Divisions...

Improving Transfer of Hospital Information

The Aged Care GP Panels Program is a Department of Health & Ageing (DoHA) initiative which aims to improve access to and quality of medical care provided to residents of Aged Care Homes. As part of this program Victorian divisions are exploring the aged/acute interface as a key area for development as the *'acuity level of individuals entering residential care is increasing since older people are being admitted later with higher and increasingly complex needs'*.(*) Divisions are working on systems which promote good in-hours care for residents as well as finding practical solutions to improving the transfer of hospital information from Aged Care to Emergency Departments should the need arise.

Transfer to Hospital Checklist - North East Valley Division

North East Valley Division has produced excellent resources including the Transfer to Hospital Checklist. The checklist outlines a practical step by step approach when considering transferring a resident to hospital. Hospitals included in the checklist are St Vincent's, Austin and Northern Hospitals and the checklist contains contact details and names of positions responsible within ED. The Checklist can be accessed through the division's website http://www.nevdgp.org.au/ Primary Care Support section and can be easily adapted by other divisions for other hospitals.

Hospital Transit Form - Inner Eastern Melbourne Division, Knox Division, Eastern Ranges GP Association & Whitehorse Division

Divisions across the Eastern Metro Region are promoting the use of the Hospital Transfer Form that was used by Aged Care HARP, Residential Aged Care Across Sectors Program (RACS) in 05/06. The Hospital Transfer Form accompanies the medication chart on the resident's presentation to ED. A key feature of the form which was requested by the hospitals & facilities is the service capability statement which includes an explanation of the level of care the resident is going back to [eg RN Div 1 supervisor day shift only, all other care by PCAs]. Maroondah, Box Hill and Angliss Hospitals are aware to look for the Transfer Form when a resident comes in to hospital, which has enhanced communication processes between them and the facilities. For Aged Care HARP RACS Evaluation http://www.gpdv.com.au/gpdv/documents/AC_HARPEvaluation.doc

Hospital Transit Envelope - Dandenong & District Division

Dandenong Division has developed a Transit Envelope which reduces the occurrence of lost paperwork during a resident transfer from an Aged Care Home to a Hospital Emergency Department. The envelope easily identifies any key behavioural issues of the patient, such as dementia, and the facility type they have come from, i.e. high care, low care or ageing in place. This assists allied health teams particularly in discharge planning and gives consideration to scheduling appropriate out-patient follow up. The pilot project has now been completed and the division has negotiated with Rolls Printing to establish a standard stationery item for facilities to order sets of envelopes as necessary. The Transit Envelope has been implemented in both Dandenong and Casey Hospitals and has generated much interest from other Victorian divisions.

Good in-hours Care—GP and Residential Aged Care Kit - North West Melbourne Division

Good in hours care is the key to reducing the need for presentation to Emergency Departments. This includes having up to date clinical information, so if and when the need for transfer to ED arises, accurate patient information is available to travel with the patient. The North West Melbourne Division's *GP and Residential Aged Care Kit* has been a valuable resource for the divisions. Key features of the Kit include a comprehensive suite of clinical information sheets, a guide to using MBS items and both general practice and aged care homes systems and tools for enhancing communication. The Kit is currently being updated to include additional clinical information sheets and an active learning module for divisions to implement the Kit for GPs and aged care homes.

To view the Kit visit the division's website http://nwmdgp.org.au/pages/after_hours/

State-wide Developments

On 30 May, Dr Wendy Bissinger (GPDV Board member, Chair GPDV Aged Care Reference Group, GPDV Rep EARC subcommittee of the Emergency Access Reference Committee) presented to the EARC subcommittee Victorian Divisions' progress in improving the transfer of hospital information. Wendy highlighted key achievements of the network as well as flagging the need for implementing Interim Drug Charts when a resident is discharged from hospital and returning back to an aged care home. The Interim Drug Chart has been successfully implemented in Modbury Hospital and Flinders Medical Centre in South Australia. Successful implementation of Interim Drug Charts in Victoria will provide a key step in improving patient care.

(*) Submission to the Commonwealth Review of Pricing Arrangements in Residential Aged Care. Aged Care Branch, Department of Human Services (DHS), Victoria, April 2003.

GPDV NEWS
GENERAL PRACTICE DIVISIONS VICTORIA
Winter 2006
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.

CEO's Report

The health initiatives agreed at the Council of Australian Governments (COAG) are a focus of attention for all levels of the health system. Among the many responses to these initiatives two stand out for GPDV. The first is our work on mental health with the Department of Premier & Cabinet and the Boston Consulting Group, whose report *Improving Mental health Outcomes for Victorians* was released by the Premier and the Minister for Health in early July.

The second was the inaugural meeting on 14 June of the Victorian General Practice Issues Group, a forum for Victorian general practice organisations, consumer representatives, DHS and DoHA to meet to address issues facing general practice and promote closer linkages and better communication. The meeting considered the COAG health initiatives and the Australian and Victorian budget initiatives for 2006-07, with a focus on the *Australian Better Health Initiative* (ABHI) and *Improving Care for Older People in Public Hospitals*. Discussion of successful programs of collaboration between state-funded and commonwealth-funded services, between divisions and community health services, and between the primary and acute sectors, showed the benefits for the public of effective collaboration between governments and between the components of the health system.

GPDV's work to promote this collaboration by supporting quality improvement and capacity development in the Divisions Network was exemplified in our recently-completed series of national governance training workshop reported on page 3. GPDV's successful re-accreditation review by QICSA in June gives us confidence in the strength of our own systems to support our work with divisions and to strengthen the Divisions Network's collaboration with the wider Victorian primary health sector.

Our work to strengthen the primary health sector by the increasing integration of general practice into the state's health system will be enhanced by a number of newly funded programs, among them refugee health, lymphoedema education, clinical risk management in small rural hospitals and support for partnerships between divisions and community health services.

Two programs are particularly welcome. One is our DoHA-funded work with the Victorian Aboriginal Community-Controlled Health Organisation (VACCHO) on collaboration in chronic disease management between divisions and aboriginal health services, which is complemented and enhanced by funding from DHS to review the issues for improving access to GP services by Aboriginal people and to present two forums for AHPACC Partnership agencies and divisions on quality improvement activities.The other is funding from the National Primary Care Collaborative to provide support to Victorian divisions involved in the collaborative as the program involves the third wave of practices and the focus moves to the continuing spread of the collaborative methods.

- Bill Newton, CEO

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

Statewide...

Palliative Care Forum Report - 19 May 2006

GPDV held this Forum as the final part of a DHS-funded study to review key issues in the partnership between GPs and palliative care.

Dr Michael Homewood (GP Association of Geelong) graphically illustrated that palliative care is a small component of the GP workload and that the range of demands on the GP makes it difficult to organise a practice for effective partnerships. The burden of red tape further limits GP partnerships, as the associated paperwork is burdensome. Community expectation of finding the last-minute cure is also a challenge to the GP trying to help the patient adapt to the probable outcome of a course of disease. GP communication with the palliative care team is especially important in forming a consistent approach to care in the face of conflicting hopes and expectations.

Professor Michael Ashby (Palliative Care Physician) said that the GP role in palliative care is variable but a palliative approach should be a core skill of every clinician and a basis for partnerships in palliative care. Australia has some effective structures for partnership in palliative care, notably in Perth, Newcastle, Adelaide, Tasmania, the Territories, Sydney, Geelong & Barwon and Mornington Peninsula. In each of these areas there are some common features of success: the minimisation of corporatism and managerial boundaries; a manageable scale; a history of partnership on other matters; a well defined geography and a focus on relationships more than on systems.

Karen Conte (Palliative Care Nurse Practitioner) used case studies to illustrate the importance of the partnership between GPs and palliative care services. She highlighted the great variability in the GP role in palliative care in terms of 'the good, the bad and the ugly'. There was variability in the level of expertise in palliative medicine, in the understanding of the palliative approach and in the level of interest in palliative care. Her 'good' case studies graphically illustrated what can be gained when the partnership works well.

Highlights in the discussion of collaborative models were

Dr Deb Harley (GP Association of Geelong) and Dr Rob Lewis (Mornington Peninsula Division) spoke about two models of co-operation in Victoria that could have wider application.

Case conferencing

Mornington Peninsula systematically uses case discussion by teleconference to include general practitioners who are given advance notice by fax and invited to participate. In some instances, a GP might have two or three patients discussed in the one teleconference. As the palliative care team has already discussed the case before the call is put through to the GP, the discussion is very focused on those aspects of care relevant to GP involvement. The GP component takes only a few minutes and 'big decisions are made very quickly'. The palliative care service sends the claim forms to the GP following the discussion.

Clinical attachments

Both Mornington Peninsula and Geelong-Barwon run programs of clinical attachments in palliative care that to date have reached more than 20% of the GPs in each area. The attachments improve GP skill and confidence in palliative care and at the same time strengthen the personal relationships essential to partnerships in care. They may be a more cost-effective way to extend the benefits of PEPA 2 clinical attachments to a greater number of GPs.

Gold Standards Framework

Dr Peter Martin (Palliative Care Physician) and Professor Ashby both spoke about the NHS's Gold Standards Framework (GSF) as a model relevant to Australia. The GSF is practice-based and improves the organisation and quality of care for patients in the last stages of life in the community. It optimizes the local primary care team's provision, so that more patients are enabled to live and die where they choose, and un-needed hospital admissions are avoided. Other services and factors are also involved in admission avoidance, and GSF can help in clarifying and measuring these, to better commission local services. Peter Martin also illustrated the way in which the NHS recognises and rewards variable levels of GP involvement in palliative care.

Policy context

Very informative presentations on the policy context for the provision of palliative care were provided by Rita Evans (Director, Palliative Care Branch, DoHA), Noreen Dowd (Director, Programs Branch, DHS) and Kevin Larkins (Executive Director, Palliative Care Vic.).

Recommendations formed at the Forum

The following recommendations were formed at the Forum and will be submitted for consideration by GPDV Board for inclusion in the final study report from GPDV to DHS.

General Recommendations

Health funding arrangements should recognise and reward different levels of GP involvement in palliative care.

In addition to the models in operation at Geelong and Mornington, the NHS Gold Standards Framework (GSF) is worth exploring as a model for co-operation between GPs and specialist palliative care services.

Recommendations to DoHA and DHS

A modified form of the PEPA 2 clinical attachments should be funded to maintain the investment in GP education and strengthen the partnership between GPs and palliative care services

Divisions of general practice should be funded to support and develop the GP-palliative care partnership, especially to adapt successful models to local conditions.

Recommendations to DHS

DHS should fund a couple of local trials of partnership development in palliative care consortia.

Recommendations to DoHA

The Commonwealth should recognise the intense workload involved in palliative care by funding a palliative care MBS item.

See GPDV Website www.gpdv.com.au for presentations.

Nationwide...

Lead Teams

The National Governance Leadership Program for Divisions of General Practice

GPDV recently completed a national governance and leadership workshop series which finished in Darwin, after workshops in each major state. The series has shown that divisions' boards have an interest in working to national governance standards as an integral part of effective leadership. GP directors attending the Lead Teams workshops series responded enthusiastically to the content and took up the challenge set by the consultants by identifying numerous areas for board performance growth and development. These include the development of more robust systems for strategic planning, for division sustainability, for financial governance and risk management, for managing the board-CEO relationship and for board composition and performance review.

The series may come to be seen as a watershed in the history of the Divisions Network, reaching 76% of divisions and about 28% of board members, well above the 20% regarded as the "Tipping Point" for successful spread in a primary care collaborative. There is now no reason for directors of divisions not to be well-informed about their functions as a board or to fail to act as leaders in the full understanding of what effective leadership means. Individual board members can now move quickly past the notion that they are GPs first and directors second, with certainty that they are a director in a position of great trust with a variety of governance duties and responsibilities that are independent of and additional to their role in general practice or any other profession.

Participants in the workshop gave it very high ratings for the achievement of its objectives: 8.54/10 for being able to analyse their own knowledge and skills against the standards, 8.64 for identifying new possibilities for building stronger performance in their own board and 7.24 for developing their own learning plan as a director. The series introduced a challenging concept for directors of division boards: that the job of a director has its own set of competencies and skills, not necessarily related in any way to medical training, and requires directors to have an ongoing commitment to their own continuing professional development as a director.

Participants showed in their responses that they believe that divisions need to invest in quality improvement in governance through ongoing director recruitment and development and strong systems for performance review. They recognise that they have the responsibility to ensure that the majority of their board members are adequately trained, experienced and prepared to be effective in governance.

Follow up with respondents has identified many changes that have been made since the workshop series. There is a stronger focus on board performance review, and on examining board composition and size. Governance processes, such as annual calendars and meeting formats have been reviewed and improved, as have governance policies. There are clearer role descriptions for board members, for Chairs, for CEOs and for finance and audit committees.

The workshop series, together with the development of effective governance and management systems that is occurring in divisions as they become accredited, means that divisions will be better able to fulfil their potential as change agents for improved general practice and primary care. Currently half of Victorian divisions are accredited or recommended for accreditation, which has meant a renewed impetus for sound organisational practices, and also a renewed emphasis on effective systems for working with other organisations in the local primary care sector.

GPDV will continue to provide its annual board development program, Star Divisions and Star Boards © (**) which covers basic governance, advanced governance, chairing skills and financial governance on a regular schedule each year. Training in representation skills, collaboration and in negotiation is also available to divisions, and supports effective partnerships with other organisations.

Table A: Total participants

	CEO	Chair	Board Member	Total Participants	*SBO Participants*
QLD	14	9	41	64	*7*
WA	7	6	22	35	*1*
Vic & Tas	16	10	55	81	*8*
NSW & ACT	11	10	57	78	*3*
NT	2	3	13	18	*4*
SA	10	7	21	38	*5*
Total	60	45	209	314	*28*

Table B: Division attendance

	No. Divisions in State	No. Divisions Attended	% Divisions Attended
QLD	18	17	94%
WA	14	10	71%
Vic & Tas	33	25	76%
NSW & ACT	37	25	68%
NT	2	2	100%
SA	14	11	79%
Total	118	90	76%