

Queensland Clinical Senate

Clinician leadership. Consumer collaboration. Better care.

Low benefit care: runs on the board

7-8 November 2019 - Meeting Report

'Low benefit care: runs on the board' Meeting Report

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<https://clinicalexcellence.qld.gov.au/priority-areas/clinician-engagement/queensland-clinical-senate>

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Chairs' report

Each and every one of us has a responsibility in our clinical practice to reduce low benefit care. It's important for our patients—they deserve the best possible care and outcomes.

It's important for us, as clinicians—we want to provide care that is of high benefit to our patients.

And of course, it's important for the system—we must ensure the care we provide supports a sustainable system for future generations.

In August this year, the Queensland Clinical Senate and the Statewide Clinical Networks, hosted some 170 clinicians, consumers and health executives to talk about low benefit care and identify key priorities for Queensland Health, in collaboration with consumers, to pursue. These are:

1. Improving the quality use of medicines to optimize care in frail and older patients
2. Improving end of life planning and care in end-stage disease
3. Reducing unnecessary daily blood testing.



Prof Liz Kenny AO and Dr Alex Markwell.

Crucially, the priorities must be underpinned by educating and empowering consumers and their healthcare providers to discuss what care is needed, and the development of appropriate metrics to evaluate the impact of any interventions for reducing low benefit care.

These key priority areas, along with the other [meeting recommendations](#), have been endorsed by Queensland Health's System Leadership Team and supported by the Choosing Better Care Together Steering Partnership. We are already seeing progress in this space, which is extremely encouraging.

To build on that, and in response to an overwhelming call from clinicians, we dedicated our November 2019 meeting to a showcase of successful low benefit care programs. We were delighted to receive more than 30 abstracts from acute and primary care clinicians about low benefit care programs getting runs on the board throughout Queensland. In the appendix of this report, you will find the 24 abstracts chosen for oral or poster presentations.

It is our hope that meeting delegates walked away from the meeting feeling motivated to continue driving this agenda armed with a list of relevant programs, achieving great patient outcomes, that are ready to be implemented in their own organisation.

We encourage you to take the time to read the abstracts that could relate to your work area and consider whether you could adapt any of the programs for your workplace. We don't need to reinvent the wheel, but we do need to act, and act now both as individual practitioners and as a system.

We all want to do the best that we possibly can for our patients—to make a difference in the lives of those who entrust us with their care—so let's take this opportunity to drive change for the better.

Dr Alex Markwell
Chair
Queensland Clinical Senate

Prof Liz Kenny AO
Chair
Queensland Clinical Networks
Executive

Introduction

The Queensland Clinical Senate believes there is an individual and collective responsibility on all those in the health system, including consumers, to identify and reduce any care provided to patients that is of low benefit.

While there are many procedures and interventions that may provide little or no benefit to patients, three key priorities were identified at the Queensland Clinical Senate's August 2019 meeting:

1. Improving the quality use of medicines to optimize care in frail and older patients
2. Improving end of life planning and care in end-stage disease
3. Reducing unnecessary daily blood testing.

Crucially, the following will underpin all statewide priorities:

- Educating and empowering consumers and their healthcare providers to discuss what care is needed, and identifying which interventions are helpful and which are not
- Updating clinical decision support tools (such as HealthPathways and Smart Referrals) to guide and promote evidence-based practice by explicitly stating the benefit to patients of different management options
- Developing appropriate metrics to evaluate the impact of interventions for reducing low benefit care.

Building on that, the Senate's November 2019 meeting showcased programs of work underway across the state that address these priority areas. Fifteen papers were selected for oral presentation from more than 30 abstracts. A further nine programs of work were selected for poster presentations. Meeting delegates were invited to vote for the best presentation for each session.

This is the Senate's fourth meeting about value-based care.

What is low benefit care?

Low benefit care is the use of procedures or interventions where the evidence suggests there is little or no benefit to patients, or that the risk of harm exceeds the benefit, or the added cost of the intervention doesn't provide the proportionate additional benefits. For example, end-stage kidney disease can be managed with renal dialysis; an invasive treatment that does not cure the disease, and is costly to the patient emotionally and physically and the system financially. A Metro North Hospital and Health Service initiative is empowering patients with chronic kidney disease to make informed choices about their care, including whether they want dialysis or not.

Speakers and panellists

Ms Aimee Ballantine, Principal Project Officer, Choosing Wisely, Gold Coast Hospital and Health Service

Dr Jack Bell, Advanced Accredited Practicing Dietitian and Research Fellow, The Prince Charles Hospital and University of Queensland

Mr Richard Bolitho, Clinical Pharmacist, Metro North Hospital and Health Service

Ms Prue Brian, Senior Pharmacist, Geriatric Evaluation and Management Unit, Metro North Hospital and Health Service

Mr Phil Carswell, health consumer representative

Dr Carl de Wet, GP/General Practice Liaison Officer, Gold Coast Hospital and Health Service

Ms Erin Dunn, Pharmacist, Metro North Hospital and Health Service

Dr Erin Evans, Chair, Health Consumers Queensland

Ms Melissa Fox, Chief Executive Officer, Health Consumers Queensland

Ms Aileen Gilbert, health consumer representative

Adj A/Prof Damian Green, Chief Executive, eHealth Queensland

Dr Jon Harper, General Practitioner, Central Queensland, Wide Bay and Sunshine Coast Primary Health Network

Mr Matty Hempstalk, health consumer representative

Ms Pattie Hudson, Chief Executive, Central Queensland, Wide Bay and Sunshine Coast Primary Health Network

A/Prof Glen Kennedy, Executive Director, Cancer Care Services, Royal Brisbane and Women's Hospital

Prof Liz Kenny, Chair, Queensland Clinical Networks Executive

Dr Myat Myat Khaing, Gastroenterology Registrar, The Prince Charles Hospital

Dr Lei Lin, Gastroenterology Registrar, The Prince Charles Hospital

Ms Liza-Jane McBride, Chief Allied Health Officer, Queensland Health

Ms Helen Mees, health consumer representative

Dr Claire Naughtin, Senior Research Consultant CSIRO Data 61

Ms Rawa Osman, Clinical Lead, Choosing Wisely

Dr Sue Page, Director of Medical Services, Wide Bay Hospital and Health Service

Ms Champika Pattullo, Senior Pharmacist, Clinical Pharmacology, Metro North Hospital and Health Service

Mr Gary Power, health consumer representative

Prof Liz Reymond, Director, Office of Advance Care Planning, Metro South Hospital and Health Service

Dr Nicolette Roux, Senior Medical Officer, Wuchopperen Health Service

Ms Xanthe Sansome, Manager, Brisbane South Palliative Care Collaborative

Adj Prof Adam Scott, Director of Cardiac Services, Royal Brisbane and Women's Hospital

Dr Morne Terblanche, Senior Medical Officer Anaesthesia and Clinical Lead Patient Safety,
Sunshine Coast Hospital and Health Service

Mr Frank Tracey, Chief Executive, Children's Health Queensland

Ms Sotera Trevaskis, Project Director, Choosing Wisely, Wide Bay Hospital and Health Service

Dr Sree Venuthurupalli, Consultant Nephrologist, Darling Downs Hospital and Health Service

Ms Chezz Viner-Pallier, Senior Social Worker, Darling Downs Hospital and Health Service



Above: Panel discussion for 'Healthcare – future challenges and possible solutions'.

Left: Queensland Clinical Senate Chair Dr Alex Markwell, Queensland Health Director-General Dr John Wakefield and Queensland Clinical Senate Deputy Chair Mr Chris Raftery.

Key messages

Session 1 - Improving the use of medicines

- We must increase the knowledge and confidence of health professionals to trial non-opioid and non-pharmacological therapies for pain management, and empower consumers with the knowledge and confidence to start asking questions about medicines.
- Consumer involvement/co-design is integral to program success. Take your patients on the journey with you and will have the biggest advocate.
- Programs need a core but adaptable element that is 100 percent owned and driven by clinicians.
- Acute hospital admissions represent a unique opportunity for geriatric medicine expertise to start the deprescribing conversation with vulnerable older patients with unnecessary polypharmacy.
- Engaging and educating consumers and carers in the de-prescribing intervention is much more effective than only targeting the medical practitioner.
- An up-to-date medication list is extremely important for patients as they move between acute and primary care.
- Pharmacists integrated into clinic teams, communicating directly with patients and making home visits has proven to have a positive impact on medicines management in Wuchopperen Health Service.
- Results have shown that the addition of a pharmacist to memory clinics results in positive medication related outcomes for people with cognitive impairment or dementia who are at risk of medicine misadventure.
- The success of improving care and addressing low value care in a tertiary facility is based on establishing clinical quality systems within a clinical unit, which requires defined clinical management structures and a process to routinely capture, analyse and feedback clinical incidents and outcomes.
- As a society we are inherently biased towards acts of commission (doing things), we need to start changing our thinking to understand that doing nothing is still doing something.

Session 2: Improving the appropriateness of treatments and care pathways

- Death is often seen as a failure of treatment rather than something that is part of the circle of life.
- Advance care planning is a way of knowing what matters most to the person as they approach their end of life care. Research shows that consumers and carers are happy to be approached about advance care planning.
- We can't prescribe dignity – we need to practise dignity, and this requires a culture shift especially at the end of life.
- Value-based healthcare can't be practised unless you know what the patient wants. What is right for a consumer isn't necessarily what the medical team think should happen. Patient outcome and experience measures should drive the way the system evolves.
- Trained 'community connectors' such as hairdressers and butchers could help educate the community about programs such as advance care planning and end of life care.

Session 3: Improving diagnostic testing

- The Choosing Wisely approach can underpin so much of what is done in everyday delivery of care.
- Focusing on safe and high-quality care leads to greater sustainability of services.
- Create a culture of trying, doing things differently, learning and 'failing forward' until the service is fit for purpose.
- 'It takes the time it takes' to have conversations with patients.
- Communicate with kindness, compassion and the healing power of human touch and your patient will hear more.
- Reducing diagnostic testing based on routine/habit rather than a clinical decision could require a culture change.

Session 1 – Improving the use of medicines

Facilitator Adj A/Prof Chris Raftery

Session 1 best paper

Battling the blight of benzos in primary care with big data and small steps

Dr Carl de Wet, Clinical Lead, Gold Coast PHN and Healthcare Improvement Unit
Dr Jon Harper, GP Liaison Officer, Sunshine Coast PHN

Choosing Wisely - Opioid Wisely

Ms Rawa Osman, Clinical Lead, Choosing Wisely

Ms Champika Pattullo, Quality Use of Medicines Pharmacist, Metro North Hospital and Health Service

Making more of less. A review of deprescribing recommendations in medical discharge summaries

Ms Prue Brian, Senior Pharmacist, Geriatric Evaluation and Management Unit, Metro North Hospital and Health Service

Ms Erin Dunn, Advanced Generalist Hospital -Based Pharmacist, Metro North Hospital Health Service

'Our Medicine Woman improves medicine use': pharmacists integrated into regional primary care make a difference

Dr Nicolette Roux, Senior Medical Officer, Wuchopperen Health Service

The pharmacist in the memory clinic

Mr Richard Bolitho, Clinical Pharmacist, Metro North Hospital and Health Service

Ms Erin Dunn, Pharmacist, Metro North Hospital and Health Service

Improving vancomycin usage in a tertiary haematology unit – Statewide Cancer Clinical Network

A/Prof Glen Kennedy, Executive Director, Cancer Care Services, Royal Brisbane and Women's Hospital.



Above: Session 1 'Improving the use of medicines' presenters.



Right: Session 1 best paper presenters Dr Jon Harper, GP Liaison Officer, Sunshine Coast PHN and Dr Carl de Wet, Clinical Lead, Gold Coast PHN (right).

Session 2 – Improving the appropriateness of treatments and care pathways

Facilitator Prof Liz Kenny AO

Session 2 best paper

'Dying with Dignity' - role of renal support care clinics for managing advanced Chronic Kidney Disease (CKD) patients

Dr Sree Venuthurupalli, Consultant Nephrologist, Darling Downs Hospital and Health Service

Ms Chezz Viner-Pallier, Senior Social Worker, Darling Downs Hospital and Health Service

A Systematised, Interdisciplinary Malnutrition Program Implementation and Evaluation (SIMPLE) delivers runs on the board across improved patient reported experience measures and audited malnutrition care

Ms Liza-Jane McBride, Chief Allied Health Officer, Queensland Health

Dr Jack Bell, Advanced Accredited Practicing Dietitian and Research Fellow, The Prince Charles Hospital and University of Queensland

Advance care planning is high-value care

Prof Liz Reymond, Director, Office of Advance Care Planning, Metro South Hospital and Health Service

Ms Xanthe Sansome, Manager, Brisbane South Palliative Care Collaborative

Monitoring testing outcomes and treatment practices in metastatic colorectal cancer

Statewide Cancer Clinical Network

A/Prof Glen Kennedy, Executive Director, Cancer Care Services, Royal Brisbane and Women's Hospital

Endoscopy investigations for suspected gastrointestinal graft versus host disease (GI-GVHD) post allogeneic stem cell transplantation (SCT)

Statewide Cancer Clinical Network

A/Prof Glen Kennedy, Executive Director, Cancer Care Services, Royal Brisbane and Women's Hospital



Above: Session 2 presenters.



Right: Session 2 best paper presenters Dr Sree Venuthurupalli, Consultant Nephrologist and Ms Chezz Viner-Pallier, Senior Social Worker, both from Darling Downs Hospital and Health Service.

Session 3: Improving diagnostic testing

Facilitator Mr Sean Birgan

Session 3 best paper

Choosing Wisely with our consumers and partner organisations

Ms Megan Giles, Principal Advisor, Quality Improvement, Sunshine Coast Hospital and Health Service

Mr Matty Hempstalk, Healthcare Consumer Representative

Low value care and endoscopy in dyspepsia: retrospective observational study from a metropolitan Australian hospital

Dr Myat Myat Khaing, Gastroenterology Registrar, The Prince Charles Hospital

Dr Lei Lin, Gastroenterology Registrar, The Prince Charles Hospital

Review of routine Full Blood Count tests at Gold Coast Health

Ms Aimee Ballantine, Principal Project Officer, Choosing Wisely, Gold Coast Hospital and Health Service

Cessation of routine CXR screening in RBWH Haematology

Statewide Cancer Clinical Network

A/Prof Glen Kennedy, Executive Director, Cancer Care Services, Royal Brisbane and Women's Hospital

Testing Wisely at Wide Bay Hospital and Health Service

Ms Sotera Trevaskis, Project Director, Choosing Wisely, Wide Bay Hospital and Health Service

Dr Sue Page, Director of Medical Services, Wide Bay Hospital and Health Service



Above: Session 3 presenters.

Right: Session 3 best paper presenters Ms Megan Giles Principal Advisor, Quality Improvement, Sunshine Coast Hospital and Health Service and health consumer representative, Mr Matty Hempstalk.



Poster presentations

Best poster

Inguinal hernia imaging amongst GPs in Central Queensland

Dr Clay Renwick, Central Queensland Hospital and Health Service

Feeding patients better: protocolising enteral feeding to provide appropriate and timely nutrition care

Ms Clare Cutmore, Team Leader, Nutrition and Dietetics, Royal Brisbane and Women's Hospital

Prof Merrilyn Banks, Director, Nutrition and Dietetics, Royal Brisbane and Women's Hospital

Converting complex haematology patients treated as ambulatory patients with CADD pumps to relieve bed pressure

Statewide Cancer Clinical Network

Mr Jason Black, Director of Pharmacy, Director of Pharmacy, Cairns Hospital

Mr Kristoffer Johnstone, Advanced Pharmacist, Cancer Care

INSPIRE – Innovative New Strategy for Piperacillin / Tazobactam & Ceftriaxone, Infection Risk and Evaluation

Dr Kathryn Wilks, Infectious Diseases Physician, Antimicrobial Stewardship Director, Sunshine Coast Hospital and Health Service

Ms Patricia Kilfoyle, Antimicrobial Stewardship Pharmacist, Sunshine Coast Hospital and Health Service



Above: Senate Chair Dr Alex Markwell with Dr Clay Renwick who won best poster presentation.

Utilisation of Technology to reduce patient attendances in the tertiary hospital and reduce variation in practice through governance

Ms Aniko Cooper, Co-Clinical Chair, Statewide Cancer Clinical Network

Prof Sabe Sabesan, Clinical Director, Medical Oncology, Townsville Cancer Centre

Reviewing medical oncology clinic activity and models of care to improve the patient experience

Statewide Cancer Clinical Network

Ms Anna Kuchel, Fellow, Medical Oncology, Royal Brisbane and Women's Hospital

Dr Melissa Eastgate, Deputy Director, Medical Oncology, Royal Brisbane and Women's Hospital

Improving specimen collection in the Townsville Hospital Emergency Department

Ms Sharon Lazzaroni, Emergency Department Phlebotomist, Townsville Hospital

Dr Natalie Ly, Deputy Director, Emergency Department, Townsville Hospital

Implementation of an electronic Individual Patient Approval (IPA) system

Mr Will Tumusimme, Drug Use Evaluation Pharmacist, Ipswich Hospital

Mr Cal Winckel, Assistant Director of Pharmacy, Ipswich Hospital

Cost savings through medication substitutions

Mr Will Tumusimme, Drug Use Evaluation Pharmacist, Ipswich Hospital

Mr Cal Winckel, Assistant Director of Pharmacy, Ipswich Hospital

Metro North Robotic Surgery Program

Colleen Jen, Executive Director Health Service Strategy and Planning, Metro North HHS

Ms Kaylee Britain, Robotic Surgery Program Manager, Metro North HHS

Promoting value-based care in emergency departments

Prof Louise Cullen, PROV-ED Team, Metro North HHS

Dr Andrew Hobbins-King, Sunshine Coast Hospital and Health Service

Next steps

The Senate will continue to champion the reduction of low benefit care. This will include keeping members and other interested parties informed of the implementation of endorsed recommendations and provide further input into bodies of work as appropriate.

The Senate encourages its members to actively address low benefit care and discuss programs of work for low benefit care with HHS executive and clinical councils.

Visit the [Clinical Excellence Queensland Improvement Exchange](#) to learn about other relevant work that is happening around the state.

Special thanks to

Minister for Health and Minister for Ambulance Services, the Hon. Steven Miles MP

Director-General, Queensland Health, Dr John Wakefield

Acting Director-General, Queensland Health, Ms Barbara Phillips

Chief Aboriginal and Torres Strait Islander Health Officer and Deputy Director-General,

Aboriginal and Torres Strait Islander Health Division, Haylene Grogan

Clinical Excellence Queensland

Health Consumers Queensland

Organising committee

Dr Alex Markwell, Chair, Queensland Clinical Senate

Dr Erin Evans, Chair, Health Consumers Queensland

Ms Jane Hancock, Chief Executive, Central West Hospital and Health Service

Ms Pattie Hudson, Chief Executive, Central Queensland, Wide Bay, Sunshine Coast Primary Health Network

Mr Luke Humphries, Manager, Healthcare Purchasing and System Performance Division, Department of Health

Prof Liz Kenny, Chair, Queensland Clinical Networks Executive

Ms Jane Partridge, Director, Healthcare Purchasing and System Performance Division, Department of Health

Ms Champika Pattullo, Senior Pharmacist, Clinical Pharmacology, Metro North Hospital and Health Service

Mr Chris Raftery, Deputy Chair, Queensland Clinical Senate

Dr Ivan Rapchuk, Deputy Chair, Queensland Clinical Networks Executive

Prof Ian Scott, Chair, Statewide General Medicine Clinical Network

Ms Jo Smethurst, Senior Engagement Advisor, Health Consumers Queensland

Ms Jessica Toleman, A/Executive Director Women's and Newborn Services Royal Brisbane and Women's Hospital

Appendix 1 - Update on the Choosing Better Care Together Steering Partnership

The Department of Health is committed to support the leadership being shown by the Queensland Clinical Senate and the Statewide Clinical Networks to optimise benefits of care. In response to the recommendations arising from the Senate's meeting in August 2019, \$2.1m has now been allocated to support a program of work to take forward those recommendations in 2019-20. The program, 'Choosing Better Care Together' (CBCT), aims to optimise the appropriateness and effectiveness of clinical care and maximise evidence-based interventions that are aligned with patients' personal treatment goals.

The priorities identified by the Senate include optimising appropriate pathology utilisation, high benefit care at end of life, quality use of medicines and selected Statewide Clinical Network priorities for scale-up. All priorities will be progressed and led by relevant Statewide Clinical Networks and will be underpinned by initiatives identified by the Queensland Clinical Senate as key enablers for sustainable large-scale cultural impact, including a consumer campaign and a behavioural science approach to understanding and addressing influential factors.

Appendix 2: Abstracts selected for oral presentation

Battling the blight of benzos in primary care with big data and small steps

Towards Statewide Opioid Stewardship: The adaptation of the Opioid Prescribing Toolkit in multiple Emergency Departments

Making more of less. A review of deprescribing recommendations in medical discharge summaries

'Our Medicine Woman improves medicine use': pharmacists integrated into regional primary care make a difference

The pharmacist in the memory clinic

Improving vancomycin usage in a tertiary haematology unit – Statewide Cancer Clinical Network

'Dying with Dignity' - role of renal support care clinics for managing advanced Chronic Kidney Disease (CKD) patients

A Systematised, Interdisciplinary Malnutrition Program Implementation and Evaluation (SIMPLE) delivers runs on the board across improved patient reported experience measures and audited malnutrition care

Advance care planning is high-value care

Monitoring testing outcomes and treatment practices in metastatic colorectal cancer

Endoscopy investigations for suspected gastrointestinal graft versus host disease (GI-GVHD) post allogeneic stem cell transplantation (SCT)

Choosing Wisely with our consumers and partner organisations

Low value care and endoscopy in dyspepsia: retrospective observational study from a metropolitan Australian hospital

Review of routine Full Blood Count tests at Gold Coast Health

Cessation of routine CXR screening in RBWH Haematology

Testing Wisely at Wide Bay Hospital and Health Service

ABSTRACT # 1 - Abstract Submission Template – QCS 7-8 November 2019

Title: <i>(complete all details in the white spaces below, do not alter font size or style, do not exceed one page)</i>		
Battling the blight of benzos in primary care with big data and small steps		
Presenters		
	Name	Position
1	Carl de Wet	Clinical Lead, Gold Coast PHN and HIU
2	Jon Harper	Clinical Lead, Sunshine Coast PHN
Contact:	Carl de Wet	carld@gcphn.com.au
Introduction (frame the issue):		
Public healthcare services worldwide, including in Queensland, face unprecedented challenges from an ageing population, increasing multimorbidity and constrained resources. Consequently, initiatives like Choosing Wisely are increasingly important to help improve the efficiency of health care and ensure a high-quality, safe and sustainable service. The Royal Australian College of General Practitioners (RACGP) made 10 recommendations in 2015/16 about tests, treatments and procedures clinicians and consumers should question. However, the prevalence of low-value care associated with the recommendations are unknown, and the recommendations have not been systematically considered or implemented in primary care settings.		
Objective (what problem does the project address?):		
The project addresses three problems: the prevalence of low-value care in general practice has not (yet) reliably been quantified; Choosing Wisely recommendations are not widely implemented; and many patients are inappropriately prescribed benzodiazepines in primary care settings		
Methods (quality improvement measures / changes implemented / impact evaluation / etc.):		
The Gold Coast PHN developed and recently validated Primary Sense™, a data extraction, analysis and management tool for general practice. Primary Sense™ generates simple reports from confidential data with only three clicks about individual patients at a practice level who may benefit from specific interventions. At a regional level, data from practices are aggregated and displayed in real-time as dashboards and maps. A specific report and dashboard were developed to identify those patients who may inappropriately be prescribed benzodiazepines. The reports are used as an essential component of the Continuous Quality Improvement (CQI) projects practices undertake. At the PHN level, the prevalence of potentially inappropriate benzodiazepine prescribing is addressed through educational activities, targeted practice support and commissioning of related services.		
Results (summary of the project's results):		
General practices in the Gold Coast that registered for the Practice Incentive Payment Quality Improvement (PIP QI) initiative that was launched in August 2019 (n=>150) now routinely undertake CQI projects. 33 Practices with a combined patient population of ±250 000 patients are currently using Primary Sense™, with more are added every week from a large wait list. The PHN developed a standardized CQI process, templates, 'recipes' and resources for practices that is widely used and supported by PHN Practice Support Officers and educational events. One of the 'recipes' is for reviewing and reducing inappropriate prescribing of benzodiazepines. There is now preliminary evidence that practice teams are willing, able and ready to plan, undertake and complete CQI projects. The PHN Commissioning Team has access to Primary Sense™ data and it informs strategic planning.		
Challenges:		
Adequate funding to further develop Primary Sense™ reports and dashboards; The capacity and capability of general practice teams to undertake CQI projects; Incorporating real-time data in commissioning local services.		
Lessons learnt:		
Choosing Wisely recommendations can feasibly be implemented as CQI projects; Quick access to accurate data in real time is essential to achieve measurable improvements in primary care; GPs and practice teams are willing, able and ready to undertake CQI projects		
Consumer engagement:		
The PHN Consumer Advisory Group (CAG) provided feedback during every stage of the development and implementation of Primary Sense™		
Impact on patient care (clinician perspective):		
Providing clinicians with a sample of named patients who may benefit from a simple intervention is an acceptable and feasible strategy to increase their participation in CQI. Increased awareness of the Choosing Wisely recommendations provide a strong rationale for addressing the issue of inappropriate benzodiazepine prescribing		
Impact on patient experience (consumer perspective):		
The 'blight of benzos' has been extensively chronicled in the international literature. Efforts to reduce inappropriate benzodiazepine prescribing may therefore help improve patient safety		
Conclusions:		
Low value care can be reduced by implementing Choosing Wisely recommendations in general practice. The exemplar of inappropriate benzodiazepine prescribing identifies three important facilitators: Linking interventions to existing initiatives (PIP QI) and processes (CQI); quick access to accurate, real-time data; and allocating adequate and appropriate resources.		
If not selected for oral presentation, would you be interested in submitting a poster?		Yes: <input type="checkbox"/> No: <input checked="" type="checkbox"/>

Return completed single-page abstract to qldclinicalsenate@health.qld.gov.au by COB Wednesday 9 October 2019

ABSTRACT #2 - Abstract Submission Template – QCS 7-8 November 2019

Title: <i>(complete all details in the white spaces below, do not alter font size or style, do not exceed one page)</i>											
Towards Statewide Opioid Stewardship: The adaptation of the Opioid Prescribing Toolkit in multiple Emergency Departments											
Presenters											
		Name				Position					
1		Champika Pattullo				RBWH QUM Pharmacist; Health Improvement Fellow; Project Lead for Queensland Opioid Stewardship Program (QOSP)					
2		Benita Suckling				Opioid Stewardship Pharmacist, Redcliffe Hospital; QUM Pharmacist RBWH					
Contact:		champika.pattullo@health.qld.gov.au									
Introduction (frame the issue):											
In a landscape of increasing opioid use and harm, consistent messaging about pain management and opioid prescribing for clinicians and patients is vital in the hospital setting.											
Objective (what problem does the project address?):											
The Opioid Prescribing Toolkit (OPT) provides a systematic and scalable approach to the improvement of oxycodone prescribing on discharge from the Emergency Department (ED). Success of this intervention has translated to rollout of a Statewide Program and adaptation to other clinical areas including surgery.											
Methods (quality improvement measures / changes implemented / impact evaluation / etc.):											
Implementation includes a process of supported consultation, facilitation and identification of internal champions. Baseline data is collected from the department's oxycodone (or all opioid) prescriptions. Problem prescribing practices, such as prescription of full-box quantities, inappropriate indications or absence of GP handover of analgesic plan are identified. The OPT minimises the administrative burden of developing protocols, education, posters and leaflets, which are then customised to respond to the needs of the clinical area. A period of re-auditing occurs after approximately 6 months.											
Results (summary of the project's results):											
Significant improvement was demonstrated in the EDs of Metro North Hospital and Health Service – table below.											
		RBWH			Caboolture		TPCH		Redcliffe		
		PRE	POST	2-YEAR POST	PRE	POST	PRE	POST	PRE	POST	
Proportion of prescriptions for 10 or less tablets of oxycodone		32%	85%	71%	80%	89%	53%	92%	64%	88%	
Prescription rate for oxycodone per 1000 ED presentations		38	29	23	16	15	25	21	20	20	
Challenges:											
A consistent challenge is the reliance on the discretionary efforts of front-line clinicians within the project teams at each site to undertake audit and educational activities. This is a significant workload in addition to typically full clinical loads. This challenge however is part of the intervention's strength – that the formal and informal influence of these 'internal champions' drives and sustains change within the department beyond what could be achieved if an external party was present only for the OOPPS cycle.											
Lessons learnt:											
Lessons have included the importance of facilitating change within a department at a time when there is motivation to do so, and in a manner which is completely adaptable to the local setting, clinicians and patients because one size does not fit all.											
Consumer engagement:											
More than 30 consumers have engaged and provided feedback which have been the basis for the development and improvement of consumer educational resources/brochures for pain management. 100% of consumers surveyed found the brochure easy to read and helpful to managing pain themselves at home. Consumer representative groups continue to be consulted regarding further aspects of the project.											
Impact on patient care (clinician perspective):											
Clinicians can be empowered through practicing according to consensus guidelines from among their senior peers, improve their practice through education regarding pain management and opioid use and feedback on local practice, and be reassured they are managing their patients' pain both safely and effectively.											
Impact on patient experience (consumer perspective):											
Through the balanced approach to pain management being promoted by this project, patients in general could expect to have more robust conversations about pain management, be provided with a pain plan and education brochure, and to receive a quantity of opioid medications which is expected to meet their needs (if any is needed) while minimising their risk of long-term use or other opioid-related harm.											
Conclusions:											
The OPT has proven to be an adaptable and effective concept across multiple Emergency Departments. This has implications of an upstream culture change in pain and opioid management which demonstrably impacts individual consumers downstream in care they receive. The OPT has provided a platform to springboard further Opioid Stewardship activities across the state.											
If not selected for oral presentation, would you be interested in submitting a poster?								Yes: <input checked="" type="checkbox"/>		No: <input type="checkbox"/>	

ABSTRACT #3 - Abstract Submission Template – QCS 7-8 November 2019

Title: <i>(complete all details in the white spaces below, do not alter font size or style, do not exceed one page)</i>		
Making more of less. A review of deprescribing recommendations in medical discharge summaries		
Presenters		
	Name	Position
1	Prue Brian	Pharmacist
2	Erin Dunn	Pharmacist
Contact:	Prue Brian, Pharmacy Department, The Prince Charles Hospital, Rode Road Chermside Q 4032	ph: 31395904 email: prue.brian@health.qld.gov.au
Introduction (frame the issue):		
Inappropriate prescribing in older adults increases hospitalisation and wastes primary care resources. A gap analysis at a tertiary referral hospital identified clinical handover between hospital and primary care as an opportunity for communicating deprescribing recommendations.		
Objective (what problem does the project address?):		
The project aims to identify: <ul style="list-style-type: none"> • What proportion of patients discharged from general medicine on Potentially Inappropriate Medicines (PIMs) have a corresponding deprescribing recommendation documented in their discharge summary? • What proportion of PIMs have a corresponding recommendation? • What medicine classes commonly result in a recommendation to deprescribe? 		
Methods (quality improvement measures / changes implemented / impact evaluation / etc.):		
A retrospective audit of discharge summaries was conducted for patients aged over 75, discharged from medical wards on PIMs between September – November 2017. PIMs were identified by a team of pharmacists using the Screening Tool of Older People’s Prescriptions (STOPP).		
Results (summary of the project’s results):		
A total of 215 PIMS were identified amongst 98 patients. Eleven patients (11.2%) had a deprescribing recommendation (12 of 215 PIMs; 5.6%). Antipsychotics yielded five recommendations; corticosteroids yielded three. Proton pump inhibitors were the most commonly prescribed PIM (18.1% of patients). Others commonly prescribed included antihypertensives (8.4%), antiplatelets (6%) and diuretics (5.1%). No deprescribing recommendations were made for these medication classes.		
Challenges:		
The challenge moving forward is to encourage clinicians to think about deprescribing opportunities for all older adults admitted to hospital.		
Lessons learnt:		
There should be triggers during the inpatient care episode to prompt clinicians to pursue deprescribing opportunities in older adults, with subsequent robust documentation strategies for clinical handover to primary care.		
Consumer engagement:		
Consumers have indicated via extensive local consultation (surveys and focus groups) that polypharmacy is a major concern to them.		
Impact on patient care (clinician perspective):		
Acute care clinicians have an opportunity to minimise medication misadventure for older adults by proactively identifying deprescribing opportunities and communicating them with primary care.		
Impact on patient experience (consumer perspective):		
Polypharmacy correlates with medication harm hence patients will be less likely to suffer adverse effects if deprescribing is proactively pursued.		
Conclusions:		
Acute hospital admissions represent a unique opportunity for multidisciplinary teams to influence deprescribing outcomes for patients. Hospital clinicians should maximise this opportunity by communicating medication management plans across care continuums via quality clinical handover. This study highlights gaps that need addressing to minimise unnecessary polypharmacy for vulnerable older adults.		
If not selected for oral presentation, would you be interested in submitting a poster?		Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/>

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ABSTRACT #4 - Abstract Submission Template – QCS 7-8 November 2019

Title: <i>(complete all details in the white spaces below, do not alter font size or style, do not exceed one page)</i>		
“Our Medicine Woman improves medicine use”: pharmacists integrated into regional primary care make a difference		
Presenters		
	Name	Position
1	Jacki Mein	Director of Medical Services
2	Nicolette Roux	Senior Medical Officer
Contact:	Jacki Mein	
Introduction (frame the issue):		
Wuchopperen Health Service Ltd is a large Aboriginal Medical Service based in Cairns, and is one of two member services who attend the QH Clinical Senate on behalf of the Queensland Aboriginal and Islander Health Council. After the clinical senate in August 2019, Wuchopperen formally reviewed its priorities for low value care. Wuchopperen has worked in close collaboration with two local pharmacists for the last two years to improve services for patients. This work not only directly addresses the current senate priorities for improving medicine use, but has streamlined care pathways, and improved the quality of patient care in some unexpected ways.		
Objective (what problem does the project address?):		
To assess the impact of integrated pharmacist services at Wuchopperen Health Service Ltd, on improving medicine use in regional Aboriginal Medical Service primary care.		
Methods (quality improvement measures / changes implemented / impact evaluation / etc.):		
Qualitative semi-structured staff clinician, pharmacist and patient interview, review of Wuchopperen electronic medical records.		
Results (summary of the project’s results):		
<p>The number of completed Home Medicines Reviews has trebled over the last two years.</p> <p>Medical record audits have shown more patient education, and more prescribing of appropriate medications (eg hypertension and dyslipidaemia medication) in 2019 compared with 2017</p> <p>Streamlined and reviewed pharmacist input and clinical feedback processes and documentation which has now been shared with other services</p> <p>Well attended regular pharmacist upskilling of clinicians, as it was driven by pharmacists asking different professional groups eg health workers what they want information on</p> <p>Webster pack processes improved for patients</p> <p>Health service medicine ordering, storage, and use improved</p> <p>Excellent pathways of communication are now established with community and hospital pharmacies</p>		
Challenges:		
Integration within the service, pharmacist record access		
Lessons learnt:		
Wearing Wuchopperen uniform and using service branded cars improved staff and patient acceptance. Pharmacist access to patient records improved documentation, communication, speed of feedback and efficiency of service		
Consumer engagement:		
Pharmacists provided regular information sessions on local radio, stalls on NAIDOC days, talks at health and community groups. Local pharmacies now regularly hold stalls at health service information days		
Impact on patient care (clinician perspective):		
Better patient and staff understanding of medication, proactive improvements in service medication processes and policies, far better links with community and hospital pharmacists, resulting in much better continuity of care		
Impact on patient experience (consumer perspective):		
Almost universal strongly positive responses to HMR process and informal pharmacist contact. Pharmacist regularly invited to Wuchopperen diabetes self care group meetings, she is called “the Medicine Woman” and is the preferred allied health presenter for her clear explanations		
Conclusions:		
Pharmacist integration into our service has resulted in significant short term improvements in patient and staff knowledge, better connections to community and hospital pharmacies, and quality use of medicines.		
If not selected for oral presentation, would you be interested in submitting a poster?		Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/>

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ABSTRACT #5 - Abstract Submission Template – QCS 7-8 November 2019

Title: <i>(complete all details in the white spaces below, do not alter font size or style, do not exceed one page)</i>		
The pharmacist in the memory clinic		
Presenters		
	Name	Position
1	Richard Bolitho	Clinical Pharmacist, The Prince Charles Hospital
2	Erin Dunn	Assistant Director of Pharmacy, The Prince Charles Hospital
Contact:	Richard Bolitho, Richard.bolitho@health.qld.gov.au 0436 629 904	
Introduction (frame the issue):		
A recent study in Australia concluded that older adults with dementia were more than three times likely to be admitted to hospital for medication misadventure than those without dementia. Potentially inappropriate medication use related to cognition, clinically significant anticholinergic burden, and concurrent use of anticholinergics with cholinesterase, inhibitors negating the effect of the medications we use in dementia, have been shown to be prevalent in Australian patients being investigated for cognitive impairment or dementia. Cognitive impairment is clearly a risk factor for medication misadventures		
Objective (what problem does the project address?):		
A pharmacist was recently added to the Memory Clinic at The Prince Charles to perform medication reconciliation, identify potential medication related problems and importantly educate patients in conjunction with their carers attending clinic about medications with the aim of reducing medication misadventure in this vulnerable cohort.		
Methods (quality improvement measures / changes implemented / impact evaluation / etc.):		
The study was a single group, unblinded, experimental before and after design. The population consisted of newly referred persons who attended The Prince Charles Hospital Memory Clinic. Persons were excluded if they did not have cognitive impairment or possible dementia. Medications were recorded at baseline along with pharmacist identified medication related problems (MRPs). Study participants were followed up to see the uptake of MRPs and impact on Drug Burden Index (DBI). DBI is a tool that measures a person's exposure to medications with sedative and anticholinergic properties, increasing DBI has been associated with poorer physical function, frailty, and falls		
Results (summary of the project's results):		
50 people were reviewed by the pharmacist. 32 people were given a diagnosis of cognitive impairment or possible dementia. The mean age of the cohort was 81±8.5 years There was an average of 2.03 MRPs per person. The memory clinic prescriber agreed with 71% of MRPs. 30 participants were followed up, two thirds of MRPs had been actioned by the patient's primary care provider. Median number of medications prescribed decreased from 7 (IQR 5-12) to 6.5 (IQR 3.5-11) p 0.03 and mean DBI per person decreased from 0.48 to 0.36		
Challenges:		
Integration of another health practitioner into what was already a busy clinic was difficult. Initially patient flow through the clinic was impaired. People can be reluctant to changes in processes		
Lessons learnt:		
Engagement with various stakeholders at the beginning was essential. If you can demonstrate that you can make a difference early on both quantitatively and qualitatively it goes a long way to building trust of the other team members		
Consumer engagement:		
Qualitative feedback from clinicians was high and valued the contribution the pharmacist made to patient care in patients attending the memory clinic. Anecdotal feedback from patients has been good		
Impact on patient care (clinician perspective):		
Pharmacist review results in a reduction in medication related problems, highlights to prescribers opportunities for deprescribing, and possibly decreases functional impairment based on DBI reduction		
Impact on patient experience (consumer perspective):		
People are greater educated about their medications, decreased pill burden, decreased medication complexity, and are more empowered to ask questions of health care providers about their medications		
Conclusions:		
People with cognitive impairment or dementia have a high burden of medication related problems and are likely to benefit from pharmacist review of medications. Pharmacist intervention in a memory clinic identifies medications for deprescribing reducing polypharmacy and shows a trend to reducing DBI, possibly decreasing risk of functional impairment for people with cognitive impairment or dementia		
If not selected for oral presentation, would you be interested in submitting a poster?		Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/>

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Abstract #6 - Abstract Submission Template – QCS 7-8 November 2019

Title: Improving vancomycin usage in a tertiary haematology unit		
Presenters		
	Name	Position
1	A/Prof Glen Kennedy	Ed, CCS, RBWH
2	Paul Klages	Pharmacist, CCS, RBWH
Contact:	glen.kennedy@health.qld.gov.au	
<p>Introduction: Anti-microbial stewardship is a critical component to ensuring safe and appropriate antibiotic prescribing in health care. Application of antibiotic stewardship in sub-specialty areas can be challenging, with cohorts of chronically morbid, immune-suppressed patients with high frequency of colonization of multi-resistant organisms frequently complicating individual clinician antibiotic choice. To address these issues, in 2007, the RBWH Haematology unit, in collaboration with RBWH Infectious Diseases, developed local guidelines for management of febrile neutropenia and antibiotic use within the RBWH Department of Haematology and Bone Marrow Transplantation. These guidelines have continued to be revised on routine 4 yearly schedule, to allow updating of new practice and / or management of any emerging microbial-resistance patterns within the unit. In 2015, recognition of an increasing incidence of patients colonized with vancomycin-resistant enterococci (VRE) led to an opportunity consider limitation of prolonged vancomycin exposure in patients without MRSA or non-Staphylococcal aureus infection. Revision of unit febrile neutropenia guidelines to reflect suggested changes to vancomycin prescribing were implemented in November 2015. The guidelines are currently undergoing further scheduled routine review.</p>		
<p>Objective: To limit prolonged vancomycin exposure in patients haematology / bone marrow transplant patients without MRSA or non-Staphylococcal aureus infection</p>		
<p>Methods: Collaborative approach between haematologists and infectious disease physicians to develop practical antibiotic guidelines to limit prolonged vancomycin exposure without limiting access to vancomycin in high-risk immune-suppressed patient populations. This was achieved by a series of meetings between relevant haematology, pharmacy and infectious diseases clinician stakeholders, underpinned by local data including local microbial culture results and antibiotic usage. The new guidelines allowed commencement of vancomycin as per historic indications (known MRSA colonization; clinical skin or central line infection), but recommended cessation of vancomycin after 48-72hrs in the absence of positive culture for MRSA or a non-Staphylococcal aureus pathogen.</p>		
<p>Results: Total vancomycin usage (as 1gm equivalents) were calculated over the 16mths prior to implementation of the new guidelines, and for 38mths post-implementation (up until December 2018). Median vancomycin usage pre-implementation was 253 (1gm) vials per month (range 172.5-475), falling to 182 (1gm) vials per month (range 59-321) post-implementation (p=0.0005). This 28% reduction in vancomycin usage occurred despite a 17% increase in patient separations in the unit over the same time period, from a median of 52 separations per month pre-implementation (range 32-65) to 61 separations per month post implementation respectively (range 41-86; p=0.0005).</p>		
<p>Challenges: The new guidelines took time to develop and implement, with stakeholder meetings, agreement and re-writing of guidelines, and education of staff taking 6 months to be completed.</p>		
<p>Lessons learnt: Information and education of staff around changes to historical practice requires repetition for sustainable change. Acceptance of change was aided significantly by the collaborative process undertaken to develop the new antibiotic guidelines.</p>		
<p>Consumer engagement: Consumers were not directly asked about the change in practice.</p>		
<p>Impact on patient care: Patients received less unnecessary antibiotics, with resultant lower risk of antibiotic reactions and / or side effects, and potential lower risk of selection of multi-resistant bacterial colonization.</p>		
<p>Impact on patient experience: Less time required connected to intravenous infusions (vancomycin is typically administered as a 2 hourly infusion twice per day).</p>		
<p>Conclusions: Successful implementation based upon collaborative process to define proposed change.</p>		
If not selected for oral presentation, would you be interested in submitting a poster?		Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/>

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ABSTRACT #7 - Abstract Submission Template – QCS 7-8 November 2019

Title: <i>(complete all details in the white spaces below, do not alter font size or style, do not exceed one page)</i>		
“Dying with Dignity” role of renal support care clinics for managing advanced Chronic Kidney Disease (CKD) patients		
Presenters		
	Name	Position
1	Sree Venuthurupalli	Consultant Nephrologist
2	Annette Hodgkinson	Social worker
Contact:	Sree Venuthurupalli	Sree.venuthurupalli@health.qld.gov.au
Introduction (frame the issue):		
Patients with CKD during the last year of their life spend most of their time in and around hospitals to access services. Poor communication, lack of understanding of their condition and multiple comorbid conditions lead to prolonged hospitalisation. This in turn lead to despair, distress, disability and displacement for the patient as well as for the family. This is also associated with highest health dollars spent per patient by health providers. The one component missing in this conversation was dignity: to understand, discuss, choose and decide for their own healthcare into future.		
Objective (what problem does the project address?):		
This project was started to address the major component missing in their care. Instead of patients revolving around loops, the clinic is structured to provide holistic patient centred care by a multidisciplinary team.		
Methods (quality improvement measures / changes implemented / impact evaluation / etc.):		
The team consists of a nephrologist, CKD CN, social worker, dietitian, pharmacist and other allied health practitioners as needed. Patients with advanced CKD who either do not want dialysis or can not perform dialysis due to medical reasons were referred to these clinics. Patients and their carer/family are seen in a congenial atmosphere. These consultations are structured to provide holistic care-physical, emotional, psychological and spiritual needs. With each of them advanced care planning is discussed, and appropriate referrals are initiated. End of life essentials are addressed including place of death as chosen by patient and family. Communication is sent to their GP as well as their primary renal physician. They are reviewed in clinic on follow up. Each visit includes structured forms to assess clinical and mental status - renal palliative care outcome scale (POS) form, carer strain index form and Hydroxyapatite Crystal Deposition Disease (HADD) form.		
Results (summary of the project's results):		
This program started in March 2018 and so far 17 patients were seen in this clinic. 12 patients had their advanced care planning initiated or completed. A total of 10 admissions for 5 patients for medical reasons but reduced length of stay as in-patients. Decreased out-patient visits due to multi-disciplinary nature of clinics. 4 patients died at a place of their choice but not in Toowoomba Hospital.		
Challenges:		
Biggest challenge is a shift in culture - from hospital-centred care to patient-centred care, leading to slow uptake/referral to clinics. Determination of appropriate time of referral - not too late and not too early.		
Lessons learnt:		
Targeted education explain the purpose and values of these clinics is needed. Extend similar concept to other specialities as most patients are under shared care.		
Consumer engagement:		
Patients and families are contacted on a regular basis including feedback during and post bereavement of their loved ones.		
Impact on patient care (clinician perspective):		
Value -based care - avoidance of unnecessary procedures and treatments, reduction on polypharmacy, better symptom management, reduced out-patient visits, reduced length of stay as in-patients, and coordinated care.		
Impact on patient experience (consumer perspective):		
Family, carers and patients are on the on same alignment with regards to care and death. Restoration of dignity in care, experience of being valued and peaceful death based on choice.		
Conclusions:		
These clinics are highly effective to improve patient related outcomes and patient related experiences. This type of care should be come business as usual across all specialities.		
If not selected for oral presentation, would you be interested in submitting a poster?		Yes: <input type="checkbox"/> No: <input checked="" type="checkbox"/>

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ABSTRACT #8 - Abstract Submission Template – QCS 7-8 November 2019

Title: <i>(complete all details in the white spaces below, do not alter font size or style, do not exceed one page)</i>		
A Systematised, Interdisciplinary Malnutrition Program Implementation and Evaluation (SIMPLE) delivers runs on the board across improved patient reported experience measures and audited malnutrition care		
Presenters		
	Name	Position
1	Liza-Jane McBride	Chief Allied Health Officer, Queensland Health
2	Dr Jack Bell	AdvAPD & Research Fellow, TPCB & UQ
Contact:	Jack.Bell@health.qld.gov.au +61 7 3139 6172	
Introduction (frame the issue):		
Traditional nutrition care in hospitals for patients with, or at risk of malnutrition has relied on highly individualised, dietitian delivered care. However, unmet service demands, increased acuity of hospital inpatients, reduced inpatient lengths of stay, increases in positive nutrition screens observed post iEMR implementation, and the failure of existing models to deliver timely inpatient nutrition care to those at risk necessitated a paradigm shift in how to manage the wicked problem of malnutrition in hospitals. This issue was specifically highlighted in the 2016 Clinical Senate meeting as one of 3 potential low value allied health activities for consideration.		
Objective (what problem does the project address?):		
This program consequently aimed to identify whether shifting from a highly individualised, dietitian focussed malnutrition model of care to a new Systematised, Interdisciplinary Malnutrition Program for implementation and Evaluation (SIMPLE) influenced patient, staff, and healthcare outcomes and experiences, without increasing resources, by applying a 'disinvest to reinvest' approach.		
Methods (quality improvement measures / changes implemented / impact evaluation / etc.):		
A 2-year, multiphase pragmatic action research program adhering to the Revised Standards for Quality Improvement Reporting Excellence. A separate-sample before-and-after design evaluated the impact of SIMPLE implementation in selected wards across 6 Queensland public hospitals of varying size and location. Malnutrition risk was defined as a malnutrition screening tool score of ≥ 2 , BMI < 18.5 or dietitian referral for malnutrition assessment. Interventions were tailored to fit individual sites using a facilitated implementation science approach. Robust mixed methods process and outcomes evaluation applied the Medical Research Council framework for evaluating complex healthcare interventions. The primary outcomes measures compared pre- and post-implementation audited and patient reported nutrition care experience measures (PREMS).		
Results (summary of the project's results):		
Preliminary data is reported for 1036 patients. Combined demographic data demonstrated an older patient group (median 72 years), slight gender bias (male 52.9%), and malnutrition risk of 44.6%. There was no significant difference between groups for age ($p=0.88$), gender ($p=0.42$), or malnutrition risk ($p=0.16$) between pre- and post-intervention groups. For patients identified at risk of malnutrition, combined audit and PREMS data demonstrated that implementation of SIMPLE across test sites resulted in significantly improved inpatient food and nutrient delivery (69.9 versus 83.8%; $p=0.001$) and coordination of care (44.2 versus 55.3%; $p=0.03$) processes. Documented or patient reported malnutrition education increased post-intervention; whilst considered clinically relevant, this failed to reach statistical significance (42.6 versus 51.0%; $p=0.10$). A non-significant reduction in mean dietitian occasions of service was observed post intervention following implementation (0.68 v 0.59) and no additional clinical funding was provided. Scale and spread activities across diverse Queensland hospitals will highlight specific examples of how SIMPLE can improve staff workforce experience, deliver unfunded service expansion and enable reinvestment into alternative higher value, 'full scope' activity.		
Challenges:		
Disinvesting in low value healthcare is challenging in complex organisations with activity-based metrics. However, once innovators and early adopters demonstrate disinvest to reinvest approaches that improve overall patient and healthcare outcomes and workforce experience, it is easier for the majority to rise to the challenge.		
Lessons learnt:		
Applying robust implementation science approaches allowed engagement of diverse stakeholders to use audit and PREMS data to build a case for change, locally tailor innovative solutions to context, and iterative improvement to deliver sustainability and spread. Complex changes should only be implemented where local data demonstrates a need to change, stakeholders are ready for facilitated change and demonstrate reflexivity.		
Consumer engagement:		
This program applied a consumer co-design approach with a representative from Health Consumers Queensland on the implementation steering committee. Four of the six core outcomes metrics now implemented across > 15 Queensland Hospitals are Patient Reported Experience Measures (PREMS).		
Impact on patient care (clinician perspective):		
Patient reported experience measures and audited measures show improved nutrition care. Ongoing work will report the impact on unplanned readmissions, hospital acquired complications, mortality, and cost effectiveness.		
Impact on patient experience (consumer perspective):		
Embedding PREMS into routine clinical practice engages patients in measuring and improving healthcare.		
Conclusions:		
SIMPLE implementation provides a values-based solution that improves care provided to malnourished inpatients through a disinvest to reinvest approach. This also enables reinvestment into high value alternatives.		
If not selected for oral presentation, would you be interested in submitting a poster?		Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/>

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Abstract #9 - Abstract Submission Template – QCS 7-8 November 2019

Title: <i>(complete all details in the white spaces below, do not alter font size or style, do not exceed one page)</i>		
Advance care planning is high-value care		
Presenters		
	Name	Position
1	Liz Reymond	Director Office of Advance Care Planning
2	Xanthe Sansome	Manager Brisbane South Palliative care Collaborative
Contact:	Xanthe Sansome (Xanthe.sansome@health.qld.gov.au)	
Introduction (frame the issue):		
<p>In end-of-life care unwanted outcomes, from futile and often expensive treatments, result from a lack of shared understanding and documentation of the personal choices and wishes of the person. Regardless, advance care planning activity remains low across Australia.</p> <p>To promote advance care planning, Queensland Health has developed a values-based advance care planning document, known as the Statement of Choices. It is the first state to develop a standardised Queensland-wide system of advance care planning that encourages people to document their end-of-life choices, to have those documents clinically reviewed and uploaded to the Queensland Health Viewer so that they are clinically available when needed. This system is in its infancy and requires on-going development in terms of infrastructure, implementation and impact evaluation.</p>		
Objective (what problem does the project address?):		
To examine concordance between decedents' preferences [as documented using the Statement of Choices(SoC)] and actual end-of-life care received.		
Methods (quality improvement measures / changes implemented / impact evaluation / etc.):		
A retrospective audit investigated 600 consecutive decedents across 5 Hospital and Health Services (HHS) including Gold Coast HHS, Metro North HHS, Metro South HHS, Sunshine Coast HHS and West Morton HHS. Data regarding care was gathered from SoCs, hospital utilisation and discharge summaries via The Viewer, paper charts, and/or electronic patient files and the Queensland Health Statistics Branch.		
Results (summary of the project's results):		
Completion of a SoC generates high concordance (between 79 and 100%, across 3 measures) between end-of-life care preferences and actual care received. In accordance with their wishes decedents were significantly more likely to die out of hospital, spend significantly less days in hospital in their last 6 months of life and were less likely to be admitted to ICU, in their terminal admission, compared to those who had not completed an SoC. Findings showed that the earlier in a person's illness trajectory that a SoC was completed, the less time they spent in hospital. In clinical reality, completion of a SoC translates to more people being cared for in their place of choice, avoiding potentially non-beneficial care and less unwanted transfers to acute care facilities.		
Challenges:		
Acceptance of advance care planning by the public and Implementation of advance care planning into clinical business as usual requires a culture change that is time and clinical skills dependent.		
Lessons learnt:		
To embed advance care planning into best-practice, dedicated advance care planning facilitators and system support are required.		
Consumer engagement:		
3 focus groups of consumers helped to develop and refine the SoC		
Impact on patient care (clinician perspective):		
Advance care planning supports the right end-of-life care, at the right time and in the right place. It supports released capacity of acute-care beds.		
Impact on patient experience (consumer perspective):		
Consumers report high levels of satisfaction with the Queensland Health advance care planning facilitators who invited them to consider advance care planning.		
Conclusions:		
Queensland Health has the capacity to embed a standardised Queensland wide system of advance care planning that is acceptable to consumers and that improves both patient care and system outcomes.		
If not selected for oral presentation, would you be interested in submitting a poster?		Yes: <input type="checkbox"/> No: <input checked="" type="checkbox"/>

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Abstract #10 - Abstract Submission Template – QCS 7-8 November 2019

Title: <i>(complete all details in the white spaces below, do not alter font size or style, do not exceed one page)</i>		
Monitoring testing outcomes and treatment practices in metastatic colorectal cancer.		
Presenters		
	Name	Position
1	Melissa Eastgate	Deputy Director, Medical Oncology
2	David WYld	Director, Medical Oncology
Contact:	Glen Kennedy	
Introduction (frame the issue):		
Patients with metastatic colorectal cancer routinely have tests performed on their tumour samples to determine whether they would benefit from treatment with EGFR inhibitor treatments in conjunction with standard chemotherapy. Patients who have an identified RAS mutation in their tumour do not benefit from this treatment and as such should not be offered ineffective treatment that has significant cost and toxicity.		
Objective (what problem does the project address?):		
We want to ensure that patients receive the most effective treatment for them and do not receive futile treatment that unnecessarily exposes patients to potential side effects as well as costing the health care system. The project reviewed the type of testing performed over time and the test results to ensure that our testing protocols were best practice and providing the best evidence to guide patients treatment.		
Methods (quality improvement measures / changes implemented / impact evaluation / etc.):		
Oncologists from RBWH have developed a database of patients with colorectal cancer. Patients with colorectal cancer from RBWH, TPCH and Rockhampton Hospitals have their clinical and pathological data prospectively collected. A retrospective analysis was performed to review the rate of testing for RAS mutations, methodology used and results.		
Results (summary of the project's results):		
84% of patients had RAS testing performed on their tumours. This rate has increased over time. Between 2014 and 2019 the methodology of the test changed from no patients being tested using next-generation sequencing in 2014, to 100% in 2019. NGS is more accurate than other methods, this was evidenced by the increase in RAS mutations found by NGS. Fewer patients were eligible for EGFR inhibitor treatments, from roughly 70% being eligible in 2011, to around 30% in 2018. These treatments cost around \$2500 per fortnight and are usually given fortnightly for months depending on the patient's progress.		
Challenges:		
In order to have as complete data as possible, thus giving an accurate representation of our whole patient cohort, staff had to source pathology results from a number of pathology providers outside of Qld Health.		
Lessons learnt:		
It is important to audit our practice to ensure that we are maintaining best practice and improving outcomes for our patients, including choosing the most appropriate therapy for them.		
Consumer engagement:		
Consumers were not directly asked about the change in practice.		
Impact on patient care (clinician perspective):		
Clinicians are able to make appropriate treatment decisions with confidence for individual patients based on access to NGS testing of tumour samples.		
Impact on patient experience (consumer perspective):		
Patients are not offered treatment that will be of no benefit to them and may potentially cause significant side effects.		
Conclusions:		
This audit has demonstrated improvement in practice over time, confirming that the majority of our patients with metastatic colorectal cancer are undergoing appropriate testing. This has resulted in more targeted patient treatment decisions over time due to improvements in the testing of tumour samples.		
If not selected for oral presentation, would you be interested in submitting a poster?		Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/>

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Abstract #11 - Abstract Submission Template – QCS 7-8 November 2019

Title: Endoscopy investigations for suspected gastrointestinal graft versus host disease (GI-GVHD) post allogeneic stem cell transplantation (SCT)		
Presenters		
	Name	Position
1	Dr Ashleigh Scott	SMO, RBWH Department of Haematology
2	A/Prof Glen Kennedy	ED, CCS, RBWH
Contact:	glen.kennedy@health.qld.gov.au	
Introduction: The accepted “standard” for investigation of suspected gastro-intestinal graft versus host disease (GI-GVHD) post allogeneic stem cell transplantation (SCT) is performance of both upper and lower endoscopic investigation of the gut. However, the utility of performing both upper and lower endoscopies in all patients with suspect GI-GVHD is unproven, with generally much lower diagnostic sensitivity of upper endoscopies reported. Furthermore, data as to the optimal lower endoscopic procedure (sigmoidoscopy versus colonoscopy) to perform is also controversial. At RBWH, patients have historically had both upper (gastroscopy or gastro-duodenoscopy) and lower (sigmoidoscopy or colonoscopy) endoscopic procedures performed for investigation of suspected GI-GVHD, irrespective of their presenting symptoms or signs.		
Objective: We aimed to retrospectively assess all patients treated in our institution who underwent endoscopic investigation for suspected acute GI-GVHD post-SCT to evaluate the performance of this diagnostic strategy		
Methods: A retrospective review of all patients who underwent endoscopic investigation for suspected acute GI-GVHD post-SCT performed between 2011 and 2016 was undertaken. Clinical, endoscopic and histological findings (of endoscopic biopsies performed) were then analysed. “Upper” GI symptoms of GI-GVHD were defined as nausea, vomiting and / or anorexia, and “lower” GI symptoms of GI-GVHD as diarrhoea, abdominal pain and / or cramps, ileus, perforation or fresh GI-bleeding.		
Results: Of a total 551 transplants performed over the period under review, 123 patients (22%) undertook endoscopic investigation for suspected GI-GVHD. In total, 62 patients (50%) had both upper and lower GI symptoms, 44 (36%) lower GI symptoms alone, and 17 (14%) only upper GI symptoms. A diagnosis of GVHD was made in 76 patients overall (62%), with diagnoses in the remaining 47 patients including CMV disease, <i>C. difficile</i> colitis, and drug-related GI-toxicity. When diagnosed, GVHD most commonly involved the sigmoid colon (48% of cases) and rectum (45%). In patients who undertook colonoscopy, in all cases GVHD involved both the proximal and distal colon. Isolated upper GI-GVHD was uncommon, occurring in only 4% of cases, and only in patients with upper-GI symptoms alone. These findings suggested that our historic diagnostic strategy for investigation of suspected GI-GVHD could be safely altered, with performance of sigmoidoscopy alone for patients with either combined upper and lower or only lower-GI symptoms, and gastroscopy alone for patients with only upper GI-symptoms. Based on these findings (published in <i>BBMT</i> 2018; 24: 1294), the unit investigation pathway for suspected GI-GVHD was subsequently altered in February 2019.		
Challenges: Changing the historic “standard” for investigation of suspected GI-GVHD took time to reverse, with education of transplant haematologist staff required to be repeated several times over a 4month period. Established clinical pathways and procedures for investigation of GI-GVHD also required re-writing.		
Lessons learnt: Information and education of staff around changes to historical process requires repetition for sustainable change. Acceptance of change was aided significantly by available clinical (published) data confirming the safety of the proposed change.		
Consumer engagement: Consumers were not directly asked about the change in practice		
Impact on patient care: The change in diagnostic strategy has meant more rapid access to endoscopic investigations (no longer a requirement for combined upper and lower endoscopy slots, and no immediate requirement for colonoscopy) for patients with suspected GI-GVHD. This has allowed more rapid diagnosis of GI-GVHD, with more rapid communication to patients as to their diagnosis and prognosis.		
Impact on patient experience: Patients now undertake fewer invasive procedures for investigation of suspected GI-GVHD (only x1 rather than x2 endoscopies), and no longer require full bowel prep for their GI-GVHD investigations (now undertaking sigmoidoscopy rather than colonoscopy as standard 1 st line investigation).		
Conclusions: Successful implementation based upon local clinical data supporting change.		
If not selected for oral presentation, would you be interested in submitting a poster?		Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/>

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ABSTRACT #12 - Abstract Submission Template – QCS 7-8 November 2019

Title: <i>(complete all details in the white spaces below, do not alter font size or style, do not exceed one page)</i>		
Choosing wisely <i>with</i> our consumers and partner organisations		
Presenters		
	Name	Position
1	Dr Morne Terblanche	Medical Lead, Safety Quality & Innovation
2	Megan Giles	Principal Advisor – Quality Improvement
3	TBC	Consumer Representative
Contact:	Megan Giles, Principal Advisor – Quality Improvement	
Introduction (frame the issue):		
The success of Choosing Wisely relies upon active engagement of health consumers as well as health providers across the care continuum, so Sunshine Coast Hospital and Health Service (SCHHS) has built in these considerations into our governance processes.		
Working hand in hand with our local PHN and other partners and having not just one consumer representative on our committee but five, has broadened discussion, heightened staff awareness of the issues and also enacted real change in the ways we have approached the planning and implementing of our projects.		
Objective (what problem does the project address?):		
To work collaboratively with our consumers and partners to reduce treatment with limited evidence of overall benefit to consumer outcomes and experience.		
Methods (quality improvement measures / changes implemented / impact evaluation / etc.:		
<ul style="list-style-type: none"> • Establishment of a Choosing Wisely Faculty (steering committee) in January 2019 comprising consumers, clinicians, the primary health network, clinical schools, support functions and an executive sponsor. • Adoption of a quality improvement approach to drive engagement and reduce tests, treatments and procedures of limited value • A phased communication strategy focusing firstly on awareness raising amongst clinicians followed by a strong community-focused campaign 		
Results (summary of the project's results):		
<u>Qualitative results:</u>		
<ul style="list-style-type: none"> • Tailoring of the Choosing Wisely Australia questions to ensure relevance and meaning to our consumers • Incorporation of Choosing Wisely resources into Health Pathways for GP access • Engagement with additional partners including the Junior Doctor Society, volunteers, and library services • Enabling and focusing improvement projects amongst clinical teams 		
<u>Quantitative results:</u>		
<ul style="list-style-type: none"> • 36.1% of respondents to the 2018 baseline Consumer Survey strongly agreed that they feel confident to ask questions about tests being recommended for them. 2019 survey results are due to be reported in November • Clinician awareness of the Choosing Wisely principles and recommendations increased from 29.1% in 2018 to 55.5% in 2019. This is above the 2019 target of 40%. • 65.4% of 2019 junior medical officer respondents indicated they are aware of the recommendations and principles, and that the primary source of that information was the local health service. 		
Challenges:		
<ul style="list-style-type: none"> • Funding and resources available to support the Choosing Wisely initiative is limited. The committee continues to explore options to enhance this. 		
Lessons learnt:		
<ul style="list-style-type: none"> • Our consumers highlight the importance of getting the messaging right, inform our marketing material development, and identify areas for focus. • It is important to invite engaged clinicians who believed they could influence change, rather than force disinterested staff to participate. 		
Consumer engagement:		
<ul style="list-style-type: none"> • 5 consumers participated from the initial Faculty Kick-Off meeting ensuring a truly co-designed approach • The five consumers also elected to participate in the Shared Decision Making in the Emergency Department co-design sub-project • Our consumers contribute to the voice of the program via presentations at the local and state level 		
Impact on patient care (clinician perspective):		
<ul style="list-style-type: none"> • This is measured within specific Choosing Wisely projects for the specific target cohorts. 		
Impact on patient experience (consumer perspective):		
<ul style="list-style-type: none"> • It is anticipated that 2019 survey results will demonstrate an increase in consumer confidence to ask questions about treatment recommended for them • The Faculty has been described as the “passion committee” by one consumer representative 		
Conclusions:		
Our consumers are a vital part of our Choosing Wisely team and their perspectives challenge our thinking as clinicians and inform program implementation – for the better!		
If not selected for oral presentation, would you be interested in submitting a poster?		Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/>

ABSTRACT #13 - Abstract Submission Template – QCS 7-8 November 2019

Title: <i>(complete all details in the white spaces below, do not alter font size or style, do not exceed one page)</i>		
Low value care and endoscopy in dyspepsia: retrospective observational study from a metropolitan Australian hospital.		
Presenters		
	Name	Position
1	Dr Myat Myat Khaing	Gastroenterology Registrar
2	Dr Lei Lin	Gastroenterology Registrar
Contact:	07 3139 5430	
Introduction (frame the issue):		
Recent literature suggests that young patients aged <55 years without any alarm features are at low risk of having significant endoscopic findings (SEF) including malignancy, ulceration, and erosive oesophagitis. Guidelines recommend that this patient subgroup should undergo a trial of proton pump inhibitors (PPIs) and potentially Helicobacter pylori testing before being considered for endoscopy. Hence, endoscopy has been identified as a potential source of unnecessary expense and low-value care for health services.		
Objective (what problem does the project address?):		
We sought to assess the yield of performing endoscopy in young patients aged under 55 years with dyspepsia referred by primary care physicians; to assess the utility of alarm symptoms and of nonresponse to proton pump inhibitors for predicting significant endoscopic findings.		
Methods (quality improvement measures / changes implemented / impact evaluation / etc.):		
We retrospectively reviewed all endoscopies at our tertiary centre between January 2018 and July 2019 for investigation of dyspepsia. We excluded patients aged <18 years or ≥55 years, endoscopies performed for surveillance reasons, and endoscopies performed for non-dyspepsia related indications.		
Results (summary of the project's results):		
<ul style="list-style-type: none"> - 302 endoscopy exams met inclusion criteria, with a mean patient age of 41.0 ± 9.5 years and 43% were male. 246 (81.5%) endoscopies were performed in accordance with the guideline indications, consisting of 80 (26.5%) patients with alarm features, with 226 (74.8%) patients having had a trial of PPIs prior to referral. Only 30.8% of patients had H pylori testing prior to referral. - The most common alarm features were iron deficiency anaemia and dysphagia. Other alarm features were unintentional weight loss, persistent vomiting, upper gastrointestinal bleeding, family history of upper gastrointestinal malignancy and abnormal imaging of the of upper gastrointestinal tract. - On endoscopy, 151 (50.0%) patients had a normal examination while 24 (7.9%) patients had a significant endoscopic finding including 1 case of gastric adenocarcinoma, 3 cases of ulceration, 2 cases of Barrett's oesophagus, and 19 cases of erosive oesophagitis (Los Angeles grade B or higher). - The rate of SEF in patients with alarm features was 4/80 (5.0%) versus 20/222 (9.0%) in patients without alarm features, with an odds ratio of 0.53 (0.18-1.61, p=0.263). - The rate of SEF in patients who had endoscopy performed within guidelines was 21/246 (8.5%) vs 3/56 (5.4%) done outside of guidelines, with odds ratio of 1.65 (0.47-5.73, p= 0.432). 		
Challenges:		
Limited information on patient symptoms and alarm features in referral letters impeded accurate assessment of endoscopy indication and urgency.		
Lessons learnt:		
A substantial number of patients did not have a PPI trial or H pylori testing prior to referral.		
Consumer engagement:		
No formal consumer group had yet been consulted.		
Impact on patient care (clinician perspective):		
We aim to identify factors that lead to low value endoscopies for dyspepsia.		
Impact on patient experience (consumer perspective):		
We anticipate that focused education for primary care physicians will lead to an increase in PPI trial and H pylori testing for dyspepsia which will reduce the need for endoscopy.		
Conclusions:		
<p>We identified that 18.5% of endoscopies for investigation of dyspepsia in patients aged 18 to 54 years were performed outside of guidelines as they did not have any preceding alarm features nor a trial of PPI beforehand. However, this subgroup of patients had a clinically significant SEF rate of 5.4%, and do not clearly represent low value care episodes. A negative endoscopy itself has direct clinical utility as it relieves patient anxiety from the fear of having an underlying cancer or serious disorder and facilitates a diagnosis of functional dyspepsia so that more targeted therapies can be provided in addition to empirical PPI.</p> <p>A substantial number of patients did not have a PPI trial nor have H Pylori testing prior to referral, suggesting that many referrers are unaware of the dyspepsia guidelines which can be addressed with focused education and clear referral guidelines.</p> <p>Further studies with a prospective design from multiple centres would be helpful to expand the evidence base, and to guide initiatives for improving health care efficiency and patient outcomes.</p>		
If not selected for oral presentation, would you be interested in submitting a poster?		Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/>

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ABSTRACT #14 - Abstract Submission Template – QCS 7-8 November 2019

Title: <i>(complete all details in the white spaces below, do not alter font size or style, do not exceed one page)</i>		
Review of routine Full Blood Count tests as Gold Coast Health		
Presenters		
	Name	Position
1	Karlene Willcocks	Executive Director, DASS
2	Aimee Ballantine	Principal Project Officer, Choosing Wisely
Contact:	Aimee Ballantine	Principal Project Officer, Choosing Wisely
Introduction (frame the issue):		
<p>Since 2017/18, the Operational expenditure of Pathology services at Gold Coast Health has increased 10% (from FY17/18 \$28,704,466 to FY18/19 \$31,582,722). The activity for these services has also seen a growth of 7% for pathology (1,209,968 tests in FY17/18 to 1,288,820 tests in FY18/19).</p> <p>Full Blood Count (FBC) tests are the most frequently ordered pathology tests equating to \$2.8M (FY18/19) and have been identified as a potential low benefit test that could be reduced within the GCHHS.</p>		
Objective (what problem does the project address?):		
<p>The Choosing Wisely program at Gold Coast Health aims to work with clinicians to identify routine pathology ordering that could be considered low benefit care.</p> <p>Avoiding unnecessary blood tests will likely improve the patients experience and quality of care, alongside a potential to have a positive impact the pathology costs or at minimum stabilise the growth in these costs.</p>		
Methods (quality improvement measures / changes implemented / impact evaluation / etc.):		
<p>Using various information systems (integrated Electronic Medical Records, and Pathology Utilisation Management Portal and Laboratory Information Systems) and clinical costing data as the source, the project team uses a rich dataset and interactive dashboard to allow clinicians to visualise their pathology utilisation and repeated tests during the patient's episode of care.</p> <p>Development of sustainable decision support and education that aligns to evidence based best practice is being investigated.</p>		
Results (summary of the project's results):		
<p>An initial review of the pathology expenditure using the GCH Choosing Wisely business intelligence tool revealed that the top three specialties (by Specialty Related Group) requesting Full Blood Count tests at GCHHS are from General Surgery, Gastroenterology and Respiratory Medicine.</p> <p>Those specialties ordering the vast amount of FBC tests also display high percentage of 'retests' in the same episode of care as follows: General Surgery (42%), Gastroenterology (54%) and Respiratory Medicine (58%).</p> <p>Further analysis is being progressed to understand frequency repeated FBC tests during the same episode of care where it may not be clinically indicated, such as no change in pathology from a previous FBC test within a 24-hour timeframe.</p>		
Challenges:		
<p>Changing the culture and behaviours of health care providers. Change in system processes when ordering pathology tests and viewing pathology results or repeated tests.</p>		
Lessons learnt:		
<p>Identifying and working closely with champions within the health service to promote change; and ensure a sustainable embedded quality focused improvement is implemented. Looking at solutions in education and practice that traverse the routine turnover of medical staff.</p>		
Consumer engagement:		
<p>Consumer involvement is a high priority for the Choosing Wisely program and has well engaged spokesperson and representation from Consumer Advisory Groups, including health literacy and Consumers Health Forums.</p>		
Impact on patient care (clinician perspective):		
<p>Clinicians will be engaged into both planning and implementation to ensure support and safety.</p>		
Impact on patient experience (consumer perspective):		
Conclusions:		
If not selected for oral presentation, would you be interested in submitting a poster?		Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/>

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Abstract #15 - Abstract Submission Template – QCS 7-8 November 2019

Title: Cessation of routine CXR screening in RBWH Haematology.		
Presenters		
	Name	Position
1	A/Prof Glen Kennedy	ED, CCS, RBWH
2	Dr Cameron Curley	Director, Department of Haematology, RBWH
Contact:	glen.kennedy@health.qld.gov.au	
Introduction: Historically routine CXRs were performed weekly in all haematology patients at RBWH to screen patients for early respiratory infiltrates / infection. The clinical benefit of such practice in the modern era was negligible, with local audits confirming firstly, the lack of any change of care based on routine CXR findings, and secondly, the ready access to immediate chest imaging (CXR or CT) for diagnosis in patients with any clinical signs and / or symptoms of respiratory disease and / or infection.		
Objective: Cessation of practice of performing weekly routine CXRs in in-patient haematology patients at RBWH		
Methods: Clinical audits were initially performed to assess the utility of the practice. When these audits confirmed an absence of any change of clinical care based on routine CXR findings over the prior 6mths, an executive decision was made to cease this practice.		
Results: Performance of weekly routine CXRs in in-patient haematology patients at RBWH was ceased.		
Challenges: The historic practice took time to reverse, with education of senior clinical staff, as well as rotating junior staff and ward nursing staff required to be repeated several times over a 6month period. Clinical handover documents and unit information sheets also required re-writing.		
Lessons learnt: Information and education of staff around changes in process requires repetition for sustainable change. Acceptance of change was aided significantly by available clinical (audit) data confirming the safety of the proposed change.		
Consumer engagement: Consumers were not directly asked about the change in practice.		
Impact on patient care: There were no negative impacts on patient care. Patients experienced less exposure to radiation (fewer CXRs required). Staff experienced increased availability to perform other duties, with nursing staff and PSO's no longer required to escort patients to and from radiology, and radiology staff no longer required to perform routine portable CXRs in the ward for those patients unable to be escorted out of the ward. Significant cost savings were also realized – based on costs of CXR alone (~\$35 per CXR); cost of x30 CXRs per week for 52 weeks per year was ~\$54,600.		
Impact on patient experience: Patients experienced less time wasting in transfers to and from radiology and waiting in the radiology department for their CXR to be performed, with more available time on the ward to access other clinical consults and / or interventions as needed.		
Conclusions: Successful implementation based upon local clinical data supporting change.		
If not selected for oral presentation, would you be interested in submitting a poster?		Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/>

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Abstract #16 - Abstract Submission Template – QCS 7-8 November 2019

Title: <i>(complete all details in the white spaces below, do not alter font size or style, do not exceed one page)</i>		
Testing Wisely at Wide Bay Hospital and Health Service (WBHHS)		
Presenters		
	Name	Position
1	Sotera Trevaskis	Project Director, Choosing Wisely WBHHS
2	Dr Sue Page	Director of Medical Services WBHHS
Contact:	Sotera Trevaskis Mobile: 0436 630 645	Sotera.trevaskis@health.qld.gov.au
Introduction (frame the issue):		
Blood tests are a common and important part of patient diagnosis and management. Testing Wisely aims to rationalise ordering of routine blood tests to improve patient safety and efficiently utilise pathology services.		
Objective (what problem does the project address?):		
Testing Wisely addresses the overuse of routine blood testing in the ED through system improvement and culture change. The project aims to address hidden cultures of “we’ve always done it this way” by encouraging clinicians (medical and nursing) to be reflective in their practice and supporting test selection by implementing evidence-based guidelines.		
Methods (quality improvement measures / changes implemented / impact evaluation / etc.):		
<ul style="list-style-type: none"> • Multidisciplinary project team with visible champions leading change. • Staff survey to understand underlying attitudes towards low value care and barriers to change. • Use of Strategic Doing project frameworks, aligned to relevant Choosing Wisely recommendations. • Deliberate scheduling of meetings at fortnightly intervals to enable the Testing Wisely project team to work towards measurable outcomes in 2-week sprint cycles. • Benchmarking of baseline data for selected routine tests. • Adoption of the Australian College of Emergency Medicine & Royal College of Pathologists Australia Guidelines and WBHHS’s Nurse Initiated Pathology matrix to support appropriate test selection. • Alignment with WBHHS’s National Safety and Quality Health Service standards committees. • Targeted education for medical and nursing staff (including Nursing Graduates, Juniors & Interns). 		
Results (summary of the project’s results):		
<ul style="list-style-type: none"> • Maryborough ED: 4% increase in ED presentations during FY19 with 23% reduction in FBC, 55% reduction in CRP, 27% reduction in Coagulation Studies, 14% reduction in Point of Care Chem8 tests. • Hervey Bay ED: 9% increase in ED presentations during FY19 with 1% increase in FBC, 38% reduction in CRP, 30% reduction in Coagulation Studies. 		
Challenges:		
<ul style="list-style-type: none"> • Duplicating Testing Wisely in other departments where teams are less engaged or motivated to be part of the Choosing Wisely Program. • Engaging all clinicians and implementing changes to practice takes time. We are prepared for a marathon and not a sprint! 		
Lessons learnt:		
<ul style="list-style-type: none"> • Early buy in from clinical teams is essential for success. • Individuals require dedicated clinical support time to focus on the project. • The use of 2-week sprint cycles is important for building momentum and mobilising people into action. • Data is important to measure changes in practice. • Provide opportunities for involvement and lead change by example. • Ensure the project’s primary focus is patient safety, and not financial savings or efficiency measures. Projects aimed at reducing low value / low benefit care must be patient centred with the understanding that the program will inevitably improve cost and efficiency over time. 		
Consumer engagement:		
Consumer engagement is at the heart of what our staff do every day. We aimed to build on this by encouraging clinicians and nurses to initiate conversations with consumers and invite questions about their planned care. WBHHS has also developed a suite of “Got Questions? We’re listening” collateral for staff and consumers.		
Impact on patient care (clinician perspective):		
Reduced risk to patients, improved patient flow and better engagement with consumers. New projects and service models integrate Choosing Wisely recommendations.		
Impact on patient experience (consumer perspective):		
Improved patient flow, better facilitation of discussions about care (initiated by clinicians and nurses).		
Conclusions:		
The success of Testing Wisely is attributable to the enthusiasm and motivation of our project team and their willingness to improve safety and care. Our meetings provide a dynamic space for clinicians to reflect on their own clinical practice, think laterally about how best to initiate change and evaluate habits of practice.		
If not selected for oral presentation, would you be interested in submitting a poster?		Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/>

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Appendix 3: Abstracts selected for poster presentation

Inguinal hernia imaging amongst GPs in Central Queensland
nutrition care

Feeding patients better: protocolising enteral feeding to provide appropriate and timely
nutrition care

Converting complex haematology treatment to ambulatory care improves patient
experience and hospital resources – Statewide Cancer Clinical Network

INSPIRE – Innovative New Strategy for Piperacillin / Tazobactam & Ceftriaxone, Infection
Risk and Evaluation

Utilisation of Technology to reduce patient attendances in the tertiary hospital and reduce
variation in practice through governance

Reviewing medical oncology clinic activity and models of care to improve the patient
experience – Statewide Cancer Clinical Network

Improving specimen collection in the Townsville Hospital Emergency Department

Implementation of an electronic Individual Patient Approval (IPA) system

Cost savings through medication substitutions

Metro North Robotic Surgery Program

ABSTRACT #17 - Abstract Submission Template – QCS 7-8 November 2019

Title: <i>(complete all details in the white spaces below, do not alter font size or style, do not exceed one page)</i>		
Inguinal Hernia Imaging Amongst General Practitioners in Central Queensland		
Presenters		
	Name	Position
1	Clay Renwick	Intern
2		
Contact:	0411568895 – Clay Renwick	
Introduction (frame the issue):		
An inguinal hernia can be diagnosed with a positive clinical exam and imaging is not necessary to do so nor is it necessary to plan the ensuing surgery. In the Rockhampton Base Hospital's general surgery department it has been noticed that a large portion of patients will arrive at their outpatient department with imaging (mostly ultrasound scans) already being performed on patients with positive clinical exams. The cost associated with this imaging is roughly 100\$ per patient and represents an easy way to save on health expenditure.		
Objective (what problem does the project address?):		
Our objective was to determine the effectiveness of a groin hernia guideline put forth for the Healthpathways clinical information portal for GPs.		
Methods (quality improvement measures / changes implemented / impact evaluation / etc.):		
We had a retrospective study design that categorized our patients into 3 groups by referral dates. The first group being a pre-guideline group. The second group represented an adoption period. Finally, the third group represented the intervention group. We analysed the number of patients with imaging being done before and after the adoption period, in conjunction with the number of positive clinical exams amongst these patients.		
Results (summary of the project's results):		
A total of 116 patients were included in the study. Of these, 84 had undergone imaging which represented a 72.4% imaging rate across the 3 years worth of patients. Group 1 had an imaging rate of 61%, group 2 had a rate of 60% and group 3 had a rate of 92.5%. This represents an increase of 31.5% among the main comparative groups.		
Challenges:		
Imaging rates may have actually been higher amongst all groups. We did not have access to imaging that had been performed privately if the results had not been attached to the referral by the GP. We were also not able to ascertain what the GP found on clinical examination in all patients as we only had access to the referral letter written by them.		
Lessons learnt:		
We have realized that, although recommendations set forth for GPs may have sound guidance, the healthpathways portal may not be utilized as much as one would expect or like to see. This ultimately leads us to ask what the best course of action is to be able to reach GPs in a way that will change their practice.		
Consumer engagement:		
Impact on patient care (clinician perspective):		
We feel that patients are being subjected to more investigation than necessary and ultimately wasting funds on unnecessary imaging.		
Impact on patient experience (consumer perspective):		
Patients are being required to attend more appointments in order to get the imaging that the GP requests.		
Conclusions:		
Imaging rates for inguinal hernias have seen an increase of 31.5% over 3 years and consequently an unnecessary rise in healthcare expenditure. This comes at the direct		
If not selected for oral presentation, would you be interested in submitting a poster?		Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/>

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ABSTRACT # 18 - Abstract Submission Template – QCS 7-8 November 2019

Title: <i>(complete all details in the white spaces below, do not alter font size or style, do not exceed one page)</i>		
Feeding patients better: Protocolising enteral feeding to provide appropriate and timely nutrition care		
Presenters		
	Name	Position
1	Clare Cutmore	Team Leader, Nutrition & Dietetics
2	Prof Merrilyn Banks	Director, Nutrition & Dietetics
Contact:	Clare Cutmore	Clare.cutmore@health.qld.gov.au
Introduction (frame the issue):		
Nutrition support is an important aspect of patient care and inadequate nutrition can hinder patient healing and recovery. Enteral nutrition delivered via tube feeding is a vital nutrition intervention in patients that are unable to eat or otherwise meet their nutrient requirements due to their clinical condition.		
Objective (what problem does the project address?):		
Standardisation and protocolisation of enteral feeding practices to allow automatic commencement by medical or nursing staff has the potential to reduce delays in nutrition support, whilst also reducing dietitian occasions of service. Since 2005, the Nutrition and Dietetics Department at the Royal Brisbane and Women's Hospital (RBWH) has been working to protocolise enteral feeding across multiple inpatient clinical areas.		
Methods (quality improvement measures / changes implemented / impact evaluation / etc.):		
Using local stakeholder engagement and implementation methods, protocolised enteral feeding has been successfully implemented and evaluated in the Intensive Care Unit (ICU), and on the Neurosurgery, Head and Neck Cancer Surgical, Eating Disorders (medical) and Stroke wards. A recent hospital-wide clinical audit at the RBWH was undertaken to quantify the proportion of patients already receiving protocolised enteral feeding and identify other clinical areas that could benefit from protocolised feeding.		
Results (summary of the project's results):		
Implementation of protocolised enteral feeding has reduced delays in nutrition support across patient groups: <ul style="list-style-type: none"> - ICU: significant reduction in mean time to commencement of nutrition support for critically ill patients from 28 to 16 hrs and time to reach goal nutrition rate fell from 22 to 13 hrs (Clifford, 2010). - Neurosurgery: improvement in time to transition to supportive nutrition therapy when oral intake resumes (from day 1 to day 0) (Dux, 2019). - Head and Neck Cancer: 100% of patients commenced on enteral nutrition within 24 hrs of surgery, and goal nutrition achieved within 2 days (Roddick, 2017). - Eating Disorders: significant improvement in time to goal nutrition from 3.2 to 0.9 days (Hill, 2017), with recent data indicating good adherence (92%) and improved dietetic efficiency (Cutmore, 2019). Preliminary audit data indicates that most patients on enteral feeds at the RBWH received protocolised feeding (72%), with an additional 10% of patients being suitable for protocolised feeding. This suggests that the RBWH Nutrition and Dietetics Department has largely been successful in protocolising enteral feeding across clinical areas. This work has released time for clinical dietitians to develop and practice in expanded scope roles, lead research and service improvements, and lead state-wide initiatives such as FEEDS and SIMPLE.		
Challenges:		
Sustainability of practice change remains a challenge. With staff turnover and rotation in a large teaching hospital such as the RBWH, maintaining staff awareness of and confidence in using existing protocols requires ongoing work. The upcoming transition to digital hospital has also highlighted future challenges with achieving state-wide consensus around standardisation of practices, with Queensland sites reporting vastly different practices and conflicting clinician views around protocolised enteral feeding.		
Lessons learnt:		
While protocolised care (e.g. clinical pathways) may be perceived by clinicians as impacting professional autonomy and reducing healthcare to a 'tick box' approach, it allows for safe, effective care to be delivered to most patients in an efficient manner, redirecting clinician time to delivering care that yields the greatest benefit.		
Consumer engagement:		
Work is currently being undertaken in the eating disorder space to understand patient and caregiver perspective of protocolised feeding whilst in hospital.		
Impact on patient care (clinician perspective):		
Protocolisation of enteral feeding has resulted in more streamlined processes by allowing commencement of feeding by nursing staff and medical officers without prior dietetic input. This reduces delays in commencing feeding and time to adequate nutrition. Reduced reliance on dietitians to deliver care related to enteral feeding has allowed redirection of clinician time to delivering high value care and quality improvement activities.		
Impact on patient experience (consumer perspective):		
As above, the consumer perspective of protocolised enteral feeding is currently being explored.		
Conclusions:		
Protocolising enteral feeding has been an effective way of ensuring that patients are receiving appropriate and timely nutrition care at the RBWH. Further work is planned to build evidence around the safety of protocolised enteral feeding and formally recording dietitian time related to delivering this care, in support of achieving state-wide consensus in preparation for the transition to digital hospital. The patient perspective of protocolised feeding is acknowledged as an area that warrants further exploration.		
If not selected for oral presentation, would you be interested in submitting a poster?		Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/>

ABSTRACT #19 - Abstract Submission Template – QCS 7-8 November 2019

Title: <i>(complete all details in the white spaces below, do not alter font size or style, do not exceed one page)</i>		
Complex haematology patients treated as ambulatory patients with CADD pumps to relieve bed pressure		
Presenters		
	Name	Position
1	Jason Black	Director of Pharmacy
2	Kristoffer Johnstone	Advanced Pharmacist- Cancer Care
Contact:	Jason Black	07 42266212
Introduction (frame the issue):		
<p>Patients with advanced malignancies and on complex multi-day chemotherapy were historically admitted to Cairns Hospital as inpatients for the purposes of administering treatment. Common regimens have patients admitted initially for 5-6 days and kept in hospital during anticipated neutropenic nadir to monitor for infections. These patients could be admitted for up to 3 consecutive weeks for monitoring. Patients experienced hospital fatigue and poorer experience through the burden of treatment.</p> <p>An initiative from pharmacy utilising smart pump technology via CADD Solis® portable pumps allowed patients to be treated as outpatients during the treatment phase. They were assessed during neutropenic phase of treatment and admitted when they reached their nadir. This strategy reduced their admission by an average of 10 days.</p> <p>Secondly medications given as inpatients are not eligible for PBS reimbursement. By shifting to an outpatient model drug costs are shifted to PBS and increases revenue for HHSs.</p>		
Objective (what problem does the project address?):		
<p>Improving the use of medicines and Improving the appropriateness of treatments and care pathways</p> <ol style="list-style-type: none"> 1.To reduce unnecessary inpatient admissions and improve patient flow 2.To improve patient experience by keeping patients in their own home 3.To decrease the financial burden of medications on the HHS through Increased PBS revenue 		
Methods (quality improvement measures / changes implemented / impact evaluation / etc.):		
<p>Pharmacy designed the protocols using the Oncology Information Management System to allow for CADD pump administration. Stabilities of medication were investigated and co-ordinated with the compounder.</p> <p>Governance was implemented through relevant committee.</p> <p>Training, resources and procedures were written in the management of CADD pumps, nursing administration, patient education. Patient survey was done to assess acceptability.</p>		
Results (summary of the project's results):		
Over a 16-month period: 317 admission days avoided. \$253,637 of medication costs offset by PBS reimbursement. Patients expressed high acceptability of treatment modality		
Challenges:		
<p>Change management- New process for patients considered as high risk to remain outpatients without monitoring</p> <p>Identifying patients suitable for outpatient treatment. Compatibility and stability data were limited</p> <p>Training requirements of chemotherapy competent nurses on the ward and day unit. Getting “buy in” from the stakeholders</p>		
Lessons learnt:		
<p>Careful selection of patients suitable for home management who have good support.</p> <p>Limiting patients to local catchment so they don't present to outside hospitals.</p> <p>Ensuring patients have contact details of staff who can disconnect pumps if they present to hospital after hours.</p>		
Consumer engagement:		
<p>Patients were surveyed during the initial phase of the project</p> <p>High acceptability</p>		
Impact on patient care (clinician perspective):		
<p>Nurses – Improved resourcing and communication with staff in day unit and ward</p> <p>Doctors – Decreased unnecessary admissions improving patient care.</p> <p>Pharmacists- Improved patient centred care</p>		
Impact on patient experience (consumer perspective):		
<p>Positive impact on patient's quality of life to continue as normal in community with support network</p> <p>Patient Quotes</p> <p>” Freedom, being able to be at home”</p> <p>“ You are at home, more relaxed, and you are still able to move around and do things”</p>		
Conclusions:		
<p>The initiation of CADD-Solis® utilisation in the outpatient model in Cancer Care was safe and effective, reduced inpatient length of stay, improved patients experience and reduced resource burden of both nursing and drug expenditure to the HHS. It is scalable and could be used in other areas such as HITH and/or minor procedure units.</p> <p>This initiative represents a new model of care for the management of patients with advanced malignancies at Cairns Hospital.</p>		
If not selected for oral presentation, would you be interested in submitting a poster?		Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/>

ABSTRACT #20 - Abstract Submission Template – QCS 7-8 November 2019

Title: <i>(complete all details in the white spaces below, do not alter font size or style, do not exceed one page)</i>		
INSPIRE – Innovative New Strategy for Piperacillin/Tazobactam & Ceftriaxone, Infection Risk and Evaluation Study		
Presenters		
	Name	Position
1	Dr Kathryn Wilks	Infectious Diseases Physician / AMS Director
2	Patricia Kilfoyle	Antimicrobial Stewardship Pharmacist
Contact:	(07) 5202-8607	
Introduction (frame the issue):		
<p>Overuse of broad-spectrum, empirical antibiotics such as Piperacillin/Tazobactam and Ceftriaxone in surgical wards is a commonly occurring antimicrobial stewardship issue, with emergence of resistance and complications such as <i>Clostridium difficile</i> more likely. This study will use collaborative, behavioural strategies to implement quality improvement initiatives in surgical wards to reduce use of Piperacillin/Tazobactam and Ceftriaxone, and conversely increase guideline compliant antibiotics. The aim of the project is to reduce total volume consumption of Piperacillin/Tazobactam and Ceftriaxone in surgical wards, subsequently improving guideline compliance and reducing adverse events associated with this overuse such as <i>Clostridium difficile</i> infection and prolonged length of stay from using the intravenous route. We also hypothesize that by reducing large-scale use of these antibiotic agents, we will subsequently reduce the prevalence of ‘meropenem-requiring’ organisms (such as ESBLs/ESCHAPPMs) in our surgical patients.</p> <p>Our project will involve a multi-disciplinary cohort of engaged clinicians from general surgery, orthopaedics, patient safety and quality, nursing and allied health streams, as well as a consumer component for the 12-month duration of the study. The study will be implemented and facilitated by the Antimicrobial Stewardship team.</p>		
Objective (what problem does the project address?):		
The project addresses the overuse of Piperacillin/Tazobactam and Ceftriaxone as first-line, ‘work-horse’ agents to treat surgical infections empirically and aims to measure the consequences of changing this established practice.		
Methods (quality improvement measures / changes implemented / impact evaluation / etc.):		
Data collection for the duration of the project will be multi-faceted. Momentum for the project will be maintained by production of monthly data scorecards which will be displayed as large AO posters per ward and delivered as cards to clinicians and NUMs each month. Baseline data assessing use of antibiotics and prevalence of ‘meropenem-requiring’ organisms will be collected. During the 12-month project, an interrupted time series data collection model (ITS) of appropriate antibiotic usage will be employed to monitor change variation and the strength of any interventions implemented. Surgeons will decide during a root-cause analysis session of prescribing their chosen interventions and the AMS team will facilitate the changes. Throughout the study, fortnightly antibiotic consumption data per ward will be collated and tracked to assess total volume usage.		
Results (summary of the project’s results):		
The project data collection will commence upon research SSA approval and scheduling of the multi-disciplinary surgical root-cause analysis session.		
Challenges:		
Changing embedded prescribing habits and introducing a new culture of prescribing in managing common surgical infections will be difficult, hence the collaborative prolonged approach to interventions we plan on taking.		
Lessons learnt:		
To be confirmed		
Consumer engagement:		
One of the key components of the monthly scorecard data to be displayed on each ward and circulated to all engaged individuals is a consumer survey. The survey aims to address the current knowledge of antibiotic resistance of patients in our HHS and relates the questions specifically to our surgical cohort. Data will be collated and will be used to identify knowledge gaps and areas to focus on in future with our patient community.		
Impact on patient care (clinician perspective):		
Patients will receive evidence-based, lower-risk, guideline compliant antibiotics for established indications for the correct duration of therapy. We hypothesize that the risk from infections such as <i>Clostridium difficile</i> and more resistant, problematic ESBL / ESCHAPPM infections will be reduced consequently.		
Impact on patient experience (consumer perspective):		
Our patients will be more informed as to their antibiotic treatment by way of information displayed throughout the wards, and by participating in our rolling consumer surveys and distribution of project-tailored consumer leaflets.		
Conclusions:		
To be confirmed		
If not selected for oral presentation, would you be interested in submitting a poster?		Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/>

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Abstract #21 - Abstract Submission Template – QCS 7-8 November 2019

Title: Utilisation of technology to reduce patient attendances in the tertiary hospital and reduce variation in practice through governance		
Presenters		
	Name	Position
1	Aniko Cooper	Director, Townsville Cancer Centre
2	Sabe Sabesan	Clinical Director, Medical Oncology, TCC
Contact:	Aniko Cooper	
Introduction: Historically chemotherapy treatments, access to clinical trials and review visits for consultations required rural patients to attend larger hospitals even for short visits at significant cost for patients and health systems. Utilisation of videoconferencing tele-oncology clinics, supervised chemotherapy and tele-trials allow patients to receive quality care without travel or travel related expense; thus saving funds that can be redirected to patient care.		
Objective: Decrease patient travel to appointments where telehealth and tele-oncology is safe to provide. Increase availability of chair to other patients in the service. Offer clinical trials to suitable patients without requiring visit to Townsville which previously was a requirement for a patient to be eligible for trials. To reduce variation in practice by developing state-wide governance for tele-chemotherapy and tele-trials		
Methods: Develop program for suitable patients for tele-oncology including guideline development. Discussions internally and in hospital receiving service. Training of staff including visit to the tertiary centre. Management of drug provision. Governance and follow up protocol and schedules communicated. As process became sustained in areas, tele-trials were introduced allowing suitable patients access to clinical trials for their cancer treatments.		
Results: Established tele-oncology clinics in regional areas supervised by either or both medical and nursing staff from the tertiary service in Townsville. Significant impact in Mt Isa where nursing staff reached a level of competency where no supervision required for administration of chemotherapy. Four level three hospitals acquired capabilities to administer chemotherapy. Other level 4/5 hospitals in North Qld gained access to clinical trials as part of Northern tele-trial cluster; thus increasing patient access to four clinical trials so far. Through adherence to tele-chemotherapy and tele-trials governance, all sites followed similar practices.		
Challenges: Maintaining trained staff in regional areas especially with staff movements, some resistance of medical staff to utilise technology, technical difficulties at times causing delays and frustrations. Some challenges in terms of SSA and ethics for clinical trials in regional hospitals which were overcome with good communication and teamwork.		
Lessons learnt: Strong links required with regional services to ensure service is sustainable. Consideration of drug provision and timing of appointments also required reviewing. Management of doctors clinics to ensure timely availability for tele-links to ensure resource management at the regional site.		
Consumer engagement: Consumers were involved in providing feedback on the quality of services for QI and advocating for the services in their regions (eg Hughenden) including access to clinical trials.		
Impact on patient care: No negative impact to Patient care. Significant impact on patient satisfaction especially in reducing numbers of visits to Townsville. Ability to utilise chairs in the day unit for other patients. As per Deloitte report cost savings realized in line with PTS savings. Patients in regions able to access some clinical trials without having to visit the tertiary hospital.		
Impact on patient experience: Patients were able to stay in their home town for most of their treatments and review appointments allowing them to maintain day-to-day normality especially in terms of their jobs and families (picking up children from school etc).		
Conclusions: Successful implementation, modified and expanded around the state to QRECS. Tele-trial model is adopted in four states as a feasible model of care. While improving patient experiences and reducing unnecessary travel related expenses, these models may reduce variation in practice because of newly developed governance framework and guidelines.		
If not selected for oral presentation, would you be interested in submitting a poster?		Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/>

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Abstract #22 - Abstract Submission Template – QCS 7-8 November 2019

Title: <i>(complete all details in the white spaces below, do not alter font size or style, do not exceed one page)</i>		
Reviewing Medical Oncology clinic activity and models of care to improve the patient experience.		
Presenters		
	Name	Position
1	Anna Kuchel	Fellow, Medical Oncology
2	Melissa Eastgate	Dep Director, Medical Oncology
Contact:	Melissa Eastgate	
Introduction (frame the issue):		
Medical Oncology clinics have increasing numbers of patients coming through them each week due to a combination of an increasing population, increasing treatment options and increasingly successful treatments which allow patients to live longer thus requiring care for longer periods of time.		
Objective (what problem does the project address?):		
Can we identify a group of patients currently coming to our clinics that may be able to be cared for using a different model of care such as shared care with GPs so that patients do not need to attend the oncology outpatient clinics as often as they do currently.		
Methods (quality improvement measures / changes implemented / impact evaluation / etc.):		
We conducted an audit of our clinics over a 4 week period and documented the types of cancer, whether the patients were coming for review or treatment and what the ultimate goal of therapy was – curative or palliative.		
Results (summary of the project's results):		
The project identified that there were a large number of patients with genitourinary cancers, specifically prostate cancer, coming for regular review or subcutaneous treatment with palliative intent that could potentially have some of this care completed in the community in collaboration with oncology clinics. Moving forward there are other groups where this model could also be implemented in future.		
Challenges:		
It was labour intensive to collect all of the data during the 4 week time period, some data was missing and was completed retrospectively through chart review.		
Lessons learnt:		
Our current clinical and administrative systems do not provide the data required to look at patient numbers and demographics in this way but by completing an audit we were able to identify specific groups of patients including the volume and types of treatments, with a particular group found that could benefit from an innovative model of care.		
Consumer engagement:		
Consumers are not currently aware of this project or the proposed shared care model but moving forward consumers will be asked for input into any proposed models.		
Impact on patient care (clinician perspective):		
If a population of patients can be identified that would benefit from shared care these patients can be seen less often in medical oncology clinics leading to less overbookings/clinic waiting times.		
Impact on patient experience (consumer perspective):		
Patients will not be required to attend the clinic as often, for most patients this will be a positive as they will not have the impost of transport or parking at the hospital as frequently but with a well established model of care will be able to benefit from ongoing specialist input into their care.		
Conclusions:		
The audit has identified a group of patients that could benefit from a shared care model between oncology and our local general practitioners, a project is now underway to further look at the development of this model.		
If not selected for oral presentation, would you be interested in submitting a poster?		Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/>

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Abstract #23 - Abstract Submission Template – QCS 7-8 November 2019

Title: <i>(complete all details in the white spaces below, do not alter font size or style, do not exceed one page)</i>		
Improving specimen collection in the Townsville Hospital Emergency Department		
Presenters		
	Name	Position
1	Sharon Lazzaroni	Emergency Department Phlebotomist
2	Natalie Ly	Deputy Director, Emergency Department
Contact:	Natalie Ly	
Introduction (frame the issue):		
<p>Emergency departments (ED) are notoriously busy environments. Within this environment, human error begins to have a role in seemingly straightforward, uncomplicated tasks and procedures. The ED at the Townsville Hospital identified the high numbers of pathology-related errors, such as wrong samples in tubes (WSIT), as an issue of concern. With the introduction of integrated electronic medical records (ieMR), it became easier to “work around” the built-in safety features of patient identification and label identification. WSITs represent a patient safety issue due to the potential impact on treatment plans, based on incorrect pathological results, and therefore health outcomes of consumers. To tackle this issue, ED recruited a full-time phlebotomist, who was responsible for initiating quality improvement projects on specimen collection.</p>		
Objective (what problem does the project address?):		
<p>The aims of the project were to:</p> <ul style="list-style-type: none"> • Improve safety and quality of treatment; Improve efficiency of care and; Improve the patient experience 		
Methods (quality improvement measures / changes implemented / impact evaluation / etc.):		
<p>The role of the ED phlebotomist was to assess the situation and initiate change. Quality improvement changes included the introduction of dedicated pathology trolleys, education and feedback by the phlebotomist. The dedicated pathology trolleys were stocked with equipment required for cannulation and venepuncture. The trolleys also had all necessary technology, including computer, scanner and printer, required to complete the specimen collection process correctly. ED staff were educated and provided feedback on the importance of specimen collection, how to use the trolleys and the impact that improvised “work arounds” can have on the consumer. The impact of the quality improvement project was assessed through weekly data audits and observational audits conducted within ED and data produced from the pathology department.</p>		
Results (summary of the project’s results):		
<p>Prior to the implementation of quality improvement measures, ED completed 7% positive patient identification (PPID) collections and 32% positive patient accession identification (PAID) collections. With the introduction of the trolleys and continuous education, ED now sits at 51% PPID collections and 83% PAID collections. WSITs have reduced from 64 and 68 for 2017 and 2018, respectively, to 21 in 2019 year to date.</p>		
Challenges:		
<p>Workplace culture was a barrier to the quality improvement project. Changing staff behaviour and attitudes towards the correct process for specimen collection was and still is the main obstacle presented. ED also has a rotating roster, with a new intake of doctors every 3 months and continually changing nursing staff which influenced the momentum and continuity of the project.</p>		
Lessons learnt:		
<p>Several lessons have been learnt through the quality improvement process. Altering the culture and attitude of health professionals to new processes is a long journey and requires persistence and momentum to ensure the changes are maintained. To be successful, ED medical and nursing staff need to be included in the quality improvement process to allow opportunity to gain insight and obtain feedback on the changes and how the integration is performing.</p>		
Consumer engagement:		
<p>The implementation of the quality improvement project was identified and initiated within ED, consumer engagement occurred ad hoc when at the bedside collecting specimens, specifically scanning armbands and the new trolleys.</p>		
Impact on patient care (clinician perspective):		
<p>From a clinical perspective, ensuring the specimen collection is completed correctly decreases the ED LOS, which would benefit QEAT. There is also certainty in pathology results giving confidence to clinicians in formulating the plan for the patient.</p>		
Impact on patient experience (consumer perspective):		
<p>The quality improvement project improved the patient experience, including reducing pain and discomfort experienced, and quality of treatment by reducing the number of times specimens were recollected. There is also the potential for reduced ED LOS due to a decrease in recollections.</p>		
Conclusions:		
<p>Results from the implemented quality improvement project have demonstrated increased compliance with specimen collection procedures and a substantial decrease in WSITs. The decrease in WSITs has improved patient safety and the efficiency of care, decreasing multiple re-collections from patients. The process is ongoing in the department and will still need to be continually reassessed to ensure the current momentum is maintained.</p>		
If not selected for oral presentation, would you be interested in submitting a poster?		Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/>

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Abstract #24 - Abstract Submission Template – QCS 7-8 November 2019

Title: <i>(complete all details in the white spaces below, do not alter font size or style, do not exceed one page)</i>		
Implementation of an electronic Individual Patient Approval (IPA) system		
Presenters		
	Name	Position
1	Will Tumusiime	Drug Use Evaluation Pharmacist
2	Cal Winckel	Assistant Director of Pharmacy
Contact:	William.tumusiime@health.qld.gov.au	
Introduction (frame the issue):		
<p>Medications that are not on the List of Approved Medicines (LAM) require Individual Patient Approval (IPA) to be able to be used in Queensland Health Hospitals. At Ipswich Hospital the process involved an on-spec phone call to the Executive Director of Medical Services who would make a decision about the IPA application without the benefit of financial information or robust clinical background information to support their decision. This resulted in many issues such as:</p> <ul style="list-style-type: none"> • Poor compliance with the paper-based system. • Limited audit trail of requests. • No easily searchable central storage point for previously approved applications. 		
Objective (what problem does the project address?):		
The (IPA) process required a more robust model to improve documentation and traceability. Internal Auditors identified the need to strengthen clinical and financial governance and a digital platform was felt necessary to support this. The aim was to improve the end user experience and ensure quality and safety of patient care.		
Methods (quality improvement measures / changes implemented / impact evaluation / etc.):		
An electronic IPA system was implemented to manage a change to the IPA application process. This coincided with a change in practice and now the application is first reviewed by a nominated pharmacist with the requisite expertise, then by the clinical director for therapeutic appropriateness and finally by the divisional director who has financial delegation.		
Results (summary of the project's results):		
This change lead to robust clinical and financial assessment of applications and a 33% reduction in the monthly cost of new IPA approvals from an average of approximately \$6,800 per month in 2018 to an average of approximately \$4,500 per month since December. The digital system also enabled electronic documentation and traceability of all applications which could be analysed retrospectively for audit purposes and for analysis of trends.		
Challenges:		
<p>We imported an existing application from Cairns. Since both hospitals had an enterprise agreement it could be transferred for free. However, since the workflow from Cairns was different to Ipswich, the program needed to be amended. The Drug Use Evaluation pharmacist was upskilled to make the required changes and is now able to trouble shoot problems with the system.</p> <p>Significant stakeholder engagement was required to implement this program. Endorsement was gained by the West Moreton Medicines Management Committee, the Clinical Director Committee and the Quality and safety committee.</p>		
Lessons learnt:		
Adding appropriate levels of governance to medication approval pathways not only improves appropriate use of medicines, but it also reduces overall drug expenditure.		
Consumer engagement:		
The residents and interns were the consumers in this project. Since the initiative had strong support from the Deputy Director of Medical Services the changeover process to the electronic system was implemented rapidly. After a 2-week period there were no more paper applications.		
Impact on patient care (clinician perspective):		
Patient care improved as a result of this initiative since the patients now only received non-LAM medicines that were approved by the specialist clinical director.		
Impact on patient experience (consumer perspective):		
Patient experience did not change as a result of the implementation of this project.		
Conclusions:		
Electronic applications are effective and well-received methods for facilitating the improvement of clinical governance.		
If not selected for oral presentation, would you be interested in submitting a poster?		Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/>

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Abstract #25 - Abstract Submission Template – QCS 7-8 November 2019

Title: <i>(complete all details in the white spaces below, do not alter font size or style, do not exceed one page)</i>		
Cost saving through medication substitutions		
Presenters		
	Name	Position
1	Will Tumusiime	Drug Use Evaluation Pharmacist
2	Cal Winckel	Assistant Director of Pharmacy
Contact:	William.tumusiime@health.qld.gov.au	
Introduction (frame the issue):		
There is opportunity to decrease drug costs whilst maintaining a high level of patient care.		
Objective (what problem does the project address?):		
The medicine substitution project sought to decrease the unnecessary use of high cost medicines when less expensive alternatives were available.		
Methods (quality improvement measures / changes implemented / impact evaluation / etc.):		
<p>The Drug Use Evaluation pharmacist identified several opportunities for medication substitution which would decrease the overall drug budget whilst maintaining a high level of patient care.</p> <ul style="list-style-type: none"> • Lignocaine containing lubricating gel was replaced with non-lignocaine containing gel in patients who required urinary catheterisation under general anaesthesia. • A market surveillance of external compounding suppliers was undertaken. The antibiotic infuser supplier was changed to a less expensive supplier who provided the same products at a lower price point. • Several product presentations of metamaminol were changed to alternative suppliers that provided the same products at a lower price point. • The local anaesthetic, bupivacaine/adrenaline was replaced with ropivacaine for use as a topical anaesthetic in the operating theatres. • Lincomycin was replaced with clindamycin as the preferred parenteral lincosamide antibiotic. • Sodium phosphate and potassium phosphate concentrate “Low k Phos” was replaced with sodium dihydrogen phosphate for the treatment of severe hypophosphatemia. • Dexmedetomidine “Precedex ready to use” infusions were replaced with generic dexmedetomidine vials for use in intensive care. • Heparin 5000iu/0.2mL vials were replaced with enoxaparin 40mg syringes for use in venous thromboembolism (VTE) prophylaxis. • Pegfilgrastim was replaced with lipegfilgrastim for the production and differentiation of neutrophils post chemotherapy. 		
Results (summary of the project’s results):		
<p>The projects were implemented at various stages throughout the year and have achieved the following cost saving results:</p> <p>In 12 months, the lubricating gel initiative has saved the hospital \$7,245 In 11 months, the lipegfilgrastim initiative has saved the hospital \$30,564 In 10 months, the ropivacaine topical anaesthetic initiative has saved the hospital \$46,208 In 9 months, the metamaminol supplier initiative has saved the hospital \$37,087 In 9 months, the antibiotic compounding supplier initiative has saved the hospital \$23,819 In 6 months, the clindamycin initiative has saved the hospital \$6000 In 6 months, the hypophosphatemia initiative has saved the hospital \$20,045 In 2 months, dexmedetomidine initiative has saved the hospital \$13,235 In 1 month, the VTE initiative has saved the hospital \$6,247 The phosphate and clindamycin initiatives led to state-wide formulary changes.</p>		
Challenges:		
Liaising with key stakeholders to educate them on the fiscal benefits of medication substitutions and to demonstrate that the proposed changes were therapeutically equivalent and would not lead to patient harm.		
Lessons learnt:		
To enact change there needs to be a “forcing function” which limits the availability of the old product whilst making the new product readily available. Without this intervention, prescribing practices rarely change.		
Consumer engagement:		
The consumer of these initiatives was the medical prescriber. All projects required significant stakeholder engagement at the director level and additional consultation was required from the local Medicines Management Committee.		
Impact on patient care (clinician perspective):		
Patient care has not been adversely affected as a result of these changes		
Impact on patient experience (consumer perspective):		
The patient experience has not been adversely affected as a result of these changes.		
Conclusions:		
There are opportunities to decrease the fiscal burden of medicines whilst maintaining a high level of patient care.		
If not selected for oral presentation, would you be interested in submitting a poster?		Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/>

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ABSTRACT #26 - Abstract Submission Template – QCS 7-8 November 2019

Title: Metro North Robotic Surgery Program		
Presenters		
	Name	Position
1	Colleen Jen	Executive Director Health Service Strategy and Planning, Metro North
2	Kaylee Britain	Robotic Surgery Program Manager, Metro North
Contact:	Colleen.jen@health.qld.gov.au	
Introduction (frame the issue):		
<p>Metro North Hospital and Health Service (Metro North) is the largest health service in Australia and has one of the most populous catchments. As the population continues to grow and age the need for surgery will continue to increase and as technology advances there will also be ability to undertake more complex surgery. The Royal Brisbane and Women’s Hospital (RBWH) had a first generation da Vinci S robotic system from 2007 to 2017 which was used primarily for urology procedures. In 2017 the system was upgraded which has allowed for growth across other surgical specialities - ENT, gynaecology and general surgery. Metro North developed the Robotic Surgery Plan 2018-21 (the Plan). Metro North recognises the benefits of robotic surgery to the health system and patients and aims to guide the development of a comprehensive robotic surgery program.</p>		
Objective (what problem does the project address?):		
<p>The implementation of the Plan aims to achieve the following outcomes</p> <ul style="list-style-type: none"> • expanded application of robotics in surgical specialities based on current and emerging evidence • improved collaboration with other robotic surgery services, training and research centres • contribute to robotic surgery evidence base through improved data collection and research • better surgical outcomes for patients • better patient experience • increased workforce knowledge and skills in robotic surgery • improved job satisfaction. 		
Methods (quality improvement measures / changes implemented / impact evaluation / etc.):		
<p>Metro North established a robotic surgery working group and steering committee to guide the implementation of the Plan. These groups have overseen the development of robotic surgery reference guides which provide practical guidance of the governance and training pathways required for clinical staff who will undertake robotic assisted surgery. A clinical registry was developed to collect data on robotic and comparable non-robotic surgery including data on patient demographics, surgical event, post-surgical event, diagnostics and patient reported quality of life surveys. An economic evaluation model was also developed to quantify actual costs in a public hospital and inform decision making. The model can adjust parameters for scenario modelling (e.g. episode volume, length of stay and surgical minutes).</p>		
Results (summary of the project’s results):		
<p>In the 2018-19 financial year 175 da Vinci robotic procedures were undertaken compared to 277 non-robotic comparable procedures in urology, ENT, colorectal, hepatobiliary, and gynaecology surgery. To date data has shown decreased operating minutes and length of stay across a variety of robotic procedures including but not limited to: total hysterectomy, abdominal rectopexy and partial nephrectomy. Economic modelling suggests these outcomes have resulted in economic benefits to the system. The quantum of economic benefit is increased with higher case complexity.</p>		
Challenges:		
<p>Challenges in expansion of the program include increasing utilisation of the da Vinci robot within an established theatre template; automated data collection; validation of data.</p>		
Lessons learnt:		
<p>The importance of collaboration between clinicians, managers, executives and industry to set and implement an achievable goal. Clinical leadership is essential. High value of patient reported measures.</p>		
Consumer engagement:		
<p>A patient survey to measure patient reported outcomes pre-operatively and various stages post-operatively is offered to all patients.</p>		
Impact on patient care (clinician perspective):		
<p>Robotic surgery has allowed for surgeons to undertake a wider range of minimally invasive surgery with increased accuracy to preserve healthy tissue allowing patients to have improved recovery compared with other techniques.</p>		
Impact on patient experience (consumer perspective):		
<p>Patients undergoing robotic surgery have experienced shorter hospital stays, quicker return to normal activities, and less complications both intra-operatively and postoperatively. Early indication from patient surveys shows improved health outcomes/quality of life.</p>		
Conclusions:		
<p>The Metro North robotic surgery program has demonstrated positive benefits of robotic surgery within the public sector and has established pathways to expand the application to increase patient access, improve patient experience and outcomes and be fiscally responsible.</p>		
If not selected for oral presentation, would you be interested in submitting a poster?		Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/>