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EDITORIAL

Sue Daly
Business Manager
VCACI

YOU HAVE BEEN BUSY - HOW ABOUT US???

There is no question that as you reflect on the activities of the 1998/99 financial year you will recall a busy year in health service delivery with a major focus on efficiency. In celebrating our second birthday it is rewarding to examine key outcomes of the VCACI over the last 12 months. We too have been busy and sincerely appreciate the assistance that we have received from the Victorian HITH Coordinators and the Victorian Department of Human Services. In summary, over the last twelve months there have been major achievements in the key deliverable areas articulated in the Centre's 1998/99 service agreement. Notable outcomes include:

- coordination of 2 metropolitan and 4 rural HITH seminars,
- publication and distribution of our quarterly newsletters,
- the development and piloting of HITH Chemotherapy standards,
- the development of HITH Staff Safety Guidelines,
- collaboration in development of Clinical Pathways for fractured neck of femur, stroke and chronic heart failure at The Alfred,
- expansion of the HITH resource database which now contains over 1,800 articles,
- regular meetings with the Victorian HITH Coordinator's group (with video-conferencing links to rural sites),
- publication of the inaugural 'HITH Review' which provides a useful summary of recent publications in HITH, ambulatory care, disease management and clinical pathways,
- VCACI goes on-line with our webpage (see inside for more details),
- the development and trialing of HITH program key performance measures, and
- refinement of the VCACI enquiry database.

In conjunction with the Department of Human Services, we are in the process of finalising deliverables for the current financial year. A number of our major projects will roll into this year including:

- continuing production of the Newsletter and the HITH Review,
- generic HITH Standards,
- a national acute home care clinical pathway register,
- the Victorian HITH minimum data set, and
- the HITH patient acuity tool.

New initiatives for the coming year include:

- further HITH seminars (both metro and rural),
- a compendium of IV devices used in the home care setting,
- guidelines for assessing patient suitability for HITH,
- patient and carer educational material developed in conjunction with rural sites, and
- research into HITH patient length of stay issues.

We look forward to another busy year!

Australian Home & Outpatient Intravenous Therapy Association (AHOITA)

*Summarised by
Dr Lisa Demos, VCACI*

Annual Scientific Meeting, Melbourne, June 1999

This one day seminar was opened by the Victorian Minister for Human Services, the Honourable Rob Knowles, who gave an overview of HITH in Victoria. He emphasised the Government's support of high quality home based care as an alternative for patients and spoke of the positive feedback received from patients and carers in an early and recent surveys of HITH services. The minister also stressed the support of health professionals as critical to the success of HITH and stated that the government wanted to ensure services expanded and became part of the mainstream of acute health care services.

The seminar included invited presentations from several Australian speakers, three concurrent interactive seminars, contributed papers, a small poster section and trade displays. The hospital in the home quality indicators, which were developed by a multi-disciplinary working party and funded by the Victorian Department of Human Services through its HITH Services Development Grant, were launched at the seminar by Mr Brian Collopy, Director, Care Evaluation Programs ACHS. The three indicators unplanned return to hospital, unscheduled phone calls and unexpected staff call-out address program interruption and patient safety.

INVITED PRESENTATIONS

Dr Paul Komesaroff, President of Australian Bioethics spoke on *The future of hospitals*.

Dr Komasaroff presented an overview of the evolution of healthcare and the role of the hospitals. He highlighted the increasing gap between hospitals and the community and the decrease in this gap by some approaches such as HITH. He discussed the influence of technology such as equipment, day surgery, pathology services, communication technology, telemedicine, tele-prescribing, online journals/information and computerised patient records on the changes in healthcare. He proposed the boundaries for hospitals would no longer be needed and that the hospitals of the future would be smaller and involve several integrated components, with increased home-based and outpatient medical and nursing services. These changes will improve the teaching of health professionals by allowing patient management to occur in a more real setting with more community involvement. He stressed that care should be taken to ensure more fragmentation in healthcare did not result and that individual's privacy would be preserved. He concluded that the modern hospital is a historical construct and the successor will respond to a different society with changes driven by ethical goals of best and most appropriate patient care.

Dr Ray Lowenthal from Royal Hobart Hospital spoke on *Managing bone marrow transplants at home*.

Dr Lowenthal gave an overview on the history of bone marrow transplantation (BMT), types of BMT, procedures, protocols and complications. The 30 day BMT mortality has decreased and survival has increased with most centres having <5% mortality. With the decreased mortality along with the availability of GCSF and newer antibiotics, home therapy has been considered for BMT patients who prefer being at home. Patient selection criteria include that the patient lives less than 30 minutes from the hospital, they can be brought into hospital any time over a 24 hour period, they have a responsible carer and are emotionally suitable. Patient carer education is a top priority for treatment and includes information on side-effects and expected outcomes of treatment. Outpatient autologous stem cell transplantation involves reinfusion of haematopoietic stem cells, hydration with normal saline 1L per 100ml of cells, antiemetic plus sublingual lorazepam and baseline observations. Before a patient can be sent home there should not be any macroscopic haemoglobinuria and nausea and vomiting should be settled. The daily follow-up involves full blood examination, electrolytes, transfusions as required, nursing assessment, review by resident and registrar. The Royal Hobart Hospital program considered 19 BMT patients (14 years to 64 years) for outpatient management. Five patients were not suitable to go home at outpatient review, 3 were admitted 1-2 days before the BMT, 3 were admitted on the day of the reinfusion and 8 were admitted on day 3-7 following the BMT. The median hospital length of stay (LOS) was 13 days (range 5-28) with most having short multiple admissions. The current casemix classification may need to be reviewed for outpatient management to avoid penalisation as the LOS for complications eg haematuria may be 21 days whilst the admission for BMT may be for only 1 day. Although stem cell transplantations are reasonably safe and can be performed as outpatients, all patients require re-admission usually due to re-infection. To justify outpatient management of patients their quality of life may be an important consideration. The need for specialised nursing and medical staff currently limits home based management of these patients.

Dr Nick Santamaria from the Carer Training Centre, Alfred Hospital spoke on *The Carer's study* and *HITH video*.

Dr Santamaria reported on a study of 40 randomly selected HITH carers from a Melbourne teaching hospital. Data was collected by structured interviews at the carers' homes and

included the degree of satisfaction with HITH care, information needs, general and specific health effects and an open ended question of the HITH experience that was analysed using lexical thematic content analysis to understand the carers' psychological processes. The results indicated that the majority of carers were satisfied with the HITH experience. Carers reported that they needed further information on the patients clinical condition and the emergency procedures. There was some negative health status effects which included carer fatigue and sleep disturbances; the later was significantly correlated to self reported stress scores. Dr Santamaria also summarised the material that has been produced for carers and patients by the Carer Training Centre. This material is available to all Victorian HITH programs and includes written material on management of fever, pain, and anaphylaxis, administration of intravenous antibiotics and a video describing HITH. The video on HITH was screened at the conclusion of the presentation.

Ms Vivien Adler from the Department of Human Services spoke on *What's happening in HITH - the Government's view.*

Ms Adler presented an overview of HITH in Victoria and included some of the results of the latest KPMG survey of the Victorian HITH programs. Victorian programs commenced in 1994 giving consumers the option of receiving part or all their treatment at home and freeing hospital beds for more patients. From the results of the recent KPMG audit, the major diagnostic categories for HITH were cardiac disease, skin and breast and neoplasms. The main DRG's were chemotherapy, cellulitis, myringotomy and deep vein thrombosis. It was noted that the state average LOS for hospitalised patients with cellulitis or deep vein thrombosis was shorter than the LOS for patients managed partially or totally through HITH. The audit also brought up other issues including the management of private patients, the need for standards in particular on staff safety. The report recommended the staff safety guidelines that have been developed by the Victorian Centre for Ambulatory Care Innovation (VCACI) and acknowledged a patient acuity tool was under development. The service development grants for 1998/99 were summarised, some of which were being presented at the meeting. Service sustainability funding was made available for programs to develop strategies to continue HITH once the incentive funding ceases in 2000. The reports received to date reviewed costing though various approaches were used. The HITH costing study will be finalised in October and will provide more information on managing patients in HITH compared to in-hospital. Ms Adler brought up various issues including:

- staff training to gain patient and clinician confidence and for appropriate decision making especially on when to seek advice,
- the relocation of HITH with other domiciliary programs with consideration that HITH staff also need skills for acute care,
- information to patients is paramount,

- that different HITH models are available and Network models are an option,
- medical responsibility and review is an important component of HITH, GP involvement is variable and costing implications differ, GP involvement may reduce inconvenience to patients and streamline the HITH process though protocols may be required that incorporate GP involvement to ensure quality of care,
- community education is important so consumers know their options,
- information management and future technologies eg telehealth are also important considerations for HITH.

At this stage no comment can be made on what will happen after June 2000 but the Victorian Government has made a considerable investment in HITH and is keen to ensure that it will not be wasted.

INTERACTIVE SEMINARS

The 3 concurrently run interactive seminars which raised differences in the way programs operated and managed patients were:

Optimising drug therapy for HITH care chaired by **Professor Lindsay Grayson**, Monash Medical Centre.

Patient eligibility and selection chaired by **Dr Denise Ruth** Royal Melbourne Hospital and **Ms Jan Coconis** Prince of Wales Hospital.

Organising quality in HITH chaired by **Dr Michael Montalto**, Frankston Hospital.



GOES ON LINE!

Check us out at:

www.dhs.vic.gov.au/ahs/vcaci

You can now access the VCACI through our website. Through the website you can access our extensive database on articles regarding hospital in the home and acute care in the community setting. The site also contains information and contact details of the Hospital in the Home programs currently operating in Victoria. Our newsletter is available online and in the future you will be able to download the standards and guidelines that we have developed. The site will be regularly updated so add it to your favourites and let us help you stay in touch with the latest information about Hospital in the Home.

Chemotherapy Standards for Hospital in the Home: NOW AVAILABLE

The VCACI Chemotherapy Standards for Hospital in the Home are complete. Finally! The first edition of the standards has been printed and is now available through our office. If you would like a copy please forward a copy of the order form enclosed with this Newsletter along with your payment to Allison Loran at the VCACI. It is intended that the standards will be reviewed in two years time. We welcome any feedback you have regarding them.

AHOITA *continued*

CONTRIBUTED PAPERS

Home intravenous antibiotic therapy in tropical North Queensland from **D Bingley, B Viertel, R Norton**, Home Intravenous Therapy Unit, Townsville District Health Service.

A retrospective review of the home intravenous antibiotic service established in 1997 at Townsville General Hospital was presented as well as information on the management of melioidosis. The spectrum of infectious diseases and population treated is different to other centres of similar size. There were 350 patients enrolled in the Home Intravenous Antibiotic Program between September 1997 and January 1999, 64 were treated for cellulitis, 8 for melioidosis and 79 were bone or joint infections. There was 1 adverse event and no infected intravascular line sites. A total of 735 bed days were saved based on casemix criteria. Actual bed days saved by treating patients in the community were 2,006. Potential savings for the hospital were estimated at approximately \$1,000,000 and consumer satisfaction was significantly high across all groups.

Victorian disease specific hospital in the home outcomes study from **K Stanley, ML Grayson**, Victorian HITH Outcomes Study Collaboration involving Monash Medical Centre, Frankston Hospital, Dandenong Hospital and Geelong Hospital.

The Victorian Outcomes Study is monitoring outcomes specifically associated with Medical conditions treated in HITH. A retrospective and prospective study of Disease Specific outcomes for four large HITH units was undertaken to review treatment outcomes and develop guidelines which outline those medical conditions which can be treated safely and effectively in HITH. Standard, mandatory clinical indicators provided accurate data on efficiency of clinical treatment, duration of treatment, patient demographic and social features, treatment failures and readmission rates. Of the 2,258 episodes, 1,666 belonged to the Intravenous Antibiotic (IVAB) program, representing 74% of cases receiving HITH care. There were a wide variety of clinical conditions and acuity of patients receiving IVAB therapy. Cellulitis (n=786) was

the most commonly treated condition, other conditions were pneumonia (n=221), pyelonephritis (n=141), osteomyelitis (n=67), endocarditis (n=29), bacterial meningitis (n=23) and miscellaneous infections (n=399). Overall, treatment outcomes for the IVAB Program were positive with 93% (1,542 cases) completing treatment successfully. In 7% (124 cases) treatment failed, and in the majority of these cases treatment failure was associated with deterioration in the patient's condition. Other reasons were due to patient and environmental factors over which HITH administrators and clinical staff have little control. The predicted patient outcomes in the IVAB program was achieved for 1,542 cases (93%). This high percentage of successful treatment outcomes suggests that IVAB therapy is a safe and effective treatment modality for HITH care.

The diabetes at home program at Frankston hospital in the home from **M Montalto, M Gilfillan, C Avery, S Cole and S Smith**, Frankston Hospital.

The speakers presented the results of a survey of diabetic services provided by metropolitan HITH programs and described the Diabetes at Home program established at the Frankston HITH in April 1999, for the initiation of insulin at home for selected patients with diabetes, the care plan, clinical outcomes and patient satisfaction. The service is staffed by diabetes nurse educators, dietitians, endocrinologist and HITH staff. The program utilises in hours, after hours and on call HITH coverage.

Home is where the heart is - hospital in the home management of acute myocardial infarction from **L Jenkins, L Keighran, S LeVasseur, H Jarman, J Boxall**, Monash Medical Centre and Monash University.

A one year pilot study was undertaken to assess whether selected patients could be safely managed at home from day 3 post acute myocardial infarction (AMI). The HITH program provided 24 hour nursing and medical cover with home visits for general, cardiac and psychosocial assessments by a senior CCU nurse on days 4 and 5 with smooth transition to general practitioner care.

Between February 1998 and January 1999, 308 patients

AHOITA *continued*

were admitted to the Cardiac Care Unit with AMI. Patient criteria for HITH included: no post AMI angina, no LVF or uncontrolled arrhythmias; not diabetic; echo day 3; approval by treating cardiologist as well as general HITH criteria (telephone available; live within 25km radius; a carer to stay with; read and speak English; < 75 years of age). 29 (10%) patients fulfilled the entry criteria. GPs were notified by fax of their patient's transfer and again at discharge from the HITH program (usually day 5). Home visits were conducted by a senior Cardiac Care Unit nurse. 4 patients (14%) had angina in HITH. Their cardiologist was notified and investigation brought forward, but no patient required readmission. There were no infarcts or deaths in HITH. A total of 5 telephone calls were made by the 29 patients, usually related to medication or anxiety related symptoms.

The results of this pilot study show that approximately 10% of AMI patients may be suitable for early transfer to HITH where they can be managed safely, increasing the availability of critical care beds for other patients.

Natural history of PICC lines: Follow-up of 18 months experience from **R Starkey, S Dagg, M Loewenthal, P Dobson**, John Hunter Hospital, Newcastle.

Ms Starkey described the PICC insertion service that was established in September 1997. PICC lines are inserted by a team of skilled registered nurses. Data on the patient and insertion procedure were collected and lines were followed prospectively until removed. Results were analysed using survival analysis techniques and factors affecting line survival were compared.

During the period September 1997 to March 1999, 153 catheters were successfully inserted at 161 attempts in 124 patients ranging in age from 9-86 yrs (mean 54 yrs). These comprised 157 Groshong catheters and 4 Arrow/Cook catheters (3fr gauge 29.6%, 4fr 70.4%). 85 of the lines were managed in the unit's ambulatory IV therapy service. 2,814 line days were available for follow-up and analysis. Catheters remained insitu for an average of 21 days, and the mean complication-free PICC survival was greater than 58 days. The most common complication was phlebitis (3.2 per 1000 catheter days). Infection was rare (0.3 per 1000 catheter days).

POSTER PRESENTATIONS

Let's communicate, **J O'Keefe**, Monash Medical Centre.

This poster dealt with the development of standard information process between the patient's GP and the attending health professionals in HITH patients. GPs were sent a daily condition report via facsimile which included a summary of the diagnosis, treatment plan, clinical progress and any changes to treatment whilst their patient was participating in the HITH program. Over a period of 8 weeks, 21 of the

regions GPs were sent a daily condition report pertaining to their patient's HITH admission. Upon discharge from the program each LMO completed a questionnaire evaluating the daily condition report, including comments on the necessity of such an update, the information provided and its frequency.

14 questionnaires were returned from 14 GPs. 14 received a daily condition report, 13 indicated they did review it daily and 1 did not answer this question. All 14 were satisfied that the form provided them with enough relevant information, 11 wanted the update to continue, 3 preferred notification on admission and discharge only and 4 GPs had contact with their patients during their HITH admission. The majority of GPs indicated that they would prefer to receive a daily condition report from the nursing staff of the Dandenong HITH program. This project is to continue for a further 6 months to ensure the validity of results.

Cardiothoracic case management - from go to woe, **B Searle**, Monash Medical Centre.

This poster demonstrated the advantages and potential disadvantages of this model of case management, where the clinical co-ordinator managing the patient's whole episode of care, (including hospitalisation, at home (HITH) and rehabilitation) and provided examples of other areas where this model of case management could be implemented. The co-ordinator can provide a seamless service from four weeks prior to their cardiac surgery up until eight weeks after discharge home.

HITH units at Monash Medical Centre, Frankston Hospital, Dandenong Hospital, Geelong Hospital, Victoria, **J Gardner, M McDonald**.

An overview of the Victorian HITH Disease Specific Outcomes study was described in this poster. This study involves 4 campuses and presented results from Geelong Hospital. The specific areas targeted were intravenous antibiotics, low molecular weight heparin, wound and cardiac programs.

CONTACT US

We are keen to receive your feedback so that we can address areas of interest to you. Please feel free to contact us if you:

- would like more information about the VCACI,
 - wish to be added to our mailing list,
 - have feedback, ideas or items for future Newsletters,
- would like to share details of forthcoming conferences, seminars or workshops,
- would like more information on HITH/ Acute Care in the Home Issues.

Culturally and Linguistically Diverse Communities and HITH

by *Elwyn Davies*
North Western Health
Care Network



Maureen Spicer (left) CEH, Elwyn Davies (centre) Western, Vivien Adler (right) DHS.

In 1997 North Western Health (NWH) gained a Service Development grant from the Department of Human Services (DHS) to; "Improve Access and Responsiveness of Hospital in the Home (HITH) to patients from Culturally and Linguistically Diverse (CALD) Communities". The final report was handed into the DHS in May 1999.

The patients treated by North Western Health are an extremely diverse group and it was our intention that to make HITH more accessible in order to serve them better. Many English speaking people (and hospital staff) have had problems grasping the concept of HITH and we felt that education and publicity should be directed towards CALD communities.

The project was resourced from Western Hospital but involved all HITH programs in NWH. These were Williamstown, Werribee Mercy, Williamstown, RMH, Northern Hospital (Epping) and Western Hospital.

For Stage One of the project we employed the Centre for Culture, Ethnicity and Health, (CEH) to undertake a Service Review of HITH in NWH. Their advice was to concentrate on three key language groups, which were Greek, Vietnamese and Italian. These groups were most highly represented in both our catchment area and patients treated. CEH interviewed our staff, our patients and relatives and ran focus group discussions in the three relevant communities. The outcomes of this stage were a number of recommendations, which formed the basis of Stage Two. This was also undertaken by CEH.

Stage Two was divided into four distinct categories:

1. Service Development which involved

- the development of comprehensive cultural diversity policy document for each HITH service in the Network,
- the development of protocols for use of interpreter services for adaptation by each HITH program, and
- provision of a framework for measuring client satisfaction on an ongoing basis, including development of instruments for patient satisfaction in relevant languages.

2. Staff Development which included

- implementation of 2 two-day training sessions,
- development of crosscultural resource/reference guide aimed at staff and management, and
- design of a training program targeting all relevant staff and management covering themes such as crosscultural awareness, cultural perceptions of health and illness, communication and working with interpreters.

3. Information Provision and Development including

- development of a protocol for information provision to patients and carers from the targeted communities throughout NWH,
- development of culturally and linguistically appropriate information materials in the 3 targeted languages eg. Leaflets on patient and carer rights and responsibilities,
- development of culturally and linguistically appropriate internal documents in the 3 targeted languages eg. consent forms, and
- compilation of existing and newly developed materials into information packages that could be reproduced as required by each service within the Network.

4. Program Promotion

- conduct a localised radio and print media campaign targeting the 3 key languages,
- conduct direct community promotion activities targeting existing ethnic community groups within Network catchment area, and
- undertake public relations activities with key people from the 3 targeted community groups.

There have been many positive outcomes from the project. All staff have reported the value of the training in how to use interpreters correctly. This has been of particular use to Ann Bentley for HITH at The Northern Hospital, who has spent considerable time with the Kosovar refugees at Puckapunyal in the last few weeks. Ann reported that she had cause to call on the training she received in stereotyping and in other cultures approaches to health and disease.

Another offshoot is the cooperation and contact between all HITH programs in NWH, which has led to sharing of ideas and support. The documentation we will now share will hopefully lead to more in this vein and the development of a seamless operation amongst ourselves.

NWH is very committed to providing healthcare of a high standard to everybody in the community it serves and it recognises that the use of family members, children or staff members to act as interpreters is not appropriate and means that patients are not being treated equally. It is both unfair to the patient, their families and the person used as interpreter. It may also mean that healthcare staff do not give or receive the necessary information.

We now have a clear policy for the use of Professional Language Services and patients of HITH are given instructions to use Telephone Interpreting Service (TIS) whenever they wish to call us, with the cost borne by the hospital.

I would like to acknowledge the excellent work undertaken by CEH and the support and guidance of Dr Denise Ruth at RMH.

Copies of the Final report can be obtained by contacting me via e-mail on:

Elwyn.Davies@nwhcn.org.au or by faxing a request to 9319 6584. Cost is \$10.00 to cover postage and handling.

Hospital in the Home Toolkit Seminar

by Robyn Wall
Project Officer
VCACI

Stamford Plaza Hotel, Adelaide, May 1999

The Hospital in the Home (HITH) Toolkit Seminar was the second in a series of seminars conducted by the Australian Resource Centre for Hospital Innovations. The aim of this seminar was to present an overview of HITH by focusing on various models currently operating in Australia. Presentations covered research and surveys by leading experts in the field, a range of case studies, and issues related to HITH.

The following abstracts cover some of the papers presented at the toolkit seminar:

Acute Home Care: The Genesis and Future Direction

Presented by Associate Professor Lexie Clayton

Director, Ambulatory & Community Services, The Alfred Hospital

Connected Health, Education & Support System (CHESS) is described as an integrated system of care, developed to more effectively manage chronic diseases across the continuum.

The evolution of clinical pathways, coupled with telehealth and emerging remote monitoring technologies, has made it possible to monitor individuals and implement timely interventions and participation of individual consumers, their general practitioners and staff of The Alfred and other acute hospitals.

CHESS provides an opportunity for both Commonwealth and State governments to demonstrate the potentially significant cost savings, which will flow from a new model of integrated care for individuals suffering chronic disease by providing them with appropriate advice, monitoring and supports, thereby enabling informed disease management decision making.

An overview - Commonwealth Consultancy on Advancing HITH in Australia

Presented by Marian Shanahan

Centre for Health Economics Research & Evaluation (CHERE)

This study looked at the various HITH programs throughout Australia in terms of models, mix and volume of programs, as well as funding. Findings indicate that regardless of the HITH model, many issues faced were similar in nature. These included:

- *Barriers to program expansion:* included budgetary issues, staffing, lack of referrals and reluctance to alter practice patterns.
- *Structural Issues:* included funding (eg. Commonwealth & State); organisational issues (coordination, communication, support at senior level); staffing (skill levels & training, specialised); medical (Specialist & GP, home -v- clinic, remuneration, skill levels); and continuity of care.

Other presentations included: *Frankston Hospital in the Home: Principles Behind the Practice* by Dr Michael Montalto;

Hospital @ Home, Flinders Medical Centre by Ms Barbara Farrelly; *Urology Patients at The Queen Elizabeth Hospital - From Presentation to Home* by Ms Lisa Porter; and *HomeWard 2000* by Ms Caroline Langston. All four models were structured differently. The Frankston model is co-ordinated by Dr Montalto and uses a generalist model to provision of patient care. The Flinders program is managed by the Clinical Nurse Manager, Ms Farrelly, and also uses a generalist approach. The Queen Elizabeth Urology approach is based on a Case Management (specialist) model, and the HomeWard 2000 model is a community based program run by the General Practice Division of Western Australia.

Other issues presented at the seminar were adverse event management, tools for measuring quality and safety in the client's home.

Seminar Report

by Carole Staley
Senior Project Officer
VCACI

*International Nurses' Day
Acute and Rural Health Issues
ACCNS in association with VCACI
15 May, 1999*

Royal District Nursing Service, Melbourne

The Australian Council of Community Nursing Services (ACCNS) in conjunction with VCACI conducted a seminar in honour of International Nurses' Day on 15 May 1999. The focus of the seminar was upon acute and rural health issues. Approximately 30 people attended the seminar and there was representation from district nursing services and HITH programs throughout Victoria.

The morning program focused upon the nurse practitioner role, rural homelessness and the methadone program. Whilst the afternoon focused upon various models of HITH including rural, metropolitan, homelessness program and marketing issues for HITH.

The collaboration between ACCNS and VCACI provided an excellent opportunity for sharing of knowledge between the community based and acute health sector. Participants had the opportunity to network with colleagues from throughout Victoria and expressed high satisfaction with the overall program.

"My view you know is that the ultimate destination of all nursing is the nursing of the sick in their own homes...I look to the abolition of all hospitals and work-house infirmaries. But it is no use to talk about the year 2000." - Florence Nightingale on the Millennium

UPCOMING CONFERENCES

ATSP's ANNUAL INTERNATIONAL TELEMEDICINE CONFERENCE

15-17 September 1999
Albuquerque, New Mexico
Internet: www.atsp.org

INTERNATIONAL CLINICAL TRIALS SYMPOSIUM

15-17 September 1999
Sydney, NSW
E-mail: trials@icms.com.au
Internet: <http://www.icms.com.au/trials>
Telephone: (02) 9290-3366

MEDICAL CASE MANAGEMENT

Catch a Wave into the New Millennium
22-25 September 1999
California, USA
Telephone: 0011 1 760 431 9797

NAVAN 13th ANNUAL CONFERENCE

26-29 September 1999
Orlando, USA
Internet: www.navannet.org
Telephone: 888-57-NAVAN

CONSENSUS DEVELOPMENT CONFERENCE: SAFETY OF IV DRUG DELIVERY SYSTEMS

27-28 September 1999
Phoenix, USA
Telephone: 614-292-1514

THE 4TH ANNUAL DISEASE MANAGEMENT CONGRESS

Innovative Strategies for Total Health Management
3-6 October 1999
Boston, USA
Internet: www.nmhcc.org
Telephone: 1 888 882 2500

NAHC'S 18TH ANNUAL MEETING AND HOMECARE^{Expo}

9-13 October 1999
California, USA
Internet: www.nahc.org
Telephone: 202 547 5050

1999 CINA CONFERENCE

Canadian Intravenous Nurses' Association
20-22 October 1999
Toronto, Ontario, Canada
Internet: <http://web.idirect.com/~csotcina>
Telephone: 416-292-0687

INS FALL ACADEMY

5-7 November 1999
Boston, USA
Telephone: 617-441-3008

THE CHALLENGES FOR PHARMACISTS WITH PATIENTS AT HOME

25 November 1999
Burswood International Resort Casino Convention Centre
E-mail: jenny.chesser@armc.org.au
Telephone: 9496-5807

THE SOCIETY OF HOSPITAL PHARMACISTS OF AUSTRALIA

24TH FEDERAL CONFERENCE

25-28 November 1999, 9.00am-12.30pm
Kestral Room, Burswood International Resort Casino, Perth.
Telephone Jenny Chesser: (03) 9496 5807
E-mail: woodgate@web.solutions.net.au

ASMR 1999 NATIONAL SCIENTIFIC CONFERENCE

27-29 November 1999, Leura, NSW
Internet: <http://www.powmri.unsw.edu.au/asmrnsc/>
Telephone: (02) 9256-5450

THE CASE MANAGEMENT SOCIETY OF AUSTRALIA

10-11 February 2000, Melbourne, VIC
E-mail: f.campbell@pb.unimelb.edu.au
Telephone: (03) 9344-6389

OUTPATIENT PARENTERAL THERAPY BEYOND 2000

17-22 September 2000
Leura, NSW
E-mail: confact@conferenceaction.com.au
Telephone: (02) 9956-8333

INTERNATIONAL DIABETES INSTITUTE

Various courses and seminars
E-mail: jhaynes@idi.org.au
Telephone: (03) 9258-5053
26 July 1999

Innovation in A.C.T. Care Continuum Pathways

by Gary Frontin
Care Continuum
Pathways Project Officer



ACT Community Care (ACTCC) and The Canberra Hospital (TCH) established a project to develop a series of care continuum pathways to assist in improving coordination and continuity of care across the acute/inpatient and community settings.

The objectives as stated in the Purchase Contract

1998-99 between the Department of Health and Community Care and TCH, were to develop a health and community system which:

- is an integrated and coordinated system,
- provides a seamless, responsive service focussed on the needs of individuals and population groups,
- focuses on outcomes, evidence, quality and customer service.

Three care continuum documents (which link the acute hospital and community care system) were developed and piloted. These are the Falls in the Elderly, Breast Cancer Surgery and Myocardial Infarction pathways. A fourth pathway 'Footpath' has been identified and has been funded externally. The fifth potential pathway, Pregnancy Care, has proved impractical at present. The aim of the pilot process was to evaluate the pathway tool, not to implement the document as a permanent client record. The project development process was loosely based on the model developed by John Hunter (Newcastle) Hospital (*Module 3, How to develop a Clinical Pathway, JHH Clinical Pathways Education, May 1995*).

The project team consists of a full-time project officer, and part time administration staff. The project is overseen by a Steering Committee comprised of executive members of the Health Department, School of Clinical Medicine, Senior Allied Health, and ACT Division of General Practice.

The project aims are to develop and use pathways to build links with those in the acute care setting, thereby ensuring a seamless transition from home/pre-admission to hospital/acute care and back to community based services.

Briefly, key players from the hospitals and community care were identified and invited to attend inaugural briefing sessions held in the community. Representatives from community based consumer focus groups were also invited. From that large group, self-selected development working parties were formed for each pathway. Emphasis was placed on ensuring that members from all relevant professional areas were participating in the development groups in order to compre-

hensively cover every service area. Consumer representatives played a vital role on these working parties. Of the original four pathways, three have progressed satisfactorily. Falls and Breast Cancer are currently being trialed while Myocardial Infarction is in an advanced stage of design. Pregnancy Care is "on hold" at this time pending further developments in service delivery. Both trials use a client held document that takes into account the specific needs of each consumer group while retaining clinician best practice.

The Falls trial, diary distribution is by a select group of GPs who refer the client to community services via the single point of entry Intake and Assessment Unit. Contents include a diary page covering six weeks of observations by the client about fall incidents, separate assessment summaries and action pages for each of the six disciplines represented. General information about available community resources is also included. Evaluation for this trial is "process" only. The question is - "Does this style of documentation help improve coordination of services and enhance communication amongst clinicians?"

In contrast, the Breast Cancer pathway places the emphasis on client empowerment through information about services, relevant literature and community based support groups. Evaluation is by individual feedback forms contained in the pathway and collected by the distributors - Breast Screening Clinic, Surgical Wards or Community Nursing specialists. Clients can enter the trial at any time in the continuum from diagnosis, during or post hospitalisation. It is envisaged that, in a longer trial, clients will enter the pathway at diagnosis to facilitate maximum impact of the information.

The Myocardial Infarction pathway, which is currently in the final stages of development, will be distributed prior to discharge from hospital as a pilot and will be evaluated at the conclusion of the standard cardiac rehabilitation program.

In summary, this project has in the past eleven months, generated three pathway documents. Early feedback indicates that, although limited distribution during a very short time-frame has placed restrictions on the trials efficacy, practitioner and consumer communication is improved.

As this was one of the aims of the trial, it can be seen as reflecting limited success. However, impact on the larger issues of falls prevention, reduced frequency and severity of related injuries and improved service coordination for Breast Cancer clients will have to wait for a longer and more comprehensive trial.

The team awaits budget allocation for financial year 1999-2000 in order to continue pathway development for the already established areas and, over the next twelve months, move into new and challenging areas.

Progress Report - Hospital in the Home Costing Study

*by Alison Yum,
Project Coordinator*

A year has passed since the North Western Health Consortium won the tender to conduct the Hospital in the Home (HITH) Costing Study for the Department of Human Services (DHS). The core project have been working full time since October 1998 and are now well over half-way through the project time-line, with the final report due by the end of October 1999.

DATA COLLECTION

Medical record review for matching sample episodes:

Collection of data on HITH programs via a mailed survey, and sample episodes from medical record review, was completed by March 1999, with 35 sites across Victoria visited by the 2 research assistants. A 66% success rate for matching the sample HITH episodes to the non-HITH episodes left us with a final sample of just under 2000 episodes for costing. The remainder of the HITH episodes failed to meet the spe-

episode with which to compare the cost of each HITH episode, and the best possible match for patient condition and complexity. Individual analysis and substitute utilisation and costing is conducted on each episode, with costing to be validated along with the full sample.

Qualitative data:

In late April Ross Harrison of Health Research International conducted indepth interviews across four sites with a group of health care clinicians and managers. The "Perceptions and Attitudes study" examines which factors influence decisions to include and/or exclude patients from HITH, and internal and external forces affect the utilisation of HITH services.

ANALYSIS AND MODELLING

Multivariate statistical analysis will be conducted on the full set of quantitative data to establish the indicators of financial and clinical outcomes. This quantitative analysis along with

Is HITH Care Cost Effective?

cific criteria for matching due to factors such as; availability of patient records, miscoding of Diagnosis or Procedure, the uniqueness and diversity of conditions treated in HITH, the diverse HITH service delivery modes, and in some instances, appropriateness of HITH classification.

Costing data:

The majority of cost related data from the 35 sites has been collected. This was in the form of output from Transition where available, or full financial and activity data for manual cost processing (in the absence of an automated costing system). Processing of full episode costs is currently in progress, with validation, and analysis of inter and intra site comparability to be completed by the end of July. A preliminary costing analysis of the pilot sites at North Western Health was presented to the Steering Committee in May, and an abstract of this work displayed as a poster at the RMH's 1999 research week in June.

Many of the rural sites have been especially cooperative, and provided extensive input and analysis of their costing and clinical data, enabling the team to avoid some arduous travel, which was well appreciated.

Part 2 - Cost a HITH episode modelled as a non-HITH

A sub-sample of 800 HITH episodes has been selected for modelling as non-HITH episodes. This will provide a second

the qualitative analysis conducted earlier will address the key issues and aims of the study:

1. Differences between the cost of HITH treatment and in hospital treatment for different clinical conditions.
2. The types of conditions and treatments which are suitable for HITH and result in maximal cost-effectiveness.
3. Financial and other factors that impact on decision making to use HITH.
4. The best models of HITH care to use in current funding climate, based on projected patterns of utilisation for the next three years, and sensitivity analysis of models.
5. Recommend strategies to ensure the maintenance and viability of HITH programs within a fluctuating health care system.

To date the project is running smoothly and to plan, and we thank all those who have participated and continue to cooperate for making this possible.

Please contact me on 9342 2162 if you want further information on the study.

Core team:

Research Assistants - Jason Wasiak and Craig Williams

Advisors: Assoc Prof Don Campbell

Dr Denise Ruth

Assoc Prof C Raina McIntyre

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Conference Report Embracing Expertise and Diversity

by Carole Staley

Pioneering Uncommon Roles for Uncommon Times - AAACN 24th Annual Conference 10-13 March, 1999, San Francisco, USA

There were a number of highlights at the American Academy of Ambulatory Care Nursing (AAACN) 24th Annual Conference - Embracing Expertise and Diversity: Pioneering Uncommon Roles for Uncommon Times. Four renowned keynote speakers made presentations throughout the 4-day conference. The opening address was made by Dr. Karlene Kerfoot, Vice President, Patient Care Operations at Hermann Hospital and Memorial Hermann Healthcare System in Houston, Texas, an organisation that employs 15,000 personnel. Her presentation focused upon the merging of health care into networks, the leadership style and opportunities required to work within these organisations and the changing trends in health care. She described the trends that were currently impacting upon health care as follows:

- Population management
- Consolidation
- Increased competition
- Decreased profits
- Increased costs
- Increased overheads
- Increased risk sharing
- Integrated delivery systems
- Large group practices

Dr Kerfoot summarised these trends by stating "**The Bed is Dead**". The hospital is a cost centre, not a revenue centre. Providing health care for patients when they are not in the bed will lead to mergers, joint ventures, alliances, virtual alliances and virtual integration. The virtual organisation will be characterised by dynamic alliances; a lack of geographic limitations; integrated core competencies; shared facilities, resources, risk; and technological innovation. Visualising the future will take us across the continuum. We will move from illness to health and to prevention models and outcome management. It will then become essential to measure our work across the continuum. This vision is not unlike changes that are occurring in Australia.

Dr Kerfoot culminated her presentation by describing the type of visionary leader that would be able to assist organisations with this transition by engendering the following characteristics:

- Interdependence
- Empowerment, connection, and trust
- Collaboration - join other leaders as colleagues
- Contributions
- Group effectiveness - partnerships
- Mastery at learning skills
- Establishing relationships
- Ability to meet customers' needs

Dr Tim Porter-O'Grady's presentation also focused upon change and described the current transition from the Industrial age to the Social/Technical age. He described the chaos that is associated with this change. He stated "Chaos serves a purpose: to make it untenable for you to stay, to unbundle your attachment to where you were, to make sense to you, to make your work impossible to do so you stop doing it" and look at alternative strategies.



According to Dr. Porter-O'Grady, "In the old age we did patient care - co-dependent, passive, late stage, crisis based, intervention critical, and acute. It's the poorest way of delivering health care services and it's the most expensive." Whereas, in the new age, health care focuses on health and early engagement. The new age, he added, is "life care, taking responsibility for your care, changing the expectation of the patient, horizontal relationships, and setting mutual expectations." There will be a resulting shift in focus from how health care is provided to why it is provided, what difference it makes and whether the quality of the patient's life is better as a result.

Dr David Sobel presented a thought provoking paper that encouraged health care professionals to consider the patient as a primary care provider. He identified that 80% of health care was self-care and hypothesised the effect of increasing patients' ability to self-care. He suggested that there would be a decreased demand upon health services and improved patient outcomes. Targeting behavioural and psychological factors was presented as a way of promoting self-care as these often go undiagnosed and subsequently are inadequately treated having a significant impact upon functional status and disability.

Dr Sobel identified the following core attitudes, beliefs, and moods that affect patients' health: confidence, self-efficacy, coherence, control, hardiness, optimism, happiness, connectedness and pleasure. He emphasised that the key for health professionals is to work with patients, to teach them how to access information, solve problems, relax using imagery, sleep better, manage moods and emotions, communicate effectively and manage time efficiently. These are the skills patients need to practice effective self-care.

The final keynote speaker was Dr. Venner M. Farley who summarised many of the trends throughout the conference and finished by outlining the current culture of healthcare:

- Mutual accountability of staff with managers
- Managers giving staff decision-making power
- Commitment to partnership with physicians
- A sense of ownership for the staff

- Managers and staff both contribute to a free flow of information

Between these keynote speakers were numerous presentations including work being done on patient acuity tools, minimum data sets, disease management, evidence-based guidelines, ambulatory standards and electronic medical records.

The key messages from the conference were:

- Wellness/Health promotion/prevention focus
- Patient Self Management
- Population/Disease/Life Management
- Patient Outcomes
- Technology Changes (Internet and increased accessibility of information)
- **The Bed is Dead!**

www.check it out!

Author: College of Health

Title: College of Health

URL: <http://Homepages.which.net/%7Ecollegeofhealth/index.htm>

Country of Origin: United Kingdom

The College of Health is a national charity set up to represent the interests of patients and promote patient-centred care. This website contains information about the College, the Information Service, Research and Audit, Training and Consultancy, and Publications.

Author: Centers for Disease Control and Prevention. Epidemiology Program Office.

Title: An ounce of prevention... what are the returns

URL: <http://www.cdc.gov/epo/prevent.htm>

Country of Origin: United States of America

This report outlines 19 strategies which demonstrate how spending money to prevent disease and injury and promote healthy lifestyles makes good economic sense. The report gathers data about cost effectiveness and suggests research gaps. It is possible to download a copy of this report from the website, in PDF format.

Author: The National Library of Medicine (NLM)

Title: LOCATORplus

URL: <http://www.nlm.nih.gov/locatorplus/>

Country of Origin: United States of America

The National Library of Medicine (NLM) has launched a new Web catalogue, called LOCATORplus. This catalogue contains records of books, journals, audio-visual materials, manuscripts, and other items contained in the world's largest medical library. The website also contains links to online journals and databases.

Author: Resources for the Future (RFF)

Title: Resources for the Future (RFF)

URL: <http://www.rff.org/>

Country of Origin: United States of America

Resources for the Future (RFF) is a US think tank that "conducts independent research rooted primarily in economics and other social sciences on environmental and natural resource issues." This website includes information about the organisation, a Library section, an RFF quarterly, an online forum and other publications, some of which are in PDF format.

Conference Report

*by Carole Staley
Senior Project Officer
VCACI*

Home is where the health is: Hospital in the Home 6-7 May, 1999 Prince of Wales Hospital Sydney

The Prince of Wales Hospital conducted the Home is where the health is: Hospital in the Home Conference in Sydney over two days during May. The conference was attended by approximately 100 delegates mainly from New South Wales and focused upon the development of Hospital in the Home programs. The conference commenced with three concurrent workshops: Standards, Outcomes and Accreditation Forum; Doctors' Forum; and a Practitioners' Forum. Approximately, 50% of the delegates attended the Standards Forum, which was facilitated by Marjorie Pawsey from ACHS, and participated in outlining principles and a framework for the development of HITH Standards. This process was beneficial for work already being undertaken in NSW and Victoria and provided an opportunity for collaboration between the States and ACHS. The Doctors' and Practitioners' forums focused upon practical issues in relationship to setting up and running HITH programs. Issues raised

included: burden on carers, definition of HITH, funding and how general practitioners can be remunerated, IT infrastructure, differences between rural and metropolitan HITH programs, catchment areas, documentation and legal issues, coordination, communication, safety and culture change.

During the second day there were a variety of presentations outlining the historical background to HITH, an overview of the current status of HITH programs throughout Australia, results of the randomised control trial conducted at POW, and various perspectives from different disciplines and programs throughout NSW.

Some of the messages that came from the conference were the debate about what HITH should be called and the fact that various States have differing definitions, the concern re the burden on informal carers, and that Victoria is at the forefront of HITH in Australia and is a useful resource for other States.

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Victorian HITH Contact Names and Numbers

					Telephone	Fax
Angliss Health Services	Albert Street	Upper F'tree Gully	Mrs Debbie	Weavell	(03) 9764 6242	(03) 9764 6114
Austin & Repat Medical Centre	Studley Road	Heidelberg	Ms Helen	Fithall	(03) 9496 3378	(03) 9496 3359
Austin & Repat Medical Centre	Studley Road	Heidelberg	Ms Lisa	Hill	(03) 9496 5775	(03) 9496 5772
Austin & Repat Medical Centre	Studley Road	Heidelberg	Mr John	Scott	(03) 9496 3603	(03) 9459 0971
Bairnsdale Regnl Health Service	Day Street	Bairnsdale	Ms Gael	Traa	(03) 5152 0274	(03) 5152 6683
Ballarat Health Services	P.O. Box 577	Ballarat	Ms Patricia	Twaiats	(03) 5320 4676	(03) 5320 4549
Benalla & District Memorial	P.O. Box 406	Benalla	Ms Margaret	Aldous	(03) 5760 2258	(03) 5760 2246
Bendigo Health Care Group	P.O. 126	Bendigo	Ms Robyne	Fahy	(03) 5441 0222	(03) 5441 0280
Box Hill Hospital	Nelson Road	Box Hill	Ms Helen	Hamilton	(03) 9895 3442	(03) 9895 4901
Central Wellington Health Service	Guthridge Parade	Sale	Ms Paula	Hart	(03) 5144 4111	(03) 5149 6633
Colac Com. Health Svces Hospital	Corangamite Street	Colac	Ms Marie Louise	Tucker	(03) 5230 0275	(03) 5230 1191
Dandenong Hospital	Box 478	Dandenong	Ms Dana	Kiley	(03) 9554 8416	(03) 9554 8453
Djerriwarrh Health Service	P.O. Box 330	Bacchus Marsh	Ms Jane	Cape	(03) 5367 2000	(03) 5367 4537
East Grampians Health Service	P.O. Box 155	Ararat	Mr Ray	Elsworthy	(03) 5352 2221	(03) 5352 4612
Echuca Regional Health	P.O. Box 25	Echuca	Ms Diane	Egan	(03) 5482 2800	(03) 5482 5478
Geelong Hospital	P.O. Box 281	Geelong	Mrs Helen	Wadsworth	(03) 5226 7108	(03) 5226 7302
Hamilton Base Hospital	P.O. Box 283	Hamilton	Ms Betty	Joosen	(03) 5571 0222	(03) 5571 0240
Goulburn Valley Hospital	102 Corio Street	Shepparton	Ms Christine	Ryan	(03) 5831 6390	(03) 5822 2584
Kyneton District Health Service	P.O. Box 34	Kyneton	Ms Judith	Bloomfield	(03) 5422 1177	(03) 5422 2373
Latrobe Regional Hospital	Locked Bag No 1	Moe	Ms Rosemary	Nation	(03) 5127 0608	(03) 5127 0775
Maroondah Hospital	P.O. Box 135	East Ringwood	Ms Robyn	Kirsch	(03) 9871 3712	(03) 9871 3716
Mercy Public Hospitals Inc	Clarendon Street	East Melbourne	Ms Diana	Morgan	(03) 9270 2569	(03) 9270 2307
Mildura Base Hospital	P.O. Box 306	Mildura	Mr Paul	Hicks	(03) 5022 3333	(03) 5022 3470
Monash Medical Centre	Locked Bag 29	Clayton	Ms Fran	Chambers	(03) 9550 2433	(03) 9550 6925
Monash Medical Centre	246 Clayton Road	Clayton	Dr Lindsay	Grayson	(03) 9550 4564	(03) 9550 4533
Peninsula Health Care Network	P.O. Box 52	Frankston	Dr Michael	Montalto	(03) 9784 7241	(03) 9784 7242
Peter MacCallum Cancer Institute	St Andrews Place	East Melbourne	Dr Guy	Toner	(03) 9656 1190	(03) 9656 1408
Peter MacCallum Cancer Institute	St Andrews Place	East Melbourne	Ms Cathy	Watty	(03) 9656 1055	(03) 9656 1415
Peter MacCallum Cancer Institute	St Andrews Place	East Melbourne	Ms Helen	Fawns	(03) 9656 1312	(03) 9656 1422
Portland & District Hospital	Bentinck Street	Portland	Ms Michelle	Henningsen	(03) 5521 0333	(03) 5521 0358
Royal Children's Hospital	Flemington Road	Parkville	Ms Trish	McDonald	(03) 9345 6548	(03) 9345 6231
Royal Melbourne Hospital	Grattan Street	Parkville	Dr Denise	Ruth	(03) 9342 8549	(03) 9342 8548
Royal Melbourne Hospital	Ward 2 North	Parkville	Ms Ruth	Power	(03) 9342 7720	(03) 9342 7700
Royal Melbourne Hospital	2 Grattan Street	Parkville	Ms Karen	Palmir	(03) 9342 8597	(03) 9342 8268
Royal Women's Hospital	132 Grattan Street	Carlton	Ms Pamela	Bull	(03) 9344 2324	(03) 9348 1840
St Vincent's Hospital	41 Victoria Pde	Fitzroy	Ms Tamara	Rowan	(03) 9288 3818	(03) 9288 3848
Stawell District Hospital	P.O. Box 116	Stawell	Ms Jan	Sherwell	(03) 5358 8572	(03) 5358 4092
Swan Hill District Hospital	P.O. Box 483	Swan Hill	Ms Dallas	Brown	(03) 5033 9375	(03) 5032 9528
The Alfred	P.O. Box 315	Prahran	Ms Dianne	Richards	(03) 9276 3908	(03) 9276 2794
The Northern Hospital	185 Coopers Street	Epping	Ms Anne	Bentley	(03) 9219 8000	(03) 9219 8633
The Williamstown Hospital	P.O. Box 125	Williamstown	Ms Clare	Del Rosario	(03) 9393 0133	(03) 9393 0178
Wangaratta District Base Hospital	P.O. Box 386	Wangaratta	Ms Cath	Hattersley	(03) 5722 0348	(03) 5721 9526
Warrnambool & District Base Hosp	Ryot Street	Warrnambool	Mr Mark	Johnstone	(03) 5563 1457	(03) 5563 1627
Werribee Mercy	300 Princes Highway	Werribee	Ms Wendy	Dunn	(03) 9216 8691	(03) 9216 8692
West Gippsland Hospital	Landsborough Road	Warragul	Mrs Marie	Young	(03) 5623 0611	(03) 5623 0609
West Wimmera Health Service	P.O. Box 231	Nhill	Ms Lynne	Fraser	(03) 5391 4222	(03) 5391 4228
Western Hospital	Gordon Street	Footscray	Ms Jennifer	MacKay	(03) 9319 4222	(03) 9319 6314
Wimmera Health Care Group	Baillie Street	Horsham	Mr Don	McRae	(03) 5381 9184	(03) 5381 9187
Wodonga District Hospital	Vermont Street	Wodonga	Ms Dianne	Wicks	(02) 6051 7334	(02) 6051 7337



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