Summary of Victorian GP Liaison Officer Workshop
12 November, 2002

A. Lessons learnt re GP/hospital Collaboration

1. Barriers

Hospital	Doesn't appreciate GP role
	Doesn't value GP opinion re admissions
	A&E people do not understand GP role
	Not core function for hospital to link to community
	Not enough dollars
	Inconsistency between units in hospital
GPs	Lack skills and enthusiasm to work with hospital
	Current business ethic affects capacity, willingness to do HVs
GPs & Hospitals	Difficult to communicate
	Cultural divide between sectors
	State /Federal system creates tensions

2. Reasons to work together

To prevent readmission
To save $
To prevent duplication of tests
To coordinate post acute care
To improve the quality of patient care
To minimise the risks to patients
So individual is seen in accessible setting and speedily
So individual receives consistent information and management

3. Successes

Relationship building

- MoU between Division and hospital a potential driver
- Long term GPLO, consistent person, not project -eg St Vs, RWH
- GP presence on hospital steering committees partic if division linked
- Hospital policy involving GP/community representation
- Annual survey of GPs & joint forum re relations w hospital acts as lever with units for change.
- Intern/RMO education re GP role- eg Austin, Northern
- GPs present at Grand Round – eg Peninsula, Austin

Transitions of Care

- Automatic notification of admission, discharge and death -eg Western
- Electronic discharge summaries - eg RWH and StVs
- IT staff from clinical units
- Referrals to Outpatients - accessing approp appts-eg Austin, Ballarat
  - dedicated fax lines, phone lines, referral in using PKI
- Breast Services Enhancement Program incl EPC case conferencing- eg Northern, St Vs, Austin, Peter Mac, RWH, RMH, Freemasons, ?

Shifting Care

- Ante Natal shared care- eg Ballarat, Northern, Western, Womens, Mercy, Mornington

- MH Shared Care- eg GPs educating MH staff re needs, issues in general practice- eg St Vs
- GPs working in A&E and Outpatient Dept.
- Reduced use of A&E for assessment
- GP After Hours service close to ED- eg Peninsula, receiving ED referrals, co-payment, 15,000 pts a yr

Preventing Acute Care
- Hospital auspiced GP education

4. Success factors

Long term funding for GPLOs- from projects to core functions
Pressure from DHS to make GP relationship core business for hospitals
Clinical leadership in hospital
Managers' leadership in hospital
Divisions
- vital conduit for contacting GPs
- powerful re expectations
- advocacy
- strong influence in getting GPLOs and supporting them

B. Lessons learnt from Collaborative projects

1. What has worked well

- Clear guidelines
- Funding that requires working together
- Joint flexible funding arrangements
- Joint ownership
- Forming relationships with divisions-provided a focus, platform to build on
- Opportunity for needs analysis
- Consensus on need
- Eg Pre-admission Assessment
  - Real GP roles re risk assessment
  - Accreditation
  - Communication to patient re roles
  - Medicare billed
- Accreditation process for GP role in HITH
- Collective supervision/support of like projects eg EPC projects

2. What has been difficult

Lack of shared knowledge between projects to learn from each other eg re GP involvement in HITH
How much to pay GPs
Whether payment for GPs clinically through hospital or Medicare
No uniformity between hospitals re processes for referrals
Short-term funding
Lack of time to negotiate
What benefits to patients- need to make visible
Hospital determined HARP priorities

Hospital data arrived late for community providers
ED Systems do not give good info
Multiple projects for divisions, models competing for GPs
Some patients without GPs (10-15%)
Knock-backs on applications

3. Recommendations for next HARP round

- Community Health and Divisions and/or PCPs resourced to put in submissions
- Divisions to be involved early
- Funding to divisions for involvement
- Equitable distribution of projects re needs
- Consider submissions more broadly (not just based on ED data)
- Evaluation strategy to be included in submission
- Strategic plan/timelines in submissions
- Need for written feedback during and after submissions, particularly for knock-backs
- More than 1year funding -systems change takes time
- Encourage linkage of similar projects across hospitals to create programs.
- Standardise data collected from ED to give better info
- Process for encouraging patients to have GPs

Future Directions for GPLO meetings

Do not want Vic GPLO email network.

Want keeper of information so can access it again.
ACTION: Peter W to discuss with ARCHI
Want GPLO forums twice or three times a year.
ACTION : Peter W to discuss within DHS to resource
Want themes eg Shared care for mental health/MH strategies
How to develop working relationships w divisions
Aged care strategies
EPC work/discharge
More info re GPLO roles eg GPLO contact numbers and roles
Projects already run
Programs already in place
Clarification of what divisions want from GPLOs and what does DHS want from GPLOs