QGPL

Queensland General Practice Liaison Network

2022-23 ANNUAL REPORT

CCQ COUNTRY TO COAST, QLD

Healthy, connected communities

phn CENTRAL QUEENSLAND, WIDE BAY, SUNSHINE COAST

An Australian Government Initiative

Proudly supported by Queensland Health's Clinical Excellence Queensland

Queensland Government

ACKNOWLEDGEMENT

The Queensland General Practice Liaison Network would like to acknowledge and pay respect to the traditional Custodians of the land on which we work and live. We recognise their continuing connection to land, waters and community, and honour their cultures. We extend our respect to elders past, present and emerging.

TABLE OF CONTENTS

FOREWORD

Clinical Excellence Queensland | Queensland Government

CLINICAL EXCELLENCE QUEENSLAND

It gives me great pleasure to share the fifth Queensland General Practice Liaison (QGPL) Network Annual Report 2022–23. This year has seen the QGPL Network enjoy the greater collaboration experienced by meeting face-to-face again.

Since 2019, Clinical Excellence Queensland has partnered with the Country to Coast, QLD (CCQ) to provide statewide support for the Network. Collaborative partnerships between general practice, Hospital and Health Services (HHSs) and Primary Health Networks (PHNs) have enabled General Practice Liaison to work towards integrating services at the interface between general practice and secondary care. The work the General Practice Liaison Officers (GPLOs) do could not have been achieved without these collaborative partnerships and I look forward to this continuing in the coming years.

This report provides the opportunity to reflect on the achievements of the QGPL Network, and the innovative models of care developed across the health services. These include the ever-expanding General Practitioner with Special Interest (GPSI) roles across Queensland. This year the Sunshine Coast HHS GP Liaison Unit published about the outcomes of the GPSI program: GPs with a special interest improve connection between hospitals and primary care | InSight+ (mja.com.au)

Also highlighted in the report is the effectiveness of the HealthPathways platform in communicating the outcomes of the mentioned projects. Cairns and Hinterland HHS's development of statewide rheumatic heart disease HealthPathways for management of this preventable condition will lead to improved outcomes for Queenslanders.

There is a growing number of shared models of care between general practice and hospitals. The Darling Downs HHSs development of a shared model of care for breast cancer that also uses HealthPathways as the communication mechanism, and the Metro North model of stable ophthalmology patients being reviewed by local optometrists in Central Queensland are some examples of this important work.

I would like to thank Dr Edwin Kruys and Dr Toni Weller for their leadership as Co-chairs of the QGPL Network. The QGPL Network leadership team published an article about the Networks role in supporting the work of GPLOs and providing expert direction and advice relating to communication, clinical handover, and collaboration across primary and secondary care: GP liaison officers boost primary care connections | InSight+ (mja.com.au)

I would like to take this opportunity to thank the GPLOs for their commitment to improving patient outcomes and the health of Queenslanders today and in the years to come.

Michael Zanco,
Executive Director,
Healthcare Improvement Unit, Clinical Excellence Queensland

FOREWORD

COUNTRY TO COAST, QLD

Dear Colleagues and Stakeholders,

It continues to be our privilege at Country to Coast, QLD to coordinate activities with the Queensland General Practice Liaison (QGPL) Network and our system partners at Clinical Excellence Queensland. Throughout 2022-23, the Network continued to strengthen the interface between general practice and hospital care with a focus on:

- Clinical communication and transfer of care
- Facilitating collaborative care
- Interprofessional education and engagement
- GPLO and QGPL Network development.

Some examples of the work achieved by the QGPL Network and its members is highlighted in this report, including the success and expansion of the General Practitioners with Special Interest (GPSI) model of care, the integration of new models of care such as the Clinical Advice Line and Rapid Access Clinics, the Queensland General Practitioner Maternity Shared Care Network, and the new model of care for stable ophthalmology patients attending their review appointments remotely.

This year, we also coordinated network events with our Queensland teams working on HealthPathways to collaborate on improving the journey for patients across acute and primary care settings.

I would like to recognise the leadership of QGPL Network Co-chairs, Dr. Edwin Kruys and Dr. Toni Weller and our dedicated GPLOs, General Practitioners, Hospital and Health Services (HHSs) and Primary Health Networks (PHNs), contributing to the QGPL Network's success. I would also like to extend my gratitude to Clinical Excellence Queensland, particularly the Healthcare Improvement Unit led by Executive Director Michael Zanco, for their unwavering support and partnership. Their dedication exemplifies the spirit of collaboration that drives transformative change.

As we reflect on the accomplishments of the past year, we welcome the improvements outlined in the Strengthening Medicare Federal 2023–24 budget. These measures will support patients and primary care professionals to deliver more integrated, comprehensive primary care, with a goal of reducing the pressure on the Queensland Health HHSs.

I invite you to delve into this report to gain a comprehensive understanding of our journey, milestones, and how we are reshaping the healthcare landscape in Queensland.

Warm regards,

Julie Sturgess
CEO, Country to Coast, QLD


QGPL

FOREWORD

QUEENSLAND GENERAL PRACTICE LIAISON NETWORK

In 2011 General Practice Queensland published, with funding from Queensland Health, the landmark paper Enhancing Integration: The General Practice Liaison Officer Model.

A quote from this document describes General Practice Liaison Officers (GPLOs) as 'change agents': "This model recognises the pivotal role of the positions as 'change agents' in facilitating cross sector integration and coordination of care."

Now, twelve years later, change is more needed than ever before.

Challenges with regards to workforce, equitable primary care access, multidisciplinary care and fragmentation are still dominating the reform discussion. We need change agents who can see the big picture and help design win-win solutions based on a value-based compass, improving the patient's journey through the complex pathways of our healthcare system.

GPLOs have a deep understanding of primary and secondary care. They are skilled in systems thinking, risk assessment, strategy planning and understand the importance of co-production, which includes co-planning, co-design, co-delivery and co-evaluation.

GPLOs have developed the ability to pivot as required between the broad lens, which allows innovation and productive change in the complex adaptive space, and attention to detail and operational decision-making where needed.

It is important that we challenge the status quo (sometimes it is useful to create tension), and at the same time co-create solutions that fix cross-sector problems without causing unintended collateral damage elsewhere in the health system.

GPLOs have large networks and use longitudinal relationship-building to manage together the adaptive problems at the interface between primary and secondary care. Standing with one foot in primary care and the other in the hospital, GPLOs provide immense value to Primary Health Networks (PHNs) and their clinical councils, and Hospital Health Services (HHSs) across the state.

Connecting silos, through building trust and relationships, is essential to achieve the strategies that can deliver the right care in the right place. If your organisation does not employ a GPLO, let's start the conversation!

Dr Toni Weller and Dr Edwin Kruys,
Co-chairs, QGPL Network

ABOUT THE QGPL NETWORK

ABOUT GENERAL PRACTICE LIAISON OFFICERS

General Practice Liaison Officers (GPLOs) facilitate appropriate clinical pathways and transfer of care processes, integrating services at the interface between general practice and hospital care. Improving the interface between general practice and hospital care is vital to improve patient experience during transfer of care, with improvement focussing on:

- Transfer of care
- Clinical handover and hospital discharge processes
- Local strategies to integrate care and improve models of care
- Collaborative models of care development
- Interprofessional education and engagement about integration mechanisms and associated models of care.

ABOUT THE QUEENSLAND GENERAL PRACTICE LIAISON NETWORK

The Queensland General Practice Liaison (QGPL) Network is a multidisciplinary collaboration of clinicians that provides expert direction and advice on all strategic matters relating to integrating the patient journey of care across the interface between general practice and hospital care. The QGPL Network is funded by Clinical Excellence Queensland and delivered in partnership with Country to Coast QLD (CCQ). The QGPL Network supports the development of the GPLO role and QGPL Network and prioritises the values of:

- Patient safety
- Equity of access for all patients
- Efficient use of available resources
- Collaboration and network development between all stakeholders
- Seamless integration at the interface of general practice and hospital care.

THE OBJECTIVES OF THE QGPL NETWORK ARE TO:

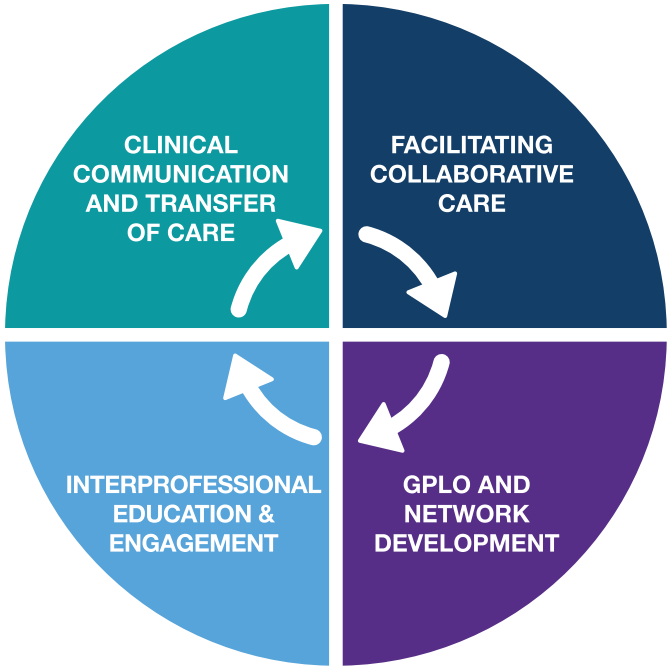
- Build the capacity and capability of GPLOs through the sharing of learning, experiences, resources and innovations
- Identify effective local strategies, solutions, and service delivery models; and share these with the QGPL Network and support their wider implementation
- Reduce duplication of effort and promote effective and equitable use of resources and equity of access for all patients
- Provide opportunities for QGPL Network members to build mutually supportive and collaborative relationships
- Implement the QGPL Network work plan
- Showcase achievements of the QGPL Network and its members, including achievements by individual GPLOs, HHS and PHN teams at local and statewide levels.

The QGPL Network gathered to attend a forum on 23 October 2023.

The QGPL Network work plan guides the QGPL Network towards achievement of the Network objectives. The work plan focus areas for 2022-2024 are:

- Clinical communication and transfer of care
- Facilitating collaborative care
- Interprofessional education and engagement
- GPLO and Network development.

The shared learnings, outcomes and achievements from the implementation of the work plan are documented and showcased in the following QGPL Network Annual Report.



Joanne Sweetser,
Principal Project Officer,
Healthcare Improvement Unit,
Clinical Excellence Queensland

Karen Mansley,
Project Coordinator QGPL Network,
Country to Coast, QLD

NORTH WEST

GROWING A GPLO SERVICE IN THE NORTH WEST

Dr Erica West, GPLO, North West HHS

Dr Erica West, a Rural Generalist and General Practitioner (GP) working across the hospital and primary care in North West HHS (NWHHS), understands how to facilitate individual and community access to the right service, at the right time, in the right place.

The General Practice Liaison Officer (GPLO) position drives innovation and collaboration between primary and hospital care, enhancing patient journeys and safety across the health service. Initially launched in partnership with the Western Queensland PHN as the Primary Care Liaison Officer (PCLO) in 2019, as part of the Emergency Department (ED) Avoidance Project, the GPLO role has evolved and broadened its scope to engage in various primary care and hospital initiatives by 2023.

Achievements in 2023:

- Stakeholder engagement to establish connections for the new GPLO role
- Facilitated GP access to GP Smart Referrals, the Health Provider Portal, iMED, CDA Discharge Summaries as well as updating the Secure Transfer Service address book
- Facilitation of peer review and feedback on referral quality for declined referrals
- Hosting a consultation evening for GPs and key stakeholder for the new model of community palliative care launched, to reduce preventable hospitalisations
- Participation in internal referral solution planning and application
- Provided advice and support to various specialties, working groups and committees
- Concurrently working as a GP with Special Interest (GPSI) in Paediatrics, building the profile of GPSI in the HHS as a solution to support service gaps and integration across NWHHS.

The GPLO role faces significant challenges due to the transient nature of both the GP and NWHHS workforce. Juggling a broad scope of responsibilities within part-time hours and lacking administrative support poses considerable ongoing challenges.

Improving communication between general practice and hospital care in NWHHS holds significant potential for enhancing patient safety outcomes. These include enhancing discharge summary quality and timeliness by resident medical staff, improving secure clinical communication with general practice through specialty healthcare team collaboration, expanding GPSI roles for waiting list management, fostering collaboration between general practice, ED, and Community Health, offering orientation and education for medical students/staff and GP registrars and contributing to sustainable workforce solutions for NWHHS.

These initiatives aim to improve continuity of care, streamline clinical handover processes and ensure effective engagement between healthcare teams, ultimately leading to better patient outcomes and integration at the interface between general practice and hospital care.

Dr Erica West,
GPLO,
North West HHS

CHILDREN'S HEALTH QLD

IDEA PROJECT – IMPROVING THE DISCHARGE EXPERIENCE FOR ALL AT CHILDREN'S HEALTH QUEENSLAND

Dr Aaron Chambers, GPLO, Children's Health Queensland HHS

The Integrated Care Team (ICT) at the Queensland Children's Hospital (QCH) Children's Health Queensland Hospital and Health Service (CHQHHS) has made significant progress in the pursuit of enhancing clinical communication and transfer of care through the Improving the Discharge Experience for All (IDEA) Project. The objective is to increase discharge summary completion rates and improve dissemination timeframes to General Practitioners (GPs) from across QCH.

At QCH, suboptimal discharge summary completion rates highlighted the need for improvement in this crucial quality indicator. The catalyst for change was a GP complaint about clinical communication regarding a critically ill child who had approximately 20 individual separations from the hospital without receiving any transfer of care communication. The referring GP complained when they received their first correspondence, which was a request for a named referral, and they had no information about the six months since their initial referral.

A small working group was established and despite initial resistance to change, multiple discussions involving various healthcare teams revealed that all teams were encountering common challenges in delivering timely and comprehensive discharge communication.

The project aimed to enhance the discharge experience for children and families while streamlining the process for the care team. Key project elements involved senior leadership endorsement, board visibility, clinical leadership, collaboration, data transparency and clear escalation pathways.

The IDEA Project expanded rapidly across QCH without additional funding and gained recognition from the Hospital Board. Strong endorsement from senior leadership within QCH focused attention amidst competing priorities and fostered a culture of accountability and commitment towards improving the discharge communication process. A hospital-wide focus week was held to highlight the importance of this work.

The IDEA Project's success relied on strongly engaged clinical leadership and champions, agile pilot testing, transparent data for informed decisions and a clearly defined escalation pathway. Further changes are anticipated and embraced by the coal-face clinicians.

The IDEA Project implementation faced challenges such as resource allocation, system integration, and managing resistance to change, necessitating careful planning and coordination, along with effective change management strategies.

Looking ahead, the CHQHHS ICT remains committed to sustaining the momentum achieved through the IDEA Project. Future efforts will emphasize expanding successful interventions, improving data analytics, collaborating with external partners, and refining communication. Building on this foundation, CHQHHS aims to consistently enhance the discharge experience for both healthcare providers and patients.

The QGPL Network would like to acknowledge the following people for their contributions to the achievement of the outcomes in this story:

- *Dr Otilie Tork: Medical Director, Child Protection and Forensic Medical Service, CHQHHS*
- *Dr Vishal Kapoor: SMO, General Paediatrics, CHQHHS, Senior Lecturer, Faculty of Medicine, University of Queensland*
- *Kim Anderson: Nursing Director, Learning and Workforce Development, CHQHHS.*

Dr Aaron Chambers,
GPLO,
Children's Health Queensland HHS

METRO NORTH/ BRISBANE NORTH

CENTRAL QUEENSLAND PATIENT REVIEW PROJECT

Jim Loughridge, GPLO Optometry, Metro North HHS and Brisbane North PHN

The Central Queensland Patient Review Project trialled a new model of care offering eye reviews closer to home for stable, clinically suitable ophthalmology patients.

Established during 2022, the project was initially developed to clinically review patients waiting for ophthalmology care, in response to workforce shortages in the ophthalmology service in Central Queensland Hospital and Health Service (CQHHS). After initial discussion, the agreed project scope by ophthalmology was the trial of stable, clinically suitable patients due for review by Royal Brisbane and Women's Hospital (RBWH) ophthalmology service.

The eye reviews were conducted using the Remote-I platform, jointly adapted for general ophthalmology by the Commonwealth Scientific and Industrial Research Office (CSIRO) and the General Practice Liaison Officer (GPLO) Optometry. Remote-I supports the secure transfer of patient clinical information and the transfer of larger scans and image files, which are unable to be transferred currently. Select patients of three RBWH ophthalmology consultants were consented to project participation and several local optometrists were engaged.

The optometrist completed the review assessment and transmitted a report including clinical data and images to RBWH ophthalmology. Upon review of the report by RBWH ophthalmology, a care plan was developed and transmitted back to the optometrist. The care plan outlined management advice and timeframes for ongoing remote review or escalation to RBWH ophthalmology as clinically indicated. The optometrist advised the patient of the review outcome and copied the report to the patient's General Practitioner (GP).

A constant challenge for the project was sourcing administrative support required to sustain the model and administrative workflows. Exploration of a virtual care, store and forward incentive and activity-based funding would improve long-term viability and sustainability of this model.

Key findings:

There were significant positive outcomes with no adverse events despite lower-than-expected trial patient numbers (12). 48.4 per cent of review patients were deemed clinically suitable for this pathway and 75 per cent of those enrolled attended their local review.

These patients saved 11,216 travel kilometres and 127.13 hours of travel time, equating to a reduction in Patient Travel Subsidy Scheme (PTSS) costs of between $6,399 and $11,520, depending if travel was by car or plane.

In conclusion, Remote-I is a fit for purpose, safe and efficient alternative to face-to-face RBWH eye clinic reviews for clinically suitable patients utilising local optometry and virtual review by RBWH ophthalmology. Patients are reviewed closer to home, providing choice, time and cost savings. This model has immense potential for scale and spread providing significant benefits to patients while reducing waitlist lists for ophthalmology services.

Jim Loughridge,
GPLO Optometry, Metro North HHS
and Brisbane North PHN

MACKAY

A YEAR OF NEW INITIATIVES FOR MACKAY HHS GENERAL PRACTICE LIAISON UNIT

Caroline Giles, GPLO, Mackay HHS

The Mackay Hospital and Health Service (MHHS) General Practice Liaison Unit (GPLU) consists of four employees, the General Practice Liaison Officer (GPLO), HealthPathways Clinical Coordinator, Project Support Officer and an Aged Care and Dementia Health Practitioner. Together the GPLU team works to improve the relationship between primary health care and the MHHS.

Improving integration at the interface between primary and secondary care can be a challenge. The MHHS GPLU team have endeavoured to identify and address the needs of the local health care system via multiple communication methods. Noticeably in our efforts, is the increasing divide between primary health care and the hospital setting.

With its inception in 2022, the Connected Community Pathway funding (CCP) provided an opportunity for the GPLU team to collaborate with primary health care providers, and to not only talk about the gaps but to put action and funding behind our ideas.

In partnership with a variety of stakeholders MHHS has been successful for several programs under the CCP funding. Two of these programs have been developed based on the GPLU team engagement with primary health care stakeholders and identifying a local need. The two programs include Together Strong Connected Communities, a First Nations secondary and tertiary chronic disease prevention program, and the Frail Aged Care Nurse Practitioner (NP) service in Bowen. Both programs are NP-led and have established a stakeholder governance committee to support ongoing collaboration.

The MHHS GPLU have also commenced supporting sexual health services to address an increasing community demand. In Mackay, the sexual health service sits within a community setting and is led by a NP who is joined by a part-time General Practitioner (GP). Key areas with increasing demand have been transgender health care, medical termination of pregnancy and sexually transmitted infection testing.

Addressing the sexual health service needs in the MHHS region has given the GPLU the opportunity to hone their health promotion and advocacy skills, in addition to a collaborative partnership with North Queensland Primary Health Network in their relevant training and education opportunities for GPs.

All three services allow local referral pathways for patient-centred care that complements and enhances the care provided by GPs.

The Mackay GPLU are proud of the achievements of 2023 and look forward to the delivering further initiatives that will integrate the care at the interface between general practice and hospital care in 2024.

Mackay HHS General Practice Liaison Officer Caroline Giles (centre) with Mackay HHS colleagues Nurse Practitioner Maree Wearne and Cultural Practice Coordinator Philip Kemp

GOLD COAST

GOLD COAST GPLU SUPPORTS CARE AT THE INTERFACE BETWEEN GENERAL PRACTICE AND THE HOSPITAL FOR FIRST NATIONS PEOPLE

Dr Kate Johnston, GPLO, Gold Coast HHS
Karen Whitting, GPLO Manager, Gold Coast HHS

The Gold Coast Hospital and Health Service (GCHHS) General Practice Liaison Unit (GPLU) team is dedicated to improving communication between the hospital and general practice and developing new approaches to optimising patient care. During 2022-23 the team was pleased to be able to work closely with GP and GCHHS colleagues to enhance care, communication, and service navigation for First Nations health consumers across our region.

Partnering with Kristy Hayes, Senior Director, Aboriginal and Torres Strait Islander Health Services at GCHHS, the team works at both the system and patient levels supporting patients across the city. The GPPE team engages with Kalwun Health Service via quarterly meetings to review service availability and accessibility, and address the ongoing challenges associated with clinical handover. Providing a point of contact for the GCHHS Indigenous Community Services, the GPPE team facilitates General Practitioner (GP) engagement, service promotion and supports communication with local GPs. Further supporting GPs, the GPPE team is developing a suite of Aboriginal and Torres Strait Islander HealthPathways.

During 2022-23, the GP Engagement Officer had the opportunity to work with GPs from Kalwun Health Service to understand a patient's reluctance to attend GCHHS outpatient appointments. By adopting a culturally safe and compassionate approach, the GPPE team was able to liaise with multiple outpatient clinics and specialists, ensuring the necessary investigations for the patient could be optimised within the community. Appointments were rationalised to avoid unnecessary visits to the hospital. The GP Engagement Officer linked the patient to the Indigenous Health Nurse Navigator for appropriate care navigation and the Indigenous Health Liaison Officer for appointment support.

The GP advice line supports all Gold Coast GPs at the patient level by addressing simple information requests and assisting with more complex scenarios. The service, established in September 2021, primarily handles information, communication, or service navigation requests and in addition aids in hospital avoidance. Notably, 76 per cent of non-urgent outpatient queries did not require specialty referral and 31 per cent of emergency advice prevented an emergency department presentation, supporting GPs to continue patient care in the community.

Artist acknowledgement: This artwork was produced for Gold Coast Hospital and Health Service by Riki Salam from We are 27 Creative.

FAR NORTH QLD
(CAIRNS & HINTERLAND HHS)

RHEUMATIC HEART DISEASE: HEALTHPATHWAYS FACILITATES A STATEWIDE APPROACH

Oona Westrheim, GPLO, Cairns and Hinterland HHS

Managing the prevalence and impact of acute rheumatic fever (ARF) and rheumatic heart disease (RHD) in Far North Queensland (FNQ) is a significant priority for Queensland Health, Queensland and Australia. Australia has some of the highest documented rates of RHD in the world and a significant number of these people live in Far North Queensland. RHD is a preventable condition and a disease of poverty that is particularly prevalent in the Aboriginal and Torres Strait Islander peoples in FNQ. People who are at the highest risk of developing RHD are:

- Young people aged 5 – 14 years
- People living in overcrowded, poor quality, inadequate housing or who are homeless
- Aboriginal and Torres Strait Islander people.

On 4 March 2022, the Hon Yvette D'Arth MP, then Minister for Health and Ambulatory Services announced the Ending Rheumatic Heart Disease: Queensland First Nations Strategy 2021-2024, to strengthen Queensland's response across the health system from early prevention to the care and support of those living with ARF and RHD. Additionally, on 30 June 2023, the coroners court of Queensland released the findings of the inquests into the deaths of the Booth, Sandy and George, the 'RHD Doomadgee Cluster', with 19 recommendations to improve the prevalence and management of RHD in FNQ.

In order to improve care for the FNQ population, it is vital that primary care clinicians have easy access to and are aware of the assessment and management guidelines as well as local referral processes for both ARF and RHD. The FNQ HealthPathways team harnessed the opportunity to make a valuable contribution to by developing statewide HealthPathways for both ARF and RHD.

HealthPathways, a web-based portal providing evidence-based information for primary on the assessment and management of common clinical conditions, guides the integration of care through presentation, referral to specialist care and public health management, localised to the region. Statewide HealthPathways provide standardised care pathways across different geographical regions, localised to reflect the local contact details and referral pathways.

The FNQ HealthPathways Clinical Editor, Dr Helen Pedgrift, worked closely with subject matter experts from the paediatric cardiology service and the RHD Register and Control Program in the Tropical Public Health Service in Cairns, to develop both the ARF and RHD HealthPathways pages. The statewide HealthPathways will support primary care clinicians across Queensland to provide evidence-based timely management of ARF and RHD for a vulnerable population. These HealthPathways will increase awareness, improving prevention, detection, and management of these conditions. Once finalised, the lead region statewide clinical pathways for ARF and RHD will be promoted extensively via a targeted communications strategy across FNQ.

The QGPL Network would like to acknowledge the FNQ HealthPathways team for their contribution to the achievement of the outcomes in this story.

Oona Westreheim,
GPLO Cairns and Hinterland HHS

DARLING DOWNS

HEALTHPATHWAYS COORDINATES PLANNED BREAST CANCER SHARED MODEL OF CARE FOR DARLING DOWNS.

Dr Theresa Johnson, Deputy Executive Director of Medical Services, A/Clinical Director of Medicine, Darling Downs HHS
Joanne Sweetser, Principal Project Officer, Healthcare Improvement Unit, Clinical Excellence Queensland

Not so long ago, receiving a cancer diagnosis would result in all treatment being provided by the specialist services at the hospital. General Practitioners (GPs) typically had minimal contact with these patients, only engaging in critical situations. With current advances in treatment, many people diagnosed with cancer have periods in their journey where there is no intensive treatment. This has led the General Practice Liaison Officer (GPLO) team at Darling Downs Hospital and Health Service (DDHHS) to consider strategies for collaborating with primary care for the management of patients whose illness is now more comparable to a chronic disease journey.

Shared care, as defined by DDHHS, is a model where both the tertiary care specialist team and the primary care specialist team maintain active involvement in patient care for the specified condition, sharing information and clinical responsibilities. They agree on common processes proactively with consistent patient engagement, ensuring the patients' needs and choices are at the centre of care. At the end of active treatment, selected patients are invited to participate in shared care arrangements for routine follow up and survivorship care.

Developing the shared model of care requires each person involved to understand their role and responsibility, including the hospital specialty team, the GP and the patient. Escalation of care criteria and clear communication methods are critical to patient safety. Facilitating the shared model of care in a HealthPathway provides a detailed workflow at the point of care. It streamlines coordination in one place, ensuring GPs participating in shared care can access the clinical decision support tools needed to safely manage their patients concerns, including visibility of the clinical roles, responsibilities and escalation criteria. The GP is encouraged to utilise smart referrals to request advice, or to escalate care. They can also access urgent phone support from the oncology registrar or breast care nurses. HealthPathways provides the GP with a patient-centred, timely and safe way of implementing a shared model of care.

Patients undergoing treatment have their progress documented in a comprehensive shared care plan. Each visit is recorded using a clinic visit template and shared through an itemised review checklist. To ensure the patient is an active team member, they are offered copies of all communication in a hand-held portfolio. After five years, and a final review with the medical oncology clinic, patients are discharged from the shared care program. HealthPathways is available to support GPs in their ongoing care post discharge. Following the recent commencement of their new GPLO, DDHHS is looking forward launching the breast cancer shared model of care and associated pathways with a multidisciplinary education forum for GPs and other clinicians in the Darling Downs catchment.

Dr Theresa Johnson, Deputy Executive Director of Medical Services, A/Clinical Director of Medicine, Darling Downs HHS

Joanne Sweetser, Principal Project Officer, Healthcare Improvement Unit, Clinical Excellence Queensland

Dr Joanna Pappas, GPLO, Darling Downs HHS


QGPL

METRO NORTH/ BRISBANE NORTH

THE UNIQUE SCOPE OF A GPLO WITH AN INTEREST IN MENTAL HEALTH

Dr Caroline Clancy, GPLO Mental Health, Metro North HHS and Brisbane North PHN
Sandra Balfour, Senior Project Officer, Metro North HHS

Brisbane North Primary Health Network (BNPHN) and Metro North Hospital and Health Service (MNHHS) are in the unique position of having a General Practice Liaison Officer (GPLO) with a focus on mental health. Metro North Mental Health (MNMH) provides services for people with severe and complex mental health needs, as well as alcohol and other drug services across the life span. MNMH delivers services to over one million people of diverse needs who reside in the catchment from the Brisbane River to north of Kilcoy. Since the COVID-19 pandemic, General Practitioners (GPs) saw a significant rise in mental health presentations. The GPLO in mental health supports GPs in patient management, providing education and connecting GPs with the local services for patients and their carers.

The role outcomes in 2023 include:

- Promoting the Initial Assessment and Referral (IAR) decision support tool for general practices across the BNPHN region. This tool helps GPs identify the most suitable level of care and available local services for mental health patients. BNPHN funded the IAR training, with 110 GPs participating as of August 2023
- Collaborating with Caboolture and Redcliffe Hospitals Adult Mental Health Teams to develop and promote a pathway for patients stabilised on long-acting antipsychotic medication and clozapine, to transition to community care with GP support, including shared care and re-entry guidelines
- Facilitating two mental health education events for GPs. The first focused on upskilling GPs to conduct brief psychological interventions with patients e.g., CBT, psychoeducation. The second event focused on low intensity psychological services, spotlighting BNPHN funded services including Culturally and Linguistically Diverse (CALD) World Wellness Group services, eMHPrac digital supports and the New Access Program
- Assisted hosting the statewide gender services webinar in March providing case-based learning regarding gender diversity and gender affirming care of trans, gender diverse and non-binary (TGDNB) adults
- Working with the Behavioural Emergency Response Team (BERT) to develop and advertise a General Practitioner with Special Interest (GPSI) role
- Collaborating with the UQ RELEASE study to trial the effectiveness of RELEASE and RELEASE+ interventions compared to usual care, facilitating safe patient cessation of long-term (>12m) antidepressants in cases without clinical indication for continued use. Practices started recruitment in 2023.

In 2023, the mental health GPLO role successfully connected GPs with essential skills and services for mental health patients, integrating care between general practice and specialist mental health care.

Dr Caroline Clancy, GPLO Mental Health, Metro North HHS and Brisbane North PHN

Sandra Balfour, Senior Project Officer, Metro North HHS and Brisbane North PHN

CAIRNS & HINTERLAND

MENTAL HEALTH ON-THE-GO FOSTERS ENGAGEMENT WITH GENERAL PRACTICE IN CAIRNS AND HINTERLAND

Lynsey Sweeney, Mental Health PCLO, Cairns and Hinterland HHS
Oona Westrheim, GPLO, Cairns and Hinterland HHS

The Cairns and Hinterland Hospital and Health Service (CHHHS) provides health care services to a large community stretching across a geographical area of 142,900 square kilometres. As part of the post-pandemic world, it became apparent that mental health issues had increased in the population, and the health service needed to find a way to reach across the general practice (GP) network to introduce mental health specialists to their primary care colleagues in a way that promoted discussion and created access solutions for patients. The Mental Health On-the-go events were established as a platform to facilitate these introductions.

During the planning phase, a group of ten general practices, including practices from rural and remote areas, were invited to participate in a consultation and provide feedback about proposed events, topics and formats. The responses received requested information about a variety of topics including pharmacotherapy, addiction, child and youth engagement, a general approach to assessment and differential diagnosis from the GPs in Schools Pilot and other psychiatric, alcohol and other drugs themes. Securing a convenient time for all practices to engage posed a challenge, but by providing ample notice in advance, a mutually suitable monthly time was successfully established.

With the support of Dr Michael Tervit, Clinical Director, Mental Health & ATODS, CHHHS, psychiatrists were called upon to contribute their input and time during lunch breaks. A substantial response was received, enabling the creation of a schedule from February to November 2023 that aligned with the majority of participants' availability. The outcome of this robust and consultative planning phase was the successful establishment of Mental Health On-the-go events, scheduled monthly on a Thursday at 1:30 pm for 30 minutes.

Our successful events production relies on a collaborative effort, with the CHHHS General Practice Liaison Officer (GPLO) promoting Mental Health On-the-go through regular clinical updates. The Mental Health Primary Care Liaison Officer (MH PCLO) facilitates the events, aiding the psychiatrist speaker in delivering concise online presentations. Healthcare professionals, including GPs and practice nurses, join the online event via Microsoft Teams. The agenda begins with a Welcome to Country and an introduction to the presenting psychiatrist, followed by a 10-minute presentation, discussion, and Q&A. Post-event resources are shared with all attendees through the Microsoft Teams library.

Mental Health On-the-go has successfully fostered positive engagement in general practice, offering education and strengthening working relationships across the expansive CHHHS region. The CHHHS GPLO team anticipates future growth and continued success for the Mental Health On-the-go engagement program.

The QGPL Network would like to acknowledge Dr Michael Tervit, Clinical Director, Mental Health & ATODS, Cairns and Hinterland HHS, for contributing to the achievement of the outcomes in this story.

Oona Westreheim, GPLO Cairns and Hinterland HHS

Lynsey Sweeney, Mental Health Primary Care Liaison Officer, Cairns and Hinterland HHS

WEST MORETON

THE QUEENSLAND GENERAL PRACTITIONER MATERNITY SHARED CARE (QGPMSC) NETWORK- ENHANCING MATERNITY SHARED CARE THROUGH NETWORK COLLABORATION

Dr Tanusha Ramaloo, GPLO, West Moreton HHS and Darling Downs West Moreton PHN

The QGPMSC Network strives to improve maternity collaboration and partnership across Hospital and Health Services (HHSs), Primary Health Networks (PHNs), general practice and other maternity care providers to ensure safer, more equitable and consistent General Practitioner (GP) shared care for women.

Maternity shared care in Queensland is supported by a foundational framework, which includes the Queensland Health Maternity and Neonatal Operational Framework, Clinical Prioritisation Criteria, GP Smart Referrals, Statewide HealthPathway and maternity alignment and shared care symposia.

The QGPMSC Network identifies levers for incremental change aligning with best clinical practice, and the Queensland Health Maternity and Neonatal Operational Framework for Maternity shared care. (Guideline: Maternity Shared Care Operational Framework (health.qld.gov.au))

The QGPMSC Network is a peer group of GPs with extensive experience in improvement projects, Statewide Clinical Networks, steering committees, GP with Special Interest (GPSI) roles and who are members of the Queensland General Practice Liaison (QGPL) Network.

The QGPMSC Network shares insights about maternity alignment and collaboration programs, seeking grants and research opportunities to improve maternity shared care. They provide GP representation in various forums, identifying and sharing key GP clinical updates via established channels.

The QGPMSC Network strength lies in engaging its members extensive expertise and networks to establish consistent GP shared care across HHS and PHN regions. Their goal is to navigate the complex health system effectively, preventing gaps in care for pregnant women and enhancing maternity and neonatal outcomes through shared decision-making between GP's, patients and maternity care providers.

The QGPSC Network's future includes progressing a GP maternity shared care research project, collaborating with QGPL for improvement opportunities and enabling Secure Web Transfer (SWT) for bidirectional information sharing during pregnancy.

The QGPL Network would like to acknowledge the following people for their contributions to the achievement of the outcomes in this story:

- *Dr Ka-Kiu Cheung, Practising GP, GPSI in Obstetrics and Developmental Paediatrics at Gold Coast HHS, Board Director, Gold Coast PHN*
- *Dr Meg Cairns, Practising GP and GPLO, Metro North HHS and Brisbane North PHN*
- *Dr Kim Nolan, Practising GP and GPLO Maternity, Metro South HHS*
- *Dr Wendy Burton, Practising GP and foundational GP in establishment of QLD Maternity Shared Care*
- *Dr Tara Hillier, Practising GP, GPSI in Obstetrics and Gynaecology, Townsville HHS.*

Dr Tanusha Ramaloo,
GPLO, West Morteon HHS,
Darling Downs West Moreton PHN

TOWNSVILLE

IMPLEMENTING A RESIDENTIAL AGED CARE NURSE PRACTITIONER SERVICE IN TOWNSVILLE

Dr Toni Weller, Co-chair QGPL Network and GPLO, Townsville HHS

In August 2022, Townsville Hospital and Health Service (THHS) received the welcome news of their successful funding application for the Connected Community Pathways (CCP) program from Queensland Health for a Residential Aged Care Nurse Practitioner Service (RAC-NPS). This has allowed THHS to implement a new service which was part of a broader proposed new model of care developed following a quality improvement (QI) research project commissioned by the North Queensland Primary Health Network. The QI research project was delivered by the General Practice Liaison Officer (GPLO) in collaboration with a multidisciplinary team including Nurses, General Practitioners (GPs) and an Emergency Medicine Specialist.

The RAC-NPS will bridge the gap between GP primary care services and emergency department management for people residing in Residential Aged Care Facilities (RACFs). It is a relationship-based approach with a particular Nurse Practitioner (NP) employed by THHS to work within a RACF regularly. The NP supports GPs and RACF staff with acute care and early nursing intervention as well as transition care after a RACF resident returns from inpatient care at any hospital. The GP remains the resident's primary care giver and may opt for additional support from the NP for specific aspects of chronic disease management and care planning. The advantage of a relationship-based service is the NP and GP provide an individual patient-centred approach and the interprofessional collaborative working relationship agreed to.

The governance is managed, and the service implementation facilitated by THHS. The GPLO and emergency specialist provide coordination in partnership with the NPs. A deed of agreement between the RAC-NPS service and each RACF documents the scope of NP care provision and aligns with patient-focused information sheets, which assist in preventing patient misunderstandings about the NP role.

Another important aspect of the RAC-NPS is the provision of an education and upskilling program to RACF care assistants and nursing staff. Education sessions are based on the RACF needs assessments and data on common clinical presentations into THHS services for RACF residents. These educational events range from full day to evening and small events, provided at the point of care. Additionally, the education and upskilling program creates a supportive community of practice amongst nurses and care assistants working in aged care to discuss sector-specific issues and understand how valued their work is.

The RAC-NPS currently employs two NPs and a NP candidate (NPC) and has planned a four-year phased approach to expand the service to include four NPs and an NPC on an ongoing basis, which will provide high quality workforce development and training.

The RAC-NPS service is an integrated, consistent and stable part of the RACF care team, known personally to the residents, providing high quality health and wellbeing services to older people within their home environment within a sustainable model of service.

Dr Toni Weller,
Co-chair, QGPL Network
and GPLO, Townsville HHS

SUNSHINE COAST

THE SUNSHINE COAST GENERAL PRACTITIONER WITH SPECIAL INTEREST (GPSI) MODEL

Dr Michelle Johnston, GPLO, Sunshine Coast HHS

The General Practitioner with Special Interest (GPSI) model was successfully implemented in the Sunshine Coast Hospital and Health Service (SCHHS) in 2018 and has since become business as usual within twenty specialities (table 1).

The GPSI model has improved collaboration between primary care and the hospital sector and demonstrated benefits for patients by improving access and reducing waiting times.

The GPSI program continues to evolve and is implemented according to the needs of each speciality and the skills of the GPSI. Examples of work done by current GPSIs are supporting the palliative care day unit, providing breast and bowel cancer follow up, performing colposcopies and procedures in the plastic surgery rapid clinic.

Three of the recently recruited GPSI roles include:

Ophthalmology GPSI:

Dr Anthony Rososinski was the first ophthalmology GPSI in Queensland (and possibly in Australia). Dr Rososinksi manages common presentations in clinic and was also instrumental in improving communication from SCHHS ophthalmology outpatient clinics, by modelling timely letters back to the referring General Practitioner (GP).

Ear, nose and throat (ENT) GPSI:

Dr Tanya Obertik has been working in the ENT GPwSI role for the past two years. Dr Obertik's work covers sleep-disordered breathing for children and adults, grommets, globus and sinusitis and she has also been trained to perform nasal endoscopies in clinic.

Dr Obertik has become a mentor for new ENT GPSIs commencing in the team.

Radiation oncology GPSI:

Dr Christelle Greeff has previously worked as one of our palliative care GPSIs and has now commenced a position reviewing radiation oncology patients with troublesome symptoms. These roles have given her extended skills to be able to manage palliative care patients in the semi-rural community where she practices as a GP. Dr Greeff is always happy to share her knowledge with her peers.

Read more about how GPSIs improve connection between hospitals and primary care

GPSIs IN SCHHS

- Cardiology
- Dermatology
- Ear, nose and throat
- Gastroenterology
- General Surgery
- Gynaecology
- Immunology
- Mental Health
- Neurology
- Obstetric medicine
- Opthalmology
- Orthopaedics
- Paediatrics
- Palliative Care
- Plastic Surgery
- Radiation oncology
- Respiratory medicine
- Rheumatology
- Urology
- Vascular surgery

Table 1

Dr Michelle Johnston and Dr Edwin Kruys present the GPSI Model at the Asia Pacific Conference on Integrated Care (APIC3), November 2023.

METRO NORTH/ BRISBANE NORTH

IMPLEMENTATION OF A GPSI COMMUNITY OF PRACTICE

Dr Srishti Dutta, GPLO, Metro North HHS and Brisbane North PHN

General Practitioners with Special Interest (GPSI) are General Practitioners (GPs) who work as a clinical intermediary between primary, secondary, and tertiary care; RACGP - General Practitioners with Special Interests. Employed as senior medical officers, GPSIs become part of consultant-led clinical teams, working in one or more hospital outpatient clinic sessions per week, in addition to their work as community GPs.

The GPSI model began in the United Kingdom and commenced as a pilot in Queensland in 2018. The GPSI positions were initially funded by Clinical Excellence Queensland, and in Metro North Hospital and Health Service (MNHHS), managed by the GPSI project in Healthcare Excellence and Innovation (HEI). MNHHS has GPSIs working in breast surgery, ear, nose and throat, gastroenterology, gender, general medicine, neurology, renal, urology, and in the virtual ward and virtual emergency services. Following the initial project, the GPSI positions transitioned to business as usual, working in the related clinical stream and facility.

GPSI positions continue to grow in MNHHS, their role adding value to clinical teams. As MNHHS has five main facilities and provides tertiary level services over a large geographical area, the GPSIs have had limited opportunities for peer interaction, education and to share the growth of the model.

Discussion about how to address this has led to the development of the GPSI Community of Practice (CoP) with GPLOs Dr Srishti Dutta, Dr Meg Cairns and Dr Stephanie Huxley, who were involved with the inception, implementation and delivery of the GPSI CoP and continue to support it.

Communities of practice are groups of practitioners with shared concern or passion for something they do and learn how to do it better as they interact regularly. Key pillars include shared goals, peer support, learning new and improved ways to do things, shared knowledge and resources. The University of Wisconsin (UW) framework was utilised to implement the five phases of a CoP as a way of continued improvement, engagement and measuring outcomes.

In 2023, the GPSI Community of Practice involves 17 GPSIs and seven GPLOs as well as members from the HEI Team. The Community of Practice has met three times this year, once in person and twice via Teams. It continues to grow, strengthening the effectiveness and outcomes of the GPSI model for MNHHS. The CoP will meet for a social gathering of the members as the last event of this year to celebrate the achievements and contributions of all the members.

Dr Srishti Dutta: GPLO, MNHHS and BNPHN
Dr Meg Cairns: GPLO, MNHHS and BNPHN
Dr Stephanie Huxley: GPLO, MNHHS and BNPHN

Sandra Abeya: Principal Project Officer, Outpatient Strategies, HEI, MNHHS
Meredith Nelson: Nursing Director, Outpatient Strategies, HEI, MNHHS

METRO NORTH/ BRISBANE NORTH

THE CARE COLLECTIVE – CABOOLTURE

Dr James Collins, GPLO, Metro North HHS and Brisbane North PHN

Patients enrolled in the Care Collective at Caboolture (the Care Collective) pilot program achieved a 75 per cent reduction in emergency department (ED) presentations. In its first year, it produced savings of at least double its funding in reduced health service use.

The Health Alliance (the Alliance) is a strategic collaboration between Brisbane North Primary Health Network (PHN) and Metro North Hospital and Health Service (MNHHS) that aims to eliminate health system barriers. In early 2022, the Alliance began to investigate solutions to problems associated with the high numbers of people with complex chronic disease and significant socioeconomic disadvantage residing in the northern region of Moreton Bay. Many of these patients frequently present to ED despite often achieving minimal apparent benefit from such visits.

The Care Collective candidates are identified in ED and now, more proactively, in primary care. By funding complex care coordinators in general practice, the Care Collective builds capacity to better support each person in the community. An individual framework is developed for each person, which includes establishing or strengthening connections to available services. Coordinators are often practice nurses with long-established relationships with patients enrolled in the practice they work in. The Care Collective has enabled the coordinators and their HHS counterparts to form a community of practice for mutual assistance and the collaborative development of relevant knowledge and skills.

General Practice Liaison Officer (GPLO) Dr James Martin joined the Care Collective Steering Committee in March 2022. With 12 years of experience as a GPLO, Dr Martin is well placed to actively navigate the challenges of multiple interconnected health environments. Having also been a General Practitioner (GP) in the Bribie Island area for 15 years, Dr Martin has an insight into the cohort supported by the Care Collective and the significant challenges faced by GPs trying to meet the needs of these people. For Dr Martin, in a nutshell, forming the Care Collective allowed primary care teams a little more of the time and funding needed to coordinate care for complex patients inadequately provided for by existing Medicare limitations.

It was extremely encouraging to hear that increased funding from the Australian Government and Queensland Government has recently been secured to continue and expand the Care Collective in 2023-24. This model of care has scalability, in terms of both patient numbers and eligible chronic conditions, as well as high applicability to other geographical areas.

More information about the Care Collective can be accessed here: https://metronorth.health.qld.gov.au/news/pilot-program-chronic-health

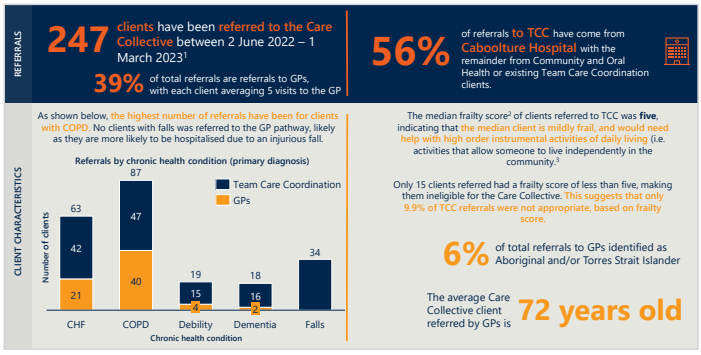


Fig. 1: Early Care Collective patient demographics

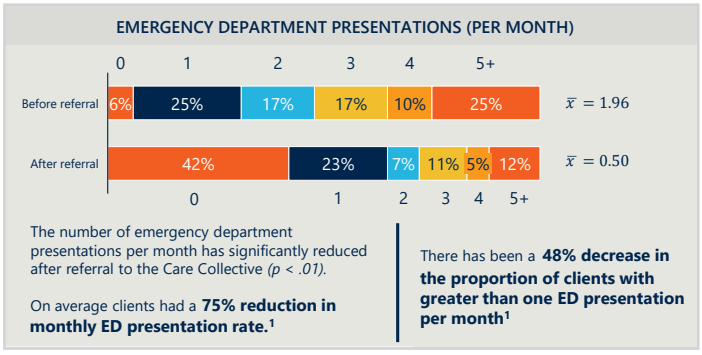


Fig 2: Impact on ED presentations in enrolled Care Collective clients

METRO NORTH/ BRISBANE NORTH

METRO NORTH HEALTH RAPID ACCESS CLINICS AND THE CLINICAL ADVICE LINE

Dr Srishti Dutta, GPLO, Metro North HHS and Brisbane North PHN

Dr James Collins, GPLO, Metro North HHS and Brisbane North PHN

Integration of Clinical Advice Lines with Rapid Access Clinics in Metro North provides timely access to care for patients in the Metro North Hospital and Health Service (MNHHS) and Brisbane North Primary Health Network (BNPHN) catchments. General Practice Liaison Officers (GPLOs) have been involved in the development of two innovative models of care, the Clinical Advice Line and the Rapid Access Clinics.

The Clinical Advice Line was developed following a co-design workshop involving BNPHN, local General Practitioners (GPs), Specialist Clinicians, Consumers, Carers and the GPLO team. The co-design workshop aimed to reimagine patient care alternatives to attending outpatient clinics. This developed during the COVID-19 pandemic into the Clinical Advice Line proof of concept project that received Connecting Your Care (CYC) funding from the Queensland Health in 2021, with integral involvement from the GPLO team in both development and implementation.

Rapid Access Clinics were funded and operationalised alongside this initiative, offering an alternative to emergency presentations. They cater to patients requiring escalation of care for assessment and treatment, accessible by GP referral.

The GPLO team engaged with specialty teams to streamline access for GPs to the Clinical Advice Line and Rapid Access Clinics by consolidating them under a single phone number. This unified point of access reduced barriers and increased awareness of both services. This information was published on the MNHHS Refer your patient webpage.

The GPLO team led further development of the process, with advice provided by the specialty Clinical Advice Line being escalated to a Rapid Access Clinic appointment if clinically indicated. The Clinical Advice Lines currently provide access to the general medicine, heart failure, community care, virtual ward and vestibular Rapid Access Clinics. An innovation matrix model, combining incremental and radical innovations was utilised for optimum results in implementing Rapid Access Clinic and Clinical Advice Line models of care.

The GPLO team continue to explore further opportunities with specialist teams, including linking the Heart Failure Rapid Access Clinic with the virtual ward, allowing ongoing monitoring to prevent an inpatient admission.

The change in the mindset of patient management, from attending an outpatient clinic to participating in an asynchronous advice model of care accessed by their GP will continue to grow. As the models evolve, more services will participate, leading to comprehensive specialty service coverage across MNHHS.

Dr Srishti Dutta,
GPLO, Metro North HHS
and Brisbane North PHN

Dr James Collins,
GPLO, Metro North HHS
and Brisbane North PHN

METRO SOUTH/ BRISBANE SOUTH

COLLABORATING FOR GREATER IMPACT IN GENERAL PRACTICE LIAISON AND ENGAGEMENT

Rebecca Gauci, Acting ADON Primary Care Partnerships Unit, Patient Flow and Central Clinical Services, Metro South HHS

Christine McCormack, Manager Strategic Partnerships, People, Engagement and Research Division, Metro South HHS

Given the importance of primary health care to patient-centred integrated care, Metro South Hospital and Health Service (MSHHS) has reviewed how it partners with primary care stakeholders to meet the organisation's operational and strategic needs. Key to a more systemic approach is the development of diverse partnerships that draw on the resources and expertise of others to intentionally design solutions that are inclusive and deliver sustainable outcomes. MSHHS has subsequently uplifted its general practice (GP) liaison and engagement response by establishing a Strategic Partnerships Team.

While the team has a broad mandate of working with multiple stakeholders across a range of issues, one of its primary functions is enabling improved relationships with the primary care sector and complementing the operations of the existing General Practice Liaison Officer (GPLO) program.

The GPLO program provides vital practical support to GPs and other practice staff through their phone line, email support and practice visits. The nurse-led GPLO roles undertake service navigation and real-time problem-solving with general practice on a daily basis to ensure patients get the right care, from the right service, at the right time. The GPLOs have a clear understanding of the daily operations of clinical services, referral management and clinical handover, and through their work, identify and investigate issues and risks.

The MSHHS Strategic Partnerships team, together with the GPLO program, are now well positioned to lead a more regional and strategic approach to responding to opportunities to improve the patient journey across and between sectors.

METRO SOUTH/ BRISBANE SOUTH

EMPOWERING PRIMARY CARE WITH DIRECT SUPPORT AT METRO SOUTH HEALTH

Lisa Lee, GPLO, Primary Care Partnerships Unit, Patient Flow and Central Clinical Services, Metro South HHS

Metro South Hospital and Health Service (MSHHS) General Practice Liaison Officer (GPLO) Program is a small nurse-led team that has developed a strong relationship with general practice and Brisbane South Primary Health Network (BSPHN), providing direct support for primary care to promote safe and quality patient care.

The GPLO is integral to bridge the gap between hospital and general practice (Clifford, Kunin et al. 2021), where poor communication between primary and secondary care can lead to negative outcomes for patients.

MSHHS GPLOs enhance the patient journey across the five facilities and community services by supporting communication with general practice. Telephone support advice is available to general practice and the GPLO team have developed KPIs that are dependent on feedback complexity, to close the loop on enquiries back to primary care, ensuring high-quality patient focus is achieved and maintained.

GPLO engagement with general practice and primary care has rapidly increased since focussing on the flow of referrals from external referrers. The nurse-led model benefits General Practitioners (GPs) through an understanding of medical terminology, general practice models of care, the ability to access systems and detailed knowledge to monitor the patient referral journey to specialist outpatients, and back to the GP and patient. By utilising referral software, the Health Provider Portal, Enterprise Discharge Summary, integrated electronic medical records and Secure Transfer Services systems, the GPLO team identifies gaps and quality improvement opportunities in both referral processes and clinical handover. The GPLO team uses their clinical knowledge to escalate risks utilising local, statewide and national clinical standards to guide clinical judgement and pathway advice.

Key achievements where the MSHHS GPLO program has enhanced direct support for primary care include:

- Fostering strong working relationships with stakeholders across the health continuum to support primary care clinicians in navigating the evolving health service
- Supporting provision of quality clinical handover via secure electronic transmission methods
- Promotion and support of electronic referral methods
- Monthly primary care engagement audits, which enable sharing of common themes with key stakeholders by escalating feedback to relevant HHS committees and partnership programs to ensure optimal patient safety and continual quality improvement initiatives.

Post-COVID-19 recovery has required re-establishment and enhancement of relationships with primary care, which has been achieved by face-to-face engagement with general practice and other key stakeholders.

Metro South Health GPLO Team (L-R): Lisa Lee, Casey Riches, Sara Mondy, Amanda Vaggelas

METRO SOUTH/ BRISBANE SOUTH

METRO SOUTH HEALTH RESTATES THE SCOPE OF COMMUNICATING FOR SAFETY

Danielle McLeod, Principal Partnerships Advisor, Strategic Partnerships, People, Engagement and Research Division, Metro South HHS

Christine McCormack, Manager Strategic Partnerships, People, Engagement and Research Division, Metro South HHS

Healthcare providers share information with each other about patients for each occasion of service they provide. Secure and efficient transmission of clinical information to and from primary care providers is essential to patient safety and continuity of care. In line with privacy legislation and health care standards, this communication should be timely, secure and fit-for-purpose. From a user perspective, it needs to be easy to use.

Analysis of feedback from General Practitioners (GPs) and an environmental scan of Metro South Hospital and Health Service (MSHHS) identified a lack of consistency surrounding the knowledge and processes for electronic transmission of clinical information to and from primary care providers, particularly with respect to secure messaging which is only available in a limited number of MSHHS settings and case use scenarios.

MSHHS Strategic Partnerships team in partnership with the Metro South General Practice Liaison Officer (GPLO) program identified that there was an opportunity to explicitly re-state the scope of the MSHHS Executive Standard 6 Committee 'Communicating for Safety' to include 'communicating safely with primary care'. In doing so, the MSHHS Executive Standard 6 Committee became the sponsor for secure messaging across MSHHS and a governance structure was developed to ensure its comprehensive implementation, aligning with the three indicators for communicating safely; content, timely and secure.

At time of writing, both the Executive and facility-based Standard 6 Committee structures and Terms of Reference are currently being aligned and leveraged to explicitly state their purpose of supporting 'communicating safely with primary care', both strategically and operationally. The membership on all Standard 6 Committees is being updated to include a GP representative from either the Strategic Partnerships team (Executive committee) or the GPLO program (facility committees) so that issues and opportunities surrounding clinical handover can be addressed locally and strategically.

The efforts of a few dedicated individuals have seen the uptake and prudent use of MSHHS's limited secure messaging capabilities in a discreet number of isolated settings and case use scenarios. Using a revitalised Standard 6 Committee structure across MSHHS, these successes and related learnings will be shared, scaled and spread for the benefit of all patients, the organisation and most importantly general practice.

Danielle McLeod,
Principal Partnerships Advisor,
Strategic Partnerships, People,
Engagement and Research Division,
Metro South HHS

Christine McCormack,
Manager,
Strategic Partnerships, People,
Engagement and Research Division,
Metro South HHS

METRO SOUTH/ BRISBANE SOUTH

METRO SOUTH HEALTH OPTIMISES ACCESS TO CARE CLOSER TO HOME

Danielle McLeod, Principal Partnerships Advisor, Strategic Partnerships, People, Engagement and Research Division, Metro South HHS

Christine McCormack, Manager Strategic Partnerships, People, Engagement and Research Division, Metro South HHS

Metro South Hospital and Health Service (MSHHS) Strategic Partnerships Team has collaborated with Brisbane South Primary Health Network (BSPHN), Queensland Ambulance Service (QAS) and the MSHHS General Practice Liaison Officer (GPLO) program to implement hospital avoidance strategies diverting patients from the Emergency Department (ED) to existing local service options. The launch of rapid access services such as virtual EDs, satellite hospitals and Urgent Care Centres (UCC) that complement initiatives such as Hospital in the Home (HITH), 13 HEALTH and MH CALL, underscores the importance of consumer support for informed decision-making in accessing timely and appropriate care.

Connecting GPs to alternatives to the Emergency Department

General Practitioner (GP) feedback identified that the expanding range of services has made navigating the rapid access and urgent care services more challenging. The MSHHS Strategic Partnerships Team collaborated with local GPs to co-design and enhance HealthPathways content, making new services more accessible. This update facilitates GPs to quickly identify the most suitable care option for patients. Intensive face-to-face engagement with general practice, facilitated by BSPHN and MSHHS GPLO program, supports the implementation of these HealthPathways updates.

Connecting consumers to primary care as an alternative to the Emergency Department

The Strategic Partnerships Team is supporting a MSHHS patient flow initiative called Connecting Consumers with Emergency Choices (CCEC). The Emergency Choices website, developed and hosted by BSPHN, was reviewed by the CCEC initiative and opportunities were identified to further refine the information available. Consequently, improvements in service location for consumers were made, including GP appointments and community services. Website use has increased more than 600 per cent and ongoing user consultation will continue to shape further improvements, aiding consumers in understanding the scope of primary care services.

Connecting GPs and their patients for early intervention

QAS collaborated with MSHHS regarding alternative care pathways for patients who fall at home and do not require transport to ED. GP feedback indicated often patients fall without the GP being aware to implement preventive measures. In response, a falls follow-up pathway was established in July 2022 involving collaboration between QAS, MSHHS Community and Oral Health and BSPHN, which includes a detailed assessment of the patient's biopsychosocial risk factors, communicated to the GP. Over 300 patients have been referred to the pathway with nearly 20 per cent reporting multiple falls. This collaborative care approach facilitates early targeted assessment and prevention strategies through effective clinical communication between health service providers.

METRO SOUTH/ BRISBANE SOUTH

COLLABORATING TO OPTIMISE PRIMARY HEALTHCARE ENGAGEMENT IN THE BRISBANE SOUTH REGION

Martine Waters, Principal Partnerships Advisor, Strategic Partnerships, People, Engagement and Research Division, MSHHS

Debbie Cowan, Director Strategic Partnerships, People, Engagement and Research Division, MSHHS

Danielle McLeod, Principal Partnerships Advisor, Strategic Partnerships, People, Engagement and Research Division, MSHHS

Primary healthcare is the cornerstone of a functioning healthcare system and plays a critical role in promoting the health and wellbeing of individuals and communities. Working together is a key enabler that drives the delivery of quality healthcare every day. Brisbane South Primary Health Network (BSPHN) and Metro South Hospital and Health Service (MSHHS) are collaborating to develop a primary care engagement plan, designed to streamline the communication and information exchanged between MSHHS, BSPHN and primary care providers in the Brisbane South region. The plan encompasses a range of mechanisms and strategies to foster collaboration and create a unified single front door for primary care engagement issues and information to be communicated, coordinated, consolidated and progressed.

A series of three workshops were run between February and July 2023, attracting 30 attendees representing six primary care engagement teams within MSHHS and BSPHN. The workshops facilitated a shared understanding of experiences and perspectives and identified issues for problem-solving. The workshops contributed to a more holistic understanding of engagement purposes that included Public Health updates, promotion of services and new models of care, providing clinical service updates and referral information, and education and support for general practices. There were 22 general practice engagement mechanisms identified, including email, general practice visits, websites, HealthPathways and social media. The workshops also identified an opportunity for enhanced coordination of joint communication campaigns targeted to a general practice audience.

In order to understand primary care engagement requirements, a survey was developed with primary care input and jointly disseminated by BSPHN System Integration and Coordination Team and MSHHS General Practice Liaison Officers (GPLOs). Survey respondents included 39 General Practitioners (GPs), eight Practice Nurses and 26 Practice Managers who provided feedback about their preferred communication mechanisms and current information channels related to the key areas of engagement identified. The feedback and knowledge gathered through the workshops and from primary care providers will be used to optimise engagement for general practices.

MSHHS is currently forming a governance structure to support the engagement plan, with the aim of creating a single front door for GP engagement.

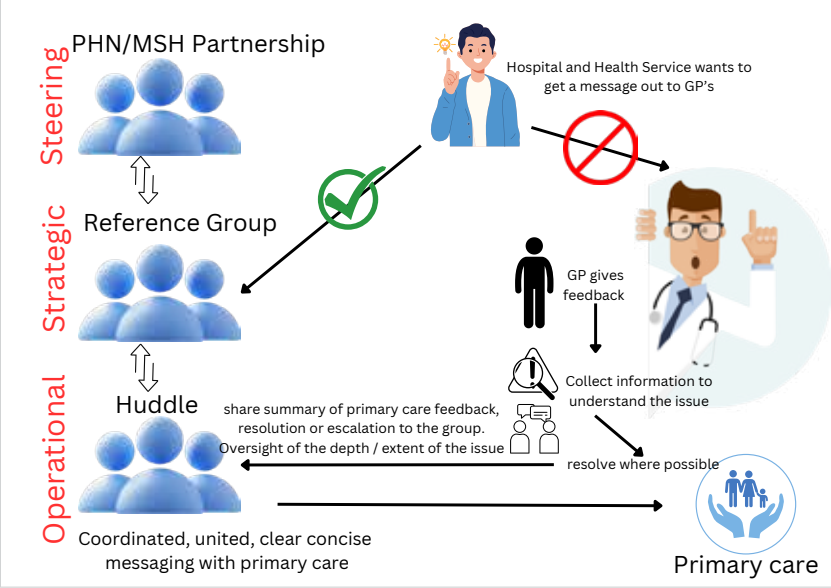


Image supplied by Metro South HHS

MATER

MATER HEALTH GPLO – GETTING BACK ON TRACK

Cath Ingram, GPLO, Mater Health

Joining Mater Health as the General Practice Liaison Officer (GPLO) in January 2023, Cath Ingram shares her experience of starting out in the role and her focus for the coming 12 months.

Mater Health (Mater) GPLO role was vacant for close to two years prior to Cath's appointment, so much work had been done to re-establish the role within Mater, and to rebuild relationships and bridge communication gaps between primary care, external stakeholders and Mater Health. Confidence is slowly returning in the community, reflected in the improved working relationships between general practice and key Primary Health Network (PHN) and Hospital and Health Service (HHS) stakeholders. This was in no small way, due to membership of the Queensland General Practice Liaison (QGPL) Network, the support, experience and knowledge of its members and the enduring foundation built by Cath's predecessor.

Being new to Mater, Cath has built an understanding of Mater Health, its mission and its work in provision of health services to public patients. From a patient perspective, there is little difference to a Queensland Health Hospital and Health Service facility in their experience. However, from a General Practitioner (GP) perspective, there are subtle differences. These are mainly to do with key modes of communication that are unique to Mater Health.

A further differentiation for GPs is that most of the Mater's services for public patients are not mapped to a specific region, unlike each HHS. The alignment of Mater public and private health services in Queensland under a single clinical governance structure provides Mater Health with opportunities to offer comprehensive, person-centred healthcare, delivered in the right place, at the right time, and by the right people.

Priority areas for the coming year include:

- Broadening the focus statewide in improving the interface between Mater Health and primary care
- Clinical communication and transfer of care focussing on specialist outpatient clinics and use of electronic letters sent to GPs via secure messaging
- Working with medical education and specialties with the ongoing education of junior doctors, and orientation and support of new principal house officers, registrars, senior medical officers and consultants in setting and supporting expectations in communication with primary health care
- Revision of Materonline.org.au as a comprehensive information source for GPs
- Working with Mater Health to position primary care relationships as a priority in the development of work processes and practices for the Mater Hospital Springfield – Stage 2 expansion, which will deliver an additional 174 public beds.

To reach out to the Mater GPLO with any enquiries, please contact: MaterGPLiaison@mater.org.au

Cath Ingram,
GPLO, Mater Health

ACKNOWLEDGEMENT
OF CONTRIBUTING ORGANISATIONS

QGPL Queensland General Practice Liaison Network

Proudly supported by Queensland Health's Clinical Excellence Queensland

Queensland Government

CCQ COUNTRY TO COAST, QLD
Healthy, connected communities

phn BRISBANE SOUTH
An Australian Government Initiative

phn DARLING DOWNS AND WEST MORETON
An Australian Government Initiative

phn NORTHERN QUEENSLAND
An Australian Government Initiative

phn WESTERN QUEENSLAND
An Australian Government Initiative

Cairns and Hinterland
Hospital and Health Service

Children's Health Queensland
Hospital and Health Service

Queensland Government

Gold Coast Health
always care

Queensland Government

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government

Metro North Health

ACKNOWLEDGEMENT
OF CONTRIBUTING ORGANISATIONS

mater

North West Hospital and Health Service

Metro South Health | Queensland Government

Queensland Ambulance Service

Sunshine Coast Hospital and Health Service | Queensland Government

Mackay Hospital and Health Service
Queensland Government

Queensland Government
Torres and Cape Hospital and Health Service

Townsville Hospital and Health Service

West Moreton Health

Darling Downs Health | Queensland Government

Community HealthPathways

QGPL Queensland General Practice Liaison Network

QGPL
Queensland General Practice Liaison Network

CONTACT US

QUEENSLAND GENERAL PRACTICE LIAISON NETWORK

admingplonetwork@c2coast.org.au
www.qgpl.org.au

HEALTHCARE IMPROVEMENT UNIT

07 3328 9148
HIU@health.qld.gov.au
Healthcare Improvement Unit

COUNTRY TO COAST, QLD

Sunshine Coast: 07 5456 8100
Gympie: 07 5482 6770
Hervey Bay: 07 4196 9800
Bundaberg: 07 4131 0800
Rockhampton: 07 4921 7777
info@c2coast.org.au
www.c2coast.org.au

CCQ COUNTRY TO COAST, QLD
Healthy, connected communities

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

Proudly supported by Queensland Health's Clinical Excellence Queensland

Queensland Government