GP SERVICE COORDINATION WORKSHOP

3/02

Summary

The first workshop in this series of three on GP Service Coordination was held in March. The theme was collaboration between PCP and Division staff, and particularly about shared, strategic visions and actions. This report summarises the key messages from each presentation. The powerpoint presentations are on the GPDV website www.gpdv.com.au. The next workshop is on Wednesday July 31st.

SETTING THE SCENE

Dr Rae Walker –

- Introduced the idea that PCP staff and Division staff are important players in creating successful partnership activities between agencies and the division – as 'Collaboration Tacticians'.
- PCP and Division program staff are neither managers, nor service providers, but rather stand somewhere in the middle of these groups. In a collaboration or partnership situation, PCP staff and Division staff often spend time getting to know other organisations and helping them to understand yours (so work between their own and other organisations). Additionally, PCP and Division staff also have to help their own organisation be open to the challenges and expectations of change that are inevitable in any working collaboration (work within their own organisation to promote understanding of others).
- Provided a brief overview about the role of Collaboration Tacticians (see ppt)

Bronwyn Diffey (DHS) & Pete Marshall (DoHA) –

The two key areas for PCP and Division staff to work on together are:

- Coordinated referral & feedback between GPs and other Service Providers
- Multidisciplinary care planning that includes GP as medical case manager in the community

Recognised that what divisions do/have done in these areas, and what the PCP agenda is in these areas are different in scale, but not in overall purpose. PCP and Division program staff need to work together to undertake actions that make sense to both organisations in their different contexts. Much can be gained from each organisation recognising the others core purpose, culture and expertise.

PARTNERSHIP PRESENTATIONS

Outer East Alliance & Whitehorse, Knox, Yarra Valley & Sherbrooke/Pakenham Divisions of General Practice:

Alina Tooley (Knox division) -

- Provided an overview of Outer East Alliance and GP Engagement (see ppt)
- Key achievements to date include –
  - substantial division staff and GP representation on committees, working groups etc.
  - able to involve 3 private practice GPs in the technical trial of the Service Coordination tool templates so that they could provide meaningful and considered feedback
  - players know each other and well positioned to develop joint HARP proposals

Jon Hilton (Outer East Alliance) -
Immediate priorities for GP Engagement are:

- Practices, Processes, Protocols for Initial Contact, Initial Needs Identification and Care Planning developed in consultation with GPs and to include appropriate involvement of GPs
- Invitations to GPs to participate in care planning and delivery through referral from other providers in PCP

Upper Hume PCP with Border & North East Victoria Divisions of General Practice
Sheryl Follett (Upper Hume PCP)
Two presentations provided a "worked example" of the workshop task on Visions and Goals and Actions (see ppts)

- Two weeks earlier, Sheryl Follett from Upper Hume PCP, Rochelle Thomas from Border Division & Sandra Beirs from NE Vic Divisions did a workshop by teleconference with Rae Walker and Sonya Tremellen. Together they worked through the process of developing/drafting a vision, goals and action steps to guide and describe what they would do together to increase service coordination between GPs and other primary care service providers. They were able to reach a shared vision involving GPs, Consumers and Other Service Providers working together. They then identified some goals that they each agreed were important for achieving the vision. Choosing one goal – improving feedback after a referral - they then drafted some action steps to help meet that goal.
- It was a useful and challenging exercise for them to do - recommended that others have a go.

Postscript:
Since this workshop, Sheryl, Rochelle and Sandra have been holding workshops in various towns to explore referral and feedback processes between GPs and local service providers.

VISIONS & GOALS WORKSHOP TASK:
Participants were asked to draft a vision & goals for their work together.

Key themes from the draft visions and goals developed on the day:
RELATIONSHIP THEMES

- Outcome for relationship
- Trust
- Empowerment and support for consumer/community
- Sustainability

SERVICE DEVELOPMENT THEMES

- Sustainability
- Comprehensiveness
- Common state/commonwealth funding streams
- Impact of broader environments – policy
- Professionals linking

INFORMING THE VISION FOR USE OF SERVICE DIRECTORIES BY GENERAL PRACTICE:

Paul Butler
Key messages –

- service directory & referral and other data transfer tools not enough to achieve effective referral
- tools are there to support a referral pathway and process that has been negotiated and agreed by all stakeholders. This necessarily involves working through fundamental cultural differences.
- The existence of agreed referral pathway and processes (and tools to support them) does not mean that they will be used (particularly true in GP sector, but not limited to them). Implementation requires dedicated resources for support, education, change mgt etc

Paul Butler related the experience of a project in the northern metro area on referral between private practice GPs (20 GPs in the division) and public allied health services (CH and HACC providers in 4 CHSs). He found, from focus groups, that there was enough agreement from GPs, service providers and consumers to pursue priority access for GP's patients according to "urgency". Please note that there wasn't agreement to give priority access on the basis of the GP's clinical assessment ie service provider would still undertake an assessment of their own.

Project worked to establish priority access to services by allied health provider based on a GPs request for "urgent" service; and at the same time, GP acceptance and use of service provider criteria for "urgent" service when making the referral. Service directory and tools were developed to support the agreed referral pathways and processes. There were both common and discipline specific criteria to incorporate into the GP referral forms.

The project didn't get beyond initial implementation due to loss of key staff who were needed to provide support and 'incentive' to GPs to adopt this new referral pathway. Paul's final slides gave the following advice regarding lessons learnt from the project:

- ***Tools not sufficient***
- Building relationships
- Expect patchy implementation
- Create opportunities
- Expect difficulties

A handout on what the research says about GP referral behaviour was distributed at the workshop. Please contact Sonya Tremellen on s.tremellen@gpdv.com.au if you would like a copy.

QUALITY CARE PLANNING WITH GENERAL PRACTICE:

Rosemary Fenech –
Key messages:

- EPC MBS items seemed like a 'gift' to PCP BATS service coordination in that they allowed GPs to be remunerated for multi-disciplinary care planning, which relates to one of the BATS elements.
- However, the implementation of EPC care planning and service coordination work is complex. Recommend - need to refocus on steps that will form a sustainable pathway to GP Engagement. Useful to focus on issues such as referral based on good assessment, service

access agreed or negotiated, timely & accessible feedback, involvement in quality care planning with GP as medical 'case manager'.

- Don't rely solely on EPC MBS items to achieve GP engagement, the items are one tool.

Challenges & Opportunities:
It is a challenge for Division and PCP staff to understand the changing context of the EPC MBS – eg changes to the MBS schedule relating to EPC, and review of the RACGP EPC Standards & Guidelines. There is an opportunity to work together on solving problems regarding their implementation.

It is a challenge to promote the EPC MBS items to GPs, and other service providers given their complexity. It is also an opportunity to work together to facilitate effective pathways for GPs to claim EPC payments and for service providers to work with GPs in such a way as to ensure the GP can claim the items. For instance:

- **Appropriately identifying patients who will benefit from a care plan (and for whom an EPC care plan will meet MBS requirements).** For instance, recent clarifications to the MBS schedule are that patient must have chronic AND complex conditions (not just chronic). Practices that have developed systems for providing EPC care plans to patients with a chronic condition such as hypertension will now find that this approach on its own does not meet MBS requirements.

- **Check for existing Care Plans:** Easy for this to be done poorly due to different service providers having different perceptions and definitions of their care planning processes. Opportunity for division and PCP staff & reps to facilitate the identification of key care planners in local areas and to explore how GPs can contribute to existing care plans (meeting EPC requirements) and initiate EPC care plans with these providers.

- **Plan care to meet identified goals:** implementation issue related to discussion with and possible assessment by other service providers necessary before care plan can be finalised. This has implications for GPs regarding the stage at which billing of MBS can be completed.

- **Identify and contact providers who can best meet patient's specific needs: communication between GPs and other service providers about the content of the multidisciplinary care plan is often done poorly.** Major issue is that some GPs approach the Care Plan as though it was a referral and do not ensure that contact is made with service providers prior to sending a draft care plan. Opportunity for Division and PCP staff & reps to develop effective responses to assist GPs and other service providers to improve communication.

Overall service coordination task to achieve quality care planning between GPs and other service providers is:

- Developing appropriate pathway(s) for GPs and other service providers to follow that target EPC MBS services to particular patient groups **AND**
Identifying patient groups (eg population health approach and/or service sector approach) who are likely to meet eligibility requirements for EPC MBS Care Planning.

There is a challenge for divisions and PCP service coordination staff, in assisting GPs to recognise how their role intersects with service system, in particular for patients with greater needs, where there are assessment & case management services already in place.

Mary Mathews – Working together on care planning.
Softly, softly … Some promising signs

Progress report on two examples of work promoting multidisciplinary care planning between GPs and other service providers. One project is being developed between Monash division of general practice, in collaboration with two other divisions, and Middle South Area Health Service. The other project is between Monash division and Bentleigh Bayside Community Health Service.

Key messages:

- small, incremental steps are fine, starting with 1 GP is fine.
- "one step forward, two steps back" – progress is dependent on a lot of good will between agency and division at all levels – management, project/program officer and service delivery staff.

Middle South Area Mental health service – GP contribution to care plans.

At MSAMHS, part of normal practice is to develop an individual service plan (ISP) for each client. The divisions saw this as an opportunity to facilitate GP contributions to an existing multi-disciplinary care plan using EPC MBS items. Worked with staff in the mental health service to develop and pilot a protocol. As part of preparing an ISP, a letter is sent to the patient's own GP inviting him/her to contribute to the development of the ISP.

Bentleigh Bayside Community Health Service – multi-disciplinary approaches

In order to build positive experience of the value of a GP's contribution to multi-disciplinary care amongst health centre staff, Monash division paid for a GP (group of GPs on roster - about 6 so far) to attend monthly case discussions at the Centre. (Issue re: privacy was raised at the workshop – case discussions now run with de-identified records). Work is continuing to develop this project so that GPs can participate in case conferences, using EPC MBS items, for their own patients.

The division also negotiated for community health nurses employed by the CHS to be available to conduct EPC over-75 health assessment (in patient's home) on a fee for service basis. The CHS is therefore an alternative to RDNS or a GP's own practice nurse in providing this service. This has been taken up by one GP initially. The CHS nurses are now exploring the potential for working with this GP and others on EPC care plans for those over-75s who have chronic & complex conditions.

Mary's final slide listed the following success factors.

- Committed staff member with clout to lead the agencie's involvement
- Belief in the value of GP input by the agency
- Understanding each other's existing priorities
- Acknowledging challenges
- Working with existing structure/process
- Early runs on the board
- Close monitoring and fine tuning