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Collaborative Research Hub – Summary of key papers

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<td>• Assist in identifying strategies to support teamwork and team based models of care; • Provide evidence of frameworks and funding models that encourage collaboration; • Facilitate greater understanding of the role of PHCOs in supporting multidisciplinary team based care.</td>
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### Knowledge Networks in Primary Health Care

Two papers exist under this briefing series, each of which is outlined below.

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| **The Role of Knowledge Networks in Primary Health Care: Key Findings** | This briefing series explores the impact of the translation of knowledge into practice and policy in relation to reform in primary health care. | Provides a framework to:  
  - Facilitate the rapid understanding and adoption of health care reforms;  
  - Foster collaborative policy and planning;  

| **The Role of Knowledge Networks in Primary Health Care Reform** | | | |

### General Practice Liaison - supporting the GP-hospital interface

| Key findings of evidence base: Role of GPLO in supporting the GP-hospital interface | This briefing series provides key findings on the impact of the General Practice Liaison Officer (GPLO) role in supporting the primary-secondary care interface, highlights key barriers and challenges, potential future models of supporting the GPLO role and the policy drivers for workforce planning. | Provides a governance and leadership framework to supporting cross sector integration;  
  - Documents the system level platforms required to supporting the GPLO role;  
  - Provides a useful platform from which to advocate and develop policy in this area. | [www.gpqld.com.au](http://www.gpqld.com.au) |

| Policy implications for practice: role of GPLO in supporting the GP-hospital interface | | | |

| Workforce policy implications for practice: role of the GPLO in supporting the GP-hospital interface. | | | |
Summary: Knowledge networks in primary health care

This Knowledge networks in primary health care briefing series explores the impact of the translation of knowledge into practice and policy in relation to reform in primary health care.

Overview of key findings

- Knowledge Networks are formal networks that bring together experts from different fields around a common goal or issue;
- Knowledge Networks provide a key platform for supporting the rapid adoption and generation of health information within the primary health care sector to advance health care services;
- Knowledge Networks have the capacity to provide a strategy for the adoption of innovation in health care as they are positioned at the nexus between research, policy and practice.

Barriers and challenges within the current system

- Passive dissemination of information is insufficient to bring about change;
- Delays occur between knowledge creation, innovation and uptake into practice;
- Lack of a current platform in Australia to coordinate the interaction required to draw upon knowledge and facilitate its translation across the whole of the health sector.

What action is required?

- Engagement of practitioners in the creation of information and consensus regarding its meaning;
- Creation of an expanded learning community that can develop and disseminate knowledge rapidly across artificial divides;
- Research and evidence which is more relevant and meaningful to practitioners, policy makers and consumers;
- A consistent, integrated response, during periods of reform and change;
- Partnership and collaboration;
- Building of an evidence base and leadership capacity that will support healthy communities.
Report: Knowledge networks in primary health care

Dr Kylie Armstrong and Professor Elizabeth Kendall

This briefing was prepared as part of a primary health care research collaboration between Griffith University and General Practice Queensland.

This briefing explores the impact of the translation of knowledge into practice and policy in relation to reform in primary health care. The key findings are a summary of the publication Armstrong, K., & Kendall, E. (2010) Translating knowledge into practice and policy: the role of knowledge networks in primary health care, Health Information Management Journal, Vol 39 No 2 2010 ISSN 1833-3583 (PRINT) ISSN 1833-3575 (ONLINE), 9-17. This paper was also presented at the Inaugural World Health Care Networks Conference in Auckland, New Zealand June 21-24, 2010.

Background

The establishment of Knowledge Networks provides a promising method for supporting the rapid adoption and generation of health information within the primary health care sector to advance health care services. Local Knowledge Networks provide a platform to support innovation in health care through a collaborative approach designed to influence health policy and planning, thus driving systematic and institutional change. Knowledge Networks have the capacity to provide a strategy for the adoption of innovation in health care as they are positioned at the nexus between research, policy and practice. These networks will be particularly important to the implementation of the national reform agenda in providing responsive decision-making and the translation of new frameworks into practice.

Demand for primary healthcare services is expected to increase in the future. Factors such as the rise in chronic and complex chronic disease, an ageing population with multiple comorbidities, workforce shortages, geographical dispersion, increasing health care costs, advances in technology and changes in inter-professional service delivery models of care (Humphreys & Wakeman 2008; National Health and Hospital Reform Commission 2009; Tran et al. 2008). There is recognition that we must invest in preventive healthcare and early intervention (Armstrong et al. 2007, National Health and Hospital Reform Commission NHHRC 2009; Dooris 2004; Swerissen & Taylor 2008) and address social inequality in health, especially for Indigenous Australians (NHHRC, 2009; National Preventative Health Task Force 2009).
Policy and Practice Reform – The Role of Knowledge Networks

Australia is currently faced with significant changes associated with reform in the health care sector and there is a need for support to provide the growth and leadership required to sustain the proposed primary health care vision (Jackson & Nicholson in press). This is particularly important in recognition of the proposed new models of Primary Health Care Organisations (PHCO)/Medicare Locals that were recently announced by the Australian Government as the foundation pillars and mechanism to support the implementation of primary health care governance and leadership. Our hospital system and GP-led primary care system must work together to provide an integrated, coordinated and seamless service to the Australian people. This includes working closely with Local Hospital Networks and PHCO’s to ensure that innovation and the adoption of research is translated into practice.

We know from International research that countries with stronger primary healthcare systems, effective chronic disease management models and support for addressing the systematic determinants of health, have better health outcomes and lower costs (Starfield & Shi 2007; Swerissen & Taylor 2008). However, we know from reform experiences in both Canada and the United Kingdom that strategies are needed to support the transformation and improvement of our primary healthcare system. Mere exposure to information and new models of practice is insufficient to bring about change. We have learnt from these international experiences that transformation of evidence is dependent on:

• The presence of key agents of change;
• The accumulation of collective knowledge of the evidence;
• The development of critical mass and;
• The full engagement of the clinical and community sectors to drive local activity (Baum 2007; Dobbins et al. 2009).

Collaborative and interactive mechanisms between researchers and practice/decision-makers are fundamental to the exchange of knowledge and its utilisation in practice. Having access to current knowledge to enable informed decision making to - review, consider and evaluate its implications for policy and practice are fundamental. However, acquiring these skills is a complex process, which requires an interactive, collaborative approach to effectively support and communicate information so it can be easily adopted into practice (Graham et al. 2006; Innvaer et al. 2002; Jacks et al. 2010). Strategies are required to incorporate more research evidence into the policy development process (Kalucy et al. 2009; Lomas et al. 2005). A new way of organising and sharing evidence will be necessary to achieve the translation of knowledge into practice and policy.
This approach must focus on:

- Engagement of practitioners in the creation of information and consensus about its meaning in practice.
- Creating an expanding learning community (Kalucy et al. 2009; Kilpatrick et al. 2003) that can develop, disseminate knowledge rapidly across artificial divides.
- Research and evidence which is more relevant and meaningful to practitioners, policy makers and consumers …………if it is to influence the future shape of health services in Australia.
- A consistent, integrated response, particularly during this turbulent period of reform and rapid change.
- Partnership and collaboration.
- Build the evidence base and leadership capacity that will support healthy communities.

The reform recommendations of A Healthier Future for all Australians (2010) highlighted the importance of leadership and the formation of agencies that could act as platforms for creating healthy communities and integrating these elements of the health system. The establishment of regional primary healthcare organisations (PHCOs) as a key recommendation from the reform commission and the National Health and Hospitals Network: Further Investments in Australia’s Health (Department of Health and Ageing 2010b) were endorsed by the Council of Australian Governments (COAG) other than Western Australia, to support major reforms and injection of funds into the Australian health system (COAG Communiqué 19 & 20 April 2010). The PHCO’s provide a pathway to support strengthening and increasing support in primary health care as a strategy to improve efficiency, reduce hospitalisations and mortality, address inequality and access and improve health outcomes. Although the full implications of the reform recommendations on primary healthcare have yet to be understood, now, more than ever, there is a need to draw on our current knowledge in order to shape services in the future. No current platform exists in Australia to coordinate the level of interaction that would be required to draw on this knowledge and facilitate knowledge translation across the whole health sector. Knowledge Networks have the potential to provide such a platform as a cross-sectoral interface for knowledge translation and innovation.

Emerging Knowledge Networks – Queensland Context

New ways of supporting and facilitating good research practices and improved primary health care outcomes are required to not only support practitioners who want to conduct research, but also to support entire PHCO’s, which will need relevant research “on-demand” information to inform planning and health outcomes. In Queensland, the establishment of the Collaborative Research Hub (www.gpqld.com.au/page/Partnerships) was a response to this need and has a key focus on increasing the relevance and use of health service research to inform primary health care decision-making by facilitating knowledge transfer and exchange. The Collaborative Research Hub provides an important nexus between the primary health care and research sectors, maintaining a focus on collaborative projects that engage relevant stakeholders in the pursuit of solutions. The Collaborative Research Hub engages in knowledge transfer through “linkage and exchange” (Lomas 2005) – the interaction,
collaboration, and exchange of ideas. This collaboration aims to increase the dialogue between researchers, service providers, funding bodies and consumers at each of the critical stages of development in setting priorities, doing the research, sharing the findings and ensuring end-user application.

The Collaborative Research Hub provides knowledge translation and exchange activities, which has also led to the proposal of Knowledge Networks as a strategy to meet the challenges of the current reform agenda. The role of decision makers involved with Knowledge Networks is fundamental to supporting the translational research agenda. Active participation and engagement of health managers, early dissemination of key findings and discussion about the implication of these findings in practice are key elements of the Knowledge Networks and are critical to supporting the adoption of evidence in practice. Collaboration and partnership development also plays a key role and Queensland Partnership Councils supported through the Connecting Health Care in Communities (CHIC) Initiative would be well positioned as regional structures to support the emergence of Knowledge Networks in advancing innovation in service delivery.

The proposed Knowledge Networks would focus on four identified priorities, which have been informed by a combination of sources. These priority areas include:

1) Health promotion and preventive medicine;
2) Capable consumers;
3) Coordinated systems of care; and
4) Workforce development.

It is intended that the Knowledge Networks would include both public and private representation and would require a mixed funding allocation model including all stakeholders, but with predominant government investment for establishment and maintenance. In each priority area, the proposed Knowledge Networks would support building participation and capacity in the application of existing and new knowledge to inform the practice community and decision-makers. When fully established, the Queensland Knowledge Networks will contribute to a reflective and collaborative approach to reform in primary health care, providing a platform for discussion and supporting the process of translation. The KTE activities will address a range of identified areas of critical need. They will bring together diverse databases, collective knowledge and inter-disciplinary skills to inform policy development with a view to improving health capacity for Queensland including health managers and policy makers who support translational research through the adoption of evidence informed approaches.

References


Summary: Multidisciplinary team based approaches in primary health care

This Multidisciplinary team based approaches in primary health Care briefing series provides an overview of the impact of the health reform agenda on team based approaches to primary health care.

Overview of key findings

- Teamwork and collaboration in health care are key priorities within the health care reform agenda;
- Demand for access to primary health care is increasing;
- Strong support and recognition is given to the need to invest in multidisciplinary team based models of care;
- Integrating the health care system through multidisciplinary team based care provides benefits including – efficiency, responsiveness, safety and quality of care, reduced workload burden and improved health outcomes.

Barriers and challenges within the current system

- Fragmentation between Medicare and other funded health care programs;
- Few incentives for the provision of coordinated services;
- Workforce supply;
- Dominant GP fee for service payment systems;
- Burdensome administrative systems;
- No clear terminology consensus regarding multidisciplinary team based care;
- Complexity regarding integrated electronic health care records;
- Limited integration of team based approaches to education, training and professional development.

What action is required?

- Clear terminology regarding ‘multidisciplinary teamwork’ in primary health care;
- Clearly defined roles and competency standards for members of the multidisciplinary team;
- Development of communication protocols to support cross-sector coordination and collaboration;
- Scoping of funding and business models to support teamwork in practice;
- Ongoing workforce development to expand roles and skill-mix;
- Research and development into the relationship between teamwork and health outcomes;
- Development of evaluation tools, indicators and checklists for teamwork;
- Education on best-practice models through knowledge translation strategies aimed at supporting innovation in multidisciplinary teamwork.
This briefing was prepared as part of a primary health care research collaboration between Griffith University and General Practice Queensland. The collaborative partnership with Dr Lucio Naccarella from the University of Melbourne, Health Workforce Australia and General Practice Victoria is acknowledged as part of an emerging Workforce Knowledge Network.

This briefing explores the impact of reform on team-based approaches, barriers to teamwork and common themes and characteristics of multidisciplinary teams.

Teamwork: Reform Priorities and Impacts

Teamwork and collaboration in healthcare are ‘priority’ issues for Australians, with recent reform reports (National Health and Hospital Reform Commission NHHRC, 2009; National Preventative Health Task Force, 2009) highlighting this as a priority. Chronic and preventable illness has reached the point where we can no longer sustain the level of burden of disease (Productivity Commission, 2005; Swerissen & Taylor, 2008). Demand for primary healthcare systems is expected to increase due to an ageing population with multiple co-morbidities, an increase in chronic and complex disease, workforce shortages, increasing health care costs, advances in technology and changes in inter-professional service delivery models (Armstrong & Kendall, 2010; Humphries & Wakeman, 2008; NHHRC, 2009; Tran et al., 2008). These challenges are coupled with the uncertainty of how best to balance the funding of health services across the public and private sectors (Armstrong et al., 2007; Muenchenberger & Kendall, 2010). There is strong support and recognition that we must invest in multidisciplinary team based models using collaborative partnership approaches which support integration and coordination of health services (Hills et al., 2007; NHHRC, 2009; Mitchell, 2008; Naccarella et al., 2010a; Pinnock et al., 2009; Tieman et al., 2010; Yates et al., 2007; Quinlan & Robertson, 2010; Zwar et al., 2006). It is now widely recognized that no single profession can meet the primary care needs of Australian communities, and that expanding the skill-mix through multidisciplinary team based care provides the opportunity to enhance the quality, efficiency and responsiveness of care. Integrating elements of the health system to support team based care creates the potential for economies of scale. In Australia, a spectrum of team-based models of care has emerged to address these challenges (Naccarella et al., 2010a).

A healthcare system that supports multidisciplinary team based care can improve the quality and safety of patient care and reduce the workload burden of health professionals through supporting a coordinated, integrated collaborative service delivery model (Harris et al., 2009; Naccarella et al., 2010a; Zwar et al., 2007). Strengthening and increasing support in primary health care is already a well established strategy used to improve
efficiency, address inequality and access, reduce hospitalisations and mortality and improve health outcomes (Armstrong and Kendall, 2010).

Barriers to Teamwork

The Australian health system is complex, multifaceted and characterised by non-linear interactions, with networks of open feedback-loops which includes populations in which people influence each other’s behaviour across time and in unpredictable ways (Ehrlich et al., 2009). ‘Linkages between Medicare and other funded programs (e.g. state based programs, community care programs) are fragmented’ (Swerissen & Taylor, 2008: 6), and considerable time and effort are invested in trying to integrate the various elements of the system. The Commonwealth’s current Medicare service items for prevention and management of chronic disease are restrictive, complex and are counter-productive to developing an integrated team based approach. There are few incentives for practitioners to provide coordinated services across health and social services (Swerissen & Taylor, 2008). The complexity is further fragmented, as there is overlap between state based initiatives, commonwealth funded Medicare item numbers and the Department of Health and Ageing funded NGO’s like divisions of general practice and Domiciliary Nursing Agencies.

No consensus exists in terms of the definition of multidisciplinary team based care. Terms such as multidisciplinary, interdisciplinary, inter-professional, coordinated care, teamwork are often used interchangeably, creating a complex phenomena. There is a need for more definition of team member roles and greater understanding about how best to support information and communication transfer across teams. Addressing barriers, particularly around funding models, and change management around leadership, cultural norms and behaviour change to support a team led approach versus a silo-orientated model are required. It is necessary to create opportunities for health professionals to engage in critical reflection and dialogue with other health professionals, ensuring that clinical champions who advocate for team based approaches are supported as well as integrating team based approaches into education, training and professional development (Naccarella et al., 2010a&b; Zwar et al., 2006 & 2007).

Research on multi-disciplinary teamwork over the past 30 years has been limited. Despite gaps in the evidence, the concept of multidisciplinary team based care and collaboration in primary health care is broadly supported as an effective means of coordinating care delivery. Facilitating teams of health professionals to work in collaboration and with the individual, family and carers to provide a tailored package for the client/patient is a key priority of health reform in Australia. Key skills for the future will include collaborative planning and monitoring the broad determinants of health and working in partnership across sectors (Gudes et al., 2010; Muenchenberger & Kendall, 2010).

The current funding models and incentives in Australian primary health care setting come from a mix of Commonwealth and state level programs. The funding model is a dominant GP fee for service payment system with burdensome administrative systems and a focus on process as opposed to client/patient outcomes. In 2007, the Australian Government emphasised the importance of multidisciplinary teams care in managing chronic and complex conditions by announcing new MBS item numbers for Chronic Disease Management (CDM); the General Practice Management Plans (GPMPs) and Team Care Arrangements (TCAs). According to Naccarella et al. (2010a), there has been no rigorous evaluation of the extent to which these item numbers have encouraged GPs to work as part of multidisciplinary teams to improve client/patient care. Other researchers have
concluded that there is no indication that the items have improved communication between primary health care professionals or improved teamwork (Harris et al 2009; Mitchell et al 2008). The barriers that have been identified to the use of these item numbers have included: paperwork, time delays, workload issues, change in treatment goals; inconsistency between referral processes (Harris et al, 2009; Hartigan et al 2009; Mitchell et al, 2008) and the lack of reimbursements for allied health and nursing. According to Naccarella et al. (2010a), the introduction of these items is based on the assumption that the GP will retain the lead and coordinating role within a team even when this may not be in the patient’s best interests or be desired by the team.

Another government initiative aimed to support collaboration within primary and secondary health care was the Practice Incentives Program (PIP). However, this program provides payments for achieving capacity rather than funds to invest in building that capacity in the first instance. This focus has meant that collaborative outcomes have been pursued without considering the process. Ironically, such an approach can have a negative impact on the development of teamwork. A practice nurse subsidy (MBS Item) was also introduced to support the involvement of practice nurses in chronic disease prevention and management. This item was designed to encourage collaborative work between GPs and nurses to produce improved services overall. However, the MBS Item number limits the nurse to specific tasks and requires GP approval for the task. Thus, this item number inadvertently acts as a barrier to true collaborative teamwork (Harris & Harris 2006; Harris &Zwar 2007; Mitchell et al., 2008).

Electronic health systems and integrated electronic health records (IEHRs) have the potential to improve teamwork processes as they allow the sharing and quick access of information by a range of health professionals. Dennis et al. (2008) identified the potential for IEHRs to improve teamwork, but noted that this was conditional upon professionals being provided with suitable training and incentives to apply electronic methods. Currently, the complex challenges associated with using these programs remains a barrier to the effectiveness of incentives to encourage introduction of IEHRs.

Models for Supporting Teamwork

The context plays a significant role in driving team based care. Specifically, consistent policies; human resourcing; supportive frameworks and funding models can encourage collaboration (Canadian Health Research Foundation, Teamwork in Healthcare, 2006; Kendall et al., 2009; Tieman et al., 2007; Zwar et al., 2006). There is agreement that teams are defined by several features, including efficiency, flexibility, shared goals, a holistic view of the client/patient, good communication, minimal structure, parallel approaches, and the personal and professional characteristics of participants (Hills et al., 2007; Naccarella et al., 2010a; Tieman et al., 2007; Zwar et al., 2006 & 2007). Kendall et al., (2009) identified a combination of key elements that are required to facilitate continuous client experiences, including: coherent information transfer; inter-professional and cross-service communication; interaction with a parsimonious team of professionals who have clearly defined roles and; the opportunity to develop an interpersonal relationship with one or more members of that team. There must also be sufficient flexibility to adjust to the changing needs of the individual over time. To provide a holistic response requires input from a diverse range of health professionals, community workers and non-physician workers in supporting the client’s needs.

Nurse-led models of care have seen considerable growth and interest as an emerging key strategy in reforming primary health care by expanding the skill-mix and workforce
demand management strategies (Kendall et al., in press; Naccarella et al., 2010ab; Patterson et al., 2007). Zwar et al. (2007) noted that supporting training of primary care staff in a multidisciplinary team approach (for the management of chronic disease), with clear role delineation and financial incentives to support nurse-led models of care was required. Naccarella et al. (2010b) at a recent International Medical Workforce Collaboration in New York, USA (May 2-5, 2010) highlighted key factors that can influence teamwork including the: ‘extent to which organisational context supports team working; types and levels of leadership available to the team; team composition including the mix of skills, knowledge and experience; extent to which members have shared objectives, communicate, make decisions jointly, support innovation and review working progress; extent to which funding arrangements reward teamwork; the available practice infrastructure and support; attitudes to teams/team work within the team; extent to which team members have had inter-professional education, learning and training opportunities; and extent to which regulatory mechanisms support/value/reward teamwork’ (Adapted from Naccarella et al (2010b; p 4) - based upon key references: Grumbach & Bodenheimer, 2004; Lemieux-Charles and McGuire, 2006; McNair et al., 2005; Mickan, 2000; Oandasan et al., 2006; Sicotte et al. 2002). Thus, it is critical to improve the capacity and expertise of the health workforce in addition to providing incentives, tools and processes to facilitate team work (Ehrlich et al., 2009; Naccarella et al., 2010a; Wolff & Boult, 2005; Zwar et al., 2006 & 2007).

To support team based care will require considerable education, attitude change, leadership and collaboration (Naccarella et al., 2010a). According to Sibbald et al. (2004), workforce capacity can be increased in several ways, namely by enhancing the role of some professionals, substituting one type of worker for another, delegating tasks both vertical and horizontal or through innovation (i.e. the creation of new roles or new workers). To address any of these methods, Naccarella et al. (2010b) highlighted the importance of changes to undergraduate training for the medical and allied health workforce to embed inter-professional education and learning initiatives into curricula and clinical practice placements. Regional health organisations must also play a key role in facilitating and supporting multidisciplinary teamwork. Meso-level organisations, such as Divisions of General Practice, can support teamwork by providing information management systems, decision support systems, disease registers, coordinating networks, facilitating coordinated care teams, establishing links between specialists and programs, providing liaison officer support roles, supporting practices to access funding for teamwork under the Medicare Item numbers and supporting the use of collaborative methods and tools (Gudes et al, 2010; Naccarella et al., 2010a).

The Australian Government is increasingly supporting and encouraging linkages and collaboration to support teamwork between primary health care providers, particularly for clients/patients with complex chronic needs (Department of Health and Ageing, 2010b; NHHRC, 2009; COAG, 2010). The final report of the NHHRC (2009) made many recommendations that reflected a shift towards team based multidisciplinary care, including cross-organisational partnering. Collective action at the level of the team is clearly being seen as a way of addressing fragmentation in the health system and facilitating the broader integration of services and the development of shared models of care (Whitehead, 2007). As demand for primary health care systems increases, so too does the need to invest in alternative workforce models of team based care. Models should focus on establishing supportive environments and building capacity as a way of using available incentive approaches, which aim to influence and develop the capacity to engage and support teamwork in practice.
Reference


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Summary: Role of the GPLO in supporting the GP-hospital interface

This Role of the GPLO in supporting the GP-hospital interface briefing series provides key findings with regards to the impact of the General Practice Liaison Officer (GPLO) role in supporting the primary-secondary care interface, highlights key barriers and challenges, the potential future models of care to support the GPLO role and the policy drivers for workforce planning.

Overview of key findings

- Demand and pressure on the interface between the primary and secondary care interface is expected to increase for a range of reasons;
- The primary – secondary care interface is recognised globally as a key organisational feature of the health system;
- The role and functions of GPLOs have emerged as critical change management positions in influencing successful outcomes and systematic change.

Barriers in the current system

- Lack of clear governance and leadership in supporting the GPLO role;
- Lack of GPLO role definition, identified priorities, strategic objectives and guiding framework to support improved integration and coordination of services across the primary-secondary interface;
- Limited access to education, training and professional development for health professional teams in supporting the primary-secondary interface;
- Limited support and networks for clinical champions who advocate for GP-hospital approaches;
- Complexity with regards to integrated electronic health records which have the potential to improve GP-hospital work processes.

What action is required?

- Development of a statewide framework for GPLO in supporting the primary-secondary care interface;
- Collaborative partnering to support management systems, leadership and governance;
- Development of communication protocols which support cross-sector coordination and collaboration;
- Scoping of funding models to support embedding the GPLO role within the health system;
- Mapping of other Queensland ‘liaison’ and ‘advisory’ roles including defining and identifying how these roles interface with the GPLO role;
- Research and development into the impact of the GPLO role in influencing system level change and health outcomes for consumers.
Report: Role of the GPLO in supporting the GP-hospital interface

Dr Kylie Armstrong and Professor Elizabeth Kendall

This briefing was prepared as part of a primary health care research collaboration between Griffith University and General Practice Queensland.

This briefing provides key findings with the regards to the policy drivers in supporting the GPLO role across the GP-hospital interface.

Primary-secondary system level challenges

The primary-secondary care interface is recognised globally as a key organisational feature of the health system (Powell Davies et al., 2006; Stafield & Shi, 2007; Starfield et al., 2005; Swerissen & Taylor, 2008; Towards a National Primary Health Care Strategy, 2008). Timely access to hospital services is important for improved patient health outcomes and demand on other areas of the health system (Australian Institute of Health and Welfare AIHW, 2010; Swerissen & Taylor 2008).

There is strong support and recognition that we must invest in alternative workforce models, using collaborative partnership approaches, to support cross-sector integration and coordination of health services (Hills et al., 2007; NHHRC, 2009; Nicholson, 2009; Mitchell et al., 2008; Naccarella et al., 2010a; Pinnock et al., 2009; Tieman et al., 2010; Yates et al., 2007; Quinlan & Robertson, 2010; Zwar et al., 2006).

The GPLOs have emerged as critical change management positions in influencing successful outcomes and systematic change in this area (Comms Team, 2009; Jackson & Nicholson, In Press; Queensland Health, 2007).

Barriers to supporting primary-secondary interface

- Lack of clear governance and leadership in supporting the GPLO roles (Jackson and Nicolson, in press)
- Limited planning and working in partnership across sectors to support primary-secondary interface (Muenchenberger & Kendall, 2010).
- Lack of GPLO role definition, identified priorities, strategic objectives and guiding framework to support improved integration and coordination of services across the primary-secondary interface.
- No clear consensus exists in defining the various ‘liaison’ and ‘advisor’ type roles which have emerged within and across the primary-secondary interface.
- Greater clarity associated with the operations and functions of the GPLO is required in order to better identify the key tasks and performance indicators to support this position. GPLO functions will continue to operate with substantial variation amongst regions and without defined objectives (Comms Team, 2009).
• Limited opportunities for health professionals to engage in critical reflection and dialogue with other health professionals.
• Limited supports and networks for clinical champions who advocate for GP-hospital approaches.
• Limited access to education, training and professional development for health professional teams in supporting the primary-secondary interface.
• The Australian health system is complex and considerable time and effort are invested in trying to integrate the various elements of the system.
• Few incentives provided for practitioners to provide coordinated services across primary and secondary hospital services (Swerissen & Taylor, 2008).
• Workforce supply shortage.
• Commonwealth-state cost shifting and funding mechanisms leading to ‘blame game’.
• Policy and program duplication.
• Many regulations exists and burdensome administrative systems.
• GP engagement and partnering is ad hoc (Kendall et al., 2009).
• Focus on process as opposed to client/patient outcomes is impacting on the micro, meso and macro level of health system enablers in supporting GP-hospital activity and teams of health professionals (Naccarella et al., 2010b).
• Poor communication at time of referral has resulted in patients undergoing unnecessary diagnostic procedures, including hospitalization in secondary care.
• Complexity of integrated electronic health records (IEHRs) which have the potential to improve GP-hospital work processes are currently complex and a barrier to the effective utilisation.
• There is limited knowledge and a need for more research in defining:
  o the role of the GPLO and other ‘liaison/advisor’ roles;
  o how best to support information and communication transfer across teams;
  o incentives to promote teamwork and cross sector collaboration;
  o funding models and the effect of specific funding parameters on cross sector activity;
  o change management around leadership and behaviour change to support improved integration between primary-secondary interface;
  o the ability of the GPLO to talk ‘clinician to clinician’.

Supporting the GPLO workforce

• Economies of scale can be created by integrating elements of the healthcare system at the primary-secondary interface.
• By expanding the skill-mix within the sector, alternative roles and workforce models can provide opportunities to:
  o enhance the quality, efficiency and responsiveness of care;
  o improve the quality and safety of patient care;
  o address ‘long wait’ patients awaiting specialist outpatient appointments (Queensland Health, 2007);
• reduce referrals from primary care to secondary sub-acute hospital and improve discharge planning processes (Berendsen et al., 2009; Victorian Department of Health, 2010);
• improved communication between the GP-hospital interface (Akbari et al., 2008; Comms Team, 2009);
• reduce the workload burden of health professionals through supporting a coordinated, integrated collaborative service delivery model (Naccarella et al., 2010a; Zwar et al., 2007; Harris et al., 2009);
• improve efficiency, address inequality and access, reduce hospitalisations and mortality and improve health outcomes (Armstrong & Kendall, 2010; Muenchberger & Kendall, 2010; Starfield & Shi 2007).

• GPLOs have been shown to influence reductions in patient hospital usage, improved communication, skills and mutual learning of the primary care team, improved treatment compliance, reduced referrals to secondary care, and improved staff and patient satisfaction (Emmanuel et al., 2002).

• GP ‘Advisors’ in the UK have traditionally acted as change agents within their locality and work in areas of leadership, strategy, service redesign, communication and education (Macmillan GP Advisors, 2010).

• In New Zealand research has shown that the GP liaisons were instrumental in providing GP education about the guidelines and feedback on the appropriateness, quality and timeliness of referrals received at the hospital (Goh & Barry 2003). A high proportion of GPs changed their practice and performed additional procedures that would otherwise have required referral. This resulted in reduced waiting lists, a decrease in the number of GP referrals to elective services and an improvement in the quality of information provided in the referrals received. An improved understanding and clarity of primary-secondary care roles at a local level was reported (Goh & Barry 2003).

• There is a need to explore models of care that improve information flow for referral from GPs to outpatient services, including feedback loops for the referral and discharge from outpatient services to GPs and other services (Akbari et al., 2008; Grimshaw et al., 2006).

• Of the models of care supporting the GP-hospital interface, the GPLOs, who work on improving information flow between GPs and specialist services, have shown the most promise (Amos & Boughey, 2006; Comms Team, 2009; Queensland Health, 2007; Victorian Department of Health, 2010).

**GPLO workforce planning to optimise improved GP-hospital activity**

• To address the need for coordination, it is critical to improve the health workforce expertise and capacity (Ehrlich et al., 2009; Naccarella et al., 2010a; Wolff & Boult, 2005; Zwar et al., 2006 & 2007).

• Facilitating changes required to support GPLO roles (and skill mix and other liaison roles) will require considerable education, attitude change, leadership and collaboration (Naccarella et al., 2010a).

• Supporting the training of primary care staff through clear role delineation and financial incentives to support alternative workforce models was required (Zwar et al., 2007).
• Regional primary health care organisations and government health services play a key role in facilitating primary-secondary interface by supporting:
  o information management systems;
  o decision support systems;
  o disease registers;
  o coordinating shared care networks;
  o facilitating coordinated care teams;
  o establishing links between specialists and programs;
  o coordinating liaison officer support roles;
  o supporting collaborative methods and tools (Naccarella et al., 2010a).

• GPLOs have emerged as a pivotal role in influencing the successful outcomes and supporting systematic change at the GP-hospital interface (Comms Team, 2009; Jackson & Nicholson, in press; Queensland Health, 2007, Victorian Department of Health, 2010). The findings highlighted the key role the GPLO played, particularly in relation to resolving operational issues across both sectors in a coordinated, collaborative and strategic manner (Comms Team, 2009).

• There is a need to further explore the unique role of the GPLO in being able to talk ‘clinician to clinician’ and advocate for ‘both sides’ of the primary-secondary interface.

• The following activities identified by stakeholders were regarded as the primary focus of GPLOs (Comms Team, 2009):
  o improving patient access to health services;
  o improving dialogue and problem solving opportunities for general practice and hospitals;
  o identifying strategic priorities of services to be improved or issues resolved to achieve the most significant outcomes for all parties (i.e. electronic discharge summary);
  o improving and promoting the importance of continuity of care in both primary and acute care settings;
  o building strong working relationships that enable and promote sustainable collaboration; and
  o improving the quality of primary and acute health care.

• Some GPLO roles and functions focus on hospital and general practice liaison activities whilst others adopt a broader focus on improving the interface and continuity of care between acute and primary care.

Policy Drivers

There are currently a range of policy drivers for improving the engagement of general practice with the sub-acute hospital sector in Queensland. The current evidence highlights the effectiveness of the GPLO in providing leadership, strategic cross-sector coordination and integration of services.
The broader policy context plays a significant role in providing:
   o consistent government policies;
   o human resourcing;
   o supportive frameworks and funding models that encourage collaboration
   o (Canadian Health Research Foundation, Teamwork in Healthcare, 2006; Kendall et al., 2009; Tieman et al., 2007; Zwar et al., 2006).

A number of implications have been identified for consideration. These include:

• Development of a **Queensland Framework for GPLO in supporting the primary-secondary interface**.

• The framework would define and establish:
  o a common role description for GPLOs (position description);
  o core functions of the role;
  o strategic directions for GPLOs that address areas of mutual interest between primary health care and health service district in improving the primary-secondary interface;
  o key performance indicators;
  o planning and accountability processes.

• **Guiding elements** to support GP-hospital model of care in supporting improved coordination and integration of care include: clinical leadership, governance, collaboration/networking, strategy, service re-design, advocacy, communication, funding models & education.

• **Collaborative partnering** to support management systems, leadership and governance.

• **Communication protocols** developed to support cross-sector coordination and collaboration.

• Development of a **change management strategy** to support the GPLO role.

• Supportive policy and program development at a state and local level where support and capacity is provided to GPLO roles in **supporting integrating information systems, practice guidelines and care pathways**.

• **Scope funding models** to support embedding the GPLO role within the health system.

• Clearly defined **roles for State Based Organisations** to support the network of GPLO roles including facilitating planning and reporting, professional development and training, research, leadership and advocacy. This also includes information sharing and promoting key outcomes as a knowledge translation strategy.

• **Mapping** of other Queensland ‘liaison’ and ‘advisory’ roles, including defining roles and how they interface with the GPLO role (reducing duplication).

• Ongoing **workforce development** to expand the roles and skill-mix.

• Scope **infrastructure needs** to support primary and secondary care systems.

• Research and development into the impact of the GPLO role in influencing system level change and **health outcomes** for consumers.

• Facilitate the translation of evidence into policy making.
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