Thriving vs surviving after Acquired Brain Injury- the efficacy of telehealth delivery of a group community rehabilitation program in rural and remote Queensland

Areti Kennedy¹, Ben Turner¹, Stephanie Fletcher¹, and Melissa Kendall¹

¹Acquired Brain Injury Outreach Service, Princess Alexandra Hospital, Metro South Hospital and Health Service, PO Box 6053, Buranda, 4102

Aim:
To examine the efficacy of home-based telehealth technology for STEPS Skills Program delivery to adults with Acquired Brain Injury (ABI) in rural/remote communities in Queensland.

Since inception in 2008, the STEPS Program- a specialist rehabilitation group program addressing community re-integration following ABI- has developed a strong presence in many regional communities. However, access for adults in rural/remote areas remains a challenge.

Methods:
A multi-methods design examined experiences and outcomes for two groups completing the STEPS Skills Program: a control group (n = 8) via usual face-to-face delivery, and an experimental group (n = 5) via telehealth.

Participants completed outcome measures before and after the 6-week program and in-depth semi-structured interviews afterwards. Non-parametric statistical analyses were used for quantitative data and a case study approach utilising 4-staged thematic analysis for qualitative data.

Results:
Control group participants recorded significant improvement over time on Satisfaction with Life Scale. While improvements were observed over time, no other statistically significant differences were found for either control or telehealth groups. Interestingly, telehealth participants typically scored higher than control on outcome measures pre and post program.

Qualitatively, both groups benefited from: shared learning environment, peer support, and peer-professional leadership structure. All telehealth participants successfully managed the videoconferencing software, which they preferred to teleconferencing. However, major connectivity issues compromised videoconferencing reliability, impacting on program participation (e.g., hesitancy to contribute to discussions due to fear of dropping out).

Conclusion:
This study supports the use of home-based telehealth technologies in STEPS Skills Program delivery. Improving reliability of connectivity will enhance outcomes over time.
Sustaining rural communities – A case study of the benefits of charity retail outlets in rural Tasmania

S Auckland1, J Woodroffe J2, A King3, S Whetton4

1 Centre for Rural Health, Locked Bag 1322, Launceston, Tas 7250, Stuart.Auckland@utas.edu.au
2 Division of the DVC, Access, Partnerships and Participation, University of Tasmania, Locked Bag 1351, Launceston Tas 7250, Jessica.Whelan@utas.edu.au
3 Centre for Rural Health, Locked Bag 1322, Launceston, Tas 7250, Alexandra.King@utas.edu.au
4 Centre for Rural Health, Locked Bag 1322, Launceston, Tas 7250, Sue.whelton@utas.edu.au

Background
Charity retail outlets play an important role in rural communities as advocates for disadvantaged communities, outlets for second hand goods and service provision. Little is known about the broader social and economic value that the outlets bring to their host communities. The Centre for Rural Health in Tasmania was commissioned by the St Vincent De Paul Society (Vinnies) to undertake an assessment of its network of 34 retail outlets.

Methods
A mixed method approach generated data about Vinnies retail outlet customer base, their expectations and experiences as well as their shopping habits. Customers were encouraged by outlet staff to complete surveys made available to them at each of the 34 outlets. A series of focus groups with customers were held in regional centres across Tasmania.

Results
A total of 664 surveys were completed, representing an overall response rate of 50.3%. Approximately 75% of respondents were female aged between 45 – 64 years. Over 60% of respondents visited an outlet once a week or more. The most common reason given for visiting an outlet was shopping or looking to “grab a bargain.” Opportunities for social interactions was highly valued particularly with customers accessing outlets in smaller rural communities.

Discussion
Vinnies retail outlets are overwhelming viewed as having broader social and economic benefits to their host communities. In particular, these benefits were evidenced in smaller communities where outlets were valued for providing a space for social interaction, making affordable goods to people on low incomes and building the capacity of communities.
Implementing a nutrition care pathway for identifying and capacity building older people at nutritional risk using multidisciplinary, restorative care

Chadia Bastin,1 Shanayde Daly,2 Carol Ho,3 Denise Leyden,4 Tenealle Nicholson5

1 Gateway Health, PO Box 224 Wangaratta VIC 3676, chadia.bastin@gatewayhealth.org.au
2 Albury Wodonga Health, PO Box 326 Albury NSW 2640, shanayde.daly@awh.org.au
3 Gateway Health, PO Box 224 Wangaratta VIC 3676, carol.ho@gatewayhealth.org.au
4 Goulburn Valley Health, 121-135 Corio St Shepparton VIC 3630, denise.leyden@gvhealth.org.au
5 Goulburn Valley Health, 121-135 Corio St Shepparton VIC 3630, tenealle.nicholson@gvhealth.org.au

Background: Identification of malnutrition and subsequent intervention is generally poor across all health settings despite associated high rates of morbidity and mortality. The prevalence rate in community settings is as high as 30% and solutions which tend to create dependency are over-prescribed. In acute and residential aged care settings, nutrition screening and referral pathways are used. Aim: To develop and implement a nutrition care pathway for older people at nutritional risk living in the community to improve identification rates and increase referrals for restorative care. Method: Analysis of nutrition risk screening and assessment practices amongst community services via interviews and file audits was conducted along with a literature review of tools successfully used in community settings. A pathway for screening and investigating capacity to access nutrition was drafted, introduced at regional training and its impact evaluated using questionnaires and repeat file audits. Results: Barriers to timely identification include lack of awareness of consequences of malnutrition, use of inadequate screening methods, poor acceptance of referrals to Dietitians and misconceptions about their roles. Insufficient assessment of functional capacity around food access and care planning leads to blanket, routine interventions such as meal provision and shopping services. Discussion: The draft nutrition care pathway improved identification of malnutrition risk however the decision support function required refining to support more referrals for multidisciplinary, capacity building interventions. The re-developed pathway has been incorporated into a training toolkit for Dietitians and disseminated state-wide. Recommendations: Further evaluation is required to determine effectiveness in increasing restorative approaches to care.
Revitalising child development outreach services for children in rural North Queensland

Melissa Smith¹, Carly Hislop²,

¹ Child Development Service Townsville, Townsville Hospital and Health Service, 138 Thuringowa Drive, Kirwan. Qld, 4817, melissa.smith2@health.qld.gov.au
² Child Development Service Townsville, Townsville Hospital and Health Service, 138 Thuringowa Drive, Kirwan. Qld, 4817, carly.hislop@health.qld.gov.au

Child Development Service (CDS) Townsville has long provided developmental services to children and families in Townsville and across the Hospital and Health Service (HHS) more broadly.

While the CDS model of care delivered to children and families in Townsville is contemporary and aligns with evidence informed best practice, the outreach model of care is inefficient, ineffective and dislocated from local service providers.

Population measures of children’s development at school entry indicate that geographic isolation and socio-economic disadvantage are associated with higher rates of developmental vulnerability. CDS Townsville outreach locations demonstrate levels of developmental vulnerability significantly higher than state and national averages, yet referral numbers to the outreach service are low.

CDS Townsville has developed a new, sustainable, evidence based model of care to improve HHS-wide access to high quality, integrated, and contemporary specialist child development services, and to improve outcomes for children and families living in outer regional, rural and remote locations in North Queensland. The model is transdisciplinary in nature, family-centred, partners with local community service providers and paediatric medical services, and utilises telehealth to support care provision. It is anticipated that the principles of the new model of care will have applicability to outreach services in other Hospital and Health Services.

The new outreach model of care, informed by the literature review, consumer and community stakeholder feedback and the success of an interim model of care, will be implemented across the Townsville HHS in 2016, and evaluated after 6 months.
“Patient driven radiotherapy information movies”

Katelyn Williams¹, Jenna Blencowe¹, Melissa Ind¹, David Willis¹

¹ - North West Cancer Centre, Johnson Street, Tamworth. NSW. 2340. Katelyn.williams@hnehealth.nsw.gov.au

Background: Misconceptions about Radiotherapy processes can compound the anxiety patients experience at the commencement of treatment. In partnership with patients an information video program was initiated to counter this phenomenon and help patients explain treatment to family and friends. The project was conducted in a regional department where 45% of patients travel more than 100km for care.

Method: Patient consultation and a literature review informed video content. Footage of treatment processes was augmented with 3D software. Videos were produced voluntarily by staff, outside clinical hours with loaned equipment. Patient-approved videos were incorporated in information sessions and made available online and on DVD. An ethics-approved survey was conducted to assess how effectively the videos met patients’ informational needs.

Results: Patient feedback was overwhelmingly positive. Patient engagement permitted iterative improvements and creation of multiple videos. The program received professional recognition for both quality and originality. Surveyed patients reported that the video met one or more of the listed information needs (98% n=60) with 3D software explanations of complex concepts regarded as helpful (85%). Fifty percent credited the videos with reducing anxiety. Patients watched again at home (53%), primarily to explain treatment processes to loved ones (40%).

Discussion: Collaboration and personal commitment to a shared goal has allowed patients and staff to produce high quality information resources with no budget. The 3D visualization software assisted in explaining dosimetry technicalities and treatment delivery in a range of patients. Standardised videos provided efficient and consistent information and permitted subsequent review at home.
The Home Medicines Review (HMR) program has been found to raise awareness of medication safety, reduce adverse events and improve medication adherence. Aboriginal and Torres Strait Islander (Indigenous) clients are the most likely of all Australians to miss out on HMRs despite their high burden of chronic disease and high rates of hospitalisation due to medication misadventure. This study investigated how pharmacists, through the HMR program, might better address the medication management needs of Indigenous people. It explored the attitudes and perceptions towards medication review of clients, health professionals in Aboriginal Health Services (AHSs) and pharmacists. Eighteen focus groups with 101 Indigenous clients, and 31 interviews with health professionals were conducted at 11 AHSs. Focus groups and interviews were recorded, de-identified and transcribed. Transcripts were coded and analysed thematically. A cross sectional survey was used to gather demographic, qualitative and quantitative data from HMR accredited pharmacists.

Barriers to provision of medication review to Indigenous clients included paternalistic attitudes of health professionals, the GP-client relationship, and the need for more culturally responsive pharmacists. Onerous, inflexible HMR program rules were impediments to health professionals, pharmacists and clients alike. Remodelling of the HMR program is needed to increase the awareness, accessibility, acceptability and effectiveness of the HMR program for Aboriginal and Torres Strait Islander people. Like many health programs, the HMR program was designed without consultation or input from Indigenous people. This presentation will explore how research can result in changes in policy and increased consultation with Aboriginal and Torres Strait Islander people.
Going back to ‘the village’: the effect of UDRH allied health student placements on rural practice intention

Annie Farthing¹, Tony Smith², Keith Sutton³, Sabrina Pitt⁴, Daniel Terry⁵

¹ Centre for Remote Health, PO Box 4066, NT 0871, annie.farthing@flinders.edu.au
² University of Newcastle Department of Rural Health, Manning Education Centre, 69A High Street, Taree, NSW 2430, tony.smith@newcastle.edu.au
³ Monash University Department of Rural and Indigenous Health, PO Box 973, Moe, Victoria 3825, keith.sutton@monash.edu
⁴ University Centre for Rural Health, Western Sydney University, POBOX 93 Lennox head, NSW 2478, Sabrina.Pitt@ucrh.edu.au
⁵ Department of Health, PO Box 6500, Shepparton, Vic 3632, d.terry@unimelb.edu.au

Background
Medical workforce research shows rural undergraduate student placements impact positively on graduates taking up positions in non-metropolitan locations. However, little is known about the impact of such placements on allied health students. This presentation profiles allied health student placements at the 11 University Departments of Rural Health (UDRH) in Australia and examines the impact on students’ intention to enter rural practice after graduation.

Methods
Under the Australian Rural Health Education Network (ARHEN) Student Survey Working Group, staff from all UDRHs collaborated to develop a student placement evaluation questionnaire that included 21 common questions. Data collected between July 2014 and November 2015 was aggregated and analysed for demographic information, length and type of placement, satisfaction with various aspects of the placement, and future intention to work in a rural or remote area.

Results
In total, 1,536 allied health students responded. The largest disciplines were Pharmacy (17.5%) and Physiotherapy (16.8%), followed by Dentistry (11.1), Speech Pathology (9.6%), Dietetics (9.24%) and Occupational Therapy (9.18%). The sample was 76% female and 13 respondents (0.85%) identified as Indigenous. The majority of students had placements of 5 weeks to 3 months duration (49.3%) and were placed in Public Hospitals (38.0%) and Community Health (35.2%) settings in locations classified as MMM 3 to 5 (81.7%). Overall satisfaction was high at 91.8%. Before placement, 55.2% said they intended practicing in a rural location after graduation. After their placements this had increased to 65.0%, demonstrating a positive net gain in students’ intention to enter rural practice.
Can Occupational Therapy Hand Assessment and Treatment Sessions be conducted via Telehealth?

Tess Worboys¹, Melinda Brassington², Elizabeth Ward³, Petrea Cornwell⁴

¹ Occupational Therapy, Charleville Hospital, South West HHS, PO Box 219, Queensland, 4470, melindapetkov@hotmail.com
² Occupational Therapy, Charleville Hospital, South West HHS, PO Box 219, Queensland, 4470, tess.worboys@health.qld.gov.au
³ Centre for Functioning and Health Research, Metro South HHS and The University of Queensland, PO Box 6053, Buranda, Queensland, 4102, liz.ward@uq.edu.au
⁴ Allied Health Research Collaborative, Metro North HHS, and Menzies health Institute of Queensland, Griffith University, 627 Rode Rd, Chermside, Queensland, 4032, Petrea.cornwell@health.qld.gov.au

**Background:** A solution to help deliver Occupational Therapy (OT) services for hand therapy in rural and remote locations is telehealth, however to date no research has been conducted. The current study aimed to determine the level of agreement between a Telehealth OT (T-OT) and a Face-to-face OT (FTF-OT) during a hand assessment and treatment session and explore patient and clinician satisfaction.

**Methods:** Eighteen (18) patients referred for hand therapy to a rural/remote hospital based outpatient service were assessed simultaneously by a T-OT and FTF-OT via videoconferencing. An Allied health assistant (AHA) assisted with the collection of objective measures at the patient end. Clinicians assessed patients across a range of objective measures, subjective scales and patient reported information. Minimal level of percent exact agreement (PEA) between T-OT and FTF-OT was set at ≥ 80%.

**Results:** Level of agreement for all objective measures (dynamometer/pinch gauge reading, goniometer flexion, goniometer extension, circumference in millimetres) ranged between 82-100%PEA. Clinician judgements for scar and general limb observations were 82-100%PEA. Assessment of exercise compliance showed 80-100%PEA. Documentation of patient’s pain severity and sensitivity location were 100%PEA. Ratings of activities of daily living (QuickDASH) was 89%PEA. The multiple Global Ratings of Change scales (GROC) collected were ≥95%PEA. Patient and clinician satisfaction was high. There were 3 instances where visual issues impacted the session.

**Discussion:** Clinical decisions made via telehealth were comparable to a traditional clinical session model. Consumers were also satisfied, therefore supporting the potential for implementing a telehealth model of hand therapy in a regional/rural setting.
Exploring an extended scope for rural allied health assistant (AHA) role in nutrition and dietetics: Can AHAs assist in malnutrition assessment?

Cristal Newman¹, Petrea Cornwell², Elizabeth Ward³, Annmarie McErlain¹, Adrienne Young⁴

¹ Community and Allied Health, Roma Hospital, 197-234 McDowall St, Roma, Qld 4455, cristal.newman@health.qld.gov.au
² Allied Health Research Collaborative, The Prince Charles Hospital; and Menzies Health Institute Queensland, Griffith University, 627 Rode Rd, Chermside, Qld 4032, petrea.cornwell@health.qld.gov.au
³ Centre for Functioning and Health Research, Metro South HHS; and The University of Queensland, St Lucia, Qld 4072, PO Box 6053, Buranda Qld, 4102, liz.ward@uq.edu.au
⁴ Department of Nutrition & Dietetics, Royal Brisbane and Women’s Hospital, Butterfield St, Herston, Qld 4029, Adrienne.young@health.qld.gov.au

Background: Malnutrition has a significant impact on hospital length of stay and patient outcomes. A solution for rural and remote dietitians to provide timely assessment and treatment of malnutrition could be to have extended scope allied health assistants (AHAs) complete initial assessment of malnutrition to guide dietetic services and interventions. The aim of this study was to assess the accuracy and confidence of trained AHAs to conduct the Subjective Global Assessment (SGA) in comparison to dietitians.

Methods: A non-inferiority cross-sectional design was used. A convenience sample of 45 adult inpatients admitted to a rural and remote health service was recruited to the study. Participants were assessed independently by both a trained AHA and dietitian within 24 hours. Order of assessment was randomised, with the second assessor blind to outcome of the initial SGA. Minimal level of percent exact agreement (PEA) between AHA and dietitian was set at ≥80%.

Results: Level of agreement for the overall SGA score was 84.4% (kappa = .839, p<.001), while for individual components of the SGA PEA ranged from 64.4 to 86.7%. Mean confidence in completing the SGA based on a 10-point scale was 7.5±1.7 for AHAs and 9.0±1.4 for dietitians. Where discrepancies were identified in overall SGA ratings AHAs tended to score more conservatively than dietitians.

Discussion: AHAs can assist in completing malnutrition assessments to help identify patients who require further assessment and management by a dietitian. Further investigation is required to determine the benefits of incorporating this extended role into rural and remote healthcare services.
An audit of process and outcomes from a pilot telehealth spinal assessment clinic: a South Australian story

Matthew Beard¹, Joseph Orlando¹, Saravana Kumar²

¹ Royal Adelaide Hospital, North Terrace, Adelaide, South Australia, 5000, Joseph.Orlando@sa.gov.au
² International Centre for Allied Health Evidence (iCAHE), University of South Australia, North Terrace, Adelaide, South Australia, 5000.

Background: There is consistent evidence that people in rural and remote areas have limited access to health care and poorer health outcomes. Innovative models of care such as telehealth are one way of addressing this inequity. The aim of this pilot trial was to determine the feasibility, appropriateness and access of a telehealth clinic. Methods: A prospective audit was conducted on a Spinal Assessment Clinic telehealth pilot trial for patients with spinal disorders requiring non-urgent surgical consultation. Data was recorded from all consultations via videoconference between the Royal Adelaide Hospital and Port Augusta Community Health Service, South Australia between September 2013 and January 2014. Outcomes included analysis of process, service activity, clinical actions, safety and costs. Data was compared to a Spinal Assessment Clinic outreach trial to the same area between August and December 2012. Results: There were 25 consultations with 22 patients in the telehealth trial. Spinal disorders were predominantly of the lumbar region (88%); the majority of initial consultations (64%) were discharged to the general practitioner. There were few requests for further imaging, minor interventions and other specialist consultation. Patient follow-up post telehealth trial revealed no adverse outcomes. The total cost of AUD$11,187 demonstrated 23% reduction in favour of the telehealth trial with the greatest savings in staff travel costs. Savings in patient travel were equally demonstrated by telehealth and outreach trials. Conclusion: The telehealth model of care improved access and demonstrated safe and efficient management of patients with spinal disorders in rural regions requiring non-urgent surgical consultation.
Evaluation of an integrated oral health program using Tele-dentistry in rural and regional aged care facilities: A mixed method study

Anna Tynan1,2, Lisa Deeth3, Debra McKenzie4 Eileen Shepherd5, Helen Linnerman6

1 Darling Downs Hospital and Health Service, Baillie Henderson Hospital, PO Box 405 Toowoomba, Queensland, 4350. Anna.tynan@health.qld.gov.au
2 School of Public Health, The University of Queensland, Herston Road, Herston, Queensland, 4006.
3 Darling Downs Hospital and Health Service, Baillie Henderson Hospital, PO Box 405 Toowoomba, Queensland, 4350. Lisa.Deeth@health.qld.gov.au
4 Toowoomba Oral Health Clinic, Toowoomba Hospital, Darling Downs Hospital and Health Service, 280 Pechey Street, Toowoomba Queensland 4350. Debra.mckenzie@health.qld.gov.au
5.  Toowoomba Oral Health Clinic, Toowoomba Hospital, Darling Downs Hospital and Health Service, 280 Pechey Street, Toowoomba Queensland 4350. Eileen.shepherd@health.qld.gov.au
6.  Toowoomba Oral Health Clinic, Toowoomba Hospital, Darling Downs Hospital and Health Service, 280 Pechey Street, Toowoomba Queensland 4350.

Background

People living in residential aged care facilities (RACFs) have been identified as a significant risk group for oral disease. These problems are associated with barriers they encounter accessing adequate dental care including their physical, cognitive and medical impairments. The purpose of this research was to evaluate the impact of an integrated oral health program using oral health therapists and Tele-dentistry in 8 rural and regional RACFs.

Methods

A mixed method study was conducted. Chart audits based on RACF oral health guidelines were completed pre and post implementation of the program. In-depth interviews were completed with RACF staff members with and without access to the integrated program. A geriatric oral health quality of life was also completed with residents with and without access to the integrated program.

Results

Preliminary results show that RACFs without access to the integrated program, accessing a dentist was difficult due to physical and cognitive limitations of some residents and distance to closest service. The clinical audit showed an improvement in performance of meeting RACFs’ oral health guidelines at settings with the program. There were minimal differences between oral health quality of life between residents with access to integrated program compared to those without. Overall staff observed improvements in managing oral health care needs of residents with the program.

Discussion

The integrated oral health program incorporating Tele-dentistry and visiting oral health therapists improves access to oral health prevention and treatment services, particularly for residents with significant cognitive and physical limitation residing in rural and regional RACFs.

Words: 250
“Maxi Kids: Strengthening, building and caring for rural and remote children”

Elizabeth Whale

Marathon Health 106 Talbragar St, Dubbo, NSW, 2830, elizabeth.whale@marathonhealth.com.au

Maxi Kids is a six week health promotion and intervention program for children aged between 3 and 7 years of age. Maxi Kids assists parents and carers, early childhood educators, early childhood teachers and health staff discover each child’s strengths and areas of need for intervention specific to their developmental ages and stages and health development using the medium of play. Facilitated by an Allied Health Assistant under the remote supervision of an Occupational Therapist, children are screened in the domains of gross motor, fine motor, visual perceptual, auditory processing, and social skills. The program is tailored to the individual and the identified needs of the child and implemented at weekly intervals within school and preschool environments. Parents, carers, early childhood educators and teachers, and the child’s General Practitioner are informed on and included in the child’s direct and broader healthcare specific to an individual’s needs. These supports and intervention directly affect the child and indirectly affect parental and stakeholder capacity and caregiving environments. Early findings for the Maxi Kids program have identified significant improvement on individual assessments pre and post program. The Maxi Kids program January to June 2015 delivered 8 programs to 25 children with 83% of participants obtaining a score of 100% in their developmental and health screening indicators post program. Customer satisfaction surveys have universally and overwhelmingly identified as “highly satisfied” with the program content, outcome and service delivery. The program often identified as “brilliant”, “awesome” and “wonderful” when asked for further comments or feedback.
A public-private rural physiotherapy service
Carr, Jeremy¹, Maloney, Catherine²

¹ Back On Track Physiotherapy, Corowa, NSW 2646 E: jeremy@backontrackphysio.biz
² Murrumbidgee Local Health District, Wagga Wagga NSW 2650 E: catherine.maloney@gsahs.health.nsw.gov.au

Background:
A collaborative of agencies including a primary health care organisation, hospital service, local government councils and aged care facilities commissioned a project to investigate the viability of a private physiotherapist to provide services to the communities surrounding Finley NSW, given service gaps, population demographics and the prevalence of obesity and osteoarthritis.

Method:
The private physiotherapist outreached from a regional township to two rural communities where service gaps in physiotherapy had been identified. Allied Health Assistants were utilised to enhance the service between visits from the physiotherapist. Shared governance arrangements were established between the primary health care organisation, local health district and the private physiotherapist to monitor service delivery and train and supervise allied health assistants.

Results:
During the pilot project period there were 754 physiotherapy and allied health assistant occasions of services across service streams which included chronic disease, acute and post-acute care, and private clientele. The project has now been expanded to incorporate a further two communities in the Finley-Berrigan-Jerilderie region.

2015 NSW Health Innovation Awards Recipient – NSW Health Secretary Award for Integrated Care
2015 NSW Health Innovation Awards Finalist – Integrated Healthcare

Discussion:
Private sector allied health services in rural communities are a potential resource in areas of workforce shortages.

Agencies working together to pool resources can foster consistent yet flexible service delivery models that meet the needs of rural communities, address service gaps in primary health service provision and support sustainable business development for private sector allied health.
Goal setting in Transition Care: Challenges and opportunities in clinical practice
Holly Campbell

1 CHSALHN, Port Lincoln Health Services, PO Box 630, Port Lincoln, SA, 5606, holly.campbell@sa.gov.au

Background:
Transition from hospital to community is a critical time as it is imperative that clients are supported to regain function and independence. The Transition Care Programme helps to achieve this by providing short-term restorative care to eligible older people. This client-centered programme uses client goals to formulate care plans and inform service delivery. While the evidence for and the importance of goal setting is well documented, implementing this in clinical practice is a real life challenge. Challenges include variability in how goals are documented, reviewed and the way in which client progress toward goals is recorded.

Methods:
Based on best practice standards in goal setting, a clinical audit of all clients who completed a Transition Care episode over a period of three months in Country Health SA was conducted. Medical records, including the goal summary form, were audited using a customised audit tool. The purpose of the audit was to evaluate current practice against established best practice across rural health regions in South Australia.

Results:
Findings from the audit of approximately seventy medical records indicated variable compliance of client-centered goal setting practice. Challenges to client-centred goal setting included lack of awareness and knowledge, poor functionality of existing tools and competing priorities. As a result numerous opportunities to change practice, such as development of a goal setting guideline and targeted resources, have been identified.

Discussion:
Reducing variability and improving consistency in health care is critical. This initiative highlights important learnings about how to achieve consistent practice in client-centered goal setting.
Escape a fracture nightmare to a virtual dream!
Virtual Fracture Clinic (VFC), from dream to reality.
Jenny Wheeler

Dubbo Hospital, Myall St, Dubbo, NSW, 2830, jenny.wheeler@health.nsw.gov.au

Patients living outside Dubbo, WNSWLHD, were travelling hundreds of kilometres for simple fracture management. Patients, family and friends incurred costs from time off work, school, travel, food, accommodation and discomfit, often for a ten minute service. Historically half of Dubbo’s 110+ fracture clinic patients weren’t Dubbo residents, clinics regularly ran late resulting in staff overtime, with many patients’ travelling after dark.

VFC’s multidisciplinary approach allows retention of specialist orthopaedic review, however patients receive local fracture management. Referrals include peripheral ED’s, GP’s, or an initial treatment at Dubbo fracture clinic with local follow up. VFC patient x-rays, now taken locally, are viewed electronically by the orthopaedic registrar in Dubbo. Management plans are sent to local clinicians where casting/removal is provided by a local physiotherapist or nurse. Casting occurs primarily in 14 sites, not all employing a physiotherapist, servicing patients from over 30 towns.

Additionally, Dubbo resident’s not requiring x-ray or orthopaedic review now have cast removal in the physiotherapy department, not fracture clinic.

In 20 months-

- Fracture clinics in Dubbo decreased by 16%
  - VFC provided 900 OOS
  - Fracture clinic finishes on time
  - Clinic physiotherapists decreased from 3 to 2
  - Peripheral x-rays increased by 338%
  - VFC patients saved 300,000 km travel (8 trips around the world!)
  - Patients saved $198,000 car costs
  - Patients retained $206,100 wages
  - Patient saved on average $449 per visit (not including food and accommodation)

Survey results show patient and staff satisfaction as very high, while maintaining a high quality service.
Outreaching Diabetes Management: from patient to practice nurse – a holistic and sustainable approach to managing diabetes within rural communities

Shellie Burgess¹, Lesley Wilcox²

¹ Marathon Health, PO Box 175 BATHURST, NSW, 2795, shellie.burgess@marathonhealth.com.au
² Marathon Health, PO Box 175 BATHURST, NSW, 2795, lesley.wilcox@marathonhealth.com.au

Background: Marathon Health provides many services within rural NSW and among the greatest in demand is diabetes education. The primary health services team recognised that a more sustainable and effective service delivery model was needed to manage the ever increasing demand and a strategic plan was developed that incorporated a wraparound service for the consumer while at the same time building capacity within the area to provide diabetes education services into the future.

Models:
A more efficient mode of service delivery was developed incorporating a combination of face-to-face and telehealth sessions with both the Diabetes Educator and Dietitian. This enabled an increased frequency of service delivery and continuity of support for the consumer, while reducing expenditure. The inter-program referral between the Diabetes Educators and Dietitians enhanced the care for the consumer which was further improved by linking with the Marathon Health Connecting Care and Supplementary Services team for care coordination and specialist interventions.

To build workforce capacity, a Diabetes Management for Practice Nurses education package was developed and delivered by Credentialed Diabetes Educators (CDE) throughout the region to not only enhance clinical knowledge but also provide the opportunity to develop a network of clinicians to support each other, particularly those working in isolation. A Diabetes Support Network was established and with regular tele and videoconferencing an opportunity for ongoing education, support and interagency liaison has been sustained. An expansion of both the education package and the support network to target Aboriginal Health Workers occurred during 2016.
Supporting expansion of telehealth-delivered allied health services

Ilsa Nielsen¹, Jayne Kirkpatrick², Melody Shepherd², Peter Fuelling²

¹ Allied Health Professions’ Office of Queensland, Level 6, William McCormack Place (Stage 2), 5B Sheridan Street, Cairns QLD 4870, ilsa.nielsen@health.qld.gov.au
² Cunningham Centre, Darling Downs Hospital and Health Service, PO Box 405, Toowoomba, QLD AHET@health.qld.gov.au

Background
Telehealth is proposed as a key strategy to enhance consumers’ access to care particularly in rural and remote areas, and improve service efficiency. Queensland Health has identified key barriers to allied health service delivery via telehealth, including limited practical information on successful models and methods to redesign allied health clinical services for telehealth delivery.

Methods
Strategies commencing in 2015 to address the resource and training needs of allied health professionals and facilitate expansion of telehealth use in Queensland health services have included:

- development of training programs/products related to service and clinical redesign for telehealth,
- initiation of an allied health telehealth collaborative network to support dissemination of information on successful service models, and
- collation and distribution of resources that assist teams to evaluate telehealth services.

Results
Training products supporting clinical practice redesign for telehealth delivery have required a specific focus on high-frequency allied health clinical functions such as home environment functioning, mobility and transfers, multi-professional diabetes management and paediatric rehabilitation. Service redesign topics such as business modelling, scheduling and data collection processes, and hub/recipient site collaborative service models have had strong engagement from allied health professionals through the network and the training program development stage.

Discussion
Expanding service access through the use of telehealth requires allied health workforce capacity development that extends beyond basic skills in the use of the equipment. Clinically relevant and practical training, examples and peer support are in demand by health professionals who need to adapt the way they practice for the new technological mediums.
Real Life: A student reflection

Sophie Peter¹’s, Kristie-Lee Evans², Maeva Hall³

The Western Australian Centre for Rural Health (WACRH) is a University Department of Rural Health with a focus on education and research to meet workforce needs now and in the future. We are located in Geraldton, WA with services across the Midwest and Pilbara. Providing non-traditional rural placement opportunity is one of our many strategies across what we call the Rural Health Pipeline. This presentation, as just one option within our student placement program, will provide a student reflection on their time and specific experience across regional, remote and island remote work within 7 weeks!

The presentation will cover aspects of;

• Preparation and understanding of cultural perspectives including Indigenous, Malay and Chinese on their practice.
• Flexibility and innovation
• Being prepared for everything!
• Working within a interprofessional practice model
• The diversity of rural practice
• Cultural understanding in practice
• Service delivery and how this can change
• Key lessons learned from a clinical and practice context
• Collaborations with partner organisations for the islands section of the placement to be achieved

This presentation will include stories directly from the students involved as they reflect on the differences and learnings across Geraldton, Mt Magnet and Christmas/Cocos Keeling Islands.

¹ Edith Cowan University 4th Year Occupational Therapy student
² Edith Cowan University, 4th Year Occupational Therapy student
³ Western Australian Centre for Rural Health. PO 109 Geraldton WA 6531, Maeva.Hall@uwa.edu.au
Trenna’s prosthetic rehabilitation, a team effort

Chris McCann
Clinical Lead Orthotist/Prosthetist,
Orthotics/Prosthetics Services,
Country Health SA local Health Network,
Whyalla Hospital & Health Services

This presentation outlines the developing story of Trenna, a 26 year old woman who underwent a high trans-femoral amputation to her right leg as an infant, and has been unable to wear prosthesis comfortably for more than 12 years. This has resulted in Trenna relying on the use of elbow crutches for mobility in her daily life.

We will review her journey so far and discuss some of the prosthetic and mobility challenges she has faced in daily life, as well as the people involved in getting her to where she is today. We will identify this brave young lady’s goals for the future and those people and health professionals involved in helping her as she begins her new journey. In March this year Trenna underwent Osseo integration surgery in the hope of walking with a bone anchored prosthesis in the near future.

The presentation will highlight how the health system has assisted Trenna and how the people involved in Trenna’s rehabilitation come from rural, state, national and international backgrounds. This demonstrates that the size and shape of our “village” (that it takes to raise a child) can be dynamic and ever changing according to individual needs.
Grasping sustainability in rural and remote areas: a case study.
Johnstone M¹, Huxley C², FitzGerald G³

1 The Department of Health Queensland, Funding Strategy and Intergovernmental Relations Branch, Level 9, 160 Mary Street, Brisbane, 4000, Melissa.Johnstone@health.qld.gov.au
2 The Department of Health Queensland, Capital Infrastructure Delivery Unit, Level 5, ANZAC Square, Brisbane, 4000, Craig.Huxley@health.qld.gov.au
3 Queensland University of Technology, School of Public Health and Social Work, Faculty of Health, QUT
Victoria Park Road, Kelvin Grove, Queensland, 4059, gj.fitzgerald@qut.edu.au

Aims and Objectives
An exploratory case study of a commercial, multidisciplinary organisation operating in 25+ locations was undertaken in two phases. A summary of phase 1 was presented at the National Allied Health Conference in 2015. The topic of this presentation is phase 2 which aimed to validate the findings from phase 1, and further explore the five key components found to impact sustainability: business, staff, work, environment and leadership.

Methods
All staff were invited to partake in an online questionnaire. Twenty employees (43.5%), whose roles included clinicians, managers, co-ordinators, receptionists and administration support with ages ranging from ‘<20’ to ‘51-60’ participated. All questions were generated as a result of phase 1; each one represented a broad category impacting sustainability. Response options were also generated following phase 1; free text was permitted to create new responses. Four of the five key questions asked respondents to rank their preferences, whilst one question asked them to ‘select all responses that apply’. Collated data was exported into a spreadsheet and a score for each response was generated. The popularity of each response was analysed, as well as the cross-over of answers relating to different aspects of the organisation’s model.

Results
Of the 66+ possible responses for the five key questions, six responses surfaced repeatedly. These included: income generation from multiple sources; multidisciplinary care provision; autonomy/independence; flexibility; community-tailored services; and relationships with key stakeholders.
Thriving communities and the role of allied health

Mr David Butt

Chief Executive Officer, National Mental Health Commission PO Box R1463 Royal Exchange, NSW 2000, david.butt@mentalhealthcommission.gov.au

The National Mental Health Commission’s Review of Mental Health Programmes and Services – *Contributing Lives, Thriving Communities* – highlighted the existing complexity, inefficiency and fragmentation of Australia’s mental health system. It presented a compelling case for long term sustainable reform and overall system redesign.

Central to this reform and system redesign is a person-centred approach to mental health care, and the development of integrated care pathways to improve outcomes for people experiencing mental ill health and their families. A greater focus on prevention and early intervention in community and primary health services is a key enabler for this person-centred service model. This will support people and carers to lead fulfilling productive lives.

Allied health professionals have a key role in linking people with the services that they need, and joining services in ways that suit the needs of individuals, rather than individuals needing to make do with traditional service approaches. Care teams will be designed that are required by the individual - for example, Psychologists and other Allied Health Professionals, Aboriginal Health Workers, Non-Clinical service providers, Psychiatrists and Community Mental Health Services.

The Commission’s findings, and the Australian Government response outlining comprehensive reform of the mental health system, will be presented. This reform will transform the way services are planned and delivered within three years. The need for action is critical when almost four million people across Australia will experience a mental illness each year.
Utilising Simulated Interprofessional Practice (SIPP) to Provide Targeted Education across the Paediatric Allied Health Workforce of Queensland.

**TITLE**

K.Kelly¹, L.Findlay¹,³, S.Goodman¹,⁴, S.E.Wright¹,²

1. SLIPAHP, Level 7a, Lady Cilento Children’s Hospital, Brisbane, Qld, 4101, sarah.wright@health.qld.gov.au
2. Physiotherapy Dept, Level 7a, Lady Cilento Children’s Hospital, Brisbane, Qld, 4101
3. Occupational Therapy Dept, Level 7a, Lady Cilento Children’s Hospital, Brisbane, Qld, 4101
4. Speech Pathology Dept, Level 7a, Lady Cilento Children’s Hospital, Brisbane, Qld, 4101

**BACKGROUND**

Interprofessional practice (IPP) results in improved communication, patient safety and care outcomes and reduced service duplication¹². IPP relies on effective teamwork where complementary skills are shared in working partnerships. Interprofessional education (IPE) promotes IPP increasing job satisfaction and recruitment/retention rates in rural settings¹², and is most effective when contextualised to consider regional issues/priority areas¹³. Paediatric healthcare education is a priority across Australia⁴, however the challenges to implementing IPE in rural/remote areas have been well documented.²

**AIM**

To facilitate IPP by provision of context/location specific paediatric IPE using SIPP delivered locally via the SLIPAH(Simulated Learning in Paediatrics for Allied Health) program.

**METHOD**

A combined approach of e-learning and SIPP were delivered across rural/remote locations in collaboration with experienced local therapists and subject matter experts. IPP scenarios were derived based on local priorities, with emphasis on IP core competencies⁵ and evidence-based practice. SIPP provided clinical opportunities to develop safe, effective performance; to refine existing skills and explore innovative solutions to local challenges and patient flow. Impact evaluation included change in participant’s self-efficacy across IP competency domains (teamwork, roles/responsibilities, values/ethics, communication). Participant and manager feedback served to refine program delivery in terms of accountability, performance and responsiveness.

**RESULTS**

SLIPAH collaborated with 8 Queensland Health facilities to deliver to 230 participants in 2015 totally 762 hours. Participants’ self-efficacy across IP core competencies significantly improved across all 4 domains (p<0.05). Qualitative manger feedback was highly positive.

**DISCUSSION**

SIPP developed in collaboration with rural/regional healthcare teams is effective in teaching IP competencies and provides a responsive method for problem-solving local priority issues.

**REFERENCES**

No more dieting, Move Nourish Enjoy!

Esther Miller¹, Amy Trengove²

¹. Port Pirie Regional Health Service, The Terrace & Alexander Street, Port Pirie SA 5540, esther.miller@sa.gov.au
². Clare District Hospital, Webb Street, Clare SA 5453, amy.trengove@sa.gov.au

Move Nourish Enjoy (MNE) is an evidence-based group piloted July-Sept 2015 in the Mid North ‘Village’, SA. It was initiated due to the high demand for dietetic services for weight management. MNE enabled peer support and education through an intensive weekly program, aiming to improve non weight related health outcomes through behaviour change and self-management. It focussed on active living, pleasurable and healthful eating and positive self-image, using Rick Kausman’s non diet approach to weight management.

Nine participants were recruited. Pre and post evaluation measured activity and nutrition health behaviours, knowledge and attitudes, and quality of life. Participants attended for 2hrs per week for 8 weeks with 45minutes of low impact movement and a 60min workshop. Process evaluation occurred at the end of each session and on completion of the program.

The waiting list decreased by 30%. MNE achieved an average attendance of 78%. The group reported a total increase in nutritious foods and decrease in discretionary choices. All increased their physical activity with a total increase from 1100min to 1190min per week. Rate of perceived exertion decreased from a total of 24 (light to moderate) to 6 (nothing or very light). Participants experienced a 2% overall decrease in BMI (not the focus).

100% of participants enjoyed the program and felt confident in their new skills to continue their health and wellbeing journey. MNE improved health outcomes and contributed to a reduced dietetic waiting list therefore two more groups are scheduled for 2016.
Rollout of the NDIS in Queensland. Investigation of the impact on practitioners working in the remote, rural and regional primary health care sector, and on service planning and delivery.

Jo Symons¹, Melissa Johnstone¹, Dave Wellman¹

¹ Health Workforce Queensland, GPO Box 2523 Brisbane, QLD 4001, jsymons@healthworkforce.com.au

The roll out of the National Disability Insurance Scheme (NDIS) from July 2016, marks a major change in the way support is funded for people with a permanent disability in Australia. To date, information sharing and service development has placed the focus on eligible participants of the scheme, their families and the disability sector itself. However, the impact on the broader Primary Health Care (PHC) workforce has not been investigated. Furthermore, the cross-sectoral planning and service delivery demands within remote, rural and regional communities have not been clarified in practice, or in the literature. What is known is that people with a disability, their families/carers and communities will have the best health, wellbeing and quality of life outcomes if a collaborative planning and implementation approach is taken. In Qld, there were three NDIS transition sites: Townsville, Charters Towers and Palm Island that commenced in early 2016. An exploratory study was undertaken to investigate the early NDIS experiences of practitioners and organisations working in the PHC sector in the transition sites through purposive sampling and structured interviews.

Findings will support the wider remote, rural and regional PHC workforce through the changing disability service delivery environment and will underpin the development of integrated service models.

Recommendations provided will address the support and implementation challenges practitioners working in the PHC sector have faced, and opportunities to develop integrated cross sectoral service planning and delivery for scheme participants.
Reducing Social Isolation in a Rural Community through Diversional Therapy

Jane George¹, Danielle Durrant², Joy Aiton³

¹ West Coast District Health Board, Grey Hospital, PO Box 387, Greymouth, New Zealand jane.george@westcoastdhb.health.nz
² West Coast District Health Board, Buller Hospital, PO Box 387, Westport, New Zealand danielle.durrant@westcoastdhb.health.nz
³ West Coast District Health Board, Grey Hospital, PO Box 387, Greymouth, New Zealand joy.aiton@westcoastdhb.health.nz

Introduction:
Reducing social isolation in the community through Diversional Therapy, is part of the wider vision of reducing the number of falls, depression and unnecessary hospital admissions; and improving connection and support within the community.

The Buller Community Diversional Therapy Service was implemented in September 2015, as an initiative to reduce social isolation as part of the future direction of health of older people in Westport, Buller.

Objectives/Purpose:
Diversional Therapy recognises and facilitates purposeful recreational activities with the individual client choice to increase the physical, intellectual, psychosocial, emotional, cultural, spiritual and sexual wellbeing of all ages in many environments.

Social activities in the community range from weekly bus trips to craft groups, coffee mornings and RDA. Each person’s activity schedule is based on their own interests, desires and aspirations. There is no single solution to social isolation as everyone has different needs.

Results:
Referral rates and goals, as well as transition pathways and sustained engagement in community activities will be presented.

Implications:
New community groups are now being created and supported successfully with wider support being provided than what was already available or previously not being fully utilised.

Ensuring capacity responses to the rapid growth of this service remains paramount.

Conclusion:
Participants and clinicians report significant improvements in people’s wellbeing and community engagement.

Other rural areas may benefit from a similar service, especially with the growth of community rehabilitation and reduced aged care facilities.
Foundations for the Future - Learnings from an NDIS trial site

Wendy Thiele\(^1\), Meredith Stewart\(^2\)

\(^1\) Country Health SA Local Health Network, 71 Hospital Road, Pt Augusta 5700, wendy.thiele@sa.gov.au
\(^2\) Country Health SA Local Health Network, PO Box 270 Angaston 5353, Meredith.stewart@sa.gov.au

The National Disability Insurance Scheme (NDIS) trial commenced in South Australia in 2013 until 30 June 2016 with a focus on services to Aboriginal children living in remote communities in Yalata and Oak Valley. Tullawon Aboriginal Community Controlled Health Service, auspice the program on behalf of the National Disability Insurance Agency (NDIA) the organisation who administers the NDIS.

Country Health SA Local Health Network (CHSALHN) as a registered NDIA Service Provider agreed to provide paediatric Allied Health therapy services to children in these communities for the period of Trial.

The Local Area Coordinator (LAC) based at Yalata works with the local community, service providers and with CHSALHN staff about the needs of children and families who are participants of the NDIS.

Partnership at every level is key to the success of the program. Having the commitment of Community Controlled Aboriginal Health Services, the Local Area Coordinator, an NDIA Service Provider and NDIA staff has been essential to address the challenges associated with establishing NDIA services to children in remote Aboriginal communities.

The paper will present key learnings from the SA trial generally and more specifically learnings for working with very remote Aboriginal Communities. Future directions and the implications for NDIA services to Aboriginal children in remote communities will be discussed from the Community and NDIA Service Provider perspectives.
"Meeting the needs of patients with dementia"

Adam Wittwer¹, Brittany Prout²

¹ University of South Australia, 108 North Terrace, Adelaide, South Australia, 5001, witap001@mymail.unisa.edu.au
² University of South Australia, 108 North Terrace, Adelaide, South Australia, 5001, probm001@mymail.unisa.edu.au

Background

“Meeting the needs of patients with dementia” was a nine week community development project facilitated by fourth year UniSA Occupational Therapy students Adam Wittwer and Brittany Prout, in collaboration with the Whyalla Hospital in April-June 2015. The project was undertaken in response to needs expressed by staff for increased support in working with patients with dementia, and to increase occupational engagement for patients in an often time and resource-limited setting.

Methods

Staff were invited to have a participatory role in the project’s needs analysis, decision-making, and strategy development processes, through various discussions, workshops and meetings. Through the project’s needs analysis three main themes were identified: 1) enhanced *engagement* and stimulation for patients during their time in hospital, 2) increased *education* for staff and families surrounding dementia and best care practices, 3) a more supportive physical and socio-cultural hospital *environment*.

Results

From the needs analysis findings, the staff and project facilitators collaboratively worked to create two practical resources for use in the hospital: an *Understanding Dementia* education resource, and a hospital-specific *Personal Life Journal*. These were disseminated to the hospital in the project’s final week.

Discussion

The project and resulting resources worked to build capacity within the hospital community by increasing understanding of dementia and need-driven behaviours, provide practical information to support staff and families, and enable staff to better know and engage with their patients. Thus, the project worked to promote a collaborative, person-centred approach to the care of patients with dementia in the Whyalla Hospital.
Development, implementation and evaluation of the role of dietetic assistants in tackling malnutrition: what worked, what didn’t and why it matters?

Antonella Jarvis1,2, Saravana Kumar1, Georgina Rassias2

School of Health Sciences, International Centre for Allied Health Evidence (iCAHE), C7-61 City East Campus, University of South Australia, Adelaide, SA 5000, saravana.kumar@unisa.edu.au
1. Clinical Dietetics Department, Royal Adelaide Hospital, North Tce, Adelaide, SA 5000

Background
With an ageing population requiring ongoing health care, the frequency of hospital visits continues to rise. Within these settings, malnutrition among the elderly is a well-recognised problem, which requires dietetic intervention. While the importance of addressing malnutrition through dietetic interventions are well recognised, due to lack of timely identification, competing clinical priorities, staffing issues, it is often not addressed. This is especially the case in rural and remote areas where access to care may be limited due to staffing and resource limitations. Dietetic assistants (DAs) could assist in tackling malnutrition and this project tested this new model of care.

Methods
A systematic scoping literature search was undertaken to identify the evidence for the role of DAs. A comprehensive change management strategy was adopted. A targeted training package was developed for and delivered to DAs within a large tertiary hospital by a senior dietitian. Qualitative and quantitative data were collected to demonstrate the impact of DAs across a range of measures.

Results
The literature evidence (n=5) highlighted the positive impact on acute patient nutritional intake, anthropometric indices and ability to assist in reducing mortality. Qualitative interviews with DAs (n=3) and dietitians (n=4) revealed support for this role in practice. Quantitative data indicated improved access to dietetic care and timely intervention with patients (n=25) satisfied with the DA interactions.

Discussion
Despite these positive findings, implementing a new model of care was fraught with challenges. While health reform and innovation continues to be at forefront, effectively translating these into practice continues to face barriers.
Promoting local partnerships: allied health graduate cross service support clusters
Christie Van Beek¹, Lauren Heller²

¹ Victorian Department of Health and Human Services, 50 Lonsdale Street, Melbourne, Victoria, 3000, Christie.vanbeek@dhhs.vic.gov.au
² Victorian Department of Health and Human Services, 50 Lonsdale Street, Melbourne, Victoria, 3000, Lauren.heller@dhhs.vic.gov.au

Background

Interprofessional graduate support is vital for allied health professionals’ successful transition from student to practitioner and is a key recruitment and retention initiative in rural areas. Low graduate numbers in Victorian rural health services creates a challenge for interprofessional graduate support activities. To address this, in 2015 the Victorian Department of Health and Human Services awarded grants to initiate the formation of cross service support clusters for rural and regional health services. This funding supported the development of systems, processes, and agreements between services to deliver improved support for allied health graduates.

Methods

Each cluster led the design, development and delivery of a program to support their allied health graduates based on the specific needs identified. Program evaluation was undertaken using a multi series case design. Preliminary data regarding program design, reach and impact was collected and will be analysed for all clusters, and quantitative data from each individual program evaluation has been reported for further summary into to broad themes for discussion.

Results

14 clusters were successfully created involving over 64 health services including small rural hospitals, private health, community, specialist education, and disability services. Each cluster approached graduate transition support and interprofessional programs in a way that suited local needs.

Discussion

This program demonstrates the success of creating geographically based clusters across multiple health sectors and services to enable interprofessional allied health graduate learning opportunities, supportive peer networks, and create economies of scale for small and regional health services to provide essential graduate support.
Engaging the unengaged: what we have learnt about letting consumers design their NDIS services

Kirsty Egan¹, [Click here and enter an author]², [Click here and enter an author]³

¹ South East Regional Community Health Service, Country Health SA, PO Box 267, Mt Gambier SA 5290, kirsty.egan@sa.gov.au
² [Click here and enter an Organisation, Postal Address, State, Postcode, Email Address for Author 2]
³ [Click here and enter an Organisation, Postal Address, State, Postcode, Email Address for Author 3]

Stream: Healthy People: “Consumer Directed Care”

Introduction:
The first stage of the National Disability Insurance Scheme (NDIS) was rolled out in South Australia on 1st July 2013 for children aged 13 years and under. This was a transformational change in what and how health care is delivered for children and their families with consumer-directed care informing this new philosophy of care. While the theoretical underpinnings of consumer-directed care are strong, large scale practical application of, and testing in, real life practice remains. This projects aims to highlight learnings from the coalface about letting consumers design their NDIS services.

Methods:
Reflections from allied health clinicians working across rural and remote South Australia.

Results:
A number of expected and unexpected learnings were identified. Engaging early with families, especially vulnerable families, to help them get the most value for their child’s plan is critical. The concept of payment for services may be new to some, especially the complexity of families who self-manage their funds. Networking and engaging with other stakeholders, such as NDIS Local Area Coordinator, is important in order to ensure seamless access to services and promote public and private sector collaborations. From a service point of view, managing demand carefully through adequate resourcing and staffing is important. This is particularly relevant as public health services now have to adopt a “business approach” to providing services.

Discussion:
Consumer-directed care is here to stay, in one form or the other. Sharing learnings can assist improvements in service delivery for all health care stakeholders.
Accessing technology in secure mental health facilities – a case study.

Yvette Black

1 Macquarie Unit, Orange Health Service – Bloomfield campus, Mental Health Drug & Alcohol services, Western NSW LHD, Locked Bag 6008, Orange NSW 2800. Yvette.black@health.nsw.gov.au

Background: Our lives are increasingly focussing on computer access via desktop computers, laptops, tablets and smart phones. Mental health patients in psychiatric facilities have typically been restricted to accessing computers and smartphones during their admission, even though they may use the internet as much as the general population (Khazaal et al, 2008). For patients in forensic and justice health services, their long admissions result in loss of knowledge, skills and confidence in using the evolving technologies. Method: Facilities, such as the Burrendong Room and the Macquarie Unit, provide access for patients to computers linked to the internet, under staff supervision. The Burrendong Room and Macquarie Units were funded through a partnership between private and public services, with approval from MHDA executive for an external IT provider to set up software and maintain function. Results: The statistics for use of the rooms, particularly the Burrendong Room, since 2010 has indicated increased use for groups and individual sessions, as well as TAFE courses in Information Technology. The MHDA service has recently been successful in obtaining training for staff and made a successful submission for a research grant into online cognitive remediation programs. Discussion: Barriers to progression have included delayed payment of invoices and slow upgrading of outdated hardware through the health service. The urgency of providing access to computers for patients on campus is increasing an online cognitive remediation program pending. The success of the facilities and the benefits of online cognitive remediation may assist allied health professionals to establish this resource in secure facilities.

Reference:
Improving access to compression garment services through service and workforce redesign
Fiona Hall¹, Julie Hulcombe², Catherine Stephens³ Susan Gordon⁴

¹ Allied Health Professions' Office of Queensland, Clinical Excellence Division, Department of Health, Queensland Government, P.O. Box 5607, Cairns, 4870, Fiona.Hall@health.qld.gov.au
² Allied Health Professions' Office of Queensland, Clinical Excellence Division, Department of Health, Queensland Government, PO Box 2368, Fortitude Valley BC, Qld 4006, Julie.Hulcombe@health.qld.gov.au
³ Allied Health Professions' Office of Queensland, Clinical Excellence Division, Department of Health, Queensland Government, PO Box 2368, Fortitude Valley BC, Qld 4006, Catherine.Stephens@health.qld.gov.au
⁴ School of Health Sciences, Flinders University, Clinical Teaching and Education Centre at ViTA, 17 Rockville Avenue, Daw Park, South Australia, 5401 sue.gordon@flinders.edu.au

Background
The implementation of a Health Service Directive that supported equitable access for clients across the state, with an ongoing need for compression garments to manage lymphoedema, prompted Queensland Health stakeholders to examine the scope of compression garment selection, fitting and supply that can be safely and effectively delivered by generalist occupational therapist and physiotherapists, particularly those in smaller regional, rural and remote locations to improve local access to this service for community members.

Methods
A trial of compression garment selection, fitting and monitoring provided by generalist occupational therapists and physiotherapists with the support of lymphoedema therapists via telehealth coaching and the provision of an education program, and implementation resources was undertaken.

Results
Seven HHSs enrolled in the telehealth supported compression garment selection, fitting and monitoring service model trial. There were 69 referrals and 58 garments provided during the 12 month trial. The evaluation demonstrated that delivery of compression garment selection, fitting and monitoring by generalist occupational therapists and physiotherapists supported by defined training, supervision and governance processes is safe, effective and positively evaluated by clients and health professionals.

Discussion
The service model has provided clear and consistent processes for clinicians and improved access to care for patients. The service model provides a sustainable workforce and service solution. If the full benefits of the service model is to be realised, the implementation will require significant cultural change to increase service capacity and to expand the number of generalist physiotherapists/occupational therapists and facilities who are able to provide compression garments.
Using key performance indicators to measure allied health expanded scope of practice activity

Liza-Jane McBride¹, Belinda Gavaghan²

1 Allied Health Professions’ Office Queensland, PO Box 2368, QLD, 4006, liza-jane.mcbride@health.qld.gov.au
2 Allied Health Professions’ Office Queensland, PO Box 2368, QLD, 4006, belinda.gavaghan@health.qld.gov.au

Background
Allied health expanded scope of practice initiatives have been shown to improve the delivery of timely, effective and high value health services for Queensland communities. In order to measure the implementation of recommendations from the 2014 Ministerial Taskforce on health practitioner expanded scope of practice, key performance indicators were identified and statewide questionnaires distributed annually for three years.

Methods
A self-administered questionnaire was distributed to Directors of Allied Health across all Queensland Hospital and Health Services in June 2014 (baseline), 2015 and 2016. Directors were asked to measure expanded scope activity, including undertaking primary contact roles, prescribing and administering scheduled medicines, ordering diagnostic investigations and undertaking new procedures. The survey also explored Directors perceptions of the enablers and challenges of implementing and sustaining allied health expanded scope roles. Survey findings were compared to baseline results.

Results
Preliminary findings indicate that while the number of allied health professionals working in primary contact roles and undertaking new procedures has increased since the implementation of Taskforce recommendations, the percentage of the workforce engaged in these roles remains small. Barriers to expanded scope roles were consistent with baseline findings and include legislation and accreditation standards, funding restrictions, workforce training models and health service culture.

Discussion
While there has been a slight increase in expanded scope roles across the state, implementation has been slow and inconsistent and the number of professions remains small. A number of real and perceived barriers continue to inhibit workforce reform. The findings from this survey will be used to prioritise funding and guide the implementation of initiatives to embed expanded scope of practice for allied health professionals.
Remote novice allied health professional workforce preparation, recruitment and retention: Personality as an influence

Narelle Campbell¹, Diann S Eley², Lindy McAllister³

1 University of Queensland; Flinders Northern Territory. narelle.campbell@flinders.edu.au
2 School of Medicine, The University of Queensland. d.eley@uq.edu.au
3 Faculty of Health Sciences, The University of Sydney. lindy.mcallister@sydney.edu.au

Background

Attracting and retaining an allied health (AH) workforce in rural and remote areas is an ongoing issue. Key trends from medical and nursing have shown that personality factors play a role in recruitment and retention. However, there has been very little research aimed at understanding personality factors that might influence AH professional recruitment and retention. This paper will address the gap, with a particular focus on novice AH professionals in remote and rural positions.

Methods

This national mixed methods study of the AH workforce comprised two strands: an investigation of personality characteristics using an internationally validated personality inventory, and a follow up study using a structured interviews. This combination of data sought to uncover personality characteristics and factors that contribute to successful recruitment and retention in remote and rural areas.

Results

The results (n=562) showed that a sense of adventure (Novelty seeking) and acceptance of uncertainty (Harm avoidance) was a useful combination of personality traits for recruitment potential. Younger professionals had higher Harm avoidance. Retention in remote included factors beyond personality characteristics such as confidence in a ‘generalist’ role, and a sense of contributing to the health of individuals and the community. Younger AH professionals were significantly more challenged by practicing in remote and more likely to consider that their expertise was under-valued by colleagues and community members.

Discussion

Policy implications and practical outcomes related to recruitment and retention of novice remote AH professionals will be presented from the research. ‘The village’ approach to raising successful remote AH professional ‘children’ will be emphasised.
The virtual journey: from the coast to the outback—working towards improving quality of life and health outcomes for outpatients experiencing persistent pain.

Heather Scriven¹, Darren Doherty ²,

¹ South West Hospital & Health Service, St George Hospital, St George Community & Allied Health Building – P.O Box 602 St. George, QLD, 4487. (Work email) heather.scriven@health.qld.gov.au and (home email) rjscrivo@bigpond.net.au

² Gold Coast Hospital & Health Service. Interdisciplinary Persistent Pain Center. 2 Investigator Drive, Robina, QLD 4226. darren.doherty@health.qld.gov.au

Two Allied Health Professionals, 571 kilometres apart, united in their determination to conquer geographical distance and challenges for rural patients to access specialist persistent pain management services. The use of tele-health technology as a form of communication to present a pain management program is a new but expanding field. Innovation and partnership has resulted in developing a model of service that meets the needs of rural patients with persistent pain in South West Queensland. The Interdisciplinary Persistent Pain Management Centre (IPPC) – Gold Coast and St George Community & Allied Health -South West Hospital and Health Services; developed a partnership in providing such a service. Manage Your Pain – South West (Telehealth) Group is an out-patient education and virtual support group for patients in South West Queensland. Patients from multiple sites across the SWHHS district have simultaneous access to allied health specialists in persistent pain management from the IPPC via Telehealth, whilst still being provided with continuity of care through facilitation of the program by local allied health professionals.

For future sustainability, research into the effectiveness is required. Research funding has been approved and ethical clearance obtained to commence research in 2016 – 2018. This presentation is the fore-runner to the outcome of the pending research; The presentation will provide a snapshot of the experiences of two Allied Health professionals in developing the partnership between rural and tertiary services; and using telehealth to deliver a persistent pain management program to a virtual group within a rural context.
Putting a stamp on quality improvement through documentation

Robyn Vincent¹, Jordan Madigan²

¹ Allied Health Professional (Occupational Therapist), Community based support, Transition Care Program, Murray Mallee Community Health Service, Riverland Mallee Coorong Region, CHSALHN, PO Box 346, Murray Bridge SA 5253, email: robyn.vincent@sa.gov.au
² Physiotherapist, Transition Care Program, Murray Mallee Community Health Service, Riverland Mallee Coorong Region, CHSALHN, PO Box 346, Murray Bridge SA 5253

Background
The Transition Care Program (TCP) multidisciplinary team (MDT) services the Murray Mallee area of CHSALHN in South Australia. A review of current processes against the National TCP Quality Standards of Care demonstrated insufficient evidence in complying with some sections of Standard 2: Multidisciplinary Approach. The existing weekly MDT meeting was minuted on a proforma and made available to attendees. There was no evidence in client medical records of MDT discussion, either around goal achievement or of regular meetings.

Methods
All MDT team members participated in a 4-month trial of an ink-stamped proforma, to facilitate the agenda of meetings and give structure for documentation in client medical records. The stamp included prompts to focus discussion around client centred goals, summary of achievements/highlights, agreed actions and attendance.

Results
A clinical audit of medical records was conducted post the introduction of the stamp and a questionnaire was conducted with the MDT. The audit showed the stamp provided evidence in the medical record of multidisciplinary involvement. Other key outcomes included: improved meeting structure, decreased extraneous discussion resulting in greater time efficiency.

Discussion
This was a low cost strategy providing evidence of compliance with National TCP Standards. The structure of the meeting increased focus on client goal achievement, with greater engagement of clinicians in documenting client discussion, whilst meeting time constraints. Recommendations include continued use of the stamp; making it more generic and available across CHSALHN TCP programs; and adding Estimated Discharge Date to provide further evidence for the standards.
Growing our village size using telehealth group balance and mobility clinics across seven rural sites
Claire Taylor1, Lisa Baker2

1 Gayndah Rural Allied & Community Health, 69 Warton St, Gayndah, 4635,
Claire.Taylor2@health.qld.gov.au
2 Gayndah Rural Allied & Community Health, 69 Warton St, Gayndah, 4635, Lisa.Baker@health.qld.gov.au

Background
The Wide Bay HHS has the highest population > 65 in Australia (21%). This elderly demographic are particularly prone to falls due to poor mobility and balance placing a burden on the acute health service. Gayndah Rural Allied & Community Health provides 3 FTE physiotherapists to service seven rural communities. A group balance class at each site was not viable due to lack of critical mass at each site. This challenge was addressed by developing a telehealth group clinic servicing all seven sites simultaneously utilising allied health assistants.

Methods
A group balance and mobility clinic was designed to provide education and exercise activities to people identified with a significant falls risk. The clinic was initially trialed in a single site in 2014 and then adapted for telehealth delivery using allied health assistants.

Results
Thirty three participants attended the telehealth group balance class in 2015. Outcome measures and client satisfaction surveys were collated as a quality activity indicating the viability and efficacy of a telehealth group balance class. Participants showed improvements in outcome measures that compared favourably with 2014 face-to-face delivery and patient satisfaction was very high. No adverse events occurred during the group class.

Discussion
The use of group telehealth and allied health assistants allowed greater accessibility for rural clients to balance and mobility services and afforded some additional benefits. Telehealth delivery of an exercise class poses unique service challenges. Adaptations to service delivery, tips on allied health assistant training and recommendations are discussed in the presentation.
The First Rural and Remote Subacute Service; Inception to Implementation

Helen Wassman, Elaine Heffernan

South West Hospital and Health Service, 197 - 234 McDowall St 4455  helen.wassman@health.qld.gov.au
South West Hospital and Health Service, 197 - 234 McDowall St 4455  eliane.heffernan@health.qld.gov.au

The South West Hospital and Health Service (SWHHS) covers 319,870 square km and provides services to an estimated population of over 27,000 people. The Service consists of 11 hospitals, four outpatient clinics, two residential aged care facilities and two community health centres. In order to provide increased subacute access to the people in the SWHHS a new 7 bed sub-acute care unit at Roma Hospital commenced in 2014. It was the first such unit to be established within a Queensland Health rural and remote Hospital and Health Service. The Subacute Rehabilitation Unit provides rehabilitation, transition care, geriatric evaluation and management, stroke, psychogeriatric and palliative services. The unit has a hub-spoke relationship with major secondary and tertiary hospitals. There is a committed telehealth model in place with geriatrician support. This unique unit did not spring up overnight. To make our dream a reality it took time to identify need, as well as research to create our model. Our successes to date have come through a united vision of a dedicated and diverse group of clinicians working towards our single purpose, to deliver high quality care safely in our local communities. This presentation seeks to outline the challenges and opportunities the Subacute Service faced from inception to implementation. Building a new health service in rural and remote Queensland has not been without its challenges. The result now is, however, a valuable, responsive and resourceful service that would not exist without the partnership between the community and the South West Hospital Health Service.
Putting a smile in the minds of children

Jodie Marshall

1 J Marshall Psychological Services, PO Box 1102 Nuriootpa SA 5355, marshalljo@bigpond.com

As a private psychologist and mother of primary school aged children, I noticed teachers talking about apparent increases of symptoms of anxiety in children at progressively younger ages. In response to this I volunteered to assist one teacher to bring mindfulness practice to their classroom, using the ‘Smiling Mind’ education program (www.smilingmind.com.au). Mindfulness is the process of being ‘present in the moment’, and is used across all ages to calm the mind and settle the stress response of the nervous system. Smiling Mind is an Australian web and app-based program which allows free access to a range of mindfulness meditations ranging from 30 seconds to 45 minutes.

The use of Smiling Mind in one classroom quickly caught the interest of the leadership group in the school and resulted in the beginning of a school-wide mindfulness approach. By increasing the awareness of mindfulness within school families and the wider community, we have been able to improve the capacity of the students to manage emotions, stressors and daily pressures and empower the teachers to find alternative ways to experience calm, manageable classrooms. My presentation outlines the process of expanding the reach of mindfulness in one rural primary school over a 12-month period.
Getting the message across- the health literacy challenge

Linda Beaver¹

¹ The Health Education Consulting Company Pty Ltd, #48, 21 Battye St, Bruce ACT 2617 E: linda@healtheducationmedia.com.au

Working in a rural and remote environment places extra responsibility on the health care system to provide resources and structure to support health service provision. Supporting the ‘ownership’ of personal health as a growing expectation, necessitates the recognition of health literacy issues amongst the adult population in this country.

For patients, the understanding, remembering and applying health information provided by health care practitioners is often challenging. Being able to benefit from health information necessitates an ability to fully grasp the applications and implications of the information. If every second adult has a less than average ability to comprehend and use health information (ABS, 2006), the health care community, as a whole, has a responsibility to provide health information in a straightforward, relevant, context driven format, accessible and targeted to an individual’s needs.

Helping to start conversations, share experiences and draw on a variety of resources can empower community members to ask the ‘why’ and ‘how’ of their health care.

Using an ‘Awareness, Respect and Action’ model to patient communication can generate change in the way in which the information pathway is managed by health care professionals.

Basic principles of adult learning, styles and preference underpin the required strategies. Challenging the status quo will encourage the providers of health care to consider and refine communication, consultation dialogue and patient instruction.

My presentation will consider the problems of health literacy, what it means to the community, ways to generate a changing mindset for health care providers and options for improved information resources.
Development, implementation and evaluation of a modernised Initial Service Response process in children’s health and development: lessons from rural and remote South Australia

Wendy Thiele¹, Darlene Wyatt², CHAD Forum and team members

¹ Country Health SA, Manager, Children’s Health and Development (CHAD) Programs, C/- Pt Augusta Hospital, Hospital Road Pt Augusta SA 5700. Wendy.Thiele@health.sa.gov.au
² Country Health SA, Clinical Senior Social Worker, Pt Lincoln Health Service, Oxford Terrace, Pt Lincoln Sa 5606. Darlene.Wyatt@health.sa.gov.au

Introduction:
The only constant in health nowadays is change. Health services in rural and remote Australia too are not immune to this, especially with the introduction of the National Disability Insurance Scheme (NDIS). NDIS introduced opportunities for reform and one such area was the Initial Service Response process for the Children’s Health and Development (CHAD) Programs within Country Health SA Local Health Network (CHSALHN). Prior to the introduction of the Initial Service Response teams clinical intake processes was varied and shaped by historical practices, changed over time to meet evolving needs, staffing availability and local stakeholders’ needs and requirements, resulting in inefficiencies and variability at a systems level.

Method:
Using a collaborative, partnership approach between frontline allied health clinicians, managers and researchers, a modernised clinical intake process was developed, implemented and evaluated within CHSALHN sites. A customised initial service response conversation tool (iREWARDS instrument) was developed, which spearheaded the implementation process. Targeted change management strategies (such as site-visits and workshops) were also undertaken.

Results:
Quantitative and qualitative data from the sites support the value of and impact from the modernised Initial Service Response process. The results indicate improved timely access to allied health services and a consistent framework of service delivery across CHSALHN. While there were positive findings, some challenges also remain including managing parent expectations, timely and regular communication with key stakeholders and change fatigue.

Discussion:
Improving access to consistent and best practice allied health care in rural and remote regions is the cornerstone of quality health care. This initiative provides valuable lessons of how this can be achieved through a collaborative, partnership approach.
Rural disability services: the illusion of choice and control.

Mr Edward Johnson¹, Dr Monique Hines², Prof Michelle Lincoln³

¹ Faculty of Health Sciences, the University of Sydney, NSW, PO Box 170
Lidcombe NSW 1825, edward.johnson@sydney.edu.au

² Faculty of Health Sciences, the University of Sydney, NSW, PO Box 170
Lidcombe NSW 1825, monique.hines@sydney.edu.au

³ Faculty of Health Sciences, the University of Sydney, NSW, PO Box 170
Lidcombe NSW 1825, michelle.lincoln@sydney.edu.au

Background
This paper describes experiences of carers accessing disability services (particularly allied health) for their children with intellectual disability in rural and remote areas. It explores carers’ understanding and experience of family-centred practice (FCP), person-centred practice (PCP), and transdisciplinary practice (TDP). It reveals innovative solutions these parents have used to access services, and shares some of their hopes and expectations for the future, including their views on the NDIS and how they feel that it will work in the bush.

Methods
Semi-structured interviews were conducted with carers and then transcribed verbatim. Thematic analysis and open coding were used to analyse data, where each utterance was coded as a content unit. Content units were grouped to form categories, and categories were grouped to form themes. Data was triangulated through recruiting a broad range of participants, as well as cross-referencing thematic analyses between investigators to ensure agreement on categories and themes.

Results
Salient themes included “timeliness of services”, “giving up”, “schools as support networks”, and “collective parental knowledge”.

Discussion
Individuals in rural and remote areas lack access to clinicians with specialist skills in disability, and there is little competition in the local market. Despite this, many consumers feel obliged to take advantage of the limited choices in their local areas that aren’t always timely or suitable, because the alternative is accessing no services at all. Can telehealth, FIFO, and a more person-centred-place-based approach to services in the bush help to solve these issues? Will the NDIS really bring choice and control?
RFDS primary healthcare services: More than a flying doctor

Lauren Gale¹, Lara Bishop², Martin Laverty³

¹ Royal Flying Doctor Service of Australia, Level 2, 10-12 Brisbane Ave, Barton ACT 2600, lauren.gale@rfds.org.au
² C/- Above
³ C/- Above

Background:

For 88 years, the Royal Flying Doctor Service (RFDS) has been providing critical health services to Australians living in remote and rural areas. The best-known service of the RFDS is likely emergency aeromedical evacuations – flying medical staff to remote destinations to retrieve critically injured or unwell patients and transport them to hospitals.

Perhaps less well-known are the comprehensive primary healthcare services delivered by the RFDS in remote and rural areas, particularly in places where low population numbers make it unviable to support permanent, local health services. This includes regular fly-in fly-out general practitioner (GP) and nursing clinics; a 24/7 telehealth service; oral health programs; mental health programs; and, health promotion activities.

Methods:

In 2015, the RFDS commissioned an independent report by the Centre for International Economics (CIE) to assess the value of RFDS primary health services, drawing on previously unpublished RFDS data.

Results:

The CIE report demonstrated that every year around 65,000 people are seen by RFDS primary healthcare staff, including dentists and allied health professionals, and have access to GP consultations over the phone and to pharmaceuticals in almost 1,800 remote locations. The CIE demonstrated the importance of the innovative service model of the RFDS in communities too small to support all the health services required, and where there are huge travel and time costs accessing primary and tertiary care facilities.

Discussion / recommendations:

In this presentation, the CIE’s findings will be outlined and the service model that delivers the suite of RFDS primary healthcare, dental, telehealth and other services described and quantified.
Enhancing educational opportunities for health science students on rural placement.

Rosanne Crouch¹, Joyti Zwar²

¹ UniSA Department of Rural Health, PO Box 546, Port Pirie, SA, 5540, rosanne.crouch@unisa.edu.au
² CHSALHN, PO Box 546, Port Pirie, SA, 5540, joyti.zwar@sa.gov.au

Background: As a means of improving the quality and capacity of both local country clinical staff and undergraduate clinical education/placements, the Port Pirie Regional Health Service (PPRHS) prioritized to investigate the delivery of clinical services within a student led interprofessional (IP) clinic. The aims included:

• increasing students experience and understanding of IP models of care.
• Delivering a comprehensive IPL education program including an opportunity for team discussion and reflection.
• enable students to experience a practical IP model of care.
• enable students to understand and value the contribution of a range of professions to a client’s care though participation in case discussions.
• encourage students to engage in self-directed IPL whilst on placement.

Method: Students were asked to voluntarily complete the Readiness of Interprofessional Learning Scale (RIPL) Questionnaire pre and post involvement in the clinic. Students also have the opportunity to reflect on their learning through weekly Interprofessional Learning (IPL) sessions.

Results: The clinic was commenced in July 2014 with students from all disciplines being rostered to the clinic. An overview of the program and an analysis of the outcomes will be discussed.

Discussion: The establishment of this clinic enabled the implementation of evidence based clinical and education practice, where the focus remains on patient centered care. A student led clinic offers the potential to deliver interprofessional clinical education, where students across professions are engaged within mentoring to understand the different roles and skills of multidisciplinary team members, principles of collaborative team-work and respectful, positive attitudes to multidisciplinary team work.
Social work approach on decreasing blood lead levels in Port Pirie

Emma Nunan¹, Charlotte Dean², Hannah Herrmann³

¹ Environmental Health Centre, 117 Gertrude Street Port Pirie, SA 5540 emma.nunan@sa.gov.au
² Environmental Health Centre, 117 Gertrude Street Port Pirie, SA 5540 charlotte.dean@sa.gov.au
³ Environmental Health Centre, 117 Gertrude Street Port Pirie, SA 5540 hannah.herrmann@sa.gov.au

Background:

The Port Pirie Environmental Health Centre (EHC) helps protect children from the harmful effects of lead in their environment. Port Pirie has a history of lead contamination resulting from more than 100 years of smelting in the town. The Social Work team's responsibility at EHC is to provide comprehensive case management focusing on early intervention and collaboration with the families and local community to reduce lead exposure pathways. There is no 'safe' level of lead exposure and exposure should be reduced or prevented to keep blood lead levels as low as possible. Young children and pregnant women are most at risk from the health impacts of lead exposure.

Purpose:

EHC identified that children's blood lead levels increased within the first two years of the child's life. Due to this knowledge and the previous research on pathways in Port Pirie, early intervention strategies were identified as a plan forward to reduce children's exposure to lead. The social determinants of health were recognised as an impact on children's overall health, particularly their blood lead levels.

Method:

A review of services identified a need to refocus EHC service provision. A service plan proposal was developed utilising the analysis of blood lead levels technical paper, AEDC and child development knowledge, which was approved by senior staff members. Advocacy for additional resources, with two allied health FTEs employed, to expand the team's ability to provide more intensive early intervention case management. Partnering with children and families is central to increase engagement and health outcomes for their children in Port Pirie.

Results:

Results will be discussed with reference to technical paper data and case examples.

Conclusion

Exploring case examples and utilising statistical data provides evidence that early intervention and prevention is the most proactive and efficient way forward in managing children’s exposure to lead in Port Pirie.
Eye and Ear Surgical Services program: achieving improved health outcomes through a comprehensive partnership approach.

Karen Hale-Robertson¹, Jacqui Hawgod², Aidan Hobbs³

CheckUP Australia, PO Box 3205 South Brisbane, QLD 4101, khalerobertson@checkup.org.au
CheckUP Australia, PO Box 3205 South Brisbane, QLD 4101, jhawgood@checkup.org.au
CheckUP Australia, PO Box 3205 South Brisbane, QLD 4101, ahobbs@checkup.org.au

The CheckUP Eye and Ear Surgical Services (EESS) Program aims to improve access to ENT and Ophthalmology surgical services for Aboriginal and Torres Strait Islander people and people living in rural and remote locations for the treatment of eye and hearing health.

Recognising the importance of comprehensive multidisciplinary care, the EESS program is directly supported by a range of integrated Allied Health, Nursing, General Practice and Medical Specialist services that are delivered through parallel Commonwealth funded Outreach programs. These wrap around services support the entire continuum of patient care - from the initial screening, diagnosis and then surgical intervention through to follow up care. This has resulted in the refinement and reduction of lengthy public surgical waitlists and improved the quality of services available to disadvantaged communities.

The delivery of successful surgery under the CheckUP EESS program has relied heavily upon innovative delivery models and collaborative support led by the local stakeholders within each community. These partnerships have resulted in local in-kind support including negotiated reductions in fees to cover patient travel and accommodation, catering, surgery and staff time, hospital and theatre, equipment and consumables as well as general patients support. Subsequently producing significantly greater patient numbers receiving surgery within the EESS budget.

The contribution of local partnerships with Aboriginal and Torres Strait Islander groups has been critical in optimising access to the EESS program. Patient support was provided by local Aboriginal liaison officers who are familiar with the patients and understand the care pathways required for surgery.

To date, under the CheckUP Surgical Services program, CheckUP in partnership with local stakeholders, have delivered cataract surgery to 92 patients across the South East and South West region and ENT surgery to 33 patients across the South East Region. Further cataract surgery is planned for the North West Region and ENT surgery planned for the Far North, North and Central Regions under the 15/16 CheckUP Surgical Services funding.
The use of a remote footwear manufacturing facility in China to provide high quality, cost effective footwear for residents in South Australia.

General Stream Oral, Thriving Communities

Fiona Murray¹, Claire Easterbrook¹, Johnathon Hereen²

¹Country Health South Australia Local Health Network 22 King William Street Adelaide SA 5000  fiona.murray@health.sa.gov.au
²Comfootcare, 2 Dunalbyn Drive Aberfoyle Park. Comfootcare@qq.com

The provision of appropriate footwear for clients with clinically high-risk feet is a key strategy in reducing recurrent ulcerations and maintaining independence.

Background

Footwear prescribed by podiatrists in Country Health South Australia (CHSA) has historically been provided by traditional boot makers. Each boot maker uses different measuring and construction methods, which are traditional hand crafting techniques; dependent on the experience of the boot maker. They are time and labour intensive which is reflected in the cost of the footwear. Most boot makers are located in Adelaide, which can mean multiple, long trips for many clients in order to obtain shoes.

Methods

A partnership was developed with a pedorthotist based in China who has developed the ‘SmartFit Scanning System©’. This system consists of a portable 3D foot scanner with a bespoke software application that produces a 3D image of the foot which can be digitally adjusted. By utilising this unique technology it means that footwear can be manufactured remotely without the pedorthotist actually seeing the client. This has required the development of a unique partnership approach between the pedothotist in China and the Podiatrist working in CHSA.

Results

Clients that received footwear using the SmartFit Scanning System©, found it more comfortable and aesthetically pleasing. There was a 30-50% reduction in costs, delivery time averaged 6-8 weeks versus 3-6 months.

Discussion
This project supports the concept of remote manufacturing to provide access to timely, cost effective, aesthetically pleasing and functionally appropriate footwear, for clients in even the most remote areas in Australia.
Building an e-toolkit to promote good mental health in rural and remote areas

C Rogers¹, H Sturk¹, A White¹, D Kavanagh¹, D Sanders¹

¹ Queensland University of Technology, Lvl 6, 62 Graham Street, South Brisbane, Q 4101, carla.rogers@qut.edu.au

**Background:** The past decade has seen significant growth in the use of information and communication technology to support and improve mental health care in Australia. E-mental health is the use of technology to deliver mental health information and support services for a range of health issues including depression, anxiety, stress and substance use. E-mental health services provide assessment, treatment and support through telephone, mobile phone, computer and online applications. They range from the provision of health information and peer support services, through to delayed or real-time interactions with practitioners trained to assist people experiencing mental health issues. These prevention or intervention programs and applications can be self directed or guided and used either independently or as an adjunct to face-to-face support services. The accessibility of the e-mental health approach to provide cost effectiveness support and assistance to anyone, any time, anywhere, is a significant advantage particularly for people in rural and remote regions. Furthermore, the potentially anonymous nature of such services makes e-mental health options ideal for people who are reluctant to use face-to-face mental health services for reasons of stigma or preference.

**Method:** This paper explores the range of e-mental health resources available to both health practitioners and consumers alike, and uses an interactive approach to showcase a number of e-tools that promote good mental health.

**Discussion:** The e-mental health approach holds significant promise to optimise and enhance the mental health and wellbeing, especially in rural and remote areas where access to services is an on-going challenge.
Enhancing remote physiotherapy services for consistent patient care.

Ellen McMaster¹

¹ Murrumbidgee Local Health District, Hillston MPS, 48 Burns Street, Hillston, NSW, 2675
ellen.mcmaster@gsahs.health.nsw.gov.au

Background In response to significant gaps in Physiotherapy services in Hay in the 12 month period preceding project initiation, the project team analysed the factors contributing to the problem and developed an action plan to improve consistent access to physiotherapy services. The option of using telehealth for clinical care delivered using the internet and computers was explored. Barriers to implementation were identified and managed. Method This process involved community consultation; development of Allied Health Assistant competency requirements to be able to facilitate a Physiotherapy consultation using telehealth; adopting a model of care in which the Physiotherapist was located at a base location and linked to the Remote “recipient” site where the Allied Health Assistant facilitated the consultation with the patient and carer. Two role plays using telehealth to deliver the service were used initially to test equipment, train staff, improve competency and confidence, and to test procedures. A pilot study was then done with two physiotherapy patients requiring high priority follow-up when there was a gap in service delivery. Results Patient Feedback was positive and access to physiotherapy services improved from 40% to 81% of the time in a 12 month period. Discussion The skill set developed is being used to embed the use of telehealth in clinical practice for consistent patient care in outreach to Hay. Information was shared with the district Physiotherapists and an Action Working Group formed to continue with implementation of Telehealth in Physiotherapy across the local health district and to ensure equitable, sustainable practice in rural areas.
Abstract

The innovation of iCare therapy is providing access to physiological rehabilitation in rural and remote settings.

Return to mobility following stroke (CVA) cerebro-vascular incident, (MVA) Motor vehicle accident (TBI) traumatic brain injury and other neurological impairments is difficult without repetition and support. The iCare is an acronym for an ‘intelligently controlled assisted rehabilitation elliptical’. This machine provides cardiovascular strength for lower limbs, improves balance, core strength required for balance along with the neuroplastic change required to regain mobility.

Outcomes have been significant with 1. 10 metre walk tests improving 100% in 20 x weeks, 2. A return to independent walking from being wheelchair bound with a subsequent return of independent ADLs after three months training, together with improved fitness, providing National Heart Foundation NHF cardiovascular risk factor guidelines to a population in need.

Keywords: rehabilitation, cardiovascular strength, neuroplastic change, independence, mobility, rural and transportable

Barbara Wicks
MApSc(UQ) Clinical Exercise Science
ESSAM.AEP.AES
Improving the physical health of people living with a serious mental illness in regional Australia.

The life expectancy of people living with a serious mental illness (SMI) is up to 10-15 years less than the general population. Accessing timely and appropriate physical health care is crucial; however, people with a SMI living in regional Australia can experience additional barriers to accessing services. This is in part due to the difficulties associated with recruiting and retaining health professionals in regional Australia. This paper examines the role non-government organisations can play in addressing the physical health needs of people with a SMI, ensuring that people with a SMI living in a regional area receive have regular health care audits. This paper explores the use of the Health Improvement Profile (HIP) with people with a SMI. It considers the workers’ experiences of using the HIP and the self-described aspects of the HIP workers perceived as being most and least helpful. This study highlights the important role NGO workers in regional Australia could have in helping people with SMI to address their physical health needs. It provides a viable alternative in parts of the world where it may be difficult to recruit health professionals, such as nurses. Based on the responses of participants, four main themes emerged: taking control; accessing services; guiding my conversation; and working with others. In addition, a number of recommendations are made to modify the HIP to tailor it to regional Australia. The adoption of a tool, such as the HIP, would allow for a shared understanding between professionals and has the potential to improve continuity across services.