

Queensland Clinical Senate

Connecting clinicians to improve care

Value-based healthcare – shifting from volume to value

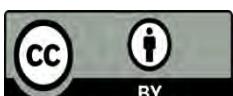
17-18 March 2016

Meeting report

Royal on the Park, Brisbane

Queensland Clinical Senate, Meeting Report

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Contents

Chair's report.....	4
Executive summary	5
What is value-based healthcare?	7
Consumer and clinician perspectives	8
Some global perspectives	10
High-value healthcare in action	11
Low-value healthcare	15
Future funding priorities.....	21
Appendix 1: Do not do priorities	24

Presenters and panellists

- Dr Neil Soderlund, Health Outcomes Australia
- Mr Rob McAdam, Health consumer
- Mr Doug Porter, Health consumer
- Dr Anthony Brown, Director of Medical Services, Northern Zone, Torres and Cape Hospital and Health Service
- Dr Julie McEniry, Divisional and Medical Director Critical Care, Division of Critical Care, Lady Cilento Children's Hospital
- Ms Jenny Brockie, journalist and television presenter
- Ms Ilse Berquier, Clinical Nurse Consultant, Metro North Hospital and Health Service
- Ms Amy Holmes, Nurse Manager, Telehealth Services, Sunshine Coast Hospital and Health Service
- Ms Gemma Turato, Sunshine Coast Hospital and Health Service
- A/Prof Edward Strivens, Cairns and Hinterland Hospital and Health Service
- Prof Nick Graves, Health Economist, Queensland University of Technology, The Australian Centre for Health Services Innovation
- Ms Sue McKee, Chief Executive, West Moreton Hospital and Health Service
- Dr Robin Littlewood, Director, Dietetics and Food Services, Children's Health Queensland
- Dr John Wakefield PSM, Deputy Director-General, Clinical Excellence Division, Queensland Health
- Laura Damschroder, Author of the Consolidated Framework for Implementation Research, Ann Arbor, Michigan, USA.
- Dr Jeremy Long, Sunshine Coast Hospital and Health Service
- Dr Robyn Lindner, NPS MedicineWise and Choosing Wisely Australia
- A/Prof Ian Scott, Director, Internal Medicine and Clinical Epidemiology, Princess Alexandra Hospital
- Dr Peter Gillies, Darling Downs Hospital and Health Service
- Ms Margaret Broomfield, Director, Metro South Health@Home and Aged Care Service
- Ms Roisin Dunne, Director, Clinical Governance, West Moreton Hospital and Health Service

Chair's report



The future sustainability of the healthcare system is one of the most significant challenges facing health administrators and us as clinicians and consumers. With an ageing population, increased chronic disease and ever-increasing costs of technology, the demand on the system fiscally and physically is reaching crisis point – it cannot be sustained.

We work in a system that has historically been funded according to activity throughput. While in many cases, activity throughput can equate to high quality care, it is not always the case. In addition, many of the highest value health services we can deliver, reduce throughput by keeping people with chronic disease well and away from acute hospital care and as such are continuously vulnerable to budget rationalisation.

We can no longer continue to use the ‘we have always done it this way’ argument. We need to adopt a new way of thinking – to challenge ourselves continuously around the value of the service being provided to the community for the investment of resources used.

The value-based healthcare meeting gave senior clinicians and consumers the opportunity to shine the spotlight on high-value innovative models of care around Queensland. There are remarkable stories of innovation and success but we often fail to champion our successes across the system, resulting in duplication of effort and missed opportunities.

Our expert panel challenged us to think differently about how we share and implement new innovations. ‘Implementation science’ will need to become embedded within normal business practice if we are to achieve more reliable results into the future.

On the other side of the coin are those healthcare services that absorb resources without offering much (if any) qualitative value to our patients – in some instances even causing harm. We learned about the behavioural factors around discontinuing traditional but low value healthcare, explored opportunities for disinvestment and identified where governance and responsibility for that change needs to lie.

I was delighted with the level of interest and enthusiasm by our members and guests but remain conscious that this is merely a conversation starter and the real challenge lies in the implementation of these principles into our everyday work. The Senate will encourage programs around value-based healthcare across the state and I urge all clinicians and managers to champion the need to improve value throughout and across health services to ensure resources are being directed to highest value healthcare.

A handwritten signature in black ink, appearing to read "Dr David Rosengren".

Dr David Rosengren
Chair, Queensland Clinical Senate

Executive summary

To ensure a sustainable healthcare system, it is acknowledged that clinicians and consumers must question existing models of care to ensure there is real benefit to the patient for the investment of resources. As clinicians we must strive for a system that identifies what a quality outcome is for our patients, both at the individual and community level, and ensure that this is front and centre in all health care delivery. The Queensland Clinical Senate challenges clinicians and healthcare executives to find opportunities to move resources away from low-value to high-value models of care.

High-value care

High-value care generates a large amount of health benefit for individuals and the community for the resources invested.

Queensland clinicians submitted more than 35 high-value care initiatives from across the state. While a selection was presented to the meeting (See page 11), all submissions have been collated into a [compendium](#), which is available to learn from and to share. (Note: link to compendium is only accessible to Queensland Health employees. Please contact the QCS Secretariat if you are interested in viewing the compendium).

While a lot of great high-value care initiatives are underway, it is the responsibility of all clinicians to look for and create opportunities to champion high-value care initiatives and share experiences with colleagues.

To ensure the successful implementation of such initiatives, it is vital that implementation science is part of the discussion. Implementation science provides the structure and tools to ensure innovative outcomes can be translated broadly across the system. Implementation Science is a new concept for the health system but needs to become embedded within all research and redesign efforts if we are to make a sustainable improvement in value outcomes from our health dollar investment.

Low-value care

Low-value care delivers little or no health benefit for an investment of resources. On occasions healthcare can actually lead to harm.

Strategies such as *Choosing Wisely* have emerged across the globe and are gaining increasing momentum in Australia however it is clear that success around reducing investment in low-value care has been mixed. The Senate received insight into the challenges around low-value disinvestment from both the health economist and clinician perspective.

Delegates worked in their professional streams to select a low-value opportunity to become a 'do not do' priority and identified strategies and governance /leadership for the change (Page 18). Proposed low-value targets were:

- **Medicine** - Avoid imaging for patients with non-specific acute low back pain and no 'red flag' indicators of a serious cause
- **Allied Health** – Allow patients to be discharged from outpatients' specialist waiting lists if suitable, after primary contact allied health intervention
- **Nursing** – Avoid routine non-targeted risk screening (such as Waterlow Score, dysphagia screening tools etc) for all admitted patients.

The Senate will work with stakeholders to facilitate and champion interventions directed at reducing the low-value care identified.

Future funding priorities

Hospital and Health Service (HHS) Chief Executives were invited to work together to present proposals (Page 20) for high-value outcome initiatives that are not readily fundable in the current activity-dominated funding system. Senate members voted these initiatives into clinical priority order.

The projects in order of priority (as voted by Senate members) are:

1. Innovative dental care for children - Torres Cape HHS
2. Routine bariatric surgery in the public system - Darling Downs HHS
3. The Older Persons Enablement Program (OPEN) - Cairns and Hinterland HHS
4. Rapid Response@Home for >65yo after discharge - Metro North HHS
5. A mobile-enabled care model (Me-CARE) - West Moreton HHS.

The Department of Health has reviewed the chief executive submissions in the context of the Senate prioritisation and committed to invest in the first two projects at this point in time.

What is value-based healthcare?

'Value-based healthcare is where we both measure the costs and resources we use for our healthcare services and also measure the amount of health benefit we get back from our healthcare services. It could be we give years of life to patients by reducing mortality or we improve the quality of years of life of patients by removing morbidity.'

Professor, Nick Graves, Health Economist and Academic Director of The Australian Centre for Health Services Innovation (AusHSI)

Why value-based healthcare?

- Globally, healthcare systems are struggling with rising costs, increasing demand for services, inequitable access and variations in the safety and quality of services.
- For our healthcare system to be sustainable we must move to a value-based model that aims to improve patient outcomes with lower healthcare costs.

Low-value care

- Low-value care happens when we provide services that deliver very small or even zero health benefits.
- It could be that we just do no good, or maybe even harm people. For example: PSA testing in men over 75 could lead to interventions and services that don't extend their life or improve their quality of life, it could even reduce their quality of life.¹

High-value care

- High-value care is when a large amount of health benefit is generated for a relatively small investment of resources.
- For example, appropriate management of hypertension could reduce the risk of stroke and heart attack at a modest cost.¹

¹. Professor, Nick Graves, Health economist and Academic Director of The Australian Centre for Health Services Innovation (AusHSI)

Consumer and clinician perspectives



- Nationally acclaimed television journalist Jenny Brockie (far left) hosted a panel discussion to set the scene for the meeting through a broad understanding of what value means to consumers and clinicians.

Health consumer, Rob McAdam – diagnosed with prostate cancer

'Just because you don't ask questions, doesn't mean you don't need information.'

- Diagnosed with prostate cancer on my 50th birthday.
- The 10-week period between diagnosis and surgery was a 'wild ride'.
- To give me more certainty during an uncertain time, I would have liked more information – a flow chart – outlining what procedures I was having, when, and why.
- Having a good relationship with my GP meant that I felt more comfortable to ask questions and spend more time discussing the situation with him.
- Once you find a GP you can relate to, they are worth their weight in gold.

Health consumer, Doug Porter – living with cystic fibrosis (CF)

'The highest value for me is definitely quality of life. The reality for me is that I can't run a marathon or climb a steep hill - I can live with that. But I would still like to be able to drive a car, get the groceries, see my kids grow up and get married without an oxygen bottle next to me the whole time.'

- What I value is always recognised in my care and my family and I are all included in the picture.
- Sometimes I feel like I am the doctor and a lot of CF patients are like that - we do know our bodies very well. So while the clinician will have his or her idea of what the best treatment might be we are always asked first what we want to do.



- There is a lot of negotiation between the doctor and patient in our CF clinic and as patients and consumers we are heavily involved in the process.
- If we can keep people out of hospital and healthy at home that's a big step forward – to do that we must embrace new digital technologies.

Dr Anthony Brown – rural General Practitioner

'It takes three to five years to really understand the culture of the community and that's when you start to understand your patients within their context.'

- The longer you know them the better you tailor their care and try to put yourself at the centre of the care – you get more empowerment to do that and I think that's how it should be that the GP should be directing the patient through their care.
- I think the relationship with patients that you have in a small country town means that you have a greater investment in the patient's outcome and therefore you do take more time with the patient.
- You learn from your specialist and we had a good relationship because you would work together and I would assist during the operation – it was a nice system.
- What guides me in deciding what's value? We have to make a decision about whether what we do is going to make a difference.

Dr Julie McEnery – Intensive Care Physician, Lady Cilento Children's Hospital

'You can't start with an assumption of what people want - you have to ask them.'

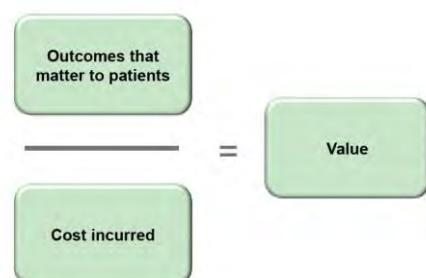
- If you were taking a population health view of value, you would probably invest all of the ICU money into prevention and surveillance and providing care to people in the community.
- That runs completely counter to what I see of families of the children in ICU who really value intensive care.
- Sometimes clinicians mistake outcomes for value – what children value is the experience, the day-to-day experience.
- It's the experience for many people that is the value - they don't want an outcome at any cost.
- Conversations are very important – you need to talk with the families about what they want and share your experience. It's very much a team sport in intensive care.



Some global perspectives

Dr Neil Soderlund, Health Outcomes Australia

- Value-based healthcare is a simple proposition of considering both the outcomes that matter to patients, and the costs of delivering them



- Variations in healthcare outcome and expenditure across OECD (Organisation for Economic Co-operation and Development) countries suggest there is an opportunity - where there is variation there is opportunity to improve.
- Outcomes can mean different things to clinicians and consumers.
- Clinicians look at mortality, prevention of adverse events, complications, readmission
- Patient-reported outcome measures include health-related quality of life, symptoms and measures of function ability.
- Focusing on mortality alone may obscure large differences in outcomes that matter most to patients.
- In some instances, the healthcare we provide can actually be delivering worse outcomes, but if we don't consistently measure we won't know.
- Sometimes the greatest value is in demonstrating that outcomes don't differ systematically. For example, a large proportion of colonoscopies performed in Victoria do not result in earlier detection and better survival from colorectal cancer.
- Australia has some success stories. For example, the national hip and knee replacement registry has recorded a dramatic reduction in revision surgery – repeat hospital costs avoided amount to \$240 million.
- Measuring and feeding back outcome data is a good intervention in itself.
- The International Consortium of Health Outcome Measurement (ICHOM) focuses on global standards and benchmarking.
- Health Outcomes Australia provides practical support for local implementation.
- ICHOM has developed 13 standard sets (Localised prostate cancer standard set pictured right), covering 35 per cent of the global disease burden.
- A further eight standard sets are being finalised in 2016.
- Global movement in uptake of outcome measurement is rapidly gaining pace.



Full presentation: <https://www.health.qld.gov.au/publications/clinical-practice/engagement/qcs-pp-1603-soderlund-1.pdf>

www.ichom.org

High-value healthcare in action

Kidney Supportive Care program (KSCp)

Ilse Berquier, Clinical Nurse Consultant, Metro North Hospital and Health Service (MNHHS)

'World wide, kidney services are now recognising the need for supportive care models. Supportive care needs to be accessible to patients just as chronic kidney disease, dialysis and transplantation care currently are.'

- It is known that there is a vulnerable group of kidney patients within MNHHS who would benefit from a pathway of care that up until now they have not had access to.
- Without distributive justice, patients are entering high cost models of kidney care that are not the right fit for their individual needs.
- The KSCp provides a structured, best-practice care framework for those patients whose kidney disease will not respond favourably to interventions such as dialysis, have made a personal choice not to undertake dialysis, have a symptom burden load in excess of likely benefit or are considering withdrawal from dialysis.
- This program promotes patient access to conservative care of high clinical quality, which prioritises quality of life and minimises interventions that have no clinical benefit.
- The results of this program will include qualitative and quantitative evaluations demonstrating a formalised structured supportive care pathway addressing patient symptom distress, futile care delivery, patient, carer and clinician satisfaction.

Full presentation: <https://www.health.qld.gov.au/publications/clinical-practice/engagement/kidney-supportive-care-program.pdf>

Palliative care delivered directly to the home: a telehealth clinic

Amy Holmes, Nurse Manager, Telehealth Services, Sunshine Coast Hospital and Health Service

'The ability to see more patients within current staffing levels means the service is high performing, and cost saving.'

- Many palliative care patients are too unwell to travel to centres for specialised palliative care.
- A home visiting model exists but due to consultant schedules and distance issues, not all patients were being seen in a timely manner.
- The new model involves a specialist nurse visiting the patient at home with a telehealth-enabled iPad.
- The patient is able to speak with the consultant via videoconferencing, eliminating the need for patients and the consultant to travel.
- 198 patients have been seen this financial year (July – Jan 2016), comparable with 56 patients from last year, without the model.
- First in home (staff delivered) service via telehealth in Queensland.
- The innovation was the overall winner at the Health Round Table, November 2015.

Full presentation: <https://www.health.qld.gov.au/publications/clinical-practice/engagement/qcs-pp-1603-holmes.pdf>

The Musculoskeletal Pathway of Care

Gemma Turato, Sunshine Coast Hospital and Health Service

'This model of care has significantly reduced the wait times for category two and three orthopaedic patients to be seen.'

- The Musculoskeletal Pathway of Care (MPC) was required to assist in managing the Sunshine Coast Hospital and Health Service (SCHHS) orthopaedic waitlist.
- A majority of patients on the waitlist were non-operative, but waiting extensive periods in order to be assessed, thus delaying access to non-operative treatment.
- The cost was high, e.g. orthopaedic surgeons clinics were full of new patient appointments that were non-operative and taking up their time to assess and send to physiotherapy outpatient clinics.
- Patients waiting on an orthopaedic wait list that do not actually require surgery and their condition becoming chronic is a burden and huge cost on the healthcare system.
- The MPC involves an advanced physiotherapist doing the initial triaging and reviewing the category two and three referral letters (post orthopaedic consultant categorisation) to determine whether the patient is referred to the operative or non-operative musculoskeletal pathway of care.
- The number of patients seen since the program started in March 2014 is 5,231 with 37 per cent (1,932) returned to the operative wait list and 63 per cent (3,299) referred to the MPC.
- This model of care has proven its success in reducing the SCHHS orthopaedic wait list over a relatively short period of time (two years) and significantly reduced the wait times for patients to be seen in category two and three.



Full presentation: <https://www.health.qld.gov.au/publications/clinical-practice/engagement/qcs-pp-1603-turato.pdf>

Recruitment of Volunteers to Improve Vitality in the Elderly

Associate Professor Edward Strivens, Cairns and Hinterland Hospital and Health Service

'Qualitative feedback from staff, family, volunteers and patients has been very encouraging.'

- Delirium affects as many as 50 per cent of hospitalised patients over the age of 65, causing high rates of morbidity and mortality.
- It increases length of stay, rates of falls, incontinence, pressure sores and readmission.
- Across the hospital and health service there is a lack of staff awareness around delirium and no consistently used hospital-wide screening tool for delirium.
- As a result many patients experiencing a delirium are not correctly identified and in cases where a correct diagnosis is made, management is inconsistent resulting in subsequent increased morbidity and mortality.
- The Recruitment of Volunteers to Improve Vitality in the Elderly (ReViVe) was introduced to

improve patient outcomes and care.

- The model uses a trained volunteer workforce to target known risk factors for delirium namely being over the age of 70; impaired with mobility; decreased independence with activities of daily living; mini-mental state exam (MMSE) score of <24; visual or hearing impairments and malnourishment.
- Volunteers spend time with at-risk patients assisting with specific activities the patient enjoys, general discussion and company, walking with independently mobile patients and sitting with patients at mealtime.
- The major long-term goal for ReViVe is to have trained volunteers working throughout Cairns Hospital and in regional hospitals across our health service with staff at each site championing their own delirium prevention programs.

Full presentation: <https://www.health.qld.gov.au/publications/clinical-practice/engagement/cairns-revive.pdf>

Panel discussion - spreading and maintaining innovation



Panel: L to R – Dr Robyn Littlewood, Sue McKee, Professor Nick Graves, Dr John Wakefield, Laura Damschroder.

How do we take clinical excellence and spread it to hospital and health services to get good quality health outcomes for our health resource?

- Statewide Clinical Networks and Queensland Clinical Senate are important avenues for sharing information and innovations – we don't need to continue to reinvent the wheel.
- Change in thinking – instead of just thinking locally, look at overall strategy and take a systems approach.
- It's not intentional that health services don't share their innovations – local services fix their internal problem and move on - sharing innovation is just not a priority.
- Leaders having good networks is an important part of sharing and learning from other organisations.
- The use of pilot sites to demonstrate cost effectiveness of an innovation will give other centres confidence that they are improving the efficiency of their health services.

- Siloed budgets could however be a barrier to this - someone's cost saving could generate a cost elsewhere.
- The best way for clinicians to share a value proposition is to disseminate to peers simple, good quality research that makes a simple point.
- The challenge of implementing good ideas is a phenomenon that is shared worldwide.
- We are good at generating new knowledge about what works in controlled circumstances but not so good at translating that knowledge and implementing them into practice within complex and challenging health care settings:
 - For every 100 grants that are funded, only two to three are funded to focus on how we get those discoveries out to patients and into policy and practice to benefit patients
 - For every 100 systematic reviews, only two to three are focused on how we get these guidelines into the hands of the practitioners and policy makers to benefit the patient.
- Implementation science is a catalyst for system change. It's about what works, where and why so that information can be used systematically to assess likely implementation challenges, tailor strategies for implementing innovations, and guidance for adapting innovations to maximise benefit for patients.
- AusHSI is investing in implementation science projects to develop research around good implementation. In addition to grants, support from health economists and implementation scientists can partner to test new approaches and address the barriers that impede effective implementation of research.
- Clinicians know the business and the value to patients so when they can come up with the solution it is very powerful – but they may not know the next step. This is where partnerships with researchers / implementation scientists are key.
- The health system needs a change of mindset about implementation science. Currently, less than five per cent of NHMRC expenditure is allocated to health services implementation research.
- Education is one element to effect behaviour change and changes in practice. Social, behavioural science, human factors engineering, design and technology are more critical in driving behaviour change.
- The Department of Health should not invest in innovation and change projects unless implementation science has been considered and built into the model - this will deliver a more reliable result.

Low-value healthcare

Reducing unnecessary radiology and other investigations

Dr Jeremy Long

Sunshine Coast Hospital and Health Service (SCHHS)

- Established practice was to stage all cases of breast cancer seen in the surgical clinic, including CT chest and abdomen, bone scan and tumour markers.
- Guidelines internationally have questioned the use of routine staging in early breast cancer.
- SCHHS reviewed the guidelines and conducted an audit of practice of patients presenting at the breast multidisciplinary team (MDT)
- Presentation of audit to the MDT noting no pick up of metastatic disease in any of the staging but noting the need to perform additional scans or procedures to confirm incidental findings resulting in patient inconvenience and additional resource use and cost.
- Decision that the MDT as a group (surgical, medical oncology, radiation oncology, radiology, pathology) makes the decision for the need for additional staging.
- Default staging was stopped by the surgical clinic, now comfortable with a group decision.
- Education/reassurance of colleagues about the risk and benefits of practice vs evidence-based practice.
- Reduced resource use and therefore greater access to investigations by those truly needing the investigation.

Full presentation: <https://www.health.qld.gov.au/publications/clinical-practice/engagement/low-value-care.pdf>

The Choosing Wisely Experience

Dr Robyn Lindner, NPS MedicineWise and Choosing Wisely Australia

'Wise management of healthcare resources is a core tenet of medical professionalism.'
Wolfson et al, Academic Medicine 89 (7) 2014

- Responsible stewardship of finite healthcare resources is a health professional's responsibility.
- A culture shift is required in this space because there is a gap between aspiration and behavior in regards to attitudes towards inappropriate care. For example, despite knowing that a particular test will not be of value to a patient, evidence shows that a doctor may still do it if a patient demands it.
- *Choosing Wisely* is a campaign/social movement that aims to effect a culture shift about how we think about medical tests, treatments and procedures.
- To do that it aims to start a conversation about inappropriate care among a diverse group of stakeholders – good communication is central to quality health care.
- *Choosing Wisely* has challenged health professional bodies to come up with lists of evidence-based recommendations of things that should be questioned.
- Impact requires a multifaceted implementation program to effect change.

- A recent NPS MedicineWise program effectively changed clinician behaviors around Diabetes management by increasing appropriate metformin prescribing and decreasing glitazone prescribing for patients with type 2 diabetes resulting in better patient outcomes.
- *Choosing Wisely* is inviting hospitals to be pilot sites to implement programs in the next 12 months around patient and clinician education and quality improvement.
- Gold Coast Hospital and Health Service has expressed an interest in becoming a Choosing Wisely pilot hospital and is currently assessing use of pathology and ways to reduce inappropriate testing.

Full presentation: <https://www.health.qld.gov.au/publications/clinical-practice/engagement/choosing-wisely.pdf>

Low value care and opportunities to disinvest - the problem and the opportunity: a health economists perspective

Professor Nick Graves, Health Economist, Queensland University of Technology, The Australian Centre for Health Services Innovation

- Identifying opportunities to disinvest in low value services can be met with opposition from policy-makers and politicians who face public scrutiny. This can make reform difficult.
- For example, the Australian National Hand Hygiene Initiative was successful on face value because hand hygiene improved.
- AusHSI did a cost effectiveness evaluation that showed it cost \$2.8million per year to prevent 67 cases of staphylococcus aureus bacteraemia and generate 96 years of life. This was relatively expensive compared to other infection control alternatives.
- The program remained unchanged because of political pressures and public expectations outweighed evidence about value for money.
- Do we have a culture of evidence-based policy in this country or a culture of policy-based evidence (evidence found to support the policy decision)?
- In Australia, for every \$1 we spend on category one research with NHMRC or Australian Research Council, we spend \$3 on commissioned research with consulting firms, which is not peer reviewed or transparent.
- Are we collectively focused on good value for money and maximising health benefits from our scarce resources or are we lots of a small tribes competing for our own personal gain?
- For healthcare we need to be altruistic – we all need to work together for the common good. If we are self-interested that is to the detriment of society in healthcare.
- Reallocating resources away from low-value services and into high-value services is a difficult process because it generates winners and losers.



Full presentation:

https://prezi.com/kedtet_btstd/clinical-senate-low-value-care/

The problem and the opportunity – a cognitive perspective

Associate Professor Ian Scott, Director of Internal Medicine and Clinical Epidemiology, Princess Alexandra Hospital

- Very few interventions are clearly of low value in most or all patients.
- Many interventions are ‘at the margin’ where genuine uncertainty exists as to who will and will not benefit from them.
- More interventions do not automatically lead to better care and outcomes – more money doesn’t automatically mean better healthcare.
- Nearly all treatments—medical or surgical—have their own risks and unintended consequences.
- Many tests, procedures and treatments that are still performed have been identified as low value.
- If we are aware of this, why are they still performed? Cognitive dissonance and bias have a major effect on the decisions that are made, and the ability to stop performing low-value healthcare. Examples are:
 - Making a decision based on personal judgments, beliefs and preferences, is much quicker and automatic, whereas scientific-focused analysis of evidence is generally more time consuming
 - Inability to reconcile new evidence with highly ingrained prior beliefs that both determine and are reinforced by routine practice
 - What we believe (and want to believe) is tightly bound to the central human need to belong to, and seek affirmation within, a group that shares similar values and outlook
 - Clinician regret at not administering a treatment which **may** lead to benefit (regret of omission) overpowering regret for the **real** consequences of an unnecessary treatment (regret of commission)
 - Pro-intervention bias, especially among younger clinicians, towards choosing action over inaction even if marginal benefits of action are very small
 - Accepting evidence that is contrary to one’s beliefs and refutes what had been regarded as effective interventions can threaten one’s sense of competence, professionalism and freedom to choose
- How do we overcome cognitive dissonance and biases?
 - Knowledge translation / implementation science will get some change (10-15%), but tackling cognitive biases will see greater change. For example, we must acknowledge uncertainty and talk through reasoning, and share decision-making with patients.
 - We must change the behaviors of the next generation of physicians, and disseminate reports that unequivocally show harm from commonly performed interventions – this will change practice.
- When thinking of disinvestment strategies, we must think of and address cognitive biases.

Full presentation: <https://www.health.qld.gov.au/clinical-practice/engagement/clinical-senate/meetings-publications/previous-archive/default.asp>

'The problem is that doctors often (unknowingly) rely on biased evidence: what others have taught them, what is common practice, what appears to work, and on studies that fit with their beliefs.'

Professor Ian Harris, 2015

'Do not do' priorities for Queensland

Senate members and meeting guests were separated into professional streams and challenged with an activity:

- to consider a number of low-value opportunities (from a pre-determined shortlist);
- select one and discuss strategies to make a difference in reducing investment; and
- identify responsibility for governance and leadership.

Summary results of the workgroups: (See appendix for full transcripts)

Medical

Avoid imaging for patients with non-specific acute low back pain and no 'red flag' indicators of a serious cause (**topic discussed by 6 out of 9 medical tables**)

Key strategies for behaviour change:

- Understand where the variation is occurring – understand quantitative and qualitative data in terms of cost and imaging burden and to establish core beliefs of practitioners and patients
- Combine all of the existing pathways for imaging and back pain into an overarching document that would outline a management strategy but also summarise the evidence, clarify, standardise and define what red flags are so that everyone was on same page. Disseminate evidence to patients (to meet expectations) and clinicians (for ordering)
- Strategies around restriction of payment for ordering imaging in low back pain where imaging guidelines or clinical decision support tools weren't met
- Integration of clinical pathway into electronic ordering (if available) and broader marketing and communication campaign about using electronic media.

Where should governance/leadership lie for this to be championed across the state over the next few years?

- Clinical Excellence Division and the division's Safety and Quality Unit with contribution by a multi-disciplinary group
- Pilot sites need the support of their Clinical Senate, Clinical Excellence Division and the Department of Health
- Use of ICHOM standard set for lower back pain.

Nursing

Avoid routine non-targeted risk screening (such as Waterlow Score, dysphagia screening tools etc) for admitted patients (**topic discussed by all nursing tables**)

Key strategies for behaviour change:

- Drivers for doing these tests that are reflected regularly in tests – need to assess if these drivers should be there
- Robust accurate data is necessary to support or not support strategy
- Review penalty process for nurse sensitive indicators (NSI)
- Review of current practices across state – assessment and timing
- Return clinician autonomy
- Link tools to specific demographic areas
- Change management processes – cultural shift
- Use of the networks and learn from lessons learned across other disciplines
- Increase consumer involvement – targeted risk assessment.

Where should governance/leadership lie for this to be championed across the state over the next few years?

- Office of the Chief Nurse in conjunction with the EDMNS leadership group
- Engage nurses working in acute, primary and aged care
- Robust evaluation and work with AusHSI
- Nursing needs to take back ownership of profession and senior nurses must mentor young nurses
- Patient centred – give ownership of the journey back to the patient.

Allied Health

Allow suitable patients to be discharged from outpatients' specialist waiting lists after primary contact allied health intervention (**topic discussed by all allied health tables**)

Key strategies for behaviour change:

- Engage and collaborate with patients and consumers, clinicians, allied health, specialists, GPs, PHNs etc.
- Data collection and analysis
- Look at existing research, evidence and innovations
- Capture improvements in patient and/or healthcare metrics
- Culture to support the change
- Understanding of funding models required but funding to support good practice rather than driving model design
- Willingness to let go and move resources
- Process for change – care plans, business rules, education, transparent outcome measures, funding models.

Where should governance/leadership lie for this to be championed across the state over the next few years?

Governance

- Hospital and health services - medical/allied health/executive governance

Leadership

- The Allied Health Professions' Office of Queensland
- Consumer engagement - Health Consumers Queensland, Queensland Health Consumers Collaborative
- Public Health Networks
- Local champions – colleges, networks and communities of practices across allied health/medical
- Clinician Excellence Division.

Clinical Councils work across both governance and leadership

Future funding priorities

Five Queensland Health hospital and health services presented innovative, high-value healthcare delivery ideas that are not easily implemented in the context of an activity-based funded health system.

Senate members voted to prioritise the projects. The Department of Health has reviewed the Hospital and Health Service submissions in the context of the Senate prioritisation and committed to invest in the first two projects at this point in time.

1. Innovative Modes of Dental Care

Torres and Cape Hospital and Health Service (TCHHS)

- Remote communities have a severe burden of oral disease, particularly among children, and very limited access to dental personnel due to their remoteness
- TCHHS has developed oral health training for remote Aboriginal and Torres Strait Islander health workers and nurses to be delivered online and via video-conferencing
- Intra-oral cameras will also be used to support clinical dental telehealth consulting
- The project aims to:
 - Reduce the impact of early childhood caries on infants and children in remote Indigenous communities
 - Reduce the number of children requiring multiple dental extractions in distant regional hospitals and associated cost

Full presentation: <https://www.health.qld.gov.au/publications/clinical-practice/engagement/qcs-pp-1603-torres-cape.pdf>

2. Should bariatric surgery be routinely provided in the public system?

Dr Peter Gillies Darling Downs Hospital and Health Service

- In 2015, the National Heart Foundation rated Darling Downs – Maranoa as the most obese and inactive place in Australia. Toowoomba was the 10th worst in Australia.
- Patients with a BMI greater than 40 are generally not considered suitable for joint replacement surgery at Toowoomba Hospital because of increased risks.
- At any one time there are up to 40 patients on the waiting list whose weight alone precludes them from joint replacement surgery.
- It has been identified that a number of obese patients are returning to orthopaedic outpatients for regular review with a diagnosis of hip or knee osteoarthritis where joint replacement would be appropriate but still not feasible because of their obesity.
- The clinicians are frustrated at not being able to offer these patients a more useful service, and the patients are frustrated feeling the hospital is not addressing their needs.
- Toowoomba Hospital is planning to undertake a small prospective trial where obese osteoarthritic patients on the waiting list for a joint replacement are randomised into a conservative management group or a bariatric surgery group.

Full presentation: <https://www.health.qld.gov.au/publications/clinical-practice/engagement/publicly-funded-bariatric-surgery.pdf>

3. Cairns is OPEN for business

**A/Prof Eddy Strivens, Clinical Director, Older Persons Health Services
Cairns and Hinterland Hospital and Health Service (CHHHS)**

- In CHHHS in 2014:
 - 12,000 admissions from emergency were people aged over 65
 - 75 per cent of people aged over 75 who present to emergency were admitted to hospital.
- Nationally, 600,000 admissions each year are potentially avoidable with integrated community intervention in the month prior to admission.
- Hospital care is more expensive than community intervention - \$5,000 per admission versus \$300 per community intervention.
- The Older Persons Enablement (OPEN) program targets elderly patients at risk of hospitalisation without appropriate primary care in the community.
- It aims to coordinate specialist community care for this group of patients that could assist them to stay well at home through early diagnosis and intervention.

Full presentation: <https://www.health.qld.gov.au/publications/clinical-practice/engagement/cairns-open.pdf>

4. Rapid Response@Home

**Margaret Broomfield, Director Metro South Health@Home and Aged Care Services
Metro South Hospital and Health Service**

- Currently, patients aged 65 years and over who are discharged from hospital and in need of support to stay at home wait for around 18 days for existing community services to begin.
- Risk that these patients will require readmission to hospital without early home support.
- Rapid Response @Home (RR@H) fills the gap between acute and primary care by assessing patients within 24 hours of arriving home and coordinating community services.
- The service (limited to 28 days) offers a multidisciplinary assessment and intervention with the aim of preventing avoidable admissions to hospital (from ED/SSU) and supports timely/early discharge of patients (from wards).
- One referral - MDT response, direct same day clinician-to-clinician contact enabling rapid response to referrals.
- Each referral prevents three days (median) of inpatient occupied bed days.
- This service supports patient flow for Metro South Hospital and Health Service public hospitals.

Full presentation: <https://www.health.qld.gov.au/publications/clinical-practice/engagement/rapid-response-home.pdf>

5. West Moreton MeCare Program

**is n Dunne Director Clinical Governance
West Moreton Hospital and Health Service**

- Huge demand in West Moreton Hospital and Health Service (WMHHS) for chronic disease management – large per cent of health budget spent on this cohort of patients.
- The chronic disease road is arduous for patients and current models of care are not sustainable:
 - there is a lack of integration between acute and primary services
 - goals are short term rather than long term and do not consider generational changes.
- MeCare is a new model of care to be implemented in WMHHS that empowers patients to move to a wellness model of care.
- It is a mobile-enabled care model that connects patient at home (or in another health facility) via a bluetooth-enabled tablet with a team of health professionals - general physician, GP, pharmacist, nurse and wellness coaches.
- Patient biometric data and other information (based on a care plan developed in partnership with GP and patient) is transferred via bluetooth back to the healthcare team.
- The program targets four chronic disease groups:
 - cardiovascular
 - kidney
 - diabetes
 - respiratory.
- The aim is to keep patients out of hospital and improve their quality of life.
- MeCare is a partnership between WMHHS and Philips.

Full presentation: <https://www.health.qld.gov.au/publications/clinical-practice/engagement/qcs-pp-1603-dunne.pdf>

Appendix 1: Do not do priorities

Medical

1. Avoid imaging for patients with non-specific acute low back pain and no 'red flag' indicators of a serious cause - (*discussed by 6 of 9 medical tables*)

Key strategies for behaviour change:

- Measure current state – quantify the problem
 - Repeat investigation – primary care and hospital
 - Demand curve increasing due to private machines
- Review current evidence - incidence, burden, cost
- Audit
 - primary care – practice audits/pilot PHN
 - burden of imaging – federal database
 - slice audit – patient journey based (patient info, GP info)
 - audit PCEHR
- Investigate current pathways - don't reinvent the wheel
- Targeted approach – education and change management process
- Standard OPD referrals process
- PCEHR
 - access to all images, VIEWER is unidirectional
 - reimbursement strategies – not reimburse non red flag X-ray
- Disseminate the evidence (Choosing Wisely) to clinicians (hospital and primary care), consumers and workplace/employers/OHS
- Primary Care – clinical indication criteria for investigations to be rebatable
- Hospitals
 - Decision support tools in iEMR for test ordering
 - Physio in ED should be able to prescribe/refer/manage if appropriate
 - Community – cheaper and closer to home for consumer
- Patient needs community access to services – musculoskeletal service as it saves hospital referral, rapid access, refer back to primary care, faster back to work, fewer ED presentations
- Educate physicians as to evidence of benefit with more targeted use of back imaging – no change in management, just as good an outcome, lower imaging use costs, more efficient
 - Appreciation and agreement on red flags
 - Risk management approach
- Identify high-use areas / institutions/ populations
 - Public awareness that 'low risk pain' is 'normal', self-limiting
 - Visual aids in GP surgeries, EDs
 - Peer groups with back pain
 - Patient narratives where imaging led to intervention leading to a bad outcome
 - Patients receive something: brochure, leaflet re physiotherapy/self-management
 - Imaging does not disclose the soft tissue pathology
- Clinical guidelines
- Make it a 'do not do'
- Link the reimbursement to the patient to the indication, so that when not indicated not reimbursed
- Give an alternative so there is a strategy to deal with non-specific acute low back pain

- Strategies for patients – media campaign
 - RANZCR, RACGP
- Electronic requesting and decision support.

Where should governance/leadership lie for this to be championed across the state over the next few years?

- HHSs and PHNs
- HHS and PHN clinical councils
- Queensland Health Clinical Excellence Division
- Colleges to run joint education programs
- Government – be strict, have guidelines
- Facilities have a pathway – ED program, referral to physio
- Pilot study
 - Including:
 - HHS/PHN collaboration (working group of ED doctors, GP, physio, consumer, radiologist)
 - Endorsing organisations – RACGP, FACEM
 - Funding organisations – Queensland Health Clinical Excellence Innovation Fund, AusHSI
 - Evidence appraisal and summary document
 - Behaviour change strategies
 - Data-driven evaluation and feedback (AusHSI, QH innovation fund)
 - ED network
 - Consumers
 - Choosing Wisely
 - Multifaceted
 - ICHOM standard set
 - Patient information incorporated into a pathway
 - Inclusion of relevant peak professional radiology body, orthopaedic, primary care, ED, physio/allied health

2. Avoid routine insertion of intravenous cannulas unless IV therapy is required (*discussed by 2 of 9 medical tables*)

Key strategies for behaviour change:

- Education and dissemination of evidence-based information
- Audit – size of issue, adverse costs, worth proceeding
- Collect data – data is king
- Feedback linked to targeted education; marketing patient story with bad outcome; multi-faceted appeal; linked to hand hygiene
- Re-audit
- Identify alternatives
- Target audience
- Supervision/modelling of senior clinicians
- Indication clarified through education, policy, guidelines
- Reverse what is the norm
- Multidisciplinary
- Explore the core beliefs, which lead to a particular behaviour. Do the market research of GPs.
- Introduce within early training a culture of questioning why
- Demand (Patients, GP) – supply (radiologists). Consider third party payer
- Restrict access to ordering/payment – reward/encourage good physical examination, e.g. via item number payment

Where should governance/leadership lie for this to be championed across the state over the next few years?

- Clinical council for each hospital and health service and primary health network – council to then advise chief executive
- Queensland Health Clinical Excellence Division
- Emergency Medicine Clinical Network
- Policy – statewide clinical networks
- Evidence analysis – disseminate
- Education – standardised but can be tailored locally
- Medical schools
- Professional colleges (orthopods, neuro, RACGP)
- Third party payers – insurers
- Consumer organisations/groups
- Clinical Leaders – infection control and specialities
 - Protocols/guidelines
 - Education

3. Avoid surveillance of urine cultures and treatment of bacteriuria (*discussed by 1 of 9 medical tables*)

Key strategies for behaviour change:

- Multidisciplinary training
- Individual education – screen savers, management agenda, audit reports, Choosing Wisely agenda in departments
- Group – senior leadership forums, department heads, stakeholders, private, GPs
- System – policy and recommendations
- Clinical effectiveness cycle – policy, audit, reflection
- College/university training

Where should governance/leadership lie for this to be championed across the state over the next few years?

- Clinical networks - Choosing Wisely
- HHSs - Choosing Wisely, KPI/sponsor
- Queensland Health, Clinical Excellence Division

Nursing

Avoid routine non-targeted risk screening (such as Waterlow Score, dysphagia screening tools etc) for admitted patients (*topic discussed by all nursing tables*)

Key strategies for behaviour change:

- Education regarding risk management/risk profiling
- Change guidelines
- Change management process – culture shift
- Robust accurate data to support or not support strategy
- Review of current practices across state
- Review penalty process for NSI
- Referral pathways – look at the evidence
- Links screening tools to specific patient demographic groups

- Lessons learned from other disciplines and use clinical networks
- Strategies should return to targeted only
- Get quality and safety on board
 - Look at current tool-reduce level of assessment required
 - Need a prompt to think about it but it shouldn't need to be completed for all
 - 'Specials' – authorisation of same
- Set criteria / flow chart that is evidence-based
- Clinical development of sensible care plans
- Embedding patient-centred-care using PCOMS
- Listen to patient / family experience and avoid 'tick and flick'
- Patient/family member to assist in completing pre-admission forms
- Consider software pop ups
- Funding aligned to Waterlow Score / review evidence and impact of tools.

Where should governance/leadership lie for this to be championed across the state over the next few years?

- Senior state nursing bodies
- Return 'power' of decision-making and leadership to senior local clinicians
- Local leadership:
 - OOTCNM/EDNMS
 - Patients/consumers
 - Systems to identify clinicians versus one task for all
- Office of the Chief Nurse and Midwife in conjunction with nurses across sectors (acute, aged care, primary care)
- Use health economics (Involve AusHSI) and implementation science
- Clinical networks
- Universities – empower students in critical thinking / decision making
- Interdisciplinary approach
- Engage consumers at hospital level.

Allied Health

Allow patients to be discharged from outpatients' specialist waiting lists if suitable, after primary contact allied health intervention (**topic discussed by all allied health tables**)

Key strategies for behaviour change:

- Clinician buy in – specialists to agree that allied health can discharge
 - Also need top-down approach
- Engagement and expectation management for GPs and patients of new program
- GP education strategy for referrals direct to allied health by providing clear criteria for referral
- Ensure new model within hospital outpatient setting is co-designed with input from all stakeholders (allied health, specialist, management)
- Understanding of funding models required but funding to support good practice rather than driving model design
- Consider involvement of primary care allied health, e.g. pathways to allow referral back to primary care physicians. Statewide pathways that are consistent across the state as much as possible – may need to localise if needed
- Incentivising by looking at MBBS – team care arrangements; fill the gaps to support GPs to take on care; link in with primary care

- Collaborate with PHN to link with GP
- Generate evidence-based data (prove it is good value for money) and show health service leaders
- Incentivise – to give framework for pick up changes in care
 - Set up environment to let clinicians lead.

Where should governance/leadership lie for this to be championed across the state over the next few years?

- Clinician Excellence Division
- Hospital and Health Service Chief Executive Officer KPI / link with purchasing division
- HHS medical/allied health/executive governance
- Medical, nursing, allied health advisory forums
- Current HHS/PHN collaboratives
- Allied health governance / professional bodies, e.g. Society of Hospital Pharmacists, The Allied Health Professions' Office of Queensland
- Health Consumers Queensland
- Queensland Health Consumers Collaborative
- Clinical Council.