



The Health Advocate

Your voice in healthcare

Allied health
Untapped potential

Sidney Sax
Medallist 2015
Prof. Len Notaras

**Medication +
collaboration**
The push for integrated care

Health funding
A consideration of
alternative models

**+MORE
INSIDE**



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

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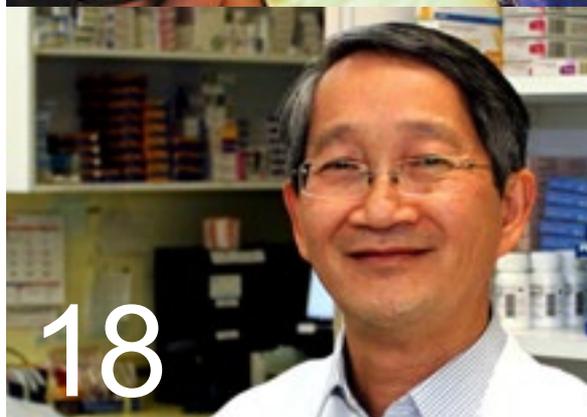
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AHHA in the news

HAVE YOUR SAY...

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

AHHA congratulates Sussan Ley on her reappointment as Minister for Health

In late September, the AHHA congratulated Sussan Ley on her reappointment as Minister for Health in Prime Minister Malcolm Turnbull's first Cabinet, and welcomed Senator Fiona Nash and Ken Wyatt as they assume their respective new posts as Minister for Rural Health and Assistant Minister for Health.

"We look forward to continuing our positive relationship with Minister Ley and her staff as we work to confront the challenges facing the health sector," said AHHA Chief Executive, Alison Verhoeven.

"It is important Minister Ley makes sure the conversation about health funding remains front and centre as the government reframes its approach to economic management – a strong economy depends on the good health of its citizens.

"Australians expect the Government to provide a high quality and sustainable health system, which is affordable and accessible to all patients," Ms Verhoeven said.

Primary Health Networks to drive needed reforms

Primary Health Network (PHN) boards can drive significant reform but will need to recruit the right team, embrace innovation, build evidence and create constructive relationships according to a new book by authors Stephen Duckett, Marilyn Beaumont, Gabrielle Bell, Jane Gunn, Amanda Murphy, Rod Wilson and Tom Crowley, published by the AHHA in late September.

The book, *Leading Change In Primary Care: Boards of Primary Health Networks Can Help Improve the Australian Health Care System*, explores lessons that can be learnt from the Medicare Local experience for the new PHN boards. The authors suggest PHNs can facilitate widespread change by building positive and constructive relationships with and between health professionals, as well as engaging clinicians and the community during their decision-making processes. The need to carefully target funding, commission for health outcomes, promote integration and encourage the delivery of important services is also emphasised. The ePub version of the book can be accessed from the AHHA website at: <http://ahha.asn.au/leading-change-primary-care>.



Chronic disease needs broad plan of action.

National plan needed to combat growing burden of chronic disease

In late August, the AHHA called for the urgent development of a national plan for chronic disease management in a submission to the government.

According to AHHA Chief Executive Alison Verhoeven, for the plan to be effective, it requires engagement across the health sector. "It must be developed in genuine partnership with all levels of government, health service providers, health researchers, consumers and the broader health community," Ms Verhoeven said.

The AHHA's submission to the House of Representatives Standing Committee on Health Inquiry into Chronic Disease Prevention and Management in Primary Care has put forward a proposal for a new national plan.

"We believe chronic disease management should be centred on patients, not diseases, so patients with multiple chronic conditions can be better treated," Ms Verhoeven said.



Australians expect access to a high quality, sustainable and affordable health system.

Medicare services review sensible, but purpose should be to ensure we get the right healthcare that is affordable and safe

On 29 September, the AHHA welcomed the consultation process on the Medicare Benefits Schedule (MBS) initiated by Health Minister Sussan Ley.

“This builds on the work commenced by the Medical Services Advisory Committee, and will contribute to a much-needed speeding up of that Committee’s work. It should take into consideration the work being done separately by the clinician-led Choosing Wisely program, led by the Government-funded organisation, NPS MedicineWise,” said AHHA Chief Executive, Alison Verhoeven.

“The processes for review should be undertaken with broad consultation, and with due diligence – the multiple review processes being undertaken across a range of areas in health at the moment create a risk of fragmented responses, poor communications with key stakeholders, and even poorer decision-making. This will neither be helpful to governments looking for budget savings, or for ensuring that Australians have access to a high quality, safe and affordable healthcare system.”



Medicare services review requires broad consultation.



Affordability and accessibility of care must remain central to budget considerations.

Affordable healthcare must not be lost in quest for budget savings

Reforms to primary healthcare must respond to the needs of people with chronic and complex health conditions, according to the AHHA in its submission to the Commonwealth Government’s Primary Health Care Advisory Group on 3 September.

“Our primary healthcare system must be centred on patients, rather than diseases or providers, and funding should support affordable, accessible person-centred care,” said AHHA Chief Executive, Alison Verhoeven.

“Region-specific approaches to primary healthcare are needed to allow for better care coordination. Consideration could be given to some pooling of Commonwealth and state health funding for commissioning of regional services by the Primary Health Networks. These should focus on improving health outcomes, rather than on fee-for-service arrangements.”

AHHA welcomes two new Board members and farewells three

The AHHA Board has appointed two new Directors effective from 15 September. They are: Nigel Fidgeon, who is the Chief Executive of Merri Community Services in Victoria, and Adrian Pennington, Chief Executive of Wide Bay Health and Hospital Service in Queensland. They will join Paul Dugdale (Chair); Elizabeth Koff; Deborah Cole, Gary Day and Walter Kmet.

Kathy Eagar, Philip Davies and Paul Scown ended their Board roles on 15 September. The AHHA would like to thank Kathy, Philip and Paul for their contribution to the Board and extend a warm welcome to Nigel and Adrian in their new roles. We look forward to their contributions in the year ahead. 



PAUL DUGDALE

Chair of the Australian Healthcare and Hospitals Association (AHHA)

Meeting the challenge of sustainability

Some of the top priorities for public hospital funding

The AHHA's *Think Tank on Sustainable Funding of Public Hospitals* in Brisbane last month provided 100 leaders with the opportunity to discuss the future of hospital funding and the challenges involved in ensuring Australians will benefit from a durable, affordable and accessible health system into the future.

From the debates and discussions on the day, a clear picture emerged of the top priorities for public hospital funding in Australia at the moment.

Commonwealth public hospital funding growth beyond 2017 needs to cover the growing burdens of an ageing population and emerging technological developments, not just population growth and CPI increases as anticipated in current Budget provisions.

The reform of the Federation process has proposed new arrangements for public health funding between the Commonwealth and state governments. It is essential this be sustainable, durable, and well-coordinated.

A third priority identified during the Think Tank was the urgent need to tackle chronic disease.

With more and more Australians suffering from chronic and complex conditions, improved funding and care coordination arrangements are essential.

However, while these challenges will

require cooperation between governments and health leaders, the Think Tank also identified ways in which the health sector could increase its own efficiency to prepare for the funding challenges of the future.

As illustrated by AHHA Senior Research Leader Dr Linc Thurecht in his *Communique on Sustainable Funding for Public Hospitals*, published following the Think Tank and available at <https://ahha.asn.au/node/89>, better integrated care across different sectors in the health system will help hospitals cope with demand in an environment of fiscal restraint.

If the system promoted better integration between primary, acute and aged care, there would be greater opportunities to manage

If the system promoted better integration between primary, acute and aged care, there would be greater opportunities to manage individual healthcare needs drawing on community and primary health services, helping to avoid expensive hospital admissions.

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This integrated care should be led by regional bodies as a single fund holder. Commissioning healthcare at a regional level means the services provided are better suited to meeting community needs, while

establishing a single funder for healthcare would bring clear roles and responsibilities to the system. Efficiency and patient outcomes would likewise improve.

Increasing the value of the healthcare provided by the system was also identified as an important factor in reform. Focusing on the value of expected patient health outcomes from individual treatments would enable the health system to direct limited resources towards achieving the greatest health benefit.

Our Think Tank was followed by further debate of potential reform in the forum on bundled care options for primary health. Participants discussed Dr Paresch Dawda's recent research into the obstacles facing the introduction of bundled healthcare in Australia.

The AHHA was also pleased to hold its 2015 Sidney Sax Medal Dinner, and I was honoured to present this year's medal to the Chief Executive of the Northern Territory Department of Health, Professor Len Notaras AM. Professor Notaras is a very worthy addition to the list of outstanding healthcare leaders, following on from 2014 winner Professor Judith Dwyer.

I would also like to take this opportunity to once again thank our speakers for their presentations, including our featured keynote speakers Dr Tony Sherbon, Dr Stephen Duckett and Ms Elizabeth Koff.

All speakers, presenters, panellists and moderators engaged in the debates with gusto, and I hope the ideas raised and discussed will provide a blueprint for the future of public health funding.

Ultimately, all governments and health administrators who are grappling with budget challenges must take this opportunity to reform financing and payment models across the public health sector. **ha**



ALISON VERHOEVEN
Chief Executive
AHHA

Use of social impact bonds in primary care

Can it work in Australia?

Innovative and outcome-focused primary healthcare financing models such as social impact bonds have been proposed as a possible reform to health funding by Associate Professor John Fitzgerald from the University of Melbourne in a Deeble Institute for Health Policy Research issues brief.

Social impact bonds (SIB) focus on the outcomes of investment, and promote private investment in evidence-based preventive services. They have been used in social services, but have not yet been fully explored in primary health. The typical application of SIBs involves a client based intervention for particular behaviours with a captive population, such as in a prison setting.

SIBs involve private investors funding interventions and government paying back the principal as well as a return on the investment. This “payout” only occurs once the program meets its goals. The attractiveness of SIBs lies in risk mitigation to government, cash flow management for government departments and the potential to promote innovation and increase accountability in service delivery via public-private partnerships.

Successfully used in countries such as the United States, SIBs have funded initiatives in justice, out of home care, social welfare and education. There have been some examples of successful SIBs in the US health sector, particularly in asthma prevention, diabetes and primary health.

In the United Kingdom one of the National Health Service’s regional primary health Clinical Commissioning Groups introduced a SIB project focused on “social prescribing” to support 8,000 people with long-term health conditions such as lung disease, diabetes and asthma.

There has also been interest in using SIBs in Australia. The New South Wales Government and UnitingCare launched the Newpin pilot SIB program in 2013 with \$7m of private investment. The purpose of the program is to restore children from foster care back to their homes, or to prevent them from entering out-of-home care in the first place. It does so by creating safe home environments through training and support services to families. By September 2014, the program had successfully restored 28 children to their former homes and prevented another 10 from entering foster care. Based on the terms of the SIB, reaching this milestone led to interest payments of 7.5% of the initial investment being returned to investors.

In a subtle way, impact investing requires a change in mindset away from discussions of which interests (private or public) are responsible for ill-health. The focus shifts to the mitigation of ill-health by adjusting tastes and behaviours.

However, it’s not all good news for impact investing. SIBs focus on outcomes, but the process of measuring these is not simple in primary care. Outcomes may not be realised for many years, and so the attribution of an outcome to an intervention requires a more sophisticated evaluation technique.

The newly constituted Primary Health Networks have an opportunity to engage in impact investments such as SIBs in order to respond more directly to local needs. A funded

emphasis on better health outcomes rather than simply focusing on payments based on activity is consistent with the commissioning role envisaged for the new Primary Health Networks.

More work is needed to determine the applicability of SIBs to the Australian primary health environment. Both federal and state governments will be keeping a close eye on the success of efforts like the Newpin pilot program, because SIBs may prove to be a valuable tool for the future sustainability of the Australian health system. While SIBs may not be the only solution for these problems, a discussion about them might get us to ask deeper questions about how our health system

might operate differently. Current attempts to control GP demand through price controls may have caused us to lose focus on what matters most – the health and wellbeing of our citizens. SIBs might be one way that we can achieve a blend of financing in our health system that places focus on outcomes.

The Australian Healthcare and Hospitals Association will host a roundtable on social impact investing in health in Sydney on 29 October to discuss the potential for social impact investing to drive quality and efficiency in health at a time of significant change in health sector funding arrangements.

For more on SIB, view our *Options for Finance in Primary Care in Australia* issues brief online at <http://ahha.asn.au/publication/issue-briefs> 

While SIBs may not be the only solution for these problems, a discussion about them might get us to ask deeper questions about how our health system might operate differently.



Professor Len Notaras.

Sidney Sax Medallist 2015

The AHHA congratulates Professor Len Notaras

The AHHA is proud to announce Professor Len Notaras as the winner of the Sidney Sax Medal for 2015, following on from last year's recipient, Professor Judith Dwyer.

Professor Notaras has been a leading figure in the health sector for many years, and has served as the Chief Executive Officer of the Northern Territory Department of Health since April 2014.

Prior to this, he spent five years as the Executive Director of the National Critical Care and Trauma Response Centre (NCCTRC), a world-class national and regional medical hub based in Darwin.

"The Sidney Sax medal is awarded to an individual who has made an outstanding contribution to the development and improvement of the Australian healthcare system in the field of health services policy, organisation, delivery and research," said AHHA Chief Executive, Alison Verhoeven. "Professor Notaras is a very worthy recipient of the medal, having worked tirelessly to address Aboriginal and Torres Strait Islander health issues in the Northern Territory, for his managing of the disaster response to the Bali bombings, and for his role in establishing the NCCTRC in Darwin."

Professor Notaras was the strategic founder of the centre, and he retains overarching responsibility for the organisation. Under his leadership the NCCTRC has become a national leader in disaster management, and even reached out to regional neighbours including Timor L'Este and Indonesia to provide vital medical training and support.

In recent years, the centre has become a regional hub of disaster management, having provided aid to the Solomon Islands during a dengue outbreak in 2013, and to the Philippines following the destruction wrought by Typhoon Haiyan that same year. In 2010,

Professor Notaras arranged the NCCTRC's deployment of an international team of medical personnel to Pakistan in response to devastating floods. The team treated more than 11,000 people during 10 weeks in the country.

The creation of the NCCTRC was announced by then-Prime Minister John Howard following the infamous Bali bombings in 2002.

Professor Notaras played a vital role in the medical response to these attacks, in which 202 people – including 88 Australians – were killed. As the General Manager of the Royal Darwin Hospital at the time, Professor Notaras jointly coordinated the evacuation and treatment of nearly 100 victims of the terrorist attacks, 70 of whom were critically injured.

In recognition of his management of the Australian medical response to the tragedy, Professor Notaras was made a Member of the Order of Australia in 2003. His other accolades include the Best Individual Contribution to Healthcare in Australia Award, presented to him during the 2005 Australian Medical Association's National Conference.

The dedication that Professor Notaras has shown to healthcare during his distinguished career has seen him take up leadership roles with a wide number of organisations. He has served as a former Chair of the Northern Territory Pharmacy Board and is a

former NT President of the Australian College of Health Service Management. He was directly involved in the development of the Northern Territory Clinical School, where he holds the position of Senior Lecturer. He has also served as Deputy Chair of the NT Medical Board and is Chair of the NT Radiographers Board. He is a long-serving board member of the Australian Council on Healthcare

Standards and an inaugural member of the Australasian Council for Safety and Quality in Healthcare.

"It is an honour to be recognised in such a positive and prestigious way by a group of peers," Professor Notaras said. "The name Sidney Sax is iconic and synonymous with his successes and achievements, and for me to

"It is an honour to be recognised in such a positive and prestigious way by a group of peers," Professor Notaras said. "The name Sidney Sax is iconic and synonymous with his successes and achievements, and for me to just share in a part of that reflected glory is breathtaking. It is one of the proudest moments of my life."

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Professor Notaras was last year honoured with an Honorary Doctorate in Science from Charles Darwin University in recognition of his contribution to medicine. This year he was made a Professorial Fellow in the Medicine, Nursing and Health Sciences faculty at Flinders University. He holds Bachelor degrees in Medicine, Commerce and Law and Arts, as well as separate Masters degrees in History and Hospital Management. 



GARY DAY
Editor-in-Chief
Australian Health Review

Improving the system: One action at a time

A framework for implementing system-wide reform

In a 2013 televised address the then-Chief of the Australian Army, Lt. Gen. David Morrison, said “The standard you walk past is the standard you accept”.¹ While Morrison was talking about unacceptable behaviour in the Australian Army at the time, equally there are messages here for those who are involved in managing and leading health services. What is the standard of healthcare expected in Australia today? The alternative questions could be: What standards do we walk past in relation to patient safety and quality or compassionate care? or What standards do we walk past in terms of bridging the gap in Indigenous health disadvantage?, among others.

If there is a commitment to improving health care in Australia, the system can be viewed in terms of examining five interconnected elements: patients (or clients), processes, people, priorities and partnerships. These five elements provide a framework to understand critical health service components if there is a desire to make systems improvement.

Patients

Revelations from the 2013 Francis Inquiry into the failings of the National Health Service (NHS) Mid Staffordshire Trust provide a case study of failing standards across the five elements, however what appeared to be the most telling were the reports of nursing care that were callous and uncaring. The Inquiry reported among other things “...call bells going unanswered, patients left lying in their own urine or excrement, or with food and drink out

of reach”.² Tellingly, the “Trust was operating in an environment in which its leadership was expected to focus on financial issues, and there is little doubt that this is what it did. Sadly, it paid insufficient attention to the risks in relation to the quality of service delivery this entailed.”³ Clearly, there was a lack of professional courage or an acceptance that the level of care that was being provided to those patients was good enough, which led to adverse patient outcomes and deaths. Surely these are standards that are unacceptable, but somehow they were overlooked, ignored or walked past.

Francis made the point in his executive summary “...there needs to be a relentless focus on the patients’ interests and the obligation to keep patients safe and protected from substandard care. This means that the patient must be first in everything that is done: there must be no tolerance of substandard care”.³ Improving the health system will require putting patients in the centre of all care and healthcare decisions, with processes, people, priorities and partnerships being critical elements to understand and actively manage.

Processes

Over the past three years an increasing emphasis on critical health service processes by the Australian Commission on Safety and Quality in Healthcare has seen the implementation of 10 core mandatory health service standards.⁴ These standards focus on

organisational processes to ensure quality and safety in the patient experience. Even still in today’s healthcare system, with these standards and the available technology, we can still give the patient the wrong drug, undertake the wrong surgery or give a patient an infection through failing to undertake simple procedures such as handwashing. Processes are only as good as the people who implement them and it requires every member of the healthcare team to play a part in identifying, speaking up and not walking past when a process is breached. In TeamSTEPPS® training to improve team communication and patient safety, every team member has ability to “stop the line” if they sense or discover an essential safety breach.⁵ It is evident that we need more “stop the line” moments to improve our healthcare system.

People

If patients are considered the centre of care, then staff are essential to make this happen. In addition to proactive workforce development and providing positive safe work cultures, the interactions of staff are critical if there is a commitment to patients’ interests. In 2008, Garling identified “...one impediment to good, safe care which infects the whole public hospital system. It is the breakdown of good working relations between clinicians and management which is very detrimental to patients”.⁶ Morrison aptly stated that “Every one of us is responsible for the culture and reputation of our [service] and the environment in which we work”.¹ At times

it appears that patients become peripheral to health service operations as managers and clinicians have conflicting views on health system performance, activity, funding and delivery. The health system deserves and expects health professionals, both clinicians and managers, to work together for the patient, rather than each trying to wrestle control from the other. Every staff member must be working towards safe and quality care, not working against each other to the detriment of the patient. What standard should be expected of the health workforce, either in terms of creating positive, collaborative work cultures or working collectively to solve some of this country's complex health issues? How can we expect to deliver safe, effective, patient centred care when the workforce is demoralised or culturally 'bankrupt'? The Francis Inquiry clearly demonstrated the outcomes of a demoralised workforce on patient care, and this is a standard that cannot be walked past if there is a seriousness about improving the system.

Priorities

Where do Australia's health priorities lie and how does this impact on the type of health system we currently have? The current Federal Government has signalled its priorities with reduced funding for dental health; a move away from activity-based funding; reduced commitments to hospital funding by over \$50 billion between 2017 and 2025; establishment of Primary Health Networks; and reviews

of the Medicare Benefits Schedule, primary health funding and electronic health records, just to name a few. The extent to which these priorities put patients in the centre of care and improve access, equity and improved health outcomes must be assessed – what are we prepared to accept and what will we walk past?

Partnerships

Partnerships are critical to improving our health system, whether it is between Federal and State governments; different clinical groups; primary and secondary health services; health services and universities; clinicians and researchers; health organisations and consumer groups or Indigenous health initiatives. Every partnership takes trust, commitment and time. Are we prepared to walk past an opportunity to work in partnership to improve our healthcare system?

The appeal of this five-element approach is that it works equally well for the frontline caregiver as much as the hospital CEO or the Director-General of Health. Each and every frontline clinician, support staff and manager can make a difference if they choose to make continuous, incremental improvements in their own practice area across these five elements. The Personal commitment to improving the system in our own areas of influence starts with rejecting poor standards: of care; substandard communication; unworkable processes; misdirected priorities and lack of teamwork.

What did we do differently today than we did yesterday to make the health system better

for tomorrow? What it takes is to not walk past one more poor standard, just one action at a time. [ha](#)

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Body & mind

David Butt, Chief Executive Officer of the National Mental Health Commission, on care for the whole person across the whole system

In April, the National Mental Health Commission (the Commission) conveyed the importance of addressing the physical health of people with a mental illness in the release of its Review of Mental Health Programmes and Services. Compiled with input from more than 2,000 public submissions and guided by Terms of Reference provided by the Australian Government to assess the efficiency and efficacy of programmes and services in supporting individuals experiencing mental ill-health and their families, the review's vision was to ensure all people in Australia to achieve the best possible mental health and wellbeing.

Key to this vision is a holistic whole-of-life perspective. Such an approach is evident in the Review's examination of the physical health needs of people with mental illness, which highlights a system that does not see the whole person. The Commission believes that physical and mental health should not be seen as separate, but rather as

interdependent and mutually-integral in protecting, promoting and achieving overall wellbeing.

The appallingly high levels of physical health problems experienced by people with a mental illness, as well as high levels of comorbidities and premature death — as seen in the reduced life expectancy for people with psychosis between 14 and 23 years of age — requires that the treatment of mental health and physical health is routine and regular. Clinical deterioration of people with mental ill health problems, high rates of undiagnosed/late diagnosed, and poorly treated physical health complications make people with complex mental health needs a high priority. To establish a person-centred approach, where a person's holistic needs are taken into account, necessary services need to be “wrapped around” them, their families and communities.

One of the Commission's various reform recommendations to help achieve this is for

the new Primary Health Networks (to be renamed as Primary and Mental Health Networks) to take on greater responsibility for mental health in recognition of the importance of mental health as an embedded part of general practice and primary healthcare.

The Commission also proposed that COAG should agree to a new national target for the physical health of people with a severe mental illness. This includes an indicator to increase the proportion of adults over 18 with a disclosed mental illness who are screened every 12 months for physical and dental health issues to 40% in four years and 90% in 10 years. In addition, there should be the adoption of a single care plan and single eHealth record to include physical *and* mental health information.

The adoption of the Healthy Active Lives (HeAL) Programme as the standard intervention framework for people with psychosis on antipsychotic medications was also proposed. This would help to



support physical health and wellbeing and enable young people experiencing psychosis to have the same life expectancy and expectations of life as their peers who have not experienced psychosis. Another recommendation was to develop, agree and implement a National Mental Health and Suicide Prevention Plan with states and territories, in collaboration with people with lived experience, their families and support people. Such a plan should require action on the link between physical health and mental health to reduce current unacceptable rates of clinical deterioration.

The current level of identification of clinical deterioration among people with a mental illness is frankly unacceptable, given what we know about quality and safety in healthcare. This applies as much to the clinical deterioration of a person's mental state as it does to the clinical deterioration of the physical health of a person with a mental illness. Problems experienced by people with mental illness

often are dealt with in isolation, with various structural, cultural and practice barriers to integrated, wraparound supports leading to system inefficiencies and poorer mental and physical health outcomes for individuals.

In its review report, the Commission emphasised the logical integration of primary and mental healthcare to look at the needs of the whole person and not simply at separate diseases or body components. This whole-of-person approach requires a whole-of-system strategy – delivered through health and other non-health portfolios, e-mental health and other phone and online services, as well as broader services – to actually improve the physical health of those with a mental illness. Luckily, there are already signs that this type of thinking is spreading.

Soon after the Commission released the findings of its review, a second report was released by the Royal Australian and New Zealand College of Psychiatrists

(RANZCP). Titled *Keeping Body and Mind Together – Improving the physical health and life expectancy of people with serious mental illness*, the RANZCP report called for psychiatrists to broaden their role beyond just thinking about psychiatric symptoms to thinking about the whole person, their overall health and the relationship between body and mind.

This historic convergence of two major mental health reports provides the best chance of coming to an agreed national approach on how to manage the physical health of people with a mental illness. To maintain the momentum on this issue, the Commission is now developing an approach to work with the Commonwealth, states and territories, RANZCP and other colleges, together with consumers, carers and service providers, to work collaboratively on the development of a national approach for the identification and care for the physical health of people with a mental illness. ^{ha}

Remote but not removed

How the **Remote Area Health Corps'** online training is helping prepare urban-based health professionals to work in Indigenous communities.



Established in 2008, Remote Area Health Corps (RAHC) is funded by the Australian Government Department of Health under The Indigenous Australians' Health Programme: Stronger Futures Northern Territory to help "address persistent challenges to accessing primary healthcare services for Aboriginal and Torres Strait Islander people in the Northern Territory".

RAHC recruits, culturally orientates and deploys health professionals to enable the provision of increased primary healthcare services to help address the shortfall in health service delivery in remote Indigenous NT communities. Its focus is on recruiting new urban-based health professionals and providing them with an array of support

mechanisms to help them better transition to remote Indigenous practice. Such mechanisms include cultural and clinical training prior to first placement and access to remote educators – health professionals with an in-depth understanding of clinical and cultural issues in Indigenous communities. Since its inception, RAHC has placed 846 health professionals into remote communities in the Northern Territory, who collectively have provided the equivalent of 299 years of service.

In line with its mission, RAHC recently developed a suite of online clinical training modules designed especially for health professionals working in remote Indigenous

Since its inception, RAHC has placed 846 health professionals into remote communities in the Northern Territory, who collectively have provided the equivalent of 299 years of service.

communities in the Northern Territory (NT): The RAHC Introduction to Remote Health Practice Program. Developed as an online training tool to provide timely, high quality orientation and learning materials for RAHC health professionals preparing to work in remote health clinics and services,



Children of Ampilatwatja, NT. Image courtesy of RAHC.

the training modules cover the following areas:

- Introduction to Indigenous Health
- Communication and Education
- Chronic Conditions Management
- Mental Health
- Paediatrics
- Maternity
- Major Incident Management
- Managing Medical Emergencies
- Trachoma
- Ear Health
- Oral Health
- Primary Eye Care Checks
- Eye Health and Diabetes
- Managing Scabies and Crusted Scabies

• Sexual Health in a Primary Health Care Setting

The suite of 15 free online modules is available to all health professionals with an interest in Indigenous health, whether they will undertake a RAHC placement or not. Specific modules been developed in conjunction with leading organisations such as One Disease and the Indigenous Eye Health Unit at the University of Melbourne. The modules are endorsed by six professional governing bodies and Continuing Professional Development (CPD) points are awarded upon completion of individual modules (varying between one to four points).

High regard for the eLearning modules was demonstrated when the RAHC program won the Northern Territory iAward in the

Health Services category at an event held in Adelaide on 12 June 2015. The awards are presented in recognition of ICT innovations with potential to have a significant and positive impact in the community, as well as those with proven success already.

Philip Roberts, General Manager of RAHC, said, “We are delighted to have our online eLearning program recognised with an iAward. Our eLearning program prepares urban-based health professionals to work in remote Indigenous communities and this greatly assists in closing the gap in Indigenous health outcomes. Our eLearning program is part of preparing and educating our urban-based health professionals about the clinical and cultural challenges unique to the Northern Territory.” ^{ha}



AVNESH RATNANESAN
Chief Executive Officer
Energesse

Lessons from the United Kingdom

10 insights for sustainable healthcare in Australia from Sir Robert Naylor

At a recent conference hosted by the Health Services Innovation group in Tasmania, I had the privilege of engaging with a few leading CEOs and researchers in healthcare. Whilst there were many highlights, Sir Robert Naylor, the CEO of University College London Hospitals (UCLH), had some outstanding insights. UCLH has been ranked the fourth highest performing National Health Service (NHS) Trust in the United Kingdom (UK) and a large part of that is due to its clinical and executive management approaches. A few key points that he made included:

1. Payers in the UK, i.e. government funding authorities, are increasingly wanting to pay for value, rather than activity. This sentiment has been echoed in Australia as we are placing more thought on how Medicare can move toward a model of payment for outcomes, rather than activities.

2. Providers need to focus more on “transformation” rather than “translation”. Sir Robert suggested that there is a need to form integrated systems along pathways. In order to do this, incremental changes are no longer good enough and patient pathways have to be viewed and changed as a whole.

3. It is imperative to engage patients as active partners in their care. “Doctors need to change from being God to Guide”. We need to change the current archetypal image so patients have more ability to take responsibility for their care.

4. Better integration would help us to improve outcomes and reduce costs. The word “integration” is used often, but the word means different things to different stakeholders.

5. Sustainability is the “nirvana” that we are looking to achieve. In the UK, healthcare has an 8% reduction in funding in the next year due to a “cost improvement program”.

6. Consumers and the public trust doctors, hence Sir Robert feels that we have to get clinicians to communicate with the community. People want a good relationship with their GP, as well as GPs that understand their patients’ concerns.

7. He also emphasises the need for more clinical leadership in executive teams and for clinicians to be better trained in business and management skills. His own Medical Directors manage the money, the people and the quality of care.

8. Sir Robert observed that Australia is five years behind the UK in terms of the performance data currently published, which is not sufficiently meaningful for real change. Publishing league tables is good for improving transparency and performance; at UCLH they publish mortality rates down to doctor level. The 2013 Francis Report on failings in Mid-Staffordshire NHS Trust noted a lack of transparency – this is why league tables are very useful.

9. The top priorities at UCLH are based around patient quality. The three primary priorities are:

- patient outcomes (is it going to make me better?);
- patient safety (is it safe for me?); and
- patient experience (compliments/ complaints).

These priorities are put up on whiteboards on each ward, with top metrics updated daily, such as staff levels and infection rates. Each of UCLH’s 9,000 staff need to have these priorities translated in a way that is meaningful to them, including janitorial staff.

10. In terms of the current thinking on innovation in the UK, a five year forward review by Simon Stevens suggested:

- a radical upgrade in prevention and public health;
- breaking down barriers between GPs and public hospitals;
- new models of integrated care (Dalton Review); and
- a re-design emergency and urgent care.

Sir Robert recommends that tertiary health centres focus only in a couple of

areas of expertise where possible as it improves outcomes, e.g. cancer and neurosciences. This is to establish critical mass, and in the case

of UCLH, involves giving up some patients to other centres but, in the end, will dramatically improve mortality rates and build capability. 

Sustainability is the “nirvana” that we are looking to achieve.

Energesse specialises in research, advisory and analytics of patient experience and integrated care strategy for organisations in the US, UK and Australia.





LYN MORGAIN
Chief Executive
cohealth

Medication + collaboration

Improving the quality and accessibility of pharmacy services for high-need populations

One of the largest community health services in Australia, cohealth is the result of a merger between three long-standing Victorian community health services on 30 April 2014. Providing a broad range of prevention and treatment services – including medical, dental, allied health, mental health support and homelessness services – one of the unique offerings to date has been a not-for-profit pharmacy service. Located at cohealth's Collingwood site, the pharmacy is the only one of its type in the country, and has been in operation for over two decades.

The service employs pharmacists to work alongside general practitioners (GPs) and other health providers within an integrated setting. It provides low cost medication, medication review, monitoring and education in collaboration with other health providers, to local community members from disadvantaged and marginalised groups. Annually, the service dispenses about 30,000 prescriptions.

Clients of the service are people living in significantly disadvantaged circumstances, with generally low levels of health literacy and often multiple chronic diseases. Around 40% of clients are from non-English speaking and low English proficiency backgrounds. The integrated service includes the use of interpreters with both GPs and pharmacists. This ensures that people actually get their prescribed medication, and that they actually understand what they need to know in order to take it safely and appropriately.

There are also large numbers of clients who are homeless or living in insecure housing, as well as those with other significant risk factors like drug and alcohol dependence.

These clients require tailored pharmacy practice not available in standard pharmacy settings. Compared to those settings, the cohealth pharmacy service has enhanced capacity to review the appropriateness of medication, and to minimise the risk of over-medication or medication errors. This is achieved through close collaboration with GPs and other healthcare providers, use of interpreters where required, and a strong commitment to a person-centred response which meets the needs of people who experience difficulty in accessing services and also have high-level needs. For example, pharmacists often develop tailored dispensing regimes for at-risk populations, those with mental health issues, substance use issues and the elderly.

The integrated setting ensures a common electronic record is used, which facilitates visibility and promotes collaboration between health professionals. It includes simplified referrals and communication pathways between different professions, including GPs, pharmacists, alcohol and drug workers, mental health clinicians, and nurses. In addition to providing comprehensive care and enhancing access for vulnerable groups, the pharmacy service also operates a lower cost than the standard model of for-profit retail pharmacies. Department of Health data indicates that the average cost of a prescription through the cohealth pharmacy service is 31% lower than the average government cost per prescription for PBS medication. This represents a saving to the government of almost \$250,000 per annum.

While the pharmacy service is currently supported by the Commonwealth, it has

been announced that this funding may cease from 1 January 2016. Currently, cohealth is working with the Department of Health to progress approval under the Sixth Community Pharmacy Agreement (as suggested by the Department), but options under the existing legislative and regulatory frameworks appear limited. Still, cohealth remains committed to not only continuing the model at its Collingwood site, but also exploring opportunities to expand the model to additional sites.

The cohealth integrated pharmacy model is consistent with the directions promoted by the Australian Medical Association and the Pharmaceutical Society of Australia, towards developing an integrated model with pharmacists as part of the primary care team. This approach is echoed in the National Mental Health Commission's National Review of Mental Health Programmes and Services, which recommends routine pharmacist involvement in the mental healthcare team.

A number of national reviews and inquiries are currently focusing on ways to improve the health system to better meet the needs of people with chronic and complex conditions. These include the House of Representatives Standing Committee Inquiry into best practice in chronic disease prevention and management in primary healthcare, and the Primary Health Care Advisory Group – better care and support for people with chronic and complex illness. The cohealth pharmacy model provides an operational example of integrated practice which is both efficient and effective in improving the quality and accessibility of pharmacy services for high-need populations.



Case study

Robyn Williams says she's a modern day miracle. The inner north Melbourne resident was diagnosed with Multiple Sclerosis over 20 years ago but today remains independently mobile. Her neurologist, who gave her the "miracle" label, says Robyn is his only patient with either MS or Parkinson's that is still getting to and from appointments without the aid of a wheelchair or carer.

Robyn is adamant that her good health is a direct result of the integrated care she receives from cohealth's Collingwood community health centre, Australia's only GP/community pharmacy that houses doctors, nurses, pharmacists and a range of allied health professionals under the one roof.

"The integrated pharmacy arrangement has allowed me, with my Multiple Sclerosis, to keep my mobility and to maintain my quality of life a lot longer than I might have thought possible," Robyn said. "The staff know me, and can talk to each other about the care I receive, including the medicine I need."

The benefits of the integrated GP/pharmacy model are three-fold. For older Australians like Robyn with chronic or complex health needs, the greatest benefit is the ease of access to coordinated care. "The doctor and the pharmacy working together have been integral for me to not be in a wheelchair. To be able to come down here and treat me medically and to keep me alive – it's just so important," she said. ^{ha}

“Will I ever feel safe again when it rains?”

Susie Burke, senior researcher at the Australian Psychological Society, explains the psychological impacts of anthropogenic climate change.

The much-anticipated Lancet report on climate change and health, which was released this June, highlighted some of the potentially devastating consequences of climate change for human health, warning that this is so great it could undermine the last fifty years of gains in development and global health. As well as affecting our physical health, climate change also has significant impacts on mental health.¹ Every impact of climate change, whether it be extreme weather devastating human settlements, changed rainfall and temperature reducing food security and land habitation, or ill health from shifting disease vectors, has flow-on effects on people’s psychological, social and emotional wellbeing.

Understanding the psychological impacts of climate change is a crucial step in coming to terms with and then psychologically adapting to a climate-changed world and reality.

Acute psychological effects come from a range of climate-related extreme weather events – bushfires, cyclones, floods, severe storms, heatwaves, drought – that can have devastating consequences for individuals and communities. People can be bereaved, lose their properties and become displaced from their communities.

Some psychological impacts are caused by climate change’s more gradual impacts

on the environment, human systems and infrastructure. These include things like higher average temperatures, spread of disease, changes in agricultural conditions, increases in food insecurity, sea level rise, more extreme weather, associated increases in displaced people, or greater wear and tear on infrastructure and associated increases in disruptions to transport, energy supply and cost of living. The potential impacts of these direct or gradual changes range from mild stress responses to chronic stress and significant mental health problems. The composite term “mental health and psychosocial wellbeing” is often used to capture the full spectrum.

Mental health refers to diagnosable mental health conditions. There is a significant risk of mental health problems following extreme weather events, for example. The most common are Post Traumatic Stress Disorder, depression and complicated grief. Approximately 30% of people affected by a disaster are at risk. These impacts represent some of the most potentially devastating effects of climate change in terms of human suffering.²

Psychosocial wellbeing refers to non-clinical indicators of wellbeing that are affected by direct, indirect or vicarious effects of climate change. These are almost certain to increase as the impacts of climate

change become more widely experienced and acknowledged. Many people may feel seriously concerned, frightened, angry, pessimistic, distressed, or guilty in response to climate change. Qualitative research finds evidence of some people being deeply affected by feelings of loss, helplessness, and frustration due to their inability to feel they are making a difference.³ New terms such as “eco-anxiety” are sometimes used to describe this. Other impacts on wellbeing that can result from particular climate-related stressors like loss of liveability include: higher levels of stress, substance use, strain on relationships, family breakdown, grief, loss of autonomy, loss of identity, increased rates of suicide, and reduced social participation.⁴

Community health includes impacts on community fabric and interpersonal relationships. These are understudied, but may involve things like diminishment in community cohesion, loss of community identity, threats to a sense of belonging as people are forced to move in and out of communities because of environmental stressors; and an increased likelihood of violence and aggression as community members experience various stressors that are related to climate change.⁴

There are several different reasons why it is important to understand how climate

change is affecting us psychologically. How people think about and react to direct threats like extreme weather, or their anxiety about future threats to the environment, or their distress about vicarious threats to other people in other places, or their existential fears about changes to life as they know it, are important factors in what people do next. People need to be able to manage these feelings so that they can properly accept the reality of climate change and not avoid it. Coping with the feelings we have about climate change is very important so that:

- we don't become overwhelmed by these feelings;
- we don't try to avoid the feelings and hence the problem;
- we can stay engaged with the problem of climate change; and
- we can keep functioning well whilst accepting the reality of climate change, both in our everyday lives, as well as on the changes we are making to reduce the threat of climate change.

People can, of course, react to the threat of climate change in all sorts of unhelpful ways – they can try to minimise the threat, distract themselves, blame “the authorities” for the disaster, hope for possible silver-bullet solutions, become dependent on others like

the government or other countries to solve the problem, or become helpless/hopeless, and resigned to the disaster.

Or people can respond adaptively. Taking environmentally-responsible action is one way to manage and reduce the anxiety and distress about climate change. People feel empowered and more hopeful and optimistic when they take action, or work with others to address climate change.⁵ Other good climate change coping techniques identified in the psychological research include social support-seeking, becoming more attentive to the issue, accepting climate change as a threat, shifting values to a more “pro-environmental” position, expressive coping, and problem-solving.

Evidently, climate change is as much a psychological and social problem as it is an environmental or ecological catastrophe. The more we know about how people are feeling, thinking and doing in relation to climate change, then the more we are able to help them respond in useful ways – in ways that both reduce the threats of climate change as well as prepare people to adapt to the changes that cannot be avoided. 

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Allied health

Kathleen Philip, Chief Allied Health Advisor of Victoria, highlights the untapped potential for allied health in the Australian health system.

Australians receive healthcare by three main workforces; allied health, medical and nursing. Although comprising about 25% of Australia's healthcare workforce, allied health and its contribution remains poorly understood and largely invisible in the Australian system. There is strong evidence demonstrating the benefits of allied health in improving patient outcomes, minimising risk and harm from illness and improving health system efficiency and capacity to meet increased demand in a cost-effective manner. Despite this, the existing health model, funding arrangements and culture prevent us from effectively accessing these benefits at a system level. A transformational change in the Australian health system in how, where and by whom care is provided is necessary. This will entail cultural change in health that needs to be embraced, if not led, by doctors alongside the realignment of funding models.

The challenges facing the health system are well documented: population ageing and increasing demand, chronic disease and multi-morbidity; technology increasing the domains of care; and escalating healthcare costs. Consumers are increasingly engaged and seeking empowerment in their care.

Information communication technology (ICT) has transformed business models and modes of interaction (social, knowledge transfer and commercial) with instantaneous outcomes and consumer sovereignty becoming the new norm.

Other industry sectors have responded with transformative change in how they do business to survive and capitalise on an ICT-enabled and consumer dominant environment. The health industry, however, has remained fundamentally unchanged. The essential business model, provider-focused transaction and funding models are similar to those of the 1950s. At that time, the health system was constructed to combat infectious disease and maternal/perinatal mortality – life and death metrics. This “medical model” focused on acute, episodic care provided in hospitals by doctors and nurses. Allied health was not incorporated in the “medical model” funding, having largely developed since the 1960s, tending to war and poliomyelitis survivors living with serious ongoing disability. Since then, allied health has been added “at the edges” rather than developing an integrated model of care and funding.

In 2015, chronic disease is our major problem. Quality of life and wellbeing, social and economic participation are the

community's health metrics. Nearly 35% of Australians aged over 45 years have two or more lifestyle-related chronic conditions. Co-morbidity requires radically different approaches for managing both the cost and demand pressures on our health institutions and the implications of chronic ill health on individual's labour and social participation.¹ Chronic condition care needs are complex and long term. They require multiple professional interactions, which means moving away from more disease-specific approaches and instead recognising the importance of shared health determinants and risk factors. They also tend to be characterised by the need for intensive periods of intervention as well as monitoring and education over time.

Allied health practises in an evidence-based paradigm, providing diagnostic capability, functional restoration and improvement in quality of life. This is focused on the need for effective ways of keeping people healthy in their homes and actively connected to family and community, returning them to work and other life functions, for better social and economic participation. These social determinants all have an impact on the individual's health status and population health outcomes. Allied health's contribution





"Tulane Psychologists Study Infant Motor Coordination" by Tulane Public Relations. Image sourced from Flickr (CC BY 2.0: <https://flic.kr/p/9dQGku>).

to health, well-being and wealth creation is made along the continuum of care and therefore, takes a whole of health view. This recognises the absolute need to expertly manage those with the highest needs, to help people maintain function and independence, and support those with early risk factors to prevent them becoming the future “tip of the complexity triangle”.

Allied health’s non-episodic therapeutic paradigm has particular resonance in the management of chronic conditions. There is substantial evidence demonstrating the impact of allied health interventions (such as exercise, nutrition, good foot health and mental health) on chronic diseases such as diabetes, cardiac and respiratory health; as well as reducing acute exacerbations of chronic and multi-morbid conditions, and hospital admissions.

Allied health also plays a key role in acute health services in diagnostic technologies, in minimising risk and harm from disease (swallowing dysfunction, functional decline or medication error), mitigating lengths of stay and facilitating effective and sustained discharge. Economic evaluations have shown that increasing allied health services reduces

length of stay and reduces medication error, providing large cost savings at organisation and system level. Nevertheless, the health and funding models have not adapted to this new capability in healthcare and potential to manage chronic conditions better; and when acute health services have a funding shortfall, allied health is usually among the first casualties.

Changing the funding model requires a fundamental cultural shift, and it has to start with our doctors. Individually and intellectually, most doctors embrace multidisciplinary health teams as best practice and providing best patient outcomes, and work as key players in interdisciplinary teams. However, collectively, the culture of health is conservative and medicine within that milieu historically wields undue power and decision-making influence. This extends to influence over the roles of other health professions and around how resources are allocated.

This influence is rooted primarily in the conservative culture of health and custom, rather than in evidence-based and contemporary practice knowledge. The changes that have transformed other business sectors will need to start here and be embraced, if not led, by

our senior doctors. It should be informed by evidence of safety, clinical appropriateness, efficacy and cost effectiveness rather than “how we have always done it”.

The health system of the 2020s should be based on achieving best health and consumer outcomes, the most effective and cost-effective management in the most effective and cost-effective setting by the most effective and cost-effective provider. The expertise exists to improve our management of chronic disease, but it is not currently provided for in the health system. As funding drives behaviour (both provider and consumer), the funding models and culture of the health system must change to support this. The health model and culture needs to genuinely involve the consumer and all three healthcare workforces.

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Agile and fit for purpose

Creating an allied health workforce that suits our needs

The shortages and misdistribution of the health workforce in Australia are well documented.¹ A flexible and agile workforce can improve workforce capacity and drive delivery of quality outcomes.² Reallocation of suitable tasks from Allied Health Professionals (AHPs) to Allied Health Assistants (AHAs) makes sense from a workforce efficiency and economic perspective. It is unproductive for AHPs to continue to complete tasks that do not require their level of qualification or expertise. Embedding the AHA role into health services is critical to achieving a workforce designed for the future. Utilising the total allied health workforce to its full potential is therefore a key driver behind delivering a sustainable and self-sufficient health workforce.

Alfred Health and Monash Health, in partnership with the Department of Health and Human Services, have developed and implemented a new model of care termed, the Victorian Assistant Workforce Model – Allied Health (VAWM). The model guides workforce redesign and strategically builds allied health workforce capacity. Underpinned by the Victorian Supervision and Delegation Framework for Allied Health Assistants, the model aims to provide increased access and continuity of care to patients.³

The VAWM methodology has been based on principles of consultation, organisational priority, and change management. The model is implemented in three phases, consisting of six elements which include a suite of activities to support health service implementation. The VAWM methodology can be customised to local contexts, whilst providing a framework for planning, collecting information, making evidence-based decisions, and improving a broader scope of practice in allied health. A successful long term outcome of the VAWM is that the allied health workforce is fit for purpose, with the right worker completing

the right tasks, within the appropriate scope of practice. The model provides a robust methodology to:

- identify tasks that can be safely delegated to an allied health assistant under the appropriate supervision framework;
- best use the skills of allied health professionals;
- increase job satisfaction for allied health assistants and allied health professionals;
- create a flexible and adaptable health workforce that can quickly meet our service needs; and
- improve sustainability of our allied health workforce and health system by increasing efficiency.

The VAWM methodology was implemented from 2012-15 through a three stage rollout across rural and regional, metropolitan, and community and ambulatory settings in Victoria. Fourteen allied health disciplines participated, including 4,357 allied health staff (3,867 AHPs and 490 AHAs) across 112 health services (176 sites). This represents just over 50% of the AHA workforce in the Victorian public health sector. Allied health assistants made up 10% of Victoria's total allied health workforce at the time of the model implementation.

The opportunity for AHA workforce growth was highlighted by AHPs, who quantified that up to 24% of their time is spent undertaking tasks that can safely be delegated to an appropriately qualified and supervised AHA. This equates to an additional 517 full time allied health assistant positions. This has significant implications for Victoria's allied health workforce in terms of the potential to reduce health service cost and efficiency, while still maintaining patient quality and safety.

The VAWM is the first Victorian large scale effort that is replicable and scalable across different clinical contexts jurisdictions and service sizes. Early results show that enhancing the allied health skills mix in healthcare teams is a cost effective way to manage efficiency, demand, and sustainability whilst maintaining quality patient care and improving job satisfaction of both AHAs and AHPs. The VAWM is a flexible and sustainable model of care that matches the right allied health task, to the right worker, in the right place. ^{1a}

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A country mindset

Dane Ware on help for Borderline Personality Disorder in rural areas

In the June 2015 edition of *The Health Advocate*, I explained how, working as a Support Facilitator with Partners in Recovery, I became aware of the lack of rural services supporting either people battling with Borderline Personality Disorder (BPD), their carers, or the clinicians attempting to help them.

It is generally accepted that people who display BPD traits are subject to chronic and systemic stigmatisation. A psychiatrist from the Spectrum Personality Disorder Service, Dr Josephine Beatson, told ABC radio show “All in The Mind” (Sunday 23 November, 2014) that people battling BPD suffer stigmatisation to a greater degree than with most other mental health issues.

It became apparent to me that a social culture which supports stigmatisation impacts on a person’s ability to access community services and on the quality of assistance they are offered. There appeared to be a need to develop a program of community education on BPD. To do so, I developed a partnership with a professional mental health trainer, Wayne Horwood, and Diamond Clubhouse Adelaide.

As the program progressed, we were lucky to have Catherine Bennett become involved. Catherine has a lived experience of being diagnosed with and recovering from BPD. In addition to her involvement in our program, she works as Consumer Consultant for Alfred Psychiatry and Consumer Advisor to Spectrum. Catherine is a great asset to the program and is actively involved in the training.

We now have a two-day program with the option of an advanced class in the evening of the first day. We have completed three

programs and are planning programs at least monthly into the foreseeable future. The program includes units such as: *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.*

The feedback from participants has been overwhelmingly positive with some excellent suggestions, which are being integrated into future courses.

The goal from the outset has been to provide a program which can be effectively presented to rural communities, which was practical, financially self-sustainable and which engaged attendees emotionally. The emotional engagement is part of building the attendees’ understanding of the emotional position of people suffering BPD, and the patterns of logic behind behaviours such as self-harm. It is expected this enhanced understanding will help promote empathy, compassion and an ability to work more effectively with people struggling to overcome BPD or other complex illnesses.

Currently we are within our budget plan, and indications are that we will be able

to sustain and develop this program in the long term. It is even possible that we will be able to make funds available to other organisations via loans or grants. Although we are based in rural South Australia, we will be looking to present this course interstate in the near future. We are also in the process of developing a “train the trainer” program and will be looking for people with experience in supporting people with BPD, or in stable recovery from BPD to train as presenters.

The emphasis in selecting trainers will be on their commitment to helping others and more specifically people with BPD traits. We are working towards extending the program into a range of areas, including instigating a rural support program for people affected by BPD,

carers, clinicians and others suffering from similar traits. Perhaps the most important goal is that we will continue to inform the general public in the hope of reducing stigma. ¹

The goal from the outset has been to provide a program which can be effectively presented to rural communities, which was practical, financially self-sustainable and which engaged attendees emotionally.

For further information about the program or to express interest in having the training course presented in your local area, please contact me, Dane Ware, on 0408 495 160 or via email at dware@cobh.org.au.

A close-up photograph of an elderly man with a mustache and glasses, wearing a straw hat and a dark blue jacket over a white shirt and red tie. He is holding a wooden cane with both hands. The background is blurred, suggesting an outdoor setting.

The problem of Parkinson's disease

Tien Kheng Khoo of the Menzies Institute of Health Queensland discusses one of the growing concerns for Australia's ageing population.

Parkinson's disease (PD) is the second most common chronic neurodegenerative condition after Alzheimer's disease and, like the latter, it has a predilection for the elderly. At present, approximately 25 people are diagnosed with the disease every day with an estimated 50,000 individuals currently living with the condition in Australia.¹ With 15% of the Australian population 65 years and older, the prevalence of PD is expected to more than triple in two decades with changing Australian demographics that veer towards one of an ageing nation.² In 2005, it was estimated the total economic cost of PD was \$6.8 billion with the Australian Government bearing 40.5% of this cost and the remainder borne by state and territory governments, private insurance, patients and carers.³ This echoes the findings of the recent 2015 Intergenerational Report that urgently calls for a national plan for chronic disease management which underpins the importance of conditions such as PD.

PD is often known by its cardinal clinical features of motor impairment, namely tremor, rigidity, slowness in initiating movement (bradykinesia) and postural instability that can lead to falls. Besides motor symptoms, a myriad of non-motor symptoms that include neuropsychiatric symptoms such as anxiety and depression are known to frequently occur and tend to evolve throughout the course of disease with the majority of those with long-term PD eventually experiencing cognitive impairment to a degree severe enough to be deemed as dementia.⁴ Many other non-motor symptoms associated with PD include gastrointestinal issues such as constipation and swallowing difficulties, sleep problems such as excessive daytime somnolence and disruption of normal sleep cycles, and many more. Also of great importance is that many of these symptoms remain undeclared by patients and are not detected by treating clinicians.⁵ The resultant effect of symptom burden on quality of life can be significant and sufficient to cause disability and caregiver distress that is likely to translate to greater effects on the community.⁶

A concerted effort is required to address the issue of chronic diseases in Australia.

Using PD as an exemplar of a highly prevalent multisystem morbidity, appropriate priorities of management will include accurate diagnosis, expert review, treatment and follow-up as well as regular access to specialist nursing care, allied health therapists and palliative care. Importantly, it has been shown that effective interprofessional practice can lead to better patient outcomes in the community, thus reducing inpatient hospital admissions. The importance of interprofessional education and practice has been duly recognised by the World Health Organisation Framework for Action on Interprofessional Education and Collaborative Practice 2010.

While the treatment of the individual should be prioritised, one must not forget the collective; stakeholders should explore the utility of cost efficient means to deliver effective healthcare. While this will best involve interprofessional practice, utilising technology such as telemedicine will allow for far-reaching input of healthcare even in rural communities though certain challenges to effective implementation will need to be overcome. In addition, synergistic opportunities should not be neglected. Examples include charities such as Parkinson's Australia that not only provide education and support to people with PD and their carers but also raise valuable funds that provide additional clinical care in the form of specialist nurses and support valuable research.

Research into conditions such as PD also present an opportunity for the nation's growing education and biotechnology sector. The formation of effective research studies and research networks will help streamline processes to help overcome the shortfall in understanding this complex condition while potentially acting as a catalyst in numerous sectors that can seed and attract local and international talent. This structured approach is needed to remain competitive in a country with a relatively sparse population, thus replicating similar underlying principles already practised in more populous nations is likely to be advantageous in a process that inevitably involves discrete optimisation.

At Griffith University's School of Medicine, and the recently launched Menzies Health

Institute Queensland, we are currently undertaking observational research in PD with a view to helping us determine key characteristics of disease and individual traits that contribute to disability and impaired wellbeing. With this knowledge, it is hoped we can better manage this condition that will only be increasingly common in Australia. During this process, we are engaging with local stakeholders that include clinicians, patient groups and charitable organisations, such as Parkinson's Queensland.

While the saying "time and tide wait for no man" may be an inadvertent pun in PD with its slightly higher predisposition in males, it may also serve as a timely reminder that chronic diseases need to be prioritised in the Australian healthcare system. Relatively more advanced healthcare and research networks have been established in other developed nations such as Britain and Netherlands. Perhaps the time for us to plan for our future is now. 

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RACHEL MARTIN
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No drill, no needle

Reducing anxiety in the treatment of dental decay

Dental decay (dental caries) is one of the most common chronic diseases in young children and its prevalence is increasing. Recent data shows that 48% of children have experienced caries by the age of five.¹ Childhood dental decay causes pain, abscesses and infection, and can cause great anxiety for children and their families in their interactions with oral health services, with long lasting implications for social, educational and health outcomes.

Oral health ranks highly in preventable hospital admissions data. In 2012-13, dental treatment was the second most common cause of hospitalisation, after asthma, for 0-14 year-olds with an average cost per admission of AU\$2,508.^{2,3} Dental decay is largely preventable by forming positive early oral health habits. It is also becoming increasingly easier to treat, with early identification both via oral health clinicians and other early childhood professionals. In applying preventive and early detection methods, the need for costly interventions for dental treatment, such as general anaesthesia, can be reduced.

A relatively new method for managing early childhood caries is the Hall Technique (HT), a method of treating tooth decay in primary molars. It involves no tooth cutting and no local anaesthesia; no drill, no needle. A decayed primary molar that is not causing pain has a stainless steel crown cemented directly over the decayed area. The complete

sealing of the tooth in this way prevents the decay from progressing by isolating the bacteria and starving it of oxygen and simple carbohydrates that are required for the progression of decay within the tooth.

Identified in Scotland in the late 1990s by Dr Norna Hall, a randomised control trial was then undertaken to test the success and acceptability of the technique against conventional restorations. There were 132 children that each had one HT crown and one conventional restoration placed. At their three year follow-up, 19% of the teeth with

exhibited a clear preference for the HT over conventional restorations.^{4,5,6} Another study found children who received the HT crown (n=100) reported less dental anxiety and were more likely to report enjoying their visit than those who received conventional restorations (n=90). After six months, those with conventional treatment had twice as many dental abscesses as those who received the HT, and nearly three times as many replacement fillings.⁷

Dental Health Services Victoria recently partnered with other local health agencies



conventional restorations failed and required extraction, compared to 3% of the teeth with HT crowns. This was a statistically significant finding. Children, carers and clinicians also

to conduct the first study of HT in Australia. Comprising 12 clinicians and 251 children, aged 3 to 7 years, the aim is to assess the acceptance, success and cost-effectiveness

of HT at six, 12 and 24 months, and to help develop guidelines, policy and training in the technique for oral health professionals.

The baseline results of the study were presented in July 2015 at the International Association of Paediatric Dentistry conference in Scotland. Using the Facial Image Scale, a validated tool for assessing anxiety in children as young as three years old, the children responded overwhelmingly positively to the experience of HT.^{8,9} Their parents and carers were equally positive about the ease, comfort and speed of the technique, with 98% of carers reporting they would be happy for their child to have HT treatment in the future.

The Hall Technique has the real potential to reduce stress and anxiety for children and their families around dental treatment, and has the potential to reduce referrals for general anaesthesia for the management of dental decay in young children. Clinicians are already seeing the advantages of HT compared to the traditional filling method. Oral health therapist, Alyson Bettega said: "... it's so much better having the kids leave with the job done and no tears... I feel very confident in this technique and the parents are amazed at how easy and quick it is."

Sealing early-to-moderate levels of tooth decay stops it from getting worse. The majority of children in the HT study did not experience any discomfort during the sealing procedure, which is very simple and takes about five minutes to complete. This exciting

innovation could dramatically reduce the need for drilling and filling children's baby teeth, and thereby alleviate the suffering and anxiety many young children feel in the dental chair, and in more serious cases, in hospital. Children don't want to sit for very long in the chair, and very young children don't like drills, needles or the numb feeling and discomfort of conventional treatment.

For many children, a less anxious dental treatment experience will help to build resilience and encourage good oral health habits into the future; a future with less fearful adults who won't be so inclined to avoid preventative visits to the dentist. [ha](#)

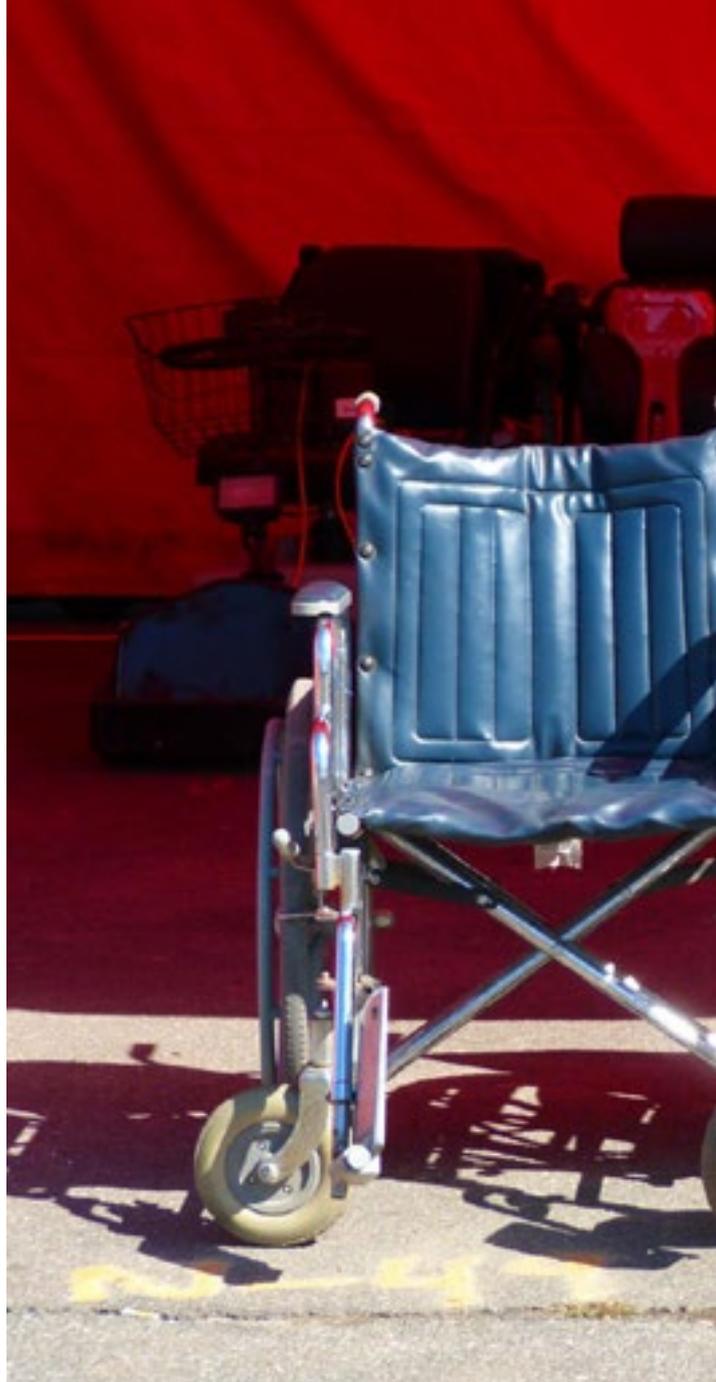
The Australian Hall Technique study is being funded by the William Buckland Foundation, and the study partners are North Richmond Community Health Limited, Dental Health Services Victoria, Monash Health, Barwon Health, Melbourne Dental School, University of Adelaide and Deakin University. Some Hall Technique researchers at Dundee University, Scotland, and University of Otago, New Zealand, are also advising the study team.

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Care in the community

Youngcare CEO, **Samantha Kennerley**, discusses how we can do better to support young people in residential care.



The report from the recent Senate Committee inquiry into residential care for young Australians with disabilities, released this June, charts a clear path for us to solve a decade-old injustice. Young people caught living in aged care – where the average age of residents is 83 years – is an issue that has dogged the healthcare system for many years. Now is the time for Commonwealth, state and territory governments to step up and fulfil the mission that Youngcare and its supporters have been championing for the last 10 years: to help transition young people out of nursing homes and into age-appropriate housing, where they have options and independence.

Youngcare's own experience in this area has led us to develop a unique model of care – based on the actual needs and wants of young people with high care needs – that

has set the standard for accommodation providers internationally. Our new blueprint for the development of communities that are accessible and inclusive for people of all ages and abilities is a ground-breaking tool for decision makers, planners, governments and investors. It includes a housing design guide – built on years of research in union with Griffith University – which demonstrates how to provide young people with a home – in any community, in any location – that ensures their complex support needs are met, while also allowing them to lead a fulfilling, productive life. This may be as simple as enabling them to pop down the street to a local café or have friends visit for a dinner party.

Youngcare also provides direct support for young people who want to remain at home or move out of residential aged care,

hospital or some other long-term health facility. While we are continuing to make great strides in helping as many young people living in, or at risk of entering aged care, we, as a nation, need to be looking towards a whole-of-care approach. The recent Senate Committee inquiry's recommendations and the roll out of the National Disability Insurance Scheme (NDIS) have both presented great opportunities for improving the outlook for people living with disabilities, but we need to do more.

In the short term, young people in aged care will need access to state and territory aids and equipment schemes. Presently, young people in aged care are unable to access state-funded schemes because they are actually funded through the federal aged care system. This creates an even heavier cost burden onto families which is



'Big E 2011' by Rusty Clark. Image sourced from Flickr (CC BY 2.0: <https://flic.kr/p/anUzde>).

unfair and limits the options available. The requirements of state-funded schemes also vary around the country, so a more uniform approach is needed. Another avenue for reform would be to remove the requirement of bonded fees for young people with high care needs and providing appropriate prescribed specialist services like speech, physiotherapy, occupational therapy and other allied health services.

In the longer term, we must address the issue of how funds are allocated for all areas relating to young people in care,

A future where no young Australian has to call aged care “home” is feasible within our lifetime. For it to become a reality, we must adopt a collaborative approach and view it as our community responsibility.

from the previously mentioned health care tools and services to bigger issues such as age-appropriate housing. It is not always

correct to assume that money is the reason why young people are ending up in aged care. There are many young people with permanent disabilities who are residing in hospitals and rehabilitation units because there is nowhere

suitable for them to go and their families have resisted pressure to send their loved ones into the aged care system.

A comparison of the costs of hospital care to disability care, either at home or in supported accommodation, is striking. The cost of daily care in an Australian hospital can be as high as \$2,195, which equates to \$801,175 annually. Considering the maximum allowance for high care needs in the NDIS budget is \$606 per day, equating to \$221,540 per year, there is no apparent reason why a lack of funding should be the key issue for providing appropriate care for young people. It is more accurate to suggest that the distribution of funding between government departments is misaligned and needs to be reviewed.

A future where no young Australian has to call aged care “home” is feasible within our lifetime. For it to become a reality, we must adopt a collaborative approach and view it as our community responsibility. ^{ha}





JULIE COLLINS

National Health Priorities Officer
Central and Eastern Sydney PHN

Supporting nurses in general practice

An overview of services provided by Central and Eastern Sydney Primary Health Network (PHN)

The increasing burden of chronic disease in Australia is changing the face of general practice, with greater need for preventive health activities along with long-term, multidisciplinary care for chronic patients. Recent statistics show that one in three Australians currently live with a chronic condition, and this number is likely to rise with the growing prevalence of risk factors, such as obesity.¹ General practice nurses are integral to the delivery of primary care services and they play a critical role in managing chronic and complex patients.

Currently, there are more than 10,500 nurses working in general practices across Australia, with more than 60% of general practices employing at least one practice nurse.² The role of the general practice nurse is multifaceted and covers a range of activities including patient triage and assessment, health promotion, coordination of patient care, infection control and clinical risk management.

Central and Eastern Sydney PHN provides support to general practice nurses in the Sydney region, stretching from Strathfield to Sutherland and as far east as Bondi. The services we provide recognise the unique and important role that nurses hold in general practice. These services range from recruitment and orientation to general practice, to chronic disease management support, as well as professional development and networking.

Many nurses transition to general practice from the acute sector, and a growing number of nurses are being employed in general practice following university graduation. To

facilitate their transition – from university or from hospital – we provide new general practice nurses with information on the primary care system, the Medicare Benefits Schedule and the Practice Incentive Program, national general practice accreditation standards, local community services and referral pathways, as well as professional development and networking opportunities. According to new practice nurse Kathy Sun Young Kim, the services provided by the Central and Eastern Sydney PHN have been much appreciated. “All resources provided from the practice nurse support program are very informative and help to understand the roles of a practice nurse in a GP setting,” she said.

Central and Eastern Sydney PHN also delivers a number of population health support services, including identifying at-risk patient cohorts, establishing recall and reminder systems for preventive screening, assistance with health assessments, care plans and cycles of care, along with access to best practice guidelines. We are also at the forefront of quality improvement in general practice and work closely with nurses to implement strategies for improvement.

Another popular service that we facilitate is a quarterly networking meeting for practice nurses. The meeting provides a space for general practice nurses to come together, share ideas and experiences, as well as obtain additional nursing-specific education. For those who do not have the support of other nurses in their workplace, the meetings offer an opportunity to encourage each other and provide some mentoring to new nurses. According to one general practice nurse,

Lea Boyd, these meetings are an invaluable sounding board. “They provide a wonderful environment for starting conversations, bouncing ideas, sharing new information, offering a wide variety of perspectives on different situations and helping to find solutions to common problems,” she said. “Networking is important for nurses as it engenders confidence and validation. The more we learn, upskill and enhance our scope of practice the greater our ability to deliver best practice, great service and patient-centred care. Networking helps us to remember we are advocates for our patients and the nursing profession alike.”

General practice nurses are critical to the changing model of primary healthcare delivery in Australia. With the increasing burden of chronic and complex conditions in general practice, nurses play a vital role in identifying risk and coordinating patient care. By providing them with more support, we will be better placed to achieve more efficient care and better patient outcomes into the future. [ha](#)

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The value of breast care nurses

JustHealth Consultants' review highlights the importance of the McGrath Foundation and the expanding role of breast care nurses across Australia

On 7 September, coinciding with its 10th anniversary, the McGrath Foundation launched a new campaign to highlight the value that breast care nurses can bring to the lives of people experiencing breast cancer. In turning the stereotypical idea of a charity ad on its head, the campaign emphasises the message that breast cancer is not always about losing someone; it can actually be about gaining someone – a McGrath breast care nurse to be precise.

The television commercial leading the campaign shows portrait shots of five real women holding photographs of other women, giving the impression that the women in the photos are friends or loved ones that they have lost. It's not until the women in the photograph step into the frame that the audience realises that they are McGrath breast care nurses who have supported these women through their breast cancer experience.

McGrath breast care nurses are registered

nurses who have specialist training and qualifications in breast care. With a thorough understanding of breast cancer and support service and provide clients, families and carers with a consistent source of information, support and care throughout treatment. They are the flagship of the McGrath Foundation, which was co-founded by Jane McGrath and her cricketer husband Glenn, after Jane's initial recovery from breast cancer.

The Foundation's main aims are to raise money to place McGrath breast care nurses in communities across Australia, as well as increase breast cancer awareness in young Australian women. In 2009/10, the Foundation conducted an initial study to determine how many breast care nurses were required to complete its mission. Five years later, the AHHA's business arm, JustHealth Consultants, was commissioned to provide an update on the role of breast care nurses in Australia.

With an estimated 15,270 Australian women diagnosed with breast cancer in 2014, and

17,210 new cases of breast cancer diagnosed in women by 2020, the JustHealth review showed that demand for breast care nurses continues to grow. This is not only due to the increasing number of new cases each year, but from decreased mortality rates and improved survival as well. It also showed that the role of breast care nurses is also extending and expanding, and will vary relative to the context the care is provided in, reflecting geography, culture and the scope and skills of the multi-disciplinary team.

With this continual and growing demand for breast care nurses services in mind, McGrath Foundation CEO Petra Buchanan said that throughout this 10th anniversary year, there would be a firm focus on the free support that its breast care nurses provide to families across Australia. The Foundation's goal is to increase the number of its nurses to 110 to help an additional 10,000 families through breast cancer – which will cost \$14m per year. ¹⁴



Still from the McGrath Foundation commercial, developed by DDB Sydney.

Living well with persistent pain

Jane Goode, Chronic Disease Liaison Officer at Adelaide Primary Health Network, discusses the role of patients in their pain-management pathway

Chronic pain services in South Australia are limited. They are predominantly based within tertiary organisations which are struggling to meet the changing needs of the population with their current level of resources. Data around the impact of chronic pain in the Adelaide region are difficult to find, however the most recent prevalence was put at 18%.¹ This suggests a figure of 250,000 South Australians living with chronic pain, with 70,000 requiring input from a tertiary service. SA Health acknowledges the waiting time to access tertiary pain services are the longest in the country. This leads to a situation where approximately 80% of South Australians living with chronic pain are not receiving treatment and support which could improve their health and quality of life.

Best practice models of care for pain management set out that patients of low-to-medium complexity should be managed within the primary care sector.² However, chronic pain management is often seen by general practice as “not rewarding” and “too time- and resource-consuming”.³ This means people living with chronic pain may experience stigma and other difficulties trying to access pain management in their local community.

Recognition of the level of services providing pain management options in primary care in northern Adelaide led to the implementation of the PainWISE® program, *Living Well with Persistent Pain*. The program was enacted by the Northern Adelaide Medicare Local in partnership with Elizabeth Family Health, the Northern Adelaide Local Health Network (NAHLN) and the Royal Adelaide Hospital Pain Management Unit (RAH PMU). *Living Well with Persistent Pain* is now being delivered by the Northern Health Network, with funding provided by the

Adelaide Primary Health Network.

The use of pain clinics and programs is well supported in the literature as an important part of pain management.⁴ Treatment often starts with an initial assessment by a care coordinator and goes on to involve a multi-disciplinary team, including a GP, all of whom support the person with an individualised plan for coordinated management of pain. This could include diagnostic assessments, physical therapies, behavioural techniques and medication management.

Living Well with Persistent Pain is such a program. Based on the successful Gold Coast PainWISE® program *Turning Pain into Gain*, it combines primary care services and self-management strategies. Together, these support individuals to better understand their pain condition and equip them with the necessary tools to improve their quality of life. This then minimises the burden of pain on them, their families and the wider community. The program focuses on people currently waiting for tertiary pain management services, aiming to provide an accessible, local, patient-centred alternative.

Although still in a pilot phase, the 8-10 month program currently provides support for 40 participants through a holistic self-management course, case coordination and extended allied health services. A GP with a particular interest in managing persistent pain is also available for access. A care coordinator undertakes an initial assessment and supports the patient and GP through the process of both group sessions and one-on-one allied health services with providers, including an accredited pharmacist, dietitian, exercise physiologist, plus physiotherapists and psychologists.

Self-management support is at the heart of *Living Well with Persistent Pain*. Both the education sessions and the individual care plan are centred on the concept that

the patient is best placed to determine their own pain-management pathway. The individual assessment is structured in a way that assists the patient to identify their own life-based goals. The education sessions support the individual plan by providing a wide range of self-care options and links. The sessions are also a forum for participants to share their thoughts and experiences with others. Participants are actively attending both the group sessions and working on their individual treatment plans with the health team. Many of them report better understanding about how their pain responds to their thoughts and actions and are endeavouring to put this new knowledge into practical strategies for change.

The Adelaide Primary Health Network and the Northern Health Network together feel that *Living Well with Persistent Pain* represents an opportunity to better support individuals experiencing chronic pain, in an innovative and efficient way. Future plans for the program include a second intake for northern Adelaide and also potential expansion to other areas in need of primary care pain management services. [ha](#)

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HESTA launches Reconciliation Action Plan

Becomes first industry super fund to formally recognise its commitment to reconciliation with Aboriginal and Torres Strait Islander peoples and organisations

The \$32 billion industry super fund's Reconciliation Action Plan (RAP) was formally launched by the Hon. Curtis Pitt MP – Queensland Treasurer and Minister for Aboriginal and Torres Strait Islander Partnerships – on 31 July in Cairns.

The RAP set out the steps HESTA will take to build relationships with Aboriginal and Torres Strait Islander stakeholders and is endorsed by Reconciliation Australia – an independent, national, not-for-profit organisation that promotes reconciliation by building relationships, respect and trust between the wider Australian community and Aboriginal and Torres Strait Islander peoples.

Chief Executive Officer of Reconciliation Australia, Justin Mohamed, said he is very proud to have HESTA join the Reconciliation Action Plan community. "As the first industry super fund to develop a RAP, HESTA will help to drive reconciliation action in their sector," Mr Mohamed said.

In developing its RAP, HESTA engaged an Aboriginal consultant to ensure culturally appropriate mechanisms are developed at the Fund, focused on addressing the issues confronting Aboriginal and Torres Strait Islander peoples and communities.

HESTA Chief Executive Officer, Debby Blakey, acknowledged the RAP as an important step in turning the Fund's good intentions into meaningful actions, in partnership with HESTA members and industry stakeholders. "Our members are at the coalface of the country's commitment to closing the health gap between Indigenous and non-Indigenous Australians," Ms Blakey said. "The ideals of reconciliation are very important to them and what matters to our members, matters to us at HESTA. This is evidenced in our long and proud history of advocacy on behalf of our members – to make super more equitable and accessible for all Australians, whether Indigenous or non-Indigenous, male or female."

The actions in the Fund's RAP reflect HESTA's values to be a responsible leader and a voice of advocacy. HESTA is already involved in a number of activities that foster the spirit of reconciliation, in collaboration with partner associations in health and community services including the National Rural Health Alliance and Indigenous Allied Health Australia. To further these efforts, representatives from national and state-based Aboriginal organisations and leaders will be invited to participate in the implementation of HESTA's RAP.

Through the implementation of its RAP, HESTA has committed to increasing cultural awareness internally, continuing its work breaking down barriers to accessing super within the Indigenous population and increasing its engagement with members. For more information on HESTA's RAP, go to hesta.com.au/RAP. For further information on Reconciliation Australia and frameworks for action, go to reconciliation.org.au 

HESTA parts ways with Transfield Services

After much careful consideration, and following an extensive period of consultation with various relevant stakeholders, as well as engagement with the company, the HESTA Board determined to divest from Transfield Services.

The Board's review of this investment involved a prescribed and well-established environmental, social and governance (ESG) escalation process. In accordance with this policy, if a company is identified as not complying, directly or indirectly, with international laws, standards or guidelines,

the Fund may consider divestment of any such companies.

A number of independent non-government organisations have found that the mandatory, prolonged, indefinite, and non-reviewable nature of detention at asylum-seeker processing centres breaches the fundamental principles of international human rights law.

For this reason, the outcome of the escalation process was that HESTA should divest from Transfield Services – the company responsible for managing Australia's off-shore detention centre in Nauru.

As a responsible owner of the companies it invests in, HESTA's decision to divest involved a rigorous process, informed by advice from its internal investment team and external engagement service providers. 

HESTA is the industry super fund dedicated to health and community services, with more than \$32 billion in total assets and 800,000 members. HESTA's investment in Transfield was approximately \$23 million, representing a 3.5% stake in the company.



***On HESTA's
Reconciliation Action Plan:***

“We make this public commitment as a national organisation, a leader in superannuation services and as the fund for health and community services professionals.”

Debby Blakey, HESTA Chief Executive Officer.

“We seek to build respect through understanding and shared learnings, increase confidence and choice in retirement for the first Australians and achieve equity in the treatment of non-Aboriginal and Aboriginal peoples.”

Sophie Sigalas, HESTA Executive – People Strategy, speaking at the launch of HESTA's RAP during the 2015 Cairns Indigenous Art Fair.

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Live a long & fruitful life

New SPC ProVital portion controlled fruit cups

The ageing population is one of the largest and fastest growing sectors of the market – but unfortunately the elderly are often overlooked when it comes to packaging design. Hard-to-open food packaging is not uncommon, especially with old age and fine motor skill difficulties, and is not just a source of frustration for patients but a barrier to nutrition.

One of the key roles of packaging is to protect its contents, but what happens when it is so well protected, that a consumer can't access it? With this in mind, SPC worked in consultation with healthcare professionals to develop a range of new portion-controlled fruit cups under the SPC ProVital brand. The range comes in an easy-to-open cup and aims to provide more accessible quality nutrition for consumers with fine motor skill difficulties.

Available from October onwards, the new SPC ProVital portion control cups are acknowledged for their packaging, which is perceived to be superior to alternative options currently in the market in terms of accessibility, safety and cost efficiency. The tab is easier to locate and grip, which reflects the force required to open/peel the cover. The cup shape and size offers a more convenient hold and grip. It has shown to be an excellent alternative for many healthcare patients.

The cup features:

- A textured and lengthened pull tab for easier grip.
- Clear instructions for opening.
- Optimised seal to reduce opening force.
- Decagon shape for easier grip.
- Portion controlled to deliver one serve of fruit.
- Smaller grip span for easier hold.
- Easy to locate and read best before date.
- Extra-large font for improved legibility.

The easy opening packaging allows people to access the nutrition they deserve, whilst not compromising on the delicious tastes of natural fruit. SPC ProVital prides itself on being Australian-made, with each cup containing high quality Australian fruit.* Rigorously tested to meet Australian Food Safety Standards, the cups are health star rated and feature new "Cold Fill" technology to lock in fruit goodness. This "cold fill" technology and cooking by retort are gentle on the fruit, resulting in improved integrity of the diced fruit, vibrant colour, consistent texture in our purees and most importantly delicious taste.

The packaging is recyclable and the design creates less wastage and improved nutrition as patients are able to access their food more easily. Portion-controlled accessible packaging offers cost savings and efficiency within the

healthcare system, including all indirect costs such as time to serve, cost of container, storage, waste, cleaning, labelling, etc.

SPC ProVital improves your kitchen's efficiency with pre-packaged portion control fruit with:

- Less waste, as patients are able to access their food without help
- More controlled sizes, as 120g packs are scientifically portioned
- Improved food safety, as packs are hygienically packed & protected

SPC ProVital will be running a Product Familiarisation Program within the Sydney healthcare environment to gain end user insights and recommendations on how hospitals should engage with the new SPC ProVital portion control cups.

An SPC ProVital Advisory Board Meeting was held in Sydney in March 2015 to gain directions on the objectives of delivering and optimising this Product Familiarisation Program within a hospital environment; to help SPC understand how to best educate patients and to gain advice from key opinion leaders on how to communicate the product range to the hospitals and aged care sector.

* excluding the fruit salad which has imported pineapple.



Master of Bioethics



The Monash University Master of Bioethics program provides a structured course of study in ethical theory, applied ethics, healthcare ethics, research ethics, public health ethics, and related policy issues. While the program is particularly well-suited to healthcare professionals and scientists who face complex ethical issues in their working lives, it is also valuable for those involved in the formulation of public policy and law regarding these issues, as well as for anyone who wishes to explore these issues of public concern in greater depth. The course is designed to accommodate students with little or no prior background in ethics or philosophy, but it is also suitable for philosophy graduates who wish to pursue further study of bioethics.

Offered on-campus and online

May be taken full-time or part-time
(Depending on prior education/experience, students may be able to complete the course in 1 – 2 years full-time or 2 – 4 years part-time)

For further information about the Masters Course, including registration, please visit:

future.arts.monash.edu/master-bioethics/

Intensive Bioethics Course

This five day course is designed to provide medical professionals, members of human research ethics committees and those with a general interest in bioethics an in-depth introduction to bioethical thinking and the ethical issues that emerge in related clinical and policy contexts. Though this is a standalone professional development course, those who complete it may receive credit if they later enrol in the Master of Bioethics program.

WHEN

November 29 – December 4th

WHERE

This year's course is being held at Country Place Retreat in the beautiful Dandenong Ranges close to Melbourne, Australia.

QUESTIONS

If you have any questions about the course or you are interested in participating please contact Dr Ryan Tonkens:

ryan.tonkens@monash.edu

DETAILS

Full details about this course including program and registration details are available here:

future.arts.monash.edu/intensive-bioethics-course/

Seminar | International Perspectives and Australian Experiences on Patient Engagement and End of Life Care

Date: November 2015

Time: 9:00am - 12:30pm (Patient Engagement and the Patient Experience)
1:30pm - 5:00pm (End of Life Care)

Venue: 75 Talavera Road
Macquarie University
North Ryde

Cost: Member full day - \$250
Member half day - \$180
Non-member full day - \$350
Non-member half day - \$280

AHHA is pleased to present a seminar that will contrast international perspectives on Australian experience in two key areas, patient engagement and the patient experience and end of life care.

Eric de Roodenbeke, Director General of the International Hospital Federation (IHF), is visiting Australia for a limited time and will be presenting on two key studies that the IHF have undertaken. He will be accompanied by a line-up of leading thinkers, researchers and advocates who will discuss the Australian context and what we can learn from these international studies. Registration options are available for the whole day, or either the morning or afternoon session if you have a particular interest in only one of the topics.

Patient Engagement and the Patient Experience

Consumer engagement is recognised as being key to developing health services that better meet the needs of the people they treat. Empowering people to make informed decisions about their own treatment is commonly talked about, but what does it mean?

The IHF, in collaboration with the International Association of Patient Organizations, has launched a worldwide survey to assess the institutional set up in healthcare facilities permitting involvement of patients. Although results show a large diversity of practices there is an excellent congruence country by country between the response from the side of healthcare facilities and from the patient associations. The involvement of patients through representative organisations is still limited and when it exists, it exerts limited influence on the decision making process.

This session will discuss the results of the IHF study and contrast them with work being undertaken in Australia to create greater engagement with consumers. Speakers include:

- Eric de Roodenbeke, Director General, IHF
- Leanne Wells, CEO, Consumers Health Forum
- Virginia Armour, Clinical Excellence Commission
- Bernadette Brady, Founder PartneringwithPatients

End of Life Care

While 70% people state their preference to die in their own homes, only 14% do. As a result, palliative care is often provided in the hospital setting and the number of hospitalisations for palliative care has increased by over 50% in the past decade

The IHF, under the auspice of the IHF University hospital special interest group, has undertaken a survey which provides a perspective on end of life care in University hospitals from an institutional perspective and compares practices across continents.

While there remains a limitation to international comparisons, the results of this survey shows that although practices and definitions vary within a country and across countries, there are some major similarities in organising responses to the need of patients.

This forum will discuss the results of the IHF survey and showcase international experiences which can be used to inform practice development in Australia. Speakers include:

- Eric de Roodenbeke, Director General, IHF
- Professor Ken Hillman AO, University of New South Wales
- Zoe Austin-Crowe, Department of Health and Human Services, Victoria

Register at www.ahha.asn.au/events

AHHA acknowledges the Australian Institute of Health Innovation of Macquarie University for its generous support of this event.



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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 almost 70 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.

By becoming a member of

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

The Deeble Institute for Health Policy Research was established by the AHHA to bring together policy makers, practitioners and researchers to inform the development of health policy. In joint collaboration with 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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AHHA Council and supporters

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

AHHA Board

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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ACT Health (Chair)

Dr Deborah Cole
Dental Health Services Victoria

Mr Walter Kmet
Wentwest, NSW

Prof Gary Day
Griffith University, Qld

Mr Adrian Pennington
Wide Bay Health and Hospital Service, Qld

Mr Nigel Fidgeon
Merri Community Services, Vic

AHHA National Council

The AHHA National Council oversees our policy development program. It includes the AHHA Board as well as a range of members. The full list of Council members can be found at:

<http://ahha.asn.au/governance>

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Deeble Institute

Ms Cassandra Hill
Administration Officer, AHHA

Mr Adam Vidler
Communications Officer

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:

Prof Gary Day
Editor in Chief

Dr Simon Barraclough
Associate Editor, Policy

Prof Christian Gericke
Associate Editor, Models of Care

Dr Linc Thurecht
Associate Editor, Financing and Utilisation

Dr Lucio Naccarella
Associate Editor, Workforce

Ms Danielle Zigomanis
Production Editor (CSIRO Publishing)

AHHA Sponsors

The AHHA is grateful for the support of the following companies:

- HESTA Super Fund
- Good Health Care

Other organisations support the AHHA with Corporate, Academic, and Associate Membership.

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

CERTIFICATION BODY

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



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



For more information on pricing and registration please
contact: 02 6162 0780
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