Hume Moreland Primary Care Partnership

Evaluation of

"Bringing GPs into the Loop"

Pilot Project

June 2004

Background to the Project

In 2003, North West Division of General Practice and Hume Moreland PCP applied to the first round of DHS Service Coordination with General Practice small grants for funding for a project entitled "Bringing GPs into the Communication Loop". Although this application was not successful, the PCP subsequently received a smaller $5000 grant from DHS Northern Region to implement the project on a more modest scale.

This project proposal was based on the findings of a previous GP project conducted by Carer Links North, in which GPs had indicated that they would like to be notified when their clients are referred between other agencies. The PCP project aimed to do this by building on existing Hume Moreland PCP protocols, which require participating agencies to acknowledge receipt of referrals – at this stage by faxing the Referral Acknowledgement form (and if requested Assessment Outcome form) developed by the Northern Metropolitan Region PCPs. Under the original project proposal, five agencies were to trial copying the Referral Acknowledgement and/or Assessment Outcome form to 15 GPs (with client consent).

A sub group of the Hume Moreland PCP Service Coordination Working Group, made up of representatives of the major agencies implementing service coordination and GP Division and PCP staff, met to consider modification of the proposal. It was agreed that the project should be implemented in two stages. The first stage would involve only one primary care agency and a limited number of General Practices. Following evaluation of this trial, the project would be expanded to include a larger number of both agencies and Practices. The North West ACAS agreed to become the trial agency. It was chosen because it was well advanced in service coordination, had centralized referral intake procedures, and had already established good working relationships with many General Practices in the area.

The ACAS nominated ten General Practices which already referred a relatively large number of clients for assessment to be invited to participate. It was assumed that these Practices had relatively large numbers of older clients who would generate a significant number of referrals from other agencies to ACAS, and that the GPs involved were likely to be interested in more information about these referrals. GPs already receive a letter (or copy of a letter) from the ACAS informing them of the outcome of assessments of their clients, regardless of the source of the referral. Where the GP makes a referral to the ACAS, they also receive the Referral Acknowledgement form within five days indicating the approximate waiting time for assessment. In addition, those doctors in those Practices participating in the trial would receive a faxed Referral Acknowledgement within five days of referral to the ACAS by other agencies. It was envisaged that this would provide them with the opportunity to provide input to the assessment process, potentially utilizing the Medicare Benefits Schedule Enhanced Primary Care (EPC) items, particularly case conferencing.

Each of the GPs in the practices, plus the Practice Manager, received a joint letter from the Division and the PCP, inviting them to participate in the trial. Practice Managers were then followed up by telephone, with five Practices agreeing to participate. The reason given by those who refused was generally that the GPs were already overwhelmed by information and requests coming into the Practices. The PCP Service Coordination Officer and the Division Communication and Liaison Program Officer visited each of the participating Practices to provide them with more information about the trial, including the broader service coordination context. In three cases, this involved meeting with the Practice Manager only, while in two cases one of the GPs was present.

The Service System Context

Most General Practices in Hume Moreland fall into the catchment area for the North West Melbourne Division of General Practice. According to the Division's Annual Report for 2002-2003, there are between 90 and 100 Practices in the area, and approximately 220-240 GPs. Of these, 75 Practices and 178 GPs are located in the Hume Moreland area. The Division has been actively involved in the PCP since its establishment, and is represented on the Service Coordination Working Group by a practicing GP. Practices in the area vary considerably in terms of the number of GPs working in the practice, whether they employ a Practice Manager and/or Nurse, and the type and sophistication of Information Technology that they are using. Referral practices to other primary care providers also appear to vary widely. Primary care agencies report that they receive a mixture of phone calls, faxes and written referrals from GPs, as well as self referrals by clients made at the specific suggestion of GPs. While there are some reported instances of GP referrals being faxed to agencies on the Victorian Statewide Referral Form (the GP version of the core SCTT tools), this is still unusual and has not been the result of any formal training or support program by the PCP or the Division.

The five Practices which participated in the pilot reflected this diversity. The smallest Practice consisted of three GPs with no Practice Manager, while the largest had 10 GPs (some of whom were part time) and a Practice Manager and Nurse. Four of the Practices used Medical Director as their client management software. GPs from two of these Practices who were interviewed were aware that the Victorian Statewide Referral Form existed and was included in the Medical Director software package. However, neither of them had actually used it. The fifth Practice used Medi Pak. One Practice had a fully electronic client record system, with documents received in hard copy scanned into the system. Another Practice was almost completely electronic in terms of its records, but still kept some hard copy referrals on file. The other three Practices operated combined paper/electronic systems, with the balance between the two types of records varying. Two practices already had PKI registration and broadband connection, two had made definite plans to switch from dial-up to broadband and to gain PKI registration while the fifth was actively considering making a change. The introduction of HIC Online, and associated incentive payments, seemed to have been a motivating factor in encouraging these particular Practices to upgrade their IT. The same trend is likely to be repeated across the Hume Moreland area.

As indicated above, the Practices which were invited to participate in the trial (or at least some individual GPs within the Practices) were all relatively frequent referrers to the ACAS. As part of the evaluation of the trial project, one GP from each Practice was interviewed. During the evaluation interview, GPs were asked about referrals to other primary care agencies. All GPs indicated that they regularly referred clients to RDNS. The level of referrals to community health services appeared to vary, largely because of long waiting times, although at the very least GPs occasionally referred patients on low incomes to community health service physiotherapists. Some GPs also reported referring clients to occupational therapists, podiatrists and diabetes nurse educators at community health services. A couple of GPs expressed the hope that the new Medicare Plus arrangements would make it possible for them to refer more clients to private allied health practitioners and psychologists. Some GPs referred clients directly to council home care services, while others suggested on occasions that clients self refer. Again, the existence of long waiting lists, especially for home help services in the Moreland area, were reported as a disincentive to referral.

GPs were asked about other primary care agencies to which they referred clients. There was very little commonality in their responses. Agencies/services nominated included Church Nursing Service, CoAsIt, primary mental health, Melbourne City Mission, Wesley Mission and the Aged Care Shared Program at Broadmeadows Health Service.

The major primary care agencies in Hume Moreland have differing practices in place with respect to providing feedback to GPs who have referred clients to them. The ACAS procedures have been outlined above. The procedures of the other major agencies are:

RDNS – RDNS provides referrers with a date for the first visit/assessment when the referral is received. This usually occurs within 24 to 48 hours. With client consent, RDNS then faxes a GP notification form to the client's GP after the first assessment. This occurs regardless of whether the GP made the referral to RDNS. The form provides details of the care being provided by RDNS, the frequency of visits, other community services involved in caring for the client, and contact details for the primary RDNS nurse working with the client. At present, RDNS does not provide a standard discharge notification to GPs.

Moreland Community Health Service – Where GPs send/fax a paper referral, they will receive the completed NMR PCP Referral Acknowledgement form in return. This does not occur if the referral is made by phone. In the case of 3rd party referrals, the client's GP is not informed unless there is a particular reason to do so.

Dianella Community Health Service – as above.

Sunbury Community Health Service – as above

Moreland City Council – Where a GP sends/faxes a paper referral, they are called back by phone to ensure consent has been gained for the referral. Similarly, where a GP makes a phone referral, the intake worker (or team leader) checks consent procedures. In either case, the intending client is then sent a letter informing them

that they have been placed on a list for assessment. There is normally no further communication with the GP.

Hume City Council – No specific feedback to GPs unless further information is required.

Project and Evaluation Methodology

The trial period began in November 2003. It was originally anticipated that the trial would run for three months, with the evaluation taking place in February 2004. However, by the end of January 2004 the trial had generated only 23 Referral Acknowledgement forms to General Practices (out of a total of 540 non-acute hospital referrals to the ACAS during that period). This experience led to a realization by the Service Coordination Working Group of the importance of documenting existing referral flows and patterns before instituting major system changes. At a more immediate, practical level, it was agreed that the low number of forms which had been faxed to Practices did not provide a basis for a meaningful evaluation of the trial. It was agreed that rather than proceeding with the evaluation at that point, the trial should be extended for another two months. The project would then conclude with an evaluation which would involve not only an assessment of the experience from the perspective of the ACAS and the participating Practices, but also the documentation of information from other Hume Moreland primary care agencies about referral practices and patterns, including any pre-existing feedback mechanisms with General Practice.

For the purposes of the evaluation, the cut-off date was eventually set at 20th April 2004. (However, the NW ACAS staff have agreed to continue the trial until the evaluation has been completed and considered by the Service Coordination Working Group.) As of that date, there had been 72 Referral Acknowledgement forms faxed to GPs as part of the trial. The five Practices had received between eight and 23 forms each, with individual GPs receiving between none and 17.

The evaluation took place in May 2004. A short (approximately 15 minute) interview was conducted with the GP at each of the five Practices who received the largest number of forms. These interviews were conducted face to face, for which a payment of $30 was made to the GP. Additional contextual information about participating Practices was collected by phone from Practice Managers. The NW ACAS team was interviewed about their experience of participating in the trial. Representatives of other major primary care agencies represented on the Service Coordination Working Group were also asked for information about their GP referral practices and procedures.

Findings

ACAS Experiences

The project trial was designed to build upon existing use of the NMR PCP Referral Forms, and thus to minimize the extra administrative burden on the agency or agencies faxing out the additional forms. Nevertheless, there were some unforeseen complications. Initially, it was envisaged that the same Referral Acknowledgement

form would be faxed to the referring agency and the client's GP, with the GP's name added to the form as a cc. In this way, the referring agency would be aware that the client's GP had been informed of the referral, and the GP would be aware of which agency had referred their client to the ACAS. This was seen as 1) providing the referring agency and (in particular) the GP with useful information about the client and their service system 2) potentially encouraging the GP to contact the referring agency, the ACAS, or both and specifically 3) providing the GP with the information necessary to initiative a Case Conference under the Medicare Enhanced Primary Care Item.

However, this proved difficult to implement for technical reasons. As a result, separate Referral Acknowledgement forms were completed and faxed to the GPs. This, in turn, added to the administrative burden on the ACAS intake workers, who already fax out an average of 15 Referral Acknowledgement forms per day. Moreover, it meant that the GPs did not receive the information about who had initiated the referral to the ACAS.

Another as yet unresolved problem encountered by the ACAS related to the issue of consent. The ACAS has not necessarily contacted a client directly to arrange an assessment appointment at the time that the Referral Acknowledgement is faxed back to the referring agency (that is, within 5 days of reception of the referral). In these cases, the Referral Acknowledgement provides an estimated waiting time for assessment (eg 2 weeks). Therefore, in order to gain the client's consent to disclose to the GP the fact that they have been referred to the ACAS requires the ACAS workers to either contact the client more quickly (which is difficult given the time pressures on the ACAS) or to delay faxing the Referral Acknowledgement to the referrer and/or the GP.

Moreover, from the perspective of the ACAS, there was no indication that the additional work that they were undertaking to keep GPs informed was resulting in any additional input or participation from GPs in the period leading up to the assessment. The GP responses below support this perception.

GP Experiences

Three of the five GPs interviewed were aware of receiving the additional Acknowledgement Forms. One was not sure, and the fifth stated that he was not aware that his Practice was participating in the trial or that he had received any additional Acknowledgement Forms from the ACAS. (This GP also confirmed that nothing could be placed in a client's file without his seeing it). There are a couple of possible reasons for this low level of awareness. Firstly, the fourth and fifth GP had only received four forms each, which is not a lot over a period of six months. Secondly, as it eventuated, there was nothing to distinguish these Acknowledgement Forms from those that the GP would have received had he been the initiator of the referral to the ACAS.

The three GPs who were aware of receiving the forms said that it had been useful to know that one of their clients was going to be assessed by the ACAS, and the time frame involved.

None had changed their management of the clients concerned in any way, although one felt that under certain circumstances they might contact the referrer or the ACAS.

In general, the GPs said that they were satisfied with the information that they received from the ACAS about their clients. One felt that the ACAS assessment reports were sometimes a bit slow, and another cited an example where a report/letter had been misplaced. GPs were keen to know when clients were going to be assessed, with a couple providing specific examples of the vulnerability of this group in the period between referral and assessment, and issues related to carer availability, cognitive problems and risk of falls. They also valued being informed of the outcome of the assessment, particularly (but not only) if it involved a move to residential care. Nevertheless, despite the longstanding role of the ACAS, and the fact that these GPs all had a lot of elderly clients, some still seemed a little unclear about the precise role and function of the ACAS.

Four of the GPs either had no suggestions for improvement of ACAS feedback, or emphasized the importance of consistency and timeliness in implementation of the existing procedures. One suggested that to maximize the benefit of informing GPs that a client had been referred to the ACAS by another agency, the form should be redesigned to specifically ask and provide for GP input about the client. This GP also suggested that where appropriate the ACAS should take the initiative in suggesting a Case Conference in these circumstances – this GP said that he felt that he should use this MBS Item more often, but tended not to think of it in the pressure of daily work.

Like the ACAS, the RDNS was generally seen as providing good feedback to GPs about their clients. Indeed, one GP joked that he sometimes received too much communication from RDNS. On other hand, another GP felt that the level of feedback depended on the particular nurse, and that it was not always sufficient.

There was no unanimity among the GPs in their perceptions of feedback from community health services. To an extent, this probably reflects differences between services and between different types of practitioners within services. Some GPs said that they often received good reports from clinicians once their clients were actually seen, but that they were not always given information about when those clients would begin treatment.

On the whole, GPs reported that they did not receive direct feedback from Council home care services about clients referred to them. Some did not seem to see this as a problem (particularly where they did not make the referral themselves). Others saw it as a shortcoming – in particular, they wanted to know when their clients would be assessed for a service and, if deemed eligible, when the service would actually begin.

The two issues which arose most consistently in discussing primary care referrals with GPs were problems for clients in accessing many services because of long waiting lists, and the related difficulties for GPs of keeping informed about what services were available, their availability, and how to contact them.

Conclusions

The main achievement of this trial project has been the generation of specific information about interactions between GPs and other primary care providers in the Hume Moreland area, and the factors which are likely to facilitate and impede improved communication. The knowledge which has been gained provides a valuable basis for making further decisions about how to encourage GP engagement in improving service coordination in Hume Moreland.

In terms of the specific interaction between the ACAS and GPs, it is questionable whether the results of the trial justified the additional workload involved for the ACAS. This is at least partly due to the fact that the GPs were not provided with as much information about the referral of their clients as had originally been envisaged.

Overall, the service coordination priorities for GPs in relation to other primary care providers appear to be:

1. Easy accessibility to up to date information about available services, contacts and waiting times
2. Feedback from primary care services about specific clients referred by GPs, particularly in relation to waiting times/dates for assessment and service provision

Possible options for future activity in the area of GP engagement by the Hume Moreland PCP which emerge from the experience gained during the trial include:

- Facilitating quick and simple access by GPs to information about available primary care services, contacts and waiting times

- Generating better information about existing referral patterns between GPs and other primary care providers. This could assist further engagement in several ways, including the identification of specific General Practices which share significant numbers of clients with other primary care providers, and may therefore have a particular interest in service coordination, including use of the SCTT for referrals and care coordination.

- Working with the NW Division of General Practice to monitor the take up of broadband access and PKI registration among General Practices, with a view to identifying Practices which may be in a position to implement electronic referral.

- Informing primary care agency staff about the existence and significance of the MBS EPC items, and ways in which they might encourage their use by GPs of shared clients.

- Supporting primary care agencies in the development of appropriate models of feedback to GPs