Rural Innovations Changing Healthcare (RICH) Forum

PATIENTS, FAMILIES, COMMUNITIES – PARTNERS FOR BETTER OUTCOMES

15th March 2016

Rural Health Network

Share these great innovations #RICH2016

EVALUATION REPORT
Executive Summary:
The Rural Innovations Changing Healthcare (RICH) Forum is a ‘virtual’ forum designed to connect healthcare professionals and consumers for professional development and sharing innovative practices across NSW using a combination of face to face, videoconference, social media and live webstreaming technologies to reduce costs associated with travel and time lost from work.

The first of it’s kind in NSW, the RICH Forum is now an annual event and attracts on average 200 delegates who can pop in for sessions of relevance and earn Continuing Professional Development (CPD) hours which contribute to National Registration purposes without being absent from workplace for the whole day as is the case with conventional Forums. The Implementation framework is now well established, and a Resource Kit has been developed.

The RICH Forum has been held and evaluated annually for three years with refinements made each year in response to evaluation comments to continually meet the need of the Local Health Districts and broader rural health fraternity. As technology has improved, so has the ability for eHealth NSW to work with ACI in developing and establishing live webstreaming platforms; internally for NSW Health employees, and externally for other organisations. RICH Forum 2016 reached audiences interstate with the ability to interact via social media for Q&A. Below is a brief summary of the three RICH Forums held to date, and the modifications that have been made to increase networking and access to quality, flexibility and diversity in innovation for the interdisciplinary rural health workforce across NSW, and more recently interstate.

Background:
On 14th March 2014, the first Rural Innovations Changing Healthcare (RICH) Forum was held, having refined existing Conference Organising Committee practices to identify selection criteria, call for abstracts, selection of oral papers onto the RICH program and a keynote speaker.

Selection Criteria for oral papers included:
- an innovative approach to an existing local issue
- that change had been embedded and was sustainable
- the ability to be taken up by other health sectors.

RICH 2016:
18 sites were linked via VC and 200 were registered to attend. The theme for the day was Patients, Families and Communities: Partners for better outcomes with two powerful patient keynote stories setting the scene for the day; Ms Kelly Foran: Friendly Faces / Helping Hands, and Ms Mary-Louise Clifford; A Journey form Coma.

A program containing 9 person-centred projects was presented with 4 additional projects showcased as ePosters over the lunch break. To compliment internal live webstreaming for NSW Health employees piloted in 2015, and to enable greater access to the forum, ACI worked with eHealth NSW to build a platform which enabled access to live webstreaming for external organisations for the first time in 2016. The capacity for people to attend by either internal or external live webstreaming doubled the uptake and usage of webstreaming across NSW and interstate, and included attendance from WA, SA, and Qld Departments of Health.

Of the 170 RICH 2016 evaluations received, 100 had attended via live webstreaming representing 60% of total RICH attendance, with Q&A facilitated by a combination of live access through VC, SMS Text messaging and Twitter. Primary Health Networks, Sydney Children’s Health Network, Universities, WA Country Health, Victoria Health, Health Workforce Queensland, some Metropolitan LHDs, NGO’s and numerous small Multipurpose Service facilities doubled webstream attendance. Some live webstream attendees participated
as individuals from desktop PCs, whilst others attended in small teams as ‘virtual hubs’ indicating a strong desire to expand webstreaming as a modality. As a result, there were less attendees at the satellite hubs. The day was recorded and is available for viewing at https://vimeo.com/album/3972767 (password acirich16).

“I loved the real stories. Often it is the smallest things that have the biggest impact eg. washing the patient’s hair! It made me reflect on my clinical practice”

Sessions are 20 minutes each, with 10 minutes for Q&A which is facilitated in a supported manner through a blend of SMS Text Messages and a roll call of sites to optimise participation. Over the course of the day there were 222 tweets generated and 185,754 impressions which contributed to conversations following RICH 2016.
An ePoster display was conducted as a slide show over the lunch break showcasing more innovative projects with demonstrated potential to be taken up elsewhere. All oral and ePoster presentations from RICH 2016 can be viewed at http://www.aci.health.nsw.gov.au/resources/rural-health/rural-innovation-changing-healthcare-forums/rich-2016

RICH 2016 saw the same number of evaluations received and Certificates of Attendance issued as for RICH 2015 despite there being lower attendance at the Satellite hubs. With improvements in technology and the addition of live webstreaming for internal and external organisations, or staff members from home, the overwhelming increase in attendees accessing live webstreaming for RICH 2016 may well influence webstreaming as the preferred modality for future RICH Forum planning. This would establish the annual RICH Forum as a fully ‘virtual’ and cost neutral event, yet still with interactive capacity to reach clinicians statewide and interstate.

The RICH Forum has become known as an annual ‘virtual’ forum where all attendees are able to interact regularly and are treated to a trip around NSW without the need for travel or accommodation. Overall, 2016 evaluations concluded that the accessibility and cost effectiveness of the ‘virtual’ model, the diversity and quality of projects presented on the day and the flexibility of allowing people to come and go according to work commitments led to a meaningful and informative day.

From an Organisational perspective, there was a noticeable drop in abstracts received during the Call for Abstracts period over January in preparation for RICH 2016 in March. Consideration will be given to moving the Call for Abstracts 2017 back to February and the RICH Forum back to April to avoid conflict with the Christmas School Holidays.

As one participant commented: “Regional areas say thankyou! More of this type of education please?”

Summary to date:

For the inaugural RICH Forum in 2014, 17 sites were linked via VC and 100 people registered to attend. Evaluations from this first RICH Forum concluded that it was an extremely cost effective way to provide professional development and a networking opportunity with participants stating that they loved the diversity and quality of the presentations and the ability to ‘pop in’ for sessions of relevance without having to be absent from the workplace for the whole day.

A keynote speaker was identified; Dr Sue Kurrle (Senior Staff Specialist Geriatrician Hornsby and Bateman’s Bay) to set the scene for the day and presenters were able to present their work from the nearest ‘satellite hub’. “The program offered flexibility, diversity and the ability to come and go according to work commitments. Overall it was an extremely professional, inspiring and informative day”. Each presentation went for 20 minutes, with ten minutes for Q&A where all sites were invited to ask questions or provide comment via roll call of sites.

During the forum nearly 300 tweets were generated from 22 participants in the Twitter discussion. This was significant as social media had not previously been effectively harnessed as a tool at rural health conferences and it created opportunities for commentary and discussion following the Forum. The only cost to ACI was catering at the sites which equated to $12 per person, 80 Certificates of Attendance were issued for CPD and it was strongly recommended that RICH be offered annually.

ACI Participants at the RICH 2014:
Photo A Langton
For **RICH 2015** it was decided to introduce a Theme for the day; **Collaborative Teams**, based on evaluation feedback from 2014. 17 sites were linked via VC and 200 were registered to attend.

A keynote speaker was again invited to set the scene for the day; Dr John Lambert (Chief Clinical Information Officer eHealth NSW) and a further 9 projects were presented. With technology improving, the NSW Health Bridge was able to offer live webstreaming to NSW Health employees for the first time, in addition to the linked regional satellite hubs.

Live webstreaming enabled 55 staff (33% of total RICH Attendance) to juggle their clinical load to see patients as well as joining for sessions of relevance from their desktop PC, whilst still be able to participate in Q&A via SMS Text Message. “I can’t speak highly enough of this excellent initiative! This is the way forward!” In addition, the day was recorded so that it could be available for staff not able to attend, and to enable RICH to be used on inservice calendars in Local Health Districts. For the first time, criteria was developed and ePosters were invited to be run as a slide show over the lunch break to further showcase another 6 projects with potential to be taken up elsewhere.

The value of social media in promoting the event, and sharing lessons learned in real time during the event was maximised with 500 tweets generating 300,000 impressions captured by Twitter. This was double the activity from RICH 2014, and included national and international conversations. 170 evaluations were received and Certificates of Attendance issued.

<table>
<thead>
<tr>
<th>Summary</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people attending</td>
<td>Site VC: #: 100</td>
<td>Site VC: #: 115</td>
<td>Site VC: #: 70</td>
</tr>
<tr>
<td>Live Streaming: #: 0</td>
<td>Live Streaming: #: 55</td>
<td>Live Streaming: #: 100</td>
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</tr>
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<td>Keynote/Focus of the forum</td>
<td>No Theme</td>
<td><strong>Collaborative Teams</strong></td>
<td><strong>Patients, Families and Communities: Partners for better outcomes</strong></td>
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<tr>
<td>Number of tweets</td>
<td>300 Tweets</td>
<td>500 Tweets</td>
<td>222 Tweets</td>
</tr>
<tr>
<td></td>
<td>300,000 impressions</td>
<td>185,754 impressions</td>
<td></td>
</tr>
</tbody>
</table>

For further information, please see:
- RICH 2016 Program Appendix 1,
- Full Evaluation for comments and take home messages Appendix 2,
Evaluation results:

There was a significant increase in webstreaming from 2015 to 2016; people attended for one or two sessions of relevance whilst at work, others ran the stream all day.

In 2015, 33% RICH attendees participated by live webstreaming (Internally to NSW Health employees only).

In 2016, 60% RICH attendees participated by live webstreaming both internally for NSW Health employees PLUS externally to outside organisations using a new YouTube Conference Channel accessed via URL link.

The largest live webstreaming user groups were external organisations making up 20% of live webstream attendees. Organisations such as Western Australia Country Health, Victoria Health, Health Workforce Queensland, Primary Health Networks, University of Wollongong, Hammond Care and Kincare. Many of the smaller Multipurpose Services and District Hospitals also live webstreamed sessions of relevance, either as individuals or as groups.
The majority of attendees were nursing and allied health clinicians, or managers.

98% Webstream attendees indicated that Audio Visual Quality was good – excellent.

Some of the smaller sites had the highest attendance Eg Cootamundra, Multipurpose Services.
The Patient Stories and Palliative Care Presentation had highest attendance, but average participation per session was 100 attendees.

**Themes emerging from the RICH 2016 presentations?**

- **Person-Centred care** – all presentations focussed on the patient experience and empowering patients/carers and families to be involved in their care. *“Nothing about me without me”*.  
  o The rural patient is a person and their broader family has requirements well beyond medical care when accessing specialist care in a regional or tertiary setting eg, costs involved in travel, parking, accommodation, meals, time lost from work and school.  
  o Health information is being crafted in new and exciting ways eg social media, Instagram, 3D Videos.  
  o It is often the littlest things which make the biggest impact for the patient eg washing a patient’s hair, a clinician having a bad day, smell of nasal prongs.  
  o Many patients don’t have an advocate in the NSW Health system which is complex, fragmented and difficult to navigate at times.

- **Care closer to home** – Home grown projects and creating relationships with other health service providers frequently fill the gap and meet a local need. Flexible workforce models, the use of Telehealth and community based programs which share resources, extend the reach of services and reduce length of stay in hospital were key components.

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*Patient Driven Radiotherapy Movies; presented by David Willis, HNE LHD has won several awards for innovation.*
Lessons Learned

- Live webstreaming offered greater flexibility and access to the RICH forum.
- Due to the nature of webstreaming it was difficult to know who and how many people were online at any one time. ACI will work with eHealth NSW to develop a LOGIN process that captures attendees contact details and viewing time.
- Planning and preparation including testing use of all technology ensured there were minimal problems on the day.
- With the RICH Forum scheduled in March as an appetiser leading up to each LHD Health Awards, the Call for Abstracts has been over December and January. There was a marked decrease in abstracts received in 2016, possibly due to the conflict with Christmas School holidays. A recommendation from the RICH Organising Committee is to Call for Abstracts January / February and hold the RICH Forum in April.
- Using Health Wide Area Network (HWAN) to link VC units within hospitals guarantees audiovisual quality control using the NSW Health Bridge.
- With a reduction in people attending through traditional video conferencing methods, alternative methods for asking questions were required to be developed including SMS Text Messaging and Social Media (Twitter), which allowed every participant the opportunity to interact.
- RICH is a cost effective method to deliver a conference, as the only cost incurred was catering for some satellite hubs – < $1,500 equating to $9 per person.
- The day was recorded and edited into individual sessions by the ACI Web Team, and is available on the ACI Website for easy access and workforce development.
- Collating evaluations and generating certificates of attendance was labour intensive. Online survey evaluations to be sourced for RICH 2017.
- Continue the “come and go” structure to allow clinicians to attend according to work commitments – Certificates of Attendance issued increased from 91 in 2014, to 170 in 2015 and 2016.

2016 evaluations concluded that the accessibility and cost effectiveness of the ‘virtual’ model, the diversity and quality of projects presented on the day and the flexibility of allowing people to come and go according to work commitments led to a meaningful and informative day.
Overall Opinion of RICH 2016

98% RICH Forum attendees rated RICH 2016 as very good to excellent.

Fiona Grogan and Dr Dan Fry; Palliative Care Partnering with Cootamundra Community, Murrumbidgee LHD

Sarah Lawty; Drain the Pain, Lismore, NNSW LHD

Karen Height, Kaleidescope, Northern Child Health Network; Cerebral Palsy Hip Surveillance – A Virtual Clinic, HNE LHD
Appendix 1: RICH 2016 Program

RICH Forum

Rural Innovations
Changing
Healthcare

RURAL HEALTH:
Patients, Families,
Communities – Partners
for better outcomes.

A one day ‘virtual’ forum linking
18 satellite hubs via
videoconference across rural
NSW

or join via Live Webstream

15 March 2016
9am – 4.00pm (est)

ACI NSW Agency for Clinical Innovation
Aim
To showcase and share rural models of care which:
- show a resourceful and innovative approach to an existing issue
- have potential to be taken up by other rural health settings
- demonstrate sustainability in embedding the change

Audience
The forum is aimed at the rural multidisciplinary workforce including those who work in non-government organisations (Local Health Districts, General Practice and Practice Nurses, Aboriginal Medical Services, Primary Health Networks, Residential Aged Care Providers, NSW Ambulance, Royal Flying Doctor, University Departments of Rural Health and Royal Far West Kids). Come for sessions of interest or stay for the day! This is a conference without the travel.

Cost
The forum is free – but please advise if you register and are then unable to attend.
To receive Certificate of Attendance for CPD, register to attend or participate via live webstream by Monday 14th March 2016

Satellite Hubs

<table>
<thead>
<tr>
<th>LHD</th>
<th>Site</th>
<th>Venue</th>
<th>Local Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>HNE</td>
<td>Singleton</td>
<td>Dangar Conference Room</td>
<td>Wendy Mason-Jones</td>
</tr>
<tr>
<td></td>
<td>Gunnedah</td>
<td>Hospital Function Room</td>
<td>Helen Ross</td>
</tr>
<tr>
<td>NNSW</td>
<td>Tweed Heads</td>
<td>Lecture Theatre</td>
<td>Casey McCarron</td>
</tr>
<tr>
<td></td>
<td>Lismore</td>
<td>Crawford House, Ground Floor Meeting Room</td>
<td>Jonathan Magill</td>
</tr>
<tr>
<td></td>
<td>Grafton</td>
<td>Education Room</td>
<td>Sue Coombes</td>
</tr>
<tr>
<td>MNC</td>
<td>Coffs Harbour</td>
<td>Education Room 2</td>
<td>Lorraine McGhee</td>
</tr>
<tr>
<td></td>
<td>Port Macquarie</td>
<td>Hospital Education Room 1</td>
<td>Dianne Penberthy</td>
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<tr>
<td>WNSW</td>
<td>Bathurst</td>
<td>Community Mental Health</td>
<td>Katreena Forsyth</td>
</tr>
<tr>
<td></td>
<td>Dubbo</td>
<td>Maternity Meeting Room</td>
<td>Belinda Byrne</td>
</tr>
<tr>
<td></td>
<td>Orange</td>
<td>Lecture Theatre</td>
<td>Catherine Richards</td>
</tr>
<tr>
<td>Murrambidgee</td>
<td>Narrandera</td>
<td>Tutorial Room</td>
<td>Pauline Hatherly/ Karen Absolom</td>
</tr>
<tr>
<td></td>
<td>Cootamundra</td>
<td>HealthOne Meeting Room</td>
<td>Jennifer Apps</td>
</tr>
<tr>
<td>NSW</td>
<td>Narooma</td>
<td>Community Health Meeting Room</td>
<td>Jeanette Colovatti</td>
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<tr>
<td></td>
<td>Goulburn</td>
<td>Staff Education Centre</td>
<td>Christine Ottaway</td>
</tr>
<tr>
<td>FW</td>
<td>Broken Hill</td>
<td>Kincumber Boardroom</td>
<td>Wendy Gleeson</td>
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<tr>
<td></td>
<td>Wentworth</td>
<td>Hospital Meeting Room</td>
<td>Karen Behsman</td>
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<tr>
<td>IS LHD</td>
<td>Shoalhaven</td>
<td>Cancer Care Centre, Meeting Room 1</td>
<td>Bill Jansens</td>
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<td>ACI</td>
<td>Chatswood</td>
<td>Yandhai Room, Level 7</td>
<td><a href="mailto:Jenny.Preece@health.nsw.gov.au">Jenny.Preece@health.nsw.gov.au</a></td>
</tr>
</tbody>
</table>

Back up Teleconference Line: Phone 02 9426 0698  Conference ID: 4001#

Live Webstream Link for NSW Health Facilities
http://tcs.hss.health.nsw.gov.au
http://10.22.33.66/tcs

Live Webstream Link for External Organisations
This link is only live on the day for the duration of the Forum.

About the ACI
The Agency for Clinical Innovation (ACI) is the lead Agency in NSW for promoting innovation, engaging clinicians and designing and implementing models of care. Our clinical networks, Taskforces and Institutes provide a forum for doctors, nurses, allied health professionals, managers and consumers to collaborate across the NSW health system. The NSW ACI Rural Health Network works collaboratively with rural Local Health Districts, health service providers and consumers to identify and showcase innovative models of care and to provide critique for models of care being developed to ensure compatibility for implementation in rural communities.

To join an ACI Clinical Network, go to www.aci.health.nsw.gov.au/join-a-network
RICH Program

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.30am</td>
<td>Arrival / Registration</td>
<td></td>
</tr>
<tr>
<td>9.00</td>
<td><strong>Introduction, Acknowledgement to Country and Housekeeping</strong> – Jenny Preece, ACI Rural Health Network Manager</td>
<td>ACI</td>
</tr>
<tr>
<td>9.10</td>
<td><strong>Official Opening</strong> – Raj Verma, Director Clinical Program Design and Implementation, ACI</td>
<td>ACI</td>
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<tr>
<td>9.15</td>
<td><strong>Patient Stories:</strong> Through the Mirror Darkly – A Journey from Coma; Mary-Louise Clifford, Central Coast Friendly Faces, Helping Hands; Kelly Foran, Glen Innes</td>
<td>ACI</td>
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<tr>
<td>10.15</td>
<td><strong>Improving Access and Reducing Inequality:</strong> Jane Conway, NCPHN</td>
<td>Tweed Heads</td>
</tr>
<tr>
<td>10.45</td>
<td>Morning Tea</td>
<td></td>
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<tr>
<td>10.00</td>
<td>Let’s Look at Lunches; Maxine Molyneux, NNSW LHD</td>
<td>Lismore</td>
</tr>
<tr>
<td>11.00</td>
<td>Drain the Pain; Sarah Lawty, Lismore</td>
<td>Lismore</td>
</tr>
<tr>
<td>12.00</td>
<td><strong>Narrabri Venous Thromboembolism (VTE) Prevention Project:</strong> Jocelyn Palmer, HNE LHD</td>
<td>Gunnedah</td>
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<tr>
<td>12.30</td>
<td>Lunch – ePoster Display</td>
<td>ACI</td>
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<tr>
<td>1.00</td>
<td><strong>Patient Driven Radiotherapy Movies:</strong> David Willis, HNE LHD</td>
<td>ACI</td>
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<tr>
<td>1.30</td>
<td>Orthogeriatric Inpatient Specialist Distance Reviews; Tracey Drabsch, WNSW LHD</td>
<td>Orange</td>
</tr>
<tr>
<td>2.00</td>
<td><strong>Palliative Care Partnering with the Cootamundra Community:</strong> Fiona Grogan, Dr Dan Fry, Murumbidgee</td>
<td>Cootamundra</td>
</tr>
<tr>
<td>2.30</td>
<td>Afternoon tea</td>
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<tr>
<td>2.45</td>
<td>Cerebral Palsy Hip Surveillance - A virtual clinic; Karen Height, HNE LHD</td>
<td>Newcastle</td>
</tr>
<tr>
<td>3.15</td>
<td><strong>Where am I? A standardised Capacity Testing Process for Confused Patients:</strong> John Shibu, MNC LHD</td>
<td>Coffs Harbour</td>
</tr>
<tr>
<td>3.45</td>
<td>Evaluations and Close – Raj Verma</td>
<td>ACI</td>
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</tbody>
</table>

Mary-Louise Clifford

Mary-Louise is a Child Care Centre Director and Early Childhood Teacher who went to work for a very normal day on the 6th February 2013 and had a small accident in the workplace. Mary-Louise sustained a sprained ankle and torn calf muscle when she slipped on a piece of tomato one of the children had thrown on the floor at lunch time in the toddler’s room. This set in place a chain of catastrophic events that were very nearly fatal. She suffered an asystolic out of hospital cardiac arrest caused by a deep vein thrombosis and massive pulmonary embolus, endured life sustaining CPR for 19 minutes, fractured ribs, multi-organ failure and her outcome prognosis was grave to say the least. Her care was nothing short of amazing, and Mary-Louise is here to share her story and provide some insights into how primary, community, and acute care providers can work together to improve communication and support service change to be patient journey centric rather than system processes. She believes she is able to make a difference in the way in which clinicians approach patients and their families in the most catastrophic time of their lives; a time where the emotional and mental impact is devastating.

Kelly Foran

Kelly Foran, founder and CEO of the Friendly Faces Helping Hands Foundation is an enthusiastic businesswoman but above all she is human. From firsthand experience she knows the frailty of life and of the often overwhelming challenges faced when country people become ill or injured. For several years from 2002 Kelly and her young son endured a harrowing list of illnesses, which saw her family leaving their home in rural New South Wales and spending large amounts of time in hospitals in Sydney and Brisbane. The logistics of handling not only operations and depleted funds, but of finding basic services in a strange environment led Kelly to form Friendly Faces Helping Hands, a foundation which links country people to major hospitals and invaluable health services. In the five years since the Foundation’s inception over 50,000 people have been assisted by sourcing information on hospitals and health facilities on the website and by ringing a hotline, which Kelly answers herself. Kelly regularly does presentations and speaking engagements, which rarely leave a dry eye in the audience, and she co-ordinates all fund-raising for the Foundation. [http://www.friendlyfaces.info/](http://www.friendlyfaces.info/)
10 Minutes Q&A for each session – Send your questions via SMS Text to Chloe 0438 854 534

**Oral Presentations**

**Local Solutions Category**

**Orthogeriatric Inpatient Specialist Distance Reviews;** Tracey Drabsch, Senior Physiotherapist Orange, WNSW
Orthogeriatric inpatients often require orthopaedic follow up at rural referral hospitals requiring the patient to travel for an xray and specialist appointment. For inpatients only requiring a decision regarding weight bearing status the specialist appointment is unnecessary. Collaborative care by the sub-acute care team Physiotherapist has enabled distance orthopaedic follow up to be co-ordinated. The multidisciplinary sub-acute care team now participate in fracture clinic follow up distance reviews when the Physiotherapist is unavailable, co-ordinating care with the local treating teams. An estimated $27k has been saved in Patient Transport use, and 115 hours of travel time eliminated during 2015.

**Improving Access and Reducing Inequality;** Jane Conway, Disadvantaged Clinics, North Coast Primary Health Network
Northern Rivers and Tweed Heads have a high proportion of homeless people who experience detrimental effects on physical and mental wellbeing and a diminished capacity to access health services. Clinics have been systematically established to provide clinic services for homeless people in Soup Kitchen environments familiar to them. Soup Kitchens provide a safe and welcoming environment for people experiencing disadvantage, and therefore a perfect location for an outreach clinic. During 2015, 172 GP and 128 Community Nurse occasions of service were provided; bringing medical and nursing care to homeless clients at the Winsome and Lismore Soup Kitchen; the majority of whom were male, and 23% of those identified as Aboriginal.

**Building Partnerships Category**

**Drain the Pain;** Sarah Lawty, Acting Quality Manager, Lismore, NNSW LHD
This project developed a flexible admission process for end stage liver disease patients requiring regular large volume paracentesis. Admission is initiated by the patient and avoids the Emergency Department, reducing length of stay and improving end of life care. A Clinical Practice Guideline was developed, with a standardised approach to streamline bed management, chronic disease management, paracentesis management and end of life planning. Length of stay for this regular Palliative Procedure has been reduced by 66% from 4 days to 24 hours; with a reduction in overall bed days equalling cost savings of $210,000 in 12 months.

**Narrabri Venous Thromboembolism (VTE) Prevention Project;** Jocelyn Palmer, CNE Narrabri, HNE LHD
A pre-audit at Narrabri Health Service undertaken in 2015 revealed that 0% of adult admissions had a VTE risk assessment documented, and 8% had prophylaxis which was not distinguished as being appropriate. Following Clinical Leadership Program methodology, a VTE team was developed, VTE Prevention education was planned and implemented, and community engagement was actively sought and obtained. Post implementation, 95% adult admissions have received VTE risk assessment with 33% receiving appropriate prophylaxis, with plans to expand education and events throughout the Mehi Cluster in pursuing ‘VTE prevention - every patient, every time’. “Community involvement was a key to the success of the project”.

**Where am I? A Standardised Capacity Building Process for Confused Patients;** John Shibu, Social Worker, Coffs Harbour, MNC LHD
The aged demographic of the MNC LHD reflects ever increasing admissions of aged confused patients, yet there was no process for assessing the confused inpatient's capacity to make independent medical, living or financial decisions resulting in hospitalisation for longer periods than necessary. Process review led by a multidisciplinary team developed and implemented a testing process and procedure with a designated pathway and objective assessment tools. A key aspect of the procedure is a decision-making flow chart. As a result, documentation has improved and the person-centred approach has reduced length of stay for these vulnerable patients with diminished capacity, where there is limited access to geriatricians or psycho-geriatricians.
**Integrated Healthcare Category**

**Cerebral Palsy Hip Surveillance - A virtual clinic:** Karen Height, Service Manager Kaleidescope Paediatric Rehabilitation Service, HNE LHD

Children with Cerebral Palsy have a greater risk of hip dislocation and require regular hip surveillance – yet a co-ordinated hip surveillance program was not available in the Northern Child Health Network. A Virtual Clinical Model was developed, whereby x-ray services are provided in the child’s local community, results are accessible online and reviewed by a Cerebral Palsy Hip Surveillance Service. Follow up processes are determined and only the children with an issue highlighted are required to attend a clinic. This model utilises local resources and limits unnecessary travel and face to face appointments, reducing the costs to families and the health system. Early detection of progressive hip disease has demonstrated that hip salvage surgery and further disability and pain can be prevented.

**Palliative Care Partnering with the Cootamundra Community:** Fiona Grogan, Nurse Unit Manager HealthOne, Dr Dan Fry, GPVMO/Anaesthetist, Steve Pollard, NSW Ambulance, Cootamundra. Murrumbidgee LHD

Palliative Care patients in Cootamundra historically were cared for in an inpatient hospital based service model. Palliative Care providers identified that with changes to after-hours services and improved integration of existing services most of these clients could be cared for within their homes. An integrated Palliative Care service model was developed between NSW Ambulance, General Practitioners, Local Health Advisory Group, community Palliative Care services, the local Nursing home and another local Aged Care facility, as well as the Acute and Community Health Services. Introduced were: multidisciplinary case conferences, joint home visiting with nurse and Doctor, increased integration with NSW Ambulance and introduction of ambulance protocols, increased use of advance care directives and improved pain management systems and the opportunity to use the palliative care suite at the local community Nursing Home, as an alternative to hospital admission. The HealthOne Cootamundra Clinical Co-Ordination Palliative Care Group now share resources and have a model which is beneficial to all palliative care clients within the Shire.

**Patients as Partners**

**Patient Driven Radiotherapy Movies:** David Willis, Chief Radiation Therapist, Tamworth, HNE LHD

Radiotherapy patients in Tamworth reported feeling anxious at the start of treatment as they were uncertain about what to expect during the treatment processes. In response, clinical staff collaborated with patients to plan, produce and review a series of information videos. Concepts that could not easily be explained with real footage were described using footage from “PEARL” 3D visualisation software. PEARL is typically used for student training as it provides an interactive model of the treatment environment, including the machine, lights, sounds and “virtual patients”. PEARL footage was mixed with real footage of patients who volunteered to have their treatments filmed. Videos now form part of the standard ‘check list’ for individual consultations and information sessions with all new patients. Survey analysis found videos enhanced patient understanding and reduced pre-treatment anxiety. Access to DVD and online versions of the videos allow patients to share the information with loved ones who are unable to attend consultations. This is highly valued by patients who travel to receive care in Tamworth. The patient information videos convey complex concepts simply, are cost neutral and can be replicated or adopted easily by other Radiotherapy Services.

**Healthy Living**

**Let’s Look at Lunches:** Maxine Molyneux, Health Promotion Officer, NNSW LHD

Childhood obesity is a public health concern as it leads to chronic disease which can mostly be prevented through improved diet. It was identified that providing information to parents regarding packing healthy lunchboxes would lead to behaviour change. Let’s Look at Lunches (LLaL) commenced in February 2015 by developing a subscriber base and commencing a fortnightly e-Newsletter and Instagram profile to increase healthy lunchbox information using Social Media channels which span geographic boundaries. The numbers subscribing, opening e-Newsletters and Instagram posts increase daily indicating that this is an effective and sustainable way to access information. The Let’s Look at Lunchboxes interactive platform enables consumers to engage and also drive change, and the communication strategy is transferable across other health domains.

**ePoster Presentations - A rolling slideshow over the lunch break**

**Developing and Trialling a Culturally Appropriate Falls Prevention Program for older Aboriginal People:** Caroline Lukaszyk, Research Fellow, The George Institute for Global Health, University of Sydney

**Surgical Services Plan Implementation:** Sarah Luff, Surgical Services Manager, Wagga Wagga, Murrumbidgee

**Wait List Elective Initiative WATTLE:** Lucy Duncan, Project Facilitator, Cootamundra, Murrumbidgee LHD

**Patient Centred Management of Multi-resistant Organisms:** Bethany Gill, Registered Nurse, Griffith, Murrumbidgee LHD
Appendix 2: Evaluation Comments

Evaluations returned: 170

First experience of multi-session Videoconference event? Yes: 88 No: 80

Key take home messages?

Patients / Families and Communities as partners
- Rural sites are innovators! Small sites have to look outside the box
- Loved the ‘real’ stories – It is sometimes the littlest things that aren’t really clinical that make the biggest impact for the patient eg washing a patients hair, the language used, attitude of staff “having a bad day” can adversely affect the patient for the whole year!
  - Look at the whole person and their family situation
  - Reminds us why we work in health
  - Made me reflect on my practices
  - This is critical professional development
  - Be more vigilant with empathy
- Loved the ‘across the state’ discussions - Statewide solutions; implemented locally
- Patient experiences drive Quality Improvement – the Patient comes first
- Health Literacy – great concept to personalise videos for patient / family education (adults and children).
- Use technology and social media / instagram to further the health message to the community

Virtual Forum Model
- Reduces isolation, promotes sharing of ideas, networking and collaboration, relatively cost neutral and reduces systemic siloing of services, regions and professionals.
- Use virtual conferencing – Fantastic way forward. Roll it out statewide.
- More of this kind of education please – Regional NSW says Thankyou!
- Great access to PD.
- Great to have virtual forums in groups as it promotes discussion within the group
- I think it is the way of the future for rural clinicians. Very flexible – Being able to pop in for sessions. Staff can come and go. Good variety of sessions. I was able to see relevant topics and still see clients. Excellent to come and go as work day demands.
- Each clinician could take something away from the day
- No cost / No travel
- Could use this approach for all sorts of initiatives and projects
- Access to recording and webstreaming has improved access, will attend again next time
- I hope Queensland can do something like this!
- I was sceptical about how user-friendly this type of forum would be, as I don’t like videoconferencing. This was extremely well co-ordinated – the vision and sound were clear. The surprising thing was the sense of pride I felt about being rural – there is so much metropolitan focus that one forgets what rural healthcare contributes to a vast area and huge population.
- As site co-ordinator, I really appreciated the supportive communication, documentation and organisation prior to the day. It streamlined the process and made it easy to manage.
- There is a huge amount happening across the state, but we are still not good at sharing. This is a great way to share without it costing a fortune.

What would have made the day better?

Promotion
- Staff participation from our local health service was disappointing – RICH needs to be promoted at site level better.
- More staff in attendance at the hubs, although many were live webstreaming.

Infrastructure
- Better connection to be able to see the slides
- Improved technology and use of VC for presenters to zoom in on themselves after presentation.
- Live webstreaming was great!
Screen Format
- Need the camera on the speaker during question time.
- More reminders re Twitter and the SMS Text Number on screen
- Some of the short videos pixelated a little

Preparation
- Send detailed information about each session to webstream participants
- Ensure program is available for live webstreamers
- Use camera to zoom in on speakers / presenters
- Clarity of data being presented. Some graphs and stats were hard to read. Flow charts too small.

Live Webstreaming
- Really opens attendance up to all clinicians regardless of location or client load
- At times the screen was quite pixelated and it was difficult to see pictures or video images. But it’s great to live stream from your desk, and to come and go and continue other work and focus on presentations that were relevant. Loved the SMS option for Q&A.
- Live webstreaming for external organisations also allows for part-time staff to access the education opportunity from home.
- There was a 3 second lag between viewing the slides and hearing the presentation.
- The transmission between the presenting site via weblink was out of focus at times and difficult to view. A wonderful forum, thank you!
- ‘A great opportunity to join in for topics of interest. Well done!

Future Themes?
Many commented that they liked the diversity and variety offered on the RICH Program and the day was interesting and relevant. Some suggested future RICH themes were:

- MPS Program
- Disability in rural areas
- Connecting the unconnected – for patients and carers with no GP or required to travel long distances to access GP or Specialist
- Telehealth Programs
- Preventative Health
- Paediatric
- Volunteers - as partners
- Allied Health Innovation
- Hospital / GP Integration
- Mental Health
- Community Health / Outpatients
- More patient stories

Appendix 3: Acknowledgement - RICH 2016 Working Party members

<table>
<thead>
<tr>
<th>Name</th>
<th>Title / Organisation</th>
<th>Location</th>
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<tbody>
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<td>Chloe Model</td>
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<td>NSW Kids &amp; Families</td>
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