Clinician leadership. Consumer collaboration. Better care.

Reimagining Healthcare

Meeting Series Report 2022

Queensland Government

Meeting report: ‘Reimagining Healthcare’

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Contents

Chair's report ... 1

Introduction and background ... 2

Principles for reimagining healthcare ... 4

Why do we need to reform healthcare? ... 8

Keynote speaker ... 11

Reimagining Healthcare Pathways ... 12

- Specialty support to primary care and community ... 13
- Transition to home pathways ... 16
- Pathways for urgent clinical support ... 19

The enablers and barriers to reimagining healthcare ... 22

- Rapid Access Services – bridging the gap with tertiary care ... 22
- Transition to home pathways ... 23
- Virtual urgent care ... 24
- Funding and activity capture ... 25
- Digital technologies ... 26

Next steps ... 27

Special thanks ... 27

- Speakers and panellists ... 27
- Meeting organisers ... 28
- Queensland Clinical Senate Support Team ... 28

Glossary of terms ... 29

- References ... 30

Appendices ... 31

- Appendix 1 – Green Shoots – working models reimagining care now ... 31
- Appendix 2 – Meeting agenda ... 38

Acknowledgement of Traditional Owners

We acknowledge the Traditional Custodians of the land on which we work and live. We pay our respects to Elders past, present and emerging.

Chair's report

Now is the time for fundamental reform of Queensland's Health system. It is well recognised that the challenges of workforce, an increasing population and growing demand on services are competing with our ability to provide sustainable healthcare into the future. This means not only changes at a system level but also in the way we, as clinicians, go about our daily work. This type of reform is not about short-term fixes as we must move well away from the break/fix cycle of health care.

It is essential that clinicians and consumers are actively involved in discussions around reform, which is why the Senate designed a three-part meeting series with consumers and clinicians from a range of specialities and experience levels to contribute to our meetings and workshops to ultimately present a set of recommendations to the health system.

We asked our members and guests to be bold and brave in their thinking, and to imagine what great care could look like for our patients right now and over the next 5 years. How can we provide care closer to people's homes that is timely, consumer centred and sustainable?

Throughout the COVID-19 pandemic, we saw what was possible. Ideally, we want a lot of that change to stay – but what fundamental system barriers need to be addressed to scale and support these models into the future?

Our first session focused on the 'why' – the burning platform for change and in this report, you can read the compelling thoughts of our Director-General, Shaun Drummond, our Health Reform Clinical Lead, Dr Liz Whiting, and health consumer Zehnab Vayani about why change is critical right now. From this meeting we were able to take forward an understanding of what matters to our consumers—timely, high value care that is close to home. We also pin-pointed the great things we have to build on—our passionate workforce, virtual care and our engaged consumers who are willing and able to participate in co-design.

In our second meeting we focused on 'What' and looked at a number of excellent models of care that need system effort to enable them to scale at a statewide level. We used design thinking with Clinical Excellence Queensland and Queensland University of Technology Bridge Labs, to reimagine three consumer experiences to positively transform the experience away from waiting lists and hospital centred care into something that is far more accessible and responsive.

In our third and final meeting, we focused on 'How', and it was from this meeting that we ultimately landed on the recommendations we have presented to the Director-General and the Queensland Health Reform Office. These recommendations focus on a **more direct relationship between specialty teams and primary care**, with rapid specialty access pathways, models for in-home and shared care, and streamlining urgent care pathways for consumers.

We have a really big opportunity right now in Queensland to make vital and lasting change for future generations— to leave a legacy of an accessible, high quality and sustainable health system.

Dr Tanya Kelly
Chair, Queensland Clinical Senate

Introduction and background

The Senate meeting

The Queensland Clinical Senate hosted a series of three meetings to explore 'Reimagining Healthcare'. Right now, in the context of significant enablers for change—the post-pandemic experience, digital disruption, and Queensland Health's major reform program—the Senate took the opportunity to bring together senior clinicians, consumers and healthcare executives to discuss and ultimately contribute to the state's healthcare reform agenda, with the Reform Office being actively engaged throughout.

There are many areas of opportunities to reimagine healthcare, from prevention through to urgent care. In this series the Queensland Clinical Senate focussed on the relationship with the public health system and primary and community services, in recognition that public hospitals are part, but not all of the healthcare system and that better collaboration with our major partners in healthcare, with its many challenges - is a goal worth pursuing.

The meetings consisted of; two virtual and one in-person two-day event. The meetings were attended by over 130 attendees and utilised a design thinking approach supported by the Queensland University of Technology / Clinical Excellence Queensland Bridge Labs and Health Consumers Queensland.

Session 1: 9 March 2022 (virtual) – The Why
Session 2: 20 April 2022 (virtual) – The What
Session 3: 2-3 June 2022 (in person) – The How

As part of, and in addition to the general Senate membership, representation included: Queensland Ambulance Service, 13 HEALTH / Health Contact Centre, Retrieval Services Queensland, the Royal Australian College of General Practitioners, the Australian College of Rural and Remote Medicine, Telehealth Emergency Management Support Unit, Health Consumers Queensland, the Primary Health Networks, the Queensland Aboriginal and Islander Health Council, the Royal Flying Doctor Service, all Hospital and Health Services and all Queensland Clinical Networks, including the Queensland Aboriginal & Torres Strait Islanders Clinical Network and the Queensland Digital Health Improvement Network.

The recommendations from this meeting series are advisory and represent a collation of clinical and consumer views and experiences. They are intended to provide advice and complement other activities within the system, such as the work of the Reform Office.

*See Appendix 2 for meeting agendas

Concurrent activities, strategies, and recommendations in the healthcare landscape

1. Queensland Health Reform agenda
2. *2020-25 National Health Reform Agreement*
3. *Future focused primary health care: Australia's Primary Health Care 10 Year Plan 2022-2032*
4. *Unleashing the Potential: an open and equitable health system*
5. *Advice on Queensland Health's governance framework (McGowan Report)*
6. *Department of Health Strategic Plan 2021-2025 (2022 update)*
7. *Advancing health service delivery through workforce: A strategy for Queensland 2017 – 2026*
8. *My health, Queensland's future: Advancing health 2026*
9. *Rural and Remote Health & Wellbeing Strategy 2022 – 2027*
10. *Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 206-2026*
11. *Queensland Health Virtual Healthcare Strategy 2021*
12. *Queensland Health Telehealth Strategy 2021 – 2026*
13. *Digital Health 2031 – A digital vision for Queensland's health system*
14. *Prevention Strategic Framework 2017 – 2026*

Principles for reimagining healthcare

1. Timely specialty support for primary care early in the care journey enables better care planning and delivery.

Delay can cause harm. Delay, whether through long outpatient and surgery wait times, long Emergency Department (ED) wait times or ambulance ramping, can result in clinical deterioration, duplication of investigations, and increased clinical complexity with the involvement of more care teams and care plans, as the patient seeks alternatives whilst waiting.

Where required, early specialty advice and support to primary care, can:

- Provide support to primary care practitioners to enable care to be maintained in the community
- Facilitate direct in-person review and direct hospital admission
- Ensure the most appropriate care is provided (e.g. redirect to allied health, nursing or a more appropriate alternative specialty team)
- Provide early (interim) care advice, whilst a person waits for outpatient review

Senior advice should be front-loaded in clinical management decisions. Interdisciplinary teams and clinical roles at top of scope are fundamental in the delivery of these contemporary models.

Desired safety, quality and efficiency outcomes should be clearly articulated and monitored (including the use of patient follow-up) as part of the design of novel clinical pathways along with the use of contemporary implementation science when scaling programs.

2. Addressing system barriers enables successful models to scale.

The potential for health improvement is often viewed through the lens of successful models operating within clinical units. These models often form part of a higher-level patient care pathway that are subject to system barriers and enablers. Local success is often supported by clinical champions who work around system level barriers and motivate colleagues to adopt new workflows. With system level barriers persisting, it is unlikely that these models will scale as the influence of clinical champions only goes so far, and tolerance of workarounds only lasts for so long.

In order to scale successful models, system level barriers (such as funding models, lack of care continuity between agencies and care teams, lack of information exchange between digital systems etc) need to be addressed.

3. A high level of collaboration is essential - across care teams, agencies, and levels of government.

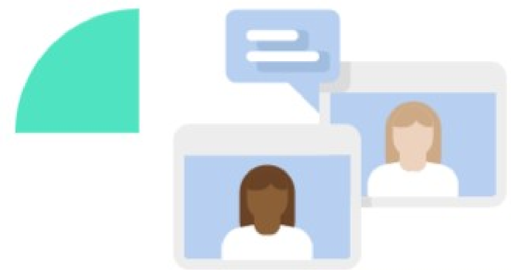
To deliver timely care to the community, many teams and systems need to work together, including commonwealth and state funders, primary care, community, and hospital-based clinical teams and many other agencies that share parts of the consumer journey across the care continuum.

Clinicians, consumers, and system managers all have a key enabling role and without commitment from all parties and a reliable framework for engagement, it is unlikely that novel pathways that operate at-scale will come to fruition.

4. Consumers must be deeply involved in co-design and feel connected, informed, and confident when using the system

Consumers should be well connected to their healthcare teams, actively involved in their own care, and empowered to make decisions about what is important to them. Consumers must be deeply involved in the design of that system. Navigating the health system can be an incredible challenge. Consumers need a system that is straightforward, with seamless transitions between care teams. Consumers should be presented with available options in both urgent and planned care settings. Through consumer co-design enables the design of pathways that are intuitive, navigable and provide the greatest opportunity for informed decision making, consumer choice and confidence.

Queensland Clinical Senate Reimagining Healthcare



Six Key Recommendations

1. **Scale Rapid Access Services** for direct and early specialty team support:
   - For patients known to the specialty
   - For new patients identified in primary care

2. **Scale specialty team virtual in-home care** following in-hospital admission
   - to complement generalist Hospital In The Home (HITH) services.

3. Incorporate specialty / general practice and community **'shared care'** models, as part of the transitional pathway home

4. Support specialty teams to have **'high availability care' roles** within clinical teams, including: GP support, rapid access in-person review, direct admission, virtual ward rounds etc.
   - Reconfiguration of multidisciplinary team activities within the working day, with recognition of these activities within funding models.
   - Align service delivery to **peak demand** e.g., 'twilight clinics' and weekend services, where required.

5. Streamline a **single multi-agency pathway** for urgent care.
   - Establish a forum for collaboration.
   - **Streamline a single virtual front door** and incorporate **virtual urgent** care.
   - Align **clinical pathways** of Queensland Health and care partners.

6. **Align State and Commonwealth government**
   - planning, funding, and reform processes, particularly in relation to the interfaces in healthcare.
   - Formalise the relationship between primary care, community care and Queensland Health.

Ten supporting recommendations

7. Advocate for **Commonwealth government recognition** of the critical importance of funding the **additional time** required for primary care to engage in:
   - 'Rapid Specialty Access' models.
   - 'Shared Care' models and multidisciplinary team meetings.

8. Recognise **'hospital to primary care' advice** within activity-based funding models.

9. Incorporate **patient outcomes** in funding models.

10. Digitally enable **information sharing and engagement** between Queensland Health and **clinical partners,** where access to the clinical information follows the patient journey.

11. Enable consumers to access their data and **actively interact** with their clinical information, to support a high level of engagement with their care, and sharing of information with their care teams in a timely manner, including through **consumer portals**.

12. Rollout connected digital health systems **statewide**.

13. Support a rapidly reconfigurable digital solution, to inform **consumer choice** and **access to services based on personal healthcare needs.**

14. Change the title of 'Discharge Summary' to reflect the transition home.

15. Advocate for initiatives that boost and sustain both **after-hours and rural and remote general practice**.

16. Support general practice through **rotational workforce** models between hospital and primary care.

Why do we need to reform healthcare?

Mr Shaun Drummond, Director General
Queensland Health

'As the leaders of the health system, it is incumbent on us to leave a legacy of sustainable clinical services for the future people who will be working inside the system and sustainable models that provide effective care for our population. That is our burning platform for reform.'

- In 2020, there were 25 million residents in Australia. By 2050, it is predicted that we will have 47 million people living in Australia – a 90 per cent increase in population.
- In 2020, 80 per cent of the population was in the workforce. By 2050, only 70 per cent of the population will be in the workforce.
- So at that time, our population will have gone up 90 percent, we will have only increased the workforce by 65 per cent.
- This is a people and workforce issue, not a budget issue.
- If the increased activity that we have seen over the past five to six years continues, by 2050 we will be doing 250 per cent more activity than today – four times the increase in activity than the change in our workforce. Effectiveness of treatment has also increased demand over time.
- COVID showed us how agile we can be in crisis, how quick we were to make decisions, how we streamlined processes.
- When the crisis is over, we could easily slip back into old behaviours because we no longer have that urgency.
- But I believe the urgency has never left. Because when I look at our legacy as leaders in health, I don't want to leave a broken system. If we don't make the strategic changes now, that's what we'll be leaving.
- It is a huge challenge, and it is multifactorial—the solution isn't about passing the work to someone else.
- We are going to have to be brave, we're going to have to be bold and we're going to have to accept risk on change and reform.
- We are going to have to try new things and disinvest in other things.
- There is a lot of opportunity to reimagine.

Dr Liz Whiting, Clinical Lead
Healthcare Reform, Queensland Health

'We have a universally accessible healthcare system and what's really in jeopardy here is the sustainability of that free and accessible care, for everyone – that is profound in terms of what is at stake.'

- The purpose of reform must be sustainability.
- We have a challenge in terms of continuing our health service as we know it from a funding, workforce, infrastructure perspective, and the services we deliver.
- In the developed world we are all in the same position in terms of the challenges—there is a global trend.
- The Reform Office is considering the whole health system, not just Queensland Health. This is whole-of-system reform.
- We are not in crisis, but we do need reform. We need to sit up and take notice and do something differently.
- The system is currently judged on access and flow, particularly with ambulance ramping, access to emergency departments and waiting lists. While we have this immediate imperative, we also need to think about the big picture and think differently.
- In the Reform Office, we are trying to look at the root of the problem.
- The solution to the problem is not working harder and faster. We have complex and interlinked problems and challenges, and as we think about it, we need to think about patient stories and get back to basics—what does good care look like?
- Exemplar models of care across the globe are all looking at the same things—integrated care, person-centred care, good data, and virtual care.
- We need to be thinking about outcomes and not activity.
- The reform team is currently in a 'discovery' phase and developing a blueprint for reform – direction setting that leaves us open to explore.
- What we do now will set us up for meaningful big system reform over the next five to 10 years.

Ms Zehnab Vayani
Healthcare Consumer Advocate

'Although we've got a really good health system here in Australia, there's so much more that can be done to make the system value-based, timely and patient-centred for better health outcomes.'

- From a consumer perspective, some of the principles that are important to me are timely and value-based healthcare.
- In terms of value-based care, we need the consumer to be empowered to agree and/or disagree to care; it's okay for the consumer to say no and make the decision they feel is appropriate.
- Timely care – especially now as care is being switched back on from COVID-19, people are on waiting lists and it's really important that they are not waiting too long as this really influences health outcomes and can make things more complex. It can also affect mental health.
- Timely care can mean many things from a consumer perspective. From systems change, it could be a GP liaising over the phone with a specialist for a short consult to do a simple drug change rather than waiting on a wait list for an outpatient clinic for example. It can also look like adequate information.
- Virtual health is a hugely important resource for rural and remote health, but there is so much work to be done in this space, such as infrastructure for high-speed internet, technology literacy and to be equitable for all Australians.
- Health literacy – holistic and situationally focused. There needs to be the capacity in our healthcare system to cater for people of all abilities to enable the consumer to make the right decision.
- We really need to look at the whole system from a social determinants perspective with the consumer at the centre of this.
- Seamless information sharing would reduce the burden on carers and consumers being able to navigate and connect supports.
- We have such a fragmented system, it is difficult to connect, especially for complex conditions.
- At the centre of all of this is co-design with consumers. All of these changes and innovations need to be done in co-design with consumers.
- Ultimately, a reimagined healthcare system to me would result in consumers who are connected, informed and confident about their healthcare and more likely to be active in their health and wellbeing, allowing them to make decisions about what's important to them, with the ability to navigate from tertiary to primary care seamlessly.

Keynote speaker

Prof Erwin Loh, Group Chief Medical Officer & Group General Manager of Clinical Governance, St Vincent's Health Australia

Healthcare has traditionally centred around the provider and despite the best intentions to move towards consumer-centred care, are we there yet? Do we really have truly patient-centred care?

From a consumer perspective, care can often look confusing with multiple teams 'orbiting' around themselves, not talking to each other, seemingly putting the provider in the centre. Redesigning these systems with consumers at the centre, will align the care, the teams and the environment around the one thing that really matters, good patient outcomes.

The St Vincent's experience of patient-centred care includes real time consumer feedback benchmarking against Australian and international data. Staff access real time patient feedback about quality of care.

How do we do this? Ultimately it is about attitude and challenging the way we 'do health'. It's not going to happen overnight but if we believe that there is another way that we can do things and challenge the status quo, change can happen. Bit by bit, ward by ward, department by department we can work together to really co-design our system to really keep patients at the centre.

You can read more from Prof Loh here: https://insightplus.mja.com.au/2022/23/patient-centred-care-a-copernican-shift-to-the-centre-of-gravity/

Reimagining Healthcare Pathways

Recommendations 1 through 4 outline models that provide a more direct clinical relationship between specialty teams, primary care and consumers. Specialty Rapid Access Services are designed to provide early advice in a timely fashion, rather than requiring all patients who require non-urgent specialty advice, to go through to a classical outpatient appointment and review.

When connected these models form a pathway that continuously supports primary care.

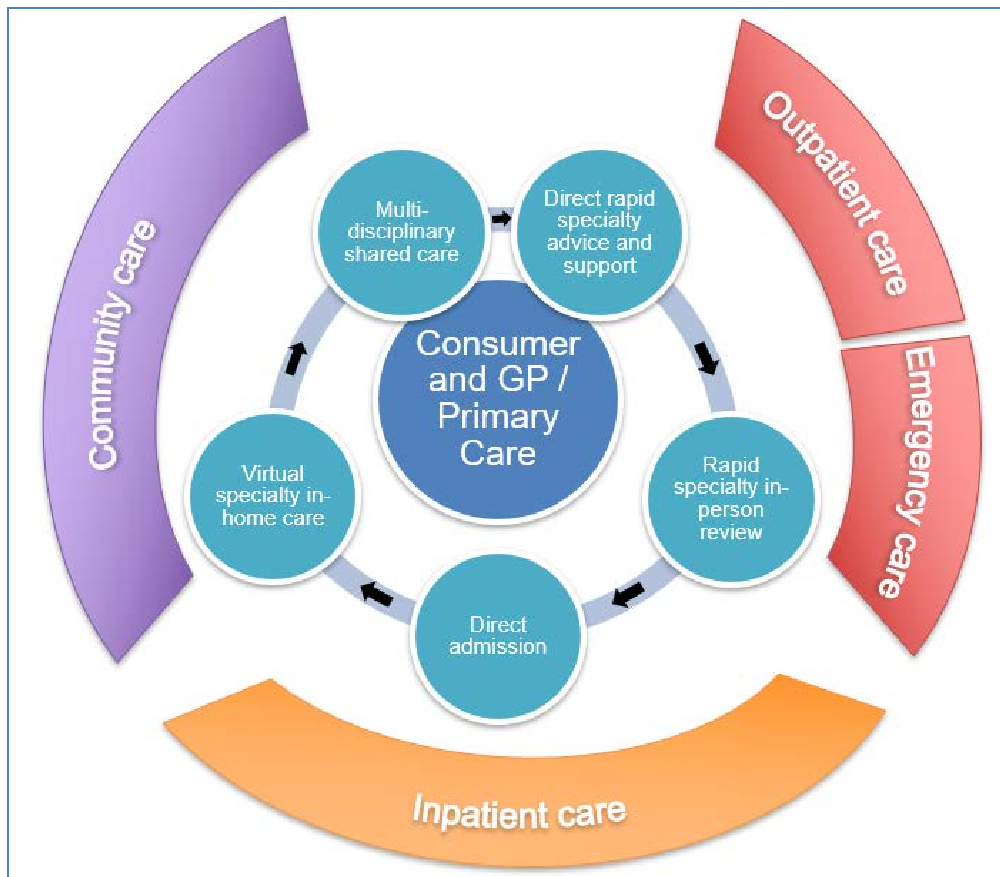


Figure 1 - Specialty support pathways (inner flow) providing a closer connection with primary care, supported by classical services (outer circle)

Specialty support to primary care and community

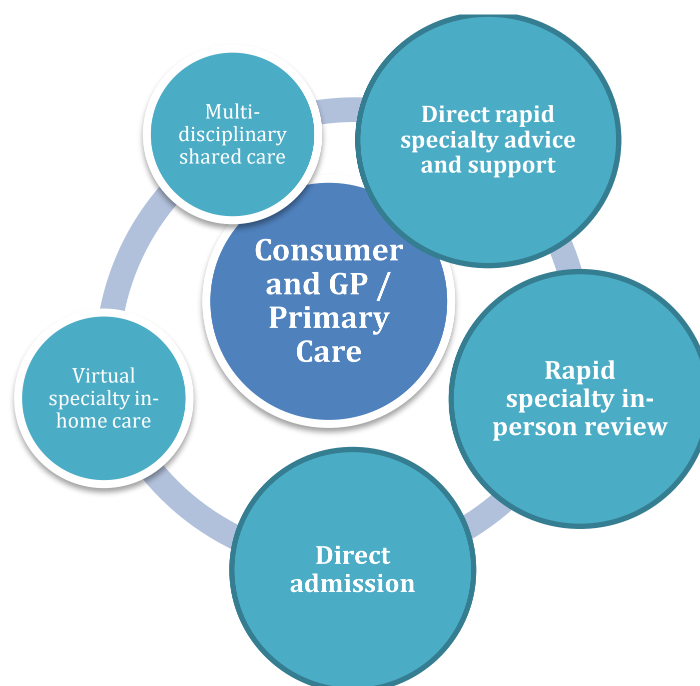


Figure 2 - Reimagining Healthcare Pathways with Rapid Specialty Access components enlarged

Description of major pathways

There are three key components of Rapid Access Services:

Figure 3 – Components of Rapid Access Services

Rapid Specialty Advice and support include (but are not limited to) two major clinical pathways:

1. **Rapid Specialty Access Services – Known patient:** where the patient is already known (e.g. recently discharged or currently involved in regular outpatient review) to a specialist clinical team. The pathway enables the patient to make direct contact with clinical teams (subject to the local model) to access advice, physical review and / or direct admission.

2. **Rapid Specialty Access Services – New Patient**: where the new and undifferentiated patient is not currently engaged with specialist clinical teams. This includes two sub-pathways:
    1. enables the general practitioners to contact clinical specialty teams (e.g., via a virtual urgent care or a generalist supported phone number / digital system) to access advice, physical review and / or direct admission.
    2. enables the emergency department to refer patients for scheduled rapid specialist review (generally next day) at a Rapid Access Review Clinic where clinically appropriate.

    Key features of these pathways (subject to local variation) include:
    - Single and / or direct point of contact.
    - High availability clinician/s within specialist teams to undertake review and management
    - Review could be synchronous or scheduled in a short timeframe
    - Physical space to enable clinical review, investigation, and initial management, with clinical governance by relevant specialist team
    - Direct admission processes.

Consumer perspective

The referral pathway from GP to specialist

67-year-old Mae lives in Tambo, a small rural town on Bidtjara land about 3.5 hours away from Longreach.

Mae has had a hard time establishing a relationship with a GP over the years, with what feels like a constant revolving door of clinicians in Tambo. Her care has been very fragmented, having to travel long distances and bouncing between GPs and specialists.

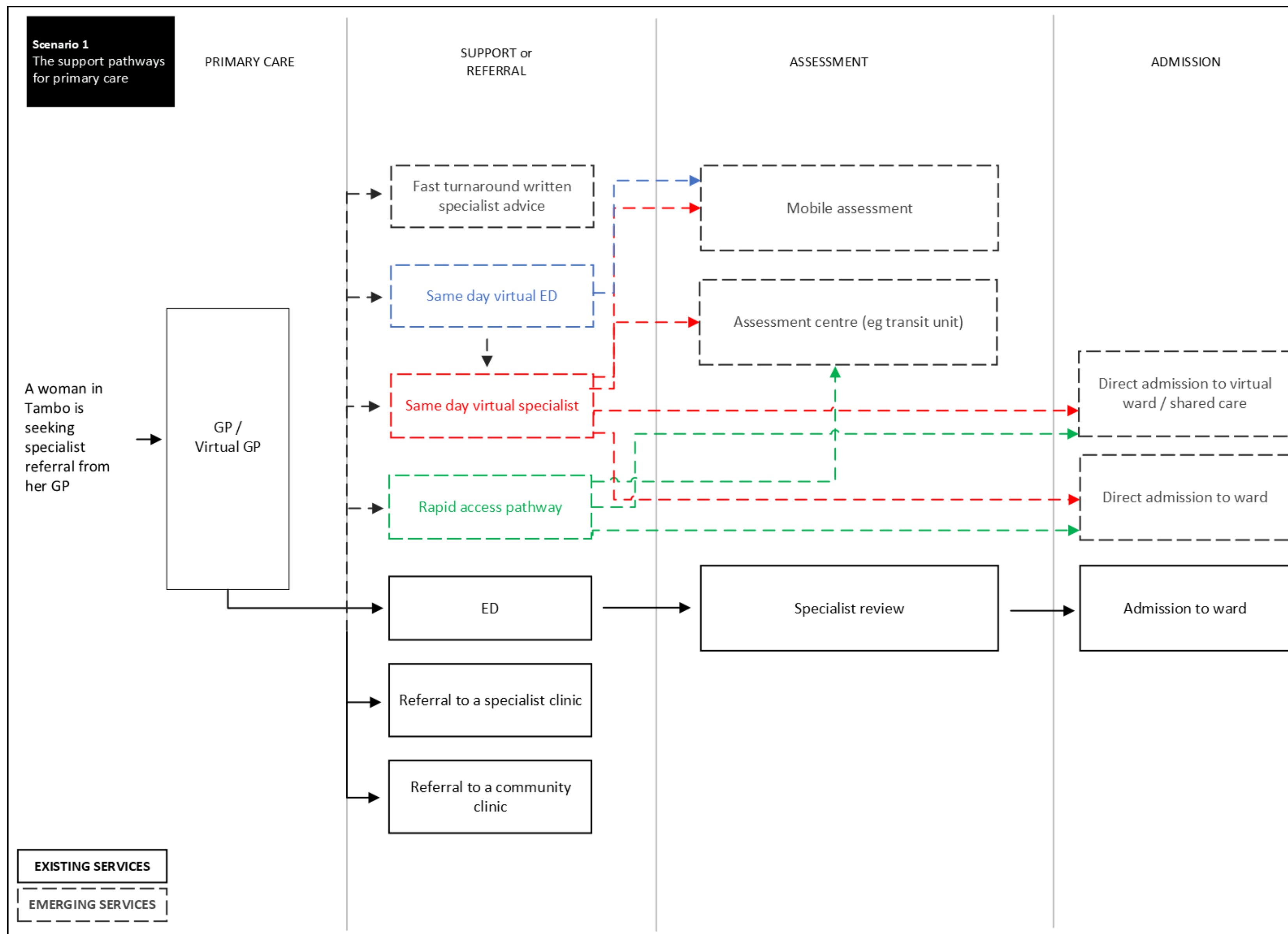
Mae has osteo-arthritis, diabetes and is overweight. With her previous knee surgery, after spending months on a waiting list, she travelled 12 hours to Rockhampton for her specialist appointment - only to be told by the orthopaedic surgeon that she needed to lose weight before being considered for the surgery.

Mae is now experiencing pain in her other knee and is concerned this knee may also need to be replaced. Mae knows she will need months of appointments, rehabilitation, and recovery. Mae is also increasingly concerned about her diabetes and might need to see a dietician or even an endocrinologist.

Mae feels isolated, she wishes the process was simpler and there were other options.

This scenario was designed with a consumer, inspired by their own lived experience, to prompt exploration of issues that are important to them. Delegates were asked to redesign each of these experiences and present what they could look like in 2027.

Specialty support to primary care and community pathway (wall map) The following wall map (revised following input from the meeting) was used to facilitate interagency discussion about the reach of involved teams, their areas of greatest expertise and value, the greatest challenges, and opportunities for collaboration



Transition to home pathways

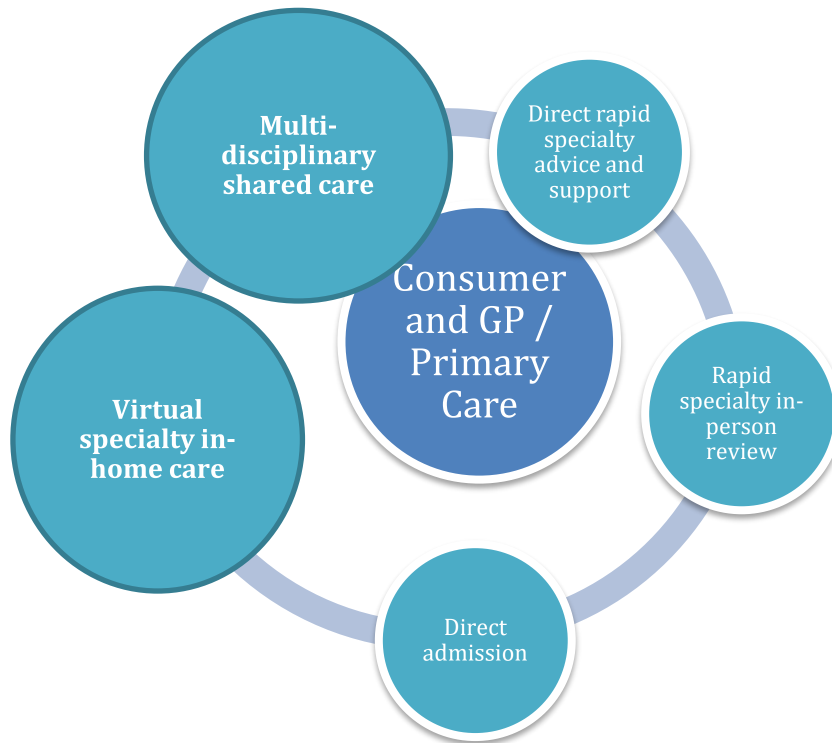


Figure 4 - Reimagining Healthcare Pathways with Transition to Home components enlarged

Description of pathways

The pathways from inpatient care to home have a significant interface between hospitals, primary care and other community supports. They are all dependent on high quality transition of care planning. Patients benefit from a cohesive approach between hospital-based specialty teams, primary care and community-based teams.

Transition pathways from inpatient care to home currently include: transition to Hospital in the Home services, transition to community based and centre-based care. Specialty team in-home care could complement existing services.

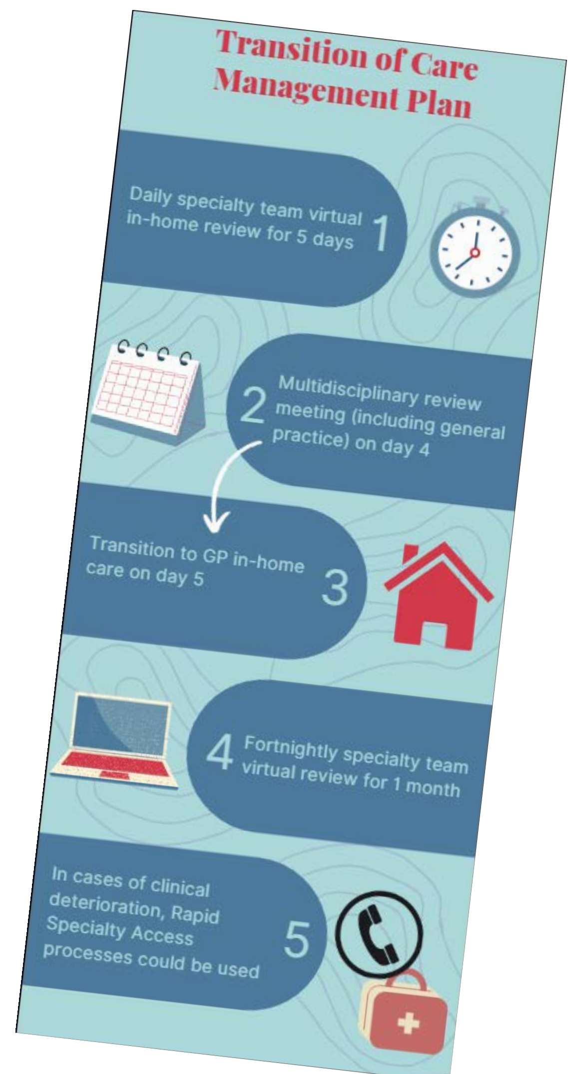
Specialty team involvement in virtual in-home care, enables a greater array of options depending on the clinical context such as:

- Generalist Virtual care – stand alone
- Generalist model with specialty shared care
- Specialty team virtual care model with generalist support
- Specialty team virtual care – stand alone

Specialty team in a virtual in-home care results in greater continuity of care at the point of transition home and may result in earlier transfer from in-hospital to in-home care.

Clinical governance during this transitional period could be retained by the hospital-based specialty team (to maintain continuity of care), transferred to generalist teams or community-based care team or transferred to the general practitioner using a shared care model.

Planning for the transition home could take the form of a Transition of Care Management Plan, where the transitional stages are outlined.

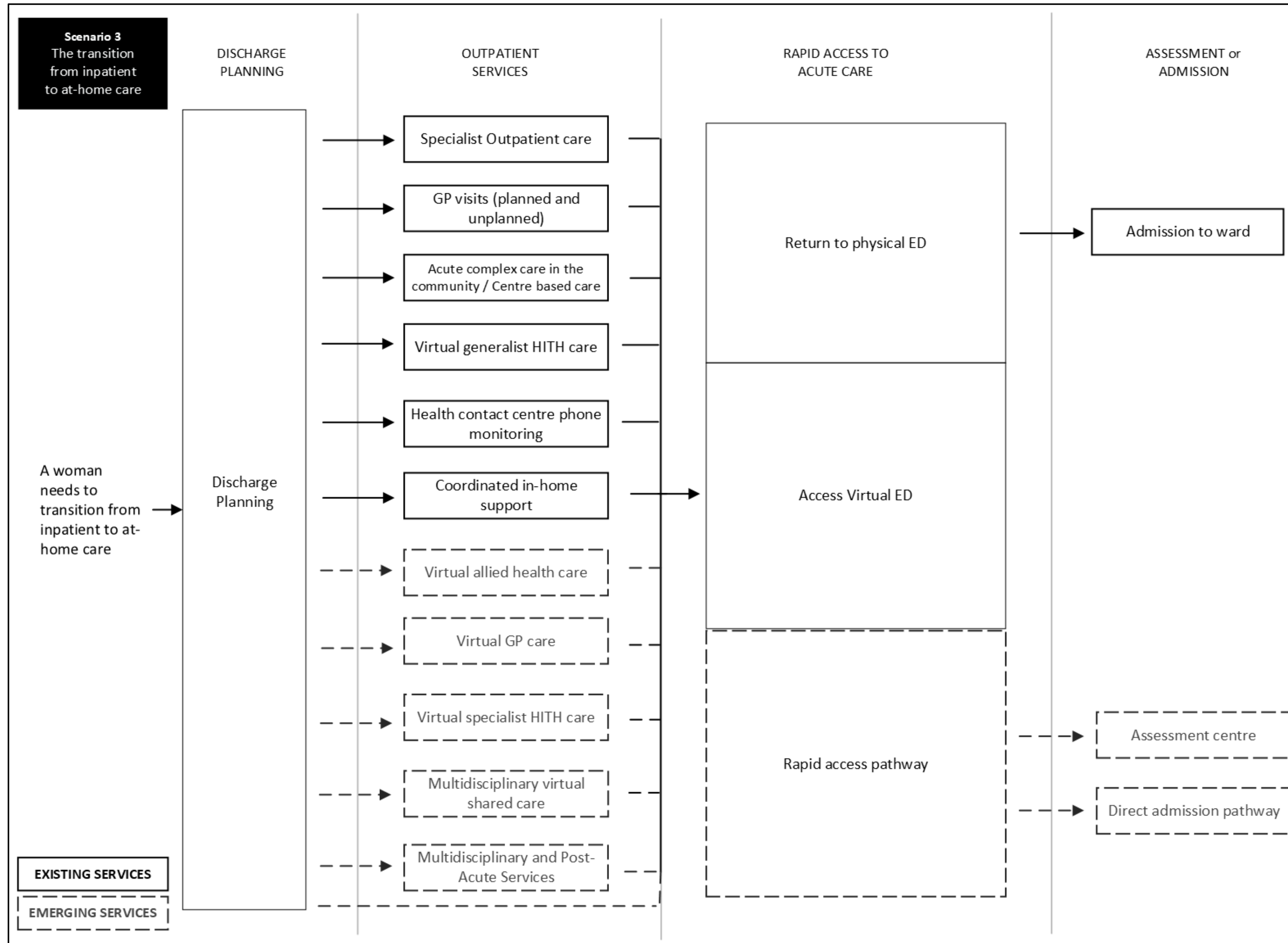


Example Plan:

- ✓ Daily specialty team virtual in-home review for 5 days
- ✓ Multidisciplinary review meeting (including GP) on day 4
- ✓ Transition to GP in-home care on day 5
- ✓ Fortnightly specialty team virtual review for 1 month.
- ✓ In cases of clinical deterioration, review through Rapid Specialty Access Service.

Transition to home (wall map)

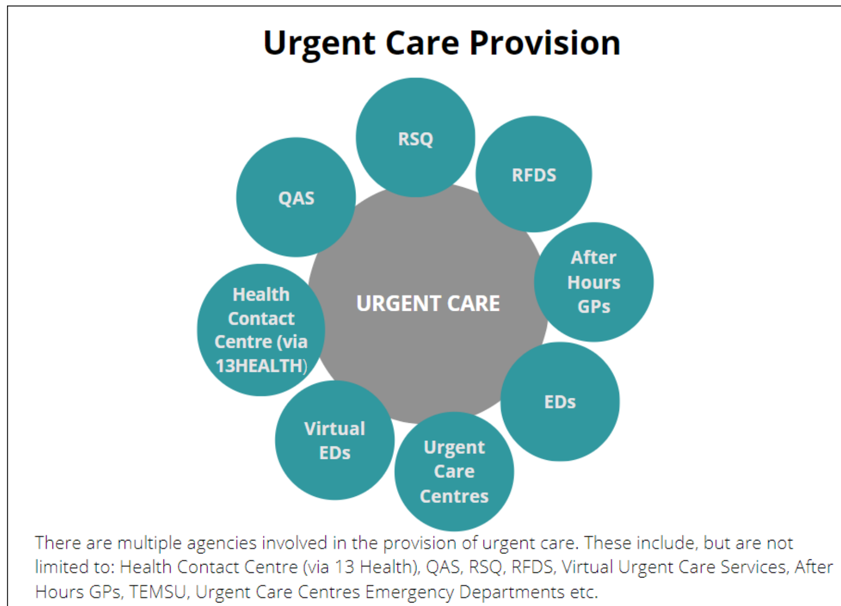
The following wall map (revised following input from the meeting) was used to facilitate interagency discussion about the reach of involved teams, their areas of greatest expertise and value, the greatest challenges, and opportunities for collaboration.



Pathways for urgent clinical support

Description of pathways

There are multiple agencies involved in the provision of urgent care from first point of contact to receiving the required care at the right place in the right timeframe.



There are multiple agencies involved in the provision of urgent care. These include, but are not limited to: Health Contact Centre (via 13 Health), QAS, RSQ, RFDS, Virtual Urgent Care Services, After Hours GPs, TEMSU, Urgent Care Centres Emergency Departments etc.

Both generalist and specialty team-based clinicians have important roles in providing virtual urgent care. Desired safety, quality and efficiency outcomes should be clearly articulated and monitored as part of the design of urgent care pathways.

Consumer perspective

The experience of being unwell, at home, at night

Will is 15 years old. After coming home from school, he has had a worsening headache. After dinner, he informs his parents that his headache is now quite severe. He is upset and in distress.

His parents are not exactly sure where to turn for advice - as their GP clinic was closed, they did a quick google search on headaches in adolescents.

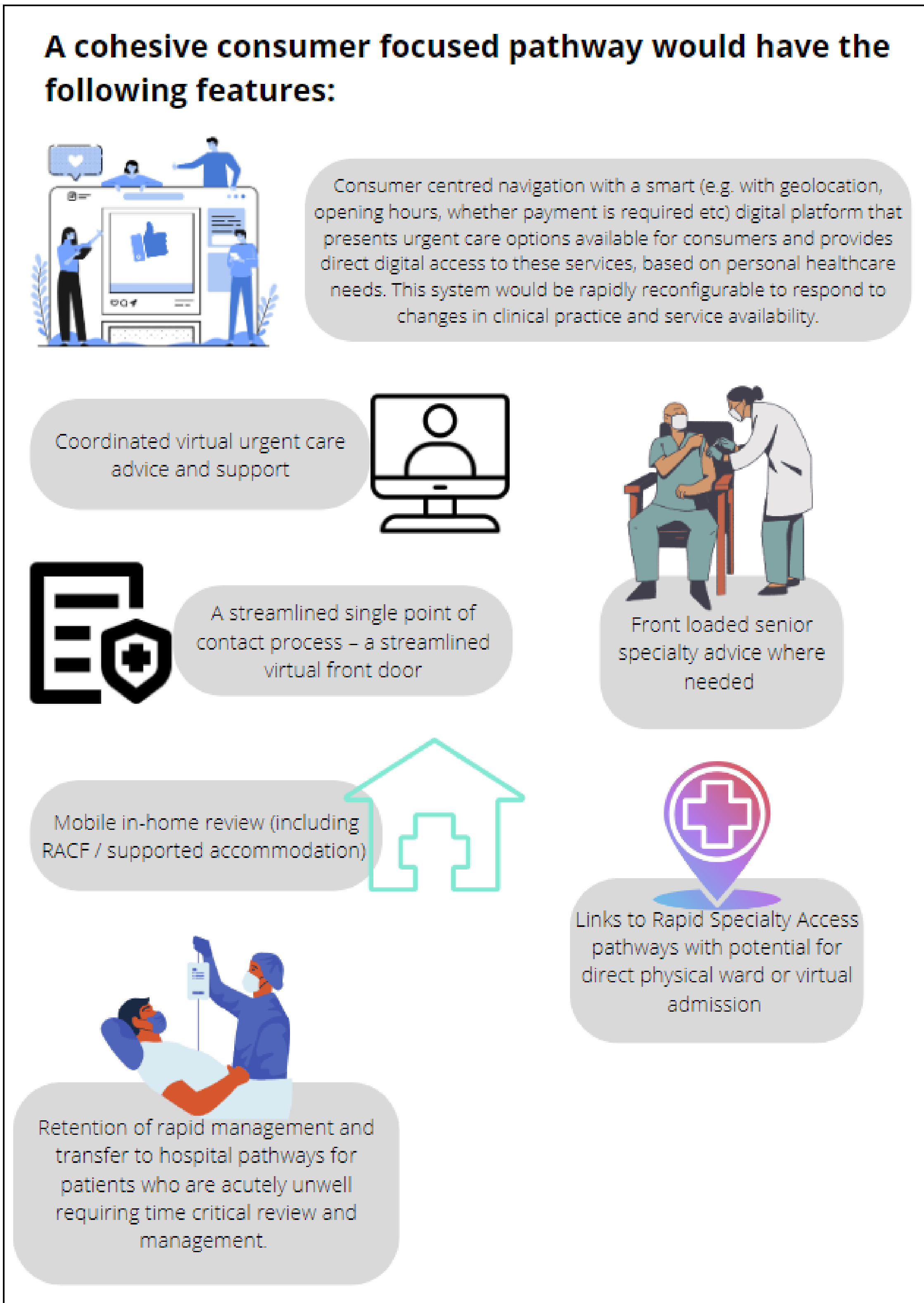
At 8pm, they rang 13HEALTH who reassured them about how to monitor the situation, however Will's headache is worsening.

It's a cold evening and the local emergency department is known to be very busy - they rang the after - hours doctor, but the predicted wait time was 3-4 hours.

At 10pm, his parents take him to the emergency room; he speaks to the triage nurse who performs a review and asks them to take a seat in the waiting room.

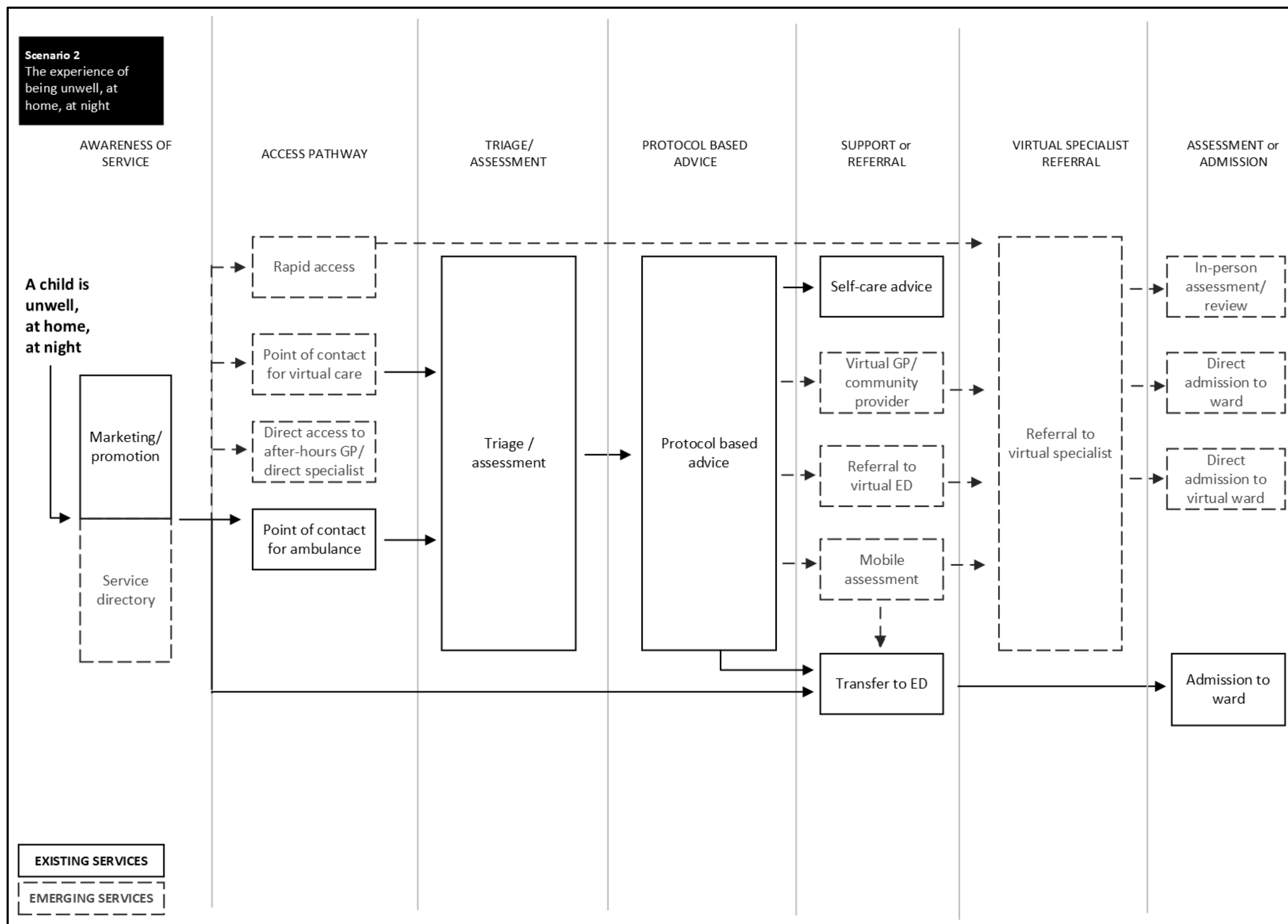
This scenario was designed with a consumer, inspired by their own lived experience, to prompt exploration of issues that are important to them. Delegates were asked to redesign each of these experiences and present what they could look like in 2027.

High patient satisfaction has been reported for virtual urgent care visits (Khairat S, 2021). A cohesive consumer focused pathway would have the following features:



Pathways for urgent care (wall map)

The following wall map (revised following input from the meeting) was used to facilitate interagency discussion about the reach of involved agencies, their areas of greatest expertise and value, the greatest challenges, and opportunities for collaboration.



The enablers and barriers to reimagining healthcare

Rapid Access Services – bridging the gap with tertiary care

Enablers

- High level of commitment and leadership from senior clinical leaders and hospital executive teams.
- Engagement of primary care and hospital-based clinicians and consumers in the design and change process.
- Culture and Change – Recognition that these models will result in a reprioritisation of work and changes in the structure of daily work activities, particularly for specialty units, resulting in the need for high levels of clinical engagement.
- Recognition of the important role and high value of primary care services.
- System level implementation planning to enable roll-out of Rapid Access Specialist Services at scale.
- High availability experienced clinicians within specialty teams to respond to Rapid Specialty Access requests.
- Access to high availability virtual generalist or emergency clinicians for new / undifferentiated patients as part of the 'new patient' rapid access pathways.
- Physical areas (appropriately staffed) to enable clinical review, IV access, early treatment, rapid access to pathology and radiology, where clinically appropriate.
- Clarification of the medical legal implications for virtual / phone based clinical advice.
- Success of changes introduced in response to COVID-19 along with new rapid access models.
- Alignment of the processes of multiple parties and clinical teams involved in the Specialist Rapid Access Services (and potential alignment to other virtual urgent care access points) to simplify the patient experience and reduce duplication of processes (e.g. to avoid multiple access phone numbers and triage processes).

Barriers

- Limited structures (including resourcing, physical infrastructure, rostered staff availability) for rapid access specialist review or admission.
- Limited time for primary care teams to engage with Rapid Specialty Access pathways
- Limited funding structures for clinician-to-clinician advice.
- Transitional impacts – the risk of increased clinical workload as specialist rapid access reviews would be required along with high demand for outpatient review for those currently on waiting list.
- Workforce shortages across the healthcare sector, including capacity constraints in primary care.

Transition to home pathways

Enablers

- Engagement of primary care and hospital-based clinicians and consumers in the design and change process.
- Development of models (resources, processes, clinical guidelines, technology, quality assurance and monitoring) for maintenance of virtual specialty team care upon transition home.
- Integration of specialist and primary care while the patient is at home using shared care models
- Top of scope roles e.g. advanced practice nurses supporting medical specialists, particularly in specialty virtual in-home care.
- Alignment of the multiple agencies involved in Transition to Home pathways to simplify the patient experience, reduce duplication of processes and optimise the contribution of the strengths of individual teams in the pathway.
- Consumer desire for continuity of care.
- Aligned workflows with specialist teams, generalist HITH teams, general practice and community and centre-based services.

Barriers

- Multiple care teams and agencies involved in the pathway home.
- Nomenclature – Service naming implies in-hospital only services e.g.: specialist **inpatient** service
- Limited digital information sharing
- Limited funding structures for shared care.

Virtual urgent care

Enablers

- Consumer desire for greater choice and simplified systems.
- Engagement of clinicians and consumers in the design and change process
- Alignment of the multiple agencies involved in Urgent Care pathways to simplify the patient experience, reduce duplication of processes (e.g. reduce multiple call centres and triage processes) and optimise the contribution of the strengths of individual agencies in the pathway.
- Aligned clinical workflows and shared clinical information across agencies to enable a streamlined urgent care pathway which minimised 'clean-slating' - where consumers need to redescribe their condition and go through duplicated triage and review processes as they move between agencies and care teams.
- Consumer desire for integrated care.

Barriers

- Limited and varying pathways for virtual urgent care review
- The complexity (recognising also, the high value of these groups) associated with multiple agencies involved in urgent care such as Health Contact Centre (HCC), Queensland Ambulance Service (QAS), Retrieval Service Queensland (RSQ), Telehealth Emergency Management Support Unit (TEMSU), General Practice, Minor Injury and Illness clinics, HHS lead Virtual Emergency Departments, Community Controlled Health Services, Residential Aged Care Facility Support Service (RASS). Requires a high level of coordination.
- Limited digital information sharing
- Lack of clear nomenclature and understanding of the concept of virtual urgent care

Funding and activity capture

Enablers

- The capture of clinician-to-clinician advice as an occasion of service
- Voluntary nomination of the patient's GP and care team, that can be rescinded at any time by the patient.
- Workflows that digitally capture newly recognised 'occasions of service' as activity
- Primary care funding support for GP access to high availability virtual advice and support.

Barriers

- Lack of a definition of an 'occasion of service' for phone-based (or virtual) specialist advice to GPs or community-based health practitioners (including 13 HEALTH), resulting in an ability to 'see' or fund the activity.
- Funding conflicts that inhibit GPs from participating in shared care models (including multidisciplinary team meetings) when patients are admitted as inpatients to a hospital virtual ward, on the same day.
- Lack of funding for time required for GPs to make and receive advice and support from virtual specialty services.
- Lack of incentives for after-hours general practice.
- Lack of integration between state and commonwealth health funding in relation to urgent care, specialist advice and support for GPs and shared care.

Digital technologies

Enablers

- Connected digital systems in place across the state
- Digital information sharing between Qld Health and clinical partners, where access to the clinical information follows the patient journey, within relevant privacy provisions.
- A smart and rapidly reconfigurable digital platform that presents the healthcare options available for consumers and provides direct digital access to these services.
- Enable consumers to access and actively interact with their clinical information and care teams e.g., through consumer portals.

Barriers

- Lack of information sharing between Qld Health digital systems and care partners, limiting access to clinically relevant information and active engagement between teams throughout the patient journey
- Lack of workflows that enable new patients to be digitally registered in the system for ad hoc phone advice to GPs, resulting in an inability to document the consultation in the clinical record.
- Inability to document ad hoc phone advice could have medicolegal implications
- Clinical information held by various agencies results in cumbersome processes for consumers to access this information and share this information between their clinical teams.
- Lack of policies and digital systems to enable dynamic consumer consent to information sharing

Next steps

The recommendations in this report will be presented to the Executive Leadership Team for Queensland Health. The Senate will seek updates on the implementation of endorsed recommendations to keep members and other interested parties informed of progress and provide further input into bodies of work as appropriate.

To find out the progress of this meeting and recommendations, please contact the Senate Secretariat via email on qldclinicalsenate@health.qld.gov.au.

Special thanks

Speakers and panellists

Dr Helen Brown, Deputy Director-General, Clinical Excellence Queensland

Dr Ellen Burkett, Emergency Medicine Consultant, Princess Alexandra Hospital

Dr Satyan Chari, Program Director, CEQ Bridge Labs, Clinical Excellence Queensland

Ms Toni Cunningham, Senior Director, Healthcare Purchasing, and Commonwealth Funding representative

Dr Carl de Wet, Clinical Director, Specialist Medical Services, Gold Coast Hospital and Health Service

Mr Shaun Drummond, Director-General, Queensland Health

Ms Jordan Frith, Health Consumer Representative

Mr Damian Green, Deputy Director-General, eHealth Queensland

Dr Kim Hansen, Director Virtual ED, Metro North Hospital and Health Service

A/Prof Craig Hukins, A/Prof Respiratory Medicine, Princess Alexandra Hospital

Prof Erwin Loh, Group Chief Medical Officer and Group General Manager of Clinical Governance, St Vincent's Health Australia

Professor Keith McNeil, Chief Medical Officer

Professor Evonne Miller, Director, QUT Design Lab

Dr Gaurav Puri, Staff Specialist Endocrinology, Logan Hospital

Dr David Rosengren, Chief Operating Officer, Queensland Health

Dr Sabe Sabesan, Staff Specialist, Oncology Services, Townsville University Hospital

Professor Ian Scott, Chair, Queensland Clinical Networks' Executive

Dr Mark Waters, Senior Clinical Advisor, HPSP

Dr Elizabeth Whiting, Clinical Lead, Reform Office, Queensland Health

Ms Maureen Woodward, Health Consumer Representative

Ms Zehnab Vayani, Healthcare Consumer Representative

Meeting organisers

Dr Tanya Kelly, Chair, Queensland Clinical Senate

Adj. A/Prof. Chris Raftery, Deputy Chair, Queensland Clinical Senate

Dr Erin Evans, Chair, Health Consumers Queensland

Ms Melissa Fox, Chief Executive Officer, Health Consumers Queensland

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Queensland Clinical Senate Support Team

Mr Ian Johnson, Manager, Queensland Clinical Senate Secretariat

Ms Amanda Garbutt, Principal Project Officer, Queensland Clinical Senate

Ms Rebecca Griffin, Communications Lead, Queensland Clinical Senate

Glossary of terms

Term	Meaning
Specialty team	A multidisciplinary specialty clinical team that provides care in the context of inpatient (or virtual) admission, GP / Community advice and support (e.g. written advice, virtual support, outpatient review) often with continuing care over a period of time, within the clinical governance of medical specialists.
Emergency Team	Multidisciplinary clinicians providing Emergency Medicine services within the clinical governance of emergency physicians.
Rapid Specialty Access	Rapid Access to Specialist (Continuing Care) Teams for clinical review and management, either through written advice, virtual support, in-person review or direct admission pathways.
Primary Care	Healthcare provided in the community by providers such as General Practice, Dental, Allied Health and Pharmacy services. It includes health promotion, prevention, early intervention, treatment of acute conditions, and management of chronic conditions (AIHW, 2021).
Community Care	Services provided in the community that support patients in a community setting. These services include clinical and broader support services.
ACCHO	Aboriginal Community-Controlled Healthcare Organisation.
TEMSU	Telehealth Emergency Management Support Unit – provides telehealth support for urgent care in rural and remote areas.
Shared Care	A process where care is shared by two or more clinical teams over a period of time, most often between specialty and generalist care providers.
Known patient	In the context of Rapid Specialty Access Services – a patient who has been recently discharged or currently involved in regular outpatient review.
High availability roles	Roles where access to care is provided either on-demand or scheduled within a short timeframe.
Clean-slating	A process whereby consumers need to redescribe their condition and go through duplicated triage and review processes as they move between agencies and care teams, owing to a lack of information sharing and non-aligned clinical processes.

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Appendices

Appendix 1 – Green Shoots – working models reimagining care now

There are many innovative working models within Queensland and beyond, that are reimagining healthcare now (McGeoch G, 2019) (The Prince Charles Hospital, 2018) (Clinical Excellence Queensland, 2022) (NSW Government Agency for Clincial Innovation, 2022). Several of these models are described below.

Community Based Multidisciplinary MND Clinic

Presenter: A/Prof Craig Hukins, A/Prof Respiratory Medicine, Princess Alexandra Hospital

An integrated community based (home delivered) model of care for people with Motor Neurone Disease (MND).

Why

Traditionally, the model of care for this complex patient group involved frequent hospital attendance at multiple clinics, high rates of unplanned admissions (often end of life care) and poorly coordinated delivery of essential Allied Health support in addition to poor collaboration with primary care.

How

Patients are assessed and managed at home by a multidisciplinary team, who then coordinate their care between outpatient, inpatient and at-home care.

Key benefits and outcomes

- Patients are seen in a timely fashion in their own home by multidisciplinary team
- Fewer appointments and less travel for patients with reduced hospital outpatient occasions of service and unplanned admissions
- Coordinated care with increased collaboration with primary care
- 85-90 per cent of patients are seen by community services within two weeks of referral
- 100 per cent of patients have appropriate end of life planning and timely palliative care referral with most people choose end of life care outside of the acute hospital
- Improved family support.

Ongoing challenges

Not a funded program and only for MND. Currently no direct access to Speech Pathology.

More information: https://metrosouth.health.qld.gov.au/news/one-of-a-kind-service-helping-mnd-sufferers-at-home

Queensland Remote Chemotherapy Supervision (QReCS) Model

Presenter: Prof Sabe Sabesan, Staff Specialist, Townsville Cancer Centre, Townsville University Hospital

The administration of chemotherapy regimens in rural and remote hospitals using a remote telenursing chemotherapy supervision model.

Why

Most rural towns cannot provide chemotherapy services locally as a stand-alone facility due to shortage of and inability to attract specialist nurses, doctors, and pharmacists. This forces people to waste time and money on travel when they are faced with potentially shorter survival.

How

Co-designed by statewide rural and cancer clinical networks, statewide telehealth services and staff of Townsville Cancer Centre and Townsville Hospital and Health Service (THHS) rural sector, the model uses established telehealth platforms and systemic therapy administration frameworks to deliver therapy closer to home.

Key benefits and Outcomes

- Cancer care closer to home in many rural towns.
- Shared care models with primary care at many rural sites.
- Enhanced collaboration between larger centres and rural sites and enhanced scope and capabilities of rural sites.
- Collaboration between HHSs, with some HHSs incorporating the model as routine business.
- Accepted as a model of care by CEQ. Other services leveraging the model including neurology, nephrology, and rheumatology. Western Australia Department of Health (DoH) has used this model to serve the entire state.
- Feasibility and efficacy of QReCS proven through research (Sabesan S, 2018).
- Proven return on investment by Deloitte evaluation.

Ongoing challenges and opportunities

- Implementation largely in the hands of champions
- Greater system ownership at Queensland DoH, and executive & divisional layers within HHSs, along with activity based funding recognition will improve scale up.
- Models of care could be explicit in operational plans of HHSs and DoH.

More information: https://clinicalexcellence.qld.gov.au/improvement-exchange/nqrcs

Virtual Outpatient Integration for Care Delivery (VOICeD)

Presenter: Dr Gaurav Puri, Clinical Director Endocrinology, Logan Hospital

VOICeD allows a person receiving care from more than one clinician to see multiple healthcare providers at one appointment, via telehealth. The person can see each care provider individually and / or a multidisciplinary team meeting can be held to further support comprehensive care.

Why

Making care more accessible and convenient for consumers with chronic disease.

How

Consumer co-designed model designed around user experience using telehealth.

Key benefits and outcomes

- Care close to, or at home – 'brings you care, anywhere'.
- Improved user experience for both consumers as well as care providers for better clinical outcomes and cost efficiency of care.
- The service is expanding.
- VOICeD releases 16 per cent capacity back into the system.
- VOICeD received coveted 'Consumer Choice Award' at Clinical Excellence Showcase 2021.

Ongoing challenges and opportunities

- Greater system-wide engagement will improve timely dissemination of innovation.
- Lack of unified Queensland Health (QH) Virtual Care identity and branding.
- Critical important of consumer testing /of multiple products for a variety of consumers.

More information: https://clinicalexcellence.qld.gov.au/improvement-exchange/virtual-outpatient-integration-chronic-disease-voiced

Residential Aged Care Facility Acute Support Service (RASS)

Presenter: Dr Ellen Burkett, Emergency Medicine Consultant, Princess Alexandra Hospital

A model of care that has expanded the choice of care setting for residents of aged care facilities with acute healthcare needs. When a resident has an acute care need, their clinician can access a specialist via telephone triage in a timely manner.

Why

Evidence tells us that ED presentations for older people are markedly increasing and are often associated with a prolonged length of stay, high transport costs, and higher rates of re-presentation and hospital re-admission. Consumers have an expressed wish to be treated closer to home.

Key benefits

- Telephone triage accessible to clinicians across the care continuum.
- Care is collaboratively planned with the resident or their health decision maker and the GP and facility clinicians.
- A variety of responses are available including telehealth or in-person specialist reviews, or streamlined access to an appropriate hospital or community service.
- Evidence-based clinical pathways from point of illness support improved care and standardise referrals.
- ED and inpatient care is being improved by gerontic specialist nurses performing structured gerontic assessment and care planning, supported by geriatric education modules for ED nurses.
- Supports positive collaboration between RACF, primary care and hospital sectors including bilateral education across the care continuum.

Outcomes

- Significant avoidance of ED presentations, reduced hospital admissions and improved outcomes for residents.
- Improved processes of care across a range of clinical indicators
- External evaluation has identified a 610 percent return on Queensland Health investment.

Ongoing challenges and opportunities

- QH data systems do not currently support accurate identification of the RACF resident – a real-time data linkage to Commonwealth aged care identifiers is urgently required
- There is an increasing shortage of GPs servicing aged care residents that warrants an urgent collaborative response from Commonwealth and state governments to support sustainable models of primary care for aged care residents

More information: https://clinicalexcellence.qld.gov.au/priority-areas/service-improvement/improving-quality-safety-and-care-older-queenslanders/rass

Metro North Virtual Emergency Department (Virtual ED)

Presenter: Dr Kim Hansen, Director Virtual Emergency Department, Metro North Hospital and Health Service

The Virtual ED enables GPs and other clinicians to speak with a triage nurse followed by a consult with an Emergency Physician. A direct patient facing model has also been established via a video consult platform.

Why

Increasing ED presentations, with a large cohort of patients presenting as a means to access healthcare, rather than requiring emergency medicine and nursing care.

Key benefits

- Allows healthcare workers such as general practitioners to consult an emergency specialist doctor when with their patient, without the resources involved in a transfer and presentation to a physical ED to get an opinion.
- Allows patients to access timely emergency care from their own home via a video consult.
- The Virtual ED team can manage a series of patients from a large geographic area.

Outcomes

- About 80 per cent of patients are able to stay at home, hence a decrease in patients presenting to EDs.

Ongoing challenges

- Multiple digital and paper information systems.
- Rapid growth.
- An evolving model with increasing understanding of elements such as patient cohorts, patient flow and costings.

More information: https://metronorth.health.qld.gov.au/hospitals-services/virtual-ed

eConsults – Healthcare Improvement Unit

Presenter: Matt Page, Principal Project Officer, Telehealth

A type of telehealth where healthcare providers can communicate online, requesting and receiving timely written clinical assessments from a specialist service.

Why

To improve access to specialty advice for community healthcare providers. Accepted and used in numerous health systems around the world and literature supports eConsults as a core component of reform and optimisation.

Key benefits and outcomes

- Allows rapid access to specialist service opinion.
- Can inform the referral decision and if required, can enhance the referral.
- Potentially to reduce unnecessary or avoidable outpatient occasions of service .
- Supports community general practice and rural and remote and regional health facilities to treat patients closer to where they live.
- Doesn't require the patient to be present and doesn't require real-time communication.

Ongoing challenges and opportunities

- No standard platform or agreed way to do this across Queensland Health. The aim of developing the enterprise solution, and working in partnership with the Smart Referrals team, is to resolve this.
- Takes time to submit at requester end and time to review at specialist end.
- To date, 11 instances of eConsult in several HHSs have gone live across the state, with a further seven sites in the business requirements phase.
- An enterprise digital solution for any specialist service, is also under development to improve consistency.

Rapid Access Specialty Care

Presenter: Dr Mark Waters, Senior Clinical Advisor, Healthcare Purchasing and System Performance Division.

A model of care that enables patients with chronic respiratory disease to bypass the Emergency Department and directly access their known clinical care team during acute episodes, allowing continuity of care with their treating team. Currently being trialled at Sunshine Coast University Hospital (SCUH) (Clinical Excellence Queensland, 2022).

Why

Known patients of specialist teams are required to seek care from the Emergency Department during an exacerbation of their chronic illness, rather than going directly to their known care team. This adds to the presentations at EDs, and patients are usually admitted.

How

When known patients of the service are discharged from the respiratory ward, they are given the respiratory nurse practitioner's (NP) mobile phone number. General Practitioners are also advised of this number. When calling the NP, there are three options:

1. Telephone advice.
2. Consult with NP and respiratory advanced trainees in rapid access clinic that day or next day.
3. Direct admission to the ward, in consultation with advanced trainee or consultant

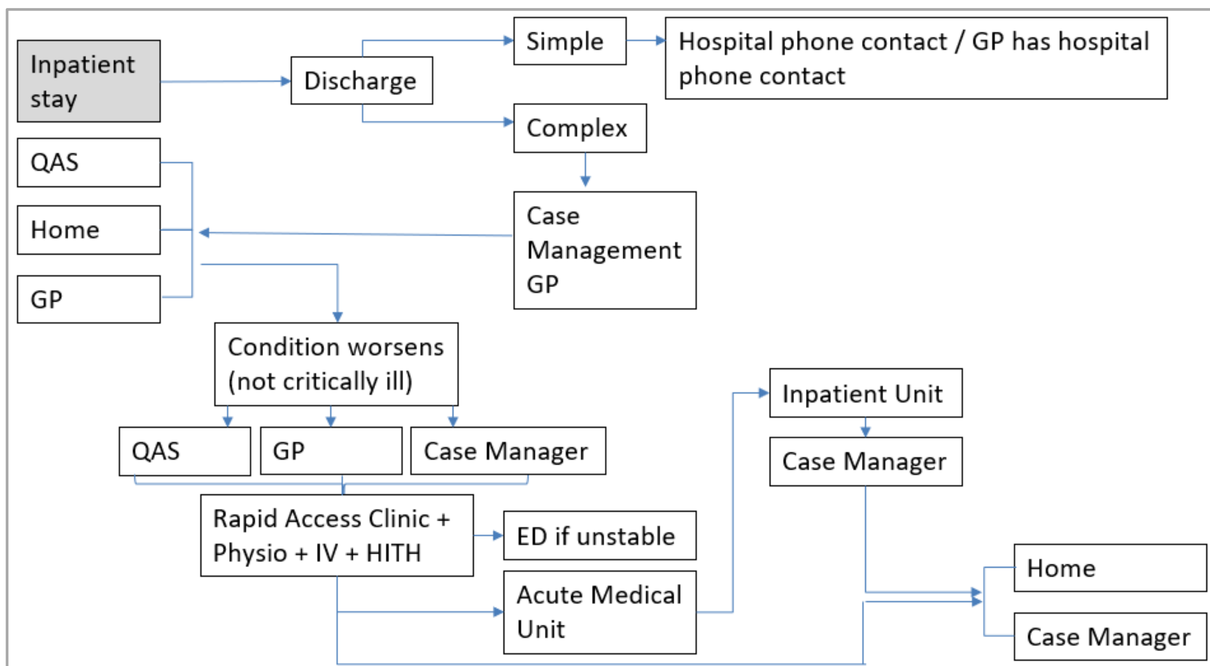

Figure 5 Proposed known patient rapid access workflow

Key benefits

- Scalable and almost cost-neutral.
- Continuity of care with known patients having direct access to specialist team.
- Reduced ED congestion.

Outcomes

In the first four weeks of the trial, 64 patients had accessed the service. Of those 64, 10 had telehealth consultations, 40 had physical reviews in the rapid access clinic, 13 were directly admitted to the ward, only one patient was directed to the Emergency Department.

Appendix 2 – Meeting agenda

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Reimagining healthcare: for the next phase and beyond (radical thinking required!)

10.00am – 12.00pm, Wednesday 09 March 2022

Please join by clicking on the **Zoom** link below (from 9.30am for 10.00am start):

From 9:30am	**Join** **Click to join Zoom meeting:**
10:00am	**Meeting facilitator: welcome, acknowledgement, context and housekeeping** Dr Tanya Kelly, Chair, Queensland Clinical Senate - Use of Zoom and Mentimeter - Encourage questions and/or chat in the discussion - Framework for meeting series ○ Session 1 (09 March 2022) – Setting the scene and understanding what matters to us (2 hours). ○ Session 2 (20 April 2022) – Design thinking Workshop - What does great care look like right now? Includes a sequence of consumer scenarios (3 hours). ○ Session 3 (25 May 2022) – How do we get there, what barriers need to be removed? (2 hours).
	Session 1: Setting the scene to reimagine healthcare Objective: To understand the current healthcare landscape, forward strategy and reform activities. - Questions and answers after each presentation
10:05am	**Healthcare reform** Mr Shaun Drummond, Chief Operating Officer, Queensland Health
10.35am	**Clinical perspectives on healthcare reform** Dr Elizabeth Whiting, Executive Director Clinical Services, Metro North Hospital and Health Service
10:55am	**Consumer experience** Ms Zehnab Vayani, Healthcare Consumer Representative

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11.15am	**Meeting facilitator check-in** Dr Tanya Kelly, Chair, Queensland Clinical Senate
11:20am	**Individual work** (30 mins remaining in main group, individuals will use Mentimeter to answer 3-5 questions depending on time) - Everyone log onto Mentimeter (2 minutes) - What are you personally most concerned about on a day-to-day basis? - Over the longer term, what challenges are important from your perspective? - What do we do really well that we can build on? - What is the elephant in the room for you? - If it is so obvious, why haven't we fixed it? - What consumer / clinical scenarios should we explore in session 2?
11.50am	**Feedback from groupwork** (5 mins) • Opportunity to raise any key gaps/problems identified (remainder captured through MS Forms)
11.55am	**Wrap-up and reflection** (5 mins) Dr Tanya Kelly, Chair, Queensland Clinical Senate - *Opportunity to complete meeting evaluation via*
12.00pm	**Meeting Close**

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Reimagining healthcare: for the next phase and beyond (radical thinking required!)

10am – 1pm, Wednesday 20 April 2022

Please join by clicking on the **Zoom** link in the appointment (from 9.30am for 10.00am start):

From 9:30am	**Join (see link in appointment)**
10:00am	**Meeting facilitator: welcome, acknowledgement, context and housekeeping** Dr Tanya Kelly, Chair, Queensland Clinical Senate - Introduction - Framework for meeting series o Session 1 – The Why: The burning platform for change and understanding what matters to us (2 hours - virtual). o **Session 2 – The What: Consumer Scenario Design Workshop – Rewriting the scenario for plus 5 years. (3 hours - virtual).** o Session 3 – The How: How do we get there, what barriers need to be removed? (2 days – face to face: 2nd/3rd June 2022). - Video update from session 1 along with key learnings
10.10am	**System innovation and Bridge labs** (3 minutes) Dr Satyan Chari, Program Director, CEQ Bridge Labs, Clinical Excellence Queensland
10:13am	**HEAL and design lens** (3 minutes) Professor Evonne Miller, Director, QUT Design Lab
10:18am	**Green shoots – working models that are reimagining healthcare (4 minutes each)** 1018 – Telechemotherapy – Dr Sabe Sabesan, Staff Specialist, Oncology Services, Townsville University Hospital 1022 - VOICED – Virtual Outpatient Integration for Chronic Disease (VOICeD) – Dr Gaurav Puri, Staff Specialist Endocrinology, Logan Hospital

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Time	Item
	1026 – Community Based Multidisciplinary MND Clinic – A/Prof Craig Hukins, A/Prof Respiratory Medicine, Princess Alexandra Hospital 1030 – Residential Aged Care Facility Acute Support Service (RASS) – Dr Ellen Burkett, Emergency Medicine Consultant, Princess Alexandra Hospital 1034 – Metro North Virtual ED – Dr Kim Hansen, Director Virtual ED 1038 – eConsults – Healthcare Improvement Unit
10:42am	**BREAK** (8 mins)
10:50am	**Scenario presentations** (10 mins total) 1. **The referral pathway from GP to specialist** (*3 minutes, presented by Maureen Woodward, consumer representative)* 2. **The experience of being unwell, at home, at night** *(3 minutes, presented by Zehnab Vayani, consumer representative – pre-recorded)* 3. **The transition from inpatient to at-home care** *(3 minutes, presented by Jordan Frith, consumer representative)*
11:00am	**Groupwork** (break into 12 Zoom groups) – *Facilitator to act as scribe. Each team to choose pitch presenter.* 1. Idea generation (30 minutes) – design a model that improves outcomes and experience 2. Develop a 3-minute pitch (10 minutes) Rating scale: • Radical (disruptive potential) • Timely (provides care when and where it is needed) • Quality (maintains or improves quality of care) • Interdisciplinary (helps teams work together) • Sustainable (addresses resource constraints) Deliverable: • A one page (PowerPoint slide) summary of idea with title, description of how it works, how it helps the consumer and how it addresses the rating scale.
11:40am	**BREAK** (10 mins)
11:50am	**Shark Tank with whole group** (max 5 minutes per group with changeover) 3-minute pitch presentations with live whole of group rating (based on 5-point rating scale above) with Mentimeter Options to add further team comments in the Zoom chat
12:50pm	**Wrap-up, reflection and connection to session 3** (10 mins) Dr Tanya Kelly, Chair, Queensland Clinical Senate - *Opportunity to complete meeting evaluation via MS Forms*
13.00pm	**Meeting Close**

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Reimagining healthcare: for the next phase and beyond - Session #3

5.00–9.00pm, Thursday 2 June 2022, evening session
Venue: Hotel Grand Chancellor, 23 Leichhardt Street, Brisbane 4000
Roma, Terrace and Wickham rooms

Time	Item
5:00 pm	**Registration and networking (pre-function area, level 1)**
6:00 pm	**Welcome to Country** Songwoman Maroochy
6:15 pm	**Overall learnings from 'Reimagining Healthcare' sessions 1 and 2** Dr Tanya Kelly, Chair, Queensland Clinical Senate
6:45 pm	**Dinner & dessert**
7:45 pm	**Consumer Insight** Mrs Zehnab Vayani, Consumer and Carer Representative
8:00 pm	**Leaders Q&A panel** • Mr Shaun Drummond, A/Director-General, Queensland Health • Dr David Rosengren, A/Chief Operations Officer, Queensland Health • Dr Helen Brown, A/Deputy Director-General, Clinical Excellence Queensland • Dr Elizabeth Whiting, Clinical Lead, Reform Office, Queensland Health • Prof Keith McNeil, A/Deputy Director-General Prevention Division, Chief Medical Officer and Chief Clinical Information Officer
8:45 pm	**Meeting close**

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Reimagining healthcare: for the next phase and beyond - Session #3

8.00am–4.00pm, Friday 3 June 2022
Venue: Hotel Grand Chancellor, 23 Leichhardt Street, Brisbane 4000
Terrace, Wickham & Leichhardt rooms

8.00 am	**Check in**
8.10 am	**Official opening and welcome** Mr Shaun Drummond, A/Director-General, Queensland Health
8.20 am	**Opening address** Prof Erwin Loh, Group Chief Medical Officer & Group General Manager of Clinical Governance, St Vincent's Health Australia
8.40 am	**Healthcare Reform – A local and global challenge** Queensland Health, Healthcare Reform Team
9.00 am	**'Pathways to care' introduction and plan for the day** Dr Tanya Kelly, Chair, Queensland Clinical Senate
9.10 am	**Workshop 1 – Enabling these models through activity capture and funding** Ms Toni Cunningham, Senior Director, Healthcare Purchasing, and Commonwealth Funding representative
10.10 am	**Morning tea**
10.30 am	**Workshop 2 – Enabling these models through digital technologies** Mr Damian Green, Deputy Director-General, eHealth Queensland

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11.30 am	**Workshop 3 – Enabling these models through internal changes** Prof Ian Scott, Chair, Queensland Clinical Networks Executive Dr Mark Waters, Senior Clinical Advisor, HPSP
12.30 pm	**Lunch**
1.30 pm	**Workshop 4 – Enabling these models in primary care** Dr Carl de Wet, Clinical Director, Specialist Medical Services, Gold Coast Hospital and Health Service
2.30 pm	**Afternoon tea**
2.50 pm	**Recommendation development and close** Dr Tanya Kelly, Chair, Queensland Clinical Senate
3.50 pm	**Meeting close**
4:00pm	**Depart**

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