

General practitioner multidisciplinary skills for enhanced primary care



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Enhanced Primary Care (EPC) was introduced in November 1999 with the aim of encouraging general practitioners to conduct health assessments, care plans, and case conferences, and to achieve improved health outcomes for patients with chronic and complex care needs.¹ The Health Insurance Commission (HIC) released statistics in October 2000² revealing that, while health assessments had been readily taken up by GPs, care plans and case conferencing had not. They were slow to adopt the program in the Macarthur Division of General Practice (MDGP). As a result, the Macarthur Health Service developed an education package to assist GPs develop skills in care planning and case conferencing to improve the uptake of these EPC items.

This multifaceted education program and a re-structure of multidisciplinary community health services commenced in March 2001. Participants were the 145 members of the MDGP and 30 allied health professionals, together with 18 primary health (community) nurses employed by the Macarthur Health Service.

Our educational interventions used group sessions, compact discs, and assistance with practice organisation (Table 1).

Methods

The Commonwealth Department of Health

and Ageing⁴ provided de-identified data (2001–2003) on the uptake of the three groups of EPC item numbers, 700 (health assessment), 720/722 (care planning), and 740 (case conference). Data were available for GPs by division which gave the number of GPs per division that were active (active EPC GP) versus inactive in the uptake of EPC items and the total usage for each item number.

Results

All parts of the educational intervention related to the EPC item numbers 720/722 for multidisciplinary care planning and conferencing. There was no significant difference between the mean uptake of these items numbers in the MDGP as compared to state and national figures for the period before the educational intervention. Following the intervention, there was an increase in the use of the EPC items by all GPs in the MDGP, which was far in excess of the state and national figures (Figure 1). The mean of the eight quarterly values (September 2001–June 2003) of EPC per GP was significantly higher for GPs in the MDGP than the mean EPC per GP for all divisions nationally for the same period ($p=0.004$). The mean for the MDGP was 9.2 EPC per GP and the mean for all divisions nationally was 2.4 EPC per GP. The difference was 6.8 EPC per GP with a 95% confidence interval from 5.2–8.3 EPC per GP.

Table 1. Educational interventions

Group education session designed to:

- Improve skills in multidisciplinary case conferencing through role playing
- Meeting and developing an understanding of the skills of the participating health care providers

Material designed to:

- Explore the skills, assessment tools, and clinical language of all participants
- List conditions that are suitable for EPC care planning and case conferencing³
- Demonstrate five complex case scenarios commonly seen in the community

Removal of barriers by organisational restructure between health service and GPs:

- Primary health nurse visiting practices July 2001 to February 2002
- Project officer developing and disseminating educational material about EPC
- Bimonthly liaison between local state health services and the local division of general practice

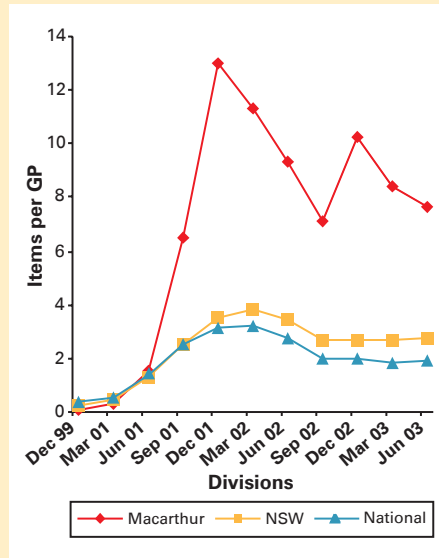


Figure 1. care planning (item 720/722) per GP

The initial peak in EPC care planning in the MDGP has decreased. This has followed the state and national trend but has remained nearly three times higher than the New South Wales and national average for 2 years.

Discussion

We found a rise in the use of EPC multidisciplinary care plans after the training program that followed the Australian trend for care plans. This rise was associated with the practice visits and education program. The increase was significantly greater than the national increase. However, EPC care planning decreased over the following year. This was in spite of the continuation of the organisational changes. Perhaps the education program was more important, or possibly there were other reasons for the decrease.

Implications of this study for general practice

- Multidisciplinary care is possible at a much higher level than currently practiced.
- Education activities may change practice for a period of time.
- Relationships between a broad range of allied health professionals and GPs may be a factor in sustained practice change.

Conflict of interest: none declared.

References

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