The Health Advocate

Your voice in healthcare

Mastering healthcare transformation

Introducing value-based healthcare in the oral health sector

IRONing out Maternity Blood Management

A smartphone- and Internet-based system to support management of gestational diabetes

+MORE INSIDE

The official magazine of the Australian Healthcare and Hospitals Association

ISSUE 51 / December 2018

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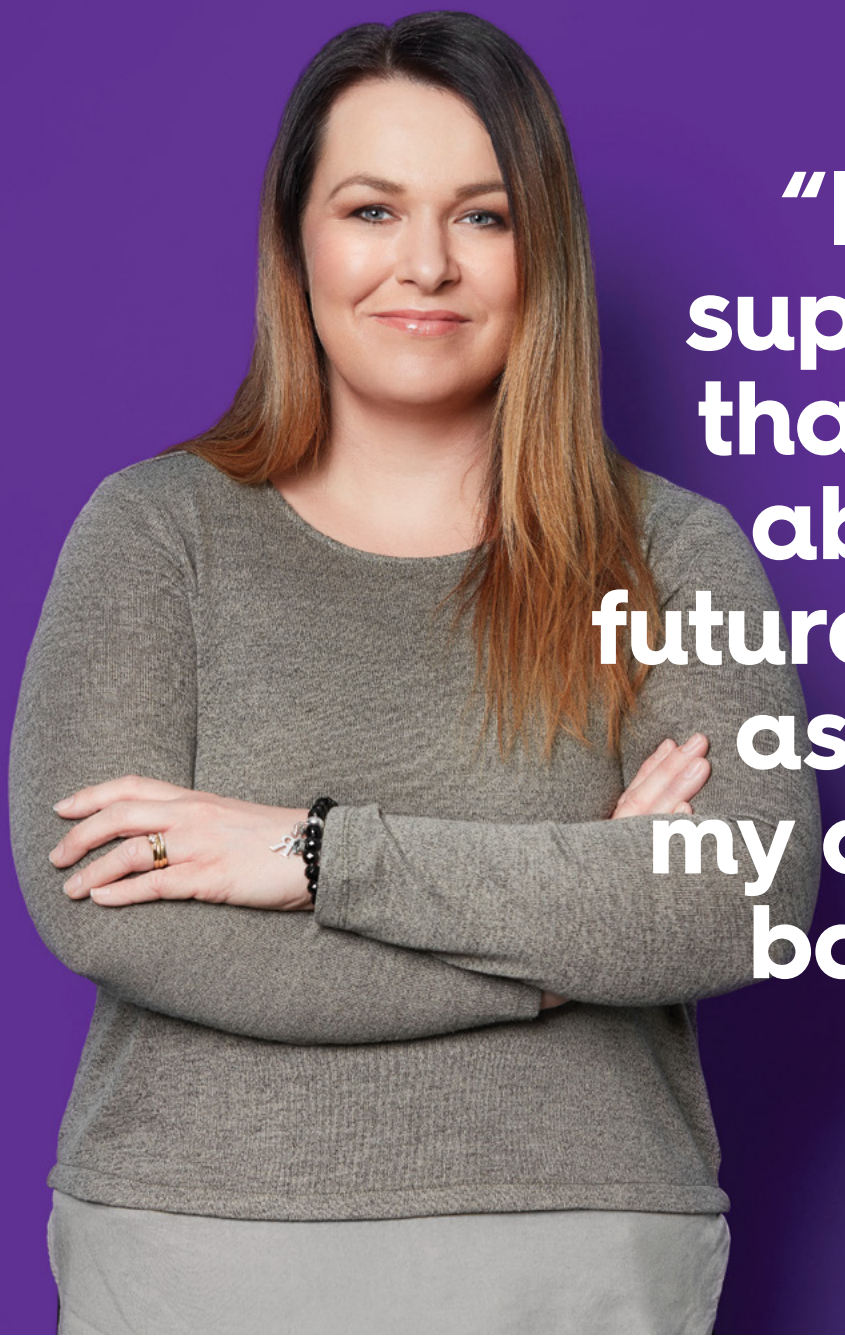

"I want a super fund that thinks about my future world, as well as my account balance."

Rachael Sydir,
HESTA member

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We want our actions to drive long-term, meaningful change. So the world you retire into is a healthy, happy and fair one.

That's the HESTA impact.

HESTA

An Industry SuperFund

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DEBORAH COLE
Board Chair, Australian Healthcare and Hospitals Association (AHHA)

Connections in healthcare—and a successful 2018 World Hospital Congress

Humans have an innate need for connection with others. So much so that the increasing impact of social isolation and loneliness on the physical and mental wellbeing of individuals and other aspects of society has been recognised this year in the UK with the appointment of a 'minister for loneliness' or more formally, a Minister for Civil Society.

The benefits of connection, to the individual and the collective, this 'social capital', generates a huge amount of academic and policy interest. This emerging public health challenge of loneliness in the UK was raised by Nigel Edwards, Chief Executive, Nuffield Trust at the World Hospital Congress in Brisbane in October, in a panel discussion about integrating health services around the patient. It's a challenge not faced in Egypt though. Demonstrating the importance of context — Nagwa Metwally, Member of Supreme Council, Egyptian Red Crescent responded that loneliness is not the problem with large extended families often living together in one house.

Connection in health care is also fundamentally important because the system is large, complex and fragmented. Without connection, each sector responds to problems they face, building solutions based on its own partial visions. There are many different dimensions of connection—patients connecting to clinicians, service providers connecting with funders, governments connecting at different levels, advocacy groups connecting with media, just to name a few. This diversity in stakeholders presents significant challenges for each stakeholder to understand each other and work to delivering optimal outcomes.

Considering the applicability of 'solutions' to different contexts is also critical in our system. We advocate for evidence-based programs, but it is the context in which they operate that also plays a critical role in influencing their implementation and effectiveness.

All those who joined us at the World Hospital Congress will agree that the connections made will benefit us for a long time to come. New connections re-shape how we think about health and health care, and these new connections are not just coming from the usual players in the health sector. Boundaries are shifting around the way healthcare is delivered, e.g. with biotechnologies, digital health, better data usage and increased patient control. The impact of social factors on achieving health outcomes is also being integrated with how we shape health care. Who we need to connect with is shifting and expanding. Who we can connect with to share and learn has expanded to a global community.

> **"All those who joined us at the World Hospital Congress will agree that the connections made will benefit us for a long time to come."**

The World Hospital Congress saw patients at the centre of the program, speaking at all plenary sessions, as keynotes and panellists. With Chris Pointon from the UK, we were reminded that the simple act of introducing yourself, #hellomynameis, is the first step to connecting in providing person-centred, compassionate care. With Melissa Thomason from the US, we were inspired with her story and the transformational power of patient engagement in healthcare. Karen Knight from Vision Australia shared the hospital experience of people who are blind or have low vision and how services can help. The team from the Value Institute for Health and Care at Dell Medical School in the US prompted delegates to evaluating the value of care through connecting with patients by asking 'how are you?' and not 'how were we?'

Technology is increasingly being used in diverse ways to connect players across the health sector. Professor Cullen spoke of the Rockhampton experience in using telehealth to connect patients to evidence-based care through a regional hospital. Experiences were about improving the capture and use of data to improve care, including through mobile self-monitoring interventions, from places as diverse as Kazakhstan, Belgium, United Arab Emirates, Zambia, Taiwan, Spain, the Philippines and more—discussion considered the different settings and different levels of resources in achieving a common goal.

Networks were formed between clinicians and data specialists, academics and managers, executives and patients—across services, across sectors, across countries.

As we move forward in healthcare improvement and reform, connections must continue to be made. Locally and globally, we can learn from each other, understanding our differences as well as our similarities, understanding each other's perspectives and experiences, and moving towards a healthcare system that will meet the needs of our patients and communities. ha

ALISON VERHOEVEN
Chief Executive
AHHA

World Hospital Congress, and honouring a lifetime commitment to health service improvement

WHAT A WORLD HOSPITAL CONGRESS THAT WAS!

As we wind down to the end of the year, I cannot help but think of how successful the 2018 World Hospital Congress was.

In this issue of *The Health Advocate* you will find many reflections, from keynote speakers to Australian prize-winners in the International Hospital Federation Awards, to one of our Early Career Health Professionals Scholarship winners, to the heartfelt personal thoughts of our student volunteers from the Queensland University of Technology.

As a quick reminder:

- **Day 1** was all about value-based healthcare. Outcomes, not volume. Patient interests, not entrenched interests.
- **Day 2** was about integrated care and care coordination beyond the traditional walls of the traditional hospital.
- **Day 3** was about data, data sets and data technology and how best to use this information for the biggest healthcare benefit.

All these aspects of modern healthcare will be highly topical in 2019 and beyond.

There are many people to thank—too many to thank individually here—but thank you to the International Hospital Federation, and to the Congress scientific and organising committees. Thank you to our many sponsors, but particularly the Queensland Health Clinical Excellence Division and Novartis Australia. Thank you to our wonderful speakers, our session chairs, our timekeepers, all of our volunteers, and the AHHA and Iceberg staff who all did an amazing job. And thank you to all participants.

Finally, I would like to pay a special tribute to our conference organiser, AHHA Engagement and Business Director Lisa Robey, who lived and breathed this event for over 12 months before it finally happened.

2018 SIDNEY SAX MEDALLIST—DR PAUL SCOWN

The AHHA's 2018 Sidney Sax medal was presented to Dr Paul Scown at the World Hospital Congress gala dinner in Brisbane on 10 October.

This medal is awarded to a person who has made an outstanding contribution to the development and improvement of the Australian healthcare system in the field of health services policy, organisation, delivery and research.

Paul has demonstrated outstanding service and commitment to the Australian health sector in a career spanning almost four decades. A University of Queensland medical graduate, he worked clinically for a number of years in metropolitan, rural and regional Queensland prior to moving into medical administration and then senior leadership roles.

Paul has held senior and chief executive positions in public health services in Queensland, New South Wales, South Australia and Victoria. He is currently Chair of Nexus Primary Health, a Victorian community health service.

Paul has also demonstrated commitment to the mission and values of the AHHA, including through his active participation in and membership of the organisation. He is a former AHHA Board Chair and currently a member of the AHHA's Deeble Institute for Health Policy Research Advisory Board. He represents AHHA on the Australian Council on Healthcare Standards (ACHS) and was elected to the ACHS Board for a 3-year term in early 2018.

Dr Paul Scown

Many AHHA members have had the opportunity to work with Dr Scown and experience his commitment, leadership and guidance, both in supporting their professional roles, and more broadly to public health services in Australia. Paul Scown is a most worthy recipient of the Sidney Sax medal for 2018.

PROFESSOR JOHN DEEBLE, AO

In this issue of *The Health Advocate* we have included a two-page tribute to John Deeble, the 'Father of Medicare' and former Sidney Sax Medal winner, whom our Deeble Institute for Health Policy Research is named after. Sadly, John died on 5 October 2018 aged 87. ha

AHHA in the news

12 DECEMBER 2018

Government's $1.25 billion health boost welcome but let's spend all health money wisely

With the Morrison Government announcing a $1.25 billion boost to health ahead of the December 2018 Council of Australian Governments meeting in Adelaide, AHHA called on political leaders to put people first and ensure that budget commitments to health are wise.

'This will mean some reforms instead of tinkering around the edges financially with a system that reflects the medical knowledge, infectious diseases and patterns of illness, injury and death of 40 years ago', said AHHA Senior Research Director, Dr Linc Thurecht.

'A year ago, AHHA gave Health Ministers an early Christmas present—a blueprint on how to transform our healthcare system into a fit-for-purpose 21st century system that will meet the needs and expectations of the Australian population—a population that is rapidly ageing and suffering more long-term chronic diseases than at any other time in history.'

'As we count down to the next federal election, there's even greater reason to remind our political leaders of their responsibility for universal healthcare—that is, equitable access to health services that does not depend on ability to pay.

'It's no use investing in research and innovation if we don't have health services in place which are focused on value and outcomes, and ensure that all Australians can access affordable, safe, quality care. This requires investing in resources, training and data to maximise the value achieved through health spending.

'The health inequity experienced by Aboriginal and Torres Strait Islander people must be at the top of the priority list—and investments here need to be aimed at community-led solutions in primary care.

11 DECEMBER 2018

Atlas of Healthcare Variation points the way to better healthcare for all

'The *Third Australian Atlas of Healthcare Variation*, released by the Australian Commission on Safety and Quality in Health Care, points the way towards better healthcare for all', AHHA Senior Research Director Dr Linc Thurecht said.

'The report highlights where changes are most needed to improve equity of access to needed care, and reduce the potential harm and waste resulting from unnecessary prescriptions and procedures.

'The work of the Commission is extremely important, and the wide variations in healthcare shown in the report should be a concern for governments, health professionals and private health insurers alike', Dr Thurecht said.

'For example, in children aged 0–9 years, the antibiotic medicine use rate in Australia is three times that of Norway and the Netherlands.

"...the wide variations in healthcare shown in the report should be a concern for governments..."

'Aboriginal and Torres Strait Islander Australians have higher rates of cataract, but lower rates of cataract surgery than other Australians.

'And, despite having higher rates of heart disease, people in regional areas have lower rates of cardiac stress tests and imaging than people living in major cities.'

'AHHA always seeks to improve equity in health and healthcare across Australia in the interests of the best health outcomes and affordable, quality healthcare.

HAVE YOUR SAY...

We would like to hear your opinion on these or any other healthcare issues. Send your comments and article pitches to our media inbox: communications@ahha.asn.au

5 NOVEMBER 2018

Improved efficiency in public hospital care a good thing—but not the only thing

AHHA Chief Executive Alison Verhoeven was commenting on the Australian Institute of Health and Welfare report, *Costs of admitted patients in public hospitals from 2012-13 to 2014-15*.

'We really need more information on quality and patient outcomes in order to get a more holistic picture of the performance of our hospitals and the value of care provided', Ms Verhoeven said.

The AIHW report showed that in the three years to 2014-15, hospital activity rose by 6% in line with population growth, while spending rose only 5%.

The cost of delivering an average service to acute admitted patients ranged from $3,300 to $6,400, depending on the hospital.

'There are many reasons for these variations, and while some have been accounted for in the report, we really need more work on measures that combine quality and cost', Ms Verhoeven said.

'We urge governments in Australia to go down this path in the interest of value-based care—in other words healthcare that brings the best changes in individual health status per health dollar spent.

'We also need more timely data—knowing what happened three years ago is not all that useful in planning right now.

'The older the data are, the more uncertain things become in planning and funding future care.

'More certainty in funding hospitals means we can avoid disputes like the current funding disagreement between the Commonwealth and the states where the states and territories are claiming they are owed money by the Commonwealth for procedures already carried out in public hospitals.'

27 SEPTEMBER 2018

No level of safe alcohol use in pregnancy—but is the message being heard?

'Despite national guidelines recommending that the safest option for pregnant and breastfeeding women is not to drink, almost half of pregnant women in Australia consume some alcohol during their pregnancy—one of the highest rates in the OECD,' said Deeble Institute for Health Policy Research Director, Dr Rebecca Haddock.

AHHA's Deeble Institute for Health Policy Research has released an Issues Brief, *Reducing harms related to alcohol use in pregnancy—policy and practice recommendations* authored by Dr Amy Finlay-Jones, a postdoctoral research fellow at the FASD Research Australia Centre of Research Excellence, Telethon Kids Institute.

Dr Finlay-Jones developed the paper as part of a Deeble Institute for Health Policy Research Summer Scholarship, supported by HESTA.

'The widespread use of alcohol during pregnancy is a significant public health concern in Australia, increasing the risk of miscarriage, stillbirth and Fetal Alcohol Spectrum Disorder' (FASD), Dr Finlay-Jones said.

'There are lifelong impacts for people living with FASD, including increased risk of mental illness, disengagement from education and work, and contact with the justice system.

'Reducing alcohol use in pregnancy should be a public health priority, and requires comprehensive and coordinated prevention strategies to improve public awareness that there is no established safe level of alcohol use during pregnancy.

'In addition to better targeted and more consistent messaging about alcohol use, routine alcohol screening should be undertaken for women who are pregnant or planning a pregnancy.'

Vale Professor John Stewart Deeble AO

9 July 1931 – 5 October 2018

Father of Medicare, who leaves an enduring legacy to the nation.

Professor John Deeble was the co-architect of Australia's first universal health system Medibank, and an integral part of its re-introduction as Medicare in 1984. His expertise lay in being able to think innovatively about big issues, while never losing sight of the humans who were affected by them. He was an apolitical academic crusader against social injustice who did not align himself to anyone—rather they aligned themselves to him and his ideas. He was a conceiver, implementer and defender of universal healthcare for nearly 50 years.

Although John was most closely associated with Canberra, where he lived and worked in senior policy positions for over 40 years, he was born in the Wimmera wheat field town of Donald in Victoria near the South Australian border. He grew up in Woodend where he attended Woodend Primary (skipping two grades), Kyneton High and later Trinity Grammar Melbourne. He left school at the age of 15, half way through his matriculation year in 1946 at the behest of his father, who was worried that jobs might become scarce with the return of servicemen from the Second World War. Initially, he went to work in a bank in Melbourne but then passed the navy entrance exam with flying colours and became an officer straight away. Despite developing a love for sailing, John decided the navy's rules were not for him.

He then worked at various full-time jobs while completing a Commerce Degree part-time at Melbourne University (1956). It was at the university that John met Eunice Callam, whom he married in 1955, and then had four children: Karen, Geoffrey, Michael and David. In 1957, John became Assistant Manager of the Peter McCallum Institute—Melbourne's specialist cancer treatment facility. He was in charge of finances at what was, for the time, a very high-tech hospital and it troubled him that people refused cancer treatment because they could not afford it. So he returned to university to study hospital costs and gain a Diploma of Hospital Administration from the University of New South Wales (1958).

By 1965, aged 34, he had obtained a full-time research position at the Institute of Applied Economic Research at the University of Melbourne, headed by Professor Ronald Henderson. There he met another researcher by the name of Dick Scotton and this partnership was to have a profound impact on the Australian health care system. The complementary nature of their backgrounds, research interests and temperaments enabled Deeble and Scotton to develop a close and mutually supportive partnership, strengthened over the next decade by shared experience. Much of John's early work in health economics was in assembling the first set of Australian health expenditure statistics. The statistical analysis he undertook prompted scepticism about the inequity of the then voluntary system of private health insurance. The system produced uneven access and costs, the burden of which was borne largely by those who could least afford it. John was also worried about its overall cost, and the inefficiency of the many small private health insurers. Against this background, Deeble and Scotton conceived the idea of a compulsory public national health insurance scheme based on the principles of universal coverage, equity of access and payment according to means through the taxation system.

In the mid-1960s, Opposition Leader and future Prime Minister Gough Whitlam was exploring new policy options for Australia, including universal healthcare, and seeking expert advice. Whitlam was attracted to Britain's National Health Service, but he was also aware that the Australian Constitution did not appear to permit any government to control doctors' fees. So Dr Moss Cass, later a Whitlam Government Minister, convened a now-famous meeting at his Melbourne home on 8 June 1967, involving Whitlam, Deeble and Scotton. Also present were: Professor Rod Andrew (Dean of Medicine at Monash University); Dr Harry Jenkins (ALP spokesperson on health in the Victorian State Parliament); and Jim Lawson (Medical Director at Footscray Hospital). At the conclusion of the long discussion about the inadequacies of voluntary private insurance, Whitlam turned to Deeble and Scotton and said:

'Well, you've described the problem. Have you any solutions?'

It would take eight difficult years of political debate and planning before universal health insurance was delivered. But from that meeting onward, John was committed to achieving that goal. In 1970, this work gained him a PhD from the University of Melbourne.

After the Labor Party's win in the 1972 election, John (Special Adviser to then Social Security Minister Bill Hayden) had the difficult task of designing the administrative and legislative detail of Medibank. Two-and-a-half years of planning and political battles ensued, including rejection in the Senate three times, a double dissolution election fought largely on health issues, and the eventual passing of the legislation in a joint sitting of both Houses in 1974.

What became obvious during this period was that John was much more than an ideas man. He could also nurture, develop, implement and defend an idea. He was dogged and courageous in the face of hostility and criticism—but, as became his hallmark, always playing the issue, not the person. Unfortunately, the long hours and total dedication to that task took a toll on his marriage, and at the beginning of 1975, John and Eunice parted and John brought up the children.

Australia's first universal health insurance scheme, Medibank, was finally delivered in July 1975. For the first time, everyone could have free access to a public hospital as a public patient. But after the fall of the Whitlam government in November 1975, Medibank was progressively dismantled by the Fraser Government. John took on a new role as Director of the NHMRC Health Economics Research Unit at the Australian National University (ANU), which was the

start of an enduring association with that university.

In 1980, sensing that a change in government was possible, John teamed up with Neal Blewett, then Shadow Minister for Health in the Bill Hayden-led Labour Opposition. With their battle-hardened combination of intellectual, policy and political skills, they were able to make the universal healthcare phoenix rise again as Medicare. Such was their readiness, in a kinder political climate this time, that the introduction of Medicare on 1 February 1984 came only 11 months after the election of the Hawke government in March 1983.

John once again showed his ingenuity, persistence and capacity for hard work in pursuit of a just, equitable and efficient health system. He then became a defender rather than conceiver or implementer of Medicare; in the ensuing years, it came within the sights of Treasury, Finance, the Department of Prime Minister and Cabinet and the government's Expenditure Review Committee (the 'razor gang'). Luckily, a relatively stable political decade was enough for Medicare to gain universal acceptance.

Now John moved to a First Assistant Secretary role in the Department of Health. Following on from the initial work of others, notably Dr Sidney Sax, he advocated for a central collection body for national statistics on health status and health services use. The Australian Institute of Health (now Australian Institute of Health and Welfare or AIHW) was established within the Department of Health for this purpose, and John was its first Director between 1985 and 1986 before it became an independent statutory authority in 1987. John also served on the Health Care Committee of the National Health and Medical Research Council, was Chair of the National Health Technology Advisory Panel and a major contributor to the National Health Strategy coordinated by the Department of Health.

From 1989 to 2005 John was a Senior Fellow in Epidemiology and an Adjunct Professor in Economics at the National Centre for Epidemiology and Population Health at the ANU.

As an endnote to a remarkable career, his other works include being a World Bank Consultant on healthcare financing in Hungary, Turkey and Indonesia, and an adviser to the government of South Africa from 1995 to 2005. An area of John's work which is often overshadowed by the scale and immensity of his other achievements is his work on Aboriginal and Torres Strait Islander (ATSI) health issues. As an area

of social policy and social justice, it is not surprising it attracted John's attention and absorbed him in his later years. He co-authored an Australian Institute of Health and Welfare paper on expenditures on Aboriginal and Torres Strait Islander health in 2008, and published an article on the health service use by the Indigenous Australians in 2009. Although he was then approaching his 80th year, he had lost none of his research skills, his writing ability, his passion for his work or his commitment to social justice.

John was the recipient of many prestigious awards and honours throughout his career. In 1969 he was awarded the Royal Society of Victoria Research Medal and in 1970 the Australian College of Hospital Administrators Research Prize. In 1994, he was awarded the Australian Healthcare and Hospitals Association's Sidney Sax Medal for his outstanding contribution to health services policy, organisation, delivery and research. He was awarded an Order of Australia (AO) in 1996, 'In recognition of services to community health in the fields of health economics and health insurance policy.' In 2009, John became a Life Member of the Australian Healthcare and Hospitals Association (AHHA). Two years later, in 2011, AHHA created the Deeble Institute for Health Services Policy Research, with John as its Patron.

As amazing as his achievements were, John was also renowned for his personal qualities. Former colleague and friend Professor Peter Read said:

'He was the most humble man I have ever known. He treated everyone the same—princes or paupers, cabinet ministers or cabinet makers—all were treated with dignity and respect. He was genuinely interested in people and listened intently to their views, not always agreeing but always giving them the courtesy of a hearing. I never once heard John raise his voice and if he was critical of anyone, his criticism was about policy or ideas, never personal. It was not in John's make up to be mean- spirited to anyone.'

In 2002, John found happiness again in his personal life when he married Mary Beers, described by his family as 'his true soul mate'. His family was a treasured part of his life and although a very busy man, he gave unconditional love and wise counsel, and was always interested in everyone's achievements.

John Deeble has made an indelible mark on the Australian health care system and left us with an enduring legacy. A full generation has now passed since the introduction of Medicare and no one under the age of 34 has ever felt the uncertainty of not being able to access medical and hospital services when they were needed. ha

John Deeble died peacefully on 5 October 2018 aged 87 years. He is survived by his wife Mary Beers Deeble; children Karen, Geoffrey, Michael and David; stepdaughter Sophie Beers; son-in-law Ian; daughters-in-law Susan, Caroline and Letitia; grandchildren Mitchell, Courtney, Sophia, Valentina, Ainsley, Callam and Maisie; and great granddaughter Maija.

Nigel Harding, Public Affairs Manager, AHHA
Karen Deeble

Mastering healthcare transformation

Our World Hospital Congress experience.

On 10–12 October 2018 the Value Institute for Health and Care was privileged to participate in the 42nd International Hospital Federation (IHF) World Hospital Congress in Brisbane. Our perspective, delivered by Elizabeth Teisberg, launched the World Hospital Congress with the message that the goal of healthcare must be to achieve its medical and humanitarian purpose—helping people with health challenges to achieve capability, comfort, and calm.

Returning healthcare to its purpose is the signature goal of our Institute. We support healthcare transformation that enables better health outcomes for the money spent in order to provide better health for more people. In addition to accelerating clinical transformation, our initiatives include thought leadership on translational research, educational programs, and partnerships.

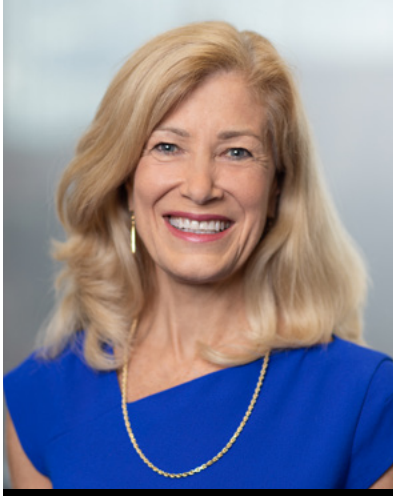
Leading into the Congress, we facilitated a two-day interactive workshop on implementing value-based health care. More than 65 leaders in dentistry, medicine, surgery, pharmaceuticals, medical devices, insurance, and government attended. Building on the World Hospital Congress's theme of 'Evolving health care to meet 21st century demands', our workshop focused on the actionable steps required to catalyse and accelerate transformation in participants' organisations.

The Value Institute's educational programs provide participants with specific tools they need to deliver high-value, relationship-centred healthcare. The programs teach participants to conduct qualitative research to understand individuals' and families' needs beyond the clinical setting, design solutions for specific patient segments, create integrated practice units (IPUs) that drive team-learning, and implement payment models that align medical success with financial success.

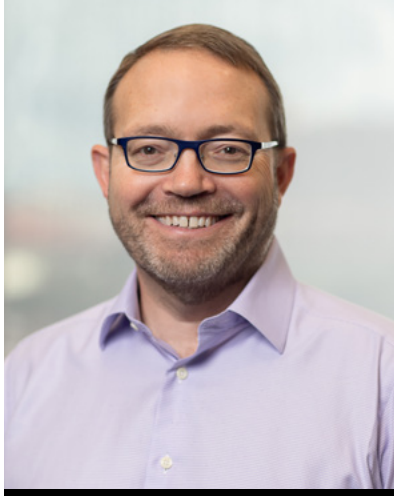
Participants at the workshop focused on identifying the most relevant outcome measures and using the results of those measures to start the process of care transformation. The general lack of outcome measurement in healthcare is stunning given that improving health outcomes is the purpose of healthcare. Even more stunning, however, is the power of meaningful measurement to drive change. Workshop participants studied multiple organisations using patient outcome measurement to drive care transformation.

Measurement that drives transformation uses the outcomes that matter most to patients, which address increases in capability (the ability to do the things that are important to the individual or family), comfort (reduction in physical and emotional suffering), and calm (relief from the burdens that seeking treatment or waiting for help can foment).

Value Institute workshop on Implementing Value-Based Care, 8–9 October 2018



ELIZABETH TEISBERG
PhD, Executive Director
Value Institute for Health and Care,
Dell Medical School and McCombs School of Business, The University of Texas at Austin



SCOTT WALLACE
JD, MBA, Managing Director
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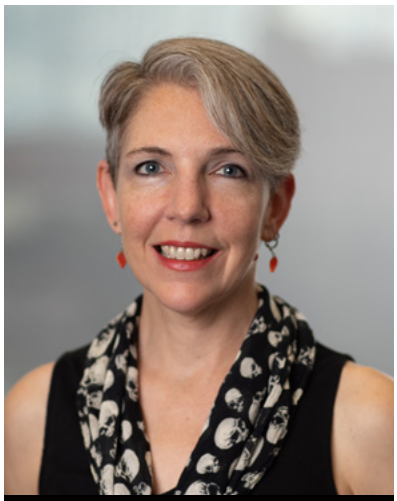
ALICE ANDREWS
PhD, Director of Education
Value Institute for Health and Care



VICTORIA DAVIS
PhD, Research Writer
Value Institute for Health and Care

The key questions about health are often lost amid the plethora of required measures and metrics reflecting process compliance, patient satisfaction and hospitality. Refocusing on health requires changing from asking 'How were we?' to asking, 'How are you?' Of course, healthcare must ensure safety and respect to every patient, but these should be the floor, not the limits of our aspirations.

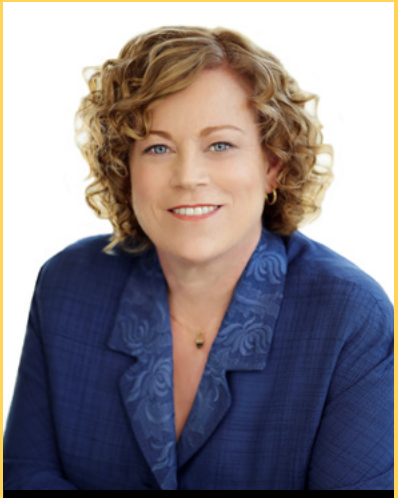
Measuring outcomes that are meaningful to patients also helps reduce clinician burnout. Aligning measurement with purpose supports professional goals rather than pushing clinicians to work harder and faster. Through development, review, and iteration of outcome measures, teams build a culture of learning and improvement that enables the care team to do usual things exceptionally well.

The goal of our interactive workshops is to empower participants to do something differently when they get back to work. Participants leave with tools and implementation frameworks as well as insights from pioneering healthcare leaders whose work is changing the way healthcare is delivered. Programs include the value-based healthcare overview showcased at the Congress, as well as programs taking a more in-depth look at cost and outcomes measurement, designing services from patients' perspectives, creating teams that learn and improve together, and growing high-value services.

In Autumn 2019 the Value Institute will begin offering a Master of Science in Health Care Transformation program. A joint degree granted by both Dell Medical School and the McCombs School of Business at The University of Texas at Austin, the program will educate leaders in system transformation that enhances value by achieving better health outcomes. The one-year, part-time program will be delivered for leaders throughout the health sector in a hybrid (in-person and online) cohort format that enables building strong relationships among the students and with faculty.

The Value Institute is formalising the community-building aspect of our mission by establishing a Partnership Program that will to enable partners to deliver world-class value-based healthcare education programs at their own location and collaborate with us in research on value-based healthcare implementation.

We want to thank the International Hospital Federation and the Australian Hospital and Healthcare Association for being such gracious hosts; we had a great time connecting with other healthcare leaders who are also working to #TransformHealthCare. You can learn more about our executive education and master's program at dellmed.utexas.edu/units/value-institute-for-health-and-care. ha



SUSAN MCKEE
Executive Director, Value Based Healthcare Implementation, Dental Health Services Victoria

"Only one in four eligible people accessed public dental services in 2015–16, with another 6% of eligible people waiting for care."

Introducing value-based healthcare in the oral health sector

A new approach to improve oral health outcomes.

As the lead public oral health agency in Victoria, Dental Health Services Victoria is transitioning to a model of care that reflects the principles of value-based healthcare. By co-designing a new system in partnership with our consumers and staff, we are driving better health outcomes and experiences for patients.

We are thrilled that our work towards introducing value based oral healthcare has been recognised internationally, and we look forward to continuing to share our experiences with the health community and learning from other innovations in this space.

THE NEED FOR CHANGE

There are an estimated 2.46 million people eligible to receive public dental services in Victoria (41% of the population). Only one in four eligible people accessed public dental services in 2015-16, with another 6% of eligible people waiting for care.

People who access public dental care in Victoria have more disease and fewer teeth than the general population and are less likely to access services than the general population. And when they do access care, it is not always focused on achieving better health outcomes.

Our clinicians had become disillusioned by the lack of impact they were having in improving health outcomes, especially given most dental disease is preventable. At the same time, our consumers felt frustrated with the difficulty in accessing patient-centred care, and felt that no one was listening to them.

We also discovered huge variations in the services provided across the public dental sector. The variation in topical fluoride treatments was 14-fold from lowest to highest, while variation in the provision of root canal treatments was also 14-fold.

We wanted and knew we could do better.

A NEW MODEL OF CARE

In February 2017, we started developing a model for value-based oral healthcare. We hosted a series of workshops with academics and researchers, clinicians, senior management and consumers. We worked with them to map out the current state of emergency and general care at the Royal Dental Hospital of Melbourne (RDHM). We then mapped out the ideal state (what it would look like with no financial or operational restraints) followed by a more realistic future state.

The new model focused on five key areas:

- achieving the best health outcomes at the lowest cost
- creating a patient-centred system organised around what patients need
- ensuring the right services are being provided by the right person at the right locations
- integrating care across separate facilities
- measuring outcomes and costs for every patient.

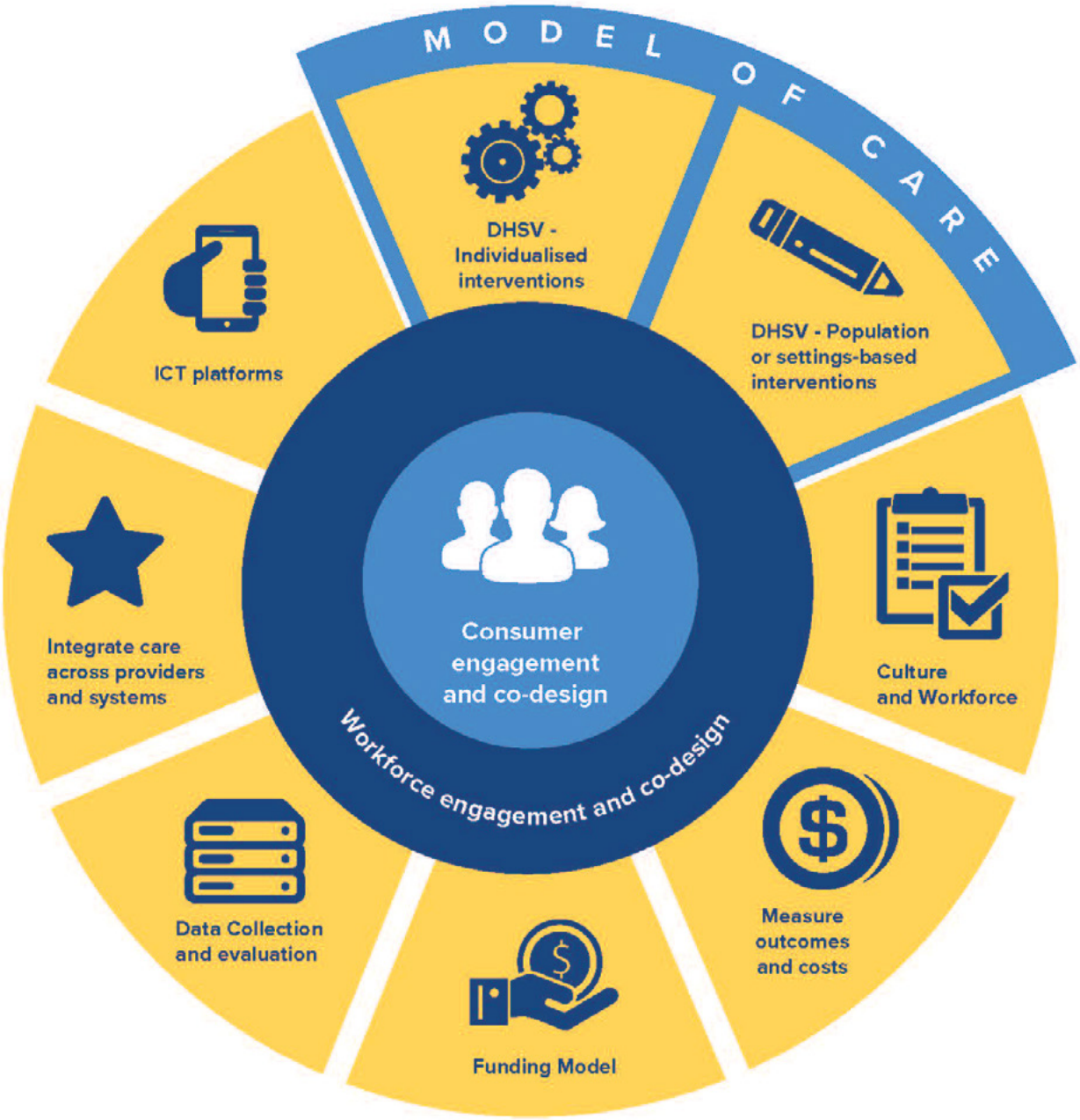
The model comprised eight key elements (see diagram) with consumer engagement and co-design being at the centre of the model.

THE FUTURE STATE

A trial of the new model began in October 2018 at RDHM with a focus on achieving:

Improved consumer access: Before consumers arrive at the clinic, they receive comprehensive information so they know what to expect and where to go. Their care is coordinated and efficient, respectful of their culture and language, and they have control over what happens to them.

Comprehensive assessment: Consumers spend time being educated on how they can best improve their oral health. All information



is easy to understand and preferably provided in their language. We collect information on the health outcomes that matter to them and use the information to design their care plans.

Co-production of the care plan: Consumers are involved in the development of their dental care plans. Everyone's responsibilities, goals and timeframes are clear. Consumers feel supported by their families and carers, and receive accurate information when asking questions.

Education and care for better health: Consumers are better informed about their health and what they can do to improve it. All oral health care is evidence-based and focuses on maximum prevention as well as minimal and early intervention.

Preventive practice: Our prevention efforts are population-based and place-based. Modifiable risk factors are addressed prior to treatment commencing, and we only focus on interventions that improve health outcomes.

Enabling technology: We use technology to make life easier for our consumers and staff. Digital radiography is available, and all patient information is electronic. We use artificial intelligence to help in our decision-making.

Patient-centred care: We offer flexible appointments where all members of the family can be seen at the same time. We work in partnership with families to implement healthier choices and better dental hygiene practices.

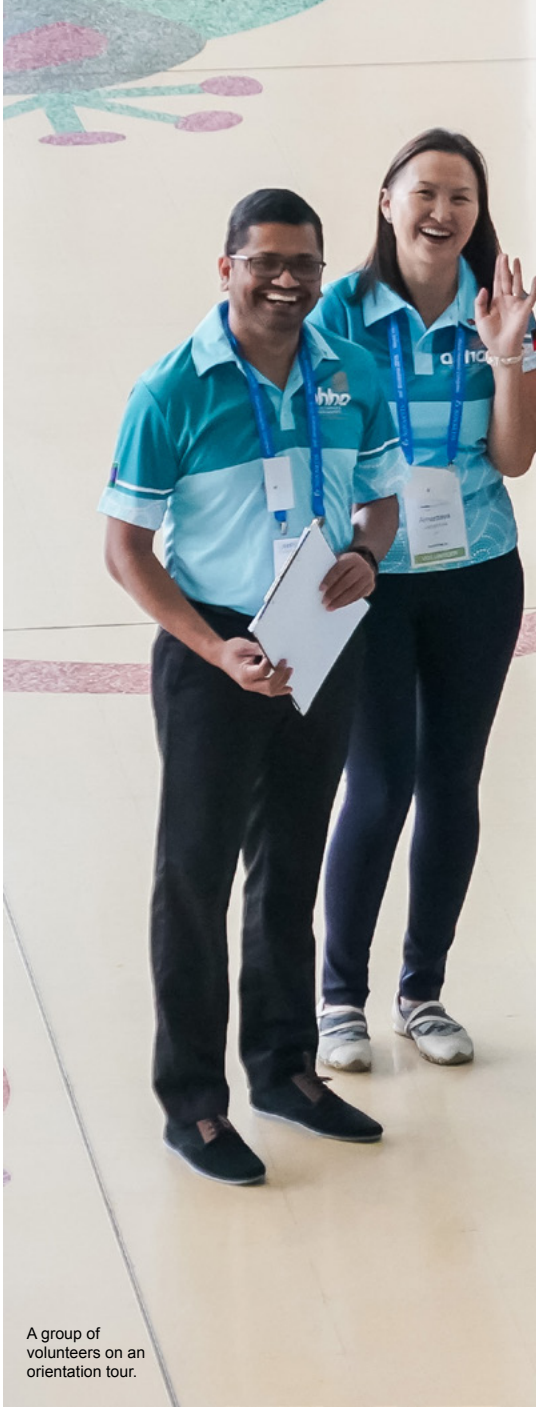
Engaged staff: Staff feel empowered to improve the way we do things, and understand what we are trying to achieve. All members of the dental team work to their full scope of practice, with a passion for patient safety and improving health outcomes.

Our new model of care will continue to evolve, but we will continue to keep the goal in sight—creating an oral health system that improves the health outcomes that matter to patients so they can live happier and healthier lives. ha

The 'Introducing value-based healthcare in the oral health sector' project was a finalist in the 2018 International Hospital Federation (IHF) Awards and won a Gold citation in the IHF/Dr Kwang Tae Kim Grand Award.

NATASHA ROBERTS
PhD student, School of Public Health and Social Work, Queensland University of Technology

Volunteering at the World Hospital Congress 2018



A group of volunteers on an orientation tour.

I am a PhD student in the School of Public Health and Social Work at the Queensland University of Technology. As a stroke of luck I received an email calling for volunteers to assist at the World Hospital Congress 2018, here in my home town of Brisbane. I signed up immediately. This is a brief description of my experience.

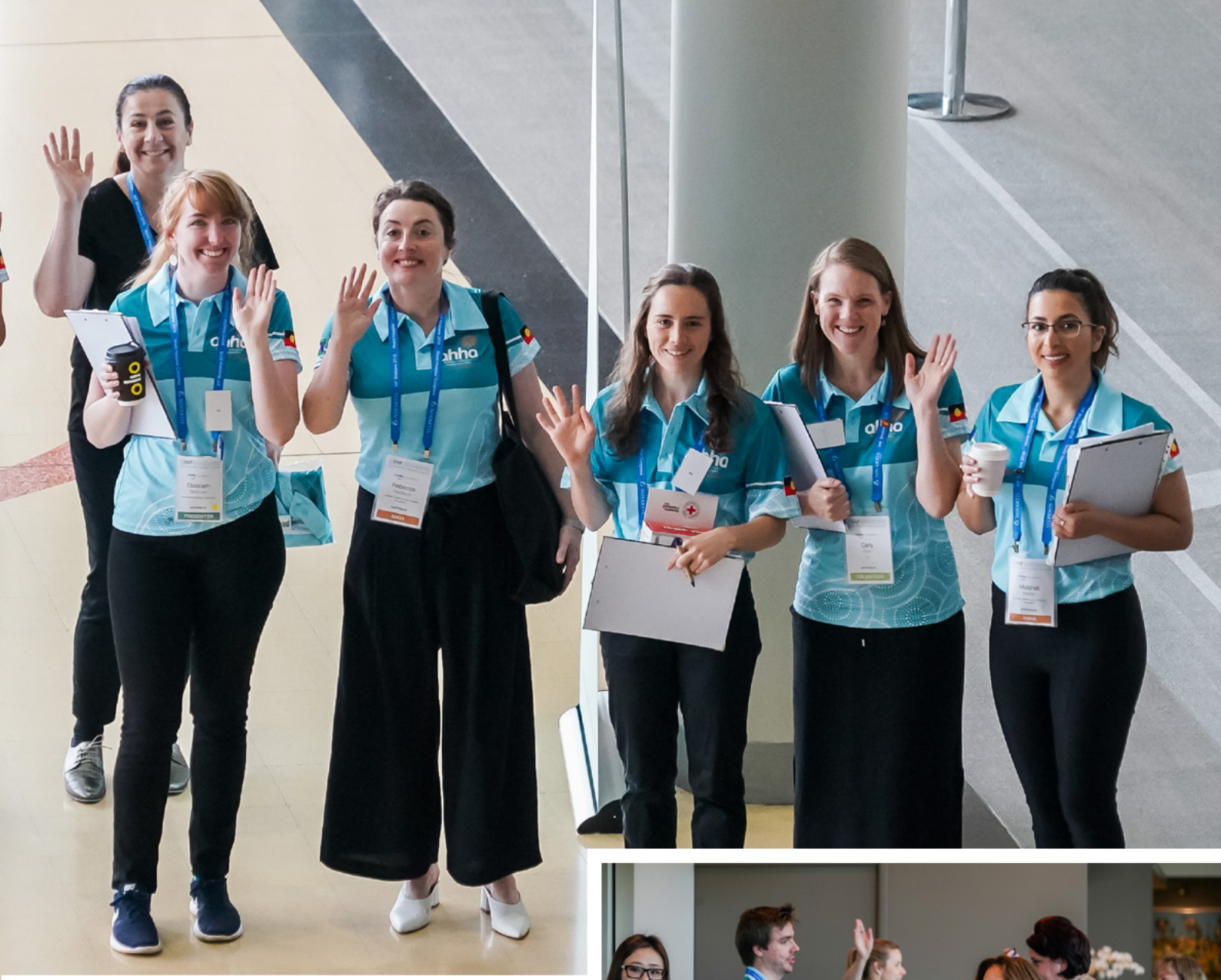
To be honest, I did not have many expectations of the conference. My knowledge about hospital health services was limited, and had been gleaned from clinical experience in hospitals over the years. Before attending the World Hospital Congress, I knew how to function within a hospital system, and what I needed to teach my patients to work the health system. That knowledge was usually only confined to where I worked, and usually limited to one department. But, I was becoming aware that I need to understand more. My PhD research project, a Phase IV intervention implementation, had been directing me to learn more about Health Services Research. It was these uneasy knowledge gaps that motivated me to volunteer.

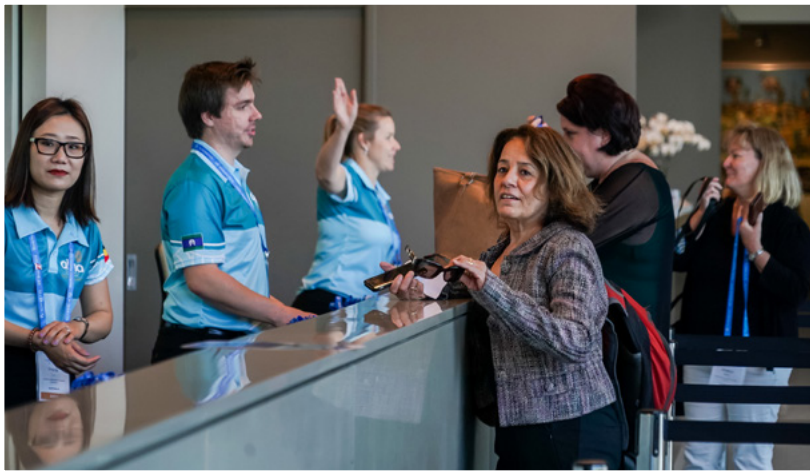
Day 1 was buzzing with energy. I was taken aback by the diversity of the delegates. It really reinforced that so many had travelled so far and wide to attend. We Australians are a long way from most places in the world. The privileged position of being able to attend really struck home. I felt quite proud walking up the stairs to take a seat with everyone. As I sat down, another student from the university saw me. We sat side by side smiling from ear to ear, the same thoughts in both our minds: 'I can't believe my luck'.

Both Day 1 and Day 2 delivered sessions that taught me something, that gave me an insight into our health system. I learnt why the system moves the way it does. I learnt what frustrates me about the system, and how it is universally recognised as requiring change. My compassion for patients and healthcare workers was acknowledged, as experts articulated the fragmented obstructive way we work while trying to provide the best care we can. I also came to understand how I can contribute to the improvements, that there is so much hope in the future. I got to talk to other student volunteers about their projects, and they asked about mine. Over the course of those two days, my muddled PhD brain slowly became clearer and clearer. I felt like I was getting a bigger picture of what my research is about and why I like working in healthcare so much.

My volunteering gave me a fresh new perspective. More sessions, but I had a chance to meet the other delegates, talk to them about my local health system, and hear about theirs. With pride I took a group of delegates up to the prayer room so they could pray. With pride I shared my notes so that a delegate had written answers to a question she had asked. With pride I went to the Aussie Sundowner drinks and helped people take photos with Australian animals. I was proud to be there because all of the delegates were so gracious and appreciative of every gesture to assist. It was very rewarding.

Before the Congress I was happily plodding along towards completing my PhD, largely working in isolation. Now I have a much bigger picture for my PhD. To understand the context of one's research feels like finding the gold at the end of the rainbow. For my research, this context is informed by the wisdom and research of experts like Professor Elizabeth Teisberg, Professor Jeffrey Braithwaite, Chris Pointon, and all the health services around the world, looking for the pieces of the puzzle that want to give the best to their patients. No wonder I feel so lucky, and proud. Thank you to AHHA for the opportunity. ha





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Recipient of AHHA/HESTA/Lowitja Institute

Early Career Health Professionals Scholarship

2018 World Hospital Congress.

"I was extremely moved by the talks about consumers' experiences of the health system when they were at their most vulnerable, and how they and those around them became strong advocates for patient-centred care. it was also heartening to see the positive impact of patient-centred care in their journeys through the medical system."

Jayden Nguyen

Jayden Nguyen recipient of an ***Early Career Health Professionals Scholarship***

Pictured L to R: Angela Damm, Jodi-Ann Jerard, Jayden Nguyen, AHHA Strategic Programs Director Chris Bourke and Cathy Davison

INTRODUCTION

Jayden Nguyen was one of four recipients to receive an *Early Career Health Professionals Scholarship* to attend the 42nd World Hospital Congress. This was made possible by the Australian Healthcare and Hospitals Association, HESTA Australia and the Lowitja Institute.

Jayden is of Aboriginal and Vietnamese heritage, with connection to the Narrungga community of Point Pearce, South Australia (from his grandfather's side) and Eastern Arrente, south-east of Alice Springs (from his grandmother's family).

Jayden works as a Research Assistant at the University of South Australia within the Wardliparingga Aboriginal Research Unit, South Australian Health and Medical Research Institute (SAHMRI). Jayden's work focuses on the health disparities of the South Australian Aboriginal community, in particular Type 2 Diabetes, in the South Australian Aboriginal community.

'Working as a Research Assistant over the past 2 years has given me the opportunity to learn and better understand approaches to Aboriginal and Torres Strait Islander health research', Jayden says.

'It has also given me exposure to the many social and health disparities that Aboriginal people are challenged with in their day-to-day lives, and how research can make a difference through addressing these social inequities for Aboriginal people and their communities.'

WHY I APPLIED FOR THE SCHOLARSHIP

There have been few opportunities for me to attend health conferences in this early stage of my career. I saw the *Early Career Health Professionals Scholarship* as an opportunity to experience an international conference for the first time. I was most interested to sit in on the topics of Indigenous Health, Health Economics and Health Technology. I was also eager to meet other professions both interstate and internationally, and hear their contribution to health agendas.

CONGRESS EXPERIENCES

I found the experience of attending the 42nd World Hospital Congress most valuable. To listen and watch how presenters, both local and international, handle public speaking gave me an idea of techniques I could adopt for the future.

I found interesting posters of delegates' work, and the Expo of Health Ideas and the Gala Dinner were fun experiences. It was inspiring as well as a great learning experience for me to hear how patient-centred care has made a positive impact in hospital operations for both consumers and providers.

I was extremely moved by the talks about consumers' experiences of the health system when they were at their most vulnerable, and how they and those around them became strong advocates for patient-centred care. It was also heartening to see the positive impact of patient-centred care in their journeys through the medical system.

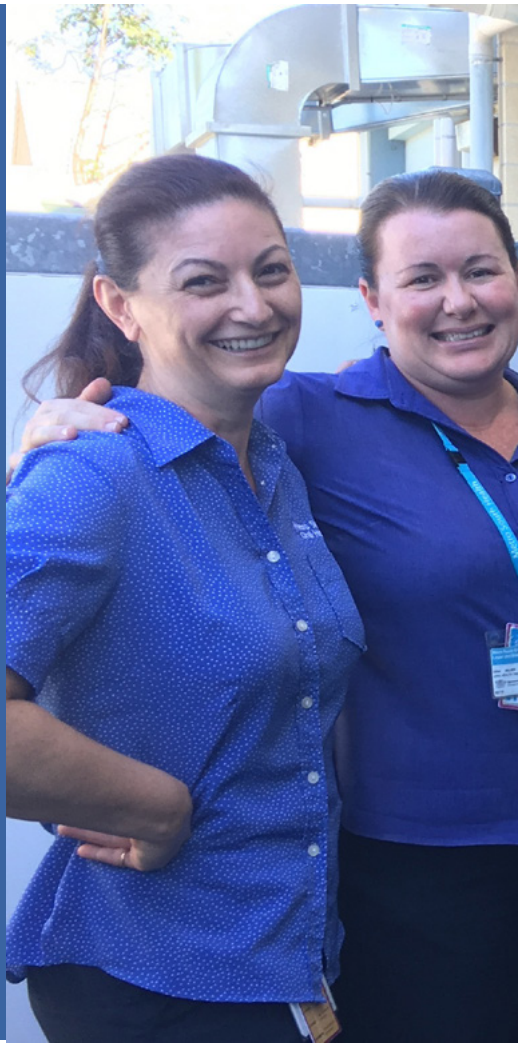
REFLECTIONS AND CONCLUSION

Attending the 42nd World Hospital Congress gave me a lot to reflect on. I thought of what would I personally would experience as a patient, and what I would advocate for as a consumer. As someone who aspires to build a career in the health industry, I was able to build on my understanding of the importance of listening to consumers and the impacts, both positive and negative, that can have on patients and their families.

The 42nd World Hospital Congress was a great opportunity to see health professionals come together and exchange ideas. The event far exceeded my already good expectations! I would like to thank Australian Healthcare and Hospitals Association, HESTA and the Lowitja Institute for this experience. ha

Improving access to oral health with a patient centred focus to a vulnerable community

Metro South Refugee Health Service and Metro South Oral Health Service, Queensland Health.



ACCESS TO ORAL HEALTH SERVICES FOR THE NEWLY-ARRIVED

Oral health care is identified as one of the primary health needs of people with a refugee or asylum seeker background on arrival in Queensland.

Due to past experiences, many newly arrived people have dental caries, while others report removing their own teeth due to untreated dental pain or infection. Many refugees and asylum seekers also experience long term physical and emotional issues due to displacement, trauma, torture, family separation and deprivation. These factors impact on past and future oral hygiene practices and the ability to seek and successfully receive dental care. Timely access to appropriate patient centred oral care is important as it significantly reduces the risk of other health issues.

Access to culturally safe and early preventative oral health services within Metro South Health for these clients required a review and revision of the existing model of care, to reduce barriers and timely access to care.

Previously our refugee and asylum seeker clients had to navigate through many obstacles and barriers, with many clients not aware of how to access care or if they were eligible for dental care.

IDENTIFYING ACCESS BARRIERS

After listening to community feedback from clients and support agencies (through the Refugee Health Network Queensland) a number of access barriers were identified.

Notably, access to the service and appropriate appointments via the usual pathway using the Oral Health Hub (Call Centre) created a significant barrier due to requirements to engage with the Hub verbally in English. Clients ability to access an interpreter to contact the Oral Health Hub on their behalf was reported as being problematic.

Not all clients who successfully navigated the Referral Hub pathway attended for care when an appointment was available, due to a change in their contact details/address and or correspondence with the service about upcoming appointments being sent in English.

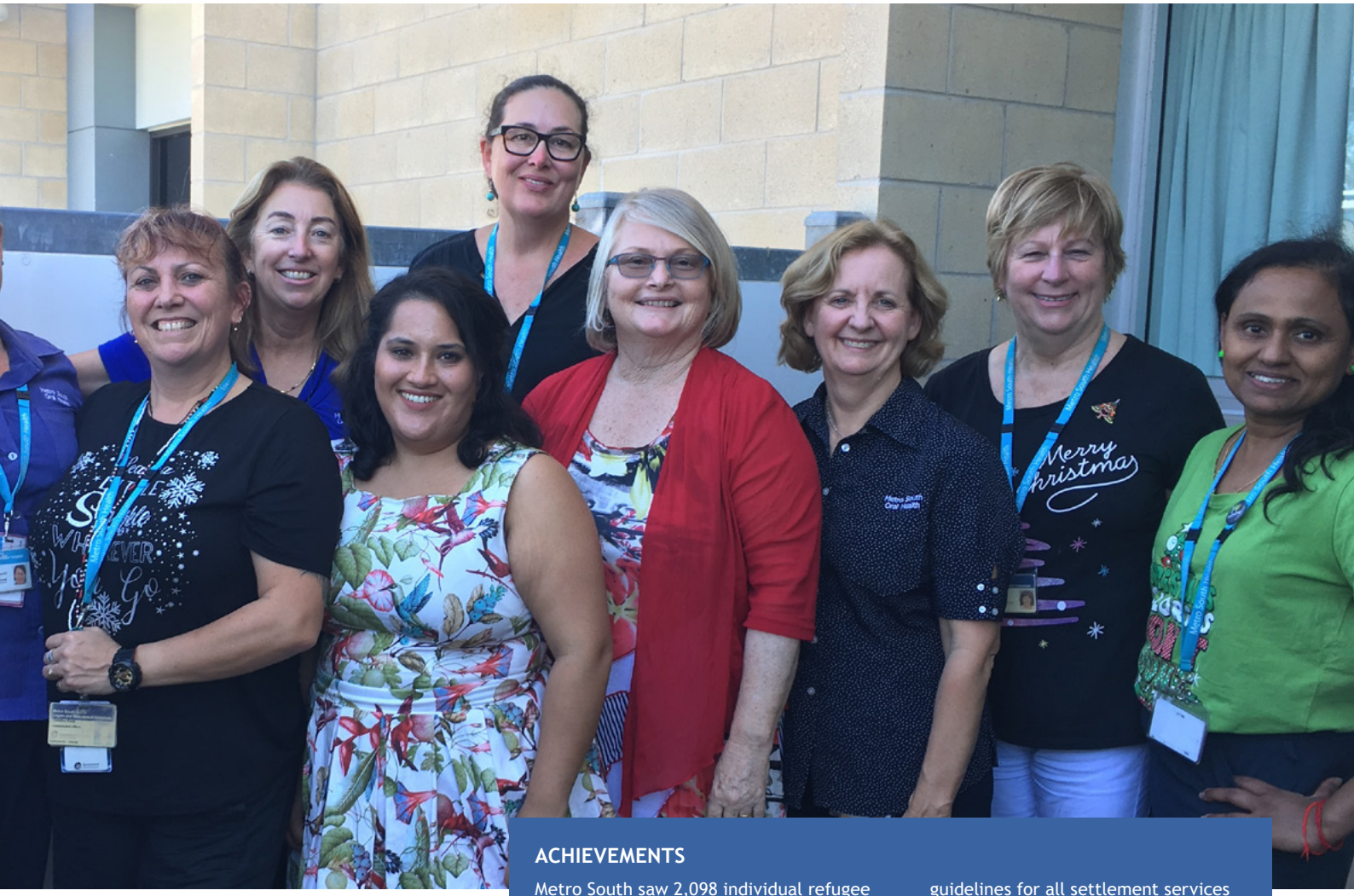
Other identified barriers were clients' health literacy, limited entry pathways, fear, lack of trust, and misperceptions of the service.

A NEW SERVICE MODEL

Working collaboratively, Metro South Oral Health Service (MSOH) and Metro South Refugee Health Service (MSRHS) have implemented a unified, innovative service model (the first in Queensland) enabling harmonious, inclusive, fair and safe access to timely and appropriate total health care for newly arrived refugees.

Initially, by just having a conversation, these two Metro South Health departments determined that incorporating oral health and general health into the existing nursing-led health assessment pathway for all newly arrived people would enable culturally safe care, reduce duplication and provide initial screening, triage and preventative dental care within 28 days of arrival.

Before 2016, MSOH had over 700 refugee and asylum seeker patients waiting over a year for their initial dental appointment—now



The Metro South clinical team delivers oral health services to refugees and asylum-seekers.

all clients are seen within an acceptable time frame to commence their dental care.

Refugee and asylum seeker patients are eligible for dental care at Queensland Health (QH) dental clinics within 12 months of arrival (Queensland Health policy). This new model of care is an early access preventive screening program and combines oral health and general health care. An Oral Health Therapist works alongside the nurse-led multidisciplinary team at the MSRHS to enable quality health outcomes for these vulnerable families. This partnership approach has been instrumental in connecting consumers to culturally safe, timely and accessible oral health care. ha

The 'Improving access to oral health with a patient-centred focus to a vulnerable community' project was a finalist in the 2018 International Hospital Federation (IHF) Awards and won a Merit citation in the IHF/Bionexo Award for Corporate Social Responsibility.

ACHIEVEMENTS

Metro South saw 2,098 individual refugee clients, or 65% of the State total of 3,246, between March 2016 and March 2018.

Key elements of success and achievements in improving access to oral health care for this vulnerable population included:

- delivering a family-centred model of care
- establishing wider links with primary health care providers, community services, settlement services and NGOs (Tzu Chi Foundation, Access Community Services, Mater Refugee Health Service, Multicultural Development Association, Red Cross, Metro South Primary Health Networks and NSW Refugee Health)
- holding three Dental Fairs seeing over 400 patients, with the Fairs including community education on accessing oral health and building health literacy.
- reducing confusion with, and barriers to, accessing care
- establishing an oral health link on the Refugee Health Network Queensland website
- developing an access pathway and guidelines for all settlement services
- establishing new referral pathways for asylum seekers and other non-Medicare eligible arrivals
- developing a triaging tool, so patients care be risk-assessed and have access to the most appropriate and timely oral health care
- a strengthened and culturally sensitive workforce
- developing and sharing oral health promotion resources across government and non-government agencies
- develop a suite of patient education and information sheets translated into multiple languages
- instigating the Queensland Refugee Oral Health Working group—ensuring the sustainability and sharing of successes across the state
- aligning the model of care with the Queensland Multicultural Charter
- contributing to the Queensland Refugee Health and Wellbeing Policy and Action Plan 2017-2020.
- sharing the new referral pathway, tools and resources at both state and national levels.

SUSAN FREIBERG
Facility Manager, Redland Hospital and Wynnum-Manly Community Health Centre

A smartphone and Internet-based interactive system to support the management of women with a first time diagnosis of Gestational Diabetes Mellitus

AIMS AND GOALS

To provide women with gestational diabetes a technology-based solution to monitor and manage their Gestational Diabetes Mellitus.

GESTATIONAL DIABETES MELLITUS

Gestational diabetes mellitus (GDM) is a condition that occurs during pregnancy for some women. Hormones produced during pregnancy may lead to insulin resistance resulting in higher than normal blood glucose levels. GDM is becoming more common in Australia with known risk factors including: increasing maternal age, maternal obesity, ethnicity, previous diagnosis of GDM, Polycystic Ovarian Syndrome, early testing and lower diagnostic criteria. In Australia, GDM now affects around 10% of pregnancies but can occur in up to 30% in high-risk populations.

THE PROBLEM

GDM is associated with an increased risk of complications in pregnancy and birth, as well as a greater likelihood of mother and child developing type 2 diabetes later in life. There have been huge advances in the knowledge about the management and treatment of GDM and the importance of a healthy lifestyle in keeping gestational diabetes and its complications under control. Scientific evidence is beginning to show that controlling glucose levels can result in less serious foetal complications (such as macrosomia) and increased maternal quality of life.[1] However, due to the dwindling economic resources allocated to health services, access to specialised healthcare facilities is becoming more difficult.

In addition:

- An increasing number of pregnant women are diagnosed, which leads to increasing numbers in clinics.
- Health care costs are increasing: costs of outpatient visits to primary and secondary care, cost of inpatient hospital care before and after delivery, the use of insulin, delivery costs and baby's stay in the neonatal intensive care unit.[2]
- It is often inconvenient for pregnant women to travel to a clinic living far away, or with no independent means of transportation, or needing to rest to avoid preterm delivery.[1]
- This leads to poor attendance and adherence.[3]
- Diagnosed individuals need to closely monitor their blood glucose levels multiple times during the day, to see if their levels are on target.

THE SOLUTION

Leveraging from a validated design that links post heart attack patients to clinicians throughout a cardiac rehabilitation program[4], an innovative platform comprised of a smartphone app and web portal was developed. Known as MoTHer, it will support women with GDM through their gestational period. The MoTHer platform is designed to improve the health and quality of life for women with GDM, but it will also reduce costs to the health system by enabling clinicians to provide more timely interventions when deteriorating health is detected.

The smartphone app accompanies and guides women with GDM through every step of their gestational period by monitoring

Gold citation in the IHF/Austco Excellence Award for Quality and Safety in Patient-Centred Care. L-R: Chris Power, Francisco Balestrin, Wendy Dutton, Susan Freiberg, Lawrence Lai and Satoru Komatsumoto

The 'Gestational Diabetes Mellitus App and Interactive Clinician Portal (Internet Based)' project was a finalist in the 2018 International Hospital Federation (IHF) Awards and won a Gold citation in the IHF/Austco Excellence Award for Quality and Safety in Patient-Centred Care. It also won the 2017 Health Round Table Innovation award for improving self-care and the 2018 MSH Board Chair's Award for innovation through digital technology.

health measures, delivering simple interactive questionnaires and provision of educational multimedia content. The web-portal enables clinical care providers to view their client's progress and provide individualised feedback and/or early care intervention. Functional requirements and features for both the app and portal have been developed from workshops with clinicians and client representatives as part of the user-centred design process.

After being diagnosed with GDM, clients can monitor symptoms and health indicators such as blood glucose level, dietary intake, body weight and exercise through the smartphone app. When women take their blood glucose levels (BGLs) via finger prick testing, the results from their glucose monitor can upload automatically, via Bluetooth, to the app on their smartphone. The entries on the app will be automatically updated to the web portal, whereby clinicians can view the results during clinic or multi-disciplinary team reviews. The app provides visual (graphical) and textual progress reports, and motivational messages and information to assist individuals in the management of their GDM.

This project has brought together the Metro South Hospital and Health Service (MSHHS) and Australian e-Health Research Centre (AEHRC) at CSIRO, who have devised an engaging platform to meet the needs of GDM clients and their clinicians. CSIRO engineers built a smartphone app (Android and iOS), and a web portal, which has now been evaluated through a small pilot study, to ascertain levels of program efficacy, successful health-related outcomes and user satisfaction.[5] ha

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A Pharmacist-led, Hospital-based Opioid Stewardship Service

L–R: Benita Suckling (Senior Pharmacist), Margaret Walsh (Clinical Nurse), Angela Schweikert (Clinical Nurse) and Dr Jeff Mott (Acute Pain Consultant Anaesthetist)

The collaboration between Redcliffe Hospital's Acute Pain Service and Opioid Stewardship Service has provided positive results for patients.

The Opioid Stewardship Service (OSS) at Redcliffe Hospital is a pharmacist-led program that works closely with the existing Acute Pain Service (APS) to address issues of opioid safety, and appropriate use and misuse within the hospital and local community.

The OSS has initially been focused on improvement for patients in Surgical and Orthopaedic wards at our 250-bed outer-metropolitan hospital. It was initially funded through a February 2017 innovation grant from Metro North Hospital and Health Service.

WHAT IS OPIOID STEWARDSHIP?

Opioid use and associated adverse events (including deaths) are increasing in Australia and internationally. Many patients have their first opioid prescribed in a hospital setting, and as many as 10% of previously opioid-naïve patients are still using an opioid medication one year after low-risk surgeries.[1]

Further, each additional week of post-surgical opioid supply increases the risk of overdose or misuse by 20% for opioid-naïve patients.[2]

Hospital rates of incidents and admissions at Redcliffe Hospital coded as related to opioids were higher than in other benchmarked hospitals, and were a catalyst for action at our hospital.

Our objective has been *to implement a service that identifies and addresses safety concerns associated with opioid use within the hospital, and supports dose reduction and discontinuation after discharge.*

The Service at Redcliffe hospital therefore aims at *Optimising analgesic selection, dosing, route, and duration of therapy to maximise a patients' pain management and function while limiting the unintended consequences, such as the emergence of dependence, adverse drug events, and cost.*

This is achieved through three key aspects of care delivered by a multi-disciplinary Pharmacist-Clinical Nurse team, in collaboration with the Acute Pain Service:

1. Inpatient review—Doing hospital rounds with the Acute Pain Service and providing clinical review, promoting the provision of discharge plans and communication between teams, and obtaining referrals for outpatient follow-up.

2. Outpatient follow-up—Providing review of discharged patients by phone or in person to ensure pain and analgesic side-effects are managed and to opportunistically promote de-escalation with the patient and General Practitioner

3. Quality improvement and education—Reviewing incident reports and undertaking audits in order to plan and provide targeted education and quality improvement activities to nurses, pharmacists and medical staff.

From the outset of the Service, an intervention to promote appropriate APS documentation of discharge plans to reduce and discontinue opioids has been a priority.

To assess the effect of this intervention, a review of patient charts (25 pre- and 25 post-intervention) has also been undertaken to assess the presence of, and compliance with, APS discharge recommendations. The average number of immediate-release oxycodone 5mg tablets prescribed on discharge was reviewed pre- and post-intervention in the Orthopaedic and Surgical wards has also been reviewed pre- and post-intervention. In both measures, a statistically significant improvement was achieved.

Beyond this intervention, incident reports are consistently reviewed to identify trends and target education and training scenarios for Pharmacists, Nurses and Medical Staff.

CHALLENGES AND INCIDENT THEMES

Challenges and incident themes were identified through the project and have included:

- Incomplete and error-prone documentation and monitoring of analgesic patches
- Identification and management of opioid-induced constipation
- Under-identification and management of opioid tolerant patients
- Selection errors with sound-alike drugs, different formulations, error-prone storage within safes
- Mismatch between APS plans and actual discharge prescriptions (communication)
- Cultural change required around the provision of analgesia on discharge

To date, these challenges have been targeted with a variety of practical scenario-based or in-service education for nurses, pharmacists and doctors across Medical, Surgical, Orthopaedic, Maternity, and Anaesthetic service lines. Quality improvement activities are also underway in the Emergency and Day Procedure Units, the organisation of medications within Controlled Drug safes is being reviewed, and guidelines for practice around opioids is being researched and discussed among relevant stakeholders.

RESULTS SO FAR

Overall, it seems a Pharmacist-Led Opioid Stewardship Service is an innovative and dynamic approach to identify and address the risks of opioid use within the hospital and at transitions of care. The Service has already begun to change trends in opioid prescribing on discharge, and provide targeted interventions around the challenges which have been and continue to be identified. The experiences gained through the implementation of the Service may serve as a blueprint or opportunity for collaboration on such a service at other hospital sites. ha

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The 'Pharmacist-led Hospital-based Opioid Stewardship Service' project was a finalist in the 2018 International Hospital Federation (IHF) Awards and won a Merit citation in the IHF/Austco Excellence Award for Quality and Safety in Patient-Centred Care.

IRONing out Maternity Blood Management

In 2015, the National Blood Authority released its *Patient Blood Management Guidelines Module 5: Obstetrics and Maternity*. Concern about inappropriate or unnecessary use of transfusions has driven renewed research and efforts to conserve a patient's own blood. The guidelines include information on how to maximise a woman's haemoglobin at the time of delivery to reduce reliance on transfusions.

Canberra Hospital and Health Services (CHHS) identified a gap in maternity blood management—namely, in antenatal detection and management of Iron Deficiency (ID) and Iron Deficiency Anaemia (IDA). Together with the Australian Red Cross Blood Service, CHHS commenced a Clinical Practice Improvement (CPI) project to fill this gap.

After initial success at CHHS, the Blood Service subsequently partnered with the Women's and Children's Hospital (WCH) in Adelaide and the Darling Downs Hospital and Health Service (DHHS) in Toowoomba to run similar projects tailored to respective local conditions.

THE PROBLEM WORTH SOLVING

Anaemia (low red cell count or haemoglobin levels) is at one end of the spectrum of iron deficiency, and is routinely screened for through measuring haemoglobin levels. Iron deficiency without *anaemia* is three times as common as iron deficiency anaemia, but there is no standardised guidance available for establishing lack of iron stores through testing blood ferritin levels.

Baseline data across the three hospitals showed that anaemic (Hb≤110 g/L) maternity patients were up to 6 times more likely to receive a red cell transfusion following delivery compared with non-anaemic patients.

Subsequent data analysis demonstrated that iron deficiency during the first trimester of pregnancy correlated with lower haemoglobin at delivery.

Therefore, it was important to not only identify women with IDA and ID, but also provide a standardised method to increase the use of iron therapy to treat the iron deficiency.

The key interventions were:

- development of a standardised algorithm for patient haemoglobin and ferritin levels, for use in antenatal clinics
- development of a patient information handout on recommended oral iron
- maternity staff education on using Clinical Practice Improvement tools
- a telephone audit of women diagnosed with iron deficiency to assess awareness and the utility of the patient information handout.

A POSITIVE OUTCOME

In each project, a target was set, e.g. *'To optimise antenatal haemoglobin levels and iron stores in 80-100% of women who have their first visit at ≤20 weeks'.*

Key data were collected and correlated with the interventions, including patient haemoglobin and ferritin levels, red cell transfusions, and staff and patient feedback.

The algorithms provided staff with guidance and a consistent approach that enabled them to become confident in ferritin result interpretation and management of ID and IDA.

Jodie Grech, BloodSafe Transfusion Nurse Consultant at WCH said, 'It's important to promote and provide education to all clinicians on the impact of iron deficiency on women and babies; it's also important to convey this to the women in a consistent manner'.

During the pilot periods, haemoglobin and ferritin requests increased at all hospitals. Overall, two in every three women screened for ferritin had iron deficiency. With a 95% compliance rate for oral iron therapy, the intrapartum rate of anaemia reduced. In turn, this reduced the number of transfusion episodes.

Along with the implementation of a hospital-wide single-unit transfusion policy, CHHS managed to reduce usage by nine units per month. ('Single-unit transfusion' refers to a standard dosing scheme of one unit [around 525 mL] of red blood cells, platelets or plasma in the non-bleeding patient, followed by an assessment of the patient.)

A clinical practice improvement project to improve detection and management of iron deficiency and anaemia in pregnant women A clinical practice improvement project to improve detection and management of iron deficiency and anaemia in pregnant women. **Australian Red Cross Blood Service**

Pixabay

The initial CHHS project has already gained recognition through several awards, including:

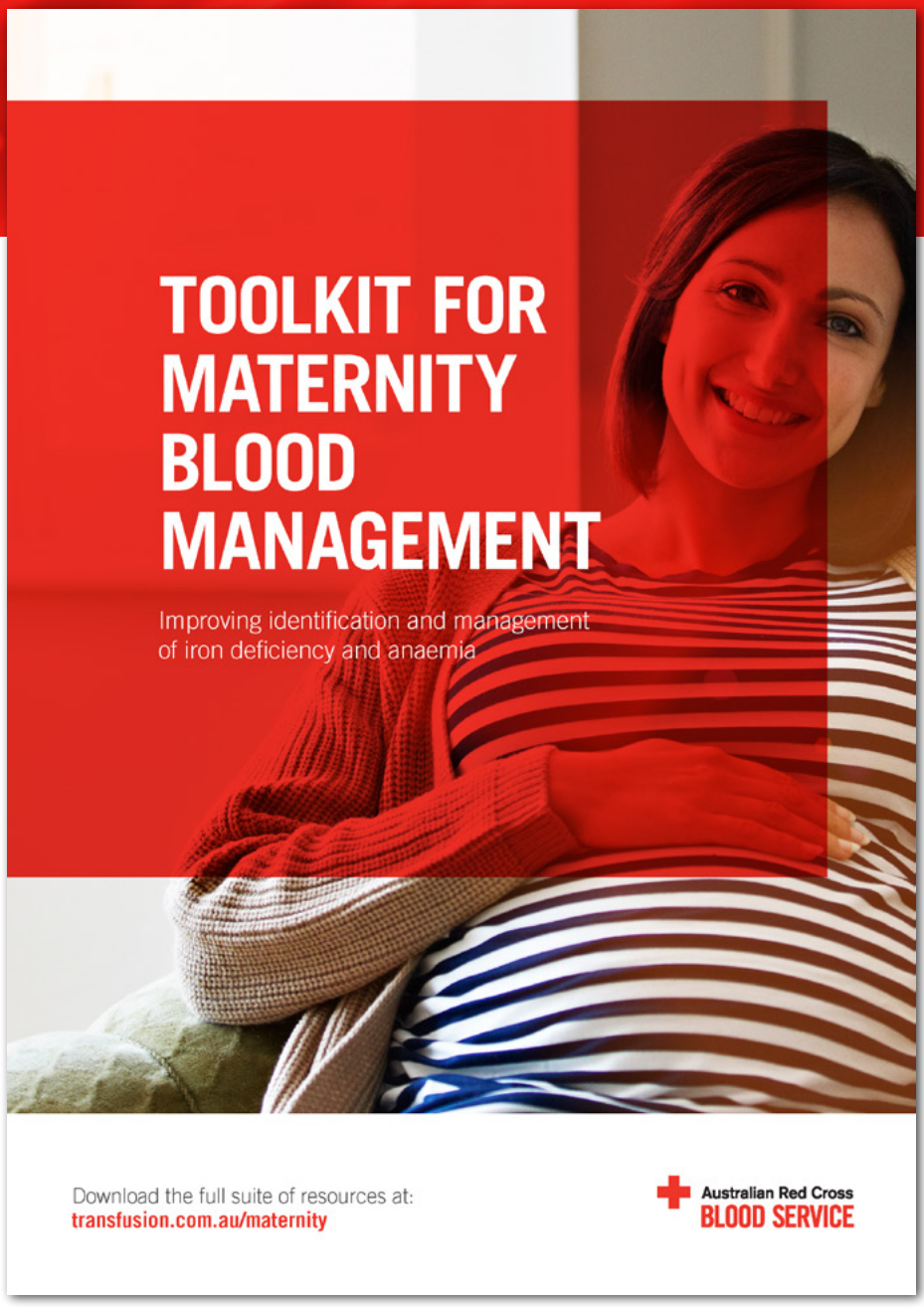
- Winner—2015 Society of Obstetric Medicine of Australia and New Zealand President's Award (Dr B Stephens)
- Finalist—2016 ACT Public Service Awards for Excellence (CHHS Maternity Blood Champions)
- Winner—Innovation, The Health Roundtable June 2016 (Dr P Crispin)
- Winner—2016 Australian New Zealand Society of Blood Transfusion Presidential Symposium for best oral presentation—The Presidential Award (Dr C Flores).

The practice improvement has now been embedded in all three pilot project hospitals.

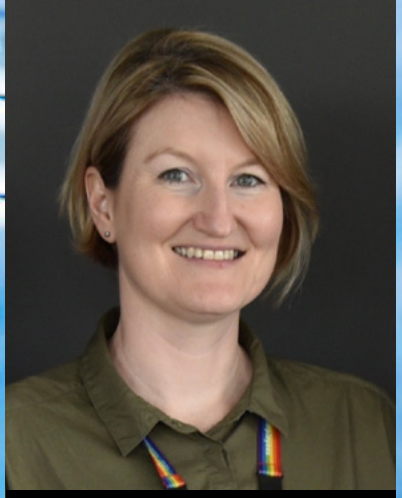
Following successful results, a *Toolkit for Maternity Blood Management* has been produced that includes proven change strategies and practical tools to support clinical practice.

The toolkit is available at transfusion.com.au/maternity for other institutions across Australia to adopt and use to improve blood management in pregnant women. ha

The 'IRONing out Maternity Blood Management' project was a finalist in the 2018 International Hospital Federation (IHF) Awards and won a Merit citation in the IHF/ Austco Excellence Award for Quality and Safety in Patient-Centred Care.



ASSOCIATE PROFESSOR STEPHEN STATHIS
Medical Director Child and Youth Mental Health Service, Children's Health Queensland Hospital and Health Service (CHQ HHS)



OLIVIA DONAGHY
Team Leader, Lady Cilento Children's Hospital (LCCH) Gender Clinic and Statewide Service

Developing a statewide Child and Adolescent Gender Clinic

The importance of patient, parent/carer and community engagement.

Lindsay Henwood

PRIORITISING THE NEEDS OF A VULNERABLE POPULATION

Increasing visibility and social acceptance of gender diversity in Australia means more children and adolescents are presenting to specialist healthcare services seeking gender-affirming psychological and medical treatment. Queensland's Department of Health prioritised the needs of this vulnerable population in the 2016 Mental Health Connecting Care to Recovery Plan and Sexual Health Strategy, with recurrent funding to establish the first statewide paediatric service in 2017.

The TransPathways study of youth and their parents living in Australia1 reported high rates of co-occurring mental illness in transgender young people, including depression (74%), anxiety (72%), high rates of self-harm (79%) and attempted suicide (48%).

Suicidal thoughts and behaviours are high due to body dysphoria (unease, dissatisfaction or stress with one's body) and a culmination of experiences of transphobia, abuse, exclusion or prejudice, together with common life stressors experienced by all young people.[1]

Increasing evidence shows that with timely, specialist, gender-affirming care during childhood and adolescence, harms can be ameliorated, and mental health and wellbeing outcomes significantly improved.[2]

LADY CILENTO CHILDREN'S HOSPITAL GENDER CLINIC AND STATEWIDE SERVICE

The aim of the Lady Cilento Children's Hospital (LCCH) Gender Clinic and Statewide Service is to optimise the mental health, wellbeing and function of Queensland children and young people experiencing challenges in the area of gender identity through coordinated, family-focused, multidisciplinary assessment and care.

As the statewide hub for paediatric gender healthcare, the Service works to promote wellbeing through adopting internationally recognised practice guidelines and focusing on the strong protective impact of parental support in mental health outcomes in this population.

Patient safety and quality is a key commitment of the Children's Health Queensland Hospital and Health Service (CHQ HHS) and the development of the Service provided the opportunity to put into practice key principles that underpin safe, timely, effective and appropriate patient centred care.

The meaningful inclusion of the voice of transgender children and their parents/carers has been critical in the evolution of the Service. A Trans community development worker was engaged for a three-month community consultation project to form focus groups with parents of gender diverse children and young people on the model for the Service. Consultation also occurred with community paediatric transgender interest group of general practitioners, community health workers and Transgender advocates. This resulted in a short video to inform pathways to care and help reduce anxiety for new families on our website. At the Service's inception, patients wrote interview questions and sat on interview panels for staff recruitment.

RESULTS

Since its commencement, the Service's reach has exceeded expectations. Despite a 126% growth in referrals, specialist outpatient waiting times have been reduced from over 17 months to 3 months for adolescents. Young people previously waiting over a year for an initial appointment, and who may have developed irreversible secondary sex characteristics, now have access to timely treatment. Given the Service also identifies and treats co-occurring mental illness, such interventions have also contributed to a reduction in mental health morbidity in this vulnerable population.

The Service's success in patient engagement has led to meaningful partnerships from the service's inception, and the evolution of a diverse range of projects, support groups and advisory roles, as well as direct engagement in the way that clinical services are delivered. A bi-monthly Parents' Support Group uses teleconferencing to reach rural and regional parents across Queensland. The group creates opportunities for social and emotional support and connection amongst families, helping to enhance the health outcomes for their children. Ongoing community partnerships has therefore enabled the Service to have greater reach and impact on reducing social determinants of health such as social isolation, discrimination and familial attunement.

EVALUATING EFFECTIVENESS

There is limited published evidence regarding the efficacy, safety, and quality-of-life impact of gender-affirming treatment in adolescence. To evaluate effectiveness in achieving better health and life outcomes, measurements of improved health outcomes has been integrated into all assessment and treatment protocols since the Service commenced.

The Gender Mapping Study (GeMS) seeks to longitudinally follow children and adolescents treated at the LCCH Gender Clinic and Statewide Service, and has collaborated with other Australian gender clinics with a view to a national cohort study.

This study will document the characteristics of gender diverse young people, and report on psychosocial wellbeing and endocrine care delivered within the Service with internationally recognised psychometric measures derived from synthesis of best practice international guidelines. The study was established following consumer consultation, to ensure respectful and ethical use of data and exploration of research questions that are relevant and meaningful to people who identify as Transgender. ha

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1. Strauss P, Cook A, Winter S, Watson V, Wright Toussaint D & Lin A (2017). Trans Pathways: the mental health experiences and care pathways of trans young people. Summary of results. Perth: Telethon Kids Institute.

2. Hidalgo MA, Ehrensaft D, Tishelman AC, Clark LF, Garofalo R, Rosenthal SM et al. (2013). The Gender Affirmative Model: what we know and what we aim to learn. Human Development 56:285–90.

The 'Developing a statewide Child and Adolescent Gender Clinic' project was a finalist in the 2018 International Hospital Federation (IHF) Awards and won a Merit citation in the IHF/ Austco Excellence Award for Quality and Safety in Patient-Centred Care.

MICHELE SMITH
Executive Manager, Aged and Community Care - Brisbane North Primary Health Network

Older people benefit from medical outreach trial

Better healthcare for acutely unwell aged care residents in Brisbane North.

Geriatrician-led medical outreach to residential aged care facilities (RACFs) has been shown to improve quality of patient care and dramatically reduce preventable Emergency Department presentations and hospitalisations.

The Geriatric Outreach Assessment Service (GOAS) model-of-care was trialled over 12 months at 24 RACFs in North Brisbane within the Prince Charles Hospital catchment.

Brisbane North PHN contributed Australian Government funding to cover approximately two-thirds of trial funding, with Metro North Hospital and Health Service providing the balance.

The project team included a part-time geriatrician, a full-time registrar, two clinical nurses and an administration officer, with support from an external service facilitator and clinical nurse consultant.

Cross-sector collaboration across aged care, primary and secondary care, was key to the successful design, planning and implementation of the GOAS.

RESULTS BY THE NUMBERS

The evaluation found the GOAS treated 744 acutely unwell RACF residents and potentially prevented 638 emergency department presentations.

Over the life of the pilot project, the team provided 960 episodes of care (an average of four episodes per day) in total.

The average length of stay for residents of in-scope RACFs who were hospitalised was 1.68 days, compared with 2.3 days for out-of-scope RACFs, a reduction of 0.62 days.

The GOAS also managed to win overwhelming support among the aged care residents and staff involved.

Results from more than 1,700 survey responses showed the GOAS had improved quality of care for RACF residents, with 98% of consumers likely to recommend the service to others.

These and other survey results confirm that GOAS provides responsive, high quality and person-centred medical care at the right time and in the right place.

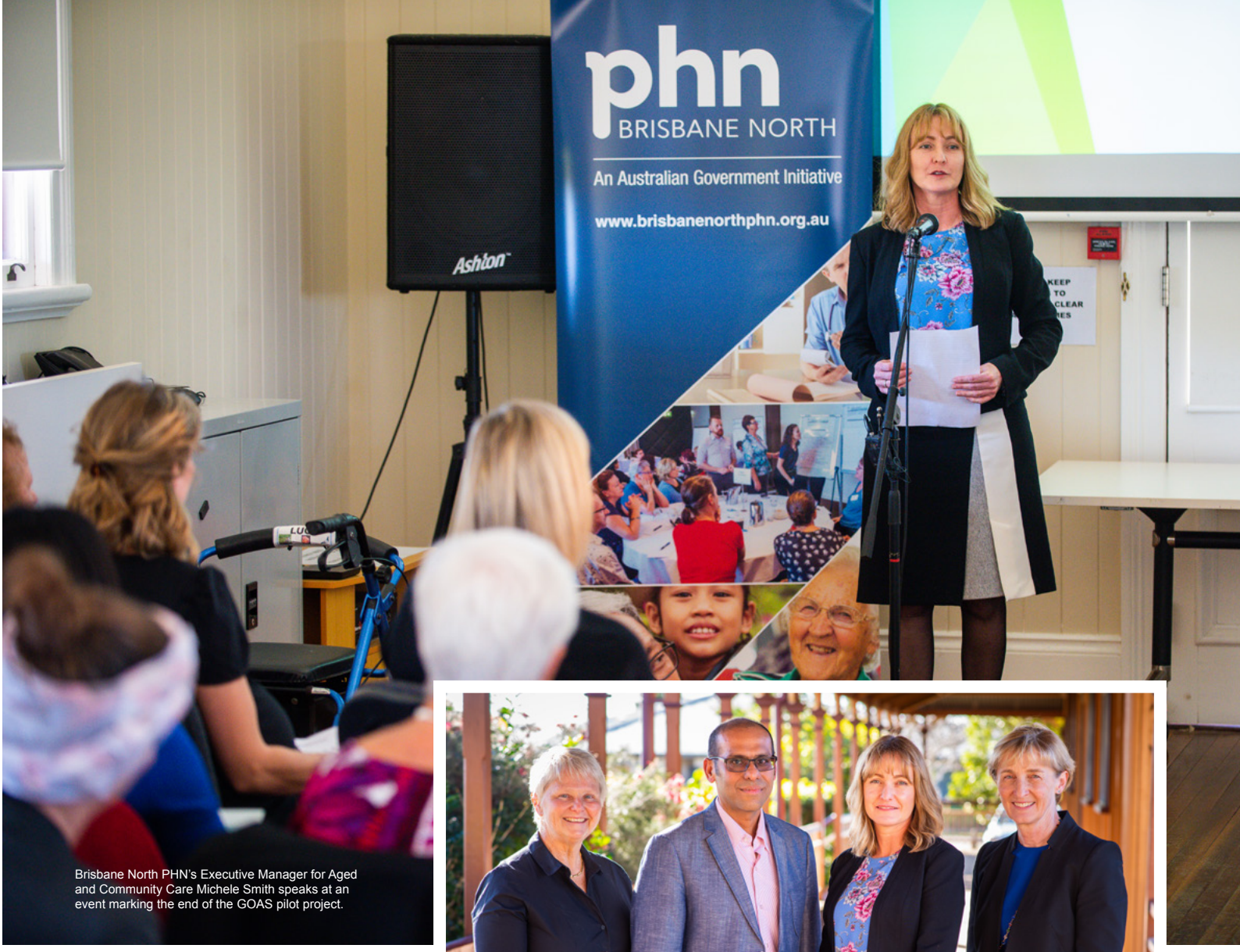
Among other evaluation findings:

- 24 in-scope RACFs within the TPCH catchment showed a declining trend in inpatient hospital admissions compared to out-of-scope RACFs
- Emergency Department presentations by residents of in-scope RACFs remained stable, despite an increase in available RACF beds within the catchment area
- 71 per cent of GOAS episodes of care were same-day services and 91 per cent of episodes were seen by both a Registrar and a Clinical Nurse.

COST SAVING TO HOSPITAL

The evaluation also showed the GOAS model-of-care could save the Queensland Government up to $4 million a year.

Our analysis revealed that without the GOAS, it would have cost the Government



Brisbane North PHN's Executive Manager for Aged and Community Care Michele Smith speaks at an event marking the end of the GOAS pilot project.

At an event to mark the end of the GOAS pilot project were (L-R): Dr Anita Green (Board Chair, Brisbane North PHN), Dr Gurudev Kewalram (General Physician and Geriatrician, TCPH), Michele Smith (Executive Manager, Aged and Community Care, Brisbane North PHN), and Dr Elizabeth Whiting (Executive Director Clinical Services, Metro North HHS).

anywhere from $3.5m to $4.3m to treat the residents involved in this trial.

By comparison, our pilot project cost $746K, inclusive of set-up expenses, and we expect GOAS will cost just $464K per year to run on an ongoing basis.

According to Dr Elizabeth Whiting, Executive Director of Clinical Services at Metro North HHS, engagement at the interface between acute and aged care had been critical to project success.

'While more time is needed to assess the long-term effects of GOAS on acute care, surveys show a vast majority of aged care workers are now more confident in managing an acutely unwell resident', Dr Whiting said.

The GOAS team provided 417 training sessions on 22 clinical pathways to upskill the 3,019 aged care staff involved in the project.

NEXT STEPS

Dr Whiting has advised that Metro North Hospital and Health Service will continue to offer the GOAS as part of its Residential Aged Care Assessment and Referral (RADAR) Service, available between 8.00am–4.00pm weekdays (phone 1300 072 327).

Meanwhile, the evaluation has recommended an expansion of the GOAS across all hospitals in Brisbane North to ensure a regionally consistent approach to the provision of healthcare to unwell RACF residents.

Another recommendation from the evaluation is to apply a population health approach to the funding and provision of care of older people in all community and hospital settings to improve coordination and integration across the whole patient journey.

This is consistent with the key directions identified in the jointly agreed *Five Year Health Care Plan for Older People who Live in Brisbane North (2017-2022)*, available at http://bit.ly/2NlSDjW. ha

A summary report on the GOAS evaluation and the full 126-page report can be found at http://bit.ly/2Nl2cQc.

From the lab to the world

Cochlear implants, pacemakers, spray-on skin…Australia's medical scientists keep punching above their weight in transforming patient care through innovation.

And HESTA is supporting their life-changing work by investing actively in medical research, creating a better future for you, your industry and our community.

One of our private equity investment managers, Brandon Capital Partners, steers the Medical Research Commercialisation Fund (MRCF). The MRCF is a collaboration of 50 plus research institutes and hospitals in Australia and New Zealand focused on developing Australia's latest medical breakthroughs.

In a unique collaboration, the MRCF works with research institutes to identify promising medical discoveries that could be commercialised and translated into real-world products or treatments. The MRCF provides the funding and market know how to help researchers take their work from the lab to the world.

Brandon Capital Managing Director and MRCF Chief Executive Dr Chris Nave is a strong supporter of driving medical innovation to improve public health.

"The MRCF collaboration is innovation in action: we provide a path for taking medical science out of the laboratory and into the real world," Chris says. "We give elite medical researchers access to capital and commercial expertise, so they can turn great science into cutting-edge medical therapies that save lives and can improve quality of life."

NEW TECHNOLOGY FOR PARKINSON'S PATIENTS

A standout venture within the MCRF portfolio is Global Kinetics Corporation (GKC), a medtech company providing point-of-care measurement and reporting of Parkinson's disease motor symptoms. Their lead product, the Parkinson's KinetiGraph (PKG)™ system, empowers neurologists and healthcare providers to better manage patients' symptoms, improving their quality of life. To date more than 25,000 PKG patient reports have been delivered around the world. GKC is headquartered in Melbourne, with offices in London, UK, and Minneapolis and Boston, USA.

Developed by the Florey Institute of Neuroscience & Mental Health's Professor Malcolm Horne and Dr Rob Griffiths right here in Australia, the PKG™ is worn on the patient's wrist, so symptoms can be monitored continuously whether they're at home or out and about.

That data informs clinical decision making, revealing deep insights into patients' disease status, enabling care teams to tailor specific therapies that can result in life-changing benefits. The device is a ground breaker in tackling Parkinson's, the second most common neurological disease in Australia.

FROM LAB TO MARKET: EXPANDING HORIZONS FOR OUR MEMBERS, AND FOR YOUR INDUSTRY

HESTA General Manager Unlisted Assets Andrew Major is watching our investment in medical innovations like this yield exciting results for researchers, and strong returns for our members.

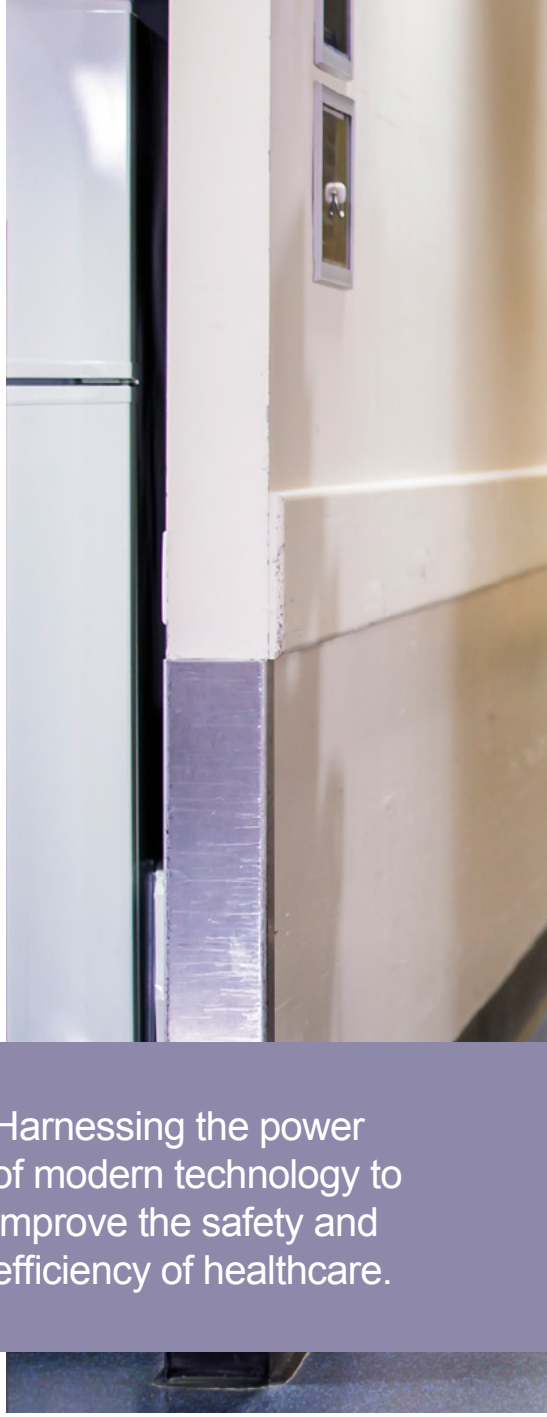
"Clearly one of our strengths as a country is our research and our ability to innovate," Andrew says. "Supporting research that is then commercialised into products or treatments is clearly beneficial for HESTA members and for the community. We're investing in the pool of research talent, and that's having positive flow-on effects from a broader societal perspective. It gives our members a greater ability to deliver innovative care.

"From the performance side for members, everything we do is about risk and return. When we're investing in life sciences at the early stage, some will fail – but some can make many times more from a small initial investment, to become something of substantially greater value for our members."

And with a raft of emerging technologies set to drive more innovation in digital healthcare, we're looking forward to partnering with pioneers in your industry for years to come.

HESTA

DR STEPHEN AYRE
Chief Executive
Metro South Health, Queensland



Our Metro South Health transformation to Australia's first digital health service

Harnessing the power of modern technology to improve the safety and efficiency of healthcare.

Metro South Health, servicing an estimated 23% of Queensland's population spanning from the Brisbane River to Redland City, further south to Logan and to the eastern points of the Scenic Rim is Australia's first digital health service.

Providing acute medical, cancer, surgical, rehabilitation, maternity, cardiology, orthopaedics, renal, and other specialty services for both children and adults, Metro Health South embarked on an ambitious project to roll out the integrated electronic medical record (ieMR) across all hospitals and facilities.

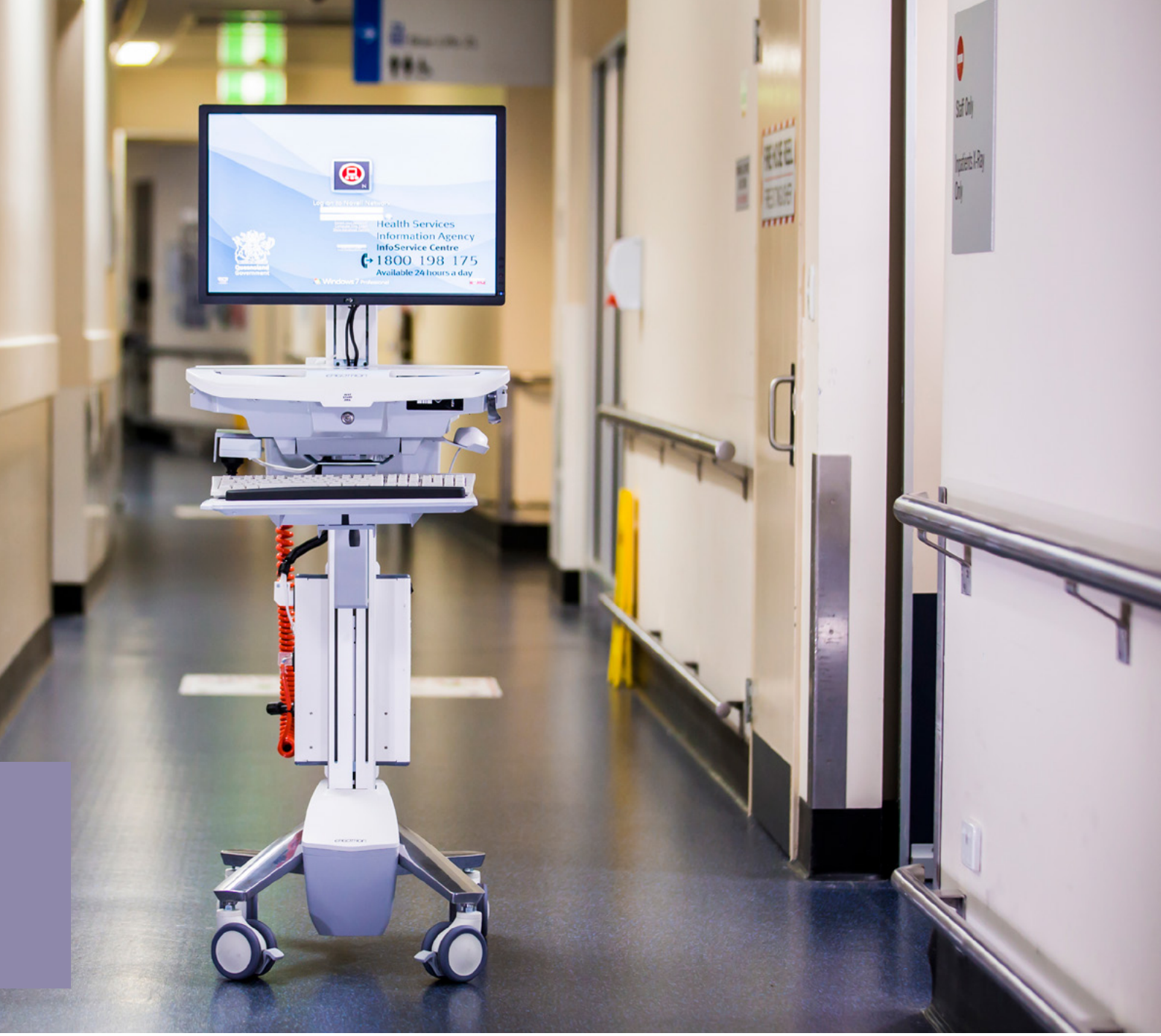
The ieMR program of work commenced in 2015 at Brisbane's Princess Alexandra Hospital (PAH), being the first large scale public hospital in Australia to replace paper-based medical records. Employing an ieMR means a patient's medical information is documented and accessed via a secure electronical medical record. The record automates uploads of observations and vital signs from patient monitoring devices, allows efficient electronic ordering of radiology and pathology tests, and provides decision support for clinicians in prescribing, verifying and administering medicines to our patients.

A CLINICAL CHANGE PROJECT

Metro South's transformation into Australia's first digital health service was a large-scale and highly complex task, requiring massive clinical change while ensuring the highest levels of safety and quality for patients. The project exemplifies the use of innovative information and communications technology (ICT) to achieve better-connected, and more efficient, integrated, and safer care.

Upgrading to a digital platform has required significant effort, including redesigning 'brownfield' sites, wards and medication rooms in preparation for ICT and medical devices while keeping up with the regular demands of a health service. The transformation required extensive training and engagement to ensure 100% staff readiness for 'Go Live' day.

Over a period of 13 months, over 3,300 medical and ICT devices were installed, and 109,700 hours of training was delivered to 14,000 staff to transform the way we deliver health care. Creative use of communication and embedding the new processes within established clinical change networks at each facility was underpinned by staff commitment to the clinical change.



As with any large-scale change in a healthcare organisation, the digital implementation necessitated changes to models of care. For clinicians, it changed the way they thought about healthcare systems; changed the way care was provided, in particular engagement between patients and clinicians and changed multidisciplinary team interactions.

For these reasons, there was no single 'one size fits all' model that could be applied throughout the transformation—changes had to be designed and delivered in close consultation with each unique clinical area.

Throughout the delivery of the digital hospital system across Metro South, our staff have embraced the significant clinical change required to realise the benefits of the system.

TANGIBLE IMPROVEMENTS TO PATIENT CARE

Transformation of our Health Service to become a digital hospital system was the largest and most complex change we had ever undertaken. The commitment of staff and leadership has been exemplary in delivering tangible improvements to patient care.

At the Princess Alexandra Hospital these improvements have resulted in a 44% drop in medication errors, a 17% reduction in emergency readmissions within 28 days of discharge, 14% lower drug costs per weighted activity unit, a 56% reduction in hospital-acquired pressure injuries, a 37% drop in healthcare associated infections, and a 59% rise in early identification of deteriorating patients.

Through digitisation the Health Service will also benefit from long-term accumulation and analyses of comprehensive quantitative data on patient care outcomes, clinical workflows and hospital operational costs. These analyses will inform future healthcare services decisions and ongoing clinical and operational excellence. ha

For more information about the Metro South Health digital transformation visit MetroSouthDigital.health.qld.gov.au.

The 'Metro South Health Transformation to Australia's First Digital Health Service' project was a finalist in the 2018 International Hospital Federation (IHF) Awards and won a Silver citation in the IHF/ Dr Kwang Tae Kim Grand Award.

ADRIAN PENNINGTON
Chief Executive
Wide Bay Hospital and Health Service

CHRISTINA ONGLEY
Director of Communications
Wide Bay Hospital and Health Service

Wide Bay Hospital and Health Service's Amazing Sustainable Turnaround

PROBLEMS

When Wide Bay Hospital and Health Service (WBHHS) was established as part of a Queensland Health restructure in 2012, its vital statistics were ailing.

WBHHS was not just failing to meet its key performance targets—it was failing miserably, with specialist outpatient waits of up to 12 years, endoscopy procedure waits of up to 3.5 years, and elective surgery waits of up to 3 years.

Compounding that was emergency department performance that wasn't meeting clinically recommended timeframes, and a budget deficit that had blown out to $45 million.

Something had to change, and change quickly.

In September of that year, new Chief Executive Adrian Pennington joined WBHHS, following a long career in the UK's National Health Service that included running a university hospital and leading a national cardiac health improvement program with great success.

'I remember my first executive meeting at WBHHS very vividly', Adrian recalls.

'There were 22 executives around the table. There was little vision or strategic direction—it was chaos.'

CHANGES

The changes were swift and immediate, but with longer-term outcomes in mind.

The executive team changed significantly, both in personnel and size, streamlining to only include key senior managers, and leading to other organisational restructures that were crucial to running the service more efficiently and accountably.

The health service worked with its Board on an ambitious strategic plan, in which clinicians were closely consulted to ensure everyone shared the same vision.

The strategic plan, *Improving health, together*, focused on key goals such as reducing waiting times, working with partners to expand specialist services, creating a robust clinical governance framework, developing strong workforce recruitment and retention strategies, and developing sustainable financial management.

'The strategic plan wasn't just a glossy document—it represented the aspirations of our staff', Mr Pennington said.

'We said openly what we needed to do and by when, and then we did it.'

RESULTS

The results started to speak for themselves, with the help of strong clinical and managerial leadership and a determined collaborative effort from all members of staff, regardless of their role.

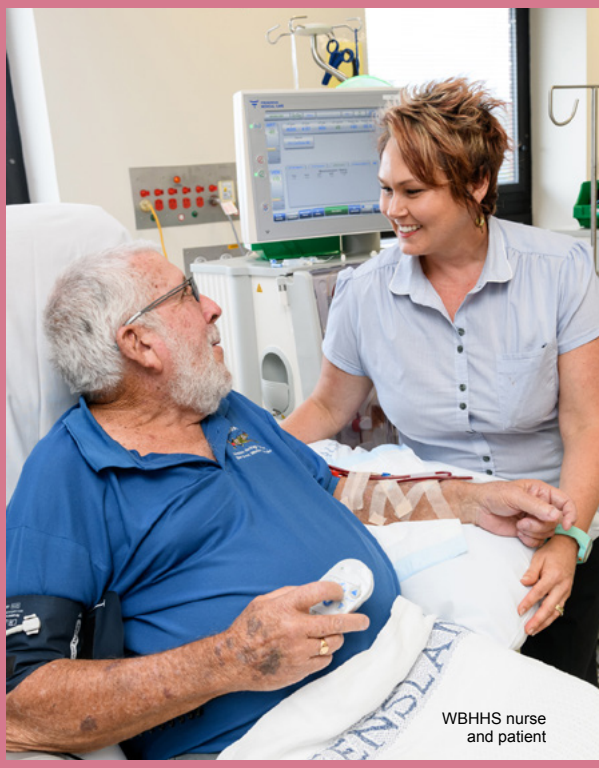
By 2014, no Wide Bay patient was waiting longer than clinically recommended for elective surgery—a record WBHHS has maintained for the past 4 years.

By 2017, all waiting list targets were also sustainably delivered for specialist outpatients and endoscopy procedures.

Emergency department performance steadily rose and is now consistently among the best in Queensland.

And in the latest financial year, WBHHS


WBHHS staff


WBHHS nurse and patient

"Underpinning all the improvements in WBHHS's performance has been a determination to strengthen its clinical governance frameworks, through a combination of education, an open reporting culture, and a drive to bring about meaningful improvements."

posted a $5.5 million surplus thanks to a sustained financial improvement program that included reducing locum doctors and improving procurement procedures, while still prioritising safety and quality of care.

But it wasn't just the numbers improving. Other things were happening too.

'The biggest result has obviously been that our community's health outcomes are better—they're being diagnosed earlier, treated earlier, and they're benefiting from the many new services we've built or expanded in the past few years', Mr Pennington said.

'But staff are also proud to work for WBHHS again. They can see they're part of something bigger that's genuinely improving the lives of their community, and that the roles of everyone in the organisation—clinical or non-clinical—all depend on each other for the whole service to function at its best.

'They're also led by an exceptional executive team who show integrity, lead by example and are open and consultative in their decision-making.'

Underpinning all the improvements in WBHHS's performance has been a determination to strengthen its clinical governance frameworks, through a combination of education, an open reporting culture, and a drive to bring about meaningful improvements.

This was a work in progress over 5 years, but it culminated in September 2017 with the launch of the Short-Notice Accreditation Assessment Pilot, a national trial that WBHHS has been leading alongside Logan Hospital (part of Metro South Hospital and Health Service in south-east Queensland).

The idea was to create a model that moved away from 4-year accreditation cycles—as per the current Australian system—to a more realistic representation of a hospital's safety and quality standards.

'A key part of that was a cultural change so that accreditation moved out of the hands solely of quality managers and became everyone's business', Mr Pennington says.

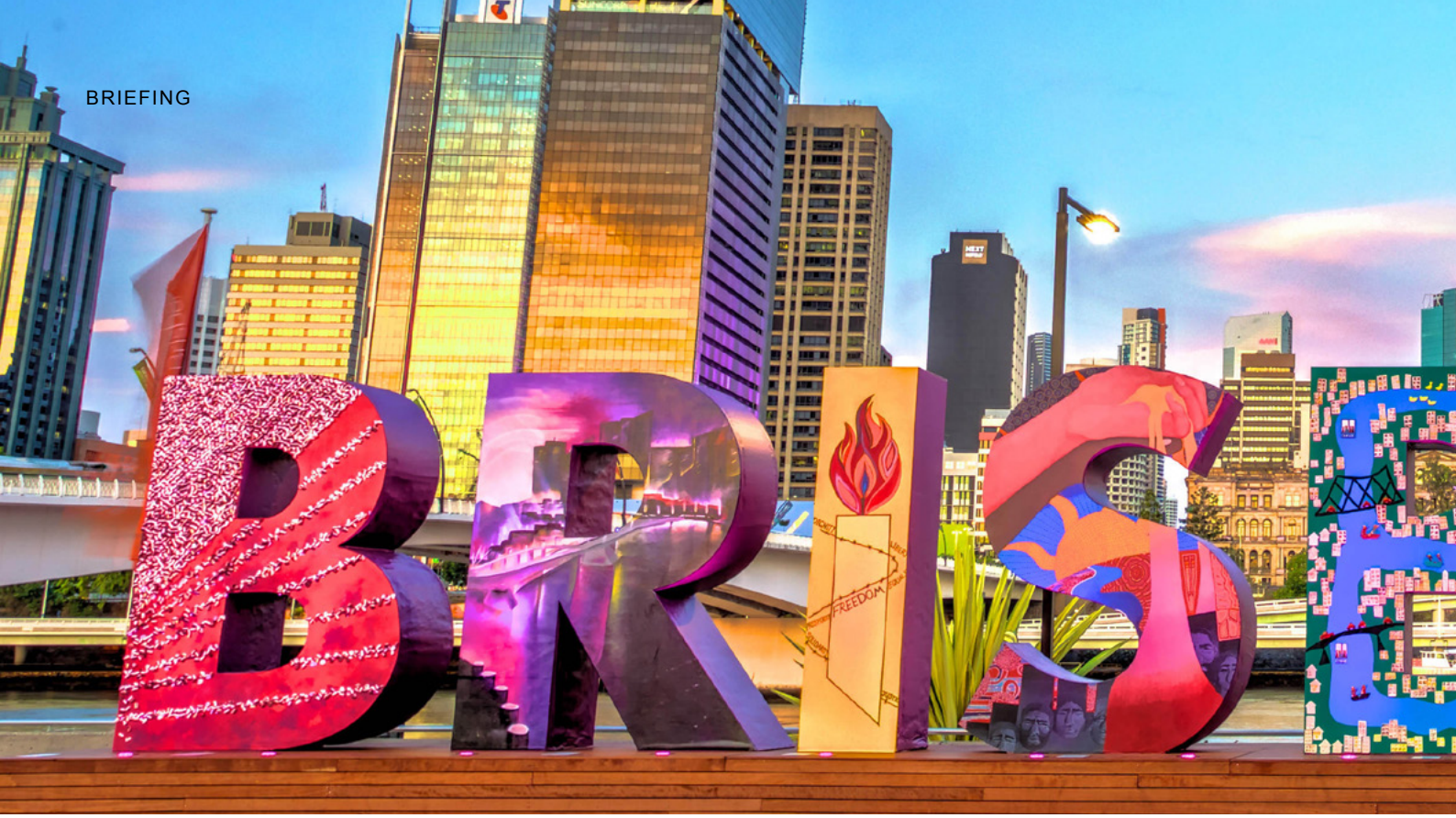
'We believe this model is the future of hospital accreditation because it means patients can trust in the safety and quality of services being delivered at any given time, and not just every 4 years.

'The early signs of the trial have been really positive, and there's been a great deal of interest in it from around Australia and around the world, including at the recent World Hospital Congress.'

'I'm proud of is that we've gone from being one of the worst health services in Queensland to being a leader on a number of fronts, and we continue to lead.

'We're in the process of launching our next strategic plan, and I know that will provide the platform to take our care to the next level and keep on improving the health and wellbeing of our community.' ha

The 'Wide Bay Hospital and Health Service's Amazing Sustainable Turnaround' project was a finalist in the 2018 International Hospital Federation (IHF) Awards and won a Bronze citation in the IHF/Dr Kwang Tae Kim Grand Award.



42nd World Hospital Congress

Volunteering Health Students' Perspectives.

AMBROSIA MUIR

While Brisbane was facing dark and rainy weather, the sun was shining on delegates at the Brisbane Convention and Exhibition Centre during the 42nd World Hospital Congress of the International Hospital Federation, 10-12 October 2018.

Kofi Annan, former United Nations secretary once said, 'If our hopes and dreams of building a better and safer world are to become more than wishful thinking, we will need the engagement of volunteers now, more than ever'. With this in mind, when I heard about the opportunity to volunteer at the Congress, I was eager to apply.

Hello, *nín hǎo, hola, namaste, ciao, kumusta* and *marhaba* were all greetings that I had come very familiar with over the course of the Congress, especially during my volunteering day. Despite these differences however, we all had gathered with one thing in mind—to create meaningful change that ultimately contributes to better health outcomes for all. The Congress really proved to me that no matter where you are in the world, health professionals are dedicated to providing care that is of value.

The Congress included a vast range of presentations, posters, innovative interventions and tools that were based on topics ranging from providing disaster relief care, to the best way to utilise data, to the world of robot surgeons.

The experience was personally enjoyable and engaging, and allowed me to meet people of all cultures, ages, backgrounds and professions. Most importantly, it supported the development of my future practice as a Registered Nurse.

I was able to gather evidence-based information, and experience how the skills and content I am learning about at University work in the 'real world of health'. I also can now share my newfound knowledge and experiences with my peers and fellow colleagues in order to assist our future patients to reach desired health outcomes.

In saying that, the contact details of a neurologist living in China who invited me to 'come and stay anytime' was an unexpected highlight!

EILISH SHORT

The Congress was the perfect mix of addressing the fundamental elements of healthcare while also showcasing the rapid development of information technology and pharmaceuticals that help manage the increasing demand of growing populations.

I liked the theme of the Congress; 'From volume to value'. Also, it was riveting to hear how people from all over the globe from different cultures and levels of healthcare were striving to achieve this outcome. Another highlight was being able to share the experience with familiar faces from my University, and new friends from different health fields and stages of their careers.

Participating in this conference provided me with so many ideas and hopes for my own practice as a Registered Nurse. Although the plenary sessions on topics such as ethics in epidemic trauma nursing were fascinating, the one piece of advice

Our volunteer group: (L-R) Ambrosia Muir, Sabine Feeney, Malisha Abdul, Jaffly Chen, Radhika Sewram, Amanda Petrie, Keonie Browne, Davoud Pourmarzi, Aojun Zhang, Margaret Langford

I will carry with me and advocate for, for the rest of my career, was that of the "Hello My Name Is…" initiative. It is now clear to me that the importance of a simple introduction makes a world of difference when building patient rapport and therapeutic relationships. I think it is humbling that after 3 days of listening to experts present awe-inspiring ideas, patient-centred communication remained a central theme of the Congress.

SABINE FEENY

I enjoyed getting to meet and volunteer with people from different universities doing different degrees across health and talk about contemporary health issues. I also enjoyed going to different areas of the Congress while volunteering, as I was able to see how each part of it was run. For example, in the morning I was helping with a panel discussion, and in the afternoon I was on one of the smaller talks where I was exposed to some really innovative ideas.

The whole experience has made me more aware of how many people from different areas of healthcare and all over the word play an important role when it comes to healthcare delivery. It also made me realise that when working on solutions or programs, there are many factors to consider in addition to what governments, the media, and other stakeholders may say. ha

Healthy people, healthy systems

Strategies for outcomes-focused and value-based healthcare: A BLUEPRINT FOR A POST-2020 NATIONAL HEALTH AGREEMENT

Developed through substantial consultation across the health sector, AHHA's strategic vision for how Australia's health system needs to be reformed, ***Healthy people, Healthy Systems,*** provides feasible steps to reorientate our healthcare system to focus on patient outcomes and value-based healthcare, rather than the current focus on throughput and vested interest.

Recommendations relate to four domains:

1. **Governance** – a nationally unified and regionally controlled health system that puts patients at the centre
2. **Data** – performance information and reporting that is fit-for-purpose
3. **Workforce** – a workforce that exists to serve and meet population health needs
4. **Funding** – funding that is sustainable and appropriate to support a high quality health system.

Across each of these, there are case studies from across Australia that exemplify the recommendations – providing current examples of innovative and best practice in Australia.

Healthy people, healthy systems is a solid blueprint with a range of short, medium and long term recommendations on how to reorientate our healthcare system to focus on patient outcomes and value rather than throughput and vested interests. It maps out how to transform our healthcare system into a fit for purpose 21st century system that will meet the needs and expectations of Australians.

Access the blueprint and case studies at www.ahha.asn.au/blueprint

ahha
australian healthcare & hospitals association

Calling all carers, clinicians, community and aged care workers and volunteers!

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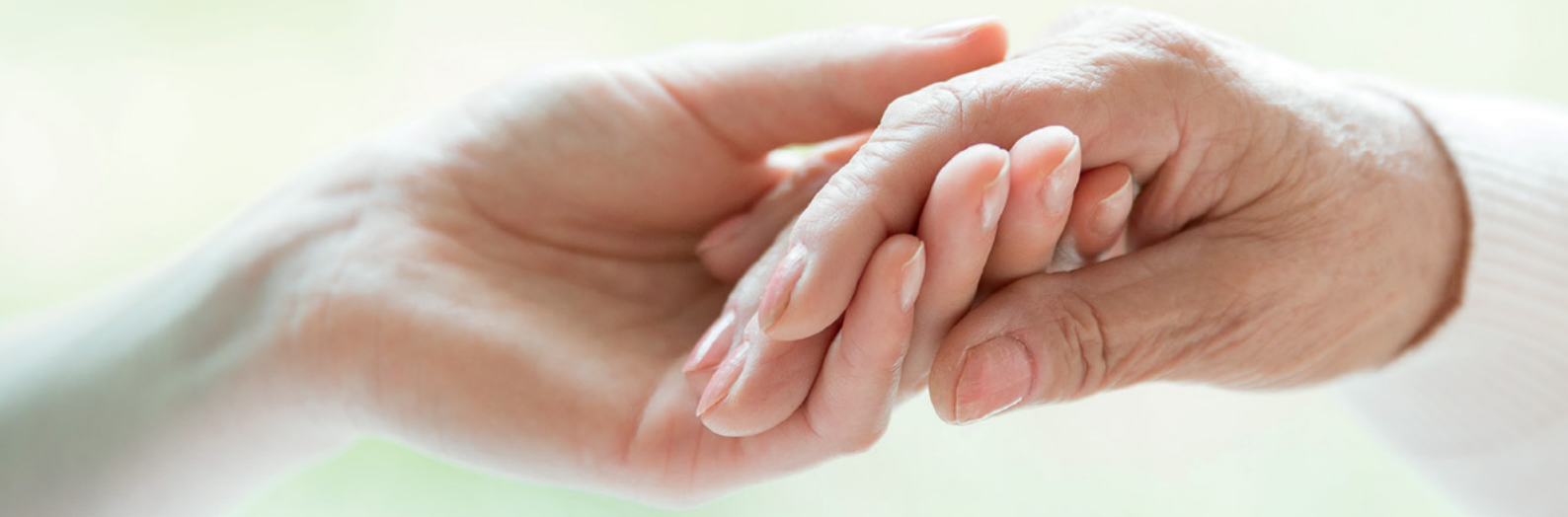

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DR WYMAN KWONG
Healthcare Program Lead
Novartis Pharmaceuticals Australia

Reducing potentially preventable hospitalisations —four key domains

Pre-World Hospital Congress thought leadership forum.

Novartis Australia shone a light on the challenging issue of reducing preventable hospitalisations ahead of the IHF 42nd World Hospital Congress in Brisbane on 10-12 October. Potentially Preventable Hospitalisations (PPH) is a whole-of-health issue requiring stakeholders from across the healthcare system to work together.

The Novartis-hosted pre-congress thought leadership forum covered four key domains relating to PPH, highlighting the following aspects in each of the four sessions.

1 New models of care

These may play a role in preventing unnecessary hospitalisations, with an opportunity to examine the emerging roles of primary, community and allied health.

In the opening session, panel members represented leadership in primary care, acute care, health economics, and the pharmaceutical industry. The roles of preventative health programs, home-based models of care, service coordination, system integration, and Aboriginal and Torres Strait Islander health were examined. The role of triple and quadruple aims of healthcare and the evolution of workforce models in relation to PPH were also explored by the group. Case examples were described in each session to contextualise the discussion. Session 1 examples included 'Integrated care plans for chronic disease management NSW', 'Introduction of nurse navigators supporting complex needs patients in regional Queensland', and 'Integrated healthcare model for chronic heart failure patients in Germany to address the burden of readmissions'.

2 Patient experience, engagement, participation, and health literacy

These aspects were discussed by leaders in clinical innovation, primary healthcare and patient activation. Topics included evidence of effective strategies, patient perspectives on healthcare, the activated patient and measures of patient activation.

Local case examples included the Children's Health Queensland model of care and the Capital Health Network heart failure project in the Australian Capital Territory (ACT). Both examples highlighted the importance of patient experience and were followed by further group discussion of patient activation.

KEY POINTS

- New patient-centred models of care delivering accountable comprehensive team-based healthcare are associated with improving reductions in PPH from primary care.
- Digital interoperability, useable data, clinical pathways, and care coordination are some of the key enablers to reducing PPH.
- There is a need for activity-based incentives for health providers and allied healthcare workers to collaborate.
- It is important to understand social determinants and include them in decision-making to maximise patient activation.
- The current Australian criteria for defining PPH would benefit from review.
- It is important to find leaders that will push ahead with initiatives to address PPH, despite limitations or potential barriers.

3 Service quality and patient safety

The importance of these aspects was emphasised, along with different approaches to measure PPH and health outcomes across primary and secondary care.

Panel members included academic leaders in health services, senior executives for health quality and safety from both public and private sectors, health service managers, and quality indicator and data experts.

The group discussed linkage of patient data, decision support using quality measures, shortfalls in current criteria for defining PPH, quality measures based on medication errors, health outcome measures in practice, the importance of patient experience measures, and the predictive powers of data on future risks.

4 Technology and innovations supporting PPH initiatives —'tip of the iceberg'

The final session included panellists from leading private health insurance companies, health technology transfer/accelerators, academic research institutes, medical device companies, and community and rural service providers.

The forum heard about examples of innovation and technology that underpin the service delivery model. Different aspects of technology were highlighted—for example, MeCare at West Moreton Health, Queensland, in partnership with global medical device company, Philips Healthcare; the application of Curve Tomorrow digital health technology at the Murdoch Children's Research Institute and the Royal Children's Hospital in Melbourne; and a broad portfolio of existing and emerging health technology platforms.

Novartis Australia, in partnership with consumers and the healthcare community, aims to improve health outcomes and reduce potentially preventable hospitalisations by supporting several multi stakeholder public-private projects in this area. We wish to thank all participants of the pre-congress thought leadership forum for their participation.

The views expressed herein are of a general nature as discussed by participants during the forum and do not necessarily reflect the views of Novartis or of each individual participant on the day.

Novartis Australia is proud platinum sponsor of the IHF 42nd World Hospital Congress, 2018. Novartis Australia provided financial support for several participants at the pre-congress thought leadership forum, and complies with the Medicines Australia Code of Conduct.

Big data analytics meets aged care

To meet the expectations of clients, their families and the wider public, the aged care sector will need to embrace information and communication technology. Although the sector is rapidly moving towards using electronic data systems, the data within these systems remain vastly underutilised, and their potential to support providers to monitor and improve aged care quality is largely unrealised.

At the Australian Institute of Health Innovation at Macquarie University, our *Aged Care Evaluation and Research* team has partnered with aged care providers and their clients to unlock the potential of electronic data systems. While ensuring best practice client privacy, our research has empowered providers to turn their routinely collected data into meaningful information that can be used to identify clients and facilities who may need extra support, and answer critical questions about the effectiveness of aged care service models.

TURNING DATA INTO INFORMATION

Unfortunately, the current design of many electronic systems in aged care lacks inherent data standardisation, limiting the usefulness of these data. For example, medication management systems often record administered drugs as free text, and specific health conditions can be entered using several different names, with abbreviations, or with spelling errors.

Our team has developed coding algorithms that map free text data to widely used classification systems. We recently mapped over 12,000 unique medicine names to the Anatomical Therapeutic Chemical Classification System (WHO) using sophisticated string searching techniques to generate medication profiles for over 4,500 residential aged care clients. We found that 84% of residents were using five or more medications (polypharmacy) and 41% were using 10 or more medications (hyper-polypharmacy).[1] We are currently working with free text data to develop a longitudinal health profile of aged care clients, who are often underrepresented in national surveys of health status. The coding algorithms for these studies will be iteratively applied to newly recorded data with our partner providers and drive the creation of structured systems for data entry.

TURNING INFORMATION INTO INTELLIGENCE

Standardised electronic data means that aged care providers can monitor and track important care indicators without the burden of periodic audits. Pressure injuries, for example, are still commonly measured with form-based assessments at single points in time. However, wound care data is increasingly being entered into electronic systems by staff when they examine and dress resident wounds each day.

Following data standardisation, our team were able to investigate variation in the incidence of new pressure injuries over a two-year period across 60 aged care facilities. We linked data from other parts of the electronic system to account for differences between facilities in their residents' health (risk-adjustment) to make more meaningful comparisons. On average, 14% of facilities had risk-adjusted pressure injury rates that were higher than expected in each quarterly period.[2] Facilities located in socioeconomically disadvantaged areas were more likely to have persistently high risk-adjusted pressure injury rates.[2] This is just one example of the vast potential of integrated electronic data to generate accurate and timely information about at-risk clients and facilities for targeted intervention.

USING INTELLIGENCE TO DRIVE EFFECTIVE SERVICE MODELS

Through data analytics, providers can now track client journeys and examine how the services they provide make a difference to their clients lives. For example, using routinely-collected data to follow over 1,100 new home care clients, we found that 21% of clients entered permanent residential aged care over an 18 month period.[3] By integrating service use and outcomes information for each client, we demonstrated that clients who received a greater volume of home care services had significantly delayed entry into permanent residential aged care. In fact, for each additional hour of home care received per week, clients experienced a 6% *lower* risk of entry into residential care, after accounting for important factors such as age and care needs.[3] Importantly, we found that use of social support services were particularly valuable in keeping people in their own homes for longer,[3] which has important implications for government funding and policy. Utilising electronic systems intelligently, it is now possible to trial new models of care and examine their effectiveness in close to real time.

Data analytics cannot replace the human interaction at the heart of aged care. However, it can enable aged care providers to monitor and improve care quality, and provide greater transparency about the equity of care and outcomes for our ageing population. ha

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How electronic data systems can drive aged care quality.

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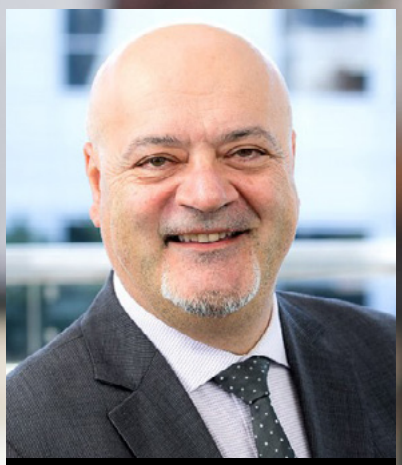

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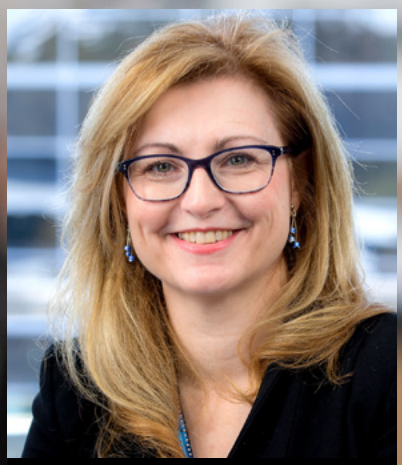

PROFESSOR JOHANNA WESTBROOK
Director, Centre for Health Systems and Safety Research, Australian Institute of Health Innovation, Macquarie University

"...our research has empowered providers to turn their routinely collected data into meaningful information that can be used to identify clients and facilities who may need extra support, and answer critical questions about the effectiveness of aged care service models."

Taduuda

Become an AHHA member

Help make a difference on health policy, share innovative ideas and get support on issues that matter to you – **join the AHHA**.

The Australian Healthcare and Hospitals Association (AHHA) is the 'voice of public healthcare'. We have been Australia's independent peak body for public and not-for-profit hospitals and healthcare for over 70 years.

Our vision is a healthy Australia, supported by the best possible healthcare system. AHHA works by bringing perspectives from across the healthcare system together to advocate for effective, accessible, equitable and sustainable healthcare focused on quality outcomes to benefit the whole community.

We build networks, we share ideas, we advocate and we consult. Our advocacy and thought leadership is backed by high quality research, events and courses, consultancy services and our publications.

AHHA is committed to working with all stakeholders from across the health sector and membership is open to any individual or organisation whose aims or activities are connected with:

- the provision of publicly-funded hospital or healthcare services,
- the improvement of healthcare,
- healthcare education or research, or
- the supply of goods and services to publicly-funded hospitals or healthcare services

Membership benefits include:

- Capacity to influence health policy
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- An avenue to key stakeholders including governments, bureaucracies, media, like-minded organisations and other thought leaders in the health sector
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- Access to networking opportunities, including quality events
- Access to education and training services
- Access to affordable and credible consultancy services through JustHealth Consultants
- Access to publications and sector updates, including:
  -Australian Health Review
  -The Health Advocate
  -Healthcare in Brief
  -Evidence Briefs and Issues Briefs

To learn about how we can support your organisation to be a more effective, innovative and sustainable part of the Australian health system, talk to us or visit ahha.asn.au/membership

Our goals

In partnership with our members, we aim:

- **To enhance the health and wellbeing of Australians through improved standards in primary, acute, community and aged care**
- **To improve health service provision and health outcomes by developing, providing, disseminating and promoting research and education**
- **To support the delivery of high quality healthcare by promoting evidence-informed practice and advocating for funding models that support primary, acute, community and aged care services**
- **To support the health sector through the provision of business, education, advisory and consultancy services by connecting the diverse contributions of health practitioners, researchers, policy makers, and consumers**
- **To promote and support universally accessible healthcare in Australia for the benefit of the whole community**
- **To focus on innovation that enhances integration of care, including development of new models of care, and funding models that support health reform that responds to emerging issues.**

More about the AHHA

Who we are, what we do, and where you can go to find out more information.

AHHA Board

The AHHA Board has overall responsibility for governance including the strategic direction and operational efficiency of the organisation, the protection of its assets and the quality of its services. The 2016-2017 Board is:

Dr Deborah Cole (*Chair*)
Dental Health Services Victoria

Dr Michael Brydon
Sydney Children's Hospital Network

Dr Paul Burgess
NT Health

Ms Gaylene Coulton
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ACT Health

Mr Nigel Fidgeon
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Prof. Adrian Pennington
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AHHA National Council

The AHHA National Council oversees our policy development program. It includes the AHHA Board as well as a range of members. The full list of Council members can be found at: **ahha.asn.au/governance**

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Chief Executive

Mr Murray Mansell
Chief Operating Officer

Dr Linc Thurecht
Senior Research Director

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Events Officer

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Australian Health Review

Australian Health Review is the journal of the AHHA. It explores healthcare delivery, financing and policy. Those involved in the publication of the AHR are:

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Editor in Chief

Dr Simon Barraclough
Associate Editor, Policy

Dr Luca Casali
Associate Editor

Dr Ann Dadich
Associate Editor

Prof Christian Gericke
Associate Editor, Models of Care

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Associate Editor, Financing and Utilisation

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Production Editor (CSIRO Publishing)

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AHHA—the voice of public healthcare

The Australian Healthcare and Hospitals Association (AHHA) is the 'voice of public healthcare'—we have been Australia's peak body for public and not-for-profit hospitals and healthcare for over 70 years.

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