Outpatients co-design project

Feedback Loop: summary of ‘Discover’ and ‘Design’ phases.

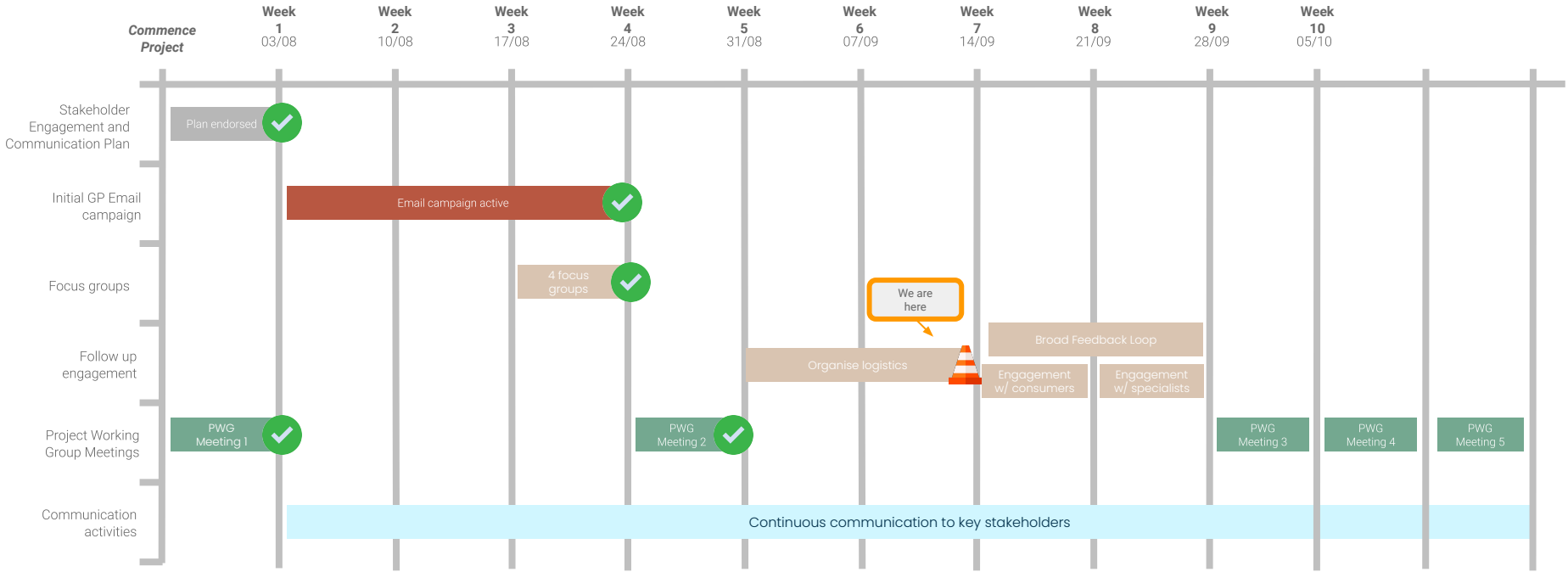
September 2020

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Hospital and Health Service

BEACON STRATEGIES

Project timeline



Discover

Engage broadly with key stakeholders to resolve immediate issues and explore what is working well and what isn't.

Define

Touch base with the project working group to define 'the problem' and determine scope and non-negotiables

Develop

Test widely with stakeholders through an online feedback loop as well as conduct targeted consultation with GPs, specialists, consumers and carers. Report back to project working group to test solutions with decision makers.

Deliver

Engage intensively with the project working group to narrow testing of prototypes, seek endorsement and commence implementation and change management planning.

‘Discover’ phase engagement snapshot

Seeking input from General Practice: Brisbane North Outpatients Co-Design Project

Are you a GP or practice manager in the Brisbane North PHN region interested in improving Metro North HHS outpatient services? We want to hear from you!

What are we seeking your insight about?
Brisbane North PHN, in partnership with Metro North HHS is inviting interested GPs and practice staff to participate in remunerated and remotely delivered focus groups relating to the redesign of the delivery of outpatient services in the Brisbane North region.

Who should attend?
General Practitioners and Practice Managers.

How do I register?
A total of 4 online focus groups of 2-hour duration will be facilitated, with up to 10 participants per group. Find a time that suits you by clicking on the link to the right.

How will the session be structured?
Focus groups will be facilitated via Zoom with the primary voice to be GPs and practice managers. Metro North HHS staff will be in attendance to support the conversation and answer questions.

What will we cover in the session?
Areas of inquiry will include:

- GP-HHS interface (information and specialist advice to guide GP decision-making, referral management and integrated models of care
- Identification of pain points and barriers
- Identification of bright spots
- Suggest areas of improvement

Session 1
When: Monday 17th August 5pm-7pm.
Where: via Zoom
Register: https://outpatients-project-1.eventbrite.com.au

Session 2
When: Tuesday 18th August, 6pm-8pm
Where: via Zoom
Register: https://outpatients-project-2.eventbrite.com.au

Session 3
When: Thursday 20th of August, 5pm-7pm
Where: via Zoom
Register: https://outpatients-project-3.eventbrite.com.au

Session 4
When: Friday 21st of August, 7am-9am
Where: via Zoom
Register: https://outpatients-project-4.eventbrite.com.au

Project background
Brisbane North PHN is assisting Metro North HHS through an engagement and co-design process with key stakeholders in primary and specialist care to redesign the management of a defined cohort of patients, specifically Category 3 referrals and outpatient models of care.

Brisbane North PHN, in partnership with Metro North HHS, has engaged Beacon Strategies to deliver the engagement and co-design process.

The recent impact of COVID-19 on specialist outpatient services and the management of Category 3 patients has highlighted an opportunity for a new approach to the delivery of outpatient services across the Metro North HHS catchment.

For more information, email codesignoutpatients@brisbanenorthphn.org.au or contact your Primary Care Liaison Officer

GPs and Practice Managers will be remunerated by the PHN for their participation.

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This activity is supported by funding from the Australian Government through the PHN program.

A total number of 4 focus groups were delivered during the week starting the 17th of August, with attendance including:

- **Session 1:** 6 GPs, 1 Consumer rep, 3 HHS / PHN staff
- **Session 2:** 7 GPs, 1 Practice Manager, 3 HHS / PHN staff
- **Session 3:** 9 GPs, 3 Practice Managers, 5 HHS / PHN staff
- **Session 4:** 5 GPs, 1 Practice Manager, 5 HHS / PHN staff

The sessions worked through the GP / HHS interface, inclusive of identifying common touch points relating to: information for GPs, specialist advice, referral management, shared care models and system/workforce development.

At each touchpoint, participants were asked to:

- **Identify issues -** what are the pain points, barriers or missing pieces?
- **Propose solutions -** what are the opportunities for improvement that would address some of these issues?

Touchpoints

Information

- Info newsletters and emails
- Health Pathways
- HHS/PHN websites
- Clinical Prioritisation Criteria
- Info from patient
- Refer Your Patient
- Handbooks
- QH performance page
- GPLO emails
- Specialist Outpatient Services Implementation Standard

Advice

- Phone calls with on-call registrar or consultant
- Virtual ED
- OPD letters
- Discharge summaries
- Advice lines (RADAR, GRACE)

Referrals

- Refer Your Patient
- Sending referral to Central Patient Intake Unit (fax or secure messaging)
- Admin letter to confirm receipt, categorisation
- Health Provider Portal / The Viewer
- GP Smart Referral
- Acute Care Team
- Request for further information or returned referral

Shared care

- Antenatal
- Diabetes (Beacon)
- Haematology
- Community palliative care
- Allied health
- Keeping Kidneys in the Community
- Rheumatology
- Mental health
- General Practitioner with Special Interest (GPwSI)

System-level

- Practice visits (PCLO)
- General Practice Liaison Officers (GPLO)
- Education events

While most of the common touchpoints between GPs and the HHS were identified in the sessions, not all GPs were aware of all touchpoints.

Issues identified

Information

- Huge volume of information
- Finding right info, right person at right time difficult
- Clinical info is OK, but practical service info harder
- Need info for GPs on services relating to non-medical presenting issues
- Lack of clear, single source
- HealthPathways needs updating and not that useful
- Overload of information in newsletters
- Not aware of all new services
- Patient management info frequently changes
- Not GPs role to understand the HHS internal 'system' - our job to make clinical decision about what patient needs
- Hard for new GPs to find out who/how

Advice

- Need to get timely info, ask specific question about a known patient
- Unsure if some conditions warrant referral
- OPD waitlist very long
- Specialists not accessible for GPs to contact
- Registrars often not adequate source of advice for GPs
- Registrar often has to call back - requires multiple calls
- Quick advice can help inform a referral decision
- No systematic or timely response to requests for advice
- Difficult to know what info needed for referral
- Obtaining imaging when only specialist can order
- Can lead to disagreement over which specialty responsible for advice (based on previous experience with GRACE)

Referrals

- Frustration with rebound/rejected referrals due to insufficient info or minor things
- Uncertainty regarding long wait times for clinics—patients ask GPs why wait so long
- Don't feel specialists actually read referrals
- One-way traffic - no easy way to communicate or update specialist
- Time lag between sending referral and acknowledgement of receipt/triage
- Lack of 'person' at other end (CPIU) and can't call to discuss a referral
- Lack of transparency around why patient is categorised a certain way
- Difficulties for patients attending F2F OPD appointments (multiple not scheduled on same day, transport to hospital, appointment times not confirmed)
- Inconsistent upload of info to Viewer, delays in receiving correspondence, and/or sent to wrong doctor
- Can't attach some test results e-referral
- GP access to Powerchart needed
- Don't always know what services a facility has
- Unclear roles in ordering and follow-up of tests
- Uncertainty around re-referrals due to COVID
- Named referrals vs public can waste GP time
- Particular issues observed with referrals to Ophthalmology, Psychiatry, Pain, Ortho

Shared care

- Post-acute care done by specialists that could be done in primary care
- Shared care models logistically difficult for GPs
- Shared care needs foundational structures, communications and understanding between GPs and specialties
- Uncertainty over roles (e.g. follow up)
- Inadequate 'care team' interface
- Models tend to be developed by specialists for GPs
- Duplication of services in some cases
- Should be working together to troubleshoot to prevent hospitalisation
- Limited advice when patient under shared care
- Specialist clinics clogged with review appointments for patients who could be managed in primary care

System-level

- **Should use telehealth more**
- Cross cultural training may be required
- GPs provide unique perspective for hospital specialists
- Separation of GP and hospital care is outdated and unhelpful to work as partners
- Lack of nurse involvement
- Not incentivised to holistically assess and manage range of presenting issues
- Education residents and registrars with how to communicate effectively with GPs
- Difficulties with registering for systems due to multiple systems
- Care closer to patient's homes
- Why mental health not part of normal referral system
- Allied health access needed
- Gaps between adult and child/youth services

Proposed solutions

Information

- Improve HealthPathways content and uptake
- Enhance routine communication (e.g. email newsletter)
- Deliver In-person information evenings and networking opportunities
- Provide Access to joint education e.g. Integrate primary care into ‘grand rounds’
- Establish a central GP hotline
- Explore nurse-led navigation models
- Design access to the Viewer to meet the needs of primary care
- Consistency in discharge processes (letters, verbal handover etc)

Advice

- Establish bi-directional communication pathway and protocols (incl. Processes for non-urgent and semi-urgent advice)
- Establish specialist advice line
- Enhance access to ‘the viewer’ (e.g. improve information availability and GP accessibility)
- Document and replicate Virtual ED
- Enhance integration of GP Special Interest roles

Referrals

- Streamline referral and discharge process in and out (incl. communication, information management, systems, training)
- Enhance access to specialists for guidance and collaboration re: interim support for patients on waiting lists
- Establish triage clinic (assess referral categories and offering initial advice on management)
- Shared real-time data re: estimated patient waiting time

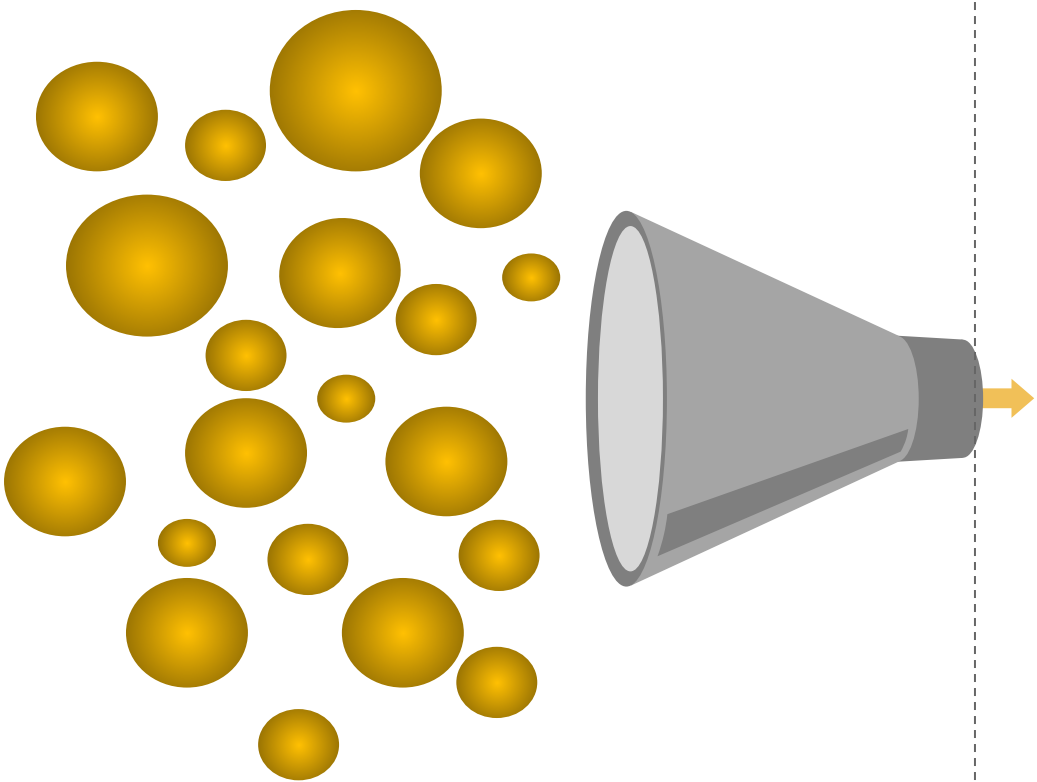
Shared care

- Establish broad shared care framework and protocols to guide delivery of shared care models across the region
- Document and summarise shared care ‘bright spots’
  - GP Alignment Program (antenatal)
  - GP/Psychiatrist MBS arrangement (MBS #291)
  - kidney shared care clinic model
- Integrate available shared care models with HealthPathways
- Increase opportunities for GP placements with inpatient/outpatient teams
- Utilise telehealth to enhance coordination between GP, specialist and patient.
- Establish Liaison Office at each MNHHS facility
- Enhance communication regarding shared patients (via email, technology)
- Real-time interaction with GPs e.g. virtual ward rounds for chronic patients

System-level

- Establish training, protocols and systems regarding bidirectional communication between Primary Care and HHS.
- Deliver relationship and networking building opportunities between each hospital and local GPs
- Facilitate training and collaboration regarding development of referral pathways
- Drive focus on patient-centered care at all levels
- Enhance access to allied health advice and specialised investigations
- Explore integrated care models (in-hospital GPs / involvement in MDTs / specialist OPD sessions at GP clinics).

Discovery & Define phase



Develop and deliver phase

1. GP Advice Lines
2. Bidirectional communication
3. Shared Care Models
4. Availability of information

Project team has facilitated an initial conversation with Brisbane North PHN's Clinical Advisory Group - gathering feedback from 8 GPs in attendance.

Project steering group prioritisation process

GP Advice Lines

Objectives

- Support the delivery of care within the community setting
- Minimise the number of referrals to the outpatients department that could be addressed in primary care with timely advice

Issues and challenges

No systematic response to requests for clinical advice available

Specialists aren't generally accessible for GPs to contact directly for clinical advice

Variable experience with registrars when seeking advice from outpatients department

Outpatients department waitlist can be long

GPs are unsure if some conditions warrant referral

GPs unsure of how to provide interim care whilst patient is on waitlist

Disagreement and confusion regarding which specialty is responsible for advice

Where is it working elsewhere?

Virtual ED: a central phone number for GPs to be connected directly to a triage nurse and emergency specialist (via phone or video) to receive advice regarding managing the patient within the community.

RADAR: central phone number to access Nurse Navigators who in turn facilitate access to hospital based and outreach services for acutely unwell and deteriorating people living in RACFs

GP Haematology advice line: direct access to an on call Haematologist 8.00am - 9.00am Monday to Friday for advice regarding laboratory results and clinical questions regarding patients.

GP Persistent Pain advice line: GP to Pain Medicine Consultant service that accessible between 9:00am and 12:00pm Monday to Friday to seek advice on acute or complex pain cases.

Local design considerations

Direct contact with doctors and specialists that are able to give clinical advice

Processes and protocols established to drive shared understanding of medicolegal issues

Ideally the availability of a single phone number in but direct linkage to relevant department/speciality

Advice must be delivered in a timely fashion acknowledging that effective advice can have a positive impact on referral decisions

Considered responses however appreciated **even over** instant advice

Dedicated focus on delivering education to GPs 'just in time' rather than 'just in case'

Preference for a mixed modality advice approach e.g. delivered via phone (urgent) and email (non-urgent).

Questions

We are seeking further feedback via a brief survey - head to the Survey Monkey link at the end of the presentation to have your say!

To what extent would establishing a GP advice line improve your experience of working with the outpatients department?

From a GP perspective, do you have anything further to add regarding the establishment of a GP advice line?

Bidirectional communication

Objectives

- Improve communication between primary care and specialists regarding known patients to deliver better patient outcomes
- Reduce unnecessary presentations to outpatients department for issues that could be dealt with in primary care

Issues and challenges

One way traffic regarding communication - there is no easy way to communicate with specialists.

Oversupply or undersupply of information re: discharge summaries depending on speciality and specialist

Referrals often rejected due to insufficient information.

Lack of information back to GPs re: patient categorisation and limited opportunity to contact specialist to discuss further.

Inconsistent use of The Viewer as a tool to enable communication e.g. sharing test results, examinations etc.

Unclear roles in ordering and follow up on tests

Where is it working elsewhere?

Metro North HHS Cardiology Speciality: patients discharged from Cardiology back to primary care are done with adequate patient information in addition to materials to enhance treatment in primary care e.g. a flow chart with accompanying guidance around how to manage issue in primary care

Rheumatology / haematology patients with positive experience

Local design considerations

Establish bidirectional communication pathway, protocols and systems across health service and define role/expectations of specialists vs. GP

Agreed and consistent referral pathways in to specialist (communication, information management, systems and training).

Direct contact (ideally by phone) with GP when discharging patient back to primary care

Develop a consistent discharge planning process (e.g. letters and level of information provided to GP).

Design access to patient information to meet the needs of primary care (e.g. system support attachments, e-referrals are compatible with common medical software)

Explore the establishment of triage clinic (assess referral categories and offering initial advice on management)

Provide advice/guidance regarding how to assess/manage patients who are on longer waiting lists as well as rapid return pathways for patients seen by specialists and discharged

Questions

We are seeking further feedback via a brief survey - head to the Survey Monkey link at the end of the presentation to have your say!

To what extent would improving bidirectional communication improve your experience of working with the outpatients department?

From a GP perspective, do you have anything further to add regarding improving bidirectional communication between GPs and specialists?

Shared Care Models

Objectives

- Primary Care and Specialists to work together to troubleshoot issues to prevent hospitalisation
- Deliver health care in the community, as close to home as possible.

Issues and challenges

Post acute care done by specialists when it could be done by GPs in primary care.

Specialist clinics are clogged with review appointments for patients who could be managed in primary care.

Circumstances where uncertainty exists over roles and accountabilities (e.g. GP vs. specialist).

Shared care models can be logistically difficult for GPs

Shared care models are generally developed by specialists for GPs

Duplication of services occurring on both sides of the fence.

Where is it working elsewhere?

GP Alignment Program (Maternity): operated through a well documented maternity GP Shared Care Guideline, supported by structured education and networking opportunities. Considered 'gold star' by many GPs.

Hematology Shared Care Program: focus on low grade haematology conditions and deliver shared care through clinical education and networking.

GP and Psychiatrist MBS arrangement (MBS #291) - GPs and Psychiatrists delivering shared care arrangements through development of a 12 month management plan generated by the Psychiatrist.

Keeping Kidneys in the Community Shared Care Program: integration between primary care, GPs with Special Interest and nephrologists of Metro North Kidney Health Service. Focus on training, education and networking.

Local design considerations

Ensure foundational structures are in place (communication, shared understanding, protocols and frameworks between GPs and specialists).

Ensure a strong focus on education workshops, networking opportunities and relationship development.

Explore innovative ways to integrate primary care and specialists e.g. specialist clinics in the primary care setting and real-time interaction with GPs e.g. virtual ward rounds for chronic patients.

Utilise and integrate HealthPathways as a tool to enable shared care approaches.

Utilise telehealth to enhance coordination between GP, specialist and patients.

Consider utilisation of diverse workforce e.g. social workers/nurses for effective delivery of shared care models.

Questions

We are seeking further feedback via a brief survey - head to the Survey Monkey link at the end of the presentation to have your say!

To what extent would establishing shared care models improve your experience of working with the outpatients department?

From a GP perspective, do you have anything further to add regarding establishing shared care models?

What specialties should be an immediate priority for development of shared care approaches?

Availability of Information e.g. HealthPathways

Objectives

- Improve HealthPathways content and uptake
- Improve visibility of referral pathways to and from outpatients department
- Allow GP's to manage patients in the community and assess whether onward referral to outpatients is required

Issues and challenges

No clear single source of information relating to localised referral pathways

Many GPs don't like using HealthPathways due to usability issues

GPs report that many available HealthPathways are not localised or relevant to Brisbane North context

GPs have to access and navigate a huge volume of information and need to access the right info, just in time

Limited practical service information available for GPs to refer patients to e.g. locally available support services.

Patient management information changes regularly and it is hard to be across everything.

Not perceived as GP's role to understand the HHS internal system

Where is it working elsewhere?

Brisbane North PHN: Some Brisbane North GPs state that they use HealthPathways regularly and are happy with the level of detail.

HealthPathways Melbourne: Joint funded by NWMPHN and EMPHN with over 713 pathways published. Availability of analytics (new pathways established and volume of user access by pathway). PCLO team actively train practices to increase uptake.

WAPHA: 537 pathways published and GPs regularly collaborate in exchange for CPD points. Supported by online webinars and extensive toolkit.

Local design considerations

Consolidate or differentiate use of HealthPathways and Refer Your Patient

Localise and update HealthPathways, starting at most relevant/widely used pathways relating to the outpatients department.

Consistently promote and communicate about HealthPathways as the 'tool of choice'

Store referral and patient management information in a central place with a good search engine to access relevant information

Integrate information regarding HealthPathways with education and networking opportunities to increase uptake.

Consider the utilisation of HealthPathways alongside Nurse-led navigation models and Peer-led navigation models.

Specialists to be engaged in pathway development and redirect/education GPs on availability of information.

Questions

We are seeking further feedback via a brief survey - head to the Survey Monkey link at the end of the presentation to have your say!

To what extent would improving the content and uptake of HealthPathways improve your experience of working with the outpatients department?

From a GP perspective, do you have anything further to add regarding improving the content and uptake of HealthPathways?

Feedback loop ‘call to action’

Next steps

In addition to opening a **broad feedback loop** for further GP insight, the project team is conducting concurrent **targeted engagement** with: Metro North HHS specialists and consumers/carers to gather insight from other critical perspectives.

All consultation will be concluded by Friday the 25th of September. At this point, a **series of co-design meetings** will be facilitated with the project steering group to further develop, prioritise and plan for the delivery of possible solutions.

What do we need from you?

We need your advice and insight regarding regarding how to further develop and operationalise each of the programs of interest.

GP Advice Lines

Bidirectional communication

Shared care models

GP information (e.g. HealthPathways)

Head to the link below to have your say!

https://www.surveymonkey.com/r/metronorth-OPD-survey