

# GP Links Wide Bay

## 2009-10, Version 2

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### Document History

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If you require further technical assistance please contact:

- PHC RIS Assist on **1800 025 882** or [phcris.assist@flinders.edu.au](mailto:phcris.assist@flinders.edu.au), or
- refer to the on-line support material on the PHC RIS website, [www.phcris.org.au/divisions/reporting](http://www.phcris.org.au/divisions/reporting)

Concerns and comments regarding the content of this document can be directed to your local State/Territory Office (STO), or provided in the [feedback section](#) at the end of this document.

## Division Contact Information

Division name: GP Links Wide Bay  
Division legal name (if different): GP Links Wide Bay Association Inc  
Division legal status: Incorporated Association  
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## Organisational Chart

To view organisation chart, please click CTRL + [here](#)

## Board Membership

Position on the Board	Expertise	Relevant Qualifications (required)	Relevant Experience (optional)	Name (optional)	Length of Service on the Board
Member	N/A	MBBS	3yrs Board experience	Elaine Dunne	5 years
Treasurer	N/A	MBBS, FRACGP	12yrs Board experience	Ajesh Ishri	4 years
Chair	N/A	MBBS	11yrs Board experience	Paul Neeskens	7 years
Vice Chair	N/A	MBBS	10yrs Board experience	John Potter	7 years
Non-GP Member	N/A	MB BCh, Diploma in Obstetrics, MRNZCGP, Executive MBA, Certificate in Health Economics, FRNZCGP, General Managers Program (AGSM), FRACMA, FRACGP	N/A	Tim Smart	1 years
Secretary	N/A	MBBS	2yrs Board experience	Preshy Varghese	3 years
Member	Intern Nambour General Hospital Jh Bundaberg Base Hospital GP Registrar Linden Clinic Bundaberg GP Registrar Aberdovy Clinic Partner GP Aberdovy Clinic GP Supervisor for GP Registrars	MBBS, FRACGP, Cert in Primary Skin Cancer Medicine (UQ)	8yrs Board experience	Daud Yunus	1 years

## Characteristics

### 1. Division demographics

Population of Division	Number	Percentage	Data source
Total population	194227	N/A	ABS June 07
Aged 65 and over	34934	17.99	ABS June 07
Under 25 years of age	60231	31.01	ABS June 07
Indigenous population	5089	2.62	ABS June 06
Australian born	146248	75.3	ABS June 06
Unemployed	4924	2.54	ABS June 07

### 2. General Practice information

Practice type	Number	Percentage	Data source
Total number of practices	60	N/A	DIS
Solo practices	16	26.67	DIS
Practices with 2-5 GPs	37	61.67	DIS
Practices with 6 or more GPs	7	11.67	DIS
Corporately owned	0	0	Division Records
Practices with a Practice Nurse	51	85	DIS

### 3. Health workforce

Profession	Number	Data source
Total number of GPs	176	DIS
International medical graduates (IMGs)	81	Division Records
Number of female GPs	52	DIS
Number of GPs aged >55 years	43	DIS
Registrars	12	DIS
Aboriginal Medical Services	0	DIS
Other primary medical care practitioners (e.g. Royal Flying Doctor Service)	0	N/A
Total number of practice nurses	106	DIS

### 4. Division membership

Type	Number
GPs (excluding IMG's & Registrars)	108
IMGs	50
Registrars	2
Allied Health Professionals	32
Practices nurses	69
Practice staff (other than practice nurses)	76
Medical specialists	0

Social Workers, Community Health Nurse, Counsellor, Dentist, Program Officer/Coordinator, Pharmacists, DoN (RACF), ADON (Hospital), Medical Students, Meical Officers (Hospital)	35
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## 5. Further Information

GP Links Wide Bay was established in late 1998 in Bundaberg. In July 2002 GPs from Hervey Bay, Maryborough, Biggenden, Mundubbera, Eidsvold and Gayndah elected to join the Division. This amalgamation essentially doubled the number of practices, GPs, population and geographic spread that the Division is required to service and brought increased diversity to the Division which covers RRMA 3-7.

Offices and staff in Bundaberg, Hervey Bay and Maryborough enable the Division to provide local support to most practices, but considerable travel is involved in servicing the more remote centres, particularly North Burnett and Agnes Water.

The Division works with the Wide Bay and Fraser Coast Health Services of the Sunshine Coast Wide Bay Health Service District and has established positive collaborative and integrated partnerships with community and health service organisations to respond to the health issues of the community.

The demographic profile of the expanded Division is one with pockets of high Indigenous populations and high and fast growing aged populations.

The Wide Bay region is classified as socio-economically disadvantaged compared to the average across Queensland. The characteristics of the region's population ensure a high burden of chronic disease resulting in a greater demand for both the primary health care and secondary and tertiary services.

A key issue to the effective delivery of primary health care is shortage and sustainable General Practitioner, nursing staff, lack of specialists in secondary and tertiary, shortage in allied health staff providing subsidized services through MBS causing an increase on demand on primary care.

## Strategic Direction

### Mission statement

To enhance and support General Practice

### Vision statement

gp links wide bay will navigate Primary Health Care forward

### Long-term goals

- gp links wide bay will be robust and viable - an annual budget of \$10 million by 2012
- gp links wide bay will increase its membership - 2,400 associate members and 150 GP members by 2012
- gp links wide bay will build equity to increase strength and flexibility - \$2 million in equity by 2012 (in any form)

### Strategies to pursue long-term goals

Strategic Objective One - General Practice and Primary Care

- To play the key role in taking General Practice and Primary Care forward.

Strategic Objective Two - Allied Health

- Increase local allied health service capacity with a focus on integration with General Practice
- Enhance capacity to manage mental health issues in the community

Strategic Objective Three - Information Management

- Support the uptake of e-health and other IM initiatives, which promote effective health care and practice management.

Strategic Objective Four - Corporate Services

- Organization to maintain ISO Accreditation.

Strategic Objective Five- Business Development

- Promote a model of health care that coordinates regional health infrastructure and services.

## **PROGRAMS**

1. DIVISIONS OF GENERAL PRACTICE PROGRAM
2. GENERAL PRACTICE IMMUNISATION INCENTIVES SCHEME
3. ABHI - PCIP (ALL DIVISIONS AND THE TAS, ACT, NT, SA SBOS)
4. MORE ALLIED HEALTH SERVICES
5. WORKFORCE SUPPORT FOR RURAL GENERAL PRACTITIONERS

## Program 1: Divisions of General Practice Program

### DGPP Access 1

The number and proportion of PIP practices within the Division claiming practice nurse services.

#### Planned activities/approaches:

Increase the capacity within General Practice of services that can be provided by Practice Nurses through:

- Practice Nurse education of MBS item no's.
- Whole of practice awareness of the effectiveness of utilizing Practice Nurses
- Promote the use of an effective Practice Nurse Business Model

### DGPP Access 2

The number of health checks and health assessments provided to patients of Aboriginal and Torres Strait Islander origin by general practitioners within the Division (compared to the estimated ATSI population in the area who could benefit from the health check).

#### Planned activities/approaches:

Increase the number or proportion of Indigenous people who have had a health check by:

- Collaborate with Indigenous Healthcare Agencies to increase Indigenous people accessing General Practice.
- Support General Practice in understanding the benefits to the Indigenous community of conducting Health Assessments to patients of ATSI origin.
- Facilitate local educational programs to assist general practice to improve patient outcomes related to Indigenous health.

### DGPP Prevention 1

The number of 45-49 year old health checks provided to at-risk patients by GPs within the Division (compared to the total population aged 45-49 years in the Division).

#### Planned activities/approaches:

Increase the number of 45-49 year old health checks by:

- Support General Practice in understanding the benefits of conducting health assessments to this target group.
- Support General Practice through disseminating resources and information, facilitating education events.

### DGPP Prevention 2

The average childhood immunisation coverage rates for the 60 to < 63 months age group within the Division.

#### Planned activities/approaches:

Maintain over 90% coverage rate of immunisation for this target group by:

- Support General Practice through disseminating resources and information, facilitating education events.

### DGPP Prevention 3

The number and proportion of electronic transfers of childhood immunisation data received by the Australian Childhood Immunisation Register (ACIR).

#### Planned activities/approaches:

Optimize the number of electronic transfers of immunisation data to ACIR by supporting General Practice through conducting practice visits, disseminating resources, information and facilitating education events.

## Program 1: Divisions of General Practice Program

### DGPP Prevention 4

The number and proportion of female patients aged 20-69 whose patient record shows that they have had a Pap smear during the previous two year period.

#### Planned activities/approaches:

Increase the number of GPs providing data to identify the proportion of patients in the target group having had a pap smear in the previous two years by:

- Promoting the benefits of utilising de-identified data extraction tools in General Practice to patients in the target group.
- Facilitate education programs to enhance general practice screening skills and improve patient uptake
- Collect data from GPs utilising APCC and Canning Tool to report against this indicator
- Increase the uptake of General Practices utilising APCC and Canning Tool

### DGPP Chronic Disease Management 1

The number and proportion of general practices within the Division using electronic register/recall/reminder systems to identify patients with a chronic disease for review and appropriate action.

#### Planned activities/approaches:

Support General Practice in using electronic register/recall/reminder systems for chronic disease management and increase the number of practices providing data by:

- Encourage General Practice to utilise a best practice framework when using electronic register/recall/reminder systems.
- Promote the use of the data extraction tools to facilitate chronic disease identification
- Promote to General Practice the benefits of utilising electronic practice register/recall/reminder system.
- Facilitate local educational programs and the development of promotional materials to enhance general practice uptake of electronic practice register/recall/reminder system.

Increase the number of diseases represented on an electronic register/recall/reminder system by:

- Promote the use of the data extraction tools
- Promote the uptake of standardised diagnostic terminology
- Aim for the representation of the following 3 chronic diseases to be represented on the General Practices Register/Recall/Reminder Systems (Diabetes, Coronary Heart Disease and COPD/Asthma)

Increase the number of General Practices providing data for this indicator by:

- Trialing an electronic version of the Division Annual Survey to capture this data
- Investigate other mediums of obtaining this data.

### DGPP Chronic Disease Management 2

The number and proportion of patients within the Division with diabetes whose last recorded HbA1c within the previous 12 months was:- less than or equal to 7.0%;- greater than 7.0% but less than or equal to 8.0%;- greater than 8.0% but less than 10.0%;- greater than or equal to 10%; or- not recorded.

#### Planned activities/approaches:

Improve the diabetes management within the population by identification, clinical management and data analysis.

- Liaise with General Practice to identify the at-risk population.
- Promote the uptake of standardised diagnostic terminology
- Promote to General Practice the benefits of diabetes early intervention and subsequent management.
- Facilitate local education programs and the development of promotional materials to assist general practice in evidence-based clinical management of diabetes.
- Promote the benefits of utilising de-identified data extraction tools in General Practice to patients in the target group.

## Program 1: Divisions of General Practice Program

- Collect data from GPs utilising APCC and Canning Tool to report against this indicator
- Increase the uptake of General Practices utilising APCC and Canning Tool

### DGPP Chronic Disease Management 3

The number and proportion of patients within the Division with coronary heart disease whose last recorded blood pressure (BP) within the previous 12 months was less than or equal to 130/80 mmHg.

#### Planned activities/approaches:

Improve the management of coronary heart disease within the population by identification, clinical management and data analysis.

- Liaise with General Practice to identify the at-risk population.
- Promote the uptake of standardised diagnostic terminology
- Promote to General Practice the benefits of coronary heart disease early intervention and subsequent management.
- Facilitate educational programs to assist general practice in evidence-based clinical management of coronary heart disease.
- Promote the benefits of utilising de-identified data extraction tools in General Practice to patients in the target group.
- Collect data from GPs utilising APCC and Canning Tool to report against this indicator
- Increase the uptake of General Practices utilising APCC and Canning Tool

### DGPP Uptake of National Initiatives 1

The number and proportion of general practitioners within the Division who prepared and reviewed GP Mental Health Care Plans, and the number and proportion of general practitioners who provided focussed psychological strategies.

#### Planned activities/approaches:

Increase the number of GPs who prepare and review GP Mental Health Care Plans by:

- Promote to GPs the benefits of GP Mental Health Care Planning and subsequent management.
- General Practice Visits
- GP Orientation Pack
- Chapter Meetings
- PN and PM Forums
- Website

Increase the number of GPs who have undertaken training and are providing focussed psychological strategies by:

- .
- Facilitate access to training and support to provide focussed psychological strategies.

### DGPP Uptake of National Initiatives 2

The number and proportion of PIP practices within the Division.

#### Planned activities/approaches:

Increase the number of accredited general practices by:

## Program 1: Divisions of General Practice Program

- Develop and facilitate a Mentoring Framework to assist Practices undergoing accreditation and re-accreditation.
- Promote to General Practice the benefits of accreditation.

### DGPP Local 1

The percentage of GPs within the division who are satisfied with discharge referrals from local hospitals. Numerator: Number of GPs satisfied with various aspects of discharge referrals Denominator: Number of GPs surveyed

#### Indicator File Attachment

To view file, please click CTRL + [here](#)

#### Planned activities/approaches:

Improve the quality of discharge referrals from hospitals to GPs by measuring an improvement in GP satisfaction levels in relation to hospital discharge referrals over time.

- Develop an agreed schedule for hospital units to mail/fax/securely email a de-identified copy of the survey to every GP who receives a discharge referral from that unit for a given month.
- Provide a copy of the GP Hospital Discharge Summary Survey for GPs to complete that will be distributed to GPs via local hospitals and collated by the Division.
- Results of the surveys to be reported to the Hospital executive on a regular basis

### DGPP Local 2

Improved access to appropriate medical care of older persons in residential aged care facilities in the region.

#### Indicator File Attachment

To view file, please click CTRL + [here](#)

#### Planned activities/approaches:

Increase the number of GPs providing care in RACFs by:

- Implement the 'Service Delivery Model for the medical care of older person in RACFs'
- Promote and raise awareness of the benefits of CMAs and Care Plan Contributions to RACF staff and GPs
- Facilitate appointment of GPs on Medication Advisory Committee (MAC)
- Facilitate and support communication between RACFs, GPs and AHPs (eg communication templates available via website, Chapters)
- Facilitate RACF clinical staff, GP and AHPs access to Continuing Professional Development for the care needs of RACF residents.

## Program 2: General Practice Immunisation Incentives Scheme

### **GPII 1 (12 Month)**

Develop and implement strategies and/or education tools for increasing immunisation coverage e.g. resource kits and newsletters.

#### **Planned activities/approaches:**

Support General Practice to improve immunisation awareness by:

- Conduct Needs Analysis to compare against the baseline audit to determine type and level of support required
- Source educational tools and resources for dissemination to General Practices
- Provide regular updates on immunisation and vaccine management

### **GPII 2 (12 Month)**

Promote quality of service by disseminating up-to-date information on immunisation guidelines and procedures, such as cold chain management.

#### **Planned activities/approaches:**

Support General Practice to provide a quality immunisation service by:

- Provide timely and reliable information on immunisation guidelines and procedures including vaccine management through a variety of communication strategies via:
  - Division website
  - Division Quarterly Newsletter
  - Weekly mail out to all Practices
  - Weekly GP Fax out to all Practices
  - General Practice visits
  - GP Chapter monthly meetings in Hervey Bay and Maryborough
  - NiGP Network Forums
  - NPS Facilitator
  - GP Hospital Liaison Project

### **GPII 3 (12 Month)**

Develop and implement strategies for improving timeliness and quality of data forwarded to the ACIR.

#### **Planned activities/approaches:**

Support General Practice to improve timeliness and quality of data to ACIR by:

- promote the importance of quality data management
- Support and facilitate immunisation professional development and collaborative activities for GPs and Practice Nurses
- Identify issues associated with maintaining practice immunisation performance

Provide regular practice based and information management support to improve practice systems and management of practice data

### **GPII 4 (12 Month)**

Develop and implement strategies to target groups of children who have been traditionally difficult to immunise.

#### **Planned activities/approaches:**

## Program 2: General Practice Immunisation Incentives Scheme

Wholistically promote the benefits of childhood immunisation

- Identify target groups that have been traditionally difficult to immunise
- Liaise with key service providers to promote the uptake of childhood immunisation

### **GPII 5 (12 Month)**

Promote data cleaning activities; e.g. by reconciling ACIR reports with the practice patient immunisation data.

#### **Planned activities/approaches:**

- promote the importance of quality data management
- Provide General Practice with educational activities on Data Cleaning

### **GPII 6 (12 Month)**

Develop and implement strategies to improve the reported childhood immunisation coverage within the Participant's boundaries of operation.

#### **Planned activities/approaches:**

Improve the reported coverage rate of childhood immunisation by:

- Support General Practice through disseminating resources and information
- facilitate education events for GPs and Practice Nurses
- Identify issues associated with maintaining practice immunisation performance
- Liaise with key service providers to promote the uptake of childhood immunisation

### **GPII 7 (12 Month)**

Promote best practice in immunisation.

#### **Planned activities/approaches:**

- Support General Practice through disseminating evidence based resources and information
- Facilitate education events for GPs and Practice Nurses.

## Program 3: ABHI - PCIP (All Divisions and the TAS, ACT, NT, SA SBOs)

### ABHI-PCIP 1 Work Plan

An attachment of the ABHI PCIP Work Plan  
**Indicator File Attachment**

To view file, please click CTRL + [here](#)

#### **Planned activities/approaches:**

Please see attachment for Planned Activities/Approaches

### ABHI-PCIP 2

The number and proportion of general practices using integrated shared care pathways or business rules to support chronic disease prevention and management.

#### **Planned activities/approaches:**

Conduct an Annual Survey to General Practices : Question: Does your practice use integrated shared care pathways or business rules with other health organisations to support chronic disease prevention and management?; No or Yes, please list

Contact Allied Health Professionals associated with Division Programs to identify number and type of agreed communication and coordination processes with General Practices

Measure the number of new and existing patients referred by GPs to Division Allied Health Programs

Provide information to GPs about allied health services.

Support General Practice in understanding the benefits using integrated shared care pathways to support chronic disease prevention and management.

Support General Practice through developing resources to support GPs using integrated shared care pathways to operate well.

Attend regular meetings with Health Services to address and formalise care planning and referral coordination within the Division.

### ABHI-PCIP 3

Divisional involvement in the work being progressed locally through state government funded programs eg the HealthOne NSW initiative, to support chronic disease prevention and management.

#### **Planned activities/approaches:**

Explore and secure funding opportunities that support chronic disease prevention and management.

Develop partnerships that involve the Division to progress work locally in supporting chronic disease prevention and management

### ABHI-PCIP 4

The extent to which general practices use a communications application, or an electronic system between primary care providers and hospitals where relevant, that supports the timely and appropriate exchange of patient information (eg clinical software tools, secure messaging).

#### **Planned activities/approaches:**

The Division is in the process of applying to DoHA to utilise surplus funds from 2008-09 to include *ABHI - PCIP 4 Indicator: The use of electronic systems or communications applications to support integrated primary care* to implement the Health ReferralNet project.

The planned activities and approaches are:

## **Program 3: ABHI - PCIP (All Divisions and the TAS, ACT, NT, SA SBOs)**

### **ABHI-PCIP 5 (12 Month)**

The number and proportion of general practitioners claiming MBS GP Management Plans, Team Care Arrangements and Multidisciplinary Care Arrangement.

#### **Planned activities/approaches:**

Auditing of General Practice clinical data utilizing Pen Clinical Auditing Tool to enable GP to identify patients diagnosed with a chronic disease who are eligible to have a GPMP and/or TCA

Practice Site Visits to demonstrate the Pen CAT Tool to General Practices

Development and signing of Practice Agreements re: privacy of data and responsibilities.

### **ABHI-PCIP 6 (12 Month)**

The number and proportion of general practitioners claiming case conferencing items.

#### **Planned activities/approaches:**

Develop Division Strategies to further facilitate care planning and referral pathways to increase the number of AHP claiming AH Services MBS items.

Auditing of data utilizing the Pen Clinical Auditing Tool to enable General Practice to identify patients diagnosed with a chronic disease who are eligible to have GPMP and TCA.

### **ABHI-PCIP 7 (12 Month)**

The number and proportion of general practitioners claiming Medication Management Review items.

#### **Planned activities/approaches:**

Liaise with GPs to promote the benefits of Medication Management Reviews

Conduct Information Sessions on Medicare Management Reviews at PN / PM Networking Forums, Chapter Meetings and ACAI Meetings

### **ABHI-PCIP 8 (12 Month)**

The objective of the Integration Program is to encourage more integrated patient centred care by supporting general practice to:

- Engage with the work of local Primary Care Partnership Councils, and other state funded primary care initiatives that seek to improve service co-ordination and integrated chronic disease prevention and management;
- Communicate and link better with other primary care providers;
- Make better use of existing primary and community care services including commonwealth, state and non-government organisation funded services with a focus on patients with chronic disease;
- Utilise tools/strategies that will assist in better managing patients with chronic disease (e.g. disease registers, referral, recall & reminder systems, care planning); and
- Contribute to work around developing local chronic disease care pathways (generic or specific) or other priority activities with a chronic disease management focus.

#### **Planned activities/approaches:**

Continue to be actively involved on Wide Bay Fraser Coast Partnership Council - Executive

Attend regular meetings with Health Services to address and formalise care planning and referral coordination within the Division.

Formalise Partnerships with Aboriginal Health Community Controlled Organisations within the Division to develop strategies that aim to increase Indigenous people accessing Primary Health Care services

Support General Practice through developing resources to support GPs using integrated shared care pathways to operate well.

### Program 3: ABHI - PCIP (All Divisions and the TAS, ACT, NT, SA SBOs)

Develop Division Strategies to further facilitate care planning and referral pathways to increase the number of AHP claiming AH Services MBS items

Develop partnerships that involve the Division to progress work locally in supporting chronic disease prevention and management

#### ABHI-PCIP 9 (12 Month)

The Participant has been funded to support and encourage general practice to incorporate integrated primary health care into their core business and to work more collaboratively with other primary care providers in the prevention and management of chronic disease.

##### Planned activities/approaches:

Support General Practice through developing resources to support GPs using integrated shared care pathways to operate well.

Support General Practice in understanding the benefits using integrated shared care pathways to support chronic disease prevention and management.

#### ABHI-PCIP 10 (12 Month)

The Participant has been funded to adopt a range of strategies that include (but not exclusively):

- Working collaboratively with the ABHI Primary Care Incentive Program State-wide Coordinator, ensuring that where relevant, activities are implemented consistently across the State (or Territory);
- Promoting to general practice the importance and benefits of integrated primary care service delivery in the prevention and management of chronic disease;
- Building a knowledge-base on the factors that act as barriers against, or act to increase, the engagement of general practice in integrated primary care service delivery to prevent and manage chronic disease;
- Promoting and identifying examples of best practice and facilitate transfer across general practices;
- Providing resources, and where relevant, training (or organising training) to general practice staff in the use of information tools and services, in the context of integrated primary care services delivery; and
- Sharing with the Divisions of General Practice Network best practice knowledge and resources around integrated primary care service delivery models relevant to the prevention and management of chronic disease. In this respect, any materials produced in the course of this Project (e.g. communication strategy, business rules etc) by the Participant are to be shared with the Divisions Network via the AGPN clearinghouse.

##### Planned activities/approaches:

Participate on ABHI PCIP Project Officer Network Teleconferences

Promote to General Practice the importance and benefits of using integrated shared care pathways to support chronic disease prevention and management.

Conduct an Annual Survey to General Practices :

Questions:

Does your practice use integrated shared care pathways or business rules with other health organisations to support chronic disease prevention and management?; No or Yes.

If YES please specify.

If YES, Please answer the following questions:

What are the factors when using integrated primary care services that act as barriers to manage your chronic disease patients effectively?;

What are the enablers that assist you in using integrate primary care services to manage your chronic disease patients effectively?;

Develop strategies based on findings from survey

Promote identified examples of best practice at Chapter Meetings, PN and PM Forums

The provision of any materials / resources (e.g. communication strategy, business rules etc) to be placed on the Division website for access by General Practices

### **Program 3: ABHI - PCIP (All Divisions and the TAS, ACT, NT, SA SBOs)**

The provision of any materials produced in the course of this Project (e.g. communication strategy, business rules etc) to be placed on the AGPN clearinghouse.

## Program 4: More Allied Health Services

### MAHS 1

The number of allied health services provided and the number of allied health service providers by provider type.

#### Planned activities/approaches:

- Conduct an audit of current allied health services funded under this program
- Establish a Communication Strategy for Allied Health Professionals participating in MAHS program
- Develop an Engagement Strategy to recruit AHPs to participate in MAHS Program
- Maintain MAHS database

### MAHS 2

Who did the Division collaborate with to address shared planning and priority setting with other local organisations and what was the outcome?

#### Planned activities/approaches:

Conduct a needs assessment to investigate establishing a multi-disciplinary approach to service areas funded under this program by:

- Develop and conduct a Needs Assessment with a Consultation Group that consists of rural GPs, consumer representatives, community groups and allied health providers and other service providers
- Feedback results of Needs Assessment to the Consultation Group and other local organisations
- Implement recommendations from Needs Assessment within budgetary constraints

### MAHS 3

The number of GPs within the Division referring their patients to MAHS services.

#### Planned activities/approaches:

- Promote MAHS to General Practice and other health services through communication strategies (Division website, newsletters, emails, presentations, visits to practices and key stakeholders)
- Provide GPs a MAHS Resource Kit and Allied Health Service Provision Manual
- Maintain MAHS database

### Additional Information

The Division employs or contracts private allied health professionals to provide services to clients referred by their GP.

The MAHS services are delivered outside the RMMA 3 districts within the Division's boundary sessionally as per a 6-monthly MAHS Services Schedule. Psychology services are transferred to BOiMHC program and the Diabetes Clinic schedule is capped to maximise other MAHS services within budget. Diabetes education targeting youth obesity issues is provided within the Headspace model and encouraging healthy lifestyles. Services are provided primarily for individual treatment.

The MAHS services are co-located in Queensland Health and/or Regional Council - Community Health facilities through an agreed arrangement.

## Program 5: Workforce Support for Rural General Practitioners

### WSRGP 1

The number of GPs supported under the WSRGP Program.

#### Planned activities/approaches:

To support newly arrived and existing GPs in rural practice by:

- Liaise with GPs under the WSRGP program to identify required support, feedback and evaluation of WSRGP program
- The provision of GP Orientation Pack and resources
- The provision of follow-up with ongoing education and IMG Mentoring Support
- The provision of Letters of Support upon request

To encourage new medical practitioners to consider rural medical careers

- Provide orientation support for new GPs and medical students in collaboration with Hospitals and General Practices

### WSRGP 2 and WSRGP 3

The number of GPs attracted and/or retained through activities provided under the WSRGP Program.

#### Planned activities/approaches:

- Provide orientation support for new General Practitioners, their families, registrars and medical students
- Maintain an accurate profile of General Practitioner workforce
- Work in collaboration with and support the activities of Health Workforce Queensland Agency
- Support the families of GPs through the Queensland Rural Medical Family Network
- Support GPs and practice staff with practice accreditation and management issues
- Facilitate access to CPD that is based on local needs and assist doctors who wish to undertake additional training to develop or maintain procedural skills and/or qualifications, e.g. emergency medicine, anaesthetics, obstetrics, surgery, radiology and other disciplines that are important to rural practice
- Provide opportunities for GPs to provide peer support to each other and increase networking opportunities with other service providers.

### WSRGP 4

The number of registrars encouraged to rural areas through early immersion into rural medical practice under the WSRGP Program.

#### Planned activities/approaches:

To encourage registrars to consider rural medical careers

- Provide orientation support for new GPs and medical students in collaboration with Hospitals and General Practices
- The provision of 'follow-up' and offered involvement GP educational events
- The provision of abridged GP Orientation Pack and resources

### WSRGP 5

The number of medical students who received mentoring under the WSRGP Program.

#### Planned activities/approaches:

## Program 5: Workforce Support for Rural General Practitioners

- Provide medical students mentoring and increase networking opportunities with other service providers.

## Feedback

### Comments and Feedback

Please provide any information you think is relevant. Provide your comments by entering information into the table below. The headings on the left are just prompts for the type of information we would expect, but please also provide any other information. This information will be collated once all the plans/reports have been submitted. If you would like to be contacted regarding your comments then please indicate so. If you have any immediate queries or feel that your comments could have an immediate impact on the process or people involved please contact an appropriate person as detailed on the [Support pages](#).

Suggested topics (All optional)	Your Comments and Feedback
About the content of this plan/report	No feedback
About any technical issues	No feedback
Any other information	No feedback