NSW HEALTH | *Clinical Services Redesign Program*

APAC/GP Shared Care

Supporting GP management of patients in the community

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APAC/GP Shared Care

The Acute Post Acute Care/General Practitioner (APAC/GP) Shared Care model operates on the Central Coast of NSW and the Northern Beaches of Sydney. This is a joint initiative between the Central Coast and Manly Warringah Divisions of General Practice and the Acute/Post Acute Care Service of Northern Sydney Central Coast Area Health Service. In 2007/08 the model will be rolled out across the area health service.

Why a shared care model?

GPs often want to manage their patients in the community. Until now they have not always been able to adequately access the resources needed to support patients acute conditions.

There is also evidence that patients prefer treatment in their own home environment when they can achieve the same clinical outcomes as in hospital.

Examples of acute conditions that can be safely substituted in the community environment include:

- deep venous thrombosis
- pneumonia/chest infection
- cellulitis
- chronic obstructive pulmonary disease/Bronchiectasis
- urinary tract and other long-term infections.

A substantial body of evidence shows that patients with these conditions who are medically stable can be managed in the community with as good or better clinical outcomes and at a reduced cost to the health system.

What is APAC?

APAC offers an alternative to in patient (hospital) care to suitable, consenting patients in their home.

It aims to provide holistic, multi disciplinary, patient centred care to avoid hospital admissions or reduce inpatient length of stay.

How does this model work?

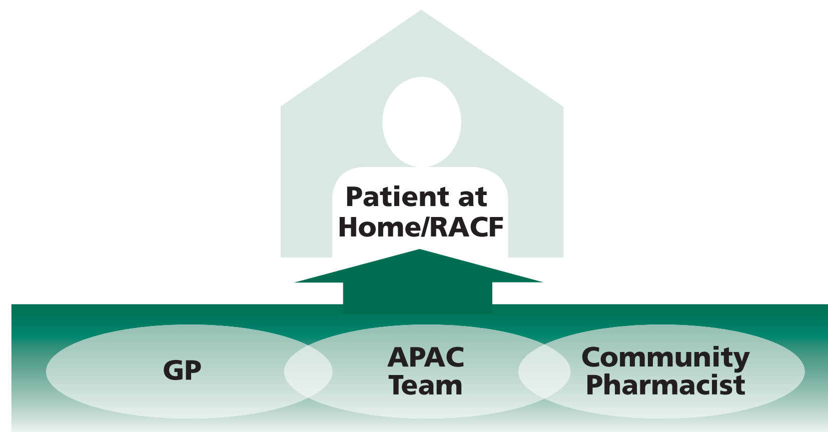
The GP and the APAC team work together to manage the patient in the community. The GPs role is to establish the clinical diagnosis, prescribe and administer the first dose of treatment. The APAC team under the ongoing clinical management of the GP continue the care.

This model ensures that where possible the patient does not need to go to hospital for initiation of clinical care. Conditions specifically targeted in this APAC/GP Shared Care model are those that have not responded to oral antibiotics or other interventions or therapies.

Program Set Up Challenges and Solutions

Challenges	Solutions
Access, within a timely manner, to medications, IV drugs.	Develop partnerships with community based pharmacists to stock participating doctors surgeries with the required medications.
Cost and payment for drugs not traditionally used in general practice.	The initial treatment dose is funded through the Area Health Service APAC team. The patient pays for subsequent PBS doses.
Adequate levels of support and access for GPs to manage acute conditions in the community.	APAC's multi-disciplinary staff support the GPs. Participating GPs are provided with direct access to medical specialist review as required. Opportunities provided for GPs to access education related to key conditions.
Limited access to clinical guidelines focussed on community management.	GP specific evidence based guidelines developed in close consultation with GPs.
Clarity regarding clinical governance of the APAC/GP Shared Care patient e.g. the roles and responsibilities of the key service providers.	Identification of each provider's medical and legal responsibility e.g. the Area Health Service provides the legal liability for APAC service staff. Service agreements between APAC and key community service providers.

Recruitment to the shared care program



1. General Practice

A key component of this program's success is the mutual understanding, and appreciation of the environments where GPs and hospitals function.

The Divisions of General Practice are pivotal to establishing gateways to individual or groups of General Practitioners. The Divisions play a key role in:

1. Orientating, linking and supporting GPs to services in the community.
2. Disseminating legislative information about the Medicare Benefits Scheme and other updates from the Commonwealth Department of Health and Ageing.
3. Coordinating services such as the APAC/GP shared care model between the Area Health Service and GPs.
4. Providing direct and regular communication and dissemination of relevant information.
5. Providing support for Information Technology processes and related business processes.

Tip For Success:

The Central Coast Division of General Practice employed a Project Officer with a working knowledge of the operational function of APAC. The purpose of this role was to act as a conduit between the Area Health Service and General Practitioners and to provide guidance during the implementation of the shared care program within GP practices.

Strategies for Engagement

The Division of General Practice hosted a series of inclusive meetings and workshops for GP's. Doctors attending these sessions were able to apply for Continuing Professional Development points.

The sessions were used to:

- explain the APAC service
- provide advice about the shared care model
- obtain feedback from GPs
- recruit GPs to the program.

The orientation sessions were supplemented with small clinical workshops. Supportive GPs acted as the Master of Ceremony and specialist doctors such as a Haematologist, Microbiologist, Aged Care and Respiratory Physicians and the APAC CNC presented on topics such as:

- Cellulitis.
- Deep venous thrombosis.
- Infectious diseases, antibiotic therapeutics and new advances.
- COPD and community acquired pneumonia.
- Challenges of managing aged care patients.
- Access to the Respiratory Intervention Unit.
- Cannulation.

Clinical Guidelines

It was recognised early in the establishment of the model that GPs needed directed guidelines to support them in the management of patients in the home. Initially, specific APAC/GP Shared Care evidence based clinical guidelines were developed in close consultation with GPs.

An independent evaluation recently recommended that these guidelines be incorporated into one APAC Clinical Guideline. This will mainstream the guidelines across the Northern Sydney Central Coast Area Health Service.

General practitioners, allied health and specialist doctors have provided input into the development of these evidence based clinical guidelines. These guidelines are available on the Central Coast Division of General Practice and the APAC website. They can be accessed via an information package forwarded to GPs who are registered with the APAC service. The guidelines are supported with quick reference clinical management flow charts.

Documents such as medication charts, referral letters and management plans have been imported into the GPs computer program (Medical Director and Best Practice). These templates can be downloaded and populated so that the GP can claim on appropriate MBS items.

Access to clinical champions

An added success factor to date to recruiting GPs to the program has been the strengthening collaboration between the GPs and staff specialists from the area health service. Staff specialists such as the haematology specialists, infectious disease specialists, respiratory specialists and their investigation units, emergency physicians and aged care specialists from the local hospital are able to provide clinical support to GPs to manage patients in the community. This assists GPs to manage conditions that they may not usually manage.

2. Community Pharmacists

The role of the community pharmacist is to replenish ongoing medications at the surgeries of APAC registered GPs. Typically community based pharmacists do not stock intra-venous (IV) or sub-cutaneous (SC) drugs, such as antibiotics and low molecular weight heparin (LMWH). Providing GPs with access to these types of medications is pivotal to the management of APAC/GP patients in the community.

Tip for Success for working with General Practitioners:

- ***Use the local GP Collaboration Unit***
- ***Identify champions at all levels.***
- ***Take time to establish credibility.***
- ***Make sure that GPs interests are taken into account and that they are represented in any decision making.***
- ***Aim for systemic change that is voluntary, resourced, and sustainable.***
- ***Use rigorous, evidence based clinical guidelines that provide support, capacity and alternatives.***

Strategies for engagement

In the set up stages, local pharmacists were engaged to obtain local knowledge and methods to promote the service. Negotiation and consultation ensured that local pharmacies were willing to replenish medications relevant to the APAC/GP Shared Care model. This approach helps to build on prior relationships and provides further support to both the GP and the patient.

Orientation

Direct contact via faxes and mail outs were made with all the community pharmacists in the local area to introduce them to the model. They had representation on the implementation steering committee and the project officer made one on one visits to each of the community pharmacies.

Targeting

Individual GP practices identified pharmacies they had existing links with so that they could be specifically targeted for the program.

Ongoing Communication

Post implementation mass mail outs were sent to individual pharmacies in the Central Coast and Northern Beaches areas. The mail outs highlighted the new service and provided opportunities for feedback from the pharmacists.

Tip For Success:

Nomination of a champion community pharmacist who is willing to support other pharmacists and play the role of key contact.

Residential Aged Care - Initiative on the Central Coast and Northern Beaches

An integral component of the success of the APAC/GP shared care model is the Residential Aged Care Facilities (RACF) initiative. This initiative allows GPs to support patient management in the RACFs in conjunction with local hospital Geriatrician support. Older patients can then be cared for in the familiar surroundings of their home.

RACFs registered with APAC have access to the relevant clinical guidelines, program forms, consumables and medications. APAC can then support the initiation and delivery of care immediately after the GP begins medical management. APAC staff give training to help RACF staff become familiar with the APAC/GP clinical guidelines and to deliver care within the agreed standards.

Tip For Success:

Identify RACF Directors of Nursing who actively support their staff and the GP in the shared care model and publicly advocate its benefits.

3. Other stakeholders

Key stakeholders were offered an orientation session to gain their support and understanding of the program. These stakeholders included:

- Diagnostic Pathology Services
- General Practice Managers.
- General Practice Nurses.
- Aged Services Emergency Teams (ASET).
- Nurse Managers of Community Nursing Services.
- Representatives of hospital based clinical services including General Managers and Directors of Nursing and Medicine.
- Australian General Practice Network, Alliance of NSW Divisions.

The Model in Practice

Patient presents to GP.

GP able to bill for **Chronic Disease Management Items** such as
- Case conferencing
- Care Planning
- GP Management Plan.

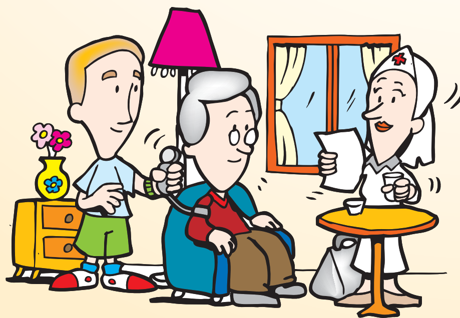
Tips for Success/Essential Components

- Every service provider involved signs an agreement.
- Prescribed treatment must comply with the clinical practice guidelines.
- Liability lies with the provider of each service e.g. the Area Health Service covers the APAC team, the GP has their own liability cover.

Diagnosis made. Patient consents to treatment and is **referred to the APAC/ GP Shared Care program.**

GP uses APAC supplied starter kit to give patient initial treatment dose.

Script sent to Pharmacist so that APAC can continue treatment. Patient uses PBS to pay for these subsequent doses.



The multidisciplinary APAC Team visits and treats the patient at home e.g. nursing, physiotherapy, occupational therapist.

The GP provides ongoing medical management.

GPs are supported with clinical guidelines and specialist support e.g. geriatrician, respiratory specialist.

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