General Practitioner Liaison Officer (GPLO) Program in Southern NSW

What

COORDINARE – South Eastern NSW PHN and Southern NSW Local Health District (SNSWLHD) have established a partnership to employ four General Practitioner Liaison Officers (GPLOs) as a collaborative approach to:

- improve healthcare providers' awareness of available services across primary and secondary care settings.
- establish and enhance communication between medical practitioners across hospital and primary care
- identify system based challenges impacting on access to and quality of care provided across the region
- identify opportunities for incremental and transformational changes to improve system functionality to support health professionals in the coordination of care across the health care continuum.

Why

A baseline GP survey was completed in each cluster area with a range of shared and specific cluster questions.

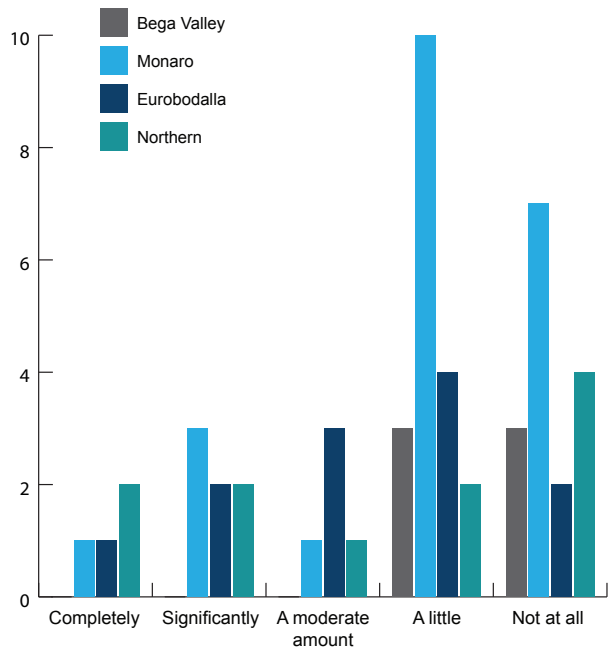
More than 50 responses were received between April and May 2018 across the four clusters.

Overall, survey results indicate GPs don't feel part of the care team when their patients are in hospital with opportunities for improved communication regarding hospitalised patients.

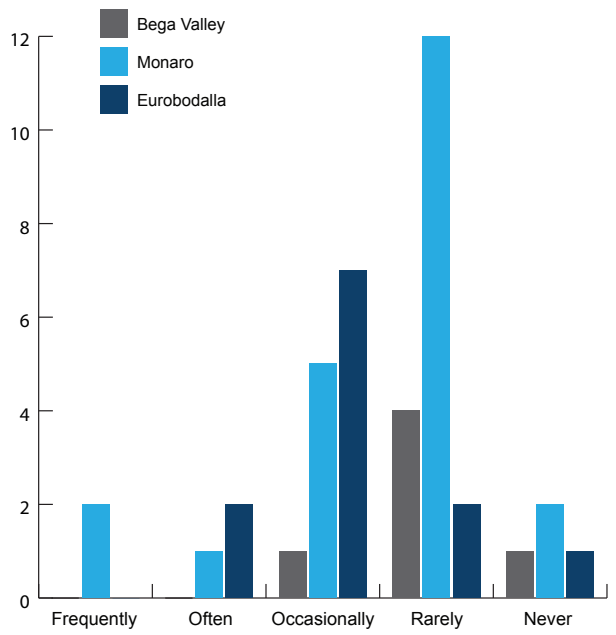
However, communication with ED was considered generally good as was the delivery of timely discharge summaries.

There was a range awareness levels across clusters of services provided by community health and overall referral into community services was considered to be poor.

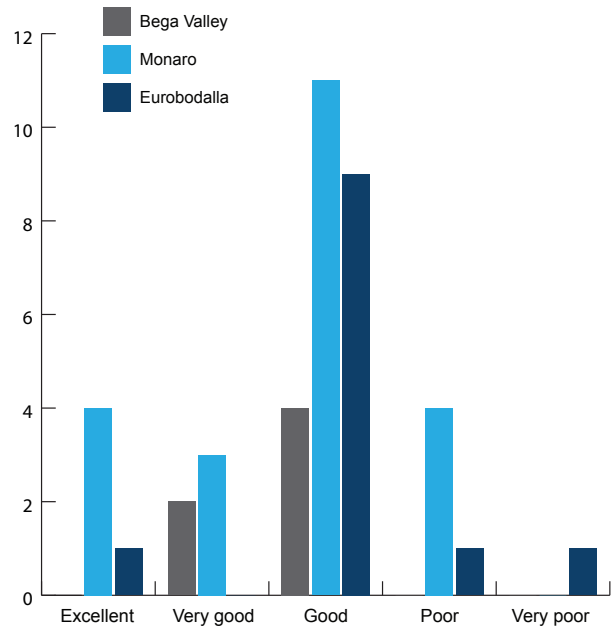
To what extent do you feel part of the management team when your patients are admitted to your local Hospital?



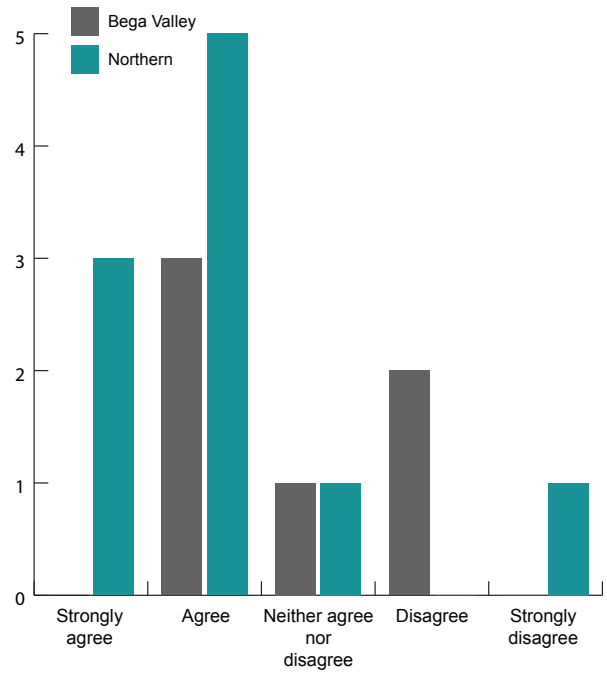
How often are you contacted regarding the management of a patient in your local hospital?



How would you rate the communication with your local Emergency Department when referring in an acutely unwell patient?



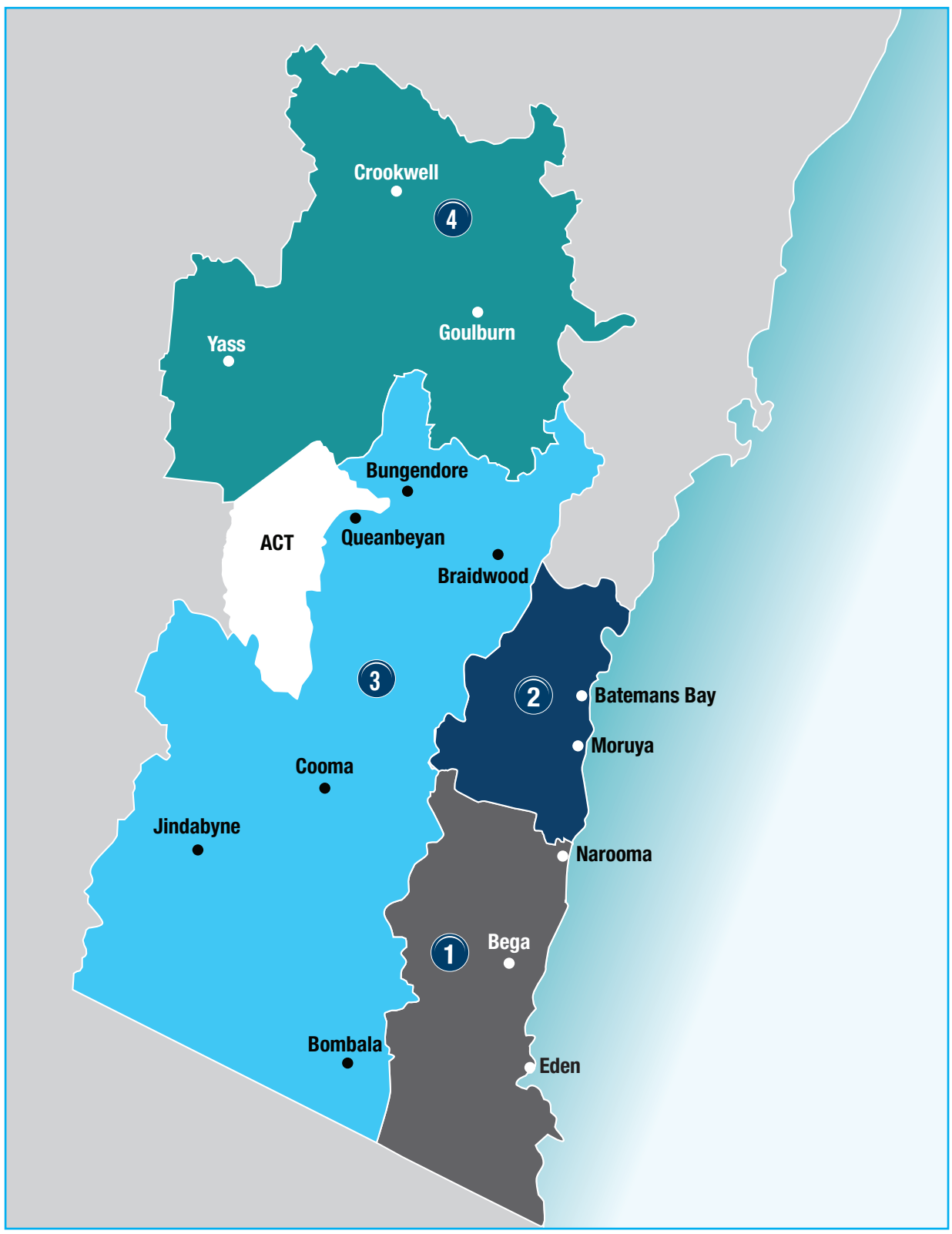
Your local Hospital doctors understand the work and role of the GP



How

Each GPLO is employed to work one day per week for 12 months in one of the four geographical clusters across Southern NSW:

1. Dr Duncan MacKinnon: Bega Valley Cluster – including South Eastern Regional Hospital, Pambula and surrounding community
2. Dr Louise Tuckwell: Eurobodalla Cluster – including Moruya and Batemans Bay Hospitals and surrounding community
3. Dr Melanie Dorrington: Monaro Cluster – including Cooma, Queanbeyan, Bombala and Delegate Hospitals and surrounding community
4. Dr Roslyn Davis: Northern Cluster – including Goulburn Base, Bourke Street Health Service, Crookwell, Yass and Braidwood Hospitals and surrounding community



Key projects/outcomes

Region-wide

Project/Activity	Progress / Action	Outcome
Promotion of HealthPathways	• Promote use of HP for clinical guidelines and referral pathways during practice visits, in particular download of RTF community health central intake referral form into practice software • Ensure referral information correct for Monaro region (public and private)	• Increased use of HP in 17/18 over prior year – 85% increase sessions and 54% increase in users • Increase service utilisation through increased awareness
Creation of local GP and services lists	• General practice lists provided to ED (Euro/ Monaro) and practice details updated in iPM • Improved forms for notification of practice / GP updates to iPM • Creation of new iPM Engine Rules Validation message against the GP tab in Patient Details in iPM – pop up message to advise GP being reviewed and updated if "GP: Dr Nil" or GP not been updated within last year • Hospital service directory lists created and available on HealthPathways	• Contact list and contact systems established that are successful and readily available • Improved awareness of service and providers (GPLO survey) • Service directories regularly updated and available across sites/care settings
General Practitioner participation in Leading Better Value Care Projects	• Targeted participation in LBVC projects across sites including • Renal Supportive Care – Eurobodalla • Diabetes Inpatient care – Eurobodalla, Monaro • OACCP & OPR – Bega Valley • COPD & CHF – Bega Valley, Northern	• Outcomes align to LBVC projects with specific focus on transition and coordination of care back into a primary care setting
Winter Audit	• Bega Valley, Monaro and Northern GPLOs will undertake a practice audit of COPD population at high risk of hospitalisation, to be completed by end of 2018	• Development of data informed quality improvement activities • Reduce preventable hospitalisations

Bega Valley

Project/Activity	Status	Progress / Action	Outcome
Paediatric referral process	In progress	• Paediatric referrals are now acknowledged on receipt and are triaged by a paediatrician, with letter of acknowledgement to referral source (GP) • Working towards a single point of referral for all paediatric services – automatic referral to allied health or other services at point of paediatrician referral. Site Allied Health Manager assisting with process.	• Improved patient experience • Paediatrician visit optimised • General practice not required to follow up referrals
Integrated care project	Development phase	• Visited NSW sites undertaking integrated models of care and evaluation of relevance for Bega Valley context • Leadership for Bega Valley staff to ensure inclusion of General Practitioner in care team • Targeted interviews with General Practices with the Integrated Care Clinical Nurse Specialist	• Improved care coordination • Improved patient experience
Outpatient referral process	In progress	• Liaison with LHD staff and specialists to increase awareness of outpatient services provided in Bega Valley • Work with site managers to improve the access to outpatient services and reduce referral issues (lost/delayed patient referral) • Investigation into use of Paediatric registrars at SERH to support outpatient service provision	• Improved patient experience • Specialist visit optimised • General practice not required to follow up referrals • Future functionality for central intake to oversee referrals for targeted clinics

Eurobodalla

Project/Activity	Status	Progress / Action	Outcome
ED communication	In progress	• Provision of mobile phone to ED physicians for GP contact • Phone number but poor quality android phone is reducing utility • Plan to audit calls to provide assessment of impact on admissions and patient care	• Reduced inappropriate ED presentations • Streamlined ED admissions • Improved patient experience • Enhanced provider satisfaction
Promotion of HealthPathways during practice visits	In progress	• Promote use of HP for clinical guidelines and referral pathways in particular download of RTF community health central intake referral form into practice software	• Increased use of HP in 17/18 over prior year – 85% increase sessions and 54% increase in users
Batemans Bay Locum GP fast track induction video	Evaluation phase	• Video completed and now loaded onto LHD website • Access and views to be assessed	• Improved provider knowledge of fast track clinic processes • Improved communication by fast track clinic with primary care • Increased use of MHR

Monaro

Project/Activity	Status	Progress / Action	Outcome
ED + hospital communication	In progress	• Improve understanding of constraints within GP as well as ED/IPU for health professionals in each setting • Provision of mobile phone to ED physicians for GP contact • Improve inclusion of allied health information in discharge summaries	• Reduced inappropriate ED presentations • Streamline ED admissions/ hospital presentations • Improve collegiality • Improved quality of discharge summaries
Creation of local GP and services lists	In progress	• General practice lists provided to ED • General practice details updated in iPM • Improved forms for notification of practice / GP updates to iPM • Creation of new iPM Engine Rules Validation message against the GP tab in Patient Details in iPM – pop up message to advise GP being reviewed and updated if “GP: Dr Nil” or GP not been updated within last year • Hospital service directory lists created and available on HealthPathways	• Improved discharge summary delivery rates • Increase service utilisation through increased awareness
Mental health discharge and communication	In progress	• Liaison with LHD MH team to understand issues • Look into provision of a document for GPs about the TEC Service • Reviewing communication to GP following MH team assessment	• Improve GP knowledge and understanding of and use of the TEC service • Improve delivery and quality of MH discharge summaries

Northern

Project/Activity	Status	Progress / Action	Outcome
Provision of discharge summaries to GPs	In progress	• Repeat audits on patients at Goulburn Base to identify accuracy of GP information in patient records • LHD - Communication with practice managers, PAS teams, ward staff and patient liaison • General Practice - Development of newsletter articles to encourage practices to provide regular updates on GP contact details to LHD	Improved communication and discharge delivery to GPs as a result of: • Audit results show current GP listed in 95% of patient notes in rehab and medical wards up from 55% • System now developed with Patient Liaison for regular tracking and updating of patient’s GP details • GP lists updated across facilities in Northern Cluster leading to increased satisfaction in Patient liaison and ward clerks
Develop an antenatal shared care model for Goulburn	Development phase	• Reviewing antenatal shared care models operating elsewhere • Surveying to determine GP interest in providing antenatal shared care • Collecting pregnancy data to understand current service provision • Formal proposal to be developed early 2019	• Improved patient experience • Improved care coordination • Enhanced provider satisfaction
ED and Community Mental Health receiving inappropriate referrals	Evaluation phase	• Communication with general practices regarding mental health referrals to the Emergency Department	• Reduction of inappropriate referrals • Improved satisfaction from Mental Health Teams with GP awareness of referral pathways
Integrated care for frequent service users	In progress	• Provide GP and medical leadership for the clinical redesign project in Goulburn, including link to General Practice for care coordination	• Diagnostics finalised, identification of key themes for frequent emergency department users