

Clinical Access and Redesign Unit

Combined Statewide Diabetes, Cardiac and Renal Clinical Networks forum

11 June 2013
Forum report

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Clinical Access and Redesign Unit

Combined Statewide Diabetes, Cardiac and Renal Clinical Network Forum

Tuesday 11 June 2013

Auditorium, Education Centre, RBWH

7.45	Registration & coffee
8.10	Welcome & Housekeeping <i>A/Prof Anthony Russell, Chair of Statewide Clinical Network Chairs</i>
8.15	Opening Address <i>Dr Tony O'Connell, Director-General, Department of Health</i>
8.30	Statewide Diabetes Clinical Network – Year in Review <i>A/Professor Anthony Russell & Dr Trisha O'Moore-Sullivan Co-Chairs, Statewide Diabetes Clinical Network</i>
8.55	Statewide Renal Clinical Network – Year in Review <i>Professor David Johnson & Dr Nicholas Gray Co-chairs, Statewide Renal Clinical Network</i>
9.20	Statewide Cardiac Clinical Network – Year in Review <i>Dr Paul Garrahy, Chair, Statewide Cardiac Clinical Network</i>
9.45	Morning tea
10.15	Chronic Disease Management Framework <i>Ms Vickie Scells, Director Clinical Access and Redesign Unit</i>
10.45	Working together with Medicare Locals <i>Dr John Kastrissios, Medicare Local – Metro South</i>
11.15	Primary Health Care, CQI and Closing the Gap <i>Ms Ru Kwedza, Statewide Coordinator (PHC CQI), Cape York HHS</i>
11.45	Panel Discussion – working together to find solutions that improve outcomes for patients living with chronic disease without increasing the burden on clinicians. Facilitated by Mr Jason Currie (Executive Director, Clinical Access & Redesign Unit) <i>Clinical Network Chairs, Vickie Scells, John Kastrissios & Ru Kwedza</i>
13.00	Lunch <i>(Close of Videoconference Session)</i>
13.45	Concurrent Sessions: Cardiac, Diabetes, Renal

2 Introduction

The Combined Statewide Diabetes, Cardiac and Renal Clinical Network Forum was held on 11 June 2013 at the Education Centre, Royal Brisbane and Women's Hospital, Brisbane. This was the first instance that several statewide networks have come together to offer a combined forum. The three networks have a shared interest in the management of chronic disease.

The day was opened by the Director General, Dr Tony O'Connell. He outlined the important role of clinicians in both the planning, delivery and improvement of health services. Key vehicles for influence include the Statewide Clinical Networks, the Clinical Senate and partnerships with Medicare Locals and Hospital and Health Services.

The conference was attended by some 200 people from across Queensland covering all but one of the 17 Hospital and Health Services. Approximately 17 locations participated via video conference. Attendees included clinicians from a range of health care disciplines, administrative/project staff and stakeholders from non-government organisations. There was fairly even representation from each of the three networks.

The key objectives of the conference were to:

- Share the various activities and priorities of each network
- Provide information about the objectives, strategies and intent of the Chronic Disease Framework being developed and sponsored the Clinical Access and Redesign Unit
- Present the role and issues of the GP in the management of chronic disease
- Provide opportunity to discuss issues and possible areas of improvement in the management of chronic disease.

3 Combined morning session

3.1 Statewide Diabetes Clinical Network – year in review

Associate Professor Anthony Russell and Dr Trisha O'Moore-Sullivan

Co-chairs, Statewide Diabetes Clinical Network

The Statewide Diabetes Clinical Network (SDCN) co-chairs outlined their major priority is to reduce avoidable admissions relating to diabetes. The network has been working on this priority in several areas including:

- models of care
- diabetic ketoacidosis
- diabetic foot
- gestational diabetes
- insulin adjustment by nurses and dietitians.

The network continues to work on developing clinical guidelines and educational resources for patients and clinicians in diabetes related topics.

Throughout the last year, the SDCN have also worked collaboratively with the System Policy and Performance Division to develop the Diabetes Services Statewide health service strategy 2013 outlining a 10 year approach to future diabetes services delivery.

3.2 Statewide Renal Clinical Network - year in review

Dr Nicholas Gray

Co-chair, Statewide Renal Clinical Network

Dr Nicholas Gray presented an overview of the activities of the Statewide Renal Clinical Network including the completion of the statewide costing and counting audit for dialysis, the development of standardised dialysis prescriptions, the completion of the Statewide Disaster Management Project, development of the haemodialysis prescription form and the anticoagulation in patients with HIT who are on haemodialysis guidelines.

The SRCN have also created two new working groups:

1. Renal palliative care working group
2. Growing hospital capacity through increasing the utilisation of home therapies working group

Dr Gray also provided an update around the NxStage implementation and evaluation pilot program, CKD Qld and activity based funding for the 2013-2014 financial year.

3.3 Statewide Cardiac Clinical Network - year in review

Dr Paul Garrahy

Chair, Statewide Cardiac Clinical Network

Dr Paul Garrahy presented an overview of the activities of the Statewide Cardiac Clinical Network including:

- Cardiac Information Solution Program (CISP)
- acute coronary syndrome (including the Australia and New Zealand ACS snapshot audit)
- heart health service redesign
- the Heart Education Assessment and Rehabilitation Toolkit (HEART) online toolkit in partnership with the Heart Foundation
- cardiac genetics project
- Indigenous cardiac health.

3.4 Chronic Disease Management Framework

Ms Vickie Scells, Director, Clinical Access and Redesign Unit

Ms Vickie Scells discussed the current trends in chronic disease Queensland in terms of admissions, length of stay and costs. A collection of the evidence based interventions for chronic disease were discussed as well as the importance of a comprehensive chronic disease model.

Ms Scells outlined the work that the Clinical Access and Redesign Unit is currently progressing in the chronic disease management space including:

- chronic disease management framework and patient process pathways
- clinician engagement
- health innovation fund
- standardised healthcare coaching and self-management training
- ICT solution
- minimum dataset & funding framework
- centralised referral process
- a framework for evaluation.

3.5 Working together with Medicare Locals and Primary Care Providers

Dr John Kastrissios, General Practitioner, Metro South Medicare Local

Dr Kastrissios discussed the interaction and partnering between the Hospital and Health Services and Medicare Locals. He explored our health system using a diagram that showed the interaction between the person and their family and carers, general practice, hospital services, medicare local and other health care services within the community.

Dr Kastrissios outlined some of the work that Metro South Medicare Local has been focusing on with Metro South Hospital and Health Service, including:

- general practice liaison officer role and site expansion
- advanced care referral pathways with decision support
- central referral hub with published wait times and options

- telehealth services to Bay Island / rural practices and ACFs
- linked data systems and analysis capacity.

3.6 Primary Health Care, CQI and Closing the Gap

Ms Ru Kwedza, Statewide Coordinator (Continuous Quality Improvement in Primary Health Care), Cape York Hospital and Health Service

Ms Kwedza provided a background to the key competencies to tackle chronic conditions, focusing on quality improvement. She outlined modern continuous quality improvement principles including:

- engagement of managers and practitioners to know
 - what changes will lead to improvements
 - how to evaluate the efforts
 - translating evidence into practice
- good quality data
- raising general standard of care
- incremental improvements
- continuous steps
- no blame.

Ms Kwedza discussed the indigenous and non-indigenous death rates for Queensland and some of the factors that contribute to this gap. Research shows that 80% of the health gap is explained by chronic disease, and many of these chronic diseases are preventable through risk factor management.

Ms Kwedza presented some of the outcomes from the Continuous Quality Improvement program across Australia with specific reference to diabetes, influenza, cardiovascular disease and lipid control. A collection of case studies were presented showing the impressive results that have been achieved by the CQI program.

3.7 Panel discussion – *Working together to find solutions that improve outcomes for patients living with chronic disease without increasing the burden on clinicians.*

Jason Currie, Executive Director, Clinical Access and Redesign Unit facilitated the panel discussion that focused on working together to find solutions that improve outcomes for patients living with chronic disease without increasing the burden on clinicians. Panel members included all presenters from the morning; A/Professor Anthony Russell, Dr Trisha O'Moore-Sullivan, Professor David Johnson, Dr Nicholas Gray, Dr Paul Garrahy, Ms Vicki Scells, Dr John Kastrissios and Ms Ru Kwedza.

In addition to more focus on early detection and more screening for those Queenslanders at risk, the following themes and solutions were identified throughout the discussion.

Data systems

Panel members agreed that there currently is a gap with information transfer and communication between general practitioners and hospitals. The establishment of a data system that all providers could access would be a significant improvement for information sharing and ongoing partnership in providing care to patients.

Care plans and referral pathways

To assist improving the coordination of care, it was identified that formalizing the process of providing care plans back to the general practitioners needs to occur. The care plans should have clear direction on the treatment for patients (e.g. five key points), detail the care team involved and include discharge back to the general practitioners. With a clear and concise care plan, general practitioners would be able to take more responsibility for ongoing patient care.

Working with general practitioner liaison officers in developing transfer criteria needs to dovetail into this group for clear referral pathways for complex chronic disease patients. Referral criteria should be defined and co-education activities between general practitioners and specialists ought to occur.

Standardisation

The need to create standardised treatment methods was raised to ensure clinicians are providing the same advice for all patients depending on their condition. Guidelines should be developed and accessible to all clinicians to ensure standardisation across Queensland and one point of reference.

Panel members providing the following comments around strategies for sustaining project outcomes; demonstrating the cost effectiveness, keeping patients out of hospitals, engagement of clinicians and consumers, paradigm shift, visible pathways, workforce investment and finally, good data feedback has the potential to inspire change.

4 Afternoon sessions

The group broke into the individual network groups for the final session.

Renal Session

- iEMR (Electronic Medical Record) Planning
- Financial management/cost containment in tight economic times.
- Increasing home therapy percentage and reducing in-centre starters (including self care in in-centre settings)
- The move to home –do we care for the carer?
- Pre-dialysis assessment tools of suitability for home therapies.
- CKD education: what works and what doesn't.

Diabetes Session

- DKA Project Update - *Trisha O'Moore-Sullivan & Susan Hunt*
- GDM Project Update - *David McIntyre & Alison Barry*
- Tracking the Length and Width of Qld's Foot Ulcers - *Ewan Kinnear*
- iEMR (Electronic Medical Record) – *Marian Linnane*
- Future Directions - *Anthony Russell & Trisha O'Moore-Sullivan*

Cardiac Session

- Acute Coronary Syndrome Snapshot Audit: Where to now? – *Tegwen Howell*
- Motivational Interviewing - *Dr Stan Steindl, Psychology Consultants*
- ieMR – What's in it for Cardiac? *Marian Linnane*

Clinical Access and Redesign Unit

Forum/Workshop Title

**Combined Statewide Diabetes, Cardiac & Renal
Clinical Network Forum - Tuesday 11 June 2013**

Hospital/Organisation you are representing

Name (Optional)

Overall responses

Category of Staff

Please read each statement then circle the number that best represents your response:	Strongly Agree	Agree	Some-what Agree	Some-what Disagree	Disagree	Strongly Disagree	Average Score
	6	5	4	3	2	1	
1. The objectives of the forum were clearly outlined	21%	61%	16%		2%		5.0
2. The forum stimulated my interest	26%	63%	11%				5.1
3. The presentations were useful and relevant	31%	58%	11%				5.2
4. The objectives of the forum were achieved	18%	62%	18%		2%		4.9
5. There was sufficient time to meet the forum/workshop objectives	13%	62%	21%	2%	2%		4.8
6. There were sufficient opportunities for sharing ideas	16%	65%	19%				5.0
7. The forum was well organised	40%	56%	4%				5.3
8. Information was presented in a user friendly format	27%	53%	16%	2%	2%		5.0
9. The facilitator maintained a supportive and participative forum environment	35%	53%	12%				5.2
10. I found value in networking with colleagues	46%	49%	5%				5.4
11. The venue used was suitable	60%	40%					5.6

Overall Comments

Overall, the comments showed that participants were keen to continue this approach of collaborative forums tackling holistic chronic disease management. The morning combined session was well organised with presentations that were both relevant and interesting.

There were comments about increasing the proportion of group work and other interactive activities to make the forum more engaging to the participants, both in person and via videoconference. Having clearer goals and objectives for action set out at the beginning of the day would have helped to better set the scene for the presentations.

While the sessions both in the morning and afternoon were interesting and relevant, there were comments suggesting that some elements needed more time than allocated. Suggestions were received about conducting the forum over two days to allow more time for interaction and group work.

Suggestions for future forums

Many participants suggested that there was benefit in a combined chronic disease approach and that this style of forum should continue in the future. Suggestions for future topics include more presentations on rural and remote activity, primary and community health. There were also requests for future presentations focusing on data and quality improvement strategies and examples.

Video Conference Participants only

Email to Katie_Wykes@health.qld.gov.au

12. Did you feel you were able to interact in forum discussions and contribute to network business using the video conference facilities?

YES

NO

90%

10%

What could be done to improve your experience with video conferencing?

A small portion of VC sites had difficulty viewing the powerpoints during the presentations. Their experience could be enhanced through early provision of powerpoint presentations to the VC sites via email (when provided in time by the presenters) and improved education and utilisation of VC technology.

Thank you for taking the time to complete this evaluation form