Enhanced Primary Care

Activity, resources and program integration

Divisions, State Based Organisations and Australian Divisions of General Practice

March 2001

Prepared by ADGP and validated by SBOs and Divisions of General Practice Jan/Feb 01

	Activities/resources	Program links
Australian Divisions of General Practice	National coordination, support and management to SBOs and Divisions.	
	Coordination and support of Eyre Care software for use by GPs.	IT
	Integration of EPC with GP Business Advantage to demonstrate to GPs how EPC can be included in a GPs practice as an integral part of their business plan.	GP systems support
	Establishment of an EPC website to make available resources developed by SBOs, Divisions and GPs (www.adgp.com.au/epc).	IT
	Exploring opportunities for EPC to be included in accredited training courses for practice staff.	Training
	Exploring opportunities for EPC to be included in the programs of the national health priority areas, particularly with care planning and case conferencing.	Diabetes Aboriginal health Asthma Cardiovascular Mental health
	Ongoing distribution of EPC kits to stakeholders other than GPs.	
	Plenary speaker at the Chronic Disease Self Management Conference July 2000.	
	Invited guest at the EPC Taskforce meetings.	
	Member of EPC Clinical Audit Steering Committee and Working Party.	Clinical audit

	Member of the National Asthma Week steering committee. Contact: mclark@adgp.com.au	Asthma

NEW SOUTH WALES

New South Wales	Resources/Activities	Program links
Coordinated Care Trials prior to EPC	Care Plus Illawarra Linked Care Wilcannia	 Aboriginal health
State Based Organisation	**Resources/Activities**	**Program links**
Alliance of New South Wales	NSW offered area health services a one-off round of funding of $40,000 for pilot funding for care planning and case conferencing with GPs. A rural area health service (which includes 3 Divisions of General Practice) was successful. The Chronic and Complex Care Implementation Group (CCCIG) established by NSW Health has provided $45m over 3 years to support the establishment of three Priority Health Care Programs in the CVD and its risk factors (including diabetes), respiratory disease and cancer. Each CCIG has been requested to include EPC and the new MBS item numbers into the program. Working with Area Health Services ▪ Northern Sydney Area Health Service establishing links with GPs to facilitate care plans and case conferencing Working with the Aboriginal Health and Medical Research Council (NACCHO Affiliate in NSW)to promote the use of health assessments, care plans and case conferences among Aboriginal communities. National Demonstration Hospitals Projects ▪ Hornsby Ku-ring-gai Hospital developed a case conferencing model	Rural health Community linkages Chronic and complex care Community linkages Cardiovascular disease Diabetes Respiratory disease Cancer Community linkages Aboriginal health Hospitals Community linkages

	through implementation of a three part multi-disciplinary protocol for the management of CAL/COPD patients through an episode of care, focussing integration and communication between hospital, community service and GPs. ▪ Prince of Wales Hospital, Post Acute Care Services (PACS) utilising EPC Item Numbers and promoting case conferencing for patients recruited to the Pulmonary Rehabilitation Program and the REACH OUT Project (Rehabilitation of the elderly and care at home or usual treatment). Contact: jannewland@answd.com.au	Hospitals Cardiovascular Aged care Community linkages
New South Wales Divisions of General Practice	**Resources/Activities**	**Program links**
Bankstown	Integrating EPC in project workshops. Working with Bankstown Health Service. Contact: division@bankstowngp.com.au	Community linkages Urban Division
Barrier	Incorporating EPC into mental health, drug and alcohol services. Contact: bardivgp@pcpro.net.au	Mental health Drug and alcohol Rural Division
Blue Mountains	'Handy hints' for assessing EPC items and case conferencing. Developing a model of improving relationships between ACAT and GPs. Developing a joint initiative with Wentworth Area Health Service Community and Extended Care Service that would see community health staff visiting selected general practices once per month for up to four case conferences/care plans on patients with complex conditions.	Training Community linkages Community linkages Chronic and complex care

	Contact: admin@bmdgp.com.au	Urban Division
Canterbury	CME Workshops to aid GPs in implementing the EPC items in their practices as part of the Cardiovascular and Diabetes programs. Contact: candivgp@one.net.au	GP systems support Cardiovascular disease Diabetes Urban Division
Dubbo Plains	GP Patient Support Project where patients with complex/chronic issues are referred to the support service which assesses their need re counselling and access to other allied health professionals. Case conferences and care plans are set up for each client. Contact: gpdubbo@dubboplainsdgp.com.au	Chronic and complex care Community linkages Allied health Rural Division
Fairfield	Quarterly meetings with Fairfield Hospital to develop models for incorporating GPs into hospital and community multidisciplinary teams. Division provides a regular column on EPC in the hospital newsletter. Working with the local AHS to investigate an Asthma GP Shared Care Program incorporating the new Medicare item numbers. Contact: fdgpadmin@fairdiv.org.au	Hospitals Community linkages Chronic and complex care Asthma Urban Division
Hornsby Ku-Ring-Gai	Participant in the Coordinated Care Trials – Linked Care. Working with local mental health services to improve communication between the services and GPs. Collaborating with Northern Sydney Division Ku-ring-ai Division and Chatswood Mental Health Services on a model similar to the Consultation Liaison in Primary Care Psychiatry model (CLIPP) which links a consultation-liaison model with shared care. Working with Area Health Service to explore ways of utilising EPC MBS Item Numbers in normal work practice.	 Mental health Community linkages

	Incorporating EPC MBS Item numbers across all programs in the Division. Contact: office@hkdgp.org.au	 Urban Division
Hunter Rural	EPC being implemented in conjunction with the Division's immunisation program. Contact: brian@hrdgp.org.au	Immunisation Rural Division
Hunter Urban	Negotiation with Hunter Area Health Aged Care Services to involve GPs in discharge case conferencing and discharge care planning. The pilot is to commence February 2001. Negotiation with Hunter Area Community Health Services to develop a generic health assessment tool with the aim of avoiding duplication of assessment processes. Negotiation has begun with Hunter Area Mental Health Services to conduct a pilot for care planning and case conferencing activities. Contact: hudgp@hudgp.org.au	Aged care Hospitals Community linkages Generic health assessment tool Mental health Urban Division
Illawarra	Working with the Department of Community Services to incorporate EPC care plans and case conferences conducted between the GP, Clinical Nurse Consultant and Case Worker from DOCS for children in their care, particularly children with disabilities. Contact: idgp@idgp.org.au	Disabilities Childcare Community linkages Urban Division
Liverpool	Promoting medication reviews to GPs through their NPS relationship. Contact: ldgp@liverpoolgp.com.au	Medication reviews Urban Division
Macarthur	Conducted a survey to gain a snap shot of the number and type of services that would be required if GPs were to utilise EPC item numbers. The	EPC needs assessment survey

	information has been presented to area and local health services for consideration to accommodate EPC within current systems and human resources. Producing an EPC educational audiovisual package for GPs and other health care providers. Contact: macdivgp@acenet.com.au	Community linkages Video Allied health Community linkages Urban Division
Mid North Coast	National Innovations Funding Pool. Enhancing care for Aboriginal people. ▪ To develop a culturally appropriate EPC communication strategy ▪ An Aboriginal Health Liaison Officer employed to work with local Aboriginal communities and GPs to encourage Aboriginal people to take advantage of EPC Draft patient information brochure suitable to promote EPC among Aboriginal communities on the Mid North Coast. A model for incorporating MBS Item Numbers into case conferences between the GP, teachers, psychologists, speech therapists etc for children with ADHD. Developing a protocol for incorporating EPC into the AHS Aged Care Transitional Intervention Program, a short term intervention for elderly complex patients in the community. Aboriginal Health Coordinated Care Trial on the Mid North Coast of NSW incorporating EPC. Contact: info@mncdgp.org.au	Aboriginal health Consumer ADHD Child health Aged care Community linkages Allied health Aboriginal health Rural Division

Nepean	Practice visits in collaboration with ANSWD Outreach Educator. Developing working relationships with local mental health teams, Ambulatory Detoxification Service and ACAT. Developing a 6-month Health Assessment Pilot Program where a nurse, employed on a casual basis, will collect information on behalf of the GPs. Developing EPC items and criteria 'quick reference' brochure. Contact: ndgpyvon@pnc.com.au	 Mental health Alcohol and drugs Aged care Health assessment service Nurse support Urban Division
New England	The Armidale Community Health ACAT are working with the Division in seeking GPs interested in performing annual health assessments as part of a patient work-up on patients aged over 75 who are referred to ACAT and don't have their own local GP. In this area 80% of referrals to ACAT were not GP-based. Contact: nepdg@nedgp.org.au	Community linkages Aged care Rural Division
NSW Central West	Incorporating case conferences into outreach Diabetic Foot Clinics involving GPs, podiatrist and community health. Progressing the use of EPC item numbers for case conferences/care planning for patients with eating disorders. Website www.cwdgp.org.au Contact: nswcwdgp@ix.net.au	Diabetes Community Linkages Eating Disorders IT Rural Division
North West Slopes	GPs working with a Palliative Care Specialist from Tamworth Base Hospital in care plans and case conferences for patients with a terminal illness.	Palliative care Hospitals

	Contact: division@nwsdgp.org.au	Rural Division
Northern Rivers	Working with GPs and local Drug and Alcohol services who support patients in the community who are addicted to alcohol or other drugs. Incorporating EPC item numbers into their existing cardiac rehabilitation program that involves GPs in the ongoing care of their patients with chronic heart disease. Contact: manager@nrdgp.org.au	Alcohol and drugs Community linkages Cardiac rehabilitation Cardiovascular Rural Division
Northern Sydney	Working with local mental health services to improve communication between the services and GPs. Collaborating with Lower North Shore Mental Health Services on a Collaborative Liaison in Primary Care Psychiatry model (CLIPP) of shared mental health care. Contact: mail@nsdgp.com.au	Mental health Shared care Urban Division
Port Macquarie	Linking EPC into a diabetes program. Contact: gpdiv@pmdgp.org.au	Diabetes Rural Division
Shoalhaven	Developed a protocol for a private hospital to incorporate GP involvement in discharge care plans and case conferences for patients with chronic illness. Contact: gpdiv@shoalhaven.net.au	Hospitals Rural Division
South East Sydney	EPC tutorials. Linking EPC to mental health program. Contact: sesdgp@clinipath.com.au	Training Mental health Urban Division
St George	A successful model in use with a Home Hospice service. Contact: stgeorge@stgeorgedgp.asn.au	Palliative care Urban Division

Sutherland Division of General Practice	Referral forms for local ACAT has been developed and piloted. EPC items have been incorporated into GP referrals to Mental Health Access Team. A model has been developed using a medication review for the elderly through NPS program. EPC is integrated into the program for CME workshops. Contact: bmichie.sdgp@shiregps.org.au	Aged Care ACAT referral forms Mental Health Aged Care Medication review Training Urban Division
Tweed	Working with GPs and local Drug and Alcohol services who support patients in the community who are addicted to alcohol or other drugs. Contact: office@tvdgp.org.au	Alcohol and drugs Community linkages Rural Division
Wagga Wagga	Incorporating the new item numbers into a "Health Integration program – Dementia Shared Care" to develop partnerships between GPs, ACAT and other service providers such as HACC. Contact: division@wwddgp.com.au	Dementia Shared care Community linkages Rural Division
Western Sydney	Management support for GPs. EPC is being integrated into existing health related programs such as Cardiac Recovery, Mental Health, GP-Hospital, and communication. Continuing education support. Contact: wsdgp@wsdgp.com.au	GP systems support Cardiovascular Mental Health Hospitals Urban Division

AUSTRALIAN CAPITAL TERRITORY

SBO and Division	Activities/Resources	Program links
Coordinated Care Trials	CarePlus	
ACT Divisions of General Practice	EPC Helpline, GP Practice Visits, Newsletter Aged Care Assessment Project to encourage a team approach to the care of patients in nursing homes, through the organisation of multidisciplinary case conferences led by the patient's general practitioner. The project found that "the case conference reviews were beneficial in terms of the overall outcomes to residents and carers, mortality reduction and medication cost reduction". EPC is being incorporated into the Division's Mental Health program, the Division's Aged Care Program and the IT Education. Focusing on the use of the items in Residential Aged Care Facilities. Contact: reception@actdgp.asn.au or: j.rynehart@actdgp.asn.au	Training Aged care Mental health Aged care IT Residential aged care facilities Urban Division

VICTORIA

	Activities/Resources	**Program links**
Coordinated Care Trials	North Eastern Health Care Network Southern Health Care Network	
State Based Organisation	**Activities/Resources**	**Program links**
General Practice Divisions of Victoria	Train the trainer. Victorian divsions have adopted a partnership approach with division EPC project worker and GP trainer working together to develop and deliver EPC training locally. GPDV resources and provides training skills development to EPC trainers in divisons. Memorandum of Understanding between VACCHO and GPDV provides a framework within which EPC models can be developed. Working with mental health, diabetes and hospital integration at a state level. Working with the Victorian Department of Human Services around integrating EPC within Primary Care Partnerships as a tool for GP engagement. Contact: r.fenech@gpdv.com.au	Training Aboriginal health Mental health Diabetes Hospitals Primary Care Partnerships
Divisions of General Practice	**Activities/Resources**	**Program links**

Ballarat and District	Information for GPs and practice managers. Linking with BHS, St John of God Hospital and The Ballarat Community Health Centre. Contact: contact@bddgp.org.au	GP systems support Hospitals Community linkages Rural Division
Bendigo and District	National Innovations Funding Pool – evaluation of the implementation of health assessments under the new MBS items. Nursing staff support for home health assessments. An assessment tool has been developed to support GPs in Health assessments. Contact: division@bgodivgp.org.au	Evaluation Nurse support Assessment tool Rural Division
Border	Business plans for GP practices utilising EPC (available on ADGP website – www.adgp.com.au/epc) Contact: staff@bordergp.org.au	GP Business plans GP systems support Rural Division

Central Bayside	Programs for a partnership approach being run by RDNS to support GPs in health assessments. Incorporating EPC into a Medical Case Management Project. Protocol and agreement development with Como Private Hospital. Care planning being integrated through all Divisions programs. Development of health organisational linkages at the Primary Care Partnerships level and at a bi lateral agreement level. Contact: info@centralbayside.com.au	Nurse support Case management Hospitals Community linkages Primary Care Partnerships Urban Division
Central Highlands	Some GPs in the Castlemaine area have been working closely with the Rehabilitation Hospital to develop Discharge Care Plans. The Division has collaborated with local nursing service providers (hospitals and community health centres) to provide home based assessment services. EPC is being linked with the CVD Mini clinic program. CHDGP developed EPC resource information is being disseminated to OHS providers throughout the Division. Models of Case Conferencing and Care Planning are being developed with RACF's. Contact: centhigh@chdgp.com.au	Hospitals Nurse support Cardiovascular Allied health Community linkages Residential aged care facilities Rural Division

Central West Gippsland	Incorporating EPC into a Community Liaison Program. EPC is being incorporated into the 'better practice in diabetes care program'. Contact: cwgdogp@cwgdogp.com.au	Community linkages Shared care Diabetes Rural Division
Dandenong and Central Bayside	National Innovations Funding Pool – a division based strategic framework for the implementation of multi-disciplinary care planning in general practice. Contact: dandiv@netlink.com.au	Multidisciplinary care Chronic and complex care Urban Division
East Gippsland	Case conferencing manual developed by SGDP. EPC incorporated into Divisions mental health program. EPC incorporated into Koori Health Programs. Contact: egdgp@net-tech.com.au	Training Mental health Aboriginal health Rural Division
Geelong	Pilot program for health assessments and example of an audit Trialing patient health assessment cards. Contact: ggold@tjlink.net	Clinical audit GP systems support Urban Division
Goulburn Valley	Developed a model for a nurse assisting GPs in the Division with Health Assessments. Contact: gvgp@gvgp.com.au	Nurse support Rural Division

Inner Eastern Melbourne	EPC Hotline. Epworth Hospital Discharge Case Conference model includes: • A brief EPC information sheet • GP request for involvement in the case conference • Proformas for consent and outcomes • Patient information about case conferences This model has now been distributed to several local hospitals and health providers as a reference point for development of their models. Contact: iemdgp@iemdgp.com.au	Hotline Hospitals Consumers Community linkages Urban Division

Knox	Development of protocols for Western Palliative Care (domiciliary palliative care service) to involve local GPs in their weekly case conferences on new patients. This includes initial letter to GP re patient, explanation of case discussion activities of the service, and an offer to be included by teleconference in activities as well as an explanation of the appropriate item and remuneration available. Letter stresses the importance of the GP in ongoing care. Feedback from GPs is positive. The Division's two patient services – the Knox Diabetes Education and Support Service, and the Knox Cardiac Program, are services for General Practitioner-referred patients (only) comprising a range of allied health professionals. For every patient referral, GPs are being encouraged to initiate a care plan for each patient together with the service's referral form. The Division has commenced information sessions for the staff from these two services, advising them of their roles and responsibilities as contributors to care plans. Many GPs have patients on a methadone program, who are being seen by a local counselor at the Knox Community Health Service and are receiving methadone at local pharmacists. A basic model care plan has been developed which outlines for all participants the long-term plan for medication and harm minimisation,. In some cases where counseling is not available one GP is also willing to remunerate a psychologist for a patient assessment, therefore providing a more comprehensive service at no cost to the patient. Contact: manager@knoxdiv.com.au	Palliative care Diabetes Cardiovascular Allied health Drug rehabilitation Medication review Urban Division

Mallee	Beginning to develop linkages/models with the three Koori Co-ops within the division, where after orientation/education sessions with Koori health workers and GPs, protocols will hopefully be put in place to allow health assessments to be attended at the Koori client's place of residence by a Koori health worker, who will then be responsible for following up/transporting the client to a GP for the remainder of the assessment. Contact: admin@malleedgp.com.au	Aboriginal health Rural Division
Melbourne Division	Academic detailing for GPs and Practice staff. CME forums which focus on using the new EPC MBS item numbers for specific chronic illnesses such as diabetes, osteo-arthritis, dementia, drug and alcohol abuse and cardiac illness. Working groups of GPs and appropriate allied health to develop protocols for care planning and case conferencing with respect to specific chronic illnesses (as above). Demonstration project of EPC implementation and GP involvement in generating discharge care plans at the Mercy hospital. Information provision and sharing, agreements and protocol development with Royal Melbourne, Women's & Children's Hospitals, St Vincent's Hospital and the Mercy hospital. Protocols for EPC developed and in development with St Vincent's Mental Health Service, Breast Services Enhancement Program & Sharing Shared Care (Royal Women's, Mercy and Sunshine Hospital). EPC protocols developed with Diabetes Alliance Group.	Training Diabetes Osteo-arthritis Dementia Drug & Alcohol Cardiovascular Allied health Hospitals Demonstration project Hospitals Mental health Women's health Shared care Diabetes

	Proposed: ▪ To contract a registered nurse to perform health assessments for GPs within the division subject to demand. It is anticipated that the nurse will fill the role of 'practice nurse' for practices (solo or small) that do not have one (a large proportion in our division) ▪ EPC incorporated in to falls prevention project Contact: division@mdgp.com.au	Nurse support Falls prevention Urban Division
Monash	National Innovations Funding Pool – identifying a role for Division and practice nurse in EPC. A model for care planning and diabetes has been developed with Beentleigh-Bayside Community Health service. A model for care planning and case conferencing is being developed with Mental Health Services and other Divisions. Exploring the possibility of GPs employing community nurses to assist with health assessments through the Community Health Service. RDNS has developed a partnership model to work with GPs in supporting health assessments. Contact: mdmadmin@rubix.net.au	Practice nurse Diabetes Community linkages Mental health Nurse support Community linkages Nurse support Urban Division
Mornington Peninsula	Allied health and other agencies are participating in a working party to develop work practices and protocols involving EPC. Possibility of emerging models in palliative care, RDNS, GP Unit at Frankston Hospital, Peninsula Health Psychiatry Dept. Contact: contact@mpdgp.org.au	Palliative care Nurse support Hospitals Mental health Urban Division

North East Valley	The Division is working with the Northern Metro Region Acquired Brain Impairment Network with GPs in case conferencing. The Division has completed a formal MOU with the RDNS to support busy practitioners in undertaking a range of health assessments, care plans and case conferences. The Division, through the newly appointed GP/Hospital Liaison Officer has developed a series of protocols, pro-formas and information documents in preparation for the introduction of a number of trials for Discharge Case conferencing and case conferencing with selected medical units within the hospital. Introducing a number of trials for discharge case conferencing and case conferencing with selected medical units within the Austin and Repatriation Hospital. Contact: nevdgp@nevdgp.org.au	Acquired Brain Impairment Mental health Nurse support Hospitals Hospitals Urban Division
North East Victoria	Integrating EPC into practice support Contact: patryder@nevicdgp.org.au	GP systems support Rural Division
North West Melbourne	With two other Divisions have developed a care plan for diabetes and plan to trial the care plan with local diabetes services through hospitals and community health centres. The trial will be held over a 2-3month period RDNS nurses for health assessments Contact: admin@nwmdgp.org.au	Diabetes Hospitals Community linkages Nurse support Urban Division

Sherbrooke and Pakenham	Working with allied health service providers on a range of aged care and community case services and also with aged care/psych services in a hospital setting Contact: spdgp@spdgp.com.au	Allied health Aged care Community linkages Mental health Hospitals Rural Division
Southcity GP Services	Development of a pilot discharge case conference program with the Epworth Hospital. The program sees patients selected by Epworth staff as suitable for a discharge case conference, the patient's GP is notified of the intention to hold the conference and receives information from the Epworth staff about the process including several possible times for the conference to be held. The GP is then contacted by the Division and is supported throughout the process depending on his/her level of confidence/skill in case conferencing activities. Interest in this model has been expressed by three other hospitals, and the Division is expecting to begin work on similar pilots with them shortly. Working with major community health providers in the area to implement EPC. Contact: isemdgp@isemdgp.org.au	Hospitals Pilot program Community linkages Chronic and complex care Urban Division
South Gippsland	Incorporating EPC in a Diabetes program. Contact: info@sggp.com.au	Diabetes Rural Division

Western Melbourne	Including EPC into a health promotion program Focusing on falls prevention and the interface with EPC Including EPC into Aboriginal health programs Contact: westgp@labyrinth.net.au	Health promotion Falls prevention Aboriginal health Urban Division
West Victoria	EPC being incorporated into current Division programs. Contact: ararat@westvicdiv.asn.au	 Rural Division
Westgate	With two other Divisions have developed a care plan for diabetes and plan to trial the care plan with local diabetes services through hospitals and community health centres. The trial will be held over a 2-3month period. Contact: wgdiv@netlink.com.au	Diabetes Pilot program Hospitals Community linkages Urban Division
Whitehorse	Incorporating EPC into a mental health program. Assessment kits for over 75 years – includes assessment tools for Adult Daily Living Skills, Alcohol Audit, Geriatric Depression Scale and Mini Mental State Examination. Agreements with hospitals regarding inclusion of GPs in discharge conferences (Maroondah Hospital Family Conferences) and discharge care planning (Box Hill Hospital Outer East Post Acute Care). Working towards multidisciplinary care through community health centres and RDNS. Academic Detailing and small group discussions via practice visits. Chronic Illness Sharing Health Care Initiative: The Good Life Club. This	Mental health Health Assessment tools Hospitals Multidisciplinary care Community linkages Nurse support Shared care

	project is to demonstrate that coaching in self-management skills can help patients with chronic diseases such as diabetes and CVD, to achieve short and long term health goals. Integral to the project are GPs and multi-disciplinary Care Plans that clearly identify goals. The program will include GP mentoring for writing Care Plans and goal identification. Contact: admin@wdgp.com.au	Chronic disease self management Diabetes Cardiovascular Urban Division
Yarra Valley	Developing a model for case conferencing with the RDNS and working with other health care service providers. Contact: yvdgp@hotkey.net.au	Community linkages Nurse support Urban Division

QUEENSLAND

State Based Organisation	Activities/Resources	Program links
Queensland Divisions of General Practice	**State- level coordination of GPESCL Program including**: Development of resources, tools and case studies/examples, regular Divisional teleconferences, newsletters, updates, workshop facilitation, development and maintenance of the EPC Q & A database**.** State-level community linkages with key community, allied health and private sector organizations, including private hospitals. Integration of EPC across all QDGP program areas, including MAHS, Mental Health, Practice Systems Support, Business Systems Unit, IM/IT and other Population Health areas. General Practice and Psychiatry Partnerships (GPAPP) The General Practice and Psychiatry Partnerships (GPAPP) is a model based on collaborative mental health service delivery. The program facilitates the development of effective, sustainable and collaborative ways of working between general practitioners and mental health service providers resulting in improved care for the mental health consumer. The pilot is currently being piloted throughout metropolitan, rural and provincial sites within Queensland. The QDGP EPC Team working with the General Practice Integration Team to coordinate the next phase of the GPAPP program for the pilot sites. Care Planning will provide the avenue for the transfer of long term Mental Health Consumers from their Mental Health Service into the care of a GP. **Contact: aliddy@qdgp.org.au**	Primary Care Integration Primary Care Workforce GP Systems Support Business Systems Support

Divisions of General Practice	Activities/Resources	Program links
Bayside	Participant in Combined Southside Divisions Discharge Planning project involving QE II Hospital. Based on consultation with GPs and Hospital and Community staff, pathway established to facilitate GP participation in discharge case conferences and care plans from QEII Hospitals' Rehabilitation Ward. Documentation developed including information leaflets for GPs, Practices and Hospital staff.	Hospitals
	Education and training focused on Care Planning for GPs and Practice staff.	GP systems support
	Practice visits to support education initiatives.	GP systems support
	Community Linkages with both public and private sector allied health.	Community linkages Allied health
	Division EPC Help Desk.	Training
	Mental Health program (program undertaken in conjunction with local District Mental Health service) adapted to incorporate care planning and case conferencing opportunities.	Mental health
	Community Resources Manual to include details on local allied health providers. Contact: division@baysidegp.org.au	Community linkages Community resources manual Urban Division
Brisbane Inner South	Participant in Combined Southside Divisions Discharge Planning project.	Hospitals
	Focus on increasing Practice capacity through Practice staff education and building practice systems.	GP systems support

	Integrating EPC work into Divisional population health activities, particularly diabetes. Building stronger linkages with local Indigenous Health Service. Participant in Combined Southside Divisions Discharge Planning project involving QE II Hospital. Based on consultation with GPs and Hospital and Community staff, pathway established to facilitate GP participation in discharge case conferences and care plans from QEII Hospitals' Rehabilitation Ward. Documentation developed including information leaflets for GPs, Practices and Hospital staff. Care Planning incorporated into Refugee Health program. Working with NPS and EPC with medication reviews. Contact: admin@bisdiv.com.au	Diabetes Aboriginal health Hospitals Refugee health Medication review Urban Division
Brisbane North	Residential Care Project (Innovations funding). The focus of this project is to develop a best practice pathway for new residents of RACFs. This will involve a comprehensive assessment to be undertaken by the GP and will also create opportunities for care planning and case conferencing. Practice visits to support uptake of EPC (targeting GPs and Practice Staff) and Practice staff workshops. Small GP group education sessions (Care Plan tutorials). Promote and integrate EPC activities within other Divisional priority areas – mental health, GP hospital liaison, coordinated care trial, Shared Health Care.	Residential Aged Care Facilities GP Systems support Training Mental health Hospital Share care

	Use of EPC items within Indigenous Health settings. Current project with Qld Health to facilitate improved understanding and use of EPC MBS items. Contact: bndgp@bndgp.com.au	Aboriginal health Urban Division
Brisbane Southside Central	Participant in Combined Southside Divisions Discharge Planning project involving QE II Hospital. Based on consultation with GPs and Hospital and Community staff, pathway established to facilitate GP participation in discharge case conferences and care plans from QEII Hospitals' Rehabilitation Ward. Documentation developed including information leaflets for GPs, Practices and Hospital staff. Focus on care planning in asthma and CVD. This project will involve GPs working with Mater Hospital staff in developing paediatric asthma care plans. GP Education and training sessions. Trialling of Practice model incorporating allied health sessions within a General Practice setting. Contact: info@bscdgp.com.au	Hospitals GP systems support Asthma Cardiovascular GP systems support Allied health Urban Division
Bundaberg	Focus on Health Assessments, Care Planning and Case Conferencing workshops and practice visits. Multidisciplinary meetings involving GPs and allied health professionals. Collaboration with local health service district.	GP systems support Community linkages Allied health Multidisciplinary care Palliative Care

	Linking EPC into Division programs – palliative care, CVD, Diabetes, Aged care and hospital integration. Aged Care and Palliative Care programs will involve specific meetings between Divisions and other health service providers to develop models of service delivery incorporating care planning and case conferencing. Contact: generalmail@bundaberggp.org.au	Cardiovascular Diabetes - MAHS Aged Care Hospitals Urban Division
Cairns	Focus on practice staff education through practice visits and workshops. Improving referral and communication processes. Division will partially fund a trial practice/EPC facilitator for indigenous health Progressing the Shared Care Mental Health initiative in collaboration with the Far North Queensland Division of GP. Continuation of community linkages. Including EPC into Division's programs – diabetes, hospital integration and MAHS Contact: cdgp@cdgp.org.au	GP systems support Indigenous health Mental health Hospitals Diabetes MAHS Urban Division
Capricornia	Progressing and integrating EPC into established collaborative partnerships in mental health and diabetes management programs. Integration with MAHS activities. Maintenance of Health Services Directory.	Diabetes Mental health MAHS Community linkages Services directory

	Practice visits and education to support uptake of EPC. Linkages with local Aboriginal Medical Service. Education to target GP Registrars and Medical students. Contact: admin@capdivgp.cqdoc.com	 Aboriginal health Training Urban Division
Central Qld Rural	GP and practice staff education through practice visits. Integration EPC into MAHS program. Health Assessment Workshops for practice staff and RN's. Including EPC into Division's programs – aged care, diabetes, mental health, falls prevention. Contact: cqrdgp@tpg.com.au	GP systems support MAHS Nurse support Aged Care Diabetes Mental Health Falls Prevention Rural Division
Central West Qld Rural	GP and practice staff education through practice visits. Integrate EPC into MAHS program. Contact: cwqrdgp@tpg.com.au	GP systems support MAHS Rural Division
Far North Queensland	Integration of EPC into established Mental Health programs. "A Model for Sharing Mental Health Care in Far North Queensland" has been developed which incorporates suggested referral pathways and options for shared care. Resources have been developed for GPs and Mental Health Services include MH Case Conferencing Form, Mental Health Care Plan/Case Conference Checklist and patient consent forms. Integration of EPC in MAHS activities.	Mental health MAHS

	Meetings with local hospitals to implement Discharge care planning and case conferencing arrangements. Practice visits and education to support uptake of EPC. Consolidate linkages with key allied health and other service providers. Contact: admin@fnqrdgp.com.au	Hospitals GP systems support Allied health Community linkages Rural Division
Gold Coast Division	Focus on Practice staff and GP education through practice visits and workshops. Care Planning initiative involving recently discharged patients from the local Hospital. Resources developed include a GP Care Planning Flowchart and a reminder form which is completed by the local service provider/hospital and faxed to a patients usual GP to suggest the development of a GP initiated Community Care Plan. Integration of EPC in established Mental Health (GPAPP) and Diabetes programs. Contact: gpdvgold@gcdgp.com.au	GP systems support Hospitals Mental health Diabetes Urban Division
Ipswich & West Moreton Division	Integration of EPC through existing program areas focusing on building practice capacity through care planning and case conferencing. Discharge Care Planning and Case Conferencing in Public and Private Hospitals. Continue work with local AMS to integrate use of new items. Focus on practice staff and GP education through practice visits and workshops.	GP systems support Hospitals Aboriginal health

	Care Planning and Case Conferencing in Community Organisations. Integration with MAHS activities. Incorporating EPC in Division's programs – mental health, diabetes, CVD, IMIT, Palliative care, Hospital integration Contact: iwmdgp@iwmdgp.org.au	Community linkages MAHS Mental Health Diabetes CVD IMIT Palliative Care Hospitals Urban Division
Logan Division	Participant in Combined Southside Divisions Discharge Planning project involving QE II Hospital. Based on consultation with GPs and Hospital and Community staff, pathway established to facilitate GP participation in discharge case conferences and care plans from QEII Hospitals' Rehabilitation Ward. Documentation developed including information leaflets for GPs, Practices and Hospital staff. "Division In the Practice" (DIP) approach. Increasing workforce to create education and facilitation linkages, including EPC, IT, NPS and Immunisation initiatives. Focus on practice staff and GP education, and where possible, with allied health and/or community health professionals. Incorporating EPC in Division's programs – CVD, Mental Health to develop sustainable models. Contact: admin@ladgp.com.au	Hospitals GP systems support Community linkages Medication review Allied health Cardiovascular Mental Health Urban Division

Mackay Division	Focus on practice staff and GP education through practice visits and workshops. GP Liaison officer to work with Discharge Care Planning and Case Conferencing. Incorporating EPC into Division's programs – mental health, diabetes, MAHS. Contact: admin@mackaydgp.com.au	GP systems support Hospitals Mental Health Diabetes MAHS Rural Division
Northern Qld Rural Division	Building practice capacity through GP and practice staff education and community linkages. Allied Heath staff employed through MAHS project will be upskilled on EPC. Incorporating EPC into Division's programs – diabetes, mental health, IMIT to ensure integrated approach to practice education and support. Currently developing Regional Health Service proposal targeting the development of an Allied Health Service model which will incorporate EPC. Contact: nqrdgp@bigpond.com	GP systems support Allied health MAHS Diabetes IMIT Mental Health Rural Division
Redcliffe, Bribie, Caboolture Division	Focus on building practice capacity through practice staff education and community linkages. Incorporating EPC into Division's programs – mental health, diabetes, NPS.	GP systems support Mental Health Diabetes Medication review

	Contact: rbcdgp@rbcdgp.com.au	Urban Division
Sunshine Coast Division	Focus on GP and practice staff education through practice visits (GP detailing). Diabetes Support Service – Division funded project providing a Diabetes Educator to GPs practices to develop Care Plans. Integration of EPC across all existing programs – mental health, NPS. Contact: division@scdgp.org.au	GP systems support Diabetes Mental health Medication reviews Rural Division
Southern Qld Rural Division	GP and practice staff education through practice visits and workshops Incorporating EPC into Division's programs – diabetes, mental health, hospital integration. Contact: sqrdgp@sqrdgp.com.au	GP systems support Diabetes Mental Health Hospitals Rural Division
Toowoomba & District Division	Practice based approach through employment of GP Advisor and Practice Manager. Discharge Care Planning and Case Conferencing in Public and Private Hospitals. Building practice capacity through practice staff education and community linkages. Incorporating EPC into Division's programs – diabetes, IMIT. Contact: tddgp@tddgp.com.au	GP systems support Hospitals Community linkages GP systems support IMIT Diabetes Rural Division
Townsville Division	Discharge Care Planning and Case Conferencing in Public and Private Hospitals – GP Liaison.	Hospitals

	Practice visits and Practice staff education. Incorporating EPC into Division's programs – mental health, diabetes, CVD, asthma, aged care, IMIT. Contact: tdgp@tdgp.com.au	GP systems support IMIT Mental Health Diabetes Cardiovascular Asthma Aged Care Urban Division

SOUTH AUSTRALIA

	Activities/Resources	**Program links**
Coordinated Care Trials	Care 21 – now renamed as Northern Venture	Northern Division of General Practice
State Based Organisation	**Activities/Resources**	**Program links**
South Australian Divisions of General Practice	Working with the Palliative Care Council of South Australia on how EPC can be incorporated into a GP practice so that it is financially viable. Department of Human Services Health Outcomes Unit – Cardiac Depression Project A project has commenced that involves GPs as participants in case conferences with hospital psychiatric liaison staff, the cardiac rehabilitation nurse and the GP. The case conference will take place around discharge of a patient with a chronic cardiac condition who has been newly diagnosed with co-morbid depression. The GP is invited to participate in the case conference, so it is a nice safe introduction to the new EPC MBS items numbers. GPs arrange a follow up case conference at 3 months post discharge if required. This project is a randomised controlled trial so it is only GPs in the intervention arm of the project who will be involved in the case conferencing, but this will include approximately 500 GPs from across the state. Any patients with a chronic cardiac condition who are admitted to Royal Adelaide Hospital, Flinders Medical Centre, Queen Elizabeth Hospital or Lyell McEwin Hospital may be recruited to the project, so patients from anywhere in the state may be recruited. They will be screened for depression, and then the depressed patients will be randomised to the control group for usual management of the cardiac condition, and the intervention group will have the 'enhanced' treatment where the GP,	Palliative Care Mental health Randomised controlled trial Cardiovascular

	psychiatric liaison team and cardiac rehabilitation nurse case conference and monitor the patient's progress (for both cardiac and depression outcomes). Working with Department of Education, Training and Employment and Divisions in developing care plans for children in schools. Discussing the potential to link EPC with new policy implementation work in health support planning being undertaken during 2001 in South Australian schools, preschools and childcare services. Contact: mansert@health.on.net	 Child health
Divisions of General Practice	**Activities/Resources**	**Program links**
Adelaide Central and Eastern	Links with key service providers in the region. A successful CME evening was a role play of a teleconference Case Conference with different community service providers involved in the role-play. Contact: acedgp@health.on.net	Training Urban Division
Adelaide Hills	Incorporating EPC into Diabetes program. Each patient sees three allied health professionals and the GP at the one venue and a care plan is written. Set up an 'interest and support group' for GPs wanting to incorporate EPC into mental health. Contact: ahdgp@senet.com.au	Diabetes Mental health Rural Division
Adelaide Northern	A project commencing soon that involves GPs being participants in case conferences with hospital psychiatric liaison staff and the cardiac rehab nurse. Mental Health EPC Model being developed: ▪ Division EPC program officer has been coordinating and supporting case conferences for GPs with Child & Adolescent Mental Health Service,	Mental health Hospitals

	Adelaide North West Mental Health Service, Division Psychiatrist. Division's role seen as temporary and introductory until it is self-supporting. Mental Health Services have been looking at taking over the coordination role in the future. ▪ Liaison with the MHS's has resulted in change in their organisation to establish a position as a point of contact for discharge care planning and case conferencing with GPs ▪ Division assisting by identifying service providers to link with for best support of particular patients eg. Co-morbid mental health, intellectual disability, dual diagnoses etc ▪ The EPC program builds on a previous shared care project Pharmacist employed by the Division for the QUM project has been involved in some case conferences. Division working with practice staff teaching them to pre-book teleconferences etc. Step by step instructions given to GPs so the GP is supported when interacting with patients and other service providers. Health assessment training provided to GPs and practice RNs. This was followed up with telephone support and requested practice visits. The Mental Health Project Officer also worked in the training sessions to promote case conferencing and care planning. Contact: andgp@health.on.net	 Medication review GP systems support Training Nurse support Urban Division
Adelaide North Eastern Division	Regular meetings with a private hospital and adjacent hospice who have been positive and keen to involve GPs in the regular discharge process. Both the hospital and the hospice have assigned a person to assist in the process. The Division has sent a letter describing the discharge care plan and a copy of the proforma to all GPs encouraging them to access the item numbers with patients who are admitted to hospital, and in particular the	Hospitals

	private hospital and hospice. A Care Plan proforma has been designed and implemented in the Diabetes Mini Clinics. These clinics have a Dietician and Diabetes Nurse Educator so it is easier for the GP to access two other allied health providers. The Division is looking at a way of making it available for all practices within the area (those without the clinics). Regular Mental Health EPC Meetings have taken place where local Mental Health providers are invited to attend to discuss the new item numbers and how GPs can be targeted to take them up. Contact: anedgp@anedgp.on.net	 Diabetes Mental Health Urban Division
Barossa Division	A standardised discharge care plan has been devised and is currently being considered by the local hospitals. All the hospitals in the area have a different format for discharge planning – if they had any at all. An EPC GP Link group meets in the Valley regularly, with representation from each of the major practices. The path for implementation of the EPC items has been smoothed considerably as a result of these sessions and they have now evolved as an excellent problem solving forum. The Barossa Division has applied for funding to employ a Social Worker, Youth Counselor and Psychologist to increase the mental health network within the region. One of the key roles of the social worker will be to link in with GPs, psychologist and youth counselor to increase the uptake of the MBS case conferencing and care planning items. Contact: division@bdgp.net	Hospitals GP support Mental Health Youth health Rural Division
Eyre Peninsula	Eyre Care Software being developed to support all EPC items and to be distributed free of charge to all Divisions and GPs in Australia.	IT

	The Diabetes care plan program uses the MBS items in a sustainable manner. Item numbers are used to fund the Diabetes GP and the health coordinator. The Healthplus "winddown" program has been successful in careplanning the "at risk" patients and offering a Chronic Disease Self Management Program in Port Lincoln and Whyalla. Contact: epdgp@camtech.net.au / epdgp@epdgp.org.au	Diabetes Chronic Disease Self Management Rural Division
Flinders and Far North	The Division has been assisting GPs to re-organise their practice to be able to utilise the EPC items to lead to a more sustainable practice for GPs. In some practices, nurses have been employed to assist the GPs in using the item numbers. Contact: flindiv@flindiv.com.au	Nurse support Rural Division
Limestone Coast	The Division has trained three GPs to be the peer educators in their region. A growing number of GPs are showing interest in using EPC items. The Division has the support of a new EPC coordinator since January 16th 2001. Parts of the Division's plan of action for the months are as follows: • meetings with Community Health to increase effectiveness of linkages between GPs and Allied Health Services • Community awareness campaigns focused on Health Assessments & Care Plans • Organizing a CME event focused on Care Planning and Case Conferencing with participation of Allied Health Professionals. Contact: administrator@sesadgp.org.au	Training Consumers Community linkages Allied health Rural Division
Mid North	Breakfast 'networking' sessions found to be of benefit to GPs and health	Training

Division	professionals in understanding each others roles, referral mechanisms, caseload, range of services, access of issues etc. Consumer education campaign has commenced. A poster for waiting areas to promote the Health Assessments has been distributed. Trial of case conferencing for Diabetes with Port Pirie practices. Formal processes for Community Nurses at Port Pirie and Clare to undertake part of the Health Assessment has been established. The Division has applied for funding for practice based primary health care nurses to assist with diabetes care management, and to assist in the education and support of people with chronic disease. Contact: mndgp@mndgp.org.au	GP support Consumers Diabetes Nurse support Nurse support Diabetes Chronic disease self management Rural Division
Murray Mallee	The EPC coordinator involved in a Collaborative Care in Mental Health project. Following on from the project, the Management Committee of the Division have agreed to hold quarterly informal meetings with the mental health team to continue to develop relationships. Diabetes Clinics in the Murray Mallee region now use the case conferencing and care planning items as standard practice. The GP and Allied Health workers review local diabetic patients in succession. The Division has applied for funding for respiratory nurse educators to work from medical practices to provide education and support to patients with respiratory illness. Asthma management plans will be developed using the item numbers.	Mental health Diabetes Allied health Respiratory disease Asthma

	Contact: mmdgp@lm.net.au	Rural Division
Riverland Division	Developed user friendly workbook on the three areas of EPC items that were individualised to each GP in the area. These are being distributed to the GPs at each training session held. The Division has applied for funding for a practice based primary Mental Health worker who will be involved in case conferencing and care planning. Contact: rivdiv@riverland.net.au	Training Mental Health Rural Division
Southern Division	*Discharge Planning* • Division has an established mental health program and a mental health officer • Division identified 2 GPs with a high mental health case load and established GP psych-liaison with Morier Ward (Psych unit) at Noarlunga Health Service • Now developed into discharge case conferences when the patients of these GPs are discharged from Morier Ward • Division has provided advice on which EPC numbers to use • This model is now standing on its own GPs are being called for a multidisciplinary discharge planning meeting from the Cardiac Surgical Ward at Flinders Medical Centre on a regular basis. Case conferencing and care planning have been added to the standard model of discharge planning for patients from the Orthopaedic Ward at Flinders Medical Centre. A lot of the background development for this was due to the NDHP3 project. *Mental Health Services*	Coordinated Care Trial Mental health Community linkages Hospitals Hospitals Mental health

	The Division lobbied MHS's to modify their procedures to include GPs contribution in care planning by faxing the care plan. A trial with 15 GPs quelled initial fears with allied health workers and the model is now working. *Supported Residential Facilities* Victor Harbour has 5 Supported Residential Facilities – hostels. Since many residents have mental health problems this has been a problem when new arrivals need care from local services. A case management plan has been developed between GPs, Glenside Hospital, local hospital and community mental health so discharge notes are sent down for each person discharged from Glenside to the SRFs. A care planning meeting is held, with the GP funded to attend this at the local hospital. Location of case notes, care plan etc is now determined in advance of an emergency. The Division is conducting an Innovations project: a randomized controlled trial in residential care facilities with emphasis on managing challenging behaviours and performing medication reviews. Case conferencing is the key tool in this project. Contact: sdgp@health.on.net	Allied health Residential Aged Care Facilities Mental health Community linkages Medication reviews Randomised controlled trial Mental health Urban Division
Western	Developing a model to increase GP care for the chronically ill patients with a mental health comorbidity in hostels (SRFd) where there are a number in the Port Adelaide area. The model will be about establishing a multi disciplinary team and case conferences. Involved in a working group that is developing a sustainable model for discharge planning in which the item numbers will play a key role. The Division is now holding regular GP forums with the hospital to discuss matters of interest such as discharge planning.	Mental health Hospitals

	Diabetes mini-clinic for interested GPs is now linked with the MBS items. Contact: awdgp@health.on.net	Diabetes Urban Division
Yorke Peninsula	Discharge care plans with Moonta Private Hospital have been incorporated as standard procedure. Yorke Peninsula previously had a successful mental case conferencing activity where mental health workers had a regular time booked each month to discuss patients with the GP. The project ceased in 1999. The Division is now trying to resurrect this model using EPC. Successful negotiations have taken place with the Aboriginal Health Team and local GPs will commence undertaking home health assessments for Aboriginal patients in this region. Contact: ypdgp@yp-connect.net	Hospitals Mental health Aboriginal health Rural Division

WESTERN AUSTRALIA

	Activities/Resources	**Program links**
Coordinated Care Trials	Bunbury	Indigenous health
State Based Organisation	**Activities/Resources**	**Program links**
General Practice Divisions of Western Australia	Extensive consultation and education with Divisions and GPs (rural and metro)- "GPDWA Issues Paper" written, outlining barriers to item implementation from GP perspective.	General Practice
	Qualitative research study investigating " Health consumer and health professional views regarding an annual health assessment in the aged".	Consumers
	Member of the Royal Australian College of GPs (RACGP) Steering Group, for the development of GP, Allied Health and Consumer Guidelines, for the Sharing Health Care component of EPC.	Sharing Health Care
	Member of the Western Australian Agency Liaison Group (WAALG).	Aged Care
	Convenor - Hospital Working Party to address issues associated with hospital discharge items.	Hospitals
	Scoping report “Barriers to implementation of the hospital discharge care planning and case conferencing items”.	Hospitals
	Collaboratively developing a pilot study proposal with the Hospital Liaison GP / St John of God Hospital - Murdoch to identify working model for GPs to contribute to discharge care plan (item 728).	Hospitals

	Extensive consultation with Aboriginal Medical Services (AMS) in rural and remote Western Australia, including the Kimberley, Pilbara, Eastern Goldfields, Midwest and Greater Bunbury Divisions of General Practice. Barriers to implementation of the new items were addressed at each individual AMS.	Aboriginal health
	Haematology Cancer Patient – Shared Care Project ▪ Patients who are part of this program are cared for by both specialist and tertiary facilities as well as their general practitioner. The pivotal aspect of the program is a "patient held" health care record which is kept with the patient throughout the period of their illness, and which is taken with the patient to all medical appointments, treatment appointments and during admissions to hospital. The program is looking at using both hospital discharge case conferencing items and community care planning items to ensure the patient, GP, specialist and other multidisciplinary team members are aware of unexpected hospital admissions, communicating changes in management and treatments. This program is investigating the implementation of telehealth conferencing for those patients and their GPs living in rural and remote locations.	Haemotology Cancer Patient Shared Care
	Disability Services Commission ▪ Disability Services Commission (DSC) in WA is particularly interested in implementing the community care plan items. DSC believes there is significant scope to improve the delivery of their services through the coordination of community care plans through a DSC Local Area Coordinator (LAC). The role of the LAC is to	Disability Services

	liaise between the patients, home helpers and other health and community service providers who assist disabled clients to remain living independently in the community. The new items now provide the scope for the DSC LAC to engage the clients usual GP in the coordination of health care delivery.	
	Hospital School Services ▪ Hospital School Services provides an integral educational service to students K – 12 currently located in the metropolitan area for students who are homebound for medical reasons. The service is able to do this by operating an off-site outreach service comprising visiting teachers to work with homebound students. The service is hoping to actively organise and contribute to community care plans for those children with chronic and complex health problems and who have recurrent episodes of hospitalisation or home care. Children with conditions such as cystic fibrosis, asthma, haemophilia, diabetes, arthritis and thalassaemia frequently require lengthy periods of convalescence at home prior to returning to school these children often require a multidisciplinary approach to community care. The Hospital School Services believe they can play an integral role and collaborative role in the holistic delivery of care and this role can be enhanced through the new MBS community care plan items.	Youth health
	Alma Street and Peel South West, Mental Health Services ▪ Both Mental Health Services are actively working with GPs in their respective Divisions to accommodate and implement community case conference items. The Alma Street team currently consists of the psychiatric liaison GP and mental health nurse, who attend the	Mental health

	GP surgery with the patient. Hence, including the GP, a community team of three is in place to assist a coordinated approach to patient care Key note presentation at Health Horizons Conference - Developing Partnerships with GP. Panel Discussion - Creating Partnerships with GPs - 4th National Allied Health Conference. Contact: belinda.bailey@gpdwa.com.au	Allied Health
Divisions of General Practice	**Activities/Resources**	**Program links**
Canning	Working with Royal Perth Hospital Aboriginal Liaison GP and Aboriginal Health Workers. Commonwealth Care Link Centre. Electronic Care coordination kits for GPs include electronic tools for health assessments and care plans. Contact: admin@canningdivision.com.au	Aboriginal Health Care Link Centre IT/ IM Urban Division
Central Wheatbelt	Identifying scenarios for care plans. Working with GP practice staff to raise awareness of new MBS Items. Including care planning and case conferencing in Divisional Diabetes program. Including care planning and case conferencing in Divisional Mens Health program.	Training GP systems support Diabetes Mens health

	Contact: central@wheatbelt.com.au	Rural Division
Eastern Goldfields	Care planning with Diabetes program. Awareness raising with Regional Health Services - care planning and case conferencing. Awareness raising with local hospitals - care planning and case conferencing. Awareness raising with Community Health Nurses. Awareness raising with remote communities and all available health services - Leonora, Laverton, Leinster, Wiluna, Southern Cross, Esperence, Norseman. Consultation with AMS' Contact: info@egmdgp.com.au	Diabetes Allied Health Hospitals Community linkages Nurse support Community Linkages Remote General Practice Aboriginal Health Rural Division
Greater Bunbury	Working with various allied health community service providers, practice staff and a pain management clinic. Contact: division@gbdgp.com.au	Allied health Community linkages Pain management Rural Division
Great Southern	Care planning integrated with CVD rehabilitation program, and "at risk". Community care planning through Divisional based dietician and diabetes educator with Family and Children's Services. State wide program (Building Blocks) using a multidisciplinary	Cardiovascular Diabetes Diabetes Children's health Women's health

	approach to pregnant women at risk. Health assessment nurse. Contact: gsdgp@gsdgp.com.au	 Aged care Nurse support Rural Division
Kimberley	Identifying a working model for implementation of the items in remote Aboriginal Medical Services. Consultation with Aged Care Services. Interactive workshops with GPs and : Mental Health Extended Care Occupational Therapists Physiotherapy Community Nurses Consumer brochures. GP clinical audit and CME for Sharing Health Care. Contact: kdgp@kdgp.com.au	Aboriginal health Aged Care Mental Health Aged Care Allied health Community Health Consumers Sharing Health Care Clinical audit Rural Division
Mid West	Educational Tools - EPC Video. Care planning - Diabetes / CVD Management in General Practice. Case Conferencing - ADHD. Awareness raising - Geraldton Health Services CEO - Community Linkages.	Video Diabetes Cardiovascular ADHD Community Linkages

	Shared Care -Health Assessment - ACAT and Silver Chain. Awareness raising - Community Care Advisory Committee. Residential Aged Care Facilities. Carelink collaboration. Contact: mail@midwestdgp.com.au	Aged Care Community Linkages Aged Care Residential aged care facilities Carelink Rural Division
Osborne	Conducting a Mental Health Liaison pilot project using MBS items. Establishing relationships to work with Osborne Park Hospital, Joondalup Hospital. Raising awareness with Consumer Forum. Raising awareness with Allied Health. Comprehensive Web Site. Incorporating EPC into other programs, ie NPS and diabetes. EPC will be a part of new programs where relevant. Visiting GPs in their surgeries to inform them of the new item numbers and how they can be incorporated into practice. Resource folder developed for visits. By the end of March will have visited 25 GPs. They will be revisited after 6 months. Contact: info@odgp.com.au	Mental health Hospitals Consumers Allied Health IM/IT Diabetes Medication reviews GP systems Support Urban Division
Peel/South West	Working with GP practice managers.	GP systems support

	Awareness raising with local hospital to address implementation issues of the discharge items. EPC has been integrated into Healthy Lifestyles Program with Care Plans and Case Conferences for diabetes and obesity. Contact: office@peelswdgp.com.au	Hospitals Diabetes Obesity Rural Division
Perth	Working with practice managers to support GPs. Working with Mercy Hospital and Royal Perth Hospital. Working with local Residential Aged Care Facilities. Community Mental Health incorporating care planning and case conferencing. Contact: info@perdivgp.com.au	GP systems support Hospitals Aged Care Aged Care Residential aged care facilities Mental health Community linkages Urban Division
Perth Central Coastal	Establishing relationships with community allied health and community service providers. A Divisional based nurse is supporting GPs with health assessments. Contact: mgr@pccdgp.com.au	Allied health Aged care GP Systems Support Urban Division
Pilbara	Awareness raising with Gumala Aboriginal Corp. Awareness raising with Regional Health Services - care planning and	Aboriginal Health Community Linkages

	case conferencing. Awareness raising with local hospitals - care planning and case conferencing. Awareness raising with Community Health Nurses. Identifying implementation model at Jigalong Aboriginal Community. Consultation with Aged Care Facilities. Collaboration with Centrelink. GP clinical audit and CME for Sharing Health Care. Contact: info@pilbdivgp.com.au	 Hospitals Community linkages Nurse support Aboriginal health Residential aged care facilities Aged care Centrelink Clinical audit Shared care Rural Division
Rockingham/ Kwinana	HeartBeat is a community-based program for patients following hospitalisation at Rockingham Kwinana District Hospital as a result of a cardiac event. It focuses on the GP in the role of care coordinator with individualized care plans being developed for patients. It also focuses on diabetes intervention. With the support of a Divisional based nurse 250 Health Assessments were conducted over 3 months. Conducting a pilot discharge planning project with Rockingham Kwinana District Hospital.	Cardiovascular Diabetes Nurse support Aged care Hospitals

	Conducting a pilot project with psychiatric services. Contact: rkdgp@southwest.com.au	Mental health Urban Division
Swan Hills	A Divisional based nurse is supporting GPs with Health Assessments. Investigating working model for case conferencing and care planning at the Autumn Centre. Comprehensive website. Working with District Hospital to identify effective strategies to implement discharge MBS items. Contact: reception@shdgp.com.au	Aged care Nurse support Aged care IT/IM Hospitals Urban Division

TASMANIA

	Activities/Resources	**Program links**
Coordinated Care Trials	Stakeholder in the Tasmanian Coordinated Care Trial "Careworks" until its completion March 2000.	Southern Division
State Based Organisation	**Activities/Resources**	**Program links**
Tasmania General Practice Divisions	Collaboration is occurring within the SBO, across the EPC, Mental Health and the MAHS program focussing on Mental Health as a vehicle to demonstrate the potential for GPs to develop shared care strategies using the MBS Items.	SBO and Divisions and Mental Health MAHS
	Awareness raising with the Tasmanian Consumer Advisory Group (TasCAG) for Mental Health.	Consumers Mental health
	Working with the Heads of Medicine, Royal Hobart Hospital highlighting the opportunities for improving integration between the GP and the hospital, linking with Divisions, and the particularly in relation to the continuum of care and discharge planning.	Hospital Aged care
	Working with the three major hospitals to establish a GP/Hospital Liaison Officer in each.	Hospitals
	Collaborative working relationship with the Discharge Planning Coordinator, Royal Hobart Hospital.	Hospitals
	Working collaboratively with the Sharing Health project and facilitating links to Divisions.	Shared care
	Involvement in the Advisory Group for Partnerships Against Domestic	Domestic Violence

	Violence, Training Model for Rural Health Professionals, University of Tasmania incorporating the potential of the MBS Items for care planning and case conferencing.	Rural health
	Participating as a key stakeholder in the Single Entry Point Comprehensive Assessment project Reference Group of the State Department of Health and Human Services, incorporating EPC into the discussions, establishing links with the Divisions and communicating progress via Division newsletters.	HACC Services
	Discussions have commenced with the Department of Health and Human Services to incorporate EPC into the Child, Youth and Family Support Program (CYFS), Youth Justice Detention Centre.	Youth Health Child health
	Have worked with senior Social Workers from (CYFS) to identify appropriate case studies to use in EPC presentations.	Training
	EPC presentation to the Tasmanian Early Intervention and Diversion Forum (COAG Illicit Drug Diversion Initiative).	Drug
	Working collaboratively with DHAC, the Division and the South Eastern Tasmanian Aboriginal Corporation promoting EPC in relation to caring for Aboriginals with Sexually Transmitted Infections.	Aboriginal health
	Working collaboratively with DHAC, the Division and the Mersey Leven Aboriginal Corporation promoting EPC in relation to the implementation of an exercise program following a Health Assessment.	Aboriginal health
	EPC presentation to the Statewide ACROD Convention and the Borneo Veterans Association for February/March 2001. Contact: jharper@tdgp.com.au	Disability Veteran Affairs

Divisions of General Practice	Activities/Resources	Program links
Northern Division	One to one contact or practice sessions are the preferred methods used for the GP education and support sessions. EPC presentation to Division program staff. Workshops on Developing Strategies for GP Education and Strategies for Evaluation for Division Program Officers. Collaboration within the Division to promote the potential of the new MBS items across programs, particularly case conferencing for Palliative Care patients and establishing links at the GP/hospital interface to improve discharge planning. Links facilitated with GPs, Health Care providers and key Organisations such as the Aged Care Assessment Team, Diabetes Centre, Community Nursing, Social Work, Disability Services Case Managers and Resource Team staff. Contact: ndgp@ndgp.org.au	Training Palliative care Hospitals Aged care Diabetes Community linkages Nurse support Disability Rural Division
North West Division	Major focus for the Division has been on educating and supporting GPs in the use of the EPC items across the four distinct geographic areas of the rural Division. Attendance by Division Program Officers at workshops "Developing Strategies for GP Education" and "Evaluation". "Train the Trainer" workshop attended by the GP coordinating the GP education sessions.	Training Training

	The Division has applied for MAHS funding to employ a mental health worker and podiatrist. Division has a strong link to Carelink Centre with a partnership approach to service delivery. Contact: nwtasdivgp@tassie.net.au	Mental Health Podiatry MAHS CareLink Rural Division
Southern Division	Major emphasis within this Division is education and resources to support GP implementation of the items in their practice which includes: ▪ Individual and group practice visits ▪ Lunchtime Care planning workshops ▪ Evening forums in regional areas ▪ Divisional GP and practice staff newsletter articles highlighting EPC information, "GP perspectives" of item usage and IT help ▪ Education of Division staff of the EPC items and the potential for GP to use these items within the program areas that the Division supports ▪ Developing a model for enhancement of GP care planning and case conferencing with the Residential Aged Care Facilities ▪ National Prescribing Service (coordinator input into medication review.) The second focus of the Divisions EPC activity is to enhance the GP management of patients with complex needs through integration with the Divisions' existing programs. In conjunction with the Mental Health Sub program, developing a project that will support GP care planning and case conferencing with Mental Health Services, Specialists and other Allied Health providers within defined local areas. It is envisaged this model has the potential to be sustainable within the community.	Training IT GP systems support Residential aged care facilities Medication review Mental health Allied health Medical specialists

	In conjunction with the Developmental Disability Sub-program, provided education, resources and support to GPs and allied health providers to care plan and case conference for patients who were relocating from institutional care into residential housing within the community. Integrating a multi-disciplinary care planning and case conferencing model within the Diabetes Shared Care Sub-program to enhance GP management of diabetic patients. This project is initially being organised within a rural community. Contact: southtasdgp@southtasdgp.com.au.	Disability Allied health Community linkages Diabetes Rural Division

NORTHERN TERRITORY

State Based Organisation	Activities/resources	Program links
Northern Territory Divisions of General Practice	EPC Help Desk Development of ATSI Proformas for use in Health Assessments, Care Plans and Case Conferences (available on ADGP website – www.adgp.com.au/epc). Supporting GPs and Aboriginal Health Clinic teams to utilise the items to collaborate with clinic staff and visiting specialists on site and have nurses and/or Aboriginal Health Workers available to undertake the health assessments on GPs behalf. Assisting key service providers – Community Care Nurse, Diabetes Australia, Darwin mental health Services and Aboriginal Health Clinic teams in supporting GPs. Contact: geoff@gpdnt.asn.au	Training Aboriginal health Aboriginal health Nurse support Diabetes Mental health Aboriginal health
Divisions of General Practice	**Activities/resources**	**Program links**
Top End	Developed patient reminder stickers Multidisciplinary workshops held to integrate EPC into Aged Care, Diabetes, Mental Health. Teleconference workshops for rural and remote areas. Contact: office@tedgp.asn.au	GP systems support Aged care Diabetes Mental health Rural and remote health Rural Division

Central Australia	Care plans done in Footy Fitness Program in Anyinginyi (remote area). Exploring opportunity to include care planning in alcohol addiction programs in remote areas. Exploring the potential to include care planning in ear health for under fives. Once the care plan format is tried and a set format for Congress established then there can be a focus on Specialist clinic areas. Will be focussing on palliative care, mental, alcohol and other drugs, aged care. Contact: cadgp@cadgp.org.au	Aboriginal health Remote health Alcohol Remote health Aboriginal health Aural health Palliative care Mental health Drug and alcohol addiction Rural Division