributed to these and what limited its success. There are a number of ways to define success, one of the more obvious being in terms of the end-point: usage of the EPC items. To reach this end-point requires intermediate steps- process and cultural change- to occur. Therefore, before examining item usage, we will discuss the respondents' viewpoint on the Victorian EPCSCL program's achievement of its stated goals, then give an overview of the program's perceived impact upon health care, prevention and population health.

Achievement of goals

The stated goals of the Victorian EPCSCL program were to:

- To build capacity in divisions that is sustainable beyond the life of the program
- To establish change leaders and advocates within the divisions
- To allow divisions to adopt approaches suitable to their own context, history and contemporary work plan

Whilst each of these goals was achieved to a varying extent, two interesting issues emerged from people's responses. Firstly, there was not a great awareness that these were the stated goals of the program, however secondly when people discussed some of the drivers and barriers of the program's success these issues emerged. Thus one can draw the conclusion that the goals selected underpinned key issues for success, and secondly that GPD-V did not adequately promote the stated goals.

'Didn't realise that these were the goals of the program, news to me'. (GP trainer)

'I hadn't seen the goals before.' (EPC coordinator)

In order to guide future activity at SBO and divisional level, capacity building and sustainability achievements are explored in greater detail at the end of this report. The achievement of the other goals is addressed below.

Change leaders

Nearly all of the divisions made reference to the importance of a local GP advocate or EPC 'champion' to promote the use of the items as a key requisite for the program's success.

'It has probably increased realisation of the need for change leaders and advocates in divisions.' (GP trainer)

' The use of a trusted local GP who can say I've done it and it works [was critical]*'* . (CEO)

' What we lack here is converted GPs to champion EPC' . (EPC coordinator)

Nevertheless, gains in this area were offset to some degree by ambivalence within the GP community. For instance, there was some resentment amongst GPs who regarded this initiative as further encroachment on their professional autonomy. For other GPs there was general disinterest.

'Staff are pushing the initiative to a membership that are only vaguely interested in it. Some GPs are even antagonistic of 'yet another government push on their private practice' . (EPC coordinator)

' We roll our eyes at yet another Commonwealth initiative that we have to try to sell and not get attacked by GPs' . (EPC coordinator)

'Some GPs have been resistant (solos and those about to retire) and others have welcomed the items. Some of our GPs were part of the push for the items to be introduced' . (CEO)

Flexibility and ownership

Divisions valued the flexibility of being able to design and adapt the program to suit their circumstances, which resulted in greater ownership than other programs that were more prescriptive. The program's flexibility allowed divisions to build on their past achievements and adapt the program to best suit the requirements of their division and their members.

'There was increased ownership of the EPC program because it wasn't prescribed like other programs' . (CEO)

'Very successful in allowing divisions to adopt their own approaches. This allowed them to capitalise on their past history and gains from other projects.' . (CEO)

'The structures related to the program's operation e.g. practice viability measures and promotion of continuity of care across the sector have probably been more useful than the education itself' . (CEO)

Some divisions were more strategic in their overall programmatic and organisational structure: they were better able to cope with short term project funding without it being disruptive to the work they were undertaking. Staff could adapt and take on new projects that were incorporated as a part of their work and the division's overall objectives.

The divisions that appear to have had the most success were those that had already established a culture of health assessments and/or had made some previous attempts at working collaboratively with other service providers. For example some divisions had been part of the coordinated care trials, or the Department of Veterans Affairs clinical care planning. However this has also meant that it is was difficult to attribute success solely to the EPCESCL program.

'Following the training it was integrated with other programs, such as MAHS and the Practice Support Program.' (CEO)

'*It impacts on a range of other projects in division such as IT and different diseases*' . (EPC Coordinator)

'EPC is a part of life now; it is integral in the business and strategic plans. We will be involved with the next round of EPC whether funded or not. It is part of the Division's broader community plan to build linkages. It builds on the PCP - it is all embedded.' (CEO)

The level of flexibility had its downside. Some respondents felt that the lack of centrally developed resources, tools and templates resulted in considerable waste of staff and GP time and funds.

Although there may have been ownership within the divisions, this did not always translate to their membership.

'EPC was taken on board and the division's enthusiasm did not wane. Workers grabbed it with both hands. Once understood it became central business of the Division, it was easier than other projects.' . (GP Trainer)

'I have found the program more difficult to implement than others... we have been unable to transfer this ownership to our members'. (CEO)

'The division's enthusiasm waned given the lack of response from the GPs.' (GP Trainer)

'The items have become part of GP culture for some, but not all GPs.' (GP Trainer)

Other contributors to success

The monetary incentive for GPs was probably the main incentive and arguably a key contributor to the success of the EPCESCL program. Respondents thought that without the monetary incentive for GPs, the uptake of the items would have been considerably lower.

'Because of the increased dollars (involved), GPs were more likely to take the advice of the division'. (CEO)

However other commentators noted that the financial incentives were insufficient.

'GPs are not currently convinced of the economic viability' . (CEO)

Another contributory factor was the 'synchronicity' with the Primary Care Partnerships (PCPs) who also had an objective of fostering collaboration between service providers. One example was the development of service directories. The partnerships and liaison between divisions were also raised as contributory factors in the program's success.

Limitations to success

In addition to the significant cultural and organisational change required in the use of the items, respondents raised a number of factors that had limited the program's success. These barriers essentially related to:
a) The poor introduction and roll out of the EPC items
b) The suitability and availability of resources and materials.

a) Poor roll out of EPC hampered early use of EPC Items

The timelines and method of introduction of the EPC program was a considerable challenge for divisions to overcome. The timing of the introduction of the items in November, just prior to the extended Christmas break was also noted as an obstacle. Divisions were just starting to build momentum and then there was the extended Christmas break.

'It would have helped if the timing of introduction hadn't been at the end of the year'. (GP Trainer)

The early phase of the introduction of the items was characterised as confusing, with a lack of clarity regarding the detail and operation of the items. There were considerable requests for clarification from the DHA and HIC regarding the eligibility, criteria and usage of the items. The items were also introduced prior to the availability of resource and support material.

'When the education program was originally introduced it was too soon to put the onus on practices themselves to take up the items.' (EPC Coordinator)

'At first there was confusion because the rollout preceded the availability of the resources. This created some problems with regard to GP acceptance and uptake'. (CEO)

'*Needed a much longer set up time and be better organised before the program actually begins. The College kit came out seven months after the items were introduced'* (EPC Coordinator)

'There were some inadequacies in the training program, e.g. lack of information available for trainers. This impacted on their confidence to pass on information' (EPC Coordinator)

The time-limited funding also limited the program's impact. Many of the respondents commented that the rollout was too short. They were only just starting to see results in terms of increased GP interest when the funding for the support finished.

'EPC became more successful as it developed. At the beginning there was a lack of clarity that wasn't anticipated in the strategic plan. There were start up problems with the way the Commonwealth implemented the program and the timing of the funding changes.' (CEO)

'EPC funding finished too early as it was only now just starting to be understood' (EPC Coordinator)

The introduction of the new MBS items was also mentioned as a distraction. Respondents thought that GPs would focus on these rather than the EPC items.

b) Lack of co-ordination in development of materials

Two types of information were disseminated:

i) Overview information and rationale of the items to inform and promote the benefits to GPs to understand associated issues and benefits
ii) Tools and templates to facilitate the use of the items.

The lack of co-ordination in the development of materials and general information was a major limitation. Initially, the material was not in simple to understand language that GPs could easily relate to, and resulted in an initial impression that EPC was too cumbersome and too difficult to understand.

' Inch thick books are no good for GPs, they need simplified, short versions in simple language with no jargon, or in GP jargon. An A4 summary page, double spaced which explains the concept in an easy to see glance, the detail can follow later. The information came to GPs from multiple sources (Commonwealth, GPD-V, RACGP, AMA and the division). It was all slightly different as they all had their own version. It was all very

confusing for GPs, and they put it all aside and did not read it. All the information needed to be consolidated, linked and just come from the one source.' (GP Trainer)

'*All EPC information originally sent by the Commonwealth was in 'poly speak' as opposed to doctor speak'. It was not user friendly; it was too wordy, cumbersome, it made concepts difficult, and looked 'big brother'. This material was thrown out by GPs and led to low initial uptake. Once the division simplified and rewrote the rationale and other information then it was better understood by GPs.*' (GP trainer)

Much time was expended in simplifying the material to make it more useable and easily understood by GPs. A more systematic approach would have helped.

'We needed more timely and generic information instead of everyone making their own. A lot of staff time was spent in developing material when we could have been going out and making contact.' (EPC Coordinator)

'GPD-V should collate what others have done, and make this known to all the other divisions so that we avoid reinventing the wheel.' (GP Trainer)

'Central development of generic tools and forms would have been preferable to each division having to do this. Information giving needs to be supported by systems guidance. 'GP engagement is a real problem. Divisions aren't marketing experts and perhaps would benefit from some marketing advice. For example, GP suspicions of government (initiatives) need to be overcome.' . (GP Trainer)

'*Greater collaboration across divisions to achieve economies of scale in producing materials and conducting training.'* (CEO)

Other barriers that limited the program's success

The extensive paper work GPs must complete to claim EPC items hampers their usage. Divisions expended considerable resources in trying to simplify systems and in producing templates and tools to assist the GPs to use the items.

The repetition and restrictions in the divisions' reporting requirements to GPD-V was also raised. Divisions noted that the reporting formats restricted their ability to report on their significant informal activity in supporting the uptake of the EPC items. The report format focused on the formal activities such as conducting education seminars. Considerable staff time in unplanned interaction and follow up with GPs was not captured in the reports.

The program's perceived impact upon health care, prevention and population health

Most interviewees thought that the program had added to the divisions' existing work in the population health domain. Discussion of the EPC items had acted as a catalyst for further promotion of a population health approach. In addition, a number of respondents highlighted that the EPC program increased the relevance and usefulness of the division itself to GPs.

' Because the potential for increased dollars for GPs, they are more likely to take the division's advice. EPC gave additional string to the division's bow. The EPC program also promoted the division to GPs' (EPC Coordinator)

'There are so many CMEs being conducted these days, a lot from the drug companies, so many GPs don't go to division CMEs. so the EPC has been a major event undertaken by the division that has attracted GPs who otherwise don't have much to do with the division' . (GP trainer)

It was consistently noted that promoting items use involved more than just getting the GPs to do an extra task or activity with their patients: it required a cultural shift. In conjunction with other initiatives such as the chronic diseases initiatives, the EPC items invite GPs to see their role and method of practice in a different context. This behavioural change takes considerable time and effort, and for some, particularly the older GPs, they may not be willing or interested in changing.

'A shift is needed from problem centred consultations to preventative. The longer consultation helped but there is a long way to go' . (CEO)

'EPC has caused GPs to look at the bigger picture of what happens beyond their consultation' . (EPC Coordinator)

'The items have made GPs more aware of 'whole of patient contact' approach as compared to 'intervention based medicine' when there is a problem.' . (CEO)

'Most GPs treat symptoms. Long way to go before GPs operate at that (preventive health*) level'*. (EPC Coordinator)

' It has created forward thinking and planning for patients. Patients have had things done because of the items that may not have happened, or have been picked up otherwise' . (GP Trainer)

'GPs are starting to think in terms of longitudinal care in a more formal way. There has been forward planning and some self management promotion. GPs would probably not necessarily have done so before EPC'.(EPC Coordinator).

The EPC items challenged GPs to think about their practice in different ways. This involved a shift from problem centred consultations to health promotion and preventive consultations. In addition, the EPC items encouraged the GP to consider their patients in a different context, more strategically and proactively, for example identifying all of their diabetes patients, or identifying and contacting all of their patients over 75year of age.

'The items start GPs thinking about what is their patient population, how can I identify, say all my diabetes patients'. (GP Trainer)

'The EPC program has enabled this (population health planning) to occur in a shorter timeframe than might otherwise have been the case.' (CEO)

'EPC is one of a number initiatives, such as IT and the shift in PIP payments, to shift towards population health activities.' (CEO)

The financial incentives involved in the EPC items served to formalise an approach for GPs that were open to and to some extent already taking this approach. However for other GPs there has been only limited impact on their practice.

'Some GPs were already working on population health activities, the funding enabled this to be put on everyone's agenda' . (CEO)

' The program has formalised a preventive health amongst GPs who were already open to that type of approach.' (CEO)

'*I was doing something like this anyway before EPC - reviewing medications, liaising with other service providers, but for others EPC introduced the idea of annually reviewing and adjusting people's medication.'* (GP Trainer)

Where is the evidence?

This positive scenario is based upon anecdotal evidence. The actual impact of the use and effectiveness of the EPC to promote a population health approach is not really known. Similarly with regard to preventative health, there was only anecdotal evidence that any division could cite for GPs being more involved in preventative health. In spite of the increased uptake of the MBS items in Victoria, respondents were reticent to use this as evidence of improved outcomes as a result of the EPCESCL program.

'*Health assessment item use has been good, but I don't know that this means better health outcomes for patients.*' (EPC Coordinator)

Nor do we have the data to assess whether the items were used in a systematic, an opportunistic or an ad hoc manner.

' We don't have data on the population of the practice so we don't know on what percentage of their practice the GP has used the items. Because we have not practice or division registers of the population (i.e., demographics etc) then we can't know'. (CEO)

A number of issues related to the question of evidence of improved outcomes were raised. These included: the evidence base underpinning the EPC initiative; the extent of the use of the items; the quality in the use of the items; and overall impact upon general practice.

Given the importance of an evidence base to underpin action, many GPs requested evidence that use of the items did in fact improve health outcomes of their clients. It was an obstacle that the divisions had to overcome that there was not an extensive evidence base that could be highlighted to support and endorse the use of the items.

'GPs asked for evidence that the items improved (client) outcomes'. (EPC Coordinator)

Many respondents also noted that it was a weakness of the roll out of the EPC items that there was not a corresponding opportunity to build an evidence base by evaluating outcomes.

'We only have anecdotal evidence. It was a weakness that we didn't have an evaluation along side the EPC rollout (to build an evidence base)'. (CEO)

There was a mix of comments regarding the impact of the items and the perceived variation in the quality of the items' usage. Some GPs had considerable commitment to the preventive care and collaborative working philosophies that underpin the items. For other GPs the motivating factor for using the items was the financial incentive and that was reflected in the quality and depth of their work.

'We have concerns with reporting numbers, since this doesn't reflect the quality of health care (delivered)'. (CEO)

'The focus has been on numbers and that has been the goal, rather than the effects per se' (EPC Coordinator)

'I have been told by some GPs that Health Assessments are the best thing they've done with older patients. Care plans are the most empowering things for patients with complex, chronic needs: patient empowerment goes beyond knowledge, especially for diabetes where patients have a fair amount of control if they choose to take what's on offer.' (EPC coordinator)

'There has been positive consumer group feedback. Patients have been very pleased with the items and encouraged others to have health checks.' (CEO)

'Patients like it but I don't know if it has improved health' (EPC coordinator)

'Health Assessments allowed me to find out information about some of my 75 year olds that I had been seeing for 20 years that I did not know. You often just tend to deal with the current problems and not the longitudinal issues, this is also worsened when you inherent patients'. (GP trainer)

'I'm not sure if GPs are using items because they believe in the preventative health measures or just because of the dollars' (EPC coordinator)

'Health Assessments are not valued by GPs as they don't find anything wrong. If the GP needs to generate clients then the Health Assessments are fine. But many of the GPs in our division are too busy, both in the larger and smaller towns.' (EPC coordinator)

This last quote identifies a number of interesting issues relating to the use of the items that warrant further examination. Firstly, the GP misses the point of preventative care and considers the only benefit of a Health Assessment is if something is found wrong with the patient, an illness approach rather than a health approach. The Health Assessments are considered here primarily as an income generator rather than as a systematic tool that assists GPs to provide better care for their older patients.

This also raises the issue regarding the use of the items in the practice. The available information does not reveal how the items were used by GPs, whether use was opportunistic when patients presented, or systematically across the practice. There may have been a high number of assessments in a division, but how widespread was the use amongst GPs: was it a relatively small number who used the item extensively or a larger number of GPs who used the item intermittently?

The final issue raised by this quote is that there is reduced scope to use the items in practices that are already very busy, for example in rural and metropolitan fringe areas where respondents noted that the shortage of GPs impacted on their ability to increase the use of the items.

Outcome: the uptake of EPC items across the Divisions

Here we look at possible influences on the degree of item uptake across Victoria. The divisions were ranked based upon the percentage uptake during the period November 2000 to October 2001. Low rates were more prevalent in the inner urban areas. They were not consistently linked to staff throughput in the EPC Coordinator position, nor to other changes within the divisions. A low ranking cannot be explained by lack of support: indeed, most divisions received support from GPD-V and other sources.

Given that all divisions provided education on all items and attempts were made to provide user-friendly materials, any variation in uptake is more likely to be attributable to the reach and subsequent impact of the education on changing GP behaviour. This will be explored in greater detail by the National evaluators. For the purposes of the current evaluation, the cumulative data (7/00 to 9/01) on attendance at educational events was investigated across divisions. The proportion of GPs who had attended an event during that period was calculated, using 'eligible membership' as the denominator. There was a positive association between item uptake and membership coverage. The divisions in the top quartile for item uptake had, on average attracted a greater percentage of their GPs to events during the period concerned than those in the bottom quartile (81.75 vs 67.85%). Similarly, those in the top quartile had engaged more allied health providers in educational programs. To confirm this trend would require more detailed investigation than the available data permits. The data needs to be treated with great caution for several reasons. The data is not weighted for either the patient or allied health provider denominators in each division. We do not know whether the same GPs or other providers attended several events, or whether the totals represent independent data points.

We hypothesized that conducting practice visits could be positively related to item uptake. However, all but two divisions conducted practice visits, so this is not an independent contributory factor. Indeed, the division with the best uptake rates did not conduct practice visits. Similarly, GP follow-up to reinforce item usage was not associated with actual uptake, nor was the presence of negotiated protocols with other service providers.

Finally, item uptake tended to be higher where the CEO felt that the division had been able to meet the needs of all their members. This may suggest that those GPs who had interacted with the division had gone on to use the items, but again, without specific individual practice and/or GP level data, no further hypotheses of this nature can be tested.

Summary

This section has highlighted the extent to which the program achieved its goals and noted the factors that limited its success. The main points are summarized below.

- The flexibility of the EPC program and the scope of divisions to develop the project to best work within their other projects were contributors to success. The EPC program also linked well with the IT network information sessions. The use of IT to support the capacity of GPs to undertake the processes involved in EPC was important. Indeed, some respondents considered the tools and systems support to be more critical factors in supporting the success of the EPC program than the education program.

- The initial rollout in the implementation phase was not good and the program was slow to take off.

- The items required considerable systems support at the practice level in terms of tools, IT and administrative support.

- The use of the items required considerable cultural change: the GP had to have an interest and some commitment to using the items. The monetary gain offered in the EPC program had certainly improved the incentive for GPs to be involved in health assessments and care plans, which provided the 'carrot' for many GPs to

be interested in the information and support offered by the divisions. The support of a GP 'champion' also helped.

- At best there was only anecdotal evidence of improved health care for those with complex needs. Some respondents noted considerable benefits and positive outcomes from the use of the items, whilst others commented on the range of quality and commitment in the use of the items. More detailed evidence will be needed before the program's success can be more clearly defined.

Working with allied health professionals

A primary evaluation question was 'In what ways are divisions working with other agencies and providers to use the items in addressing specific clinical and service delivery problems?' The previous sections provided the divisions' perspective upon this question. Here, we consider the feedback received from the providers themselves. We assess the degree of concordance across the two sectors and consider the way forward.

The allied health professionals' perspective

A limited number of interviews were conducted with participants who attended EPC training workshops. Two seminars were selected: a rural seminar conducted by DHS staff and an urban fringe seminar conducted by the division. A total of 35 people were approached for an interview and 10 participated in an interview.

The aim of this secondary set of interviews was:

- To gain an appreciation of the training methods and how they were received by participants
- To gain an understanding of how the EPC items were perceived. As both GPs and allied health professionals attended the workshops we hoped to gain an understanding from both the perspectives of allied health professionals and GPs who, unlike the division interviewees, had not directly been involved with the roll out of the program.

One of the seminars was conducted in 2000, so a number of people no longer considered EPC to be applicable to their role or they had moved on from their positions and were no longer contactable. Two GP registrars who were from the same practice as the GP had completed their training, left the practice, and were no longer available. For example, two GP registrars had completed their training, left the area and were no longer available. However some of the people who declined the interview also reflected a lack of interest in the EPC program. Three practice staff declined to participate and one GP. The GP indicated that that he, together with other GPs from his practice who attended, considered the EPC training a waste of time and left. He declined the interview stating that he was not interested in EPC. The practice staff indicated that they did not 'get a lot out of the training', and did not think they could spare the time for the half hour interview. One allied health professional also declined the interview due to some organisational fallout from their participation in the PCP.

The training methods

The experiences of the allied health professionals were consistent in both of the seminars even though one was conducted by DHS and the other by the division. They found the scheduling, content and format of the EPC training to be positive, although some would have liked greater time for discussion. They also valued the opportunity to discuss case examples and to have a range of health professionals in attendance. None of the allied health participants had much experience in using the items subsequent to the training due to a lack of GPs who were using the items.

The practice manager interviewed was quite negative about the training session and thought it was a waste of her time and that of the other practice staff.

'The training session was more for professional staff. There were a few receptionists there and it went totally over our heads. We didn't learn too much. ...it was a waste of time' (Practice Manager)

The other issue for the practice manager was that their GP was not interested in the EPC, so it was difficult for practice staff to have any influence in promoting the items. In this context, it was considered that practice level support and a practice visit for the staff and GPs would have been more beneficial. Although the practice had received extensive information in the mail, the practice manager had no knowledge of the tools and information that were available, suggesting communication problems at practice level.

'It's up to the doctor really. I don't know what role I can have if the doctor does not want to use it.' (Practice Manager)

'Is there a website or something where we can get the information and materials?' (Practice Manager)

Working more effectively with other service providers?

The responses from the allied health staff were consistent in the two seminars. Although they found the content of the seminars useful, they have since had limited experience in using the EPC items due to very limited or no GP referral.

The relationships between GPs and other service providers are at the heart of effective case conferencing and care planning. Responses from interviewees indicated that where relationships between GPs and other service providers and/or relationships with the division and other service providers were good, then the EPC items facilitated further good work. However where there were no relationships or the relationships were strained, then the EPC items did not work well. Most of the allied health professionals contacted during the evaluation also noted that working collaboratively has always been a part of their ethos, and their difficulty has often been the reluctance of the GPs to engage with them. In many ways the EPC program has had limited impact upon this.

'GPs who are working with us were doing so before EPC, there hasn't been any change'. (Case Manager allied health)

We only have one GP who is truly involved and has the best interests of the patients at heart ...[to the others] everything comes down to money' (Case Manager allied health)

'We have managed to establish good links with a select few GPs based on a common client.' (Service Manager CHS)

'All other agencies can work on a complex plan, but GPs sabotage the work. .... The new items have allowed them to participate but it doesn't happen. We need to keep searching for ways to engage GPs.' (Service Manager CHS)

The two pharmacists interviewed as part of the evaluation also noted that there had been little change as a result of EPC. This was due to the minimal usage of the care planning items by the local GPs. Where they had received requests, there had been no direct GP contact. Rather, the GP had sent through a request and the pharmacist had acted upon it in a similar manner to in the past. That is, they had spoken to the patient about their medication. The difference lay in a formal recording of the GP contact and a greater likelihood to follow-up with the patient on a subsequent occasion.

A number of the allied health respondents who attended the EPC training noted that the major impediment to the EPC initiative was the GPs' attitude. The EPCESCL program had not done enough to change GP attitudes and that it was the 'usual 2-3 already converted GPs' who attended the training and not the wider GP community.

'*The issue of low GP attendance was not addressed. The usual 2 or 3 motivated GPs ended up at these sessions, but what about the others?'* (Manager RDNS)

'*Our primary focus was to engage GPs even before EPC … the education sessions have had very little impact but we still encourage staff to attend, it's about representing our organization, being part of the picture'.* (Service Manager CHS)

'*More GPs could have attended. We need to find creative ways of engaging them.'* (Service Manager CHS)

'The problem is the lack of acceptance of some GPs to work together when other people see the benefits of working together' (Case Manager allied health)

The respondents highlighted that, within their organizations, activities encouraged by the EPC items were already occurring. It was considered part of the ethos of many allied health professionals to work collaboratively and in preventative health. The challenge remained to engage the GPs.

'We use all of the items as a part of our job anyway, but separately from EPC.' (Case Manager allied health)

'We try to engage GPs and send them care plans that we do for clients. We always invite the GP to our case conferencing, but with limited success.' (Case Manager allied health)

'*Case management with GPs would be fantastic in the ideal.'* (Case Manager allied health)

'*Allied health professionals are used to doing care planning and health checks, it is already in their working ethic. …I think the difficulties all relate back to trying to interface with a private professional (the GP) with resistance.'*(Service Manager CHS)

'It's all dependent on GP characteristics/personality. The response has been varied, some GPs are willing whilst others are not. In terms of organisational aspects, GPs don't like to wait and we struggle with this, because there are limited staff resources. … GPs are not comfortable with using an interpreter and are not trained to use them.' (Team Leader Migrant Resource Centre)

'It wasn't the EPC program itself but GP practices that limit EPC. GPs are isolated in the health profession, by choice, as opposed to AHP who consistently work together with their colleagues. It's obvious that there is resistance towards the items by a lot of GPs particularly the older GPs. It appears; as though some are keen others are not.' (Information Education Officer PCP)

'*GPs in this region don't seem to be accepting of it, and that's why it hasn't taken off. They have worked the same way for years, why should they change'* (Case Manager allied health)

Effectiveness of linkages to other providers- consolidation of effort

The divisional interviews acknowledged that the successes in developing linkages with other service providers had been modest. There were challenges related both to the personnel and to the systems within which they operated. There was clearly concordance in this regard. The issue remained how to address these challenges.

In some divisions, a decision was made to ignore case conferencing as 'too difficult to achieve' and the focus was on health assessments (primarily) and care planning. Some respondents felt that the whole issue of case conferencing was not really feasible due to the difficulties of trying to get a range of service providers, including the GP, to be available at the same time. They also noted that informal case conferencing had already been occurring, but that the professionals may not speak in 'real time': that they considered was an unrealistic criteria of the EPC item.

Although there was some ambivalence on both 'sides', the overall picture indicated a commitment to pursue attempts to work together. The EPC items offered a catalyst for collaboration that could be built upon.

'*EPC gave us a common language when talking to other service providers'* (CEO)

'The money provided an excuse for GPs and the division to talk to allied health providers' (EPC Coordinator)

'The hospital never looked at (GPs role in) discharge planning previously' (GP Trainer)

A range of strategies to assist collaboration was referred to. Several divisions conducted joint programs with other organisations. For example, a division and community health centre jointly funding the appointment of a GP for a few hours per week to act as a central liaison for case conferencing.

' The division is on the executive committee of the PCP. We are able to provide information to GPs via this link. Specifically we are working on an initiative to engage Practice Nurses'. (Information Education Officer PCP)

'We have been involved with in the divisions, through being a signatory of the PCP MoU.' (Team Leader Migrant Resource Centre)

'We are more committed to GP engagement, and to streamline their access to the wider Primary Care System. EPC has enhanced our existing processes.' (Information Education Officer PCP)

'It is part of the division's broader community plan to build linkages. It builds on the PCP - it is all embedded.' (CEO)

Some benefits had already been seen. Others would take longer to emerge.

'In nursing homes, case conferencing has made a significant difference. Sometimes the GPs don't realise the extent of medication a patient is on, because you often inherent patients and they keep going on the medication that they are on. When the pharmacist is involved in the case conferencing, a review is done of their medication and changes are made as to the drugs they are given.' (GP Trainer)

'*It has brought GPs and providers together where otherwise they would not. In practice whether they work as teams, this remains to be seen.'* (EPC Coordinator)

Some challenges could not be addressed by the program itself. For instance, the lack of capacity in many of the allied health agencies, particularly in community health centres to deal with the increased workloads flowing from the GP referrals.

'There is a six month waiting list for podiatry' (CEO)

These systems factors will need input from State and Commonwealth Government as part of ongoing workforce initiatives.

Has the EPCESCL program built capacity?

Background

All division CEOs, EPC Coordinators, and GP Trainers were asked for their views on how the EPCESCL model had built the division's capacity to support GPs to use systematically the EPC items. All interviewees were reminded that one of the goals underpinning the EPCESL program was that it was designed to build divisional capacity to support GPs usage of the EPC items.

Responses tended to reflect interviewee respective positions in divisions. For example, CEOs were the most positive about the EPCESCL program, given their strategic role. EPC Coordinators were less positive about the EPCESCL program, given their pragmatic/practical roles. The mixed views of GP Trainers may be partially explained by some GPs being too removed from divisional policies, structures and strategic directions.

EPCESCL program contribution to division workforce development

Overall most respondents agreed that the program has contributed to workforce development.

Respondents endorsed that the EPCESCL program had contributed to Divisions workforce development and they highlighted that the program had:

- increased staff knowledge and skills;
- enhanced working relationships; and
- extra staff resources.

Most CEOs agreed that the program had provided training to divisional staff, enabled extra staff resources (eg nurses), and had increased working relationships within divisions.

'The program assisted the coordinator's understanding of the GPs role and integration needs with regard to the items. GPDV workshops helped to overcome some of the challenges of GP training'(CEO)

''The Coordinator and the GP trainer worked together to complement one another in program implementation.' Raising awareness will sustain program to some extent' (CEO)

'Yes, enabled nurses to be funded a part of division workforce' (CEO)

However, several CEOs also commented that the funds were too short term for workforce development.

'Yes, as initially staff members needed upskilling, but no as need more money for another 12 months to contribute to division workforce particularly, to develop links' (CEO)

Most EPC Coordinators commented that the EPC program had contributed to the development of division workforce, as it contributed to staff knowledge and skills development, in terms of EPC.

"Yes, if it were not for GPD-V it may not have happened" (EPC Coordinator)

"Staff now trained in EPC, and incorporated into program plans" (EPC Coordinator)

However, a few EPC Coordinators commented that the process was hampered by the program being integrated into other divisional programs; or that not enough funds were provided to develop the divisions workforce.

"No not really, as EPC is already integrated into divisional GP programs" (EPC Coordinator)

Several EPC Coordinators also expressed concerns regarding the lack of continuity of support.

"The division has developed specific skills. Unfortunately that specific role cannot be further supported. Program sustainability may work in larger divisions where there are more (closer to) full time staff" (EPC Coordinator)

Most GP Trainers agreed that the program had provided structures, resources (education, training) and overall coordination to staff involved in supporting GPs use of EPC items.

"Yes, provided support to division staff that GPs could access" (GP Trainer)
"Yes, as provided structures, resources, coordination and recommended actions for program delivery and Professional development via trainer the trainer workshops. (GP Trainer)

Five GP trainers indicated they were not sure or simply did not know.

"Not at this stage- still lots of questions about resources and priorities" (GP Trainer)

EPCESCL program contribution to organisational development of division

Overall most EPC Coordinators agreed that the EPCESCL program had contributed to organisational development.

Respondents endorsed that the EPCESCL program had contributed to organisational development and they highlighted that the program had:

- reinforced existing divisional policies, structures and strategic directions
- acted as a catalyst for strategic reviews of organisational structure

"We will use EPC as an underlying strategy for all our work on practice support. We will continue to work to improve practice systems and assist in encouraging practices to use the items" (EPC Coordinator)

"There has been organisational change in the division, with clearer staff roles. The board has responsibility for tasks in an explicit document produced by the EPC coordinator" (EPC Coordinator)

However, EPC Coordinators commented that this process was hindered by the fact that:

- initiatives aimed at capacity building take a longer timeframe and ongoing resourcing.
- division organisational polices, structures and programs already existed.

Comments about existing organisational structures hindering the process was also made by CEOs. Some noted that the program had not contributed further to an existing robust support system.

"Yes, but it takes more time…it depends on ongoing funding….beyond June" (EPC Coordinator)

"No, due to division already has polices, structures, processes and programs set up to support GPs" (EPC Coordinator)

"Not really as already doing it and have practice support structures already" (CEO)

"No- has increased EPC training to GPs, but division already doing practice support" (CEO)

CEOs mostly agreed as the EPCESL program had either reinforced divisional policies/models that they were using or that it had facilitated EPC item specific structures (e.g., Reference Groups).

'The program acted as a catalyst for a strategic review of the organisational structure of the division.' (CEO)

"Yes, facilitated us to set up a Care Planning Reference Group….which is sustainable" (CEO)

However, several CEOs also commented that funding was an issue.

"Money was not sufficient to change anything outright, but it enables some changes to occur to divisions operations" (CEO)

GP Trainers were divided in their views about whether the program had contributed to organisational development. GP Trainers who agreed commented that the program generally had assisted organisational change occurring, and specifically that EPC now featured in divisional business and strategic plans.

"The program assisted organisational changes that were occurring concurrently within the division". (GP Trainer)

"Yes this was all a part of it (i.e. strategic plan, policies and information systems). The Division took the challenge and helped to sell EPC." (GP Trainer)

Several GP Trainers who agreed also commented that organisational development was dependent on ongoing funding, more time and GPD-V ongoing involvement

"Yes, system is now in place, but need GPD-V to be part of sustainability" (GP Trainer)

However, several GP Trainers commented that they were not sure or it had not made any difference to the division as the EPC program already fitted into what the Division was doing.

"It did not make that much difference because the planing is already well structured. It did not really change anything, it was just one more arm of the cog" (GP Trainer)

"Not really, as EPC program already fitted into what Division is doing" (GP Trainer)

EPCESCL program contribution to division resources

Overall most interviewees agreed that the program had contributed to divisional resources. There was also a great deal of corroboration about how the program had contributed, namely; provision of funds to pay for nurses, assisted existing programs;

- enabled GP Trainers to come on board
- enabled training sessions to be held
- enabled tools/resources to be adapted/developed

"Yes, funds were provided, enabled us to bring in nurses to do health assessments and this opened doors in GP Clinics" (CEO)

"Enabled dedicated staff time. 'In future, there's not an argument for dedicated EPC funding for divisions. It is core to all our activity. The changes to promote capacity and financial viability of practices that have occurred within general practice over the past years mean the items will be part and parcel of that cultural move" (CEO)

"Yes, as provided resources to develop training" (GP Trainer)

"Yes, as funds enabled the GP Trainer to come on boar" (EPC Coordinator)

However, several CEOs also commented that ongoing funding was required and one CEO also commented that the amount of resources that the division had contributed also had to be considered.

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"Yes, but requires ongoing funds and resources, with the PCP on side" (CEO)

"Yes, got money, but not aware of how much divisional resources have gone into it" (CEO)

Several GP Trainers also commented that a longer timeframe was needed.

"Yes, has provided resources - but need longer timeframe (1-2 yrs)- maybe in yr 3 will GPs make best use" (GP Trainer)

Discussion

This section briefly discusses the capacity building evaluation findings in three ways. Firstly from a methodological perspective. Secondly, with respect to any trends that have emerged with regard interviewees responses. Lastly, the context within which the EPCESCL program has operated is discussed.

Methodological perspective

The evaluation findings may need to be interpreted with caution for two main reasons. Firstly, as elsewhere, the findings have emerged predominantly from self-report data (semi-structured interviews).

Secondly, given that the EPCESCL program only states expected outcomes but has no Key Performance Indicators, the evaluation has had to extrapolate and interpret the self-report data with regard to the extent to which the GPD-V program has contributed to capacity building. Furthermore, it needs to be recognised that the evaluation is not a research project itself, thus there were limitations on how much data could be collected so as not to place added demands on already busy CEOS, EPC Coordinators, and GP Trainers.

A related point methodologically, is the terminology and concepts that were used in the evaluation, in particularly 'capacity building'. Most interviewees, when initially asked for their views on how the EPC program had built the divisions capacity to support GPs hesitated and were confused. In response to this hesitation and confusion about the question, in particular amongst the GP Trainers, further explanations were provided by the interviewer. Namely that the concept of 'sustainability' was being operationalised into three domains: workforce development, organisational development and division resources. Furthermore the interviewer emphasised that the section was aimed at capturing the contribution of the GPD-V program and not the divisional program to supporting GPs to use the items.

Overall there appeared to be limited understanding about the concept of capacity building and overall interviewees did not necessarily conceptualise the GPD-V program as a capacity building program. Interviewees also had difficulty identifying/articulating/assessing the contribution of the GPD-V program as compared to the divisional program with regard to capacity building to support GPs to use the items, which may be related to the short-term timeframe of the program, uncertainty about future funding of the GPD-V program and the finite divisional funds.

Emerging Trends

This section provides a discussion of any trends that have emerged from the interviews response regarding responses about the contribution of the EPCESCL program to building the capacity of divisions to support GPs to use the EPC items.

There was a great deal of corroboration in responses within division CEOs, EPC Coordinators and GP Trainers. The only exception was GP Trainers who were divided in their views about the contribution of the EPCESCL program to organisational development.

Overall there were no clear trends in interviewee responses about sustainability and three key dimensions of implementation:

- the way the EPC program had been structured at the division level;
- the processes that were used to enhance community linkages; and
- perceptions about the support received from GPD-V.

Similarly, clustering divisions according to uptake of EPC items by GPs revealed no clear trends.

Possible reasons for a lack of trends include:

- the one-off nature of the EPC program as opposed to an ongoing systematic program of support; and
- the centralised support and local delivery nature of the EPC program which has inherent advantages (ownership, coordination) and disadvantages (variable quality and implementation).

Several tentative patterns emerged. For example, for divisions that had existing related initiatives/projects the EPC program appeared to provide a *platform* for further building capacity. However, in one division where the EPC program was implemented via an existing practice support structures, respondents reported that the EPC program had *not value added*. In divisions that were in the process of reviewing organisational structures and directions the EPC program acted as a *catalyst* for clarifying capacity building dimensions.

Contextualising the Findings

Lastly, it is important to recognise the context within which the EPCESCL program has been implemented when considering the extent to which is has contributed to capacity building. The extent of capacity building may have been impacted upon by several factors that are considered beyond the control of the program including:

- **General Practice-** the ongoing changes regarding the support structures and financing of GP (PIP etc); the ongoing debate about the core business of GPs and of divisions etc
- **Providers of Education, Training and Support-** it is important to recognise that EPC education, training and support has been provided at several levels**: Locally**- divisions; **Regionally**- PCPs; **Statewide**- DHS, GPD-V and RACGP- and that divisions were free to respond and participate in such activities
- **Evidence base –** there is limited literature regarding what models, structures and processes contribute to capacity building in the Divisions of General Practice context
- **Other Service Provider perspectives:** given that the concept of 'partnership/collaboration/integration' is also key to sustainability, the results of this section need to be considered in relation to the views of other service provider with regard to the EPCESCL program
- **GPs**- the diversity of GPs and ongoing and increasing demands on GPs by government, general practice & primary health care organisations and structures, community and patients; and the lack of a consensus amongst GPs about what is the core business of general practice

Lessons Learnt

Several key lessons have emerged from the evaluation including:

- The term sustainability as operationalised into capacity building concepts such as: workforce development, organisational development, and division resources is not widely understood

- Despite the fact that capacity building was a goal underpinning the EPCESCL program, interviewees appeared not to be conceptualisising the GPD-V program as as such
- There was general agreement amongst CEOs, EPC Coordinators and GP Trainers that the EPCESCL program had contributed to divisions workforce development, and Divisional resources
- There was general agreement amongst CEOs and EPC Coordinators that the EPCESCL program had contributed to organisational development but GP Trainers were divided in their views about whether the EPCESCL program had contributed to organisational development
- CEOs were the most positive about the EPCESCL program, given their strategic perspective of divisional activities as exemplified by there comments such as: gaining extra resources or reinforcing current policies and programs
- EPC Coordinators were less positive about the EPCESCL program, given their roles which requires them to have a pragmatic/practical perspective at the coalface with GPs and other service providers as exemplified by comments such as: division already has policies, program that support GPs, whereby the GPD-V program was seen as not value adding or duplicative
- GP Trainers were overall not familiar with capacity building concepts, and many appeared to be too removed from divisional policies, structures and strategic directions.
- Overall there appeared to be confusion about identifying/articulating/assessing the contribution of the GPD-V program as compared to the divisional program with regard to capacity building to support GPs to use the items- clarifying this will require contextualising the results of this section to the results of the other sections
- The short-term timeframe of the EPCESCL program; the uncertainty about future funding of the GPD-V program; and eminent end of local divisional funds in June 2002 may have contributed to confusion about the sustainability of the GPD-V program
- Overall there were no clear trends in interviewee responses about sustainability and three key dimensions of implementation: the way the EPC program had been structured at the division level; the processes that were used to enhance community linkages; and perceptions about the support received from GPD-V. Possible reasons include: the one-off nature of the EPC program as opposed to an ongoing systematic program of support; and the centralised and local delivery nature of the model.

The evaluation of the sustainability of the EPCESCL program has also highlighted the need to undertake future research into ongoing systematic programs of support and models of program support and delivery.

Overall there was a great deal of agreement and corroboration amongst and within division CEOs, EPC Coordinators, and GP Trainers that the EPCESCL program had contributed to division's capacity (i.e., workforce development, organisational development, resources) to support GPs to use the EPC items. Only GP Trainers had mixed views about whether the program had contributed to organisational development.

Several key strategies emerged as ways in which divisions intended to sustain the EPC program including:

- actively tranferring EPC knowledge and skills to all divisional staff;
- integrating EPC into existing practice support programs;
- incorporating EPC into divisional business and strategic plans; and
- providing ongoing support and resources

The way forward: an analysis using the RE-AIM model

The EPCESCL program was analysed using the RE-AIM framework, a public health promotion evaluation model[2]. The RE-AIM model seeks to assess a program's worth based upon its performance across the following domains: 'reach', 'efficacy', 'adoption', 'implementation' and 'maintenance'.

Reach

Reach refers to the proportion of the targeted population/organisations (e.g. divisions, GPs, patients and community agencies) that participated in the intervention or organised activities.

Clearly all divisions participated in the program. The EPCESCL had a reasonable reach at both GP and community levels. Education and support had been offered to all GPs and reached over half the GPs, but there was variation across the State. In the absence of a denominator, it is more difficult to assess the reach to other health providers, but clearly awareness has been raised across this sector.

Efficacy

The evaluation was not explicitly designed to assess efficacy, ie. positive or negative program outcomes. The global statistics indicate the implementation of the EPC items. More than half Victorian GPs have used an EPC item. However, in terms of behaviour change across general practice, most respondents reported that cultural change had been both slow and variable. This response was consistent, regardless of the divisions' actual ranking in terms of actual uptake. GPs had only gradually begun to use the items. Whilst some GPs were yet to consider the items' usage, respondents thought that there remained some scope to encourage uptake by more GPs. A positive process outcome was that EPC coordinators had learnt from their peers regarding strategies. They frequently referred to the ideas they had gleaned from other coordinators. Divisions who reported most success were generally those who had been engaged in complimentary initiatives, for example the coordinated care trials, and the Department of Veteran Affairs initiative, thus the philosophy and culture inherent in the use of the EPC items was not new.

Adoption

Adoption here refers to the proportion or representativeness of settings (divisions, GP clinics, GPs) that adopted the program

Divisions attempted to reach all their members. However, few had reflected upon how they might target particularly challenging groups. The respondents clearly recognised the challenges involved in promoting EPC item uptake amongst solo and rural GPs. A number of divisions specifically targeted the solo GPs, in some cases organising contract staffing to assist in the completion of health assessments. Other divisions chose to focus upon practices that already had systems in place that would facilitate item usage. For example, practices that had computerised recall systems were given IT support to use these in flagging relevant patients for the EPC items. Measures such as these should assist broader adoption across the general practice sector.

The EPCESCL program had acted as a catalyst for divisions to engage both their members and local service providers in networking and collaboration. There remains much scope for awareness raising, relationship building and joint activities. Consumer empowerment will be a vital component of this.

[2] Glasgow. RE, Thomas M., Boles., Shawn, M (1999). Evaluating public health impact of health promotion interventions: the RE-AIM framework, *American Journal of Public Health*, 89(9):pp 1322-1327.

Implementation

Implementation refers to the extent to which the program was implemented as intended.

GPDV-s' goals were met to varying degrees, although respondents commented that they were not aware of the explicit goals of the program. Divisional ownership of the program was achieved. Many divisional personnel had emerged as change leaders and advocates for the program. The 'Train the Trainer' model enabled the program to be adopted by divisions, although the education they provided was not always implemented as intended. Due to the program's flexibility, there were a wide range of models implemented for the training which makes it difficult to attribute success to one particular training model (although an analysis of the stages necessary for the uptake of the items is contained in final section below). At the GP level, the program was less successful at getting GPs to use the EPC items routinely and systematically with their patients. There were some concerns that the items had not been used as intended, reducing the quality of the EPC process. This will need to be addressed via future support activities.

Maintenance

Maintenance measures the extent to which the intervention was institutionalised at the individual and organisational level.

The program aimed to build capacity in divisions that would be sustainable beyond the life of the program. Integration of EPC item promotion across divisional programs will assist maintenance of support for GPs to use the EPC items. The goodwill and motivation engendered to date will need to be sustained across divisions, general practice and the allied health community. Whilst the EPCESCL funding has ceased, the use of the EPC items will continue. Capacity building systems such as the use of practice nurses, recall and reminder systems and joint programs should assist sustainability.

Key stages of the EPCESCL program's implementation

In reflecting upon the EPCESCL, it is useful to consider the different stages that divisions had to work through for the uptake of the items to increase. Whilst the train the trainer model was a critical success factor in raising awareness and the general intention to use the item, it was insufficient in and of itself to generate use of the items. GPs also needed detailed working knowledge of the items, and to have adequate systems established in their practice such as IT, templates and proformas. In addition, relationships had to be established or strengthened with local allied health professionals. These factors will now be examined in turn:

1. **Awareness raising**

   The first stage of the education and support program was awareness raising, stimulating the general interest of the GPs to find out more about the EPC items and to consider ways that they could use them in their practice. In nearly all divisions this was done through conducting CME events. It involved answering the general questions of GPs and getting them interested in finding out the details of EPC item usage. It was in this stage that the use of the GP advocate was important, in highlighting that the use of the items was feasible.

2. **Detailed knowledge of items, paper work, requirements**

   Once the GPs were interested in using the items, they required detailed knowledge of the EPC's criteria, guidelines, and applicability. They needed to be able to complete the forms and other paper work required to use the items and claim payment. The general consensus amongst divisions was that the best way to impart this detailed and technical information was practice visits. It seemed that the CME events were too large a forum to impart via such detailed

information. One division used small discussion groups for 6-8 GPs and commented that the level and sophistication of the questions asked at the smaller groups was much higher than at CME events. Whilst a small number of divisions did use the CME events to impart this level of information, it was not the norm.

3. Systems issues

In addition to the GPs' knowledge, the use of the items required considerable systems support in their practices. The use of the EPC items involved the use of templates, and proformas. Practices that had an IT system were at an advantage as it was easier and quicker to use the templates directly from Medical Director. Divisions distributed both paper and IT based proformas. Other material included laminated flowcharts and A4 summaries. The use of the items required considerable support i.e., for the identification and recall of patients over 75 or with diabetes. Other systems issues which supported or detracted from the GP's ability to use the items included the size of the practice e.g. it was more difficult for solo practitioners to use the items, and whether there was a practice nurse to conduct the health assessments. Divisions used practice visits to assist the GPs and the other practice staff to understand the requirements and workings of the EPC at their practice level. The inclusion of practice staff in the discussion and dissemination of information was critical. However discussion with the practice staff was not fruitful unless the GP was interested. Obtaining the GPs' agreement was a pre-requisite for the practice visit.

4. Relationships with other providers

Having good relationships with allied health professionals was at the heart of the case conferencing and care planning. The use of these items required a significant change in the culture, attitude and practice of many of the GPs, who generally work independently. It seemed that the use of the case conferencing and care planning items was limited to GPs who already worked in some way with allied health professionals. The EPC items seemed to formalise and enhance existing relationships, with limited impact on GPs who did not already have a relationship with other providers. Whilst the CME events with both GPs and allied health providers assisted in fostering communication and networking, the comment from allied health professionals was that it was the 'usual 2-3 converted GPs' who attended. Considerable more work and effort is needed to promote culture change across general practice.

The lessons learnt in the implementation of the EPCESCL program will hopefully guide GPD-V and the Victorian Divisions of General Practice in the continued support of GPs to use the EPC items. The capacity and relationships built should be maintained and strengthened to add value to associated endeavours in the primary health care sector.

Appendices

Appendix 1

Divisional CEO Interview

This interview contains four levels of questions. These are:

1. **Background**
2. **Your impressions of the EPC Education, Support and Community Linkages (EPCESCL) program**
3. **Views on the promotion and implementation of the program**
4. **How you think the EPCESCL model has built the Division's capacity to support GPs to use systematically the EPC items**

Background

1a How long have you been in position as the Division's CEO ?
1b What has been your role with regard to the EPCESCL program ?

The next questions are about the support you have received, both internally and externally **:**

2a Can you briefly describe the support you have received from GPD-V to assist you in implementing the EPCESCL program?

2b Apart from GPD-V, has the EPCESCL program been assisted by other sources of support? Please specify.

3 Have there been any changes within your Division that have impacted on you implementing the EPCESCL program?

Impressions of the EPCESCL program

The goals and philosophy that underpin the Victorian EPCESCL program are as follows:

- To build capacity in Divisions that is sustainable beyond the life of the program
- To establish change leaders and advocates within the Divisions
- To allow Divisions to adopt approaches suitable to their own context, history and contemporary workplan

1 How successful do you believe the Victorian EPCESCL program has been to date?

2a How is the EPCESCL program perceived within the Division? (Is it seen as a core program, integrated within other programs or as a peripheral activity?)

2b With regard to program diversity and flexibility, do you think your Division has had ownership of the proqram?

3 A stated goal of the program was improved healthcare for those with complex care needs. Do you have any evidence of this i.e. improved healthcare for those with complex care needs?

4 What evidence do you have that the items have enabled GPs to become more involved in preventive health?

5 Has the Victorian EPCESCL program added value to what Divisions already do to support GPs to be involved in population health activities?

6 What evidence do you have that the items have enabled GPs to work more effectively with other service providers?

7 What aspects of the Victorian EPCESCL program do you feel have contributed to its success? (Please consider strategies; processes, structures, products, and partnerships)

8 What aspects of the Victorian EPCESCL program do you feel have limited its success? (Please consider strategies; processes, structures, products, and partnerships)

9 How do you think the EPCESCL program has linked with other GPD-V programs?

GPD-V are interested to learn whether the 'local GP trainer,' train the trainer approach used to implement the EPC support program in Victoria is worth repeating for future programs

10 Do you see the local GP trainer approach as a potential model that can be used by Divisions to implement other population health activities?

11 Can you suggest any other ways in which the EPCESCL (and similar programs) could be better delivered to Divisions?

Views on the promotion and implementation of the EPCESCL in your Division

In this section we want you to reflect upon the diversity, impact and reach of the program. We will look at the program's three components in turn.

A Education

1 What role (if any) did you have in the educational aspect of the EPCESCL program?

2 What support did the EPC Coordinator receive from the Division in implementing the EPCESCL program ? (From marketing through to maintenance)

3 (Where appropriate) How well did the education materials tie in local circumstances eg services available, waiting times?

4 Can you comment on the reach of the educational program to other local providers? (e.g. DHS, hospitals, health agencies, aboriginal health services, LGOs, private practitioners, PCPs, RDNS)

5 We can see what the numbers tell us about the training program. However, in terms of behaviour change across general practice how would you rate the effect of the training?

B Support

1 What strategies have been used to promote the EPCESCL program within your Division (e.g. Exec. Officer, Board, and Programs)? Have they worked?

2 What GP follow up has occurred, to reinforce promotion of EPC item usage? (*Where applicable*: with what frequency?)

3 With regard to EPC uptake, has the Division had the capacity to meet the needs of all its GPs? (e.g. NESB GPs, part time GPs).

C Community linkages

1 What strategies has the Division used to develop linkages between GPs and other providers? (*How did you liaise with local services regarding the EPC items? How effective has the provision of information to other services been?*)

2 Has the Division been able to negotiate protocols with local agencies for specific proqrams that promote EPC item usage?

3 Have other agencies provided policy, training or financial support to assist EPC use? (e.g. DHS)

4 Overall, how effective have linkages to other services been in enabling item usage to address specific clinical and service delivery problems? (*Can you comment/summarise your views on the success of arrangements to involve other local providers e.g. DHS, hospitals, health agencies, ACAS*)

Sustainability of EPCESCL program

The model was essentially designed to build Divisional capacity to support GPs usage of the EPC items. With this goal in mind, we want to end by obtaining feedback on aspects of capacity building that have occurred.

Reflecting upon the Division's capacity to support GPs, the following questions consider how the EPCESCL model has built the Division's capacity to support GPs to systematically use the EPC items. You may wish to consider these in relation to the current strategic planning activities the Division is conducting.

1 How has the EPCESCL program contributed to the **development of Divisions workforce** to support GPs to use items with their patients (with regard to professional development and support)?

2 How has the EPCESCL program contributed to the **organisational development of Division** to support GPs to use items with their patients (with regard to Division strategic plan; policies; structures, and information systems)?

3 How has the EPCESCL program contributed to **Divisional resources** to support GPs to use items with their patients (with regard to financial, staff, tools etc)?

Thank you very much for your assistance.

Appendix 2

Divisional EPC Coordinator Interview

This interview contains four levels of questions. These are:

5. **Background**
6. **Your impressions of the EPC Education, Support and Community Linkages (EPCESCL) program**
7. **Views on the promotion and implementation of the program**
8. **How you think the EPCESCL model has built the Division's capacity to support GPs to use systematically the EPC items**

Background

1a How long have you been in position as EPC coordinator ? (how were you recruited; what is your time fraction)
1b What has been your role/ what have been your responsibilities as the EPC coordinator? (do you have any other roles at the division?)

2 Did you receive any professional education and training for this position ?

The next questions are about the support you have received, both internally and externally **:**

3a Can you briefly describe the support you have received from GPD-V to assist you in your role?

3b Apart from GPD-V, has your position been assisted by other sources of support? Please specify.

4 Have there been any changes within your Division that have impacted on you implementing the EPCESCL program?

Impressions of the EPCESCL program

The goals and philosophy that underpin the Victorian EPCESCL program are as follows:

- To build capacity in Divisions that is sustainable beyond the life of the program
- To establish change leaders and advocates within the Divisions
- To allow Divisions to adopt approaches suitable to their own context, history and contemporary workplan

1 How successful do you believe the Victorian EPCESCL program has been to date?

2a How is the EPCESCL program perceived within the Division? (Is it seen as a core program, integrated within other programs or as a peripheral activity?)

2b With regard to program diversity and flexibility, do you think your Division has had ownership of the proqram?

3 A stated goal of the program was improved healthcare for those with complex care needs. Do you have any evidence of this i.e. improved healthcare for those with complex care needs?

4 What evidence do you have that the items have enabled GPs to become more involved in preventive health?

5 Has the Victorian EPCESCL program added value to what Divisions already do to support GPs to be involved in population health activities?

6 What evidence do you have that the items have enabled GPs to work more effectively with other service providers?

7 What aspects of the Victorian EPCESCL program do you feel have contributed to its success? (Please consider strategies; processes, structures, products, and partnerships)

8 What aspects of the Victorian EPCESCL program do you feel have limited its success? (Please consider strategies; processes, structures, products, and partnerships)

9 How do you think the EPCESCL program has linked with other GPD-V programs?

GPD-V are interested to learn whether the 'local GP trainer,' train the trainer approach used to implement the EPC support program in Victoria is worth repeating for future programs

10 Do you see the local GP trainer approach as a potential model that can be used by Divisions to implement other population health activities?

11 Can you suggest any other ways in which the EPCESCL (and similar programs) could be better delivered to Divisions?

Views on the promotion and implementation of the EPCESCL in your Division

In this section we want you to reflect upon the diversity, impact and reach of the program. We will look at the program's three components in turn.

A Education

1 (Where unclear from reports) Did you provide education about all the EPC items?

2a What was/were the source(s) of the education modules you used?
(Was material from other services distilled to make it user friendly?)

2b What professional training strategies have you used to train personnel (e.g., Practice Visits, CMEs)? How have they been received?

2c What types of approach did the division find most useful? (e.g. CME, practice visits, self education, satellite broadcasts. Also consider scheduling of events and what has worked best)

3 How well did the education materials tie in local circumstances eg services available, waiting times?

4 (*Where unclear from reports)* Has the Division been able to disseminate information to practice staff as well as GPs?

5 (*Where used*) Who was targeted for Practice visits? Were visits made by trained personnel?

6 Can you comment on the reach of the educational program to other local providers? (e.g. DHS, hospitals, health agencies, aboriginal health services, LGOs, private practitioners, PCPs, RDNS)

7 We can see what the numbers tell us about the training program. However, in terms of behaviour change across general practice how would you rate the effect of the training?

B Support

1 What strategies have you used to promote the EPCESCL program within your Division (e.g. Exec. Officer, Board, and Programs)? Have they worked?

2a Beyond educational activities, what strategies have you used to support GPs in using the EPC items? (Were protocols and tools provided to assist item use? By whom? Why was that?) How have they worked?

2b What GP follow up has occurred, to reinforce promotion of EPC item usage? (*Where applicable* : with what frequency?)

2c Have you learnt any lessons from certain types of GP where uptake has been low that could be used to increase uptake in groups or individual GPs with similar characteristics?

3 What type of information and/or resources have GPs requested? Were you able to meet their needs?

4 To what extent have you been able to address the needs of NESB groups?(eg providing translated material, assisting NESB GPs)

C Community linkages

1 What strategies have you used to develop linkages between GPs, the Division and other providers? (*How did you liaise with local services regarding the EPC items? How effective has the provision of information to other services been?*)

2 Has the Division been able to negotiate protocols with local agencies for specific proqrams that promote EPC item usage?

3 Have other agencies provided policy, training or financial support to assist EPC use? (e.g. DHS)

4 Overall, how effective have linkages to other services been in enabling item usage to address specific clinical and service delivery problems? (*Can you comment/summarise your views on the success of arrangements to involve other local providers e.g. DHS, hospitals, health agencies,ACAS*)

Sustainability of EPCESCL program

The model was essentially designed to build Divisional capacity to support GPs usage of the EPC items. With this goal in mind, we want to end by obtaining feedback on aspects of capacity building that have occurred.

Reflecting upon the Division's capacity to support GPs, the following questions consider how the EPCESCL model has built the Division's capacity to support GPs to systematically use the EPC items. You may wish to consider these in relation to the current strategic planning activities the Division is conducting.

1 How has the EPCESCL program contributed to the **development of Divisions workforce** to support GPs to use items with their patients (with regard to professional development and support)?

2 How has the EPCESCL program contributed to the **organisational development of Division** to support GPs to use items with their patients (with regard to Division strategic plan; policies; structures, and information systems)?

3 How has the EPCESCL program contributed to **Divisional resources** to support GPs to use items with their patients (with regard to financial, staff, tools etc)?

Thank you very much for your assistance.

Appendix 3

Divisional EPC GP Trainer Interview

This interview contains four levels of questions. These are:

1. **Background**
2. **Your impressions of the EPC Education, Support and Community Linkages (EPCESCL) program**
3. **Views on the promotion and implementation of the program**
4. **How you think the EPCESCL model has built the Division's capacity to support GPs to use systematically the EPC items**

Background

1a How long have you been in position as EPC trainer? (how were you recruited; what is your time fraction)
1b What has been your role/ what have been your responsibilities as the EPC trainer? (do you have any other roles at the division?)

2 Did you receive any professional education and training for this position? (Did you attend the training skills workshop run by GPDV?)

The next questions are about the support you have received, both internally and externally **:**

3a Can you briefly describe the support you have received from GPD-V to assist you in your role (both at the outset and subsequently)?

3b Apart from GPD-V, has your position been assisted by other sources of support? Please specify.

4 Have there been any changes within your Division that have impacted on the implementation of the EPCESCL program?

Impressions of the EPCESCL program

The goals and philosophy that underpin the Victorian EPCESCL program are as follows:

- To build capacity in Divisions that is sustainable beyond the life of the program
- To establish change leaders and advocates within the Divisions
- To allow Divisions to adopt approaches suitable to their own context, history and contemporary workplan

1 How successful do you believe the Victorian EPCESCL program has been to date?

2a How is the EPCESCL program perceived within the Division? (Is it seen as a core program, integrated within other programs or as a peripheral activity?)

2b With regard to program diversity and flexibility, do you think your Division has had ownership of the proqram?

3 A stated goal of the program was improved healthcare for those with complex care needs. Do you have any evidence of this i.e. improved healthcare for those with complex care needs?

4 What evidence do you have that the items have enabled GPs to become more involved in preventive health?

5 Has the Victorian EPCESCL program added value to what Divisions already do to support GPs to be involved in population health activities?

6 What evidence do you have that the items have enabled GPs to work more effectively with other service providers?

7 What aspects of the Victorian EPCESCL program do you feel have contributed to its success? (Please consider strategies; processes, structures, products, and partnerships)

8 What aspects of the Victorian EPCESCL program do you feel have limited its success? (Please consider strategies; processes, structures, products, and partnerships)

9 How do you think the EPCESCL program has linked with other GPD-V programs?

GPD-V are interested to learn whether the 'local GP trainer,' train the trainer approach used to implement the EPC support program in Victoria is worth repeating for future programs

10 Do you see the local GP trainer approach as a potential model that can be used by Divisions to implement other population health activities?

11 Can you suggest any other ways in which the EPCESCL (and similar programs) could be better delivered to Divisions?

Views on the promotion and implementation of the EPCESCL in your Division

In this section we want you to reflect upon the diversity, impact and reach of the program. We will look at the program's three components in turn.

A Education

1 (Where unclear from reports) Did you provide education about all the EPC items?

2a To whom did you provide education?

2b What was/were the source(s) of the education modules you used?
(Was material from other services distilled to make it user friendly?)

2c What professional training strategies have you used to train personnel? How have they been received?

2d What types of approach did you find most useful? (e.g. CME, practice visits, self education, satellite broadcasts. Also consider scheduling of events and what has worked best)

3 How well did the education materials tie in local circumstances eg services available, waiting times?

4 (*Where unclear from reports)* Have you been involved in the dissemination of information to practice staff as well as GPs?

5 (*Where used*) Who was targeted for Practice visits? Were visits made by yourself or by the EPC coordinator ?

6 Can you comment on the reach of the educational program to other local providers? (e.g. DHS, hospitals, health agencies, aboriginal health services, LGOs, private practitioners, PCPs, RDNS)

7 We can see what the numbers tell us about the training program. However, in terms of behaviour change across general practice how would you rate the effect of the training?

B Support

1 What GP follow up has occurred, to reinforce promotion of EPC item usage? (*Where applicable*: with what frequency?)

2 Have you learnt any lessons from certain types of GP where uptake has been low that could be used to increase uptake in groups or individual GPs with similar characteristics?

3 (Where appropriate) What type of information and/or resources have GPs requested? Were you able to meet their needs?

4 With regard to EPC uptake, has the Division had the capacity to meet the needs of all its GPs?

C Community linkages

1 Have you personally been involved in developing linkages between GPs, the Division and other providers?

2 Overall, how effective have linkages to other services been in enabling item usage to address specific clinical and service delivery problems? (*Can you comment/summarise your views on the success of arrangements to involve other local providers e.g. DHS, hospitals, health agencies,ACAS*)

Sustainability of EPCESCL program

The model was essentially designed to build Divisional capacity to support GPs usage of the EPC items. With this goal in mind, we want to end by obtaining feedback on aspects of capacity building that have occurred.

Reflecting upon the Division's capacity to support GPs, the following questions consider how the EPCESCL model has built the Division's capacity to support GPs to systematically use the EPC item. You may wish to consider these in relation to the current strategic planning activities the Division is conducting.

1 How has the EPCESCL program contributed to the **development of Divisions workforce** to support GPs to use items with their patients (with regard to professional development and support)?

2 How has the EPCESCL program contributed to the **organisational development of Division** to support GPs to use items with their patients (with regard to Division strategic plan; policies; structures, and information systems)?

3 How has the EPCESCL program contributed to **Divisional resources** to support GPs to use items with their patients (with regard to financial, staff, tools etc)?

Thank you very much for your assistance.

Appendix 4

Primary Care Provider Enhanced Primary Care (EPC) Interview

This interview contains three levels of questions. These are:

1. **Background information**
2. **Contextual information (your impressions of EPC education and training; and promotion and implementation of EPC items in your agency)**
3. **Impact information (impact of the EPC Items and your impression about the community linkages)**

You have been contacted for an interview because you attended training on the EPC items that are: Health Assessments, Care Planning and Case Conferencing. We are interested in your personal perspective. You are not expected to provide the perspective of your employing agency, nor of the agency that nominated you for interview. Your responses will be kept confidential and will be included in the analysis of the overall evaluation report. These questions are being asked of a range of primary care providers, so some questions may not be relevant to you.

The Department of General Practice, The University of Melbourne has been commissioned by General Practice Divisions–Victoria (GPD-V) to evaluate the Victorian Enhanced Primary Care Education, Support and Community Linkages (EPCESCL) Program. This involves the systematic conduct of interviews with the Division of General Practice CEOs, EPC Coordinators, GP trainers and other primary care providers.

SECTION 1. BACKGROUND INFORMATION

1a. What is your agency? (Local Govt, CHS, hospital etc)

1b. What is your role in your agency?

1c. What has been your role and what have been your responsibilities with regard to the EPC package?

2. Have there been any changes within your agency that have impacted on your working with GPs to use the new EPC items (e.g. staffing, resources, policies) ?

SECTION 2. CONTEXTUAL INFORMATION
A. Your impressions of EPC Education and training

3. Impressions of EPC Educational Activities

Which of the following EPC related educational activities you been involved in:

Attended a division facilitated education seminar	Yes	No
Attended a Dept Human Services education seminar	Yes	No
Attended a Primary Care Partnership educational Seminar	Yes	No
Had a visit by a GP or GP Division staff	Yes	No
Other educational activities:……		

Distinguish between events if you attended more than one to indicate how the education responsive to your needs in terms of:

3 a) presenter(s)
3 b) content
3 c) format
3 d) time
3 e) venue

4. We are interested in what factors contribute or limit linkages between GPs and primary care providers. Please consider the following items:

4 a) Personal Characteristics: your own knowledge, training, profession, role and responsibilities

4 b) Organisational Practices: your organisation's role, practices, staffing, resources

4 c) Context: broader factors such as socio-economic status of your area, funding, wider partnerships and organisational issues

4 d) Practices and characteristics of GPs: which can either promote or detract from linkages

5. Did the educational activity/ies address any of these factors? If yes, how?

6. Overall, how responsive has the education you have received been to meeting your needs in service provision? (consider timing, skills, knowledge, and demands. Distinguish between events if you attended more than one).

7. Can you suggest any ways the education could have been improved ? (structure, content, process, timing)

SECTION 2. CONTEXTUAL INFORMATION

B. Uptake of EPC items & dissemination of information

8. Have you been involved in conducting:

Health Assessment	Yes	No
Care Planing	Yes	No
Case Conferencing	**Yes**	**No**

9. What impact has the EPC education you received had upon your current work practices (consider planning, service delivery etc)

10. Has the EPC education you received enabled you to conduct these activities?

If yes, please describe in what ways. If no, what have been the barriers?

11. Have there been any unexpected outcomes of participating in the educational activities. If yes, please describe? (e.g. contacts made at the training, new projects) What aspects of the educational activity contributed to these outcomes?

12. Have you (or anyone else) provided any EPC education to other staff in your agency

Yes **No** ***If yes, please describe (consider format, resources used)***

13. Can you suggest any other ways in which education about the EPC items package (and similar programs) could be better delivered to primary care agencies?

SECTION 3. IMPACT

A. Community linkages

14. What strategies has your agency used to support staff in working with GPs to implement the EPC items, ie care planning, case conferencing, health assessments? (Consider staff schedules, client waiting times, telephone systems etc)

15. What barriers have not been addressed? (Consider staff schedules, client waiting times, telephone systems etc)

16. What strategies have you (or your organisation) used to develop linkages between (other) GPs, the Division and other providers?

17. Has your agency been able to negotiate protocols with GPs/Clinics/Divisions for specific proqrams that promote EPC item usage?

18. Has your agency provided policy, training or financial support to assist EPC item use?

19. Overall, how effective have linkages to other services been in enabling item usage to address specific clinical and service delivery problems? (Can you comment/summarise your views on the success of arrangements to involve other local providers)

20. What impact did the training you received have on your ability to establish linkages with other services?

SECTION 3 IMPACT
B. Your overall impressions about the impact of the program and the uptake of the EPC items

21. A stated goal of the program was improved healthcare for those with complex care needs. Do you have any evidence of this i.e. improved healthcare for those with complex care needs?

22. What evidence do you have that the items have enabled GPs to become more involved in preventive health?

23. What evidence do you have that the items have enabled GPs to work more effectively with other service providers?

24. Do you think your organisation has changed as a result of the EPC initiative? If yes, how?

25. What aspects of the EPC program do you feel have contributed to its success? (consider strategies, processes, structures, products, timing, education, resources and partnerships)

26. What aspects of the EPC program do you feel have limited its success? (consider strategies, processes, structures, products, education, resources and partnerships)

Thank you very much for your assistance.