



General Practice Links Program - Indigenous Program

Catherine McCloy

Canning Division Of General Practice



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GP LINKS SERVICE

MAY 2006



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Introduction:

- Collaborative service between RPH & Canning Division of GP
- Commenced in February 2003
- Initially funded by OAH
- Recurrent funded by RPH
- Current Contract signed for 3 years (2006-2009)





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Reasons for developing the service

- Life expectancy of Aboriginal people
 - Life expectancy remains 20 years lower at last census
 - 3% of people in WA are Aboriginal
- Admission rates to RPH
 - 9% RPH patients are Aboriginal
 - On average, each ATSI patient was admitted 3.7 times in 12 months
 - (for others, the rate is 1.5)



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Aims of the service

To improve continuity of care for
Aboriginal people by:

- providing culturally appropriate care
- improving access to local GPs
- improving access to other community
based services

Reduce re-attendance at RPH

To foster patient independence in the
medium to long term





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Model of Care

- Employment of 2 Aboriginal Community Liaison Officers (with a health worker background or equivalent)
- Daily (week days) hospital visiting at Royal Perth Hospital & obtain a list of patients residing in the SE Metropolitan area
- Initially visit Aboriginal people at the bedside and following discharge from RPH
- Inform patients about the Service and enrol them in the program



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Follow up visits include:

- Contact at home following discharge
- Visit as required for up to 3 months
- Link with local GP (as required)
- Assist with making and attending out-patient appointments
- Assist with linking to other services including:
 - Silver Chain Palliative Care
 - Home and Community Care packages
 - HomesWest
 - Centrelink
 - Tenancy Advice Service

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Evaluation

Service evaluation is monitored through:

Quantitative comparison of readmission and emergency department presentations between cohort and controls

Process evaluation - statistics

Qualitative data from:

Satisfaction patient survey

GPs

ACLOs

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Results

Between 2003 to 2006 there has been:

- 253 clients admitted to the program
- 198 clients have received home visits
- 561 telephone calls (follow up & appointments)
- 79 clients have been referred to GP
- The readmission rate to RPH has decreased by 3.26% in 2004
- Another readmission evaluation study is underway

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Results

- Attendance at out-patient clinics has improved because of transport provision
- Some GPs are requesting assistance for other Aboriginal patients who have not participated in the Service
- Family members of patients have requested assistance with their own health and related issues
- HACCC packages are being accessed



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Benefits

- Project is unique, starting to address challenges in Aboriginal Health
- Client is linked to a mainstream GP
- Client receives a follow up service for 3 months post discharge from RPH
- Readmission rates to RPH have decreased
- Building General Practice capacity to offer an appropriate ATSI service

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Client One:

Errol was admitted to RPH in Renal Failure

Prior to discharge Errol enrolled on the GP Links program and the ALO assisted Errol as follows:

- Arranged a visit with Errol to his GP
- Reviewed all follow up appointments made by RPH
- Checked Errol's medication list and supply
- Assisted with emergency housing accommodation
- Contacted Centre-link and arranged Errol's sickness benefits
- Provided support letters for Homes West and Centre-link



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Client Two

Vanessa was admitted to RPH with a brain tumor.

- Vanessa was enrolled on the GP Links program early as she spoke in another dialect which the ALO was able to interpret. The ALO assisted in Vanessa's discharge as follows:
- Linked Vanessa to a GP that bulk-bills client visits and who Vanessa was comfortable with and attended visits with Vanessa to interpret
- Sorted out Vanessa's chemotherapy appointments at RPH and provided transport to and from these appointments
- Vanessa was lonely so the ALO arranged for her to relocate near people that were from her own cultural group and who speak her language



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- Client Three
- Bob was admitted to RPH suffering from many medical co morbidities
- The ALO enrolled Bob in the GP Links program prior to discharge
- Bob required aging in place care and was placed in a Care Awaiting Placement facility
- The ALO assisted the family in arranging an ACAT assessment and permanent accommodation for Bob
- The ALO convened meeting between the family regarding Bob future placement and health
- Bob is now in an aged care facility and happy with his placement



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Key Message

- Investment of resources into ACLOs has benefits for:

Aboriginal community

General Practitioners

Hospitals

