

# The Health Advocate

Your voice in healthcare

## Health literacy

Why it should be everyone's business

## Lean philosophy

Helping organisations reach ambitious targets

## Consultation at the coalface

Views from Health Minister Sussan Ley

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INSIDE**

## Improving healthcare

Getting better value for money by emphasising integration and prevention



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# AHHA in the news

## HAVE YOUR SAY...

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



## Bariatric surgery in public hospitals: better access, better data needed

New research shows that while bariatric surgery, a procedure to treat obesity, is becoming increasingly common in Australia, access to public-funded services is limited, and this may be partly attributed to increasing numbers of private patients requiring subsequent revisions/reversals in public hospitals.

These findings are reported in 'Quantitative analysis of bariatric procedure trends 2001-13 in South Australia: implications for equity in access and public healthcare expenditure' by Samantha B. Meyer et al, featured in the latest issue of the *Australian Health Review*, the AHHA's peer-reviewed academic journal.

"Bariatric surgery is one of the fastest growing forms of surgery conducted in Australia, and obesity is a leading contributor to the burden of disease, yet only 10% of bariatric procedures are undertaken in public hospitals. Better access to affordable surgery is undoubtedly needed, as is better data so that we can understand how such surgery is being funded and delivered," said AHHA Chief Executive, Alison Verhoeven.

## Concerns over potential ABS Census cutbacks

A proposal from the Australian Bureau of Statistics (ABS) to conduct the Census every ten years instead of five would come at an unacceptable cost to healthcare planning. AHHA Chief Executive Alison Verhoeven said that while the proposal might help the ABS fund its planned IT systems upgrade, significant flow-on effects would negatively impact the Australian healthcare system.

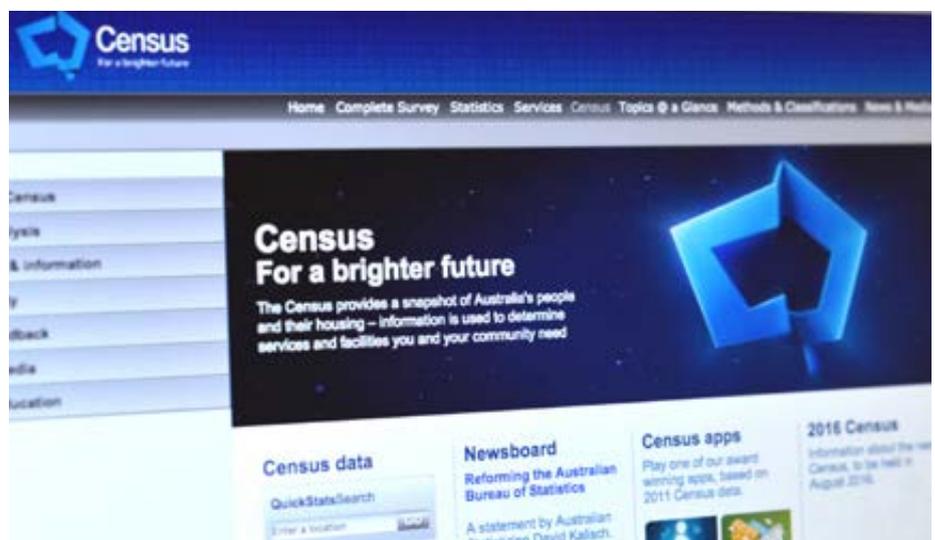
"The Census is such an important asset for the health sector that any changes should be the subject of wide consultation, and should be aimed at improving the data available to inform policy for a strong, productive and healthy Australia," Ms Verhoeven said.

In particular, the ABS proposal would limit the country's understanding of the population health needs of Indigenous people and those living in rural and remote areas. "Less frequent Census data and a reliance on sample-based surveys are of particular concern for these groups that already experience significant health inequity compared with other Australians," Ms Verhoeven said.

## Health rationing: how Australia can learn from international examples

As governments around Australia grapple with health budget challenges, a focus on rationing healthcare is inevitable. Australia already has some well-regarded rationing processes in place, but we can look to international examples to improve current rationing practices. A new health policy issues brief by the AHHA's Deeble Institute 2014 Writing Prize Recipient, Elizabeth Martin, urges Australian governments to look at international best practice to facilitate better healthcare rationing in Australia.

"To ensure healthcare resources are used as efficiently as possible, Australian governments need to adopt a more consistent, explicit and evidence-informed approach to rationing," Ms Martin said. "Governments will then be better placed to decide whether to continue funding programs, services and treatments or to fund better value for money programs, services and treatments instead."





## Government must come clean on dental programs

AHHA Chief Executive Alison Verhoeven said millions of Australians would be impacted if the Government fails to deliver on its 2013 election commitment to the National Partnership Agreement (NPA) on Adult Public Dental Services, and its support for the Child Dental Benefit Schedule (CDBS) and the National Oral Health Promotion Plan.

“When it comes to election promises and oral health, the Government’s report card looks extremely disappointing,” Ms Verhoeven said. “The \$1.3 billion in funding for the NPA has been delayed, a review of the CDBS hasn’t eventuated and the implementation of the National Oral Health Promotion Plan doesn’t appear to be on the table.”

Ms Verhoeven said that the May Budget would be an excellent opportunity for the government to demonstrate its commitment to pre-election promises on dental health. “We recognise the need to contain health costs and our pre-Budget submission has highlighted opportunities for efficiencies and savings,” Ms Verhoeven said. “However, a Budget commitment is required to ensure better oral health in Australia.”

## Closing the Gap: AHHA calls for Government commitment

While only limited progress in closing the gap has been reported in the 2015 *Close the Gap - Progress and Priorities* report, the AHHA welcomed the report recommendations and urges the Government to take action on these. “Aboriginal and Torres Strait Islander peoples experience a significantly higher burden of disease and a reduced life expectancy in comparison to other Australians. The Government must commit to renewed investment in prevention strategies including anti-tobacco and drug and alcohol programs as a priority,” said AHHA Chief Executive, Alison Verhoeven.

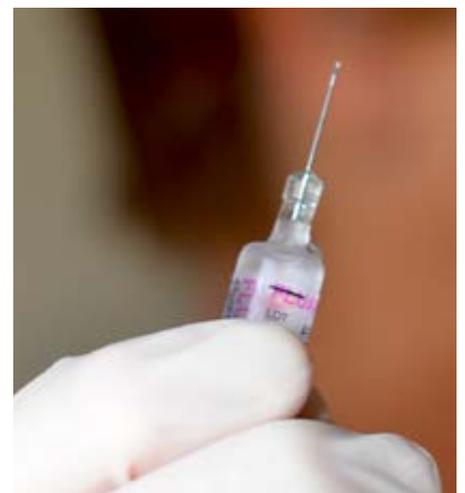
In its pre-budget submission, the AHHA has called for support for programs that encourage effective collaboration between Aboriginal community-controlled services and mainstream services that serve to develop the capacity and resilience of individuals and communities. There is particular opportunity through the establishment of Primary Health Networks to entrench better connectedness with non-Indigenous health services at the primary level, but also better planning for the healthcare needs and challenges facing Aboriginal and Torres Strait Islander people.

## Research shows gap in healthcare data surveillance

With an estimated 175,000 Australians affected by healthcare-associated infections (HAI) each year, new research published by the AHHA supports the introduction of a national data surveillance program.

AHHA Chief Executive Alison Verhoeven says that the research, featured in the organisation’s peer-reviewed journal, the *Australian Health Review*, shows how the health sector can act to curb rates of infection. “While there a number of Australian states and territories that employ HAI surveillance programs, these are not standardised like we see in many other countries,” Ms Verhoeven said.

“As a result, the use of the data collected by these disparate surveillance programs is very limited... By leveraging off existing Australian and international programs, we can develop an effective surveillance program that can detect clusters or outbreaks of HAIs, identify programs and evaluate prevention and control measures; ultimately driving improvement.” <sup>ha</sup>





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## Clinical Practice Improvement Short Course

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The short course – also suitable for patient safety officers, quality improvement officers and clinical risk managers – is presented by the Australian Healthcare and Hospitals Association in collaboration with Peloton Health Care Improvement Consulting.

### Short course dates

#### Sydney

4-5 May 2015, Novotel Sydney Central

#### Melbourne

11-12 May 2015, Mantra Southbank

#### Brisbane

15-16 June 2015, Novotel Brisbane

Limited places available

### Contact us

E: [admin@ahha.asn.au](mailto:admin@ahha.asn.au)

T: (02) 6162 0780





PAUL DUGDALE

Chair of the Australian Healthcare and Hospitals Association (AHHA)

# Rethinking Federalism

## Starting point should be health, not finance

**T**he health sector needs both a greater level of certainty on how the increasing pressure on public hospitals is going to be funded and a stronger focus on preventative health. In striving toward these goals, the AHHA supported the calls made by NSW Premier Mike Baird for the Commonwealth Government to explain how future hospital funding will be placed on a sustainable footing. This follows the 2013-14 Budget, which saw the Commonwealth Government's unilateral withdrawal from the long term hospital funding arrangements that had been mutually agreed between the Commonwealth, states and territories.

The Commonwealth cannot expect the states and territories to fund the Commonwealth Government's budget repair, part of which it has said will include drastically cutting funding to public hospitals through the Commonwealth-state funding agreement by over \$50 billion from 2017.

The Prime Minister and Treasurer point to the Reform of the Tax System and of the Federation as the way to re-consider financial relations between tiers of government and how critical public services like public hospitals could be funded. While reform of our Federation and the tax system are important dialogues that governments need to have between each other, and with the Australian public, we need action on hospital funding now.

The 2015 Budget, to be released in May, provides the Commonwealth Government with an opportunity to undo the damage to sustainable hospital funding caused by the 2014 Budget. The Government has already withdrawn several measures from last year's Budget, showing some flexibility in achieving their financial objectives and meeting the

health needs of the Australian public

The White Paper's process to Reform the Federation repeatedly refers to the issue of vertical fiscal imbalance – the Commonwealth raising more revenue than required for their responsibilities, and the states and territories having greater service commitments than they have the capacity to fund. This was a point of discussion at the AHHA's *Think Tank on Reform of the Federation and Health* on 16 March 2015 at Old Parliament House, Canberra.

It was acknowledged at the event – which brought together over 130 health leaders from around Australia – that the funding and determination of health priorities are a shared responsibility across governments. Changes cannot be made at one level of government without contemplating the impact this will have on the other. The so-called vertical fiscal imbalance is in fact a beneficial result of the states ceding taxation powers to the Commonwealth in the act of federation, done with the recognition that it can be fairer and more efficient for the Commonwealth to run the lion's share of the nation's taxation regime and then distribute a goodly share of the proceeds to the states, than for each state to run their own tax systems.

The AHHA calls on the Government to use the coming Budget to reinstate appropriate levels of funding for public hospitals – funding that recognises the growing demand for hospital services and the efficiencies that are being achieved as part of national health reforms.

In regards to the need for a stronger focus on preventative health, the recently-released fourth Intergenerational Report (IGR) confirmed that participation and productivity are cornerstones of a healthy economy into the future, and both of these are dependent

on a healthy population, able to work and contribute to their full potential.

The report recognises the contribution of health promotion efforts to the excellent health outcomes enjoyed by most Australians. Anti-tobacco policies and initiatives such as the introduction of seatbelts have had a major impact on the better health outcomes we now enjoy. Yet there is little recognition in the report of the role governments must play in investing in health promotion activities.

With the significant disparity in Indigenous health outcomes, rates of obesity on the increase and excess alcohol consumption placing a major burden on the health system, we must as a nation invest in health promotion and primary care. Otherwise the goals of increased participation and labour productivity improvements forecast in the IGR will be jeopardised.

On the positive side, the IGR states that projected growth in Australian government spending on health will broadly keep pace with Australia's growing and ageing population and will be slower than projected in previous IGRs. This may already be evident in the reduction reported in 2013-14 by the Australian Institute of Health and Welfare. It is surprising that the proposed policies from the Commonwealth therefore appear to be based on a view that the pace of growth is unsustainable and requires drastic measures.

Health must be seen as an investment in the future, not a drain on budgets to be managed to meet short-term electoral goals. Governments at all levels must work together to ensure appropriate funding for public hospitals and primary health – revisiting the National Partnership Agreements agreed by all jurisdictions would be a good starting point. **ha**

# Reform of the Federation and health

## AHHA's Alison Verhoeven and Linc Thurecht discuss opportunities for change

**A**s a contribution to the Reform of the Federation process, on 16 March 2015 the Australian Healthcare and Hospitals Association (AHHA) brought together over 130 health leaders to discuss the challenges and opportunities for change in the way health services are provided to all Australians.

The Prime Minister has called for a mature debate on the process of reforming the Federation. This Think Tank provided the opportunity for representatives with a wide range of perspectives to discuss how our health system could be alternatively structured to realise better health outcomes for all Australians.

Many issues were raised and debated on the day. But perhaps the threshold issue related to complexity in our current system. This results in the many known problems of accountability gaps, waste, confusion amongst both consumers and providers, and a system that does not fully meet the health needs of large sections of our population.

A diverse range of solutions were canvassed, from a call for one big idea to drive reform as a catalyst for positive change, to a call for radical change due to the current complexity providing an excuse for failure. In contrast were

proposals for a focussed set of small ideas to make incremental but meaningful and tangible change.

The challenge of managing chronic disease, both in terms of prevention and the need for integrated patient-centric care, was a constant theme. Those with chronic disease are not being served well by the current system according to many commentators, and the cost burden is large with 36% of health expenditure being spent on the top four chronic diseases in Australia. The more strategic way we have responded to communicable diseases was contrasted to the current approach to chronic disease.

E-health was also identified as essential in improving how the health system operates, and in particular, improving quality of care and patient safety. Information is the critical link on the handover between GPs and community care, primary and acute care and needs urgent attention. The importance of nationally consistent data collections to improve efficiency and accountability was also discussed.

Regional healthcare planning was seen as crucial in the provision of good healthcare, and localism was proposed in meeting the needs of communities as “we live in a community, not a health system”. Examples of success with

the provision of integrated care and local community engagement were shared, as was the need to avoid a postcode lottery of services.

How the health system should be funded was a key focus of the day's discussions. The prevailing view of Government that health spending is out of control was not widely accepted by participants, and it was noted that the Government's fiscal strategy has been to increasingly shift the cost burden to the states and territories and to consumers.

It was argued that “finance should serve good health policy, not the other way around”, and that while we do not have a “crisis in tax”, there are challenges to address, including the need to strengthen the tax base. The distributional impacts associated with reform of taxation need to be at the forefront of any proposed change.

Some characterised the health system as performing well, while many others called for alternative models of healthcare with the patient at the centre. A view was expressed that to devise the best health system, we should not start with Federalism. It was also argued by some participants that health reform does not need to be linked to tax reform.

So what role should the Commonwealth play



The Hon. Catherine King MP  
Shadow Minister for Health



The Hon. Sussan Ley MP  
Minister for Health



Senator Richard Di Natale  
Greens spokesperson on health

in healthcare? National interest considerations relating to quarantine and health system regulation were accepted, though for one speaker, obvious areas for the Commonwealth involvement in the health system were “hard to find”. The possibility of devolving MBS and PBS responsibilities to the states and territories was also canvassed. It was proposed that the Commonwealth’s role in health be re-cast to be that of a steward, concerned with strategic issues and ensuring accountability.

What to make of all this? With a diverse range of delegates came a diverse range of views. There was unanimous agreement on the need for change in the way health services are provided. There was also an overall sense that the Commonwealth should devolve the majority of its health service delivery responsibilities.

But if this responsibility should be passed to states and territories or even lower to provide a more focussed regional approach was not resolved. The Commonwealth could retain a role as an overarching steward of a new system of health service provision. Specific objectives, responsibilities and powers in this respect would need to be further explored.

More fundamentally, there was a view that a simple devolution of health delivery responsibilities is not enough. Providing

a clear demarcation of responsibilities between levels of government and other ad-hoc incremental change is only patching a system not well designed for the contemporary health needs of Australians. Alternative models of care with the patient at the centre and with a system of healthcare based on a core set of principles could be explored. This suggests that the Reform of Federation process should not be based on legacy institutional arrangements.

With respect to funding of health services, the analysis presented did not suggest that we are in a fiscal crisis, though many participants noted that the Commonwealth’s decision in 2014 not to honour partnership agreement provisions for growth funding of hospitals presents an enormous challenge for the states and territories.

The Commonwealth Government’s current approach to health funding is clearly pushing the growing burden of funding healthcare onto the states, territories and individuals. Any changes to the tax system need to ensure the long term financial sustainability of healthcare providers, and that the distributional impacts of any increase in individual contributions to health care costs do not adversely affect the less well-off.

The Prime Minister in his Sir Henry Parkes Oration last October called for a “measured debate” and noted that, “What’s needed now is not a final answer but a readiness to consider possibilities.”

The next formal step in this reform process is the release of the two Green Papers on Reform of the Federation and Reform of Australia’s Tax System. If these Green Papers are to be as visionary as the Prime Minister has called for, they need to do more than just propose the passing of a set of functions between levels of government.

A measured debate around all these issues must include the broad engagement of all health stakeholders, not just selected advocacy or private sector groups. It should build on the work done by the National Health and Hospitals Reform Commission, and take into account the very real health needs that are not being met adequately within our current institutional and funding arrangements.

And finally, it should consider new ways of doing things, not just a passing of the baton from one level of government to another, or worse, a palming off of responsibility to ensure high quality health services for all Australians. [ha](#)



Rosemary Calder AM  
Mitchell Institute for Health and Education Policy



Lyndon Seys  
Alpine Health



Barbara Reid  
ACT Health



'The flagpole in central Sydney's Darling Harbour' by James Cridland.  
Image sourced from Flickr (CC BY 2.0: <https://flic.kr/p/3sWhGW>).



**THE HON. SUSSAN LEY**  
Minister for Health; Minister for Sport  
Australian Government

# Consultation at the coalface

## Informing Australia's health policy of the future

Since my appointment as Minister for Health and Minister for Sport, I've been travelling the country talking to a wide variety of health professionals and patients to discuss their views and ideas about how best to ensure our health system remains world-class for generations to come.

I am a strong believer in the essential role preventative health plays in keeping us happy and healthy in our daily lives, as well as the importance of being able to access high-quality care and treatment when we need it.

I also believe the fact we're living longer as a result of these ongoing health advancements should be celebrated, rather than seen as a negative burden on the health system.

However, as we all understand from running our own budgets – whether it's a small practice, a large hospital or the nation's finances – we also need to ensure we spend wisely to ensure we get maximum benefit for patients and health professionals from our investment.

This can be a difficult balancing act to get right, particularly in such an important public policy area like health that interacts with the daily lives of all Australians.

It is certainly something that I come across regularly as a regional member of parliament representing a third of NSW, where health issues vary as widely as the size of the cities and small rural and remote communities throughout my electorate.

That's why I'm determined to deliver on my promise to be a consultative Minister for both Health and Sport and get out

there on the ground talking to people at the coalface.

I want to ensure the Government has a clear understanding of the challenges currently facing the health system and how we can improve on them for the benefit of health professionals and patients alike.

A key part of this from a Federal Government perspective includes protecting Medicare for the long-term.

In the last decade spending on Medicare has doubled from \$10 billion in 2004-05 to \$20 billion in 2014-15. Spending is projected to climb to \$35 billion in the next decade.

Yet, you may not be aware that we currently raise only about \$10 billion from the Medicare Levy – or about half of all Medicare spend. This has fallen from about 67% ten years ago.

We also have a situation where 72% of services provided to non-concessional patients were bulk billed last year. There are therefore clearly those with the means to make a modest contribution to the cost of their care.

A modest co-payment is something that has long been proposed by groups such as the Australian Medical Association and even the Labor Party and I will continue to consult with health professionals about the Government's current proposal.

As such, I have set the following four

principles to help guide my Medicare consultations and deliver constructive proposals:

- protecting Medicare for the long term;
- ensuring bulk billing remains for vulnerable and concessional patients;
- maintaining high quality care and treatment for all Australians; and
- ensuring that those who have the means make a modest contribution towards the cost of their care.

The consultations with health professionals have been positive and have seen many constructive ideas put on the table for consideration.

Yes, at times there has been some frank advice and honest feedback during these sessions and I welcome it.

I consider this a genuine consultation effort on Medicare reform and therefore we are listening carefully to what is being said and taking note.

However, overall I continue to be impressed and spurred on by the general understanding and

optimism about the need for genuine reform of the way health services are funded in this country.

Rest assured my consultative approach as Minister will continue across the broader Health and Sport portfolios and I hope to work closely with you in 2015. **ha**

**I want to ensure the Government has a clear understanding of the challenges currently facing the health system and how we can improve on them for the benefit of health professionals and patients alike.**

**ALISON VERHOEVEN**

Chief Executive  
AHHA

# New Primary Health Networks announced

Now is the time for them to get to work and for the Commonwealth to show health policy leadership

The announcement by Health Minister Ley of the successful bids for the new Primary Health Networks (PHNs) on 11 April has provided clarity for the organised primary care sector, their staff and clients. But strong support is now needed from all levels of government and from professional groups to ensure the PHNs are able to get to work and make a positive contribution to the health system, particularly in the commissioning of regional health services based on community needs.

With only 11 weeks for PHNs to be fully operational – with new partners, governing boards, clinical and community advisory councils, premises and staff to support primary health across much larger regions than in the past – the job will be challenging. Maintaining patient services, for example in mental health, must be a priority as transition plans are implemented and organisations are developed.

The previous transition from Divisions of General Practice to Medicare Locals (MLs) was problematic in some areas, and similar difficulties can be expected. It will be important to build on the experience of MLs, and not lose hard-learned lessons. Support will be required from the Commonwealth and state and territory governments, as well as professional groups, to ensure the new organisations are fully effective in a timely manner. Stronger policy leadership on the role of primary care is needed from the Commonwealth in particular – work on the National Primary Care Strategic Framework, which has been in limbo for 18 months, must be reactivated.

Despite the disruption of the past 12 months, there is significant goodwill amongst all parts of the health system and across Australia to ensure that the new PHNs make a strong contribution to a high functioning primary care sector, maintaining continuing of care

for clients, and exercising leadership in collaboration with clinicians, consumers and the community, to develop innovative models of care which will improve health outcomes for all Australians. The AHHA looks forward to working closely with them.

The hard work and commitment of Medicare Local staff and board members across Australia over the past 12 months, as they faced uncertainty about their employment, must be acknowledged. Every day, more than 3,000 Medicare Local staff across the country have continued providing important services to support the health needs of their clients, many of whom are amongst the most vulnerable in our communities. It is unfortunate that some staff have today learned of their loss of employment via news reports in the media. The AHHA applauds the Medicare Local network and staff for their dedication and resilience. [ha](#)

## Primary Health Network

## Applicant (Lead)

## State/Territory

Central and Eastern Sydney	EIS Health Limited	New South Wales
Northern Sydney	Northern Sydney Medicare Local Ltd	New South Wales
Western Sydney	Wentwest Limited	New South Wales
Nepean Blue Mountains	Wentworth Healthcare Limited	New South Wales
South Western Sydney	South Western Sydney Medicare Local Ltd	New South Wales
South Eastern NSW	Coordinare Limited	New South Wales
Hunter New England and Central Coast	HNECC Ltd	New South Wales
North Coast	North Coast Medicare Local (NSW) Ltd	New South Wales
North West Melbourne	Melbourne Primary Care Network Ltd	Victoria
Eastern Melbourne	Eastern Melbourne Health Network Ltd	Victoria
South Eastern Melbourne	South Eastern Melbourne Primary Health Network	Victoria
Gippsland	Gippsland Medicare Local Ltd	Victoria
Murray	Loddon Mallee Murray Medicare Local Limited	Victoria
Grampians and Barwon South West	Barwon Medicare Local Pty Ltd	Victoria
Brisbane North	Partners 4 Health Ltd	Queensland
Brisbane South	Metro South Medicare Local Ltd	Queensland
Gold Coast	Primary Care Gold Coast Limited	Queensland
Darling Downs and West Moreton	Darling Downs and West Moreton Primary Health Network	Queensland
Western Queensland	North West Hospital and Health Service	Queensland
Central Queensland and Sunshine Coast	Sunshine Coast Health Network Ltd	Queensland
Northern Queensland	Mackay Hospital and Health Service	Queensland
Adelaide	Northern Adelaide Medicare Local Limited	South Australia
Perth North	WA Primary Health Alliance Limited	Western Australia
Perth South	WA Primary Health Alliance Limited	Western Australia
Country WA	WA Primary Health Alliance Limited	Western Australia
Tasmania	Tasmania Medicare Local Limited	Tasmania
Northern Territory	Northern Territory Medicare Local Ltd	Northern Territory
Australian Capital Territory	ACT Medicare Local Ltd	Australian Capital Territory

# International Hospital Federation

## 2015 International Awards

*Supporting recognition of excellence, innovations and outstanding achievements in global healthcare leadership and management.*

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- Quality and Safety and Patient-Centered Care
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#### Eligibility

- AHHA membership
- Demonstrated excellence and achievement at facility or unit level through an activity with proven results

#### Award trophy and prizes

##### Winners:

- US\$2,500 to cover travel and accommodation to attend the 39th World Hospital Congress in Chicago in October 2015
- 2 complimentary Congress registrations
- International exposure through IHF publications and healthcare media network

##### Runners-up:

- 1 complimentary Congress registration/category
- International exposure through IHF publications

### IHF/DR KWANG TAE KIM GRAND AWARD

#### Eligibility

- AHHA membership
- Demonstrated fields of excellence and achievements with proven results at health system or facility level in several areas such as:
  - quality and patient safety
  - corporate social responsibility
  - innovations in service delivery at affordable costs
  - healthcare leadership and management practices

#### Award trophy and prizes

##### Winner:

- US\$5,000 to cover travel and accommodation to attend the 39th World Hospital Congress in Chicago in October 2015
- 3 complimentary Congress registrations
- International exposure through IHF publications and healthcare media network

##### Runners-up:

- 2 complimentary Congress registrations
- International exposure through IHF publications

### ENQUIRIES

Sheila Anazonwu  
IHF Partnerships and Project Manager

**Email:** [2015awards@ihf-fih.org](mailto:2015awards@ihf-fih.org)

**Tel:** +41 (0)22 850 9422

### ENTRY SUBMISSION

Submissions are online-only. To submit, go to:

**[https://congress.ihf-fih.org/awards\\_login](https://congress.ihf-fih.org/awards_login)**

**Submission deadline:** 12 June 2015

**Winners announced:** 7 August 2015

**Note for Asian countries:** If you are considering entering the IHF International Awards, you may also want to enter the **HMA Asian Hospital Management Awards**. Please visit <http://hospitalmanagementasia.com/>

<http://www.worldhospitalcongress.org/en/abstracts-awards>





# The science behind harm prevention in healthcare

**Ms Bernie Harrison** of Peloton Health Care Improvement Consulting writes about the origins of improvement science and its relevance to Australia's health system in 2015

**T**here has been an increasing focus, both in Australia and internationally, on the design or redesign of healthcare services to prevent harm. This represents a shift away from simply reporting or counting harm and, instead, going a little further ‘upstream’.

It is an approach used successfully by other industries or sectors – such as in aviation, nuclear and mass transit systems – that have developed high-reliability through tackling issues or systematic errors at their root cause.

When looking at human factors for example, it is important to examine what the brain does well and what it does poorly, then implementing safeguards and creating more efficient systems. This is the crux of improvement science: to design and redesign systems to improve efficiency and, where possible, reduce or remove the chance of error.

Its history stems back to the work of W. Edwards Deming and Joseph M. Juran, who worked to improve large scale manufacturing processes in America in the 1940s. They believed that the people who work on the frontline – within the system – are the ones with the profound or fundamental knowledge key to process improvement and waste elimination. This principle is the main essence of improvement science today.

To improve the efficiency or safety of treatment in health services in Australia, we need to ensure that the micro-system design or redesign is inherently local.

This means that, whether it’s working to prevent harm in the operating theatre or making sure patients don’t go home without their medication, it’s essential to include health professionals involved in the microsystem; it’s what the nurse does, it’s what the pharmacist does, and it’s what the doctor does.

It is not a process that can be carried out by senior managers, executives or bureaucrats in isolation from the health professionals who provide the care, write the scripts and administer the medication. It is because health professionals are at the

‘pointy end’ of healthcare that they are best placed to give a proper diagnostic of process failure and begin to find a solution.

Through the Clinical Practice Improvement Short Course, delivered in partnership with the AHHA, participants are invited to do just this; to identify an existing issue in their workplace and undertake small cycle testing of a process change within their work environment. This allows health professionals to discover any possible flow-on effects in the system before widespread implementation of change.

This testing is an essential step because when changes are implemented before ever being tested – as they often are in healthcare – we fail to ask the important question: when is the change going to work and when is it going to fail?

Using improvement science in this way helps to overcome a criticism of the healthcare sector that is often made by other industries that we are far too reliant on the flawed human memory.

The problem with health professionals providing non-standardised care which results in widespread variation in practice is that you can’t guarantee an outcome. Not only is there variation between facilities, but there is also variation within facilities, with the possibility of clinicians varying their approach day to day.

This standardisation of procedures is often met with suspicion from medical professionals because they value and aspire to clinical autonomy, and warn of the dangers that can come from ‘cookbook medicine’. However, this need not be the case.

The idea of mass customisation – the 80/20 rule – is particularly applicable to healthcare, in that 80% of patients with common presenting conditions like heart attacks, asthma, appendicitis and pneumonia can be treated on a protocol, while the other 20% require customised treatment because of their co-morbidities.

The advantage of systematising routine

care is that the analytical part of the brain is left to do the problem solving and deal with the more difficult cases. While we never want health professionals to lose the ability to deal with novel situations, the vast majority of patient presentations are predictable.

For instance, 10 years ago we saw the development of ‘fast tracking’ through emergency departments in hospitals for patients who have lower triage scores. This allowed these patients, many of whom just needed an x-ray, to get a quick referral to a fracture clinic or physiotherapist instead of waiting for hours to be seen.

While this has now become standard practice for most emergency departments,

it was very innovative at the time and came with its own set of challenges and flow-on effects. We had to learn that if you fast track a patient through

the emergency department, then you also had to be able to fast track them through the radiology suite, pathology clinic and plaster clinic etc.

This shows the tremendous difference that improvement science can make, creating a more efficient model that both eliminates waste, reduces harm and improves the patient experience.

Good clinicians often make it their business to understand and improve the multiple and complex processes within the healthcare system because, ultimately, it helps save money, reduce harm and increase patient satisfaction. And that’s a goal that we can all aspire to. 

**To improve the efficiency or safety of treatment in health services in Australia, we need to ensure that the micro-system design or redesign is inherently local.**

**Bernie Harrison is the founder of Peloton Health Care Improvement Consulting and is currently providing short courses on Clinical Practice Improvement and Root Cause Analysis in partnership with the AHHA. For more information, visit the AHHA website: [www.ahha.asn.au](http://www.ahha.asn.au)**



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**CHRISTINE ILETT**  
Clinical Nurse Consultant  
Wide Bay Hospital and Health Service

# Promoting change

## Why a culture of process improvement and waste elimination needs to start at the top

**T**he Wide Bay Hospital and Health Service (HHS) includes three major hospitals – Bundaberg, Hervey Bay and Maryborough – and eight rural hospitals, with each serving the distinct needs of their respective communities and responding to unique sets of challenges.

When considering process improvement and waste elimination, it is important to have an organisation-wide culture where staff at our various facilities can help drive performance, ensuring that the patient journey is as smooth and timely as possible. The Wide Bay HHS fortunately has a senior management team that understands this, having fostered an organisational culture that is conducive to change.

However, the culture hasn't been created overnight; it has followed a period over the last few years where we have done some really hard yards to lift performance. In doing so, we have built an environment receptive to the philosophy of Lean thinking, with a staff that understands the importance of continuously striving to improve.

We have now developed a strategic plan to guide the organisation through the next three years, providing clear direction and strong foundations needed to achieve our goals. Part of this plan involved the development of five pledges, to which we will align all of our future organisational activities, programs and decisions. These include: 1) delivering a sustainable, patient-centred quality health service; 2) engaging with our community and partners; 3) developing and empowering our workforce; 4) encouraging innovation and excellence; 5) delivering value for money.

With these foundations in place, it is an opportune time for our staff to undertake the

Lean training run by LEI Group Australia in partnership with the AHHA.

We are excited at the potential that will come from the course, which includes a group of about 50 of our employees across three groups currently undertaking Yellow Belt training, and a further 12 employees undertaking the more in-depth Green Belt training. The Yellow Belt training will provide staff members with an overview of the basic Lean principles and tools to support the

to come out of the training, with many positive overlaps and flow-on effects trickling through the organisation. We are all eager to see the results, which shows the importance of having senior management setting the tone and letting that culture spread down to the staff on the ground. Part of empowering employees is giving them the tools and techniques necessary to be leaders within the workplace; that's one of the reasons that this Lean training is being undertaken. We are



Yellow Belt Group 1. Image courtesy of Wide Bay HHS.

Green Belt participants both in identifying Lean opportunities and implementing major projects within Wide Bay HHS facilities.

I am sure there will be a variety of projects

confident that it is the right way to continue to drive improvement across our facilities and their varying caseloads, ultimately helping Wide Bay HHS better meet the challenges of the future. **ha**

# Getting value for money

LEI Group Australia's Business Manager **Margaret Ledwith** reviews the value of healthcare continuous improvement projects



**H**ow confident are you that any healthcare continuous improvement initiatives that you have been involved in, are planning, or are considering undertaking, actually represent value for money?

For some, this question may be easy to address as it may call to mind ‘no brainer’ projects which simultaneously saved money and improved quality. Continuous improvement approaches, such as the Lean management philosophy, are increasingly used in healthcare precisely because they are frequently credited with benefiting patients, improving staff morale and enhancing the financial performance of service providers.

Often however, it can be difficult to even complete the initial step of clearly outlining a value for money criterion against which to judge a project. Furthermore, continuous improvement in healthcare is a broad term that encompasses a range of types of potential projects, outcomes, implementation tools and methods. As such, continuous improvement approaches may comprise a combination of training, role redesign, reorganisation of workplace layout and changes in how data is measured and communicated. Investing in continuous improvement may involve releasing staff time to undertake the mapping of processes, improving visual controls and implementing rapid improvement projects so as to improve the efficiency with which information, people, equipment and medications interact within healthcare processes.

In addition to the direct staff and training costs generally associated with continuous improvement projects, there may also be expenditure on external consultants and mentors or investments in enabling technologies. The redesigned processes that result from such investments may have cost and benefit impacts that span multiple departments, which may also extend beyond the sponsoring organisation. It can be far from straightforward to work out how to take an integrated approach that appropriately accounts for the multiple returns to patients, staff and healthcare funders from continuous improvement investments. Comparing the relative returns on investment of diverse

continuous improvement initiatives in diverse areas of an organisation, each with different measures of benefit, can also be challenging.

The massive ongoing development and adoption of services derived from the collation and analysis of healthcare data – such as electronic healthcare records, e-prescribing, clinical decision support systems, knowledge management systems and the products that will result from increasingly sophisticated linkage and interrogation of multiple healthcare datasets – mean that the next decade and beyond is likely to be characterised by further significant change in how healthcare processes are designed and implemented.

Change on this scale involves potential risks as well as benefits for healthcare organisations. Not all continuous improvement strategies will be successful or will represent value for money. Some continuous improvement investments may result in unintended consequences such as creating new sources of error, more rapid and widespread replication and dissemination of individual errors, increased administrative burden on clinical staff and making some information less accessible. It is therefore increasingly important that healthcare organisations have access to high quality, context-relevant information about the potential clinical and financial impacts of the continuous improvement strategies they are considering.

That said, data and analyses relating to the value of continuous improvement strategies are scarce and, when available, are not always of high quality. Unlike medicines and medical devices – where purchasing decisions are informed by a significant body of quality health economic data (a significant proportion of which is funded by the manufacturers and marketers of these products) – there is almost a complete absence of full economic evaluations of methodologies, such as Lean, and the overall quality and transferability of health information technology economic evaluations has been widely noted as unsatisfactory (though it is improving). Furthermore, administrators and clinicians in healthcare organisations have limited skills and confidence in understanding and applying health economic evaluation evidence, which

is predominantly written for and by those engaged in re-imburement policy making (an overly narrow focus by health economists that has been described by others as ‘the addiction to adoption’).

The underdeveloped linkages between health economics and continuous improvement is something that needs to be addressed to provide meaningful evidence to help decision-makers to achieve optimal returns from their continuous improvement investments. There are a number of specific areas in which increasing the use of health economic tools and techniques can make significant contributions.

At the heart of healthcare continuous improvement approaches, such as Lean, is the placement of patient needs at the centre of every decision in a process, as well as an understanding of value from the perspective of the patient. Health economic preference elicitation techniques provide a means of quantifying the value to patients of continuous improvement outcomes as well as information of wider potential usefulness than patient satisfaction surveys.

Full health economic evaluation techniques, such as cost-benefit, cost-effectiveness and cost-utility analyses, provide integrated measures of costs and consequences deploying well validated value for money benchmarks. In addition to addressing questions of value for money through these approaches, budget impact analyses can provide additional information relating to questions of affordability.

Some health economic evaluation techniques such as discrete event simulations are natural companions to process mapping activities. These can provide detailed modelling that inform decisions about complex projects with potentially significant outcomes.

Leading Edge Group ran a series of training workshops in Canada and Ireland last year focusing on the health economics of continuous improvement and an online Green Belt course on this topic will be available soon. Hopefully, these and other initiatives will encourage greater use of valuable health economic techniques in both assessing the performance of previous continuous improvement projects and informing future investment decisions. **ha**



# Embracing the Lean philosophy

From huddle forums to vision boards, Lean techniques are currently being implemented to great effect at the Royal Dental Hospital of Melbourne. The Manager of Surgery at Dental Health Services Victoria (DHSV), Wesley Smith, spoke to the AHHA's **Dominic Lavers** about how recent training has helped put the organisation on track to meet some ambitious targets.

As part of its aim to increase the number of eligible Victorians it cares for from 14 to 20% of the state by 2016, the Royal Dental Hospital of Melbourne last year undertook a Lean training course in improving processes and eliminating waste.

The training, run by LEI Group Australia in partnership with the AHHA, encouraged both clinical and non-clinical staff to think differently about their roles; moving beyond their particular skills towards new models of care that consider the whole system.

The hospital has since incorporated Lean philosophy into its day-to-day activities, with DHSV Manager of Surgery, Mr Wesley Smith, saying that staff members have driven significant change within the organisation.

"We're creating processes that allow us to do more with less human effort, space, capital, and time," Mr Smith said. "Our goal is to deliver services that are cost and time effective and it's fantastic that our staff have been achieving a lot more with the resources we have. We have some of the best clinicians in the world. And to make sure that we provide the best service that we are capable of, we are always working together to find new ways to improve our

systems and service flow. The beauty of Lean training is that it equips both our clinical and non-clinical staff with the tools to take a step back and look at the way their roles function within the system.”

To encourage this kind of thinking, teams begin each day by forming ‘huddle forums’, five minute meetings where each staff member is invited to share learning and ideas on how to improve services and patient care.

The huddle forums give staff members the opportunity to communicate regularly with each other about any process or procedural limitations, look at a particular function through a fine lens and make sure any internal work flows are aligned with the most efficient process.

For example, one project looked at the equipment used in the operating suite which previously required the Central Sterilising Service Department to spend about 1.5 hours every day on sterilisation processes. Dental assistants also had to manually select 26 individual items to prepare for each individual case and numerous staff were involved in setting up the operating suite.

It was identified by a staff member in

a huddle forum that the 26 items used in the sterile surgical setup could be acquired through one disposable product, rather than packed individually and later sterilised.

“We took that idea and developed a working party, examining what impact the change would have on efficiency, cost and waste,” Mr Smith said. “As a result, we have gone from a linen-based service to a single-use disposable option, which means that staff members don’t have to prepare all 26 individual items. It is an example of one simple innovation that has certainly reduced our waste and improved efficiency. As the items come to the hospital already sterilised, it has saved our sterilising team 1.5 hours each day, as well as reduced our electricity, water and steam usage significantly across the organisation. There have also been flow-on benefits for other departments. This idea has actually turned into a more wide-reaching Lean project itself, as we seek to identify further opportunities to reduce waste and find more efficient ways of doing things.”

Mr Smith said that Lean philosophy had become a culture within the organisation, with staff being involved every step of the way. “We have built up now what we call ‘vision boards’, which communicate to staff members the status of current Lean projects. This allows them to see the progress made in turning their ideas into everyday practice, as well as letting them know that the team have turned their vision into a Lean improvement. The staff has really engaged with the training

and we have people talking about it every day; sharing with colleagues when they have identified a possible Lean opportunity or discussing ideas with my surgery team as we do our

daily rounds with the other departments. Ultimately, The Royal Dental Hospital of Melbourne wants to deliver better care for patients and achieve our goal of providing services to 20% of Victorians by 2016,” Mr Smith said. “With the help of Lean, we’re well on our way.” 

**“We’re creating processes that allow us to do more with less human effort, space, capital, and time”**



**YVETTE BLOUNT**

Macquarie University Centre for  
the Health Economy

# Sustainable telehealth

## Rethinking the culture and skills required

**T**echnology is a major driver of change in many industries such as retail, travel and banking. Health care delivery is no exception.

Access to affordable fast broadband, public and private hospital information systems (including the personally controlled electronic record), the ability to capture high resolution photos, video-conferencing and cloud storage as well as increasingly sophisticated smartphone apps are changing the way health care is delivered and how patient data is collected and stored.

Patients can use smartphone apps, not just to monitor conditions such as blood pressure or glucose levels, but to obtain a diagnosis.

Eric Topol explains in his book, *The Patient Will See You Now: The Future of Medicine is in Your Hands*, how a patient who after using an electrocardiogram (ECG) app (approved by the U.S. Food and Drug Administration) sent him the ECG results with the message: “I’m in atrial fib, now what do I do?” In other words, increasingly, these apps not only record data – they can diagnose.

So what do these technologies mean for telehealth and the culture and skills for stakeholders, particularly clinicians?

The Australasian Telehealth Society defines telehealth as *delivering healthcare services over distance using information and communication technologies (ICT)*. Increasingly health services can be delivered using technology wherever the patient resides.

This is important for regional and rural Australia because rural patients wait, on average, twice as long to see a general

practitioner when compared to their city counterparts (more than six days compared to three days). In some regions the wait is four times as long (more than 13 days).<sup>1</sup> Rural patients have similar issues with access to specialist services. Telehealth has the potential for more equitable access to health services by closing this gap.

In a recent study by Macquarie University’s Centre for the Health Economy, 45 registered nurses, general practitioners, specialists and allied health professionals were interviewed. The purpose of the study was to examine the barriers to the sustainable adoption of telehealth from the perspective of the clinicians. A key theme that emerged was the reluctance of clinicians to use technology and/or change their business practices.

The success of telehealth in rural and regional Australia relies on relationships between the clinicians involved in the care of the patient, in particular, the general practitioner and the specialist.

Leaving the issues of funding and business models aside (an area that requires further research), the first hurdle is identifying the clinicians who are willing to provide telehealth health care services.

For example, one rural general practitioner noted that some specialists do not always continue their telehealth practices because “they’ve got appointment books that are already overflowing... their books are full

with local patients so there’s no time [for telehealth consultations].”

For telehealth to work, clinicians need the skills to operate in a virtual team with multiple stakeholders. For example, a consultation involves the patient, specialist, general practitioner, possibly a practice nurse, as well as someone to set up the technology and appointment to facilitate the consultation. This in itself can be a challenge for rural and regional areas, as

some communities don’t have a general practitioner who can assist with the consultation.

The consultation also requires schedules to align (one clinician may be running late for example), the patient has to show up, the clinical notes have to be recorded

**The success of telehealth in rural and regional Australia relies on relationships between the clinicians involved in the care of the patient, in particular, the general practitioner and the specialist.**

and someone has to be accountable for follow-up.

Telehealth is more than just a video conference. Follow-up support to the general practitioner may be required from the specialist via phone or email. There is a role for specialists to work with general practitioners to increase their knowledge about specific areas of practice, such as diabetes treatment.

If telehealth is to be sustainable, it must be both effective (clinically appropriate) and efficient (economically justified). Health data is being captured in various health information systems and apps in large



databases (such as the Personally Controlled eHealth Record).

Clinicians will need skills to be able to access the large volumes of data, make sense of that data and use that data to provide appropriate health services. At the same time, clinicians will need an understanding of the privacy and security issues associated with using technology. <sup>1a</sup>

The Macquarie University Centre for the Health Economy has released a white paper, *Connected Care: Realising the Vision* outlining the key issues relating to the Health Economy. Download the paper at: [http://health-economy.mq.edu.au/research/research\\_papers\\_and\\_journals/white\\_papers/connected\\_care\\_realising\\_the\\_vision](http://health-economy.mq.edu.au/research/research_papers_and_journals/white_papers/connected_care_realising_the_vision).

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**GEOFF SIMS**  
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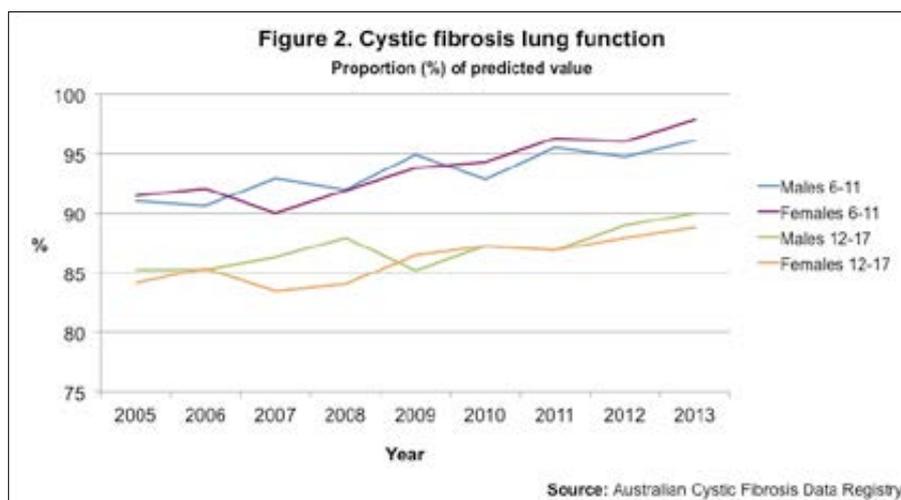
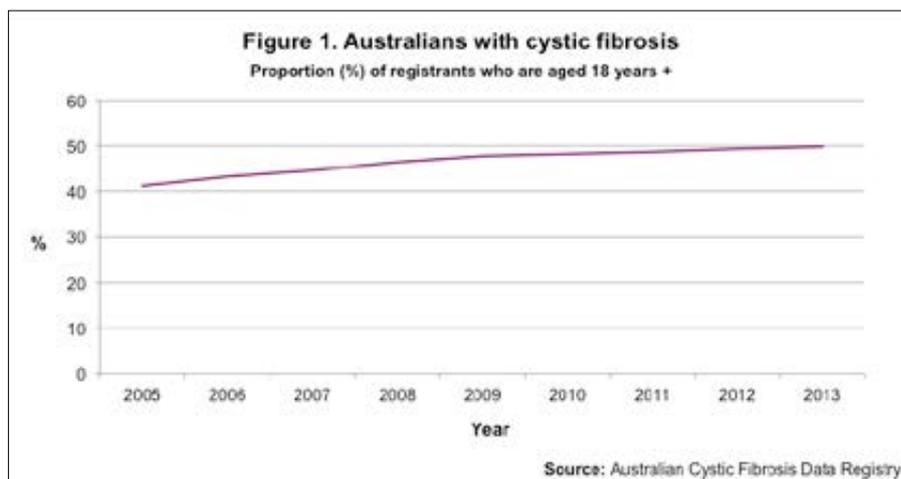
# The Australian Cystic Fibrosis Data Registry

## More than just descriptive epidemiology

The Australian Cystic Fibrosis Data Registry is soon to release its 16th annual report, detailing data up until the year 2013.<sup>1</sup> Demographic, clinical, treatment and social characteristics of over 3,200 people in Australia with cystic fibrosis (CF) are described annually in some detail, and clinically relevant data are returned to the 23 specialist CF treatment centres that contribute data about their patients.

Population-level trends map impressive progress with improving outcomes for people with CF (see figures 1 and 2). Contributing factors to improving survival include early diagnosis via newborn screening, management in specialist CF care centres, better antibiotics and a variety of improved care practices.<sup>2</sup> Implications for the nature of care required for a population that is changing so rapidly are also signalled by these trends. Growth of around 5% per year in the number of adults with CF has placed increased pressure on adult care centres, where patient management issues include a focus on social and family life issues as well as managing complications – such as CF-related diabetes and depression – that had not been as prevalent in younger CF populations of a generation ago. In response, one state government has recently announced additional resources to address the pressures in its adult CF centres.

Registries can be key contributors to knowledge about the progression of rare diseases. CF registries are credited with making an important contribution to the improvement of patient outcomes.<sup>3</sup> Registry data now pervade the CF literature and inform large numbers of presentations



at international CF conferences, from which findings flow into best practice and treatment guidelines. In fact, maintenance of national registries is acknowledged as a quality management component of recently published European Standards of Care for CF.<sup>4</sup> Some current measures of best practice,

such as in nutrition management and the treatment of lung infections, have had direct origins in registry-based comparative studies of outcomes alongside clinical practices at centre level. The Australian registry has contributed to this international pool of learning through published research about

the contribution of neo-natal screening to early diagnosis – which can lead to better long term outcomes – as well as the effect of temperature on the propensity to acquire lung infections.<sup>5,6</sup>

Australian patient data are being pooled with data from other national registries in an important international project at Johns Hopkins University. This ‘CFTR2’ project is progressively identifying which of approximately 2,000 known mutations of the Cystic Fibrosis Transmembrane Regulator (CFTR) gene are CF-causing, and describing their functional characteristics.<sup>7</sup>

Research focus on the specific CFTR mutations has seen the emergence of mutation-specific therapies. Ivacaftor, a novel mutation-specific drug recently approved for funding under the PBS in Australia, is reversing the effect of the G551D mutation on cell function – good news for the 7% of Australians whose CF is caused by at least one mutation of the G551D type. For novel therapies like Ivacaftor, registry data play a role in clinical trial design, in economic evaluation for funding decisions and in post-authorisation safety and efficacy studies (PASS and PAES) – just beginning in the United States and the United Kingdom.

To serve all of the purposes to which registry data are applied, an emphasis on high quality, verifiable, data is important. In this respect, a relationship with eHealth is envisaged in a Framework for Australian Clinical Quality Registries, developed by the Australian Commission for Safety and Quality in Health Care and endorsed by the Australian Health Ministers’ Advisory Committee in March 2014.<sup>8</sup> The Australian CF

data registry has embraced fledgling eHealth activity since 2006, when first provision was made to upload an entire annual dataset from hospitals that had introduced an electronic medical record (EMR) for CF patients. However, hospital data systems are not yet ready for seamless transfer of data to registries, so the real benefits of eHealth for registry data quality are yet to be realised.

The Australian CF registry is managed by Cystic Fibrosis Australia, in a long-standing collaboration with Directors of specialist CF treatment centres. All Australian centres contribute. Patient or parental consent is obtained at centre level and is rarely denied. An Advisory Committee of medical specialists, consulting with allied health professionals, oversees scientific practice. A memorandum of understanding with a Sydney hospital’s Ethics Review Committee provides for oversight of ethical practice, including for use of de-identified patient level data by researchers. Research interest is encouraged.

The 16th Annual Report from the Australian CF Data Registry will be available from Cystic Fibrosis Australia and at its website at [www.cysticfibrosis.org.au/data-registry](http://www.cysticfibrosis.org.au/data-registry). For international focus, reports from other national and regional registries can be obtained through the Cystic Fibrosis Data Network website: <http://www.cysticfibrosisdata.org>. 

**Geoff Sims has managed the Australian CF Data Registry for Cystic Fibrosis Australia for the past 13 years. He is project leader for a Harmonisation of International CF Registry Data project.**

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# Will they understand?

**Cassie Moore**, from Murrumbidgee Medicare Local, tells us why health literacy is everyone's business

**T**he World Health Organisation defines health literacy as *the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health.*

More than half of Australians experience difficulties regarding health literacy. It is a key social determinant of health that is impacting on the wellbeing of Australians, with people experiencing difficulties with health literacy being up to three times more likely than those with higher degrees of health literacy to experience poorer health and live with comorbidity.

The United States has estimated that inadequate health literacy costs its economy \$106-236 billion annually. It is also known to impact its hospital system, with health illiterate individuals requiring longer hospital stays.

While health literacy is an area with many dimensions, taking actions to address illiteracy does not have to

be expensive or complicated. Results are achievable with limited dedicated resources.

The Murrumbidgee Medicare Local (MML) is a primary healthcare organisation covering the large rural and regional area of Southwest NSW. The MML has been addressing health literacy since early 2013, pursuing the vision of being recognised as a health literate organisation. A key factor in the success of the organisation's progress has been due to the commitment from its executives to tackle this issue head on.

As a starting point, the organisation engaged an accredited local provider to deliver a series of interactive workshops for operational staff, senior managers, executive and board directors, as well as providing opportunities of other primary health providers in the region.

Following the training sessions, a Health Literacy Steering Group was formed to develop a plan of action for the organisation. Membership of the

group included the MML's CEO, executive directors, appropriate senior managers and operational staff, with leadership from the Manager of Planning and Health Promotion.

The MML health literacy action plan is nearing completion, with the organisation having now undertaken a wide range of initiatives. These include:

- Development of a consumer friendly map;
- Reviewing signage both outside and inside buildings to assist with access;
- Development of an organisation wide policy;
- New processes for the development of resources and communication with consumers, including seeking consumer feedback;
- Development of an advertising campaign and supporting resource to empower consumers to take control and ask questions when they do not understand;

- Development of a “while you wait” resource to send to patients ahead of their initial appointment; and
- Development of a health literacy toolkit that is available to staff to support the adoption of health literacy principles in their day-to-day work.

The changes implemented as a result of the action plan have ranged from subtle adjustments to complete reviews in operations. The most important aspect throughout the implementation process has been the ownership that staff have had over the changes, not to mention the interest and commitment to make such changes.

Following the provision of training and the implementation of changes to procedures, an evaluation was undertaken to measure the impact of the health literacy initiative. The results were overwhelmingly positive. The majority of managers reported observing changes in the service delivery of their teams, including greater awareness of the kind of

language used and consideration of health literacy principles in any planning and implementation moving forward.

Another indication from the evaluation was that over three quarters of participants in the health literacy program have not only modified their service delivery following participation in the training workshop but they have also observed benefits from incorporating health literacy principles in their day-to-day work. These benefits include patients having a better understanding of their health; patients being more engaged and able to focus during consultations; and clients being comfortable to ask more questions and seek clarification. The adoption of health literacy principles within the organisation has also seen more of a focus on patient-centred care and consumer engagement in processes generally.

A further way that the organisation has evaluated its achievements in health literacy is the use of the ‘10 attributes of a health literate organisation’ tool.

This internationally recognised tool paints a picture of what a health literate organisation looks like and how it operates. Prior to the development and implementation of the health literacy action plan and formation of the steering group, the MML met very few of these indicators. Now, 18 months down the track, the MML reflects each of these attributes and is proud to hold the status of a health literate organisation.

The MML will expand this work into the future by providing support to primary healthcare organisations and providers to assist them in incorporating health literacy principles in their day-to-day practice and ongoing engagement and empowerment of consumers.

Health literacy is everyone’s business and is the responsibility of the entire health sector. It is important to constantly ask ourselves ‘...will they understand?’ Making small changes can make a big difference to the health outcomes of Australians. 

# Pharmacy in review

Following the Pharmacy Practitioner Development Committee's (PPDC) review of the National Competency Standards Framework for Pharmacists in Australia taking place in 2015, **Dominic Lavers** shares findings from some initial background and consultation work undertaken by the AHHA earlier in the year.



**A** move towards a much more streamlined, user-friendly and robust competency standards framework for pharmacists has been supported by a number of key stakeholders at consultations run by the AHHA in 2015.

The AHHA, commissioned by the PPDC to help inform its regular review of the competency standards, is also conducting a national survey, a literature review and an examination of other competency frameworks used in Australia and around the world.

While the findings of this national survey are yet to be released, PPDC Chair Shane Jackson said the literature review and consultations had already provided some

great feedback that would help guide the review of the framework.

"We've received feedback that the profession wants to see the one set of competency standards that act in a continuum from entry level – from university graduation to advanced practice – rather than have two separate frameworks like we have currently," Dr Jackson said.

"There's also been feedback around making sure the descriptors within the competency frameworks are more behaviourally based. So, the framework could perhaps be more focused on the behaviours of the individual as opposed to the tasks that they might undertake."

The current National Coordinator of

the Pharmacy Guild of Australia's Guild Intern Training Program, Ms Hayley Smilie, said the different perspectives offered in the consultation environment helped to provide a holistic view of the profession.

"It's been great to be able to discuss the different ways in which the competency standards are used," Ms Smilie said.

"A number of people have raised that the competency standards in their current format are quite unwieldy; they're large and complex. Streamlining them and making them more relevant and accessible to the general pharmacist out there would be really useful."

Dr Jackson said this desire to make the framework more user-friendly was valuable feedback to come out of the consultations.



'Pharmacy' by Army Medicine. Image sourced from Flickr (CC BY 2.0: <https://flic.kr/p/bGVXxD>).

“There’s no use creating standards if people aren’t aware of them or think that they don’t apply to them,” Dr Jackson said.

“Some of the things we’ve talked about during the consultations are having an overarching framework and then developing implementation or support tools, and certainly we’ll be looking at those types of things to help the profession use the competency standards framework better.”

Professor of Pharmacy Practice at Melbourne’s Monash University, Carl Kirkpatrick, welcomed the opportunity to take part in the consultation, and said it was important for universities to be involved in the review of the competency standards.

“Monash University educates pharmacists from undergraduate level through to intern

training and postgraduate level, so it’s important for us to not only understand what’s happening in the profession but also to help drive where it needs to go,” Professor Kirkpatrick said.

“For this reason, the competency standards need to not only capture what a current, competent pharmacist looks like but also have enough flexibility to allow future roles to develop without restriction. This is because universities need to be able to develop curriculums and teaching practices that equip the pharmacists of tomorrow with the skills to undertake those future roles. As such, this consultation provides a great opportunity to improve current competency standards and assist education providers in producing the

practitioners and leaders of the future.”

Dr Jackson also said the work undertaken by the AHHA has shown that it is essential to engage with the wider professional community to ensure the competency standards are as usable as possible.

“As part of its research, the AHHA has done some fantastic work in engaging with people whom we haven’t engaged with formally before, from individual pharmacists to non-pharmacy organisations such as doctor, nursing and consumer groups,” Dr Jackson said.

“Not only has this been important in helping to inform the review, but it will also help to inform pharmacists about what the community expects of them in the future.” **ha**

# Palliative care gets a boost

**Yasmin Birchall** outlines the benefits of new funding for the AHHA's online training program that can be accessed anywhere, anytime

**A**s technology continues to enable broader, more rapid and more flexible access to information and training, the AHHA is pleased to announce that it has secured funding to expand its innovative palliative care training modules through technology-enabled modes. The three-year project will result in a comprehensive, innovative and accessible online information training portal aimed at frontline palliative care workers, predominantly those working with older persons in the community setting.

While healthcare providers across Australia face considerable resource pressures when delivering their services, the AHHA's new project will create opportunities for free education and training which will provide the workforce with a cost-effective opportunity to acquire further skills in the delivery of evidence-based palliative care.

Under the Australian Government's National Palliative Care Projects funding,

which focuses on the priority area of service delivery improvement in the palliative care sector, the project will involve the development of a comprehensive online education portal which will improve palliative care education and training for the health and aged care workforce.

The project will expand on AHHA's four highly successful online palliative care training modules which have attracted over 17,000 registrations across Australia. A new information portal will be developed to host interactive, engaging professional development activities and links to best-practice resources to support improved services and client experiences across the palliative care sector.

**The project will expand on AHHA's four highly successful online palliative care training modules which have attracted over 17,000 registrations across Australia.**

The AHHA has partnered with registered training provider Silver Chain Training to develop the online portal and two new palliative care training modules in the first half of 2015.

Similarly to the first four modules, the new units will be based around the Guidelines for a Palliative Approach to Aged Care in the Community Setting (COMPAC Guidelines). The content will be mapped to nationally recognised competencies to support formal training outcomes, and endorsed for continuing professional development credit with professional bodies.

The new modules and information portal will draw upon contemporary



# Palliative Care Training

online education software to allow for streamlined, accessible internet-based training on the Moodle platform. Moodle is open-source software used by thousands of organisations globally. It is stable, accessible via mobile devices and multiple operating systems. It provides excellent reporting functionality, is highly flexible, and can scale to accommodate very high numbers of accounts without decreased performance. Learners will be able to access support from a dedicated team around the clock if required.

At a course level, contemporary instructional design principles will be applied to ensure appeal, ease of use, engagement, optimum knowledge retention and learning outcomes, and mobility of content delivery across devices and operating systems.

At a time when many organisations are challenged by reduced training budgets, the palliative care online information and training portal will promote increased efficiency in healthcare and deliver

numerous benefits. The strengths of online learning have been widely documented and include:

- More cost-effective than traditional in-person delivery – no cost to access the portal or complete the training modules;
- Module completion can be scheduled around work commitments rather than impinging on work time;
- No travel time and associated costs to attend training;
- Consistency of content delivery;
- Self-paced, with no time limits for completion;
- No specialised equipment required other than a computer with internet access;
- Flexibility to join discussions in the bulletin board threaded discussion areas at any time;
- Ability to engage with other participants or facilitators remotely;

- The use of video, audio, imagery and animation adds richness to the learner experience;
- Learners can test out or skim over materials already mastered and concentrate efforts in mastering areas containing new information; and
- Self-marking assessments provide learners with immediate feedback on their progress.

In addition to providing valuable learning opportunities for health professionals, the palliative care online training modules offer a particular opportunity for service providers to easily and at low cost embed the free training in internal activities for related staff and volunteers by utilising the portal's content in professional development or induction.

To find out more about the first four modules in the free, online training, visit [www.palliativecareonline.com.au](http://www.palliativecareonline.com.au) or contact Project Manager Yasmin Birchall at [ybirchall@ahha.asn.au](mailto:ybirchall@ahha.asn.au) 



**SINGITHI CHANDRASIRI**  
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# The view from the starting line

## A practical application of critical reflective analysis

**T**he conceptual and theoretical aspects of critical reflection, and subsequent recommendations for incorporating it into adult education curricula and competency frameworks, are abundant in modern medical management. But why do we need critical reflection and how do we translate its theory into a practical means of managing doctors and of managing organisations?

It has been argued that critical reflection enables us, as medical managers, ‘to embrace subjective understandings of reality as a basis for thinking more critically about the impact of our assumptions, values and actions on others... (and thereby) helping us to develop more collaborative and responsive ways of managing organisations.’<sup>1</sup> Adopting such an approach is said to provide ‘a means to improve our clinical practice, a means to change and challenge dominant power relations and structures and a means to create possibilities to enable practice in organisational contexts that are not conducive to clinical practice.’<sup>2</sup>

While the benefits of critical reflective thinking are well documented, current literature proves far more elusive as to objectives which can be translated into everyday practice, and how young doctors who are new to the field can implement such an approach in a way that is relatable and of benefit to them. My own personal experience provides one such perspective that may be of help to others.

At the start of my career as a medical management trainee, during a multidisciplinary meeting, an employee – who had been a health service provider for a great many years – openly contradicted me

on a statement I made. The interruption was sudden, vehement, and rather blunt. Not only did it contribute very little to the subject under discussion, it was also in complete opposition to what I had said.

In undertaking a critical reflective analysis of such a situation, one must first identify the initial reactions and assumptions that will provide the baseline for analysis. In this case, where the recipient of such commentary is likely to have been caught off guard and left feeling rather persecuted, the immediate reflexive internal response would be to adopt a defensive standpoint. The instant thought process, in all likelihood, would oscillate between feeling self-righteous indignation about having been unjustly criticised; a sense of immediate threat to one’s ego and pride, as well as anxiety about fear of failure.

Like other young and inexperienced trainees, I was no different. My mind conjured up a multitude of reasons as to why this individual deserved some form of counter-attack to put them in their place; to be told exactly what was on my mind – in no uncertain terms.

At times such as this, one must take a step back, for this is, indeed, a crucial moment; a moment when our internal reaction will

inevitably formulate an external response, and a point at which critical reflection can equip us with the tools to actively choose which direction that response will take.

It is at these precise moments that we – especially trainees of medical management – need to actively challenge our reactive assumptions and put into practice learned emotional intelligence principles. We need to develop self and emotive awareness. Only then can we restrain impulsivity and cultivate patience and humility in trying to explore alternative ways of behaving so that we can

minimise personal and professional damage.

Several years ago, at an intern teaching session, I was advised to ‘develop thick skin as a doctor.’ Adopting a similar mentality as a registered practitioner, and applying the principles of critical reflective thinking, have enabled me to change my perspective for situations

such as those described above. My own experience has shown that actively pursuing critical reflection can help restrain self-imposed projections of criticism as the catastrophic events that we so often assume them to be. In doing so, it ensures that we have the capacity to modify our reactions

**While the benefits of critical reflective thinking are well documented, current literature proves far more elusive as to objectives which can be translated into everyday practice, and how young doctors who are new to the field can implement such an approach in a way that is relatable and of benefit to them.**

and behaviour in more constructive and contextually appropriate ways.

There are likely to be a myriad of situations and events in our future careers as medical leaders where we may be criticised or humbled, albeit unjustly with inaccurate claims. But taking ill-conceived measures to preserve a sense of pride and sustain the ego in the eyes of other colleagues at the expense of damaging inter-professional relationships would be counter-intuitive to the practice of emotional intelligence principles and the greater goal of becoming an inspirational leader and manager. Through continued practical application of critical reflection, we are better equipped to redefine social interactions as power-neutral exchanges, rather than attempts to challenge or maintain hierarchies — social and/or organisational.<sup>2</sup>

Practising these principles, and making an attempt to restrain impulsivity, helps us to grow as leaders and health professionals; to show respect for other people's points of view, adopt non-confrontational language to diffuse tense situations and modify our responses in a more constructive and contextually appropriate manner — even in the face of blunt inaccurate opposition. While 'asking critical questions about our previously accepted values, ideas and behaviours can be anxiety-producing... (it is only) as we abandon assumptions that had been inhibiting our development, we experience a sense of liberation.'<sup>3</sup>

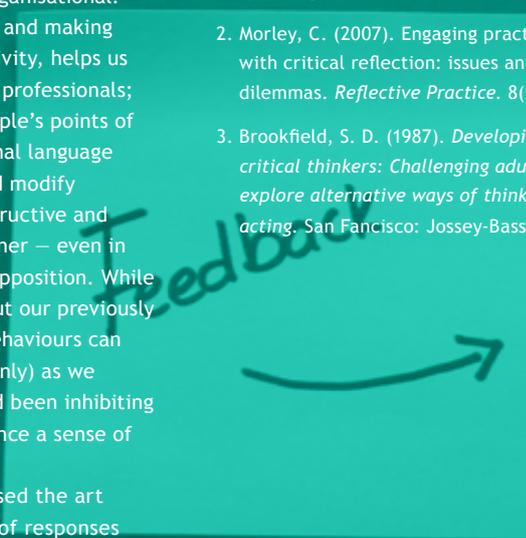
Having now actively practised the art of critical reflective analysis of responses to a variety of incidents, I have a new-found appreciation for the conceptual and theoretical aspects of why we need to continuously engage in and develop the

practice of critical reflection as medical management trainees. Whether we are still at the start, or well progressed in our medical management journey, maintaining a reflective approach to our work and our colleagues allows us to respond from a range of emotional, communication and intellectual styles in order to react in a collaborative and constructive manner.

Above all, it ensures that we remain adaptive to change which is, after all, the sentiment that should underpin our very practice as future medical leaders. **ha**

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An elderly couple is walking on a sandy beach. The woman is on the left, wearing a grey cardigan over a white top and a white shawl. The man is on the right, wearing a white t-shirt, a grey jacket, and white shorts. They are holding hands. A golden retriever is walking on the beach to the right of the couple. The background shows the ocean and a clear blue sky.

# Helping people self-manage their diabetes

**Diabetes Australia** provides an overview of new support services currently available

**W**ith the ever-growing prevalence of diabetes, a complex chronic health condition that requires close monitoring and potentially significant lifestyle adjustments, all people in Australia diagnosed with diabetes should be registered on the National Diabetes Services Scheme (NDSS). This helps ensure that they have access to the wide range of support services available to assist them, their families and their carers to learn about managing life with diabetes.

Currently, more than 1.2 million Australians have registered on the NDSS. This number is growing by around 100,000 people every year, which is equivalent to 275 people each day. Generally providing services and programs free of charge, the NDSS helps people self-manage their diabetes as well as access to affordable products, such as subsidised blood glucose testing strips; subsidised urine testing strips; free insulin syringes and pen needles (for people using insulin or an approved non-insulin injectable medication); and subsidised insulin pump consumables (for people with type 1 diabetes and gestational diabetes). Such products can be obtained through NDSS Agents and NDSS Access Points (e.g. community pharmacies), which can be found online using the NDSS Online Services Directory at [osd.ndss.com.au](http://osd.ndss.com.au). All products can be ordered by phone, mail, fax, email or online and can be delivered directly to the person with diabetes. Postage of NDSS products is free. Further information on how to order products is available from <http://ndss.com.au/en/About-NDSS/Product-and-Supply/>.

In addition to providing access to subsidised diabetes management products, another key service included in the scheme is the NDSS Infoline (1300

136 588), which, in addition to ordering NDSS products, can be used to get advice from health professionals and to find out more about local NDSS and other health services. A further feature of the scheme is the provision of information about healthy eating programs, physical activity programs, as well as group support programs - such as support for those newly diagnosed with diabetes, peer support for people with type 1 diabetes or young people with diabetes. The scheme also directs the creation and distribution of fact sheets, brochures and other information about diabetes, as well as information about various health professionals who can assist in the self-management of the condition.

To help increase literacy and autonomy around diabetes self-management, greater awareness of gestational diabetes is required. Gestational diabetes is associated with higher than normal blood glucose levels during pregnancy, and thus an increased risk of developing type 2 diabetes for both the pregnant woman and her child. As part of the NDSS, a National Gestational Diabetes Register (NGDR) has been established to assist women diagnosed with gestational diabetes, and their families, to understand how to take steps to reduce the risk of developing type 2 diabetes in the future. Registrants of the NGDR are notified by the NDSS to visit their GP for a glucose tolerance test once their baby is born, and annual reminder letters

to have a screening test for type 2 diabetes are also distributed.

Efforts to further expand diabetes management resources were marked by the release of a new range of resources in December 2014, launched by the Hon. Peter Dutton, former Minister for Health. These resources have been developed to assist Aboriginal and Torres Strait Islander

peoples; older people with diabetes; women with diabetes who are planning a pregnancy, or who are pregnant; and people with diabetes from culturally and linguistically diverse communities. The resources are available online at [http://www.ndss.com.au/en/About-NDSS/NEWS/Launch-of-NDSS-](http://www.ndss.com.au/en/About-NDSS/NEWS/Launch-of-NDSS-Resources/)

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Resources/. To request a hard copy please contact the NDSS Infoline on 1300 136 588. 

An initiative of the Australian Government, the NDSS is administered by Diabetes Australia and delivered through state and territory diabetes organisations. Further input and support is provided from two key national health professional organisations dedicated to diabetes in Australia: the Australian Diabetes Society and the Australian Diabetes Educators Association.





**MARTIN HOPKINS**  
PhD Candidate and Lecturer  
Murdoch University

# Violence against nursing students

The need to better prepare our future nurses to manage the challenges of clinical placements when it comes to treating aggressive patients

**A**s a former emergency department nurse, I've worked in some very busy clinical environments and encountered aggression and violence on a daily basis. I've since become passionate about A) how to prevent it and B) how we can deal with it as nurses.

Moving into the world of academia as a lecturer, I was curious as to whether students were exposed to the same levels of aggression and violence as registered nurses. I realised that there was actually nothing reported from Australia about nursing students, and very little globally as well.

As a result, I interviewed 150 students undertaking clinical placements in Perth hospitals – the results were surprising.

While I expected a level of aggression and violence to be experienced by our nursing students, I didn't expect it to be so high. More importantly – and what is more concerning – is the impact it is having on them.

The impact that aggression and violence is having on students is really significant, to the point where we have had students say that they have considered leaving the

profession. This is a real shame because it shows we have students who are leaving before they've even begun their career.

Some of the reported incidents have been considerable, and have the potential to cause life-threatening injuries; we had people who were bitten, slapped, kicked and punched. One of our third year students even had an attempted stabbing on them.

I don't think students consciously think they'll face aggression and violence when they begin their nursing education. While it's unwritten that *nurses* are subjected to aggression and violence, no one has really looked at whether *nursing*

*students* are. Therefore, there is nothing in the undergraduate program to address it. There may be ad hoc education looking at aggression and violence in certain places, but there is certainly nothing across the board to say that this problem exists and how it can be addressed. In terms of post-registration and clinical environments,

though, there are lots of courses available to post-graduate staff and that tends to be on an individual facility basis.

One of the issues is that there is no directive from any nursing bodies about how to address this problem, and there is no benchmark or gold standard that says what we should be aiming for.

As part of this study, we have realised that we can't really prevent a lot of the aggression and violence because it's manifested through so many different mechanisms. But, what we can do is better prepare our students to deal with it and build some resilience in them to cope with these situations.

Here at Murdoch University, we've implemented an education strategy and had some very positive results. What I have done is integrate aggression and violence education into the undergraduate curriculum, scaffolding it through the three year training. This is because what the first year students require in their first semester is very different to what the third year students require in their last semester, and we structure the curriculum accordingly.

Through these kinds of activities, we can help prepare students for the personal, emotional and psychological impacts that nursing can have on individuals entering the profession. As my research has shown, aggressive incidents – even if not physical – can have a considerable and negative impact on nursing students. That is definitely something we need to rectify. **ha**



Dr Bob Walker with patients. Image courtesy of Tasmania Medicare Local.

**M**any general practitioners across Tasmania have embraced the idea of integrated care and, together with Tasmania Medicare Local (TML), have been working closely with other health providers to improve patient outcomes. While integration can take many forms, one model – such as that used by the state’s Lindsfarne Clinic near Hobart – allows people to see a variety of providers in the same location, thereby reducing the need for multiple referrals and assessments.

The clinic has extended allied health services available at the site to include access to a lactation consultant and sleep technician. The clinic now covers a broad range of services, from psychology and speech pathology to sleep consultancy, physiotherapy and feeding and lactation

advice. Such a model can be particularly important in rural areas where access to allied health and other service providers can present challenges and transport to regional centres may not always be an option.

The Lindsfarne Clinic’s practice principal Dr Bob Walker said the face of general practice was changing “for the better” with the inclusion of these allied health services. “Our clinic has been purpose-designed for GPs of the future,” Dr Walker said. “The opportunity to meet, discuss and share experiences onsite is invaluable, both in formal education sessions as well as informally in the staff room where nurses, doctors and allied health

professionals can learn from each other and work to enhance health care delivery.”

With consulting rooms, treatment rooms, conference rooms and operating theatres, practice manager Mandy White said the large scale to which the Lindsfarne Clinic can offer rooms to allied health practitioners has significantly enhanced the delivery of primary health care services to the local community. “Co-located general practitioners conduct their individual practices at the clinic but enjoy the economies of scale with shared administration, practice nursing support, leave and after hours care,” Ms White said.

While accessing resources to implement more integrated care and other new ways of working can be challenging, several practices

**“Our clinic has been purpose-designed for GPs of the future”**

# The changing face of general practice

How **Tasmania Medicare Local** is working towards an integrated model of primary care



in Tasmania have been able to do this effectively. For example, the Patrick Street Clinic at Ulverstone received a \$500,000 Primary Care Infrastructure Grant in 2011 from the then Department of Health and Ageing to expand its practice. The funding, which was matched by an investment by the clinic, has been used to support the provision of a range of allied health and other services. These include physiotherapy, gym, pilates, Australian Hearing's visiting audiology service, nutrition and dietetics, psychologist, care coordination, and health education and group education programs; all of which operate onsite.

Dr Emil Djakic says the practice welcomed the improved access to specialists and better health outcomes that the new resources and infrastructure were expected to deliver.

"A portion of the funds has also been used towards improving the clinic's telehealth communication and e-health initiatives," Dr Djakic said. "Video conferences between a patient and a GP, in particular, are a great alternative to face-to-face consultation which can be conducted without devaluing the clinical experience. "This system will enable us to continue coordinating and providing comprehensive, whole-patient medical care with a focus on convenience and accessibility."

Another way general practices are providing integrated care is through the employment of a practice nurse. Patrick Street Clinic nurse manager Sharon Brain said integrated care for practice nurses meant responding to a patient's health needs and working in partnership with them, their carers and

their family. "It is also a partnership with allied health and other health professionals to provide a connected and collaborative service where the GP is at the centre of their care," Ms Brain said. "We see the aim of care in general practice is to increase patients' knowledge, encourage independence and enhance self-management for improved health outcomes." <sup>na</sup>

Tasmania Medicare Local supports general practices and other primary healthcare providers focused on connecting care. It does this through programs including care coordination, Australian Primary Care Collaboratives, and eHealth, such as securing messaging and electronic discharge initiatives. It has also been successful in its application to become the Primary Health Network for Tasmania from 1 July 2015.



**CHRIS CARTER**  
Chief Executive Officer  
Inner North West Melbourne ML

# Collaborating for better health

## A partnership to benefit Melbourne's inner north-west

**A**cross Australia, chronic and complex care needs are straining our healthcare resources. Data from the Australian Institute of Health and Welfare shows that chronic conditions increase with age and can be characterised by complex causality, multiple risk factors, long latency periods, a prolonged course of illness and functional impairment or disability. Care that is poorly integrated and uncoordinated is ineffective and costly. If we continue delivering care in this way, hospital admissions for the treatment of chronic conditions will increase to unsustainable levels. Clients will continue to receive disjointed services and they will not be empowered to manage their own health.

In July 2012, cohealth, Inner North West Melbourne Medicare Local (INWML), Melbourne Health and Merri Community Health Services formed an innovative partnership to improve care in Melbourne's inner north-west. These four partners each play a unique role within the healthcare system in the catchment and all made a commitment to work together to trial and then mainstream different service delivery models to improve the coordination of care for patients.

A formal collaborative framework outlines our shared commitment to improve patient care, outcomes and pathways and to support a common goal of patients receiving the right type of care, at the right time, in the right setting. All four partners share a commitment to jointly plan and redesign healthcare, particularly across the acute/primary interface, so that we can better meet the needs of patients and healthcare

providers in our region.

Recognised principles of partnering and information have informed the development and ongoing management of the collaborative. The collaborative commenced with the development of a strategic directions document that clearly articulates the shared goals and purpose of the partnership and commitment of resources to develop and implement flagship projects as a focus for working together. The initial four projects included diabetes pathways and systems, chronic kidney disease service coordination, improving ICT interfaces and eHealth, and lower back pain clinics. A fifth project on advanced care planning was recently endorsed by the Chief Executive Group and work is underway on scoping this project.

The framework articulates our common goals and includes the following indicators of success.

The goals of the first two years have been achieved and there is good progress towards the longer-term goals.

A key purpose of the collaborative is to improve the patient journey, creating smoother transitions through a better-coordinated system. This is being achieved directly through work at the project level and indirectly through changes in policy, culture and routine practice in partner organisations. The following broad areas of achievement are being pursued.

**Encouraging healthcare in community settings:** Through the collaborative, new primary care pathways are being developed for patients with chronic disease. The back pain project includes specialist triage at the Royal Melbourne Hospital from orthopaedic and neurology wait lists and referral into community-based back pain treatment clinics, thereby reducing time to treatment and

### Within two years:

- Two collaborative projects/programs implemented to address priority areas;
- Annual Collaborative Forums established;
- Shared understanding of the population and health needs documented;
- Strategic Plan for the region developed
- Shared Evaluation Framework developed to measure the effectiveness of collaboration; and
- Scope and develop an agreed position on a region based Electronic Medical Record.

### Within five years:

- New to follow up outpatient ratio at the Royal Melbourne Hospital reduced;
- Collaborative presentations on integrated service models delivered;
- Collaborative research projects established to provide academic focus to priority area projects/programs;
- Two collaborative projects are mainstreamed in priority areas;
- Joint research grants awarded; and
- Mechanism for collecting and analysing client feedback on their journey through the system established.



Healthcare on the move.  
Image courtesy of INWMMML.

providing care closer to patient's homes.

**Improving quality of healthcare:** Service quality to patients is being enhanced through the development and use of quality guidelines, service directories and clinical pathways. For example, the chronic kidney disease project has developed a screening tool for use in community health settings and the diabetes project is piloting GP practice-level quality improvement strategies including data mining and providing multi-disciplinary care in partnership with hospital clinicians. In addition, 21 diabetes clinical pages have been developed as part of the HealthPathways program and an annual consumer diabetes forum has commenced.

**Improving local service coordination:** Work is progressing innovative models of primary care that deliver evidence-based practice supported by hospital specialists. Models that support inter-sectoral and cross-profession knowledge sharing can improve coordination of services for patients living with, or at risk of, chronic healthcare conditions.

**Enhancing workforce collaboration:** Cross-system care coordination strategies are improving communication and data sharing between GPs, health services and community healthcare providers. This collaboration is building wider professional communication and networks. Whilst engagement of managers and clinicians in the collaborative has increased understanding amongst the partners of each other's role in the care continuum, additional plans are being developed for shared training and leadership opportunities to facilitate this alignment.

**Improving system connections:** A joint commitment to increasing the take-up of the Person Controlled E Health Record (PCEHR) across the catchment is resulting in improved transfer of information across the acute and primary care sector. For example, cohealth GPs are using the PCEHR with their patients and a chronic disease project based from the Royal Melbourne Hospital will be focused on increasing meaningful use of the PCEHR through increased uploads of health summaries. The work of

the collaborative is not a separately funded, one-off 'project' of the partner organisations: rather, it represents an ongoing commitment by four key health organisations in one geographic catchment to improve the design and delivery of healthcare across the care continuum.

The collaborative has required significant leadership and commitment, and the evaluation to date indicates that there is strong support for the partnership amongst stakeholders. Evidence is emerging that the collaborative is contributing to the cultural change required to provide better coordinated care to patients and to better manage our resources. We hope that collaborative leadership across the care system is recognised as essential for improved outcomes within the Australian healthcare system, and that work such as this is supported and expanded. <sup>na</sup>

Inner North West Melbourne Medicare Local is part of a consortium that will constitute the North West Melbourne Primary Health Network from 1 July 2015.

**HELEN KELEHER**

Adjunct Professor, School of Public Health and Preventive Medicine  
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# The power of partnerships

## Vehicles for primary care reform

**M**any ideas have been put forward about how to reform the primary care sector, as governments seek to reduce expenditure and shift costs to individual consumers. Debate has been polarised around co-payments at the level of individual consultations, but broader systems thinking is needed for cost savings to bite. Systems-thinking requires investment in infrastructure at local and regional levels to enable health providers to be involved in the building of solutions to systemic problems.

We might think of doctors, psychologists, physiotherapists, or speech and occupational therapists as one-on-one health professionals working by and large in isolation from each other, and certainly in isolation from other sectors. But in primary care, evidence is emerging that supporting these health professionals to collaborate and work with other sectors through partnerships on specific projects can produce dividends. Collaborative ways of working increase the impact of individuals and organisations with multiple advantages.

Health professionals are very well aware of what doesn't work well in the systems they work with, but rarely are they given opportunities to develop new approaches. Secure messaging and electronic referral systems, streamlining the myriad of Advance Care Planning tools and working with the local aged care sector to increase their use, increasing cancer screening rates across a local population, using telehealth to link GPs with Residential Aged Care Facilities to reduce presentations to Emergency Departments, reducing the burden of alcohol and drug abuse, or the prevention of violence against women and children – these are all programs of work

which have been developed by partnerships of health professionals in conjunction with Medicare Locals. Many of the new Primary Health Networks will have opportunities to build on these initiatives.

There is much to be gained, not just across the primary care sector and the broader health system but intersectorally if more attention were paid to partnerships. This is because collaborative action can bring about reforms. As organisations and individuals learn about each other, they also learn what resources are available, what skills are held in which agencies, and what those agencies are funded to do. Collaborative advantage is what happens when a partnership finds:

- synergies;
- how best partnering organisations can work together to drive the delivery of outcomes; and
- that each organization, through the collaboration, is able to achieve its own objectives better than it could by working in isolation.

This means, for example, that a Local Hospital Network working alongside health providers, and local governments, non-government organisations, government departments and local citizens, can use partnerships and collaboratives to increase their own impact, while working more broadly on outcomes that impact on their own business.

It is difficult to show causal relationships between partnerships and outcomes, so it is critical that partnerships work from a strong evidence base, and use a program logic approach to service development and when appropriate, a theory of change. Partnerships working on reform are not talk-

ests – health providers don't have time to sit around chatting. Partnerships are successful when people have a business approach to achievement and a constant sense of momentum. To work in this way, they need support to develop quality evidence briefs, to maintain the rhythm of the partnership, develop a business case, redesign and redevelop the delivery of care, implement strategies and have their progress evaluated. However, health providers don't have the luxury of doing the hard yards required to actually do the implementation, and that is where Primary Health Networks will have a vital role.

Partnerships require backbone support by an organisation dedicated to coordinating the work processes of the partnerships and the collaborators involved in the initiatives. Medicare Locals/Primary Health Networks are these kinds of organisations. An exemplar is The Peninsula Model for Primary Health Planning for which the Frankston-Mornington Peninsula Medicare Local is the backbone. This collaborative model demonstrates the value and advantages that can result from collaborative action. The support provided by backbone infrastructure keeps people around the table, ensures that effort is maintained, and that momentum is constantly moving towards desired outcomes.

As Primary Health Networks evolve, they will have a common purpose: to strengthen the capacity of organisations to improve both individual and population health, and reduce health risks. There is significant potential for reforms to be implemented at local and regional levels through the expertise and energy for better ways of working that a collaborative provides. **ha**





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[WWW.AHHA.ASN.AU/EVENTS](http://WWW.AHHA.ASN.AU/EVENTS)

# Root Cause Analysis Workshop

If you are a frontline clinician or clinician manager, join this one-day workshop and develop your skills in measuring patient harm and undertaking clinical investigations of sentinel events.

The workshop will give participants an understanding of root cause analysis methodology and provide them with a prevention strategy framework for avoiding or managing events that may lead to patient harm.

Participants will be invited to engage in reflective discussion throughout the workshop and will together conduct an audit using one of the patient harm detection methods.

The workshop – also suitable for patient safety officers, quality improvement officers and clinical risk managers – is presented by the Australian Healthcare and Hospitals Association in collaboration with Peloton Health Care Improvement Consulting.

### Short course dates

**Sydney**  
7 May 2015, Novotel Sydney Central

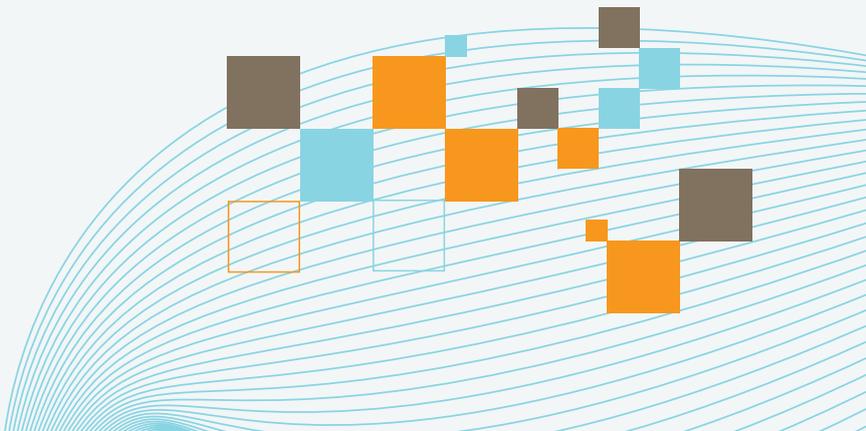
**Melbourne**  
13 May 2015, Mantra Southbank

**Brisbane**  
17 June 2015, Novotel Brisbane

Limited places available.

### Contact us

**E:** [admin@ahha.asn.au](mailto:admin@ahha.asn.au)  
**T:** (02) 6162 0780



# Who's moving

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

**T**erry Welch has moved to Maryborough District Health Service as Chief Executive Officer, previously as Chief Executive Officer at Yarrowonga District Health Service.

**Shane Thomas**, Associate Professor and Executive Director of International Academic Engagement at Monash University, is moving to South Australia to become the new Pro-Vice-Chancellor (International) at the University of Adelaide.

**Rebecca Graham** has been promoted within SA Country Health Local Health Network. Previously Executive Director of Mental Health, she is taking on the position of Chief Executive Officer.

**Andre Nel** has moved to Western Health as Executive Director Medical Services. Dr Nel was previously in a similar role at Bendigo Health.

**Ian Jacobs** has just started in the roles of Vice-Chancellor and President of the University of New South Wales. He moved to

Australia from his position as Vice-President and Dean at the University of Manchester as well as Director of the Manchester Academic Health Science Network.

**Matt Kropman** has moved from his role at Director Junior Medical Workforce with Northern Health and has accepted the position of Director Medical Workforce with Alfred Health.

**Tim Daniel** has moved to Greenslopes Private Hospital as Chief Executive Officer. Previously he was Chief Executive Officer at Westmead Private Hospital.

**Anton Peleg** has become the new Professor-Director of Infectious Diseases at Alfred Health. He was previously the Associate Professor of Infectious Diseases and Microbiology at Alfred Health and Monash University.

**Lexie Spehr**, Executive Director and Director of Nursing at Redcliffe Hospital, has taken on the position of Executive Director of Nursing and Midwifery at Metro North Hospital and Health Service.

**Leon Berkovich** has recently joined Southern Sun Healthcare as their new Chief Executive Officer. He was previously the Chief Operating Officer for GE Healthcare.

**Martin Bean**, who has been the Vice-Chancellor of The Open University in the United Kingdom since 2009, has returned to Australia to take up the position of Vice-Chancellor and President of RMIT.

**Elizabeth Forbat**, a Reader in Cancer and Palliative Care at the University of Stirling, is moving to Australia to become Professor of Palliative Care at the Australian Catholic University and Calvary Health Care ACT.

**Aaron Groves** is moving from the Mental Health division of the North Metro Area Health Service in Western Australia to take up a position as Chief Psychiatrist in South Australia.

**Tarun Bastiampillai** has recently accepted the position of Director Mental Health Strategy with South Australia Health.

**Helen Palmer** has recently moved from Capital Day Surgery to the position of Perioperative Services Manager with Calvary Health Care Riverina.

**Kerryn Dillon** has moved from a role as Director of Broadreach Employee Relations to take up a role as General Manager People and Culture with TLC Aged Care.

**Christine Bessell** will shortly leave her role as Executive Director Medical Services at the Royal Women's Hospital in Melbourne to take up the position of Executive Director Medical Services at the Royal Victorian Eye and Ear Hospital. 



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

# Become an AHHA member

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

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

By becoming a member of

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

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

In joint collaboration with our university partners and health service members, the Institute: undertakes rigorous, independent research on important national health policy issues; publishes health policy Evidence Briefs and Issue Briefs; conducts conferences, seminars, policy think-tanks

and workshops; and helps policymakers, researchers and practitioners connect when they need expert advice.

The AHHA's JustHealth Consultants is a consultancy service exclusively dedicated to supporting Australian healthcare organisations. Drawing on the AHHA's comprehensive knowledge of the health sector, JustHealth Consultants provides expert skills and knowledge in areas including: corporate and clinical governance training; strategy and business planning advice; organisation design and improvement; health services planning and program evaluation; and board induction training.

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

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

To learn more about these and other benefits of membership, visit [www.ahha.asn.au](http://www.ahha.asn.au)



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# AHHA Council and supporters

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

## AHHA Board

The AHHA Board has overall responsibility for governance including the strategic direction and operational efficiency of the organisation, the protection of its assets and the quality of its services. The 2014-2015 Board is:

**Dr Paul Dugdale**  
Chair  
**Ms Elizabeth Koff**  
Deputy Chair  
**Dr Deborah Cole**  
Treasurer  
**Dr Paul Scown**  
Immediate Past Chair  
**Prof Kathy Eagar**  
Academic Member  
**Prof Gary Day**  
Member  
**Mr Philip Dwyer**  
Member  
**Mr Walter Kmet**  
Member

## AHHA National Council

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

**Dr Michael Brydon**  
**Dr Deborah Cole**  
**Ms Gaylene Coulton**  
**Ms Jill Davidson**  
**Prof Philip Davies**  
**Prof Gary Day**  
**Dr Martin Dooland AM**  
**Dr Paul Dugdale**  
**Ms Learnie Durrington**  
**Prof Kathy Eagar**  
**Mr Nigel Fidgeon**

**Mr Andrew Harvey**  
**Ms Siobhan Harpur**  
**A/Prof Noel Hayman**  
**Mr Matt Jones**  
**Mr Lewis Kaplan**  
**Mr Walter Kmet**  
**Ms Elizabeth Koff**  
**Mr Ben Leigh**  
**Mr Robert Mackway-Jones**  
**Ms Sue McKee**  
**Ms Jean McRuvie**  
**Mr Ross O'Donoghue**  
**Mr Michael Pervan**  
**Ms Prue Power AM**  
**Ms Lizz Reay**  
**Ms Barbara Reid**  
**Mr Anthony Schembri**  
**Dr Paul Scown**  
**Ms Annette Schmiede**  
**Mr Lyndon Seys**  
**Mr John Smith**  
**Mr Tom Symondson**  
**Ms Sandy Thomson**

## Secretariat

**Ms Alison Verhoeven**  
Chief Executive  
**Mr Andrew McAuliffe**  
Executive Director/  
Chief of Staff  
**Mr Murray Mansell**  
Business Manager/Accountant  
**Dr Linc Thurecht**  
Senior Research Leader  
**Ms Vanessa Vanderhoek**  
Transitional Director,  
Deeble Institute  
**Ms Yasmin Birchall**  
Project Manager, JustHealth  
**Ms Lisa Robey**  
Engagement Manager  
**Ms Kylie Woolcock**  
Policy Manager

**Ms Emily Longstaff**  
Editor, *The Health Advocate*  
**Ms Sue Wright**  
Office Manager  
**Mr Daniel Holloway**  
Web/Project Officer  
**Mr Dominic Lavers**  
Communications Officer

## Australian Health Review

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

**Prof Andrew Wilson**  
Editor in Chief  
**Dr Simon Barraclough**  
Associate Editor, Policy  
**Prof Christian Gericke**  
Associate Editor, Models of Care  
**Dr Linc Thurecht**  
Associate Editor, Financing and Utilisation  
**Dr Lucio Naccarella**  
Associate Editor, Workforce  
**Ms Danielle Zigomanis**  
Production Editor (CSIRO Publishing)

## AHHA Sponsors

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

HESTA Super Fund

Good Health Care

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

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The views expressed in *The Health Advocate* are those of the authors and do not necessarily reflect the views of the Australian Healthcare and Hospitals Association.  
ISSN 2200-8632

# The Improvement Challenge

## How local health performance information creates opportunities to improve rural and remote health outcomes | 24 May 2015

This is a workshop designed to help rural and remote health service managers, clinicians, consumers and researchers make better use of data to improve patient experiences and outcomes.

The workshop will focus on data and evidence available to Local Health/Hospital Networks and to the new Primary Health Networks that are due to begin operations on 1 July 2015. The workshop will also explore both international and Australian experiences with performance measurement and will equip participants with a greater understanding of the local health data available to them and how it may be best used for improving health service and healthcare performance.

Participants will have the opportunity to identify data they need, even data that may not yet be available, and to have a conversation with key government and non-government agencies about the practical support they need to measure

and improve health service performance and the health and wellbeing of the people within their region.

Speakers will include Alison Verhoeven, Chief Executive of the Australian Healthcare and Hospitals Association, Diane Watson, Chief Executive of the National Health Performance Authority, a senior officer from the Federal Department of Health, and health care managers and researchers experienced in rural and remote healthcare delivery.

*The Improvement Challenge is hosted by the Australian Healthcare and Hospitals Association and the National Health Performance Authority ahead of the National Rural Health Alliance's 13th National Rural Health Conference (24-27 May, Darwin Convention Centre, NT).*

For more information, or to register, visit [www.ahha.asn.au](http://www.ahha.asn.au) or contact the AHHA at [admin@ahha.asn.au](mailto:admin@ahha.asn.au) or on 02 6162 0780.

