The Health Advocate

Your voice in healthcare

Integrated care

Lab-testing integrated care, from a PHN perspective

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The official magazine of the Australian Healthcare and Hospitals Association

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Contents

The Health Advocate

Issue 41 / April 2017

In depth

Briefing

Advertorial

From the AHHA desk

DEBORAH COLE
Chair of the Australian Healthcare and Hospitals Association (AHHA)

Integrated care

The importance of providing value to consumers.

I recently travelled to the US to attend various health conferences and think tanks. I participated in 'STIR—The Experience Lab', an event hosted by a company called 'Advisory Board' in New York, where I joined 200 healthcare leaders to envision what's possible in healthcare. I also travelled to North Carolina to participate in workshops hosted by Vidant Health before heading to Boston where I met with the International Consortium for Health Outcomes Measurement to discuss patient-reported outcome measures. At the end of my trip I attended the values-based healthcare course at Harvard Business School which was inspiring to say the least.

One theme that dominated at all of these events was the importance of healthcare providers providing value to consumers. The term 'value-based healthcare' gets bandied around a lot, but what does it actually mean and how do we achieve it?

Michael Porter and Thomas Lee (2013) define value as 'improving health outcomes that matter to patients relative to the cost of achieving those outcomes'. Integrated care is a core component in delivering value-based healthcare and essential if we are to have any chance of transforming Australia's healthcare system to meet the increasing demand for care and associated costs.

Integrated care can only be properly achieved through the creation of multidisciplinary teams of healthcare professionals who are able to address the physical, psychological and social needs of the patient. It requires collaboration, communication and joint accountability with the team's common goal being to improve the patient's health outcomes with minimal waste of time and resources. The integration must occur across organisational boundaries, which is a challenge for health and other organisations.

A lot of healthcare systems are designed around a single disease or injury—an approach that doesn't meet the complex requirements of the ageing and high risk population. Rising rates of chronic disease and the prevalence of multiple co-morbidities means that it's essential for healthcare professionals to take into account a patient's complex medical, social and psychological conditions. Treating a single illness within a silo just doesn't work. We need a complete transformation of health delivery systems in Australia if we are to have any hope of increasing the value of care.

A colleague of mine recently told me the story of her father who had to undergo two major heart surgeries—a quadruple bypass and aortic valve replacement. At 69 years of age, he suffered from type 2 diabetes, asthma, high stress levels and had a history of strokes. When he was admitted to the cardiac unit it was discovered that he was on multiple medications resulting in drug interactions and a delay in the urgent surgery. One GP had prescribed blood thinners for his strokes while another GP had prescribed insulin for his diabetes along with a host of other medications. There had been no follow-up regarding his diet or any other preventive health measures. While in hospital his cardiothoracic surgeon revised his cocktail of medications but after being discharged he was once again left to his own devices. His diet deteriorated, he gained the 10 kg he had lost while in hospital, and his stress levels continued to increase his risk of suffering another stroke or heart attack.

This story is a clear indication of why it is so important to transform the way we organise and deliver care. Without providing holistic care that addresses a patient's complex requirements, we are effectively setting them up to fail.

Care must be delivered around the unique needs of each patient by a team of diverse clinical and non-clinical professionals. This team should assume responsibility for engaging the patient and their family, empowering them to take a more preventive approach to their health while focusing on treating not only the disease but also related conditions and complications. The team's overarching goal needs to be maximising the patient's health outcomes in the most efficient way possible.

All over Australia we are seeing innovative and integrated models of care emerging as more and more health professionals adopt new strategies to meet the needs of patients. The Medical Home Model ensures GPs are responsible for ongoing, comprehensive, whole-person medical care. In the 'medical home', patients and their families have an ongoing relationship with a GP supported by a practice team and other clinical services that 'wrap around' the patient and their family as required. The value of this model is achieved through a diverse team and an integrated approach.

We know we need to provide value-based healthcare. We know integrated care fits the value agenda. It's time to step out of our comfort zones and transform fragmented healthcare in Australia. ha

Reference

Porter ME & Lee TH 2013. The strategy that will fix health care. Harvard Business Review. October.

ALISON VERHOEVEN
Chief Executive
AHHA

Visitor from Finland

Risto Miettunen, CEO, Kuopio University Hospital, Finland, Treasurer, International Hospital Federation.

It was our pleasure in early March to host a visit from Risto Miettunen, who is Chief Executive Officer of the Kuopio University Hospital in Kuopio, Finland, and also serves as the Finnish representative on the Governing Council of the International Hospital Federation. He is also Treasurer of the Federation.

Finland ('land of a thousand lakes') is a country with a population of 5 million people in an area the same size as Germany (where the population is 85 million!). Kuopio, a lakeland harbour town, is the eighth largest city in Finland.

Despite its small population, Finland has no shortage of government. Although the national government, through the Ministry of Social Affairs and Health, has the highest decision-making authority, responsibility for provision of all health care services lies with 320 individual municipalities. Primary care is usually provided through municipal health care centres, secondary care through district and regional hospitals, and tertiary care through five university teaching hospitals, of which Kuopio is one. The system is mostly publicly-funded—the private sector is very small in comparison.

Unnecessary hospitalisations is a 'big issue' in Finland, just as it is in Australia, despite the differing levels of government responsible for health care services in Finland compared with Australia. Nevertheless, accusations of 'cost-shifting' among sectors and governments are part of daily health politics in Finland too!

Reform is on the way in Finland with the coming establishment of 18 new regions to replace the numerous municipalities.

Risto says he is looking forward to the development of 18 regionally-based integrated care systems in health to cut through and clarify the numerous care systems and levels that previously existed. The emphasis will increasingly be on primary and out-of-hospital care services—for example, the number of hospital beds available at Kuopio Hospital has steadily reduced from 750 beds down to 600 in the last five years.

Risto says this process has not been problem-free. For example, some older people being cared for in the community rather than in hospital will typically become anxious at night, and when they get anxious will come to the hospital for assurance, just in case there is something seriously wrong. This points to the need for better home care and better after-hours care services (a debate we are also having here in Australia).

As to his position on the Governing Council of the International Hospital Federation, Risto says that he represents his country as one of the hospital CEOs rather than on behalf of a national hospital association or professional group, as they do not have such a group in Finland.

Despite this dissimilarity, Risto and I agreed that health and health services issues are on the whole very similar between our two countries. This includes a gap in health between our nations' First Peoples and the rest of the population—but Finland's First Peoples, the Sámi (known in the past as Lapps), appear to have a slightly better life expectancy than other Scandinavians.

Of the estimated 50,000 to 65,000 Sámi inhabiting northern Scandinavia, about 7,500 are living within Finnish borders. They have inhabited the country for over 4,000 years, and 2,000 years ago they comprised the entire population of Finland. Land rights, sovereignty, self-determination, and retention of languages and culture are all issues shared with Australia and its First Peoples.

World Hospital Congress, Brisbane 2018

Opportunities to share similarities and differences between health systems from around the world will abound when, in October 2018, AHHA hosts the annual World Hospital Congress with the International Hospital Federation.

The Congress will be held in Brisbane from 10 to 12 October 2018, and will bring hospital and health service leaders from around the world to share views and experiences, network, and develop excellence in healthcare and hospitals leadership.

To keep up with news on the 2018 World Hospital Congress, please visit the AHHA website and subscribe to our mailing list. ha

Vale: Jeff Cheverton

A huge loss for primary healthcare in Australia.

It is with great shock and sadness that we pass on the news that AHHA Board member Jeff Cheverton died suddenly on 2 March. He was 49 years old.

Jeff's passing is a huge loss for the primary health care community. His enthusiasm, his drive, his 'can do' attitude and his continuing unwavering contribution to improving health and human services are not easily found or replaced.

Government, non-government, change management, system reform, aged care, disability, mental health, housing, and of course primary healthcare—Jeff had done it all, and with a vigour and commitment to equity, human rights, and economic empowerment that benefited not only clients, but organisations he worked for, the teams he led, and the many boards he sat on, including the Board of AHHA.

As an AHHA Board member Jeff represented us in the most engaged and exemplary manner, notably as our representative on the National Aged Care Alliance. In short, he did a lot for us. When Jeff was in the room things always became exciting and interesting, and solutions to seemingly impossible tasks suddenly became a whole lot clearer and 'do-able'.

We will miss Jeff, and our hearts go out to his partner Roddie, and to his family. ha

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

Aboriginal and Torres Strait Islander heart health program gets next stage funding green light

On 10 February, just under $8 million in government funding for Phase 3 of the Lighthouse Indigenous cardiac care project was officially announced by Minister for Aged Care and Indigenous Health Ken Wyatt. (*Note*: Lighthouse is a joint initiative between the Heart Foundation and AHHA. We announced the funding extension decision to readers in the February issue of *The Health Advocate)*.

The official Ministerial announcement was at Liverpool Hospital in Sydney's west, and also involved the newly appointed Minister for Health in New South Wales, Brad Hazzard.

Heart Foundation National CEO Adjunct Professor John Kelly commended the government, and Minister Wyatt in particular, on making closing the gap in cardiovascular disease a priority.

'This initiative will enable us to better achieve this by helping ensure that more Aboriginal and Torres Strait Island Australians receive appropriate evidence-based care in a culturally safe manner', Prof. Kelly said.

'Aboriginal and Torres Strait Islander peoples experience cardiovascular disease earlier than non-Indigenous Australians, it progresses faster and is associated with greater co-morbidities. Add to this more frequent hospitalisation and greater risk of premature death and the gravity of this issue along with the need to address it becomes clear.'

AHHA Acting Chief Executive Dr Linc Thurecht also welcomed the announcement, saying that Lighthouse 'drives change in hospital settings to improve care and outcomes for Aboriginal and Torres Strait Islander peoples experiencing Acute Coronary Syndrome (ACS)'.

'Aboriginal and Torres Strait Islander Peoples are more likely to be admitted to hospital for ACS episodes—heart attack or angina—and are more likely to die in hospital as a result of these episodes.

'But while in hospital, Indigenous Australians are less likely than non-Indigenous Australians to undergo coronary tests and procedures. And they are also more likely to leave hospital against medical advice.

'Hospitals have a critical role to play in improving access to evidence-based care and reducing disparities in care. Together with reducing self-discharge rates, these improvements will lead to better patient outcomes as well as resulting in long term savings to hospitals and the health care system', said Dr Thurecht.

Phase 3 will also focus on improving the integration of health services and care coordination by enhancing relationships between hospitals, local Aboriginal Community Controlled Organisations and Primary Health Networks.

Australian Senate should restore child dental funding

On 7 February 2017, AHHA publicly urged the Australian Senate to disallow the federal government's December 2016 decision to reduce the two-yearly maximum Medicare-claimable amount for child dental care under the Child Dental Benefits Schedule.

'The Australian Senate has an opportunity to work together and restore public dental funding for Australian children', AHHA acting Chief Executive Dr Linc Thurecht said.

'While we welcomed the government's 15 December 2016 commitment to continue public funding for child dental health through the Child Dental Benefits Schedule, we did not welcome the government cutting funding from Medicare funded child dental care.

'The government's proposed $300 cut per eligible child reduces the amount of dental care the schedule provides over two years to $700 per child rather than $1,000 per child.

'The government's own figures show that for about 1 in 5 children using the schedule more than $700 per year is being spent.

'In many cases, children most affected by the reduction in funding will be those with the greatest dental need', Dr Thurecht said.

The National Oral Health Alliance's modelling of costs showed that over a two-year period children were likely to need:

- between $410 and $460 of care if at low risk of dental caries;
- between $758 and $1,123 of care if at moderate risk; and
- up to $2,050 worth if in the highest 10% need group.

'The $700 cap will not provide enough care for children with either moderate or high need', said Dr Thurecht.

'Funding has never been generous for public dental health, so we call on the Senate to restore public dental funding for Australian children most in need—often from families least able to afford it.

'Restoring public dental funding will help parents provide needed care for their children rather than delaying treatment because of a lack of money.'

AHHA in the news

Pulling teeth nothing compared with extracting a commitment to public dental funding

At the 9 December 2016 Council of Australian Governments (COAG) meeting there was no announcement from the Commonwealth on continuing funding for public dental health—despite the then-current arrangements with the states and territories being due to expire by 31 December. We issued a media release showing our extreme concern.

'Public dental services will soon be in disarray thanks to Commonwealth Government stalling on funding for the Child Dental Benefits Schedule and the National Partnership Agreement on oral health that runs out in 3 weeks' time', said AHHA Chief Executive Alison Verhoeven.

"Funding has never been generous—but certainty should not be too much to ask."

'The last Federal Budget anticipated that funding for the Child Dental Benefits Schedule and a National Partnership Agreement on oral health would be wound up and replaced by a new Child and Adult Public Dental Scheme.

'This requires legislation, but that has not happened. In the meantime the reality on the ground is that funding ceases on 31 December, and public dental services are in limbo and starting to wind down services and lay off staff because salaries and operating costs cannot be guaranteed beyond the end of this year.

'The Government has said they would be in contact with the states and territories, and would be providing details on the rolling over of funding for a further period—but we have not yet seen any signs of this.

'Today's COAG meeting would have been the ideal opportunity to consult with the states and territories, but it appears that once again, oral health funding has been overlooked.

'Funding has never been generous—but certainty should not be too much to ask.

'Please let's have a commitment to at least continuing funding for public dental services at current levels until long term solutions can be agreed on in the Parliament', Ms Verhoeven said.

A poor Christmas for people relying on public dental services

On 15 December 2016 the Commonwealth Government announced the continuation arrangements for public dental funding, but they included harsh cuts. We joined many others in the media in stating our opposition.

'Public dental services are set to be severely compromised thanks to the Commonwealth Government's slashing of funding for public dental health services for the next three years', AHHA Chief Executive Alison Verhoeven said.

'It's harsh and particularly heartless that the government has seen fit to compromise the dental health of those Australians least able to afford proper dental care'.

'Today's announcement provides a fortnight's notice to the states and territories of a massive cut to public dental funding—down to less than $107 million per year for the next three years for adult public dental health services.

'The original Budget measure in 2013-14 promised $391 million in 2016-17', Ms Verhoeven said.

'This [was] reduced…to about $155 million in calendar year 2016.

'Now it's down to less than $107 million per year. This will result in as many as 338,000 people losing access to public dental services from next year.

'We welcome that the government has committed to continue public funding for child dental health through the Child Dental Benefits Schedule.

'But we do not welcome that funding per child is to be reduced…with a cap of $700 per child (previously $1,000)' [over two years].

'So, from now on their parents will have to find the extra money. For many the only viable alternative will be not to have the treatment needed.'

'How little the government must think of these kids—or care', Ms Verhoeven said.

Researchers 'rattle cages' in February 2017 issue of *Australian Health Review*

On 2 February 2017 we released the then latest edition of *Australian Health Review*, with AHR chief editor, Professor Gary Day, saying AHR contributors had 'rattled a few health and health services cages' as well as 'being prepared to dig into and question a variety of issues in health'.

One research team, from Sydney and Wollongong universities, used mapping techniques to graphically show accessibility and care provision gaps in mental health services in the Western Sydney Local Health District.

Another team from Victoria looked into the actual environmental impact, through energy and water use, of steam sterilisers, which have been an integral and effective component of hospital health care for over 75 years.

A Melbourne University research group investigated private paediatric care in Melbourne in terms of availability of appointments, waiting times, and the dollar cost to patients of that care—which the team found to be 'considerable'.

'Australia's health workforce has not escaped scrutiny', Professor Day said, with one study 'considering in some detail, quantitatively and qualitatively, the adequacy of Western Australia's rural surgical workforce, both now and into the future'.

Another study looks into the costs and returns on investment of training psychologists in cognitive behavioural therapy for social anxiety disorder.

In the safety and quality area, a team from South Australia investigated how to screen for unwarranted variations in clinical practice by examining processes of care, costs and outcomes. This could prove to be incredibly valuable in health care, where no two cases are exactly the same but consistent high standards and practice are a must—patients are not easily able to vote with their feet when they feel a service is not up to scratch.

Another interesting study was a systematic analysis of the effects a research culture in a health service organisation had on the provision of services. Broadly the authors found that it had a very positive effect.

'We like to think that encouraging and publishing research ourselves has a positive effect on the way we engage with our stakeholders and members, and perform our various functions on their behalf', Professor Day said.

Return of $1,000 child dental benefit cap welcome—but what about the adults?

On 8 February 2017 the government bowed to pressure and restored the child dental funding cap to $1,000 over two years. AHHA welcomed the decision by Health Minister Greg Hunt, and urged him to similarly turn his attention to previously-announced reductions in adult public dental funding.

'Last December the government reduced the 2-year maximum amount claimable per child under the Child Dental Benefit Scheme from $1,000 to $700. AHHA acting Chief Executive Dr Linc Thurecht said.

'Along with colleagues at the National Oral Health Alliance and the Australian Dental Association, we argued strongly that the children most affected by the reduction in funding would be those with the greatest dental need, and we were pleased to see members of the Senate yesterday give notice of motion to disallow the cut.

'Modelling by the National Oral Health Alliance showed that children in the top 10% highest need group would be likely to need up to $2,050 worth of dental work over two years, and children at moderate risk would need up to $1,123 worth of work.

'Minister Hunt's decision will help parents to continue to provide needed dental care for their children rather than delaying treatment because of a lack of money.

'Also, attending to problems early will help reduce dental care needs and costs for these children in the longer term.

'Early intervention is a principle of prevention, which the Turnbull government has stated will be an area of focus in government health policy in 2017', Dr Thurecht said.

'The government now needs to apply the same principle to adult public dental health services.

'Last December the government provided less than a fortnight's notice to the states and territories of a significant cut to public dental funding—from $155 million in calendar year 2016 down to less than $107 million per year for the next three years.

'This will result in many Australian adults putting off needed treatment because they cannot afford it, which will lead to more severe problems later on.

'This is preventive health in reverse. We urge the government to be true to its stated focus on preventive health so that Australian adults who can least afford dental care can receive it.

AHHA welcomes Greg Hunt as new Health Minister

On 18 January 2017 Greg Hunt was announced as the new Health Minister following the resignation of the previous Health Minister, Sussan Ley. Ken Wyatt was also elevated to Cabinet as the Minister for Aged Care and Minister for Indigenous Health.

'We congratulate Greg Hunt on his appointment as Health Minister, and very much look forward to working with him', AHHA Chief Executive Alison Verhoeven said.

'Greg Hunt is seen by his peers as a safe pair of hands, and a good performer. We are hoping that he will bring to the job a coordinated and considered approach to health policy, supporting a strong public sector as well as the private system, but always having regard to equity and affordability for patients.

'Unfortunately, some policy decisions in the recent past, designed to streamline the system and save money, for example the freeze on Medicare rebates, have had their own side-effects of significant increases in out-of-pocket costs, and patients delaying seeking medical care as a result.

'Delays in seeking care can lead to higher costs later on for the health system if that patient presents later in a worse state of health through lack of medical attention', Ms Verhoeven said.

'The positive Health Care Homes primary care reform initiated by the former Minister Sussan Ley will continue, but there are also substantial associated risks with this, including the funding of the program, its design, and its supporting e-health and data infrastructure.

'Mr Hunt must consider these issues as the 2017-18 budget is formulated. The Health Care Homes reform must deliver positive results for governments, health services and consumers, or it will go the way of previous primary care reform attempts.

'In addition to primary care reforms, private health insurance reforms are pressing—neither the government (via its subsidisation of private health insurance premiums), nor consumers, are getting value for money, and a proposed rise in premiums is up for consideration in the immediate future.

'An agreement with the states and territories on public hospital funding beyond 2020 also requires urgent attention. Further, public dental funding is woeful and there is almost no preventive health agenda—both of which have long term consequences for individual health and wellbeing, as well as for overall health expenditure.

'Healthcare and hospitals are crucial services for all of us, while also being resource-intensive for the nation.

'The best leaders in health, in fact the best leaders generally, are genuinely consultative and collaborative, and good negotiators. They draw on robust evidence in making decisions; and ensure that their decisions are aligned to an overarching vision and strategy, and to stakeholder and electorate values.

'Any Minister taking this approach will almost certainly avoid most of the hard lessons learned by previous health ministers.

'It's also pleasing that Ken Wyatt has been given formal ministerial responsibility for Indigenous health, and we look forward to his leadership in this most important and concerning area.' ha

Partnering with Consumers 2017 | Workshop 1

An experience based co-design masterclass

Date: 25 May 2017

Time: 8:30am - 5:00pm

Venue: PwC Office
2 Riverside Quay
Southbank, Melbourne

Cost: $120 - CHF & AHHA Member
$250 - Non-member

The Consumers Health Forum of Australia (CHF) and the Australian Healthcare and Hospitals Association (AHHA) are pleased to present the first workshop in our 2017 Partnering with Consumers Series - an experience based co-design masterclass.

Experience Based Co-Design

This Masterclass will provide participants with an understanding of the evidence, benefits and a range of effective tools and approaches to engage staff, consumers and family members to co-design health and care services.

Participants will increase their understanding in the following areas:

- The context, value and evidence base for working closely with patients and their families;
- Awareness of a staged process to engage staff and patients, capture their experiences, organise and identify themes for improvement and to co-design future services;
- Increased knowledge of a range of specific customer service design methods including observation, shadowing, interviewing, emotion mapping and co design; and
- Measurement of improvements which incorporate the emotional context of experiences.

The masterclass will include presentations, group work, discussions and case study examples so that participants can maximise their learning.

More information and registration at www.ahha.asn.au/events

Who Should Attend?

Anyone interested in developing their skills in engaging meaningfully with consumers and particularly those involved in creating health services will find this workshop of interest. Specifically:

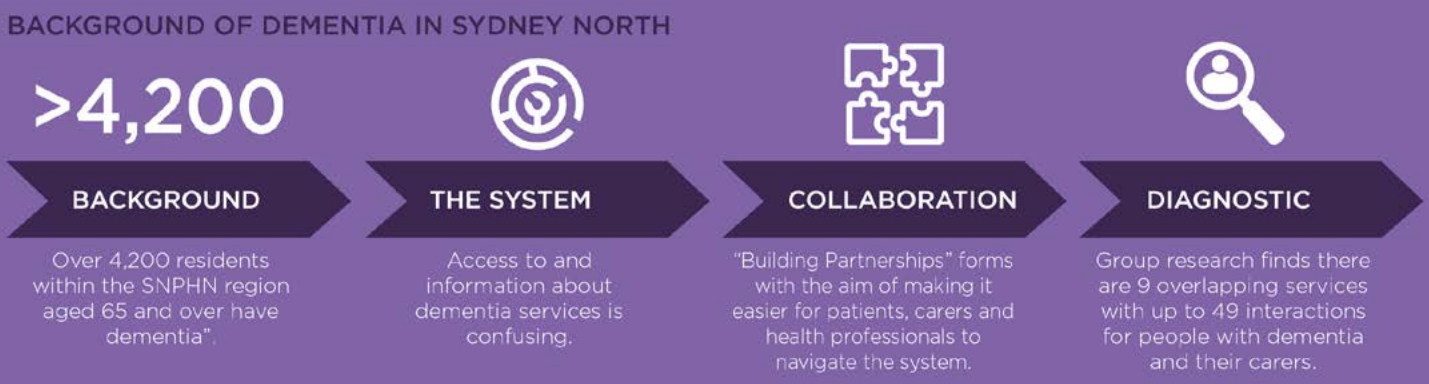
- Primary Health Network staff and hospital executives responsible for planning and commissioning;
- Consumer advisers to PHNs and hospitals including staff as well as committee or councils representatives;
- Chairs and other representatives of PHN and hospital consumer and community advisory committees;
- Researchers with an interest in co-creation approaches to health system and service development would be other interested parties.

PHN and hospital staff are strongly encouraged to attend with a consumer representative.

Sponsored by: pwc

Dementia: better journeys

A collaborative partnership between the **Northern Sydney Primary Health Network, the Northern Sydney Local Health District,** and community-based health services, is resulting in a better journey for people with dementia and their carers.



In the Northern Sydney region, a unique collaborative partnership is beginning to improve the journey for people living with dementia and their carers. Results are being achieved through a strong focus on better healthcare integration and delivery of dementia care in the region.

Dementia Better Journeys is a collaboration between the Northern Sydney Primary Health Network (NSPHN), Northern Sydney Local Health District (NSLHD), Alzheimer's Australia NSW and Community Care Northern Beaches (CCNB) with representation also from a consumer. The collaboration was formed with support from the NSW Agency for Clinical Innovation's (ACI) 'Building Partnerships' initiative, and aimed to strengthen access and navigation of dementia health services. While a wide range of dementia services exists in Northern Sydney, information is difficult to find, and access to the services is confusing for both consumers and healthcare professionals.

Like many parts of Australia, the Northern Sydney region has an ageing population, with dementia being identified as a rapidly growing contributor to the total burden of disease. The federal seat of Bradfield, which takes in the 'leafy' suburbs of St Ives, Killara, Lindfield, Roseville, South Turramurra, Wahroonga, Waitara, Hornsby and Asquith, currently has the fifth-highest prevalence of dementia in the state. By 2021, it is projected that 23% of people living in the area aged over 75 years will be affected by the condition. Dementia causes severe and impaired memory loss as a result of disorders affecting the brain.

People with dementia are also relatively high users of acute hospitals. In Australia, the mean length of stay for all hospital separations is 8.6 days, compared with a mean of 19.6 days for any diagnosis of dementia and 30.1 days for separations with a principal diagnosis of dementia (Draper 2007).

In the early stages of the collaborative project, diagnostic and gap analysis activities were undertaken using the Patient Journey Modelling essomenic methodology. Local services were mapped by conducting three focus groups comprised of subject matter experts, including local geriatrician Professor Susan Kurrle, as well as community members and health professionals. The groups recommended 60 areas for improvement.

One of the key recommendations was to improve the transfer of care and communication for people with dementia leaving hospital. Limitations in information-

Bec Lewis: blimaging.com.au

sharing between the acute and primary care settings, as well as communication delays, were negatively affecting patients' health outcomes, particularly after hours.

The NSPHN commissioned a brand new service 'first': a Hospital Discharge Referral Service. It was designed to support people with dementia after leaving hospital and reduce the likelihood of re-admission and impact on after-hours 'crisis' presentations. Two local providers of community support services, Kincare and Just Better Care (JBC), were commissioned to provide the Hospital Discharge Referral Service across the region.

JBC has begun working with public and private hospitals in the Hornsby local government area and has implemented the 'Stay at home' program to assist people with dementia to stay in their own homes and avoid re-admission to hospital.

Kincare's 'Remember me' program allows the smooth transition of a person living with dementia from hospital to home. It is being run in conjunction with public hospitals in the region, including Ryde, Royal North Shore, Mona Vale, and Manly, as well as private hospitals.

Both programs have delivered strong results: every patient referred to the program has progressed well with the support of their General Practitioner (GP) and other services, with no subsequent re-admissions to hospital.

"Dementia causes severe and impaired memory loss as a result of disorders affecting the brain."

The collective expertise of the partnership has also resulted the creation of an information booklet, *Memory problems*, for consumers and health professionals. The 8-page booklet features educational information on topics such as: the stages of dementia and what to expect; local support groups; services to help at home, for the person with dementia and their carer(s); financial advice; legal matters; planning for the future; and palliative care services.

Another key focus of the partnership is to better support and build capacity in General Practice—GPs play an integral role in a patient's timely diagnosis and ongoing management.

Research shows that it usually takes an average of three years for a formal diagnosis of dementia to take place. To reduce timeframes for diagnosis, the collaborative is currently working with the Improvement Foundation on a set of dementia quality indicators. These indicators will support best practice in early detection, diagnosis and management of dementia in primary care, and will be used to create a national quality program for dementia management.

The NSPHN is also building its first online diagnostic and management support tool—HealthPathways. Designed for GPs and primary care providers, one of the HealthPathways will provide clinical and local services information about dementia.

The Dementia Better Journeys collaborative has so far created real change in the lives of many people living with dementia and their families. Through providing practical and sustainable solutions, the collaborative has successfully provided better access to care and prevented re-admissions to hospital for people with dementia, which will continue into the future. ha

ABBE ANDERSON
Chief Executive Officer,
Brisbane North PHN

Lab-testing integrated care, from a PHN perspective

Experiments in the shared space between the acute, primary, aged and community care sectors.

Integrated healthcare—putting it into practice

The academic argument in favour of a more integrated healthcare system is well established, but less well understood is how this lofty goal should be put into practice.

Herein lies one of the great advantages of Primary Health Networks, which are uniquely positioned to experiment in the shared space between the acute, primary, aged and community care sectors.

Brisbane North PHN is a Primary Health Network that supports clinicians and communities within North Brisbane, Moreton Bay and parts of the Somerset region, with a population of over 900,000.

The PHN's Team Care Coordination program was one of the first truly integrated care programs in the country, and continues to support GP patients with complex chronic conditions today.

Team Care Coordinators are Registered Nurses who can assist GPs to assess a patient's health and care needs and can arrange the services the patient needs to stay healthy and active.

A Queensland Health study into the initial program trials found avoidable hospital admissions for the targeted patient cohort were reduced by 26%. It also found that patients would benefit from a shared electronic health record (SEHR).

An SEHR system was subsequently set up around 10 years ago, allowing local GPs to share patient health summary information with hospital clinicians and vice versa.

Building on this success, the Queensland Government announced the 'Staying Healthy, Staying Home' initiative in September 2015 to extend the Team Care Coordination model-of-care to accept referrals from public hospitals in our region.

Integrated care increasingly the norm for complex chronic conditions

Integrated care models are now increasingly the norm in the care of people with complex chronic conditions. Examples include the Integrated Team Care program, which provides funding to Close the Gap in Indigenous health outcomes, and the Coordinated Veterans' Care program.

Our organisation has partnered with the Institute for Urban Indigenous Health to deliver our Closing the Gap program, which includes Integrated Team Care, as well as community aged care, mental health, and alcohol and other drug treatment services.

There is a significant Aboriginal and Torres Strait Islander population of around 14,000 people in North Brisbane and, in the last financial year, the Institute for Urban Indigenous Health delivered services to around 800 patients through the former programs that were merged to form Integrated Team Care.

The PHN has also partnered with the Metro North Hospital and Health Service (HHS) and other stakeholders to deliver various initiatives aimed at increasing care integration in our region.

Collaborative consortia

One of the more successful strategies we have implemented is to engage our stakeholders, including peak bodies and consumer and carer representatives, in collaborative consortia.

One of these consortia is a Regional Assessment Service, the sole focus of which is to assess the eligibility of older people for aged care services across the Brisbane North, Brisbane South and Caboolture regions.

We also lead a consortium that delivers Commonwealth Home Support Program (CHSP) services within the Brisbane North PHN catchment.

In addition to service delivery, the members of both consortia work to identify opportunities to better integrate aged care and healthcare services.

Late last year we hosted a workshop with residential aged care providers to look at the ways we could work together to improve systems of care and reduce preventable hospital admissions.

These themes will be reflected in a region-wide 'older persons plan' we are

Residential aged care professionals at a Brisbane North PHN workshop discuss ways to improve systems of care and reduce preventable hospital admissions, 26 October 2016.

Aged care professionals at Brisbane North PHN's annual community aged care forum, 8 September 2016.

Aged care consortium members meet with the Australian Government Department of Health, 19 February 2016.

developing with the Metro North HHS, which will cover all services used by older people across the entire continuum of care.

Another project to arise from these consortia is our Aged Care Transition Collaborative, which aims to enhance the patient journey between the acute and community sector by improving communication, and developing systems and processes to improve collaboration.

We are also supporting consortium member Burnie Brae Ltd to trial a personal carer-led, aged care in-home wellness program.

Trial participants are selected from existing CHSP consortium clients and undertake 18 weeks of regular in-home exercise training, incorporating activities targeted toward improving and maintaining their capacity in activities of daily living.

By training personal care workers to deliver this program, we believe it can be provided safely and cost-effectively to a larger number of participants than would have been the case otherwise.

We also continue to lead the North Brisbane Partners in Recovery (PiR) consortium, which supports people with severe and persistent mental illness with complex needs, and their carers and families.

Integration is central to PiR because its focus is to encourage the multiple healthcare services and human services agencies, with which participants have contact, to work in a more coordinated and integrated way. ha

Very recently, we released *Steady, invested, strong—a consortium and commissioning toolkit* to tell the story of collaborative work we have undertaken in conjunction with our partners through our three consortia. The Toolkit is available for download free of charge here: www.consortium-commissioning.org.au

Co-design for integrated service delivery

An integrated mental health and drug and alcohol program delivered through a Social and Emotional Wellbeing model.
Northern Territory PHN

Aboriginal and Torres Strait Islander peoples in the Northern Territory (NT) with co-morbid mental health disorders are receiving integrated care delivered through a Social and Emotional Wellbeing (SEWB) model.

In response to a community need for mental health, and drug and alcohol services, Northern Territory PHN (NT PHN) and partners from the health sector are delivering the integrated program, which began operations in March 2017. Increased coordination to deliver drug and alcohol treatment services across sectors will improve outcomes for Indigenous people with, or at risk of, mental illness and/or suicide.

The SEWB model reflects Aboriginal and Torres Strait Islander holistic philosophy where health encompasses the physical wellbeing of a person, and the social, emotional and cultural wellbeing of the community[1]. The model is guided by the National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing, and is endorsed by both the Commonwealth and NT governments.

The integrated program centres on three streams of care for mental health, and drug and alcohol services: medical, therapeutic and social. Applying the SEWB model helps ensure that treatment is targeted and culturally appropriate. The medical stream of care is delivered through primary health care clinics to ensure access. Northern Territory PHN (NT PHN) has commissioned the therapeutic and social streams to complement the model.

'The program was co-designed with key stakeholders to ensure relevance to NT, and ensure that it had the flexibility to be applied to differing local circumstances', said Le Smith, Executive Manager, Regional Partnerships and Procurement.

'Initially, NT PHN conducted a needs assessment and mapped existing services from 84 clinics to identify communities most in need.'

'When we commission health services, our major focus is always on improved health outcomes for consumers', Ms Smith said.

Stakeholders were engaged through specialised NT Aboriginal Health Forum working groups. Provider expertise and experience with drug and alcohol services, and NT services and issues, was also incorporated.

'Working with key partners has helped us to develop a comprehensive understanding of the local service system, service gaps and community needs', Ms Smith added.

NT PHN CEO, Nicki Herriot says that the organisation's vision is for the NT population to enjoy their best health and wellbeing.

'To achieve this, we are continuing to collaborate with regional health professionals and the community to plan and design integrated high quality services that truly meet the community's health needs.'

'The successful co-design of the integrated mental health and drug and alcohol program is a great example of this.' ha

Reference

1. Australian Indigenous HealthInfoNet 2013. Social and emotional wellbeing (including mental health). Accessed 6 February 2017, <www.healthinfonet.ecu.edu.au/other-health-conditions/mental-health/reviews/background-information>.

“Increased coordination to deliver drug and alcohol treatment services across sectors will improve outcomes for Indigenous people with, or at risk of, mental illness and/or suicide.”

Northern Territory PHN

Northern Territory PHN is a partnership between Aboriginal Medical Services Alliance Northern Territory (AMSANT), the NT Government Department of Health, and Health Providers Alliance NT (HPANT).

Through commissioning the delivery of health services, providing support to the primary health care workforce and working to support integration across the acute and primary health care sectors, we help Territorians receive the right health care, in the right place, at the right time.

While the Northern Territory covers a large area (1.3 million square kilometres), it is sparsely populated with approximately 245,000 people, including a significant constituency of Aboriginal people. To provide effective coverage of this area, NT PHN has offices in Darwin and Alice Springs.

Photo by Cristian Newman

ANTHONY TASSONE
President (Victorian Branch),
Pharmacy Guild of Australia

Pharmacist Chronic Disease Management pilot program

Early this year the Victorian Government announced a new Pharmacist Chronic Disease Management pilot program.

It is a major—and very welcome—step forward in helping patients across the State manage their chronic conditions and medication in four priority areas: management of hypertension, elevated cholesterol; asthma; and anti-coagulation (or blood thinning) medicines.

In Victoria more than one-half of all visits to GPs currently involve the management of at least one chronic condition.

This pilot program is especially important because it more fully uses the skills and expertise of community pharmacists in chronic disease management, as part of a GP-led healthcare team. In each team the pharmacist will be an associate or employee of a pharmacy that the general practice has an established relationship with.

Having community pharmacies working in collaboration with GPs to further enhance patient care means patients will be able to better and more easily access the healthcare they need when they need it.

Pharmacists are the most accessible healthcare professionals, and pilot programs such as this one will ultimately be assessed on how they can help chronic condition sufferers get easier access to professional help. Pharmacies are the most-visited and accessible primary care destination in Australia—about 87% of the Australian population lives within 2.5 km of a community pharmacy.

This program is a good example of better using community pharmacy infrastructure and medicine experts—community pharmacists—to help provide accessible and timely healthcare for the community. The team-based approach of pharmacist and GP working together also gives patients the best possible chance of beneficial health outcomes.

Patients will benefit by having a tailored care plan led by the GP, with pharmacists helping to provide a range of services including regular monitoring, dose refinement, earlier intervention, and prompt

Photo by Joanna M. Foto

A welcome step forward in GP–pharmacist integrated care.

referral to their GP for resolution of any issues associated with management of their chronic condition, and/or associated medication.

The Pharmacy Guild of Australia therefore congratulates the Victorian Minister for Health, Jill Hennessy, on her initiative, which demonstrably recognises the great value of community pharmacies in helping deliver positive health outcomes for the people of Victoria.

The pilot program also showcases the role of community pharmacists as members of the broad healthcare team, and that the high accessibility of community pharmacies is important to chronic illness patients, for whom travel may be difficult.

"Pharmacists are the most accessible healthcare professionals, and pilot programs such as this one will ultimately be assessed on how they can help chronic condition sufferers get easier access to professional help."

The Pharmacy Guild has been closely involved in the development of this program from the beginning, when the Department of Health and Human Services established an External Advisory Group that included representatives from medical, pharmacy, health and consumer groups, including the Australian Medical Association, Royal Australian College of General Practitioners, the Pharmacy Guild of Australia, the Society of Hospital Pharmacists of Australia, the Pharmaceutical Society of Australia, the Victorian Primary Health Network Alliance, National Heart Foundation, the Asthma Foundation of Victoria and the Australian Health Practitioner Regulation Agency.

This group provided advice on the chronic conditions and therapies to be included in the pilot, patient selection and eligibility, care plan design, training of pilot site pharmacists and evaluation of the pilot.

The group's work has also been pivotal in assisting and advising the Department of Health and Human Services and the Minister for Health (Victoria) in developing and implementing the program.

When the program was first mooted in 2015 there was a degree of resistance by some medical groups. Since then, however, the involvement of organisations like the AMA and the Guild in the Expert Advisory Group has led to a very close and collaborative working relationship in the interests of patients.

At the Guild we look forward to continuing to work closely with all stakeholders to ensure patient care is improved through a team-based approach, and we are confident that this program will help reduce the burden of chronic disease in Victoria. ha

The Hunter Alliance

Bringing the primary and tertiary sector together to transform healthcare.

The Hunter Alliance is a partnership that allows sharing of the unique abilities, knowledge and specialist skills of major health care providers across the Hunter Region.

The Alliance is led by a team of specialist senior health clinicians and executives from the Hunter New England Central Coast Primary Health Network, the Local Health District, Calvary Mater Newcastle public hospital, and Hunter Primary Care.

The impetus for the creation of the Alliance was the unsustainable burden of chronic disease facing our local health system. We examined a broad range of population health data to identify the top three problems. These are:

- Diabetes
- Chronic Obstructive Pulmonary Disease (chronic breathing difficulties)
- Care in the last 12 months of life.

The Hunter Alliance approaches the management and treatment of these conditions from a true partnership perspective. All organisations completely share responsibility for developing innovative ways to improve people's healthcare in these three areas. There is no 'blame-shifting' as everyone has 'skin in the game'.

The Diabetes Workstream

A good example of the Alliance's success is demonstrated by the Diabetes Workstream project, which won the Integrated Health Care category of the 2016 NSW Health Awards.

Diabetes Workstream has been successful in improving outcomes and experience of care for patients with Type 2 diabetes (T2DM) by integrating care provision within the patient's own general practice team.

> **"Diabetes Workstream has been successful in improving outcomes and experience of care for patients with Type 2 diabetes (T2DM) by integrating care provision within the patient's own general practice team."**

The project is a collaborative partnership between key clinicians (private and public), consumers, Diabetes NSW and health service managers, using a new model of care focused on the patient's needs.

The project was piloted in 8 randomly selected GP practices out of 15, after calling for expressions of interest. As a result of positive feedback from both clinicians and patients, with encouraging initial clinical outcome improvements, a further 12 practices participated in 2016.

General Practices recruited 30 patients at moderate-to-high risk of complications to participate in case conferences of 40 minutes with their own GP, the practice nurse, visiting endocrinologist and diabetes educator. During the integrated consultation an agreed management plan involving treatment options and individual lifestyle preferences were discussed and implemented. All follow-up was undertaken by the patient's primary care team.

Evaluation

This project has provided a practical on-the-ground example of how integrating care successfully leads to a seamless, person-

Hunter Alliance diabetes team case conference

centred approach that can be delivered in a flexible manner to benefit patients, clinicians and healthcare systems by developing strong relationships between primary and tertiary care teams.

The integrated care clinics have allowed an understanding of the issues and barriers faced by both systems, which in turn has supported a review and co-design of referral criteria. This ensures that appropriate care based on the patient's risk is delivered in the right place at the right time.

A sub-analysis of 64 patients seen with seen with glycated haemoglobin (HbA1c) levels levels at >7% found that 75% improved. Around one-half (51%) of patients seen had lost weight and 100% of clinicians involved felt the experience was 'satisfying' or 'very satisfying'. Patients reported feeling involved, comfortable and supported.

Future prospects

During consultations primary care clinicians received intense 'upskilling' that has enabled them to work at the top of their scope of practice, which has a benefit for all of their patients with T2DM. We anticipate that the repeated yet variable nature of the many consultations will continue to build skills and knowledge in the primary care team that can be used in managing new or additional patients with T2DM in their practices.

An innovative funding model using existing MBS item numbers has been implemented, and has demonstrated that adequate remuneration for both the primary and tertiary care teams is available to sustain the model.

There have been many process improvement changes identified and implemented by primary care teams as a direct result of the project. For example:

- establishing diabetes-nurse-led clinics to ensure that all annual cycle-of-care requirements are completed thoroughly.
- using recall systems to identify 'at risk' patients.
- identifying and using diabetes 'champions' within practices with 'protected time' available to monitor data and develop response processes (PDSA cycles).

The acceptability and success of this integrated care model has resulted in many more general practices registering their interest to participate in both metropolitan and rural areas.

There is every reason to be confident that the model is transferable to other health services with diabetes specialist teams, and may also be applicable to other chronic disease conditions. ha

Scott White, Communication Manager, Hunter New England Central Coast Primary Health Network

KATE SILK
Policy Analyst, AHHA

GEOFF CHIN
Associate Director,
Patient Access and Healthcare
Systems, Novartis Australia

Integrated care for heart failure patients

New program in Tasmania aims to improve care and stop the 'hospital revolving door'.

Extent and costs of heart failure

Chronic heart failure remains a major public health issue despite advances in clinical management. Heart failure is the most common cause of hospitalisations in people over 70 years of age internationally. In Australia there are an estimated 30,000 people diagnosed with the debilitating condition and approximately 300,000 patients living with the condition every year.

Apart from poor prognoses, hospital admissions impose considerable financial burden on the healthcare system. Recurrent hospitalisations cost the national economy more than $1 billion each year. The total annual cost of managing heart failure is much higher and estimated to be more than $2.5 billion.

Tasmania has higher rates of heart disease than the rest of Australia, with around 38,600 Tasmanians estimated to have at least one heart condition. Heart failure is among the top 6 diagnoses of preventable hospitalisations in Tasmania, with 1,295 potentially avoidable hospital separations at an average length of stay of 5 days in 2014-15.

Heart failure imposes both direct costs to healthcare systems and indirect costs to society through morbidity, unpaid care costs, premature mortality and lost productivity.

The case for integrated care

Despite significant advances in medical management of heart failure, prevalence remains high, outcomes are sub-optimal, and financial and emotional costs are significant. Indicators suggest case detection and diagnosis is poor, care is inconsistent and disconnected, and hospital admissions are frequent.

Integrated care involves the provision of seamless, coordinated effective and efficient care across the disease continuum, and is important in helping individuals to self-manage, keeping people healthy, independent and out of hospital for a long as possible.

The need for, and increasing emphasis on, this kind of care model has grown with the rising prevalence of multiple risk factors for chronic disease, and multiple chronic and complex conditions. In this type of health environment, a strong focus on integrated care among preventive, primary, acute, aged and disability care health professionals can bring significant benefits to patients. Programs necessarily should match needs and local system capacity, including the

flexible use of local healthcare professionals.

Heart failure is strongly associated with co-morbidity and multi-morbidity, leading to increased healthcare utilisation and high mortality. It is therefore ideally suited to integrated care.

Enabling patients to access integrated care for their heart failure ensures that their care is consistent, is person-centred and that there is early recognition of deterioration or change, thus improving service responsiveness and patient outcomes.

How the new Tasmanian program will work

A new program to improve care and stop the 'hospital revolving door' for Tasmanians with heart failure will begin in February 2017. It is the result of a partnership between Primary Health Tasmania, the Tasmanian Department of Health and Human Services, Heart Foundation Tasmania, the Australian Healthcare and Hospitals Association and Novartis Australia. The collaboration seeks to better integrate primary and acute care, using a 'community of practice' approach to address gaps in care of patients with heart failure.

The program focuses on supporting a system of integrated community care involving general practitioners, practice nurses, specialist heart failure nurses, pharmacists and allied professionals, all trained and equipped in their work to manage the condition.

This project examines the effect of providing targeted education and support for general practitioners and practice nurses to assist with the management of patients with heart failure. It particularly focuses on improving the coordination of care between the specialist, hospital and general practice, enhancing care continuity to help transitions between acute and primary care to be as seamless as possible.

The project interventions include:

- improving workforce capability in the management of heart failure, through targeted education and enhanced support
- improving linkages between acute and primary care, through improved utilisation of the Tasmanian HealthPathways web portal, and shared transfers of care
- promoting the use of low-health-literacy tools for individuals living with heart failure, to support better self-management. ha

DAVID CAMILLERI
Executive General Manager
mi-Clinic

The role of technology in integrated care

Technology can be a key enabler of true integrated care—but it is not a magic bullet.

Image source: Flickr: DFID UK Department for International Development

How technology can help

In healthcare, like most fields, technology has become a key component of achieving *organisational* outcomes, including with integrated care.

When quality operational activities and procedures underpin integrated care, everyone knows what they are doing, and what the processes are at organisational interfaces. They are also committed to and talking about improvement—sometimes under the guidance of a framework such as ISO certification.

That, in turn, can have a direct impact on patient outcomes.

It's not hard to list the ways in which technology can help teams to integrate care, from sharing information to laying out protocols and alerts for exceptions, monitoring results, facilitating joint decision-making, remote patient monitoring and of course telehealth.

For patients, technology can also help with patient engagement by providing information tailored to that patient in terms of test results, education or self-monitoring.

If you are making the move to integrated care, ideally operational processes, outcomes and requirements should be considered at the outset, with the technology as an enabler, rather than the processes being tailored to what 'the system' can cope with.

In the real world, it may be that only some technological aspects of integrated care can be automated, while others remain independent and rely heavily on paper-based, phone or face-to-face communications processes.

Whatever the method, integrated care requires all people caring for a particular person to have access to the relevant information about that patient and his or her treatment, regardless of where the patient is being seen and who is seeing them.

Integration can extend to back-end processes between multidisciplinary teams, including IT systems, reporting systems, patient bookings systems and virtual file storage. If care is already integrated, technology can help improve operations in support areas such as transcriptions, appointment scheduling or practice management.

However, the high standards expected when it comes to the privacy and security of patient data mean that some standardised tools, and outsourced service providers, may not be appropriate unless they can demonstrate independent quality certifications.

Process improvement as the foundation

Ideally, any move to an integrated care model would start with process improvement—to identify a streamlined operating model that serves the needs of all parties without having processes that are unnecessary or more complex than they need to be.

Large organisations inevitably build up layers and layers of complex and convoluted direction as to correct processes and standards. In a community care or social service setting, processes may be less formalised.

Some downsides of unnecessary processes are that they:

- eat up time
- are inconsistent with organisational goals
- are usually duplicated elsewhere
- reduce client/staff satisfaction
- are counterproductive
- waste money.

Processes should be reviewed with an eye to why they exist, whether they serve their intended purpose, and, if not, whether they can be simplified or eliminated.

Process improvement starts with identifying and documenting the processes and procedures of all parties involved in the patient's care in all settings, with one question at the forefront: 'Why?'

Why is the process necessary? Why is this step needed? Why should it be done by that person rather than this one? Why do this in-house?

"For patients, technology can also help with patient engagement by providing information tailored to that patient in terms of test results, education or self-monitoring."

Substantial efficiencies can result from process improvement in areas such as transcriptions. For example, outsourcing this function could potentially save hospitals 20% or more on costs without compromising quality, reliability or speed.

In areas where efficiencies can be achieved, the benefits of those efficiencies should be shared across all of the care organisations involved—if the benefits are not shared, buy-in will be hard to get.

Likewise, with any new technological investment, all organisations and people involved need to have a say in laying out their needs and requirements—this can help in overcoming reservations or resistance to change. ha

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With a background in IT leadership, David Camilleri is the Executive General Manager of mi-Clinic, which provides services including transcriptions, and has quadruple ISO certification in Information Security, Quality, Environment and Health & Safety.

Using data to drive better

An innovative program is supporting health agencies to make use of data on how people use health services to inform the development of integrated care models. **Sax Institute**

NSW Agency for Clinical Innovation Aged Health Network Manager Glen Pang is working with Sax Institute Analysis for Policy Program Manager Mark Bartlett to develop an integrated care framework for older people with complex needs.

integrated care

"In Australia, however, we lack integrated datasets that can easily give us this information. A Sax Institute program called *Analysis for Policy* helps solve this problem by enabling decision-makers to integrate the data they need."

How do you provide seamless care for older patients with complex needs like dementia? How can you help people with chronic illness avoid hospitalisation?

One of the steps decision-makers are taking to answer these and many other complex policy questions is by using research data to better understand patient needs and how they are using services.

In Australia, however, we lack integrated datasets that can easily give us this information. A Sax Institute program called *Analysis for Policy* helps solve this problem by enabling decision-makers to integrate the data they need.

It does this by analysing large datasets such as the self-reported information from Australia's largest longitudinal population health study, the *45 and Up Study,* and linking this information with other administrative data, such as on hospitalisations and general practice use.

'This is helping policy and program agencies look at better ways of integrating care for some of the most vulnerable people in our community', says *Analysis for Policy* program manager Mark Bartlett.

'We work with people to answer real-world questions and help them build better systems for health and wellbeing, and this approach is proving particularly valuable in integrated care for people with complex needs.'

Identifying patients at high risk of hospitalisation

'Data analysis is at the heart of the Central Coast Local Health District (LHD) Integrated Care team's 10-year vision to streamline care for patients with high needs, such as vulnerable aged people and those with chronic or complex conditions', says Dr Peter Lewis, Director of the Central Coast Public Health Unit.

The LHD is working with *Analysis for Policy* to explore ways to predict which people in the community are more likely to be admitted to hospital in the next 12 months.

'Because 45 and Up Study participants have answered questions such as whether they live alone and what type of support networks they have, the data will provide valuable insights into people's full health and social care journeys', Dr Lewis says.

'This information can then be linked with a range of other datasets, including Medicare, hospitalisations, and home care data, to reveal patterns in people's interactions with not only medical services, but with other community-based services.

'Regardless of where people live, we know there will be elements to the pattern of services used that will still be of interest', he says.

The data will also help the Central Coast LHD answer pressing questions such as what factors are red flags for people being at an increased risk of hospitalisation in the near future, and what can be done to avoid this.

Breaking down silos

For older people, especially those with conditions such as dementia or Parkinson's disease, healthcare silos make navigating the system particularly challenging—it is this group of people that are a key focus of the New South Wales Agency for Clinical Innovation (ACI) efforts to better integrate care.

The ACI enlisted the help of the *Analysis for Policy* program to understand the types of services older patients with complex needs use and how they use them.

ACI Aged Health Network Manager Mr Glen Pang said that analysis of *45 and Up Study* data had revealed that older patients with complex needs have higher use of hospital services and specialist care than those without complex needs. However, they do not show higher use of primary care services.

The findings demonstrate the key role played by specialist doctors in managing complex disease, as well as highlighting the potential to better integrate care by strengthening the role of general practice.

After analysing the data, the ACI has established a framework for use in New South Wales that encourages the establishment of local partnerships to design and implement new integrated care models for older people with specific complex needs.

'Effective healthcare for older people with complex health needs, their carers and their families requires a diverse range of health care professionals working together—and services must be coordinated through a shared plan with joint accountability', Mr Pang says.

'By bringing specialist and GP services together in partnership, we were able to look at whether there might be alternative ways to manage the care of older people with complex care needs. Our framework is starting to have an impact on the ground in local regions.' ha

More information

You can watch a short video about *Analysis for Policy* at www.saxinstitute.org.au/our-work/analysis-for-policy/.

New stepped care model

For primary mental health care in the ACT.

Gaylene Coulton (L) and Lauren Anthes

Capital Health Network
ACT's primary health network

phn ACT
An Australian Government Initiative

Capital Health Network (CHN), through the Australian Capital Territory's primary health network program (ACT PHN), is introducing a ground-breaking integrated primary mental health stepped care model for the ACT. As a first in Australia, the new model will provide greater flexibility for people experiencing mental ill health to access services that will meet their changing needs. CHN believes establishing a stepped care approach to mental health will make real inroads into lifting the overall rate of access to mental health care in the ACT.

Primary Health Networks play a critical role in the Commonwealth Government's current reforming of the mental health system—they are key regional facilitators for planning primary mental health programs, funding services and developing integrated care pathways.

Stepped care is a central element of these mental health reforms, and recognises the need to provide the community with a greater number and more effective array of primary mental health care options. Stepped care is defined as an evidence-based staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs.

"Approximately 9% of the ACT population will experience mild symptoms of a mental illness—mostly anxiety and depression."

Stepped care model

The new stepped care model will become part of the ongoing mental health service landscape in the ACT. The model is based on the UK's Improving Access to Psychological Therapies (IAPT) model and has two parts: low intensity and high intensity interventions.

The model operates based on three key stepped care principles:

1. The lowest intensity intervention is offered first, where possible.
2. Routine measurement is conducted to ensure that clients are receiving the appropriate care and that they are improving.
3. Stepped care is systemic, ensuring there are integrated steps for clients to be stepped up and down without having to navigate a fragmented system by themselves, and ensuring that they receive high quality, consistent treatment in every step.

Several public consultations were held with health professionals including GPs and mental health professionals, consumers, carers and a range of mental health service provider organisations in the community. Overall, there was agreement that this model could play a useful role in diversifying the ACT's primary mental health services.

The program aims to particularly help vulnerable people who face financial barriers or access barriers—such as children, youth, Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds.

New Access low intensity service

Approximately 9% of the ACT population will experience mild symptoms of a mental illness—mostly anxiety and depression.

Over the past three years, CHN has successfully piloted the New Access low intensity psychological support service.

CHN is a national leader in this area, as it has been one of only two PHNs providing a low intensity service. Nearly 2,000 Canberrans with mild to moderate depression and/or anxiety have received support through this service to date.

Adding high intensity service

Approximately 7% of the ACT population may experience moderate to severe mental disorders.

The new stepped care model will soon add a high intensity service to provide effective primary mental health care for hard-to-reach or underserviced population groups. The service will enable people with moderate to severe symptoms to access face-to-face care from mental health professionals.

The aim of this service is to provide interventions in a primary care setting to a cohort of people who have historically not received adequate mental health services in primary care. It is anticipated that this will result in a lower number of people with moderate to severe presentations needing to be stepped up into tertiary services when they become acutely unwell. To avoid duplication of services, those who are already accessing psychological interventions or are able to receive the support they require through the *Commonwealth's Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) Initiative* are not eligible.

High intensity psychological interventions are provided across 6 to 18 sessions depending on the individual's need. The assessment is person-centred, and treatment goals are jointly agreed between the client and mental health professional.

With the consent of the client, the mental health professional will communicate with the client's treating GP or clinician throughout treatment.

Easy access

The service aims to be easily accessible, with people being able to self-refer. Alternatively they can be referred by their GP, ACT Mental Health Clinical Manager or other provisional referrers.

To determine eligibility and the appropriate level of intervention, a client assessment is completed. The assessment will focus on determining the client's severity of symptoms using referral information, clinical tools and discussions with the client and treating GP or clinician.

Step up step down

The strength of this model is that a client can be stepped up or stepped down within the service without a new referral, in consultation with the treating clinician, e.g. GP, clinical case manager. If the client needs to be stepped up to external services such as ACT Health secondary or tertiary services, the worker or mental health professional will refer the client in consultation with the client's treating GP and clinician.

This new integrated primary mental health stepped care model will play a useful role in diversifying the ACT's primary mental health service landscape and ensuring continuity of care for mental health clients. ha

Gaylene Coulton, Chief Executive, and Lauren Anthes, Senior Manager, Primary Mental Health & Alcohol and Other Drugs, Capital Health Network.

JANE CAMPBELL
Regional Manager, Clinical Strategy and Development, Central Queensland, Wide Bay, Sunshine Coast PHN

Integrated care: a person-centred approach

An integrated care approach to health aims to minimise gaps in care and improve care coordination, which in turn reduces fragmentation and improves both care experiences and health outcomes. It enables people with chronic disease and mental health conditions to move away from disease silos towards tailored and person-centred care that improves the overall patient journey and health outcomes.

Why does it matter to the patient experience and why should health professionals care?

At the heart of the health professions is a desire to support and improve the health of the community. By using an integrated care approach, commissioning organisations and health care providers can work together to empower people and guide them on their journey to achieving longer, healthier lives.

Rather than simply treating symptoms as they occur, under an integrated care approach health professionals can work together to offer a mix of both acute and preventive services tailored to an individual's needs. However, the extent to which these can be provided quickly, efficiently and cost-effectively can depend on the person's health literacy and capacity to manage their own health.

As with acute care, preventive health strategies provided using an integrated care approach are focused on the individual, who engages and works in partnership with health providers.

Prevention strategies may include a range of large- and small-scale initiatives such as awareness campaigns and accessible disease self-management education in the community. Health providers bring in additional experience and can assist by providing lifestyle tools and information on topics such as smoking, alcohol and nutrition.

> **"An integrated approach can help reduce the disease burden in a community and therefore costs to the health system."**

An integrated approach can help reduce the disease burden in a community and therefore costs to the health system.

An integrated system enables people to engage and work in partnership with health providers to plan and manage their own health.

Royalty free from GraphicStock

According to AIHW data, the highest burden of ill-health in the community (measured by healthy years of life lost due to disability or death) is the result of chronic diseases such as cardiovascular disease, cancer, diabetes, and mental health and respiratory conditions. Therefore robust prevention strategies can yield large benefits.

Experience in the UK suggests that people who are proactively engaged, motivated and provided with education and support are more likely to maintain better health. Improved levels of health literacy and confidence obtained in this way can enable people to detect changes in their health at an earlier stage, and to seek appropriate care and intervention sooner. This can reduce subsequent costly and unexpected hospitalisations.

Our organisational approach

Our organisational approach to integrated care includes working meaningfully with partners and stakeholders across primary and tertiary care to understand the health needs of our local population. This results in reduced duplication and improved quality of accessible health services that match the needs of the individual.

We are committed to commissioning person-centred and population-orientated coordinated care that covers the entire patient journey from the community to primary care, to tertiary facilities and back home again. We are sharing that commitment through our PHN networks, including our Clinical Councils, Community Advisory Councils and Mental Health Strategic Collaborative.

At a local level we support cross-sectoral integration through joint planning, tailored education and training for health providers, and co-funded initiatives that include digital health projects. We provide access to tools that support person-centred care, such as HealthPathways (decision support tool for clinicians) and eReferral pathways. Integrated health workforce initiatives include nurse practitioner care services for patients with low-urgency health needs. ha

Jane Campbell has worked in the primary health care sector for over 10 years in various management roles, as well as in the tertiary sector as a nurse and midwife. Jane holds qualifications in nursing, business, and project management.

Effects on long-term career aspirations

Rural placement and junior doctors from urban backgrounds.

Despite important training and workforce initiatives in recent years, maldistribution of medical practitioners in Australia, particularly in regional, rural and remote areas, continues to concern governments and health workforce organisations, as well as impacting on patient care.

The Australian Government has attempted to address this issue by increasing medical student places, targeting students from a rural background, and instituting programs to provide medical students and junior doctors (from graduation to completion of speciality training) with a rural experience.

While previous research has focused on identifying the characteristics of medical students and doctors who choose to 'go rural', less is known about what hinders urban-based junior doctors from pursuing a rural career and what could be changed to increase participation in rural practice.

Doctors continue to make career decisions during their early postgraduate years, and experiences (either positive or negative) at this stage of a person's medical career may have a long-lasting effect on attitudes towards type and location of practice.

In our paper published in the *Australian Health Review* in December 2016[1] we provided qualitative insights from 41 urban-based (Adelaide, Brisbane and Melbourne) junior doctors on the effect of post-graduation rural placements and rotations on their view of non-metropolitan practice.

"Rotations from metropolitan to regional and rural hospitals in the prevocational years (years 1–3 post-graduation) are common and usually compulsory."

Rotations from metropolitan to regional and rural hospitals in the prevocational years (years 1-3 post-graduation) are common and usually compulsory. There may also be voluntary or compulsory rotations during specialty training.

Our findings suggest that the attitudes of junior doctors from urban backgrounds towards non-metropolitan medical practice fall into three main types:

1. First are those who are simply not orientated towards rural practice, and who resent being 'conscripted' to work in regional and rural hospitals. These doctors are unlikely to ever voluntarily practice outside major cities. Unfortunately, their negative attitude is sometimes reflected in the manner in which they treat patients and other staff during a compulsory rural rotation, resulting in an

unhappy experience for all concerned.

2. In contrast are the doctors who have a strong desire to work in rural areas—indeed, their desire to do so may have been an important motivating factor in studying medicine, and rural placements often cement their desire and decision to 'go rural'.

3. The third group comprises those with a more general orientation or openness to rural practice. For some, rural placement offers an opportunity for new experiences. Doctors in this group are willing to extend themselves into unfamiliar territory, both geographically and medically. It is for this group in particular that experiences encountered in a rural rotation have the capacity to alter long-term career aspirations regarding locus and type of practice.

Regardless of type of attitude, our cohort indicated that rotations from metropolitan hospitals were often problematic in terms of lack of preparation and information about what to expect, lack of practical support about how to manage in a new place, and inadequate clinical support and supervision in the placement.

While the quality of the placement experience involves personal and social aspects, the amount of professional support in these rural rotations appeared to be one of the most defining aspects of the rotation.

Some junior doctors found it a challenging, but enjoyable experience. Others faced a number of instances of very sick patients with little or no outside assistance, and therefore found the rotation a very negative experience involving significant anxiety. Most had little clinical experience before being sent rurally, resulting in feelings of extreme vulnerability when faced with unexpected or life-threating situations with little backup.

Unfortunately, poorly supported rural exposure shifted the aspirations of a number of junior doctors who may have been open to rural practice.

These findings suggest a number of issues that, if addressed, could enhance the impact of rural placements on junior doctors' willingness to work in non-metropolitan areas:

- One is to take the orientation or 'rural-mindedness' of junior doctors into account when allocating interns and junior doctors to rural areas.
- Another is to provide sufficient supervision and/or professional support, either in person, online or by telemedicine, to enhance doctor confidence and patient safety.
- Third, providing adequate information about, and preparation for, the placement would help enhance the quality of the experience.

In summary, the message most apparent to us from this study was the importance of investing in high quality rural placement experiences because the resulting positive experiences will have lasting effects in encouraging rural practice. ha


Goondiwindi Hospital in South West Queensland

pixabay.com/en/road-desert-australia-outdoors-sky-432161/

Reference

1. Brodribb WE, Zadoroznyj M & Martin B 2016. How do rural placements affect urban-based Australian junior doctors' perceptions of working in a rural area? Australian Health Review 40:655–60.

Wendy Brodribb, MBBS, IBCLC, PhD, FABM, Honorary Associate Professor, Discipline of General Practice, Faculty of Medicine, The University of Queensland; and Maria Zadoroznyj, BA, MSc, PhD, Associate Professor, Institute of Social Science Research, School of Social Science, The University of Queensland.

Acknowledgments

We acknowledge the contributions of the late Professor Bill Martin to the study and earlier versions of this paper. This research was commissioned and funded by Rural Health Workforce Australia, the national body for the state and territory rural workforce agencies.

Reducing seclusion and restraint

Hearing from consumers and their supporters.

THE UNIVERSITY OF MELBOURNE

MELBOURNE SOCIAL EQUITY INSTITUTE

You go into [a mental health facility] seeking help and surviving the traumas in your life, but you end up having to cope with even more trauma. It's pointless.'

These are the words of a mental health consumer who experienced seclusion during a stay in a mental health facility and who took part in our research project funded by the National Mental Health Commission.

Seclusion and restraint are interventions currently permitted for use in mental health and other services to control or manage behaviour. These interventions can have serious repercussions for those subject to them.

Much has been written about what service providers can do to reduce seclusion and restraint, but little about what consumers and their supporters think about these interventions and what they would like to see changed.

As part of an interdisciplinary research project involving 12 researchers, we ran 10 focus groups with 30 consumers and 36 supporters (parents, siblings, partners and advocates) in New South Wales, Queensland, Victoria and Western Australia. We also analysed responses to an online survey on attitudes towards seclusion and restraint from 1,150 consumers, carers and mental health practitioners.

Focus group participants nominated several areas with potential barriers to reducing seclusion and restraint. These included the physical environment of in-patient settings, a perceived lack of accountability for human rights breaches, power imbalances and paternalism.

The survey results indicated strong agreement across all participants that the use of seclusion and restraint is harmful, breaches human rights and compromises the therapeutic relationship and trust. However, some benefits were also nominated, particularly by practitioners. Benefits included increasing consumer safety, increasing the safety of staff and others, and setting behavioural boundaries.

Across focus groups and survey results there was considerable consensus that seclusion and restraint could be reduced, if not eliminated.

Focus group participants suggested that state and federal governments had an important role in leading change, as well as in improving complaint systems, to better enable public accountability and ensuring that action was taken in relation to complaints.

At the service level, consumers and their supporters proposed that there be more opportunities to obtain advocacy services, to lodge complaints, and for services and staff to be accountable for their decisions and actions.

There was strong agreement that formal consumer and carer roles within mental health services, as well as peer support

and advocacy, are vital to ensuring that understanding, empathy, and recovery-oriented practice occur in in-patient settings.

In one-half of the focus groups there were suggestions that more carer or family involvement could help reduce or eliminate seclusion and restraint. This was seen as particularly important for Indigenous people.

Suggested strategies to improve the environment included: using non-fluorescent lighting; creating warmth by adding colour, pictures and quotations to walls; and providing options for sensory modulation. These suggestions could be implemented easily within existing in-patient settings.

Other suggestions included unlocking the doors to the main ward and constructing a separate therapeutic environment connected to emergency departments.

"Suggested strategies to improve the environment included: using non-fluorescent lighting; creating warmth by adding colour, pictures and quotations to walls; and providing options for sensory modulation."

Respectful, recovery-oriented and sensitive care in crisis situations was also recommended. One consumer pointed out that recovery 'is all about self-responsibility and self-direction, whereas seclusion and restraint is all about someone else's control, so it doesn't actually sit well with recovery at all'.

Participants suggested that staff needed to be more prepared to respond to people who are distressed. There was confidence among participants that de-escalation strategies can work.

Our research indicates that the lived experience of consumers and their supporters can make an important contribution to deepening the understanding of what is happening in mental health practice and what needs to change and why.

As one supporter said, current practice is about 'controlling and defusing the situation by just dominating, whereas if there was some sense of trying to calm the situation rather than contain it, it would be quite different'. ha

Bernadette McSherry, Lisa Brophy, Bridget Hamilton, Cath Roper and Juan José Tellez, Melbourne Social Equity Institute, The University of Melbourne.

Patient perception of discharge from hospital following trauma

A case for increased patient involvement in follow-up care.

Royalty free from GraphicStock

A large qualitative study on patients' opinions of discharge from an acute hospital following trauma, and how this could be improved from their perception, was published in *Australian Health Review* in December 2016. This study, by Kimmel and others, involved 94 patients admitted to selected Victorian hospitals for treatment of a lower limb fracture. The main issues described by the patients were:

Lack of information provided on discharge—'...and they will say all of this information, and they go "you understand". And you sort of sit there and like "yeah", but in reality you're so foggy and stuff from everything, from all the drugs and that, that you don't really understand.' (Female, 25, non-compensable, discharged home).

Lack of patient involvement and understanding of the choices made with regard to their discharge destination—'I guess for me the thing that was confusing about discharge is questions have been raised as to whether I would need to go to rehab, or whether I could go straight home, and over the course of a couple of days I continued to receive basically conflicting advice...' (Male, 31, non-compensable, discharged home).

Concerns regarding their follow-up care—'I was happy with the treatment in the hospital, but I was upset that there was no after-care; there was no being told what I needed to do after I went home.' (Male, 24, non-compensable, discharged home).

Additionally, for those discharged to inpatient rehabilitation, patients reported a wide variety of experiences at the rehabilitation facility:

- 'Nothing but praise. I wouldn't be where I am now if it wasn't for them. Simple as that...' (Male, 54, non-compensable).
- 'In all honesty, it's next to nothing. For 23 hours of the day you are in bed, for 40 minutes you are doing physio...' (Male, 19, compensable).
- There often appeared to be a lack of understanding of rehabilitation goals and what needed to be achieved pre-discharge, leading to many patients reporting that they self-discharged from the rehabilitation facility: 'I just self-discharged because they didn't think I was ready' (Male, 19, compensable, discharged to inpatient rehabilitation).

There were also differences in patient perceptions of the factors leading to recovery. Patients discharged to inpatient rehabilitation more commonly reported external factors such as physiotherapy as their primary reason for recovery, while those discharged directly home were more likely to report self-motivation:

- '...the main things are definitely rehab, just frequent rehab; just keep going there and doing the exercises they put out for you and just pushing the limit, pushing yourself to do it'. (Male, 27, compensable, discharged to inpatient rehabilitation).
- 'Probably mind. Making sure I kept mobile. Probably your own mindset really.' (Female, 62, non-compensable, discharged home).

The patient insights provided by this study should be taken into account when acute hospitals consider discharge planning and post-discharge care of a trauma patient. These insights can be summarised as follows:

- Patients believe there is a need for them to have more involvement in decision-making in terms of discharge from acute and rehabilitation hospitals. This can and should be easily facilitated by treating teams.
- Patients should have increased ownership of decisions regarding their care. The fact that patients report a lack of understanding of their discharge goals needs to be addressed.
- Self-discharging from hospital can be regarded as a failure of care of the patient—increased patient understanding of the need for ongoing inpatient care may provide a solution.

For patients, the challenges of recovery did not end at hospital discharge. Care pathways need to consider this. Participants commonly reported dissatisfaction with arrangements for equipment, follow-up care and physiotherapy—especially those who went directly home.

In-patient rehabilitation appeared to provide patients with a greater feeling of support on discharge; but both the inpatient rehabilitation and home discharge groups reported a lack of communication from the acute hospital and poor awareness of who to contact should adverse events or issues arise: 'I wouldn't know who to ring. I wouldn't know which department to ring'. (Male, 24, non-compensable).

The use of a single point of contact such as a discharge coordinator may ease patient concerns with and understanding of their follow-up care.


Dr Lara Kimmel with trauma patient Hussein Ibrahim

Further research is needed on effective methods of providing post-acute hospital care for trauma patients. This could include using rehabilitation prediction tools to ensure patient involvement in decision-making, and evidence-based determination of discharge destination (home compared with inpatient rehabilitation).

In summary, the information provided by participants in this study may prove useful in reforming discharge practice to include increased patient involvement in discharge decisions, and improved information for patients on rehabilitation goals and expected duration. ha

Dr Lara Kimmel is affiliated with the Department of Epidemiology and Preventive Medicine at Monash University, and with the Physiotherapy Department at Alfred Hospital, Melbourne.

Dr Lara Kimmel on behalf of her co-authors of an article originally published in *Australian Health Review* 40(6) December 2016: Kimmel LA, Holland AE, Hart M, Edwards ER, Page RS, Hau R, Bucknill A & Gabbe BJ. Discharge from the acute hospital: trauma patients' perceptions of care.

Reasons to buy an established healthcare practice

Few medical practitioners consider doing so, but there are many benefits.

Why buy?

Many medical practitioners choose to set up their own healthcare practice once ready, but few actually consider purchasing something already established. Purchasing an established practice can help to secure a medical practitioner's financial future, and is sometimes more beneficial in the right circumstances.

Buying into an established practice gives you a predictable cash flow from the start and practitioners can greatly benefit from gaining an existing customer base and staff who are trained for the business. This is in addition to acquiring equipment and premises, which are all secured.

As the practice is established, practitioners are spared the time and capital it would take to traditionally build a new business. New businesses also run the risk of racking up unforeseen out-of-pocket expenses, another obstacle that can be avoided if purchasing something established.

Below are some tips to keep in mind when looking to make such a purchase.

Finding the right practice

It is imperative to understand what kind of business you are buying, as well as what you want out of it. One way to determine this is to try working in the same area to understand the clientele, or, if possible, work at the practice you are considering buying to gain an intimate understanding of how it operates. If you are employed by a practice that you could be interested in

PAUL FREEMAN
Head of Practitioner Segment at NAB Health and CEO of Medfin Finance

"Buying into an established practice gives you a predictable cash flow from the start and practitioners can greatly benefit from gaining an existing customer base and staff who are trained for the business."

owning, put your feelers out to see if there are any options to eventually buy into it.

You may also want to consider what kind of work-life balance you would like before you buy into a particular practice. For example, if you buy into a relatively new practice, you may have to work hard to establish the business. However, if you buy into an already established practice with a large clientele, you may be able to free up your time for life outside of work.

Make sure you also consider what kind of clientele you would like to treat, as some areas might draw more families and children, whereas others might attract a younger demographic.

Establish clear intentions

It's important to ensure you have a clear agreement in place with the existing owner before you begin the acquisition process to avoid wasting time going back and forth on details. Include a specific exit strategy for the existing owner so that there are no crossovers that might cause problems.

Purchasing cost

Take into account all the factors that might influence the price of the practice, including location, ongoing equipment leasing and rental or mortgage costs. The location has a direct correlation with the latter of the two factors, with urban practices potentially being more expensive due to the convenience of the location, while regional practices may cost less to purchase. Although regional practices may be cheaper, they may also offer a smaller clientele, which may affect your potential income.

Ongoing staff

An upside of buying an established practice is that they often already have trained staff who know the business inside and out. Keep in mind how existing staff are used to working and what systems are in place, to ensure a smooth transition. Alternatively, if you are considering making changes to the established system, keep in mind the potential training and on-boarding costs.

Existing equipment

Equipment often comes with an existing practice; however, you need to consider if the equipment has been purchased outright or is being paid off or leased. Before buying the practice, make sure you take this into account to avoid unforeseen costs.

Use a specialist adviser or lender

Making a big decision such as purchasing a business can be difficult, with many things to consider. A specialist adviser or lender can simplify the process exponentially while keeping you informed, and reminding you where due diligence is most needed.

An adviser will also make sure you are aware of exactly what you are buying, including liabilities, and that you have adequate income protection, and accident and life insurance. You are the business asset, so you need to make sure **you** are being taken care of! ha

Photo by Taduuda

Working with the Remote Area Health Corps

A fortunate experience. **Dr Bruce Barker**

I have been a GP for 35 years, mostly in semi-urban centres such as Launceston. An injury forced a lay-off from work for me for 5 months. It gave me the time and opportunity to rethink how I wanted to spend my 'medical twilight'. My wife is also a GP, and it was our mutual decision to approach the Remote Area Health Corps (RAHC) about working in the Northern Territory.

Medicine in Central Australia is not like going to another country—it is like going to another planet! Our longest stint was at Urapuntja (Utopia). It is about 250 km from Alice Springs. Prior to going, RAHC provided a forum as well as a very useful online educational package on the clinical issues we were to face.

The communities we helped were all Indigenous. Their health problems included chronic skin infections, diabetes, hypertension, unbelievable amounts of renal disease (beginning even in teenagers), auto immune disease (lupus in particular), social problems, anaemia, severe bacterial infections, results of domestic violence, and sexually acquired infections—we were always on the lookout for syphilis, especially in young people.

We stayed for one month at a time, and each time we built up more experience—not only of the medical problems, but the social issues, as well as the incredible natural beauty right outside our houses.

We re-learned our abilities to work with teams in addressing both acute and chronic problems—bush nurses, elders, Aboriginal health workers and long term locals.

The acute problems can either be straightforward illnesses, or highly complex cases requiring management of serious electrolyte disturbances, septicaemia and the like. Chronic problems often require multiple medications, frequent monitoring (both clinically and biochemically), and a great deal of education. Some patients have very little education, as well as endemic deafness, and can be notoriously medically non-compliant. A child without a discharging ear, or with clear uninfected skin is the exception rather than the norm.

"A child without a discharging ear, or with clear uninfected skin is the exception rather than the norm."

Are we helping? I think without a doubt the answer is 'yes'. There have been vast improvements in child mortality and life expectancy due to the medical and nursing care in community settings. The passion, commitment, and knowledge of community of all the health workers we met was inspiring.

However, if I could choose between building a modern clinic in a remote, unserviced part of Australia, and providing adequate, abundant clean water, I would choose the latter. It is impossible to wash effectively when the water supply is poor—and, for example, facial washing, not antibiotics, is the best preventative strategy for trachoma.

Social forces are powerful in remote Aboriginal communities, with all kinds of causal relationships and associations with health. Teasing these out can help point to areas where renewed efforts may lead to lasting overall health benefits.

In my view, a fundamental thing to do would be to optimise the antenatal, uterine environment to give new Aboriginal babies normal healthy organs and the necessary reserves of iron and nutrition.

Antenatal traumas can include alcohol abuse, high levels of smoking, persisting iron deficiency, missing antenatal visits,

prematurity, mothers who already have kidney disease and diabetes, and poor maternal nutrition.

Poor child nutrition, compounded by early and frequent diseases such as ear infections, trachoma, chest infections and rheumatic fever, too often lead to a huge burden of ill-health even before a child gets to school.

The Utopia Clinic has been particularly imaginative in educating and encouraging young mothers to turn this around.

Government programs can also help—for example, at school, children are assured of getting regular meals and regular washing, which they might not get at home. School attendance can be poor, however.

My impression is that the places with the best health profiles are those where there is access to better food, the majority of working age adults are educated and have jobs, the number of Aboriginal health workers is relatively high, alcohol is controlled, elders are healthy and respected, and where basic hygiene is possible due to installed (and working) bathrooms and toilets.

There is ample evidence that Aboriginal people know what the problems are and know what to do—but some infrastructure is beyond what they, as communities, can provide. Similarly, it is beyond the reach of individual doctors like me, despite the improvements we make as GPs.

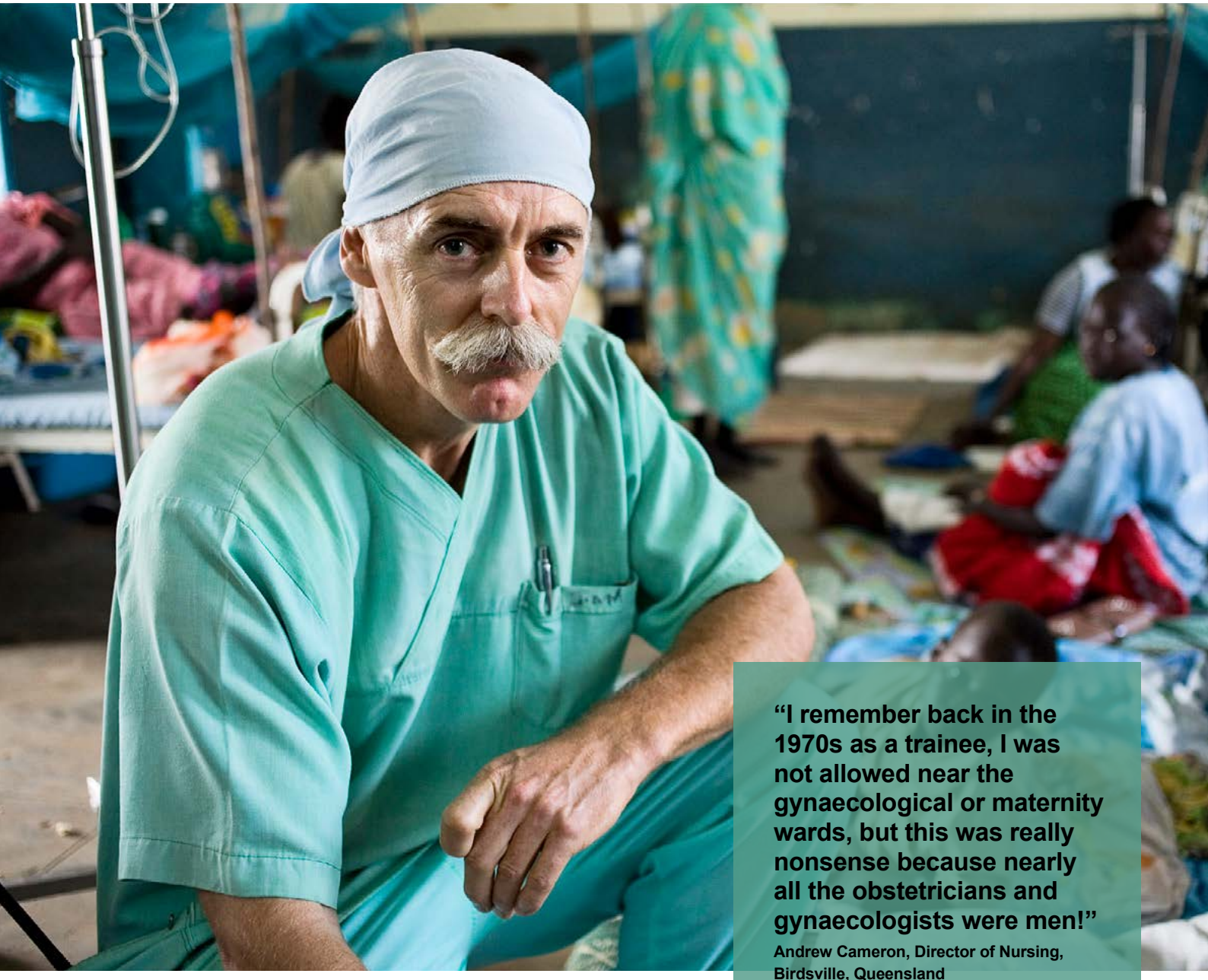
There is so much more to learn and talk about. To any colleagues considering it, the work is very challenging and rewarding, with the RAHC team being supportive and interested at all times. It has been a privilege to work with them in the Northern Territory. ha

Dr Bruce Barker in Alice Springs

The Remote Area Health Corps (RAHC) was established in 2008, and is funded by the Australian Government Department of Health under *The Indigenous Australians' health programme: stronger futures Northern Territory* to 'address persistent challenges to accessing primary healthcare services for Aboriginal and Torres Strait people in the Northern Territory'.

A healthy future needs gender balance

Workplace Gender Equality Agency.



"I remember back in the 1970s as a trainee, I was not allowed near the gynaecological or maternity wards, but this was really nonsense because nearly all the obstetricians and gynaecologists were men!"

Andrew Cameron, Director of Nursing, Birdsville, Queensland

Australians today are living longer than ever before.

In 2017 the average Australian life expectancy is 82 years of age, a 10-year increase on the average lifespan 50 years ago.

The number of Australians aged over 75 is expected to increase by 4 million by 2060, and at that point there will be one person aged 100 or more for every four babies.

Our ageing population is fuelling a growing demand for health and aged care workers. Demand is projected to outstrip supply by 2025 with a shortfall of approximately 85,000 nurses, rising to 123,000 by 2030.

As younger generations look to the future, contemplating life choices and careers options, it is much more likely that girls rather than boys will pursue a career in health care. Currently only 1 in 10 nurses is male, and this trend looks set to continue, based on student enrolments.

Statistics show that the proportion of men working in Australia's two most female-dominated industries of Health Care and Social Assistance actually declined between 1995 and 2015.

While there are numerous initiatives in place to address workforce shortages in the health sector, gender is rarely part of the conversation.

Libby Lyons, Director of the Workplace Gender Equality Agency (WGEA), says it is 'beyond time' to bring gender into the conversation about workforce shortages in the health sector.

'The fact we are not even talking about the lack of men in predominantly female industries is confounding, especially when we consider the long-term social and economic forecast for Australia', says Lyons.

'Although we recognise the need to attract more women into skilled technical roles; we are not doing anything to encourage men into female-dominated industries and jobs. It is possible that our failure to encourage men into female-dominated roles is a symptom of gender bias.'

Recent research published in the *Australian Journal of Advanced Nursing* found that men who do buck this trend and pursue a career in the female-dominated profession of nursing can often encounter gender stereotypes. A number of men interviewed as part of the research study reported feeling like outsiders in a 'woman's job', encountering stereotypes ranging from assumptions about their sexuality to their actual role.

Such stereotypes are nothing new for men working in nursing, according to Andrew Cameron who has been a nurse for over 40 years. Reflecting on his first few years in the profession, Mr Cameron recalls being discriminated against for being a male.

'I remember back in the 1970s as a trainee, I was not allowed near the gynaecological or maternity wards, but this was really nonsense because nearly all the obstetricians and gynaecologists were men!'

Over the course of his career Andrew has risen to the top of his profession, receiving the Australian Nurse of the Year award in 2004 and the Florence Nightingale Medal in 2011 for exceptional courage and devotion to victims of armed conflict.

Although things were not always easy for him as a man in a predominantly female profession, he says that it has got easier over the years.

Times have changed, and as the percentage of men in nursing has slowly increased and peoples' attitudes have largely changed as well, this is all for the better', Andrew says.

If Mr Cameron's career is anything to go by, nursing can lead to a great range of possibilities for both women and men. Research shows that organisations can also benefit from more men entering the profession, as greater gender diversity has been linked to improved innovation and performance.

The 2015–16 WGEA dataset covers nearly 600,000 employees in the Health Care and Social Assistance industries, with women making up 80.2% of this workforce.

The WGEA is an Australian Government Agency charged with promoting and improving gender equality in Australian workplaces. It works with employers across all industries to help them comply with the reporting requirements under the *Workplace Gender Equality Act 2012*.

Under the Act, non-public sector employers with 100 or more employees are required to report to the Agency on progress against key gender equality indicators.

Employer reporting to the Agency begins on 1 April 2017. If your organisation is required to report, the Agency is holding several education sessions in the coming weeks to help organisations prepare for the reporting period. ha

Andrew Cameron, Director of Nursing, Birdsville, Queensland

FAST FACTS: HEALTH CARE AND SOCIAL ASSISTANCE

- **80.2% of employees are women.**
- **Gender pay gap: 14.7%.**
- **59.7% of employers have a formal gender equality policy.**
- **63.2% of CEOs are men.**

For more gender equality data, visit data.wgea.gov.au.

Why women need to boost their super

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Workshop: End-of-life care - the next steps

22 May 2017

12:30pm - 5:00pm

Rydges on Swanston
701 Swanston Street
Melbourne

Members - $180
Non-Member - $320

The discussion around enabling meaningful end-of-life care is gaining momentum in Australia, and in National Palliative Care Week the Deeble Institute for Health Policy Research will bring together researchers, practitioners, policy makers and consumers for a workshop that will build on the policy issues brief 'Improving end-of-life care in Australia' published by the Deeble Institute and previous events convened in 2015 and 2016.

The Deeble Institute invites the sector to help advance this work and answer the question: what policy and practice change is needed to improve end-of-life care in Australia?

Join us for an engaging workshop as we look to progress this important work.

For more information or to register visit www.ahha.asn.au/events

Think Tank: Hospital avoidance and prevention

Where to next for the Australian health system?

23 May 2017

9:00am - 5:00pm

Rydges on Swanston
701 Swanston Street
Melbourne

Members - $300
Non-Member - $540

Targeting reduction in preventable hospitalisations is a specific objective of health care reform in Australia, with the aim of improving patients' outcomes, reducing pressure on hospitals and enhancing health system efficiency and cost-effectiveness. Measuring preventable hospitalisations also provides important insights into how well health systems are performing in keeping Australians healthy and out of hospital.

This Think Tank features academics from the Deeble Institute who seek to answer the question: how should the health system respond to the growing pressure to reduce the rates of preventable hospitalisations?

Join us to hear the latest research and in-depth discussion of this key issue for the Australian health system.

For more information or to register visit www.ahha.asn.au/events

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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 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 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*). ha

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

More about the AHHA

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 2015-2016 Board is:

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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: **ahha.asn.au/governance**

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