The Health Advocate

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Value-based health care

The official magazine of the Australian Healthcare and Hospitals Association

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Advertorial

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The Health Advocate

ISSUE 64 / August 2021

JOHN GREGG
Chief Executive
AHHA

The value of value-based health care in a post COVID world

Welcome to the value-based health care themed issue of *The Health Advocate*. Having recently joined the AHHA, I am eager to continue advancing value-based health care in Australia.

Value-based health care is the key to moving health care investments from volume to value, focusing on the health outcome for the consumers of healthcare services. Broadly speaking, it is about achieving the outcomes that matter to health consumers at a cost that is acceptable to consumers and the health system. It is a concept that has been evolving for many years globally, and we are now seeing some activity and system transformation taking place here in Australia as health services and systems adopt the principles of value-based health care.

In May, AHHA and the Continuous Improvement in Care Cancer Project facilitated the inaugural Value-Based Health Care Conference. This conference showcased and celebrated national and international value-based health care in practice.

In this issue you can read a wrap up of the conference as well as several feature articles from keynote presenters at the Conference, including Elizabeth Teisberg and Julie McCrossin and outlines of services and projects that were recipients of the inaugural Value-Based Health Care Innovation and Collaboration awards.

COVID-19 continues to challenge the healthcare sector and also provides opportunities for us to reflect on how VBHC principles may assist support services redesign delivery and assistance to our consumers. AHHA's Deeble Institute for Health Policy Research recently published a brief which examines how value-based health care offers a path to managing the long-term health consequences of COVID-19 in Australia (see page 15).

The COVID-19 pandemic has highlighted the importance of health literacy and how our health systems need to provide avenues for our communities to feel more confident in their own health decision making, including options and risks with vaccinations. The focus that value-based health care has brought to understanding the outcomes that matter to patients is noteworthy, but we must also continue to work to support improvements in health literacy and provide the opportunity for consumers to take an active role in their own health care.

One of the drivers behind uptake of value-based health care concepts is a focus on moving the health sector to a more sustainable footing. Sustainability in this context is often thought of in terms of funding, but a recent Deeble health policy brief has considered broader environmental sustainability concepts, exploring the opportunity for value-based health care transformation to guide consideration of climate change and its impacts on health and health care (see page 12).

"Value-based health care is the key to moving health care investments from volume to value, focusing on the health outcome for the consumers of healthcare services."

The principles of value-based health care offer the opportunity to reorient our health system to provide all Australians with effective, accessible, equitable and outcomes-focused health care delivered in a sustainable manner.

I look forward to working with AHHA members as we pursue our shared vision of a healthy Australia supported by the best possible healthcare system.

To learn more about AHHA's value-based health care work, visit the Australian Centre for Value-Based Health at valuebasedcareaustralia.com.au.

AHHA in the news

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

17 MAY 2021

New Chief Executive for AHHA

The Australian Healthcare and Hospitals Association (AHHA) announced today the appointment of Mr John Gregg as Chief Executive, following the retirement of its current Chief Executive, Adjunct Professor Alison Verhoeven in June.

'On behalf of the Board of AHHA, I would like to thank Alison Verhoeven who is retiring after an outstanding eight years as Chief Executive and welcome John Gregg,' AHHA Chair, the Hon Jillian Skinner, said today.

'John comes to AHHA after a distinguished career in the health and community services sectors in Australia and internationally, and most recently as Chief Executive of the North Queensland Primary Health Network.

26 MAY 2021

Long term health consequences of COVID-19: can value-based health care provide a way forward

'Australia has succeeded in limiting and largely controlling the spread of COVID-19 and we must now shift our focus to responding to the long term health consequences of COVID,' says Australian Healthcare and Hospitals Association Chief Executive Adj Prof Alison Verhoeven.

An issues brief, Managing the long term health consequences of COVID-19 in Australia, published today by the Australian Healthcare and Hospital Association's (AHHA) Deeble Institute for Health Policy Research examines how a value-based health care approach can support Australia's response to the long term health consequences of COVID-19.

Deferral of care, workforce burnout and Long COVID are just some of the long term consequences that present significant challenges for the health system, according to authors A/Prof Martin Hensher et al from the Institute for Health Transformation and Deakin Health Economics, Deakin University.

27 MAY 2021

Leadership on environmental issues drives value in healthcare

'The severe weather events in recent years have shown us that health systems are at the forefront of responding to the impacts of climate change, but health systems too have a carbon footprint that contributes to climate change and must be addressed,' says Australian Healthcare and Hospitals Association Chief Executive Adj Prof Alison Verhoeven.

An issues brief, Transforming the health system for sustainability: environmental leadership through a value-based health care strategy, published today by the Australian Healthcare and Hospital Association's (AHHA) Deeble Institute for Health Policy Research examines how a value-based health care approach can support health systems to transform for sustainability.

The brief provides recommendations for a value-based strategic framework that supports the transformation to sustainable models of health care.

28 MAY 2021

Three Australian health services honoured in the Value-Based Health Care Awards

Dental Health Services Victoria (DHSV), Sydney Local Health District and Concord Repatriation General Hospital are the three winners honoured in today's Value-Based Health Care Awards.

The awards were presented at the inaugural Value-Based Health Care Conference in Perth, co-hosted by the Australian Healthcare and Hospitals Association's Australian Centre for Value-Based Healthcare and the Continuous Improvement in Care Cancer Project.

'Australian health services are leading the way in value-based health care through innovative, inspiring and collaborative projects that are improving patient outcomes and reducing costs,' said Australian Healthcare and Hospitals Association (AHHA) Chief Executive Adj Prof Alison Verhoeven.

AHHA in the news

3 JUNE 2021

COVID-19 and health inequity: latest Australian research

The latest issue of the Australian Health Review, the academic journal of the Australian Healthcare and Hospitals Association (AHHA), examines the various responses and impacts on health organisations during the height of the COVID-19 pandemic in 2020.

A perspectives piece from Nigel Lyons, Cathryn Cox and Vanessa Clements from NSW Health provides practical insights into the value of clinical leadership and engagement in a time of crisis. It describes the role of COVID-19 Communities of Practice, what they have achieved and their importance in supporting the ongoing pandemic response in New South Wales.

Dr Rachael Smithson, Elisha Roech and Christina Wicker from Gold Coast University Hospital examined patient and provider experiences of virtual care during COVID-19 to provide a way forward to further develop models of virtual care. The results from their evaluation demonstrated the value and viability of virtual care. ha

14 JUNE 2021

Supporting people with dementia in the community: reablement makes a difference

'Most people with dementia live in the community and rely on family to provide care that enables them to live healthy and independent lives,' says Adj Prof Alison Verhoeven, Australian Healthcare and Hospitals Association (AHHA) Chief Executive. 'Yet despite this, access to interventions that address the impact of dementia on everyday life is limited.'

An issues brief, Reablement interventions for community dwelling people living with dementia, published today by the AHHA's Deeble Institute for Health Policy Research examines how reablement interventions in dementia care can be adopted in Australia to support people with dementia to live healthy and independent lives.

'The 2021 Royal Commission into Aged Care Quality and Safety identified a failure to meet the needs of those living with dementia. This is partly due to people with dementia and their carers not being provided with the support they need,' says report author Dr Miia Rahja, Research Associate, Flinders University and 2021 Jeff Cheverton Memorial Scholar. ha

24 JUNE 2021

Telehealth funding reforms must prioritise value for patients

'Telehealth should be supported and continued beyond the immediacy of the pandemic, but funding reforms are needed to ensure the extension of telehealth services focuses on delivering improved health outcomes and value,' says Australian Healthcare and Hospitals Association (AHHA) Chief Executive John Gregg.

An issues brief, Towards a sustainable funding model for telehealth in Australia, published today by the AHHA's Deeble Institute for Health Policy Research examines how telehealth can be funded to achieve improvements in health outcomes in a cost-effective manner.

The rapid rollout of the telehealth program during the COVID-19 pandemic resulted in increased spending for new MBS items and ICT infrastructures according to the report's author Michelle Tran, PhD candidate, University of Queensland and 2021 Jeff Cheverton Memorial Scholar. ha

Value-Based Health Care Conference 2021
a patient-first approach
practical strategies for implementation

Australian Centre for Value-Based Health Care

The 2021 **Value-Based Health Care** Conference

In May, the Australian Healthcare and Hospitals Association (AHHA) and the University of Western Australia's Continuous Improvement in Care Cancer Project partnered to host the inaugural Value-Based Health Care (VBHC) Conference in Perth. The conference aimed to showcase and celebrate VBHC innovation, initiatives, implementation, research, and training from all areas of the health care system.

“There is not a one-size-fits-all approach to VBHC, and there’s much that can be learned from jurisdictions like NSW and Singapore, both in what they have been able to achieve in a relatively short period of transformation and from the frameworks they have established through which to progress and evaluate their work.”

CAPABILITY measures a patient’s functional status.

COMFORT measure relief from physical and emotional pain.

CALM measures the extent to which patients can continue to live their life in the way they want.

Patients first

The conference, themed **Patients first**, started with a lively keynote session featuring Professor Elizabeth Teisberg, Executive Director of the Value Institute for Health and Care at the Dell Medical School, University of Texas at Austin, and Julie McCrossin, a patient advocate.

Professor Teisberg’s discussion of patient outcomes used the **Capability, Comfort and Calm** framework, describing this approach as consistent with both patients’ reasons for seeking care and their experience of it, as well as clinicians’ professional identities.

Julie McCrossin noted that while her cancer care experience helped restore **capability** and in the longer term, **calm**, she had had an adverse experience in relation to **comfort** and emotional pain, particularly during radiation therapy for a head and neck cancer.

She talked about strategies to ensure patients were heard and were included in decision-making about their care. Trust and relationships, choice and empowerment to participate in decision-making were strong themes throughout these discussions.

Implementing VBHC in different jurisdictions

The second keynote session, focused on implementing VBHC in different jurisdictions, featured Elizabeth Koff, Secretary of NSW Health, and Dr Daphne Khoo, Executive Director of the Agency of Care Effectiveness (ACE), Singapore Ministry of Health.

This session highlighted that the approach to VBHC implementation will vary depending on the jurisdiction, based on the capabilities and enablers that are in place, the health outcomes they are seeking to optimise, and the priorities for their respective governments.

There is not a one-size-fits-all approach to VBHC, and there’s much that can be learned from jurisdictions like NSW and Singapore, both in what they have been able to achieve in a relatively short period of transformation and from the frameworks they have established through which to progress and evaluate their work.

Social determinants, funding and variation

The final keynote session examined key themes including social determinants of health, funding and variation. Joseph Conte, Executive Director of the Staten Island Performing Provider System (PPS) in New York, spoke about the dramatic improvement in health outcomes across a range of programs supporting very vulnerable patients including homeless people, refugees and migrants. The Staten Island PPS is an **accountable care organisation**, purchasing social care as well as health care, and working in very close partnership with (and funding) both community services like the justice system, public housing, schools, and employment agencies, as well as with health providers in the primary and acute care sectors.

Dr Ross Crawford, an orthopaedic surgeon from Brisbane, was compelling in his arguments that we must address variation in health care, that to do this we needed to leverage big data and AI to best understand where efforts should be directed, and that we need to be more agile in testing, adopting and evaluating new technologies like robotics if we are to provide the best available health care, achieve the best outcomes and pay the best prices.

In addition to the keynote presentations, the conference featured over 50 speakers examining topics from measuring what matters to patients, to changing culture, implementation approaches and VBHC enablers. Linking the presentations was a focus on practical examples, lived experience and pragmatic advice.

In this special value-based health care themed edition of The Health Advocate, we continue to shine a light of value-based health care, and we feature two special articles from Elizabeth Tesiberg and Julie McCrossin.

If you’re interested in learning more about AHHA’s VBHC work, visit valuebasedcareaustralia.com.au.

Transforming the health system for sustainability

Environmental leadership through a value-based health care strategy

"Currently one of the greatest threats to health care sustainability is climate change with the World Health Organization declaring 'climate change the greatest threat to global health in the 21st century'.[6]"

Figure 1: Simplistic representation of sustainability

Sustainability is most often described as *'meeting the needs of the present without compromising the ability of future generations to meet their own needs'*.[1] Although commonly depicted as three interconnected circles reflecting environment, economy and society, it is also a complex, multifaceted concept that continually evolves depending on the perspectives of different sectors and professions, and their respective expertise and interests.[2]

Health services primarily focus on economic sustainability, or rather, the proper use of available financial resources.[3] However, 'the assumption that sustainability at the financial and the economic levels is sufficient, on its own, to enhance the effectiveness of the health care system and to overcome the momentous challenges which a ffect the performance of health care organisations neglects the wicked nature of sustainability-related issues'.[4]

The Sustainable Development Goals represent an agreed global conceptualisation of sustainability signifying the indivisible nature of economic, social and environmental dimensions, with sustainability only to be achieved when these areas are pursued collectively.[5]

Value based Healthcare (VBHC) is a global movement which provides a holistic patient centred way to support sustainable decision making in healthcare. The classic definition of value-based health care is based on work initially led by Professors Michael Porter and Elizabeth Teisberg (2006) who propose that value is the health outcomes that matter to patients, divided by the costs of delivering those outcomes.

Figure 2: Teisberg et al., (2020). Defining and Implementing Value-Based Health Care: A Strategic Framework. Academic Medicine. 95 (5): 682-685 doi: 10.1097/ACM.0000000000003122

Currently one of the greatest threats to health care sustainability is climate change with the World Health Organization declaring 'climate change the greatest threat to global health in the 21st century'.[6] The strategic framework for VBHC transformation developed by Teisberg et al (2020) (Figure 2) provides a framework structure to support the consideration of climate change and its impacts on health care at the patient level and within each level of the system.

The Australian Healthcare and Hospitals Association's (AHHA) Deeble Institute for Health Policy Research published a health policy brief titled *Transforming the health system for sustainability: Environmental leadership through a value-based health care strategy* which provides an in-depth analysis of the alignment of sustainability and VBHC and provides series of recommendations on how policy makers and health leaders can work together to implement this holistic approach. >

"The brief also recommends that strong leadership is demonstrated across the health system through a series of actions, including the commitment to achieve net zero emissions."

The brief recommends that environmental sustainability be encompassed in the national vision and strategy for outcomes-focused, value-based health care in Australia. This requires recognising the significant contribution of health care to Australia's carbon footprint as a cost within the value equation and focusing on the populations who are most vulnerable to the impacts of climate change.

The brief also recommends that strong leadership is demonstrated across the health system through a series of actions, including the commitment to achieve net zero emissions.

Data-driven improvements in the health outcomes of individuals and populations should be enabled. However, improved health outcomes should not be achieved through care pathways that create poorer health outcomes from their environmental impacts.

Health workforce strategies and plans must recognise the impact climate change will have on exacerbating health workforce shortages, particularly in rural and remote areas and already vulnerable communities.

Funding models should be introduced to incentivise environmental sustainability and climate and health research that provides a strong evidence base to support health sector sustainability must be supported. ha

deeble institute

Deeble Institute for Health Policy Research

For more information about *Transforming the health system for sustainability: Environmental leadership through a value-based health care strategy* or to access the full copy, click here.

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Managing the long term health consequences of COVID-19 in Australia

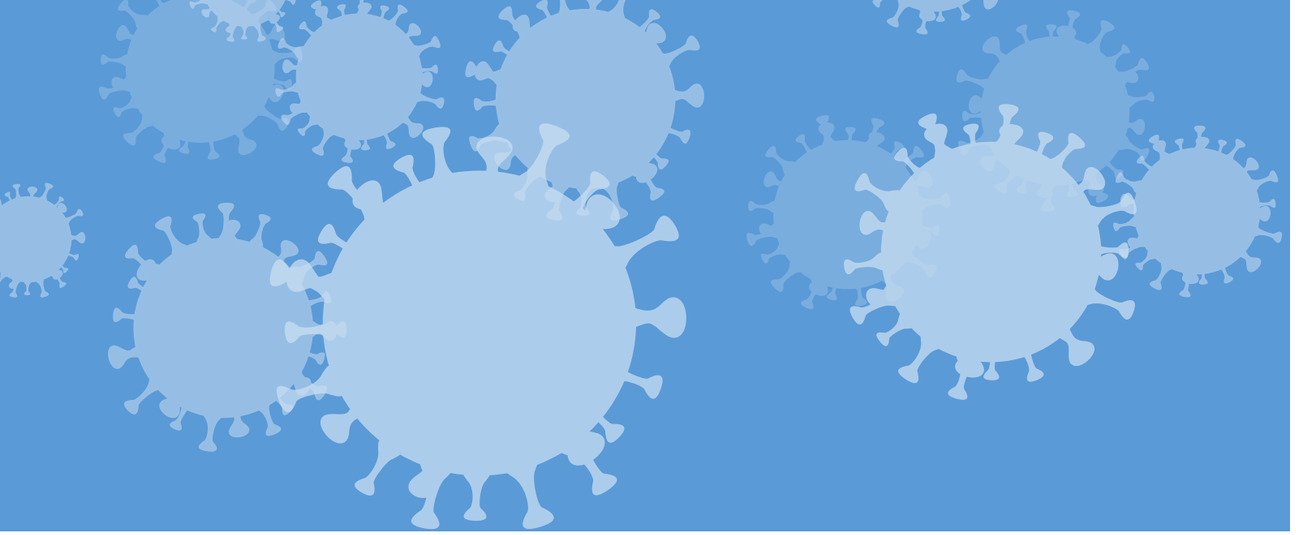
Can value-based health care provide a way forward?

"The brief focuses on how Australian governments should now consider an effective and proportionate value-based response to COVID-19, Long COVID and its other longer-term consequences, that considers both patient health outcomes and costs."

Australia is one of a group of countries who has succeeded in limiting and largely controlling the spread of COVID-19 within the national borders. As a result of these effective control measures, Australia has suffered a much lower burden of COVID-19 disease than most other countries; with rates of infections and deaths being an order of magnitude lower than those seen in most other high-income nations.

However, in those countries which have suffered more severely than Australia, concerns about the long-term consequences of the pandemic are increasingly focused on the long-term clinical sequelae being seen in survivors of COVID-19, including Long COVID and a wide range of other conditions. Additionally, during the COVID-19 pandemic, Australia experienced a large scale reduction in healthcare utilisation and deferral of care. There are also lingering concerns about mental health, well-being and health workforce burn out. As we move toward a post-COVID world, this has the potential to impact negatively on health outcomes.

The Australian Healthcare and Hospitals Association's (AHHA) Deeble Institute for Health Policy Research recently published a health policy brief titled *Managing the long term health consequences of COVID-19 in Australia.* The brief focuses on how Australian governments should now consider an effective and proportionate value-based response to COVID-19, Long COVID and its other longer-term consequences, that considers both patient health outcomes and costs. >



"Although estimated case numbers in Australia are low, the emergence of Long COVID provides an opportunity to implement new approaches to integrated, well-coordinated, multidisciplinary, person centred care."

deeble institute

Deeble Institute for Health Policy Research

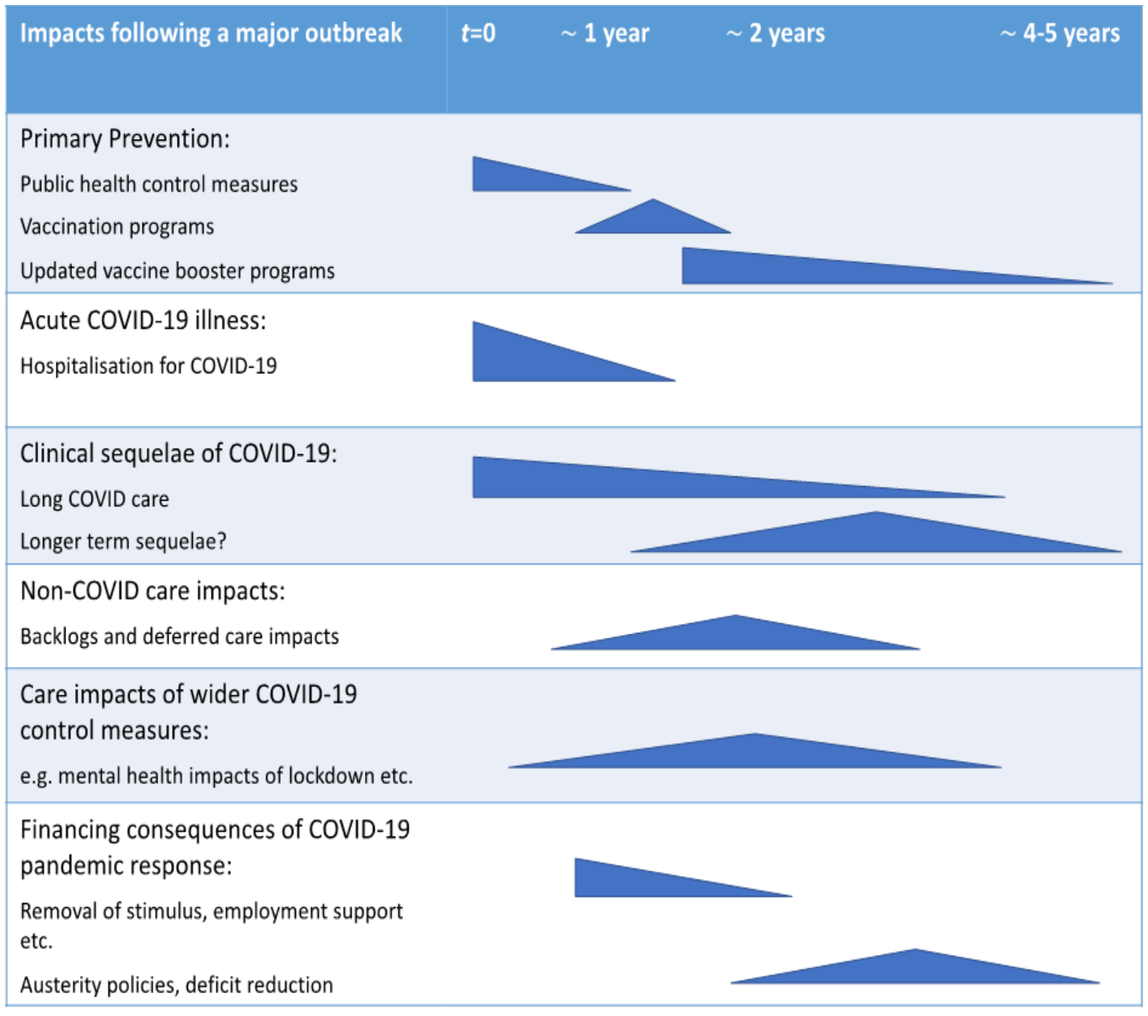


Figure 1. Possible health system impacts of COVID-19 over the short to longer term time horizon.

A path forward

Primary prevention of COVID-19 should be prioritised as the most effective means of mitigating the long-term health consequences of infection at population level, however plans must be put in place to allow rapid scaling-up of long-term care were COVID-19 control measures to fail.

Although estimated case numbers in Australia are low, the emergence of Long COVID provides an opportunity to implement new approaches to integrated, well-coordinated, multidisciplinary, person centred care. This will require health care professions to be supported to work at the top of their scope of practice and should occur through:

- a national post-COVID Centre of Excellence and state-based care coordination centres;
- a nationwide COVID-19 data registry that combines patient-level data on COVID-19 and subsequent health and healthcare utilisation history;
- ommissioned research and modelling on the morbidity burden of Long COVID and post-COVID sequelae in different age and population groups that supplements emerging data on the mortality burden of COVID-19 and associated control measures;
- the development of regular, updated clinical guidelines that reflect evolving evidence on the long-term management of post-COVID care; and
- MBS and PBS benefits that adequately support patients living with Long COVID or other sequelae and other "safety net" measures put in place to mitigate out-of-pocket costs for chronic disease management to support these patients fully.

The Australian and state and territory governments should consider the long-term care consequences of COVID and its associated additional cost burden in resource allocation and risk management decision processes in parallel with COVID-19 control strategy policies.

Support should also be provided for research that focuses on health policy, health economics, social determinants and more directly on the effect of COVID-19 on the structure and function of the health system.

Although Long COVID is not yet fully understood, health policy makers should be preparing to address it. ha

For more information about Managing the long term health consequences of COVID-19 in Australia or to access the full copy, click here.

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

Patients First

What does this mean and what is needed to achieve it?

GraphicStock

“Clinicians need to ask each patient: What matters to you? What brings you joy? Asking these questions helps clinicians recognise—and connect with—patients as individuals.”

There are opportunities everywhere to improve health care value by recognising unwarranted differences in health outcomes and closing those gaps. To see the gaps, one starts from the patient perspective: Patients First.

Why patients first? Patients are why health care exists: the purpose of health care is to help individuals and families with health issues.

‘Patients’ include everyone who needs and wants help, not just those who present for care. This observation has two implications. One is that care needs to be designed to include people who are underserved or served ineffectively now. The other implication is that the highest-value health care prevents people from becoming patients. So, when health care really gets it right, the design of care is human centred, meaning it addresses individuals’ and families’ needs effectively, inclusively, and, when possible, proactively.

Patients First does not mean clinicians last; instead, it requires *relationship-centred delivery of care*. The healing relationship matters. We can create systems that make respect, empathy, and kindness normal in the care processes, rather than extra work undertaken by clinicians and staff. Health care is full of smart, caring, hard-working people, working in systems that often don’t make the right things easy or make enough time for human interaction. Clinicians then put in extra effort because they care. It is no wonder so many health care professionals feel worn down.

If systems were redefined to make the right things easy—to truly be relationship centred—there would be support for the patients, the families *and* the clinicians. The starting point is to be explicit that transforming to high-value health care requires clarity that the purpose is to help and to heal, enabling quality of life and dignity of death. To achieve this purpose, care must focus on achieving the outcomes that matter most to individuals and families.

Of course, what most concerns individuals depends on the health issues they face and the contexts in which they live. So, Patients First means knowing what matters and using that knowledge in care delivery, care design, and care improvement. Clinicians need to ask each patient: What matters to you? What brings you joy? Asking these questions helps clinicians recognise—and connect with—patients as individuals. It is foundational to high-value, relationship-centred care.

Asking what matters to individuals is consistent with, yet different from, developing systems to measure patient-centric outcomes and drive ongoing improvement. Both are needed. For illustration, the shared outcome that matters to patients at risk for diabetic retinopathy may be retaining eyesight; however, individual patient goals may be driving, reading, doing needlework, or seeing the smile on a grandchild’s face. The specific goals frame the individual discussions with patients, yet the ability to do needlework need not be measured for every patient. Retaining vision is the outcome to be measured and improved.

The dynamic of improvement requires research with patients and families who have shared medical circumstances. The research enables insight on patients’ hopes and fears, the outcomes that matter to them, and the obstacles and gaps that make those outcomes harder to achieve. From these insights, health care improvement can focus on achieving outcomes beyond current successes, and beyond improving the in-clinic experience. Of course, every patient should receive safe, respectful, compassionate care; the point is simply that kindness and safety > should be the norm, not a stretch goal. Kind, safe care should focus on helping improve health outcomes.

The Value Institute for Health and Care uses a qualitative research approach that works with groups of individuals facing similar medical

“Patients First can be implemented to achieve both empathic response to patients and professional support for clinicians by accelerating teams’ learning and improvement.”

challenges and life circumstances to gain insights on what outcomes matter and what gets in the way of them achieving what matters. We’ve found that patients often don’t readily articulate these things, even to wonderful, beloved doctors and nurses. Instead, they say thank you. So, the most caring and respected clinicians may not hear about challenges that they could help mitigate or address. With the right research, clinical teams can anticipate these unarticulated concerns and use the insights gained to improve care delivery, track a few highly meaningful outcomes, and speed learning for the clinical team. In this way, Patients First can be implemented to achieve both empathic response to patients and professional support for clinicians by accelerating a team’s learning and improvement. That improvement, in turn, enables better care and outcomes for future patients.

The Value Institute for Health and Care is a hub of an international community driving transformation that improves outcomes of relationship-centred, high-value care. Please join us! valueinstitute.utexas.edu/

Together we can improve health; we can improve care; we can make kindness and respect the norm; and we can reduce health disparities. It all comes back to understanding and addressing unmet needs—even the unarticulated needs of the people we serve. This means, of course, the starting place is patients. Patients First.

Dell Medical School’s Value Institute for Health and Care is the global leader in value-based health care and a proud partner of AHHA. The two organisations are proud to present the Australian health community with a series of high quality workshops and short courses. If you’re interested in finding out more about how you can get involved contact communications@ahha.asn.au.

JULIE McCROSSIN AM
Patient Advocate, Cancer Survivor and Grandmother

“My experience of treatment and recovery from stage four oropharyngeal cancer taught me to focus on the experience of my clinical team.”

The Courage to Measure Outcomes: A Patient’s Perspective

The focus on value-based health care offers a new opportunity to give patients and their families a voice so we can achieve real-time improvements in treatment in partnership with our multidisciplinary team. At the same time, we can collect large data sets to enable us to do systemic, structural improvements to care over time. This approach gives an active role to patients and their families. It is, quite simply, a win-win-win situation.

It takes courage to measure results, including finding out what your patients and families really think. My experience of treatment and recovery from stage four oropharyngeal cancer taught me to focus on the experience of my clinical team. I needed to understand their perspective and challenges if I were to work with them to improve the experience and results for head and neck cancer patients like myself.

My life-saving treatment of 33 sessions of radiation therapy, bolted down to the bed of my radiation machine by a rigid thermoplastic mask, plus weekly chemotherapy, was brutal. This is not a complaint. It is simply a fact. The side effects, short and long term, are tough.

I came to understand that members of compassionate, multidisciplinary cancer teams are almost frightened to truly comprehend the impact on patients and families of the treatment regime because they are not sure they can address the unmet need. Cancer teams are working so hard to deliver the basic curative care, or care to prolong life, it would be too overwhelming to collect and interrogate the nature and scope of our unmet needs.

This is especially the case with the impact on families. My cancer treatment was all outpatient >

“In my keynote address to the Value-Based Healthcare Conference 2021 in Perth, I described three positive examples of clinical teams who have had the courage to measure outcomes for patients and improve care. The first example gives a voice to families as well.”

care. My family and friends drove me to and from the hospital and kept me alive as I progressively lost speech, swallowing, cognitive capacity and over 20kgs in weight over six weeks. My recovery has involved a multitude of appointments with a variety of doctors, dentists, nurses and allied health professionals over eight years. This continues today. In the acute phase, it involved the safe administration of a multitude of medications, including essential opioids for pain relief, plus the management of crucial oral care to address what happens inside a mouth and throat subject to extensive radiation. Yet, amazingly, the family carer receives very little attention.

In my keynote address to the Value-Based Healthcare Conference 2021 in Perth, I described three positive examples of clinical teams who have had the courage to measure outcomes for patients and improve care. The first example gives a voice to families as well.

My first example is an electronic, web-based patient-reported outcome tool called My Health My Way from Princess Alexandra Hospital Brisbane. It offers two ways to hear the patient and family voice during cancer treatment — via a stand-up podium in the waiting area with a touch screen, or by a personalised SMS message to their device. They can enter data on how the experience of treatment is going, connect with the team and receive automatic referrals based on the information provided. It addresses physical, emotional, home, distress and other needs. In the video of my presentation, you can see pictures of this tool and my interview with Dr Bena Brown PhD, Advanced Speech Pathologist and Researcher, who worked at Princess Alexandra Hospital in Brisbane for 15 years in radiation oncology and was instrumental in the development of this tool. She is now at the Menzies School of Health Research. My Health, My Way is validated for carers. Over 7,000 entry points of data have been received. It has led to a 25% drop in outpatient appointments. Overservicing has been reduced, while underservicing has been addressed. Increasingly, the right patient gets the right care, at the right time, from the right professional.

The other two examples I outline in my presentation are an app at the Peter MacCallum Cancer Centre and the NSW Health Osteoarthritis Chronic Care Program Service.

These three examples show us that it is possible for a caring group of skilled clinicians to really listen to patients and families and to make change. I urge you to ask yourselves, ‘What tools can we give patients and families so they can report to us during treatment, and we can improve their care in real-time?’ Imagine the professional satisfaction you will experience if you could also generate large data sets and build the evidence base for structural improvements to your models of care. On top of this, you will give an active voice to patients and families. When you, or someone you love, is a patient, you don’t want to be a cork bouncing on the ocean of the health care system and subject to tidal forces you can’t influence. You’ll want to help yourself and others. We’re in this together.

www.juliemccrossin.com

EMMA WARREN
Smile Squad
Communications Lead

Smile Squad recognised as school dental innovator

Smile Squad means that every Victorian child can have a healthy smile

Winner of the 2021 Value-Based Health Care Innovation Award

Students at Fitzroy North Primary School celebrate the launch of Smile Squad services at their school

Parents and students all over Victoria are quickly becoming familiar with the bright orange fleet, smart uniforms, friendly staff, and great customer care the Smile Squad school dental program delivers.

Smile Squad is the Victorian Government's free school dental program. Smile Squad provides free annual oral health examinations and free follow up treatment for all Victorian public primary, secondary and specialist school students.

In May 2021, extensive planning, collaboration, and testing were rewarded as Dental Health Services Victoria (DHSV) was awarded the Innovation Award at the inaugural Value-Based Health Care Awards.

The award, sponsored by Queensland Health, recognises projects in their start-up or early phases of development that are significantly innovative and was presented at the 2021 Value-Based Health Care Conference.

DHSV Chief Operating Officer Mark Sullivan was delighted by the win and highlighted the importance of delivering innovative, accessible, high-value dental care to all Victorian public school students.

'School dental services have existed for a number of years and we're excited that Smile Squad has seen the return of dental vans to our schools,' said Mr Sullivan.

'We have learnt a great deal from previous programs and those learnings have armed us with the knowledge and experience needed to deliver a truly innovative next generation service,' he added.

School dental program Director Melanie van Altena reflected on the key aspects of the Smile Squad program that will lead to improving health outcomes that matter to patients — students attending Victoria's public schools.

'The Smile Squad value proposition is simple — to increase access to dental services for public school students, reduce preventable hospitalisations due to dental conditions and improve students' oral health, all while saving families time and money,' said Ms van Altena.

'Our aim is to add value to the relationships we have with all community dental agencies to provide support in the provision of Smile Squad oral health services to as many eligible students as possible.

'Smile Squad provides its patients with excellent dental care that is consistent, trusted and held to a high standard. That high standard of care comes without cost to the student's family and students enjoy the experience of having a dedicated, supportive, and caring oral health team to help them take control of their own oral health. >

Student receiving a dental check-up at Fitzroy North Primary School

The bright orange Smile Squad treatment van fleet

‘When the program reaches full rollout by the end of 2023 ,we will reach approximately 650,000 students attending public primary, secondary and specialist schools at more than 1,500 locations across Victoria each year.

‘The reaction to Smile Squad has been overwhelmingly positive. Agencies, schools, teachers, parents and students are all telling us they want and are benefiting from our services. I’ve heard wonderful reports of students seeing an oral health clinician for the first time and others who are overcoming fears based on previous negative experiences,’ she added.

In the 2019—20 State Budget, the Victorian Government announced $321.9 million in funding over four years for the Smile Squad school dental program.

Dental vans started visiting a limited number of schools in Term 3 2019 as part of a Proof of Concept and the program progressed to statewide rollout in Term 1 2021 following a lengthy pause in 2020 due to COVID-19 restrictions.

The program was inspired by a need and desire to improve the oral health of all Victorian young people. Approximately one quarter of all Australian children have untreated tooth decay and in Victoria, dental conditions are the highest single cause of preventable hospitalisations for children under 10.

The free program adds value for the government by reducing the number of school aged children experiencing tooth decay and reducing those preventable hospital admissions.

Smile Squad has been planned and implemented in line with the DHSV value-based health care framework. It focuses on ensuring the right services are provided in the right place at the right time and that the clinical workforce is utilised to their full scope of practice. We have developed an Oral Health Questionnaire to measure what outcomes matter to our patients so their management program can be tailored appropriately.

Smile Squad considers the needs of all students and is firmly patient-centred. The program has a strong focus on preventive services and promotes the values of eating well, drinking well and cleaning well — for life. ha

“The free program adds value for the government by reducing the number of school aged children experiencing tooth decay and reducing those preventable hospital admissions.”

Smile Squad is a partnership between Dental Health Services Victoria, the Department of Health, Department of Education and Training, community dental agencies and public schools.
www.smilesquad.vic.gov.au

DR RICHARD HOLLAND
Consultant Rheumatologist

PRIYA GNANAKUMARAN
Clinic Co-coordinator

Winner of the 2021 Value-Based Health Care Collaboration Award

Leading Better Value Care

A patient focused Osteoarthritis Chronic Care Program

Pixabay

Osteoarthritis is a major cause of disability and early retirement in Australia, and it is forecast that by 2030 over three million Australians will be living with osteoarthritis, with treatment costs expected to exceed $2.9 billion. Data obtained by the Agency for Clinical Innovation indicated that few patients had tried conservative management prior to joint replacement surgery. The non-surgical management of osteoarthritis is frequently fragmented, with most clinicians working in silos.

The Concord Hospital osteoarthritis chronic care programme (OACCP) was established in April 2018, and to date has enrolled over 500 patients. The programme is a coordinated, multi-disciplinary ambulatory care clinic designed and implemented for patients with knee and hip osteoarthritis as part of the Leading Better Value Care (LBVC) initiative and was established after careful consideration of the needs and challenges of patients with hip and knee osteoarthritis. The objectives were to improve health outcomes (pain, function, mobility and anxiety) and patient experiences in the non-surgical management of osteoarthritis of the knee and hip. To address the biological, social, and psychological impacts of disease, we included a range of clinicians with appropriate skills in managing chronic disease.

We recognised that a single physical space, incorporating individual consultation rooms, an open exercise/assessment space and a meeting room would be essential to deliver healthcare in a way that was sensitive to the needs of patients with reduced mobility and function.

Following an initial review by the musculoskeletal clinical lead (senior physiotherapist), patients are scheduled to attend a multi-disciplinary (MDT) clinic. The MDT clinic utilises the skills of experienced, motivated clinicians including a physiotherapist, psychologist, podiatrist, dietician, occupational therapist, social worker and rheumatologist. The close collaboration of the clinicians ensures highly coordinated care and facilitates the discussion of barriers to change and challenges faced by each patient.

Participants are provided with a comprehensive, evidence-based and individually tailored management plan focused on maximising health outcomes important to the patient. Adjustments to the plan are made following regular follow-up appointments using both clinical and patient reported outcome measures (PROMs). A robust set of measurable outcomes are used to monitor the effectiveness of the service, with the focus on PROMs.

The programme has demonstrated strong results, with a significant reduction in the number of patients proceeding to total joint replacement. Formally-assessed patient outcomes using Promis29 have been excellent, and most overweight patients lost weight by three months, improving with time. Patient feedback has been very positive, and highly complimentary of the service provided. Qualitative patient assessment revealed enhanced confidence and ability to start exercising, and those proceeding to surgery reported rapid recovery, facilitating a reduction in length of stay. Assessment of provider experiences demonstrated high levels of professional satisfaction, achievement and engagement with the multidisciplinary clinic format. A whole of experience review revealed opportunities for increased efficiency such as enhanced psychology and podiatry services,
adding value with modest investment.

In NSW, LBVC services have successfully demonstrated a move from admitted care to non-admitted care. Specifically, the OACCP has led to a significant 7% reduction in business as usual activity for Sydney Local Health District. The diabetic high risk foot service, osteoporosis re-fracture prevention programme, and OACCP all contributed to cost savings of approximately $5 million for Sydney Local Health District in the 2018/19 financial year.

At inception, only patients on the surgical waiting list for total hip or knee joint surgery were invited to participate in the programme. With the success and positive outcomes of the programme, referral criteria have broadened to allow all patients to attend the clinic following specialist referral. As the service continues to mature, it is forecast that the volume of patients accessing the service will grow, and in turn, increase the volume of patients deferring or cancelling their surgery.

The COVID-19 pandemic has been a significant challenge to the service in 2020. We have managed to continue outpatient clinics through the implementation of telehealth, socially-distanced and COVID-safe face-to-face services, and referral to hospital and community run virtual exercise sessions. The continuity of care, particularly in light of cancelled/deferred surgical procedures due to the pandemic, has been gratefully and positively received by patients. ha

low interest rates

Interest rates in Australia have reached all-time lows. What does this mean for you?

Why do interest rates go up and down? Is this a good thing or a bad thing? While these can appear to be difficult questions, the answers are simpler than you'd think.

Interest rates are adjusted to help create healthy and sustainable economic development. In the same way you adjust your driving speed to match the road conditions, interest rates are adjusted to help the economy operate smoothly through the current environment.

In Australia, interest rates are currently at record lows to help support the COVID-19 recovery.

Let's take a look at how low-interest rates affect superannuation investments.

Let's take a look at some of the exciting projects currently in Brandon Capital's portfolio (and your portfolio with HESTA).

ARE LOW INTEREST RATES GOOD OR BAD FOR ME?

Is there an upside to low interest rates? Yes. It lowers the cost of debt. It becomes cheaper to repay debt (such as personal loans and mortgages). It is cheaper for businesses to borrow money and invest in economic growth. This may have a positive effect on the value of bonds and the stock market. Your HESTA investment option may hold bonds and stocks.

Can there be a downside to low interest rates? Yes. Lower interest rates mean money held at the bank or invested in cash products (such as a term deposits) will generate lower performance. Your HESTA investment option may hold cash and term deposits.

WHAT DOES THIS MEAN FOR MY INVESTMENTS WITH HESTA?

HESTA has a range of investment options. Each option holds a different blend of assets. These assets include Australian shares (e.g. Telstra), international shares (e.g. Apple), cash (e.g. ANZ Term Deposits), etc.

When interest rates are low, the cash asset component in your HESTA investment option will generate a lower return. In Australia, interest rates are already at record lows. It is possible that market conditions could lead to a scenario where cash rates continue to decrease. In some countries, interest rates have gone below zero.

It's worth pointing out that there are two investment options that hold significant proportions of cash assets: the HESTA Conservative option and HESTA Cash & Term Deposits option.

It's important to remember that this low-interest rate scenario will not persist forever, but we need to be prepared for a low interest rate environment for the next few years.

WHAT CAN I DO?

As part of being with HESTA, you have access to a team of dedicated HESTA advisers who can help you get the most out of your superannuation investments. Together with your adviser, you might want to look at strategies that include reviewing your investment option and income strategy. It's easy to get help from us — and it could give you extra peace of mind.
Visit hesta.com.au/adviser for more ways to get advice.

Not with HESTA yet?
Join us today at hesta.com.au/join

HESTA

An Industry SuperFund

DR INES RIO
Chair, North Western Melbourne Primary Health Network

Beyond COVID-19

Australia's response to the coronavirus pandemic has not always been perfect, but we still have much to be proud of

Photo credit Leigh Henningham

The human and economic cost has been high, but not nearly as high as it could have been. And it has shown us time and again what we are capable of; from the resilience of the millions who endured the many effects of lockdown to the tireless efforts of healthcare workers, there are many success stories from 2020.

However, there is no doubt we will be left with an ongoing health and economic burden that needs acknowledgement and addressing. We have seen cancer diagnoses fall, fewer presentations to general practice for cardiovascular events, preventative health screening and chronic disease management, and more presentations for distress and mental health concerns.

All of these can be expected to have flow in effects in the next few years. Cancer stage progression, more end organ effects from vascular diseases and diabetes, and the effects of poor mental health on the wellbeing of individuals, families, and communities. The cost of mental illness in Australia is $600 million a day, and only likely to grow with the ongoing fallout from the pandemic and recent drought and bushfires.

We also need to consider the effects of long COVID in our community, given the majority of COVID cases in Australia have come from our region. We need more research and support for people suffering long COVID, and to reinforce the importance of anyone diagnosed with COVID to stay in touch with their GP in the long term.

I have argued previously that the problem in many areas is not so much the lack of services, as the difficulty for patients, families, and GPs in finding a way through the maze of different providers and a lack of coordination between services. From where I sit, a successful system development has been the HeadtoHelp service in Victoria.

Announced by the Australian Government in August 2020 as a measure to support Victorians struggling through a protracted lockdown, it is run by Victoria's six Primary Health Networks. It consists of a state-wide single point intake service where patients, families or GPs and other health professionals can refer all but the most acutely unwell person to.

The central service is staffed by experienced mental health professionals who (along with referring GP if a GP has referred) make an initial assessment and determine the level of care required and then access that service for the person.

At lower level acuity it may be cognitive behavioural or talking therapy and mindfulness apps and social connection; at low-to medium it may be referral to a psychologist or social worker; at medium it may be referral to dedicated health care hubs that have multidisciplinary teams that include mental health nurses, psychologists, social workers, alcohol, and other drug workers; and at higher acuity to the regional hospital run mental health care service.

While COVID-19 may have exacerbated it, Australia's mental health epidemic is far from new, and it has long been acknowledged that we are not dealing with it well. It is beyond time for us to apply the solutions-based thinking we have shown in the face of COVID-19 to a problem that affects so many of us every day. >

With a collaborative mindset and a stringent focus on a patient-centred, evidence-based model, we can seize this moment to deliver the mental health system that Australia truly deserves. The recent National Federation Reform Council statement on mental health reported that patients are currently confronted with a system that is 'fragmented, complex to navigate for Australians and their families and carers, and not sufficiently focused on prevention and early intervention'.

"It is hard to overstate the importance of this. The international evidence tells us the best results come when the patient is surrounded and supported by a team that responds to their individualised care and service needs."

The same goes for their GP and other care providers. It quotes recent reports, including Victoria's Royal Commission into Mental Health, that call for a more compassionate, coordinated and consumer-centred system. We need to build on the HeadtoHelp model to reduce fragmentation and build integrated models.

It is hard to overstate the importance of this. The international evidence tells us the best results come when the patient is surrounded and supported by a team that responds to their individualised care and service needs. And this is nowhere more important than in the mental health space.

This is not to say there is a smooth or easy road ahead. Entrenched divisions and silos will require hard work and good will to break down. With the present the connection between inputs and need and outcomes far from clear, we will also need tools to evaluate the success or failure of what we are attempting. These measures should be viewed through the prism of the quadruple aim of primary care by measuring outcomes, patient experience, provider experience and cost.

HeadtoHelp is currently funded as a temporary, pandemic-related measure. It is a missed opportunity to let this crucial part of system development fall away. HeadtoHelp should be expanded, with the hubs also having access to psychiatrists and drug and alcohol medical specialists. Better integration between services was a key recommendation of the Royal Commission into Victoria's Mental Health System and from the hundreds of stakeholders that contributed to our Regional Plan for Mental Health – this is a chance to make that happen.

HeadtoHelp should also be extended, so that it is a permanent part of the system and continues to evolve in response to feedback form patients, families, GPs and other providers and performance indicators.

The COVID pandemic is a key moment for Australian health, and an opportunity we must take. If the past year has taught us anything, it is that when pressed, we can adapt our systems rapidly and effectively to meet a crisis. Just as Victoria has evolved in leaps and bounds on systems for contact tracing in COVID-19 when it was apparent there was systems failure, we have recognised failure our mental health care systems and the embedding and evolution of a HeadtoHelp is a sensible and demonstrated enhancement with major positive impacts.

This article was originally published in North Western Melbourne Primary Health Network's Primary Pulse (Autumn 2021) magazine.

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Values aligned organisational culture as the foundation for workforce wellness **Is it a pipe dream?**

“We feel optimistic that sustainable system solutions can be implemented since many organisations and government departments have chosen their values and purposes and are endeavouring to adhere to them.”

Workforce wellness and engagement have become buzzwords in healthcare settings since there is an intimate relationship between staff wellbeing and performance of the healthcare system. Wellness initiatives such as wellness champions and wellness committees have been set up in response to emerging workforce mental health issues. These are largely reactive rather than being proactive in addressing or preventing the root cause of mental health issues.

Moral injury is increasingly considered to be a central tenent to disrupting workforce wellness.

Moral injury refers to the psychological, social, and spiritual impact of events involving betrayal or transgression of one’s own deeply held moral beliefs and values occurring in high stakes situations. In the context of healthcare, staff may face situations that do not allow them to deliver care in the way they have been trained (that is, to help people and do no harm), or staff may observe contradictions between organisational values and operational behaviours, processes and actions and feel powerless to rectify them. Moral injury in healthcare workers can result in anger, disengagement, and burnout.

Across the country and internationally, moral injury experienced within the health system occurs mainly as a result of ‘contradictions’ between organisational values and operational behaviours, actions and processes that exist within healthcare organisations. It seems that clinicians and managers around the world waste considerable amounts of time, energy and passion trying to overcome these contradictions, just to get on with delivering the essential components of the universal health systems.

Contradictions can be observed at all levels of health systems. The idea that the system constructs itself is one of the first contradictions.

Health policy is determined by political agendas, loud advocacy bodies, lobby groups and power brokers rather than driven by evidence-based community needs and contemporary health management principles. This may be partly responsible for unstructured spending and wastage of resources.

Though teamwork, shared decision-making, and distributed models of leadership are encouraged at clinical levels, in most management settings, the health system is largely autocratic with decision-making accountability mostly being assigned to an individual. In democratic societies, autocratic systems and unilateral decision-making are bound to cause moral injury.

The question then becomes, how can health systems and leaders respond with sustainable system solutions to minimise these ‘contradictions’?

Within healthcare teams, the promotion of a strong sense of shared purpose along with strong leadership has been shown to reduce rates of mental health problems in staff. Many authorities believe that organisational values are the foundation of organisational culture, and alignment of values and purpose across all levels of organisations may minimise moral injury and promote positive emotions amongst staff.

We feel optimistic that sustainable system solutions can be implemented since many organisations and government departments have chosen their values and purposes and are endeavouring to adhere to them. To start a new narrative, the first step is clarification of values and purpose. Recognising the importance of organisational culture as the foundation for workforce wellness, solutions that ensure that the values are lived should be implemented. These values should not be confused with personal or human values that we learnt from our families, schools, and universities. Organisational values are operational values related to processes, operational behaviours, and actions. Selected practical examples are listed in table 1 under commonly used organisational values such as excellence, respect, engagement, and compassion. >

Values	Corresponding actions
Excellence	• Develop and implement action plans to achieve strategic mission and vision of organisations
Compassion	• Regularly identify matters that cause distress to staff and advocate for solutions to reduce workforce distress • Proactively keep the waiting lists down • Provide care closer to home models of care as routine business • Fill vacancies in a timely manner to avoid fatigue for other staff • Set targets related to health outcomes and patients' outcomes • Develop clinician-enabling processes for recruitment, and research regulatory matters
Respect	• Respond to email and queries in a timely manner • Receive feedback and input from staff before finalising plans • Avoid saying "NO" without evidence of ineffectiveness of an idea and/or input from other team members
Engagement	• Adopt team-based operations and team-based decision making rather than adopting autocratic decision making • Co-design system improvements through clinician, management, and consumer partnership models

Table 1: Examples of organisational values and corresponding actions

Values aligned actions need to be embedded at all layers, including in both the national health policy and local operational levels.

Examples of these solutions include formal team-based operations and co-design of system improvement initiatives through clinician, consumer and management partnership models at all layers. Team=based operations would also align with modern management concepts such as 'incomplete leader, and complete teams that recognise that every leader is incomplete with their own weaknesses'. These collaborative management models have the potential to involve, engage and empower the workforce, instill a sense of belonging and ownership and as a result enhance workforce wellbeing at all levels and layers of the health system. This values-aligned culture is ever so important at the time of impending austerity created by COVID-19 when the workforce needs to be taken on the journey of creating efficiency with psychological and moral safety. ha

LEANNE DREW-MCKAIN
CEO Coach Pty Ltd

Resuscitating respect— the heartbeat of workplace psychosocial safety

An interview with Martyn Campbell,
Chair of the Heads of Workplace Safety Authorities

Martyn Campbell

"I endured condescending behaviours when I started at the hospital. While working at one ward, staff would talk negatively toward me, ignore my questions and leave me to new tasks or areas without any orientation …This led to weeks of bullying behaviour which caused me to eventually leave that ward. I feel the negative behaviours lead to unsafe practices for patient wellbeing and personally I feel unsupported and have lost a lot of confidence. My anxiety has increased to a point where I experience physical symptoms."

Health staff reports of unprofessional behaviour

89.4%
reported **experiencing bullying and incivility during the past year**

38.8%
reported **experiencing them at least weekly**

50%
reported **a moderate or major negative impact on patient care**, frequency of errors, or quality of service

38.4%
reported **a moderate or major negative impact on their wellbeing**

Source: Westbrook et al, 2020
The prevalence and impact of unprofessional behaviour among hospital workers

This nurse's piercing account of bullying will resonate deeply with at least 60% of readers, according to workplace bullying statistics inside and outside the health sector. It is also a succinct real-life summary of the all-too-well-established evidence that in health workplaces 'negative workplace behaviour, especially negative communication, is known to … have a serious impact on workplace performance, productivity and personal wellbeing'.[1]

However, after more than a decade of digesting data on the extent and impacts of workplace bullying, and declaring stirring 'zero-tolerance' pronouncements, the sector's workplace bullying and incivility statistics are on the rise. Indeed, across sectors, current interventions are failing.[2]

'It's time to talk solution, not problem', says the man driving workplace psychosocial safety efforts nationally. Martyn Campbell—CEO of Safe Work SA and Chair of the Heads of Workplace Safety—is implementing Australia's most pioneering regulatory reforms to understand and prevent workplace incivility, bullying and harassment, in a determined attempt to turn the tide.

I recently had the opportunity to interview Martyn for the launch of the Australian Healthcare and Hospitals Association's (AHHA) workplace bullying prevention program—Bully Zero Culture of Excellence—to talk solution. Indeed, as a workforce communication coach, I comment regularly that in our organisations 'the thing we talk about least is how we talk to each other.' So, let's start that conversation … >

Martyn, in your view, why have we made so little progress on workplace bullying over the years?

I think there are several reasons. The first is that we have a very poor understanding of what bullying behaviours actually look like. Broad definitions such as 'aggression, violence, intimidation, threats, harassment' don't offer practical working descriptions, and they also hide a multitude of harmful disrespectful behaviours that are sadly too commonly traded in workplaces. The problem with that is that our workers aren't supported to identify these behaviours as unprofessional. They then commonly go unaddressed, leaving the recipient simply feeling vulnerable and inadequate.

Research note: Researchers Burnes & Pope assert that 'concentrating only on bullying and aggression is counterproductive, because it misses out the wider damage done by more prevalent forms of negative behaviours such as incivility'.[3]

What are some of these behaviours?

The evidence is strongly pointing our attention to the role of quite subtle behaviours in causing psychosocial harm. Klingberg suggests that as a health team worker you might experience reduced wellbeing impacts when for instance a colleague on occasions has:

- put you down or was condescending to you
- paid little attention to you or showed little interest in your opinion
- made demeaning or derogatory remarks about you
- ignored or excluded you from professional camaraderie
- addressed you in unprofessional terms either publicly or privately
- doubted your judgement on a matter for which you have responsibility.

What are the impacts of these negative communication behaviours?

Unfortunately, they are weighty. UK health workforce researchers Burnes and Pope tell us that negative behaviours deeply affect staff, citing 'feelings of isolation, insecurity, fear, worthlessness and lack of value', and of feeling undermined, powerless and vulnerable. Studies by Riskin (2015) indicate that staff exposed to even mildly rude behaviour 'perform poorly on cognitive tasks, exhibit reduced creativity and flexibility, and are less helpful and prosocial'.[4]

Of course, the business costs are immense too. Fiscally, as organisations pour disproportionate funds every year into costly HR and industrial interventions in response to bullying and team breakdowns, lost time and productivity, stress leave etc. Then in the health context, soberingly, we have the impacts on patient experience, safety and outcomes to consider.

In addition to all these factors, our failure to address harmful communication behaviours leads over time to more egregious behaviours such as violence, aggression and sexual harassment and assault. Researchers at La Trobe University recommend that preventing and eliminating workplace violence requires putting all our efforts into stemming these lower-order harmful behaviours.[5]

So, let's talk solution. So many experts such as Klingberg assert that we need to foster a culture of respect and good communication. That's a gargantuan task. How do we do that?

Fundamentally, we need to skill and support our workers to call out these types of behaviours. But they can only do that if they:

1. know what behaviours to look for
2. feel supported to address them
3. have the words to use—we can't ask for respect if we're not extending it ourselves.

This is why I am putting my full weight behind the AHHA and the Bully Zero Foundation as they launch the Bully Zero Culture of Excellence to the health sector. There isn't another anti-bullying program in the country that is working solely to equip organisations to create a culture of prevention and elimination of harmful behaviour.

Its very purpose is to give an entire workforce a common awareness of unprofessional behaviours, a common language to discuss them, and a common responsibility for disallowing them. >

Coach Pty Ltd survey data suggests that the Top 10 most prevalent negative communication behaviours reported in the workplace are:

1. **Being persistently negative** (80%)
2. **Talking negatively about you or others in your or their absence** (65%)
3. **Making patronising, condescending, sarcastic or derisive comments** (65%)
4. **Commonly adopting negative body language or critical facial expressions towards you or others** (53%)
5. **Interrupting you or others in discussions** (51%)
6. **Dominating conversations and making it difficult for you or others to speak** (49%)
7. **Adopting a consistently negative position in meetings and discussions** (48%)
8. **Ignoring your presence, comments or requests** (38%)
9. **Implying criticisms or making statements with innuendo to insult or persuade** (36%)
10. **Commonly speaking to you in a cold or critical tone** (35%)

"For senior health administrators, it is a comprehensive, measurable, single-source response to meeting its Safe Work obligations. But much more than that, it is the means to lift their people to a culture of respect that in turn unlocks their wellbeing, performance and their patient outcomes."

How does the Bully Zero Culture of Excellence work?

The program essentially comprises five steps:

1. Auditing of current state—which is essentially where Bully Zero familiarises itself with the policies and procedures currently in place relevant to workplace psychosocial safety.
2. Engaging the whole workforce in an information, awareness and positive behaviour-change program called Class Act Conduct—to create that shared language and responsibility.
3. Creating an organisational communication charter through a staff-wide survey in the Class Act participation process.
4. Integrating that charter (and the behaviour-change facilitated by the Class Act program) into the organisation's HR policies and practices.
5. Practising the new behaviours with organisational development support and measuring the growth through pulse surveys over time.

The steps are fully led by Bully Zero and paced over three years to keep the load low and feasible for busy CEOs and people-and-culture leaders.

The health sector at-large has been asking for this type of change support for years, and I sincerely gratulate the AHHA for responding with this solution. For senior health administrators, it is a comprehensive, measurable, single-source response to meeting its Safe Work obligations. But much more than that, it is the means to lift their people to a culture of respect that in turn unlocks their wellbeing, performance and their patient outcomes.

Thank you, Martyn, it has been a pleasure. ha

For information about the Bully Zero Culture of Excellence program click here.

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Building a robotic surgery program at Macquarie University Hospital

“Internationally, robotic surgery has been used successfully for decades and is unquestionably the future of minimally invasive surgery. So from the beginning, we built robotics into our services strategy. Our success today is a result of that early investment.”

Conjoint Associate Professor Walter Kmet

Macquarie University Hospital is the first hospital in Australia to have three robotic surgical systems. It remains the busiest centre for robotic urology in New South Wales and has rapidly growing programs in other areas. What is behind the Hospital’s success?

Macquarie University Hospital opened its doors in 2010 as Australia’s first private hospital on a university campus. A cornerstone of the academic precinct known as MQ Health, the Hospital supports the larger entity by delivering excellence in patient care through clinical care combined with teaching and research.

Conjoint Associate Professor Walter Kmet, CEO of Macquarie University Hospital, says that the story of robotics at the Hospital is driven by its academic health sciences identity.

‘As part of an academic endeavour, one of the core values of the Hospital is innovation, so it’s imperative that we look at ways to bring advanced approaches to healthcare in Australia,’ explained Associate Professor Kmet, who has spent more than 30 years working in human services and health care management in Australia, South East Asia and the United Kingdom.

‘Internationally, robotic surgery has been used successfully for decades and is unquestionably the future of minimally invasive surgery. So from the beginning, we built robotics into our services strategy. Our success today is a result of that early investment.’

Robotics boosts precision and accuracy and shines particularly when operating in deep pelvic spaces. The approach is heralded for its benefits to patients: less bleeding, shorter hospital stay and faster overall recovery.

‘It’s about giving surgeons another choice in delivering the best care,’ said Associate Professor Kmet. ‘When a robotic approach could be performed for a particular procedure, there has to be clear patient benefit in selecting it. A well-proven shorter laparoscopic procedure might better serve a patient. The priority is always patient benefit.’

A diversified approach

Macquarie University Hospital recently acquired its third robot, making it the first private hospital in Australia to have three systems. The busiest robotic urology centre in New South Wales, the Hospital now also has rapidly growing programs in cardiothoracic, gynaecology, colorectal, and head and neck surgery. There has also been an investment in an assisted robotic system for knee arthroplasty and the latest generation navigation system for neurosurgery.

Macquarie University Hospital runs two da Vinci Xi Surgical Systems — still the mainstay for most urological procedures, including radical prostatectomy, simple prostatectomy, partial cystectomy and bladder diverticulectomy, radical nephrectomy, partial nephrectomy, nephro-uretetectomy and pyeloplasty.

Gynaecology also has a long-established record with the da Vinci — its real advantages apparent when operating on difficult and challenging cases, especially large fibroids, advanced endometriosis >

“Last year, the Hospital selected the Versius Surgical Robotic System as it looked to expand, making it the first Australian hospital to invest in the next-generation British system.”

and pelvic floor prolapse. The Hospital also offers robotic lung operations, and was the site of the first robotic kidney transplant in the Southern Hemisphere using the da Vinci.

Last year, the Hospital selected the Versius Surgical Robotic System as it looked to expand, making it the first Australian hospital to invest in the next-generation British system. Professor David Gillatt — Director of Medical Services at Macquarie University Hospital — said that the business case for selecting the versatile and compact Versius was strong.

‘The Versius can be moved easily, is quick to set up and can be used in virtually any operating room, so it provides a different opportunity as far as costs go,’ explained Professor Gillatt, a world-renowned urological surgeon who has been instrumental in strengthening the Hospital’s robotic program.

‘The modular configuration of the system is also ideal for developing hybrid procedures where shared access to the operative field means we can start a procedure laparoscopically, and then switch to the Versius for intracorporal suturing, for example, where the vision and advanced wristed instruments allow us greater surgical access and dexterity.’

For now, different disciplines at Macquarie University Hospital — notably general, colorectal and cardiothoracic surgery — are finding their niche with the Versius. As the hospital pioneers the use of the system in Australia — without the decade-long local knowledge that now exists for the da Vinci — the highly collaborative and rich learning environment of MQ Health’s academic setting is paving the way for its success.

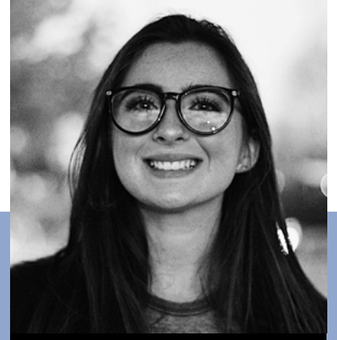
A training and development partner

Macquarie University Hospital has a ten-year history of working with Intuitive Surgical to implement, improve and train other surgeons in robotics. MQ Health surgeons have used the da Vinci at the Hospital to livestream robotic-assisted procedures as part of discipline-specific international and international conferences, reaching thousands of viewers.

Macquarie University Hospital is currently the home of Versius training in Australia. CMR Surgical’s structured training course incorporates online and simulator-based training, followed by experience using cadavers in an operating theatre environment — all of which MQ Health can support as an academic health sciences precinct.

‘The robotic program is not just about acquiring the technology,’ Associate Professor Kmet said. ‘It’s about the ability of the team to implement the approach in a safe and effective way. This takes an investment in people — in having a highly skilled team that can not only train the next generation of robotic surgeons and nurses but also provide feedback on clinical experience to companies. In urology, gynaecology and cardiothoracic, we have some of the most experienced surgeons in the country operating at Macquarie University Hospital.

‘If companies produce robots, they are coming to us for implementation and refining. So there is research and evaluation taking place alongside clinical work, and as I walk around the Hospital it’s fantastic to see medical students and residents learning and experiencing not only what the technology can do, but how a hospital system functions with robotic systems in it. It’s really a comprehensive approach to adopting and integrating robotics at all levels of our activities.’ ha



ANNA BRENNAN
DetectED-X Research Assistant

Cloud-based Technology Reduces COVID-19 Mortality Rates

COVID-19 identification through CT scans is necessary for early patient treatment and isolation

Pixabay

The number of patients suffering from the life-threatening symptoms of COVID-19 has outpaced the number of skilled staff required to accurately diagnose the lung CT scans. Because of this, a technological platform assisting in the diagnoses of incoming cases has been essential.

DetectED-X is a cloud-based technology that presents itself as an educational solution that improves radiological detection rates based on an intelligent interactive educational platform. The COVID-19 pandemic took over all aspects of life for Australians, illuminating the importance of healthcare and healthcare workers. So as a response to that pandemic, this program was updated to be utilised in a way to assist radiologists dealing with COVID-19.

DetectED-X was founded by a group of Australian-based radiation and imaging experts to help doctors and radiologists worldwide to diagnose cases of breast cancer, lung case and COVID-19 faster and more accurately. DetectED-X follows on from the highly successful BreastScreen Reader Assessment Strategy (BREAST) platform, which was created by a team including DetectED-X founders in 2010 at the University of Sydney and implemented across Australia, Europe, Asia and North America.

In 2019, the Australian Government commissioned our team to deliver a similar solution for diagnosing dust disease using High-Resolution Computed Tomography. The platform then accommodated a COVID-19 diagnosis tool during 2020. Through DetectED-X's free virtual clinical environment, clinicians are able to become better at recognising the early CT signs of COVID-19.

DetectED-X is a browser-based application that allows clinicians to improve their detection performance on their computer or laptop. In the clinician's own reading environment, they view and judge a set of Lung CT cases via their machine with connectivity to the internet. They view the cases in DICOM format on the computer and mark the cases using online scoring software via their trackpad or mouse.

Once the clinicians have completed the test-sets, they are presented with results describing their performance metrics including specificity, sensitivity, true positive, true negative, false positive and false negative scores. Also, a reader specific image file is instantly generated that enables them to review all the images that were within the test-set just completed, as well as demonstrating your decisions alongside the expert truth for each image.

This platform was created to support clinicians through the COVID-19 pandemic but will also continue to benefit other medical fields through the creation of platforms including the BreastED, LungED, ImagED, LinED and UltraED platforms. Each platform is for a different category of medical imaging, but due to the continuous evolution of technology, this online network allows for the practitioners to become better at diagnosing different diseases and conditions.

Additionally, due to this being a cloud-based platform, easy access allows for sustainability and quick diagnosis training. This new form of clinical training is revolutionary and will encourage higher quality of diagnosing by medical practitioners which will result in the lower rates of mortality across a variety of diseases. ha

SAM HARKUS
Principal Audiologist, Aboriginal and Torres Strait Islander Services, Hearing Australia

New research shows kids' ear and hearing health is an urgent priority

Otoscopy 2 Daynawa

For the majority of Australian children who experience it, otitis media or middle ear infection is a painful but relatively short-term condition, happily unlikely to impact children's long term listening and communication skills development.

However, Aboriginal and Torres Strait Islander children have a significantly different experience of middle ear disease than non-Indigenous Australian children. They tend to acquire ear disease earlier, as young as six weeks old. It's often without obvious signs. It's more prevalent and more likely to become chronic: one in three children will have at least one type of middle ear condition and will experience middle ear disease over 10 times longer than non-Indigenous children.[1] More children experience the severest forms, at rates the World Health Organization call 'a massive public health problem requiring urgent attention'.[2] Persistent otitis media is not confined to remote communities however, almost half of a group of Aboriginal babies in an ongoing Perth study had developed middle ear infection by the age of six months.[3]

When otitis media presents like this, it impacts development and life trajectories. It often persists throughout the critical years when foundational listening and communication skills are learned, important for many reasons including literacy. Three Australian studies now show a link between chronic otitis media in early childhood and delay across a range of developmental domains at school entry.[4, 5, 6] Many Aboriginal and Torres Strait Islander children are starting their formal education years at a disadvantage.

Hearing Australia is committed to reduce the rate of hearing loss in Aboriginal and Torres Strait Islander children by at least half by 2029.

Avoiding long term developmental impacts

Hearing Australia's research division, the National Acoustic Laboratories, recently recommended that, in order to avoid development impacts, Aboriginal and Torres Strait Islander children with significant otitis media-related hearing loss should have hearing loss remediated as early as possible before they turn one year old, or within three months of diagnosis.

Hearing can be improved through several means: through primary health care with guidance from clinical guidelines like the Otitis Media Guidelines >

"Aboriginal and Torres Strait Islander children make up almost ten percent of Australian children with hearing devices and most have hearing loss caused by otitis media."

for Aboriginal and Torres Strait Islander Children; through specialist medical or surgical treatment; and through use of hearing devices to make sound easily audible.

Aboriginal and Torres Strait Islander children make up almost ten percent of Australian children with hearing devices and most have hearing loss caused by otitis media. Currently, only around one in four receive their first hearing aid by the age of five years.[7] This can be significantly reduced by earlier diagnosis of persistent otitis media and prompt referral for hearing assessment.

Unfortunately, many Aboriginal children do not connect with specialist ear health care until around the same age. A recent national survey of hearing health practitioners indicates Aboriginal and Torres Strait Islander children commonly wait two to four years for surgical care, such as insertion of grommets). Ear disease hospitalisation data also suggests young Aboriginal children are under-represented in in-patient pathways: hospitalisation rates for non-Indigenous Australian children aged 0-4 years are almost double those for Aboriginal children aged 0–4 years, while for Aboriginal children aged 10–14 years, the rate is almost three times higher.[8]

What can be done?

So, what can be done to ensure Aboriginal and Torres Strait Islander children get early support for ear and hearing trouble and the impacts on their developing listening and communication skills are minimised?

1. **Make use of the clinical guidelines.** The 2020 Otitis Media Guidelines for Aboriginal & Torres Strait Islander Children guide practitioners through diagnosis, management and referral, and are now an App! www.otitismediaguidelines.com
2. **Look in ears regularly.** The signs of otitis media can be subtle and easily missed. Don't wait for family to raise concerns: look in Aboriginal children's ears regularly, from as early as age as possible. If you need a refresher, primary health practitioners can register for free on-demand training through TAFE NSW's new Ear Train program: www.tafensw.edu.au/eartrain
3. **Pair otoscopy with tympanometry.** Working out what's happening in a child's middle ear is challenging by visual inspection alone, even for audiologists. A tympanometer, which measures middle ear movement, boosts the chance of a correct diagnosis. To refresh tympanometry knowledge, use online resources like Ear Train or this one from Hearing Australia: www.hearing.com.au/Resources-for-health-professionals/General-Practitioners/Tympanometry-training-for-primary-health-services
4. **Take a listening skills approach.** Listening is the first literacy skill to develop. Listening skills develop in an ordered way and are a reliable indicator of hearing status. New checklists help primary health staff evaluate listening skills, work out whether children are on track and guide referrals: www.plumandhats.nal.gov.au
5. **Refer early for hearing assessment.** HAPEE hearing assessments for all Aboriginal & Torres Strait Islander children not yet attending full time school are available for primary health to refer to in many community locations and at Hearing Australia centres. These assessments are free* for families: www.hearing.com.au/Hearing-loss/HAPEE
6. **Build listening and communication skills.** All children with ear and hearing trouble will benefit enormously from plenty of daily opportunities to practice their listening and communication skills. Yarning at Home provides families with a starting point on how to do this. https://plumandhats.nal.gov.au/listening-yarning-skills/

Disclaimer* The Hearing Assessment Program is an initiative of the Commonwealth Department of Health. Aboriginal and Torres Strait Islander children not yet attending full time school are eligible to be seen. All services provided under this program are free of charge. A hearing check includes a number of age appropriate tests of hearing and middle ear function.

"Currently, only around one in four receive their first hearing aid by the age of five years.[7] This can be significantly reduced by earlier diagnosis of persistent otitis media and prompt referral for hearing assessment."

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KERREN HOSKING
Director Medical Programs, Humpty Dumpty Foundation

Paediatrician Dr Louise Woodward and baby Davey who was the first child transported in the neonatal transport incubator donated to Royal Darwin Public Hospital.

Small gains translate into big differences

How one charity helps public hospitals improve health equity for kids

In 2019, the Federal Government launched the *National Action Plan for the Health of Children and Young People: 2020—2030*, outlining the 'national approach to improving health outcomes for all children and young people, particularly those at greatest risk of poor health'.

Priority area one of the national action plan highlights the importance of addressing health inequity for children and young people — the social and other determinants that contribute to this are complex and often compounded, and as health care professionals we are exposed to this daily, regardless of where we practise. Our goal is to treat and meet the individual needs of each patient, but there is often huge variation in the tools and resources we have available to help us do this.

The crux of national plans like this is the need for collective and collaborative efforts at all levels of society. This is not easy to coordinate and operationalise, especially when trying to bring together both public and private sectors. But there are ways to genuinely and effectively work in partnership to achieve even small gains in health equity.

All public hospitals and health services, from remote clinics to major tertiary centres, are subject to fiscal constraints. This is a reality of public funding. In the absence of budget, public health services either need to look elsewhere for support or continue to make do with what they have. Some of our larger centres and regions are lucky enough to have their own fundraising foundations, but these are few and far between.

Understanding the avenues of non-government support available to public health services is an important first step, and the charitable sector is an increasingly important partner for our public health system when it comes to supplementing and enhancing the services we provide to our patients. It is reassuring to know there are organisations >

> **“ It shouldn’t matter where you live, but all too often the geography lottery means children in rural and remote Australia are unable to access the same level of care as children in metropolitan areas.”**

able to support and work collectively with us towards improving health outcomes for children.

For 30 years the Humpty Dumpty Foundation has worked to help bridge the gap that often exists between available resources and actual needs through the donation of paediatric medical equipment. Humpty, like many other charitable initiatives, began with a humble goal. Its Founder and Executive Chairman, Paul Francis OAM, together with Patron Ray Martin AM, set out to raise some money to paint the walls of the Children’s Ward at Royal North Shore Hospital.

Three decades later Humpty is the largest provider of children’s medical equipment to public hospitals and health services in Australia behind governments, supported by a very generous private and corporate donor base.

To date more than 440 hospitals and health services have shared in over $85 million of essential and lifesaving medical equipment for sick and injured paediatric patients. The concept is pretty simple—individual health services identify a specific, unmet equipment need where government funding is not available and apply for this to be included on Humpty’s Wish List. Applications are reviewed by a committee of medical and policy experts to ensure the need is clear and justified, and the equipment is fit-for-purpose for the level of service provided.

Approved Wish List requests are promoted to Humpty’s donor base and beyond in the hope of finding a donor.

And find donors they do. In the past six months alone Humpty has donated around $3 million in paediatric equipment to over 100 hospitals and health services right across the country — from remote health clinics to major children’s hospitals. The equipment provided ranges from intravenous access devices such as EZ-IO drills right through to sophisticated neonatal transport incubators and ventilation devices.

Against the backdrop of tight health budgets, the work of foundations like Humpty brings much needed private investment into the public health system to address key areas of need and improve health equity. It shouldn’t matter where you live, but all too often the geography lottery means children in rural and remote Australia are unable to access the same level of care as children in metropolitan areas.

While equipment alone doesn’t solve this problem, it can make a tangible difference at the coal face and help to save lives. For health care professionals it provides some confidence they have the right tools on hand to effectively stabilise, monitor and treat small patients until retrieval teams arrive. For families it might mean the difference between receiving treatment close to home or being forced to relocate away from their support systems.

Mid North Coast Local Health District Corporate Relations Manager Sharon Fuller said the support of Humpty Dumpty Foundation and its donors means nursing and medical staff can access the specific equipment they need.

‘Our Paediatric, Midwifery and Emergency teams know exactly the equipment they need to make a difference in the lives of their young patients,’ Mrs Fuller said.

‘The Foundation and its supporters help transform those wish lists into real medical equipment, from items that monitor jaundice to life-saving paediatric laryngoscopes in ED.

‘The difference this equipment makes can’t be measured in dollars alone. It saves lives, it reunites families and it boosts staff morale… our doctors and nurses know they have the community’s support for the very important work they do every day of the year.’

Humpty’s work is evolving, creating exciting opportunities for health services, local hospital districts, governments and service providers to work collaboratively, address areas of genuine need and make a real difference. Recent initiatives include large scale rollouts of equipment to support screening and early detection programs for Aboriginal and Torres Strait Islander children, building regional capability for transfer and retrieval services, and equipping smaller hospitals to better manage critically ill neonates while awaiting transfer to a higher level unit. ha

Hospitals wishing to make equipment requests can visit the website www.humpty.com.au. If you are interested in a discussion with Humpty about ways to work together, please email medical@humpty.com.au or call (02) 9419 2410.

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Improving the quality of healthcare?

Not wasting clinicians' time would help

Ismael Nieto

"The overall quality of resident care increased: staff spent more time with residents; responded better to resident needs; and managed the 'delicacies of dignity' better."

Most submissions to government in health call for increased funding to improve outcomes for patients and other consumers. But putting more funds into a wasteful system can exacerbate, rather than solve, problems.

Studies from Australia and around the world show that nurses spend about 30% of their time on paper-based and electronic records.[1] There are roughly 280,000 FTE nurses in Australia, so maintaining these systems costs about $7.5 billion per year.

Wasting nurse time in this way distracts from care. It is well established that more nurse time with patients means faster patient recovery, fewer readmissions and reduced lengths of hospital stays.[2]

A 2-year independent evaluation by the University of Canberra of a deployment of Humanetix 'ACE' in Jindalee Aged Care in the ACT found that ACE improved the quality of care while increasing efficiency and saving employee time.

ACE is a point-of-care documentation, decision-support and clinical workflow system. It can be applied in a variety of clinical environments.

The evaluation by the University of Canberra was funded by the Australian Government. It found that ACE reduced staff time on 'waste' activities. Nurses spent 6% less time searching for information and took 25% less steps per shift. Nurse time on documentation fell from 20.4% to 6.4%, bringing total time saved by nurses to 20%.

The overall quality of resident care increased: staff spent more time with residents; responded better to resident needs; and managed the 'delicacies of dignity' better.

Quality of documentation improved, including legibility, completeness and data accessibility. Resident-focused goal setting rose from 56% to 88% and completed nursing evaluations rose from 31% to 88%. Completion of resident assessments increased from 68% to 96%. Documentation of the nursing process increased from a median score of 10 pre-implementation to a median score of 17, out of a possible score of 18.

The improved quality and completeness of documentation is an important advance on earlier forms of electronic-based health records. Previous research found that while electronic health records reported better process and documentation structure, with no illegible handwriting, paper-based records provided more complete and accurate documentation. By contrast, ACE has shown to improve both the quality, accuracy and the completeness of records.

These improvements came despite the deployment being during COVID-19 pandemic, when staff and residents reported significant stress and behavioural issues.

The results show major improvements from streamlining the administration load on nurses. Ensuring nurses can spend more time with residents means that resources are effectively deployed. This improves health outcomes and employee satisfaction.[3] High quality, comprehensive data at the point-of-care also assists clinical decision-making and further improves care.

Technological solutions like ACE are resources we can invest in now. These investments in health deliver strong returns by improving employee satisfaction and patient health outcomes and ensuring resources are used as best as possible. ha

Learn more about the University of Canberra's study of ACE in this short video.

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- healthcare education or research
- the supply of goods and services to publicly-funded hospitals or healthcare services.

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- access to networking opportunities, including quality events
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  -The Health Advocate
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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.

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The AHHA Board has overall responsibility for governance including the strategic direction and operational efficiency of the organisation.

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