GPDV GENERAL PRACTICE DIVISIONS VICTORIA

NEWS

Summer 2006

Quality Improvement Council
GPDV is a QIC accredited organisation

Mission Statement

GPDV works at the state level to support Victorian divisions of general practice. Divisions build capacity in general practice, working at the local level towards a skilled, viable and effective general practice sector to improve the health and well-being of Victorian communities.

GPDV is part of the Divisions Network which is funded by the Department of Health and Ageing

Building Healthy Communities through Partnerships

We take our theme for this newsletter from the title of this year's Divisions Network Forum, *Building healthy communities through partnerships*, which focuses on strengthening the primary health care system to improve the health and wellbeing of all Australians.

The choice of theme is a reminder that one of the most important roles of the Divisions Network is to support the better integration of general practice into the wider health system. Whether we are in a division working to achieve this at the local and regional level, a State-based organisation at the state level or ADGP working nationally, the only effective approach is to develop working partnerships with others in the health system and the wider community services sector.

In this newsletter we showcase work by Victorian divisions ranging from partnership with large hospitals through links with indigenous and refugee agencies and a rural after-hours partnership between GPs, hospitals and the community, to a partnership of four divisions in eastern Melbourne. All these show that, as the West Vic Division puts it, divisions are trusted organisations and well placed to bring partners together.

At GPDV we play our part in the development of effective partnerships by offering our *Introducing Divisions* workshops. These are designed to give potential partners, including government departments which have been very appreciative participants, a clear understanding of what divisions are, what they are funded to do and how they can contribute to the improvement of health services at all levels. We suggest ways to approach divisions and strategies that will be effective in working with general practice.

GPDV also works with the Victorian Primary & Community Health Network to include divisions in a strong partnership of primary care sector agencies that can work together to improve the health system. Our aim is a united primary care sector that will carry more weight in negotiations with health departments and governments and will be able to agree on operational collaboration and system changes that will benefit the consumers for whom we are all working. It will also be able to mount a better argument to demonstrate, as the item on working with Primary Care Partnerships on page 4 proposes, that the provision of adequate resources is the key to an effective primary care sector.

But partnerships with the primary care sector, or with organisations with a similar approach to community services, are just the start. To be effective, primary care must have strong partnerships with the acute sector to help secure the necessary resources for work at the primary level to deliver more appropriate services that will also help take the pressure off acute services. The work of the Dandenong Division (page 7) and the Western Melbourne Division (page 10) are good examples of working successfully with a large hospital as well as with primary care services.

The other vital partnership in our efforts to enable general practice to influence the direction of the health system at the state level is with the Victorian Department of Human Services (DHS). As well as the work with the Primary Care partnerships through the Primary Health Branch of DHS set out at page 4, GPDV has worked in partnership with other branches of DHS to deliver, through divisions, programs in Clinical Risk Management in small rural hospitals, Hepatitis C education for GPs, a palliative care project under the PEPA 2 Program and, with the Lymphoedema Association of Victoria and the National Breast Cancer Centre, a program of GP education in Lymphoedema.

We hope that this issue of the newsletter will encourage readers to contact divisions to make use of their potential as partners in the development or improvement of services.

- Bill Newton, CEO

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Promoting effective partnerships in Victoria

"There are loads of opportunities to work with divisions- this workshop has given me more knowledge about divisions and therefore increased confidence to approach the local division"

This was one of the main conclusions expressed by a participant in GPDV's Introducing Divisions workshop in March 2006. This workshop is offered several times annually and over the last two years has reached 188 people from 52 separate organisations in the health sector in Victoria. The workshop has appealed to a broad range of organisations which are keen to learn more about partnership opportunities with general practice including:

- Aboriginal community controlled health organisations
- Community health services
- Primary Care Partnership member agencies
- Carer organisations
- Hospital networks
- Family Planning services
- Drug & Alcohol services
- Local government
- Womens' health services
- Non government organisations with specific health interests eg. arthritis, cancer, diabetes

Staff from Commonwealth and state health departments have also valued the workshop as a way of learning more about the industry of general practice, what divisions actually do and how divisions can be involved in government policy and program development and implementation.

The **Introducing Divisions** workshop aims to provide an orientation to the purpose of divisions and their relationship to General Practice and explores strategies and protocols for working collaboratively with divisions.

One of the questions put to participants in the evaluation of these workshops is " what attribute of general practice is the most important in providing impetus for you to work with general practice?" This provides a window into some of the key reasons for partnering

- GPs clinical knowledge base is critical
- GPs know about allied health service needs and gaps in the region
- General practice is the accessible first point of entry to the health system
- Patient trust in GPs enables GPs to offer prevention and early intervention advice
- General practice has regular contact with a large percentage of the Australian population
- Patients look to GPs to refer them to appropriate local services

The annual national survey of divisions provides a picture of the reasons why divisions seek and initiate collaborative partnerships.

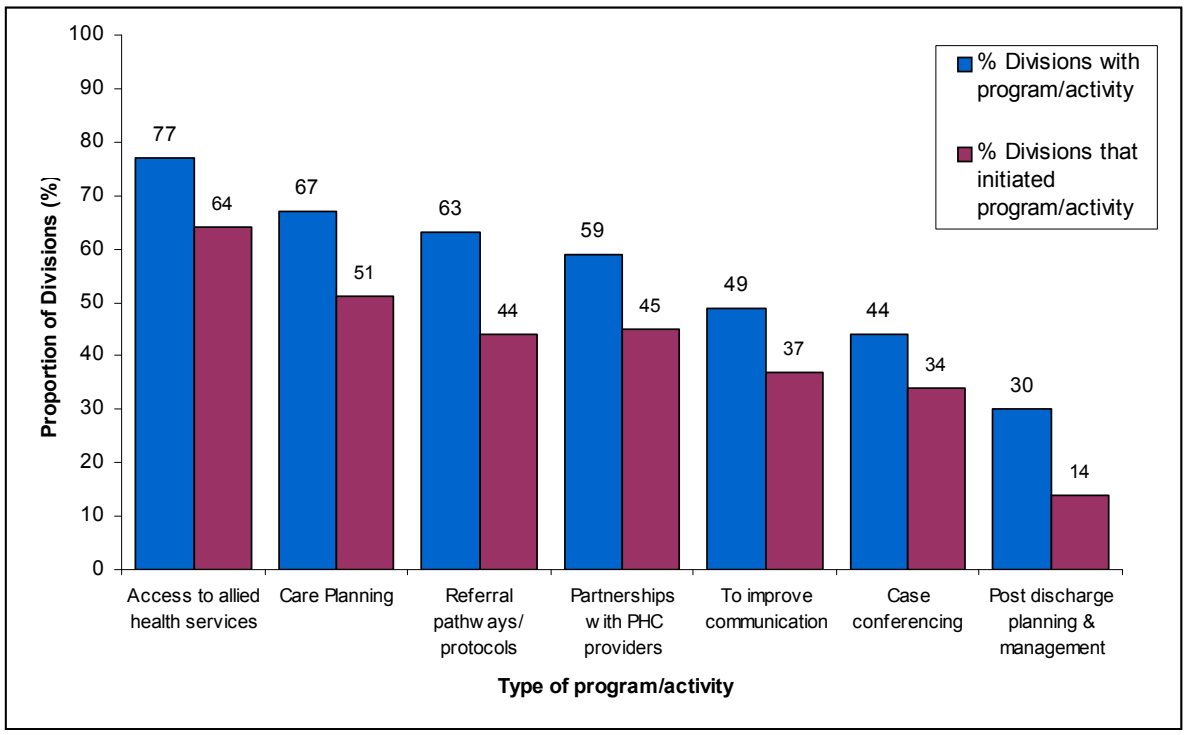
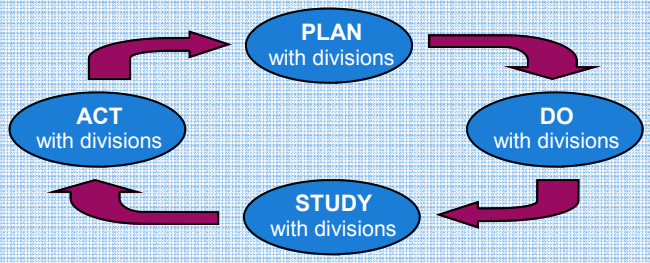


Figure 8.5: Proportion of Divisions initiating programs or activities to improve GP collaboration with other primary care providers, 2004-05

Source: Hordacre, AL., Keane, M., Kalucy, E., Moretti, C. (2006). *Making the connections. Report of the 2004-2005 Annual Survey of Divisions of General Practice.* Adelaide: Primary Health Care Research & Information Service, Department of General Practice, Flinders University, and Australian Government Department of Health and Ageing.

Protocols for collaborating with general practice through divisions



1. Work together at each step of a PDSA approach in creating change
2. Clarify common objectives, roles and responsibilities and record these in written statements
3. Plan together to build the evidence base and business case which will encourage GP engagement
4. Work with the divisions' network to identify and include GP "champions"
5. Acknowledge the expertise of divisions in GP engagement
6. Share data and findings and work with divisions to interpret their meaning
7. Support GP champions to disseminate the findings through divisions to other GPs
8. Develop a final report, a policy recommendation, a new funding proposal together with the division
9. Approach divisions through the CEO or the Chair of the Board

Refer to the DHS "Guide to General Practice Engagement in Primary Care Partnerships" as a useful resource

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The Primary Care Partnership Strategy in Victoria—Primary Care agencies building healthy communities through partnerships with divisions

Primary Care Partnerships (PCPs) form a strategic platform for health service planning and integration in Victoria. Division involvement in local PCP governance decisions has been remarkably widespread (almost 100%) and sustained since 2001. Over 75% of PCPs reported that their local divisions are routinely involved in PCP planning and activity implementation (23 out of 27 respondents) (p.3) [(1)]

Divisions say that the positive outcomes for general practice have been:

- ✓ More representation of general practice sector views in local health service planning and design
- ✓ A higher level of understanding of the GP sector by other service providers
- ✓ Improved quality of working relationships between GPs and other providers
- ✓ Improved quality of communication between GPs and other providers
- ✓ Enhanced capacity of GPs to use e-referral processes

How has General Practice been involved in PCPs?

The importance of including general practice in building a primary care strategic platform in Victoria has been recognised by the Victorian Department of Human Services from the beginning. DHS Primary Health Branch has shown this support through:

- Funding a Primary Health Care Consultant position at GPDV;
- Requiring PCPs to develop a GP engagement strategy, with a focus on the area of service coordination;
- DHS development of a GP version of the Service Coordination Tool Templates for referral;
- Funding for Small Grants for GP participation in service coordination.

Service Coordination:

To progress the development of processes and relationships, significant work has been done by DHS through PCPs on improving systems to assist GP participation in partnerships; this is referred to as service coordination.

- What have been the outcomes for consumers?

In 2004 a KPMG evaluation of how service coordination has developed in the first four years [(2)] found:

- 30 minute to one hour reductions in time to complete intake and assessment activities, although some agencies reported increases in time to complete intake and assessment activities due to a more comprehensive approach and improved practices;
- reductions in numbers of service sessions required for some clients due to the ability to move toward single session therapy as service times are longer due to reduced administrative load;
- reduced waiting times for services through better prioritisation of patients.

- What are the outcomes from the involvement of General Practice in service coordination?

Over four years DHS has provided Small Grants for division and PCP/member agency staff to explore GP participation in service coordination and, more recently, integrated health promotion.

- Fifty nine projects have been funded to date with a total allocation of approximately $800,000.
- Twenty eight out of 30 divisions have been involved in at least one Small Grant project.

Small grants have shown that:

- **relationship building and agreed clinical pathways** are needed for GPs to engage in service coordination, and use tools such as the Victorian Statewide Referral Form (SRF) for referral to the DHS primary care sector.
- **face to face networking and facilitated discussion** about issues in service provider communication improve GPs' understanding of and willingness to consider use of the SRF as well as help agencies to be more flexible about receiving high quality referrals in other electronic and legible formats.

Through this ongoing partnership with Divisions of General Practice, PCPs will facilitate further developments. With appropriate resources, PCPs and divisions will be able to:

- support use of Victorian SRF in general practice
- engage GPs and practice nurses in implementation of protocols for referral and feedback, and multidisciplinary, coordinated care planning, with public and private primary care service providers.
- reach shared understanding and agreement amongst key stakeholders about connectivity and e-referral platforms that enable general practice and public and private providers to transfer patient information.
- achieve integration outcomes such as:
  - timely access to allied health for agreed patient target groups
  - systematic assessment and feedback to GPs from service providers about treatment outcomes
  - viable and innovative co-location and multidisciplinary, coordinated care models

(1) PCP Evaluation 2005 – Feedback relevant to the General Practice Sector, Australian Institute of Primary Care, June 2006 (unpublished report – please contact Jenk Akyalcin, Jenk.Akyalcin@dhs.vic.gov.au, for more information)

(2) Analysis of the impacts of Service coordination on Service Capacity in Primary Health Care Sector, November 2004, KPMG. See http://www.health.vic.gov.au/pcps/coordination/pcpimp.htm

Current DHS initiatives in which divisions are involved that build upon the PCP strategic platform.

Initiative/Strategy	Contact name for more information	Website address(es) and email address(es)
PCP Strategy The Primary Care Partnership (PCP) Strategy has made significant progress towards the development of a stronger, more integrated community based health and community service sector. Divisions have a significant role in these Partnerships.	DHS - Jenk Akyalcin	www.dhs.vic.gov.au/rrhacs/primarybranch.htm Jenk.Akyalcin@dhs.vic.gov.au
GPs in Community Health Services (CHS) Strategy The GPs in CHSs Strategy reflects the government's commitment to strengthening the valuable role played by GPs who work in or with CHSs. The strategy is a key element of delivering quality medical care through the Community Health policy.	DHS - Julie Jenkin	www.dhs.vic.gov.au/rrhacs/primarybranch.htm www.health.vic.gov.au/communityhealth/gps/index.htm Julie.Jenkin@dhs.vic.gov.au
Including Projects coordinated by GPDV on:	GPDV - Pete Marshall	p.marshall@gpdv.com.au
Collaborative Practice Models for Careplanning - General Practitioners and Community Health Services Funding of $17,000 each has been allocated to 3 small projects in which CHSs, PCPs and/or Divisions will develop and demonstrate the models.	DHS - Diana Herd	diana.herd@dhs.vic.gov.au
GP in CHS Strategy funds to support Aboriginal Health Promotion and Chronic Care (AHPACC) Partnerships Additional funding to the nine AHPACC partnership sites has been provided to support general practice involvement.	GPDV – Lesley Czulowski DHS – Adele Hamlyn	l.czulowski@gpdv.com.au Adele.Hamlyn@dhs.vic.gov.au
GP Health Assessments for Refugees GPDV is funded to work with divisions to encourage the wider use of a consistent refugee assessment approach. This work will focus on the 8 PCPs with high refugee populations that are funded to establish guidelines for care coordination between GP practices and other health providers	GPDV – Annette Dupont DHS – Bernice Murphy	a.dupont@gpdv.com.au bernice.murphy@dhs.vic.gov.au
Small Grants for GP participation in service coordination and integrated health promotion Nineteen small grants of up to $20,000 each have been funded in 05-06. There are two streams: • referral and feedback and/or multidisciplinary care planning • referral pathways to support lifescripts implementation	GPDV – Sonya Tremellen DHS – Diana Herd	s.tremellen@gpdv.com.au diana.herd@dhs.vic.gov.au

Initiative/Strategy	Contact name for more information	Website address(es) and email address(es)
HARP CDM The Victorian Government Hospital Admission Risk Program (HARP) funds preventive models of care involving hospitals, community agencies and general practice focused on people with chronic and complex conditions. Priority is given to high volume and/or frequent users of the acute public hospital system. GP participation is facilitated by divisions of general practice and General Practice Liaison Officers (GPLOs) in hospitals.	DHS - Sue Race	www.health.vic.gov.au/harp-cdm/ Sue.Race@dhs.vic.gov.au
Care in your Community Divisions are represented in three pilot projects to test application of a planning framework for ambulatory care service delivery models and facilities in Victoria. These test sites will show how this approach to planning can enhance established and successful elements of the current health system at local and regional levels, including effective linkages with GPs.	DHS - Paul Butler	www.health.vic.gov.au/ambulatorycare/careinyourcommunity/index.htm Paul.Butler@dhs.vic.gov.au
Early intervention in Chronic Disease (EliCD) in CHS The EliCD initiative provides additional funding to increase and enhance service delivery to people with chronic disease. GP liaison and involvement of general practice in referral and care planning is a critical component of the chronic disease management model advocated, and divisions are participating in implementation.	DHS - Adele Hamlyn	www.dhs.vic.gov.au/rrhacs/primarybranch.htm Adele.Hamlyn@dhs.vic.gov.au
Aboriginal Health Promotion and Chronic Care (AHPACC) Partnership Aiming to encourage Community Health Services, Aboriginal Community Controlled Health Organisations (ACCHOs) and divisions to work collaboratively, to improve health outcomes for Aboriginal Victorians with, or at risk of, chronic disease.	DHS - Adele Hamlyn	www.dhs.vic.gov.au/rrhacs/primarybranch.htm Adele.Hamlyn@dhs.vic.gov.au
Diabetes Prevention—A 'Go For Your Life' Program (DPP) This program aims to identify people with pre-diabetes and provide an intervention to support lifestyle changes to reduce the risk of progression to diabetes. Currently three pilot sites are funded in Victoria. Specific GP engagement funding ($60,000 pa) is provided to partner divisions through PCPs.	DHS - Chrissie Pickin	Requests for more information to: chrissie.pickin@dhs.vic.gov.au
General Practice Liaison Officers (GPLO) Program GPLO roles form part of a broad range of initiatives aimed at bridging the acute/primary care interface in the Victorian Health care sector. A review of the GP Liaison Program was recently undertaken; the report on this review will be available on the website in December 2006. NB. GPLOs (GP and/or Project Officer roles) are funded either wholly by DHS or in conjunction with individual health services. In two cases partial funding comes from divisions.	DHS - Wendy Davis	www.dhs.vic.gov.au/ahs/emergelect.htm Wendy.Davis@dhs.vic.gov.au

Paving the Way to Integrated Care

Diabetes Cardiovascular Risk Management Program (DCRMP)

The DCRMP is a DHS funded Hospital Admission Risk Program. It commenced in January 2004 and is now part of the mainstreamed HARP Program. The program was auspiced by the South East Primary Care Partnership. The Dandenong District Division of General Practice was the lead agency and fund holder. Southern Health acute and primary care were partners in this program.

The DCRMP was designed to enhance the care of individuals with type 2 diabetes and significant cardiovascular risk/ disease. One of the key features of the model was to support GP's in their role as care coordinators within a multi-disciplinary team. In addition the aim was to streamline the flow of consumers between health-care providers as well as promoting the self-management and empowerment of those living with these conditions. The program aimed to reduce the hospital presentations and admissions of this target group.

Recruitment to date (Aug 06):

- 498 consumers
- 264 (57%) referred directly via the GP stream involving 146 individual GPs
- (43%) referred directly via the acute sector
- 240 GPs are involved in referral and/or ongoing care

Project services

Project services were developed in collaboration with consumers and partner organisations across the service system. Service development linked patient needs with local knowledge and expertise. Service development was informed by the latest evidence/ best practice.

Services include:

- Central coordination and assessment service
- Support & recommendations to GPs when addressing more complex needs associated with diabetes & CVD
- Assistance with insulin initiation and stabilisation
- Access to an inter-disciplinary advisory clinic at Dandenong Hospital
- Access to self-management programs and other lifestyle opportunities

This program was highly commended in the category of *Excellence in Continuity of Care* at the Victorian Public Health Awards held in October 2006

Central Coordination Service (DCAS)

The central coordination & assessment service located at the Division of GP is central to the success of the program. It supports and enhances an effective system of service coordination and delivery by providing a dynamic interface between the patient and service providers. In particular DCAS staff help mediate the cultural differences between GP practices and health care providers working in community health and the acute setting. This promotes and facilitates a smooth patient journey.

The primary function of DCAS is to receive referrals, assess, triage, track and monitor patients as they move through the service system. Referrals are received directly from GPs and specific areas of the Dandenong Hospital. Assessment processes ensure consumer needs are matched appropriately to available services.

DCAS provides GPs with a standardised referral process incorporating the use of the Statewide Service Coordination Tool templates. All GPs referring to this program use these Tool Templates.

Key Results

- 1% reduction in HbA1c from baseline to year 1 (p = 0.50)
- Significant increase in HDL (p = .007)
- Significant increase in patient's ability to access appropriate support
- Reduction of $1700 per participant hospitalisation cost

The Division has coordinated GP engagement for this program and benefits from supporting its members as a system facilitator and partner in health care delivery. The following highlights some of the successful GP engagement strategies used.

- GP ownership – representation during planning, implementation and maintenance
- GP "champion" involved at reference group level
- Inclusion of practice staff in the engagement strategy
- Support from division staff with rapport & understanding of general practice environment & culture
- Project Management staff located in Division – increased opportunistic access to GPs
- Destination for referral (DCAS) seen as GP friendly and supportive
- Adequate remuneration for GP involvement in development and planning

The project has clearly demonstrated the ability to coordinate and better integrate diabetes cardiovascular services across the acute and primary care service system. This has been achieved in the context of maintaining the GP as the care coordinator.

This project has recently been 'mainstreamed'. The Dandenong Division continues to work collaboratively with Southern Health in providing access to a range of high quality integrated services to this high risk target group.

Feedback from Practices referring to DCRMP

"The Diabetes Coordination & Assessment Service (DCAS) staff know how to relate to GPs. I am confident the service combines assisting the welfare of the patient while supporting the GP role. It is a great conduit to appropriate patient services"
(GP in Dandenong)

"I like the feedback from DCAS as it compliments the recall and reminder system in place at the practice"
(Practice Nurse in Berwick)

"The Diabetes Self Management Program really helped [the patient] to understand diabetes and self management"
(GP at Narre Warren)

"I feel confident that patients are moving through the services and receiving quality information."
(Practice Nurse in Berwick)

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Dr Graeme Downe, Diabetes Program Advisor, admin@dddgp.com.au

Enhancing program delivery through inter-divisional collaboration

The Eastern Region Divisions Network (ERDN) consists of Eastern Ranges GP Association, Inner Eastern Melbourne, Knox and Whitehorse Divisions of General Practice. The Divisions have been using a collaborative approach to enhance a number of Division programs over recent years. Each of these programs has been highly successful, and has increased the overall capacity of individual Divisions to provide a wider range of services to the GP Members.

There are many benefits to working together. Staff from each Division have had the benefit of being exposed to the varying cultures of the other Divisions. They can also experience first hand the complexities and proficiencies demonstrated in differing environments and circumstances.

Sharing of expertise between staff greatly contributes to each Division's success in programs, and also adds to the skills of individual Divisions' staff groups. It can be positive, too, to mix up the roles and responsibilities of managerial and operational staff, who are then able to participate in vertical learning. In this way, project staff are able to access professional development well beyond what can be learned within one Division.

Another practical benefit of working together is an increase in GP numbers attending activities, while not quadrupling the workload. While it is still important to maintain individual identity, and to continue to run programs and events at a local level, for activities that easily cross the borders of other Divisions it can be a more efficient and effective method of delivery.

Working together can increase consistency and efficiency through cost savings, which not only benefits our organisations, but also other strategic partners with whom we share common boundaries, such as DHS and other health care services. Relevant strategic partners have the opportunity to reach many more GPs than would be accessible through single Division activities. The ability to promote and present a united front to various regional stakeholders is important. These stakeholders are able to liaise at one point, yet access all four Divisions and present their message to a larger audience than would otherwise be possible.

To date this has been achieved by allocating one Division as fundholder and coordinator of each project so that the reporting and direction of the program is clear. This is a role that is shared across the four Divisions, and allows each Division to choose the lead role in an area in which they have strength, allowing the other Divisions to draw on that strength.

Standard templates have been designed and are in use across a range of inter-Divisional activities. These templates are consistently reviewed, as we learn more about each other and how interdivisional activities should be organised.

The Eastern Region Divisions Network is looking to the future with optimism, aiming to strengthen the partnership and work together wherever beneficial and appropriate. Steps are in place to continuously improve this collaboration and to strengthen it for the many projects to come.

GPs enjoying a break at the recent Eastern Region Divisions Network GP and Family conference, titled *Developments at the Coal Face: What's New in General Practice.*

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Whitehorse Division of General Practice
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Northern network nurtures new arrivals

The Refugee Health Services Project at the Northern Division of General Practice

Working with newly arrived refugees can involve managing rarely-encountered diseases, complex immunisation catch-ups, and caring for people traumatised by war, who speak little English. In the past, many of these patients have been initially cared for by Community Health Centre doctors and their colleagues. With today's GP workforce shortages, this is not always possible. A new partnership in Melbourne's northern suburbs is addressing these issues by cooperation between community health, general practice and settlement agencies.

The Department of Human Services (DHS) has funded Primary Care Partnerships (PCPs) to make sure that newly arrived refugees can effectively access the range of health services they need. This project supports the refugee health nurse project, which has placed nurses in Community Health Centres that see high numbers of recent refugees. The North Central Metro Primary Care Partnership (NCMPCP) is conveniently co-located with the Northern Division of General Practice and has engaged the Division's assistance to carry out the new project. The existing close relationships with Darebin Community Health and with local settlement services, together with an active group of interested general practitioners already meeting regularly in the Division's Refugee Small Learning Group, have facilitated the smooth and speedy development of the Refugee Health Services Project.

Workforce shortages, together with the complex health needs of most newly arrived refugees, means that GPs in Community Health Service GPs are overstretched, so the program aims to build expertise and interest in local private general practice to share the load. Interested GPs, practice nurses and practice managers attended a three-part Active Learning Module run with Foundation House at the Division with the support of local settlement services and Darebin Community Health. GP consultant Dr Joanne Gardiner is working with Division Program Coordinator Nancy Atkin to prepare a Refugee Resource Kit (with concise information such as referrals, screening, and Medicare Items) for practices; this information and more is being put on the Division's website, www.ndgp.org.au. The Division is offering practice visits by Dr Gardiner, to conduct training or provide resources according to the needs of the particular practice.

Dr Jo Gardiner, GP Consultant

This small project, scheduled for completion by the end of 2006, has already had a number of positive outcomes. For GPs, it is building awareness and relevant knowledge to work with refugee patients, and supplying practical tools for example for screening. Information on care pathways, and on the assistance available from the refugee health nurse, supports GPs and their staff in providing better care for their patients. Workforce issues are being addressed in a small way, by building skills of private GPs, and training practice nurses to share work for example in initial screening.

These resources and training opportunities have been promoted widely in Division publications. At the same time, partner agencies such as the North East Migrant Resource Centre, and AMES and Darebin Community Health hear from their clients about GP practices commonly attended by various clients from various refugee backgrounds. Working together and sharing this information has enabled the project to target practices that have appreciated the offer of additional resources and training; as well as enlisting the additional practices to help share the workload.

Newly arrived refugees have their settlement needs coordinated by AMES, whose local coordinator, Nihad Aganovic, is based at the Migrant Resource Centre in Preston. Nihad has the challenging task of arranging initial health assessments for new arrivals. He has been keen to work with the Division to streamline this process, and the new partnership has already assisted him to find GPs with appropriate language skills in the right locations for his clients.

Refugee Health Services Project Reference Group

The Division had already brought together GPs interested in refugee health over the past three years, through our Refugee Health Small Learning Group. The Refugee Health Services project has created a wider network, linking GPs with local organisations responsible for the care and settlement of newly arrived refugees. It has also highlighted the gaps in the system, with new refugees being settled on the urban fringe, beyond the official catchment of Darebin Community Health, in areas with fewer GPs and further from specialist health services.

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Improving secure electronic transmission between health care providers—the Western Melbourne Report

There are numerous projects in the health sector currently attempting to support the flow of clinical information between key providers. In essence all of these projects have been striving to supply a cost effective means of delivering a secure electronic communications network for the transferring of sensitive health information.

Early in 2005 the Western Melbourne Division of General Practice (WMDGP) engaged CNS Health to provide a secure communication platform to transfer confidential patient, clinical and healthcare information between GPs and healthcare providers. This system has been locally renamed 'Western Melbourne Report'. The initial scope of the project was to link GPs and Private Specialists to allow for referrals and reports to be exchanged securely. However the potential of this communication platform to link a virtually unlimited number of health providers to GPs was recognised.

In late 2005 Western Health became a partner in the project and integrated the daily faxed / posted notifications and reports to GPs into 'Western Melbourne Report' as it was recognized that the current system was costly to the sender and receiver, unstable, and had issues associated with security and misfiling. A Steering Committee was established with representatives from WMDGP, Western Health, General Practice, Private Specialist and the vendor (CNS Health) and a 6 month trial project commenced. Although initial implementation of the 'Western Melbourne Report' commenced in August 2005, the official trial phase began in February 2006.

Outcomes for General Practice

The trial group commenced with 60 providers from both general practice and the private specialist sector using 6 different types of clinical software Medilink, Genie, Bluechip, Zedmed, MedTech 32 and Medical Director.

In consultation with all stakeholders, the following two components of secure messaging were agreed on and transmitted during the trial:

1. Communication between GPs and Specialists
2. Reports from Western Health to GPs
   - ✓ Endoscopy Reports (Footscray Only)
   - ✓ Deceased Advice
   - ✓ Outpatient Appointment Advice
   - ✓ Elective Waiting List Advice
   - ✓ Waiting List Advice
   - ✓ Admission Advice
   - ✓ Same Day Admission Advice (including Pregnancy Day Stay Unit Advice)
   - ✓ Discharge Advice

   To date over 4585 messages have been sent and received via 'Western Melbourne Report' to 14 General Practices. 90% of reports have been generated from Western Health.

Summary of findings

- This project has successfully achieved its aim of supplying a cost effective means of delivering a secure electronic communications network between services providers for the transfer of sensitive health information.
- For practices as an alternative to the AUTOFAX system, sending status reports/notifications to GPs via 'Western Melbourne Report' has proved to be efficient and effective. Messages sent electronically and stored against patient results in the practice software has made a significant contribution to work processes in private practice environment.
- With the trial group of GPs and small number of Private Specialists having already adopted the 'Western Melbourne Report' as a secure means of transferring sensitive patient information, the solution has clearly been successful in both acceptance of the product and the changing of work processes and practices.
- Important to the success of this project was the high level of collaboration between Western Health, WMDGP, GP's, Private Specialists and the vendor (CNS). The in-kind resources from CNS for software development made the trial of this solution possible. CNS and WMDGP provided 'Western Melbourne Report' software and the implementation services to GPs and Private specialists at no cost.

Outcomes for Partners

The implementation of a secure messaging solution for GPs and Western Health in Western Melbourne has improved the timeliness and security of receiving patient information. The use of a point to point secure system as well as practice management processes whereby clinical documentation can be easily integrated into the practice information systems has enhanced the sharing and delivery of clinical information. It has also enhanced the partnerships that currently exist between service providers in the region.

Moving Forward

The project has been successful for the 6 month trail period and is continuing to operate. Commitment has been made by participating partners to further develop and continue the operation of 'Western Melbourne Report' and to commence discussions with neighbouring Divisions and other interested parties.

WMDGP has recently elevated the project to core service status. From here on in the focus will be:

- Providing increased support to practices to encourage the take up PKI
- Implementing a 'Western Melbourne Report' roll-out strategy for all western region GPs and Private Specialists
- Adapting this secure platform to other Division program areas. This has already commenced in the ATAPs program between participating GPs and psychologists.

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Building healthy communities through partnerships
Indigenous Communities

Main findings of the partnership

Western Suburbs Indigenous Gathering Place is an Aboriginal community controlled health organisation. Westgate Division and the Western Suburbs Indigenous Gathering Place have been working together with community health, childrens' services and local government to improve access to services for the indigenous communities across two local municipalities following a population analysis which revealed that approximately 1000 indigenous people were not using local mainstream services.

The aim of the collaboration was servicing the indigenous communities with the first phase being to reach young families in a booming growth area with a service which would focus on bringing indigenous children, family and carers together to enjoy each other's company, exchange ideas and have fun together while giving each other support.

Effective links between the partners provided important direct and long term benefits and value to all sectors. Benefits for the Division included increasing partnerships with other organisations that could build significant capacity for program implementation and future initiatives. One of the highlights is the development of a wellness program for Aboriginal communities.

Outcomes

A satellite centre for the indigenous community was opened in early 2006, which is based within a mainstream service. This structure has enabled the community to access other mainstream GP and allied health services. A mobile play group services the young families from both municipalities and as a consequence other services are introduced and made available to the families as they become familiar with the surroundings.

Feedback from general practitioners has been positive since they have welcomed locally based services which are culturally appropriate for the indigenous communities. This has also resulted in the design of a framework for the capture of ATSI data across many programs of the Division.

'Our Mind Our Body Our Spirit' Wellness Program

This eight-week health and wellness program run separately for indigenous men and women focuses on prevention, early intervention and active health promotion models. The program measures health and well being, what services have been chosen post the program, and whether inequalities have been reduced in the case of men and women accessing services and health information.

Program achievements:

- dispelling myths regarding health issues
- identifying barriers indigenous people face in health settings
- increase in physical activity
- education about nutrition
- weight management strategies
- increasing social interaction within the community
- encouraging access to and use of mainstream health services
- increasing cultural identity

Self esteem issues are also an area of focus. Men and women work together within a group setting to address a range of presenting issues including post traumatic stress syndrome, drug and alcohol issues, sexuality, self esteem, anxiety and depression.

The Division has gained immeasurably through a more sustained interaction with an indigenous agency. This has impacted from the Board down to program development and implementation with more culturally sensitive programs being introduced and ensuring that current programs reach our indigenous communities.

This has cemented the relationship with the Western Region Indigenous Gathering Place and has enabled the Division to address Koori issues which has a potential for major development in the future.

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Partnerships addressing workforce shortage in the after hours period

There is a national and global shortage of general practitioners that can not be reversed in the short term. This shortage is occurring at a time of increased demand for primary care services due to our ageing population, chronic disease, shorter hospital stays and increased consumer expectations. Workforce solutions in our area can not only be solved through the recruitment of more general practitioners but through the development pragmatic, integrated and workable support systems. These systems make a difference where it matters: access to primary care services and sustaining rural general practice. In our rural area, with limited health resources, such systems are built by local partnerships that allow health resources to be shared. The Grampians After Hours Service (GAHS) is a system built on partnerships that assists the rural general practitioners and our rural community to participate in consistent and quality services in the after hours period.

The system's success is based on cooperation between GPs, general practices, Health Services and most importantly the rural community it services. The GAHS, currently funded from the Commonwealth After Hours Primary Medical Care Program is an integrated rural after hours care system. It utilises shared health resources and capacity to provide a confidential, reliable and consistent after hours health service from 6:00pm to 8:30am, 7 days a week.

The GAHS Team

GAHS is a virtual rural after hours general practice clinic. Practices across our Division switch their clinic phones at 6.00pm to a shared after hours clinic nurse who provides a triage service to general practices across a geographical isolated 62,500km2 and a population of 78,000. This nurse sits within one of our rural hospitals and is a valued member of the general practice team. The after hours clinic nurse operate on a rotating roster from 4 hospital sites. We currently have a team of 6 nurses. Local management by WVDGP ensures the system can be flexible and responsive to all, enabling the service to function across our diverse geographical area.

GAHS provides the community with access to a quality local after hours service system regardless of where they live and incorporates expert knowledge of local infrastructure and accessible health care services both in and out of hours. The GAHS Clinic Nurse has a clinical role that not only includes triaging patients, but also:

- Discussing patients needs with GPs over the phone;
- Participating in clinical problem solving taking into account the geography, and resources available locally;
- Facilitating phone contact or face to face assessment by Emergency Department nurses and or GP;
- Facilitating a GP appointment in the morning;
- Ensuring continuity of care between services, by informing GP of after hours contact made by their patients.

To date the service has received over 10,000 calls and reduced calls to GPs by over 60%. The annual Division member survey reinforced that GPs value this service. The service has effectively reduced the burden of after hours on rural GPs while improving the quality of service to the consumer and supporting skill development in the rural health service nursing workforce.

An established regional and partnership approach also provides a framework to engage new partners. The establishment of the Victorian Governments state wide health assist line Nurse - on –Call, has raised concerns of duplication of effort and increased referrals to general practitioners in the after hours period. The management team of GAHS have been able to establish a partnership with the management team of NOC to ensure the appropriate management of people in our area in the after hours period. Protocols have been developed that ensure that consumers from our area who contact NOC and need after hours primary medical care are transferred to GAHS. GAHS and NOC and sharing data to measure the impact of NOC in our area.

The main lesson learned is that the Division is a trusted organisation and well placed to bring partners together across our region. Being a not - for – profit organisation that advocates for diverse communities across a region, allows the Division to engage town based agencies to participate in systems outside their historical patterns. This in turn allows health resources to be shared creating increased capacity for general practice to provide quality services in our area.

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