

## WINNER RURAL HEALTH SERVICE OF THE YEAR KYABRAM AND DISTRICT HEALTH SERVICES



Kyabram and District Health Services (KDHS) provides an integrated health service to 16,000 people primarily living in Campaspe Shire in northern Victoria. It offers community health and allied health based services in the towns of Stanhope, Tongala and Kyabram. The acute services are based in Kyabram (39 acute beds, six-bed day procedure unit, two operating theatres, emergency services) as is a 42-bed nursing home, with 12 dementia specific beds. It employs approximately 285 staff with a budget of \$17 million. It treats 3,380 inpatients and has over 4,000 emergency presentations, plus another 1,000 outpatients. The number of surgical treatments have increased every year for five years and now total 1,250. Births have remained steady at 136 for the last three years.

### Providing sustainable, well-managed and efficient health services

In line with our core value of innovation we launched a number of initiatives:

- 'Keepers', is a program that uses volunteers to support and promote recruitment and retention rates for new allied health and nursing employees and for students undergoing a rural placement at Kyabram

- an outreach component to our shared care midwifery program to expand a very successful consumer-driven program to four towns
- 'Count Us In' program to ensure nursing home residents remain part of the community
- our commitment to the environment and success in recycling was recognised by Waste Wise
- we piloted 'better oral health in residential care' delivery option, which was the only one in Victoria and this program will now go national
- we introduced new ways to capture near misses, especially in medication management and this has had a dramatic impact.

We developed a workforce planning initiative, which focuses on sustainable and innovative methods of recruitment and retention in our acute and theatre wards, which eliminated vacancies.

For the 12-month period to 30 March 2009, we generated a surplus of \$640,000 prior to depreciation and capital, and a surplus of \$290,000 after depreciation and capital. We have run surpluses for the past three plus years.

A community fundraising appeal to fund the final stage of the transformation of our nursing home stands at \$1.55 million with \$750,000 to be raised over the next two years.

### Providing timely and accessible health services

This year we are achieving all our acute, aged care and primary health targets. Aged care bed occupancy is 99.85 per cent. This year we expect to meet our acute health target to within 0.05 per cent. Providing additional district nursing hours and community health, allied health and maternity outreach services have improved access to our services and has helped keep our community well.

In 2006, KDHS was successful in a submission with the Rural Midwifery Initiative. This led to the development of an ante-natal midwifery clinic, incorporating a shared care model and then a satellite model in 2009 to four towns.

In 2006, KDHS took the innovative role of becoming one of the first level C hospitals to establish and implement a 'chronic disease model of care.' Increasing demands on services has seen the development of an innovative *Self-Management for Diabetes Program* in early 2009. The program has demonstrated improvements in a range of quality of life, self-management and clinical indicator measures for people newly diagnosed with type 2 diabetes mellitus.

Our drought services focused on difficult to reach clients by making home calls to farmers and connecting them to support groups and to financial counsellors for drought and farm grant assistance. Community Health has responded with two outreach centres in Stanhope and Tongala for easier access, and travels to Rushworth. Home-based services including our innovative 'remote patient monitoring project' are provided to disadvantaged groups.

Youth programs include:

- Stepping Stones Program to local secondary school
- counselling services and support
- creation of a youth council
- *Kids Go for your life* program.

KDHS is ready to deal with any pandemic and is prepared for an emergency.

### Promoting least intrusive and earliest effective care

Remote monitoring of patients with chronic illnesses has improved the management of their illnesses and improved their quality of life. We are examining ways to make this financially sustainable.

Active HACCC programs include tai chi, strength training and gentle exercise to focus on improving independence and physical and social wellbeing. Health promotion is leading by example, so in early 2009 tai chi was also offered to staff.

*Well for life* initiative focused on improving nutritional and physical activity opportunities for older people in planned activity groups. The last 12 months has seen a huge increase in number of volunteers participating in our programs and this will increase further with two new programs, *Keepers* and *Count Us In*.

Our self-management for diabetes program has dramatically improved the quality of life of clients as measured by survey. It has improved mental health and wellbeing as measured by the K10 scale. Few clients need referrals for counselling support. Walking speeds have increased. Haemoglobin A1C levels were all

maintained below seven per cent! All clients lost weight and lowered their cholesterol levels. Average blood pressure levels improved.

These programs have reduced emergency presentations, reduced the pressure on beds by keeping our community healthier. They are providing a virtuous cycle of freeing up acute funds to prevent further acute episodes, while ensuring the sustainability of services, such as obstetrics, by adopting new models of care.

### Improving health service safety and quality

KDHS has a quality and risk reporting system (ORR) that encourages everyone to report incidents and near misses. This is used in conjunction with the *Riskman* system of incident capture.

We introduced the 'management advantage' software into our nursing home so that our incidences could link to both the resident care plan and to the overall capturing of systemic incidences. Soon this system will integrate with *Riskman* and allow easier benchmarking.

During the past year, renewed focus was placed on incident reporting, including the definition of an incident and education relating to the relationship between the use of data to drive quality improvements and changes to clinical practice. Results to date have demonstrated a reduction to actual medication errors by 50 per cent and an increase to medication near misses by 100 per cent.

We have achieved accreditation for the maximum time possible with ACHS, Aged Care Standards and have no outstanding issues with these bodies.

### Strengthening the capacity of individuals, families and communities through effective prevention and health promotion

In addition to the chronic disease management program, an integrated health promotion plan has been developed in collaboration with Campaspe Primary Care Partnership's Community Health Plan.

Priority areas have included:

- mental health and well-being
  - drought initiative
  - youth initiative
- physical activity and nutrition
  - *Well for Life* project
  - *Kids Go for your life*
  - promoting healthy communities project.

### Improving health and wellbeing for disadvantaged people and communities

We overcame the difficulties of the new police checks and changes to legislation to allow prisoners from the nearby prison to come each week and work with our aged care residents and our grounds and gardens staff.

A new, community-inclusive model was developed and is now into its second year in the Tongala township. A social and holistic model of service was developed and the community have embraced it, as identified by increasing referral numbers, increasing community consultation and increasing services being delivered from the site.

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