

Getting GPs involved in case
conferenceing and care planning.

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Why?

- Improves patient outcomes in several settings

eg

Stroke

COPD

Palliative care

Stroke

- Care planning with active engagement of GPs improves functional outcome

NNT 7

(same as using latest clot-buster drugs as emergency stroke treatment)

(Fjaertoft 2003, 2004)

- Cursory engagement does not.

(Askim 2004, Faberberg 2000)

Effects of case conference from time of death

Case conference effect

	≥183 days	71-182 days	36-70 days	15-35 days	≤14 days
Favours intervention				Nausea Memory Ability to concentrate	McGill generic QoL*** Help with hygiene/dressing Ability to do what you like Sleep
Favours controls	Trouble with bowels Ability to share worries	Help with hygiene/dressing Trouble with bowels Difficulty sleeping Meaningfulness of the day	Hours spent lying down Trouble with bowels Amount of worry	Help with hygiene/dressing	

DEATH

***Yellow type** denotes $p < 0.05$ Normal type denotes trend result – $0.05 < p < 0.10$ ** control/ intervention *** QoL: Quality of life

Effect of teleconferences

Referral



Case conference

Plans established

Relationships developed

Independent of time
from case conference
to death



Stable phase-

Plans not needed



Illness progresses

- rapid deterioration

Plans implemented

How to engage GPs?

Think like a GP:

- Want to do the best for patients
- Sometimes uncertain of role delineation between specialists and GPs
- Busy – 10-15 mins per patient
- Calls
- Lots of specialists vying for his/her time

Solutions


- Minimise admin burden for GP
- Engage practice staff, esp practice nurse and practice manager
- Try to fit intervention around the GP's normal work pattern
(eg while visiting nursing home anyway)

25% not participating

- Part time
- Female
 - Many with family responsibilities
 - Concerns about security
- <10 yrs in general practice
- Worry about house calls
- Worry they are not as competent as the specialists.
- Don't want the responsibility

The role of experience

- Relationship between years in practice and comfort in palliative care
- Therefore getting young GPs engaged is hugely important

A wide-angle photograph of a calm, deep blue ocean stretching to the horizon. The sky is a lighter shade of blue with wispy, white clouds. The water's surface shows subtle ripples and a slight reflection of light on the left side.

How???

Principles

- ALWAYS give ALL GPs the option of participating (don't assume the answer will be "no"). Offer different levels of involvement
- Remind the GP we are talking about "their" patient
- When calling, identify it's about (NAME PATIENT)
- Think about the care of the patient being the general practice's responsibility – hence practice nurses have a role

- Identify hurdles to participation and possible solutions
- Clear negotiation of roles – positive responsibilities for GPs identified
- Clear lines of communication

Care planning

- Sequential consultation with allied health personnel.
- Chronic disease and complex health problems
- Enhanced Primary Care Plan
 - GP Management plan and Team Care Arrangements
 - Disease specific – asthma, diabetes
 - Mental Health

General Practice (GP and practice nurse) centric
Complex paperwork

Health Checks

- 75+ health assessments
- 45-49 health checks
- Indigenous health checks
- Intellectually disabled checks

Case Conferences

- Simultaneous case discussion between health professionals
- Can be via teleconference
- Can include family and patient but not necessary

Hard to organise because everyone is busy

CC by teleconference

- Organised by specialist service
- Consent held by service
- Book time in GP diary
- At time with routine team meeting
- Notes taken by service (normal practice)
- Copy of notes and consent to GP

Issues

- Service has to see it as important
- Some extra admin
- Work of running teleconference – “artificial”, takes practice
- Ensure truly multidisciplinary and not a dialogue between GP and chair
- Most practical, but not ideal, solution to interprofessional communication.