The Health Advocate

Your voice in healthcare

Improving immunisation rates in the community
Helping to ensure good health

Knowledge translation
Insight into recent research projects

What next for primary health?

How best to meet the needs of local communities

The Quantum Leap
Reasons to attend this year's conference

Health information management problems
Lessons learned from an international success story

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The official magazine of the Australian Healthcare and Hospitals Association

ISSUE 25 / August 2014

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From the AHHA desk

PAUL SCOWN
Chair of the Australian Healthcare and Hospitals Association (AHHA)

Information is key to sound decision-making

The AHHA continues its call for evidence-based health policy and greater collaboration between policymakers and researchers

The refusal of requests by the AHHA and others to the Departments of Human Services and Health for information on bulkbilling and co-payment modelling is a timely reminder that we must continue to promote the need for greater evidence and scrutiny of healthcare decisions. As the core theme running through this August edition of The Health Advocate, evidence-based policy and research must remain a priority as structural reform in the health sector continues.

The Abbott Government's co-payment proposal is just one example of how available data has not been developed or properly utilised. Oral health is another area where greater attention to evidence on the impacts of poor oral health on overall health and wellbeing is needed to ensure that gaps between the 'haves' and the 'have nots' do not widen. As our article on oral health demonstrates, there is recognition that current care models are not as effective as they could be, and we have the foundations to create a new and superior model. Similarly, the benefits of primary care partnerships should not be underestimated. As the collaboration between the West Moreton Hospital and Health Service and West Moreton Medicare Local shows, the coordination of primary care provision can be greatly improved as barriers to care are removed. Lesley Dwyer and Sue Scheinpflug provide some excellent firsthand insight into this matter.

In his article on the Australian health workforce, Mike Davis takes a step back from some of the major topics of debate that have recently surrounded healthcare funding by highlighting other ways that we can innovate the way we provide healthcare — through greater promotion of new nursing and allied health roles. Such diversification in the health workforce is expected to contribute to improved system efficiency.

Terry Hannan tackles efficiency from another angle: using better clinical information management practices to drive change. With an emphasis on training both practitioners and patients in the collection of patient information, especially in rural and remote areas, there are important lessons to be learned for a sparsely populated country like Australia.

Philomena Horsely and Sharleen O'Reilly both highlight largely hidden women's health issues, from the beginning of motherhood to the frailty of old age. Carol Holden discusses a similar dilemma of the 'unknown' with regards to men's health, emphasising the need to revise the way that men's health issues are taught in medical schools. All three authors were participants in a recent knowledge translation workshop hosted by the AHHA's Deeble Institute for Health Policy Research.

These are just some of the stories covered in this edition of the magazine. And in these, as in all health-related matters, evidence is key. It is with this sentiment that the AHHA encourages health leaders to ensure strong evidence underpins health policy changes. It is up to all who play a role in the health system to ensure that we gather, analyse and critique information so that the ever-growing pool of evidence cannot be ignored.

To celebrate research and innovation in health, the AHHA and the Australian Council on Healthcare Standards are holding our annual conference — The Quantum Leap — in Sydney on 9-10 September. The conference will include a range of local and international speakers, who will present an information-rich program of plenary sessions, as well as invited papers and workshops exploring the key issues and innovations to inspire and improve service delivery. Topics include: improving quality and safety through the development and promotion of care standards; providing broader representation of the public healthcare sector at a national level; and encouraging the specialisation of hospital management. Trade exhibitors will also be showcasing their products and services to industry leaders and decision-makers.

The following pages provide additional information on the conference for your convenience. We hope to see you there! ha

REGISTRATION NOW OPEN

The Quantum Leap

Health Innovation: Making Quality Count

TUES. 9 TO WED. 10 SEPTEMBER 2014
NOVOTEL, BRIGHTON LE SANDS, SYDNEY

ahha australian healthcare & hospitals association

THE AUSTRALIAN COUNCIL ON HEALTHCARE STANDARDS ACHS

The Quantum Leap is a collaboration of the Australian Council on Healthcare Standards (ACHS) and the Australian Healthcare and Hospitals Association (AHHA). For more information or to register, visit www.thequantumleap.com.au or phone the AHHA on 02 6162 0780.

DAY 1: Tuesday 9 September 2014

7.30am - 8.45am	**Registration**		
8.45am - 9.00am	**CONGRESS OPENING:** Alison Verhoeven, CE AHHA; Lena Low, CE ACHS		
	Welcome to Country		
9.00am - 9.30 am	**PLENARY SESSION 1: Opening address**		
9.30am - 10.30am	**PLENARY SESSION 2: The politics of national health reform** — Professor John E McDonough, Director, Centre for Public Health Leadership, Harvard University. Former Snr Advisor on National Health Reform, US Senate Committee on Health		
10.30am - 11.00am	**Morning Tea**		
11.00am - 11.30am	**PLENARY SESSION 3: e-health and the digital hospital** — Richard Royle, Executive Director, UnitingCare; Chair, PCEHR Review		
11.30am - 12.00pm	**PLENARY SESSION 4: Revolutionising the health supply chain** — Megan Main, Chief Executive, Health Purchasing Victoria		
12.00pm - 12.30pm	**PLENARY SESSION 5:** Mark Britnell, Global Head of Health, KPMG UK-Europe		
12.30pm - 1.30pm	**Lunch**		
1.30pm - 2.45pm	**CONCURRENT SESSION 1: Technology** (sponsored by KPMG) **1. Bedside patient management system** (Eastern Health/Deakin University) **2. Big Data linkages — synergies between health and sport** (Troy Baker SportsTech) **3. Implementation of an Electronic Medical Record** (Lyn Jamieson, Austin Health) **4. Social Media leading a healthy communication revolution** (Lisa Ramshaw, APHA)	**CONCURRENT SESSION 2: Evidence-based service development** (sponsored by KPMG) **1. Social determinant approach to health improvement** (Katie Thurber, ANU) **2. Improving rural health through community engagement** (Nerida Hyatt, La Trobe University) **3. Evidence-based health rationing** (Elizabeth Martin, QUT) **4. Clinical registries and quality improvement** (Geoff Sims, Australian Clinical registries)	**CONCURRENT SESSION 3: Service redesign** (sponsored by KPMG) **1. Food Services for Patients with Allergies** (Mary Anne Silvers, Monash Health) **2. Early mobilisation post elective orthopaedic surgery** (Andrew Muldoon, Bathurst Health) **3. Case studies in efficiency** (Dental Health Service Victoria) **4. Working with Indicators** (Glenna Parker, Ramsay Health Care)

The Quantum Leap

Health Innovation: Making Quality Count

9-10 SEPT. 2014 | NOVOTEL, BRIGHTON LE SANDS, SYDNEY

2.45pm - 3.15pm	**Afternoon Tea**		
3.15pm - 3.45 pm	**PLENARY SESSION 6:** Dr Richard Di Natale, Senator for Victoria; Greens Health Spokesperson		
3.45pm - 4.30pm	**PLENARY SESSION 7:** Joe Gallagher, Chief Executive, First Nations Health Council, Canada		
4.30pm - 5.00pm	**PANEL SESSION 1: Consumer engagement** — Mary Draper, Health Issues Centre; Nicola Dunbar, ACSQHC; Joe Gallagher, First Nations Health Council; Andam Stankevicius, Consumers Health Forum		
5.00pm - 5.30pm	**ACHS 40th Anniversary celebration**		
7.30pm - 11.00pm	**Conference Dinner** (sponsored by HESTA): Bill Moss AM + the Honourable Peter Dutton, Minister for Health		
	DAY 2: Wednesday 10 September 2014		
7.30am - 8.45am	**Registration**		
7.30am - 8.30am	**BREAKFAST SESSION: Lean thinking in healthcare for executives**		
9.00am - 9.30am	**PLENARY SESSION 8:** Stephen Jones, Shadow Assistant Minister for Health		
9.30am - 10.30am	**PLENARY SESSION 9: Implementing national clinical reform** — Professor Roopen Arya, Professor of Thrombosis and Haemostasis, King's College London (sponsored by Clinical Excellence Commission)		
10.30am - 11.00am	**Morning Tea**		
11.00am - 12.30pm	**CONCURRENT SESSION 4: Safety and Quality** (sponsored by KPMG) **1. Accreditation models & elements** (David Greenfield, UNSW) **2. Application of Open Disclosure standards** (Matthew O'Brien, Cognitive Institute) **3. Home-based chemotherapy** (Fiona Lynch, Healthcare at Home) **4. Innovation in achieving NSQHS Standards** (Amritphal Dhillon, Peter MacCallum Cancer Centre)	**CONCURRENT SESSION 5: Transition to PHOs - Opportunities and Risks** **1. Governance and contractual issues** (Tim Smyth Holman Webb) **2. Acute service delivery and coordination** (Lesley Dwyer, West Moreton HHS) **3. Primary care service delivery and coordination** (Sue Scheinpflug, West Moreton-Oxley Medicare Local) **4. Training, education and research issues** (Claire Jackson UQ CRE)	**CONCURRENT SESSION 6: Workforce and training** (sponsored by Studiocode) **1. Joint replacement surgery reviews by physiotherapists** (Bernarda Cavka Melbourne Health) **2. e-training medical staff** (Simon Woods, Cabrini Hospital) **3. Nurse Endoscopy Service** (Sylvia Constantinou, Austin Health) **4. Training and Development for Line Managers** (Keith Townsend, Griffith University)
12.30pm - 1.30pm	**Lunch**		
1.30pm - 2.30pm	**PANEL SESSION 2: A blue sky future — what do we want? When do we want it** — John McDonough, Harvard University; Mark Britnell, KPMG; Joe Gallagher, First Nations Health; Elizabeth Koff, Sydney Children's Hospital Network; Further panelists TBC. (sponsored by the Australian Association for Quality in Health Care)		
2.30pm - 3.00pm	**AHHA 2014 SIDNEY SAX MEDAL: Presentation and address**		
3.00pm - 3.30pm	**PLENARY SESSION 10: Closing Address** — Professor Cliff Hughes, CEO, Clinical Excellence Commission		
3.30pm	**Conference Close**		

For more information or to register, visit www.thequantumleap.com.au

REGISTRATION NOW OPEN

More on the conference dinner

Featuring special guest speakers, **Bill Moss AM** & **Peter Dutton MP**

When Bill Moss decided in 1984 to leave a prestigious job and take a salary cut to join the boutique investment firm that later became Macquarie Bank, he faced the challenge of starting a real estate investment business from a small desk in an open-plan office, with just one fulltime employee working for him. In its first year of operations, the business made a profit of just $40,000. Some 22 years later, when he retired as the legendary head of Macquarie Bank's real estate and banking division and one of Australia's highest paid executives, Bill had built a global business and created thousands of jobs.

Up until a few years before deciding to retire, Moss fought every step of the way to conceal a grim personal secret from work colleagues, business associates and friends. When he was 27, Bill was told by doctors he had a degenerative and incurable muscle-wasting disease, a form of muscular dystrophy called FSHD, which the ambitious driven young businessman was assured would leave him crippled and in a wheelchair by the age of 50.

Join us to hear Bill speak about his early life in a fibro house in a working class suburb of Sydney. And how he used innovation and drive to become a committed philanthropist, passionate campaigner for disability rights, and the founder of a global medical and scientific research foundation bringing hope to FSHD and other dystrophy sufferers around the world.

Also speaking at the dinner is the Honourable Peter Dutton, Minister for Health. Following 10 years as a member of Queensland Police, Dutton was elected to the House of Representatives as the Member for Dickson in 2001. In 2008, Dutton took on the Shadow Health portfolio, subsequently becoming Minister after the Coalition victory in 2013. The Minister says he sought the Health portfolio as it provides great opportunity and capacity to help Australians who rely on the healthcare system.

Throughout 2014, Mr Dutton has used conference addresses to flag policy directions including increased private sector involvement in primary care and the need for greater contribution by individuals to healthcare costs. With the Abbott Government's 2014-15 Budget initiatives like the $7 co-payments facing a hostile Senate, the Minister's address at the conference dinner is sure to be of interest to all in the health sector. ha

When? Tues. 9 November, 7.30pm

Where? Novotel, Brighton Le Sands

All conference delegates receive one complimentary dinner ticket as part of their conference registration. For more information or for additional conference or dinner tickets, visit www.ahha.asn.au or phone 02 6162 0780.

The Quantum Leap

Health Innovation: Making Quality Count

9-10 SEPT. 2014 | NOVOTEL, BRIGHTON LE SANDS, SYDNEY

REGISTRATION NOW OPEN

RiskMan joins the AHHA at TQL 2014

An overview of the Total Information Management system

The Australian Healthcare and Hospitals Association in conjunction with the Australian Council for Healthcare Standards (ACHS) are delighted to announce a partnership with RiskMan.Net at their forthcoming 2014 conference, The Quantum Leap.

RiskMan.Net is an affordable Total Information Management system. The flexibility of the RiskMan framework provides no limits to the amount and type of information that can be managed, monitored and analysed.

Real time alerts and escalations ensure that the right people in your organisation are notified about the important events at the right time. Every Module in RiskMan.Net includes:

- a unique configurable data set;
- a full user permissions system specific to each module;
- a fully customisable Alerts system; and
- a reporting framework for creation/ customisation of reports specific to each module.

RiskMan.Net provides a simple, yet powerful web based data capture system that can be made available for every staff member to submit any type of notification. The broad framework allows notification and management on any type of event, including: incidents; complaints; risks; workplace claims; security events; governance risks; environmental issues; equipment failures; quality activities; legalcompliance; audits; recommendations; investigations; asset reviews; and fraud events.

For more information, visit RiskMan.Net at Booth 7 & 8 at The Quantum Leap or contact www.riskman.net.au. ha

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Speaking from years of experience

A snapshot of keynote speaker, **John E McDonough**

Professor John E McDonough will bring a unique perspective on health policy reform to The Quantum Leap. With a background as a politician in the United States (US), Director of a consumer health advocacy organisation, health policy advisor to the US Senate, and an academic, Professor McDonough has been in the thick of health reform for over 25 years.

From 1985 to 1997, he served as a member of the Massachusetts House of Representatives. During this time, he co-chaired the Joint Committee on Health Care, working with Michael Dukakis, Governor of Massachusetts and later presidential candidate, to enact a universal health care law and the subsequent expansion of Medicaid in 1996-97.

His description of the health reform processes during this period parallels the experience of many in Australia in recent times: 'One consistent thing in all those is that they all took so much more time than anyone imagined was possible. Second, to anyone involved, it always felt like a bus careening down a mountain with no guardrail, with the possibility of failing off the cliff at any moment a constant reality. So the reality is the ups and downs and the treacherous paths and times when it feels like it's all over is actually all par for the course with major health reform efforts. And some do fall off the cliff.'[1]

In November 1997, John then took up a teaching position at Brandeis University. For five years from 2003, he was then the Executive Director of Health Care For All, a coalition of consumers, advocates and policy experts seeking to 'to create a consumer-centered health care system that provides

comprehensive, affordable, accessible, culturally competent, high quality care and consumer education.'

Between 2008 and 2010, he served as a Senior Advisor on National Health Reform for the US Senate Committee on Health, Education, Labor, and Pensions. In 2010, he was the Joan Tisch Distinguished Fellow in Public Health at Hunter College in New York City. Since January, 2011, he has been working as the Professor of Public Health Practice at the Harvard School of Public Health.

In addition to his regular academic duties, Professor McDonough has recently hosted a Massive Open Online Course (MOOC) on the MIT-Harvard led platform, edX, entitled Introduction to US Health Policy. In his Health Stew blog for boston.com, John described the idea for the course as arising from his experience in speaking about the Affordable Care Act across the US and finding that much of the difficulty in explaining the impact of Obamacare was the limited understanding that people had of the existing system: 'If you don't understand the system, then it is much harder to understand its reform.' Clearly this a strong message for Australian policy makers and system advocates.

McDonough's course provided an overview of the structure and function of the US health system with a focus on impact of the Affordable Care Act on the five branches of the system — patients, providers, purchasers, payers and policymakers. The free 13 week self-directed course (PH210x) can be accessed by registering with at www.edX.org. There are no formal prerquisites; all you need is an email address and motivation to learn — in this case, from John's years of experience in the health policy arena. ha

Reference:

1. Jonas, M. (2010). John McDonough on health care's milestone. *CommonWealth*. Retrieved 14 July 2014 from http://www.commonwealthmagazine.org/News-and-Features/Online-exclusives/2010/Winter/McDonough-on-health-care-milestone.aspx

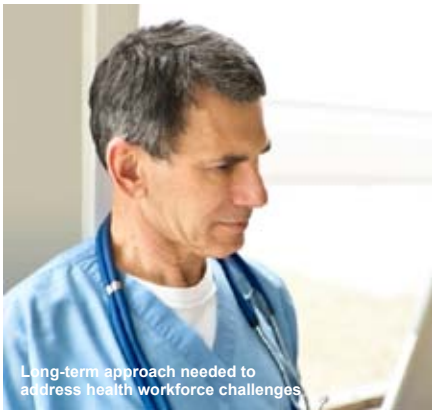
AHHA in the news

HAVE YOUR SAY...

We would like to hear your opinion on these or any other healthcare issues. Send your comments and article pitches to our media inbox: communications@ahha.asn.au

Long term approach needed to meet health workforce challenges

The AHHA welcomes moves by the Australian Health Ministers Advisory Council (AHMAC) to maintain a focus on addressing strategic health workforce issues, given the closure of Health Workforce Australia (HWA). While the AHMAC discussion to date has been in private sessions, the proposed September discussion should include a broader range of stakeholders including health professions, service providers, educators and consumers. "Ongoing analysis of workforce supply and demand is critical to meeting the future needs of the Australian population, particularly with changing demand patterns arising from the growth in chronic disease and the ageing of the population," said AHHA Chief Executive, Alison Verhoeven. "It is critical that discussions about workforce issues go beyond consideration of the overall demand and supply issues and focus on the disparities that exist in terms of availability and access to health services. Some geographic areas of Australia and some population groups continue to have difficulty accessing appropriate care in a timely manner. A long-term approach is needed to address these inequities."



Long-term approach needed to address health workforce challenges

Submission to Human Rights Commission

The AHHA has made a submission to the Inquiry into Children in Immigration Detention being conducted by the Australian Human Rights Commission. It is the Commission's third such inquiry in recent years examining the damaging impacts of detention. In its submission, the AHHA raises concerns about evidence suggesting the physical and mental wellbeing of children is at risk as a result of immigration detention, particularly in locations without specialist health services available to support their needs. AHHA's concerns are exacerbated by the lack of data and transparency regarding health services provided in immigration detention and the inadequacy of complementary services which influence health (such as poor housing).

Jury still out on pay-for-performance incentives

Can we improve the health system with pay-for-performance? is a Health Policy Issues Brief that was released by the AHHA's Deeble Institute for Health Policy Research in late May. Outlining Australian and international experiences with pay-for-performance, the brief unpacks the latest research evidence and implications for policymakers. "We need to remember there is no single fix to improve service delivery and patient outcomes, to ensure financial sustainability and to increase accountability and transparency in a health system," said Krister Partel, Policy Analyst with the Deeble Institute. "The jury is still out on whether financial incentive mechanisms, such as pay-for-performance, work as intended and deliver value for money, but if we want to go down that route then the research literature is rich in lessons to keep in mind when developing and rolling out pay-for-performance programs."

John Smith

2013 Sidney Sax Medal awarded to John Smith

A lifelong commitment to delivering high quality health services in Australia, and particularly in rural communities, has been acknowledged by the AHHA, in its awarding of the Sidney Sax Medal for 2013 to John Smith, West Wimmera Health Service Chief Executive. The award recognises outstanding achievement in, and contribution to the development and improvement of the Australian healthcare system. "Throughout his career, John has taken every opportunity to represent the views and the needs of health consumers and communities, particularly in rural areas, and in doing so has gained the respect of his colleagues," said AHHA Chief Executive, Alison Verhoeven.

Bulkbilling data and co-payment modelling 'missing in action'

On 6 June 2014, the Department of Human Services refused an AHHA request for information on the number of people who were bulkbilled in 2012-13 on the grounds that the information did not exist and that to produce it would require the development of a computer program. Later in June, the AHHA subsequently obtained information that the Department of Health had similarly refused a Freedom of Information request for summary documents arising from all modelling conducted under the Abbott Government regarding co-payments for medical services and increased co-payments under the Pharmaceutical Benefits Scheme. With all of this critical information currently 'missing in action', the Government's defence of the introduction of co-payments stands on very shaky grounds.

Health Minister's claims about overstated hospital activity by states must be supported by evidence

In an address to the National Press Club in late May, Federal Health Minister Peter Dutton cited the recommendations of a range of reviews as underpinning the health measures in the 2014-15 Federal Budget and called for an informed and measured conversation to support the reforms he believes are necessary to deliver a sustainable health system. "The Minister's desire for an open conversation would be greatly enhanced if the Government were to release the evidence it used to inform a range of Budget measures," said AHHA Chief Executive, Alison Verhoeven.

Guarantees sought for public dentistry patients

There is a real fear that progress on adult oral health will be set back by postponement or cuts in much-needed and long-promised investments. The fact that public dental services may be caught up in savings measures suggests a lack of awareness of the inequity faced by so many people when it comes to oral health services. This, in turn, threatens to set back recent progress in narrowing the gap between privileged Australians and those in hardship. The AHHA, along with other peak health organisations, has therefore called on the Abbott Government to guarantee its commitment to timely and continued funding for adult public dental health services.

Oral health matters

New modelling reveals negative impact of co-payment

The Australian Healthcare and Hospitals Association (AHHA) says that research findings published in mid-July on the impact of the proposed GP co-payment on emergency department waiting times highlight the major problems associated with co-payments and the need for the Commonwealth Government to ensure health policy is based on sound evidence. The research presented in The Conversation, found that the scheme could increase average emergency department visit length by between six minutes and almost three hours. AHHA Chief Executive Alison Verhoeven said that the impact of the co-payment, which is scheduled to start on 1 July 2015, needs to be properly investigated before the legislation passes through the Senate. "We know that our emergency departments are already stretched," Ms Verhoeven said. "There is widespread agreement that the co-payment, as it is currently proposed, would only add to the burden faced by these vital services." As outlined in the June edition of the AHHA's peer-reviewed journal, Australian Health Review, public hospitals are working hard to overcome overcrowding issues — by improving capacity management systems, streamlining services and increasing hospital-wide collaboration. However, these efforts will be undermined by the co-payment, and will result in longer waits for patients. ha

ALISON VERHOEVEN
Chief Executive
AHHA

When a cut is not a cut

A closer look at proposed changes to hospital funding in the 2014-15 Federal Budget and what it means for the states and territories

The old adage that there's more than one way to skin a cat certainly rings true when talking about health budgets. In the past few months, Australians have listened to politicians and health commentators telling two very different stories — there's more money in the health budget, and there's less money in the health budget.

While each side of the equation has produced billion dollar bottom lines, either positive or negative, what is at play, once again, is the shifting of costs, responsibilities and blame between the Commonwealth and the states and territories. And once again, it is those who rely most heavily on our public health system who will suffer.

A quick reference to the Budget Papers reveals the scale of cuts that the states contend will seriously compromise their ability to deliver public hospital services.

One line reads that 'the Government will achieve savings of $201.0 million over three years from 2015-16 by ceasing reward funding under the National Partnership Agreement on Improving Public Hospital Services.'

Another line says that 'the Government will achieve savings of $1.8 billion over four years from 2014-15, by ceasing funding guarantees under the National Health Reform Agreement 2011, and revising Commonwealth Public Hospital funding arrangements from 1 July 2017. From 2017-18, the Commonwealth will index its contribution to hospitals funding by a combination of the Consumer Price Index and population growth.'

The sweetener bottom line for both cuts is that savings will be invested in the Medical Research Future Fund.

The states and territories argue that this reduction in funding from commitments previously agreed in the National Health Reform Agreement is a cut. Specifically, the Government has walked away from the commitment that no state would be worse off, and for guaranteed funding of at least $16.4 billion over 2014-15 to 2019-20, and the provision of 50% of growth funding from 2017-18.

The Commonwealth says that, regardless of this reduction, there is still increased funding being directed to Australia's public hospitals. It is yet to acknowledge that it has backed away from the explicit promise made in its health policy statement, released prior to the 2013 election, that 'a Coalition Government will support the transition to the Commonwealth providing 50% growth funding of the efficient price of hospital services as proposed.'

The losers in this political stoush are the Australian public. Most of us, at some stage in our lives, will rely on a public hospital, regardless of whether we have private health insurance. This is because emergency department services and highly complex medical and surgical services are largely provided via the public hospital sector.

Prime Minister Abbott has argued that the states and territories run public hospitals, so funding them is their problem. This simplistic notion overlooks history and the legal and formal arrangements which underpin federal-state financial relations.

Taxpayers rightly assume that the taxes they pay contribute to services delivered by government in the public good. Historically, some of our income taxes have been transferred to the states to deliver services such as hospitals. To argue that the Commonwealth should no longer be funding public hospitals in the way it has in the past because it doesn't own hospitals, aside from the Mersey Hospital, is contentious to say the least.

It also poses an immediate challenge to the states and territories to find funding either from their own taxes, such as payroll tax or stamp duty; or to push for an increase to, or broadening of, the GST.

A Federation White Paper is flagged to explore these issues further — but the cuts were set to implemented from 1 July, long before that paper is prepared and debated. To resolve the shortfall by finding efficiencies will not be achievable in the short time frame available, nor in the quantum required to meet the gap.

Historically, some of our income taxes have been transferred to the states to deliver services such as hospitals. To argue that the Commonwealth should no longer be funding public hospitals in the way it has in the past because it doesn't own hospitals, aside from the Mersey Hospital, is contentious to say the least.

As the states and territories have indicated, the cuts will have an immediate effect on their ability to achieve service delivery standards, and will negatively impact the improvements made in elective surgery and emergency department waiting times.

Certainty around sufficient funding to meet current and future health needs is critical to a well-performing health system. The dissent being expressed by Premiers and Chief Ministers across the country demonstrates the serious implications of this decision for patients and health services.

The Australian public not only expects its governments at all levels to manage budgets effectively, but it has a right to expect good and honourable behaviour from its leaders. This should include an expectation that the Commonwealth and the states and territories will keep their word when they sign nine-way agreements, even where one or more of those jurisdictions has a change in political leadership. ha

SUE SCHEINPFLUG
Chief Executive Officer
West Moreton-Oxley Medicare Local

LESLEY DWYER
Chief Executive Officer
West Moreton Hospital & Health Service

What next for primary health?

Tackling the challenge of how best to meet the needs of local communities

After the 2013 Federal Election, the newly-appointed Coalition Government appointed Professor John Horvath — former Australian Government Chief Medical Officer (2003 to 2009) — to review the Medicare Locals established under Labor. However, the concepts behind Medicare Locals precede the then Labor Government. Medicare Locals actually emerged from the Divisions of General Practice, an initiative of the Keating Government in 1992-1993.

The Divisions of General Practice were reviewed by the then Coalition Government during Tony Abbott's term as Health Minister in 2003-2004.[1] The Australian General Practice Network undertook their own reviews in 2007 and 2009. Then, in 2009-2010, the Rudd Government released two significant reports on reforming and building a stronger primary healthcare system. Also in 2009, the National Health and Hospitals Reform Commission recommended a significant role for the Commonwealth in primary healthcare policy and funding.

What is common in all of these reports and reviews is an express recognition and commitment to the significant role of primary healthcare, to prevention, early intervention and to better local integration and coordination of health services across jurisdictions and sectors. This is primarily for the benefit of patients, but it is also necessary to achieve a more appropriate deployment of limited health funds which are under continuously increasing demand.

The World Health Organisation's 1978 Declaration of Alma-Ata defined primary healthcare as: incorporating curative treatment given by the first contact provider along with promotional, preventive and rehabilitative services provided by multi-disciplinary teams of health-care professionals working collaboratively. Primary healthcare delivers 'health equity; people-centred care and a central role for communities in health action.'[2]

In 2010-2011, in response to the previous reviews, more than 120 Divisions of General Practice were reformed into 61 Medicare Locals involving GPs but with broader health, allied health and community participation. The link between Medicare Locals and Local Hospital Networks was recognised as critical to the success of the Medicare Local initiative.

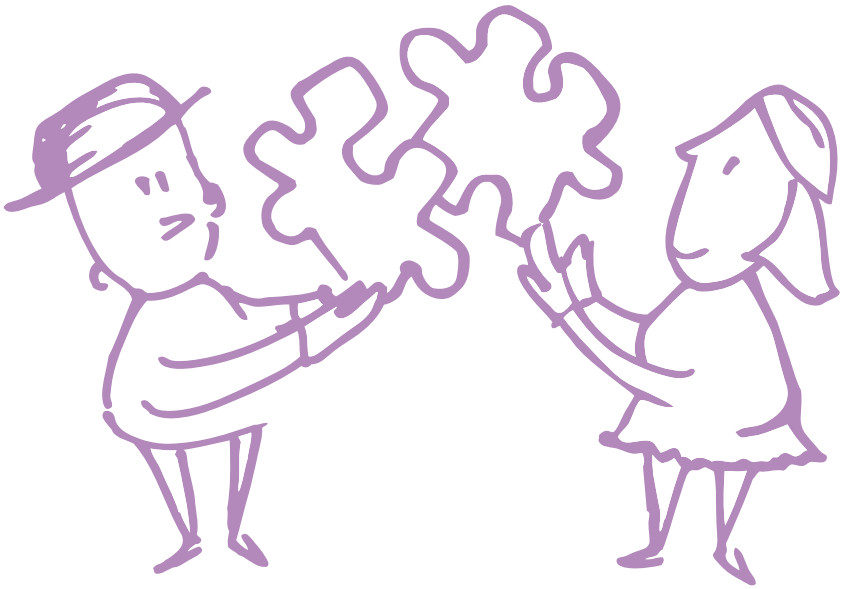
The Horvath report, whilst making several recommendations for change, was largely and strongly supportive of the ongoing need for a network of regionally based primary healthcare organisations. The recent federal budget supported the implementation of most of the recommendations from the Horvath report, including replacing Medicare Locals — via a competitive tender process — with a fewer number of Primary Health Networks nationally.

Somewhere in the recent discussions and announcements, the recognition of progress already made in systemic change; the building of collaborative solutions; improvements in health literacy; regional cooperation in reducing unnecessary hospital admissions; better partnerships between allied health and medical professionals; more patient-focused pathways to better health; and more efficient and appropriate use of the limited health dollar, have all been overlooked.

Whilst there has always been receptivity in the health sector to adapt to change and new ideas that improve the system and benefit patients, the recent announcements and the proposed method of their implementation are potentially and significantly disruptive.

Whilst there has always been receptivity in the health sector to adapt to change and new ideas that improve the system and benefit patients, the recent announcements and the proposed method of their implementation are potentially and significantly disruptive.

The partnership between West Moreton



Oxley Medicare Local and West Moreton Hospital and Health Service is strong. We will be relying on our resilience to ensure these changes do not reverse the gains already made on services to patients, health professionals and the community.

In the less than three years since Medicare Locals were established, much has happened to address the systemic barriers to improving primary healthcare in the West Moreton region. Lesley Dwyer was appointed as CEO of the West Moreton Hospital and Health Service in July 2012 and Sue Scheinpflug was appointed as CEO to the West Moreton Oxley Medicare Local in January 2013.

Since then, working collaboratively, we have managed to significantly improve the coordination of our organisations' efforts strategically, through policy and through practice to better integrate the primary, secondary and tertiary healthcare sectors in the West Moreton region. Our commitment to working together is expressed through a partnership protocol jointly signed by our Board Chairs.

Our region has significant challenges in terms of socioeconomic disadvantage, significant health issues and forecast rates of rapid population growth. We know from our shared analysis of national, state and regional data that, in addition to the generally poor health status of the region, there are major issues relating to access to health services — by price, location and availability.

Our partnership protocol has given us the foundation for working collectively and collaboratively to address these issues, including:

- joint research, planning and information sharing on the current and future health needs of the region;
- shared mechanisms for engaging with and working closely with consumers and local communities — ensuring that the community members have direct access to both organisations;
- shared models of care for chronic disease, palliative care and end of life, paediatrics, older persons, mental health and rural and regional health services;
- successful transition of the delivery of the Home and Community Care (HACC) program from the hospital and health service to the Medicare Local;
- joint work supported by Queensland Health Clinical Redesign School researching category 4 and 5 presentations at the Ipswich Hospital Emergency Department and developing appropriate responses for alternative patient pathways; and
- development of a more seamless transition across the health sector so that patients can receive the health support they need when and where they need it.

To date, we have worked constructively together to simplify a patient's access to, and experience of, a complex system (primary, secondary and tertiary health, multiple jurisdictions, medical and allied health professionals). A concern emanating from the Horvath Report and the recent federal budgetary decisions is the proposal to increase the size of the geographic coverage of the Primary Health Networks. This brings associated risks of removing the possibility of a genuinely 'local' approach, reducing the agility to respond, increasing rather than reducing red tape, and may well significantly reverse the progress that has already been made!

People working in the frontline of care-giving organisations, such as healthcare, are primarily motivated by wanting to make a difference for the people they serve. Australia's health sector tends to attract and retain talented and committed care-giving professionals. The irony of consistent and consecutive policy adjustments is that these much-needed care-giving talents are too often diverted away from the needs of patients, health professionals and the community. ha

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Barney doing exercises with Katie-Jane.
Image courtesy of Tasmania Medicare Local.

Going from strength to strength

Benefits of a free exercise program offered by **Tasmania Medicare Local**

A year ago, Launceston local, Barney Reynolds, could not join his hands together behind his back even if he wanted to. Today, the 63-year-old would be able to pass this test with flying colours, and probably running laps around you in the process. This is no mean feat, as chronic disease is a daily reality for Barney.

In addition to living with type 2 diabetes and high blood pressure, with which he was diagnosed in 2004, Barney suffers from multiple other conditions including spondiolithesis (a spinal issue present from birth), chronic and debilitating post-traumatic stress disorder and major depressive disorder

He has also struggled with his weight for more than a decade, and was recently diagnosed with angina as well as two significant artery blockages.

Combine all these chronic health issues together with difficulties in breathing and recurrent back pain, it is no surprise that Barney has long been put off by the idea of exercise.

"At one stage my partner Lesley and I were walking 45 to 60 minutes every evening around the Launceston CBD," Barney said. "However, the walking was becoming something of an ordeal, with me needing to stop every so often to rest. My doctor - who was aware of my chronic conditions and was helping me manage them — suggested we try various avenues for improving my overall health so that walking could continue."

Initially, Barney tried physiotherapy, but unfortunately this proved unsuitable for his needs.

Later, in early 2013, he met with a nurse at his doctor's practice for an annual diabetes check. "It was this champion who referred me to Tasmania Medicare Local for consults with a dietitian, diabetes educator, podiatrist and exercise physiologist," he said.

The exercise physiologist to which Barney was referred asked him if he would like to participate in Strength2Strength, a new program offered by the Tasmania Medicare Local at the Northern Integrated Care Service. Barney didn't need much convincing; he signed up on the spot.

Strength2Strength is a free 12 week exercise program established as part of the Australian Government's Tasmanian Health Assistance Package. It is designed specifically for older Tasmanians and people living with multiple chronic health conditions.

Participants undertake weekly supervised exercise sessions, with specific attention to muscular development, cardiovascular health and balance. They are also provided with regular education sessions on posture, core strength, and healthy eating.

> **"People come in who are a bit shy and unsure, but by week 12 they are doing things they didn't think possible."**

"The first session was great and a learning process for us all. I could see people of varying ages and sizes as well as fitness levels," Barney said. "We finished that first session sweaty and, for me, exhilarated."

While Barney found the program quite a challenge physically, the mental and health benefits have been incredibly rewarding.

"I was the youngest in the group, at 62, but we all bonded over time and found strength and support from each other," he said.

"There were no false targets to reach and we were always reminded that we could slow down or stop at any point in any exercise. My weight, which at the start of the program was above 140kg, has dropped to 124kg and I can now go walking and climbing stairs without an issue. Life's good and getting better. I joined the Strength2Strength program with a strong desire to improve my physical health and drag the mental health with it. It worked."

Since commencing the program in June 2013, exercise physiologist Katie-Jane Brickwood and her team at TML Clinical Services North have delivered classes to more than 150 participants, with 100 sessions run just this year.

"The program is hugely important, not just for increasing strength and functional capacities but in building confidence in participants," Katie-Jane said. "People come in who are a bit shy and unsure, but by week 12 they are doing things they didn't think possible."

Feedback about the program has also been very positive, with many people saying that they not only feel healthier, but that they feel stronger and fitter as well.

The most notable health improvements, according to Katie-Jane, have been in the function abilities and quality of life scores of participants. "Obviously we hoped for good results but these were higher than expected. The fact that participants are doing their own targeted exercises is probably why we are seeing greater levels of improvement," she said.

As a testament that dedication and self-belief can, indeed, move mountains, Barney is now closer than ever to his goal of reaching the pinnacle of Quamby Buff, a mountain in the Great Western Tiers of Northern Tasmania; a goal that he is now running — not walking — towards.

For more on Strength2Strength, contact Katie-Jane Brickwood on (03) 6336 2145 or kjbrickwood@tasmedicarelocal.com.au ha

ANDREW MCAULIFFE
Executive Director
AHHA

Rationing healthcare

The act which shall not be named

The impending reductions in hospital budgets arising from the cuts in the Federal Budget have public hospital managers pouring over their 2014-15 financial plans as they attempt to balance reduced funds with increasing demand.

With treasury and health departments in states and territories receiving little notice before the cuts start to bite, there is limited room for skilled finessing of expenditure, and heavy handed reductions to services may well be the inevitable outcome. This raises the question of what drives the decision-making process when health services need to be rationed.

Rationing is not a phrase that is routinely used when discussing health services. While terms such as demand management, service allocation and resource redistribution roll off the tongue, 'rationing' seems to be the Voldemort of most health service planners and managers' vocabularies — 'that which shall not be named'.

Despite this, rationing occurs every day and in every way according to Lesley Dwyer, Chief Executive of West Moreton Hospital and Health Service in South-East Queensland (featured on page 14) who gave her perspective at a roundtable discussion hosted by the AHHA and the Australian Centre for Health Services Information in Brisbane last month. From waiting lists to staffing levels, nearly every decision and process within the hospital is a form of rationing in its pure definition as they impact on the availability of services and result in finite levels of a resource being available to users.

What was made clear from the roundtable discussion is that there are tools available to assist informed evidence-based approaches to rationing in the provision of healthcare.

In Australia, the work of the Pharmaceutical Benefits Advisory Committee (PBAC) and the Medical Services Advisory Committee is focused on cost-effectiveness analysis of pharmaceuticals and medical services. When it was established in the mid-90s, the PBAC was considered world-leading. But according to Elizabeth Martin, a PhD candidate at Queensland University of Technology and Deeble Institute Summer Scholar, other countries have left us behind. The work of the UK National Institute for Health and Care Excellence (NICE), for example, is currently applying far more rigorous cost-effectiveness methods.

Prioritising, when costs were equal, between providing care for one 95-year-old person with pneumonia or immunising 4,000 children against measles is, on the surface, straight forward... But translating a straightforward cost analysis into policy and practice may remain an insurmountable obstacle.

The apparent lack of analysis that preceded the Abbott Government's announcement of the planned introduction of co-payments for general practice, pathology and diagnostic imaging services is a prime example of the limited application of economic or social impact evaluation underpinning major health policy initiatives in Australia. The attempts by the AHHA and others to access the impact modelling undertaken in relation to the co-payment policy has been unsuccessful with the Department of Human Services and Department of Health denying Freedom of Information applications on the grounds that relevant data did not exist and that no impact modelling had been undertaken.

Having strong economic analysis on which to base decisions is one component of the rationing process. The greater challenge is actually making the decision to redirect resources from one client group to another. The acceptability threshold for what is considered appropriate in terms of cost versus benefit will vary by context and setting.

Prioritising, when costs were equal, between providing care for one 95 year old person with pneumonia or immunising 4,000 children against measles is, on the surface, straight forward.

But while many Australians continue to avoid challenging discussions around end of life care and clinicians still pride themselves on heroic actions and 'saving the un-saveable', translating a straightforward cost analysis into policy and practice may remain an insurmountable obstacle.

While the process of making rationing decisions is challenging, what is clear is that until policymakers, service providers, clinicians and consumers engage as equals in open discussions supported by robust data, rationing will remain a taboo subject. ha

Reception area at refurbished MCHS site. Image courtesy of Merri Community Health Services.

A step forward in the right direction

Energy efficiency at **Merri Community Health Services**

In 2013, Merri Community Health Services (MCHS) commenced the refurbishment of its Coburg site with the aim of improving energy efficiency under the Commonwealth's Community Energy Efficiency program, and provide improved spaces and additional clinical areas to meet community needs. The upgrades resulted in newly refurbished areas including reception, kitchen and meeting spaces, additional consulting spaces, a dedicated student hub and cosmetic works to the external building.

As of May 2014, the overall figures have found a $5,878 reduction in energy costs, with a 16,219 kWh/year in energy savings for the heating, ventilation and air conditioning system, and 14,080 kWh/year in savings for the lighting system.

MCHS worked closely with a range of partners for this project including the Moreland Energy Foundation Ltd who provided technical guidance and expertise around environmental sustainability.

The site was officially launched on 31 July 2013 by Victorian Minister for Health, David Davis MP. ha

A wheelie successful immunisation campaign

WentWest encouraging families in Western Sydney to get vaccinated

A healthcare initiative for Western Sydney has rewarded local families for taking a proactive role in having their four year old children immunised. Throughout April, local children had an opportunity to win one of 12 bikes and helmets, as part of a campaign to increase participation in four year old immunisations, which is the final component of the National Immunisation Schedule.

The competition, run by AHHA member, WentWest, in collaboration with local GPs, was a resounding success with more than 60 practices participating across the region, a 46% increase on last year.

The prize giving was held on Wednesday 28 May at WentWest's Learning Centre in Blacktown, with local GP, Dr Michael Fasher, on hand to present the 12 excited children with their prizes.

The annual campaign was introduced in 2011 to increase childhood immunisation rates across Western Sydney. The National Immunisation Program aims to increase the immunity of children in the community against preventable diseases. Immunisation at the age of four is essential because it is the final vaccination a child receives before starting school. Immunisation ensures children are protected against infectious disease which can circulate in the playground. It is also vital in providing adults and children with a defence against infectious and dangerous pathogens.

"It's important that we complete required immunisations," said WentWest's Clinical Lead for the NSW Health Integrated Care Program, Dr Michael Crampton. "Immunisation is by far the safest and most effective way of safeguarding both individuals and general health in the community and protecting against outbreaks of diseases such as measles. It is critical to continually focus on childhood immunisation requirements at every opportunity and not let our immunisation rates fall." ha

Liza Eusebio with son Paolo, enjoying the Competition Prize Giving. Image courtesy of WentWest.

Immunisation on the rise in Far North Queensland

FNQ Medicare Local shows improvement in vaccination processes

Far North Queensland (FNQ) has the highest national rate of fully immunised 2 year old Aboriginal and Torres Strait Islander children at 97% according to the latest Healthy Communities report *Immunisation rates for children 2012-13* by the National Health Performance Authority (NHPA).

The FNQ Medicare Local's strategy for increasing immunisation rates is yielding results, according to its enthusiastic Chief Executive Officer, Dr Michael Wilson. "Our immunisation program has an impact at the frontline through education campaigns, extensive GP engagement and targeted programs like the reminder-recall system that helps parents keep up to date with their child's immunisation schedule," said Dr Wilson.

The latest NHPA report analyses Australian Childhood Immunisation Register (ACIR) data between July 2012 and June 2013 and data from the Human Papillomavirus Vaccination (HPV) Register for the 2012 calendar year. It shows that the percentage of children who are fully immunised in FNQ is 91.77%. "Our target is 92% of children fully vaccinated," said Dr Wilson. "This is considered the minimum level at which we can protect those vulnerable members of the community who are too young or whose medical condition prevents vaccination against vaccine-preventable diseases."

The report provides comparisons of 61 regions against the national vaccination rate. For children who are 5 years of age, the national rate is 91.5% while the corresponding rate for FNQ is 92%. Similarly, among 2 year olds, the national rate is 92.5% while in FNQ it is 93.3%, and among 1 year olds, the rates are 91.2% and 90% respectively.

Overall, Dr Wilson was very positive about FNQ's performance: "We are very pleased to be above the national average rate of fully immunised children in 2 of the 3 age brackets. For children at 1 year of age we are working to increase the rate through immunisation marketing material targeting local parents. We believe this is having an impact as the most recent quarterly data shows FNQ's rate for children at 1 year of age has increased to 91.7% and is fast approaching our 92% target." ha

Quick facts about early vaccinations

From six weeks until 12 months of age, vaccinations are given at four different times to protect infants against 11-12 different vaccine-preventable diseases.

It is critical that children under 1 year of age are immunised as they have developing immune systems. They are more susceptible to, and at the highest risk of, severe health outcomes from vaccine-preventable disease including death and disability.

Timeliness of immunisation is vitally important to ensure that a baby is protected. Missing an immunisation even by a week increases a baby's likelihood of getting a vaccine-preventable disease such as Hib or whooping cough.

Young girl braves the needle. Image courtesy of FNQ Medicare Local.

DEBORAH COLE
Chief Executive Officer
Dental Health Services Victoria

New models of care for public dentistry

Developing a different approach to the patient journey

The Victorian public dental sector has benefited from a period of unprecedented funding that has enabled us to treat more patients and significantly reduce waiting times across the state.

Since the 2014-15 Federal Budget was handed down in May, it's become clear that we, along with other health services, will have to navigate a very tough financial year. With $390 million in dental funding for Australia being deferred until 2015-16, it is essential that we introduce new and more cost effective models of care for public dentistry to help deal with the increased demand for care.

If we are honest with ourselves, what we are doing isn't working. While we have significantly increased the number of patients we treat in the public dental sector, we are still only reaching less than 20% of the eligible population in Victoria. Despite being largely preventable, tooth decay remains one of our most common health problems.

The dental sector is also no different to other health services in that we often provide services that are not supported by evidence and, in some cases, don't make people healthier.

So how do we treat more people with the limited resources at our disposal? We move away from 'the way things have always been done' and introduce more innovative models of care that are patient-centred, multidisciplinary, collaborative and evidence-based. This new approach to the patient journey needs to focus on the prevention and early intervention of oral disease while ensuring that all members of the dental team are working to their full potential.

The 2014-15 Federal Budget has provided a burning platform for us to accelerate our progress towards implementing a new and more cost effective approach to the patient journey.

About two years ago, we stood back and analysed the patient journey, starting well before our patients walk through the clinic doors. After deciding on a set of principles that would underpin our new models of care — including a population health approach, preventive techniques and evidence-based interventions — we looked at all the factors impacting oral health. We also looked at how we could better integrate oral health messages into services like early parenting programs, chronic disease programs and general health screenings.

Despite being an essential component for overall health and wellbeing, dental conditions still suffer from a low health profile with the mouth viewed as separate to the rest of the body in the general health arena. If we want to see a real improvement in the oral health of the community, we need to ensure that oral health inches up the priority list by building stronger partnerships with community and health services.

A great example of this is the work we have done in championing oral health through midwives. Through the Healthy

Future dentists hard at work. Image courtesy of Dental Health Services Victoria.

Families, Health Smiles initiative, Dental Health Services Victoria (DHSV) offered online oral health training to midwives taking part in the Midwifery Initiated Oral Health Education Program. Participants improved their knowledge about oral health during pregnancy and the training engaged a new workforce in oral health promotion that are trusted sources of information for pregnant women. Over the coming years we are going to focus on expanding our collaborative initiatives to build our army of oral health champions.

Along with building strong partnerships, we need to ensure that dentistry is funded in the same manner as general health rather than being approached as a predominantly out-of-pocket expense. We also need to revolutionise the way we approach the patient's clinical journey.

In our development of new models of care, we went back to basics and looked at who was receiving care, who was delivering the care and what type of care was being provided. It became clear that workforce reform would be a crucial component in providing more cost effective treatment.

DHSV has invested significant resources into expanding the scope of practice of members of the dental team. We have supported 13 dental assistants to complete their Certificate IV qualification in oral health promotion and radiology, with 60 more enrolled to complete a Certificate IV qualification in the coming year. These qualifications enable dental assistants to take on more diverse responsibilities like delivering oral health promotion and completing radiographs and fluoride applications. We have also supported our oral health therapists to expand their scope of practice to treat adults aged 26 years and over. Upskilling these members of the dental team supports a more preventive approach and reduces the cost per patient by enabling dentists to focus on complex procedures.

Slowly but surely, we are getting our ducks in a row and laying a solid foundation to introduce new models of care in the public dental sector. The 2014-15 Federal Budget has provided a burning platform for us to accelerate our progress towards implementing a new and more cost effective approach to the patient journey. I am confident that we are on the right track to help more people experiencing disadvantage live healthier and happier lives. ha

‘24 weeks’ by Sara Neff. Image sourced from Flickr via a Creative Commons Attribution 2.0 Generic Licence (https://flic.kr/p/nGtboN).

RESEARCH TRANSLATION WRITING PRIZE WINNING ENTRY

SHARLEEN O'REILLY
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www.ahha.asn.au/deebleinstitute/shortcourse

Mind the gap!

Working with GPs to bridge the evidence-to-practice gap for diabetes prevention in women at risk

If you ask a GP which condition they see the most often, diabetes normally makes it into their top three. The least common form of diabetes — gestational diabetes — typically doesn't get the notoriety of type 2 diabetes, mostly because it will only occur during pregnancy which automatically reduces the population size. That being said, gestational diabetes is definitely not a condition to be dismissed. Evidence suggests, however, that this is exactly what happens once a woman delivers her baby.

More than 20,000 Australian women are estimated to have a pregnancy complicated by gestational diabetes annually. This figure is likely to underestimate the current rate as the incidence has been climbing alongside population obesity rates. Having gestational diabetes will increase a woman's risk of having complications during the pregnancy and birth but it also dramatically increases her risk of further health complications after her baby is delivered. One in two women who have had gestational diabetes will go on to develop type 2 diabetes and they are also at increased risk of developing heart disease. While this on its own is concerning, their babies are at increased risk of obesity and diabetes which means the cycle of diabetes becomes expanded within families as time goes by.

Gestational diabetes is not all doom and gloom though. Clinical trials demonstrate that the incidence of type 2 diabetes can be reduced by 58% with lifestyle change and the effect continues 10 years after the trial has stopped. Several guidelines exist, in Australia and internationally, to support GPs providing appropriate diabetes prevention care to women who have had gestational diabetes. Typically, they describe the need for regular diabetes screening and lifestyle change advice.

Unfortunately, because there are some discrepancies in the various guidelines, GP's are often left asking which one is best to follow, which can then lead to inertia. An additional issue is that women who have had gestational diabetes do not perceive themselves to be at elevated risk. This is further compounded by the fact that having a young family regularly causes women to neglect their own health.

The National Gestational Diabetes Register (NGDR) launched in mid-2011 and is the first gestational diabetes registry in the world. The NGDR aims to help women experiencing gestational diabetes to manage their own health into the future by providing relevant information and annual reminders to women and GPs about screening for the disease. As only about one in four women are typically getting screened, having the NGDR alone will not improve diabetes prevention care. As such, a systems-based approach is needed.

With this idea in mind, the National Health and Medical Research Council funded the Mothers After Gestational Diabetes in Australia (MAGDA) partnership project. The components of the system change established by MAGDA are: a gestational diabetes registry and screening recall; a postnatal diabetes prevention program designed specifically for women with gestational diabetes; diabetes prevention care delivery in general practice; and scaling up to the level of policy and operational health services.

In an ideal world, the views of stakeholders would be prominent in the design or redesign of any form of service delivery. In reality, the stakeholder opinion is frequently seen as optional or only a small part of the solution. This is why research into the perspectives of women who have had gestational diabetes — and the GPs who see them in general practice — though critical to the feasibility and sustainability of any changes to primary care, has not yet been done in Australia. To rectify this issue, the National Health and Medical Research Council have funded a Translating Research Into Practice (TRIP) Fellowship to work specifically on this matter. The information gained from this fellowship will feed back into the larger MAGDA project.

Part of the recent work by the MAGDA team has been the development of an anonymous online survey. The survey is about getting a national picture of how GPs and women who have experienced gestational diabetes view the current situation and potential areas where improvements might be made. Data obtained from the survey will be used to inform a pilot intervention based in Victoria, aimed at lessening the impact of gestational diabetes in the lives of women into the future by harnessing the voice of GPs. Essentially; the goal is to optimise diabetes prevention care in a meaningful and sustainable way. GPs from across the country are invited to participate in the survey, which can be easily accessed through the MAGDA study's website (www.magdastudy.org.au). If you are a GP, consider yourself invited! ha

PHILOMENA HORSLEY
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www.ahha.asn.au/deebleinstitute/shortcourse

Sexual assault and older women

Shining a light on a hidden problem

When sexual assault is raised as an issue in the health and community sectors, most people think of potential or actual victims as young women. Rarely do people envisage the sexual assault of an 83 year old woman in an aged care facility, or a 92 year old woman lying in her hospital bed, or a 75 year old woman in her own home.

The sexual assault of older women is a little understood phenomenon. The lack of community awareness can be partly attributed to commonly held assumptions of older women as asexual or 'unattractive' and therefore not at risk. What is unimaginable becomes unsayable or invisible.

Norma's Project was conceived in response to the experience of Norma, a vulnerable 83 year old woman who was sexually assaulted by a male staff member while in respite care. Four researchers from La Trobe University, the University of Melbourne, and the National Ageing Research Institute received funding from the Australian Department of Social Services to investigate the issue.

Over 80 family members, community members and service providers from the justice, health, aged care and community sectors provided researchers with accounts of sexual assault of older women and their views on prevention and intervention strategies. This data was combined with insights provided by the limited available international and Australian research data. For instance, the Australian Bureau of Statistics (2013) estimates that women over 45 years make up about one in five of the 87,000 women sexually assaulted in 2012. There has also been a 14% rise in reports to the Commonwealth with regard of 'unlawful sexual contact' in aged care residential settings (nearly 280 reports in 12 months).

Service providers, particularly those in the aged care and health care sectors, can improve their capacity to both prevent and respond to the issue of sexual assault of older women by addressing gaps in staff training and organisations' policy and practice.

The research indicates that older women, like all women, are most at risk of assault by people that they know. However, older women have a number of potential vulnerabilities which include frailty, dependence and isolation. Sometimes, sexual assault has continued over many years, perpetrated by husbands and other relatives who hold traditional views of women. One account involved a frail woman in her 80s who was 'being repeatedly raped by her husband' — a man who had been prescribed Viagra despite his dementia.

Other incidents involved assaults in aged care settings and retirement villages. One account involved a woman aged in her 90s in residential care who became suddenly unwell and confused. When she told the Nurse Manager that a man had raped her in her room she was not believed. When sent to hospital a urinary tract infection was diagnosed. However, her persistent complaints led to further examinations which uncovered occipital fractures of both hips, consistent with someone lying on top of her.

The research concludes that:

- women over 65 years remain at risk of sexual assault despite their age;
- such assaults occur primarily in places where older women should feel safe: at home, when accessing services, and in aged care settings;
- the sexual assault of older women is a hidden issue that is under-reported and little understood by the community and service providers; and
- sexual assault can have a significant affect the health of older women, and can reduce their life expectancy.

The research suggests that service providers, particularly those in the aged care and health care sectors, can improve their capacity to both prevent and respond to the issue of sexual assault of older women by addressing gaps in staff training and organisations' policy and practice. To assist in this process a Resource Kit is being developed for service providers and community groups.

For further information about the research, go to: www.normasproject.org.au ha

Uncovering the harms posed to some of the most vulnerable people in the community.

LEE DAVIS
Chief Information Officer
Silver Chain Group

Game changing technology

Video conferencing and telehealth at Silver Chain

Technology is a game changer for home health and community services, particularly in rural and remote areas. It has the power to increase access to services; improve health and wellbeing outcomes; enable and empower clients to manage their own health conditions; as well as reduce the cost of care.

Technology is seen as a vital tool in the delivery of Silver Chain services. We have been using telehealth technology since 2010 to support client care and improve health outcomes for clients unable travel to cities to meet their healthcare needs.

Originally, such services began as a trial. We wanted to test whether self-monitoring via home-based telehealth equipment could, when combined with ongoing remote monitoring of the patient's results by a nurse, reduce the incidence of hospitalisations and emergency department (ED) visits for people with Chronic Obstructive Pulmonary Disease (COPD).

Our research found that, through the use of telehealth technologies, the number of COPD related hospitalisations and ED admissions halved. Health costs were also reduced by an average of $2,931 per person per year. A follow up study in 2011 then found further, long-lasting benefits after the equipment from the 2010 study had been removed, including improved awareness and understanding of the clients' own conditions.

After the success of the pilot, we started to rollout the technology to remote areas as a management and training tool. This soon expanded to include diabetes education services and chronic disease management.

Currently, our telehealth clients are provided with medical devices, including pulse oximeters, blood-glucose monitors, weighing scales and thermometers, which transmit data via Bluetooth enabled Samsung devices. The data is pushed to the Silver Chain telehealth cloud service and monitored by nurses who respond when they receive 'out of bounds' data like an elevated pulse.

Videoconferencing has also been widely implemented across the Silver Chain Group. We use Polycom desk phones for voice and video calls, plus Polycom's RealPresence Mobile application on our tablet devices which means we can connect with our staff at all times, regardless of where they may be.

In South Australia, we also offer a service called Virtual Hospital, where clients are loaned Samsung tablet with Polycom video conferencing. This links directly to our Client Care Centre staffed by qualified nurses. Similar services are provided in New South Wales, where the tablets and software are provided to patients in palliative care.

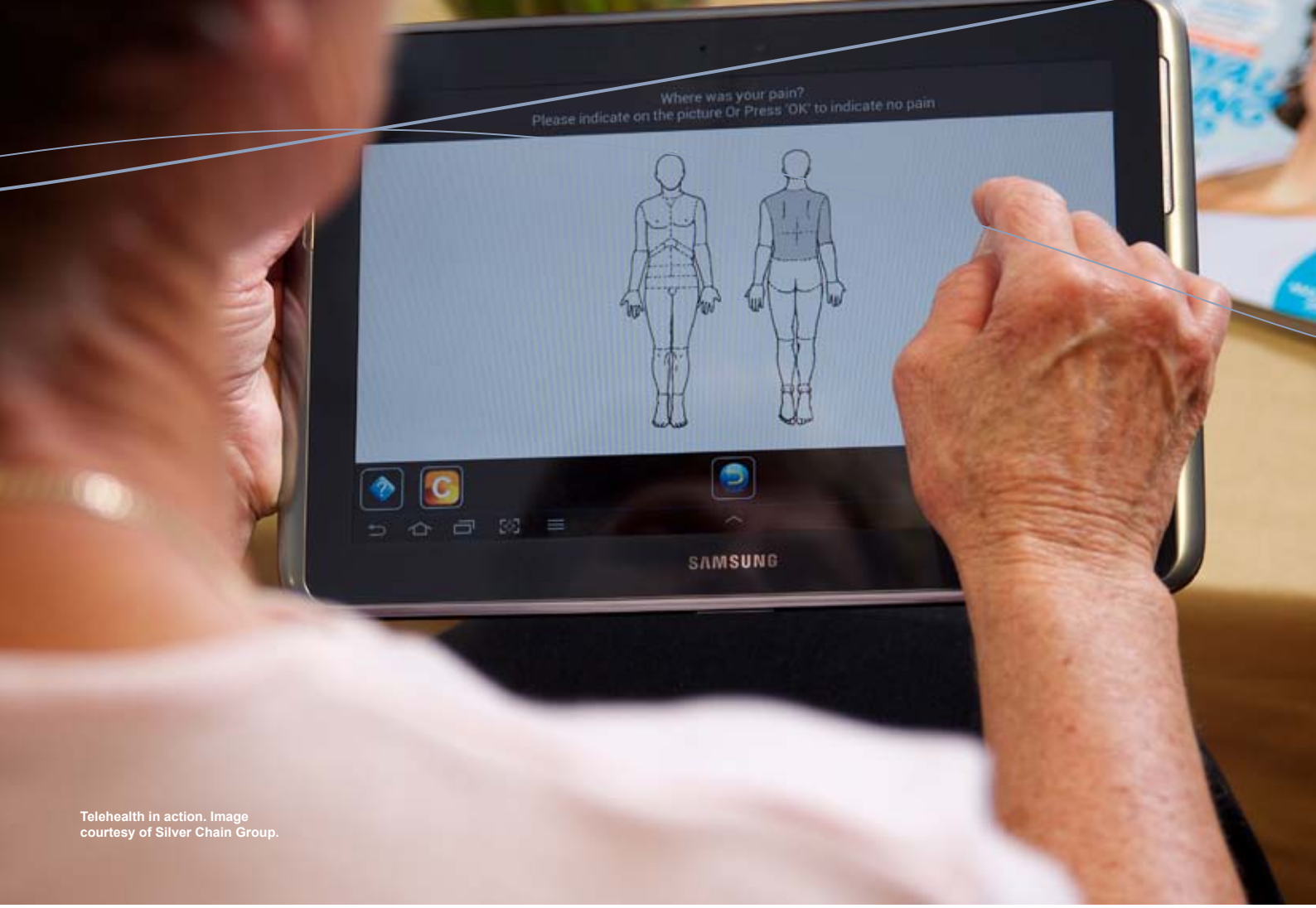
Video communication technologies have also been used in the introduction of virtual meeting rooms so we can have group training sessions with Silver Chain clinical and non-clinical staff across Australia. This has significantly improved the way we provide training to our staff. With our centres being scattered across the country, it is often not practical for staff to close their centre for a day, or sometimes even days, to travel for training. However, video allows us to offer training to multiple staff from remote locations without anyone needing to travel.

In addition to training, video has been used in the assessment of mandatory skills. This method has proven to be more successful than staff attending classrooms hosted externally by other staff, as work practices tend to be workplace-specific. As well as eliminating the need for travel, the use of video technologies also allows our assessors to see how the nurses function in their familiar day-to-day environment.

Clearly, the introduction of telehealth and video technologies has enormous benefits. At Silver Chain, it means that we can now connect both our staff and clients to specialised clinical services and education programs from the comfort of their own home. Being able to communicate visually with our patients, who are often in remote parts of Australia, also allows us to be able to see exactly what the issue or medical condition may be, and subsequently, to provide safer recommendations.

Estimates suggest that since introducing of videoconferencing, we have eliminated around 25 flights and all associated accommodation costs. To help put this into perspective, Silver Chain's Country Services General Manager Carole Bain spent about $20,000 on travel last year. With the introduction of video technologies, her yearly travel bill is expected to be slashed by 50%. Such a drastic reduction in administrative costs means that we are able to increase our investment into direct care and the extension of our community care services.

To further capitalise on these gains, we have been expanding the telehealth model from June 2014 as part of services funded by the Home and Community Care Program and Home Care Packages. This expansion will further enhance our service provision and provide more options for those individual with chronic disease management. It is hoped that such efforts will have a positive impact on quality of life and assist our clients to remain and avoid unnecessary hospital admissions. ha



Telehealth in action. Image courtesy of Silver Chain Group.

HIV patient trained for e-data capture in remote and rurual areas. All Images (except OpenMRS map) courtesy of William M Tierney, CEO of the Regenstrief Institute.

TERRY HANNAN
Consultant Physician
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Solving a health information management problem

An international success story

From the World Health Organisation Charter, and experts such as Australia's Enrico Coiera, we now know that 'information is care'. But what does this actually mean?

In routine care, clinicians collect data such as patient history, perform physical examinations, create reports, access laboratory data, read X-rays results, and then record these data through the production of notes, operative reports, prescriptions and diagnostic test results. Clinicians are also involved in transmitting these data through various means: through telephone, paper documents, electronic charts and email. Finally, they process this information to arrive at a diagnosis, or deduce a hierarchy of possible diagnoses and initiate treatment(s). This process becomes an iterative cycle of data and information management so that care can be monitored, adjusted and measured.

The successful implementation of clinical information management systems over a 25 year period was documented in a special issue of the International Journal of Medical Informatics (1999, Vol. 54). Could this knowledge be translated internationally with particular emphasis on developing nations?

In 2000, there were 40 million people living with AIDS in sub-Saharan Africa. In one location in Kenya (Eldoret), 50% of hospital beds were filled with people less than 25 years of age, dying of AIDS. Poverty, migrating workers, polygamous marriages and poor physical infrastructures all contributed to an environment of depression and despair.

Status of Kenya AIDS program in 2000.

An international partnership between the Moi University and the Regenstrief Institute, including myself, implemented an e-health system in a remote clinic near Eldoret.

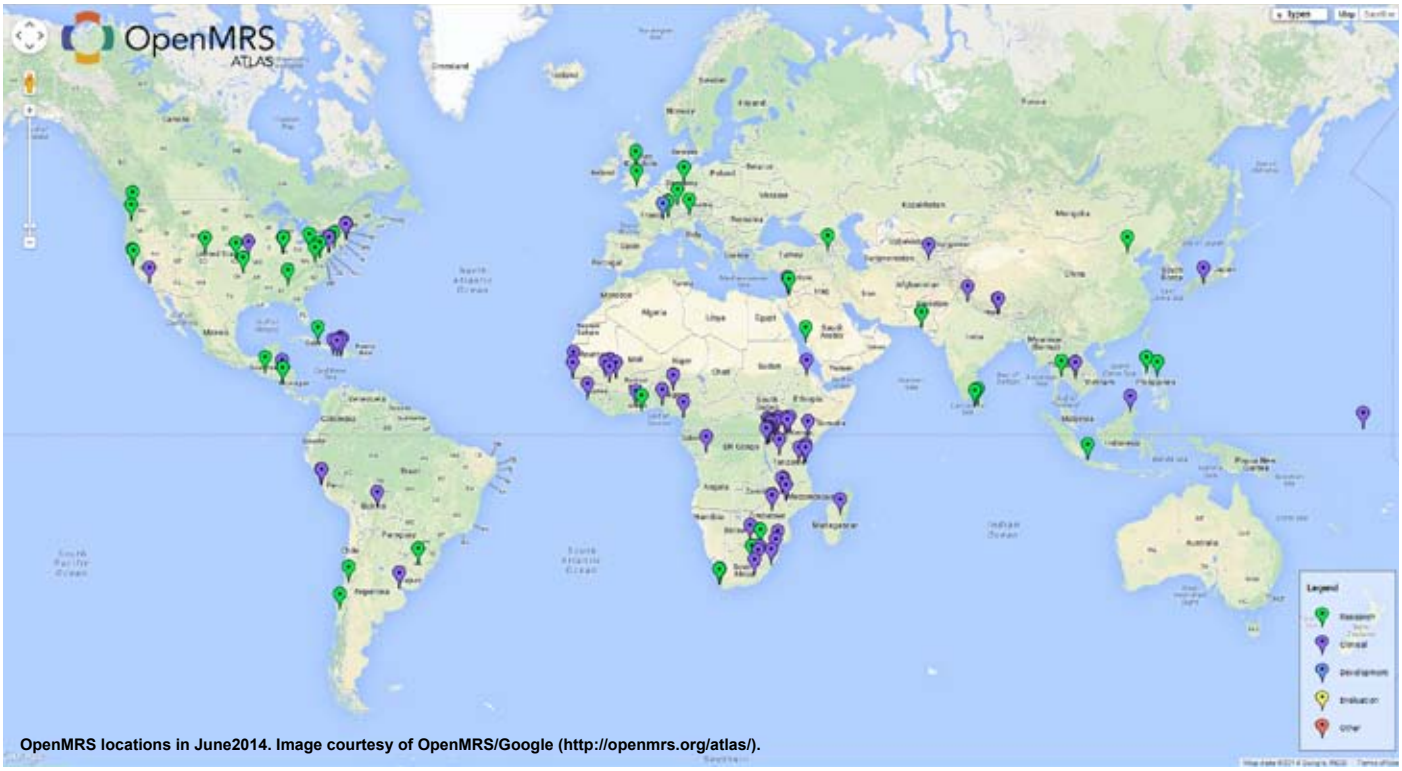
Critical to the success of the project was collaboration and, as Professor William Tierney put it, 'we sat in the dirt — physically and metaphorically — with the end users for 18 months.' During this time, it was the end users, not the doctors, who entered clinical care data and produced reports on all clinic activities.

After two years, and with data on more than 63,000 patient encounters, the clinical system produced a report that revealed that despite a 14% prevalence of HIV/AIDS, the incidence of cases documented (and associated cases of tuberculosis) was 0%.

This powerful information management output promoted the Kenyan government to request that this system be in 'every clinic in Kenya!' — many of which were remote, had poor electricity supplies, and staff with poor computer literacy. As well as being able to work in these kinds of conditions, the system had to manage millions of patients.

Thus a new system of e-health was born: the OpenMRS record system.

The OpenMRS is built in accordance with the knowledge principles of all good e-health systems: promotes collaboration, scalability,



OpenMRS locations in June2014. Image courtesy of OpenMRS/Google (http://openmrs.org/atlas/).

sustainability, and flexibility; is rapid from design; uses standards; supports high quality research; supports intermittent connectivity; is low cost (preferably free/open source); and, above all, is clinically useful.

Since 2006, the e-health system in Eldoret, operating as AMPATH (ampathkenya.org), has been used to store and use 120,000,000 coded observations for clinical decision making, research and health planning. This essentially saw Kenya go from having a relatively non-existant AIDS program to a point where it has one of the largest e-health projects in developing nations, and is sharing this new knowledge with developed economies.

As with the implementation of any e-health project, evaluation of AMPATH/OpenMRS was critical. In 2009, Braitstein published his evaluation of the project under the title *About a Revolution*, citing the following:

Just a few short years ago, the political will, infrastructure, and funding levels for health care in sub-Saharan Africa seemed no match for the relentless devastation from HIV/AIDS. Now HIV/AIDS programs are not only in place but some of them, including the partnership between the United States Agency for International Development (USAID) and the Academic Model Providing Access to Healthcare (AMPATH) are openly speaking of bringing the pandemic to its knees over the next five years through widespread screening and effective treatment and prevention of HIV. Successful scale-up of HIV/AIDS programs in the world's poorest countries sends a powerful message: In the public sector, systems of care can emerge that are capable of managing complex chronic diseases. The evolving success story of HIV care programs demands a rethinking of what is possible by applying the lessons learned to unmet needs of those in low income countries who are living with and dying from other diseases.

Two of the most important lessons learned from AMPATH are: 1. Health care is an information business. Managing patient care requires managing patients' data at many levels; 2. An electronic health record (EHR) system is necessary to manage a chronic medical condition such as HIV in a large patient population.

The OpenMRS project was nominated for the Nobel Peace Prize in 2007. To find out more about OpenMRS, go to www.openmrs.org ha


Patient data capture in the community.

National Palliative Care Week 2014

Celebrating the people who deliver end-of-life care

The theme for Palliative Care Week for 2014 (25-31 May) was *Palliative care is everyone's business: Let's work together.* This year, as part of Palliative Care Week celebrations, the AHHA and Silver Chain showcased their joint training initiative at a lunch held in Melbourne on 26th July, 2014.

The partnership's online training initiative (www.palliativecareonline.com.au) is designed to encourage the use of the Guidelines for a Palliative Approach for Aged Care in the Community Setting. At the lunch, it was announced that the program was continuing to have great success, having just registered its 10,000th participant.

Launched in June last year and developed by Silver Chain, the AHHA, e3Learning and leading expert, Molly Carlile, with funding from the Australian Government Department of Health, the palliative care training modules continue to draw participants from across Australia. With a Platinum Award for Best eLearning Model at the prestigious LearnX Awards already firmly under its belt, the training is evidence of the huge potential that e-Learning has for improving the healthcare sector.

Terrie Paul, Director of the AHHA's JustHealth Consultants said, "We are delighted that this training is being recognised so widely. But more importantly, it is clear that it is filling a much needed void in educating health professionals and the community to improve the quality of end of life care delivered to older Australians."

The lunch also featured Dr Ranjana Srivastava, a renowned medical oncologist, who spoke on *The Ancient Problem of Dying and The Dilemmas of the Modern Doctor* and explored some of the key barriers to palliative care in modern society and ways of addressing them.

Recent Order of Australia recipient and National Ambassador for Dying to Know Day, Molly Carlile spoke about the importance of building community capacity in conversations about dying.

Victorian Health Minister David Davis closed the lunch with a presentation on the commitment the Victorian government provides to palliative care services to truly make a difference to the lives and deaths of people in the community. ha

CAROL HOLDEN
Chief Executive Officer, Andrology Australia; Deeble Institute knowledge exchange short course participant.

www.ahha.asn.au/deebleinstitute/shortcourse

Waiting in the wings

A national men's health curriculum for Australia's medical schools

In recent years, men's health has received greater community recognition, given reports of poorer health status for Australian men compared to women across a range of indicators.[1] In response, the Australian Government released a National Male Health Policy in 2010, thereby giving some legitimacy to the growing community awareness of men's health.[2] Despite limited financial commitment to the broad range of initiatives outlined, the policy includes recommendations to improve primary care access for men to complement broader healthcare reforms.[3]

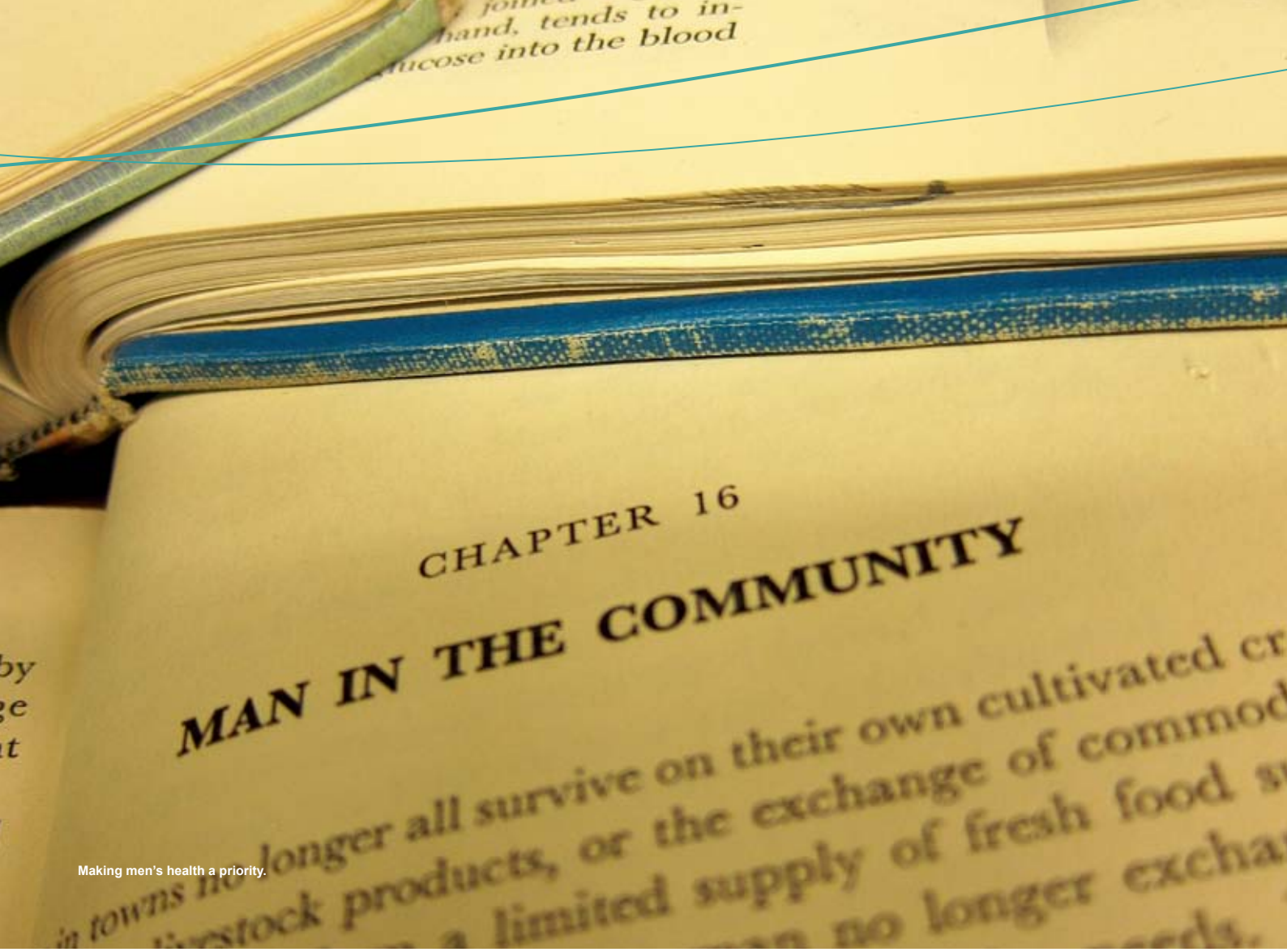
Evidence suggests that health care professionals often lack the requisite skills, confidence and knowledge in specific men's health issues, particularly sexual and reproductive health.[4,5] Further training and up-skilling of the workforce in the management of male health issues is therefore needed to foster a 'male-friendly' health service delivery approach.[2,6] Yet there is little in the way of undergraduate and graduate men's health education to meet current and future workforce need.[7] In the absence of a dedicated 'men's health' professional specialty, Andrology Australia is taking a leadership role to prepare for a future where health professionals are more knowledgeable and skilled in managing men's health issues. Andrology Australia has primarily delivered male reproductive health education to the current health care workforce. To create long-term change in men's health generally, education directed to the future medical workforce is also needed.

Anecdotal evidence suggests that wide variation exists between medical school curricula with respect to the extent of inclusion of male health topics and the manner in which they are taught.

Over the last few years, Andrology Australia has identified gaps in medical school teaching and student experience and knowledge in men's health issues. Anecdotal evidence suggests that wide variation exists between medical school curricula with respect to the extent of inclusion of male health topics and the manner in which they are taught. The need for an integrated male health medical school curriculum, akin to those offered in women's and children's health, has been identified. However, numerous barriers exist to incorporating new content into already tightly packed medical school curricula.

In 2011, Andrology Australia established a Working Group with medical school representatives from four Universities (Monash University, University of Tasmania, University of Adelaide and University of Western Australia), together with members of the Australian Medical Students Association, to develop male health content for both undergraduate and graduate curricula. The Working Group has assisted with the development of a comprehensive and flexible male health curriculum framework, together with relevant evidence-based resources that can be integrated into medical school curricula nationwide. The aim of the framework is to re-position male health in undergraduate and graduate medical courses to ultimately improve the recognition and management of men's health among practising health professionals, thus leading to better health outcomes for men.

The Framework comprises ten core modules and associated learning outcomes defined for each of the domains of knowledge, skills and behaviours. The Framework covers both basic science and clinical/professional skills for each topic allowing for vertical integration into the curriculum and the inclusion of sub-sections of the Framework to complement already existing male health topics. Case studies and



Making men's health a priority.

a range of additional resources are described for each module to support a problem-based learning approach.

The Framework was designed with consideration of established curricula and pressures on medical schools to respond to changes in the health and medical environment. To address these challenges, a 'curriculum enhancement strategy' was proposed rather than replacement or expansion.[8] A formative evaluation was undertaken to refine the approach and to identify the support systems and resources needed to facilitate the implementation of the framework into medical curricula, without compromising other disciplines.

Formative evaluation included focus groups and interviews with academics, curriculum developers and students at several universities. The evaluation identified that each university has different needs with respect to implementation of curriculum enhancement activities. All universities who participated in the evaluation were enthusiastic about a defined men's health curriculum framework but highlighted the need for tools that would assist in identifying gaps in their current curriculum where the men's health topics could be integrated. They also discussed the need for flexible, evidence-based resources that would support teaching across all years of education, including clinical placement.

Andrology Australia aims to pilot test the implementation of the Framework with several universities, starting in the latter part of 2014. This will ensure that the right resources and support are provided to medical schools to effectively incorporate the Framework with minimal disruption to their curriculum development activities, moving men's health from the 'wings' onto the curriculum stage.

For more information about the project, contact: info@andrologyaustralia.org ha

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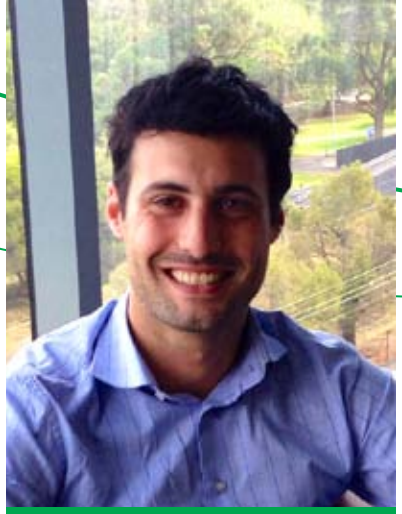

MIKE DAVIS
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www.ahha.asn.au/deebleinstitute/shortcourse

Innovating Australia's health workforce

An overview of some promising initiatives

The political theatre of 2014 has seen the all-important discourse regarding the future of Australia's healthcare system diverted, from innovation in quality healthcare service provision, to rationalisation of services and the sustainability of Medicare.

There has been significant focus on the inefficiency of the public health sector, with a scathing Commission of Audit report and meagre 2014-15 Federal Budget all but silencing debate on progressive measures to improve health system efficiency.

Though vital that this health debate continues, it is also time to take a step back and revisit some key health workforce innovations that have emerged recently. This is because newly emerging roles such as nurse practitioners and allied health assistants have the potential to innovate Australia's health workforce, improving capacity and reducing cost in the healthcare system as a whole.

Nurse practitioners

Nurse practitioners are registered nurses who have completed both advanced university study (at master's degree level) as well as extensive clinical training. It wasn't until 2002 that we began to see nurse practitioner roles emerge here, at which time there were only two — both working in New South Wales. By 2013, according to Health Workforce Australia, there were 736 nurse practitioners working in primary care, emergency and hospital sectors around the country. Earlier this year, the Australian College of Nurse Practitioners went on to announce its 1,000th nurse practitioner endorsement.

The key benefits of nurse practitioners is that they can offer medical treatment, at a lower cost than doctors, as part of collaborative arrangements in a range of service gap areas, including chronic disease management, mental healthcare and drug and alcohol services. Further, their work in aged care and mental health has the potential to reduce avoidable hospital admissions, through early intervention and management.

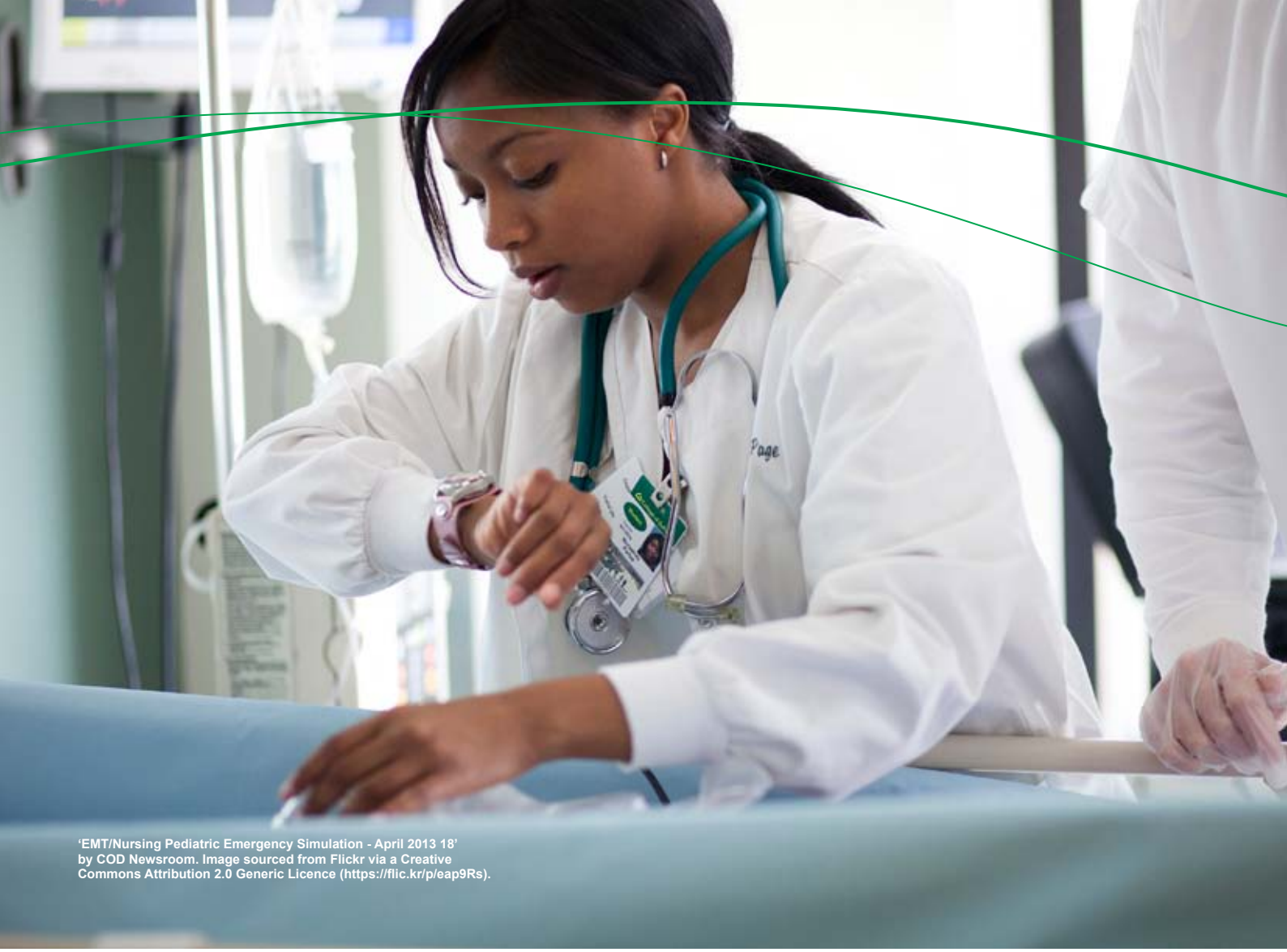
Nurse practitioners are also particularly effective at working in complementary roles alongside physicians and general practitioners in rural and remote areas where there are higher burdens of chronic illness than in metropolitan areas. They excel at patient education and are well suited to models of care that empower patients to care for themselves at home and keep themselves out of hospital.

Given Australia's rapidly ageing population, nurse practitioners can play an important role in aged care, particularly at residential aged care facilities, many of which lack a continuous medical presence. Indeed, recent research reveals high levels of satisfaction among aged care residents (and their families) receiving care from nurse practitioners.

The problem is that, despite universal commitment from all governments to support workforce innovation and reform, most governments are yet to commit adequate funding for new positions and training pathways that would allow nurses to up-skill. Additional barriers to the expansion of nurse practitioner roles include a lack of access to Medical Benefits Schedule items and a lack of support from GPs and physicians, many of whom do not have a sufficient understanding of the nurse practitioner role and scope of practice.

Despite universal commitment from all governments to support workforce innovation and reform, most governments are yet to commit adequate funding for new positions and training pathways.

Still, some governments have taken the lead in embracing these cost-effective innovations. The Northern Territory Government, for example, recently announced a plan to fund an additional 25 full-time positions for nurse practitioners to work in rural and remote areas, by 2016.



'EMT/Nursing Pediatric Emergency Simulation - April 2013 18' by COD Newsroom. Image sourced from Flickr via a Creative Commons Attribution 2.0 Generic Licence (https://flic.kr/p/eap9Rs).

Similarly, the Victorian Department of Health has collaborated with the Centre of Palliative Care to help fund 11 new nurse practitioner positions to work in the acute palliative care setting.

Allied Health Assistants

Whereas nurse practitioners expand on the traditional nursing role toward an advanced scope of practice, allied health assistants fulfil a support and assistance role to allied health practitioners. This helps to alleviate the heavy administrative burden and time spent on low-skill tasks which, in turn, enables allied health practitioners to allocate more time to tasks that align better with their professional training and education, and better utilise their advanced skills.

Given the shortage of allied health service workers operating in outer metropolitan, rural and remote areas, the gradual introduction of a skilled allied health assistant workforce is an innovative approach that could change the way that healthcare is provided in this country. As the 2013 Mason report on the state of Australia's health workforce programs revealed, allied health assistants working under the supervision of allied health professionals could allow professionals to significantly boost their work capacity.

Despite these findings, greater support for the allied health workforce is needed. Such support is critical for ensuring equitable access to healthcare for Australians who are disadvantaged by their rural or remote location and lack of mobility due to age.

The majority of full time allied health assistants work in occupational therapy performing rehabilitative services, physiotherapy, social work and speech therapy and are well placed to meet rural and remote health needs as well as to complement existing urban health needs.

While rural health bodies have expressed great support for the expansion of allied health assistant programs, other professional bodies have been less supportive. A major barrier to expansion is the lack of evidence-based research into the clinical effectiveness of the role as well as patient satisfaction and productivity gains.

However, a collaborative project led by the Victorian Government in partnership with Alfred Health (Allied Health Assistant Implementation Program) has already yielded some impressive results regarding allied health assistant satisfaction levels and allied health practitioner confidence in allied health assistants.

Approximately 84% of allied health practitioners in the study expressed confidence delegating clinical tasks to allied health assistants and satisfaction in the use of allied health assistants in the profession. Further, 86% of allied health assistants report that they are satisfied or highly satisfied in their role, working under the supervision of allied health practitioners.

There is certain to be further research into the success of these innovative and emerging roles as governments move to evaluate the success of such initiatives in coming years. The development of a comprehensive evidence base in this area will be critical to future success and further implementation of the nurse practitioner and allied health assistant roles.

It will also strengthen our understanding of how best to achieve a flexible, diverse and innovative health workforce that ensures the best healthcare is available for all Australians. ha

Process improvement

Jane Bishop, Director of Healthcare Services, Leading Edge Group, looks at how to strengthen healthcare processes using simulation techniques.

Process improvement in healthcare, while not new, is still in its infancy when compared to the improvement work done in manufacturing globally for the past 50 years. We are only now beginning to understand the importance of removing non-value-added activities from our processes in order to have the capacity to meet the demands on our services and the increasing need to meet regulatory requirements.

While we are charged with doing more with less in order to contain the rising costs of healthcare, we do not always have the ability to focus on what is truly adding value to our patients' care or our healthcare system generally. Therefore, we are not always able to make informed decisions as to what can be cut and in order to still meet the demand for service and ensure quality outcomes.

While we are charged with doing more with less in order to contain the rising costs of healthcare, we do not always have the ability to focus on what is truly adding value to our patients' care or our healthcare system generally.

Many process improvement efforts involve the use of Plan, Do, Check, Act (PDCA) cycles to trial new processes in a clinical setting. A continuous review of these trials allows the improvement team to constantly try new ideas until a process improvement occurs.

Simulation has the potential to improve healthcare practices and to enable potential improvements to be tested before being implemented in a clinical setting. Simulation is a technique — not a technology — to replace or amplify real experiences with guided experiences. It is these guided experiences that evoke or replicate substantial aspects of the real world in a fully interactive manner.[1]

Many simulation techniques have historically been used to teach medical and clinical techniques. More recently, simulations have been used to test designs for new medical facilities or to test process improvements in existing environments.

Software simulations allow participants to change the test parameters. This enables closer examination and isolation of the impact of process changes on specific areas of interest, such as patient flow, patient outcomes and throughput, staffing ratios and budgetary impacts. Some types of simulations also use props to allow participants to experience a hands-on approach to process improvement.

By using simulation techniques, staff who are interested in quality management and process improvements can test improvements ideas in a safe and supported environment. They can also quickly redesign process improvements and trial these new ideas far more easily than they could if testing changes in the real world. Furthermore, measuring the process improvement and outcome metrics through simulations allow staff to prioritise which ideas are best used for PDCA cycles in the clinical settings. This creates some degree of confidence that any implemented improvement strategies will likely result in positive outcomes.

Staff at Halton Health Services in Oakville, Ontario, recently used simulations to test new process improvement ideas for their Emergency Department (ED), which is often under pressure. As the existing ED is set to move to a newly built hospital in the vicinity, the staff felt it was important to streamline processes as much as possible, prior to the move.

A total of 25 participants embarked on

Process improvement students at Halton Health Services using simulation techniques. Image courtesy of Jane Bishop.

a six month process improvement course which included four instructor-led days. Here, participants had the opportunity to move 'patients' though the system from registration and triage to discharge or admission, all in a classroom environment.

The simulation mimicked real life events in the ED, including the arrival of code patients and long bottle necks in process steps, such as diagnostic imaging and admission to hospital. Metric collection allowed the team to audit patient outcomes, patients in progress through the system, lead times and queue times, as well as cost to the hospital budget.

After the students had learnt some basic principles and tools involved in process improvement, they redesigned processes and the physical design of their ED.

They again ran a simulation exercise under the same conditions with the same variables, such as number of staff and code patients. The metrics for round two showed a significant improvement in patient flow, reduction of bottlenecks, increased rate of discharge, reduced lead and queue time, as well as a decrease in the costs involved in treating each patient.

The students are now trialling new processes in their existing ED in hope of reducing the pressure prior to moving to their new facility. ha

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Who's moving

Readers of *The Health Advocate* can track who is on the move in the hospital and health sector, courtesy of the AHHA and healthcare executive search firm, Ccentric.

Damian Armour, who has been the CEO of Epworth Freemasons Hospitals, is taking up a dual position within Epworth Healthcare as CEO of the new Epworth Geelong Hospital and Executive Director of Diagnostics and Radiation Oncology Epworth Healthcare.

Following in Damian's place at Epworth Freemasons Hospital, **Mr David Nowell** will take over as Executive Director. Previously he was the General Manager at Cabrini Brighton.

Robynne Cooke has made the move from Northern Health, where she was the Executive Director Acute Health and Chief Nursing Officer, to Sydney to become the General Manage of Liverpool Hospital.

Michael Lee has recently moved from Pfizer, where he was the Medical Director/Asia Pacific Head of Medical Affairs, to become Senior Director and Regional Medical Head, APAC/ANZ for Shire Pharmaceuticals.

Peter Stewart has recently joined Roche Products Australia as their new Country Medical Director. He was previously the Medical Director and Head of PCBU Medical for Pfizer.

Nicole Waldron, who has been with Epworth Healthcare since 2011 in various positions, has been appointed Executive Director of Epworth Richmond.

Professor Philippa Pattison, previously the Deputy Vice-Chancellor (Academic) at the University of Melbourne, is moving to the University of Sydney to become Deputy Vice-Chancellor (Education).

Professor Pankaj Sah, who has been the Deputy Director of the Queensland Brain Institute at the University of Queensland, has been made Director of the new Science of Learning Centre.

Ms Sue Williams is joining Peninsula Health as its Chief Executive Officer, previously working as the General Manager of the Healthcare Division at Spotless.

Alex Demidov has recently joined Healthscope as General Manager for the Nepean Private Hospital. He was previously General Manager at Dalcross Adventist Hospital.

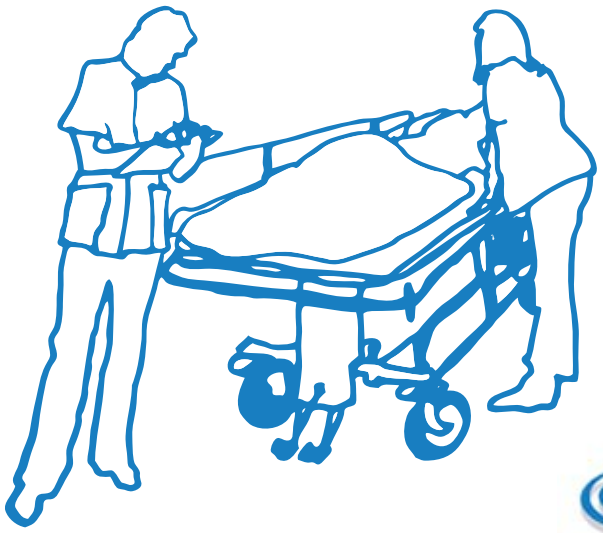
Brett Goods was appointed as the General Manager of the Dalcross Adventist Hospital, having previously held the position of CEO of the Mayo Private Hospital in Taree.

Professor Steven Doherty has moved to the University of New England as the Head of the School of Rural Medicine, having previously been at the University of Newcastle as Head of the Tamworth Clinical School.

Mr Simon Hamilton has moved back into the health sector to take on the Human Resources Manager position at the Garvan Institute of Medical Research.

Mr Paul Geddes has just left his position at St Vincent's Hospital Toowoomba as Perioperative Services Manager to start with the new Sunshine Coast University Private Hospital as the Assistant Director of Clinical Services Perioperative.

Ms Susan O'Neil, who has been Executive Director of Nursing at Cabrini Health since 2009, will be moving to Albury Wodonga Health to become the new Chief Executive Officer. ha



Ccentric Executive Search

If you know anyone in the hospital and health sector who's moving, please send details to the Ccentric Group: editor@ccentricgroup.com

Become an AHHA member

Help make a difference to health policy, share innovative ideas and get support on issues that matter to you – join the AHHA

The Australian Healthcare and Hospitals Association (AHHA) is the only independent national peak body advocating for universal and equitable access to high quality healthcare in Australia.

With over 60 years of engagement and experience with the acute, primary and community health sector, the AHHA is an authoritative voice providing: strong advocacy before Ministers and senior officials; an independent respected and knowledgeable voice in the media; and a valued voice in inquiries and committees.

By becoming a member of the AHHA, you will gain access to AHHA's knowledge and expertise through a range of research and business services.

The Deeble Institute for Health Policy Research was established by the AHHA to bring together policy makers, practitioners and researchers to inform the development of health policy. In joint collaboration with seven university partners and health service members, the Institute: undertakes rigorous, independent research on important national health policy issues; publishes health policy Evidence Briefs and Issue Briefs; conducts conferences, seminars, policy think-tanks and workshops; and helps policymakers, researchers and practitioners connect when they need expert advice.

In addition to this guidance in health policy and research, the AHHA offers various business services through JustHealth Consultants. This is a national consultancy service exclusively dedicated to supporting Australian healthcare organisations at state, regional, hospital and community levels and across various sectors. Drawing on the AHHA's comprehensive knowledge of the industry, JustHealth Consultants provides expert skills and knowledge in areas including: corporate and clinical governance training; strategy and business planning advice; organisation design and improvement; health services planning and program evaluation; and board induction training.

In partnership with the LEI Group, the AHHA also provides training in 'Lean' healthcare which delivers direct savings to the service provider and better outcomes for customers and patients.

To help share important developments across these various health research, policy wand training spheres, the AHHA also publishes its own peer-reviewed journal (*Australian Health Review*), as well as this health services magazine (*The Health Advocate*).

To learn more about these and other benefits of membership, visit www.ahha.asn.au ha

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The AHHA Board has overall responsibility for governance including the strategic direction and operational efficiency of the organisation, the protection of its assets and the quality of its services. The 2012-2013 Board is:

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Australian Health Review is the journal of the AHHA. It explores healthcare delivery, financing and policy. Those involved in the production of the AHR are:

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A detailed understanding of the theory and effective application of Lean Healthcare concepts, tools and practices, This involves the implementation of a work-place project to develop quantitative improvements.

LEAN HEALTHCARE BLACK BELT

A practical application of advanced Lean Healthcare tools and techniques, appropriate process improvement, leadership and programme management skills to drive and sustain changes necessary for successful Lean transformation.

CERTIFICATION BODY

ahha
australian healthcare & hospitals association

The Australian Healthcare and Hospitals Association (AHHA), is the independent membership body and advocate for the Australian healthcare system and a national voice for high quality healthcare in Australia.

LEI Group Australia is proud to partner with the Australian Healthcare and Hospitals Association to prepare healthcare professionals and organizations to increase efficiencies and improve organisational performance through the delivery of a series of Lean Healthcare educational programmess at Yellow, Green and Black Belt levels.

For more information on pricing and registration please contact: 02 6162 0780
email: admin@ahha.asn.au

HTTP://AHHA.ASN.AU/LEAN-TRAINING

TUES. 9 TO WED. 10 SEPTEMBER 2014
NOVOTEL, BRIGHTON LE SANDS, SYDNEY

The Quantum Leap

Health Innovation: Making Quality Count

In a health system under pressure from rising demand, cost increases and budget restraint, the focus on value for money continues to grow. Clinicians, managers and policymakers are striving to balance the drive for efficiencies with the need to maintain and improve quality health outcomes.

The *Quantum Leap – Health Innovation: Making Quality Count* will highlight the challenges and achievements of successful innovations in health, showcasing a range of award-winning local healthcare pioneers as well as international perspectives on health service management and delivery.

Keynote speakers include:


Peter Dutton / Federal Minister for Health


John E McDonough /
Harvard School of Public Health


Joe Gallagher /
First Nations Health Authority, Canada


Mark Britnell /
KPMG Head of Healthcare UK


Roopen Arya / Clinical Lead, UK National VTE Prevention Programme

For more information or to register, visit www.thequantumleap.com.au or phone the AHHA on 02 6162 0780.

REGISTRATION NOW OPEN

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THE AUSTRALIAN COUNCIL ON HEALTHCARE STANDARDS ACHS

The Quantum Leap is a collaboration of the Australian Council on Healthcare Standards (ACHS) and the Australian Healthcare and Hospitals Association (AHHA).