GPLO WORKSHOP, March 25th,2003

"Engaging Divisions"
Jenny Downes Brydon, GP Consultant to Southern Health

Introduction:
In general practice 15 years, with experience in ED, AH work, teaching at Monash med school, freelance med.journalism (smattering)
Southern Health GP Consultant since Aug 2002. Began at 6hrs/wk. Now 20 hours per week due to work load and my own change of focus.

Sharon Monagle, also GP Consultant to Southern Health: GP, Board of Central Bayside, GPDV work.
Employed by Southern Health since May 2002. 12 hrs /week at present.

Southern Health has 5 GP Divisions in catchment- Dandenong, Monash, GSE, Central Bayside, Eastern Ranges

My vision of my role: the challenge to me is to explore and contribute to changing the culture that surrounds the GP/Hospital Interface at present.

- no incentive to communicate with GPs
- limited knowledge and understanding of the benefits of communicating with GPs
- previous unsatisfactory experiences with projects/systems that may have supported communication

GP Consultant role at SH aimed at a more global/strategic level
So in keeping with a "global theme" I'd like to introduce you to my "Battle Plan" for engaging Divisions (and others)- based on ancient 15th C Chinese Battle Plan (with thanks to Anne Peek, CEO of Dandenong Division)

1.STUDY THE ENEMY

Know your divisions-where
-who- leaders, their backgrounds, user friendly
-what- their projects, members with special skills eg:IT
-when- meetings, social events, be included on committees
-?work within division or be on board
-newsletter distribution
Enlist the help of GPDV

2.AVOID PREDICTABLE ATTACK

Be neutral
Dispel myths about who you are, what you represent.
Be a facilitator

3.DO NOT BE NEGLIGENT EVEN IN TRIFLING MATTERS

Sharon researched the literature on evidence supporting hospital –GP communication. This behaviour can be extended to divisions-GPLO: reduces duplication, right care/project undertaken by right people

Model good communication
So follow up meetings with EMAIL, letter, plan
Take time to comment on projects, articles, hospital issues that may interest or involve divisions
Offer input/overview /assistance to be seen as proactive.

4.THE WAY IS IN TRAINING

Time to become familiar with divisions, members, their expectations of you and what you might be able to achieve together

Learn the lingo- stakeholders, functionality, benchmark performance, governance, tools, systems
Know your acronyms PTSD VVCS ACIR HMRs SEPIX. Make up your own and see how long it takes for someone to ask you what it means.

Contribute reports/updates to newsletters of divisions so people know you are still around.
Continuity in role important

5.DEAL WITH PERCEPTION NOT SIGHT

Be open minded
Preconceived ideas from both sides of the interface about what the other believes/represents. – hospitals see divisions as unwilling to commit/standoffish
-divisions have seen hospitals undertake expensive projects that have flopped and see further advances as going the same way

Try and dispel these misconceptions- laborious job but worthwhile presenting a real picture of the GP with workforce shortage, costs to run, medical defence, CME issues, bulkbilling issues etc
Encourage divisions to practice patience with hospital projects- discharge summaries, GP Registers etc. Gradually making a difference

Act as a mediator

6.DO NOT ENGAGE IN USELESS ACTIVITY

Operate at a strategic level, don't get drawn into small incidents.

Explore projects – ascertain if there is overlap. Unique position to span the interface/ what opportunities to combine forces eg: my experience with preadmission committees from 2 SH sites/ overlap with hospital cancellation work etc. Help division as manpower to report back from some meetings in a neutral fashion

7.KNOW THE WAY OF MANY WEAPONS

Diversify your involvement, to be seen in many spheres.
Work on local projects but engage in broader education/conferences and be able to report back to divisions on the experience of others that may be useful to them.
Broadened my horizons in researching GP AH collocated clinic to Whitehorse/ Goulbourn Valley/ Commonwealth Workshop on AH Care
Liasing with Peninsula in developing a model for GP role in newly developing hospital at Berwick

8.PLAN LOGICALLY BUT ATTACK EMOTIONALLY

9.DO NOT INTEND TO WOUND BUT TO KILL
This comment is not exclusive to female GPLOs.

If you follow the seven steps above we are in a position to contribute to culture change.

GPs have been gradually, insidiously edged out of the acute sector, with many negative consequences. The present climate indicates a growing uneasiness amongst stakeholders. Systems are breaking down.

To make a change, though, we have to make changes.
GPLOs are a reintroduction of GP presence into the acute sector
We can be – a voice
- a role model
- offer a different perspective.