2017-2018

Queensland General Practice Liaison Officer Network

Annual Report

CHECKUP

Proudly supported by Queensland Health's Clinical Excellence Division

Queensland Government

Contents

Forewords

General Practice Liaison Officers (GPLOs) identify and address service gaps at the interface between primary care and specialist outpatient care. June 2018 marks the end of the third year of recurrent funding for the GPLO positions and the 2017-18 GPLO annual report giveg us an opportunity to reflect on the highlights and achievements of the Queensland Health GPLO network.

The Clinical Excellence Division has worked with the GPLO program since its inception, providing statewide support in partnership with CheckUP. GPLOs are now involved in many innovative projects that deliver better integration of care, address fragmentation in services and provide high-value healthcare. The work GPLOs do could not be achieved without collaborative partnerships between general practice, Hospital and Health Services (HHSs) and Primary Health Networks (PHNs). GPLOs are pivotal to progressing key initiatives including elements of the Specialist Outpatient Strategy and engagement and education activities for General Practitioners.

I would like to take this opportunity to thank our partners and all GPLOs for their commitment and contribution to improving patient outcomes through equity of access initiatives, reduced duplication, and better coordinated care. I look forward to seeing many more outstanding achievements in the years to come by members of the GPLO network.

Michael Zanco
Executive Director
Healthcare Improvement Unit
Clinical Excellence Division
Queensland Health

As an organisation that is committed to creating healthier communities, CheckUP is proud to coordinate the Queensland GPLO Network.

This year marks 10 years of involvement for us starting back when we were known as General Practice Queensland, though our transition to CheckUP in 2013.

Over the years we have had the privilege of supporting the program as it has gone from strength to strength with the goal of better connecting our health system.

The stories in this report are testament to the valuable role GPLOs play and the contributions that individuals and teams have made to improve the health of Queenslanders. I congratulate each and every GPLO on the work they have done to put people at the centre of health service delivery.

Ann Maree Liddy
Chief Executive Officer
CheckUP

It gives me great pleasure to share the GPLO network annual report for 2017-2018. The report highlights the continued great work GPLOs from across Queensland are undertaking in partnership with the Hospital and Health Services (HHSs) and Primary Health Networks (PHNs). As the report highlights, GPLOs are a dedicated group of clinicians who are improving the patient journey and care by identifying and addressing barriers between primary and secondary care across the six focus areas (see page 7). This work continues to support the strategies launched in the Specialist Outpatient Strategy in 2016 by the Minister of Health.

It is an exciting time to be in healthcare. The GPLOs have been involved in new models of care including the GP with Special Interest program and digital health strategies such as HealthPathways and the Health Provider Portal that contribute to patient care.

General Practice liaison across Queensland continues to go from strength to strength and I welcome our new GPLOs that have joined our network in the past year. I encourage you to seek out your local GPLO to assist you with any initiatives across primary and secondary care. GPLOs now sit across most HHSs and PHNs across the state.

The 2018-2019 period will see the implementation of the new outpatient e-referral system, Smart Referrals, and the Referral Service Directory. GPLOs will continue to support their local hospitals and GPs in the roll-out of these programs.

We look forward to the GPLOs continuing to be integral in future healthcare initiatives to improve the care of our patients in Queensland.

Dr James Collins
GPLO and GPLO Network Chair
Metro North Hospital and Health Service & Brisbane North PHN

About the GPLO Network

General Practice Liaison Officers (GPLOs) play an important role in facilitating better integration between Queensland Hospital and Health Service and primary health care providers.

The GPLO Network commenced in 2008 under the sponsorship of General Practice Queensland (now CheckUP). Queensland Health funded 20 GPLO positions for two years in the 20 largest public hospitals under an election commitment in 2012. The Department of Health funded the positions for a further 12 months and following an evaluation of the GPLO program, recurrently funded these positions.

Since this time the program has grown and strengthened with the collaboration and partnerships developed between the Healthcare Improvement Unit, Clinical Excellence Division, Queensland Health, CheckUP, Hospital and Health Services (HHSs) and Primary Health Networks (PHNs).

GPLO's work with their respective Hospital and Health Services and PHNs to facilitate:

- appropriate clinical pathways between settings
- streamlined transfer of care and discharge from hospital
- better integration of services
- identification of service gaps, especially at the interface between primary and specialist outpatient care.

The objectives of the Queensland Health GPLO Network are to:

- Build the capacity of the GPLO Network through shared learnings, experience, resources and solutions.
- Identify effective strategies and service delivery models that can be shared across the GPLO Network.
- Reduce duplication and inequity across the health system.
- Provide an opportunity to build supportive and collaborative relationships among the GPLO Network members.
- Inform and endorse the GPLO Network Annual Workplan.
- Showcase achievements by members of the GPLO Network.

CheckUP coordinates the statewide GPLO Network in partnership with Queensland Health and facilitates the exchange of information between members. Membership of the GPLO Network is open to all Queensland GPLOs and support staff working at PHNs or HHSs in Queensland.

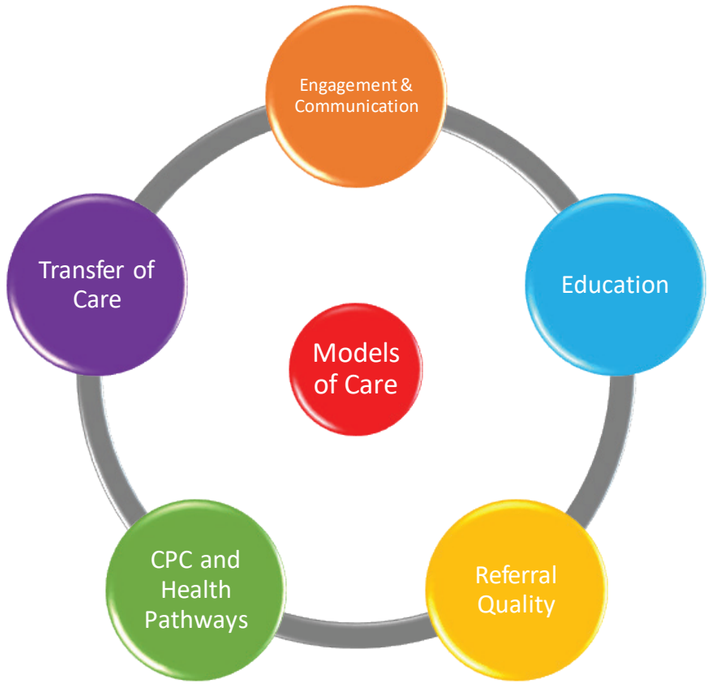
The GPLO Workplan

The GPLO Network Workplan highlights priority areas for GPLOs and prioritises the current key focus areas of work.

The Workplan has six key focus areas:

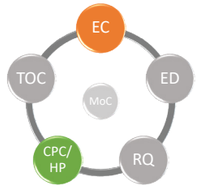
1. Improve communication between general practice and HHSs (hospitals)
2. Facilitate GP education to improve integration, transfer of care and HealthPathways utilisation
3. Contribute to improved referral quality
4. Support the implementation of the Clinical Prioritisation Criteria (CPC) program and development of HealthPathways
5. Contribute to improved transfer of care to general practice
6. The GPLO role contributing to the development of new models of care

This report is aligned with the priority areas of the GPLO Network Workplan and showcases achievements made through the program.



Working together, making a difference

Danielle McLeod, GPLO, **Metro South Hospital and Health Service**
Nalani Cooper, CPC Coordinator, **Metro South Hospital Health Service**
Michael Copestake, Senior Accounts Manager, **Brisbane South PHN**



Communication CPC/Pathways

A strong partnership between Metro South Hospital and Health Service and Brisbane South Primary Health Network (PHN) is improving connections between primary care and hospital services on Brisbane's Southside.

A shared approach to solution design, implementation and engagement has improved the patient journey with a focus on improving the quality of referrals, secure electronic messaging and establishing SpotOnHealth HealthPathways to ensure GPs and other primary health clinicians have access to the information they need to plan patient care across the system.

Through ongoing collaboration, the Metro South Health GPLO Program and the Brisbane South PHN have celebrated multiple successes and have enriched the quality of engagement with primary care practices throughout the region.

Using the implementation of the Clinical Prioritisation Criteria and relaunch of the Metro South Health Refer Your Patient website as a catalyst, the GPLO program and PHN have continued to work together to optimise unique engagement and deliver targeted messaging to help support the implementation and sustainability of multiple Queensland Health, Metro South Health and PHN priority initiatives. These joint initiatives all aim to support primary care but most importantly improve the journey through the healthcare system for the patient.

The Clinical Excellence Division, Queensland Health funded the implementation of CPC and Health Pathways under the Specialist Outpatient Strategy.

Key Enablers

- Building and maintaining relationships between teams
- Collaborative service planning, Data sharing for targeted engagement
- Advocating and escalating the primary care perspective
- Sharing of lessons and learnings and adjusting strategies
- Ongoing commitment to collaborate

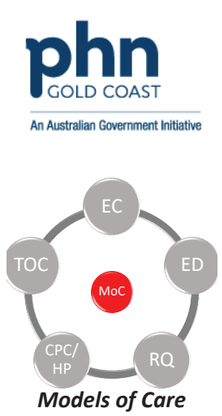
GP Engagement

- Coordination of communication channels and engagement activities
- Joint clinic visits
- Targeted engagement activities
- Escalation points and actioning feedback

Brisbane South GPLO Program: A snapshot

Less waiting with Direct Access Colonoscopy

Sneha John, Director of Endoscopy
Max Mansoor, GPLO
Carl de Wet, GPLO
Gold Coast Hospital and Health Service



A new Direct Access Colonoscopy model supported by GPLOs on the Gold Coast is helping suitable patients access their procedure quicker by eliminating an unnecessary visit to the hospital for assessment.

The demand for colonoscopy is increasing, mainly due to an increase in the incidence and awareness of colorectal cancer. This has led to an increase in waiting times for colonoscopy, which can be distressing for patients who are referred by their GP due to concern of serious pathology.

The overall goals of the Direct Access Colonoscopy model are to improve waiting times for colonoscopy by streamlining appropriate patients and to study efficiencies gained through targeted resource allocation.

Through the new model, patients are booked directly for their procedure upon receipt of a GP referral. The principle behind this approach is that it is safe to do so as the GP has already undertaken an assessment.

Before the Direct Access Colonoscopy model was introduced, all GP referred patients were placed on a wait list to attend an Endoscopy Assessment Clinic (EAC) at the hospital. After this assessment the patient would be placed on another waiting list for colonoscopy.

The new model enables patients who meet the criteria to bypass the EAC and prepare for their procedure using a 'virtual Direct Access Clinic'. This clinic is supported by a GP with Special Interest (GPwSI) and an experienced gastroenterology nurse.

The role of the GPwSI is to categorise patients and if appropriate, to give feedback to the referring GPs (a positive feedback learning loop). All the necessary information is posted to patients before the nurse phones them to clarify any concerns, check any missing information on the referrals and book their colonoscopy. Patients are given the option to pick up the Bowel Prep at the hospital or at their usual community pharmacy.

Evaluation has demonstrated the success of the model. Direct Access Colonoscopy patients are waiting much less time to access a colonoscopy. Wait times for other patients have also decreased as some of the patients move to the Direct Access stream.

L-R: Racheal Lister, Registered Nurse, Anaesthetic Department, Dr Kevin Tang, Gastroenterologist, Max Mansoor, GP Liaison Officer, Fiona Crisp, Clinical Nurse Endoscopy, Tracy Weekes, Clinical Nurse Consultant, Endoscopy

Patient Criteria

(developed in consultation with senior clinicians)

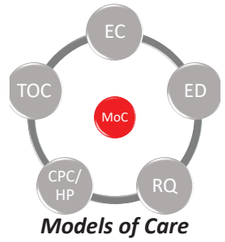
- Aged under 50 years (now under 60 years).
- Not on insulin or anticoagulants/ antiplatelets.
- BMI less than 35 and not a high anesthetic risks.

Key Outcomes

- Significant reduction in all waiting times for colonoscopy.
- Reduction of human resources per patient. In comparison, the virtual clinic has a third of the EAC human resource for a similar output.
- Reduced the re-scope rate to less than half of the EAC patients.
- Freed up outpatient rooms in the hospital.
- Reduced burden on patients e.g. shorter waiting time and less travel.

Day in the life of a Hepatology GPwSI

Ingrid Frances, GP with Special Interest (GPwSI)
Gold Coast Hospital and Health Service



Models of Care

I have been part of the Hepatology team at Gold Coast University Hospital for more than 18 months now.

It has been an interesting journey, with many challenges, but also a real feeling of camaraderie and doing something to improve outcomes for an often disadvantaged part of our society.

I work with remarkable Clinical Nurses (CNs) and consultants, managing Hepatitis C patients. Some are straight forward clinical cases, but others have complex medical and psychosocial situations.

The day starts with the Hepatology CNs giving me a folder with the clinical information they have on the patients booked in for the day and any pathology results or clinical information from other providers relevant to the patient.

The nurses and I manage straight forward cases ourselves. We request that the referring GPs receive copies of our test results and provide advice on how they can help monitor progress in the community. The nurses monitor the progress of patients using spread sheets to consolidate hospital and community test results.

I have learnt a lot about the clinical information systems used at the Gold Coast University Hospital since commencing here and have a new appreciation for the complexity of this for hospital staff. When I return to GP practice, I will enjoy the relative simplicity of our GP clinical programs, with one inbox, simply set out clinical records, embedded scripting and medication PI in one clinical program. Next time you want to bag out your choice of GP medical software - don't, just don't!

The patients have been great, they are really excited with the new access the Hepatology Clinic by the GPwSI and the resulting access to direct acting antivirals and are very appreciative to be offered this therapy.

I now have an understanding why referrals to the HHS require the detailed information and test results to support them. Just as General Practice loves a good discharge summary, a complete referral simplifies the process hugely. Many of my colleagues do send compete and clinically succinct referrals and I make a point of telling their patients how great their GP is.

The nursing staff have been a very impressive group of people to work with, some have decades of experience in hepatology, and so I am always learning from them. We have recently started doing scripts for our local prison patients, relying on good communication and collaboration with the nursing team in the corrective services and again the CNCs are highly skilled and dedicated to improving outcomes for their patients.

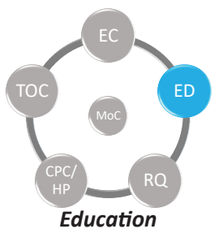
Working in Specialist Outpatients has given me direct access to consultants to ask questions and double check management, which is much harder to access in general practice. Yes, I know we can ring our friendly specialist colleagues, but working alongside experienced specialists has been a really valued part of my time with the Hepatology team. Having GPwSI in hospitals also gives hospital clinicians insight into the way GPs work. GPs are skilled clinicians who assess and manage patients competently, efficiently and safely, referring the patient for specialist advice when and where necessary.

After a morning of reviewing and prescribing for an interesting and eclectic bunch of patients, I then rush off for an afternoon of opiate substitution therapy prescribing in a local private clinic, another interesting side to General Practice. We really do cover the breadth of medicine as GPs in our varied roles, with our varied patients.


Dr Ingrid Francis with Brendan

Engaging GPs with targeted education

Dianne Shkurka, GPLO
Cairns and Hinterland Hospital Health Service



An education program that connects GPs with their local hospital specialist is improving patient care and referral pathways in Far North Queensland.

The program provides GPs and other primary care clinicians with regular interactive sessions that aim to improve the treatment and management of patients in the community and provide clear pathways of care for those needing specialist outpatient services.

Topics are determined with GP input to make sure the knowledge and expertise gained is relevant for their patients. During the sessions, GPs and clinicians are given the opportunity to discuss individual cases and learn about new treatments, and alternative management and referral options.

The program is delivered through a partnership approach involving the HealthPathways team and North Queensland Primary Health Network (PHN). The sessions enable GPs and clinicians attending to receive guidance and support on patient assessment and management as well as up-to-date information to support the planning of patient care through primary, community and secondary health care systems.

The education program was developed as a result of the annual GP survey, conducted by the GP Liaison Service. The survey results indicated that GP education from local specialists was important. The Cairns and Hinterland HHS Clinical Council saw this as an opportunity to improve engagement and communication with local GPs.

The HealthPathways team and North Queensland Primary Health Network (PHN) were invited to be involved as the education program was developed.

Local GPs gather for the popular session

Program Features

- GPs determine topics.
- Opportunity for GPs to meet the specialist that would receive their referrals.
- Interactive sessions based on community case studies.
- Regular sessions scheduled.

Key Outcomes

- Established partnership approach between the GP Liaison Service, the CHHHS Clinical Council, FNQ HealthPathways and North Qld PHN.
- Specialty areas covered so far include Orthopedics, Vascular, Women's Health and Endocrinology.
- Between 30 to 40 GPs attend each session.
- GPs are regularly updated on hospital initiatives that improve connection between primary and secondary care (e.g. GEDI (Geriatric Emergency Department Intervention) program, GPwSI, Nurse Navigators, External Fracture Clinic).

A breath of fresh air

Dr Srishti Dutta, GPLO (ICIF COPD project)
Brisbane North PHN

Patients with COPD are breathing easier in Brisbane's North thanks to a project that is developing an integrated, high quality and consumer valued service delivery network across the HHS and PHN catchment.

Early identification of COPD allows for both public health and primary care-based interventions to be used in order to prevent deterioration and maintain quality-of-life for patients. Evidence shows that patient outcomes can be improved when GPs and other clinicians have the right resources to plan the best quality care possible, and when patients have access to pulmonary rehabilitation.

The Integrated Care Innovation Fund COPD Project aims to:

- Improve timely access to and uptake of pulmonary rehabilitation.
- Improve the ongoing management of patients with a diagnosis of COPD presenting at both GP practices and Metro North HHS facilities.
- Improve GP case finding of patients living with or at risk of COPD.
- Build the capacity of the general practice team to provide evidence-based management of patients with COPD.

The project is a collaboration involving clinicians from the three major hospitals within Metro North HHS, the Brisbane North PHN and the Lung Foundation and funded through the ICIF from The Healthcare Improvement Unit, Clinical Excellence Division, Queensland Health.

The Project Coordinator and GPLO work with the PHN to deliver education events as well as support the 25 practices involved in the Project's clinical audit.

Key Activities

- Nurse COPD workshop - supported by Lung Foundation Australia.
- Spirometry training for nurses - supported by Queensland Health Spirometry Training Program.
- COPD PEN CAT Clinical Audit – aimed at supporting practices to improve the management and care of patients who have a diagnosis of COPD.
- Satellite Pulmonary Rehabilitation Programs including trial underway on Bribie Island, which is an identified area of need.
- Establishment of Exacerbation Working Group and proposed model of care for patients admitted with exacerbation for better care in the community.
- Trial of single point of referral for pulmonary rehabilitation with a view to it becoming accessible to all patients in the area.

Key Outcomes

- Education and training – four events for GPs and nurses have been held in regard to spirometry as well as management of patients with COPD (attended by 49 GPs and 79 nurses). The spirometry training was attended by 40 nurses.
- Clinical Audit – 25 practices (53 GPs) participating. Interim review shows over 200 spirometry tests performed at these practices as part of the audit.
- Coordination of satellite pulmonary rehabilitation programs across the catchment, including seven free MNHHS programs. The programs have achieved an impressive 75 per cent completion rate and the clinical outcome measures show significant improvements in function and quality-of-life.
- Development of a care co-ordination model, and an assessment and management tool for patients with COPD exacerbation. In addition, there has been encouraging use of the COPD Action Plan as a tool for better communication, self-management and care planning in the transition between primary and secondary care.

Next Steps

- The project will be evaluated by the Australian Centre for Health Service Innovation (AusHSI).

Brighton Pulmonary Rehab group

Amie Horwood (COPD project co-ordinator Brisbane North PHN), Susan Marshall (Psychologist, Complex Chronic Disease Team), Judy Powell (Partnerships Manager, Lung Foundation Australia), and Sharon Hodby (Principal Project Officer, ICIF COPD Project) at the GP ALM event held on 17 March 2018.

Expanding GP Education in Brisbane's North

Dr James Collins, GPLO
Kris Muller, Principal Project Officer, Outpatients
Metro North Hospital and Health Service and **Brisbane North PHN**

The expansion of the Brisbane North GP education program to include a wide variety of specialties is helping GPs manage suitable patients closer to home.

The ageing population and exponential growth of chronic diseases continues to drive an increasing demand for specialist outpatient services in Queensland. To ensure patients have access to the best treatment options for their situation it is important that GPs have access to education that helps them manage appropriate patients in a primary care setting.

Collaboration between the Brisbane North PHN and Metro North HHS smoothed the way for this to happen by enabling specialty departments within Metro North HHS to easily and effectively facilitate primary care education.

A standardised process was developed, and a coordinated approach maximised opportunities to provide local secondary care updates to support GPs through a tailored education program.

The education sessions also provide an opportunity for GPs to meet HHS clinicians and strengthen communication channels.

The expanded education program benefits patients through:

1. Optimisation of clinical care and referral practices across health care settings.

2. Improving continuity of care through greater collaboration and relationships between primary and secondary health care providers.

As the sessions may lead to some patients receiving their treatment in a primary care setting, the program has the potential to help reduce demand on SOPD services.

The expanded program builds on the success of Metro North's GP Alignment Program, which has been running for five years and has been very well received by local health providers.

The GP Alignment Program was focussed on the specialties of maternity and gynaecology to support connected patient-centred care for women and babies. However, with GPs requesting education across a wide variety of specialties and HHS clinicians wanting to support this, the education suite was expanded to include sessions from the following departments:

- Respiratory
- Neurology
- Rheumatology
- Gastroenterology
- Healthy Spine Service (Back Pain)
- Mental Health and
- Paediatrics.

All education sessions are eligible to achieve the appropriate CPD points to ensure GP learning needs are met.

Key Outcomes

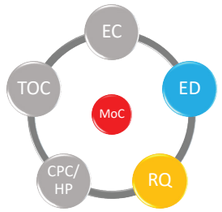
- The education sessions improve understanding of services provided locally and strengthen relationships between primary and secondary care providers.
- Improved quality of referrals.
- GP learning needs met.
- Identifying HealthPathways for development.
- Throughout 2017/18 more than 400 GPs have attended education sessions.

GPs gather for COPD Education

Healthy Spine Service

Louise Endicott, Healthy Spine Project Manager, COSI
Dr James Collins, GPLO
Metro North Hospital and Health Service

Models of Care, Education & Referral Quality



The Back Pain Pathway project in Metro North HHS is taking an innovative approach to develop a patient-centred service that focus on coordinated care; improved access to services; timely treatment; the right level of care for patients; and tailored education for patients and care providers.

The Back Pain Pathway project has enabled existing pathways to be remodeled to enhance current service provision for patients with back and neck pain. This is supported by communication, coordination and collaboration across the care continuum, to ensure cohesion between services and more effective service delivery. The project was funded by the Clinical Excellence Division ICIF funding and the GPwSI funded under the Specialist Outpatient Strategy New Models of Care funding.

The benefits for patients are realised through the project objectives:

- To enhance coordination of care by improving the quality of referrals and information received through collaboration with primary, community and secondary care providers.
- To improve decision making for the right level of care based on individual patient needs through single-point referral pathways using evidence-based screening and triage tools.
- To increase capacity and access for patients with back pain by creating a sustainable model of care and reducing service duplication through primary and community care collaboration.
- To provide timely access to care through reduced specialist outpatient waiting times and the majority of patients are seen within a clinically recommended period. Key enabling factors include the adoption of innovative models of care, more integrated care and the use of telehealth.
- To promote and support education activities associated with back pain to provide informed care and management plans to patients and primary care providers.
- To provide treatment and management care plans to back pain patients who live outside MNHHS by providing education and support to their local HHS, primary and community care and through use of telehealth.

What is Happening?

The Healthy Spine Service consists of:

- Spinal Health Hub: A single point of entry hub for all back and neck pain referrals received into MNHHS. Referrals are categorised in accordance with the Clinical Prioritisation Criteria (CPC) and streamed to the most appropriate MNHHS facility and department by the GPwSI.
- Healthy Spine Clinic: GPwSI led clinic providing rapid access and early intervention for category 2 and category 3 patients with back and neck pain. The clinic operates from the Northwest Community Health Centre with the aim of initiating a change in the patient's expectation of surgical intervention and hospital-based healthcare.
- Healthy Spine Program: An education program delivered to patients with a focus on positive health attitudes. The program also provides support and information for patients to empower them to proactively self-manage their condition.

Key Outcomes

The project and associated Healthy Spine Services experienced earlier than anticipated positive outcomes. These outcomes relate to:

- Back and neck pain are consistently in the top three most-viewed primary care pathways on Health Pathways.
- Over 4,500 referrals processed, categorised and streamed through the single point of entry referral hub.
- An 81% reduction in referrals requiring categorisation by an Orthopaedic or Neuro Surgeon.
- First General Practitioner with Special Interest (GPwSI) employed within MNHHS.
- 34% of referrals accepted into MNHHS move through the Community Health GPwSI-led clinic.
- 80% of patients seen within the Community Health Clinic are discharged back to primary care.
- Over 500 patient referrals could be treated in a primary care setting and not sent through to secondary care facilities.

The Healthy Spine Service team

Next Steps

- Healthy Spine Service (hub, clinic and program) continues operation.
- Continue progression of the Healthy Spine Program to include direct entry from primary care.
- Ongoing education opportunities with primary care GPs through a partnership with Brisbane North PHN.

Queensland's first Paediatric Integrated Care Strategy

Dr Dana Newcomb, Medical Director Integrated Care
Dr Aaron Chambers, GPLO
Hannah Johnson, Senior Project Officer Integrated Care
Children's Health Queensland HHS

Children's Health Queensland Hospital and Health Service

Communication

Children's Health Queensland (CHQ) has launched Queensland's first Paediatric Integrated Care Strategy putting children and families at the centre of health service design.

The Integrated Care Strategy 2018-2022 (the Strategy) will provide an important framework for the provision of seamless, effective and efficient care across primary care and hospital settings. Importantly, it will also promote the need to engage with young people and their families to better understand their needs and care experiences.

Patient outcomes will improve through improved service design and as children and families are provided with the knowledge, skills and confidence to understand and manage their own care, where appropriate.

The Strategy defines integrated care as it relates to children, young people and their families, and is written as a practical guide for clinicians and service leads.

It is anticipated the Strategy will:

- Build upon the existing strong foundations of integrated care initiatives within CHQ.
- Inform quality improvement activity within CHQ, so that services become more collaborative and focused on partnerships in the future.
- Raise the profile of the role of the primary care sector, non-health government departments, and other agencies in the care of children and young people.
- Assist other jurisdictions to understand how Integrated Care can be applied in a paediatric context.
- CHQ is the current statewide provider of tertiary healthcare for children, and the Strategy meets the need for a framework dedicated to paediatric integrated care. While there is growing recognition of the need for integrated care, there is currently no national or international published framework dedicated to paediatric integrated care.
- Written specifically to describe the foundations and enablers of integrated care that are easy to translate into practice, the Strategy contains a 'toolkit' that clinicians across the health system can embrace immediately to drive improvements.

Key Outcomes

- Services for children are developed and delivered in a more integrated way.
- Reduced fragmentation and duplication of care due to services being better coordinated and based on patient and family needs.
- Increased staff satisfaction due to improved communication, collaboration and innovation, clarity of roles and responsibilities, and encouragement of clinicians to work to the top of their scope of practice.
- Better use of health care resources.

The Strategy is the first of its kind and aims to provide a platform to implement and evaluate integrated care from a child's or young person's perspective.

New HealthPathways for Queensland kids

Dr Dana Newcomb, Medical Director Integrated Care
Dr Aaron Chambers, GPLO
Dr Fabian Jaramillo, GP Clinical Editor
Children's Health Queensland HHS

Children's Health Queensland Hospital and Health Service

HealthPathways

General Practitioners (GPs) across Queensland are being empowered to treat children closer to home and access the most suitable specialist services with the launch of new statewide paediatric clinical pathways.

The pathways have been developed by Children's Health Queensland (CHQ) in close collaboration with General Practice funded through the Specialist Outpatients Strategy, Healthcare Improvement Unit, Clinical Excellence Division, Queensland Health.

CHQ is responsible for providing specialist services for children across Queensland and a close relationship between CHQ and General Practice is essential for providing the best possible care for children no matter where they live.

Accessed through HealthPathways, a web platform that provides access to localised advice on best-practice management of a myriad of medical conditions, the new paediatric pathways will include Clinical Prioritisation Criteria (CPC) guidelines where available.

The new paediatric pathways have achieved centralised consistency, which is necessary for a tertiary service, while providing information on locally available treatment options. This was done through the development of a single source of exemplar guidelines with regions having the ability to localise content.

Creating standard guidelines for GPs across Queensland is important as it fosters equitable access to care, clear guidance on latest evidence for assessment and treatment, and supports clear communication between specialist and GP.

Children on specialist outpatient waiting lists can expect more consistent and comprehensive care from their GP whilst awaiting specialist review. Some may even avoid a hospital visit through access to alternative models of care suggested by a pathway, whilst others may be able to be effectively treated by their GP.

CHQ's Integrated Care team were integral to the development of the new paediatric pathways. The team engaged extensively both within Children's Health Queensland and broadly across the state's regions to ensure content was relevant and meaningful for many different patient cohorts. Pockets of high demand were identified early in consultation and this has resulted in an additional project aimed at better using new electronic systems. The project will collect and analyse data to inform the drafting of future HealthPathways.

Key Outcomes

- The first CHQ Health Pathways are live with a suite of 61 due to be completed by September 2018.
- CHQ has regular stakeholder engagement with all Queensland HealthPathways regions (HHS & PHN) as well as collaborating with our paediatric counterparts in Victoria and New South Wales.
- To ensure CHQ pathways meet the needs of all Queensland GPs, all paediatric pathways are sent for regional consultation and review prior to being published.
- Paediatric Healthpathways will be the primary resource for GPs to obtain accurate CPC referral information. CPCs will be implemented at CHQ during the 2nd half of 2018.

The final pathways are now being drafted. The CHQ Integrated Care team is working with the regions, GPLO Network and CHQ Medical Directors to determine pathways to be developed and the order of prioritisation.

Dr Aaron Chambers, GPLO & Dr Dana Newcomb, Medical Director Integrated Care

Starting out...

Dr Theresa Johnson
Darling Downs HHS

Kristy Glover
Central Queensland HHS

Dr Toni Weller
Townsville HHS

GPLOs work in many different ways to improve integration between hospitals and primary health care in their respective areas. Dr Theresa Johnson from Darling Downs HHS, Kristy Glover from Central Queensland HHS and Dr Toni Weller from Townsville HHS share their experience of what it is like to start out in this important role and what they hope to achieve.

How are you getting to know your HHS and PHN?

Dr Theresa Johnson
Having previously worked in the Darling Downs HHS, coming back to the Toowoomba Hospital has been like coming home. It has been great to reconnect with former colleagues and build new relationships with the team here. I have been actively meeting with staff across key areas that directly impact the GP/Hospital interface to learn current systems and identify any challenges and areas of need. I have enjoyed meeting with the staff at the local PHN and getting a better understanding of their mission and the work they are doing to improve connected care. I have also been invited to participate in the PHN Clinical Council meetings which I feel will be invaluable to my role as a GPLO across DDHHS and PHN.

Kristy Glover
I know the Central Queensland HHS well having worked here for over 10 years in various positions including Health Promotion Officer, and more recently as a Medical Education Officer working with Medical Interns, Junior Doctors and International Medical Graduates. Getting to know the PHN has been an easy task as staff are friendly, approachable and very supportive. I have been learning the ins and outs of Health Pathways with the Health Pathways Coordinator, attending joint PHN/Queensland Health practice visits, and attending meetings and networking opportunities with the PHN GPLO. I have been fortunate to be invited to participate on the local PHN Clinical Council. The CQHHS is geographically large and the populations within each area diverse. I have also been fortunate to meet with the PHN Practice Support Officers in each of the three areas. I am certain they will be a great help moving forward with the role.

Dr Toni Weller
My primary workspace is within the HHS, so this makes it easier to get to know people and places in the hospital. The Health Pathways team here is very active and well established, working with clinicians, support staff and department heads. They have been invaluable for introducing and supporting me. The THHS Executive team and our Director of Medical Services have all created time to orientate and include me in meetings and decision-making processes. It helps that our PHN is only a short stroll away and I have been welcomed as part of the team. Having been a member of the local clinical community as a GP for many years and undertaking student rotations and an internship at the old “Townsville General” means I’m getting to reacquaint myself rather than start over.

I take whatever opportunity I can to be productive and involved and I am lucky to be working within a supportive local medical community.

We know it’s early days but what opportunities have you identified to improve the interface between primary care and HHS services?

Dr Theresa Johnson
I have hit the ground running as we are now only three weeks away from our launch of HealthPathways and CPCs. I see this project as a great opportunity to improve the Primary Care/HHS interface. The Darling Downs HHS is ever-changing and expanding so to have an up-to-date and accurate “one-stop” resource for condition specific advice, health service mapping and referral criteria will be an invaluable tool for GPs. I feel that it will help to improve understanding and access and reduce frustration at the primary care level. I am excited to be able to be a part of the engagement team and intend to use this opportunity to get to know GPs across my HHS, build networks and improve mutual understanding.

Kristy Glover
Central Queensland HHS has not had a GPLO for some time so there is a lot of catching up to do to bridge the communication gap between primary care and the HHS. I will be looking at all opportunities to support connections. Recently I travelled to 43 of our 63 GP practices within the catchment to promote the GPLO position and service. The differing shared care models that are starting to emerge are very interesting and present great opportunities for future partnership between the HHS and primary care. The introduction of CPC in our catchment will also provide opportunities.

Dr Toni Weller
Improving clinical communication and connectivity between local primary and tertiary health practitioners is still a key factor in effective and efficient person focused care. Without this you are more likely to have duplication and gaps in care and a greater risk of adverse events for patients. Facilitating primary health care engagement with Townsville HHS and better, more timely two-way communication at a macro and micro level creates better patient care and lateral problem solving with more effective service delivery.

What do you plan to work towards in your first year?

Dr Theresa Johnson
As well as the continued engagement and roll out of HealthPathways and CPCs, in my first year I am looking forward to working closely with the team of residents within the HHS to improve their understanding of primary care. I also plan on supporting them in the timely production of high quality discharge summaries to improve continuity of care.

Kristy Glover
I am focusing on the simple things we need to get done and making sure we are doing them well. I am currently working on revitalising the referral templates for Best Practice, Medical Director and Genie and updating our specialist lists. We have re-established a bi-monthly local GP newsletter and have recently distributed our first annual GP Communication Survey

Starting out...(continued)

based on the survey shared by Dianne Shkurka from Cairns HHS at the last GPLO Network forum. The results will give us a good solid base line to work with as we raise communication levels between the health service and the local GPs. I plan to continue building my networks and will attempt to address the findings of the survey. I will also work closely with our CPC Project Manager as CPC rolls out.

Dr Toni Weller
One of my main goals is to create and strengthen connectivity for our local GPs with THHS clinicians and services, including our closed local GP Facebook page and annual Health Pathways GP education event each September. Implementing and promoting CPC internally and externally will be an important part of this. It is also important to understand which services have higher community demand and how they can be supported or consider other models of care. Where appropriate I would like to promote existing solutions such as GPwSI and ECHO (already being explored by our persistent pain team). We have recently implemented direct GP referral to our Older Persons Ambulatory Care Clinic (OPACC) and will look at this possibility for some other THHS services which are currently internal referral only, where it may lead to admission avoidance and a better journey for the patient.

So far what has been your best day as a GPLO and why?

Dr Theresa Johnson
My best days as a GPLO so far have been days where I have had the opportunity to talk to GPs, hear their ideas and be able to communicate what is being done to address their concerns. I have been encouraged daily by the team here in the DDHHS and the commitment they show to improving healthcare and engagement across the region.

Kristy Glover
So far it has all been a very rewarding journey with lots of learning. I am enjoying the phone calls from practices and helping to trouble-shoot problems.

Dr Toni Weller
My best day so far was the day after our PHN-supported GPLO “meet and greet” event. I learnt of connections made within our medical community, ideas shared and possibilities for the future. We also made our Facebook page live that day, which was the culmination of considerable planning.

Doctors in a Room

Dr Chris Woollard, GPLO
Dr Nick Yim, GPLO
Central Queensland, Wide Bay, Sunshine Coast PHN

Education

Informal education events and networking gatherings have fostered valuable connections between doctors and other clinicians on the Fraser Coast.

The events have been developed to improve communication and information sharing between Fraser Coast GPs, HHS specialists and private specialists. Fraser Coast has quite a complex network of public, private, local and out-of-region services which traditionally learn about each other through trial and error.

The monthly GP Education Evenings and bi-monthly GP-Specialist Networking Evenings have enabled shared understandings of the local health network, which leads to improved patient journeys through primary and secondary care.

Events have been well attended and the informal setting, which is free of sponsorship, provides a relaxed environment for local GPs to regularly mingle with other doctors, specialists and allied health clinicians.

More informed and well-connected GPs lead to better patient outcomes as they have up-to-date knowledge on how to access the right service, at the right time, in the right place for their patients.

Feedback indicates that patients’ often comment positively when it is evident that their GP and specialist hold a mutual regard and are in communication with each other, which is usually a result of having met face-to-face. The events also foster discussions and ideas around how to achieve ‘best practice’ and tackle local system issues.

The events have involved consultants and clinical directors from most of the HHS specialist departments, many private specialists, and around 30 to 40 GPs.

Key Outcomes

- Well-informed and connected GPs.
- Better targeted education topics with a local flavour in terms of ‘service delivery’ (e.g. availability, referral pathways and criteria).
- Better patient outcomes through improved understanding of complex local and regional health networks, and the confidence that comes with ‘knowing’ the specialist to which one is referring.
- Improved understanding of the HHS by GPs, and an improved understanding of General Practice by specialists. The same applies for Allied Health.
- An established and predictable education and networking calendar, with allocated funding.
- Improved relationships between primary care and specialist care.
- Improved individual confidence and improved relationships between GPs and specialists.

GPLO in the Spotlight

Sunshine Coast Hospital and Health Service
Exceptional people. Exceptional healthcare.

phn CENTRAL QUEENSLAND, WIDE BAY, SUNSHINE COAST
An Australian Government Initiative

Dr Edwin Kruys, GPLO
Sunshine Coast Hospital and Health Service

In the seventeenth century the term 'liaison' referred to a thickening or binding agent for sauces. I like this gastronomic reference as there are parallels with the work of Queensland's General Practice Liaison Officers.

In the hectic kitchen of healthcare there are many processes that, when aligned in the right way, result in a wholesome menu.

Queensland Health has to be congratulated for recognising that the different parts of healthcare, including primary care, cannot be seen in isolation but are highly interdependent – and that a broad vision and innovative models of care will assist us to better connect the dots.

I am equally impressed with my GPLO colleagues across the state who have become experts in working at the interface of hospital and community and, on a daily basis, 'bind sauces', put out kitchen fires where needed and bring wonderful new concepts to the table.

Although individual expertise and skills are key, healthcare also needs bridge builders; people who work across the boundaries of disciplines and organisations and facilitate collaboration. People who remind others that the sum of the whole is greater than its parts.

My role as a GPLO has allowed me to take a step back, look at the bigger picture and work on solutions that are beneficial for our hospital, primary care and improve the patient journey through the healthcare system. What I have learned is that wherever people work in healthcare, there is so much passion to get the care for our patients right. Ultimately, this is what binds us all.

No matter where we work in the kitchen, what processes, ingredients or dishes we are responsible for, it is all about the people we are looking after - and that at the end of the day they are going home with a positive experience.

I am grateful for the opportunity to play a small part in integrating Queensland's healthcare system.

Same day discharge summaries - changing culture and improving safety

Sunshine Coast Hospital and Health Service
Exceptional people. Exceptional healthcare.

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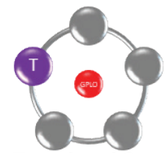
Dr Michelle Johnston, GPLO
Sunshine Coast Hospital and Health Service



Transfer of Care

The Sunshine Coast Hospital and Health Service (SCHHS) is taking action to enable discharge summaries to be sent to GPs on the same day that patients leave the hospital.

The goal is to improve health outcomes by ensuring continuity of care when patients are discharged from hospital to a primary care setting.

The GP Liaison service has supported this important initiative which will ensure timely, streamlined and safe transfer of care to the community.

The need to improve the quality of discharge summaries was identified through an internal audit and GP feedback. A Discharge Summary Steering Committee was established in early 2017 to guide planning for improvement. The committee included representatives from SCHHS Executive, GP Liaison, Clinical informatics, Medical Education departments, as well as Consultants, Registrars, Nurses and Junior Doctors.

Clinicians and support staff were engaged early to ensure practicality of new clinical processes and identify future change champions.

The planned procedure was recognised as a major change in culture and clinical processes, therefore the steering committee liaised with the SCHHS communications department to develop a multi-pronged awareness campaign. The campaign ran for three months prior to the launch of the new procedure, allowing time for feedback from all staff. Members of the Steering Committee presented at staff forums, intern education sessions, GP forums, and developed a set of posters which became screensavers on hospital computers in the lead up to "Go-Live".

On 16 October 2017 a 'Same-Day Discharge Summary' expectation was launched, backed up by a new formal procedure.

A system, developed by Clinical Informatics, was put in place to capture data and produce fortnightly summaries to monitor impact over time. This information is then provided to clinicians and SCHHS Executive.

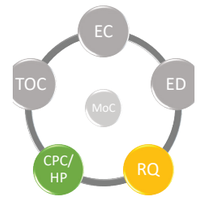
The overall aim is for 100% of discharge summaries to be completed before the patient leaves hospital. However, during 2018, teams will be considered on target if they have a 90% or over same day discharge summary rate.

Key Outcomes

- Same day completion of discharge summaries improved from approximately 20% in January 2017, and increased sharply to approximately 70 % in the fortnight post "Go-Live".
- Sustained and continuous improvement achieved by supporting and educating teams who are not meeting their target.
- Achievement rates, as at June 2018, were 79% across the SCHHS and the GP Liaison Service is continuing to work with all teams to achieve a higher rate.

Changing referral behaviour on the Sunshine Coast

Dr Jon Harper, GPLO
Central Queensland Wide Bay Sunshine Coast PHN &
Dr Marlene Pearce, GPLO
Sunshine Coast Hospital and Health Service



CPC/Pathways & Referral Quality

The continued roll-out of HealthPathways in the Sunshine Coast and Wide Bay region is enabling better quality referrals and more equitable access to hospital care.

The local HealthPathways was first launched in November 2016 to provide evidence-based information on the assessment and management of common clinical conditions including referral guidance. HealthPathways is funded in partnership with the Healthcare Improvement Unit, Clinical Excellence Division under the Specialist Outpatient Strategy. Information is accessed through a dedicated web portal and is tailored for GPs and primary health clinicians in the Sunshine Coast and Wide Bay area.

Since the launch, the use of HealthPathways in this area has continually increased with the portal now recognised as a 'go to' resource for public hospital referral information.

GPs use HealthPathways prior to making a referral to ensure they are aware of the best treatment options for their patients. In addition to referral information, GPs can access a wealth of clinical support tools to assist them manage suitable patients within primary care rather than refer to an outpatient clinic. This is good news for these patients as they can be treated closer to home by a GP who has a better knowledge of their overall health requirements. Specialists use HealthPathways to access triaging criteria, including the Clinical Prioritisation Criteria (CPC) where available. This helps ensure referrals to public specialist outpatient clinics are triaged according to clinical urgency in a safe, consistent and equitable manner.

General Practice Liaison Officer's from the Sunshine Coast HHS and PHN have been involved with the roll-out of HealthPathways since inception, playing an important role in portal page content development and engagement with local GPs and SCHHS staff.

The HealthPathways clinical pathway content has been developed through collaboration between local GP clinical editors and specialists. The program provided numerous opportunities to review current referral processes and connection between clinicians in primary and specialist care, which has enabled a greater understanding of each other's roles. Specialist clinicians have also been encouraged to adopt greater leadership functions in developing referral criteria, including statewide CPC and local criteria.

The successful engagement of general practice was achieved with an intensive GP engagement strategy. All general practices received at least one face to face visit from a GPLO. This was made possible through close collaboration between the PHN and the SCHHS and involvement of GPLOs from both services. Peer-to-peer engagement allowed discussion of the purpose of HealthPathways and gave it greater credibility.

Within the SCHHS, the GP Liaison team met with clinical directors and central referral office staff to outline the implementation of referral criteria. Evaluation procedures where put in place to record the effect of the CPC on GP referrals and specialist triage. Clinical staff were educated in navigating the HealthPathways website to access the CPC information with every computer desktop provided with a shortcut link.

Key Outcomes

As of June 2018:

- Sunshine Coast and Gympie HealthPathways has 368 localised live pages with a further 78 near completion. It has had 5244 individual users.
- Development of 33 specialty-specific referral criteria. In many cases, the re-evaluation of the status quo led to establishing innovative models of referral flow or service delivery.
- Over 80% of general practitioners reported using HealthPathways frequently.
- HealthPathways and CPC are gaining wider recognition and support from hospital teams.

HealthPathways presentation to the Sunshine Coast Local Medical Association

GPLO model at the Mater

Louise O'Reilly, GPLO
Mater Health Services

All areas

With a focus on partnerships the General Practice Liaison Program at Mater Health supports integrated care across departments, facilities, regions and sectors.

Mater Health provides public hospital services for eligible patients through Queensland Health funding and with additional revenue generated through Mater Private Hospitals. Patients can be referred to services from any location across the state. As a result, the Mater's General Practice Liaison Program has been tailored to accommodate this unique service.

The program works with a change management approach to improve patient journeys through advocating integration between general practice and hospital-based care settings. Strategies include improved communication, capacity building and partnership development across traditional geographical catchments.
This year, the General Practice Liaison Program has been involved in several exciting initiatives that demonstrate the valuable role of partnerships in supporting integrated care.

These include:
- New models of care funded under the Clinical Excellence Division funding for the Specialist Outpatient Strategy Models of Care Futures Project to address barriers to access for patients with viral hepatitis and patients requiring breast reconstruction.
- Co-design and delivery of a new discharge summary system - Communication from Hospital at Transfer (CHaT).
- Alignment of referral guidelines with statewide Clinical Prioritisation Criteria to improve clinical safety and equitable access for publicly funded specialist outpatient services.
- Participation in, and support of, deployment of HealthPathways locally and across Queensland funded by the Clinical Excellence Division under the Specialist Outpatient Strategy.
- Improved data integrity and analysis approaches by complementing Mater's Analytics and Performance application with the uptake of Management Information System technology.
- Proof of concept testing of an e-Consulting service offering specialist written advice to GPs to support ongoing primary care management.
- Establishment of a 'Smart Forms' pilot for electronic and intuitive GP referrals to outpatient services.
- Formation and maturity of a Partnering for Integrated Care committee to more formally govern and direct collaboration and partnerships at Mater.
- Region-wide access strategies for long waiting patients at peer facilities to access care specialist pathways more quickly through supported transfer.

These projects rely on strong and strategic linkage across and between the General Practice Liaison Program, Mater hospitals, General Practice (and associated Primary Health Networks), other service providers (including peer HHSs) and Queensland Health.

With these projects, and the General Practice Liaison Program, Mater Health continues to demonstrate commitment to best practice and to the broad agenda of public health care reform.

Mater e-Consulting - If we build it will they come?

Louise O'Reilly, GPLO
Mater Health Services

Mater Health is currently trialling an e-Consult program with a partnering general practice to test its ability to improve access to specialist outpatient services.

Current transactional funding models in health care commonly remunerate traditional face-to-face consultation in a bricks and mortar physical setting. There is growing evidence that addressing the GP/Specialty interface through asynchronous consultation models can improve access, efficiency and costs as well as the integration of general practice and specialty care.

This proof-of-concept trial will test if it is likely an e-Consult program would:

1. Be adopted and utilised by GPs seeking specific specialist advice to support ongoing care.
2. Reduce the number of referrals to specialist outpatient services by supporting ongoing management of the patient in the primary care setting.
3. Decrease the median wait-time for input from the specialist.
4. Be a satisfying model for involved clinicians.

The partnership focuses on support for frail and elderly people. During the trial the general practice will receive advice from a general physician at the Mater via a timely written response. The GP will use the advice to appropriately manage the patient.

Scope for the proof-of-concept included:
- Communication securely messaged
- Response time no longer than 72 hours
- All transactions and responses recorded in the patient medical record
- A query did not constitute a referral
- A time period of 50 cases or up to 6 months.

Louise O'Reilly (GPLO), Anna Tart (Referral Management Centre Clinical Nurse), Bronwyn Jennings (Clinical Access Officer), Skye Ring (BPIO)

In the early stages of this work, ten 'Requests for advice' have been received resulting in nine responses where the GP maintained management and referral was not required with input from the specialist. Only one patient required referral to the hospital due to complexities and comorbidities that could not be safely assessed without a more detailed consultation.

Next Steps

Another practice will be recruited to the trial to increase the volume of requests and collection of data around participant satisfaction. On completion, the scope may be increased to consider impacts of the written advice model for hospital avoidance and its transferability across different specialty areas, population groups and in combination with other digital modalities of health care.

For more information about the Queensland GPLO Network contact...

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