GOVERNMENT OF WESTERN AUSTRALIA

Sustainable Health Review

Public Submission Cover Sheet

Please complete this sheet and submit with any attachments to the Sustainable Health Review Secretariat

Your Personal Details ***This information will be used only for contacting you in relation to this submission***	
Title	Mr ☐ Miss ☐ Mrs ☐ Ms ☐ Dr ☒ Other ☐
Organisation	Cardiovascular Health Network (Health Networks, Department of Health)
First Name(s)	Jacquie
Surname	Garton-Smith
Contact Details	[redacted]
AND	
Title	Mr ☐ Miss ☐ Mrs ☐ Ms ☐ Dr ☒ Other ☐
Organisation	Cardiovascular Health Network (Health Networks, Department of Health)
First Name(s)	Tony
Surname	Mylius
Contact Details	[redacted]

Publication of Submissions

Please note all Public Submissions will be published unless otherwise selected below

☐ I do not want my submission published

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Submission Guidance

You are encouraged to address the following question:

In the context of the Sustainable Health Review Terms of Reference listed below, what is needed to develop a more sustainable, patient centred health system in WA?

- Leveraging existing investment in Primary, Secondary and Tertiary healthcare, as well as new initiatives to improve patient centred service delivery, pathways and transition;
- The mix of services provided across the system, including gaps in service provision, sub-acute, step-down, community and other out-of-hospital services across WA to deliver care in the most appropriate setting and to maximise health outcomes and value to the public;
- Ways to encourage and drive digital innovation, the use of new technology, research and data to

Submission Guidance

support patient centred care and improved performance;

- Opportunities to drive partnerships across sectors and all levels of government to reduce duplication and to deliver integrated and coordinated care;
- Ways to drive improvements in safety and quality for patients, value and financial sustainability, including cost drivers, allocative and technical efficiencies;
- The key enablers of new efficiencies and change, including, research, productivity, teaching and training, culture, leadership development, procurement and improved performance monitoring;
- Any further opportunities concerning patient centred service delivery and the sustainability of the WA health system.

Submissions Response Field

Please type your response into the field below. Alternatively you may provide your submissions as a separate attachment (Suggested Maximum 5 pages).

Cardiovascular Health Network submission to the Sustainable Health Review

Prepared on behalf of the Cardiovascular Health Network by:
Dr Jacquie Garton-Smith
(Clinical Lead, Cardiovascular Health Network, Hospital Liaison GP, Royal Perth Hospital & GP); and
Dr Tony Mylius
(Clinical Lead, Cardiovascular Health Network, Cardiologist & Consultant Physician)

Background

Cardiovascular conditions are a leading cause of death in Australia. In 2015, cardiovascular disease was responsible for almost 45,400 deaths, 29% of all deaths (AIHW Report, September 2017), and are responsible for 13% of hospitalisations (Atlas of Variation, 2017). Australia has had decline in death rates for cardiovascular disease for older groups, however these trends have slowed in younger age groups. The slowing of falls in cardiovascular disease death rates are concerning, given the high disease burden, and the potential social and economic impacts. To address rates of cardiovascular hospitalisations, risk factors must be reduced through public health initiatives. System changes are needed to improve access to primary health care for high-risk groups, and primary and secondary prevention for individuals needs to improve. Increasing the health literacy of high-risk groups and their ability, to self-manage risk factors is a vital component of any strategy.

Overarching principles

The Cardiovascular Health Network (CVHN) proposes the consideration of a broader level of principles which might be applied and implemented in the health system to promote and enhance sustainability, resilience, accountability and continuous improvement. These principles in dot point form include:

1. Implementing genuine patient empowerment and health literacy enhancing processes including strategies to improve 'consumer sovereignty' in the health system – increasing informed consumer choice driving continuous quality improvement.
2. Embedding consumer involvement in clinical governance processes to provide genuine, effective consumer influence and authority in the health system – genuine co-design of services or care.
3. Embedding clinical best practice guidelines to support and drive clinical decision-making based on evidence using documents such as Models of Care, guidelines etc
4. Ensuring cost-effectiveness and cost-efficiency are integral in the 'usual business' of health care.
5. Developing and implementing effective mechanisms for clinician engagement with clinical outcomes and health service management including resourcing of outcomes registries and effective decision support tools – supporting both clinical and health service business decision making. Peak clinical advisory and/or reference groups across health services and sectors are essential and Health Networks have a role in facilitating relationships to achieve this.
6. Ensuring patient safety is a key performance driver.
7. Ensuring continuous improvement processes are embedded in the usual operation of health services to drive evolution, development and continuous improvement.
8. Building on the existing work undertaken interstate and at the commonwealth level with regard to appropriate services and procedures - including dis-investment from ineffective and inappropriate procedures and services.
9. Embedding effective population health outcome measures as drivers across the health service to prevent 'siloing' and defensive decision making of providers, to positively reinforce that the central goal of all the efforts of health service providers – separately and together - is enhanced health outcomes and to drive collaboration across the system (including public and private sectors).
10. Ensuring the health system embraces and embeds the future characteristics and skills requirements of the workforce including problem solving, communication, collaboration as well as flexible, critical and strategic thinking.
11. Addressing structural barriers to collaboration and joint activity between public and private sector (including for-profit and not-for-profit) health service delivery organisations and providers – including:
    a. flexible, accountable joint-venturing mechanisms across the system
    b. addressing public sector 'deal-breakers' preventing effective collaboration
    c. addressing workforce dynamics and frameworks which limit flexible, cost-effective health service delivery and innovation.
    d. ICT limitations and chronic lack of strategic investment.

Specific Programs/Initiatives identified

Specific gaps in cardiovascular care that require urgent attention have been identified. An upfront investment is likely to be required to establish sustainable programs/initiatives that will later save money and/or increase capacity and improve outcomes. Many will be more efficiently, consistently and sustainably undertaken across Area Health Services, rather than by individual health services. Health Networks provide a significant opportunity for system wide perspective on health care provision and to assist standardised implementation.

a. **Heart failure** has been identified in The *Second Australian Atlas of Healthcare Variation (2017)* (https://www.safetyandquality.gov.au/atlas/atlas-2017/) produced by the Australian Commission on Safety and Quality in Health Care as a major contributor to potentially preventable hospitalisations in 2014-2015 with significant variation between local areas, demonstrating substantial potential for improvement. Heart failure comprehensive, collaborative care bridging primary, secondary and tertiary health care sectors is critical. There is good evidence that nurse-led heart failure support programs linking with GPs and specialists to reduce unnecessary hospital presentations and reduce bed-days. (*1.*Simon Stewart. Nurse-led Care of Chronic Heart Failure. Heart Lung and Circulation Oct 2012 Vol 21 Issue 10 p649; *2.* Phillips CO, Singa RM, Rubin HR, Jaarsma T. Complexity of program and clinical outcomes of heart failure disease management incorporating specialist nurse-led heart failure clinics. A meta-regression analysis. Eur J Heart Fail 2005; 7: 333-341.)

b. Improved **regional service provision models of cardiac care** including visiting specialists, Telehealth and collaborative service provision models including GPs, Nurse Practitioners, Nurses and Aboriginal Health Care Workers.

c. **Improved collaboration and engagement with Aboriginal Health Services and Health Care Workers** around the whole range of cardiological health related management challenges for Aboriginal patients.

d. **Cardiac rehabilitation and secondary prevention services** integrated across primary, secondary and tertiary (private and public) sectors as repeat events account for a substantial burden of costs. (Deloitte Access Economics. ACS in Perspective: The importance of secondary prevention. 2011)

e. Streamlined services for **outpatient evaluation and management** to improve patient outcomes and demand management on the public sector. Examples of successful evidence-based models include the Rapid Access Chest Pain Clinic at RPH.

f. **Non-invasive cardiac testing** services out-sourced across private and public sectors.

g. **Cardiac outcomes registries** with data-collection resources to drive quality improvement and service planning.

h. Development and implementation of patient-centred, comprehensive **electronic health record** systems to enhance care collaboration and patient outcomes.

i. Address **workforce and training across public sector cardiology service providers** to improve distribution, service provision and appropriate training for future cardiology services.

j. **Obesity:** Identify and implement improved models of care for the prevention, assessment and interdisciplinary management of obesity in collaboration with other Health Networks and primary care. A lack of action addressing obesity will lead to a growing disease burden and cost to the system (Scally B, Xiao J, Somerford P. The cost of excess body mass to the acute hospital system in Western Australia: 2011. Perth: Department of Health WA; 2013.) Investment in evidence-based solutions needs to be a priority.

Responses to the focus areas are provided below:

Focus 1: Leveraging existing investment in Primary, Secondary and Tertiary healthcare, as well as new initiatives to improve patient centred service delivery, pathways and transition;

AND

Focus 2: The mix of services provided across the system, including gaps in service provision, sub-acute, step-down, community and other out-of-hospital services across WA to deliver care in the most appropriate setting and to maximise health outcomes and value to the public;

There is great opportunity for WA Health/Health Services to collaborate with primary care to develop more sustainable models and improved health outcomes. A more responsive, patient-centred, health system will allow increased management in primary care and create capacity for improved access to specialist advice and consultation where required. Opportunities for service improvement and collaboration for the purposes of improved health and condition management exist in the following areas:

- Health promotion and disease prevention (specifically to coordinate efforts/maximise impact/avoid duplication).
- Early detection and screening.
- Consumer health literacy and health education.
- Emergency and acute care GP advice and referral pathways (e.g. After-Hours GP services, Comprehensive Primary Care/Health Care Homes, HealthPathways, Acute Medical pathways, redesign).
- Care coordination for chronic and/or complex conditions, including linkage to Comprehensive Primary Care/Health Care Homes and upskilling use of non-medical staff to support care where appropriate. Community-based programs such as COPD Linkage and Heart failure nurse support programs have a good evidence base. Perverse incentives around reduction in activity and the likelihood of keeping the less sick out of hospital thereby those admitted are frailer, more complex cases with longer stays need to be addressed.
- Shared care (e.g. there is potential to expand the Maternity model into other conditions – Heart Failure in particular).
- Chronic condition self-management.
- Secondary prevention and cardiac rehabilitation.
- Overweight and obesity pathways and interdisciplinary models of care.
- End of life care (including better identification of life-limiting illness and communication with consumers and other health professionals involved in that patient's care around the diagnosis, prognosis and options for both malignant and chronic conditions. Use of Advance Care Planning and Advance Health Directives needs to be encouraged and supported and mechanisms to engage the GP in the Goals of Patient Care initiative need consideration.)

Focus 3: Ways to encourage and drive digital innovation, the use of new technology, research and data to support patient centred care and improved performance;

- **Improve information sharing and communication through:**

- Provision of transparent service information to facilitate improved use of existing services and streamlined referral processes (e.g. Hospital websites, HealthPathways).
- Invest in data registries, including cardiac data, to support high quality service delivery, clinical communication/handover and research. Optimising data collection at the point of care will avoid the need for additional data entry. Smart solutions that avoid duplicate data collection where there are comorbidities are preferable, and which are interoperable with existing health solutions. The potential for external health providers to access and add information to provide a more complete view needs to be explored.
- Improving communication with GPs (while there has been significant progress on discharge communication, outpatient communication is still lacking, and neither ED or OP correspondence is sent by secure electronic messaging) and facilitate electronic referral maximising auto-population of relevant clinical and demographic information and decision support to ensure adequate information is included including required investigations.

- Increasing electronic record sharing. While not a substitute for direct communication with GPs, increasing information uploaded into the My Health Record will facilitate improved information sharing. Additional investment in integrated clinical information systems and the hardware is required to realise the potential in this area.
- Developing electronic tools to support collaborative chronic and/or complex care planning.

- **Digital health options to improve consumer access to information and services:**

- Expand Telehealth opportunities – rural/remote and metropolitan, especially where mobility and/or access are issues.
- Develop and make available high-quality health consumer apps to increase access to:
    - decision support in the event of an emergency (eg chest pain or shortness of breath),
    - evidence based therapies such as Cardiac Rehabilitation,
    - Chronic Condition Self-management especially for ischaemic heart disease, heart failure, diabetes, overweight and obesity.
- Explore the potential for tele-monitoring and wearable technology.
- Promote consumer (and clinician) use of the My Health Record (MyHR), and ensure WA Health uploads relevant information as soon as possible, including pathology and imaging reports, emergency department and outpatient correspondence. Currently only inpatient discharge summaries are uploaded if the patient has a MyHR.
- Leverage WAPHA's HealthPathways for a consumer-based program. HealthPathways currently develop pathways to assist GPs in managing patient conditions and navigating the wider health system as required. A similar program aimed at consumers could help improve health literacy and managing expectations of consumers in the current health environment. A consumer education program could align with the launch of this type of program.
- Consumer information provided/printed through WA Health and through HealthPathways should take account of ABS data on health literacy, patients/family who have a primary language other than English and targeted education for ATSI patients/families.

<u>Focus 4</u>: Opportunities to drive partnerships across sectors and all levels of government to reduce duplication and to deliver integrated and coordinated care;

Partnerships with Government sectors outside health are essential to address the social determinants impacting health, particularly cardiovascular.

Good working relationships across Health Service Providers are essential to enable optimal and equitable cardiovascular service delivery, especially where transfer of patient care between health services is required. The Cardiovascular Health Network has been working on strengthening these, particularly through the Acute Coronary Syndromes Clinical Reference Group (engaging Metropolitan and regional and rural practitioners, Cardiology, Emergency and other specialities, St John Ambulance, the Royal Flying Doctor Service and primary care) and through regular meetings with the Cardiology Heads of Departments.

Good working relationships will include partnerships with patients, family and significant others in delivering holistic care.

- **Aboriginal Health**

In particular there should be an understanding and redressing of issues, historical, learned and therefore intrinsic, related to Aboriginal and Torres Strait Islander populations reluctance to engage in participating in healthcare. Focus areas can include:

- Improved integration between Primary and Secondary Care in regional areas.
- Improved, holistic care pathways (involving primary and secondary care) between regional and metropolitan areas; taking account of leaving country. Evidence based care and governance should always, by definition, take into account patient/family preferences.

Within the broader health sector, partnership with WAPHA underpins primary care collaboration, complemented by collaboration across health services and with public health, the Aboriginal Community-controlled Health sector, migrant health, mental health, Aged Care, NGOs and other government agencies such as Corrective services.

- **Other specific health areas for focused attention include:**
  - Migrant and refugee health.
  - Mental Health (that brings risk of increased medical morbidity).
  - Prison Health.
  - Child and Youth Health, and transition from youth to adult care (especially for Congenital Heart Disease and Rheumatic Heart Disease).
  - Aged Care (especially around end-of-life options and decisions and collaborative models of care for chronic heart failure).

Focus 5: Ways to drive improvement in safety and quality for patients, value and financial sustainability, including cost drivers, allocative and technical efficiencies;

There is a need to rationalise service provision to disinvest from unnecessary and/or inefficient care in order to improve access and capacity.

Many of the suggestions explored in the focus areas above will assist achieving improved safety and quality of care in a more sustainable way. Financial disincentives inherent in an Activity-Based Funding model need to be addressed.

Flexible funding models where the funds follow the patient need to be explored to enable more equitable access to care, better match of resources to care requirements, a reduction in perverse disincentives that create barriers to good service delivery, and the promotion of innovative service delivery, including increased use of telehealth.

An up-front investment is likely to be required to allow development of new models that will later be more efficient, economical and sustainable in the long term.

A mechanism to investment to facilitate operational initiative pilots that span different Area Health Services needs to be established, in order to take advantage of economies of scale, avoid duplication and enable consistent evidence-based processes.

Focus 6: The key enablers of new efficiencies and change, including, research, productivity, teaching and training, culture, leadership development, procurement and improved performance monitoring;

- **Suggestions for Research, education and training:**
  - Cardiovascular research and research translation, including studies involving primary care/ GPs, and specifically focusing on improved care across transitions and on sustainability.
  - GP education and upskilling (including HealthPathways, GP educational events and networking with health service staff, GPs upskilling in clinics, increased training and use of GPs with Special Interests (GPSIs) and hospital outreach).
  - Medical staff education around what GPs do, what conditions they can manage (with a view to unnecessary reducing internal referrals – HealthPathways may be useful tool which hospital staff should be encouraged to consult prior to internal referral that is not in line with standard disease management protocols) and the importance of good GP communication. GP Units within hospitals, GPs working in ED, clinics and inpatient settings can also help educate staff.
  - Transition education programs away from single-professional siloed interventions towards involving interdisciplinary team approach in managing patients; the team is to include family and significant others.

Focus 7: Any further opportunities concerning patient centred service delivery and the sustainability of the WA health system.

The introduction of patient reported outcomes; e.g. similar to a tool for heart failure being trialed in Victoria, is worth considering.
(Thompson C, Sansoni J, Morris D, Capell J and Williams K , Patient-reported outcome measures: an environmental scan of the Australian healthcare sector. Sydney: ACSQHC; 2016).