Divisions...

Healthy at Home

A successful HARP project auspiced by Whitehorse Division of General Practice

Healthy at Home (H@H) is a model that supports general practice management of aged, frequently admitted medical patients. Key components of the model are:

- Team of Division One nurses (x 6) who provide medium - long term, 'medical / nursing' case management for patients who have had frequent hospital admissions. The aim is to keep patients out of hospital.
- The nurses work in a shared care model with the GP
- The project is based at the Whitehorse Division, but is expanding to cover all the Eastern Health boundaries through Eastern Ranges, Knox and Inner Eastern Melbourne Divisions.
- Identified as a GP-friendly and GP-appropriate service
- Patients referred in by GPs, Eastern Health Hospitals or other HARP programs

Evidence of outcomes:

- GPs and Patients have shown high levels of satisfaction
- Program results have been verified by DHS data from the Victorian Admitted Episodes Dataset & Victorian Emergency Minimum Dataset & Victorian Emergency Minimum Dataset. This data shows a significant decrease in admissions and decreases in lengths of stay for patients on the program.

Further elaboration of the model:

Two other models are being trialed within H@H:

- A practice is engaged to utilise one of their own practice nurses to deliver H@H case management to eligible patients of that practice by increasing the practice nurses time by one day per week.
- A H@H nurse working out of the division is sent to a practice one day a week (where the practice has no nurse) to run a 'case management clinic' for eligible patients within that practice.

Contact: Whitehorse Division of General Practice
(03) 8878 3755, www.wdgp.com.au

West Vic Division and the *Physical Activity Community Enabler (PACE) Program*

West Vic Division employed a Population Health Project Officer to strengthen their work in health promotion. Initial data research identified Cardiovascular Disease (CVD) as a major health issue for the division catchment population. Following research into effective population health interventions through general practice and GP advice about what works, the board decided to give priority to addressing physical inactivity.

Discussion and 'scoping' of possibilities with key organisations with an interest in promoting physical activity built a partnership approach, including the tangible commitment of an allocation of resources. From this point, the physical activity community enabler model was developed, with the following components:

- GP identifies physically inactive patient.
- GP refers this patient to a local Physical Activity Community Enabler (PACE), who will assist the patient to access appropriate physical activity. Enabler phones patient (initial contact then 3, 6, 9 & 12 month intervals) to discuss progress, issues and barriers to increasing physical activity.
- Feedback is provided to the referring GP after each call from the PACE to the patient.

A local GP champion tested the tools and the model for practice appropriateness and possible improvement. Her first hand experience proved successful for promoting the model to other GPs in the division catchment. So, starting with 1 GP and 1 PACE (0.4 EFT), the model has been adopted, expanded and made sustainable, having built the capacity of the local health system to respond to community health issues in a population health framework.

In July 2004, 25 GPs had made approximately 250 referrals, and a year later, 603 referrals have been made by 50 GPs. The patients that are referred to the PACE are mostly women (73% compared with 27% men) and of those patients 58% are referred due to weight issues, while 34% are referred due to high blood pressure.

Currently there are 7 PACEs located in different community and health settings across the catchment, and a further 5 are likely to be in place by the end of 2005. Each of the PACEs have incorporated the role into their existing job descriptions, been trained to Cert IV in Exercise Leadership, and participation in the program has been endorsed by their organisations. For instance, cardiac rehabilitation nurses and dietitians now do PACE work as well, finding the role a rewarding and effective component of their role.

The West Vic program logic was used to develop the Physical Activity Community Enabler model. To obtain a copy of the West Vic program logic or further information on the Community Enabler model please contact Joanne Martin at West Vic on (03) 5381 1756.

GPDV Privacy Statement

GPDV is committed to a Privacy Policy which outlines existing legal and ethical obligations consistent with current State and Federal Privacy legislation and addresses the National Privacy Principles determined by the Privacy Commissioner.

The policy sets out how GPDV collects, uses, keeps secure and discloses information. It also acknowledges that individuals have the right to know what information is held about them, and to correct that information should that be necessary.

Further details are available on the GPDV website.

If you do not wish to continue receiving this newsletter please contact Linda McKenzie on 9341 5200 or l.mckenzie@gpdv.com.au

GPDV GENERAL PRACTICE DIVISIONS VICTORIA NEWS
Spring 2005
Quality Improvement Council
GPDV is a QIC accredited organisation

Mission Statement

As the peak body for divisions of general practice in Victoria, GPDV supports divisions in their endeavours to ensure a skilled, viable and effective general practice workforce, to improve the health and well-being of the people of Victoria.

From The CEO

This is the first issue of our newsletter in its new quarterly format. Our focus will be on the results of the work of divisions of general practice in Victoria with the aim of showing how divisions work within the Victorian health system and what they can offer as partners in the improvement of health services.

For GPDV there are two priority areas of work - the support of Victorian divisions in the development of their capacity to achieve their objectives, and the greater integration of general practice into the state-based health system through our ongoing work with DHS and a range of statewide health services.

For the Divisions Network 2005 has been the year of the Review Implementation Committee (RIC). Many of the changes arising from the work of the RIC have been implemented by divisions since 1 July but others are still in the pipeline. The development and implementation of these will give rise to important debates in the coming months about major issues, including

- the role of divisions in service delivery, which is now mainly limited to the delivery of services through DoHA-funded programs such as MAHS or specifically-funded local or regional projects. The possibilities range from an increase in these specifically-funded projects and programs to the greater use of the Divisions Network as budget holders for the roll-out of new national programs in primary care or for integrated programs funded jointly by state and federal governments.
- how the Divisions Network should work within the primary health care sector to develop strategies that will strengthen the sector. The first step in this was the publication of the network's position paper on primary health care, launched at the ADGP Forum on 5 November, which we expect to lead to constructive discussions with other stakeholders.
- the role of divisions in addressing the shortages in the GP workforce and the need to extend this role to include all members of the general practice workforce, or even more widely if divisions are to be fully engaged in service delivery. As shortages in the general practice workforce can only be addressed effectively in the context of the whole health system any solutions must be based on continuing work with DHS.
- ensuring that the current major developments at the State and Commonwealth level to improve the electronic transfer of patient information will enable general practice to participate in state systems.
- how divisions can best contribute to responses to emergency situations and public health alerts. GPDV is working with DHS and divisions with an initial focus on pandemic influenza and on planning for emergency response capacity for the 2006 Commonwealth Games in Melbourne.

We will be including items on all these in future newsletters and will include in each issue items from the division, state and national levels.

- Bill Newton

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Statewide...

DHS Small Grants: State funding to support GP participation in Service Coordination

Although the Small Grants for GP participation in Service Coordination started as a small, one-off funding pool in 2002-03, it has proved to be a robust strategy. DHS has been interested to hear from the field the lessons about what has worked, and what has not worked in the various projects. To this end, GPDV convened a statewide workshop to enable participants to analyse the outcomes to date, and develop a consensus view of what we have achieved so far. This article provides a brief overview of the Small Grants projects, and a summary of the lessons to date.

From an original funding pool for 8 projects, a total of 39 projects have now been funded.

Year	No. applications rec'd	No. projects funded	
		Central	Regional
2002-03	23	8	2
2003-04	21	14	2
2004-05	14	13	-

About one third of divisions have received funding from each of the three funding rounds, and half have received funding for more than one project.

	Divs involved in Projects	PCPs involved in projects
0 projects	5	6
1 projects	10	12
2 projects	6	6
3 projects	9	7

The types of activities that projects have focussed on can be broadly grouped as

- Training in use of Statewide Referral Form or Statewide Services Directory in the practice (4)
- Consultations/facilitated processes/networking focussed on shared understanding of and agreement about quality referral and feedback (10)
- E-referral focus (25)

Division and PCP/agency staff involved in implementation of projects agreed that some strategies were more likely to succeed than others. In summary they said

- Identify the right kind of general practice
  - 'Readiness index' – a list of criteria to help identify practices best placed to implement service coordination
  - Targeting winners/early adopters e.g. computerised, already know community providers
- Strategies to build and maintain effective relationships and communication
  - Regular working group meetings
  - Face to face meetings between sectors including GPs meeting with other practitioners as well as org/org meetings.
  - Allow $ to fund GP participation in face to face where necessary
  - Strong feedback loops
  - Promote value of participation
  - Networking – getting players face to face
- Respecting GP needs
  - Supporting existing workflow
  - Recognise, appreciate and build on existing workflow and systems in a practice
  - Include of practice staff
  - Protected GP time e.g. breakfast/lunch time meetings with food, remuneration when GP time is for advice, consultation etc
  - Ensuring GP input in project development for relevance
- Resources
  - Use of credible expert trainer
  - $: IT: manual
  - Project co-ordination
- Small scale incremental steps
- Need for champions/staff with responsibility for getting things done
  - Dedicated Driver
  - Division staff and GP champion (sellers of the message)
  - Champions in other sectors too.
  - Agreed implementation messages and goals
  - Engagement of practice principals and staff
- Focus on general practice business processes/systems approach
  - Sell value and benefits
  - Demonstrating relevance to GP & benefits to patients
  - Clarity re what's in it for GPs / patients
  - Education re value of a good referral / feedback
  - Link to MBS item use
  - Make it easy – meet an identified need
- Careful use of language
  - Make careful claims i.e. single referral form not true; single referral form for DHS funded primary care services is closer to true.

GPDV and DHS will present these findings at the ADGP Forum in November, 2005.

Nationwide...

Access to Allied Psychological Services Projects

The Access to Allied Psychological Services projects, a component of the *Better Outcomes in Mental Health Care* (BOIMH) initiative, allow divisions to fund hold and administer a GP patient referral service which provides patients with six free sessions of psychological treatment from an approved mental health professional, usually a psychologist. Currently, 102 projects covering 111 divisions have been funded in three major funding rounds to conduct Access to Allied Psychological Services projects. As reported by the fourth interim evaluation report, at 31 December 2004, more than 1771 GPs had referred 12,578 consumers to 569 allied health professionals. (1)

One of the most encouraging findings of the evaluation is that the projects are reaching their target group. The majority of patients are on low incomes (62%), and have been diagnosed with depression (76%) and /or anxiety disorders (56%) by their GP. Interestingly, almost half the patients referred have no previous history of specialist mental health care. Most patients are adults in their middle years and predominantly more women (73%) are being referred than men. It appears, however, that young people, and people from culturally and linguistically diverse communities are under-represented.

The projects are using a variety of models of service delivery, such as direct employment, contracts or arrangements with community health centres or psychology clinics. The evaluation reported that no models are associated with higher consumer access to care than others: all models appear to be performing well in assisting consumers access low-cost, high quality mental health care. (2)

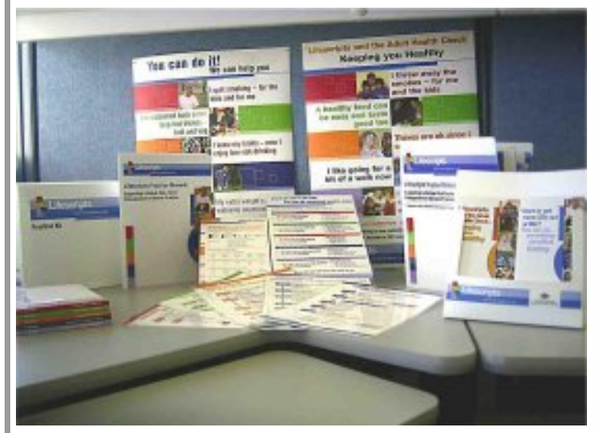
In general, the projects have been successful, with positive comment from GPs, patient satisfaction reported, and support registered from mental health professionals wishing to participate in the projects. Many GPs are pleased to have appropriate and highly skilled mental health professionals to refer their patients who would otherwise find considerable difficulty in accessing private providers. In addition, GPs report favourably on the opportunities for building relationships with local mental health providers, for upskilling, particularly where the provider is co-located, and for support from their division.

Conversely, allied health providers have welcomed the opportunity to work more closely with GPs, to extend their referral base, and to learn more about the role of divisions. Where consumer satisfaction has been recorded, consumers identify improved access to psychological services and improved mental health as positive outcomes arising from the projects.

(1) Kohn, F., Morley, B., Pirkis, J., Blashki, G., Burgess, P. *Evaluating the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care program.* Fourth Interim Evaluation Report. Melbourne: Program Evaluation Unit, School of Population Health, University of Melbourne, 2005.

(2) Pirkis, J., Morley, B., Kohn, F., Blashki, G., Burgess, P. *Evaluating the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care program: Models of service deliver: profile and association with access.* Fifth Interim Evaluation Report. Melbourne: Program Evaluation Unit, School of Population Health, University of Melbourne, 2005.

Lifescripts are here!



After a very successful introductory workshop, the Lifescripts tools and resources have hit divisions! These tools are great resources that can be used in a variety of ways by GPs, Practice Nurses, Aboriginal Health Workers and general practice administration staff, to assist patients address a variety of lifestyle risk factors — smoking, nutrition, alcohol, physical activity and weight management — and improve health.

If you would like further information about how your division could use the Lifescripts resources, please contact Angela Fielder at GPDV on 9341 5235 or a.fielder@gpdv.com.au.