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**Primary Health
Networks**
Challenges and
opportunities

Mental ill health
Reducing the stigma

**Funding and
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A review of the 2015-16 Budget

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2013 winners, left to right: John van Bockmeer, Craig Maloney, Alison Gibson and Jodie Mackell representing MIA.

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AHHA in the news

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New palliative care training modules available at www.palliativecareonline.com.au

Supporting those who support our most vulnerable

In conjunction with National Palliative Care Week, the AHHA was pleased to announce the development of new online palliative care training resources for those who support the dying in our community.

AHHA Chief Executive Alison Verhoeven said the new online training and information portal, due to be launched on 1 July, would provide a valuable resource for those who are involved in providing palliative care.

“The new portal will be a combination of current resources, new resources, and specifically targeted learning content. The focus will be skills development for improved quality of care, and it will be a source of genuine value to the palliative care workforce across the country,” Ms Verhoeven said.

The new online portal will build upon the success of the original award-winning training modules based on the COMPAC Guidelines for community based palliative aged care, which have already been used by over 20,000 people across Australia and internationally. In response to stakeholder feedback, the new portal will feature two new units on pain management and recognising deteriorating clients.

Death of 1987 AHHA Sidney Sax Medallist, Dr Donald Child

The Australian Healthcare and Hospitals Association (AHHA) was sad to announce the death of Dr Donald Child, AHHA Past President and 1987 Sidney Sax Medallist, on 19 March 2015.

Dr Child provided significant leadership to the Australian health system over a long and eminent career. As Chief Executive of the Royal Prince Alfred Hospital, he introduced many new services and facilities including a number of Community Outreach Clinics which took the Royal Prince Alfred Hospital into the community.

Dr Child was a President of the University Teaching Hospitals' Association of New South Wales and had a particular interest in the educational and research functions of the teaching hospital system. He also made a major contribution to academic medicine, particularly with the development of a Cancer Research Institute at the University of Sydney.

Mental health: integrated service approach required

In April, the AHHA supported the call for user-focused mental health services based on prevention, early intervention and recovery, as proposed in the review of mental health programs by the Australian Government's National Mental Health Commission.

“Expenditure on health, including mental health, must be viewed as an investment in a productive community and economy,” said AHHA Chief Executive Alison Verhoeven.

Ms Verhoeven also said that while greater investment in well planned community-based mental health services is required, this should not be at the expense of acute services. “Any major funding shift needs to be planned and delivered over time in the context of an integrated service approach to mental health. A blanket reduction of acute care services before the capacity of community-based programs is increased would be disastrous.”



Mental health expenditure vital to economy.

Health leaders gather for AHHA think tank on federalism and health

As a contribution to the current Reform of the Federation process, the AHHA brought over 130 health leaders together to Old Parliament House 16 March 2015 to discuss the challenges and opportunities for change in the way health services are provided to all Australians.

While many issues were raised and debated on the day, the common thread related to the complexity in our current system. Participants agreed that the opportunity to address accountability gaps, waste, confusion amongst both consumers and providers, and a system that does not fully meet the health needs of large sections of our population, must be seized with this reform process.

Choosing Wisely Australia launches just in time for Medicare review

The AHHA welcomed the Commonwealth Government's announcement to review the items funded through the Medicare Benefits Schedule, however it stressed that the process should be informed by initiatives like the Choosing Wisely campaign.

"It is essential that any such review of Medicare is based on a solid evidence base, developed in consultation with consumers, clinicians and health service representatives, and that the implications and impacts are considered across the whole health system," said AHHA Chief Executive, Alison Verhoeven.

"The launch of Choosing Wisely Australia comes at an opportune time, as it can provide much needed guidance as the government embarks on its formal review process. It will do this by starting important conversations with healthcare stakeholders."



Senator for the ACT Katy Gallagher speaking outside the AHHA's Think Tank on Reform of the Federation and Health.

Lighthouse project highlights best practice healthcare for Aboriginal and Torres Strait Islander patients

The April release of the *Australian Burden of Disease Study: Fatal burden of disease in Aboriginal and Torres Strait Islander people 2010*, highlighted the need to better address disparities faced by Indigenous heart attack patients and the importance of the Lighthouse Hospital project, now underway in a joint partnership between the Heart Foundation and AHHA with support from the Australian Government.

The report found around 3,000 Indigenous Australians die each year, resulting in almost 100,000 years of life lost due to premature death. Cardiovascular disease contributed the most fatal burden of all diseases (21%).

National Heart Foundation CEO, Mary Barry

said that when Aboriginal and Torres Strait Islander peoples present to hospitals they do not receive the same level of care as other Australians. "It is unacceptable that Aboriginal and Torres Strait Islander people continue to die from cardiovascular disease at greater rates and at younger ages than other Australians," Ms Barry said.

AHHA Chief Executive Alison Verhoeven said the collaboration between primary care, acute hospitals and Aboriginal health services is essential to improving coordination and quality of care, as well as reducing the disparities in health outcomes. "There is much scope for this work to be further developed, across Australia, and across disease groups," Ms Verhoeven said. ^{ha}

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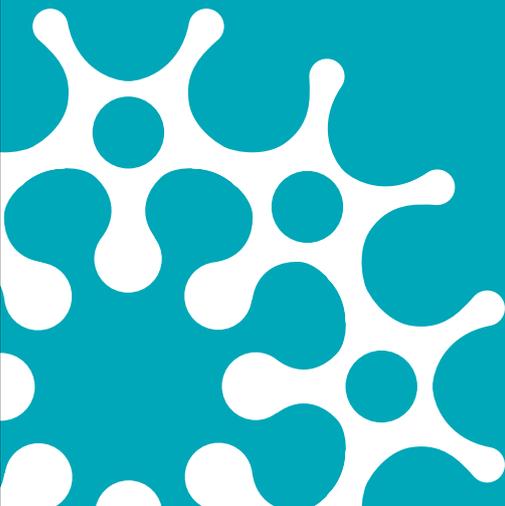
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PAUL DUGDALE

Chair of the Australian Healthcare and Hospitals Association (AHHA)

A plan for chronic disease management

Working with consumers, clinicians and service providers to improve the health system as a whole

The 2015 *Intergenerational Report* noted that the increased prevalence of chronic health conditions and the associated demand for care are key drivers in the growth of health spending in Australia. A national plan for chronic disease management is urgently required to address this.

The attempt to create an overarching framework for chronic disease management has, until recently, been absent from the Commonwealth Government agenda. Instead, with the exception of diabetes and mental health, we have seen funding holes and service overlaps due to programs and treatments being funded through different levels of government. To tackle this issue, we need to examine ways to better integrate primary care, hospitals and specialised community-based services (including allied health services).

With the Health Minister indicating that chronic disease is a priority area for the Primary Health Networks, however, I am hopeful that we are heading towards a better, more integrated approach to managing diseases such as diabetes, heart disease and cancer.

To achieve this, we will need to improve upon significant structural issues in the current system; making it more connected and coordinated, easier for patients to navigate and including a stronger focus on both illness prevention and innovative treatment.

We also need to turn our attention to untangling the “complex web” – as our healthcare system is described by the *Reform*

of the Federation White Paper – in order to reduce confusion amongst consumers, providers and funders.

The Commonwealth Government’s plan to Reform the Federation has been identified by many as an opportunity to address fragmentation in health, by helping to address accountability gaps and increase efficiency. This hope was evident at the AHHA’s Think Tank on Reform of the Federation and Health in March, with better management of chronic disease a common theme among the more than 130 health leaders in attendance.

In particular, the participants agreed that any such reform

needs to focus on the structural issues around funding models and the delivery of services between different levels of government, moving away from the “complex web” that gives rise to shifting responsibilities and an endless blame game. It is within this inter-governmental divide that various funding responsibilities between allied health services and the Medicare Benefits Schedule (MBS) overlap in an untidy way.

With reports suggesting the Health Minister is considering the introduction of bundled care plans in primary care, something the

AHHA has been recommending for several years, there is an indication that we are taking steps in the right direction.

Similarly, the AHHA commended the Commonwealth Government’s recent decision to review items funded through the MBS, believing it to show a positive change in direction away from cost-shifting and other blunt fiscal measures, towards more strategic efforts aimed at reducing

waste, increasing efficiency, and improving health system sustainability and patient care.

However, it is essential that any such review of Medicare, as with the development of a national chronic disease

management plan, is also based on a solid evidence base, developed in consultation with consumers, clinicians and health service representatives, and that the implications and impacts are considered across the whole health system.

Ultimately, we need a national chronic disease management plan to ensure that consideration is given to better ways to manage this major issue over the long term. In doing so, we can ensure we are providing high quality health services for all Australians in the most efficient manner possible. **ha**

We will need to improve upon significant structural issues in the current system; making it more connected and coordinated, easier for patients to navigate and including a stronger focus on both illness prevention and innovative treatment.



ALISON VERHOEVEN
Chief Executive
AHHA

Reflection on the 2015-16 Budget

Why a long-term vision must prevail over short-term actions

While the Commonwealth Government has committed to a stronger focus on strategic, long-term health policy in its 2015-16 Budget media statement, there is a distinct lack of information or long-term planning evident for many important program areas in health.

As is often the case, the devil is in the detail.

The Government has indicated, for example, that around \$1 billion will be removed over five years from a range of program areas. However, the Department of Health has not yet clarified which programs will be affected.

As these funds support programs across important areas such as alcohol and drug services, mental health, Indigenous health and palliative care, and many are

delivered by not-for-profit agencies, the level of funding uncertainty will have profound impacts on the sector.

Similarly, the lack of commitment to preventive health, including a specific cut to research, is also deeply concerning in a health system which is grappling with an increasing burden of chronic disease.

The AHHA urges the Government to

The AHHA urges the Government to further engage hospitals and health service providers, consumers and the broader health system in its decision-making processes to ensure the implications of any large-scale changes across the sector are considered.

further engage hospitals and health service providers, consumers and the broader health system in its decision-making processes to ensure the implications of any large-scale changes across the sector are considered.

It needs to

move away from a haphazard approach to health policy, based on short-term funding

measures, announcements of reviews without subsequent public reporting, and deferring complex issues for future Reform of Federation discussions.

While Health Minister Ley has taken some important steps in building the credibility of the Government in the health sector, a quick look at a number of key areas shows that there is still much to be done.

Public Hospitals

The Government has failed to address the \$57 billion in cuts to public hospital funding made in last year's Budget, which will have a significant impact on the sector – and all Australians – between 2017-18 and 2024-25.

The Government's own White Paper processes to reform the Federation and tax system have shown that the states and territories do not have the capacity to replace the funding, which had been agreed upon through bipartisan negotiations, for these essential hospital services.

With that decision, the Government will also walk away from activity-based funding based on efficient hospital pricing in 2017-18 despite the cost efficiencies that have been

achieved through this approach.

Primary Health Networks

It is pleasing that the potential role for Primary Health Networks (PHNs) in system reforms such as the primary care review has been acknowledged. However, some of the funding decisions reported in the Budget appear to be at odds with this sentiment; for example, while PHNs will reportedly have a role in working together with general practice to ensure availability of after hours GP services, the only funding identified for this work is for GP Practice Incentive Payments.

Ultimately, in order to achieve real and sustainable change and to improve the effectiveness and efficiency of the health system, the Government must make a strong and enduring commitment to supporting the implementation of the PHNs as well as the better integration of primary and acute care.

Medicare

The AHHA has welcomed the provision of

\$34 million over two years in the 2015-16 Budget for a comprehensive review of items funded through the Medicare Benefits Schedule, and the recently-announced review of primary care funding models.

However, mechanisms are required for regular ongoing reviews to ensure that Medicare-funded services reflect best practice and best value. The review also needs to engage consumers and the health providers across the broader health system to ensure the implications of changes across the sector are considered.

Dental Health Services

The Government's commitment to dental reform must be questioned following further cuts revealed in the 2015-16 Budget, despite having pledged to "...honour the arrangements under the National Partnership Agreement (NPA) on Adult Public Dental Services..." prior to the 2013 election.

The NPA was intended to deliver \$1.3 billion over four years starting from 1 July

last year. However, so far, the Coalition's pledge has amounted to a 12-month delay, a nearly 25% cut to the 2015-16 allocation – from \$200 million to \$155 million – and the wiping of the remaining \$1.15 billion from the forward estimates.

e-Health

The Government's investment in e-health, newly rebadged as MyHealthRecord, should be welcomed with some caution. Centrelink's investment in IT systems, and the Department of Health's investment in expanded analytical capability, have the potential to positively contribute to improved health data resources for Australia, particularly if health data linkage programs are supported.

However, given the lack of information from the Government, it is unknown whether this new allocation of funds will deliver significant progress for clinicians and consumers, or if it will be more of the same wasteful approaches and staggering steps towards the goal of a better connected health system. [ha](#)



Primary Health Networks: challenges and opportunities

With the Primary Health Networks (PHNs) officially opening their doors on 1 July 2015, the AHHA spoke to sector leaders about their priorities, challenges and opportunities. Here's what they had to say...

“ This is a great opportunity to really make Australian primary healthcare the envy of others, but needs the Commonwealth to allow PHNs to do this. It is time to end the self-imposed secession of mental health from the rest of the health system. PHNs working with GPs and people with a lived experience of mental illness can really make a difference. Let's learn from others in the United Kingdom, Western Europe, New Zealand, Canada and the United States of America and adapt the best to strengthen primary healthcare in Australia. Done well, PHNs will help shape, support and strengthen Australian primary healthcare. ”

Dr Tim Smyth (Board, Central and Eastern Sydney Primary Health Network; Chair, Eastern Sydney Medicare Local)

“ There are a lot of health challenges in the north and west of Melbourne, but we're confident in our ability to work with health professionals, organisations and providers to create more integrated, responsive and efficient health care for our community. We've already begun identifying the priority health needs of our region and the existing systems and programs which can best meet those needs. We will be focusing on supporting services which are person-centred, have a proven track record of improving health outcomes and which deliver strong value for money. ”

**Associate Professor Christopher Carter
(CEO, Melbourne Primary Care Network)**

“ General Practice is crucial in developing high performing and cost effective primary health care. Recognition of this fact has been a priority with Eastern Melbourne Medicare Local (EMML) and should be an absolute priority for all of the new PHNs. It should be noted that some MLs moved their focus away from general practice and this had a negative impact on overall patient care. This failure to support general practice may, in fact, be one of the key reasons the current Federal Government has dropped MLs and gone with a different model for service delivery. ”

**Kristin Michaels
(CEO, Eastern Melbourne Medicare Local)**

“ Reducing the fragmentation across both acute and primary healthcare is critical to improving patient and community health. By building and increasing the health literacy of communities, coupled with collecting their views on patient experiences and outcomes, we can create changes to health in WA. Our clinical and community engagement model will ensure all voices in the community are heard, resulting in new and innovative solutions to many of our health challenges in today's society. ”

**Learne Durrington
(CEO, WA Primary Health Alliance)**

“Based on our successful track record, strong engagement with GPs and effective consumer engagement model, the PHN in the Nepean-Blue Mountains region is well placed to make a positive impact on the integration of the local healthcare system but we recognise much work is required to achieve this and there are high expectations and a limited budget.”

Lizz Reay
(A/CEO, Nepean-Blue Mountains
Primary Health Network)

“Tasmania’s in the fortunate position of having a single ML with a statewide boundary which is transitioning to a single PHN with a statewide boundary. We are bringing our established stakeholders and partners with us, which will help make the transition as smooth as possible. The Tasmanian PHN aims to build on Tasmania ML’s solid groundwork around coordinating, connecting and streamlining care through work that goes to the heart of the PHN objectives. We will continue to build bridges between different parts of the health, aged and social care systems and facilitate a no-wrong-door, team approach to person-centred care. We embrace the challenge to do things differently with our provider community as we work towards the shared goal of improving health outcomes for Tasmanians.”

Phil Edmondson
(CEO, Tasmania Primary Health Network)

“We have an enormous depth and breadth of skill and experience leading the PHNs across the country. From an organisational perspective, I think it would be very valuable and helpful to have a forum to bring together this knowledge; to share ideas and address challenges collectively. A shared voice for PHNs is needed to ensure that primary healthcare is kept at the forefront of the health debate, as it remains the most effective way to improve the health of individuals and communities.”

Pattie Hudson
(CEO, Sunshine Coast Health Network)

“One of our challenges with the new PHN will be ensuring we have the required diversity of GP and other primary healthcare engagement across Western Victoria. This will ensure we collaborate efficiently and effectively to provide solutions that improve the health outcomes of patients, particularly those at greatest risk of poor health outcomes in regional and rural areas.

Jason Trethowan (CEO, Grampians and Barwon
Primary Health Network)

“PHNs provide an ideal structure with which to roll out regional commissioning models as contemplated by the Government in the competitive tender. Good quality regional commissioning has been shown to achieve a better match between resources and needs, and to reduce the inefficiencies associated with program and organisational silos.”

Adjunct A/Prof Walter Kmet
(CEO, WentWest)

“A significant priority for us is increasing the capacity of primary care to manage people with chronic conditions, thus keeping people well and out of hospital. With strong community and general practice leadership, we will collaborate with our hospital colleagues as well as private, state and federal funders to shape the model for the future. “We see a key role for PHNs in aged and disability care – acting as local information sources and coordinators of local providers – ensuring a navigable and streamlined system for the community.”

Abbe Anderson
(CEO, Brisbane North Primary Health Network)



THE HON. CATHERINE KING
Shadow Minister for Health
Australian Labor Party

Working in good faith

Negotiating healthcare system reforms

The Abbott Government's cuts to public hospital funding have critical implications for the future of Commonwealth-state relations in health.

The \$57 billion cut to public hospitals in the Abbott Government's first Budget is the single biggest contribution to the spending reductions in the Intergenerational report.

The \$57 billion was removed by abandoning Labor's agreement, and the Coalition's own election policy, that the Commonwealth would move to fund 50% of growth in the efficient price of hospital based activity over the next decade.

Instead, the Abbott Government has now said it will only fund CPI and population growth, which is around a third of the actual growth in health costs.

But health, of course, is not something you can just turn off. People won't stop getting sick, won't stop going to hospital and won't stop needing treatment.

It just means in many cases hospitals make do with less, and people wait even longer and the costs are simply shifted from the Commonwealth to the states and territories.

As the Premier of New South Wales,

All healthcare system reform in Australia has only ever come about via negotiation and not once has this occurred without furious debate, significant and challenging political contexts, contention and compromise.

Mike Baird, said in a recent interview with Michelle Grattan, "What happened last federal budget is not sustainable. That was, the Commonwealth Government said, 'We are going to allocate a large part of the future growth in health costs from ourselves to the state governments.' The states do not have the capacity to meet those health costs on their own. The Commonwealth has a critical role to play."

The Abbott Government made this cut with absolutely no discussion with the states or territories. In fact, it systematically deceived them. The Prime Minister promised in the election "no cuts to health". Even after the election, he has continued to deceive them.

Just a month before the 2015-16 Budget at the COAG meeting with the leaders of all states and territories, the Prime Minister and Treasurer failed to even mention to any of their Liberal colleagues they were about to destroy their health budgets.

It had been previously agreed that not only would hospital funding be made more secure, but that funding would be used to drive some real reforms to improve patient care in a way that made hospitals much more efficient.

These agreements came after almost three years of negotiations that began with a full slate of Labor governments, and ended with a lot

of Liberal state governments, underpinned by recommendations from the National Health and Hospitals Reform Commission.

While not all recommendations were

agreed upon, at all times two things were clear: fundamental reforms were needed if we were to maintain a strong public health system, and this could only happen if reforms were driven by the Commonwealth, in close co-operation with the states and territories.

In April 2010, there was an historic agreement for the Commonwealth to take on full funding and policy responsibility for all general practitioner and primary healthcare and aged care services.

There were other parts of the reform process as well:

- An agreement on a National Prevention Strategy which included increased funding to the states and territories to fund prevention initiatives particularly to tackle obesity, as well as a national body to invest in prevention research and evaluation and disseminate the findings;
- The funding and development of the architecture for an e health record; and
- The development of 61 Medicare Locals critical to the process of achieving an integrated primary care system, closing gaps in service delivery, particularly after hours GP access, mental health and indigenous health services, and providing the Commonwealth, for the first time, the capacity to engage in population-based local interventions in immunisation, tobacco control.

As a suite of reforms they were, in short, the most significant reforms to the health system since the introduction of Medicare, negotiated by a Labor Government in cooperation with



the states and territories as a result of years of careful negotiation.

After just six months in power, the Abbott Government effectively sought to cast these reforms aside; part of its continuous efforts to justify savage cuts to health by declaring that health funding is unsustainable and, in the process, dispensing with reforms that would have otherwise reduced waste and duplication, and thus led to greater efficiencies in the longer term.

Instead of ensuring scarce health dollars are used to deliver health services as effectively

and efficiently as possible, we've gone back to simply providing funding to each jurisdiction at levels which won't even come close to matching the growth in demand for these services.

It's clear despite all the rhetoric about 50-year plans, federation white papers and intergenerational reports, the only real agenda here is to slash costs, abandon reform, push cost on to the states and territories, and blackmail them into lifting taxes. This is no way to run a health system, nor is it a way to run a country.

All healthcare system reform in Australia

has only ever come about via negotiation and not once has this occurred without furious debate, significant and challenging political contexts, contention and compromise.

This is why, if we are fortunate enough to be returned to government in 2016, Labor will immediately return to the path of cooperative federalism.

It is only when the Commonwealth drives the process, and works in good faith with all states and territories, Labor and Liberal, that real reform happens in health for the benefit of both patients and providers. **ha**

Managing medical records

Alison Choy Flannagan of Holman Webb Lawyers guides us through what needs to be done with medical records when closing down a health service (including a Medicare Local).

What laws apply?

All healthcare service providers are required to retain medical records. The requirements can differ depending upon:

- The type of records which are created and retained;
- Whether the healthcare provider is public sector or private sector; and
- Depending upon which State or Territory of Australia the health service provider operates

All Australian private sector healthcare providers are required to comply with the Privacy Act 1988 (Cth). There are also specific acts which apply to health records for both the private and public sector in:

- ACT – Health Records (Privacy and Access) Act 1997 (ACT);
- NSW – Health Records and Information Privacy Act 2002 (NSW);
- Victoria – Health Records Act 2001 (Vic.)

In Victoria, Statutory Guidelines were issued on 22 February 2002. They set out additional steps that must be taken to notify individuals who received a health service of the cessation or transfer of the service and how the health service provider proposes to deal with the records. A copy of the Statutory Guidelines (with HPPs 10 & 11 attached for easy reference) are available as one document

on the Health Services Commissioner website at <http://www.health.vic.gov.au/hsc/legislation.htm#guidelines>.

Obligations on public sector organisations include, for example, in relation to New South Wales:

- The State Records Act 1998 (NSW),
- The Government Information (Public Access) Act 2009 (NSW); and
- NSW Health Policy, for example, NSW Health PD 2005_282 (Records Retention and Disposal on the Closure of Health Organisations).

There are similar obligations in other states and territories.

Additional record keeping obligations are imposed upon individual health care practitioners such as under the Medical Board of Australia *Good Medical Practice: A Code of Conduct for Doctors in Australia* (March 2014), sections 3.15 and 8.4. That Code of Conduct is issued pursuant to the Health Practitioner Regulation National Law (as adopted in each state and territory).

Section 3.15 of that Code of Conduct states:

“When closing or relocating your practice, good medical practice involves:

- (a) giving advance notice where this is possible; and*
- (b) facilitating arrangements for the continuing medical care*

of all your current patients, including the transfer or appropriate management of all patient records. You must follow the law governing health records in your jurisdiction.”

Other obligations

Special rules can also apply to specific types of medical records, for example, mental health records under the Mental Health Act 2007 (NSW).

You also need to be aware of your contractual obligations in relation to medical record retention, for example, under Commonwealth Funding Agreements.

For the purposes of retaining medical records for the purposes of defending claims, medical records should be retained for as long as required by relevant Australian, state or territory government legislation. Generally, this means that inactive individual patient medical records should be kept until a paediatric patient has reached the age of 25 years or for a minimum of seven years from the time of last contact – whichever is the longer.

If there is a claim pending (such as a medical negligence claim) or audit (such as a Medicare audit), then the record should be retained until the claim and/or audit is resolved.

Recommended steps

If you are closing or selling a health service you should do the following:

1. Determine what medical records are held by you and their location(s).
2. Prepare an index of these records (including the names of the persons and contact details).
3. Identify which patients/clients are current or active clients.
4. Determine whether a significant proportion of patients/clients do not have English as their first language and confirm whether there is a newspaper in the other language circulating in your locality.
5. Check your contractual obligations and subject to contractual obligations, determine which programs and services are going to:
 - (a) transfer to another health service provider; or are
 - (b) going to cease.
6. Prepare notices for:
 - (a) your premises;
 - (b) the English language newspaper circulating in your locality that you have chosen to place a notice; and
 - (c) if applicable, the non English newspaper(s) circulating in your locality that you will also place a notice.
7. Prepare a letter (or an email if appropriate) to be sent to each current or active client advising of the transfer or cessation of the service, outlining their options and providing a simple way for them to notify their preferences to you.
8. Determine the dates to display the notices, publish the notices in the newspaper(s) and send the letters/emails to active or current patients (remembering the timeframes set out in the legislation).
9. Organise the transfer of records for continuing patients/clients of a service being transferred to the new health service provider(s) where relevant (with copies going to the patient or client and/or their nominated new health service provider if specifically requested by the patient/client).
10. Organise the transfer of records for patients/clients of a service that is ceasing that have requested that their record be transferred to them or to a health service provider nominated by them.
11. Arrange secure storage of the remaining records with a suitable organisation (while remembering the minimum record retention requirements).
12. Do not store records indefinitely: subject to minimum retention requirements, periodically check and destroy as necessary.
13. Ensure all records are retained securely.
14. If you transfer records, keep a record of what records are being transferred;
15. Keep a written record of what has happened with the various sets of clinical records.
16. Ensure that you procure run-off professional indemnity insurance and directors and officers insurance (preferably for at least three years) to cover claims after the closure/sale/transfer of your business relating to events which occurred prior to closure. ^{ha}

This article is provided for general information purposes only and should not be relied upon as legal advice. For more information please contact:

Alison Choy Flannigan
 Partner, Health, aged care & life sciences
 Holman Webb Lawyers
 alison.choyflannigan@holmanwebb.com.au
 T: +61 2 9390 8338

 HolmanWebb
 Lawyers



ROSEMARY CALDER

Director, Health Policy and Research
Mitchell Institute for Health and Education

Health policies, funding and Federalism

A chance to move from disintegrated healthcare towards integrated health policy and services

Australia's current health policies, funding and service models are failing about one quarter of the population. Preventable diseases and chronic conditions – like diabetes, heart disease and stroke – affect a substantial and growing proportion of people living in Australia and this lies at the heart of the current health cost discussion.

A large part of the problem is that funding and service models are not geared towards preventative healthcare. Indeed, our lack of policy attention to this capacity means that access to preventative care is an optional extra, often limited to those with the financial and social capacities to access strategies that improve or maintain their good health.

If we maintained this same attitude towards what were the most prevalent health conditions of the past (infectious diseases), we would not have the economy or nation we now have today. It is hard to imagine just what life would be like if Australia, along with other countries, had not established the highly successful polio prevention program that commenced in the 1950s. Even more recently, with a resurgence of infectious diseases such as measles and whooping cough, we have effective population protection strategies and high risk response systems in place that work effectively before the disease becomes an epidemic.

The prospect that future health policy now should have a strong focus on the contemporary health challenge of chronic

disease prevention and management is not new, and it has been a focus of both current and previous Australian governments who have acknowledged it as a major challenge. But the complexity of our federated health arrangements – in policy, funding and service delivery – along with rising health

healthcare arrangements to move towards a high-functioning system. Interestingly, the 2014 Commonwealth Budget included an intention to establish a national health productivity and performance commission. Little if anything has been said about this by the Commonwealth since, which suggests



'International Medical Graduates Doctors (IMG's)' by DIBP images.
Image sourced from Flickr (CC BY 2.0: <https://flic.kr/p/9NiQWj>).

costs, the ageing of the population and the growing impact of preventable chronic diseases, altogether mean that unless we make significant changes, the costs of preventable illness and resulting healthcare demand will continue to be a blinding headache for governments and individuals alike.

Recent discussions around federation reform provide an opportunity to articulate the measures that are needed to enable our

that it is no longer being pursued, despite the opportunities it presents.

Lessons can be learned from the establishment of the Hospital and Health Services Commission in 1973, which was charged with creating a comprehensive approach to healthcare policy and delivery at the local and national level. In its five years of operation, it led to major changes in the planning and delivery of services across the healthcare spectrum, including

the first Medibank program – a cooperative arrangement with the states and territories that, combined with the Medical Benefits Scheme and the Pharmaceutical Benefits Scheme, provided national comprehensive universal insurance and access to public hospital care.

The proposition to consider the establishment, in consultation with the states and territories, of a new commission for national health productivity and performance makes sense. Since these previous efforts at creating a nationalised health system, there has been a persistent muddling of governments' responsibilities for service provision, and the complex cobweb of payments between different levels of government and to service providers – a continuous source of contention and confusion for healthcare consumers and policymakers alike.

A contemporary national commission could – and should – be established to provide a non-partisan, multilateral platform for shared responsibility and accountability in the development and implementation of coherent and consistent health policy, with a focus on national interest, encompassing, but not limited by, sectional and jurisdictional interests. This commission should comprise both Commonwealth and jurisdictional governments as members, with independent experts from the health sector including consumers.

Its core mission should be to provide policy advice to all governments on the provision of comprehensive and coordinated health services for the nation. Successful

achievement of this goal would require the commission to have the authority and capacity to influence the structural and funding arrangements for acute and primary health services that create – or fail to address – barriers to coordinated, clinically effective and efficient healthcare; that is, healthcare delivered in the most cost-effective setting, particularly for chronic disease.

It also important for such a commission to have a mandate to work with private health insurers and private health providers to enable it to advise on the implementation of comprehensive, clinically and cost effective healthcare arrangements for people with chronic and complex healthcare needs. The lack of direct engagement between primary care services, particularly GP services, and specialist consultant care, as well as acute care services, has been one of the major barriers to effective and coordinated service provision for chronic health conditions, for both consumers and clinicians.

A national – federated – strategy could, over time, encompass other essential elements of a national health system as well, for example, national standards and criteria for the provision of individual electronic health records for implementation throughout Australian health services, as well as health workforce planning and development. The latter would logically fit within the purview of a commission focused on performance and productivity. Therefore, this commission should have a mandate to work with education agencies

and authorities to develop health workforce education and policies to meet the population healthcare needs for increased primary and community care service capacity.

To function effectively and eliminate duplication of effort, the commission would need to work closely with the existing national endeavours towards effective federalism and the goal of the national interest, namely the AIHW and national health and welfare data and information, and the national registration of qualified health professionals.

With the quality of Australia's health services – and the health professionals who deliver them – increasingly under stress, reform of the federation could re-focus funding from a myopic attention to healthcare to a broader attention to health; to prevention and early intervention services to reduce the risk of avoidable diseases; and, to optimal coordination of primary, community and acute care services for people with chronic diseases who require long term and complex management and for those needing high cost healthcare.

Health and education are critical to providing citizens with real opportunities for social and economic participation. Now is the time to drive significant improvement to the leadership and governance of Australia's healthcare system, to recognise and support the common-wealth that would be derived by better serving the health risks and needs of today's and future citizens. **ha**

Are we ready for change?

How innovation and hospital redesign
are impacted by real-world challenges

Manager of the Centre for Clinical Effectiveness at Monash Health, Angela Melder, recently undertook the AHHA's Deeble Summer Scholar Program in Canberra. The AHHA's **Dominic Lavers** spoke with Ms Melder about her examination of innovation and hospital redesign, as well as the competing priorities that often arise.

A new Issue Brief by the AHHA's latest Deeble Summer Scholar will identify common hurdles faced in innovation and hospital redesign, highlighting the gap between theory and real-world challenges. From common challenges ranging from capacity-building to organisational culture and preparedness for change, Angela Melder said her research will provide policymakers with a summary of the issues hospitals need to navigate when seeking to innovate and improve processes.

Ms Melder said the research undertaken for the forthcoming Issue Brief involved a literature review, interviews with academics, health service providers and other health agencies in Victoria, NSW and Tasmania. "In speaking with these academics and health agencies, it has become clear that there are a number of opportunities, challenges, enablers and barriers when talking about frameworks of change," Ms Melder said.

The disconnect is in the provision of resources — time, money and expertise — necessary for organisations, not just in the collection and management of data, but in the use of such data to drive innovation and hospital redesign. "It is clear that organisations are often eager to use the data they collect to drive change, but they do not always take a considered and well-directed approach," Ms Melder said. "Research stresses that hospitals and health service

providers really need to know how to navigate and manage the data to be able to set goals and track progress towards them. Furthermore, organisations are not always ready for change. When seeking to improve organisational culture, or establish a culture that is ready for change, it's important to ask: 'Is it safe to make change? Are we ready for change? Have we provided resources to undertake such a transition?' This is because, when we talk about change, we often assume that it's going to be for the better, but sometimes an organisation isn't going to get it right; sometime it's going to fail."

The issue faced by resource-stretched hospitals is then to allocate staff or funds towards delivering innovation or hospital redesign, with Ms Melder saying that, while this may be best practice according

to academia, it was not always so easy in the real-world hospital scenario. "While the academics I spoke with said that hospitals and health service providers need to be able to give people the capacity in terms

of resources to undertake change, it is very difficult for a hospital to stop somebody being a doctor or nurse while they become involved with the system design or redesign," Ms Melder said. "This kind of activity takes time and money, and, even if it is likely to provide long-term benefits, is often hard to undertake when immersed in the day-to-day running of a busy health organisation."

Ms Melder also said that there was a

tension between the desire for responsive organisational change and the timelines necessary for innovation and hospital redesign. "Hospital and health service management need to have things done 'now'," Ms Melder said. "So, they balance all of these things and, at the same time, face the difficult challenge of undertaking change at an organisational level to deliver long-term benefits for patients. However, as the academics I spoke to said, change can take a little while. Therefore, that tension needs to be resolved and I suspect it's all around the implementation process and culture. The external challenges are always going to be there, but a culture that is conducive to change will help significantly, as will an understanding of the need to invest time and money into the process."

Ms Melder said she has enjoyed the opportunity provided by the Deeble Summer Scholar Program to assemble learnings from experts and research to help inform policymakers and health service leaders about innovation and hospital redesign. "My experience has been very positive as well as intellectually and professionally stimulating," Ms Melder said. "It has provided a very valuable insight into how research can shape policy. The scholarship program has given me the opportunity to speak with academics and leaders in national bodies that support and enable health service personnel to undertake innovation and change, to gain further insights about change and redesign. The time has allowed me to coherently gel the key concepts associated with change and innovation alongside the experiences of those involved with these activities." 

This Issue Brief will be available soon at www.ahha.asn.au/issue-briefs



Dementia research: a comprehensive review

Kimberly Ashby-Mitchell, a Deeble Institute Summer Scholar and PhD candidate at the Australian National University, discusses the need for ongoing investment in dementia research.

Modifiable lifestyle factors such as diet and physical activity have been shown to promote brain health and offer some protection against memory loss. Moreover, they have been also been recognised as risk factors for other leading causes of death in Australia such as certain cancers, diabetes and cardiovascular disease.

There has been considerable investment in scientific research in the fight against dementia by both governments and non-governmental organisations. However, there continues to be a need for this investment in research and innovation. That being said, scientific studies take time and it is in our best interest to develop interim intervention strategies using the best evidence presently available for reducing the risk and prevalence of dementia until more conclusive findings are available.

During my period at the Deeble Institute, I conducted a review of published studies and reports in order to make inferences about the effectiveness of diet and physical activity interventions aimed to reduce dementia risk and prevalence. The research shows that higher ratios of saturated fat to monounsaturated fats are predictive of negative mental function. In addition, high mid-life serum cholesterol levels and excessive caloric intake have been found to be associated with impaired cognitive

It is in our best interest to develop interim intervention strategies using the best evidence presently available for reducing the risk and prevalence of dementia until more conclusive findings are available.

function. Increased intakes of fish, vegetables and legumes, in addition to antioxidant rich foods and adequate amounts of certain types of B-vitamins have been reported to have a protective brain effect.

Increased levels of physical activity have been found to promote neuro-protective changes in the hippocampus of the brain – a region central to learning and memory. This brain region is one of the first areas affected by dementia. Most studies have demonstrated that a high level of physical activity in adults with no dementia is associated with a 30% to 50% reduction in the risk of cognitive decline and dementia. Some studies also theorised that poor physical function may precede the onset of dementia and Alzheimer's disease and higher levels of physical function may be associated with delayed onset. Results from the Australian

Bureau of Statistics National Health Survey (2011 - 2013) show that many Australian adults do not meet the National Physical Activity Guidelines (to do at least 30 minutes of moderate intensity physical activity on most days) as more than half the population is inactive. Further, two-thirds of Australians are now overweight/

obese and a large proportion of total energy consumed comes from foods considered to be of little nutritional value. An intervention that focuses on improving diet and physical

activity habits therefore has the ability to produce inestimable benefits.

In the Issue Brief I produced as a result of this literature review, titled 'The Road to Reducing Dementia Onset and Prevalence – Are diet and physical activity intervention worth investing in?', I highlighted that policy-makers must be cognizant of the fact that no single government intervention operating on its own can have the effect of changing lifestyle habits. Six actions for policy-makers are identified which together have the potential to have immeasurable benefits:

- 1) Development of a comprehensive dementia prevention strategy;
- 2) Establishment of a body whose aim is to keep track of scientific research (central to this will be the establishment of a national digital dementia research repository);
- 3) Adoption of a multisectoral approach in the fight against dementia that includes both 'traditional' and 'incidental' health agencies;
- 4) Continued investment into research and innovation;
- 5) Identification of incentives beyond the health domain; and
- 6) Development of longevity literacy programs.

These actions all have as their foundation the Health in all Policies Initiative and social determinants of health approach. 

This Issue Brief will be available soon at www.ahha.asn.au/issue-briefs



Knowledge Translation and Exchange short course

SCHOOL OF POPULATION HEALTH



Do you want policymakers to take more notice of your research?

The Deeble Institute's short course on knowledge translation and exchange will assist academic researchers in making their work more accessible and useful to policymakers. This three-day course is presented by AHHA, SPH and the Deeble Institute.

Outline

Course sessions will cover a range of topics including:

- Why knowledge exchange and research translation is becoming more important for academic researchers, and the various ways it can be done for different audiences;
- The realities of the policy making process and the environment in which policymakers work;
- Engaging effectively with the media and non-academic audiences, and;
- Opportunities to secure funding for policy and practice-relevant research.

Combining theory with a strong practical focus, you will receive training on the fundamentals of writing for policymakers and communicating in the mainstream media.

Practical focus

You will have the opportunity to enhance your skills in small groups, applying the theory presented to your own research projects.

Working individually, you'll be able to further develop a piece of your own research by translating it into a media release and one-page backgrounder suitable for a generalist policymaker (bring your own research material, e.g. peer-reviewed paper).

You will also have the opportunity to experience a media interview and to receive feedback on your performance from a professional journalist.

Course presenters and panellists include:

- Prof Gary Geelhoed, WA Health
- Dr Tarun Weeramanthri, WA Health
- Dr Fadwa Al-Yaman, AIHW
- Alan Singh, NHMRC
- Alison Verhoeven, AHHA
- Michael Moore, PHAA
- Prof Mike Daube, PHAIWA
- Prof Christobel Saunders, CAAC
- Anne McKenzie AM, UWA/TKI
- Jim Codde, Notre Dame University
- Dr Paul Nicosarakis, Lorica Health
- Learne Durrington, WA PHN
- Karalee Katsambanis, Corporate Media Services

Short course details

- Monday 13 - Wednesday 15 July 2015
 - 9am to 5pm (8:30am registration)
 - Harry Perkins Institute of Medical Research
 - Cost:
 - Deeble Founding Partners: \$2,200
 - AHHA Members: \$2,600
 - Non-members: \$2,700
- All fees are GST inclusive.

Registration and more details

www.sph.uwa.edu.au/courses/winter-spring-summer-school/knowledge-exchange

**School of Population Health,
Faculty of Medicine,
Dentistry and Health Sciences**
The University of Western Australia
M431, 35 Stirling Highway
Crawley WA 6009
Tel: +61 8 6488 1261
Fax: +61 8 6488 1188
enquiries-sph@uwa.edu.au
sph.uwa.edu.au

Invitation to participate: new research project about palliative care

The AHHA is currently seeking palliative care workers for a research study that aims to identify factors that help and hinder evidence-based palliative care.

Participants who register for the four training modules on the Guidelines for a Palliative Approach for Aged Care in the Community Setting (COMPAC Guidelines) will be invited to join the longitudinal mixed methods research study.

Those who choose to participate in the study will be asked to respond to a

short series of questions online prior to completing the training modules. The questions will examine care worker awareness and understanding of the COMPAC Guidelines, care worker attitudes towards, and beliefs about palliative care, and the factors that help, hinder, and sustain evidence-based palliative care.

Participants will then be asked to complete three further short online surveys at three-monthly intervals after completing the training.

The results will help plan future health initiatives and progress local

and national knowledge of best practice in palliative care. They will also inform service providers and those in the education and training sectors of the effectiveness of e-learning as a knowledge translation tool. The study will provide insights about evidence-based practice in the palliative care sector and identify quality improvement opportunities.

Registrations for the longitudinal study are welcomed at the palliative care online training website: www.palliativecareonline.com.au from 1 July. ^{ha}

An overview of AHHA's palliative care training: a participant's perspective



Ms Jennifer Nicholson

Ms Jennifer Nicholson, a nursing teacher at TasTAFE, writes about the JustHealth Online Palliative Care Training run by the AHHA and why she recommends it to her students...

Having worked in acute palliative care for more than 15 years and, for the last two years, in nurse education for TasTAFE, I know how important it is for nurses and nursing

students to have access to high quality professional development opportunities.

However, there is not a lot out there in the same format as the AHHA's online training modules, which make it easy to undertake the training at a time and place that suits you.

It doesn't take long to do and helps participants consolidate what they already know and transfer that knowledge to their own work or learning context. In this sense, it helps encourage reflective practice; an essential part of improving health practice.

The modules do this by inviting participants to examine how they currently operate. For instance, they may ask questions of themselves like:

- What am I doing, is it working and how can I make it better?
- Am I doing something that is effective, is it just a waste of time and could it even be doing harm?
- How would I respond to a certain situation and what evidence do I have to show that my response would be the right one?

The training provides learnings in key areas including allied health involvement and how the multi-disciplinary team works, communication, opportunities to examine communication between nursing staff and palliative care clients.

As it is such a solid basis, in each of the palliative care units I teach to the diploma of enrolled nursing students at TasTAFE, I put the web link to the AHHA training up on the board at the beginning of the unit and encourage them to do it in their own time.

It is the perfect opportunity for students who are interested in extending their understanding and knowledge of palliative care.

For example, one of my students with a special interest in palliative care came back from the Easter break this year and had done the modules during the holiday period. She said that the learning was enjoyable and complemented the learning that she had done in the classroom. It was an encouraging response and, as a teacher, it is important to get that feedback - I know I can be confident in putting the link up on the board next year! ^{ha}



REGISTER NOW:
WWW.AHHA.ASN.AU/EVENTS

Forming effective clinical councils and community advisory committees

Primary Health Networks (PHNs) are required to form Clinical Councils and Community Advisory Committees which will provide input to the PHN boards on locally-relevant clinical and consumer issues. However, creating such groups that are able to effectively work together and provide relevant, considered and realistic advice and input on complex, multi-faceted matters can be easier said than done.

This workshop aims to provide tools and information to assist PHNs to create collaborative, high-functioning Clinical Councils and Community Advisory Committees that add value and genuinely assist the PHN board. Further, the workshop will examine the important issue of engaging in a meaningful way with Aboriginal and Torres Strait Islander Peoples.

Topics addressed will include:

- Governing in a complex environment and the implications for Clinical Councils and Community Advisory Committees;
- Building trust across the community;
- Making Committees and Councils work;
- Collaborative mindset in theory and practice;
- Working with others while retaining control of your agenda; and
- Structuring effective engagement spaces with Aboriginal and Torres Strait Islander peoples.

Short course dates

Melbourne

18 June 2015, Bayview Eden

Sydney

6 August 2015, Boulevard Hotel

Limited places available

Contact us

E: admin@ahha.asn.au

T: (02) 6162 0780



Evidence-based care

Rosio Cordova from the Australian Commission on Safety and Quality in Health Care discusses the development of new standards for clinicians and patients

Ensuring consumers, clinicians and health services have the same understanding of the care that should be offered is one way of improving appropriateness of care and improving health outcomes.

The Australian Commission on Safety and Quality in Health Care (the Commission) has been working in collaboration with consumers, clinicians, researchers and health organisations to develop national Clinical Care Standards.

The Clinical Care Standards identify the key components of care a patient should be offered for a specific clinical condition or a defined part of a clinical pathway. They are based on the most up-to-date clinical guidelines, with consideration of what is important to clinicians and consumers.

The Clinical Care Standards are developed in a user-friendly format to help clinicians identify the information they need, support clinicians in delivering best practice, and provide guidance for health services on the systems that need to be in place to support their clinicians to deliver best practice.

There is also a separate information leaflet for consumers to help encourage discussions between clinicians and consumers on the merit of treatment options.

Following a broad public consultation process, the Commission released Clinical Care Standards to improve care in the

areas of Antimicrobial Stewardship and Acute Coronary Syndromes in 2014. The Acute Stroke Clinical Care Standard will be launched in June 2015.

The Commission is currently developing Clinical Care Standards to address gaps in care in delirium and hip fracture care.

A hip fracture is a break occurring at the top of the thighbone (femur), near the pelvis.

Hip fracture is a common and debilitating injury in older people. The incidence rate of hip fracture increases exponentially after 50 years of age. In Australia, 91% of hip fractures occur in people aged 65 years and older, with the vast majority associated with a fall.¹

An estimated 19,000 people over the age of 50 are hospitalised with a hip fracture each year,² an event that often signifies underlying ill health.³ As the Australian population continues to age, the annual number, and associated burden of people admitted to hospital with a hip fracture is expected to increase.⁴

The quality of care for patients who have hip fracture has been shown to depend upon orthopaedic and geriatric service configurations. In the absence of effective systems of care, key markers of quality of care – including time to surgery, peri- and post-operative complication rates, readmission rates and length of stay – have been demonstrated to vary considerably.⁵

Delirium is defined as an acute disturbance of consciousness, attention and cognition that is common in older people, especially when they

are in hospital. They may be experiencing delirium at the time of admission, or may develop delirium during their hospital stay.

Delirium is associated

with severe complications. People with delirium are at increased risk of falls, have a greater chance of being discharged to a higher dependency of care, are more likely to develop dementia and are at increased risk of death.^{6,7} Despite existing guidelines on managing delirium, it is often not recognised,

misdiagnosed and or not treated.^{8,9}

The draft Clinical Care Standards on hip fracture care and delirium have been released for public consultation. Feedback from this process will be used to refine the documents.

For more information on the Clinical Care Standards www.safetyandquality.gov.au/ccs 

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Provide your feedback

Public consultations on the draft Clinical Care Standards for delirium and hip fracture care are now open. To contribute, visit:

www.safetyandquality.gov.au/ccs/consultation

The consultation period closes on 3 July 2015.



The rainbow tick

Pam Kennedy from Quality Innovation Performance discusses the need to aspire for excellence in LGBTI-inclusive practice

In 1978, at a primary healthcare conference in Kazakhstan, the Alma Ata declaration was developed. This declaration involved 132 countries committing to two key goals – better health for all by the year 2000, and a whole-of-government, whole-of-community approach to reducing health status inequality. The leaders representing these countries recognised health was impacted by many factors beyond the control of the health system and the social model of health emerged. Several years later, in 1986, the Ottawa Charter further progressed the intention of this declaration by articulating health improvement action areas; specifically, a focus on creating supportive environments, developing personal skills and re-orienting health services.

The Alma Ata declaration was definitely

revolutionary for its time; however, 37 years later, we still have quite a way to go to achieve its aim.

Health inequality does still exist. Research shows that LGBTI people experience higher rates of harassment and abuse than the general population and the threat of heterosexist violence is part of many LGBTI people's everyday lives. As a result, many LGBTI people are wary when approaching a new service or individual providers and will often scan a service for clues to determine how LGBTI-friendly a service is.

It is for this reason that, in 2013, Quality Innovation Performance (QIP) and Gay and Lesbian Health Victoria (GLHV) co-launched a set of standards to guide responsive, respectful and inclusive practice for working with members of the lesbian, gay, bisexual,

transgender and intersex (LGBTI) communities – the Rainbow Tick Standards.

The Rainbow Tick Standards provide a quality framework for services to benchmark their performance relating to:

- Organisational capability, culture and quality improvement relating to LGBTI-inclusive practice;
- Cultural safety for LGBTI people accessing your service;
- Professional development for all staff to ensure an accessible, responsive and respectful service to LGBTI people;
- LGBTI consumer participation in the planning, development and review of services;
- Both sensitive and appropriate responses towards disclosure and documentation which protects



an LGBTI person's privacy and confidentiality; and

- Access and entry/admission processes which indicates LGBTI people are welcomed into the service.

The Standards and corresponding accreditation program provide objective and independent evidence to the LGBTI communities that organisations and services are applying better practice to being inclusive of and safe for their members who seek their services, and committed to achieving better health outcomes.

To achieve the Rainbow Tick requires commitment and dedication and, as the accrediting organisation for the Rainbow Tick Standards, QIP does not lightly award this achievement to health services. Rainbow Tick accreditation signals a standard of excellence in care

that is demonstrated by an organisation-wide commitment to cultural change and well-developed systems of care that enable all staff to work respectfully and also appropriately with every LGBTI person who accesses their service.

Thinking right back to Kazakhstan for a moment – the right to a high standard of health and wellbeing was recognised as a basic human right, enshrined in the Alma Ata. This right is no less for members of the LGBTI community; however, we

know LGBTI people experience poorer health outcomes across a number of measures.

At QIP, we very are passionate about

improving health equality for LGBTI communities and hope your health service shares this passion. It is an exciting time to work together, to be part of history, and

make a real difference to the health and wellbeing experiences and outcomes of LGBTI people. [ha](#)

Rainbow Tick accreditation signals a standard of excellence in care that is demonstrated by an organisation-wide commitment to cultural change and well-developed systems of care that enable all staff to work respectfully and appropriately with every LGBTI person who accesses their service.



JOHN WALKER
Director of Communications
Northern Melbourne Medicare Local

Looking after our most vulnerable

Bringing vital dental care to those sleeping rough

More than 373 Victorian clients who are homeless or at risk of homelessness have received vital dental care during an innovative trial hosted by Dental Health Services Victoria in partnership with the Northern Melbourne Medicare Local.

The trial centred on the use of a priority access card – a small wallet-sized card, entitling the recipient to immediate dental care without the barrier of a waiting list and waiving any co-payment fee. In using the card, the client is not required to explain their circumstance when utilising any of the participating dental services. This helps to reduce stigma attached to being homeless and, thus, with seeking help for health-related matters.

The trial of the card took place across eight homeless service agencies in the north west region, with case workers and community nurses playing an important role in explaining the program and assisting with referrals to public dental care providers. According to Dr Colin Riley from Dental Health Services Victoria, the engagement of case workers and community nurses “was one of the key success factors” of the program, which is built on the basis that maintaining good oral health is a major contributor to achieving good overall health – and thus, is something that should be prioritised.

“People who are homeless, or at risk of becoming homeless, could use the card at a number of practices in the area,” Dr Riley said. “To target the right people we have engaged case workers and community nurses to ensure those most at risk could get the dental care they needed. They have helped to identify need, explain the purpose of the

card and discuss any barriers or issues. They have also played a key role in facilitating attendance where possible.”

Homeless services and dental agencies were very positive about the initiative, as one participant commented: “I found it (the card) a really good engagement tool – talking about oral health helps build rapport with the client and it was great having something to offer them.”

Clients used the card to access both routine care and to address significant issues such as pain, toothaches, decaying teeth, and emergency care. The vast majority of clients reported that their experience of using the card was good, very good or excellent.

The success of the trial suggests that there would be benefit in extending the implementation of the card for homeless people across Victoria. ^{ha}

It is so good when they can smile again

John* aged 48 has been homeless for many years, with a history of imprisonment, substance use, family breakdown and anxiety and depression. Knowing that he was very self-conscious about his teeth, a nurse from the Royal District Nursing Service Homeless Persons Program suggested the priority access card. John agreed to use the card to see a local dentist and the nurse organised an appointment and made arrangements to take him.

At his first appointment, John was advised that he needed his front teeth extracted and dentures fitted. However, John did not want to have his teeth extracted because he was too self-conscious to be without his front teeth for any length of time.

After discussion with the dentist, it was agreed that John could have his teeth extracted and new dentures fitted on the same day. So John and the nurse made a follow up appointment and arrangements for John to attend.

At the next appointment, John's front teeth were extracted, and new dentures fitted. John told the nurse that he was “very happy with the whole experience [and] grateful that the dentist had listened to his concerns and completed the extraction and fitting all at once.”

The nurse also felt that the entire process had been respectful to John and well managed. “It is so good when they can smile again,” she said.

For more information, visit: www.nmml.org.au/dental



Going mobile

St Vincent's Hospital's Jenny O'Mahony spoke with the AHA's **Dominic Lavers** about its Community Outreach Medical Emergency Team (COMET), a mobile health service dubbed the world's smallest hospital.

A little while ago, staff members at St Vincent's Hospital Sydney came across a 72-year-old gentleman rough sleeping in the city, suffering from two large skin cancers on his face and having a strong dislike of the hospital system.

He was afraid that a check-up would result in a similar diagnosis he had been given years before and, with other concerns around accommodation, told himself his cancers were rashes in the hope of avoiding the long and intensive treatment process ahead.

According to Jenny O'Mahony from St Vincent's Hospital Sydney, this was where the Community Outreach Medical Emergency Team (COMET) came into its own.

The service began in March 2007, with the help of generous philanthropists, the New South Wales Ministry of Health and two cars donated by Sandersons Mercedes Benz, when it was identified there were a lack of primary care services for people who experience homelessness.

"The idea was to create a primary care service – the world's small hospital – to help with prevention, early intervention, facilitation and capacity building; increasing the health literacy of those most at need in the community," Ms O'Mahony said. "With a number of individuals using the hospital's emergency department (ED) as their primary care provider, COMET's focus on prevention has helped a provide more efficient use of hospital resources, as well as offering better care to these at-risk clients."

What St Vincent's had found was that people were coming into the ED and requiring quite a lengthy hospital admission because their health had deteriorated so

significantly. By servicing the needs of individuals doing it tough in the community – before they require an ED admission – the health issues faced by many individuals, in many cases, do not escalate and become as painful or life-threatening.

The service also helps remove the stigma that a lot of homeless people feel when seeking primary care. "It means being able to provide support in an environment familiar to these clients, where they don't feel threatened or judged by other members of the community," Ms O'Mahony said. "It is also important to provide care at a pace that patients are ready for; sometimes it takes a few consultations before a client is ready to visit a hospital or go to another healthcare provider. This kind of behaviour can be difficult for a GP in a building to manage, and the COMET's vehicles make a big difference in allowing us to take clients from where they are to the health service they need to access."

In the case of the 72-year-man mentioned earlier, Ms Mahony said COMET staff worked intensively in engaging him in his health, building a rapport, until he was encouraged to get the help he needed. "As our staff were able to intervene quite quickly, he has since been receiving treatment making some promising progress," Ms O'Mahony said. "Furthermore, through the process of engaging with that COMET staff, he was also willing to look at his accommodation situation; he is now in an aged-care hostel. This example shows that simply being able to have those conversations meant that the door opened for a whole range of other supports that he would not have even considered without this service."

COMET now relies on the donations of donors and philanthropic investors – as it does not currently receive government funding, Ms O'Mahony says the organisation is very thankful for the support it has received. "We've seen how important community outreach is in provide healthcare services to people outside of the hospital," she said. "In many cases, it's also about following up with a patient in a way that a hospital or general practice cannot do. COMET fills the gap for people who really struggle with mainstream health services – it helps them access the right healthcare, at the right time, in the right place."

Since 2006, the service has assisted more than 1,100 homeless clients and, in 2015, it has been seeing about 25 high needs clients per month. While Ms Mahoney says the COMET's nurses and doctors will encounter anything and everything that you would see in the general population, there is a particular focus on skin infections, abscesses and minor wounds.

"Due of lifestyle reasons, many of these injuries and illnesses can end up being quite dangerous and require a much more intensive treatment," Ms O'Mahony said. "In some cases, people may have gone to a hospital and had no follow up care, and they might have a cast on or they haven't had any physiotherapy or access to pain relief. Most importantly, since the development of COMET, we've had some fantastic outcomes for clients at risk of these kinds of issues. I think they feel that someone's taking the time to come out and see them and they're not just a number when they come into the hospital – they feel valued and important." **ha**



COMET staff with COMET vehicle. Image courtesy of Robert Catto / St Vincent's Hospital.



'Portrait of a man' by Yuri Samoilov. Image sourced from Flickr (CC BY 2.0: <https://flic.kr/p/h8Uexy>).

Reducing **stigmatisation** through training

Support facilitator with Partners in Recovery for Kadina in South Australia, **Dane Ware**, writes about the challenges around providing support for people with severe and persistent mental health issues in rural areas, and how a new program is seeking to overcome them.

Shortly after moving to Kadina, I became aware of a lack of support for those living with personality disorder traits, their clinicians and service groups – especially in rural areas. At first, I considered a training program for local clinicians, but dismissed this as unsustainable; the life span of the program would be limited by funding and clinicians are spread over a wide geographical area, spanning from north of Adelaide to the Western Australia boarder.

After discussions with a range of stakeholders, I adopted a whole of community approach, seeking to reduce stigmatisation around personality disorders through education. Historically, community education programs have been successful in reducing stigmatisation surrounding epilepsy, diabetes and asthma. As such, it seemed probable that by reducing stigmatisation, I could similarly improve access to services and improve wellbeing for the individual and all key stakeholders.

With this in mind, two fundamental goals were established for the development of a training program. First, a **social goal** to provide training that increases society's awareness of the needs of members of the community living with a personality disorder, resulting in earlier detection, more appropriate and cost-effective therapies, reduction in stigmatisation (or self-stigmatisation) and an enhanced quality of life for members of the community living with a personality disorder. Second, a **business goal** to become a financially independent program with the capacity to sustain paid personnel and to finance ongoing research and development related to mental health. This second goal

would make the program independent of political impacts on funding.

In order to develop the training program, I pulled together a team comprising Wayne Oldfield of The Station Community Mental Health Centre, Wayne Horwood a professional mental health trainer and myself. Funded by Partners in Recovery and operating under The Station banner, we held two community forums that drew participants from as far away as Sydney. The outcome was a picture of the primary issues from the viewpoint of those living with personality disorder traits and other key stakeholders.

The strongest message gained from the community was that clinical qualifications were considered less important than attitude, and that stigmatisation was, indeed, the most significant barrier to those support. Subsequently, we elected to develop a two-day course, formulated to be rural friendly; meaning late start on day one and early finish the second making it viable for clients who needed to commute from surrounding towns and stay overnight. We also focussed on networking, as such opportunities to develop positive and lasting working relationships are limited in rural areas.

The working title of the course is 'Whole of Community Approach to Personality Disorders', however we are seeking input from other stakeholders on this. The current framework of the course, outlined after the initial forum, is as follows:

- Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition) and how it identifies and provides treatment guidelines for personality disorders;

- Understanding challenging behaviours – communicating the unmet need;
- Self-harm and suicide – related but separate;
- Carers, family and friends – connections that work; and
- Recovery in the community. What we can all do to support the recovery process.

Other units will be included as determined by the needs of the participants.

The initial project to develop the training program is funded through Partners in Recovery Country Northern South Australia, with the funds held by Diamond Club House (Adelaide). The first training sessions will be held in Whyalla on 17-18 June, the second in the Yorke Peninsula and third in Adelaide, prior to moving interstate.

The success and quality of this program will be measured continually; we will be looking for an overall approval rate of 4/5 and for the program to quickly become financially independent.

The plan for the future is to hold ongoing reviews by key stakeholders, supporting interested organisations to host courses, and the development of modules for Culturally and Linguistically Diverse communities, the National Disability Insurance Scheme, and for clinicians generally. I will be presenting the project at various conferences, and Wayne Horwood will be presenting at the International Clubhouse Conference in America later in the year.

Some bursaries will be available for the initial courses in Whyalla in June. If you are interested in applying, contact me via email at dware@cnorthhealth.com.au 





SABRINA NEMORIN
Aged Care Project Officer
SANE Australia

Planning ahead

How to manage growing old with mental illness

In 2010 I found myself in a hospital waiting room, signing off on a medical procedure that would change my dad's life forever. He had been sick for years, but never, in all the conversations we'd had, did we speak about the future – what I should do if I had to make decisions on his behalf.

That was nearly five years ago, and my dad is no longer with us. When he died last year, we weren't prepared, even though he had been unwell for some time. The question that remains is: why didn't we talk about it? Why didn't we sit down as a family and discuss my dad's wishes for the future?

My personal experiences have helped me to develop SANE's *Ageing Well: A Planning Guide*. The guide will help people, just like my family, to have the conversation we never had and start planning for the future.

Research by SANE Australia has found that the majority of people living with mental illness and their carers are not doing this. This is because the process of planning ahead can be confronting for all involved. It's not a comfortable situation to sit down with your loved ones and plan for the worst. Discussions about a person's wishes and needs as they age can be difficult, but are crucial to ensure choice, comfort and quality of care.

One of the biggest challenges is that many older Australians who live with a mental illness have managed their symptoms over a number of years, and they're often pretty resilient. But as they get older, additional challenges impact on their lives.

The death of a carer can lead to an urgent need for support. And if the person's family aren't aware of preferred support services – or even know of services available – there's danger they will receive inadequate support,

or find themselves living in inappropriate accommodation.

Also, the long-term effects of medication on physical health can affect people's independence, stopping them from being able to do the activities they enjoy. These changes may contribute to a deterioration in mental health, and we must remember that mental ill-health is not a normal part of ageing. Likewise, we must remember that physical health is not a secondary concern. People living with a mental illness have a life expectancy 20 years less than the general population, and research shows they are at a higher risk of physical health conditions such as diabetes, heart disease and obesity. So there's plenty of reasons to plan.

So how and where do we start? There is a lot to think about when planning for the future. As a first step, find out as much as possible about the services available. This can include living arrangements, physical and mental health care, legal, financial and lifestyle matters. Making a plan can protect your assets and income, or simply ensure you can continue to age well and be active.

It is especially important to look after your mental health during this time. Start with a conversation with your GP or other health professional. The GP may be able to assess you for a Mental Health Treatment Plan which provides affordable access to support from psychologists and other suitably-qualified health professionals at a Medicare-rebated cost.

Many people who live with mental illness are supported by a partner, parent, child, friend, or sibling. As carers start to grow older themselves, questions about who will provide the essential supports in the longer

term need to be considered. If you are a carer who is growing older yourself, you will need to think about preparing for a time when you are no longer able to provide care. Again, as a first step, find out as much as possible about the services available. You and the person you care for may have previously accessed supports through mental health services, but aged care supports may also be available.

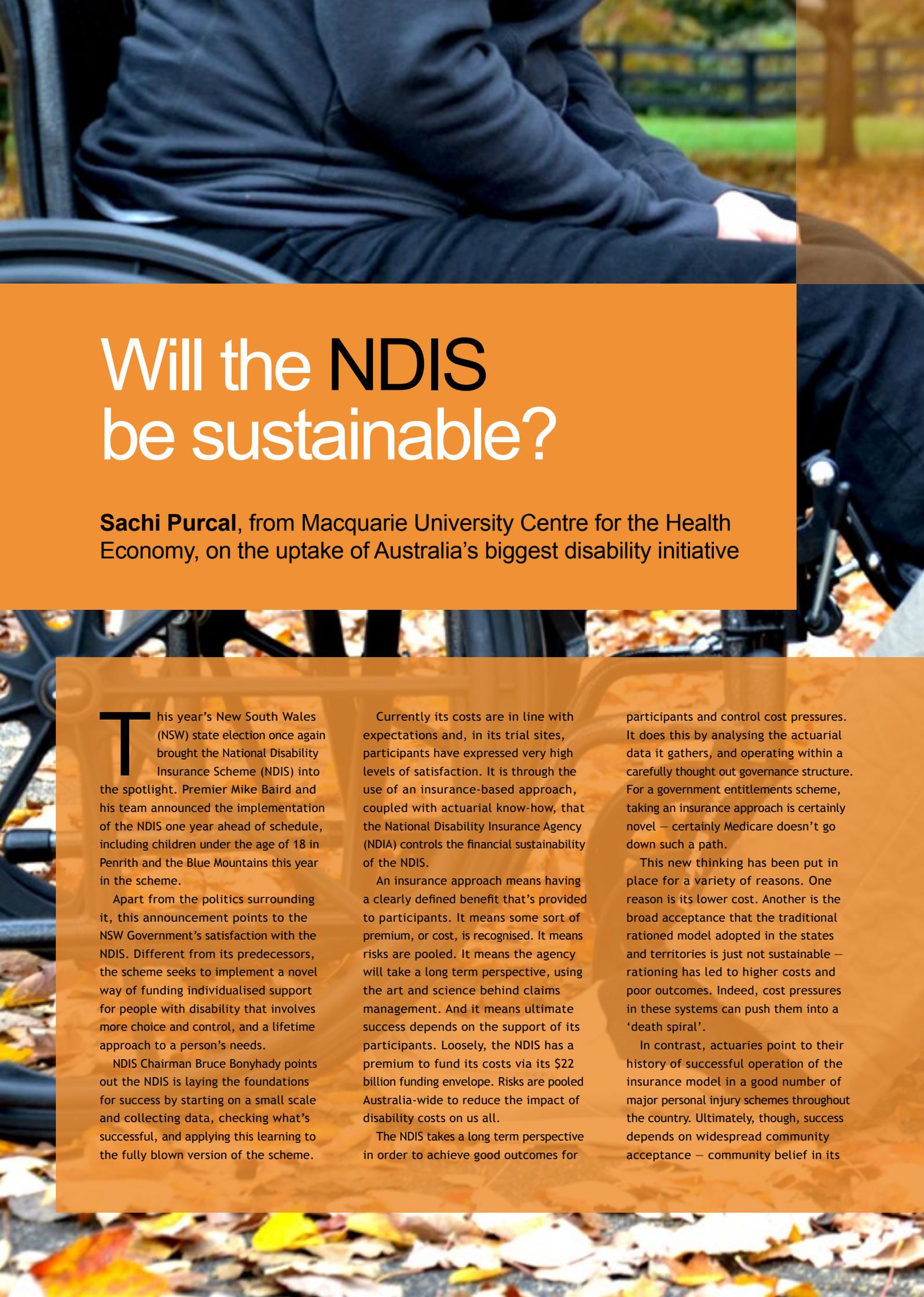
Planning ahead is important for all of us, but is especially important if you live with a health condition – whether mental, physical or both. I encourage you all to use SANE's resources to help you make your own plans.

Below are five practical tips from my own experience to help you get started.

Five tips to help you plan ahead:

- If you or the person you support lives with a health condition, learn as much as you can about it. For information, advice and referral contact the SANE Helpline, 1800 18 7263.
- Make time to consider the options. We all get caught up in everyday life, but it is important to make time to think about your wishes for the future.
- Try to be informed about the services available. Contact the My Aged Care service at www.myagedcare.gov.au or 1800 200 422.
- Download SANE's *Ageing Well: A Planning Guide* (www.sane.org/projects/aged-care) to help you develop your plan. You can work your way through the checklist at your own pace.

As hard as these conversations can be, it is much harder having to manage difficult situations that have not been prepared for. 



Will the NDIS be sustainable?

Sachi Purcal, from Macquarie University Centre for the Health Economy, on the uptake of Australia's biggest disability initiative

This year's New South Wales (NSW) state election once again brought the National Disability Insurance Scheme (NDIS) into the spotlight. Premier Mike Baird and his team announced the implementation of the NDIS one year ahead of schedule, including children under the age of 18 in Penrith and the Blue Mountains this year in the scheme.

Apart from the politics surrounding it, this announcement points to the NSW Government's satisfaction with the NDIS. Different from its predecessors, the scheme seeks to implement a novel way of funding individualised support for people with disability that involves more choice and control, and a lifetime approach to a person's needs.

NDIS Chairman Bruce Bonyhady points out the NDIS is laying the foundations for success by starting on a small scale and collecting data, checking what's successful, and applying this learning to the fully blown version of the scheme.

Currently its costs are in line with expectations and, in its trial sites, participants have expressed very high levels of satisfaction. It is through the use of an insurance-based approach, coupled with actuarial know-how, that the National Disability Insurance Agency (NDIA) controls the financial sustainability of the NDIS.

An insurance approach means having a clearly defined benefit that's provided to participants. It means some sort of premium, or cost, is recognised. It means risks are pooled. It means the agency will take a long term perspective, using the art and science behind claims management. And it means ultimate success depends on the support of its participants. Loosely, the NDIS has a premium to fund its costs via its \$22 billion funding envelope. Risks are pooled Australia-wide to reduce the impact of disability costs on us all.

The NDIS takes a long term perspective in order to achieve good outcomes for

participants and control cost pressures. It does this by analysing the actuarial data it gathers, and operating within a carefully thought out governance structure. For a government entitlements scheme, taking an insurance approach is certainly novel – certainly Medicare doesn't go down such a path.

This new thinking has been put in place for a variety of reasons. One reason is its lower cost. Another is the broad acceptance that the traditional rationed model adopted in the states and territories is just not sustainable – rationing has led to higher costs and poor outcomes. Indeed, cost pressures in these systems can push them into a 'death spiral'.

In contrast, actuaries point to their history of successful operation of the insurance model in a good number of major personal injury schemes throughout the country. Ultimately, though, success depends on widespread community acceptance – community belief in its



having delivered good outcomes for participants at reasonable cost, and better than under the traditional rationed approach.

From 1 July 2014, Australia's Medicare Levy was raised by half a percentage point to help fund the implementation of the NDIS. The annual amount raised, approximately \$3.5 billion currently, isn't the overall annual gross cost of the NDIS. In actual fact, the total funding envelope was estimated in the 2011 Productivity Commission (PC) report into disability care and support, and subsequently revised by the Australian Government Actuary, to be approximately \$22 billion when the scheme is fully rolled out (2019-2020).

While these costs are significantly greater than the current government spending on disability, they do not tell the whole story. Cash flow projections of the NDIS costs, and those of more the traditional rationed model, show the NDIS costs level off over time whereas the

rationed model exceeds them within five years of the NDIS' full roll out, on a path to ultimate blow out.

The PC recognised two major economic benefits of the reform. Firstly, it saw positive welfare impacts for people living with disabilities and their carers, conservatively put at \$7.8 billion annually (the value of implicit income transferred to this group by the NDIS). Secondly, the NDIS should realise much higher levels of employment of people with disabilities. By 2050, this is estimated to amount to an increase of 1% of GDP – \$32 billion in that year alone.

The PC noted, however, that these benefits would likely be offset by the reductions in informal employment and output, as the level of volunteer caring would be reduced as people with disability had their reasonable and necessary support needs met in the formal economy.

What underpins the NDIS is the aim of getting people with disability to achieve

higher levels of social and economic participation. It's not going to be easy to achieve, given the existing stigma faced by people with disability and current low levels of employment.

Indeed, it is not only the NDIS, which looks after supports, that will help people with disabilities achieve an ordinary valued life. Appropriate government investment in housing, transport, health, education and the physical environment, as promised under both the National Disability Agreement and the National Disability Strategy, also has to happen.

This investment is needed so people with disability can truly participate and be included in Australian society. In fact, the financial sustainability of the NDIS requires it. Any expectation that the NDIS can work well beyond its carefully planned remit will send its costs sky rocketing and doom it to ultimate failure.

Let's hope that there's strong follow through on infrastructure provision to back the promise of the NDIS. **ha**

RAHC
REMOTE AREA HEALTH CORPS

Be part of the effort

To improve Indigenous health outcomes in the NT



Pictured (left to right): Fiona Wake (RAHC Clinical Manager), Anna Heisar (Award Recipient), Dr Tony Austin (RAHC Chairman). Image courtesy of RAHC.

For those who go the extra mile

Celebrating the efforts of health professionals in support of their communities and their colleagues

Remote Area Health Corps (RAHC) awarded the Annette Walker Award for 2014 to Registered Nurse, Anna Heisar, at an event held in Sydney on 13 March 2015. Anna was recognised as having gone “the extra mile” to provide excellent support to other health professionals in health centres across the Northern Territory.

The Annette Walker Award is named in honour of a much-loved and respected member of the RAHC team who passed away unexpectedly in 2012. The award recognises an outstanding contribution by a health professional on a RAHC Placement during the year focussing on the attributes Annette brought to her work – passion, a commitment to excellence and a “can do” attitude.

2014 winner, Anna Heisar, came to RAHC as an agency nurse with over 35 years of experience in a range of disciplines, including midwifery, emergency, paediatrics and general nursing. However, what makes Anna “an absolute joy to work with,” according to Christine Kuhl, RAHC’s Travel and Logistics Coordinator, is when you pair her clinical abilities with her personality of exuding warmth, positivity and flexibility.

In May 2010, Anna embarked upon her first RAHC placement and has since completed a full 17 placements in total. In doing so, she has provided over 110

weeks of service working in various health centres across the Northern Territory, run by both Aboriginal Medical Services and the Department of Health.

For the past two years, she has worked primarily in the West Arnhem Land communities of Gunbalanya and Warruwi where she has forged strong community ties. “Anna doesn’t just look at her placement as work but also an opportunity to get involved in all aspects of the community – even becoming a part of the community’s family,” said Billie Munson, Top End Regional Coordinator, RAHC.

An example of this was during the recent cyclones in the Northern Territory, when Anna went above and beyond the call of duty to help evacuate the Warruwi community into Darwin. Anna was in full swing, caring for and attending to the members of the community, which was typical of her commitment and dedication.

Back in June 2014, after 14 successful placements, Anna became one of RAHC’s Remote Educators. The Remote Educators help to assist new-to-remote health professionals who are unfamiliar with remote environments to make a smooth transition to remote practice. “Anna has extraordinary commitment to transitioning new-to-remote health professionals to ensure they feel comfortable on their

placements. Anna embodies a holistic attitude when she is mentoring health professionals drawing upon her clinical skills, strong cultural awareness and her caring personality,” said Fiona Wake, Clinical Manager of RAHC.

The Remote Educator program relies on the dedication, support and passion from the experienced Registered Nurses like Anna. Since the inception of the program, RAHC has supported 95 new-to-remote health professionals to various health services across the Northern Territory.

According to Philip Roberts, General Manager of the RAHC: “We are delighted to recognise Anna’s outstanding contribution to working to close the gap in Indigenous health outcomes. The feedback from the nurses who have worked with Anna in the Northern Territory has been overwhelmingly positive. They describe Anna as regularly going above and beyond their expectations, providing them with a home away from home on their first placement and most importantly, providing terrific support as they worked for the first time in a remote autonomous capacity.”

For more information about short-term paid placements in remote Indigenous communities in the Northern Territory log on at www.rahc.com.au or call the RAHC team on 1300 697 242. 



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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 healthcare executive search firm, Ccentric

Dr Yahya Shehabi, currently the Medical Director of Acute Complex and Community Care Clinical Services Program at Prince of Wales Hospital, has accepted a role as the Program Medical Director of Critical Care with Monash Health.

Mr Mark Summerville has recently joined Paul Hartmann ANZ as Managing Director. He was previously the General Manager of Australia and New Zealand at Abbott and Managing Director at Biolife Healthcare.

Dr David Panter is leaving his role as Chief Executive Officer of Central Adelaide Local Health Network to take up the position of Chief Executive Officer with ECH Group.

Ms Lesley Dwyer has resigned from her post as the Chief Executive Officer of West Moreton Hospital and Health Service to take up the position of Chief Executive Officer with Medway NHS Foundation Trust located in the United Kingdom.

After three years as Chief Executive Officer with the Australian Primary Healthcare Nurses Association, Kathy Bell is taking up a new role as Program Strategy Lead with the MedicineInsight Program at the National Prescribing Service in Melbourne.

Dr David Russell-Weisz will commence as the new Director-General of Western Australian Health after finishing up in August

as Chief Executive Officer of Fiona Stanley Hospital.

Dr Deepak Doshi, who was previously Director of Emergency at Campbelltown Hospital, has just started a new position as Director of Medical Services at Roma Hospital.

Ms Kathryn Cook is moving back to New Zealand to take up the position of Chief Executive Officer at Mid Central District Health Board. Ms Cook has held various senior leadership positions across Australia including Chief Executive Officer at Western Health and Partner at KPMG Health practice.

Dr David Ward, from Townsville Hospital and Health Service, is moving to Metro North Hospital and Health Service as the new Clinical Director of Adolescent Psychiatry.

Mr Brett Thompson, Chief Operating Officer at Northern Adelaide Local Health Network, is moving to Murrumbidgee Local Health District as Director of Operations. 



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 an independent national peak body advocating for universal and equitable access to high quality healthcare in Australia.

With more than 60 years of engagement and experience with the acute, primary and community health sectors, 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.

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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 our 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.

The AHHA's JustHealth Consultants is a consultancy service exclusively dedicated to supporting Australian healthcare organisations. Drawing on the AHHA's comprehensive knowledge of the health sector, 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 and training spheres, the AHHA publishes its own peer-reviewed academic journal (*Australian Health Review*), as well as this health services magazine (*The Health Advocate*). ¹

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



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Who we are, what we do, and where you
can go to find out more information

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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 2014-2015 Board is:

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Australian Health Review

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

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Editor in Chief

Dr Simon Barraclough

Associate Editor, Policy

Prof Christian Gericke

Associate Editor, Models of Care

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Production Editor (CSIRO Publishing)

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Contact details

AHHA Office

Unit 8, 2 Phipps Close
Deakin ACT 2600

Postal address

PO Box 78
Deakin West ACT 2600

Membership enquiries

T: 02 6162 0780

F: 02 6162 0779

E: admin@ahha.asn.au

W: www.ahha.asn.au

Editorial enquiries

Emily Longstaff

T: 02 6180 2808

E: elongstaff@ahha.asn.au

Advertising enquiries

Lisa Robey

T: 02 6180 2808

E: lrobey@ahha.asn.au

General media enquiries

E: communications@ahha.asn.au

AHHA National Council

The AHHA National Council oversees our policy development program. It includes the AHHA Board above and the following members:

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Dr Deborah Cole

Ms Gaylene Coulton

Ms Jill Davidson

Mr Philip Davies

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Award trophy and prizes

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- US\$5,000 to cover travel and accommodation to attend the 39th World Hospital Congress in Chicago in October 2015
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ENQUIRIES

Sheila Anazonwu
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