INNER EASTERN MELBOURNE DIVISION OF GENERAL PRACTICE AND BOROONDARA PCP
GP ENGAGEMENT STRATEGY

SERVICE CO-ORDINATION WITH GENERAL PRACTICE – SMALL GRANT REPORT TO DHS

1. Project description

The Inner Eastern Melbourne Division of General Practice (IEMDGP), in collaboration with Boroondara Primary Care Partnership (BPCP), designed a project to test the PCP Service Co-ordination tool templates (SCoTT) in the General Practice setting for a period of 3 months, with a series of real patients as they presented to the practice.

The objectives of the project were as follows

1. To increase GP involvement in BPCP service co-ordination activities.
2. To support GPs (and their practice) to pilot the SCoTT for initial contact, initial needs assessment and referral.
3. To produce a case study of successful implementation of the SCoTT in general practice.

An expression of interest was sort from the 80 membership practices within the IEMDGP catchment. An eligibility criteria was set prior to the expression of interest being sent out, which required the practice to have its own infrastructure including a practice nurse, manager and relevant level of computerisation.

Following selection of an appropriate practice, a meeting was arranged with the Principal GP, Practice Manager and Practice Nurse to discuss the requirements of the pilot. A training session was then organised to inform the practice (GPs and staff) of the requirements of the pilot as well as the use of the SCoTT. A process evaluation was conducted at the 2 month interval to assess progress and a final evaluation was done at the conclusion of the pilot with all practice staff (including GPs) involved.

A protocol, including recruitment targets, was designed by IEMDGP in collaboration with the practice for implementation of the pilot. (Refer to appendix for Protocol). IEMDGP also designed a short questionnaire, which was given to patients who were asked to complete the Consumer Information form. The purpose was to assess the patient's compliance with filling in the form.

It is important to note that the practice, although computerised, did not use the SCoTT electronically as they do not use *Medical Director*. The simplified version of the SCoTT on *Medical Director* was introduced part way through the pilot phase and therefore it was determined not appropriate to introduce the template to the practice's system and so change the pilot from a paper-based pilot to an electronic-based pilot mid way through.

The practice was paid (in instalments) for their time in participating in the pilot.

2. Project reach

The practice involved in the pilot is a longstanding, community orientated, group practice and has been involved in several pilot projects in the past.

As stated above, the design of this project was to demonstrate the use of SCoTT within an individual practice, and it was expected that three (3) GPs would participate in the project. Five (5) full-time GPs in total participated in the project, including the principal, which accounts for 100% of the full-time staff at the practice, and 42% of the total number of GPs at the practice. The practice manager and practice nurse were significantly involved in the 'operation' of the pilot within the practice, as were 2 key reception staff within the practice. Other reception staff were involved in a lesser capacity.

Training was provided to the 5 participating GPs, the practice manager and practice nurse by an IEMDGP lead GP, the BPCP chair and the IEMDGP project officer. The practice manager and practice nurse agreed to be responsible for the training of the practice staff who were involved in the pilot. This training was done in house in the practice. On going training was provided to the practice which included fortnightly phone calls to the practice to assess progress, and one follow up meeting to clarify requirements.

Patient recruitment targets were set for the practice as follows

Consumer Information form.
(Target of 250 forms to be completed; in most cases by the patient).

- Current patients aged 65 and over who present to the practice
- Current patients aged 75 and over who have an EPC Annual Health Assessment completed in their home
- Current patients aged 18 and over who have a chronic and complex condition who present to the practice

Summary and Referral form.
(Target of 100 forms to be completed; in most cases by the GP and/or Practice Nurse).

- Only for patients who meet the above criteria, who have completed a Consumer Information Form AND require REFERRAL to a PUBLIC health service provider
- The Summary and Referral forms are to be used to referral patients to public providers at the following agencies:
  - ACAS – St George's Hospital
  - ACAS – Peter James
  - Boroondara Community Health Centre
  - Boroondara Council
  - Whitehorse Community Health Service
  - Whitehorse Council

3. Efficacy/effectiveness

A total of 75 Consumer Information forms were completed. The short Divisional questionnaire that was attached to the Consumer Information Form collected data pertaining to who completed the form and the ease of filling in the form.

The key results of the questionnaire are as follows.

- 75% of the Consumer Information forms were completed by the patient
- 16% of the Consumer Information forms were completed by the Practice Nurse or with assistance by the Practice Nurse
- 88% of patients stated the form was easy to complete
- 8% of patients stated the form took an unreasonable amount of time to complete

- 14% of patients stated they were unsure or did not understand all the questions on the form
- 91% of patients stated they felt comfortable giving out the information requested on the form

Anecdotally, GPs reported that some patients could see the benefit of the forms to save on duplication on referral. Only 6 patients refused to complete the Consumer Information Form on the grounds that it was too difficult to understand.

At the beginning of the pilot, the practice felt that the completion of 250 Consumer Information Forms was an achievable target during the 3 months, however only 30% of this target was met. The practice stated that the low number was due to lower than expected patient presentations fitting the criteria.

It was a requirement that for a Summary and Referral Form to be completed, the Consumer Information Form was also to be completed. Of the 75 Consumer Information Forms completed, a total of 5 Summary and Referral Forms were completed, which accounts for 5% of the Summary and Referral Form target.

The Practice Nurse completed all the Summary and Referral Forms on behalf of the GPs. The Practice Nurse initiated 4 of the 5 Summary and Referral Forms and a GP initiated the other one. A GP stated that in one case he made a referral to one of the identified agencies without using the tools, and then remembered that he could have used the tools, but decided that it would be too difficult to back track.

It is interesting to note that apparently the practice did not receive appropriate feedback on the referrals made in the required format.

The practice stated the following factors which limited the results of this pilot.

- The forms had to be completed by hand
- The forms were time consuming to complete during a consultation. One GP stated that to fill in the forms whilst consulting with an elderly patient would make a standard consultation into a 45 minute consultation.
- The forms are not well set out, “streamlined” or easy to read for the visually impaired/ elderly patients.
- There are too many pages to complete.
- Relatively few referrals are made to the public system from this practice. (Estimated 10 – 15%).

Although the quantitative results of the pilot were lower than expected for all parties involved, three main positive qualitative results emerged. They are as follows:

- The practice identified gaps in their information collection, components of which were address on the Consumer Information Form.
- Participating in the pilot demonstrated how well the practice worked together as a team to implement the process.
- The patients were easily engaged in the process.

The practice stated that the training and support provided by the Division for implementation of the pilot was effective and sufficient, and additional training and support would not have made a difference to the final results.

4. Adoption

It is difficult to generalise from this limited pilot study the extent of uptake of the SCoTT in different general practice settings, or the proportion of practices which will use it. The data and results from this pilot clearly indicate that there are difficulties in implementing the process. The practice stated that their current system for collection

of data and referring patients is effective and works well for the practice, and the SCoTT (as they piloted them) did not fit neatly into that system.

To implement the tools would require a systems change within the practice. The practice did say that if the tools were available electronically, and all data downloaded directly, then they would consider using the tools for both public and private referrals. The practice did highlight however that the tools, once printed, did use too many sheets of paper (to be faxed on to an agency), and this was a particular problem for a practice endeavouring to be paperless. They stated a telephone call to an agency to make a referral is quicker, easier and eliminates the need for paper.

A practice that may readily take up the opportunity to use the SCoTT would be one that is interested in changing their current data collection/ referral process to be more streamlined. The practice would have to be computerised, would need a practice manager and practice nurse to support the process, and have GPs who are willing to change their referral process and who are compute literate. It may also be advantageous to the practice to be able to e-refer. The pilot practice suggested that perhaps it would also be easier to implement the process in a smaller (less number of GPs) practice where all staff are dedicated to the process.

A difficultly that is highlighted in a catchment such as Boroondara, with its high socio-economic status, is that anecdotally, 85 – 90% of referrals are made to private providers. Given that SCoTT is aimed at use with and referral to public providers, it is suggested that adoption of the tools within this catchment would be limited. It is possible that in a catchment where the majority of referrals are to public providers, and practices are keen to make a systems change, adoption of the tools by general practice would be higher.

5. Implementation

As stated previously, the pilot practice stated that IEMDGP and BPCP provided sufficient information as well as effective training and support during the pilot phase. Regular fortnightly contact with the practice from the Division ensured the pilot was on track and gave the practice the opportunity to highlight any issues.

The protocol that was developed prior to the implementation of the pilot ensured that every aspect of the process was addressed, and, as it was designed in collaboration with the practice, it fitted in with their current system. The protocol was available at the practice for all staff involved to follow.

In initial liaison with the practice, the practice principal and practice manager determined which staff would be involved in the pilot. It was decided that it would be best to have all full-time staff involved in the project as they would be at the practice each day and be able to identify patients more readily than staff who were at the practice less regularly.

Two extenuating circumstances delayed implementation of the pilot. Firstly the practice was undergoing renovations which caused disruption of the practice premise during that phase, and secondly, the practice was undergoing re-accreditation. Neither of these factors could be overcome due to the timelines of the project/funding.

6. Maintenance

As mentioned previously, there are obviously a number of major systems changes that would require implementation before the SCoTT can be taken up more universally. In this study it is important to note that the GPs and the practice support staff were

interested to be involved in the pilot and were 'open minded' regarding the possible outcomes. In this context, the systems issues were seen as more significant barriers to implementation than the practice culture. A local issue was the traditional pattern of referral from the practice to private providers of primary health care.

However there were a number of positive outcomes both for the practice and the Division.

- The practice identified gaps in their current information collection, components of which were addressed on the Consumer Information Form.
- Participating in the pilot demonstrated how well the practice worked together as a team to implement the process
- That practice stated that had the forms been completed electronically, target results would have been higher and the practice would consider using the forms for both public and private referrals
- The pilot strengthened the relationships between the practice and the Division
- The patients were easily engaged in the process

In summary, further implementation of SCoTT will require the Division to develop on going relationships with particular practices, in order to enhance confidence among our member practices that the implementation of the tools is relevant even for a small proportion of their clinical practice. In addition, we would wish to discuss with the practices the possibilities of using SCoTT for private referral. Finally in discussions with these practices, we would wish to highlight possible improvements to the practices' current registration processes.

Further testing of the forms on computer software also needs to be carried out as a priority in order to clarify GPs concerns regarding the problems associated with completing the forms by hand.

Stephanie Mavrodoglos, Integration Program Officer, Inner Eastern Melbourne Division of General Practice
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11th February 2004

APPENDIX

***Practice Name* and**
Inner Eastern Melbourne Division of General Practice

GP ENGAGEMENT STRATEGY
DEMONSTRATION PILOT PROTOCOL
22nd September – 21st December 2003

FORMS TO BE PILOTED

- DHS/PCP Consumer Information form
  (This will include a short questionnaire from IEMDGP re completion of the Consumer Information form)
- DHS/PCP Summary and Referral form

PRACTICE STAFF INVOLVEMENT

- 4 – 5 GPs (as appointed by Practice Principal and Practice Manager)
- Practice Manager
- Practice Nurse
- Practice Staff (as directed by Practice Manager)

PATIENT RECRUITMENT CRITERIA

Consumer Information form. (Target of 250 forms to be completed)

- Current patients aged 65 and over who present to the practice
- Current patients aged 75 and over who have an EPC Annual Health Assessment completed in their home
- Current patients aged 18 and over who have a chronic and complex condition who present to the practice

Summary and Referral form. (Target of 100 forms to be completed)

- Only for patients who meet the above criteria, who have completed a Consumer Information Form AND require REFERRAL to a PUBLIC health service provider

PATIENT REFERRALS

The Summary and Referral forms are to be used to referral patients to public providers at the following agencies:

- ACAS – St George's Hospital
- ACAS – Peter James
- Boroondara Community Health Centre
- Boroondara Council
- Whitehorse Community Health Service
- Whitehorse Council

IMPLEMENTATION

1. Identification of patients

Eligible patients will be identified from the daily patient lists and highlighted. The participating GPs will be asked about eligibility of these patients. The patient files will be identified with a sticker, to show that they had been asked to take part. If patients do not wish to take part this will be noted on the sticker. (So they will not be inconvenienced when they have a repeat appointment).

Those who agree to fill in the forms will be given them when they arrive for their appointment.

2. Completion of forms

The patients will be asked to fill in the forms whilst they wait for their appointment in the waiting room, (and after their appointment if necessary). A clipboard will provided. They will be offered help if necessary from the receptionist or the Practice Nurse if needed.

Consumer Information form

To be completed by

- The patient, or
- The GP, or
- The Practice Nurse, or
- The patient with assistance by a practice staff member

**All patients who are asked to complete the Consumer Information form are also required to complete the short Inner Eastern Melbourne Division questionnaire (included on the patient letter).

Summary and Referral form

To be completed by

- The GP, or
- The Practice Nurse (under the direction of the GP)

Please note:

- A Privacy form MUST also be completed and signed by the patient when the Summary and Referral form is used.
- A copy of the Consumer Information form MUST be completed and accompany the Summary and Referral form when a referral is made

3. Collection of forms

The receptionists will collect the forms at reception. The completed Division surveys kept in reception for collection by IEMDGP and the completed forms were numbered and for filing in the patient files

4. Storage of forms

The forms will be stored in the patient folders for future use.