SERVICE COORDINATION WITH GENERAL PRACTICE - 2003/2004
SMALL GRANTS

Project Descriptions:

Project title: GP Referral – implementing the statewide referral tool and feedback loop
Monash Division of General Practice
Southcity GP Services
Kingston Bayside PCP
Inner South East Partnership in Community Health
Description of proposed project:
Based on the findings of the pilot project, which involved a small number of GP practices, this project will significantly increase the number of GPs trained in the use of the statewide referral tools and the service directory. The project aims to increase the capacity of a significantly larger number of general practitioners (50 in total) to uptake and realise the value of the service coordination tools and services directory.

Importantly the project will be integrated with the first e-referral trial between GPs and primary care agencies to occur in either PCP catchment. The e-referral pilot is being managed by Kingston Bayside PCP and includes agencies from the catchment of both PCPs.

The project will also strengthen the relationships between individual GPs and key primary care agencies. PCP member agencies will initiate the training and support to GPs in the use of the SCTTs when they receive referrals through existing processes. At this point they will inform the GP (or practice nurse) that as part of the PCP service coordination strategy their agency has adopted the SCTT for referrals and that GP Divisional staff are available to visit the practice to provide training and support in utlising it. A workshop will be held to assist agency staff to develop effective strategies to engage GPs at the point where they receive referrals through existing processes.

Based on the successful finding of the pilot project the training package will be delivered on a one on one or group approach; targeting not just general practitioners but practice nurses and other practice staff as appropriate. Follow up and monitoring of referral and feedback process will occur as part of the evaluation of the service coordination protocols – to be undertaken by both PCPs.

The provision of feedback to the referring practitioner is a key element of both ISEPICH and Kingston Bayside's service coordination protocol. Based on the findings of the Central Victorian Health Alliance small grant project both ISEPICH and Kingston Bayside PCPs will amend the service coordination protocol to highlight the importance of timely and relevant feedback and will support the implementation of this through the delivery of training to individual agency staff.

Project title: Electronic Gateways for Service Coordination for Local GPs
Melbourne DGP
North West Melbourne DGP
Moonee Valley Melbourne PCP
Description of proposed project:
This project focuses on establishing processes and practices for electronic referral from an identified GP clinic – the Keilor Road Medical Clinic - to local primary care agencies. It builds on existing referral patterns of the clinic to primary care agencies in the MVM PCP catchment. The Keilor Road Clinic was identified as a regular referrer to Moonee Valley City Councils' Aged and Disability Service and other local primary care providers who are registered e-Referral agencies, (RDNS, ACAS and Doutta Gala. CHS). On discussion with this clinic, it was identified that they were keen to participate in a project that expands their current e-Business activities to include e-referral processes using the Service Coordination Tool Templates, from within the MedTech 32 client software.

The project will promote capacity building and stronger working relationships between primary care services and this large GP practice (7 + GPs) and provide professional development and education for the practice manager and GPs to engage in the use of e-referral processes. The project will achieve a shared agreement about what defines or describes a quality referral pathway for patients/clients.

It is predicted that the use of e-Referral using the service coordination tool templates will enable GPs to refer quickly and consistently using the PCP patients/clients summary and referral information forms. It is also predicted that immediate feedback from the primary care provider (electronic) will alleviate past frustrations of GPs re: communication with primary care agencies.

In collaboration with the two Divisions of General Practice, Melbourne and North West this project also aims to showcase this project to other GPs through ongoing communications and a presentation at a forum for other GPs. It is anticipated that a presentation by the GP practice that has implemented the e-referral processes and practices will provide significant impetus to other GP's in the catchment interested in improving their referral pathways.

Project title: Creating Connections
Northern Melbourne DGP
North Central Metro PCP
Description of proposed project:
The project will establish a network of GPs, Primary Care and Acute health providers who refer patients between services using the Statewide Referral Form (SRF) and electronic referral using PKI.

The project will initially target GPs and agencies that have capacity for electronic referral using PKI and the SRF and will build on the work and relationships developed in the committee referred to in the previous section. Agencies and GPs will be assisted in the practical use of PKI and secure email transmission.

At the completion of the project;
A group of general practices will be competent in using the statewide referral forms
GPs will be able to refer their clients to multiple agencies using the referral tools and encryption for transmission. (However, GPs will also be able to fax the SRFs should they prefer)
Service providers involved will receive all the necessary information from GPs needed to effect a referral. This leads to reduced need for follow up phone calls to GPs and patients to seek new information or clarify details.
GPs will routinely receive feedback on the outcome of referrals
The process will be able to be rolled out to more agencies in the NCMPCP and additional GP practices.

It is the intention to work with the GPs who have previously expressed an interest in using their medical software to greater advantage, and to link in with those organisations / service providers that have implemented the SRFs and PKI. As the project progresses, more GPs will be encouraged to work towards safe encrypted transmission of patient data and the state-wide referral forms. These GPs will be used as a model to portray to their peers the uses of the SRF and the ease of emailing it to the intended organisation(s). Referrals will provide accurate and comprehensive clinical notes and using the SRF with PKI will improve patient management and lead to a better outcome for patients.

Project title: Electronic Referral and Feedback – "A Two-Way Street"
Mallee DGP
Northern Mallee PCP
Description of proposed project:
Effective referral and feedback processes between general practice and other health service providers is a key issue being addressed in a variety of formats. Evidence collected by the Mallee Division of General Practice indicates that quality referral and feedback processes are essential if the total care of

the patient is to be enhanced. General practice is often accused of the poor quality of their referral processes and we believe these processes can be improved through the use of a secure, electronic referral process using the Service Coordination Tool templates or other referral formats depending on the situation. One of the concerns of the broader primary care sector has been how to feedback information to the GP that is able to be accessed by the GP and is appropriate to his/her needs. Electronic Referral and Feedback – "A Two Way Street" project is designed to demonstrate the benefits to all parties of effective electronic referral and feedback processes and to test a vehicle for carrying out this process.

The project will concentrate on electronic referral and feedback between GPs and the two Multi-Purpose Services [MPSs] in the Nth Mallee PCP area. The two MPSs are quite different in how they relate to general practice services:

The Mallee Track Health & Community Services [MTHCS], situated in Ouyen, has GPs employed as part of their total service provision.

The Robinvale & District Health Service [R&DHS] does not employ GPs but relates to two local GP clinics, one of which operates as a private business, whilst the other is an Aboriginal Medical Service. The MPS in the community is responsible for the majority of the allied health services as well as the acute services delivered through the hospital.

Using these two quite distinctive services, the Electronic Referral & Feedback – "A Two Way Street" project aims to demonstrate the benefits of a stable, secure, electronic data transfer system, between general practice and the broader primary care services provided by the two MPSs. Using the two MPSs enables the project team to maintain tighter control over the process, whilst having the opportunity to test the system in two totally different environments. The lessons learned in the project can then be used to effect in the broader, more diverse setting.

For some time now GPs have had access to the DHS Service Coordination tools in Medical Director. Although there have been a small number of GPs that have used the tools, there has been a general reluctance amongst GPs to make more use of them. It is important to appreciate that GPs work predominantly in the medical model of health and their referral patterns are much wider than the DHS funded services. This has meant that GPs are being asked to use two systems to handle their total referral output. It is not surprising then that under these circumstances GPs have been reluctant to embrace the Service Coordination tools as a system of choice. The 'Electronic Referral & Feedback – "A Two Way Street" project aims to eliminate the problems caused by the use of two systems through the use of a secure, encrypted data transfer and messaging system called 'MalleeReport'. The Mallee Division of General Practice has been involved in the roll out of 'MalleeReport' for several months and currently has the system working in several GP practices as well as a number of medical specialist's rooms. The Division is currently negotiating with the Mildura Base Hospital to install the program in the hospital's Emergency Department and with the Mildura Private Hospital in its medical records department. Using 'MalleeReport' as the vehicle to carry referrals will give GPs the flexibility to use the Service Coordination tools for referral to those services mandated to use the templates or some other format, as requiredby the specific service, all through the click of a button. Both the Nth Mallee PCP and the Mallee Division of General Practice are keen to spread the use of the 'MalleeReport' to include a range of allied health and community service providers.

From the GP perspective, one of the failings of most of the work to date around the use of the Service Coordination tools and other forms of secure, electronic information transfer systems is that they have ignored the importance of feedback. For GPs to maintain a holistic patient record it is essential that they receive relevant feedback from the services they refer their patients to. It is also important that any feedback GPs receive is able to be included in the patient's electronic record with the minimum of fuss. The 'MalleeReport' program is capable of incorporating feedback information directly into the patient's clinical record, eliminating expensive and time consuming double handling and cutting down on the reliance on paper based records.

The 'Electronic Referral & Feedback – "A Two Way Street" project will be one of the first activities under the 'Service Coordination & Access' heads of agreement between the six key agencies in the Nth Mallee PCP.

Project title: Diabetes Care Framework – A community path to self management
Goulburn Valley DGP
Goulburn Valley PCP
Description of proposed project:
The Goulburn Valley Integrated Diabetes Care Program (GVIDCP) is a three year funded program through the Best Practice & Quality Improvement Fund of the Department of Human Services. The purpose of this aspect of the program is to develop a 'Diabetes Care Framework' that is most suitable for integrating diabetes care in the Goulburn Valley and this submission is to gain support to market the framework to key stakeholders. Key stakeholders include general practitioners, allied health care providers, nurses, diabetes specialists, people with diabetes and their carers.

The GVIDCP has three inter-related goals:

Workforce development
Promoting diabetes self-management
Integrating diabetes care

The Diabetes Care Framework has been developed to clearly map diabetes care in the Community and develop an evidence-based pathway for diabetes care outside of the acute setting. This project aims to assist the Diabetes Integrated Care Program to roll out the care framework to GPs through academic detailing and Continuing Professional Development sessions.

This project is consistent with many aspects of the Goulburn Valley PCP Community Health Plan including service coordination, GP engagement and Chronic Disease.

Project title: Building practice capacity for using the statewide referral tools
Dandenong DGP
South East PCP
Description of proposed project:
This proposal aims to build on the work commenced through the first round training project, with a stronger emphasis on promoting the tools to practice staff and providing a resource for GPs and practice staff to undertake self directed learning.

The proposal includes two components:

Conduct forums for both Practice Managers and Practice Nurses, in conjunction with the Division's respective networks.

Develop a CD-based training resource based on the training program developed previously, that can be used by individuals and that provides a step by step introduction to the Service Coordination Tools.

This proposal recognises the role and responsibilities of practice staff in supporting change and referral processes within the practice setting. The CD component acknowledges that hands-on training and support is not necessarily sustainable over the long term, although Division staff will continue to provide support as required in promoting the Statewide Referral Tools.

Project title: One Referral Form for primary care – your choice! (A multi-faceted approach to promoting communication between GPs and the primary care sector)
Greater South Eastern DGP
Whitehorse DGP
Central East PCP
Description of proposed project:
Specific project work with GPs has focused on falls prevention, residential aged care, patients with depression and patients from CALD communities. More general service coordination work has

engaged small groups of GPs in piloting the service coordination tools, use of the electronic service directory and Electronic referral. All of this work has incrementally further linked GPs to the primary care sector. Now that the Service Coordination tool templates are embedded into medical software it is timely to conduct a specific practice approach that will help develop a broad general awareness campaign of using one referral form to access primary care agencies.

There will be three components to the project. The first component will focus on working with eight GP clinics, the second will be a broad awareness campaign for all GPs and the third will be specific work with two Divisional programs that have high referral rates from GPs. Overall this project will be will be known as **one referral form for primary care – Your Choice!**

GPs can now directly populate a referral form that will be received by at least ten core services, these include the Aged Care Assessment Service, the Royal District Nursing Service, Local Council HACC services, Community Health and many many more. This referral form is now being promoted for Mental Health agencies, Drug and Alcohol services and Disability services. Ultimately the referral form will be used by all major primary care agencies.

One referral form is being promoted for a range of reasons these are:
To promote increased efficiencies in referring
To decrease confusion for primary care providers that refer to a range of services.
To encourage common data sets across providers
To build client/patient information from provider to provider
To limit the need for clients/patients to give their demographic details repeatedly
To encourage multiple referrals for clients/patients with high needs

The first part of the project will continue to work closely with eight GP practices that have already been initiated to PCP work through the service directory project. Divisional project workers will facilitate practice visits to the practice manager and all of the GPs in the practice. Divisional staff will be trained in the use of the SCTT forms through the medical software. They will then assist GPs to refer to primary care agencies with the one-referral form. The individually tailored practice visits will cover:
Information of one referral form for all primary care agencies
The use of letter writer and the SCTT to improve usability by GPs
Updating patient records to ensure seamless use
Explore the possibilities of linking to faxing software to reduce paper usage
Linking to the electronic referral program developed in the Central East will be considered on a practice by practice basis
Information on core agencies (ACAS, RDNS and Local Council HACC services) plus the new HARP projects that are specifically looking for GP referrals
Customising letter writer for ease of use

Based on this work with the eight practices an information kit will be created that explains the ‘how to’ for the use of one referral form to primary care agencies. This information kit will be linked to a help desk operating from each Division and overtime will encourage a broad reach to all GP practices. The help desk will provide phone support during business hours.

The second part of the project will be an awareness campaign that will highlight the value of one referral form and the benefits enjoyed by the eight practices. The awareness campaign will occur through print media and training sessions of the Division over a three month period. This awareness campaign as stated will be linked to a Divisional help desk that will assist GPs to adopt the SCTT. (The training materials from the South East and Kingston PCPs will form part of the kit). Divisional staff will be trained to show GPs how to maximise their current procedures to use the one referral form. The campaign aims to ensure a maximum number of GPs will be encouraged to use the referral form over the next three month period. The final two months will be used to monitor uptake.

The third component of the project will be the encouragement of the use of the SCTT form in "two specific" projects at each of the Divisions. These are the 'Healthy at Home' HARP project at the Whitehorse Division and the Diabetes project at the Greater South East Division. The purpose of focusing on specific projects is that GPs often respond to change when there is a clear incentive, such as access to a service for their patient. Hence it is seen as both practical and sensible to encourage the use of the SCTT form at this project level in concert with the general practice change.

Project title: Linking Loddon
Murray Plans DGP
Bendigo Loddon PCP
Description of proposed project:
Project goal: Improve referral and feedback processes between GPs and primary care providers in the Shire of Loddon by using the SCTT in a secure electronic environment.

Activity	How this builds on existing activity
Meet with GPs in Inglewood, Boort and Wedderburn	Murray Plains Division Area Manager provides regular individual support to these GPs (via monthly practice visits in addition to support visits when required)
Identify the agencies the GPs refer to	Murray Plains Division supports some allied health services through MAHS (More Allied Health Services) funding; linkages already exist between the General Practices, the Division and many agencies through relationships developed through active participation by the Division with Bendigo Loddon PCP.
Support each GP to register for PKI	Info session held 11 March (primarily for Campaspe region). Health Insurance Commission has conducted some onsite practice visits to assist with sign up & registration for PKI, this will be repeated in the Loddon region later in 2004.
Provide information session for member agencies on e-referral and PKI registration	Protocols for e-referral will be in interagency protocols currently being redeveloped by the PCP. From the experiences currently being encountered through the Campaspe PCP ehealth project, it is recognized that this is an essential foundation to ensure timely, efficient referrals (and feedback) are received.
Use Connecting Care (CCC) for referrals	PCP has contract with Carelink to update and maintain data on the CCC data base. PCP also participates in the CCC user group and CCC Strategic Group to provide input into enhancements and developments to CCC.
Training for : use of CCC accessing SCTT through medical director PCP service coordination	The Murray Plains Division has been conducting quarterly Information Management Sessions in computer labs enabling "hands on" training for the last 18 months; these sessions are to be introduced to the Loddon region on 31st March and will also be conducted on 17th June, 2004 and 18th November 2004. These sessions will be supported by one-to-one training during practice visits on an "as needed" basis. The PCP has developed a CCC User Guide and

	administrator training. The PCP service coordination working group has a register of Service Coordination Train the Trainer participants and has facilitated training sessions open to all member agencies. Brokerage funds are available for additional service coordination training.

Project title: General Practice Feedback Loop Project
Mornington Peninsula DGP
Frankston-Mornington PCP
Description of proposed project:

The FMPPCP General Practice Feedback Project is a new project.

It aims to build on the previous project by going to the second stage in the service coordination process, to develop the feedback loop into the FMPPCP Seamless Access System.

Project participants will include those involved in the previous project:

Lang Park Medical Centre

Mt Eliza ACAS – R.A.P.C.S. (Rehabilitation, Aged & Palliative Care Service) **Access Unit**

as well as the addition of:

R.D.N.S. Frankston Centre

It will build the next stage by developing a feedback loop, as follows:

Referral from Lang Park Medical Centre to Mt Eliza RAPCS Access Unit;

Patient consent, and

Preliminary assessment by MEACAS. Referral on to RDNS

Patient/client consent, and

Loop back to Lang Park Medical Centre from Access Unit, notifying further referral

Feedback to Lang Park from RDNS on referral status and care plan.

When the loop has been tested and is working well between the trial participants it will be built into the existing protocol developed for the whole of the FMP PCP Seamless Access System. When completed the feedback loop protocol would have wider application across Victoria.

Project title: Secure Electronic Referral Linkages in the Upper Hume PCP
Border DGP
North East Vic DGP
Upper Hume PCP
Description of proposed project:
The key objective of this pilot project is to develop and implement a self-sustaining messaging transport to support encryption/decryption processes in a generic format that is independent of the users electronic operating environments.

Develop agreed Practices, Processes, Protocols and Systems to support secure e-messaging practices for inclusion in the UH-PCP Service Coordination Manual.

This project will be an opportunity for GPs and their practice managers/nurses to utilise more fully the Victorian Statewide Referral Form for the purposes of referral and service coordination with other service providers.

Project title: GP Connect Project
Eastern Ranges DGP
Knox DGP
Whitehorse DGP
Outer East PCP
Description of proposed project:

TARGET: General Practitioners and Practice Staff (*hereafter referred to as GPs and is inclusive of General Practice staff*) in Knox, Maroondah and Yarra Ranges Local Government Areas. The participating GPs will act as 'champions' to support other GPs to adopt the GP Service Coordination model, including the uptake of the Statewide referral form.

LOCATIONS: Three general practices across Outer Eastern Melbourne, one in each Division of General Practice. These three practices may vary in size, number of GPs and location however will all have broadband access to assist in capturing a range of issues and considerations for future implementation. Their local Division of General Practice and the Outer East Health & Community Support Alliance will support each general practice in their use of the Statewide referral forms and training and resourcing requirements.

BUILDING ON PREVIOUS ACTIVITIES: The GP CONNECT project gives GP's access to the primary care sector with a focus on Community Health Services through Service Coordination, Information Management & Support and Care Planning. It builds on the work undertaken to date in Service Coordination and General Practice Engagement.

This project builds on existing activities by increasing connections between General Practice and service providers. It will decrease isolation of GPs in the Outer East by building capacity both in general practices and Divisions of General Practice through the use of Service Coordination tool and processes. This project forms an important platform for future GP Engagement.

Project title: GP engagement and improved service coordination through secured and seamless transport of client information
PCP South West and Southern Grampians and Glenelg PCP
Otway Division of General Practice
South West Alliance of Rural Health (SWARH)
Description of proposed project:
While e-referral is happening in the South West, future goals of the group are to secure email via the use of PKI encryption (current security occurs using winzip/password security) and to develop import/export functionality to ensure seamless transfer of information between service providers. These goals are seen to be crucial to future GP engagement.

To achieve the above goals we have commenced discussions with ARGUS Connect and a scoping activity is underway.

Initially the project will focus on the transfer of clinical data in letter form from the mental health service to several general practitioners using Argus Mail a secure email system specially designed to encrypt messages. This process will provide the opportunity to iron out any IT and change management issues before extension of the project to include the SCoTT in a messaging environment and other GP clinics.

Already one participating clinic – Robinson Medical clinic is using the ScoTT from Medical Director and participants in the initial project will be required to also use the electronic tools so that change management issues are sorted out prior to the development of messaging involving the ScoTT.
To facilitate the ease of using the ScoTT from Medical Director and to ensure the sending of agreed documentation, work will be done to separate the ScoTT 'bundle' into separate forms.

The second part of the project will involve the development of standard templates which will enable import of ScoTT data into both PJB – and Medical Director and create a seamless transfer of information between GPs and other Primary Care providers.

Project title: Service Coordination with General Practice
Central West Gippsland DGP
Central West Gippsland PCP
Description of proposed project:
It is proposed to take advantage of the positive work of the HARP project and the high level of GP interest to develop processes and protocols to improve referral and feedback between the acute sector and general practice. The aim is to involve GPs in the development of discharge care plans, with appropriate use of the SCTT. The development of processes and protocols will be done in conjunction with key stakeholders, with a view to contributing to the work of the 'Better Health Care in Gippsland' regional service coordination project. Education and support will be provided to GPs in their practices, an approach that has proved highly successful in the delivery of Division programs.

Project title: Increasing General Practitioner use of Statewide Referral Form (SRF) within the MedTech 32 User Group in the Ballarat and District Division of General Practice membership.
Ballarat & District DGP
Central Highlands PCP
Description of proposed project:
Previous work has enabled the SCTT to be imported as a template into the MedTech 32 software thus allowing many fields to be self populated from the General Practitioners electronic patient history. The completed document can then be forwarded to the referral agency.

This project will concentrate on utilising the electronic template to actually send referrals to CHPCP agencies. General Practitioner engagement will be sought from the MedTech 32 users group. This group of 6 to 8 practitioners will be provided with training to refer appropriate patients utilising the SCTT MTTemplate.

The trial will be coordinated in consultation with Julie MacDougall service coordinator project officer Central Highlands PCP, and Tim Reed IM/IT Coordinator for Grampians PCP currently working on the connecting care project. The role of the PCP in this project will be to participate in the key stakeholder working group, ensure that agencies are aware of the project and provide training to key BDDGP staff and General Practitioners in the use of the Statewide Referral Form in MedTech 32.

Project title: GP pilot use of Service Coordination Tool Templates through General Practice Software
North East Victoria DGP
Lower Hume PCP
Description of proposed project:
Improve referral and feedback processes between General Practice and other service providers

- The project will update GPs daily address books with relevant local services
- It will improve the knowledge of GPs of the local services available and the extend to which these services can compliment the work they undertake
- It will provide opportunities for GPs to network and liaise with local service staff – through referrals and PD sessions / dinners.

- The project will be supported by key service providers in the region – Community Health Centres and Local Government.

Increase the number of GPs (and General Practices) implementing the medical software version of the Service Coordination Tool Templates (SCTT).

- The project takes a "whole of practice" approach to educating GPs, Practice Managers and Practice Nurses on the use and benefits of the SCTT.
- GPs from the pilot practices will be utilised as SCTT champions, sharing their experiences with their colleagues and demonstrating the success of the tools for referral and feedback.
- The project will demonstrate a best practice model for the integration of SCTT into GP practices where the local Division of General Practice takes a lead role in educating and supporting GPs in the use of the SCTT.

Project title: Quality Referrals Between General Practitioners And Other Primary Care Providers – Information And Practice Standards Required For Meaningful, Quality Referrals

Central Highlands DGP
Bendigo & District DGP
Central Vic Health Alliance

Description of proposed project:

The objectives of the project are:

1. To undertake an extensive needs analysis across the primary care sector of the documentation required for meaningful quality referrals (i.e. referral data sets)
2. To identify and develop criteria for quality patient/client information exchange practices (i.e. best practice standards), that meets General Practice accreditation standards and the needs of the receiving service providers.
3. To develop functional service access and quality referral information resources to support and to improve practice links between needs identification, service access, service eligibility and referrals
4. To hold a series of General Practice / Other Primary Care Agencies Network Forums across the CVHA catchment:
   a. To facilitate General Practice / Other Primary Care Agencies relationships and understandings of referral needs and referral pathways
   b. To incorporate the outcomes of the needs analysis and "quality referral practices" and resources developed
5. To hold these Network forums in each shire for a range of mutual program areas:
   a. Mental health and community welfare services
   b. Health Promotion and Chronic Disease projects – focus Physical Activity
   c. Aged Care and disability services
6. To make recommendations to DHS and GPDV on the findings of the project