

# General Practitioners in Community Health Project

Improving Health in Hepburn  
Shire.

GP's Strategy Projects review Forum 2007

# Overview

- 2 year Funded Project, starting Jan 07
- Rural setting, low income, limited access to GP
- 2 GP Practices- EFT 8.0
- CHS- AHP
- Transport- limited

# Aim of Project

To develop a sustainable model of integrated health care & care planning that will improve the health status of people with a chronic disease living in Daylesford.

- Improved access to both GP & CHS
- Improved communication , integration and co-ordination of health care

# Planned Action –Establish a Model

- Project Team-Project Manager, 2 Primary Health Care Nurses, Diabetes Educator
- Steering Committee/working group formed and meet 2/52
- Registers and recall systems-Diabetes
- Referral systems & IT systems

# Planned Action- Establish a Model

- Increase MBS/EPC items uptake
  - GPMP, TCA, EPC referrals
- Recruit private practitioners-AHP
- Existing practitioners included
- All patients with diabetes included

# Planned Action- Implementing the Model

## ➤ Patient Handheld record

- Includes all information for pts
- Includes all information for practitioners
- Prevents duplication
- Allows pt to begin “self management”

# Planned Action

## Ensuring Sustainability

- Up to date recall and register
- Priv. AH Practitioners self funded
- Public practitioners increase in no. pts
- Practice nurses self fund through MBS

# Expected Outcomes for Patients

Target: Diabetes - increase in at least 20% of pts;

- with HbA1c < 7
- with BP < 130/80
- Cholesterol < 4.0
- Annual cycle of care
- TCA
- Increase allied health visits – MBS

# Results- Initial

- MBS item numbers-

(Jul-Dec 06) 144      (Jan-June 07) 217

Significant increase in Item 723-TCA

- SIP increases 58%-79%, 40%-70%

- Diab Ed- (Jun-Dec 06) 274 pts with 38 referral from GP, (Jan-Jun 07) 313 with 96 referral GP

- Increase in Priv Prac visits- fortnightly

# Outcomes for the Community

- Access to AHP-public and private
- Non cardholder v “working poor”
- Self management/responsibility
- Ongoing checks
- Better health-for all not just the motivated

# Enablers

- Communication between practitioners
- Sharing of information & ideas
- NPCC
- Community- overlap between LGA and HHS

# Challenges

- Consistency
  - Between GP
  - Allied Health
- Paperwork
  - Excessive
  - IT
  - Time
- CHC Reception-impact

# Reflection

- E-referral
- Access to GP and staff
- Feedback from patients
- For all people in Daylesford/ Trentham
- Review, review, review!