The Health Advocate

Your voice in healthcare

- What is value in healthcare?
- New Australian Centre for Value-Based Health Care
- Value and outcomes in public dental funding
- Care coordination for children with chronic conditions

Value and outcomes

+MORE INSIDE

The official magazine of the Australian Healthcare and Hospitals Association

ISSUE 54 / June 2019

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

Providing real value requires a healthcare revolution

As a healthcare professional, one of the hardest things to admit is that what you're doing doesn't work. One of the most challenging things is to change it. And one of the most rewarding things is to see that change achieve meaningful results.

I have just returned from Europe where I had the honour of accepting the international Value Based Health Care (VBHC) Prize 2019 for Excellence in Primary Care on behalf of Dental Health Services Victoria (DHSV). As CEO of DHSV I couldn't be prouder that our organisation was recognised on such an esteemed international stage. It was a wonderful recognition of our commitment to providing value to patients by focusing on the health outcomes that matter most to them.

While our move towards providing value-based oral health care is still in its infancy, we are already seeing incredible results. I'd like to briefly share our experience thus far in the hope that it inspires more health leaders to join the global VBHC movement.

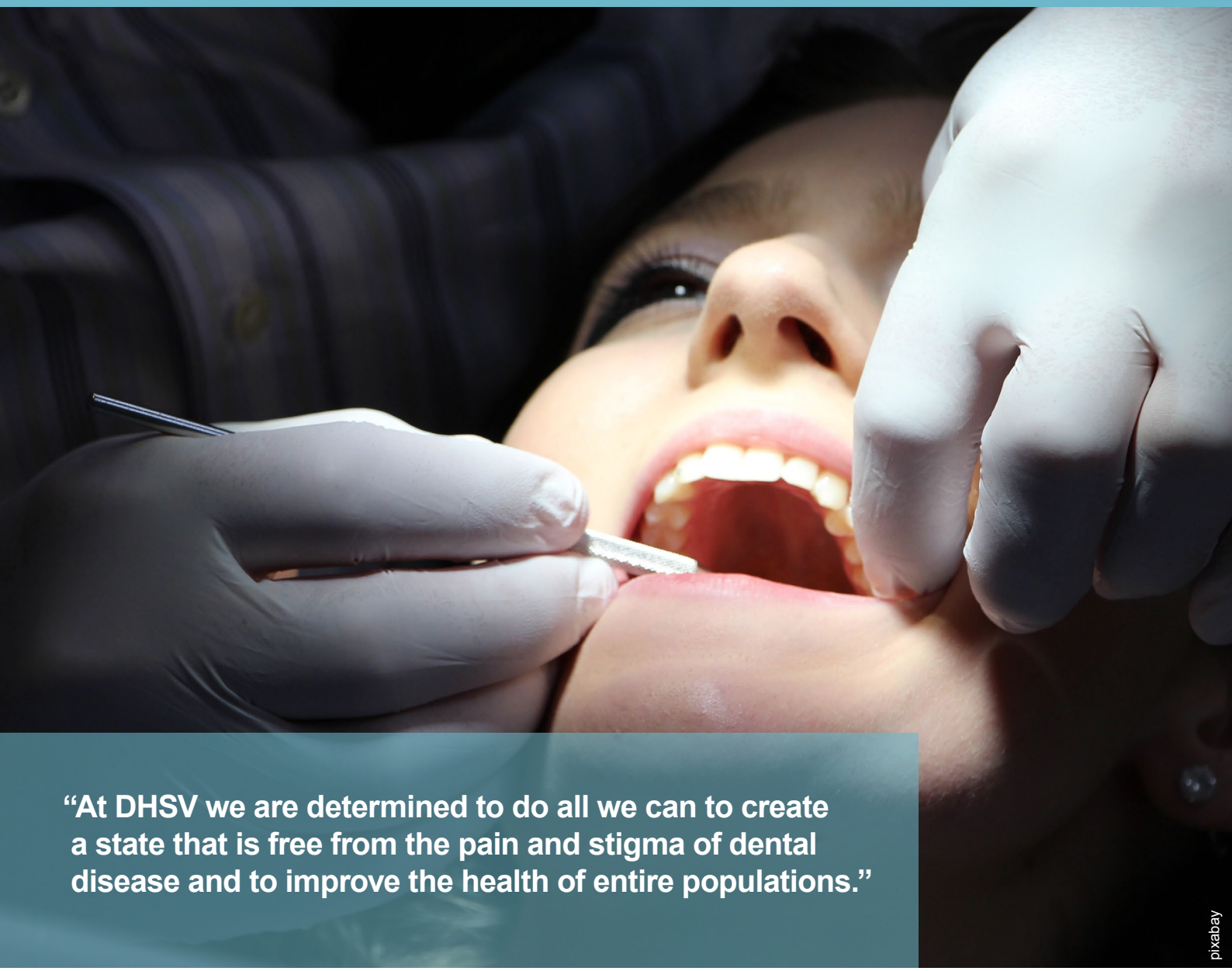
Two years ago, we looked at the state of oral health in Victoria and realised that our system was fundamentally flawed. There were significant unwarranted variations in the quality and type of services being provided. Oral health wasn't improving. Our clinicians were frustrated. And our clients felt disempowered.

Like most healthcare organisations, we had a finite amount of funding and resources. The only way to effect change was to focus on value and outcomes from a patient perspective.

We reviewed *The strategy that will fix healthcare* paper by Porter and Lee and used it to inform our framework for the future. We applied Porter and Lee's VBHC principles, enhanced them for our setting and developed our value-based health care model for oral health care. Throughout this process we were navigating unchartered territory. It was confronting and exhilarating all at once. It required us to face our failures and commit to incredibly complex change without reverting to the safety of the familiar. Every step was debated, hypothesised, repeatedly revisited and most importantly, co-designed with our clients.

Last October, we launched our VBHC proof of concept clinic and the results have been exceptional. By focusing on prevention and early intervention along with appropriate workforce mix, we are delivering the best health outcomes at the lowest cost.

We've seen a 60% increase in preventative interventions and an 80% decrease in dentists doing work that can be done by other dental professionals. We've also seen a significant drop in failure-to-attend rates from 18.9% down to 5.8%.



"At DHSV we are determined to do all we can to create a state that is free from the pain and stigma of dental disease and to improve the health of entire populations."

pixabay

While these statistics are a solid indication that we are beginning to get it right, nothing quite compares to the personal experience of our clients. At one of our workshops, a client named Julie pulled aside one of our facilitators to say that this was the first time in all her years of navigating the oral health system that she felt listened to and respected. She finally feels like we see her. Like we understand her and her family's needs. That moment and the look on her face has made the last two years all worth it.

At DHSV we are determined to do all we can to create a state that is free from the pain and stigma of dental disease and to improve the health of entire populations. This may sound idealistic but if the history books have taught us anything, it's that dreaming big often delivers.

If healthcare leaders across Australia and the world re-focus their energy towards providing value and improving health outcomes, the results could astound and delight us all. We often talk about the challenges we face in the health industry, and there are many. But by focusing on the opportunities and being brave enough to embrace complex change, we might just spark a much-needed healthcare revolution. ha

ALISON VERHOEVEN
Chief Executive
AHHA

Let's not be afraid of reform

Welcome to this June issue of *The Health Advocate*, which will be coming to you shortly after the 18 May Federal election.

Our 'value and outcomes' theme for this issue is something that AHHA and its members are passionate about, as you can see from the submitted articles.

In the run-up to the May 2018 election we put 'pedal to the metal' on value and outcomes with the major parties, topped by our setting up of a new Australian Centre for Value-Based Health Care (ACVBHC), which will be officially launched in Melbourne on 11 June 2019. More information on the Centre is available in 'The new Australian Centre for Value-Based Health Care' article in this issue.

In our view, as well as that of many others, we need 'better bang for the health buck' from our health system. This is not about saving money—it is about achieving better outcomes. For example, reducing the cost of a treatment for which there is no proven benefit will save money, but that treatment is still of little value. Conversely an expensive treatment that has been proven to bring great results may be of high value and worth the investment.

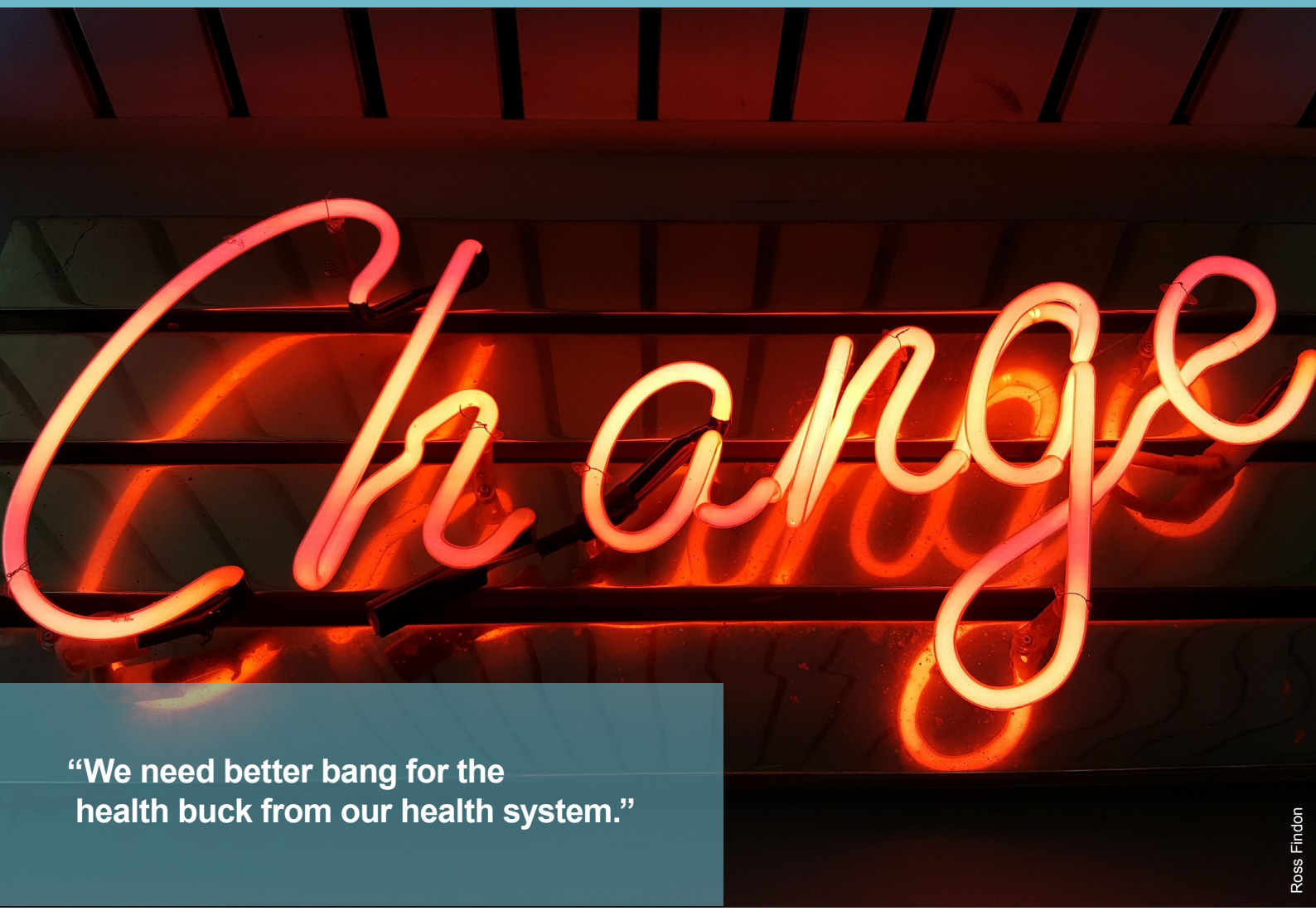
Before the May 2019 election the Coalition, Labor, and the Greens all promised welcome extra health dollars and reduced out-of-pocket costs for electors—but public commitment to getting better value for those dollars was muted.

Before the election we asked questions such as 'Do you really need that extra appointment with the doctor to renew a script or have a specialist referral updated? Do you really need to pay a GP to carry out a treatment or give an injection when a trained nurse can do it just as effectively? Why are some treatments still subsidised by Medicare when more effective evidence-based treatments are available? Why get that injury treated in hospital when it could be done just as well at your local primary care clinic for a fraction of the cost?

We need to shift the whole system to value-based healthcare—that is, better outcomes for patients relative to costs—or the right care in the right place at the right time by the right provider.

This will often involve teams of health professionals providing ongoing care for chronic conditions. Team-based care models with professionals working at the top of their licence may offer more effective, more timely and better value care than traditional care systems.

To enable this, funding arrangements need to move away from a reliance on traditional fee-for-service models, which can entrench fragmented care. Rewards and funding should be re-oriented



"We need better bang for the health buck from our health system."

Ross Findon

to what matters to patients, namely health outcomes and ongoing effective management of chronic conditions.

To reform the health system in this way, governments will need to commit to working in partnership to create a health system not constrained by constitutional barriers or politics.

Bringing the acute and primary care sectors closer together, pooling funds, and sharing information, are key to system changes and reductions in preventable hospitalisations.

To achieve this, governments will need to show leadership in dealing with the inevitable opposition that will come from those who like the system just the way it is.

Flexibility in funding arrangements will be needed to cater for vulnerable populations in specific regions. Research on innovative approaches to healthcare delivery will need to be supported.

It is a major and difficult task. Innovation in health has never been easy—but let's not be afraid of reform.

It makes sense to reorientate our healthcare system to focus on patient outcomes and value rather than throughput and vested interests. It makes sense to boost universal healthcare, equity in health, and coordinated and integrated care. Let's do this during the term of the new Parliament. ha

AHHA in the news

19 MAY 2019

How good is Australia? Only as good as the health of all its people

'The Australian Healthcare and Hospitals Association congratulates the Coalition on its return to government, and urges renewed vigour and attention to health policy as it settles back into power', said AHHA Chief Executive Alison Verhoeven, commenting on the victory by the Coalition Government in the 2019 Federal election.

'Last night, the Prime Minister asked how good is Australia, and in our view, the answer is that it can only be as good as the health of all its people.

'Large, structural reforms are needed to deliver better healthcare access and affordability for all Australians.

'We can no longer reward service volume when we need to shift the whole system to value-based healthcare—that is, better outcomes for patients relative to costs. Simply throwing new money at old problems will be doing current and future generations of Australians a disservice.

'These are issues being explored by our recently established Australian Centre for Value-Based Health Care, and we invite the Government and the incoming Health Minister to engage with us on this work.

'Reforming healthcare cannot be accomplished overnight—but some areas need serious attention right now. In particular, addressing out-of-pocket costs must be prioritised.

'There is ongoing work needed to reform the role private health insurance plays in our health system and to ensure the $6 billion of taxpayers' money subsidising these businesses each year represents good value investment in health.

'Progress towards better coordination of services must be accelerated, both within the health sector and across to other sectors such as aged care and disability services. This will ensure better service delivery, improved efficiency, better outcomes and improved quality of life for those who need combinations of such services. It makes sense to support a holistic view of health and wellbeing.' ha

28 MAY 2019

Reconciliation is the task of nation building

'To date, reconciliation in Australia has focused on citizenship rights and better statistical outcomes for Aboriginal and Torres Strait Islanders peoples, when true reconciliation is much more difficult and much more rewarding', says the Australian Healthcare a nd Hospitals Association (AHHA) Chief Executive Alison Verhoeven.

HAVE YOUR SAY...

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

'Reconciliation Week's theme for 2019, "Grounded in Truth: Walk Together with Courage", challenges us all to understand the history of our country and have the courage to be truthful about this history.

'Reconciliation is the task of nation building and is not something that will happen quickly.

'As a nation, we need to acknowledge the past 200 years and understand its impact on Aboriginal and Torres Strait Islander peoples.

'We need to have the courage to apologise for the dispossession and racism experienced by First Australians—representing a significant 3.3% of the Australian population.

'We need to atone by acting together to improve the statistical outcomes of Aboriginal and Torres Strait Islander peoples under a range of indicators such as health, education, employment, housing and culture.

'And we need a process of truth-telling that will lead to a treaty and voice for Aboriginal and Torres Strait Islander peoples protected by the Australian constitution—as called for in the Uluru Statement.' ha

10 MAY 2019

Accreditation and culture usually go hand-in-hand in health organisations

A positive attitude to accreditation usually signifies good leadership and a positive culture in health organisations—and vice versa, says the Australian Healthcare and Hospitals Association (AHHA).

The Association has released a Deeble Institute for Health Policy Research Evidence Brief, *Assessing the value of accreditation to health systems and organisations*.

Lead author Ryan Swiers said that although healthcare quality and safety accreditation processes are embedded in health systems in more than 70 countries around the world, the actual benefits have not received much research attention, and are not well understood.

'This does not mean, however, that accreditation or the available research are of no value', Mr Swiers said.

'Because accreditation is usually a "point in time" audit process, a successful accreditation result cannot guarantee the complete safety of a health facility. But the available studies do indicate a positive association between accreditation success and a good safety culture, high quality care, high patient satisfaction and good outcomes.

'Some studies also demonstrate a positive association between accreditation and quality indicators such as infection control and adherence to guidelines and protocols.

'However, some organisations view accreditation as a costly, time-consuming bureaucratic burden that adds little value in terms of patient care.'

'In such situations accreditation tends to be seen as a separate "event", with the organisation focusing on short-term compliance rather than long-term continuous improvement— everything reverts to "normal" once the accreditation visit has finished.'

'In addition, some commentators suggest that accreditation has "failed" in Australia, pointing to variations in complication rates across Australian hospitals, and safety failures resulting in patient deaths at hospitals in Queensland, New South Wales and Victoria' ha

AHHA in the news

23 APRIL 2019

Fixing health—why housing and income policy must be part of the mix

'Fixing social disadvantage makes a difference to health outcomes—for example, in reducing world childhood death rates, the World Health Organization estimates 50% of the reduction has been due to non-health-sector investments', said Alison Verhoeven.

'One notable example of people experiencing multiple layers of disadvantage is Aboriginal and Torres Strait Islander end-stage kidney disease (ESKD) patients in remote areas of the Northern Territory (NT).

In an AHHA issues brief released today, *Improving access to housing for Aboriginal and Torres Strait Islander renal patients with complex care needs,* Deeble Institute Jeff Cheverton Memorial Scholar, Stefanie Puszka outlines why housing and income policy changes needed to improve health outcomes.

'These patients have ESKD rates 15 times those of non-Indigenous Australians. To obtain lifesaving dialysis treatment and manage other complications, 80% have to relocate from their remote communities to urban areas. But after 8 weeks of temporary accommodation provided by the NT government, patients are expected to make their own arrangements.

'They then find they have nowhere to stay that's affordable, accessible and culturally safe. Sometimes they are kept in hospital when accommodation cannot be found, leading to delays for other patients.

'The waiting time for a one-bedroom public housing unit in Darwin is 8 years—longer than the average survival time for these ESKD patients (6 years). Even with priority access on medical grounds, the wait is still 3–4 years. And public housing demand continues to grow faster than supply.

'Renal patients are unlikely to be able to work. And it is common for them to wait for up to 6 months, sometimes over a year, to get their applications for the Disability Support Pension approved by Centrelink.

'With no income and nowhere to stay, these patients and their carers are at severe risk of homelessness and may return to their communities and high risk of an early death.

'Our Issues Brief makes several practical recommendations for housing and income support which will improve health equity in this situation.' ha

4 APRIL 2019

More patients, better treatment, rising costs, constrained budget—solutions please?

An opinion piece on value-based healthcare by renowned breast cancer surgeon and commentator Professor Christobel Saunders, AO, leads topics covered in the April 2019 edition of *Australian Health Review* (AHR). AHR is the peer-reviewed academic journal of the Australian Healthcare and Hospitals Association (AHHA).

'We all know the statistics, and the disconnect, between increasing numbers of cancer patients, increasing costs of better treatments and constraining the health budget', Prof. Saunders writes. 'Yet we continue to struggle to find a systematic way to tackle this.'

'Health systems are trying to do this by increasingly measuring and proscribing the multitude of steps it takes to deliver healthcare—yet we still struggle to measure the value we get out of the care we deliver.'

'Contrast this to manufacturing industries whose mantras are "If you can't measure it, you can't improve it" and "The customer is always king".'

Professor Saunders suggests that we may be measuring the wrong things in health: 'If we really want to put the patient first, should we not be measuring the things that matter most to patients, including the long-term outcomes of their disease and treatment, and then improving our services based on this information?'

Prof. Saunders says that the time to implement value-based healthcare—patient outcomes divided by the cost of achieving those outcomes—is now, and the keys to making it work are 'tantalisingly close'. ha

21 MARCH 2019

Close the Gap with refreshed focus on income, education, institutional racism

'Today is National Close the Gap Day—and to truly close that gap we badly need a refreshed focus on the social determinants of health, including income, education, racism and intergenerational trauma', says Australian Healthcare and Hospitals Association (AHHA) Chief Executive Alison Verhoeven

'These factors account for over one-half of the difference in health outcomes between Aboriginal and Torres Strait Islander people and non-Indigenous Australians.

'To reduce such inequities, as a nation we need to have concrete action on things many non-Indigenous Australians take for granted. Things such as quality housing, effective education, jobs, community activities, access to healthy food and clean water, and access to appropriate healthcare.

'When we say "appropriate healthcare" we mean more than medically appropriate—we mean culturally safe healthcare services.

'When dealing with the healthcare sector Aboriginal and Torres Strait Islander peoples should feel safe and secure in their identity, culture and community. There should be no challenge to whether they should be able to access culturally safe services. Whether a service is "culturally safe" or not needs to be determined by Aboriginal and Torres Strait Islander people themselves.

'In this vein, we have much to do in tackling institutional racism—which is different to individual racist acts, and mostly goes unacknowledged.' ha

14 MARCH 2019

Better public dental health services, fluoridation and a sugary drinks tax sorely needed

'It is high time that we as a nation got serious about improving our oral health', said Australian Healthcare and Hospitals Association (AHHA) (then) Acting Chief Executive Dr Linc Thurecht.

'With over 30% of Australian adults having untreated tooth decay, and out-of-pocket costs for dental care being higher than for any other category of health spending, clearly things need to change.

'The fact that oral conditions are the third-highest reason for preventable hospital admissions is also a major concern.

'If we keep things going just as they are in dental health, the situation will only worsen', Dr Thurecht said.

'Universal dental health coverage is the ideal—that is, everyone receiving adequate and affordable dental treatment when they need it regardless of income. But wise money must also be directed to preventing decay and other oral health conditions happening in the first place.

'There are three pressing immediate needs: better funding for public adult dental health services, fluoridated water supplies in every community, and strategies to reduce sugar consumption.' ha

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

SCOTT WALLACE, JD, MBA, Managing Director, Value Institute for Health and Care

SARAH O'HARA, MPH Course and Content Specialist, Value Institute for Health and Care

What is value in healthcare?

What do organisations mean by value?

Value-based healthcare has become a common phrase. Throughout Australia and around the world, healthcare organisations routinely proclaim that 'value creation' is a primary aspiration.

But what do these organisations mean by value? The technical definition is that value in healthcare is the improvement in patient health outcomes for the cost of achieving those outcomes. The healthcare system creates value when it provides people with better health for an equivalent or lower amount of money.

Value is often confused with cost reduction. While reducing unnecessary costs is important, cost reduction alone won't solve the problems facing healthcare. If care is ineffective at improving health, simply paying less for it may reduce wasteful spending, but doesn't create value. The focus of reform must be to improve health outcomes.

In that same vein, value differs from quality improvement. Quality tends to focus on improving processes, some but not all of which improve outcomes. Handwashing compliance, for instance, is a common hospital quality indicator, but it creates value only if it reduces healthcare-acquired infections.

Value is often confused with cost reduction. While reducing unnecessary costs is important, cost reduction alone won't solve the problems facing healthcare.

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How can providers achieve high value within their organisations?

The Value Institute for Health and Care in Austin, Texas studies high-value healthcare organisations around the world. We've found that the greatest gains in value creation occur when organisations restructure care around patients' needs, use dedicated, multidisciplinary teams to deliver comprehensive solutions, and measure the results of their care.

Organising care around patients is a departure from how care is typically organised. Consider a woman with diabetes. In most health systems, she would see a range of caregivers—from endocrinology to podiatry to nutrition. Most would practise in different locations, and the patient would be tasked with coordinating their services. Rarely would anyone track whether her health improves overall.

In a value-based system, the patient would receive care from an interdisciplinary team that might include physicians, nurses, social workers, dieticians, and others assembled specifically to meet the needs of people with diabetes. The care team would be able to address both medical issues and non-medical challenges that typically impact the health of people affected by this condition. The team would measure the outcomes and costs of its care and would use that information to drive improvements. >

"High-value health care organisations bring together teams of providers from across the healthcare landscape—not just physicians and nurses but also physical therapists, social workers, nutritionists, and more, depending on patient needs."

Four key pillars of value creation

The example given above highlights four key pillars of value creation:

ORGANISE CARE AROUND PATIENT SEGMENTS:

Segments are groups of patients with shared health-related needs, such as 'people with migraine headaches' or 'low-income frail elderly'. Segment definitions transcend purely medical circumstances and focus on needs that affect health. With care organised in this way, clinicians can readily anticipate and efficiently provide the services that most patients within the segment will need most of the time, while maintaining flexibility to customise as individual patients require.

DELIVER COMPREHENSIVE SOLUTIONS:

Having identified patients' shared needs, clinicians can determine which services most effectively address those needs. As mentioned above, these services often go beyond clinical care to address other factors that impact health, such as mental illness or housing and food insecurity.

DEPLOY AN INTERDISCIPLINARY TEAM:

Comprehensive solutions require a team of caregivers. High-value health care organisations bring together teams of providers from across the healthcare landscape—not just physicians and nurses but also physical therapists, social workers, nutritionists, and more, depending on patient needs. One compelling example we've studied includes solicitors on the team to address legal challenges that affect patients' health outcomes. Teams ideally work in the same physical setting; where co-location isn't possible, they leverage technology to ensure constant communication.

MEASURE OUTCOMES:

To understand whether care actually improves patient health, high-value healthcare teams measure outcomes. They focus on the outcomes that matter most to patients within the segment they serve. These will vary between segments but typically fall into three categories: *capability* (does care help you function at the highest level possible given your condition?), *comfort* (is care reducing the pain and anxiety associated with your condition?), and *calm* (are you able to live normally while receiving care?). These questions help the team identify improvement opportunities and drive further innovation.

Care delivered in this way is not only better for patients, but also better for the team and the health care system. Allowing clinicians to focus on what their patients need as whole people, rather than on tasks that often seem to have little bearing on health outcomes, supports the professionalism of team members and returns purpose to the practice of medicine. Delivering effective care efficiently also lowers costs, in large measure by reducing the need for ongoing care. ha

At the Value Institute—a joint initiative of Dell Medical School and McCombs School of Business at the University of Texas at Austin—we're supporting people who want to transform medicine so that high-value health care becomes the norm worldwide. To learn more about our work, visit dellmed.utexas.edu/units/value-institute-for-health-and-care.

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THE NEW

Australian Centre for Value-Based Health Care

Bringing together education, research and best practice to promote value-based healthcare in Australia.

From delivering volume to delivering value

Since the 2006 publication of *Redefining Health Care: Creating Value-Based Competition on Results* by Professors Michael E. Porter and Elizabeth Teisberg, health organisations around the world have been exploring how to move the focus of their activities from delivering volume to delivering value. In doing so, they have sought to re-orient health service delivery to provide improved patient outcomes, often while reducing the overall cost of delivery.

While much of the work to date has taken place overseas, the value-based health care movement is building momentum in Australia.

Section 7c of the February 2018 COAG Heads of Agreement on public hospital funding and health reform includes 'paying for value and outcomes' as part of new long-term system-wide reforms agreed for further development by the COAG Health Council.

Many proof-of-concept trials are under way, and state health departments are actively pursuing value-based care projects.

To implement value-based healthcare principles within the Australian health system, an evidence base (including research and case studies) within the Australian context will be needed, as well as local resources to support training, implementation and evaluation.

The new Australian Centre for Value-Based Health Care

In view of the developments outlined above, AHHA has established the Australian Centre for Value-Based Health Care. The Centre will act as a hub, bringing together educational and training opportunities, as well as quality research, best-practice case studies and other resources to support thought leadership, advocacy and skill development in implementing value-based healthcare.

The Centre aims to:

- increase knowledge and understanding of the principles of value-based healthcare
- build the skills required to successfully implement value-based healthcare
- influence public policy to enable the transition to value-based healthcare, focused on outcomes and patient-centred models of care and supported by innovative funding models
- curate and share best-practice examples, theory and research on value-based healthcare
- be recognised as the Australian thought leadership organisation for value-based healthcare.

"The work of the new Australian Centre for Value-Based Health Care is just beginning. In coming weeks, we will release our first research papers and hold an initial series of webinars."

Further, the Centre aims to encourage collaboration, building a network of people and organisations working to improve healthcare through value-based activities.

The work of the new Australian Centre for Value-Based Health Care is just beginning. In coming weeks, we will release our first research papers and hold an initial series of webinars.

Get involved

We are seeking partners and supporters for the new Centre. There are many opportunities to become involved, including:

Research: Our research hub is under development and we are calling for submissions of already-published research to be included in the hub. For those looking to publish new research, our peer-reviewed academic journal, *Australian Health Review* invites submissions on value-based healthcare.

Case studies: If you are undertaking a value-based healthcare project, we invite you to contribute case studies that explore what works, what doesn't work, and enablers and barriers to change.

Education and training: The Centre is developing a suite of educational and training resources and is seeking partners who may be interested in delivering training.

Events: We are seeking partners interested in holding events to discuss issues and showcase their work.

In addition, we are actively seeking financial supporters who are able to fund pilots and research.

The Centre's vision is a healthy Australia, supported by the best possible healthcare system. We look forward to sharing the value-based health care journey with innovative organisations from around Australia. ha

For more information on how your organisation can become an Australian Centre for Value-Based Health Care partner, contact AHHA Engagement and Business Director Lisa Robey on lrobey@ahha.asn.au.

Australian Centre for Value-Based Health Care

WALTER KMET
Chief Executive Officer, Macquarie University Hospital and Clinical Services

The challenge of implementing integrated health care

Farewell speech as departing CEO, Western Sydney Primary Health Network.

There is a term, the 'foreseeable future', which is sometimes used in the commercial world to describe a contract term that cannot be reasonably articulated for events beyond a certain time.

When I signed up to be CEO of the Western Sydney Primary Health Network (WentWest) in early 2012, I could not have foreseen what I would learn about general practice, primary, and social care between then and today, my last day with the organisation. Nor could I have foreseen what was set to occur in this section of the health sector.

I am immensely grateful for the opportunities I've have had to make these discoveries, for the pleasure of meeting and working with a range of the most inspirational and capable individuals, and for the opportunities and support I have received as a CEO, to pursue an agenda that has been unparalleled in a thirty-year career in health.

A time of change

These seven years spent working in a primary health care organisation as part of the health system have not been for the uncommitted. General practitioners and others who have worked in this space for a much longer time than I have done would understand that well.

A general feeling of being under-rewarded, over-worked, and subject to fragmentation comes to mind when reflecting upon what others have said to me. WentWest itself was subject to two major primary care sector government reforms during my tenure—let me say both of which were completely unnecessary and costly.
One, in relation to GP training, was destructive.

Against this backdrop, investment in the regional 'organisation' of primary care and general practice has been a bright spot internationally, with many examples of what could broadly be termed as accountable care organisations, dealing with some of these issues. New Zealand, Denmark, the US and other countries have excellent operational versions of organised primary care in place. Perhaps nothing new here.

The struggle for integrated care

One of the first things I picked up when I started in the sector was a 2011 King's Fund paper which among other things argued:

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> *"There is a need for general practice to adapt rapidly so that it operates at a scale that can provide a platform for integrated care."*

Even further back in 2004 the then Health Minister Tony Abbott said in the Government's response to the review of the then Divisions:

> *"The Divisions network is a national infrastructure providing a mechanism to integrate various elements of the health care system."*

Yet primary health care organisations in Australia, and their iterations as Divisions, Medicare Locals and Primary Health Networks (PHN) have either not been able to reach their obvious potential, or have often been treated with suspicion by some politicians and their advisers, governments and the profession alike.

In addition, there has probably never been such a period of antagonism between various professional bodies, all seemingly advocating for their own patch of funding, often through proposals that only further fragment care to patients.

This has done nothing to enhance patient-centred care or the foundations of integrated care itself. We could do well to adopt strong policy direction, perhaps based on the UK's Primary Care Workforce Commission's Report, which said:

> *"Primary care will have at its heart active collaboration between healthcare professionals and the people they care for. This patient-focused approach will require collaboration between professionals and strong team working, both within and across organisational boundaries."*

Governments have also probably never been more likely to invest sporadically in small disconnected programs, and join the arms race of more hospital beds and infrastructure. >

"Hospitals and specialties have a vital role, if not responsibility, to support capacity and capability for primary care to keep people out of hospital."

The need for leadership and investment

A shared vision, even starting with primary care, of what a high-quality integrated health care system looks like, and recognition of the excellent background work, already done by the Productivity Commission and the Australian Healthcare and Hospitals Association (AHHA), would be beneficial at this time.

To achieve this, no one could sum up what was needed better than US quality and safety luminary, Don Berwick in his response to the superb 2017 Vital Directions for Health Care document:

> *Leaders must recruit the courage to make the case and put their own political and organisational futures on the line. The public must develop a sense of solidarity about the aims and a sense of impatience with resisters. Those who stand to lose in the short run have so far been highly successful in slowing and often stopping the changes that will help the nation in the longer run. Only social solidarity on overarching a*ims can overcome that resistance."

Realising primary care's potential

What does that have to do with Australians, coming from a health system that is as broken as any? Everything, as we are foreseeing the future if we don't recognise, at least in part, that organised primary health care has a vital role in enabling the system to meet its population's needs. In my view the PHNs' role is one that can improve the impact of policy and funding—translating complexity into workable solutions on the ground, and effectively advocating up, so that new programs reflect best practice and experience.

There are some clear misunderstandings about primary care—that it's the simple part of the system; that it needs less investment than all the technology and complexity we see at hospitals and the like.

Quite to the contrary, primary care and social care present the most complex challenges.

Unlike hospitals this part of the medical world does not get better with single purpose, technical or specialised solutions, and doesn't have a time-limited responsibility. We can't discharge people from their communities. Hospitals and specialties have a vital role, if not responsibility, to support capacity and capability for primary care to keep people out of hospital.

Primary care will benefit from more effective policy to support its potential; a rebalanced approach to funding, more broadly away from fee for activity; long term investment in the best and brightest clinical leaders that solve complex problems in teams; and an approach to consumer engagement that reflects co-creation of health, not cookie cutter offerings.

A tall order, perhaps. I know many of my colleagues in PHN-land and I have been immersed in this implementation challenge for some time. It's the right direction.

I've loved the implementation challenge at WentWest and in this sector. I very much look forward to an ongoing contribution in my new role at Macquarie University Health, based on this most excellent experience. ha

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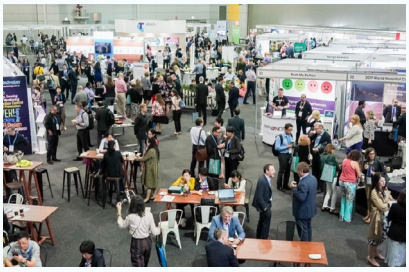

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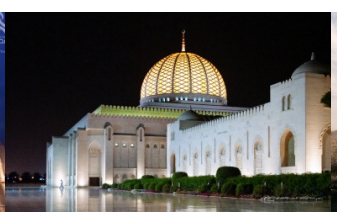

DR SHALIKA HEGDE
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Value and outcomes in public dental funding

The Dental Health Services Victoria experience.

Australia's public oral healthcare system is relentlessly impacted by uncoordinated funding reforms at both the Commonwealth level and within individual jurisdictions.

Such approaches to funding fail to achieve best outcomes and value for patients, funders, payers and service providers due to:

- duplication of efforts at the Commonwealth and state levels
- inefficiencies
- fragmentation of services
- lack of harmonisation across the states and territories in the provision of oral health services
- significant variation in per capita level of investment in public dental services among states and territories.

Re-orienting current fee-for-service public dental funding models in Australia to support 'outcomes over outputs' and 'value over volume' therefore has many potential benefits, including improved value for money, financial sustainability and care coordination for governments, and better oral health outcomes for patients and the community.

A value-based public dental funding model in Victoria

In 2018, Dental Health Services Victoria (DHSV), the lead public oral health agency in Victoria, became the first organisation in Australia to implement a patient-centric, and outcomes and prevention focused value-based health care (VBHC) model in the public dental sector.

To assess which funding model provided the best option to support VBHC in the public dental sector,

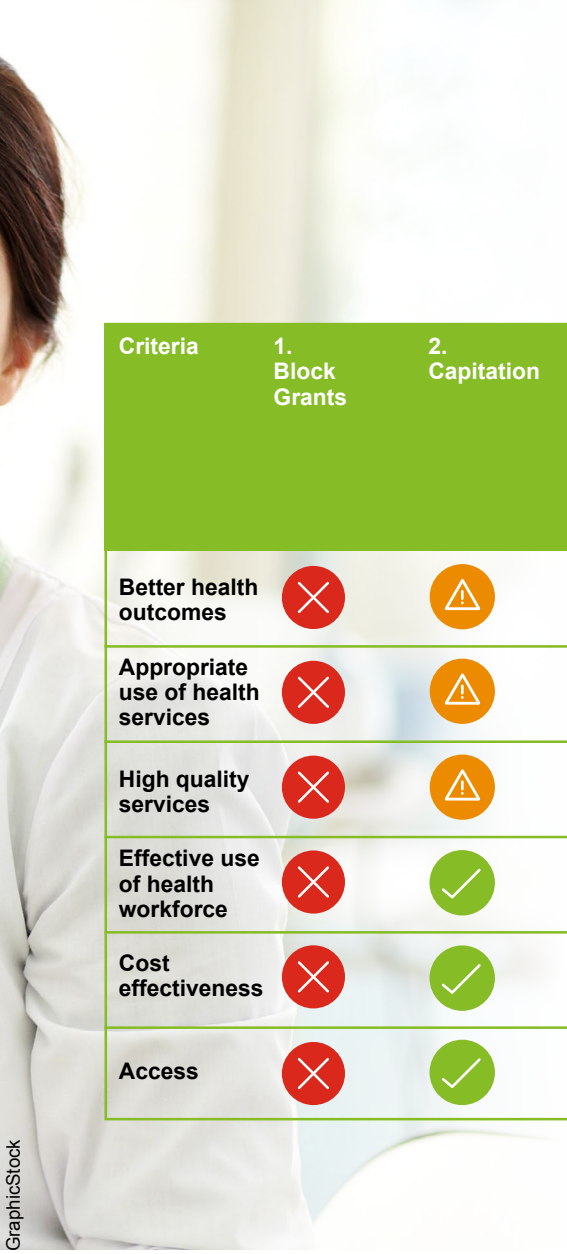

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Table 1: Results of the funding model review against the VBHC criteria

Criteria	1. Block Grants	2. Capitation	3. Fee-for-service	4. Activity-based Funding	5. Payment by Result (PbR)	6. Value-Based Funding	7. Blended Funding - Capitation and value-based	8. Blended Funding - Fee for service / ABF and value-based
Better health outcomes	✗	⚠	✗	⚠	⚠	✓	✓	✓
Appropriate use of health services	✗	⚠	✗	⚠	⚠	✓	✓	✓
High quality services	✗	⚠	✗	⚠	⚠	✓	✓	✓
Effective use of health workforce	✗	✓	✗	✓	✓	✓	✓	✓
Cost effectiveness	✗	✓	⚠	⚠	✓	✓	✓	✓
Access	✗	✓	⚠	✓	⚠	⚠	⚠	⚠

Key: ✗ The funding model does not satisfy the given criterion
⚠ The funding model partially satisfies the given criterion
✓ The funding model strongly satisfies the given criterion.

DHSV reviewed models from across the globe, comparing and analysing them against six VBHC criteria:

1. better health outcomes
2. appropriate use of health services
3. high quality services
4. effective use of health workforce
5. cost-effectiveness
6. access.

The eight types of funding models considered by the review included: Block Funding (Block Grants, and Capitation); Per Unit Funding (Fee for Service, and Activity-Based Funding); Outcome-Based Funding (Payment by Result, and Value-Based Funding); Blended Funding (Capitation Base with Value-Based Component, Fee for service/ABF Base with Value-Based Component)—see Table 1.

Results

Following the analysis, and understanding how each model functioned in a practice context, a Blended Funding model (no. 7 in Table 1) was recommended for transitioning Victorian public dental health to a reimbursement system aligned to VBHC principles.

The model chosen combines a risk-adjusted capitation base with a value-based outcome component. *(Capitation is a set amount for each enrolled person assigned to an organisation, per period, whether or not that person seeks care).*

Blended payment models of this kind are increasingly being used in primary healthcare settings in several Organisation for Economic Co-operation and Development (OECD) countries. The Productivity Commission supported the use >

of such blended payment methods for public dental services in its report *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services.* The Independent Hospital Pricing Authority (IHPA) has also shown interest in models of care that incorporate a focus on outcomes.

Outcome measures needed

To measure 'value', payment models must be tied to a set of standard and measurable patient-centric health outcomes. Patient-reported outcome measures (PROMs) are one example.

The International Consortium for Health Outcomes Measurement (ICHOM) works with health leaders and consumers internationally to develop sets of standardised outcomes for health conditions. DHSV collaborated with ICHOM, the Harvard School of Dental Medicine and the Hospital Contribution Fund (HCF) Research Foundation to develop a standard set of outcome measures for use in the dental sector. Both clinical and patient-reported outcomes were included.

DHSV is now trialling this set of measures to analyse the effectiveness of its services and to prioritise high-value care while limiting low-value care. The measures will also enable monitoring of health system performance and assist in benchmarking best practices.

National implications

Beyond limited hospital safety and quality data, health outcomes are not routinely collected and published at a national level in Australia. For public dental services, most of the data currently collected and reported are *inputs* (such as funding levels and numbers of dental professionals), and *outputs* (activity and mix of services).

Strong national leadership and the cooperation of all jurisdictions will be needed to implement a national public dental funding system focused on value and outcomes, but all parties will benefit. A nationally consistent outcomes data set on public dental service provision will enable better evidence-informed policy decisions.

The Commonwealth could consider:

- negotiating with the states and territories to move to an agreed blended funding model comprising a risk-adjusted capitation base and value-based health outcome components to achieve a balance between health equity and overall costs
- standardised tracking of health outcomes and costs of care. This will require comprehensive and enhanced data collection systems with strong IT infrastructure.
- developing an agreed national minimum dataset and data dictionary for oral health to enable the capture of nationally consistent and comparable outcomes data
- modelling the impact of proposed funding reforms and evaluating them during and after implementation.
- developing pilot programs with inbuilt scalability to larger geographical areas with different patient segments. ha

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Care coordination for children with chronic conditions

Making life better and saving money for the healthcare system.

Having a child frequently admitted to hospital or requiring ongoing medical care is very stressful for families. The worry about the child's health and the determined attention needed by families to navigate our complex health system is a great challenge.

According to the Australian Institute of Health and Welfare, over one-third (37%) of Australian children have long-term health conditions, and frequently need care from multiple providers in diverse healthcare settings. Long-term health conditions include asthma, diabetes and allergies, but some children have very complex conditions including developmental, genetic or chromosomal disorders.

These children are frequent visitors to hospital clinics, emergency departments (ED) and healthcare services in the community. Many families, however, rely on tertiary children's hospitals in metropolitan centres for most of their health care, because that is where their trusted interdisciplinary specialist teams are located.

This is not sustainable. Attending tertiary children's hospitals is costly for families due to travel, accommodation costs, family disruption and loss of income for the parents. Further, it is costly for the health system because highly specialised tertiary children's hospitals are high-cost settings. Ideally, families would prefer to receive excellent care for their children closer to home, while keeping them out of metropolitan children's hospitals.

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Integrated care model at Sydney Children's Hospitals Network

An innovative integrated care model for children living with medical complexity (CMC) implemented at the Sydney Children's Hospitals Network (SCHN)—and evaluated by us—does just this. It has resulted in significant benefits for the SCHN, for healthcare providers and, most importantly, for families.

Savings of almost $5 million over 2 years are estimated due to reduced hospital encounters for CMC, including a 40% reduction in ED presentations and 42% reduction in day-only admissions for around 540 children accessing the new model of care—entitled 'KidsGPS'. Over 50,000km in family travel was also saved and 370 school absences prevented. KidsGPS is valued not only by families but also by healthcare providers. We know this because a comprehensive evaluation was embedded from the beginning of implementation.

The new model of care addressed key concerns raised by the Organisation for Economic Cooperation and Development (OECD) that navigation of the Australian healthcare system is 'too complex for patients'. Families experience emotional, logistical and financial challenges while navigating the complex healthcare system to access the right care for their child. Our healthcare system is predominantly designed for episodic care, with limited natural opportunities for care continuity and integration among largely siloed specialties, fragmented hospital and primary care sectors and a mix of private and public providers. >

"Integrated care and care coordination should be available to all children living with medical complexity regardless of their postcode."

The KidsGPS included care coordination, shared care planning, appointment streamlining, telehealth and shifting care (where possible and safe to do so) closer to home as well as to lower cost-settings in local hospitals and primary care.

Importantly, the model also included upskilling of healthcare providers working in local hospitals, general practitioners, and the families themselves to increase their capacity to provide self-care to these medically complex children.

Families of children living in regional and rural Australia stand to gain the most through reduced out-of-pocket expenses on travel, accommodation and food—and less family disruption.

Success factors

The success of this and other integrated care innovations depends very much on teamwork, and co-design and co-production approaches. Complex problems often require complex solutions to be developed by diverse teams of researchers, clinicians, managers and decision-makers. Undertaking extensive formative evaluation to develop a deep understanding of the problems from provider, patient, family and healthcare system perspectives is essential to support the development of the right solutions.

Supported by funding from NSW Health, SCHN managers worked with clinical academics from the Universities of NSW and Sydney to develop and implement KidsGPS. Uniquely, embedding a researcher with expertise in implementation science and systems research from the Australian Institute of Health Innovation at Macquarie University to support mixed-methods implementation research and evaluation, generated evidence to maximise sustainability and to support scaling up of the successful model of care to regional and rural healthcare settings.

Looking ahead

Integrated care and care coordination should be available to all children living with medical complexity regardless of their postcode. Integrated care networks and learning communities should be established to create opportunities for knowledge sharing based on the principles of learning healthcare systems.

The World Health Organization, the International Society for Quality in Health Care and the International Foundation for Integrated Care are putting their weight behind models of care such as this, and point to primary care and self-management as keys to providing patient-centred, integrated care.

Current policy-related knowledge and directions have very much focused on moving towards decentralised and integrated patient-centred care as the key to a sustainable health system of the future. These concepts support the notion that the healthcare delivered should provide value to the patient, the provider and the system, whilst removing incentives that reward for the volume of delivered care. ha

RHONDA FLEMING
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Strengthening primary care capacity in Outback Queensland

The Western Queensland Health Care Home.

The Western Queensland Health Care Home Model

In Australia there is an appetite for evidence-based models that support patient-centred approaches to providing coordinated and team-based models of care.

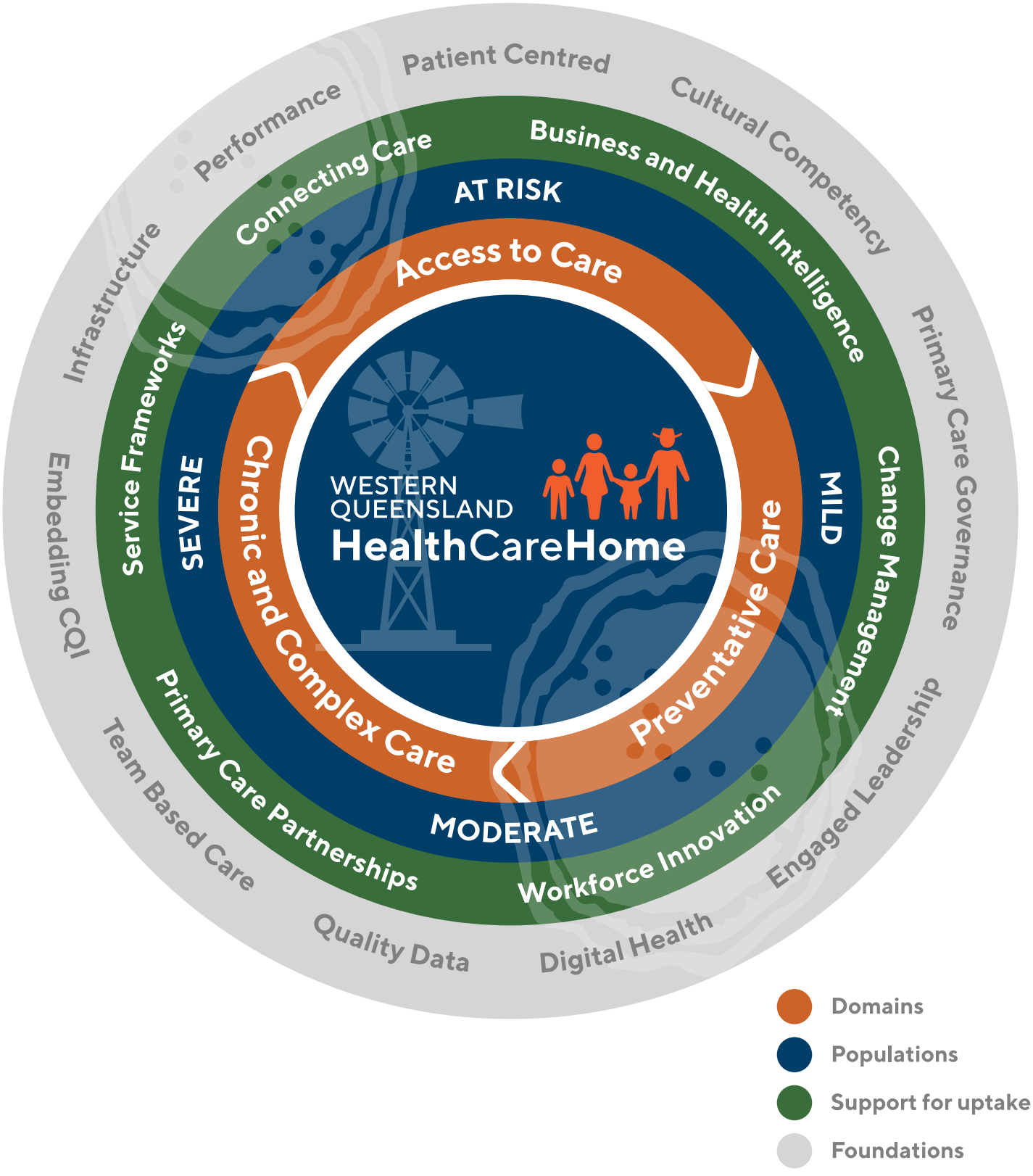
Western Queensland Primary Health Network (WQPHN) over the past two years has undertaken comprehensive consultation and research to identify a new approach to better support patients, General Practices and connection across the healthcare neighbourhood. This led to the development of the Western Queensland Health Care Home (WQ HCH) Model of Care, which is conceptualised within 3 core Domains of care, 10 Foundations and 6 Supports for Uptake to provide elements needed for General Practice to succeed as a WQ HCH.

The model has a focus on value-based health care through strengthening primary care capacity by creating a clear vision and building leadership capacity to drive and inspire change. Engagement of practices, patients and families is a critical element to effective implementation.

Trialling effectiveness

To trial effectiveness of the model, an Early Adopter Program (EAP) was developed, with the overall objective of building capacity of primary care networks through evaluating the >

"Queensland's outback and remote settings present unique and complex challenges for health system design and sustainability."



quadruple aims of healthcare including: maximising population health outcomes; enhancing the patient healthcare experience; improving service provider experience; and improving efficiency and financial sustainability.

Six EAP practices were invited to participate after a rigorous recruitment process where practices were ranked against capability criteria. The EAPs completed four evaluation assessments, including the Patient Satisfaction Survey, Team Health Check, WQ HCH-Maturity Matrix, and Practice Performance Analysis (PPA). Areas for improvement were identified and WQPHN Practice Coordinators supported practices to develop an Implementation Plan.

Patient satisfaction data was captured over a four-week period following a GP appointment, with 739 participants (60% female, 38% male, 2% other) completing the survey. Of the participants 18% identified as Aboriginal and Torres Strait Islander.

Results

A high proportion of all patients (93%) were satisfied with the health and medical care they received, including very high satisfaction (95%) with the courtesy and friendliness of reception staff.

Satisfaction with wait times to get an appointment were lower, with 82% of participants stating it was good, 10% stating it was okay and 2% stating it was bad.

Overall Team Health Check responses were strong, with all aggregated responses (75 participants) scoring 4 or higher on the 0–5 Likert scale.

WQ HCH-Maturity Matrix level scores across the three domains provided a baseline for WQ HCH readiness: access–entry level (2.3); preventative–advanced (3.1); and chronic and complex– advanced (3.1) (Maturity levels are on a scale of 1 to 4).

The PPA identified potential MBS income gaps for chronic conditions, including recommended priority population groups based on Socio-Economic Indexes for Areas (SEIFA) adjusted data. Based on the outcomes of the pre-assessment measures, EAP practices have implemented improvement strategies with the support of WQPHN Coordinators.

Evaluation Framework

An Evaluation Framework has been developed, supported by two evaluation partners as follows:

- **The University of Qld Mater Research Institute led by Professor Claire Jackson** and team has assisted in developing a Western-Queensland-related-and-relevant Maturity Matrix to enable practices to assess the transformation journey through four stages of WQ HCH maturity—preparation, entry, advanced and aspirational.
- **Professor Sabina Knight from the Centre of Rural and Remote Health (CRRH) and James Cook University (JCU)** is leading a team conducting an on-the-ground evaluation including Patient Reported Experience and Outcomes Measures (PREMS/PROMS) surveys, and interviews and focus groups involving practice staff, WQPHN Coordinators, the WQ HCH Management Team, and WQ HCH Working Group members.

The evaluation results and recommendations will inform the rollout and continuation of the program.

Conclusion

Queensland's outback and remote settings present unique and complex challenges for health system design and sustainability. By evaluating progress through the quadruple aims, WQ HCH Early Adopter Practices are able to respond to feedback by implementing change and improvement initiatives across the whole practice and wider WQ HCH neighbourhood. The testing of the model and collateral is providing important understandings of new approaches that reinforce access to care, prevention, and proactive management of chronic conditions through a more sustainable, better-connected and patient-centred model of care—the WQ Health Care Home. ha

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Value-based healthcare: are we ready for it?

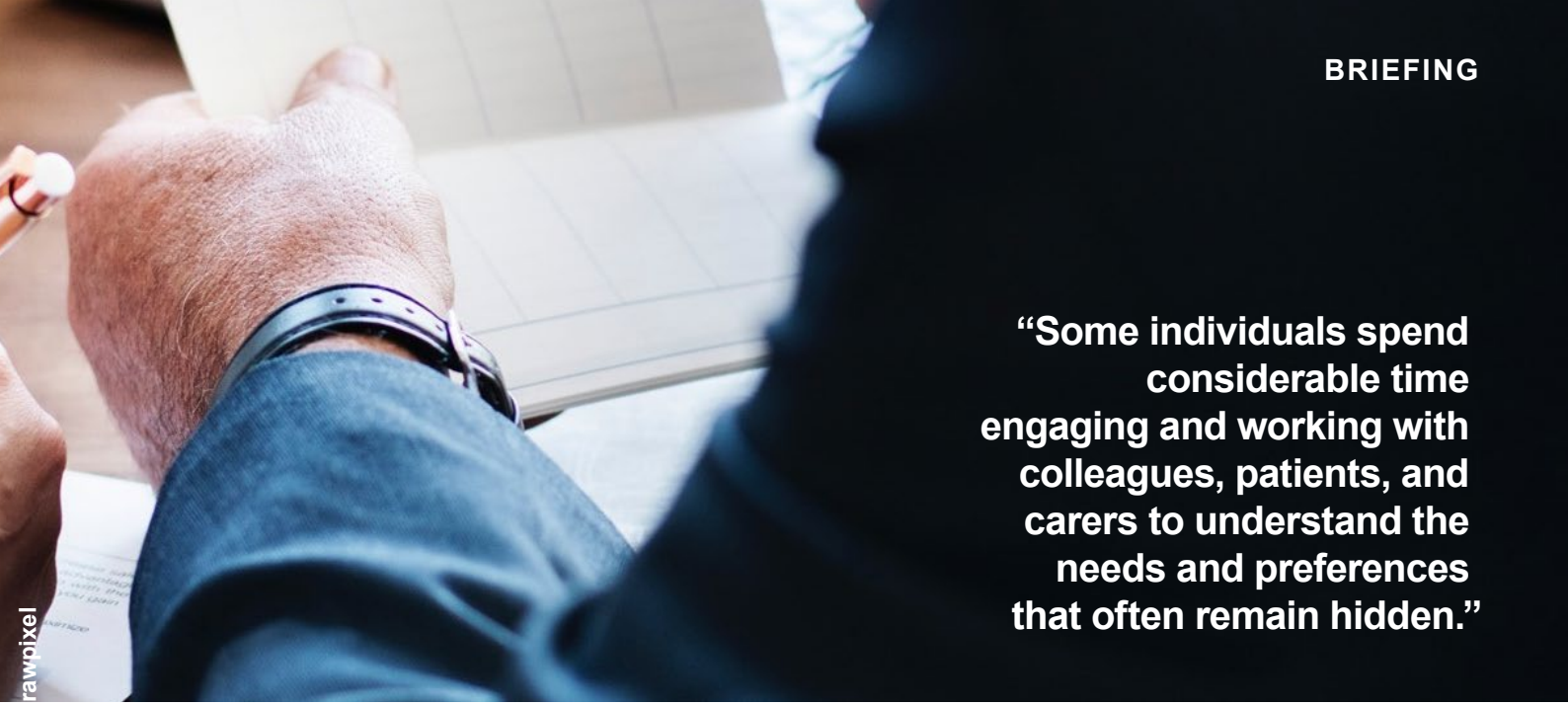
There is increasing interest in value-based healthcare, with the Australian Healthcare and Hospitals Association recently launching the **Australian Centre for Value-Based Health Care**. Growing reference to value-based healthcare piqued my own interest, particularly regarding what it is, whether Australia needs (or wants) it, and its feasibility.

Value-based healthcare is a model to guide the delivery of healthcare, where 'care is organized around the patient and meeting a defined set of patient needs over the full care cycle'[1]. In Australia the **NSW Ministry of Health**[2] recognises value-based healthcare as 'delivering services that improve… health outcomes that matter to patients'. There is considerable international interest in value-based healthcare, with the Economist Intelligence Unit finding, 'approaches are being implemented incrementally and at varying speeds across the world's healthcare systems'[3].

How does Australia compare with other nations? According to the Economist Intelligence Unit, Australia demonstrates a moderate capacity to deliver value-based healthcare. Although it can be helpful to learn from international experiences, it can also be helpful to consider whether value-based healthcare in Australia is indeed feasible.

The feasibility of value-based healthcare is perhaps evident when a linear approach to receiving care is assumed with care organised by 'a defined set of patient needs over the full care cycle'[1]. Consider your defined needs as a patient requiring surgery to a broken limb. In addition to you, as the patient, the 'full care cycle' is likely to require several inputs, including: a referral from an appropriate clinician; information about your changing situation; surgical equipment; medications; competent staff; as well as space. Each input can be accounted for (directly or indirectly) to gauge effectiveness and efficiency and pursue opportunities towards value-based healthcare. This seems logical enough.

Yet, what of other clinical realities? Consider your 'defined… needs'[1] as an older person with early-stage dementia living at home. How might



"Some individuals spend considerable time engaging and working with colleagues, patients, and carers to understand the needs and preferences that often remain hidden."

you indicate, and how might staff subsequently capture your spiritual wishes and needs? Although the importance of engagement and compassion in healthcare is recognised, the ease of codifying them is yet to be determined.

Equally important is the experience of staff providing care. How might experiences of burnout and bullying be captured? It is also worth noting that care is not the sole remit of clinicians—it is provided by managers, administrators, orderlies, cleaners, patients, carers, and volunteers, among others. And each individual is likely to have different capacities to articulate their 'experience of providing care'[2].

Some individuals spend considerable time engaging and working with colleagues, patients, and carers to understand the needs and preferences that often remain hidden. They use innovative approaches to engage the senses and elicit emotions. Yet, it seems value-based healthcare would require these individuals to do this expeditiously, to readily and regularly gauge value.

The tension here lies in defining a 'set of patient needs over the full care cycle'[1] that pays heed to: 'health outcomes that matter to patients'; 'the experience of receiving care'; and 'the experience of providing care'[2]. Despite growing interest in value-based healthcare, we are yet to know whether it can (readily) account for experiences and needs that are difficult to enunciate and categorise. Nevertheless, two points are worth noting. First, given that value-based healthcare is not necessarily new, there is considerable opportunity to learn from previous efforts, regardless of whether they occurred within or beyond a health service. And second, value-based healthcare represents fertile ground for innovative approaches to explore whether and how the potential of value-based healthcare might be realised.

The point of this article is not to cast doubt on value-based healthcare—but rather, to ignite questions to collectively discuss and address. Without this, the longstanding issues within the Australian health system might be exacerbated, thereby contravening the spirit of value-based healthcare. ha

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The medicalisation of dying from natural causes

Unacceptable to patients, low-value for the health system.

Australians can now expect to see their ninth decade. In 2017 Australia had 3.5 million people aged 65 years or more who will become octogenarians, a figure that will double by 2050.

But many people in their last years can expect some degree of reduced physiological reserve, irreversible organ failure, cancer, and/or disability from other chronic illnesses, and frailty.

The combination of chronic conditions and acute complications can be used to prognosticate time to death and plan more appropriate and less aggressive care. Yet, patients often find themselves having surgical procedures, and taking multiple medications that can cause adverse symptoms and complications or lead to burdensome hospitalisations that could have been avoided. We know health professionals, especially doctors, are often slow to recognise the person approaching 'End of Life' until the last weeks or days.[1]

The health system offers older dying people in their last year more interventions with the unrealistic hope of prolonging life, due to family pressure, system policies, ambiguity about goals of care, and clinical inertia.

The system is overtreating dying older patients[2] by admitting them to intensive care when there is no real prospect of survival and the chances of harm outweigh any potential benefits. Or hospitalising when the condition can be managed in general practice or in a nursing home; or by doing CPR when there is a 'not-for-resuscitation' order, or when CPR is futile.

Importantly, prolonging suffering through non-beneficial treatments when older people

"Importantly, prolonging suffering through non-beneficial treatments when older people are reaching the natural end of their lives is often not aligned with their wishes or personal values."

Ismael Nieto

are reaching the natural end of their lives is often not aligned with their wishes or personal values.[3] This removes comfort and dignity from their dying, creates false hope for families, results in job dissatisfaction for the clinicians administering futile treatments, and generates unsustainable costs of care.

Our health system will not be able to cater for the demand of the growing ageing population unless we turn the tide soon. We believe the following would be helpful.

Prognostication

Clinicians can use validated time efficient tools (eg CriSTAL,[4] SPiCT, the Surprise Question) in admission assessments to recognise patients in their last year of life and plan End of Life care. Shared decision-making based on the patient goals of care should be promptly established.

Education

Education on disclosing bad news can improve clinicians' capacity for conversations with patients and families about treatment options for those expected to die from their irreversible chronic illness. A public awareness campaign to encourage earlier patient discussions with families on values and preferences can reduce unrealistic demand for treatments.

Remuneration

The lengthy and multiple conversations needed about the limits of medical care and patient care preferences are best initiated by a trusted >

"...de-medicalisation' of dying and embracing of a natural end to life needs to be adequately resourced by an aligning of health policy and budgets with the evidence."

health professional, and preferably before a health 'crisis'. Hence the MBS schedule needs to reflect the value of this process.

Alternatives to the acute hospital

General practitioners and community nurses are well placed to contain unnecessary returns to the emergency department. Government could shift some of the costs of unnecessary hospital-based aggressive interventions to provide a more family-friendly environment and cost-effective service in the community, with timely access to comprehensive high-level home care for the frail.

GPs need realistic funding for domiciliary visits, and aged care facilities need adequate Registered Nurse staffing.

Creating Compassionate Communities

Finally, a critical mass of volunteers can be gathered through the Compassionate Communities and Cities (CCC) movement, which can enable a family to provide care at home for a dying person to supplement health system services.

In summary the 'de-medicalisation' of dying and embracing of a natural end to life needs to be adequately resourced by an aligning of health policy and budgets with the evidence. Only then will sustainability for the health system be achieved and comfort be the norm for our elders at the end of life. ha

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Don't bury your head in the sand when it comes to your super. Knowledge is power. Set up your online access to check your balance and see how you're tracking. And if you change jobs, just remember — you can always take your account with you.

2. Keep your super together

Six million Australians have more than one super account. That's six million of you being charged more than one set of fees. It couldn't be easier to consolidate your super, either online, over the phone or by mail.

3. Find the right balance for you

Even though you can't access it until a bit later in life, making extra voluntary contributions to your super — and getting the balance right between before and after-tax contributions — could help your super savings in the long term.

4. Know how your super's invested

Super is one of the biggest investments most of us will make. Most of our members are invested in our MySuper-authorised option, Core Pool. You can see how Core Pool is invested at **hesta.com.au/invest**, and read about the other options that are available.

5. Check your insurance

Having insurance is an important way to help safeguard your quality of life, right now. Most HESTA members receive insurance automatically when they join. Find out if you have the right type of insurance for you — you can check this in your online account.

WHY JOIN HESTA?

Super is one of the most important investments you'll ever make. And here at HESTA, it's our role to help you make the most of it.

hesta.com.au/join

PROF. CHRISTOBEL SAUNDERS
Project Chief Investigator, Consultant Surgeon (Royal Perth Hospital, Fiona Stanley Hospital, St John of God Subiaco Hospital), Professor of Surgical Oncology at the University of Western Australia

DR NELI SLAVOVA-AZMANOVA Associate Investigator, Cancer and Palliative Care Research and Evaluation Unit, University of Western Australia

LESLEY MILLAR Research Program Manager, Cancer and Palliative Care Research and Evaluation Unit, University of Western Australia

The Continuous Improvement in Care Cancer Project

Evaluating outcomes that matter most to patients, and improving care.

What is CIC Cancer?

The Continuous Improvement in Care Cancer (CIC Cancer) Project is a multi-institutional program of research that seeks to bring value-based healthcare (VBHC) to public and private healthcare settings in Western Australia (WA), using a model detailed in *The Health Advocate* in December 2017.

The project aims to create value through improving outcomes while containing costs (see **www.ciccancer.com**).

This is achieved through measuring and acting on variations in outcomes that are important for people diagnosed with cancer.

The results of combined clinical and patient-reported outcome measures will feed back into clinical management processes to:

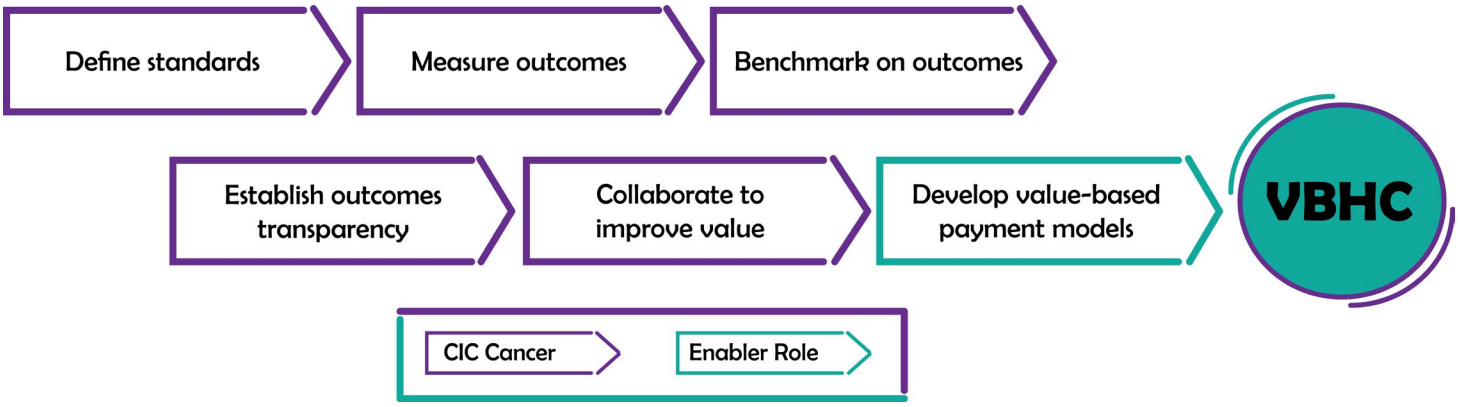
- improve care;
- help determine needs for clinical intervention; and
- allow units to assess and improve their practices (see Figure 1).

To the best of our knowledge, this is the first time that VBHC processes have been implemented simultaneously across multiple hospitals in both public and private healthcare sectors within Australia.

DR ANGELA IVES
Associate Investigator, Cancer and Palliative Care Research and Evaluation Unit, University of Western Australia

"The needs of the CIC Cancer Project are complex and multi-dimensional—and the implementation of an effective engagement and informatics system is integral to successful measurement of outcomes for cancer patients."

Figure 1: CIC Cancer role in VBHC in WA



The project has been under way for 18 months. In that time, many of the desired short-term outcomes have been successfully achieved and work is under way towards achievement of desired mid-range outcomes.

SHORT-TERM OUTCOMES

- Clinician and consumer engagement and input informs data collection and research needs.
- A secure and effective informatics infrastructure is in place that meets the needs of clinicians and consumers, and links to health services systems where possible.

MEDIUM-TERM DESIRED OUTCOMES

- Outcomes important to patients are measured and the information is used to benchmark and inform care provision across sites and the disease trajectory.
- The International Consortium for Health Outcomes Measurement (ICHOM) standard datasets are enhanced and improved through the results of WA trials.
- Consumer input informs priority-setting for research into improvements in care provision.
- New interventions are identified/researched/translated to practice to address >

deficits/gaps and areas of unmet need in care pathways to ensure continuity of care and care outcomes meet optimal care pathways.
- Understanding of value-based health care is increased.

Stakeholder engagement

Five hospital sites, five tumour streams (colorectal, lung, breast, prostate and ovarian cancer), and nine lead clinicians working across the sites have been engaged. Support has also been secured from health care providers, data and information teams, key senior health service managers at each site or health service group, and WA Health.

In addition, a model is in place to successfully involve consumers in:
- the development of ovarian cancer patient-reported outcome measures (PROMs);
- acceptance of the data capture system across all tumour streams; and
- relevance of consumer-related key messages and communication pathways.

Local, national and international collaborations have resulted in increased access to expertise, implementation of associated research; and improved understanding of effective processes.

Data capture system development

A key component of CIC Cancer Project is the implementation of a single informatics system to capture both clinical and patient-reported outcomes (PROs).

A low-cost, easily adaptable, open source system is essential to ensure flexibility to incorporate additional data elements to support clinical and research work, and sustainability, and allow for future long-term uptake and ownership by public and private health services.

Development and deployment of a bespoke informatics system is under way following review of commercially available applications, and a decision taken to undertake internal development. This builds on a framework currently used for other rare disease registries—the Rare Diseases Registry Framework1—which allows registry administrators to construct web-based patient registries with minimal software developer effort.

The CIC informatics system will incorporate three components to collect and report on clinical and PROs data:

1. A 'Site System' housed within the health service intranet, to provide a repository for clinical information to be captured.
2. A 'PROMs Platform'—an external entity to complete PROMs. This information will be securely and regularly transferred into the 'Site System' and will allow clinicians to have a much better understanding of what matters to patients about their care and its outcomes.
3. A database for use by the research team, where de-identified data are securely transferred offsite to allow for analysis and evaluation.

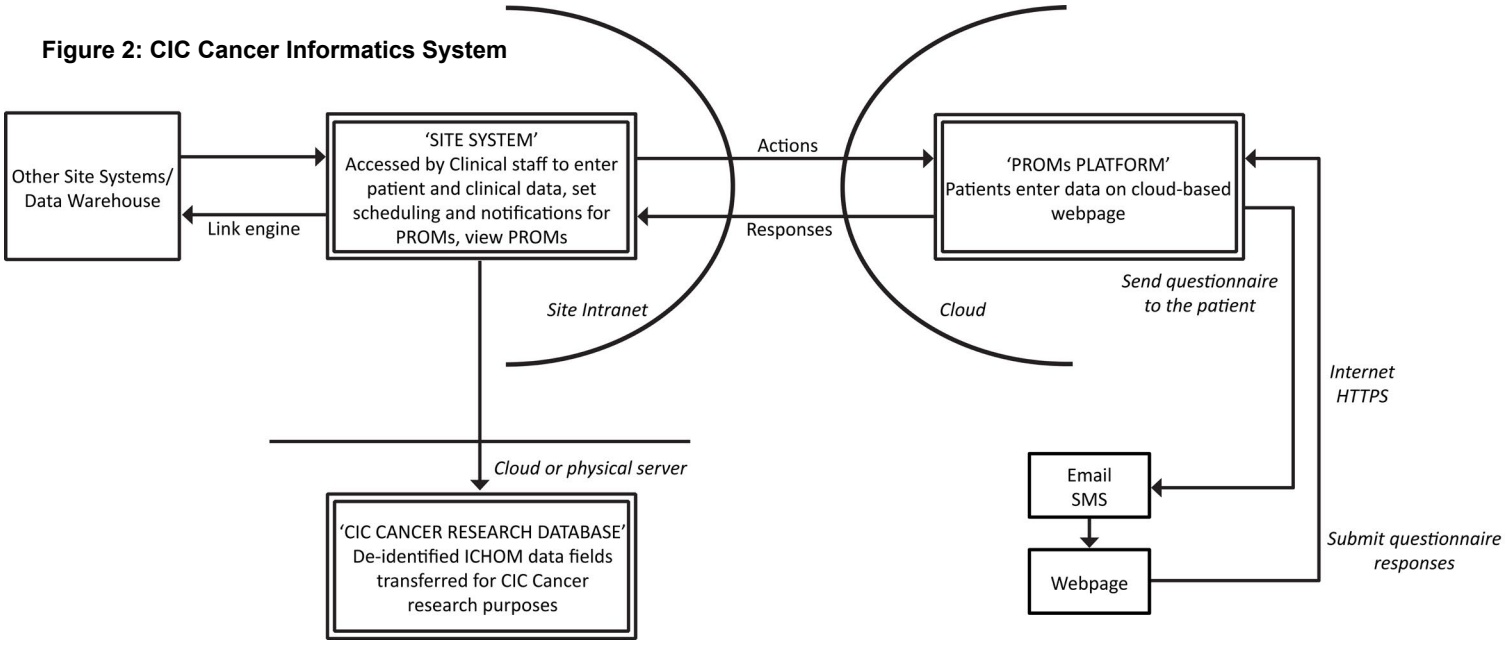
The informatics system is being built to allow functional integration with multiple, differing health services information platforms used within public and private health sectors in WA.

To ensure effective use of resources and long-term sustainability, the informatics system will push/pull data necessary to capture information from across the care pathway, and allow external analysis, while adopting open data standards. This will be achieved by installing it as an enterprise system for both the public and private health service providers involved.

Outcomes measurement

Dataset determination is under way using OECD-endorsed ICHOM standard datasets for colorectal, lung, breast and prostate cancer, amalgamated

Figure 2: CIC Cancer Informatics System



with clinician-requested additions such as mapping and integration with other clinical registries and psychosocial data items.

Both consumers (through focus groups and interviews) and clinicians have been fully involved in the development of a suitable standard dataset for ovarian cancer. The use of the EQ-5D-5L (EuroQol Group measure of health-related quality of life) has also been incorporated to allow for capture of change in quality-adjusted life years as part of the health economics evaluation incorporated into the research program.

Pilot involvement in the All. Can patient survey conducted internationally and within Australia has resulted in an initial understanding of patients' perspective on how the care experience could be improved, focusing on what matters most to patients.

The results, scheduled to be launched in May 2019, will be used to inform discussions with policy-makers on how to improve cancer care. This will bring the voice of the patient into the decision-making process, in an effort to ensure cancer policies focus on meaningful outcomes for patients.

Moving forward

The needs of the CIC Cancer Project are complex and multi-dimensional—and the implementation of an effective engagement and informatics system is integral to successful measurement of outcomes for cancer patients.

Lessons learnt from the initial 'bedding down' of the program are yet to be fully identified. These will be discussed in future updates. ha

Reference

1. MI Bellgard, L Render, M Radochonski & A Hunter 2014. Second generation registry framework. Source Code for Biology and Medicine 9:14.

Major funding source: Cancer Research Trust

Collaborators: University of Western Australia (UWA), Cancer and Palliative Care Research and Evaluation Unit (CAPCREU), Murdoch University, Notre Dame University Australia, Curtin University, WA Cancer and Palliative Care Network, Cancer Council WA, Consumer and Community Health Research Network, St John of God Health Care, and Queensland University of Technology.

TRACEY JOHNSON
Chief Executive Officer, Inala Primary Care; Churchill Fellow; Deputy Chair Primary Care Advisory Group, AIHW; Healthcare Homes Evaluation Working Group Member

Right care, right place, right team

Inala Primary Care generates value

Running a general practice and running a business are synonymous. Sales of clinics to private group practices and publicly listed corporates mean that clinics owned by doctors invested in their community are dying. Increasingly, doctors, allied health workers and nurses are working as sub-contractors paid a share of revenue billed. Volume rules, with few incentives to offer comprehensive cradle-to-grave care.

In disadvantaged communities there is no easy medicine. Rates of diabetes can be five times as high as the national average, smoking rates more than double, and heart disease and respiratory illness are known to every family. Mental illness complicates more than one-third of patient interactions. Multiculturalism results in one in six consultations taking twice as long due to interpreter use. Welfare dependence in more than two-thirds of patients reduces medication adherence and means referrals to private specialists are rare. Welcome to Inala, Queensland's most disadvantaged suburb!

A charitable general practice, Inala Primary Care (IPC) has been showing that real value can be generated if healthcare becomes a 'team sport'. That team includes patients, their families, doctors, nurses, allied health workers and even specialists working out of the practice.

Diabetes model of care gives outstanding results

Independent evaluation of the IPC diabetes service has shown that when GPs, a Diabetes Educator, Podiatrist and Endocrinologist all share care, more patients can be seen than in hospital outpatient settings (2.7 times the hospital rate), care targets are met at three times the rate, and the cost is one-fifth of equivalent hospital services.

Another study found patients were half as likely to be hospitalised as a result of their diabetes. If this model of care was to be rolled out nationally, estimated national savings would be $132.5million per year. The Productivity Commission and Grattan Institute have both recommended the model for wider implementation but have acknowledged that funding reliant on volume stands in the way.

When the same model was applied to kidney disease, the most frequent reason for hospital attendance in Australia, the evaluation was also positive. Sustaining and replicating the model,

Lessons from Australian General Practice of the Year 2016.

which had a nurse as the lynchpin around which GPs and nephrologists worked, was stymied by current funding models.

Small business model of General Practice no longer fit-for-purpose

General practice can reduce hospital admissions related to chronic disease. Funding such care are MBS items for GP Management Plans and Team Care Arrangements.

Inala allocates nurses one hour each year per patient to create new plans and provide education, care navigation and social prescribing. Doctors spend 20 minutes with patients to write scripts, generate specialist referrals and bill. Nurses arrange quarterly or half yearly reviews of the plans and coach patients on how to achieve their healthcare goals and make lifestyle adjustments in 30 minutes of contact.

Without this model in place, Inala would experience difficulties completing nationally recommended cycles of care.

The Grattan Institute reported that less than one-quarter of patients with diabetes completed all the elements of care found to reduce disease progression. Doctors simply cannot attend to the care coordination needs of patients when more than one-half of their consultations involve multi-morbid patients. Under the current funding system, with practices receiving just 30–35% of billings, most cannot afford to employ the nurses and other team members to make the system deliver.

In an environment of privatised medicine, the UK House of Lords recently concluded that the 'traditional small business model of General Practice is no longer fit-for-purpose and is inhibiting change'.

Australia outlays more than $2 billion each year on preventable admissions. Sharing the savings that result from better care with general practice will foster the virtuous circle of healthcare integration and teamwork.

At $371.40 per Australian in 2016–17, a rise of just 80 cents on the previous year, General Practice offers great value compared to hospitals. Hospital services cost more than $2,500 per Australian, with costs nearly doubling in a decade. More government dollars diverted to team care in general practice has the potential to bring significant savings to the health system overall through reduced hospital admissions. ha

ADJ. PROF. GAYLENE COULTON
Chief Executive, Capital Health Network

MS JULIE PORRITT
Executive Manager—Innovation and Improvement, Capital Health Network

Successful trial results: pharmacists located in general practice

A successful two-year pilot in the Australian Capital Territory has shown the benefits of having a non-dispensing pharmacist in general practice as part of the health care team.

The pilot, held in three general practices across Canberra, was evaluated by the University of Canberra. The main conclusions were that having a pharmacist on board increased quality of prescribing, increased support to GPs, saved GPs time and reduced costs to patients.

The evaluation report also found that 100% of patients surveyed supported the continued availability of a pharmacist in their general practice.

The successful pilot by Capital Health Network (CHN), through the ACT Primary Health Network (PHN) program, was conducted in the following three general practices in Canberra: Isabella Plains Medical Centre; YourGP@Crace; and the National Health Co-op.

Due to the positive results, CHN has now launched a new program to provide support to another four general practices across Canberra to employ a part-time pharmacist: Althea Wellness Centre; Conder Surgery; Gungahlin Medical Practice; and Health Plus General Practice.

Further proof of the success of the pilot is that Isabella Plains Medical Centre and YourGP@Crace have both continued to employ a pharmacist following the end of pilot funding.

Dr Mel Deery, YourGP@Crace Practice Principal, said that their GPs were so committed to having the pharmacist continue that they (the GPs) have co-invested in order to continue to employ pharmacist Katja Naunton-Boom:

> 'Our Pharmacist Katja is a great support for questions that GPs ask, and helps save us time. For example, I currently see a patient developing renal failure who is on 15 medications. Katja has worked out which medications to adjust, which is improving the outcomes for our patient'.

YourGP@Crace Pharmacist Katja Naunton-Boom said she feels she is a key part of the care team:

"The evaluation report also found that 100% of patients surveyed supported the continued availability of a pharmacist in their general practice."

> 'When a patient is getting a health assessment or care plan completed, the patient meets with the nurse, then I review their medication and then we all come together with the GP to discuss findings at a case conference with the patient. Patients appreciate this wrap-around care. I have also seen that GPs now have a better relationship with community pharmacies as I'm often a communication point between community or hospital pharmacies'.

Dr Divya Sharma, Isabella Plains Medical Centre Practice Principal, has also continued to employ a pharmacist and said that she would highly recommend to other general practices to get a pharmacist on board:

> 'Our Pharmacist Brendon Wheatley has been conducting clinical audits for patients with conditions such as diabetes, arthritis, Crohn's disease and hypertension. His assistance in this area is unlimited and his advice has resulted in improved medication management. Our patients really like seeing Brendon as he provides them with extra time, value and ultimately improved patient care'.

Capital Health Network Chief Executive Adj. Prof. Gaylene Coulton said that Capital Health Network's role is to advance the way health care is delivered in Canberra:

> 'The success of this pilot and subsequent new program is a good example of how CHN through the PHN programme designs services that fill gaps and deliver lasting improvements. This demonstrates how we can use our local knowledge to design solutions to meet community need, which are timely, effective and high worth'.

The Pharmacist in General Practice Program is supported by funding from the Australian Government's PHN Program.

phn ACT
An Australian Government Initiative

Capital Health Network
Partnering for better health

FI MERCER
CEO and Founder,
Governance Evaluator

GOVERNANCE EVALUATOR

How to genuinely partner with consumers

A key area of focus for clinical governance.

In 2017 Safer Care Victoria and the Australian Commission on Safety and Quality in Health Care created new Clinical Governance Frameworks. A key area of focus for clinical governance was, and remains, genuinely partnering with consumers.

As part of their broader conversation about the governance of clinical care, Fi Mercer, CEO and Founder of Governance Evaluator, talked with Dr Sue Matthews, CEO of the Royal Women's Hospital (Victoria) and now Chair of the Victorian Healthcare Association about how to lead positive outcomes in consumer engagement.

SUE: *Genuinely partnering with consumers is an important opportunity for improvement if we are prepared to stop and listen. In that regard I think that the advice of our Royal Women's Hospital Consumer Advisory Committee is essential.*

Understanding from consumers what they want is key—and moving from a 'teach and tell' approach to a 'listen and explore' style is an essential part of getting this right. We genuinely must shift the way we do things.

*We need to remember that while each of us has expertise, we are not complete experts about other people. We need to provide expertise and information to our consumers and communities so **they** can then decide what **they** want, because **they** are the experts on their own lives.*

To illustrate this point, and show how organisations can better 'listen and explore' Sue told a story from her experience in another organisation involving an elderly inpatient with diabetes who did not speak English.

SUE: *The gentleman in question was put into a set regime for diabetes care, including diet, medication and so on. He was about to go home, and everyone thought he and his wife were going to manage very well.*

I had a suspicion, however, that he might have been blankly smiling and nodding about all the compliance orders, and he probably would not adhere to them once at home.

I took it upon myself to chat to the man's daughter about this, even though our excellent staff had given the best professional advice and programs.

The response from the daughter was 'Are you kidding me? My dad—an elderly Italian man—

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being expected not to eat pasta, drink wine or have sweets?!"

It did indeed seem unrealistic, and we wasted no time in changing the man's regime—in partnership with his daughter—to one that he could adhere to.

It is quite possible that had this gentleman gone home and not adhered to his regime, it could have resulted in the genuinely very caring staff labelling him 'non-compliant' which in turn could have led to further difficulties with diabetes care.

SUE: *Rightly or wrongly it is 'human' to label people. That would have been unfair in this case, which is a very good example of 'we told but did not listen'.*

Due to the military origins of our nursing profession, we are trained to solve others' problems—but we listen to work out a solution, not to genuinely hear the patient's story or learn about their uniqueness.

*With military precision on behalf of others, we assess, plan, and implement—but **for** them not **with** them!*

Sue strongly believes that for healthcare professionals to move forward in genuinely partnering with consumers and creating exceptional healthcare experiences for them, we need to start by asking questions of our patients and/or their families, carers and community to gain better knowledge of them as people living within their own unique social and personal environment.

We can then move to providing the supports they **really** need, with all parties willing, in a positive way, to be accountable for the results. This is the foundation for co-designing and co-producing high quality and safe health services.

SUE: *An organisational culture that encourages and supports co-design with consumers, carers and community results in empowered and healthier clients. The key ingredients are:*

- *Knowledge—access to information*
- *Support—ask 'What do you need?'*
- *Accountability—everyone involved in the process is accountable, in a positive way.*

Finally, the key to success is learning from mistakes—even though it is the hardest thing to do, it results in the best outcomes for patients. ha

To find out more click here or contact solutions@governanceevaluator.com.

ELIZABETH KOFF
Secretary, NSW Health

Value-based healthcare in NSW: understanding what matters to the patient

How do we create sustainable value and health outcomes?

The vision for NSW Health is a sustainable health system that delivers outcomes that matter to patients and the community, is personalised, invests in wellness and is digitally enabled.

Patients now have greater expectations and understanding of the care that they need and what they expect from their interactions with the health system. Delivering care has become increasingly demanding with growing pressures from high rates of chronic disease, new technology and an ageing population. Expenditure on healthcare increases each year and demand continues to rise. Amid this demand and complexity, putting the patient at the centre remains the most important thing we can do in all care settings. This applies equally to primary and social care.

To meet these challenges and aspirations we are focusing on what value means for patients, clinicians and the health system in NSW. Our definition of value covers four dimensions: improved health outcomes, better experiences of receiving and providing care, and improved effectiveness and efficiency. Value-based healthcare approaches offer the best way to sustainably deliver the outcomes that matter to patients by improving how we organise and provide care.

As one clinician has said, 'Sustainability is the challenge. It's about long term change and the evidence to support it'.

The size and complexity of the NSW health system is challenging. 234 public hospitals and facilities employ over 130,000 staff and serves a growing population of almost 8 million people across a diverse geography of over 800,000 km.

Delivering health services, especially specialist care and post-acute care, in the community is central to the health system for the future. Enhanced and well-resourced community care must be at the centre of a value-based healthcare system. Our patients expect greater choice about the care they receive and where and how they receive this care and they want their care coordinated across providers, regardless of the

"Our definition of value covers four dimensions: improved health outcomes, better experiences of receiving and providing care, and improved effectiveness and efficiency."

funding stream. Utilising the most appropriate care setting will improve outcomes and experiences for patients, while creating capacity in the system.

Digital enablers and technology are changing the experience of receiving and delivering care. Care that would have previously required hospital admission can now be delivered in a virtual setting. Ongoing digital monitoring can predict and prevent further intervention. By connecting data, people and information we can empower clinicians and patients to make more informed choices about their care.

Measuring and evaluating health outcomes and experiences will also inform how services are provided, organised and funded in future. Data and analytics help us to understand and deliver the best care for each person and to inform decisions about resources and prioritisation. Whilst many health systems have become increasingly good at measuring activity, they fail to focus on the patient's own experiences and outcomes.

We are now collecting and using patient reported measures in a more systematic way as a direct account of the patient's personal experiences and health outcomes. In NSW patient reported measures will be used in real-time for clinicians and their patients to inform care planning, shared decision making and support timely person-centred care. The information will also be collected over time, linked and analysed to improve quality, planning and understand the value our care adds to patients.

Leading Better Value Care (LBVC) is just one NSW Health program that is supporting the system to deliver value-based healthcare. It uses a structured scalable approach to embed evidence-based practice and best value care, experiences and health outcomes across the state. LBVC implements and measures the same clinical initiatives in every local health district. Leading Better Value Care builds on the enabling work that is already being done across the state.
A collaboration of the Ministry of Health, Agency for Clinical Innovation, Clinical Excellence Commission, and the Cancer Institute NSW delivers support and tools to help clinicians apply the best available evidence. Other statewide strategies include our focus on integrating care and applying a commissioning for better value approach to non-clinical support areas.

Making value a sustainable reality involves commitment, effort, cultural change, improved governance and system capability. It calls for us to review existing funding and commissioning models to ensure these don't act as barriers for providing the most appropriate care. Robust budgetary processes will be essential, with informed thinking about invest that creates value for patients, clinicians and the system.

NSW and other jurisdictions are progressing this long term aspiration to unlock value. It demands greater maturity of our processes and the combined efforts of many people. These are early days but the long-term goals are clear and will be driven by the expectations of our patients and clinicians. ha

More information: health.nsw.gov.au/value

AHHA Member Benefit Partners

AHHA has negotiated special rates and offers for our members with the following organisations.

Employsure is Australia's largest provider of workplace relations and health and safety advice, servicing more than 21,000 small business clients nationwide. In one place, Employsure offers access to a team of trusted advisers, employment law experts, HR professionals and workplace consultants. AHHA members can access free workplace relations assistance and advice through Employsure. To access, call **1300 798 990** and quote the Assist Code ERA0296.

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Make it Cheaper makes it easy for Australian homes and businesses to save on their energy bills by providing an obligation-free and fast way to identify whether your current energy retailer is offering you a competitive rate. Make it Cheaper provides a free energy comparison service to AHHA members and their employees to help identify great energy savings for homes and businesses in the ACT, NSW, SA, South East Queensland and Victoria. Register online today at **ahha.mic.energy** to find out how much you could save or call **02 8880 4327** to speak to one of our energy experts.

Kineo is one of the largest e-learning specialists in Australia and New Zealand, and part of the City & Guilds Group, with a 140-year global history of corporate learning. We deliver best practice for learning and help the world's leading businesses improve performance through learning impact. Kineo offers AHHA members online training on a wide range of topics including Workplace Health and Safety, Workplace Relations, Front of House, Ethics and Conduct, and Health Care. Find out more at: **ahha.asn.au/online-training-portal**

Foregenix is a team of cyber security experts. We have global presence, enriching us with a deep understanding of the global cyber-threat landscape, including coast-to-coast specialists across Australia. We help organisations at every stage of their cyber security programs—from proactively stopping future breaches, to 24x7 security monitoring for threats, as well as minimising the pain, cost and damage of an existing breach. AHHA members are entitled to a 10% discount on all Foregenix services. For further details, please contact the dedicated representative for AHHA members, Dan Ball on **0431 693 607** or **dball@foregenix.com**, and quote reference AHHAMember.

The Productive Series programs were originally designed by the NHS Institute for Innovation and Improvement to release more time to care for frontline staff who typically spend less than 30% of their time providing direct care. Often termed 'Lean in a box', the Productive Series programs are based on Lean improvement techniques that encourage frontline staff and management to work together to improve patient care. The Productives link directly to the achievement of activity targets and the National Safety and Quality Standards. Hospitals talk about being 'accreditation ready every day!' thanks to the Productives.

AHHA, in association with Qualitas, is now able to offer The Productive Series programs across Australia. For more information visit: **ahha.asn.au/The_Productive_Series**

Become an AHHA member

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

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

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

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

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

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

Membership benefits include:

- capacity to influence health policy
- a voice on national advisory and reference groups
- an avenue to key stakeholders including governments, bureaucracies, media, like-minded organisations and other thought leaders in the health sector
- access to and participation in research through the Deeble Institute for Health Policy Research
- access to networking opportunities, including quality events
- access to education and training services
- access to affordable and credible consultancy services through JustHealth Consultants
- access to publications and sector updates, including:
  -Australian Health Review
  -The Health Advocate
  -Healthcare in Brief
  -Evidence Briefs and Issues Briefs.

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

‘Our vision is a healthy Australia, supported by the best possible healthcare system.’

Our goals

In partnership with our members, we aim:

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

More about the AHHA

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

AHHA Board

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

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

Dr Michael Brydon
Sydney Children's Hospital Network

Dr Paul Burgess
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Ms Gaylene Coulton
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AHHA National Council

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

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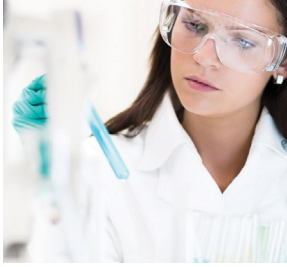

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