Table 6 - Summary of issues/needs and strategies to address (include all priorities identified in the Excel spreadsheet established as priorities for 2014-15)

Issue/ Need	Strategy	Description of Strategy Activities	Justification	Expected Outcome
Access to Allied Health in Rural and Remote areas	To Increase access to Allied Health services in Rural and Remote areas of the Barwon Medicare Local Region.	• Establish a health network with membership from each of the key health organisations in the rural and remote areas of the Barwon Medicare Local Region to; • Identify and quantify allied health service needs. • Work with key stakeholders and organisations to identify and develop possible service models that ensure best access to allied health services in rural and remote areas and use of resources using a social equity and cultural lens. • Implement identified service models in the rural and remote areas of the catchment. • Utilise ehealth service delivery and training technologies (tele/video conferencing, telehealth, webinars) • Provide cultural awareness support to providers servicing rural and remote areas	The Health Workforce Australia, National Rural and Remote Health Workforce Innovation and Reform Strategy, was released in May 2013 and sets out priority recommendations for the development of the health workforce in rural and remote areas. The identified priorities are as follows; 1. Develop the rural and remote workforce through: • promoting better use of existing roles • redesign of existing roles • creating new roles on the basis of consumer need. 2. Support and enhance the growth of education, clinical training and career opportunities in rural and remote Australia. 3. Support leadership at all organisational levels to ensure sustainability of the health system and responsiveness to the health needs of consumers now and into the future. 4. Plan for the optimal use of skills and adoption of workforce innovation and reform, by developing appropriate planning and modelling approaches for the rural and remote health workforce. 5. Support and enhance the industrial and legislative framework to promote and facilitate the implementation of workforce reform policy to sustain and build the rural and remote health workforce.	Increased access to allied health services in the rural and remote areas of the catchment in response to identified allied health needs. Improved collaboration and leveraging of existing resources in the rural and remote areas of the catchment between health and community services. Allied health service models implemented. Allied health workforce strategy documented implemented to ensure sustainability of models implemented. Increased use of telehealth for service delivery in rural and remote areas. Increased understanding of cultural awareness amongst service providers in rural areas.

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Health Literacy	To improve health literacy in the Barwon region.	Interdisciplinary CPD events to encourage shared learning and understanding on particular topics. Continue to promote HealthPathways across the range of Barwon Medicare Local programs and networks. Work in collaboration with key community agencies to develop resources / education strategies for general practice and allied health providers to address the identified needs of patients for information and engagement in decision making. Use of the docgeelong website and kiosk as an information tool for consumers on how to access general practice, pharmacy and dental services. Support practices to register patients for the eHealth Record and upload shared health summaries. Work in collaboration with Barwon Health's Respecting Patients Choices Program® and GPs to develop a sustainable model of GP initiated ACP.	There is no one way to measure health literacy. The approach taken by the Australian Bureau of Statics (ABS) in determining the number of people that are and are not health literate has been based on reading and numeracy ability. This focus is clearly on individual health literacy. There has been much less focus on the measurement of the health literacy environment. That is, how effective the health services and systems are in assisting health consumers to navigate to the service that they need and to be supported in self-management of their health care. The health literacy systems environment is the one that Barwon Medicare Local can influence through HealthPathways, our existing relationships with primary care and community providers and this will positively influence individual health literacy. Advanced Care Planning In 2010 the GP Association of Geelong (now Barwon Medicare Local) collaborated with Barwon Health's Respecting Patient Choices Program (RPC)® and two local GPs, to trial a pilot project titled, 'Advance Care Planning in General Practice'. The project was based in two general practices and run over a six month period. Project outcomes revealed an increase in ACP uptake (completed plans) when initiated in the general practice setting (86% completion rate compared to average 50% rate prior to this project). Consenting patients were identified through routine consultations and provided with ACP information prior to meeting with an RPC® Facilitator. Consumer feedback was positive; indicating a desired level of control over their future health	Increased understanding of the work that people from other disciplines perform. Increasing uptake and use of HealthPathways resulting in consistency of care and referral of patients for appropriate and timely health care. Improved communication with patients regarding critical aspects of care and the service system. Increased awareness amongst consumers of docgeelong website and kiosk. Increased number of patients registered for an eHealth Record. Increased number of health summaries uploaded to eHealth Records. The development of a sustainable model for ACP in primary care. Increased awareness

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		Promote awareness of the Australian Governments Child Dental Benefits Schedule and the role of Maternal and Child Health nurses and other existing oral health programs amongst GPs and practice nurses and other service providers in the Barwon region through the provision of information through newsletters, events and the website.	outcomes. On this basis, a larger number of practices (18) were recruited to participate in the Australian Primary Care Collaborative Medicare Local Wave in 2011 - 2012 to test the validity of the outcomes achieved in the 2010 pilot. From December 2011- December 2012 there were 1345 General Practice initiated Advanced Care Plans completed compared with less than 200 in 2010 and 2011 calendar years. Demonstrating the important role of General Practice as an initiator and facilitator of Advanced Care planning.	amongst GPs and practice nurses of the dental services and rebates available for children and young people in the Barwon region.
Diabetes	To increase awareness and knowledge amongst GPs and practice nurses of best practice guidelines for the management and prevention of diabetes in primary care	CPD event about diabetes prevention and management in primary care for GPs and practice nurses. Education for allied health about feeding back quality information to GPs regarding outcomes of treatment/services provided to patients. Promotion and support of general practice and allied health services in the use of CdmNet. Working with general practices and private primary care providers in establishing business models, which facilitate access to diabetes related services for people at risk of or diagnosed as having diabetes.	**National evidenced based guidelines for the primary prevention of type 2 diabetes** Published by Diabetes Australia, National Health Medical and Research Council and the University of Sydney. Recommendations: Lifestyle modifications that focus on increased physical activity, dietary change and weight loss should be offered to all individuals at high risk of developing type 2 diabetes (Grade A). Pharmacological interventions (including metformin, acarbose, rosiglitazone and orlistat) could be considered in people at high risk of developing type 2 diabetes (Grade B). Bariatric surgery can be considered in selected morbidly obese individuals (based on weight alone or the presence of co-morbidities) at high risk of type 2 diabetes (Grade C). Individuals at high risk of diabetes should be identified through the use of risk assessment tools (Grade C). **Guideline for patient education in type 2 diabetes**	Increased knowledge amongst GPs and practice nurses of diabetes management in primary care.

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		Development of referral pathways for diabetes management using HealthPathways.	Published by Diabetes Australia This guideline covers issues relating to patient education in adults with type 2 diabetes. Its aim is to inform and guide health care providers with evidence based information about what education strategies and areas have been shown to improve patient outcomes. These guidelines stipulate: - All patients with type 2 diabetes should be referred for structured diabetes patient education. **The RACGP guidelines for preventive activities in general practice** also provide evidence based guidelines for prevention activities: These include; • Timing of screenings- every three years from age of 40 or age of 18 for Aboriginal and Torres Strait Islander people • Guidelines for identification or people at risk • Tests to detect diabetes • Prevention interventions which include; increasing physical activity; GP advice on healthy low fat diet; referrals to dietitian and physical activity group; provide pre-conception advice to women with a history of gestational diabetes.	
Chronic Obstructive Pulmonary Disease	Improve management of patients with Chronic Obstructive Pulmonary Disease	Investigate a business model utilising the MBS item numbers and private allied health providers for a nurse led pulmonary rehabilitation model. Development of a pathway within HealthPathways for identification	**COPDX Plan- Australia and New Zealand Guidelines for the management of COPD 2012** Much can be done to improve quality of life, increase exercise capacity, and reduce morbidity and mortality in individuals who have COPD. The Australian and New Zealand guidelines seek to summarise current evidence around optimal management of people with COPD. It is intended to be a decision support aid for	The development of a viable business model for nurse led pulmonary rehabilitation clinics. Promotion of smoking cessation and available services in this region

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		and management of COPD.	general practitioners, other primary health care clinicians, and hospital based clinicians and specialists working in respiratory health. Published evidence is systematically searched for, identified, and reviewed on a regular basis. The COPD Guidelines Evaluation Committee meets four times a year and determines whether the reviewed evidence needs incorporation into the guideline. The key recommendations are summarised in the 'COPDX Plan': • **C**onfirm diagnosis • **O**ptimise function • **P**revent deterioration • **D**evelop a self-management plan and manage • e**X**acerbations **Local GMHBA funded project to set up pulmonary rehabilitation for respiratory patients at the Eastbrook Medical Centre** Pulmonary Rehabilitation is a key method of improving the health outcomes of patients with lung disease. Our patients were not accessing this important therapy due to long waiting lists, cost, geographic distance and lack of knowledge. Therefore, the proposal of running a Pulmonary Rehabilitation program at our own medical clinic was initiated to increase the clinical outcomes (quality of life) of patients with lung disease by physical exercise and disease education and by teaching strategies for self-management of stress and anxiety The program was led by the practice nurse who devised a collaborative model with the support of Barwon Medical Local. Three 8 week courses were funded by a local health industry with weekly sessions of 2.5 hours. Health professionals: physiotherapist, psychologist, GP, dietician and pharmacist, were approached to deliver the program which was co-ordinated by the	amongst GPs. Work with Healthy Together Geelong on their Nicotine Replacement Therapy Project. Increased continuity and consistency of care for people with COPD.

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			practice nurse. Participants were assessed prior to participation and at 8 weeks, 6 months and 12 months post completion. Outcome measures were the incremental treadmill test, blood oxygen saturation and questionnaires. Over the three groups there was an 80% completion rate, with all participants giving positive feedback about the program. There have been no admissions to hospital and no increased emergency visits to GPs. Pulmonary Rehabilitation improves participants' confidence in self-management of their disease. Improvement in the incremental treadmill test and maintenance or improvement of blood oxygen saturation also signified an improvement in overall physical fitness. Successful programs have demonstrated positive clinical outcomes can be successfully initiated and implemented by practice nurses in a general practice setting.	
Aged Care	To provide timely and responsive services to residents in Residential Aged Care facilities (RACF)	Promote awareness of after-hours services in the Barwon Medicare Local Region and www.docgeelong.com amongst RACFs Promote and assist residents in RACFs to register for the PCEHR eHealth Record. Increase access to Telehealth within RACFs, general practices (outside of RA1 area) and specialists through the installation of Clearsea Licences and development and dissemination of a Barwon Medicare Local	A survey of GPs in relation to the provision of care in RACFs identified the following issues: • In-hours services are happening after-hours as a result of GPs being booked up consulting during the day • Travel distances and time • Increasingly complex care needs A survey of 39 out of 45 RACFs identified the following issues; After-hours • Timeliness of locum service • Locum doctors reluctance around palliative care • Increasingly complex care needs • Reluctance to write prescriptions Service gaps	Improved access to specialist care for residents in RACFs via teleconferencing. Improve coordination of care of residents in RACFs through increasing registrations with the eHealth Record. Improved awareness amongst RACFs of after-hours Services. A comprehensive aged care GP business model developed and

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		Telehealth Directory. Identify best practice business models for delivery of aged care services by GPs and Allied Health in Residential Aged Care Services (RACS).	• Allied health service gaps with the main areas being social work and dental services Care coordination • Difficulties in accessing and receiving information about residents from the Emergency department and hospitals • Lack of communication between services Not many specialists visit aged care facilities	disseminated to all new GPs to the area and existing GPs. A comprehensive aged care Allied Health business model developed and promoted to Allied Health providers in the region.
Alcohol and Other Drugs	To increase awareness and knowledge amongst GPs about the referral pathways and best practice guidelines for the management of alcohol and other drugs in primary care.	Develop local referral pathways for alcohol and other drug services within HealthPathways, including referral pathways specific to refugee and Aboriginal and Torres Strait Islander populations and referral pathways for drug seeking patients to better equip health professionals with reliable and accurate information. Run a Continuing Professional Development (CPD) event for GPs and practice nurses to enhance their knowledge and skills in managing patients with alcohol and other drug issues - incorporating local referral pathways using HealthPathways. Promote practice nurse education and training sessions around alcohol and other drug issues. Promote NHV pharmacotherapy	The NHMRC has **produced 'Consensus- Based Clinical Practice Guideline for the management of volatile substance use in Australia'**. This includes information for health professionals about identifying, assessing and treating people who use volatile substances in metropolitan, rural and remote communities across Australia. These guidelines are developed for use by health professionals including medical practitioners, nurses, aboriginal health workers, alcohol and other drug workers and allied mental health workers. The National Drug and Alcohol Research Centre has developed evidence-based guidelines for the **Treatment of Alcohol Problems**. These guidelines are based on a review of the evidence about the effectiveness of treatments, and on the clinical experience of an expert panel. They are designed to provide evidence that guides treatment, education and professional development for all health workers and medical practitioners who come into contact with dependent or problem drinkers. The RACGP has produced **SNAP: a population health guide to behavioural risk factors in general practice'** which contains information around GP management of excess alcohol consumption, as well as, a range of other behavioural risk factors. The RACGP is also in the process of developing the **'RACGP Good**	Development of local referral pathways for alcohol and other drug services within HealthPathways. Increased knowledge and skills in managing alcohol and other drug issues amongst GPs and practice nurses. Increased knowledge amongst GPs and practice nurses of the local referral pathways to drug and alcohol services for patients with alcohol or other drug issues.

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		training sessions to GPs working within the Barwon Medicare Local catchment.	**Practice Guide: Drugs of Dependence in General Practice'** which will include new benzodiazepine prescribing guidelines, which can be used in general practice to treat patients with a drug addiction. This document will summarise the complex levels of formal and informal controls around these drugs and describe how applying a clinical governance framework can improve patient care and reduce the abuse, misuse and dependence. This document is currently in draft form and under internal review. External consultation will commence before June 2014. **Alcohol Treatment Guidelines for Indigenous Australians**- This document has been developed to guide healthcare providers working with Indigenous clients who are adversely affected by alcohol consumption. **General Practice Victoria (Networking Health Victoria)** Networking Health Victoria (NHV) runs the GP Pharmacotherapy Training Program which provides GPs with the skills and required accreditation to prescribe pharmacotherapies for opioid dependence within the Victorian regulatory framework. **Drug and Alcohol Clinical Advisory Service (DACAS)** provides a series of facts sheets to assist physicians treating alcohol and other drug related presentations in the general practice setting.	
Overweight/ Obesity	To increase awareness and knowledge amongst GPs and practice nurses around best practice guidelines for the	Deliver a CPD evening on the management of obesity in primary care. Develop an appropriate referral pathway on HealthPathways for overweight/obesity. Barwon Medicare Local to act as a	**Management of overweight and obesity in primary care** The Department of Health (Federal) has published a guide for the management of overweight and obesity in primary care. The key messages have been rated by the National Health and Medical Research Council (NHMRC) according to the body of literature available in these areas. The rating system can be found on page three of the document.	Increased GP awareness of obesity management in primary care. Increasing uptake and use of HealthPathways resulting in consistency of care and referral of patients for appropriate

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	management of obesity in primary care.	platform for advocacy where general practice and primary care can feed into policy change agendas.	The most important messages derived from recommendations in the Obesity Guidelines and highlighted by clinical experts to promote for obesity management in primary care are: **For adults** 1. Measure waist circumference in addition to calculating BMI. 2. Discuss readiness to change lifestyle behaviours. 3. Convey the message that even small amounts of weight loss improve health and wellbeing. 4. Use multicomponent approaches - these work better than single interventions. 5. Refer appropriately to assist people to make lifestyle changes or for further intervention. 6. Support a self-management approach and provide ongoing monitoring. **For children and adolescents** 1. Use percentile charts to monitor growth. 2. Promote physical activity, dietary modification and healthy behaviours to families. 3. Encourage healthy behaviours, such as drinking water and reducing screen time. 4. Aim for weight management- this is an acceptable goal. 5. Know when to refer. **RACGP Guidelines for preventive activities in general practice (8th edition)** The RACGP has evidence based guidelines for prevention activities for Overweight/Obesity. These include: • Identifying risks of obesity related complications • Assessment and preventive interventions • Obesity and risk of Cardiovascular disease and type 2 diabetes	and timely healthcare.

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			• Implementation strategies	
Sexually Transmitted Infections among young people	To increase awareness amongst GPs and Practice Nurses on the management of STI's in primary care	Run a CPD event for GPs and Practice nurses to enhance their knowledge and skills in sexual health with a focus on young people Promote practice nurse education and training sessions around sexual health outside of the Headspace youth service Maintain existing services around Docs and Teems Program	**The RACGP Guidelines for preventive activities in general practice (**8th edition) has guidelines for the management of Chlamydia and other STI's in general practice. This includes information about the sexual health consultation, Chlamydia screening, identifying risks and test to detect STI's and implementation information. **HIV, viral hepatitis and STI's a guide for primary care 2008** Australasian Society for HIV medicine This document presents guidelines on the primary care management of STI's. This includes information on the challenges of managing patients with STI infection, Natural history, Assessing the patient with a possible STI, Physical examination, taking tests, psychosocial assessments, making a diagnosis and giving treatment, treatment of specific STI's. **Government of western Australia Department of Health- Guidelines for Managing Sexually Transmitted Infections- WA updated 2013** These guidelines contain the most up to date evidence-based practice recommendations and is complemented with a wide range of patient and health professional resources. **Docs and Teens Program** Barwon Medicare Local has implemented a program in the secondary school system that helps increase youth access to local health services (including GPs). The Docs and Teens workshops increase young people's knowledge of these services, broadening their definitions of health and ill-health.	Increased knowledge and skills in sexual health amongst GPs and practice nurses Increase in screening for STI's in General Practice Identify STI screening champions and work with them to develop screening models and best practice.

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			Research Study Role of Practice nurses in sexual health Practice nurses and sexual health care- Enhancing team care within general practice Collaboration between general practitioners (GPs) and practice nurses (PNs) can enhance health care delivery. The role of PNs is well recognized in areas such as chronic disease management and immunization, but is underdeveloped in sexual health care. Despite the high prevalence of sexually transmissible infections (STIs) in Australia, management of STIs is suboptimal and opportunities for STI screening in general practice are missed. General practice is well placed to access at-risk patients and acceptability to patients of general practice-based sexual health care is high. Public sexual health clinics are valuable, but have limited reach into the general population and most STI care is delivered in general practice. **Implications for general practice** General practice is ideally situated to deliver sexual health care. The role played by PNs and a team approach to sexual health care in Australian general practice is underdeveloped. Increased recognition and support of enhanced PN roles in sexual health is needed, including access to training and supportive practice systems, such as incorporating sexual health into triage, care planning and health assessments. Simple practice resources which affirm PN roles in sexual health care may assist.	
Early Years	To enhance collaborative practice and integrated care	To Provide multi-disciplinary CPD to a range of professionals, including GPs, specialists, allied health and community services	Ongoing identification by Government (Victoria's Vulnerable Children's Strategy 2013-2022) and General Practice (RACP Position Statement Early Intervention for children with developmental disabilities August 2013), Australian Medical	Early years' service provider profiles mapped including capacity and capability and

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	amongst early years services.	around identified early year's issues including Health Pathways and service coordination. Connect primary care providers and early year's services through service mapping. Maintain Paediatric Network to provide linkage's with early year's services regarding primary care issues including service coordination, integration and communication.	Association (AMA) Position Statement –(Developmental Health and Wellbeing of Australia's Children and Young People 2010) that multidisciplinary and cross sector collaboration is important and essential for effective support of families and children. Local consultations with early year's providers, consistently identified the need for a collaborative approach that enhances the knowledge of the role and understanding of each service provider involved in providing care to a child and family. There is a need to identify and map services that can be utilised across sectors specifically primary care to enhance capacity to make effective referrals. The World Health Organisation identifies the pivotal role that health care systems have as a gateway to early childhood services and supports. This view is supported by Federal and State Government reports that recognise and prioritise the need for improved collaboration across health, child protection and education systems. The AMA sees the role of general practitioners and practice nurses as key to early identification of concerns in children and sees them as central to the coordination of services (Australian Medical Association, 2010)	documented and included in HealthPathways and circulated via the Paediatric Network. Children's needs will be identified earlier, and children who have been currently slipping through the system will have their needs identified.
Immunisation	Lack of access to the influenza vaccination by the homeless	Provide the influenza immunisation free of charge to people experiencing homelessness in the Barwon Medicare Local Region. Promote the benefits of the influenza immunisation to those experiencing homelessness. Advocate for the inclusion of homelessness in the Eligible	Homelessness in itself does not entitle a person to a free government supplied seasonal influenza vaccine. While many people who are homeless would be eligible due to their health status they are a group that has limited contact with health and medical services. Eligible groups for free government supplied seasonal influenza vaccine • People who are 65 years of age and over • Pregnant women at any time during their pregnancy • Aboriginal and Torres Strait Islander people aged 15	Improved access to influenza immunisation by people experiencing homelessness. Reduced incidence of influenza and complications of influenza for those experiencing homelessness.

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		groups for free government supplied seasonal influenza vaccine.	years and older • Residents of nursing homes and other long-term care facilities • Any person 6 months of age and older with a chronic condition predisposing to severe influenza illness that requires regular medical follow-up or hospitalization, including children aged 6 months to 10 years undergoing long-term aspirin therapy, and people with: ○ cardiac disease ○ chronic respiratory conditions ○ immunocompromising conditions ○ renal disease ○ diabetes and other metabolic disorders ○ chronic neurological conditions ○ haematological disorders ○ Down syndrome and fall under one of the above categories ○ obesity (BMI greater than or equal to 30 kg/m^2) and fall under one of the above categories ○ alcoholism requiring regular medical follow-up or hospitalization in the preceding year and fall under one of the above categories. Evidence indicates that people who experience longer periods of homelessness are more likely to suffer from serious mental and physical health conditions than people who have only experienced short periods or people with no history of homelessness. Recent research has demonstrated that savings in mainstream justice and health budgets can be achieved by investing in homelessness services. (Homelessness Australia, Creating a Framework for Ending Homelessness. Submission for Priorities for the 2014-2015 Budget.) Investing in the provision of influenza vaccinations for those experiencing homelessness will also result in savings to the health system.	Improved awareness amongst those experiencing homelessness of the availability of free influenza vaccination.

Issue/ Need	Strategy	Description of Strategy Activities	Justification	Expected Outcome
			Influenza vaccination, inverse care and homelessness: cross-sectional survey of eligibility and uptake during the 2011-2012 seasons in London. The above study assessed eligibility and uptake among homeless adults of the influenza vaccination. The study approached people in homeless hostels, day centres and drug services in London. The study demonstrated that the homeless population have high levels of chronic health problems predisposing them to severe complications of influenza, but vaccine uptake levels that are less than half of those seen in the mainstream GP patient population. The results of the study provide the justification for intensifying efforts to ensure homeless people have access to influenza vaccination.	