Our Health Care Future Response

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TASMANIAN HEALTH SERVICE

Tasmanian Government

Improvement Area 1: Improved Community Care

We propose the consideration of standardising outpatient chronic disease management within the THS and to improve the identification of populations most at risk of poorer health outcomes by developing an Integrated Care Strategy and Network across the state for key stakeholders within outpatient chronic disease management, in accordance with existing evidence based National Frameworks and models of care (National Strategic Framework for Chronic Conditions | Australian Government Department of Health, *2018;* Better Outcomes for people with Chronic and Complex Health Conditions, *2015*), *references available on request*.

The primary focus of this strategy is to improve both the experience of care for people and their family living with chronic conditions and to improve the experience of service providers and clinicians caring for people with chronic conditions. The primary goal of this strategy is to therefore efficiently integrate all aspects of care and chronic disease management, to reduce unplanned and avoidable hospital admissions and to improve THS capacity in response to the needs of patients accessing chronic disease care.

Specialty chronic disease areas for consideration within this targeted integrated care strategy relate to disease processes commonly seen in our patient population (The State of Public Health Tasmania, 2018) and those most at risk presenting to the hospital setting. Chronic diseases identified include renal disease, diabetes, heart failure/hypertension and COPD/respiratory failure/smoking cessation, dental and podiatry. Figure 1 outlines a summary of key components proposed within a THS Integrated Care Network focusing on a three-tier approach to chronic disease management, to improve community care.

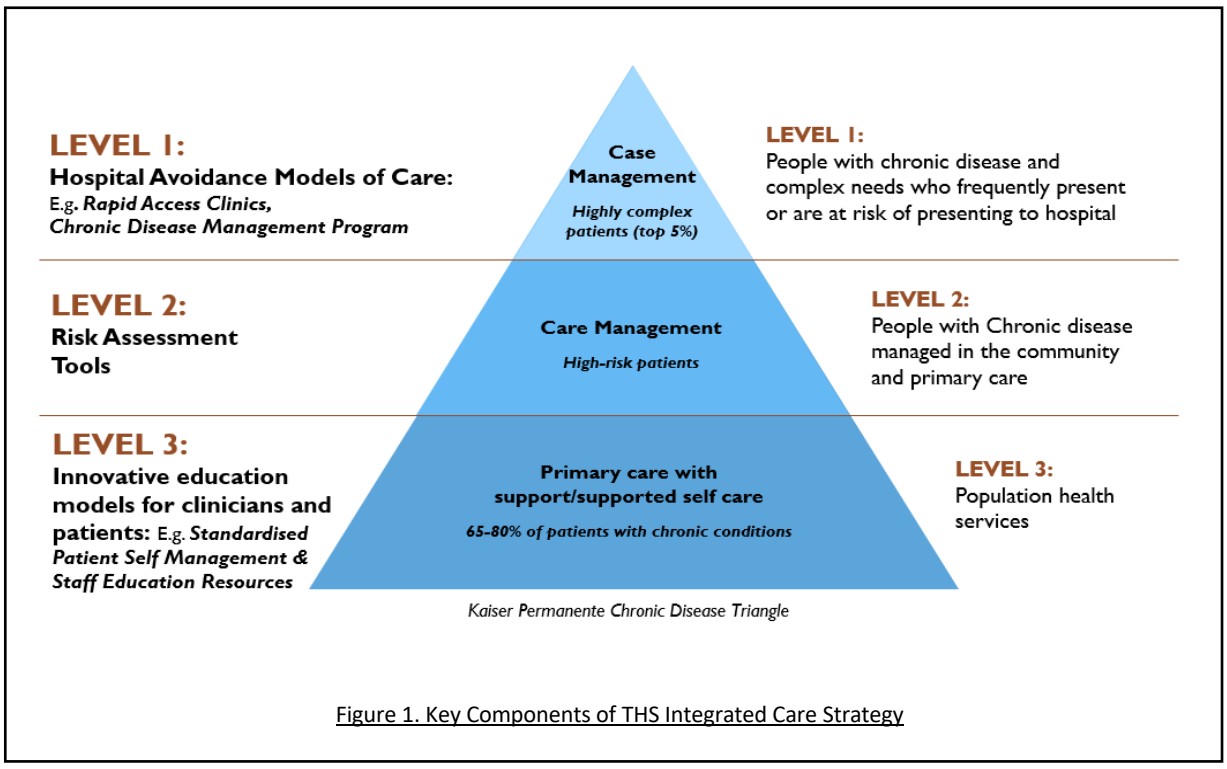

Figure 1. Key Components of THS Integrated Care Strategy

Q2. How can we shift focus from hospital-based care to better care in the community?

- Establish a Chronic Care Network and strategic plan/framework for the THS
    - Form a Network made up of all key stakeholders (public and private + consumers)
    - Development of a task force to oversee this Framework and Network
        - Should include newsletters/updates/education events
    - Foster communication across disease disciplines and key stakeholders within the Network
    - Champion local projects/continue to fund projects that deliver outcomes, promote this via the network
    - Improved patient care plans and access to these between stakeholders and services

- Improved coordination of care across all identified key chronic disease areas
    - Establish a targeted approach to chronic disease management and care coordination for patients identified/flagged as being most at risk of presenting to hospital
    - Consider use of chronic disease coordinators or a chronic disease management program, targeting populations most at risk of hospital presentation (multiple comorbidities) designed to link THS and primary care more efficiently
    - Better understanding of the needs of people living with chronic conditions within the THS
    - Introduce scheduled monitoring and review for high risk patients
    - Improved access to allied health services across all identified key chronic disease areas
    - Improved identification and assessment of 'at risk patients' and cultural groups via an improved electronic health system and risk stratification identification/automatic 'flagging' to target health care and provision of service
        - *E.g. HARP, PAM-13, Australian absolute cardiovascular risk calculator, Diabetes risk calculator*
    - Improved integration and communication across all chronic disease teams via the establishment of a chronic disease network
    - Encourage interdisciplinary collaboration and case review

- Establish shared care guidelines and pathways across
    - Establish post discharge review pathways, shared care planning, utilise patient goal setting strategies

- Reduce outpatient clinic waiting times
    - Review patient booking systems and how appointments are booked to be more patient led not service driven, outpatient clinic locations and accessibility of specialty services, improved triage of patients entering the service
    - Use of Rapid Access Clinic models across disciplines, utilising existing service provisions/staffing and NP models
    - Utilise more nurse led clinic models and shared care clinic arrangements within primary care

Q3. How can we facilitate increased access to primary care?

- Utilising a care coordination approach within the integrated care model would facilitate access to services
- Support and assistance on navigating primary care options

Q4. Barriers and opportunities for implementing a model for urgent care not identified in the UCC Feasibility Report?

- Consider use of Nurse Practitioner Rapid Access Clinic models for key chronic disease areas for hospital avoidance strategy
- Disease/Case Management approach for high risk populations

Q5. How can we make better use of telehealth?

- Reviewing current Telehealth platform used by THS and general internet connectivity issues across the state

Q6. How can we make better use of our district hospitals regarding public health step down and patient flow?

- Incorporate outreach and shared care clinic models within the facilities for general outpatient review, post discharge review and ore admission review

Q7. How can we improve integration across all parts of our health system and its key interface?

- Development of an integrated electronic medical record system for outpatient and inpatient services
    - Include inbuilt risk assessment/calculation tools and (service) referral forms/systems
    - Improved communications systems to Primary Care (2 way- so THS can also access Primary Care)
    - Incorporate recall systems and flagging to allow for improved follow-up to manage high nonattendance and lost to follow-up rates in outpatient clinics
- Utilising an Integrated Care Strategy/Chronic Disease Management Program for targeted hospital avoidance
- Introduce shared governance between primary care and THS for disease management that allows capacity for effective communication and collaboration
- Culture of data collecting and data sharing across the THS to monitor basic KPIs for the Integrated Care Networks progress and patient outcomes
- Improved identification and integration of GP
    - Ensure GP name is on patient flow

Q8-Q9 are not relevant to this proposed program

Q10-11. Incorporating improved health literacy and self-management approaches/preventative health initiatives

- Activate patients to engage in their health and self-manage chronic disease
    - Tailor education to specific patient needs to support self-management in the community, including established pathway for enquiry

        - Empowerment education programs for patients- within the Chronic Disease Management Network/Framework- with a focus on medication management, disease monitoring and self-management principles
    - Identifying patient's readiness to change, monitoring this at regular/annual time intervals, offering education and resources based on this assessment- targeting patient populations and educational needs, as monitored within a (sophisticated) EMR
    - Standardise patient support and education to include shared decision making and goal setting, utilising health coaching techniques within our health workforce
    - Ensure targeted health coach education provided to specific HCP in our workforce

- Population based health education initiatives to target known modifiable risk factors and behaviours
    - School education programs embedded within curriculum and state school canteen programs for nutrition, heart disease and diabetes, smoking cessation, dental etc.
    - Identify gaps where engagement with health services is poor and target engagement within local communities and groups via Integrated Care Network
    - Improved education and training opportunities (both online, face to face and via Telehealth) for all health professionals working in outpatient (and inpatient) chronic disease management

Q12. How can we provide clear pathways into our health system so that patients are accessing the most appropriate care for them?

- Appropriate assessment of patients within Primary Care/the community
- Use of risk stratification tools to direct care and patients most at risk, as mentioned previously
- Flagging of patients within the revised EMR system and direct referrals for outpatient specialty review/follow up
    - *E.g. Automated referral/tagging of patents with diabetes within Track-ED following ED presentation for specific DRG of severe hypocalcaemia and diabetes ketoacidosis*
- Regular assessing of patients' engagement and activation in health, to tailor and direct patient health care on specific care pathways
- Clear and transparent referral pathways into all chronic disease service providers for both referring clinicians and for patients
    - Improved communication and literature on how to refer, who to refer, waiting time expectations and what could be done as an interim measure by clinicians and patients while they are awaiting review
- Offer support and assistance in navigating acute care and outpatient services/systems for patients and referrers
- Less 'siloed' health care systems and disease management approaches
- Established education programs re chronic disease management and health coaching principles for all clinicians working in chronic disease management/primary care
- Co-location and/or shared care clinic models for outreach care between Primary care and THS
    - Utilising THS NPs, CNCs & CNS's in primary care in-between specialist THS review
    - Improved RHH/THS internet website for patients
        - Include education/information re disease, follow-up, appointment, telehealth portal, appointment booking requests etc

Improvement Area 2: Modernising Tasmania's Health System

Q1-Q2 How can we target our digital investment and what digital opportunities should be prioritised?

- Introduction of a sophisticated electronic medical record system which should include features such as: e-prescribing, connectivity with diagnostic Bluetooth devices and diagnostic equipment (temp, BP,BGL monitoring), connectivity for pathology downloads across all agencies, access to all patient records, appointment scheduling., e-forms, risk calculator tools, embedded and sophisticated flagging systems for referral and alerts

Q3. What information should be prioritised in My Heath Record to assist clinicians in treating patients across various settings

- Risk stratification tools (*HARP, PAM-13, Australian absolute cardiovascular risk calculator, Diabetes risk calculator) +* social determents of health e.g. Psychological, physical, and social determents of health
- Chronic disease management care plans
- All clinicians should be able to see/access notes from ALL teams across the THS/Primary Care, no use of satellite record systems

Q4 What are the opportunities to develop a digital interface between hospitals and other care providers

- Consider use of interim EMR models, such as the Audit 4 medical record which is already utilised by Rheumatology and Renal
- Improved discharge planning form both inpatient and outpatient services back to primary care

Q5. What information would help improve patient or consumer experience interacting with a public hospital

- Dedicated preadmission clinics to manage risk factors prior to surgery, to improve post-operative outcomes
- Transparent consumer information and continued communication on wait lists and basic timelines
    - Providing honest public access to 'real time' data for outpatient clinic reviews and emergency department, via a public dashboard or internet website
- Review of outpatient do not attend (DNA) rates across all outpatient clinics across the THS
- Providing consistent messaging, education and information to patients cross chronic disease areas- realistically education is similar, we could also share resources and better integrate between teams
- Asking patients at time of booking if they would prefer face to face, email, telephone, or video consult
- Improved public access internet website for RHH/THS

Q6. What technology would best help you to deliver improved patient outcomes

- Electronic Medical Record
- e-prescribing
- 'flagging' systems for patients (via an EMR) most at risk of presenting to hospital
- Ensuring quick turnaround times for document scanning, ensuring all clinicians write in the notes, ensuring all clinicians can access all databases- e.g. TrackEd.
- Improved intranet for RHH employees

Q7. How can we use technology to empower patients with their own selfcare?

- Need to monitor readiness to change and disease stress in order to first determine who is ready to be empowered. This assessment needs to be ongoing.
- Utilise online learning platforms, smart phone applications, telehealth
- Utilising health coaching & case/disease management models
- Motivational technology, equipment, and messaging
    - Apple watch/Fitbit, podcasts, SMS, channels within the hospital and waiting rooms with key health messaging on them

Q8 What is the key paper or manual administration processes that would provide the most benefit to digitise?

- The entire THS Workforce should have access to online time sheets/payroll systems.
- Improve electronic linkages between current databases and DMR to reduce the impact and time impost associated with printing and scanning documentation from one platform (databases) to another (DMR).

Improvement Area 3: Planning for the future

3a

Q1-Q3. What are the major priority areas that should be considered in the development of a 20-year infrastructure plan, ensuring the right balance for infrastructure across a broad range of settings, ensuring facilities are fit for purpose?

- More efficient use of HCP working within chronic disease management
    - Development of an 'integrated health care hub' which houses all chronic disease specialties- Allied health, nursing, and outreach specialty review clinics
    - Sharing of education programs and resources across disciplines, ensures better use of workforce productivity
    - More convenient for patients and allows improved access for patients
    - Encourages a multidisciplinary approach to health care
    - Sharing access of services widely and not centralising at RHH
- Building of infrastructure within communities/areas most at risk and most at need
- Greater understanding by policy makers re chronic disease process and long-term health outcomes regarding the aging population and what current disease progression rates will project to be in 20 years and allocation of resources accordingly, targeting:
    - Current childhood obesity rates
    - Current smoking rates for < 18 years of age
    - Health literacy/education level
- Addressing the need for culture change within the THS/organisation to ensure improved service planning
- Technology
- Integration of all health services across the THS
- Reducing rates of diabetes, obesity, heart, and kidney disease to be the lowest in the country!!!!!!

Q4. What are the key factors when considering the development of modern health care facilities?

- Consumer and wide stakeholder engagement in the planning of facilities, systems, and care models
- Ensuring facilities are closer in proximity to areas of need

Q5. How do we integrate our capital investment planning with the private sector?

- The establishment and introduction of a THS Integrated Care Network would address this concern and ensure all stakeholders are working together, communicating and planning care systems appropriately

3b

Q1-Q3 are not relevant to the proposed program

Q4. What innovations or changes are needed to our health workforce to align our professional health teams more closely with the future needs of Tasmania

- Succession planning
- Strong leadership
- Developing a culture of change within the THS
- Stronger links with the community and opportunities for consumers to participate in service co-design

Q5- Q6. How do we support health professionals to work to their full scope of practice?

- Improved leadership and career pathways
- Explore roles and scopes of nursing practice
- Ongoing interdisciplinary education opportunities in best practice management principles
- Prioritise ongoing learning within the culture of the organisation
    - Ensure staffing allocation to allow HCP/nurses to attend education programs
- Ensure accountability for education and that value is received in turn by the organisation – i.e. THS needs to ensure adequate return on investment for all HCP training

3c

Q1-5. Strengthening relationships and engagement with consumers, developing models of consumer engagement

- Integrating a culture of shared decision making
- Utilising more consumer representatives on committees/groups
    - Having a dedicated (and coordinated) consumer representative group or pool of consumers. All need to have applied to be a consumer representative
    - Include a consumer representative within the Integrated Care Network
- Ensuring consumer codesign and ongoing service decision making is incorporated within the culture of our organisation
- Care coordination models with allow for 'on the spot' consumer feedback to allow form improved commination between services and consumers, ensuring the 'consumer' voice' is heard
- Development of regular consumer surveys
    - This will also require culture change within the organisation to embed this within service models

Q6. How do we strengthen education and training for health professionals and health policy makers and planners in relation to the importance of consumer engagement and participant across all levels of healthcare?

- Strengthen via Integrated Care Network
- Development of online education and training models
    - Especially for all new staff entering THS