



STORIES OF
INNOVATION
IN HEALTH
PARTNERSHIPS



gp
General Practice
NSW



Australian Government
Department of Health and Ageing

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Cover Image: Waratah - State floral emblem of NSW.

STORIES OF INNOVATION IN HEALTH PARTNERSHIPS

NSW Divisions of General Practice Network

INTRODUCTION

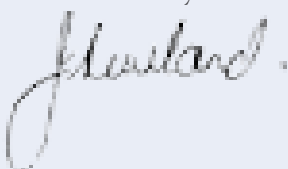
Established in 1992 by the Australian Government, NSW Divisions of General Practice provide support to general practice and other health care providers with the aim of ensuring that all Australians have access to a high quality health system. NSW Divisions provide this support in terms of health promotion, early intervention and prevention strategies, chronic disease management initiatives, medical education, workforce support and by assisting general practice in responding rapidly to technological advances in health care.

The Divisions network also provide general practice with a means of influencing the organisation and delivery of health care locally by bringing together clinical and non-clinical expertise across a broad range of multidisciplinary services and programs. More than 90 percent of General Practitioners (GPs) in NSW are members of their Divisions with a growing number of practice nurses and allied health professionals also becoming members.

When we consider models of practice in illness prevention and health care we must aim to make meaningful changes to the quality and continuity of care, be innovative in our approaches and take into account the different needs of people within our communities. NSW Divisions are continuously developing and testing new, innovative and more effective ways of delivering health care that address the diverse social and health needs of their local community. This is most often achieved through enhancing general practice capacity, performance, care delivery and coordination, especially for the most vulnerable groups in our society.

The sharing of best practice approaches among general practices, health care providers, decision makers and local communities are integral to the process of developing more effective systems of delivering innovative, holistic and patient focussed health care. The aim of this resource is to showcase and share these insights, ideas and effective practices across NSW to generate awareness, understanding and recognition of Division projects and their contribution to reducing the burden of illness in our communities.

The *Stories of Innovation in Health Partnerships* provides an introduction to the many initiatives of NSW Divisions and articulates the critical success factors for each of the programs. This resource will be useful for those wishing to invest in similar programs and fulfills a fundamental goal of helping the sector continually learn and grow. Detailing innovative programs or activities also stimulates creativity and provides ideas for others to adopt change. The wide range of organisations, strategies and different stages of implementation represented in this resource demonstrate the diverse ways organisations can work together to make meaningful improvements in health care and service delivery in their local communities.



Jan Newland
Chief Executive Officer

ABORIGINAL HEALTH
AGED CARE
COORDINATING CARE
E-HEALTH
HEALTHIER LIFESTYLES
MENTAL HEALTH
WORKPLACE HEALTH



LEADERSHIP | SUPPORT | ADVOCACY

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MURDI PAAKI DOG HEALTH, GOOD HEALTH

What is the initiative?

The NSW Outback Division of General Practice's Murdi Paaki Dog Health Program facilitates community-based dog health clinics in some of NSW's most remote outback Indigenous communities.

Why is it important?

In outback Indigenous communities there are large numbers of un-desexed dogs. Local studies have shown that these community dogs, which often run free among different families, have little or no access to veterinary treatment and can carry illnesses known as zoonoses, which may spread directly to adults and children. The very real link between human health and animal disease is a major concern for health workers and families living in these remote areas.

Who has been involved?

The Program is project managed by the NSW Outback Division in partnership with the Greater Western Area Health Service Population Health Unit, RSPCA and Aboriginal Medical Services in North Western NSW. The Division has developed working collaborations with the RSPCA and the Greater Western Area Health Service, Population Health unit and secured funding through its partnership with Aboriginal Medical Services. The project is underpinned by a team of animal health professionals who travel to individual communities fully resourced with medications and surgical equipment necessary to conduct clinics. Wide community consultation is undertaken and a range of stakeholders support the clinics, including local government, Aboriginal organisations, local vets and community groups. A component of the program includes community education and primary schools have enthusiastically participated in workshops and exhibitions offered by the clinic teams.

What has been achieved?

Broken Hill, Ivanhoe, Wilcannia, Bourke, Brewarrina, Walgett, Collarenebri, Enngonia and Weilmoringle have all received two dog clinics during the last 18 months. Almost 1,500 dogs have received health checks, 900 sterilisations (65% surgically), 70 dogs have been euthanised and almost 100 cats have been treated half of which have been de-sexed and 40 euthanised. All primary schools through western NSW have received visits from the RSPCA to learn about animal health and there have been four open community days where the team have provided education to the wider community. Pet owners, schools and the wider community have benefited from a variety of education programs and will help them to become responsible pet owners, understand what animal cruelty is and the important link between their own health and that of their dog.

What is planned for the future?

The program has been funded through the Commonwealth Departments of Health and Aging and Families, Housing, Community Services and Indigenous Affairs grants which potentially conclude in 2010. Our plan is to secure ongoing funding to support clinics to help manage the dog population numbers in the future. The Division is also exploring the potential to create Indigenous environmental health officer trainee positions to support the initiative.

What have been the critical success factors?

- Interagency collaboration.
- Recognition of and capitalising on primary health care program synergies.
- Locally delivered solutions and excellent engagement with Aboriginal pet owners, families and community groups.
- Under community support enhanced by linking their own health outcomes with those of their pets.



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BUILDING HEALTHIER OUTBACK COMMUNITIES

What is the initiative?

While most communities in NSW take for granted ready access to suitable playing fields, for some communities in the NSW Outback Division of General Practice, access to green ovals has not been a reality. In Bourke and the little remote Aboriginal village of Enngonia, the Division has been working with local Aboriginal organisations and a variety of stakeholders to oversee the construction of modern ovals in each community in recognition of the importance of access to suitable recreational areas to maintain healthy lifestyles.

Why is it important?

Bourke and Enngonia, two communities severely affected by drought, have identified access to green space as a key priority for their health and well-being. Both communities have a significant Aboriginal population and excessive rates of chronic disease morbidity for conditions such as diabetes, hypertension, obesity and mental health. Ensuring access to sustainable green areas is a key element of urban health infrastructure and evidence indicates that green areas assist the modification of lifestyle related risk factors associated with common chronic conditions.

Who has been involved?

The NSW Outback Division, Bourke and Enngonia Aboriginal Community Working Party, Murrawarri Aboriginal Corporation, Aboriginal Water trust, the Commonwealth Departments of Health and Aging, and Families, Housing, Community Services and Indigenous Affairs and Bourke Shire Council.

What has been achieved?

Modern state-of-the art ovals have been established in Bourke and Enngonia. Highly efficient sub-surface irrigation systems have been selected with remote surveillance and low maintenance features. Turf was laid on each oval to provide a high quality surface and all works were undertaken using local Aboriginal workers. The Bourke oval reclaims a formally desolate space adjacent the primary school and high density Aboriginal community housing. In Enngonia, a remote village of less than 140 people, the new modern National Rugby League oval is the only green zone in the entire community. Both ovals have rapidly become venues for opportunistic health promotion and school activities.

What is planned for the future?

Partnerships have been developed with the Birrang Community Development Employment Projects to ensure ongoing maintenance of the oval infrastructure. The Division has also commissioned a feasibility study into the recycling of waste water in Bourke and continues to work with local stakeholders and Aboriginal groups to explore funding opportunities to build sustainable urban environments conducive to maintaining health lifestyles.

What have been the critical success factors?

- Working collaborations with community groups and preparedness to diversify core business to address community priorities.
- The Division's capacity to manage funds satisfactorily and its positive relationship with funding agencies.
- Experienced project management and community development skills within the Division.
- Community confidence in project management and strong links to community organisations.



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‘WHILE YA DOWN THERE’

What is the initiative?

Hastings Macleay General Practice Network supported a multipronged Aboriginal women’s health intervention involving the employment of dedicated staff, establishment of recall and reminder systems, outreach, referral, vaccination and education services (accredited Well Women’s Screening course) to improve rates of Aboriginal women attendance to the Women’s Health Nurse Clinic and treatment follow-up.

Why is it important?

The development of this project was in response to the low proportion (approximately 1%) of Aboriginal women in the region attending mainstream services for women’s health needs including low numbers attending follow up for abnormal results of gynaecological tests, including Pap smears.

Who has been involved?

The program represents a successful partnership between Durri Aboriginal Medical Service (AMS), the Hastings Macleay General Practice Network and Hastings Macleay Women’s Health Service.

What has been achieved?

During the program period, 81% of women screened via the Women’s Health Service were of Aboriginal or Torres Strait Islander descent. Ninety-one percent of these women had a pap test at the time of the visit. Of these, 41% had never had a pap test, or were overdue for a pap test. Eleven percent of women having a pap test were found to have abnormalities that required a repeat test within two years and 4% had high grade abnormalities requiring further investigation and/or biopsy. All women who had a cervical abnormality have had follow up with a General Practitioner (GP) or specialist within the recommended timeframe, effectively reducing the risk of further disease progression.

A number of the women attending the health service had not had a screening mammography and were referred to the NSW BreastScreen service in line with screening protocol. Referrals to GPs within the AMS, and to other health care providers, were made as other health problems and risks were identified.

What is planned for the future?

Maintaining reminder systems so that local GPs can be alerted to follow-up abnormal and routine screening is ongoing. Planned for the future are efforts to negotiate a designated Area Health Worker to support the women’s health nurse, particularly when providing outreach services, and encouraging the AMS nurse to undertake training so that there is always a designated worker to screen opportunistically if funding for a women’s health nurse is not ongoing.

What have been the critical success factors?

The high number of ‘failure to attend’ is an ever-present challenge in Aboriginal communities and should not be a deterrent to providing services. Due to transport issues and the high number of funerals in these communities flexibility is the key to effective service provision.



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ABORIGINAL HEALTH COALITION

What is the initiative?

On 12 March 2008 the Blue Mountains GP Network and Sydney West Area Health Service (SWAHS), Community Health held the 2008 Blue Mountains Aboriginal Community Sharing and Learning Circle. Sixty-two members of the Blue Mountains community (indigenous and non-indigenous) attended the Sharing and Learning Circle and discussed and agreed on a list of issues with regard to Aboriginal Health in the Blue Mountains.

The members of the Sharing and Learning Circle directed the Blue Mountains GP Network and SWAHS to establish a coalition of represented organisations to progress the health issues raised. The Blue Mountains Aboriginal Health Coalition commenced operation in April 2008 and included the Blue Mountains Division of General Practice, Sydney West Area Health Service and the Blue Mountains Aboriginal Culture Resource Centre and members of the Aboriginal community.

Why is it important?

The Blue Mountains community lives in a string of 26 townships and villages that run along the sandstone ridgeline, which extend over 100kms across the Blue Mountains. Due to the geography of the Blue Mountains and the location of the nearest Aboriginal Health Service being in Mount Druitt, (90kms away), the Aboriginal and Torres Strait islanders that live in the Blue Mountains have had difficulty accessing health care services.

Who has been involved?

The Blue Mountains Aboriginal Health Coalition expanded in 2008 to include Blue Mountains GP Network; Blue Mountains City Council; Sydney West Area Health Service (Community Health); Blue Mountains Aboriginal Culture and Resource Centre; Darug Tribal Aboriginal Corporation, Gundungurra Tribal Council, Gundungurra Aboriginal Heritage and Link Up (NSW).

What has been achieved?

The Coalition was successful in securing Round One Funding from the Office of Aboriginal and Torres Strait Islander Health in 2008. Phase one of this program focussed on establishing baseline information on the health of Aboriginal mothers, babies and children, the quality of life of Aboriginal people with a chronic condition and the incidence of adult chronic disease. The Coalition then formed a Healthy for Life Steering Committee of all eight members to develop the phase two of the Healthy for Life proposal. If funded, the second proposal will enable a virtual primary health care model of care to operate for Aboriginal and Torres Strait Islanders in the Blue Mountains. The model was developed by the Healthy for Life Steering Committee in conjunction with the three general practices and two community health sites.

What have been the critical success factors?

The willingness and commitment of key community groups and organisations has been essential in the success of this initiative.



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ABORIGINAL HEALTH WORKERS IN GENERAL PRACTICE

What is the initiative?

The aim of the Aboriginal Health Workers in General Practice project was to increase the number of qualified Aboriginal Health Workers throughout the New England region of NSW. The project ensured more local community members were given the opportunity to obtain the nationally recognised qualification HLT 33207 Cert III Aboriginal and/or Torres Strait Islander Primary Health Care and educated general practices on business models that support the employment of Aboriginal health workers. An integral component of the project was the mentoring and support that was made available to the training participants between the face-to-face workshops by the trainer (a New England Division employee). By establishing small support networks among their home town groups, the participants supported each other throughout the training and have developed ongoing contact.

Why is it important?

This project addressed Aboriginal rural workforce capacity issues ensured culturally appropriate health care environments and provided an avenue for interested community members to gain qualifications that they may not have otherwise achieved. It also provided some Aboriginal health care workers the opportunity to gain formal recognised qualifications.

Who has been involved?

New England Division of Genreal Practice (NEDGP) partnered with Booroongen Djugun College, a multi-award winning Registered Training Organisation in Kempsey to deliver the training course in a flexible mode, over seven workshops of four days each, running over a period of four months. By engaging stakeholders such as Hunter New England Area Health Service, general practices throughout the region, and residential aged care providers, the participants were able to consolidate their theory with practice. NEDGP also accessed the Aboriginal Enterprise Development Officer and New Careers for Aboriginal People programs to assist with job readiness and interview skills for the participants, many of whom had not previously been in the workforce and some who had not completed their high school education.

What has been achieved?

Nine local community members graduated with a HLT 33207 Cert III Aboriginal and/or Torres Strait Islander Primary Health Care qualification.

What have been the critical success factors?

The adoption of a whole of community approach was an important factor in the success of this initiative.



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TAMWORTH ABORIGINAL MEDICAL SERVICE

What is the initiative?

In 2007 the North West Slopes Division of General Practice became the auspice organisation for the local Tamworth Aboriginal Medical Service (TAMS). The Division is responsible for the operational management of the service and works with the elected Community Controlled Executive Committee with the aim of reaching fully independent operation.

Why is it important?

There are approximately 4,500 Aboriginal people in the area covered by the Aboriginal Medical Service. They comprise almost 7% of the local population and their access to primary health services is through either mainstream general practice or the developing Tamworth AMS. Tamworth is an area with a chronic General Practitioner (GP) workforce shortage and timely access to services is difficult for everyone. The Division has been keen for a number of years to work with the local Aboriginal community to improve health standards and this supported management arrangement has provided the opportunity.

Who has been involved?

The North West Slopes Division of General Practice has worked closely with the Executive Committee, the staff of TAMS, the Office of Aboriginal and Torres Strait Islander Health and the Aboriginal Health and Medical Research Council on this project. At the commencement the Division engaged an Integration Coordinator who has provided the liaison between the organisations.

What has been achieved?

In the two years since the Division has been involved, staff numbers have doubled and the range of services provided at TAMS has grown. A Social and Emotional Health team has evolved and primary medical and health care services have expanded with additional nursing, allied health and medical specialists providing services in the centre. Men's health is addressed with a designated position working with a coalition of Aboriginal men in other local health and welfare agencies. The sole GP in the centre has been joined by a Registrar. Seven thousand eight hundred patient services were provided to 1,340 individual patients in 2008. By 2009 over 12,100 services were provided to an extra 400 people, meaning that more follow-up care was available to more people. The service became accredited under the RACGP standards in early 2010.

What is planned for the future?

Another medical practitioner will join in 2010 and, with three GPs working in the service, consideration is being given to the range of outreach services that may be possible. Additional chronic care and maternal and child health positions will come on board, with drug and alcohol positions joining the Social and Emotional Health team. Outgrowing its current venue, the service will relocate to larger premises in mid 2010. The Division and the Executive Committee will commence the countdown to a handover to full independent operation by the end of 2011.

What have been the critical success factors?

Mutual respect and determination to do the right thing for the community have been the key motivators for the two main partners: the Division and the Executive Committee. Both organisations are gaining a greater understanding of the other's perspectives and early tensions have eased as achievements stack up and greater trust is built. The Division has learned valuable lessons about the extent of Aboriginal health disadvantage and the commitment of many members of the community to improve life for their people.



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ABORIGINAL HEALTH WORKERS IN GENERAL PRACTICE

What is the initiative?

The strategy aims to address the high burden of illness within the Aboriginal population by providing a skilled Aboriginal Health Worker and nursing work force to general practice to engage the Aboriginal community, facilitate access to Enhanced Primary Care initiatives for improved early intervention and management of chronic conditions, and participate in the delivery of these services.

Various models have been trialled over the last four years including;

- Aboriginal Health Workers and Aboriginal enrolled nurses employed full time in general practice;
- Aboriginal Health Workers visiting a number of General Practitioners (GPs) providing outreach services; and
- Aboriginal Health Workers employed by Aboriginal Community Controlled Health Organisations and collocated in general practice under a partnership arrangement.

Why is it important?

According to 2006 ABS data, the four shires (Cobar, Bourke, Brewarrina and Walgett) within the NSW Outback Division of General Practice have a population comprising 26.8% Aboriginal people. All indicators relating to social determinants, morbidity, mortality and risky lifestyle behaviours are higher than both state and national averages.

Who has been involved?

Partners in the strategy include NSW Outback Division of General Practice, Aboriginal Community Controlled Health Organisations, local general practices, Aboriginal Health and Medical Research Council, and Medicare.

What has been achieved?

Medicare data indicates the Division has the most consistently high uptake of the Aboriginal and Torres Strait Adult and Child Health Assessments (between 3.1% and 40.9%) when compared to other NSW Divisions of General Practice.

What is planned for the future?

Under the Close the Gap initiative and in consultation with local general practices, the Division is planning to expand the model to increase access to Aboriginal Health Workers and associated services by all practices in the Division.

What have been the critical success factors?

Critical to the success of this project has been the willingness of general practice to recognise Aboriginal Health Workers and Nurses as members of the practice team, and support for Aboriginal Health Workers working towards National Accreditation to attain Provider Numbers through Medicare.



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COBAR PRIMARY HEALTH CARE SOLUTIONS

What is the initiative?

The remote community of Cobar was facing the prospect of being another town without any General Practitioners (GPs). On the eve of the last GP in town departing, the NSW Outback Division of General Practice accepted an invitation from the local shire and community health group to assist with the recruitment of GPs and establish an integrated primary health care service for the town. The Division immediately moved to integrate the three private practices and related clinical records and consolidate the service in the newly constructed primary health building in the heart of the town. Three GPs, a practice team of nurses and practice administration were recruited. A partnership was established to enable an Aboriginal health service to be integrated with co-located pathology services and a range of allied health and visiting specialist services.

Why is it important?

Cobar is one of the most remote communities in western NSW and is over 350kms from the nearest regional centre of Dubbo. Access to reliable GP services and additional secondary primary health care interventions is critical to ensure the management of chronic conditions and early intervention for lifestyle diseases. Ensuring a stable and comprehensive primary health care program is critical in supporting the local hospital and to the recruitment and retention strategies of local organisations and three large mines operating in Cobar.

Who has been involved?

NSW Outback Division, Cobar Shire Council, Cobar Primary Health Committee, Greater Western Area Health Service, NSW Rural Doctors Network, Cobar Aboriginal Community working party, Bourke Aboriginal Medical Centre, Lillian Brady Village and a range of health professionals who undertook to establish services at the Cobar Primary Health Care Centre.

What has been achieved?

The Cobar Primary Health Care Centre now provides a comprehensive range of primary health care services including early intervention programs, visiting allied health and specialist services, chronic conditions care planning and aged care support. The Division has successfully recruited GPs to support the Centre and service the local hospital. The Centre is accredited and in 2009 won a national award for innovation in Local Government.

What is planned for the future?

The Centre will take its first medical students from the University of Sydney and introduce a GP registrar program in 2010. Additional allied health programs to support general practice and increases in community based early intervention programs such as smoking cessation, exercise and weight loss are planned. Outback Division has also launched a work-based health assessment program with Peak Gold Mine in partnership with the Heart Foundation and Sydney University with plans to roll this out for the entire mining sector during 2010.

What have been the critical success factors?

- The preparedness of the Outback Division Board to accept risk for the Centre when no establishment capital was available.
- Expertise in GP recruitment and practice systems.
- Consolidating GP services and creating a health service inclusive of clinical information, allied health, visiting specialist and other diagnostic support services.
- That GP led primary health care can be dynamic, show leadership and develop highly relevant products for their local communities.



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HEALTHY FOR LIFE PROJECT

What is the initiative?

The Healthy for Life project has a dual focus of preventative health activities and chronic disease management for local Indigenous Australians. Following community and General Practitioner (GP) consultation, Healthy for Life initiated two Koori Diabetes Day Clinics, which represent an integrated, multidisciplinary response, bringing together all of the existing service providers in one location. GPs refer their patients to the clinics through a team care arrangement.

Why is it important?

It was found that the health journey for a Koori person with diabetes was a journey that required many health professionals and that the maze was often impossible to navigate. In rural areas these services are difficult to access and time consuming to organise. The service providers are often working in isolation from each other with limited communication between them.

Who has been involved?

The Healthy for Life team of nurses and Aboriginal health workers arrange all the appointments and transport for patients, as well as undertaking basic observations, point of care testing and providing feedback to GPs. An endocrinologist attends each clinic funded through the Indigenous Specialist Outreach Program. The Greater Southern Area Health Service provides a podiatrist, diabetes educator and dietitian, while foot care and additional dietetics are supplied by the Eurobodalla Small Communities Access Program. The Menzies School of Health Research provides continuous quality improvement tools.

What has been achieved?

Based on population and prevalence figures, the clinics are reaching 90% of their target population. Each clinic attracts an average of 18 patients, with an average of 74% attending twice or more and an average of 77% attending within the past six months. More than 80% of Koori Diabetes Day patients believe they are managing their diabetes better. Fifty-one percent of clients have had a reduction in HbA1c (a test used to identify the average blood sugar concentrations over a prolonged period of time) results since attending clinics, while 60% have a team care arrangement in place and 75% have completed an annual cycle of care.

How clients feel about a service is critical to its success and future effectiveness. Results of a client survey have found that clients are very positive about the friendliness, cultural appropriateness, knowledge, quality of care and teaching provided by the Healthy for Life team, with 78% believing they understood their diabetes better, 82% felt they were managing their diabetes better, 57% reported significant behaviour change leading to lifestyle modification and 70% described an improved sense of wellbeing.

What have been the critical success factors?

A cornerstone to the success of the Healthy for Life program has been the use of validated evidence-based audit tools, system assessment and web-based data entry and reporting tools. These resources have allowed the multidisciplinary team to work together to set goals and actions for improvement.



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GOOD HEALING - BUGALWENA

What is the initiative?

The name Bugalwena comes from the Bundjalung Nation. Where “Bugal” means “good” and “wena” means to “heal or recover”. The Tweed Valley General Practice Network’s Indigenous medical centre, Bugalwena General Practice, was established in 2008 to address health and other areas of disadvantage experienced by Aboriginal and Torres Strait Islander peoples.

Why is it important?

Indigenous people have unacceptably lower life expectancy rates and much higher incidences of diseases and illnesses. Often at the heart of this crisis lies the failure of conventional health services to culturally connect with Aboriginal and Torres Strait Islander communities. By establishing this culturally sensitive practice in consultation with the local Bundjalung community we hope to overcome some of these barriers.

Who has been involved?

The local Bundjalung community has been consulted at every stage of the practice’s development and the Network has, where possible, appointed staff to the practice from the local community. This venture would not have been possible without funding from the Office of Aboriginal and Torres Strait Islander Health and the co-operation of the North Coast Area Health Service’s “Bugalwena” Indigenous Service.

What has been achieved?

Achievements to date include 546 patients accessing the practice. Of these, 97% are Indigenous people with the remaining 3% being partners/spouses of Indigenous people. Of the 42 patients with a chronic disease 60% have a current care plan. In addition 10% of patients have undertaken an Indigenous health check. The practice employs not only General Practitioners (GPs) but a Practice Nurse, Dietitian, Healthy for Life Officer and engages the services of an Optometrist, Audiologist and Diabetes Educator. These health providers work together to provide coordinated and integrated health care. By the provision of clinical services and the promotion of self management we are gradually seeing an improvement in the health of a number of patients.

What is planned for the future?

Bugalwena General Practice has been steadily growing since its inception with the inclusion of an on-site optometrist, diabetes educator and hearing clinic. In the last six months we have included a dietitian and Healthy for Life program officer. We aim to continue to grow the practice and to fully integrate our services with those delivered by the North Coast Area Health Service Bugalwena Indigenous Service located within Community Health.

What have been the critical success factors?

By working with the local elders and other members of the Indigenous community we have provided a culturally-sensitive service that local Indigenous peoples can regularly access.



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MAKING AGED CARE EASIER

What is the initiative?

Bankstown Division of General Practice and the University of Western Sydney (UWS) developed a small group counselling intervention and evaluation framework to address social isolation and grief in residents of aged care facilities. Implementation involved trained intern psychologists facilitating small group sessions of 8-12 residents, under the supervision of an experienced researcher. Each group met six times, and once for follow up evaluation.

Why is it important?

This program addresses a common co-morbid condition of the elderly – depression, which is a significant contributor to the burden of disease among residents of aged care facilities.

Who has been involved?

The UWS was a key partner in this initiative. The intervention was initially trialled in two Residential Aged Care Facilities (RACFs) with 27 residents. A further six local RACFs with 66 eligible residents have since volunteered to participate.

What has been achieved?

Results of the trial to date have included residents self-reporting increased feelings of well-being. They report being more socially active and have developed ongoing friendships. Further evaluation will include changes in medication use, RACF staff reports regarding resident engagement and General Practitioner (GP) reports of changes in clinical presentation. UWS interns advise the Division of a number of residents who were identified as requiring one-on-one interventions. The Division in turn advise the residents' GPs of the recommended referrals.

What is planned for the future?

While funds are available the Division will continue to roll out the intervention. RACFs have indicated they will include this intervention as evidence of meeting the requirements of Aged Care Standard Agency Accreditation. The partnership developed between the Division and UWS has provided a forum for discussions about other joint programs related to primary care including the possibility of UWS undergraduate nurse placements in local practices and youth health promotion programs.

What are the critical success factors?

The foresight and energy of a small number of GPs and the willingness of the RACFs to take part in the program greatly assisted the early promotion and recruitment of residents in the early stages of the trial. Moreover, the flexibility of Department of Health and Ageing Aged Care Access Initiative (ACAI) grants criteria made it possible for UWS to commit significantly to the program.

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A MEDICARE REFERENCE GUIDE FOR AGED CARE

What is the initiative?

Central West Division of General Practice has developed a funding incentive reference guide for health professionals and groups considering or working in residential aged care facilities (RACFs). Funding arrangements, IT support options for remote desktop access, issues when running clinics in RACFs, useful links, resources for aged care and a glossary have been included in this valuable guide.

Why is it important?

An understanding of Medicare and other available funding arrangements for private and public health care providers to deliver services in residential aged care facilities is an important enabler in the delivery of optimal person-centred and flexible care planning for residents requiring both high and low care. Lack of knowledge about available funding enticements has been reported by health professionals to be a barrier to allocating greater time to aged care work.

Who has been involved?

The production of the guide has involved significant collaboration between RACF staff, General Practitioners (GPs), practice staff and allied health, with valuable professional partnerships developed as a result.

What has been achieved?

Early feedback on the usefulness of the resource has been very positive, with some practice change in relation to increased service provision in RACFs noted. An electronic version of the guide is available via the Central West Divisions website to ensure ready and free access.

What is planned for the future?

The reference guide has been reviewed by Medicare Australia and the Australian General Practice Network with consideration now underway to modify the tool for national use. Supportive education modules are being developed to further complement this work.

What have been the critical success factors?

The resource has been successful because it was compiled collaboratively with potential users and represents a reliable ready reference that fills an important gap in information for those working in aged care and general practice.



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AGED CARE ACCESS INITIATIVE - ALLIED HEALTH SERVICES

What is the initiative?

The aim of the Commonwealth Government Aged Care Access Initiative (ACAI) is to improve access to primary care (GP and Allied Health Services) for residents of aged care facilities. After consulting with participating aged care facilities, Hawkesbury-Hills Division of General Practice purchased the services of relevant local allied health professionals.

Why is it important?

The allied health services provided under ACAI are used to enhance the quality of life of residents with low care needs, through the provision of services that may otherwise not be available to them. Many residents assessed as having low care needs do not have private health insurance and find it difficult to pay for such allied health services even when access to such services is provided by the aged care facility in which they reside.

Who has been involved?

In consultation with the Directors of Nursing from all residential aged care facilities within our Division boundaries, allied health services that would provide residents with the most benefit and that could reasonably be implemented within the timeframe were identified.

What has been achieved?

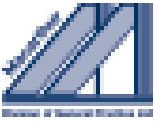
Four hundred and forty-five (445) allied health services were delivered. Of those 445 allied health services, 32% were delivered by exercise physiologists (focussing mainly on pain management); dietitian services 22% (individual resident menu reviews); physiotherapy services 22%; psychological services 10% (dealing with grief issues); diversional therapy services 7%; and oral hygiene services 6%.

What is planned for the future?

Our plans for the future are to deliver more services with the available funding, particularly those services that can be delivered in a group environment, for example group exercise programs. Such a program would help residents to improve balance, muscle strength and flexibility, help with sleeping problems and blood pressure control, and increase their energy levels.

What have been the critical success factors?

The ability to devolve selection of services to the local aged care facility while adhering to the ACAI guidelines maximised the opportunity for the most appropriate services to be provided to individual residents. The high degree of cooperation received from aged care facilities, in particular the Directors of Nursing, was critical to the effective and timely implementation of the program. Aged care facility representatives reported that they had seen noticeable differences as a result of ACAI funding and that the initiative was most welcome. Facilities did not object to the very tight time-frame under which we were all operating as, according to Directors of Nursing, it had encouraged quick planning and inspired staff.



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IMPROVING ORAL CARE FOR AGED CARE RESIDENTS

What is the initiative?

The Macarthur Division of General Practice Improving Oral Care Access for Aged Care Residents program is an intervention aimed at improving oral care access for dependent people living in Residential Aged Care Facilities (RACF), including patient assessments, in-service and half day seminars on oral health education sessions for carers, development of a 'train the trainer' program for RACF Nurse Educators and the development of a DVD on Oral Health Care for Elderly Dependent People as a resource for staff in-service education.

Why is it important?

The role of health professionals in aged care facilities is significant in the maintenance of oral health of residents to prevent oral disease, periodontal (gum) disease and infections. Professional carers are likely to be the first ones to detect any abnormalities or oral discomfort experienced by residents and refer the problem in a timely manner.

Who has been involved?

The Special Care Dentistry (SCD) Department's Outreach Team of Sydney South West-Oral Health Services, Division of General Practice of Macarthur, Fairfield and Liverpool and local RACFs have collaborated in the development and implementation of this program.

What has been achieved?

Out of the 1,241 residents examined, 459 (37%) needed dental treatment and were referred to a range of public and private services including 12% of patients referred to the Medicare Chronic Disease Program to see private dental practitioners in the local area, 8% were financed under the Veterans Affairs entitlements scheme, 6% treated in SCD clinic, Sydney Dental Hospital and 5% were issued vouchers funded by the fee for service scheme to see private dentists in their locality.

What is planned for the future?

A continued focus on attracting further funding for this program is planned. It is internationally recognised that oral care is a reliable indicator of general patient care.

What have been the critical success factors?

Appropriate oral care training and education for professional carers to ensure day to day effective oral hygiene management for dependent residents and close cooperation and appreciation of staff supporting these initiatives have been critical to the success of this program.



The Shoalhaven Division of General Practice

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COMMUNITY INTEGRATION GARDEN PROJECT

What is the initiative?

The aims of the Shoalhaven Division of General Practice Community Integration Garden Project are to improve the health and wellbeing of residents of aged care facilities; improve school age children's understanding of food and positively influence their food choices; and lift local community spirit. The project is based on the Stephanie Alexander approach to promoting healthy eating which has of four components - growing, harvesting, preparing and sharing. Health improvement activities offered in parallel by the Division in local aged care facilities included group counselling sessions conducted by local psychology services and a specifically designed exercise physiologist program to improve balance and core body strength, promote exercise and reduce the rate of falls.

Why is it important?

An analysis of the needs of the elderly in local aged care facilities found that depression, social isolation and lack of integration with the wider community were having a significant negative impact on their health. The rising level of childhood obesity was identified as a concomitant local health concern.

Who has been involved?

An oversight committee was convened, which comprised Division staff, the school principal, school teachers, aged care managers, a horticulturalist from the local TAFE college, the Aged Care Program Coordinator and staff from a local garden supplier. Parents and teachers assisted on working bee weekends by filling the garden beds with soil. The school students established the seeds in the class room and worked alongside the aged care residents to plant them. A local chef cooked the produce while instructing the children and aged care residents on how to make healthy meals. Local businesses donated funds for various project materials and other needs.

What has been achieved?

This project offers gardening and healthy eating education and cooking skills. It also offers an appreciation of the environment by teaching water saving approaches, composting, worm farming and others. The project also importantly provides the opportunity for aged care residents to socialise with members of the wider community and for school students to socialise with and better understand aged care residents.

What have been the critical success factors?

Critical success factors of this project include the whole of community effort in making it a success, the generosity of local residents and businesses, and the organisational skills and commitment of Division staff.



SHOWCASE 1



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PRACTICE NURSE DIABETES PROGRAM

What is the initiative?

Eastern Sydney Division of General Practice has worked hard to ensure the ongoing establishment and implementation of diabetes clinics and facilitation of Practice Nurse Diabetes Education forums.

In this program Division staff support practice nurses to recognise and archive old patient data and clean records of patients with diabetes to allow accurate identification of the diabetes patient populations in each practice. Once patient data is cleaned, the practice is supported to establish registers of patients with diabetes. Further to this, the Division worked with St Vincent's Hospital Diabetes Centre to establish regular Practice Nurse Education forums.

Why is it important?

Diabetes is known to cause substantial illness and death in Australia. The use of diabetes recall registers that are aligned to clinical management guidelines means patients can be pro-actively and readily offered best practice diabetes care.

Regular Practice Nurse Education forums ensure nurses working in general practice throughout the Division have the opportunity to continue their learning and development in the area of diabetes prevention.

Who has been involved?

Several general practices in the Eastern Sydney Division as well as St Vincent's Hospital Diabetes Centre, which has established and regularly delivers practice nurse diabetes education forums, have been involved in this initiative.

What has been achieved?

Three additional diabetes clinics are now available in Eastern Sydney and a reliable avenue is available to practice nurses for effective up-skilling and linkage to other local practice nurses.

What is planned for the future?

The Division hopes to continue to extend this model to more practices in the Eastern Sydney Division of General Practice.

What are the critical success factors?

The combination of clinical mentoring, education and improving data quality at the practice level has been critical to the success of this program.

**GP Access**

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PILOTING NURSE PRACTITIONERS IN AFTER HOURS CARE

What is the initiative?

GP Access has developed and implemented a staged Primary Health Care Nurse Practitioner (NP) trial at an afterhours general practice clinic. Phase 1- the Nurse Practitioner, who was supervised by a General Practitioner (GP), worked with 19 GPs and managed more than 180 patients. Phase 2 - scope of practice and clinical practice guidelines were developed by the NP, a local GP and a local pharmacist and forwarded to the Nurses and Midwives Board for approval. Phase 3 - the development and formal implementation of a plan to ensure the smooth transition of the NP working at the clinic.

Why is it important?

Research conducted in Australia shows NPs provide a safe, efficient and cost effective way of delivering quality primary health care, that is well received by patients. In mid 2006, 256 GPs were actively involved in GP Access After Hours (GPAAH). This number has declined to 231 in June 2009 and while the downward trend in GP recruitment continues, the numbers of patients attending the clinics has increased. PN recruitment was identified as a viable workforce strategy.

Who has been involved?

This initiative was fully supported by a GP Reference Group and local health providers.

What has been achieved?

Since authorisation, the NP has managed 120 patients. A full evaluation is planned for the future; however it can be reported that no patient has refused to be managed by the NP and praised their professionalism. Ninety percent of patients were 'very satisfied' with the treatment they received and all patients said they would be happy to be seen by a NP again. GPs were also very positive about their inclusion with over 94% indicating they would be happy to work with a NP within a documented scope of practice approved by GP Access After Hours.

What is planned for the future?

Full evaluation, including GP surveys, patient satisfaction surveys, workflow efficiency, number of patients and clinical outcomes.

What have been the critical success factors?

The willingness and commitment of stakeholders to support alternative models of patient care to ensure that required health services were available was a key factor in the development of this initiative. A major barrier to the more common use of NP is the current poor business case it represents, that is, without the ability to access Medicare and pharmaceutical benefits, every patient the NP manages means a loss of revenue to the practice.



GP Network Northside

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RYDE HOSPITAL ADMISSION ALERT FAX FOR GPs

What is the initiative?

This initiative has been developed and supported by GP Network Northside since September 2009. The Admission Alert Fax (AAF) is a project for General Practitioners (GPs) caring for patients admitted to Ryde Hospital through their emergency department where an Admission Alert Fax is sent to each patient's nominated GP, with patient consent, detailing the date of admission, the ward the patient was admitted to, the admitting medical officer's name and medical staff pager numbers. The fax also requests relevant clinical information and/or care plans from the patient's GP. The project supports better communication about medical history, current medications, adverse reactions, and test results and other relevant health and social information early on in the patient journey and aids communication between the hospital and general practice to improve the patient's transition from hospital to home.

Why is it important?

The impetus for this project was a result of two local GP surveys that found that GPs were not being informed when their patients were admitted to, or had died in hospital; that avoidable adverse reactions were occurring due to lack of consultation with GPs about medication changes; and that there was inefficient and delayed treatment due to duplication of recently performed tests.

Who has been involved?

Ryde Hospital ED is implementing the AAF. The hospitals were instrumental in initiating the project and will continue to be in sustaining it beyond the end of project funding. One patient ward in Hornsby Hospital served as a pilot site and the lessons learned have informed full implementation at Ryde. Funding has been provided through the Australian Better Health Initiative and implementation has been facilitated through the Northside GP Collaboration Unit, a joint initiative between the Division and Northern Sydney Central Coast Area Health Service.

What has been achieved?

Between September and December 2009, over 1000 faxes have been sent to GPs. Interim data showed approximately one-third of faxes were being responded to by GPs, with varying levels of information returned, ranging from confirmation that the patient was known to that GP/Practice to provision of team care arrangements, health summaries and specialist letters.

What is planned for the future?

The next key phase is the transition from project implementation to standard practice/hospital policy and determining responsibility for troubleshooting beyond project funding. Qualitative evaluation is underway via interviews with key hospital staff and local GPs to determine the extent of project awareness, how well it is progressing, how it is assisting them in their work, what benefits they perceive patients are receiving and how it could be further enhanced. The full final report will be available around mid 2010.

What have been the critical success factors?

The support of the Ryde Hospital, who have the authority and clinical credibility to facilitate hospital-wide system change, has been critical. So too the support of Ryde Hospital ED staff, without whom, implementation would not have been possible.

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HOSPITAL, GENERAL PRACTICE AND COMMUNITY HEALTH INTEGRATION PROJECT

What is the initiative?

This integration project has several elements, including:

- A notification system between Blacktown Hospital and general practice when a patient presents or is discharged from the Emergency Department.
- Discharge teleconferences to update General Practitioners (GPs) about the management and treatment of the patient. The hospital provides the necessary information and a plan of patient care to continue in the community. This process is coordinated by the GP Liaison Nurse from community health and patient flow coordinators from the hospital.
- GPs involved in the community health integration arm of the project identify patients with complex chronic conditions and using an auto-populated template, fax the patient's background and a GP management plan to the community health team who continue care based on the management plan. A community case conference is also organised to build a multidisciplinary care plan through which the patient is broadly supported to manage their chronic condition.

Why is it important?

Focused discussions with relevant local professionals had identified problems in the care coordination of patients including concerns that discharge summaries were not sent to the GPs directly and summaries that were received from patients were often not legible, and a change to treatment was often not recorded in the summary. GPs were also not approached preadmission, on admission or through admission to develop plans of care that meet patient's ongoing need.

Who has been involved?

WentWest Division of General Practice partnered with Sydney West Area Health Service and worked closely with various teams in the hospital and community health, including clinical redesign, care navigation, discharge planning, community nursing and engaged GPs and other stakeholders to implement the solutions for integration.

What has been achieved?

Results to date indicate that 323 notifications were sent from ED through care navigation to GPs from September 2008 to July 2009, 33 Discharge teleconferences have been held with the GPs from the hospital and 30 GPs have been registered under ABHI. These GPs are utilising the integrated primary care model in collaboration with community nurses and allied health services to support patients with chronic conditions.

What have been the critical success factors?

Dedicated staff to coordinate care using existing mechanisms and opportunities has been a critical factor in the success of this project.

**GP Access**

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IMPROVING GENERAL PRACTICE MANAGEMENT OF DIABETES

What is the initiative?

The GP Access Improving General Practice Management of Diabetes program is a focussed diabetes management strategy, encompassing education in the use of relevant technology. The program supports the use of the PEN Clinical Audit tool to facilitate better clinical record keeping, quality management, electronic clinical decision support and clinical improvement tracking. Practice teams were also supported to identify and implement change in their practice systems using the Plan, Do, Study, Act (PDSA) quality improvement methodology. They were encouraged to review a list of sample PDSAs and identify which strategies could be implemented in their practices. Royal Australian College of General Practice Quality Assurance and Continuing Professional Development (QA&CPD) points have been allocated for this activity.

Why is it important?

In 2007, GP Access recorded the highest number of patients with Type 1 Diabetes and the second highest number of patients with Type 2 Diabetes of any Division of General Practice in NSW. Diabetes is a growing chronic health problem that requires the active participation of medical and other professional health groups, and the public to reduce its current and future societal burden.

Who has been involved?

Division staff, practice staff and General Practitioners (GPs) across the Division region have been involved in this initiative. Support has also been gained through relevant non-government organisation programs such as the Heart Foundation's Just Walk It program.

What has been achieved?

GP Access began collecting practice information on diabetes outcomes in 2007. Early data from 900 patients indicated only 27.5% had a diabetes blood test HbA1c (a test used to identify the average blood sugar concentrations over a prolonged period of time) recorded that was less than 7%. As at June 2009, regional data for 12,500 patients with diabetes showed 42% had an HbA1c < 7, with nearly 7,000 annual cycles of care performed in the Hunter region. This number is currently increasing at a rate of 15% per annum. Additionally, sustained improvements have been made by eight practices participating in the Australian Primary Care Collaboratives, which are performing well above state and national averages on diabetes indicators, with over 56% of patients with an HbA1c less than 7%, and over 73% of patients receiving an annual cycle of care.

What have been the critical success factors?

A number of factors underpin the success of this program, including the ongoing dedication and commitment to improve the health of the local community by all involved and the feedback of performance data to practices highlighting the positive impact of the program.



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ELECTRONIC QUALITY IMPROVEMENT PROGRAM

What is the initiative?

GP Network Northside's Electronic Quality Improvement Program encourages general practice to improve the delivery of health care and the health of their patients by engaging in well-established and structured quality improvement processes. Practices submit de-identified patient data on a range of clinical indicators relating to coronary heart disease (CHD), diabetes, asthma and cervical screening and receive regular feedback reports, which include practical suggestions on how to make improvements based on ideas tried and tested by other local practices. Practices decide for themselves the area on which they want to focus their improvement efforts, which recognises the diverse ways in which general practice operates and thereby maximises participation in the program.

Why is it important?

"If you always do what you've always done...you always get what you always got!" This has been the mantra instilled in local general practices by the Divisions Practice Support Team since participating in the first wave of the National Primary Care Collaborative in 2004. The ageing population and the increasing burden of chronic disease on the health care system, without an equally increasing health care budget, means we have to look for smarter ways to deliver health care.

Who has been involved?

The Division participated in the original and Local Primary Care Collaborative waves and has successfully applied the learnings from that experience to adapt a program to suit local needs in order to sustain the initial benefits gained over the long term. Fifty-eight general practices have participated at varying levels since the original program began in 2004.

What has been achieved?

An improvement in the quantity and quality of blood test result data being submitted by practices is the key achievement. As at June 2009, the total number of patients on asthma, diabetes and CHD registers was 15 463. Fifty-six percent of asthma patients have had their smoking status recorded. thirty-two percent of diabetes patients reached the target HbA1c (a test used to identify the blood sugar concentrations over a prolonged period of time) of ≤ 7 . Twenty percent of CHD patients have reached the target BP of $\leq 130/80$.

What is planned for the future?

An increased focus on cervical screening data collection and feedback, which is a relatively new measure, is planned. Maintaining the motivation of practices currently submitting data to continue to make small and sustained improvements and recruiting more practices onto the program remains a key focus.

What have been the critical success factors?

Reducing the intensity of the program to a more manageable level to sustain long term involvement by practices, while maintaining program benefits and principles, has been important.

Individualising reports to meet the needs and priorities of each practice participating. Program flexibility means practices are free to leave and return to the program at any time, which recognises the time to address major events such as reaccreditation, moving premises, GPs on holiday and other day-to-day events.


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HEALTH PROVIDER COMMUNICATION PROGRAM

What is the initiative?

Hastings Macleay Division of General Practice Health Provider Communication Program involves the planning, installation and testing of secure messaging technology (Argus™) to support improvements in patient information communication between health care providers.

Why is it important?

This initiative supports sustainable improvements in the coordination and management of patients from acute care to general practice and vice versa. The initiative recognises that for General Practitioners (GPs) to provide consistent best patient care, they need to be informed and/or consulted about treatment regimes when patients are admitted or discharged from hospital.

Who has been involved?

The initial pilot program involved five GPs, five allied health professionals and five medical specialists. The subsequent extension of the program involved over half the GPs in the local region.

What has been achieved?

Prior to Port Macquarie Hospital adopting secure messaging technology, the program had been extended to over half of the GPs in the local area. With this level of connectivity among GPs, electronic discharge summaries were able to be immediately forwarded to a large proportion of local GPs. Furthermore, medical specialists involved in the program report that secure messaging has improved the speed of referral processes and communication with general practice.

What is planned for the future?

With many of the patients discharged to Residential Aged Care Facilities (RACFs), the opportunity to share clinical information and critical discharge planning information with the RACF was identified. While this has been too expensive to continue beyond the trial period, the Division has been supporting GPs to explore ways to use their own secure messaging through remote access when visiting the RACF.

What are the critical success factors?

Implementing quality systems associated with the use of the secure messaging, and up-skilling practice staff to take on the role of managing quality data systems have been critical factors in the success of the project.



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CLINICAL INFORMATION EXCHANGE PROGRAM

What is the initiative?

The Manly Warringah Division Clinical Information Exchange program has involved the planning, collaboration and implementation of e-health solutions (secure messaging and practice data analysis systems).

Why is it important?

This initiative supports sustainable improvements in the coordination and management of patients with chronic and complex conditions.

Who has been involved?

The Division convened a group of local General Practitioners (GPs) with a keen interest in information and technology solutions to provide advice, solutions and future directions on Information Management and Technology to the Division Board. This group has also been involved in clinical trials of technology that support improved chronic disease management, including e-prescribing pilots for Medisecure, ERX and a pilot of My Diabetes Health record – an online self management tool to support patient and GP monitoring of clinical diabetes care.

What has been achieved?

Within 18 months, 50% of Division GPs, 20 medical specialists and 15 private allied health providers were using Argus™ secure messaging to exchange critical patient information, and eight practices had data analysis systems installed.

GPs and medical specialists report improvements in timely referrals and team care planning arrangements, and patients report improvements in communication between their providers.

What is planned for the future?

The Division continues to work with practices in the education and implementation of secure messaging solutions and in improving practice data integrity to enable a better understanding of practice patient populations.

What are the critical success factors?

The appointment of the Divisions regional coordinator as a change agent has been critical in supporting general practice to adopt the new technology and influence change at the local level.



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CHRONIC DISEASE COLLABORATIVE PROGRAM

What is the initiative?

The Mid North Coast Division of General Practice Chronic Disease Collaborative Program is a quality improvement program that targets populations of patients with diabetes by establishing, maintaining and improving data quality in diabetes registers, regularly monitoring patient blood pressure, blood sugar and cholesterol measures, developing strategies to improve these measures, establishing recall/reminder systems for patient appointments and sharing ideas and experience across local practices. The program activities include the following:

- Practice staff, General Practitioners (GPs) and practice nurses attend local bi-monthly informal meetings to discuss progress and share ideas.
- Three learning workshops are provided to practice staff covering a range of areas including the what, how and why of the improvement model and process, and clinical management updates by local specialists.

Practices have now also started work on setting up Coronary Heart Disease registers and improving the care of patients with CHD using the new APCC measures and the same principles.

Why is it important?

The collaborative care model has been shown to be effective in ensuring comprehensive evidence based care is provided to patients with heart disease and diabetes in primary care.

Who has been involved?

Overseeing the program activities is a local diabetes working group, which includes general GPs, practice nurses, a local endocrinologist, local Diabetes NSW representatives and an allied health representative.

What has been achieved?

Two thousand, eight hundred and fifty (2,850) patients with diabetes are now involved in the program. Since its inception there has been a 200% improvement in measured HBA1c < 7 (a test used to identify the average blood sugar concentration over prolonged periods of time) and a 56% improvement in patients with normal range blood pressure. Process achievements include 15 practices establishing and maintaining diabetes registers for the first time and four practices who have established nurse led clinics.

What have been the critical success factors?

- Regular practice visits by the Program Manager to discuss and support progress.
- Local collaborative meetings which help practices share ideas and support each other to make progress.
- Using collaborative core model within existing health core funding arrangements and processes such as referral to allied health and community services which can be built into practice protocols.



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WEDGETAIL PATIENT HELD HEALTH RECORD

What is the initiative?

The Northern Rivers General Practice Network has developed and tested a web-based patient-held health record called Wedgetail, which allows a timely and consistent summary of medical information to be available and accessible to all health care providers of individual patients.

Why is it important?

This project recognises the importance of informed clinical practice, patient self management and personal monitoring of conditions, health outcomes and targets. Should a patient find themselves in an acute medical situation away from their usual providers, they can access personal up-to-date clinical information on line and share this with treating clinicians by providing them with guest log-in access to their on-line health record.

Who has been involved?

The project was trialled with 68 patients who have chronic and complex health needs.

A collaborative team of 20 health care providers including six General Practitioners (GPs), ten pharmacists, two practice nurses, one practice manager, and a medical specialist has underpinned the project's support. There are currently 94 patients and 41 providers enrolled in Wedgetail.

What has been achieved?

The development and implementation of an effective tool that supports improved clinical management through efficient sharing of clinical information.

Wedgetail has reduced information silos and allows clinicians to communicate in real time. The product will be National E-Health Transition Authority (NEHTA) standards compliant and can be accessed by the patient or health care provider via the internet. Wedgetail is open source and free.

The development and implementation of the Wedgetail-Doctors Control Results Service has seen over 5000 results uploaded to Wedgetail in the first two months of operation.

What is planned for the future?

The organisation is currently working with other software providers on possible interoperability, which will support additional features to improve ease of use for patients and health care providers.

What are the critical success factors?

Robust processes of engagement, promotion and change management have been critical in the development and implementation of this project.

Ongoing collaboration between GPs with an interest in patient-centred open source program development has ensured relevance, utility and efficiency in program design.



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SECURE MESSAGING INITIATIVE

The Secure Messaging Project enables health care practitioners to send, receive and share clinical information with their colleagues securely via the internet, making the communication of important information including clinical reports and referrals, faster and more accurate.

Why is it important?

The Secure Messaging Project was instigated to improve communication between health care providers to ensure optimum patient care across the continuum.

Secure messaging information is directly imported into patient notes, negating the need for time consuming scanning and eliminating the difficulties of trying to decipher poor quality faxed copies.

Who has been involved?

As part of sourcing a competent provider, the Northern Sydney General Practice Network took part in the accredited secure messaging software vendor Argus™ Affinity Program. A pilot program saw ten practices introduced to secure messaging and Argus™.

Following on from the success of the Affinity Program, the Northern Sydney General Practice Network promoted Secure Messaging and Argus™ on a larger scale, including hosting a function to promote secure messaging and encourage networking, attended by 80 diverse health care providers. Providers were enthusiastic and discussed ways to integrate the benefits of secured messaging into their practice and patients.

What has been achieved?

There are 225 Argus™ users who are registered under the Northern Sydney General Practice Network's umbrella and this number is increasing. These users include Specialists, General Practitioners (GPs) and Allied Health Providers.

What is planned for the future?

The Northern Sydney General Practice Network is now one of the leading Divisions that promote, support and provide services to those who require or have Argus™ software.

Northern Sydney General Practice Network shall continue to identify and encourage other health care providers and health care facilities to use secure messaging.

What have been the critical success factors?

A key driver of success has been GP champions who have enabled the notion and benefits of secure messaging to be understood by other health care providers.

Promotion following the introduction of the e-PIP (Practice Incentive Program), which requires practices to have an accredited secure messaging software vendor such as Argus™, also encouraged practices to take up secure messaging.

The Northern Sydney General Practice Network confirmed its commitment to promoting secure messaging by offering free installation to any site that is within its area. Northern Sydney General Practice Network engaged three IT contractors who have been installing Argus™ as well as training all the users on how to use it and maximise its utility.



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PARTNERSHIP FOR DIABETES PREVENTION PROGRAM

What is the initiative?

The Central Coast Division of General Practice Partnership for Diabetes Prevention Program is an initiative to support the local community and General Practitioners (GPs) in the management and prevention of Type 2 Diabetes. A number of parallel activities were undertaken to achieve this goal including the establishment of partnerships with allied health and relevant local businesses, distribution of physical activity and Lifescripts resources, and the utilisation of allied health professionals in general practice and practice nurse educational events. Key to this initiative is the provision of services by Accredited Exercise Physiologists (AEPs) for a number of practices that make available free or subsidised use of facilities. In return, the AEPs opportunistically screen patients aged 40-49 years for Type 2 Diabetes risk factors using the AUSDRISK tool. Through this screening the AEPs have identified eligible patients for the local Lifestyle Modification Program. The AEPs provide recommendations to the practice where the GP is subsequently able to make appropriate referrals and access relevant Medicare Benefit Schedule (MBS) items. In addition, patients diagnosed with Type 2 Diabetes can be offered relevant AEPs services such as group physical activity sessions.

Why is it important?

Type 2 Diabetes is a growing chronic health problem that requires the active participation of the medical and allied health workforce, and the public to reduce its current and future societal burden.

Who has been involved?

The Division has established sound partnerships with local Accredited Exercise Physiologists (AEPs) and local gymnasiums to support the implementation of this initiative.

What has been achieved?

The increased awareness of the role of AEPs in lifestyle interventions has improved communication and utilisation of AEPs as key allied health professionals in primary health care for risk factor prevention and chronic disease management utilising both MBS and government funded programs.

What are the critical success factors?

A crucial factor in the success of this program has been regular communication with the general practice team to identify how this program fits within their current practice structures and processes.



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SYDNEY DIABETES PREVENTION PROGRAM

What is the initiative?

The Sydney Diabetes Prevention Program is an initiative testing the effectiveness and feasibility of an evidence-based diabetes prevention model in the NSW primary health care setting. Participating General Practitioners (GPs) screen people aged 50-65 years who are at-risk of Type 2 Diabetes with the Australian Type 2 Diabetes Risk Assessment Tool (AUDRISK) to determine their eligibility for the program. Once referred, participants are offered a 90-minute initial consultation; three 2-hour group education sessions, regular follow up phone calls (at three, six and nine months); a 90-minute final consultation (at 12 months) and GP checkups (at four and 12 months). The program, which is free for eligible participants, is expected to empower people with the knowledge and skills to lead a healthier lifestyle. The aim is to achieve and maintain a healthy weight, be physically active and follow a healthy balanced eating plan. Apart from the mainstream, the program is also being run for the Arabic and Mandarin speaking populations of the Central Sydney area.

Why is it important?

Type 2 Diabetes affects a growing number of Australians. In 2004–05, ABS estimated 582,800 Australians (3% of the population) had the condition and this number which reflects only diagnosed cases is likely to underestimate the true prevalence of the disease. Previous studies have found the prevalence of the condition in those aged 25 years and over to be around 7.4% with an additional 16.4% of adults showing early signs of the illness. The total annual cost of diabetes in Australia is estimated to be \$2.2 billion or \$5360 per person per year and costs for NSW may conservatively be estimated at about \$AUS850 million per year.

Who has been involved?

The program is being implemented in three Divisions of General Practice (Central Sydney, Macarthur and Southern Highlands) in collaboration with Sydney South West Area Health Service, Institute of Obesity, Nutrition and Exercise, based at the University of Sydney, and Diabetes Australia – NSW. It is funded by the NSW Department of Health.

What has been achieved?

Data collection is underway to enable a formal evaluation of the program. Three sites are up and running and referrals are being accepted for the mainstream, Arabic speaking and Mandarin speaking streams of the program. There are over 300 people currently participating in the program and many of these are making significant changes to their lifestyle. The success of the program in terms of health and lifestyle improvements and the factors contributing to the success will become more apparent upon completion.

What is planned for the future?

The plans for the future are largely dependant upon the outcome of the evaluation. It is hoped that the evaluation is favourable and the program will be rolled out on a larger scale.

What have been the critical success factors?

Referral pathways for people with pre-diabetes or people at high risk of diabetes have previously been requested by GPs and a large number view this program as an excellent opportunity to actively screen and refer their high risk patients. A major learning has been that the referral process needs to be simple with as little paperwork as possible. The Arabic and Mandarin speaking GPs and participants greatly value the program as it is the only one of its kind available to them in the areas under study.



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HEALTHIER MEN! HEALTHIER FAMILIES! HEALTHIER COMMUNITIES!

What is the initiative?

Healthier Men Healthier Families Healthier Communities is a men's health education program aimed at promoting health and building resilience and skills in men in rural drought-stricken communities. The program has been developed by men for men and runs for three 2 hour sessions over a 6 week period. The program introduces health facts and information around health promotion, encourages help seeking behaviour and aims to reduce stigma around help seeking both from a physical and mental health perspective. It also provides detailed practical information around improving overall health and wellbeing through exercise, diet, stress management, anger management, communication and relationships. The workshop includes health checks, such as blood pressure checks, waist circumference, blood sugar, BMI, resting pulse, and depression screening, all of which are followed up as appropriate. The participants also receive information about the local physical and mental health services they can access in their local area, which should improve pathways to the services and encourage access.

Why is it important?

The long-running drought and associated hardship endured over the past seven years has impacted significantly on most farming families in the region. Day-to-day stressors in these regions impact negatively on the overall health of men. Additionally, barriers exist for rural men seeking assistance for general or mental health. Fundamental issues include stigma and negative beliefs about male help-seeking behaviour. Statistics also indicate that males in rural and remote areas have a significantly higher rate of suicide. Community members identified the rising problem of poor health in male members.

Who has been involved?

The Dubbo Plains Division of General Practice and the YWCA worked in partnership to provide this education initiative.

What has been achieved?

One hundred and ninety-six men attended across the four locations (Armatree, Coonamble, Warren, Quambone). Seventy one partners also attended the program. Given that two of the locations are villages with only a few houses and a pub, the other two locations are relatively small communities approximately 1500-5000 population, the attendance can be considered high.

What is planned for the future?

Areas under consideration for the future include whether separate workshops should be developed that may be more appropriate for elderly men; the need for increased contingency planning i.e. if it rains, funeral in a small village, presenter or organiser unwell; and, finally increased and earlier promotion (the next dates of workshops and offering participants a reminder flyer for the following workshop).

What have been the critical success factors?

Supportive community and partner organisations have been important, as has feedback from the community on their perceptions of impact of the education.



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RESET YOUR LIFE - PROGRAM TO REDUCE THE RISK OF DIABETES

What is the initiative?

The Reset Your Life program aims to educate and support patients to reduce their risk of developing Type 2 Diabetes. It was specifically developed for people aged 40-49 years who are at high risk of developing the condition. High risk is determined following completion of the Australian Type 2 Diabetes risk assessment tool. Participants need to be referred by their General Practitioner (GP) to the program.

Why is it important?

Type 2 Diabetes is a largely preventable highly prevalent disease. Associated with obesity, cardiovascular disease, kidney disease and marked absenteeism in the workplace. Any program that can help people reduce their risk of developing Type 2 Diabetes has considerable physical and psychological benefits for those people. Additionally, national health expenditure and rates of absenteeism would be reduced.

Who has been involved?

The Reset Your Life program was developed for the Australian General Practice Network by experts from the Baker IDI Heart and Diabetes Institute with financial support of the Department of Health and Ageing. The sessions are delivered by a facilitator together with qualified allied health professionals (such as a physiotherapist and an intern psychologist).

What has been achieved?

Fourteen percent of eligible patients have completed the program and a further 29% have completed at least six of the seven sessions in the program. A third group of participants will be commencing the program late February. Given the challenges faced and efforts required in gaining eligible referrals to the program, the positive feedback from those who have completed the program and those still participating, indicate that the program has helped to equip them with the skills and knowledge to modify their lifestyle.

What is planned for the future?

In the future our aim is to add local businesses with large workforces to the program promotion plans, and to increase the number of trained facilitators. We will also specifically target and support those practices that have made the greatest number of referrals to assist further increases in referral rates.

What have been the critical success factors?

Support from the Division's Board and the continual promotion of the program to GPs and practice nurses by all staff who visit practices has been integral to the success of the program.



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DIABETES CARE CARD AND EMERGENCY CARE CARD

What is the initiative?

The Hunter Rural Division of General Practice (HRDGP) has developed two purpose-designed, durable, wallet friendly cards for people with diabetes. On one side of the Diabetes Care Card are recommendations for an annual cycle of care, which lets the patient know what needs to be completed and when, including blood pressure testing, foot examination, cholesterol and eye examination. On the other side of the card, there is space to record five appointment dates, so that the patient can keep track of the details of upcoming appointments.

The Emergency Care Card has on one side three grave scenarios that someone with diabetes could potentially find themselves in. It allows people that may come to a patient's aid to know that they have diabetes and that this could be the reason for their sudden ill health. It also tells them what to do in an emergency. On the other side of the card there is space to write emergency contact person details in case the patient is unable to communicate.

Why is it important?

Diabetes and its substantial negative impact on health are increasing in Australia. The care complexity and large number of measurable health care parameters contribute to an often below optimal level of management of the condition. Empowering patients to better understand the condition and its management allows them to actively participate in care coordination. For example, completing the Diabetes Care Card means that when patients go to the Doctor and are asked whether they had their foot or eyes checked they have within their wallet an easily retrievable record of appointments.

Who has been involved?

Important partners in this initiative include the Hunter Rural Division of General Practice CEO and Practice Support Coordinators; patients and local general practices.

What has been achieved?

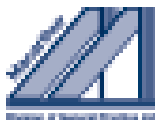
Distribution of the cards has been made to all general practices and pharmacies within the Division boundaries.

What is planned for the future?

It is planned that the cards will be distributed to HRDGP practices on an ongoing basis.

What have been the critical success factors?

Patient understanding of and willingness to be actively involved in the Diabetes Annual Cycle of Care has been critical to the success of this initiative.



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EAT IT! WORK IT! MOVE IT!

What is the initiative?

The Macarthur Division Eat It! Work It! Move It! (EWM) program is a secondary schools healthy lifestyle program that supports an increased health focus within the existing operation of schools through policy improvement and realistic programs. A set of core activities is supplemented by a localised action plan to target and enhance the specific needs and goals of each school community. Elective subjects supported include Personal Development, Health and Physical Education, Home Economics and Welfare.

Why is it important?

Childhood obesity is a growing health concern in Australia. Targeting the school and home environments has been identified as critical in obtaining favourable outcomes from interventions aimed at achieving sustained weight management in children.

Who has been involved?

The Macarthur Division of General Practice first developed the EWM program in collaboration with one high school in 2006; the program now operates across eight secondary schools in the Macarthur region. The Division, General Practitioners (GPs), allied health professionals and education staff work collaboratively in program delivery and improvement.

What has been achieved?

Achievements to date include a 74% increase in skim milk consumption, a 59% decrease in the purchase of flavoured milk, a 50% increase in kids eating the recommended five serves of vegetables per day, a 61% increase in student knowledge of the importance of being active for at least 60 minutes per day and a 62% increase in student knowledge of a maximum of two hours in front of a screen per day. Enrolment applications indicate that by the end of 2009, the number of participating students will reach 10,000 and school staff 2,500 respectively across 13 schools.

What is planned for the future?

Increasing the rigour of evaluation of the EWM program through the development of a partnership with the University of Western Sydney is planned.

What have been the critical success factors?

Partnerships between many organisations have been pivotal in the success of EWM. The complexity of linking education and health has been reduced through strong support from the NSW Department of Education and Training and each school Principal. Corporate partners (including six first grade football players who have been trained as EWM Ambassadors and an official EWM local media partner) and the Australian Department of Health and Ageing through the Active Australia Healthy Community Grants program has ensured access to the program at no cost to the current eight public high schools involved.



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DIABETES INTEGRATION PROJECT

What is the initiative?

This initiative sought to increase access for patients with Type 2 Diabetes to group physical activity opportunities via general practice management plans. Patients with Type 2 Diabetes and a GP Management Plan are entitled to one bulk billed individual assessment and eight group services per calendar year under Medicare. All programs are run as eight week structured programs and are facilitated by exercise physiologists (EPs) with support from a dietitian for one or two of the sessions. Programs are held in a variety of locations including physiotherapy clinics, family friendly gyms, and council owned aquatic centres. Each exercise session begins with approximately ten minutes of education and group discussion in a supportive environment to help facilitate the development of social networks. The EPs provide patients with motivation, support and encouragement during the program. If a patient misses a session the EP follows up with the patient to discuss any barriers to continuing the program.

Some of the important issues that arose in earlier attempts at this type of initiative includes the following:

- Several local exercise physiologists had established programs in the past but there were insufficient referrals to make the programs viable.
- Many General Practitioners (GPs) are not familiar with the exercise physiology profession.
- Most exercise physiologists are not clinic based and GPs tend to refer patients to services at 'bricks and mortar' locations.
- Not all GPs do GP Management Plans.
- Many GPs do not use diabetes registers and patient recall systems.

Why is it important?

Regular physical activity improves sensitivity to insulin and helps in the management of blood glucose levels in people with Type 2 Diabetes.

Who has been involved?

The Nepean and Blue Mountains Divisions formed a consortium to pool their resources for the project.

What has been achieved?

Programs are currently running at six locations. Sydney University has been engaged to assist with the Outcome Evaluation Study. This study will measure the impact of participation in the group program on knowledge and self-reported diet and exercise behaviour in the self management of Type 2 Diabetes.

What is planned for the future?

These programs are not sustainable in the short term without constant reminders to general practice through practice visits and newsletters. Over time, however, the number of referrals has increased to a sustainable point through increased practice and patient awareness of the program and its benefits.

What have been the critical success factors?

It is as important, if not more important, to educate practice nurses as they are often responsible for providing much of the chronic care and have more patient face to face time. The Division needs to support general practice in the use of GP Management Plans, diabetes registers and patient recall systems.



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SUPPORTING PATIENTS TO MANAGE THEIR HEALTH

What is the initiative?

Supporting patients to manage their health is a multifaceted initiative to improve self management support skills. Elements of the project include the provision of health coaching workshops and the provision of one-on-one support to a small number of practices to date in a quality improvement process aimed at identifying gaps in self management support. A quality improvement approach is used to support goal setting, self management education, and problem solving skills, patient involvement and linking with community supports. This process is further aided by practice staff training to help patients set goals and action plans, teach problem solving skills and encourage patient involvement. Resources are provided to enable links to community groups and services including the development of an electronic local service directory. A local television commercial has been produced to encourage people to take responsibility for their health, to adopt healthy behaviours and to seek support from their General Practitioner (GP), Practice Nurses and local community services.

Why is it important?

With the incidence of chronic disease on the rise, a shrinking health workforce and finite health budget, a greater emphasis is being placed on encouraging people to take responsibility for their health and to make decisions that will improve health related behaviours and clinical outcomes. General practice provides a robust platform to effectively support patients in managing their health.

Who has been involved?

The Riverina Division of General Practice and Primary Health incorporating Barrier Division worked in conjunction with the Murrumbidgee General Practice Network, local General Practices, community services and Health Coaching Australia in this initiative.

What has been achieved?

Thirty-seven health professionals have been trained in health coaching including 21 Practice Nurses and nine staff from the local Area Health Service. A pre and post assessment showed that participants' confidence increased across all eight self management support skills. There were also positive responses to the usefulness of the content covered with all participants also reporting they would be recommending the workshop to their peers.

What is planned for the future?

Practice Nurses have continued to be supported through further workshops specifically targeting the use of health coaching with chronic disease management items in general practice and also through the establishment of a Chronic Disease Self Management Network List Server and networking group. Plans are being made for health coaching training targeting General Practitioners.

What have been the critical success factors?

The wide ranging scope and involvement of key groups have been critical factors in the success of the project.



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IMPROVING PATIENT SELF MANAGEMENT THROUGH ACCESS TO TRANSPORT

What is the initiative?

The aim of this initiative was to identify where referral and community support systems, which aid patient self management, were underperforming and subsequently develop strategies and resources which could be implemented to overcome the identified problems. A patient survey tool was developed by the program partners to support the assessment of improvement opportunities.

Why is it important?

Effective community based support services improve the self management of chronic conditions which in turn can improve self efficacy and quality of life, and reduce the need for hospital admissions.

Who has been involved?

This project was an effective collaboration between the Prince of Wales Hospital, local Community Health personnel, South Eastern Sydney Division of General Practice (SESDGP), as well as patients and their General Practitioners (GPs) (23 patients were surveyed, of which 17 gave consent to also survey their doctor).

What has been achieved?

Poor access to affordable patient/community transport was identified as an important problem hindering self management. Specifically, this problem was identified as contributing to missed appointments, and an inability to collect medications and shop for fresh fruit and vegetables. The lack of educational resources and local service referral pathway information for people with chronic obstructive pulmonary disease was another important problem identified in the patient survey. SESDGP is currently working with the Prince of Wales Hospital in developing referral pathway processes as well as a simplified resource for use by GPs to ensure patient education and referral uniformity.

What is planned for the future?

To ensure that community members benefit from available transport services, SESDGP has compiled a comprehensive transport brochure. Plans are also in place for the development of an advisory committee with representation from all local community transport providers to identify funding options that will enable the "Patient and Community Transport" brochure to be kept up-to-date.

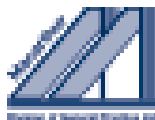
Options for delivery of chronic obstructive pulmonary disease educational material to newly diagnosed patients will also be identified. Prince of Wales Hospital admission reduction records will be used to demonstrate positive Divisional involvement with local services.

What have been the critical success factors?

Patient involvement in identifying the areas where referral and community support systems are not working and service providers being involved in developing strategies and resources to overcome the identified shortfalls have been critical to the success of this program.


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SYDNEY SOUTH WEST INTEGRATION PROJECT FOR DIABETES

What is the initiative?

The Southern Highlands Division is the fund holder for the largest Australian Better Health Initiative (ABHI) funded integration program in the State. The Sydney South West Integration Program (SSWIP) is a consortium of the Southern Highlands Division, the expanded Macarthur Division and Central Sydney GP Network. A major achievement of this Project has been its 'ComDiab' Program, which is a partnership between SSWIP, the Area Health Service and Diabetes Australia (NSW). The enhanced CARDIAB Program registers newly diagnosed Diabetes patients as well as people with a pre-diabetes state and monitors their ongoing care. The computerised program provides the usual clinical audit feedback but most importantly, the data flow to the Division has two key features. First, the data relates to the full set of diabetes risk factors and second, it is patient identified. This combination allows our Diabetes Educator to identify individual patients who may be in need of special attention. This feature of the Program gives us early warnings of potential complications.

Why is it important?

Diabetes can reduce a person's life expectancy. Premature heart disease is the most common cause of suffering and death, but other complications of diabetes are also contributory factors. Diabetes is the most common reason for renal replacement therapy worldwide, the most common cause of blindness in the under 65s, and the most common cause of non-traumatic amputation. With our current knowledge, most of these devastating effects can be prevented or delayed, or their impact minimised. This requires a focus on the prevention, early detection, and appropriate management of the complications of diabetes in adults.

Who has been involved?

Collaborators in this initiative include Southern Highlands Division, the expanded Macarthur Division and Central Sydney General Practice Network, the Area Health Service and Diabetes Australia - NSW.

What has been achieved?

This initiative is being tested by a fourth university study of our program which has to date found the program leads to higher rates of early detection of potential diabetes complications, and is more likely to lead to appropriate management and improved patient health outcomes.

What is planned for the future?

The next move is to integrate the Sydney Diabetes Prevention Program (Live Life Well), currently being trialled in our Division, into our overall Division Diabetes Program. This will provide a structured Diabetes Prevention Program based on the use of the 'AUSDRISK' detection tool and lifestyle modification. The Division is to conduct a research program over the next four years to study the impact of the lifestyle modification.

What have been the critical success factors?

This program provides formal training for Practice Nurses and Community Health Service Nurses to undertake diabetes patient education to patients triaged as having a low risk complication status. This frees up the credentialed Diabetes Educators, who are in very short supply, to attend to high-risk and more difficult cases.



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DIABETES GROUP PROGRAM

What is the initiative?

The Diabetes Group Program is a multi-professional, multifaceted diabetes lifestyle modification education and training program that was established under a Memorandum of Understanding between St George Division of General Practice (SGDGP) and the St George Hospital. The six week program with weekly 1.5 hour sessions incorporates an hour of education facilitated by the guest specialist followed by a half hour exercise session facilitated by the exercise physiologist. The St George Hospital Education Centre provides resources for the group participants.

Why is it important?

The St George Hospital Education Centre had lost the capacity to provide an ongoing educational program for those clients suffering from Pre-Diabetes and Type 2 Diabetes.

Who has been involved?

The SGDGP utilised its existing staff members of a General Practitioner (GP), exercise physiologist, dietitian, psychologist and nurse. This team was supported by the Diabetes Educator from St George Hospital, a community podiatrist and an ophthalmologist. The University of NSW has published the benefits of the program and importance of recognising Pre-Diabetes in the general practice setting.

What has been achieved?

GPs have been given the opportunity to refer their patients to a comprehensive multi-disciplinary approach to lifestyle modification, with the added reassurance that the needs of their (culturally and linguistically diverse) population are also addressed. GPs are provided with written progress reports and encouraged to take an active role in supporting participants in maintaining their lifestyle changes on completion of the active phase of group participation. Referrals to the Diabetes Group Program have been generated as follows: GP referrals 66 (27%); Diabetes Education Centre, St George Hospital 95 (38%); self referrals 25 (10%); St George Hospital Dietitian Services 3 (1%); other allied health providers 55 (22%). Post screening evaluations have indicated improvements in a range of indicators including weight, blood pressure, blood tests HbA1C (a test used to identify the average blood sugar concentrations over a prolonged period of time) and knowledge.

What have been the critical success factors?

The partnership arrangements, emphasis on sustainability and multiple referral pathways combine to make this a very successful program.



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LINKS 2 BETTER HEALTH PROGRAM

What is the initiative?

The Links 2 Better Health is a group program that teaches young people aged 8-14 years and their families about weight management and making healthy lifestyle choices. A team of health professionals from the St George Division of General Practice provide a six week program and instruct on physical activity, nutrition and behaviour. Children who attend the program are accompanied by one parent who is encouraged to take a whole family approach to weight management and healthy lifestyle choices. Program format:

Week 1: Baseline Measurements, orientation and introduction to outdoor activities.

Week 2: Behaviour Modification: identify unhealthy behaviour.

Week 3: Nutrition: food choices, portion sizes and preparation of healthy snacks.

Week 4: Physical Activity: skill development and initiating regular activity.

Week 5: Structured Behaviour Modification: rewarding positive behaviour.

Week 6: Nutrition: label reading and evaluation.

At six months there is a follow up appointment to assess physical health and behavioural change. This is done as a final group activity with goal setting exercises. If necessary, the participants are then referred to a psychologist, dietitian or exercise physiologist for individual management.

Why is it important?

This program was initiated in 2005 following our General Practitioner's (GP's) concerns at the number of children presenting to general practice suffering from obesity and already showing signs of chronic disease process, such as hypertension.

Who has been involved?

Referrals to the program come from general practices within the St George Area. The St George Hospital provides referrals from the Dietetics Service, Endocrinology Department and the Paediatric wards. Parents, allied health providers and specialists also refer to this service.

What has been achieved?

Ninety-two children have benefited from this intervention to date, with an average group size of six.

What is planned for the future?

Supplemented by a Healthy Active Australia grant, the St George Division has increased the promotion of this service and designed an interactive poster to engage the child and parent in the waiting room of the GPs surgery. It is hoped that this will encourage discussion between parents and GPs in the promotion of healthy eating and lifestyle choices. A nurse will conduct practice visits to deliver the poster and promote the St George Divisions Lifestyle Risk Factor Management Services.

What have been the critical success factors?

Community acceptance and willingness to participate are critical to the success of initiatives such as the Links 2 Better Health program.



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PHYSICAL HEALTH CARE FOR MENTAL HEALTH PATIENTS

What is the initiative?

Central Sydney GP Network (CSGPN) has developed an innovative service model for the provision of holistic and integrated physical health care to community mental health clients, ensuring the early diagnosis and pro-active management of existing co-morbid conditions.

Why is it important?

Research indicates that people with mental illness often have poor physical health, greater rates of chronic illness and higher rates of early mortality. It has also been found that affected individuals are less likely to access primary or secondary health care, and are at significant risk of 'falling through the cracks' between mental and physical health services.

Who has been involved?

The Sydney South West Area Health Service (SSWAHS) and CSGPN partnered in the development of the model. A private GP was engaged to conduct a Medicare funded clinic within the state-funded mental health clinic to specifically target community mental health clients who do not have their own GP. These clients were identified and referred by SSWAHS clinical staff for health checks, preventative care and management of chronic disease.

What has been achieved?

Based on evaluation over the twelve month trial period, findings indicate that the model was successful in improving disease diagnosis and care in community mental health clients. Over a 41 week period, 50 individual clients had 213 consultations. In the 50 clients, new diagnoses were made of high blood pressure (two clients), Type 2 Diabetes (three clients), impaired fasting blood sugar (four clients), hepatitis C (one client) and chronic airways disease (two clients). Twelve clients were newly diagnosed with high cholesterol and/or triglycerides. Six clients who had previously been diagnosed with these risk factors were found to be non-compliant with advice given by doctors about diet and exercise. Sixty-six percent (33) of the 50 clients reported being current cigarette smokers. Counselling on smoking cessation and/or lifestyle changes was provided.

What have been the critical success factors?

Key factors in the success of this initiative were identifying clinical and operational leadership within the Area Health Service and having the support of the community mental health team. Other critical factors include the recruitment of the 'right' GP for the role (one who had adequate commitment to and experience in working with marginalised population groups in the local area), and Division support in providing the GP with logistical and medical software and other resources needed to fully support the role. Issues and challenges encountered during the collaborative process between public and private community health systems centred on concerns about the legal framework that would enable a GP to operate a Medicare funded service in a NSW Health facility.



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HEADSPACE: MAKING A DIFFERENCE FOR YOUNG PEOPLE

What is the initiative?

Funded under the Federal Government’s Youth Mental Health initiative, the Central West Division of General Practice Headspace program provides a one-stop ‘walk-in’ shop for a range of mental and physical health concerns of people aged 12 – 25 years.

Why is it important?

Mental health is the number one health issue affecting young Australians today. One in four young people aged 12 to 25 experiences a mental health problem in any 12-month period, yet only 25% seek help. Early intervention has been found to significantly reduce the likelihood of future mental health problems.

Who has been involved?

The Central West Headspace initiative was established by a consortium of local organisations including the NSW Central West Division of General Practice as the lead agency, Bathurst Regional Council, Greater Western Area Health Service, Central West Group Apprentices, TAFE NSW, Department of Education and Training – Bathurst District, Housing NSW and Centacare. Services (all provided free of charge) include General Practitioners (GPs); psychology; drug and alcohol counselling; vocational and social services; dietitian; exercise physiology; sexual health; and women’s health. All patient records are shared by providers through the use of a shared electronic client management system to support good communication and seamless service for patients.

What has been achieved?

More than 500 young people have been supported in just 10 months, which equates to 7.5% of the local population aged 12-25. More than 4500 occasions of service have been delivered, including assessments, psychology, GP, drug and alcohol counselling, vocational and social assistance, dietary and exercise advice, exercise physiology, sexual health and women’s health. Around 11% of the young people reviewed have been Aboriginal, compared to local community representation of 2-3%.

There has also been a range of beneficial activities since the formation of Central West Headspace including the establishment of a local Youth Advisory Group, the delivery of education programs to more than 175 people, the conduct of more than 100 community awareness activities (to raise awareness of mental health in the community and increase early help-seeking by young people), ‘life skills’ workshops, including ‘job search preparation’ and art workshops to improve social connectedness through creative expression.

What have been the critical success factors?

A consortia of local organisations committed to the well-being of young people and the ability to share clinical information among the various health care providers in real time have significantly contributed to the success of this initiative.



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YOUTH MENTAL HEALTH NURSING PROJECT

What is the initiative?

The Illawarra Division of General Practice (IDGP) has united with Greenacres Disability Services and local General Practitioners (GPs) to provide 'Better Days': a peer-led support service for people living in the community with severe mental illness. The service is facilitated by the IDGPs Mental Health Nurse who, under the Mental Health Nurse Initiative, provides individual and group services to Greenacres clients, referred by their GP.

What has evolved is the establishment of a sustainable peer-based support service, co-facilitated by multidisciplinary health professionals, seeing clients form relationships to improve health, maintain wellness and promote recovery.

Why is it important?

Chronic mental illness is under-treated and can severely debilitate individuals and families. It was found that 10% of clients who were working in supported employment had severe mental illness and were not receiving adequate clinical support in the community. This joint collaboration sees clinicians and vocational workers work together to ensure collective treatment and support occurs through client recovery.

Who has been involved?

Greenacres Disability Services, nine local GPs, the Illawarra Division of General Practice Mental Health Nurse Service, South East Sydney Illawarra Health Vocational Educational Training Employment Program, private psychiatrists and a private practicing psychologist specialising in people with a disability.

What has been achieved?

The joint collaboration has enabled the provision of a community based specialist mental health service for people severely debilitated by mental illness. Reported health outcomes include:

- Reduced absenteeism from work
- 100% reduction in hospital admissions over December 2009 quarter in relation to previous years
- Increased social networking, friendships and support
- Collaborative development of crisis and safety plans

What is planned for the future?

2010 will see the program focus on and expand to include healthy lifestyle education, problem solving skill development and coaching to manage symptoms and relapse prevention.

What have been the critical success factors?

- Team work
- Cross sector collaboration
- Consumer driven – giving clients the opportunity to:
 - a) Be supported and support others in their recovery journey
 - b) Develop recovery orientated strategies
 - c) Identify group goals
 - d) Develop buddy systems and build relationships
 - e) Instigate social outings
 - f) Design and develop 'better days' individual crisis management plans



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SPLASH - YOUTH SUICIDE PREVENTION MODEL

What is the initiative?

The SPLASH (Suicide, Prevention, Listen, Ask, Safety, Help) program was part of the National Suicide Prevention Initiative (NSPI) funded by the Commonwealth from 2007 to 2008. SPLASH is an arts-based two day educational program that engages young people (14-25 years of age) in learning a range of skills and knowledge including the risk factors preceding suicide, the SPLASH youth suicide prevention model, suicide prevention and youth support organisations, problem solving skills, art activities such as creating a series of 'Suicide Prevention' posters.

The NSPI program also provided funding to conduct a series of experiential workshops which were attended by local Aboriginal groups including Koori women's and men's groups; Indigenous parents, elders, and those involved in the Youth off the Streets program. These workshops provided skills and education on identifying youth at risk, learning strategies to feel comfortable when listening to and providing support to a person at risk and an understanding of appropriate local treatment services.

Why is it important?

In 2002 the local Koori Youth Forum produced a report about important issues affecting young Aboriginal people in Griffith. The report highlighted youth suicide as a major problem. Research has demonstrated that knowledge in how to identify the signs of a young person at risk of suicide, active listening, supporting and assisting with help seeking behaviour can prevent a potential suicide.

Who has been involved?

The Griffith Aboriginal Medical Service (GAMS), Murrumbidgee General Practice Network (MGPN) and members of the local Indigenous youth community actively participated in the development of the local SPLASH program. A broad member based committee had an oversight role for the project - the NSPI Steering Committee consisted of representatives from NSW Police, Department of Education, MGPN, GAMS, Greater Southern Area Health and Aboriginal community member representatives.

What has been achieved?

The SPLASH program and associated initiatives have been well received by the local Indigenous and non-Indigenous communities. Furthermore, the newly developed close partnership between the Griffith Aboriginal Medical Service and the MGPN has given rise to a number of new Indigenous community projects.

What have been the critical success factors?

Critical to the success of this program has been the strong partnership between GAMS and MGPN.

The NSPI steering committee was instrumental in finding extra funding to continue with the experiential training program after the funding of NSPI expired, and permitted continual marketing of the SPLASH information at several local community events.



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TALKING HEADS

What is the Initiative?

The Talking Heads project aims to improve knowledge and awareness of co-morbid mental health and substance use issues in young people and how to manage them. The first phase of this project has been to recruit and train young people as peer educators in the area of co-morbidity and for them to engage with other young people at a range of community events and venues. During this interaction there are opportunities to de-stigmatise mental health issues, increase awareness and knowledge, provide resources and obtain information through a participant survey. The second phase of the project will involve interdisciplinary education for health and youth work professionals utilising knowledge gained from phase one. We will also develop appropriate referral pathways and communication mechanisms to facilitate access to relevant services.

Why is it important?

It is increasingly recognised that the use of both legal and illegal substances impacts on the developing brain and can be associated with both short and long term mental health issues. However, young people may not recognise features of mental illness for what they are or identify that substance use impacts on their mental health and they consequently often do not seek help for these issues from health professionals.

Who has been involved?

In this project the Sutherland Division partnered with our local area adult and youth mental health services and Shire Wide Youth Service, all of which are members of our local Youth Health Committee.

What has been achieved?

Seven peer educators were trained by mental health staff, a consumer, and youth workers. Approximately 400 young people were engaged at community events and 320 participant surveys were collected. Collation of the surveys is currently under way. Anecdotal feedback from the peer educators indicated that stigma is still a significant issue; while some young people did not take mental health seriously, those who knew someone who had experienced mental illness were more open minded; and the majority of those who had previous contact with mental health services had had a positive experience. A wallet-sized card with contact details of local youth / health services was developed and distributed via peer educators.

What is planned for the future?

We will be holding multidisciplinary education sessions in 2010 for General Practitioners (GPs), psychologists, school counsellors and youth workers to improve knowledge and awareness, provide feedback on the peer education experience, and to identify how we can improve services for young people with co-morbidity.

What have been the critical success factors?

The various services participating in Talking Heads knew each other through our involvement in the local Youth Health Committee. We were able to build the project using the experience of Shire Wide Youth Service with peer education; the knowledge of our mental health services; and the primary care and education experience of the Division of General Practice.



SHOWCASE 1



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SALEYARD HEALTH STRATEGY

What is the initiative?

Coordinated under the Network’s Mental Health for Drought Affected Communities Initiative, the Albury Wodonga Regional General Practice Network Saleyard Health Strategy was a three day screening and assessment program targeting those working in the local livestock industries. The program offered chronic disease health screening, flu vaccines, and advice and resources to support sound physical and mental health. Copies of the National Prescribing Service Medicines Talk brochures were also presented to participants during general health discussions to support a better understanding of medicines and their implications.

Why is it important?

Hard to reach population groups, such as workers in rural areas, particularly males, require tailored interventions to ensure disease prevention and health care is appropriate to the specific lifestyle context. Convenient timing of such interventions is also important. Sound models for engaging and interacting with groups who traditionally do not actively seek medical services are needed.

Who has been involved?

The Saleyard Health Strategy was a group effort involving Albury Wodonga Regional General Practice Network, North East Division of General Practice, the primary mental health team from North East Health, Indigo North Health, two Adelaide Western General Practice Network General Practitioners (GPs) and a number of local medical students.

What has been achieved?

Approximately 150 people attended over the three days, with 123 formally participating in the program. One hundred and twelve influenza vaccinations were given over the three days of the strategy. Approximately 20% of participants recorded an elevated blood pressure and one was identified as requiring specialist cardiac referral. Approximately 50% of participants were found to have waist measurements that placed them in high risk groups for developing a range of chronic diseases and were counselled accordingly. Approximately 20-30% of participants were referred to their GP (or other health providers) for further assessment and/or intervention.

What is planned for the future?

Future opportunities for the Network include formalising a more strategic program. This will offer the opportunity to expand the collaborative work with other organisations, improve the profile of the Network and improve pathways to general practice.

What are the critical success factors?

Work environments, such as saleyards, are busy locations and it is therefore vital to provide the program in an effective and efficient manner to minimise any disruption to the daily routines and prevailing work priorities.



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WORKPLACE QUIT SMOKING PROGRAM

What is the initiative?

The Stahmann 'Pecan Nut' Farms Quit Smoking Program was a workplace quit smoking initiative. The program involved three central education sessions including an initial sign-up session where measurements, a survey, smoking cessation presentation and two Quit-Line short films were delivered. At this initial session, arrangements were made for participants to see their General Practitioner (GP) for assessment and further advice. The second session, held three weeks after included a follow-up survey, a staying motivated to quit presentation by a psychologist and a presentation by a dietitian about avoiding excess weight gain when quitting. The final session, held six months after the initial session, included measurements, a final survey, follow-up advice and a panel discussion with experts.

All participants were provided with a start-up package which included a Quit Pack, Quitline referral, Nicotine Replacement Therapy DVD, healthy eating information, Quit Smoking resources with quitting tips, adverse health effects of smoking and passive smoking. Additional information included a motivational handout, a guide to avoiding weight gain when quitting smoking and increasing fruit and vegetable consumption and the Australian Guide to Healthy Eating brochures. A Healthy Habits Newsletter published by Barwon Division was also sent to participants.

Why is it important?

Calls for all Australian workplaces to be made 100% smokefree, indoors and out, have been made by experts after new studies showed smokefree workplace laws reduce heart attacks significantly. The rising cost of cigarettes, growing community awareness about the risk of passive smoking and the resulting increased restriction in smoking opportunity in public and work places, declining social acceptability for smoking, and health education programs are some of the known factors likely to lead to quitting.

Who has been involved?

The Barwon Division of General Practice, supported by a grant from the Heart Foundation, Stahmann Farms and its employees and a local Dietitian, Psychologist and doctor were all involved in this program. All participants saw their own GP at the beginning of the program.

What has been achieved?

Every permanent employee of Stahmann Farms who were smokers attended at least one education session as part of the Quit Smoking Program. All participants were males with 70% aged 40 years or older. 50% of participants smoked 30 to 40 cigarettes per day at the initial session. All participants had tried to quit smoking prior to the start of the program. Three weeks later five people had quit smoking, however by six months this had fallen to three participants. When compared to the success rates of other quit smoking initiatives, a 30% quit smoking rate is a positive result. Participants responded to the following questions about the program Q: *What did you like about the quit smoking program?* A: Group support; information received on related medical issues; information on diet and nutrition and Q: *What did you not like about the Quit smoking program?* A: Not quitting smoking; finding out about health problems.

What is planned for the future?

The evaluation results will be fed back to staff, the Department of Health and Ageing and the Heart Foundation, and will be used in future planning for Lifestyle Risk Factor Management Programs in the Barwon area.

What have been the critical success factors?

An education program purpose designed to boost participant motivation to want to quit smoking, an enthusiastic workplace and the availability of funds were all critical to the success of this program.



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