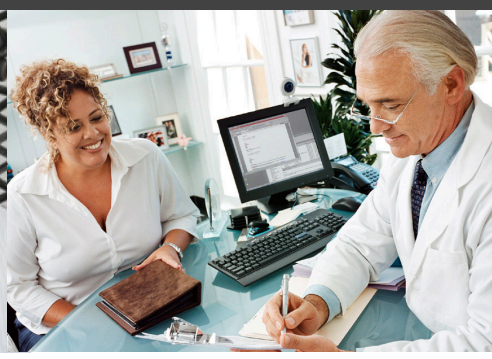
Digital Regions Initiative
cdmNet Australia

Final Report
July 2009 – September 2012



precedence
healthcare

Australian Government

Department of Broadband, Communications and the Digital Economy

DIGITAL REGIONS INITIATIVE – FINAL REPORT
PROJECT NAME: CDMNET AUSTRALIA
PERIOD COVERED: JULY 2009 TO SEPTEMBER 2012

Participating Authority	Barwon Health
Project Partners	Cisco Ballarat and District Division of General Practice (Grampians Medicare Local) Central Queensland Rural Division of General Practice Diabetes Australia Victoria Fred Health General Practice Association of Geelong (Barwon Medicare Local) General Practice Victoria GP Links Wide Bay (Wide Bay Medicare Local) Goulburn Valley Division of General Practice (Goulburn Valley Medicare Local) GP South (Tasmania Medicare Local) Monash University Murray Plains Division of General Practice (Lodden Mallee Murray Medicare Local) Precedence Health Care Queensland Health RHealth West Vic Division of General Practice (Grampians Medicare Local)
Geographical area covered	Victoria – Goulburn Valley, Murray Valley, Grampians , Ballarat, Geelong Tasmania – Hobart region Queensland – Southern and central Queensland Western Australia – South-west
Sector	Health
Funding amount	Commonwealth: $4,000,000 Matching: $8,485,828
Has the project been completed?	Yes

Project Overview

Executive Summary

The cdmNet Australia project used innovative digital technologies to tackle the most urgent and challenging global problem in healthcare: the prevention and management of chronic disease. The project targeted regional, rural and remote regions of Victoria, Queensland, Tasmania, and Western Australia, covering a population of over 1.2 million and addressing a major gap in service delivery in those regions.

Chronic illness is common, costly and increasing in Australia. Over 33% of Australians have one or more chronic diseases and in 2008, chronic diseases were the underlying cause in 75% of deaths. In 2003, almost half of healthy living time that was lost due to the burden of disease and injury was due to chronic disease. More than 7 million Australians have a chronic disease at a cost to the health care system of more than $60b per year.

This project aimed to create a new paradigm of healthcare delivery and management, enabled by digital technologies, that would transform the management of healthcare and in particular the treatment of chronic disease. This new paradigm is information based, allows connection between all the relevant players, coordinated, and non silo-based: in essence where the treatment of care is coordinated across the healthcare value chain.

The project built upon the cdmNet (Chronic Disease Management Network) technology trialled in an earlier Clever Networks project. cdmNet is a broadband ("cloud") service that automates the entire chronic disease care management process in primary care, from the creation of individualised care plans to review and follow up, continuously monitoring the care of the patient in real time across the whole care team.

The primary outcomes of the project were:

- The rollout a network of digital healthcare services based on innovative broadband and mobile technologies across regional, rural and remote communities in all states of Australia
- A transformational change in the delivery of chronic disease management services in these regions;
- Expansion of the digital healthcare services by linking with other major national and state initiatives in these regions and establishing a network of high priority e-health solutions including telehealth, pharmacy services, and the national eHealth infrastructure; and
- Provision of data sets of previously unavailable health and service-use information for chronic disease management in the primary care setting.

Since the baseline in December 2009, there have been 24,000 new registrations on cdmNet with 85% from regional, rural, and remote regions of Australia. Over 1,700 GPs and 3,600 Allied Health providers and specialists across Australia are registered on cdmNet.

Chronic disease management is encouraged in primary care with specific Medicare Benefits Schedule (MBS) items associated with delivering chronic disease management services. cdmNet facilitated the provision of these services, with more than 22,000 Health care provider appointments and 26,000 chronic disease MBS items delivered over the project period.

Effecting clinical changes in chronic disease is notoriously difficult. However, the research study conducted by Monash University of patients with diabetes found substantial and statistically significant improvements in key clinical measures through the use of cdmNet:

- Patients of cdmNet users demonstrated significant improvements in clinical outcomes with lower HbA1c, lower blood pressure, lower LDL and total cholesterol over a 13 month period.
- 80% of patients of cdmNet users had regular follow up and review compared to the national average of 20% by non-users of cdmNet. This will help address one of the major deficits in the current approach to chronic care.
- GPs using cdmNet for performing reviews achieved a 90% compliance with best-practice guidelines compared to a 50% compliance by GPs who do not do regular reviews.
- GP Practice productivity more than doubled using cdmNet.

The health care industry is evidence driven and data that supports the benefit of systematic care has hitherto been difficult to obtain. The role of cdmNet in gathering this data while supporting best practice care for patients with chronic disease has the potential to benefit Medicare Locals in addressing local healthcare needs and to inform national policy.

This project implemented a network of innovative digital healthcare technologies and services that leverage one another and will further expand with the implementation of the National Broadband Network. These innovations included important enhancements to the cdmNet service to improve the disease management workflow and make compliance with best practice care easier.

In addition to the core cdmNet capability, project partners linked cdmNet to other digital healthcare technologies including CISCO Webex collaborative telehealth services and Fred Dispense pharmacy systems.

Integration with Cisco Webex provided cdmNet users the ability to easily communicate via video with other care team members and patients in case conferences and consultations. The integration with cdmNet is the first known example of a telehealth capability fully integrated into a patient's plan of care and shared health record.

With the integration to Fred Dispense, pharmacists can now see the entire health record, care plan and progress notes of their chronically ill customers. Enabling pharmacists to participate in the management of these patients as informed team members is a major transformation in the role of pharmacists in primary care and will drive further uptake of health services delivered and supported by the NBN.

Additionally, interfaces between cdmNet and the Personally Controlled Electronic Health Record (PCEHR) and the National eHealth Infrastructure were developed during the project period. cdmNet services were also integrated with a CSIRO home monitoring technology that uses low cost mobile devices. Each of these innovations has the potential to transform health care delivery and further leverage the value of the NBN.

Activities in this project were directed at meeting a service gap in providing best quality care to patients with chronic disease. cdmNet is now available across Australia. The project has extended the uptake of and access to cdmNet to provide best practice care for chronic disease management and the use of efficient work practices across Australia.

The use of cdmNet has directly addressed Australia's health and workforce reform agendas, leading to improved quality and safety of care, increased efficiency of the health system, more equitable access, reduced healthcare costs, and increased workforce productivity.

cdmNet is sustained by a proven business model for providing its chronic disease management services. The market will drive the long-term sustainability of this service. As a productivity tool, there is no net cost to the government or providers for adopting cdmNet, offering a win-win solution to one of the greatest challenges to our healthcare system.

1. Introduction

The cdmNet Australia project aimed to use innovative digital technologies to tackle the most urgent and challenging global problem in healthcare: the prevention and management of chronic disease. The project targeted regional, rural and remote regions of Victoria, Queensland, Tasmania, and Western Australia, covering a population of over 1.2 million and addressing a major gap in service delivery in those regions.

Chronic illness is common, costly and increasing in Australia. More than 7 million Australians have a chronic disease at a cost to the health care system of more than $60b per year (~60% of the system costs) [1]. More than half of all potentially preventable hospitalisations are related to common chronic conditions [2]. Chronic disease is a huge community and personal burden on those with disease and the underlying cause in 75% of deaths in Australia [3]. In 2003, almost half of healthy living time that was lost due to the burden of disease and injury was due to chronic disease [4].

The treatment and management of chronic disease is recognized as being highly complex, unsustainable, inefficient, uncoordinated, and silo-based with limited sharing of information. This has led to gross inefficiencies in the system, suboptimal healthcare outcomes and escalating costs to the key players in the value chain. Unless the industry looks at a new paradigm, the healthcare system will be unsustainable in the future.

This project aimed to create a new paradigm of healthcare delivery and management, enabled by digital technologies, that would transform the management of healthcare and in particular the treatment of chronic disease. This new paradigm is information based, allows connection between all the relevant players, coordinated, and non silo-based: in essence where the treatment of care is coordinated across the healthcare value chain.

Against this background there is widespread recognition that coordinated and collaborative care and better use of information technology could play a critical enabling role in improving the efficiency and effectiveness of the healthcare system. There is also recognition that this approach will allow patients to be more proactively involved in the management of their health which will ultimately lead to better, more informed healthcare outcomes.

Barwon Health was the lead agency for the project with Precedence Health Care responsible for its management. The other partners included nine Divisions of General Practice in Tasmania, Queensland, and Victoria; General Practice Victoria; Diabetes Australia Victoria, Fred Health, Cisco Systems, Queensland Health, Southern Health, and Monash University.

cdmNet

The project builds on the cdmNet (Chronic Disease Management Network) technology trialled in an earlier Clever Networks project [5]. cdmNet is a broadband ("cloud") service that links general practitioners and their patients to allied health care teams. It automates the entire care management process, from the creation of individualised care plans to review and follow up, continuously monitoring the care of the patient in real time across the whole care team. It removes the complexity associated with the management of chronic disease and compliance with Medicare requirements, maximising the effectiveness and efficiency of the practice.

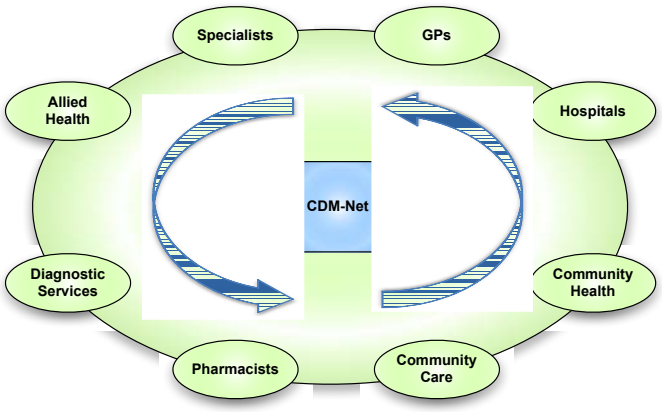


Figure 1 - cdmNet manages communication and work processes for the entire life cycle of chronic disease

cdmNet allows practices to take a systematic, evidence-based approach to the management of their entire population of chronically ill patients without the heavy overheads this usually involves. Central to this transformation of care is the adoption and support of a widely accepted, evidence based approach to chronic disease management – the Chronic Care Model (CCM)[6].

"Many managed care and integrated delivery systems have taken a great interest in correcting the many deficiencies in current management of diseases such as diabetes, heart disease, depression, asthma and others. Those deficiencies include:

- Rushed practitioners not following established practice guidelines
- Lack of care coordination
- Lack of active follow-up to ensure the best outcomes
- Patients inadequately trained to manage their illnesses

Overcoming these deficiencies will require nothing less than a transformation of health care, from a system that is essentially reactive - responding mainly when a person is sick - to one that is proactive and focused on keeping a person as healthy as possible"[6].

cdmNet supports the following key elements of chronic disease management:

- Planning
- Collaboration (team care)
- Monitoring
- Review (follow-up)
- Patient self management
- Documentation
- Compliance (with the plan and with Medicare requirements)

These elements have been identified in the CCM as core elements essential to the management of chronic disease and are recommended by the Royal Australian College of General Practitioners.

2. Project outcomes and benefits

The primary outcomes of the project were the:

- Rollout a network of digital healthcare services based on innovative broadband and mobile technologies across regional, rural and remote communities in all states of Australia;
- Transformational change in the delivery of chronic disease management (CDM) services in these regions;
- Expansion of the digital healthcare services by linking with other major national and state initiatives in these regions and establishing a network of high priority e-health solutions including telehealth, pharmacy services, and the national eHealth infrastructure; and
- Provision of data sets of previously unavailable health and service-use information for CDM in the primary care setting.

The benefits of the project accrued to multiple stakeholders, including:

- Patient /consumer: Better health outcomes; increased self-management support; reduced community/carer burden; improved quality of life; and improved accessibility to care.
- GPs, Allied Health, Specialists, pharmacists: Higher quality, safer care; increased adherence to best practice care; higher financial returns.
- Hospitals, community services, day clinics: Better coordination with primary care; reduced adverse events; fewer admissions and shorter length of stay.
- Payers: More efficient care; lower costs; improved health outcomes; comprehensive evidence-base for CDM; broader workforce involvement, thereby ameliorating the growing shortage of skilled healthcare professionals.
- Employers: Reduced sick days, improved workforce productivity and participation.
- Industry: Seeding of a new industry in the emerging US$60B collaborative-care market worth $1B domestically and $1.2B in exports per annum based on innovative digital health services and technologies.
- Research/policy organisations: Access to previously unavailable primary healthcare data for developing policy and models of care, education, and training.
- Communities: Improved skills and retention of professionals by facilitating best-practice locally-based collaborative care; increased employment opportunities for individuals to assist in the design and delivery of CDM-Net services and spur the development of local broadband-based businesses.

The basis for these benefits are described below.

Uptake and usage

Since the baseline in December 2009 there have been 24,000 new registrations on cdmNet with 85% from regional, rural, and remote regions of Australia. Over 1,700 GPs and 3,600 Allied Health providers and specialists across Australia are registered on cdmNet.

Chronic disease management is encouraged in primary care with specific Medicare Chronic Disease Management (CDM) items associated with delivering the services. cdmNet facilitated the provision of these services, with more than 22,000 Health care provider appointments and 26,000 chronic disease Medicare Benefits Schedule (MBS) items: General Practice Management Plans, (GPMPs),

Team Care Arrangements (TCAs), Reviews of the GPMP and TCA, and Home Medicine Reviews delivered over the project period.

cdmNet enabled general practices to create these plans more easily and to review these plans more regularly, providing more systematic care and promoting better adherence with plans by patients. For patients on multiple medications, Home Medicine Reviews (HMR) were more frequently requested by GPs and more frequently provided by pharmacists, helping minimize adverse events from medication problems.

cdmNet increased communication and collaboration among a patient's care team and with the patient themselves. cdmNet also provides processes and alerts that help healthcare providers deliver best-practice care and allows patients to be part of, have access to, and be informed of the goals and tasks involved in their care.

Healthcare providers have logged into cdmNet 74,000 times and viewed over 3.1 million pages of cdmNet, showing the degree of collaborative activity and systematic care underway. Nearly one million of the page views were Practice Nurses or Practice Managers who manage much of the chronic disease process. Improving the efficiency of CDM delivery by practice nurses has been a major benefit to practices and their patients.

Over 17,000 patients have been registered for cdmNet. These patients received over 70,000 sms and email reminders about their chronic disease plans and tasks. They logged in over 6,000 times and had over 33,000 page views of cdmNet. Including the patient in the team, providing access to their plans and health record, and receiving notifications and reminders is an important part of chronic care model.

Clinical outcomes

The independent study conducted by Monash University investigated the use of cdmNet for the management of diabetes mellitus (types 1 and 2). Effecting clinical changes in chronic disease is notoriously difficult and yet the study found substantial and statistically significant improvements in key clinical measures through the use of cdmNet. The measure of diabetes control that improved were:

- HbA1c (7.2 to 6.9%, $p<.001$);
- systolic blood pressure (139 to 136 mm/Hg, $p<.01$);
- total cholesterol (4.5 to 4.2 mmol/L, $p<.001$); and
- LDL (2.5 to 2.2 mmol/L, $p<.001$).

The clinical improvement were even greater for patients whose baseline clinical values were higher than the recommended targets:

- HbA1c (8.5 to 7.5%, $p<.001$),
- systolic blood pressure (153 to 141 mm/Hg, $p<.001$),
- diastolic blood pressure (89 to 82 mm/Hg, $p<.001$), and
- total cholesterol (5.1 to 4.6 mmol/L, $p<.001$).

These clinical outcomes indicate improved health and a reduction in the burden of disease, which should result in decreased costs to the health care system.

Process outcomes

Process outcomes are based on meeting the key elements of the Chronic Care Model: Following best practice guidelines, collaboration among the care team, regular monitoring and review of the patient, and support for patient self management. Users of cdmNet achieved improvements in all these processes.

Compliance with best practice guidelines

Monash University evaluated these process outcomes using measures from both the UK-based Quality and Outcome Framework (QOF) and Australian diabetes management guidelines. The results show that the required clinical data was recorded for 85-95% of patients on a cdmNet care plan and cdmNet users showed very large improvements in the processes of providing best practice according to the guidelines.

Collaborative (team) care

Users of cdmNet created more Team Care Arrangements (TCAs) than the national average, reducing the number of care plans without a TCA by half. cdmNet may make the process simpler and enable more efficient creation and management of TCAs.

Regular monitoring and review

The usual manual processes involved in chasing and collating the information to conduct a review has meant that few GPs regularly review their patients' progress against their care plans. Using cdmNet, the number of GPs who regularly reviewed their patients was four times the national average based on Medicare data (80% vs 20%). In addition, the results show that patients who received regular reviews complied with best practice guidelines more than the those who did not receive reviews (85% vs 44% respectively). The study also found that the monitoring and reviewing of patients statistically improved the key clinical outcomes of patients.

These measures of clinical improvement not only result in improved quality of life for people suffering chronic illness, but also are likely to result in improved long term outcomes such as reductions in limb amputations, blindness, and chronic kidney disease.

Innovative digital enablement

This project implemented a network of innovative broadband-based digital technologies and services that leverage one another and will further expand with the implementation of the National Broadband Network.

These innovations included important enhancements to the cdmNet service to improve the disease management workflow and make compliance with best practice care easier. In addition, computer desktop components were created to improve the interoperability of the major GP software systems with the cdmNet "cloud" services, facilitating GP engagement.

In addition to the core cdmNet capability, project partners created links between cdmNet and technologies including CISCO Webex collaborative telehealth services and Fred Dispense pharmacy systems. Additionally, interfaces between cdmNet and the Personally Controlled Electronic Health

Record (PCEHR) and National eHealth Infrastructure were developed during the project period. cdmNet services were also integrated with a CSIRO home monitoring technology that uses mobile devices.

This network of digital services based on cdmNet is now reaching a "tipping point" with a critical mass of health providers that will further escalate uptake. In the longer term, this helps establish Australia as a key contributor to a global market in digital collaborative health services worth over $60B [5].

Enabling increased access to services in rural, regional and remote Australia

Systematic, collaborative longitudinal care is key to overcoming the challenge of chronic disease and building a sustainable healthcare system. This can only be accomplished with the use of digitally-enabled services. This project has implemented broadband-based technologies to overcome this problem by extending cdmNet into rural and regional Australia, and increasing the number of patients who have plans to manage their chronic diseases and improve their health outcomes.

As a result of the project, broadband-based, systematic chronic disease management services have been introduced to rural, regional and remote parts of Australia that were previously relying on inefficient and ineffective manual processes.

With support from the Divisions of General practice, this led to increased involvement of the rural workforce and regional population in chronic disease planning and management. This activity has increased the awareness of the benefits that information technologies and the National Broadband Network can bring to their communities and increased ehealth and telehealth use for the benefit of regional communities.

The impact of Digital Health and the NBN on a small rural town

An interesting anecdote from one of the project target rollout regions provides some insight into the potential impact of the NBN and the cdmNet technology. A GP in rural Tasmania used cdmNet to create plans for her chronic disease patients. Because cdmNet increased her productivity she was able to put many more patients on to plans and refer them to allied health providers in a systematic way. This increase in organised activity meant that the allied health providers started visiting the town regularly to provide health care services, whereas in the past patients had to travel up to 2 hours to receive these services. Not only did that save time and difficulty, but the visiting allied health providers used local services in the town, which gave a boost to the local economy. The GP is now a heroine in town, with happy patients and happy shopkeepers.

A new source of data for service improvement and policy development

The health and service use information that has been gathered using cdmNet is unique. For the first time, longitudinal de-identified data relating planned and actual service use with clinical outcomes for individual patients in the primary care sector is available. This data will support research to grow the base of evidence for collaborative care and analysis will support service improvement and rational policy development.

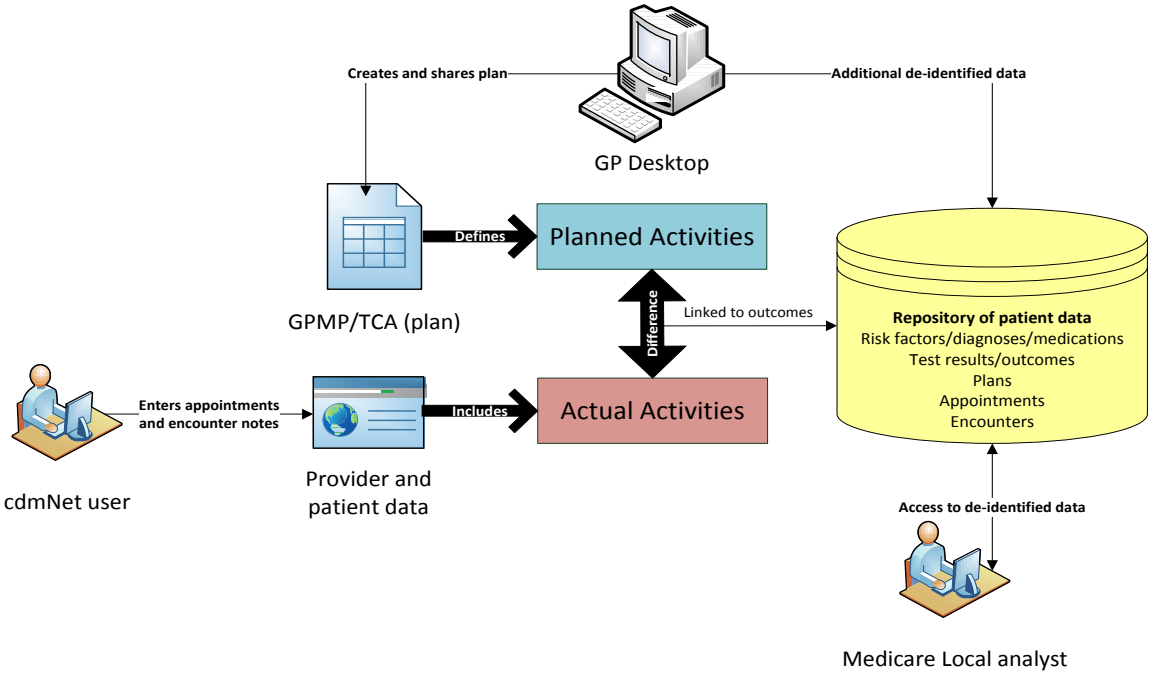


Figure 2. Linked clinical and service delivery data

3. Government priorities

The project activities addressed national and state government priorities for health in regional and rural Australia. The primary priorities are described below.

Commonwealth priorities

Implementation of cdmNet helped address the following Strategies:

The National E-Heath strategy [7]

cdmNet is strongly aligned with the National e-Health Strategy and the standards being progressively developed by NeHTA. The cdmNet architecture is based on NeHTA's recommended service-oriented approach to the design of the National E-Health Infrastructure (NEHI) and the applications that use it. cdmNet complies with the standards and requirements for foundation e-health components, including healthcare identifiers, healthcare provider directories and authentication services.

The modular, service-oriented architecture of cdmNet ensures that any new standards can be readily incorporated. Such standards include:

- The National Health Data Dictionary and Snomed terminology
- Messaging and communications, such as NeHTA Web Services Architecture
- Security, authorisation and authentication (NASH)
- Message content (CDA).

The cdmNet services, including the integrated telehealth are electronic consultation services, directly address the National eHealth Strategy Priority Solutions for service delivery; namely "Encouraging development of specific tools that improve the management of chronic disease and the accessibility of care delivery. Chronic disease management solutions enable timely identification and monitoring of individuals and support management of their condition by providing automated reminders and follow-ups. Telehealth and electronic consultation tools enable improved rural, remote and disadvantaged community access to health care services."[7]

cdmNet and the Vision of eHealth

The National eHealth Strategy proposes a vision for chronic disease management if the strategy were to be implemented. cdmNet realizes this vision in its entirety.

> "Mrs Jones is a 68 year old lady who has been diagnosed with a chronic illness. Her GP determines that Mrs Jones would benefit from attending sessions with allied health professionals and educators who are able to assist with her condition. Mrs Jones' GP uses an electronic care planning system which assists in development of a team care plan tailored to her specific needs.
> Through the care planning system, the GP has access to a registry of care providers and can search for suitable health professionals. During a consultation, Mrs Jones and her GP identify and discuss which care providers she would prefer to meet, taking into account geographic location. A printed map of each relevant location is then generated to assist Mrs Jones attend appointments.
> The GP sends an electronic notice inviting each healthcare provider to participate in Mrs Jones' care. On acceptance of this invitation, and with Mrs Jones' permission, the GP sends relevant information from her electronic health record to each team member. When Mrs Jones arrives for her appointments she is not required to relay her medical history, provide paper documents or remember test results. For Mrs Jones, this may reduce unnecessary visits to healthcare providers and improve the effectiveness and timeliness of her care." [7(page 6)]

National Primary Care Strategy [8]

- **Improving access and reducing inequity**. By providing a "cloud" service for chronic disease management, cdmNet allows access by patients and providers to the service via internet anywhere, anytime. By providing a more efficient and cost-effective service, cdmNet allows anyone with chronic illness, at no cost, to access these services.
- **Better management of chronic conditions.** By providing a service that supports the entire end-to-end process of chronic disease management according to best practice standards.
- **Increasing the focus on prevention.** By better managing chronic illness, cdmNet helps prevent complications and further deterioration in the progress of the disease.
- **Improving quality, safety, performance and accountability**. By electronically tracking the entire cycle of care, cdmNet helps improve quality, safety, and productivity, as well as provide a complete audit trace of care.

Key reforms from the National Health and Hospitals Reform Commission Report [9]

- **Creating an agile and self improving health system for long term sustainability.** Improved shared care and team collaboration for people with chronic conditions. cdmNet facilitated the creation of personalised care plans, and communication and collaboration amongst the health care providers in patients' care teams. This is the first time sharing of clinical data across the whole team including Allied Health and the patient has been achieved on such a scale [see Attachment 3].
- **Tackling major access and equity issues that affect health outcome for people now**. Improved accessibility of care. cdmNet facilitated general practices to provide systematic

care for many more people. In regional areas, this increased efficiency has in some cases led to reorganisation of services as the volume of referrals increased, reducing the need for travel and improving accessibility for people in rural and remote settings. The telehealth capability provides the health workforce with additional options to provide care. Integrated telehealth means health care providers can easily access the record and video conference with others in the care team including the patient. This will transform access to specialist care in regional and remote areas and has the potential to transform care to the aged and elderly. See Attachment 4 for the Regional / Rural distribution of uptake.

- **Redesigning our health system so that it is better positioned to respond to emerging challenges**. Implementation of a national ehealth system. Able to provide integrated care plans, measurements and allied health and other event summaries to the national ehealth system. cdmNet is able to significantly add value to the PCEHR by actively using the information resource to improve collaboration and management of care for people with chronic disease.

  With links with pharmacy systems, state hospital systems, an integrated telehealth capability, and links with allied health providers in a wide range of settings, cdmNet is showing how ehealth can transform the delivery of health care and provides a powerful addition to the national ehealth system.

The COAG Human Capital Reforms [10]

- **Increasing labour force participation by reducing the impact of chronic disease**. The quantitative research has shown that cdmNet improved key clinical indicators for patients with diabetes implying a reduced burden of disease with a corresponding increase in labour force participation.

- **Increasing the effectiveness of the health system through more integrated care delivery.** Data continues to be gathered to support further health economic analysis to more precisely quantify benefits such as the reduced impact of chronic disease on labour force participation. The cdmNet system facilitates collaboration amongst the whole care team. This communication has been a major factor in Allied Health participation. Their inclusion has increased the effectiveness of health care delivery by allowing a systematic approach to patient care. Studies of cdmNet show that more frequent review has enhanced individual compliance with the chronic disease plans. cdmNet can also provide valuable data comparing planned services with actual service uptake that will help in planning health services and integrated care.

The National Health Reform Agenda [9]

- **Primary Health Care**: The project strongly supports the role of Medicare Locals in coordinating, integrating and monitoring primary health care services in local communities. In addition Primary Health Care Centres and Superclinics are well supported.
- **Prevention**: Chronic care has been identified as being central to systemic improvement. The project has helped towards addressing an urgent need in the acute sector by bolstering activities and support for primary care programs that contribute to the systemic reduction of chronic care presentations, hospitalisations and outpatient appointments.

- **eHealth:** The project builds on and contributes to the eHealth reforms outlined in the National Health Reform Agenda, including the PCEHR. Interoperability has been a priority for cdmNet and it is compliant with NeHTA standards.

  As a result of participation in the Wave 2 PCEHR implementation sites the project has established the key technology to integrate cdmNet with the PCEHR and also to use the identifiers and the National PCEHR Infrastructure. Information available to be shared includes:
  - Care plans
  - Event summaries from allied health care team members
  - Measurements such as blood pressure, height and weight from the GP, patient and care team
  - Pathology test results from the GP system
  - Progress notes from the entire care team
  - Upcoming appointments and a history of alerts and reminders

  There is a significant opportunity for cdmNet to contribute valuable information to a patient's PCEHR, with potential to massively increase the content and value of the PCEHR to the 7 million Australians who have a chronic illness.

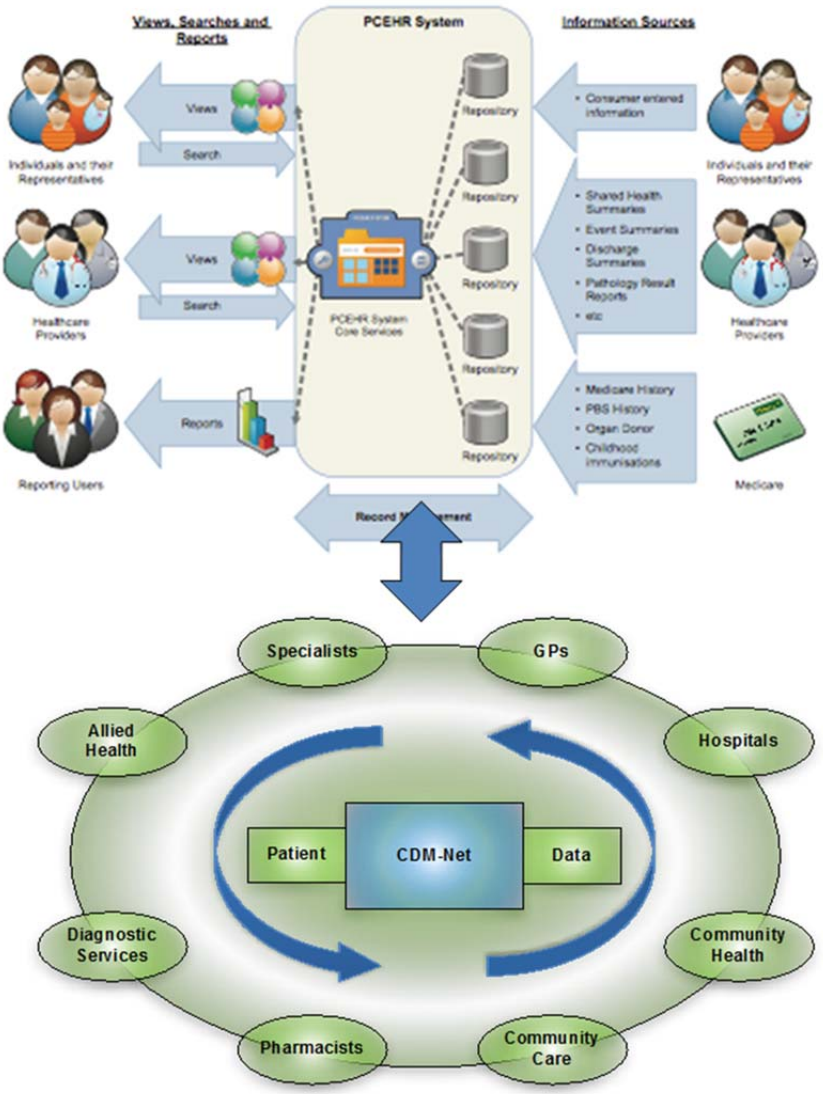


Figure 2. cdmNet linking to the National Infrastructure

State Government Priorities

cdmNet complements and leverages many State government disease management and prevention initiatives, including the Chronic Disease Management programs in Victoria, Queensland, WA and Tasmania. The CDM programs in these states vary considerably but cdmNet services continues to support the practical delivery of many state led change management and workforce capacity building in CDM.

- In **Victoria**, the government supports integrated Chronic Disease Management with early intervention initiatives, diabetes self help initiatives and forums, and self help funding to build capacity. cdmNet is working with Medicare Locals to provide CDM services to GP practices and Community Centres that link with these initiatives.
- The **Queensland** government established the Diabetes Clinical Network to provide advice to the government and implement various initiatives in care management. The project

worked with this group and General Practice Queensland to ensure awareness of cdmNet and potential future integration into these programs.

- **Western Australia** has a chronic disease prevention directorate and a strategy for Chronic Disease Self Management (2011 – 2015). cdmNet aligns with the strategic aims of WA and supports patients with self management and their team of healthcare providers.
- **Tasmania** developed the Connecting Care strategy (2009 – 2013), which has principles of coordinated and integrated multidisciplinary care and a person-centred approach for people with chronic diseases. cdmNet aligns with this strategy.

4. The project and the National Broadband Network

The National Broadband Network (NBN) will affect cdmNet services and its uptake will in turn be affected by cdmNet. In short, users of cdmNet will benefit from the enhanced digital communications capabilities of the NBN and the use of the NBN itself will be driven by users of cdmNet seeking high-value digital healthcare services.

cdmNet currently provides useful services across relatively low bandwidth connections, with simple layered mechanisms to expand the capabilities and services offered as available bandwidth increases. In the health care environment, where effecting change in business processes is difficult and often slow, this ability to provide an entry-level service on a basic internet platform is essential and assists in readying participants for the introduction of new capabilities.

Although most of the regional areas involved with cdmNet had sufficient internet connectivity and reliability to use the basic cdmNet services, some regional areas had very slow internet speeds, which had some impact on the current use of cdmNet and particularly the use of telehealth services. During the period of the project, few of the regional areas had access to the NBN.

While cdmNet can thus deliver some services well to most areas of Australia, the NBN will significantly improve the user experience, speed, and reliability of the communications between the user and cdmNet—needless to say, fundamentally important in a healthcare application. In addition, the availability of the NBN will increase the range of services able to be offered by cdmNet and the other broadband healthcare services integrated with cdmNet.

In particular, the NBN will improve the cdmNet service capability (and particularly the integrated telehealth and remote monitoring services) by providing:

- High speed and capacity
- Ubiquity of access
- Increased reliability and stability
- Low latency and jitter
- High speed upload and download of data
- Able to scale (to all users)
- Interoperability (all users able to interconnect with one another)
- Replicability (able to standardise approach and solution implementation)

On the other side of the coin, the high value derived from cdmNet services by healthcare providers and patients will help drive uptake of the NBN itself. cdmNet achieves this by aligning closely with the NBN Telehealth Program[7] and the National Digital Economy Strategy [11] in the following ways:

- Delivering telehealth services to the home in new and innovative ways, integrated with a patients care plan and care team, and enabled by the high speed, reliable broadband provided by the NBN;
- Making health services—in particular, chronic disease management services—more accessible in regional, rural, remote and outer metropolitan areas;
- Reducing health-related transport needs through both telehealth capabilities and more accessible health workforce (e.g., see breakout box on Page 13);
- Enabling consumers to collaborate and communicate with their carers and health service providers to improve quality of care and health outcomes;
- Reducing unnecessary hospitalisations;
- Providing broadband-based "cloud" services that are highly scalable and able to provide an increased volume of care without a corresponding increased cost;
- Enabling collaboration via the internet, so that location-dependent or regional health workforce skills shortages may be mitigated;
- Providing an infrastructure that increases healthcare access and can reduce social isolation; and
- Improving the response to health emergencies through access to patients' care plans and health records, as well as the integrated telehealth capability.

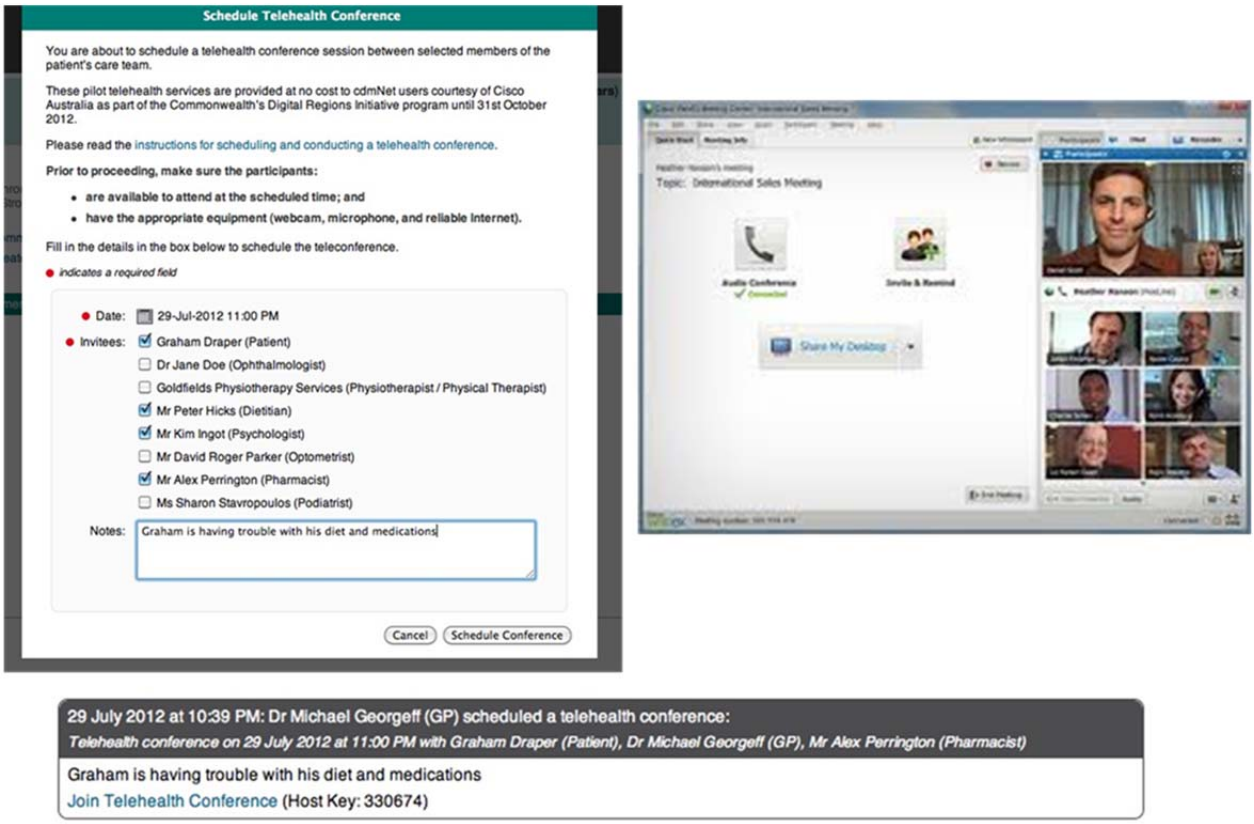


Figure 3. Integrated telehealth in cdmNet

This project has also enabled the development and early deployment of integrated telehealth technologies that combine collaborative multidisciplinary care management services with high-definition video conferencing. Providing an integrated high definition, low-latency and reliable video conferencing service to the health care sector will help transform health care delivery to both chronically ill and the elderly, improving health outcomes and allowing them to stay at home longer and happier.

5. Delivering on the project aims and objectives

The aim of the project was to roll out a broadband-based, collaborative chronic disease management system across regional, rural and remote regions of Victoria, Queensland, Tasmania, and WA.

The project objectives were to:

a) significantly improve the delivery of chronic disease management services to regional, rural and remote regions;
b) expand collaborative care services by linking with other major national and state initiatives; and
c) provide data sets of previously unavailable health and service-use information in the primary care setting.

The Project Outcomes and Benefits section above largely covered what was achieved with respect to these objectives. Some of the challenges and successes are further explored here.

Project management

Barwon Health was the lead agency for the project. Precedence Health Care was responsible for day-to-day management of the project with advice from the Management Committee together with the advisory committees with the aim of ensuring that resources were deployed effectively to maximize mutual economic benefit and achievement of project goals.

The Management Committee provided advice to Precedence as to how the project could best be carried out in accordance with the Implementation Plan.

Precedence was responsible for overall project coordination, planning, management (including financial management), resourcing, and evaluation. It was also responsible for the overall business architecture of the IT systems and networks and the operation of cdmNet.

Precedence Health Care established processes to ensure that grant funding was spent appropriately and that grants were acquitted correctly. These included rigorous business controls and quarterly reporting of financial information (including cash and in-kind expenditure), project performance, and project risks. Each partner organisation was required to submit quarterly reports of progress and performance against budget. Funds were made available in stages according to the project plan and work conducted. Any variations from plan were reported to the Management Committee, where appropriate in consultation with the Department of Broadband, Communications and the Digital Economy.

Engaging Divisions of General Practice to assist with service delivery improvements

The project enrolled practices in all Australian states and in regional, rural and remote areas. The regional areas of Queensland, Victoria and Tasmania were engaged using Divisions of General Practice. These Divisions had contracts and implementation plans to engage their primary care community in understanding the processes of chronic disease management and the benefits of effective and efficient care. This was achieved via newsletters, seminars, and local visits by Division staff.

The Divisions' targets for GPs registrations to cdmNet were achieved. They overcame local disasters and major organisational changes. The change management processes and subsequent cdmNet uptake was a steady and iterative process as the local community came to understand chronic disease best-practice processes and the use of the enabling technology.

There were two major hurdles that were faced

- Floods in Victoria and Queensland caused significant delays at the start of the project
- The preparation and transition to Medicare Locals that diluted the Divisions' Executive focus on CDM change management

Some regions took a holistic practice change approach and were very successful – Central Queensland Rural Division of GP and Murray Plains Division of GP particularly. Some Divisions—in

particular West Vic and Tasmania—experienced difficulties obtaining the first champion user of cdmNet in their area, had a population of conservative practices, or their practices wanted others to go first. These Divisions took longer to reach their targets; however, they overcame initial set-backs and achieved steady uptake by the end of the project. Change management was, as expected challenging but the uptake data indicate that the efforts in this area were very successful.

Ongoing uptake and sustainability

Engagement with Divisions through the project has helped establish strong engagement with Medicare Locals. cdmNet helps meet the key objectives of Medicare Locals:

- **Improving the patient journey through developing integrated and coordinated services** by implementing a collaborative care model of integrated information and communication.
- **Provide support to clinicians and service providers to improve patient care** by providing accessible and easy to use online care management services for all providers.
- **Identification of the health needs of local areas and development of locally focused and responsive services** by making it easy to gather, organise and analyse information to support regional service and population health planning.
- **Facilitation of the implementation and successful performance of primary health care initiatives and programs** by providing an IT platform that supports collaborative and shared care with integrated support for performance monitoring.
- **Be efficient and accountable with strong governance and effective management** by providing information to support an effective and robust audit and compliance framework.

Work with Medicare Locals is a core component of the ongoing strategy for rollout of cdmNet to ensure continued uptake and sustainability.

Broader engagement with other interested parties

The engagement of State based services in Queensland was slowed to some extent by changes in Queensland Health Department policy and again later as a result of policy changes prompted by a change of government in Queensland. As a result, Queensland Health was unable to continue formally with their project commitments. Precedence Health Care contributed additional resources to the project in Queensland. As a result, despite the reduction in effort by Queensland Health, rollout to GPs and other health care providers in regional Queensland was a resounding success, leading to significant and sustainable activity. In the last year of the project, Queensland Health engaged with the DOHA Diabetes Care Project leading to significant uptake of cdmNet in the Wide Bay, Toowoomba and Gold Coast.

The project built on the implementation and learnings of the CDM-Net Clever Networks project and established additional partnerships with various organisations and initiatives to help drive the level of change necessary to effect a transformation in primary care practice. The most important of these relationships was the collaboration between Precedence Health Care and the Royal Australian College of General Practice, the peak GP body in Australia; working closely with the Australian Primary Care Collaboratives in Tasmania; and the selection of cdmNet as the core technology for the

Department of Health and Ageing's landmark Diabetes Care Project. These activities, leveraging state policies and projects where possible, supported and promoted the rollout and uptake of cdmNet.

The engagement of GP practices, Health professionals and patients in the project has also provided valuable data on service provision and clinical outcomes in the treatment of chronic disease. This data, consented and de-identified, was independently analysed by Monash University (see Attachment 3) and is providing valuable information on chronic disease management for policy development and clinical practice evaluation.

6. Project Deliverables

The Project had three major deliverables:

- Change management and implementation in targeted regional areas
- Technology innovation
- New care plans

Change management and implementation in targeted regional areas

The project exceeded the implementation targets set at the start of the project. For the regions directly involved in the project, 345 General Practitioners, 3,000 Allied Health, and over 5,000 patients registered with cdmNet. More than 16,000 MBS CDM services were delivered using cdmNet.

Nationally, nearly 1800 General Practitioners, 3,600 Allied Health and 17,000 patients registered during this period, with over 9,500 patients on care plans and 26,000 MBS CDM services delivered.

Technology innovation: cdmNet Desktop integration, Fred Dispense, Cisco WebEx

Precedence developed an integrated desktop software component, cdmNet Desktop, to link GP practice software with cdmNet. cdmNet Desktop makes it easier for users by providing for simple, secure login to the web based service, and a "one click" interface to allow secure sharing of patient information. It also enables targeted alerts to the user from the web site when a patient is eligible or due for a CDM service. This innovation has had a major impact on ease of use of cdmNet and its uptake. The registrations and use of cdmNet increased substantially after its introduction in May 2011. A full list of technology innovations is provided in Attachment 7.

The Fred pharmacy dispensing system, Fred Dispense, was integrated with the cdmNet cloud service. Fred Dispense is the leading pharmacy dispensing system in Australia, with a 60% market share. The integration of Fred Dispense with cdmNet allows pharmacists to view patients' care plans at the point of dispensing medications. For the first time, pharmacists can now see the entire health record, care plan and progress notes of the patient. Pharmacists interact with the patient when dispensing their medications, and frequently provide essential health care support and advice. This support is provided at no cost but provides important information to the patient with a corresponding effect on health outcomes. Enabling pharmacists to participate in the management of chronically ill patients as informed and valued team members is a major transformation in the role of pharmacists in primary care, and will drive further uptake of health services delivered and supported by the NBN.

Integration with Cisco Webex provided cdmNet users the ability to easily communicate via video with other care team members and patients in case conferences and consultations. Cisco WebEx is the world's leading collaborative telecommunications service, in use by over 5.5 million people worldwide. The service also mediates the scheduling and reminders of case conferences that are essential for busy healthcare providers. The integration with cdmNet is the first known example of a telehealth capability fully integrated into a patient's plan of care and shared health record.

New care plans: mental health, breast cancer, and chronic kidney disease

Mental Health care plans were developed to help in the management of mental health in primary care. These plans meet the requirements of the mental health Medicare items and cover a range of mental health conditions. The plans will help GPs, mental health nurses as well as other allied health providers to effectively communicate and collaborate with one another and their patients. Making mental health plans easier to develop, manage and monitor will greatly assist practices in helping their patients especially as mental health is one of the major health burdens faced by the population.

The Chronic Kidney Disease care plans were for released in mid 2012 after consultation with Kidney Health Australia and a team of nephrologists as part of a project funded by the Department of Health Victoria. This is an important addition as kidney disease, if left untreated, eventually leads to the need for expensive treatments such as dialysis or transplants. Increasing numbers of patients with diabetes also have kidney disease, particularly in indigenous communities.

During the project, breast cancer care plans were developed and are currently being trialled with Southern Health. In 2013 a refugee health plan will be trialled that will help manage both social issues and infectious diseases.

7. Efficiencies

System level efficiencies

The Chronic Care model developed by the McColl institute recommends a proactive approach to the management of chronic disease that includes adherence to best practice guidelines, care coordination, and active follow-up including regular, systematic review. These components drive major efficiencies through the health system.

Based on the business model developed by the Centre for Strategic Economic Studies [ref the Final Report of the cdmNet project], the identified potential savings to the health system from use of cdmNet, assuming a 35% uptake in the targeted regions, was $141.5 million, comprising:

- Hospital savings through reduced admissions and shorter length of stay: $24.8 million annually
- Reduced adverse events: $3.4 million annually
- Reduced community burden: $19.3 million annually
- Increased workforce participation: $94.0 million annually

For the actual national uptake to date of 17,000 patients, the predicted future savings are estimated to be:

- Hospital savings: $2.3 million per annum
- Reduced adverse events: $0.3 million per annum
- Reduced community burden: $1.8 million per annum
- Increased workforce participation: $8.8 million per annum

In addition to increased efficiencies of the health system, use of cdmNet also has the potential to reduce wasted expenditure: that is, expenditure on healthcare services that are unlikely to result in better health outcomes. In the case of chronic illness, as discussed earlier, the Commonwealth expends funds on certain MBS items for promoting best-practice care management,

Current national MBS billing data shows that less than 20% of care plan MBS items claimed are regularly reviewed, suggesting that 80% of such care plans may be ineffective. The cost of these "unreviewed" care plans to the Commonwealth through MBS payments to GPs and Allied Health was $440 million in 2012 and growing at $70 million per year. In contrast, the research data from this project shows that 80% of cdmNet plans are regularly reviewed (see Attachment 3). By these measures, if rolled out nationally, cdmNet could reduce the cost of ineffective care plans by $340 million per year.

Monash research also shows that , for patients with diabetes, those who had regular reviews showed 90% compliance with their plans against 50% otherwise.

Practice productivity

The uptake of MBS items implies increased efficiencies in delivering healthcare, helping to address the current and predicted chronic shortage of skilled health care professionals. In particular, primary care practices that have reengineered their processes to support collaborative care using cdmNet can be expected to achieve a two- to three-fold increase in practice productivity with consequent economic benefits [5]. Allied Health services and pharmacy services, such as Home Medicines Reviews, also increase substantially with the use of cdmNet. Whether or not this reflects increased productivity or increased demand generated through adherence to best practice care was not determined.

Longer term productivity impact

For doctors, hospitals, and allied health professionals, the use of cdmNet provides greater efficiency, more informed health decisions, increased productivity and better financial returns.

Through the Medicare Locals, improved service integration and coordination will result in further productivity gains and reduced cost of service delivery.

By promoting broader collaboration, the project will enable greater and more sustainable participation of the wider healthcare workforce in delivering healthcare and addressing the current and predicted chronic shortage of skilled health care professionals.

The reduction of paperwork and improved efficiency of service provision, easier access (e.g., less travel), and other benefits of reduced waste will have indirect environmental benefits.

8. Additional benefits above and beyond the implementation plan

The project led to major additional benefits beyond the implementation plan. These additional benefits were realised through new projects involving the use of cdmNet as the core platform for care management. These projects included:

- **Diabetes Care Project.** The Diabetes Care Project (DCP) is a three-year project testing a new model of healthcare delivery for people with diabetes. The project will evaluate whether the new model of care can deliver better quality healthcare outcomes, enable care to be provided in more flexible ways, improve patient and practitioner experiences, and prove economically sustainable and scalable nationally. The project is using cdmNet with a flexible funding model that will include improved support payments for practices, a Care Facilitator role to manage the integrated care approach and an education and training program for consumers and healthcare providers. The DCP project will play a large role in influencing future funding models for diabetes care and the National Health Reform Agenda.

- **PCEHR Wave 2 Sites.** cdmNet was selected in two of the Wave 2 implementation sites for the rollout of the national Personally Controlled Electronic Health Record (PCEHR). This involved building interfaces between cdmNet and the National eHealth Infrastructure to support data exchange and interoperability. The interfaces were successfully built, tested and demonstrated. The projects provided a compelling example of the capacity to add value to important national investments.

- **Chronic Kidney Disease (CKD) Project.** The Department of Health, Victoria, the Victorian Renal Clinical Network, Kidney Health Australia and Western Health have been working with General Practice Victoria (GPV), Precedence Health Care and Pen Computer Systems (PCS) to change the behaviour in General Practice around early identification and continued management of at risk kidney disease patients. This involves gathering information on potential at risk patients, prompting early clinical testing and the options for better care management. cdmNet was selected to provide the core chronic disease management services. The solution is currently under trial with the Macedon Ranges and North West Melbourne Medicare Local.

- **Refugee Health Clinical Hub.** cdmNet was selected as the core chronic disease management service for the project entitled 'Refugee Health Clinical Hub – a Model for Integrated Clinical Care using NBN'. This project was funded by the Victorian Government's Broadband-Enabled Innovation Program (BEIP). The objective of the project is to create an electronic hub where health providers and patients can communicate and share relevant information about patients of refugee background. This includes the care plan in primary care (cdmNet), video-conferencing with providers and interpreters and development of a system and integration to the major Hospital Refugee Health Clinics in Victoria.

- **CSIRO Home Monitoring Project.** The aim of this project was to enhance cdmNet to enable patient self-management and to provide monitoring feedback of their lifestyle risk factors by incorporating CSIRO's validated mobile phone platform. This will provide options for patients to self-manage their disease and simultaneously enable the multidisciplinary care team to view their patients' biometric measurements more regularly. This will increase the efficiency and effectiveness of chronic disease management, leading to better quality of care. The

outcome of the project included a mobile phone application to automatically stream data from a Bluetooth-enabled self-monitoring device directly to their cdmNet care plan and a smart phone web browser to enable manual input of self-monitoring data that is then uploaded to their cdmNet care plan. This provides a simple and easy way for patients to input self-measurements into their cdmNet care plan.

9. The project's future and sustainability.

The CDM-Net Australia project has demonstrated how digital technologies and services have the capability to transform the management of chronic disease and to realise the vision of Australia's eHealth and health reform agendas. The future impact of the project depends on three key requirements: (1) the sustainability of cdmNet itself; (2) the implementation of national eHealth infrastructure and the rollout of the NBN to support the cdmNet services network and other high-value digital healthcare services; and (3) sufficient support for the massive change management necessary in primary care to move to more collaborative, systematic models of care.

On the first requirement, cdmNet is sustained by a proven business model for providing its chronic disease management services. The market will drive the long-term sustainability of this service. As a productivity tool, there is no net cost to the government or providers for adopting cdmNet—it is a win-win proposition.

The National eHealth Infrastructure is progressing but still missing key elements, such as a fully operational Health Services Directory including allied health and more flexible conformance standards for the PCEHR.

The third requirement requires strong government support for the use of digital healthcare services and the change management necessary to see their broad adoption. To help achieve this objective, cdmNet has been proposed as a key enabler in various government initiatives. Some of these are described below.

eCollaborate Australia project. Precedence is leading a consortium including the Australian Medicare Local Alliance and a group of Medicare Locals in an application under the Federal Department of Health and Ageing Chronic Disease Prevention and Service Improvement Flexible Fund to establish the eCollaborate Australia project.

The primary aim of this project is to develop a nationally scalable program for the delivery of effective, evidence-based collaborative care for people with chronic conditions.

The unique features of the program are that it will:

- Use cdmNet services as the basis for re-engineering primary care collaborative processes at the practice level
- Use cdmNet to collect service use data that (a) links service use to health outcomes, (b) includes service use data across both the private and public sector, (c) compares planned service use to actual (realised) service use at the individual patient level
- Use this information to enable Medicare Locals to provide continuous improvement in service provision, integration and coordination responsive to local needs.

It aims to reach 19 Medicare Locals, 4,000 General Practitioners and up to 300,000 patients by 2014-15.

Upper Hume PCP eCare Planning Project. Precedence has proposed the use of cdmNet as the Electronic Care Planning for Chronic Disease Management solution for the Upper Hume PCP Primary care E-Communications Initiative.

This project aims to use cdmNet as a key enabling technology for care planning and management activities within the Upper Hume Primary Care Partnership. This will provide important links between the cdmNet partners and the Victorian State government strategy for provision of primary care services involving Primary Care Partnerships.

The initial proposal has been accepted by the PCP and discussions are underway pending a response from the Commonwealth Department of Health and Ageing.

Integrated Home Telehealth Proposal. The Royal District Nursing Service (RDNS) and other consortium members have submitted a proposal under the NBN Enabled Telehealth Pilots program to pilot the development and delivery of telehealth services to NBN-enabled homes with a focus on aged and palliative care services, including advanced care planning services.

Consortium partners Precedence, Cisco, the CSIRO Australian eHealth Research Centre, Monash University and Telstra are involved in this proposal, along with Care Innovations, Health-e, the University of Melbourne Institute for a Broadband Enabled Society and various Medicare Locals.

The project proposes to use and extend the digital services developed by consortium partners including Precedence and Cisco to deploy NBN-enabled telehealth capabilities based on the cdmNet platform and Cisco WebEx to a broad range of health care providers and consumers.

Long-term sustainability

The long-term sustainability of the acheivements of the CDM-Net Australia project is driven by the increasing need of caring for people with chronic disease within a sustainable health care system and the realisation of primary care providers of the potential that digital technologies provide.

The dramatic rise in chronic illness, the ageing population, and the high cost of hospital care is driving a change in emphasis from acute, hospital care to primary care. The potential impact of innovative digital and mobile technologies in primary care is particularly strong. The importance of information and communication technologies for health care has been recognized globally and now considered essential to the delivery of high quality, equitable care and a sustainable health care system. Given the enormous expenditure in health care (9% of GDP in Australia), the market drivers for investment in health care digital technologies are very strong.

Precedence Health Care has established that general practices that are ready to take a systematic approach to chronic disease management are willing to pay a reasonable fee for a service that enhances their productivity. This project has confirmed that general practices are slow to make decisions relating to practice organisation and even slower to effect change. The project team was aware of this difficulty, and took measures to ensure that cdmNet would be a viable and sustainable service:

- The roll-out of cdmNet has built on change management processes in conjunction with Divisions of general practice and Medicare Locals.

- Embedding chronic disease management as a key component of practice change initiatives of the Medicare Locals has helped establish cdmNet as a sustainable service that will address the needs of their communities

This approach has lead to a sustained and rapidly growing uptake of cdmNet. Health is an incentive driven market so the ongoing drivers for primary care to maintain the use of the cdmNet technology for chronic disease management and ensuring that it delivers benefits to all participants will continue. In addition the alignment of the project with the health reform agenda assists in helping meet the needs of increasing numbers of people with chronic disease.

10. Gaps in Service delivery

Gaps in the National eHealth Infrastructure and services have been noted above. These gaps increased the overall effort required of the project team and project partners and had some impact on the speed of uptake and the scale of the rollout.

Providers visiting some remote areas were unable to use cdmNet while in those areas and had to use the service from their bases in larger (relatively) regional centres. It is anticipated that the rollout of the NBN will assist in spreading the reach of internet services in remote areas.

The project identified a mismatch in health service delivery between the “best practice” target of who should be on care plans and the existing practice of only putting those with more complex chronic disease on a cdmNet plan. Change management to encourage best-practice activities for chronic disease management in primary care is slow and needs strong drivers if change is to be effective.

Technology interoperability in the health sector is still a major problem. Currently, the lack of standard or even published interfaces means that most GP practice software systems do not integrate seamlessly with other digital services. Many other health services are not yet digitally enabled.

Telehealth is offered as an integrated system in cdmNet. A major gap in organising telehealth consultations is having directories of specialists who are able to receive telehealth referrals. This capability is only just under construction (RACGP, ACCRM). In addition many public hospital specialists already have significant waiting lists for face-to-face consultations and have expressed limited desire for additional sessions.

References

1. Australian Institute of Health and Welfare (AIHW) 2006. Chronic diseases and associated risk factors in Australia, 2006. Canberra: AIHW
2. Australian Institute of Health and Welfare 2009. Australian Hospital Statistics 2007-08. Health services series no 33. Cat. No HSE 71 Canberra : AIHW.
3. AIHW 3303.0 - Causes of Death, Australia, 2008.
4. Begg S, Vos T, Barker B, Stevenson C, Stanley L, Lopez AD, 2007. The burden of disease and injury in Australia 2003. PHE 82. Canberra: AIHW.
5. CDM-Net. A broadband Health Network for Transforming Chronic Disease Management. Final Report March 2010.
6. The Chronic Care Model. Improving Chronic Illness Care, MacColl Institute for Healthcare Innovation, Group Health Research Institute. http://www.improvingchroniccare.org
7. National E-Health and Information Principal Committee. National E-Health Strategy 30 Sept, 2008.
8. Primary Health Care Reform in Australia. Report to Support Australia's First National Primary Health Care Strategy. ISBN: 1-74186-936-6, 2009.
9. National Health and Hospitals Reform Commission. A Healthier Future For All Australians – Interim Report December 2008. ISBN: 1-74186-808-4. Published 2009
10. National Reform Agenda – human capital Indicative outcomes and associated progress measures across the lifespan (Attachment D: COAG communiqué 14 July 2006).
11. Australia's Digital Economy: Future Directions. Commonwealth of Australia, 2009. www.dbcde.gov.au/digital_economy/final_report

Australian Government

Department of Broadband, Communications and the Digital Economy

Supplementary or supporting documentation

A list of presentations is provided in Attachment 5 and a list of publications are provided in Attachment 6.

Achievement against milestones

Milestone Description [as agreed in Annexure A of the Implementation Plan]	**Evidence of Completion** [as agreed in Annexure A of the Implementation Plan]	
National rollout of CDM-Net complete	Rollout report: GP and Allied Health recruitment numbers and location details	The target was 60 GPs registered in the targeted areas. The project registered 1787 GPs over the time period with 259 registered in the Divisions of General Practice engaged with the study. Allied Health providers listed on the cdmNet Directory number 14,730 with 3,606 accessing the system. Detail of the provider numbers and their postcode areas are shown in Attachment 1. Delays in the uptake by the Divisions were experienced due to floods and then organisational changes caused by the change of many Divisions to Medicare Locals. Change management was the major activity and the Divisions who managed implementation through their clinical experts rather than eHealth specialist, s experienced the greatest success in implementing cdmNet. However some areas were very conservative and are only gradually changing practice.

<table>
<tr><td></td><td></td><td>
<table>
<tr><th>Division</th><th>GP</th><th>Patients</th><th>CDM Items</th></tr>
<tr><td>Geelong</td><td>86</td><td>3,297</td><td>13,032</td></tr>
<tr><td>Ballarat</td><td>6</td><td>357</td><td>753</td></tr>
<tr><td>West Vic</td><td>21</td><td>54</td><td>54</td></tr>
<tr><td>GVGP</td><td>24</td><td>0</td><td>0</td></tr>
<tr><td>Murray Plains</td><td>29</td><td>386</td><td>682</td></tr>
<tr><td>GP South</td><td>77</td><td>183</td><td>403</td></tr>
<tr><td>Rhealth</td><td>34</td><td>201</td><td>444</td></tr>
<tr><td>Wide Bay</td><td>46</td><td>130</td><td>307</td></tr>
<tr><td>CRQLD</td><td>22</td><td>396</td><td>857</td></tr>
<tr><td>Total</td><td>345</td><td>5,004</td><td>16,532</td></tr>
</table>
</td></tr>
<tr><td>Initial dataset collated for evaluation

Draft evaluation report complete</td><td>Draft evaluation report</td><td>The clinical evaluation was performed by Monash University and is provided in Attachment 3.

This is the final version of the research report.</td></tr>
<tr><td>Project evaluation and final report complete</td><td>Final report accepted</td><td></td></tr>
</table>

Report against Performance Indicators for entire period of the project

Performance Indicator	Measure	Report against PIs
Performance Indicator 1 *The extent to which regional, rural and remote communities are positively impacted by Digital Regions Initiative*	(PI 1.1) Physical location and classification of communities that will benefit from funded projects as identified in rollout schedule. (PI 1.2) Physical location and classification of communities that have benefited from funded projects as measured by postcodes of CDMS registered users and postcodes of communities serviced by registered users. (PI 1.3) Description of benefits and impacts in relation to original proposal – presented as brief case studies in project progress reports and/or at the project end.	(PI 1.1) Rollout was achieved in Geelong, Ballarat, West Vic, Murray Plains, GP South, Rhealth, Wide Bay, and CRQLD, with general practitioners, allied health providers and patient numbers increasing in all the regions. Six regions were successful, one regions failed to implement cdmNet – (Goulburn Valley). Implementation was extended nationally during the project an registration of providers for each postcode is listed in Attachment 1. (PI 1.2) Benefits within communities from the uptake of cdmNet by users has been demonstrated with the number of users increasing and the geographic spread of providers registering being extensive as shown in attachment A . (PI 1.3) Benefits and impacts are highlighted in section 2 of the main body of the report.

<table>
<tr>
<td>Performance Indicator 2

Improvements in the delivery of health, education and/or emergency services enabled by digital technologies supported by Digital Regions Initiative projects</td>
<td>(PI 2.1) Description of service delivery benefits by sector at the project end.</td>
<td>(PI 2.1) Service and delivery benefits are also provided in Attachment 3: In addition benefits included:

a. Increased service items generated by GPs

Medicare Benefits Schedule CDM Items claimable by GPs for the period April 2010 – September 2012.
<table>
<tr><th></th><th>GPMP (Item 721)</th><th>TCA (Item 723)</th><th>GPMP Review (Item 732)</th><th>TCA Review (Item 732)</th><th>ACoC</th><th>HMR (Item 900)</th></tr>
<tr><td>Number</td><td>8,105</td><td>5,971</td><td>3,631</td><td>2,638</td><td>338</td><td>2,279</td></tr>
</table>
b. Improved Health to patients: Improved Clinical indicators. The Monash University Research finding (Attachment 3) found that:

The measure of diabetes control that improved were:
• HbA1c (7.2 to 6.9%, p<.001);
• systolic blood pressure (139 to 136 mm/Hg, p<.01);
• total cholesterol (4.5 to 4.2 mmol/L, p<.001); and
• LDL (2.5 to 2.2 mmol/L, p<.001).

The clinical improvement were even greater for patients whose baseline clinical values were higher than the recommended targets:
• HbA1c (8.5 to 7.5%, p<.001),
• systolic blood pressure (153 to 141 mm/Hg, p<.001),
• diastolic blood pressure (89 to 82 mm/Hg, p<.001), and
• total cholesterol (5.1 to 4.6 mmol/L, p<.001).</td>
</tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td>c.) Improved provision of best practice care

Best practice care of care plans and team management with regular review was provided with by providers using cdmNet.

• 80% of GPMPs/TCAs were regularly reviewed compared with less than 20% nationally
• 90% compliance to best practice care vs 50% otherwise (p < 0.001)</td>
</tr>
<tr>
<td></td>
<td>(PI 2.2) Growth of new or improved services/applications at project end as measured by

• Number of new electronic care plans and reviews.</td>
<td>(PI 2.2). Figures below are the new plans and reviews from the baseline data of users (15th Dec 2009 – national, ie. all regions):

Dec 2009 – Oct 2012 period.

<table>
<tr><td>GPMPs (Care Plans)</td><td>9,805</td></tr>
<tr><td>TCA</td><td>6,864</td></tr>
<tr><td>GPMP Reviews</td><td>4,197</td></tr>
<tr><td>TCA Reviews</td><td>2,922</td></tr>
<tr><td>HMR</td><td>2,445</td></tr>
</table>
Web page accesses since Dec 15 2009: 2,393,123</td>
</tr>
</table>

<table>
<tr>
<td></td>
<td>

- Number of CDMS web page accesses by providers.

</td>
<td>
The number of emails and sms messages indicate the degree to which technology is assisting CDM these were:

<table>
<tr><td></td><td>Emails</td><td>SMS’</td></tr>
<tr><td>Patients</td><td>53,351</td><td>17,317</td></tr>
<tr><td>Providers</td><td>75,489</td><td>1,836</td></tr>
<tr><td>Total</td><td>128,840</td><td>191,53</td></tr>
</table>

The number of accesses to online shared records indicate the degree of collaboration

<table>
<tr><td>Number of cdmNet shared record accessed by Access Type</td><td>Count</td></tr>
<tr><td>Healthcare providers views
Login Events
Total web page</td><td>
74,327
3,098,497</td></tr>
<tr><td>Patients views
Login events
Total web page</td><td>
6,883
33,630</td></tr>
</table>
</td>
</tr>
</table>

	(PI 2.3) Impact of new or improved applications and service delivery outcomes presented in project progress reports and/or project end as measured by: • Number and type of health care services delivered under care plans.	(PI 2.3). New and/or improved applications and service delivery. a. **Number of services** delivered under care plans - See Attachment 8 for all providers**.** Appointments were made with service providers and over 26,000 Chronic disease items MBS items were performed during the project. b. **Applications:** The functionality of the cdmnet application has improved during the project see Attachment 7. They included: • cdmNet Desktop was introduced, which substantially improved the user friendliness of using cdmNet by its seamless integration with the GP desktop software. • Telehealth was integrated so video conferencing is integrated with the clinical functions of the team and the care plan. • Fred Health integration allows pharmacists to view the entire health record, care plan and progress notes of their patient. • cdmNet has created the web services and integration in readiness for publishing to the PCEHR and created the facility to store the IHI.

Speciality	**Number of Appointments**
GP	13,290
Podiatrist	1,713
Diabetes Educator	1,195
Dietitian	936
Optometrist	750
Unknown (Assigned To Organisation)	652
Practice Nurse	606
Pharmacist	602
Physiotherapist	508
Ophthalmologist	406
Exercise Physiologist	403
Dental	110
All others	1,497
Total	**22,558**

Performance Indicator 3 Extent to which Australian Government investment is leveraged by Digital Regions Initiative projects	(PI 3.1): The level of investment by project partners as a result of funded projects as per financial reports. (PI 3.2): Description of how the project builds on other government projects or adopts models of service delivery: - National e-Health Strategy - Use of NeHTA foundation infrastructure and standards - The National Primary Health Care Strategy - The National Health and Hospitals Reform Commission report	(PI 3.1) Inkind and cash • Precedence Health Care $3,112,455 • Queensland Health $3,895,810 • Cisco - $197,200 • Fred - $94,000 • GP VIC - $100,000 • GPAG - $50,000 • Barwon Health $187,500 • Diabetes Victoria Australia $150,000 • Other Divisions $23,729 • Monash $723,612 Total: $8,485,828 (PI 3.2): The project alignment with government strategies is detailed in section 3 of the main body of the report. These include; • National E-Health Strategy [7] • Primary Health Care Strategy [8] • National Health and Hospitals Reform [9] • COAG Human Capital Reforms [10] • Australia's National Digital Economy Strategy [11]

-	(PI 3.3): The number, location (name of town or nearest town, postcode or latitude and longitude) and type of additional activities/applications that have occurred through the project beyond the scope of the implementation plans tracked for (PI1.1 and PI 1.2 above) and reported at end of project.	(PI 3.3): Additional activities and projects. See main report for details section 8. Active projects • Diabetes Care Project – SA: Adelaide and Adelaide Hills; Victoria: Northern Melbourne; Queensland: Toowoomba, Hervey Bay, Gold Coast. Additional implementation of cdmNet targeting diabetes. • PCEHR Wave 2 Sites (two sites, ACT, NSW)). Integration with PCEHR projects in those regions. • Chronic Kidney Disease (CKD) Project – Northern Melbourne. New care plans and disease groups. • Refugee Health Clinical Hub - Victoria: Melbourne Shepparton, Mildura. Integration with hospitals and telehealth and new care plan. • CSIRO Home Monitoring Project (national). Home monitoring integration with cdmnet Projects under consideration • eCollaborate Australia Project • Upper Hume PCP eCare Planning Project • Integrated Home Telehealth Proposal
	(PI 3.4) The level of additional investment and benefits that has occurred beyond the scope of implementation plans and as a result of funded projects over the life of the DRI program as measured by project other contributions and cash expenditure reports at project end.	(PI 3.4). Additional investment. • Chronic Kidney Disease (CKD) Project – North-West Melbourne $64,818 • Refugee Health Clinical Hub - Victoria: Melbourne Shepparton, Mildura $26,456 • Diabetes Care Project – SA: Adelaide and Adelaide Hills; Victoria: Northern Melbourne; Queensland: Toowoomba, Hervey Bay, Gold Coast $1,079,601 • PCEHR Wave 2 Implementation (two sites) $944,918 Total $2,115,803

<table>
<tr>
<td></td>
<td>(PI 3.5) Description of additional benefits achieved by project through the opportunities created by the National Broadband Network as measured by the number and type of users interacting with CDMS using broadband and mobile services at project end.</td>
<td>(PI 3.5). Broadband users

The additional users were (Dec 2009 – Oct 2012 period):.
<table>
<tr><th>Role</th><th>New Users (Registrations) (national)</th></tr>
<tr><td>Allied Health</td><td>3,606 (14,730 listed)</td></tr>
<tr><td>Patients</td><td>16,696</td></tr>
<tr><td>General Practitioner</td><td>1,787</td></tr>
<tr><td>Medical Specialists</td><td>1,545</td></tr>
<tr><td>Practice Nurses</td><td>629</td></tr>
<tr><td></td><td>24,262 (35,387 listed)</td></tr>
</table>
The benefits:

Delivering telehealth services to the home in new and innovative ways, integrated with a patients care plan and care team, and enabled by the high speed, reliable broadband provided by the NBN;
Making health services—in particular, chronic disease management services—more accessible in regional, rural, remote and outer metropolitan areas;
Reducing health-related transport needs through both telehealth capabilities and more accessible health workforce (e.g., see breakout box on Page 13);
Enabling consumers to collaborate and communicate with their carers and health service providers to improve quality of care and health outcomes;
Reducing unnecessary hospitalisations;
Providing broadband-based “cloud” services that are highly scalable and able to provide an increased volume of care without a corresponding increased cost;
Enabling collaboration via the internet, so that location-dependent or regional health workforce skills shortages may be mitigated;
Providing an infrastructure that increases healthcare access and can reduce social isolation; and
Improving the response to health emergencies through access to patients’ care plans and health records, as well as the integrated telehealth capability.

</td>
</tr>
</table>

(PI 3.6) Description of how the longer term sustainability of the project will be assured.

The above performance indicators will be addressed by one or more of:

The level of revenues received by regions from Medicare, including Medical Benefits Schedule Chronic Disease Management item rebates, allied health rebates and practice incentive payments.

The longer term sustainability of CDM-Net and other high priority solutions as measured by:

- cash flow positive at end of project

- future predicted revenue streams.

(PI 3.6). Longer term sustainability - see section 9 in the main body of the report.

The revenues received during the project for CDM items for participating practices were:

Revenue generated through Medicare Benefits Schedule CDM Items claimable by GPs for the period April 2010 – September 2012.

	GPMP (Item 721)	TCA (Item 723)	GPMP Review (Item 732)	TCA Review (Item 732)	ACoC	HMR (Item 900)
Number	8,105	5,971	3,631	2,638	338	2,279
Value ($)	$1,102,685	$643,673	$246,908	$179,384	$13,520	$332,734

Revenue generated through Medicare Benefits Schedule CDM Items claimable by Allied Health providers for the period April 2010 – September 2012.

Allied Health Provider	$1,063,935
Pharmacists (HMRs)	$442,286
Dentist (assume $1,000 per visit)	$110,000

Precedence Health Care was comfortably cash flow positive at the end of 2011/12. Staffing has doubled over the period. Revenues, staffing, and EBITDA are anticipated to continue to increase over the following years and long term.

Future predicted revenue and sustainability : see section 9 in the main body of the report.

Baseline Data Measurement

<table>
<tr><th>Baseline data measure</th><th>Measurement as at project commencement</th><th>Report against Baseline data measure</th></tr>
<tr><td>(PI 1.1) Physical location and classification of communities that will benefit from funded projects as identified in rollout schedule</td><td>To be identified in rollout agreements and identified in project rollout schedule. (Milestone in Report 2)</td><td>(PI 1.1) At the start of the project cdmNet was primarily in Geelong in Victoria and Eastern Goldfields regions of WA, and this has now been now extended across Australia

Report (Attachment 1 and 2) shows new providers and consumers and registered since December 2009 in all postcodes nationally.</td></tr>
<tr><td>(PI 2.2) Growth of new or improved services/applications as measured by

Number of new electronic care plans and reviews.

Number of CDMS web page accesses by providers.</td><td>Baseline data for existing registered users, electronic care planning and collaboration activity will be available from the cdmNet database reporting system at project commencement.

Baseline for other regions is zero.</td><td>(PI 2.2). Baseline data for the project will be the relevant figures reported for the final report of the Clever Networks project (baseline date is 15th December 2009):
<table>
<tr><th></th><th>Baseline 12/12/2009</th><th>Report (June 2011)</th><th>Report (Dec 2011)</th><th>Since Baseline (Oct 2012)</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Care Plans</td><td>733</td><td>1,292</td><td>3,711</td><td>9,805</td></tr>
<tr><td>TCA</td><td>245</td><td>1,031</td><td>2,531</td><td>6,610</td></tr>
<tr><td>Reviews GPMP</td><td>186</td><td>719</td><td>1,378</td><td>4,197</td></tr>
<tr><td>Reviews TCA</td><td>86</td><td>526</td><td>1,023</td><td>2,922</td></tr>
<tr><td>HMR</td><td>342</td><td>80</td><td>1090</td><td>2,557</td></tr>
<tr><td>Total CDM items</td><td>1,592</td><td>3,648</td><td>9,733</td><td>26,091</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Web page downloads</td><td>90,034</td><td>189,265</td><td>560,595</td><td>2,393,123</td></tr>
</table>
</td></tr>
</table>

(PI 2.3) Impact of new or improved applications and service delivery outcomes as measured by:

Number and type of health care services delivered under care plans

(PI 2.3) Chronic Disease services covered are indicated by the number of CDM items. Across all the states these totalled over 26,000 since the start of the project see above in 2.2.

a. **Number of services** delivered under care plans - See Attachment 8 for all providers**.** Appointments were made with service providers and over 26,000 Chronic disease items MBS items were performed during the project.

Speciality	**Number of Appointments**
GP	13,290
Podiatrist	1,713
Diabetes Educator	1,195
Dietitian	936
Optometrist	750
Unknown (Assigned To Organisation)	652
Practice Nurse	606
Pharmacist	602
Physiotherapist	508
Ophthalmologist	406
Exercise Physiologist	403
Dental	110
All others	1,497
Total	**22,558**

The chronic disease care plans increased to over 9000 during the project. The patients had the following targeted and integrated care plans created since Dec 15 2009.

Disease	GPMP	TCA	GPMP review	TCA review
Diabetes	3,836	2,998	2,579	2,008
Asthma	1,551	972	600	415
Chronic heart failure	368	245	147	83
Chronic kidney disease	449	290	187	100
Chronic low back pain	1,031	787	352	225
COPD	771	517	308	188
Chronic heart disease	1,447	1,017	664	429
Depression	1,426	1,080	864	644
Osteoarthritis	3,150	2,310	1,253	842
Stroke	369	252	161	103
Total	14,398	10,468	7,115	5,037

(PI 3.5) Description of additional benefits achieved by project through the opportunities created by the National Broadband Network as measured by the number and type of users interacting with CDMS using broadband and mobile services

(PI 3.5) Additional benefits – to be measured as part of the evaluation

Additional uses: 15th Dec – Oct 2012

Role	Baseline Number	New registrations (June 2011)	New Registrations (Dec 2011)	New Registrations (Oct 2012)
Allied Health	223	1,064	12,377	14,730*
Patients	733	1,241	3,855	16,696
General Practitioner	97	143	664	1,787
Medical Specialists	16	459	737	1,545
Practice Nurses	29	35	168	629
Total	1098	3,204	17,801	35,387

*Listed providers in cdmNet: 3,606 accessed plans.

The benefits are listed in section 1 of the main report.

Attachment 1

Provider postcode count. Data can be provided in electronic format if required.

State	Postcode	Total Providers	Baseline (15-12-2009)	New Providers
ACT	2100	2.	.	2.
ACT	2150	1.	.	1.
ACT	2600	40.	.	40.
ACT	2601	28.	.	28.
ACT	2602	15.	.	15.
ACT	2603	7.	.	7.
ACT	2604	8.	.	8.
ACT	2605	9.	.	9.
ACT	2606	20.	.	20.
ACT	2607	2.	.	2.
ACT	2608	2.	.	2.
ACT	2609	4.	.	4.
ACT	2611	9.	.	9.
ACT	2612	7.	.	7.
ACT	2613	1.	.	1.
ACT	2614	4.	.	4.
ACT	2615	3.	.	3.
ACT	2616	3.	.	3.
ACT	2617	29.	.	29.
ACT	2618	1.	.	1.
ACT	2900	8.	.	8.
ACT	2903	2.	.	2.
ACT	2905	3.	.	3.
ACT	2906	2.	.	2.
ACT	2912	5.	.	5.
ACT	2913	3.	.	3.
ACT	3216	1.	.	1.
ACT	3280	1.	.	1.
ACT	3500	1.	.	1.
ACT	5068	1.	.	1.
NSW	0000	1.	.	1.
NSW	1230	1.	.	1.
NSW	1300	1.	.	1.
NSW	1355	3.	.	3.
NSW	1465	1.	.	1.
NSW	1470	1.	.	1.
NSW	1640	1.	.	1.
NSW	1710	1.	.	1.
NSW	1805	1.	.	1.
NSW	1825	4.	.	4.
NSW	2000	163.	.	163.
NSW	2001	4.	.	4.
NSW	2006	2.	.	2.
NSW	2007	13.	.	13.
NSW	2008	3.	.	3.
NSW	2009	10.	.	10.
NSW	2010	199.	.	199.
NSW	2011	28.	.	28.
NSW	2015	4.	.	4.
NSW	2016	5.	.	5.
NSW	2017	5.	.	5.
NSW	2018	4.	.	4.
NSW	2020	1.	.	1.
NSW	2021	13.	.	13.
NSW	2022	101.	.	101.
NSW	2023	6.	.	6.
NSW	2024	10.	.	10.
NSW	2025	10.	.	10.
NSW	2026	13.	.	13.
NSW	2027	18.	.	18.
NSW	2028	22.	.	22.
NSW	2029	9.	.	9.
NSW	2030	3.	.	3.
NSW	2031	55.	.	55.
NSW	2032	8.	.	8.
NSW	2033	6.	.	6.
NSW	2034	10.	.	10.
NSW	2035	23.	.	23.
NSW	2036	11.	.	11.
NSW	2037	25.	.	25.
NSW	2038	19.	.	19.
NSW	2039	17.	.	17.
NSW	2040	27.	.	27.
NSW	2041	21.	.	21.
NSW	2042	29.	.	29.
NSW	2043	2.	.	2.
NSW	2044	2.	.	2.
NSW	2045	4.	.	4.
NSW	2046	12.	.	12.
NSW	2047	8.	.	8.
NSW	2048	7.	.	7.
NSW	2049	7.	.	7.
NSW	2050	14.	.	14.
NSW	2052	26.	.	26.
NSW	2059	1.	.	1.
NSW	2060	24.	.	24.
NSW	2061	2.	.	2.
NSW	2062	3.	.	3.
NSW	2063	6.	.	6.
NSW	2064	7.	.	7.
NSW	2065	42.	.	42.
NSW	2066	24.	.	24.
NSW	2067	70.	.	70.
NSW	2068	8.	.	8.
NSW	2069	5.	.	5.
NSW	2070	11.	.	11.
NSW	2071	7.	.	7.
NSW	2072	10.	.	10.
NSW	2073	11.	.	11.
NSW	2074	9.	.	9.
NSW	2075	17.	.	17.
NSW	2076	12.	.	12.

State	Postcode	Total Providers	Baseline (15-12-2009)	New Providers
NSW	2077	51.	.	51.
NSW	2079	1.	.	1.
NSW	2081	1.	.	1.
NSW	2082	3.	.	3.
NSW	2084	1.	.	1.
NSW	2085	4.	.	4.
NSW	2086	9.	.	9.
NSW	2087	10.	.	10.
NSW	2088	42.	.	42.
NSW	2089	15.	.	15.
NSW	2090	6.	.	6.
NSW	2092	4.	.	4.
NSW	2093	13.	.	13.
NSW	2094	1.	.	1.
NSW	2095	25.	.	25.
NSW	2096	2.	.	2.
NSW	2097	4.	.	4.
NSW	2099	19.	.	19.
NSW	2100	13.	.	13.
NSW	2101	7.	.	7.
NSW	2102	5.	.	5.
NSW	2103	22.	.	22.
NSW	2104	1.	.	1.
NSW	2105	1.	.	1.
NSW	2106	5.	.	5.
NSW	2107	11.	.	11.
NSW	2109	1.	.	1.
NSW	2110	2.	.	2.
NSW	2111	8.	.	8.
NSW	2112	9.	.	9.
NSW	2113	10.	.	10.
NSW	2114	14.	.	14.
NSW	2115	1.	.	1.
NSW	2117	2.	.	2.
NSW	2118	21.	.	21.
NSW	2119	9.	.	9.
NSW	2120	13.	.	13.
NSW	2121	16.	.	16.
NSW	2122	19.	.	19.
NSW	2124	1.	.	1.
NSW	2125	1.	.	1.
NSW	2126	5.	.	5.
NSW	2127	1.	.	1.
NSW	2131	11.	.	11.
NSW	2132	2.	.	2.
NSW	2133	1.	.	1.
NSW	2134	38.	.	38.
NSW	2135	11.	.	11.
NSW	2136	1.	.	1.
NSW	2137	15.	.	15.
NSW	2138	5.	.	5.
NSW	2139	3.	.	3.
NSW	2140	4.	.	4.
NSW	2141	7.	.	7.
NSW	2142	4.	.	4.
NSW	2144	9.	.	9.
NSW	2145	30.	.	30.
NSW	2146	5.	.	5.
NSW	2147	11.	.	11.
NSW	2148	31.	.	31.
NSW	2150	40.	.	40.
NSW	2151	7.	.	7.
NSW	2152	3.	.	3.
NSW	2153	46.	.	46.
NSW	2154	47.	.	47.
NSW	2155	14.	.	14.
NSW	2156	1.	.	1.
NSW	2157	1.	.	1.
NSW	2158	4.	.	4.
NSW	2159	1.	.	1.
NSW	2160	13.	.	13.
NSW	2162	6.	.	6.
NSW	2164	16.	.	16.
NSW	2165	31.	.	31.
NSW	2166	17.	.	17.
NSW	2167	2.	.	2.
NSW	2168	4.	.	4.
NSW	2170	46.	.	46.
NSW	2171	9.	.	9.
NSW	2173	1.	.	1.
NSW	2176	8.	.	8.
NSW	2177	1.	.	1.
NSW	2190	4.	.	4.
NSW	2191	1.	.	1.
NSW	2193	4.	.	4.
NSW	2194	14.	.	14.
NSW	2195	2.	.	2.
NSW	2196	8.	.	8.
NSW	2197	1.	.	1.
NSW	2198	1.	.	1.
NSW	2200	43.	.	43.
NSW	2203	4.	.	4.
NSW	2204	12.	.	12.
NSW	2205	2.	.	2.
NSW	2206	7.	.	7.
NSW	2207	3.	.	3.
NSW	2208	1.	.	1.
NSW	2209	4.	.	4.
NSW	2210	11.	.	11.
NSW	2211	3.	.	3.
NSW	2212	7.	.	7.
NSW	2213	4.	.	4.
NSW	2214	1.	.	1.
NSW	2216	14.	.	14.
NSW	2217	35.	.	35.
NSW	2218	2.	.	2.
NSW	2219	1.	.	1.
NSW	2220	45.	.	45.
NSW	2221	2.	.	2.
NSW	2222	2.	.	2.
NSW	2223	7.	.	7.
NSW	2224	8.	.	8.
NSW	2225	1.	.	1.
NSW	2226	1.	.	1.
NSW	2227	10.	.	10.
NSW	2228	27.	.	27.
NSW	2229	17.	.	17.
NSW	2230	18.	.	18.
NSW	2232	20.	.	20.
NSW	2233	11.	.	11.
NSW	2234	16.	.	16.
NSW	2250	42.	.	42.
NSW	2251	9.	.	9.
NSW	2256	7.	.	7.
NSW	2257	4.	.	4.
NSW	2258	2.	.	2.

State	Postcode	Total Providers	Baseline (15-12-2009)	New Providers
NSW	2259	14.	.	14.
NSW	2260	11.	.	11.
NSW	2261	17.	.	17.
NSW	2262	6.	.	6.
NSW	2263	12.	.	12.
NSW	2264	4.	.	4.
NSW	2265	1.	.	1.
NSW	2280	3.	.	3.
NSW	2281	1.	.	1.
NSW	2282	9.	.	9.
NSW	2283	10.	.	10.
NSW	2284	1.	.	1.
NSW	2285	4.	.	4.
NSW	2287	3.	.	3.
NSW	2289	9.	.	9.
NSW	2290	17.	.	17.
NSW	2291	9.	.	9.
NSW	2292	5.	.	5.
NSW	2296	1.	.	1.
NSW	2298	1.	.	1.
NSW	2299	9.	.	9.
NSW	2300	19.	.	19.
NSW	2302	6.	.	6.
NSW	2303	9.	.	9.
NSW	2304	2.	.	2.
NSW	2305	3.	.	3.
NSW	2308	3.	.	3.
NSW	2309	1.	.	1.
NSW	2315	7.	.	7.
NSW	2316	1.	.	1.
NSW	2317	1.	.	1.
NSW	2318	1.	.	1.
NSW	2320	9.	.	9.
NSW	2321	2.	.	2.
NSW	2322	1.	.	1.
NSW	2323	13.	.	13.
NSW	2324	3.	.	3.
NSW	2325	7.	.	7.
NSW	2326	1.	.	1.
NSW	2327	4.	.	4.
NSW	2330	6.	.	6.
NSW	2333	3.	.	3.
NSW	2340	20.	.	20.
NSW	2346	1.	.	1.
NSW	2347	1.	.	1.
NSW	2348	1.	.	1.
NSW	2350	14.	.	14.
NSW	2352	1.	.	1.
NSW	2357	1.	.	1.
NSW	2360	2.	.	2.
NSW	2370	1.	.	1.
NSW	2372	1.	.	1.
NSW	2380	3.	.	3.
NSW	2390	3.	.	3.
NSW	2400	5.	.	5.
NSW	2406	1.	.	1.
NSW	2422	3.	.	3.
NSW	2428	12.	.	12.
NSW	2429	3.	.	3.
NSW	2430	9.	.	9.
NSW	2431	2.	.	2.
NSW	2440	6.	.	6.
NSW	2443	3.	.	3.
NSW	2444	26.	.	26.
NSW	2445	1.	.	1.
NSW	2446	4.	.	4.
NSW	2447	1.	.	1.
NSW	2448	2.	.	2.
NSW	2450	21.	.	21.
NSW	2452	3.	.	3.
NSW	2454	2.	.	2.
NSW	2460	17.	.	17.
NSW	2464	2.	.	2.
NSW	2470	5.	.	5.
NSW	2473	2.	.	2.
NSW	2474	2.	.	2.
NSW	2477	4.	.	4.
NSW	2478	24.	.	24.
NSW	2479	2.	.	2.
NSW	2480	19.	.	19.
NSW	2481	12.	.	12.
NSW	2482	6.	.	6.
NSW	2483	3.	.	3.
NSW	2484	11.	.	11.
NSW	2485	11.	.	11.
NSW	2486	10.	.	10.
NSW	2487	5.	.	5.
NSW	2488	1.	.	1.
NSW	2489	1.	.	1.
NSW	2500	104.	.	104.
NSW	2502	7.	.	7.
NSW	2508	4.	.	4.
NSW	2515	19.	.	19.
NSW	2516	19.	.	19.
NSW	2517	13.	.	13.
NSW	2518	18.	.	18.
NSW	2519	13.	.	13.
NSW	2520	3.	.	3.
NSW	2521	1.	.	1.
NSW	2522	2.	.	2.
NSW	2525	11.	.	11.
NSW	2526	2.	.	2.
NSW	2527	5.	.	5.
NSW	2528	10.	.	10.
NSW	2529	41.	.	41.
NSW	2530	9.	.	9.
NSW	2533	17.	.	17.
NSW	2534	1.	.	1.
NSW	2535	6.	.	6.
NSW	2536	8.	.	8.
NSW	2537	3.	.	3.
NSW	2538	2.	.	2.
NSW	2539	5.	.	5.
NSW	2540	6.	.	6.
NSW	2541	17.	.	17.
NSW	2546	8.	.	8.
NSW	2548	15.	.	15.
NSW	2549	5.	.	5.
NSW	2550	15.	.	15.
NSW	2560	39.	.	39.
NSW	2565	3.	.	3.
NSW	2566	2.	.	2.
NSW	2567	13.	.	13.
NSW	2570	11.	.	11.
NSW	2571	4.	.	4.
NSW	2574	2.	.	2.

State	Postcode	Total Providers	Baseline (15-12-2009)	New Providers
NSW	2575	5.	.	5.
NSW	2576	25.	.	25.
NSW	2577	5.	.	5.
NSW	2580	7.	.	7.
NSW	2582	3.	.	3.
NSW	2590	3.	.	3.
NSW	2594	3.	.	3.
NSW	2601	1.	.	1.
NSW	2619	1.	.	1.
NSW	2620	13.	.	13.
NSW	2621	1.	.	1.
NSW	2622	1.	.	1.
NSW	2624	1.	.	1.
NSW	2625	1.	.	1.
NSW	2627	1.	.	1.
NSW	2630	6.	.	6.
NSW	2632	2.	.	2.
NSW	2633	2.	.	2.
NSW	2640	26.	.	26.
NSW	2641	2.	.	2.
NSW	2646	1.	.	1.
NSW	2650	30.	.	30.
NSW	2666	1.	.	1.
NSW	2672	1.	.	1.
NSW	2680	5.	.	5.
NSW	2700	4.	.	4.
NSW	2705	3.	.	3.
NSW	2710	4.	.	4.
NSW	2715	2.	.	2.
NSW	2720	6.	.	6.
NSW	2731	4.	.	4.
NSW	2745	3.	.	3.
NSW	2747	3.	.	3.
NSW	2750	43.	.	43.
NSW	2752	1.	.	1.
NSW	2753	12.	.	12.
NSW	2754	2.	.	2.
NSW	2756	6.	.	6.
NSW	2758	1.	.	1.
NSW	2759	2.	.	2.
NSW	2760	12.	.	12.
NSW	2761	2.	.	2.
NSW	2763	3.	.	3.
NSW	2765	2.	.	2.
NSW	2766	2.	.	2.
NSW	2768	3.	.	3.
NSW	2770	6.	.	6.
NSW	2773	2.	.	2.
NSW	2774	5.	.	5.
NSW	2776	1.	.	1.
NSW	2777	7.	.	7.
NSW	2778	1.	.	1.
NSW	2779	1.	.	1.
NSW	2780	9.	.	9.
NSW	2782	2.	.	2.
NSW	2785	4.	.	4.
NSW	2790	5.	.	5.
NSW	2794	3.	.	3.
NSW	2795	23.	.	23.
NSW	2799	1.	.	1.
NSW	2800	13.	.	13.
NSW	2820	1.	.	1.
NSW	2829	1.	.	1.
NSW	2830	16.	.	16.
NSW	2844	1.	.	1.
NSW	2847	1.	.	1.
NSW	2850	10.	.	10.
NSW	2852	4.	.	4.
NSW	2870	5.	.	5.
NSW	2871	1.	.	1.
NSW	2877	2.	.	2.
NSW	2880	4.	.	4.
NSW		.	.	.
NSW		.	.	.
NT	0800	14.	.	14.
NT	0804	1.	.	1.
NT	0810	16.	.	16.
NT	0811	2.	.	2.
NT	0812	1.	.	1.
NT	0813	2.	.	2.
NT	0820	4.	.	4.
NT	0821	1.	.	1.
NT	0822	1.	.	1.
NT	0830	1.	.	1.
NT	0832	1.	.	1.
NT	0836	1.	.	1.
NT	0839	1.	.	1.
NT	0845	1.	.	1.
NT	0870	12.	.	12.
NT	0871	3.	.	3.
NT	0872	1.	.	1.
NT	4558	1.	.	1.
OTHER	6008	2.	.	2.
QLD	2348	1.	.	1.
QLD	2480	1.	.	1.
QLD	2486	2.	.	2.
QLD	4000	91.	.	91.
QLD	4001	5.	.	5.
QLD	4004	2.	.	2.
QLD	4005	12.	.	12.
QLD	4006	8.	.	8.
QLD	4007	9.	.	9.
QLD	4009	1.	.	1.
QLD	4010	5.	.	5.
QLD	4011	14.	.	14.
QLD	4012	16.	.	16.
QLD	4014	3.	.	3.
QLD	4017	16.	.	16.
QLD	4019	9.	.	9.
QLD	4020	6.	.	6.
QLD	4021	4.	.	4.
QLD	4026	1.	.	1.
QLD	4029	7.	.	7.
QLD	4030	8.	.	8.
QLD	4031	8.	.	8.
QLD	4032	27.	.	27.
QLD	4034	21.	.	21.
QLD	4035	11.	.	11.
QLD	4036	1.	.	1.
QLD	4037	1.	.	1.
QLD	4051	40.	.	40.
QLD	4053	39.	.	39.
QLD	4054	13.	.	13.
QLD	4055	13.	.	13.
QLD	4059	20.	.	20.

State	Postcode	Total Providers	Baseline (15-12-2009)	New Providers
QLD	4060	14.	.	14.
QLD	4061	10.	.	10.
QLD	4064	32.	.	32.
QLD	4065	11.	.	11.
QLD	4066	33.	.	33.
QLD	4067	14.	.	14.
QLD	4068	37.	.	37.
QLD	4069	27.	.	27.
QLD	4070	2.	.	2.
QLD	4072	8.	.	8.
QLD	4073	4.	.	4.
QLD	4074	19.	.	19.
QLD	4075	19.	.	19.
QLD	4076	2.	.	2.
QLD	4077	4.	.	4.
QLD	4078	6.	.	6.
QLD	4101	66.	.	66.
QLD	4102	26.	.	26.
QLD	4103	16.	.	16.
QLD	4104	3.	.	3.
QLD	4105	8.	.	8.
QLD	4108	3.	.	3.
QLD	4109	22.	.	22.
QLD	4110	5.	.	5.
QLD	4113	4.	.	4.
QLD	4114	9.	.	9.
QLD	4115	3.	.	3.
QLD	4116	5.	.	5.
QLD	4118	13.	.	13.
QLD	4119	1.	.	1.
QLD	4120	18.	.	18.
QLD	4121	18.	.	18.
QLD	4122	38.	.	38.
QLD	4123	2.	.	2.
QLD	4124	3.	.	3.
QLD	4125	1.	.	1.
QLD	4127	9.	.	9.
QLD	4128	7.	.	7.
QLD	4129	8.	.	8.
QLD	4131	6.	.	6.
QLD	4132	3.	.	3.
QLD	4133	7.	.	7.
QLD	4151	13.	.	13.
QLD	4152	38.	.	38.
QLD	4154	1.	.	1.
QLD	4155	5.	.	5.
QLD	4156	1.	.	1.
QLD	4157	12.	.	12.
QLD	4159	7.	.	7.
QLD	4160	6.	.	6.
QLD	4161	3.	.	3.
QLD	4163	13.	.	13.
QLD	4165	12.	.	12.
QLD	4169	3.	.	3.
QLD	4170	14.	.	14.
QLD	4171	18.	.	18.
QLD	4178	15.	.	15.
QLD	4179	6.	.	6.
QLD	4183	2.	.	2.
QLD	4184	1.	.	1.
QLD	4200	1.	.	1.
QLD	4207	15.	.	15.
QLD	4208	11.	.	11.
QLD	4209	28.	.	28.
QLD	4210	14.	.	14.
QLD	4211	28.	.	28.
QLD	4212	31.	.	31.
QLD	4213	14.	.	14.
QLD	4214	38.	.	38.
QLD	4215	97.	.	97.
QLD	4216	48.	.	48.
QLD	4217	34.	.	34.
QLD	4218	51.	.	51.
QLD	4219	2.	.	2.
QLD	4220	40.	.	40.
QLD	4221	23.	.	23.
QLD	4222	3.	.	3.
QLD	4223	12.	.	12.
QLD	4224	5.	.	5.
QLD	4225	19.	.	19.
QLD	4226	37.	.	37.
QLD	4227	10.	.	10.
QLD	4228	1.	.	1.
QLD	4229	1.	.	1.
QLD	4230	6.	.	6.
QLD	4270	1.	.	1.
QLD	4271	2.	.	2.
QLD	4272	26.	.	26.
QLD	4280	3.	.	3.
QLD	4285	6.	.	6.
QLD	4300	31.	.	31.
QLD	4301	8.	.	8.
QLD	4304	20.	.	20.
QLD	4305	152.	.	152.
QLD	4306	17.	.	17.
QLD	4310	6.	.	6.
QLD	4311	15.	.	15.
QLD	4340	2.	.	2.
QLD	4341	7.	.	7.
QLD	4343	9.	.	9.
QLD	4350	162.	.	162.
QLD	4352	17.	.	17.
QLD	4354	3.	.	3.
QLD	4355	1.	.	1.
QLD	4357	4.	.	4.
QLD	4370	6.	.	6.
QLD	4380	4.	.	4.
QLD	4385	1.	.	1.
QLD	4390	33.	.	33.
QLD	4405	4.	.	4.
QLD	4413	2.	.	2.
QLD	4420	1.	.	1.
QLD	4454	1.	.	1.
QLD	4455	5.	.	5.
QLD	4465	2.	.	2.
QLD	4470	3.	.	3.
QLD	4477	1.	.	1.
QLD	4487	1.	.	1.
QLD	4490	1.	.	1.
QLD	4500	30.	.	30.
QLD	4503	10.	.	10.
QLD	4504	3.	.	3.
QLD	4505	6.	.	6.
QLD	4506	7.	.	7.
QLD	4507	8.	.	8.
QLD	4508	2.	.	2.

State	Postcode	Total Providers	Baseline (15-12-2009)	New Providers
QLD	4509	12.	.	12.
QLD	4510	14.	.	14.
QLD	4519	1.	.	1.
QLD	4520	4.	.	4.
QLD	4521	1.	.	1.
QLD	4550	1.	.	1.
QLD	4551	33.	.	33.
QLD	4552	8.	.	8.
QLD	4555	2.	.	2.
QLD	4556	25.	.	25.
QLD	4557	10.	.	10.
QLD	4558	41.	.	41.
QLD	4559	4.	.	4.
QLD	4560	16.	.	16.
QLD	4561	1.	.	1.
QLD	4562	2.	.	2.
QLD	4563	5.	.	5.
QLD	4564	3.	.	3.
QLD	4565	5.	.	5.
QLD	4566	11.	.	11.
QLD	4567	13.	.	13.
QLD	4568	2.	.	2.
QLD	4570	14.	.	14.
QLD	4572	2.	.	2.
QLD	4573	8.	.	8.
QLD	4575	21.	.	21.
QLD	4605	12.	.	12.
QLD	4606	1.	.	1.
QLD	4610	22.	.	22.
QLD	4613	1.	.	1.
QLD	4614	1.	.	1.
QLD	4625	1.	.	1.
QLD	4630	1.	.	1.
QLD	4650	27.	.	27.
QLD	4655	61.	.	61.
QLD	4660	4.	.	4.
QLD	4670	90.	.	90.
QLD	4671	5.	.	5.
QLD	4674	1.	.	1.
QLD	4680	13.	.	13.
QLD	4700	51.	.	51.
QLD	4701	22.	.	22.
QLD	4702	3.	.	3.
QLD	4703	4.	.	4.
QLD	4709	2.	.	2.
QLD	4710	1.	.	1.
QLD	4714	6.	.	6.
QLD	4715	16.	.	16.
QLD	4717	22.	.	22.
QLD	4718	1.	.	1.
QLD	4719	28.	.	28.
QLD	4720	51.	.	51.
QLD	4721	7.	.	7.
QLD	4722	4.	.	4.
QLD	4730	2.	.	2.
QLD	4740	29.	.	29.
QLD	4741	1.	.	1.
QLD	4744	1.	.	1.
QLD	4800	4.	.	4.
QLD	4802	4.	.	4.
QLD	4804	2.	.	2.
QLD	4805	2.	.	2.
QLD	4807	5.	.	5.
QLD	4810	17.	.	17.
QLD	4811	1.	.	1.
QLD	4812	22.	.	22.
QLD	4814	19.	.	19.
QLD	4815	1.	.	1.
QLD	4817	9.	.	9.
QLD	4818	3.	.	3.
QLD	4819	1.	.	1.
QLD	4820	1.	.	1.
QLD	4825	6.	.	6.
QLD	4850	5.	.	5.
QLD	4860	4.	.	4.
QLD	4868	2.	.	2.
QLD	4869	1.	.	1.
QLD	4870	40.	.	40.
QLD	4871	3.	.	3.
QLD	4873	3.	.	3.
QLD	4874	1.	.	1.
QLD	4875	2.	.	2.
QLD	4877	1.	.	1.
QLD	4878	5.	.	5.
QLD	4879	1.	.	1.
QLD	4880	2.	.	2.
QLD	4883	5.	.	5.
QLD	4885	1.	.	1.
QLD	4888	1.	.	1.
QLD	4895	1.	.	1.
QLD	9726	3.	.	3.
QLD		.	.	.
QLD		.	.	.
SA	2027	1.	.	1.
SA	4000	1.	.	1.
SA	4891	1.	.	1.
SA	5000	133.	.	133.
SA	5001	3.	.	3.
SA	5005	1.	.	1.
SA	5006	61.	.	61.
SA	5007	10.	.	10.
SA	5008	9.	.	9.
SA	5009	28.	.	28.
SA	5011	36.	.	36.
SA	5013	3.	.	3.
SA	5014	3.	.	3.
SA	5015	5.	.	5.
SA	5016	1.	.	1.
SA	5017	1.	.	1.
SA	5018	5.	.	5.
SA	5019	4.	.	4.
SA	5020	1.	.	1.
SA	5021	11.	.	11.
SA	5022	31.	.	31.
SA	5023	8.	.	8.
SA	5024	4.	.	4.
SA	5025	17.	.	17.
SA	5031	10.	.	10.
SA	5032	20.	.	20.
SA	5033	20.	1.	19.
SA	5034	20.	.	20.
SA	5035	12.	.	12.
SA	5037	10.	.	10.
SA	5038	28.	.	28.
SA	5039	20.	.	20.
SA	5041	36.	14.	22.

State	Postcode	Total Providers	Baseline (15-12-2009)	New Providers
SA	5042	10.	1.	9.
SA	5043	10.	.	10.
SA	5045	52.	1.	51.
SA	5046	21.	2.	19.
SA	5047	3.	.	3.
SA	5048	24.	4.	20.
SA	5049	2.	.	2.
SA	5050	1.	.	1.
SA	5051	25.	1.	24.
SA	5052	5.	.	5.
SA	5061	19.	.	19.
SA	5062	10.	.	10.
SA	5063	34.	1.	33.
SA	5064	17.	.	17.
SA	5065	13.	.	13.
SA	5066	3.	.	3.
SA	5067	57.	.	57.
SA	5068	16.	.	16.
SA	5069	18.	.	18.
SA	5070	13.	.	13.
SA	5071	1.	.	1.
SA	5072	8.	.	8.
SA	5073	5.	.	5.
SA	5074	21.	.	21.
SA	5075	5.	.	5.
SA	5076	2.	.	2.
SA	5081	9.	.	9.
SA	5082	7.	.	7.
SA	5083	3.	.	3.
SA	5085	2.	.	2.
SA	5086	14.	.	14.
SA	5087	5.	.	5.
SA	5090	2.	.	2.
SA	5091	3.	.	3.
SA	5092	35.	.	35.
SA	5093	3.	.	3.
SA	5095	3.	.	3.
SA	5096	6.	.	6.
SA	5097	3.	.	3.
SA	5098	7.	.	7.
SA	5107	1.	.	1.
SA	5108	50.	.	50.
SA	5109	8.	.	8.
SA	5110	4.	.	4.
SA	5112	19.	.	19.
SA	5113	1.	.	1.
SA	5114	8.	.	8.
SA	5115	1.	.	1.
SA	5116	3.	.	3.
SA	5117	2.	.	2.
SA	5118	18.	.	18.
SA	5125	11.	.	11.
SA	5126	3.	.	3.
SA	5127	1.	.	1.
SA	5136	1.	.	1.
SA	5142	2.	.	2.
SA	5152	15.	.	15.
SA	5154	5.	.	5.
SA	5157	1.	.	1.
SA	5158	11.	1.	10.
SA	5159	21.	9.	12.
SA	5160	1.	.	1.
SA	5161	10.	1.	9.
SA	5162	38.	10.	28.
SA	5163	1.	.	1.
SA	5165	10.	1.	9.
SA	5167	2.	.	2.
SA	5168	7.	2.	5.
SA	5169	9.	.	9.
SA	5171	8.	.	8.
SA	5172	1.	.	1.
SA	5173	1.	.	1.
SA	5201	1.	.	1.
SA	5203	1.	.	1.
SA	5204	1.	.	1.
SA	5210	2.	.	2.
SA	5211	10.	.	10.
SA	5213	2.	.	2.
SA	5214	4.	.	4.
SA	5223	1.	.	1.
SA	5234	2.	.	2.
SA	5238	1.	.	1.
SA	5241	6.	.	6.
SA	5243	2.	.	2.
SA	5244	2.	.	2.
SA	5245	6.	.	6.
SA	5250	10.	.	10.
SA	5251	23.	1.	22.
SA	5253	1.	.	1.
SA	5255	4.	.	4.
SA	5268	1.	.	1.
SA	5271	6.	.	6.
SA	5272	1.	.	1.
SA	5275	1.	.	1.
SA	5276	8.	.	8.
SA	5277	1.	.	1.
SA	5280	1.	.	1.
SA	5290	23.	.	23.
SA	5302	1.	.	1.
SA	5330	2.	.	2.
SA	5333	3.	.	3.
SA	5340	1.	.	1.
SA	5341	3.	.	3.
SA	5343	6.	.	6.
SA	5352	2.	.	2.
SA	5355	3.	.	3.
SA	5412	1.	.	1.
SA	5417	1.	.	1.
SA	5422	1.	.	1.
SA	5453	3.	.	3.
SA	5461	1.	.	1.
SA	5482	1.	.	1.
SA	5491	1.	.	1.
SA	5522	1.	.	1.
SA	5540	5.	.	5.
SA	5554	2.	.	2.
SA	5556	1.	.	1.
SA	5558	2.	.	2.
SA	5571	2.	.	2.
SA	5580	1.	.	1.
SA	5600	8.	.	8.
SA	5605	1.	.	1.
SA	5606	5.	.	5.
SA	5608	3.	.	3.
SA	5640	1.	.	1.
SA	5700	4.	.	4.

State	Postcode	Total Providers	Baseline (15-12-2009)	New Providers
SA	5725	2.	.	2.
SA		.	.	.
SA	6500	1.	1.	.
SA		.	.	.
TAS	3204	1.	.	1.
TAS	4215	1.	.	1.
TAS	7000	264.	.	264.
TAS	7001	5.	.	5.
TAS	7004	51.	.	51.
TAS	7005	53.	.	53.
TAS	7006	1.	.	1.
TAS	7008	64.	.	64.
TAS	7009	30.	.	30.
TAS	7010	21.	.	21.
TAS	7015	6.	.	6.
TAS	7016	4.	.	4.
TAS	7018	51.	.	51.
TAS	7019	3.	.	3.
TAS	7025	1.	.	1.
TAS	7030	12.	.	12.
TAS	7050	37.	.	37.
TAS	7053	1.	.	1.
TAS	7109	13.	.	13.
TAS	7112	6.	.	6.
TAS	7116	1.	.	1.
TAS	7117	1.	.	1.
TAS	7162	1.	.	1.
TAS	7170	1.	.	1.
TAS	7172	3.	.	3.
TAS	7173	3.	.	3.
TAS	7210	7.	.	7.
TAS	7212	1.	.	1.
TAS	7248	5.	.	5.
TAS	7249	6.	.	6.
TAS	7250	96.	.	96.
TAS	7253	1.	.	1.
TAS	7256	1.	.	1.
TAS	7262	1.	.	1.
TAS	7270	1.	.	1.
TAS	7275	1.	.	1.
TAS	7306	1.	.	1.
TAS	7307	12.	.	12.

State	Postcode	Total Providers	Baseline (15-12-2009)	New Providers
TAS	7310	38.	.	38.
TAS	7315	7.	.	7.
TAS	7320	19.	.	19.
TAS	7322	2.	.	2.
TAS	7330	1.	.	1.
TAS	7470	1.	.	1.
TAS		.	.	.
TAS		.	.	.
VIC	0000	2.	.	2.
VIC	2142	1.	.	1.
VIC	2148	1.	.	1.
VIC	2168	1.	.	1.
VIC	2225	1.	.	1.
VIC	2300	1.	.	1.
VIC	2710	1.	.	1.
VIC	2785	1.	.	1.
VIC	3000	115.	.	115.
VIC	3001	1.	.	1.
VIC	3002	64.	2.	62.
VIC	3003	2.	.	2.
VIC	3004	89.	19.	70.
VIC	3006	7.	.	7.
VIC	3007	1.	.	1.
VIC	3008	1.	.	1.
VIC	3010	5.	.	5.
VIC	3011	40.	.	40.
VIC	3012	18.	.	18.
VIC	3013	4.	.	4.
VIC	3015	10.	.	10.
VIC	3016	15.	.	15.
VIC	3018	4.	.	4.
VIC	3020	16.	.	16.
VIC	3021	20.	.	20.
VIC	3023	11.	.	11.
VIC	3024	2.	.	2.
VIC	3025	5.	.	5.
VIC	3026	2.	.	2.
VIC	3027	1.	.	1.
VIC	3028	6.	.	6.
VIC	3029	16.	.	16.
VIC	3030	34.	.	34.
VIC	3031	9.	.	9.

State	Postcode	Total Providers	Baseline (15-12-2009)	New Providers
VIC	3032	30.	.	30.
VIC	3033	6.	.	6.
VIC	3034	1.	.	1.
VIC	3036	10.	.	10.
VIC	3037	10.	.	10.
VIC	3038	7.	.	7.
VIC	3039	31.	.	31.
VIC	3040	55.	1.	54.
VIC	3041	11.	.	11.
VIC	3042	9.	.	9.
VIC	3043	9.	.	9.
VIC	3044	13.	.	13.
VIC	3045	4.	.	4.
VIC	3046	17.	.	17.
VIC	3047	34.	.	34.
VIC	3049	7.	.	7.
VIC	3050	13.	.	13.
VIC	3051	17.	.	17.
VIC	3052	20.	.	20.
VIC	3053	107.	.	107.
VIC	3054	29.	.	29.
VIC	3055	6.	.	6.
VIC	3056	36.	.	36.
VIC	3057	10.	.	10.
VIC	3058	53.	.	53.
VIC	3059	4.	.	4.
VIC	3060	13.	.	13.
VIC	3061	1.	.	1.
VIC	3064	14.	.	14.
VIC	3065	42.	.	42.
VIC	3066	17.	.	17.
VIC	3067	10.	.	10.
VIC	3068	42.	.	42.
VIC	3070	27.	.	27.
VIC	3071	8.	.	8.
VIC	3072	29.	.	29.
VIC	3073	14.	.	14.
VIC	3074	18.	.	18.
VIC	3075	24.	.	24.
VIC	3076	53.	.	53.
VIC	3078	38.	.	38.
VIC	3079	53.	.	53.

State	Postcode	Total Providers	Baseline (15-12-2009)	New Providers
VIC	3081	14.	.	14.
VIC	3082	17.	.	17.
VIC	3083	30.	.	30.
VIC	3084	65.	.	65.
VIC	3085	1.	.	1.
VIC	3086	2.	.	2.
VIC	3087	6.	.	6.
VIC	3088	45.	.	45.
VIC	3089	7.	.	7.
VIC	3093	3.	.	3.
VIC	3094	1.	.	1.
VIC	3095	41.	.	41.
VIC	3099	1.	.	1.
VIC	3101	62.	.	62.
VIC	3102	6.	.	6.
VIC	3103	37.	.	37.
VIC	3104	27.	.	27.
VIC	3105	6.	.	6.
VIC	3106	3.	.	3.
VIC	3107	22.	.	22.
VIC	3108	24.	.	24.
VIC	3109	24.	.	24.
VIC	3111	15.	.	15.
VIC	3113	4.	.	4.
VIC	3114	1.	.	1.
VIC	3115	1.	.	1.
VIC	3116	10.	.	10.
VIC	3121	92.	.	92.
VIC	3122	70.	.	70.
VIC	3123	16.	.	16.
VIC	3124	66.	.	66.
VIC	3125	8.	.	8.
VIC	3126	10.	.	10.
VIC	3127	32.	.	32.
VIC	3128	74.	.	74.
VIC	3129	12.	.	12.
VIC	3130	58.	.	58.
VIC	3131	23.	.	23.
VIC	3132	32.	.	32.
VIC	3133	12.	.	12.
VIC	3134	78.	.	78.
VIC	3135	34.	.	34.
VIC	3136	45.	.	45.
VIC	3137	5.	.	5.
VIC	3138	16.	.	16.
VIC	3139	3.	.	3.
VIC	3140	23.	.	23.
VIC	3141	35.	.	35.
VIC	3142	21.	.	21.
VIC	3143	29.	.	29.
VIC	3144	143.	.	143.
VIC	3145	22.	.	22.
VIC	3146	25.	.	25.
VIC	3147	62.	.	62.
VIC	3148	18.	.	18.
VIC	3149	30.	.	30.
VIC	3150	41.	.	41.
VIC	3151	11.	.	11.
VIC	3152	50.	.	50.
VIC	3153	3.	.	3.
VIC	3155	17.	.	17.
VIC	3156	14.	.	14.
VIC	3158	1.	.	1.
VIC	3160	8.	.	8.
VIC	3161	32.	.	32.
VIC	3162	54.	.	54.
VIC	3163	33.	.	33.
VIC	3165	75.	1.	74.
VIC	3166	22.	.	22.
VIC	3167	1.	.	1.
VIC	3168	42.	.	42.
VIC	3169	2.	.	2.
VIC	3170	29.	1.	28.
VIC	3171	16.	.	16.
VIC	3172	9.	.	9.
VIC	3173	15.	.	15.
VIC	3174	35.	.	35.
VIC	3175	97.	3.	94.
VIC	3177	2.	.	2.
VIC	3178	15.	.	15.
VIC	3179	2.	.	2.
VIC	3180	4.	.	4.
VIC	3181	74.	1.	73.
VIC	3182	19.	.	19.
VIC	3183	47.	.	47.
VIC	3184	9.	.	9.
VIC	3185	23.	.	23.
VIC	3186	57.	.	57.
VIC	3187	26.	.	26.
VIC	3188	31.	.	31.
VIC	3189	13.	.	13.
VIC	3190	16.	.	16.
VIC	3191	28.	.	28.
VIC	3192	38.	.	38.
VIC	3193	19.	.	19.
VIC	3194	13.	.	13.
VIC	3195	14.	.	14.
VIC	3196	13.	.	13.
VIC	3197	3.	.	3.
VIC	3198	4.	.	4.
VIC	3199	93.	.	93.
VIC	3200	3.	.	3.
VIC	3201	10.	.	10.
VIC	3204	49.	.	49.
VIC	3205	19.	.	19.
VIC	3206	19.	.	19.
VIC	3207	9.	.	9.
VIC	3208	1.	.	1.
VIC	3212	5.	.	5.
VIC	3214	42.	1.	41.
VIC	3215	32.	7.	25.
VIC	3216	189.	18.	171.
VIC	3218	29.	6.	23.
VIC	3219	42.	6.	36.
VIC	3220	259.	31.	228.
VIC	3221	1.	1.	.
VIC	3222	44.	7.	37.
VIC	3223	8.	5.	3.
VIC	3224	7.	1.	6.
VIC	3225	7.	2.	5.
VIC	3226	19.	2.	17.
VIC	3227	5.	.	5.
VIC	3228	56.	11.	45.
VIC	3230	11.	4.	7.
VIC	3232	1.	.	1.
VIC	3250	6.	.	6.

State	Postcode	Total Providers	Baseline (15-12-2009)	New Providers
VIC	3260	3.	.	3.
VIC	3264	1.	.	1.
VIC	3280	13.	.	13.
VIC	3284	1.	.	1.
VIC	3300	6.	.	6.
VIC	3305	7.	.	7.
VIC	3318	1.	.	1.
VIC	3331	26.	6.	20.
VIC	3337	20.	.	20.
VIC	3340	12.	.	12.
VIC	3342	1.	.	1.
VIC	3350	100.	.	100.
VIC	3351	1.	.	1.
VIC	3353	1.	.	1.
VIC	3354	1.	.	1.
VIC	3355	23.	.	23.
VIC	3356	6.	.	6.
VIC	3357	3.	.	3.
VIC	3364	1.	.	1.
VIC	3377	17.	.	17.
VIC	3380	2.	.	2.
VIC	3400	11.	.	11.
VIC	3402	1.	.	1.
VIC	3407	1.	.	1.
VIC	3409	1.	.	1.
VIC	3418	2.	.	2.
VIC	3429	16.	.	16.
VIC	3430	1.	.	1.
VIC	3435	1.	.	1.
VIC	3437	14.	.	14.
VIC	3442	5.	.	5.
VIC	3444	7.	.	7.
VIC	3450	11.	.	11.
VIC	3451	1.	.	1.
VIC	3460	6.	.	6.
VIC	3461	1.	.	1.
VIC	3465	3.	.	3.
VIC	3467	1.	.	1.
VIC	3478	3.	.	3.
VIC	3480	5.	.	5.
VIC	3483	1.	.	1.
VIC	3496	1.	.	1.
VIC	3498	1.	.	1.
VIC	3500	14.	.	14.
VIC	3501	1.	.	1.
VIC	3502	1.	.	1.
VIC	3506	9.	.	9.
VIC	3518	1.	.	1.
VIC	3523	1.	.	1.
VIC	3525	4.	.	4.
VIC	3533	1.	.	1.
VIC	3550	54.	.	54.
VIC	3551	1.	.	1.
VIC	3552	9.	.	9.
VIC	3555	6.	.	6.
VIC	3561	10.	.	10.
VIC	3564	67.	.	67.
VIC	3566	1.	.	1.
VIC	3571	1.	.	1.
VIC	3574	1.	.	1.
VIC	3579	2.	.	2.
VIC	3585	5.	.	5.
VIC	3612	5.	.	5.
VIC	3616	1.	.	1.
VIC	3619	1.	.	1.
VIC	3620	1.	.	1.
VIC	3629	7.	.	7.
VIC	3630	53.	.	53.
VIC	3631	16.	.	16.
VIC	3636	7.	.	7.
VIC	3640	1.	.	1.
VIC	3644	3.	.	3.
VIC	3654	6.	.	6.
VIC	3658	1.	.	1.
VIC	3660	3.	.	3.
VIC	3666	2.	.	2.
VIC	3672	5.	.	5.
VIC	3677	12.	.	12.
VIC	3685	2.	.	2.
VIC	3690	9.	.	9.
VIC	3691	1.	.	1.
VIC	3699	2.	.	2.
VIC	3700	2.	.	2.
VIC	3707	1.	.	1.
VIC	3714	3.	.	3.
VIC	3717	2.	.	2.
VIC	3723	1.	.	1.
VIC	3724	1.	.	1.
VIC	3730	7.	.	7.
VIC	3737	1.	.	1.
VIC	3741	1.	.	1.
VIC	3747	5.	.	5.
VIC	3752	8.	.	8.
VIC	3754	18.	.	18.
VIC	3756	2.	.	2.
VIC	3757	11.	.	11.
VIC	3759	1.	.	1.
VIC	3763	1.	.	1.
VIC	3764	3.	.	3.
VIC	3765	1.	.	1.
VIC	3767	2.	.	2.
VIC	3775	1.	.	1.
VIC	3777	6.	.	6.
VIC	3782	1.	.	1.
VIC	3784	1.	.	1.
VIC	3788	4.	.	4.
VIC	3791	1.	.	1.
VIC	3793	5.	.	5.
VIC	3796	15.	.	15.
VIC	3797	2.	.	2.
VIC	3802	26.	.	26.
VIC	3803	9.	.	9.
VIC	3804	4.	.	4.
VIC	3805	54.	.	54.
VIC	3806	42.	.	42.
VIC	3807	2.	.	2.
VIC	3808	1.	.	1.
VIC	3810	9.	.	9.
VIC	3818	5.	.	5.
VIC	3820	10.	.	10.
VIC	3825	5.	.	5.
VIC	3827	1.	.	1.
VIC	3831	1.	.	1.
VIC	3840	4.	.	4.
VIC	3842	1.	.	1.
VIC	3844	8.	.	8.

State	Postcode	Total Providers	Baseline (15-12-2009)	New Providers
VIC	3850	7.	.	7.
VIC	3860	5.	.	5.
VIC	3875	13.	.	13.
VIC	3881	2.	.	2.
VIC	3909	5.	.	5.
VIC	3910	13.	.	13.
VIC	3911	2.	.	2.
VIC	3912	24.	.	24.
VIC	3915	6.	.	6.
VIC	3918	1.	.	1.
VIC	3922	4.	.	4.
VIC	3930	11.	.	11.
VIC	3931	54.	.	54.
VIC	3934	9.	.	9.
VIC	3936	2.	.	2.
VIC	3938	1.	.	1.
VIC	3939	19.	.	19.
VIC	3943	1.	.	1.
VIC	3950	1.	.	1.
VIC	3953	7.	.	7.
VIC	3960	1.	.	1.
VIC	3975	1.	.	1.
VIC	3976	7.	.	7.
VIC	3977	32.	.	32.
VIC	3984	3.	.	3.
VIC	3995	5.	.	5.
VIC	3996	1.	.	1.
VIC	4719	2.	.	2.
VIC	4720	2.	.	2.
VIC	5062	1.	.	1.
VIC	5171	1.	.	1.
VIC	5540	1.	.	1.
VIC		.	.	.
VIC		.	.	.
WA	3148	1.	.	1.
WA	6000	37.	2.	35.
WA	6001	1.	.	1.
WA	6003	3.	1.	2.
WA	6004	2.	.	2.
WA	6005	15.	.	15.
WA	6006	11.	.	11.
WA	6007	9.	.	9.
WA	6008	64.	4.	60.
WA	6009	36.	.	36.
WA	6010	21.	.	21.
WA	6011	13.	.	13.
WA	6012	5.	.	5.
WA	6014	25.	.	25.
WA	6015	1.	.	1.
WA	6016	6.	.	6.
WA	6017	7.	.	7.
WA	6018	46.	.	46.
WA	6019	10.	.	10.
WA	6020	9.	.	9.
WA	6021	6.	.	6.
WA	6022	3.	.	3.
WA	6023	14.	.	14.
WA	6024	12.	.	12.
WA	6025	14.	.	14.
WA	6026	7.	.	7.
WA	6027	40.	.	40.
WA	6028	2.	.	2.
WA	6029	1.	.	1.
WA	6030	19.	.	19.
WA	6032	1.	.	1.
WA	6036	1.	.	1.
WA	6041	1.	.	1.
WA	6044	1.	.	1.
WA	6050	21.	.	21.
WA	6051	4.	1.	3.
WA	6052	2.	.	2.
WA	6053	4.	2.	2.
WA	6054	2.	.	2.
WA	6055	1.	1.	.
WA	6056	35.	5.	30.
WA	6057	1.	1.	.
WA	6058	5.	.	5.
WA	6059	4.	1.	3.
WA	6060	5.	1.	4.
WA	6061	10.	.	10.
WA	6062	26.	1.	25.
WA	6064	4.	.	4.
WA	6065	11.	.	11.
WA	6066	9.	7.	2.
WA	6070	1.	.	1.
WA	6072	1.	.	1.
WA	6073	7.	.	7.
WA	6076	11.	3.	8.
WA	6084	2.	.	2.
WA	6090	6.	.	6.
WA	6100	8.	.	8.
WA	6101	12.	.	12.
WA	6102	7.	.	7.
WA	6104	5.	1.	4.
WA	6105	8.	.	8.
WA	6106	1.	.	1.
WA	6107	9.	.	9.
WA	6108	4.	.	4.
WA	6109	1.	.	1.
WA	6110	8.	.	8.
WA	6111	6.	.	6.
WA	6112	5.	.	5.
WA	6122	1.	.	1.
WA	6148	8.	.	8.
WA	6149	12.	.	12.
WA	6150	12.	.	12.
WA	6151	5.	.	5.
WA	6152	13.	.	13.
WA	6153	16.	.	16.
WA	6154	17.	.	17.
WA	6155	12.	.	12.
WA	6156	8.	.	8.
WA	6157	13.	.	13.
WA	6158	5.	.	5.
WA	6159	1.	.	1.
WA	6160	28.	.	28.
WA	6162	3.	.	3.
WA	6163	15.	.	15.
WA	6164	6.	.	6.
WA	6167	3.	.	3.
WA	6168	16.	.	16.
WA	6169	3.	.	3.
WA	6208	3.	.	3.
WA	6209	1.	.	1.
WA	6210	26.	.	26.
WA	6220	2.	.	2.

State	Postcode	Total Providers	Baseline (15-12-2009)	New Providers
WA	6225	4.	.	4.
WA	6230	26.	.	26.
WA	6232	2.	.	2.
WA	6233	2.	.	2.
WA	6239	1.	.	1.
WA	6255	1.	.	1.
WA	6258	3.	.	3.
WA	6271	1.	.	1.
WA	6280	10.	.	10.
WA	6281	2.	.	2.
WA	6285	2.	.	2.
WA	6311	1.	.	1.
WA	6312	1.	.	1.
WA	6317	3.	.	3.
WA	6324	1.	.	1.
WA	6330	25.	.	25.
WA	6333	3.	.	3.
WA	6369	1.	.	1.
WA	6401	8.	.	8.

State	Postcode	Total Providers	Baseline (15-12-2009)	New Providers
WA	6415	1.	.	1.
WA	6430	46.	30.	16.
WA	6438	2.	2.	.
WA	6443	1.	1.	.
WA	6450	25.	11.	14.
WA	6502	2.	.	2.
WA	6519	1.	.	1.
WA	6530	17.	.	17.
WA	6531	1.	.	1.
WA	6556	1.	.	1.
WA	6569	1.	.	1.
WA	6701	2.	.	2.
WA	6707	2.	.	2.
WA	6714	2.	.	2.
WA	6720	1.	.	1.
WA	6722	1.	.	1.
WA	6725	1.	.	1.
WA	6743	3.	.	3.
WA	6751	1.	.	1.

State	Postcode	Total Providers	Baseline (15-12-2009)	New Providers
WA	6845	2.	.	2.
WA	6865	1.	.	1.
WA	6903	1.	.	1.
WA	6904	1.	.	1.
WA	6935	1.	1.	.
WA	6954	2.	.	2.
WA	6956	1.	.	1.
WA	6959	2.	.	2.
WA	6964	1.	.	1.
WA	6966	2.	.	2.
WA	6981	1.	.	1.
WA	6984	1.	.	1.
WA	6985	1.	.	1.
Total		17,319.	263. 17,319	17,056.

Attachment 2.

Consumers by Postcodes Data can be provided in electronic format if required.

Postcode	Total Consumers	Baseline (15-12-2009)	New Consumers
0000	1.	.	1.
0021	1.	.	1.
0379	1.	.	1.
0812	1.	.	1.
0832	1.	.	1.
0870	1.	1.	.
1234	1.	.	1.
1890	1.	.	1.
2000	1.	.	1.
2010	4.	.	4.
2011	2.	.	2.
2016	3.	.	3.
2017	1.	.	1.
2022	2.	.	2.
2024	2.	.	2.
2026	7.	.	7.
2027	1.	.	1.
2028	1.	.	1.
2033	1.	.	1.
2034	1.	.	1.
2035	1.	.	1.
2063	1.	.	1.
2066	5.	.	5.
2067	7.	.	7.
2068	1.	.	1.
2072	1.	.	1.
2073	1.	.	1.
2081	1.	.	1.
2085	1.	.	1.
2096	1.	.	1.
2100	2.	.	2.
2111	1.	.	1.
2120	1.	.	1.
2131	2.	.	2.
2132	1.	.	1.
2133	1.	.	1.
2135	1.	.	1.
2136	1.	.	1.
2137	1.	.	1.
2140	1.	.	1.
2141	1.	.	1.
2144	2.	.	2.
2145	3.	.	3.
2146	2.	.	2.
2147	6.	.	6.
2148	4.	.	4.
2150	1.	.	1.
2151	1.	.	1.
2153	1.	.	1.
2155	3.	.	3.
2162	1.	.	1.
2164	8.	.	8.
2165	12.	.	12.
2166	2.	.	2.
2167	22.	.	22.
2170	3.	.	3.
2175	1.	.	1.
2176	6.	.	6.
2177	1.	.	1.
2178	2.	.	2.
2179	1.	.	1.
2194	1.	.	1.
2195	1.	.	1.
2199	2.	.	2.
2204	1.	.	1.
2225	1.	.	1.
2230	2.	.	2.
2232	2.	.	2.
2233	1.	.	1.
2261	1.	.	1.
2290	1.	.	1.
2299	1.	.	1.
2300	3.	.	3.
2316	2.	.	2.
2326	3.	.	3.
2327	1.	.	1.
2335	1.	.	1.
2340	1.	.	1.
2370	1.	.	1.

2400	2.	.	2.
2404	1.	.	1.
2405	2.	.	2.
2408	6.	.	6.
2409	17.	.	17.
2410	5.	.	5.
2444	1.	.	1.
2463	1.	.	1.
2464	1.	.	1.
2474	1.	.	1.
2478	4.	1.	3.
2484	2.	.	2.
2485	2.	.	2.
2486	18.	.	18.
2487	1.	.	1.
2488	1.	.	1.
2500	16.	.	16.
2505	1.	.	1.
2515	32.	.	32.
2516	78.	.	78.
2517	81.	.	81.
2518	33.	.	33.
2519	14.	.	14.
2525	5.	.	5.
2526	1.	.	1.
2527	51.	.	51.
2528	23.	.	23.
2529	198.	.	198.
2530	10.	.	10.
2533	24.	.	24.
2534	8.	.	8.
2546	1.	.	1.

2548	119.	.	119.
2549	14.	.	14.
2550	24.	.	24.
2551	1.	.	1.
2560	1.	.	1.
2564	14.	.	14.
2565	4.	.	4.
2567	2.	.	2.
2571	1.	.	1.
2577	1.	.	1.
2622	1.	.	1.
2633	10.	.	10.
2640	1.	.	1.
2650	1.	.	1.
2665	1.	.	1.
2666	3.	.	3.
2668	1.	.	1.
2671	1.	.	1.
2710	15.	.	15.
2731	90.	.	90.
2745	4.	.	4.
2747	10.	.	10.
2748	1.	.	1.
2749	3.	.	3.
2750	6.	.	6.
2756	1.	.	1.
2760	6.	.	6.
2763	2.	.	2.
2765	2.	.	2.
2766	1.	.	1.
2768	2.	.	2.
2770	1.	.	1.

2785	1.	.	1.
2799	1.	.	1.
2830	4.	.	4.
2835	1.	.	1.
2844	1.	.	1.
2850	1.	.	1.
2852	18.	.	18.
2869	1.	.	1.
3000	3.	.	3.
3002	2.	.	2.
3003	3.	.	3.
3004	5.	.	5.
3006	1.	.	1.
3008	1.	.	1.
3011	17.	.	17.
3012	15.	.	15.
3013	6.	.	6.
3015	4.	.	4.
3016	1.	.	1.
3018	2.	.	2.
3019	13.	.	13.
3020	22.	.	22.
3021	14.	.	14.
3022	5.	.	5.
3023	8.	.	8.
3025	4.	.	4.
3028	9.	.	9.
3029	2.	.	2.
3030	3.	.	3.
3031	8.	.	8.
3032	11.	.	11.
3033	3.	.	3.

3034	3.	.	3.
3036	1.	.	1.
3037	4.	.	4.
3038	3.	.	3.
3039	4.	.	4.
3040	8.	.	8.
3041	2.	.	2.
3042	3.	.	3.
3043	21.	.	21.
3044	20.	.	20.
3046	40.	.	40.
3047	40.	.	40.
3048	24.	.	24.
3049	20.	.	20.
3051	4.	.	4.
3052	3.	.	3.
3053	3.	.	3.
3055	2.	.	2.
3058	14.	.	14.
3059	8.	.	8.
3060	51.	.	51.
3061	8.	.	8.
3063	1.	.	1.
3064	40.	.	40.
3065	7.	.	7.
3066	2.	.	2.
3067	3.	.	3.
3068	3.	.	3.
3070	12.	.	12.
3071	5.	.	5.
3072	42.	.	42.
3073	81.	.	81.

3074	91.	.	91.
3075	151.	.	151.
3076	70.	.	70.
3078	15.	.	15.
3079	19.	.	19.
3081	128.	.	128.
3082	75.	.	75.
3083	62.	.	62.
3084	46.	.	46.
3085	26.	.	26.
3087	12.	.	12.
3088	67.	.	67.
3089	23.	.	23.
3090	4.	.	4.
3091	6.	.	6.
3093	9.	.	9.
3094	19.	.	19.
3095	64.	.	64.
3096	5.	.	5.
3097	3.	.	3.
3099	5.	.	5.
3101	23.	.	23.
3102	1.	.	1.
3103	2.	.	2.
3104	9.	.	9.
3105	2.	.	2.
3106	13.	.	13.
3107	3.	.	3.
3108	6.	.	6.
3109	13.	.	13.
3110	1.	.	1.
3111	76.	.	76.

3113	4.	.	4.
3114	12.	.	12.
3116	12.	.	12.
3121	11.	.	11.
3122	27.	.	27.
3123	15.	.	15.
3124	7.	.	7.
3125	3.	.	3.
3126	1.	.	1.
3127	9.	.	9.
3128	9.	.	9.
3129	4.	.	4.
3130	21.	.	21.
3131	31.	.	31.
3132	67.	.	67.
3133	11.	.	11.
3134	37.	.	37.
3135	8.	.	8.
3136	52.	.	52.
3137	11.	.	11.
3138	6.	.	6.
3139	10.	.	10.
3140	12.	.	12.
3141	3.	.	3.
3142	3.	.	3.
3143	3.	.	3.
3144	4.	.	4.
3145	24.	.	24.
3146	8.	.	8.
3147	6.	.	6.
3148	4.	1.	3.
3149	6.	1.	5.

3150	9.	1.	8.
3151	6.	.	6.
3152	7.	.	7.
3153	5.	.	5.
3155	2.	.	2.
3156	6.	.	6.
3160	3.	.	3.
3161	6.	.	6.
3162	13.	.	13.
3163	21.	2.	19.
3165	41.	7.	34.
3166	15.	3.	12.
3167	4.	1.	3.
3168	5.	.	5.
3169	2.	.	2.
3170	5.	.	5.
3171	7.	.	7.
3172	11.	.	11.
3173	5.	.	5.
3174	25.	.	25.
3175	11.	.	11.
3177	5.	.	5.
3178	7.	.	7.
3179	4.	.	4.
3181	6.	.	6.
3182	2.	.	2.
3183	4.	.	4.
3184	1.	.	1.
3185	1.	.	1.
3186	4.	.	4.
3187	10.	.	10.
3188	6.	.	6.

3189	7.	.	7.
3190	10.	.	10.
3191	1.	.	1.
3192	10.	.	10.
3193	1.	.	1.
3194	2.	.	2.
3195	3.	1.	2.
3198	2.	.	2.
3199	2.	.	2.
3202	1.	.	1.
3204	17.	2.	15.
3207	1.	.	1.
3212	8.	1.	7.
3214	85.	16.	69.
3215	216.	62.	154.
3216	1,055.	40.	1,015.
3218	53.	10.	43.
3219	197.	29.	168.
3220	91.	11.	80.
3221	38.	5.	33.
3222	511.	4.	507.
3223	227.	7.	220.
3224	55.	3.	52.
3225	4.	1.	3.
3226	38.	1.	37.
3227	12.	1.	11.
3228	433.	87.	346.
3230	77.	29.	48.
3231	3.	1.	2.
3232	8.	2.	6.
3233	1.	.	1.
3239	1.	.	1.

3240	15.	3.	12.
3241	10.	1.	9.
3243	1.	1.	.
3249	1.	.	1.
3251	1.	.	1.
3272	1.	.	1.
3280	1.	.	1.
3292	1.	.	1.
3293	1.	.	1.
3304	1.	1.	.
3321	51.	9.	42.
3322	1.	.	1.
3324	2.	.	2.
3328	62.	4.	58.
3329	16.	1.	15.
3330	5.	1.	4.
3331	180.	21.	159.
3332	27.	5.	22.
3333	31.	9.	22.
3334	5.	.	5.
3335	1.	.	1.
3337	4.	.	4.
3338	3.	.	3.
3340	3.	.	3.
3342	1.	.	1.
3345	2.	.	2.
3350	201.	.	201.
3351	24.	.	24.
3352	50.	.	50.
3355	69.	.	69.
3356	101.	.	101.
3357	9.	.	9.

3363	2.	.	2.
3364	1.	.	1.
3373	3.	.	3.
3379	1.	.	1.
3380	1.	.	1.
3381	1.	.	1.
3387	1.	.	1.
3392	1.	.	1.
3427	2.	.	2.
3428	1.	.	1.
3429	2.	.	2.
3433	1.	.	1.
3434	2.	.	2.
3435	2.	.	2.
3437	1.	.	1.
3440	1.	.	1.
3444	1.	.	1.
3446	1.	.	1.
3451	1.	1.	.
3465	1.	.	1.
3477	2.	.	2.
3478	5.	.	5.
3480	54.	.	54.
3482	1.	.	1.
3490	1.	.	1.
3518	1.	.	1.
3523	1.	.	1.
3525	2.	1.	1.
3537	1.	.	1.
3556	1.	.	1.
3561	9.	.	9.
3562	4.	.	4.

3563	10.	.	10.
3564	252.	.	252.
3565	2.	.	2.
3566	4.	.	4.
3567	3.	.	3.
3568	2.	.	2.
3580	1.	.	1.
3610	2.	.	2.
3616	1.	.	1.
3620	5.	.	5.
3621	12.	.	12.
3622	3.	.	3.
3629	5.	.	5.
3630	5.	.	5.
3639	6.	.	6.
3658	1.	.	1.
3669	1.	.	1.
3672	2.	.	2.
3673	1.	.	1.
3675	2.	.	2.
3676	3.	.	3.
3677	21.	.	21.
3678	5.	.	5.
3682	1.	.	1.
3727	1.	.	1.
3732	2.	.	2.
3749	2.	.	2.
3750	4.	.	4.
3751	2.	.	2.
3752	26.	.	26.
3754	114.	.	114.
3755	2.	.	2.

3756	5.	.	5.
3757	57.	.	57.
3761	2.	.	2.
3763	6.	.	6.
3764	1.	.	1.
3770	2.	.	2.
3777	3.	.	3.
3793	2.	.	2.
3795	4.	.	4.
3796	39.	.	39.
3799	3.	.	3.
3802	3.	.	3.
3805	3.	.	3.
3806	2.	.	2.
3808	1.	.	1.
3885	1.	.	1.
3888	2.	.	2.
3903	1.	.	1.
3909	2.	.	2.
3910	2.	.	2.
3912	14.	.	14.
3913	1.	.	1.
3915	1.	.	1.
3918	1.	.	1.
3931	1.	.	1.
3939	1.	.	1.
3941	3.	.	3.
3942	2.	.	2.
3975	1.	.	1.
3977	2.	.	2.
3984	1.	.	1.
4014	1.	.	1.

4019	2.	.	2.
4030	1.	.	1.
4051	1.	.	1.
4065	1.	.	1.
4069	1.	.	1.
4070	1.	.	1.
4073	1.	.	1.
4074	4.	.	4.
4076	3.	.	3.
4077	2.	.	2.
4078	2.	.	2.
4101	10.	.	10.
4103	1.	.	1.
4109	1.	.	1.
4110	1.	.	1.
4114	3.	.	3.
4116	3.	.	3.
4118	6.	.	6.
4120	1.	.	1.
4123	2.	.	2.
4124	4.	.	4.
4125	3.	.	3.
4127	7.	.	7.
4128	2.	.	2.
4130	1.	.	1.
4131	80.	.	80.
4132	4.	.	4.
4133	5.	.	5.
4151	1.	.	1.
4152	1.	.	1.
4157	1.	.	1.
4173	1.	.	1.

4179	1.	.	1.
4183	2.	.	2.
4205	3.	.	3.
4207	8.	.	8.
4208	35.	.	35.
4209	59.	.	59.
4210	29.	.	29.
4211	73.	.	73.
4212	109.	.	109.
4213	42.	.	42.
4214	67.	.	67.
4215	128.	.	128.
4216	227.	.	227.
4217	28.	.	28.
4218	26.	.	26.
4220	39.	.	39.
4221	23.	.	23.
4223	16.	.	16.
4224	3.	.	3.
4225	2.	.	2.
4226	74.	.	74.
4227	41.	.	41.
4228	6.	.	6.
4230	1.	.	1.
4270	7.	.	7.
4271	44.	.	44.
4272	74.	.	74.
4280	1.	.	1.
4285	1.	.	1.
4295	1.	.	1.
4300	87.	.	87.
4301	58.	.	58.

4303	7.	.	7.
4304	75.	.	75.
4305	259.	.	259.
4306	99.	.	99.
4307	4.	.	4.
4309	10.	.	10.
4310	29.	.	29.
4311	120.	.	120.
4312	12.	.	12.
4313	2.	.	2.
4340	13.	.	13.
4341	81.	.	81.
4342	16.	.	16.
4343	49.	.	49.
4344	21.	.	21.
4346	7.	.	7.
4347	4.	.	4.
4350	157.	.	157.
4352	144.	.	144.
4353	1.	.	1.
4354	19.	.	19.
4355	7.	.	7.
4356	1.	.	1.
4358	1.	.	1.
4359	1.	.	1.
4360	1.	.	1.
4361	1.	.	1.
4363	1.	.	1.
4370	1.	.	1.
4385	1.	.	1.
4388	8.	.	8.
4390	157.	.	157.

4400	4.	.	4.
4401	5.	.	5.
4420	11.	.	11.
4422	1.	.	1.
4423	1.	.	1.
4470	2.	.	2.
4494	1.	.	1.
4496	1.	.	1.
4505	1.	.	1.
4510	1.	.	1.
4511	1.	.	1.
4551	1.	.	1.
4552	4.	.	4.
4556	2.	.	2.
4558	3.	.	3.
4570	5.	.	5.
4600	5.	.	5.
4601	19.	.	19.
4605	57.	.	57.
4606	26.	.	26.
4608	4.	.	4.
4610	6.	.	6.
4612	3.	.	3.
4613	11.	.	11.
4615	1.	.	1.
4621	1.	.	1.
4625	1.	.	1.
4627	1.	.	1.
4630	1.	.	1.
4650	146.	.	146.
4655	416.	.	416.
4659	35.	.	35.

4660	11.	.	11.
4662	4.	.	4.
4670	340.	.	340.
4671	55.	.	55.
4673	3.	.	3.
4674	2.	.	2.
4680	2.	.	2.
4700	33.	.	33.
4701	5.	.	5.
4702	51.	.	51.
4707	1.	.	1.
4709	4.	.	4.
4710	1.	.	1.
4711	1.	.	1.
4714	5.	.	5.
4715	4.	.	4.
4717	70.	.	70.
4718	16.	.	16.
4719	126.	.	126.
4720	74.	.	74.
4721	4.	.	4.
4722	100.	.	100.
4723	16.	.	16.
4724	1.	.	1.
4746	2.	.	2.
4812	1.	.	1.
4860	1.	.	1.
4870	3.	.	3.
4879	1.	.	1.
5000	28.	.	28.
5006	6.	.	6.
5007	27.	.	27.

5008	56.	.	56.
5009	43.	.	43.
5010	22.	.	22.
5011	36.	.	36.
5012	35.	.	35.
5013	66.	.	66.
5014	48.	.	48.
5015	11.	.	11.
5016	18.	.	18.
5017	18.	.	18.
5018	11.	.	11.
5019	20.	.	20.
5020	4.	.	4.
5021	30.	.	30.
5022	39.	.	39.
5023	99.	.	99.
5024	37.	.	37.
5025	33.	.	33.
5031	19.	.	19.
5032	33.	.	33.
5033	34.	.	34.
5034	9.	.	9.
5035	19.	.	19.
5037	77.	.	77.
5038	38.	.	38.
5039	20.	.	20.
5040	11.	.	11.
5041	21.	.	21.
5042	5.	.	5.
5043	27.	.	27.
5044	16.	.	16.
5045	31.	.	31.

5046	12.	.	12.
5047	9.	.	9.
5048	15.	.	15.
5049	9.	.	9.
5050	2.	.	2.
5051	8.	.	8.
5052	8.	.	8.
5061	14.	.	14.
5062	10.	.	10.
5063	9.	.	9.
5064	8.	.	8.
5065	2.	.	2.
5066	5.	.	5.
5067	7.	.	7.
5068	8.	.	8.
5069	18.	.	18.
5070	28.	.	28.
5071	1.	.	1.
5072	13.	.	13.
5073	29.	.	29.
5074	33.	.	33.
5075	25.	.	25.
5076	18.	.	18.
5081	9.	.	9.
5082	31.	.	31.
5083	12.	.	12.
5084	28.	.	28.
5085	20.	.	20.
5086	4.	.	4.
5087	7.	.	7.
5088	2.	.	2.
5089	4.	.	4.

5090	5.	.	5.
5091	8.	.	8.
5092	25.	.	25.
5093	9.	.	9.
5095	11.	.	11.
5096	30.	.	30.
5097	5.	.	5.
5098	16.	.	16.
5107	34.	.	34.
5108	144.	.	144.
5109	56.	.	56.
5110	45.	.	45.
5112	22.	.	22.
5113	11.	.	11.
5114	19.	.	19.
5115	3.	.	3.
5116	3.	.	3.
5117	2.	.	2.
5118	4.	.	4.
5120	8.	.	8.
5121	3.	.	3.
5125	10.	.	10.
5126	7.	.	7.
5127	8.	.	8.
5140	2.	.	2.
5152	28.	.	28.
5153	15.	.	15.
5154	12.	.	12.
5155	7.	.	7.
5156	1.	.	1.
5157	2.	.	2.
5158	68.	2.	66.

5159	47.	8.	39.
5160	1.	.	1.
5161	25.	5.	20.
5162	84.	5.	79.
5163	11.	1.	10.
5164	9.	1.	8.
5165	3.	.	3.
5166	2.	.	2.
5167	6.	.	6.
5168	9.	.	9.
5169	24.	.	24.
5170	1.	.	1.
5171	1.	.	1.
5173	6.	.	6.
5174	1.	.	1.
5201	4.	.	4.
5211	9.	.	9.
5212	1.	.	1.
5214	1.	.	1.
5232	1.	.	1.
5235	3.	.	3.
5238	3.	.	3.
5240	1.	.	1.
5241	30.	.	30.
5242	1.	.	1.
5243	3.	.	3.
5244	13.	.	13.
5245	18.	.	18.
5250	14.	.	14.
5251	75.	.	75.
5252	25.	.	25.
5253	1.	.	1.

5254	1.	.	1.
5255	10.	.	10.
5272	8.	.	8.
5275	2.	.	2.
5276	28.	.	28.
5290	10.	2.	8.
5291	3.	.	3.
5330	1.	.	1.
5343	2.	.	2.
5372	1.	.	1.
5400	1.	.	1.
5412	1.	.	1.
5473	1.	.	1.
5501	3.	.	3.
5571	3.	.	3.
5572	1.	.	1.
5583	1.	.	1.
5600	1.	.	1.
5608	5.	.	5.
6000	1.	.	1.
6004	1.	.	1.
6006	2.	.	2.
6015	3.	.	3.
6018	8.	.	8.
6019	2.	.	2.
6021	1.	.	1.
6026	1.	.	1.
6027	1.	.	1.
6030	5.	1.	4.
6050	5.	.	5.
6051	1.	.	1.
6052	2.	.	2.

6059	4.	.	4.
6061	2.	.	2.
6062	3.	.	3.
6063	1.	.	1.
6066	8.	.	8.
6069	1.	.	1.
6100	1.	.	1.
6104	2.	.	2.
6105	7.	.	7.
6109	1.	.	1.
6151	1.	.	1.
6153	1.	.	1.
6208	1.	.	1.
6280	1.	.	1.
6312	1.	.	1.
6330	3.	.	3.
6346	1.	1.	.
6429	4.	2.	2.
6430	184.	144.	40.
6431	1.	1.	.
6432	65.	52.	13.
6433	7.	3.	4.
6436	1.	.	1.
6437	1.	.	1.
6438	23.	20.	3.
6440	1.	1.	.
6442	3.	2.	1.
6443	24.	24.	.
6445	1.	1.	.
6446	1.	.	1.
6448	6.	4.	2.
6450	64.	46.	18.

6510	1.	.	1.
6517	2.	.	2.
6714	1.	1.	.
6720	1.	.	1.
6725	1.	.	1.
7000	15.	.	15.
7004	17.	.	17.
7005	33.	.	33.
7007	5.	.	5.
7008	8.	.	8.
7009	10.	.	10.
7010	11.	.	11.
7011	5.	.	5.
7012	1.	.	1.
7015	8.	.	8.
7016	1.	.	1.
7017	1.	.	1.
7018	61.	.	61.
7019	3.	.	3.
7021	1.	.	1.
7024	2.	.	2.
7025	2.	.	2.
7027	1.	.	1.
7030	9.	.	9.
7050	10.	.	10.
7052	6.	.	6.
7053	13.	.	13.
7054	3.	.	3.
7108	1.	.	1.
7109	4.	.	4.
7112	14.	.	14.
7113	1.	.	1.

7116	1.	.	1.
7117	2.	.	2.
7120	7.	.	7.
7150	1.	.	1.
7155	1.	.	1.
7170	2.	.	2.
7171	4.	.	4.
7172	1.	.	1.
7173	9.	.	9.
7177	1.	.	1.
7209	49.	.	49.
7210	133.	.	133.
7211	17.	.	17.

7212	3.	.	3.
7213	31.	.	31.
7214	2.	.	2.
7216	2.	.	2.
7248	15.	.	15.
7249	11.	.	11.
7250	94.	.	94.
7253	1.	.	1.
7258	1.	.	1.
7260	2.	.	2.
7270	1.	.	1.
7275	2.	.	2.
7277	2.	.	2.

7290	5.	.	5.
7301	1.	.	1.
7302	1.	.	1.
7303	1.	.	1.
7304	1.	.	1.
7305	4.	.	4.
7306	1.	.	1.
7307	14.	.	14.
7310	56.	.	56.
7320	2.	.	2.
7777	1.	.	1.
9726	1.	.	1.
Total	16,696	716	15,980

Attachment 3. Evaluation Report Piterman L. et. al., The cdmNet Australia Evaluation – Final Report (Unpublished), Monash University, Australia.

Please see separate report.

Attachment 4.

Medicare Local Uptake – Total to 18 Oct 2012

	Metro or Rural	# Patients with GPMP	Total GPMP	Total TCA	Total GPMP Review	Total TCA Review
Unknown eg Northern Territory 4(90 GPs)		149	152	126	35	16
Barwon (86 GPs)	Rural	3,280	3,702	3,276	2,835	2,242
Bayside (35 GPs)	Metro	154	166	105	58	14
Bentley - Armadale (4 GPs)	Metro	5	5	0	0	0
Central Adelaide and Hills (111 GPs)	Metro	332	332	0	0	0
Central Queensland (22 GPs)	Rural	439	439	355	30	9
Country South SA (25 GPs)	Rural	3	3	0	0	0
Darling Downs - South West Queensland (55 GPs)	Rural	221	221	152	31	19
Eastern Melbourne (29 GPs)	Metro	181	181	139	48	16
Eastern Sydney (14 GPs)	Metro	8	8	0	0	0
Far North Queensland (10 GPs)	Rural	1	1	0	0	0
Frankston - Mornington Peninsula (16 GPs)	Metro	20	20	18	1	0
Gippsland (5 GPs)	Rural	1	1	0	0	0
Gold Coast (106 GPs)	Metro	185	185	90	17	10
Goldfields - Midwest (26 GPs)	Rural	343	358	234	134	52
Goulburn Valley (25 GPs)	Rural	5	5	0	0	0
Grampians (24 GPs)	Rural	362	362	190	72	1
Greater Metro South Brisbane (32 GPs)	Metro	103	103	91	14	13
Hume (4 GPs)	Rural	27	27	0	0	0
Hunter Rural (3 GPs)	Rural	3	3	0	0	0
Illawarra - Shoalhaven (30 GPs)	Rural	425	425	272	54	27
Inner East Melbourne (55 GPs)	Metro	415	425	279	86	17
Inner North West Melbourne (73 GPs)	Metro	15	15	5	0	0
Inner West Sydney (12 GPs)	Metro	11	11	0	0	0

Kimberley - Pilbara (3 GPs)	Rural	1	1	0	0	0
Loddon - Mallee - Murray (36 GPs)	Rural	435	435	183	14	5
Macedon Ranges and North Western Melbourne (85 GPs)	Metro	141	141	4	0	0
Metro North Brisbane (17 GPs)	Metro	1	1	0	0	0
Murrumbidgee (8 GPs)	Rural	3	3	0	0	0
North Coast NSW (20 GPs)	Rural	1	1	0	0	0
Northern Adelaide (30 GPs)	Metro	11	11	0	0	0
Northern Melbourne (153 GPs)	Metro	211	212	126	63	6
Northern Sydney (7 GPs)	Metro	1	1	0	0	0
Perth Central and East Metro (14 GPs)	Metro	23	23	1	1	0
Perth North Metro (16 GPs)	Metro	13	13	1	0	0
Perth South Coastal (5 GPs)	Metro	1	1	0	0	0
South Eastern Melbourne (13 GPs)	Metro	50	50	51	2	0
South Eastern Sydney (8 GPs)	Metro	6	6	6	0	0
Southern Adelaide - Fleurieu - Kangaroo Island (52 GPs)	Rural	59	59	48	14	0
Southern NSW (17 GPs)	Rural	143	143	104	2	1
South Western Sydney (20 GPs)	Metro	64	64	23	0	0
South West WA (8 GPs)	Rural	3	3	0	0	0
Sunshine Coast (14 GPs)	Metro	1	1	0	0	0
Sydney North Shore and Beaches (17 GPs)	Metro	12	12	4	0	0
Tasmania (112 GPs)	Rural	563	566	391	103	26
Western NSW (7 GPs)	Rural	22	22	9	0	0
Western Sydney (26 GPs)	Metro	13	13	1	0	0
West Moreton - Oxley (86 GPs)	Rural	368	369	320	59	46
Wide Bay (47 GPs)	Rural	363	343	58	13	13
Townsville - Mackay (13 GPs)	Metro	1	1	0	0	0
Nepean - Blue Mountains (12 GPs)	Rural	24	24	0	0	0
Grand Totals (1,738 GPs)		9,222	9,669	6,662	3,686	2,533

Attachment 5.

Presentations;

Presentations were made at the following Conferences and seminars

1. Web-Enabled Collaborative Care and the Management of Chronic Disease (The Final Frontier: Australian Primary Care Collaboratives Wave 4 Workshop, Sydney, 26 February 2010)
2. Implementing the National E-Health Agenda: First Steps (The 12th Annual Health Congress, Sydney, 5 March 2010)
3. The Use of CDMS for Collaborative Care (E-Health and Telemedicine Forum: Day of Innovation, Adelaide, 12 March 2010)
4. Chronic Disease Management and Improving Care Co-ordination (E-Health: National co-ordination and alignment, Sydney, 14 April 2010)
5. The Future of IT Enabled Healthcare (Healthcare World 2010, Sydney, 22 April 2010)
6. Developing the patient Centred Coordination Plan Profile (IHE Open Day, Canberra, 15 April 2010)
7. E-Health: Shaping the Future of Healthcare (5th International Conference in Health Care: Quality around the World, Melbourne, 22 May 2010)
8. Transforming the system through electronic Chronic Disease Management (AGPN eHealth Conference, Melbourne, 17 June 2010)
9. Diabetes: Future Directions (Diabetes Australia Victoria and Baker IDI annual symposium, attended by 200 health care professionals, May 2011) – Presentation delivered by Baker IDI Heart and Diabetes Institute
10. cdmNet:Simplifying Chronic Disease Management (GP Super Clinics Conference, May 2011) - Presentation delivered by Precedence Health Care
11. GP Management of patients with a chronic disease using Medicare Items (721,723,732,900) and a broadband-based service (Monash QIP Workshop 2, May 2011) - Presentation delivered by Precedence Health Care
12. cdmNet:Simplifying Chronic Disease Management (Realising the Benefits of eHealth, May 2011) - Presentation delivered by Precedence Health Care
13. Screening and Diagnosis of Diabetes (Diabetes Care at the Centre: Delivery at the Front Line Symposium, Alice Springs, June 2011) - Presentation delivered by Baker IDI Heart and Diabetes Institute
14. Diagnosis and Monitoring of Diabetes (ADS GP Education Day, Melbourne Convention Centre, June 2011) - Presentation delivered by Baker IDI Heart and Diabetes Institute
15. e-Health presentation (Baker IDI Pre-Diabetes and Type 2 Diabetes Workshop, Melbourne, June 2011) - Presentation delivered by Precedence Health Care
16. e-Health presentation (Baker IDI Insulin Management Workshop Workshop, Melbourne, June 2011) - Presentation delivered by Precedence Health Care

17. Chronic Illness target group consultation on the personally controlled electronic health record (PCEHR) (Nation e-Health Transition Authority, June 2011) - Presentation delivered by Precedence Health Care
18. cdmNet: Simplifying Chronic Disease Management (Goulburn Valley GP Association, June 2011) - Presentation delivered by Precedence Health Care
19. The Path to Transforming Healthcare (CeBIT eHealth Conference, June 2011) - Presentation delivered by Precedence Health Care
20. Chronic Disease Management and Medicare: The Baby and the Bathwater (Future of Medicare 2010, 2nd Annual Conference, 11 November 2010) – Presentation delivered by Precedence Health Care
21. cdmNet: Making the right thing to do the easy thing to do (AGPN National Forum 2010, 5 November 2010) – Presentation delivered by Precedence Health Care
22. eHealth Innovation and Opportunities for Small Business (Victorian eHealth Cluster – Information and networking event, 25th November 2010) - Presentation delivered by Precedence Health Care
23. cdmNet Seminar (University of Melbourne Faculty of Information Services, 26th November 2010) - Presentation delivered by Precedence Health Care
24. eHealth and Chronic Disease Management (Australian Health Congress, 29th – 30th Nov 2010) - Presentation delivered by Precedence Health Care
25. E-Health as a policy tool for Chronic Disease Management (Diabetes Policy Conference, 1 – 3 December 2010) - Presentation delivered by Precedence Health Care
26. ePrescribing in chronic disease management (Pharmacy Congress, Melbourne) – Presentation delivered by eRx
27. Process of MBS billing for CDM & diabetes (Practice Nurses Forum, Melbourne) – Presentation delivered by Baker IDI
28. Chronic Disease Management using cdmNet (Novartis Diabetes Educator Day, Melbourne) – Presentation delivered by Baker IDI
29. The future of eHealth (Bundaberg – Best Practice Summit, March 2011) - – Presentation delivered by eRx
30. Future Trends in Health Informatics (UWS HI Summer School 2011, Jan 2011) - Presentation delivered by Precedence Health Care
31. Broadband: The Way to Transform Healthcare (Broadband and Beyond. Feb 2011) - Presentation delivered by Precedence Health Care
32. Collaborative Care Cluster Australia: Progress Report (to DBI, Feb 2011) - Presentation delivered by Precedence Health Care
33. Identifying and responding to workforce challenges with a focus on Chronic Disease Management (HISA Vic "Working in healthcare 2015 and beyond" Melbourne, Victoria, March 2011) – Presentation delivered by Precedence Health Care
34. cdmNet: Transforming Chronic Disease Management (Baker IDI Diabetes in the Elderly Workshop, Melbourne, March 2011) - Presentation delivered by Precedence Health Care
35. E-Health and Collaborative Care: cdmnet (Allied Health Peak Organisations Meeting, March 2011) - Presentation delivered by Precedence Health Care

36. E-Health and Collaborative Care: Changing the Picture (IBM Smarter Seller University 2011, March 2011) - Presentation delivered by Precedence Health Care
37. Diabetes: Future Directions (Diabetes Australia Victoria and Baker IDI annual symposium, attended by 200 health care professionals, May 2011) – Presentation delivered by Baker IDI Heart and Diabetes Institute
38. cdmNet:Simplifying Chronic Disease Management (GP Super Clinics Conference, May 2011) - Presentation delivered by Precedence Health Care
39. GP Management of patients with a chronic disease using Medicare Items (721,723,732,900) and a broadband-based service (Monash QIP Workshop 2, May 2011) - Presentation delivered by Precedence Health Care
40. cdmNet:Simplifying Chronic Disease Management (Realising the Benefits of eHealth, May 2011) - Presentation delivered by Precedence Health Care
41. Screening and Diagnosis of Diabetes (Diabetes Care at the Centre: Delivery at the Front Line Symposium, Alice Springs, June 2011) - Presentation delivered by Baker IDI Heart and Diabetes Institute
42. Diagnosis and Monitoring of Diabetes (ADS GP Education Day, Melbourne Convention Centre, June 2011) - Presentation delivered by Baker IDI Heart and Diabetes Institute
43. e-Health presentation (Baker IDI Pre-Diabetes and Type 2 Diabetes Workshop, Melbourne, June 2011) - Presentation delivered by Precedence Health Care
44. e-Health presentation (Baker IDI Insulin Management Workshop Workshop, Melbourne, June 2011) - Presentation delivered by Precedence Health Care
45. Chronic Illness target group consultation on the personally controlled electronic health record (PCEHR) (Nation e-Health Transition Authority, June 2011) - Presentation delivered by Precedence Health Care
46. cdmNet: Simplifying Chronic Disease Management (Goulburn Valley GP Association, June 2011) - Presentation delivered by Precedence Health Care
47. The Path to Transforming Healthcare (CeBIT eHealth Conference, June 2011) - Presentation delivered by Precedence Health Care
48. Future Trends in eHealth Research (Monash School of Primary Health Care 2011, July 2011) - Presentation delivered by Precedence Health Care
49. cdmNet: Simplifying Chronic Disease Management (Murray Plains GP Division, Echuka, August 2011) - Presentation delivered by Precedence Health Care
50. eHealth in primary care: What's new and does it make a difference? (17th Wonca Europe Conference, Informatics Working Party and EQuiP, Warsaw, Poland, 8-11 September 2011) – Presentation delivered by Monash University
51. Putting the PCEHR to Work: Simplifying the Management of Chronic Disease (AGPN e-health Conference, Brisbane, August 2011)) - Presentation delivered by Precedence Health Care
52. Enabling Collaboration Through Technology (Victorian Healthcare Association, Melbourne September 2011) - Presentation delivered by Precedence Health Care

53. Invited presentations at the ADS-ADEA Conference, Perth, Sep 2011 - - Presentation delivered by Baker IDI
54. Improving chronic disease management through the use of information technology: The CCCA project (Making change happen: Monash University Department of General Practice Research Conference, Melbourne, Australia) - Presentation delivered by Monash University
55. Self-Organizing Maps for Translating Health Care Knowledge: A Case Study in Diabetes Management (24th Australasian Joint Conference on Artificial Intelligence, Perth, Australia) - Presentation delivered by Monash University
56. Diabetes care management: indicators based on data from chronic disease management network (Making change happen: Monash University Department of General Practice Research Conference, Melbourne, Australia) - Presentation delivered by Monash University
57. Lifestyle Prevention and Reversal of Type 2 Diabetes: Is it possible? (Australian Lifestyle Medicine Association, Third Annual Lifestyle Medicine Conference, Sydney, Nov 2011) - Presentation delivered by Baker IDI
58. cdmNet: Simplifying Chronic Disease Management (ICT and Diabetes Forum, AEHRC, Brisbane, Aug 2011) - Presentation delivered by CSIRO
59. cdmNet: Improving Quality of Care for Chronic Disease (Baker IDI, Melbourne, October 2011) - Presentation delivered by Precedence Health Care
60. cdmNet: Improving Quality of Care for Chronic Disease (Menzies Institute, Melbourne, Oct 2011) - Presentation delivered by Precedence Health Care
61. Update on eHealth: Can Better IT Systems Make a Difference (The John Murtagh Annual Update Course for General Practitioners, Melbourne, Nov 2011) - Presentation delivered by Precedence Health Care
62. cdmNet: Simplifying Chronic Disease Management (RHealth- eHealth symposium, Stanthorpe, Qld, Nov 2011) - Presentation delivered by Precedence Health Care
63. cdmNet: Getting Best Practice Guidelines into Use (RACGP e-Guidelines Committee, Melbourne, Nov 2011) - Presentation delivered by Precedence Health Care
64. How AI can Transform Healthcare (Australian Workshop on Artificial Intelligence in Health, AIH 2011, Perth, Dec 2011) - Presentation delivered by Precedence Health Care
65. cdmNet: Simplifying Chronic Disease Management (Murray Plains GP Division, Echuca, Dec 2011) - Presentation delivered by Precedence Health Care
66. cdmNet: Simplifying Chronic Disease Management (ACT Medicare Local, Canberra, Feb 2012) - Presentation delivered by Precedence Health Care
67. cdmNet: Simplifying Chronic Disease Management (Eastern Sydney Division of General Practice, Sydney, Feb 2012) - Presentation delivered by Precedence Health Care
68. The Role of eHealth Technologies in Managing Chronic Conditions (Technology in Healthcare Summit 2012, Sydney, Feb 2012) - Presentation delivered by Precedence Health Care

69. cdmNet: Simplifying Chronic Disease Management (Ministry of Health Malaysia, PutraJaya, Malaysia, Apr 2012) - Presentation delivered by CSIRO AEHRC & Precedence Health Care
70. Implementing e-health innovations in chronic disease management (PHCRIS conference) – Presentation delivered by Monash University
71. GPCE – PNCE Conference (organised by Reed Business Conferences, Sydney May 2012) - Presentation delivered by Precedence Health Care
72. Tasmania Medicare Local Collaboratives Program (Tasmania Medicare Local May 2012) - Presentations delivered by Precedence Health Care
73. Factors contributing to the development of team care arrangements for patients with type 2 diabetes, (Australian disease management association conference,13-14 September 2012, Melbourne), Presentation delivered by Monash University

Attachment 6 Publications in Journals and Magazines

1. Jon Hilton and Michael Georgeff (Sept 2010) Why is telemedicine not more widely used, Pulse IT, issue 19, pages 32-41.
2. De Silva D, Alahakoon O, Wickramasinghe LK, Alahakoon D, Georgeff M, Hilton J, Schattner P, Jones KM, Piterman L, Business Intelligence (BI) Techniques for Decision Support in Chronic Disease Management, Abstract submission for The Royal Australian College of General Practitioners and the Australian Association of Practice Managers combined national conference (GP'10), Cairns, Australia, October 2010
3. Wickramasinghe K, Guttmann C, Georgeff M, Thomas I, and Schmidt H, An Adherence Support Framework for Service Delivery in Customer Life Cycle Management, Book title: Proceedings on Coordination, Organization, Institutions and Norms in Multi-Agent Systems (COIN 2010), Lecture Notes in Artificial Intelligence (LNAI), Volume: 6541 – In Press
4. Wickramasinghe K, Georgeff M, Guttmann C, Thomas I, and Schmidt H, Cost/Benefit Analysis of an Adherence Support Framework for Chronic Disease Management, Book title: Proceedings on Behaviour Monitoring and Interpretation – Well Being, (BMI KI'09) – Accepted for publication
5. Jones KM, Dunning T. Users' perspectives of the Chronic Disease Management System (CDMS): a pilot study. Journal of Diabetes Nursing, 2011; (10):381-386
6. Jones KM, Schattner P, Adaji A, Piterman L. Patient's use of, attitudes to, and beliefs about web based care planning (GPMPs, TCAs and subsequent reviews). Telecommunications Journal of Australia 2011; 61 (4): 68.1-68.10. Available from:http://tja.org.au.
7. Paterson M, Jones KM. IT-based collaborative healthcare initiatives: a legal analysis. Telecommunications Journal of Australia 2011; 61(3) 42.1-42.10 http://tja.org.au
8. Paterson M, Jones KM, Schattner P, Adaji A, Piterman L. Electronic care plans and medicolegal liability. AFP, 2011; 40(6):432-434
9. Wickramasinghe LK, Alahakoon D, Georgeff M, Schattner P, DeSilva D, Alahakoon O, Adaji A, Jones K, Piterman L. Chronic Disease Management: a Business Intelligence Perspective. Paper appeared in the Australasian Workshop on Health Informatics and Knowledge Management (HIKM 2011), Perth, Australia, January 2011.
10. Wickramasinghe K, Alahakoon D, Georgeff M, Schattner P, De Silva D, Alahakoon O, Adaji A, Jones K, and Piterman L, Chronic Disease Management: a Business Intelligence Perspective, Conference abstract for Health Informatics and Knowledge Management stream of Australian Computer Science Week 2011, 17-20 January 2011, Perth – Accepted for publication
11. Jones K, Piterman L. GP Management of patients with a chronic disease using Medicare Items (721, 723, 732, 900) and a broadband-based service. RACGP GP11 Hobart, Tasmania 6-8 October 2011
12. eRx tackling Chronic Disease Management by David Freemantle, eRx News (Fred Health internal publication)
13. M Gill & J Grant, Connected GP, White Paper published by Cisco Inc
14. Self-Organizing Maps for Translating Health Care Knowledge: A Case Study in Diabetes Management Book Chapter-accepted, Proceeding of the 24th Australasian Joint Conference on Artificial Intelligence, Lecture Notes in Artificial Intelligence (LNAI) by Leelani Kumari Wickramasinghe, Damminda Alahakoon, Peter Schattner, Michael Georgeff
15. Precedence to Add Telehealth – cdmNet by Kate McDonald, Pulse IT Magazine, 15 February 2012

16. L.K. Wickramasinghe, P. Schattner, G. Russell, D. Alahakoon, M. Georgeff, K. Jones, R. Jayasena, L. Piterman, Diabetes management in Australia: clinical indicators from chronic disease management network, Proceedings of the International Primary Health Care Reform Conference, international Innovation, policy setting and research, 6-7 March 2012, Brisbane, Australia.
17. Jones K, Biezen R, Piterman L. GP Management of patients with a chronic disease using Medicare Items and a broadband-based service (cdmNet) 4th Primary Care Health Conference, Brisbane, 6-7 March 2012
18. Feature: CDM Nets Funds for Diabetes Care Project by Kate McDonald, Pulse IT Magazine, 13 April 2012
19. PhD Thesis "A case study of collaborative dynamics in the design and evaluation of a web based care plan". Awarded to Dr Akuh Adaji May 2012. Supervisors L Piterman, P Schattner H.Piterman
20. P. Schattner, A. Adaji, M. B. Beovich, L.K. Wickramasinghe, G. Russell, K. Jones, Does information and communication technology (ICT) improve chronic disease management?, Proceedings of the Primary Health Care Reseach Conference, inform, influence, implement: research improving policy and practice, 18-20 July 2012, Canberra, Australia.
21. L.K. Wickramasinghe, P. Schattner, J. Enticott, M. Georgeff, G. Russell, L. Piterman, Care plans for patients with type 2 diabetes: patient variables that contribute to plan formation, Proceedings of the Primary Health Care Research Conference, 18-20 July 2012, Canberra, Australia.
22. Jones K, Biezen R, Piterman L. GP management of patients with a chronic disease using Medicare Items and a broadband-based service (cdmNet). PHCRIS, Canberra 18-20 July 2012
23. Biezen R, Jones K, Piterman L. Medicare items and a broadband-based service (cdmNet) – patients' perspective. PHCRIS, Canberra 18-20 July 2012
24. Schattner P, Adaji A, Beovich B, Wickramasinghe L, Russell G, Jones K. Does information and communication technology (ICT) improve chronic disease management? PHCRIS, Canberra 18-20 July 2012
25. Jones K, Biezen R, Piterman L. GP Management of patients with a chronic disease using Medicare items and a broadband-based service (cdmNet). ADMA 8th Annual National Conference, Melbourne 13-14 September 2012
26. Jones KM, Dunning T, Costa B, Fitzgerald K, Adaji A, Chapman C, Piterman L, Paterson M, Schattner P, Catford J. The CDM-Net Project – the development, implementation and evaluation of a broadband-based network for managing chronic disease. International Journal of Family Medicine, 2012;doi:10.1155/2012/453450
27. L.K. Wickramasinghe, P. Schattner, J. Enticott, M. Georgeff, L. Piterman, Factors contributing to the development of team care arrangements for patients with type 2 diabetes, Proceedings of the Australian disease management association conference,13-14 September 2012, Melbourne, Australia.
28. Adaji A, Schattner P, Jones K, Beovich B, Piterman L. Care planning and adherence to diabetes process guidelines: Medicare data analysis. Australian Health Review – accepted for publication

Attachment 7 Development in cdmNet

New solutions implemented in cdmNet broadband-based service

- Fax to providers where preferred or email not available
- Sortable patient registry
- Patient metrics summary report
- Annual Cycle of Care for diabetes added to cdmNet
- Optimisation and enhancement of software infrastructure
- Development to support future data mining and reporting requirements
- Enhancements to support patient self management : self monitoring measurements
- Organisation assignment and search improvements
- Improvements to software infrastructure to support current and approved care plans
- Same screen appointment, measurement, goal and task editor for improved system performance and usability
- Medication notes
- New review screen to streamline reviews
- Warning messages shown to care plan creators when assigning care team members that don't receive notifications due to lack of email or phone number details
- Changes to provider mandatory details to make adding providers with missing contact data easier
- Ability to edit an account user name after creation
- CSV file support for automating the uploading of lists of providers, organisations and preferred providers
- Individual Health Identifier (IHI) ingestion and display
- Improved patient information banner for clearer identification
- Remembering patient list settings between sessions
- Searching provider improvements including postcode search
- cdmNet Number support - allowing patients and GPs to display and print a barcode and unique patient number that can be used to receive additional care services in the future, including Fred Dispense related use.
- Improved automatic detection of medical conditions
- Improved patient filtering for GPs
- Web service updates for use by external and internal system
- cdmNet Desktop release 1.0 for Best Practice
- Added Medical Director 3 support to cdmNet Desktop

- Added organisation agreements to TCAs.
- Added ability to assign empty organisations to tasks.
- Improved Measurement Type detection
- Release of cdmNet Desktop 1.2
- Web service updates for use by external and internal system
- Added provider self registration
- Retrieval of IHIs from GP desktop software
- Added support for use of test patients for training
- Added reports for GPs
- Improvements to ACoC workflow
- Added organisation preferred providers
- Added ability to add all providers of a given postcode
- Self registration improvements
- Updated Allied Health Referral Forms
- Updates ACoC PDF creation
- Adding/Removing organisation members
- Improvements to editing responsible parties
- Creating health records without a care plan
- Allied Health Referral forms can now be created for current and next year
- Ability to allocate more than 5 allied health services each year
- Providers can register additional organisations
- Providers can register new preferred providers
- Additional specialities
- Improved medication display in documents
- Editable Next Date for tasks
- Number of occurrences for tasks
- Assigning specialties to tasks
- Improved specialty names
- Registration updates
- AHPRA numbers
- Editable Task Names
- Preferred Providers at organisation level

- Care Plan Creators at organisation level
- Progress Note deletion with auditable function
- Telehealth service via Cisco WebEx
- Fax notifications

- cdmNet Desktop – integration with Medical Director and Best Practice

Integration

- cdmNet integration with RACGP Sidebar
- cdmNet integration with Fred Pharmacy Dispensing Systems
- cdmNet integration with Cisco WebEx and telehealth services
- cdmNet integration with CSIRO Mobile Health platform
- cdmNet integration with the Wave 2 Personally Controlled Electronic Health Record and National Infrastructure:
    - CDA Care plan pdf document
    - CDA Shared Health Summary document
    - GP Health Summary and Care Plan Repository
    - Reporting on usage and for audit
    - Interfaces with local (affinity domain) Provider Directory
    - HI Service Support
    - XDS Repository
    - Retrieve Information for Display
    - Basic Patient Privacy Consents
    - Consistent time IHE profile

New care plan types

- Electronic care plan templates and rules for breast cancer
- Electronic care plan templates and rules for mental health care

Attachment 8 . Number of services delivered under care plans

Speciality	Number of Appointments
GP	13,290
Podiatrist	1,713
Diabetes Educator	1,195
Dietitian	936
Other (Unknown)	806
Optometrist	750
Unknown (Assigned To Organisation)	652
Practice Nurse	606
Pharmacist	602
Physiotherapist	508
Ophthalmologist	406
Exercise Physiologist	403
Dental	110
Cardiologist	82
Osteopath	65
Respiratory Nurse	50
Endocrinologist	41
Occupational Therapist	39
Psychologist	26
Chiropractor	19
Community Health	19
Rheumatologist	18
Asthma Educator	13
Dermatologist	13
Nurse Practitioner	13
Respiratory Educator	13

Thoracic Medicine Physician	12
Aboriginal Health Worker	11
Gastroenterologist	11
Neurologist	11
Urologist	11
Orthopaedic Surgeon	10
Speech Pathologist	10
Nurse Educator	9
Physician	9
General Surgeon	8
Medical Oncologist	7
Internal Medicine	6
Paediatrician	6
Psychiatrist	6
Nephrologist	4
Other (Women's And Men's Health Physiotherapist)	4
Clinical Haematologist	3
Health Educator	3
Mental Health Worker	3
Vascular Surgeon	3
Audiologist	2
Diagnostic And Interventional Radiologist	2
Infectious Diseases Specialist	2
Other (Consultant Physician)	2
Palliative Medicine Specialist	2
Practice Manager	2
Radiation Oncologist	2
Clinical Immunologist	1
Counsellor	1
Geriatrician	1
Neurosurgeon	1

Ophthalmic Surgeon	1
Orthotist	1
Other (Intake Worker)	1
Other (Clinic Staff)	1
Pain Management Specialist	1
Total Appointments	22,558


Barwon
Health


precedence
healthcare


Central Queensland Rural Division
of General Practice Assn Inc


cisco


diabetes
australiavic


FRED
WE KNOW PHARMACY


GPV
GENERAL PRACTICE VICTORIA


medicare
local
BARWON
Connecting health to meet local needs


medicare
local
GOULBURN VALLEY
Connecting health to meet local needs


medicare
local
GRAMPIANS
Connecting health to meet local needs


medicare
local
WIDE BAY
Connecting health to meet local needs


medicare
local
LODDON MALLEE MURRAY
Connecting health to meet local needs


medicare
local
TASMANIA
Connecting health to meet local needs


MONASH
University


Queensland Government
Queensland Health


RHEALTH
Your Health Our Health