
Engaging and supporting general practice in refugee health

FINAL REPORT



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victorian refugee
health network



each

About the agencies

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The Victorian Refugee Health Network (the Network)
is auspiced by the Victorian Foundation for Survivors of
Torture Inc. (Foundation House) and was established
in June 2007. The Network aims to facilitate greater
coordination and collaboration among health and
community services to provide more accessible and
appropriate health services for people from refugee
backgrounds.

The Victorian Foundation for Survivors of Torture (also
known as **Foundation House**) was established in 1987
to meet the needs of people in Victoria who have been
subjected to torture or other traumatic events in their
country of origin, or while escaping those countries.
Foundation House is a not-for-profit organisation funded
by the Victorian and Commonwealth governments,
charitable trusts and donations that provides direct
torture and trauma counselling services as well as
considerable work in research and policy.

Foundation House and the Network have a respected
history of building relationships within a range of sectors,
and more specifically developing resources, referral
guides and clinical supports for general practitioners.
The Primary Care Project builds on existing and historical
supports for general practice to provide high-quality,
coordinated care to people from refugee backgrounds.

ISIS Primary Care is a not-for-profit community health
organisation delivering primary health care and allied
health services. It is one of the largest providers of
community health service in the western metropolitan
region and is predominantly funded by Department of
Health and Human Services.

EACH Social and Community Health provides an
integrated range of health, disability, counselling and
community mental health services across Australia.
It has evolved over the last 41 years to become a
responsive, community-based organisation with locations
along the eastern seaboard. EACH has a comprehensive
range of services that address physical, mental and
psychosocial needs at a community and primary care
level and are committed to integrated and coordinated
service provision.

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Many people participated in this project at various stages over the past two years, and there is a long history of work in primary care by those in the refugee health sector.

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- Survey respondents, including those in private general practices as well as those working in the refugee health sector.
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Foreword

General practices are a major provider of refugee health care in Australia. People from refugee backgrounds need access to timely health assessment and ongoing care in a primary healthcare setting. Many challenges have been identified by all concerned.

This report provides an overview of a detailed two-year developmental program of work undertaken by specialised refugee health and generalist primary healthcare providers. It builds on an existing body of work that reflects over two decades of endeavour.

The primary aim was to better understand and then develop and document effective approaches to engaging and supporting general practice to deliver services to refugee-background populations. There was a focus on trialling approaches in private general practice settings.

The three key domains identified for action are clinical care, communication, and coordination and management. This involves everyone in a general practice setting: general practitioners; nurses; receptionists; practice managers and allied health services.

Co-creation principles were used in the development of tools and resources for general practice and specialised refugee health services. The active involvement in this process by the inter-sectoral project advisory group; community health service project partners and participating general practices was invaluable. A suite of very practical resources is the result.

The establishment of Primary Health Networks during the life of the project provides an opportunity for dissemination and further development of this work to support general practices in their day-to-day work with patients from refugee backgrounds.

We look forward to future collaborative efforts across primary health care services to disseminate and further develop these and other resources to support the provision of services to our community.



Sue Casey
Manager, Sector Development and Partnerships
Victorian Foundation for Survivors of Torture

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Abbreviations

ASID	Australasian Society for Infectious Diseases
CEO	chief executive officer
DIBP	Department of Immigration and Border Protection
EOI	expression of interest
DSS	Department of Social Services
GP	general practitioner
IHMS	International Health and Medical Services
MBS	Medicare Benefits Schedule
the Network	Victorian Refugee Health Network
PAG	project advisory group
PBS	Pharmaceutical Benefits Scheme
PHN	Primary Health Network
RHeaNA	Refugee Health Network of Australia
RHGPF	refugee health general practice facilitator
SRSS	Status Resolution Support Service
TIS	Translating and Interpreting Services
UNHCR	United Nations High Commissioner for Refugees
VFST	Victorian Foundation for Survivors of Torture

Language and Definitions

People from refugee backgrounds

The term 'people from refugee backgrounds' refers to those who have been granted humanitarian visas, people seeking asylum and those who come from refugee backgrounds and may be on another visa type, including family migration and skilled migration.¹

Primary health care

Primary health care is the first level of contact individuals, families and communities have with the healthcare system. It includes health promotion, illness prevention, treatment and care, advocacy, community development and rehabilitation.²

Primary care

Primary care is a key part of comprehensive primary health care, and refers to 'a person's first point of contact with the health system and involves the management of a person's illness or condition in a service that is typically contained to that care setting'. This first point of contact usually includes the general practitioner or family physician.²

General practice

General practice includes general practitioners (GPs), practice nurses, practice managers, allied health professionals and administrative staff, and includes those working in private practice as well as those in the community health context. There is considerable diversity in size and complexity of general practices in Victoria.

Refugee health general practice facilitators

Refugee health general practice facilitators (RHGPFs) have been identified in this report as those who work in the refugee health sector and have a general practice capacity-building role. They may include refugee health nurses, refugee health fellows and Primary Health Network staff.

Patients or clients

This report uses 'patients' when referring to service users who are receiving health care in general practice to ensure the language is consistent with that setting. 'Clients' is used when referring to service users within community health, such as the Refugee Health Program, for consistency with that program. When a person is receiving services in both settings, 'patient' will be used, as general practice capacity building is the main subject of this report.

Refugee health sector

The refugee health sector refers to a diverse group of health professionals who do most of their work with people from refugee backgrounds, including refugee health nurses, refugee health fellows, specialist services providers, settlement service providers, asylum seeker support agencies, researchers and state government departments.

Primary care sector and the mainstream general practice setting

When speaking about the broader primary care sector, including general practice, this report refers to those working within mainstream primary care settings (including direct service provision and service coordination) where people from refugee backgrounds are a minority population/patient group.

Note: this project took place over a time of change in the primary care sector with transitions from Medicare Locals to Primary Health Networks. Therefore the language varies throughout the report depending on the stage of the project.



Executive Summary

The Victorian Refugee Health Network (the Network) led the two-year Primary Care Project, which was guided by a multi-sectoral project advisory group (PAG). EACH Social and Community Health and ISIS Primary Care partnered with the Network for one year to develop and trial approaches to facilitating practice change with general practice.

The project aimed to develop and trial an approach to engaging with general practices to promote the delivery of accessible and appropriate health care to people from refugee backgrounds, including those seeking asylum. By modelling, documenting and making the project tools available it was hoped this approach would work in the future to increase the number of general practices who are able, willing and confident to work in this area.

Comprehensive mixed-method scoping explored approaches to facilitate change in general practice, and built an understanding of the experiences of communities from refugee backgrounds when accessing a general practice. Mapping of existing approaches to engaging general practice in refugee health provided a foundation for this project, but also demonstrated there was no common approach among Victorian services.

Principles of co-creation were used in the project in two key ways — in the development of tools and resources to support refugee health general practice facilitators (RHGPFs) and to co-create practice-based interventions with general practices.

Development of the approach was negotiated between a multi-sectoral PAG and the project team of RHGPFs. The tension of navigating between the state-funded Refugee Health Program and the business model of private general practice highlighted the need to support RHGPFs to navigate these different service models.

A Framework for Continuing Improvement in Refugee Health was conceptualised to support RHGPFs. This identified three key components in the delivery of accessible and appropriate health care to people from refugee backgrounds: communication; coordination and management; and clinical care. The framework outlines the foundational and additional skills and systems required in each of these three areas and resources to support implementation of practice change.

A Facilitator Interview Guide was used to facilitate conversations with 19 staff from seven practices in

various roles to understand their individual values, motivations and challenges in working with people from refugee backgrounds in their practices.

Practice staff were generally motivated to work with people from refugee backgrounds by compassion; clinical skills and learning; financial considerations; the delivery of an inclusive service; or making use of bilingual staff or staff expertise in the practice. They valued being able to assist in meeting both health and settlement needs; the relationships that were formed; the opportunity to increase knowledge, skills and experience; and to increase the patient base.

Identifying challenges, methods used to overcome these challenges and 'wish lists' assisted practices to identify areas of change and to work with RHGPFs to develop plans. A mixture of formal and informal action plans were developed with the practices.

A number of data sources were used during the project to evaluate both the process and the outcomes. Data sources included practice profiles, facilitated interview notes, action plans and evaluation documentation. In addition to this, for the duration of the project, each RHGPF kept a diary. The diary assisted in the documentation of the steps taken, the time frames within which activities occurred, the various methods and platforms of engagement with the practices, key themes, agreed actions and reflections. Reflective interviews were also conducted with the four RHGPFs and three members of the PAG. Three practices were contacted to participate in a reflective interview, and one was able to participate.

Findings from the project related to co-creation principles offering an effective approach to negotiating practice-led change; the importance of relationships and identifying shared values between RHGPFs and the practices; the resources required for practice engagement, particularly time; engaging with the whole practice team in facilitating change; and navigating competing stakeholder perspectives. Support required for RHGPFs to be able to effectively engage with general practice to facilitate change included the development of both clinical skills and practice facilitation skills, the role of the Network facilitator to support reflection and problem solving, and having management support for time required. The potential to work more closely with Primary Health Networks provides opportunities

to engage more effectively with practices, capitalise on complementary skills and embed sustainable approaches.

Limitations of the project included that refugee health fellows and PHN practice facilitation staff were not included in the project team as RHGPFs; community consultation only occurred once; and the sample size with which the approach was trialled was very small. Additional developmental work, including research, is required to add to the evidence base around meaningful indicators that measure general practice performance in delivering health care to people from refugee backgrounds.

While all RHGPFs in this project were refugee health nurses, it is hoped that the resources have broader application to others doing refugee health general practice facilitation.

More information is available on the Victorian Refugee Health Network [Primary Care Project web page](#).





Introduction

The Victorian Refugee Health Network (the Network) led a two-year Primary Care Project, which was guided by a multi-sectoral project advisory group. EACH Social and Community Health and ISIS Primary Care partnered with the Network for one year to develop and trial approaches to facilitating practice change with general practice.

The project aimed to develop and trial an approach to engaging and collaborating with general practices to promote the delivery of accessible and appropriate health care to people from refugee backgrounds, including those seeking asylum. By modelling, documenting and making the project tools available it was hoped this approach would work in the future to increase the number of general practices who are able, willing and confident to work in this area.

Objectives

The project had four objectives.

Objective 1: To understand current approaches to engaging and supporting general practice in refugee health in Victoria.

Objective 2: To develop and pilot an evidence-informed, practical model or approach to engaging and supporting general practice in the delivery of accessible and appropriate health care to people from refugee backgrounds in Victoria.

Objective 3: To utilise both formal and informal communication channels to ensure that the project was both informed by and informed the primary care sector, including general practice.

Objective 4: To ensure that the experiences, needs and priorities of refugee-background communities were reflected in the approach to general practice engagement and capacity building.

Key phases

In order to meet its objectives, the project had four key phases.

Phase One: Scoping

This phase included the development of a background paper, including mapping of current and historical general practice capacity-building work in the refugee

health sector; consultation with key stakeholders, including those with service provider and community perspectives; and a review of the academic literature to understand practice-based interventions to engage general practice in the improved delivery of health care to people from refugee backgrounds.

This phase of the project highlighted the need for a flexible, practical, evidence-informed approach to engaging general practice in practice-led change to ensure that people from refugee backgrounds receive good quality, accessible and appropriate health care.

Phase Two: Development of an approach and resources

During this phase, the project team was formed, an approach to engaging general practice in refugee health was developed, and supporting resources were created. The project team was informed by a co-creation expert in primary care and a project advisory group with representation from primary care, settlement and refugee health.

The approach and supporting tools were developed to support RHGPFs to engage general practices in refugee health; to facilitate and evaluate practice-based improvements; and to ensure that these improvements are consistent with good practice in refugee health.

Phase Three: Trialling of approach

This phase involved the piloting of the approach and associated tools with general practices in two or more sites by each RHGPF in the project team. This process was documented and the tools were further refined based on feedback and reflections during this phase.

Phase Four: Documenting and embedding learnings

This phase involved review of the extensive project documentation, reflections from the project team and practices involved, and the compilation of this project report.

This report and project web page is intended as a resource for practitioners, researchers and policy makers; it outlines the detailed two-year process undertaken, the feedback from the diverse stakeholders engaged, and the tools that were created. This report and project web page with the tools that were developed constitute part of the process of disseminating the learnings.

Further work to embed the learnings and trial the tools with more practices will be supported by the Network over the coming years, including the development of and initial support to a community of practice of RHGPFs and maintaining the online resources for RHGPFs.

More information is available on the Victorian Refugee Health Network [Primary Care Project web page](#).





Section 1: Policy and Service Context

Australia's Refugee and Humanitarian Programme

Australia is a signatory to the 1951 *Convention Relating to the Status of Refugees*. The Australian Government Department of Immigration and Border Protection (DIBP) manages the Refugee and Humanitarian Programme and issues visas to people found to be in need of protection, both offshore and onshore (within Australia).³ DIBP forecast the number of Refugee and Humanitarian Programme visas every year that will be issued each year, currently a minimum of 13,750.⁴ This number is set to increase with Commonwealth budget commitments. About a third of humanitarian arrivals settle in Victoria; in the past five years, this has amounted to 22,070.⁵

Health impact of refugee experience

Many people from refugee backgrounds will have experienced interrupted access to health care prior to arriving in Australia. This may be due to the breakdown of health services in situations of war and conflict; constraints on their access to health services in the context of human rights abuses; or limited access to health care in countries of first asylum. Refugee-producing countries often have poorly developed healthcare infrastructure and have a limited capacity to treat those with acute health concerns, let alone offer illness prevention and mental health support programs.⁶

As a result, people from refugee backgrounds may have injuries, diseases and conditions (some sustained or acquired as a consequence of deprivation and trauma) that have been poorly managed in the past. They are also likely to have had limited or disrupted access to mental health support or to illness prevention programs such as immunisation.⁶

Commonwealth health policy

Medicare Benefits Schedule

The Medicare Benefits Schedule (MBS) funds a voluntary one-off health assessment for refugees and other humanitarian entrants (refugee health assessment) within one year of arrival or visa grant.⁷ The assessment is conducted over a series of consultations. The assessment is conducted to identify immediate and

long-term health care needs, to initiate treatment and to introduce preventative health care such as immunisation, maternal and child health care and breast and cervical screening.⁷ The health assessment includes the patient's physical, psychological and social functioning.⁷

Fee-free interpreting

A medical practitioner providing MBS funded services can access fee-free interpreting services through Translating and Interpreting Services (TIS) National, provided through the DSS.⁷ Fee-free interpreting is not provided for allied health professionals, therefore access to Commonwealth-funded services provided via extended primary care and mental health plans are limited for people with low English proficiency.¹ The exception is counselling services provided by the Access to Allied Psychological Services program, which provides access to fee-free interpreting.

Pharmaceutical Benefits Scheme

The Commonwealth also subsidises some medicines through the Pharmaceutical Benefits Scheme (PBS) and pharmacists dispensing PBS medications also have access to fee-free interpreting services through TIS National.⁷

Medicare Locals and Primary Health Networks

In the years prior to Primary Health Networks (PHNs), some Medicare Locals had well developed refugee health programs and have provided a range of initiatives to support those in general practice to work in refugee health (see Appendix 1). Primary Health Networks began on 1 July 2015 and aim 'to increase efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and improving coordination of care to ensure people receive the right care in the right place at the right time'.⁸

Victorian policy context

There are a number of Victorian policy initiatives to improve access for people of refugee backgrounds (including people seeking asylum), including priority of access for dental and all other community health services (i.e. nursing, allied health, counselling, child health services and chronic disease programs); fee waivers for general and specialist dental and other services; and funded catch-up immunisation for specified vaccines.

Section 1: Policy and Service Context

People seeking asylum have free access to emergency hospital and ambulance services and special access to other Victorian government programs such as emergency transport.

The Victorian Government Department of Health and Human Services funds the Refugee Health Program, delivered through community health services in 17 local government areas. This supports access to primary care and coordination of care for people from refugee backgrounds.⁹ The Refugee Health Program is staffed by refugee health nurses and allied health who provide health assessments, triage, advocacy and referral services, health education using health literacy principals and work in collaboration with medical services in community health services and private general practices. Specialist refugee health clinics (e.g. infectious disease, paediatrics) are located in a number of community health and hospital settings. The Refugee Health Fellows Program provides secondary consultation and other supports to GPs and other healthcare providers.¹⁰



Section 2: Scoping

Scoping for the project included the development of a background paper including mapping of current and historical general practice capacity-building work; the formation of a project advisory group; an academic literature review; and mixed-method scoping consultations with key stakeholders to inform the project's design.

The scoping phase of the project aimed to:

- understand what works in engaging general practice in practice-based change
- explore and understand the experiences of communities from refugee backgrounds when accessing a general practice, including barriers and what works well
- explore and understand the current approaches to engaging general practice in refugee health, including barriers and what works well

The project advisory group provided valuable insights to the project facilitator in the development of consultation strategies and the project methodology.

Background paper and formation of project advisory group

A project advisory group (PAG) was formed in late 2014 to provide both expert strategic and content advice ensuring the project was informed and supported by those in the refugee health sector and those in the mainstream general practice setting.

A **background paper** was developed to provide context and a common understanding of the key issues, including the policy and practice context, about the delivery of health care to people from refugee backgrounds. The paper included data about the numbers of people from refugee backgrounds in Victoria, common health concerns, including access to services, the delivery of primary care services, the role of general practice and a history of previous work in engaging and supporting the primary care sector in the delivery of services.

The membership of the project advisory group was diverse, and included: those in a range of roles, including non-clinical roles, in the mainstream general practice/primary care sector; those in the refugee health sector, including research; and settlement services. This diversity of perspectives was intentionally sought. The background paper was developed to inform discussion in the first instance and the project advisory group provided broader contextual information that informed

the development of the project approach. The PAG met approximately quarterly for the duration of the project.*

Literature review

Below is a summary of *Engaging general practice in refugee health: a literature review*.^{11†}

The literature review aimed to identify practice-based interventions to increase general practice engagement and improve effectiveness of healthcare delivery for people from refugee backgrounds and other vulnerable groups. General practitioners face multiple barriers to providing care for refugees, and these barriers inhibit attempts to increase the capacity of GPs in private practice.¹²

A search strategy was developed with advice from key researchers in the field. MEDLINE, EMBASE, CINAHL, PUBMED and Informat were searched for peer-reviewed papers published between 2009 and 2014. Abstracts were screened for relevance and reference lists were searched. Additional papers from key sources were also sought.

Findings

There was a dearth of literature articulating practice-based interventions and engagement strategies for general practice and work with vulnerable populations.

There was not consensus in the literature about whether specialised refugee health services or more general primary care are the best approach to providing primary health care for people from refugee backgrounds. It is recognised, however, that the point of transition from specialised to mainstream general practice can present challenges as there is a need for general practice capacity building in refugee health. While the flexibility of the general practice setting enables innovative approaches to refugee patients, there is a need for greater supports as 'most practices continue to feel isolated as they search for solutions'¹³(p. 1).

Practice-based interventions targeting practice change around a particular health issue were more widely documented. These included sexual health¹⁴, mental health,¹⁵ back pain,¹⁶ childhood obesity,¹⁷ responding to family violence¹⁸ and chronic disease.¹⁹⁻²³

* Full details of the PAG including the Terms of Reference can be found on the project web page: <http://refugeehealthnetwork.org.au/engage/primary-health-care/>.

† The full poster may be viewed under Project Publications on the project web page: <http://refugeehealthnetwork.org.au/engage/primary-health-care/>.

Section 2: Scoping

Interventions typically included externally driven skills/performance-based strategies, such as training and education, academic detailing, practice visits and support, clinical/referral resource provision.^{14,17–19,24,25} Internally driven interventions included enhanced team care approaches, and interventions enhancing the role of practice nurses¹⁴ and non-clinical staff.^{21,22,24}

General practice engagement requires ongoing relationships, accurate and concise information, and utilisation of a whole-of-practice approach to ensure effectiveness of the intervention.²⁵ More sustainable practice change requires both skills/performance-based strategies and broader organisational change strategies as the broader organisational context can present a significant barrier to successful intervention.^{14,16,17,19} Additionally, different engagement approaches are needed to facilitate change that considers the mix of practice staff.²¹

Stakeholder consultation

A key objective of the project was to ensure that it was both informed by, and informed, the primary care and refugee health sectors; and that development of the project would ultimately meet the needs and priorities of communities from refugee backgrounds. See Appendix 2 for the project consultation strategy.

The consultations took a mixed-method approach, including discussion groups, semi-structured interviews, and online surveys. During the course of the project, the objectives of the consultations evolved. In the initial stages, consultation aimed to understand the experiences of communities from refugee backgrounds when accessing a general practice, including both the barriers and what worked well; and to understand service provider perspectives about common approaches to general practice engagement in refugee health, including barriers and what works well.

In later stages, the consultations became more focused and sought to explore the perspectives of the refugee health sector and the broader primary care sector about the competencies required to deliver accessible and appropriate health care to people from refugee backgrounds; and approaches to general practice engagement in this area.

Table 2.1: Consultation participants

Discussion group and interview participants	
AMES settlement community guides	7
Foundation House community liaison workers	7
Refugee Health Research Consortium	Approximately 10
Medicare Local program staff (including 1 GP liaison)	5*
Refugee Health Program – metro	3
Refugee Health Program – rural/regional	2
Refugee Health Program – statewide	1
Expert GPs/refugee health fellows	2
General practice engagement workers in other areas of health	2
Survey participants	
Refugee Health Program (survey pilot)	29
Refugee health sector	9
General practice staff	6
Total	83

* From 4 different Medicare Locals, including 2 rural MLs

Discussion group participants, interview participants and survey respondents were recruited through established networks within the Victorian Refugee Health Network and the project advisory group member networks.

Discussion group and interview findings COMMUNITY PERSPECTIVES

When those with community perspectives were asked about the challenges when accessing a general practice, the most common responses related to language and cultural barriers, and the use of interpreters. This related to the experience with GPs as well as reception and pharmacy staff. The reception experience was particularly important, including the need for people to feel welcome in the practice, and practicalities associated with making, changing or cancelling appointments.

Challenges with reception when calling to make or change appointments. (community liaison worker)

[It is difficult] when the system is automated – this means people do not know which option to press, which needs to be done before they can ask for an interpreter.

(community liaison worker)

Bilingual GPs were identified as potentially both a challenge and an enabler for good experiences with general practice. Bilingual GPs were preferred by many people from refugee backgrounds for ease of communication. However, there were some views that

the depth of understanding of the Australian health system by bilingual GPs may be more limited.

In the [country of origin] community, people prefer to see a bilingual GP in their language, but then they complain about the GP. (community liaison worker)

[The community] prefer to see bilingual GPs, however are not always satisfied with their service or with their language skills. For example, Persian speaking GPs are seeing Hazaragi speaking people because the language is similar, [however] it is the specific and important medical terminology that is often missed – so crucial health information is not understood.

(settlement community guide)

A perceived lack of time with GPs complicated by health and systems literacy challenges was seen to culminate in a range of unmet needs.

People feel that they are not being listened to and that they have not had enough time with the GP.

(community liaison worker)

GPs do not explain the difference between physical and mental health – and this [is important] when medication is prescribed. People think that they will start to feel better once the medication is taken. However, often it takes a period of time before they will notice changes – this is not understood. (community liaison worker)

Practical concerns included waiting times, both in general practice for appointments and for referrals made to specialists, and costs and other barriers for people seeking asylum who did not have access to Medicare.

When asked what makes for a good experiences when accessing a general practice, common themes included the interaction with the GP, such as cultural sensitivities/appropriateness, using interpreters, and clear explanations of health issues and medications.

Clear and detailed explanation of health issues and medications by both GP and pharmacist.

(settlement community guide)

A GP who has understanding of the refugee experience [is valued], even if they are not from the same background.

(community liaison worker)

If people know that an interpreter will be used in their appointment, they are more likely to go.

(community liaison worker)

Additional characteristics of good experiences with a general practice included the experience at reception, including use of interpreters; bilingual GPs and practice staff including those in reception; and having a good understanding of the roles of various health professionals and the services provided.

In some practices the reception may ask if a longer appointment is needed – this would be useful so that people have the opportunity to get a longer appointment and have all of their needs met.

(settlement community guide)

Good experience when there is an understanding of the role of specific health professionals and what they do.

(community liaison worker)

SERVICE PROVIDER PERSPECTIVES

When asked about the barriers to engaging general practices, service providers noted that general practices are required to do a lot, and therefore even initiating the discussion of refugee health can be challenging. There may be a perception, particularly by practice managers, that refugee health is both time consuming and expensive. In addition, there was a perceived lack of understanding of the refugee experience, particularly for reception staff. Lack of flexibility in the approach to working with people from refugee backgrounds, limited interpreter use and communication between general practices and Refugee Health Program staff were all identified.

It is always very difficult to know if change is occurring or sustained as we don't get feedback from practices.

(service provider interview participant)

One practice will not use interpreters – this is difficult as a lot of people from refugee backgrounds go there because there is a bilingual GP. However, if they have to see another GP an interpreter will not be used.

(service provider interview participant)

When asked what works well when engaging general practice, good relationships with practice staff, including GPs, practice nurses and practice managers, were identified as important. Common enablers, including having a champion GP, practice nurse or practice manager as a key contact, helped with general practice engagement. In addition, offering tangible, flexible, practical and persistent support acted as an enabler. This included clinical support, MBS item support and support for the upskilling of practice nurses. It was also identified

Section 2: Scoping

that having the whole practice on board made general practice engagement work well. An additional enabler to general practice engagement included identifying entrepreneurial opportunities and innovative grant opportunities.

Service providers identified that priorities for general practice engagement would vary depending on the practice.

This depends on the practice and their clients.

(service provider interview participant)

Common priorities included engaging practice managers and administration staff to support practice cultural change and capacity building for non-clinical staff; cultural competence/refugee experience training for all practice staff; working with interpreters for all practice staff; business guidelines and support; and localised training and supports.

In the initial stages, the refugee health nurses really had to sell the program. However, they took the time to look at the local needs and at what others were doing in the area.

(service provider interview participant)

SURVEY FINDINGS

The surveys were designed to understand approaches to general practice engagement; tools and resources used to support general practice engagement; and to develop an understanding of the competencies required to deliver good health care to people from refugee backgrounds. The findings of the surveys indicate that the perspectives of the refugee health sector and those in mainstream general practice were aligned in many areas, including the importance of the refugee health assessment, and particularly in areas related to clinical care. However, a number of differences were identified in relation to the knowledge and skills required to deliver good health care to people from refugee backgrounds as outlined below.

A significant difference was noted regarding "ability to undertake a cross cultural, trauma informed mental health screening, prepare an appropriate mental health care plan and make appropriate referrals". Almost 90% of respondents in the refugee health sector identified this as essential, while only 40% of respondents in general practice identified this as essential. 60% of general practice respondents noted it was important, but not essential. Similar results were found for knowledge of settlement experience and stressors, for example housing, English classes, Centrelink, separation from

family and ongoing conflict in country of origin/transit; and referral options for follow-up care.

The differences were also pronounced in the following areas, with 90% of respondents in the refugee health sector identifying the following knowledge and skills as essential, compared to 40% of general practice respondents. These differences were found for incidental counselling skills; approaches to addressing low health literacy; confidence in working cross-culturally; and preparedness to engage with a person's social circumstances.



Section 3: Development of an Approach and Resources

This section outlines the process used to develop the approach to engaging and supporting general practice in refugee health. The project scoping identified that the refugee health sector, including the Refugee Health Program, has an important role in general practice capacity building and identified common challenges and experiences. Various approaches are taken to this work, including how it is prioritised, documented, evaluated and shared within the sector. Phase 2 of the project set out to develop and trial an approach to engaging general practice in refugee health, with an emphasis on documenting and sharing the learnings from this process. The approach evolved as outlined below involving the following steps.

Institutional Ethics Committee review

The project received ethics approval from the VFST Institutional Ethics Committee. The project was assessed as low or negligible risk. Nonetheless, this was viewed as an important step to ensure all ethical considerations had been made. Previous experience of the Network demonstrated that undertaking an institutional ethics review allowed for greater opportunities to publish findings in academic journals, which was part of the project's dissemination strategy.

Partners

In June 2015 an expression of interest (EOI) was sent to six community health services with refugee health programs who received significant numbers of referrals of people who had recently arrived through the Refugee

and Humanitarian Programme. Sites that were part of a National Health and Medical Research Council partnership grant proposal for a general practice capacity building project, which was being developed throughout this period were not included in the EOI process.[‡]

The EOI outlined key requirements for the community health service and their nominated RHGPF for participation in the project, including:

- an understanding of the general practice context in their catchment, including examples of good practice in refugee health as well as service gaps
- good communication and relationship-building skills
- organisational support to participate in general practice capacity-building work for the duration of the project
- that the community health service and nominated facilitator demonstrated a willingness to trial different approaches and innovative practice.

The Refugee Health Program provides services to newly arrived people from refugee backgrounds, including those seeking asylum. The Refugee Health Program operates in different geographical and service system contexts, so flexibility is afforded for the program to develop tailored models of delivery.

EACH Social and Community Health and ISIS Primary Care nominated to take part in the project. The Network entered into partnership agreements with both of the community health services. Agreements outlined time lines, resources each agency would contribute and

[‡] *Optimising refugee health*. Monash University. Retrieved from <http://www.monash.edu/news/articles/optimising-refugee-health>, accessed 9/8/2016.

Figure 3.1: The Approach



Section 3: Development of an Approach and Resources

deliverables. The EACH Social and Community Health and ISIS Primary Care models are described below.

EACH Social and Community Health

The EACH Social and Community Health Refugee Health Program model involves a comprehensive nursing assessment of all new arrivals to the region using a standardised assessment tool. Depending on client complexity, they may be referred to a community health service GP for review before being referred to an external GP.

Internal and external referrals are made for services such as dental screening or treatment, optometry, audiology, Foundation House, preventative health screening and other allied health services. The program also provides a Mantoux screening clinic, catch-up immunisations, high-dose vitamin D and an outreach paediatric clinic with the Royal Children's Hospital.

The program also provides secondary consultation and support to other service providers and facilitates the Regional Refugee Health Network.

ISIS Primary Care

By comparison, the Refugee Health Program at ISIS Primary Care has a different service model, and the refugee health nurses perform different roles.

The Refugee Health Program at ISIS Primary Care links newly arrived people with a general practice which completes the refugee health assessment.

The Refugee Health Program provides a coordination role between clients, GPs, settlement services and specialist services including optometry, dental, torture and trauma services, audiology and other allied health services as required. Refugee health nurses provide a support and advocacy role and linkages to social support services.

The community case worker role assists with referrals for housing, Centrelink and school, and attendance at legal appointments.

Refugee Health Program members attend regional refugee health networks and work with a range of health and social support agencies.

The project team

Team members

The project team consisted of a project facilitator from the Victorian Refugee Health Network and four refugee

health nurses – referred to in this report as refugee health general practice facilitators (RHGPFs).

The project team had a diverse range of skills, expertise and experience including refugee health nursing, practice nursing, hospital-based and theatre nursing, health promotion and project work.

Refugee health nursing experience ranged from one year to eight years. All of the refugee health nurses had experience engaging with general practice. However, this was done in a variety of ways, including formal engagement projects or informal engagement when working with shared patients.

Establishing the team

A full-day workshop was held to bring the team members together for the first time; present the findings from the project scoping; undertake team-building exercises; and to participate in professional development.

Navigating between the state-funded Refugee Health Program and the small business model of private general practice was raised as a tension. This highlighted the need to ensure the approach to general practice engagement and facilitation supported RHGPFs to navigate these different service models.

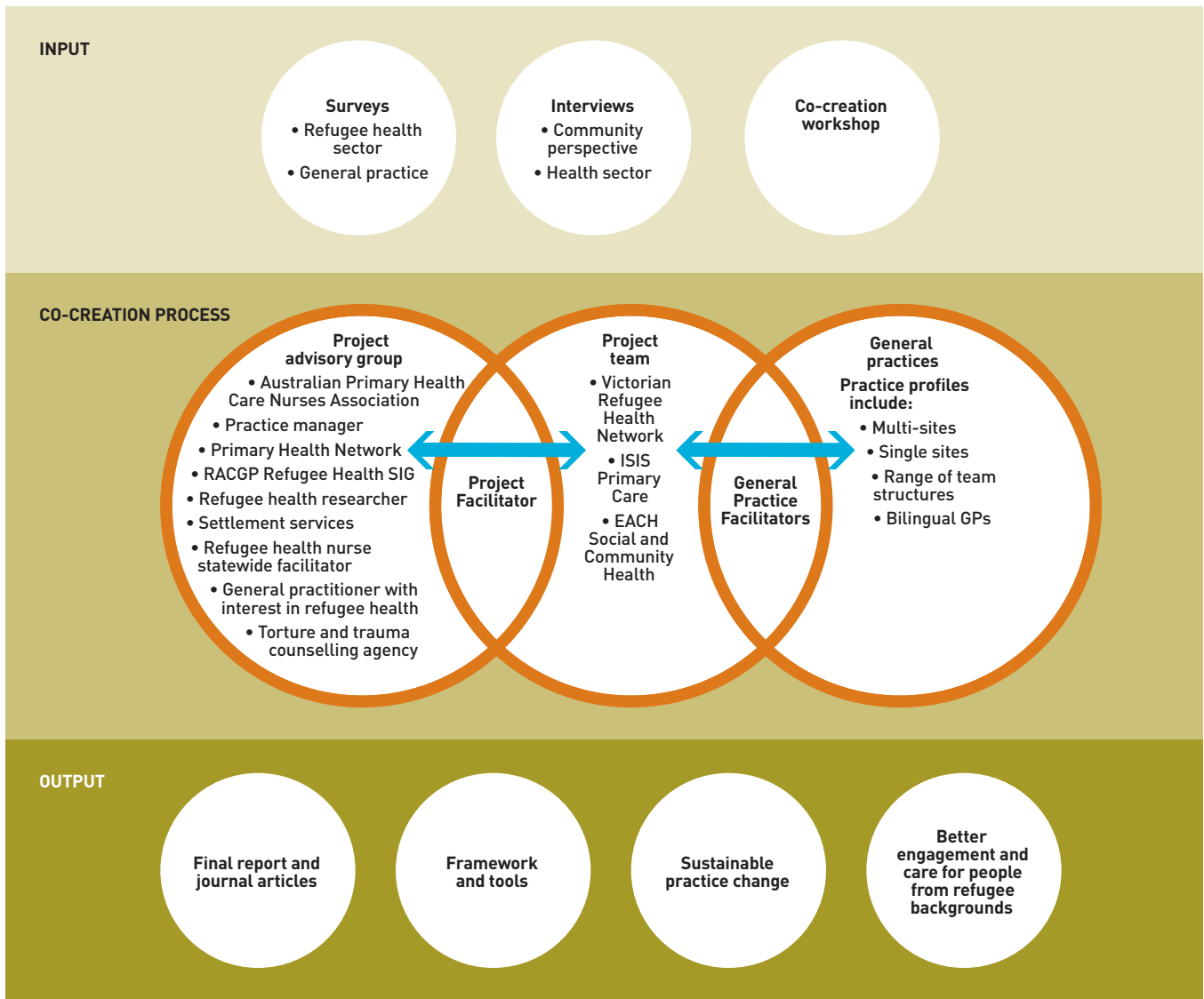
Co-creation

The principles of co-creation were adopted and applied to the project in two key ways (Figure 3.2). The co-creation of an approach with associated tools and resources to support RHGPFs in their engagement with practices between the multi-sectoral PAG and project team was informed by the scoping information. In addition to this, the RHGPFs went on to use these tools to co-create practice-based interventions with general practices as outlined in Figure 3.2.

A co-creation professional development workshop was attended by the project team, two members of the project advisory group and a GP refugee health fellow.

Many of the barriers to general practice engagement presented in this session echoed those that were identified during the scoping phase of the project. Additional and important barriers that were explored included constantly competing initiatives that lead to 'change fatigue' in general practice, and change initiatives that are 'done to' general practice and not 'done with' general practice.

Figure 3.2: Process diagram – utilising the principles of co-creation



Three key triggers for practice change were identified: the desire to improve patient health outcomes, the desire for potential financial benefits, improvements in time management and the working processes within the practice.^{26a} Practice change is enabled by building relationships and trust, aligning work with the practice's priorities, building on existing processes that have clear benefits to the GP and the practice, easy-to-use resources and maintaining high-frequency communication using multiple platforms.^{26b}

Acknowledging co-created value; maintaining flexibility of the innovation; utilisation of champions in general practices and in partner or stakeholder organisations; using 'real practice data' to demonstrate positive outcomes of change throughout the process; providing appropriate education and training; and maintaining

support were all important aspects of co-creating change with general practice.^{26a,b}

Refugee health general practice engagement tools were conceptualised and co-created over a period of time with both the project advisory group and the project team. Development of the tools occurred over multiple feedback rounds, both in face-to-face meetings and out of session. This process utilised a range of methods including paper-based group workshoping, online platforms and web conferences.

Principles of innovation^{§,27} were utilised by the project team and the project advisory group during the

§ Relative advantage; compatibility; low levels of complexity; trialability; observability; reinvention; fuzzy boundaries; low risk; task issues; knowledge; augmentation/support

Section 3: Development of an Approach and Resources

development of the tools. At each face-to-face meeting, these principles were visible on the walls in the room to ensure that the group maintained a focus on practical and realistic innovation that could be applied in the general practice context, and that considered its staff and their motivators for change.

In addition to this, the project team engaged in the iterative process of attending fortnightly web conferences hosted by the Network project facilitator. In these web conferences the team further developed the tools after feedback rounds from the PAG. Later in the project, these fortnightly teleconferences provided a forum for team members to reflect on their experiences using the tools, to track progress and maintain momentum with the practices engaged in the project, troubleshoot and share solutions to common problems.

Development of tools

General practice engagement occurs in a range of ways through the Refugee Health Program, Refugee Health Fellow Program, Primary Health Networks and Primary Care Partnerships, in the form of formalised projects as well as informal engagement when discussing mutual patients. The pilot survey findings indicated that the way in which general practice engagement is conducted and prioritised in the Refugee Health Program is dependent on service models, and approaches to this vary within the refugee health sector.

A series of tools to support general practices in the delivery of health care to people from refugee backgrounds, and also to support those involved in general practice engagement and facilitation existed. However, there was no coordination or consistency across sites.

Scoping for this project highlighted that refugee health can be perceived as complex, time consuming and expensive, and that this can act as a barrier to engaging general practice to work with people from refugee backgrounds. Scoping also indicated that those working in the refugee health sector can have high expectations about what is required of general practices to deliver accessible and appropriate health care to patients from refugee backgrounds.

In order to balance the views of the refugee health sector and those of general practice and primary care to develop a pragmatic approach, it became necessary

to document and reach agreement on the foundational systems and skills required for the delivery of good health care to people from refugee backgrounds and the additional systems and skills that work towards best practice in this area (see Section 4).

In preparation for engagement with general practices, the project team and the project advisory group documented and prioritised the key components in the delivery of effective primary health care to people from refugee backgrounds. There was an agreed aim to include the whole-of-practice team in identifying skills and systems, with the view that this would assist with the facilitation and sustainability of practice change.

This negotiation process was time consuming and occurred over three face-to-face meetings, fortnightly web meetings and out-of-session email feedback and modification. A working framework took approximately four months to develop. This process was challenging and contested, as it required consideration of a range of perspectives and data sources, including survey and interview responses, project team perspectives and PAG member perspectives. See Section 6 for further discussion.

Tools for co-creating with general practice

Alongside the documentation of foundational skills and systems required, a set of tools was developed to assist RHGPFs to co-create practice change with general practices. The principles of co-creation, including the importance of practice-led interventions, were used to facilitate a shared understanding between RHGPFs and the general practices involved in the project. A set of interview questions was developed (in the Facilitators Interview Guide, see Figure 4.2). This approach aimed to start conversations with practices to identify their values, needs and priorities, and to ensure the approach was not prescriptive and would be practice-led.

The practice profile (see Section 4) assisted facilitators to identify practice readiness for change in their delivery of health care to people from refugee backgrounds.

It was anticipated that engagement with practices would occur with two meetings to determine needs and establish an action plan, and that this would be followed by monthly or quarterly meetings between key practice staff and the RHGPF to track and measure progress.

Action plan and evaluation templates were developed based on input from the PAG about common approaches to quality improvement activities in general practice.

Evaluation

A number of data sources were used during the project to evaluate both the process and the outcomes. Data sources included the practice profiles, facilitated interview notes, action plans and evaluation documentation.

For the duration of the project, each RHGPF kept a diary. A template for this diary was developed by the team to ensure consistency. The diary assisted in the documentation of the steps taken, the time frames within which activities occurred, the various methods and platforms of engagement with the practices, key themes and agreed actions. The diary also included a reflective component.

Reflective interviews were conducted with the four RHGPFs at the end of the project using an interview guide developed by the project advisory group. Three practices were contacted to participate in a reflective interview, and one was able to participate. In addition, reflective interviews were conducted with three members of the PAG.

An evaluation template was also developed as part of the Refugee Health General Practice Engagement Tools to evaluate the practice facilitation process and the outcomes in the practices.



Section 4: The Resources: Framework and Tools

This section presents all of the tools that were developed during the course of the project. These tools were developed through the process of co-creation (see Section 3) for RHGPFs to use in their engagement with general practices. The tools provide a sense of structure and guidance to engaging and supporting general practices in practice-led change. The tools are intended to be used flexibly to meet the diverse needs of RHGPFs and the general practices that they work with. Section 5 presents the experiences of the project team in using the tools.

Framework for Continuing Improvement in Refugee Health

The Framework for Continuing Improvement in Refugee Health identifies three key components in the delivery of accessible and appropriate health care to people from refugee backgrounds: communication; coordination and management; and clinical care.

The framework outlines the foundational and additional skills and systems required in each of these three areas to enable general practice to deliver efficient and effective health care to people from refugee backgrounds.

The framework also identifies resources to support implementation of practice change and whole-of-practice suggestions in order to provide guidance for general practices and RHGPFs.

The framework utilises a whole-of-practice approach and therefore identifies both clinical and non-clinical skills and systems (see Figure 4.1 for a snapshot of the framework). The complete framework can be viewed on the [project resources web page](#).

The framework was developed to support RHGPFs to engage with practices and identify steps towards delivering quality care. This framework outlines three central components for the delivery of health care to people from refugee backgrounds. Communication, coordination and management, and clinical care were identified by the project team as making up the framework, with each component having a number of skills and systems within.

The components of this framework formed a web resource for general practices to access, compiling the existing resources on each of the three key thematic areas and

practice suggestions for implementation. Resources for both clinical and non-clinical staff are provided on the [project resources web page](#). During the time of the project, the *Recommendations for Comprehensive Post-Arrival Health Assessment for People from Refugee-Like Backgrounds* ('ASID/RHeaNA Recommendations') were being updated, so the communication and coordination and management components were prioritised and were more fully developed, as the clinical component would rely heavily on the updated recommendations for guidance.

Refugee Health General Practice Engagement Tools

Alongside the Framework for Continuing Improvement in Refugee Health, the Refugee Health General Practice Engagement Tools were developed to assist RHGPFs in their engagement with general practices and the co-creation of practice-based change.

The Refugee Health General Practice Engagement Tools include the Project Introduction Sheet, Practice Profile Template and Facilitator Interview Guide, action plan template, evaluation template and the project diary.

Project Introduction Sheet

The Project Introduction Sheet outlines the context for the project, such as the numbers of people from refugee backgrounds in Victoria and the need for more general practices, and the approach that facilitators would use to support the practice in their delivery of health care to people from refugee backgrounds if they agreed to participate.

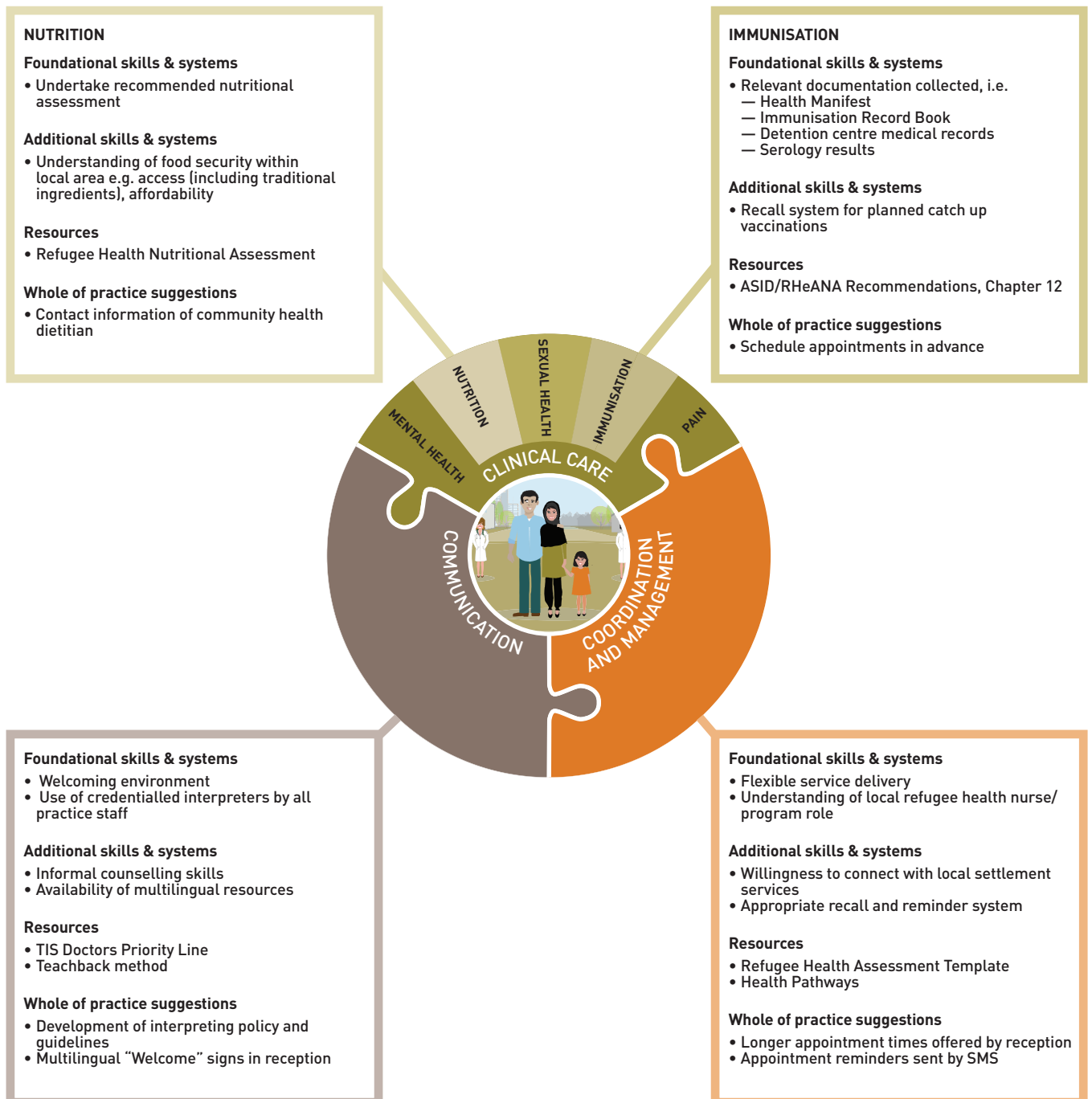
The Project Introduction Sheet provides a succinct means of introduction that can be shared and discussed within practice teams, and can be modified by RHGPFs as required.

Practice Profile Template

The Practice Profile Template creates an overview of the practice context for the RHGPF. It assists in the documentation and understanding of the practice make-up and size of the practice team, including those in non-clinical roles. This draws attention to the whole-of-practice approach with practices in the initial stages of engagement.

Section 4: The Resources: Framework and Tools

Figure 4.1: Snapshot of Framework for Continuing Improvement in Refugee Health



For detailed framework see the project resources web page

<http://refugeehealthnetwork.org.au/resources-for-engaging-and-supporting-general-practice-2/>

The Practice Profile Template encourages facilitators to ask, 'Do you see people from refugee backgrounds and how do you know?' This allows for a preliminary discussion about the identification of people from refugee backgrounds in the practice and a starting point for practice change. The template encourages facilitators to ask, 'Does your practice routinely use interpreters? And if no, are you willing to use interpreters with support?' This question sets a minimum requirement for ongoing engagement with RHGPFs, as practices that are not willing to work with interpreters are not seen as ready to change their practice to improve the delivery of health care to people from refugee backgrounds. This can assist RHGPFs in the allocation of practice engagement resources.

Facilitator Interview Guide

The Facilitator Interview Guide is used to facilitate a conversation with practice staff in any role, and to understand their individual values, motivations and challenges in working with people from refugee backgrounds in their practices. This guide allows practice staff to reflect on their role in meeting the needs of people from refugee backgrounds, and ensures that a diversity of perspectives are considered in the project. For example, a GP may value clinical knowledge or outcomes in their work with people from refugee backgrounds, while a practice manager may value the full patient load. The Facilitator Interview Guide allows a rich understanding of the interviewees, and forms the basis of a relationship based on a shared understanding.

Priority setting and action planning

The action plan template provides guidance for the identification of priorities within the practice. It assists in the identification of tasks and actions, roles and responsibilities, time lines and indicators for measurement. In addition to the blank template, a sample action plan provides detailed examples about common challenges in general practice. A practice that is new in this area may be able to utilise the sample action plan, and it also provides tangible examples for the development of the joint action plan.

The action planning tool may also be able to assist practices in the area of new policies and practices, and accreditation responsibilities.

Evaluating change in practice

The evaluation template provides guidance for facilitators and practices to evaluate the approach used, the

Figure 4.2: Facilitator Interview Guide

1. What are the things that motivate you / what would motivate you (as a GP/Practice Nurse/principal GP/PM...) to see people from refugee backgrounds, including those seeking asylum, in your practice?
(prompts: a passionate person in the practice, demographics of the practice, bilingual GP, interesting medicine, don't know if they do or not, relationship with RHN or others)
2. What do you value most about seeing patients from refugee backgrounds in your practice?
(prompts: It makes me feel positive;...)
3. What do you find challenging when you work with people from refugee backgrounds? (please describe)
(prompts: existing practice systems and structures; infrastructure; overcoming language barriers with clients; overcoming cultural barriers with clients; medical challenges; workforce (not enough staff in the practice; other staff not as supportive or interested); time; referral pathways; team-based care requirements; lack of specific education and training in key areas)
 - a. How do you work to address or try to overcome these challenges?
(prompt: systems, human resources, referral pathways, collaborating with others)
 - b. Where do you go for support or information?
4. If money, resources and time were no object what would facilitate the delivery of accessible and appropriate health care to people from refugee backgrounds in your general practice?
5. How would you prioritise this wish list? (list your top 3 most immediate needs)

strategies implemented to improve practice in priority areas and how they will be embedded into ongoing practice. The cyclical nature of the co-creation process means that additional areas for improvement may be identified during this process for the development of future action plans.

Project diary for RHGPFs

The project diary documents the interactions with practice staff, the method of engagement, the issues or

topics discussed, any resources or advice provided and any follow-up required.

The Framework for Continuing Improvement in Refugee Health including the supporting resources for general practice, and the Refugee Health General Practice Engagement Tools can be accessed on the [project resources web page](#).





Section 5: Trialling of the Approach: Engaging General Practices

In December 2015, the project team began to engage general practices in the project. Practice engagement was expected to typically follow the steps outlined below.

This section documents the practice engagement process and use of the Framework for Continuing Improvement in Refugee Health and the Refugee Health General Practice Engagement Tools. This section draws on data collected in the practice profiles, the facilitated interviews, the ongoing project diaries and the fortnightly project team teleconferences.

Practice selection

The project team members selected two or three practices in their local areas to approach about the project: at least one practice that was known to the Refugee Health Program in their area and which may see some or a lot of patients from refugee backgrounds; and at least one practice that was lesser known. Facilitators were encouraged to develop a better understanding of the knowledge, skills and systems that general practices working with people from refugee backgrounds utilise in order to deliver effective and efficient health care. This would enable them to pick up practice tips and suggestions for newer practices, while also supporting more experienced practices to improve in areas of importance to them.

Nine practices were approached and the rationale for their selection included:

- Practices where there was a known champion for refugee health, regardless of their role in the practice
- Practices that were known to see patients from

refugee backgrounds, even if they had not previously had a relationship with the Refugee Health Program

- Practices that were known to have bilingual GPs
- Practices where there had been previous communication challenges about patients in the past
- Practices where there was an established relationship with practice staff, regardless of their role
- Practices that were considered to be in a convenient location for patients to attend

Each practice was contacted by the RHGPF, generally by phone, and then a follow-up email was sent with the Project Information Sheet and the Interview Questions that would be discussed at the initial meeting. The initial phone call was directed at the staff member with which there was an established relationship where one existed, or the practice manager.

The time taken from the initial contact with the practices to the first meeting and completion of the practice profiles and facilitated interviews ranged from 2.5 weeks to 14 weeks, with the average amount of time being eight weeks between the initial contact with the practice and the first meeting. A number of factors may have contributed to this, including engagement in December 2015 at a time when both practices and refugee health facilitators were having holidays; practice staff turnover in several practices; illness; and competing practice priorities.

Practices that declined to participate

Of the nine practices that were approached, two formally declined to participate in the project.

One of these practices was interested in the project, but after a number of attempts at contact, eventually

Figure 5.1: Steps in practice engagement



declined due to being too busy at the time, despite seeing many patients from refugee backgrounds and having a bilingual GP in a community language. This was a small practice with only three GPs. On reflection, the RHGPF identified that the formality of the project and the steps involved may have been off-putting to this practice. The facilitator continued to periodically check in with this practice, as many patients from refugee backgrounds were known to attend the clinic, and reflected that perhaps an informal discussion about their motivations, values and challenges may have led to increased engagement and the development of an action plan.

The second practice that declined to participate was relatively unknown to the Refugee Health Program, despite the practice having a number of bilingual GPs and patients from refugee backgrounds who attended the clinic. This practice was contacted, and while the practice manager was receptive to hearing more about the project, when this was passed on to the GPs the practice declined to participate.

A third practice did not formally decline to participate in the project. An initial meeting took place with one GP completing the facilitated interview questions and returning them to the RHGPF by email. Upon receipt of this response, the RHGPF attempted twice to make contact with the practice manager to ascertain their interest in participating in the project and to follow up any additional facilitated interview responses. No response was received from the practice manager, and it was the RHGPF's assumption that the practice therefore did not wish to participate. The GP in this clinic then made contact with the Victorian Refugee Health Network coordinator to follow up about the lack of contact from the RHGPF. Several communication breakdowns contributed to this practice not formally participating in the project. This GP was provided a number of supports for specific issues that were raised, including linking in with a refugee health fellow. With permission from this GP, the facilitated interview data has been included in the facilitated interview responses.

Practice profiles

Practice profiles were taken in order to understand the practice make-up, services offered, and to facilitate a discussion about identification of people from refugee backgrounds and use of interpreters. These were identified as core requirements in order for the RHGPF to

identify the practices' readiness to work with people from refugee backgrounds and to change their practice where required.

The six practices that completed profiles varied considerably in their size, team structure, services provided and their degree of experience in working with people from refugee backgrounds.

Table 5.1: Data from practice profiles

Practices engaged in the project	6
Practice profiles completed	6
Number of staff	14-106
Practices with allied health	5
Practices that see patients from refugee backgrounds	6
Practices that routinely use interpreters	5
Practices that were willing to use interpreters	6

The smallest practice consisted of 14 staff and the largest was a multi-site company with approximately 106 staff.

Five practices also provided allied health services, including audiology, physiotherapy, podiatry, psychology, dental, dietetics and pathology.

Approximately half of all GPs were identified as working with patients from refugee backgrounds in almost all of the practices. However, the practice with the largest number of GPs (39) indicated that two GPs saw almost half of their patients from refugee backgrounds.

Two practices had considerable numbers of bilingual or multilingual staff, including bilingual GPs, allied health and reception staff.

All six practices indicated that people from refugee backgrounds attend their practices. However, when asked how they know this, the responses varied from referrals received from AMES, Life Without Barriers, Red Cross or refugee health programs; 'asking them'; 'they speak another language'; or they were unsure.

Five practices indicated that they routinely use interpreters, including on-site and telephone. One practice reported that they did not routinely use interpreters as most clinical staff were bilingual and more than half of their reception staff were bilingual or multilingual. All practices indicated that they would be willing to use interpreters with support – a key requirement of the project.

Facilitated interview responses

In total 19 practice staff participated in the interviews; including nine GPs, six practice managers, three practice nurses and one CEO.

Table 5.2: Staff who completed facilitated interviews

Total staff who participated	19
GPs	9
Practice managers	6
Practice nurses	3
CEO	1

All practices were emailed the interview questions prior to the interviews taking place to allow participants time for reflection and preparation. Interviews were conducted in various ways by the RHGPFs. Most interviews were conducted in person, either one on one or with a group of practice staff, others were completed in writing individually by practice staff and returned via email. This was dependent on the approach the facilitator and the key practice contact agreed to take.

Motivations

When practice staff were asked what motivated them to see people from refugee backgrounds, responses were typically related to compassion for people from refugee backgrounds; clinical skills and learning; business rewards; the delivery of an inclusive service; or making use of bilingual staff or staff expertise in the practice.

Those who were motivated by compassion highlighted an understanding of the refugee and settlement experience and a sense of responsibility to ensure people from refugee backgrounds were made to feel welcome and to have their health and medical needs met.

Those who were motivated by clinical skills and learning highlighted that working with people from refugee backgrounds gave opportunities for increasing clinical knowledge about unfamiliar medical conditions, such as strongyloides, and additional experience for doctors and nurses in working with people and families.

As a practice manager it helps to fill the appointment schedule and gives new GP registrars and medical students an interesting and diverse client load.
[practice manager]

Those who were motivated by business rewards were typically GPs or practice managers, indicating that working with people from refugee backgrounds was a way to increase the patient base.

Others were motivated by the need to deliver an inclusive practice that is open for all, and saw working with people from refugee backgrounds as part of the job in treating the wider community. The CEO of a large, multi-site practice was driven by the notion that '[People] need a home for their health care.'

Other staff were motivated by the ability to provide services to people from refugee backgrounds, as they had staff with experience in this area or had bilingual staff or were from diverse backgrounds themselves.

Values

When asked about what they valued about working with people from refugee backgrounds, several themes emerged. These included placing value on being able to assist in meeting both health and settlement needs; the relationships that were formed; the opportunity to increase knowledge, skills and experience; and the opportunity to increase the patient base.

Those who valued being able to make a difference in meeting the health and settlement needs of people from refugee backgrounds made the following statements about what they value in working in this area:

Being able to see families able to adapt to a safe environment. (CEO)

Being able to give families the help needed.
(practice manager)

I'm happy to see them kicking healthcare goals and to see them integrate and settle comfortably into mainstream Australian society, e.g. by learning how to speak, read and write English, engaging in education and work, and gaining health literacy and self-efficacy to engage with the health system beyond our clinic. It makes me feel like I am achieving something for myself and the patient. (GP)

Others indicated that they valued the relationship with patients, and one practice manager valued the appreciation of patients from refugee backgrounds.

The interactions with the refugees, forming relationships with them, making a difference and relating to them. (GP)

Those who valued the additional knowledge, skills and experience that working with people from refugee backgrounds brought typically mentioned the diversity that they bring medically and culturally and the chance to utilise previous experience or bilingual staff.

One GP valued their contribution to the business, indicating, 'We are a business and they increase the patient base.'

Challenges

Practice staff were asked about the challenges that they face when working with people from refugee backgrounds. Challenges were highlighted relating to communication, coordination and management, and clinical care.

Communication and language barriers were identified as a significant challenge by many participants. This related to communication between patients from refugee backgrounds, clinical and non-clinical staff, and other patients in the practice. Communicating practice information and systems to people from refugee backgrounds was identified as challenging, and follow-up appointments were difficult if this could not be done at the end of one appointment with an interpreter on the phone.

Communication is the number-one challenge. (CEO)

Other communication challenges related to systemic issues with interpreting services such as lack of interpreting services, particularly on-site; difficulties with pre-bookings; long wait times; particular languages being unavailable when required; and lack of funding for interpreting for allied health.

There are several patients whose first language is not covered by TIS (e.g. many Chin dialects and Liberian Gio), and communication is compromised. I either have to attempt to consult in English with the patient and we can't understand each other; or we have to use a TIS interpreter in the patient's second or third language, and things get lost in translation, or they have to bring a relative to translate for them, or worse still with TIS in their second or third language – making it a six-step loop! Sometimes, the quality of interpreter is poor as they don't know medical terminology. I've noted that the translated answer provided by the interpreter does not match the question sometimes – again, this could be due to interpreter or patient factors. Also, there are many medical terms and concepts that would not have an equivalent in their language and vice versa. All this is risky for the patient and for the GP. (GP)

Coordination and management challenges included the time taken to use interpreters, but also to arrange review, recall, or follow-up appointments which were further complicated by frequently changing addresses or phone numbers. Additional requirements were required for team-based care. Missed appointments, including specialist appointments to which referrals had been made, were identified as a challenge. However, one GP noted that this was not unique to people from refugee backgrounds.

This seems to be an issue for both refugee/asylum seeker and other patients alike. I don't know how to deal with this as it wastes our time and we don't get paid for it and it blocks access to others needing appointments. (GP)

The complexity of health concerns was also raised, including the need for longer appointments which can have an impact on the practice. There were concerns about referral – for example, lack of knowledge about pathways for dental services or of local psychiatrists who bulk bill and use interpreters, or absence of such services to refer to. Concerns about billing if the patient did not have a Medicare Card, and how to address people in distress, were also raised.

Some of our doctors do not wish to see refugee clients due to the above challenges. (practice manager)

Clinical care concerns were expressed, including:

- Providing catch-up immunisations including need for translation of immunisation records and people missing catch-up appointments, and further complicated by changing contact details and the No Jab No Pay and No Jab No Play policies.
- Changing guidelines and protocols regarding latent and active TB, Hepatitis B referrals and treatment, treatment for different 'gut' infections (schistosomiasis, campylobacter, blastocystis, shigella), particularly if there are multiple infections especially in children, were also identified as presenting challenges.

There was a need expressed for advice regarding people who have experienced torture/trauma, and referrals in the area.

Services and systems challenges included expired bridging visas and Medicare cards; communicating with overstretched SRSS providers; accessing detention health summaries from IHMS and DIBP; the reliance on GPs to assist with medical exemptions for job training and job seeking as a condition of Newstart, etc.

It's difficult to provide all the minute detailed information and medical documentation they need within the time constraints of a single consult, and patients can get anxious and desperate, and seem to expect us to influence Centrelink's decision in their favour. I have to go to great lengths to explain that I can only provide accurate and complete info as we have on file, and that Centrelink's decision is entirely out of my control, so that they don't hold me responsible if they are rejected. (GP)

Overcoming challenges

Practice staff were asked what they had done to overcome challenges. Responses included working with refugee health nurses; pre-booking interpreters; working with bilingual staff and doctors; use of visual aids in clinical consults; making follow-up appointments with interpreters; checking contact details regularly; opportunistic follow-up when patients visiting for other reasons; translating relevant practice information and displaying them as wall signs; long appointments that are spaced out with two family members at a time; and that the practice manager was very proactive in the management including the booking of appointments and the booking of interpreters.

Make sure refugees know their date of birth to make appointments. This makes this a lot easier and faster for them and for the practice, especially when there are many similar names. (practice manager)

Where staff get support

When asked where they go for support and information, practice staff identified information provided by previous Medicare Local staff; local refugee health programs and community health centres; special interest doctors group; settlement services; Eastern Health; Royal Melbourne Hospital Infectious Diseases Clinic; Victorian Refugee Health Network website; care plan nurses; and the head office of their organisation.

Wish lists and priorities

When asked about their wish lists, practice staff typically spoke about:

- upskilling practice nurses in refugee health
- increasing the awareness and personal capacity of patients from refugee backgrounds, their proposers and their community guides about GP processes and systems and their rights and responsibilities – such as using TIS to make or change appointments

- greater information communication and information from diagnostics providers about out-of-pocket expenses
- more bilingual staff
- directories of private specialists and allied health that bulk bill and use interpreters.

Development and implementation of the action plan

Upon completion of the interviews, the key practice staff and RHGPFs were asked to identify the practice priorities and tangible actions that could be taken during the course of the project. This would be documented in an action plan. As outlined previously, the action plan identified actions, roles and responsibilities, time lines and indicators for measurement of practice change. This process had mixed results.

Table 5.3: Action plan progress with practices

Participating practices	6
Action plans developed	1*
In the process of writing action plans with RHGPF	2
Action plan developed with PHN	1
Postponed action plan	1
Informal actions undertaken	2

* This practice also went on to develop an action plan with the PHN.

Case studies

ACTION PLAN DEVELOPED

One practice developed an action plan with two key strategies for implementation. The first was the identification and development of a clear referral process between the local Refugee Health Program and the practice for patients from refugee backgrounds. The practice manager – the most active refugee health champion in this practice – had recently left this practice, and so the referral process with the Refugee Health Program had broken down.

A new process was developed during a face-to-face meeting with the RHGPF and the new practice manager, and a practice staff member was allocated the responsibility for implementing the strategy and booking interpreters when a referral was received from the Refugee Health Program. To evaluate whether the process was effective, the action plan identified the

number of referrals made from the Refugee Health Program as a source of data to indicate practice-based change.

Throughout 2015, before the practice manager and refugee health champion left, 13 referrals** were made to this clinic by the Refugee Health Program. Up until 31 March 2016, no referrals had been made by the Refugee Health Program to this practice as there was no supporting system in place. The development of this strategy occurred during a face-to-face meeting on 21 March 2016 and between 1 April and 17 June, five referrals were made to this clinic. This is an example of indicators developed by the practice and the RHGPF to measure the impact of the strategy.

Another priority for this practice was understanding the updated immunisation requirements for people from refugee backgrounds. The actions that were identified included the provision of updated immunisation information for clinicians in the practice by the RHGPF. This information and catch-up tools were provided by the RHGPF. However, the action plan did not identify indicators for evaluation, so it is unclear whether this has had an impact in the practice.

Work with this practice provides an example of both the identification of practice priorities related to both systems and skills.

This practice then had a change in practice manager. The RHGPF had engaged with the new practice manager, and this practice then went on to apply for a Primary Health Network grant in the area of refugee health. A more detailed action plan was developed with the Primary Health Network.

ACTION PLAN DEVELOPED WITH PRIMARY HEALTH NETWORK

The practice received a quality improvement grant from a PHN for a refugee health related project, and has submitted an action plan through this process. The tools were shared with the PHN and the development of this action plan followed the format of the action plan template. Actions arising from this plan included a one-hour training session delivered by a refugee health fellow to practice staff covering cultural awareness (six non-clinical staff and 16 clinical staff); clinical health information, such as common health conditions and the refugee health assessment; and HealthPathways (16 clinical staff). Key strategies and action areas outlined in the action plan included updating their New Patient

Information Form to include year of arrival, country of birth, language spoken and interpreter required; implementing an immunisation clinic on a particular day in the practice; and developing a practice protocol for the delivery of care for newly arrived people from refugee backgrounds as well as those who may not have previously been identified as being from a refugee background.

ACTION PLANS IN PROGRESS WITH RHGPFs

Two of the six practices engaged were in the process of refining their practice priorities and then developing their action plans with the RHGPFs at the time of writing.

One practice identified that key areas for action were likely to be around clinical implications of the new ASID/RHeaNA Recommendations, and that training would be delivered. However, this was still being scoped. In addition to this, other potential areas for action that related to practice systems were likely to include follow-up and recall, appointment scheduling for bloods tests, immunisation schedules and eligibility criteria. During the course of the project, this practice self-initiated the implementation of an SMS recall and reminder system and reflected that this had had positive results, including fewer missed appointments and greater rates of return for test results. However, this had not been formally evaluated.

Now with the text message, it's not in any specific language other than English, but patients have been coming in with the message and showing us and so they're realising that [practice name] needs to talk to them or they need to have an appointment, so we've been having a lot more follow-up appointments and coming back for results, etc. – so it is working. I'm not sure if we're kind of really doing a checking to see if it has helped, but we can definitely see the improvement.
(practice nurse)

The key contact in this practice has since gone on maternity leave. However, the RHGPF is engaged with the practice manager and GPs in the clinic. This practice is currently in the process of developing an action plan based on the priorities of staff in the clinic and had the following reflections about the action plan approach.

I think it definitely does work. Because it kind of gives you something to look at what was documented and how we can use it – like something to refer back to. To have a plan. I think that works in a GP setting. (practice nurse)

** Referrals may be for an individual or family group.

Another practice identified that their key areas of action would be focused around: improving the knowledge and confidence of practice nurses in undertaking catch-up immunisation schedules; working more closely with the local Refugee Health Program regarding referral pathways; and updating GPs on the new clinical recommendations. A practice visit was organised with one of the refugee health fellows to address some clinical questions relating to latent TB and treatment of parasitic infections. Another visit with the practice facilitator involved education and information sharing regarding referrals to Foundation House and general counselling services for patients. The practice facilitator is working with the practice to evaluate these strategies.

ACTION PLAN POSTPONED

One practice was undergoing dual accreditation shortly after the interview was conducted and postponed further work until later in 2016. The RHGPF provided a number of information resources related to immunisation, clinical guidelines, and the Refugee Health Fellows Program as requested and agreed to re-engage with the practice at this point for further exploration of priority areas and areas for action.

INFORMAL ACTIONS UNDERTAKEN

Two practices engaged in the project were provided with informal information and support after completion of the facilitated interviews. Information and supports related to immunisation implications related to the implementation of the No Jab No Pay policy during this project; information relating to the ASID/RHeNA Recommendations; information about the availability of allied health services in community health with access to interpreters; and translated health information.

One practice was linked with a refugee health fellow to deliver an immunisation information session. However, this was ultimately declined by the practice. It was understood by the RHGPF that this was because the refugee health fellow was unable to provide lunch. This was viewed as very unusual by a general practice sector representative from the PAG.

This is very old school. I do practice visits and it is difficult to get in to see a GP. It is very rare to be declined for not bringing lunch ... this may happen to us perhaps once a year. (mainstream general practice facilitator)

One practice was provided with key refugee health resources and information about access to translated

materials. However, as this practice was seeing only a small number of people from refugee backgrounds more tangible actions were difficult to identify.

RHGPFs followed up with the practices to see if the information provided had been useful and if further support could be provided, however there were no further discussions about the development of an action plan or indicators to evaluate the effectiveness of the information provided. Both RHGPFs then went on extended leave. However, the details of the Refugee Health Program within which they work were provided for further support if required.

The intentions were good and the enthusiasm was there but no time/priority given to project work. (RHGPF)

So there was – I guess with my practice that I did end up working a lot with, or the most with, there was feedback about what their needs were and me saying, 'This might help you' – so it was a two-way street, but not as formalised. The co-creation didn't feel formalised at all, and that's because we didn't get around to doing the action plan – it was all a bit rushed. (RHGPF)

So we didn't develop an official action plan, bottom line. At my last meeting with the practice, which was – I really only had two meetings – so the one with the interview questions and the one where we tried to clarify exactly how I could help. So because I knew that I had limited time by that stage, I kind of just took it more as an informal 'How can we help in this short amount of time? What can we do for you?' So if I had more time then, then we could have potentially developed a bit more of an action plan. (RHGPF)



Section 6: Findings and Discussion

The project aimed to model an approach to engaging and supporting general practices to improve the delivery of accessible and appropriate health care to people from refugee backgrounds. This section outlines key themes, successes and challenges that emerged during both the development and trialling phases of the project.

Utilising co-creation principles in practice facilitation

Throughout the project, and upon reflection, there was strong support for the co-creation principles by RHGPFs and the PAG. RHGPFs were particularly supportive of this approach during the development of the framework and tools with the multi-sectoral PAG. This was related to feeling confident that the resources developed considered a range of perspectives, including those experts in refugee health, and those in a range of roles in mainstream general practice.

The [co-creation] concept is really good ... having more or less the support and having other professionals actually look through and give their stamp of approval actually gives you the confidence to say, 'Yes, I can give it out to the clinic.' (RHGPF)

When engaging with practices, facilitators supported use of the co-creation principles as they promote a practice-led approach, assisting in relationship formation with practices and meeting their unique needs in the delivery of health care to people from refugee backgrounds.

I was able to sort of say, 'Look this project is guided by you and where you're sitting at the moment and what your needs and challenges are – and what your capacity to work with this project is.' So that was a really good selling point and I think that really engaged them. (RHGPF)

[The approach developed] recognised that [practice change] was practice led ... that's a strength ... because you need the practice to engage with the practice facilitator. So what I liked about the co-creation principles is that it is practice led. (settlement services provider)

The development of the resources enabled a sense of structure and support for practice facilitation. While some facilitators noted that they have historically done general practice engagement in this way, they added that formalisation of the approach provided additional guidance and confidence. The project provided the ability

to document and develop a structure to general practice engagement that has typically been ad hoc in the past.

I suppose in the past we always have [been] informally doing co-creation with the clinics we work with ... because out there every GP is different. (RHGPF)

A lot of it is not new. It's not new information, but it has been well put together. The co-creation model was a really good example of how to work with practices – and not dumping things on them – which we've all been guilty of at times. You know? 'This is the way to do it, this is the only way to do it.' But actually to formalise it, because we all kind of know that you shouldn't do it that way. But to formalise a model that actually supports not doing it that way was good for me.

(mainstream general practice facilitator)

RHGPFs are well connected with the refugee health sector, including settlement services. Using co-creation principles enabled broad analysis of the challenges in general practice and their potential solutions. For example, one practice identified difficulties with the translation of immunisation documents in languages where they do not have bilingual staff. While interpreters were able to translate these documents if they are on-site, many interpreters used in the general practice setting are on the telephone. The RHGPF was able to take this issue to not only the Refugee Health Program team within which they worked, but also to the local refugee health network that has representation from many key stakeholders. While this issue is still being worked through, it allowed for the co-creation of a solution with key stakeholders, including settlement services, and general practices that may have previously been unconnected, and thus enabling the generation of solutions that will be practical and achievable.

So at the moment, I brought it up with the [Refugee Health Program] team so we are still just thinking about a way – and maybe [at the] local refugee health network group, where we have a meeting with the settlement services ... we can bring it up and they might have some suggestions. Because if we offer some suggestions, it might not be really practical for [settlement and general practice] to do ... And that's where we can find some solutions. (RHGPF)

The project took a strengths-based approach to practice change, recognising that there was much that could be learned from the general practices involved. RHGPFs viewed the relationship as a partnership rather than an expert imparting knowledge to the general practice.

Section 6: Findings and Discussion

A lot of the stuff that I've been writing down is about how the practice works with this population group. And I think that's important when you're building capacity with other practices, to find out how they do it and how they run it and how it's doable. (RHGPF)

The approach has acknowledged the existing skills and resources of the practice – so it didn't start from scratch ... so it's a strengths-based approach in my eyes. (settlement service provider)

However, there were challenges. While practice staff had considerable goodwill around improving their practice for people from refugee backgrounds, the commitment to action plans and identification of indicators to measure change was more difficult. Negotiating the action planning process, including indicator identification, took considerable time, and required continuity of staff and a long-term relationship between the RHGPFs and general practice staff.

Relationships between practice facilitators and practices

Developing relationships and identifying shared values was important, with diverse stakeholders at various stages of the project, including those involved in the scoping phases, the PAG, the project team and general practices.

For RHGPFs, developing relationships with key members of staff in the practice was critical for ongoing engagement. Initial contact was made by phone either through a known contact or the practice manager. The Project Introduction Sheet was then sent by email and personal follow-up was required in order to develop ongoing relationships. The ability of the RHGPFs to form and maintain relationships with people working general practice was essential.

it's not just one visit, it's not just one phone call. You have to continually engage with the practices. (RHGPF)

While the facilitated interview was conducted with practice staff in various ways and with various degrees of engagement, those who participated reflected that there was value in this process.

I just think it [the facilitated interview] was a good chance to actually reflect on why we do what we do, and the positives and also the negatives. I think it was just really good to refresh our memories on how important refugee

health is and what we can do to help refugees and our clients from this background.

(practice nurse from participating practice)

It was actually really nice to conduct that interview because I got to hear what the doctors enjoyed about working with this clientele and there were lots of positives, and then I got to hear about the realities of what the struggles were – which is really hard for us to know. (RHGPF)

The facilitated interview allowed for RHGPFs to develop new skills in relationship development. Typically the experiences of RHGPFs was that practice engagement occurred when there were shared patients or at the point of transition to a mainstream general practice from a specialised refugee health service. This was therefore a new approach.

I was nervous because I'd never done it before, but it was really exciting and really encouraging. Both practices ... really wanted to engage, wanted to work with refugees and asylum seekers and knew that they had areas that could be improved around it – but they were passionate about looking after our clients. And so that was really encouraging to hear. (RHGPF)

The opportunity to reflect on their work in the facilitated interview was valued by practice staff, but importantly this process allowed the identification of shared values between RHGPFs and general practice staff. These shared values fostered deeper relationships based on mutual understanding and an enthusiasm for practice improvement.

Very excited by interview and having so many people present. Very pleased with their answers to the interview questions – such a positive view towards our clients and it's great to hear it articulated so. Neat to be in a position to ask such great questions that otherwise probably never would have been voiced. Makes me curious about my other clinics and how they would respond – it may be just as encouraging! if only we asked. (diary entry, RHGPF)

Relationships were formed with people working in a range of roles in general practice, including GPs, practice nurses and practice managers. While it was important to identify champions in the practice and develop relationships with key staff members, staff continuity was a challenge in four of the six practices. This included staff members leaving and being replaced, but also included those who went on maternity leave or extended annual

leave. This created challenges as momentum in the project often stalled. New staff needed time to settle in to their new roles and there was uncertainty about whether replacement staff would be as engaged in the project.

The project found in a number of scenarios that it is important to identify at least two key staff members in the practice who are responsible for oversight of the change process, including the action plan. Having clinical and non-clinical staff involvement and someone in the practice who plays a coordinating role in practice change allows for the necessary internal communication, implementation of the systems and documentation to support the changes. This included booking the professional development, making resources available for different practice staff, monitoring change indicators and providing feedback to the whole staff group about how they were tracking.

Flexibility, time and resources

The consultations and the literature review identified the importance of flexible engagement in order to support general practice in practice-based change. Each practice is unique, and flexibility was crucial in both the engagement approach and in the identification of priorities and actions. It became evident as the project evolved that the time taken to develop relationships with the practices was significant. This was perceived to be the result of a number of factors, including large volumes of work, competing priorities and staff turnover.

Frustrated with delay but understand her reasons – dual accreditation cannot be easy! Pleased she let me know and continues to be keen to be part of the project.
(diary entry, RHGPF)

Each [practice] has its own uniqueness – and that sometimes makes it challenging to produce a generic tool – because I am also looking at it from the lens of sustainability and using this resource as an ongoing reference for general practice. (settlement service provider)

Early exploration of the values, motivations, and priorities of general practice staff to work with people from refugee backgrounds assisted facilitators to tailor the intervention to the needs of the practice.

However, practices were busy and faced competing demands, and it was essential for RHGPFs to embrace this and remain flexible in order to maintain relationships with the practices.

Felt bad for [practice manager] for such a terrible week so early in her new role but glad to be flexible and acknowledge her stress levels & maintain our relationship. (diary entry, RHGPF)

RHGPFs also faced competing demands. Staff in practices took holidays or other forms of extended leave, worked part-time, were unwell or were simply too busy, this was also the case for the project team.

Didn't realise a whole month had gone by without contact with clinic. (diary entry, RHGPF)

Despite the extensive time taken for initial engagement, it was important to maintain flexibility in the process to stay engaged with the practices. This meant maintaining a realistic focus on what could be achieved within the time frames.

I think the whole concept is fantastic and it is really important, but I think this has taught me that it's so hard on a practical level to do it as ideally as we would have liked to. (RHGPF)

Taking a flexible approach meant that consideration had to be given to each practice context and the areas for action selected. In one instance, the formality of the project was identified as a potential barrier, the RHGPF reflected that perhaps a more informal approach may have been more successful.

... having the interview guide and the questions and the project information – I found that really helpful with the practice that I am currently engaged with, however I feel like it was the thing that put off the other clinic – the formality of it. So perhaps I could just have asked the questions informally. (RHGPF)

As the RHGPFs became more confident in their roles, they relied less on the framework and tools developed to assist them earlier in the project.

Another example of flexibility in the process was the range of strategies that facilitators used to conduct the facilitated interview. While face-to-face interviews with practice staff allowed for a rich exploration of ideas and assisted in the establishment of deeper relationships, those that were completed via email allowed multiple staff in the organisation to participate in their own time, thus creating broader awareness about the project in the practice.

Engaging the whole-of-practice team

The project aimed to take a whole-of-practice approach and included those with expertise in a range of roles in refugee health and in general practice on the PAG. In addition, the Framework for Continuing Improvement identifies the foundational skills and systems required in both clinical and non-clinical work and represents the role that all practice staff play in the delivery of appropriate and accessible health care in general practice to people from refugee backgrounds.

It [the framework] definitely has a role – especially when it comes to the not just the nursing, but the client services staff. Because they are always the first people we ring up and have to make appointments with, change appointments. And unless you have that relationship with them, it is hard to get past. (RHGPF)

So pulling this whole thing apart and looking at the key things and looking at the tools ... we say whole-of-practice approach all the time, but it is absolutely key. If you've got consumers using a service and saying 'the reception is mean to me, or doesn't listen, or is not welcoming, I don't want to go there'. To me, that's a slap in the face. So we keep saying it, but that makes it meaningful to me. So [this framework is] breaking it down for us – what can we do for practices.

(mainstream general practice facilitator)

The tools were designed to be used with practice staff from a range of roles, including those in non-clinical roles and the information sheet highlighted that the project was taking a whole-of-practice approach. While practice managers and a CEO were engaged in several practices, no reception staff were formally engaged. The input of reception staff into the facilitated interviews and the identification of challenges and strategies in their roles would have been beneficial. While it is unclear if reception staff were unable, unwilling or not given the opportunity to participate, one practice nurse reflected that 'They would have been able to or encouraged to complete the interviews if we had known to include them.'

The tools were updated to explicitly encourage this.

Nonetheless, one practice reported that being involved in the project and communication about this to reception staff had improved practice in reception when working with people from refugee backgrounds.

I feel like it has [made a difference to the patient experience] – I feel like it's probably made us – including the reception staff – more culturally aware. It's very difficult for, I guess, all staff to choose words and speak correctly, and so I feel like just discussing the fact that we've been involved in it and that refugee health is very big and important in our clinic – it has made everyone a bit more aware. Like of the words we use, and how we book interpreters and just things like that at the front desk. Because it's the first thing the patient sees, you know? Like even greeting the patient with a smile, it makes them more inclined to come back.

(practice nurse from participating practice)

The fact that the receptionists were engaged, even informally, and that has enhanced the performance in one practice is really good. Because I do see that the reception is the front point of triaging and seeing the client, so involving the receptionists was excellent.

(settlement services provider)

Recognising and supporting the role of RHGPFs

Refugee health nurses and others working in refugee health have considerable expertise and are valuable resources in building the capacity of general practice. The development of the framework and tools provided an important reference to assist the refugee health nurses working as RHGPFs to communicate with practices.

They now see us as having a role in general practice capacity building and not just as a referral source.

(RHGPF)

To look at that, it really breaks it down into something that you go, 'Yeah, that's exactly it. It's so succinct.' I mean being in the space you know how much is in each one of those, but it just shows it in a really succinct way that makes it even seem a little bit more manageable. I don't think that there's much in it that is new, that we didn't already know, but it is interesting to hear it and see it in one place. And it has clarified a lot of things in my thinking. So that's useful, because if it's clarified my thinking then it's going to help other practice managers.

(mainstream general practice facilitator)

All of the refugee health nurses that acted as RHGPFs in this project acknowledged that general practice engagement was seen as a part of their ongoing role in the Refugee Health Program. There were

various approaches to this. However, all facilitators acknowledged they had limited time and many competing priorities.

... it's a lot of work for a refugee health nurse to do this type of project – and I tell you now, refugee health nurses have a lot of things that they have to be doing. And they'll do, we'll do engagement at an ad hoc level as the need arises but doing something formal is just too time consuming. (RHGPF)

The project agreement ensured that each RHGPF was supported by their organisation to participate in the project for 0.5 days per week for the duration of the project. This meant that time was accounted for in the project, and participation was supported and endorsed by management in the community health service.

Well it's always been part of our role I suppose [general practice engagement], but having the project is really good because also for management to be aware that that is part of our role and it's not just a project – that it is definitely there. And the project has helped us to develop some of those resources that are definitely most needed in the GP practice and in supporting GP practices. (RHGPF)

I think sometimes it's reactive, what we do. And that's just the nature of what we do and the nature of our time constraints. You know, we have in the past, myself and the rest of the team not as often, but tried to go over to our [local] clinic and because they have two registrars come through every year – so we've tried to go over when the new registrars start and have a conversation – but it doesn't happen every year. (RHGPF)

As well as time allocation, there were a number of other supports identified to enable RHGPFs to confidently engage with general practices.

Facilitation role of the Network

The Network provided a facilitation role in the project to bring together, coordinate and negotiate the diverse perspectives of those involved in the project. This included regularly bringing together the PAG and reporting back to the project team, as well as the facilitation of a fortnightly web conference with the project team to maintain momentum and provide a forum for facilitators to provide updates on their practice engagement, share ideas and resources, and troubleshoot common problems.

And it was nice having feedback from PAG and all the GPs and everybody in that – and getting updates from

you [the project facilitator] from those meetings were good because we weren't at them ... And nice thinking of different ways – platforms – different ways that we could engage with practices and even with each other. (RHGPF)

Having Lisa talk to us about it [general practice engagement] – because she's an expert in it, and not just an expert in theory, but she's got practice in place with it as well – and so seeing how she used it, and then having the notes and then having discussions around it as our group, the facilitators and yourself [project facilitator] and various other people ... So yeah, that was good – even when we met up those few times and moving bits of paper around and figuring out how the framework was going to work – that was a big part of the co-creation, that wasn't just us or you – it was everybody, so it was good. (RHGPF)

Ongoing supports for people doing general practice facilitation

When asked what supports RHGPFs felt they needed to do effective general practice capacity building, they identified dedicated time and also skills related to evaluation.

The practice needs to know what they're doing and that it's working ... evaluation is definitely something that I think when you're doing capacity building, gets missed a little bit. (RHGPF)

The PAG and the Network reflected that facilitation skills were essential for effective practice engagement. This includes working with uncertainty, working flexibly and feeling confident in the approach as well as being up to date with clinical and other related information.

... for them to go out and provide that support, they need the ongoing training ... the resources need to be updated. You know, cross-cultural training, updates about different client groups, changing migration patterns. (settlement service provider)

A space for sharing practice about general practice engagement and capacity building was identified by the project team and members of the PAG as a useful support. This was suggested in order to be able to spend a dedicated, short period of time discussing approaches and strategies with others doing general practice engagement, troubleshooting and learning from each other.

I think it would be good to have it as a bit of a ... like a call-in webinar ... around capacity-building skills ... it would be about ... what other people are doing.

People love to know, 'Oh, how are you working with that practice?' (RHGPF)

Working together with Primary Health Networks

During the project nationally funded primary healthcare organisations underwent a major reform, transitioning from Medicare Locals to Primary Health Networks. The PAG had representations from both Medicare Locals and Primary Health Networks, which assisted in keeping up to date with the evolving context. In addition, their involvement brought considerable expertise about practice engagement and facilitating improved practice.

In December 2015, a quality improvement grant round was announced by the Primary Health Network in one of the project areas. One of the general practices working with a RHGPF was successful in receiving a grant for the implementation of quality improvement activities in refugee health. The PHN and RHGPF agreed to work together to support this practice, and this practice developed a detailed action plan. Engagement with the RHGPF has since been intermittent. It is likely that, because the receipt of the grant required greater accountability to the PHN engagement with the PHN has continued, with occasional support from the RHGPF.

This raises an important point about the necessary skill sets required to do general practice engagement in refugee health. The refugee health nurses who acted as RHGPFs developed a unique skill set that included, but was not limited to, clinical skills as well as skills in engaging a range of general practices and facilitating change.

I think the practice is much more inclined to listen to someone who knows the ropes. You can't go and talk to practices about how difficult it is or how to more effectively care for refugee patients, to some extent unless you're actually doing the work.

(refugee health fellow)

While it is important to have up-to-date clinical skills, there are a number of potential benefits of partnerships with the PHNs, including their funding for and expertise in general practice engagement and facilitation; their ability to mainstream some of the work, i.e. orientating practices nurses on how to engage an interpreter during routine practice orientation; and their understanding of broader general practice cycles of accreditation, Commonwealth policy and initiatives targeted at primary care.

Well I think it would be, in some ways, more useful or effective if someone from the PHN was to engage with doctors who they knew were willing to learn in this area, they could kind of highlight some of these things and then if they needed to they could [utilise] the refugee health nurse in that area to help some of the action plan to actually be actioned upon. (RHGPF)

... the PHN to some extent bring the gravitas and power, because they've got money. So they can pour energy and resources into practices [and the]... refugee health nurse [has]... got the nous [clinical skills]. So a partnership with the two is actually really good, because you've got the organisation that's got money and kudos and the person who ... knows how to do the work, working together to gee up the practice – it's much better. (refugee health fellow)

... the practice staff recognise this as a positive approach – that they recognise the need for practice change and culturally appropriate service for refugees and asylum seekers. But that's again assuming that there needs to be an ongoing relationship between practice facilitators and the general practice and it becomes a resource issue. (settlement service provider)

Practice facilitation is a skill set that many PHN staff have. Opportunities exist for PHNs to work more closely with RHGPFs, their roles are complementary. In addition, the tools have been utilised by one Primary Health Network, and their potential for use has been identified in others.

It has crystallised in my mind what we can do from a PHN perspective with practices. It's actually broken it down into some really key things that if we were to develop...a package, as units, and using the tools as part of all of that ... for practices particularly in places like [a Melbourne suburb], that are well meaning and eager, but just don't know where to start. And I was a bit the same, not knowing where to start with them. But the tools are already there. (mainstream general practice facilitator)

Well they are already being used by a Primary Health Network, because I've had lots of conversations with [PHN staff] and I've had a look at their website and I think they've got a link to what you've done, so that's really exciting. So that's definitely being used. And I suppose if the PHN continues to engage with practices there's going to be even more opportunities to promote the tools that have already been developed. And the possibility for more feedback is useful as well. (refugee health fellow)

it's much clearer to us now that the PHNs have a focus on supporting general practice ... and these tools can assist them in their planning and especially in their planning of anything to do with refugee health.

(settlement service provider)

Balancing stakeholder views

Objectives 3 and 4 of the project sought to ensure that development of the approach to engaging general practice was informed by the sector, including those in the refugee health sector and those in primary care and general practice, and that it reflected the needs and priorities of people from refugee backgrounds. This required an ongoing process of negotiation throughout the project to ensure that these diverse perspectives were considered and was both a strength and a challenge in the project. Ongoing negotiation was required to determine what was included in the framework, and the tools and how they were ultimately used.

The process, my sense of that was that it was very collaborative ... what helped I think was having all the perspectives around the table and not just having doctors telling you how things should be done.

(refugee health fellow)

Community voices were sought during the scoping consultations with the AMES community guides and the Foundation House community liaison workers. These perspectives were critical, as outlined in Objective 4, and were sought to ensure the project would meet the needs and priorities of communities from refugee backgrounds. These voices highlighted the critical importance of the reception experience and many of the challenges associated with communication and coordination, with both clinical and non-clinical staff.

I agree on the challenge identified to balance the voices and give privilege or more weight, however I also feel that the voice of the community and the grass roots, that was really unique and important. (settlement services provider)

This led to understanding that a whole-of-practice approach to general practice engagement was essential, and assisted in the identification of the three key areas in the Framework for Continuing Improvement: clinical care; coordination and management; and communication.

As the project progressed, the voices of the multi-sectoral PAG and those of RHGPFs were critical to the development of the tools to support practice-based change.

Identifying the priority practice skills and systems in refugee health for inclusion in the framework was contested and therefore time consuming. Diverse perspectives had ongoing representation in the project, creating challenges in determining what should be included in the framework and what weight they should be given.

When you work day in day out in the [refugee health] space you go, 'No you must do this, you must do that, but actually no, just make sure you can communicate with the patient – let's make sure that you boil it down into something that's a bit more practical. Because if you make it too big it's not going to happen – we all know that, because it's overwhelming for practices.

(mainstream general practice facilitator)

Some voices reflected in depth knowledge of the context of general practice, while others reflected significant expertise in working with people from refugee backgrounds. Those in the refugee health sector tended to be more inclusive when determining which elements of refugee health practice were foundational to support the delivery of primary health care to people from refugee backgrounds (see Section 2).

It was difficult to mediate this process but was essential in order to ensure the development of a practical approach that could be utilised with practices who had varying degrees of experience in working with people from refugee backgrounds. Bringing such a diverse group of stakeholders together allowed for a rich and deep understanding of a range of perspectives, and the lengthy process of compromise and consensus led to the development of a nuanced framework that can be utilised in a range of approaches to general practice engagement.

It was very much a group effort and there was a sense of being heard and being listened to in the process.

(mainstream general practice facilitator)



Conclusion

I'm very excited about this. Because I do think for refugees and asylum seekers to be empowered to access primary care, it's not only through the hospital or the local community health services. When they're accessing the health system in Australia the general practice is the most sustainable. (settlement service provider)

This project had four key objectives related to the development and trialling of an approach to engaging and supporting general practice in refugee health. These objectives ensured the approach was informed by both the evidence base and the practice experience of the refugee health and primary care sectors, and that it was reflective of community needs and priorities.

This report reflects the achievement of these objectives throughout the course of the two years during which this project occurred. The broad consultation and mixed methods included in the scoping phase allowed for the understanding and documentation of the approaches to engaging and supporting general practice in refugee health in Victoria (Objective 1). This process and the ongoing engagement of a multi-sectoral PAG ensured that the project was informed by the primary care sector, including general practice (Objective 3). In addition, the community perspectives that were sought during this phase informed the framework and the whole-of-practice approach (Objective 4).

The findings in this report suggest general practice engagement should be practical, flexible and based on the needs, priorities and resources of the practice. The findings also illustrate that using co-creation principles encourages a strengths-based approach to practice change.

While general practice engagement is seen as a part of many people's roles in the refugee health sector, there are specific and unique skills and supports required to do this effectively. The framework and tools provide guidance, and the findings demonstrate that there are additional supports that are required to ensure the approach is effective in engaging and supporting general practice in the delivery of accessible and appropriate health care to people from refugee backgrounds.

While this was a two-year project, considerable time was spent scoping and developing the tools. This left less time for practice engagement than was originally planned. For those wishing to resource similar work, it is estimated that for a RHGPF to engage two new practices, complete the facilitated interviews, develop

and implement an action plan and evaluate the practice change that 12 months would be a reasonable time frame that considers a full-time role with 0.5 days per week for general practice engagement.

Limitations of the project included that refugee health fellows and PHN practice facilitation staff were not included as RHGPFs in the project team, that community consultation only occurred once, and the sample size with which the approach was trialled was very small. Further depth may have been added if a refugee health fellow and a PHN practice facilitator were part of the project team and acted as RHGPFs, engaging practices throughout the trialling phase and bringing experiences of using the tools to the project meetings. Furthermore, community consultation only happened in the scoping phase; it would have been valuable to receive community feedback on the framework after it had been developed, particularly when assessing whether skills and systems were foundational or additional. Lastly, it would have assisted with the strength of the project finding to have more completed general practice action plans.

Additional developmental work, including research, is required to add to the evidence base around meaningful indicators that measure general practice performance in delivering health care to people from refugee backgrounds. This project had hoped to uncover practice-based indicators to measure change in practice related to the delivery of health care to people from refugee backgrounds. This was difficult to facilitate in several practices and is in progress with others as they develop and implement their action plans. Further developmental work would assist both practices and RHGPFs to identify and measure relevant indicators based on their available data sources within the practice. This would help to demonstrate more concrete outcomes of practice facilitation and of the strategies included in the action plans.

Further work is needed to understand the optimal skill set for refugee health general practice facilitation, particularly the balance between clinical skills in refugee health and general practice facilitation skills. A greater understanding of the unique skills and the balance required could uncover the potential for partnership work between those with clinical skills in refugee health and those with practice facilitation expertise.

The suite of tools developed during this project was carefully refined over many iterations by a multi-sectoral group. While all RHGPFs in this project were

Conclusion

refugee health nurses, it is hoped that the resources have broader application to others doing refugee health general practice facilitation. The framework and tools provide guidance to general practices and to general practice facilitators, and can be used by facilitators in a range of roles including refugee health nurses, refugee health fellows and Primary Health Network staff. It is hoped that they are picked up, adapted where necessary and utilised by others in order to engage more general practices in the delivery of health care to people from refugee backgrounds. They are also ideal for supporting joint work undertaken between PHNs and the refugee health sector.

it puts fire in the belly and that's a good thing.

(mainstream general practice facilitator)

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Appendixes

Appendix 1: Historical and current work to support general practice in refugee health

There are considerable existing and historical supports for general practice to work in refugee health, and these have been mapped below. Please note this was developed in December 2014.

Year	North	East	South	West
2002	Refugee Health and General Practice Development Program http://refugeehealthnetwork.org.au/wp-content/uploads/GP-Final-Report.pdf			
2004	Diversity Unit established, Department of Human Services First refugee health action plan developed			
2005	Refugee Health Assessment Item introduced to Medicare Benefits Schedule http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare_mbsitem_refugees Subsumed into general health assessment items in 2010 with same guidelines			
2005-present	Refugee Health Nurse Program http://www.health.vic.gov.au/pch/refugee/nurse_program.htm <ul style="list-style-type: none"> RHNs are located in the four NW region CHCs. The RHNs from ISIS work mainly with private general practices; Western Region Health Care works mostly with community health general practices; Dianella works mainly with mostly private general practices and has an RHN based in the general practice connected to the CHC. Plenty Valley Community Health is currently developing its service. RHNs provide general practice liaison which involves: <ul style="list-style-type: none"> RHNs receive referrals for people of refugee background or asylum seekers with more complex needs from general practices and work to coordinate their health assessment and care. RHNs initiate and maintain partnerships with private general practices. They provide a service that works in close collaboration and communication with settlement services, general practices, specialist services and allied health services. RHNs provide education to service users regarding the health systems and understanding of access issues and referral pathways into community health. http://refugeehealthnetwork.org.au/refer/refugee-health-nurse-program http://www.health.vic.gov.au/pch/downloads/rhnp.pdf			
2005-present	Professional Development for Nurses (Foundation House and statewide refugee health nurse facilitator) <ul style="list-style-type: none"> Training for nurses implemented in partnership with the statewide refugee health nurse facilitator, including: a two-day 'Introduction to Refugee Health for Nurses' course; a rotating one-day workshop for nurses in paediatric and adolescent health, men's health, women's health and sexual and reproductive health, infectious diseases over two years; and a networking support days for refugee health nurses. Expanded to allied health in 2014. Partnership with Monash University in writing and delivering postgraduate online unit in Refugee Health and Wellbeing Statewide RHN facilitator is developing short courses for health workers in partnership with Monash University. http://www.foundationhouse.org.au/home/index.html			
2005-present	Professional Development for General Practitioners (General Practice Divisions – Medicare Locals and VRHN) General practice annual forums and/or seminar series, with overtime supported by Medicare Locals and VRHN			
2006-2009	General Practice Active Learning Modules Foundation House developed a 6-hour active learning module – RACGP approved, mental health points.			
2005-2009	Primary Care Partnerships Service Coordination projects Project funding by DoH to develop local area service coordination projects in areas of significant settlement including general practice Resources include: <ul style="list-style-type: none"> HealthWest PCP – Complex Service Coordination model; complexity screen http://www.health.vic.gov.au/pch/downloads/refugee_sc_manual.pdf Various GP practice manuals and training opportunities			
2007-present	Victorian Refugee Health Network (established in 2007) Network established in 2007 to build the capacity of Victorian health sector to respond to health concerns experienced by people of refugee background. Resources include: <ul style="list-style-type: none"> A library of resources on the Network website and a monthly e-Bulletin The Network's resources for health providers: <ul style="list-style-type: none"> An Initial Health Assessment Template – developed by General Practice Victoria (updated in partnership with VRHN) Comprehensive guide for General Practitioners – 'Promoting Refugee Health: A Guide for Doctors, Nurses and other Health Care Providers Caring for People from Refugee Background' Desktop guide for general practices – 'Caring for Refugee Patients in General Practice: A Desktop Guide' Advocacy around the MBS items relating to health care for people of refugee background and asylum seekers, including greater role for practice nurses and bicultural workers, and interpreting funding for MBS-funded allied health http://refugeehealthnetwork.org.au 			

Year	North	East	South	West
2007-2014	<p>Victorian Refugee Health Network – various working groups focusing on primary care, including GP Working Group, initial health assessment, and ongoing care and primary health working groups. Various initiatives and fact sheets produced, including:</p> <ul style="list-style-type: none"> Referral protocol between AMES and GPs developed http://refugeehealthnetwork.org.au/wp-content/uploads/GP-Settlement-Provider-Communication-Flowchart_FINAL1.pdf Background paper – http://refugeehealthnetwork.org.au/wp-content/uploads/2008_Initialhealthassessment_backgroundpaper.pdf 			
2009	<p>Access to specialist services by refugees in Victoria report http://refugeehealthnetwork.org.au/access-to-specialist-services-by-refugees-in-victoria/ Describes service models in Victoria</p>			
ongoing	<p>RACGP Special Interest Group on Refugee Health An Australia-wide network of general practitioners interested in refugee and asylum seeker health. This group is considering the development of a 6-hour active learning module in refugee health, building on an earlier module developed by Foundation House and delivered in partnership with GP Divisions (at the time) http://www.racgp.org.au http://www.racgp.org.au/support/library/subject-portals/refugee http://www.racgp.org.au/download/Documents/NFSI/nfsirefugeehealthig.pdf</p>			
2009-present	<p>Refugee Health Research Consortium Dandenong health data report (2009) http://www.monashhealth.org/icms_docs/6619_Southern_Academic_Primary_Care_Research_Unit_Report.pdf http://www.ceh.org.au/downloads/Diversity_in_Health/Posters/A202_Cheng_poster.pdf Framework for primary care – including appendixes (2013) http://files.aphcri.anu.edu.au/reports/Grant%20RUSSELLFinal%20Report.pdf</p>			
	<p>Australian Primary Care Research Institute – IMPACT study http://www.med.monash.edu.au/sphc/research/research-assets/sapcru-bmedsc-student-projects-2015.pdf http://www.med.monash.edu.au/sphc/impact/</p>			
2011-present	<p>Medicare Locals (ML) - Resources to support general practice and primary care, varies within each ML All ML – Strategic planning around population need</p>			
	<p>INNWML & NMML Education, screening and appropriate referrals; builds relationships and referral pathways between settlement services and general practices; and keeps a list of general practices with skill and experience in working with people of refugee background and asylum seekers.</p> <p>GP training – mental health http://www.nmml.org.au/page/Events__Education/Past_Events/Healing_in_a_new_land</p>	<p>Eastern Medicare Local Inner East Medicare Local</p>	<p>SEMML Conducts research in the area of refugee population health; training, referral support and advice for general practice staff.</p> <p>GP Refugee Health Saturday Seminar Partnership with SEMML, Northern Division of GPs and PivotWest</p>	<p>SWMML and MR&NWML General Practitioner capacity building and training (Dr. Karen Linton, General Practitioner one day per week. GP outreach sessions, training stations, asylum seeker group sessions run by medical students, refugee health clinic establishment in 4 general practices... http://mrnwm-ml.org.au/refugee-health/</p>
2012	<p>Communication Guide for GPs and settlement services http://refugeehealthnetwork.org.au/wp-content/uploads/GP-Settlement-Provider-Communication-Flowchart_FINAL1.pdf</p> <p>Promoting Refugee Health: a guide for doctors, nurses and other health care providers (4th edition) – (first edition 1998) http://refugeehealthnetwork.org.au/wp-content/uploads/PRH-online-edition_July2012.pdf Refugee Health Assessment pro forma update (1st edition 2009 by General Practice Victoria)</p>			
2012	<p>Practice Nurse Incentive Program introduced (not refugee specific) https://www.medicareaustralia.gov.au/provider/incentives/files/9689-1208en.pdf</p>			
	<p>CEH – Cultural competency tools http://www.caldgroup.com.au/pdf/Working%20Effectively%20with%20Interpreters%20in%20Private%20General%20Practice.pdf</p>			
2009-present	<p>Refugee Health Fellows (RHF) RHF provides advice, secondary consultation and liaison for general practice staff regarding health issues common to people from refugee backgrounds and asylum seekers.</p> <ul style="list-style-type: none"> Provides education for general practice staff. <p>http://refugeehealthnetwork.org.au/engage/engage-sub-page/ http://www.rch.org.au/uploadedFiles/Main/Content/immigranthealth/Refugee%20Health%20Fellows.pdf</p>			

Appendices

Year	North	East	South	West
2014	Refugee Health Clinical Hub Clinical database (Cloud-based) <ul style="list-style-type: none"> • RMH, RCH, Barwon, Monash Health • GP Portal • Working on consumer portal http://health.vic.gov.au/telehealth/refugee-health.htm			
2014	Bridging the Gap – maternity focused, but refugee health nurses involved – MCH, Maternity, perhaps GPs in future http://www.mcric.edu.au/research/research-projects/bridging-the-gap/			
2014	Victorian Refugee Health Network Primary Care Forum 2014 http://refugeehealthnetwork.org.au/primary-health-care-forum-2014-report-and-powerpoints/			

Key*

Service coordination/relationships

GP training

GP Support

Research

Resources

Community Advisory Groups

- SEMML – service literacy project with Afghan community
- Chin Groups meeting at EACH
- Foundation House – Children and Families focus – Service Literacy program

* An attempt has been made to highlight various aspects of GP support. However, many programs overlap between categories.

Appendix 2: Victorian Refugee Health Network Primary Care Project: Consultation Strategy

Aim

To build the capacity of general practice for people from refugee backgrounds in a way that is meaningful for communities and engaging for service providers.

Objective

To consult with a range of stakeholders in order to strengthen understanding of the issues related to refugee health in general practice (and inform development and implementation of the model at various stages throughout the life of the project).

Defining consultation

The Centre for Culture, Ethnicity and Health (2011) has defined consultation as 'participation in a structured discussion where knowledge is shared on a particular topic'. This may occur in a number of ways, including focus groups, forums, community consultations, stakeholder interviews and surveys.

A key objective of the project is to ensure that the project both informs and is informed by the primary care sector in order to support uptake and sustainability; and that development of the project meets community needs and priorities. Consultation will be used to ensure that broad views are represented, including those from rural and regional areas, those from a diverse range of perspectives within general practice and primary care and those from refugee backgrounds and service users.

A range of consultation and feedback strategies will be used as appropriate for the diverse stakeholders in this project.

Ethical considerations

To ensure the project consultation processes are conducted in an ethical manner, an ethics application will be submitted to the Victorian Foundation for Survivors of Torture Institutional Ethics Committee. Those consulted will do so in their paid work roles, and appropriate mechanisms for the communication of progress will be considered.

In addition to this, the project team will ensure that those whose input is required are not over-consulted if there are existing available sources of information. The project team will use other documented consultation processes where appropriate.

STRATEGY 1: To convene a project advisory group with broad representation from those with knowledge, experience and expertise in the refugee health sector, including research, the primary care sector, including general practice, government departments, settlement services and others as determined by the group.

STRATEGY 2: To consult with settlement community guides and Foundation House community liaison workers to identify issues and priorities from the community perspective.

STRATEGY 3: To conduct a teleconference with regional and rural Medicare Locals, refugee health nurses and key general practices in order to scope issues, inform approaches and identify potential pilot sites and project advisory group representation.

STRATEGY 4: To consult with research experts to ensure rigour throughout the project and co-author research publications.

STRATEGY 5: To consult with stakeholders and experts as required throughout the project.

STRATEGY 6: To document consultation findings, with ethics approval, throughout the project.

STRATEGY 7: To store all data collected securely on a password-protected computer.

Feedback methods

Feedback methods will be determined by stakeholders using a range of methods. The project advisory group will receive action oriented meeting minutes, and feedback will occur during meetings. Stakeholders will receive feedback and updates of project progress through the Primary Care Project Page on the network website, Primary Care Forum, eBulletins, and regional and other meetings. Community advisers and others who have participated in consultation will receive feedback in a way that is determined to be most appropriate by them during the consultation process.

Centre for Culture, Ethnicity and Health, 2011, 'Consumer Participation Strategies', http://www.ceh.org.au/downloads/CEH_TipSheet4_Mar2011_Web.pdf, accessed 07/01/2015.