connecting you to health

Adelaide PHN & CALHN GPs/Hospital Consultants Workshop

Summary Report
June 2019

Government of South Australia
SA Health

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An Australian Government Initiative

1 Introduction

On the 26 June 2019 Adelaide Primary Health Network (Adelaide PHN) hosted a workshop to give CALHN, General Practitioners (GPs) and Hospital Consultants working in the Adelaide metropolitan region an opportunity to identify the Opportunities and Issues involved in reaching a successful and productive working relationship and for achieving better health outcomes.

This report documents the proceedings and outputs of the Issues and Opportunities workshop held at The Precinct Conference Centre and facilitated by Brett Haly from Enzyme.

2 Objectives

The objectives of this workshop were to:

- Bring everyone to a common understanding of the background and current situation
- Identify and prioritise the Issues, Opportunities and Critical Success Factors that must be addressed in order to build a productive working relationship between Adelaide PHN, CALHN and GPs / Hospital Consultants, to achieve better health outcomes
- Identify and agree a set of next steps for success

3 Participants

There were 11 participants from across the metropolitan region – six from CALHN and five GPs.

4 Issues and Opportunities

4.1 Affinity Diagram

Participants individually brainstormed the Issues and Opportunities involved in reaching a successful and productive working relationship between Adelaide PHN, CALHN, GPs / Hospital Consultants for better health outcomes. They then selected up to six of the most important, transcribing them onto white Stikki notes (one Issue / Opportunity per sticker). The Stikkis were then placed on a wall in theme sets, and the group developed headings for each of the sets.

The affinity diagram method of combining and synthesising associated ideas was used to identify the Issues and Opportunities as follows:

A Time pressures and heavy workload

- Time pressure constraints in GP / Hospital specialist practice
- Workload of GPs and Consultants

B *Quality information from data*

- We need good data to target our care and prioritise our work (public health data and local general practice data)

C *Functionality of technology*

- Use of technology (e.g. Telehealth)
- Improved IT innovation – integrated care
- Reduce paperwork at all levels
- EMR implementation in CALHN
- Secure electronic communication (say goodbye to fax machines)
- Cost effective communication. Hospital – GP using MyHR
- Contact registry of emails for doctors +/- working hours so can easily contact both in and out of acute system

D *Respectful and productive relationships between all parties*

- Greater support for GPs
- Listening to each other's needs
- Identifying support needs of GPs of acute services
- GP practices are mostly multi-disciplinary, so we need to involve the whole sector (GPs do not work in isolation)
- Mutual recognition of the value/ role/ effort/ care being provided by everyone
- Hospital doctor's thinking GPs are slow, thick – all GPs have been junior hospital doctors and have had been guilty of it themselves
- Greater appreciation of the work of GPs and the needs of our shared patients
- Judgemental attitudes from Hospital staff re: difficult patients – they swear – they don't know a lot of words, they're frustrated. Don't send security – walk them out of the hospital
- Pain Clinic – we don't know the person or their pain – work from guidelines / must do, no flexibility, no understanding. Send back to stop all medications – get five allocated care visit (BB) + 10 psychologist / psyche BB
- Equal respected claim for the patient
- Clarify roles and responsibilities

E *Primary care funding and access*

- Appropriate funding and infrastructure
- Funding – Medicare etc doesn't always encourage / reward interventions / continuity by GPs
- Funding incentives, disincentives, inequalities
- Funding barriers / restrictions (e.g. Medicare)
- Programs being funded for a few years, then call for tenders. Funding then going to another organisation – change counsellors, psychology – mid treatment of patient
- Appropriate financial incentives for GPs and their practices to support CALHN (new money)

F *Poor clinical communication*

- Build efficient communication pathway that address patient needs. Good two-way communication
- "Seamless" communication

- **Communication** – of patient plans to GPs; of alternative strategies; early communication with specialists
- CALHN – GP communication channels – non-verbal, text, email, other
- Streamlined communication, email based GP – CALHN; clear call pathways for urgent issues
- Improving communication methods between CALHN / GPs (handover) written and verbal
- Administration / HR - recognition of time needed for communication / handover + greater access for all players to clinic letters
- Case conference so we know who is doing what, when and for how long
- Improved discharge summaries; accurate medication lists, clear plan, plain language for patients
- Discharge summaries or handover – email
- Ability to call / discuss / contact acute system prior to CTP sending into hospital

G Poor access and understanding of CALHN / Adelaide PHN services

- GP concierge – one point access to services
- Increased ability for GPs to access information about CALHN services and partnerships. HealthPathways or directory or single point of contact
- GP portal – web-based access / GP site for resources and access to patient information (path, imaging etc)
- Inpatient referral pathways other than the ED
- Established communication and core pathways for Rapid Assessment Clinics
- CALHN system navigation for external practitioners. Services they can access and associated expectations
- Advertising to GPs about services available and how to refer
- Better information with education about what CALHN / Adelaide PHN does
- A regular forum for communication between GPs and hospital doctors
- Access to expertise, Geriatrics and Clinical Pharmacy?
- More medical staff in CALHN leadership

H Lack of collaborative vision

- Common vision and governance which is patient Centred
- Lack of vision / direction for Primary – Acute Care models of contemporary care
- Involve GPs **early** in a process of change – not at the stage they have little control
- People can get lots of input they don't understand and then it goes often with no understanding of what happens then
- Primary health care for LHN workers

I Feedback pathways

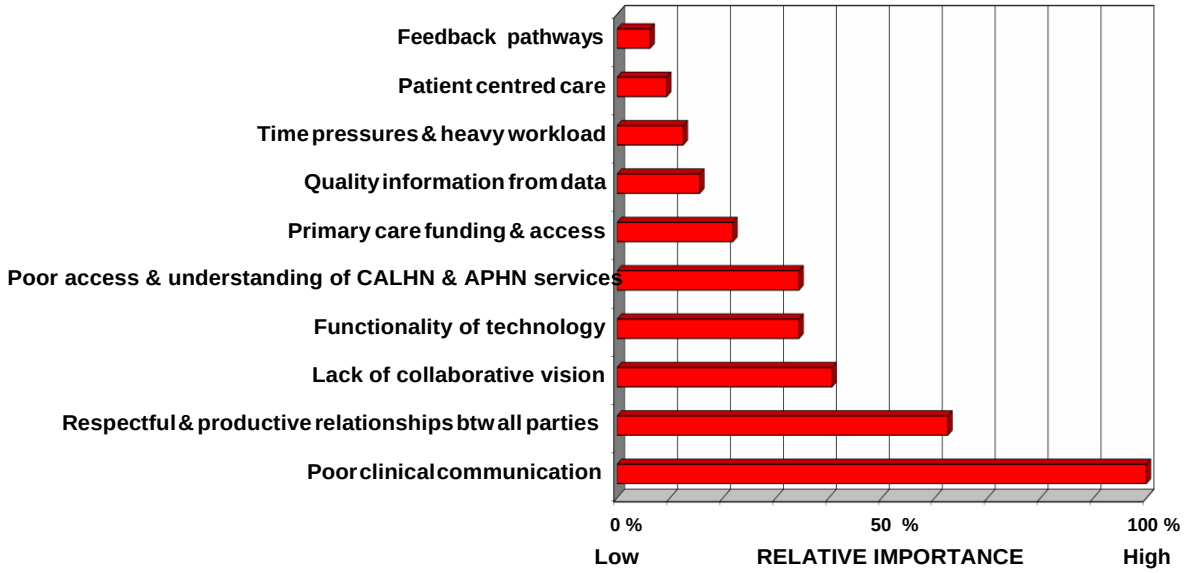
- Non-punitive pathways for performance feedback
- Ways to feedback about services and access
- Adelaide PHN competent staffing

J Patient centred care

- Difficulty accessing quality mental health services
- Residential aged care combined with EOL planning
- Risk of litigation often a driver for admission e.g. fall in RACF in px on blood thinners
- Homeless – high ED users

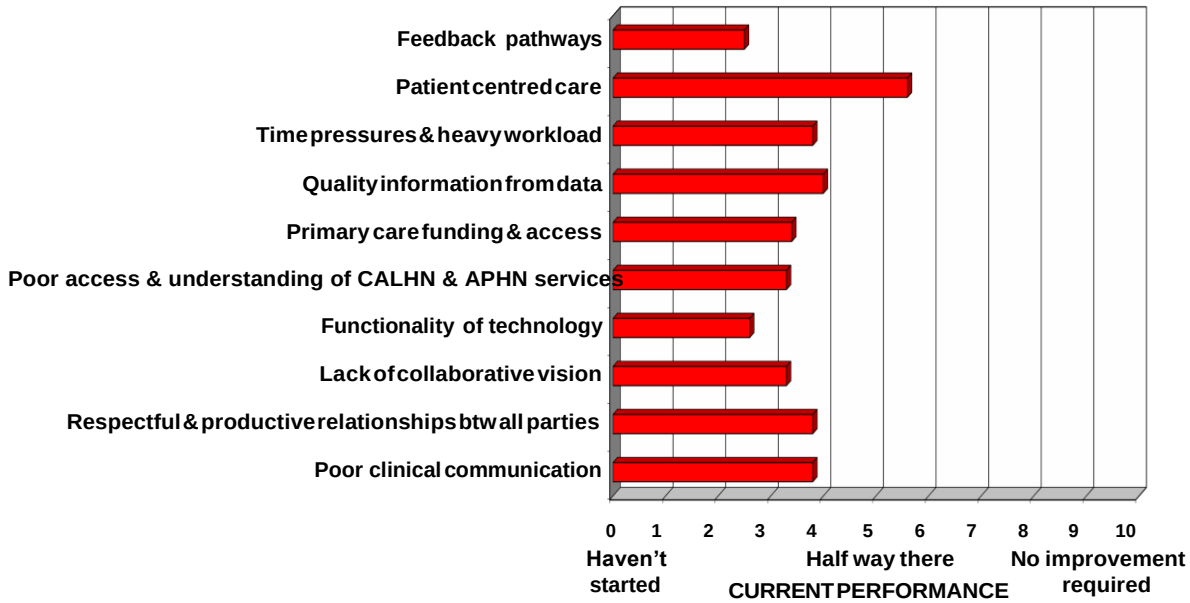
4.2 Critical Issues and Opportunities Charts

Hierarchy of Issues / Opportunities



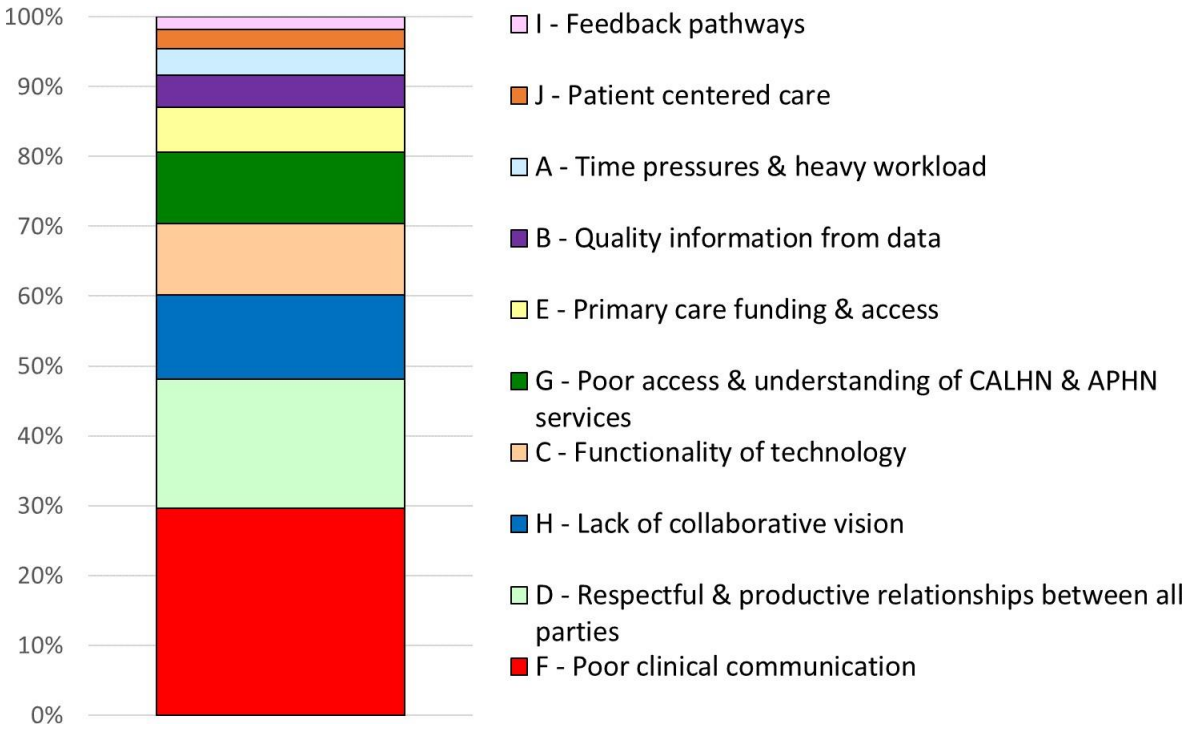
The most important Issue / Opportunity is set to 100% and the remaining expressed relative to the most important. As can be seen in the above chart the most important Issue / Opportunity is 'Poor clinical communication'.

Issues / Opportunities Performance



One of the OptionFinder® votes was Current Performance, where the Participants were asked to indicate the Current Performance of how well each Issue / Opportunity is being addressed. The outcome is shown in the above chart.

Issues / Opportunities Pareto



The Pareto Chart is calculated by adding together the scores for all Issues / Opportunities and then expressing each as a percentage of the total. It helps to identify the few Issues / Opportunities that constitute the majority of the weight of importance.

The above Pareto chart shows that approximately 80% of the total weight is coming from five Issues and Opportunities:

- *F – Poor clinical communication*
- *D – Respectful and productive relationships between all parties*
- *H – Lack of collaborative vision*
- *C – Functionality of technology*
- *G – Poor access and understanding of CALHN & Adelaide PHN services*