Over 40 people came to hear Health Agencies from across the region showcase projects of innovation at the Best Practice and Innovation Forum that was held on March 29th at West Wimmera Health Service – Goroke Community Health Centre. Presentations from Wimmera PCP (WPCP), Rural Northwest Health (RNH), West Wimmera Health Service (WWHS), Wimmera Health Care Group (WHCG), Ambulance Victoria (AV), Federation University (FedUni) and Harrow Bush Nursing Centre (HBNC) were all presented with some agencies presenting up to four innovative projects.

Topics included – Launch of Wimmera Southern Mallee Health Alliance (WSMHA) Recruitment Video (WPCP); Play to Learn – A Community Health Group (RNH); Quality Improvement at Dunmunkle (WWHS); Clinical Outcomes, Cardiac Arrest & Stroke (AV); Key Worker Role in the Sub-Acute Setting (WHCG); Improving Communication Across a Diverse & Mobile Health Workforce using a web-based Project Management Platform (Basecamp) (WHCG); Moulded Meals a Sight for All (RNH); The Wimmera Information Portal – WIP (FedUni); Wimmera Tele-Oncology Experience (WPCP & WHCG); Pathways to Harrow – Stories that strengthened the community (HBNC); Building Cultural Bridges & Two-way Understanding: Aboriginal people leading mainstream health (WPCP); Compulsory Training where Fun is Mandatory (RNH); Qlik Sense – Business Intelligence that Works (WHCG).

This newsletter will highlight these stories plus more.
Wimmera health agencies are confident a new video promoting the uniqueness of the region will help attract health workers from all corners of the globe.

The four health agencies of the Wimmera Southern-Mallee Health Alliance (WSMHA) launched the video release on Wednesday at the Regional Best Practice and Innovation Forum at Goroke Community Health Centre.

The video clip takes a brief look at the range of people from different backgrounds that have made the move to the region to work and encourages people to consider the Wimmera and Southern-Mallee as a great step for career and lifestyle.

The health services will use the clip on their individual websites, job advertising platforms and social media networks in the hope to highlight the positives of living and working in the region.

Staff members profiled in the clip include:
- Kathleen Ballinger (Edenhope and District Memorial Health Service)
- Ngareta Melgren (Rural Northwest Health)
- Charlie
- Sittichochaitawee (West Wimmera Health Service)
- Feby Baulose (West Wimmera Health Service)
- Yakep Angue (Wimmera Health Care Group)

WSMHA Spokesperson, Mark Knights, said the video was impressive and would help attract a varied range of health professionals.

“When people look for work in health professional roles, they look at the entire region and its opportunities” Mr Knights said.

“The clip will help show the opportunities for both career progression and great work-life balance in the Wimmera and Southern-Mallee” he said.

“We believe the passion we have and our people have for this region comes across in the clip and will help promote the Wimmera and Southern-Mallee as a great destination for a range of people across the health sector. It is up to us as a region to convince everyone else what we know is great about everything on our doorstep, this is one way we can do this.”

The video clip, produced by Horsham videographer Lynton Brown, can be viewed on YouTube using the link https://youtu.be/WXKElh6QehI

For more information on the video please contact Emily Delahunty at Wimmera PCP on (03) 5362 1224 or email Emily.d@grampianscommunityhealth.org.au
The aim of **Play to Learn** was to link in with the Yarriambiack Shire’s partnership with the ‘Linking Learning Birth to 12 years Project’ which is to improve learning outcomes for Victorian children, by supporting parents, educators, practitioners and professionals across early childhood and primary school settings to develop a comprehensive, cohesive and seamless approach to learning and family rewards program.

The objectives were to provide informal education and health literacy to parents and children across multiple discipline areas; for clinicians to develop an understanding and use of language goals in their service delivery and to promote and link Rural Northwest Health’s community health services.

Participants in the program were children from 0 to 5 and their parents/caregivers. Community Health Clinicians also attended – Speech Pathologist, Dietitian, Physiotherapist, Exercise Physiologist and Occupational Therapist. Five free sessions were held once a month on a Monday morning in the RNH Community Room with no charge and morning tea provided. Each session gave children a fun environment with lots of play activities which exposed them to concepts around health development language. Additionally giving parents the opportunity to further understand and develop skills in supporting their child’s development.

**Outcomes measures to date:** Participant numbers ranged from 17-30; Age of participants attended within 0-1 years (30%), 1-3 years (60%) and 3-5 years (10%). 1 referral was received to Speech Pathology.

The program was expanded to Base 8 Young Mums Group where sessions were held at the Baptist Church. 5 Sessions were run in term 1 with only 2 clinicians attending at a time.

Participants numbers range from 23-27. Age of participants attended within 0-1 years (30%), 1-3 years (60%) and 3-5 years (10%). 1 referral was received to Speech Pathology.

The program also expanded to Hopetoun where 5 sessions were run in term 3 at the Hopetoun P-12 School in conjunction with their ‘Shake Rattle & Read’ program and ‘Healthy Active Kids Program’.

**Learnings:** increased activities for children and parents; increased exposure & opportunity to communicate with a range of clinicians; relationship built with consistent Speech Pathologist; participants were comfortable to attend as no stigma around other attendees; participants because familiar with the health service so would be more comfortable to use the facilities when needed; once program was set up the duplication costs were low due to less time needed in the planning phase and take to other areas and settings with a different focus not language concepts.

For further enquires please contact Kelsey Hamilton Speech Pathologist on 53961267 or email Kelsey.Hamilton@rnh.net.au

"Kids learnt without knowing they were learning through play"
"Kids enjoyed playing"
"Good opportunity for the kids & gave ideas for activities at home"
"Kids mixed more with other children"
"Enjoyed numbers & matching numbers"
"Kids had fun"
"Brilliant, gave ideas on how to use everyday items at home"
Quality Improvement at Dunmunkle: Helping people from falling through the cracks of the system

Authors: Di Knoll, Peter Hill and Tracey Chenoweth, Dunmunkle Health Services and Donna Bridge, Wimmera Primary Care Partnership

Background

In 2013 the Victorian Department of Health announced that the Community Health Indicators would become a reporting requirement for Community and Women’s health funded programs.

This moved from an hours of service reporting method to a set of clinical indicators encompassing the measuring of client experiences, health outcomes, efficiency and effectiveness of health services.

In order to implement these indicators, Dunmunkle Health Services has been working with the Wimmera Primary Care Partnership over the past three years to collect the data, review practices with the aim of improving service delivery to their local population and delivering high quality coordinated care.

Shared Care Meetings in Action

Dunmunkle have also implemented a regular Shared Care meeting which brings together staff from Community Health and District Nursing departments to discuss any red flags or clients of concern.

This has enabled staff to identify at risk clients, share care plans and work together to assist clients who may be finding it hard to keep well at home.

In December 2015, a client was referred to the Dunmunkle Cancer Resource Nurse. A home visit was conducted and home help was arranged, which was all the client would accept at the time.

The Cancer Resource Nurse kept in regular contact with the client, and was aware that District Nursing service could be needed at any time. This client was subsequently discussed at each Shared Care Meeting.

In May 2016 after returning home from an acute hospital admission, an urgent referral was made to District Nursing, and Hospice also became involved.

Because District Nursing was already aware of the situation they were more able to act quickly and implement strategies to support the client and family.

Conclusions

This work positively demonstrates the power of the PDSA quality improvement process as a successful way to monitor progress and change practice.

Rural clients now have better access to services, improved processes to ensure they receive the care they need and high quality coordinated care.

Method

Utilising a Plan, Do, Study, Act continuous quality improvement approach to implementing the Department of Health and Human Services Community Health Indicators, a monthly meeting is held with the Dunmunkle hot CHIP (Community Health Indicators Project) team and led by the Wimmera Primary Care Partnership.

Performance of the health service against the indicators is critically reviewed, ideas for improvement are tested, and results are reflected on by the team and then implemented at the Minyip campus.

Results

This quality improvement approach has developed better processes across key indicators for how:

- Clients access services at Dunmunkle
- Needs are identified and services can be delivered to meet these for clients
- There is a consistent process for developing and sharing care plans with clients and other staff and GPs as appropriate
- Care plans are reviewed with clients and changes to their care reflect this

For further information contact:
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The VST is a state-wide service that links regional hospitals to a network of neurologists who provide advice on patients who present to emergency within 4.5 hour of onset of stroke symptoms. VST is funded by state and federal governments and is under the Auspice of the Florey institute for neurosciences and mental health.

VST was first piloted in Bendigo - 16 hospitals have “Gone live” around Victoria since 2014. WHCG was the 11th. There is much interest in rolling a similar service out around Australia.

We have a Teledoc which is simple to use and can be repaired and maintained remotely. 10-12 neurologists are on a roster to provide cover 24/7 to the regional hospitals.

Access to specialist expertise not only improves equity of care but most noticeably reduces decision making delays and thereby increases our rate of thrombolysis in ischaemic stroke.

We work closely with Ambulance Victoria – who notify us enroute to the hospital that they have a suspected stroke patient. We phone the VST hotline and activate our Emergency Medical review call. Patients are assessed by local clinicians and VST neurologist. CT brain scans are sent directly to the neurologist from the CT machine.

Further consultation occurs, exclusion criteria are assessed, a decision is made with the patient/ family and if appropriate thrombolysis occurs within 60 minutes.

In December 2015 we formed a multidisciplinary steering committee – included Radiology, our physicians, pharmacists, registrars, nursing staff in Emergency and ICU and the wards, allied health, Health information services and IT. We identified areas where we could save time, implemented an Emergency medical review stroke call on pre-notification from AV.

From that we decided to send all our acute strokes to resus and change classification to a Cat 1 – immediately seen by a doctor. We updated and improved our clinical pathways, engaged all teams and listened to feedback.

Preparation to “Go Live” took almost 4 months and finally occurred on 18 March 2016 after much information sharing. We had discussions with neurologists via the teledoc, conducted in-service sessions, used You tube to teach the National Institute of Stroke Scale score and attended webinars and conferences – resulting in over 255 contacts in 8 months.

Since going live on 18 March – we had a total of 65 consultations with a neurologist – a service not previously available . Obviously not all are stroke patients. We have provided 14 thrombolysis treatments in 12 months and sent two patients for ECR. The gold standard for thrombolysis in Stroke is a door to needle time of less than 60 minutes. The national stroke audit 2015 shows that 26% of eligible stroke patients received thrombolysis ( compared with 43% in USA and 56% in UK) It sounds easy but when we need to do a brain CT and angiogram prior to decision making the minutes add up quickly.

There has been an improvement in door to needle time for thrombolysis at WHCG since we went live. It is particularly interesting to see the correlation between door to CT and Door to needle time – Door to CT was identified very early as a problem area for us. The team have worked very hard to bring our times down.

We get our patients to CT quickly now, sometimes within a minute of arrival. This combined with the rapid decision making by the Neurologist has helped us reduce our door to needle time significantly.

We also speak to community groups about recognition of and response to stroke symptoms (over 160 contacts to date). Maintaining and improving great times requires vigilance, ongoing education for all new staff and new ideas to improve. It has been great to be a part of a state-wide team and we have shared ideas with all the other 15 VST co-ordinators but we need to especially acknowledge the fabulous response we have had from the staff – particularly in Emergency and thank them very much. WHCG acknowledges: Emergency Department staff – Nursing and Medical; Medical Team – Physicians and Medical Registrars; Radiology staff; Ambulance Victoria – Wimmera region; Pharmacy staff; Health Information Services; Clinical Risk and Clinical pathway team; Information Technology team; ICU, Oxley and Wyuna.

Presented by Leanne Taylor & Sally Motton
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Ambulance Victoria provides:

- Emergency medical response and pre-hospital care
- Emergency medical transport by road or air
- Non-emergency patient transport (including road and air stretcher transport and clinic transport for walking and wheelchair patients)
- Major incident management and response
- Retrieval of critically ill adult patients (including advice and bed coordination)
- Assistance for ambulance patients to access appropriate care when paramedic care or transport is not required
- Support for other health services in communities where the full range of services are not easily accessible
- Community education in pre-ambulance arrival emergency care
- The Ambulance Membership Scheme (ambulance insurance)

Quality Improvement Processes include Audit and Reporting; Clinical Review Process; Clinical Incident Review Committee; Clinical Reports - Pain management; Stroke; OHCA; Others

### Pain Management

- % of all severe pain cases (>8) meeting a minimum 2 point pain reduction. (Target 90%)
- % of adult and paediatric patients experiencing traumatic pain (Target 90%)
- % of adult patients experiencing severe cardiac pain (Target 90%)

### Stroke

- AV Stroke Performance 2010 – Regional; Identified a significant proportion of patients with stroke in regional Victoria did not have access to SUC or thrombolysis for AIS; Percentage of stroke patients delivered to thrombolysis capable health services, before 6 hours (6 hours was the measurement used at this time) had elapsed after onset of symptoms: Metro 89% - Rural 65%

### Out of hospital cardiac arrest (OHCA):

- Ambulance Victoria attended 5,899 OHCA events 2015 - 2016 FY (492 pm, 113 pw, 16 per day)
- 99% involve adults
- Crude incidence of rural 128.6 vs metro 89.7 events per 100,000 population
- Males - 125.5 events per 100,000
- Females - 52.1 events per 100,000
- Similar results over last decade
- 72% presumed cardiac cause
- Response time: Metro Median 7.4 mins 90th percentile 12.5 mins; Rural Median 9.9 mins 90th percentile 21.4 mins
- Bystander CPR - 61% (’06-07 36%)
- EMS treatment occurred in 46% OHCA patients
- ROSC in adult all EMS treated events was 37%
- Survival for all-cause adult OHCA was 27%
- Survival to hospital discharge was 11%
- ROSC for adult EMS treated patients presenting in a shockable rhythm was 53% with 31% surviving to hospital discharge
- Survival 76% for adult EMS treated patients presenting in a shockable rhythm and witnessed to arrest by EMS Survival to hospital discharge 68%
- Adults presenting in asystole or pulseless electrical activity experienced the poorest survival outcomes to hospital discharge Asystole 0.3% PEA 7%

### Strategies for improvement:

- Improved data monthly data and the ability to review specific cases; Audit / Review Non compliant cases audited and reviewed with staff; CPG changes (analgesia, 12 leads, PHT, Ketamine); Equipment changes (monitors); Information sharing and discussion; Education Reporting on Activity.
Implementing the Key Worker Role in the Rural Sub-acute Setting

Presented by Courtney Seipolt & David Kerr
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The key worker (KW) is an individual from Allied Health (AH) assigned to a GEM or Rehabilitation admitted patient. They are the ‘Key contact person’ during admission and are responsible for ensuring AH administrative tasks are completed. The KW are also the key communicator between team, patient and family.

**Why the key worker (KW) role?** Not a new concept in the sub-acute setting; New facility; Discharge errors; Lack of communication vs. overlap of information; Patient ‘voice’; Timely documentation responsibility.

In the beginning WHCG working party consisted of a mixture of sub-acute allied health (AH) clinicians & nurse unit manager (NUM) who’s job it was to liaise & benchmark with other Sub-acute facilities.

**Benchmarking**
Queen Elizabeth Centre (Ballarat Health Services), Barwon Health, South West Healthcare, Western District Health Service, Austin Health, Cabrini Health - Phone interviews, PROMPT search; Only half of the facilities continued with the role, most facilities had trialled and ceased the model. Epworth were continuing to use KW model.

The aims and objectives were to facilitate two way communication between the patient, family and all professionals involved in the patient’s care; to be professional, competent and knowledgeable about the patient’s sub-acute stay; promote shared-decision making between patient/family, the AH team, nursing and medical team to reach patient goals and plan; to ensure relevant documentation completed in a timely manner; have a primary contact person and to achieve PATIENT CENTRED CARE.

**Inter-professional Collaboration and the KW**
Rehab patients had been through a life changing event with medical co-morbidities, different social experiences and from cultural backgrounds. They had complex conditions and no one right answer or one right pathway was the answer. Health care is about solving problems, cooperatively working together. Inter-professional team rather than a single discipline ensured health care professionals assumed complementary roles. Discipline expertise plus creative thinking = sharing responsibility for problem-solving.

**How it works:**
A KW is to allocated according to AH worker most involved and most appropriate to the patients needs. The KW is client-centred, not based on EFT. The KW can also be changed mid admission if required or due to extenuating circumstances. Only GEM and rehab funded patients receive a KW only. Nursing staff are not allocated to eliminate shift work issues.

**Administrative:** FIM scores completed on admission and Discharge; Care planning documentation; Weekly case conference & video conference documentation

**Clinical:** Introduction of self and role, rehab expectations and orientation; Bedside goal setting: weekly MDT summary and goals discussion, barriers to discharge, discharge plan and estimated discharge date; Contact next-of-kin to discuss above (only with patient’s consent, cognitive concerns, etc; Communicate overall discharge plan and outpatient follow-up plan to patient and contact person; Point of contact for general enquiries from patient/and or family; Prompt people to follow up discharge requirements e.g. organising outpatient services, outpatient appointments, etc..

**Evaluation:** Surveys sent out to the next of kin for patients admitted in a GEM or Rehabilitation funded beds - January to June, 2016; The aim of evaluation was to allow consumers the opportunity to provide feedback and any recommendations on the KW Role in sub-acute; Consumers survey: Provide comments - Rate the ‘Overall Satisfaction Level’ (1 being the lowest, 5 the highest) - Provide recommendations; 25% of surveys were returned; Overall Satisfaction: 1- 4% - 2- 0% - 3- 0% - 4- 20% - 5- 76%

**Recommendations:** There were no recommendations specific to the KW role. Recommendations included family meeting closer to admission would have been helpful; Twice day physiotherapy would have been beneficial; medical review on admission and to admission would have been helpful; Twice day physiotherapy would have been beneficial; medical review on admission and more regularly.

**Why it works for WHCG:** Smaller facility than those that we benchmarked against; New facility allowing opportunity for new processes; Filled the gaps we needed; No specific role designated to admission and discharge on ward at the time; Moved from multidisciplinary to inter-professional team work model; Informal positive feedback from patients/families; Stable senior allied health presence who all work full time; Increased staff satisfaction; Average LOS within state averages for GEM and Rehabilitation.
PROBLEM

Doctors on rotation from two city hospitals = 65 Interns (First Year) + 72 Registrars (Third Year and beyond)
5 Employed Registrars in different departments = Obstetrics and Gynaecology + Anaesthetics + Emergency Department
Medical students from two Universities = 40 Medical Students ranging from third year to final year + placement duration from 2 weeks to 12 months

COMMUNICATION CHALLENGE

Information = prior to placement + during placement + after placement
Timely = urgent (real time) + for noting
Targeted = only to who needs to know
Accessible = multiple devices + not intranet based

WHY BASECAMP?

Web based Project Management Program = Features: Web or App based + Notifications can be tailored (email or to device) + Direct messaging (free SMS!) + Affordable ($1 per day) + Funky!

FEATURES

Campfire = chat Room
Message Board = can notify whole group or select individuals + can attach files + members can comment
To-dos = task Allocation
Schedule
Automatic Check-ins
Docs and Files = can notify whole group or select individuals + version control + categories

EVALUATIONS

Surveyed at completion of placement = 100% of respondents rate as Awesome or It’s OK + “Basecamp has made a huge difference”
Things to note = not HL7 compliant + Spend time setting up correctly + notifications and time zones + app works best for mobile devices + PC browser best for management

Doctors on rotation from two city hospitals = 65 Interns (First Year) + 72 Registrars (Third Year and beyond)
5 Employed Registrars in different departments = Obstetrics and Gynaecology + Anaesthetics + Emergency Department
Medical students from two Universities = 40 Medical Students ranging from third year to final year + placement duration from 2 weeks to 12 months
Due to swallowing difficulties some people require modified diets. These modified diets maybe minced moist or smooth puree. Prior to implementing food moulds these diets would be presented like scoops of ice-cream.

These diets are now presented like the food that they are – in moulded form i.e. carrots in the shape of carrots.

Establishment
Moulded Meals were proposed to RNH at the end of 2013 following new dietitian appointment from South Australia who had seen them in her previous work. We followed Osborne Park Hospital, Perth’s ‘Puree to Perfection’ manual and used moulds ordered online at www.pureefoodmolds.com.

The Speech Pathologist and then dietitian trialled recipes for puree moulded meat and vegetables. We further trialled different freezing and heating options. Kitchen staff then implemented these recipes and processes into their daily routine.

In the beginning we rolled out puree moulded meat and vegetables at our Warracknabeal campus at lunch time only. In-service was provided to all staff regarding what puree moulds were, what were the benefits, what RNH processes for implementation were and feedback. Evaluation of moulds was conducted from staff, residents and families with both positive and negative responses. We then rolled out puree moulded meat and vegetables at Hopetoun and then at tea time at Warrack and Hopetoun.

Speech Pathologist and kitchen staff visited Bendigo Health and trialled their processes and some products. From there we rolled out minced moulded meat and vegetables at both Warrack and Hopetoun at lunch and tea times. Total moulded meals currently are 14 mince and 4 puree.

The Speech Pathologist and dietitian begun to trial moulded desserts & collecting data on this. Dessert moulds, both puree & mince have currently begun being rolled out in Warracknabeal & Hopetoun lunch time only.

Outcomes include increased socialisation- residents coming to dining room to eat, increased independence - eating with knife and fork not spoons, some weight gain, and increased cognition in regards to what they are eating.

Protected meal times were also implemented. These provide a calm atmosphere where the main focus is on serving appetising meals and providing residents with uninterrupted time to eat and enjoy a vital part of their day – mealtimes. Unwanted traffic is also limited through the dining room and this includes:

- All un-necessary team members – admin, environmental services and maintenance
- Visitors of residents who are not enjoying a meal with them
- Medications – lunch and dinner
- Close doors to dining rooms

Perceived outcomes was to continue to engage residents in a home like environment meal which included not interrupt their meal and having them cease their meal because of this. Residents have reported that they are extremely happily with their protected meal times.

Accolades:
- Had a Skype session with Kooweerup Health to provide them with education for implementation of food moulds in their service eating.
- Phone session with Stawell dietitian as investigating options to introduce food moulds into their service.
- Winner of the Betty Richardson Award: (video of nomination)

Where to next?
- Currently food moulds are provided to RNH acute and one community member who has sourced us to supply for their father. It has been thought we could expand to provide to PAG & meals on wheels when required.
- A complete roll out- cold desserts at tea time also & expanding options
- Flavour Creations Rep came & did trial for chocolate cake using their product.

Presented by Kelsey Hamilton kelsey.hamilton@rnh.org.au
Wimmera Information Portal (WIP)

**Partners:**
- Department of Health and Human Services
- Department of Justice and Regulation Horsham
- FedUni – Wimmera campus
- Grampians Community Health
- Horsham Rural City Council
- Victoria Police Horsham – Western District Division Four
- Wimmera Drug Action Taskforce
- Wimmera Primary Care Partnership
- Wimmera Southern Mallee LLEN
- Wimmera Uniting Care

**Initial Scope:**
A one stop shop for data including:
- Health indicators
- Education
- Police data informing health indicators
- Youth & child development
- Demographic profile LGA
- Trends - including climate

**Datasets so far:**
- Australian Bureau of Statistics (ABS) 2011 Census Estimated Resident Population (ERP)
- Public Health Information Development Unit (PHIDU) Social Health Atlas of Australia
- Department of Health and Human Services Victorian Population Health Survey Sport & Recreation Facilities
- Department of Education and Training Victorian Child and Adolescent Monitoring System (VCAMS) School Locations
- Australian Early Development Census Developmentally vulnerable children
- Victoria Police Smoking Fruit & Veg consumption Sugar-sweetened drinks Prevalence of Obesity Physical Activity – Sedentary behaviour Psychological distress Social Health Atlas Youth unemployment Workforce participation Public Hospital presentations

**What has been mapped so far:**
- Victorian Population Health Survey Smoking Fruit & Veg consumption Sugar-sweetened drinks Prevalence of Obesity Physical Activity – Sedentary behaviour Psychological distress Social Health Atlas Youth unemployment Workforce participation Public Hospital presentations

**Challenges**
- **Maps can be subjective** Small geographic areas are prone to classification problems
- **Sample sizes** Need to ensure representation of: Confidence Intervals (CI) RSE (Relative standard error) Outliers
- **How to show trends** Data attributes change between data collections

The WIP is still in demo mode and hasn’t been released for agency use as yet - watch this space!

http://wip.tism.cecc.com.au

Angela Murphy aa.murphy@federation.edu.au
Health outcomes tend to be poorer for people living in rural Australia compared to those living in major cities as opportunities for good health differ somewhat.

Teleoncology was started with the aim to improve patient experience by streamlining access to equity for cancer consultations and to determine the acceptability of telehealth consultation for rural cancer patients.

The VC link was established using the Health Direct web based platform. Donna Bridge (Wimmera Southern-Mallee Health Alliance Project Officer) worked with Carmel O’Kane (WHCG Oncology Nurse Practitioner) and Kate Wyatt (Ballarat Oncology Practice Manager) to make the link which utilises Google Chrome, a free program. A virtual Wimmera Oncology Consulting room was established which can be used again for future consultations.

Over 12 months 7 Telehealth clinics were conducted with patients selected by complexity of condition and treatment. Improvements such as: a WCNP-led clinic, increased clinician buy-in, and embedding the clinics in the Medical Oncology clinic calendar have occurred over the 12 months. The 12 months of data was provided by Health Informatics utilising IPM.

Who were our patients:

100 Wimmera Patients

Patients could see their Oncologist in Horsham via telehealth rather than having to drive to Ballarat

63 Patients from Edenhope, Rupanyup, Murtoa, Minyip, Warracknabeal, Hopetoun, Gymbowen, Douglas, Natimuk, Goroke, Dimboola, Nhill, Klata, Kaniva, Lillimur, Jeparit, Rainbow & Woomelang

How far did they travel?

Instead of travelling 43,454kms to Ballarat patients saved 34,340Kms by using telehealth

How much money was saved by these patients using Telehealth?

Telehealth saved these 100 Wimmera patients lots of $

$22,665

These stats were developed from the IPM system and cost savings and travel was determined with a standard formula of .66c per km.

Remember that these patients would have been eligible for VPTAS (Victorian Patient Transport Assistance Scheme) which supports patients who are required to travel more than 100km one way for health treatment and consultation.

This amount of money covers travel only - not costs associated with time off work; carers time etc

How much time was saved?

Analysis of time and miles saved for patients and clinicians clearly suggests that TeleOncology is an efficient means of consultation in Rural Victoria. Moving forward these clinics are now pre-booked for the year although we can add for emergency consultations at immediate notice if the clinicians are available.

Currently this format of consultation is being utilised by Ballarat Oncology and haematology Service. Talks are underway to begin TeleOncology by the Ballarat Regional Integrated Cancer Centre hopefully in 2017; and discussions will begin shortly with Ballarat Austin Radiation Oncology Centre to begin TeleOncology reviews of Radiation patients.

This work is an initiative of the WSMHA in collaboration with Ballarat Oncology and Haematology Services and supported by Wimmera PCP. Carmel.o’kane@whcg.org.au
In 2012 Staff at Harrow Bush Nursing Centre identified a need to “increase social connectivity opportunities to reduce the impact of isolation on health for the women of Harrow and district”. The project needed to align to their Core Values and their mission. It also needed to add value to the clients who were their community. It also aligned with the Wimmera PCP Priorities of Social Connections.

The project was: Innovative ~ a new way; Collaboration ~ relationships; Social connectivity - Community health (self esteem, mental health, facing issues); Preservation of local history; Promotion ~ health, living rural & remote, role of women.

**PLANNING ~ HOW THE GOALS WERE ACHIEVED?**

**Sub Project ONE** - Five diverse, local women ever year for 5 years (25) - Plus 16 smaller stories and pioneering history in complete collection; Answer core questions: why come to Harrow and why stay? Advertising and marketing - Management of volunteers; Legal considerations (copyright etc.); Volunteer management; Publishing the Stories

**Deliverables** - 1 booklet printed every year for 5 years; Complete collection published at the end of 5 years which will be a limited edition hard cover book

**Sub Project TWO** - Event Management - Catering (food safety); Bar (manage liquor sales); Staffing & Volunteers; Risks; Security & Safety; Ticket sales and registration; Advertising & Marketing; Sound and Audio; Staging; PowerPoint presentations; Decorating; Raffles and prizes; Order of Proceedings; Volunteer management; Launching the Books

**Deliverables** - Ticketed Chicken & Champagne; luncheon every year on 15 October in Harrow - Each woman makes presentation of her story; Launch books; Sell books

What does it provide for the organisation and community? Innovative ~ a new way; Collaboration ~ relationships; Social connectivity; Community health (self esteem, mental health, facing issues); Preservation of local history; Promotion ~ health, living rural & remote, role of women...

Financing - Fully funded by HBNC however wherever possible: Grants, Sponsorship, and Donations were sourced.

**PROJECT HIGHLIGHTS**

Diversity and Disability inclusive; Every year Launch sold out; Strong Sponsorship (16) and Grants (3); Raised many life issues which were supported by HBNC

**Awards** - Winner 2013 Bendigo Bank Volunteering Award; Winner of 2013 VWV Community Health Project; Winner West Wimmera Shire Event of the Year 2013; Winner MP National Volunteer Awards Electorate of Mallee 2013; Presented at Emergency Services Forum 2015; Presented at IAVE Volunteering Conference Gold Coast 2014

**Quick Stats** - 1000 people at launch; 41 published stories via 6 published books

**Final Outcome** - We asked the community for feedback on the project & here is a selection of responses ~ “Wonderful community spirit of acceptance of all people” “Loved hearing the stories” “Bring on the next one…” “stories straight from the heart” “we ‘know’ the speakers but so interesting to hear their stories! “Enthralling”

**Presented by Anita McGuigan operationsadmin@hbnc.org.au**
Aboriginal and Torres Strait Islander peoples living in rural and remote locations have a unique position and opportunity to lead mainstream health towards a more culturally welcoming and therefore increased accessed service. Since 2010 Wimmera PCP has led the Towards Cultural Security project and since 2014 has successfully delivered a bi-partisan model of cultural training using Aboriginal and non-Aboriginal facilitators. Over 20 training sessions have been held with 300+ participants across 18 agencies and 4 LGA’s. Training has extended beyond health and wellbeing workforce to Education – teachers, counsellors and students; Police; Employment agencies; Council staff and HACC workforce.

Outcomes from the training includes a positive change within workplaces including the adoption of relevant cultural protocols, policy change for Aboriginal employment and support and engagement of existing identified staff, identification of cultural champions, establishment of an Aboriginal Advisory Group to inform policy and Board and Executive endorsement to fulfil targeted outcomes.
How a small rural health service used imagination and fun to improve team member mandatory education compliance and workplace culture.

Rural Northwest Health (RNH) is led by an energetic and innovative CEO, supported by a leadership team of 5. Total team members is 249.

With the Board of Management support, the CEO and her leadership team have worked with team members to transform the organisation and the services it delivers to residents, patients, clients and the community. The organisation won an award for Excellence in Person-Centred Care in 2012 and during 2015 won two Australian National Better Practice Awards for innovation in both the Rural Remote and Personal, Medical Clinical Care categories and then won the Victorian small Health Service of the year - which they received again in 2016.

Engaging team members in mandatory education can be problematic. RNH has developed a model incorporating the FISH principles which ensures team members are enthusiastic to not only complete mandatory education but retain the information provided.

The FISH principles is a very successful cultural change program originally based on an initiative at the Pike’s Place Fish Market in Seattle. The four principles are relevant to the organisation’s work. Team members are asked to choose their attitude, make someone’s day, be there and have fun. Together these principles have meant team members respond positively to the daily routine and unexpected situations. Team members give their full attention to colleagues, clients and residents. They go out of their way to make people feel special and appreciated. They are encouraged to play with ideas which are creative and most of all they should have fun.

Two catalysts inspired the leadership team to change how some of the mandatory training was undertaken. First was a lack of team member participation in the People Matter Survey which is a survey providing an opportunity to assess workplace culture. The organisation needed more than just anecdotal evidence there has been a culture shift within the organisation following the introduction of the FISH principles. Despite trying a range of initiatives, the organisation could not get the % of staff completing the survey past 28.1%.

In 2008 a Nurse Educator was contracted to provide a number of education sessions to the organisation, including an Essential (or mandatory) Training day. Knowing RNH had introduced the FISH principles, she developed a team member Essential Training package around these principles.

Her creativity and ability to engage all team members provided inspiration to the Leadership team, giving them confidence to develop a second mandatory training session. One which would be based around the People Matter Survey providing us with more accurate data on workplace culture.

The idea to build the training around an innovative theme was born.

It was decided to set the training at 4 hours and even though the People Matters Survey was the motivation for the training we also asked ourselves what quality, safety or risk issues were we struggling to obtain compliance by staff e.g. uptake of Influenza vaccination. Also many staff drive hospital vehicles – again ensuring compliance that all drivers have a current license had been problematic – so staff were required to bring a copy of their licence. Computers were set up in the education room for team members to undertake on line training and to read the set policies and protocols. Some policies covered over the years include risk management, open disclosure, social media, confidentiality etc.

Compliance with personal and professional development plans or team member appraisals had been poor. Team members were instructed they were required to complete these with their managers prior to the day and actually present the completed form to be signed off.

A small team of 4 were nominated to coordinate the training. This consisted of 2 Executive team members, the publicity and marketing officer and the Education and Quality Manager.

In 2014, the leadership team created a nautical experience in the education room. Serious sessions such as completing the People Matter Survey were interspersed with fun activities such as ‘fishing’ prizes of fresh fruit or confectionary.

A total of 13 sessions were held twice a day in two campuses over the course of two weeks. The two groups on each day shared lunch providing yet another opportunity for team members from the different departments to mix. The leadership team continually refined the day based on experience and feedback. Team members could participate in as many of the activities as they wanted and received a stamp for completing each activity.

Topics covered included Bullying, Reviewed Position Descriptions and completed Personal and Professional Development Plans; Information on the importance of receiving an influenza vaccination. A nurse was available to administer the free flu vaccination.

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The success of this innovative method of providing education to team members promoted the organisation to repeat the same type of education session the following year but with a new theme – STAFF SAFARI.

Once again the Education room was transformed – this time into a jungle. Important topics were covered including the People Matter Survey, policies and protocols, new happenings within RNH for the following year, and the employee assistance program. A nurse was available again to administer the influenza vaccination.

Last year we had staff siesta with the room decorated in a Mexican theme. Again the theme was to have fun and be very interactive. The organising team noted as this was the 3rd year how staff attitudes had improved. All Team members choose their attitude and with an openness and excited expectation of what was to come.

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<thead>
<tr>
<th>EVALUATION</th>
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<tr>
<td></td>
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<tr>
<td>% of TOTAL staff completing People Matter Survey</td>
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<tr>
<td>2013 (baseline)</td>
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<tr>
<td>28.1%</td>
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<tr>
<td>% of TOTAL staff immunised for Influenza</td>
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<tr>
<td>2013</td>
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<td>54.3%</td>
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Engaging Team members in mandatory training can be problematic and challenging and we believe this is an innovative model which can be adapted to any sized organisation. Despite Rural Northwest Health being a small rural health service, it prides itself in being brave and innovate. The leadership team have led by example in the development of an innovative model to improve staff mandatory education compliance. Most importantly organisational culture should encourage innovation and fun and make these mandatory components of compliance education. We look forward to this years theme – the Groove Train.
The more that people use analytics, the more value people get from analytics. Business Intelligence is only optimized when you harness the collective human intelligence across an organization. This accelerates organizations towards their goal of being more agile, more data driven, to uncover and take advantage of new possibilities.

Data-driven possibilities are possible when you connect all of your people to all of your data and all of your ideas.

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Qlik’s associative model empowers everyone to see the whole story that lives within their data. It enables users to probe all the possible associations that exist in their data, across all of their data sources. This means users are not limited by predefined hierarchies or preconceived notions of how data should be related, but can finally understand and explore how it is truly related.