Outpatient Care – A look to the future

Clinical Senate Meeting

Final Report

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Presenters

- Ms Marie Taylor, Nyungar Elder
- Professor Julie Quinlivan, Chair, Clinical Senate WA
- Dr David Russell-Weisz, Director General, Department of Health
- Mr Jeffrey Moffet, Chief Executive Officer, WA Country Health Service
- Mr Lesley Ayton, Consumer
- Ms Melissa Vernon, Chief Operating Officer, Strategy and Reform, WA Country Health Service
- Dr Jared Watts, Senior Registrar, Obstetrics and Gynaecology, Joondalup Health Campus
- Dr Michael Civil, General Practitioner, Stirk Medical Group and Co-Lead, Primary Care Health Network, Department of Health
- Associate Professor Graeme Boardley, Executive Director, Midwifery, Nursing and Patient Support Services, Women and Newborn Health Service
- Ms Christine Carroll, Clinical Nurse Specialist, G61 Ward, Sir Charles Gairdner Hospital
- Professor David Joske, Head of Department, Haematology Centre, Sir Charles Gairdner Hospital
- Ms Karen Banks, Project Director, Outpatient Reform, South Metropolitan Health Service

Expert Witnesses

- Ms Kate Gatti, Executive Director, Population Health, Ambulatory Care and Strategic Allied Health, South Metropolitan Health Service
- Dr Michele Genevieve, Clinical Lead, Emergency Department, Swan Districts Hospital
- Ms Lynda Miller, Clinical Lead Coordinator, Antenatal Clinic, Joondalup Health Campus
- Dr Frank Willis, Consultant, Paediatric Department, Fiona Stanley Hospital and Consultant, Department of Nephrology, Princess Margaret Hospital
- Dr Marianne Wood, Liaison General Practitioner (Aboriginal Health), Royal Perth Hospital
- Associate Professor Dale Edgar, Senior Physiotherapist, Burns Rehabilitation, Fiona Stanley Hospital

Introduction

The role of the Clinical Senate of Western Australia (WA) is to provide a forum where collective knowledge is used to discuss and debate current strategic health issues. Recommendations are made in the best interest of the health of all Western Australians and are subsequently provided to the Director General (DG), the State Health Executive Forum (SHEF) and through the DG to the Minister for Health.

The third meeting of the Clinical Senate of Western Australia for 2015 was held on 4 September at the University Club of WA. The topic for debate was Outpatient Care – A look to the future.

The specific debate focus was to drive innovation in outpatient care, whilst ensuring care remained patient centred, value for money and evidence based. For the purpose of this debate Outpatient Care was defined as patient-centred care of an individual who is not an inpatient in a healthcare facility and whose care is delivered by a provider at that facility. Outpatient care may be provided through face to face contact or via telemedicine and may involve consultation or an intervention or minor surgical operation. Outpatient care may be provided by medical, nursing or allied health staff.

In planning for the debate, multidisciplinary healthcare professionals, senior and emerging leaders, clinical leaders from primary care and private and public health services, researchers and academics were invited as expert witnesses to share their expertise in outpatient care.

In her opening address Senate Chair, Professor Julie Quinlivan spoke of the historical origins and purpose of outpatient care. She emphasized innovation was a careful balance between retaining the best of the past, whilst optimizing the advantages of the future. She challenged Senators to consider two issues. Firstly, how do we innovate outpatient care through utilisation of technological advances and modern therapeutics to improve patient outcomes? Secondly, how do we stop practices that are no longer relevant, effective or patient centred?

Director General, Dr David Russell-Weisz officially opened the debate acknowledging the importance and diversity of the clinical senate and its role in engaging clinicians, and utilising its expertise to add value to WA Health. He outlined his WA Health priorities, and defined WA Health's core business as delivering safe care in a way that optimises patient experience and outcomes.

Dr Russell-Weisz challenged the Senators to consider how to improve efficiency of outpatient services given WA costs are considerably higher than Eastern states benchmarks. He asked Senators to advise how WA Health could incrementally improve outcomes over the next 5-10 years within this space. He posed three questions: Do patients receive the right services? Do we move patients excessively between care providers? Could we better use general practitioners?

In setting the scene for debate, Executive Sponsor Mr Jeffrey Moffet emphasised the need to push boundaries and look into the future. He stated current performance could be improved. He asked if WA Health really put the patient first, or did we keep patients and use old ways of working as it suited us? He reflected on the lack of a universal definition of outpatient care and the difficulties in measuring performance. He highlighted that outpatient services represent a $660M annual cost within ABF (14% of total budget). He noted there were significant variations in occasions of services delivered nationally due to different service models, and a lack of agreed outcome measures, governance and regulation. From a purchaser perspective, he questioned what value is derived from outpatients? Are some services discretionary or unnecessary, and what is the role delineation with the private and non-government sector?

Mr Moffet also highlighted three examples of patient experiences that emphasized the challenges of accessing services, the benefits of broader use of technology and the importance of improving care coordination.

1. Process

The Clinical Senate in Western Australia was established in 2003 and each debate follows a standard process that has been refined over time. This process ensures that senators and others involved have a clear understanding of what is required and receive sufficient information to discuss the topic and then develop recommendations for the Director General of Health (DG) and the State Health Executive Forum (SHEF). A copy of the program is included (Appendix A).

Prior to the debate, attendees received a series of webinars and pre-reading documents containing background information in preparation for the debate.

The full day Senate debate traditionally commences with a Welcome to Country, which for this debate was offered by Nyungar Elder, Ms Marie Taylor.

Following the Welcome to Country, the Chair of the Clinical Senate, Professor Julie Quinlivan welcomed attendees and gave an update on senate activities and introduced the topic by providing a historical account of the origins of outpatient care.

The Director General, David Russell-Weisz officially opened the debate. He outlined his priorities for WA Health into the future defining core business as delivering care to our patients in a safe way and in a way that improves that optimises patient experience and outcomes. He highlighted the need for financial sustainability in the current economic environment and in the wake of massive change and reform in health across the entire state.

Executive Sponsor Mr Jeffery Moffet was charged with setting the scene for debate and emphasised the need to push the boundaries and to consider while we need to look into the future, we must also be real about today and the fact that we are not doing as well as we could. He posed the critical question, are we really putting the patient patients first or are we keeping patients and using old ways of working as it suits us?

Consumer Mr Lesley Ayton joined the conversation via videoconference from Albany, Western Australia. He shared his lived experience and showcased the benefits of telemedicine which for him and his wife means he is able to receive care closer to home.

The next stage of the Clinical Senate process was a traditional plenary debate entitled “The Patient Experience”. It consisted of eight rapid five minute presentations where a presenters used a traditional debate format and provided four key arguments for and four key arguments against the provocative premise “Outpatients is dead”. The aim was to encourage clinical senators to consider innovations in outpatient care, without losing sight of the features of care that are effective.

The presenters for this session included: Ms Melissa Vernon, Prof Julie Quinlivan, Associate Professor Graeme Boardley, Professor David Joske, Dr Jared Watts, Dr Mike Civil, Ms Christine Carroll and Ms Karen Banks.

This gave participants a foundation for the free flowing debate that followed where both senators and invited experts considered the current state of play and opportunities to innovate in this area.

The afternoon sessions were devoted to two concurrent workshops in which participants focused either on:

a) Innovations in outpatient care or
b) What to stop.

Recommendations from the workshops were presented in the final session of the day and ranked in order of importance by the full Senate. The Clinical Senate Executive issued a

request for a response by the Director General of Health to each recommendation at the next debate. Responses could be:

a) endorsed,
b) endorsed in principle, or
c) not endorsed.

2. Presentations

Mr Bevan Bessen, facilitator for the day, opened proceedings by welcoming participants and introducing Nyungar Elder Ms Marie Taylor who offered the Welcome to Country.

Ms Marie Taylor offered the welcome in Nyungar language. She acknowledged the aboriginal custodians who she stated welcome all people here on this, the land of the rolling hills, running water of rivers, swamps and rock holes where the grass, tree, the gum tree, and the banksia grow and bloom beneath the glowing sun while the booming sea rolls over the golden sand to call upon the singing magpies whose song will awaken the sleeping people and remind us that our heartland dreaming is to learn from the past today before shouting victory tomorrow.

She closed wishing senators well in their deliberations and offering this Nyungar Irish blessing "May the road rise up to meet you, May the wind be always at your back, May the sun shine warm upon your face; the rains fall soft upon your fields and until we meet again, may God hold you in the palm of His hand".

Mr Bessen introduced Clinical Senate Chair, Professor Julie Quinlivan, who recognised the traditional owners and thanked Ms Taylor for her welcome and blessing.

In her opening address Senate Chair, Professor Julie Quinlivan provided a historical reflection of outpatients. She stated that innovation is a careful balance of retaining the best of the past, whilst optimizing the advantages of the future. Prof Quinlivan expressed that in thinking about how outpatient care may change in the future it was important to reflect upon its' origins.

For the purpose of this debate she stated, Outpatient (non-admitted) Care is defined as patient-centred care of an individual who is not an inpatient in a healthcare facility and whose care is delivered by a provider at that facility. Outpatient care may be provided through face to face contact or via telemedicine. Outpatient care may involve consultation or an intervention or minor surgical operation. Outpatient care may be provided by medical, nursing or allied health staff.

Prof Quinlivan stated "with a desire to look to the future, but not leave the best of the past behind, I challenge you to consider two issues". Firstly, how do we innovate outpatient care considering advances in the technology and therapeutics in order to improve patient outcomes? Secondly, what is no longer relevant, effective or patient centred for the future and therefore we should no longer be continued.

Prof Quinlivan introduced the list of speakers whom she stated would inform the debate and kick start the discussion. The Sponsor of the debate Mr Jeffrey Moffett would set the scene followed by consumer, Mr Lesley Ayton who will share his personal experience. Following on from this would be a traditional debate presenting four key arguments for and four against the provocative premise "Outpatients is Dead". The aim is to encourage you to consider innovations in outpatient care, without losing sight of the features of current care that are effective.

The presenters for this session were: Speaking to the affirmative:
Ms Melissa Vernon: Telehealth is the way of the future; Professor Julie Quinlivan: Outpatients should be the new day surgery; Associate Professor Graeme Boardley: Better clinical guidelines and work up is required; and Professor David Joske: Follow up for follow up sake.

The four presenters speaking to the negative were:
Dr Jared Watts: Outpatients supports teaching and research; Dr Mike Civil: Outpatients supports primary care; Ms Christine Carroll: Outpatients reduces LOS and Hospitalisation rates; and Ms Karen Banks: Rehabilitation – no direct referral- complex cases.

She next welcomed senators, in particular new term members to their first debate as well as member representatives and emphasised the process of how the Clinical Senate of WA does business:

- To work collaboratively, setting aside individual and organisational agenda.
- To state your opinions freely, drawing on your clinical experience and expertise.
- To empower you to influence others in all your professional spheres with the new perspectives gained through the debate.
- To play a leadership role in health reform, developing strong, valid, priority recommendations in the best interests of the health of all Western Australians.

Prof Quinlivan reminded participants that all recommendations would go to the Director General of Health and his executive with an explicit response requested.

In introducing newly appointed Director General, David Russell-Weisz, to respond to the Senate recommendations, Prof Quinlivan welcomed him to his first senate meeting and thanked him for responding to the recommendations from the senate debate on Clinician Engagement and opening the debate.

Dr Russell responded whilst this was his first appearance at the Clinical Senate as Director General of WA Health, he was not new to the Senate as he was an inaugural member in 2003. He was well aware of the value of the senate and its role in contributing to, and leading, clinical and system-wide reform and looked forward to facilitating the clinical senate to continue this important work.

Dr Russell-Weisz stated it protocol that he start proceedings by reporting back on the recommendations developed during the previous Clinical Senate debate. In June 2015, the Senate discussed a topic" very close to my heart" – clinical engagement. This topic is important not only because there is a clear link between clinical engagement and health service performance - but also because there is consistent and growing evidence that clinical engagement is necessary for health reform.

Dr Russell-Weisz reported, given WA Health was in the midst of a substantial reform program, this debate proved timely as there was the need to consider how we can best engage our clinicians, and embed a culture of clinical engagement in our healthcare settings.

He stated that in reviewing the report and recommendations from that debate – I was pleased to see that a lot of work is already being done across our health system in regards to clinical engagement. From engagement frameworks and leadership programs, to values-based recruitment and a focus on creating strong, multidisciplinary teams – our hospitals and health services are embracing the fact that clinical engagement is not an optional extra. It needs to be part of our core business however, there are still clinicians in our health systems that do not feel engaged - so there is still work to be done.

The Director General reported that nine of the ten recommendations were endorsed. The report on each recommendation follows in the order in which the DG presented. He chose to group the related recommendations together. His report was as follows:

<u>Recommendation 1- Endorsed:</u>

WA Health refines, implements and embeds best practice in strategic human resources management, with a specific focus on:

- Values-based recruitment and selection.
- Optimising orientation of new appointments into the culture of the organisation.
- Regular and appropriate performance management that's meaningful to clinicians and the organisation (and links to patient, team and business outcomes).
- Talent management and succession planning frameworks and initiatives.

With the aim to improve engagement processes in the organisation

Response: Dr Russell-Weisz reported it his understanding that for the first time the Clinical Senate's top recommendation was endorsed by the full chamber. He reported that he fully endorses this recommendation and it was critically important to get the values of the organisation right.

He noted that individual hospitals and health services will be responsible for implementation of this recommendation. Therefore, the Chief Executive Officers of Area Health Services will need to be consulted to ensure compliance and that performance management is meaningful.

He next reported on three inter-related recommendations, numbers 9, 3 and 2 which he stated were all endorsed and ask that WA Health articulates a common vision, framework and tool to manage clinical engagement.

He started with recommendation 9:

Recommendation 9: Endorsed

WA Health to commit to the development of a common vision for all health services in WA.

To:

1. Achieve unity in shared values and collaboration
2. Inspire engagement
3. Focus on patients as the core
4. Link these common values to orientation/leadership/appraisal process

Response: The Department of Health would work with the relevant people throughout the system to ensure a common vision is created to engage clinicians across the health system.

Recommendation 3: Endorsed

1. WA Health establishes a system-wide framework for effective clinical engagement (in addition to consumer, carer, community) to be used in strategic reform, policy development, system redesign, safety and quality improvement and ICT development.
2. The framework could include the following:
    - Multi-disciplinary/professions/level/services
    - Adequate resources
    - Leadership models
    - Training
    - Infrastructure to support
    - KPI's
    - Process and implementation plan

Response: He referenced the framework presented at the meeting (IAP2) and stated he has requested it be presented to SHEF at their September meeting. Note: The IAP2 public participant spectrum is internationally recognised as and evidence based engagement framework therefore, the Department of Health supports establishment of a clinical engage framework based on IAP2.

Recommendation 2- Endorsed

WA Health to adopt an agreed clinician engagement tool that is measured annually and reported to SHEF.

- Each health service to develop an engagement strategy
- Engagement outcomes are to be correlated annually against an agreed set of quality indicators, determined with clinician input (and which include a measure of patient experience)
- Departmental results must be feedback to clinicians at the front line

Response: DG consideration of the appropriate tool to be adopted for use by all Area Health Services will be part of the development of a system-wide framework – as outlined in Recommendation 3. He stated he agreed that there be one uniform tool for Health.

One such tool has already been successfully piloted by the North Metropolitan Health Service and has baseline data. The Department will draw on the North Metropolitan Health Service's experiences when considering an appropriate system-wide tool.

He next reported on recommendations 4, 5 and 6 which he stated all relate to the importance of leadership development and therefore the training and support of our health systems clinicians as leaders.

Recommendation 4: Endorsed

The Chief Officers from Medical, Dental, Nursing/Midwifery and Health Professions, work collaboratively with the Institute for Health Leadership (IHL) to ensure future leadership programs are interprofessional and more accessible (i.e. more places, all levels of employees, equitable access).

Response: This involves ensuring that we have more places, include all levels of employees, and offer equitable access.

The Institute for Health Leadership is working proactively create more interdisciplinary development opportunities and - where possible - support new clinician development programs.

The Chiefs and IHL will make sure we are building these into future leadership programs – what are the competencies across the clinical workforce. We have developed leadership programs and we want a framework to be adaptable for different people in the organisation.

The Institute is also collaborating with all three medical schools to embed leadership development and service improvement training in undergraduate medical training from 2016. They will also explore opportunities with all health science faculties to embed leadership development across all health professional education.

He stated he was a great believer in clinicians leading health care and we have moved well away from non-clinician leadership.

Recommendation 5: Endorsed

WA Health to develop a clinical leadership framework that outlines the competencies required across all levels of the clinical workforce.

- Picking up on Health LEADS* and other work in this area
- In partnership with education providers as appropriate
- Aligned with existing efforts or programs
- Includes performance appraisal

http://www.hwa.gov.au/sites/uploads/Health-LEADS-Australia-A4-FINAL.pdf

Response: The Institute for Health Leadership has been working collaboratively with Queensland Health and other jurisdictions to offer staff a HealthLEADS 360-degree feedback tool to be used as a clinical leadership framework.

It will continue to assess the cost and quality of this tool before suggesting its broad use across WA Health.

Recommendation 6: Endorsed

WA Health increase opportunities for participation in health leadership programs with a focus on clinician engagement through Clinical Service Redesign (CSR).

- Engagement in CSR is part of annual performance review
- Participation in CSR is a pre requisite for contract renewal

Response:

In regards, to leadership, Recommendation 6 stipulates that WA Health increases opportunities for participation in health leadership programs with a focus on clinician engagement through Clinical Service Redesign (CSR).

This includes making engagement in Clinical Service Redesign part of an annual performance review and a prerequisite for contract renewal.

The Institute for Health Leadership will continue to work collaboratively with the Chief Officers to identify and create more interdisciplinary development opportunities.

This recommendation will also require us to investigate how to provide protected non-clinical time for clinical staff to lead team-based or service-based improvement initiatives.

Recommendation 7: Endorsed

WA Health sponsor and oversee/train facilitators to enhance and progress team based service delivery. These facilitators may be sourced from within DoH, IHL, from other Clinical Leads, or external. [The facilitator is external to the team being considered].

Response:

The Institute of Health Leadership will continue to work with Health Services to support them to design and deliver interventions that improve the quality of teamwork and the organisational culture. The Institute will also work with the Health Reform Team to ensure teamwork is an active component of health reform.

Recommendation 10: Endorsed

WA Health commits that adoption of all new information technology systems will require a process that engages clinicians with active patient contact in their design, configuration and ongoing development. This should be incorporated into the implementation of the WA Health ICT Strategy.

Response:

The Director General stated that as it stands, the current WA Health ICT strategy states that clinical leadership is critical to establishing systems that deliver better care.

The ICT Executive Board and ICT Program Committee will be asked to adopt strategies to ensure this recommendation is implemented, particularly in the context of the new ICT proposal process.

Recommendation 8: Not Endorsed

WA Health to adopt an online moderated platform* – specifically "Patient Opinion Australia" and "Carer Opinion Australia" – in order for health services and clinicians to listen to and engage with the experiences, good and bad, of consumers and carers.

* https://www.patientopinion.org.au/

Response:

Dr Russell-Weisz reported this was the only recommendation from the previous Clinical Senate that was not endorsed. He explained the reason the recommendation was not endorsed was because WA Health already had a process in place to respond to, and report on, consumer feedback. That said, we want to make sure that the processes we have are the right ones; and need to acknowledge the increasing education and IT literacy of consumers.

Therefore, this recommendation will be referred to staff responsible for undertaking the upcoming review of the WA Health Consumer and Carer Engagement Framework and they will be asked to consider how Health might incorporate on line tools into consumer feedback.

In addressing the topic of the day, Outpatient Care – A look to the future, Dr Russell-Weisz reported that Outpatient care accounts for an ever-increasing proportion of the health care provided by our health system, thanks to advances in technology and medical treatments, as well as our continuing challenge to ensure our services provide value for money.

Given that this trend will only increase in time, he stated we need to be sure that the outpatient care we provide is patient-centred, evidence based and cost effective. We also need to ensure that we are providing the right kinds of outpatient care, in the right ways – and that we are not doing things simply because, historically, that is the way we have always done it.

He highlighted the need for fiscal accountability in the wake of economic realities and State-wide health reform. Dr Russell-Weisz challenged the Senators to consider how to improve efficiency of outpatient services given WA costs are considerably higher than Eastern states benchmarks. He asked Senators to advise how WA Health could incrementally improve outcomes over the next 5-10 years within this space. He posed three questions: Do patients receive the right services? Do we move patients excessively between care providers? Could we better use general practitioners?

He stated that some of these questions could prove difficult, and would require tough decisions such as: 'Do we axe specific outpatient clinics that are not producing evidence-based results?' Yet, others may push us some of us out of our comfort zones – for example: 'Should outpatient services that don't involve examination, procedures or minor surgery stop being face-to-face?'

In closing, Dr Russell-Weisz urged senators to embrace the opportunity to discuss these important issues, knowing that the outcomes from the debate would be vital in helping WA Health to deliver appropriate and effective outpatient services into the future. I look forward to receiving your recommendations.

Mr Bessen thanked Dr Russell-Weisz for his address and introduced the first speaker for the day, Executive Sponsor Mr Jeffrey Moffett, Chief Executive Officer WA County Health Service.

In setting the scene for debate, he emphasised the need to push the boundaries and to consider while we need to look into the future, we must also be real about today and the fact that we are not doing as well as we could.

He posed the critical question, are we really putting the patients first or are we keeping patients and using old ways of working as it suits us?

His initial reflections on the topic highlighted the lack of universal definition of outpatient care and the difficulties in measuring performance in this area. He presented an alternative definition of outpatients, which demonstrated the different perceptions and understandings of outpatients in the system within WA. In the acute space, there is clarity about service definition, measurement and performance monitoring however this is not the case for outpatient services.

He presented evidence of current occasions of service for outpatient care and relative investments across the diverse types of services provided in Australia. He highlighted the significant variations in occasions of service nationally were due to the use of different measurement techniques. Clinical governance and regulation should be strengthened in outpatients.

Mr Moffet reported there is significant investment in WA for outpatients with an estimate of $660m or 14% of the total ABF budget for 2015/2016(consider reference here AIHW). Whilst WA has approximately 2.2 million occasions of service for outpatients, it raises little revenue to support the high volume activity. From a purchaser perspective, he stated, we should anticipate what value is derived from outpatients. Are some services discretionary or unnecessary, the role delineation with the private and non-government sector and the appropriate costing of services?

He provided three patient experiences which identified the challenges of accessing services, the benefits of broader use of technology and modalities and the importance of care coordination for better patient care.

The linkage between outpatients and primary care providers needs investment to clarify role delineations, pathways for care and to increase support for GPs to provide ongoing care for patients rather than rescheduling ongoing outpatients appointments. There is a need for KPIs that reflect movement into primary care rather than increasing occasions of service in outpatients.

Mr Moffet closed by stating that outpatients have the capacity to contribute significantly to improved health care access and outcomes.

Mr Bessen thanked Mr Moffet for setting the scene for the debate and introduced consumer Mr Lelsey Ayton who joined the conversation via videoconference from Albany, Western Australia. He shared his lived experience and showcased the benefits of telemedicine which for him and his wife meant he was able to receive care closer to home. Mr Ayton attends well-structured appointments with his specialist in Perth at which he could manage his care, discuss medications and treatment options and importantly ask questions he had about changes in his condition and discuss his care plan.

What followed was eight rapid five minute presentations where a presenters used a traditional debate format to provide four key arguments for and four key arguments against the provocative premise “Outpatients is dead”. The aim was to encourage clinical senators to consider innovations in outpatient care, without losing sight of the features of care that are effective.

The presenters for this session included: Ms Melissa Vernon, Professor Julie Quinlivan, Associate Professor Graeme Boardley, Professor David Joske, Dr Jared Watts, Dr Mike Civil, Ms Christine Carroll and Ms Karen Banks.

Arguments for the affirmative discussed the value of Telehealth to replace traditional outpatients in both rural and metropolitan locations, increasing opportunities to convert inpatient admissions to outpatients (see and treat) occasions of service, availability of better clinical guidelines and models of care and to need to stop follow up for “follow up sake”.

Arguments for the negative discussed how outpatients support teaching and research, supports primary care, reduces LOS and hospitalisation rates and support for patients with complex care needs.

A short summary of each talk was as follows:

For:

Ms Melissa Vernon: Telehealth is the way of the future

Melissa reported that Telehealth is rapidly replacing old style of outpatient care; provides support to remote family, is also applicable to metro families; provides solutions to consumer access and provides greater choice. It empowers the patient with increased confidence for both patient and GP through involvement with specialist. As for the barriers she identified ABF funding and quoted once consumer who said "if the disease doesn't kill me the travel will".

Professor Julie Quinlivan: Outpatients should be the new day surgery

She argued that traditional models are inefficient- inpatient admissions can be converted to outpatient visits, tests don't always need to be performed by specialists or in the inpatient setting. The challenge is to consider what admissions could move to outpatient and/or could be converted to single see and treat sessions through better models of care.

Associate Professor Graeme Boardley: Better clinical guidelines and work up is required

Graeme stated that the reliance on tertiary specialist is no longer acceptable especially when antenatal women are travelling for care. Models of Car (MOCs) are the way of the future – regional nurses can work in partnership with specialists to provide care closer to home. Clinical guidelines should provide guidance to GPs in order to manage specific conditions in the community. Furthermore, continuity of care could be improved thru new MOCS.

Professor David Joske: Follow up for follow up sake

David made the case for why change is needed identifying three reasons. First of all there is an increased workload due to an increasing prevalence of cancer. Secondly, we are not meeting needs of cancer patients and unmet needs lead to fear of relapse- need to coordinate care with GPs- pts desire to access tertiary care if necessary. Lastly, follow up is variable across services – there is a need for achieving excellence in survivorship care. Patients need information and a plan so do GPs – the answer is survivorship nurses coordinators rather than specialist OP appointments

Against:

Dr Jared Watts: Outpatients supports teaching and research

Jared stated we must build on the opportunities for research and funding in outpatients. He identified 5 ways it assists teaching: holistic and complicated care better in OP; preventative medicine; observational medicine, and provides clinicians with access to patients at all stages of their disease.

Dr Mike Civil: Outpatients supports primary care

Mike stated that the outpatient system is a place where the GP can no longer manage the patients. It gives GPs the opportunity to access special treatments and complex treatment regimens e.g. chemotherapy and access to diagnostic techniques. It provides reassurance to GPS that they are providing the right care. GP could sit in on Telehealth with specialist to increase knowledge and skills in patient care.

Ms Christine Carroll: Outpatients reduces LOS and Hospitalisation rates

Christine argued the point that whilst outpatients reduces LOS and hospitalisation, some patients do require ongoing specialist opinion. Some things cannot be checked by Telehealth e.g. physical exams and follow up OP could occur 24 hrs a day. Patients like the autonomy of OP appointments rather than admission There is a need for expert opinion in many cases – diagnostic scopes –rapid access, reduced LOS, ED presentation and admission rates. Lastly, OP allows multidisciplinary teams to discuss patient without hospital admission.

Ms Karen Banks: Rehabilitation – no direct referral- complex cases (patient for life)

Karen stated that there has to be change, but not everything! Sharing the journey of a friend she spoke from a patient experience perspective.

Quoting Dr Frances Peabody" the essence of the practice of medicine is that it is an intensely personal matter". She highlighted the importance of trust and understanding as core and vital between patient and clinician. Success in treatment as well as the impact on the patient's depression/anxiety she argued is facilitated by the patient's opinion of the experience of clinician. Care of the patient must be personal, it is more than a photograph, and it is the environment around them which must be able to be understood in order to care for patients with chronic conditions. Furthermore, patients with long term complex chronic conditions require numerous appointments often spread across our health services.

She argued that for some people with chronic complex conditions who have very complex needs, there must still be outpatient availability.

Mr Bessen thanked all presenters for sharing their perspectives. He stated that all of the presentations confirm that there must be change and there must be innovation and it needs to be around all of the things you have heard and now need to consider. However, we need to maintain and keep the values.

Presentations from the day can be found on the Clinical Senate website:

http://ww2.health.wa.gov.au/Improving-WA-Health/Clinical-Senate-of-Western-Australia/Clinical-Senate-debates-and-publications/2015-Clinical-Senate-debates

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Following the morning break, Senators engaged in an open plenary debate.

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3. Plenary Debate

3.1 Plenary: How do we innovate outpatient care?

Facilitator	Mr Bevan Bessen
Presenters/ Expert Witnesses	➢ Mr Jeffrey Moffett ➢ Ms Melissa Vernon ➢ Dr Jared Watts ➢ Dr Michael Civil ➢ Assoc Prof Graeme Boardley ➢ Ms Christine Carroll ➢ Prof David Joske ➢ Ms Karen Banks ➢ Ms Kate Gatti ➢ Dr Michelle Genevieve ➢ Ms Lynda Miller ➢ Dr Frank Willis ➢ Dr Marianne Wood ➢ Assoc Prof Dale Edgar

Mr Bevan Bessen facilitated the plenary session which for this debate consisted of a traditional debate followed by a free flowing plenary session. He welcomed the expert witnesses and invited guests and outlined the rules for debate and the aim of the session.

This was followed by a plenary debate "How do we innovate outpatient care?" where senators and experts discussed current practice, innovation and patient experiences in the delivery of outpatient care.

They also considered what traditional practices could possibly be stopped. The debate generated key themes which were grouped using Mind map technology and taken into the concurrent workshops.

With regard to innovation most felt the drive must be towards empowering patients to be part of their own care and improving access to care closer to home. There was a strong desire to reassess to use of standardized check-ups and consider opportunities for greater involvement with primary care for follow up.

Senators acknowledged the economic environment and the need to make use of what we have in a better way. They suggested there be investment in care coordination as it will drive efficiency. The missing link is clinician engagement, clinical drivers and GP involvement to determine what is best for my patient in order to coordinate their care. Note: There is huge investment by both the federal and state governments and we need to partner to make best use of what is available.

Clinicians identified the need to streamline the process of referral and to limit unnecessary referrals. They also identified the need to review which support services could be integrated and ways to address DNAs and internal referrals of which the majority are from within – should we have barriers in place for internal and multiple referrals STOP internal referrals

It was recognized that it wasn't a case of completely stopping face to face outpatients' appointments as the necessity for hands on assessments, opportunities for teaching and

research and creation of a personalized approach to care were all valuable components of this type of care.

At the conclusion of the plenary session Mr Bessen confirmed that the key themes emerging from the full morning session had been captured using mind map software and would inform senators in the afternoon workshops (Appendix 2). The Map was distributed to all participants who attended the workshops.

Key themes for innovation were: universal use of technology, adopting systematic performance measurement tools, establishing a universal definition of outpatient care, improving links between hospitals and primary care, better models of care for general practitioners, using opportunities to build on research and teaching, and improving the patient experience.

Key themes for “what to stop” were: traditional practices of bringing patients back repeatedly (to suit clinicians), minimizing the number of hospital initiated outpatient services, increasing the role of private and NGO providers, stopping annual reviews, making patients travel when telemedicine is available, and investment of care coordination rather than providing patients with multiple different outpatient appointments with multidisciplinary providers.

All participants then broke for lunch.

Following the lunch break Senators participated in their choice of the following two workshops: Innovations in outpatient care and what to stop?

What follows are the workshop notes and final senate recommendations.

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4. Afternoon Workshop One

4.1 Innovations

Facilitator	Mr Bevan Bessen
Executive Committee Member(s)	Prof Julie Quinlivan Ms Nerida Croker Dr Dan Xu Ms Pip Brennan Ms Gerladine Ennis
Expert Witnesses	Mr Jeffrey Moffet
Support	Ms Barbara O'Neill

Bevan Bessen opened the workshop stating the focus was to consider how to innovate outpatient care.

Participants formed four groups and were provided with the mind map from the morning session. They were directed discuss what might be missing. All groups brought their issues forward and consensus was reached on five themes, with participants self-selecting to a theme of their choice.

Four groups worked across the eight themes:

1. Mapping
2. Systemic Measurement (KPIs)
3. Optimising TXR
4. Managing the appointment system (DNAs)
5. Information and Communication
6. Transition
7. Partnering with primary care
8. Patient Journey/Experience

At the end of the workshop, each group presented their recommendations. Thirteen recommendations were put forward to the workshop for voting. The top five recommendations were taken to the final session.

A summary of the group discussions during the recommendation forming stage is provided below.

Group 1

Participants addressed the following two themes:

- Mapping first appointments
- Systemic measurement through the use of KPIs

They called for the need for the Department of Health, as system managers, to develop non-admitted KPIs that can be measured across health services to inform performance, accountability and patient access. Importantly, there must be clear definitions.

Participants considered development of a pilot project to enhance patient literacy around health and in fact the health system. This could include education and information around navigating the health system; the provision of tools; care coordination etc... They proposed through the

partnerships with the Health Consumers' Council and primary care there would be efficiencies and understanding with regard to appointments, documentation; test results etc…

In considering how to facilitate innovations in outpatient care they discussed the need for WA Health Networks and WA Chief Officers to work together to further develop models of care that support alternative workforce to ongoing medical specialist review (i.e. allied, nursing, aboriginal health workers, general practitioners, midwives etc…).

Group 2 – Information and Communication

Participants considered information and communication.

They identified the need to expand the Telehealth Strategy to enable Telehealth between hospital and private connection (both rural and metro) e.g. patient at home. GP rooms, aged care facilities, prisons and to identify funding for GPs to participate in hospital –patient consultations to facilitate clinical examination and GP continuing care.

The agreed the Department of Health should consider expanding consultant JDFs to include the provision of advice to GPs by telephone (and other appropriate means) and that this activity be recognised.

Senators called for WA Health to resource the service redesign required internally to support the use of Health Pathways by GPs/in primary care.

They proposed there be an outpatient policy that required the patient be referred back to their GP unless there is an identified and documented reason for an appointment in line with Health Pathways.

The key recommendation from this group called for SHEF to mandate that the ICT Strategy specifically address outpatient communication including letters and results as well as care plans that go directly to the GP and into the PCEHR with access at the clinic.

Group 3

Participants addressed the following two themes:

- Partnering with primary care
- Transition- paediatric to adult services

Discussed were the need for better integration with primary care and the need to support the development and implementation of an on-line state-wide portal to direct referrals or clinical queries, integrated into CRS (live). They suggested this could be in conjunction with the primary care network.

They called for the need for innovation with regard to safe/efficient transition of paediatric patient to appropriate adult care. Recommended was that in order to facilitate this must develop pathways and a streamlined process. Consideration should also be given to paediatric friendly appropriate settings.

Similar to other groups they acknowledged the need for centralised coordination of care through GPs with GPs coordinating referrals. Also considered were: diverse specialist to specialist referrals; a reduction in the number of specialist to specialist referrals and time limited referrals.

Group 4

Participants addressed the following three themes:

- Optimising TXR
- Patient Experience/Journey
- Managing the appointment system (DNAs).

In considering how to optimise teaching and research participants determined the need for every episode of care in WA Health there should be a corresponding teaching or research outcome. They recommended that all PPP agreements be required to report teaching and research outcomes, from any funded outpatient service in proportion to their activity.

With regard to mapping the outpatient appointment system they combined their recommendation with that of the information group to recommend that the outpatient system be reviewed with some considerations. These included the need for all internal/external referrals there be a discipline authorisation unless they are part of a pathway of LOS initiative. They proposed this could be achieved through a phased clinical redesign process with a view to: reducing DNA rates; reducing unnecessary referrals and reducing the rate of follow up to new appointments. Importantly, there should be a focus on keeping patients at home/community and or seen by primary care. Consideration must also be given to ensure patients are always referred back to their GP to coordinate care unless there are documented reasons by a consultant for further follow up at hospital.

Participants also considered managing the appointment system and highlighted areas for improvement. They discussed the opportunity to review DRGs and LOS and recommended that for every inpatient DRG involving a stay of 4-23 hours there be a review to determine if clinical service redesign could transform the care into an outpatient procedure, minor operation or therapy /occasion/service. This should be a contracted body of work.

Senators also considered Cat 3 referrals. They identified the need for WA Health to consider a process whereby consultants triage results in a telephone call to the referee to advise them of likely time to be seen, other options to be seen and/or managed in the community and telephone advice in order to reduce waiting times according to pathways.

Participants considered the importance of improving the patient journey. They recommended that WA Health commit to implement a well-designed independent, longitudinal patient experience tool at a state-wide level. Outcomes of the baseline assessment could inform the review of the 2007 Consumer, Carer Engagement Framework which needs to take a patient centred direction.

A total of 14 recommendations were developed by participants in workshop one. Participants agreed to merge two recommendations leaving a total of 13 for priority voting. The top 5 recommendations were taken to the final session.

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5. Afternoon Workshop Two

5.1 What do we stop?

Facilitator	Ms Margo O'Byrne
Executive Committee Members	Mr Shane Combs Adj Assoc Prof Kim Gibson
Expert Witnesses	Ms Kate Gatti
Support	Ms Kimberly Olson /Ms Joanne Cronin

Ms Margo O'Byrne facilitated workshop two. She welcomed participants and stated the focus of the workshop as to consider how to ensure outpatient services are efficient and effective.

She outlined the process as to firstly, discuss the issue streams brought forward via the mind map, to identify any additional issues, group them into themes and finally, develop recommendations. All recommendations she stated, would be voted on, with the top five brought forward to the final session.

Margo gained consensus that two themes from the mind map would not be covered in workshop two: GPs for routine follow up and using private and non-government organisations (NGOs).

At table level participants worked in small groups to discuss the mind map themes in more detail and determine any additional themes. One additional theme around consumer shaping (informed decision making) was suggested for inclusion.

The full group worked to consider the main themes with consensus reached to include one additional theme to the following for development of recommendations:

Four groups worked across the ten themes.

1. Unnecessary clinics e.g. pre admission
2. Making inpatient treatment become outpatient care
3. Unnecessary travel
4. Review traditional approach
5. Fragmented care
6. Specialist care
7. Reduce unnecessary referrals
8. Work up /diagnosis
9. Administrative burden e.g. complex referral processes.
10. Patient experience

Group 1

Participants addressed the following three themes:

- Unnecessary clinics
- Making inpatient treatment become outpatient care
- Unnecessary travel

.

Recommendations formed by participants highlighted the need for clinicians to drive an audit of all day surgery and short stay admissions for potential provision in see and treat clinics.

In addressing unnecessary clinic activity they proposed that each area health service benchmark against private sector workforce practices (e.g. Nursing, allied health, general practice) in areas of preadmission screening, workup and review and follow-up.

Participants considered the link to primary care as a means to moving patients out of the clinics. They recommended that the Chief Officers sponsor and work with the Health Service Improvement Unit (HSIU) to analyse existing data in order to identify high volume MBS activity that could be transferred to primary care through partnerships with the Primary Health Networks (PHNs).

Senators recommended the use of the Primary Care Health Network to work with each of the Networks to identify from the 'models of care', occasions of service currently provided as outpatient care that could be safely transferred to primary care.

Group 2

Participants addressed the following three themes:

- Review traditional approach
- Fragmented care
- Specialist care

They developed five recommendations.

Discussion around specialist care yielded two recommendations focussed on de-centralising (non-tertiary) approach to the access and distribution of specialised supplies, aids and equipment. They also considered the need to improve referrals by empowering clinicians to provide timely (early) triage and expert/effective triage.

Participants discussed fragmented care calling for the introduction of patient centred care coordination earlier in the care pathway (and embedded in all service planning). They identified the need for using a multi-disciplinary approach.

In reviewing the traditional approach in order to reduce unnecessary referrals, senators identified the need to drive down activity through: embedding the use of outcome measures and using predictive algorithms to guide review frequency. After discussing this recommendation with other groups they agreed to merge this recommendation to include: improved governance of outpatient services through the introduction of performance expectations including safety and quality, patient experience and efficiency/effectiveness key performance indicators.

They also agreed to the need for a review of the traditional clinical training models with a view to introducing innovations, inter-disciplinary and patient centred training modules.

Participants called for improved governance of outpatient services through the introduction of key performance expectations including safety and quality patient experience and efficiency/effectiveness key performance indicators (KPIs). They agreed to combine their recommendation with another group to include that non-admitted KPIs need to exploit embedded outcome measures that will enable area health services to drive down clinic activity through the use of predictive algorithm and maintain or improve the quality of care and patient experience.

Group 3

Participants addressed the following two themes:

- Administrative burden
- Patient experience/consumer shaping

Participants discussed the need to reduce the administrative burden for consumers and health workers particularly the complex referral processes. They proposed this could be achieved by: using a standardised referral form (not hand written); identifying technology solutions to facilitate information transfer – avoiding duplication; and ensuring new solutions do not increase administrative load.

Also considered was the need to provide information to consumers and health workers such as: alternative service options; wait times; location and cost of services. This information would ensure consumers could make informed decisions about their health. The concept of informed decision making was incorporated into a recommendation from the group considering patient experience and driving down outpatient activity. The recommendation identified the need for the Health Service Improvement Unit (HSIU) to develop clinical redesign projects that decrease face to face consultation in favour of telephone/videoconferencing. They determined this could aid in stopping unnecessary outpatient appointments for minor consultations in both metropolitan and regional patients for preadmission clinics, benign pathology results and post-operative wound checks.

Group 4

Participants addressed the following two themes:

- Reducing unnecessary referrals
- Work up/diagnosis

Senators considered how to stop unnecessary and inappropriate referrals. In considering what to stop they discussed: unnecessary follow up in the hospital setting; centralisation of specialist services; the bureaucracy of referrals e.g. named referral, finance barriers; incompatible PAS and lack of transferability; sub-specialisation clinics and silos of care; and pre-admission clinics on complex cases.

They determined that the GP and in fact, primary care were critical for change in this area. They identified opportunities through better partnerships with GPs to improve access and referrals to new and existing primary care service models such as RITH, HITH etc...

They determined there must be a focus on opportunities to ensure patients are referred to the right service with the need for affordable diagnostics and comprehensive care in the primary care setting that is coordinated by the GP.

They proposed that specialist care could be brought into primary care models e.g. diabetes, respiratory, elderly and identified the need to map what clinics could possibly be brought out of tertiary setting.

Senators called for the integration of Health Pathways into the entire patient journey with recognition that entry into the pathway could be either internal or external.

The main recommendation from this group called for promotion of an integrated electronic health record to service providers and at risk populations and to modify hospital employment practices to ensure hospital employees have access to the PCEHR.

A total of 19 recommendations were developed by participants in workshop two. Participants agreed to merge two recommendations leaving a total of 17 for priority voting. The top 5 recommendations were taken to the final session.

In the final session, senators were presented with five recommendations from workshop one and five recommendations from workshop two. A total of ten recommendations were voted on and ranked forming the final prioritised recommendations from the day.

6. Final Session

In the final session senators reviewed each of the recommendations presented from both workshops. A total of ten recommendations were therefore put forward from the debate for final voting.

In conclusion, the senate found the current performance of outpatient systems was not optimal, but there are ways the executive can ensure outpatients become more effective and efficient yet retain their valuable teaching and research roles. The key message was “outpatients is not dead” but does require reform. The Department of Health, as system manager, is well positioned to build on the senate’s recommendations to work with area health services and public private providers to contemporize the delivery of outpatient care.

The Clinical Senate Recommendations that follow have been ranked in order of importance by the full Senate. The Clinical Senate Executive issued a request for a response by the Director General of Health to each recommendation at the next debate. Responses could be:

a) endorsed,
b) endorsed in principle, or
c) not endorsed.

7. Clinical Senate Recommendations

Outpatient Care – A look to the future

1. That WA Department of Health, as system manager, develops non-admitted Key Performance Indicators (KPIs) that can be measured across health services to inform patient care, performance, accountability, and patient access, including clear definitions. The KPIs need to exploit embedded outcome measures that will enable Area Health Services to drive down clinic activity through use of predictive algorithms and maintain or improve the quality of care and patient experience.

2. That WA Health ensures the ICT Strategy Implementation Plan Priority Area 2- Information Sharing and Management specifically addresses in outpatient and ambulatory care information sharing and communication, outcomes that:
   - Optimising outpatient/ambulatory care information sharing by secure electronic messaging to the GP AND uploading into the PCEHR, including outpatient summaries/letters, outpatient investigation results (pathology, imaging and other) and care plans
   - Promote information sharing via an integrated electronic health record (likely the PCEHR) to health professionals and the at risk population e.g. (Aboriginal people, elderly, chronic conditions and musculoskeletal)
   - WA Health employees be provided with access to and training in the use of the PCEHR (to reduce duplication of tests and improve quality of care).

3. That the Health Services Improvement Unit (HSIU) organises clinical redesign projects that decrease face-to-face consultation in favour of telephone/videoconferencing (including government facilities and personal use devices) to stop unnecessary outpatient appointments for minor consultations for both metropolitan/regional patients for:
   - Preadmission clinics
   - Benign pathology results
   - Wound checks post-op
   - Clinical follow-ups/'check ins'

4. That WA Health ensures the outpatient appointment system is reviewed with the following considerations:
   a) All internal outpatient referrals require senior discipline authorisation unless they're part of a pathway or LOS initiative. This might be achieved by a phased clinical re-design process that aims to reduce DNA rates, unnecessary referrals, increases use of telehealth, focuses on keeping patients within their communities and benchmarks the rate of new to follow up appointments and number of internal derived appointments.
   b) All patients are always referred back to their GP to coordinate care, and are not referred to another discipline within the hospital or given a further review appointment unless there is a documented reason by a consultant.

Recommendations continued on next page

5. The Chief Officers from Medical, Dental, Nursing/Midwifery and Health Professions to sponsor and work with HSIU to analyse existing data to identify high volume MBS activity that can be transferred to primary care through partnership with the Primary Health Networks (PHNs).

6. That the Primary Care Health Network, Department of Health work with each Health Network to identify from the 'Models of Care' occasions of service currently provided as outpatient care that could be safely transferred to primary care.

7. That innovation in the transition of paediatric to adult care can be achieved by WA Health developing pathways to transfer paediatric cases into adult services using streamlined patient centred processes.

8. That WA Health organise see and treat or see and diagnose clinics. This can be achieved by reviewing every inpatient DRG involving a LOS of 4-23 hours to determine if clinical service redesign could transform the inpatient care episode into an outpatient occasion of service.

9. WA Health through the WACHS CEO (as the State Telehealth Executive lead) include in the WA Telehealth Strategy
   1. Funding options to support telehealth in the public sector using the Queensland ABF model and other sustainable options
   2. Propose a strategy to align the effort of jurisdictions, professional colleges, and key stakeholders e.g. WAPHA to make recommendation/s related to:
      a. MBS and alternative funding options to support consumer access to GPs via telehealth in areas of high need (low GP numbers and high access need).
      b. Telehealth enablement for NGO's-NFPs, private hospitals, GPs, prisons and aged care facilities to achieve linkage with public health services for the "public good".
      c. Public Outpatients Services specialists to be able to VC - link to GPs to support GP care to patients to reduce the need for unnecessary travel and increase GP capacity to provide outpatients related services.
   3. Metropolitan Outpatients to determine how they might increase their linkage to GPs and to smaller public hospitals to support local service access.

8. Appendix 1: Program

Outpatient Care – A look to the future

Friday 4 September 2015
Banquet Hall South
The University Club of Western Australia
Crawley, Western Australia

7.45am	Registration	Tea & coffee

Executive sponsor: Mr Jeffrey Moffet, Chief Executive Officer, WA Country Health Service
Facilitator: Mr Bevan Bessen

Time	Session	Speaker
8.30am	Welcome to Country	Ms Marie Taylor
8.40am	Welcome and senate update	Professor Julie Quinlivan
8:45am	Director General's response to recommendations	Dr David Russell-Weisz
9.00am	Setting the scene	Mr Jeffrey Moffet
9.20am	A consumer perspective	Mr Lesley Ayton

9.30am Panel Debate – Outpatients is dead!

For	Against
Ms Melissa Vernon: Telehealth is the way of the future	Dr Jared Watts: Outpatients supports teaching and research
Professor Julie Quinlivan: Outpatients should be the new day surgery	Dr Mike Civil: Outpatients supports primary care
Associate Professor Graeme Boardley: Better clinical guidelines and work up is required	Ms Christine Carroll: Outpatients reduces LOS and Hospitalisation rates
Professor David Joske: Follow up for follow up sake	**Ms Karen Banks:** Rehabilitation – no direct referral- complex cases

10.15am	Morning tea	Banquet Hall Foyer

10.45am Plenary debate: How do we innovate outpatient care?

Additional Expert Witnesses: Dr Frank Willis, Dr Marianne Wood, Associate Professor Dale Edgar, Ms Lynda Miller Dr Michele Genevieve, Ms Sue Morey and Ms Kate Gatti

12.15pm	Lunch	Banquet Hall Foyer

1.00pm Workshops

Workshop 1 – Banquet Hall South
Innovations

- Facilitator: Mr Bevan Bessen
- Executive Sponsor: Mr Jeffrey Moffet

Workshop 2 – Banquet Hall North
What do we stop?

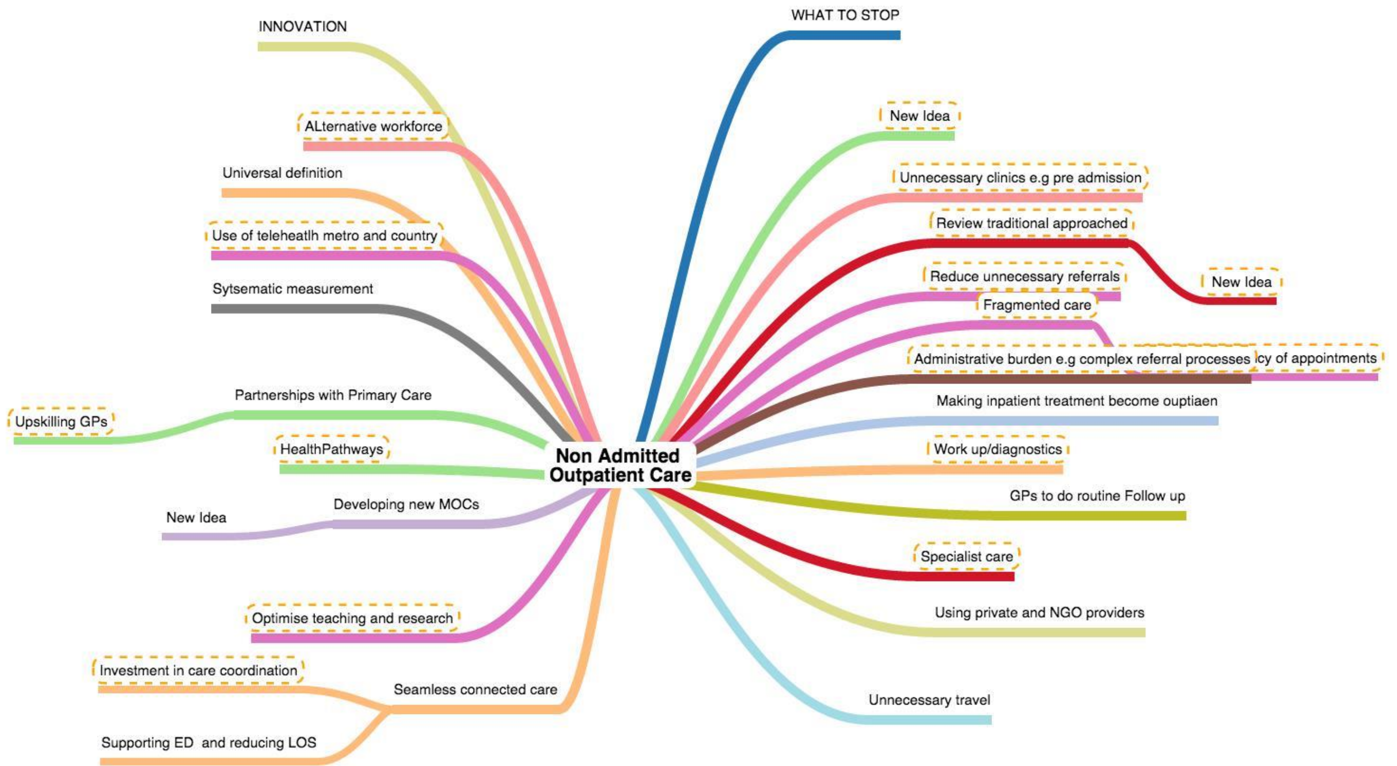
- Facilitator: Ms Margo O'Byrne
- Expert: Ms Kate Gatti

2.40pm	Afternoon tea	Banquet Hall Foyer

3.00pm Final session

Time	Session	Speaker
3.00pm	Presentation and prioritisation of recommendations	Mr Bevan Bessen
3.20pm	Closing remarks	Mr Jeffrey Moffett
3.30pm	Close	

9. Appendix 2: Mind Map



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