

VERTICAL INTEGRATION OF PREVOCATIONAL TRAINING IN GENERAL PRACTICE

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Western Australian General Practice Education and Training (WAGPET) is involved in both the Community Residency and the Prevocational General Practice Placements Program. The programs aim to give prevocational doctors an experience in general practice as well as addressing the increased number of training places that are required for the rise in the number of medical graduates entering the workforce. The programs also aim to improve the interface between the public healthcare service, general practice and community-based health services by placing prevocational doctors in a vertically integrated training environment.

The program models enable prevocational doctors to experience a community medicine placement through the vertical integration of medical students, prevocational doctors and GP registrars in general practice and hospital discipline placements. These can occur in outer metropolitan and rural hospitals, general practices and other community medicine organisations.

Questions can arise when considering vertically integrated training models — are they safe and do they provide a structured and well nurtured training environment for all of the doctors involved, including the supervisors?

In this session the presenter will outline the results of an independent evaluation of the program models as they have expanded across the state. They will reflect on the key elements of the program models and the quality and safety framework around them that makes it so attractive to junior doctors, GP registrars and GP supervisors. They will take you through the day to day experiences of the prevocational doctors and registrars working in a vertically integrated environment and share their reflections on their experiences.

MORE THAN A ONE STOP SHOP: FOUR MODELS OF VERTICAL AND HORIZONTAL INTEGRATION IN PRIMARY HEALTH CARE IN THE BOGONG REGION

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GP super clinics and the 'one stop shop' concept are key components of the government's focus on delivering high quality primary health care services specific to the needs of local communities. Within this framework, it is expected that such clinics will also facilitate vertical and horizontally integrated training systems for medical students, prevocational doctors, GP registrars and allied health professionals.

In recognition that no single model can be overlaid on all communities regardless of size, socio-economic status or population demographic, this paper showcases four distinctly different GP practices in the Bogong region. Each is addressing the challenges of vertical and horizontally integrated training within the framework of a holistic community-focused primary health care system.

In embracing contemporary business models, each clinic has formed lasting and co-operative partnerships with a diverse range of primary care, ancillary and complementary health service providers. In this way, each practice is able to tailor medical services specifically to the needs of their unique communities. The four stories show that no 'one size fits all' and reveals how vertical and horizontally integrated training is being achieved in communities with markedly different characteristics.

A GENERAL PRACTICE COMPONENT TO A RURAL HOSPITAL PGY2 PAEDIATRICS POST - COMMUNITY, EDUCATIONAL AND GP TRAINING BENEFITS

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Mount Gambier Hospital has recently introduced a three months hospital/community post as part of a PGY2 rotation, extending the possibilities for medical students in the Flinders PRCC graduate program to train in the region for their last two years of undergraduate medicine (their intern year and PGY2 year) and thence strong local ties are developed to local GP training and substantive long term GP positions.

A feature of the post is significant involvement in relevant community paediatric services, which involves attendance at a large local general practice (Hawkins Medical Clinic) for two, two-hour sessions per week, consulting with acute paediatric presentations to the clinic.

The clinic recently set up a no appointments walk-in service at 11.00 am Monday to Friday for any acutely unwell paediatric patient in the town (population 25,000). The aim is for concerned parents to have easy access for assessment of their children without the need to negotiate triage processes within the clinic reflecting under provision of GPs. As such the service reduces pressure on an over stretched local A and E department and children do not face long waits as low triage categories for clinical assessment. It is also very helpful for the management of many of the children with self-limiting illnesses to be able to guarantee timely follow up in the same clinic under the same walk in access if they fail to make the progress predicted (for example in managing URTIs without the use of antibiotics except when the clinical picture changes adversely). The PGY2 “trainee” is, after initial orientation and training, the principal medical officer for the walk-in service at the clinic on Tuesdays and Thursdays; and in this way contributes to the improved service for the community.

Mount Gambier Hospital has two consultant paediatricians, a registrar and the PGY2 “trainee” and averages of little over one paediatric admission daily. Involvement in the GP clinic significantly increases the exposure of the PGY2 “trainee” to a range of paediatric presentations and extends their clinical experience. In particular there is ample opportunity to become familiar with managing children with self-limiting illnesses while watching for the symptoms and signs of the seriously ill child with experienced GP supervision as required — a very valuable educational experience for future GP work. There is also the satisfaction for the trainee of following some patients from GP presentation through their hospital care and back to the community.

Local general practice also benefits from the employment of the PGY2 “trainee” as described above as they provide a personal channel of communication for local GPs to the paediatric services in the hospital and community. There is also the opportunity to familiarise future GP registrars with the administrative aspects of general practice (computerised records, Medicare charging system and so on) and the medical personalities and staff of local practices in advance of their GP terms. They can therefore quickly settle into general practice when they reach this stage and make helpful contributions to provision of services (as well as quickly move on to more interesting educational goals).

Therefore there are benefits for the local community, education of the trainee, and for general practice training. Win, win, win.

VERTICAL AND HORIZONTAL INTEGRATION OF EDUCATION AND TRAINING IN AN ABORIGINAL MEDICAL SERVICE

Dr Peter Sharpe, Ms Julie Tongs, Dr Jennifer Thomson
Winnunga Nimmityjah Aboriginal Health Service

This presentation will showcase the medical education and training activities of Winnunga Nimmityjah Aboriginal Health Service (Winnunga), which is an urban community controlled Aboriginal health service located in Canberra and serving the Aboriginal and Torres Strait Islander people of the region.

Winnunga has a vertically integrated stream of GP training with medical students from the ANU Medical School undertaking general practice attachments, junior doctors rotating from the Canberra Hospital for 10

week terms and GP registrars from CoastCityCountry Training undertaking GP terms. Other medical training includes psychiatry registrar attachments and nurse attachments from the Canberra University.

The teaching programs will be described including the integration of teaching and learning at various levels. The team-based approach to teaching will also be showcased with our public health physician, nursing, midwife, allied health staff, visiting specialists and emotional and social welfare team all engaged in teaching of our future GPs. GPs also engage in teaching of nurse students and psychiatry registrars.

CREATING PGPPP PLACEMENTS FOR JUNIOR DOCTORS IN ABORIGINAL HEALTH. THE WINNUNGA NIMMITYJAH EXPERIENCE SO FAR!

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In 2010 the Australian National University Medical School (ANUMS) as part of its Indigenous Health Stream has set up a Prevocational General Practice Placement Program (PGPPP) training place at Winnunga Nimmityjah Aboriginal Health Service in urban Canberra. This will create a vertically integrated pathway for students and young doctors to train in Indigenous health and most importantly to stay connected to Indigenous health during their junior doctor years. It will also create opportunity for five junior doctors per year from the Canberra Hospital to be exposed to Aboriginal health during their crucial hospital training years.

This paper will discuss the implementation of a PGPPP post in an Aboriginal medical service (AMS) and look at some of the strengths and challenges that are unique to an AMS when implementing such a post. We will discuss a number of key issues that required creative strategies such as supervisor teaching loads, organising cultural mentors and delivering an Indigenous curriculum within the term. Our model involves supervision and cultural mentoring being shared across the doctors and Aboriginal health workers working in the AMS. Teaching is vertically integrated so that the junior doctor is connected to teaching sessions with both registrars and students in the health service. External support for the post is provided by a medical educator with Indigenous health experience who runs tutorials and sessions in small groups for our PGPPP junior doctors and deals formally with the key aspects of the syllabus. Another benefit of this model is that the other PGPPP doctors in general practice placements get Indigenous health training also.

It is hoped that through a well supported PGPPP post in Indigenous health a number of junior doctors will be inspired to consider working in Aboriginal health in the future. Our experience so far is that junior doctors seem keen. However we believe another key benefit of this post is that the junior doctor will take back to their JMO peers real experience and knowledge of Indigenous health and thereby impact on the attitudes and knowledge of their colleagues in the hospital setting both informally and formally through JMO networking and peer teaching sessions.

Central Ideas

Open space is back! This time it's a choice, more spontaneous and with more time for talking. Get thinking, get ready, get talking.

Celebrating our time in Central Australia the popular free-form ideas and discussion session is back! In response to feedback the session has been modified for 2010.

Key changes

- 'Central Ideas' will be a session option rather than a plenary session
- Discussion time will be maximised
- The session will be held later in the Convention (the second afternoon) allowing it to be a place to develop ideas triggered by the first day and a half of the program
- It will be a 'fresh ideas only' session so we can discuss the big issues that are on your mind while in Alice Springs (i.e. there will be no call to submit ideas before the Convention).

How it works

Central Ideas is based on the 'Open Space' conference concept. Anyone present can put forward an idea they would like to discuss. Participants then select the idea that interests them the most, thus forming a group. During the time period participants may stay with one group or move from group to group. Ideally each group will have an outcome, either personally or collectively. This can, if desired, be shared with conference participants in follow up materials.

How the session will run for 2010

Get Thinking — Ideas can be submitted (with your name!) to the conference desk any time after registration opens. There will be a final call for ideas at the start of the session on day two.

Get Ready — There will be a 'marketplace' in which all the available ideas are presented. Participants decide which group they will initially join then the groups disperse to find a suitable location for discussion.

Get Talking — The rest of the session is spent in group discussion i.e. the main group does not reconvene. Any outcomes to be reported should be submitted to the convenor at the end of the discussion time.