

Integrated health promotion is making a difference...

A practical example:

Wimmera and Grampians Pyrenees PCP

What were the issues?

In response to the Grampians and Wimmera Regions' high incidence of cardiovascular disease, a risk factor approach targeting physical inactivity was identified as a unified challenge. To successfully engage GPs the intervention needed to be evidence based, rapid, strategic and match general practice workflow. The outcome was the Active Script Service, which is now known as the PACE Service. The service model links sedentary, medically stable patients to a local health professional who motivates, educates and links patients to suitable local physical activity options. The health professional provides phone support to the patient every three months over a twelve month period. The GP receives regular feedback on the patient's progress.

Stakeholders:

- West Wimmera Health Service
- Lowan Rural Health Network
- East Wimmera Health Service
- Coleraine Health Service
- Stawell Regional Health
- East Grampians Health Service
- Beaufort and Skipton Health Service
- West Vic Division of General Practice
- Wimmera PCP
- 76 General Practitioners

What has been the integrated health promotion response?

Strategies included:

- Education over 30 health professionals (including allied health workers) in certificate three and four in fitness.
- Identification of a key 'Physical Activity Community Enabler (PACE)' in each Health Service to act as the referral point and 'navigator' of exercise options for the patient.
- A joint partnership between the West Vic Division and eight other state-funded health services to provide an agreed service model for increasing community physical activity.
- The West Vic Division provides tools, resources and 'Enabler' support to ensure the PACE Service remains relevant to Health Services, the patients and GPs.
- Quarterly 'Enabler' teleconferences to review the Active Script Service and identify issues for service improvement.

What are the impacts?

The PACE Service continues to grow and develop. To date there have been over 850 referrals from 76 GPs. The key reason for referral is weight issues (62%), blood pressure (37%) and diabetes (25%), with most patients being referred for more than one condition. The 'Enablers' have commented that the PACE Service has allowed them access to what has traditionally been a 'hard to reach' audience who are not

linked to services. The reported improvement in physical activity and general wellbeing has been extremely positive. The service has not been formally evaluated at this point in time.

What's next?

The initial role of the 'Enablers' was as a physical activity referral point, however there is a need to expand the position to include other lifestyle risk factors such as nutrition, smoking and obesity. Referrals have recently been opened up to Practice Nurses. The population health response has been well received by general practice, health services and patients.