10 YEARS
Promoting Greater Health
2001 - 2011

University Department of Rural Health
Acknowledgements

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Photo: Heywood, Victoria
## Contents

Chapter One: About GGT UDRH .......................................................... 5  
Chapter Two: Foreword ................................................................. 7  
Chapter Three: Director’s Report .................................................... 8  
  Board of Management  
  Board Members  
  Current Staff  
Chapter Four: Foundations ............................................................ 14  
Chapter Five: Setting the agenda .................................................... 17  
Chapter Six: Improving the rural health experience ......................... 19  
Chapter Seven: Calculating the risks .............................................. 21  
Chapter Eight: The Finnish connection .......................................... 23  
Chapter Nine: Supporting students ............................................... 25  
Chapter Ten: Cardiovascular Disease ............................................ 28  
Chapter Eleven: Living with Diabetes ............................................. 30  
Chapter Twelve: Mental Health .................................................... 34  
Chapter Thirteen: Indigenous Health ............................................ 38  
Chapter Fourteen: Developing the workforce ................................ 39  
Reflections .................................................................................... 45  
Publications .................................................................................. 46  

Photo: Flagstaff Hill, Warrnambool, Victoria
Our Mission:

To create a ‘network for excellence’ in health service, public health and workforce research and health professional education.

The Greater Green Triangle University Department of Rural Health (GGT UDRH) is one of eleven Australian UDRHs and is part of the Australian Rural Health Education Network.

The GGT UDRH research program is driven by contemporary health issues and focuses on research into the chronic diseases diabetes, depression and cardiovascular disease; quality improvement in health service delivery; and workforce issues related to the recruitment and retention of health professionals.

An extensive education and training program focuses on continuing professional education for medical, allied and other health professionals, research capacity building for primary health care workers, and academic programs for both pharmacists and mental health professionals.

Both the research, and education and training programs bring together national and international academic institutions, health agencies, professional organisations and community groups to promote “greater health” in the Greater Green Triangle region and beyond.

The GGT UDRH has a strong presence in the Greater Green Triangle region with offices in Hamilton, Mt Gambier and Warrnambool and a dispersed network of innovative multi-disciplinary student support, teaching and research sites embedded throughout the region and in metropolitan Victoria and South Australia.

The GGT UDRH is located within the Flinders University Prevention, Promotion and Primary Health Care cluster, which is one of five clusters within the School of Medicine, Faculty of Health Sciences. The cluster also includes research units working in the area of public health, mental health promotion and primary health care.

Since 2009 it has also operated an office in Melbourne on Deakin University’s Melbourne Burwood Campus as a research ‘hub’ for metropolitan-based researchers working on the Department’s National Health and Medical Research Council (NHMRC) and primary health care grants. It is part of Deakin’s Population Health Strategic Research Group.

The GGT UDRH also runs a student support program that provides support for undergraduate and postgraduate students undertaking clinical or research placements in the Greater Green Triangle region. The student program also offers an education program that focuses on Aboriginal and Torres Strait Islander (ATSI) health and related issues. This program is offered in collaboration with regional ATSI communities.
Australia’s UDRH network

Graphic provided by ARHEN (Australian Rural Health Education Network)

The Greater Green Triangle Region
Chapter Two

Foreword - Professor John Catford

“Roads? Where we’re going, we don’t need roads”

Doc Brown (Back To The Future) 
in a cinema near you, 1985

This celebration of the first ten years of Greater Health provides an invaluable opportunity to look back on how a modestly funded program with strong direction and leadership can make a difference to a rural region’s health and capacity. The choice of establishing a university department of rural health straddling two states, south west Victoria and the south east South Australia, and in partnership with two rather different universities, Deakin and Flinders, was a truly ‘courageous decision’. Nevertheless, as the following pages demonstrate, the bold adventure was successful. It is a result of two essential ingredients – competence and character.

At the opening ceremony of the GGT UDRH in Warrnambool I quoted the Chinese proverb “Success has many parents but failure is an orphan”. The challenge for the Director, the Board members and the teams of staff that have contributed over the years was to win the commitment of a sufficient number of key decision makers across the region and beyond. To that end they have shown great competence in presenting a cogent strategy, creating supportive environments and investing in actions which have produced significant benefits. But, the success is also due to the character of the region itself. Certainly the Greater Green Triangle had an urgent health need, a major workforce crisis and a development imperative, but its community also had the tenacity and skill to seize the opportunities that were presented.

As a long standing member and chair of the Board I have been enormously privileged to see at first hand how innovation can be transformed into advancement, and in a way that has set a very high bar for other health agencies. I congratulate and thank all those who have participated. Much has been achieved and much still needs to be done, but whatever the blind spots and shortcomings, Greater Health has been an important tipping point in rural health development. Well done!

In his 1986 State of the Union Address, President Ronald Reagan quoted one of the most successful sci-fi films ever, Back to the Future. In response to the jibe “Why even bother, McFly? You don’t have a chance; you’re too much like your old man. No McFly ever amounted to anything in the history of Hill Valley”, Marty McFly responded “Yeah, well, history is gonna change”. I remember people making similar pronouncements ten years ago about the birth of a new health group in the ‘Wild West’. But unlike Back to the Future, Greater Health is a real phenomenon and it did change history.
Chapter Three

Director’s Report - Professor James Dunbar

“Study the past, if you would divine the future.”

Confucius

The purpose of this little book is to record our history, what we have done, why, and what we have learnt over our first 10 years. This book is our organisational memory. It will help those joining the GGT UDRH to make sense of how their role contributes towards improving the health, health services and workforce in GGT and beyond.

Nearly 11 years ago, when I was applying from Scotland for the Directorship, the disparity in health between metropolitan and rural Australians astonished me, and it still does. Basic information about risk factors for the killer diseases of heart disease and diabetes was missing.

You can read about the early days when advised by Erkki Vartiainen, Edward Janus, John Catford, Dale Ford and Alan Wolff, we made cardiovascular disease and diabetes our main priorities, and why we added depression a few years later.

We formed the GGT Cardiovascular Disease Prevention Partnership including Phil Tideman, and with Erkki’s support, Tina Laatikainen came on a sabbatical year to conduct the first risk factor study in rural Australia. The results didn’t seem to explain entirely the health problems of GGT and with help from Phil and Anne Taylor we compared the results with a similar study conducted in north-west Adelaide. So far as we can tell, the disparity in the health of rural Australians is less to do with risk factors and more to do with access to services and socio-economic circumstance. These are important findings for policymakers.

During 2004, Tina Laatikainen set up the GGT Diabetes Prevention Program which was identified by the Council of Australian Governments in 2006, contributing to the national diabetes prevention policy in 2007 but more importantly, the Life! Taking action on diabetes Victorian diabetes prevention program. A number of GGT staff became actively involved in working with Diabetes Australia Victoria to roll it out across the state in 2007. Subsequently it has become the largest systematic diabetes prevention program in the world.

In these early days it was clear that much more was known about the solutions to workforce issues than about the health disparities. Nadia Marsh and Tanya Tonissen visited other UDRHs which had gone into business up to five years earlier and had set up systems to improve student placements in the hope that they would return as graduates to work in rural areas. We copied and improved what was underway in other UDRHs.

Karen Stagnitti set up the Allied Health Workforce Survey which identified the need for continuing professional development as a major reason for allied health professionals leaving rural areas. With Adrian Schoo, she obtained funding from the Department of Health in Victoria to set up CPDWorks which now provides CPD for all allied health across Victoria, Northern Territory, Queensland and South Australia.

GGT UDRH also contributed to improving health services through new models of service delivery. For acute coronary syndrome, a project was run in Horsham and Mt Gambier in partnership with the National Heart Foundation during Steve Bunker’s time. Ruth Stewart, John Menzies and others set up the Corangamite Managed Clinical Network improving the way that GP obstetricians, midwives and nurses provided the service in Camperdown, Terang and Timboon. It was a bold and important initiative. The TrueBlue project enhances the role of practice nurses in looking after people who have diabetes and or heart disease with depression. It brought GPs Mark Morgan and Dale Ford and psychologist Prasuna Reddy into GGT UDRH as research collaborators. Kevin Mc Namara has pioneered ways in which pharmacists can reduce the risk of cardiovascular disease in their patients. Kate Schlicht works on a number of projects to improve mental health services in our community.
Chapter Three

Through the Australian Primary Care Collaboratives, Dale Ford, Principal Clinical Adviser, has made a huge contribution to improving care for patients with CHD, diabetes and other chronic diseases.

From the start of 2011 GGT UDRH has been part of an APHCRRI Centre for Research Excellence. The Centre’s work in GGT aims to improve the safety and quality of care for patients.

What about the future? As the trend towards metropolitan life continues, workforce problems will be an uphill battle. CPDWorks under Annette Dunham will use new social media and e-health technologies to improve the efficiency and reach of the program. The student support and Indigenous health program go from strength to strength under Mel Robertson’s leadership assisted by Amanda Urquhart.

The prevalence of chronic diseases continues to grow and the predictions for diabetes alone have huge potential consequences for the economy. Heart disease, diabetes and depression together will be an enormous burden on the workforce and the economy. It makes sense to continue to seek NHMRC and other funding for these significant health problems.

Rolling out the Life! program across Australia has now become the primary policy aim of Diabetes Australia and will involve GGT staff.

These have been 10 productive years and I owe a great debt of thanks to Professor Lindon Wing as Chairman of GGT UDRH Board for most of that period, his successor John Catford and now Michael Kidd, our collaborators especially Erkki and Tiina but also at the University of Washington, The University of Melbourne, The University of Queensland and elsewhere who have made our work possible.

Our future builds on a solid past.

Professor James Dunbar

James is the inaugural Director of the GGT UDRH and has held the position since 2001. James graduated from the University of St Andrews and received his Doctorate from the University of Dundee. He was previously Medical Director at Borders Primary Care National Health Services Trust in the United Kingdom. He is the author of books, book chapters and almost 200 original peer reviewed articles. He holds grants from the NHMRC and has a Centre of Excellence in Primary Health Care Research with Professor Claire Jackson at the University of Queensland. Professor Dunbar teaches Clinical Governance and Risk Management for Flinders University in Adelaide, Singapore and China. He was the inaugural Director of the Australian Primary Care Collaborative. His research interests include the prevention of diabetes and quality improvement in health care, especially for depression, diabetes and heart disease.
Chapter Three

Board of Management

Professor Michael Kidd (Chair)
Executive Dean
Faculty of Health Sciences, Flinders University

Professor James Dunbar
Director
Greater Green Triangle University
Department of Rural Health

Mr Grant King
Chief Executive Officer
Regional Development Australia, Limestone Coast

Ms Chris Faulkner
Director of Health and Aged Care
Department of Health, Barwon South West Region

Professor Brendan Crotty
Head, School of Medicine, Faculty of Health
Deakin University, Geelong

Dr. Peter Chapman
Chief Medical Adviser Country Division, Department of Human Services, Adelaide

Ms Karen Large
Director
Health Strategies Branch, Victorian Office
Department of Health and Ageing

Ms Josie Dichiera
Senior Project Officer
Regional Training Models Section
Training and Distribution Branch, Health Workforce Division, Department of Health and Ageing

Ms Karen Evans
Assistant Director, Regional Training Models Section, Medical Education and Training Branch, Health Workforce Division, Australian Government Department of Health and Ageing

Ms Sue Cameron
Head Speech Therapy, Western District Health Services, Hamilton, Victoria (Local Clinician’s Advisory Group representative)

Ms Karen Glover
CEO of Pangula Mannamurna Inc, Mount Gambier

Steven Smith
Third year Medical student, Parallel Rural Community Program (PRCC), Rural Clinical Schools, School of Medicine, Faculty of Health Sciences, Flinders University (Flinders University student Representative)

Christopher Kearney
Third year Medical student, Integrated Model of Medical Education in a Rural setting (IMMERSe), Rural Clinical School of Medicine, Deakin Health (Faculty of Health) Deakin University (Deakin University representative).
Chapter Three

Board Members

2001
Professor Lindon Wing, Dean, School of Medicine, Flinders University
Dr Paul Worley, Director of the Rural and Remote Health Unit, Flinders University
Ms Robyn March, Acting Senior Administrator for the Greater Green Triangle University
Department of Rural Health
Professor Lawrence St Leger, Dean of Health & Behavioural Sciences, Deakin University
Associate Professor Pauline Nugent, Head of School of Nursing, Deakin University
Mr Grant King, Chairperson of the Greater Green Triangle Region Association.
Dr Bruce Mugford, Executive Officer of the Interim Board of Management, Rural & Remote
Health Unit, Flinders University.
Ms Edwina Mason, Workforce Policy Unit in the Department of Human Services, Victoria.
Ms Lynne Pool, Director of Operations for Country Division in the Department of Human
Services in South Australia.
Mr Craig Lindsay, Director, Workforce Support Section, Office of Rural Health, Department of
Health and Aged Care.
Ms Tanya Boston, Assistant Director, Workforce Support Section, Office of Rural Health, Department of
Health and Aged Care. (observer)
Mr Craig Lindsay will be the Commonwealth representative when Ms Joanna Davidson,
National Manager of the Office of Rural Health, is unavailable.
Ms Edwina Mason, Victorian Department of Human Services.

2002
Professor Lindon Wing, Ms Raelene Burke, Professor John Catford, Mr Grant King, Mr Craig
Lindsay, Dr Bruce Mugford, Associate Professor Pauline Nugent, Ms Robyn March, Ms Lyn
Poole, Ms Edwina Mason, Professor Paul Worley, Professor James Dunbar, Ms Nadia Marsh.

2003
Professor Lindon Wing, Ms Raelene Burke, Ms Christine Canning, Ms Jennifer Colbert,
Professor John Catford, Mr Grant King, Professor James Dunbar, Ms Nadia Marsh, Dr Bruce
Warton, Ms Claudia Netterfield, Ms Rebecca Nelson, Ms Katy Balmaks, Ms Kim Wight.

2004
Professor Lindon Wing, Professor John Catford, Ms Katy Balmaks, Ms Raelene Burke, Ms Leah
Christensen, Mr Geoff Lavender, Mr Grant King, Ms Hannah Sundquist, Ms Kim Wight, Dr
Bruce Warton, Ms Katrina Whiting, Professor James Dunbar, Ms Nadia Marsh.

2005
Professor Lindon Wing, Ms Katy Balmaks, Dr Peter Chapman, Ms Leah Christensen, Mr Geoff
Lavender, Dr Bruce Warton, Ms Kim Wight, Mr Grant King, Ms Catriona Buchanan, Professor
John Catford, Professor James Dunbar, Ms Nadia Marsh, Ms Diane Petchell, Mr Andrew
Kallaur (proxy for Dianne Petchell), Ms Sue Cameron, Mr Jason Mifsud.

2006
Professor Lindon Wing, Professor John Catford, Ms Sue Cameron, Dr Peter Chapman, Mr
Andrew Kallaur (proxy for Dianne Petchell), Mr Grant King, Mr Geoff Lavender, Mr Jason
Mifsud, Ms Katy Harrison, Professor James Dunbar, Ms Nadia Marsh, Ms Karen Large, Ms
Dianne Petchell, Dr Adrian Schoo.

2007
Professor Lindon Wing, Professor John Catford, Ms Sue Cameron, Mr Grant King, Mr Geoff
Lavender, Mr Jon Coldwell, Dr Peter Chapman, Mr Andrew Kallaur, Professor James Dunbar,
Ms Nadia Marsh, Dr Adrian Schoo, Ms Karen Large, Professor Roy Goldie, Mr Tony Podpera.
Chapter Three

2008
Professor John Catford, Ms Sue Cameron, Mr Peter Chapman, Mr Tony Podpera, Ms Lorraine O’Connor, Mr Grant King, Ms Carolyn Siddel, Professor Paul Worley, Professor Roy Goldie, Ms Karen Large, Professor James Dunbar, Dr Adrian Schoo, Ms Melanie O’Dea, Ms Sue Willmott.

2009
Professor John Catford, Ms Sue Cameron, Professor James Dunbar, Mr Grant King, Ms Karen Large, Associate Professor Adrian Schoo, Ms Carolyn Siddel, Dr Peter Chapman, Ms Maree Guyatt, Professor Michael Kidd, Mr Tony Podpera, Ms Sue Willmott, Professor Michael Kidd, Ms Anne Hoey, Ms Melanie Robertson.

2010
Professor John Catford, Professor James Dunbar, Professor Michael Kidd, Mr Tony Podpera, Ms Sue Cameron, Mr Joshua Mark, Ms Maree Guyatt, Mr Grant King, Dr Peter Chapman, Ms Moira Macdonald-Young, Ms Cathy Ray, Ms Karen Large, Ms Sue Willmott, Ms Melanie Robertson, Mr Dave Hallinan, Ms Jessisca Chueh, Ms Chris Faulkner, Ms Sue Willmott, Dr Michael Coates, Prof Prasuna Reddy, Ms Josie Dichiera, Ms Melanie Robertson.

2011
Professor John Catford, Professor James Dunbar, Professor Michael Kidd, Mr Grant King, Dr Michael Coates, Ms Mel Robertson, Ms Sue Willmott, Ms Karen Large, Ms Chris Faulkner, Dr Peter Chapman, Ms Lorraine O’Connor, Ms Sue Cameron, Ms Karen Evans, Ms Karen Glover, Mr Steve Smith, Mr Chris Kearney, Ms Josie Dichiera, Ms Padmaja Jha.
Chapter Three

Current staff

Director
Professor James Dunbar

Program Directors
Dino Asproloupos  Senior Program Manager (NHMRC Grants)
Dr Michael Coates  Deputy Director
  Senior Research Fellow & Program Coordinator PHCRED
Melanie Robertson  Senior Program Manager

Research Staff
Dr Amr Abou Elnour  Post-Doctoral Research Fellow (CRE)
Dr Marian Abouzeid  Research Fellow
Victoria Brown  Research Assistant (PHCRED)
Dr Nathalie Davis  Research Fellow
Dr Annette Dunham  Senior Research Fellow (CPDWorks)
Andrea Hernan  Research Associate
Dr Rosalind Lau  Senior Research Fellow (NHMRC Gestational Diabetes Project)
Kevin Mc Namara  Research Fellow (PAUDRH)
Dr Mark Morgan  Senior Research Fellow (PHCRED)
Benjamin Philpot  Research Fellow & Biostatistician
Kate Schlicht  Senior Research Fellow (UDRH Mental Health Project)
Frances Walsh  Research Associate (PAUDRH)

Administration Staff
Fiona Aulsebrook  Office Administrator
Gillian Beard  Personal Assistant to the Director
Sandra Byrd  Finance Administrator
Katie Dopheide  Administrative Assistant (CPDWorks)
Sandi Elliott  Networks Administrator
Lynette Hewitson  Project Administrative Assistant (NHMRC Grants)
Judith Houghton  Accounts Clerk
Liz Jackway  Administration Assistant (PHCRED)
Leonie Kenny  Personal Assistant to the Senior Program Manager
Angela McLaren  Student Support Officer
Jacqui Michalski  Student Support Officer
Angela Paulin  Administration Assistant
Liz Stewart  Program Coordinator (NHMRC Melbourne Diabetes Prevention Study)
Steve Trickey  IT Manager (Remote Support)
Amanda Urquhart  Student Support Administrator
Sue Willmott  Grants Officer

Adjunct Staff
Rachel Boak, Dr Steve Bunker, Dr Ann Dunbar, Dr Dale Ford, Professor Edward Janus,
Professor Tiina Laatikainen, Dr Mark Morgan, Professor Adrian Schoo, Professor Erkki Vartiainen,
Dr Bruce Warton, Professor Alan Wolff.
Chapter Four

Foundations

The University Department of Rural Health program was introduced by the Australian Government in 1996 as a strategic initiative designed to address rural workforce problems.

A strong population health focus and improving health service development underpinned the program which involved partnerships between existing health providers in a targeted region and the university sector.

Talks had been progressing for several years towards achieving a rural health unit in south-west Victoria. As early as 1993 the then Warrnambool and District Base Hospital (later South West Healthcare) had initiated discussions about the establishment of a rural health unit in Warrnambool.

The involvement of two universities from two different states finally saw that dream become a reality.

The Greater Green Triangle University Department of Rural Health (GGT UDRH) was created in response to a proposal made to the Federal Government in 1999 by Flinders University in South Australia and Deakin University in Victoria.

The Greater Green Triangle (GGT) region incorporates south-east South Australia, south-west Victoria and the Wimmera-Mallee in Victoria. It stretches loosely from Salt Creek in South Australia to Warracknabeal and Apollo Bay in Victoria. Its largest cities include Warrnambool, Mt Gambier, Horsham, Portland, Hamilton and Colac.

The Department serves a population of about 225,000 and crosses 18 local government bodies across the two states.

It was widely recognised at the time the application was being developed that the region needed to be more active in rural health and do more to support students. A 1996 feasibility study by the Victorian Department of Human Services had identified the need for a rural health training unit in Warrnambool.

Existing state-based health consortia had relatively little influence on the GGT region and the proposed UDRH was seen as a mechanism to break down the barriers caused by the state border and to bring a greater focus to health issues in the region.

In 1999, Flinders and Deakin universities, with support from the community and specifically from South West Healthcare based in Warrnambool, Victoria, and the Mt Gambier and District Health Service, based in South Australia, lodged a submission to the Federal Government arguing for the establishment of the GGT UDRH.

The consortium believed the GGT UDRH would complement and extend the range of courses on offer in the region and provide a well-integrated learning environment specific to rural health.

It was a fitting meeting of the minds with the Federal Government actively expressing interest in improving health support services in the region.

The Government allocated funding to the consortium in its 2000-2001 budget to establish the GGT UDRH. Funding had been previously announced for UDRHs at Mt Isa, Broken Hill, Geraldton, Whyalla, Alice Springs and Launceston.

The GGT UDRH became the first and only UDRH to address sensitive cross-border issues. It also dealt with the need for support from universities outside of the consortium.

There were initial suggestions that it be developed as a ‘mini UDRH’ but Professor Lindon Wing, Dean of Flinders University’s School of Medicine, and Professor Lawrence St Leger, Dean of Deakin University’s Faculty of Health and Behavioural Sciences, argued that the region’s population and its cross-border status necessitated funding as a fully-fledged UDRH.

However, annual funding was pegged at $1 million for the first year of operation in 2001, less than other UDRHs. This was subsequently increased to $1.25 million.

Following the announcement of funding, an interim board of management was established to guide the development of the Department. It included Professors Wing and St Leger, Dr Paul Worley and Dr Bruce Mugford from Flinders University, Associate Professor Pauline Nugent and Dr Mardi Townsend from Deakin University, Dr Daryl Pedler and Ms Judy Nichols from South West Healthcare, Greater Green Triangle Region Association Executive Officer Mr Michael Whitehead and South East South Australian Division of General Practice Director Dr Lucie Walters.

Deakin University was already active in the region with a campus based in Warrnambool and Flinders University aimed to extend its activities in the region under the umbrella of the UDRH.

Lindon said the region faced distinct health issues and there was a recognised lack of support for medical students on local placements.
Chapter Four

Melbourne and Monash universities placed students around Warrnambool and Hamilton but there was a perception that more could be done to support those students.

Lindon said both Deakin and Flinders were keen to fill the void. “Flinders was putting medical students into hospitals in Darwin and became involved with the Centre for Remote Health in Alice Springs, and we were keen to place students in the Mt Gambier region,” he said.

“We had experience in rural health and UDRHs so there was a good basis for being involved in a UDRH in the Green Triangle region.”

While training students was not the focus of the UDRH, having a broad-based, multi-disciplinary Department in the region would provide support to medical and allied health students.

Public health care consultant Dr Jack Best was involved in discussions with the universities to formalise the funding proposal.

Professor Paul Worley, at the time a senior lecturer and now Dean of the School of Medicine at Flinders University, worked with Daryl Pedler, to write the proposal.

“Daryl and I had discussions with Jack Best about whether Deakin and Flinders could work up a bid for a UDRH,” he said.

At the time Dr Best was the national architect of the UDRH program and he was enthusiastic about establishing a department in the Greater Green Triangle region, partly to test the cross-border capabilities of the program.

“Four universities in Victoria were involved with a UDRH in Shepparton but the west of the state wasn’t being looked after,” Paul said. “It was the same in South Australia where the one UDRH in Whyalla had very little to do with the south-east of the state.”

Flinders had a medical program in south east South Australia and had been asked to spread the service to Hamilton in Victoria.

Paul said the opportunity to attract more funding and to increase community engagement influenced the universities to proceed with the application.

“Flinders University had a medical school and a proven track record in collaboration over distance. Deakin University didn’t have its own medical school at the time but saw the opportunities in the region. The existing UDRH in Victoria was bogged down and didn’t really have a focus on the region so there was scope for a new entity.”

Warrnambool was suggested as the home base for the UDRH with plans for a secondary centre in Mt Gambier and at other sites as needed; Hamilton and Horsham emerging as options to complete the triangle. The cross-border strategy was considered a key ingredient to the Department’s success.

The submission to the Federal Government outlined 14 main aims for the GGT UDRH.

1. Improve training and support for health professionals within the region.
2. Further develop rotations of undergraduate and postgraduate health professional trainees of all disciplines within the region and ‘value-add’ to the existing student placements.
3. Enhance skills in clinical care, population health and community development.
4. Provide a milieu within the region to encourage appropriate clinical, population and health services research.
5. Actively seek to encourage health professionals to work in rural areas.
6. Increase intellectual capital by encouraging senior university staff to live and work in the Greater Green Triangle.
Chapter Four

7. Encourage health professionals to be leaders within their community.
8. Promote rural health careers to secondary and tertiary students.
9. Encourage succession planning for staff in all health care settings.
10. Work with community organisations and individuals to improve health service delivery.
11. Identify, examine and inform on issues that affect rural health.
12. Develop strategic partnerships with other organisations in the region to improve health service delivery.
13. Disseminate beyond the region information about locally developed initiatives and their outcomes.
14. Work beyond state boundaries for the benefit of the region.

Strategies were developed to deliver on these goals and a departmental structure adopted with a director at the helm and key personnel placed across the region to coordinate education and training, health research and development, and clinical service.

Deakin University agreed to provide office space at its Warrnambool campus and a base was also established in Mt Gambier. Subsequently an office was established in Hamilton.

The UDRH saw collaboration with existing institutions as an essential part of its charter and recognised the history of rotations for medical students in regional hospitals. It was considered that the UDRH would add value to current university programs and placements in the region.

A Memorandum of Understanding was developed between Deakin and Flinders universities to guide the establishment and operation of the Department. The funding contract was negotiated with Flinders University.

The then Member for Wannon David Hawker backed the proposal, saying Western Victoria had the infrastructure, enthusiasm and potential to be a leading region for rural health care education.

With funding approved, the interim board moved swiftly to put structures and staff in place to ensure the GGT UDRH started to address the health needs of the region.

In the period of time prior to the stocktake by Dr Best there had been a series of meetings, in south west Victoria and south east South Australia, with significant contributions by Dr Daryl Pedler, and both Limestone Coast and Otway Divisions of General Practice.

Their experience and gap analysis showed that medical practice and health practice more generally would be enhanced in this region by having a greater academic linkage from existing health services and practices, and that local training of health professionals in the region would produce a more sustainable workforce into the future.

The end result of lobbying on all these fronts was to end up with the establishment of the University Department of Rural Health (Flinders / Deakin), which in turn led to the Parallel Rural Community Curriculum training for medical students in both Victoria and South Australia, and the Deakin University Medical School.

The background work associated with the early meetings also led to the formation of the Greater Green Triangle GP Education and Training organisation, which for the first time allowed vocational GP training to be run from the region itself.

All of these developments would not have occurred without the hard work of those who thought about what could be, and then through lobbying and promotion, set about making them happen. It is important that we continue to lobby for their continuation, as all of these initiatives show the importance of local governance, and accountability.

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Dr Dale Ford

Dale is a GP with the Hamilton Medical Group with Western District Health Service privileges in General Medicine and ICU.

Dale has particular interest in CVD and Diabetes.

He is Principal Clinical Advisor for Improvement Foundation (Australia), Adelaide SA. His GGT UDRH contributions include Associate Investigator – APHCRU Centre of Research Excellence, and Honorary Senior Lecturer, School of Medicine, Flinders University, membership of the TrueBlue Project Advisory Board, Cardiovascular Disease Prevention Partnership and Clinicians Advisory Group.

Dale is also a Board Member of Active Health Portland and Southern GP Training Ltd, Medical Director of the Otway Division of General Practice.
Chapter Five

Setting the agenda

The GGT UDRH wanted to be responsive to the needs of communities within the Greater Green Triangle region and set about formalising its priorities.

The Dean of Flinders University's School of Medicine, Professor Lindon Wing, became the inaugural chairman of the Board, which also included representatives from the Department of Human Services from both South Australia and Victoria, and Professor Lawrence St Leger, Dean of Deakin University's Faculty of Health and Behavioural Sciences.

With funding in place, one of the first tasks was to appoint a Director to guide the Department towards its desired goals. An international search led to the appointment of Professor James Dunbar. Professor Dunbar was previously Medical Director at Borders Primary Care National Health Services Trust in the United Kingdom, but he was becoming increasingly frustrated by the limitations on innovation in health care and research in the UK.

“We wanted to turn the world upside down but were constantly coming up against hurdles. I decided it was a global market and I didn't have to put up with it,” James Dunbar said.

Lindon said the newly appointed Director had a proven track record and was not afraid to move to a new challenge in another part of the world.

“James had the energy, drive and passion and the ability to set up networks to achieve what was needed,” he said.

James Dunbar started on December 14, 2001, marking the first formal day of the GGT UDRH. As part of a Memorandum of Understanding developed between the two universities, staff employed by the UDRH came on as Flinders University employees.

Thanks to the internet, the new Director already had a good grasp of the issues that needed to be addressed.

“Prior to my interview I went on the internet and found the Victorian Burden of Diseases study which clearly defined heart disease and diabetes as the major health issues affecting the state,” he said.

Local stakeholders agreed with that assessment – which also mirrored priorities set by the funding bodies - and cardiac disease and diabetes soon became major research planks for the Department.

Consulting the local community was a key to setting the agenda for the GGT UDRH’s research and education programs.

A series of three stakeholder organisational development workshops were held throughout the Greater Green Triangle region to bring together health professionals and some of the Department’s academic collaborators.

The stakeholder meetings were intended to promote the Department, gauge interest in collaborative work and to find out what directions local health professionals would like the Department to take. The focus was on Indigenous health, workforce development and research, which in turn led to programs on cardiovascular disease and diabetes.

The Department was in its infancy and keen to take on board the wants and needs of community groups as expressed in the stakeholder meetings, while following the parameters of the UDRH initiative.

However, funding presented a problem.
Chapter Five

Professor Paul Worley said the UDRH was “behind the eight ball” after receiving only two-thirds of its requested budget. “We were not funded as much as other UDRHs which meant we could employ fewer people, though the parameters of what was required did not change,” he said.

“Flinders was expanding its rural programs for medical students and was able to secure funding from the Rural Clinical School program. That meant the focus for the UDRH could be on allied health, nursing and research rather than medical,” Paul added.

“It was a very exciting time. We were very fortunate to attract James Dunbar as Director as the local professorial pool was quite limited.”

The UDRH had to overcome not only its funding limitations but also resistance from other universities in Victoria.

Paul said the first UDRH in the state was “becoming a bit of a disaster” but the universities involved remained opposed to a South Australian university having a stake in Victoria’s western region.

“We were told by one university official that we would get a UDRH over his dead body. There was a lot of opposition from the Melbourne establishment because we were from interstate and they had a sense that they owned the state, even though they weren’t really taking an interest in rural regions,” he said.

“The local community was not interested in being owned. They wanted a choice, wanted to be understood and they wanted to have universities with an interest in rural medicine.

“Flinders had credentials in rural medicine and Deakin was committed to the region. As partners we were keen to give rural communities a major voice rather than them being the recipient of leftovers.

“We saw rural placements as a workforce development initiative and arranged for students to spend a whole year in rural practices, not just a token holiday experience.”

It had been his personal interest in rural medicine that drew Paul from his rural practice to the university and he was determined to follow through on his passion.

“I was convinced that universities were not doing all they could to support rural practices so I joined Flinders to put my money where my mouth was,” he said.

“I could see the opportunity to use university education as one arm in the campaign to overcome workforce issues in rural areas.

“The GGT UDRH has been very successful in this regard and in proving that rural communities can be excellent platforms for world class health services research.”

An early focal point was to support interaction between a wide range of organisations and to confirm their involvement with the UDRH.

Strategic and business plans were adopted to guide the GGT UDRH operations and the objectives for 2001 set an agenda for:

- Improving rural experiences for students in health professions
- Providing training and support for students
- Embracing a strong public or population public health focus
- Providing training to ensure health professionals are sensitive to Indigenous health issues
- Providing a base for senior university staff to practice their skills in a rural setting
- Developing innovative service delivery models to meet the needs of rural and remote areas
- Undertaking research into rural and remote health issues
- Identifying and addressing cross-border issues.

With the region’s health priorities being assessed, the Board and Director set about assembling a team and securing funding to meet the objectives and conducting a series of risk factor surveys of the local population.
Chapter Six

Improving the rural health experience

The GGT UDRH established its goals based around research, education and training, resources and services.

Nadia Marsh was recruited in late 2001 as Senior Program Manager to pull together teams to support education and training and undertake research projects.

As the second employee of the UDRH, under the direction of James Dunbar, Nadia was tasked with setting up the infrastructure, the organisational structure and ensuring the right people were in place to deliver projects.

Within a few years up to 40 people had worked under the GGT UDRH banner on various projects. “It was a challenge for a rural organisation to find the right people,” Nadia recalled. “We needed a wide range of people from senior academics to junior administrators. It is tough in a regional area to recruit people but we did very well,” she said.

“We made sure our stakeholders were represented in the decisions.”

By 2002-2003 the GGT UDRH had several projects in development to improve the rural health experience for students and to address health issues in the region.

Projects included:

• Developing a risk tool for cardiovascular conditions and diabetes in conjunction with the National Cardiovascular Disease Prevention Partnership
• Assessing children’s development by observing them at play
• A GP hospital integration project
• Development of an in-service nursing education program
• Evaluation of GP registrar training.

The needs of allied health workers were the subject of a survey which elicited more than 150 responses.

Linkages with health services were well established. A Clinical Advisory Group was established and included representatives of the three Divisions of GPs in the region. An Executive Officers Committee was also established.

The system adopted for implementing programs eventually saw three administrators with their own portfolio being located in the three points of Greater Green Triangle, Hamilton, Mt Gambier and Warrnambool.

The Department learned from existing UDRHs. “We visited other UDRHs, regional medical hubs and rural and regional universities and took the best of what they did and adapted it to fit our region and our priorities,” Nadia said.

The priorities established by the GGT UDRH reflected national and state priorities and local needs.

“The government funding was initially quite prescriptive of what we needed to do, including work in the areas of Indigenous health, student support and health capacity building,” Nadia said.

“Over time our programs started to reflect not only the national priorities but the research interests of the Director and staff and the issues identified at stakeholder meetings.

“In most cases they all coincided and it became increasingly evident that diabetes, cardiovascular disease and later mental health were the top priorities.”
Student support was a significant undertaking and a high priority. The Department’s first Student Support Officer, Tanya Tonissen, visited Tasmania, Spencer Gulf and Albany in Western Australia to further knowledge in the field. “Our (UDRH) contract at the time was specific in what had to be done, and for the most part even the towns in which we were to establish infrastructure and provide support were detailed. We appraised a wide range of accommodation options in many of the towns of the GGT to ensure that long term we were heading in a resource-effective and sustainable direction.” Tanya said.

Staff visited 20-30 faculties, speaking with students, promoting the GGT UDRH and its programs and researching options to ensure that students undertaking placements with the UDRH would have enhanced experiences with maximum support. “Born from all this was the need of students for cheap accommodation situated near hospitals and the provision of computers. The vision then became to have a student support program that supported an increasing number of students, from a range of universities and health disciplines, throughout the region and have student support officers in all three office locations,” Nadia said.

“Not only were we keen to increase the number of students in the region, but also how long they stayed here,” Nadia said.

“Someone suggested that we start a dating service with farmers but that never eventuated,” she laughed.

The number of students undergoing placements in the region has grown from about 100 when the GGT UDRH started to close to 1000 today.

“One of our priorities was to increase the range of disciplines which we have achieved,” Nadia added.

There were less than 15 staff in the GGT UDRH in the first couple of years and although resources weren’t immense the Department was horizontally integrated, concentrating on research and education and training in the priority areas.

Nadia Marsh

Nadia was the inaugural Senior Program Manager of the GGT UDRH from 2001 until 2007. Since this time she has continued her association with the Department working on a range of strategic, human resource and web-based projects. Nadia holds a Master of Science by research from the University of Tasmania, and a Master of Public Health from Monash University. She completed her undergraduate studies, a Bachelor of Science with Honours, at the University of Melbourne. She also holds a Graduate Diploma in Financial and Resource Management. She has worked extensively in Australia, and overseas in Germany and the United Kingdom.

Prior to joining Flinders University Nadia worked in management and research roles within the plantation forestry sector in Tasmania, Victoria and Western Australia. Her publications include peer-reviewed articles in national journals, presentations at national and international conferences, and numerous contracted reports. Nadia’s research interests lie around environmental influences on health.

Associate Professor Ruth Stewart

Ruth is the Director of Clinical Studies for the Deakin Integrated Model of Medical Education in Rural Settings (Deakin IMMERSe). She brings to this role 20 years of experience living and working as a rural doctor with procedural skills in Camperdown. Ruth has experience teaching undergraduate students and vocational trainees in this community. She established Deakin IMMERSe and has been the chair of the General Practice Curriculum Writing Group for Deakin School of Medicine. She has served on the board of the Australian College of Rural and Remote Medicine since 2002 and has a particular interest in rural maternity care. She has been on the Nurse Practitioner Advisory Group to the Department of Health and Ageing, and is an executive member of the Expert Advisory Committee for the National Evidence Based Antenatal Guidelines.

Ruth is currently writing a doctoral thesis on the Corangamite Managed Clinical Network, a network designed to support the development of locally adapted evidence-based guidelines, local team-based professional development activities and workforce model development across three rural low volume maternity services.
Chapter Seven

Calculating the risks

Three risk factor surveys were undertaken by the GGT UDRH to investigate the prevalence of major cardiovascular disease risk factors among the general population in the Limestone Coast region, Corangamite Shire and in the Wimmera region.

The surveys, started in 2004, took a random sample of more than 3000 people aged 25 to 74 years across the three regions.

The pilot population non-communicable risk factor survey in the Limestone Coast region of South Australia measured major chronic disease risk factors such as blood pressure, cholesterol and weight, as well as many behavioural factors such as smoking, physical activity and dietary habits. In total, 245 females and 233 males participated in comprehensive health checks and a further 47 women and 27 men completed a questionnaire.

The second risk factor survey was undertaken in the Corangamite Shire in south-west Victoria. The survey aimed to estimate the prevalence of recognised risk factors for cardiovascular disease; to raise community awareness about cardiovascular disease and to provide a comprehensive ‘health screen’ for participating volunteers.

The final survey was in the Wimmera region in north-west Victoria and randomly sampled about 1200 people, with an additional sample of 300 people aged between 75 and 84 years.

The surveys were carried out by nurses recruited and trained by Dr Tiina Laatikainen, who joined the GGT UDRH on sabbatical from Finland, and Anna Kao-Philpot. The Corangamite Risk Factor Survey was managed by Dr Andrew Baird, a local GP. The Limestone Coast Risk Factor Survey was managed by Tiina and the Wimmera survey was managed by Ms Anna Chapman.

The studies would not have been possible without support from colleagues in the Greater Green Triangle Cardiovascular Disease Prevention Partnership, including Dr Philip Tideman and Rosy Tirimacco from iCARNet, Mount Gambier Health Service, Limestone Coast and Otway Divisions of General Practice, Corangamite Shire, West Vic Division of General Practice, Wimmera Health Care Group and the local media. Also, Dr Malcolm Whiting and the SouthPath Clinical Trials laboratory staff at Flinders Medical Centre contributed through the analysis of blood samples.

A team of 10 academics in the Department analysed the data. They were led by Dr Sami Heistaro, also on sabbatical from the National Public Health Institute in Finland.

The publication of the Greater Green Triangle Risk Factor Study report in 2006 was the first time chronic disease risk factors and related health behaviour in the GGT region or anywhere in rural Australia had been described.

The data collected and analysed during the three risk factor studies have resulted in many peer-reviewed publications in national and international journals as well as various conference presentations.

Information gathered from the surveys has been used for epidemiological research and the development of targeted disease prevention programs in the Greater Green Triangle region.

The surveys also aimed to raise community awareness about cardiovascular disease and to provide a comprehensive ‘health screen’ for participating volunteers.

They provided valuable information about the health of people living in this region and about the prevalence of diabetes and cardiovascular disease, and were integral in the establishment of definite research priorities for the GGT UDRH.

Surveys of students, allied health staff and medical professionals also painted a picture of their needs and led to the development of support programs to improve their rural experience.

A summary of published peer-review papers by topic is listed below (refer to publications index for specific details):

**Overweight, obesity and metabolic syndrome**

The prevalence of overweight and obesity combined was 74.1% (69.7–78.5) in males and 64.1% (59.5–68.7) in females. According to International Diabetes Federation criteria, the overall prevalence of metabolic syndrome was 31.8% (28.6–35.1). With only 30% of the population within the ‘normal weight’ range, urgent action is required at the highest level to change unhealthy lifestyle habits by improving diet, increasing physical activity and making our environments supportive of these objectives.
Chapter Seven

**Hypertension**

This study emphasises suboptimal detection and treatment of hypertension, especially in men, in rural Australia. This will have serious future consequences in terms of cardiovascular outcomes if left unaddressed. Overall, one-third of participants had hypertension and one-third of those were not aware of a previous diagnosis. Only half of those diagnosed were treated and half of the treated actually achieved blood pressure control.

**Physical activity**

One-fifth of adults in rural Australia were inactive, with few individuals engaged in daily physical activity at moderate to vigorous intensity to achieve health benefits. Leisure-time physical activity has the most potential for improvements to be made at a population level.

**Psychosocial**

A third of the rural population reported psychological distress, with the highest prevalence observed in middle-aged men and women. Thus, health professionals should attend not only to physical health, but also to mental health status, in this age group. It is also important to target prevention strategies to the 20% who reported moderate levels of psychological distress, in order to prevent the development of more serious conditions.

**Metabolic syndrome and depression**

The data show an association between metabolic syndrome and the cognitive and affective components of depression in a rural population, with the prevalence of depression in individuals with metabolic syndrome being 50% higher. Based on the findings of this study, awareness of depressive symptoms as part of metabolic syndrome could be as important in clinical management as blood pressure or cholesterol.

**Smoking cessation**

The overall prevalence of smoking was 15%, the rate decreasing with age. Those smokers in the 25–44 years age group were most likely to want to stop but were less likely to have received advice on smoking cessation than older smokers. This suggests a need for greater vigilance in proactively targeting younger smokers.

The results have also contributed to local and state level health improvements including:

- The development of a diabetes prevention program that has now been adopted throughout Victoria
- Managed clinical networks, with clinical pathways for co-morbid depression in acute coronary syndrome
- Collaborative care for patients with diabetes, coronary heart disease or both
- Improving attendance at cardiac rehabilitation
- Community pharmacy support for general practice in the prevention of cardiovascular disease

The risk factor studies provided a comprehensive basis for future health planning and monitoring approaches for the GGT region and have helped to improve the health outcomes and raise awareness of health risks faced by the population in these areas.

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**Dr Stephen Bunker**

Stephen has a health professional background having worked for many years as a clinical nurse specialist in cardiology and prior to that, in mental health.

Stephen was Manager of the National Heart Foundation (Victorian Division) cardiac rehabilitation and secondary prevention program for 15 years. This included a five-year period as National Program Manager responsible for providing leadership and strategy for the Foundation’s cardiac rehabilitation and secondary prevention activities throughout Australia.

Stephen has a strong interest in research and evaluation and has worked as a Senior Research Fellow on Public Health and Health Services Research projects in the areas of diabetes prevention, chronic disease risk factor prevalence and depression and heart disease.

As well as research, Stephen has a strong interest in health professional education and has been involved in delivering smoking cessation workshops in association with QUIT and depression recognition workshops in association with beyondblue – the national depression initiative.

Stephen is currently Research Consultant to Medibank Health Services providing input and advice in relation to evidence-based chronic disease prevention and management programs.
Chapter Eight

The Finnish connection

Erkki Vartiainen was a Visiting Professor at Edinburgh University and working with James Dunbar in the Scottish Borders when James decided to take on his role with GGT UDRH.

Professor Vartiainen, from the National Institute for Health and Welfare in Finland and with a background in cardiovascular epidemiology and prevention, was helping in the development of community-based programs and strategy to prevent and control chronic diseases in Scotland.

It seemed like their paths were going in different directions after Erkki went back to Finland and James went to Australia.

However, fate and a common interest in health prevention intervened and Erkki was invited to Australia in July 2002 as a consultant to help develop priorities for the GGT UDRH’s research priorities and to set up a major study in the region into the prevalence of recognised risk factors for cardiovascular disease.

“It was a very interesting invitation; usually you can get this type of opportunity only a few times in your life,” Erkki said.

The role was not totally new as Erkki was involved in developing a chronic disease prevention department at National Public Health Institute in Finland in early 1980s and Cardiovascular Health Branch to CDC in USA in early 1990s.

It was his first visit to Australia but long discussions about the main aims of the Department, its general role in the area and nationally, personnel needed and leadership helped to clarify where it was heading.

Erkki said a health interview survey to get self-reported health indicators was well developed but very little information was available on biological risk factors like lipids, blood pressure or diet on nutrient levels.

“A health examination survey was one of the first things to do. For rational public health planning this basic information is needed. It is like orienteering in the forest: If you do not know where you are it does not matter where you go,” he said.

“Data is also a very strong tool in political decision making.”

The first positive results on diabetes prevention were published in Finland and in the US. The next question was how to implement these results in normal health services.

The GGT UDRH team also had to deal with the question from the perspective of health services in rural areas.

Erkki said the enthusiasm of the key players was encouraging and he was confident the challenge could be met.

“I got a feeling that this was going to work,” he said.

Professor Erkki Vartiainen

Erkki graduated in medicine in 1981 and completed his doctorate in 1983. He has been an Adjunct Professor in Public Health at the University of Kuopio in Finland since 1985 and Research Professor in National Institute of Health and Welfare (THL) since 2000. His Welfare and Health Promotion Division at the National Institute for Health and Welfare is one of the world’s largest groups conducting research into the prevention of chronic diseases.

His distinguished record of consultancies and collaborations includes work for the World Health Organisation, World Bank, European Union, and national governments. Since 2004 he has been Director of the World Health Organisation Collaborating Centre for Non-Communicable Disease Prevention. He has published over 350 papers.

Erkki has maintained a close association with the GGT UDRH since 2002 when he provided invaluable assistance with the development of the Diabetes Prevention Project. Since this time he has continued to offer advice and a breadth of experience, including leading on various research grants; substantive contribution to the Department’s public health programs’ strategic directions; participation in writing retreats and various other public health workshops, and mentorship of academic staff.
Chapter Eight

He later assisted with the recruitment of Tiina Laatikainen to join the GGT UDRH team to help with the risk factor study.

“I asked Tiina if she was interested to go to Australia for a year or so to work in a rural health department. She came back in fifteen minutes and said yes.”

They took a leading collaborative role in establishing the Life! Taking Action on Diabetes program.

Erkki has kept touch with the Department and has been back several times to Australia.

“Research work was expanding to different networks. It was difficult to work only by emails and teleconferences. Then we developed an idea that if we take two weeks in a year and have a writing retreat where we have time to concentrate to writing, developing new ideas and data analyses. We have had six retreats. They have all been very interesting and useful arenas to learn new things.”

More recently their colleagues Sami Heistaro and Annamari Kilkkinen have been working in the Department.

James said the Finnish connection had been of huge benefit to the Greater Green Triangle region and the broader Australian community.

“Erkki is one of the best in his field in the world and his involvement has been of great value to us.”

Tiina Laatikainen was recruited to act as the head of the public health team in the GGT UDRH in 2004.

“Having a background with over a decade of work with the National FINRISK Study in Finland it was a great experience and somehow also a challenge to utilise and adopt the knowledge gathered in Finland to the circumstances in rural Australia,” she said.

“Even though the theoretical principles in data collection are more or less the same, all practicalities including sampling, ethics applications, purchase of supplies, recruitment and training of nurses, establishment of databases and many other things had to be planned and adopted to local circumstances.

“The year in Australia widened my understanding of the public health work globally, taught me to apply my knowledge and experience in new challenges, brought me valuable networks in many topics and enabled to engage many good relationships,” Tiina said.

Since her return to Finland the fruitful collaboration with the Department has continued. “More or less every year I have returned to Australia to analyse data, write publications and plan future research together with my old colleagues.”

Many staff members from Warrnambool have also visited Finland on several occasions.

### Professor Tiina Laatikainen

Tiina obtained her MD degree from the University of Helsinki in 1996 and a degree of associate professor in public health in 2005. She has also an adjunct professor degree at the Flinders University, School of Medicine, Faculty of Health Sciences in Australia.

She is currently the director of the Chronic Disease Prevention Department in the National Institute for Health and Welfare in Finland where she has been working since 1996. In 2004, she worked as a senior lecturer in GGT UDRH building up public health research and prevention activities in rural areas.

Her main areas of expertise are cardiovascular disease epidemiology and surveillance, prevention programs and intervention studies. She has been one of the main investigators in the large Finnish surveillance and intervention studies on CVDs and other NCDs and published up to 150 papers in peer reviewed journals. She has advised on the development of non-communicable disease surveillance in many countries, including Australia, Bosnia, Herzegovina, Russia, Tunisia and Tanzania.
Chapter Nine

Supporting students

Although student support programs existed prior to the GGT UDRH, it was widely acknowledged that they did not adequately serve the region and the UDRH objectives.

The Department set about making significant advances in the field, as reflected in the growth of students undertaking placements throughout the Green Triangle.

With a declining number of health professionals nationwide, a major objective of the GGT UDRH was always to promote the benefits of rural health careers.

The student support program was introduced to provide support for undergraduate and postgraduate health professional students undertaking clinical or research placements in the region. The program aims to improve the clinical and learning experiences of students on placement by provision of a range of services and resources. Multidisciplinary interaction, for example through shared accommodation facilities, is designed to prepare students to work in multidisciplinary teams.

In 2002 KPA Consulting and the Department collected data on student flow into the region. Senior Program Manager Nadia Marsh said a gap analysis was performed to identify the data that was still required. “Overall the response to the presence of the GGT UDRH in the region was positive, with most universities being prepared to send increased numbers of students once accommodation and other support was available,” she said.

The Department of Health and Ageing contract specified towns in which accommodation was to be established, but the GGT UDRH reviewed the choices to ensure they “made sense”. The Department also needed to identify other towns where high numbers of student placements occur, such as Horsham, and then develop proposals for infrastructure development.

Staff visited 20-30 university faculties, speaking with students and staff to find out what they needed to make their rural experiences more productive.

Accommodation was quickly identified as a major issue. “We looked at caravan parks and the Commonwealth considered looking at leasing properties,” Nadia recalled.

It was decided that basing student support officers in GGT offices would be the best way to service the region.

Nadia said the concept was designed to increase the number of students in the region and support them to stay longer. “We believed that if students came to the region for a longer stay they were more likely to appreciate the experience of rural life and stay here or to return after their studies,” she said.

The Department established an online student booking system and provided subsidised accommodation and infrastructure support.

Financial subsidies were later introduced as another incentive to attract students and to make a rural stay more affordable.

Tanya Tonissen joined GGT UDRH in 2002 as the Student Placement Officer and was involved in the Clinical Placement Project headed by Director Professor James Dunbar and Nadia Marsh.

“My role was aimed at improving rural experiences for students by promoting clinical placement opportunities, setting up suitable accommodation, preparing orientation information, and supporting students while on placements,” Tanya recalled.

Her role included developing alliances with universities, health practitioners and community groups. “They were very enthusiastic and willing to support the students, which I believe was the basis of the project’s success,” she said.

“We believed that if students came to the region for a longer stay they were more likely to appreciate the experience of rural life and stay here or to return after their studies.”
Chapter Nine

The position also entailed liaising with students on rural placements, and highlighting to students the benefits of rural career opportunities, close networks and the relaxed social rural lifestyle while also assisting them with overcoming challenges such as geographical distances, professional isolation and multiple roles held by practitioners in rural settings.

Tanya and Dr Karen Stagnitti, who had joined the GGT UDRH in an education and training role, travelled to several universities and health practices researching the supply of medical, nursing and allied health students to the Greater Green Triangle region.

By 2003 accommodation had been established in Hamilton, Mt Gambier, Portland, Camperdown and Warrnambool. This accommodation included study areas with computers, internet and printer access. Arrangements for accommodation in Millicent and Naracoorte were underway in partnership with local hospitals.

“There was a critical shortage of accommodation that was affordable for students, and that met their needs whilst studying away from their home universities,” Nadia said.

The student support program was introduced to provide support for undergraduate and postgraduate health professional students undertaking clinical or research placements in the region. The program aimed to improve the clinical and learning experiences of students on placement by provision of a range of services and resources. Multidisciplinary interaction, for example through shared accommodation facilities, is designed to prepare students to work in multidisciplinary teams.

A high-functioning booking process was established in 2007 via the GGT UDRH website.

Services and resources include:

- The provision of accommodation
- Financial support to assist with the cost of accommodation or placement, if eligibility criteria are met
- Access to computers, wifi, the internet and printing facilities, in accommodation
- Information on towns within the region and on the region itself
- Free orientation tours in a number of towns within the region
- Information on events hosted by regional young professional networks
- Access to a variety of education and training opportunities, including Aboriginal and Torres Strait Islander (ATSI) Cultural Awareness Training
- 24/7 access to Student Learning Centres

The GGT UDRH now offers accommodation to support undergraduate and postgraduate health professional students on clinical or research placements in Colac, Edenhope, Hamilton, Horsham, Millicent, Mt Gambier, Naracoorte, Portland and Warrnambool.

Accommodation is close to the main hospital and associated health services of each town.

Student Learning Centres (SLCs) are offered in Hamilton, Warrnambool and Mt Gambier.

Students can access either a workstation or laptop port, access is also available to a web cam, headphones, and photocopying, fax and scanning facilities, and a notice board advertises local events, educational seminars and other information.

Access is also available to photocopying, fax and scanning facilities. Local calls can be made from a telephone located within the SLC.

In recent years infrastructure grants have been submitted to refurbish student accommodation facilities in Horsham, Warrnambool and to purchase a property in Hamilton to address student accommodation shortages.

The program presently has three Student Support Officers (1.5FTE) who are primarily concerned with the wellbeing of students on clinical placement and are strategically located throughout the region.

Population Health Seminars, funded via the Department of Health and Ageing, are also run in collaboration with the CPDWorks program. The program aims to expose students on clinical placement to the population and disease trends in the region, and to the challenges of rurality and its implications for public health and Aboriginal health.

The student support program is very well developed and highly regarded amongst all university and health service providers in the region.
Chapter Nine

Comments by students

“The overall program was very influential; it enlightened us regarding aspects of rural life and health care that we were previously unaware of. The program certainly positively changed by preconceived ideas about potentially working in a rural area in the future.”

“Keep up the good work! The student discounts and the Warrnambool welcome pack were lovely! Accommodation was well-organised; we were kept informed via email. Felt positive and well-supported! THANK YOU!”

“The accommodation on offer by GH was exceptional. For myself as a student from another area, it was great to stay somewhere so close to the hospital and the town centre, while being affordable. I was pleasantly surprised to find the kitchen well stocked, all essential appliances supplied and such a comfortable bed on offer. It is a credit to the program for myself to leave the house having had such an amazing experience. Thank you again, and I will have no hesitation suggesting others to use your program.”

“Greater health run a great program, and it does entice people from the metro areas to want to move down to eg: Warrnambool, as staying with other students and talking with them, they agreed they would love to move to the area, as they and I felt very welcome, especially all the little enticements from greater health with their Welcome bag of goodies, gives you the incentive to look around the area, not just go to your placement and go back to your room. Thanks Greater Health for a pleasant stay.”

“The Greater Green Triangle provides wonderful resources to visiting students and runs a very good program to introduce students to the south western parts of Victoria. This area is very lucky to have such an organisation set up to help attract future healthcare workers and definitely made Warrnambool more attractive to come back to and work in for me personally. Thank you heaps to empowering me to explore this part of the state.”

“It was great to be a part of the programs run by greater health. I got a lot more out of my rural placement because of the cultural awareness training and the population seminar, and as such I am much more inclined to consider working in a rural area if the opportunity arose. Thanks for all your help and great work!”

Current Student Support Officers are (from left) Angela McLaren, Amanda Urquhart and Jacqui Michalski.

Professor Karen Stagnitti

Karen started in an education and training role in May 2002 and made a lot of connections with the regional services and hospitals, particularly the allied health department.

When the GGT UDRH started, a core key area of performance was to engage health students who undertook their fieldwork clinical placement in the region. When Karen started at the GGT UDRH it was apparent that workforce issues were an untouched area of investigation in the region. A health workforce is needed to maintain a health service and so looking at issues surrounding workforce recruitment and retention became a focus of her time at the GGT UDRH.

She developed a seminar series for health students when they were on placement, along with a training program for clinical supervisors. Karen now holds a Personal Chair in the School of Health and Social Development at Deakin University in Geelong.
Chapter Ten

Cardiovascular Disease

Although deaths from cardiovascular diseases have declined over the past three decades, they remain one of the biggest killers of Australians.

The Australian Bureau of Statistics shows that in 2007-08, 6.4 per cent of all Australians aged 15 years or over had some form of heart, stroke or vascular disease, down from 7.2 per cent in 2001.

Better prevention, treatment, advances in medical technology, a greater awareness of risks, public health measures and healthier lifestyles have contributed to the fall.

The GGT UDRH has been a major contributor to improving knowledge about the diseases.

GGT Cardiovascular Disease Prevention Partnership

In 2002 Professor James Dunbar formed a GGT Cardiovascular Disease Prevention Partnership with all primary and secondary care medical and other services represented. It was linked to plans at the National Heart Foundation.

The main project linked to this initiative, led by Dr Phil Tideman from Flinders Medical Centre, was iCarNet and Phil was also involved in GGT’s survey of risk factors for heart and other diseases. No survey of this type had been done in Australia for 10 years, and it highlighted the inaccuracy of self-reported data and the omission of details such as blood pressure or cholesterol levels.

Professor Edward Janus, a physician in Horsham and previously Professor of Medicine in Hong Kong, chaired a heart disease risk factor study in Hong Kong similar to that needed in the Greater Green Triangle. The methodology used in his study was virtually identical to that proposed by visiting consultant Professor Erkki Vartiainen, whose colleague Dr Tiina Laatikainen was seconded for a year to undertake the study which was funded by Departmental resources and a grant to Dr Tideman from Pfizer.

Work on this project was also of interest to the National Vascular Disease Prevention Partnership, which comprises Diabetes Australia, National Heart Foundation, Stroke Association and the Renal Disease Association. The Partnership is chaired by Professor Andrew Tonkin, and is currently conducting a Department of Health and Ageing-funded project that aims to develop an absolute risk test common to all four disease groups. As a member of the steering committee, Professor Dunbar arranged focus group work with GPs and consumers in the GGT region.

Three risk factor surveys undertaken by the GGT UDRH investigated the prevalence of major cardiovascular disease risk factors in the Limestone Coast, Corangamite Shire and Wimmera regions.

Information gathered from the surveys was used for epidemiological research and the development of targeted disease prevention programs throughout the region.

Dr Phil Tideman

Phil is the Senior Staff Cardiologist, Department of Cardiovascular Medicine at the Flinders Medical Centre. He received his Bachelor of Medicine and Surgery from the University of Adelaide, worked as a GP and achieved his Diploma of Obstetrics in Mildura before undertaking specialist training at the Flinders Medical Centre as a cardiologist and consultant physician.

Phil has particular interest in point of care pathology and medical information and communication technology, and cardiovascular epidemiology.

He is the Clinical Director of the Integrated Cardiac Assessment Regional Network.

His involvement with GGT UDRH stems back to the origins of the Department and includes research into cardiovascular epidemiology and involvement in the risk factor studies.
Chapter Ten

Food And Move

Another good health project undertaken by the GGT UDRH was Food and Move, a collaborative project with the students, staff and parents from four Warrnambool secondary colleges.

In 2004 Clare Vaughan was appointed project officer for this school-based obesity project Food and Move, with Tiina Laatikainen providing supervision.

The project evolved from an awareness of the limitations of the education system to address the increasing weight of students.

“There was a lot of potential for schools to be part of the obesity prevention solution and the role provided me with time to reflect on the education system, take some baseline measures and test ideas for intervention,” Clare said.

Its focus was on promoting healthy eating and physical activity in secondary schools and it built capacity for ongoing health promotion to address overweight/obesity.

The project aimed to increase awareness amongst students, parents and staff of the links between regular physical activity and good nutrition to achieve optimal health and the implications of childhood obesity, and improve opportunities for students to access healthy food at their school canteen and participate in physical activity at recess and lunchtime.

The project was completed in December 2005.

Clinical Pathways For People With Co-Morbid Depression And Coronary Heart Disease

The Evidence-Based Best Practice Model Clinical Pathways for People with Co-Morbid Depression and Coronary Heart Disease examined the clinical pathways for patients with heart disease across health care settings.

The project, completed in May 2006, explored the literature on prevalence, assessment and treatment of co-morbid depression and heart disease, as well as current activities of clinical pathways for these conditions; process mapped the care provided to coronary heart disease patients to identify basic elements and timeframes used to deliver patient care as well as problem points in the existing process; identified best practice model clinical pathways for the patient group based on health provider interviews and patient discovery interviews; and informed the implementation of a pilot phase of clinical pathway in a general practice setting in the GGT region and guidelines for best practice in primary care settings for this patient group.

Professor Edward Janus

Edward is Director of General Internal Medicine at Western Hospital in Footscray, Melbourne and Professorial Fellow in the Department of Medicine, University of Melbourne as well as adjunct professor in GGT UDRH. After graduating from the University of Otago in New Zealand he completed his PhD in lipoprotein metabolism in London in 1978. He has a long standing research interest in the epidemiology and prevention of diabetes and cardiovascular disease. He was Chairman of the World Heart Federation Council on Arteriosclerosis and founder secretary of the Asian Pacific Society of Atherosclerosis and Vascular Diseases in 1995, President from 1999-2002 and remains active in this Society.

Edward has worked in clinical and laboratory medicine and research in New Zealand, England, Hong Kong and Australia. He has more than 200 publications and holds NHMRC grants.

His association with GGT UDRH commenced when he was a consultant physician at Wimmera Base Hospital in Horsham from 2000-2006 and he has been a part of the major ongoing GGT UDRH research projects in cardiovascular risk factor epidemiology and diabetes prevention from the outset.
Chapter Eleven

Living with Diabetes

Diabetes is the fastest growing chronic disease in Australia.

It is estimated by Diabetes Australia that by 2031 3.3 million Australians will have type 2 diabetes.

Diabetes is the sixth biggest killer of Australians and is the second highest contributor to the Australian burden of disease. It presents an enormous economic burden for the nation.

It is estimated that 60 per cent of type 2 diabetes could be avoided by lifestyle modifications.

With the Green Triangle region recording some of the highest rates of diabetes in Australia, the GGT UDRH has throughout its 10-year history placed strong emphasis on addressing the problem.

In south-west Victoria more than 5500 people have diabetes. The Glenelg Shire has the worst record with 7.2 per cent of residents reporting type 2 diabetes, according to 2011 figures. Many more cases of type 2 diabetes are believed to be unreported.

Greater Green Triangle Diabetes Prevention Project

Between 2004 and 2006 the Greater Green Triangle Diabetes Prevention Project (GGT DPP) lifestyle intervention project aimed to prevent the onset of type 2 diabetes among high risk individuals.

In November 2003, Professor Tiina Laatikainen and Professor James Dunbar had submitted a proposal to the Australian Government Department of Health and Ageing to seek funding for the GGT DPP. Its aim was to evaluate the feasibility and effectiveness of structured group program for lifestyle modification in Australian primary care settings.

The GGT DPP was one of the three projects funded in 2004 by the Council of Australian Governments initiative that aimed to prevent or delay the onset of type 2 diabetes.

Three general practice clinics in Hamilton, Horsham and Mount Gambier participated in the study which combined behavioural theories with evidence-based intervention goals.

Tiina arrived in Australia for a one year sebbatical to lead the project coordinating team in implementing the study. This team included Lucinda Franklin and Anna Chapman, both Research Associates at GGT UDRH.

Initial challenges for the coordinating team included the large distances between implementation sites and the Warrnambool office, as well as the increased logistical issues faced when ensuring protocol standards are maintained at three different locations, each with unique characteristics.

Prior to commencing work on the project, all field staff (nurses, physiotherapists and a dietitian) participated in a three-day intensive training program. Patients were then screened at general practice clinics and, if eligible, were invited to participate in the intervention which consisted of six structured 90 minute group sessions over eight months and were facilitated by project nurses. Clinical tests were also scheduled at baseline, three months and 12 months and consisted of anthropometric and biochemical measures as well as a self-administered questionnaire.

A total of 331 adults were recruited for the study and 237 completed the structured group-counselling sessions facilitated by trained project nurses, dieticians and physiotherapists. The sessions aimed to motivate and support participants to adopt lifestyle changes.

It was hoped that providing them with skills and social support they would be able to modify their diet and physical activity levels.

The structured group program held sessions over eight months and provided participants with information, goal setting, planning and implementation, regular self-assessment and performance monitoring, feedback and reinforcement, and enhanced social support.

A new risk assessment tool for identification of patients at high risk of diabetes was introduced and used in the intervention. Results provided evidence that a type 2 diabetes prevention program using lifestyle intervention is feasible in a primary health care setting, with reductions in risk factors approaching those observed in clinical trials.

At the beginning of 2005, Tiina returned to Finland and the project coordination was transferred to Anna Chapman for the period prior to Dr Sami Heistaro commencing his sabbatical in mid 2005.

30. GGT UDRH
Chapter Eleven

At the completion of the program, improvements were seen in weight, waist circumference, fasting plasma glucose, plasma glucose after two hours oral glucose challenge, blood lipids, and diastolic blood pressure - all of the clinical measures except for systolic blood pressure. These results demonstrated the feasibility and effectiveness of the structured group program in an Australian primary health care setting. Based on the improvement in clinical measurements it was estimated that the risk of type 2 diabetes reduced by 40 per cent.

In mid 2006, Sami successfully received funding from the Ubergang Foundation for an extension of the GGT DPP. This next phase aimed to maintain the health benefits for people who had completed the original GGT DPP by testing the effectiveness of a simple support intervention to aid self-management. This was achieved by using a telephone intervention designed to maintain the lifestyle changes in diet and physical activity, and participants were randomised to either telephone support and self-care information or self-care information only. The intervention duration was 18 months and clinical tests and questionnaires were administered at the 18 month time point.

The project coordinating team and field staff from the original GGT DPP continued their involvement in this next phase of the study. On the return of Sami to Finland at the end of 2006, Dr Steve Bunker and Anna Chapman coordinated the project.

A subsequent telephone support follow-up project presented participants with either telephone support and self-care information (intervention group), or a self-care information only (control group).

Following the success of the GGT DPP, Professors Laatikainen and Vartiainen returned to Australia and attended a meeting of the Office of the Prime Minister and Cabinet to propose a rollout of the structured lifestyle intervention in Australia.

**Life! - Taking Action On Diabetes**

The data from the GGT DDP study showed that intervention could be effective and it led to the development of the Life! - Taking Action on Diabetes program, one of the most significant and influential programs of the GGT UDRH.

Life! - Taking Action on Diabetes took the primary care-based lifestyle behaviour change program from the Greater Green Triangle region and introduced it to 25,000 Victorians aged 50 years and over, and Aboriginal Victorians of all ages, who are identified as at high risk of developing type 2 diabetes.

The Department of Health funded Diabetes Australia - Victoria the lead agency for the Life! program. The GGT UDRH conducted the training of facilitators and took a leading role in the evaluation and development of the program.

Participation in the Life! program was initiated via an easy to use risk assessment tool- the Diabetes Risk Test- that assesses the risk of developing type 2 diabetes. A person’s level of risk is confirmed in a visit to their General Practitioner. Those at high risk (with scores >12) then undergo a series of clinical tests and physical measures, including height, weight and waist circumference measurements. They were referred to a lifestyle behavioural change program of six group sessions - the first five sessions are at fortnightly intervals and the final session is at eight months.

Topics covered in the sessions include understanding food and the healthy eating guidelines; the benefits of being healthy and active, and how to reduce the risk factors for diabetes. Participants are supported to set achievable healthy eating and physical activity goals and to work through any issues that may be barriers to achieving their goals.

The program is widely recognised as a world-leader in diabetes prevention. It has been funded for a second lot of four years, partly based on representations made to Victorian Minister for Health David Davis by Erkki and Tiina.

**Anna Chapman**

Anna was a Research Associate at GGT UDRH from 2004-2007 and was a key project team member for both the Greater Green Triangle Diabetes Prevention Project and the Greater Green Triangle Risk Factor Surveys.

Anna is currently a Research Fellow and PhD candidate at the Primary Care Research Unit, Monash University. Her PhD thesis is titled ‘Effectiveness of the Happy Life Club™ study: A cluster randomised controlled trial of a type 2 diabetes health coach intervention’.

Her research interests include the prevention and management of chronic disease (particularly type 2 diabetes) and knowledge translation.
Chapter Eleven

Hospital Admissions Reduction Project


This project quantified hospital and other medical service utilisation for diabetes and diabetes complications and audited the associated diabetes management systems against recommended models. It also identified the psychosocial risk factors of depression and social isolation; systems barriers and enablers to optimum diabetes management and causes of preventable hospital admission for complications of diabetes.

Mothers After Gestational Diabetes In Australia (MAGDA) Study

It is estimated that about 50 per cent of women who have had diabetes in pregnancy (gestational diabetes mellitus – GDM) will go on to develop type 2 diabetes mellitus (T2DM).

This alarming statistic prompted a team of researchers and clinicians, under the leadership of the GGT UDRH, to develop an National Health and Medical Research Council partnership grant in 2009 to evaluate the effectiveness and cost effectiveness of a 'recall and reminder register' and a lifestyle based 'diabetes prevention program (DPP)' for women post-GDM in Victoria and South Australia.

Funded in 2010 by the NHMRC, South Australia Health, Victorian Department of Health and Diabetes Australia – Victoria, and with significant in-kind support from the Diabetes South Australia and General Practice Victoria, this five-year study will run at the Royal Women's Hospital and Sunshine Hospital in Melbourne, and the Lyell McEwin Hospital in Adelaide through to 2015.

Deakin University is implementing this multi-site trial in close partnership with Flinders University, Melbourne University and the University of Tasmania, to measure the reduction in risk of developing T2DM in a group of women who have had GDM and have participated in the ‘recall and reminder register’ and the ‘DPP program’.

The MAGDA Study will also evaluate the pathway from research to policy in this important area of public health policy.

Melbourne Diabetes Prevention Study (MDPS)

Funded by the NHMRC, this important study is built on the foundations of the GGT DPP, which evaluated a structured lifestyle intervention to prevent the development of T2DM in the GGT rural catchment area during 2004-2006. The MDPS aims to evaluate the effectiveness and cost effectiveness of the Life! Taking Action on Diabetes program for adults aged 50 – 75 in the Melbourne area. This randomised control trial will track nearly 800 participants over a 12-month period to see whether participants who receive the program reduce their risk of developing T2DM versus the control group who will receive usual care from their GP over the same 12-month period.

This study, managed through the Deakin Burwood office by Elizabeth Stewart, who joined in 2011, will run for three years and is being implemented in close partnership with Diabetes Australia – Victoria.

The pilot study was completed in June 2011 and its results will soon be published. These results will inform the development of a subsequent study which is now recruiting people aged between 50 and 75 in Melbourne's eastern suburbs who are at high risk of developing T2DM.

Epidemiology Of Type 2 Diabetes And Gestational Diabetes In Victoria

International studies indicate that some ethnic and socio-economic groups suffer from a high prevalence of T2DM, its associated risk factors (including GDM) and its complications.

Australia is one of the most multicultural nations on Earth, with more than 200 languages spoken in the community and a quarter of all residents born overseas. As such, identifying the groups at highest risk of GDM and T2DM in the local context is imperative, and has major implications for health service planning, prevention initiatives and clinical practice.

The Epidemiology of Type 2 Diabetes and Gestational Diabetes in Victoria project has examined the ethnic and socio-economic distribution of these conditions in Victoria, and in so doing fills a major knowledge gap.

Complementing the Department’s research focus on prevention of T2DM in high risk groups (Life!), including its world-first work in preventing T2DM in mothers after gestational diabetes (MAGDA), this project provides essential background information by profiling the groups in Victoria at greatest risk. The gestational diabetes component, which has not been comprehensively examined in the Victorian context with a socio-cultural focus since the early 1990s, involves collaboration with the Victorian Department of Health.

32. GGT UDRH
Chapter Eleven

Measurement Of Ethnicity And Health

Ethnicity is a multi-dimensional construct that encompasses a range of different parameters, and is therefore a fundamentally difficult concept to characterize and measure. In the late 1990s, in recognition of the need to standardise measurement of ethnicity across data sets and disciplines, the Australian Bureau of Statistics published a series of guidelines that stipulate what and how to measure. Despite such guidelines, there remains considerable variation in measurement practice.

As Australia is home to a multi-cultural population, it is essential that ethnicity is measured in a consistent and appropriate manner. This project has examined the various ways in which ethnicity is measured in the health arena in Australia, and how well we are faring in meeting the existing guidelines.

This project, led by Dr Marian Abouzeid, involves collaboration with a world-leading expert in the field, Professor Raj Bhopal, based at the University of Edinburgh. Findings have led to a series of recommendations for how to improve current practice. This work has implications not just for the Australian health research and clinical arena, but also provides lessons for the international community.

Spreading The Word

In 2010 the GGT UDRH contributed to a world-first book on diabetes prevention programs.

Director Professor James Dunbar and then Director of Research Professor Prasuna Reddy co-edited and contributed three chapters of the Diabetes Prevention in Practice book which was launched at the 6th World Congress on the Prevention of Diabetes and its Complications at Dresden in April.

The book outlines how the Life! Taking Action on Diabetes program was developed in the Greater Green Triangle region and later expanded throughout Victoria and became recognised as the largest systematic diabetes prevention program in the world.

In a chapter outlining the scaling up of type 2 diabetes prevention programs in Australia, Professors Dunbar and Reddy argue that economic analysis and scientific evidence of effectiveness supported the case for a national policy on diabetes risk reduction.

The book, edited by Professors Dunbar and Reddy along with Colin Greaves from the United Kingdom, and Peter Schwarz and Jaqueline Schwarz from Germany, was designed to inform governments, health service professionals and researchers about what can be achieved through diabetes prevention programs and identify what is successful and what is not so easy to achieve.
Mental Health

The wider recognition of depression as a serious illness that impacts on the lives of thousands of Australians has shaped a significant portion of the GGT UDRH's work.

The GGT UDRH has led several projects that trace the links between the onset of depression and chronic illnesses, such as cardiovascular disease and diabetes, and set about finding ways to reduce the burden.

Recognising the relationship between physical and mental health, the aim of the PANORAMIC Consortium was to improve systems of care, quality of life, and health outcomes of people with co-morbid physical and mental illness.

The Consortium focused on four main areas: collaboration, research, policy development and service development and aimed to develop primary care (general practice) and acute care (hospital) evidence-based best practice model clinical pathways for people with co-morbid depression and coronary heart disease.

The Consortium was successful in obtaining competitive grant funding from both beyondblue - the national depression initiative and the National Heart Foundation to undertake two complementary projects.

TrueBlue evolved from D_TECT (Depression Treatment Evaluation Care Team) and was developed from a Primary Health Care Research Evaluation and Development (PHC RED) bursary award to Dr Mark Morgan in 2006.

The PHC RED practice research bursary proposal was to develop and test a patient calendar to better coordinate chronic disease management for patients with diabetes and heart disease.

A separate PHC RED bursary had been awarded to Dr Dale Ford to look at ways depression could be identified and managed in patients with heart disease and diabetes. The basis of Dale's bursary was that depression is a major risk factor for poor outcomes but it is under recognised and under treated in these patients.

The two bursaries were combined into the "patient pathways" project which identified points where depression screening could occur and screened patients who attended cardiac rehab groups for depression.

In D_TECT, six rural practices in south-eastern South Australia and western Victoria were recruited to trial depression screening and follow up of their patients who had diabetes and heart disease.

D_TECT developed a purpose-built template for a GP Management Plan (GPMP). Completed by the nurses during their consultation, the GPMP presented GPs with the findings that included depression scores, blood test results, physical measurements and documented lifestyle goals, and highlighted where there were gaps in care compared to the 'best practice' guidelines of the National Heart Foundation and of Diabetes Australia. These new roles for practice nurses were amongst the first in the country.

The trial demonstrated that the approach was feasible and led to funding for the TrueBlue program to conduct a full clinical trial.

The TrueBlue project was also funded by beyondblue. Its extensive advisory committee included the then president of RACGP, Chris Mitchell, divisions of general practice and academics in primary care research. The committee decided that a randomised trial would be the best way to show improved clinical outcomes of nurse-led collaborative care. The program was trialed in 14 general practices in south-west Victoria, the Northern Rivers area of New South Wales, and in Adelaide.

Dr Mark Morgan

Mark is a Senior Research Fellow with Greater Green Triangle University Department of Rural Health. After completing medical training in Cambridge and Oxford, Mark worked as a rural GP in Mt Gambier. He is now a GP partner in Hills Medical Service in Aldgate, South Australia where he provides the full range of longitudinal family care from antenatal to palliative care with a particular interest in chronic disease management.

Mark is currently involved with the TrueBlue project which is examining models of collaborative care for depression in patients with diabetes or heart disease. His research interests include quality improvement in general practice and collaborative care for chronic disease management in primary care. Mark is a clinical tutor for University of Adelaide medical students and a senior lecturer with GGT UDRH.
Chapter Twelve

Collaborative care had been demonstrated to be effective in the management of depression in USA by Wayne Katon’s IMPACT project. The GGT study decided to also focus on patients who had depression and either diabetes or heart disease. Even more responsibility was passed on to the practice nurse to be the case manager – making appointments and confirming that patient care was coordinated, follow ups were attended every three months, blood tests and physical checks were performed, and that depression was improving. If depression was not improving then a step up in treatment with medication or, more commonly, a mental health referral was initiated. The nurses, trained in TrueBlue workshops and supported by local facilitators and by peer support in hosted monthly teleconferences, gained in confidence to deal with complex chronic disease at a higher level than ever before.

TrueBlue’s aim was to achieve best practice care. Depression scores, physical measures, blood test results, goal setting, referrals to mental health workers and self-reported exercise were all outcome measures cleverly extracted from the customised GP management plan document.

The study has achieved success in all the expected outcomes, including:

- After six-months of the TrueBlue intervention, the mean depression score for the intervention group was significantly lower than for the control group.
- There was an even better improvement in the scores after a year of the intervention.
- The intervention group demonstrated an intensification of treatment for depression, with increases in exercise rates, referrals to exercise programs and referrals and visits to mental health workers, whereas there were no significant changes in the control group.

“This has, I think, now proved that protocol-driven care with the practice nurse as case-manager can achieve better health for our patients than can usual episodic care from time-pressured GPs,” Mark said.

Feedback from patients, nurses and GPs suggests that the model is well liked by all, and the economic data is starting to show that it is affordable under existing Medicare funding – a win-win situation!

The next step is to gain support for a wider roll out of TrueBlue which will have the effect of changing the face of general practice into one in which the patient thinks of the nurse as team leader for these chronic diseases and the GP as consultant to lead clinical decisions.

Mental Health Mapping

The Barwon South West Mental Health Mapping Project (Strategic Health Development and Innovations Advisory Service) looked at the provision of services for the high frequency psychological disorders, depression and anxiety, in south-west Victoria in the context of the increased priority being placed on mental health services by both the Australian and State governments. It also focussed on the experience of the consumer in accessing appropriate services.

The main aims were to identify the capacity and structure of the current services available to those with depression and anxiety, determine points of entry and service pathways from a consumer perspective, identify service gaps, barriers and enablers to service utilisation, analyse the impact of the new Medicare Benefits Schedule items on service usage and the mental health workforce and propose recommendations to streamline service delivery through consultation with key stakeholders.

The project was completed in December 2008.

The GGT UDRH was also a collaborating partner with Monash University in a Pragmatic Trial of Stepped Care Intervention for People with Depression and Cardiac Failure. The beyondblue-funded study examined the effectiveness of a stepped care model of treatment for the co-morbidities of depression and cardiovascular disease, and the enablers and barriers to successful treatment.

An Evidence-Based Best Practice Model Clinical Pathways for People with Co-Morbid Depression and Coronary Heart Disease project was completed in 2006. This project examined the clinical pathways for patients with heart disease across health care settings.

During 2006-2007 a Type 2 Diabetes and Depression: Assessing the Prevalence in Victoria and Identifying Effective Public Health Interventions examined both the extent of co-morbid depression among people with type 2 diabetes and the most effective public health interventions for early detection and treatment of such co-morbid depression.
Chapter Twelve

**Rural Mental Health Academic**

In 2005 the Rural Mental Health Academic position was created and later filled by Kate Schlicht. It came about as a result of Director Professor James Dunbar’s lobbying of the Department of Health and Ageing and Federal Minister for Health Tony Abbott.

James discussed the need to address mental health issues in rural areas. “We pointed out that rural mental health was poorly staffed and so a proposal was developed to appoint senior lecturers at the 11 UDRHs,” James said.

The University Department of Rural Health Mental Health Project is funded by the Department of Health and Ageing and provides support and training to health professionals and raises awareness of, and the need for improved management of, mental health issues.

The program also works with the GGT UDRH’s Student Support Program to increase the number, and improve the experience, of students from mental health disciplines, like psychology and occupational therapy, who undertake their clinical placement in the Greater Green Triangle region. The program offers health professionals access to a range of education and training sessions, seminars and workshops.

It also aims to develop and implement a range of resources and tools for health professionals and the general community that assist with raising awareness and improving management of mental health issues.

The Rural Mental Health Academic position was designed to increase access to mental health services for rural and remote Australians; improve the ability of other health professionals to recognise and deal with mental health issues among clients and patients; increase the awareness of mental health issues among people living in rural and remote areas, and mentor and supervise undergraduate and post graduate students of mental health disciplines.

The Mental Health Academic (MHA) organised post graduate students (doctoral and masters students) to be placed in rural areas. The rural placements have included general practitioner rooms; community mental health services; and acute impatient mental health services and have ranged between 14 days and three months. Although the bulk of the placements have been with psychology students, there has also been a placement organised for a nurse practitioner. Placements have been organised for numerous universities in Victoria and South Australia.

Kate has been involved with numerous research projects within the GGT region and nationally, including an active role in TrueBlue investigating the development of a collaborative model of care in general practice.

Enhancing partnerships with local health services to develop mentoring and research has been another priority. An example of this is involvement with South West Healthcare and the development of its Shared Decision Making research (see MyVOICE).

An important part of the role is the provision of education and training to health professionals. The education has varied widely, from focus groups to women’s education sessions and speaking to dairy farmers. The community education sessions continue to develop and grow. The Applied Suicide Intervention Skills Training (ASIST) course is delivered to the GGT region in conjunction with Lifeline. The ASIST course was originally offered once a year but in 2012 it is planned to run 6-8 times to a mix-level of health professionals and the community.

Local health care services had requested support to increase knowledge about diagnosing and managing mental health issues. The input by Kate to health professionals’ education has further developed to include medical students with the introduction of the Deakin Medical School into the GGT region, medical registrars and more recently general practitioner supervisors.

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**Kate Schlicht**

Kate has been working at GGT on the Mental Health Academic project since 2008. Prior to this she worked in the public mental health system as a team leader. During this time she has also completed a management course (major in human resources). Kate has been actively involved in the debriefing team at South West Healthcare and continues to work in a clinical role in the primary mental health team. Kate is also a registered nurse with an Intensive Care Certificate. Her research interests are comorbidity/mental health and chronic disease management, and decision making in mental health.
Chapter Twelve

The education sessions are aimed at enhancing the ability of rural health professionals to identify mental health problems earlier so appropriate assistance can be provided more quickly.

The MHA position’s original focus was providing rural placements and supervision but now incorporates:

- Rural placements for postgraduate allied health students
- Community sessions and awareness raising for mental health issues
- A broad education and training program to the community and health professionals
- Research

The MHA built on partnerships within the GGT area and provides mentorship, supervision and facilities to enhance the delivery of optimal mental health care.

MyVOICE

The South West Healthcare Mental Health Services’ MyVOICE program has been developed in collaboration with the GGT UDRH and investigates how to increase the input of consumers in their treatment.

The study is looking at how shared decision making can be embedded into clinical practice as a core part of publicly funded mental health services.

MyVOICE project manager Mark Powell said patients with chronic medical illnesses want to participate in making decisions around their treatment.

It aims to increase the ‘voice’ of consumers in their treatment planning and improve clinicians’ experience in delivering mental health care.

Ben Philpot

Ben is a research fellow/biostatistician and commenced work with the Department in January 2006. In addition to a strong focus on statistical analysis and methodology, his interests include prevention and management of cardiovascular disease and diabetes as well as depression.
Chapter Thirteen

Indigenous Health

Indigenous Australians have a greater burden of poor health than the rest of the population.

That fact also applies in the Greater Green Triangle region which is home to nine Aboriginal communities.

The GGT UDRH Aboriginal Cultural Awareness Training program is funded via the Australian Government Department of Health and Ageing. The program hopes that exposure to Aboriginal health and cultural issues will help students and health professionals to see that what they do as individuals can make a difference to the health and wellbeing of Aboriginal people.

The GGT UDRH recognised the need to address this ongoing imbalance and early in its existence hosted a stakeholder meeting at Brambuk in The Grampians to develop a way to work with Indigenous communities on health issues.

At the time Jason Mifsud was employed by South West Healthcare as an Indigenous Health Liaison Officer. He was seconded to GGT UDRH (on a 0.5 basis) for 18 months to work on community engagement, to improve cultural awareness and to create alliances between communities and mainstream health services.

It was recognised that Aboriginal communities needed their own time to work things out and therefore the pace of the support program was dictated by their needs, not those of the GGT.

An Indigenous Health Committee was established and was particularly keen to improve the capacity of all Aboriginal health workers and to improve the cultural capacity of the mainstream health workforce.

GGT UDRH’s inaugural Senior Program Manager Nadia Marsh spent time at the Spencer Gulf UDRH where solid programs in Aboriginal health were well established. “Our staff needed cultural awareness training to enable them to develop their skills” she said. Nadia subsequently oversaw an expanded student support program with different levels of cultural awareness training.

Mel Robertson, Senior Program Manager since 2007, continues to coordinate Aboriginal and Torres Strait Islander (ATSI) Cultural Awareness Training in collaboration with local ATSI communities.

The training offered is designed to provide students with clinical insight into Indigenous health issues. It aims to assist students in developing skills and knowledge that will assist them as health practitioners to deliver culturally-safe clinical care, and to see that what they do as individuals can make a difference to the health and well being of Indigenous people.

A range of resource material is also available to help improve a student’s understanding of Aboriginal health and to provide practical advice to students who may work with Aboriginal clients during their clinical placement.

Mel Robertson

Mel started with the GGT UDRH as an administrative assistant for the Statewide Allied Health Workforce Enhancement Project program in October 2004. She was later promoted to Office Administrator for the Hamilton Office in 2005. In 2007 her role changed to Finance Administrator and she became the Senior Program Manager in October 2007. This was initially an acting position whilst Nadia Marsh was on maternity leave but in November 2011 Mel was officially appointed Senior Program Manager for the GGT UDRH.

The main portfolios that she manages are the Student Support Program, Indigenous health, IT, infrastructure proposals and Commonwealth reporting requirements. She has Certificate II and III of Office Administration and a Bachelor of Education.
Chapter Fourteen

Developing the workforce

**Education and Training**

The GGT UDRH has developed a strong education and training program as part of its commitment to strengthening the numbers and capacity of health professionals in the region. The program is driven by the issues of lower recruitment and retention of health professionals, and contemporary issues that face many regional, rural and remote areas.

The program focuses on continuing professional education for medical, allied and other health professionals, research capacity building for primary health care workers, and academic programs for both pharmacists and mental health professionals.

**CPDWorks**

CPDWorks (formerly the Statewide Allied Health Workforce Education Program) aims to support the educational needs of allied health professionals in Victoria. It is also available to allied health practitioners from South Australia, Northern Territory, Tasmania and Queensland Health, and Services for Australian Rural Remote Allied Health members.

The program aims to develop and implement a range of resources and tools for health professionals that assist with professional development and networking opportunities. These include delivery of a number of workshops, access to articles, presentations, videos, information about supervision courses and useful links to other websites. Multi-disciplinary participation in virtual discussion forums is encouraged.

It complements continuing professional programs offered by professional associations and teaching universities.

Over the longer term it is expected that the initiative will improve recruitment and retention of allied health professionals by offering better support structures and networks and facilitating improved career development.

The success of the CPDWorks is well illustrated by its statistics.

Site members have grown from 1495 in December 2008 to just short of 5000 in 2011; 2411 people in Victoria have attended live presentations since 2009 and there are more than 5000 site hits each month to see what presentations are coming up, check out the recent headlines or to view a recording of presentations.

The CPD program started in Hamilton with a focus on physiotherapists and has now gone to the national level for allied health professionals. It has achieved great success in engaging health students who undertook their fieldwork clinical placement in the region.

Professor Karen Stagnitti joined the Department in an education and training role in May 2002. “The development of the CPD program from a local program to a state-wide program and now to a national program is a high achievement,” she said.

From 2004 Professor Adrian Schoo led the CPD program, starting with physiotherapists before it developed into a statewide program for 22 allied health professions that continues to be supported and funded by the Department of Health.

**Professor Adrian Schoo**

Adrian is Professor of Physiotherapy and Head of Clinical Education at the Medical School of Flinders University, and honorary staff member of the GGT UDRH. His clinical and teaching interests include musculoskeletal management, rural health and interprofessional practice, and supporting clinical educators. Research interests include chronic (musculoskeletal) disease and maintaining physical activity and exercise, and clinical education and continuing professional development as part of allied health workforce development and rural health service enhancement. His books, book chapters, peer-reviewed journal articles and research reports inform health professionals as well as managers and policy makers.
Chapter Fourteen

Adrian also received funding for a regional recruitment and retention program that merged with other regions to become a state-wide recruitment program that works together with CPDWorks and informs on regional CPD needs and that promotes educational activities.

A number of states have negotiated online access to the program.

Most recently Dr Annette Dunham has stepped into the position of Director of Education and Training for CPDWorks and has identified potential for future growth.

“There is potential to build on the existing resources developed for the program by providing programs and workshops targeted at different experience levels and/or roles across the allied health professions. Developments in e-Learning methods and formats also represent future directions for CPDWorks.

“As CPDWorks has grown in terms of resources and number of subscribers, there has been an accompanying need for protocols and procedures to be developed to support and ensure quality and consistency across resources and access. Establishing these is a high priority to accommodate recent and anticipated future growth,” Annette said.

The dissemination of CPDWorks resources is also highly dependent on a well-developed local infrastructure of allied health professionals and this indicates another future direction for CPDWorks.

Local and/or regional “communities of practice” have the potential to provide ideal forums for the use of CPDWorks resources whether face-to-face or via videoconferencing, or by viewing recorded presentations at a convenient time for users.

The twin aims of CPDWorks have always been to increase access to continuing professional development for rural allied health professionals and to decrease professional isolation. By encouraging the development of actual and/or “online” communities of practice it is hoped that CPDWorks can attend to both.

Dr Annette Dunham

Annette trained as an Occupational Therapist in New Zealand. She worked for several years as a registered Occupational Therapist before accepting a role as a consultant to management and staff of rest and residential homes for the aged. This fueled her interest in training and development and led her to return to tertiary study, focusing on organisational psychology. Annette completed her BA in Psychology, M.Sc. with First Class Honours in Applied Psychology (Industrial and Organisational), and PhD in Psychology at the University of Canterbury. She was the recipient of a New Zealand Tertiary Education Commission Top Achiever Doctoral Scholarship.

Annette’s PhD thesis involved several studies that focused on organisational memory and mentoring, including the development of a self-report organisational memory scale. She has a strong interest in career and professional development, mentoring and developmental relationships, knowledge sharing within networks and organisations, and issues relating to the ageing of the workforce.
Chapter Fourteen

**PHC RED**

The Primary Health Care Research Evaluation and Development (PHC RED) program was one of several Commonwealth funded research capacity building initiatives across the country with the aim of enhancing high quality primary health care research by offering opportunities for research training and support.

The program included the Research Capacity Building Initiative (RCBI) and the Researcher Development Program (RDP).

The RCBI aimed to increase both research capacity and activity amongst primary health care provider groups and support groups in the Greater Green Triangle region. It did this in a number of innovative and sustainable ways which gave researchers opportunities to participate in an education and training program, financial support and mentorship through provision of a research bursaries and access to a wide range of research resources.

The RDP aimed to allow graduates with a broad range of backgrounds to develop their knowledge and skills in primary health care through participating in current research.

Rachel Boak joined the GGT UDRH in 2005 after working in the UK and took on the challenge of running the PHC RED program.

“The opportunities for professional development have been immense for me, for other GGT UDRH staff, and in particular for supporting and enabling local health professionals and organisations to undertake research,” Rachel said.

There were many partnerships formed through PHC RED including linkage and collaboration with government, regionally-based training providers, health services, general practice, and consumers.

The critical thinking program was developed with the GGT General Practice Education and Training organisation (now Southern GP Training) which saw the program extend successfully to all regions around Mt Gambier, Hamilton, Warrnambool, and Colac. Support and collaboration with colleagues at Flinders University and from other national PHC RED programs was an important part of these successes.

Dr Michael Coates joined GGT UDRH in mid-2008 and in 2009 took over the role of coordinator of the PHC RED program, seeing it through to the end of its current phase in 2011. “Having come from a physical-sciences background where I studied the physical processes that occur within lakes, estuaries and the ocean, it was a steep but interesting learning curve and challenge to move into the health area,” he said.

“The PHC RED program was going along quite nicely when I took over. Perhaps the biggest disappointment was the fact that I was seeing the end of the current program. I was particularly sad to see the end of the bursary program in which local clinicians and other members of the community were able to obtain small research grants to investigate an area of interest and be supervised through the research process to completion.”

“The bursary program has been really successful in allowing clinicians and community members to get a taste of what research really means. It’s particularly nice to see their ideas on paper converted into something more concrete.”

The GGT UDRH had four Researcher Development Positions (RDPs) and 36 bursary projects supported by PHC RED.

**Dr Michael Coates**

Michael is a physicist by training, studying the physical processes that occur in lakes, estuaries and the oceans. He joined the GGT UDRH in 2008, and is currently Deputy Director, where he manages the Research Capacity Building and Researcher Development programs and provides mentoring to Department staff and affiliated researchers.

He has been part of the TrueBlue project team which has demonstrated that nurse-led collaborative care leads to better outcomes for patients with depression and diabetes/heart disease. In his earlier work, he used numerical (computer) modelling to help understand how the various processes interact with each other in large bodies of water. This is important as these processes are hidden in what was actually observed. As the same situation occurs in health, he is interested in using these same computer-modelling techniques to help untangle the complex interactions that occur in chronic disease. The computer models will provide improved information to guide interventions and make better forecasts for the future chronic-disease burden.
Chapter Fourteen

Dr Coates said the bursary projects covered a diverse range of ideas, from promoting healthy eating and physical activity in a secondary school through to applying UK quality outcomes to Australian General Practice.

Some bursaries developed into much larger projects. For example, a bursary awarded to Dr Mark Morgan, now a GGT UDRH Senior Research Fellow, on a patient-pathways approach to the management of depression in patients with diabetes and heart disease has developed into the TrueBlue evaluation trial.

Two other bursary holders, Dr Nathalie Davis and Kate Schlicht, are now part of the research team; and RDP for 2008 and 2009, Andrea Hernan, continues her primary health care research career with the Department as a Research Fellow.

PHC RED led to some excellent outcomes for GGT UDRH, building invaluable links between the Department and the health services, both within the GGT area and further afield within Victoria and interstate. The valuable support from PHC RED allowed the Department to build a network of primary health care practitioners and researchers which has assisted in the conduct of evaluative trials, such as TrueBlue, the GGT Risk Factor Study and the GGT Diabetes Prevention Program (GGT DPP). The training, networking and mentoring that the PHC RED program facilitated has been of great benefit to staff, bursary holders and the community in general, and will stand the GGT UDRH in good stead as it moves into its next phase as a Centre of Research Excellence.

The Department’s PHC RED program actively engaged with its Local Clinicians Advisory Group, chaired by Ms Sue Cameron. This committee was composed of representatives from a range of primary health care disciplines and organisations within the Greater Green Triangle region, and provides opportunities for the local representatives to comment on the Department’s activities.

The PHC RED program was also part of the Tri-State Program, a collaboration between the University of Adelaide, Flinders University, the Spencer Gulf Rural Health School in South Australia, the Centre for Remote Health in the Northern Territory and the Greater Green Triangle University Department of Rural Health in Victoria. It provided a means for the partners to work collectively towards the program’s aims.

Rachel Boak

Rachel is a lecturer in the School of Health and Social Development at Deakin University. She is also an Accredited Practising Dietitian and Accredited Nutritionist. Rachel is currently undertaking PhD research with The Jack Brockhoff Child Health and Wellbeing program in the Melbourne School of Population Health at the University of Melbourne. Her PhD research investigates healthy weight, oral health, social disadvantage and the influence of government policy on the food and drink choices made for 0-5 year old children. Rachel also holds the honorary position of adjunct senior lecturer at Flinders University in the Greater Green Triangle University Department of Rural Health. Her research interests also include chronic disease prevention and measuring adult’s and children’s eating patterns.
<table>
<thead>
<tr>
<th>PHC RED Bursary Projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Supporting Junior Doctors Going Bush</td>
</tr>
<tr>
<td>2. The Psychosocial Experience of Female Secondary Infertility in Australia: A Literature Review</td>
</tr>
<tr>
<td>3. Application of a UK Quality Outcome Framework to an Australian General Practice</td>
</tr>
<tr>
<td>4. Are Medicare Benefits Schedule Programs Beneficial to Client Health and Wellbeing?</td>
</tr>
<tr>
<td>5. Assessing an Effectiveness of Stress Management Courses in an Australian Adult Education Centre</td>
</tr>
<tr>
<td>6. Barriers to Update and Completion of Cardiac Rehabilitation in South West Victoria</td>
</tr>
<tr>
<td>7. Census of Doctors who have completed an Advance Rural Skills Post</td>
</tr>
<tr>
<td>8. Chronic Illness and Depression</td>
</tr>
<tr>
<td>9. Corangamite Risk Factor Survey Results</td>
</tr>
<tr>
<td>10. Community South West - Identifying Regional Research Capacity</td>
</tr>
<tr>
<td>11. Delivery of Best Practice Obesity Management</td>
</tr>
<tr>
<td>12. Develop and Evaluate a Team Approach to the Management of Diabetes Using a Patient Held 'Calendar of Preventive Care'</td>
</tr>
<tr>
<td>13. Diabetes Prevention for Culturally and Linguistically Diverse (CALD) Groups</td>
</tr>
<tr>
<td>14. Effectiveness of a Stress Management Program Conducted in a Rural Australian Adult Education Centre</td>
</tr>
<tr>
<td>15. Establishing Best Practices for the Electronic Transfer and Usage of Patient Information</td>
</tr>
<tr>
<td>16. Evaluating the Effectiveness of Falls Programs in the Community Health Setting</td>
</tr>
<tr>
<td>17. Farmers' Markets - A Model for Community Development and Primary Health Care</td>
</tr>
<tr>
<td>18. Health, Wellbeing, and Active Transport</td>
</tr>
<tr>
<td>19. Interviewing Practice Nurses involved in a Collaborative System of Care and Co-morbidity regarding their Experiences and Impact on Service Provided</td>
</tr>
<tr>
<td>20. Healthy Minds for Country Youth</td>
</tr>
<tr>
<td>21. Managed Clinical Networks as they relate to the Australian Context</td>
</tr>
<tr>
<td>22. Maternal Postpartum Adjustment in the South West Region - A Rural Perspective (Project #1)</td>
</tr>
<tr>
<td>23. Maternal Postpartum Adjustment in Victoria's South West: A Rural Perspective (Project #2)</td>
</tr>
<tr>
<td>24. Metabolic Syndrome and Depression</td>
</tr>
<tr>
<td>25. Nicotine Navigator</td>
</tr>
<tr>
<td>26. Oral Healthcare Model for South West Victoria</td>
</tr>
<tr>
<td>27. Podiatry in South West Victoria - Workforce Needs and Recruitment</td>
</tr>
<tr>
<td>28. Promoting Healthy Eating and Physical Activity in a Secondary School Setting in order to Address the Issues of Overweight and Obesity in the Community</td>
</tr>
<tr>
<td>29. Risk Factor Project for Corangamite Shire</td>
</tr>
<tr>
<td>30. Rural Dental Workforce and Oral Health Service Enhancement in South East of South Australia and South West Victoria</td>
</tr>
<tr>
<td>31. Study of the Increased Primary Health Risk of Developmental Dysplasia: A Rural and Urban Comparison</td>
</tr>
<tr>
<td>32. Systematic Approach to Undertaking 45 to 49 year old Health Checks in General Practice</td>
</tr>
<tr>
<td>33. To Develop a Chart/Protocol for the Examination and Management of Neonatal Instability of the Hip (NIH) in Neonates Born in Regional and Rural South Australia and Victoria</td>
</tr>
<tr>
<td>34. Training in a Rural Community versus a Metropolitan Setting</td>
</tr>
<tr>
<td>35. Validate and Operationalise Coronary Heart Disease and Diabetes Register of Practice</td>
</tr>
<tr>
<td>36. What are the Barriers to Implementing the Victorian Department of Education and Training Guidelines Regarding the Provision of Nutrient Dense Food Options in School Canteens?</td>
</tr>
</tbody>
</table>
Chapter Fourteen

Centre of Research Excellence

The Department was in 2010 awarded an Australian Primary Health Care Research Institute (APHCRI)-funded Centre of Excellence for Research in Building Quality, Governance, Performance and Sustainability in Primary Health Care through the Clinical Microsystem approach. This is a partnership with the Universities of Queensland and New South Wales.

This Centre will undertake research into building improved quality, governance, performance and sustainability in a primary health care setting.

The research will be undertaken over four years and will identify best practice quality and safety procedures and define how they can be implemented in General Practices across Australia, using a clinical microsystems approach.

Research Stream 1 will investigate quality, governance and sustainability in maternity share-care and is based in Queensland, whilst Research Stream 2 is based in Warrnambool and aims to improve the safety and quality of primary healthcare.

The research team has expertise in general practice, nursing, allied health and other specialties and aims to identify best practice quality and safety procedures and how these can be best implemented in a general practice setting.

The Centre will work closely with the Australian Commission on Safety and Quality in Health Care, Australian General Practice of Accreditation Limited, Improvement Foundation Australia, Australian Practice Managers Association, Australian Practice Nurses Association, the Chronic Illness Alliance and the Royal Australian College of General Practitioners.

Dr Amr Abou Elnour and Andrea Hernan were appointed in 2011 to carry out the GGT UDRH stream of the research.

The Rural Pharmacy Program

The Pharmacist Academics at University Departments of Rural Health program – or PA UDRH, for short – started in Warrnambool in 2003.

Kevin Mc Namara was the first incumbent into the position, and was joined by Frances Walsh in Mt Gambier six years later.

Enhancing the experiences for students during clinical placement and selling the benefits of practice in the GGT has always been a priority for the program. Students have the opportunity to learn from visits to several other health professionals, be exposed to local Aboriginal culture, visit depot pharmacies and a pharmaceutical plant, and of course learn about rural pharmacy.

The focus of pharmacy research has mainly been in cardiovascular disease, in line with one of the key areas of focus for the Department. Kevin was involved in the GGT risk factor studies which helped to identify key gaps in the management of medicine use in the region. This evidence has facilitated the funding of three significant intervention projects in community pharmacies, involving dozens of community pharmacists from across western and south west Victoria. Over the past 18 months, Frances has started to develop innovative preceptor support research for community pharmacies, the results of which are just starting to materialise.

Kevin Mc Namara

Kevin Mc Namara arrived from Ireland in mid-2003 to take up the Pharmacist Academic position at GGT UDRH, having worked as a research fellow in the Department of General Practice and Primary Care at Trinity College Dublin (Ireland). Since 2003, he has been actively involved in supporting students and pharmacists within the region, and in developing a research profile in primary care. Most of his research looks at issues around cardiovascular disease prevention, both from epidemiological and health services research perspectives. In 2008 he was awarded the NHMRC National Institute of Clinical Studies – National Prescribing Service Quality Use of Medicines Fellowship 2008-2010 to investigate implementation of CVD prevention activities in community pharmacy. He has also acted as chief investigator for a number of clinical trials and other studies in the area of CVD prevention in primary care.

44. GGT UDRH
Reflections

**Professor Lindon Wing:** It was definitely something worth doing and has consolidated its presence as a very successful enterprise across the Greater Green Triangle region. With Flinders University still active in the region and Deakin now having a Medical School it is more so needed now than 10 years ago.

**Professor Adrian Schoo:** GGT UDRH has achieved outstanding results in several areas that well and truly surpass the boundaries of the GGT. The challenge will be to not lose its connection with the region.

**Edward Janus:** “The progress over the past 10 years has been remarkable which has much to do with the vision, enthusiasm and interpersonal skills of James Dunbar as Director.”

**Clare Vaughan:** “My experience at GGT UDRH continues to influence my work as a health promotion practitioner”

**Karen Stagnitti:** “The development of the CPD program from a local program to a state-wide program and now to a national program is a high achievement of the GGT UDRH.

**Dale Ford:** 10 years later, Greater Health has achieved most of Minister Wooldridge’s aims of the Rural Stocktake consultancy. In particular, the cross border nature of the UDRH initiative has linked health communities across the State border, and established a local research base that had not previously been in existence.

**Dr Phil Tideman:** “A major achievement of the GGT UDRH has been bringing international quality cardiovascular epidemiology to a UDRH and practiseing it at a high level in an Australian rural setting. Being able to build capacity to a rural medical and allied health workforce has been another significant achievement.”

Photo: Blue Lake, Mt Gambier, S.A.
Publications

2002


2003


2004


46. GGT UDRH
Publications


2005


Publications

2006


17. Schoo A. Outcome of an evidence-based CPD program for rural physiotherapists on clinical skills when applicability and access are optimised. 2006.


Publications


2007


2008


50. GGT UDRH
Publications


2009


Publications


2010


Publications


2011


